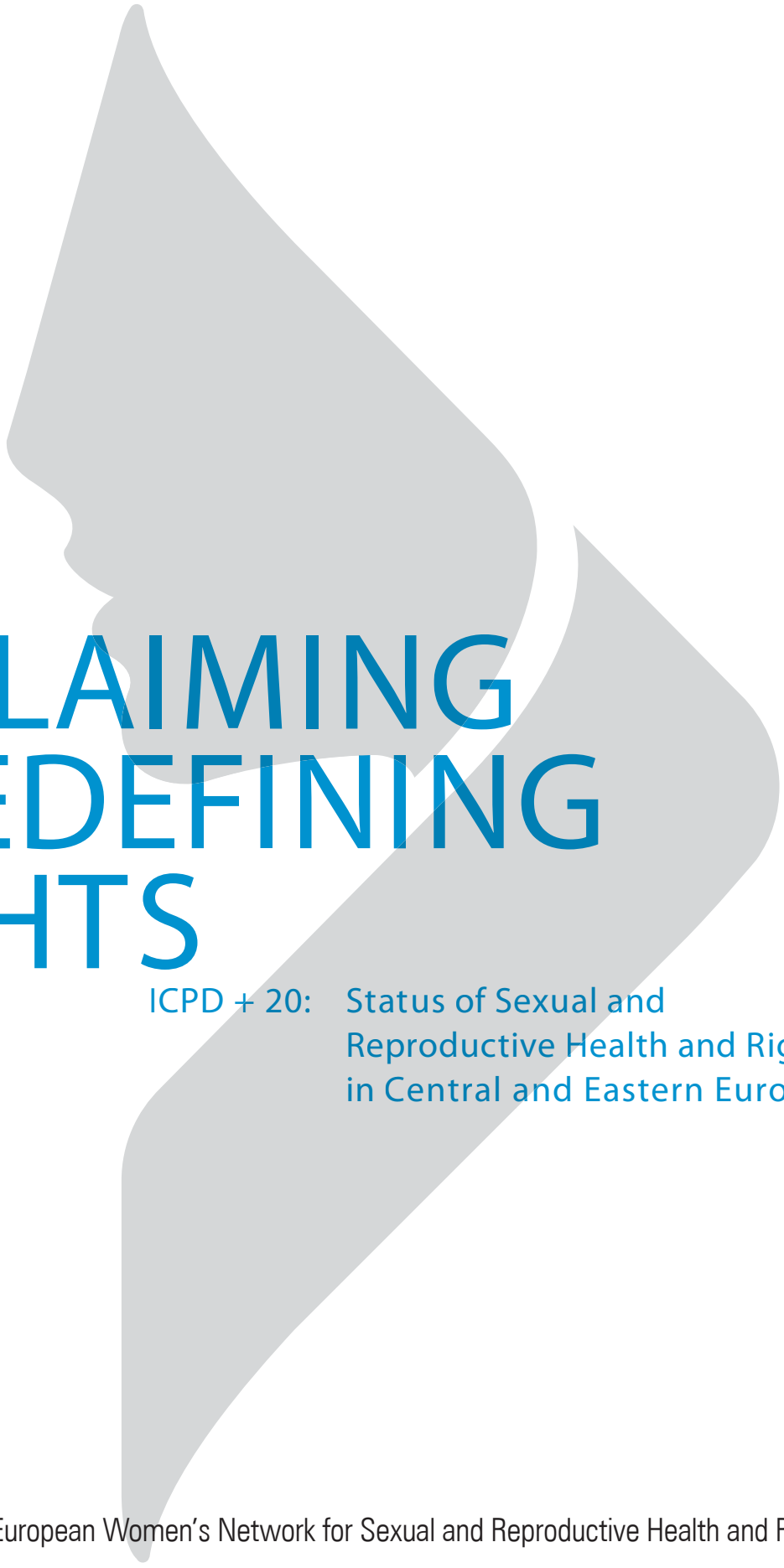
monitoring report
october 2012

RECLAIMING & REDEFINING RIGHTS

ICPD + 20: Status of Sexual and Reproductive Health and Rights in Central and Eastern Europe

by
ASTRA
Central and Eastern European
Women's Network for Sexual
and Reproductive Rights and Health



RECLAIMING & REDEFINING RIGHTS

ICPD + 20: Status of Sexual and Reproductive Health and Rights in Central and Eastern Europe

ASTRA
Central and Eastern European Women's Network for Sexual and Reproductive Health and Rights

Published by:
ASTRA Network Secretariat
Nowolipie 13/15, 00-150 Warsaw, Poland
Email: info@astra.org.pl
Website: www.astra.org.pl

Written by: Katarzyna Pabijanek
Edited by: Pamela Wells
Cover and layout design: Kann Press
Printer: PPHU Jerzy Kink

This monitoring project and report were funded by Ford Foundation and Asian-Pacific Resource and Reasearch Centre for Women (ARROW).

ISBN 978-83-88568-44-2

Warsaw, Poland, October 2012

LIST OF BOXES

LIST OF TABLES

LIST OF TABLES IN THE ANNEX

GLOSSARY

ANC	Antenatal Care
ARH	Adolescent Reproductive Health
ART	Anti-Retroviral Treatment
ARV	Anti-Retrovirus
BEmONC	Basic Emergency Obstetric and Neo-natal Care
BBC	Beyond Beijing Committee
CEmONC	Comprehensive Emergency Obstetric and Neo-natal Care
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CEE	Central and Eastern Europe
CIS	Commonwealth of the Independent States
CoE	Council of Europe
CPR	Contraception Prevalence Rate
CRC	Convention on the Rights of the Child
CSOs	Civil Society Organisations
D&C	Dilation and Curretage
DHS	Demographic Health Survey(s)
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
EmOC	Emergency Obstetric Care
EU	European Union
FP	Family Planning
FPAs	Family Planning Associations
FSW	Female Sex Worker
GDI	Gender-related Development Index
GDP	Gross Domestic Product
GEM	Gender Empowerment Measure
GHE	Government Health Expenditure
GNP	Gross National Product
HDI	Human Development Index
HDR	Human Development Report
HIV/AIDS	Human Immunodeficiency Syndrome/ Acquired Immunodeficiency Syndrome
HPV	Human Pappilomavirus
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
IDP	Internally Displaced Persons
IDU	Injecting Drug User
ILO	International Labour Organisation
IUD	Intra-uterine device
LGB	Lesbian, Gay, and Bisexual
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex people
MARP	Most at Risk Population
MDGs	Millenium Development Goals
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
MR	Menstrual Regulation
MSM	Men Who Have Sex with Men
MSW	Male Sex Worker
MVA	Manual Vacuum Aspiration Method
NASP	National AIDS/STD Programme
NDHS	National Demographic Health Survey
NGO	Non-Governmental Organisation
NHA	National Health Account
ODA	Overseas Development Assistance
OOP	Out of Pocket
PHE	Private Health Expenditure
PITC	Provider Initiated Testing and Counselling
PLHA	People Living with HIV/AIDS
PLHIV	People Living with HIV
PMTCT	Prevention of mother-to-child transmission
PoA	Programme of Action
PPH	Postpartum haemorrhage
PPP	Purchasing Power Parity
PPTCT	Prevention of parent-to-child transmission
PRSP	Poverty Reduction Strategy Papers
RH	Reproductive Health
RHM	Reproductive Health Matters
RR	Reproductive Rights

RTI	Reproductive Tract Infection
SHI	Social Health Insurance
SIECUS	Sexuality Information and Education Council of the United States
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SRVAW	Special Rapporteur on Violence against Women
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendants
TFR	Total Fertility Rates
THE	Total Health Expenditure
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNData	United Nations Data
UNDESA	United Nations Department of Economic and Social Affairs
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
UP	Uterine Prolapse
VAW	Violence Against Women
VCT	Voluntary Counselling and Testing
WHA	World Health Assembly
WHO	World Health Organisation

ACKNOWLEDGEMENTS

This report was written by Katarzyna Pabijanek and copy-edited by Pamela Wells. This report was reviewed by TK Sundari Revindran and Aleksandra Solik.

Secondary data collection was undertaken by Ambika Varma (Programme Officer, Information & Documentation Centre, ARROW), who also prepared all the tables of the report. Additional readings were undertaken by Krystyna Kacpura (Executive Director, Federation for Women and Family Planning), Marta Szostak (ASTRA Youth Coordinator), and Martyna Zimniewska (Project Officer, Federation for Women and Family Planning).

ASTRA Network's national country partners in the ICPD+20 monitoring project
The ICPD+20 monitoring project spanned seven countries and was undertaken by ASTRA Network's national country partners who carried out national studies, inputting and verifying country data:
Armenia: Society Without Violence
Azebaijian: Women and Modern World Center
Georgia: Association HERA XXI
Hungary: PATENT
Poland: Federation for Women and Family Planning
Russian Federation: Novgorod Gender Center
Ukraine: Charitable SALUS Foundation

The monitoring project also involved independent researchers in the region:
Boris Denisov (Moscow University, Russian Federation), Katalin Fintané (Hungary), Kara Setian Marston (Women's Resource Center, Armenia), Anush Poghosyan (Women's Resource Center, Armenia), Gohar Shahnazaryan (Women's Resource Center, Armenia), Sudaba Shiraliyeva (Azerbaijan), Giorgi Soselia (Georgia), Olexandra Sluzhynska MD, PhD (Scientific-Research Institute of Hereditary Pathology, Ukraine), Mariia Telishevska MD, PhD (Ukraine).

The comments of Anna Nikoghosyan, Iatamze Verulashvili, Evgenia Koulikova and Julia Spronz were also appreciated.

EXECUTIVE SUMMARY

The 1994 Cairo International Conference on Population and Development (ICPD) adopted a 20-year Programme of Action (PoA) with a broad mandate on interrelationships between population, sustained economic growth and sustainable development, and advances in the education, economic status and empowerment of women. The year 2014 marks the 20th anniversary of the Cairo Conference. It is, therefore, necessary to reflect on the progress made, the challenges encountered and, based on these, to formulate strategic goals for ICPD's agenda beyond.

Central and Eastern European (CEE) countries failed to use ICPD as a framework to build a sustainable architecture to protect and promote women's rights. The social and economic upheaval that took place in the CEE region in the 1990s has brought declining socio-economic conditions and increasing inequity throughout the region, and in all CEE countries there is a huge gender gap in the economic activity rate. Decision-making and political power is firmly held by men and not one of the seven countries surveyed for this report is even close to reaching the 30% quota of women's political participation. This reflects the prevalence of deep-seated gender stereotypes that define women primarily as mothers and wives, assigning their role to the private sphere. Countries of the region are suffering a resurgence of patriarchal discourses and religious fundamentalisms which is reflected in setbacks with population and reproductive rights policies. In Hungary, Poland, Ukraine, and Russian Federation, there is a swing back towards pre-Cairo right-wing positions which limit people's rights to make their own sexual and reproductive choices.

As a result, twenty years after Cairo, women still die unnecessarily due to unsafe abortion, pregnancy, or childbirth. Women and teen girls are suffering from the consequences of unsafe abortion and childbirth, and lack of access to respectful, caring, quality health services to which they have a right as citizens. A similar scenario of continued ill health and suffering exists for women with HIV/AIDS, reproductive cancers and infections, and unwanted pregnancies, in spite of the fact that the necessary technology and medical interventions are known. Neoliberal health policy transforms patients with rights to sexual and reproductive health into consumers who can (or cannot) pay for sexual and reproductive health. Another common denominator for the region is rampant homophobia and transphobia.

ICPD implementation has been slow in all countries, despite the acknowledged need to accelerate commitment and the effort to meet women's needs and rights, known as the spirit of Cairo. While many new population and reproductive health policies have been introduced in the countries that form part of this study, they still do not clearly incorporate a human rights and women's rights framework, either at a conceptual or programme level. There is also a large gap between what is stated and the actual implementation.

Barely two years to the end of the ICPD, the prognosis for achieving the objectives of the ICPD is generally not reassuring. Time is limited and population issues are generally difficult to turn around quickly. However, strategic or targeted planning, coupled with commitment, could still achieve much within a short time. While national conditions vary, the outcome of this monitoring project suggests that renewed focus by all countries – regarding the accessibility of sexuality education, affordable contraception and abortion services, as well as addressing the spreading HIV/AIDS pandemic – could galvanise Central and Eastern Europe's lackluster move towards 2014 and beyond.

CHAPTER 1

INTRODUCTION

INTRODUCTION

Women's empowerment and the recognition of women's human rights have been acknowledged as crucial for combating poverty and for people's wellbeing.

International Human Rights Instruments and Conferences that were endorsed during and after the UN Decade for Women marked the groundbreaking shift from quantitative, demographically driven reasoning to a women's reproductive health and rights paradigm. In 1994, the United Nations International Conference on Population and Development (ICPD) reiterated and solidified a rights-based approach to reproductive health, marking a shift from an emphasis on population control to women's empowerment more generally.

Almost twenty years after the ICPD, women's lives have only seen minimal improvement. Findings from NGO country-monitoring studies in the Central and Eastern Europe (CEE) region reveal that, despite agreement to achieve the clear objectives and strategies outlined in the ICPD Programme of Action (PoA), governments have not yet been successful in implementing the majority of actions promised at that landmark conference.

MONITORING ICPD+15

Monitoring government commitment to international conferences and to international covenants is a key activity of non-governmental organisations in holding governments accountable.

This is the eighteenth year of the implementation of the ICPD PoA, and 2014 will mark the target year for achieving the commitments stipulated in 1994.

The implementation of the ICPD PoA is chequered: the PoA was sidelined by the Millennium Development Goals (MDGs); it was hindered by hostility to several dimensions of sexual and reproductive health and rights in many countries; and the Global Gag Rule which was in force for eight years of the Bush administration hampered US development funding for abortion services in developing countries. In the last 15 years, programme implementers and policy makers in countries have changed, and the new cadre is not familiar with the vision and the commitments of the PoA.

At this pivotal juncture, it is crucial to measure and track the progress of the implementation of the ICPD PoA. It is imperative to know and to understand what progress has or has not been made, in order to inform inter-governmental organisations, governments and non-governmental organisations about actions that need to be taken. It is with this aim that ASTRA Network[1] has joined Asian-Pacific Resource and Research Centre for Women (ARROW) in an attempt to create an avenue for the Global South perspective on development agenda.

ASTRA Network's monitoring framework for ICPD+20 included input from country partners and thematic research papers which would provide an overarching look at the critical issues affecting the realisation of sexual and reproductive health and rights in the Central and Eastern European region.

ASTRA'S ICPD+20 MONITORING PROCESS AND OUTCOMES

ASTRA's ICPD+20 monitoring project spans seven countries in Central and Eastern Europe and Commonwealth of Independent States (CIS).

These seven countries have been identified as the priority countries for ASTRA through its organisational strategic planning process. ASTRA has working relationships with NGOs operating in the field of sexual and reproductive health and rights (SRHR) in all of these seven countries.

In the report, "Central and Eastern Europe" is used to refer to the post-communist European countries of Poland and Hungary plus five countries of the former Soviet Union: Armenia, Azerbaijan, Georgia, Russian Federation, and Ukraine. Poland and Hungary joined the European Union (EU) in 2004, and all seven countries are member states of the Council of Europe (CoE). What holds all the surveyed countries together as a group is not just their shared history of subjugation to the former Soviet Union. This region is also held together by their common identification as a particular political-economic coordination group of post-communist countries, and their experience of "transition" from communism to democracy.[2]

HOW WERE THE INDICATORS CHOSEN?

ASTRA, with input and verification from partners, collected and analysed the 80 cross-country indicators for the ICPD+20 project.

We made a conscious attempt to divide the indicators into 5 different components: women's empowerment, reproductive health, reproductive rights, sexual health and sexual rights. This ensured that each aspect of SRHR and cross-cutting gender empowerment indicators were adequately covered.

ARROW recommended trend analysis as useful for monitoring progress. Thus, where possible and appropriate, monitoring covered three periods: 1995, 2000, 2005-2008.

SCOPE OF THE INDICATORS

The scope of this review covers the following four different but inter-linked components of SRHR: reproductive health, reproductive rights, sexual health, and sexual rights.[3]

The concepts of reproductive health, reproductive rights[4] and sexual health[5] were endorsed by UN conventions and conferences such as: Convention on the Elimination of All Forms of Discrimination against Women (CEDAW); Convention on the Rights of the Child (CRC); ICPD; the Fourth World Conference on Women: Action for Equality, Development and Peace in Beijing and the World Conference on Human Rights in Vienna; and the Millenium Development Goals.

These documents, particularly the ICPD PoA, do not explicitly state 'sexual rights.' Although 'sexual rights' was written for the first time in the ICPD PoA draft, it was not retained in the final text.[6]

However, the ICPD PoA acknowledges sexual rights when it states that in order "to have a safe and satisfying sex life", men and women should have "the capability to reproduce and the freedom to decide, if, when and how often to do so..."[7] The interpretation of what constitutes a "safe and satisfying sex life" and the conditions that provide for this, include key aspects of sexual rights such as consensual sexual relations, the choice of sexual partners, and the achievement of sexual pleasure. Sexual rights, therefore, are embedded in the ICPD PoA and it is important to monitor these.[8]

Box 1: Key Definitions

Reproductive Health	Reproductive Health implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the rights of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. (WHO)
Reproductive Rights	Reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly about the number, spacing and timing of their children, to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. (ICPD)
Sexual Health	Sexual health implies a positive approach to human sexuality where the purpose of sexual health care should be the enhancement of life and personal relations, as well as counselling and care related to reproduction and sexually transmitted diseases. (adapted, UN)
Sexual Rights	Sexual rights embrace human rights that are already recognised in national laws, international human rights documents and other consensus documents. These include the rights of all persons, free of coercion, discrimination and violence: to the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive health care services; to seek, receive and impart information in relation to sexuality; to sexual education; to respect for bodily integrity; to their choice of partner; to decide to be sexually active or not; to consensual sexual relations; to consensual marriage; to decide whether or not, and when to have children; and to pursue a satisfying, safe and pleasurable sexual life. (WHO, working definition)

CHANGES IN THE REGION WHICH AFFECT THE IMPLEMENTATION OF THE POA

The CEE countries vary widely in terms of historical and cultural background, population homogeneity, income levels, and political processes.

Poland and Hungary, for example, have benefited from relative political stability and have strategically positioned themselves toward European integration, becoming full members of the EU in 2004. They have established reasonably functioning market economies with fairly effective social safety nets, as well as reforming their healthcare systems. The countries of Central Asia and Caucasus (Armenia, Azerbaijan, Georgia) have experienced significant economic crises, geopolitical pressures, ethnically motivated conflict, and political unrest, with large numbers of their populations being displaced. Since independence, the Republic of Armenia has faced numerous obstacles as it transitions to a market economy, including the Nagorno Karabakh conflict, repercussions of the 1988 earthquake, the collapse of the national economy, the production crisis, extreme inflation, and increased unemployment. As a result of these endemic issues, nearly one million people, or twenty five percent of the population, have migrated from Armenia since 1991, the majority of which are men.[9] An estimated 30 000 people were killed and more than a million were displaced in Azerbaijan. Consequently, Azerbaijan supports about 800 thousand internally displaced persons and refugees. Most of these do not work, and the health status of internally displaced and refugee women and children, as a rule, leaves much to be desired. Also, in Georgia the secessionist conflicts in Abkhazia and South Ossetia had negative impact on the living conditions and health status of local population. The third conflict zone under review is Russia, where the North Caucasus remains the most problematic region. Although the so-called counter-terrorism operation in Chechnya was declared to be over in April 2009, the North Caucasus remains the region where the worst and most massive violations of human rights take place: state and non-state actors are responsible for enforced disappearances, abductions, acts of torture including rape, as well as extrajudicial executions and the targeting of civilians by armed groups.[10] Until recently, Ukraine had been relatively isolated, although political and economic change is now occurring, if only in a somewhat stuttering manner. The economic development of some countries in the region such as Russia and Azerbaijan have benefited from access to natural resources in recent years, most notably with the escalation of oil prices. Across the region, however, socio-economic inequities have grown alarmingly and access to public resources has declined. While income differentials have grown, and a small hyper-affluent elite has benefited substantially, large sections of the population have suffered and become marginalised. The size of vulnerable populations has grown, with migrants, ethnic minorities, the homeless, and people working in the informal economy being particularly at risk. The global economic crisis has hit hard the whole region. Bad economy affects both the citizens (and women especially, as they are more likely to become unemployed or be paid a low wage for their work, more often to be a single head of the household, more often to be responsible for unpaid care work) and health care systems in respective countries. The collapse of communism led to the elimination of various state programs that paid particular attention to the needs of women, such as family and child care support, and the whole responsibility was transferred to women who have been struggling to balance and satisfy their paid and unpaid work responsibilities.

Eighteen years after Cairo, it is important to recognise developments external to the health sector that affect the implementation of the PoA.

These are:

1. Health sector reforms, including the various forms of privatisation, and their impact on women's SRHR;

2. The new aid architecture and funding mechanisms for governments and how these affect the health sector; and

3. Decentralisation and its impact on health policy formulation, programme implementation, and service provision.

In addition to these, important developments emerged such as the expanding definitions and understanding of sexual preferences, sexual identities and gender identities, and social movements in the Central and Eastern European region advocating for the sexual rights of all human beings.

Further, paragraph 8.25 of PoA which specifies "abortion, where legal" has limited application in changing prohibitive national laws and in extending access to abortion beyond the time-limit specified by the law. This hampers efforts to concretise women's reproductive rights in many countries.

METHOD AND THE FORMAT OF THIS REPORT

The methodology, outline, and concept of the project draws largely on Asian-Pacific Resource and Research Centre for Women (ARROW)'s experience with earlier reviews of ICPD (ICPD+5, ICPD+10, ICPD+15).

We have structured this monitoring report in three sections.

In the second chapter we deal with the regional context of women's empowerment and health financing. To monitor progress on women's empowerment, this section identifies governments that signed up to international conventions, declarations, and programmes of action. We look at women's empowerment as measured by enrolment of girls and women in primary, secondary and tertiary education, as well as women's participation in the labour force and politics. Women's empowerment has a direct bearing on sexual and reproductive decision-making.[11]

In this section we also focus on health financing, among the other factors affecting the health system, as this reflects the priorities of governments and makes them responsible and accountable for the resources they have allocated within the health sector. Health financing for SRH affects the way women access SRH services and aids in the progressive realisation of rights.

Both aspects – women's empowerment and health financing – set the stage for monitoring progress on the specific SRHR components which follow in the next two sections.

In the third chapter, we focus on progress related to reproductive health and reproductive rights in the seven countries. This section includes subsections on contraception, pregnancy and childbirth-related mortality and morbidity, abortion and reproductive cancers.

In the fourth chapter on sexual health and sexual rights, we focus on progress in the seven countries in the key areas of STIs and HIV/AIDS, adolescent sexual rights and sexual rights.

In each subsection we present regional and sub-regional trends, as well as evidence to denote progress or lack of progress at country level. Recommendations are presented in the fifth and last section.

DATA SOURCES FOR THE INDICATORS

The report mainly relies on primary data generated by ASTRA member organisations and secondary data obtained from various sources: United Nations Department of Economic and Social Affairs (UNDESA), United Nations Development Programme's (UNDP) Human Development Report (HDR), International Labour Organisation (ILO), World Health Organisation (WHO) National Health Accounts, WHO Global Database, UNData, UN Secretary-General's Database on Violence Against Women, Demographic Health Surveys (DHS) or comparable national studies such as family or population surveys,[12] United Nations General Assembly Special Session on AIDS (UNGASS) progress reports, the Centre for Reproductive Rights, Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) government reports and NGO shadow reports of the respective countries, scientific papers from journals such as The Lancet, International Journal of Gynaecology and Obstetrics, Reproductive Health Matters (RHM) and country studies. Additionally, a survey focusing on issues not covered by existing literature was carried out. The standardised survey form also specifically asked respondents to identify other important issues in relation to sex work in their country.[13]

ENDNOTES

1 ASTRA Central and Eastern European Network for Sexual and Reproductive Health and Rights is a network of 29 CSOs from 18 countries of Central and Eastern Europe working towards promotion of reproductive and sexual rights and health on national, regional, and international level.

2 Gal, S., & Kligman, G. (2000). The politics of Gender After Socialism. Princeton, New Jersey: Princeton University Press, p.10.

3 Carroll, A., & Periolini, M. (2007). *International Human Rights References to Sexual and Reproductive Health and Rights (regarding LGBT populations and HIV/AIDS and STIs).* Europe: International Lesbian and Gay Association (ILGA).

4 While the term 'reproductive health' was first developed by institutions, such as the World Health Organisation (WHO), in the early-1980s, the term 'reproductive rights' was initially first used in feminist meetings in the late 1970s and was clearly defined in the International Women and Health Meeting (IWHM) of 1984 as described in Petchesky, R.P. (2003). *Transnationalizing Women's Health Movements. In Global Prescriptions: Gendering Health and Human Rights* (p. 4). London, UK: Zed Books.

5 The term 'sexual health' has been defined as early as in 1975 by WHO. Education and treatment in human sexuality: the training of health professionals. Geneva, World Health Organisation, 1975 (WHO Technical Report Series No. 572).

6 Correa, S.,& Careaga, G. (2004). Is Sexuality A Non Negotiable Component of the Cairo Agenda?, Development Alternatives With Women from a New Era (DAWN) Web site: http://www.dawnnet.org/resources-papers.php?id=51

7 Paragraph 7.2. of the ICPD PoA.

8 Although "sexual rights" as a term has not been established in international agreements, its definition and content were adopted within the human rights framework in the Beijing Platform for Action, Paragraph 96.It is worth noting that even governments expressing reservations in opposition to "sexual rights" used the term in their statements at the closing session of the Beijing Conference.

9 ASTRA Network Country Report: Armenia, Gohar Shahnazaryan and Anush Poghosyan, 2012 (unpublished).

10 Amnesty International: Russian Federation. Briefing to the Committee on the Elimination of Discrimination Against Women. 46th session July 2010.

11 Gupta, G.R., and Malhotra, A. (2006). Empowering Women through Investments in Reproductive Health and Rights. Retrieved August 27, 2009, from Website: www.packard.org/assets/files/ population/.../pop _ rev _ gupta.pdf

12 Demographic Health Surveys are available for Armenia (2000, 2005), Azerbaijan (2006), and Ukraine (2007). Since the DHS are carried out in cycles of 5-10 year's time. For other countries, Georgia, Hungary, Poland, and Russia data is obtained from their respective studies such as Reproductive Health Survey Survey.

13 See: Box 2: ASTRA questionnaire synthesis file.

CHAPTER 2

SETTING THE CONTEXT

BOX 2:

QUESTIONNAIRE SYNTHESIS FILE

Reclaiming and Redefining Rights. ICPD+15 Status of Sexual and Reproductive Health and Rights in Armenia, Azerbaijan, Georgia, Hungary, Poland, Russia and Ukraine.

Methodology: Interviews based on a closed questionnaire were used to gather qualitative information for this report on the Status of Sexual and Reproductive Health and Rights in Central and Eastern Europe.

We worked with a small sample of 20 interviewees, recruited among representatives of stakeholders from the region: there were two representatives from decision making bodies, two activists from grassroots organisations activists, two academic researchers, three service providers (medical doctors), one lawyer, and the rest were employees of NGOs working in the field of SRHR in their respective countries.[1] We managed to interview three people per country, with the exception of Azerbaijan where we only managed to recruit two respondents. We identified people to be interviewed by seeking individuals falling into the category of "privileged witnesses or people who, because of their position, activities or responsibilities, have a good understanding of the problem to be explored". Data analysis was undertaken by identifying and writing down the main themes that emerged during the interviews. Then, the main ideas for each topic were identified and illustrated with quotes from interviewees. The objective of the study was to supplement other qualitative and quantitative data collected for the report.

1. What are the key sexual and reproductive health and rights issues in your country/region?

Lack of sexuality education, high abortion rates, attempts to restrict access to abortion, and low prevalence of modern contraceptives were brought up as main issues regarding SRHR by those who were interviewed for the current report. An employee from KARAT Coalition, (a network dealing with women's economic rights in CEE) said that high maternal mortality, (e.g., Azerbaijan); selective abortion (Azerbaijan, Armenia); forced marriages (Central Asia); and sexual violence are among most pressing SRHR issues in the region. (This opinion was not reflected by statements of nationals from these countries).

Respondents from Georgia, Azerbaijan and Poland listed the lack of access to **comprehensive sexuality education** in school curricula as the most burning problem to be addressed by decision makers. A respondent from Hungary said that, although sexuality education continues to be a part of the national curriculum, it is likely to be limited under the current conservative government and its new Act on Family Protection that was adopted in December 2011. Moreover, the current approach to sexuality education is biologically biased and fails to address the human rights context of sexuality. Also, Polish peer sex educator said that young people in Poland, especially from rural areas, do not receive any sexuality education and the existing subject Preparation for Family Life often contains biased information rather than neutral science-based facts. A Ukrainian respondent linked the lack of comprehensive sexuality education with the high rate of teen pregnancies in Ukraine.

High **abortion** rates were mentioned as the most pressing issue by interviewees from Armenia, Hungary and Ukraine, while those in Poland stressed the problem of the Polish restrictive law on abortion and extremely limited access to lawful pregnancy termination. Hungarian and Russian interviewees

pointed to attempts to restrict abortion in their countries as the issue of the highest importance. Those from Russian Federation interpreted the new regulation restricting access to abortion as a blatant example of patriarchal backlash. Stigmatisation of abortion, forced childbearing, pre-abortion counselling as well as attacks on pro-choice professionals were listed as most dangerous issues at the moment in Russian Federation.

The new Hungarian constitution, which came to force at the beginning of the year, and the new Act on Family Protection, which was adopted in December 2011, both contain the provision on the "right to life" and "protecting fetal life from conception". It is likely that the current liberal legislation regulating access to abortion will be contested by the Constitutional Court. The Christian Democratic Party filed an amendment to Hungary's budget, cutting the amount set aside for the abortions provided within the health system funding, but it was rejected in December 2011. According to polls, 71% of Hungarians declare themselves pro-choice. Hungary's high abortion rate is linked to the high prices of **contraception**. With economic crisis and growing poverty, the price of contraceptives becomes a real financial challenge for Hungarians, Georgians and Poles.

Furthermore, Polish informants pointed to the limited information on modern contraceptives that is reflected in the low prevalence of modern contraception in Poland. Moreover, the unfavourable climate around family planning in Poland has recently led to an initiative by a group of Polish pharmacists to use the conscientious clause as an excuse to stop selling hormonal, especially emergency contraceptives. The low prevalence of modern contraception is a problem in Armenia, where the most commonly used method continues to be withdrawal (25%), followed by the male condom (15%).

Another Armenian respondent said that women face difficulties negotiating condom use with their partners, which often leads to the spread of STIs. A Ukrainian respondent pointed to the existing misconceptions regarding modern contraception among the general population, as well as among family planning providers. She argued that the low awareness regarding contraception is the reason behind Ukraine's extremely high level of teen pregnancies, three times higher than levels of teenage pregnancies in countries such as Belgium and Austria.

Other issues

An interviewee from Ukraine pointed to the **HIV/AIDS** epidemic, and the high prevalence of other **STI**s in her country. She underlined the growing number of newly registered cases, especially among young people and heterosexual male to female transmission, as the most important issues.

A Polish interviewee mentioned the danger of restricting access to IVF, which is currently not regulated and not included in the insurance system, as another important SRHR issue nowadays in Poland.

Existing regional **inequalities** in access to SRHR was brought up by respondents from Armenia, Azerbaijian, Georgia, Ukraine and Poland. A peer sex educator from the Polish volunteer group PONTON stated that "Poland is one of the few countries in the European Union where sexual and reproductive rights, especially of women and young people, are severely restricted due to the fact that the existing law imposes a practical ban on abortion in the country". She pointed to an acute discrepancy between the attitude towards SRHR in Poland and the rest of the European Union. Others drew attention to serious differences in access to SRHR services and supplies between rural and urban areas in their countries.

Interviewees from Hungary and Armenia reflected on the **inequality between men and women** and prevailing **stereotypes regarding gender roles** as factors obstructing access to SRHR in their countries.

Polish and Armenian respondents pointed to the fact that because sex is perceived as a taboo, this a cause of various problems regarding SRHR in their countries.

Growing poverty was a recurrent motif of testimonies. From Georgia, it was said that decreasing public expenditures results in the underfunding of medical facilities, including reproductive health services. From Hungary, the example was given of a press article that argued it is cheaper to have an abortion than to use contraceptive pills.

Interviewees mentioned also a problem with a **lack of resources** to push the SRHR agenda forward. They pointed to the transformation of national health systems and international donors' withdrawals from the region as main problems (Poland, Ukraine, Armenia).

Finally, Polish respondents mentioned the lack of legal recognition of gay and lesbian couples as another key issue to be addressed.

2. *When working "on the ground", what are the key challenges/barriers you face going about your work on SRHR?*

Interviewees agreed that one factor that contributes largely to an unfavourable atmosphere around SRHR in our region is an **increasingly conservative discourse** and the **influence of religious fundamentalisms**. A Russian respondent's phrasing about the "clericalisation of state power and institutionalisation of misogyny" applies also to Poland. A Polish researcher and gender studies lecturer argued that the "popular understanding of SRHR is usually very limited and the influence of the Catholic Church on both the public discourse and decision makers is still enormous. In contemporary Poland IVF is discussed in terms of 'sophisticated abortion' and abortion in terms of a 'holocaust of the innocents'. Importantly, such discourse is propagated by **mainstream media**, so it is extremely difficult not only to change the law and practice, but to open up public debate". A Georgian researcher mentioned that knowledge on SRHR issues is very poor among Georgian media representatives. Also, a Russian interviewee complained about a lack of interest in addressing SRHR in the media.

Hungarian and Polish respondents pointed to a **lack of political will** to address gender equality issues, including women's reproductive needs, in the government and amongst decision makers at all levels. Russian respondents, on the other hand, had a different way of discussing the same issue, complaining about the misogyny and explicit efforts of Russian decision makers to restrict women's rights.

Two Georgians and one of the Ukrainian researchers mentioned the **transformation of the health system** and shifting responsibilities for provision of SRHR services as main factors challenging their efforts to promote SRHR. **Lack of funding opportunities** was mentioned by Polish and Georgian interviewees. Georgian and Armenian interviewees listed **gender stereotypes** and exclusion of men from SRHR-related programmes as the most pressing challenges. Polish and Ukrainian respondents, both of whom are peer sexuality educators, said that the main challenge is the belief that providing information about sexuality to adolescents will incite them to start sexual life. According to the Polish sex educator, "Sexuality is still a taboo in Poland and introducing the ideas of comprehensive sexuality education for young people and children can be challenging, especially since public life in Poland is heavily influenced by the Roman Catholic Church teaching and hierarchy".

Two Ukrainian interviewees, who both happen to work for National AIDS Center in Lviv, said that the **lack of information and knowledge about HIV transmission routes**, as well as **stigmatisation of people living with HIV/AIDS**, constitute the most difficult aspect of their work. One of Russian respondents mentioned the **lack of resources and advocacy know-how** as main challenges faced currently by her organisation. A similar point was raised by our Azebaijiani and Polish sources. An Armenian interviewee listed a **lack of SRHR awareness** in society as a serious challenge to her work.

3. *What is your take on the current situation with regards to SRHR? Have spaces for initiating policies and programmes on SRH, which respect women's rights, expanded or been constrained since Cairo? Give examples. What could be some of the reasons?*

Hungarian interviewees reflected on the recent negative changes introduced to the field of SRHR by the new government. They pointed to two main issues: the threat of restrictions in access to abortion, and restrictions imposed on midwifes assisting home births. A Polish interviewee said that, although it is rather difficult to expect positive changes in the area of SRHR in Poland in a very short time, there are some

positive signals that things at last may start improving. For example, in the last Parliamentarian election, a number of seats were won by a new political party – with a secular and modern approach to issues which are often treated as a taboo in Poland – and this is already making a difference in the public discourse. On the other hand, she underlined that in the case of women's right to abortion the situation has deteriorated – 17 years of criminalisation of abortion has strongly affected the recognition of a woman's right to chose, as well as doctors' attitudes towards pregnancy termination in Poland. "In Poland even left-wing parties are still too cautious when it comes to pushing for gender equality and SRHR, and these aspects are the first to go when there are negotiations," she said. Another Polish interviewee argued: "In my opinion, spaces for initiating policies and programmes on SRH have shrunk during the last decade. This is due to the conservative, neoliberal character of current global politics. Thus, programmes on SRH are often cut for supposedly economic reasons, and are discussed in terms of 'a luxury' the budget cannot afford." This is in line with the third Polish testimony, coming from a sex educator who said: "Looking from the Polish perspective, there are much fewer spaces to pursue progressive SRHR policies compared to a decade ago. The political scene has been dominated by right-wing forces for many years, and a similar tendency is clearly visible on the EU level, which is very worrying." A respondent from Georgia was more positive, pointing to the improvements in primary health provision system that were developed over the last two decades in Georgia. The Georgian Ministry of Health adopted 12 guidelines on family planning, but mechanisms for monitoring adherence to these protocols are still missing. An interviewee from Ukraine mentioned a number of positive developments that took place after 1994: the adoption of various bills including the Family code of Ukraine (2002); regulations concerning usage of reproductive technologies; three national programs of reproductive health; and the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (1997). However, she also said that a general low level of awareness regarding women's rights slows down the process of recognising these on an institutional level. According to one respondent in Ukraine, it is the high level of HIV/AIDS prevalence rather than Cairo Program of Action that facilitates advocacy for SRHR. Also, an Armenian interviewee stated that HIV/AIDS-related advocacy is a gateway to address some SRHR issues. Russian respondents stated that Cairo PoA has little influence on national policies regarding women in Russian Federation. They agreed that Russian women's situation has been subjected to a constant deterioration over the last decade and one said, "The policy of the Russian establishment for women's rights and resolving the demographic problem in the past 10 years has acquired the direction right opposite to Cairo agreement". Another mentioned, in addition to the recent restriction on access to abortion, that women's access to paid labour, women's representation in the decision making bodies and gender based violence (including reproductive violence) were main areas of deterioration in women's status in Russian Federation. Our interviewee from Azerbaijan pointed to the target date of 2015 as a possible chance to push the government to commit itself to improve women's situation. The National Strategy on the Reproductive Health 2008-2015 is being currently implemented in Azerbaijan. The Armenian researcher said that, although Armenia adopted ICPD PoA, nothing has been done to adjust binding legislation in order to meet its recommendations.

All respondents agreed that the Cairo conference provided advocates with tools to promote SRHR (Cairo Program for Action: RR&H definitions; language human rights approach to population issues) and in this sense spaces for SRHR expanded. However, the situation in the SRHR area strongly depends on the political situation in the country and at the international level.

4. How have political commitment and financial commitment for your work/ organization been in the last 20 years? What are the key challenges?

"We often could not complete our work, because of insufficient funding," complained Sudaba Shiralyeva, head of Azerbaijan-based organisation Women and the Modern World. Funding was also raised as a main challenge by Armenian, Ukrainian, Hungarian and Polish organisations. "Financial stability is also a problem, as most EU funds on gender equality are

allocated for programs related to the labour market," stated a Polish activist. It seems that approaches towards governmental funding vary greatly, even within one country. A representative of Hungarian Civil Liberties Union said that her organisation does not accept any state funding, in order to stay neutral; whereas, another association PATENT mentioned receiving 700 EUR annually from the state to support its activities. A Polish respondent said: "In terms of funds, the situation is more difficult nowadays. It was easier when Poland was not an EU member and was regarded more as a growing economy and developing state." Lack of state funding was mentioned by Central Asian interviewees from Armenia, Azerbaijian and Georgia. A respondent from Ukraine mentioned the negative impact the general financial crisis has had on funding for her organisation. The head of Russian Family Planning Association said that "family planning, sex education and other related topics have lost government financial support". Two other Russian representatives of grassroots feminist organisations said they have never received any funding from the state.

While discussing political commitment, interviewees from Russian Federation, Poland and Hungary underlined the fact that, although the political climate changes with elections and power shifts, there is a general tendency to restrict women's rights through the promotion of conservative, patriarchal discourse in their countries. One of the respondents said: "The key challenge in Poland is to stay active in the face of an unresponsive political sphere, a largely apathetic citizenry and media that are not interested in debating SR health and rights." A Georgian respondent expressed approval towards the stance of the current Georgian government and its body, the National Reproductive Health Council, designated in 2006 to promote SRHR. From Armenia, it was stated that SRHR activists are seldom given a chance to cooperate with government. Ukrainian interviewees praised their government's willingness to address SRHR (with the implementation of three national programme on reproductive health).

5. How do you think the SRHR agenda needs to be taken forward? What needs to be prioritised in terms of actions and issues?

Addressing this question, our interviewees agreed that non-governmental activists, politicians and academics should jointly and consequently lobby for comprehensive reproductive health and rights laws. "Regaining the secular, non-biased language on reproductive health issues like pregnancy and abortion should also become a priority," stated one Polish activist. A respondent from Ukraine said, "Addressing demographic problems, women should be universally empowered, not only with the aim of maintaining their health and well-being for motherhood." A Russian interviewee said: "I recently interviewed, (as a journalist, for an article I'm writing for an online magazine), several gynecologists and psychologists who work with women wishing to terminate their pregnancies. I was shocked to find out that every one of the specialists I talked to was adamant that embryos were actual babies that were being killed. Not one of them seemed to have the slightest idea that this was not an established fact, but rather just one point of view. So I'm sure that some educational work should be done with medics, probably with students in medicine." Enumerating priority areas for their organisations, Hungarian and Polish respondents also listed abortion, while a Georgian interviewee said that her organisation's priority is comprehensive sexuality education. The idea that sexuality education is a key issue that should be prioritised was seconded by Tatiana, a Ukrainian peer sex educator. Another Georgian responded claimed that it is essential to strengthen advocacy with key international donors, to prioritise problems based on a regional context, and to build a solid evidence base for advocacy. Strengthening collaboration with government and civil society institutions was recommended by an Armenian interviewee. Ukrainian respondents mentioned the country's high level of HIV/AIDS prevalence, and called for more programme addressing HIV/AIDS within the particular Ukrainian context (poverty, gender stereotypes, migration). An Armenian respondent's statement well summarises the general feeling of contributions we received: "It is really difficult to prioritise just one aspect of SRHR,

as they all are interconnected and depend on each other. Education and access to affordable health care services – contraception, perinatal care and abortion – are definitely among the most important. On a more general level, we need actions and programme that would strengthen women's agencies and the possibility to make informed choices. But in order to do so, it needs to be recognised that economic barriers are equally important as mental/cultural ones." Respondents agreed that SRHR are seldom prioritised by national governments or transnational bodies, such as EU or CoE. Thus, we heard that programme and projects concerning SRH often fall victim to austerity measures. Another important factor that was disussed is the revival of nationalist and patriarchal discourse. Moreover, the interviews reflected that SRHR initiatives and programme are seldom integrated into general plans of social and economic development. Respondents said this resulted in a situation where both decision makers and the general public are unaware how SRHR relate to the society's well-being.

6. Is there a real improvement in the women's and youth lives after ICPD?

Generally, respondents from Hungary, Poland and Russian Federation claimed there was no improvement in the women's and youth lives after ICPD in their countries. "I wouldn't say that any international documents had any influence on Russian politics at all," said one interviewee. Two young respondents from Poland were slightly more optimistic. Anka said: "Yes, I believe since ICPD – and because of it – the lives and health of women and youth have improved in many parts of the world. Issues such as the right to sexuality education have become part of the daily debate, which is very important. Also, many countries have made big steps towards ensuring that women have the right to safe and legal abortion as needed." Ela stated: "There are improvements in some areas, but mostly on a local level. In more general terms, what we have is a new language, new discourse we can use, which is very important. But, so far, I don't see long terms practical effects." A Georgian responded claimed that ICPD influenced many state policies and led to various improvements in the field of SRHR in her country. She quoted a growing contraception prevalence and a decline in infant mortality rate as changes in SRHR indicators that were inspired by the ICPD PoA. She said: "Between 1999 and 2010, condom use among couples increased 2.5 times (from 6% to 14%) and IUD use increased from 10% to 13%, becoming the first and second most used methods, respectively. Infant mortality declined from a rate of 41.6 per 1000 live births in the period of 1995 to1999, to 21.1 per 1000 live births in the period of 2000 to 2005. Declining again to 14.1 in the period of 2005 to 2009, the child-under-five mortality rate dropped nearly 64% during these years." Another respondent from Georgia pointed to deterioration of women's status on labour market and their absence from decision making, to argue that ICPD did not bring any positive change in women's lives. Ukrainian respondents saw a positive influence from Cairo's conference on the life of Ukrainian women. Tatiana said: "Even though financial crisis and other difficulties do not allow for all goals to be reached and all tasks implemented that were mentioned in the PoA, but there are still a lot of positive changes regarding improvement on SRHR issues in the country."

A common feature of answers to this question was that respondents underlined the deterioration of women's status as a consequence of political transformation in the 1990s and the current financial crisis, rather than providing positive outcomes of Cairo PoA's recommendations.

7. Who are the different players in the region?

The respondents listed politicians, Catholic Church, Orthodox Church and other religious forces, governments, local leaders, EU, CoE, women's organisations, donors, international organisations, health services providers, media, pharmaceutical companies, and LGBT organisations as main players in the region. Respondents mentioned only a few names of organisations that they consider important players in the region: Center for Reproductive Rights, ASTRA Network, and USAID.

8. What are the factors that affect SRHR?

Respondents list the following factors: so called "religious values" and religious institutions; inadequate laws (on abortion, IVF, accessibility and

availability of contraceptives, sterilisation, etc.); gender stereotypes and prejudices; poverty and lack of resources; lack of sexual education and human rights education; lack of youth-friendly RH services; lack of political will; violence against women; lack of gender awareness; and lack of recognition of sexual and reproductive rights. One of the respondents noted: "The economic situation is the main factor here. In times of crisis, SRHR becomes a side issue for many, and this impacts our projects a lot." This was seconded by a Hungarian respondent who said: "The financial crisis is affecting state budgets as well, including expenditures for contraceptives and other SRHR related issues." A Georgian respondent added conflicts and their consequences as factors that affect SRHR. An Armenian interviewee pointed to gender inequality and stereotypical gender roles.

9. How can we facilitate access to SRH services?

Respondents agreed that we need a renewed global commitment to SRH services and a way to monitor its implementation, (as well as education on what SRH services are in the first place). All interwiewees made a point of stressing the fact that services should be accessible and affordable. Moreover, they mentioned alliances with decision makers in order to create new policies taking into account specific needs of women depending on their status and location. Finally, increasing evidence-based resources for advocacy and knowledge dissemination, (including via mass media), was mentioned as conditions sine qua non for promoting SRH services in societies were SRHR awareness is scarce.

HEALTH AND DEMOGRAPHY IN CEE

The CEE region has experienced dramatic changes in its demographic and health indicators, which compare unfavourably with the indicators in Western Europe.

In the post-war period, the Soviet system made considerable progress in establishing universal health and education systems, implementing universal immunisation programme and eradicating cholera, malaria, and typhoid based on scaling up basic interventions.[2] As a result, into the late 1960s, many former Soviet republics were achieving increasingly good health outcomes given their level of economic development. However, these healthcare and health promotion systems were less effective when undertaking more complex programme required to respond to the changing disease patterns and risk factors associated with aging, urbanisation and industrialisation (smoking, alcoholism), and noncommunicable diseases. Consequently, since the 1960s, life expectancy in most countries of the CEE did not improve in line with rises achieved in the West.[3] This epidemiological departure was driven largely by rising death rates from heart disease, injuries, and violence. The persistence of the previous system's deficiencies was exacerbated by complex transition processes, which resulted in worsening mortality and morbidity outcomes. Life expectancy at birth is below that in Western Europe. At the beginning of the transition period, all of the surveyed countries had life expectancies between 69 and 73.5, which is considerably less than in the EU. The CEE countries experienced a slow but steady improvement in life expectancy throughout the entire decade, cumulating in a one year increase. Russia and the Caucasian countries all experienced a sharp decline in life expectancy between 1990 and 1994: it decreased by six years in Russia, and two in the Caucasus. It then began to rise again in these countries, reaching pre-transition levels in the Caucasus by 1998, and gaining back three years of the decline in Russia. From 1998 to 2001, life expectancy remained stable in the Caucasus but began to decline again in Russia, relinquishing almost the entire gain of the mid-1990s. Furthermore, gender differences in life expectancy are generally large in these countries, particularly in Russia, where the gender differential is more than 12 years.[4] Moreover, the region is one of only two in the world where life expectancy is currently declining, with the other being sub-Saharan Africa.[5]

The last 20 years was a period of economic reforms, combined with armed conflicts and political revolutions. This transition period coincided with radical political and economic liberalisation, accompanied by the expansion of market forces and building of new political relationships with the United States, the European Union (EU) and its member states, China, and Iran. Some of the changes that took place reflected a popular desire to move away from the legacy of the past, while in other cases external forces played a major role. In some countries, rejection of communist ideology was combined with a strengthening of nationalistic sentiment, the former being identified with Russian dominance. However, change was more often unplanned, brought about by the economic collapse arising from the disruption of traditional production and trading relationships. In some places, this was exacerbated by civil disorder. The social consequences of the break-up of the Soviet Union were significant. In many cases, the collapse of whole industries that were no longer competitive in the global economy, and the disruption of long-standing trading links led to widespread poverty, unemployment, macro-economic instability and a decline of the population's economic and social resources. In many countries, the gross national product (GNP) declined by 50%. In some areas, the collapse was particularly rapid, notably in social security protection and other public services. Migration, erosion of social networks and values, armed conflict, and a rise in high-risk behaviour such as selling sex, alcoholism, and drug use contributed to social disruption and compounded economic insecurity. International development assistance for health in the region remains low in relation to health and economic needs[6].

WOMEN'S EMPOWERMENT[7] AND SRHR

The relation between women's empowerment and their access to SRHR is complex. The more empowered women are, the better able they are to claim their reproductive and sexual rights. At the same time, having access to SRHR empowers women and strengthens their position in the society.

In order to assess women's empowerment in the CEE region, we will look at governments' signed commitments to international human rights instruments and conferences' final conclusions, national machinery which facilitates women's empowerment, national legislations about eliminating violence, women's empowerment as measured by the Gender-related Development Index (GDI), Gender Empowerment Measure (GEM), Gender Inequality Index, Inequality-adjusted Human Development Index, enrolment of girls and women in primary, secondary and tertiary education; as well as women's participation in the labour force and politics. Then, we will look at health financing and the responsibility and accountability of the state with regards to resources allocated to health. We review health expenditure, the share of government and private sector expenditure and the share of out-of-pocket expenditure on health in these countries, with the aim of establishing financing trends in the region and their effect on the sexual and reproductive health of women.

The democratic transition that followed the collapse of the Soviet Union, regional armed conflicts and growth of conservative forces will be analysed as a background to reflect on how political changes influence situation of women in the region. The second section of the chapter will analyse the health systems in the region and impact that health system reforms had on women's access to SRHR services.

Endorsed by 179 countries, the ICPD PoA puts women's empowerment and autonomy at the centre of development, and shifts the population paradigm from quantitative, demographically driven goals to women's reproductive health and rights.

In this chapter we provide an overarching view of women's empowerment in the seven countries and of health financing, since these are two critical factors which will facilitate or hinder the implementation of the ICPD PoA. These two vital aspects have an impact on the way women make decisions and exercise choice, as well as how they execute those decisions and choices, especially with regards to their sexual and reproductive health.

SIGNATORIES TO INTERNATIONAL HUMAN RIGHTS INSTRUMENTS AND CONFERENCES

Signing international conventions and endorsing international conferences' final documents works in two important ways.

Firstly, it enables NGOs to hold their governments accountable to international standards on human rights, especially the rights of those who are marginalised. Secondly, it makes governments accountable to their constituencies. These human rights instruments have been important and useful in promoting women's sexual and reproductive health and rights.[8] On the other hand, the lack of political will on behalf of governments to implement international agreements is a serious obstacle to the promotion of women's human rights all over the region. An excellent illustration of this is the problematic issue of national machinery facilitating women's empowerment.

The main rights elaborated and protected by the human rights instruments and international conferences' outcome documents are: the right of individuals and couples to enjoy and control sexual and reproductive life; the right to choose whether or not to marry, plus whether and when to have children; the right to found and plan a family; the right to health care and health protection; the right to access sexual and reproductive information, health and care, free from discrimination; the right to privacy; the right to the benefits of scientific progress; and the right to be free from all forms of violence, ill treatment, torture and death. Moreover, these internationally recognised instruments enable governments, NGOs and international organisations to derive specific reproductive rights, sexual rights and health rights. All seven countries participating in the research are signatories to major human rights instruments such as the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and the Convention on the Rights of the Child. With regards to CEDAW, the seven countries do not have any reservations, which means that they embrace Article 12 of CEDAW addressing access to health services. Hungary, Poland, Russian Federation, and Ukraine originally had reservations on Article 29 (1), but they all subsequently lifted those reservations. All surveyed countries also participated in and endorsed the ICPD PoA, the Beijing Platform for Action, and the Millennium Development Goals.

International human rights instruments are useful in cases pertaining to discrimination in SRHR services. Since domestic legislation often fails to take into account cumulative discrimination, an international body such as the CEDAW Committee can be the only remedy. This was the case for the Hungarians who brought their cases of non-consensual sterilisation[9] and domestic violence[10] to the Committee on the Elimination of All Forms of Discrimination against Women in order to hold their governments accountable for not protecting them from discrimination.

For member states of the Council of Europe, the European Convention on Human Rights (ECHR) is another important measure for the protection of human rights. The Convention protects: the right to life; the right to a fair hearing in civil and criminal matters; the right to respect for private and family life; freedom of expression; freedom of thought, conscience and religion; the right to an effective remedy; the right to the peaceful enjoyment of possessions; and the right to vote and to stand for election. The Convention was ratified by all of the surveyed countries. The European Court of Human Rights (ECtHR) was established to ensure that states respect the rights and guarantees set out in the Convention. The Court is currently the most commonly used human rights instrument in the CEE region. The Court's judgments are binding and the countries concerned are under obligation to comply with them.[11] So far there have been several ECtHR's judgments regarding access to SRHR in the region. The ECtHR's ruling from 2007 concerned a severely visually impaired Polish woman who was denied lawful abortion in Poland (Tysiąc v. Poland). Although her pregnancy and delivery posed a serious health risk, she was

Table 1: Status Of Major International Human Rights Instruments

Governments who participated in and endorsed International Conferences & Reservations on the ICPD Programme of Action

Name of the Country	International Conference on Population and Development (ICPD 1994)*	Beijing Platform for Action (1995)**	Millennium Development Goals (2000)***	International Covenant on Economic, Cultural and Social Rights (1966)	International Covenant on Civil and Political Rights (1966)	Convention on All Forms of Discrimination Against Women (1979)	Convention on the Rights of the Child (1989)
Armenia	1994	1995	2000	1993	1993	1993	1993
Azerbaijan	1994	1995	2000	1992	1992	1995	1992
Georgia	1994	1995	2000	1994	1994	1994	1994
Hungary	1994	1995	2000	1974 (1969 signed, 1974 ratified)	1974	1980	1991
Poland	1994	1995	2000	1977	1977	1980	1991
Russian Federation	1994	1995	2000	1973	1973	1981	1990
Ukraine	1994	1995	2000	1973	1973	1981	1991

Sources: ICPD Programme of Action (POA)*; Report of the Fourth World Conference on Women, Beijing, 4-15 September 1995**; MDG Monitor: Tracking the Millennium Development Goals. Available online at: http://www.mdgmonitor.org *** For ICESCR, ICCPR, CEDAW, CRC: http://hdr.undp.org/en/media/HDR_20072008_EN_Complete.pdf

repeatedly refused a certificate to enable the pregnancy to be terminated. After finally obtaining a certificate authorising the abortion, she turned to a public hospital only to have her request refused again. At this point, the woman had no choice but to carry her pregnancy to term. After the delivery, her eyesight badly deteriorated due to hemorrhages in her retina, and she currently faces a serious risk of blindness. The Court found that Ms. Tysiąc had been denied access to an effective mechanism capable of determining whether the conditions for obtaining a legal abortion had been met, in violation of her rights to respect for one's private and family life.[12]

Another important victory for SRHR advocates was the ECtHR's ruling against Poland in the case of a woman who was deliberately refused genetic tests during her pregnancy by doctors who opposed abortion (R.R. v. Poland). The woman and the doctors suspected a severe genetic abnormality in the fetus, but the doctors withheld the tests until the legal time limit for abortion had expired. The woman saw numerous doctors and went to several hospitals. Only when it was too late for an abortion was her suspicion confirmed that the foetus she was carrying had a genetic abnormality. The baby was subsequently born with Turner syndrome. The ECtHR ruled there was a violation of the article banning inhuman or degrading treatment and article on respecting one's private and family life.[13]

NATIONAL MACHINERY FACILITATING WOMEN'S EMPOWERMENT

UN conventions and conferences have promoted and facilitated the establishment of national plans, programmes and institutional machinery to plan and advocate for gender equality and monitor progress on the advancement of women.

Various mechanisms for advancement of women were created throughout the CEE region and action plans for strengthening women's position in society were implemented in the 1990s after Cairo and Beijing conferences. However, although governments in all seven countries attempted to promote gender equality and eliminate discrimination against women through policy and programming, the states failed to establish sustainable framework for promoting women's rights.

The countries managed to establish following institutions and specific developments plans for women:

- Armenia – Department of Women's, Family and Children's Issues within the Ministry of Labour and Social Issues was established in 2002;[14] National Programme to Improve the Status of Women and to Enhance Their Role in Society in the Republic of Armenia for 2004-2010; the 2011-2015 Strategic Action Plan to Combat Gender-Based Violence.[15]

- Azerbaijan – State Committee on Women's Issues was established in 1998; National Plan of Action on Women's Issues 2000-2005; National Plan of Action on Family and Women's Issues for 2007-2010; National Action Plan on Family and Women's Issues for 2008-2012, Second National Action Plan on human trafficking 2009-2013; Strategy on Reproductive Health in Azerbaijan of the Ministry of Health 2012.[16]

- Georgia – Governmental Commission on gender equality at the State Minister's office was established in 2004; National Action Plan aimed at advancing women's status was designed for 1998-2000; Action Plan to Combat Violence against Women (2000-2004), Action Plan to Combat Trafficking in Persons (2003-2005).[17]

- Hungary – Equal Treatment Authority[18] was established in 2005 but it has no special focus on women's issues; Department of Gender Equality under the Main Department of Equal Opportunities was functioning during the previous government as a national machinery; Main Department of Equal Opportunities remained after elections in 2010 but without any specialised unit of women's issues and The Secretariat for Social Equality Between Women and Men has not been dismissed formally, but nor has it been convened; National Strategy for the Advancement of Gender Equality (2010-2012) adopted by the previous government.

- Poland – Government Plenipotentiary for Equal Treatment replaced the earlier Government Plenipotentiary for Equal Status of Women and Men, which replaced the Department for Women, Family and Counteracting Discrimination at the Ministry of Labour and Social Policy, established in 1995; national Action Plans for Women were implemented in Poland till 2005.[19]

- Russian Federation – Intersectoral Commission for the Promotion of Equality between men and women (established in 2006) handles a wide range of gender issues at the state level; national and regional mechanisms for monitoring the status of women established after the Beijing Conference in 1995, but ceased to exist after the reform of the Federal government (2004); National Action Plan for the advancement of women and enhancing their role in society (2001-2005) ended in 2005.[20]

- Ukraine – Currently no institution at central executive authority level responsible for family and gender policy development, after recent reorganisation of the Ministry of Family, Youth and Sport, which specialised in gender policies, trafficking and domestic violence issues; legal documents adopted since 1994: "About warning violence in family" (2001), "On Ensuring Equal Rights and Opportunities for Women and Men" (2005), "On Improvement of central and local authorities to ensure equal rights of women and men" (2005), "On preparation and holding of the Year of Gender Equality" (2007), "On the advisory bodies of the family, gender, demographic development and combating trafficking in human beings" (2007), "National plan of actions on the improvement of position of women and assistance to introduction of gender equality in society" (2001-2005), "State family support programme 2007-2010", "State program for the promotion of gender equality in Ukrainian society until 2010";[21] Supreme Council of Ukraine ratified the European Social Charter (revised) in 2006.

The Georgian Governmental Commission on gender equality at the State Minister's office was created in 2004 and is headed by the State Minister on European Integration.[22] Combining machinery for advancing women's rights with European integration is a trend that was also observed in Hungary and Poland, before their accession to the EU. Once these states complied with the EU's requirements for candidate countries regarding women's rights, activities aimed at further improvement of women's status ceased. Comparing Hungarian and Polish indicators of women's empowerment (participation in the labour market and in decision making processes) with old member states proves that the new members lag behind. Nevertheless, the EU has observed a shift from promoting women's empowerment to fighting discrimination on multiple grounds, and there are no incentives for new member countries to catch up and improve women's status.[23]

In Poland and Hungary, the few positive legislative steps taken are mostly the result of legal harmonisation obligations regarding European Union directives related to gender equality. However, even in these cases, the real aim and spirit of these directives are not followed and legislators tend to conduct formal, technical harmonisation. It is often argued that general gender-neutral measures are sufficient to deal with gender issues, as well and provide appropriate protection for women.

Overall, in spite of some developments regarding legislation and implementation of measures in specific fields, such as raising awareness on gender in education, or in fighting domestic violence, the region displays a clear lack of a consistent gender policy. Sporadic and superficial initiatives and measures do not lead to any fundamental change, and the lack of commitment is often visible in the very limited financial resources women's rights field receive. Fields outside the realm of the world of work, such as health, violence (from sexual harassment through domestic violence to prostitution and trafficking in women), gender stereotypes, reproductive rights and others, are either not addressed at all, or are addressed in an ad hoc manner not guided by a comprehensive policy on the advancement of women's human rights.

LACK OF RECOGNITION OF WOMEN'S HUMAN RIGHTS

The status of women in CEE is strongly influenced by cultural, historical and socio-economic factors.

On the level of society, it is important to mention the phenomenon of so called "male democracy"[24] that can well serve as a common denominator to describe troubled relationship between the state and women, or more accurately, between the state and the female body in CEE.

"Political authority is, in part, reconstituted through arguments about reproduction".[25] All surveyed countries experienced severe backlash against women's rights that are identified with the past, communist regime.[26] This, combined with a growing political conservatism and growing religious fundamentalism (that has been reported as a growing problem by informants from all the surveyed countries except Armenia), leads to various attempts to restrict existing laws regulating women's access to SRHR. The situation is especially alarming in case of Azerbaijan where strict gender and social norms focused on heterosexual-centered and extended family prevail. The family decision-making is focused on the elders of the family who make decisions for all other family members and keep the traditions. There is a high degree of segregation between male and female activities, as well as between the social spaces where they gather. Women are expected to function primarily within a family and single women are perceived by society as a failure once they have passed the marriageable age (21-23 years). The concept of 'family honour' prevails in Azeri families, limiting women's mobility, placing them in a vulnerable situation if they have sex before marriage or decide to live independently. Families limit their daughters' access to education to protect the 'family honour' by not allowing them to attend universities in other cities. Women who travel abroad alone or study abroad may lose the opportunity to get married because it is assumed they had sex outside of marriage when they were away from family control. Statistics show that early, informal marriages are increasing every year in Azerbaijan.[27] Restrictive stereotypes regarding gender roles persist in all countries of the region and continue to limit women's participation in society.[28] Poverty and cultural attitudes also contribute to discrimination against women in CEE. The low status of women is often reflected in the phenomenon of son preference.

SON PREFERENCE

The issue of son preference and selective abortion is underreported in the CEE region. In the Gender Gap Index 2011,[29] Armenia ranked 134 out of 135, with a female to male ratio of 0.89. Two of Armenia's immediate neighbours were not far ahead. Georgia ranked 129, followed by Azerbaijan at 130, both with a female to male ratio of 0.90.[30] According to the "Prenatal sex selection" resolution[31] adopted by the Parliamentary Assembly of the Council of Europe (PACE) in October 2011, the disproportion in sex selection is "alarming" in Armenia, Azerbaijan, Georgia and Albania. Research initiated by the United Nations Population Fund (UNFPA) and conducted in 2011 across Armenia among 2,800 women who have ever had pregnancies suggests that 7,200 women (or 0.8% of all women of reproductive age, of whom there are an estimated 900,000 in Armenia) have resorted to sex-selective abortions in the past five years.[32] The report "Prevalence and Reasons of Sex Selective Abortions in Armenia" suggests that this seemingly small percentage of women who have abortions based on the sex of the foetus accounts for some 1,400 abortions every year. This is almost one in ten abortions made in Armenia

(according to the national statistics there are around 10,000 abortions annually). According to the new study, Armenians are six times as likely to prefer baby boys than girls – something that perhaps accounts for many abortions when future parents learn that foetus is female.[33] Widespread preference for sons is an apparent, as well as worrisome, indicator of gender inequality in Armenia, Azerbaijan and Georgia.

FUNDAMENTALISM

After the fall of communism, religious leaders have gained growing influence on political life in the region. The region is dealing with the growing influence of religious leaders (Catholic Church, Orthodox Church, Islam) and their attempts to influence the State's say about women's rights, with special emphasis on women's access to sexual and reproductive rights and health. The problem is especially acute in Poland and Russia. In Poland, where the Catholic Church sets the tone for all kinds of debates regarding reproductive health, the church successfully lobbied for delegalisation of abortion in the 1990s. Currently, Catholic leaders are the driving force behind anti-choice rallies and the bullying of the few clinics that perform abortions. Moreover, the church actively participates in the debate on in vitro fertilisation and lobbies for criminalisation of this procedure.[34] Also in Russia, the church campaigns extensively against advances in reproductive health and rights.[35] The Russian Orthodox Church promises financial support for women who resign from their idea of having an abortion.[36]

VIOLENCE AGAINST WOMEN

Physical, sexual, psychological, and verbal violence are reminders of the actual status of women. Violence against women is a big problem in CEE. The national legislation eliminating violence against women and related issues are discussed in Chapter 4.

MEASUREMENTS OF WOMEN'S EMPOWERMENT[37]

The sixth annual World Economic Forum's (WEF) "Global Gender Gap Report 2011"[38] shows improvement in gender equality in 85% of countries worldwide. Of the 135 countries taking part, the CEE region scored poorly. The highest positions were scored by Poland and Russian Federation, placing 42nd and 43rd respectively. Ukraine scored 64th, whereas Armenia, Hungary and Georgia placed 84th to 86th respectively. Azerbaijan, with the 91st position, had the poorest score of the region. The report highlights national gender gaps in economic, political, educational, and health opportunities, and ranks countries accordingly as a comparative tool. In doing so, it aims to raise awareness about the challenges created by gender gaps, and the benefits in reducing them. The report measures the gender-based gaps in access to resources, irrespective of the development level of countries and the resources available.

GENDER DIMENSIONS OF DEVELOPMENT

In order to look at gender dimensions of development, the Human Development Index (HDI) has been gender-adjusted to show the Gender Development Index (GDI).[39]

Table 2 shows the progress regarding HDI for the seven countries. When GDI was first calculated in 1991, the CEE region ranked high internationally in gender equality. Key factors contributing to the communist gender-equality legacy were women's high educational levels, state support for childcare and working mothers, and women's high level of participation in the labour force. After 1995, GDI rankings dropped, while HDI started to rise with economic recovery, and in those countries which developed fastest towards free-market capitalism (such as Hungary and Poland), HDI and GDI rankings converged.

The present economic crises put at risk many of the achievements attained during the past few years, and increase the level and the number of challenges identified in the economy. Moreover, there is a general lack of gender-sensitivity in government responses to the crises. While the surveyed countries are grouped among the countries with high human development, their HDI rankings are lower than those of the EU countries. The lower HDI scores reflect a relatively lower life expectancy (especially in Russia and Ukraine) and increasing poverty, although officially reported adult literacy and educational attainment have remained high. Indeed, countries with economies in transition comprise a whole new category of nations in that their literacy levels, technological advances and cultural and religious characteristics more closely mirror those of the industrialised world than those of the developing countries in the southern hemisphere.

Among the seven countries surveyed, their GDI rankings are (in descending order): Hungary (0.805), Poland (0.795), Russian Federation (0.719), Azerbaijan (0.713), Ukraine (0.710), Georgia (0.698), Armenia (0.695).

A measure of gender inequality can be derived by using the ratio of the two indicators – GDI/HDI. If the ratio equals 1, then there is no gender disparity; if it is >1, there is

female advantage; if it is <1, there is gender disparity. The lower the value of the fraction, the greater the gender disparity[40]. Comparing GDI/HDI ratios, using the 2010 data as shown in Table 2, it looks as if none of the countries in the region show gender disparity. However, the GDI, does not capture or include rights as an area of measurement. For example, the GDI is not an accurate reflection of girls' rights to education or women's rights to work or in work.

GENDER EMPOWERMENT MEASURE

The Gender Empowerment Measure (GEM) measures gender equity in terms of opportunity, whereas GDI measures gender equity in terms of capabilities.[41] GEM is based on women's representation in parliaments, women's share of positions classified as managerial and professional, women's participation in the active labour force and their share of the national income. The GEM value for the surveyed countries varies from 0,385 for Azerbaijan to 0,614 for Poland.[42] It is also important to examine in detail the indicators on gender equality in education, participation in the labour force and politics.

Table 2: Comparison of HDI and GDI ,GDI/HDI ratio and GEM values and ranks

Country	HDI value and rank (2010)	GDI value and rank (2010)	GDI/ HDI (2010)	GEM value and rank (2007)
Armenia	0.695 76	0.695 76	1	N/A
Azerbaijan	0.713 67	0.713 67	1	N/A
Georgia	0.698 74	0.698 74	1	0.414 79
Hungary	0.805 36	0.805 36	1	0.569 50
Poland	0.795 41	0.795 41	1	0.614 39
Russian Federation	0.719 65	0.719 65	1	0.489 71
Ukraine	0.710 69	0.710 69	1	0.462 75

Sources: Human Development Report 2007-2008; Human Development Report 2010.

EDUCATION OF WOMEN AND GIRLS

Education and gender differentials in education are counted into the overall numbers of HDI and GDI.

Girls and women have equal chances for entering all level of education in all of the surveyed countries of the CEE. The most problematic situation persists in some parts of Russian Federation and Azerbaijan where early marriage and bias against girls acquiring education may obstruct girls' access to education.[43] Otherwise, girls tend to enrol in all levels of education on a equal footing with male peers and are, in general, better

educated even if facing a lack of employment after finishing school (Armenia, Poland, Ukraine, Russian Federation). Stereotypes regarding traditional gender roles are reflected in low enrolment of women in tertiary education, especially in Azerbaijan and Armenia. However, drop-out rates are high, particularly in tertiary education, all over the region.

Table 3: Girls' share of primary, secondary and tertiary enrolment (2005)

Country	Gross primary enrolment, female ratio (%)	Gross secondary enrolment, female ratio (%)	Gross tertiary enrolment, female ratio (%)
Armenia	96	89	31
Azerbaijan	95	81	14
Georgia	94	83	47
Hungary	97	96	78
Poland	98	99	74
Russian Federation	128	91	82
Ukraine	107	85	75

Sources: Human Development Report 2007/2008; Fighting Climate Change: Human Solidarity in a Divided World.

LABOUR FORCE PARTICIPATION

The early integration of women into the labour force was a feature of communist development. However, despite the well-established limitations to advances for women during the command-economy era, capitalist development has brought deterioration[44]. Currently, Hungary and Poland have the lowest labour force participation rate, while the highest rates are observed in Armenia and Azerbaijan.

Table 4: Labour Force Participation Rate (2009) – Female/ Male (%)

Labour Force Participation Rate (%)		
Name of Country	Female	Male
Armenia	59.6	74.6
Azerbaijan	59.5	66.8
Georgia	55.1	73.8
Hungary	42.5	58.8
Poland	46.2	61.9
Russian Federation	57.5	69.2
Ukraine	52.0	65.4

Source: Human Development Report 2011.[45]

The gender pay gap tends to be relatively high in CEE countries, with the average wage for females being only about 50-60% of the average wage for males.[46] In all countries in the CEE region, there are important variations by sector (where the gap tends to be higher in the private sector than in the public sector), by occupation and educational level (where the gap is generally larger with regards to higher education). Other explanations for the gender pay gap include women's greater role in part-time employment, general undervaluing of women's work, and direct discrimination. The economic value of unpaid work remains widely unrecognised. In all countries, the economic activity rate of women is lower than that of men. Many women continue to work in the informal economy, including in home-based market-oriented production of goods and services, and subsistence food production. Unemployment remains generally higher for women than for men. In places where female unemployment is lower than men's (Russian Federation, Ukraine), this reflects the possibility that women are more likely than men to accept jobs below their qualifications or to retire early from the labour market. Part-time employment has a female face throughout the region.

POLITICAL PARTICIPATION OF WOMEN

Although the positive inheritance after the Soviet Union is a high rate of women's participation in the labour market and a high rate of women's enrolment in higher education, the region has poor representation of women in national parliaments.

Russia (11.5%) lags behind all developed nations with regards to the number of women occupying parliamentary seats. The situation is similar in Ukraine, where 8.2% representation of women in parliament gives Ukraine 149th place in a ranking of 175 countries. The situation is almost as bad in Poland (20%) and Hungary (11.1%). Azerbaijan, the first Muslim democratic republic to give women equal political rights with men (1918-1920), now has 11.4% female representation in parliament. A lack of political will on behalf of politicians and prevailing stereotypes regarding traditional gender roles are the most important structural and social barriers faced by women who want to enter politics in the region.

Table 5: Percentage of parliamentary seats occupied by women

Seats in Parliament Held by Women (%of total)	
Name of Country	**2011**
Armenia	9.2
Azerbaijan	16.0
Georgia	6.5
Hungary	9.1
Poland	17.9
Russian Federation	11.5
Ukraine	8.0

Source: Human Development Report 2011 http://hdr.undp.org/en/media/HDR_2011_EN_Tables.pdf

WOMEN'S RIGHTS ORGANISATIONS

Since the ICPD PoA, several NGO coalitions have been created in the field of sexual and reproductive health and rights (SRHR) and are successfully working at regional level, one example being the Central and Eastern European Women's Network for Reproductive and Sexual Health and Rights (ASTRA). This network of NGOs supports women's rights to free and informed choice on and access to abortion, modern contraceptives, information, education programs, and SRHR services. ASTRA provides regular updates to the public and to providers via monthly e-bulletins with respect to the latest developments in SRHR at international, national, and regional levels. In 2008, representatives of organisations and institutions from 11 countries in Eastern Europe and Central Asia (former Soviet Union Republics), with the support of the International Consortium for Medical Abortion (ICMA), established the European Alliance for Reproductive Choice. The aim of the Alliance is to protect the reproductive rights of women by improving their access to comprehensive abortion services, by analysing the situation of abortion in Eastern Europe and Central Asia, by developing information and educational programmes, and by organising advocacy campaigns about medical abortion in member countries. Given the lack of political commitment on behalf of governments and donors moving away from the CEE region, the situation of women's rights organisations is becoming more and more difficult.

OVERVIEW

As it was mentioned earlier, all of the countries participating in the survey have adopted and implemented a number of policies and programmes aimed at incorporating international treaties and conventions into national legal systems, but very often not enough was done towards adjusting the binding legislation to requirements of international treaties.

For example, although Armenia, Azerbaijan, Georgia, Hungary, Poland, Russia and Ukraine acceded to CEDAW without reservations, CEDAW is not really incorporated to the domestic laws and does not have precedence over conflicting national regulations. Our informants reported that there is a general lack of clarity regarding the direct applicability of the Convention. ICPD PoA has had significant and beneficial implication for CEE countries, particularly in terms of quantitative goals for significantly reducing maternal mortality, but has not been used as a comprehensive framework for building a sustainable architecture to protect and promote women's rights. In several places, the female economic activity rate has declined, and in all CEE countries there is a huge gender gap in the economic activity rate. Decision-making and political power is firmly held by men and not one of the seven countries is even close to reaching the 30% quota of women's political participation. Even states presenting some determination to combat women's issues, face various challenges in implementing action plans. Difficulties in achieving plan goals can be attributed to the absence of monitoring mechanisms to enforce implementation and progress; a lack of government accountability; weak cooperation between the government and civil society; and the lack of public awareness and grassroots mobilisation.

HISTORICAL BACKDROP

Health financing has a pivotal role for SRHR status as it affects the way women access SRH services and aids in the progressive realization of rights.

Before the collapse of communism, countries under the influence of the Soviet Union shared a similar model for their health system.[47] The system sought to provide universal access through an extensive network of facilities. The healthcare systems were publicly financed, through general taxation, with the state owning the facilities and providing all health services. Access to care was free at the point of use. The formal private sector was nonexistent. The system was labour-intensive, largely because it was possible to keep the wages of health professionals in the health sector low when the state was the monopoly employer. Moreover, the Soviet-style health system placed emphasis on curative rather than preventive services, allocated funding according to the number of hospital beds, relied on too many hospitals and hospital-based, specialised physicians, and did not maintain adequate primary health care services.

With the end of the centralised Soviet administration and post-communist economic decline, the costly hospital-based curative system became impossible to maintain. Most hospitals lacked minimal equipment, drugs, and supplies, and could not afford maintenance costs. Extensive health care sector reforms started all over the region as early as in mid 1990s. After 1991, in many places the system collapsed in the face of serious financial shortages, triggering a huge increase in out-of-pocket payments, and reducing coverage of essential interventions.

THE DIRECTION OF REFORMS

All the countries (except Ukraine[48]) followed a similar pattern with regards to reforms in their health system:

(1) The first radical health financing reform was a move from tax-based to social insurance systems, seeking to cover the whole population with a comprehensive package of services. The compulsory social insurance model (based on the Bismarckian sickness funds system) formally upheld the principle of universal access to care, while seeking to mobilise resources given the narrow tax base, to safeguard healthcare funding flows, and promote strategic purchasing. However, its most explicit objectives were to improve transparency and accountability of health sector[48] financing, and to reduce its dependence on short-term political priorities. The shift from central government budgets to compulsory health insurance has involved varying degrees of competition and state subsidy, as well as expansion of out-of-pocket payments[49]. In most countries, there was a separation of purchasing and provision, often with health insurance funds acting as third-party insurers contracting care; (2) Changes to the delivery of primary care across the region include development of general practice (family medicine) to replace the former polyclinic-based model; (3) Management training for administrators remains limited and systems of resource allocation and reporting inherited from the soviet model are still in place, with important implications for the sustainability of reform models and the introduction of incentives to engineer change; (4) Efforts to create a private sector or liberalise existing provision have largely been limited to the pharmaceutical sector and out-

patient care in urban settings, where the ability to pay is greater; (5) Most countries have sought to decentralise their healthcare systems; (6) Professional organisations of physicians have been re-established and have begun to play a role in training, licensing, and quality control as well as becoming partners in health sector reform by setting clinical guidelines and advising on contracts of packages of care.[50]

CURRENT SITUATION

Table 6: Consolidated National Health Accounts for CEE Countries

Consolidated National Health Accounts for CEE Countries		
Name of Country	2005	2010
ARMENIA		
Total expenditure on health as % of Gross domestic product	4.9	4.4
General government expenditure on health as % of total expenditure*	30.4	40.6
Per capita total expenditure on health (PPP international $)**	199	239
General government expenditure on health as % of total government expenditure	6.8	6.4
Private expenditure on health as % of total expenditure on health*	69.6	59.4
Out-of-Pocket expenditure as % of private expenditure on health	95.7	92.9
AZERBAIJAN		
Total expenditure on health as % of Gross domestic product	7.8	5.9
General government expenditure on health as % of total expenditure*	11.3	20.3
Per capita total expenditure on health (PPP international $)**	343	579
General government expenditure on health as % of total government expenditure	5.2	4.2
Private expenditure on health as % of total expenditure on health*	88.7	79.7
Out-of-Pocket expenditure as % of private expenditure on health	93.6	87.2
GEORGIA		
Total expenditure on health as % of Gross domestic product	8.6	10.1
General government expenditure on health as % of total expenditure*	19.2	23.6
Per capita total expenditure on health (PPP international $)**	302	522
General government expenditure on health as % of total government expenditure	6.2	6.9
Private expenditure on health as % of total expenditure on health*	80.8	76.4
Out-of-Pocket expenditure as % of private expenditure on health	95.0	89.5
HUNGARY		
Total expenditure on health as % of Gross domestic product	8.3	7.3
General government expenditure on health as % of total expenditure*	72.3	69.4

Per capita total expenditure on health (PPP international $)**	1411	1469
General government expenditure on health as % of total government expenditure	12.0	10.3
Private expenditure on health as % of total expenditure on health*	27.7	30.6
Out-of-Pocket expenditure as % of private expenditure on health	85.9	78.3
POLAND		
Total expenditure on health as % of Gross domestic product	6.2	7.5
General government expenditure on health as % of total expenditure*	69.3	72.6
Per capita total expenditure on health (PPP international $)**	857	1476
General government expenditure on health as % of total government expenditure	9.9	11.9
Private expenditure on health as % of total expenditure on health*	30.6	27.4
Out-of-Pocket expenditure as % of private expenditure on health	85.3	80.6
RUSSIAN FEDERATION		
Total expenditure on health as % of Gross domestic product	5.2	5.1
General government expenditure on health as % of total expenditure*	62.0	62.1
Per capita total expenditure on health (PPP international $)**	615	998
General government expenditure on health as % of total government expenditure	11.7	8.0
Private expenditure on health as % of total expenditure on health*	38.0	37.9
Out-of-Pocket expenditure as % of private expenditure on health	82.4	82.8
UKRAINE		
Total expenditure on health as % of Gross domestic product	6.4	7.7
General government expenditure on health as % of total expenditure*	59.5	56.6
Per capita total expenditure on health (PPP international $)**	359	519
General government expenditure on health as % of total government expenditure	8.7	9.4
Private expenditure on health as % of total expenditure on health*	40.5	43.4
Out-of-Pocket expenditure as % of private expenditure on health	92.5	93.4

* *In some cases the sum of the ratios of general government and private expenditures on health may not add to 100 because of rounding. In the Ratios, when the number is smaller than 0.05% they may appear as zero. For per capita expenditure indicators, this is represented as <1.*

** *A new Purchasing Power Parity (PPP) series resulting from the 2005 International Comparison Project (ICP) estimated by the World Bank, has been used.*

Source: Health expenditure series, World Health Organization, Geneva, February 2009 (latest updates are available on http://www.who.int/nha/en/)

Generally, in all the countries the process was designed to address all aspects of the healthcare sector and to place emphasis on quality of care, improved access, efficiency, and rehabilitation on the primary health care system. Decentralisation has been a major component of the reform process. However, the combination of transition from a communist economy and war (Armenia, Azerbaijan, Georgia) or political storms (Hungary, Russia, Ukraine) does not seem a favourable environment for succesful health system reform. Two decades after the political revolution, the health sytems of all the surveyed countries are still in transition, the level of essential medical interventions reduced and out-of-pocket payments increasing. Over the last decade, budgetary cuts and a regional trend towards privatisation have had detrimental consequences of reducing access to healthcare. Attempts to mount effective policy responses have been stunted by the absence of functioning governance systems.

The realisation of sexual and reproductive health and rights depends on women's ability to make decisions about health care and to have access to such care when they need it. One of the indicators that demonstrates whether or not governments have facilitated women's access to health care is the area of health financing.

Therefore, to assess the extent of governments' commitment to health, a set of six indicators have been used in the current report to monitor the state of health financing in the seven countries. These include: total health expenditure (THE) as a percentage of GDP; general government expenditure on health as a percentage of the total health expenditure; private expenditure on health as a percentage of the total health expenditure; per capita total expenditure on health; out-of-pocket expenditure as a percentage of the private expenditure on health; and the provision of social health insurance. These six indicators are able to demonstrate the extent of the privatisation of health that is taking place in the seven countries. By privatisation of health, we mean: the marketisation of health for profit; the shifting of responsibility of service provision to the private, commercial sector; and the shifting of financing of health to out-of-pocket payments by households.

TOTAL HEALTH EXPENDITURE

Total expenditure on health as a percentage of GDP falls below 10% in all of the countries surveyed except for Georgia.

The three countries where it exceeds 7% are Georgia (10.1%), Hungary (7.4%), and Poland (7.1%). The lowest total health expenditure relative to GDP was in Armenia (3.8%) and Russia (5.4%). It is also important to keep in mind how much each government is spending on health as a percentage of their total expenditure to understand the government's commitment to providing healthcare to their citizens. The WHO National Health Accounts record this as: Armenia 6.6%, Azerbaijan 3.7%, Georgia 6.1%, Hungary 10.2%, Poland 10.9%, Russia 8.5% and Ukraine 8.6%. Poland and Hungary spend a relatively high amount of their budgets on health. The lowest government spending on health in relation to total government expenditure is in Azerbaijan and Armenia. Total current healthcare expenditure varies significantly in Europe. The healthcare expenditure exceeds 11% of GDP in France, the Netherlands, Germany and Denmark, which is almost triple the share of healthcare expenditure relative to GDP recorded in Armenia and almost double the share of healthcare expenditure relative to GDP recorded Azerbaijan and Russia.

PER CAPITA EXPENDITURE ON HEALTH

Per capita expenditure (expressed in international $ as purchasing power parity or PPP) shows the resource availability for health in a country, including public and private spending. The disparity between European countries is even bigger when comparing the level of total healthcare spending per inhabitant, which varies from PPP 180 in Ukraine to PPP 4,286 in Luxembourg. Notwithstanding the differences in organising and financing healthcare systems, these comparisons suggest that individuals living in those countries with a

higher average level of income per capita generally spend more on purchasing healthcare goods and services.

It is also important to note that healthcare staff-to-population ratios in CEE continue to be high. Although there is a wide variation across the region, there is a paradoxical case of overcapacity and ineffective function.[51] All the surveyed countries except Poland[52] have a proportion of medical staff (physicians, nurses) to population higher than the European average. In this situation, the shift from a highly regulated and hierarchical system to a decentralised system with unclear regulatory channels has especially severe consequences for local medical staff who are underpaid or left without employment. Despite changes in funding in recent years, from taxation to insurance, most healthcare facilities continue to receive budgets allocated according to the number of beds and staff, rather than volume or quality of services.[53]

GOVERNMENT EXPENDITURE ON HEALTH AS A PROPORTION OF TOTAL HEALTH EXPENDITURE

Nevertheless, it is also important to understand the nature of total health expenditure within the countries as this includes both public and private expenditure in health.

Prioritisation of health by respective governments can be gauged by the general government expenditure on health as a percentage of total health expenditure (GHE). Both government health expenditure and private health expenditure added up make total health expenditure. The mix of public and private funding of healthcare in the surveyed countries of the CEE region reflects specific arrangements in healthcare financing systems. The share of public funding in current healthcare spending ranges from 20.3% in Azerbaijan, 23.6% in Georgia, 40.6% in Armenia, to 56.6% in Ukraine to 62.1% in Russian Federation. Public funding dominates the healthcare sector in Poland and Hungary (more than 70%).

PRIVATE EXPENDITURE ON HEALTH AS PERCENTAGE OF TOTAL EXPENDITURE ON HEALTH

The economic downturn that came after the transition from communism to market economy meant that public expenditure on health fell, leaving private health expenditure to fill the gap – mainly with out-of-pocket

payments. Since almost all health care was provided free at the point of use during the communist regime, the move to establish or formalise user fees have been met with much resistance. This change has led to problems beyond affordability – such payments often encourage expensive and unnecessary treatments. Moreover, widespread under-the-table payments pose the greatest challenges.

The major source of private funding is direct household payments, referred to as out-of-pocket expenditure.

OUT-OF-POCKET EXPENDITURE AS PERCENTAGE OF PRIVATE EXPENDITURE ON HEALTH

Out-of-pocket expenditure, including both formal co-payments and informal, under-the-table payments constitute the major source of private funding.

Out-of-pocket expenditure constitutes from 78.3 % of private expenditure on health in Hungary to 93.4% in Ukraine.

Although evidence for their extent and magnitude is incomplete – an indication of their illegal status – the under-the-table payments are especially common in Armenia, Azerbaijan, Georgia, and Ukraine where they now constitute a major source of healthcare expenditure. Informal coping strategies such as offering money to doctors or nursing staff or using connections, for example with urgent hospitalisation, are seen as acceptable strategies.[54] Physicians are the main beneficiaries of informal payments, with the largest payments often going to those who work in hospitals. Such payments create a very complex system, perhaps explaining the difficulty in their elimination. In some cases they provide resources for essential but otherwise unavailable treatments, and in others they supplement low salaries of health workers.[55]

Access to care has been further challenged by reforms that have included a shift from a taxation-based system to an insurance-based system, while budgetary support has been maintained for rigid, highly verticalised structures. In many countries, patient access to care is less equitable than before the collapse of the Soviet Union.[56]

While we study the different health financing sources, it is also important to look at social health insurance (SHI). In Armenia, entitlement to free health care was removed from the Constitution that was enacted in 1995. A system of health insurance was subsequently imposed but the insurance only covers a limited package of services. In Azerbaijan, financing of the health service still remains the responsibility of the government. There is a constant growth in the percentage of the GDP allocated to health since the 1990s, with the current figure estimated at 5.8%. Access to medical health is a constitutional right for each citizen of Azerbaijan. The concept of health care financing reform (2008) strengthened the right of all citizens to obtain a state-guaranteed basic package of medical services, although the full extent of this package will be determined only at the end of 2012. It is important to notice the specified measures related to the official definition of the state-guaranteed free access to medical care. In reality, patients quite often should pay at their own expense for medicines or services that theoretically should be available for them free of charge. Also, in Georgia, the process of privatisation of the health system is planned to be completed by the end of 2012. Although the Georgian GDP improved

in recent years, healthcare expenditures comprise a decreasing portion of public expenditures, resulting in the underfunding of medical facilities, including family planning (FP) and reproductive health (RH) services. The government finances programme such as TB, HIV/AIDS, immunisation, mother and child health, and provides insurance coverage for people under the poverty line for a limited package of service. Hungary and Poland increase their budget spending on health in order to catch up with the EU member states. Health expenditures of Russian government are unbelievably low. Ukraine has a comprehensive guaranteed package of health care services provided free of charge at the point of use as a constitutional right, however user charges are widely levied in the Ukrainian health system. In all the countries of the region, government attempts to define a more limited benefits package have left it to the individual facilities to determine which services are covered by the budget and which are subject to user charges. For the poor, out-of-pocket expenditures often represent a barrier to care, thus restricting demand.[57] With limited investment in infrastructure maintenance, this pattern looks set. Despite official commitment to guarantee universal coverage (with most insurance packages covering virtually all medical conditions apart from cosmetic surgery and dentistry), the reality is that profound barriers to access exist for substantial populations.

SUMMARY

Falling government revenues, spiraling inflation (and devaluation) faced by CEE countries meant existing public health systems started to collapse. Nominally, they continued to operate, by paying wages late and avoiding any investment in equipment and facilities. This led to an insidious deterioration in the healthcare structures and ineffective functioning. Currently, the general trend seems to be in the direction of increasing privatisation of healthcare in the seven countries. There is significant evidence that since the transition, people living in this region have experienced barriers to effective health care, and that neoliberal health policy turns patients into clients and consumers. Analysis of the health financing indicators demonstrated the extent to which the principles of universal access that underlined the former Soviet health systems have eroded.[58] One in five of those who had experienced an episode of illness that they felt would have justified seeking health care did not seek it. This percentage was the highest in Armenia (42%) and Georgia (49%), where both countries have experienced dramatic economic declines as well as civil conflict, and where the health care systems effectively collapsed during the 1990s. Even symptoms such as chest and severe abdominal pain would often be self-treated using either traditional remedies, for example herbal and alcohol-based remedies, or by direct purchase of pharmaceuticals.[59]

Furthermore, despite legislative and administrative measures for implementation of the rights recognised by international treaties regarding their health systems, the total expenditure on health level in CEE remains far below the level of developed countries. Although the ICPD PoA itself talks of SRH service provision by the private sector, it simultaneously calls for universal access to SRH. Within this context, the implications of health sector reforms (with decentralisation as a feature) that are currently underway in the region, appear to have created additional complexities in realizing the ICPD PoA for the progressive provision of comprehensive sexual and reproductive health services. The privatisation of health is a worrying phenomenon. It transforms women with rights to sexual and reproductive health into consumers who can (or cannot) pay for sexual and reproductive health. This, in turn, marginalises the women who may need sexual and reproductive health services the most. This phenomenon also reduces the accountability of governments to provide sexual and reproductive health to their citizens.

It is essential to institute mechanisms, within the existing National Health Accounts, which will be able to track public and private expenditure on sexual and reproductive health (SRH) services, and also track exactly which services and supplies are being offered by governments. It is critical to do this if we are to be able to gauge resource allocation and, thereby, the

commitment of governments to provide for the right to sexual and reproductive health for their women citizens. It is also essential to advocate for governments to increase spending on health as a percentage of the general government expenditure on health in the CEE region.

Both sections of this chapter – women's empowerment and health financing – set the stage for monitoring progress on the specific SRHR components which follow in the next two chapters. Women's empowerment and health financing are two critical factors which will facilitate or hinder the implementation of the ICPD PoA. These two factors influence the way women make decisions, exercise choice and execute those decisions and choices, especially with regards to their sexual and reproductive health. Globally and nationally, there seems to be a lack of political will, as shown in the MDG goals and indicators for monitoring, and at times an outright opposition to and a lack of recognition of the central role of gender equality in promoting sexual and reproductive health and rights. This is especially true when discussing how essential service packages are calculated – with abortion and services preventing maternal deaths often left out.

Although the link between systems for health financing and health outcomes is very complex, we need to understand the implications of reform initiatives for population health. Finally, there is still much work to be done to respond to the special needs of some population groups – such as migrants, the Roma minority and those with disabilities – who face substantial barriers to access to health services.

ENDNOTES

1 List of organisations that participated in the survey: international networks: KARAT Coalition Secretariat (Poland), ASTRA YOUTH Secretariat (Poland), 8th March Women's Coalition (Poland), Hungarian Civil Liberties Union (Hungary), PATENT (Hungary), SALUS Center (Ukraine), National AIDS Center (Ukraine), Women's Center (Georgia), HERA XXI (Georgia), Women and the Modern World (Azerbaijan), Russian Family Planning Association (Russia); Women's Rights Center for Armenia (Armenia); Real World, Real People (Armenia), Representatives of Polish and Armenian Ministry of Health participated in the survey anonymously.

2 Stillman, S. (2006). Health and Nutrition in Eastern Europe and the former Soviet Union during the decade of transition: A review of the literature, Economics and Human Biology, 4 (2006), 104-146.

3 McKee, M., & Shkolnikov, V. (2001). Understanding the toll of premature death among men in Eastern Europe, Br. Med. J. 323, 1051-1055.

4 Stillman, S. (2006). Health and Nutrition in Eastern Europe and the former Soviet Union during the decade of transition: A review of the literature, Economics and Human Biology, 4 (2006), 104-146.

5 McMichael, A. J., McKee, M., Shkolnikov, V. M., Valkonen, T. (2004). Global trends in life expectancy: convergence, divergence - or local setbacks? Lancet 2004; 363:1155-1159.

6 Ibidem.

7 Women's empowerment is a loosely defined term and this has simultaneously been its strength and its weakness. Its strength lies in the fluidity of its interpretation, making women shape its meaning according to their contexts, while its weakness is its lack of operational clarity at the policy and program levels. In order to compare progress across countries with regards to women's empowerment, however, it is necessary to think through the term, attribute key indicators to it, and track governments' progress in this area. Nevertheless, this is not meant to limit women's empowerment only to these aspects that are measured.

8 Schuler, M.A., Thomas, D. Q. (1997). Women's Human Rights Step by Step. A Practical Guide to Using International Human Rights Law and Mechanisms to Defend Women's Human Rights. Washington, D.C.: Women, Law & Development International.

9 Szijjarto v. Hungary, Communication No. 4/2004.

10 Ms. A.T. v Hungary, Communication No. 2/2003.

11 Schuler, M.A., Thomas, D. Q. (1997). Women's Human Rights Step by Step. A Practical Guide to Using International Human Rights Law and Mechanisms to Defend Women's Human Rights. Washington, D.C: Women, Law & Development International.

12 Center for Reproductive Rights - On the Case: R.R. v. Poland, S&T v. Poland, Z. v. Poland, and Tysiąc v. Poland. Litigation Briefing Series. Center for Reproductive Rights and Federation for Women and Family Planning, 2011; accessible here: http://reproductiverights.org/en/document/rr-v-poland-st-v-poland-and-z-v-poland-polish-language-litigation-briefing-series-pdf (last visited 27.03.2012).

13 Ibidem.

14 Implementation of UN Convention on all Forms of Discrimination Against Women. Period 2002-2007. (Armenia_NGO_shadow_report, http://www2.ohchr.org/english/bodies/cedaw/docs/ngos/DTAAUWArmenia_43.pdf).

15 ASTRA Network Country Report: Armenia, Gohar Shahnazaryan and Anush Poghosyan, 2012 (unpublished).

16 ASTRA Network Country Report: Azerbaijan, Sudaba Shiraliyeva, 2012 (unpublished).

17 ASTRA Network Country Report: Georgia, Giorgi Soselia, 2012 (unpublished).

18 Equal Treatment Authority, http://www.egyenlobanasmod.hu/index.php?lang=en

19 Czerwińska, A. , Piotrowska, J. (2009). Raport: 20 lat- 20 zmian. Kobiety w Polsce w okresie transformacji 1989-2009. Warszawa: Fundacja Feminoteka, Heinrich Böll Foundation.

20 Violence Against Women in the Russian Federation. Alternative Report to the United Nations Committee on the Elimination of All Forms of Discrimination Against Women, 46th Session, July 2010, ANNA National Centre for the Prevention of Violence, http://www2.ohchr.org/english/bodies/cedaw/docs/ngos/ANNANCPV_RussianFederation46.pdf

21 ASTRA Network Country Report: Ukraine, Mariia Telishevska, 2012 (unpublished).

22 ASTRA Network Country Report: Georgia, Giorgi Soselia, 2012 (unpublished).

23 Current Status and Directions for Advancement of Sexual and Reproductive Health and Rights (SRHR) in Central and Eastern Europe – Report 2011, ASTRA Network 2011.

24 Eisenstein, Z. (1993). Eastern European Male Democracies: A Problem of Unequal Equality, in N. Funk and M. Mueller (eds) *Gender Politics and Post-Communism* . New York: Routledge, pp.303–330.

25 Gal, S., & Kligman, G. (2000). *The politics of Gender After Socialism.* Princeton, New Jersey: Princeton University Press.

26 Einhorn, B. (1993). *Cinderella Goes to Market: Citizenship, Gender and Women's Movements in East Central Europe.* London: Verso.

27 ASTRA Network Country Report: Azerbaijan, Sudaba Shiraliyeva, 2012 (unpublished).

28 Gal, S., & Kligman, G. (2000). *The politics of Gender After Socialism*. Princeton, New Jersey: Princeton University Press.

29 The Global Gender Gap Report. World Economic Forum, 2011. Available at: http://www.uis.unesco.org/Library/Documents/global-gender-gap-report-education-2011-en.pdf (last visited 27.03.2012).

30 Because reliable statistics on sex-selective abortion do not exist, the analysis employs the sex ratio at birth (defined as the ratio of male births to female births) as an indirect indicator of sex-selective abortion.

31 Pre-natal sex selection. CoE Report. Available at: http://www.assembly.coe.int/CommitteeDocs/2011/ASEGAselectionprenatalee.pdf (last visited 27.03.2012).

32 "Prevalence and Reasons of Sex Selective Abortions in Armenia", UNFPA Armenia, http://eeca.unfpa.org/webdav/site/eeca/shared/documents/Armenia%20Sex%20Selective%20Abortions%20-%20Conclusions_Eng_Final.pdf (last visited 27.03.2012).

33 ibidem.

34 Nowicka, W. (2000). Struggles For and Against Legal Abortion in Poland, in: Advocating for Abortion Access. Eleven Country Studies, in Klugman, B. and Budlender, D. (eds), Johannesburg: The Women Health Project, pp. 223-249.

35 Faulconbridge, G. and Ferris-Rotman, A. Russian Church calls for tougher abortion laws (2010). Reuters. Available at: http://www.reuters.com/article/2010/06/01/us-russia-church-abortions-idUSTRE65052320100601 (last visited 27.03.2012)

36 Russian Orthodox Church will provide financial aide to women who decide against abortion. Synodal Information Department of the Moscow Patriarchate. Available at: http://www.pravoslavie.ru/english/45637.htm (last visited 27.03.2012).

37 Women's empowerment is viewed from the perspectives of resources, agency and achievements. Resources include material, human and social resources. Agency is defined as the ability to define one's goals and act upon them – 'power to' and 'power over.' Both resources and agency constitute the measure of capabilities as calculated by the Human Development Index (HDI) and Gender Development Index (GDI). Achievement is calculated by the Gender Empowerment Measure (GEM). All three - resources, agency and achievement - are continuously synergizing and contributing to different levels of empowerment.

38 http://www.uis.unesco.org/Library/Documents/global-gender-gap-report-education-2011-en.pdf (last visited 27.03.2012).

39 The GDI "measures achievement in the same basic capabilities as the HDI does, but takes note of inequality in achievement between women and men. The methodology used imposes a penalty for inequality, such that the GDI falls when the achievement levels of both women and men in a country go down or when the disparity between their achievements increases. The greater the gender disparity in basic capabilities, the lower a country's GDI compared with its HDI. The GDI is simply the HDI discounted, or adjusted downwards, for gender inequality." Measuring inequality: Gender-related Development Index (GDI) and Gender Empowerment Measure (GEM). (2008). Retrieved August 16, 2009, from UNDP Human Development Reports Web site: http://hdr.undp.org/en/statistics/indices/gdi_gem/

40 Measuring inequality: Gender-related Development Index (GDI) and Gender Empowerment Measure (GEM). (2008). Retrieved September 18, 2009, from UNDP Human Development Reports Web site: http://hdr.undp.org/en/statistics/indices/gdi_gem/

41 Fukkuda-Parr, S. (2003). The Human Development Paradigm: Operationalizing Sen's Ideas on Capabilities. In Agarwal, B.; Humphries, J.; Robeyns, I. (Eds.) Amartya Sen's Work and Ideas, Feminist Economics Vol 9, No 2 & 3 (p. 301). London, UK: Routledge.

42 Human Development Report 2007/2008, http://hdr.undp.org/en/media/HDR_20072008_EN_Complete.pdf

43 Alternative Report. Monitoring the Implementation of the Convention on Elimination of All Types of Discrimination Against Women (CEDAW) in Azerbaijan, http://www2.ohchr.org/english/bodies/cedaw/docs/ngos/Monitoring_Azerbaijan44.pdf; Russian Federation. Briefing to the Committee on the Elimination of Discrimination Against Women, 46th session July 2010. Amnesty International.

44 Einhorn, B. (1993). *Cinderella Goes to Market: Citizenship, Gender and Women's Movements in East Central Europe.* London: Verso.

45 http://hdr.undp.org/en/media/HDR_2011_EN_Tables.pdf

46 Pollert, A. (2005). Gender, Transformation and Employment in Central Eastern Europe, European Journal of Industrial Relations 11, 2 (2005), 213-230.

47 Stillman, S. (2006). Health and nutrition in Eastern Europe and the former Soviet Union during the decade of transition: A review of the literature, Economic and Human Biology 4 (2006) 104-146.

48 Officially, Ukraine has a comprehensive guaranteed package of healthcare services provided free of charge at the point of use as a constitutional right, nevertheless user charges are widely levied in the Ukrainian health system. Government attempts to define a more limited benefits package have left it to the individual facilities to determine which services are covered by the budget and which are subject to user charges. This has led to a lack of transparency in the system which has contributed to an increase in informal payments. Most health financing comes from general government revenues raised through taxation (value-added taxes, business income taxes, international trade, and excise taxes). Personal income tax is not a significant contribution to total revenues. Out of pocket payments are also account for a significant proportion of total health expenditure and there are some limited VHI schemes. Funds are pooled at the national and the local level, as local governments retain a proportion of the taxes raised in their territory. There are also interbudgetary transfers to boost the coffers of poorer local authorities which cannot raise as much revenue. (ASTRA Network Country Report: Ukraine, Mariia Telishevska,, 2012 (unpublished)).

49 Lewis, M. (2002). Informal health payments in Central and Eastern Europe and the Former Soviet Union: issues, trends and policy implications. In: Mossialos, E.A., Dixon, A., Figueras, J., Kutzin, J.(Eds.) Funding Health Care: Options for Europe. Buckingham: Open University Press.

50 Richard B. Saltman,Vaida Bankauskaite,Karsten Vrangbæk(2007), Decentralization in health care: strategies and outcomes, WHO.

51 Parfitt, B. (2009). Health reform: The human resources challenges for Central Asian Commonwealth of Independent States (CIS) countries, Collegian (2009) 16, 35-40.

52 The exodus of Polish physicians to UK and Ireland has depleted Poland's health system, leaving only 203 doctors per 100 000 population, a significantly lower number than in neighbouring nations, e.g. 356 doctors to 100 000 in Czech Republic, 313 in Slovakia, and 348 in Germany. (Mishtal, J. (2010). Neoliberal reforms and privatization of reproductive health services in post-socialist Poland, in: Reproductive Health Matters, Volume 18, Number 36, November 2010, pp. 56-66.).

53 Saltman, R.B., Bankauskaite,V. ,Vrangbæk, K. (2007), Decentralization in health care: strategies and outcomes, WHO.

54 Belli, P., Gotsadze, G., Shahriari, H. (2004). Out-of-pocket and informal payments in health sector: evidence from Georgia, Health Policy 70 (2004) 109-123.

55 Rechel, B., McKee, M. (2009). Health reform in central and eastern Europe and the former Soviet Union, Lancet 2009; 374:1186-95.

56 Habibov, N.N., Afandi, E.N. (2011). Self-reted health and social capital in transitional countries: Multilevel analysis of comparative surveys in Armenia, Azerbaijan, and Georgia. Social Science and Medicine 72 (2011) 1193-1204.

57 Balabanova, D., Coker, R. (2004). Health Systems of Russia and Former USSR. In International Encyclopedia of Public Health, San Diego, CA: Academic Press.

58 Ibidem.

59 Belli, P., Gotsadze, G., Shahriari H. (2004)..Out-of-pocket and informal payments in health sector: evidence from Georgia, Health Policy 70 (2004) 109-123; Fugueras, J., McKee, M., Cain, J., and Lessof, S. (2004). *Health Systems in Transition: Learning from Experience*. Copenhagen: European Observatory on Health Care Systems; Gotsadze, G.. and Gaal, P. (2010). Coverage Decisions: Benefit Entitlements and Patient Cost Sharing. In Kutzin, J., Cashin, C., and Jakab, M. (Eds.) *Implementing Health Financing Reform: Lessons from Countries in Transition, Copenhagen: WHO*.

CHAPTER 3

REPRODUCTIVE HEALTH AND REPRODUCTIVE RIGHTS

REPRODUCTIVE HEALTH AND REPRODUCTIVE RIGHTS

This chapter focuses on progress regarding Reproductive Health (RH) and Reproductive Rights (RR) achievements in the seven CEE countries.

Related to these issues, we will look at the following areas: the existence of population policies, the provision of reproductive health services (contraception, pregnancy), childbirth-related mortality and morbidity, abortion and reproductive cancers.

According to the ICPD PoA,[1] a comprehensive approach to reproductive health entails family planning counselling, information, education, communication and services; education and services for prenatal care, safe delivery and postnatal care; prevention and appropriate treatment of infertility; abortion as specified in paragraph 8.25, including prevention of abortion and the management of the consequences of abortion; treatment of reproductive tract infections; sexually transmitted diseases and other reproductive health conditions; and information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood; referral for family-planning services; and further diagnosis and treatment which should always be available, as required, for complications of pregnancy, delivery and abortion, infertility, reproductive tract infections, breast cancer and cancers of the reproductive system, sexually transmitted diseases including HIV/AIDS; and active discouragement of harmful practices, such as female genital mutilation. The PoA stipulates further that the full range of reproductive health services should be an integral component at the primary health care level: the health care system which is accessible to most of the population, especially women.

Moreover, the ICPD PoA deals with contraception and family planning, as it calls for removal of demographic targets (Paragraph 7.12); universal access to a full range of safe and reliable family planning methods (Paragraphs 7.16 and 7.23); safer, affordable, convenient and accessible information and services (Paragraphs 7.19 and 7.23); as well as free and informed choice, quality of care and service, privacy and confidentiality (Paragraph 7.23). These paragraphs of the ICPD PoA refer to the right of individuals and couples both to services on contraception and self-determination to regulate fertility.

Although the recognition of reproductive health is a major factor in forming favourable demographic prospects of a country, the inclusion of the reproductive health and reproductive rights perspective into jurisprudence has been a slow process in the CEE region. Legal regulations regarding reproductive health are fragmented and only affect the disparate aspects of reproductive problems. Moreover, even the principles on which agreements were based on are being challenged by some governments and religious groups in the seven countries surveyed. Almost 20 years after the adoption of the ICPD PoA, most countries in the CEE region apply a narrow definition of reproductive health and put resources into maternal and child health programmes, neglecting a full range of other services.

POPULATION POLICIES

Looking at population policies of seven CEE countries, using the criteria of availability of services and existence of law regulating the access, we can see that realisation of the ICPD PoA's goals remains a substantial challenge for the region.

While only few countries in the region have systematic population policy, incentives and compensations for promotion of childbearing are widespread. In all the surveyed countries, family planning services are integrated into national health services and focus on prenatal and postnatal care and counselling. Contraceptives are not subsidised, therefore many individuals do not have easy access to high-quality sexual and reproductive health services that would prevent unwanted pregnancies and reduce reliance on abortion as a method of family planning.

Analysis of this approach reveals that the current policies are often informed by anti-feminist backlash and religious fundamentalisms. This tends to counterbalance the liberal approach to reproduction that is linked with the former era with conservative approach to sexuality and reproduction. As a result the number of operating legislative acts that frame realisation of reproductive rights in the region is limited.

Armenia has ratified the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). Under its constitution, everyone has a right to health (Article 38).[2] Under the Health Care and Services for the Population law, everyone also has a right to receive health care free of charge from state medical programmes. The 2002 Reproductive Health and Human Reproductive Rights law includes a main focus on safe motherhood. It declares that motherhood and childhood are protected by the state and that women have the right to safe motherhood and protection of their health during pregnancy, childbirth and after delivery. Legislation such as the HIV Prevention law also contributes to the protection of reproductive and maternal health rights.[3]

The 1995 constitution of Azerbaijan maintains the formal guarantees of access to health care as a citizen's right. These rights are further specified in the 1997 law on Protection of Health of the Population. Maternal health care is intended to be provided either free at the point of service or, for some designated services, on a fee-for-service basis. Azerbaijan has adopted the relevant international conventions and standards. Additionally, a state programme of activities for the protection of maternity and childhood was adopted in 2006.[4] In Georgia, the Law on Health Care defines the rights of mothers and children and is supported by legislation such as the Law on Patients' Rights.[5]

Hungary has had a mixed record in terms of fulfilling reproductive rights as a whole. The new Hungarian constitution recognises the protection of life from conception and this provision makes Hungary the only European Union and Council of Europe member state to do so.[6]

There is no definition of reproductive health and rights in Russian legislation. In the early 1990s, the wave of democratic changes helped to adopt the federal target programme Family Planning. In 1994, this programme gained support from the president of Russia, and was adopted as part of the Children of Russia programme. The programme was designed to fundamentally change societal attitudes towards reproductive rights and create conditions for the realisation of these rights. Implementing this programme, the Russian Ministry of Health established a network of hundreds of family planning clinics. Many specialists obtained advanced courses and extensive training in related areas. Considerable work was undertaken to improve the sexual culture. Expert groups prepared implementation programmes for the sexuality education of adolescents, but these activities provoked harsh criticism and

resistance from more conservative parts of society. Currently, a stiff pro-natalist approach dominates the Russian governments' position on women's status.[7]

Reproductive rights and health are not covered by Polish legislation, and a restrictive Family Planning act remains the only attempt to regulate Polish citizens' access to sexuality education, contraception and abortion services.

In 2006 in Ukraine, the Cabinet of Ministers approved the Ukrainian State Programme "Reproductive health of the nation in 2006-2015", with the main objective of achieving the goals announced by the ICPD. This programme was preceded by a series of long-term national programmes: National Family Planning Programme 1995-2000, Reproductive Health Programme 2001-2006, and the Reproductive Health Programme 2006-2011. However, the recent public administration reforms have laid waste to earlier efforts of the preceeding 10 years. Currently, there is no institution at central executive authority level responsible for family and gender policy development, since these functions were not passed to any ministry after the recent reorganisation of the Ministry of Family, Youth and Sport, which was earlier responsible for gender policies, trafficking and domestic violence issues.[8]

From another perspective, the sharp decline in fertility in the region, dramatic aging of the society and high mortality rates provide a favourable political climate for populist pro-natalist discourse that is gaining popularity in most of the surveyed countries. All surveyed countries except Azerbaijan are experiencing a decline in population growth. Over the past decade, Russia has experienced what is referred to as a demographic crisis, with a decline of about 800,000 in population per year. Ukraine is experiencing the highest rate of population reduction in Europe and the current population is projected to decrease by 28% by 2050. Emigration and seasonal migration have further affected recent demographic trends. The CEE governments have introduced new demographic policies to increase the birth rate, protect motherhood and childhood, reduce the mortality rate, and increase life expectancy.

CONTRACEPTION

To assess the accessibility of contraception we will examine total fertility rates (TFR), wanted fertility rates, contraceptive prevalence rates (CPR), male contraception, informed choice on contraceptive method, unmet need and non-use of contraception.

Many of these indicators for contraception represent a convergence of health and human rights indicators. These indicators are a reflection of the extent to which women have the means to control their fertility. They are also indicative of the health risks posed to women by unwanted fertility, (which can lead to unsafe abortions in the absence of legal services), high fertility, maternal deaths and maternal morbidity.

TOTAL FERTILITY RATES AND WANTED FERTILITY RATES

Total Fertility Rate is the number of children an average women would have, assuming that she lives her full reproductive lifetime, while wanted fertility rate is an estimate of what the total **fertility rate** would be if all unwanted births were avoided.

There have been precipitous declines in fertility in the surveyed countries since the dissolution of the Soviet Union and communist block. With respect to rights around contraception, we compare TFR with wanted fertility rates in the seven countries surveyed. The TFR has fallen in Hungary, Poland and Ukraine, remaining steady in Armenia, Azerbaijan and Russia. The Georgian TFR went up from 1.7 in 1995 to 2.0 in 2010. All over the region (except in Georgia), wanted fertility rates are lower than total fertility rates.

Table 7: Total Fertility Rates

Total Fertility Rates			
Name of Country	Total Fertility Rate		
	1995	2003-2005	2008-2010
Armenia	1.7 (DHS 2000)	1.7 (2000 DHS)	1.7 (2010 DHS Prelim report)
Azerbaijan		2.1 (RHS 2001)	2 (2006 DHS)
Georgia	1.7 (RHS 1996)	1.6 (RHS 2005)	2.0 (GERHS 2010)
Hungary	1.7 (HDR 1990-1995)		1.4 (HDR 2005-2010)
Poland	1.9 (HDR 1990-1995)	1.3 (HDR 2000-2005)	1.3 (HDR 2005-2010)
Russia	1.5 (HDR 1990-1995)	1.3 (2005)	1.5 (2010)
Ukraine	1.6 (RHS 1999)		1.2 (DHS 2007)

Sources: Demographic and Health Survey(s) for Armenia (2000, 2005); Azerbaijan (2006); Ukraine (2007) & Human Development Report 1995, 2003, 2010

Table 8: Wanted Fertility Rates compared to TFR

Wanted Fertility Rate			
Name of Country	Wanted Fertility Rate		
	1995	2003-2005	2008-2010
Armenia		1.5 (DHS 2000)	1.6 (DHS 2005)
Azerbaijan		3.5 (RHS 2001)	1.8 (DHS 2006)
Georgia	3.5 (RHS 1999)		2.6 (RHS 2005)
Hungary			
Poland			
Russia			
Ukraine		0.8 (RHS 1999)	1.1 (DHS 2007)

Sources: Demographic Health Survey(s) for Armenia, Azerbaijan and Ukraine (2007)

CONTRACEPTIVE PREVALENCE RATES

Although the ICPD PoA does not specifically cover the issue of CPR, this is an important indicator to look at, and many interesting trends are evident.

According to WHO, the "contraceptive prevalence rate is the proportion of women of reproductive age who are using (or whose partner is using) a contraceptive method at a given point in time".[9] The use of modern contraceptives is low in the region, with high reliance on traditional means of family planning such as withdrawal and on abortion in the event of unwanted pregnancies. The most popular contraceptive methods are oral contraceptives and intrauterine devices. Surgical contraception is very uncommon in CEE. Both female and male sterilisation is legally permitted (with the exception of Poland), but there are restrictions. In Georgia and Ukraine, sterilisation is performed after submission of a written application from a citizen older than 35 years, having at least two children. Female sterilisation constitutes the most common means of surgical contraception in all countries. Laparotomy and laparoscopy are used with equal frequency. The annual number of female sterilisations in the whole region is approximately 50,000 and the number of male sterilisations is approximately 10 times less.[10]

Table 9: Contraceptive Prevalence Rate by method

	Armenia (2010)	Azerbaijan	Georgia (2005)	Hungary (1992-1993)	Poland (1991)	Russia (2007)	Ukraine (2007)
Any Method	53.1 (2005)	51.1 (2006)	47,3	80,6	72,7	79,5	66,7
Any Modern Method	19,1	13,2	26,6	71,3	28	65	47,5
Female Sterilisation	0,6	0,4	2,2	5	0		0,6
Male Sterilisation	0	0	0		0		0
Pill	0,8	1,1	3,2	39,4	3,4	14,1	4,8
Injectable	0	0	0				0
Implant	0	0					0
IUD	9,4	9,2	11,6	18,2	8,4	20,4	17,7
Male condom	8,1	2,2	8,7	8,1	13,4	30,3	23,8
Vaginal barrier	0,2	0,2	0,9	0,6	2,8		0,5
Other Modern Method	0	0	0	0	0	5,2	0
Any Traditonal Method	34	37,9	20,7	9,3	44,7	14,6	19,1
Rhythm	3,8	4	9,5	2,6	28,4	14,5	7,2
Withdrawal	27,7	32,5	11,2	6,5	16,3	13,6	10,3
Other Traditional Method	2,5	1,4	0	0,2	0	2,9	1,6

Sources: World Contraceptive Use 2011; Country Demographic and Health Survey(s), Armenia 2010 Preliminary Report, Azerbaijan 2006, Ukraine 2007.

With regards to other preferred methods, condoms are widely available in the surveyed countries. They are accessible in pharmacies, drug stores and shops. Moreover, condoms are mostly used as a contraception method and their role in preventing STIs is often neglected. Most of the countries that took part in the project mentioned very low contraceptive use, noting the lack of current research and reliable data on the issue. Informants from Azerbaijan, Armenia and Georgia mentioned stereotypes regarding the side effects from using of hormonal contraception also among health practitioners.[11] Getting a prescription, which is necessary to obtain contraception in Poland, Hungary and Russia, seems a real barrier for accessing contraception in Poland. Doctors have a right to refuse a prescription on moral grounds, and recently also pharmacists have claimed their right to conscientious objection in refusing to sell hormonal contraceptives. Emergency contraception is available in all of the countries. In Poland and recently also in Hungary, anti-choice activists spread propaganda presenting emergency contraception as an abortifacient.[12] Due to the traditional outlook on family roles, a woman is responsible for family planning. Many women report problems with negotiating condom use with their partners. For example, in Armenia, where the dominant type of HIV infection is husband-to-wife transmission, men refuse to use condoms as they see it as implying mistrust.[13] Male contraception methods comprise condom usage, male sterilisation and withdrawal. Independent from accessibility, cultural norms regulating use of contraception impose this burden on women.

Also the burden of suffering from side effects also falls on women. Male involvement, as equal partners, in decision-making about reproduction as stipulated in the ICPD PoA seems to have had limited headway in all seven countries in the past 20 years.

Table 10: Male contraception as % of total contraception

Male contraception as % of total contraception		
Name of the Country	Male Sterilisation	Male Condom
Armenia(2005)	0	8.1
Azerbaijan(2006)	0	2.2
Georgia(2005)	0	8.7
Hungary(1992-1993)	-	8.1
Poland(1991)	0	13.4
Russia(2007)		30.3
Ukraine(2007)	0	23.8

Sources: World Contraception use 2011 and Country Demographic and Health Survey(s)

http://www.un.org/esa/population/publications/contraceptive2011/contraceptive2011.htm

CONTRACEPTIVE USE: INFORMED CHOICE

Informed choice about family planning methods is an important rights indicator.

However, it has not been commonly regarded as an important aspect of the service provided with the contraception method. Informed choice includes: information on the full range of methods including traditional and male methods; information on side effects of all methods and the appropriate course of action; and information on the efficacy of each of the methods. However, data is not available for many countries for this indicator. Overall, the network of family planning counselling services is under-developed in all seven countries and it is the gyneacologist's role to inform women about their contraceptive choices. Providers' biases appear to affect the availability of information on hormonal contraceptives to users in Azerbaijan, Georgia, and Poland.

UNMET NEED FOR CONTRACEPTION

As shown above, contraceptive use varies both between and within CEE countries.

Additionally services are less available in some countries for young people, for immigrants and for people in rural areas. In most countries of the region, modern methods of contraception must be imported and are extremely costly. This is especially the case in Russia. As a consequence, statistics show that abortion rates are higher than in most other parts of the world, since it has served as the most accessible means of managing unwanted pregnancy.

Table 11: Unmet Need for Contraception

Unmet Need for Contraception (Family Planning)			
Name of Country	Unmet Need for Contraception		
	1995	2003	2007
Armenia		11.8 (2000)	13.1 (2005)
Azerbaijan		11.5 (2001)	15.1 (2006)
Georgia		23.8 (2000)	16.3 (2005)
Hungary	7.0 (1993)		
Poland			
Russia			
Ukraine		17.5 (1999)	10.3

Note: Data pertains to women aged 15 to 44. Excluding women who are currently pregnant, currently seeking to become pregnant, subfecund, or who are not sexually active, which includes women practicing post-partum abstinence. Including fecund married women, currently sexually active, currently exposed to the risk of pregnancy, not wanting to become pregnant, and not using a method of contraception other than folk methods, douches, breastfeeding or lactational amenorrhea (LAM). RHS.

Source: Official UN MDG Indicators: http://unstats.un.org/unsd/mdg/Default.aspx

The unmet need for contraception is the percentage of fertile women of reproductive age who do not want to become pregnant and are not using contraception".[14] The concept of unmet need is an important one, because it assesses the "need" for contraception based on whether and when a woman wants a child or another one rather than focusing on government limits on family size. Differentials of wealth, area of residence, age and education are all important correlations to unmet need. If in most cases unmet need is caused by women's concerns about side effects, health consequences and inconvenience of methods of contraception, it is also important to look closely at other reasons for non-use of contraception.[15]

Difficulties in achieving prescription and cost are the most common barriers for use of modern methods in Poland, where health providers (doctors and pharmacists) refuse to provide women with prescription of a "sinful" method of contraception. In former Soviet Republics (Ukraine, Georgia, Azerbaijan, Armenia[16]) health concerns are presented as a main reason for non-use of contraception.[17] Women in rural areas with limited number of pharmacies report shame as a factor obstructing their free use of contraception.[18]

The impact of the Catholic Church on physicians' attitudes and choices seems to be strong in Poland, where the Church maintains an affiliation of 89%, and where many women claim that their religion stops them from using modern contraception.[19]

Furthermore, informants from all the surveyed countries stressed the fact that women with lower or no education, poor women, women who lived in remote, hard-to-reach areas had less access to contraception and hence, less control over their fertility in comparison to their educated, wealthier, urban counterparts. Socio-economic inequities are closely inter-linked with higher rates of unintended births and it is important to ensure access to contraception to all groups of women.

OVERVIEW REGARDING CONTRACEPTION

There is much progress to be made in improving women's access to contraception and usage.

Informed choice about contraception methods and side effects have not been emphasised in service provision and hence have been very poorly provided in all countries. Governments during the Soviet period asserted that modern contraceptive methods such as the oral contraceptive pill were dangerous and family planning and reproductive health were largely ignored – much of what women knew was misconception and myth. Adding to this milieu are negative physician attitudes toward (certain) modern methods of contraception, possibly based on the providers' own misinformation, their financial gains reaped from "under the table" payments for abortions, and/or attitudes about the status of women.

Across all the countries, the low numbers of both male sterilisation and of condom use reflect the gender power imbalance in negotiating the responsibility of bearing the burden of both pregnancy prevention and disease prevention. Cultural and gender norms about roles and values of men and women in sexual relationships and perceptions about male and female sexuality all play a key role in these low rates.

The lack of knowledge of and access to family planning methods extends to the rest of the reproductive health domain, including emerging problems like STIs and HIV. Efforts to improve women's health through safe and effective modern family planning methods are further complicated by governmental concerns that support for family planning methods will negatively affect a declining fertility rate, rather than shift family planning choice from abortion to modern contraceptives. Lack of knowledge and misperceptions about modern contraceptive methods are cited as the primary reasons for the heavy reliance on abortions in CEE.

ADOLESCENT PREGNANCIES

One of the objectives stated in paragraph 7.44 of the ICPD PoA is to substantially reduce all adolescent pregnancies. Adolescent fertility, characterised by births to women under age 20, account for 11% of all births worldwide. They account for 23% of the overall burden of disease (disability-adjusted life years) due to pregnancy and childbirth. Early childbearing entails an increased risk of maternal deaths or physical impairment. Adolescent fertility rates are high throughout the region, which is the consequence of lack of sexuality education and affordable contraceptives.[20]

Table 12: Adolescent Fertility Rate

Adolescent Pregnancies-Adolescent Birth Rates			
Name of the Country	Adolescent Birth Rates per 1000 women		
	1995	2003	2008
Armenia	66.6	29.2	27.2
Azerbaijan	39	27.4	41.5
Georgia	64.2	33.2	43.8
Hungary	31.4	20.8	19.9
Poland	22	14.7	16.4
Russia	43.9	28	30.1
Ukraine	54.3	29.6	29.9 (2007)

Source: UN MDG Indicators Database: http://unstats.un.org/unsd/default.htm

Young people are not provided with sexuality education and information on contraception methods. The need for SRHR services is also highlighted by the fact that in many countries young people are engaging in sexual activity earlier than they previously did.[21] Moreover, the need to present a prescription and lack of subsidies for contraception are barriers faced by adolescents.

ABORTION

One of the biggest challenges for many women across the CEE region is access to safe, legal abortion.

Although abortion is one of the most contentious issues within the ICPD PoA,[22] it is regarded as an integral component of reproductive health services. The ICPD PoA calls for reducing numbers of abortions through contraception, pre- and post-abortion counselling. The ICPD PoA locates abortion and strategises about it in the context of public health. Furthermore, the ICPD PoA states that all countries should have access to services for the management of complications arising from abortion. The Beijing Platform for Action further contributed to the shift in framing abortion from a public health perspective to a human rights perspective, giving women's groups an opening to frame abortion within a rights perspective.

In this section we examine: the legal status of abortion in the seven countries; changes in the law since ICPD; the extent to which the abortion law is known and acted upon; the incidence of unsafe abortion and percentages of maternal deaths attributed to unsafe abortion. Many of these indicators represent a convergence of health and human rights indicators. Induced abortion remains the major form of birth control among women in CEE, contributing to their excess mortality and preventable morbidity.[23] Reliance on abortion is attributed to limited access to information concerning modern methods of contraception and to widely held misinformation among women regarding family planning and reproductive health.

LEGAL STATUS OF ABORTION IN THE REGION

From the end of World War II, women in most of the former Soviet block had easy access to abortion, which was paid for by social security.[24]

With the striking exception of Poland, liberal abortion laws remain in place in most of these countries and recognise a woman's right to abortion without restriction up to at least 12 weeks of pregnancy. The Polish law criminalises abortion unless the woman's life or health is in danger, the fetus is incurably deformed, or the pregnancy resulted from rape.

The next table maps the grounds on which abortion is permitted in the seven countries. Among the surveyed countries, all countries except Poland have abortion

available on request. Poland has one of the most restrictive abortion regulations in Europe, and it is difficult to obtain lawful abortion even within the frame of restrictive regulation.

Table 13: Grounds on which abortion is permitted in CEE countries

Country	Grounds on which abortion is permitted						
	To save woman's life	To preserve physical health	To preserve mental health	Rape or incest	Foetal impairement	economic or social reasons	On request
Armenia	+	+	+	+	+	+	+
Azerbaijan	+	+	+	+	+	+	+
Georgia	+	+	+	+	+	+	+
Hungary	+	+	+	+	+	+	+
Poland	+	+	+	+	+	-	-
Russia	+	+	+	+	+	+	+
Ukraine	+	+	+	+	+	+	+

Source: World Abortion Policies 2011 (UN)

USE OF CONSCIENTIOUS CLAUSE

Apart from procedural barriers that obstruct women's right to seek lawful abortions, the conscientious clause is the most common obstacle to access abortion, especially in Poland.

Polish legislation has a "chilling effect" on doctors. Fear of consequences and anti-choice bullying stops some doctors from performing even legal abortions or from certifying that a woman needs an abortion unless it is 100% certain that she will not survive birth. Some doctors claim that fetal life should be prioritised. Under the Polish law, the Profession of a Physician Act allows doctors to object to carrying out an abortion based on their conscience. Although doctors using the conscience clause are supposed to refer the woman to another doctor who will perform the service, enabled by a complete lack of mooonitoring of conscientious objection, they often refuse to make referrals. The objections are not always genuine, instead are often the result of anti-choice bullying from the Catholic Church and medical establishment. A doctor who openly performs abortions in a hospital in a small town would be under extreme pressure from the Church, colleagues and anti-abortion activists, so it is likely that instead of insisting on carrying out abortions in a hospital, such doctor would offer women clandestine abortions at high prices in the privacy of private clinic. Clandestine abortions are enormous business with a huge revenue, and the conscientious clause is a powerful tool in the hands of the medical establishment to maintain the status quo. Apart from refusing lawful abortions, medical doctors and staff also use different tactics of discouraging women from claiming their rights. The information provided by doctors is often false, biased, or manipulative. Some doctors go as far as to break the

regulations in force, questioning the referrals for abortion (even they are not authorised to do so), or attempting to make women feel guilty. All in all, the legal framework regulating access to abortion in Poland is so repressive that it functions as a shield to doctors who do not want to perform abortions based on their conscience, and stifles the willingness of others to provide any care that might possibly have an effect on the fetus for fear of consequences.[25]

BARRIERS IN ACCESS TO LAWFUL ABORTION

It is important to underline that conscientious objection is an important barrier impeding women's access to abortion, even if it is allowed according to the law. In Poland, women "seeking to exercise their legal right, even women who meet the legal criteria for abortion usually encounter obstacles that are impossible to overcome."[26] The most important barriers encountered by women who want to terminate pregnancy are institutional – the Polish women's cases in ECtHR that were presented in Chapter 1 concerned women who did not manage to get a referral for abortion or for prenatal testing. In countries where legal status of abortion is more favourable, women often use unsafe abortions or travel for abortion abroad because doctors abuse their power to question women's decisions, making unfavourable comments. Informants from Russia and Georgia pointed to the fact that often the need to travel long distances to medical facilities providing abortions makes women choose unsafe illegal abortion, which does not require them to travel and neglect their every day duties.

CHANGES SINCE ICPD

Imposing restrictions on access to abortion in Poland (1993) led to abortion tourism and the growing involvement of private practice in performing abortions.

Women can locate providers through newspaper advertisements in which such euphemisms as "discrete" , "vacuum", and "all services" signify abortion.[27] The current cost of illegal abortion exceeds now the cost of travel and service cost abroad therefore a growing number of women choose travelling abroad to undergoing an illegal procedure in the country. Women on Web operate a Polish language service for women who want to self-administer medical abortion. The organisation reports that there is a large and constant interest in their services from Polish women. Hungary made its abortion law more restrictive in 2000, imposing the obligation of "counselling" by a health employee whose responsibility is to try to persuade the woman to continue her pregnancy, followed by a mandatory waiting period. The new law also restricted governmental funding of abortion. In Russia, attempts to restrict access to abortion have intensified since 2003. The Governmental Decree significantly reduced the number of social indications for second trimester abortions from 13 to 4. The number of medical indications has also been reduced. Access to second trimester abortion has

been severely restricted by this measure, which could have serious consequences because 6-7% of abortions in Russia are usually performed in the second trimester. Implementation of the WHO definition of live birth and the obligatory registration of all infants born after 22 weeks of pregnancy and/or weighing over 500g has further restricted access to second trimester abortion in the region[28].

Recently Russia (2011), Hungary (2011), and Ukraine (2012) faced attempts to restrict women's access to abortion services. The new Russian bill that was adopted in December 2011 requires a mandatory waiting period before performing an abortion, and allows doctors to abstain from performing abortion. The new Hungarian constitution that came into effect on January 1, 2012 prescribes protection for the foetus, defines marriage as a union between man and woman, states that the family is the basis of the nation's survival and encourages a commitment to have children.

INCIDENCE OF ABORTION

Central and Eastern Europe continue to have the highest abortion rates in the world.[29]

A number of factors contribute to the region's high abortion rate. Post-soviet countries share a history of liberal legislation on abortion, shortages of high-quality modern contraceptives, and a resistance from doctors towards oral contraceptives and surgical sterilisation. Many women from the region still rely on and accept abortion as a means of fertility control. Moreover, any drop in abortion rates is often simply a failure of the registration system. The recent figures likely underestimate the magnitude of the problem, since many abortions are self-induced or performed "under the table". Because of the development of private or commercial delivering of medical aid, a portion of commercial abortions really does not get into official statistics (despite that the law requires to report).

BARRIERS TO ACCESS

Accessing safe abortion in Central and Eastern Europe is more difficult now, not only because of legal barriers.

These barriers may make women turn to unsafe abortion, or make them hesitant to seek care even when urgently needed due to complications of unsafe abortions. Social and cultural beliefs against abortion are other barriers to accessing services. Whether legal or illegal, abortion is frequently censured by religious teachings and ideologies, hidden due to fear of reprisals or because of social condemnation and restrictive laws, whether de facto or de jure.

In the countries of the CEE region, where abortion has historically been available free of cost in the public

sector, health sector reforms have resulted in changes in the cost of abortion services for women. Throughout the region, certain groups such as migrants and those without a permanent address are particularly at risk and may face barriers in accessing care due to bureaucratic obstacles and informal pressure to pay.

Women have to travel long distances to find an abortion provider because many clinics in rural areas have been closed or because there is no gynecologist in the existing facility. Furthermore, the increased cost of an abortion is no longer covered by medical insurance or by the state. This is not a problem for women with means, but poor women, the unemployed, adolescents, displaced women, and vulnerable women in other social categories are the ones who suffer most. The shortage of physicians is a serious challenge in offering abortion services in the poorest countries of Central and Eastern Europe, particularly in countries where only gynecologists are legally allowed to perform these procedures.

In Poland, lawful abortions are difficult to obtain because some hospital directors invoke the conscience clause on behalf of entire facilities.[30] Thus, legal abortions plummeted from 82,000 in 1989 to 641 in 2010. Despite legal commitments to abortion, however, access to abortion services has been challenged in recent years in the CEE region. Concerns about declining birth rates and pressure from local and international religious groups have reduced support for family planning and abortion all over the region. Lack of knowledge about abortion laws – among women and among service providers – continues to be an issue in Poland. Further, the majority of Polish women of a reproductive age haven't had any kind of sexuality education in school and, in most cases, their parents were not able to provide them with knowledge on sexuality either. This often results in situations where women are unable to decipher the most basic messages coming from their body. When this lack of knowledge about sexuality and existing legislative framework overlaps with medical mistakes, it often ends with tragedy.

UNSAFE ABORTIONS

Where induced abortion is restricted and largely inaccessible, or legal but inaccessible, little information is available on abortion practice.[31]

In such circumstances, it is difficult to quantify and classify abortion. Occurrances tends to be underreported in surveys, and unreported or underreported in hospital records. No records are available for women who had complications due to unsafe abortions but who did not seek post-abortion care in public facilities. Therefore, only the "tip of the iceberg" is visible with the number of deaths and the number of women who seek medical care following complications.[32]

Women are often reluctant to admit to an induced abortion, especially when it is illegal, and underreporting occurs even where abortion is legal. When abortions are outside the framework of the law, they may not be reported at all or may be reported as spontaneous abortion (miscarriage). The language used to describe induced abortion reflects this ambivalence. Terms include "induced miscarriage" (*fausse couche provoquée),* "cleaning the belly", "menstrual regulation", and "regulation of a delayed or suspended menstruation". Abortion complications remain one of the leading causes of maternal mortality in many countries of Central and Eastern Europe.[33]

In Russian Federation, 18.5% of all maternal deaths in 2003 were abortion-related. A study conducted in Russian Federation also found that 67% of women who died from abortion-related complications had their pregnancies terminated under non-medical conditions and 78% of these cases consisted of second trimester abortions.[34] It is difficult to understand why so many women continue to submit themselves to unsafe

abortions in non-medical conditions performed by non-medical practitioners in countries where abortion is legal and sterile facilities are available. The fact that one-third of all abortion-related maternal deaths in Russia occur following a pregnancy termination performed in medical facilities is a great concern.[35] The growing number of movements and legislative initiatives in many European countries aimed at prohibiting abortion, together with a dangerous tendency to restrict access to second trimester pregnancy termination in others, represents a significant threat to women's access to safe, legal abortion.

Poland, with its extremely restrictive abortion regulation, presents an interesting phenomenon: overall maternal mortality remains at the level it was prior to the abortion ban, which suggests that illegal abortions are being performed by "white coats" underground. However, the incidence of unsafe abortion still continues to be a pressing problem in the region. Despite permissive laws and a well-developed network of facilities, the incidence of unsafe abortion and the resulting maternal mortality is unacceptably high in Central and Eastern Europe, with one-quarter of all maternal deaths reported to occur as a consequence of abortion.[36] Among the reasons that oblige women to submit themselves to risky procedures are new legislative barriers to accessing pregnancy termination, an unequal distribution of abortion services and healthcare providers, increased costs of abortion services or unofficial payments, together with an increase in the number of impoverished and disadvantaged individuals.

While most abortion-related maternal deaths in the region occur at an advanced gestational age, the increasing number of barriers to accessing a second trimester abortion – changes in the law, or not being eligible for a legal termination, or requirements that include seeking official permission from a large committee deciding on abortions which, thereby limits confidentiality – may hamper any further reduction in the number of women who die as a consequence of abortion. The number of cases of post-abortion morbidity is also high. The high incidence of sexually transmitted infections in many of these countries, the lack of evaluation of the possible presence of infection and the prevention of complications are most probably the causes of the high numbers of complications after induced abortions. Among late complications, most frequently reported were chronic pelvic pain, irregular bleeding and chronic infection. Although women who have their pregnancies terminated in medical facilities die almost exclusively from complications of second trimester abortions, unsafe methods such as the instillation of hypertonic saline or prostaglandins continue to be used for this purpose.

QUALITY OF CARE

Another major regional concern is the poor quality of abortion services, specifically in terms of the technology used, the practice of infection prevention and pain management, patient-provider interactions, the provision of information on the procedure, and appropriate follow-up care, post-abortion contraception, and privacy and confidentiality.

In many countries, out-of-date methods with higher complication rate are still used for the termination of pregnancy in the first and second trimester of gestation.[37] The quality of abortion services remains very poor. Less safe methods, such as dilatation and curettage and general anesthesia are widely used in the

region. Unsafe techniques are also practiced extensively in the case of second trimester abortions.

Throughout the region, there is a strong need to improve the quality of care in abortion services. In some of the countries, only surgical abortion services are provided and most procedures are performed by vacuum aspiration. Outdated protocols of care are being used for vacuum aspiration procedures and doctors are not familiar with current cervical priming techniques. In Armenia, the aspirators in use are models that are 10–15 years old, and it is common practice to perform mechanical dilatation of the cervix prior to aspiration[38]. In Armenia, Mifepristone was registered in 2007 and Misoprostol was registered in 2008, but the medications are not yet readily available. Anecdotal evidence suggests that Misoprostol is being obtained from private pharmacies, where it can be purchased without a prescription. There is some concern among policymakers that women are using Misoprostol to self-induce abortion, but very little information is available on the prevalence of this practice, or on how knowledgeable pharmacists are about using Misoprostol for pregnancy termination. In Russian Federation, the most widespread method is still curettage. One-fourth of abortions in Russian Federation are performed with vacuum-aspiration. In 2006, out of a total 1.6 million abortions in Russian Federation, only 16.7 thousand cases were medical abortions.

The use of medical abortion may also be shaped by norms in clinical practice such as off-label drug use.[39] For example, in Russian Federation, the need for off-label use of Misoprostol in the prescribed Mifepristone regimen has proven a barrier to use of the method. Indeed, several Mifepristone products are currently available in Russian Federation, including Mifegyne, a Russian product called Penkraston and, most recently, the Chinese drug Mifolian.[40] Unlike in many countries of the former Soviet Union, Misoprostol is also available in Russian Federation. Nevertheless, Misoprostol is only registered for gastro-intestinal indications, and Russian providers are reluctant to use it for off-label indications. As a result, very few providers offer medical abortion.[41]

Ukraine has tried to realise the WHO recommendations, according to which manual or electric vacuum aspiration together with a medical method of abortion (a combination of Mifepristone followed by a prostaglandin) are most appropriate techniques in the first trimester. Safe abortion techniques, including manual vacuum aspiration under local anesthesia and medical abortion, are slowly being implemented, especially in Ukraine. In Poland, where abortion is provided in very limited circumstances, anecdotal evidence suggests that providers are using medical abortion. Nonetheless, under such circumstances, lack of proper training of medical personnel and inadequate information may inhibit women's access to this method and to good quality services.

There is no consistent policy regarding pain management. most women pay an additional cost for general anaesthesia, which is not included in the price for the procedure. Women who are unable to afford general anaesthesia are offered local anaesthesia. Thus, one of the most urgent tasks for the public health in the region is quality improvement of induced abortion technique.

Moreover, abortion in CEE is often performed in poor conditions. Widespread shortages of equipment and medications, crowded facilities, poor hygienic conditions, lack of training, use of out-dated abortion technologies, inadequate standards and guidelines, and the fact that post-abortion contraception is often not provided, combine to create an unnecessarily low standard of care. Although many fewer women die from abortion-related causes in Europe than in other parts of the world, abortion-related deaths represent just over a quarter of maternal deaths in the region – an unacceptably high toll.

OVERVIEW REGARDING ABORTION

It has been almost twenty years since ICPD, and women are still dying from abortion in Europe.

Reliance on abortion for fertility control is still wide-spread and widely accepted, resulting in some of the highest abortion rates in the world. Governments' commitments to making abortion accessible to women must also be followed up with programme implementation through the provision of service, facilities and personnel trained on procedures.

On the other hand, the access for women in Central and Eastern Europe and Central Asia to safe, legal abortions is substantially better than in other parts of the world. Abortion laws are liberal in almost all the countries in these regions and, in most cases, pregnancy terminations are performed in medical settings by qualified physicians, using approved medical techniques. However, the situation is far from perfect, since abortion rates remain extremely high and too many women continue to die from abortion-related complications. Although numbers of abortions have fallen significantly in Eastern Europe over the last decade, both in rates and in absolute numbers, this region continues to have the highest abortion rates in the world. Concerted efforts by governments, professional associations, and international donors are needed to reduce the consequences of unsafe abortion. Unsafe abortion and its consequences remain a significant maternal health issue in areas where safe abortion services are highly restricted, lacking, or of poor quality.

Although access to safe abortion services has been linked with a lower incidence of unsafe abortion (and lower percentages of maternal deaths due to unsafe abortion), progress on amending laws seems slow. Although most countries have made some provisions for post-abortion care after ICPD, there is still a challenge to shift the paradigm to providing abortion upon request, and within the public health system in countries with restrictive laws,.

PREGNANCY & CHILDBIRTH-RELATED MORTALITY AND MORBIDITY

In this section we will focus on the aspect of the prevention of maternal deaths and examine measurements of maternal mortality such as the maternal mortality ratio (MMR), lifetime risk of maternal death, and interventions to prevent maternal deaths such as EmOC, skilled attendants at birth and post-partum care. Maternal health refers to a woman's overall physical, mental, and emotional health and well-being during and before pregnancy. A maternal death is "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration or site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental causes".[42] The direct causes of maternal deaths worldwide are haemorrhage, sepsis, obstructed labour, preeclampsia and eclampsia or the hypertensive disorders of pregnancy, and complications from unsafe abortion. The most important fact about maternal deaths is that these complications cannot be predicted or prevented, except those resulting from unsafe induced abortion. All pregnant women are at risk of developing complications at any time during pregnancy, at delivery, or in the postpartum period. Improvements in maternal health due to changes

in health habits and better life conditions are not accompanied by reductions in maternal mortality.

Recent reforms in the health sector in CEE have had an unfavourable effect on women's maternal health. It was mentioned that rates of death after unsafe abortion continue to be high throughout the region. This is an especially interesting phenomenon of the CEE, as the region continues to have high level of births attended by professionals.

The strategies needed to reduce maternal mortality – increased access to emergency obstetric care (EmOC) during pregnancy and childbirth – must be considered when setting priorities, framing strategies, designing programmes, and choosing indicators to use for monitoring and evaluation of maternal health and mortality. This has significant repercussions on the allocation of financial, human, and technological resources. All women should have access to EmOC and a package of critical health services which, when provided immediately and competently, can save their lives.

PREVENTION OF MATERNAL DEATHS

Globally, an estimated 287,000 maternal deaths occurred in 2010, a decline of 47% from levels in 1990. The global MMR (Maternal Mortality Rate) in 2010 was 210 maternal deaths per 100,000 live births, down from 400 maternal deaths per 100,000 live births in 1990. The MMR in developing regions (240) was 15 times higher than in developed regions (16). The maternal mortality rate for the Caucasus and Central Asia region is 46.[43] In the CEE region, the MMR is below 40, with the highest in Russia (39) and Azerbaijan (38) and the lowest in Poland (6). Despite this decrease in the maternal mortality ratio in most countries of the CEE region, it remains high and exceeds the average rates for EU new member states (less than 10 maternal deaths per 100,000 live births), and is noticeably higher than in the group of the EU-15 countries (less than 6 maternal deaths per 100,000 live births).[44]

Table 14: Maternal Mortality Ratio per 100,000 live births

Maternal Mortality Ratio (MMR, Deaths per 100 000 live births)				
Name of the Country	Estimated MMR			
	1995	2005	2008	Lifetime Risk of Maternal Death, 1 in:
Armenia	44	32	29	1900
Azerbaijan	79	44	38	1200
Georgia	58	52	48	1300
Hungary	23	10	13	5500
Poland	17	5	6	13300
Russia	74	39	39	1900
Ukraine	49	26	26	3000

Sources: Trends in maternal mortality estimates developed by WHO, UNICEF, UNFPA and World Bank 2010, Data Source 2008 http://whqlibdoc.who.int/publications/2010/9789241500265_eng.pdf

ACCESSIBILITY TO MATERNAL HEALTHCARE SERVICES AND INFORMATION

The most important barriers are inequity in the distribution of qualified service providers, the cost of services, a lack of public awareness, gender inequality and the lack of transportation to services.

No groups are officially excluded from accessing services and/or information in any countries. However, there is some evidence that in practice some groups such as Roma, young people and asylum seekers feel excluded and that poorer women and Roma women are less likely to use such services. In general, the impact of the range of barriers to care is well understood but may not be evidence-based. Unequal provision of services and lack of access are issues in Georgia and Azerbaijan. The impact of informal payments is an important factor in Azerbaijan, Georgia, Hungary and Russia. The majority of maternal care is provided through public services with the exception of Georgia, where 100 percent of care is provided by private facilities. Maternal health care is free of charge in Armenia. Recently introduced monetary incentives to service providers' salary structures have reduced occurrences of informal payments by patients.[45] This initiative had a positive impact on making maternal health services more accessible. Barriers to access to care include poverty and geography, the latter for women who live in mountainous regions. The lack of reproductive health services, including maternal health care provided at the primary health level, forces women from rural areas to travel to district and regional centres to receive RH and maternal care. As a result, women may experience problems associated with cost and availability of transport. It is possible that the relatively low level of antenatal care and higher level of home births among rural and lower-income women are related to issues of access to care and information.[46]

ANTENATAL CARE

WHO recommends a minimum of four antenatal visits based on a review of the effectiveness of different models of antenatal care.

This takes into account important services like the treatment of hypertension to prevent eclampsia, tetanus immunisation and micronutrient supplementation. The antenatal care coverage (of at least four visits) is defined by the percentage of women aged 15-49 with a live birth in a given time period who received antenatal care four or more times with any provider (whether skilled or unskilled).

In Armenia, ANC coverage is very high with 93% of women receiving professional help during pregnancy and an estimated 71% participating in at least four antenatal visits, (the WHO recommended minimum). The DHS identifies a slight disparity between urban and rural populations (94% and 83% respectively).[47]

There are varying estimates of the level and content of antenatal care in Azerbaijan. Official statistics indicate

94% of women have at least one care visit. The number of women receiving the WHO recommendation of four visits is estimated at 45%. In Azerbaijan, domestic violence has been linked to a loss of independence, a loss of access to reproductive health services and to selective abortion. The Ministry of Health estimates that domestic violence accounts for 8% of maternal mortality by limiting access of women to antenatal care.[48] In Georgia, 95% of women receives at least one ANC visit with 75% receiving at least four prenatal care visits, which was more common among women in urban areas (86%) than in rural areas (64%).[49] ANC is assumed to be nearly universal in Hungary, Poland and Russian Federation along with multiple visits during the pregnancy.

INTERVENTIONS TO PREVENT MATERNAL DEATHS

Emergency Obstetric care is recognised as key to maternal mortality reduction.

The provision of EmOC is the core component of any programme to reduce maternal deaths. A health facility that provides administration of antibiotics, oxytoxics, and anticonvulsants, manual removal of placenta or other retained products of pregnancy, and an assisted vaginal delivery is considered a Basic EmOC facility. A health facility that provides all the six interventions of the Basic EmOC, plus caesarean section and safe blood transfusion facilities is considered a Comprehensive EmOC facility. WHO, UNICEF, and UNFPA, issued the guidelines for the monitoring and availability of EmOC in 1997.

The majority of the countries in CEE meet the UN recommendation of four basic emergency obstetric care facilities per 500,000 people.50 There are 64 maternity hospitals providing emergency obstetric care in Armenia.[51] Of these, 10 are health centres with intake of up to 100 deliveries per year providing basic emergency obstetric care, and there are 54 hospitals which can provide comprehensive emergency obstetric care. Some 300 health-care facilities provide emergency obstetrics (EmOC) care in Azerbaijan,[52] which equates to over 17 centres per 500,000 people, exceeding the UN Process Indicator for EmOC guidelines. obstetric care in Georgia is provided by 97 units nationally.[53] Two units provide comprehensive emergency obstetric care (EmOC) representing 0.21 comprehensive units per 500,000 people, (where the UN Process Indicators recommendation is for 1 per 500,000). The Russian Federation ratio is 148 in 500,000.[54] The level of

Table 15: Antenatal care coverage (number of visits)

Antenatal Coverage						
Name of the Country	Antenatal Coverage					
	At least 1 visit			4 visits		
	1995	2003-2005	2008-2010	1995	2003-2005	2008-2010
Armenia	82% (1997)	93% (2005)	93% (2005)	64.7% (2000)	70.9% (2005)	N/A
Azerbaijan	98.3% (1997)	76.6 (2006)	76.6 (2006)	30.4% (2001)	N/A	45.2% (2006)
Georgia	74% (1997)	94.3	94.3	N/A	75% (2005)	N/A
Hungary	N/A	N/A	N/A	N/A	N/A	N/A
Poland	N/A	N/A	N/A	N/A	N/A	N/A
Russia	N/A	N/A	N/A	N/A	N/A	N/A
Ukraine	N/A	98.5% (2005)	98.8% (2007)	N/A	N/A	74.8% (2007)

Source: UN MDG Indicators Database http://unstats.un.org/unsd/default.htm

geographical coverage is high with only very remote areas (with low population density) likely to have gaps in provision. Throughout the health sector, there is an ongoing tendency towards inpatient care and overuse of the hospital system. Arguably, maternal care is over-medicalised with high numbers of ANC visits per pregnancy and high levels of hospitalisation of women during pregnancy. Over-medicalisation of pregnancy as a mean to secure regular out-of-pocket payments from patients is being reported by researchers analysing Russian, Polish and Hungarian antenatal services.

SKILLED ATTENDANTS AT BIRTH

A skilled attendant, according to WHO, refers to "an accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns". Traditional Birth attendants (TBA), either trained or untrained, are excluded from the category of skilled health workers.

Table 16: Skilled Health Attendants at Birth

Skilled health attendants at birth				
% skilled health worker (doctors, nurses, midwifes and other cadres of health workers)				
Name of Country	1995	2005	2007	ICPD/ ICPD+15 targets for 2015 met?
Armenia	97.3 (1997)	97.8	99.9	yes
Azerbeijan	99.8 (1998)	99.7 (2004)	88.0 (2006)	yes
Georgia	90.8 (1993)	98.3		yes
Hungary	99.4	99.6	99.5 (2008)	yes
Poland	99.8 (2002)	99.9		yes
Russia	99.1	99.4	99.6 (2008)	yes
Ukraine	99.6 (1996)	99.8	99.7	yes

Source: MDG indicators official website

It was agreed at the ICPD, that all births should be assisted by trained persons, preferably nurses and midwives, but at least by trained birth attendants. Across Eastern Europe and Central Asia, the percentage of antenatal care coverage (with at least one visit to antenatal services) and the presence of a skilled attendant at birth are generally high. In many countries antenatal services coverage is almost universal and generally, across the region, there is evidence of a steady improvement in both indicators.[55] Information on the number of women receiving a minimum of four episodes of ANC, as recommended by WHO, is not uniformly accessible. In Hungary, Roma women tend to have lower access and usage of these services. In Armenia, where the vast majority of deliveries are within health facilities (97%) and are attended by a doctor, the proportion of home births has declined. According to official data, the national rate of attended births is 88% in Azerbaijan. Almost all deliveries occur at maternity hospitals and, in rare cases, at regular or peripheral hospitals, village ambulatories or "feldsher accoucher" posts (FAP) in rural areas. In Georgia, the rate of births attended by a skilled professional is high at 92%. The place of delivery provides insight into the access and use of emergency obstetric care. National statistics indicate that 98.5% of all deliveries took place in healthcare institutions, while the reproductive health survey estimates a rate of 92.5% which raises the potential for the underreporting of home births.[56] In Hungary, Poland, Russia and Ukraine, 99% of births are delivered by professionals.

POSTNATAL CARE[57]

A large proportion of maternal deaths occur during the first 24 hours after delivery. Hence, postnatal care constitutes a critical safe pregnancy intervention.

The first two days following delivery are critical for monitoring complications arising from the delivery. The high level of skilled birth attendance at births means that majority of women receive postnatal checkups from skilled health professional within two days after the delivery in all of the surveyed countries. Azerbaijan has the lowest level of attended births (the 2006 DHS estimated a level of 89%). The DHS estimated that 78% of births took place in a health facility. There are marked differences between rates in rural (less than 66%) and urban (91%) areas.[58] The place of delivery can provide an indication of access to emergency care and the disparity may indicate problems with access to care. There is some evidence of a move away from deliveries in health centres in the early 2000s due to the cost of care. The 2001 reproductive health survey estimated that 36% of rural women delivered at home and that income is a key factor, with lower income women four times more likely to have a home delivery.[59] According to DHS (2006), Azerbaijan has the highest number of women who do not receive postnatal checkup.

OVERVIEW FOR PREGNANCY & CHILDBIRTH-RELATED MORTALITY AND MORBIDITY

The right to the highest attainable standard of sexual and reproductive health is enshrined in the ICPD PoA and safe pregnancy is essential to every woman's right to life and dignified well-being.

Governments in the region have to be accountable to women, ensuring that pregnant women do not die or experience poor quality of life resulting from the complications of pregnancy. From what we have already seen, the seven countries have made progress in reducing their maternal mortality.

EmOC is a critical intervention for addressing high maternal deaths. The ICPD PoA notes that every birth should be attended by a skilled attendant, and the ICPD+5 target reiterates that at least 80% of births should be assisted by skilled attendants by 2005. This goal has been met by surveyed countries.

No groups are formally excluded from reproductive health-care information and services. However, socio-economic and geographical factors have resulted in unequal access to care in Armenia, Azerbaijan, and Georgia. The CEE region achieved the ICPD targets for maternal mortality, but there is space for improvement in other areas. The tendency to criminalise abortion is an important signal suggesting that there might be increases in MMR related to unsafe abortions in the region.

A noteworthy success has been the Human Rights Council Resolution on maternal mortality and morbidity.

The Human Rights Council, at its eleventh regular session in 2009, adopted a landmark resolution on "preventable maternal mortality and morbidity and human rights".[60] In this resolution, governments expressed grave concern for the unacceptably high rates of maternal mortality and morbidity, acknowledged that this is a human rights issue and have committed to enhance their efforts at the national and international levels to protect the lives of women and girls worldwide.

The political will of the state is crucial to prevent maternal mortality and morbidity, which violate a woman's right to life. Resource allocation, coupled with the political will of the state and international donors in prioritising and financing maternal health interventions, can make a huge difference in further reducing the number of maternal deaths. It is time to act, to ensure that all women go through a safe and fulfilling childbirth experience. The responsible stakeholders need to be held accountable to ensure women do not die unnecessarily.

REPRODUCTIVE CANCERS[61]

The health transformation that took place after the Second World War in Europe was significantly delayed in CEE countries, compared to countries in Western Europe.

However, as death rates from cardiovascular disease began to fall, since the 1990s, cancer has emerged as the most common cause of death among young and middle-aged adult women (20-64 years old) in these countries. In the coming decade, it seems likely to be the leading cause of death among young and middle-aged adult men.

In CEE countries, deficiency of primary prevention is a main reason for poor health consciousness, (the consequence of smoking, fatty diet and low physical activity). Late introduction of secondary prevention responses results in worsening survival rates of cancer patients. However, tertiary prevention is implemented in a similar way as in Western Europe.

The 58th World Health Assembly resolution on cancer prevention and control (WHA58.22) adopted in May of 2005, calls on member states to intensify action against cancer by developing and reinforcing cancer control programmes. The resolution recognises that, of all cancer sites, cervical cancer – causing 11% of all cancer deaths in women in developing countries – has one of the greatest potentials for early detection and cure and that cost-effective interventions for early detection are available, yet not widely used. The resolution also recognises that the control of cervical cancer will contribute to the attainment of international development goals and targets related to reproductive health. Reproductive cancers include breast, ovarian, endometrial, and cervical cancers. Both cervical cancer and breast cancer are at epidemic proportions. Cervical cancer accounts for approximately 12% of all cancers in women. It is the second most common cancer in women worldwide.

CERVICAL CANCER

At the beginning of the 21st century, the annual number of new cases of cervical cancer in CEE was estimated to be 13,000 (whereas in the EU-15 the corresponding figure was 24,000). In 2002, in CEE, almost 5,700 deaths from cervical cancer were recorded, (whereas in the EU-15 the figure was about 5,800). In the same year, the mortality rate in CEE (7.1/100,000) was more than four times higher than in the EU-15 (1.7/100,000). In Western Europe, there was a continuing decrease in mortality from cervical cancer in all age groups throughout the last half of the twentieth century. Over that period, death from cervical cancer, especially in some North European countries became very rare. This continuous decline was in sharp contrast with the situation in Central and Eastern Europe. Cervical cancer mortality has been significantly higher in each of the CEE countries than the average for the entire EU-15. The decline observed in some CEE states, (Hungary and Poland), began much later, (in the 1970s and 1980s), and has been much slower than in the EU-15. However, in the former Soviet republics there has been a continued increase in cervical cancer mortality.[62] Apart from the cost, it is important to have a functional health system, including trained health professionals, to deal with prevention, treatment and care of reproductive cancers.

BREAST CANCER

Breast cancer is the most common cancer and one of the leading causes of death among women internationally.

Breast cancer is another disease where screening and early treatment have been successful in reducing the mortality substantially. In CEE, 41,000 women annually are diagnosed with breast cancer. Most breast cancers, when detected early, can be cured if properly managed. The geographic distribution of mortality from breast cancer across CEE and CIS appears to be more influenced by differences in the efficacy of the health systems than by differences in the background risk of the disease.[63] Armenia, Georgia and Ukraine currently have the highest percentage of mortality from breast cancer, with figures exceeding 20.[64] According to the Bulletin of National Cancer Registry in Ukraine, only 46.2% of female patients in Ukraine were diagnosed with breast cancer during preventive medical investigations, among all newly diagnosed in 2009. Among all newly diagnosed cases 21.7% were in II and IV stages.[65] Early detection through proper screening and improvements in therapy reduces mortality, but unfortunately, early detection and therapy are inaccessible to large segments of the population in the region.

OVERVIEW REGARDING REPRODUCTIVE CANCERS

Inadequate health care infrastructures and standards, socio-cultural barriers, and economic realities hamper prevention, treatment and care of reproductive cancers. The governments present growing commitment towards prevention and screening measures for reproductive cancers.

CONCLUSION

Reviewing the reproductive health and reproductive rights indicators across the seven countries, certain conclusions can be made.

Progress across the region is uneven and slow with regards to reproductive health and reproductive rights. The political will of governments is crucial in making laws, allocating resources, and deploying trained staff. Across the CEE, access for marginalised groups is a concern. In all countries, women who are poor, less educated, live in remote areas and/or rural areas face greater difficulties in accessing services and realising the autonomy of their bodies. Women from ethnic minorities, women from lower classes, and younger women are also marginalised. This happens regardless of whether the service they require access to is contraception, maternal health services, safe abortion services, or the prevention and treatment of reproductive cancers. Reproductive health and reproductive rights are an issue of socio-economic equity as well as gender equity.

ENDNOTES

1 ICPD PoA. Available at: http://www.unfpa.org/public/home/sitemap/icpd/International-Conference-on-Population-and-Development/ICPD-Programme

2 The Constitution of the Republic of Armenia, http://www.president.am/library/constitution/eng/?chapter=1

3 Sexual and Reproductive Health and Rights in Europe. Report to the European Union. ASTRA Network 2006.

4 Ibidem.

5 A Review of Progress in Maternal Health in Eastern Europe and Central Asia, UNFPA 2009, p.57.

6 The Constitution of Hungary, http://reproductiverights.org/sites/crr.civicactions.net/files/documents/CRR_HWL_Constitution_comments_Hungary_March_2011FINAL.PDF

7 ASTRA Network Country Report: Russia, Boris Denisov, 2012 (unpublished).

8 ASTRA Country Report: Ukraine, Mariia Telishevska and Olexandra Sluzhynska, 2012 (unpublished).

9 http://www.who.int/whosis/indicators/compendium/2008/3pcf/en/index.html

10 Sexual and Reproductive Health and Rights in Europe. Report to the European Union. ASTRA Network 2006.

11 ASTRA Country Report: Armenia, 2012, Gohar Shahnazaryan and Anush Poghosyan (unpublished), ASTRA Country Report: Azerbaijan, 2012, Sudaba Shiraliyeva (unpublished), ASTRA Country Report: Georgia, 2012, Georgi Soselia (unpublished).

12 CEE Bulletin on Sexual and Reproductive Rights, No 08 (99) 2011.

13 ASTRA Network Country Report: Armenia, Gohar Shahnazaryan and Anush Poghosyan, 2012 (unpublished).

14 UN Population Division, Fertility and Family Planning Section, https://www.un.org/esa/population/publications/WCU2009/Metadata/UMN.html

15 See Reasons for discontinuation of contraceptive methods table in the annex.

16 Contraception- abortion connections in Armenia, DHS Analytical Studies, Westoff, C. F., Sullivan, J.M., Newby, H.A. and Themme, A.T. (2002). *Contraception– Abortion Connections in Armenia*. DHS Analytical Studies No. 6. Calverton, Maryland: ORC Macro.

17 ASTRA Network Country Report: Armenia, Gohar Shahnazaryan and Anush Poghosyan, 2012 (unpublished); ASTRA Network Country Report: Georgia, Georgi Soselia, 2012 (unpublished); ASTRA Network Country Report: Ukraine, Maria Telishevska, 2012 (unpublished); ASTRA Network Country Report: Azerbaijan, Sudaba Shiraliyeva, 2012 (unpublished).

18 Michael E. Thompson, Tsovinar L. Harutyunyan, Contraceptive practices in Armenia: Panel evaluation of an Information-Education-Communication Campaign, Social Science & Medicine 63 (2006) 2770-2783.

19 Federation for Women and Family Planning, 2011.

20 World Health Organization (WHO). (2009). Adolescent Pregnancy. Retrieved September 25, 2009, from WHO Web site: http://www. who.int/making_pregnancy_safer/topics/adolescent_pregnancy/en/ print.html

21 Sexual health: why pay attention to this issue during adolescence? Fact sheet, WHO Europe, 2012, http://www.euro.who.int/__data/assets/pdf_file/0004/163516/HBSC-Fact-sheet-sexual-activity.pdf

22 The paragraph 8.25 which specifies "abortion, where legal" has limited application in changing prohibitive national laws and in extending access to abortion beyond the time-limit specified by the law. This hampers efforts to concretise women's reproductive rights in many countries of the world.

23 Recent Trends in Abortion and Contraception in 12 Countries, DHS Analytical Studies, ORC Macro, Calverton, Maryland, 2005.

24 Kovacs, L. (2007). Abortion and contraceptive practices in Eastern Europe, International Journal of Gynecology & Obstetrics 58 (1997) 69-75.

25 Contemporary Women's Hell. Polish Women's Stories. Polish Federation for Women and Family Planning, Warsaw 2005.

26 Contemporary Women's Hell. Polish Women Stories. Polish Federation for Women and Family Planning, Warsaw, 2005. p.5

27 Mishtal, J. (2010) Neoliberal reforms and privatization of reproductive health services in post-socialist Poland, in: Reproductive Health Matters, Volume 18, Number 36, November 2010, pp. 56-66.

28 Zhirova, I., Frolova, O.G., Astakhova, T.M., Ketting, E.(2004) Abortion-related maternal mortality in the Russian Federation. Stud. Fam. Plann. 2004;35(3):178–88.

29 Hodorogea, S., Comendant, R. (2010). Prevention of unsafe abortion in countries of Central Eastern Europe and Central Asia, International Journal of Gynecology and Obstetrics 110 (2010) S34- S37.

30 Mishtal, J. (2010): Neoliberal reforms and privatization of reproductive health services in post-socialist Poland, in: Reproductive Health Matters, Volume 18, Number 36, November 2010, pp. 56-66.

31 Unsafe Abortion. Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008, WHO.

32 Hodorogea, S., Comendant, R. (2010). Prevention of unsafe abortion in countries of Central Eastern Europe and Central Asia, International Journal of Gynecology and Obstetrics 110 (2010) S34- S37.

33 Ibidem.

34 Zhirova, I., Frolova, O.G., Astakhova, T.M., Ketting, E.(2004) Abortion-related maternal mortality in the Russian Federation. Stud. Fam. Plann. 2004;35(3):178–88.

35 Ibidem.

36 Ibidem.

37 Hodorogea, S., Comendant, R. (2010). Prevention of unsafe abortion in countries of Central Eastern Europe and Central Asia, International Journal of Gynecology and Obstetrics 110 (2010) S34- S37.

38 Ibidem.

39 Abortion in Europe. Entre-Nous. The European Magazine for Sexual and Reproductive Health, No. 59-2005.

40 Ibidem.

41 Hodorogea S., Comendant R. (2010). Prevention of unsafe abortion in countries of Central Eastern Europe and Central Asia, Intrenational Journal for Gynecology and Obstetrics 110 (2010) S34-S37.

42 WHO, Health statisctics and health information systems, http://www.who.int/healthinfo/statistics/indmaternalmortality/en/index.html

43 Trends in Maternal Mortality 1990 to 2010. Who, UNICEF, UNFPA and The World Bank Estimates, WHO 2012.

44 Abortion in Europe. Entre-Nous. The European Magazine for Sexual and Reproductive Health, No. 59-2005.

45 Delivery is free of charge for all women; however, the funds allocated to cover this commitment are not adequate to pay for any medical interventions resulting from complications. To improve access to and quality of maternal and newborn care in 2008, the government almost doubled financing of perinatal services and introduced "birth certificates". For each woman who delivers a baby, the government allocates approximately $350 to a health facility and 60 percent of this money can be used for salaries of health staff. This system motivates personnel to improve the quality of offered services and also substantially increases access of pregnant women to medical care. In: A Review of Progress in Maternal Health in Eastern Europe and Central Asia, UNFPA 2009.

46 A Review of Progress in Maternal Health in Eastern Europe and Central Asia, UNFPA 2009.

47 Ibidem

48 Ibidem

49 ASTRA Network Country Report: Georgia, Georgi Soselia, 2012 (unpublished)

50 A Review of Progress in Maternal Health in Eastern Europe and Central Asia, UNFPA 2009

51 Ibidem

52 Ibidem.

53 Ibidem

54 Ibidem.

55 A Review in Progress in Maternal Heath in Eastern Europe and Central Asia, UNFPA, http://www.unfpa.org/webdav/site/global/shared/documents/publications/2009/maternal_health.pdf

56 Ibidem

57 See Postnatal care table in the annex

58 Azerbaijan Demographic and Health Survey 2006 (2008). State Statistical Committee (SSC) [Azerbaijan] and Macro International Inc.

59 Centres for Disease Control and Prevention: Reproductive Health Survey Azerbaijan, 2001, quoted in National Strategy On Reproductive Health 2008—2015,

60 UN Human Rights Council Adopts Landmark Resolution on Maternal Mortality: Governments commit to promoting women and girls' health and rights. (2009). Retrieved Aug 2, 2009, from International Initiative on Maternal Mortality and Human Rights Web site: http://righttomaternalhealth.org/node/106

61 For reproductive cancers data check table in the annex.

62 Zatoński, W., Didkowska, J. (2008). Closing the gap: Cancer in Central and Eastern Europe (CEE), European Journal of Cancer, Volume 44, Issue 10, 1425-1437, July 2008.

63 Ibidem.

64 GLOBOCAN 2008 Cancer Incidence, Mortality and Prevalence Worldwide in 2008; http://globocan.iarc.fr/

65 CANCER IN UKRAINE, 2009 - 2010 Bulletin of national cancer registry of Ukraine KYIV, 2011

CHAPTER 4

SEXUAL HEALTH AND SEXUAL RIGHTS

This chapter deals with sexual health and sexual rights. Under sexual health, we will look at sexuality education, sexually transmitted infections (STIs), and HIV/AIDS.

Within HIV/AIDS, we will focus on HIV prevalence and incidence rates, vulnerability and feminisation of HIV/AIDS, laws and policies for people living with HIV/AIDS, programmes for access to voluntary counselling and testing and anti-retroviral therapy and integration of sexual and reproductive health services with HIV/AIDS services. The second section of this chapter will look at sexual rights, although it is a highly contested term in international arenas. "Sexual rights embrace human rights that are already recognised in national laws, international human rights documents and other consensus documents. These include the right of all persons, free of coercion, discrimination and violence, to: the highest attainable standard of health in relation to sexuality, including access to SRH care services; seek, receive and impart information in relation to sexuality; sexuality education; respect for bodily integrity; choice of partner; sexuality education; decide to be sexually active or not; consensual sexual relations; consensual marriage; decide whether or not, and when to have children; and pursue a satisfying, safe and pleasurable sexual life."[1] This WHO working definition is wholly consistent with and does not deviate from the principles of the ICPD PoA.[2] This review seeks to enunciate separately the different components of sexual rights in order to build the discourse and create support for the language among governments and civil society.

We will also look at important indicators of sexual rights. In order to determine the rights around choice of partner, decision to be sexually active or not, consensual sexual relations and consensual marriage, we choose to look at the existence of arranged marriages and forced marriages. As indicators of bodily integrity we look at traditional practices harmful to women and laws on sexual violence and trafficking. As indicators of the rights to the highest attainable standard of health in relation to sexuality, in choice of partner, in consensual sexual relations and to pursue a satisfying, safe and pleasurable sexual life we look at laws around sex work, same sex sexual relations and transgender people.

SEXUALITY EDUCATION

In this section, we will look at adolescent rights and their access to information, education and services.

Therefore, it is important to assess the accessibility of sexuality education and quality of the school curricula. Moreover, we will examine young people's access to service provision for adolescents in terms of their rights: to the highest attainable standard of health in relation to sexuality, including access to SRH care services; to seek, receive and impart information in relation to sexuality; to sex and sexuality education; and to decide to be sexually active or not. These rights have been recently recognised by the 2012's Commission on Population and Development in its Resolution on adolescents and youth.[3]

Today's adolescents face increasing pressures regarding sex and sexuality, with conflicting messages and norms. Sexual activity generally begins at an earlier age than in the past, but young people have inadequate access to accurate information about safe sex and contraception and the percentage of adolescents who are informed and aware of specific methods of contraception and

Sexually Transmitted Infections (STIs) decreased in recent years.[4] Often, sexuality is portrayed in many sexuality education and health information programmes as negative and associated with guilt, fear and disease. The media often provide mixed messages, sometimes distorted or inaccurate and other times very positive.[5] The ICPD PoA acknowledges that adolescents have sexual and reproductive health (SHR) needs that must be addressed. It urges governments to address adolescent SRH issues, including unwanted pregnancy, unsafe abortion and sexually transmitted diseases, including HIV/AIDS, through the promotion of responsible and healthy reproductive and sexual behavior, including voluntary abstinence, and the provision of appropriate services and counselling specifically suitable for that age group.

Table 17: Adolescent Pregnancies – Adolescent Birth Rates

Adolescent Pregnancies-Adolescent Birth Rates			
Name of the Country	Adolescent Birth Rates per 1000 women		
	1995	2003	2008
Armenia	66,6	29,2	27,2
Azerbaijan	39	27,4	41,5
Georgia	64,2	33,2	43,8
Hungary	31,4	20,8	19,9
Poland	22	14,7	16,4
Russian Federation	43,9	28	30,1
Ukraine	54,3	29,6	29.9 (2007)

Sources: UN MDG Indicators Database http://unstats.un.org/mdg/Default.aspx; For Georgia- National Statistics; For Ukraine: UNSD&WPP2008

The lack of comprehensive sexuality education is the most burning issue of the region that is being reflected in high teen pregnancy rates and high HIV/AIDS prevalence among young people.

Table 18: Estimated young people living with HIV (2009)

Estimated People living with HIV (2009)							
	Armenia	Azerbaijan	Georgia	Hungary	Poland	Russian Federation	Ukraine
Young women (15-24) prevalence (%)	<0.1	0.1	<0.1	<0.1	<0.1	0.3	0.3
Young men (15-24) prevalence (%)	<0.1	<0.1	<0.1	<0.1	<0.1	0.2	0.2

Source: (http://www.unaids.org/documents/20101123_GlobalReportAnnexes1_em.pdf)

Sexuality remains taboo and official institutions tend to expect families to take care of sexuality education.[6] However, parents who also had no sexuality education at school are not prepared to perform this task.[7] In all surveyed countries, there are peer education and outreach programmes, but their coverage is limited. In Armenia, a sexuality education course is elective and provided on voluntary basis (since 1995). The instruction on sexual and reproductive health is included in the "Healthy Lifestyle" curriculum but it provides only very superficial and biased information promoting nuclear heterosexual family and stereotypical gender roles. Sexuality education is included in the curriculum in Azerbaijan. A survey performed in 2007 in Azerbaijan found that there was unmet need for sexuality education in the country. Sexuality education and information on SRHR are not included in the school curricula in Poland, Russian Federation and Ukraine, where young people are forced to look for information in alternative sources. In Georgia, incorporation of the principles of the "National Concept and Curriculum on Healthy and Harmonious Education" developed within the framework of the UNFPA's Reproductive Health Initiative for Youth in South Caucasus (RHYIC) project in the National Educational Plan, was approved by the Ministry of Education in 2011. This was a big step forward to provide a solid foundation for formal education on RH issues.[8] A new initiative by the Hungarian Government (2012) is to replace the existing sexuality education programme with more uniform teaching on family values and promotion of sex abstinence.[9] Knowledge on HIV/AIDS prevention

among young people is yet another concern. According to the Georgian Adolescent RH Survey (2009), only two adolescents out of every five respondents know that HIV cannot be transmitted via mosquito bite.[10] A similar lack of information is reflected in reports by Polish Group of Peer Sex Educators PONTON, affiliated with the Federation for Women and Family Planning.

YOUNG PEOPLE'S ACCESS TO SRH SERVICES

The Millenium Development Goal for HIV reduction states that, by 2010, "95% of young people should have access to [information, life skills and] services".

The attempt to provide young people with tailor-made SRH services is reflected in activities of UN agencies, NGOs and some governments. However, in countries like Poland and Hungary, reproductive health services are not effectively included in the network of adolescent clinical services.

The gold standard for adolescent-friendly SRH services is that they are "safe, effective and affordable; they meet the individual needs of young people who return when they need to and recommend these services to friends".[11] However, the CEE region lacks youth-friendly sexual and reproductive health facilities and approach. Cultural barriers and stigma, a lack of comprehensive youth policies to further promote and institutionalise youth-friendly SRH services, healthy life-style and information are the main challenges to address.[12]

In 2006, UNFPA launched a three-year regional project, the Reproductive Health Initiative for Youth in the South Caucasus, to be implemented in Armenia, Azerbaijan and Georgia.[13] Within the framework of the project, 12 youth-friendly clinics and 12 youth information centers were established and are still operating in Azerbaijan.

In Armenia, some 32 youth friendly centers were established in the country.[14] Half are affiliated with a healthcare institution and the other half were founded as a part (or on the premises) of either an NGO or quasi-state institution. The main requirements for such facilities are privacy, confidentiality and friendliness of the service. Also in Georgia, centers were established during the realisation of the Reproductive Health Initiative for Youth in the South Caucasus' project, providing free reproductive health counseling, contraceptives, diagnosis and affordable treatment, as well a wide range of reliable information on reproductive health issues. In Hungary and Poland there are no centers dedicated especially to youth and adolescent SRH issues, so young people must seek advice and help at standard facilities. There are no facilities or consultation centres to which young people, who seek advice on various help lines, can be directed. Poland has one gynecological outpatient clinic dedicated to children and adolescents that was established in 2010 in Warsaw.[15] Ukraine has more than 70 Youth Friendly Health Clinics that were developed under the frameworks of a UNICEF project and now are supported and being enlarged by The Ministry of Health of Ukraine.[16] Also in the Russian Federation, UNICEF has supported child and youth friendly clinics since 1999. Earlier, during the Soviet period, "adolescent cabinets" provided a limited range of services, including extensive screening. In 1993, Yuventa, the St. Petersburg City Consultation and Diagnostic Centre on Adolescents' Reproductive Health, under the City Health Committee, pioneered the broader concept of youth-friendly services (YFS). This was the first health clinic in the Russian Federation to provide sexual and reproductive health services exclusively for adolescents. Inspired by the youth consultation network in Sweden and the Brook Advisory Centres in the United Kingdom, Yuventa now logs nearly 250 000 visits every year.[17]

Existing youth friendly facilities represent different care models, ranging from a large clinic that serves as a referral centre, to facilities focusing on primary

care, to stand-alone centres targeting difficult-to-reach young people. It is essential for countries that have established youth friendly facilities to address the issue of sustainability of these facilities under current health reforms. Countries that fail to address specific health needs of young people, like Poland and Hungary must recognize the need to establish networks of youthfriendly services.

OVERVIEW OF SEXUALITY EDUCATION

Although the governments claim the opposite, sexuality education is not integrated in the present curricula in CEE region. It is clear from the lack of provision of education, information, and services to young people who are in dire need of these, that governments in the region are hesitant to recognize the role of sexuality beyond its function in reproduction. In all surveyed countries, young people still face many barriers, some legal, some socially discriminatory, to accessing SRH services.

The denial of young people's right to information, services, privacy and confidentiality significantly impedes their access to sexual and reproductive health[18].

SEXUALLY TRANSMITTED INFECTIONS (STIs)

The ICPD PoA urges governments "to prevent, reduce the incidence of, and provide treatment for, sexually transmitted diseases, including HIV/AIDS, and the complications of sexually transmitted diseases such as infertility, with special attention to girls and women".[19]

Also at ICPD+5, governments were called to ensure that prevention of and services for sexually transmitted diseases and HIV/AIDS are an integral component of reproductive and sexual health programmes at the primary healthcare level. As a general rule, control of STIs has a positive impact on HIV epidemics. Where control measures for STIs have been scaled-up, rapidly growing HIV epidemics have been halted and even reversed. Thus, an effective control programme for STIs reduces the burden of both HIV infection as well as other STIs. Little is known about the prevalence of STIs in CEE region. However, it is clear that major epidemics of STIs currently exist. Widespread poverty, large gaps between the very wealthy few and an impoverished majority, migration due to economic hardship and civil strife resulting in the disruption of households and family life, as well as deteriorating health and education services are among the factors that contributed to increased vulnerability and the spread of STIs. Moreover, the rapid socio-economic changes that have been taking place in the region since the 1990s have been accompanied by a shift in ideology, from collectivism to individualism and consumerism, and by a massive increase in individual risk-taking in terms of unsafe sexual and drug use behaviours.[20]

The highest rates of STIs are found in Rusian Federation, Ukraine and Georgia, but the other surveyed countries

also have relatively high prevalence rates. According to the World Health Organisation (WHO) report published in 2001, there were 22 million new cases of curable STIs in CEE.[21] The report indicated an estimated 6 million new cases of chlamydia infections among adults. Hungary had a prevalence rate of 5.4% amongst asymptomatic women.[22] The same study showed that chlamydia infections were on the rise in Eastern Europe and Central Asia: the number of estimated new cases of chlamydia infections (in 1 million) among adults was 5.07 in 1995, and 5.97 in 1999.[23] There were 3.5 million estimated new cases of gonorrhoea among adults in 1999 in Eastern Europe and Central Asia. An important increase in gonorrhoea rates has been seen in Eastern Europe, in the newly independent states of the former Soviet Union, with the highest rate of 139 per 100,000 in the Russian Federation.[24] The comparison between numbers of estimated new cases of gonorrhoea infections in adults showed an increase from 2.32 million in 1995 to 3.31 million in 1999.[25] According to WHO's report, there was an estimated 100,000 new cases of syphilis among adults in 1999.[26] The report noted that, since 1989, there had been an alarming increase in the syphilis rates in the newly independent states of the former Soviet Union, especially in Russian Federation. Syphilis incidences have increased from 5-15 per 100,000 observed in 1990, to as high as 120-170 per 100,000 in 1996.[27] There were 13 million estimated new cases of trichomoniasis among adults in 1999.[28] Again, the increase in new cases has been observed in the region of Eastern Europe and Central Asia: from 10.07 estimated new cases among adults in 1995 to 13.11 new cases in 1999.[29]

Ukraine and Russian Federation are the most affected by STIs among the surveyed countries. Analysis of numerical data from the region suggests that trichomoniasis is the most common infection, followed by chlamydia, gonorrhea and syphilis.[30] Most public health officials are especially concerned about the increase in syphilis, which, if left untreated, can have adverse effects on an individual's long-term health. Relatively high rates of syphilis – over 100 cases per 100,000 people – have been reported in recent years within the general population in Russian Federation and Ukraine. In the decade after the collapse of the Soviet Union, the rates of syphilis among the general population there reached 277 cases per 100,000.[31]

There is lack of reliable statistics concerning STIs in Poland and Hungary, although according to European Union data, the actual number of infections is larger than the number of registered cases.[32] According to the Surveillance Report by the European Centre for Disease Prevention and Control,[33] chlamydia trachomatis continues to be the most frequently reported STI in the EU. According to this report, the number of reported cases of chlamydia in 2007 was 699 for Hungary and 627 for Poland. As regards the number of reported cases of gonorrhoea, the total number of cases registered in Hungary was 1041, with 330 in Poland.

National surveillance systems for STIs (chlamydia, gonorrhoea and syphilis) consist of a mixture of voluntary, sentinel or selected laboratory systems, and frequently do not represent true national coverage.[34] Data from WHO as well as the European Centre for Disease Prevention and Control, show that major variations in surveillance systems across countries in terms of coverage, completeness and representativeness hamper meaningful comparisons. Hence, comparing numbers and reported rates between countries may be misleading, given these major differences in reporting systems and reporting behaviour. The availability of a screening programme dedicated to STI services or targeted at (sub)-groups of the population, for example pregnant women, may significantly affect the reported number of chlamydia infections. This means that the true number of incidences and prevalence rates are likely to be higher than presented here.[35]

A common denominator for the surveyed countries is a low prevalence of condoms and a biased attitude against their use. Moreover, deficient sexuality education and lack of information on sexual health contribute further to the spread of the STIs.

OVERVIEW REGARDING SEXUALLY TRANSMITTED INFECTIONS (STIS)

In the Central and Eastern Europe region, knowledge about STIs and their prevention is poor, and information is not widespread due to an absence of reliable sexuality education and counselling services.[36]

Infection rates are high, which represents a worrying trend for at least two important reasons. Firstly, the presence of STIs increases the likelihood of contracting HIV. Secondly, high rates of STIs are indicative of risky sexual behaviors. The prevention and treatment of STIs in the countries under review have largely been driven by HIV intervention efforts.[37] Unfortunately, before the shift in the development of the pandemic, HIV interventions in the region targeted high-risk behaviour groups, mostly injecting drug users. As a result, the larger population at risk of STIs were neglected by prevention and treatment programmes in the end of the twentieth century. After an epidemiological trend of increasing HIV incidence rates due to sexual transmission in Central and Eastern Europe was documented, the programmes incorporated STI testing and prevention as a measure to stop increasing HIV/AIDS pandemic.

HIV/AIDS

The high incidence and prevalence of STIs is important also from a biological point of view since co-infection with STIs can facilitate the transmission of HIV.

Eastern Europe and Central Asia is the only region in the world where HIV prevalence clearly remains on the rise. Until 10 years ago, HIV was almost nonexistent in the region – even though by the mid-1990s it had already reached pandemic proportions among the general population in several nations in sub-Saharan Africa and Southeast Asia and among specific population groups elsewhere, such as men who have sex with men (MSM) in the United States. However, by the end of 2004, according to the Joint United Nations Programme on HIV/AIDS (UNAIDS), at least 1.4 million people were living with HIV/AIDS across Central and Eastern Europe and Central Asia, a nine-fold increase over the previous decade. Russian Federation and Ukraine remain the most affected countries by far, with 311,000 and 77,000 officially registered HIV infections, respectively.[38] Estimates from UNAIDS and other organisations are often two or three times higher than the number of infections officially registered in each country – according to UNAIDS, prevalence among the adult population (ages 15-49) has reached 1% in the Russian Federation and 2% in Ukraine[39].

Table 19: Estimated People Living with HIV

Estimated People Living With HIV (adults + children)				
Name of the Country	Estimate Number of Adults and Children		Estimate Prevalence Percent of Adults and Children	
	2001	2009	2001	2009
Armenia	1400	1900	0,1	0,1
Azerbaijan	1300	3600	< 0.1	0,1
Georgia	1200	3500	< 0.1	0,1
Hungary	2800	3000		
Poland	21000	27000		
Russian Federation	430 000	980 000	0,5	1,0
Ukraine	290 000	350 000	0,9	1,1

Source: UNAIDS 2010 Global Report

At least one out of every 100 adults living in these two countries is now estimated to be carrying the virus, representing a threshold above which efforts to turn back the pandemic have failed in many other countries. The number of people living with HIV in CEE/CIS has almost tripled since 2000, reaching an estimated total of 1.4 million in 2009. Compared with 900,000 in 2001, this represents a 66% increase over this time period.[40] While the prevalence remains far lower than those in parts of Africa which are in excess of 20%, it is 10 times higher than in most of Western Europe and the United States, where HIV prevalence among the adult population has barely increased since the mid-1990s.[41]

In Central Europe, over half of the reported HIV cases are registered in Poland, but in this country and its neighbours there has been no marked increase in reported HIV cases over the past five years. In Hungary, adult HIV prevalence remains below 0.2% with between 20-40% of reported HIV cases having been diagnosed in foreigners, often migrants from former Soviet Union countries. HIV prevalence remains relatively low in Central Asia and the Caucasus, but it is rising more quickly in these countries than anywhere else in the CEE region. The actual number of people living with HIV in former Soviet Union countries is thought to be several times larger than officially registered.[42]

THE MOST AFFECTED POPULATIONS

Marginalised populations such as injecting drug users (IDUs), sex workers, men who have sex with men (MSM), and Roma continue to be at the greatest risk for contracting HIV. Many members of these groups remain unable or unwilling to access adequate healthcare or HIV prevention and treatment services because of outright discrimination (such as denial of care) or fear of harassment from authorities.[43]

TRANSMISSION ROUTES

In the first phase of the epidemic, IDUs were the most affected group and the region faced an injecting drug-related HIV epidemic.

Opium poppies have long been cultivated in the former Soviet Union, and drug injecting is not an entirely new phenomenon.[44] Central Asia and the CEE region have become a major tracking route for opium and heroin from Afghanistan, the world's largest source. In 1997, according to various authors, between 74-90% of new infections in the CEE region were among IDUs.[45] Although injecting drug use remains the primary route of

transmission in the region, public health observers and experts generally currently believe sexual transmission is a major concern, especially among the sexual partners of IDUs and among IDUs involved in sex work.[46] This is not surprising, given the relatively high prevalence of STIs, particularly syphilis, among IDUs and IDU sex workers and the lack of comprehensive interventions targeting sexual risk reduction. In many countries, drug users frequently engage in sex work, magnifying the risk of transmission.

With increasing transmission among the sexual partners of drug users, many countries in the region are experiencing a transition from an epidemic that is heavily concentrated among drug users to one that is increasingly characterised by significant sexual transmission. In 2007, heterosexual transmission was the source of 42% of newly diagnosed HIV infections in Eastern Europe.[47]

Migration is another factor influencing the spread of HIV/AIDS pandemic in the CEE region. Poverty and economic, political and social instability have resulted in the increased migration of men, women and children both within and between countries, as migrant labourers leave their homes to seek other sources of income and employment.[48] Male and female migrants are isolated from family and community relations and social support networks, and may engage in sexual activity with sex-workers and/or multiple partners, exposing themselves and by association their partners at home to HIV infection.[49]

WOMEN LIVING WITH HIV/AIDS IN THE REGION

As the rate of heterosexual transmission has increased, gender disparities in HIV prevalence are narrowing.[50]

Heterosexual contact causes nearly two-thirds of infections in women in Russian Federation and accounts for an ever-growing proportion of new infections. In Ukraine, women now represent 45% of all adults living with HIV.[51] In 2000, women comprised 20.6% of new infections, whereas in 2003 this figure was 38.5% and in 2007 the proportion had grown to 44% or 135,000.[52] In Ukraine, the growth of heterosexual transmission as a proportion of total HIV incidences between 2001 and 2006 (from 28% to 35%) is largely attributable to unprotected sex.[53] Regionally, half of all HIV-positive women became infected by partners. Women living with HIV/AIDS face double stigma and discrimination, and regionally implemented harm reduction programmes lack gender sensitivity.

Table 20: Estimated number of women living with HIV

Estimated number of women living with HIV		
Name of the Country	Estimate Number Women 15+	
	2001	2009
Armenia	<500	<1000
Azerbaijan	<1000	2100
Georgia	<500	1500
Hungary	<1000	<1000
Poland	6400	8200
Russian Federation	190000	480000
Ukraine	130000	170000

Source: UNAIDS 2010 GLOBAL REPORT

STIGMA AND DISCRIMINATION

HIV related stigma and discrimination is seen as a barrier to universal access to HIV prevention treatment, care and support.

Little has been done to curb the stigma, although the ICPD PoA urges governments to develop policies and guidelines to protect the individual rights of and eliminate discrimination against people infected with HIV and their families. Given that the most at-risk groups in the region – IDUs, sex workers and men who have sex with men (MSM) – are involved in what is viewed as socially unacceptable activities, this stigma is perhaps intensified. Stigma and discrimination against drug users and homosexuality in the region act as deterrents to seeking treatment, and according to the United Nations Development Programme (UNDP), most people living with HIV are more fearful of discrimination than they are of the negative health effects.[54] Reports from Eastern Europe and Central Asia state that people with HIV/AIDS are discriminated against by denying them healthcare, by employment redundancies, and by being excluded from their own family.[55] This affects the psychological and physical health of HIV-infected people. Moreover, it is likely to encourage non-disclosure of HIV status due to fear of stigmatization, discrimination and exclusion.

According to the ASTRA Network study on the situation of women living with HIV/AIDS in CEE,[56] in healthcare settings people with HIV can experience stigma and discrimination such as being refused medicines or access to facilities (especially reproductive health services), receiving HIV testing without consent, and a lack of confidentiality. Although it is illegal to test for HIV without a woman's consent, reports indicate that pregnant women who refuse an HIV-test may be sent to give birth in special HIV-units where the likelihood of stigma and discrimination is high. Lack of confidentiality has been repeatedly mentioned as a particular problem in healthcare settings. Many people living with HIV/AIDS do not get to choose how, when and to whom to disclose their HIV status. In the workplace, people living with HIV may suffer stigma from their co-workers and employers, such as social isolation and ridicule, or experience discriminatory practices, such as termination or refusal of employment. HIV-positive members of the family can find themselves stigmatised and discriminated against within the home. There is concern that women and non-heterosexual family members are more likely than children and heterosexual men to be mistreated. Discriminatory practices alienating and excluding people living with HIV have been reported all over the region. Stigma and discrimination against persons living with HIV (PLHIV) are key human rights and development issues that have a direct impact on the health status. Discrimination also deters individuals from accessing prevention measures such as voluntary HIV testing, as well as treatment, care and the support services needed to halt the spread of the pandemic and mitigate its impact.

LAWS AND POLICIES RELATED TO PEOPLE LIVING WITH HIV/AIDS

The HIV/AIDS pandemic in the CEE region has long been fuelled by stigma and discrimination, which has not been adequately addressed through national legal systems. A political legacy of authoritarianism and control challenges responses to HIV epidemics in the region. Faced with an epidemic that mostly affects socially excluded populations such as drug users and sex workers, post-Soviet systems and mindsets have

found it difficult to tailor inclusive responses to meet the specific needs of marginalised groups and those living with HIV/AIDS. Rigid social controls have often led to denunciation and blame of those who fail to conform, or who are caught up in systematic failures. In these circumstances, the stigma and discrimination related to fear and ignorance about HIV/AIDS find reinforcement in official attitudes of intolerance, and in existing public prejudice against those whose behaviour is seen as "anti-social" or "immoral". Policies and programmes remain strongly influenced by the legacy of the past, continuing to avoid the everyday realities of those living with HIV/AIDS and ignore clear evidence about what constitutes an effective response.[57] Several countries in the CEE region still have policies that interfere with the accessibility and effectiveness of HIV-related measures for prevention and care. Examples include laws criminalising consensual sex between men, prohibiting access for prisoners to condoms and needles, as well as using residency status to restrict access to prevention and treatment services. Further, the laws and regulations that exist to protect people with HIV from discrimination are not enacted, or fully implemented or enforced. Recently, policy makers have made attempts to re-orient national laws in order to adequately address situation of people living with HIV/AIDS: in 2010, Ukraine adopted legislation that removed mandated disclosure of HIV-positive status and provided a legal basis for opioid substitution treatment for HIV-positive people who inject drugs.[58] Russian Federation's HIV law provides certain rights and social protection for families whose children are HIV-positive – minors under the age of 18 are provided benefits and their caretakers are guaranteed social support. Although some progress has been made to re-orient national laws, some problems still persist. In Ukraine women who use drugs risk losing custody of their children.[59] In the Russian Federation, widespread negative attitudes of medical professionals towards HIV-infected pregnant women and mothers, and the stigmatising and discriminatory treatment of drug-using women, further increase the likelihood of infant abandonment or loss of custody.[60] Official interventions are often motivated by an ideology of "fixing the individual" through banishment or punishment, rather than "fixing the problem" by lending a helping or supportive hand. The prevailing view is that drug users, sex workers and HIV-positive women are "unfit mothers" or incapable of being competent parents, with the consequence that many feel pressured, shamed or coerced to abort, or to give up their children to the care of the state. Substitution therapy is illegal in the Russian Federation, which, in part, can be explained by the Russian Federation's attitude towards drug addiction and drug users. Practices to tackle drug use are defined by "narcology", a subspeciality of psychiatry originally developed in relation to alcohol addiction. One heavy critique of this approach is that treatment for drug addiction in Russian Federation is seen only within the bounds of "cure" or "failure to cure". This ignores the most effective practice of pursuing multiple outcomes, not just abstinence, including reductions in injecting and exposure to HIV and other blood-borne viruses.[61] HIV testing should always be voluntary, with pre- and post-test counselling, and testing or screening should never be carried out for employment purposes. All HIV-related information should be kept confidential. Moreover, all HIV testing programmes should respect international guidelines on confidentiality, counselling and consent. HIV testing should not endanger access to jobs, tenure, job security, or opportunities for advancement. Independent from internationally recognised standards, fear of breaches in confidentiality sometimes lead to extreme measures. In some countries, patients are not guaranteed the right to confidentiality of their medical records, and employers may access this information. In these circumstances, the repercussions of having contracted infectious diseases such as syphilis, HIV or tuberculosis may be so severe that patients will avoid seeking care, or pay bribes to healthcare workers in order to receive testing or treatment without it being recorded. In many countries, the design of systems is such that confidentiality is inherently difficult to maintain. For example, in order to receive social benefits, families may have to prove every year that a disability is still present, namely that their child is still HIV-positive. Facing annual review commissions unnecessarily expands the number of people who know about a person's HIV status.[62]

Mandatory registration for many health and social programmes sets a high threshold that dissuades many from seeking preventive or treatment services, particularly vulnerable populations. Doctors are also required to routinely report those seeking treatment for substance abuse to law enforcement authorities. Rather than a route to assistance and care, registration is perceived as a form of "branding" as social troublemakers and a potential reason for their basic rights to be prohibited. For example, on the grounds of their drug use alone, those registered can lose custody

of their children. This further diminishes their chances of social reintegration and discourages many from seeking treatment and support.[63]

In health services throughout the region, there are widespread reports of negative attitudes towards people living with HIV, who experience rejection as well as a lack of responsiveness towards their needs. Outside of the more specialised HIV services, health providers often have insufficient information or training on HIV prevention and treatment. This results in reluctance to treat HIV-positive people, both because of the inability of health workers to protect themselves from infection and because they lack the confidence, tools, and resources to treat these patients. Ignorance reinforces discrimination and mistreatment towards people living with HIV.

Apart from deficient legal responses to effectively address discrimination of people living with HIV/AIDS, it is also important to take into considerationthe limitations of existing healthcare systems. As the burden of HIV/AIDS in the region continues to grow, systems designed 20 years ago to monitor HIV as a "socially dangerous and rare disease" are starting to crack. In most countries of the Commonwealth of Independent States, the health system response to the epidemic was to create specialized AIDS centres in large urban areas. These centres reflected "vertical models" of healthcare delivery and a disease-based approach to healthcare provision inherited from the past, very much in line with the way the region responded to diseases such as syphilis and tuberculosis. Initially the AIDS centres were established to monitor spread of the disease, but later their functions evolved into also providing clinical care. Often poorly equipped and understaffed, many are located in places that are hard to reach for vulnerable populations and for women with infants and small children. Now, as the pandemic spreads from large cities into smaller towns and rural areas, the centralised system of service provision is cracking under the weight of an increasing demand for services. In 2008, antiretroviral therapy (ART) coverage among adults in the region was estimated to be only 22%, the second lowest in the world.[64] The centralisation of care provision at AIDS centres results de facto in the exclusion of HIV-positive people from services at other health facilities. AIDS centres have become places where all people living with HIV, including children, are routinely referred to for any health condition, and where they are able to access care without stigma and discrimination. However, going to a specialized "AIDS centre" is stigmatising in its own right, and has become a barrier to access, especially for young people.

While it is widely acknowledged that the intersections and interconnections between HIV/AIDS and SRHR are profound, HIV/AIDS and SRH services remains predominantly separate from the national health systems' point of view, which mostly have vertical AIDS control programmes, not integrated into the public health system.

ACCESS TO ANTIRETROVIRAL THERAPY

Most of the countries in CEE have national strategic plans for HIV and AIDS.

According to the 2008 UNGASS reports, all countries in CEE region report have in place a policy or strategy to promote comprehensive HIV treatment, care, and support. However, the programmatic interventions on HIV/AIDS in most of the countries in the region focus on "high-risk" groups/behaviours. The overall quality of these plans varies significantly, and many countries cannot guarantee sufficient programme coverage, adequate financial and human resources, or reliable procurement for the various drugs and prevention commodities that are needed. HAART (Highly Active Antiretroviral Treatment) is not provided to all PLWHA in need of antiretroviral treatment (ART).[65] In December 2008, just 22% of adults in need of antiretroviral therapy

were receiving it – a level less than half the global average for low and middle-income countries (42%).[66]

Table 21: Reported number of people receiving antiretroviral therapy (including children)

Reported number of people receiving antiretroviral therapy by sex and by age, and estimated number of children receiving and needing antiretroviral therapy and coverage percentages, 2010

Countries	Reported number of all males and females receiving antiretroviral therapy					Reported number of adults and children receiving antiretroviral therapy
	Month and year of report	Males	% of total	Females	% of total	Month and year of report
Armenia	Dec. 10	161	64%	89	36%	Dec. 10
Azerbaijan	Dec. 10	334	77%	101	23%	Dec. 10
Georgia	Dec. 10	581	70%	249	30%	Dec. 10
Hungary		…		…		
Poland	Dec. 10	3 591	73%	1 306	27%	Dec. 10
Russian Federation		…		…		
Ukraine	Dec. 10	12 024	53%	10 673	47%	Dec. 10

… Data not available or not applicable.

cThe coverage estimates are based on the estimated unrounded numbers of children receiving antiretroviral therapy and the estimated unrounded need for antiretroviral therapy (based on UNAIDS/WHO methodology). The ranges in coverage estimates are based on plausibility bounds in the denominator: that is, low and high estimates of need.

Point estimates and ranges are given for countries with a generalized epidemic, whereas only ranges are given for countries with a low or concentrated epidemic.

gAlthough no report has been received from the Russian Federation, for the analysis throughout the report, based on previous reports, an estimated 4% of the people receiving antiretroviral therapy in the Russian Federation are assumed to be children.

Source: Publication: GLOBAL HIV/AIDS RESPONSE: Epidemic update and health sector progress towards Universal Access Progress report 2011 WHO, UNAIDS, UNICEF; 2. Reported number of facilities with HIV testing and counselling and number of people older than 15 years who received HIV testing and counselling, Website: www.who.int/hiv/data/tuapr2011_annex2_web.xls

The dominant ideology of femininity, casting women as vectors of disease or merely as bearers of unborn children has greatly influenced the design of HIV/AIDS interventions. In order to protect the health of the child, pregnant women are usually tested for HIV. In terms of access to ART, pregnant women, or rather their unborn children are usually a priority group. In the Russian Federation, pregnant women must be treated with ART according to federal law, but there is no data on whether they actually receive such prophylaxis. The overwhelming majority of HIV-infected children in the region are born in the Ukraine and Russian Federation. Although the increase in rates of perinatal HIV transmission parallels the spread of HIV in Hungary and Poland, preventive programs targeting pregnant women mostly aim at raising their awareness and knowledge about HIV infection. Pregnant women are not routinely tested for HIV infection in these countries, but the opportunity to perform the test is mentioned to women.

An estimated 94% of pregnant women have access to antiretroviral (ARV) prophylaxis in the CEE region.[67] For HIV-positive children, ART coverage is estimated to be 85%.[68] These results have been realised largely as a result of the integration of preventing mother-to-child transmission (PMTCT) with already well-developed maternal and child health (MCH) services. Remaining challenges in PMTCT in the region today include improvement of primary prevention of HIV infection among young women of childbearing age, and the prevention of unintended pregnancies among HIV-positive women. The region is characterised by high pregnancy termination rates. The proportion of pregnancies among HIV-infected women ending in termination is difficult to compare across countries as the ways in which data is

collected vary and are influenced by HIV testing policies. In the Russian Federation in 2007 and 2008, 40% and 38% respectively of all pregnant women testing positive for HIV terminated their pregnancy. Women receiving HIV testing included both women attending antenatal care and those seeking terminations of pregnancy. In Ukraine, data on terminations of pregnancy among HIV-infected women are available only for those women with a known HIV infection status before pregnancy, with rates of termination reported as 9% in 2007 and 14% in 2008.[69] There are also numerous anecdotal reports of HIV-infected women being recommended to have an abortion by healthcare providers.[70] Such practices reflect both a lack of knowledge and training, with respect to the risks of mother-to-child transmission of HIV and the benefits of prevention, as well as the discriminatory attitude towards HIV-positive women held by some providers.

Enhancement of the quality of PMTCT interventions, and better outreach to marginalised and most-at-risk populations who tend to be missed by services, is critical. In addition, it will be important to provide a continuum of care for women and children, and to scale up a number of services including early infant diagnosis, early initiation of ART for infants, and the provision of ARVs for parents.

ACCESS TO COUNSELLING AND TESTING

While sporadic attempts have been made to include prevention and treatment of STIs and HIV testing and counselling into the family planning programmes, these attempts have not been sustained or fully integrated.[71]

However, some progress has been made in developing institutional linkages. During the first phase of the pandemic, compulsory testing was introduced for high-risk groups. In former Soviet republics, some health workers, particularly those outside the main cities, are ill-informed about the legal requirements, untrained and unskilled in counselling, and continue to routinely test patients, even against their will.[72] Anonymous unlinked testing for surveillance purposes, as recommended by WHO since the early 1990s, has not been implemented in the CEE region. Free and voluntary services are available only in big cities. They are anonymous but fear of discovering a HIV-positive status often stops people from being tested. HIV-positive results are routinely reported to regional AIDS centers and further compiled and confirmed at the national level.

Table 22: HIV testing

Low- and middle-income countries*a	Testing and counselling facilities, 2009		Testing and counselling facilities, 2010		Number of people aged 15 years and older who received HIV testing and counselling, 2009**b			Number of people aged 15 years and over who received HIV testing and counselling, 2010b		
	Reported number	Estimated number per 100,000 adult population	Reported number	Estimated number per 100,000 adult population	Reported number	Estimated number per 1,000 adult population	Reporting period	Reported number	Estimated number per 1000 adult population	Reporting period
Armenia	150	9,2	150	9,3	70 955	43,7	Jan. 09–Dec. 09	71 316	44,4	Jan. 10–Dec. 10
Azerbaijan	…-	…-	…-	…-	…-	…-		361 574	66,6	Jan. 10–Dec. 10
Georgia	…-	…-	334	15	…-	…-		70 615	31,8	Jan. 10–Dec. 10
Hungary	144	3	144	3	99 538	20,6	Jan. 09–Dec. 09	…	…	
Poland	2 645	13,7	…-	…-	25 452	1,3	Jan. 09–Dec. 09	…	…	
Russian Federation	…-	…-	…-	…-	…-	…-		…	…	
Ukraine	2 002	8,5	1 880	8,1	…-	…-		3 247 002	140,5	Jan. 10–Dec. 10

a See the country classification by income, level of the epidemic and geographical, UNAIDS, UNICEF and WHO regions.

b This number should include all people aged 15 years and older who received HIV testing and counselling through any method or setting, including voluntary counselling and testing and antenatal care settings. Not all countries are able to report c data from all settings.

c Some countries reported voluntary counselling and testing and antenatal care testing data separately; these data are combined here.

Source: Publication: GLOBAL HIV/AIDS RESPONSE: Epidemic update and health sector progress towards Universal Access Progress report 2011 WHO, UNAIDS, UNICEF; 2. Reported number of facilities with HIV testing and counselling and number of people older than 15 years who received HIV testing and counselling www.who.int/hiv/data/tuapr2011_annex2_web.xls

OVERVIEW FOR HIV/AIDS

There is considerable progress in the area of HIV/AIDS prevention, treatment and care in CEE. At the same time, programme interventions for HIV/AIDS need to capture a broad gender and human rights framework to effectively address the HIV/AIDS situation. Addressing the gender dimensions is critical, as noted in the ICPD PoA, since the face of HIV/AIDS has become increasingly more feminised. Women face greater danger of HIV

infection not only for biological reasons, (i.e., women have a larger mucosal surface exposed to abrasions during sex, and semen has higher concentration of HIV/AIDS than vaginal fluid does), but also for social reasons.

Cultural norms of sexual ignorance and purity for women block their access to prevention information. Gendered power imbalances make it difficult for women to negotiate for safer sexual practices (including condom use) with their partners, and economic dependence and fear of violence can effectively force women to consent to unprotected sex. Women receive inadequate care and treatment both because it is being directly withheld from them, and because what is provided is inaccessible and unsuited to their health needs.

SEXUAL RIGHTS

Politically, governments are comfortable only in recognising the reproductive functions of sexuality and the sexual rights that go hand-in-hand with these.

Non-reproductive functions are considered secondary and have not been attributed with much commitment and importance. It is necessary to delve into the bases of political power and political motivations to understand this better. In this section, we will demystify the notion of sexual rights through the use of the following indicators, and show issues of sexual rights that need to be addressed by governments: arranged/forced/child marriage; traditional practices harmful to women; laws against sexual violence – marital rape, rape, and sexual harassment; laws on the trafficking of women; laws on sex work; laws on same-sex sexual preference/relations/unions; and transgenderism.

All surveyed countries recognise women's right to bodily integrity and freedom from sexual violence and have legislated accordingly. All countries recognise the rights of choosing partners, entering into consensual marriages and consensual sexual relations although cultural practices may hinder these in some countries. Certain traditional practices, which are harmful for women and girls, seem to be continuing in the region. Among these are female circumcision and certain forms of violence against women like bride kidnapping.

EARLY AND FORCED MARRIAGE

Early marriage is a problem in Azerbaijan, Armenia, Georgia, and some parts of Russian Federation.[73] Women's rights organisations which collect information about polygamy and bride kidnapping in the North Caucasus have reported that girls as young as 12 are being kidnapped, with their families often too afraid to act. In some cases, it has been reported to Amnesty International that young girls have been returned to their families some months later, after having been raped and abused by their "husbands". Bride kidnapping has been a phenomenon in the North Caucasus for generations. While in some cases the woman might agree to being "kidnapped", different women who spoke to Amnesty International

highlighted that nowadays, in contrast to the situation 10 or 20 years ago, women and their families are often afraid of resisting the kidnapping or reporting it to the police or prosecutor's office if the man has a close connection with the authorities or is himself a member of the law enforcement bodies.[74] The problem is increasing among poor families living in rural areas in the center and south of Azerbaijan. Of girls between 15 and 19 years of age, 13% were married, divorced or widowed in Azerbaijan, with 11% in Russian Federation[75]. Also in Hungary, Roma girls drop out of school earlier because of early marriage and childbirth. Many marriages in Azerbaijan are arranged with the consent of parents, or women are kidnapped as brides.[76]

Table 23: Legal age of marriage and prevalence of early marriages among girls

Legal age of marriage and prevalence of early marriages among girls			
	Legal age of marriage/ women	Legal age of marriage/ men	Early marriage (girls/ women)
Armenia	18 (16)*	18 (16)*	Estimate 8%
Azerbajian1	18	18	13%
Georgia	18 (16)*	18 (16)*	Estimate 16 %
Hungary			
Poland	..	..	..
Russian Federation	18 (16)*	18 (16)*	Estimate 11%
Ukraine	17 (14)*	18 (14)*	Estimate 13%

*Notes: "Early Marriage" is defined as the share of girls/women between 15 and 19 years of age who are currently married, divorced or widowed. These percentages are derived from census data on the population classified by current marital status, sex and age group. Data are from 2004. *Law enables to allow marriage at earlier age under specified circumstances. Brackets specify the minimum age for the exception to be granted.*

Source: UNDP

Table 24: Number of first marriages by sex and age

Number of first marriages by sex and age				
	0 – 14 years		15 – 19 years	
	girls	boys	women	men
Armenia	..	..	2334	131
Azerbaijan	..	..	13904	567
Georgia	..	..	2279	607
Hungary	0	0	1833	401
Poland	..	..	..	..
Russian Federation	..	..	..	..
Ukraine	319	7	54997	10144

Notes: Data on first marriages provide the number of boys/men and girls/women who were married for the first time during the year, by age at last birthday. Data comes from registers, unless otherwise specified (data refer to year 2004). For Azerbaijan: data does not cover Nagorno-Karabakh; For Georgia: age group 15-19 refers to ages 16-19 and from 1993 data covers only territory controlled by the central government of Georgia; For Ukraine: from 2000-2006 the age group "0-14" refers to ages less than 16 and the age group "15-19" refers to ages 16-19.

Sources: UNDP, UNECE Statistical Division Database – Gender Statistics Sex-disaggregated datasets compiled from national official statistical sources; http://www.unece.org/stats/gender/database.htm

POLYGAMY

Polygamy is prohibited by criminal law in Azerbaijan and Poland. The 1999 CEDAW report states that the Civil Code "does not provide punishment for polygamy, since this is not a current problem in Armenia".[77] In the Russian Federation, the practice remains common within the Muslim community, particularly in the Caucasus region. Only the marriage to the first wife is recorded; subsequent wives are not considered to be legally married. In 1999, the president of Ingushetia proposed the legalisation of polygamy, a measure supported by

the majority of the population. The federal authorities prevented the law from being promulgated on the ground that regional legislation cannot run counter to federal laws.[78]

HONOUR KILLINGS

On 27 November 2008, the bodies of six women were discovered in different parts of Chechnya.

Each had been shot at point blank range in the head and chest. In line with the statement that he made in September 2008 shortly after the discovery of the women's bodies, Chechen President Ramzan Kadyrov said that he did not exclude the possibility that the women had been killed by their relatives as punishment for "immoral behaviour". While condemning the killings, Nurdi Nukhazhiev, the Chechen Ombudsman for human rights, justified the Chechen government's increased attention to issues concerning moral behaviour, regretting that "some women have forgotten how to behave".[79]

VIOLENCE AGAINST WOMEN (VAW)

Physical, sexual, psychological, and verbal violence are reminders of the actual status of women. Furthermore, it is important to note that combating violence against women is a priority area for both the Council of Europe and EU institutions.[80]

European Union efforts to curb domestic violence are relevant also for the countries outside EU, because the EU sets the direction for international policies and creates trends that are followed by countries aspiring to EU membership and neighbouring countries. The Committee of Ministers of the Council of Europe adopted a landmark Convention on preventing and combating violence against women and domestic violence (Convention CETS No. 210) in April 2011.[81] This Convention is the first legally binding instrument in the world creating a comprehensive legal framework to prevent violence, to protect victims and to end the impunity of perpetrators. It defines and criminalises various forms of violence against women (including forced marriage, female genital mutilation, stalking, physical and psychological violence and sexual violence). Unfortunately, none of the surveyed countries signed the Convention, which reflects the fact that violence against women in the family is widespread in CEE. The VAW laws in the countries where they exist are a result of the persistent efforts of grassroots and national women's organisations.

Table 25: Violence Against Women Laws

Name of Country	Violence Against Women in General Laws
Armenia	1. Armenia's implementation of the "Combating Gender-based Violence in the South Caucasus" project. (2008-2011) 2. National Programme to Improve the Status of Women and to Enhance Their Role in Society in the Republic of Armenia. (2004-2010)
Azerbaijan	Azerbaijan's implementation of the Regional Combating Gender-based Violence in the South Caucasus Project. (2008)
Georgia	1. Action Plan of Measures to be Implemented to Combat Domestic Violence and Protect Domestic Violence Victims. (2009-2010) 2. Action Plan on Prevention of Domestic Violence and Protection of Victims of Domestic Violence. (2009-2011) 3. Action Plan on Combating Violence against Women. (2000-2002)
Hungary	1. Act XIX of 1998 on Criminal Proceedings as amended by Act LI of 2006. (2006) 2. Act LXXX of 2003 on legal assistance. (2000) 3. Budgetary appropriation in 2008. (2008) 4. National Strategy of Social Crime Prevention (Government Resolution No. 1009/2004 (II. 26) Korm.). (2004)
Poland	No specific law regarding violence against women.
Russian Federation	1. Code of Criminal Procedure of Russian Federation. (2002) 2. National Strategy on Equal Rights and Equal Opportunities for Men and Women in Russian Federation. (2006)
Ukraine	1. Plan of Action under the "Stop Violence!" Platform of Action. (2008-2015) 2. State family support programme. (2007-2010) 3. State programme for the promotion of sexual equality in Ukrainian society up to 2010. (2006-2010) 4. National plan of actions on the improvement of position of women and assistance to introduction of gender equality in society. (2001-2005)

In Armenia, the lack of such legislation has been a high-priority issue for many human rights organisations in the country. In 2010, the Coalition to Stop Violence Against Women[82] was formed as an umbrella group for seven such organisations. The Women's Rights Center,[83] part of the Coalition, submitted a draft law on domestic violence. Similar initiatives in neighbouring Azerbaijan led to success, when the Draft Law on Domestic Violence, criminalising domestic violence and providing for the creation of aid centres for victims of violence was adopted by the Parliament of Azerbaijan in May 2011. In spite of the new legislation, the discussion of violence against women is a taboo subject in Azerbaijan's patriarchal society. In rural areas, women have no real recourse against violence by their husbands, regardless of the law. Although no reliable official statistics on domestic violence exist, several surveys conducted by international organisations between 2001 and 2004 found that 30-43% of women in Azerbaijan reported suffering from domestic abuse (2009).[84] In Georgia, the Law on Elimination of Domestic Violence, Protection and Assistance of Domestic Violence Victims was adopted in June 2006. The bill introduces the term "domestic violence" into Georgian legislation, as well as new mechanisms of protection of victims – restraining and defense orders, state's obligation to provide social services, shelters and rehabilitation centers for the victims and abusers.[85] In Hungary, domestic violence is adjudicated under existing assault and battery crimes in the criminal code.[86] In June 2009, the Hungarian Parliament enacted the Restraining Act in Cases of Violence Between Relatives.[87] According to this law, police may issue a restraining order that is

valid for three days, and the courts can issue longer-term restraining orders for a maximum of 30 days. The legislation has been criticised by women's NGOs for failing to provide adequate protection for victims, and for failing to place sufficient emphasis on offender responsibility. Recent family violence research states that approximately 20% of Hungarian women have been victimised by domestic violence,[88] while the Hungarian Government Report cynically states that "[t]he most serious crimes against human life [in domestic violence cases] are suffered by men" despite that 86 women and 65 men were killed in domestic violence in Hungary in 2006.[89] The Polish Law on Domestic Violence was adopted in 2005, and amended in 2010. The Act on Counteracting Domestic Violence strengthens the protection of victims of violence, especially through restraining order and possibility of eviction of the abuser from the place of residence. The Act allows also for free forensic examination for the victim and places an obligation on each municipality to help every victim, who has no legal right to the property, which she occupies with the perpetrator.[90] In the Russian Federation, there are no legal measures specifically addressing violence against women in the family. According to the statistics of Interior Ministry, 14,000 women die annually from domestic violence in Russian Federation.[91] In Ukraine, a bill was passed in 2001 to prevent violence against women, but public awareness of this law is low even among women. Paradoxically, this law authorises the police to arrest a woman if it can be demonstrated that she "provoked the violence by behaving as a victim".[92] Another problem is that the existing law does not specifically recognise domestic violence, the most common form of violence against women in the country; it is believed that half of Ukrainian women have experienced violence in their homes. Authorities are currently considering an amendment to the Criminal Code that would specifically prohibit domestic violence.[93] The fact that the CEE region still struggles to recognise women's right to life free from violence reflects the general lack of recognition of women's human rights in the region. Even in the countries where legal regulations exist, deficiencies in existing legal provisions, procedures and remedies impede the rights of victims to safe and prompt access to justice. There is also a shortage of supervisory and enforcement mechanisms. In general, legislation is gender-blind, and gender-blind legislation does not offer adequate protection for women from gender-based violence. Namely, acts of gender-based violence may remain invisible and unreported, not investigated and not prosecuted. In this way, women live without protection, while abusers go unpunished. This practice perpetuates violence against women, and does not contribute to the development of an effective preventive policy[94].

Table 26: Domestic Violence Laws

Name of Country	Domestic Violence Laws
Armenia	Gender and Politics project component on the prevention of domestic violence. (2004-2008)
Azerbaijan	1. Law on Prevention of Domestic Violence. (2010) 2. „XXI century without violence against women" project. (2008) 3. National Plan of Action on Family and Women's Problems. (2008-2012) 4. The "Complex Program of the Republic on combating domestic violence in democratic society". (2007) 5. National Plan of Action on protection of human rights. (2006)
Georgia	1. Law on the Elimination of Domestic Violence, Protection and Assistance of the Victims of Domestic Violence. (2006) 2. Action Plan of Measures to be Implemented to Combat Domestic Violence and Protect Domestic Violence Victims. (2009-2010) 3. Action Plan on Prevention of Domestic Violence and Protection of Victims of Domestic Violence. (2009-2011) 4. Action Plan on Combating Violence against Women (2000-2002)

Hungary	1. 32/2007. (OT 26) HNP HQ Instruction of the High Commissioner of the Hungarian National Police on the carrying out of tasks connected to the management of domestic violence and to the protection of the minors. (2007) 2. Protocol for Crisis Management Centers. (2007) 3. Section 176/A of the Criminal Code. (2007) 4. Resolution No. 45/2003 (IV. 23) OGY on the development of a national strategy to prevent and effectively manage domestic violence. (2003) 5. Child Protection Act XXXI of 1997 on the protection of children and guardianship administration. (1997) 6. Permanent fund for NGOs. (2000)
Poland	1. Act on Counteracting Domestic Violence (2010) 2. Ordinance of the Minister of Labour and Social Policy of 6 July 2006 concerning the standard of basic services provided by specialized support centres for family violence victims as well as detailed directions of corrective educational influences. (2006) 3. Act of 29 July 2005 on counteracting family violence (Dz.U. No 180, item 1493). (2005) 4. Guidelines for creating corrective and educational programmes for perpetrators. (2000) 5. Ministry of Justice recommendations for prosecutors. (2000) 6. „Blue card" police procedure. (1998) 7. Penal Code. (1997) 8. National Action Plan against Trafficking in Human Beings. (2009-2010) 9. National Program of Counteracting Domestic Violence (2006-2016). (2006)
Russian Federation	1. Order No. 564-st of the Federal Agency for Technical Regulation and Metrology on the approval of t henational standard dated 27 December 2007. (2007) 2. Krasnodar Territory departmental programme on the prevention of domestic violence, entitled "No to Violence". (2005)
Ukraine	1. Domestic Violence (Prevention) Act 2001. (2001) 2. Plan of Action under the „Stop Violence!" Platform of Action. (2008-2015) 3. State programme for the promotion of sexual equality in Ukrainian society up to 2010. (2006-2010) 4. National plan of actions on the improvement of position of women and assistance to introduction of gender equality in society. (2001-2005)

There is a tendency to downplay the gendered nature of domestic violence all over the region, and this is visible both in the methodology of research employed by state research institutions and in the superficial evaluation of available data. Most domestic violence incidents went unreported, largely due to the stigma of fear and shame on the part of the victim. Prosecution was also difficult and rare due to societal trends of victim-blaming. Another problematic issue is that data collected on violence against women are not disaggregated by women, men and transgender. In analysing violence as a manifestation of unequal power relations, we must recognise that women are not the only group that suffers from unequal power relations in any society. Violence also occur against lesbians, gays and bisexuals (LGB) and transgender people, but this is not documented statistically. LGB may often stay silent about their sexual orientation for fear of discrimination and violence. LGB may also face increased "violence" and "violations" from even conservative health providers.

RAPE

All countries surveyed have laws against rape and these usually exist within the penal code or the criminal code.

However, many barriers remain in being able to provide justice to victim-survivors of rape. Consent is the fine line that divides rape from consensual sex and legal definitions in all countries use non-consensual and forced vaginal penetration as definitions of rape. Furthermore, attitudes of the police on rape in general and on marital rape in particular revealed that many police officers hold views and attitudes permeated with prejudices, which make them absolutely unfit for investigating crimes of this kind. The victim-blaming attitudes and the resulting lack of action and malpractice on the part of professionals dealing with domestic violence (police, lawyers, social workers, psychologists, child custody officers, etc.) are widespread and prevalent in all the region.

Spousal rape is not specifically recognised in Armenia, Azerbajian, Georgia, Poland, Russian Federation nor Ukraine, while Hungary criminalises maritial rape.

SEXUAL HARASSMENT

In Azerbaijan, a research on the Status of Sexual Harassment Issue found that 33% of women determined themselves as victims of sexual harassment in 2007.[95]

Of the cases where women were harassed or treated in this way, 53% of the time it was by a supervisor (mostly in the private sector), with 26.3% occuring in the education sphere and 5.6% of the time from colleagues. Around 80% of these women acknowledged a dependance on the insulter at the time of the incident. The women who refused indecent proposals said it impacted negatively on their employment (17%) , or on their education (33%).[96] Informants from other surveyed countries stated that recognition of sexual harassment as an offence prevails in society.[97] However, victims of sexual harassment are often reluctant to take their cases to court because it may lead to rumours, because of a difficulty proving sexual harassment, plus fear of further discrimination or losing their job.

SEX WORK

As in most other countries of the world, state policies addressing issues of sex work in the region are rarely driven by pragmatism, scientific evidence, and human rights concerns; instead, they are often restrictive and based on moral prejudice.

Even when sex work is not technically illegal, it is frowned upon and its practitioners discriminated against and shunned by much of society. These attitudes greatly impede sex workers' access to public health services, including treatment for drug dependence as well as HIV prevention and treatment information and services. They also place sex workers in a position where their basic human rights can easily be violated and protection of these rights becomes difficult if not impossible. Nearly all countries in the CEE region have experienced an increase in sex work, largely stemming from economic necessity, in the wake of the collapse of the Soviet Union.

The rise in explicitly commercial sex work has occurred concurrently with a growing emphasis on the economic value of sexual relations in general, a development that reflects widening differentials in wealth. The sex industry appears to be growing especially rapidly in the countries of the former Soviet Union. In the region, existing legislation is much more restrictive toward organised prostitution, even in countries where prostitution itself is quasi-legal (Hungary, Poland) or not regulated.

Pimping is prohibited in all countries of the CEE region, with punishments varying from a fine to imprisonment. Prostitution in general is not subject to criminal liability. In Hungary, there are relatively new regulations in effect concerning both prostitution and human trafficking. However, as regulations were amended and/or drafted without any deeper knowledge about the social reality of either prostitution or human trafficking, a strange situation has developed where Hungarian regulations deal with the two questions totally independently, without any regard to the close relationship between the two and in different thematic environments. The wording of the regulations poses many theoretical and interpretational problems. Because of this, and ignorance about the close relationship between human trafficking and prostitution, there are also severe shortcomings with regards to implementation. Hungarian regulation about human trafficking does not even mention prostitution or sexual exploitation among the possible aims of human trafficking. Possible purposes – and also aggravating circumstances – listed in the statute might be work, unwanted physical contact with a sexual organ or intercourse, or illegal use of the human body.[98]

TRAFFICKING

Trafficking is an important problem of the region, but most of the existing laws are gender-blind and ignore the fact that women and children are the trafficking victims in most of the reported cases. Armenia is a main source and transit country for women and girls trafficked primarily for sexual and, to a lesser extent, labour exploitation to the United Arab Emirates and Turkey. This problem is being recognised and addressed by the Armenian government. Azerbaijan adopted its Law on the Fight against Human Trafficking in 2005. The law aims to combat trafficking in human beings by introducing a firm legal and organisational basis for the fight against trafficking, by giving legal protection and support to victims of trafficking. Although states

recognise the problem of trafficking, little is done to prevent trafficking and protect women from falling victims of this procedure. This is especially alarming when we take into consideration that the **former Soviet Union** and **Central** and **Eastern Europe** have replaced Asia as the main source of women **trafficked** to Western Europe. The majority of existing regulations are gender-blind.

THE STATUS OF DIVERSE SEXUAL AND GENDER IDENTITIES AND RECOGNITION OF THEIR RIGHTS

The recognition of diverse sexual and gender identities is still problematic in the region. The HIV/AIDS pandemic has revealed many issues affecting people of diverse sexual and gender identities. However, this has not led to the overall recognition of their rights. On the level of society, homophobia and transphobia are generally accepted and there is need for general action to promote tolerance towards LGBT communities. Statistics of hate crimes against LGBT people, as well as other violations of the rights of this group of people and discrimination against them, are not kept. References to "traditional values" to justify homophobic and transphobic actions, as well as support of patriarchal values and gender-stereotypical patterns of behaviour, are widely used in the media and reinforced at the political level all over the region. Deeply rooted homophobia and transphobia in public and political discourse are used to justify the limitation on most attempts to introduce relevant issues in public space. Meetings or demonstrations are forbidden, in many cases there is a refusal to register LGBT organisations, or there are obstacles to holding cultural events, with arguments on the inadmissibility of "propaganda of homosexuality" being widespread.

Table 27: LGBT situation in the region

	Armenia	Azerbaijan	Georgia	Hungary	Poland	Russian Federation	Ukraine
Anti-discrimination	Discrimination on the basis of sexual orientation and gender identity is not prohibited in any areas.	Discrimination on the basis of sexual orientation and gender identity are not prohibited in any areas.	Discrimination on the basis of sexual orientation is prohibited in the area of employment.	Discrimination on the basis of sexual orientation and gender identity is prohibited in the areas of employment, and provision of goods and services.	Discrimination on the basis of sexual orientation is prohibited in the area of employment.	Discrimination on the basis of sexual orientation and gender identity are not prohibited in any areas.	Discrimination on the basis of sexual orientation and gender identity are not prohibited in any areas.

Legal gender recognition of trans people	No administrative procedures for legal gender recognition.	No administrative procedures for legal gender recognition.	Administrative procedures to obtain legal gender recognition exist; however, only after compulsory sterilisation and compulsory divorce.	Administrative procedures to obtain legal gender recognition without compulsory genital surgery.	Administrative procedures to obtain legal gender recognition without compulsory genital surgery, however with compulsory divorce.	Administrative procedures to obtain legal gender recognition without compulsory genital surgery however with compulsory divorce.	Administrative procedures to obtain legal gender recognition - however only after compulsory sterilisation [and] compulsory divorce.
Partnership recognition	Does not provide any legal recognition of same-sex partnerships	Does not provide any legal recognition of same-sex partnerships.	Does not provide any legal recognition of same-sex partnerships.	Hungarian same-sex couples are able to enter into a registered partnership.	Does not provide any legal recognition of same-sex partnerships.	Does not provide any legal recognition of same-sex partnerships.	Does not provide any legal recognition of same-sex partnerships.
Parenting rights	Neither joint nor second parent adoption is available to same-sex couples.	Neither joint nor second parent adoption is available to same-sex couples.	Neither joint nor second parent adoption is available to same-sex couples.	Neither joint nor second parent adoption is available to same-sex couples.	Neither joint nor second parent adoption is available to same-sex couples.	Neither joint nor second parent adoption is available to same-sex couples.	Neither joint nor second parent adoption is available to same-sex couples.
Criminal law on hate speech/crime	Laws on hate and violence do not refer to sexual orientation or gender identity, and do not recognise sexual orientation nor gender identity as aggravating factor.	Laws on hate and violence do not refer to sexual orientation or gender identity, and do not recognise sexual orientation nor gender identity as aggravating factor.	Sexual orientation and gender identity are included in the law on hate and violence, and are recognised as aggravating factor.	Laws on hate and violence do not refer to sexual orientation or gender identity, and do not recognise sexual orientation nor gender identity as aggravating factor.	Laws on hate and violence do not refer to sexual orientation or gender identity, and do not recognise sexual orientation nor gender identity as aggravating factor.	Laws on hate and violence do not refer to sexual orientation or gender identity and do not recognise sexual orientation neither gender identity as aggravating factor.	Laws on hate and violence do not refer to sexual orientation or gender identity and do not recognise sexual orientation neither gender identity as aggravating factor.
Freedom of assembly/ Pride events	Pride events have never taken place / never been applied for.	Pride events have never taken place / never been applied for.	Pride events have never taken place / never been applied for.	Pride events have taken place with authorisation.	Pride events have taken place with authorisation, however LGBT public events were banned in 2004, 2005 and 2006.	No Gay Parade has ever been officially permitted in Russian Federation.	The first Gay Pride took place in 2012.

Source: ILGA-Europe, http://www.ilga-europe.org/home/guide/country_by_country

According to the newest ILGA Europe report ("Rainbow Europe Index 2011"),[99] Ukraine is the worst violator of LGBT rights in the continent, with a score of -4. The LGBT community falls victim of homophobic and transphobic prejudice all over the region. In Azerbaijan, where homosexuality was decriminalised in 2001, ILGA reported cases of police harassment and brutality, including bashings, blackmail, intimidation, bribery and invasions of privacy. LGBT people risk eviction from their homes and dismissal from their jobs. They have no legal protection against discrimination. Amnesty International is concerned about a climate of intolerance in Poland and Hungary against the LGBT community. This is characterised by the banning of public events organised by the LBGT community, openly homophobic language used by some highly placed politicians, and incitement of homophobic hatred by some right-wing groupings.

THE STATUS OF LAWS RELATED TO SAME-SEX SEXUAL PREFERENCES AND RELATIONS

Hungary was the first of the surveyed countries to allow same-sex partnership, but currently this regulation is jeopardised by the new Constitution (2012) which defines family as the union of a man and a woman. Same sex marriages are not outlawed in the Russian Federation, but when two women attempted to get married in Moscow in 2009, they were refused. The rest of surveyed countries' legislation fails to recognise same-sex unions.

THE STATUS OF TRANSGENDER PEOPLE

Legal regulation in the field of gender reassignment is underdeveloped and unsystematic in all of the countries that participated in the survey.

In general, the legislation is not adapted for addressing problems of changing documents for transgender people. Despite medical recommendations for social adaptation of transgender men and transgender women, they often can not change their documents of identity to reflect their desirable gender identities. Without suitable documents, it is almost impossible for transgender people to live as full members of a society. Some of them experience serious violence if the identity on their passport is found out. Transgender people are not able to secure employment because their gender representation and their official documents do not correspond. With such documents, transgender people cannot find employment according to their qualifications, as they have encountered a lack of understanding and intolerance from employers.

Although in the Russian Federation and Ukraine no legislation or regulation requires surgery for changing vital records, it is common practice that civil registry offices override their competencies and make the successfulness of an application dependant on the "completeness" of the applicant's gender reassignment – accordingly, surgical intervention is required and one surgical procedure is regarded as not sufficient. International research also shows that transgender people are over-proportionally avoiding access to healthcare services, which are not transgender-related, because of perceived or experienced transphobia by medical staff. Thus, transgender people are exposed to suffer from adverse effects on their health. Transgender people report about the complete absence of a professional understanding of transgender issues by general practitioners and other medical staff, leading to degrading and partly false treatment.

OVERVIEW REGARDING SEXUAL RIGHTS

The challenge for sexual health and sexual rights in the region is positioned within non-reproductive functions and expressions of sexuality.

All countries recognise the rights of women to freely choose their partners and enter into consensual marriages. In some countries in CEE, traditional practices may interfere with this choice and the exercising of this choice. All countries also recognise the rights of women and girls to bodily integrity and to live lives free from sexual violence: rape and sexual harassment. Marital rape is still a problematic concept in the region, but the idea to criminalise it seems to be gaining acceptance. All countries recognise the need to address trafficking of women and girls.

CONCLUSIONS

Reviewing the sexual health and sexual rights indicators across the seven countries, the following conclusions can be made.

Sexual health is still being framed in limited paradigms across the region. With the possible exception of some countries in Central Europe, a lack of political leadership and HIV-related stigma and discrimination are major impediments to the development and implementation of effective HIV/AIDS policies and strategies in CEE/CA. HIV/AIDS sets the defining framework for both STIs intervention and HIV/AIDS intervention, although the population vulnerable to STIs is larger and more diverse. This means that groups whichmayneed screening and treatment interventions are not receiving them. The impact of STIs on the sexual and reproductive lives of people is not being given the rightful recognition it deserves. Interventions framed within a "disease prevention" paradigm create access to services based on targeting risky behaviours instead of recognising the rights of marginalised groups (for example male and female sex workers) to services. However, this has opened the door for discussion and negotiation of these rights. There is a still a long way to go before the issues of sexual health and rights are framed in a paradigm of pleasure, autonomy and self-determination in all seven countries.

ENDNOTES

1 WHO working definitions at http://www.who.int/reproductivehealth/topics/gender_rights/sexual_health/en/ (last visited 28.03.2012).

2 UN conventions and conferences such as CEDAW, CRC, ICPD, Beijing and Vienna and the MDGs endorsed the concepts of reproductive health, reproductive rights and sexual health. These documents, particularly the ICPD PoA, do not explicitly state "sexual rights". Although "sexual rights" was written for the first time in the ICPD PoA draft, it was not retained in the final text. The ICPD PoA however acknowledges sexual rights when it states that in order to have a safe and satisfying sex life, men and women have "the capability to reproduce and the freedom to decide, if, when and how often to do so…" . The interpretation of what constitutes a "safe and satisfying sex life" and the conditions that provide for this, include key aspects of sexual rights such as consensual sexual relations, the choice of sexual partners, and the achievement of sexual pleasure. Sexual rights, therefore, are embedded in the ICPD PoA and it is important to monitor these.

3 UN CPD 45th Session, 2012, available at http://www.un.org/esa/population/cpd/cpd2012/cpd45.htm

4 Kazantseva, K., Kulchavenya, E., Sveshnikova, N. (2008) Sexuality of Russian girls and adolescents, Research TB Inst, Novosibirsk, Russia; Sexual and Reproductive Health and Rights of adolescents in Central and Eastern Europe, ASTRA Youth 2011, http://www.astra.org.pl/SRHR_of_adolescents_in_CEE_and_Balkan_countries_AY_2011.pdf

5 Summer Hotline Report 2009. Ponton Group of Peer Sexuality Educators, http://ponton.org.pl/en/raport/summer-hotline-2009 (last accessed 28.03.2012).

6 Sexual and Reproductive Health and Rights of adolescents in Central and Eastern Europe and Balkan countries. ASTRA Youth Report 2011, http://www.astra.org.pl/SRHR_of_adolescents_in_CEE_and_Balkan_countries_AY_2011.pdf (last visited 28.03.2012).

7 Sexuality Education in Polish homes. Report 2011, PONTON, http://ponton.org.pl/pl/raport/skad-wiesz-jak-wyglada-edukacja-seksualna-w-polskich-domach-raport-z-2011-r (last visited 28.03.2012).

8 Sexual and Reproductive Health and Rights of adolescents in Central and Eastern Europe and Balkan countries. ASTRA Youth Report 2011, http://www.astra.org.pl/SRHR_of_adolescents_in_CEE_and_Balkan_countries_AY_2011.pdf (last visited 28.03.2012).

9 A házasság előtti szex ellen küzd a Magyar Családtudományi Társaság (Hungarian Family Society fights again pre-maritial sex), ORIGO, 25.02.2012, , http://www.origo.hu/itthon/20120225-a-hazassag-elotti-szex-ellen-kuzd-a-magyar-csaladtudomanyi-tarsasag.html

10 ASTRA Network Country Report: Georgia, Giorgi Soselia, 2012 (unpublished).

11 WHO. Adolescent Friendly Health Services: an Agenda for Change. WHO, 2002. http://www.who.int/reproductive-health/publications/cah_docs/cah_02_14.html

12 Sexual and Reproductive Health and Rights of adolescents in Central and Eastern Europe and Balkan countries. ASTRA Youth Report 2011, http://www.astra.org.pl/SRHR_of_adolescents_in_CEE_and_Balkan_countries_AY_2011.pdf (last visited 28.03.2012).

13 www.4uth.am

14 United Nations Armenia Country Team Report for the Universal Periodic Review; lib.ohchr.org/HRBodies/UPR/Documents/Session8/AM/UNCTA_UPR_ARM_S08_2010_UNCountryTeamArmenia_Document1.pdf

15 Krzysiak, E. (2012). Warszawa. Pierwsza poradnia ginekologiczna dla dzieci i młodzieży. Widaomości24.pl, http://www.wiadomosci24.pl/artykul/warszawa_pierwsza_poradnia_ginekologiczna_dla_dzieci_i_127069.html

16 Sexual and Reproductive Health and Rights of adolescents in Central and Eastern Europe and Balkan countries. ASTRA Youth Report 2011, http://www.astra.org.pl/SRHR_of_adolescents_in_CEE_and_Balkan_countries_AY_2011.pdf (last visited 28.03.2012).

17 Kozhukhovskaya, T, Bloem, P. and Vartanova, K. (2004). Assessing Youth-Friendly Health Services In The Russian Federation, Entre Nous, The European Magazine for Sexual and Reproductive Health, No. 58-2004, UNFPA & WHO.

18 Sexual and Reproductive Health and Rights of adolescents in Central and Eastern Europe and Balkan countries. ASTRA Youth Report 2011, http://www.astra.org.pl/SRHR_of_adolescents_in_CEE_and_Balkan_countries_AY_2011.pdf (last visited 28.03.2012).

19 ICPD PoA; http://www.un.org/ecosocdev/geninfo/populatin/icpd.htm (last visited 28.03.2012).

20 Atlani, L., Carael, M., Brunet, J-B.,Frasca, T., Chaika, N. (2000). Social change and HIV in the former USSR: the making of a new epidemic, Social Science and Medicine 50 (2000) 1547-1556, p.2; Sexual and Reproductive Health and Rights of adolescents in Central and Eastern Europe and Balkan countries. ASTRA Youth Report 2011, http://www.astra.org.pl/SRHR_of_adolescents_in_CEE_and_Balkan_countries_AY_2011.pdf (last visited 28.03.2012).

21 Global prevalence and incidence of selected curable sexually transmitted infections, WHO/HIV_AIDS/2001.02, http://www.who.int/hiv/pub/sti/pub7/en/

22 Global prevalence and incidence of selected curable sexually transmitted infections, WHO/HIV_AIDS/2001.02, http://www.who.int/hiv/pub/sti/pub7/en/, Figure 5: Chlamydia prevalence rates (%) amongst asymptomatic women in European countries, 1990s.

23 Global prevalence and incidence of selected curable sexually transmitted infections, WHO/HIV_AIDS/2001.02, http://www.who.int/hiv/pub/sti/pub7/en/, Table 2. Estimated new cases of chlamydial infections (in million) among adults, 1995 and 1999.

24 Global prevalence and incidence of selected curable sexually transmitted infections, WHO/HIV_AIDS/2001.02, http://www.who.int/hiv/pub/sti/pub7/en/

25 Global prevalence and incidence of selected curable sexually transmitted infections, WHO/HIV_AIDS/2001.02, http://www.who.int/hiv/pub/sti/pub7/en/, Table 3, Estimated new cases of gonorrhoea infections (in million) in adults, 1995 and 1999.

26 Global prevalence and incidence of selected curable sexually transmitted infections, WHO/HIV_AIDS/2001.02, http://www.who.int/hiv/pub/sti/pub7/en/

27 Global prevalence and incidence of selected curable sexually transmitted infections, WHO/HIV_AIDS/2001.02, http://www.who.int/hiv/pub/sti/pub7/en/, p.22.

28 ibidem.

29 Global prevalence and incidence of selected curable sexually transmitted infections, WHO/HIV_AIDS/2001.02, http://www.who.int/hiv/pub/sti/pub7/en/, Table 5, Estimated new cases of trichomoniasis (in million) among adults, 1995 and 1999.

30 Sex Work, HIV/AIDS, and Human Rights in Central and Eastern Europe and Central Asia. Central and Eastern European Harm Reduction Network, 2005, http://www.unodc.org/documents/hiv-aids/publications/CEEAndCAsiaharm_05_sex_work_east_eur_0408.pdf (last visited 28.03.2012).

31 Ibidem.

32 Mapping of HIV/STI behavioural surveillance in Europe. ECDC Technical Report 2009, http://ecdc.europa.eu/en/publications/Publications/0909_TER_Mapping_of_HIV_STI_Behavioural_Surveillance_in_Europe.pdf (last visited 28.03.2012).

33 Surveillance Report. Annual epidemiological report on communicable diseases in Europe, 2009, http://ecdc.europa.eu/en/publications/Publications/0910_SUR_Annual_Epidemiological_Report_on_Communicable_Diseases_in_Europe.pdf

34 Ibidem.

35 Mapping of HIV/STI behavioural surveillance in Europe. ECDC Technical Report 2009, http://ecdc.europa.eu/en/publications/Publications/0909_TER_Mapping_of_HIV_STI_Behavioural_Surveillance_in_Europe.pdf (last visited 28.03.2012).

36 Sarang A., Stuikyte, R., Bykov, R. (2007). Implementation of harm reduction in Central and Eastern Europe and Central Asia. Int J Drug Policy 2007;18:129e35.

37 Atlani, L., Carael, M., Brunet, J-B., Frasca, T., Chaika, N. (2000). Social change and HIV in the former USSR: the making of a new epidemic, Social Science and Medicine 50 (2000) 1547-1556.

38 Russian data provided by the Federal AIDS Center, as of May 2005. Ukrainian data provided by the Ukrainian National AIDS Center, as of March 2005.

39 UNAIDS Global Report 2010.

40 UNAIDS Global Report 2010, p.40.

41 Sex Work, HIV/AIDS and Human Rights in Central and Eastern Europe and Central Asia, Central and Eastern European Harm Reduction Network, 2005, p.24.

42 Sex Work, HIV/AIDS and Human Rights in Central and Eastern Europe and Central Asia, Central and Eastern European Harm Reduction Network, 2005, p.25.

43 Sex Work, HIV/AIDS and Human Rights in Central and Eastern Europe and Central Asia, Central and Eastern European Harm Reduction Network, 2005, p.25.

44 Rhodes, T.; Ball, A; Stimson, G.V.;Kobyshcha, Y., Fitch, C., Pokrovsky, V., Bezruchenko-Novachuk, M., Burrows, D. et al. (1999). HIV infection associated with drug injecting in the newly independent states, eastern Europe: the social and economic context of epidemics. Addiction. 94:1323-1336.

45 Atlani, L., Carael, M., Brunet, J-B., Frasca, T., Chaika, N. (2000). Social change and HIV in the former USSR: the making of a new epidemic, Social Science and Medicine 50 (2000) 1547-1556; Sex Work, HIV/AIDS and Human Rights in Central and Eastern Europe and Central Asia, Central and Eastern European Harm Reduction Network, 2005, p.25.

46 Sex Work, HIV/AIDS and Human Rights in Central and Eastern Europe and Central Asia, Central and Eastern European Harm Reduction Network, 2005.

47 Fact sheet. HIV in WHO Regional Office in Europe, 2010, http://www.who.int/hiv/vienna2010/factsheet_hiv_euro.pdf

48 Axmann, A. (1998). Eastern Europe and community of independent states. International Migration, 36, 587–607.

49 Dehne, K. L., Khodakevich, L., Hamers, F. F., & Schwart- lander, B. (1999). The HIV/AIDS epidemic in Eastern Europe: Recent patterns and trends and their implication for policy-making. AIDS, 13, 741–749.

50 UNGASS Country Progress Report Republic of Armenia, Reporting Period: January 2008- December 2009, p.6; Report from the Seminar "Women and HIV/AIDS in CEE: Bringing Different Communities Together to Advance Common Goals", ASTRA Network 2005, Empowering Women Living with HIV/AIDS in the CEE region, ASTRA Network 2010.

51 Empowering Women Living with HIV/AIDS in the CEE region, ASTRA Network 2010.

52 Empowering Women Living with HIV/AIDS in the CEE region, ASTRA Network 2010.

53 HIV and AIDS in Russia, Eastern Europe and Central Asia, AVERT, http://www.avert.org/aids-russia.htm

54 Macauley, J.(2008). 'HIV/AIDS and UNDP in the Eastern Europe and CIS region', United Nations Development Programme website, accessed October 16th 2008.

55 Amirkhanian, Y.A., Kelly, J.A., McAuliffe, T.L. (2003). Psychosocial needs, mental health, and HIV transmission risk behavior among people living with HIV/AIDS in St Petersburg, Russia. AIDS, 2003, 17(16):2367–2374.

56 Women Living with HIV/AIDS in CEE/CIS, ASTRA Report for AIDS 2010 XVIII International AIDS Conference in Vienna.

57 Blame and Banishment: The underground HIV epidemic affecting children in Eastern Europe and Central Asia, UNICEF, p.12, http://www.unicef.org/serbia/UNICEF_Blame_and_Banishment(3).pdf

58 Earlier Ukraine adopted antidiscrimination law related to PLHIV "On AIDS prevention and social protection of population" (1998), more: http://www.unesco.org/education/uie/pdf/Oshovsky.pdf

59 Briefing to the UN Committee on the Rights of the Child on Ukraine's 4th periodic report on the implementation of the Convention on the Rights of the Child: Injecting drug use, sex work and HIV among children and adolescents at risk, the Eurasian Harm Reduction Network and the International Harm Reduction Association, April 2010, http://www.ihra.net/files/2011/02/10/EHRN_IHRA_Ukraine_report_CRC.pdf

60 Blame and Banishment: The underground HIV epidemic affecting children in Eastern Europe and Central Asia, UNICEF, p.12, http://www.unicef.org/serbia/UNICEF_Blame_and_Banishment(3).pdf

61 Elovich, R. and Drucker, E. (2008). On drug treatment and social control: Russian narcology's great leap backwards',Harm Reduction Journal 2008, 5:23.

62 Women, Harm Reduction, and HIV, Harm Reduction Development Program, Open Society Institute 2007, http://www.soros.org/sites/default/files/women_20070920.pdf

63 Blame and Banishment: The underground HIV epidemic affecting children in Eastern Europe and Central Asia, UNICEF, p.12, http://www.unicef.org/serbia/UNICEF_Blame_and_Banishment(3).pdf

64 AIDS Epidemic Update, 2009, http://data.unaids.org/pub/report/2009/jc1700_epi_update_2009_en.pdf

65 Gender and HIV/AIDS in Eastern Europe and Central Asia, WHO Europe, 2004.

66 AIDS Epidemic Update, 2009, http://data.unaids.org/pub/report/2009/jc1700_epi_update_2009_en.pdf

67 WHO, UNAIDS, UNICEF. Towards Universal Access. Scaling up priority HIV/AIDS interventions in the health sector. Progress report. September 2009.

68 Ibidem.

69 Thorne, C., et al. (2010). Implementing PMTCT and paediatric HIV care, support and treatment in low prevalence and concentrated epidemic settings in Eastern Europe and Central Asia – a review. UNICEF. 2010.

70 Women, Harm Reduction, and HIV, Harm Reduction Development Program, Open Society Institute 2007, http://www.soros.org/sites/default/files/women_20070920.pdf

71 AIDS epidemic update: December 2002; http://www.who.int/hiv/pub/epidemiology/epi2002/en/

72 Women, Harm Reduction, and HIV, Harm Reduction Development Program, Open Society Institute 2007, http://www.soros.org/sites/default/files/women_20070920.pdf

73 Forced and early marriage in Central and Eastern Europe and former Soviet Union Countries, Cheryl Thomas, EGM/GPLHP/2009/EP.08.

74 Annual Report 2011. The state of the world's human rights. Amnesty International, http://www.amnesty.org/en/annual-report/2011 (last visited 28.03.2012); Russian Federation -Briefing to the Committee on the Elimination of Discrimination Against Women, 46th session, July 2010, Amnesty International, 2010.

75 Ibidem.

76 ASTRA Network Country Report: Georgia, Sudaba Shiraliyeva, 2012 (unpublished).

77 CEDAW - Armenia - CEDAW/C/ARM/2 (1999), p.27.

78 Amnesty International: Russian Federation. Briefing to the Committee on the Elimination of Discrimination Against women, 2010.

79 Amnesty International: Russian Federation. Briefing to the Committee on the Elimination of Discrimination Against women, 2010.

80 EU Guidelines on violence against women and girls and combating all forms of discrimination against them, (2008), http://www.consilium.europa.eu/uedocs/cmsUpload/16173cor.en08.pdf (last visited 28.03.2012).

81 Convention on Preventing Violence Against Women and Domestic Violence, http://www.coe.int/t/dghl/standardsetting/convention-violence/default_EN.asp?, (last visited 28.03.2012).

82 Coalition to Stop Violence Against Women, http://www.coalitionagainstviolence.org/ (last visited 28.03.2012)

83 Women's Rights Center, http://www.wrcorg.am/en/home.htm (last visited 28.03.2012).

84 Powley Hayden, J. (2009). Azerbaijan: Baku Tackles Human Trafficking But Ignores Domestic Violence; http://www.eurasianet.org/departments/insightb/articles/eav061209a.shtml (last visited 28.03.2012).

85 ASTRA Network Country Report: Georgia, Giorgi Soselia, 2012 (unpublished).

86 Julia Spronz, PATENT Association, Personal Communication, 2012.

87 Zsofia Toth, Domestic Violence- legal background and support system in Hungary, 2010, http://www.cepprobation.org/uploaded_files/Pres%20STARR%20Par%20Toth.pdf (last visited 28.03.2012).

88 2010 Country Reports on Human Rights Practices – Hungary, http://www.unhcr.org/refworld/country,,USDOS,,HUN,,4da56dbf9b,0.html (last visited 28.03.2012).

89 Shadow Report of the Hungarian Women's Lobby on the realization of the CEDAW in Hungary, 2007.

90 Domestic Violence in the South Baltic Region: Kaliningrad, Lithuania, Poland, and Sweden, The Network of East-West Women NEWW Poland 2010, p.31.

91 Annual Report 2011. The state of the world's human rights. Amnesty International, http://www.amnesty.org/en/annual-report/2011 (last visited 28.03.2012).

92 ASTRA Country Report: Ukraine, Mariia Telishevska and Olexandra Sluzhynska, 2012 (unpublished).

93 Ibidem.

94 UNFP "Combating Gender-Based Violence in the South Caucasus" Project Armenia: Assessment of the Republic of Armenia Legislation from Gender Based Violence Perspective.

95 Gender Association Symmetry. CEDAW NGO Shadow Report. Azerbaijan 2009, http://www2.ohchr.org/english/bodies/cedaw/docs/ngos/Azerbaijan_Symmetry_Shadow_Report_CEDAW44.pdf (last visited 28.03.2012).

96 Ibidem.

97 Gender Equality and Social Institutions in Europe and Central Asia- Country Profiles, http://genderindex.org/countries/Europe%20and%20Central%20Asia

98 Shadow Report of the Hungarian Women's Lobby on the realization of the CEDAW in Hungary, 2007.

99 Rainbow Europe Index 2011, ILGA-Europe, http://www.ilga-europe.org/home/news/for_media/media_releases/rainbow_europe_map_index_2011_legal_situation_of_lesbian_gay_bisexual_trans_people_in_europe (last visited 28.03.2012).

CHAPTER 5

RECOMMENDATIONS

This chapter combines the recommendations of the writers, the reviewers and recommendations from the national partners of the ICPD+20 project.

The recommendations are focused on four major areas where urgent improvement is necessary in order to press forward to fulfil the commitments to the ICPD PoA: policy change with respect to reproductive rights and sexual rights; universal access to optimal sexual and reproductive health; continued, committed and sustained governmental and donor investment in women's sexual and reproductive health; and the concretisation of sexual and reproductive health and rights for adolescents and other marginalised groups.

Furthermore, the recommendations seek to voice needs that should be addressed in the post 2015 framework which were neglected in the ICPD PoA.

POLICY CHANGE UNDERPINNED BY COMMITMENT TO THE ICPD POA, WITH RESPECT TO REPRODUCTIVE RIGHTS AND SEXUAL RIGHTS

The political will of governments is essential to improving the status of women's sexual and reproductive health and rights.

In all areas where progress has been noted, government policies and implementation were critical for success. Now, nearly 20 years after Cairo and Beijing, it is imperative that governments become more cognizant of their women citizens and their needs and aspirations. Women are disproportionately affected by sexual and reproductive health issues, and improving sexual and reproductive health outcomes should be viewed as critical to government efforts to improve women's status and eliminate gender inequality.

1. Population policies continue to be driven by demographic norms rather than by meeting women's needs. Policies pertaining to women's sexual and reproductive health need to be underpinned by the PoA and the underlying concepts of reproductive rights and sexual rights. Policies on sexual and reproductive health and rights need to be mainstreamed into already existing national machineries, national policies and national plans in a cohesive manner.

2. Policies that determine sexual and reproductive health and reproductive rights should be aligned to provide access to a range of contraceptive methods, abortion services, pregnancy-related mortality and morbidity interventions, addressing STIs and HIV/AIDS, reproductive cancers, and male responsibility in sexual and reproductive health. Policies should also enunciate measures against stigma and discrimination.

3. Policies should be implemented and backed by functional health systems, adequate budgets, trained human resources and updated training and curriculum for health professionals. Policies

that determine SRHR must recognise the need for inter-sectoral coordination and cooperation. Existing policies which are progressive must be publicised, especially to service providers and to women, and must be translated into programme and project implementation.

4. Policies and policy review should be informed by robust data, should measure new indicators of reproductive rights, should include groups (beyond the traditional one of married women aged 15-49 years) such as unmarried single women, and include input from qualitative research in order to ensure that these policies are continually relevant. Intersectional analysis would enable governments to understand differences in policy implementation for different marginalised groups.

5. Policies and policy reviews that determine SRHR need to be created and implemented in secular spaces, free from the influence of fundamentalisms and other doctrines that restrict human rights.

6. Policy review efforts should be integrated into CEDAW, ICCPR and ICESCR reporting mechanisms in order to put pressure on governments to meet international commitments to ICPD, since ICPD itself does not have a reporting mechanism. NGO cross-movement collaborative efforts would help initiate policy review. ICPD national action plans have not materialised in any concrete manner in most countries.

7. Policy reviews should be underpinned by human rights paradigms. These can build on the 2009 call by the UN Human Rights Council to recognise preventable maternal mortality and morbidity as human rights violations, and on the 2009 NGO Berlin Call to Action by the SRHR community to address deaths resulting from unsafe abortions also as a human rights issue. This would ensure that sexual and reproductive health are framed and treated as issues of human rights, and that governments are held accountable for fulfilling them, regardless of economic climate or political change. Legislative initiatives that expand the grounds for abortion, for instance, or which repeal laws that punish women for procuring an abortion, should be introduced.

8. Policy review efforts should integrate the good practices of neighbouring countries as performance benchmarks, and engage in knowledge-sharing and learning between countries.

After these last 18 years, there is a new cadre of policy-makers who are unfamiliar with the ICPD PoA and the commitments that their governments have made. There is a dire need to reintroduce the PoA into the mindsets and agendas of the policy-makers.

REALISATION OF THE HIGHEST STANDARD OF SEXUAL AND REPRODUCTIVE HEALTH

Lack of access to SRH services and information contributes to high levels of morbidity and mortality for largely preventable SRH problems, particularly in developing countries. Every year, half a million women die during childbirth because they are not able to access life-saving emergency obstetric services. Lack of information and education on HIV/AIDS and condoms, as well as insufficient provision of condoms have contributed to the spread of STIs, including HIV. Restricted access to abortion services, contraceptives, and information on sexuality and reproductive health has led to unwanted pregnancies, botched abortions, women's impaired health and wellbeing and women's deaths. Policy formulation must be backed up by service provision ensuring universal access to sexual and reproductive health.

1. Comprehensive SRH services need to be made available, affordable, and acceptable at all levels starting from the primary healthcare level. The primary healthcare level is the one which is most

accessible to most of the population and, hence, the essential sexual and reproductive health services should be made available at this level. There needs to be renewed commitment to making available the full range of contraceptive methods (including emergency contraception and the promotion of condoms as a dual protection method); the full range of abortion services and post-abortion care; the full range of services that prevent maternal deaths, especially emergency obstetric care services and adequately equipped facilities; and the full range of services to identify and to treat victim-survivors of violence including counselling. Counselling services, especially to ensure informed choice, should also be provided. Contraceptives, anti-retroviral drugs, antibiotics, and other supplies ought to be adequately stocked in health facilities or other centres where younger and older women and men are able to gain access to them. Information and education campaigns are important, but behavioural change communication strategies have been shown to alter health-seeking behavior significantly in many cases.

2. There needs to be renewed commitment to staffing health facilities with skilled and trained human resources. Special attention should be paid to the practice of conscientious objection. While it is important to recognise the right of an individual to conscientiously object to performing a certain medical procedure based on religious, moral or philosophical objections, the occurrence of this practice is increasing and largely unregulated, especially in the field of reproductive health care. There is a need to balance the right of conscientious objection of an individual not to perform a certain medical procedure with the responsibility of the profession and the right of each patient to access lawful medical care in a timely manner. With regards to the practice of conscientious objection, we need to:

   - Oblige countries to develop comprehensive and clear regulations that define and regulate conscientious objection with regards to health and medical services, including reproductive health services, as well as to provide oversight and monitoring, including an effective complaint mechanism, of the practice of conscientious objection.

3. There is a dire need to integrate services, especially RH and HIV services, which have generally been funded separately and operated vertically, meaning that clients see a different provider for each health service. Yet, with the growing number of HIV infections being sexually transmitted, addressing RH and HIV together would better serve the needs of clients and health care providers in a more comprehensive, cost-effective, and efficient manner. Integration is a feasible means to achieve multiple key goals: prevent new HIV infections among women and girls; reduce HIV transmission from mother to child; prevent more AIDS orphans; and support HIV-positive women's reproductive rights and fertility choices. From the perspective of ethics and programme operations, women and girls who access HIV testing, counseling, and treatment through HIV/AIDS programmes have a compelling need for RH and FP services, especially relating to their fertility choices, just as much as women and girls accessing RH and FP services have a critical need for HIV information and services. In this aspect we need to:

   - Develop more effective strategies to help HIV-positive women prevent unwanted pregnancies and access contraception. This underscores the need for comprehensive SRH services where providers do not judge their clients and for the provision of safe spaces for young, HIV-positive women to access services. Responses are needed to address negative, judgmental attitudes of service providers toward HIV-positive women, especially those wanting children.

   - Strengthen the ability of local government units and NGOs to reach adolescent girls, including married adolescents, with RH and HIV information and services. Adolescent girls have poor access to confidential and affordable reproductive health and HIV services, making it difficult for them to protect themselves from HIV and unwanted pregnancy. This is an area that demands greater innovation and attention, both through facility-based approaches and other activities to reach young people.

- Develop programmes that integrate RH/FP programmes in HIV/AIDS prevention strategies. This is critical: programmes that help prevent women from acquiring HIV but do not help women prevent pregnancy are not sufficient. Women need to use dual protection – contraception and condoms – to prevent unwanted pregnancy and HIV.

4. Service providers should incorporate gender-sensitive approaches and be receptive to differences in sexual orientation and gender identities. Service providers should also mitigate misconceptions on all aspects of sexual and reproductive health. Service provision should also include accountability mechanisms and redressal mechanisms for patients and clients.

ENSURE CONTINUED, COMMITTED AND SUSTAINED INVESTMENTS IN WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS BY GOVERNMENTS AND DONORS

Until 2011, aid had been steadily increasing for more than a decade and net official development assistance (ODA) rose by 63% from 2000 to 2010.

However, a drop in ODA registered in 2011 shows that donor countries need to move more aggressively to meet the 0.7% aid target by 2015.

1. There needs to be advocacy for political support and to encourage donors and governments to meet the agreed funding requirements to ensure universal access to sexual and reproductive health services by 2015:

    - At the global level – by influencing the allocation of ODA to sexual and reproductive health and rights (SRHR) by forging partnerships with global inter-government agencies and international NGOs;

    - At the regional level – by impressing the central role of SRHR in the achievement of the ICPD and, by extension, the MDGs upon EU institutions, UN agencies and regional offices of other UN agencies such as UNDP and UNAIDS;

    - At the national level – by prioritising SRHR in national development plans and legislative initiatives, by ensuring that SRHR is supported by funds stipulated in the national budget, and by incorporating SRH service components, especially important country specific SRH issues.

    - At the sub-national or local level – by prioritising SRHR in local or provincial investment health plans at the local level, i.e., local government units, and by ensuring that funds are invested in interventions and activities that support and sustain efforts to achieve the ICPD PoA.

2. It is important to advocate that governments track expenditure on SRH. There is a compelling need to create national health accounts' (NHA) sub-accounts on RH programmes. This is a crucial tool for setting priorities, allocating budgets, and advocacy as well as for increasing transparency

and drawing accountability from governments tasked with providing RH services.

3. The capacity of partners and their constituencies needs to be strengthened, to engage effectively in policymaking and political decision-making processes. They need to: appreciate the context and understand the processes of policymaking such as setting priorities and drafting policies and engaging in health sector-wide approaches; to strategically apply political and technical tools, e.g., national health accounts' sub-account for RH to influence priorities and budgetary allocations; to forge alliances and coalitions; and to demonstrate results.

4. Donors should fulfill their commitments to the vision set out by the PoA, by funding all components of SRHR and health system strengthening from primary healthcare levels. Vertical funding mechanisms for components of SRH services need to be reviewed, putting them under the same umbrella. Shifting the agenda from ICPD to MDGs has resulted in the loss of the rights-based approach, so crucial to the full realisation of sexual and reproductive health. With the shift in agenda, the push from donors to governments to adopt women's rights, reproductive rights and sexual rights, is waning in strength.

CONCRETISE THE RIGHTS TO SEXUAL AND REPRODUCTIVE HEALTH AND THE SEXUAL AND REPRODUCTIVE RIGHTS, ESPECIALLY THOSE OF ADOLESCENTS, MARGINALISED GROUPS OF WOMEN AND THOSE WITH DIVERSE SEXUAL ORIENTATION AND GENDER IDENTITIES

Across the region, there is a tendency to restrict women's access to SRHR services and supplies.

Moreover, women who are poor, less educated, who live in remote areas, rural areas, and less developed parts of the country face greater difficulties in accessing services and realising the autonomy of their bodies. This happens regardless whether the service they require access to is contraception, maternal health services, safe abortion services, prevention and treatment of reproductive cancers, HIV testing and anti-retroviral therapy or sexual health services. Sexual and reproductive health and rights are issues of socio-economic equity as well as gender equity.

1. Adolescent-friendly policies and services need to be created, because this group faces the greatest barriers in accessing information, education and services for sexual and reproductive health. Barriers of consent and discrimination which prevent adolescents from accessing all sexual and reproductive health services including contraception, abortion and post-abortion care and counseling need to be eliminated.

2. It is important to ensure that comprehensive sexuality education is available, to inform and

empower adolescents with choices regarding safe-guarding their sexual and reproductive health and enable them to realise their sexual and reproductive rights.

3. Comprehensive programmes need to be created, with policies and plans to address marginalised groups. Ethnic minorities, elderly, disabled, and migrants will require more than one intervention to improve their sexual and reproductive health and rights. Barriers that impede their access must be understood, and these must be deliberately and systematically removed. It is important to ensure that national resources are also allocated to these marginalised groups. Sexual and reproductive health needs of these groups must be understood in a non-judgemental manner, and service provisions created if previously non-existent.

4. Policies need to be created which will include sex-workers and people with diverse sexual orientation and gender identities within service provision, which will ensure they are entitled to equal, fair, non-discriminatory sexual and reproductive health services, care and treatment. Legislation needs to be created and enacted, which will enable these groups to also realise their sexual and reproductive rights to the fullest.

5. Communities must be empowered, especially marginalised communities, to recognise their rights to sexual and reproductive health, and build their capacities to claim these rights from duty-bearers. Spaces need to be created for the participation of different marginalised communities in policy and programme formulation, encouraging their leadership at all levels.

6. Policies and programmes need to be implemented with an understanding of the different aspects of vulnerability: exposure to risks and danger as well as lack of the capacity to cope with the negative consequences of risks and threats of these marginalised groups. In situations of emergencies and disasters, it is important to fully understand the increased risk for marginalised groups and incorporate SRH into the formulation and implementation of disaster-preparedness, response and recovery plans.

In conclusion, we urge governments, donors and international organisations in the region to understand the critical need for pressing forward on the agenda of sexual and reproductive health and rights in this region. Full implementation of the ICPD PoA is fundamental for achieving the MDGs and for the advancement of women in the region.

BIBLIOGRAPHY

1. Amirkhanian, Y.A., Kelly, J.A., McAuliffe, T.L. (2003). Psychosocial needs, mental health, and HIV transmission risk behavior among people living with HIV/AIDS in St Petersburg, Russia. AIDS, 2003, 17(16):2367–2374.

2. Atlani, L., Carael, M., Brunet, J-B., Frasca, T., Chaika, N. (2000). Social change and HIV in the former USSR: the making of a new epidemic, Social Science and Medicine 50 (2000) 1547-1556

3. Balabanova, D., Coker, R. (2004). Health Systems of Russia and Former USSR. in: International Encyclopedia of Public Health, San Diego, CA: Academic Press.

4. Bardin, A., Vaccarella, S., Clifford, G.M., Lisowska, J., Rekosz, M., Bobkiewicz, P., Kupryjańczyk, J., Krynicki, R., Jonska-Gmyrek, J., Danska-Bidzinska, A., Snijders, P.J.F. , Meijer, C.J.L.M., Zatonski, W., Franceschi, S. (2008) Human papillomavirus infection in women with and without cervical cancer in Warsaw, Poland, European Journal of Cancer 44 (2008) 557-564.

5. Belli, P., Gotsadze, G., Shahriari, H. (2004). Out-of-pocket and informal payments in health sector: evidence from Georgia, Health Policy 70 (2004) 109-123.

6. Berer, M. (2010). Who has responsibility for health in a privatized health system?, in: Reproductive Health Matters, Volume 18, Number 36, November 2010, pp.4-12.

7. Berer, M. (2011). Privatisation in health systems in developing countries: what's in a name?, in: Reproductive Health Matters, Volume 19, Number 37, May 2011, pp.4-9.

8. Botros, B.A., Aliyev, Q., Saad, M., Monteville, M., Michael, A., Nasibov, Z., Mustafaev, H., Scott, P., Sanchez, J., Carr, J., Earhart, K. HIV prevalence and risk behaviours among international truck drivers in Azerbaijan. Cairo, EG; Baku, AZ; Rockville, Frederick, Baltimore, US.

9. Brand R., McKee, M. (2009). Health reform in central and eastern Europe and the former Soviet Union, Lancet 2009, 374: 1186-95.

10. Carroll, A., & Periolini, M. (2007). International Human Rights References to Sexual and Reproductive Health and Rights (regarding LGBT populations and HIV/AIDS and STIs). Europe: International Lesbian and Gay Association (ILGA).

11. Chełstowska, A. (2011). Stigmatisation and comercialisation of abortion services in Poland: Turning sin into gold, in: Reproductive Health Matters, Volume 19, Number 37, May 2011, pp.98-106.

12. Chong, E., Tsereteli, T., Vardanyan, S., Avagyan, G., Wikikoff, B. (2009). Knowledge, attitudes and practice of abortion among women and doctors in Armenia, The European Journal of Contraception and Reproductive Health Care, October 2009, 14(5): 340-348.

13. Correa, S.,& Careaga, G. (2004). Is Sexuality A Non Negotiable Component of the Cairo Agenda?, Development Alternatives With Women from a New Era (DAWN) Web site: http://www.dawnnet.org/resources-papers.php?id=51

14. Crochard, A., Luyts, D., di Nicola, S., Goncalves, M.A.G.(2009) Self-reported sexual debut and behaviour in young adults aged 18-24 years in seven European countries: Implications for HPV vaccination programs, Gynecologic Oncology 115 (2009) S7-S14

15. Czerwińska, A. , Piotrowska, J. (Eds.) (2009). *Raport: 20 lat- 20 zmian. Kobiety w Polsce w okresie transformacji 1989-2009.* Warszawa: Fundacja Feminoteka, Heinrich Böll Foundation.

16. Dolian, G., Ludicke, F., Katchatrian, N., Morabia, A. (1998). Contraception and Induced Abortion in Armenia: A Critical Need for Family Planning Programs in Eastern Europe, American Journal for Public Health, 1998 May, pp. 803-805.

17. Einhorn, B. (1993). *Cinderella Goes to Market: Citizenship, Gender and Women's Movements in East Central Europe.* London: Verso.

18. Eisenstein, Z. (1993). Eastern European Male Democracies: A Problem of Unequal Equality, in N. Funk and M. Mueller (eds) *Gender Politics and Post-Communism* . New York: Routledge, pp.303–330.

19. Elovich, R. and Drucker, E. (2008). On drug treatment and social control: Russian narcology's great leap backwards', Harm Reduction Journal 2008, 5:23.

20. Faulconbridge, G. and Ferris-Rotman, A. (2010) Russian Church calls for tougher abortion laws (2010). Reuters. Available at: http://www.reuters.com/article/2010/06/01/us-russia-church-abortions-idUSTRE65052320100601 (last visited 27.03.2012).

21. Forouzanfar, M.H., Foreman, K.J., Delossanstos, A.M., Lozano, R., Lopez, A.D., Murray, C.J.L., Naghavi, M. (2011). Breast and cervical cancer in 187 countries between 1980 and 2010: a systematic analysis, Lancet 2011; 378:1461-84.

22. Fugueras, J., McKee, M., Cain, J., and Lessof, s. (2004). Health Systems in Transition: Learning from Experience. Copenhagen: European Observatory on Health Care Systems.

23. Fukkuda-Parr, S. (2003). The Human Development Paradigm: Operationalizing Sen's Ideas on Capabilities. in: Agarwal, B., Humphries, J., Robeyns, I. (Eds.) Amartya Sen's Work and Ideas, Feminist Economics Vol 9, No 2 & 3 (p. 301). London, UK: Routledge.

24. Gal, S., & Kligman, G. (2000). *The politics of Gender After Socialism*. Princeton, New Jersey: Princeton University Press.

25. Goodwin, R., Kozlova, A., Kwiatkowska, A., Nguyen Luu, L.A., Nizharadze, G., Realo, A., Kulvet, A., Rammer, A. (2003). Social representations of HIV/AIDS in Central and Eastern Europe. Social Science & Medicine 56 (2003) 1373–1384

26. Gotsadze, G. and Gaal, P. (2010). Coverage Decisions: Benefit Entitlements and Patient Cost Sharing. in Kutzin, J., Cashin, C., and Jakab, M. (Eds.) *Implementing Health Financing Reform: Lessons from Countries in Transition*, Copenhagen: WHO.

27. Gupta, G.R., & Malhotra, A. (2006). Empowering Women through Investments in Reproductive Health and Rights. Retrieved August 27, 2009, from Website: www.packard.org/assets/files/population/.../pop _ rev _ gupta.pdf

28. Habibov, N.N., Afandi, E.N. (2011). Self-reted health and social capital in transitional countries: Multilevel analysis of comparative surveys in Armenia, Azerbaijan, and Georgia. Social Science and Medicine 72 (2011) 1193-1204.

29. Hayden, *J. P. (2009).* Azerbaijan: Baku Tackles Human Trafficking, but Ignores Domestic Violence, http://www.eurasianet.org/departments/insightb/articles/eav061209a.shtml (last visited 28.03.2012).

30. Hessini, L. (2005), Global Progress in Abortion Advocacy and Policy: An Assessment of the Decade since ICPD, in: Reproductive Health Matters 2005; 13(25): 99-100.

31. Hodorogea S., Comendant R. (2010). Prevention of unsafe abortion in countries of Central Eastern Europe and Central Asia, Intrenational Journal for Gynecology and Obstetrics 110 (2010) S34-S37.

32. Kazantseva, K., Kulchavenya, E., Sveshnikova, N. (2008). Sexuality of Russian girls and adolescents, Research TB Inst, Novosibirsk, Russia

33. Kovacs, L. (2007). Abortion and contraceptive practices in Eastern Europe, International Journal of Gynecology & Obstetrics 58 (1997) 69-75.

34. Kozhukhovskaya, T, Bloem, P. and Vartanova, K. (2004). Assessing Youth-Friendly Health Services In The Russian Federation, Entre Nous, The European Magazine for Sexual and Reproductive Health, No. 58-2004, UNFPA & WHO.

35. Lech, M.M. (2000). Oral contraceptives (OC) prescribing practices in urban areas of Poland, International Journal of Gynecology and Obstetrics.

36. Leridon, H. (2005). *Reproduction and demography in Europe,* International Congress Series 1279 (2005) 68-74.

37. Levi, F., Lucchini, F., Negri, E., Franceschi, S., la Vecchia, C. (2000). Cervical cancer mortality in young women in Europe: patterns and trends, European Journal of Cancer 36 (2000) 2266-2271

38. Lewis, M. (2002). Informal health payments in Central and Eastern Europe and the Former Soviet Union: issues, trends and policy implications. in: Mossialos, E.A., Dixon, A., Figueras, J., Kutzin, J.(Eds.) *Funding Health Care: Options for Europe*. Buckingham: Open University Press.

39. Macauley, J.(2008). HIV/AIDS and UNDP in Eastern Europe and CIS region, UNDP.

40. McKee, M., & Shkolnikov, V. (2001). Understanding the toll of premature death among men in Eastern Europe, Br. Med. J. 323, 1051-1055.

41. McMichael, A. J., McKee, M., Shkolnikov, V. M., Valkonen, T. (2004). Global trends in life expectancy: convergence, divergence - or local setbacks? Lancet 2004; 363:1155-1159.

42. Mishtal, J. (2010). Neoliberal reforms and privatization of reproductive health services in post-socialist Poland, in: Reproductive Health Matters, Volume 18, Number 36, November 2010, pp. 56-66.

43. Nowicka, W. (2000). Struggles For and Against Legal Abortion in Poland, in: Advocating for Abortion Access. Eleven Country Studies, in Klugman, B. and Budlender, D. (Eds.), Johannesburg: The Women Health Project, pp. 223-249.

44. Parfitt, B. (2009). Health reform: The human resources challenges for Central Asian Commonwealth of Independent States (CIS) countries, Collegian (2009) 16, 35-40.

45. Parkhurst, J.O., Penn-Kekana, L., Blaauw, D., Babalabanova, D., Danishevski, K., Rahmad, S. A., Onama, V., Ssengooba, F. (2005). Health system factors influencing maternal health services: a four-country comparison, Health Policy 73 (2005) 127-138.

46. Pavlova, J.V. (2010). Prospects of forming of legislation in the field of reproductive health care of citizens of the Russian Federation. Reproductive BioMedicine Online (Reproductive Healthcare Limited; Oct. 2010 S3 Supplemen, Vol.20, pS89).

47. Petchesky, R.P. (2003). *Transnationalizing Women's Health Movements. In Global Prescriptions: Gendering Health and Human Rights*. London, UK: Zed Books.

48. Pollert, A. (2005). Gender, Transformation and Employment in Central Eastern Europe, European Journal of Industrial Relations 11, 2 (2005), 213-230.

49. Powley Hayden, J. (2009). Azerbaijan: Baku Tackles Human Trafficking But Ignores Domestic Violence; http://www.eurasianet.org/departments/insightb/articles/eav061209a.shtml (last visited 28.03.2012)

50. Radowicki, S., Kunicki, M., Jarecki, R., Kozlowska-Boszko, B. (2009). The influence of experience of compliance with the dosing scheme of low-dose combined oral contraceptives among 11,397 women in Poland, International Journal of Gynecology and Obstetrics vol.107 October, 2009. p.S624-S625.

51. Rechel, B., McKee, M. (2009). Health reform in central and eastern Europe and the former Soviet Union, Lancet 2009; 374:1186-95.

52. Rhodes, T.; Ball, A; Stimson, G.V.; Kobyshcha, Y., Fitch, C., Pokrovsky, V., Bezruchenko-Novachuk, M., Burrows, D. et al. (1999). HIV infection associated with drug injecting in the newly independent states, eastern Europe: the social and economic context of epidemics. Addiction. 94:1323-1336.

53. Sakevich, V., Denisov, B. (2008), The Future of abortions in Russia, paper presented to EPC-2008 in Barcelona, Spain.

54. Saltman, R.B., Bankauskaite,V., Vrangbæk, K. (2007), Decentralization in health care: strategies and outcomes, WHO.

55. Sarang A., Stuikyte, R., Bykov, R. (2007). Implementation of harm reduction in Central and Eastern Europe and Central Asia. Int J Drug Policy 2007;18:129e35.

56. Schuler, M.A., Thomas, D. Q. (Eds). (1997). *Women's Human Rights Step by Step. A Practical Guide to Using International Human Rights Law and Mechanisms to Defend Women's Human Rights*. Washington, D.C: Women, Law & Development International.

57. Shipitsyna, E., Zolotoverkhaya, E., Kuevda, D., Nasonova, V., Romanyuk, T., Khachaturyan, A., Orlova, O., Abashova, E., Kostyuchek, I., Shipulina, O., Anttila, A., Savicheva, A. (2011). Prevalence of high-risk human papillomavirus types and cervical squamous intraepithelial lesions in women over 30 years of age in St. Petersburg, Russia, Cancer Epidemology 35 (2011) 160-164

58. Stillman, S. (2006). Health and Nutrition in Eastern Europe and the former Soviet Union during the decade of transition: A review of the literature, Economics and Human Biology, 4 (2006), 104-146.

59. Thompson, M.E., Harutyunyan, T.L. (2006). Contraceptive practices in Armenia: Panel evaluation of an Information-Education-Communication Campaign, Social Science and Medicine 63 (2006) 2770-2783.

60. Thorne, C., et al. (2010). Implementing PMTCT and paediatric HIV care, support and treatment in low prevalence and concentrated epidemic settings in Eastern Europe and Central Asia – a review. UNICEF. 2010.

61. Toth, Z. (2010): Domestic Violence- legal background and support system in Hungary, http://www.cepprobation.org/uploaded_files/Pres%20STARR%20Par%20Toth.pdf (last visited 28.03.2012)

62. Westoff, C. F., Sullivan, J.M., Newby, H.A. and Themme, A.T. (2002). Contraception– Abortion Connections in Armenia. Contraception- abortion connections in Armenia, DHS Analytical Studies, DHS Analytical Studies No. 6. Calverton, Maryland: ORC Macro.

63. Zatoński, W., Didkowska, J. (2008). Closing the gap: Cancer in Central and Eastern Europe (CEE), European Journal of Cancer, Volume 44, Issue 10, 1425-1437, July 2008.

64. Zhirova, I., Frolova, O.G., Astakhova, T.M., Ketting, E.(2004) Abortion-related maternal mortality in the Russian Federation. Stud. Fam. Plann. 2004;35(3):178–88.

65. Zordo, S., de, Mishtal, J. (2011), Physicians and Abortion: Provision, Political Participation and Conflicts on the Ground- The Cases of Brazil and Poland, Women's Health Issues 21-35 (2011) S32-S36.

ANNEX

GENERAL INDICATORS

Table 1: Total Population and by Sex

Name of the Country	1995	2003	2007	2010
Armenia	**3223**	**3061**	**3066 (2005)**	**3092**
Female	1695	1629	1635	1653
Male	1528	1432	1431	1439
Azerbaijan	**7765**	**8377**	**8588 (2005)**	**9188**
Female	3971	4279	4370	4644
Male	3793	4098	4218	4544
Georgia	**5069**	**4570**	**4477 (2005)**	**4352**
Female	2622	2411	2365	2302
Male	2407	2159	2112	2050
Hungary	**10331**	**10135**	**10087 (2005)**	**9984**
Female	5395	5320	5298	5244
Male	4936	4814	4789	4740
Poland	**38392**	**38198**	**38165 (2005)**	**38277**
Female	19736	19703	19703	19810
Male	18656	18495	18462	18467
Russian Federation	**148699**	**144880**	**143843 (2005)**	**142958**
Female	79067	77479	77108	76824
Male	69631	67401	66735	66135
Ukraine	**51122**	**47643**	**46924 (2005)**	**45448**
Female	27432	25621	25262	24535
Male	23689	22023	21661	20914

Source: Population (thousands), medium variant http://esa.un.org/wpp/unpp/p2k0data.asp Population by sex (thousands), medium variant. http://esa.un.org/wpp/unpp/panel_indicators.htm

Table 2: Life expectancy at birth male/female

Name of the Country	1995-2000	2000-2005	2005-2010
	medium variant		
Armenia			
Female	73.1	75.6	76.7
Male	66.6	68.9	70.2
Azerbaijan			
Female	69.6	70.4	73.1
Male	62.5	65	67.1
Georgia			
Female	74.7	75.9	76.5
Male	67.3	68.8	69.4
Hungary			
Female	77.6	76.8	75.4
Male	66.5	68.4	69.5
Poland			
Female	77.1	78.7	79.9
Male	68.5	70.3	71.2
Russian Federation			
Female	72.2	71.9	74
Male	59.6	58.6	61.6
Ukraine			
Female	73	73.4	73.5
Male	61.9	62	61.8

Source: medium variant, UN DATA World Population Prospects 2010 Revision http://data.un.org/Data.aspx?q=LIFE+EXPECTANCY+AT+BIRTH&d=PopDiv&f=variableID%3a66

Table 3: Gross Domestic Product Per Capita

Name of Country	1995	2003	2010
Armenia	2420 (1992)	2650 (2001)	3873 (2008)
Azerbaijan	2550 (1992)	3090 (2001)	5315 (2008)
Georgia	2300 (1992)	2560 (2001)	2970 (2008)
Hungary	6580 (1992)	12,340 (2001)	15,408 (2008)
Poland	4830 (1992)	9450 (2001)	13,845 (2008)
Russian Federation	6140 (1992)	7100 (2001)	11,832 (2008)
Ukraine	5010 (1992)	4350 (2001)	3899 (2008)

Source: Human Development Reports for the years 1995, 2003, 2010

Table 4: Percentage of population below $1.25

Name of Country	PPP$1.25 a day (%)	National Poverty line (%)
Armenia	1.3	26.5
Azerbaijan	1.0	15.8
Georgia	14.7	23.6
Hungary	0.0	-
Poland	0.0	16.6
Russian Federation	0.0	11.1
Ukraine	0.1	7.9

Source: Human Development Reports for the years 2011 http://hdr.undp.org/en/

Table 5: Multi-dimensional Poverty Index

Name of Country	Population	2011
Armenia	MPI	0.004 (2005)
Azerbaijan	MPI	0.021 (2006)
Georgia	MPI	0.003 (2005)
Hungary	MPI	0.016 (2003)
Poland	MPI	N/A
Russian Federation	MPI	0.005 (2003)
Ukraine	MPI	0.008 (2007)

Source: Human Development Reports for the years 2011 http://hdr.undp.org/en/

Table 6: Human Development Index

Name of Country	Population	1995	2003	2011
Armenia	Value Rank	0.680 93	0.729 100	0.716 86
Azerbaijan	Value Rank	0.665 96	0.744 89	0.700 91
Georgia	Value Rank	0.645 101	0.746 88	0.733 75
Hungary	Value Rank	0.855 46	0.837 38	0.816 38
Poland	Value Rank	0.819 56	0.841 35	0.813 39
Russian Federation	Value Rank	0.804 57	0.779 63	0.755 66
Ukraine	Value Rank	0.719 80	0.766 75	0.729 76

Table 7: Gender Inequality Index (2010 / 2011)

Name of Country	Population	2010	2011
Armenia	Value Rank	0.57 (2008)	0.343 (60)
Azerbaijan	Value Rank	0.553 (2008)	0.314 (50)
Georgia	Value Rank	0.597 (2008)	0.418 (73)
Hungary	Value Rank	0.382 (2008)	0.237 (38)
Poland	Value Rank	0.325 (2008)	0.164 (25)
Russian Federation	Value Rank	0.442 (2008)	0.338 (59)
Ukraine	Value Rank	0.463 (2008)	0.335 (57)

Source: Human Development Reports for the year 2011

Table 8: International Human Rights Instruments and Conferences

Name of the Country	International Conference on Population and Development (ICPD 1994)*	Beijing Platform for Action (1995)**	Millennium Development Goals (2000)***	International Covenant on Economic, Cultural and Social Rights (1966)	International Covenant on Civil and Political Rights (1966)	Convention on All Forms of Discrimination Against Women (1979)	Convention on the Rights of the Child (1989)
Armenia	1994	1995	2000	1993	1993	1993	1993
Azerbaijan	1994	1995	2000	1992	1992	1995	1992
Georgia	1994	1995	2000	1994	1994	1994	1994
Hungary	1994	1995	2000	1974 (1969 signed, 1974 ratified	1974	1980	1991
Poland	1994	1995	2000	1977	1977	1980	1991
Russian Federation	1994	1995	2000	1973	1973	1981	1990
Ukraine	1994	1995	2000	1973	1973	1981	1991

Source: From ICPD Programme of Action (POA)*; Report of the Fourth World Conference on Women, Beijing, 4-15 September 1995**; MDG Monitor: Tracking the Millennium Development Goals. Available online at: http://www.mdgmonitor.org *** For ICESCR, ICCPR, CEDAW, CRC: http://hdr.undp.org/en/media/HDR_20072008_EN_Complete.pdf

HEALTH FINANCING INDICATORS

Table 9: Consolidated National Health Accounts for 7 East European Countries

Name of Country	2005	2010
ARMENIA		
Total expenditure on health as % of Gross domestic product	4.9	4.4
General government expenditure on health as % of total expenditure*	30.4	40.6
Per capita total expenditure on health (PPP int.$)**	199	239
General government expenditure on health as % of total government expenditure	6.8	6.4
Private expenditure on health as % of total expenditure on health*	69.6	59.4
Out-of-Pocket expenditure as % of private expenditure on health	95.7	92.9
AZERBAIJAN		
Total expenditure on health as % of Gross domestic product	7.8	5.9
General government expenditure on health as % of total expenditure*	11.3	20.3
Per capita total expenditure on health (PPP int.$)**	343	579
General government expenditure on health as % of total government expenditure	5.2	4.2
Private expenditure on health as % of total expenditure on health*	88.7	79.7
Out-of-Pocket expenditure as % of private expenditure on health	93.6	87.2

GEORGIA		
Total expenditure on health as % of Gross domestic product	8.6	10.1
General government expenditure on health as % of total expenditure*	19.2	23.6
Per capita total expenditure on health (PPP int.$)**	302	522
General government expenditure on health as % of total government expenditure	6.2	6.9
Private expenditure on health as % of total expenditure on health*	80.8	76.4
Out-of-Pocket expenditure as % of private expenditure on health	95.0	89.5
HUNGARY		
Total expenditure on health as % of Gross domestic product	8.3	7.3
General government expenditure on health as % of total expenditure*	72.3	69.4
Per capita total expenditure on health (PPP int.$)**	1411	1469
General government expenditure on health as % of total government expenditure	12.0	10.3
Private expenditure on health as % of total expenditure on health*	27.7	30.6
Out-of-Pocket expenditure as % of private expenditure on health	85.9	78.3
POLAND		
Total expenditure on health as % of Gross domestic product	6.2	7.5
General government expenditure on health as % of total expenditure*	69.3	72.6
Per capita total expenditure on health (PPP int.$)**	857	1476
General government expenditure on health as % of total government expenditure	9.9	11.9
Private expenditure on health as % of total expenditure on health*	30.6	27.4
Out-of-Pocket expenditure as % of private expenditure on health	85.3	80.6
RUSSIAN FEDERATION		
Total expenditure on health as % of Gross domestic product	5.2	5.1
General government expenditure on health as % of total expenditure*	62.0	62.1
Per capita total expenditure on health (PPP int.$)**	615	998
General government expenditure on health as % of total government expenditure	11.7	8.0
Private expenditure on health as % of total expenditure on health*	38.0	37.9
Out-of-Pocket expenditure as % of private expenditure on health	82.4	82.8
UKRAINE		
Total expenditure on health as % of Gross domestic product	6.4	7.7
General government expenditure on health as % of total expenditure*	59.5	56.6
Per capita total expenditure on health (PPP int.$)**	359	519
General government expenditure on health as % of total government expenditure	8.7	9.4
Private expenditure on health as % of total expenditure on health*	40.5	43.4
Out-of-Pocket expenditure as % of private expenditure on health	92.5	93.4

Source: Health expenditure series, World Health Organization, Geneva, February 2009 (latest updates are available on http://www.who.int.nha/country/en/index.html)

WOMEN'S STATUS IN THE COUNTRY

Table 10: Percentage of parliamentary seats occupied by women

Seats in Parliament Held by Women (%of total)	
Name of Country	2011
Armenia	9.2
Azerbaijan	16.0
Georgia	6.5
Hungary	9.1
Poland	17.9
Russian Federation	11.5
Ukraine	8.0

Source: Human Development Report 2011 http://hdr.undp.org/en/media/HDR_2011_EN_Tables.pdf

Table 11: Labour Force Participation Rate – Female/Male (%)

Labour Force Participation Rate (%)		
Name of Country	Female	Male
Armenia	59.6	74.6
Azerbaijan	59.5	66.8
Georgia	55.1	73.8
Hungary	42.5	58.8
Poland	46.2	61.9
Russian Federation	57.5	69.2
Ukraine	52.0	65.4

Source: Human Development Report 2011 http://hdr.undp.org/en/media/HDR_2011_EN_Tables.pdf

REPRODUCTIVE HEALTH SERVICES INDICATORS

Table 12: Total Fertility Rates

Total Fertility Rates			
Name of Country	Total Fertility Rate		
	1995	2003-2005	2008-2010
Armenia	1.7 (DHS 2000)	1.7 (2000 DHS)	1.7 (2010 DHS Prelim report)
Azerbaijan		2.1 (RHS 2001)	2 (2006 DHS)
Georgia	1.7 (RHS 1996)	1.6 (RHS 2005)	2.0 (GERHS 2010)
Hungary	1.7 (HDR 1990-1995)		1.4 (HDR 2005-2010)
Poland	1.9 (HDR 1990-1995)	1.3 (HDR 2000-2005)	1.3 (HDR 2005-2010)
Russia	1.5 (HDR 1990-1995)	1.3 (2005)	1.5 (2010)
Ukraine	1.6 (RHS 1999)		1.2 (DHS 2007)

Source: Demographic and Health Survey(s) for Armenia (2000, 2005); Azerbaijan (2006); Ukraine (2007) & Human Development Report 1995, 2003, 2010

Table13: Reasons for Discontinuation

Armenia 1995	2003 (2000 DHS)									
Reasons for discontinuation	Modern Method				Traditional/fold method discontinued					
	Pill	IUD	Condom	LAM	Periodic abstinence	Withdrawal	Douche	Other methods	All methods	
Became pregnant while using	17,8	8,5	33,1	32	57,2	67,2	64,2	58,7	52,8	
Wanted to become pregnant	7	5,2	16	5,8	9,1	9,4	4,5	0	9,1	
Husband dissapproved	0	1,5	7,6	0,7	3,4	4,2	0	0	3,7	
Side effects	7,4	11,3	3,2	0,4	0,5	0,8	0	3,4	1,9	
Health concerns	38,5	60,1	2,4	0,6	0,3	1,1	7,5	3,9	6,8	
Lack of access/availability	7,9	0,4	4,1	0	0	0,1	1,2	0	0,8	
Wanted a more effective method	2,7	2,8	3,6	28,3	11	5,1	7,8	12,1	7,8	
Inconvinient to use	3,9	1,1	7	5,6	3,2	1,1	1,5	10,2	2,6	
Infrequent sex/husband away	6,8	5,4	9,6	1,4	9,7	7,3	10,2	0	7	
Cost too much	6,4	0	5,8	0	0,4	0	0	0	0,9	
Fatalistic	0	0	0	0	0,2	0,4	0	0	0,3	
Difficult to get pregnant/menopausal	0	1,3	1,3	0,4	2,2	1	3	7,8	1,2	
Marital dissolution/separation	0	1,1	0,9	0,2	0,5	0,5	0	0	0,5	
Other	1,6	1,4	1,9	22,1	1,6	0,7	0	3,9	3,3	
Misisng	0	0	0,1	2,4	0,8	1,1	0	0	1,3	
Don'tknow	0	0	3,4	0	0	0	0	0	0	
Total	100	100	100	100	100	100	100	100	100	
Number fo discontinuations	71	254	373	336	290	1786	91	29	3230	
Azerbaijan 1995										
Reasons for discontinuation										
Became pregnant while using										
Wanted to become pregnant										
Husband dissapproved										
Side effects										
Health concern										
Lack of access/availability										
Wanted a more effective method										
Inconvinient to use										
Infrequent sex/husband away										
Cost too much										
Fatalistic										
Difficult to get pregnant/menopausal										
Marital dissolution/separation										
Other										
Missing										
Dont know										
Total										
Number of discontinuations										
Ukraine 1995										
Reasons for discontinuation										
Became pregnant while using										
Wanted to become pregnant										
Husband dissapproved										
Side effects										
Health concerns										

	2008 (2005 DHS)									
	Modern methods					Traditional method				
	Pill	IUD	condom		other	Peridostic abstinence	Withdrawal	Other	Rhythm	all methods
	24,8	4,1	28,5		30	60,8	51,2	54,3		42,5
	12,9	15,1	20,3		5,1	10,3	13,2	8,4		13,8
	1,8	0,7	9,1		3,3	2,7	3,4	0		3,8
	6,9	17,7	0,2		0	0	0,1	0		1,9
	16,2	49,3	1,1		0	0	1,2	0,3		5,7
	0	0	0,4		3	0	0	0		0,2
	3,4	0,6	8,5		20,9	3,8	4,5	9,9		5,5
	8,1	1,2	4,5		7,5	1,3	0,8	4		2,2
	16,9	2,6	13,5		12,8	13,6	18,5	11,9		15,3
	3,6	0	5,4		0	0	0,2	0		1,2
	0	0	0		0	3,3	0,1	0		0,3
	1,8	1,1	1,9		0	2,6	2,2	0,8		1,9
	1,1	2	1,3		0	0	0,8	0		0,9
	0,4	5,8	2,3		10,7	1,5	1,5	3		2,3
	2,1	0	3		6,7	0	2,2	7,5		2,5
	0	0	0		0	0	0	0		0
	100	100	100		100	100	100	100		100
	90	172	350		55	157	1080	130		2034
	2008 (2006 DHS)									
	Pill	IUD	condom	LAM			Withdrawal		Rhythm	all methods
	37,4	3,9	18,4	4,7			55,4		63,3	43,9
	9,6	11,9	24,9	20,3			10		5,6	11,5
	6,7	5,9	21,7	18,6			16,2		7,7	14,3
	9	17,2	0	0			0,4		0	2,5
	14,6	36	0,3	1,1			0,5		1,2	4,9
	2,1	0	1,6	0			0		0	0,3
	3,9	5,6	11,3	21			4,5		7,9	6,4
	0	3,4	8,4	0,1			0,4		1,6	1,5
	5,6	1,2	6	0,7			5,5		5,3	4,8
	2,7	0	2	0			0		0	0,3
	0	0	0	0			0,2		0	0,1
	2,4	2,3	0,9	0			3,4		3,1	2,8
	0,8	0,4	1,4	0			0,2		1,4	0,6
	4,4	11,9	0,9	28,8			1,2		2,3	4,4
	0,9	0,4	2,2	4			2,2		0,4	1,9
	0	0	0	0,6		0	0		0	0
	100	100	100	100		100	100		100	100
	130	219	144	144			1406		169	2245
	2008 (2007 DHS)									
	Pill	IUD	Condom							
	5,5	3,5	8,9							
	11,5	5,3	16,5							
	0,4	0	13							
	23,3	9,6	0,2							
	18,8	21,8	1,9							

Table 14: Contraceptive use

Name of Country				
Armenia				
Methods	Among women who started the last episode of modern contraceptive method within 5 years preceeding the survey 2005			
	% who were informed about side effects or problems of method used	% who were informed about what to do if experienced side effects	% who were informed by a health and family planning worker of other methods that could be used	Number of women
Pill	24,4	26,3	34,1	No Info
IUD	49,5	47,7	37,2	No Info
Other	-	-	-	
Azerbaijan				
Methods	Among women who started the last episode of modern contraceptive method within 5 years preceeding the survey			
	% who were informed about side effects or problems of method used	% who were informed about what to do if experienced side effects	% who were informed by a health and family planning worker of other methods that could be used	Number of women
Pill	19,4	21,2	44,9	49
IUD	73,1	70,7	41,9	307
Other	NA	NA	6,4	66
Total	66,3	64,5	36,6	433
Ukraine	Among current users of modern methods age 15-49 who started the last episode of use within the five years preceding the survey, the percentage who were informed about possible side effects or problems of that method, the percentage who were informed what to do if they experience side effect, and the percentage who were informed about other methods they could use, by methods			
Methods	Among women who started the last episode of modern contraceptive method within 5 years preceeding the survey			
	% who were informed about side effects or problems of method used	% who were informed about what to do if experienced side effects	% who were informed by a health and family planning worker of other methods that could be used	Number of Women
Pill	66,5	67,6	58,7	202
IUD	82,1	84	67,6	441
Other	74,2	66,4	76	53

Source: Demographic Health Surveys for Armenia, Azerbaijan and Ukraine

Table 15: Contraceptive Prevalence Rate

Name of Country	Any Method	Any Modern Method	Female Sterilization	Male Sterilization	Pill	Injectable	Implant	IUD	Male condom	Vaginal barrier	Other Modern Method	Any Traditonal Method	Rhythm	Withdrawal	Other Traditional Method
Armenia (2010)	53.1 (2005)	19,1	0,6	0	0,8	0	0	9,4	8,1	0,2	0	34	3,8	27,7	2,5
Azerbaijan	51.1 (2006)	13,2	0,4	0	1,1	0	0	9,2	2,2	0,2	0	37,9	4	32,5	1,4
Georgia (2005)	47,3	26,6	2,2	0	3,2	0		11,6	8,7	0,9	0	20,7	9,5	11,2	0
Hungary (1992-1993)	80,6	71,3	5		39,4			18,2	8,1	0,6	0	9,3	2,6	6,5	0,2
Poland (1991)	72,7	28	0	0	3,4			8,4	13,4	2,8	0	44,7	28,4	16,3	0
Russia (2007)	79,5	65			14,1			20,4	30,3		5,2	14,6	14,5	13,6	2,9
Ukraine (2007)	66,7	47,5	0,6	0	4,8	0	0	17,7	23,8	0,5	0	19,1	7,2	10,3	1,6

Source: Country Demographic and Health Survey(s), Armenia 2010 Preliminary Report, Azerbaijan 2006, Ukraine

Table 16: Wanted Fertility Rates

Wanted Fertility Rate			
Name of Country	Wanted Fertility Rate		
	1995	2003-2005	2008-2010
Armenia		1.5 (DHS 2000)	1.6 (DHS 2005)
Azerbaijan		3.5 (RHS 2001)	1.8 (DHS 2006)
Georgia	3.5 (RHS 1999)		2.6 (RHS 2005)
Hungary			
Poland			
Russia			
Ukraine		0.8 (RHS 1999)	1.1 (DHS 2007)

Source: Demographic Health Survey(s) for Armenia, Azerbaijan and Ukraine (2007)

Table 17: Unmet Need for Contraception

Unmet Need for Contraception (Family Planning)			
Name of Country	Unmet Need for Contraception		
	1995	2003	2007
Armenia		11.8 (2000)	13.1 (2005)
Azerbaijan		11.5 (2001)	15.1 (2006)
Georgia		23.8 (2000)	16.3 (2005)
Hungary	7.0 (1993)		
Poland			
Russia			
Ukraine		17.5 (1999)	10.3

Note: Data pertain to women aged 15 to 44. Excluding women who are currently pregnant, currently seeking to become pregnant, subfecund, or who are not sexually active, including women practicing post-partum abstinence. Including fecund married women, currently sexually active, currently exposed to the risk of pregnancy, not wanting to become pregnant, and not using a method of contraception other than folk methods, douches, breastfeeding or lactational amenorrhea (LAM). RHS.

Source: Official UN MDG Indicators: http://unstats.un.org/unsd/mdg/Default.aspx

Table 18: Unmet need for family planning

Unmet need for family planning, spacing, percentage						
Country	1999	2000	2001	2005	2006	2007
Armenia		2,62		3,62		
Azerbaijan			1,81		2,92	
Georgia		5,71		4,31		
Ukraine	3,41					3,92

Unmet need for family planning, spacing, percentage							
Country	1993	1999	2000	2001	2005	2006	2007
Armenia			9,3		9,7		
Azerbaijan				9,7		12,2	
Georgia			18,1		12,0		
Hungary	7,0						
Ukraine		14,1					6,4

1. Data pertains to women agend 15 to 44. Excluding womne who are currently pregnant, currently seeking to become pregnant, subfecund, or who are not sexually active, including including women practicing post-partum abstinence. Including fecund married women, currently sexually active, currently exposed to the risk of pregnancy, not wanting to become pregnant, and not using a method of contraception other than folk methods, douches, breastfeeding or lactational amenorrhea (LAM). RHS.

2. DHS.

3. Data pertain to women aged 18 to 41. Data pertain to unmet need for limiting only. Including sexually active, fecund married men and women (excluding those in unions), not practicing contraception and not wanting additional children or with a current pregnancy that was not wanted at conception. FFS.

Source: UN MDG INDICATORS DATABASE http://unstats.un.org/unsd/mdg/Data.aspx

Table 19: Male contraception as % of total contraception

Name of the Country	Male Sterilization	Male Condom
Armenia (2005)	0	8.1
Azerbaijan (2006)	0	2.2
Georgia (2005)	0	8.7
Hungary (1992-1993)	-	8.1
Poland (1991)	0	13.4
Russia (2007)		30.3
Ukraine (2007)	0	23.8

Source: World Contraception use 2011 and Country Demographic and Health Survey(s) http://www.un.org/esa/population/publications/contraceptive2011/contraceptive2011.htm

Table 20: Informed Choice

Name of Country				
Armenia				
Methods	Among women who started the last episode of modern contraceptive method within 5 years preceeding the survey 2005			
	% who were informed about side effects or problems of method used	% who were informed about what to do if experie-nced side effects	% who were informed by a health and family planning worker of other methods that could be used	Number of Women
Pill	24,4	26,3	34,1	No Info
IUD	49,5	47,7	37,2	No Info
Other	-	-	-	
Azerbaijan				
Methods	Among women who started the last episode of modern contraceptive method within 5 years preceeding the survey			
	% who were informed about side effects or problems of method used	% who were informed about what to do if experie-nced side effects	% who were informed by a health and family planning worker of other methods that could be used	Number of Women
Pill	19,4	21,2	44,9	49
IUD	73,1	70,7	41,9	307
Other	NA	NA	6,4	66
Total	66,3	64,5	36,6	433
Ukraine	Among current users of modern methods age 15-49 who started the last episode of use within the five years preceding the survey, the percentage who were informed about possible side effects or problems of that method, the percentage who were informed what to do if they experience side effect, and the percentage who were informed about other methods they could use, by methods			
Methods	Among women who started the last episode of modern contraceptive method within 5 years preceeding the survey			
	% who were informed about side effects or problems of method used	% who were informed about what to do if experie-nced side effects	% who were informed by a health and family planning worker of other methods that could be used	Number of Women
Pill	66,5	67,6	58,7	202
IUD	82,1	84	67,6	441
Other	74,2	66,4	76	53

Source: Demographic Health Surveys for Armenia, Azerbaijan and Ukraine

Table 21: Antenatal care coverage

Name of the Country	At least 1 visit			4 visits		
	1995	2003-2005	2008-2010	1995	2003-2005	2008-2010
Armenia	82% (1997)	93% (2005)	93% (2005)	64.7% (2000)	70.9% (2005)	N/A
Azerbaijan	98.3% (1997)	76.6(2006)	76.6(2006)	30.4% (2001)	N/A	45.2% (2006)
Georgia	74% (1997)	94.3	94.3	N/A	75% (2005)	N/A
Hungary	N/A	N/A	N/A	N/A	N/A	N/A
Poland	N/A	N/A	N/A	N/A	N/A	N/A
Russia	N/A	N/A	N/A	N/A	N/A	N/A
Ukraine	N/A	98.5% (2005)	98.8% (2007)	N/A	N/A	74.8% (2007)

Source: UN MDG Indicators Database http://unstats.un.org/mdg/Default.aspx

Table 22: Maternal Mortality Ratio per 100000 live births

Name of the Country	Estimated MMR			
	1995	2005	2008	Lifetime Risk of Maternal Death, 1 in:
Armenia	44	32	29	1900
Azerbeijan	79	44	38	1200
Georgia	58	52	48	1300
Hungary	23	10	13	5500
Poland	17	5	6	13300
Russia	74	39	39	1900
Ukraine	49	26	26	3000

Source: Trends in maternal mortality estimates developed by WHO, UNICEF, UNFPA and World Bank 2010, Data Source 2008 http://whqlibdoc.who.int/publications/2010/9789241500265_eng.pdf

Table 23: Skilled Health Attendants at Birth

% skilled health worker (doctors, nurses, midwifes and other cadres of health workers)				
Name of Country	1995	2005	2007	ICPD/ ICPD+15 targets for 2015 met?
Armenia	97.3 (1997)	97.8	99.9	yes
Azerbeijan	99.8 (1998)	99.7 (2004)	88.0 (2006)	yes
Georgia	90.8 (1993)	98.3		yes
Hungary	99.4	99.6	99.5 (2008)	yes
Poland	99.8 (2002)	99.9		yes
Russia	99.1	99.4	99.6 (2008)	yes
Ukraine	99.6 (1996)	99.8	99.7	yes

Source: MDG indicators official website

Table 24: Postnatal Care

Name of Country					Timing of first postnatal checkup for mothers who delivered outside a health facility										
	Mother's age at birth	less than 4 hours	4-23 hours	Delivered in a health facility	1-2 days	within 2 days of birth	3-41 days	within 7 days of birth	within 42 days of birth	dont know/ missing	did not receive postnatal care	Number of births	total	number of women	source DHS 2000
Armenia 2000	<20			86,6		6,9		7,5	8,1	0,7	4,6	172			
	20-34			93,7		3,3		3,6	4,2	0,5	1,7	999			
	35+			88,9		4,4		5,1	5,1	0	5,9	77			
Armenia 2005	Mother's age at birth														
	<20	60,1	17,7			4,3	1,9			0	16		100	111	DHS 2005
	20-34	56	22,6			2	1,3			1,7	16,4		100	991	
	35+	73,4	16,4			0,6	0			1,1	8,5		100	74	
Azerbaijan 2006	Mother's age at birth														
	<20	42,8	4,1		9,4		2,1			1,2	40,5		100	126	DHS 2006
	20-34	46,3	7,7		13,1		4,5			2,1	26,4		100	1426	
	35+	47,9	9,6		11,1		1,9			0,6	28,9		100	133	
Ukraine 2007	Mother's age at birth														
	<20	37,3	10,7			36,7	10,6			2,8	1,9		100	106	DHS 2007
	20-34	30,5	25,3			31,9	7,3			2,7	2,2		100	900	
	35+	25,3	20,1			32,9	18,1			0	3,7		100	66	

Table 25: Timing of first postnatal checkup for mothers who delivered outside a health facility

	Mother's age at birth	less than 4 hours	4-23 hours	Delivered in a health facility	1-2 days	within 2 days of birth	3-41 days	within 7 days of birth	within 42 days of birth	dont know/ missing	did not receive postnatal care	Number of births	total	number of women	source DHS 2000
Armenia 2000	<20			86,6		6,9		7,5	8,1	0,7	4,6	172			
	20-34			93,7		3,3		3,6	4,2	0,5	1,7	999			
	35+			88,9		4,4		5,1	5,1	0	5,9	77			
Armenia 2005	Mother's age at birth														
	<20	60,1	17,7			4,3	1,9			0	16		100	111	DHS 2005
	20-34	56	22,6			2	1,3			1,7	16,4		100	991	
	35+	73,4	16,4			0,6	0			1,1	8,5		100	74	
Azerbaijan 2006	Mother's age at birth														
	<20	42,8	4,1		9,4		2,1			1,2	40,5		100	126	DHS 2006
	20-34	46,3	7,7		13,1		4,5			2,1	26,4		100	1426	
	35+	47,9	9,6		11,1		1,9			0,6	28,9		100	133	
Ukraine 2007	Mother's age at birth														
	<20	37,3	10,7			36,7	10,6			2,8	1,9		100	106	DHS 2007
	20-34	30,5	25,3			31,9	7,3			2,7	2,2		100	900	
	35+	25,3	20,1			32,9	18,1			0	3,7		100	66	

Table 26: Adolescent Fertility Rate

Adolescent Pregnancies-Adolescent Birth Rates			
Name of the Country	Adolescent Birth Rates per 1000 women		
	1995	2003	2008
Armenia	66.6	29.2	27.2
Azerbaijan	39	27.4	41.5
Georgia	64.2	33.2	43.8
Hungary	31.4	20.8	19.9
Poland	22	14.7	16.4
Russia	43.9	28	30.1
Ukraine	54.3	29.6	29.9 (2007)

Source: UN MDG Indicators Database http://unstats.un.org/mdg/Default.aspx

Table 27: Regional estimates of annual number, rates, and ratios of unsafe abortion, 2008.

		Rate and ratio calculations including only countries of each region with evidence of unsafe abortion	
Region	Unsafe abortion numbers	Unsafe abortion rate (per 1000 women aged 15-44 years)	Unsafe abortion ratio (per 100 live births)
Eastern Europe	360 000	6	13

Source: WHO, http://whqlibdoc.who.int/publications/2011/9789241501118_eng.pdf

Note: Estimates are calculated for all countries and contrasted with calculations including only countries with evidence of unsafe abortion.

Table 28: Grounds on which abortion is permitted

Name of the Country	To save woman's life	To preserve physical health	To preserve mental health	Rape and incest	Foetal impairment	Economic or social reasons	On request
Armenia	x	x	x	x	x	X	x
Azerbajian	x	x	x	x	x	X	x
Georgia	x	x	x	x	x	X	x
Hungary	x	x	x	x	x	X	x
Poland	x	x	x	x	x	No	no
Russia	x	x	x	x	x	X	x
Ukraine	x	x	x	x	x	X	x

Source: World Abortion Policies 2011 http://www.un.org/esa/population/publications/2011abortion/2011wallchart.pdf

Table 29: Reproductive Cancers Estimated Incidence, Mortality and 5-year Prevalence in Women

Name of the Country	Type of Cancers	Incidence			Mortality			5-year prevalence		
		Number	(%)	ASR (W)	Number	(%)	ASR (W)	Number	(%)	ASR (W)
Armenia	Breast	1065	26	47,3	601	20	25	3520	39,1	261
	Cervix uteri	385	9,4	17,3	202	6,7	8,7	1027	11,4	76,2
	Corpus uteri	206	5	9,2	87	2,9	3,4	665	7,3	48,6
	Ovary	141	3,4	6,3	116	3,9	4,9	325	3,6	24,1
Azerbaijan	Breast	1155	16,7	24,6	581	11,2	12,5	3964	27	114,8
	Cervix uteri	463	6,7	10	234	4,5	5,1	1309	8,9	37,9
	Corpus uteri	109	1,6	2,6	42	0,8	1	343	2,3	9,9
	Ovary	181	2,6	3,9	125	2,4	2,7	459	3,1	13,3
Georgia	Breast	1299	30,9	38,5	729	27	19,7	4265	41,4	221
	Cervix uteri	317	7,5	9,4	169	6,3	4,7	837	8,1	43,4
	Corpus uteri	595	14,2	18,7	206	7,6	5,8	2182	21,2	113,1
	Ovary	129	3,1	4,1	102	3,8	2,9	306	3	15,9
Hungary	Breast	5218	22,2	56,8	2108	15	18,6	19207	33,5	424
	Cervix uteri	1086	4,6	16,6	472	3,3	5,6	3841	6,7	84,8
	Corpus uteri	1177	5	11,5	280	2	2,2	4312	7,5	95,2
	Ovary	1008	4,3	10,7	687	4,9	6,2	2244	3,9	49,5
Poland	Breast	15571	24	48,9	5362	13,2	14,7	61217	36,7	362,3
	Cervix uteri	3536	5,4	11,6	1951	4,8	5,8	10917	6,6	64,6
	Corpus uteri	4431	6,8	13,2	1091	2,7	2,7	16721	10	99
	Ovary	3919	6	12	2507	6,2	7	9080	5,5	53,7
Russia	Breast	52469	23,1	43,2	22946	17,4	17,1	197345	32,5	299,6
	Cervix uteri	13807	6,1	13,3	7161	5,4	5,9	46588	7,7	70,7
	Corpus uteri	18789	8,3	15,1	5250	4	3,6	71749	11,8	108,9
	Ovary	12761	5,6	11	7551	5,7	5,8	31661	5,2	48,1
Ukraine	Breast	16366	22,5	40	7964	20,4	17,7	61179	30,8	282,5
	Cervix uteri	5323	7,3	16,1	2258	5,8	5,9	18305	9,2	84,5
	Corpus uteri	6989	9,6	16,7	2017	5,2	4	26774	13,5	123,6
	Ovary	4067	5,6	10,5	2486	6,4	5,9	10051	5,1	46,4

Source: GLOBOCAN 2008 Cancer Incidence, Mortality and Prevalence Worldwide in 2008; http://globocan.iarc.fr/
ASR (W): Age Standardised Rate

SEXUAL HEALTH AND RIGHTS

Table 30: Estimated People Living With HIV (adults + children)

Estimated People Living With HIV (adults + children)				
Name of the Country	Estimate Number of Adults and Children		Estimate Prevalence Percent of Adults and Children	
	2001	2009	2001	2009
Armenia	1400	1900	0,1	0,1
Azerbaijan	1300	3600	< 0.1	0,1
Georgia	1200	3500	< 0.1	0,1
Hungary	2800	3000		
Poland	21000	27000		
Russian Federation	430 000	980 000	0,5	1,0
Ukraine	290 000	350 000	0,9	1,1

Source: UNAIDS 2010 GLOBAL REPORT

Table 31: Estimated number of women living with HIV

Name of the Country	Estimate Number Women 15+	
	2001	2009
Armenia	<500	<1000
Azerbaijan	<1000	2100
Georgia	<500	1500
Hungary	<1000	<1000
Poland	6400	8200
Russian Federation	190000	480000
Ukraine	130000	170000

Source: UNAIDS 2010 GLOBAL REPORT

Table 32: HIV Prevalence in Young People

Estimated People living with HIV-2009 (http://www.unaids.org/documents/20101123_GlobalReport_Annexes1_em.pdf)							
	Armenia	Azerbaijan	Georgia	Hungary	Poland	Russia	Ukraine
Young women (15-24) prevalence (%)	<0.1	0.1	<0.1	<0.1	<0.1	0.3	0.3
Young men (15-24) prevalence (%)	<0.1	<0.1	<0.1	<0.1	<0.1	0.2	0.2

Table 33: Reported number of people receiving antiretroviral therapy by sex and by age, and estimated number of children receiving and needing antiretrovital therapy and coverage percentages, 2010

Countries	Reported number of all males and females receiving antiretroviral therapy					Reported number of adults and children receiving antiretroviral therapy		
	Month and year of report	Males	% of total	Females	% of total	Month and year of report	Adults (15+)	
Armenia	Dec. 10	161	64%	89	36%	Dec. 10	240	
Azerbaijan	Dec. 10	334	77%	101	23%	Dec. 10	426	
Georgia	Dec. 10	581	70%	249	30%	Dec. 10	796	
Hungary		…		…			…	
Poland	Dec. 10	3 591	73%	1 306	27%	Dec. 10	4 767	
Russian Federation		…		…			…	
Ukraine	Dec. 10	12 024	53%	10 673	47%	Dec. 10	20 651	

…Data not available or not applicable.

c The coverage estimates are based on the estimated unrounded numbers of children receiving antiretroviral therapy and the estimated unrounded need for antiretroviral therapy (based on UNAIDS/WHO methodology). The ranges in coverage estimates are based on plausibility bounds in the denominator: that is, low and high estimates of need.

g Although no report has been received from the Russian Federation, for the analysis throughout the report, based on previous reports, an estimated 4% of the people receiving antiretroviral therapy in the Russian Federation are assumed to be children.

Low- and middle-income countries[a]	Testing and counselling facilities, 2009			Testing and counselling facilities, 2010		
	Reported number		Estimated number per 100 000 adult population	Reported number		Estimated number per 100 000 adult population
Armenia	150		9,2	150		9,3
Azerbaijan	…		…	…		…
Georgia	…		…	334		15
Hungary	144		3	144		3
Poland	2 645		13,7	…		…
Russian Federation	…		…	…		…
Ukraine	2 002		8,5	1 880		8,1

				Estimated number of children needing antiretroviral therapy based on UNAIDS/ WHO methods, 2010			Estimated antiretroviral therapy coverage among children, December 2010[c]		
	% of total	Children (<15)	% of total	Estimate	Low estimate	High estimate	Estimate	Low estimate	High estimate
	96%	10	4%	…	<100	<100	…	40%	>95%
	98%	9	2%	…	<100	<100	…	50%	60%
	96%	34	4%	…	<100	<100	…	>95%	>95%
		…		…	<100	<100	…	>95%	>95%
	97%	130	3%	…	<100	<100	…	>95%	>95%
		…[g]		…	5 700	7 500	…	42%	56%
	91%	2 046	9%	…	2 800	4 200	…	48%	73%

Table 34: Reported number of facilities with HIV testing and counselling and number of people older than 15 years who received HIV testing and counseling

	Number of people aged 15 years and older who received HIV testing and counselling, 2009[b]				Number of people aged 15 years and over who received HIV testing and counselling, 2010[b]			
	Reported number[c]		Estimated number per 1000 adult population	Reporting period	Reported number[c]		Estimated number per 1000 adult population	Reporting period
	70 955		43,7	Jan. 09–Dec. 09	71 316		44,4	Jan. 10–Dec. 10
	…		…		361 574		66,6	Jan. 10–Dec. 10
	…		…		70 615		31,8	Jan. 10–Dec. 10
	99 538		20,6	Jan. 09–Dec. 09	…		…	
	25 452		1,3	Jan. 09–Dec. 09	…		…	
	…		…		…		…	
	…		…		3 247 002		140,5	Jan. 10–Dec. 10

a See the country classification by income, level of the epidemic and geographical, UNAIDS, UNICEF and WHO regions.

b This number should include all people aged 15 years and older who received HIV testing and counselling through any method or setting, including voluntary counselling and testing and antenatal care settings. Not all countries are able to report c data from all settings.

c Some countries reported voluntary counselling and testing and antenatal care testing data separately; data is combined here.

Source: Publication: GLOBAL HIV/AIDS RESPONSE: Epidemic update and health sector progress towards Universal Access Progress report 2011 WHO, UNAIDS, UNICEF; 2. Reported number of facilities with HIV testing and counselling and number of people older than 15 years who received HIV testing and counselling,

Website: www.who.int/hiv/data/tuapr2011_annex2_web.xls

Table 35: Reported proportion of women attending antenatal care tested for syphilis at the first visit, women attending antenatal care seropositive for syphilis, syphilis-seropositive women attending antenatal care treated, sex workers seropositive for syphilis and men who have sex with men seropositive for syphilis, as reported by low- and middle-income countries in 2010

Countries	% of women attending antenatal care tested for syphilis at the first visit	Year	% of women attending antenatal care seropositive for syphilis	Year	% of sex workers seropositive for syphilis	Year	% of men who have sex with men seropositive for syphilis	Year
Number of countries reporting	63		75		40		31	
Hungary	…	…	…	…	…	…	4,4%	NR
Ukraine	…	…	…	…	4,4%	2009	1,9%	2009

… Data not available or not applicable.

NR data not reported.

The data should be interpreted with caution, since the data may not be nationally representative and the methods varied among countries.

Source: Publication: GLOBAL HIV/AIDS RESPONSE: Epidemic update and health sector progress towards Universal Access Progress report 2011, WHO, UNAIDS, UNICEF

1. Reported proportion of women attending antenatal care tested for syphilis at the first visit, women attending antenatal care seropositive for syphilis, syphilis-seropositive women attending antenatal care treated, sex workers seropositive for syphilis and men who have sex with men seropositive for syphilis, as reported by low- and middle-income countries in 2010 (see footnote) www.who.int/hiv/data/tuapr2011_annex1_web.xls

Table 36: Legal Age of Marriage

Name of Country	Women	Men	Comments
Armenia	17	18	exception for women 16, under exceptional circumstances
Azerbaijan	17	18	exception for women 16, men 17. under exceptional circumstances
Georgia	18	18	exception is 16 for both men and women. Requires parental consent.
Hungary	18	18	exception is 16 for both men and women. Requires parental consent.
Poland	18	18	exception for women. Requires authorization of the appropriate guardianship court.
Russian Federation	18	18	-
Ukraine	17	18	exception is 14 for both men and women. Requires authorization of civil court.

Source: UN DATA http://data.un.org/DocumentData.aspx?q=LEGAL+AGE+OF+MARRIAGE&id=286

Table 37: Violence Against Women in General Laws

Name of Country	Violence Against Women in General Laws
Armenia	1. Armenia's implementation of the "Combating Gender-based Violence in the South Caucasus" project. (2008-2011)
	2. National Programme to Improve the Status of Women and to Enhance Their Role in Society in the Republic of Armenia. (2004-2010)
Azerbaijan	Azerbaijan's implementation of the Regional Combating Gender-Based Violence in the South Caucasus Project. (2008)
Georgia	1. Action Plan of Measures to be Implemented to Combat Domestic Violence and Protect Domestic Violence Victims. (2009-2010)
	2. Action Plan on Prevention of Domestic Violence and Protection of Victims of Domestic Violence. (2009-2011)
	3. Action Plan on Combating Violence against Women. (2000-2002)
Hungary	1. Act XIX of 1998 on Criminal Proceedings as amended by Act LI of 2006. (2006)
	2. Act LXXX of 2003 on legal assistance. (2000)
	3. Budgetary appropriation in 2008. (2008)
	4. National Strategy of Social Crime Prevention (Government Resolution No. 1009/2004 (II. 26) Korm.). (2004)
Poland	—
Russia Federation	1. Code of Criminal Procedure of the Russian Federation. (2002)
	2. National Strategy on Equal Rights and Equal Opportunities for Men and Women in the Russian Federation. (2006)
Ukraine	1. Plan of Action under the "Stop Violence!" Platform of Action. (2008-2015)
	2. State family support programme. (2007-2010)
	3. State programme for the promotion of sexual equality in Ukrainian society up to 2010. (2006-2010)
	4. National plan of actions on the improvement of position of women and assistance to introduction of gender equality in society. (2001-2005)

Table 38: Domestic Violence Laws

Name of Country	Domestic Violence Laws
Armenia	Gender and Politics project component on the prevention of domestic violence. (2004-2008)
Azerbaijan	1. Law on Prevention of Domestic Violence. (2010)
	2. "XXI century without violence against women" project. (2008)
	3. National Plan of Action on Family and Women's Problems. (2008-2012)
	4. The "Complex Program of the Republic on combating domestic violence in democratic society". (2007)
	5. National Plan of Action on protection of human rights. (2006)
Georgia	1. Law on the Elimination of Domestic Violence, Protection and Assistance of the Victims of Domestic Violence. (2006)
	2. Action Plan of Measures to be Implemented to Combat Domestic Violence and Protect Domestic Violence Victims. (2009-2010)
	3. Action Plan on Prevention of Domestic Violence and Protection of Victims of Domestic Violence. (2009-2011)
	4. Action Plan on Combating Violence against Women (2000-2002)
Hungary	1. 32/2007. (OT 26) HNP HQ Instruction of the High Commissioner of the Hungarian National Police on the carrying out of tasks connected to the management of domestic violence and to the protection of the minors. (2007)
	2. Protocol for Crisis Management Centers. (2007)
	3. Section 176/A of the Criminal Code. (2007)
	4. Resolution No. 45/2003 (IV. 23) OGY on the development of a national strategy to prevent and effectively manage domestic violence. (2003)
	5. Child Protection Act XXXI of 1997 on the protection of children and guardianship administration. (1997)
	6. Permanent fund for NGOs. (2000)
Poland	1. Ordinance of the Minister of Labour and Social Policy of 6 July 2006 concerning the standard of basic services provided for by specialized support centres for family violence victims as well as detailed directions of corrective educational influences. (2006)
	2. Act of 29 July 2005 on counteracting family violence (Dz.U. No 180, item 1493). (2005)
	3. Guidelines for creating corrective and educational programmes for perpetrators. (2000)
	4. Ministry of Justice recommendations for prosecutors. (2000)
	5. "Blue card" police procedure. (1998)
	6. Penal Code. (1997)
	7. National Action Plan against Trafficking in Human Beings. (2009-2010)
	8. National Program of Counteracting Domestic Violence (2006-2016). (2006)
Russia Federation	1. Order No. 564-st of the Federal Agency for Technical Regulation and Metrology on the approval of the national standard dated 27 December 2007.. (2007)
	2. Krasnodar Territory departmental programme on the prevention of domestic violence, entitled "No to Violence". (2005)
Ukraine	1. Domestic Violence (Prevention) Act 2001. (2001)
	2. Plan of Action under the "Stop Violence!" Platform of Action. (2008-2015)
	3. State programme for the promotion of sexual equality in Ukrainian society up to 2010. (2006-2010)
	4. National plan of actions on the improvement of position of women and assistance to introduction of gender equality in society. (2001-2005)

Table 39: Sexual Violence Laws

Name of Country	Anti- Rape Laws	Anti-Marital Rape Laws	Anti-Sexual Harassment Laws	Anti-Trafficking Laws
Armenia	Criminal Code 2003			
Azerbaijan	Criminal Code 2000		Laws on Gender Equality 2006	Law of Azerbaijan Republic on the Fight against Human Trafficking (#958-IIQ June 28, 2005)
Georgia				Laws on combating human trafficking 2006
Hungary		Act LXXIII of 1997 amending Act IV of the Criminal Code		
Poland	Penal Code 1997			
Russian Federation			Order No. 564-st of the Federal Agency for Technical Regulation and Metrology on the approval of the national standard dated 27 December 2007.	Order No. 564-st of the Federal Agency for Technical Regulation and Metrology on the approval of the national standard dated 27 December 2007.
Ukraine	Criminal Code of Ukraine 2001		Equal Opportunities for Women and Men Act 2006	Equal Opportunities for Women and Men Act 2006

ASTRA
Central and Eastern European Women's Network for Sexual and Reproductive Rights and Health

ASTRA - Central and Eastern European Women's Network for Sexual and Reproductive Health and Rights is a regional network created in December 1999 by women's rights organizations and activists from Central and Eastern Europe. Currently ASTRA consists of 28 organizations from 17 countries. ASTRA advocates for the full implementation of sexual and reproductive health and rights (SRHR) with special focus on specific reality of SRHR of women in Central and Eastern Europe. ASTRA aims at the prioritization of SR HR on international, regional and national agendas, in particular in the EU and UN institutions. ASTRA works towards transforming gender power relations in society so that women, girls, men and boys can enjoy their sexual and reproductive rights, and are equal, free and live in dignity.

ASTRA activities:

1. Advocacy for sexual and reproductive health and rights by organizing international seminars, meetings and public events;
2. Publishing the reports, fact-sheets, brochures, leaflets and other promotion materials;
3. Organizing the training and workshop as the support the capacity development of member NGO's and representatives of neighboring countries;
4. Preparing the open letters and position statements to the EU officials;
5. ASTRA advocates for SRHR agreements in the context of relevant international events - participation in the international conferences.

ASTRA members:

- Albanian Center for Population and Development, Albania
- A.L.E.G., Romania
- AnA Society for Feminist Analysis, Romania
- B.a.B.e., Croatia
- Bulgarian Family Planning and Sexual Health Association, Bulgaria
- Bulgarian Gender Research Foundation, Bulgaria
- Center Women and Modern World, Azerbaijan
- CESI- Center for Education, Counselling and Research, Croatia
- Demetra Association, Bulgaria
- East European Institute for Reproductive Health, Romania
- Euroregional Center for Public Initiatives, Romania
- Family Planning and Sexual Health Association of Lithuania, Lithuania
- Federation for Women and Family Planning, Poland
- Gender Alternatives Foundation, Bulgaria
- Gender Education, Research and Technologies, Bulgaria
- Institute of State and Law,Russian Academy of Sciences, Russia
- Legal Center for Women's Initiatives Sana Sezim, Kazakhstan
- Macedonian Women's Rights Center – Shelter Center, Macedonia
- Papardes Zieds, Latvia
- Pro Choice, Slovakia
- Reproductive Health Training Center, Moldova
- Salus Foundation, Ukraine
- Society Without Violence, Armenia
- Women's Center, Georgia
- Women's Health and Family Planning, Ukraine
- Women's Independent Democratic Movement of Belarus
- Women's Rights Center, Armenia
- Women's Room, Croatia

ASTRA Network
Nowolipie 13/15
00-150 Warsaw, Poland

Ph/fax: 48 22 635 93 95
Email: federa@astra.org.pl
http://www.astra.org.pl