CHAPTER 1

INTRODUCTION

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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.