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CHILD WELLBEING IN GEORGIA
2023

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Acknowledgement

Results of the Child Welfare Survey was carried out in 2022. This report was drafted by Dimitri Gugushvili, a consultant of the UNICEF Office of Research Innocenti., with technical assistance provided by UNICEF staff members Amy Clancy, Giorgi Kalakashvili and Ketevan Melikadze.

ABBREVIATIONS

CWS	Child Welfare Survey
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
EU	European Union
EU-SILC	European Union Statistics on Income and Living Conditions
Geostat	National Statistics Office of Georgia
GEL	Georgian Lari
HIES	Household Income and Expenditure Survey
MICS	Multiple Indicator Cluster Survey
MODA	Multiple Overlapping Deprivation Analysis
MoIDPLHSA	Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Assistance
OECD	Organisation for Economic Co-operation and Development
PISA	Programme for International Student Assessment
PIRLS	Progress in International Reading Literacy Study
PMT	Proxi-means testing
RTM/MICS	Real-Time Monitoring/Multiple Indicator Cluster Survey (RTM/MICS)
TIMSS	Trends in International Mathematics and Science Study
TSA	Targeted Social Assistance
UN IGME	UN Inter-agency Group for Child Mortality Estimation
WHO	World Health Organization

EXECUTIVE SUMMARY

This report presents the results of the Child Welfare Survey (CWS) conducted by the National Statistics Office of Georgia (Geostat), with support from UNICEF, in July-September 2022. The survey was developed in agreement with the Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Assistance (MoIDPLHSA) and the Permanent Parliamentary Council for the Protection of the Rights of the Child with an overarching aim of collecting data on multiple dimensions of child welfare in Georgia, including children's access to healthcare, education and social assistance, nutrition during school hours, material deprivation, methods of upbringing and functional difficulties. The survey involved interviewing 1,279 respondents who provided information on 2,438 children living in their households. The survey questionnaire was designed jointly by UNICEF Office of Research – Innocenti and UNICEF Georgia Country Office. The survey results are representative of Georgian children living in regions that are at present under the control of the Government of Georgia. The primary target audience of the report are stakeholders involved in providing services for children, including relevant line ministries, local authorities, national and international child rights organizations, and also to the general public at large.

During the survey, a multidimensional measure of child wellbeing was established, known as the child material and social deprivation index. This index pertains to situations where families lack the financial resources necessary to provide a child with essential items for their growth and development, such as food, clothing, age-appropriate books, toys, social activities with friends, etc. The child material and social deprivation index in Georgia was measured for the first time and was defined as lacking at least three out of 16 of these necessities. This index provides a more comprehensive understanding of child wellbeing beyond absolute poverty, and emphasizes access to the necessary elements for a child's biopsychosocial development. The CWS results show that37.8% of children are materially deprived. Child material deprivation rates vary considerably across urban/rural areas and regions.

In the past few years, the Government of Georgia has substantially increased the level of transfers and the scope of child benefit programme, which covers 28.6 per cent of all children under the age of 16 in the country in 2022. Almost half of materially deprived children (47%) do not benefit from the programme, supposedly due to fact that the families are above poverty line. Families of 15.5% of deprived children requested some type of social assistance in the 12 months preceding the survey and did not get it.

The CWS indicates that 5.8% of Georgian children have some form of functional difficulties, which considerably restricts their daily lives. Of these, 12.6% have official disability status. One reason for this is that up until now disability status continues to be determined based on a medical model, which does not take into consideration functional difficulties and important psycho-social dimensions of disability. The incidence of functional difficulties is higher among children aged 5-17 years (6.5%) than among children aged 2-4 years (1.8%). Materially deprived children are four times more likely to suffer from functional difficulties (10.5%) than other children (2.8%).

Although there is a law guaranteeing access to preschool education, 27.8% of preschool aged children were not attending kindergarten, with 21.6% of children not attending based on parent's

choice and 6.2% unable to attend due to barriers. The most common barriers are absence of pre-school services in some rural areas and placements on waiting lists. Satisfaction with preschool education institutions is high. Parents/family members of 93.6% of children who attend kindergartens are satisfied (or very satisfied) with the quality of pre-school services.

For children 6-17 years of age, 98.4% were attending school, university and/or vocational education during 2021-2022 school year and 1.6% of children were not in education system. Parents/family members of 79.7% of children attending schools are satisfied with the quality of schooling.

Private tutoring is used by 18.8% of 6-17 year old children, and an equal share is willing but unable to benefit from this. The most common barrier to private tutoring is lack of finances, mentioned in 87% of cases. Participation in extracurricular arts classes, such as music, dance and drawing classes is very low among 6-17 year-old children - 12.2%. Twice as many children (23.9%) would like to attend arts classes, but are unable to, mainly because their families cannot afford to pay for it (63.7%) or because such service is not available in their neighbourhood or village (22.8%). Enrolment in extracurricular sports classes is also low – 13.8% while 25.3% of children would like to engage in sports but cannot. Again, the most frequently mentioned reasons are inability to pay (69.9%) and lack of relevant sports classes in the vicinity (21.8%).

Lack of educational materials (apart from schooling materials) is also widespread, with 45.3% of children not having at least one educational item they would like to have but cannot afford. The educational items children lack the most often are laptops/computers (29.1% of all children), followed by painting materials (18.5%), books (16.5%) and musical instruments (10%).

Nutrition during school hours is a major challenge as only a little more than a quarter of children (27%) eat every day during school hours and more than a third of children (34.9%) never eat during school hours. Not eating during school hours is much more common among materially deprived children (44.9%) than among non-deprived children (28.4%). Financial barriers are mentioned as the main reason in case of 37.7% of materially deprived children who do not eat at all during school hours, while the same is true for 3.3% of non-deprived children. The absence of food vendors in the vicinity is also a major barrier, mentioned in 36.4% of cases.

The vast majority of the respondents (83.2%) believe that schools should feed children. Furthermore, 74.2% of the respondents are willing to pay for it if the prices are affordable. The willingness to pay reaches 61.8% even among parents/family members of materially deprived children.

Universal health insurance is the main source of financing medical services for children in Georgia. Of those children who needed medical care in the 12 months preceding the CWS (46.9% of all children), 68% had their services partially or fully financed through the programme. However, families also provided full or partial funding for 50.8% of children requiring medical services and another 9.9% of children had their services covered by private insurance. At the same time, 12% of all children were unable to receive some kind of required medical treatment (either fully or partially) and 4.9% did not receive a required medication. In both cases the main barriers were financial, mentioned in 82.2% and 98.8% respectively.

Parents'/family members' satisfaction with the quality of medical services received by their children is high. Parents/family members of 77.4% of children who received some kind of medical treatment reported being satisfied; in case of another 11.5% of children parents/family members were very satisfied.

Parents/family members of 62.2% of children reported that they use only non-violent methods of disciplining children, such as explaining why a particular behaviour is wrong or temporarily taking away privileges from the child. Psychological aggression, such as shouting and calling derogative names was reported in case of 29.4% of children. 4.7% of children were reported to be subjected to physical punishment, such as spanking or yelling. 0.1% of children suffer from severe physical punishments, such as being beaten with all strength.

In all dimensions of child welfare, the analysis revealed inequalities between different groups of children. Children living in rural areas are more than seven times more likely to lack access to preschool education than urban children. Compared to children without functional difficulties, children with functional difficulties are almost four times more likely to lack access to an essential medical care and more than twice as likely not to receive a required medication. Boys are 46% more likely to be subjected to violent methods of upbringing, while girls are almost 2.5 times more likely to lack access to extracurricular arts activities. However, the most profound inequalities that are evident in all dimensions of child welfare stem from material deprivation. Accordingly, tackling these inequalities is key to improving child welfare in Georgia.

1. INTRODUCTION

The Convention on the Rights of the Child (CRC) details commitments that serve as the basis for ensuring children's welfare. These include, but are not limited to, the highest attainable standard of health, access to social protection, adequate nutrition, clothing and housing, access to education, participation in cultural life and the arts, protection from all forms of violence, abuse, neglect and exploitation and so forth.

Georgia has made substantive progress in improving many of these dimensions of child welfare, but multiple challenges remain. Absolute (monetary) child poverty has decreased from 29.9% in 2013 to 22.7% in 2021 (Geostat, 2022).[1] This decrease is partially attributable to significant increases in the level and the coverage of child benefits. The incidence of material deprivation (measured in line with the EU methodology (Guio et al, 2017) is higher, affecting 37.8% of children ().

Even though access to general education (education up to and including Grade 9) is practically universal, Georgian children score low in international comparative assessments, such as PISA, TIMSS and PIRLS studies (OECD, 2019; National Assessment and Examination Centre, 2020; Miminoshvili, 2017).

The under-5 child mortality rate has decreased from 37 per 1000 live births in 2000 to 9 per 1000 live births in 2020 (UN IGME, 2022). The stunting rate has decreased from 16.1% in 1999 to 5.8% in 2018 (WHO, 2022). Since 2013, every child in Georgia is entitled to public health insurance which includes a package of in-patient and out-patient services, however there are limits on what is covered.

Since 2006, the Government has pursued a fundamental reform of state care system, resulting in deinstitutionalization of thousands of children and development of contemporary forms of alternative care. Fewer parents than before resort to unacceptable methods of child upbringing, but the Real-Time Monitoring/Multiple Indicator Cluster Survey (RTM/MICS) found that 56% of children are subject to psychological or physical violence from their parents/family members (UNICEF, 2022a).

In line with its mandate, UNICEF is supporting the Government to monitor child welfare in Georgia, including through systematically conducting high-quality studies to measure progress and identify critical issues. In 2022, at the request of MoIDPLHSA, UNICEF supported the design of a nation-wide Child Welfare Survey (CWS), which was conducted by the National Statistics Office of Georgia (Geostat). The purpose of the survey was to measure Georgian children's welfare in several core domains, including access to education, healthcare and social assistance, nutrition during school hours, safety at home, material deprivation, functional difficulties and stigma associated with disability. The current report presents the results of the CWS with a special emphasis on inequalities in welfare dimensions between different groups of children.

The report is organized as follows. The survey methodology is described in the following section. The subsequent seven sections present the results of the study. The penultimate section analyses how lack of access to different services relates to children's socio-economic and demographic characteristics. The concluding section sums up the main findings of the study, highlighting the areas that require immediate attention from the government and other stakeholders.

1 Note that this figure is calculated by Geostat based on data from HIES four quarters of 2021 whereas the 19.6% figure reported elsewhere in the report is calculated by UNICEF based on Geostat methodology using data from HIES third quarter of 2022.

2. CHILD WELFARE STUDY

The questionnaire of the CWS was designed by UNICEF's Innocenti Office of Research in close collaboration with the UNICEF Georgia Country Office. It consists of 6 modules – access to education, nutrition during school hours, access to healthcare, violent methods of upbringing, material deprivation and access to social assistance, and functional difficulties and perceptions of stigma against children with disability. The modules include questions used in international surveys such as the European Union Statistics on Income and Living Conditions (EU-SILC) and Multiple Indicator Cluster Survey (MICS), as well as new questions tailored specifically to the Georgian context. The questionnaire was pretested with 30 respondents before the launch of the survey.

The fieldwork of the survey was conducted by Geostat between July-September 2022. The respondents of the survey were selected from the sample of households who participated in Geostat's Household Income and Expenditure Survey (HIES) in July-September 2022. HIES is the main household survey which Geostat conducts on a quarterly basis in order to generate key social statistics, including data on absolute poverty. The HIES sample is selected through a two-stage stratified clustering method and its results are representative of Georgia's population. Out of 3,345 households that participated in HIES, 1,279 households with children under the age of 18 (all surveyed households who had children) were invited to participate in the CWS. Each of these households agreed. In each selected household one person most knowledgeable about children's welfare was interviewed. Child-specific questions were posed separately for each child. In total, 1,279 respondents provided information for 2,438 children. For 83.8% of children the respondents were parents, for 15.1% – grandparents. A major advantage of using the HIES subsample is that it allows linking the CWS dataset with the HIES data, thus enabling to use in the analysis a wealth of additional information about household characteristics, most importantly their consumption expenditure. To control for sampling imperfections, several weight variables were constructed for each of the six modules (depending on the module, the age of children whom the questions concerned varied, for example some questions were relevant only for school-age children, while others were relevant for all children).

In the analysis, we use two methods. First, we provide descriptive analysis of major variables of interest disaggregated by socio-economic and demographic factors. Second, we fit logistic regression models to measure the effects of key socio-economic and demographic factors on key dimensions of child welfare.

3. MATERIAL AND SOCIAL DEPRIVATION

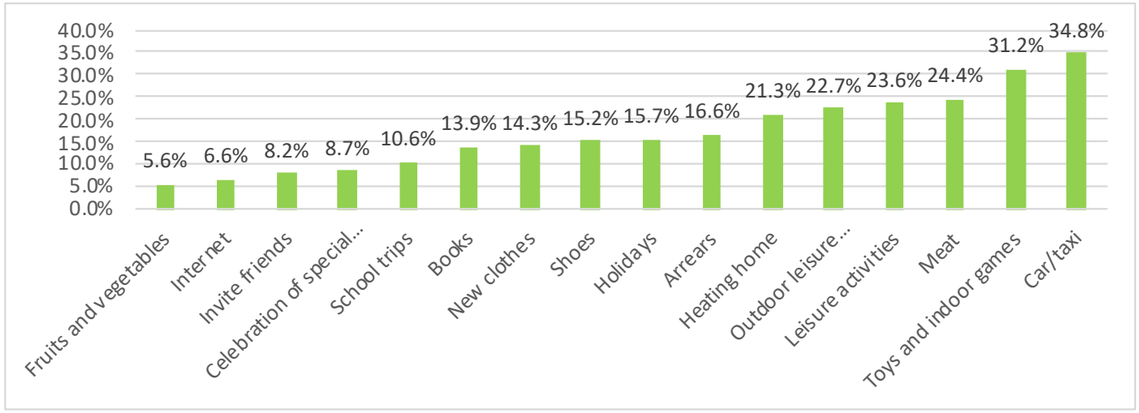
There is a growing consensus among child rights advocates, policy makers and practitioners that despite their importance, the monetary measures of poverty are not sufficient for capturing the multidimensional nature of deprivation that children experience, which in turn has adverse effects on their development and future life chances (Minujin et al, 2006; Carraro and Ferrone, 2021). This has facilitated the development of several multidimensional child deprivation indices, including the Multiple Overlapping Deprivation Analysis (MODA) (UNICEF Office of Research Innocenti, 2015), Bristol Index (Gordon and Nandy, 2012), Alkire-Foster Multidimensional Poverty Index (Alkire and Foster, 2011) and the child material deprivation index (Guio et al, 2017) used by the European Union (EU). In 2021, UNICEF commissioned a study to test the applicability of the EU child material deprivation methodology in Georgia. The study results confirmed that with a minor adjustment the EU methodology is highly useful for measuring child deprivation in Georgia (UNICEF, 2022a). The Georgia child deprivation index consists of 16 necessities, 12 of which are measured at the child, and four at the household level (Table 3.1). A child is considered to be deprived if due to lack of financial resources the family cannot provide her/him with at least three of the 16 necessities.

Table 3.1 Child necessities included in calculation of child deprivation index

LEVEL OF MEASUREMENT	ITEM
Child	Some new (not second-hand) clothes
Child	Two pairs of properly fitting shoes
Child	Fresh fruits and vegetables daily
Child	Meat, chicken, fish or vegetarian equivalent daily
Child	Books at home suitable for the children's age (excluding school books)
Child	Outdoor leisure equipment
Child	Indoor games
Child	Regular leisure activities
Child	Celebrations on special occasions
Child	Invitation of friends to play and eat from time to time
Child	Participation in school trips and school events that cost money
Child	Holidays away from home
Household	Arrears (rent, mortgage, utility bills, etc.)
Household	Home adequately warm
Household	Access to a car for private use or taxi when needed
Household	Access to internet

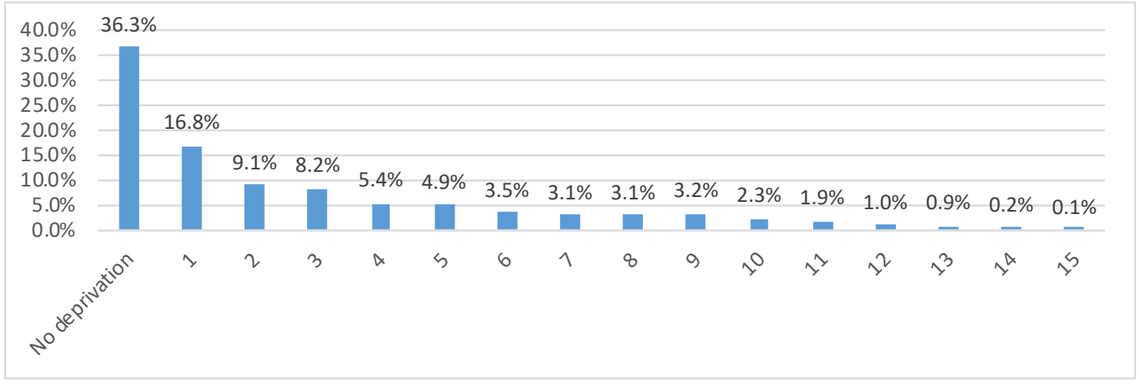
Figure 3.1 shows that the frequency of deprivation differs a lot across child and family necessities. For example, 5.6% of children are unable to eat fruits and vegetables on a daily basis because their families cannot afford it, but the corresponding figures are 24.4% in relation to having a meal with meat or a vegetarian alternative every day and 31.2% in relation to toys and indoor games relevant for child's age.

Figure 3.1 Share of children deprived of necessities



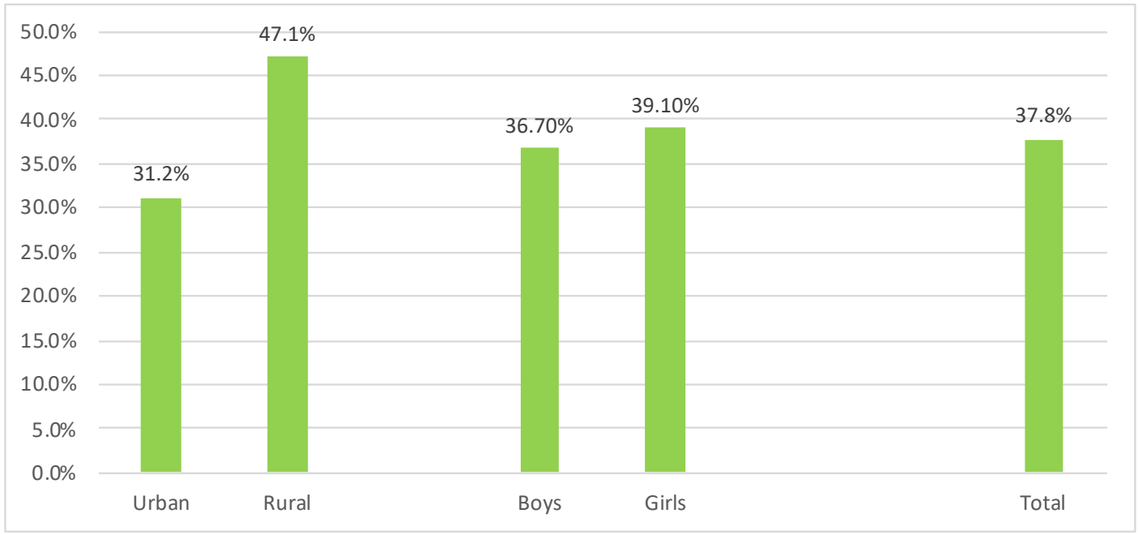
Delving into the overlaps between deprivations of different necessities, only a little more than a third of Georgian children (36.3%) do not experience any type of deprivation (Figure 3.2). Another 16.8% experience only one deprivation, and 9.1% are deprived of two necessities. The rest – 37.8% cannot afford three or more necessities, thus these children can be considered as materially deprived.

Figure 3.2 Share of children experiencing different numbers of material deprivation



Children's risk of being materially deprived differs depending on the region and whether they live in rural or urban areas. The difference between urban and rural areas is also large, with nearly half of rural children being deprived (47.1%) compared to less than a third (31.2%) among urban children. Further, girls are more likely to be materially deprived (39.1%) than boys (36.7%) (Figure 3.3).

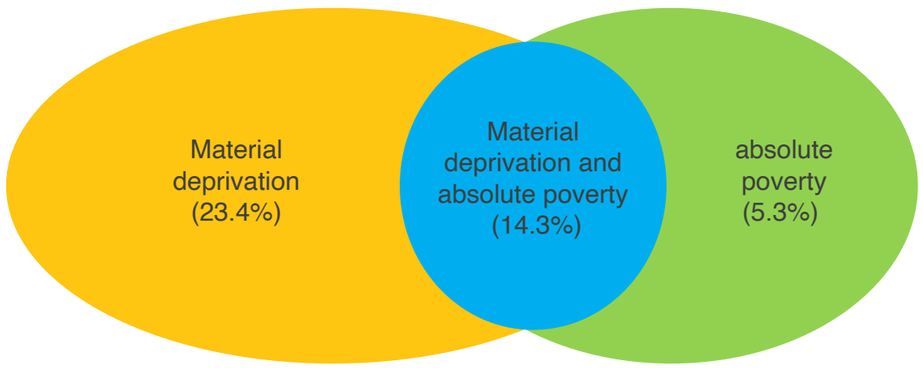
Figure 3.3 Child material deprivation rates based on gender and urban/rural areas.



The rate of material deprivation (37.8%) is higher than the absolute poverty rate among children – 19.6%.[2] Nevertheless, it should be stressed that the number of deprivations a child experiences rather strongly correlates with family consumption in monetary terms (r = -0.45). Accordingly, the average consumption of families with materially deprived children is much lower (242 GEL per month per equivalent adult) than of those families whose children are not deprived (425 GEL per month per equivalent adult).

Further, Figure 3.4 visualizes the overlap between material deprivation and absolute poverty. 23.4% of children experience only material deprivation, 5.3% only absolute poverty and 14.3% experience both of these simultaneously. This leaves 57% of children who do not suffer from either type of hardship.

Figure 3.4 Relation between absolute poverty and material deprivation



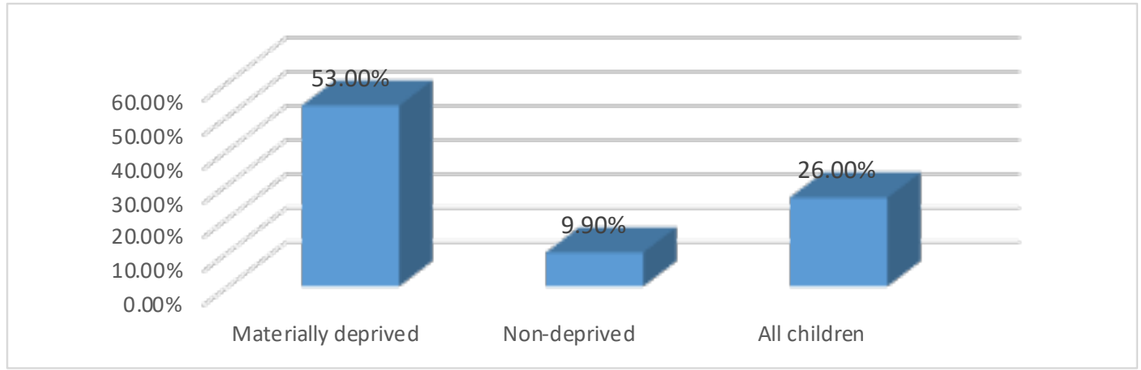
2 This poverty rate is calculated by UNICEF using the Geostat methodology and the HIES data from the third quarter of 2022.

4. ACCESS TO SOCIAL ASSISTANCE

The main social assistance scheme in Georgia is Targeted Social Assistance (TSA) programme. Households requesting support have to go through an assessment of their assets and living conditions in order to determine their eligibility for assistance, proxy means test (PMT). The household welfare score is calculated digitally based on the recordings made by the Social Services Agency representatives when visiting the applicants' homes. Households with a score below 65,001 receive cash assistance for each household member, the amount of which depends on the band of the score. In addition, every child under the age of 16 whose household has a score below 120,001 is entitled to 150 GEL a month. According to the Social Services Agency (2022), 229,633 children received this benefit as of November 2022 (26.2% of all children). In addition to TSA, most municipalities also have some social assistance cash transfers and in-kind benefits (many of these of one-off nature), though they often rely on the TSA welfare scores to determine the eligibility of their beneficiaries.

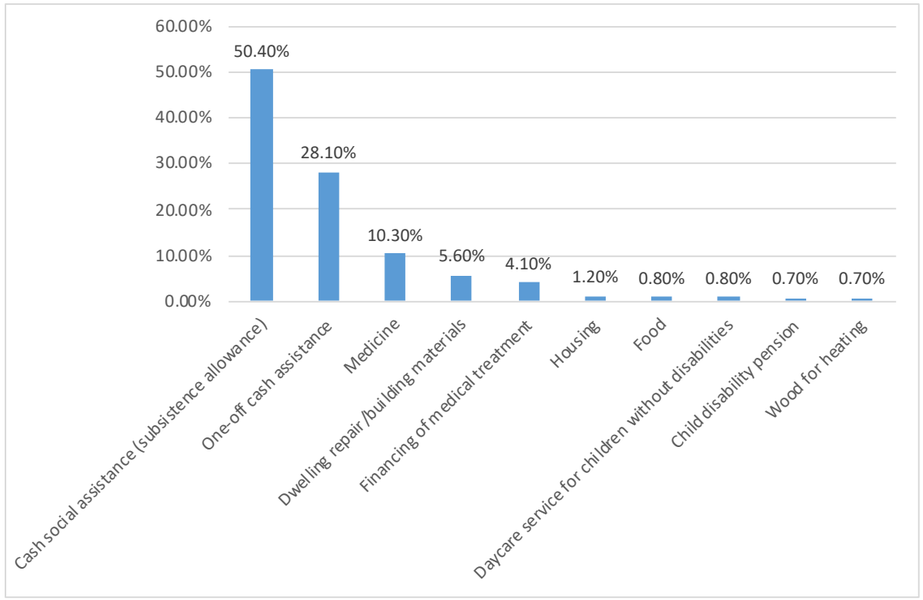
The CWS data shows that materially deprived children are five times more likely to receive the child transfer (53%) compared with non-deprived children (9.9%). This indicates good targeting of TSA. Almost half of deprived children fall outside of the social assistance system (Figure 4.1).

Figure 4.1 Coverage by child benefit



The families of 15.5% of deprived children and 2.3% of non-deprived children reported applying for some form of assistance without success in the last 12 months, supposedly due to relatively high score defining eligibility to Targeted Social Assistance. The most often requested support in such applications was inclusion in the TSA scheme (50.4%), followed by one-off cash assistance (28.1%) and medicine (10.3%) (Figure 4.2). Assistance was most often requested from the Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Protection (51.5%) and local authorities (46.4%). Importantly, the families of children have not applied to religious organizations, charities and non-governmental organizations for support.

Figure 4.2 Types of assistance requested and not received by families with children



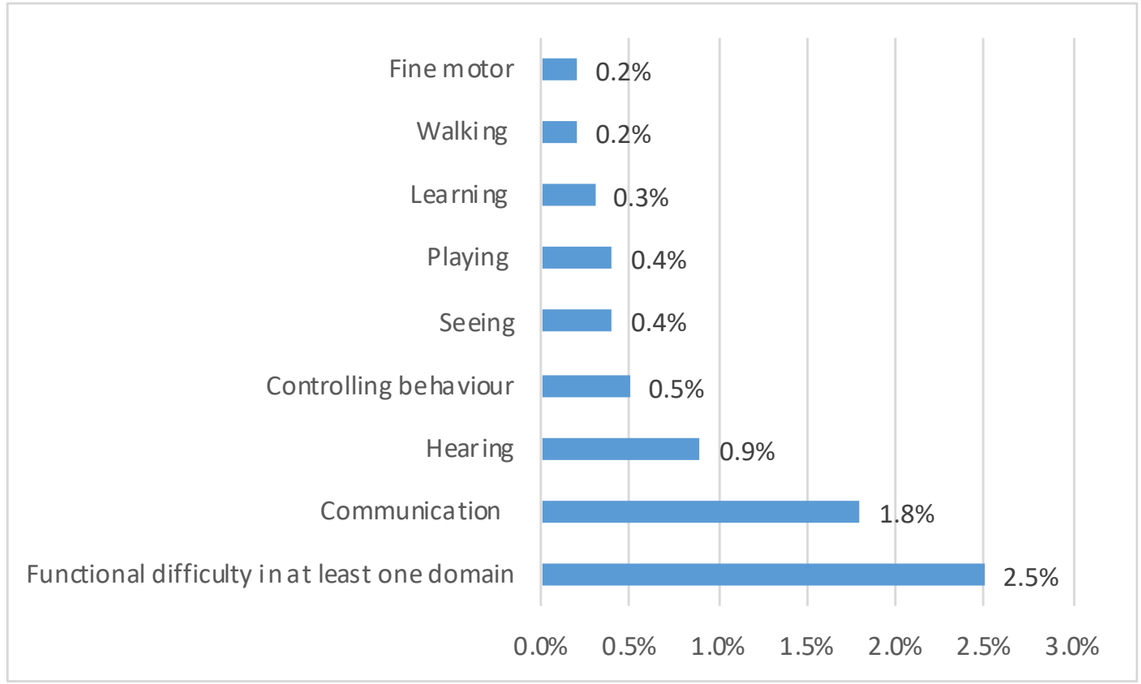
5. FUNCTIONAL DIFFICULTIES

One of the impediments to realizing the rights of children with disabilities as enshrined in the (CRC) and the Convention on the Rights of Persons with Disabilities (CRPD) has traditionally been the lack of accurate methodology and data to capture the multiple functional difficulties that children living with disabilities experience. This has prompted a collaboration between UNICEF and the Washington Group on Disability Statistics for the development of a functional difficulties' assessment framework for children, which is now widely endorsed across the globe. The functional difficulties approach goes beyond the traditional model of determining disability based purely on medical diagnosis. Alongside the physical limitations with regards to seeing, hearing, mobility, communication/comprehension and learning, it also incorporates psycho-social dimensions, including the ability to form relationships, to play with other children, to control emotions and behaviour, the ability to focus attention/concentrate and the ability to cope with change. While disability status (and the associated social transfers and services) in Georgia continues to be determined based on the medical model, UNICEF has included the functional difficulties module in 2018 MICS. The results confirmed that functional difficulties among children are much more common in Georgia than the officially confirmed disabilities defined by medical diagnosis only.

The CWS also included a module on functional disabilities, with separate questions for children aged 2-4 years and 5-17 years.

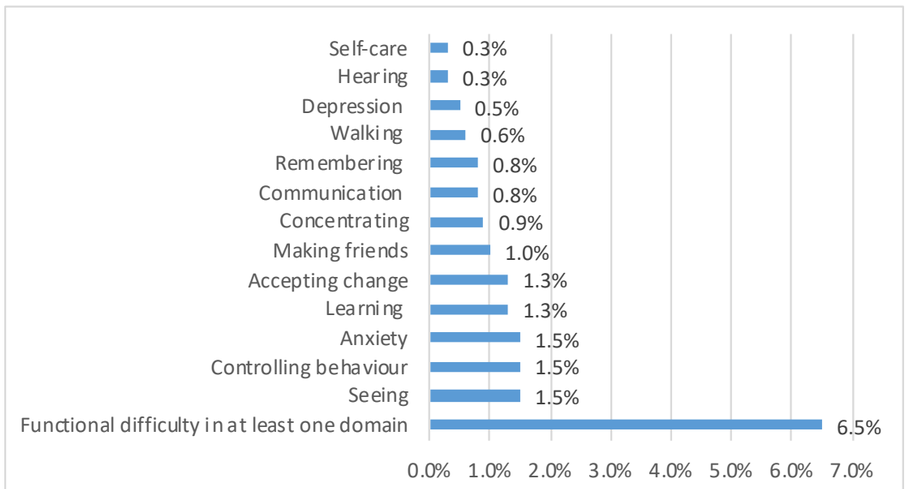
The incidence of functional difficulties among 2-4 year olds is lower than among older children, presumably as some of these difficulties develop and become visible over time as children grow. The most frequently reported functional difficulty among 2-4 year old children is problems with communication (1.8%) and hearing (0.9%) (Figure 5.1). Overall, 2.5% of children in this age group have some form of functional difficulty.

Figure 5.1 Incidence of functional disabilities among children aged 2-4 years



Among children aged 5-17 years functional difficulties are more common, affecting 6.5% (Figure 5.2).[3] The most frequent types of difficulties are problems with seeing, controlling behaviour and daily anxiety, each reported for 1.5% of children.

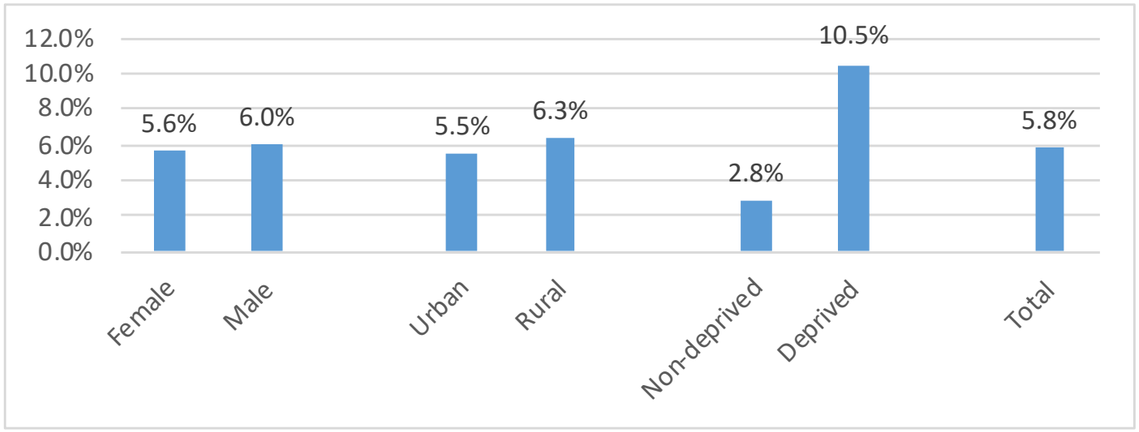
Figure 5.2 Incidence of functional disabilities among children aged 5-17 years



3 Some studies exclude depression and anxiety when measuring functional difficulties among 5-17 year olds (See for example UNICEF (2022b)). If we follow this approach, 5.4% of 5-17 year olds qualify as having functional difficulties.

Overall, in the age group of 2-17 years, 5.8% of children have some form of functional difficulties. Looking at the incidence of functional difficulties across different groups, some differences are more marked than others. The risk of experiencing at least one form of functional difficulty is higher among boys (6%) than among girls (5.6%) and among rural (6.3%) than urban children (5.5%) (Figure 5.3). But the most striking difference is between materially deprived and non-deprived children: the former are almost four times more likely to have functional difficulty (10.5%) than the latter (2.8%).

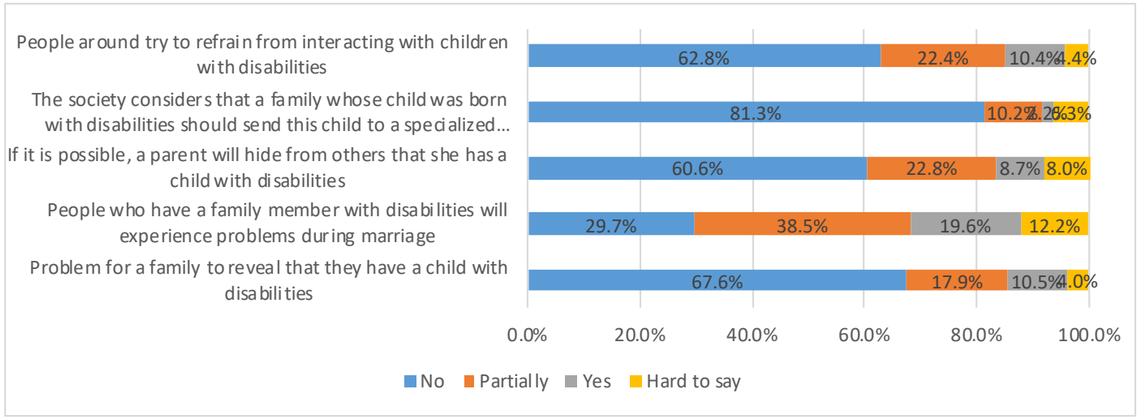
Figure 5.3 Incidence of functional difficulties across demographic and socio-economic groups



Of those children who experience functional disabilities (5.8 % of child population), only 12.6% have an official disability status. Conversely, 69% of those children who have official disability status (1.0% of child population) also have functional difficulties. One reason for this discrepancy is that the current disability assessment system recognizes only certain medical diagnoses, as explained earlier. However, in some cases, families may be reluctant to apply for an official status of disability for their children due to perceived stigma. For example, 28.4% of the respondents partially or fully agree with the idea that it is problematic for families to reveal that their child has disability (Figure 5.4). Similarly, 58.1% per cent partially or fully agree that people who have family members with disabilities will experience problems when trying to get married, 31.5% think that if possible, parents will hide child's disability, 12.4% think that the society expects children with disabilities to live in specialized institutions and 32.8% think that people try to refrain from interacting with children with disabilities. Overall, 26.1% of respondents think that children with disability are stigmatized.[4] Parents of children with functional difficulties are more likely to hold this opinion (32.3%) than other parents (25.6%).

4 Calculating this indicator involves three steps.
1) Answers to each of the 5 questions on perceived stigma against children with disabilities are recoded into "0" for "No", "1" for "Partially", and "2" for "Yes" and based on these the aggregate scores are calculated for each respondent. Questions with "Difficult to answer" responses are not included in the aggregate total score calculation.
2) The maximum possible aggregate score is calculated as a sum of the maximum scores for each question except those with "Difficult to answer" responses. If the respondent answered all 5 questions with "Yes", or "Partially", or "No", the maximum possible score is 10; if the answer to one question is "Difficult to answer", the maximum possible score will be 8, etc.
3) Relative stigma score is calculated as "aggregate score/maximum possible score" and compared to the reference value of 0.33. If the relative score is greater than the reference value (0.33), the respondent is included in the nominator, while the denominator is all respondents.

Figure 5.4 Perceived stigma associated with child disability



6. ACCESS TO EDUCATION

Nine years of general education are compulsory. After completing the 9th grade, children can continue studying at school for additional three years, termed upper secondary school, to obtain a high school diploma. Alternatively, they can pursue vocational education or drop out of the educational system. The state also is obliged to provide universal pre-school education, though it is not mandatory for children to attend this service and in some remote rural areas there are no pre-school institutions. Enrolling at universities requires passing unified national exams.

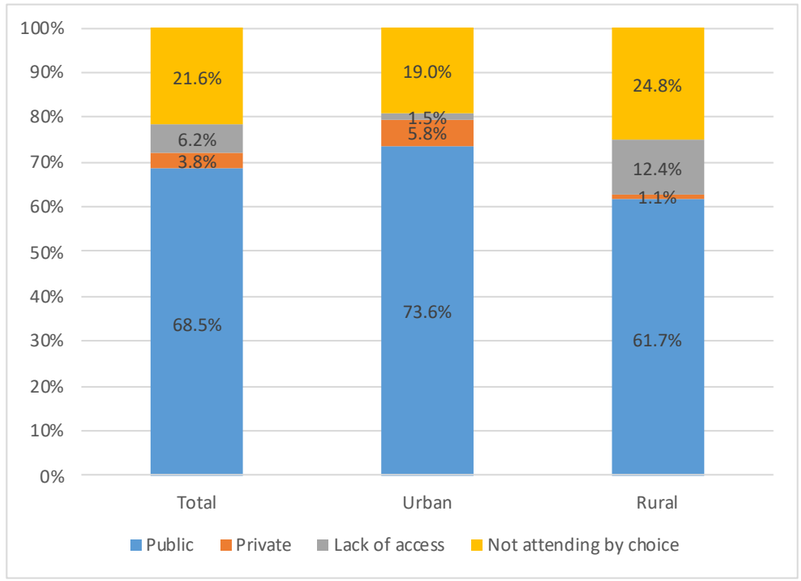
At all stages of education, parents can choose to enrol their children at private providers and, in case of general education, they can use a per capita funding voucher to which every school-age child is entitled. Depending on the child's scores in the unified national exam, students can also get partial or full state funding of their tuition fees irrespective of whether they enrol at public or private universities.

The CWS education module consisted of questions measuring access to formal and informal types of education, educational materials and satisfaction with the quality of received services. Starting with preschool education, in the school year preceding the survey (2021-2022), 68.5% of pre-school age children attended public kindergartens and 3.8% attended private kindergartens (Figure 6.1). There were 21.6% of children not going to preschool by choice and another 6.2% were unable to attend due to various barriers. The overall preschool attendance rate is lower than the rates reported in MICS 2018. A most likely explanation is the COVID-19 pandemic – while most kindergartens were open since 2021, many parents were reluctant to send their children to kindergartens in order to avoid infection.

Similar to previous years, we observe large differences between urban and rural areas in relation to preschool education. In urban areas 73.6% of children attend public and 5.8% private preschool services while in rural areas the respective figures are 61.7% and 1.1%. Children living in rural areas

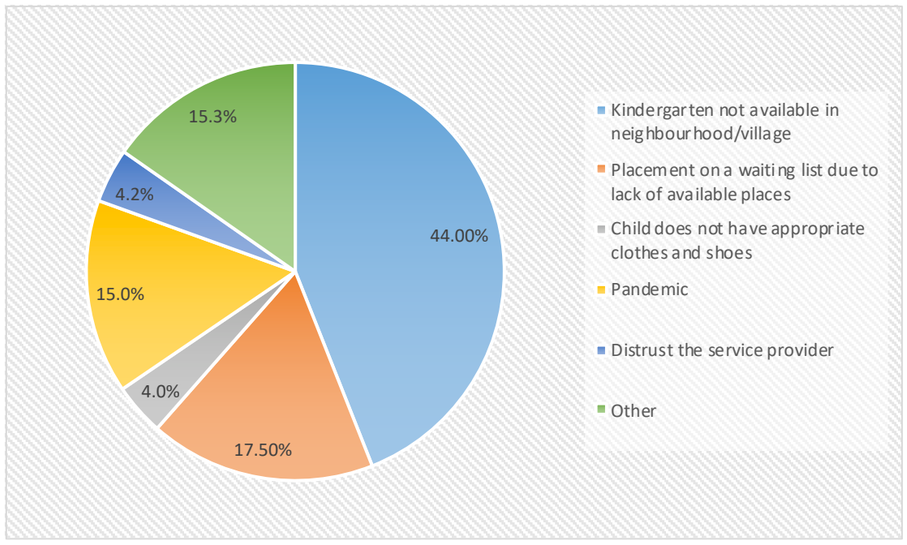
are more than seven times more likely to lack access to preschool education than urban children. Barriers to preschool education affect 1.5% of urban children compared to 12.4% of rural children. Gender differences are smaller in this respect, with 8.5% of girls facing the barriers compared to 4.3% of boys.

Figure 6.1 Access to preschool services



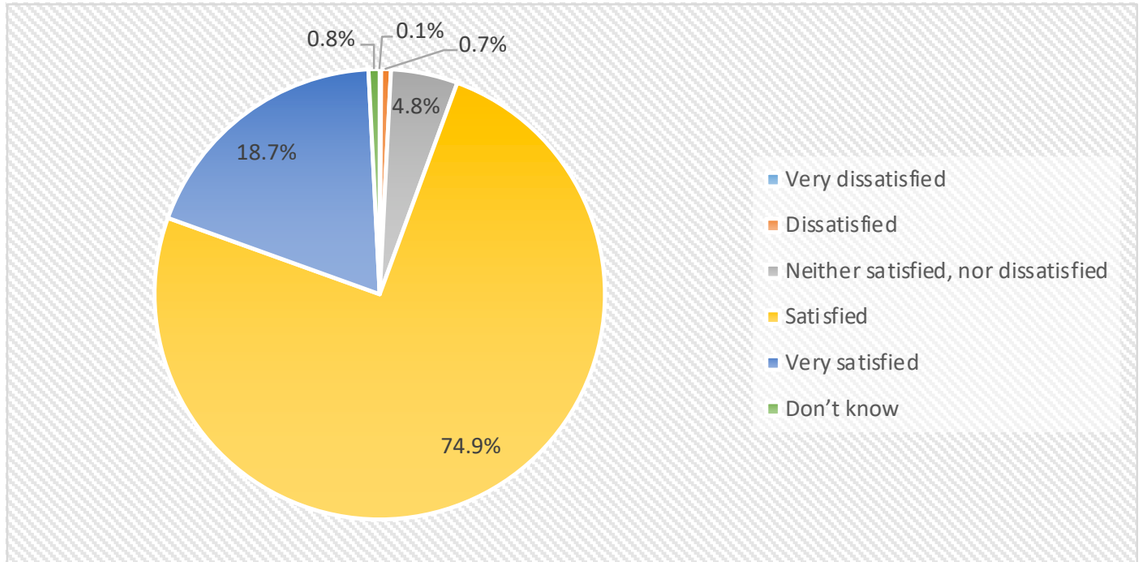
The most frequently reported barrier to preschool education is the absence of such service in the neighbourhood or village (44%) (Figure 6.2). Placement on the waiting list was reported in 15.3% of cases and the pandemic in 15% of cases. In 17% of cases other causes, such as parents not having time to take children to kindergartens was mentioned.

Figure 6.2 Types of barriers to preschool education



Satisfaction with the quality of preschool education is high. In case of 93.6% of children parents/ family members are satisfied or very satisfied with their children's kindergartens (Figure 6.3). For another 4.8% of children the assessments are neutral, leaving less than one per cent of children whose parents are dissatisfied or very dissatisfied with the quality of preschool education. Differences between urban and rural areas are small in this respect.

Figure 6.3 Satisfaction with the quality of preschool services



For school-aged children (6 – 17 years of age), there were 98.4% children in school, university and/ or vocational education, out of whom the majority (97.5%) were at school/gymnasium or lyceum (Figure 6.4). Only 0.04% children attended vocational education. 1.6% of children did not attend any educational institution during 202-2022 school year, with 1.3% due to choice and 0.3% unable to attend school due to some barrier.

The vast majority who were in school, university and/or vocational education attended public institutions in the 2021-2022 school year and others went to private institutions (Figure 6.5). Among children who were not able to attend educational instituion at least once during 2021-2022 school year contrary to the chlid's or parent's willingness, the following reasons were named: inability to pay (64.6%), taking care of another family member (15.9%), lack of the service in child's district/ village (13.5%) or lack of adaptation of the building to a child with disability or functional difficulties (5.9%).

Figure 6.4 Access to school/gymnasium/lyceum, vocational education and or university for 6-17 year old children

For school-aged children (6 – 17 years of age), there were 98.4% children in school, university and/ or vocational education, out of whom the majority (97.5%) were at school/gymnasium or lyceum (Figure 6.4). Only 0.04% children attended vocational education. 1.6% of children did not attend

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Figure 6.4 Access to school/gymnasium/lyceum, vocational education and or university for 6-17 year old children

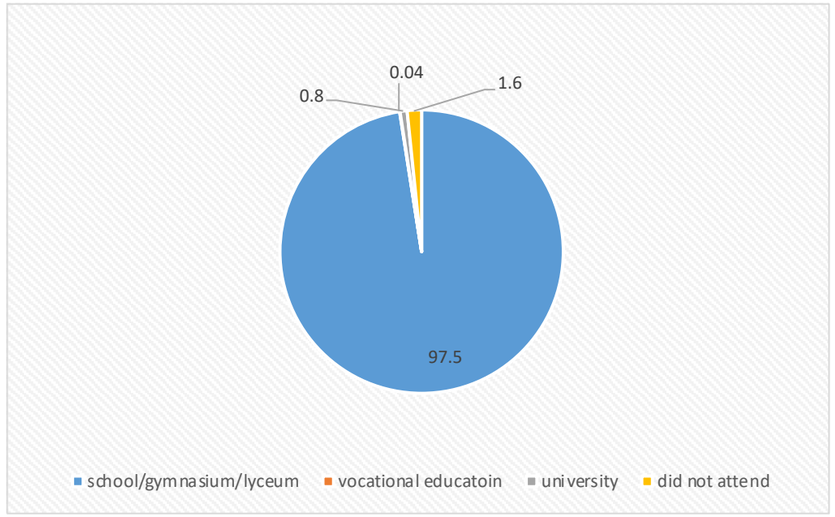
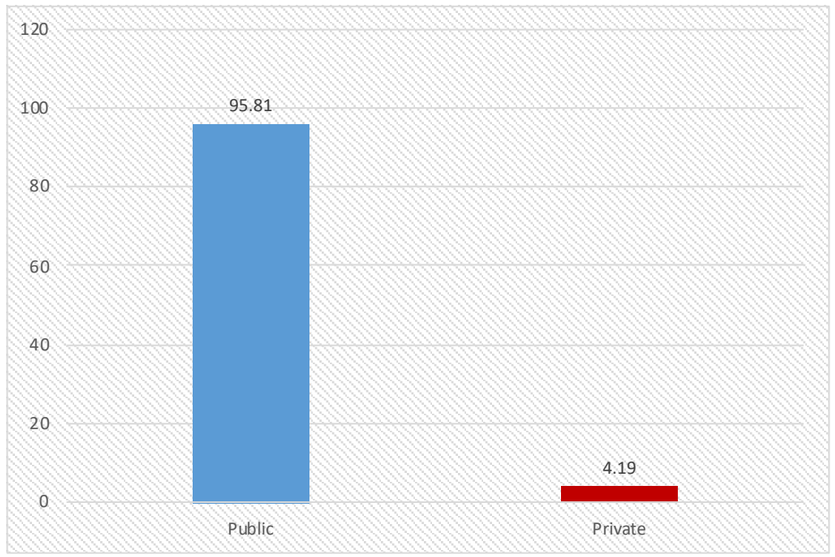


Figure 6.5 share of children in school/gymnasium/lyceum by public/private institutions



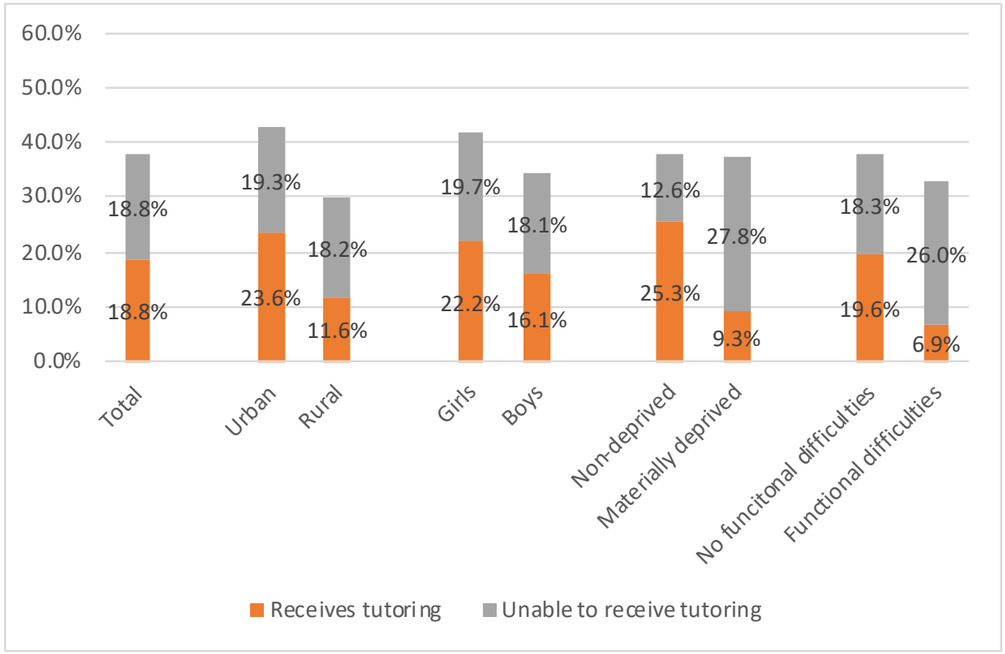
Parents/family members show high satisfaction with education providers. Parents/ family members of 66.8% of school-age children report being satisfied with the education their children receive in schools and for 12.9% of children parents'/family members' satisfaction is very high (Figure 6.6). For 15.9% of children parents/family members are neutral and for 4% the respondents are dissatisfied or very dissatisfied.

Figure 6.6 Satisfaction with the quality of schooling

In addition to formal education, Georgia has a long tradition of widespread use of private tutoring, especially for preparing children for passing exams to enrol at universities. Furthermore, extra-curricular activities, such as various arts and sports are also widely acknowledged to be essential parts of children's education and development. Therefore, the CWS also included questions about access to these forms of education.

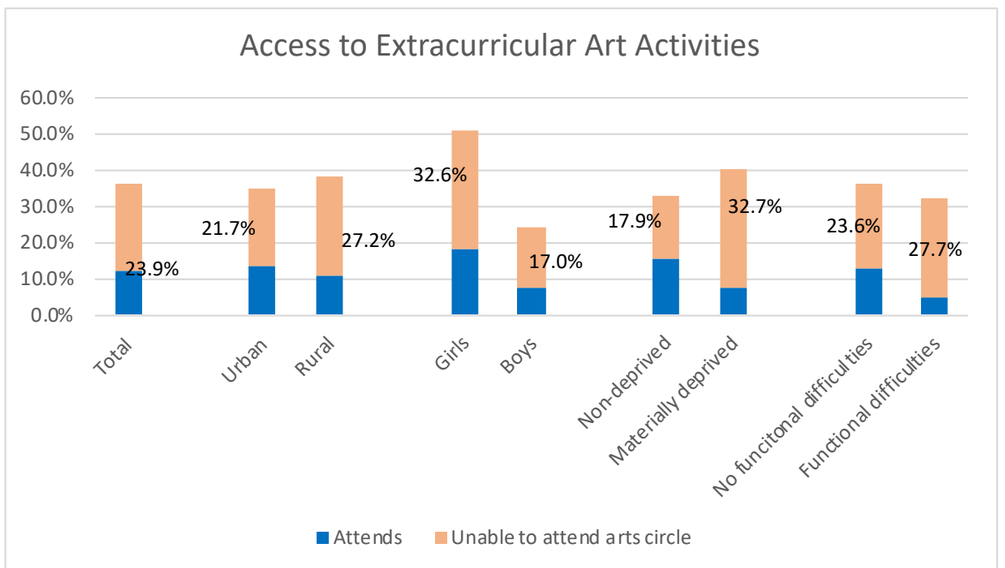
The results show that almost every fifth Georgian child aged 6-17 years (18.8%) uses private tutoring, but exactly the same proportion is unable to benefit from it despite having a desire (Figure 6.7). There are considerable differences between various groups of children in this respect as well. Rural children are more than twice less likely to have a tutor (11.6%) compared to urban children (23.6%). Girls are more likely to get private tutoring (22.2%) compared to boys (16.1%). Non-deprived children are more than three times more likely (25.3%) to benefit from tutoring compared to materially deprived children (9.3%). Children who do not have functional difficulties are almost three times more likely get tutoring (19.6%) compared to children with functional difficulties (6.9%). Inability to pay fees is the primary reason for children not being able to benefit from private tutoring, mentioned in 87.9% of cases.

Figure 6.7 Access to private tutoring



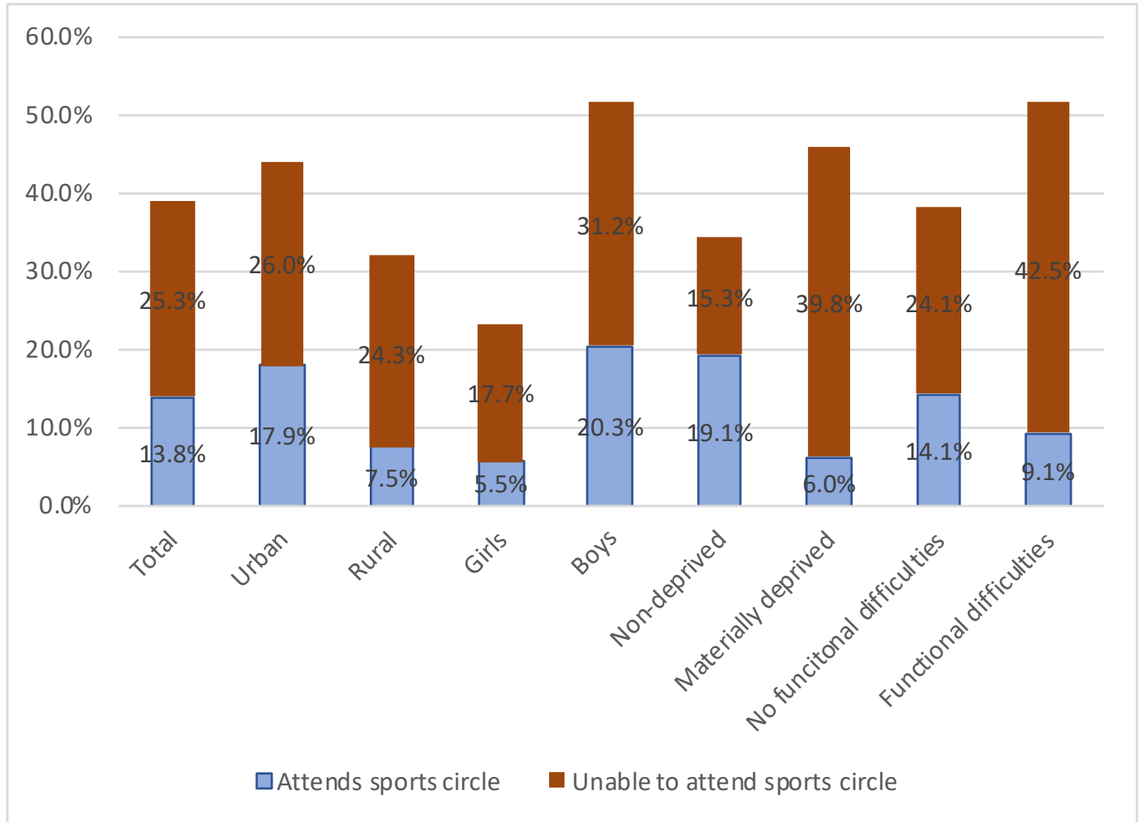
Attendance of various extracurricular arts activities, such as music, dance and drawing classes is very low among 6-17 year olds - 12.2% (Figure 6.8). Almost twice as many children (23.9%) would like to enrol in these classes but are unable to. Lack of access to extracurricular arts activities is particularly high among girls (32.6%) and materially deprived (32.7%). It should be noted though that girls are more than twice as likely to attends extracurricular arts activities (18.3%) than boys (7.4%). The most common reasons for children not being able to attend extracurricular arts activities are inability to pay (63.7%) and absence of such service in the vicinity (22.8%).

Figure 6.8 Access to extracurricular arts activities



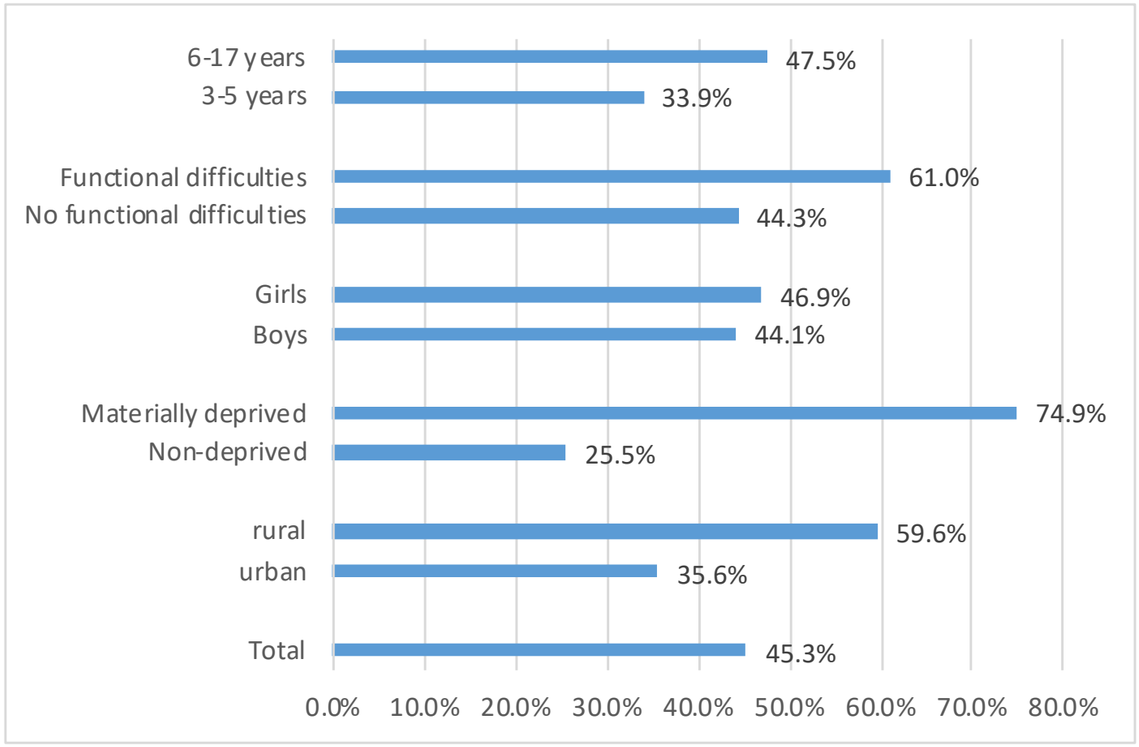
Also, a low proportion of children aged 6-17 years are engaged in extracurricular sports activities – 13.8% (Figure 6.9). The participation in extracurricular sports activities is particularly low among rural children (7.5%), girls (5.5%) and materially deprived children (6%). At the same time, demand for extracurricular sports activities is high with 25.3% of parents/family members reporting that their child wanted to attend some extracurricular sports activities but was unable to. Barriers to extracurricular sports activities is especially high for materially deprived children (39.8%) and children with functional difficulties (42.5%). The most frequently mentioned barriers are inability to pay (69.9%) and absence of relevant sports class in the vicinity (21.8%).

Figure 6.9 Access to extracurricular sports activities



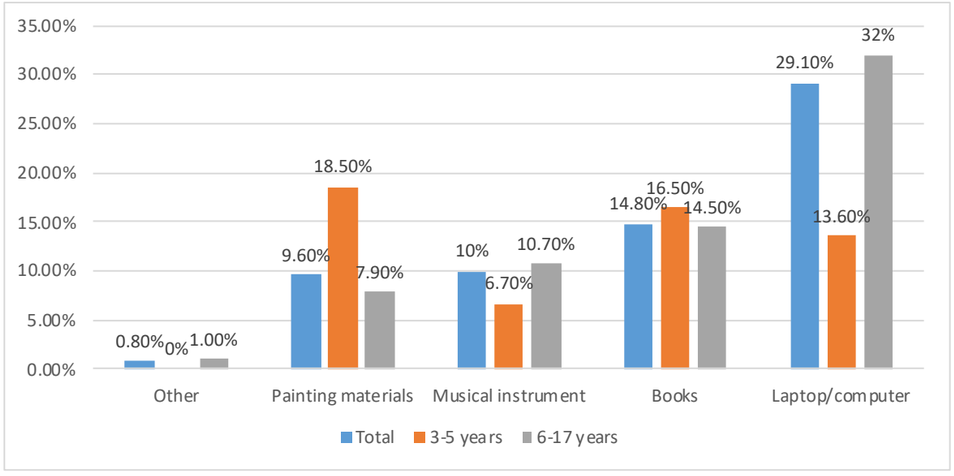
The CWS also included questions about children's access to educational materials (excluding school textbooks). Deprivation in this regard is high as 45.3% of children appear to miss at least one educational material they want to have (Figure 6.10). Urban/rural disparity is large in this case, with 59.6% of rural children lacking some educational material compared to 35.6% of urban children. Children aged 6-17 years are much more likely to lack access to educational materials (47.5%) than children aged 3-5 years (33.9%). Similarly, the differences in access to educational materials are large between children with (60.1%) and without functional difficulties (44.4%). However, the most striking difference is observed between materially deprived and non-deprived children– three out of four (74.9%) deprived children do not have some desired educational material while the same is true for one out of four (25.5%) non-deprived children.

Figure 6.10 Share of children lacking access to at least one type of educational material



The educational item children lack the most often is laptop/computer (29.1%) (Figure 6.11). It is followed by books (16.5%), painting materials (18.5%) and musical instruments (10%). However, there are considerable differences between child age groups in this respect. For example, 18.5% of children aged 3-5 years lack painting materials compared to 7.9% of children aged 6-17 years. Inversely, 32% of children aged 6-17 years lack laptops/personal computers compared to 13.6% of children aged 3-5 years. These differences to a large extent reflect the different educational interests of children at younger and older ages.

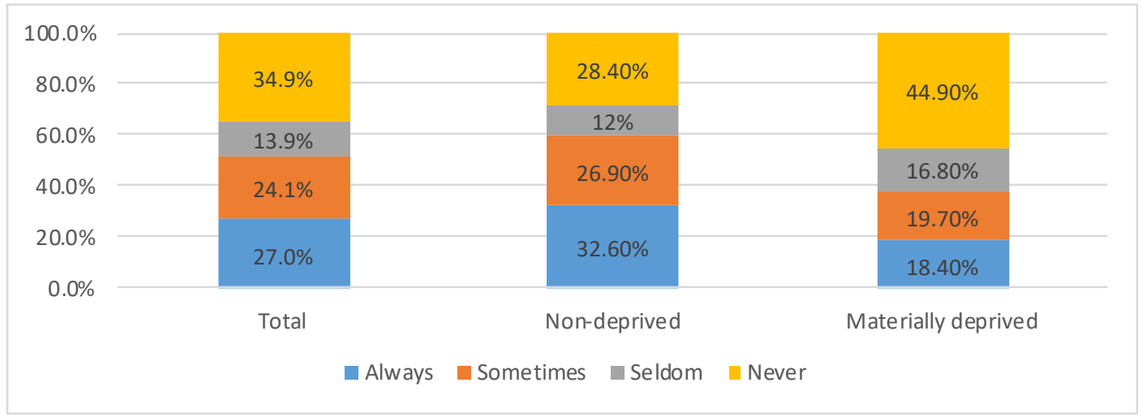
Figure 6.11 Types of educational materials children lack



7. NUTRITION DURING SCHOOL HOURS

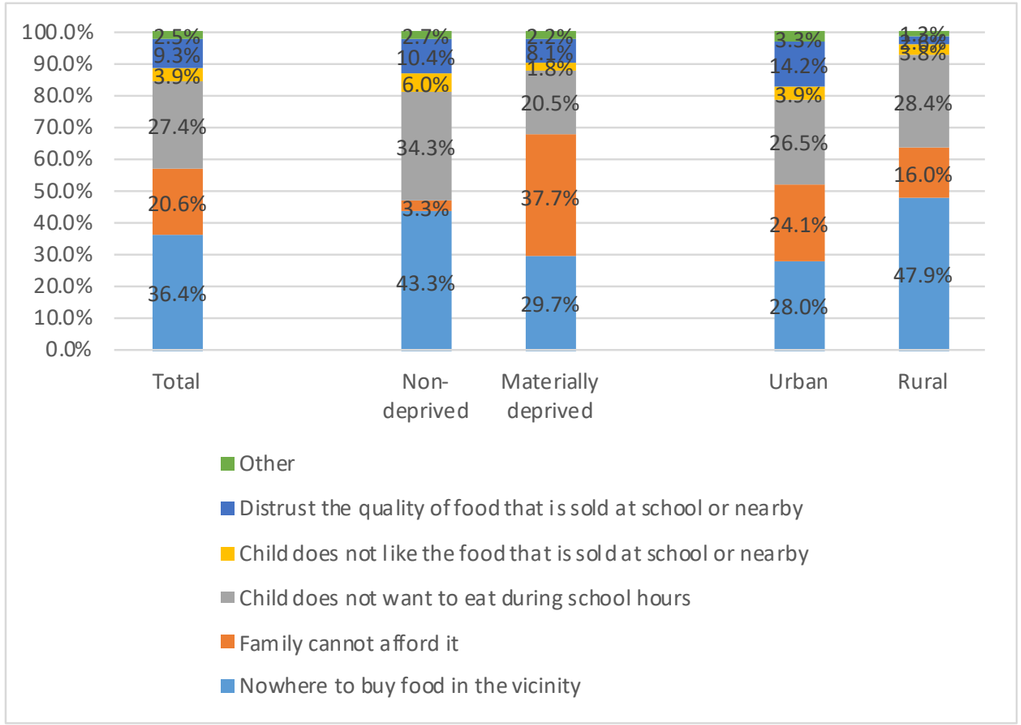
Eating regularly throughout the day is an important part of a healthy diet, especially for children. Unlike most European countries, in Georgia there is no organized system of feeding children at school. This special module on children's nutrition during school hours aims to generate information to understand the existing practices, preferences and barriers. The results show that nutrition during school hours is a significant challenge as only a little more than a quarter of children (27%) eat every day during school hours (Figure 7.1). More alarmingly, more than a third of children (34.9%) never eat during school hours. Materially deprived children are far more likely to never eat during school hours (44.9%) than non-deprived children (28.4%).

Figure 7.1 Frequency of eating during school hours



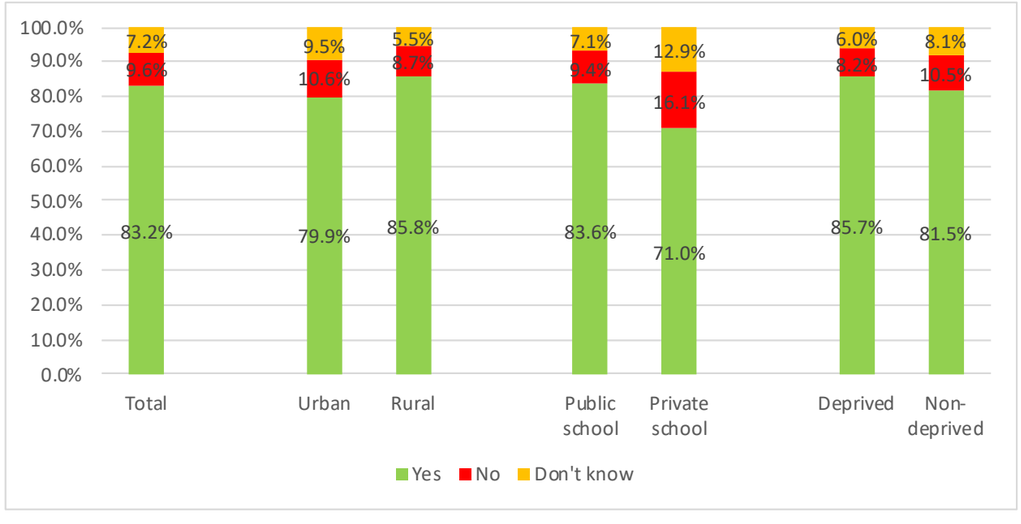
The reasons for not eating during school hours differ between rural and urban areas. In rural areas the main cause is the lack of availability to buy food at school or nearby, reported in 47.9% of cases of children not eating during school hours (Figure 7.2). In urban areas the absence of food vendors at schools or in the vicinity is less frequent (28%), but not having money to buy or prepare a packed lunch (24.1%) and parents having doubts about the quality of available food for purchase (14.2%) is more common. A more striking difference is observed between materially deprived and non-deprived children: not having enough money to buy food or prepare lunch at home accounts for 37.7% of cases why materially deprived children do not eat at school, whereas the same reason accounts for 3.3% of cases when non-deprived children miss meals during school hours.

Figure 7.2 Reasons for child not eating at school



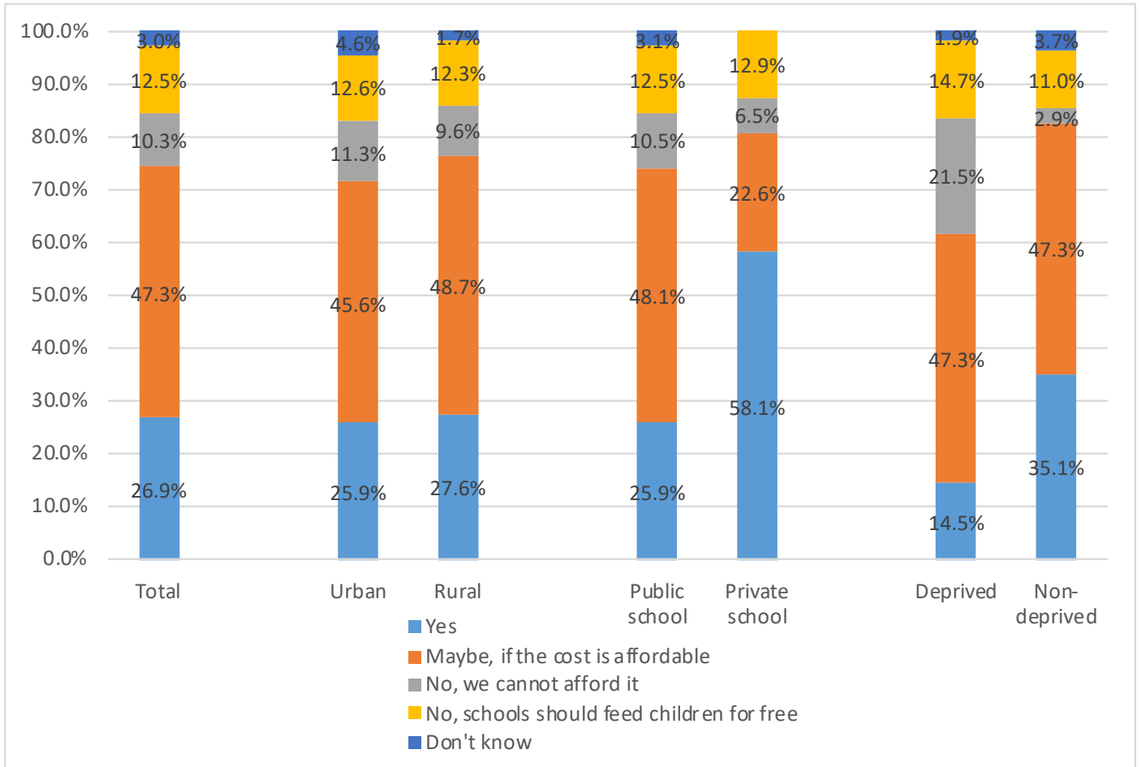
The CWS also asked the respondents whether schools should feed pupils. An overwhelming majority of parents/family members of school-age children responded positively (83.2%) (Figure 7.3). Support for school feeding is a little higher among parents/family members of materially deprived (85.7%) and rural children (85.8%) than among parents/family members of non-deprived (81.5%) and urban children (79.9%). More pronounced is the difference in opinions between respondents whose children attend public (83.6%) and private schools (71%).

Figure 7.3 Support for school feeding



The majority of respondents (74.2%) are willing to pay for school nutrition programmes, provided that costs are affordable (Figure 7.4). 10.3% stated that they cannot afford it, while another 12.5% think that schools should feed children for free. These proportions are very similar in rural and urban areas. However, there are significant differences between parents/family members of materially deprived and non-deprived children. Among the former only 14.5% express willingness to pay without reservations, 47.3% will pay if the costs are not high, 21.5% say they cannot afford it and 14.7% think that school feeding should be free. Among the latter 35.1% are ready to pay without any reservations and 47.3% will pay if costs are affordable, while 2.9% say they cannot afford it and 11% think that the school should provide meals free of charge. Further, respondents whose children attend private schools are more likely to pay without reservations (58.1%) than respondents whose children go to public schools (25.9%).

Figure 7.4 Respondents' readiness to pay for school meals

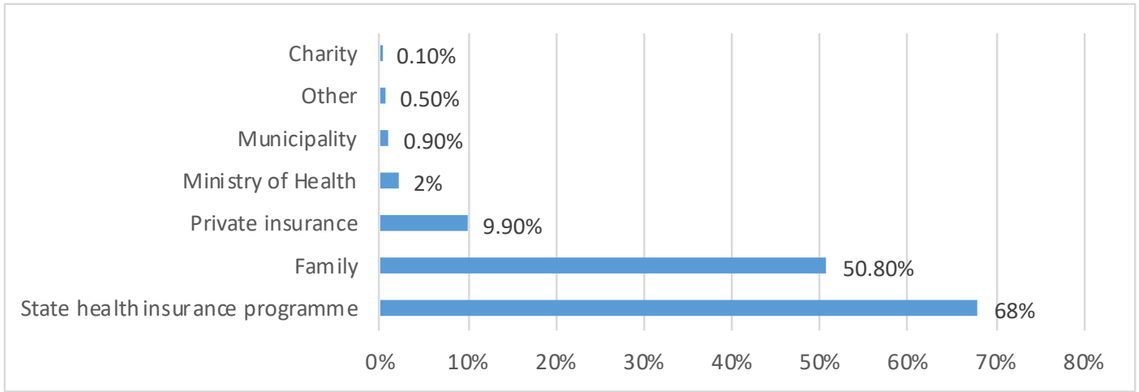


8. ACCESS TO HEALTHCARE

In 2013, the government introduced the universal health insurance programme. Having undergone several changes over time, at present the programme covers all residents of the country with the exception of those with an annual income of 40,000 GEL or more. The programme provides full or partial financing of urgent and planned inpatient and outpatient services, with caps on maximum amount for some services, including planned surgeries. A number of medications are also partially or fully financed. The content of the insurance package differs across age groups and family income status. Children under the age of 6, retired people, war veterans and TSA recipient families are entitled to the most generous packages. In addition, additional funding can be requested from the state referral programme and local authorities, though these are discretionary programmes, implying that there is no guarantee that the request will be satisfied.[5]

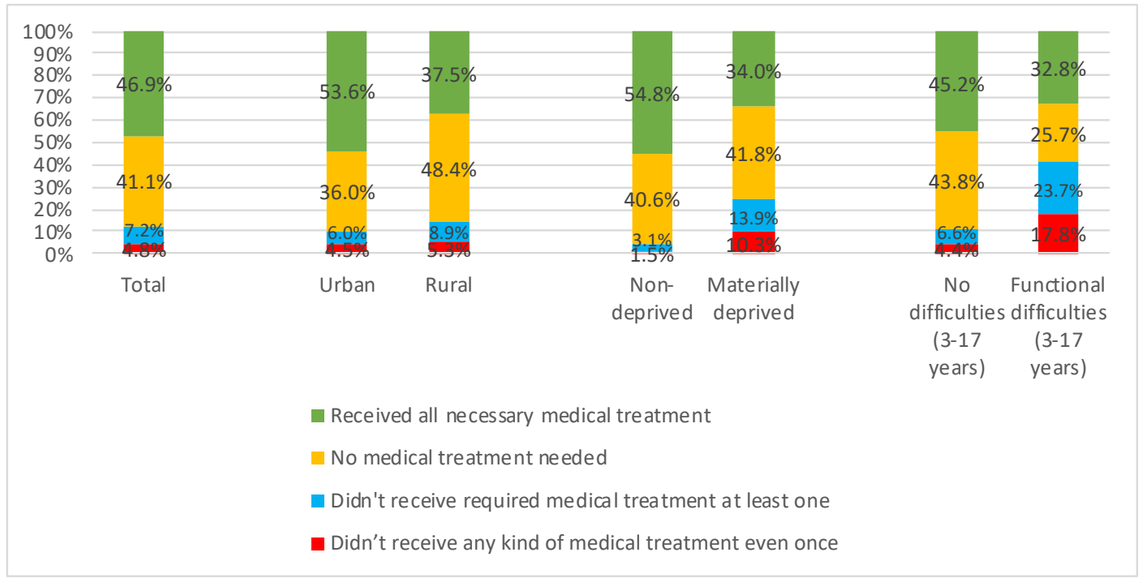
Figure 8.1 confirms that the universal health insurance is the main source of financing medical services for children in Georgia. Of those children who needed medical care in the 12 months preceding the CWS, 68% had their services partially or fully financed through the programme. Families provided full or partial funding for 50.8% of children, and another 9.9% of children had their services covered by private insurance. Very few children have received financing from other sources, including municipalities, state heath referral programme and charities.

Figure 8.1 Sources of financing medical care for children



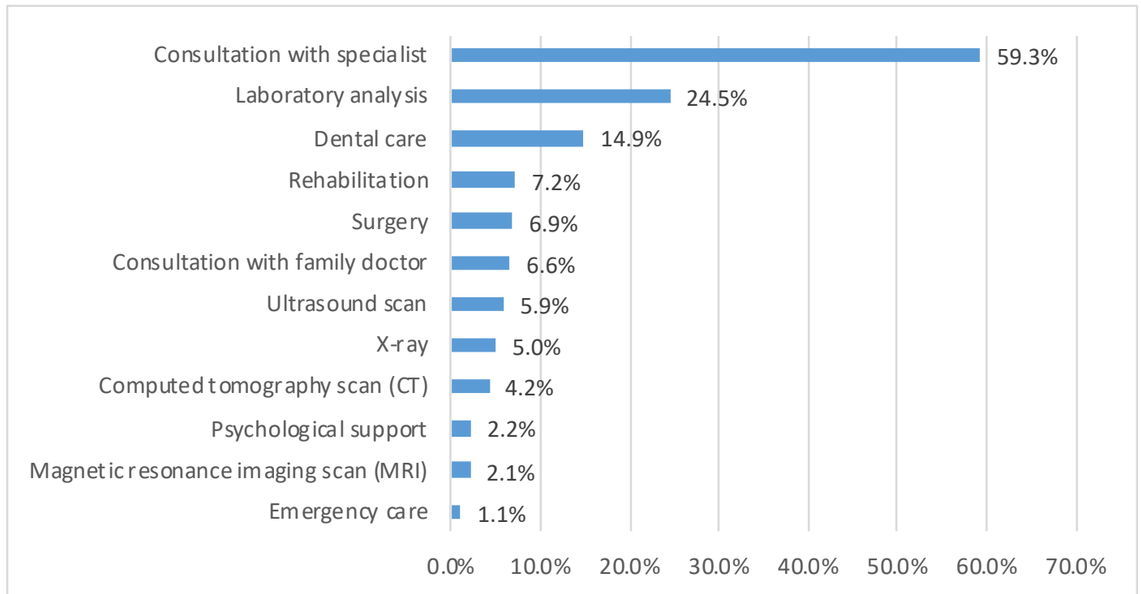
While the introduction of the universal health insurance programme improved children's access to healthcare, 12% of children were still unable to receive some kind of required medical treatment either fully or partially in the 12 months preceding the CWS (Figure 8.2). Differences in this respect are somewhat small between urban and rural areas, but clearly pronounced between materially deprived and other children – nearly a quarter of deprived children (24.2%) missed at least one essential treatment compared to 4.6% of non-deprived children. Even more striking are the differences between children with functional difficulties and other children with 41.5% of children with functional difficulties having missed an essential treatment at least once, compared to 11% of children without functional difficulties.

Figure 8.2 Children's access to healthcare services



The most frequently reported service that children were not able to receive is consultation with specialists (59.3%), followed by lab tests (24.5%) and dental care (14.9%) (Figure 8.3).

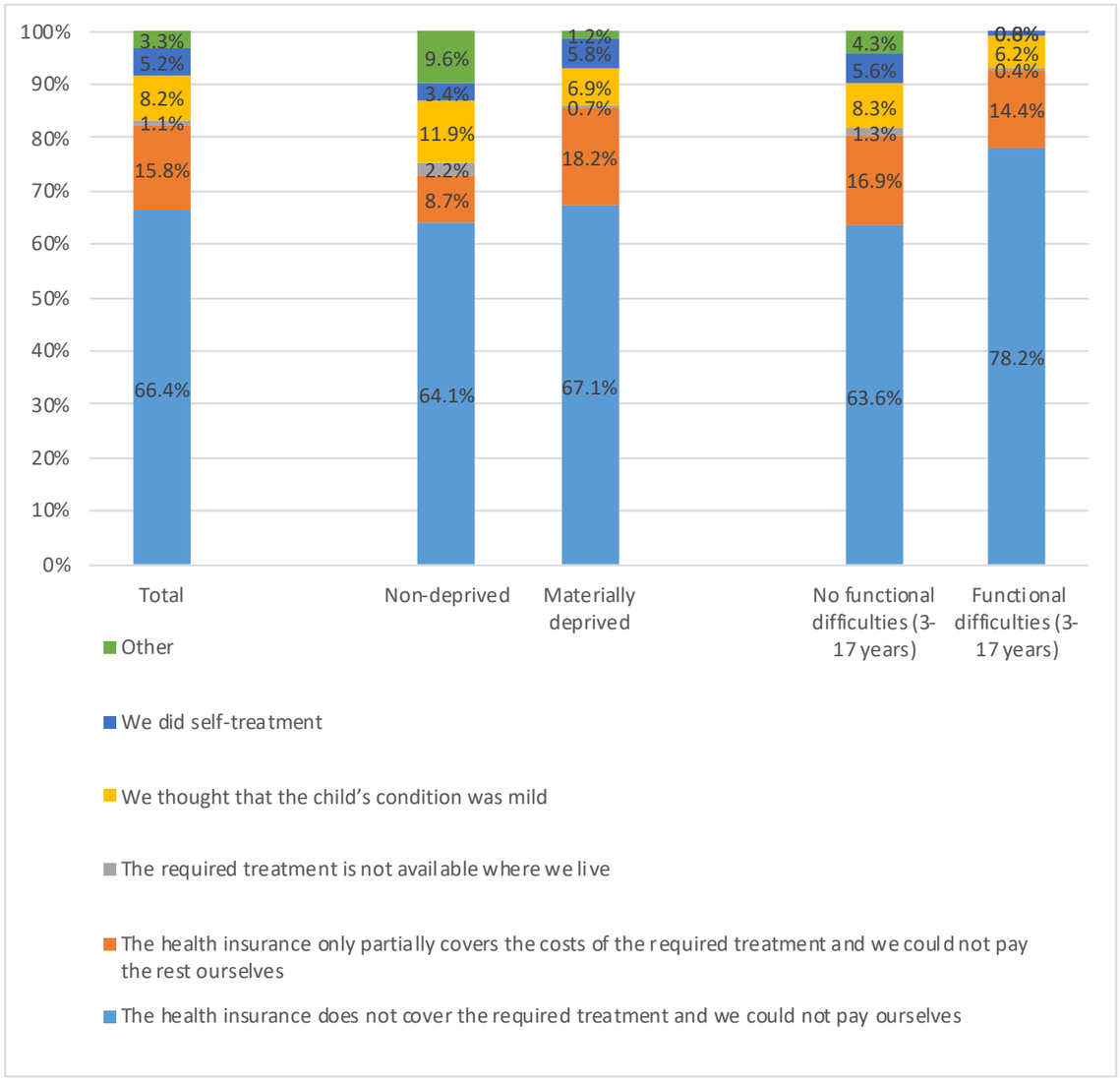
Figure 8.3 Share of children unable to receive specific types of medical services



5 At the time of writing this report, the Government made important changes in public healthcare provision. Namely, it adopted the diagnosis-related group (DRG) financing model and capped the prices of more than 1,300 medications. These reforms may result in substantial changes with regards to population's access to healthcare. For example, the DRG financing model also involves increasing co-payments to 30% for all services for all groups except the beneficiaries of TSA programme. Thus it should be stressed that the results reported below reflect children's access to healthcare prior to these reforms, which may change substantially in the near future.

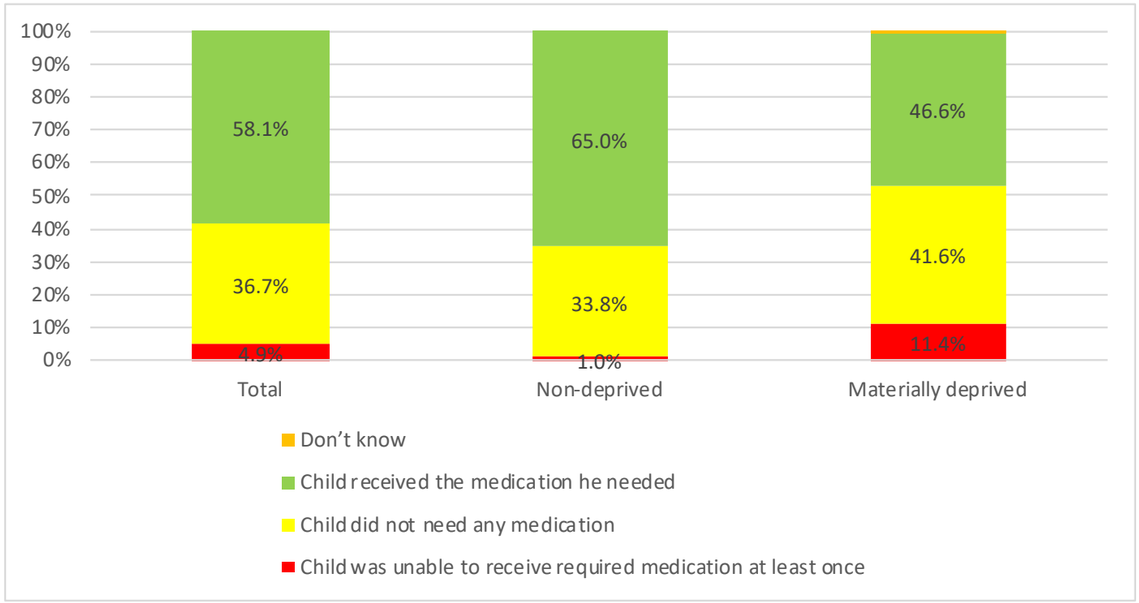
As expected, the most commonly reported reasons for children not receiving essential treatment are that either the insurance does not cover it (66.4%), or that the insurance covers it partially and the family is unable to afford the co-payment (15.8%) (Figure 8.4). Geographical barriers to health services are very rare (1.1%). Children may also not receive required professional treatment if their family members think that their conditions are mild (8.2%), or when they resort to treating children themselves (5.2%). Here too we find disparities between materially deprived and non-deprived children and children with and without functional difficulties. The inability to cover the costs of treatment either fully or partially was mentioned in 72.8% of cases when a non-deprived child was not able to receive at least one required medical service, while the same was true in relation to 85.3% of materially deprived children who missed out on at least one essential treatment. Similarly, these proportions were 80.5% and 92.6% respectively for children (3-17 years) without and with functional difficulties who did not receive at least one essential treatment.

Figure 8.4 Reasons for not receiving required medical service



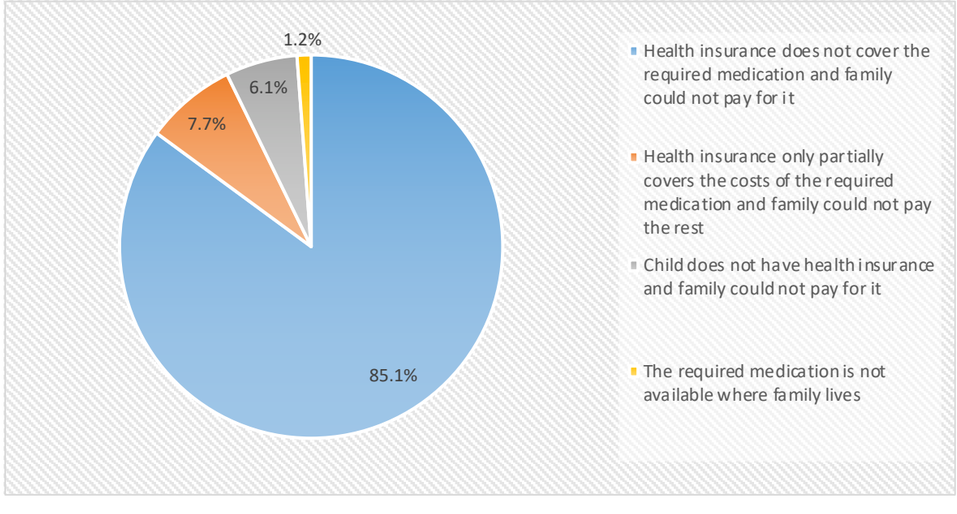
Lack of access to required medication is less common than lack of access to medical services, affecting 4.9% of children (Figure 8.5). But in this respect too there are large disparities between materially deprived and non-deprived children – 11.4% of the former did not receive a needed medication in the 12 months preceding the survey compared to 1% of the latter.

Figure 8.5 Access to required medication



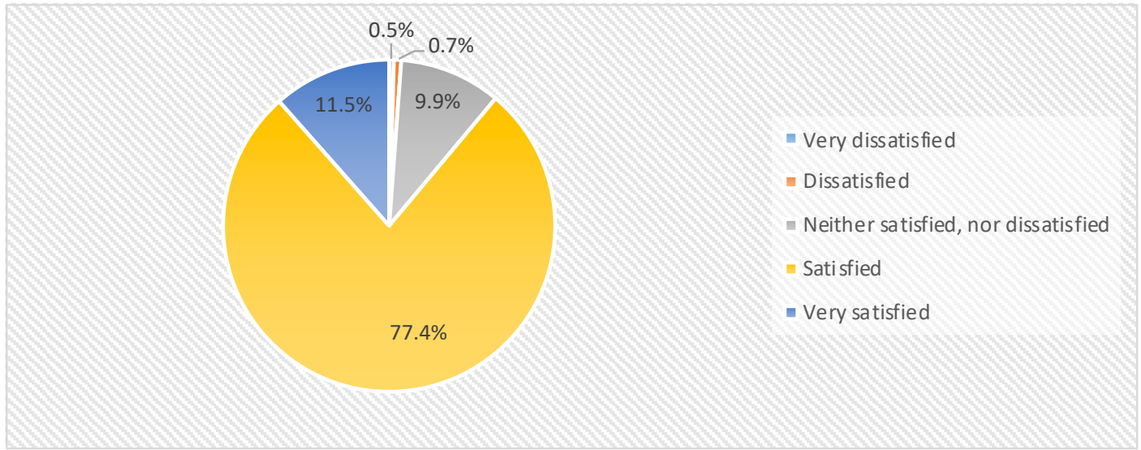
As in the case of lack of access to healthcare services, financial barriers are the primary reason why children do not receive needed medication. Only in 1.2% of cases did the respondents identify physical unavailability as the main reason why their children did not get the required medication; in all other cases, lack of money was named as the main reason (Figure 8.6).

Figure 8.6 Reasons for not receiving required medication



On a positive side, the respondents' satisfaction with the quality of medical services received by their children is high. For 77.4% of children who received some kind of medical treatment, parents/family members report being satisfied and for 11.5% of children, parents/family members are very satisfied (Figure 8.7). The share of children whose parents/family members are dissatisfied or very dissatisfied with the medical services is small – 1.2%.

Figure 8.7 Satisfaction with the quality of medical services for children



9. VIOLENT METHODS OF UPBRINGING

The frequent use of physical and psychological punishment methods for disciplining children has long been identified as a serious threat to children's safety in Georgia. In 2018 the MICS survey revealed that 28% of children aged 1-14 years were disciplined using exclusively non-violent methods (Geostat, 2019). Parents/family members of 66% of children admitted using psychological aggression and physical punishment was reported in relation to 31% of children. Most worryingly, almost 5% of children were subject to severe punishment, such as being hit on the face, head, or ears and/or being beaten up with all strength.

Based on the data from CWS the situation has considerably improved. Parents/family members of 29.4% of children admitted using psychological aggression and physical punishment was reported in relation to 4.8% of children. the respondents reported using non-violent methods in relation to 62.5% of children aged 2-17 years (Table 9.1). The use of severe physical punishment was mentioned for 0.1% of children.

Psychological and physical punishment methods are more often used in relation to children with functional difficulties than other children, with 12.4% of children with functional difficulties experiencing physical punishments and 37.3% subject to psychological aggression from their family members. The corresponding figures are 4.4% and 29.8% for children who do not suffer from functional difficulties.

Similarly, violent discipline methods are more frequently used in relation to urban children (33.3%), boys (34.8%) and children aged 6-17 years (31.9%) than in relation to rural children (27.8%), girls (26.3%) and children aged 1-5 years (28.2%).

Table 9.1 Use of non-violent and violent methods of disciplining children

	Total	Urban	Rural	Child with functional difficulties	Child with no functional difficulties (2-17 years)	Female	Male	1-5 years	6-17 years
Only non-violent discipline	62.2%	67.1%	62.9%	54%	63.0%	65.5%	59.6%	62.5%	62.1%
Psychological aggression	29.4%	32.1%	25.5%	37.30%	29.8%	25.0%	33.0%	25.0%	30.9%
Any physical punishment	4.80%	4.0%	5.9%	12.40%	4.4%	3.6%	5.7%	8.2%	3.7%
Severe physical punishment	0.1%	0.0%	0.2%	0.5%	0.1%	0.0%	0.1%	0.0%	01.0%
Any violent discipline method	31.0%	33.3%	27.8%	42.40%	31.2%	26.3%	34.8%	28.2%	31.9%

A possible explanation of the reduction in the use of violent methods of disciplining children is that the public is better aware of children's rights now than before, which may have led to an attitudinal and/or behavioural change. In 2018, 8.1% of MICS respondents thought that the use of violent methods is essential for up-bringing and/or educating children properly. According to the CWS, this proportion is reduced to 1.6% in 2022. However, further research is needed to understand what other factors contribute to the reduced use of violent methods of disciplining child, including stronger reactions from public authorities to reported cases of domestic violence against children and women.

10. EFFECTS OF SOCIO-ECONOMIC AND DEMOGRAPHIC VARIABLES ON CHILDREN'S PROBABILITY OF EXPERIENCING LACK OF ACCESS TO VARIOUS SERVICES

Throughout the report we have provided multiple examples of how the risk of children experiencing various problems differs based on their gender, place of residence, family socio-economic status and whether or not they have functional difficulties. In this chapter we take the analysis one step further by deploying regression models to estimate the net effects of various factors. For example, children living in rural areas may be more likely to lack access to a specific service because of their location, or simply because they are more likely to experience material deprivation, which in turn is the real barrier to accessing the service. Regression analysis is a powerful statistical technique that allows to measure the genuine effects of one or more factors (independent variables) on the outcome of interest (dependent variable). When the dependent variable is binary (e.g. deprived vs. non-deprived), logistic regression models are used.

Gender

Regression analysis shows that child's gender influences exposure to some of the risks, but whether boys or girls are more disadvantaged depends on the specific risk. Compared to girls, boys are considerably more likely to be subjected to violent methods of upbringing and to experience lack of access to extracurricular sports activities. Conversely, girls are more likely to lack access to extracurricular arts activities. To some extent this may reflect the traditional stereotype according to which boys should be engaged in more 'masculine' activities like sports, while girls should engage in more 'feminine' activities like music or dance. Hence the respondents may be more likely to report lack of access to a service they consider to be more 'suitable' for child's gender.

Urban/rural

Children living in rural areas are more than seven times more likely to lack access to preschool education than urban children. The most likely explanation is that in some remote rural areas there are no preschool services, as noted earlier. Rural children are also more than twice as likely to lack educational materials. Inversely, urban children are more likely to lack access to food during school hours, to lack access to extracurricular sports activities and to experience unacceptable discipline methods.

Functional difficulty

Having a functional difficulty is associated with almost four times higher likelihood of lacking access to an essential medical care and more than twice higher likelihood of not receiving a medication when needed.

Material deprivation

Of all examined factors material deprivation appears to matter the most. It is associated with a 6.7 times higher odds of lacking some kind of educational materials, 7.4 times higher likelihood of not receiving a required medication, and a staggering 18 times higher odds of not eating at school due to lack of money. The odds of all other risks except lacking access to pre-school education are also much higher when a child is materially deprived.

Child cash benefit

Means-tested nature of child benefit implies that it is designed to partially compensate for low-income families' general lack of resources. However, children who receive child benefit are still more likely not to receive medication when needed, to be unable to afford meals during school time and to miss educational materials compared to children who do not receive the transfer.

Table 10.1 Effects of socio-demographic factors on dimensions of children's welfare, logistic regression models.

	Barriers to Preschool	Not attending preschool	Tutoring	Arts circle	Sports circle	Educational materials	School meals	Healthcare	Medication	Violent methods of upbringing
Male (ref: female)	0.57	0.89	0.91	0.40***	2.31***	0.90	1.10	0.90	0.68	1.46**
Rural (ref: urban)	7.26***	2.25***	0.79	1.23	0.69**	2.20***	0.40***	0.98	1.53	0.76*
Child with functional difficulties (ref: child without functional difficulties)	0.30	0.69	1.16	1.02	1.59	1.03	2.16	3.9***	2.28*	1.43
Materially deprived child (ref: non-deprived child)	1.42	1.07	2.78***	2.33***	3.52***	6.70***	18.1***	4.67***	7.38***	1.43**
Child does not receive cash assistance (ref: child receives cash assistance)	0.68	1.10	1.03	1.17	0.77	0.56***	0.40**	0.70	0.44***	
Constant	0.02	0.25	0.16	0.26	0.15	0.41	0.02	0.07	0.02	0.40
Number of cases	456	456	1744	1744	1744	2100	1618	2219	2219	1835
Pseudo R2	0.14	0.03	0.04	0.06	0.1	0.22	0.24	0.14	0.18	0.02

Notes: *** $p < 0.001$; ** $p < 0.01$; * $p < 0.05$

11. CONCLUSION

In this final section we summarize the main findings of the report.

- 37.8% of Georgian children lack three or more out of 16 necessities. The rates of deprivation are considerably higher in rural (47.1%) than in urban areas (31.2%).

- Means-test child benefit is relatively well targeted as it covers 53% of materially deprived and 9.9% of non-deprived children. However, the families of materially deprived children often require additional support. Families of 15.5% of materially deprived children applied for some type of assistance without success in the 12 months preceding the survey.

- 5.8% of Georgian children aged 2-17 years have some form of functional difficulties. However, only 12.6% of them have official disability status. There are at least two reasons for this. First, the official disability status continues to be determined based solely on medical diagnosis. Second, a considerable share (26.1%) of parents/family members believe that child disability is associated with stigma. This can potentially discourage them from seeking official disability status for their children.

- There are 1.7% of 6-17 year old children not in school with 1.4% due to choice and 0.3% unable to attend school due to some barrier.

- Lack of access to preschool education affects 27.8% of preschool aged children who were not attending kindergarten, with 21.6% of children not attending based on parent's choice and 6.2% (12.4% in rural and 1.1% in urban areas) unable to attend due to barriers. The absence of kindergartens in close proximity and placement on the waiting list are the main barriers to preschool education.

- The levels of satisfaction with formal education services are very high. Parents/family members of 93.6% of children attending kindergartens are satisfied with the quality of preschool education. Similarly, 79.7% of parents/family members of children enrolled at schools are satisfied with the quality of school education.

- Access to informal education is rather limited. Among school-age children 18.8% receive tprivate tutoring, 12.2% attend extracurricular arts activities and 13.8% are engaged in extracurricular sports activities. At the same time, 18.8% of children would like to get private tutoring, 23.9% would like to attend extracurricular arts activities, and 25.3% would like to engage in extracurricular sports activities, but are unable to, primarily due to lack of finances and the absence of relevant service in their vicinity.

- Lack of educational materials (except school textbooks) is also common: 45.3% of children cannot afford at least one educational material they want. The most frequently missed educational materials include laptops/computers, books, painting materials and musical instruments.

- Slightly more than a quarter of children (27%) eat every day while at school. 34.9% never eat during school hours. The most common barriers to eating during school hours are the absence of food vendors in the close proximity (reported in 36.4% of cases when children do not eat during school hours) and lack of money (20.6%). 83.2% of parents/family members believe that schools should feed children and 74.2% of them are willing to pay for it if the prices are affordable.

- The universal health insurance programme is the main funder of healthcare services for children, providing full or partial funding in 68% of cases when a child needed medical treatment in the 12 months preceding the survey. However, families also provided full or partial funding in 50.8% of cases. Overall, 12% of children were unable to receive at least one essential treatment and 4.9% did not receive required medication. Lack of money is the primary barrier in relation to both medical treatments (82.4%) and medication (98.8%)

- The respondents reported using non-violent discipline methods in relation to 62.5% of children aged 1-17 years. 29.4% of children are subjected to psychological aggression, and 4.8% to physical punishments (0.1% to severe physical punishments).

Overall, on all dimensions of child welfare the analysis revealed large inequalities between different groups of children. Gender, urban/rural residence and functional difficulties affect children's access to some services and necessities. However, the most critical factor in this regard appears to be material deprivation. Children who are materially deprived score much worse than other children in practically all dimensions of child welfare, and some of the disparities are striking. Therefore, tackling these inequalities should be a central component of all measures aimed at improved child welfare in Georgia.

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