# Reproductive Health Survey
# Azerbaijan, 2001

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## Selected Findings

# REPRODUCTIVE HEALTH SURVEY AZERBAIJAN, 2001

## SELECTED FINDINGS

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# PREFACE

Over the last 10 years since regaining its independence Azerbaijan has faced considerable difficulties resolving some of the lingering problems from the previous system coupled with the challenges of the transition period. The war, the largest refugee and internally displaced population in the region, as well as ethnic, social and economic problems hinder reconstruction of governmental and administrative systems including health sector.

The reforms undertaken in public health care require first of all improvement of the health information system, particularly the statistics concerning mother and child health. Population-based nationwide health surveys serve as a significant source of information in this field and assists in clarifying several health-related issues not covered by the official statistics.

The report brought to your attention reflects preliminary results of the first nationwide reproductive health survey conducted among Azeri women. The research was funded by USAID, UNFPA and UNHCR through Mercy Corps, and carried out by ADRA Azerbaijan with the technical assistance of the Centers of Disease Control and Prevention, USA.

The research provides data on reproductive health behavior peculiarities of Azeri women, their fertility, planning status of pregnancies, abortions, use of women's health services, contraceptive knowledge and attitudes, knowledge about STD and AIDS transmission and prevention. Analysis of survey results assists in revealing high-risk groups and provides focus for future reproductive health programs.

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

Academician Ali Insanov
Minister of Health
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# I.  INTRODUCTION

Azerbaijan again became an independent country with the dissolution of the Soviet Union in 1991. A country of about 86,600 km$^2$ in the Caucasus region, it borders on Iran to the south, Armenia to the west, Georgia and Russia to the north, and the Caspian Sea to the east. The Great Caucasus Mountain range passes though the northeastern part of the country. Overall, Azerbaijan has only 0.2 hectares of arable land per capita. The industrialized Absheron Peninsula suffers from pollution of its air, soil, and water, including the Caspian Sea. The Azerbaijan State Committee on Ecology has classified the city of Sumgait, which is on the Peninsula, an ecological disaster area, a legacy of its years as a major industrial center of the Soviet Union. About 51% of the 8.1 million people of Azerbaijan live in urban areas. Approximately a third of the population inhabits the Absheron area, where the capital of Azerbaijan, Baku, is located. About 30% of the total population is under the age of 15 years, and 6% over the age of 65. Women make up 51% of the population (SCS, 2001). The life expectancy at birth has been increasing recently; its 2000 level was 75.1 years for women but only 68.6 years for men (SCS, 2001).

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

Eighty-nine percent of the population speaks Azeri, a language of Turkic origin, 3% Russian, 2% Armenian, and 6% other languages (UNFPA, 1999b). In pre-Soviet times the Azeri language was written with the Arabic alphabet. The Soviet policy forced a change to Latin (in 1926) and later to Cyrillic lettering (in 1940) but recently the written language has return to its Latin form (Gurbanov A, 1967; Elliot M., 1999). Literacy is estimated to be about 97% for the population over the age of 14 years, although rates are somewhat higher for men than for women (CIA, 2001). More than 93% of the population identify themselves as Muslim, 2.5% as Russian Orthodox, and 2.3% as Armenian Orthodox (MOH and SCS, 2001). Most people report that they do not practice their religion, and both the culture and the government are secular, not theocratic.

Upon the collapse of the USSR in 1991, Armenia and Azerbaijan, both former republics of the Soviet Union, engaged in a protracted war over Nagorno-Karabakh, the predominately Armenian-populated region within the Azerbaijan territory. In 1994, the two countries reached a cease-fire agreement, but Armenia still occupies about 20% of Azerbaijan. The fighting has left Azerbaijan with some 790,000 internally displaced persons and refugees (IDP/Rs)—570,000 Azeri ethnics displaced from Nagorno-Karabakh and the surrounding occupied territories and 220,000 Azeri residents who fled Armenia and relocated in Azerbaijan when the war started—about 10% of its

entire population (UNHCR, 1999). They constitute the largest proportion of IDP/Rs concentrated in one country of the Caucasus region. Currently, it is estimated that about two thirds of the IDPs continue to live in improvised housing conditions (e.g., public buildings, shelters, railroad wagons, mudhouses, dugouts, and tents) (UNDP, 1999).

The constitution of Azerbaijan, ratified in 1995, established the government as a democratic republic. Citizens over the age of 18 are eligible to vote and presidential elections are held every 5 years. The president appoints the prime minister and the Council of Ministers, contingent upon approval by the National Assembly. The National Assembly is elected every 5 years, with a combination of both direct and proportional representation. The president appoints the president and the vice-president of the Constitutional Court, which possesses the right of judicial review over the legislation of the National Assembly and presidential decrees. There are more than 20 political parties active in Azerbaijan. At the subnational level there are regional *raions* (counties) and city administrative units (UNDP, 1999).

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

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

During the Soviet Union years, the Central Ministry of Health in Moscow oversaw the Azerbaijan Ministry of Health. The Soviet Union handed down all plans and standards that the Republic should meet, even information sheets for patient education. Emphasis was on medical treatment and funds were allocated according to the number of hospital beds. Under the Soviet system, there were various kinds of health care facilities. Hospitals existed at several levels: small rural hospitals, raion or district hospitals for more severe cases, and republic-level hospitals for the most seriously ill and injured. Pediatric and adult polyclinics staffed with specialists served urban areas. Sometimes businesses with numerous employees also had their own polyclinics. Rural areas also had polyclinics but without specialized physicians. Feldsher-ackucher points (FAPs) also served as the

primary level of care for residents of the most rural regions. Educational institutions placed greater emphasis on producing physicians rather than nurses, physician assistants, or health practitioners from other disciplines (UNFPA, 1999b).

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

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

After the collapse of the USSR, the GDP and wages in Azerbaijan declined. The government expenditures for health in 1996 represented 1.6% of the GDP, down almost 50% from the 1990 level of 2.9%. In reality, the decline has been even more dramatic, as the total GDP declined and the population rose substantially in the aftermath of the Nagorno-Karabakh war with Armenia (Bladen C et al., 1998). The real governmental expenditures on health are estimated to be less than one quarter of the preindependence level, amounting to only about US$ 7.00 per capita (monetary

amounts refer to 1997 U.S. dollars). Most of the care is provided on a fee-for-service basis, with patients paying for the largest share of costs; however, some categories, including pregnant and post-partum women, continue to receive free health coverage (Public Health Protection Law 360-IQ, 1997; Presidential Decree 62, 1997). According to World Bank estimates, the out-of-pocket costs for health accounted for over 80% of spending in the health sector in 1995 (World Bank, 1997). Even when out-of-pocket costs are factored in, the health expenditures per capita (the sum of public and private expenditures on health divided by the country's population) amount to only $36.00 per capita, lower than in Georgia and Kazakhstan ($46.00 and $86.00 per capita) but higher than in Armenia ($27.00 per capita) (monetary amounts refer to 2001 U.S. dollars) (World Bank, 2001).

During the 1990s, Azerbaijan has experienced a steep increase in maternal mortality (UNFPA, 1999; SCS, 2001). However, after an initial surge in the maternal mortality rate (MMR) in 1991–1994, culminating with 43.8 deaths per 100,000 live births in 1994, a rate almost five times higher than the 1990 level, MMR stabilized in the 1995–1999 period and started to decline in 2000. The official estimate of maternal mortality for 2000 was 37.6 deaths per 100,000 live births, almost four times higher than the 1991 level of 10.4 deaths per 100,000 live births (MOH and SCS, 2001). According to the official statistics, only 1% of the maternal deaths in the past 3 years were due to "artificial medical abortion," none to unsafe abortions. However, a recent UNFPA country assessment report suggests that the actual maternal mortality rate is considerably higher (UNFPA, 1999b).

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

Abortion is the most common form of birth control; three fourths of sexually active women reported at least one lifetime induced abortion in a small area sample survey of Relief International clinics (Posner SF et al., 2001). Almost two thirds of women reported recent symptoms suggestive of sexually transmitted diseases, and the prevalence of pelvic inflammatory disease due to sexually transmitted diseases (STDs) is estimated to be high (Claeys P et al., 2001; Kerimova J et al, 2000). The fertility rate started to drop prior to 1990, but the decline during the past decade has been at a higher pace. From a level of 3.3 births per woman in 1980, the total fertility rate (TFR) decreased slowly to about 2.7 in the period 1981–1993 but fell abruptly to slightly below a replacement level of 2 births per woman in 1998 (MOH, 2001). The absolute number of births decreased by 36%

between 1990 and 2000 (from 182,989 births to 116,994 births) (SCS, 2001). Women typically marry and begin families at a young age, the average age at marriage being 20.5 years. Most do not have premarital sexual relationships and births out-of-wedlock are rare (less than 5% of all births, according to the Ministry of Health) (MOH and SCS, 2001). Unmarried women generally do not live on their own, no matter what their age, education, or professional status.

Although the reported fertility rate has declined, the population is expected to continue to increase because of the great number of women of childbearing age who were born during the earlier periods of high fertility. The population is expected to stabilize at about 9.5 million in 2025. There is a net emigration from the country, mostly men from the larger cities going abroad to look for better economic opportunities. Infant mortality and under-five mortality were officially presented as 12.8 deaths per 1,000 live births and 25.8 deaths per 1,000 live births, respectively, as of 2000 (SCS, 2001; MOH, 2001). Both these rates have declined considerably from those reported in the late fifties and early sixties. However, the official statistics may be plagued by problems such as the nonregistration of births of infants who die shortly after birth and the misclassification of early neonatal deaths and early deaths of premature infants as stillbirths. International agencies suggest that the actual fertility rate is 2.2 births per woman (CIA, 2001) and that the mortality rates may be much higher. Mortality rates are reportedly higher for children in rural locations or with poor socioeconomic status (UNFPA, 1999b).

These statistics should be interpreted with caution. The health information system during the Soviet times was often flawed by overreporting of "positive" results, which could bring rewards, and underreporting of undesired statistics, which could lead to disciplinary actions (Bladen C et al., 1998). Even when the data collected were reliable, they usually satisfied the needs of "centralized" decision-making but were less useful for describing the health status and the burden of disease on the population at subnational levels. Although the old system is no longer in place, some of its characteristics are likely to have been retained. In addition, with the emerging private health sector and the shifting of health costs from the state to the individual, official data are unlikely to be complete (Bladen C et al., 1998).

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

In conclusion, Azerbaijan has undergone major socioeconomic and political changes: the war with

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

-to assess fertility, abortion, contraception, and various other reproductive health issues in Azerbaijan;

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

-to study factors that affect fertility, contraceptive use, and maternal and infant health, such as geographic and sociodemographic factors, breastfeeding patterns, use of induced abortion, and availability of family planning services;

-to identify characteristics of women at risk of unintended pregnancy;

-to identify high-risk groups and focus additional reproductive health studies on them;

-to obtain data on the knowledge, attitudes, and behavior of young adults 15–24 years of age;

-to provide data on the level of reported STD symptoms and knowledge about transmission and prevention of AIDS;

-to provide data on women living in prolonged displacement.

The Division of Reproductive Health (DRH), Centers for Disease Control and Prevention (CDC), Atlanta, Georgia, was responsible for coordinating survey activities and provided technical assistance to the local implementing agency, the Adventist Development and Relief Agency (ADRA), Baku, Azerbaijan. Funding was provided by the United States Agency for International Development (USAID)—through the umbrella agreement managed by Mercy Corps (MC)—the United Nations Population Fund (UNFPA), and United Nations High Commissioner for Refugees (UNHCR).

## II. METHODOLOGY

### 2.1 Sampling Design

The AZRHS01 is based on in-person, face-to-face interviews with 7,668 women at their homes. The survey was designed to collect information from a representative sample of women of reproductive age throughout Azerbaijan. The universe from which the respondents were selected included all females between the ages of 15 and 44 years, regardless of marital status, who were living in households in Azerbaijan when the survey was carried out (excluding the autonomous region of Nakhchivan and the occupied territories of Nagorno-Karabakh and surrounding areas).

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

The household survey utilized a multistage sampling design using the recent 1999 census as the sampling frame (SCS, 2000). Four independent sampling strata were created by grouping together regions with a similar concentration of IDPs and refugees (IDP/Rs), as recorded by UNHCR. Regions with a higher concentration of IDP/Rs were oversampled for programmatic reasons. The oversampling in regions heavily populated by IDP/Rs was needed to include enough displaced women in the sample to allow independent estimates of their reproductive health status. This technique illustrates how surveys may be designed and integrated in the development, monitoring, and evaluation of targeted reproductive health programs. The oversampling of IDP/Rs was specifically designed to assess the reproductive health status of these women and measure the impact of the Azerbaijan Humanitarian Assistance Project (AHAP) funded by USAID and various projects targeting the IDP population supported by UNHCR and UNFPA. These projects aim at reducing the reliance on induced abortion by increasing access to and availability of effective contraceptive methods and by reducing the prevalence of STDs through the promotion of healthy behaviors among women (e.g., routine gynecologic exams) and child survival activities. These projects encompass various interventions, such as the establishment of modern health clinics for women, training of health professionals, development of information, education, and communication (IEC) messages, social marketing, and provision of high-quality contraceptive supplies.

The first stage of the three-stage sample design was a selection of census sectors with probability proportional to the number of households in each sector, after the sectors were grouped into four strata. This was accomplished by using a systematic sample with a random start in each stratum.

During the first stage 300 census sectors were selected and became primary sampling units (PSUs) as follows: Baku (80 PSUs), regions with over 30% of the population being IDP/Rs (100 PSUs), regions with 20%–30% of the population being IDP/Rs (50 PSUs), and all other regions (70 PSUs). In the second stage of sampling, clusters of households were randomly selected in each census sector chosen in the first stage. Determination of the cluster size was based on the number of households required to obtain an average of 20 completed interviews per cluster. The total number of households in each cluster took into account estimates of unoccupied households, average number of women aged 15–44 per household, the interview of only one respondent per household, and an estimated response rate of 90% in urban areas and 92% in rural areas. Finally, in each of the households selected, one woman between the ages of 15 and 44 was selected at random for interview (if there was more than one woman in the household).

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

## 2.2 Data Collection

The interviews were performed by 30 female interviewers specially trained in interview techniques, survey procedures, and questionnaire content before the beginning of fieldwork. Interviewer training was managed by ADRA, with the involvement of Dr. Shafag Rahimova, survey director; Conrad Vine, health coordinator; Farid Agamaliyev, project manager; Linda Fardy Hayes, survey consultant; and the CDC team (Florina Serbanescu and Natalia Melnikova for the reproductive health component and Geraldine Perry for the nutrition component). Interviewer training took place at the Ministry of Health International Training and Service Center just before data collection began and consisted of one week of classroom training in fieldwork procedures and proper administration of the questionnaire and one week of practical training in the field with close monitoring by the trainers. At the end of the training period, six teams were selected, each consisting of four female interviewers, one nutritionist, and one supervisor. Fieldwork was managed by staff of ADRA with technical assistance from DRH/CDC. The overall fieldwork implementation was supervised by two fieldwork coordinators (Saida Ismaylova and Mahbuba Khalilova). Fieldwork lasted from April through July 2001. Each team was assigned to visit a number of primary sampling units in all regions of the country and traveled by car throughout the country on planned itineraries. Interviews

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were conducted at the homes of respondents and lasted, on average, about 40 minutes (excludes 79 interviews with missing information about the time at the beginning or the end of the interview). Although most interviews were conducted in Azeri, a Russian language questionnaire was also available . All interviewers were bilingual. Completed questionnaires were first reviewed in the field by team supervisors and then were taken by the fieldwork coordinators to the national State Committee of Statistics (SCS) headquarters for data processing.

## 2.3 Response Rates

Of the 11,162 households selected in the household sample, 8,246 included at least one eligible woman (aged 15–44 years). Of these identified respondents, 7,668 women were successfully interviewed, yielding a response rate of 93%. Virtually all respondents who were selected to participate and who could be reached agreed to be interviewed and were very cooperative. Response rates were lower in Baku and its surroundings (86%) than in other urban areas (94%) and rural areas (96%) (Table 2.3.1).

TABLE 2.3.1
Results of Household Visits and Interview Status of Eligible Women by Residence (Percent Distribution)
Reproductive Health Survey: Azerbaijan, 2001

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

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

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

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

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

* SCS preliminary data based on the 1999 census.

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

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# III. CHARACTERISTICS OF THE SAMPLE

## 3.1 Household Characteristics

Similar to the definition used in other surveys and in the 1999 Azerbaijan census, *household* was defined as a person or group of persons who shared the dwelling and the related living expenses. Visitors were not counted in the household composition and were not included in the number of eligible respondents. After all eligible respondents in the household were listed, only one woman aged 15–44 years was randomly selected for the individual interview.

A typical Azeri household containing an eligible respondent was composed of almost five persons (Table 3.1.1). Households in Baku contained, on average, one person less than did rural households (4.4 persons per household vs. 5.3 persons per household). The larger household size in rural areas can be partially explained by higher fertility levels (see Chapter IV).

One- or two-person households (presumably childless couples) were very uncommon (1% and 5%, respectively); these types of households are more frequent in Baku and other urban areas (8% and 6%) than in rural areas (4%). Overall, households with eight or more persons were also uncommon; they were less prevalent in urban areas (4%) and more prevalent in rural areas (11%).

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

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

* Excludes one household whose number of inhabitants was unknown.

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

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

Among durable consumer goods, televisions were available in almost every household with women of reproductive age (91%), with higher coverage in urban areas (95%–98%) than in rural areas (86%). Almost all households had refrigerators (78%), especially in urban areas, and Baku in particular (85% and 96%), but less frequently in rural areas (65%). As expected, almost all households in rural areas had a vegetable garden (89%), whereas only one in two and one in five urban and Baku households, respectively, had such gardens. Video recorders were not very widespread: almost two in three households in Baku but only 37% and 22% in other urban and rural areas owned a video recorder. Only one in four families owned a car in Azerbaijan, with little variation by residence. Also, very few families owned a vacation home or a secondary residence (14%). The use of mobile phones was low (19% of women reported they had one) and was concentrated in Baku and other urban areas (41% and 17%). Crowding did not substantially differ between urban and rural households, although the average number of persons per household was lower in urban areas than in rural areas (data not shown). The IDP/R households were the most crowded.

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TABLE 3.1.2

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

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

\* IDP/Rs include persons who fled Nagorno Karabakh, surrounding occupied territories (internally displaced persons) or Armenia (refugees) due to war; non-IDP/Rs were further divided into non-IDP/Rs living in conflict-affected areas (CA), where 20% or more of population is IDP/Rs, and non-IDP/Rs living in areas not/less affected by the war (NCA), that is areas with less than 20% of population being IDP/Rs.

† Total number of persons living in the household divided by total number of rooms in the house (not including kitchen and bathroom) was higher than one.

## 3.2 Characteristics of the Respondents

Overall, 39% of the women in the sample were young adults (15–24 years of age) (Table 3.2.1). The age distribution was slightly younger in rural areas, where young adults represented 41% of the women, compared with 38% in urban areas. Age distribution varied little by region; the only notable exceptions were in the South region, where the population was slightly younger than the country average (43% young adults) and the Central region, where the proportion of young adults was significantly lower (32%).

A slight majority of women were legally married (58%); additionally, less than one percent was in a consensual union (unregistered marriage or living with a partner "as husband and wife" but not

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

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

legally married). Respondents in these two categories constitute currently married or in union respondents. There was no significant urban-rural or regional difference in marital status. Divorce and separation appeared uncommon; only 3% of women reported that they were previously married and 2% were widowed. More than one of three women (36%) had never been married or lived with a partner. Official statistics show that Azerbaijan has a fertility rate slightly above the replacement level of two children per woman (2.2 births per woman in 1999, according to SCS). Fertility levels reported in AZRHS01 were similar to the official estimates. Although the percentage of childless urban women (41%), was lower than in rural areas (46%), more women reported three or more children in rural areas than in urban areas (26% vs. 22%) and in the South and Central regions (27%). Baku residents were the least likely to have three or more children (18%).

Most of the respondents completed secondary education (48%) or attended some years of postsecondary school (15% attended a technical college and 12% had some university training). The proportion who had received formal education beyond the secondary level was 1.5 times higher among urban than among rural residents (37% vs. 15%). Respondents residing in Baku were significantly more likely to have some postsecondary education (45%) than were respondents of other regions, particularly than those residing in the South region (13%). Azeri was the predominant ethnic group (90%), followed by Talish (4%), Lezgi (1.5%), Tat and Avar (1.3% and 1%). Most of the Talish population was concentrated in the South while the Lezgis and Tats were more likely to reside in the North and North-East regions. Russians represent less than 1% of the population; most of them reside in Baku (3%). Azeri was the principal language spoken in the household for the majority of respondents (90%), followed by Russian (4%) and Talish (3%). Women in Baku were significantly more likely to speak Russian in the family (14%) than were women outside Baku, even if they had an Azeri background.

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

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

## IV.    FERTILITY AND PREGNANCY EXPERIENCE

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

### 4.1  Fertility Levels and Patterns

During the past decade, scientifically designed nationwide population-based surveys of reproductive health have been conducted in many countries of eastern Europe and the former Soviet Union with support from USAID and UN agencies and technical assistance from the Centers for Disease Control (Reproductive Health Surveys) or Macro Incorporated (Demographic Health Surveys). All these surveys used similar methodology and questionnaires, thus allowing for good comparability across countries. Such surveys have been implemented in several countries of Eastern Europe and the former Soviet Union. These countries share a common history, including the recent social, political and economic changes since the fall of communism and the inheritance of the same state-subsidized health care system modeled after the Russian centralized system (Semashko model). Demographically, most of these countries have much in common in the areas of fertility and fertility regulation practices. As shown in Table 4.1.1, except for Uzbekistan and Kyrgyz Republic, most countries have relatively low fertility rates that have decreased even further recently, with high levels of childbearing among women in their 20's, followed by sharp declines at age 30 or older.

Current levels of fertility presented in Table 4.1.1 were estimated with the use of age-specific fertility rates calculated from information collected through the respondents' lifetime pregnancy histories. The total fertility rate (TFR) was computed by accumulating the age-specific fertility rates (ASFRs) and multiplying the sum by five. The TFR is thus defined as the average number of live births a woman would have during her reproductive lifetime (15–44) if she experienced the currently observed ASFRs. Numerators for the ASFRs were calculated by selecting live births that occurred during the 36-month period preceding the survey and grouping them (in 5-year age groups) by the age of the mother at the time of pregnancy outcome (calculated from the mother's reported date of birth).

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**Table 4.1.1**

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

| Country | Age-Specific Fertility Rate (per 1000)[†] | | | | | | Total Fertility Rate[‡] |
|---|---|---|---|---|---|---|---|
| | 15–19 | 20–24 | 25–29 | 30–34 | 35–39 | 40–44 | |
| Eastern European Region | | | | | | | |
| Czech Republic, 1993 | 49 | 176 | 92 | 41 | 11 | 4 | 1.9 |
| Romania, 1993 | 49 | 129 | 83 | 33 | 12 | 5 | 1.6 |
| Romania, 1999 | 36 | 100 | 83 | 29 | 13 | 2 | 1.3 |
| Russia (three oblasts[§]), 1996 | 36/36/60 | 98/108/140 | 62/56/55 | 31/31/30 | 4/11/5 | 3/3/0 | 1.2/1.2/1.5 |
| Russia (three oblasts[§]), 1999 | 46/39/41 | 83/109/128 | 68/72/80 | 30/25/21 | 8/16/10 | 8/3/3 | 1.2/1.3/1.4 |
| Moldova, 1997 | 57 | 158 | 88 | 40 | 17 | 6 | 1.8 |
| Ukraine, 1999 | 49 | 114 | 66 | 36 | 14 | 4 | 1.4 |
| | | | | | | | |
| Caucasus Region | | | | | | | |
| Georgia, 1999–2000 | 65 | 113 | 92 | 48 | 22 | 7 | 1.7 |
| Armenia, 2000 | 50 | 149 | 88 | 35 | 16 | 3 | 1.7 |
| Azerbaijan, 2001 | 44 | 151 | 133 | 58 | 19 | 9 | 2.1 |
| | | | | | | | |
| Central Asian Region | | | | | | | |
| Kazakhstan, 1995 | 64 | 190 | 136 | 67 | 35 | 7 | 2.5 |
| Kazakhstan, 1999 | 40 | 167 | 106 | 64 | 24 | 9 | 2.1 |
| Uzbekistan, 1996 | 61 | 266 | 176 | 114 | 39 | 9 | 3.3 |
| Kyrgyz Republic, 1997 | 75 | 246 | 179 | 113 | 47 | 13 | 3.4 |
| Turkmenistan, 2000 | 30 | 184 | 195 | 105 | 48 | 14 | 2.9 |

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

The denominators for the rates represent the number of woman-years lived in each specified 5-year age group by those mothers during the 3-year period preceding the survey. For example, the TFR for the 3 years preceding the survey in Azerbaijan was 2.1 births per woman, slightly above the replacement level. It is about 20% higher than the fertility rate of the other Caucasus region countries, Georgia and Armenia, but substantially lower than the central Asian republics, excepting Kazakhstan.

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TABLE 4.1.2

**Three-Year Age-Specific Fertility Rates Among All Women**
**AZRHS01 and Ministry of Health (MOH) Estimates**

| | Age-Specific Fertility Rate (per 1,000)[*] | | |
|---|---|---|---|
| Age Groups | 1998–2001 AZRHS01[†] | 1996–1998 AZRHS01[‡] | 1997–1998 MOH[¶] |
| 15–19 | 44 | 59 | 40 |
| 20–24 | 151 | 191 | 152 |
| 25–29 | 133 | 132 | 110 |
| 30–34 | 58 | 64 | 55 |
| 35–39 | 19 | 31 | 26 |
| 40–44 | (9) | (1) | 7 |
| **Total Fertility Rate (per woman)** | **2.1** | **2.4** | **2.0** |

[*] Age at pregnancy outcome.
[†] Live births occurring between May 1998 and April 2001.
[‡] Live births occurring between May 1996 and April 1998.
[¶] Average of the most recent available official data (1997–1998).
( ) Time exposed partially truncated because not all cases have exposure throughout the period of analysis.

Similar to women in other countries of the region, Azeri women initiate and complete childbearing at an early age. The highest fertility levels are among 20–24-year-old and 25–29-year-old women, accounting for 36% and 32%, respectively, of the TFR (Tables 4.1.1 and 4.1.2). Fertility among adolescent women (44 births per 1,000 women aged 15–19) is the fourth highest, contributing 11% of the TFR. Women aged 35–39 and 40–44 make minimal contributions to total fertility; their ASFRs account for only 5% and 2%, respectively, of overall fertility. Compared with its Caucasus neighbors, Azerbaijan exhibits the lowest adolescent fertility but the highest fertility rates for 20–24-year-old and 25–29-year-old women. Thus, its young adult fertility rate of 195 births per 1,000 women aged 15–24 years is similar to the rate in Armenia (199 births per 1,000) and higher than that in Georgia (178 births per 1,000).

Survey results show that the median age at first marriage among women of reproductive age ranges between 20 and 22 years in all countries mentioned in Table 4.1.1, and there is a strong desire to initiate childbearing soon after marriage (median age at first birth is typically 1–2 years after marriage). In Azerbaijan the median ages at first union and first birth were 22.3 and 23.7 years, respectively (Figure 4.1). Thus, most of the fertility for the youngest women is typically marital. Out-of-wedlock births are rare in Azerbaijan and unmarried women contribute very little to overall fertility (less than 5% of births were out-of-wedlock, according to official records).

Table 4.1.2 also shows the previous two 3-year-period ASFRs between 1996–2001 calculated

**Figure 4.1**
**Percent of Women Who Have Ever Been in Union and Ever Had a Live Birth Before Given Ages and Median Age at First Event, Life Table Estimates Reproductive Health Survey: Azerbaijan, 2001**
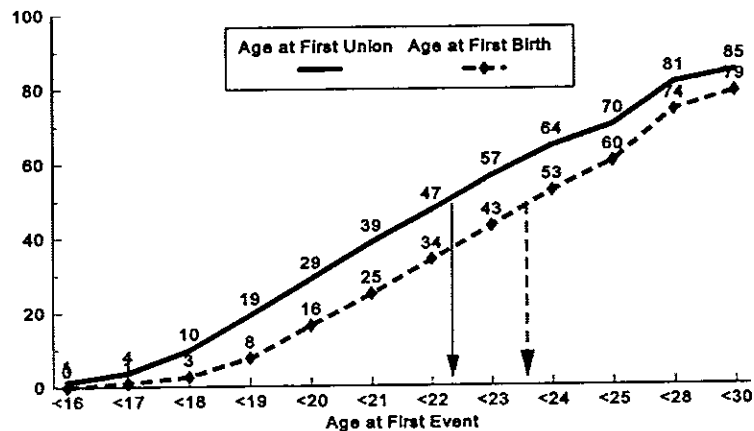
directly from the information on live births and maternal age (age at outcome) recorded in the respondents' pregnancy histories. Since women aged 45–49 years and women over 49 were not interviewed in the survey, by going farther back in time the rates for older women (age at outcome) represent partial fertility rates due to the truncation of the time exposure (e.g., some women aged 40–44 in 1996–1998 would be over 44 in 1999–2001 but only those aged 44 or less would have been selected to participate in the survey). These periods are compared with the official estimates for 1997–1998, the most recent official ASFRs available. Overall, the survey estimate of the TFR for 1996–1998 is 20% higher than the official TFR for 1997–1998. Similarly, the general fertility rate for 1998–2000, defined as the number of births per 1,000 women of reproductive age (15–44), was 70 births per 1,000 women aged 15–44 when calculated from the survey data but only 44 per 1,000 according to the vital records (data not shown). The most recent 3-year period TFR estimated from the AZRHS01 is similar to the 1997–1998 levels but probably higher than the current official reporting.

Table 4.1.3 shows the cumulative past fertility of women interviewed in the AZRHS01 (calculated as the percent distribution of women by the number of live births and stratified by the current age of each woman at the time of the interview). Overall, 43% of all women aged 15–44 were childless at the time of the interview, but only 9% of women currently in union had not had their first child. Although few women reported a birth before age 20, by age 29, 70% of all women had given birth.

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

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TABLE 4.1.3

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

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

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

Table 4.1.4 shows the ASFRs and TFRs among different subgroups. Fertility among women living in urban areas, including Baku, was on average almost 20% less than among rural women in the 3-year period preceding the interview. Most of the difference between rural and urban fertility rates was the result of higher ASFRs among rural residents aged 15–29 years; fertility at age 30 and older was similar in both rural and urban areas.

TABLE 4.1.4
**Three-Year\* Age-Specific Fertility Rates and Total Fertility Rates Among All Women Aged 15–44 Years**
**by Selected Characteristics**
**Reproductive Health Survey: Azerbaijan, 2001**

| Characteristic | Age-Specific Fertility Rate[†] | | | | | | Total Fertility Rate |
|---|---|---|---|---|---|---|---|
| | 15–19 | 20–24 | 25–29 | 30–34 | 35–39 | 40–44 | |
| **Total** | 44 | 151 | 133 | 58 | 19 | 9 | 2.1 |
| **Residence** | | | | | | | |
| Urban | 32 | 132 | 128 | 57 | 19 | 9 | 1.9 |
| Rural | 57 | 171 | 139 | 59 | 19 | 9 | 2.3 |
| **Region** | | | | | | | |
| Baku | 37 | 123 | 111 | 65 | 25 | 14 | 1.9 |
| North & North-East | 46 | 168 | 134 | 68 | 28 | 3 | 2.2 |
| West | 62 | 148 | 165 | 49 | 9 | 7 | 2.2 |
| South-West | 43 | 179 | 135 | 54 | 33 | 14 | 2.3 |
| South | 43 | 152 | 150 | 51 | 10 | 6 | 2.1 |
| Central | 33 | 148 | 119 | 51 | 8 | 9 | 1.8 |
| **Education** | | | | | | | |
| Secondary incomplete or less | 66 | 150 | 154 | 73 | 11 | 7 | 2.3 |
| Secondary complete | 39 | 175 | 123 | 54 | 24 | 9 | 2.1 |
| Technicum | 30 | 150 | 119 | 47 | 10 | 14 | 1.9 |
| University/Postgraduate | 9 | 83 | 162 | 80 | 24 | 3 | 1.8 |
| **Socioeconomic Status** | | | | | | | |
| Low | 53 | 171 | 140 | 65 | 19 | 7 | 2.3 |
| Middle | 39 | 140 | 130 | 50 | 19 | 11 | 1.9 |
| High | 25 | 117 | 112 | 53 | 16 | 8 | 1.6 |
| **Ethnicity** | | | | | | | |
| Azeri | 41 | 145 | 133 | 59 | 20 | 9 | 2.0 |
| Other[‡] | 66 | 198 | 131 | 53 | 8 | 6 | 2.3 |
| **IDP/Refugee Status** | | | | | | | |
| IDP/R | 51 | 135 | 126 | 65 | 31 | 19 | 2.1 |
| Non-IDP/CA | 37 | 148 | 119 | 50 | 16 | 10 | 1.9 |
| Non-IDP/NCA | 45 | 153 | 137 | 59 | 18 | 7 | 2.1 |

\* Live births occurring between May 1998 and April 2001.
† Age at pregnancy outcome.
‡ Includes Talish, Lezgi, Tat, Russian, and other ethnic groups.

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

younger women and diminished among older women. Generally, women with the highest educational attainment had the peak of their fertility at ages 25–29 whereas women with lower education reached their highest fertility at 20–24 years of age. Women with low socioeconomic status (SES) had, on average, 2.3 births per woman, compared with 1.9 and 1.6 births per woman, respectively, among women with middle and high SES. Fertility rates were similar for IDP/R and non-IDP/R women.

## 4.2 Induced Abortion Levels and Patterns

For several decades one of the most outstanding demographic features of most of the Eastern European countries has been the high reliance on induced abortion as a means of birth prevention. Induced abortion was the single most important factor for controlling fertility. In recent years, abortion rates and ratios in many of these countries are known to have been among the highest in the world. Among the factors frequently cited as contributing to widespread reliance on abortion have been the limited availability of contraceptive methods, poor quality of the methods available, fears about possible side effects, particularly hormonal methods, and easy access to and low cost of induced abortion.

Table 4.2.1 shows abortion rates based on data from recent reproductive or demographic health surveys conducted in Eastern European countries and the Newly Independent states (Goldberg H et al., 1993; KIIS and CDC, 2000; MACRO International 1995–2001; Serbanescu F et al., 1995, 1998, 2001; VCIOM and CDC, 1998, 2000). With the exception of Romania, where abortion was illegal until 1990, most of these countries have had some of the highest abortion rates in the world for several decades. The AZRHS01 showed that abortion rates in Azerbaijan are higher than those found in recent surveys in the Russian Federation (urban sample), Romania, and Armenia and much higher than in Moldova, Ukraine, and Central Asian republics, but lower than in Georgia. The age-specific abortion rates (ASIARs) in Tables 4.2.1 and 4.2.2 represent the proportion of women in a specific age group who terminated pregnancy by induced abortion within the 3-year period preceding the survey. These rates were calculated by using the age of the woman at the time of the pregnancy's termination. The total induced abortion rate (TIAR) was calculated by summing the ASIARs for the same 3-year period used in the analysis of fertility levels. Similar to the TFR, the TIAR describes the number of abortions a woman would have in her lifetime under the current ASIARs.

Before the Soviet Union's breakup, Azerbaijan had the lowest abortion rate in the Caucasus region (23 abortions per 1,000 women aged 15–49 compared to 31 per 1,000 in Armenia and 51 per 1,000 in Georgia), and it was significantly lower than that in the Slavic republics (Goskomstat USSR, 1990). The reported vital statistics indicate a steep decline since the break-up of the former Soviet Union (from 23 per 1,000 women aged 15–49 in 1989, to 12.7 per 1000 in 1998, and 7.7 per 1,000 in 2000), but this decline is not supported by the survey data. The ability of official abortion statistics

to document the true magnitude of the abortion levels is hampered, however, by the underreporting of abortions performed in the private sector, inherent problems related to registration data in state-run medical facilities, and the persistence of abortion performed outside clinical settings. Based on AZRHS01 data, the general abortion rate in the 3 years before the survey (May 1998–April 2001) was 116 abortions per 1,000 women aged 15–44, the total abortion rate was 3.2 abortions per woman, and the abortion-to-live-birth ratio was three abortions for each live birth. National sample surveys on reproductive health, which could have provided information about induced abortion levels based on women's self-reports, have never been carried out in Azerbaijan, so comparisons with similar data on abortion are not possible.

**TABLE 4.2.1**

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

| Country | Age Specific Induced Abortion Rate (per 1000)[†] | | | | | | Total IA Rate[‡] |
|---|---|---|---|---|---|---|---|
| | 15–19 | 20–24 | 25–29 | 30–34 | 35–39 | 40–44 | |
| Eastern European Region | | | | | | | |
| Czech Republic, 1993 | NA | NA | NA | NA | NA | NA | 1.6 |
| Romania, 1993 | 32 | 153 | 209 | 167 | 79 | 40 | 3.4 |
| Romania, 1999 | 26 | 101 | 119 | 105 | 58 | 21 | 2.2 |
| Russia (three oblasts[§]), 1996 | 45/57/30 | 132/153/148 | 124/181/129 | 93/108/81 | 54/62/49 | 34/39/20 | 2.4/3.0/2.3 |
| Russia (three oblasts[§]), 1999 | 43/63/26 | 143/169/98 | 91/141/83 | 96/120/134 | 51/73/67 | 34/58/19 | 2.3/3.1/2.1 |
| Moldova, 1997 | 12 | 74 | 81 | 46 | 31 | 16 | 1.3 |
| Ukraine, 1999 | 13 | 91 | 91 | 69 | 33 | 18 | 1.6 |
| Caucasus Region | | | | | | | |
| Georgia, 1999–2000 | 30 | 164 | 192 | 180 | 123 | 50 | 3.7 |
| Armenia, 2000 | 6 | 99 | 175 | 131 | 82 | 30 | 2.6 |
| Azerbaijan, 2001 | 6 | 86 | 177 | 176 | 132 | 63 | 3.2 |
| Central Asian Region | | | | | | | |
| Kazakhstan, 1995 | 15 | 78 | 104 | 75 | 50 | 18 | 1.7 |
| Kazakhstan, 1999 | 12 | 57 | 87 | 65 | 44 | 20 | 1.4 |
| Uzbekistan, 1996 | 2 | 18 | 32 | 36 | 23 | 15 | 0.6 |
| Kyrgyz Republic, 1997 | 6 | 57 | 77 | 81 | 58 | 22 | 1.5 |
| Turkmenistan, 2000 | 1 | 18 | 48 | 49 | 35 | 18 | 0.9 |

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

**TABLE 4.2.2**
**Three-Year* Age-specific Induced Abortion (IA)* Rates Among All Women**
**AZRHS01 and Ministry of Health (MOH) Estimates**

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

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

The TIAR was 1.5 times higher than the TFR during the 3 years prior to the survey (3.2 vs. 2.1). Unlike fertility, the age pattern of abortions in Azerbaijan is concentrated at 25–29 years of age (177 induced abortions per 1,000 women) and 30–34 years of age (176 per 1,000), two age groups that account for 50% of the TIAR. The third highest age-specific abortion rate occurred among women aged 20–24 years. Except for the youngest age groups, ASIARs are significantly higher than ASFRs (Figure 4.2). These findings suggest that Azeri women achieve their desired family size at young ages, after which most pregnancies are unintended and are intentionally terminated.

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

## Figure 4.2
### Three-Year Period Age Specific Fertility (ASFRs) and Induced Abortion Rates (ASIARs) — Women Aged 15–44 Years
### Reproductive Health Survey: Azerbaijan, 2001



A bar chart with y-axis "Event per 1,000 women" ranging from 0 to 200. Legend: ■ ASFRs, □ ASIARs.

| Age Group | ASFRs | ASIARs |
|---|---|---|
| 15-19 | 44 | 6 |
| 20-24 | 151 | 86 |
| 25-29 | 133 | 177 |
| 30-34 | 58 | 176 |
| 35-39 | 19 | 132 |
| 40-44 | 9 | 63 |
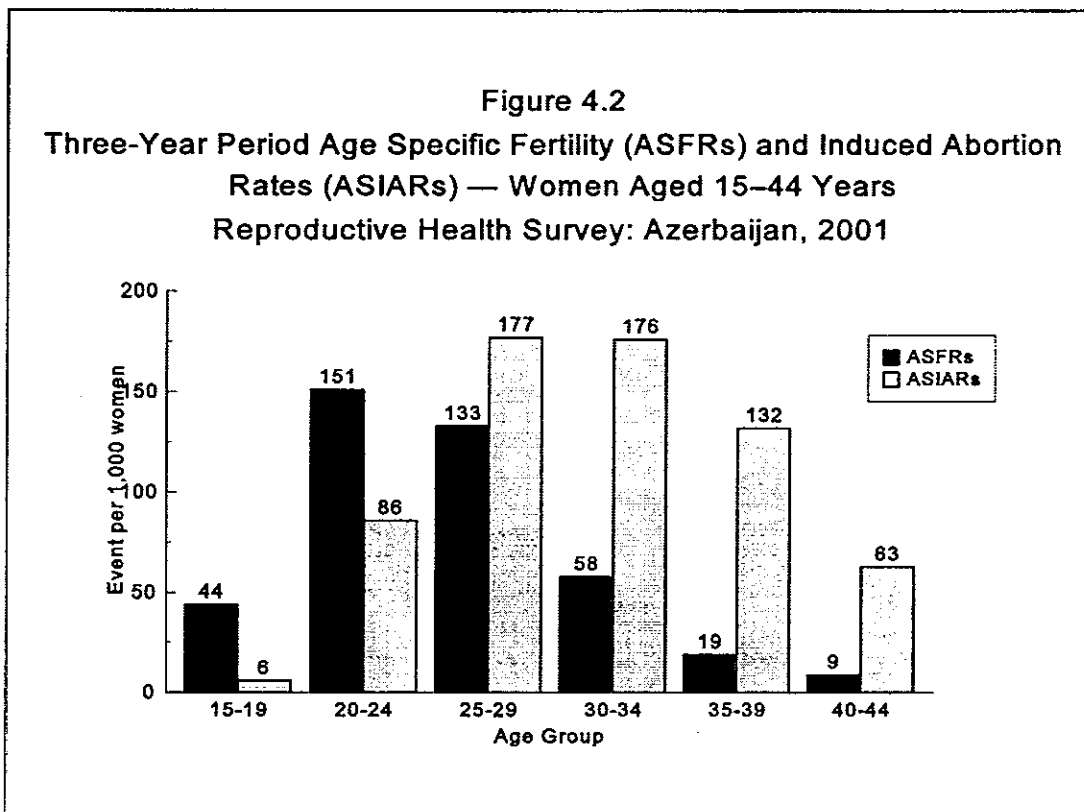
As shown in Table 4.2.3, the abortion rates among all women were equally high and varied little by their background characteristics, with the exception of the rates among IDP/Rs who reported substantially higher rates. The TIAR in rural areas was about 20% higher than in urban areas (3.4 vs. 2.8 abortions per woman). Abortion rates in the South-West (where most of the IDP/R population resides) were substantially higher than in the rest of the country whereas the rates in the South region were the lowest. The TIAR was lowest for women with a university education; on average, women with lower levels of education reported 0.7 abortions more than women with postgraduate education (3.2 vs. 2.5 abortions per woman). Most of the variation in abortion rates by education was the result of higher ASIARs among women aged 15–24 years with less than a university education. Women of Azeri ethnic background reported, on average, one abortion more than those of other background. Internally displaced and refugee women (IDP/Rs) reported the highest TIAR (4.7 abortions per woman) and all of the ASIARs among these women were higher than those among non-IDP/R women.

One means to reduce unintended pregnancies that result in abortion is through the provision of family planning services. As shown in Chapter V, a larger share of the potential demand for family planning services is among subgroups of women who have also reported higher rates of induced abortion (rural women, those less educated, women with two or more children, IDP/R women), a finding that indicates access to services is not equal and that the family planning program needs to expand its reach.

**TABLE 4.2.3**

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

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

\* Induced abortions occurred between May 1998 and April 2001.
† Age at pregnancy outcome.
‡ Includes Talish, Lezgi, Tat, Russian, and other ethnic groups.

## 4.3 Planning Status of the Last Pregnancy

For each pregnancy ended since January 1996 all respondents were asked about the planning status of their pregnancies at the time of conception. Each pregnancy was classified as either planned

(wanted at the time it occurred), mistimed (occurring earlier than intended), unwanted (the respondent wanted no more children), or unsure. Mistimed and unwanted pregnancies together constitute unintended pregnancies (Westoff CF, 1976). There is considerable evidence that women who are pregnant with an unintended pregnancy are more likely to seek an elective abortion, to enter prenatal care late or not at all, and to experience pregnancy or perinatal complications (Brown SS and Eisenberg L, 1995). Data on pregnancy intendedness should be interpreted with caution, however, and often tend to underrepresent the level of unintended pregnancies. One common source of underreporting is that induced abortions are not always reported; since the majority of pregnancies ended in elective abortion are unintended, the unintended pregnancies will be underreported to the extent that abortions are underreported. Abortion underreporting does not appear to be a major concern in AZRHS01 because abortion rates calculated from the survey exceeded recent officially reported levels. Another source of underreporting might occur for unintended pregnancies ended in live births due to retrospective rationalization and ambivalence. Women are asked to report retrospectively their thoughts about the pregnancy intention at the time of conception; retrospectively reported intentions after the child is born become more positive (Miller WB, 1994). Thus, data shown here represent conservative estimates of the true levels of unintendedness for pregnancies ended either in abortions or in live births. Despite the potential underreporting of unintended conceptions, the data in Table 4.3 show some important differences in the level of pregnancy intendedness according to pregnancy outcome and background characteristics.

Not surprisingly, given the high rates and ratios of induced abortion, the proportion of pregnancies that are unintended is quite high. Less than one of two women of childbearing age (42%) said her most recent pregnancy was intended at the time of conception; 9% reported it as mistimed (wanted at a later time); and 48% reported it as unwanted. Thus, 57% of women reported their last pregnancy as unintended and the majority of them (84%) reported it was unwanted rather than mistimed. The majority of women whose last pregnancies resulted in live births said those births were intended (85%). Conversely, all but a small percentage of women whose last pregnancy ended in induced abortion reported their conceptions were unintended (96%). It should be noted that a relatively high proportion (35%) of women whose last pregnancy ended in miscarriage or stillbirth reported it was an unwanted conception. This is four times the proportion of women with live births who reported an unwanted pregnancy, suggesting that either unintendedness had a negative influence on pregnancy development and outcome, or some of these outcomes may have been induced abortions, reported as spontaneous abortions or stillbirths because respondent's bias toward giving a socially desirable response. The relatively high unintendedness of pregnancies reported as spontaneous abortions or stillbirths was similar to that observed in other reproductive health surveys in Eastern Europe (Serbanescu F, 1995, 1998, 2000).

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

## TABLE 4.3
### Planning Status of the Last Pregnancy Among Women 15–44 Years of Age
### With at Least One Pregnancy Since January 1996, by Selected Characteristics
### Reproductive Health Survey: Azerbaijan, 2001

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

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

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

## 4.4 Future Fertility Preferences

The preference among women for small families is reflected not only in declining fertility levels and high abortion rates, but also in their stated desires not to have more children. Among women in union, over two thirds of respondents (69%) reported that they did not want to have more children (Table 4.4). Only 22% of women currently in union said they intended to have a child in the future, including 14% who wanted a child right away or within one year and 8% who wanted to wait at least 1 year before having another child. An additional 2% were unsure if they wanted to have more and 7% said they could not have any (more) children.

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

The ages by which women have had all the children they desire tend to be young, and this means they have many years of exposure to unintended pregnancy. Younger women were much more likely than older women to want more children (bottom panel of Table 4.4). The intention to have more children decreased from 79% among the youngest age group to 50% for women aged 20–24, 34% among 25–29-year-olds, 18% among women aged 30–34, 9% among women aged 35–39, and only

4% for women aged 40 and older. Of those who desire additional children, most women wanted to wait at least 1 year, with the exception of the very few women aged 35 years or older who did not want to terminate childbearing and wanted to have a child right away. The desire to have a child within a year is lower among 15–19 and 25–29-year-olds (34% and 15%), presumably because they want to space the next pregnancy. These findings are very important for the family planning program, which should consider spacing methods for younger women and long-term or permanent methods for older women. Such low levels of desired childbearing, especially with limited availability of effective long-term contraception and typically an early start (and finish) of childbearing, increases the probability of unintended pregnancies and subsequent abortion.

TABLE 4.4
Fertility Preferences of Women Currently in Legal or Consensual Marriage Aged 15–44 Years
by Number of Living Children and by Age Group
Reproductive Health Survey: Azerbaijan, 2001
(Percent Distribution)

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

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

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

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# V. CONTRACEPTION AWARENESS AND USE

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

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

## 5.1 Contraceptive Awareness and Knowledge of Use

Overall, Azeri women demonstrated a relatively high level of family planning awareness, in contrast to their low prevalence of modern contraceptive use; 87% of Azeri women had heard about at least one contraceptive method; on average, they recognized fewer than three modern methods—generally IUD, condoms, and the pill (83%, 58%, and 53%, respectively). Almost two thirds of women had heard of withdrawal (61%), the second best-known method, and/or periodic abstinence, also known as the rhythm method (39%). Only 38% of women had heard of female contraceptive sterilization (tubal ligation), and very few (6%) had heard of vasectomy (Table 5.1.1).

The level of overall awareness of either modern or traditional methods was slightly higher among urban than among rural women (Table 5.1.1). Urban-rural differences were particularly large for women's awareness about several modern contraceptive methods, ranging from 40%–50% higher for awareness of condoms (69% vs. 45%), tubal ligation (44% vs. 31%), and the pill (61% vs. 44%), to 60% and 75% higher for awareness of injectables (12% vs. 7%) and spermicides (14% vs. 8%). The least- known methods (vasectomy and emergency contraception) were those that had the largest urban-rural gap in awareness (9%–10% vs. 3%).

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

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TABLE 5.1.1
Percentage of Women 15–44 Years of Age Who Have Heard of Specific Contraceptive Methods
by Residence and by Region
Reproductive Health Survey: Azerbaijan, 2001

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

higher in Baku, especially awareness of condom, pills, vasectomy, and emergency contraception whose levels were considerably higher than in the other regions. Excepting the higher level of awareness for periodic abstinence among Baku women, there was less regional variation in the awareness of traditional methods.

Among women 15–44 years of age, the overall awareness of both modern and traditional methods was directly correlated with the respondent's age (Table 5.1.2). While only three fourths of young women (15–24 years) were aware of at least one contraceptive method, contraceptive awareness was almost universal at age 25 or older. Awareness of modern methods was 20% higher and awareness of traditional methods was 2.5 times higher among women aged at least 25 years compared to young adults (aged 15–24 years). The most widely known methods for women aged 25 or older were the IUD (94%–96%), withdrawal (79%–83%), condom (68%–69%), and the pill (63%–64%). Among the youngest women, however, the awareness of condom and the pill ranked second and third, respectively, after IUD awareness, while awareness of withdrawal ranked fourth. Nonetheless, young women knew, on average, fewer than two modern methods whereas their older counterparts were aware of at least three modern methods, on average.

TABLE 5.1.2

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

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

Virtually all currently married or cohabitating women (i.e., women in union) as well as previously married women, had heard of at least one modern method (98%) and at least one traditional method (92%). Awareness of modern and traditional methods was equally high among women in union; awareness was much higher for modern methods than for traditional methods among never (69% vs. 20%) or previously married women (93% vs. 75%). Awareness of all modern methods, particularly female sterilization, was lower among never-married than among ever-married respondents, however. Because marital status is directly correlated with age and never-married women were more likely to be young, the pattern of knowledge of specific methods among unmarried women resembled that for younger women. Similarly, the number of modern family planning methods recognized was the lowest among never-married respondents (1.7 modern methods). The level of contraceptive awareness did not vary significantly among IDP/R women and non-IDP/R women.

**TABLE 5.1.3**

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

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

The level of awareness of both modern and traditional methods was directly correlated with women's educational level. Among women with secondary incomplete or lower levels of education, awareness of specific methods was the lowest (Table 5.1.3). Particularly notable was the much lower awareness of tubal ligation, vasectomy, and emergency contraception among less-educated women. For the most widely known methods, the difference between these women and the best educated women ranged from 29% for IUD awareness to over 100% for the awareness of condom, pill, or tubal ligation. Consequently, the average number of modern methods known by these women was much lower than the average number known by the most educated women (2 vs. 3.9 methods). The overall awareness of traditional methods was also positively correlated with education.

Respondents who reported that they were aware of (i.e., "have heard of") a contraceptive method were asked whether they knew how to use the method. Knowledge about how to use any modern or traditional method was lower than the corresponding awareness of it (63% vs. 87% and 58% vs.

65%, respectively) (Tables 5.1.1 and 5.14). The proportion of respondents who know how each method or procedure is used is usually substantially lower than the proportion aware of each method or procedure. For the most widely known modern contraceptive methods (IUD, condom, the pill, and tubal ligation), there was a serious gap between awareness of the methods and knowledge of how they are used (Figure 5.1.1). Although awareness of IUDs was very high (83%), only one of two women (51%) said she actually knew how IUDs are used. Additionally, although 53% had heard of the pill, only 24% knew how this method is used. A narrower gap in knowledge was obvious for condoms, tubal ligation, spermicides, injectables, and emergency contraception, consequently further lessening the proportion of women who could start using these methods. The gap between awareness of and knowledge about use was also present for the periodic abstinence method (39% vs. 28%) and, to a lesser extent, for withdrawal (61% vs. 54%).

The difference between awareness of and knowledge about use was the greatest among young adults (74% vs. 47%) and diminished with increased age of the respondents (96%–98% vs. 87%–89%) (Tables 5.1.2 and 5.1.4). Again, the age difference in lack of knowledge about how contraception



**Figure 5.1.1**
**Awareness and Knowledge of How to Use Contraceptive Methods**
**Among Women Aged 15–44 Years**
**Reproductive Health Survey: Azerbaijan, 2001**

TABLE 5.1.4

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

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

is used was more pronounced for selected methods. For example, the proportion of women who did not know how IUDs and condoms are used decreased from 70% and 73%, among young adult women, to 37% and 48%, among women aged 25–34, and to 33% and 50%, among those aged 35–44. Similarly, the proportion of women who did not know how tubal ligation protects against pregnancy decreased from 89% to 66% between young adults and the older women, whereas the percentage of women who did not know how to use the pill decreased from 86% to 69%. Knowledge about the use of periodic abstinence was more than four times higher among women aged 25 years or older then among young adult women. As a result, young adult women, on average, could identify how contraceptive works for at most one modern method compared to two methods identified by older women.

Differences between awareness of contraceptive methods and knowledge about how they are used were larger among never and previously married women than among currently married women.

Never married women were the least likely to have knowledge about contraceptive use and had the largest gap between awareness and knowledge about use (69% vs. 36%) whereas virtually all currently married women knew how at least one contraceptive method works (94%). There was little variation in the knowledge of contraceptive use by respondents' IDP/R status. The difference between awareness and knowledge about use diminished with increased education, from 78% vs. 56% among women with less than complete secondary education to 97%–98% vs. 87% among women with postsecondary education (data not shown).
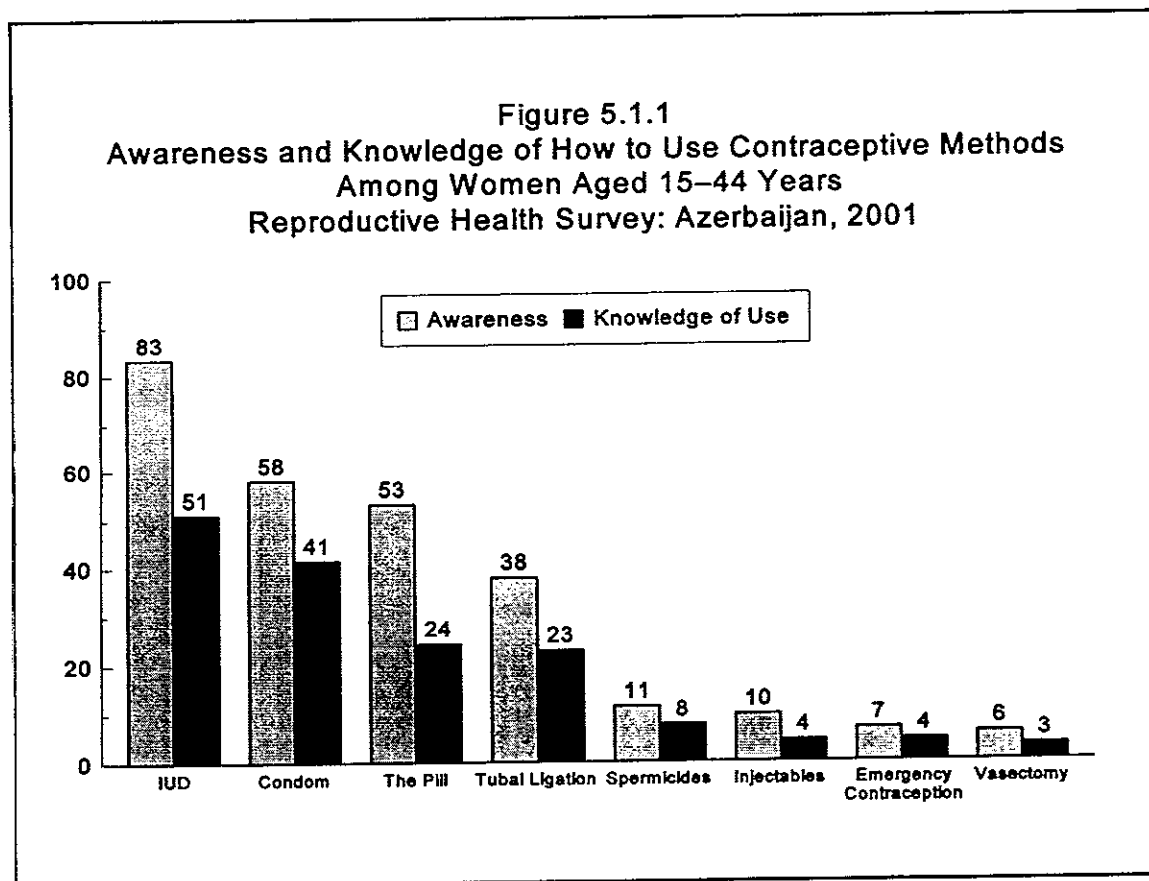
TABLE 5.1.5

Percentage of Women Aged 15–44 Years Who Say They Know Where to Get Specific Contraceptive Methods
by Age Group, Residence, and IDP/R Status
Reproductive Health Survey: Azerbaijan, 2001

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

Another indicator commonly used to evaluate information, education and communication efforts is knowledge of source(s) of contraception. The AZRHS01 found that only two thirds of women could name at least one source for supplied methods of contraception (Table 5.1.5). Respondents were more likely to know a source for the most commonly used modern methods (see also Table 5.2.1). For instance, 59% of women knew where to obtain IUDs, 44% knew a source for condoms, 36% knew a source for pills, and 26% knew where female contraceptive sterilization procedures (tubal ligations) are performed, but very few knew where vasectomies are performed or where to get injectables, spermicides, or emergency contraception. Knowledge about contraceptive source among women aged 25 years or older almost doubled that of young adults (80% vs. 43%), and it was the highest (84%) among currently married women (data not shown). Knowledge of a source was

substantially higher among women living in Baku or other urban areas than among rural residents (80% and 71% vs. 60%), but there was little difference by the IDP/R status. Knowledge of a source increased with education, especially for a source of condoms (from 26% among women with less than complete secondary education to 76% among those with university training) and pills (from 22% to 61%, respectively) (data not shown).

**TABLE 5.1.6**
**Percentage Distribution of Women Aged 15–44 Years by Their Opinion About Contraceptive Effectiveness if the Method Is Used Correctly and Consistently**
**Reproductive Health Survey: Azerbaijan, 2001**

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

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

The AZRHS01 included a series of questions in which each respondent was asked to indicate whether specific contraceptive methods (shown on a card) were very effective, effective or not effective in preventing pregnancy when used consistently and correctly. Answers to these questions are presented in Table 5.1.6, where contraceptive methods are listed in descending order of effectiveness, according to their 12-month failure rates (Hatcher RH et al., 1998). This ranking is based on studies of unintended pregnancies among users of various family-planning methods in the first 12 months of using that method (method failure), with the exception of emergency contraception for which such analysis does not apply. According to this classification, vasectomy and Norplant (whose respective specific effectiveness was not explored in the AZRHS01 because they are largely unavailable in Azerbaijan) are the most effective methods, with a failure rate at one year of use of only 0.1 pregnancy per 100 women. Injectables, female sterilization, and IUDs, have rates of failure between 0.3 and 0.6 pregnancy per 100 women. Combined oral contraceptives have very low theoretical failure (0.1 pregnancy per 100 women) but their actual failure rate, as commonly used, is much higher (6–8 pregnancies per 100 women). Condoms and other barrier methods are less

effective, with failure rates of 3%–6% during correct use and 14%–26% as commonly used. Periodic abstinence can be moderately effective if used correctly; withdrawal is listed as less effective than all other methods.

Overall, no modern method was recognized as very effective by a majority of women, partly because substantial numbers of women lacked knowledge about how modern methods are used (Table 5.1.6). Even when women who had never heard of a specific method were excluded, no very effective method (e.g., tubal ligation or IUD) was correctly recognized as highly effective. For example, if those who had never heard of tubal ligation or IUD are excluded, the methods were correctly identified as being very effective by only 40% and 32% of women. Similarly, only 10% of women who had heard of the pill considered this method as highly effective, whereas 27% of women who were aware of withdrawal answered that withdrawal is very effective. In fact, most women with contraceptive awareness of specific methods believed that these methods are somewhat effective rather than very effective and between one in ten to one in four did not know whether those methods were reliable. For the most-used modern methods, the percentage of women with awareness who believed that a method is highly effective or effective ranged from 66% for IUD, to 62% for tubal ligation, 51% for condom, and 49% for the pill. At the same time, 69% and 48% of women who had heard of withdrawal and periodic abstinence believed the methods were highly effective or effective (Figure 5.1.2).



Figure 5.1.2
Belief That Specific Contraceptive Methods Are *Very Effective* or *Effective* in Preventing Pregnancy
Among Women Aged 15–44 Years Who Have Heard of Specific Methods
Reproductive Health Survey: Azerbaijan, 2001
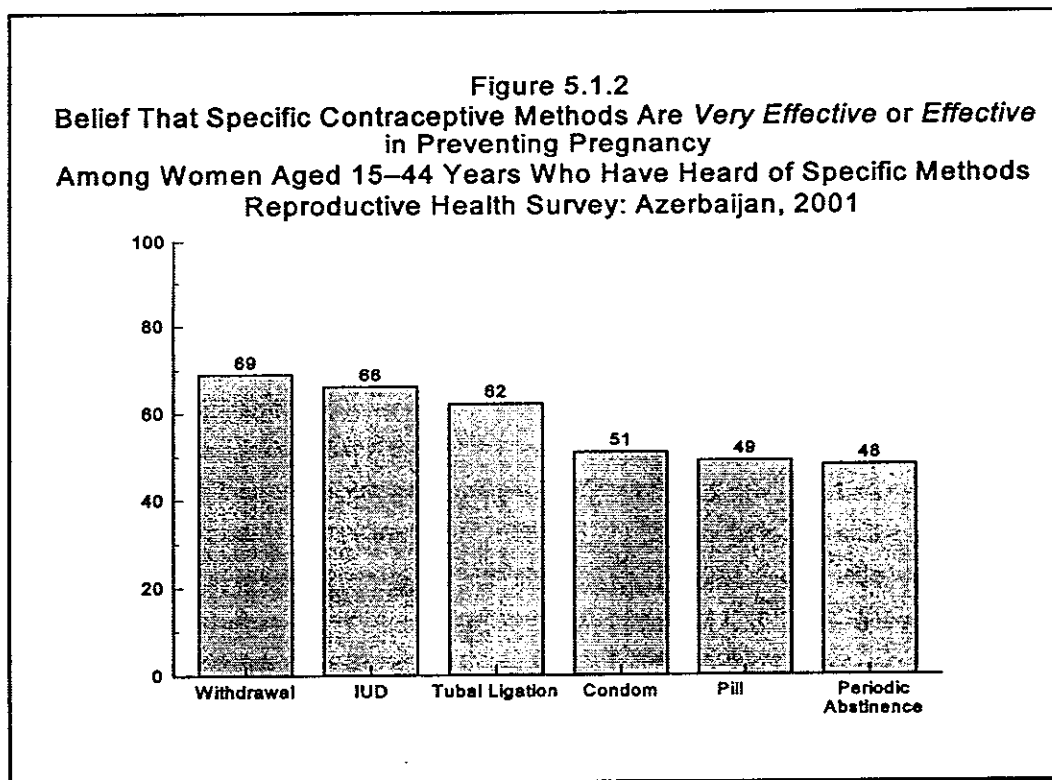
The AZRHS01 found that among women 15–44 years of age, the main source of information about birth control methods was an acquaintance or a friend (40%), followed in descending order by a relative other than a parent (19%), a physician (16%), a partner or boyfriend (11%), and the mass media (4% audiovisual media, 3% print media, and 3% books) (Table 5.1.7). Parents and school were seldom mentioned as sources of contraceptive information (1%). Young women (15–24 years of age) reported similar first sources of information as older women. More than one in three (38%) young women found out about contraception in discussions with a friend or acquaintance, 25% from the mass media or books, and 7% from a health care provider. The source of contraceptive information varied only slightly by method; more women mentioned they had heard about IUD and tubal ligation from a medical health provider (26% and 24%) and about withdrawal from their partners (48%).

These findings explain, in part, the poor quality of contraceptive information (Table 5.1.6), which is often acquired through rumors, and argue for increasing the public health efforts in educating women about the benefits of contraception through official channels (school, mass media, health providers).

**TABLE 5.1.7**
**First Source of Information about Contraception by Specific Method**
**Women Aged 15–44 Years Who Have Heard about Specific Methods of Contraception**
**Reproductive Health Survey: Azerbaijan, 2001**
**(Percent Distribution)**

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

## 5.2 Current Contraceptive Prevalence

Before 1990, the USSR health statistics reported that the lowest current use of contraception (7%) among the former Soviet Union countries was in Azerbaijan (Brackett JW, 1993). After independence, data about current contraceptive prevalence were very scarce and often difficult to interpret. Several small area surveys reported current contraceptive use as low as 47% and as high as 67% (UNFPA, 1999a; Buchholz U, 1999; Claeys P et al., 2001; Postner SF et al., 2001). A recent nationwide survey conducted by UNICEF documented that 55% of married women aged 15–49 were currently using a contraceptive method; the most-used method was withdrawal (31%). Modern methods, mostly IUDs, were used by 16% of married women (MICS, 2000). An important objective of the AZRHS01 was to assess the current levels of contraceptive practices among different subgroups of women.

This section focuses on women in legal and consensual marriages because they represent the majority of sexually active women (active within the past 30 days); because they have greater frequency of intercourse, higher fertility, and more unintended pregnancies; and because they

TABLE 5.2.1
Current Use of Contraception Among All Women, by Marital Status and IDP/R Status
(Percent Distribution)
Reproductive Health Survey: Azerbaijan, 2001

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

constitute the common denominator for most national and international studies of contraceptive prevalence. It is important to document, however, the contraceptive behaviors of all women, since never married women may have special contraceptive needs.

Most previously married women and virtually all never married women who had ever had intercourse were not currently sexually active and therefore not in need of contraception. Not surprisingly then, they were not using contraception during the month preceding the interviews (Table 5.2.1). Only 2% of previously married women were using contraception at the time of the survey; two thirds of them were using the IUD and the remaining one third was using withdrawal. By contrast, currently married women were more likely to use a traditional contraceptive method than a modern method.

About half (55%) of women currently in legal or formal unions were currently using a method of contraception, but only 12% used modern methods (Table 5.2.2).

Table 5.2.2
Current Contraceptive Prevalence Among Currently Married Women of Reproductive Age
Reproductive Health Surveys (RHS) and Demographic Health Surveys (DHS)
In Selected Eastern European and Former Soviet Union Countries, 1993-2001

| Country | Type of Survey | Any Method | Modern Method | % Modern Methods of Total Prevalence | Most Used Method |
|---|---|---|---|---|---|
| Eastern European Region | | | | | |
| Czech Republic, 1993 | RHS | 69 | 45 | 65 | Withdrawal |
| Romania, 1993 | RHS | 57 | 14 | 25 | Withdrawal |
| Romania, 1999 | RHS | 64 | 30 | 47 | Withdrawal |
| Russia (three oblasts*), 1996 | RHS | 69–77 | 50–59 | 73–77 | IUD |
| Russia (three oblasts*), 1999 | RHS | 70–75 | 49–58 | 70–77 | IUD |
| Moldova, 1997 | RHS | 74 | 50 | 68 | IUD |
| Ukraine, 1999 | RHS | 68 | 38 | 56 | IUD |
| | | | | | |
| Caucasus Region | | | | | |
| Georgia, 1999–2000 | RHS | 41 | 20 | 49 | Withdrawal |
| Armenia, 2000 | DHS | 61 | 22 | 36 | Withdrawal |
| Azerbaijan, 2001† | RHS | 55 | 12 | 21 | Withdrawal |
| | | | | | |
| Central Asian Region | | | | | |
| Kazakhstan, 1995 | DHS | 59 | 46 | 78 | IUD |
| Kazakhstan, 1999 | DHS | 66 | 54 | 82 | IUD |
| Uzbekistan, 1996 | DHS | 56 | 51 | 91 | IUD |
| Kyrgyz Republic, 1997 | DHS | 60 | 49 | 82 | IUD |
| Turkmenistan, 2000 | DHS | 62 | 53 | 85 | IUD |

\* Yekaterinburg, Perm, and Ivanovo.
† Preliminary data.
Source: Goldberg H et al., 1993; KIIS and CDC, 2001; VCIOM and CDC, 1998, 2000; MACRO International 1995-2001; Serbanescu F et al. 1995, 1998, 2001.

A similar contraceptive pattern is obvious throughout the Caucasus region and in Romania, but in Azerbaijan the proportion of modern contraceptives in the contraceptive method mix is the lowest (21%). The proportion of women in union currently using any form of contraception ranged from 3% (among childless women) to 68% (women with four or more living children) (Table 5.2.3). For the entire country, the proportion of all contraceptive users who used a modern method was 21%, ranging between 7% (among the minority group of Talish women) and 46% (among those with the highest SES and among Russian women). The proportion of women currently in union who used any contraception did not differ substantially by residence, but increased substantially with age until age group 30–34, rose sharply with the number of living children, and increased moderately with education level. It was not significantly different between the IDP/R women and non-IDP/R women.

Use of modern contraceptives was twice as high in urban areas as in rural areas (29% vs. 13%); it was higher in Baku (35%) than in any other region, among 25–44-year-olds than among young adults, and among those with at least one living child than among childless couples. The proportion doubled for women with a university education compared with women with lower levels of education. Similarly, it was significantly higher for women living in households with a high SES compared to those living in households with a low or middle SES (46% vs. 13% and 24%, respectively). Modern use as a proportion of total use was the highest among Russian women (46%) and the lowest among Talish women (7%). For all subgroups, however, the use of modern methods did not surpass the use of traditional methods.

**Figure 5.2**
**Current Use of Specific Contraceptive Methods**
**Among Women Aged 15–44 Years Currently In Union**
**Reproductive Health Survey: Azerbaijan, 2001**

No Method
45%

Pills 1%
Tubal Ligation 1%
Condom 3%

IUD 6%

Withdrawal
41%

Periodic Abstinence 3%

43
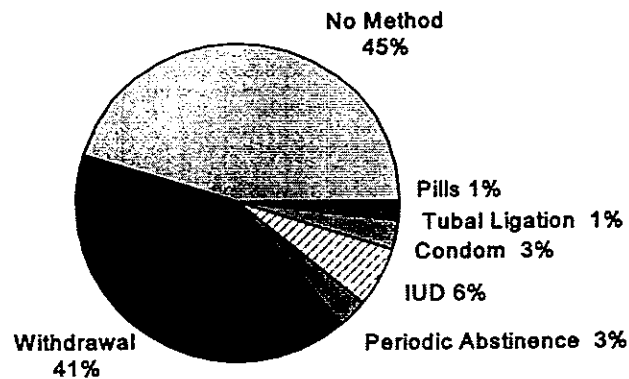
TABLE 5.2.3
Current Use of Modern and Traditional Methods by Selected Characteristics
Women in Union Aged 15–44 Years
Reproductive Health Survey: Azerbaijan, 2001

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

## TABLE 5.2.4
## Current Use of Specific Contraceptive Methods by Selected Characteristics
## Women in Union Aged 15–44 Years
## Reproductive Health Survey: Azerbaijan, 2001

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

By far the most prevalent method in use among women in union was withdrawal (41%), which accounts for 73% of contraceptive prevalence (Table 5.2.4 and Figure 5.2). IUDs, which were used by 6% of women in union, and condoms (3%) were the next most-used methods and accounted for 78% of modern methods used. Contraceptive sterilization, despite an overwhelming desire by most women to have no more children (see Chapter IV), was used by only 1% of women currently in union; the pill was also used by only 1% of women in union. Although the overall contraceptive prevalence varied little by background characteristics (except for childless and adolescent women, who had a much lower prevalence), the choice of a specific method sometimes differed substantially between various subgroups. The use of IUDs was higher than average in urban areas, particularly in Baku (8%), in the Southern region (10%), among women with a university education or with high socioeconomic status (11%), and among Russian women (12%). Condom use was also higher in urban areas than in rural areas (5% vs. 1%) and in Baku (7%); it increased with education and SES. Withdrawal was the most-used method regardless of the women's background characteristics but was considerably more prevalent among rural residents (48%), women residing in the North, South, and Central regions (45%–46%), women with three or more children (47%–51%), women with low SES (48%), and Tat women (49%).

## 5.3 Source of Contraceptive Methods

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

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

Sources varied greatly according to the contraceptive method used. Public hospitals were the primary source of IUDs (48%) and female contraceptive sterilization (95%). Pharmacies were the principal provider of condoms and pills, supplying more than two thirds and three fourths,

respectively, of condoms and pills and virtually all other modern methods (i.e., Depo-Provera and spermicides). Pharmacies also supplied 4% of the IUDs (with a prescription issued by the OB/Gyn), but the IUD must be inserted at a medical facility.

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

TABLE 5.3

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

| Source | Total† | IDP/R Status | | | Contraceptive Method | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | IDP/R | Non- IDP/CA | Non- IDP/NCA | IUD | Condom | Tubal Ligation | Pills | Other Modern* |
| **Public Medical Sector** | **53.9** | **42.7** | **58.8** | **54.1** | **93.8** | **3.1** | **94.5** | **12.4** | **3.5** |
| Hospital (Ob/Gyn ward ) | 18.5 | 12.2 | 20.1 | 18.8 | 30.2 | 0.4 | 54.6 | 0.6 | 0.0 |
| Women's consultation clinic | .21.3 | 9.9 | 14.7 | 23.4 | 42.7 | 0.3 | 0.0 | 7.7 | 0.0 |
| Maternity | 8.8 | 7.6 | 14.3 | 8.0 | 12.7 | 0.5 | 33.7 | 1.0 | 3.5 |
| Polyclinic | 1.1 | 1.6 | 0.7 | 1.1 | 2.3 | 0.0 | 0.0 | 0.0 | 0.0 |
| Rural dispensary ("FAP") | 0.9 | 4.3 | 1.3 | 0.5 | 0.7 | 0.8 | 0.0 | 2.5 | 0.0 |
| Village hospital | 3.3 | 7.1 | 7.7 | 2.3 | 5.2 | 1.1 | 6.2 | 0.6 | 0.0 |
| **NGO or Private Clinic/Office** | 2.2 | 19.3 | 3.0 | 0.5 | 0.5 | 2.4 | 5.5 | 7.0 | 0.0 |
| **Commercial Sales** | **35.2** | **27.4** | **31.5** | **36.4** | **4.9** | **67.9** | **0.0** | **77.6** | **91.8** |
| Pharmacy | 34.8 | 24.7 | 31.5 | 36.2 | 4.1 | 67.9 | 0.0 | 77.6 | 91.8 |
| Store/Kiosk | 0.4 | 2.7 | 0.0 | 0.2 | 0.8 | 0.0 | 0.0 | 0.0 | 0.0 |
| **Other** | **8.5** | **10.6** | **6.6** | **8.5** | **0.7** | **25.4** | **0.0** | **3.0** | **4.7** |
| Partner | 7.2 | 6.9 | 4.7 | 7.6 | 0.0 | 23.1 | 0.0 | 1.9 | 0.0 |
| Friend or relative | 1.3 | 3.7 | 1.9 | 0.9 | 0.7 | 2.3 | 0.0 | 1.1 | 4.7 |
| **Total** | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| **No. of Cases** | 807 | 118 | 235 | 454 | 370 | 266 | 52 | 96 | 23 |

* Includes women using spermicides and injectables
† Prescription to buy the IUD at a pharmacy and bring it to clinic/maternity for insertion

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## 5.4 Reasons for Not Using Contraception

Women currently in union mentioned a broad variety of reasons for not currently using contraception. The most common reasons given were related to pregnancy (40%), lack of current sexual activity (19%), and female fecundity impairment and the presence of pelvic inflammatory disease (15%) (Table 5.4). Pregnancy-related reasons were the respondent's being currently pregnant or breastfeeding, or the respondent's desiring a pregnancy. Female fecundity impairment includes surgical and medical causes that prevent pregnancy and failure to conceive after at least two years of effort (without using contraception). A very few women reported reasons related to family planning as contributing to their decision not to use a method, reasons such as fear of side effects (2%), personal or partner opposition to contraceptive methods (2%), and lack of access to family-planning services or lack of knowledge about contraception (1%). Reasons for not using a method did not vary much between IDP/R and non-IDP/R women but differed sharply by age group. Younger women in union were more likely to be either pregnant or in the postpartum period (52%) or were seeking to become pregnant (24%), whereas women aged 35–44 years were more likely to not be able to get pregnant.

TABLE 5.4
**Most Commonly Cited Reasons for Not Currently Using Contraception by IDP/R Status and by Age Group Among Women in Union Aged 15–44 Years**
Reproductive Health Survey: Azerbaijan, 2001
(Percent Distribution)

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

## 5.5 Unmet Need for Contraception

The unmet need for contraception is a very specific estimate that measures the gap between desired fertility and the contraceptive practices adopted to ensure that fertility preferences are met in a population. The conventional definition of *unmet need* includes women currently married or in consensual unions who are currently sexually active (within the past month), currently exposed to the risk of pregnancy (women not sexually active, currently pregnant women, and women in postpartum abstinence or amenorrhea are excluded), fecund (neither they nor their partners have any subfecundity conditions), not wanting to become pregnant (at the time of the interview), and not using any form of pregnancy prevention (Bongaarts J, 1991). In this report, the standard formulation of unmet need was extended to all women, not just those in union.

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

In addition to the unmet need for any family planning, the AZRHS01 estimated the unmet need for modern contraception—an indicator used in other Eastern European surveys that expanded the standard definition to include users of non-supplied methods in the category of unmet need. In countries with high use of non-supplied methods (i.e., withdrawal, periodic abstinence, and traditional/folk methods), the standard definition of unmet need masks the real need for more effective contraception because these methods tend to have higher failure rates. For these countries it is more useful to estimate the unmet need for modern contraception, despite the small risk of overstating the unmet need in some cases where traditional methods are used effectively. For international comparisons, however, both indicators are shown for all women and for women in union. Among all countries in Central and Eastern Europe and the former Soviet Union where population-based reproductive health or demographic health surveys have been recently conducted, Azerbaijan has the second highest unmet need for modern contraception (31%), after Ukraine (Table 5.5.1). CDC-assisted Reproductive Health Surveys (RHS) have found the unmet need for modern methods to be 23% in Moldova, 26% in Georgia, 25%–29% in Russia, 29% in Romania, and 37% in Ukraine (Serbanescu F et al. 1998, 2000; VCIOM and CDC, 1998, 2000; KIIS and CDC, 2000). Unmet need of a modern method was slightly lower in the Central Asian republics where modern contraceptive prevalence represents over 80% of the total contraceptive prevalence, and the IUD constitutes the most prevalent method.

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**Table 5.5.1**

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

| Country | Type of Survey | All Women | | Currently Married or in Union Women | |
| --- | --- | --- | --- | --- | --- |
| | | Any Method | Modern Method | Any Method | Modern Method |
| Eastern European Region | | | | | |
| Czech Republic, 1993 | RHS | 10 | 31 | 15 | 39 |
| Romania, 1993 | RHS | 9 | 39 | 11 | 55 |
| Romania, 1999 | RHS | 5 | 29 | 6 | 39 |
| Russia (three oblasts*), 1996 | RHS | 11/15/15 | 23/25/29 | | |
| Russia (three oblasts*), 1999 | RHS | 11 | 28 | 12 | 33 |
| Moldova, 1997 | RHS | 7 | 23 | 6 | 29 |
| Ukraine, 1999 | RHS | 15 | 37 | 18 | 47 |
| Caucasus Region | | | | | |
| Georgia, 1999–2000 | RHS | 15 | 27 | 24 | 44 |
| Armenia, 2000 | DHS | | | | |
| Azerbaijan, 2001 | RHS | 7 | 31 | 12 | 53 |
| Central Asian Region | | | | | |
| Kazakhstan, 1995 | DHS | 11 | 17 | 16 | 22 |
| Kazakhstan, 1999 | DHS | 6 | 16 | 9 | 22 |
| Uzbekistan, 1996 | DHS | | 3.0+ | 14 | 18 |
| Kyrgyz Republic, 1997 | DHS | | 7.5+ | 12 | 22 |
| Turkmenistan, 2000 | DHS | | | | |

\* Yekaterinburg, Perm, and Ivanovo.
  Source: Goldberg H et al., 1993; KIIS and CDC, 2000; VCIOM and CDC, 1998, 2000; MACRO International 1995-2001; Serbanescu F et al.
  1995, 1998, 2001.

Overall, the AZRHS01 found that about one of three women (38%) had a potential demand for contraception—defined as the sum of current contraceptive use (met need) and the additional contraceptive use that would be required to eliminate the risk of unwanted or mistimed births (unmet need)—including 7% of current users of modern methods, 25% of current users of traditional methods, and 7% of nonusers at risk of unintended pregnancy (Table 5.5.2). According to the most recent census data, these figures translate into an estimate of 775,000 women aged 15–44 years with a potential demand for family planning services. Because fewer than one fifth of these women are using a modern contraceptive method, about 630,000 remain at risk of an unintended pregnancy

because they do not use any method or they use traditional methods (i.e., have an unmet need for modern contraception).

As might be expected, the potential demand for family planning methods was much higher among those women who are currently married or in consensual unions than among those previously or never married (65% vs. 4% and 0.1%) (Table 5.5.2).

## TABLE 5.5.2
### Potential Demand for Family Planning (FP) Services by Age Group, Marital Status, and IDP/R Status
### Women Aged 15–44 Years
### Reproductive Health Survey: Azerbaijan, 2001

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

\* Within the past month.
† Want to get pregnant right away; includes 33 respondents who answered "when God wants."
‡ Sterilization surgery for noncontraceptive reasons, medical conditions that preclude pregnancy, infertile partners, and menopause.
§ Includes nonusers at risk of unintended pregnancy and current users of traditional contraceptive methods.

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TABLE 5.5.3
**Women Aged 15–44 Years in Need of Any or More Effective Contraceptive Methods**
**by Selected Characteristics**
**Reproductive Health Survey: Azerbaijan, 2001**

| Characteristic | Any Method | Any or More Effective Method | No. of Cases |
|---|---|---|---|
| **Total** | **6.8** | **31.4** | **7,668** |
| **Residence** | | | |
| Urban | 9.3 | **31.2** | 3,832 |
| Rural | 3.9 | **31.5** | 3,836 |
| **Region** | | | |
| Baku | 10.8 | **31.0** | 1,533 |
| North & North-East | 5.9 | **33.6** | 924 |
| West | 8.9 | **31.3** | 766 |
| South-West | 5.7 | **31.8** | 2,302 |
| South | 3.2 | **27.9** | 950 |
| Central | 5.1 | **31.7** | 1,193 |
| **Age Group** | | | |
| 15–24 | 2.0 | **9.1** | 2,414 |
| 25–34 | 7.4 | **42.0** | 2,689 |
| 35–44 | 12.5 | **49.4** | 2,565 |
| **Marital Status** | | | |
| Currently Married or In Union | 11.5 | **53.3** | 5,146 |
| Previously Married | 2.7 | **3.4** | 387 |
| Never Married | 0.0 | **0.1** | 2,135 |
| **No. of Living Children** | | | |
| 0 | 0.6 | **1.0** | 2,655 |
| 1 | 8.1 | **35.2** | 784 |
| 2 | 11.5 | **55.0** | 2,094 |
| 3 | 12.8 | **59.7** | 1,530 |
| 4+ | 13.5 | **65.4** | 605 |
| **Education** | | | |
| Secondary incomplete or less | 5.1 | **23.9** | 1,697 |
| Secondary complete | 7.2 | **33.5** | 3,868 |
| Technicum | 8.6 | **39.6** | 1,215 |
| University/Postgraduate | 6.7 | **27.4** | 888 |
| **Socioeconomic Status** | | | |
| Low | 5.2 | **32.8** | 4,068 |
| Middle | 8.9 | **31.6** | 2,770 |
| High | 7.0 | **24.7** | 830 |
| **Ethnic Group** | | | |
| Azeri | 7.1 | **31.6** | 7,189 |
| Talish | 5.6 | **27.2** | 136 |
| Lezgi | 4.2 | **34.7** | 74 |
| Russian | 7.1 | **23.4** | 59 |
| Tat | 1.5 | **24.4** | 47 |
| Other | 6.9 | **29.4** | 163 |
| **IDP/Refugee Status** | | | |
| IDP/R | 10.3 | **36.5** | 1,272 |
| Non-IDP/CA | 5.4 | **31.0** | 3,047 |
| Non-IDP/NCA | 6.7 | **30.8** | 3,349 |

Table 5.5.3 presents the unmet need by selected background characteristics of the respondents. Both definitions were used to define proportions of women in need of family-planning services. Although only 7% of all women had un unmet need for contraception, almost five times as many women have an unmet need for modern contraception. Some subgroups of women exhibited much higher levels of contraceptive unmet need than others: Baku women (11%), women aged 35–44 years (13%), women in legal or consensual unions (12%), women with at least two children (12%–13%), and IDP/R women (10%). Except for never married women and young adult women (whose need of contraception is very low because of much lower levels of sexual activity), the unmet need for a modern method ranged from 23% among Russian women to 65% among women with four or more children.

## 5.6 Communication with Family Planning Providers

Women who had used at least one modern contraceptive method in the previous 5 years were asked who advised them to use their last modern method. If the advice came from a health care provider (physician, nurse, or midwife), they were asked if they received any information about other methods, including their effectiveness and the side effects associated with their use. As shown in Table 5.6, two of three women were advised by a heath care provider to use the current or last modern method (65% by a physician and 2% by a nurse or midwife). One in four women started using her last method at the partner's suggestion (22%) or at her own counsel (4%), bypassing any potential medical advice. In 4% of cases the choice of the method was made at the suggestion of a pharmacist. In the remaining cases, the choice was suggested by a friend (3%) or a relative (1%).

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

Health providers' interactions with their family planning clients and the messages conveyed during these interactions can affect client satisfaction with services, continued use of services in the future, and correct use of the method. As shown in the bottom panel of Table 5.6, during provider-client interaction only 40% of women received general information about other contraceptive methods, one in three was counseled about the effectiveness of the method she was using compared with other methods, and 59% reported that the provider had explained possible side effects of the method

chosen. Condom users were more likely to be counseled about other contraceptive methods and their effectiveness, although the proportion who received medical advice was rather small (14%). IUD and tubal ligation users were the least likely to receive information about other methods (35% and 33%) and about contraceptive effectiveness (30% and 29%). Women who used IUDs and hormonal contraception were the most likely to have received medical advice on possible side effects (64% and 56%).

TABLE 5.6

**Percentage of Women Who Have Used a Modern Contraceptive Method Within the Past 5 Years by Who Advised Them to Use the Specific Method and Type of Counseling Received from a Heath Care Provider Reproductive Health Survey: Azerbaijan, 2001**

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

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

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

## VI. PREGNANCY, DELIVERY, AND BREASTFEEDING

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

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

### 6.1 Prenatal Care

This section describes the use of prenatal care for all pregnancies carried to term (either live births or still births) since January 1996. Women were asked in what week or month of gestation they had their first visit for prenatal care (not counting a visit that was just for a pregnancy test or just for the delivery) and the number of prenatal care visits during pregnancy. Of the 3,430 births reported since January 1996, just over two thirds of women (70%) had received some prenatal care; of those, about two thirds (45% of 70%=64%) had received their first prenatal care visit in the first trimester (Table 6.1.1). Approximately one in five of all women had the first visit during the 2nd trimester and 6% during the third trimester.

The level of any prenatal care within different subgroups varied sometimes by a considerable margin (between 53% and 89%). Rural women, residents of the South region, those who did not complete secondary education or had a low SES, and women who had already had two or more births, were more likely not to have any prenatal care. Similarly, the percentage of mothers who entered prenatal care in the first trimester varied widely, from a low of 32% to a high of 65%, but overall less than one in two women (45%) reported early prenatal care.

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

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

Women living in urban areas were more likely to start prenatal care earlier than women in rural areas (55% vs. 35%). Early entry into prenatal care was higher among women living in Baku (61%) and much lower (34%) in the South compared to other regions. Early entry into prenatal care was highly correlated with the mother's education and SES; women who had not completed high school had a lower likelihood of initiating prenatal care early (32%) compared with women with postsecondary education (60%). In addition, 47% of these women had reported no prenatal care, whereas only 11% of women with a university education had no prenatal care. Similarly, women with low SES had a much lower likelihood of initiating prenatal care early then did women with high SES (35% vs. 65%). The IDP/R women and women living in regions with a high concentration of IDPs were slightly less likely to report any prenatal care, probably reflecting the fact that these women have a lower SES than women living in areas not directly affected by the Nagorno-Karabach war. Mothers of low birth weight (LBW) babies were more likely than mothers who gave birth to normal weight babies to have no prenatal care (41% vs. 29%).

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

The adequacy of prenatal care is assessed by using the Adequacy of Prenatal Care Utilization Index (APNCU), also known as the Kotelchuck index. This index assesses the adequacy of initiation of prenatal care (month when prenatal care begins) combined with the adequacy of the number of visits received (according to the American College of Obstetricians and Gynecologists recommendation). Inadequate use is defined as either late prenatal care or less than 50% of recommended visits and includes also "no prenatal care." The three remaining levels require early initiation of care (by the fourth month of gestation). Intermediate care requires 50%–79% of the recommended number of visits, adequate care 80%–109%, and adequate care "plus" 110% or more of the recommended number of visits (Kotelchuck M, 1994). By applying this index to data from the AZRHS01, only 6% of births within the past 5 years had received adequate or adequate plus care while 81% had received inadequate prenatal care (Figure 6.1). Standards of prenatal care for routine pregnancies in the era of the Soviet Union (still in effect in the Russian Federation) closely resemble the US standards, requiring early onset of prenatal care and an average of 14 prenatal care visits before delivery (Notzon FC et al, 1999).

## Figure 6.1
### Adequacy of Prenatal Care Utilization Index*
### Births in the 5 Years Prior to the Survey
### Reproductive Health Survey: Azerbaijan, 2001

Intermediate 12%

Adequate 4%

Adequate Plus 2%

Unknown 1%
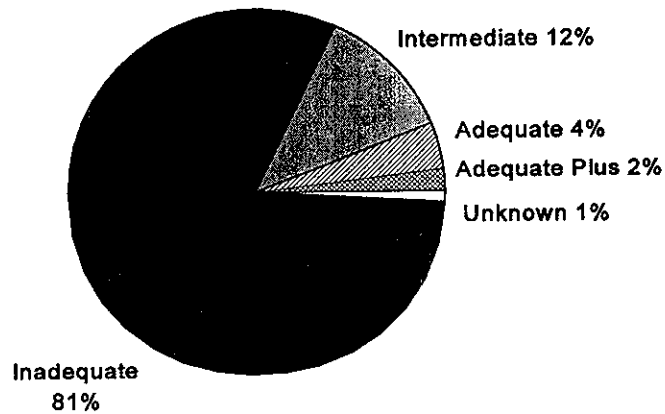
Inadequate
81%

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

Overall, in the AZRHS01, the principal source of prenatal care was a women's consultation clinic (46%). The second source of most prenatal visits was a maternity (36%) or a village hospital (13%). Rural dispensaries and private clinics provided prenatal care for 2% and 1%, respectively, of pregnant women; only 3% of women received prenatal care at home (data not shown). Thus, 97% of women reported having most of the prenatal care in a medical facility. Women's clinics were the principal source for prenatal care for all pregnancies, irrespective of women's background characteristics, except in rural areas and the South and South-West regions where most prenatal care was provided through hospitals. Generally, in women's consultation clinics and hospitals most care is provided by obstetricians. Because women's clinics and hospitals were the most used sources of prenatal care, most of the prenatal care visits (94%) were provided by obstetricians (Ob/Gyns); only 5% were provided by nurses or midwifes (data not shown). Nurses provided as much as 38% of the prenatal care for the few women who received prenatal care at a rural dispensary or at home.

## 6.2 Intrapartum Care

All births should occur in medical facilities where adequately trained personnel can monitor the progress of labor and delivery. According to AZRHS01, most deliveries in the past five years took

## TABLE 6.2.1
### Place of Delivery for Births in 1996–2001 by Selected Characteristics
### Reproductive Health Survey: Azerbaijan, 2001

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

* Includes one delivery on the way to the hospital.

**Figure 6.2**
**Place of Delivery for Births in the 5 Years Prior to the Survey**
**Reproductive Health Survey: Azerbaijan, 2001**

Maternity 56%

Private Clinic 1%

At Home 26%

Village Hospital 17%
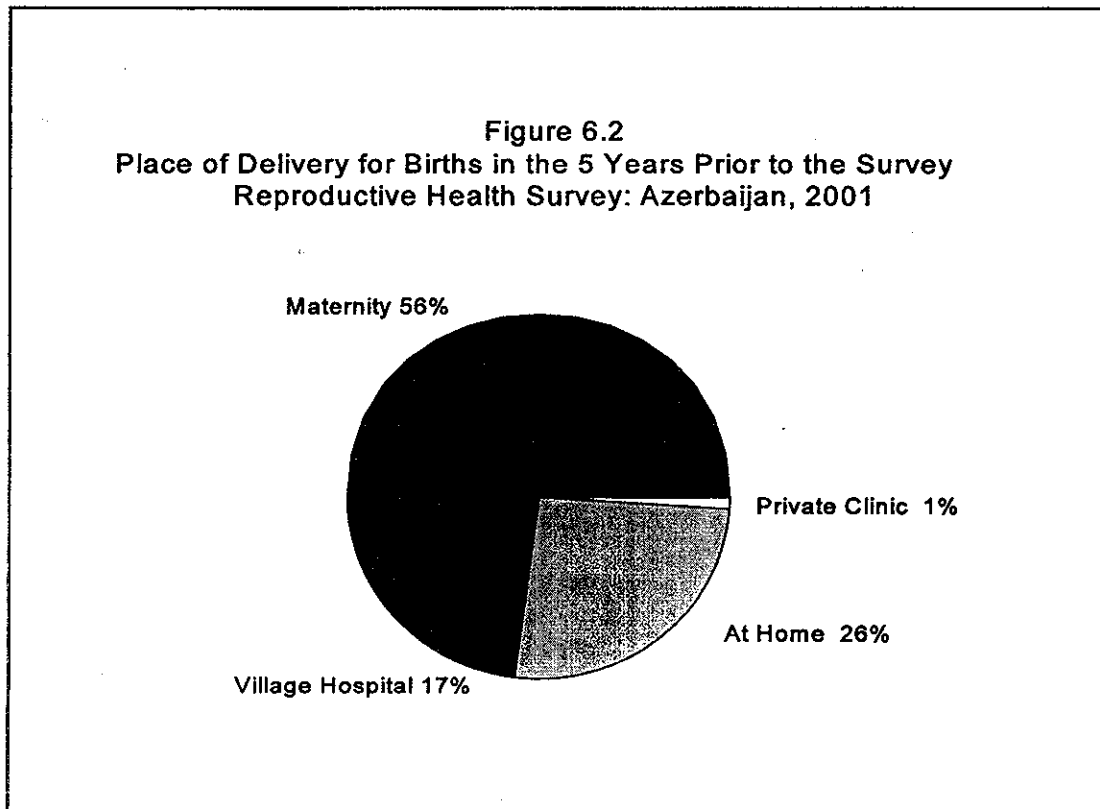
place in maternities (56%) or village hospitals with inpatient obstetrical care (17%) (Table 6.2.1 and Figure 6.2). One in four births, however, was delivered outside medical facilities and less than one percent was delivered in a private clinic. Home deliveries were relatively high among rural residents (36%), those living in the Central, South, and South-West regions (35%, 36%, and 39%), those with low levels of education or low SES (39% and 36%, respectively), IDP/R women and non-IDPs living in conflict affected areas (41% and 35%), those with four or more other births (42%), and those with no prenatal care (48%).

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

The Caesarean section (C-section) rate varies considerably among countries, from about 5% to more

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TABLE 6.2.2
Percentage of Caesarean Deliveries by Selected Characteristics
Births in 1996–2001 Delivered in Medical Facilities
Reproductive Health Survey: Azerbaijan, 2001

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

than 20% of all deliveries. The optimal rate is not known, but little improvement in birth outcomes has been demonstrated if the rate is higher than 7%. In Azerbaijan, the majority of birth were delivered vaginally, and the overall prevalence of C-section among all deliveries between 1996 and 2001 was only 2.6% (Table 6.2.2). Before the dissolution of the USSR, the C-section rate for the entire country, though not routinely published, was estimated to range between 0.7% and 7% (Petrikovsky BM and Hoegsberg B, 1990).

Women residing in urban areas were about five times as likely to have this type of delivery as women residing in rural areas. Women aged 35 years or older reported C-section rates higher than those for women aged 25–34 or 15–24 (10% vs. 3% and 1%). The C-section rate increased directly with education and SES but was not significantly different among IDPs and non-IDPs. Women who experienced prolonged labor were more likely to deliver by C-section than were women with uncomplicated pregnancies. Births with labor duration of more than 20 hours (more than 14 hours for multiparous women) had an almost five-fold increase in the rate of delivery by C-section compared to births with a shorter duration of labor. Almost half of C-sections were performed before the onset of labor.

## 6.3 Poor Birth Outcomes

Of all births during the 1996–2001 period, 21.2 per 1,000 were stillbirths (Table 6.3). The stillbirth rate was higher among women living in urban areas than in rural areas (26 vs. 17 per 1,000) among residents of the West and Central regions (38 and 31 per 1,000), among women aged 35–44 years, among women with postsecondary education, and among those with three or more previous births. The stillbirth rate did not vary significantly by the IDP/R status. Complicated pregnancies that required hospitalization were significantly more likely to have a higher stillbirth rate than uncomplicated pregnancies (42 vs. 15 per 1,000). Compared with normal labor, prolonged labor (over 20 hours for nulliparous women and over 14 hours for multiparous women) was associated with a more than two times higher prevalence of stillborns (52 vs. 20 per 1,000).

The incidence of low birth weight (under 2,500 grams) was 12%. Higher rates were reported by rural women, women in the South-West, South, and Central regions (18%, 15%, and 14%, respectively), women with low education (16%), or low SES (16%), IDP and non-IDP women living in conflict affected areas (16%), women with at least three prior births, women with no prenatal care (17%), and those who delivered at home (18%). Women who had prolonged labor (18%) or who delivered by C-section prior to the labor induction (24%) were more likely to report LBW, but their number is too small for a significant association. Interestingly, most low birth weight babies were reportedly delivered at term (data not shown). The incidence of prematurity (births before 37 weeks of gestation) was 5.7%. Except for higher rates among older women, prematurity did not vary much by women's characteristics.

## TABLE 6.3
## Poor Birth Outcomes by Selected Characteristics
### Births in 1996–2001
### Reproductive Health Survey: Azerbaijan, 2001

| Characteristic | Stillbirth Rate (per 1,000) | % Low Birth Weight Births (<2,500 grams) | % Preterm Birth (<37 weeks) | Unweighted No. of Cases |
|---|---|---|---|---|
| Total | 21.2 | 12.3 | 5.7 | 3,430 |
| **Residence** | | | | |
| Urban | 25.6 | 10.2 | 6.1 | 1,517 |
| Rural | 16.8 | 14.4 | 5.2 | 1,913 |
| **Region** | | | | |
| Baku | 21.8 | 8.4 | 8.0 | 616 |
| North & North-East | 11.2 | 10.7 | 3.6 | 475 |
| West | 38.3 | 13.1 | 8.4 | 322 |
| South-West | 20.9 | 17.5 | 5.0 | 1,151 |
| South | 15.1 | 14.5 | 4.8 | 438 |
| Central | 30.8 | 14.2 | 5.1 | 428 |
| **Age Group at Birth** | | | | |
| 15–24 | 18.7 | 12.0 | 6.1 | 1,625 |
| 25–34 | 19.2 | 12.5 | 4.4 | 1,582 |
| 35–44 | 53.1 | 13.0 | 11.1 | 223 |
| **Education** | | | | |
| Secondary incomplete or less | 15.6 | 16.2 | 5.1 | 759 |
| Secondary complete | 20.4 | 12.5 | 6.1 | 1,782 |
| Technicum | 26.8 | 10.4 | 5.6 | 521 |
| University | 28.2 | 6.2 | 5.1 | 368 |
| **Socioeconomic Status** | | | | |
| Low | 18.9 | 15.6 | 5.0 | 2,019 |
| Middle | 25.0 | 8.9 | 5.8 | 1,116 |
| High | 19.9 | 6.8 | 9.0 | 295 |
| **IDP/Refugee Status** | | | | |
| IDP/R | 20.5 | 16.0 | 3.8 | 678 |
| Non-IDP/CA | 19.1 | 15.5 | 5.1 | 1,311 |
| Non-IDP/NCA | 21.8 | 11.0 | 6.1 | 1,441 |
| **Birth Order** | | | | |
| First | 25.7 | 12.0 | 7.5 | 1,061 |
| Second | 19.9 | 9.6 | 4.6 | 1,111 |
| Third | 7.3 | 14.2 | 3.2 | 733 |
| Fourth or higher | 33.5 | 16.9 | 7.7 | 525 |
| **Prenatal Care** | | | | |
| No prenatal care | 18.6 | 16.7 | 5.7 | 1,127 |
| Any prenatal care | 22.3 | 10.4 | 5.7 | 2,303 |
| **Pregnancy Complications** | | | | |
| Yes | 41.8 | 12.3 | 9.1 | 858 |
| No | 14.5 | 12.3 | 4.6 | 2,572 |
| **Prolonged Labor** | | | | |
| Yes | 52.4 | 18.4 | 11.6 | 112 |
| No | 20.3 | 12.0 | 5.4 | 3,290 |
| No labor | 0.0 | 23.8 | 16.8 | 28 |

## 6.4 Breastfeeding

The AZRHS01 included questions about breastfeeding patterns and duration for all children under 5 years of age. As shown in Table 6.4.1, the majority of babies (95%) born during 1996–2001 were breastfed for at least a short period of time. The percentage of babies ever breastfed varied little by selected characteristics. Rates of breastfeeding were slightly lower among women living in urban areas, including Baku, women living in the Central region, and women living in households with a high SES. Infants who were delivered by C-section had a lower rate of breastfeeding than did those delivered vaginally (82% vs. 95%). Babies with low birth weight were slightly less likely to be breastfed than those with a birth weight of 2,500 grams or more (92% vs. 95%), but the difference is not significant.

According to WHO recommendations, early suckling (within the first hour postdelivery) should be promoted after all spontaneous deliveries. Table 6.4.1 (right panel) includes the time elapsed between delivery and initiation of breastfeeding. Of infants who were breastfed, only 13% began breastfeeding during the first hour after birth. The majority of children began breastfeeding between 2 hours after birth and the completion of the first day (38%) or during the second day of life (26%). About one of five babies (23%) began breastfeeding only after 48 hours of life. Breastfeeding initiation within the first hour was equally low regardless of the mothers' characteristics. Caesarean delivery substantially reduced the likelihood of early breastfeeding. For infants delivered by C-section, breastfeeding was more likely initiated after 2 days, if ever.

In Table 6.4.2 the mean duration of breastfeeding is given until the age at which a child was breastfed. An infant is exclusively breastfed if he or she receives only breast milk and is almost exclusively or predominantly breastfed if he or she receives breast milk accompanied by water or other liquids (except other types of milk). Children with exclusive or almost exclusive breastfeeding are considered to be fully breastfed (Labbok MH and Krasovec K, 1990). These indicators are recommended by WHO to assess the adequacy of breastfeeding practices in a population and allow for comparisons with findings from other countries. According to the WHO recommendations, "all infants should be fed exclusively on breast milk from birth to 4–6 months of age" and some breastfeeding should be maintained until the child is at least 1 year of age (World Health Organization, 1991).

The proportion of children under 5 years of age still being breastfed at the time of the survey was calculated by single month of age (0–59 months); the denominator included all live births in those 5 years (regardless of survival). These proportions were summed together to calculate the mean duration of breastfeeding. This method is known as the "current status mean" method (World Health Organization, 1991). Durations of exclusive and full breastfeeding were calculated the same way, where babies who had not yet initiated any other liquids or food were classified as exclusively breastfed and those who were either exclusively breastfed or who had started to receive liquids but no other food were classified as fully breastfed.

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## TABLE 6.4.1
### Percentage of Children Ever Breastfed and Their Initiation of Breastfeeding
### by Selected Characteristics
### Live Births in 1996–2001
### Reproductive Health Survey: Azerbaijan, 2001

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

\* Excludes 108 babies who died soon after birth.
† Excludes 108 babies who died soon after birth and 130 children who were never breastfed.

TABLE 6.4.2
**Mean Duration of Breastfeeding in Months, by Type of Breastfeeding, by Characteristics**
**Live Births in 1996–2001**
**Reproductive Health Survey: Azerbaijan, 2001**

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

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

The mean duration of any breastfeeding was 11.6 months (Table 6.4.2). For most of this time, however, breastfeeding was only partial. The mean duration of exclusive breastfeeding was 0.4 month and, with the exception of women residing in the Central region, did not vary greatly by maternal characteristics. Women in the South-West and West regions, those who gave birth after the age of 34, and IDP/Rs had lower mean durations. In addition, babies delivered by C-section, those with low birth weight, and those who initiated suckling 2 or more days after birth had lower mean durations of exclusive breastfeeding. Thus, very few children in Azerbaijan were exclusively breastfed for the minimum 4-month period recommended by the WHO.

## VII. WOMEN'S HEALTH

Before the dissolution of the Soviet Union, breast and cervix uteri cancers had the first and the third highest incidence, accounting for 20% and 9%, respectively, of all neoplasms among women. With uterine and ovarian cancer representing 13% of female cancers, gynecologic cancers accounted for over 42% of the total neoplasm rate in women (Zaridze D and Basieva T, 1993). In 1989, Azerbaijan, Georgia, and several Central Asian Republics had some of the lowest all-site cancer incidence rates among the 15 Soviet republics, according to incidence data reported through cancer registries (Morabia A and Levshin V, 1992). The incidence rate of breast cancer in Azerbaijan rose slightly in 1990 to 31.8 new cases per 100,000, but plummeted to 16.2 per 100,000 in 2000 while in all other former Soviet Union countries the rate increased or remained constant (WHO/EURO, HFA Database, 2002). Similarly, between 1990 and 2000, the incidence of cervical cancer decreased substantially (from 10.3 new cases per 100,000 to 5 per 100,000). Generally, data on gynecologic cancer incidence, particularly comparisons between countries, should be interpreted with caution, because of serious underreporting in countries with limited screening practices where women are registered in cancer registries only in the advanced stages of their disease (Parkin DM, Pisani P and Ferlay J, 1993). Mortality-related indicators are more reliable, although in some countries of the former USSR the coding of underlying causes of deaths and under-registration of deaths may still affect between-countries comparisons (WHO/EURO, HFA Database, 2002).

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

## TABLE 7.1
### Prevalence of Last Routine Gynecologic Examination by Selected Characteristics
### Women Aged 15–44 Years Who Have Ever Had Sexual Intercourse
### Reproductive Health Survey: Azerbaijan, 2001

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

* Fewer than 25 cases in this category.

## 7.1 Prevalence of Routine Gynecologic Visits

In the United States and western Europe it is recommended that women of reproductive age have a routine (not pregnancy related) gynecologic examination every year. The AZRHS01 shows that only about one in two (57%) sexually experienced women had ever been examined by a gynecologist during a routine exam, and only 22% had been examined in the previous 12 months (Table 7.1). Additionally, 15% of women had undergone an exam within the past 3 years and for 21% the exam had been more than 3 years ago. Rural residents, women living in the South and West, younger women, women with lower levels of education, and those not currently employed were more likely to have never received preventive gynecologic exams. Such a low prevalence of routine exams can have a substantial negative impact on screening, counseling, and health education.

## 7.2 Breast Self-Examination

Methods for early detection that can reduce breast cancer mortality include breast self-examination (BSE), breast physical examination performed by physicians, and mammography. In populations where mammography is not readily available or is too expensive (and thus unsuitable to be used in screening), BSE and medical exams can reduce breast cancer mortality if they are performed correctly and consistently. BSE is a very simple self-care procedure that can detect early modifications of the breast and can be performed by women in the privacy of their homes after minimal instruction. Appropriate follow-up by a physician should be available and accessible for women who detect breast changes through self examination.

The AZRHS01 explored only the level of awareness about BSE and its frequency of use. Overall, less than one of three (30%) sexually experienced women of childbearing age had ever heard about this technique and only one of 10 women (10%) had ever performed BSE (Table 7.2). Awareness of BSE was higher among urban residents than among rural residents (37% vs. 21%) and among women residing in Baku (49%), increased with age and educational level, and was higher among women currently employed and those who underwent routine gynecological exams, as compared to the average level of awareness. Both the prevalence of BSE and monthly practice of the exam were very low and did not vary significantly by women's background characteristics.

## 7.3 Cervical Cancer Screening

Data from large screening programs have shown that annual Pap smear screening reduces the probability of developing invasive cancer by 93.3%, screening every 3 years reduces the

**TABLE 7.2**

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

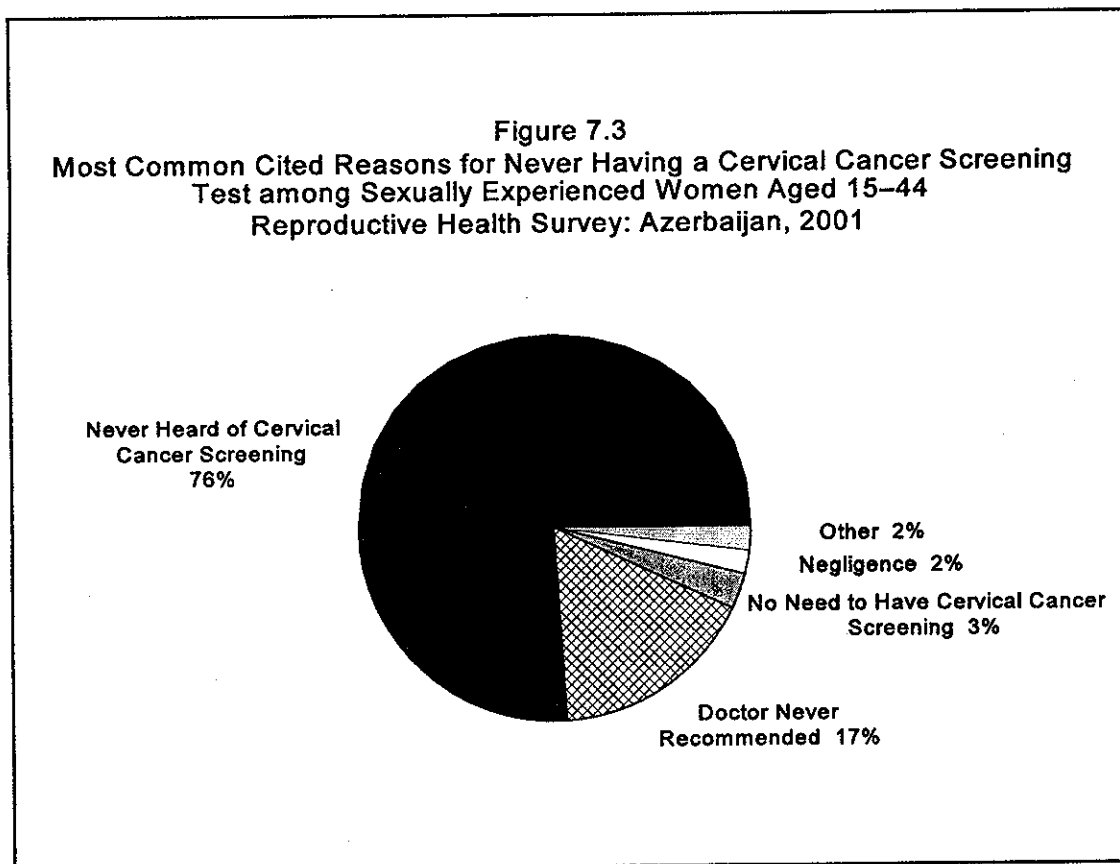| | Awareness | Frequency of Breast Self-Exam | | | | | |
|---|---|---|---|---|---|---|---|
| Characteristic | Total | Every Month | Every 3–5 Months | 1–2 Times per Year or Less | Never | Total | No. of Cases |
| **Total** | 29.5 | 6.3 | 1.8 | 2.1 | 89.9 | 100.0 | 5,540 |
| **Residence** | | | | | |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

* Fewer than 25 cases in this category.

## TABLE 7.3
### Cervical Cancer Screening History by Selected Characteristics
### Women 15–44 Years of Age Who Have Ever Had Sexual Intercourse
### Reproductive Health Survey: Azerbaijan, 2001

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

\* Fewer than 25 cases in this category.

probability by 91.2%, and screening every 5 years reduces it by 83.6% (Miller AB, 1986). Based on these estimates, most experts recommend that women who are sexually active or at least 18 years old have a Pap test annually or every 3 years, followed by the option of reducing the frequency of screening in women over age 65 who have been regularly screened with normal results. Although the self-reported rates of Pap testing are likely to be less accurate than the examination of medical records, survey results are often the only estimate available to assess the extent of cervical screening in the general population. The AZRHS01 included a series of questions for female respondents regarding Pap test history: "Have you ever had a cervical smear test (Papanicolau screening test)?", "When did you have your last cervical smear test?", and, for those who have never had a test, "What is the main reason you have never had a Pap smear?"

Overall, only 2% of sexually experienced women reported that they had ever had a Pap smear (Table 7.3) and less than 1% had their last test within the past 3 years. The prevalence of cervical cancer screening was generally very low and does not allow the study of potential determinants of preventive practices. It is worth noting, however, that the percentages of respondents not having a Pap test in the previous 3 years did not vary significantly with women's age. This finding may be of concern, as cervical cancer in situ is diagnosed most often in women aged 30–39 years, and invasive cervical cancer is diagnosed most often in women over 40 years of age (Brinton LA and



**Figure 7.3**
**Most Common Cited Reasons for Never Having a Cervical Cancer Screening Test among Sexually Experienced Women Aged 15–44**
**Reproductive Health Survey: Azerbaijan, 2001**

Never Heard of Cervical Cancer Screening 76%

Other 2%

Negligence 2%

No Need to Have Cervical Cancer Screening 3%

Doctor Never Recommended 17%

Fraumeni JF Jr, 1986). The very low prevalence (3%) of cervical screening among women seeking routine gynecologic exams is equally disturbing. Gynecologic routine visits should be viewed as opportunities to educate patients about healthy lifestyle choices and to promote appropriate screening for diseases such as cervical cancer. The most important reasons for not having a cervical cancer screening test are shown in Figure 7.3. For three fourths (76%) of respondents the most important reason was the lack of knowledge of such screening; the second most common reason was lack of recommendation of the test by a health provider (17%). Very few respondents (3%) reported that they had not had screening because they did not need such a test, and 2% of women reported that they neglected to undertake the test. These findings re-emphasize the lack of awareness of gynecologic screening procedures among women of reproductive age in Azerbaijan and the need for sustained educational campaigns for the public and changes in the practice of health care providers.

## 7.4 Prevalence of Selected Health Problems

All respondents were asked "Has a doctor ever told you that you have had (selected health problems)?" These problems were anemia, urinary infection, high blood pressure, heart disease, hepatitis B, asthma, and diabetes. In addition, the prevalence of pelvic inflammatory disease (PID), was determined by asking women if they "had ever been treated for an infection of the fallopian tubes, uterus, or ovaries, also called pelvic infection or PID?" Table 7.4 shows the percentage of women who had ever been told by a doctor that they have had these specific health problems.

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

The most common condition reported by women of reproductive age was anemia. Overall, 37% of all women and 44% of currently married women reported they had been told by a doctor that they had anemia. More than half (57%) of them had anemia outside a pregnancy (data not shown). The prevalence of anemia was higher among ever married women and increased with age and with the number of living children (data not shown). The anemia levels found in AZRHS01 (blood samples collected from women with children under 5 years of age) were consistent with the self-reported levels. Among nonpregnant women with at least one child under 5 years of age, 41% were

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## TABLE 7.4
### Percentage of Women Aged 15–44 Years Who Have Been Told by a Doctor
### That They Have Selected Health Problems by Selected Characteristics
### Reproductive Health Survey: Azerbaijan, 2000/2001

| Characteristic | Anemia | Pelvic Inflammatory Disease | High Blood Pressure | Urinary Infection | Hepatitis B | Diabetes | No. of Cases |
|---|---|---|---|---|---|---|---|
| **Total** | **36.5** | **26.8** | **17.7** | **14.0** | **1.7** | **0.5** | **7,668** |
| **Residence** | | | | | | | |
| Urban | 38.6 | 28.5 | 18.9 | 14.5 | 2.0 | 0.5 | 3,832 |
| Rural | 34.0 | 24.7 | 16.2 | 13.3 | 1.4 | 0.5 | 3,836 |
| **Region** | | | | | | | |
| Baku | 39.5 | 29.9 | 19.7 | 12.9 | 2.6 | 0.7 | 1,533 |
| North & North-East | 38.7 | 24.2 | 14.5 | 12.4 | 1.7 | 0.1 | 924 |
| West | 38.0 | 30.0 | 20.5 | 17.7 | 1.7 | 0.3 | 766 |
| South-West | 38.9 | 28.2 | 21.3 | 17.8 | 2.1 | 0.6 | 2,302 |
| South | 27.2 | 22.7 | 13.1 | 12.8 | 0.5 | 0.5 | 950 |
| Central | 35.7 | 26.8 | 19.9 | 13.6 | 1.4 | 1.0 | 1,193 |
| **Age Group** | | | | | | | |
| 15–19 | 23.0 | 1.8 | 3.8 | 6.1 | 2.3 | 0.5 | 1,207 |
| 20–24 | 37.3 | 16.7 | 12.4 | 12.6 | 1.8 | 0.1 | 1,207 |
| 25–29 | 43.0 | 31.3 | 15.0 | 14.2 | 1.4 | 0.0 | 1,156 |
| 30–34 | 42.9 | 39.2 | 23.1 | 18.4 | 1.2 | 0.2 | 1,533 |
| 35–39 | 44.1 | 44.0 | 25.7 | 19.8 | 1.4 | 1.2 | 1,531 |
| 40–44 | 33.6 | 38.8 | 32.9 | 15.5 | 2.0 | 0.9 | 1,034 |
| **Marital Status** | | | | | | | |
| Currently married, in union | 44.2 | 42.0 | 24.3 | 18.0 | 1.6 | 0.7 | 5,146 |
| Previously married, in union | 46.0 | 41.1 | 21.2 | 15.8 | 3.3 | 0.2 | 387 |
| Never married | 22.7 | 0.2 | 6.5 | 7.2 | 1.7 | 0.1 | 2,135 |
| **Education** | | | | | | | |
| Secondary incomplete or less | 34.8 | 19.6 | 14.0 | 11.5 | 0.9 | 0.6 | 1,697 |
| Secondary complete | 35.7 | 27.1 | 18.1 | 15.3 | 2.1 | 0.3 | 3,868 |
| Technicum | 40.2 | 35.5 | 22.5 | 12.9 | 1.3 | 0.8 | 1,215 |
| University/Postgraduate | 38.7 | 29.3 | 17.1 | 14.8 | 2.5 | 0.6 | 888 |
| **Employment** | | | | | | | |
| Currently employed | 41.1 | 31.4 | 22.6 | 14.4 | 1.5 | 0.6 | 1,600 |
| Not currently employed | 35.4 | 25.6 | 16.4 | 13.8 | 1.8 | 0.5 | 6,068 |
| **No. of Lifetime Partners** | | | | | | | |
| Never had intercourse | 22.6 | 0.0 | 6.5 | 7.2 | 1.7 | 0.1 | 2128 |
| 1 | 44.3 | 41.9 | 23.9 | 17.7 | 1.6 | 0.7 | 5389 |
| 2+ | 47.3 | 45.4 | 27.6 | 20.3 | 3.8 | 1.1 | 151 |
| **IDP/Refugee Status** | | | | | | | |
| IDP/R | 40.0 | 28.6 | 20.8 | 16.5 | 1.2 | 0.7 | 1272 |
| Non-IDP/CA | 35.7 | 27.6 | 20.7 | 16.0 | 1.3 | 0.6 | 3047 |
| Non-IDP/NCA | 36.3 | 26.4 | 16.5 | 13.1 | 1.9 | 0.4 | 3,349 |
| **Routine Gynecologic Exam** | | | | | | | |
| Ever Had | 47.6 | 63.8 | 26.9 | 21.5 | 2.0 | 0.7 | 3,270 |
| Never Had | 29.8 | 4.6 | 12.1 | 9.4 | 1.5 | 0.4 | 4,398 |

* Fewer than 25 cases in this category.

anemic (i.e., had hemoglobin levels under 12.0 g/dl). Most of these women (31% of 41%=76%) had mild anemia (Hb 10.0–11.9 g/dl) and less than one percent had severe anemia (Hb<7g/dl). These findings are consistent with the anemia levels measured among women with children under 5 in the 1996 Azerbaijan Health and Nutrition Survey (Branca F et al., 1996). Although not statistically different, the prevalence of anemia in AZRHS01 was slightly lower among IDP women than among non-IDP women (38% vs. 41%).

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

Other health conditions were reported as follows: one in six women reported she had been told by a doctor that she had high blood pressure; 14% reported urinary tract infection; 2% had been diagnosed with hepatitis B, and a very few women had been told that they had diabetes (1%).


## VIII. KNOWLEDGE AND EXPERIENCE OF SEXUALLY TRANSMITTED DISEASES

Since the early 1990s, many newly independent states (NIS) of the former Soviet Union have experienced major epidemics of STDs, particularly of syphilis. The extent of the increase in reported cases of syphilis, however, varies widely between the NIS countries. While the reported incidence of new cases of syphilis in several NIS countries increased 45–165 times during 1990–1998—the steeper increases were reported in Kazakhstan (from 1.4 to 231.4 per 100,000), Kyrgystan (from 2 to 144.4 per 100,000), Belarus (from 2.7 to 164 new cases per 100,000), and the Russian Federation (from 5.3 to 225.6 per 100,000)—the rates in the countries of the Caucasus region, though higher than in 1990, remained low by comparison (Riedner G et al., 2000).

The reported syphilis rate (new cases) in Azerbaijan registered a three-fold increase between 1990 and 1998, from 2.7 per 100,000 population to 8.2 per 100,000 population. Between 1997 and 1998, the number of congenital syphilis cases increased from 7 to 12 cases, and the decreased number of live births reflected a higher prevalence of untreated syphilis among pregnant women. One factor

that may have been responsible for this increase is the low antenatal care clinic attendance which lessens the likelihood of active case-finding and early treatment of syphilis among pregnant women. Interestingly, the reported incidence of gonorrhea started to increase in 1992, reached a peak in 1996 (26.4 per 100,000 population), declined thereafter, and stabilized at around 12 new cases per 100,000 in 1998–2000 (MOH and SCS, 2001). The recent drop in the reported incidence of gonorrhea is attributed more to underreporting and changes in case-finding policies and procedures than to a real decrease in incidence (UNAIDS, 1999).

As is the case with most former Soviet Union countries, Azerbaijan inherited a centrally controlled STD surveillance system centered on venereal disease (VD) clinics. Because of limited laboratory resources, very few VD clinics have the ability to provide a wide array of laboratory testing and treatment. STD reporting is believed to be seriously affected by the general lack of resources that has plagued health care services during the past decade. As is the case in other countries of Eastern Europe and NIS, women with STD symptoms are more likely to seek gynecological care in women's consultation clinics, and gynecologists seldom report these patients to the VD network, although they are required to do so (UNAIDS, 1999).

Because of scarce and competing health resources, STD prevention and education needs should become a focal component of the strategy for STD control. Preventive efforts should include dissemination of information on means of transmission of all STDs, including HIV/AIDS, promotion of safer sex, and risk reduction practices. However, information must not convey needless threats to those with a very low risk of becoming infected.

To effectively target these educational efforts, policy makers and program managers should be aware of the STD knowledge among various population groups and define population subgroups in greater need of primary-prevention messages. In addition, they need to identify factors that influence correct knowledge and to better understand misconceptions about HIV transmission. The AZRHS01 collected detailed information about the level of awareness of the most common STDs, the source of information about STDs, and the accuracy of knowledge about HIV transmission and prevention of HIV infection among women of reproductive age. In addition, for the most common STDs, the survey explored women's exposure to STD testing, self-reported lifetime prevalence, and self-perceived risk of STD infection.

## 8.1 Knowledge of AIDS and Other STDs

When asked if they had ever heard of nine specific STDs, a high percentage (74%) of women had heard of HIV/AIDS, but significantly fewer women had heard of syphilis (41%) and gonorrhea

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TABLE 8.1.1

Percentage of Women Aged 15–44 Years Who Have Heard of Specified Sexually Transmitted Diseases
by Selected Characteristics

Reproductive Health Survey: Azerbaijan, 2001

| Characteristic | HIV/ AIDS | Yeast Infection | Syphilis | Gonorrhea | Trichomonas | Chlamydia | Bacterial Vaginosis | Genital Warts | Genital Herpes | No. of Cases |
|---|---|---|---|---|---|---|---|---|---|---|
| Total | 74.1 | 57.8 | 41.4 | 34.5 | 12.4 | 8.4 | 7.4 | 6.1 | 5.3 | 7,668 |
| **Residence** | | | | | | | | | | |
| Urban | 85.1 | 67.8 | 55.4 | 41.8 | 19.5 | 12.5 | 10.8 | 8.6 | 7.5 | 3,832 |
| Rural | 61.0 | 45.8 | 24.5 | 25.8 | 3.8 | 3.6 | 3.2 | 3.0 | 2.7 | 3,836 |
| **Region** | | | | | | | | | | |
| Baku | 93.1 | 76.8 | 69.0 | 46.8 | 30.4 | 18.5 | 16.0 | 12.6 | 11.4 | 1,533 |
| North & North-East | 77.6 | 55.4 | 40.5 | 29.5 | 9.7 | 6.2 | 5.4 | 5.0 | 5.0 | 924 |
| West | 70.4 | 52.8 | 38.5 | 30.0 | 7.8 | 7.2 | 4.4 | 3.8 | 3.5 | 766 |
| South-West | 62.9 | 47.2 | 22.8 | 28.0 | 4.6 | 4.2 | 3.7 | 3.9 | 2.5 | 2,302 |
| South | 55.4 | 44.5 | 22.7 | 29.8 | 3.6 | 3.8 | 3.1 | 2.7 | 2.3 | 950 |
| Central | 70.7 | 58.9 | 35.8 | 37.6 | 8.0 | 5.6 | 7.3 | 5.3 | 3.3 | 1,193 |
| **Age Group** | | | | | | | | | | |
| 15–19 | 55.7 | 33.2 | 14.2 | 13.0 | 2.8 | 2.4 | 3.3 | 3.0 | 2.1 | 1,207 |
| 20–24 | 77.3 | 53.3 | 37.0 | 28.9 | 10.0 | 7.9 | 6.9 | 5.2 | 5.3 | 1,207 |
| 25–29 | 82.3 | 64.0 | 47.9 | 37.5 | 15.9 | 10.2 | 9.4 | 7.6 | 7.1 | 1,156 |
| 30–34 | 81.8 | 68.2 | 47.5 | 41.6 | 14.7 | 10.8 | 9.5 | 8.9 | 7.0 | 1,533 |
| 35–39 | 79.2 | 70.1 | 57.0 | 48.3 | 17.5 | 11.9 | 8.8 | 7.1 | 6.1 | 1,531 |
| 40–44 | 76.3 | 69.6 | 57.8 | 47.6 | 18.2 | 9.9 | 8.3 | 6.1 | 5.8 | 1,034 |
| **Marital Status** | | | | | | | | | | |
| Currently married, in union | 80.3 | 68.3 | 51.1 | 42.9 | 15.5 | 10.7 | 8.3 | 6.8 | 6.1 | 5,146 |
| Previously married, in union | 78.8 | 64.3 | 51.8 | 36.7 | 18.5 | 11.0 | 8.0 | 8.0 | 4.6 | 387 |
| Never married | 63.7 | 40.1 | 24.3 | 20.6 | 6.5 | 4.4 | 5.8 | 4.6 | 4.1 | 2,135 |
| **No. of Living Children** | | | | | | | | | | |
| 0 | 65.4 | 43.4 | 26.8 | 22.8 | 7.4 | 5.8 | 6.1 | 5.1 | 4.5 | 2,655 |
| 1 | 82.3 | 67.3 | 50.6 | 41.9 | 19.5 | 16.1 | 11.9 | 8.9 | 7.1 | 784 |
| 2 | 84.5 | 72.2 | 57.0 | 44.8 | 19.5 | 12.1 | 9.5 | 8.0 | 7.7 | 2,094 |
| 3 | 80.8 | 69.9 | 52.1 | 44.5 | 13.7 | 7.4 | 7.2 | 6.1 | 4.7 | 1,530 |
| 4+ | 67.6 | 58.2 | 42.2 | 38.7 | 6.7 | 4.9 | 3.0 | 2.7 | 1.5 | 605 |
| **Education** | | | | | | | | | | |
| Secondary incomplete or less | 54.5 | 39.6 | 22.2 | 19.1 | 2.4 | 1.8 | 2.0 | 1.4 | 1.8 | 1,697 |
| Secondary complete | 72.8 | 54.0 | 34.7 | 29.9 | 6.6 | 5.0 | 4.2 | 3.5 | 2.5 | 3,868 |
| Technicum | 92.5 | 79.6 | 67.0 | 54.9 | 27.3 | 16.5 | 14.6 | 11.8 | 9.2 | 1,215 |
| University/Postgraduate | 96.6 | 83.0 | 75.3 | 59.1 | 37.3 | 25.9 | 22.0 | 19.0 | 18.9 | 888 |
| **No. of Lifetime Partners** | | | | | | | | | | |
| 0 | 63.5 | 39.9 | 24.1 | 20.5 | 6.4 | 4.3 | 5.7 | 4.6 | 4.1 | 2,128 |
| 1 | 80.1 | 67.8 | 50.5 | 41.9 | 14.9 | 10.3 | 8.0 | 6.7 | 5.8 | 5,389 |
| 2+ | 83.1 | 74.6 | 75.7 | 60.6 | 44.1 | 24.8 | 18.1 | 15.5 | 13.2 | 151 |
| **IDP/Refugee Status** | | | | | | | | | | |
| IDP/R | 69.6 | 54.3 | 38.1 | 32.8 | 7.4 | 6.9 | 7.5 | 5.1 | 3.0 | 1,272 |
| Non-IDP/CA | 66.9 | 54.0 | 29.8 | 33.7 | 7.0 | 4.5 | 4.9 | 4.8 | 3.1 | 3,047 |
| Non-IDP/NCA | 76.5 | 59.2 | 44.6 | 34.9 | 14.3 | 9.6 | 8.0 | 6.5 | 6.1 | 3,349 |

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TABLE 8.1.2
**Percentage of Women Aged 15-44 Years Who Have Heard of HIV/AIDS, Percent Who Know Where HIV Testing Can Be Provided and Percent Who Believe HIV/AIDS Infection Can Be Asymptomatic by Selected Characteristics**
**Reproductive Health Survey: Azerbaijan, 2001**

| Characteristic | Have Heard of HIV/AIDS | | Know Where HIV Tests are Provided | | Believe That HIV/AIDS Infection Can Be Asymptomatic | |
|---|---|---|---|---|---|---|
| | % | N | % | N | % | N |
| **Total** | **74.1** | **7,668** | **16.2** | **7,668** | **27.6** | **5,623** |
| **Residence** | | | | | | |
| Urban | 85.1 | 3,832 | 22.4 | 3,832 | 31.1 | 3,246 |
| Rural | 61.0 | 3,836 | 8.9 | 3,836 | 21.9 | 2,377 |
| **Region** | | | | | | |
| Baku | 93.1 | 1,533 | 32.0 | 1,533 | 36.9 | 1,439 |
| North & North-East | 77.6 | 924 | 15.9 | 924 | 25.6 | 738 |
| West | 70.4 | 766 | 9.3 | 766 | 23.7 | 551 |
| South-West | 62.9 | 2,302 | 8.0 | 2,302 | 21.8 | 1,510 |
| South | 55.4 | 950 | 9.6 | 950 | 21.7 | 545 |
| Central | 70.7 | 1,193 | 11.7 | 1,193 | 24.6 | 840 |
| **Age Group** | | | | | | |
| 15–19 | 55.7 | 1,207 | 7.9 | 1,207 | 22.8 | 644 |
| 20–24 | 77.3 | 1,207 | 16.6 | 1,207 | 29.7 | 879 |
| 25–29 | 82.3 | 1,156 | 22.1 | 1,156 | 30.9 | 922 |
| 30–34 | 81.8 | 1,533 | 20.2 | 1,533 | 28.0 | 1,204 |
| 35–39 | 79.2 | 1,531 | 19.0 | 1,531 | 27.2 | 1,190 |
| 40–44 | 76.3 | 1,034 | 15.2 | 1,034 | 27.2 | 784 |
| **Marital Status** | | | | | | |
| Currently married, in union | 80.3 | 5,146 | 18.5 | 5,146 | 27.8 | 3,996 |
| Previously married, in union | 78.8 | 387 | 20.7 | 387 | 29.5 | 295 |
| Never married | 63.7 | 2,135 | 11.9 | 2,135 | 26.9 | 1,332 |
| **No. of Living Children** | | | | | | |
| 0 | 65.4 | 2,655 | 12.7 | 2,655 | 26.6 | 1,698 |
| 1 | 82.3 | 784 | 22.4 | 784 | 35.0 | 619 |
| 2 | 84.5 | 2,094 | 20.8 | 2,094 | 28.6 | 1,722 |
| 3 | 80.8 | 1,530 | 17.1 | 1,530 | 25.6 | 1,200 |
| 4+ | 67.6 | 605 | 13.0 | 605 | 23.5 | 384 |
| **Education** | | | | | | |
| Secondary incomplete or less | 54.5 | 1,697 | 7.1 | 1,697 | 18.1 | 887 |
| Secondary complete | 72.8 | 3,868 | 12.2 | 3,868 | 24.5 | 2,766 |
| Technicum | 92.5 | 1,215 | 27.3 | 1,215 | 31.2 | 1,112 |
| University/Postgraduate | 96.6 | 888 | 37.5 | 888 | 43.8 | 858 |
| **Socioeconomic Status** | | | | | | |
| Low | 61.5 | 4,068 | 9.0 | 4,068 | 21.9 | 2,538 |
| Medium | 84.0 | 2,770 | 21.0 | 2,770 | 29.3 | 2,319 |
| High | 93.1 | 830 | 30.0 | 830 | 38.0 | 766 |
| **No. of Lifetime Partners** | | | | | | |
| 0 | 63.5 | 2,128 | 11.8 | 2,128 | 26.9 | 1,323 |
| 1 | 80.1 | 5,389 | 18.3 | 5,389 | 27.6 | 4,182 |
| 2+ | 83.1 | 151 | 31.7 | 151 | 37.4 | 118 |
| **IDP/Refugee Status** | | | | | | |
| IDP/R | 69.6 | 1,272 | 13.9 | 1,272 | 25.2 | 871 |
| Non-IDP/CA | 66.9 | 3,047 | 10.8 | 3,047 | 23.0 | 2,019 |
| Non-IDP/NCA | 76.5 | 3,349 | 18.0 | 3,349 | 28.9 | 2,733 |

(35%) (Table 8.1.1). The levels of awareness about other diseases which are transmitted through sexual contact was very low; only 12% of women had heard of trichomonas, 8% had heard of chlamydia, 7% were aware of bacterial vaginosis, 6% and 5%, respectively, knew that genital warts and genital herpes are transmitted sexually.

The level of STD awareness varied slightly by characteristics. Rural and young women aged 15–19, never married women and those without sexual experience, and women with the least educational attainment were less likely to have heard of HIV/AIDS and other STDs. STD awareness did not vary significantly among IDP and non-IDP women. Although three fourths of women were aware of HIV/AIDS, only one in six (16%) said that she knew where HIV tests are provided, including the 3% who had been tested for HIV/AIDS (Table 8.1.2). The proportion of women who knew where to get an HIV test was significantly lower among rural women, women outside Baku, adolescents, never married women, and women with low education or low SES.

Awareness of HIV/AIDS did not necessarily mean that the respondents had detailed information about the disease. All of the 5,623 respondents who had heard of HIV/AIDS were asked whether they believed a person could be infected with the HIV virus and be asymptomatic (Table 8.1.2). Only slightly more than one in four (28%) of the women who had heard of HIV knew that the disease could be present with no symptoms. This fact is particularly important because the women who do not know the virus can be present without symptoms could put themselves at risk if they have sexual intercourse with an apparently healthy HIV-infected individual. Knowledge of asymptomatic HIV varied slightly by respondent characteristics. Women living in rural areas (22%), those residing in the South and South-West regions (22%), adolescents (23%), women with incomplete secondary education (18%), and those at a low socioeconomic level (22%) had less knowledge of asymptomatic HIV than did residents of Baku (37%) and those with university education (44%) and a high socioeconomic level (38%). Sexual experience and marital status had little or no effect on knowledge. Since urban settings, higher education, and higher socioeconomic level had a significant effect on increased awareness of HIV/AIDS, knowledge about HIV testing, and knowledge of asymptomatic HIV, educational programs may be most beneficial if they target women in rural settings and from lower educational and socioeconomic levels.

## 8.2 Self-Reported STD Testing and Diagnostic

Although population-based surveys represent an important addition to data gathered by STD surveillance systems, they too are vulnerable to underreporting. Individual reports about STD testing and diagnosis are also likely to underestimate the true magnitude of the STD levels because of lack of awareness, recall bias, and underreporting of sensitive information. Furthermore, surveys produce

prevalence estimates but are less useful in examining incidence levels. Despite their limitations, surveys complement surveillance data with estimates representative for the general population and various subgroups and allow for correlates of STDs with reproductive-related information and health risk behaviors.

Table 8.2.1 shows the reported levels of testing and diagnosis for the eight most common STDs in Azerbaijan. Respondents were not asked about HIV diagnosis and treatment. According to women's responses, the most often diagnosed STDs were yeast infection and trichomoniasis. Of all women aged 15–44, 5% reported having had a yeast infection, and 1% had had trichomonas infection. For these two STDs, women living in Baku (12% and 3%), women with university education (12% and 3%), and women with two or more lifetime sexual partners (22% and 9%) were more likely to report positive testing, rates that are probably due to differences in health-seeking behaviors and access to health services. A history of other STDs was very seldom reported: only 0.3% of women had been diagnosed with chlamydia, 0.2% with gonorrhea, and 0.1% with genital warts, genital herpes, or bacterial vaginosis.

In interpreting these results it should be kept in mind that laboratory testing resources in Azerbaijan are quite limited, and for most STDs, without testing there is no diagnosis. Furthermore, the differences in awareness of specific STDs (that are influenced by background characteristics) may affect the level of reporting of both testing and confirmed diagnosis. Some STDs are better known than others and may be reported more accurately. Also, some STDs require mandatory notifications to the dermato-venerology network (e.g., syphilis, gonorrhea), and respondents may be reluctant to acknowledge such infections, despite the assured confidentiality of the interviews.

Overall, only one in five sexually experienced women (19%) had ever been tested for STDs (Table 8.2.2). The most frequently tested (13%) and reported (7%) STD among sexually experienced women was yeast infection. Only 7% of women reported being tested for syphilis, but practically none of them reported that they had been diagnosed with the disease. Similarly, very few women (3%) reported gonorrhea testing and less than 1% reported a diagnosis. Trichomonas testing was reported by 4% of women, and the positivity rate was about 50% among those tested. Chlamydia was reported by 2% of women with a positivity rate of 25%. According to women's reports about viral STDs, genital warts and genital herpes were very seldom tested (0.5% and 0.6%, respectively) because diagnosis is usually based on clinical examination. Almost 5% of women reported having been tested for HIV/AIDS. Data on testing results were not collected by the survey.

# TABLE 8.2.1
## Percentage of Women Aged 15–44 Years with a Diagnosis of
## Specified Sexually Transmitted Diseases by Selected Characteristics
## Reproductive Health Survey: Azerbaijan, 2001

| Characteristic | Yeast Infection | Trichomonas | Chlamydia | Gonorrhea | Genital Warts | Genital Herpes | Bacterial Vaginosis | Syphilis | No. of Cases |
|---|---|---|---|---|---|---|---|---|---|
| Total | 5.0 | 1.1 | 0.3 | 0.2 | 0.1 | 0.1 | 0.1 | 0.0 | 7,668 |
| **Residence** | | | | | | | | | |
| Urban | 7.1 | 1.6 | 0.4 | 0.3 | 0.2 | 0.1 | 0.2 | 0.0 | 3,832 |
| Rural | 2.4 | 0.4 | 0.2 | 0.1 | 0.1 | 0.0 | 0.0 | 0.0 | 3,836 |
| **Region** | | | | | | | | | |
| Baku | 11.8 | 2.8 | 0.8 | 0.5 | 0.4 | 0.3 | 0.4 | 0.0 | 1,533 |
| North & North-East | 2.6 | 0.7 | 0.2 | 0.1 | 0.0 | 0.1 | 0.0 | 0.0 | 924 |
| West | 2.5 | 0.6 | 0.1 | 0.1 | 0.0 | 0.0 | 0.0 | 0.0 | 766 |
| South-West | 1.9 | 0.1 | 0.3 | 0.4 | 0.0 | 0.0 | 0.0 | 0.0 | 2,302 |
| South | 3.0 | 0.1 | 0.4 | 0.1 | 0.0 | 0.0 | 0.0 | 0.1 | 950 |
| Central | 5.0 | 1.0 | 0.1 | 0.1 | 0.2 | 0.0 | 0.0 | 0.0 | 1,193 |
| **Age Group** | | | | | | | | | |
| 15–19 | 0.3 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 1,207 |
| 20–24 | 2.2 | 0.4 | 0.7 | 0.3 | 0.2 | 0.0 | 0.1 | 0.1 | 1,207 |
| 25–29 | 7.8 | 1.7 | 0.4 | 0.3 | 0.2 | 0.2 | 0.2 | 0.0 | 1,156 |
| 30–34 | 6.2 | 1.1 | 0.4 | 0.5 | 0.1 | 0.3 | 0.1 | 0.1 | 1,533 |
| 35–39 | 8.7 | 2.4 | 0.3 | 0.3 | 0.2 | 0.0 | 0.1 | 0.0 | 1,531 |
| 40–44 | 7.1 | 1.3 | 0.3 | 0.1 | 0.2 | 0.0 | 0.0 | 0.0 | 1,034 |
| **Marital Status** | | | | | | | | | |
| Currently married, in union | 7.8 | 1.6 | 0.5 | 0.3 | 0.2 | 0.2 | 0.2 | 0.0 | 5,146 |
| Previously married, in union | 5.5 | 1.8 | 0.4 | 1.2 | 0.0 | 0.0 | 0.0 | 0.5 | 387 |
| Never married | 0.3 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 2,135 |
| **No. of Living Children** | | | | | | | | | |
| 0 | 1.3 | 0.2 | 0.3 | 0.1 | 0.0 | 0.1 | 0.0 | 0.0 | 2,655 |
| 1 | 10.8 | 2.5 | 1.2 | 0.5 | 0.1 | 0.0 | 0.5 | 0.1 | 784 |
| 2 | 8.3 | 2.3 | 0.3 | 0.3 | 0.5 | 0.2 | 0.2 | 0.1 | 2,094 |
| 3 | 7.4 | 0.9 | 0.0 | 0.6 | 0.0 | 0.0 | 0.0 | 0.0 | 1,530 |
| 4+ | 3.2 | 0.8 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 605 |
| **Education Level** | | | | | | | | | |
| Secondary incomplete or less | 2.6 | 0.2 | 0.1 | 0.1 | 0.0 | 0.0 | 0.0 | 0.0 | 1,697 |
| Secondary complete | 3.8 | 0.8 | 0.3 | 0.3 | 0.1 | 0.1 | 0.1 | 0.1 | 3,868 |
| Technicum | 7.3 | 1.8 | 0.1 | 0.3 | 0.2 | 0.1 | 0.0 | 0.0 | 1,215 |
| University/Postgraduate | 11.9 | 3.0 | 1.2 | 0.3 | 0.4 | 0.4 | 0.5 | 0.0 | 888 |
| **No. of Lifetime Partners** | | | | | | | | | |
| 0 | 0.3 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 2,128 |
| 1 | 7.2 | 1.4 | 0.5 | 0.3 | 0.2 | 0.1 | 0.1 | 0.0 | 5,389 |
| 2+ | 21.7 | 8.5 | 1.2 | 1.2 | 0.8 | 1.2 | 1.7 | 1.0 | 151 |
| **IDP/Refugee Status** | | | | | | | | | |
| IDP/R | 2.9 | 0.4 | 0.3 | 0.4 | 0.3 | 0.0 | 0.0 | 0.0 | 1,272 |
| Non-IDP/CA | 4.3 | 0.8 | 0.1 | 0.4 | 0.2 | 0.0 | 0.0 | 0.0 | 3,047 |
| Non-IDP/NCA | 5.4 | 1.2 | 0.4 | 0.2 | 0.1 | 0.1 | 0.1 | 0.0 | 3,349 |

**TABLE 8.2.2**
**Level of Awareness, Testing, Diagnosis, and Treatment for STDs**
**Among Women Aged 15–44 Years Who Have Ever Had Sexual Intercourse**
**by Specified Sexually Transmitted Diseases**
**Reproductive Health Survey: Azerbaijan, 2001**

| Specific STDs | Awareness of STDs | Testing for STDs | Diagnosis of STDs | Treatment for STDs | Number of Cases |
|---|---|---|---|---|---|
| HIV/AIDS | 80.2 | 4.5 | * | * | 5,540 |
| Syphilis | 51.2 | 7.4 | 0.1 | 0.0 | 5,540 |
| Yeast Infection | 68.0 | 12.6 | 7.6 | 7.5 | 5,540 |
| Gonorrhea | 42.5 | 2.7 | 0.4 | 0.4 | 5,540 |
| Trichomonas | 15.8 | 4.0 | 1.7 | 1.7 | 5,540 |
| Chlamydia | 10.8 | 2.4 | 0.5 | 0.5 | 5,540 |
| Bacterial Vaginosis | 8.3 | 0.9 | 0.1 | 0.1 | 5,540 |
| Genital Warts | 7.0 | 0.5 | 0.2 | 0.2 | 5,540 |
| Genital Herpes | 6.0 | 0.6 | 0.1 | 0.1 | 5,540 |
| **Any STDs** | **87.9** | **19.1** | **9.1** | **8.9** | 5,540 |

\* Respondents were not asked about the results of HIV testing.

## 8.3 Self-Reported STD Symptoms

In an attempt to assess the prevalence of STD symptoms among the general population, the survey included a series of questions about recent history of vaginal discharge and the presence or absence of any genital sores or ulcers. Table 8.3 shows the reported prevalence of vaginal discharge and genital sores/ulcers among sexually experienced women aged 15–44 during the 12 months prior to the interview. Almost one in three sexually experienced women reported abnormal vaginal discharge

## TABLE 8.3
### Percent of Sexually Experienced Women 15–44 Who Have Ever Had Vaginal Discharge and Percent Who Reported Other Symptoms Associated with Vaginal Discharge by Selected Characteristics
### Reproductive Health Survey: Azerbaijan, 2001

| Characteristic | Vaginal Discharge or Genital Ulcer | | | Symptoms Associated with Vaginal Discharge | | | | |
|---|---|---|---|---|---|---|---|---|
| | Vaginal Discharge | Genital Ulcer/Sores | N | Abdominal Pains | Vaginal Prurit | Pain During Intercourse | Dysuria | N |
| Total | 32.1 | 1.6 | 5,540 | 77.9 | 51.1 | 43.2 | 37.1 | 1,973 |
| **Residence** | | | | | | | | |
| Urban | 32.0 | 2.1 | 2,823 | 73.8 | 47.4 | 37.6 | 30.6 | 935 |
| Rural | 32.2 | 0.9 | 2,717 | 82.9 | 55.7 | 50.2 | 45.1 | 1,038 |
| **Region** | | | | | | | | |
| Baku | 29.3 | 2.2 | 1,145 | 63.0 | 36.7 | 34.2 | 22.2 | 342 |
| North & North-East | 30.6 | 0.8 | 674 | 79.4 | 46.1 | 44.4 | 36.2 | 207 |
| West | 40.0 | 2.1 | 568 | 83.9 | 57.2 | 48.7 | 38.0 | 240 |
| South-West | 43.7 | 1.6 | 1,647 | 85.4 | 60.6 | 53.0 | 50.3 | 718 |
| South | 26.4 | 1.3 | 640 | 82.1 | 60.1 | 39.9 | 42.9 | 186 |
| Central | 29.6 | 1.8 | 866 | 79.8 | 57.0 | 42.1 | 43.4 | 280 |
| **Age Group** | | | | | | | | |
| 15–19 | 28.0 | 0.0 | 160 | 65.4 | 45.1 | 41.6 | 38.0 | 52 |
| 20–24 | 36.1 | 1.1 | 674 | 72.8 | 42.4 | 41.9 | 37.8 | 232 |
| 25–29 | 35.5 | 2.5 | 951 | 81.2 | 47.4 | 47.9 | 32.6 | 350 |
| 30–34 | 37.4 | 1.7 | 1,393 | 79.0 | 49.1 | 40.7 | 35.4 | 560 |
| 35–39 | 30.8 | 1.7 | 1,391 | 79.7 | 62.1 | 45.8 | 41.0 | 498 |
| 40–44 | 22.8 | 1.3 | 971 | 76.3 | 50.9 | 39.4 | 38.1 | 281 |
| **Marital Status** | | | | | | | | |
| Currently Married, in Union | 31.9 | 1.7 | 5,146 | 78.1 | 52.0 | 46.7 | 37.8 | 1,839 |
| Previously Married, in Union | 33.1 | 0.4 | 385 | 75.1 | 39.5 | 5.5 | 27.4 | 128 |
| Never Married | * | * | 9 | * | * | * | * | 6 |
| **Education Level** | | | | | | | | |
| Secondary Incomplete or less | 32.4 | 1.0 | 1,057 | 80.2 | 57.7 | 47.8 | 43.9 | 388 |
| Secondary Complete | 31.6 | 1.7 | 2,845 | 80.4 | 52.7 | 43.3 | 38.5 | 1,010 |
| Technicum | 31.7 | 1.6 | 989 | 73.3 | 51.6 | 47.4 | 35.8 | 348 |
| University/Postgraduate | 34.1 | 2.3 | 649 | 70.7 | 33.5 | 29.9 | 22.5 | 227 |
| **No. of Lifetime Partners** | | | | | | | | |
| 1 | 31.9 | 1.6 | 5,389 | 78.6 | 51.7 | 43.6 | 37.5 | 1,916 |
| 2+ | 39.3 | 1.6 | 151 | 57.9 | 35.4 | 32.8 | 26.3 | 57 |
| **IDP/R Status** | | | | | | | | |
| IDP/R | 36.7 | 2.4 | 929 | 84.9 | 67.7 | 49.7 | 47.9 | 386 |
| Non-IDP/CA | 35.2 | 1.8 | 2,151 | 81.9 | 60.5 | 48.4 | 48.1 | 826 |
| Non-IDP/NCA | 30.7 | 1.4 | 2,460 | 75.7 | 45.9 | 40.8 | 32.4 | 761 |
| **Any STD Testing** | | | | | | | | |
| Ever Had | 39.4 | 3.5 | 963 | 68.5 | 48.8 | 41.7 | 30.8 | 406 |
| Never Had | 30.4 | 1.1 | 4,577 | 80.7 | 51.8 | 43.7 | 39.0 | 1,567 |
| **Any STD Diagnosis** | | | | | | | | |
| Ever Had | 48.6 | 4.7 | 476 | 65.7 | 50.4 | 43.7 | 27.9 | 245 |
| Never Had | 30.4 | 1.3 | 5,064 | 79.8 | 51.2 | 43.1 | 38.5 | 1,728 |

* Fewer than 25 observations in this category.

and 2% reported "sores, warts, or ulcers in the genital area." Reports of STD symptoms did not vary significantly by respondents' background characteristics. Reports of vaginal discharge and sores were higher among women who had ever been tested for an STD or had one diagnosed, an indication that their STD symptoms were severe enough to seek medical care. Among women who had recently experienced vaginal discharge, 78% also reported low abdominal pain, 51% reported vaginal itching, 41% reported pain during sexual intercourse, and 37% reported painful urination (dysuria).

This information could be used to decide if a syndromic approach for the case management of STDs among a female population is warranted. Syndromic case reports do not require laboratory diagnostic tests and are based on the identification of a combination of symptoms and signs (syndromes) suggestive of selected STDs. Syndromic case management combines the identified syndromes with knowledge about the most common causative organisms and their antibiotic susceptibility. However, the syndromic approach is not suitable for assessment of STD incidence and prevalence or for measurement of the impact of STD prevention programs. In addition, treatment based on syndromic case definitions leads to overtreatment, promotion of antimicrobial resistance, and social costs related to mislabeling individuals as being infected with an STD. These drawbacks should be carefully balanced against the costs associated with STD complications, continued transmission and potential increased transmission of HIV infection, and medical costs such as laboratory testing and clinical diagnosis (van Dam CJ et al., 1998).

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