PART A. INTRODUCTION

Reproductive and sexual health and rights were defined in the final document of the international Conference on Population and Development (ICPD) held in Cairo in 1994 (the Cairo Programme of Action) and restated in the final document of the Fourth World Conference on Women held in Beijing in 1995, the Beijing Platform for Action. These consensus documents were adopted by more than 180 countries.

Both the Cairo Programme of Action and the Beijing Platform for Action stated clearly that reproductive and sexual rights are an integral part of human rights. They set forth objectives and actions to be taken by the states in order to achieve the highest standards of reproductive and sexual health and rights. For this reason the provisions of the Cairo and Beijing documents are quoted here extensively as the point of reference. All countries need to be held responsible for fulfilling their commitments.

The European Union has always played an important role in promoting sexual and reproductive health and rights. It has demonstrated many times its endorsement of the rights and goals stated in the Cairo and Beijing Documents. The European Commission declared its commitment to the sexual and reproductive health and rights in the White Paper “A new impetus for European Youth” of 21 November 2001.1 Similarly, support has been declared by the European Parliament, which is visible in several Parliament’s resolutions, including: the resolution of 4 July 1996 on the implementation of the Cairo Programme of Action,2 of 9 March 1999 on the state of women’s health in the European Community,3 of 18 May 2000 on the follow-up to the Beijing Platform for Action,4 On 3 July 2002 the European parliament adopted the Resolution on sexual and reproductive health and rights. In this document the European Parliament affirms that the legal and regulatory policies concerning reproductive health falls within the Member States’ sphere of competence, and expresses the opinion that “the EU can play a supportive role through the exchange of best practices”.

In the decision of the European Parliament and Council on 23 September 2002 which adopted a programme of Community action in the field of public health (2003-2008), we read the following: "The Community is committed to promoting and improving health, preventing disease, and countering potential threats to health, with a view to reducing avoidable morbidity and premature mortality and activity-impairing disability. To contribute to the wellbeing of European citizens, the Community must address in a coordinated and coherent way the concerns of its people about risks to health and their expectations for a high level of health protection". The document states that "health is a priority and a high level of health protection should be ensured in the definition and implementation of all Community policies and activities."5

The commitment to strengthening reproductive and sexual health and rights is expressed in the European Commission programming document entitled "Aid for Policies and Actions on Reproductive and Sexual Health and Rights in Developing Countries".

The most recent declaration concerning sexual and reproductive health and rights is the “Vilnius Declaration” on Measures to Strengthen Responses to HIV/AIDS in the European Union and in Neighbouring Countries. The document the Health Ministers and other representatives of Governments from the European Union and neighbouring countries declares "willingness to Provide universal, affordable, non-judgmental and non-discriminating access to prevention services for HIV/AIDS and other sexually transmitted infections, including, but not limited to, preventive information and activities,

3 OJ C 175, 21.6.1999, p. 68.
voluntary and confidential counselling and testing, condoms, drug dependence treatment and harm reduction services for drug injectors and prevention of mother-to-child transmission"

1. Background information on Central and Eastern Europe

"Central and Eastern Europe" is used in this report to relate to an entire region consisting of 27 countries, often referred to as "countries with economies in transition." Thus, Central and Eastern Europe as used in the fact sheet refers to the following groups of countries in transition:

- Central Europe: Czech Republic, Hungary, Poland and Slovakia
- Balkan countries: Bosnia and Herzegovina, Croatia, Slovenia, FYR Macedonia, Yugoslavia (Serbia and Montenegro)
- South-Eastern Europe: Albania, Bulgaria and Romania
- Baltic States: Estonia, Lithuania and Latvia
- Commonwealth of Independent States: Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan.

The most important element which allows joint discussion of the 27 countries is the common experience of the economic and political transition following the collapse of communism. Characteristic features of the communist rule included: centrally planned economies with the vast majority of employment in the public sector, very low rates of unemployment, and social services delivered by the state. The latter included health care, which was delivered through the state health care system. Furthermore, there was an extensive system of child-care support, including long-term paid maternity leaves, family allowances and state subsidies for nurseries and kindergartens. Along with it went the high rates of employment among women. In theory - in the sphere of declarations - laws of the communist countries declared the full spectrum of rights and freedoms, including the right to equality of women and men. However, the practical reality was far from these declarations. Health care services, although accessible, remained of poor quality and there was not adequate attention given to preventive care and promotion of healthy lifestyles. Despite declarations of equality, the state has failed to ensure gender equality in practice. Women were facing many barriers and did not have equal status with men regarding work opportunities, which resulted in few women reaching higher levels of management. The gender gap in wages as well as job segregation was pervasive. In addition, women still performed the
majority of household chores, thus bearing the so-called “double burden” of the paid job and unpaid work at home.

The collapse of communist rule was followed by the democratisation of political life and transition to market economy. Countries had to deal with difficult economic situations and radically cut all state spending, including funding for health care systems. The majority of the countries reformed their health care systems and privatised many services. The state no longer covers the full range of health services, and thus access to services has drastically decreased. Many state enterprises were shut and unemployment rates increased hugely. It is estimated that there is about 10 million unemployed in CEE, 6 million of whom are women. The transition has also brought a drastic deterioration of the quality of life to a significant part of the population, bringing elevated levels of poverty and increasingly ill health. The transition countries encounter the problem of a growing disparity in the standard of living in society – among different geographical regions, between countries, between groups of the population.

In this context, the situation of women in the region is very difficult. The unemployment rate is usually higher among women than men. States have reduced funding for child-care support. Many employers are reluctant to hire women because of their reproductive capacity. The gender gap in wages and the tendency toward segregation of jobs has widened. The participation of women in decision-making and power structures is very low. In most countries of the region women constitute less than 10 % of members of Parliament and hold a similar percentage of government positions. The countries declare equality of men and women in their laws; however, in the daily reality women are treated unequally in the workplace, in the community and in the family. The governments do not show adequate commitment to bringing a change in this area.

Sharing the experience of communist rule and the economic and political transition following its collapse, and thus starting from a similar level, the CEE countries are now developing at different rates and show increasing diversity. They vary with regard to the level of the progression of democratic institutions, development of civil society, liberalisation of economies, advancement of political and social reforms, and economic situation. For instance, 10 of these countries are in the accession process to join the European Union. Disparities also arise due to cultural, religious or ethnic differences. Some countries have been strongly impacted by civil wars. These include: Bosnia and Herzegovina, Croatia, and Yugoslavia, as well as certain regions of the Russian Federation. Although the entire region, having a population of more than 400 million people is in no way uniform ethnically, culturally, politically or economically, it still bears a lot of similarities that allows discussing it together.

2. Introduction to reproductive health problems in the region

As the World Health Organisation, Regional Office for Europe indicates, there is "a widening gap in health indicators between the eastern and western halves of the European Region: a serious inequity". Sexual and reproductive health situations are paricularly dire in Central and Eastern Europe. Women of the region face many barriers in accessing satisfactory reproductive health services and in exercising their reproductive rights, including the right to free and informed decisions concerning reproduction and sexuality. This is due to the low priority given by governments to the issues of reproductive and sexual health and rights, as well as the growing influence of anti-choice, anti-woman, conservative forces representing the so-called “traditional values”. Anti-choice groups have increasingly formal and informal influence on the decision making processes in many countries of this region. There are cases where anti-choice groups gain financial support from public funds. For instance, the biggest Croatian anti-choice NGO, the Croatian Population

---

8 WHO Regional Office for Europe, Women’s and Reproductive Health Programme, “Family Planning and Reproductive Health in Central and Eastern Europe and the Newly Independent States” 2000, p. 1.
Movement, is led by a Catholic priest, and is partly funded from the state budget. Gender stereotypes – seeing women primarily as mothers and wives, and patriarchal attitudes -- remain pervasive in the societies of this region, and are a barrier to efforts to improve women’s status and to improve the state of reproductive and sexual health and rights.

The main problems in the field of sexual and reproductive health and rights in the region include:

- lack of commitment of governments to addressing issues of reproductive health and rights;
- weakness of non-governmental and international support systems in the field of reproductive health;
- low awareness of reproductive and sexual rights and health issues of the society;
- inadequate access to family planning information and services;
- high abortion rates coupled with high costs and low quality abortion services;
- low priority given to adolescents reproductive health and rights, including lack of adequate sexual education;
- rapidly growing rates of STIs, including HIV / AIDS;
- violence against women and domestic violence being a major and neglected problem in the region.

3. Selected reproductive health indicators – for Central and Eastern Europe
(compared to selected countries of the Western Europe)

<table>
<thead>
<tr>
<th>Country</th>
<th>Total population 2004 (millions)*</th>
<th>Health expenditure per capita (in USD)†</th>
<th>Total fertility rate (2000-2005)*</th>
<th>Infant mortality per 1000 live births (2001)‡</th>
<th>Maternal mortality per 100 000 live births (2001)‡</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>West Europe</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Austria</td>
<td>8,1</td>
<td>1866</td>
<td>1,28</td>
<td>4,84</td>
<td>6,63</td>
</tr>
<tr>
<td>France</td>
<td>60,4</td>
<td>2109</td>
<td>1,89</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Germany</td>
<td>82,5</td>
<td>2412</td>
<td>1,35</td>
<td>4,31</td>
<td>3,68</td>
</tr>
<tr>
<td>Netherlands</td>
<td>16,2</td>
<td>2138</td>
<td>1,72</td>
<td></td>
<td>6,91</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>59,4</td>
<td>1835</td>
<td>1,60</td>
<td>5,48</td>
<td>7,47</td>
</tr>
<tr>
<td><strong>Central Europe</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Albania</td>
<td>3,2</td>
<td>48</td>
<td>2,28</td>
<td>11,44</td>
<td>22,76</td>
</tr>
<tr>
<td>Bosnia &amp; Herzegovina</td>
<td>4,2</td>
<td>85</td>
<td>1,30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bulgaria</td>
<td>7,8</td>
<td>81</td>
<td>1,10</td>
<td>14,40</td>
<td>19,07</td>
</tr>
<tr>
<td>Croatia</td>
<td>4,4</td>
<td>394</td>
<td>1,65</td>
<td>7,68</td>
<td>2,44</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>10,2</td>
<td>407</td>
<td>1,16</td>
<td>3,97</td>
<td>8,82</td>
</tr>
<tr>
<td>Hungary</td>
<td>9,8</td>
<td>345</td>
<td>1,20</td>
<td>8,13</td>
<td>5,15</td>
</tr>
<tr>
<td>Macedonia, F.Y.R.</td>
<td>2,1</td>
<td>115</td>
<td>1,90</td>
<td></td>
<td>14,81</td>
</tr>
<tr>
<td>Poland</td>
<td>38,6</td>
<td>289</td>
<td>1,26</td>
<td>7,67</td>
<td>3,53</td>
</tr>
<tr>
<td>Romania</td>
<td>22,3</td>
<td>117</td>
<td>1,32</td>
<td>18,41</td>
<td>34,03</td>
</tr>
<tr>
<td>Slovakia</td>
<td>5,4</td>
<td>216</td>
<td>1,28</td>
<td>6,24</td>
<td>15,64</td>
</tr>
<tr>
<td>Slovenia</td>
<td>2,0</td>
<td>821</td>
<td>1,14</td>
<td>4,25</td>
<td>17,22</td>
</tr>
<tr>
<td>Turkey</td>
<td>72,3</td>
<td>2,43</td>
<td></td>
<td>36,00</td>
<td></td>
</tr>
<tr>
<td>Yugoslavia</td>
<td>10,5</td>
<td>103</td>
<td>1,65</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10 The table “Selected reproductive health indicators” compiles data from several sources in order to make it more comprehensible. However, that means that data can be given for different years. The data must be read with caution, as it is necessary to take into account the difficulties with gathering of authoritative and fully comparable statistics in this field.
### Table: Reproductive and Sexual Health Indicators

<table>
<thead>
<tr>
<th>Country</th>
<th>Total population 2004 (millions)*</th>
<th>Health expenditure per capita (in USD)†</th>
<th>Total fertility rate (2000-2005)*</th>
<th>Infant mortality per 1000 live births (2001)‡</th>
<th>Maternal mortality per 100 000 live births (2001)‡</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>East Europe</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Armenia</td>
<td>3.1</td>
<td>28</td>
<td>1.15</td>
<td>15.50</td>
<td>21.83</td>
</tr>
<tr>
<td>Azerbaijan</td>
<td>8.4</td>
<td>8</td>
<td>2.10</td>
<td>12.52</td>
<td>25.37</td>
</tr>
<tr>
<td>Belarus</td>
<td>9.9</td>
<td>68</td>
<td>1.20</td>
<td>9.15</td>
<td>14.17</td>
</tr>
<tr>
<td>Estonia</td>
<td>1.3</td>
<td>226</td>
<td>1.22</td>
<td>8.79</td>
<td>7.92</td>
</tr>
<tr>
<td>Georgia</td>
<td>5.1</td>
<td>22</td>
<td>1.40</td>
<td>10.39</td>
<td>58.69</td>
</tr>
<tr>
<td>Kazakhstan</td>
<td>15.4</td>
<td>44</td>
<td>1.95</td>
<td>19.18</td>
<td>48.92</td>
</tr>
<tr>
<td>Kyrgyzstan</td>
<td>5.2</td>
<td>12</td>
<td>2.64</td>
<td>21.59</td>
<td>49.93</td>
</tr>
<tr>
<td>Latvia</td>
<td>2.3</td>
<td>210</td>
<td>1.10</td>
<td>11.04</td>
<td>25.43</td>
</tr>
<tr>
<td>Lithuania</td>
<td>3.4</td>
<td>206</td>
<td>1.25</td>
<td>7.92</td>
<td>12.68</td>
</tr>
<tr>
<td>Republic of Moldova</td>
<td>4.3</td>
<td>18</td>
<td>1.40</td>
<td>16.38</td>
<td>43.90</td>
</tr>
<tr>
<td>Russian Federation</td>
<td>142.4</td>
<td>115</td>
<td>1.14</td>
<td>14.57</td>
<td>36.52</td>
</tr>
<tr>
<td>Tajikistan</td>
<td>6.3</td>
<td>6</td>
<td>3.6</td>
<td>27.90</td>
<td>46.03</td>
</tr>
<tr>
<td>Turkmenistan</td>
<td>4.9</td>
<td>57</td>
<td>2.70</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ukraine</td>
<td>48.2</td>
<td>33</td>
<td>1.15</td>
<td>11.38</td>
<td>23.91</td>
</tr>
<tr>
<td>Uzbekistan</td>
<td>26.5</td>
<td>17</td>
<td>2.44</td>
<td>18.38</td>
<td>34.12</td>
</tr>
</tbody>
</table>

* UNFPA, State of World Population 2004  
† World Bank, 2004 World Development Indicators  
‡ WHO, European Health for All Database

---

**PART B. Reproductive health issues in the region**

1. **Policies and strategies on reproductive and sexual health**

The international standard:

Reproductive health-care programmes should be designed to serve the needs of women, including adolescents. Governments, in collaboration with civil society, including non-governmental organizations, donors and the United Nations system, should give high priority to reproductive and sexual health in the broader context of health-sector reform, including strengthening basic health systems.

Programmes should ensure access to the full range of high quality reproductive health services including:

- information and education on health, sexuality and gender equality;
- skilled care during pregnancy, delivery and postpartum;
- prevention of infertility and counselling for sexual dysfunction;
- access to full range of contraceptive choices;
- safe abortion;
- prevention and management of reproductive tract infections, sexually transmitted infections, and other gynaecological problems;
- prevention and treatment of reproductive system cancers; and
- postmenopausal health problems, including osteoporosis.

---

11 “Cairo Programme of Action”, supra note 1, par. 7.7.  
13 HERA Women’s Sexual and Reproductive Rights and Health Action Sheets “Reproductive Rights and Reproductive Health”. 
Many countries of the CEE region have not met these requirements. Few countries introduced specific policies, which should be the consequence of commitments made in Cairo and Beijing. This results in poor accessibility and quality of reproductive health services as well as low levels of awareness of sexual and reproductive health issues in the society.

- In Georgia 28% of sexually experienced women reported never having had a routine gynaecological exam and 19% reported they had their last exam more than three years before. Only 40% had ever had a pap smear and 1/3 of women had never heard of cervical cancer screening.\(^\text{14}\)

- The incidence of breast cancer and cervical cancers appear to have increased in most countries of the region. In Latvia, the incidence of breast cancer rose from 44 cases per 100,000 individuals in 1989 to 64 per 100,000 in 1996.\(^\text{15}\) In Poland, the incidence of breast cancer in 1999 was 50.5 cases per 100,000 women.\(^\text{16}\) The rates for cervical cancer in the countries of Central and Eastern Europe are three times as high as the EU average. This is largely due to a lack of screening services and cervical cancer prevention / early detection programmes.\(^\text{17}\)

- There is a general tendency that physicians do not pay adequate attention to prophylactics. Gynaecologists do not conduct breast examinations routinely. In a survey conducted in Poland only 21.9% of women reported having had regular breast examinations by a physician. However, this figure is still overstated, since the women surveyed were better educated and had better knowledge of reproductive health than the general public.\(^\text{18}\)

- A positive example in this sphere comes from Armenia. In the beginning of the 1990s the Ministry of Health of Armenia worked in cooperation with WHO and UNFPA to develop national programme on Reproductive Health. The programme was implemented in 1997 and included the establishment of 77 family planning centres in all administrative centres of Armenia.

2. Population policy

The majority of CEE countries goes through similar demographic changes as can be observed in Western Europe – birth rate is low and still falling, with the exceptions of Albania and Georgia. Thus, the majority of CEE countries have a declining population. These demographic trends have sometimes fuelled restrictive pro-natalist policies.

- In Poland, the pro-natalist ideology gives support to measures that limit access to effective fertility control, such as: restrictive abortion law, lack of policies that promote and subsidize family planning, retention of the illegality of contraceptive sterilisation, and the lack of sexual education in schools.\(^\text{19}\) The characteristic element of such ideologies is perceiving women mainly as mothers and treating them as means to population and demographic goals.

- In Croatia in 1992 a special Division for Demographic Renewal was established by the Ministry of Reconstruction and Development. The first head of this unit was a Catholic priest, who was best known for his extreme nationalist and conservative views, especially regarding the role of women and the view on family.\(^\text{20}\)

---


\(^\text{17}\) WHO, “Family Planning and Reproductive Health …”, supra note 9, p. 19.


- In Russia, the quality of the gynaecologists’ work is evaluated based on the number of pregnant women who register and carry the pregnancy to term under their care. It is an incentive for physicians to put pressure on women to not undergo abortion.21

Population policies, such as existing in developing countries, have not been developed in CEE countries due to different demographic indicators. The support of international agendas and organisations for CEE countries in this sphere has been insufficient.

3. Family planning

The international standard:
The governments committed to:
- help couples and individuals meet their reproductive goals;
- prevent unwanted pregnancies;
- improve the quality of family-planning advice, information, education, communication, counselling and services;
- ensure that women and men have information and access to the widest possible range of safe and effective family-planning methods;
- provide accessible, complete and accurate information about various family planning methods;
- make services safer, affordable, more convenient and accessible.22

Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion.23

Contraception prevalence in the CEE countries is low and there is a high reliance on ineffective natural family planning methods, such as withdrawal or calendar method (periodic abstinence).

---

21 See id. at p. 158.
23 “Cairo Plus Five”, supra note 13, par. 63(i).
The average rate of modern contraceptive use in the Countries of Central and Eastern Europe (36.6%) is almost twice lower than that of the West. Contraceptive use varies between the countries of the Region. The highest rate of modern contraceptive use is reported in Hungary, at 68.4%, and the lowest in Albania with 15.3%. In only four countries of the region is the reported use of modern contraceptive methods higher than 50%. In 7 out of 18 countries, less than 30% of women at reproductive age use modern contraceptives.

The reasons for such low use of modern contraceptive methods are diverse. First of all, family planning services do not receive an adequate proportion of government health spending, and are not sufficiently integrated into primary public health-care programmes. Furthermore, the number of clinics specifically designed to provide family planning services and counselling is insufficient, particularly in rural areas. In addition to that, health care providers themselves often have unsatisfactory knowledge of family planning methods. They frequently have misconceptions or prejudices about the effectiveness, safety, risks and benefits of hormonal contraception, IUDs and other modern methods. Providers are commonly reluctant to perform contraceptive counselling or encourage the use of modern contraceptives. Counselling is often limited to offering one method, rather than discussing the wide range of contraceptive methods from which a woman could choose. Reluctance to counsel on contraceptive options is sometimes associated with providers’ own religious views. Yet another barrier is the high cost of modern contraceptive methods, in particular hormonal contraception, making these methods inaccessible for the majority of the population. Governments generally do not subsidize contraceptives.

---

24 United Nations, Department of Economic and Social Affairs Population Division, World Contraceptive Use 2003.
• In Ukraine, in 1999, the unmet need for contraception was estimated at 37%.

• In Georgia, only 15% of women who have had an abortion received counselling about contraception following the abortion procedure, and only 3% were given a method or prescription (1%) for a contraceptive method.

• In Poland, contraceptive sterilisation is illegal. According to the Polish Criminal Code, sterilisation is a criminal offence carrying a penalty of 1 to 10 years of imprisonment.

• In other CEE countries, where sterilisation is legal, its prevalence is very low. Usually less than 1% of the users of contraception apply permanent methods.

• In Armenia, the most widespread contraceptive method is interrupted coitus (withdrawal), a method used by 53% of those declaring use of contraception.

• The lack of the government’s commitment to provide access to the wide range of contraceptive options is very apparent in Poland, where the Ministry of Health in 1998 withdrew subsidies for five out of eight previously subsidised oral contraceptives, leaving three of the same composition.

• Prices of oral contraceptives are very high in relation to the average income. In Bulgaria, the price of pills for one month is 20 levs (DM), which is 1/5 of the minimum salary.

4. Abortion (legal status, access, quality)

The international standard:

All governments and relevant organizations are urged to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services. In circumstances where abortion is not against the law, such abortion should be safe.

Governments are urged to consider reviewing laws containing punitive measures against women who have undergone illegal abortions.

All Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women’s health, to deal with the health impact of unsafe abortion as a major public health concern, and to reduce the recourse to abortion through expanded and improved family planning services. Health systems should train and equip health service providers and should take other measures to ensure that such abortion is safe and accessible.

Abortion is legal in most of the CEE countries. However, there is a strong movement to make abortion laws more restrictive in many countries of the region. The right to have access to abortion is not strongly grounded in national legal systems and can be too easily challenged. We can observe continuing initiatives from anti-choice groups, often linked to the church, that grow in strength, in particular in Lithuania, Croatia, Slovakia, Hungary and Russia, where the Roman Catholic or Orthodox churches have considerable influence on public life.

---

26 CDC, “Reproductive Health Survey Georgia”, supra note 15, p. 166.
29 CDC, “Ukraine Reproductive Health Survey”, supra note 27, p. 87.
31 UN ESC “Concise report on world population monitoring”, supra note 26, p.29.
34 Cairo Programme of Action”, supra note 1, par. 8.25.
35 “Beijing Platform for Action”, supra note 1, par. 106k.
36 “Cairo Plus Five”, supra note 13, par. 63(i).
• Poland is the first country in the region that has submitted to the pressures of anti-choice groups, mostly inspired by the Roman Catholic Church. Since 1993 (except for the period between October 1996 to December 1997) abortion is legal only for therapeutic reasons or if a pregnancy is the result of a criminal act, and is not permitted on social or economic grounds. The practice is even more restrictive than the law. In many cases women, who have the right to legal abortion, are denied access to it. It is estimated that about 200,000 clandestine abortions per year are performed in Poland. The price for clandestine abortion is high – around 2000 PLN (€ 500), which equals an average monthly salary. Thus, the ban on abortion places a disproportionate burden on poor women, as well as women from rural areas, who cannot afford to use clandestine services.\(^{37}\)

Abortion rates are significantly higher than in Western Europe.

![Abortion rates per 1000 live births](chart)

The average legal abortion rate in the region is much higher than the average in Western EU countries. The highest rates of abortions are reported in the Russian Federation (1275.81 per 1000 live births in 2002), Romania (1176.12 per 1000 live births in 2002) and Belarus (1010.85 per 1000 live births in 2002). In many countries of the Region abortion still remains the main method of fertility control. The low level of awareness of reproductive health issues and poor availability of family planning services continues to be a barrier to the move from abortion to contraceptive culture.\(^{38}\)

Out of about 900,000 estimated unsafe abortions carried out in Europe annually, 800,000 occur in Eastern Europe. Abortion remains one of the main causes of maternal mortality in the region. The average rate of maternal deaths following abortions in the Commonwealth of Independent States is 5.66 per 100 000 live births. It is almost 8 times higher than the average in the 25 Western EU countries. Among the countries with the highest rates of maternal deaths following abortions are Romania (16.79 per 100 000 live births), Latvia (10.17 per 100 000 live births), Russian Federation (9.53 per 100 000 live births).\(^{39}\)

Abortion services tend to be of poor quality. There is no government commitment for the development and widespread use of safer, more effective, and convenient techniques of induced abortion. Lack of support for the improvement of the quality of services is in part associated with the movement to restrict access to abortion. Abortion providers rely extensively on the dilatation and curettage method, rather than on vacuum aspiration or medical abortion. Many women in the region still do not have access to safe services. This usually results from the high costs of abortion services or difficulties in accessing quality services in rural areas.


\(^{38}\) WHO, European Health for All Database.

\(^{39}\) See id. Data from 2001.
In 1997 the total number of abortions in Russia was estimated at about 2.5 million in a year.\(^{40}\) In October 2002 Russia’s chief gynaecologist announced that about 60% of all pregnancies in the country end in abortion.

In many countries, where abortion is legal, contraceptive costs are not significantly lower than the price of abortion. For instance, in Romania, prices of contraceptives vary between € 1- 5 and the price of abortion is € 5 – 15 in public hospitals, and € 11 – 33 in private medical facilities. (while the average salary in the enterprise sector is € 56).\(^{41}\)

5. Adolescents (also including the issue of sexual education)

The international standard:

- In order to protect and promote the right of adolescents to the enjoyment of the highest attainable standards of health, provide appropriate, specific, user-friendly and accessible services to effectively address their reproductive and sexual health needs, including reproductive health education, information, counselling and health promotion strategies. These services should safeguard the rights of adolescents to privacy, confidentiality and informed consent.\(^{42}\)

- Full attention should be given to the promotion of mutually respectful and equitable gender relations, and particularly to meeting the educational and service needs of adolescents, to enable them to deal in a positive and responsible way with their sexuality.\(^{43}\)

- Ensure that adolescents, both in and out of school receive the necessary information on prevention, education, counselling and health services in order to enable them to make responsible and informed choices regarding their sexual and reproductive health in order, for example, to reduce the number of adolescent pregnancies.\(^{44}\)

Adolescents should be a particular target group of reproductive and sexual health programmes. This is due to their vulnerability to health risks associated with unsafe sexual activity, such as early pregnancies, sexually transmitted infections, as well as their encountering of numerous obstacles in exercising their reproductive rights; for example, regarding access to services and information on family planning.

However, in countries of Central and Eastern Europe, there is not sufficient attention given to adolescents’ reproductive health needs. Specialised services for young people are very rare, if any. Service providers often present personal bias towards adolescents accessing reproductive health services. Anecdotal data shows that there are many cases where providers refuse to prescribe contraceptives or to counsel young people on contraceptive options. Many providers assume a paternalistic attitude towards youth and do not observe confidentiality.

Another serious problem is the lack of comprehensive and widely available sexual education for young people. Sex education is not provided at schools on a systematic basis. Curricula on sex education do not give adequate attention to topics of birth control, contraception and protection from STIs, nor do they promote safer sex practices and equitable gender relations. Teachers frequently do not have adequate training in this field.\(^{45}\) Manuals present stereotypical attitudes to human sexuality and gender roles.

The consequence of lack of proper sex education and access to family planning methods is a high rate of adolescent pregnancies in the Region. In more than half of the countries (15 out of 27) live births to mothers under 20 account for more than 8% of all live births. The countries with the highest percentage of adolescent mothers are Bulgaria (17.06) and Republic of Moldova (16.30).

WHO statistics show that in European countries the percentage of adolescent mothers declines or remains at the same level. The significant exception to the rule are two Eastern European countries:


\(^{42}\) “Cairo Plus Five”, supra note 13, par. 73 (a).

\(^{43}\) “Cairo Programme of Action”, supra note 1, par. 7.3.

\(^{44}\) “Cairo Plus Five”, supra note 13, par. 73 (e).

Azerbaijan (where between 2000 and 2002 the percentage of adolescent mothers increased from 7.32 to 12.88) and Georgia (increase from 10.65 in 2001 to 12.52 in 2002).

Another alarming consequence of the lack of attention paid to the promotion among young people of safer sex practices is the high prevalence of STIs, including AIDS, among adolescents. Vulnerability of young people to contracting STIs is heightened due to the increasing number of young people who do not complete secondary education and cannot find employment, and are thus prone to joining special risk groups, such as drug addicts or sex workers.

- The incidence of pregnancy among women under age 20 in Russia has increased over the last 30 years from 28.4% to 47.8%. In 1995 it was reported that 1500 children were born to girls under 15 years, 10,000 to those under 16 years and more than 30,000 to those under 17 years.\(^46\)
- In Moldova, in 1997 less than 14% of unmarried women aged 15-24 used modern methods of contraception at first intercourse.\(^47\)
- In Serbia, the research found that 54.3% of adolescent girls use withdrawal (coitus interruptus) as a method of fertility regulation.\(^48\)
- In Russia, 75% of the 33,000 registered cases of HIV were young people aged 15-29.\(^49\) At the same time, of those having sexual contacts, 25% think there is no risk of STIs involved, 37% think this risk is very small, and 15% cannot even say whether there is a risk.\(^50\)
- The European Council Rapporteur who visited Poland at the beginning of 2004 wrote in his report: "Sexuality remains a taboo in Polish society where the Roman Catholic Church exercises considerable influence in cultural, social and political spheres. As a result of political reluctance and budget deficits in healthcare, Poland today has poor family planning services, poor or virtually no sexual and reproductive health education, restricted access to affordable contraception and prohibited abortion (since 1993)."\(^51\)
- Albania is an exception with mandatory sex education carried out in schools. However, sex education is planned for only 9 hours per school year.\(^52\)

6. Sexually Transmitted Infections (STIs)

The international standard:

Reproductive health programmes should increase their efforts to prevent, detect and treat sexually transmitted diseases and other reproductive tract infections, especially at the primary health-care level.\(^53\)

Governments, from the highest political levels, should take urgent action to provide education and services to prevent transmission of all forms of sexually transmitted diseases and HIV and develop and implement national HIV/AIDS policies and action plans, and take steps to mitigate the impact of the AIDS epidemic by mobilising all sectors and segments of society to address the social and economic factors contributing to HIV risk and vulnerability.\(^54\)

The occurrence of sexually transmitted infections has increased alarmingly in this part of the world. Factors contributing to the spread of epidemic include mass unemployment and economic insecurity, opening of borders, liberalisation of social and cultural norms, the disintegration of the health care


\(^{49}\) S. Jejeebhoy, “Filling the gaps in what we know” in Entre Nous No. 50 – 2001, p. 9.

\(^{50}\) E. Ketting et al., “Being young and in love in Russia” in Entre Nous No. 52 – 2002, p. 12.

\(^{51}\) Council of Europe, European strategy for the promotion of sexual and reproductive health and rights (Doc. 10266), par. 62.


\(^{53}\) “Cairo Programme of Action”, supra note 1, par. 7.30 and 7.32.

\(^{54}\) “Cairo Plus Five”, supra note 13, par. 67.
system, and the low level of knowledge on STIs and protection against them, mainly due to the lack of sexual education. Protection against STIs is not integrated into primary health care. Reported rates of sexually transmitted infections are very high.

![Graph showing Syphilis incidence rate in selected new EU member countries](image)

**Syphilis incidence rate in selected new EU member countries (per 100 000 population). Source: WHO European Regional Office, The centralized information system for infectious diseases (CISID).**

The highest rates of syphilis incidence are among the former Soviet Union countries. Among the most affected are Russian Federation (143.20 per 100 000 in 2001), Republic of Moldova (85.89 per 100 000 in 2001) and Belarus (79.08 per 100 000 in 2001).

The situation in some of the new EU member countries also gives serious cause for concern. In Estonia, Latvia and Lithuania, syphilis incidence rates peaked suddenly between 1995 and 1997, with levels in Latvia extending to more than 120 cases per 100 000 population. Since 1998 the incidence rates have been decreasing but still are much higher than in the Western countries.

- *The low awareness of sexually transmitted infections in a society can be demonstrated by an example from Ukraine. In a study conducted in Ukraine, about one third of women who experienced symptoms that most probably resulted from STIs did not seek any kind of treatment for them.*
- *The incidence of syphilis (the reported number of infections in a given year) in the Russian Federation in 2000 stood at 164 per 100 000 persons, compared to 4.2 per 100 000 persons in 1987. In Latvia, reported cases of syphilis have increased 28-fold in a five-year period.*

### 7. HIV/AIDS

Eastern Europe is the region of the world with one of the fastest growing HIV epidemic. According to UNAIDS, about 1.3 million people were living with HIV at the end of 2003, compared with about 160,000

---

55 WHO European Regional Office, The centralized information system for infectious diseases (CISID).
56 See id.
57 CDC, “Ukraine Reproductive Health Survey”, supra note 27, p. 209.
58 WHO European Regional Office, The centralized information system for infectious diseases (CISID).
in 1995. Only during 2003, an estimated 360,000 people in the region became newly infected, while 49,000 died of AIDS.\textsuperscript{59}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{chart.png}
\end{figure}

**General characteristic of the Central and Eastern Region**

**Central Region**

According to EuroHIV, a total of 1427 HIV infections and 539 AIDS cases were diagnosed in the Central region in 2002. In this area, excluding Romania, 26% of new HIV infections reported in 2002 were among females, and 43% were in persons younger than 30 years of age. In Romania, over a third (122 of 335) of new HIV diagnoses reported in 2002 still concerned cases of nosocomial infection among children, probably acquired around the year 1990. Poland and Yugoslavia are two countries where HIV infection spread among intravenous drug users (IDU) in the late 1980s. These countries account for most of the cases ever reported among IDU in the Central region. In Poland, 96% of HIV diagnoses and 53% of AIDS cases are IDU-related. In Yugoslavia, 40% of AIDS cases are among IDU [HIV cases not available by transmission group].\textsuperscript{60}

In other countries of the Central region only very few HIV or AIDS cases have been diagnosed among IDU. Sex between men was the predominant transmission mode in Bosnia & Herzegovina, the Czech Republic, Hungary, Slovakia and Slovenia, while homosexual contacts predominated in Bulgaria, Croatia, the former Yugoslav Republic of Macedonia and Turkey.\textsuperscript{61}

**East**

According to EuroHIV, a total of 64,222 new HIV diagnoses were reported in 2002. Among these, 26,197 (41%) were among the IDU population, 6371 (10%) were persons infected through heterosexual contacts, and only 93 (0.1%) were in homosexual or bisexual men, while for 27,371 of cases (43%), the transmission mode was not reported; 21,261 (33%) were among women and 49,533 (77%) were people less than 30 years of age. The Russian Federation accounted for 50,401 (78%) of all new diagnoses reported in 2002.\textsuperscript{62}

Overall cases peaked sharply in 2001 in the Russian Federation (88,336 cases, 611 per million), Latvia (335 per million) and Estonia (1071 per million). The number of reported cases continued to increase in Uzbekistan (from 1 per million in 1999 to 38 per million in 2002) and increased sharply in 2002 in Lithuania (from 72 cases in 2001 to 397 cases - 108 per million).


\textsuperscript{60} HIV/AIDS Surveillance in Europe. EuroHIV End-year report 2002, No. 68.

\textsuperscript{61} See id.

\textsuperscript{62} See id.

After increasing steeply for several years, the number of new HIV diagnoses in the East declined for the first time in 2002, from 100,663 (347 per million) in 2001 to 64,222 (222 per million) in 2002 (–36%). This reduction was due to a sharp decline of cases reported among IDU (–53%). However, the number of cases attributed to heterosexual contacts continued to increase steadily (+32%). In the first affected countries, IDU cases peaked in 1996-1998 while infections through heterosexual contact continued to rise, accounting for 28% of all cases in Moldova, 29% in Ukraine and 35% in Belarus in 2002.63

**Women living with HIV**

UNAIDS estimates that at the end of 2003 the number of HIV-positive women aged 15-49 in Central and Eastern Europe reached 440,000. This is almost twice the estimated number at the end of 2001. The worst-affected countries of the European region were the Russian Federation and Ukraine. At the end of 2003, the estimated number of HIV-positive women aged 15-49 in this countries was 290,000 and 120,000, respectively.

The increase of the number of the HIV-positive women aged 15-49 was much lower in Western Europe. Between the end of 2001 and the end of 2003, the estimated number increased about 15% (from 13 000 to 15 000).64

**Mother-to-child transmission**

By the end of 2002 a total number of 8,933 children born to HIV-infected mothers were reported in the East. This is four times more than the number of cases reported in Western Europe.

In the Russian Federation in 2002, 2,793 newly diagnosed HIV infections through mother-to-child transmission were reported. This is more than twice the number of newly diagnosed cases in 2001. A similar rapid increase in the number of persons infected through mother-to-child transmission is observed in Ukraine. In each of these two countries the total number of cases reported by the end of 2002 exceeded 4,000.65

The surveys conducted by the Division of Reproductive health Centers for Disease Control and Prevention in the selected countries of the East region reveals that significant numbers of women in these countries lack knowledge of the specific means of HIV transmission. The data also reveal that a significant portion of women have misconceptions about HIV/AIDS transmission.66

---

63 See id.
66 Centers for Disease Control and Prevention, Reproductive, Maternal and Child Health in Eastern Europe and Eurasia: A Comparative Report, Atlanta 2003.)
In Tajikistan only 10% of adolescents girls had ever heard of HIV/AIDS.\textsuperscript{67}

Ukraine remains the most affected country in the region with an estimated adult HIV prevalence rate of 1% and an estimated 250,000 people living with HIV. While ¾ of infections are due to intravenous drug use, the proportion of infections (mostly among women) due to sexual transmission is growing.\textsuperscript{68}

\textbf{PART C. CONCLUSIONS AND RECOMMENDATIONS}

The full implementation of sexual and reproductive rights and the improvement of the sexual and reproductive health in the CEE region will not take place unless there is a concentrated and intense effort by both national and international institutions to make tangible changes.

Governments need to be held accountable for the commitments they have made through international conventions and consensus documents.

Valuable initiatives undertaken by non-governmental organisations in this field need to gain the support of national and international institutions in order to be sustainable and more effective.

The European Union should strengthen its policies related to sexual and reproductive health and rights, and encourage Central and Eastern European governments to give priority to these issues, in particular in the light of the 2002 recommendations of the European Parliament.

The continuance of aid for policies and especially actions on reproductive and sexual health and rights in developing countries is desperately needed.

Welcoming the initiative "Enabling Good Health for all", taken by the Commissioner for Public Health and Consumer Protection, we challenge the Commissioner to take steps to erase the unacceptable discrepancies in the sexual and reproductive health status of the populations in Western, Central, and Eastern Europe.

In the era of the HIV/AIDS epidemic, and regarding the increasing number of sexually transmitted infections in the European countries, the provision of access to modern, scientifically based sex education and methods of family planning are the most crucial tasks.

\textsuperscript{67} “AIDS Epidemic Update. December 2002”.

\textsuperscript{68} “The Barcelona Report”, supra note 67, p. 34.
This paper represents the views of its author on the subject. These views have not been adopted or in any way approved by the Commission and should not be relied upon as a statement of the Commission's or Health & Consumer Protection DG's views. The European Commission does not guarantee the accuracy of the data included in this paper, nor does it accept responsibility for any use made thereof.