CHAPTER 2

SETTING THE CONTEXT

BOX 2:

QUESTIONNAIRE SYNTHESIS FILE

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

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

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

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

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

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

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

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

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

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

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

Other issues

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. Who are the different players in the region?

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

8. What are the factors that affect SRHR?

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

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

9. How can we facilitate access to SRH services?

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

HEALTH AND DEMOGRAPHY IN CEE

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

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

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

WOMEN'S EMPOWERMENT[7] AND SRHR

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

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

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

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

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

SIGNATORIES TO INTERNATIONAL HUMAN RIGHTS INSTRUMENTS AND CONFERENCES

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

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

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

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

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

Table 1: Status Of Major International Human Rights Instruments

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

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

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

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

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

NATIONAL MACHINERY FACILITATING WOMEN'S EMPOWERMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

LACK OF RECOGNITION OF WOMEN'S HUMAN RIGHTS

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

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

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

SON PREFERENCE

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

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

FUNDAMENTALISM

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

VIOLENCE AGAINST WOMEN

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

MEASUREMENTS OF WOMEN'S EMPOWERMENT[37]

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

GENDER DIMENSIONS OF DEVELOPMENT

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

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

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

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

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

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

GENDER EMPOWERMENT MEASURE

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

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

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

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

EDUCATION OF WOMEN AND GIRLS

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

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

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

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

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

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

LABOUR FORCE PARTICIPATION

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

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

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

Source: Human Development Report 2011.[45]

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

POLITICAL PARTICIPATION OF WOMEN

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

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

Table 5: Percentage of parliamentary seats occupied by women

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

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

WOMEN'S RIGHTS ORGANISATIONS

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

OVERVIEW

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

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

HISTORICAL BACKDROP

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

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

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

THE DIRECTION OF REFORMS

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

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

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

CURRENT SITUATION

Table 6: Consolidated National Health Accounts for CEE Countries

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

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

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

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

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

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

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

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

TOTAL HEALTH EXPENDITURE

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

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

PER CAPITA EXPENDITURE ON HEALTH

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

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

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

GOVERNMENT EXPENDITURE ON HEALTH AS A PROPORTION OF TOTAL HEALTH EXPENDITURE

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

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

PRIVATE EXPENDITURE ON HEALTH AS PERCENTAGE OF TOTAL EXPENDITURE ON HEALTH

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

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

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

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

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

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

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

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

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

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

SUMMARY

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

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

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

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

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

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

ENDNOTES

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

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