CHAPTER 3

REPRODUCTIVE HEALTH AND REPRODUCTIVE RIGHTS

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

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

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

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

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

POPULATION POLICIES

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

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

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

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

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

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

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

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

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

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

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

CONTRACEPTION

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

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

TOTAL FERTILITY RATES AND WANTED FERTILITY RATES

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

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

Table 7: Total Fertility Rates

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

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

Table 8: Wanted Fertility Rates compared to TFR

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

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

CONTRACEPTIVE PREVALENCE RATES

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

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

Table 9: Contraceptive Prevalence Rate by method

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

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

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

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

Table 10: Male contraception as % of total contraception

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

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

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

CONTRACEPTIVE USE: INFORMED CHOICE

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

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

UNMET NEED FOR CONTRACEPTION

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

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

Table 11: Unmet Need for Contraception

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

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

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

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

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

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

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

OVERVIEW REGARDING CONTRACEPTION

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

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

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

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

ADOLESCENT PREGNANCIES

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

Table 12: Adolescent Fertility Rate

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

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

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

ABORTION

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

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

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

LEGAL STATUS OF ABORTION IN THE REGION

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

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

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

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

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

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

Source: World Abortion Policies 2011 (UN)

USE OF CONSCIENTIOUS CLAUSE

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

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

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

BARRIERS IN ACCESS TO LAWFUL ABORTION

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

CHANGES SINCE ICPD

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

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

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

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

INCIDENCE OF ABORTION

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

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

BARRIERS TO ACCESS

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

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

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

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

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

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

UNSAFE ABORTIONS

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

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

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

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

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

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

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

QUALITY OF CARE

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

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

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

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

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

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

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

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

OVERVIEW REGARDING ABORTION

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

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

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

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

PREGNANCY & CHILDBIRTH-RELATED MORTALITY AND MORBIDITY

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

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

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

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

PREVENTION OF MATERNAL DEATHS

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

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

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

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

ACCESSIBILITY TO MATERNAL HEALTHCARE SERVICES AND INFORMATION

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

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

ANTENATAL CARE

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

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

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

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

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

INTERVENTIONS TO PREVENT MATERNAL DEATHS

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

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

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

Table 15: Antenatal care coverage (number of visits)

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

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

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

SKILLED ATTENDANTS AT BIRTH

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

Table 16: Skilled Health Attendants at Birth

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

Source: MDG indicators official website

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

POSTNATAL CARE[57]

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

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

OVERVIEW FOR PREGNANCY & CHILDBIRTH-RELATED MORTALITY AND MORBIDITY

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

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

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

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

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

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

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

REPRODUCTIVE CANCERS[61]

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

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

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

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

CERVICAL CANCER

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

BREAST CANCER

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

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

OVERVIEW REGARDING REPRODUCTIVE CANCERS

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

CONCLUSION

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

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

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