THE FIGHT HIDDEN IN PLAIN SIGHT

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN CENTRAL AND EASTERN EUROPE AND CENTRAL ASIA

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Note: As ASTRA Network we recognize everyone's gender identity and the fact that not only women get pregnant and need access to reproductive services. The term "woman" used in the publication is a simplification made for the sake of clarity of the text.

Moreover, countries of the region lack specific data on access to SRHR for transgender men, non-binary and genderqueer persons and it would be risky and most likely inaccurate to apply data gathered on cisgender women to representatives of the queer community. Authors aimed to tackle the topic of LGBTQI+ rights in each country in a dedicated chapter.

Introduction

The year 2019 marked ASTRA Network's 20th anniversary of existence. For two decades, we have been monitoring the situation of sexual and reproductive health and rights in Central and Eastern Europe and Central Asia. Our work focuses on supporting grassroot organisations in the region and providing them with opportunities to forward their work even further – including the international arena. Our members are amazing actors in their home countries, who do game-changing grassroot work on community organizing, providing healthcare and education, mobilizing the general public and reacting to current political and social events. It is honouring and humbling to be able to bring together such initiatives. We are more than proud to say that today ASTRA Network consists of 42 organisations based in 21 countries.

The past 20 years were extremely exciting and eventful. Starting from repetitive attempts of fundamentalist movements to limit access to abortion and contraception, attacks aimed at women's and sexual and reproductive rights activists, numerous attempts to alter the law in several countries of the region so that women would struggle to actively exercise their basic human rights to decide about themselves and their bodies… And this is just the tip of the iceberg – all of the above, and so much more, is the norm for women living in Central and Eastern Europe, and Central Asia.

However, the fact that women of the region do fight back cannot go unseen – and they have been doing so for years. Protests that gained international attention, just like Polish Black Protest or Slovak Nebudeme Ticho to name the latest ones, have had the power to stop draconian laws and keep the legislature intact. However, Poland and Slovakia are not the only ones that can mobilize the people – similar initiatives, often organized or coordinated by ASTRA Network member organisations, were attended by tens of thousands in different countries of the region as well. Activists defending human rights are fighting relentlessly to not let the far-right and religious fundamentalists alter the system. Despite that fight, the situation remains a dynamic one.

Today, at the beginning of a new decade, we are presenting you with the newest and most comprehensive publication about sexual and reproductive health and rights in Central and Eastern Europe and Central Asia. The report you are holding right now is a coherent overview of 14 countries' situations regarding abortion, contraception, pre- and antenatal care, sexuality education, LGBTQI+ rights and gender-based violence – all written from the perspective of local activists. In the spirit of providing a platform for regional initiatives, all the inputs were provided by our member organisations and their national associates.

Central and Eastern Europe, and Central Asia tend to be left out of the conversation when it comes to building civil societies and protecting human rights. Hopefully, this report will change the way you think about our region – which is an unnoticed bastion of fight for basic human rights.

Albania

Abortion and post-abortion care

Abortion in Albania was fully legalized through by Law no. 8045/1995 on the Interruption of Pregnancy. Abortion can be performed on demand until the twelfth week of pregnancy. According to the law, an abortion is not allowed to be performed without the parental consent of girls under the age of 16. The law was amended by Law no. 57/2013, but it still does not foresee free health care, such as carrying out a pre-abortion analysis, abortion procedures or post-abortion visits.

In 2018, the National Institute of Statistics estimated 191 abortions per 1,000 live births showing a slight increase over 2017 (171 abortions per 1,000 live births). Unofficial sources indicate a higher number of abortions than those published that are performed illegally in un-registered private clinics. To address under-reporting and illegal abortions, the Ministry of Health released an order based on which as of January 2013, private-sector health care clinics no longer have permission to perform abortions; only public-and private-sector hospitals are be allowed to do so.

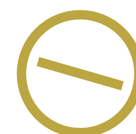
There is no full access to abortion care throughout the country and abortion still is stigmatized among community members, health care providers, men and some political parties' representatives.

As there are no national studies on abortion stigma, ACPD refers to its work with the community and service providers, and a few studies, such as the study conducted in 2013 (funded by the Packard Foundation through IPPF) to analyse abortion stigma. Interviews conducted with women who had undergone a legal induced abortion, service providers and community members and/or supporters in Tirana and Vlora, found a high level of stigma associated with abortion revealing that gender stereotypes are one of the main contributors to abortion-related stigma. Women still face barriers in accessing safe and legal abortion care due to the state's failure to ensure that women can still access abortion services in practice when medical professionals refuse care on grounds of conscience or religion. Additionally, ACPD has revealed that stigma has caused some women to carry their pregnancies to term and assume a disproportionate economic burden for care; it has led women to seek unsafe abortions clandestinely to avoid judgment by society, or contribute to women avoiding or delaying safe post-abortion care.

There is no full access to abortion care throughout the country and abortion still is stigmatized among community members, health care providers, men and some political parties' representatives.

Although a number of initiatives have been undertaken by the Ministry of Health and Social Protection to strengthen law enforcement, the 2013 study conducted by UNFPA[1] shows that a preference for sons is a distinctive feature of Albania's population structure, with fertility behaviours clearly shaped by strong gender considerations, leading to gender biased sex selection.

Medical abortions are included in the national guidelines for abortion, but there are not clear mechanisms in place as to how to provide and monitor them.



Contraception

The Albanian government has constantly given high priority and attention to Family Planning and Contraceptive Security. Access to family planning was legalized by a Government Order in May 1992. Family Planning is integrated into the Primary Health Care system. The Albanian Ministry of Health is in the process of developing strategies and policy documents: The National Strategy of Reproductive Health 2016–2020; National Strategy of Health Promotion 2016–2020; and the Guideline and protocol for the provision of FP services.

ADHS (2017–2018) reports indicate that the total fertility rate is 1.8 children per woman; the use of modern contraception among currently married women decreased from 11% in 2008–09 to 4% in 2017–18; 15% of currently married women and 11% of all women have an unmet need for family planning. The total demand for family planning among currently married women decreased from 82% in 2008–09 to 61% in 2017–18. There are many reasons associated with the decrease in numbers and lack of information due to stigma and difficulties in accessing and correctly understanding is one of those reasons.[2] Contraception is offered in Albania in the three levels of healthcare – primary, secondary and tertiary (family planning centres, maternity hospitals, healthcare centres, etc.). Contraception is provided for free, and you can access it without prescription. Although when accessed in the healthcare sector, family planning is always preceded by medical consultation on the best method to take. Contraception is provided in three forms – for the most part, it is provided for free (in 426 healthcare centres) at prices subsidized by social marketing programs, and at market prices in the for-profit private sector. Oral contraception is the one of the most used contraception methods in Albania. Also, emergency contraception is accessible without medical prescription.

Despite the fact that contraceptive methods are provided, there are still some difficulties in accessing them due to social norms and extra-social factors that hamper the protection and provision of RH rights, especially of those underserved communities. Partial data suggest that infant and child mortality rates among Roma are higher than among the rest of the population. Nineteen percent of the Roma population declared they have lost a child after birth. Early marriage and childbirth adversely affect the quality of childcare they can provide.

Furthermore, abortion is seen as a method of birth control. The average number of abortions per woman is 4.8 (for those who have had abortions). Only 44% of the Roma population are aware of a birth control method (UNDP 2012).

Sexuality Education

In Albania, youth remains the target group of sexual reproductive health: almost 65 percent of the population are between 15–64 years of age, while children under age 15 make up 23 percent of the population. In spite of up-to-date achievements and results related to sexuality education, young people still have limited access to comprehensive, rights based and gender sensitive sexuality education, specifically young people from vulnerable groups.

The DHS 2017–2018 shows that 10.5% of 15–19-year-olds and 59.1% of 20–24-year-old women have had sexual contact. Only 1% of women age 25–49 report having had their first sexual intercourse by age 15, and more than one-third (37%) had initiated sexual activity by age 20. The unmet need for family planning was 27.4 % among 15–19-year-old women and 25.9% in the 20–24 ages among currently married women. Ten percent of women and 2% of men aged 15–49 reported having an STI or symptoms associated with an STI within the past 12 months. According to the National Institute of Public Health (2018), the prevalence rate for HIV infection in our country was 0.04% in 2018, and 9.2% of all HIV infections occurred in the 16–24 age group.[3]

In this challenging landscape of information, programs that provide alternative, but complementary, means of reaching young people are sorely needed.

Albania has developed and implemented a programme called "Sexuality Education for Life Skills" for 10 to 19-year-old students under the lead of the Ministry of Education Sports and Youth with the support of UNFPA and IPPF. Since 2015, about 3,000 public school teachers have been trained to teach this program. The program seeks to go beyond improving sexual health. It also aims to prevent and reduce gender-based and intimate partner violence and discrimination; to increase gender equitable norms, self-efficacy and confidence; and to build stronger and healthier relationships. What's more Albania has already made significant progress in adopting regulations supportive of comprehensive sexuality education, and getting teachers, young people and health professionals involved in the planning and implementation process. Some attention is also given to vulnerable groups in the school curricula, but no specifications are given and no strategies are mentioned for reaching out to them.[4]

The Albanian Center for Population and Development (ACPD) provides sexuality education in its youth centres, and a few other NGOs provide youth-friendly SRH and HIV/AIDS services. General SRH services as well as contraceptive supplies are available free of charge and without age restrictions. However, studies reveal that youth commonly report stigma and discrimination from health care workers when seeking SRH services, along with cost prohibitions and transportation challenges in reaching heath facilities. Embarrassment and a perceived lack of privacy and confidentiality when speaking with adults about SRH contribute to the youths' challenges in obtaining high-quality, comprehensive information about reproductive health, contraception and condoms, and HIV.

The Family Code does not recognize the rights of same-sex couples to marry or to enter into civil union. Rights relating to property, inheritance, tax or a surviving partner's pension are not recognized for same-sex couples.

Pre- and antenatal care

Women's health problems are evident and undermine their well-being and potential in fulfilling their right to health.

The Basic Package of Primary Health Care Services (Revised and Adopted in 2015) provides a range of health care measures for women and their reproductive health, which relate to screening and preventive examinations of early pregnancy, pre- and post-natal care, cervical cancer, etc. According to this package, every woman will receive prenatal (antenatal) visits in line with WHO standards necessary to prevent, detect, and manage possible complications, and when needed, will be referred to the applicable guidelines in a timely manner.[5]

Despite the improvement of maternal and child health and nutrition indicators, there are health disparities related to age, gender, mentality, socio-economic level, geographic area and place of residence. There is a de facto lack of integrated services, resulting in critical health gaps which limit the effectiveness of sexual and reproductive health programs and compromise people's health as well as feed stigma and discrimination against vulnerable groups.

About 12% of Roma women between the ages of 15 and 30 do not receive medical assistance, including prenatal check-ups during pregnancy, while only 35% of them carry out health check-ups during pregnancy. Data show that 51% of Roma women and 25.8% of Egyptian women who give birth do not receive any health checks. As a result, many Roma and Egyptian women are affected by a number of health problems. 19.2% of Roma women and 10.9% of interviewed Egyptian women have experienced infant deaths. This is due to socio-economic factors and insufficient access to health care. Knowledge of sex education and reproductive health is obtained in higher grades of elementary school, but many Roma girls drop out of school as soon as they complete the lower cycle.[6]

LGBTQI+ Rights

Since 2010, Albania has had a Law on Protection from Discrimination.[7] Hate crimes and hate speech on the grounds of SOGI are prohibited in the Penal Code.[8] Discrimination on the grounds of SOGI is prohibited by several laws: the Labour Code,[9] the Code of Administrative Procedures,[10] the Law on Pre-University Education,[11] and the Law on Free Legal Aid.[12] The Family Code[13] does not recognize the rights of same-sex couples to marry or to enter into civil union. Rights relating to property, inheritance, tax or a surviving partner's pension are not recognized for same-sex couples.[14] The Law on Reproduction does to support the right to reproduction for lesbians and gays.[15] The Law on Asylum[16] considers affiliation to a particular social group to be a basis for granting refugee status to people facing persecution; however, it does not include explicit references to SOGI as grounds for protection.

By the end of 2018, there were 421 documented cases of discrimination at the Alliance against Discrimination of LGBTQI+ against LGBTQI+ members in Albania. In 2018 we observed a decrease in the number of cases that experienced homophobic attacks being reported to appropriate authorities. We attribute this decline due to a lack of trust in state institutions to respond and prosecute accordingly. The cases that were reported to police,

for instance, failed to follow through with an investigation or prosecution. The police lack significant capacities in recording and completing case registers, which limits their ability to continue with the investigations.

All legislative documentation in the area of healthcare is generic and makes no specific reference to SOGI or to LGBTQI+ people's health needs. Since the legal basis provides for healthcare for everyone, LGBTQI+ people should be beneficiaries of healthcare on the same basis as other citizens.

Rights to reproductive health,[17] health insurance and mental health[18] are accorded to everyone equally, but LGBTQI+ people do not always enjoy them in practice. LGBTQI+ people do not have access to assisted reproduction technology (ART); sex reassignment surgery (SRS) is not offered to transgender persons in public hospitals; and SRS and HRT costs are not covered by health insurance schemes. Intersex people are subjected to forced medical interventions, contravening their right to bodily integrity.[19]

*(*Information provided with support of the organization Alliance against Discrimination of LGBTI)*

Gender-based violence

"Albania has developed a solid legislative framework to address domestic violence, in the fields of both civil and criminal law."[20]

According to Law no. 47/2018 on some adding and changes in law no. 9669, dated 18.12.2006 on measures against violence in family relations, as amended, more subjects benefit from protection under this law.

Three important sublegal acts of this law have been adopted: the Joint Instruction on Procedures and Risk Assessment Model for Cases of Domestic Violence (no. 866, 20.12.2018); the Joint Instruction on the Procedures and Model of the Order for Precautionary Measures for Immediate Protection (no. 912, 27.12.2018); the Instruction of the Minister of Health and Social Protection on the approval of standards for service provided and functioning of crisis management Centres for cases of sexual violence (no. 816, 27.11.2018).

The Criminal Procedure Code was updated, and for the first time it, stipulated the procedural rights of the victims during the criminal proceedings.[21] These rights were harmonized with the standards of the EU Directive and the Council of Europe Convention.[22]

The Albanian Parliament adopted Law no. 22 / 2018 on Social Housing, which foresees three categories of abused women as beneficiaries of this service: victims of domestic violence; victims of trafficking; potential victims of trafficking. Statistics indicate that in 2018, 8.6% of women had 'ever' experienced and 3.6% 'currently' experienced one or more of the three types of sexual violence in their intimate relationships. Women were most likely to experience having sexual intercourse with their husband/partner, because they were afraid of what he would do if she refused (7.5% ever, 3.3% current).[23]

Furthermore, 36.6% of women 'currently' experienced violence, 33.7% of women 'currently' experienced intimate partner domestic violence, 61.8% of women dating or engaged 'currently' experienced dating violence. Among all women 18–74 years of age, 3.4% 'currently' experienced non-partner violence, 8.5% were experiencing sexual harassment and 6.9% were experiencing stalking.[24]

*(*Information provided with support of the Gender Based Violence Monitoring Network)*

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2. https://www.ishp.gov.al/wp-content/uploads/2015/04/ADHS-2017-18-Complete-PDF-FINAL-ilovepdf-compressed-1.pdf
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19 Parliament of the Republic of Albania (2015) Resolution on the protection of the human rights and freedoms of LGBTI people https://www.hrw.org/news/2015/05/08/dispatches-albania-signals-positive-step-lgbt-rights

20 GREVIO's (Baseline) Evaluation Report on legislative and other measures giving effect to the provisions of the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention) ALBANIA, Published on 24 November 2017. https://rm.coe.int/grevio-first-baseline-report-on-albania/16807688a7

21 See: Law no. 35/2017, The Criminal Procedure Code of the Republic of Albania", AS AMENDED

22 Directive 2012/29/EU of the European Parliament and of the Council of 25 October 2012 establishing minimum standards on the rights, support and protection of victims of crime, and replacing Council Framework Decision 2001/220/JHA & Council of Europe Convention on Action Against Trafficking in Human Beings, ratified by Law 9642, dated 20.11.2006.

23 INSTAT, 2018 NATIONAL POPULATION SURVEY Violence Against Women and Girls in Albania, p.81, Tirana 2019. This survey was conducted by INSTAT with technical expertise provided by and report writing led by Dr. Robin Haarr, international consultant, supported by UNDP and UN Women and financial contribution through the Government of Australia in the framework of the regional gender statistics and SDGs project "Women Count" and the Government of Sweden in the framework of the UN Joint Programme on Ending Violence Against Women in Albania. http://www.instat.gov.al/media/6123/publication-violence-against-women.pdf

24 INSTAT, 2018 NATIONAL POPULATION SURVEY Violence Against Women and Girls in Albania, p.13-14, Tirana 2019. This survey was conducted by INSTAT with technical expertise provided by and report writing led by Dr. Robin Haarr, international consultant, supported by UNDP and UN Women and financial contribution through the Government of Australia in the framework of the regional gender statistics and SDGs project "Women Count" and the Government of Sweden in the framework of the UN Joint Programme on Ending Violence Against Women in Albania. http://www.instat.gov.al/media/6123/publication-violence-against-women.pdf

Armenia

Abortion and post-abortion care

Abortions are legal in Armenia according to Article 10 of the Law on Reproductive Health and Reproductive rights (December 11, 2002). According to the law abortion is accessible up to the 12th week of pregnancy. Two abortion methods – surgical and medical, allow to better regulate the procedure. Surgical abortion is legal within the first 12 weeks and medical abortion is legal up to week 8–9 of pregnancy. Starting from 12 to 22 weeks of pregnancy, women can be provided with the procedure only in case of medical and/or social factors, i.e. rape, divorce, health issues etc. The demographics of the Republic of Armenia and 2015–16 Demographic and Health Survey (DHS) revealed that one out of four women aged 15–49 has had at least an abortion once. The probability of abortion rises with the age of the woman and number of living children. Forty-seven percent of those women have had more than two abortions[1]. Unquestionably, the legal status of abortion is a key factor ensuring the secure accessibility of abortions[2]. When it comes to financials, the average price for medical abortion is 30–40 USD, and 100–150 USD for surgical abortion, while an average salary in Armenia is 200–300 USD.

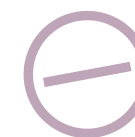
Furthermore, Article 21 of Government Order on Approving the Terms and Conditions of Abortion No. 180-N dated February 23, 2017 inhibits women's right to abortion by requiring a three day waiting period from the moment the woman first approaches the doctor requesting an abortion before the doctor may proceed with the abortion.[3] There are also several preconditions defined for terminating a pregnancy, particularly, mandatory free of charge counselling by the doctor concerning possible negative effects of the termination of the pregnancy.

Deeply embedded stereotypes, discriminatory and harmful norms that exist in Armenian society are factors that undermine women's rights to abortion and opportunities for free choice. The stigma of abortion frequently becomes a decisive aspect for denying accessibility of abortion services for women. In the patriarchal Armenian society, men benefit from the privileges of executing power and authority by refusing to use contraception, leaving the full burden of the consequences of abortion on the shoulders' of women, but simultaneously blaming women for opting for an abortion. Women are routinely shamed, labelled, and discriminated against by various individuals in society including medical service providers. The experience of Women's Resource Center's work with various groups on reproductive health shows that in more rural areas of Armenia, it is common practice for doctors to pressure women not to proceed with an abortion or even to refuse to perform it due to moral or religion objections.

The stigma of abortion frequently becomes a decisive aspect for denying accessibility of abortion services for women.

Regardless of international and national principles that regulate the realization of secure and accessible abortion rights of women, in Armenia, there are still various impediments to women's access to safe and legal abortion services, particularly for women living in rural areas who have difficulty accessing medical services due to a lack of medical institutions in those areas.

There is no official statistics for illegal abortion procedures in Armenia, but in some cases, women who want to interrupt an unwanted pregnancy obtain the medical abortion method using only 'cytotec' by themselves which causes unexpected consequences. This was supported by the findings revealed by the Women's Resource Center NGO while conducting a small survey in Lory, Shirak, Kotayq and Gegharqhuniq regions in 2017. During focus group discussions women reported that some women in Lory and Shirak regions self-induce abortions using varying unsafe methods which can have harmful consequences for their health.



Contraception

Contraception is accessible in Armenia. Contraceptive methods are grouped into two types: modern and traditional. Modern methods in Armenia include female sterilization, male sterilization, the pill, intrauterine device (IUD), injectables, implants, standard condom and emergency contraception. Only in some cases hormonal methods have to be prescribed by a doctor, other can be bought over the counter.[4] Knowledge of contraceptives is widespread in Armenia, with 97% of women and 99% of men having heard of at least one method (ADHS 2016, 73). While researching the topic, the Women's Resource Center did not encounter any cases of conscience objection standing in the way of obtaining contraception. Contraception methods are not refunded by the state; and, in reality, some methods of contraception are very expensive, for example contraceptive hormonal methods and IUDs.[5] Meanwhile, it is worth mentioning that there was a program implemented by UNFPA in Armenia which provided some contraceptive methods (standard condoms, hormonal methods and emergency contraception) for free in all regions. The methods of contraception were provided to the regional clinics , which were later distributed to the residents.[6] However, during Women's Resource Center's women's march, it became clear that women were avoiding the use of contraceptives, because health care providers often violated confidentiality and spread the information about which method they used and how many times.[7]

When it comes to emergency contraception in Armenia, it is accessible without prescription. Two types of emergency contraception pills are available in the country. However, there is a problem of accessibility in rural areas. There are no pharmacies in rural areas, so in order to obtain contraceptives, women have to travel to a nearby town or larger village

which is not always convenient due to financial and social reasons. The price of emergency contraception is relatively high what may cause obstacles in obtaining it.[8]

Among married women, use of traditional methods (29 percent) is slightly more common than use of modern methods (28 percent). Withdrawal is the most widely known traditional method among currently married women (25 percent). It is followed by standard condom (15 percent) and the IUD (9 percent). In general, women in Armenia do not begin to use contraception until they have had at least one child. The use of contraception (no matter the form) among married women is similar among urban and rural women (57 percent and 58 percent, respectively). However, urban women are markedly more likely to be using a modern method than rural women (32 percent and 23 percent, respectively).[9]

Sexuality Education

In Armenian schools, the sexuality education program is called "Healthy lifestyle" and is taught as part of Physical Education for grades 8–11. The reproductive health component is allotted eight hours out of the total 14. "Healthy lifestyle" class is taught firmly within the framework of "abstinence only" education and employs a fear-based approach wherein students are shown frightening and exaggerated stories of complications of unwanted pregnancy and STIs. At the same time, information about STIs including HIV/AIDS is scientifically complex and not adapted to the developmental level of the students.

The main challenge to the implementation of comprehensive sexuality education in Armenia is the way the "Healthy Lifestyles" program is taught. According to the report "The Attitudes of teachers of 'Healthy lifestyle' about the topics of sex education",[10] many of

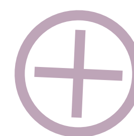
"Healthy Lifestyles" is not a separate subject and is taught as part of Physical Education, a subject dominated by male teachers.

the Physical Education teachers report being uncomfortable teaching the sections related to reproductive health and prefer it be taught by someone more qualified and trained. "Healthy Lifestyles" is not a separate subject and is taught as part of Physical Education, a subject dominated by male teachers. Due to social norms in traditional Armenian society, men especially are uncomfortable discussing topics such as contraception, abortion, and STIs, so the teachers tend to focus more on the sections about tobacco, alcohol, and drugs and often revert to asking students to merely read the sections on reproductive health on their own, therefore failing to engage the students with the material in a satisfactory way to encourage learning.

Although certain topics (such as the reproductive organs, menstruation and sex) are taught in Armenian schools as part of the anatomy curriculum, those teachers also report being ashamed to teach these elements of the class and ask students to do the readings on their own.[11]

There is no specific data regarding the level of knowledge of sexuality among young people, however, there is factual data information about contraception, STIs, pregnancy and childbirth, reproductive health which is available in the Demographic and Health Survey.[12] During Women's Resource Center's 'my body-my right' sexual education training, which has been conducted for almost 10 years now, it has become clear that young women and men have little information about sexuality, about sexual and reproductive organs, anatomy and physiology, personal hygiene, healthy sexual relationships, STIs and contraception, sexual orientation and gender identity, etc.

Knowledge of HIV/AIDS in Armenia continues to be very high. Almost 9 in 10 women and men (89 percent of women and 88 percent of men) reported that they have heard of HIV/AIDS, a slight decrease from the figures reported in the 2010 ADHS (96 percent among both women and men) (NSS et al. 2012). Awareness of HIV/AIDS is somewhat lower among the youngest and least educated respondents and among those who have never had sex, those who have not worked abroad, and those in the lowest wealth quintile. Additionally, women and men living in the Gegharkunik region (50 percent and 69 percent, respectively) are considerably less likely than respondents in other regions to have heard of AIDS.[13]



Pre- and antenatal care

In the Republic of Armenia, women have the right to safe prenatal care, which means that they have the right to receive assistance during pregnancy, childbirth, and postpartum health care with the use of methods that minimize risk to the health of the foetus and the new-born. Women have the right to information about the benefits of breastfeeding, as well as healthy and safe nutrition for infants and young children. In addition, the law also stipulates that a woman has the right to receive free or privileged medical and pregnancy care during pregnancy, within the framework of state targeted health programs.[14]

According to the order of the Minister of Health, the obstetric-gynaecological medical care and service provided in the outpatient conditions within the framework of the state-guaranteed free medical care and service is mainly provided on the basis of territorial service. At the same time, every resident has the right to choose their obstetrician-gynaecologist. In all cases in which a woman resides in the primary health care service of a given healthcare organization, but chooses to consult in another medical organization, she must present a document from her regional medical establishment that she is registered. In this regard, it should be emphasized that the above-mentioned relocation can be carried out only within the region. In other words, in case of withdrawing from the registration of a medical institution located in one of the regions of the Republic and being registered in another region, including another medical institution located in Yerevan, the person is deprived of the right to free maternity care, and the latter is provided with paid care. Such legal regulation is in fact quite problematic in terms of access to health care in the sense that in the whole territory of the Republic of Armenia medical services do not have the same level of quality development, which is why women often prefer to go to another region or come to Yerevan for more quality medical care.

Obstetric and gynaecological medical care and services in primary health care organizations within the framework of state-guaranteed free medical care include:

- Providing a free examination and counselling on human immunodeficiency virus (HIV) infection;
- Implementation of social-psychological support, training and physical preparation for pregnant women;
- Provision of medical care and services to pregnant women by specialist obstetrician-gynaecologist without limitation of specialists;

- Conduct laboratory instrumental diagnostic tests during prenatal surveillance of pregnant women without limitation if there are such need;
- Postpartum control (42 days postpartum), and others.

Every working woman has the right to paid leave during pregnancy and childbirth. Every working parent has the right to a leave when their child is born or adopted. The details are set by law.

Article 172.

Pregnancy and childbirth leave:
1. Working women are granted pregnancy and childbirth leave:
1) 140 days (70 days of pregnancy, 70 days of delivery);
2) 155 days (70 days of pregnancy, 85 days of childbirth) in case of difficult childbirth;
3) 180 days (70 days of pregnancy, 110 days of childbirth) if you have more than one child at a time.

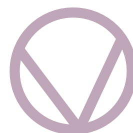
LGBTQI+ Rights

Constitution of the Republic of Armenia provides for prohibition of discrimination on the grounds generally listed by the international treaties, including discrimination on the grounds of other personal or social circumstances.[15] At the same time there is no anti-discrimination law in Armenia, which would define the concept of discrimination, its types and forms and would provide for effective mechanisms to prevent discrimination as well as effective legal remedies for victims of discrimination. According to ILGA-Europe's annual benchmarking tool[16] which ranks 49 countries in Europe on their LGBTQI+ equality laws and policies Armenia is one of three worst countries after Azerbaijan and Turkey.

Armenian society is highly homophobic (as well as biphobic and transphobic) according to a research conducted in 2016.

Armenian society is highly homophobic (as well as biphobic and transphobic) according to a research conducted in 2016.[17] There are no statistics conducted by State law-enforcement agencies on the rate of violence and discrimination on the grounds of sexual orientation and/or gender identity or expression. Hate crimes are not being legally qualified as such, because of legislative gaps.[18]

There is no legislation which allows the registration of same-sex relationships in Armenia. Furthermore, the Constitution restricts the possibility of registering any kind of marriage, defining it as a union between man and woman.[19] The only exceptions are the marriages which have been registered in another country according to the letter's legislation. Such civil acts are valid in Armenia after consular legalization.[20]



Gender-based violence

No segregated data is available on GBV in Armenia, nor there is on sexual harassment. In 2017, according to official data, there were 793 cases of domestic violence. Only 458 reached the stage of investigation. The Coalition Against Violence Against Women received 5,600 reports of violence that year. The official data of 2018 reports 519 reported cases of domestic violence. In 2017, 161 criminal cases have been registered by the Investigative Committee on sexual violence cases.

Victims face problems when trying to obtain short-term housing, as the number of beds in safe houses, currently run by NGOs, is insufficient. There is no state support for the shelters.

Rape is criminalized in Armenia with the punishment being imprisonment, but domestic violence is not criminalized in any way. There is no perpetrator rehabilitation program in the country. Rape, defined as sexual intercourse of a man with a woman against her will, using violence against the latter or some other person, with threat thereof or taking advantage of the women's helpless situation, is punished with imprisonment for a period of time ranging from 3 to 6 years.

Armenia signed the Istanbul Convention in January 2018, but has not yet ratified the treaty. Upon signing the Istanbul Convention, Armenia reserved the right to now apply several provisions.

The Armenian educational system introduces sex stereotypes and prejudices to boys and girls from a very young age. Sexist discourse is present in almost all spheres of life, creating an atmosphere of oppression and marginalization of women and girls which severely limits their rights and opportunities within both the public and private domains. These discourses deprive them of the possibility to fully realize their rights to bodily autonomy, agency and freedom and negatively impact many aspects of sexual and reproductive health, including decisions on how many children to have, family planning, which type of contraceptive to use, and whether to have sex before or after marriage.

There is no data regarding stigmatization of single parenthood in Armenia. According to NGOs that work in field, the reason for being single mother is crucial for the society. If a husband left the family because of the need to migrate for work or just left the family, it is more acceptable than the cases in which women themselves initiated separation. For domestic violence survivors who are also single mothers the atmosphere can be more hostile.

There is no research on a social pressure to stay in an abusive marriage, but NGOs working in this field can state that in rural areas, women are forced to stay in abusive marriages as social norms are stricter in these remote areas.

1 Online source: http://www.armstat.am/file/article/dhs_kir_2015-16-english.pdf

2 For a detailed map of the 2017 World Abortion Laws visit: http://worldabortionlaws.com/map/

3 See: The Government Decree on the Approval of Terms and Conditions of Abortion and annulment of Government Decree N 1116- N dated August 5, 2004 http://www.arlis.am/DocumentView.aspx?docID=111980

4 Demographic and Health Survey /2015-16/

5 Hormonal pill-start from 7000 AMD which is approximately 10 euros, IUD start from 25.000-100.000AMD which is approximately 50-200 euros

6 https://www.un.am/en/agency/UNFPA?fbclid=IwAR1S4jSquSc-C0GHui30pTYgUZPX4tFWnx0xfwev-UOhl7n_UZiXqMoniRGZI

7 Women's resource center NGO organizes the women's march every two years. Representatives of the organisation choos a region and walk through the villages and cities while talking about gender based violence and reproductive health and rights issues.

8 Emergency contraception-6000 AMD which is approximately 10 euros.

9 https://dhsprogram.com/pubs/pdf/FR325/FR325.pdf?fbclid=IwAR2M1Y85azjrPDB0-Jz6aUTAePa9047KflaIIE6haupJq0big-YF-Nimi0dT8

10 On-line source: http://www.ysu.am/files/Sex-ed_Teacher2018_WRC_CGLS.pdf

11 On-line source: http://www.ysu.am/files/Sex-ed_Teacher2018_WRC_CGLS.pdf

12 https://dhsprogram.com/pubs/pdf/FR325/FR325.pdf?fbclid=IwAR2M1Y85azjrPDB0-Jz6aUTAePa9047KflaIIE6haupJq0big-YF-Nimi0dT8

13 https://dhsprogram.com/pubs/pdf/FR325/FR325.pdf?fbclid=IwAR2M1Y85azjrPDB0-Jz6aUTAePa9047KflaIIE6haupJq0big-YF-Nimi0dT8

14 https://www.arlis.am/DocumentView.aspx?DocID=128068

15 Constitution of the Republic of Armenia, Article 29, 2015, available at: https://www.president.am/en/constitution-2015/

16 ILGA Europe, Rainbow Europe 2019, available at: https://www.ilga-europe.org/rainboweurope/2019

17 Pink Armenia, "From prejudice to equality", available at: http://www.pinkarmenia.org/wp-content/uploads/2016/06/From-Prejudice-to-Equality-English.pdf

18 European Commission against Racism and Intolerance, Report on Armenia, 2016, available at: https://rm.coe.int/fourth-report-on-armenia/16808b5539

19 Constitution of the Republic of Armenia, Article 35, 2015, available at: https://www.president.am/en/constitution-2015/

20 Family Code of the Republic of Armenia, Article 143. Available in Armenian at: https://www.arlis.am/DocumentView.aspx?docid=66138

Belarus

Abortion and post-abortion care

According to Belarusian legislation[1] a woman is given the right to independently decide on the issue of motherhood. Abortion can be carried out at a gestational age of not more than 12 weeks.

There are two groups of indications for abortion: medical indications for artificial termination of pregnancy by the mother and medical indications for artificial termination of pregnancy by the foetus. In the presence of medical indications and the consent of the woman, abortion is carried out regardless of the gestational age.[2] If there are medical indications that are not included on the list, in which continued pregnancy and childbirth pose a threat to the woman's life or may harm her health, the issue of medical abortion is decided by the medical consultation commission.

From 2000 to 2017, the number of abortions decreased fourfold. According to the latest data for 2017, there are 11.3 abortions per 1000 women of reproductive age, and almost 25 abortions per hundred births are carried out. In total, 25,200 abortions were performed in 2017.[3] According to data for 2015, in 40 % of cases, abortions in Belarus are performed by vacuum aspiration and the medical method. Eight hundred pregnancies per year are interrupted for medical reasons.[4]

Medical abortion was legalized in 2011 and is available at a gestational age of not more than 6 weeks. Medical institutions that have the right to terminate a pregnancy purchase a drug. The patient enters into an agreement, undergoes an examination and pays for the service, and is under the supervision of a doctor for several days after taking the drug.[5]

In 2013, eight out of ten social indications for abortion were cancelled. Thus, pregnancy due to rape and a court decision on the deprivation of parental rights are considered a social reason for an abortion from 12 to 22 weeks. Both for medical reasons and for social reasons, abortion is carried out in state healthcare organizations.

Restriction of the right to abortion is a rising trend. Since 2014, a doctor can refuse to carry out an abortion by informing to the head of the healthcare organization.[6] This has resulted in private medical centres (in Minsk, Borisov, Zhodino, Grodno) that do not provide abortions, and whole cities in which all specialists refuse to provide abortions (Logoisk).[7]

Restriction of the right to abortion is a rising trend.

Since December 2019, abortions have not been carried out in the Grodno regional maternity hospital. A round table dedicated to this was held at the Grodno Medical University.[8]

Since 2014, healthcare organizations are providing pre-abortion counselling for women seeking an abortion in "For Life" room. If the clinic does not have a psychologist, the institution may accept a consultant from another medical centre or public organization, and clinics actively hire pro-life activists.[9]

"Weeks of silence" are regularly taking place in the cities of Belarus: abortions are not carried out in the whole city, except for medical indications.[10] In 2017, the chief obstetrician-gynaecologist of Minsk spoke out in favour of revoking the license of private medical centres for abortion operations.[11] Thus, women in Belarus have the right to abortion, however, the realization of this right is fraught with certain difficulties due to active actions of pro-life movement.

Contraception

Belarus is among the last places in Europe in terms of access to contraception.[12] The overall level of accessibility is 44.3%, according to Contraception Atlas. On 24 June 2019, Decree No.27 of the Ministry of Health on the establishment of a list of medicines sold without a doctor's prescription came into force, regulating the sale of combined oral contraceptives[13]. A prescription from a gynaecologist now is required. The prescription is valid for up to two months. This does not apply to emergency contraception, however, the sale of emergency contraceptives will now be carried out no more than one pack on hand.

These changes affected the assessment of the generalized indicator of policies related to supplies and counselling, which fell by 17.2% starting in 2017 and was at 41.7% by 2019.[14] The deterioration of this indicator was also affected by the abolition of special reimbursement for vulnerable groups since 2017. At the moment, refunds are not available for any population group in Belarus.

The availability of on-line information indicator for 2019 increased by 21% compared to the previous year. The reason for this is the appearance of information previously not available on the costs of contraception, the level of accessibility of which is assessed as "good" now.[15]

However, in Belarus, oral contraceptives are not widely used. Surveys of women of reproductive age indicate that, according to various sources, 3–10% of women use hormonal contraception to prevent an unwanted pregnancy, and in some regions, this figure is about 20%.[16] The main obstacle for taking oral contraceptives is the existence of stereotypes in society regarding their side effects on the body, and lack of awareness.

According to data provided by the Ministry of Health of Belarus the share of women that uses intrauterine devices at a reproductive age (aged 15–49) decreased by 3.4% between 2011 and 2017. During this five-year period,

Belarus is among the last places in Europe in terms of access to contraception.

the share of women using intrauterine devices fluctuated. The share of women using hormonal contraception also decreased over considered period from 18.8% to 16.7%, which is equal to a 2.1% decline. The share of women at a reproductive age using intrauterine devices insertion has dropped from 1.1% to 0.8%.[17]

According to recent research,[18] the most popular method of contraception among Belarusians aged 18–39 is a condom (53.8% of respondents), and 21.4% of people of same age cohort, who are not planning to have children yet, do not use any contraception. Moreover, 29.4% of Belarusians age 18–39 believe, that interrupted sexual intercourse is an excellent method of contraception. This shows the low literacy level among young people and the need for effective measures to combat it.

Sexuality Education

Belarus is not an advanced state in regards of comprehensive sexuality education. There is no interest shown by the state in providing comprehensive information on sexual education and including it in the curriculum.

From 2 November 2018 the optional course "Fundamentals of family life: the curriculum of elective classes for IX–XI classes of secondary schools" was introduced.[19] In this program, the emphasis is on "traditional" family values, and there are no mentions of STDs, gender-based violence and other essential components. Such terms as "reproductive health" and "gender stereotype" are in offered in the curriculum of the course, and it can be positively evaluated. The optional course is based on comparatively old teaching materials from 1980–2000.

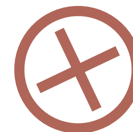
However, the program of this elective course has optional topics, which, in fact, teachers can interpret in their own way. Despite representing traditional values, this course legitimizes the opportunity to talk about sexuality education. Respectively, some psychologists and teachers (who often lead this elective course) can ask independent organizations (for example, Y-PEER Belarus, a network of peer-educators, supported by UNFPA Belarus) to conduct training, and everyone benefits from this, because volunteers deliver reliable and evidence-based information from peer educators.

Currently, state or non-governmental organizations do not monitor the current knowledge of sexuality among young people. Also, no recent data monitoring has been conducted that could produce figures on teenage pregnancies, contraceptive use and other indicators, that are showing the level of factual knowledge regarding sexuality among young people.

There are few positive examples in regards of comprehensive sexual education. Among organizations and movements, Y-PEER Belarus is one of the few to provide quality, age-appropriate and evidence-based sexuality education. Events that are aimed at developing teachers' skills, stimulating public discussion and experience exchange with other countries can also be mentioned. In April 2019, in the city of Grodno, regional advanced training courses entitled "Education in the field of reproductive and sexual health, HIV prevention, interpersonal relations of students and their parents" for social sciences teachers and teachers performing the functions of class teacher were held, in the framework of a joint project by the Belarusian Association of UNESCO Clubs and the Minsk City Institute of Educational Development with the support of the UNESCO Institute for Information Technologies in Education and the UNFPA Belarus.[20] In May 2019, the "Actual issues of creating a healthy lifestyle and HIV prevention among young people in the educational environment" conference was organized in Minsk by the Belarusian Association of UNESCO Clubs together with the Ministry of Education of the Republic of Belarus.[21] During the event, the need to introduce comprehensive sexual education as one of the forms of work on HIV prevention, life skills development and the development of healthy interpersonal relationships was repeatedly emphasized.

There is no interest shown by the state in providing comprehensive information on sexual education and including it in the curriculum.

These examples indicate signs of hope for Belarusian society to finally appear on turning point and open for a conversation. A progressive part of a society is ready to move forward and gradually change something and start to use comprehensive and beneficial methods in sexual and reproductive health education for adolescents, but the state apparatus, together with pro-life powers are reluctant to change. Belarus can move along the path of implementing reproductive and sexual health education in the official curriculum and join the block of other countries in the CEE region that also are striving to transform the narrative around this issue and positively impact policy decisions to enhance adolescents' sexual and reproductive health and rights.



Pre- and antenatal care

In Belarus, total number of pregnant women admitted to hospitals under supervision (at a gestational age of up to 12 weeks) is 97.4%. The proportion of births in hospitals is 99.8% of the total number of births. The mortality rate of pregnant women, women in childbirth and parturient women (per 100,000 live births) is 1.9%.[22]

Antenatal health services are fully available in accordance with the approved clinical protocols in the public health system. At the woman's request, antenatal care is available at private health facilities on a paid basis. A network of maternity schools operates in the capital and in regional centres. In other areas, medical institutions are not sufficiently provided with medical personnel for the additional burden of conducting maternity schools; and the purchasing power of the population and the level of education are insufficient for the development of private services. Medical services for childbirth are provided in state healthcare institutions only – in maternity hospitals of various levels.

Parental leave until a child reaches the age of three is granted to mothers (or fathers, or other people): from 35% to 45% of the national average monthly salary (payments are dependent on the income level of those take the leave). In part-time employment, the benefit is reduced to 50%. The right to take a leave is exercised mainly by mothers.

There is a systemic problem with the violation of the rights of the patient. Main challenges in this area are the following:[23]

- the right to autonomy of will is violated in case of more than 80% of women (the right to informed consent or refusal of medical interventions);
- less than 15% of women have partner assistance during childbirth (demand for the partner is more than 70%; there are barriers to partner access to the hospital where the woman in labour; usually, outside the capital and regional centres, there are no conditions for partnership in childbirth);

- more than 90% of women experience certain episodes of obstetric violence during pregnancy and childbirth. This includes the use of the Kristeller manoeuvre in 29.3% of the cases, dissection of the perineum in 44.1% of the cases and other interventions, while 98% of women lie flat on their back during delivery without support for the freedom to choose a delivery position, and 30% of births are delivered by caesarean section.

As many as 6.3% of births occur at home and this trend is growing. Such births are not provided with legal obstetric care, since it is only guaranteed only in state healthcare institutions.[24] The main reason for choosing to give birth at home included dissatisfaction with the quality of care during childbirth in maternity hospitals, barriers to partner births, insufficient alternatives, inadequate conditions for physiological births, and an inability to choose a midwife in the maternity hospital. There are no conditions for care under the guidance of a known midwife or group of midwives who lead a woman during pregnancy, childbirth and the postpartum period.

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LGBTQI+ Rights

Belarus does not have an anti-discrimination law that protects LGBTQI+ people (both in the case of hate crimes and in the case of systemic discrimination based on SOGI).[25] In earlier draft anti-discrimination laws, there is no mention of LGBTQI + as a separate social group.

Belarus does not have specialized homophobic law (similar to the Russian law on “propaganda of homosexuality”), but in 2019, religious and pro-family organizations repeatedly insisted on its adoption. Today, signatures for the adoption of a law restricting the rights of LGBTQI + citizens are conducted on the basis of several religious and social associations.[26] Homophobic propaganda is carried out in educational institutions in regional cities.

An LGBTQI + activist from Molodechno filed a lawsuit against the newspaper Vecherny Mogilev. Experts claim that articles published in the newspaper contained extremist statements towards LGBTQI + people,[27] however, the Ministry of Information, the Ministry of Internal Affairs and the prosecutor’s office did not reveal the elements of the crime. The newspaper appealed and protested the expert’s opinion. The court did not recognize the publications as extremist.

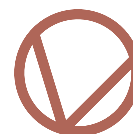
According to the Criminal Code of the Republic of Belarus, qualifications for hate crimes do are not in line with SOGI – because of this, LGBTQI + people in Belarus are not recognized as a social group in court, and crimes driven by homophobia (the murder of Mikhail Pishchevsky in 2015,[28] the beating of Nikolai Kuprich in 2019)[29] is interpreted by the court as “hooliganism”. The motive of homophobia is not considered an aggravating circumstance.

Data about the level of homophobia is not collected by state institutions, and at the state level the problem remains in silence. The public opinion is ambiguous: more publications have appeared in the media about the problems of LGBTQI+ people, but opposition from the reactionary forces has increased (for example, the website “Stop LGBT”[30] was created by social para-religious organizations to consolidate homophobic citizens). At the moment, religious organizations claim that they have collected more than 7,000 signatures for the prohibition of informing on the topic of LGBTQI + and the mention of LGBTQI + in the media).

Power structures have aggressive homophobic attitudes. For the last two years, homophobic statements have appeared on the website of the Ministry of Internal Affairs.[31] [32] Police organize raids on clubs where LGBTQI + parties are held: personal data of visitors copied, “LGBTQI + lists” are created, people are threatened with outings in the workplace.[33] In 2019, cases of “fraudulent dates” were revealed in regional cities when police met with LGBTQI + people on social networks in order to intimidate, collect data and blackmail.[34]

The head of the anti-trafficking department has repeatedly made statements that the Ministry of Internal Affairs of Belarus considers the visibility of the LGBTQI + community to be the cause of the growth of crimes against the sexual integrity of children.[35]

Belarus has no opportunity to legally regulate same-sex partnerships. One of the points of homophobic rhetoric of official and religious persons is the “fundamental and invariable” wording of marriage as the “union of a man and woman” in the Code on Marriage and Family.[36]



Gender-based violence

Every second woman in Belarus (52.4 %) has been subjected to some kind of violence at least once during her life. The prevalence of various types of violence against women include: physical violence – 28.4 %; sexual violence – 16.9 %; psychological violence – 45.2 %; economic violence – 15.0 %.[37] All four types of violence are present in the life of every eighth woman (11.6%). Every third woman has been a victim of physical and / or sexual abuse at some point throughout her life.

The Ministry of Internal Affairs annually receives about 120,000 reports of domestic violence, and in 80% of the cases, women are the victim. As a result, only 50,000 violators have been held accountable.[38] This happens for several reasons. According to Belarusian law,[39] liability only occurs after the injured party writes a report, which often does not happen. Also, the case may be dismissed at the stage of the court proceedings or while being considered by the court. If a counterclaim is filed, such a case is terminated.

The term “domestic violence” was introduced into the law in 2008, and in 2014, new measures of prevention appeared. Measures of individual prevention of domestic violence prescribed in the law include preventive conversation, official warnings and a protective order. It is necessary to file a report with the police, where the victim is obliged to “prove” the violence took place and go through the whole procedure. Only if this procedure is successful, the victim can reach the fourth stage – the application of a protective order.[40]

Belarus does not have a specialized law on the prevention of domestic violence. The situation is aggravated by an extremely small number of other effective protection mechanisms. In 2017, the Ministry of the Internal Affairs developed the concept of a bill to combat domestic violence. At the end of September 2018, after the Head of State negatively reacted to the concept developed by the Ministry of Internal Affairs, all further activities to finalize the bill were discontinued.[41]

After that, an initiative group of concerned citizens “March, Babe” was spontaneously formed as a platform to discuss future activities related to assisting and promoting the implementation of the law.[42] At the moment, almost 5,000 people have signed a petition for the adoption of the law on combating domestic violence in Belarus,[43] and in December 2019, the first picket protest against domestic violence took place.[44]

In January 2020, it was announced that plans for 2020 do not provide for the development of a bill to combat domestic violence and the initiation of a bill ”currently considered inappropriate”.[45] This decision was approved by a presidential decree of 26 December 2019. This decree was written at the request of standing committees of the House of Representatives in response to the collective appeal of representatives of “pro-life organizations”.

Belarus has not signed and ratified the Istanbul Convention. However, the concept of the law proposed in 2017 provided for the need to improve national legislation by taking into consideration the provisions of the Convention. In 2018, a global analysis of national legislation and organizational capacity to determine Belarus’s readiness to sign the Istanbul Convention was prepared, which indicated 12 points in national legislation that need to be harmonized.[46]

1 http://pravo.by/upload/docs/op/W21429399_1419368400.pdf

2 http://pravo.by/upload/docs/op/W21429399_1419368400.pdf

3 https://www.belstat.gov.by/ofitsial-naya-statistika/publications/izdania/public_compilation/index_9283/

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20 https://www.belau.info/stat_i/621.html

21 https://iite.unesco.org/ru/news/health-education-conference-minsk/

22 http://med.by/mzstat

23 According to the portraits of the respondents, research results are relevant, for the capital city of Minsk and regional centers, for women with higher education, or with a significant deterioration in the conditions for the realization of rights in other settlements, villages, women of lower social, educational status. http://radziny.by/wp-content/uploads/2018/11/001Radziny_humanrightsinchildbirth_Belarus2017.pdf (available in Russian)

24 https://www.bsmu.by/downloads/kafed-ri/k_anesteziologii/doc/2435.pdf

25 Sexual Orientation and Gender Identity https://www.coe.int/en/web/no-hate-campaign/sexual-orientation-and-gen-der-indentity-sogi

26 https://katolik.life/rus/news/sotsium/item/4156-v-belarusi-sobirayut-podpi-si-o-zaprete-lgbt-propagandy-za-i-protiv.html

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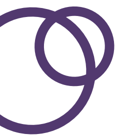
46 https://neg.by/novosti/otkrytj/lichnaya-zhizn-po-mezhdunarodnym-pravilam

Bosnia and Herzegovina



Abortion and post-abortion care

In Bosnia and Herzegovina, abortion is legally regulated at the entities' level. In the Federation BiH, the law in force is the Law on conditions and procedure for abortion (1977), taken from the former state – Socialist Federative Republic of Yugoslavia, that almost in the same way as the Law in the Republika Srpska entity (2008) regulates the procedure and duties of health care institutions. It states that each woman has the right to, according to her own choice, decide to terminate of pregnancy up to the tenth week of pregnancy. The law that has been in use all this time since 1977 is one of the most liberal laws on this matter in Europe.

Medically induced abortion is provided within the basic package of health care services from the compulsory health insurance in the entities/cantons of Bosnia and Herzegovina, whereas abortion on request has to be paid by the patient herself.

Currently there are no serious attempts undertaken to amend the existing laws in the direction of tightening the criteria and endangering this right in Bosnia and Herzegovina. The public discourse around the topic of abortion is also much calmer than in neighbouring Croatia.

Abortion is still kind of a taboo in our society, though there is not enough coverage in the media or public narrative and the educational system. Surely one of the reasons for that is traditional understanding of the reproductive sphere. For sure, the retrograde, the so called "religious" beliefs of the persons who provide these services, MPs and government officials, do not contribute to the full and free realization of this right, nor should they influence their jobs. Cases of conscientious objection by doctors/health care workers have not yet been registered.

According to the laws in BiH, the termination of pregnancy for medical reasons is free of charge and is performed in the public health care institutions. Termination of pregnancy on request is done in public, as well as private health care institutions/clinics – the patient has to pay for this service.

Data on the number of abortion procedures carried out per year in public hospitals:

Entity Federation BiH – data for 2018 (according to the Public Health Institute):

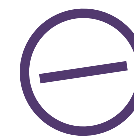
- in total 2,051 pregnancy terminations
- by the type of abortion: 751 (36.6%) abortions on request, 677 (33%) spontaneous abortions, 623 (30.4%) abortions for medical reasons

Entity Republika Srpska – data for 2017 (according to the Public Health Institute):

- 1,846 pregnancy terminations

One of the problems here is that in BiH, there is no reliable statistics or the systematic and consolidated way of gathering data on terminations of pregnancy. According to entities' laws on health care records, all public and private health care institutions that register in the sphere of health care of women and parenthood/motherhood and perform abortions have the obligation to keep records – to collect statistical data on the number of abortions. The health care institutions report that they have not received data from private clinics, even though the clinics' reporting to the institutes is a legal obligation.

There are no statistics on illegal abortion procedures in BiH.



Contraception

Contraception is relatively accessible in Bosnia and Herzegovina; 15 contraceptives are registered on the BiH market. In most cases, it does not have to be prescribed by a doctor, except emergency contraception which does have to be prescribed.

The so called "conscience objection" is not an obstacle in obtaining contraception, not that we know of. There is no substantial and relevant research on this in BiH.

Contraception in BiH is partly refunded by the state – only in entity Republika Srpska and one canton in the Federation BiH (through the essential medicines lists). In the rest of the country, people have to buy/pay for it themselves, and it is not affordable.

Emergency contraception is accessible (people have to buy/pay for it themselves), but it is not quite affordable (it costs around 23 euros a package).

The most commonly used contraception methods, according to official data, are interrupted intercourse and oral contraceptives.

Sexuality Education

There is no comprehensive sexuality education in public school system.

LGBTQI+ identities are not adequately and appropriately discussed or included in textbooks. Furthermore, textbooks usually contain stereotypical, stigmatizing representations of genders and LGBTQI+ identities in the broader scope of traditional representation of female and male gender roles.

Research was conducted by the UNFPA in BiH in 2017 entitled "Youth views on comprehensive sexuality education as a part of formal education".[1] It showed that the most current source of information on these topics is the Internet, and almost all the respondents of the online questionnaire said that sexuality education should be taught in schools. The least

There is no comprehensive sexuality education in public school system.

amount of knowledge was shown on questions about sexually transmitted diseases/infections and methods to prevent pregnancy (women scored higher in overall knowledge). Knowledge about STIs/STDs is not common. People do not get tested regularly for prevention and causes, but only in the case of an occurrence of certain troubles/problems. There is general data collected and published by the entities' institutes for public health (i.e. in 2016, the Federation BiH registered 34 persons with sexually transmitted diseases, 16 with HIV).

However, in the Canton Sarajevo (Federation BiH entity), primary school curricula include only one facultative subject for pupils from grade five to nine (aged 10–14 years old) – "Healthy Lifestyles" created by Association XY and supported by the cantonal Ministry of education, science and youth. Among other chapters/modules, it covers the topic of protection of reproductive health and gender issues – developing positive attitudes and values.

Pre- and antenatal care

In general, prenatal care in Bosnia and Herzegovina is covered by the state and is accessible to people with compulsory health insurance. Despite that, data from the state CEDAW report for the period 2013–2016 indicates that 13% of women in BiH do not receive prenatal care, nor a fifth of Roma women (21%). Main obstacles in receiving prenatal care include unequal maternity benefits' amounts in the cantons of the Federation BiH and differing regulations of maternity benefits throughout BiH administrative units. It is also worth to mention that birth courses and workshops exist within some canton/municipality health centres and hospitals. Unfortunately many healthcare facilities in the rural areas are not fully and adequatly equipped.

The concept of 'birthing rights' is implemented through various laws and procedures that regulate health care, health insurance, human rights of patients, labour relations and rights, but is not recognized as such, specific concept in any of the regulations.

LGBTQI+ Rights

By adopting the amendments to Anti-Discrimination Law in 2016, sexual orientation and gender identity have finally been accurately formulated and "sex characteristics" has been added to the list of protected characteristics, thus the Law finally explicitly regulates the protection of lesbian, gay, bisexual, trans and intersex (LGBTI) persons from discrimination.

Every third LGBTQI+ person in Bosnia and Herzegovina has experienced discrimination. However, it is worth remembering that only a small number of LGBTQI+ people disclose their sexual orientation or gender identity to a wider circle of people. This means the number of LGBTQI+ persons who have experienced some form of discrimination should be viewed in light of the reality that LGBTQI+ people generally conceal their identity out of fear from violence and discrimination.

Sarajevo Open Centre records up to ten cases of discrimination per year, on average. There is a trend of growing discrimination on the grounds of gender identity, especially in the areas of education, health care, employment, the media and in public administration. This is confirmed by the research that shows that about two-thirds of transgender persons in BiH claim they have experienced some form of discrimination. Gender expression is usually visible, making transgender and gender non-conforming persons more vulnerable than the rest of LGBI community.

There are still no court decisions on cases of discrimination on the grounds of sexual orientation, gender identity and/or sex characteristics.

Not a single administrative unit in BiH (family laws of Republika Srpska, Federation BiH and Brčko District) recognizes same-sex unions. Therefore, LGBTQI+ people are unable to claim their constitutionally guaranteed rights to freedom and security, private and family life, and home, to start a family, to enjoy the protection of property, or freedom of movement and residence, which are necessary to ensure respect and protection for same-sex unions.

In October 2018, BiH finally recognized the importance of dealing with this issue when the Government of Federation of Bosnia and Herzegovina accepted the opinion of its Ministry of Internal Affairs concerning the need for the legal regulation of same-sex partnerships due to the increased number of requests for recognizing same-sex unions from abroad in the legal system of BiH. The government will form a working group which will be drafting the Law on same-sex partnerships. Sarajevo Open Centre contacted the Ministry of Justice of Federation of Bosnia and Herzegovina in order to be included in the working group regarding the law, but the formation of the working group is still in process.

According to OSCE BiH report, around 48% of women have suffered some kind of violence starting at the age of 15 (four in ten women) from their partners or some other person.

Hate speech and hate crimes against the queer community occur frequently. In 2018, Sarajevo Open Centre documented 33 cases of hate crimes and incidents motivated by prejudice, based on SOGIESC, and 83 cases of hate speech and incitement to hatred and violence (from June 2018 to June 2019). Homophobic and transphobic domestic (9 cases in 2018) and peer violence (7 cases) have also been growing.

Gender-based violence

Victims of domestic and sexual abuse are protected by domestic and international legal instruments, by Bosnia and Herzegovina's entities criminal codes regulate sanctions for perpetrators of domestic violence/abuse. There are also laws on protection from domestic violence and family laws in force, that protect the victims. Bosnia and Herzegovina also signed and ratified the Council of Europe's Istanbul Convention.

According to criminal codes, sanctions for this crime include fines and imprisonment. There are also measures to prohibit approaching and communicating with a specific person, as well as the possibility of the court to impose a measure of compulsory psycho-social treatment and removal from a shared household, if it considers this necessary.

In BiH there are currently nine safe houses with 173 available space units. Six safe houses are located in the entity Federation BiH with 131 available space units, and three in the entity Republika Srpska with 42 available space units. They act as non-governmental organizations. According to the Federation BiH Law on protection from domestic violence, safe houses should be financed from the entity (70%) and cantonal budgets (30%). However, the provisions of the Law are rarely respected, so some safe houses get only a fifth of the amount they need to work.

Safe houses record most cases of psychological, physical, sexual and economic violence happening at the same time. Violence against teenage girls within the family or community is growing. According to OSCE BiH report,[2] around 48% of women have suffered some kind of violence starting at the age of 15 (four in ten women) from their partners or some other person. Two thirds of women consider violence against women to be common in society, and more than a quarter of the respondents consider violence to happen very often. Misogynist speech and violence in the media and public space is also quite common.

Even though some still believe in female subordination and that violence is a private matter, a small number of women thinks that the woman is guilty. Despite this, 84% of women do not report violence to the police. Recent qualitative research has shown that there is lack of trust in institutions.

More detailed data on these topics is available in Sarajevo Open Centre's Orange Report – On the state of women's rights in Bosnia and Herzegovina for the time period 2016–2019.

1 UNFPA BiH (2017). Research report "Youth views on comprehensive sexuality education as a part of formal education"

2 OSCE Bosnia and Herzegovina (2019). "Well-being and security of women – Research on violence against women in Bosnia and Herzegovina"

Bulgaria

Abortion and post-abortion care

Abortion on request has been legal in Bulgaria within the first 12 weeks of pregnancy since 1 February 1990. Between 12 and 20 weeks, abortion is only permitted for women who suffer from certain diseases that may endanger her life or that of the foetus, and after 20 weeks, abortion is only permitted if the woman's life is in danger or the foetus is severely genetically harmed. Abortion was legalized by a decree of the Ministry of Public Health on 27 April 1956, in all cases of pregnancies within the first twelve weeks on any grounds and only on therapeutic grounds thereafter. They were severely restricted by a government decree of February 1968 issued to counter declining birth rates. Most abortions required approval by a special medical board, and they were banned entirely for childless women, with only medical exceptions. Only women over 45 or with three or more children could obtain an abortion on request, except if the pregnancy was past 10 weeks or the woman had obtained an abortion within the previous six months. The restrictions were extended in April 1973 to cover women with no children or only one child; abortions could only be obtained in case of rape or incest, for unmarried childless women under 18, for women over 45 with one living child, or in cases of disease endangering the woman's life or the viability of the foetus. The restrictions were slightly relaxed in 1974, but most remained until the fore mentioned decree of 1 February 1990.[1]

Decree No. 2 of 1 February 1990 on the conditions and procedures for the artificial termination of pregnancy, as amended in 2000 (Gazette No. 12 of 9 February 1990, as amended and supplemented in Gazette No. 89 of 31 October 2000) governs the terms and conditions for the artificial termination of pregnancy, hereinafter in the Decree called "Abortion".[2]

Among 15-year-olds in the country, 40 percent of boys and 20 percent of girls said they had already had sex — but only 56 percent of those girls, and 66 percent of boys reported using a condom during their latest sexual contact.

Abortion is free of charge for women who are under 16 or over 35 years old, or registered as a disadvantaged position. Abortion is also free of charge if performed due to medical reasons or in the case of rape. In all other cases, women have to pay around 80–180€.[3]

Within the first three months of 2019 alone, 5,800 abortions were performed in Bulgaria, making the country among the leading countries in Europe in terms of the number of abortions. This is a statistic of the National Center for Public Health and Analyses (NCPHA). Of these, over 3,600 pregnancies were ended as a result of the patients' own free will.

Statistics from the National Center for Public Health and Analysis account only for surgical abortions, spontaneous abortions, and those carried out due to medical reasons, but there are no official statistics in the country about how many abortions are performed illegally. According to online sources, the number of illegal abortions in private clinics, as well as medical abortions (commonly called "the abortion pill") may be higher than in official statistics.

Contraception

Contraceptives are not included in the health insurance package. In Bulgaria, there are no legal limitations in accessing contraception, including lack of need for parental consent when obtaining contraception as a minor. A 2017 UNICEF report on Bulgarian women and children not only found that sexual initiation often occurs early, but also that teens are reluctant when it comes to using condoms. Among 15-year-olds in the country, 40 percent of boys and 20 percent of girls said they had already had sex — but only 56 percent of those girls, and 66 percent of boys reported using a condom during their latest sexual contact. Alarmingly, a 2018 study by Loveguide.bg — a Bulgarian sex ed site — found that only 42 percent of students could give a correct answer about the function of a condom.[4] All types of contraception are available in pharmacies with a prescription (officially), but in reality they can be purchased without one in the majority of points of sale. In Bulgaria, emergency contraception is generally available over-the-counter at pharmacies, though a pharmacist may first ask for a prescription. Furthermore, for some EC brands, you can directly view and obtain the pills at pharmacies (i.e. they can be found on pharmacy shelves) without requesting the pills from pharmacists.[5]

Only 10% of schools teach sexual education, according to a speech by the Bulgarian Ombudsman, Maya Manolova.

Sexuality Education

Sexuality education is not mandatory in Bulgaria; therefore, no a minimum standard for the curriculum are intact. Students and parents are able to request an optional discipline of sexuality education in which the school system relies heavily on non-governmental organizations in relaying the information in the following topical areas: reproductive systems, HIV and AIDS, contraception, and violence. In Bulgaria, sex education is not part of the compulsory curriculum in schools.

This means that it is up to every school in the country to decide whether they even want to address sexual education at all. In fact, only 10% of schools teach sexual education, according to a speech by the Bulgarian Ombudsman, Maya Manolova. With the highest teenage pregnancy rate in the European Union along with Romania, Bulgarian girls are disproportionately affected by the country's dangerous absence of sexual education. There is no official data available regarding the level of factual knowledge regarding sexuality among young people. Two activists have taken matters into their own hands by crowdfunding Bulgaria's first ever illustrated sexual health book for girls, Vagina Matters: A Sex Ed Book For Girls, which covers menstruation, sex, and the female anatomy. The guide will be distributed for free both online and offline throughout the country, providing a lifeline for young girls in Bulgaria. The book is the brainchild of human rights activists Svetla Baeva and Raya Raeva. Raeva is the campaigns director at the Bulgarian Helsinki Committee, a prominent human rights organisation in Bulgaria.[6]

Pre- and antenatal care

When discussing violence against women committed by healthcare professionals, there is no specific definition of violence and there is no data on violence and the abuse of women in hospitals in Bulgaria. Monitored types of violence are: negligence; verbal abuse (including cruel treatment, shouting and deliberate humiliation); physical violence (including refusal to relieve pain in the presence of medical indicators); and sexual abuse. These categories resemble the forms of violence observed in personal relationships, i.e. emotional, physical and sexual abuse.

An example of a good practice in the field of women's healthcare in Bulgaria is the Maternal Health Programme that secures free access for each woman to systematic healthcare activities from the beginning of the pregnancy until 42 days after giving birth. This programme encompasses early registration and systematic medical monitoring of the whole pregnancy by primary and specialised healthcare units and professionals. Pre-natal diagnostics, genetic disease prevention, regular pregnancy monitoring exams and consultations are carried out according to the schedule for the term of pregnancy, depending on pregnancy risk estimation and the presence of specific complications. Home visits by the GP or the specialist are also provided whenever needed. All programme activities are delivered to the women free of charge and are covered within the health insurance package. The concrete activities are regulated in the Ordinances of the Ministry of Health (the Ordinance on Prevention Exams, Dispanserisation), and the Ordinance on Determining the Main Package of Healthcare Activities Guaranteed by the NHIF). Usually healthcare is delivered by a GP or a specialist obstetrician, as requested by the pregnant person. Increased risk pregnancies are monitored by an obstetrician. There are still some problems with access to specialised outpatient obstetric services in remote rural areas. Deliveries in Bulgaria are carried out in specialised obstetric in-patient units with the assistance of an obstetrician, with a freedom to choose a preferred institution. Inpatient healthcare for delivery is covered by the insurance package.[7] Birthing schools exist, so do different courses for future parents, but most of them are paid. Anaesthesia is easy to receive if needed.

There are no legal requirements for expectant parent to inform their employer of their pregnancy before filing their documents for maternity leave. However, it is advisable to inform the employer in advance. Employment protection is guaranteed by the state to pregnant women and women with children aged up to three years.

Maternity leave in Bulgaria lasts for 410 days, 45 of which are to be taken before birth. With the mother's consent, when the child reaches six months, the leave can be transferred to the father for the rest of the period. During these 410 days, social security beneficiaries who have worked at least 12 months prior to taking the maternity leave are paid an allowance of 90 percent of their gross salary by the National Health Insurance Fund. At the end of the maternity leave, mothers are entitled to parental leave to raise their child until the child reaches the age of two. This leave can be transferred to the father or to one of the grandparents who work under an employment contract and have social insurance. The amount of allowance payable during this leave is equal to the minimum monthly wage. Fathers are entitled to 15 days paid paternity leave following the birth of the baby.

LGBTQI+ Rights

Bulgaria does not recognize any type of same-sex unions. The subjects of same-sex marriage, same-sex registered partnerships, adopting children by same-sex couples have been discussed frequently over the past few years.

The Constitution of Bulgaria defines marriage as a union between a man and a woman, effectively prohibiting the legalization of same-sex marriage.

The Constitution of Bulgaria defines marriage as a union between a man and a woman, effectively prohibiting the legalization of same-sex marriage. Only civil marriages are recognised by law in Bulgaria.

Since 1 January 2004, the Protection Against Discrimination Act of 2003 has prohibited discrimination and hate speech on the basis of sexual orientation in all areas (employment, the provision of goods and services, education, military service, health services, etc.). Under the law, sexual orientation is defined as "heterosexual, homosexual or bisexual orientation".

In 2015, the National Assembly amended the definition of "sex" in the law to include cases of legal gender recognition. Transgender people who have not undergone a legal recognition can now use "gender" from the list of protected grounds. Gender expression and gender identity are not explicitly mentioned in the revised Act.

Hate crimes against LGBQTI+ people are not uncommon in Bulgaria, and are often ignored and go uninvestigated by the authorities. As of 2019, Bulgaria's Penal Code still does not protect LGBQTI+ people from hate crimes

The 2015 Eurobarometer found that 17% of Bulgarians supported same-sex marriage. This was the lowest support among all of the EU's member states, and only a 2% change from the 2006 Eurobarometer, where 15% of Bulgarians expressed support for same-sex marriage. The 2019 Eurobarometer found that 16% of Bulgarians thought same-sex marriage should be allowed throughout Europe, 74% were against.[8]

Gender-based violence

In Bulgaria there is no definition of gender based violence in domestic jurisdiction. Bulgaria has criminalized domestic violence (February, 2019), sexual violence and bodily injuries.

Relevant law on domestic violence is the 2005 Law of Protection from Domestic Violence (the 2005 LPDV). The 2005 LPDV has defined the rights of victims, protective measures and enforcement procedures in situations of domestic violence. The purpose of the enforcement procedure is to provide the victims of domestic violence, including children who are in need of protection, with appropriate measures and legal alternatives, as well as to account for the liability of the violating offenders. Domestic violence, according to national law, refers to any act of physical, sexual, psychological, emotional or economic violence. It also covers any experience of such violence, forced restriction of privacy, personal freedom and personal rights committed against either family members or the partner in a relationship or in a de facto cohabitation. The definitions of "violence" against a child have been stipulated in the Regulation for implementing the Law on Child Protection as 'any form of domestic violence committed in the presence of a child is considered to be mental and emotional abuse', where "violence" in this context can be any types of physical behaviour, psychological or sexual violence, neglect, commercial or other exploitation, which has resulted in an actually or potentially harmful influence to children's health, life, development or dignity as a consequence.

The Bulgarian Constitutional Court voted on 27 July 2018 and declared the Istanbul Convention unconstitutional. The Convention is the first instrument in Europe to create a comprehensive framework for the protection of women and girls from all forms of violence. Eight of the judges in the Constitutional Court voted against the ratification of the Istanbul Convention, and four voted in favour. The majority of the judges took the view that the 2011 convention blurs the differences between the two sexes, which according to them would only make it more difficult to fight against domestic violence.

In Bulgaria, the topic of single parenthood is not discussed, although the number of single parents is growing exponentially. About 14.7% of the total percentage of Bulgarian households (more than 400,000) are run by single parents, as shown in the latest Eurostat analysis of single-parent families in the EU (the criterion for being a single parent, according to Eurostat, is formed by women abandoned by their spouse after divorce, mothers raising their child without having a marriage or widowed women). The highest number of single parents in Bulgaria live in the capital Sofia – 18.5%, i.e. or more than 80,000. Every woman in Bulgaria who has to work leaves her child all day in kindergarten or for weeks with a grandmother, as most families in Bulgaria rely on the help of relatives. Single parents struggle with several major problems: lack of time for the child, lack of work, child care assistance – for example during summer vacation – three months in the summer and countless days during the rest of the year. Being a single mother in Bulgaria is socially acceptable, but it is very difficult.

There is no data about women who are forced to stay in abusive marriages.

1 https://en.wikipedia.org/wiki/Abortion_in_Bulgaria

2 https://reproductiverights.org/world-abortion-laws/bulgarias-abortion-provisions

3 https://abort-report.eu/bulgaria/

4 https://mashable.com/article/sex-education-bulgaria-book/?europe=true

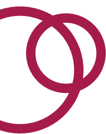
5 https://gynopedia.org/Sofia#Contraception_.28Birth_Control.29

6 https://mashable.com/article/sex-education-bulgaria-book/?europe=true

7 https://eurohealth.ie/wp-content/uploads/2012/08/eu-reports/bulgaria.pdf

8 https://en.wikipedia.org/wiki/Recognition_of_same-sex_unions_in_Bulgaria

Croatia



Abortion and post-abortion care

Abortion in Croatia is regulated by the Act on Health Care Measures for Exercising the Right to a Free Decision on Giving Birth. Article 15(2) specifies that a pregnancy can be legally terminated at the woman's request up to the 10th week of pregnancy. After that a commission may approve access to abortion if the pregnancy is a result of a crime, there is a risk to the health or life of the pregnant woman, or if there is a serious foetal impairment.[1]

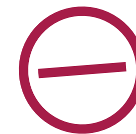
According to the report of the Croatian Institute of Public Health, in 2018 there were 2,558 of registered cases of legally induced abortions, which means 7 legally induced abortions per 100 births.[2] There are no statistics regarding illegal procedures in Croatia.

In recent years, the discussions on abortion law intensified in anticipation of a Croatian Constitutional Court decision on the constitutionality of the act. In March 2017, he Court decided that the law is in line with the Constitution, but also requested the Croatian Parliament to adopt new legislation within two years.[3] The Government and the Croatian Parliament ignored the decision and deadline set by the Court. A draft law on abortion entitled the Act on prevention and termination of pregnancy was prepared by an expert group. After consulting with stakeholders, the Act was presented to the public the beginning of 2018.

A study conducted by Ombudsperson in 2018 shows that around 60% of gynaecologists refuse to provide abortion care.

Despite the legality of abortion, women in Croatia continue to face difficulties and barriers in accessing legal abortion care. These include widespread refusals of abortion care, financial barriers, the lack of accessible evidence-based information about abortion, social stigma related to abortion and biased service provision by some medical professionals towards women requesting abortion care. As a result, some women travel outside Croatia to other countries to obtain a legal abortion.[4] The situation has particularly detrimental effects on women from economically deprived rural areas, women with low incomes, and other marginalized groups of women for whom the cost of travel to a facility providing abortion services may be prohibitive.[5] A study[6] conducted by Ombudsperson in 2018 shows that around 60% of gynaecologists refuse to provide abortion care. Five out of 28 public hospitals in Croatia refuse to provide legal abortion services for reasons of institutional policy. Abortion services are also unaffordable for many women since abortion on request is not covered by the Health Insurance Fund. In the last 4 years, the average price in public hospitals has increased by 20%.

Just as in some other countries of the region, Croatian discourse around abortion has become controversial and political in nature. The public is divided into pro- and anti-abortion stances – a result of growing impact of conservative and Church-related initiatives on possible stakeholders.



Contraception

The estimated use of modern contraceptive methods by women of fertile age is understood to be low, but official data is available, which hinders the design of appropriate and effective policy responses. The problem with data on the use of contraceptives lies in the fact that the competent institutions do not carefully keep records of utilization and do not analyse the utilization of contraceptives. According to the reports[7] by the women's primary health care practices in 2018, 90,140 visits for the family planning and/or prescribing birth control were recorded (9,8% of women at their fertile age). According to Croatian Health Statistic Yearbook 2018,[8] the most common contraceptives prescribed were oral contraceptives. Condom use is the most frequently reported form of contraception among young people, but they seldom switch to other forms of contraceptives when having been coitally active for some time. In the last few years, the percentage of young people who reported using a condom is decreasing. The hormonal contraception remains rather unpopular among young Croatian women. The reasons could be lack of information about hormonal contraception, but also negative or restrictive attitudes of gynaecologists toward the use of hormonal contraception, particularly among young women.

The relatively limited use of modern contraceptives in Croatia results from a range of barriers faced by women including widespread lack of knowledge and misperceptions about modern contraceptive methods; the lack of subsidization, which regularly makes them unaffordable, in particular for adolescent girls, young women and women from socially disadvantaged groups; and the limited availability of different types of hormonal contraceptives. Birth control pills are available with a prescription from a gynaecologist. The Government does not provide any special reimbursement for young people and vulnerable groups.

Emergency contraception is available in Croatia and LNG EC and UPA EC are distributed by local pharmacies, but emergency contraception is not covered by the state

The relatively limited use of modern contraceptives in Croatia results from a range of barriers faced by women including widespread lack of knowledge and misperceptions about modern contraceptive methods.

health insurance. In Croatia, as of the end of 2015, one of EC pills can be purchased without a prescription in pharmacies.[9]

According to 2019 Contraception Atlas,[10] Croatia needs to do more to improve government policy on access to contraceptive methods, family planning counselling and the provision of online information on contraception. An official government website with information about contraceptives does not exist, and the quality of online information provided by the government is insufficient.

Instructions for pharmacists regarding conscience-based refusal state that "every pharmacist, who considers that his/her moral or religious beliefs is preventing him/her to conduct particular pharmacy service, has to bring forth and explain the issue to the responsible persons or relevant bodies in the pharmacy and to refer patients to other service providers" and emphasized that "the patients are the first concern".[11] The incidence of pharmacists' invoking conscientious objection in the context of issuing contraceptives on prescription is worrying, as it compromises the availability of contraception, and therefore threatens women's right to reproductive health, especially on the islands, where contraceptives are frequently inaccessible.[12]

Sexuality Education

Croatia has an official curriculum for "health education", but its content and method of implementation are highly questionable.

The subject is not obligatory, but is cross-curricular, which means that many schools do not monitor if it is properly implemented, neither does the Ministry of Education or Education and Teacher Training Agency. Teachers – usually without proper preparation, additional education and support – are usually the ones to decide on what is taught during the classes, although some topics are covered by health workers who visit schools.

Secondly, topics covered in the curriculum introduced at the beginning of 2019 have an inadequate and outdated approach to sexuality. Unlike the old curriculum (2012), the new one does not cover topics like gender stereotypes, gender equality, sexual and gender minorities and promotion of positive attitudes towards sexuality amongst young people.[13]

Additionally, there is no assessment system for monitoring the youth's knowledge of sexuality. Only non-governmental scientific research papers by experts from the Croatian Institute for Public Health, and small scale research conducted by NGOs attempt to collect such data.[14] Results of their research show that young people lack knowledge on sexuality and have insufficient access to information.

Most of the good practices in Croatian sexuality education come from non-formal education conducted by NGOs. The Centre for Education, Consulting and Research – CESI, located in Zagreb, has a web page for young people which summarizes important information regarding sexuality and gender equality, and publishes research, publications and manuals for youth workers. The Croatian Association for HIV and viral hepatitis has made an application named "Sexual health" which is adjusted to participant's age and provides information about sexual health. The Lesbian organization Rijeka – "LORI" from Rijeka conducts non-formal education for secondary school students in the field of sexuality focusing on LGBTQI+ topics. The Association for Human Rights and Active Citizenship PaRiter has made a web page for young people about contraception and sexuality, and holds workshops and non-formal education on CSE.

Several organisations and activists advocate for sexuality education in schools, proving that it is necessary to teach youth about sexually responsible behaviours, STIs/STDs and unwanted pregnancy prevention. However, conservative movements are blocking such initiatives by treating sexuality education as problematic and attempting to prove that it promotes promiscuity. Some radical groups oppose teaching young people any topics related to sexual education altogether. As a result, the relevant ministries and the government are continually postponing the implementation of comprehensive sexuality education in schools by making compromises with conservative and radical right-wing initiatives in the society.

Pre- and antenatal care

The maternity and parental support system are regulated by the Maternity and Parental Aid Act,[15] and by means of Article 3 of that Act its implementation was placed under the jurisdiction of the Croatian Health Insurance Institute, while the supervision of the implementation is the responsibility of the Ministry for Demography, Family, Youth and Social Policy.

All costs relating to prenatal, intrapartum and postnatal care are covered entirely by state insurance. However, according to the RODA (Parents in Action),[16] there are problems with the quality and access to these services, for which reason many women use private healthcare during pregnancy. RODA emphasizes a huge problem regarding women being coerced into giving cash payments to gynaecologists providing antenatal care already covered by healthcare insurance system. In smaller towns, patients do not refuse to make illegal payments, because there is only one gynaecologist in the area. Midwives do not provide antenatal or postpartum care and do not have their own practices.[17]

RODA emphasizes a huge problem regarding women being coerced into giving cash payments to gynaecologists providing antenatal care already covered by healthcare insurance system.

The only private maternity hospital has a 74% caesarean section rate.

Access to gynaecological medical services in rural and isolated regions in Croatia is a problem. Gynaecological services are less accessible for women living on the islands and in the mountains. Croatia has no mobile gynaecological teams, nor a substantial number of health professionals.

In some areas of Croatia, there are not enough gynaecologists, so women are referred to seek help in another city, which makes healthcare less accessible. Therefore, some gynaecologists have too many patients, which is why the quality of health care provided is poor.

Antenatal classes exist in large cities, but not in rural areas or on the islands. Most are organised by nurses or midwives in health centres, and are not equally distributed geographically or over the year. As RODA reported, the quality of information provided in these courses is questionable and varies considerably, and there is no specific training provided for persons holding them. In general, a small portion of pregnant women prepare themselves through antenatal classes for birth – estimates vary, but the number is between 15–25%.

Although the problem of inhuman treatment in providing medical services in the field of sexual and reproductive health has been present for years in Croatia, in 2018 it was

publicly addressed after a female MP started to talk about it in parliament. As many as 32% of women undergo gynaecological procedures without anaesthesia, including D and C, stitching after vaginal birth, tissue biopsies, etc.

Croatia provides a new partner with a paid parental leave. Women get six weeks leave before their due date and have six weeks mandatory leave afterwards. Most women take one year of leave after giving birth, which is paid for by the state. Fathers have paid leave as well, but not many fathers take advantage of their leave (7.55% in 2018).

According to RODA, birthing rights exist as an idea, but in practice, patients' rights are used as opposed to maternity-human rights. However, neither of these are widespread implemented. Healthcare providers lack knowledge of human rights, and therefore, birthing rights as well. Their training does not include any rights-based information, which is why they violate the human rights of birthing women.

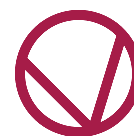
LGBTQI+ Rights

The LGBTQI+ community is legally protected against discrimination and violence by the Constitution, Gender Equality Law, Anti-discrimination Law, Criminal Code and other specific laws on media, volunteering, etc. However, the implementation of anti-discrimination provisions and the efficiency of court procedures has its challenges. Also, some laws directly or indirectly discriminate against the LGBTQI+ community, like the Family Act, the Act on the Protection of Patients' Rights, the Pension Insurance Act and National Demographic Policy. Also, the Constitution has banned same-sex marriage since the 2013 referendum for the legal definition of marriage as a union between man and woman.

As for same-sex unions in Croatia, they have been recognized as life partnerships since the introduction of the Life Partnership Act in 2014. However, the rights of same-sex life partners and heterosexual married couples are not equal, especially when it comes to adoption, which is still not legal for same-sex couples. So far, several special regulations and laws have been passed that are not in accordance with the Life Partnership Act or other regulations that prescribe equal treatment of same-sex couples. Such examples include the Real Estate Tax Act, Law on the Rights of the Croatian Homeland War Veterans, Law on Local Taxes, the regulations regarding medical treatment for insemination (intrauterine insemination) and adoption, and lastly, the Foster Care Act. Same-sex partners in Croatia that have tried to become foster care providers or that have tried to become prospective adoptees (as regulated by the current Family Law) have been turned down by the Ministry of Family. To make matters even more absurd, under the current legal framework, a single person can become both a foster care provider and adopt a child, but same-sex partners in life partnerships are discriminated and excluded on the base of their sexual orientation as one's life partnership/civil union status is available to public servants. Unfortunately, the Croatian Government clearly ignores children's rights and continues the discrimination of officially registered same-sex couples, making them second-class citizens.

Also, Croatia has a serious problem with fully accepting the members of the LGBTQI+ community and the rates of homophobia, biphobia, transphobia, etc., are pretty high. According to Eurobarometer on Discrimination in 2019, 51% of the respondents from Croatia disagree with the statement that gay, lesbian and bisexual people should have the same rights as heterosexual people, 58% disagree with the statement that there is nothing wrong in a sexual relationship between two persons of the same sex, and 55% do not think same-sex marriages should be allowed throughout Europe.[18]

In accordance with this data, discriminative and violent practices are present in the society towards LGBTQI+ community, which is especially visible and recognisable in the period around Gay Pride. This is when most homophobic, transphobic and biphobic attitudes and behaviours emerge, either on the Internet or in real life. Such comments and "critiques" range from "I'm not against it, but they should do it inside their four walls", over "It's not natural and I'm against it" to open call for violence against LGBTQI+ community. Physical violence is also not so uncommon, but it is much less frequent than those subtle discriminatory practices, like denying LGBTQI+ individuals employment, a right to express themselves openly and to publicly show affection towards one another, like heterosexual partners do. Also, they are most often victims of hate speech, alongside women, activists and foreigners.



Gender-based violence

Although Croatia ratified and put into force the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence in 2018, the problem of GBV remains. Obligations under the Convention concern strengthening the legal framework for protection of victims and implementation of laws. Therefore, Croatia already anticipated provisions of the Convention to bring it into line with its regulations by adopting the Act on Protection Against Domestic Violence, the Amendments to the Gender Equality Act, the Amendments to the Criminal Procedure Act and the Amendments to the Criminal Code, which take into account international recommendations and EU directives ensuring stronger protection of victims of violence.

The legal framework[19] could be improved, but the biggest problem is the inconsistent application of the law in practice, the individual approach of professionals who work with the abused.

Croatia's Criminal Code defines domestic violence as a criminal offence and prescribes a penalty of up to three years' imprisonment for the perpetrators.[20] Victims are not always guaranteed physical distance from the perpetrators when giving statements to the police; the problematic practices of the double arrests and penalizing both victim and the perpetrator, soft penalties for perpetrators, and domestic violence that falls under category of misdemeanours persist.[21]

Over last six years, more than 100 women have been killed in Croatia by their husbands, ex-husbands, partners, ex-partners or another man in their families.[22] One in three Croatian women would experience economic violence in intimate relationship. Research shows that 58% of young people between the ages of 16 and 26 have experienced violence in intimate relationships, more than two-thirds of that for a long time. Statistics indicate that for every reported rape case, there are 15 to 20 unreported rapes. In more than 90% of rape cases reported and convicted, the convicted person is sentenced to a minimum one-year prison sentence. There is only one centre for victims of sexual violence in Croatia.

Only 19 shelters for women victims of violence and their children exist, operated by CSOs, religious communities and other legal persons. According to the Council of Europe estimations, the capacities of existing shelters are not nearly adequate to the regulations of the Istanbul Convention.

1 Act on Health Care Measures for Exercising the Right to a Free Decision on Giving Birth, Act No. 1252-1978 of 21 April 1978

2 Pobačaji u zdravstvenim ustanovama u Hrvatskoj 2018. Godine, Croatian Institute of Public Health, 2019 Available at: https://www.hzjz.hr/wp-content/uploads/2019/07/Bilten_POBACAJI_2018.pdf

3 Rješenje Ustavnog suda Republike Hrvatske broj U-I-60/1991 i dr. od 21. veljače 2017. i Izdvojeno mišljenje, NN 25/2017

4 Sve više Hrvatica ide u Sloveniju na poba,čaj: 'Do 12. tjedna ne pitamo zašto su to odlučile napraviti'. RTL, 17.04.2019, Available at: https://www.rtl.hr/vijesti-hr/novosti/hrvatska/3434743/sve-vise-hrvatica-ide-u-sloveniju-na-pobacaj-do-12-tjedna-ih-niti-ne-pitamo-zasto-su-to-odlucile-napraviti/

5 Interactive map – access to abortion services in Croatia Available at: http://dev.codeforcroatia.org/reproduktivna-prava/?fbclid=IwAR2dgT4Kvn62FK50NqEBmvTBNti3IsqSDqowOGdVf03DibTeluL9wWGQALU

6 Izvješće o radu Pravobraniteljice za ravnopravnost spolova za 2018. Godinu Available at: https://www.prs.hr/attachments/article/2645/Izvje%C5%A1%C4%87e%20o%20radu%20Pravobraniteljice%20za%20ravnopravnost%20spolova%20za%202018.%20godinu_~.pdf

7 Hrvatski zdravstveno-statistički ljetopis 2018, Croatian Institute of Public Health, 2019 Available at: https://www.hzjz.hr/hrvatski-zdravstveno-statisticki-ljetopis/hrvatski-zdravstveno-statisticki-ljetopis-za-2018/

8 Croatian Health Statistics Yearbook 2018, Croatian Institute of Public Health, 2019 Available at: https://www.hzjz.hr/hrvatski-zdravstveno-statisticki-ljetopis/hrvatski-zdravstveno-statisticki-ljetopis-za-2018/

9 Croatia, The European Consortium for Emergency Contraception Available at: https://www.ec-ec.org/emergency-contraception-in-europe/country-by-country-information-2/croatia/

10 2019 Contraception Atlas, European Parliamentary Forum for Sexual & Reproductive Rights . 2019. Available at: https://www.contraceptioninfo.eu/node/72

11 Instruction for conducting pharmacy services that may have an impact on moral and religious beliefs, Croatian Chamber of Pharmacists, 2015

12 Ljekarnica koja se pozvala na priziv savjesti izvukla se i bez opomene, Available at: https://faktograf.hr/2018/11/27/ljekarnica-koja-se-pozvala-ne-priziv-savjesti-izvukla-se-bez-opomene/

13 The Centre for education, consulting and research – CESI published an analysis of two modules of the previous curriculum "Health education" which covered some CSE related topics. With this analysis, they have suggested necessary modifications in order to process CSE topics properly. Instead, the Ministry of Education completely left them out of the new curriculum since topics like homosexuality and gender-based violence are perceived as too controversial. The analysis is available on the following link: https://www.cesi.hr/attach/_a/analiza_prirucnika_zo~2.pdf.

14 Such findings were presented in a research done by the Association for Human Rights and Active Citizenship PaRiter. More about the results: http://www.znajznanje.org/wp-content/uploads/2017/01/Seksualnost-i-mladi-u-Primorsko-goranskoj-%C5%BEupaniji-EN-2.pdf. See also: Attitudes towards Comprehensive School-based Sex Education in Croatian Schools: Results from a National Study of Youth (Modrić, Šoh, Štulhofer, 2011.); https://www.hzjz.hr/wp-content/uploads/2016/03/HBSC2014.pdf (Croatian Institute for Public Health, 2016); https://huhiv.hr/spolno-zdravlje-sto-mladi-u-hrvatskoj-znaju-a-sto-ne-znaju/ (Croatian Association for HIV and viral hepatitis)

15 Official Gazette 85/08, 110/08, 34/11, 54/13, 152/14 and 59/

16 Prenatal Care in Croatia, RODA, find more on http://rodilista.roda.hr/english/prenatal-care-in-croatia.html

17 Choosing a Prenatal Care Provider, RODA http://rodilista.roda.hr/english/choosing-a-prenatal-care-provider.html

18 More about these findings on: https://www.ilga-europe.org/resources/news/latest-news/eurobarometer-report-lgbti-acceptance-not-full-picture

19 The legislative framework regarding GBV in Croatia: Act on Protection Against Domestic Violence, Gender Equality Act, Criminal Procedure Act, Criminal Code, Misdemeanour Law, Family Law, Anti-discrimination Act, National Strategy for Protection against Domestic Violence for the period 2017–2022, National Anti-Discrimination Plan for the period 2017-2022, Protocol on the Procedure in Cases of Domestic Violence, Protocol on Procedures to be Followed in Cases of Sexual Violence, Law on Financial Compensation for Victims of Crimes.

20 Ministry for Demography, Family, Youth and Social Policy of the Republic of Croatia, Šta trebate znati o Konvenciji Vijeća Europe o sprečavanju i borbi protiv nasilja nad ženama i nasilja u obitelji. Criminal Code of Republic of Croatia (Official Gazette 125/11, 144/12, 56/15, 61/15, 101/17), Article 179a

21 Human Rights in Croatia: Overview of 2018, available at://www.kucaljudskihprava.hr/wp-content/uploads/2019/03/Ljudska-prava-u-Hrvatskoj-2018.pdf

22 According to the Ministry of the Interior, as interpreted by the Gender Equality Ombudsman, in 2019 out of 27 murders, 11 women were murdered (of those 11, 7 were killed by their partner or ex-partner). In 2018, six women were killed by their partners, in 2017, 18 women, and in 2016, 20 women. In most cases, the motivation for committing a femicide was the decision of a woman to leave her partner.

Georgia

Abortion and post-abortion care

Although there are significant steps to improve access to abortion and post-abortion care in Georgia, the issue remains challenging. The rate of abortions declined over last 25 years, and compared with the previous year, the rate declined by 9%.[1] It is also notable that share of medical abortion has been increasing over past years, and shows highest rate in 2018 (38.9%), while it was 36.8% in 2017. In 2014, five-day waiting period requirement was imposed before obtaining an abortion on request. Under an order of Minister of Health, time can be reduced to 3 days, if woman applies for abortion in 12th week of pregnancy. According to WHO recommendation on safe abortion such "mandatory waiting periods" do not fulfill a medical purpose, undermine women's decision-making autonomy, delay access to timely, legal abortion care[2]. They also increase financial and practical costs of abortion services. This can have a disparate impact on some groups of women, including those from rural areas, living in poverty, or at risk of domestic violence[3].

SRHR services, including safe abortion, should be affordable and accessible to all women and girls, especially those living in rural areas. There is no relevant strategy on Primary Health Care to respond to SRHR issues, village doctor institution is weak, people face geographic and financial barriers to access SRHR services. Abortion services are not available in rural areas, women have to travel long distances, which requires additional transportation costs and time.[4] Only 17% from 655 medical facilities provide abortion services and only 5% of primary health care facilities provide abortion and family planning services.[5] The financial, psychological problems and unfavorable social situation often serves as reasons for women to make decisions regarding termination of pregnancy or performing life-threatening actions, which results in violation of a number of reproductive rights. Widespread Conscientious objection of service providers contravenes international human rights obligations of the state to ensure that conscientious objection is regulated so that it does not hinder women's access to lawful services.[6]

Only 17% from 655 medical facilities provide abortion services and only 5% of primary health care facilities provide abortion and family planning services.

There are discriminatory age restrictions imposed by some clinics concerning persons under 16, 16–18-year-old. The report also showed that when patients think their rights are violated during the provision of abortion services or post-abortion care, they generally tend not to apply any legal remedies.[7]

Post-abortion services is provided incompletely, e.g. patient either does not receive any kind of post-abortion care or receives superficial information (consulting) on further family planning options. Despite psychological support is mentioned in National protocol, such support is the weakest spot of post-abortion services provided to women. There is a gap in availability of informational materials on abortion.[8]

Contraception

Although more women in Georgia are now using effective, evidence-based methods of contraception than before, women still face a range of serious challenges in accessing quality and affordable contraceptive services, their unmet need for contraception is a significant concern. Maternal and Newborn Health Strategy for 2017–2030 and action plan for 2017–2019 includes activities regarding integration of provision of contraceptives in State Universal Healthcare Insurance, but no action has been taken in this regard.

Women with low level of knowledge on contraceptives and with lack of access to contraception, use abortion as primary method of family planning. In Georgia, there is no access to free contraceptives since 2015, as contraceptives are not included in the National Health Program essential medicine's list which creates obstacles for preventing unwanted pregnancies as well as Sexually Transmitted Infections (STI).[9]

Financial burden of preventing unplanned pregnancy is placed entirely on women, illustrating continuing failures to recognize access to modern contraception as a human rights issue and a health care imperative. Many groups of women cannot afford to cover the cost of modern contraception themselves: youth, IDPs, persons with disabilities, inhabitants of rural areas... Based on the Public Defender's report[10], young girls are the most restricted to have access to reproductive health services and respective information. Stigma regarding sexuality of women and young girls, neglecting law (according to the law girls from 14 to 18 can get service without parents' consent[11]), and financial dependence of teenage girls on their parents are significant barriers. [12] The problems are more visible in regions where girls try to avoid get any reproductive health service or buy contraceptive in villages due to the strong social-cultural stereotypes.

Women with disabilities (WWD's) face barriers to get adequate SRH services and information. WWD's with specific needs from early stage of life, are having less possibilities to get adequate information on family planning compared with women getting disability problems at later stage of life, as they are considered "persons without sex". Health facilities are not adapted for persons with disabilities (ie: healthcare facilities do not have interpreters for women with hearing disabilities, women are obliged to invite family member for translation, which excludes confidentiality of the service and information.)

Ethnic minorities, mainly Azeri and Armenian women with language barriers have restricted rights to make decision including on using contraceptives. Women visit RH service facilities with family members (husband, mother in law) which makes additional barrier to receive confidential information and services.

Misconceptions and myths about contraceptives are widespread. The state lacks nationwide public awareness activities on contraceptives and prevention. The general public lacks of knowledge on emergency contraception. There is a scarcity of healthcare centers and ambulatories in rural area where women can get consultancy on modern contraceptives.

Sexuality Education

Georgia has taken an obligation to implement international human rights standards in the aspect of sexuality education. Concluding observations of combined fourth and fifth periodic reports of Georgia to CEDAW emphasize "absence of age-appropriate sexual and reproductive health and rights education." Committee on the Rights of Child highlights the need of age-appropriate sexuality education in Georgia. UN Special Rapporteur under the CESCR General Comment stands to "ensure that teachers are effectively trained to provide sexuality education and that youth are involved in the development of such education programs." EU-Georgia Association Agreement emphasizes developing cooperation between parties in the field of public health, promoting healthy lifestyle. However, there is no specific law on sexuality education in Georgia.

In 2017, parliament of Georgia adopted a resolution, based on the Public Defender's Office parliamentary report,[13] recommending revisions to some aspects of the existing limited information provided in schools, this could not be seen as an introduction of the comprehensive life skills/sexuality education in schools.

Concluding observations of combined fourth and fifth periodic reports of Georgia to CEDAW emphasize "absence of age-appropriate sexual and reproductive health and rights education."

With absence of barriers in legislation for integrating sexuality education, legislative environment can be characterized as positive to implement CSE at formal education system. Respectively policy initiatives resulted in formulation of policy documents –Georgian National Youth Policy for 2015–2020[14] and Government's Human Rights Action plan for 2018–2020 years[15]. The first one was followed by approval of the Action Plan for development of State's Youth Policy 2015–2020, but there was no financial allocation for implementation of action plan. In case of the Human Rights Action Plan, objective: Integration of age specific information on sexual and reproductive health and rights, gender equality aspects in school subjects based on the UNESCO and WHO standards is not implemented yet. Policies does not guarantee provision of CSE in formal and informal education systems in Georgia. There is no political will from government side to integrate it in formal education system. Attempts were to integrate the sexuality education as a part of healthy lifestyle in biology and civic education subjects, but only partially, covering early marriage and pregnancy, STD's, sex-related physiological issues. Gender-related aspects have been integrated into the subject "me and society" from 2018–2019 academic year.

The main "deliverers" of sexuality education are non-governmental organizations that try to utilize several pathways to influence the provision of CSE in Georgia. Thus, non-formal sexuality education is almost only option nowadays to distribute proper, age-specific and comprehensive sexuality education in Georgia.

Despite widespread misconception, attitudes of parents and teachers on sexuality education are generally positive. According to survey of HERA XXI (2017), 95% of parents believe that children should get adequate information on SRHR. Another survey (2018) shows, that 97% of teachers think it is essential to teach sexuality education topics in school based settings, and puberty is right time to get respective knowledge. These surveys underlined their concern regarding lack of age-appropriate information on the SRHR.

Pre- and antenatal care

Georgia made important progress in terms of improving maternal health, reducing high levels of maternal mortality[16], still rate of maternal death is high – according to NCDC&PH data in 2018, maternal mortality rate is 27.4/100000 newborn. Certain groups of women still face serious forms of discrimination in access to maternal health care, and there are reports of continuing failures to observe adequate standards of pre- and antenatal care and ensure respect for women's rights, dignity and autonomy during childbirth.

Maternal and Newborn Health Strategy for 2017–2030 and its Action Plan for 2017–2019 serve as a general framework for maternal and newborn health, reproductive health and family planning, guide for interventions for next three years. However, Action plan does not indicate budgeting of relevant activities.[17] Based on the recommendations of Public Defender of Georgia[18] number of visits in antenatal care package doubled – increased from 4 to 8 and list of essential drugs included in state antenatal care program, has been increased. Another positive result was achieved after regionalization of health facilities providing perinatal services, which resulted in improvement of access to maternal health care services.

In 2017, Parliament of Georgia adopted Demographic Security Policy for 2017–2030, in which, one of the objectives is to ensure universal access to Reproductive Health care services, information, and education.

Although there are some positive steps towards of improvement of pre- and antenatal care, still there are some policy defaults: antenatal package of care is very basic and covers only primary needs, package does not include some lab tests that are essential for effective monitoring. Each this test is associated with additional financial burden for women. Also, package does not include PSS service coverage neither for antenatal nor postnatal stages. The need in psycho-social support is justified by analysis of increased of maternal mortality cases.[19] High rate of C-section remains an issue as it has been increased over last years and reached 44,7% (2017) of all deliveries. As for 2018 the rate of C-section is slightly decreased to 41.6%.

"Decree on Perinatal service regionalization levels and criteria for patient's referral", 2015 comprehensive document defining criteria of level of provision of perinatal services by health facilities, and defines them at 3 levels (Basic I, specialized II, and sub-specialized III). Such diversification was intended to be helpful for patient's referral needs. But referral system remains less effective between health facilities providing ante- and postnatal care services. Indeed, it is still challenge for women to get referral in case of complications after delivery

and thereby receive adequate services. Additionally, there is no overall vision of post-natal care service provision, which mainly refers to postnatal visits and care to avoid physical and mental health complication, including maternal mortality.

LGBTQI+ Rights

In Georgia lesbian, bisexual, transgender (LBT) women are victims of double discrimination – based on their sex and sexual orientation/gender identity. Causes of discrimination and violence against LBT women lie in gender stereotypes of society, gaps, shortcomings in legislation and indifferent state policy towards LBT women in particular. LBT community is marginalized in society, few issues that National Human Rights Action Plan[20] refers to SRHR, cannot effectively tackle their systemic problems, none of its parts cover issues of sexual orientation, gender identity, and gender expression neither encloses related chapter.

Intimate partner violence and adequate reflection of state to this issue is challenging. While Istanbul Convention outlines protecting rights of victims shall be secured without discrimination on any ground, SOGIE,[21] related Georgian mechanism, law of Georgia on "Elimination of Domestic Violence, Protection and Support of Victims of Domestic Violence," doesn't guarantee such clause, impedes LB women and trans persons access to protection mechanisms. Transgender women are not allowed to use national mechanism of VAW, because Law of Georgia[22] defines "victim" as "a woman or other family member."

The preventive measures against intimate partner violence and domestic violence, including public campaigns performed by state, do not cover LGBTQI+ persons and same-sex couples. Aside from the lack of legal regulation of same-sex partner relationships, the survivors' choice of such strategy is influenced by the fact that the state has clearly defined policies and legal mechanisms to tackle domestic violence.[23]

Healthcare is not inclusive of LBT needs. A study by WISG (2015) showed that healthcare workers have vague knowledge about sexual orientation/gender identity, and the needs of LBT persons in health care.[24] Such approach affects access of LBT people to high quality healthcare services. Gender Equality Council of Parliament recommends Ministry to incorporate need/specificities of lesbian, bisexual, transwoman as a target/vulnerable group into State Strategy in Healthcare with provision of information/ training to health care providers about need and sensitivity in working with LGBTQI+ persons. Ministry should develop clinical guidelines regarding gender reassignment/transmission procedure in line with international standards.[25]

Georgian legislation neither prohibits nor regulates gender reassignment surgery. This gives discretion to medical institutions to decide who is eligible for the gender reassignment surgery. Such gap may result in arbitrariness, lack of consistency and create obstacles for people willing to undergo procedure.[26]

Gender-based violence

During the past ten years, noteworthy legal and institutional reforms were made to improve policy framework on Gender Equality, Domestic Violence, and Violence against Women, SOGIE based violence and discrimination. Georgia is a contracting party to the most major human rights instruments.[27]

In 2010 Parliament of Georgia adopted Gender Equality Law. The law strengthens the protection of rights and equalities determined under the Constitution of Georgia, and also incorporates legal mechanisms and conditions for their realization in relevant aspects of public life.[28]

In 2014, Parliament of Georgia adopted Law on Elimination of All Forms of Discrimination which includes prohibition of discrimination based on sex, as well as on sexual orientation/gender identity. [29]Government of Georgia began the nationalization of Sustainable Development Goals (SDGs) in 2016, identified the priority goals, targets, and indicators through adaptation of 2030 Agenda for Sustainable Development.

Georgia signed Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention) in 2014. On 4 May 2017, Parliament of Georgia reaffirmed its commitment of combating violence against women and domestic violence via endorsing ratification of the Istanbul Convention and adopting milestone legal framework aimed at harmonization of domestic legislation with the Istanbul Convention – a package of amendments to 25 laws accompanying the Convention.

Gender-based violence (GBV) is a vivid reflection of the gender inequality and discriminatory gender stereotypes with significant consequences that impede women's and girls' ability to exercise their fundamental human rights to health, education, marriage and family life, access to employment and economic opportunities. Women and girls in Georgia, especially those from specific ethnicities, are subject to harmful practices including: forced, early and child marriage, female genital mutilation (FGM), gender-biased sex selection, also known as son preference, is practiced, especially in particular regions.

GBV affects each sphere of life, including women's health. Indeed, gender-based violence is a public health issue and human rights violation that affects women and girls physical, mental, reproductive &emotional health. Victims of violence can suffer SRH consequences, including forced and unwanted pregnancies, unsafe abortions, traumatic fistula, sexually transmitted infections including HIV, and even death. 1 in 7 women in Georgia (14%) have experienced intimate partner violence, and 1 in 4 women have experienced at least one form of Gender-based Violence.[30] Women who had experienced intimate partner violence were more likely to report miscarriages, abortions and stillbirths, e.g. 23% of women who had experienced partner violence reported having miscarriage, compared to 16% of women who had not experienced abuse. 8% of women who experienced partner violence reported having a stillbirth, compared to 3% of non-abused women. Moreover, among women who had experienced abuse, 60% reported having an abortion, compared to 44% of women who had not experienced abuse. It is notable that women who had experienced partner violence were more likely to have ever used contraception but much less likely to be currently using contraception than women who had not experienced such violence.

1 Statistical Handbook, NCDC, 2018

2 WHO, Safe Abortion Guidance, (2012)

3 Women's sexual andreproductive healthand rights in Europe, Council of Europe, December 2017

4 "Artificial Termination of Pregnancy in Georgia" (Comparative Review), HERA XXI, (2014)

5 Abortion Services Availability and Readiness Assessment (Analytical Report), HERA XXI, RFSU, Institute of Social Studies and Analysis (2016)

6 Human Rights in the Context of Sexual and Reproductive Health and Well-being in Georgia: Country Assessment, Public Defender's Office (2017)

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Kazakhstan

Abortion and post-abortion care

The state regulates access to abortion through the adoption of a series of laws in which abortion is permitted from the age of 18. For girls under 18 years of age, the presence and consent of parents is required. Counselling algorithms have been developed for family planning, contraception, infertility for medical organizations that provide primary health care.

Public opinion is divided into two camps: on one hand, society is categorical regarding abortion and believes that it should be prohibited at the legislative level. On the other hand, public opinion is more lenient towards this trend, and believes that a woman should decide for herself whether or not to have an abortion.

In Kazakhstan, there is a high number of unwanted pregnancies among young girls: more than 16% of girls between ages 15 and 19 were pregnant, 2% admitted that they resorted to domestic abortions.[1]

Another factor that leads to unwanted pregnancies of minors, is the refusal of selling contraceptives to minors in pharmacies and drug stores. Although this is not a legislative norm and even the idea of selling special condoms for minors in pharmacies has been discussed,[2] in practice sellers refuse to sell contraceptives to minors, because they are not meant to have sex according to social norms. This not only can result in unwanted pregnancies, but also exposes minors to a higher risk of STDs.

To date, girls younger than 18 cannot access legal abortion services without the permission of their parents or another adult representative. Fearing the reaction of relatives and society and not knowing where to seek help, many pregnant girls resort to illegal and unsafe abortions or hide their pregnancy and abandon the new-born babies. Minors have the right to reproductive health and services (Code of the Republic of Kazakhstan on Public Health and Healthcare System dated 18 September 2009, No. 193-IV, Art. 93, Clause 2) but at the same time they are not allowed to access medical services without the consent of their parents or legal representatives and thus cannot choose abortion independently. These contradicting provisions lead to healthcare workers being in a position to interpret the laws in the ways they wish – and this often undermines the autonomy and agency of women seeking abortions. However, the Ministry of Health has recently drafted a law that allows minors from the age of 16 to receive medical services without knowledge and consent of their parents, including abortions. This draft law is currently being examined.[3]

More than 16% of girls between ages 15 and 19 were pregnant, 2% admitted that they resorted to domestic abortions.

Contraception

Contraception is available to people over 16 years of age, some types of contraceptives are assessable freely, while others are available in clinics only. Contraceptives that require the help of a doctor should be provided only in clinics, i.e. such means as an intrauterine device, a subcutaneous implant, hormonal injections, etc. A doctor's prescription is not required, but a doctor's consultation is recommended when choosing the most suitable contraceptives.

To get free contraception, a woman needs to register at a clinic. It is necessary to pass the appropriate tests, then through a therapist, the patient receives a referral to a gynaecologist at the clinic. Depending on the tests results, she can be offered pills, condoms, IUD's, as deemed appropriate.

Emergency contraception is quite affordable and can be purchased at each pharmacy. There are various types of emergency contraception, such as hormonal drugs in the form of tablets, suppositories, and others. They can be purchased in pharmacies, after consulting with a gynaecologist.

The most common types of contraceptives are intrauterine, hormonal, barrier and chemical.

Sexuality Education

Expanding programs on educating youth about sexual and reproductive health within the education system is one of the goals of the Concept of Family and Gender Policy in the Republic of Kazakhstan Up to 2030 adopted in December 2016. However, sexuality education is currently not part of the mandatory school curriculum in Kazakhstan and there is no law or national policy that could introduce this subject into the school curriculum. Thus, teachers are not provided with systematic training on teaching sexuality education. Instead, there are subjects that include some topics of sexuality education, such as issues related to violence and sexually transmitted diseases (STD). HIV and STD related issues are taught only in grades 7–9 in biology.

Although there has been positive development in the field of sexuality education for the last years, there are indicators that show that sexuality education is much needed as an examinable subject in the school curriculum, and that the quality of this subject has to be ensured. One of such indicators is the refusal of selling contraceptives to minors in pharmacies and drug stores. Although this is not a legislative norm and even the idea of selling special condoms for minors in pharmacies has been discussed, in practice, sellers refuse to sell contraceptives to minors because they are not meant to have sex according to social norms. This not only can result in unwanted pregnancies, but also exposes minors to a higher risk of STDs.

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without knowledge and consent of their parents, including abortions. This draft law is currently being examined.

UNFPA was planning to conduct a pilot training programme at two educational institutions – the Y. Altynsarin National Academy of Education and Nazarbayev Intellectual School (NIS) where there will be no separate course on moral and sexual education, but they plan to add it to biology and natural science. The development of the innovation is planned for the academic year 2019–2020. After the experiment, the course will be added to all school curricula.

Many parents are against sexual education in schools, as they fear the risk of ostracism.

Pre- and antenatal care

Prenatal care is covered by the state in the form of paid leave, which in accordance with Article 99 of the Labour Code amounts to 126 days (70 calendar days before delivery and 56 calendar days after delivery). In case of complicated birth or the birth of two or more children, 70 days of leave are given. The number of vacation days does not depend on the duration of employment, so it does not matter how long you work for the employer.

All necessary prenatal examinations are available.

There are no maternity schools, however, there are maternity programs in clinics.

The duration of maternity leave in accordance with Article 99 of the Code is 126 days (70 calendar days before childbirth and 56 calendar days after childbirth). In case of complicated birth or the birth of two or more children, 70 days of leave are given. The number of vacation days does not depend on the duration of employment, so it does not matter how long you work for the employer.

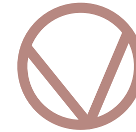
In addition to maternity leave, a leave can be granted at will, without saving wages for the care of children under 3 years of age. According to Article 99 of the Code, the father or mother of the child can receive such a leave, and if the child is left without parental care, then the next of kin, i.e. someone who will actually be engaged in raising a child can benefit from this leave.

In accordance with Article 54 of the Code of the Republic of Kazakhstan, the employer cannot dismiss a worker in connection with maternity leave. Moreover, in accordance with Article 87, the time spent on maternity leave and childcare is counted as seniority, and maternity leave even allows you to count on the next paid leave.

LGBTQI+ Rights

LGBTQI+ community is not legally protected by the state in any way, although there are also no "anti-gay propaganda" laws in place. Representatives of sexual minorities can receive the full amount of social services, usually without prejudice to their rights and interests. The law protects their rights and interests as well as the rights of other citizens of the country. However, it does not protect them from hate speech and rejection on the part of members of society. Same-sex marriage is officially prohibited, but cohabitation is not regulated by law. Compulsion to "sodomy" and "lesbianism" is punishable by criminal liability. Society is strongly opposed to same-sex relationships and the reaction is always negative from family to society.

Compulsion to "sodomy" and "lesbianism" is punishable by criminal liability.



Gender-based violence

Domestic violence remains an acute problem in Kazakhstan. Although efforts have been made to combat domestic violence, there is still room for improvement. Some administrative and criminal penalties for physical domestic violence do exist, but the system lacks resocialization laws and programs. In theory, the legislature includes penalties for sexual, emotional and financial violence but – as it is often difficult that such violence has occurred – they are rarely used in practice.

The legal basis for prevention of domestic violence in Kazakhstan is guided by: The Universal Declaration of Human Rights and the Convention on the Elimination of All Forms of Discrimination against Women, adopted by the UN General Assembly, The Constitution of the RK, the Criminal Code of the RK, Code of the RK on Administrative Offenses, Law of the RK on the Prevention of Domestic Violence, Code of the RK on Marriage (Matrimony) and the Family, Law of the RK on the Internal Affairs Bodies of the Republic of Kazakhstan and other regulatory legal acts.

In Kazakhstan, gender equality is envisaged in national legislation and guaranteed in the Constitution. However, in practice women are lagging significantly behind men in their ability to realize and exercise their rights because of patriarchal and gender norms. Additional barriers include high levels of gender violence and general inequality of opportunities between men and women in all spheres of life. For example, when a man is abusive in any way toward a woman, her parents do not accept her return to the family because it is considered shameful to leave one's husband. Low awareness of the law and human rights among the population also result in victims not knowing what their options are for redress and justice.

Despite the efforts made by the state to counteract domestic violence, the problem of violence against women remains acute, as it is a common offense in Kazakhstan. According to the sample survey on violence against women in Kazakhstan of 2017, around 16.5% of women in Kazakhstan aged 18–75 have experienced physical and/or sexual violence from their intimate partner at some point in their lifetime. Around 20.6% of women in Kazakhstan have experienced emotional violence and 6.3% have experienced economic violence from their intimate partner at some point in their lifetime. In practice, acts of violence against family members, regardless of the sex or age of the victim, are often ignored. Those experiencing domestic violence often do not tell anyone about this, and if they try, these cases rarely reach the court or are terminated in court because the parties decide to reconcile. When the parties reconcile, no measures can be applied to the offenders in order to prevent violent behaviour in the future. Often, the same parties reappear in court after the reoccurrence of another incident of domestic violence.

1 https://www.zakon.kz/4949072-uroki-polovogo-vospitaniya-v-shkolah.html

2 https://tengrinews.kz/kazakhstan_news/vopros-prodaji-prezervativov-podrostkov-trebuet-izucheniya-292071/

3 https://www.zakon.kz/4947494-o-razreshenii-abortov-v-16-let-bez.html

Latvia

Abortion and post-abortion care

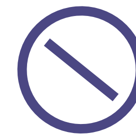
Abortion in Latvia is legal and can be performed within the first 12 weeks of pregnancy for personal reasons (49 days in case of medical abortion) and up to the 24th week for medical reasons. The woman has to visit a GP (general practitioner) or gynaecologist, who confirms her pregnancy and, if her decision is to terminate the pregnancy, it can be done after 72 hours. Before the procedure, several examinations have to be carried out, usually including blood tests, syphilis test and rhesus factor test. Two most common ways of terminating a pregnancy in Latvia are medical abortion and dilatation and evacuation (D&E).

Generally, abortion is an accessible service, although doctors have the right to refuse performing an abortion if it is against their personal (religious) beliefs and there are recorded cases of doctors using it. In rural areas, it can be harder to access the procedure, so women go to larger cities or nearby towns to have it. Medical abortion is harder to access, because not all clinics in the state offer this service, as medical abortion medication can only be used at the clinic with day stationary in presence of the doctor.

In 2018, there were 3,636 abortions performed in Latvia (8.8 per 1000 women aged 15–49).[1] The annual numbers have been decreasing over the last 10 years. However, local women's and reproductive rights activists doubt official medical abortion statistics, as it is almost certain that the full number of procedures goes unreported (ie. In private clinics).

The narrative around abortion is dual – the public opinion is mostly negative towards it, but in the professional environment, it is understood that it is a woman's right, and for personal, socioeconomic and other reasons abortion should be accessible.

Doctors have the right to refuse performing an abortion if it is against their personal (religious) beliefs.



Contraception

Contraceptives are rather accessible – only hormonal contraception has to be prescribed. Some forms of contraception (intrauterine system (IUS), implant, sterilization and vasectomy) is to be arranged with medical assistance from a doctor. Barrier methods in different variations are available freely at pharmacies and stores. Emergency contraception is easily available in any pharmacy without prescription or other obstacles, yet it may be unaffordable for some.

Contraception is not refunded by state for any group of society. For vulnerable women, safe contraception methods are not affordable, although in some municipalities, social services receive small funding to cover contraception for a certain amount of women. Free condoms are available only in HIV prevention points, which are usually focused on working with substance-dependant persons.

Due to lack of reliable statistics, it is hard to confirm, but the most commonly used contraceptive methods are most likely condoms, hormonal methods and coitus interruptus.

In 2015, the "morality law" was introduced, which prohibits the dissemination of materials that could "negatively impact the morality of students" in schools.

Sexuality Education

Topics related to sexuality education are included in school curricula, but mostly as non-mandatory, thus it depends on the school and teachers whether to implement it. The topics that should be covered from grade 5 to 9 include puberty, relationships, contraception, and STDs. There is no curriculum for high school (grades 10–12). Most of the schools cover the basics, mostly puberty (menstruation for girls, etc.), and schools often choose to invite private speakers or organizations outside of school (doctors, nurses, feminine product companies, NGOs (Red Cross, Papardes Zieds), religious representatives (True Love Waits, Crisis Pregnancy Center), and others. There is no reliable data about the level of factual knowledge regarding sexuality among young people.

Reforms in the educational systems are currently taking place, but a concern remains about the lack of appropriate coverage of health education (including SRHR topics) in the upcoming changes.

In 2015, the "morality law" was introduced, which prohibits the dissemination of materials that could "negatively impact the morality of students" in schools. It was introduced after one school disseminated brochures about safe sex that mentioned homosexuality. As a result, there have been only few more noticeable cases when this law was used (mostly because of mentioning homosexuality or rude words), but consequently, most of the teachers choose not to talk about possibly risky topics, including SRHR issues.

Due to the European Social Funding, in the years 2017–2019, Latvia had the chance to implement health promotion activities in almost every of its 119 municipalities. One of the topics of these activities was SRH. This provided wider access for different social groups to gain more information about SRH, especially young people in schools. There is no data yet about results and continuity of this project.

Pre- and antenatal care

Prenatal care in Latvia is covered by the state. It includes a gynaecological examination, a bacterioscopy of vaginal flora, blood tests, examination of foetal heart rate with CTG and I, II, III trimester screening, which includes ultrasonography.

All necessary prenatal examinations are easily accessible. If a woman desires prenatal care covered by the state, she needs to find a gynaecologist who has contractual relations with the state. She also has the right to choose a gynaecologist that will take care of her pregnancy and prenatal care. The Gynaecologist will send her for the all the necessary examinations.

Regarding differences between urban and rural areas, the main difference is that the necessary specialist could be unavailable outside the city, due to a deficit in specialists. Therefore, a woman who lives in a village or outside the city sometimes needs to travel to the closest city in order to receive the necessary medical care.

Birthing schools in Latvia are called prenatal, birthing and/or breastfeeding courses and mothers-to-be can choose which courses they want to attend. The situation for soon-to-be-fathers is rather specific, as if they want to enter the delivery room during childbirth, they are obligated to attend birthing courses beforehand.

New parents can have paid parental leave for a year and a half. It can be split up or used fully until child has reached 8 years of age.

LGBTQI+ Rights

LGBTQI+ community is not legally protected by the state. Some policies strive to eliminate discrimination and hate crime based on sexual orientation, but these actions are unfortunately not comprehensive. A notable part of the society, including politicians and decision-makers, is still highly homophobic. In the OECD data about LGBTQI+ inclusiveness, Latvia was placed among countries with lowest acceptance of homosexuality. The acceptance rate is higher among young people.

Several initiatives for legalizing same-sex relationships, and the law of partnerships have been brought in to Parliament to be discussed, but none of them has been supported or approved yet. It is also worth to mention that speaking about same-sex relationships during NGO workshops in schools is against the law.

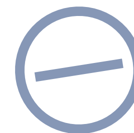
1 https://www.spkc.gov.lv/upload/Veselibas%20aprupes%20statistika/Statistikas%20dati/2019/21.06.2019/aborti_statistika_2018_21062019.doc

North Macedonia

In May 2019, the Parliament of North Macedonia adopted a liberal abortion law which removes all administrative barriers for women accessing abortion services, including mandatory counselling, a three day waiting period and high fines for service providers performing abortions.

Abortion and post-abortion care

In May 2019, the Parliament of North Macedonia adopted a liberal abortion law which removes all administrative barriers for women accessing abortion services, including mandatory counselling, a three day waiting period and high fines for service providers performing abortions.[1] This advocacy win is a result of the partnership of many NGOs and activists that over the past six years have acted jointly to change the previous restrictive abortion law. Moreover, the democratic government elected in 2017 made a political commitment during parliamentary election to partner with women's NGOs in order to change the restrictive law and ensure that abortion is a matter of choice for women. The new abortion law was drafted in collaboration with representatives from the Gender Equality Platform that were part of the abortion working group nominated by the Ministry of Health (MoH). The new law also recognizes medical abortion as part of comprehensive abortion care, regulating that medical abortion can be performed up to nine gestational weeks in the gynaecological clinics that are part of primary health care. However, medical abortion drugs are still not registered in North Macedonia, which would provide an option for women to terminate their pregnancy. The lack of human resources and medical competences in most Ob/Gyn clinics represent the main factors for the limited access to abortion services, which prevents women from accessing abortions throughout the country, especially for women living outside the capital city of Skopje. Only 25% of the Ob/Gyn hospitals in the country provide abortions in the first trimester, which is extremely low, while abortions in the second trimester are referred to the University Clinic for Gynaecology and Obstetrics in the capital Skopje.[2] There are no clinical guidelines for safe abortions available for service providers. The abortion procedures that are in practice, especially for the second trimester (3% NaCl solution) are not in accordance with methods recommended by WHO. However, following the nomination of the national working group by the MoH in November 2019 to draft the safe abortion protocol, it is expected to ensure that the procedures and care of women assessing abortion are in line with WHO Safe abortion guidelines. Moreover, the system for abortion statistics has not been revised for many years and it should be improved in order to better monitor the data of abortions performed at the national level. The number of abortions has remained stable over the last several years, and there is no significant trend of increasing or decreasing of abortions. In 2017, there were 19.5 abortion per 100 livebirths, which is relatively at the same level as the statistics for the European region. Finally, 3.3% of abortions in North Macedonia are registered among young girls up to 20 years of age.[3]



Contraception

The need for contraception among women aged 20–24 has not been met in 36.5% of cases, and only 52.7% of women who are married or in a relationship have expressed the need to use any contraception.[4] Moreover, the modern contraceptive prevalence rate is very low (12.7%), while North Macedonia is one of the countries with the lowest prevalence rate in South-Eastern Europe and Europe in general. The existing legislative and regulatory framework is supportive and permits the provision of contraceptives services by general practitioners, including the prescription/distribution of most contraceptive methods (with the exception of intrauterine device insertion and male and female surgical sterilization) for people paying or not paying contributions to the health insurance system.[5] However, GPs have less knowledge and skills, and are not heavily involved in contraceptive counselling and prescriptions of pills in practice that limit women access to contraception services at gynaecological clinics. Oral contraceptives are rarely used (5.8%) and are not covered by the Health Insurance Fund. The withdrawal method is frequently used as a contraceptive method, followed by condoms and sterilisation (for women that have given birth four times or more). Many women think that contraception has unwanted side-effects and some of them have had negative experience using oral contraceptives. Some women do not plan to use contraceptives, at all or plan to use the Intrauterine device (IUD) after giving birth as a family planning method. Roma women emphasise that the men make the decisions about contraceptives. IUD's are quite expensive, as opposed to condoms and oral contraceptives which are fairly cheap and available in pharmacies. According to legislation emergency contraception can be purchased with prescription, although in practise, pharmacies do not always require prescriptions for selling emergency contraceptives. EC is relatively expensive. In 2019, under the Preventive Program for Mother and Child Health, the Ministry of Health allocated for the first time a budget of USD 5,000 for the purchase of free contraception for the most vulnerable groups of women.[6] However, a logistic management system in the Ministry of Health is lacking for contraception distribution. None of the contraceptives are included as part of the national health insurance coverage and no efforts by the government in that direction have been made so far.

Sexuality education

With regards to the school system, there is no separate school subject entitled Sexuality Education in North Macedonia. Some elements thereof, though, are included in various other school subjects. For example, STIs are included in Biology and in Life Skills subjects. However, information related to gender, sexuality orientation, relationships or the emotional aspects of sexuality, sexuality orientation or discrimination, is insufficiently addressed during classes. Although Life Skills Education is a mandatory subject, it is only implemented during "advisory classroom" sessions (it is not part of the regular teaching curricula).[7] Also, teachers decide for themselves which topics to include during the year and those related to sexuality education are frequently omitted due to lack of skills and capacities to teach sexuality education topics. Only 7% of the teachers in the capital have talked about sexuality orientation, 8% have addressed oral contraception, 15% condom use and 35% HIV prevention.[8] The Education Strategy 2018–2025 notes that the teaching of Life Skills Education is carried out in an insufficient or inappropriate manner in many schools. Therefore, it recommends further strengthening of the status of the subject and improving its contents, in order to ensure its regular application. As many as 82% to 96% of the parents are in favour of introducing various topics related to comprehensive sexuality education in the school curricula.[9] Topics such as prevention of sexual violence, reproductive health and contraception, HIV/STIs, puberty, rights protection are seen by the parents and guardians as the most important issues that children should learn about in school. There has been good progress made with regards to improving the sexuality education content in the formal educational system throughout 2019. In collaboration with the Ministry of Education, Ministry of Labour and Social Policy, the Ministry of Finance and the Ministry of Health, an action plan 2019–2021 for piloting CSE was developed following a government decision in January 2019 to establish a national working group for improving sexuality education content in schools. HERA was a member of the working group and under its mandate a school curricula and a manual for teachers were developed. The school curricula is in alignment with UNESCO technical guidelines for young people aged 13 to 15, includes seven components (1. Gender, 2. Relationship, 3. Body and body image 4. SRH and HIV 5. Sexuality 6. Violence 7. Civil aspects) and consists of 47 educational workshops. In November 2019, the Government of North Macedonia approved the information[10] presented by the Ministry of Education for introducing pilot programme for CSE in grade 9 of the elementary school system in four schools, two schools in urban areas, one school in rural area and one school where majority of the students are coming from the minority ethnic communities.[11] According to the Action Plan the pilot project will start in 2021, once all preparation activities will be finalized, including the development of teaching materials and evaluation tolls as well as organizing training of teachers.

Pre- and antenatal care

According to the legal regulations in North Macedonia, pregnant women have the right to free-of-charge pregnancy monitoring by their gynaecologists, as well as free-of-charge delivery in state hospitals. However, at the national level, there is widespread practice of unlawful charging of reproductive health services by primary healthcare gynaecologists, and there is an uneven distribution of gynaecologists across the country. That is, there are several smaller municipalities with no single gynaecologist which limits access to basic healthcare services for women living in those areas.

The illegal charging of fees for health services provided by a primary gynaecologist is a phenomenon which has been officially tracked, registered and reported since 2012. The surveys show that a staggering 83% of the pregnant women in the municipality of Shuto Orizari stated that they did not receive the ultrasound service free of charge as they should, but had to pay the primary gynaecologist for it.[12] Other testimonies of women also suggest that they frequently had to pay for services that should have been free of charge – this was suggested by 28.8% of the Romani women and 28.4% of the non-Roma population in several cities in the country.[13]

Between 2012 and 2019, HERA registered nearly 2,000 cases when Romani women from Shuto Orizari reported illegal charges levied by 15 primary gynecologists. The Ombudsman and the Health Insurance Fund of Macedonia addressed the official complaints submitted by the women. In 2016, the Ombudsman provided an opinion to the Health Insurance Fund regarding the need to perform unannounced controls, as well as other measures to prevent the illegal levying of charges for health services provided to Romani women. The Ombudsman also asked the MoH to urgently address the issue with the lack of a primary gynaecology practice in Shuto Orizari and the employment of a gynaecologist.[14]

The state provides nine months paid maternity leave for one of the parents – as a rule for the mother, and for the father in exceptional circumstances only. The joint maternity leave of both parents is not allowed.

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LGBTQI+ rights

A new Law on Prevention and Protection against Discrimination was brought into force in May 2019, which provides protection against discrimination on the grounds of sexual orientation and gender identity – grounds which were not clearly established in the previous law.[15] On the other hand, the Criminal Code protects LGBTQI+ people from hate-based violence, but despite the legal guarantees, there are acts of violence, hate speech, and harassment that have not received legal redress, although several years have passed since they were conducted.

In 2018, 84 cases of violation of the rights of LGBTQI+ people are documented. Cases have been documented in several cities in the country, but they dominate in the capital city (57), 17 cases in Strumica and several cases in Tetovo, Gostivar, Struga, Ohrid, Kumanovo, Veles and Stip. In all documented cases, the victims are gay men (73) and transgender people (37), with the exception of one case in which the victim was a civil society activist who works with the LGBTQI+ community.[16] Most of the cases (49) are hate-based violence against LGBTQI+ people. In two cases, domestic violence has been documented against a transgender woman. There are the cases of robbery (23) against gay people, in which there is also violence, but are separated as category, because in these cases, besides violence,

there is also theft. Next, in number are cases of extortion and blackmail (11), discrimination (10) and theft (8). Only four of the cases of violence and robbery against gay men were reported to the police, while the three perpetrators were unknown and were not found. Only in one of the reported cases the police acted and punished the perpetrator. There are four documented cases of violence against gay men whose perpetrators are police officers. In three cases, there was verbal and psychological violence caused by the police, and in one case, there was physical violence.

Homophobia and transphobia is present on social media, which was especially evident before the first Pride Parade in Skopje (2019). The Facebook campaign "Don't judge" which promoted the rights of LGBTQI+ people was followed by many comments which contained hate speech, insults and prejudices against LGBTQI+ people. Many of the comments were threatening in nature and called for violence. The most explicit comments were reported to the Ministry of Interior's electronic crime sector.

Currently, there is no equality body in the country, because the mandate of the previous Commission for Protection against Discrimination has expired and a new body has not been established yet and therefore, LGBTQI+ people cannot use this protection mechanism if their rights are violated, especially if they are discriminated by private individuals.

Gender-based violence

According to the statistics of the Ministry of Interior, in 2017 there were a total of 903 reported cases of domestic violence, 84% of which involved women survivors. As many as 60% of the reported cases are gender-based related, perpetrated by women's spouses or ex-partners. In the period from 2016–2018, there were a total of 34 homicides of women, with 28 of these cases being classified as femicides.[17] Furthermore, 14% of women have experienced physical or sexual violence at the hands of a partner or non-partner since the age of 15, while 30% of women have been sexually harassed since the age of 15.[18] Surveys show that in North Macedonia, three times as many women believe domestic violence is a private matter to be handled within the family as compared with women across the EU. Women living in households that are struggling financially indicate a higher prevalence of violence, in particular physical and sexual violence at the hands of an intimate partner. The Government of North Macedonia ratified the Istanbul Convention (IC) in December 2017. Following the ratification of the IC in December 2017, North Macedonia developed, adopted, and allocated financial resources for a National Action Plan (NAP) for the implementation of the IC 2018–2023.[19] The NAP presents the most significant strategic document in the area of ending VAW, which stipulates extensively the key interventions towards achieving: i) the full alignment of the national civil and criminal legislation with the provisions set in the IC; ii) standardized protection and support services to survivors; and iii) effective prevention of all forms of VAW. Additional efforts have been made recently to improve the legislative and policy framework regarding VAW, and a new comprehensive law for the prevention of and protection against VAW is currently being drafted. For the first time, the law covers all forms of VAW and includes definitions of 'violence against women' and 'gender-based violence', as well as explicit reference to the 'principle of due diligence.' Furthermore, in 2018 the MLSP developed: (1) Standards and procedures for shelter for victims of DV; (2) Standards and procedures for psycho-social counselling of victims of DV; and (3) Standards and procedures for counselling for perpetrators of DV. In addition, in 2018 the Ministry of Health established the first three sexual violence referral centres within health institutions in three municipalities in the country. In the country there is a lack of available and accessible specialist service providers currently the existing services for women victims of violence are as follows: (1) three national SOS helplines; (2) one crisis centre provides accommodation from 24 to 48 hours; (3) six non-governmental organizations offer specialist services of free legal aid to women victims of violence; (4) five shelters provides accommodation for up to six months; (5) one centre provides psychosocial support and counselling. According to the standards of the IC in the territory of North Macedonia, there should be at least 20 shelters and a minimum of 20 counselling centres. There is one centre in the country that provides long-term accommodation for victims of sexual violence and psycho-social support (located in Skopje), but this centre also accommodates victims of human trafficking. According to the standards of the IC, there should be a minimum three shelters for victims of sexual violence and minimum five rape crisis centres in the territory of North Macedonia.

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Moldova

Abortion and post-abortion care

Every woman in Moldova over 16 years of age has the legal right to abortion on request within the first 12 weeks of pregnancy. Adolescents younger than 16 must have the consent of a parent or guardian in order to receive an abortion.[1] In the second trimester, from 12 to 22 weeks of pregnancy, the Ministry of Health permits abortions in the case of several medical and social indications, including if the woman's health or life is in danger, incurable foetal developmental abnormalities, a pregnancy resulting from crime, etc. Abortions are only carried out in authorized medical facilities by OBGYNs with the necessary training. Overall, standard safe abortion procedures, manual vacuum aspiration or medical abortion, are accessible throughout the country in all major cities, though women living in rural areas face financial barriers in accessing services. In some areas, despite all the efforts the Reproductive Health Training Center has made, dilation and curettage is still used as an abortion method (approximately 15%), though it is no longer recommended by the WHO and the Moldovan Ministry of Health as being safe.[2] Before leaving a medical institution following a surgical abortion or the prescription of drugs for a medical abortion, all women are given recommendations about contraception methods, and all the possibilities of family planning are discussed. Of all the women that receive post-abortion counselling, 68% leave the medical institution with some type of contraception (condoms, hormonal pills, intrauterine device, etc.).[3] Likewise, religious fundamentalism and anti-choice rhetoric is on the rise in Moldova, with anti-abortion rallies being carried out across the country over the past several years. In 2017, 12,025 abortions were provided in Moldova, down from previous years, with a rate of 15 abortions per 1,000 women of reproductive age.2 It is very worrisome that on average 2,500 of the 3,300 adolescent girls that become pregnant in the country annually give birth, meaning only 800 end up having an abortion.[4] This is unquestionably a result of the many existing misconceptions about abortion and subsequent pressure experienced by adolescent girls from friends and family members to carry the pregnancy to term. In 2018, no maternal deaths resulting from abortion were reported in Moldova.

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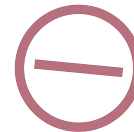

Contraception

Access to contraception is assured by the government via Law No. 138 on Reproductive Health. Combined oral contraception (COC) and condoms can be obtained free of charge from family doctors and at youth-friendly health centres by the following groups: adolescents and youth under 24 years old, people living with HIV, victims of sexual violence, people who had an abortion in the past year, people with psychosocial disabilities, people with low incomes, and people who abuse alcohol and/or other drugs. COC, intrauterine devices (IUDs), and emergency contraception can be obtained from almost any pharmacy without a prescription. Emergency contraception costs on average around EUR 8.5 in Moldova. Other types of hormonal contraception such as the vaginal ring, combined patch, and female condoms are less accessible, though they can be found in some pharmacies. Hormonal implants are expected to be approved for distribution within the six months. According to the UNICEF Multiple Indicator Cluster Survey (MICS), which was most recently carried out in Moldova in 2012, 41% of women of reproductive-age (15–49) in a relationship or union did not use any type of contraception, 18% reported using traditional methods (coitus interruptus and calendar based methods), 20% reported using an IUD, 12% said they used a male condom, and 5% used COC.[5] In addition, based on the most recent Contraception Atlas ranking, Moldova ranks at 62.6% based on policies and access to contraceptives and family planning counselling.[6] In addition, in the most recent Health Behaviour in School-Aged Children (HBSC) study conducted in 2015, 74% of 15-year-old males and 56% of females claimed they used a condom and the last sexual intercourse.[7] Likewise, 6% of males and 10% of females reported using oral contraception, respectively, which is the lowest among participating countries.[8]

Sexuality Education

Although school-based sexuality education in Moldova is mandatory by law since 2012, the same law guarantees access to contraception and family planning services (Law No. 138 on Reproductive Health), it remains primarily optional in practice. Of all the courses offered at the primary and secondary school levels in Moldova, health education has the greatest number of lessons devoted to sexual and reproductive health (SRH), and hence it possesses the most potential to deliver quality SRH information to youth; however, only 7% of adolescents were registered in the course in 2017.[9] The health education curriculum includes topics on puberty, sexually transmitted diseases, contraception, consent, sexual negotiation and decision-making, etc. It was revised by UNFPA and the Ministry of Education last year with input from various local, national, and international civil society organizations, though it still excludes many recommendations in the WHO/BZgA and UNESCO standards. Overall, considering events that transpired in 2005, when a mandatory life skills-based education (LSBE) course containing critical SRH subject

matter was almost immediately met with resistance, especially from clergy members, and in turn removed from the curriculum in a matter of months, there has unquestionably been improvement, though all too slow.[10]

Currently there is no available up-to-date representative data evaluating young people's knowledge about sexuality in Moldova, aside from that collected in the UNICEF MICS study in 2012 on knowledge of contraceptive methods and HIV prevention and misconceptions. It is worth noting that the incidence of STIs (specifically syphilis and gonorrhoea) among young people aged 15–19 was registered at 160 per 100,000 in 2014, the highest in all of Europe, and HIV incidence among young people aged 15–24 nearly doubled between 2000 and 2015.[11] According to the HBSC study, 33% of 15-year-old males and 4% of females stated they were sexually active, while response rates increased to 61% and 22% respectively for 17-year-olds.[12] Overreporting of sexual activity among males and underreporting among females could be explained by the persistence of gender stereotypes, one of which being that young males should be highly heterosexually active, whereas females should preserve their virginity.

Pre- and antenatal care

Prenatal care is covered by the state and all necessary prenatal examinations are accessible to mothers-to-be across the country. There are not any substantial differences in accessing prenatal care between urban and rural settings, besides the longer commute from the village to the city. In 2016, new Standards for Monitoring Pregnant Women in Outpatient Settings were developed and approved by the Ministry of Health (MoH). These standards include a wide variety of compulsory clinical and paraclinical examinations during the prenatal period for all pregnant women. According to these standards, pregnant persons benefit from six perinatal care visits during pregnancy. Based on MICS data from 2012, 95% of women had at least four antenatal visits, with a similar distribution in urban and rural areas.[13] Ninety-nine percent of the women who gave birth during the two years before the survey reported that during the prenatal visits a blood sample was collected, 98% said their blood pressure was checked, 99% had a urine sample collected, and 99% were tested for HIV.[14] The standards on safe maternity conditions recommend that women and new-borns receive a medical check within two days after discharge from the medical institution. In Moldova, about 98% of new-borns receive a health check after birth in a health care facility or at home.[15] The Moldovan MoH assures both paid maternal and paternal leave. Fathers in Moldova have the right to paid paternal leave up to 14 calendar days in the first 56 days following the birth of the child. Mothers can take leave starting at the 30th week of pregnancy for up to 3 years with varied payment schemes depending on the number of children being raised.

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LGBTQI+ Rights

In 2012, Law No. 121 on Ensuring Equality was passed by the Moldovan parliament. In Article 7 concerning discrimination in the job market, discrimination on the basis of sexual orientation in the hiring process is explicitly banned. When the law was being developed and reviewed by members of parliament, GENDERDOC-M, the first non-governmental organization (NGO) in Moldova to protect and promote the rights of LGBTQI+ community members, fought to include "gender identity" in the law as well, though in a compromise with government officials it was left out.[16] Though the law has been referenced in several judicial processes won by GENDERDOC-M, it does not always function as it should and many violations have gone unpunished. There is no other specific reference to the rights of LGBTQI+ community members in the legal framework in Moldova. According to Rainbow Europe data, in terms of laws and policies affecting the lives of LGBTQI+ individuals, Moldova ranks 41 out of 49 European countries.[17] Based on a study completed by the United Nations in 2015, LGBTQI+ individuals are the most rejected social group in Moldovan society. Over 40% of survey respondents described LGBTQI+ community members as being "immoral, insane" and 35% considered them to be "sick people."[18] Even more, only 18% of the population was willing to accept LGBTQI+ people as citizens and only 1% as family members.[19] LGBTQI+ groups have organized an annual Pride march in the capital since 2013 which generally has attracted violent counter-protesters. Orthodox Christian religious leaders and political leaders regularly engage in "hate speech", casting LGBTQI+ identities as alien to Moldovan and Christian values. Following his election in 2016, the president of Moldova, Igor Dodon, remarked, "I didn't promise to be the president for gays… You know my opinion. I am categorically against marches of sexual minorities and their registration in the Republic of Moldova. I'm for our traditions, traditional families, Orthodox faith."[20] Based on data provided to the Organization for Security and Co-operation in Europe (OSCE) by local NGOs, 16 attacks of violence against LGBTQI+ community members were reported in 2016.[21]

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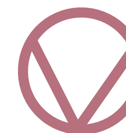

Gender-based violence

In recent years, the Moldovan government has made several important steps forward in setting up a legal framework for ensuring gender equality and establishing an efficient system for tackling violence against women. It adopted Law No. 196 on Ensuring Equal Opportunities between Women and Men, signed and ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), adopted Law No. 45 on Preventing and Combating Family Violence, and signed the Council of Europe Convention on preventing and combating violence against women and domestic violence, also known as the Istanbul Convention. In addition to such legal framework, relevant policy documents that address gender inequality and domestic violence have been developed, including the National Strategy for Ensuring Equality

between Men and Women 2017–2021 and the Strategy to Prevent and Combat Violence against Women and Domestic Violence 2018–2023. Despite these efforts, gender-based violence remains a significant problem in the Republic of Moldova. At the national level, this phenomenon was analysed through the study "Violence against Women in the Family," carried out by the National Bureau of Statistics in 2011. The study found the total prevalence rate of intimate partner violence over a lifetime (psychological, physical, or sexual) to be 63.4%, that is, 6 out of 10 women experienced at least one form of violence since the age of 15.[22] In a survey conducted by the Women's Law Center in 2015, 41% of men and 19% of women stated that there are moments when women should be beaten.[23] In another more recent survey conducted by OSCE in 2018, one third of women said they personally know someone subjected to domestic violence among their family and friends and two in five women (40 per cent) said that they experienced physical or sexual violence since the age of 15 by a partner or non-partner.[24] Fifty-five percent of women surveyed think that domestic violence is a private issue that needs to be dealt with in the family and 50% of the women surveyed believe that a good wife should always obey the husband, even if she does not agree with him.[25] Concerning crimes of violence against women included in the Istanbul Convention, the National Bureau of Statistics of Moldova only has data on rape offenses at this stage. In past years, there has been an increase in the number of rape cases among sexual offenses – from 215 cases in 2000, to 352 cases in 2014.[26] The number of rape cases per 100,000 population follows the same growth trend, increasing from six cases in 2000 to 10 in 2014.[27]

6 out of 10 women experienced at least one form of violence since the age of 15.

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Poland

Poland has one of the most restrictive abortion laws in Europe.

Abortion and post-abortion care

Poland has one of the most restrictive abortion laws in Europe. The 1993 Family Planning Act[1] bans abortion with the three exceptions:

- A foetus is diagnosed with severe and irreversible malformation or an incurable, life-threatening disease. Statutory time limit: Foetal viability. Statutory obligation: medical certificate. Service provision: public hospital with an OB-GYN department.

- Continuation of a pregnancy endangers either the life or health of a pregnant person. No statutory time limit. Statutory obligation: medical certificate. Service provision: public hospital with an OB-GYN department.

- Pregnancy resulting from an unlawful act e.g. rape, incest. Statutory time limit: 12 weeks. Statutory obligation: prosecutor's certificate. Service provision: public hospital with an OB-GYN department or private practice.

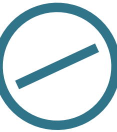
Ministerial data[2] indicate about 1000 procedures per year, whereas 98% of them are performed due to foetal impairment. Only 10% of hospitals perform legal abortions[3]. The vast majority refuse to carry out abortions by invoking conscientious objection or by rejecting patients without legitimate justification. The range of methods to extend diagnostic and bureaucratic procedures is broad: ordering unnecessary tests, repeating diagnostic process, requiring additional certificates, summoning medical councils, obligatory psychological consultations, and written refusals from local hospitals. There are no uniform procedures for hospitals that could protect patients from abuse and undue burden. Therefore, the number of women, who migrate to foreign abortion clinics despite having lawful indications for a legal abortion, is on the rise. As depicted by the experiences of the Federation for Women and Family Planning, interventions on behalf of patients, counselling, advocating for procedures and strategic litigation are important strategies to improve abortion accessibility.

The act stipulates that abortion can be carried out exclusively with a patient's consent. Minors need parental consent, and in case of disagreement, a guardianship court decides. Doctors, nurses and midwives are allowed to deny the provision of healthcare services for reasons of conscience. Legal abortions are performed with Misoprostol (Mifepriston is not registered in Poland), followed by curettage (if necessary, commonly in the second trimester abortions).

A self-induced abortion is not punishable by the law. A person who terminates someone's pregnancy in violation of the law is liable to imprisonment for up to three years. The same punishment is imposed on anyone who helps a pregnant person to terminate their pregnancy against the law, or who persuades them to do so.

With 9.1 million women in a reproductive age the number of non-statutory abortions is estimated at 80–120 thousand per year. Around 25%–33% of women have had an abortion.[4] Abortion choices depend on many conditions such as financial resources, family and work situation, pregnancy duration, time flexibility, knowledge, support and awareness. They involve ordering abortion pills, migration to a foreign clinic, private practice in the abortion underground, and (rarely) home methods.

Attempts to tighten restrictive anti-abortion provisions are regular and come from the anti-choice movements, the Church, and the ultra-conservative government, which proliferate anti-abortions myths and narratives personifying foetuses. The main actor of backlash – the Ordo Iuris Institute uses legal arguments stemming from ideological, manipulative interpretations of the Constitution, and international human rights documents. A series of counter-protests i.a. the famous Black Protest in 2016, has led to a historic and stable rise of pro-choice views. Depending on the poll, 55–69% of Poles are for legal and accessible abortion[5].



Contraception

The Family Planning Act obliges both governmental and local administration to provide citizens with an easy access to "methods and means serving conscious procreation". This responsibility has never been properly fulfilled. According to the latest Contraception Atlas, Poland occupies the last place among 46 European countries[6]. Accessibility of modern contraception was ranked at 31.5% based on respective policies, access to contraceptive supplies, family planning counselling and online information. All types of contraception are on prescription except for barrier methods – (internal) condoms, diaphragms, spermicides, cervical caps.

Only two types of combined oral contraceptive pills are reimbursed, while one of them is reported to cause more side effects, and the other is registered for therapeutic purposes, not contraception. Other means of contraception like IUDs or patches are not even partly refunded, which deepens social inequalities in accessing safe and effective contraception. The insertion of IUDs is free of charge for those insured, yet awareness about such an opportunity is not widespread and the procedure is priced too low. As a result, doctors direct patients to their private practices charging them EUR 120–400 and it is very difficult to execute one's right to this service in the public system. Voluntary sterilization is illegal for both women and men, yet vasectomy is available in the private sector (EUR 500–750).

There are no refunds or supporting mechanisms for vulnerable groups such as adolescents, the unemployed, people with a low-income or disabilities. Intrauterine devices (IUDs), vaginal rings, and emergency contraception are available in many or even most pharmacies. Other types of hormonal contraception such as the combined patch, and female condoms are less accessible, though they can be found in some pharmacies. Many forms of contraception, especially LARCs, are not affordable. Type and cost of birth control available in Poland:

- Emergency contraception – EUR 30
- Pills – EUR 5–12 /month
- Patches – EUR 10–20 /month
- Rings – EUR 10–12
- Non-hormonal IUD – EUR 25
- Hormonal IUD – EUR 120–250
- Birth control shot – EUR 10 /3 months
- Implant – EUR 250–325

According to the law, conscientious objection enables medical professionals not to carry out procedures that are against their worldview. Legal interpretations indicate that writing out prescription is an informational service and should not be denied by means of conscience clause. Yet, it is not uncommon that doctors use it as justification. Moreover, there are pharmacies that intentionally either do not sell contraception or do not have it in stock.

According to the latest Contraception Atlas, Poland occupies the last place among 46 European countries

Ideology, lack of political will to fight abuse, commercialization of healthcare, no sexuality education at schools, no family planning counselling, obligatory prescription, lacking reimbursement schemes, parental consent in the case of minors – all of these factors have a detrimental effect on accessibility of contraception. The current use of contraception method is studied in opinion polls only, thus there are outdated and sometimes inconsistent (there is no official monitoring). The most popular methods are condoms (66%), followed by pills (29%), withdrawal (21%), natural methods (13%).[7]

Sexuality Education

The Family Planning Act obliges authorities to guarantee education about “sex life, principles of conscious and responsible parenthood, the value of family, life in the prenatal phase and methods and means of conscious procreation”. The course is called “Preparation for Family Life”. The classes are conducted 14 hours per year in primary schools (grades 4–8) and in secondary schools. Theoretically, they are obligatory, but a parent may withdraw their consent for a child to attend the course. The core curriculum focuses on promoting sexual abstinence, family values, heteronormativity, and traditional gender roles. Both the curricula and text books are consistent with the Roman Catholic ethics and norms. The course can be taught by a person who is qualified to teach and has a university degree in family science or has completed postgraduate studies/ training relating to the content of the classes.[8] Both

In Poland, 50–70% of seropositive people are not aware of being HIV+.

the content, suitability, teachers’ qualifications are poorly evaluated by pupils, who find the subject ideological, politicized and discriminatory (reinforcing gender stereotypes, homophobia, misogyny, transphobia). Contraception and diverse sexual orientations are hardly ever mentioned. Consequently, as little as 60% of youth attend the subject[9].

In the absence of state-organized comprehensive sexuality education, it is for the NGOs, grassroots groups and parents that adolescents are provided with proper education. The oldest and most renowned actor is the Ponton Group, which has been providing peer-to-peer education, informational materials about contraception, consent, safe sex etc., counselling (helpline, online forum), and free workshops at schools. According to their experience, the level of knowledge on sexuality education is low, while pregnancy paranoia is on the rise. A few examples from the 2015 study on 18-year old people: 30% know how IUDs work and when probability of getting pregnant is highest, and 50% believe that withdrawal prevents pregnancy.[10] The lack of sexuality education makes youth more vulnerable to sexual violence, STI/STD and teenage pregnancy. In 2018, over 9,000 adolescents became mothers, whereas 39 were below 14 and eligible for legal abortion[11]. Given low rates of testing for STIs/STDs, there are no reliable data, but experts point to a rise in HIV/syphilis infections.[12] In Poland, 50–70% of seropositive people are not aware of being HIV+.[13]

2019 was marked by intensified attacks by fundamentalists who spread misconception about sexuality education (common ultraconservative frames of alleged sexualization), the respective WHO standards and intended to link sexual educators to paedophiles. In October 2019 the Polish parliament discussed the citizens’ bill “Stop Paedophilia” which foresees criminal penalties for “promoting sexual intercourse or any other sexual activity by a minor, while acting in connection with holding a position”. The aim was both to prevent young people from exercising their right to reliable education, and to intimidate those involved in sex education and the provision of health care to people under the age of 18.[14] Following massive protests, the bill was directed to a special parliamentary committee [as of January 2020].

Backlash against sexuality education, similarly as with abortion, contradicts societal perspectives. An opinion poll that was takes soon afterwards revealed that 80% of Poles support sex education at schools and 47% believe that classes should start at primary schools.[15]

Pre- and antenatal care

The Family Planning Act obliges central and local authorities to guarantee perinatal care as well as medical, social and financial support to pregnant people.

Healthcare is free during pregnancy and six weeks of puerperium. Prenatal programme involves 42 compulsory clinical and paraclinical examinations, including three ultrasound scans and tests for STIs. However, according to the Supreme Audit Office, only a small minority of women undergo all examinations (2% in gynaecological clinics reviewed)[16]. In the case of specific medical situations – most commonly foetal abnormalities – patients are

entitled to specialist diagnostics like amniocentesis. Accessibility varies between regions.

Perinatal and Postnatal Care Standards were first introduced in 2016, updated in 2018. As evaluated by the Childbirth with Dignity Foundation, the standards are one of the most progressive regulations of its kind in the European Union. The document is based on WHO recommendations and includes the latest research findings, guaranteeing a number of patients' rights before, during and after childbirth. One of the most important goals was to decrease the medicalization of childbirth, which has yet to be attained. Women have a right to (among others) prenatal education, care provided during midwife patronage visits, and non-pharmacological methods of childbirth pain management. There are both public and private birthing schools, which include theoretical and practical lessons about delivery, breastfeeding, child development, legal advice, postpartum depression, childcare and health lifestyle.

According to surveys, patients' rights in ON-GYN departments are not fully respected. As many as 54.3% of women experienced abuse related to the medical personnel's behaviour or not fulfilling all the procedures[17]. Patents report discrimination on maternity wards based on their age, appearance or health condition. Harmful procedures are still present – such as routine PVC insertion, birth induction, speeding up the birth by using oxytocin, episiotomy, limiting the mobility, interrupting skin to skin contact and feeding with powder milk. In 2017, epidural was used in only 10% of natural deliveries.

There are great disparities between cities and villages. In half of the municipalities, there is no gynaecological clinic, however, in rural areas, a clinic has to serve over twice as many patients as in urban ones. As a result, gynaecological care is privatized, depriving people with a low-income of high-quality pre- and antenatal healthcare. Investigations by the Supreme Audit Office indicated that in rural areas, there are higher infant mortality rates. Social disparities and varying levels of education and awareness also impact accessibility of perinatal care. Another barrier is conscientious objection, which is used – unlawfully – by some doctors to deny access to prenatal testing.

The state provides 20 weeks of maternity leave (14 weeks are compulsory) for those with employment contracts. During this leave, women receive 100% of their salary. Subsequently, they can apply for a parental leave of 32 weeks (or more in the case of multiple births), which can be shared between parents. If a woman decides to continue with the parental leave, she receives 80% of her salary throughout 52 weeks. During pregnancy, maternity and parental leaves, the employee is protected from dismissal. All insured fathers may take two weeks of 100% paid paternity leave.

LGBTQI+ Rights

In the annual review of the human rights situation of LGBTQI+ people by ILGA-Europe Poland occupies 39th place out of 49 European countries with the score of 18%.[18] The Antidiscrimination Act makes protection conditional. Despite disproportionate exposure to bias and discrimination, there is no legal protection based on sexual orientation, gender identity and sex characteristic (SOGISC) in the field of employment, education, health and access to goods and services. Poland lacks legal measures to recognise and protect same-sex couples or adoption as well as hate speech laws that would explicitly cover all bias-motivated crimes based on SOGISC grounds. Neither policies, nor laws have been introduced to tackle homo- or transphobic hatred. According to the latest report "Situation of LGBTA Persons in Poland 2015–2016" 69% encountered at least one type of violence motivated by prejudice (verbal – 63%, sexual – 14%, physical – 13%), and 28% suffer from depression[19]. Law enforcement should consider the low reportability crimes motivated by homophobia and/or transphobia (under 4%). Hate speech in Poland is most often homophobic (64%) and racist (46%).[20] Sixty-nine percent of LGBTQI+ youth have suicidal thoughts and 50% have symptoms of depression.

In 2019, there have been over 80 instances where regions, counties or municipalities have passed resolutions declaring themselves free from so-called "LGBT ideology", or have adopted "Regional Charters of Family Rights", discriminating against single-parent and LGBTI families.

In 2019, there have been over 80 instances where regions, counties or municipalities have passed resolutions declaring themselves free from so-called "LGBT ideology", or have adopted "Regional Charters of Family Rights", discriminating against single-parent and LGBTI families. These resolutions call for local governments to refrain from taking any action to "encourage tolerance of LGBTI people". In the resolution condemning such zones, the European Parliament pointed to the growing hate speech by public and elected officials and public media, as well as attacks and bans on pride parades and awareness-raising actions such as Rainbow Friday[21]. The goal of politically-motivated and orchestrated smear campaign was to slander non-heteronormative people either as a threat to the Polish culture/nation or as paedophiles to divert public attention from the paedophilia scandal in the Church. Only 40% of society is immune to homophobic propaganda.[22] Sixty percent of Poles support non-heteronormative civil partnerships, 42% – marriage equality and 22% – adoption by same-sex couples.[23] In 2019, there was a 300% increase in the number of pride parades in Polish cities and towns (up to 24), and some of them were hindered by violent attacks.

After the failure of the Gender Accordance Act in 2015, no other work was carried out to improve and change the legal (and medical) situation of transgender persons. Gender recognition requires a lawsuit against one's own parents for wrong gender assignment. Since most persons who undergo gender recognition are legally adults, the procedure violates transgender human rights standards. Due to lacking uniform national protocol on medical transition, many doctors use their own diagnostic tools, such as a notorious "real life test". Transgender people need a psychiatric diagnosis, which is extremely stigmatizing. Reassignment requirement involve medical, surgical interventions and divorce. Access to trans-specific healthcare is strongly restricted because of a very narrow group of specialists. Medical treatments related to transition are not covered by the public health insurance.

Gender-based violence

In 2005, Poland passed the Act on Counteracting Domestic Violence that provides a comprehensive framework for the protection of victims of domestic violence, yet it does not address prevention and prosecution sufficiently. Both the government and municipalities are obliged to create programmes for combating domestic

violence (94% of municipalities fulfil this obligation)[24]. Domestic violence is not a separate criminal offence, so it may fall under different criminal code articles, such as grievous bodily harm, threats, insult, or mistreating another person mentally and physically.

Main problems: gender-blindness of policies/implementation, restraining/eviction orders used too seldom/late (on average – 5 months),[25] insufficient specialist help, no institution to coordinate national anti-violence programmes, stereotypes among judges and police officers, no specific criminalization of: economic and domestic violence, marital rape; too narrow definition of domestic violence and rape; the use of reconciliatory mediation, insufficient prosecution/punishment of perpetrators.[26]

Gender-based violence, in particular sexual violence remains underreported, both to law enforcement and in opinion polls. In 2018, Police noted 165,000 cases of domestic violence cases, women being 74% of victims, minors – 14%, men – 12%. Twenty-five percent of Poles experienced domestic violence, out of which 56% experienced psychological violence, 25% – physical, 18% – economic.[27] Each year, 400–500 women lose their life due to domestic violence.[28] 87% of women experienced sexual harassment, and 22% – rape.[29] Procedures for the police and medical facilities dealing with victims of sexual violence are rarely known and observed.

Victims are entitled to comprehensive assistance covering medical, psychological, legal, and social help. There are 35 specialist support centres with 591 places for victims of domestic violence, which in 2017 helped 8,500 people,[30] and a state-supported 24/7 helpline. Under the Blue Cards Procedure, the interdisciplinary team is supposed to provide a victim with an individual assistance plan and to offer educational and corrective measures to a perpetrator (only 2–3% participate). In 2018, 73,000 Blue Cards Procedures were initiated[31].

The concept of "gender-based violence" has been severely hindered by the war on gender waged to block signing the Istanbul Convention. Ultimately, it was signed in 2012 and ratified in 2015. The conservative government (in power since 2015) has been downgrading the scope of gender-based and sexual violence. The Ministry of Justice deprived experienced NGOs of funds for combating gender-based violence. In 2017, the government considered withdrawing from the Istanbul Convention. Instead, its provisions are supposed to remain a dead letter. The government has been implementing family mainstreaming policies to fossilize/promote traditional gender roles/families. A total of 14.4% of respondents assume that violence may be justified, 20% – consider only (severe) physical violence as violence. About three quarters of those affected by domestic violence never asked for help from outside the family.[32]

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Romania

Abortion and post-abortion care

Romania has made notable progress in implementing specific initiatives to improve access to reproductive health and sexuality information and services. However, there are significant barriers in implementing strategies and initiatives assumed by Romania as part of regional European and global agreements, as well as in the implementation of specific policies and measures in reproductive health, as part of the 2014–2020 National Health Strategy. These drawbacks and barriers are reflected in the state of the population's health specific indicators that keep showing inadequate levels, as compared to the European regional context.

Abortion on demand is legal in Romania up to 14 weeks (interpreted as 12 weeks gestation). Past this limit, the law permits therapeutic abortion that can be available for medical reasons without being penalized. Abortion on request is available in medical facilities for a fee, as it is not covered by health insurance.

Law 95/2006 on the healthcare reform[1] (Article 654) sets as a general rule the obligation of the physician, nurse/midwife, employees of a facility providing medical services to secure medical care for patients who have the right to healthcare at the facility, in keeping with legal regulations. Religious or conscience motivations by medical staff are not included in the law, nor is a list of situations in which physicians may stop treating patients. In conclusion, interrupting doctor-patient relations upon physicians' initiative on religious or conscience grounds is outside legislation in force.

According to research conducted by the Euroregional Center for Public Initiatives (ECPI),[2] the number of medical facilities that performed abortions on request irrespective of religious holidays was considerably lower in 2013 as to previous years – three medical facilities carried out 15 procedures in December 2010 and 5 in April 2011.

Anti-choice narrative around abortion is shaped by the formerly called Coalition for the Family, the presence of which used to be seriously felt publicly, particularly before and during the referendum concerning the traditional family in 2018. Currently, the Coalition is self-proclaimed The Together Platform and operates online and also organizes annual Marches for Life in Romania and Republic of Moldova.

According to the 2016 Reproductive Health Survey,[3] the total abortion rate was 0.26 in 1,000 women, equal to 2004, but lower than in 1993 (1.13). The abortion rate is higher in rural areas and small towns, and among married and less educated women, the same as in previous reproductive health surveys. The procedure is available in public hospitals and private clinics for various prices. For instance, medical abortion is available at the Marie Stopes International Romania Clinic[4] for 136 Euro and at the Manual and Electric Vacuum Aspiration for 209 Euro, but this is not affordable for most women who seek the procedure at public hospitals. Statistics for illegal procedures performed are not collected or reported.

Contraception

The 2014–2020 National Health Strategy[5] purports to reduce the number of unwanted pregnancies, a recourse to abortion on demand and maternal mortality due to abortion by increasing the capacity of the family planning program that should include free contraceptives for vulnerable populations, training family physicians in family planning, and enhancing access to information and raising the awareness the population regarding reproductive health options. Still, a detailed action plan has not yet been implemented and free contraceptives are not distributed to vulnerable populations.

In keeping with the national plan, contraceptives are supposed to be dispensed free of charge in family planning clinics and family physicians included in the national program, through obstetrician-gynaecologist wards in hospitals, as well as through gynaecology departments that offer abortion procedures on demand. The categories of clients who benefit from free contraceptives are the unemployed, school and university students, people in families with social benefits, women in rural areas, women who have had an abortion in a public health facility, as well as other people with no income, who submit a statement in this regard.

According to the 2016 Reproductive Health Survey, 48% of women of reproductive age were using contraception.

In principle, contraception is available at family planning clinics, but in reality, very few family planning physicians actually have them and dispense them to clients, who are mostly referred to pharmacies. In Bucharest, the capital city, for instance, there is only one family planning clinic that still has pills, the only type of contraceptive available. Contraceptive supplies are imported and sold in pharmacies, and not distributed to family planning clinics by the Ministry of Health.

Family physicians, although trained in family planning by the Society for Education in Contraception and Sexuality (SECS),[6] are not allowed to dispense contraceptives, but only prescribe them to clients, who later purchase them in pharmacies. One hundred community medical workers were also trained in family planning, but they are not currently performing any related tasks. According to Ordinance 18/2017,[7] there should be collaboration between community medical workers and the family physicians trained in family planning, particularly since the family planning clinic network has lost its role in supplying services, providing contraceptives and training personnel.

In keeping with the most recent Contraception Atlas ranking, Romania ranks at 54.4%,

based on policies, access to contraceptives and family planning counselling.[8]

According to the 2016 Reproductive Health Survey,[9] 48% of women of reproductive age were using contraception, 38.7% modern methods, and 9.6% traditional ones. In 2016, the most frequently utilized contraceptive methods were: condoms 15.1%, pills 11.2%, tubal ligation 5.4%. The so-called "conscientious objection" is not an obstacle in obtaining contraception. Emergency contraception is also accessible and affordable at pharmacies, and there is concern that it could be abused by young women, whose sexual and contraceptive experience increased in 2016 to 67.1% from 49.0% in 2004. More than half of the young women who had at least one sexual experience stated they had used a contraceptive method during their first sexual intercourse.

Sexuality Education

No form of sexuality education is conducted in schools formally, except as part of an optional subject called 'health education' and only if school principals/home room teachers allow specialized NGO volunteers to hold classes. It is labelled "curriculum upon school decision".

The Ministry of Health, in its National Health Strategy for 2014–2020,[10] set the strategic objective no 1.2., which aims to reduce the number of teenage pregnancies and abortions.

The National Strategy for Reproductive Health and Sexuality 2012–2015[11] has remained a draft, as it has neither been officially adopted, nor financed. Objective A1/OG4/OS3 of this draft strategy includes reducing the rate of teenage pregnancies to 10% and defining a minimal knowledge package on reproductive health that should be offered in school, introducing sexuality education teacher training in universities, and involving state family planning doctors in sexuality education in schools.

In its National Youth Policy Strategy 2015–2020,[12] the Romanian Ministry of Youth and Sports sees the high adolescent fertility and abortion rates in adolescents under 19 in Romania as "an alarm signal" and "a special challenge".

According to the Child Protection Law, "Life education, including sexuality education for children" is mandatory in Romanian public schools, and has a clear purpose: "prevent their contraction of sexually transmitted diseases and pregnancies among minors".[13]

According to the 2016 Reproductive Health Survey,[14] young women's sexual and contraceptive experience increased to 67.1% from 49.0% in 2004. More than half of the young women who had at least one sexual experience stated they had used a contraceptive method during their first sexual intercourse.

Volunteers from specialized NGOs hold occasional classes in the schools that agree to their presence and have no objections from parents, who must sign a consent form. Despite the fact that hundreds of teachers have been trained in how to teach sexuality education classes, less than 6% of schools students in Romania have had the opportunity.

A very good practice has been established by the Youth for Youth Foundation,[15] which has been striving to supply sex education classes in schools for many years, despite the fact that they have been barred by the opposition since 2015.

Another best practice is the SEX vs THE STORK online sexuality education platform, created by Adriana Radu in 2013. To date, SEXUL vs BARZA[16] / SEX vs THE STORK has been watched over 10 million times on YouTube.

No form of sexuality education is conducted in schools formally

School materials are not available, except for those provided by the Youth for Youth foundation and the SEX vs THE STORK YouTube platform.

In 2014–2015, the Coalition for Gender Equality initiated an advocacy campaign[17] to bring the necessity to teach sexuality education in schools into the public debate in order to reduce the incidence of unwanted pregnancies and sexual violence in adolescent girls and facilitate informed access to contraceptive methods. In addition, the SEX vs THE STORK Association organized a national policy round table with international participation, hosted by the Chamber of Deputies health and family commission in 2018.

Pre- and antenatal care

The Ministry of Health recommends ten prenatal consultations for pregnant women in keeping with the safe motherhood criteria. According to the 2016 Reproductive Health Survey,[18] 92.9% of the 5,051 women surveyed used specialized prenatal services in both rural and urban settings. Those who did not use the services at all stood at 7.1% (6.1% in rural and 8% in urban areas).

Prenatal check-ups were mostly provided by obstetrician-gynaecologists (86.5%), followed by family physicians (58.2%), nurses (10.3%) and midwives (4.7%). Most births in the 2015–2016 interval occurred in maternity hospitals or in public/private obstetrics-gynaecology wards (98.4%). In public hospitals, births were also attended by midwives or nurses, while in private clinics, they were attended by an obstetrician. Out of the total number of births, natural deliveries accounted for 61.8%, while C-sections for 37.1%. 42% of women received post-natal care at home, with no notable differences between urban or rural areas.

The medical personnel's attitude during home calls was considered 'good' and 'very good', scoring up to 90.7%, and deemed unsatisfactory by 8% of mothers, mostly from rural areas, aged 15–19, with no occupation and low education, as well as a low socio-economic level.

Prenatal leave spans 14 paid weeks and is granted to women, while paternal leave is unpaid and granted immediately after delivery.

Law 120/09.07.1997[19] regarding paid maternal leave specifies that women insured by the social benefits system, as well as women in the military benefit from maternal leave up to 2 years, for which they receive child rearing allowance that amounts to 85% of the gross salary.

LGBTQI+ Rights

The status of the LGBTQI+ community in Romania is heavily affected by negative general social attitudes regarding sexual orientation and gender identity. The National Council for Combating Discrimination, the national equality body, constantly identifies LGBT as one of the top five most discriminated against groups in their annual survey on perceptions and attitudes regarding discrimination. Current anti-discrimination legislation mentions sexual orientation, however gender identity and gender expression are not explicitly protected.

A selection of existing data reveals the general level of societal homophobia and transphobia:

- 54% of Romanians do not believe gay, lesbian and bisexual people should have the same rights as heterosexual people. Those who agree that LGB individuals should have

equal rights represent 36% of the population, the lowest recorded number in the entire European Union.

- 69% of Romanians think there is something wrong is a sexual relationship between two persons of the same sex, the second lowest EU member state indicator.[20]

This lack of knowledge and understanding of SOGI on the part of the general population is speculated for political purposes, and homophobia and transphobia are instrumentalized under the construct of "gender ideology". Between 2015 and 2018, a religious-led coalition drafted a citizens' initiative for a constitutional referendum amending the definition of family in the Romanian Constitution as being based on marriage between a man and a woman. This constitutional referendum failed to be passed due to a strong boycott campaign, but it served as a strong contributor in demonizing the entire LGBT community with the support of the dominant Orthodox Church and Evangelical churches.

There is a large gap between existing anti-discrimination legislation and hate crime legislation and their implementation. The legal remedies that can be obtained are rather weak and inconsistent in terms of discouraging the agents of discrimination and violence, while hate crimes are not properly identified and investigated. The fragility of the institutional mechanism for combating and preventing discrimination and hate crimes in Romania is associated with a striking absence of public policies in the sexual and reproductive health and rights area: the lack of National HIV Strategies and National Strategy on Sexual and Reproductive Health for more than 10 years.

The absence of such public health policies has a disproportionate impact in the lives of LGBTQI+ people; they are not recognised as specific beneficiaries of these services. The 90–90–90 U.N. target to help eliminating AIDS epidemic is practically impossible to be met in Romania by the 2020 deadline. In the absence of HIV/ITS prevention interventions, there is a significant increase of new HIV cases among MSM. Official protocols and health literacy do not exist among health professionals dealing with transgender people, while current legislation is vague and contradictory regarding gender-affirming surgery and name change in civil status documents.

According to Rainbow Europe data, in terms of laws and policies affecting the lives of LGBTQI+ individuals, Romania ranks 37th out of 49 European countries, standing at 21.32%.[21]

Gender-based violence

Romania ratified the Istanbul Convention in 2016 and will be monitored by GREVIO in 2020.

Currently, Romania does meet the standards of the Istanbul Convention in terms of providing the national women's helpline, but does not meet the standards with regards to providing women's shelters, since the majority of beds are currently missing. At the same time, state financial support for services to ensure long-term sustainability is lacking.

Some services are available for survivors of sexual violence, but specific information on the number of existing services is unavailable. For example, there are several women's centres in Romania which provide support for women survivors of GBV. They provide counselling, legal advice and advocacy services, including: legal options, housing, employment, other support services, representation at court, police, and social services. Most of these centres are run by NGOs. A state agency, National Agency for Equal Opportunities between Women and Men, is responsible for coordination in the area of Gender-Based Violence, but does not have funding available for services run by NGOs.

Protection against GBV is still very low and the issue is not given sufficient priority by the authorities. There is one state-run national women's helpline in Romania which is available 24/7, free of charge, but the quality of this service is questionable. Victim-blaming is very common among state-run services like police, social care, courts. It is known that 12 women-only shelters are run by women's NGOs with a gender-specific, feminist approach. The state-run shelters do not seek to address violence from a women's rights perspective. Women-only shelters are available only in major cities, and the average length of stay is from 3–6 months.

There are no functioning state-run integrated support centres for survivors of rape in practice. Survivors are often retraumatised during hearing proceedings when they decide to report the abuse.

The impunity of perpetrators is still a major issue, especially in the area of sexual violence. Very few perpetrators are actually convicted and when a sentence is reached, they often benefit from shortened prison sentences for "good behaviour".

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15 Youth for Youth Foundation: http://raa.ro/oldfg/www.fondulglobal.ro/en/sub-recipients/hiv/youth-for-youth-tnt.html

16 SEXUL vs BARZA (SEX vs THE STORK): http://www.sexulvsbarza.ro/; https://www.youtube.com/user/SEXULvsBARZA

17 Coalitia pentru Egalitate de Gen (Coalition for Gender Equality): https://ongen.ro/?s=advocacy+pentru+educatie+sexuala

18 Studiul Sanatatii Reproducerii Romania 2016 (Reproductive Health Survey Romania): https://insmc.ro/uploads/documents/STUDIU_IOMC_final_23.09.2019_BT.pdf

19 LEGE nr.120 din 9 iulie 1997 privind concediul platit pentru ingrijirea copiilor in varsta de pana la 2 ani (Law no. 120 of 9 July 1997 on paid leave for child rearing up to 2 years): http://www.cdep.ro/pls/legis/legis_pck.htp_act?ida=11424&frame=0

20 European Commission, Special Eurobarometer 437 - Discrimination in the EU in 2015, p 437 T244, http://ec.europa.eu/COMMFrontOffice/PublicOpinion/index.cfm/ResultDoc/download/DocumentKy/68004.

21 Rainbow Europe - Country Ranking. 2018: https://rainbow-europe.org/country-ranking

Russia

Abortion and post-abortion care

Since the Soviet Era, women in the Russian Federation have had the legal right to abortion on request within the first 12 weeks of pregnancy. Adolescents under the age of 15 must have the consent of a parent or guardian in order to terminate an unwanted pregnancy. In the second trimester, from 12 to 22 weeks of pregnancy, the Ministry of Health (MoH) permits abortions in the case of specific medical conditions (a list of indications has been approved by the Russian Government) and only one social indication – rape (the result of crime). Abortions are carried out in authorized medical facilities by the trained doctors OB/GYNs. The standard safe abortion procedures, manual vacuum aspiration or medical abortion, are accessible throughout the country for the Russian citizens free of charge (covered by the State Health Care Standard Package – Mandatory Health Care Insurance), foreigners can receive the services for reasonable price in both governmental clinics and commercial structures.[1] Before the abortion, a woman is given the time to make a final decision on the termination of her pregnancy (48 hours in the case of 4–7 and 11–12 weeks and 7 days in the case of 8–10 weeks). According to a recommendation from the Russian MoH (2016) women have the right to informed consent (so with access to information about possible health risks related to the procedure) and to receive counselling before an abortion, during which an ultrasound picture is shown to the pregnant person and they listen to the heartbeat of the embryo in order to convince them not go ahead with the abortion. Women are also given recommendations about contraception methods (condoms, hormonal pills, intrauterine device, etc.). There is a strong movement of religious fundamentalism – anti-choice conservative groups are well financed and well organized, and they are numerous in Russia. Anti-abortion rallies are carried out regularly, signatures for anti-choice petitions are collected annually. The recent petition for banning free abortions collected a million signatures – anti-choice supporters want to withdraw abortions from the Mandatory Health Insurance Package. However the Russian MoH does not respond favourably to this initiative. During the last 5 years, the number of abortions has decreased by nearly 40% (1 million in 2013).[2] In 2018, 56,718 abortions were provided in Russia, down from previous years –the average number of abortions is 18 per 1,000 fertile women, or 37.5 for every 100 deliveries. Most often (54%), abortions are conducted in health care facilities. As many as 18% of abortions are performed spontaneously, but they are nonetheless included in these statistics. Moreover, 17% of abortions are medical abortions occurring in early stages of pregnancy. Unspecified (community-acquired) abortions accounted for 4%. The statistics of criminal abortions included only those cases that ended in state medical institutions or otherwise became known to the MoH. On the national scale, their number is small – 355 cases, which amounts to 0.06%.[3]

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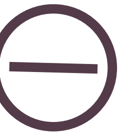
Abortion for social reasons is taken into account in the state statistics separately. Since 2012, there is only one social indication for terminating a pregnancy within the period of 12 to 22 weeks – pregnancy being a result of rape. In 2017, 22 pregnancies were terminated for social reasons. Around 7.3% of abortions were performed for women for whom it was their first pregnancy. Over 30 abortions per 1,000 fertile women in are registered 15 territories, 10 abortions per 1,000 in 13 territories, and 25–28 in the major cities of the country.[4]



Contraception

Access to a wide range of contraception is not guaranteed by the State, nor is it refunded or privileged for any of the socially marginalized groups (adolescents and youth, people living with HIV, victims of sexual violence, people who have had an abortion in the past year, people with psychosocial disabilities, people with low incomes).[5] Combined oral contraception (COC), IUDs or hormone-containing IUS, male condoms or emergency contraception (EC), and more rare methods like vaginal ring, combined patch can be bought by the patient at pharmacies. The most popular COCs cost EUR 10–50 per cycle, Ulipristal or Levonorgestrel Emergency Contraception costs on average around EUR 8–10, which is affordable for most of the population. Despite a wide range of available contraceptive methods, the proportion of unwanted pregnancies in Russia currently reaches 41%[6], exceeding the respective values in developed countries by nearly twofold.[7] Therefore, the prevention of unwanted pregnancies remains a challenging issue for Russian society. Most individual Russian cohort studies indicated that the frequency of using modern contraceptive methods is low, and the unmet need for it up to 40%. Counselling and assistance in choosing contraception in Russia are available, and are performed by obstetricians and gynaecologists in women's clinics and maternity hospitals; however, this work is not a priority for them, and the payment is not funded by obligatory medical insurance.

According to the Russian MoH, in early 2015, there 11.5% of women of childbearing age used IUDs (in 2005 – 13.7%) and hormonal contraceptives – 12.7% (2005 – 9.4%).[8] According to a study by Federal State Statistics Service, Russian Ministry of Health and WHO/UNFPA Reproductive Health of the Russian population, conducted in 2011, 38% of women had

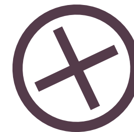
used contraceptives at some point, and 52% – used them at the time of the survey.[9] According to the respondents aged up to 17, a quarter of young Russian women have had a sexual experience (this parameter was defined by the presence of at least one sexual contact). This figure increased to 42% by age 18, and up to 61% to 19 years. In most cases, the respondents' first sexual contact occurred before marriage. As many as 59% of young women aged 15–24 who had had a sexual experience, said that they or their partners used these or other methods of contraception during their first sexual intercourse.[10]

There is no recent published data on contraceptive method-mix at hand.

Sexuality Education

In Russia, there is no mandatory form of school-based sexuality education in the school curriculum. In some institutions/schools, initiatives are undertaken to talk about pregnancy and STI/HIV prevention, but they primarily remain optional after mandatory classes. Health education is not a part of the school curriculum. National and international pro-choice civil society organizations are not allowed to work with the school children, except religious NGOs that promote abstinence only. According to the survey in 2012, 59% of young women aged 15–24, who had had a sexual experience, said that they or their partners used methods of contraception during their first sexual intercourse. The vast majority used a condom (53% of all young women with sexual experience); a very small proportion of the respondents use other modern contraceptive methods (2%) or coitus interruptus (4%). However, 41% did not use any form of contraception during their first sexual contact.[11] Currently, there is no up-to-date representative data evaluating young people's knowledge about sexuality and/or contraceptive use.

Over the past 15 years, the age structure of newly diagnosed patients has radically changed. In 2000, 87% of patients were diagnosed with an HIV infection before the age of 30. Adolescents and young people aged 15–20 years in 2000 accounted for 24.7% of newly diagnosed cases of HIV infection; and, as a result of an annual decrease in 2016, this group amounted to only 1.2%.[12] Prof. Pokrovsky (The Head of the Russian HIV/AIDS Federal Centre) states that: "The fact that the Ministry of Health does not prevent HIV infection is explained by the thick spirit of incense that hangs over officials. Condoms cannot be advertised because it "encourages debauchery and reduces fertility"; clean syringes should not be given, as this "stimulates the use of drugs"; opioid substitution therapy is the "legalization of drugs". We do not have prostitutes, since such a profession is not registered by the Ministry of Labour, and legalizing prostitution is immoral. Sexual education in schools is possible, but it must be chaste".[13]



Pre- and antenatal care

Safe Motherhood and the health of new-born children is a state priority, thus prenatal care and all necessary prenatal examinations are accessible for future mothers and are covered by the state everywhere in the country. There are no differences in accessing prenatal care in urban and rural settings. The Federal Law #323 – FZ on the Basis's of Health Care of the citizens of the Russian Federation contains three Articles (51, 52, 53) devoted to the care of future mothers and their new-born children.[14] Since the early 1990s, the Standards for Monitoring Pregnant Women in Health Care Settings were introduced by the Russian MOH. These standards include a wide variety of compulsory clinical examinations (therapeutic check, ophthalmologist, surgeon, etc.) during the prenatal period for all pregnant women, and all the examinations and tests are provided to the Russian citizens for free. There should be no less than six prenatal care visits during pregnancy: apart from general blood tests, HIV testing is required, ultrasound checks are conducted no less than three times during pregnancy, and blood pressure is measured on a regular base. The standards on safe maternity conditions recommend that women and new-borns receive a medical check within 2–5 days after discharge from the medical institution in a health care facility or at home.[15] The Russian Government assures both paid maternal and paternal leave. Mothers can take leave starting at the 30th week of pregnancy for up to three years with varied payment schemes depending on the number of children being raised. The Maternal (Parental) Capital for every next child after the first one was introduced several years ago. At the moment, it is about EUR 8,000, the family receives it as in-kind financial source (Certificate) when the second (third or fourth) child is three years old.[16]

In June, 2013 the Russian Parliament adopted a law designed "against homosexual expression" which was a chain link in the overall conservative turn, including rights for rally and the so-called "Foreign Agent" NGOs punishment.

LGBTQI+ Rights

The Russian Orthodox Church is the main opponent of liberalization (and "westernization") of Russian legislation and any form of civil society initiatives aimed for bettering access to freedom of sexual and reproductive rights. In June, 2013 the Russian Parliament adopted a law designed "against homosexual expression" which was a chain link in the overall conservative turn, including rights for rally and the so-called "Foreign Agent" NGOs punishment. The fore mentioned legal act forbids "promotion of the nonconventional sexual relations among minors" (in the former version of the law it was called just "gay propaganda"). Formulations of the law are so indistinct that under it, people could be held responsible for any activity that protect of the rights of homosexuals – from an article in the newspaper to announcements before campaigns of public informing on rally and demonstrations. Its purpose consists not only of the criminalization of information about homosexuality, but also in limiting access to reproductive health services and facilities, and also in aggressive promotion of ideas of "a traditional family" at the expense of government subsidies and other privileges.

Gender-based violence

Russia is the only country within the Council of Europe where there is no law against domestic violence. During the last decade there were 40 attempts to introduce versions of such a law in the Russian Parliament; none of the drafts passed through the hearings or readings. Furthermore, in 2017, cases of beating were excluded from the Criminal Code, and are now cases of domestic violence are treated as an administrative offence.[17] In October 2019, the public was informed about the order of

the H.E. Mrs. Valentina Matvienko, Head of Federation Council to form a Working Group in order to prepare a draft law by the end of December 2019. At the same time, according to Ministry of Internal Affairs, from January to September 2019 there were over 15,000 crimes against women in the sphere of family and household relationships. According to femicid.net, from the beginning of 2019, 1,198 women died at the hands of their husbands and partners. Nearly 80% of women who stay behind bars due to intentional killing have committed a crime in self-defence. However, the Russian Ministry of Justice gave an official reply to the questions from the European Court on Human Rights about the issue of domestic violence in Russia, which stated that the figures are exaggerated.[18]

On July 3, 2016, Federal Law 323-FL on the introduction of amendments to the Criminal Code of the Russian Federation and the Code of Criminal Procedure of the Russian Federation concerning the improvement of the bases and an order of release from criminal liability was adopted. Beatings that are committed by close relatives are not addressed by this law. Now, beating family members or other close relatives are tried as administrative offenses. Thus, the person which is repeatedly attracted for drawing a beating will be attracted by the criminal legislation.

If a victim informed law enforcement agencies about the occurrence of violence for the first time, then the offender will be threatened with only administrative responsibility, but it also provides that he caused to the victim physical pain which did not lead to such negative consequences as: disorder of health, temporary disability. The punishment includes a fine ranging from 5 to 30 thousand rubbles; administrative detention from 10 to 15 days; 60 to 120 hours of community work. The police take action only if the victim suffers injuries, bruises, hematomas, changes, etc.

Russia is the only country within the Council of Europe where there is no law against domestic violence.

Currently, there is an active discussion about the draft law concerning the prevention of domestic violence in the Russian Federation.

Official source do not provide reliable statistics on domestic violence. We have only the results of sociological research conducted by the Levada Center for opinion polls in September, 2019. According to the polls, practically every fifth respondent (19%) is aware of cases of physical violence (beating, blows) in families, and every twentieth answered that "such cases happen in my own family" (5%). Women more often than men spoke about similar cases and to a thicket regarded these or those actions as violence. More than a half of the respondents (59%) are convinced that women must contact the police if they are beaten by their husbands. At the same time, a considerable part of the respondents also supported an informal solution – contacting the police through relatives, friends or between spouses.

1 Нормативно-правовые документы, регламентирующие вопросы прерывание беременности в РФ (in Russian) http://www.ru486.ru/pravo.htm#7

2 Статистика снижения числа абортов в 2013-2016 годах (in Russian) https://newsrussia.media/society/6886-chislo-abortov-za-poslednie-pyat-let-snizilos-na-250-tysyach-sluchaev.html (2013-2016)

3 Abortions on Social Indications (in Russian) https://materinstvo.ru/art/19733

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5 Osnovnyye pokazateli zdorov'ya materi i rebenka, deyatel'nost' sluzhby okhrany detstva i rodovspomozheniya v Rossiyskoy Federatsii (Key indicators of maternal and child health, child welfare service activities and obstetrics in the Russian Federation) (in Russian). Moscow, 2013. 162 p.

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8 Dikke GB, Erofeeva LV. Modern features of National Contraceptive Awareness, use and efficiency (in Russian). Voprosy ginekologii, akusherstva i perinatologii (Questions of gynecology, obstetrics and perinatology). 2014; 13 (5): 63-71

9 Prilepskaya VN. From abortion to preserve the reproductive health: a new contraceptive (in Russian). Farmateka. 2013; 12 (265): 46-49

10 Denisov BP, Sakevich VI. The use of contraception in Russia (based on a sample survey) (in Russian). Dokazatel'naya meditsina i klinicheskaya epidemiologiya (Evidence-based medicine and clinical epidemiology). 2009; 1: 34-39

11 Ibidem

12 Statistics on STIs, HIV and Hepatites https://spid-vich-zppp.ru/statistika/ofitsialnaya-statistika-vich-spid-rf-2016.html

13 Pokrovsky` Interview https://spid-vich-zppp.ru/statistika/ofitsialnaya-statistika-vich-spid-rf-2016.html

14 Федеральный закон Российской Федерации от 21 ноября 2011 г. N 323-ФЗ "Об основах охраны здоровья граждан в Российской Федерации" http://www.ru486.ru/

15 Ibidem

16 Ibidem

17 Reconciliation of parties included in domestic violence bill https://www.svoboda.org./a/

18 Federation Council Releases Domestic Violence Bill https://trrain.ru/

Albania

Albanian Family Planning Association

Armenia

Society Without Violence   Women's Resource Center   Women's Rights Center

Azerbaijan

Center "Women and Modern World"

Belarus

Women's Independent Democratic Movement of Belarus

Bulgaria

Bulgarian Family Planning and Sexual Health Association
Bulgarian Gender Research Foundation   Gender Education, Research and Technologies
Demetra Association   Gender Alternatives Foundation

Bosnia and Herzegovina

Sarajevo Open Center

Croatia

B.a.b.e.   CESI   Women's Room   PaRiter

Georgia

HERA XXI   Real People, Real Vision   Women's Center

Hungary

PATENT   BOCS Foundation

Kazakhstan

The Legal Center for Women's Initiatives "Sana Sezim"

Lithuania

Family Planning and Sexual Health Association

Latvia

Latvia's Association for Family Planning And Sexual Health

North Macedonia

Association for emancipation, solidarity and equality of women H.E.R.A. Shelter Center

Moldova

Family Planning Association Reproductive Health Training Center

Poland

Federation for Women and Family Planning Ponton Group of Sex Educators

Romania

A.L.E.G. AnA: Society for Feminist Analysis Euroregional Center for Public Initiatives
The East European Institute of Reproductive Health

Russia

Novogorod Gender Center Russian Association for Population and Development

Slovakia

Pro Choice

Tajikistan

Gender and Development

Ukraine

Women Health and Family Planning Charitable SALUS Foundation

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