CHAPTER 4

SEXUAL HEALTH AND SEXUAL RIGHTS

This chapter deals with sexual health and sexual rights. Under sexual health, we will look at sexuality education, sexually transmitted infections (STIs), and HIV/AIDS.

Within HIV/AIDS, we will focus on HIV prevalence and incidence rates, vulnerability and feminisation of HIV/AIDS, laws and policies for people living with HIV/AIDS, programmes for access to voluntary counselling and testing and anti-retroviral therapy and integration of sexual and reproductive health services with HIV/AIDS services. The second section of this chapter will look at sexual rights, although it is a highly contested term in international arenas. "Sexual rights embrace human rights that are already recognised in national laws, international human rights documents and other consensus documents. These include the right of all persons, free of coercion, discrimination and violence, to: the highest attainable standard of health in relation to sexuality, including access to SRH care services; seek, receive and impart information in relation to sexuality; sexuality education; respect for bodily integrity; choice of partner; sexuality education; decide to be sexually active or not; consensual sexual relations; consensual marriage; decide whether or not, and when to have children; and pursue a satisfying, safe and pleasurable sexual life."[1] This WHO working definition is wholly consistent with and does not deviate from the principles of the ICPD PoA.[2] This review seeks to enunciate separately the different components of sexual rights in order to build the discourse and create support for the language among governments and civil society.

We will also look at important indicators of sexual rights. In order to determine the rights around choice of partner, decision to be sexually active or not, consensual sexual relations and consensual marriage, we choose to look at the existence of arranged marriages and forced marriages. As indicators of bodily integrity we look at traditional practices harmful to women and laws on sexual violence and trafficking. As indicators of the rights to the highest attainable standard of health in relation to sexuality, in choice of partner, in consensual sexual relations and to pursue a satisfying, safe and pleasurable sexual life we look at laws around sex work, same sex sexual relations and transgender people.

SEXUALITY EDUCATION

In this section, we will look at adolescent rights and their access to information, education and services.

Therefore, it is important to assess the accessibility of sexuality education and quality of the school curricula. Moreover, we will examine young people's access to service provision for adolescents in terms of their rights: to the highest attainable standard of health in relation to sexuality, including access to SRH care services; to seek, receive and impart information in relation to sexuality; to sex and sexuality education; and to decide to be sexually active or not. These rights have been recently recognised by the 2012's Commission on Population and Development in its Resolution on adolescents and youth.[3]

Today's adolescents face increasing pressures regarding sex and sexuality, with conflicting messages and norms. Sexual activity generally begins at an earlier age than in the past, but young people have inadequate access to accurate information about safe sex and contraception and the percentage of adolescents who are informed and aware of specific methods of contraception and

Sexually Transmitted Infections (STIs) decreased in recent years.[4] Often, sexuality is portrayed in many sexuality education and health information programmes as negative and associated with guilt, fear and disease. The media often provide mixed messages, sometimes distorted or inaccurate and other times very positive.[5] The ICPD PoA acknowledges that adolescents have sexual and reproductive health (SHR) needs that must be addressed. It urges governments to address adolescent SRH issues, including unwanted pregnancy, unsafe abortion and sexually transmitted diseases, including HIV/AIDS, through the promotion of responsible and healthy reproductive and sexual behavior, including voluntary abstinence, and the provision of appropriate services and counselling specifically suitable for that age group.

Table 17: Adolescent Pregnancies – Adolescent Birth Rates

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
Russian Federation	43,9	28	30,1
Ukraine	54,3	29,6	29.9 (2007)

Sources: UN MDG Indicators Database http://unstats.un.org/mdg/Default.aspx; For Georgia- National Statistics; For Ukraine: UNSD&WPP2008

The lack of comprehensive sexuality education is the most burning issue of the region that is being reflected in high teen pregnancy rates and high HIV/AIDS prevalence among young people.

Table 18: Estimated young people living with HIV (2009)

Estimated People living with HIV (2009)							
	Armenia	Azerbaijan	Georgia	Hungary	Poland	Russian Federation	Ukraine
Young women (15-24) prevalence (%)	<0.1	0.1	<0.1	<0.1	<0.1	0.3	0.3
Young men (15-24) prevalence (%)	<0.1	<0.1	<0.1	<0.1	<0.1	0.2	0.2

Source: (http://www.unaids.org/documents/20101123_GlobalReportAnnexes1_em.pdf)

Sexuality remains taboo and official institutions tend to expect families to take care of sexuality education.[6] However, parents who also had no sexuality education at school are not prepared to perform this task.[7] In all surveyed countries, there are peer education and outreach programmes, but their coverage is limited. In Armenia, a sexuality education course is elective and provided on voluntary basis (since 1995). The instruction on sexual and reproductive health is included in the "Healthy Lifestyle" curriculum but it provides only very superficial and biased information promoting nuclear heterosexual family and stereotypical gender roles. Sexuality education is included in the curriculum in Azerbaijan. A survey performed in 2007 in Azerbaijan found that there was unmet need for sexuality education in the country. Sexuality education and information on SRHR are not included in the school curricula in Poland, Russian Federation and Ukraine, where young people are forced to look for information in alternative sources. In Georgia, incorporation of the principles of the "National Concept and Curriculum on Healthy and Harmonious Education" developed within the framework of the UNFPA's Reproductive Health Initiative for Youth in South Caucasus (RHYIC) project in the National Educational Plan, was approved by the Ministry of Education in 2011. This was a big step forward to provide a solid foundation for formal education on RH issues.[8] A new initiative by the Hungarian Government (2012) is to replace the existing sexuality education programme with more uniform teaching on family values and promotion of sex abstinence.[9] Knowledge on HIV/AIDS prevention

among young people is yet another concern. According to the Georgian Adolescent RH Survey (2009), only two adolescents out of every five respondents know that HIV cannot be transmitted via mosquito bite.[10] A similar lack of information is reflected in reports by Polish Group of Peer Sex Educators PONTON, affiliated with the Federation for Women and Family Planning.

YOUNG PEOPLE'S ACCESS TO SRH SERVICES

The Millenium Development Goal for HIV reduction states that, by 2010, "95% of young people should have access to [information, life skills and] services".

The attempt to provide young people with tailor-made SRH services is reflected in activities of UN agencies, NGOs and some governments. However, in countries like Poland and Hungary, reproductive health services are not effectively included in the network of adolescent clinical services.

The gold standard for adolescent-friendly SRH services is that they are "safe, effective and affordable; they meet the individual needs of young people who return when they need to and recommend these services to friends".[11] However, the CEE region lacks youth-friendly sexual and reproductive health facilities and approach. Cultural barriers and stigma, a lack of comprehensive youth policies to further promote and institutionalise youth-friendly SRH services, healthy life-style and information are the main challenges to address.[12]

In 2006, UNFPA launched a three-year regional project, the Reproductive Health Initiative for Youth in the South Caucasus, to be implemented in Armenia, Azerbaijan and Georgia.[13] Within the framework of the project, 12 youth-friendly clinics and 12 youth information centers were established and are still operating in Azerbaijan.

In Armenia, some 32 youth friendly centers were established in the country.[14] Half are affiliated with a healthcare institution and the other half were founded as a part (or on the premises) of either an NGO or quasi-state institution. The main requirements for such facilities are privacy, confidentiality and friendliness of the service. Also in Georgia, centers were established during the realisation of the Reproductive Health Initiative for Youth in the South Caucasus' project, providing free reproductive health counseling, contraceptives, diagnosis and affordable treatment, as well a wide range of reliable information on reproductive health issues. In Hungary and Poland there are no centers dedicated especially to youth and adolescent SRH issues, so young people must seek advice and help at standard facilities. There are no facilities or consultation centres to which young people, who seek advice on various help lines, can be directed. Poland has one gynecological outpatient clinic dedicated to children and adolescents that was established in 2010 in Warsaw.[15] Ukraine has more than 70 Youth Friendly Health Clinics that were developed under the frameworks of a UNICEF project and now are supported and being enlarged by The Ministry of Health of Ukraine.[16] Also in the Russian Federation, UNICEF has supported child and youth friendly clinics since 1999. Earlier, during the Soviet period, "adolescent cabinets" provided a limited range of services, including extensive screening. In 1993, Yuventa, the St. Petersburg City Consultation and Diagnostic Centre on Adolescents' Reproductive Health, under the City Health Committee, pioneered the broader concept of youth-friendly services (YFS). This was the first health clinic in the Russian Federation to provide sexual and reproductive health services exclusively for adolescents. Inspired by the youth consultation network in Sweden and the Brook Advisory Centres in the United Kingdom, Yuventa now logs nearly 250 000 visits every year.[17]

Existing youth friendly facilities represent different care models, ranging from a large clinic that serves as a referral centre, to facilities focusing on primary

care, to stand-alone centres targeting difficult-to-reach young people. It is essential for countries that have established youth friendly facilities to address the issue of sustainability of these facilities under current health reforms. Countries that fail to address specific health needs of young people, like Poland and Hungary must recognize the need to establish networks of youthfriendly services.

OVERVIEW OF SEXUALITY EDUCATION

Although the governments claim the opposite, sexuality education is not integrated in the present curricula in CEE region. It is clear from the lack of provision of education, information, and services to young people who are in dire need of these, that governments in the region are hesitant to recognize the role of sexuality beyond its function in reproduction. In all surveyed countries, young people still face many barriers, some legal, some socially discriminatory, to accessing SRH services.

The denial of young people's right to information, services, privacy and confidentiality significantly impedes their access to sexual and reproductive health[18].

SEXUALLY TRANSMITTED INFECTIONS (STIs)

The ICPD PoA urges governments "to prevent, reduce the incidence of, and provide treatment for, sexually transmitted diseases, including HIV/AIDS, and the complications of sexually transmitted diseases such as infertility, with special attention to girls and women".[19]

Also at ICPD+5, governments were called to ensure that prevention of and services for sexually transmitted diseases and HIV/AIDS are an integral component of reproductive and sexual health programmes at the primary healthcare level. As a general rule, control of STIs has a positive impact on HIV epidemics. Where control measures for STIs have been scaled-up, rapidly growing HIV epidemics have been halted and even reversed. Thus, an effective control programme for STIs reduces the burden of both HIV infection as well as other STIs. Little is known about the prevalence of STIs in CEE region. However, it is clear that major epidemics of STIs currently exist. Widespread poverty, large gaps between the very wealthy few and an impoverished majority, migration due to economic hardship and civil strife resulting in the disruption of households and family life, as well as deteriorating health and education services are among the factors that contributed to increased vulnerability and the spread of STIs. Moreover, the rapid socio-economic changes that have been taking place in the region since the 1990s have been accompanied by a shift in ideology, from collectivism to individualism and consumerism, and by a massive increase in individual risk-taking in terms of unsafe sexual and drug use behaviours.[20]

The highest rates of STIs are found in Rusian Federation, Ukraine and Georgia, but the other surveyed countries

also have relatively high prevalence rates. According to the World Health Organisation (WHO) report published in 2001, there were 22 million new cases of curable STIs in CEE.[21] The report indicated an estimated 6 million new cases of chlamydia infections among adults. Hungary had a prevalence rate of 5.4% amongst asymptomatic women.[22] The same study showed that chlamydia infections were on the rise in Eastern Europe and Central Asia: the number of estimated new cases of chlamydia infections (in 1 million) among adults was 5.07 in 1995, and 5.97 in 1999.[23] There were 3.5 million estimated new cases of gonorrhoea among adults in 1999 in Eastern Europe and Central Asia. An important increase in gonorrhoea rates has been seen in Eastern Europe, in the newly independent states of the former Soviet Union, with the highest rate of 139 per 100,000 in the Russian Federation.[24] The comparison between numbers of estimated new cases of gonorrhoea infections in adults showed an increase from 2.32 million in 1995 to 3.31 million in 1999.[25] According to WHO's report, there was an estimated 100,000 new cases of syphilis among adults in 1999.[26] The report noted that, since 1989, there had been an alarming increase in the syphilis rates in the newly independent states of the former Soviet Union, especially in Russian Federation. Syphilis incidences have increased from 5-15 per 100,000 observed in 1990, to as high as 120-170 per 100,000 in 1996.[27] There were 13 million estimated new cases of trichomoniasis among adults in 1999.[28] Again, the increase in new cases has been observed in the region of Eastern Europe and Central Asia: from 10.07 estimated new cases among adults in 1995 to 13.11 new cases in 1999.[29]

Ukraine and Russian Federation are the most affected by STIs among the surveyed countries. Analysis of numerical data from the region suggests that trichomoniasis is the most common infection, followed by chlamydia, gonorrhea and syphilis.[30] Most public health officials are especially concerned about the increase in syphilis, which, if left untreated, can have adverse effects on an individual's long-term health. Relatively high rates of syphilis – over 100 cases per 100,000 people – have been reported in recent years within the general population in Russian Federation and Ukraine. In the decade after the collapse of the Soviet Union, the rates of syphilis among the general population there reached 277 cases per 100,000.[31]

There is lack of reliable statistics concerning STIs in Poland and Hungary, although according to European Union data, the actual number of infections is larger than the number of registered cases.[32] According to the Surveillance Report by the European Centre for Disease Prevention and Control,[33] chlamydia trachomatis continues to be the most frequently reported STI in the EU. According to this report, the number of reported cases of chlamydia in 2007 was 699 for Hungary and 627 for Poland. As regards the number of reported cases of gonorrhoea, the total number of cases registered in Hungary was 1041, with 330 in Poland.

National surveillance systems for STIs (chlamydia, gonorrhoea and syphilis) consist of a mixture of voluntary, sentinel or selected laboratory systems, and frequently do not represent true national coverage.[34] Data from WHO as well as the European Centre for Disease Prevention and Control, show that major variations in surveillance systems across countries in terms of coverage, completeness and representativeness hamper meaningful comparisons. Hence, comparing numbers and reported rates between countries may be misleading, given these major differences in reporting systems and reporting behaviour. The availability of a screening programme dedicated to STI services or targeted at (sub)-groups of the population, for example pregnant women, may significantly affect the reported number of chlamydia infections. This means that the true number of incidences and prevalence rates are likely to be higher than presented here.[35]

A common denominator for the surveyed countries is a low prevalence of condoms and a biased attitude against their use. Moreover, deficient sexuality education and lack of information on sexual health contribute further to the spread of the STIs.

OVERVIEW REGARDING SEXUALLY TRANSMITTED INFECTIONS (STIS)

In the Central and Eastern Europe region, knowledge about STIs and their prevention is poor, and information is not widespread due to an absence of reliable sexuality education and counselling services.[36]

Infection rates are high, which represents a worrying trend for at least two important reasons. Firstly, the presence of STIs increases the likelihood of contracting HIV. Secondly, high rates of STIs are indicative of risky sexual behaviors. The prevention and treatment of STIs in the countries under review have largely been driven by HIV intervention efforts.[37] Unfortunately, before the shift in the development of the pandemic, HIV interventions in the region targeted high-risk behaviour groups, mostly injecting drug users. As a result, the larger population at risk of STIs were neglected by prevention and treatment programmes in the end of the twentieth century. After an epidemiological trend of increasing HIV incidence rates due to sexual transmission in Central and Eastern Europe was documented, the programmes incorporated STI testing and prevention as a measure to stop increasing HIV/AIDS pandemic.

HIV/AIDS

The high incidence and prevalence of STIs is important also from a biological point of view since co-infection with STIs can facilitate the transmission of HIV.

Eastern Europe and Central Asia is the only region in the world where HIV prevalence clearly remains on the rise. Until 10 years ago, HIV was almost nonexistent in the region – even though by the mid-1990s it had already reached pandemic proportions among the general population in several nations in sub-Saharan Africa and Southeast Asia and among specific population groups elsewhere, such as men who have sex with men (MSM) in the United States. However, by the end of 2004, according to the Joint United Nations Programme on HIV/AIDS (UNAIDS), at least 1.4 million people were living with HIV/AIDS across Central and Eastern Europe and Central Asia, a nine-fold increase over the previous decade. Russian Federation and Ukraine remain the most affected countries by far, with 311,000 and 77,000 officially registered HIV infections, respectively.[38] Estimates from UNAIDS and other organisations are often two or three times higher than the number of infections officially registered in each country – according to UNAIDS, prevalence among the adult population (ages 15-49) has reached 1% in the Russian Federation and 2% in Ukraine[39].

Table 19: Estimated People Living with HIV

Estimated People Living With HIV (adults + children)				
Name of the Country	Estimate Number of Adults and Children		Estimate Prevalence Percent of Adults and Children	
	2001	2009	2001	2009
Armenia	1400	1900	0,1	0,1
Azerbaijan	1300	3600	< 0.1	0,1
Georgia	1200	3500	< 0.1	0,1
Hungary	2800	3000		
Poland	21000	27000		
Russian Federation	430 000	980 000	0,5	1,0
Ukraine	290 000	350 000	0,9	1,1

Source: UNAIDS 2010 Global Report

At least one out of every 100 adults living in these two countries is now estimated to be carrying the virus, representing a threshold above which efforts to turn back the pandemic have failed in many other countries. The number of people living with HIV in CEE/CIS has almost tripled since 2000, reaching an estimated total of 1.4 million in 2009. Compared with 900,000 in 2001, this represents a 66% increase over this time period.[40] While the prevalence remains far lower than those in parts of Africa which are in excess of 20%, it is 10 times higher than in most of Western Europe and the United States, where HIV prevalence among the adult population has barely increased since the mid-1990s.[41]

In Central Europe, over half of the reported HIV cases are registered in Poland, but in this country and its neighbours there has been no marked increase in reported HIV cases over the past five years. In Hungary, adult HIV prevalence remains below 0.2% with between 20-40% of reported HIV cases having been diagnosed in foreigners, often migrants from former Soviet Union countries. HIV prevalence remains relatively low in Central Asia and the Caucasus, but it is rising more quickly in these countries than anywhere else in the CEE region. The actual number of people living with HIV in former Soviet Union countries is thought to be several times larger than officially registered.[42]

THE MOST AFFECTED POPULATIONS

Marginalised populations such as injecting drug users (IDUs), sex workers, men who have sex with men (MSM), and Roma continue to be at the greatest risk for contracting HIV. Many members of these groups remain unable or unwilling to access adequate healthcare or HIV prevention and treatment services because of outright discrimination (such as denial of care) or fear of harassment from authorities.[43]

TRANSMISSION ROUTES

In the first phase of the epidemic, IDUs were the most affected group and the region faced an injecting drug-related HIV epidemic.

Opium poppies have long been cultivated in the former Soviet Union, and drug injecting is not an entirely new phenomenon.[44] Central Asia and the CEE region have become a major tracking route for opium and heroin from Afghanistan, the world's largest source. In 1997, according to various authors, between 74-90% of new infections in the CEE region were among IDUs.[45] Although injecting drug use remains the primary route of

transmission in the region, public health observers and experts generally currently believe sexual transmission is a major concern, especially among the sexual partners of IDUs and among IDUs involved in sex work.[46] This is not surprising, given the relatively high prevalence of STIs, particularly syphilis, among IDUs and IDU sex workers and the lack of comprehensive interventions targeting sexual risk reduction. In many countries, drug users frequently engage in sex work, magnifying the risk of transmission.

With increasing transmission among the sexual partners of drug users, many countries in the region are experiencing a transition from an epidemic that is heavily concentrated among drug users to one that is increasingly characterised by significant sexual transmission. In 2007, heterosexual transmission was the source of 42% of newly diagnosed HIV infections in Eastern Europe.[47]

Migration is another factor influencing the spread of HIV/AIDS pandemic in the CEE region. Poverty and economic, political and social instability have resulted in the increased migration of men, women and children both within and between countries, as migrant labourers leave their homes to seek other sources of income and employment.[48] Male and female migrants are isolated from family and community relations and social support networks, and may engage in sexual activity with sex-workers and/or multiple partners, exposing themselves and by association their partners at home to HIV infection.[49]

WOMEN LIVING WITH HIV/AIDS IN THE REGION

As the rate of heterosexual transmission has increased, gender disparities in HIV prevalence are narrowing.[50]

Heterosexual contact causes nearly two-thirds of infections in women in Russian Federation and accounts for an ever-growing proportion of new infections. In Ukraine, women now represent 45% of all adults living with HIV.[51] In 2000, women comprised 20.6% of new infections, whereas in 2003 this figure was 38.5% and in 2007 the proportion had grown to 44% or 135,000.[52] In Ukraine, the growth of heterosexual transmission as a proportion of total HIV incidences between 2001 and 2006 (from 28% to 35%) is largely attributable to unprotected sex.[53] Regionally, half of all HIV-positive women became infected by partners. Women living with HIV/AIDS face double stigma and discrimination, and regionally implemented harm reduction programmes lack gender sensitivity.

Table 20: Estimated number of women living with HIV

Estimated number of women living with HIV		
Name of the Country	Estimate Number Women 15+	
	2001	2009
Armenia	<500	<1000
Azerbaijan	<1000	2100
Georgia	<500	1500
Hungary	<1000	<1000
Poland	6400	8200
Russian Federation	190000	480000
Ukraine	130000	170000

Source: UNAIDS 2010 GLOBAL REPORT

STIGMA AND DISCRIMINATION

HIV related stigma and discrimination is seen as a barrier to universal access to HIV prevention treatment, care and support.

Little has been done to curb the stigma, although the ICPD PoA urges governments to develop policies and guidelines to protect the individual rights of and eliminate discrimination against people infected with HIV and their families. Given that the most at-risk groups in the region – IDUs, sex workers and men who have sex with men (MSM) – are involved in what is viewed as socially unacceptable activities, this stigma is perhaps intensified. Stigma and discrimination against drug users and homosexuality in the region act as deterrents to seeking treatment, and according to the United Nations Development Programme (UNDP), most people living with HIV are more fearful of discrimination than they are of the negative health effects.[54] Reports from Eastern Europe and Central Asia state that people with HIV/AIDS are discriminated against by denying them healthcare, by employment redundancies, and by being excluded from their own family.[55] This affects the psychological and physical health of HIV-infected people. Moreover, it is likely to encourage non-disclosure of HIV status due to fear of stigmatization, discrimination and exclusion.

According to the ASTRA Network study on the situation of women living with HIV/AIDS in CEE,[56] in healthcare settings people with HIV can experience stigma and discrimination such as being refused medicines or access to facilities (especially reproductive health services), receiving HIV testing without consent, and a lack of confidentiality. Although it is illegal to test for HIV without a woman's consent, reports indicate that pregnant women who refuse an HIV-test may be sent to give birth in special HIV-units where the likelihood of stigma and discrimination is high. Lack of confidentiality has been repeatedly mentioned as a particular problem in healthcare settings. Many people living with HIV/AIDS do not get to choose how, when and to whom to disclose their HIV status. In the workplace, people living with HIV may suffer stigma from their co-workers and employers, such as social isolation and ridicule, or experience discriminatory practices, such as termination or refusal of employment. HIV-positive members of the family can find themselves stigmatised and discriminated against within the home. There is concern that women and non-heterosexual family members are more likely than children and heterosexual men to be mistreated. Discriminatory practices alienating and excluding people living with HIV have been reported all over the region. Stigma and discrimination against persons living with HIV (PLHIV) are key human rights and development issues that have a direct impact on the health status. Discrimination also deters individuals from accessing prevention measures such as voluntary HIV testing, as well as treatment, care and the support services needed to halt the spread of the pandemic and mitigate its impact.

LAWS AND POLICIES RELATED TO PEOPLE LIVING WITH HIV/AIDS

The HIV/AIDS pandemic in the CEE region has long been fuelled by stigma and discrimination, which has not been adequately addressed through national legal systems. A political legacy of authoritarianism and control challenges responses to HIV epidemics in the region. Faced with an epidemic that mostly affects socially excluded populations such as drug users and sex workers, post-Soviet systems and mindsets have

found it difficult to tailor inclusive responses to meet the specific needs of marginalised groups and those living with HIV/AIDS. Rigid social controls have often led to denunciation and blame of those who fail to conform, or who are caught up in systematic failures. In these circumstances, the stigma and discrimination related to fear and ignorance about HIV/AIDS find reinforcement in official attitudes of intolerance, and in existing public prejudice against those whose behaviour is seen as "anti-social" or "immoral". Policies and programmes remain strongly influenced by the legacy of the past, continuing to avoid the everyday realities of those living with HIV/AIDS and ignore clear evidence about what constitutes an effective response.[57] Several countries in the CEE region still have policies that interfere with the accessibility and effectiveness of HIV-related measures for prevention and care. Examples include laws criminalising consensual sex between men, prohibiting access for prisoners to condoms and needles, as well as using residency status to restrict access to prevention and treatment services. Further, the laws and regulations that exist to protect people with HIV from discrimination are not enacted, or fully implemented or enforced. Recently, policy makers have made attempts to re-orient national laws in order to adequately address situation of people living with HIV/AIDS: in 2010, Ukraine adopted legislation that removed mandated disclosure of HIV-positive status and provided a legal basis for opioid substitution treatment for HIV-positive people who inject drugs.[58] Russian Federation's HIV law provides certain rights and social protection for families whose children are HIV-positive – minors under the age of 18 are provided benefits and their caretakers are guaranteed social support. Although some progress has been made to re-orient national laws, some problems still persist. In Ukraine women who use drugs risk losing custody of their children.[59] In the Russian Federation, widespread negative attitudes of medical professionals towards HIV-infected pregnant women and mothers, and the stigmatising and discriminatory treatment of drug-using women, further increase the likelihood of infant abandonment or loss of custody.[60] Official interventions are often motivated by an ideology of "fixing the individual" through banishment or punishment, rather than "fixing the problem" by lending a helping or supportive hand. The prevailing view is that drug users, sex workers and HIV-positive women are "unfit mothers" or incapable of being competent parents, with the consequence that many feel pressured, shamed or coerced to abort, or to give up their children to the care of the state. Substitution therapy is illegal in the Russian Federation, which, in part, can be explained by the Russian Federation's attitude towards drug addiction and drug users. Practices to tackle drug use are defined by "narcology", a subspeciality of psychiatry originally developed in relation to alcohol addiction. One heavy critique of this approach is that treatment for drug addiction in Russian Federation is seen only within the bounds of "cure" or "failure to cure". This ignores the most effective practice of pursuing multiple outcomes, not just abstinence, including reductions in injecting and exposure to HIV and other blood-borne viruses.[61] HIV testing should always be voluntary, with pre- and post-test counselling, and testing or screening should never be carried out for employment purposes. All HIV-related information should be kept confidential. Moreover, all HIV testing programmes should respect international guidelines on confidentiality, counselling and consent. HIV testing should not endanger access to jobs, tenure, job security, or opportunities for advancement. Independent from internationally recognised standards, fear of breaches in confidentiality sometimes lead to extreme measures. In some countries, patients are not guaranteed the right to confidentiality of their medical records, and employers may access this information. In these circumstances, the repercussions of having contracted infectious diseases such as syphilis, HIV or tuberculosis may be so severe that patients will avoid seeking care, or pay bribes to healthcare workers in order to receive testing or treatment without it being recorded. In many countries, the design of systems is such that confidentiality is inherently difficult to maintain. For example, in order to receive social benefits, families may have to prove every year that a disability is still present, namely that their child is still HIV-positive. Facing annual review commissions unnecessarily expands the number of people who know about a person's HIV status.[62]

Mandatory registration for many health and social programmes sets a high threshold that dissuades many from seeking preventive or treatment services, particularly vulnerable populations. Doctors are also required to routinely report those seeking treatment for substance abuse to law enforcement authorities. Rather than a route to assistance and care, registration is perceived as a form of "branding" as social troublemakers and a potential reason for their basic rights to be prohibited. For example, on the grounds of their drug use alone, those registered can lose custody

of their children. This further diminishes their chances of social reintegration and discourages many from seeking treatment and support.[63]

In health services throughout the region, there are widespread reports of negative attitudes towards people living with HIV, who experience rejection as well as a lack of responsiveness towards their needs. Outside of the more specialised HIV services, health providers often have insufficient information or training on HIV prevention and treatment. This results in reluctance to treat HIV-positive people, both because of the inability of health workers to protect themselves from infection and because they lack the confidence, tools, and resources to treat these patients. Ignorance reinforces discrimination and mistreatment towards people living with HIV.

Apart from deficient legal responses to effectively address discrimination of people living with HIV/AIDS, it is also important to take into considerationthe limitations of existing healthcare systems. As the burden of HIV/AIDS in the region continues to grow, systems designed 20 years ago to monitor HIV as a "socially dangerous and rare disease" are starting to crack. In most countries of the Commonwealth of Independent States, the health system response to the epidemic was to create specialized AIDS centres in large urban areas. These centres reflected "vertical models" of healthcare delivery and a disease-based approach to healthcare provision inherited from the past, very much in line with the way the region responded to diseases such as syphilis and tuberculosis. Initially the AIDS centres were established to monitor spread of the disease, but later their functions evolved into also providing clinical care. Often poorly equipped and understaffed, many are located in places that are hard to reach for vulnerable populations and for women with infants and small children. Now, as the pandemic spreads from large cities into smaller towns and rural areas, the centralised system of service provision is cracking under the weight of an increasing demand for services. In 2008, antiretroviral therapy (ART) coverage among adults in the region was estimated to be only 22%, the second lowest in the world.[64] The centralisation of care provision at AIDS centres results de facto in the exclusion of HIV-positive people from services at other health facilities. AIDS centres have become places where all people living with HIV, including children, are routinely referred to for any health condition, and where they are able to access care without stigma and discrimination. However, going to a specialized "AIDS centre" is stigmatising in its own right, and has become a barrier to access, especially for young people.

While it is widely acknowledged that the intersections and interconnections between HIV/AIDS and SRHR are profound, HIV/AIDS and SRH services remains predominantly separate from the national health systems' point of view, which mostly have vertical AIDS control programmes, not integrated into the public health system.

ACCESS TO ANTIRETROVIRAL THERAPY

Most of the countries in CEE have national strategic plans for HIV and AIDS.

According to the 2008 UNGASS reports, all countries in CEE region report have in place a policy or strategy to promote comprehensive HIV treatment, care, and support. However, the programmatic interventions on HIV/AIDS in most of the countries in the region focus on "high-risk" groups/behaviours. The overall quality of these plans varies significantly, and many countries cannot guarantee sufficient programme coverage, adequate financial and human resources, or reliable procurement for the various drugs and prevention commodities that are needed. HAART (Highly Active Antiretroviral Treatment) is not provided to all PLWHA in need of antiretroviral treatment (ART).[65] In December 2008, just 22% of adults in need of antiretroviral therapy

were receiving it – a level less than half the global average for low and middle-income countries (42%).[66]

Table 21: Reported number of people receiving antiretroviral therapy (including children)

Reported number of people receiving antiretroviral therapy by sex and by age, and estimated number of children receiving and needing antiretroviral therapy and coverage percentages, 2010

Countries	Reported number of all males and females receiving antiretroviral therapy					Reported number of adults and children receiving antiretroviral therapy
	Month and year of report	Males	% of total	Females	% of total	Month and year of report
Armenia	Dec. 10	161	64%	89	36%	Dec. 10
Azerbaijan	Dec. 10	334	77%	101	23%	Dec. 10
Georgia	Dec. 10	581	70%	249	30%	Dec. 10
Hungary		…		…		
Poland	Dec. 10	3 591	73%	1 306	27%	Dec. 10
Russian Federation		…		…		
Ukraine	Dec. 10	12 024	53%	10 673	47%	Dec. 10

… Data not available or not applicable.

cThe coverage estimates are based on the estimated unrounded numbers of children receiving antiretroviral therapy and the estimated unrounded need for antiretroviral therapy (based on UNAIDS/WHO methodology). The ranges in coverage estimates are based on plausibility bounds in the denominator: that is, low and high estimates of need.

Point estimates and ranges are given for countries with a generalized epidemic, whereas only ranges are given for countries with a low or concentrated epidemic.

gAlthough no report has been received from the Russian Federation, for the analysis throughout the report, based on previous reports, an estimated 4% of the people receiving antiretroviral therapy in the Russian Federation are assumed to be children.

Source: Publication: GLOBAL HIV/AIDS RESPONSE: Epidemic update and health sector progress towards Universal Access Progress report 2011 WHO, UNAIDS, UNICEF; 2. Reported number of facilities with HIV testing and counselling and number of people older than 15 years who received HIV testing and counselling, Website: www.who.int/hiv/data/tuapr2011_annex2_web.xls

The dominant ideology of femininity, casting women as vectors of disease or merely as bearers of unborn children has greatly influenced the design of HIV/AIDS interventions. In order to protect the health of the child, pregnant women are usually tested for HIV. In terms of access to ART, pregnant women, or rather their unborn children are usually a priority group. In the Russian Federation, pregnant women must be treated with ART according to federal law, but there is no data on whether they actually receive such prophylaxis. The overwhelming majority of HIV-infected children in the region are born in the Ukraine and Russian Federation. Although the increase in rates of perinatal HIV transmission parallels the spread of HIV in Hungary and Poland, preventive programs targeting pregnant women mostly aim at raising their awareness and knowledge about HIV infection. Pregnant women are not routinely tested for HIV infection in these countries, but the opportunity to perform the test is mentioned to women.

An estimated 94% of pregnant women have access to antiretroviral (ARV) prophylaxis in the CEE region.[67] For HIV-positive children, ART coverage is estimated to be 85%.[68] These results have been realised largely as a result of the integration of preventing mother-to-child transmission (PMTCT) with already well-developed maternal and child health (MCH) services. Remaining challenges in PMTCT in the region today include improvement of primary prevention of HIV infection among young women of childbearing age, and the prevention of unintended pregnancies among HIV-positive women. The region is characterised by high pregnancy termination rates. The proportion of pregnancies among HIV-infected women ending in termination is difficult to compare across countries as the ways in which data is

collected vary and are influenced by HIV testing policies. In the Russian Federation in 2007 and 2008, 40% and 38% respectively of all pregnant women testing positive for HIV terminated their pregnancy. Women receiving HIV testing included both women attending antenatal care and those seeking terminations of pregnancy. In Ukraine, data on terminations of pregnancy among HIV-infected women are available only for those women with a known HIV infection status before pregnancy, with rates of termination reported as 9% in 2007 and 14% in 2008.[69] There are also numerous anecdotal reports of HIV-infected women being recommended to have an abortion by healthcare providers.[70] Such practices reflect both a lack of knowledge and training, with respect to the risks of mother-to-child transmission of HIV and the benefits of prevention, as well as the discriminatory attitude towards HIV-positive women held by some providers.

Enhancement of the quality of PMTCT interventions, and better outreach to marginalised and most-at-risk populations who tend to be missed by services, is critical. In addition, it will be important to provide a continuum of care for women and children, and to scale up a number of services including early infant diagnosis, early initiation of ART for infants, and the provision of ARVs for parents.

ACCESS TO COUNSELLING AND TESTING

While sporadic attempts have been made to include prevention and treatment of STIs and HIV testing and counselling into the family planning programmes, these attempts have not been sustained or fully integrated.[71]

However, some progress has been made in developing institutional linkages. During the first phase of the pandemic, compulsory testing was introduced for high-risk groups. In former Soviet republics, some health workers, particularly those outside the main cities, are ill-informed about the legal requirements, untrained and unskilled in counselling, and continue to routinely test patients, even against their will.[72] Anonymous unlinked testing for surveillance purposes, as recommended by WHO since the early 1990s, has not been implemented in the CEE region. Free and voluntary services are available only in big cities. They are anonymous but fear of discovering a HIV-positive status often stops people from being tested. HIV-positive results are routinely reported to regional AIDS centers and further compiled and confirmed at the national level.

Table 22: HIV testing

Low- and middle-income countries*a	Testing and counselling facilities, 2009		Testing and counselling facilities, 2010		Number of people aged 15 years and older who received HIV testing and counselling, 2009**b			Number of people aged 15 years and over who received HIV testing and counselling, 2010b		
	Reported number	Estimated number per 100,000 adult population	Reported number	Estimated number per 100,000 adult population	Reported number	Estimated number per 1,000 adult population	Reporting period	Reported number	Estimated number per 1000 adult population	Reporting period
Armenia	150	9,2	150	9,3	70 955	43,7	Jan. 09–Dec. 09	71 316	44,4	Jan. 10–Dec. 10
Azerbaijan	…-	…-	…-	…-	…-	…-		361 574	66,6	Jan. 10–Dec. 10
Georgia	…-	…-	334	15	…-	…-		70 615	31,8	Jan. 10–Dec. 10
Hungary	144	3	144	3	99 538	20,6	Jan. 09–Dec. 09	…	…	
Poland	2 645	13,7	…-	…-	25 452	1,3	Jan. 09–Dec. 09	…	…	
Russian Federation	…-	…-	…-	…-	…-	…-		…	…	
Ukraine	2 002	8,5	1 880	8,1	…-	…-		3 247 002	140,5	Jan. 10–Dec. 10

a See the country classification by income, level of the epidemic and geographical, UNAIDS, UNICEF and WHO regions.

b This number should include all people aged 15 years and older who received HIV testing and counselling through any method or setting, including voluntary counselling and testing and antenatal care settings. Not all countries are able to report c data from all settings.

c Some countries reported voluntary counselling and testing and antenatal care testing data separately; these data are combined here.

Source: Publication: GLOBAL HIV/AIDS RESPONSE: Epidemic update and health sector progress towards Universal Access Progress report 2011 WHO, UNAIDS, UNICEF; 2. Reported number of facilities with HIV testing and counselling and number of people older than 15 years who received HIV testing and counselling www.who.int/hiv/data/tuapr2011_annex2_web.xls

OVERVIEW FOR HIV/AIDS

There is considerable progress in the area of HIV/AIDS prevention, treatment and care in CEE. At the same time, programme interventions for HIV/AIDS need to capture a broad gender and human rights framework to effectively address the HIV/AIDS situation. Addressing the gender dimensions is critical, as noted in the ICPD PoA, since the face of HIV/AIDS has become increasingly more feminised. Women face greater danger of HIV

infection not only for biological reasons, (i.e., women have a larger mucosal surface exposed to abrasions during sex, and semen has higher concentration of HIV/AIDS than vaginal fluid does), but also for social reasons.

Cultural norms of sexual ignorance and purity for women block their access to prevention information. Gendered power imbalances make it difficult for women to negotiate for safer sexual practices (including condom use) with their partners, and economic dependence and fear of violence can effectively force women to consent to unprotected sex. Women receive inadequate care and treatment both because it is being directly withheld from them, and because what is provided is inaccessible and unsuited to their health needs.

SEXUAL RIGHTS

Politically, governments are comfortable only in recognising the reproductive functions of sexuality and the sexual rights that go hand-in-hand with these.

Non-reproductive functions are considered secondary and have not been attributed with much commitment and importance. It is necessary to delve into the bases of political power and political motivations to understand this better. In this section, we will demystify the notion of sexual rights through the use of the following indicators, and show issues of sexual rights that need to be addressed by governments: arranged/forced/child marriage; traditional practices harmful to women; laws against sexual violence – marital rape, rape, and sexual harassment; laws on the trafficking of women; laws on sex work; laws on same-sex sexual preference/relations/unions; and transgenderism.

All surveyed countries recognise women's right to bodily integrity and freedom from sexual violence and have legislated accordingly. All countries recognise the rights of choosing partners, entering into consensual marriages and consensual sexual relations although cultural practices may hinder these in some countries. Certain traditional practices, which are harmful for women and girls, seem to be continuing in the region. Among these are female circumcision and certain forms of violence against women like bride kidnapping.

EARLY AND FORCED MARRIAGE

Early marriage is a problem in Azerbaijan, Armenia, Georgia, and some parts of Russian Federation.[73] Women's rights organisations which collect information about polygamy and bride kidnapping in the North Caucasus have reported that girls as young as 12 are being kidnapped, with their families often too afraid to act. In some cases, it has been reported to Amnesty International that young girls have been returned to their families some months later, after having been raped and abused by their "husbands". Bride kidnapping has been a phenomenon in the North Caucasus for generations. While in some cases the woman might agree to being "kidnapped", different women who spoke to Amnesty International

highlighted that nowadays, in contrast to the situation 10 or 20 years ago, women and their families are often afraid of resisting the kidnapping or reporting it to the police or prosecutor's office if the man has a close connection with the authorities or is himself a member of the law enforcement bodies.[74] The problem is increasing among poor families living in rural areas in the center and south of Azerbaijan. Of girls between 15 and 19 years of age, 13% were married, divorced or widowed in Azerbaijan, with 11% in Russian Federation[75]. Also in Hungary, Roma girls drop out of school earlier because of early marriage and childbirth. Many marriages in Azerbaijan are arranged with the consent of parents, or women are kidnapped as brides.[76]

Table 23: Legal age of marriage and prevalence of early marriages among girls

Legal age of marriage and prevalence of early marriages among girls			
	Legal age of marriage/ women	Legal age of marriage/ men	Early marriage (girls/ women)
Armenia	18 (16)*	18 (16)*	Estimate 8%
Azerbajian1	18	18	13%
Georgia	18 (16)*	18 (16)*	Estimate 16 %
Hungary			
Poland	..	..	..
Russian Federation	18 (16)*	18 (16)*	Estimate 11%
Ukraine	17 (14)*	18 (14)*	Estimate 13%

*Notes: "Early Marriage" is defined as the share of girls/women between 15 and 19 years of age who are currently married, divorced or widowed. These percentages are derived from census data on the population classified by current marital status, sex and age group. Data are from 2004. *Law enables to allow marriage at earlier age under specified circumstances. Brackets specify the minimum age for the exception to be granted.*

Source: UNDP

Table 24: Number of first marriages by sex and age

Number of first marriages by sex and age				
	0 – 14 years		15 – 19 years	
	girls	boys	women	men
Armenia	..	..	2334	131
Azerbaijan	..	..	13904	567
Georgia	..	..	2279	607
Hungary	0	0	1833	401
Poland	..	..	..	..
Russian Federation	..	..	..	..
Ukraine	319	7	54997	10144

Notes: Data on first marriages provide the number of boys/men and girls/women who were married for the first time during the year, by age at last birthday. Data comes from registers, unless otherwise specified (data refer to year 2004). For Azerbaijan: data does not cover Nagorno-Karabakh; For Georgia: age group 15-19 refers to ages 16-19 and from 1993 data covers only territory controlled by the central government of Georgia; For Ukraine: from 2000-2006 the age group "0-14" refers to ages less than 16 and the age group "15-19" refers to ages 16-19.

Sources: UNDP, UNECE Statistical Division Database – Gender Statistics Sex-disaggregated datasets compiled from national official statistical sources; http://www.unece.org/stats/gender/database.htm

POLYGAMY

Polygamy is prohibited by criminal law in Azerbaijan and Poland. The 1999 CEDAW report states that the Civil Code "does not provide punishment for polygamy, since this is not a current problem in Armenia".[77] In the Russian Federation, the practice remains common within the Muslim community, particularly in the Caucasus region. Only the marriage to the first wife is recorded; subsequent wives are not considered to be legally married. In 1999, the president of Ingushetia proposed the legalisation of polygamy, a measure supported by

the majority of the population. The federal authorities prevented the law from being promulgated on the ground that regional legislation cannot run counter to federal laws.[78]

HONOUR KILLINGS

On 27 November 2008, the bodies of six women were discovered in different parts of Chechnya.

Each had been shot at point blank range in the head and chest. In line with the statement that he made in September 2008 shortly after the discovery of the women's bodies, Chechen President Ramzan Kadyrov said that he did not exclude the possibility that the women had been killed by their relatives as punishment for "immoral behaviour". While condemning the killings, Nurdi Nukhazhiev, the Chechen Ombudsman for human rights, justified the Chechen government's increased attention to issues concerning moral behaviour, regretting that "some women have forgotten how to behave".[79]

VIOLENCE AGAINST WOMEN (VAW)

Physical, sexual, psychological, and verbal violence are reminders of the actual status of women. Furthermore, it is important to note that combating violence against women is a priority area for both the Council of Europe and EU institutions.[80]

European Union efforts to curb domestic violence are relevant also for the countries outside EU, because the EU sets the direction for international policies and creates trends that are followed by countries aspiring to EU membership and neighbouring countries. The Committee of Ministers of the Council of Europe adopted a landmark Convention on preventing and combating violence against women and domestic violence (Convention CETS No. 210) in April 2011.[81] This Convention is the first legally binding instrument in the world creating a comprehensive legal framework to prevent violence, to protect victims and to end the impunity of perpetrators. It defines and criminalises various forms of violence against women (including forced marriage, female genital mutilation, stalking, physical and psychological violence and sexual violence). Unfortunately, none of the surveyed countries signed the Convention, which reflects the fact that violence against women in the family is widespread in CEE. The VAW laws in the countries where they exist are a result of the persistent efforts of grassroots and national women's organisations.

Table 25: Violence Against Women Laws

Name of Country	Violence Against Women in General Laws
Armenia	1. Armenia's implementation of the "Combating Gender-based Violence in the South Caucasus" project. (2008-2011) 2. National Programme to Improve the Status of Women and to Enhance Their Role in Society in the Republic of Armenia. (2004-2010)
Azerbaijan	Azerbaijan's implementation of the Regional Combating Gender-based Violence in the South Caucasus Project. (2008)
Georgia	1. Action Plan of Measures to be Implemented to Combat Domestic Violence and Protect Domestic Violence Victims. (2009-2010) 2. Action Plan on Prevention of Domestic Violence and Protection of Victims of Domestic Violence. (2009-2011) 3. Action Plan on Combating Violence against Women. (2000-2002)
Hungary	1. Act XIX of 1998 on Criminal Proceedings as amended by Act LI of 2006. (2006) 2. Act LXXX of 2003 on legal assistance. (2000) 3. Budgetary appropriation in 2008. (2008) 4. National Strategy of Social Crime Prevention (Government Resolution No. 1009/2004 (II. 26) Korm.). (2004)
Poland	No specific law regarding violence against women.
Russian Federation	1. Code of Criminal Procedure of Russian Federation. (2002) 2. National Strategy on Equal Rights and Equal Opportunities for Men and Women in Russian Federation. (2006)
Ukraine	1. Plan of Action under the "Stop Violence!" Platform of Action. (2008-2015) 2. State family support programme. (2007-2010) 3. State programme for the promotion of sexual equality in Ukrainian society up to 2010. (2006-2010) 4. National plan of actions on the improvement of position of women and assistance to introduction of gender equality in society. (2001-2005)

In Armenia, the lack of such legislation has been a high-priority issue for many human rights organisations in the country. In 2010, the Coalition to Stop Violence Against Women[82] was formed as an umbrella group for seven such organisations. The Women's Rights Center,[83] part of the Coalition, submitted a draft law on domestic violence. Similar initiatives in neighbouring Azerbaijan led to success, when the Draft Law on Domestic Violence, criminalising domestic violence and providing for the creation of aid centres for victims of violence was adopted by the Parliament of Azerbaijan in May 2011. In spite of the new legislation, the discussion of violence against women is a taboo subject in Azerbaijan's patriarchal society. In rural areas, women have no real recourse against violence by their husbands, regardless of the law. Although no reliable official statistics on domestic violence exist, several surveys conducted by international organisations between 2001 and 2004 found that 30-43% of women in Azerbaijan reported suffering from domestic abuse (2009).[84] In Georgia, the Law on Elimination of Domestic Violence, Protection and Assistance of Domestic Violence Victims was adopted in June 2006. The bill introduces the term "domestic violence" into Georgian legislation, as well as new mechanisms of protection of victims – restraining and defense orders, state's obligation to provide social services, shelters and rehabilitation centers for the victims and abusers.[85] In Hungary, domestic violence is adjudicated under existing assault and battery crimes in the criminal code.[86] In June 2009, the Hungarian Parliament enacted the Restraining Act in Cases of Violence Between Relatives.[87] According to this law, police may issue a restraining order that is

valid for three days, and the courts can issue longer-term restraining orders for a maximum of 30 days. The legislation has been criticised by women's NGOs for failing to provide adequate protection for victims, and for failing to place sufficient emphasis on offender responsibility. Recent family violence research states that approximately 20% of Hungarian women have been victimised by domestic violence,[88] while the Hungarian Government Report cynically states that "[t]he most serious crimes against human life [in domestic violence cases] are suffered by men" despite that 86 women and 65 men were killed in domestic violence in Hungary in 2006.[89] The Polish Law on Domestic Violence was adopted in 2005, and amended in 2010. The Act on Counteracting Domestic Violence strengthens the protection of victims of violence, especially through restraining order and possibility of eviction of the abuser from the place of residence. The Act allows also for free forensic examination for the victim and places an obligation on each municipality to help every victim, who has no legal right to the property, which she occupies with the perpetrator.[90] In the Russian Federation, there are no legal measures specifically addressing violence against women in the family. According to the statistics of Interior Ministry, 14,000 women die annually from domestic violence in Russian Federation.[91] In Ukraine, a bill was passed in 2001 to prevent violence against women, but public awareness of this law is low even among women. Paradoxically, this law authorises the police to arrest a woman if it can be demonstrated that she "provoked the violence by behaving as a victim".[92] Another problem is that the existing law does not specifically recognise domestic violence, the most common form of violence against women in the country; it is believed that half of Ukrainian women have experienced violence in their homes. Authorities are currently considering an amendment to the Criminal Code that would specifically prohibit domestic violence.[93] The fact that the CEE region still struggles to recognise women's right to life free from violence reflects the general lack of recognition of women's human rights in the region. Even in the countries where legal regulations exist, deficiencies in existing legal provisions, procedures and remedies impede the rights of victims to safe and prompt access to justice. There is also a shortage of supervisory and enforcement mechanisms. In general, legislation is gender-blind, and gender-blind legislation does not offer adequate protection for women from gender-based violence. Namely, acts of gender-based violence may remain invisible and unreported, not investigated and not prosecuted. In this way, women live without protection, while abusers go unpunished. This practice perpetuates violence against women, and does not contribute to the development of an effective preventive policy[94].

Table 26: Domestic Violence Laws

Name of Country	Domestic Violence Laws
Armenia	Gender and Politics project component on the prevention of domestic violence. (2004-2008)
Azerbaijan	1. Law on Prevention of Domestic Violence. (2010) 2. „XXI century without violence against women" project. (2008) 3. National Plan of Action on Family and Women's Problems. (2008-2012) 4. The "Complex Program of the Republic on combating domestic violence in democratic society". (2007) 5. National Plan of Action on protection of human rights. (2006)
Georgia	1. Law on the Elimination of Domestic Violence, Protection and Assistance of the Victims of Domestic Violence. (2006) 2. Action Plan of Measures to be Implemented to Combat Domestic Violence and Protect Domestic Violence Victims. (2009-2010) 3. Action Plan on Prevention of Domestic Violence and Protection of Victims of Domestic Violence. (2009-2011) 4. Action Plan on Combating Violence against Women (2000-2002)

Hungary	1. 32/2007. (OT 26) HNP HQ Instruction of the High Commissioner of the Hungarian National Police on the carrying out of tasks connected to the management of domestic violence and to the protection of the minors. (2007) 2. Protocol for Crisis Management Centers. (2007) 3. Section 176/A of the Criminal Code. (2007) 4. Resolution No. 45/2003 (IV. 23) OGY on the development of a national strategy to prevent and effectively manage domestic violence. (2003) 5. Child Protection Act XXXI of 1997 on the protection of children and guardianship administration. (1997) 6. Permanent fund for NGOs. (2000)
Poland	1. Act on Counteracting Domestic Violence (2010) 2. Ordinance of the Minister of Labour and Social Policy of 6 July 2006 concerning the standard of basic services provided by specialized support centres for family violence victims as well as detailed directions of corrective educational influences. (2006) 3. Act of 29 July 2005 on counteracting family violence (Dz.U. No 180, item 1493). (2005) 4. Guidelines for creating corrective and educational programmes for perpetrators. (2000) 5. Ministry of Justice recommendations for prosecutors. (2000) 6. „Blue card" police procedure. (1998) 7. Penal Code. (1997) 8. National Action Plan against Trafficking in Human Beings. (2009-2010) 9. National Program of Counteracting Domestic Violence (2006-2016). (2006)
Russian Federation	1. Order No. 564-st of the Federal Agency for Technical Regulation and Metrology on the approval of t henational standard dated 27 December 2007. (2007) 2. Krasnodar Territory departmental programme on the prevention of domestic violence, entitled "No to Violence". (2005)
Ukraine	1. Domestic Violence (Prevention) Act 2001. (2001) 2. Plan of Action under the „Stop Violence!" Platform of Action. (2008-2015) 3. State programme for the promotion of sexual equality in Ukrainian society up to 2010. (2006-2010) 4. National plan of actions on the improvement of position of women and assistance to introduction of gender equality in society. (2001-2005)

There is a tendency to downplay the gendered nature of domestic violence all over the region, and this is visible both in the methodology of research employed by state research institutions and in the superficial evaluation of available data. Most domestic violence incidents went unreported, largely due to the stigma of fear and shame on the part of the victim. Prosecution was also difficult and rare due to societal trends of victim-blaming. Another problematic issue is that data collected on violence against women are not disaggregated by women, men and transgender. In analysing violence as a manifestation of unequal power relations, we must recognise that women are not the only group that suffers from unequal power relations in any society. Violence also occur against lesbians, gays and bisexuals (LGB) and transgender people, but this is not documented statistically. LGB may often stay silent about their sexual orientation for fear of discrimination and violence. LGB may also face increased "violence" and "violations" from even conservative health providers.

RAPE

All countries surveyed have laws against rape and these usually exist within the penal code or the criminal code.

However, many barriers remain in being able to provide justice to victim-survivors of rape. Consent is the fine line that divides rape from consensual sex and legal definitions in all countries use non-consensual and forced vaginal penetration as definitions of rape. Furthermore, attitudes of the police on rape in general and on marital rape in particular revealed that many police officers hold views and attitudes permeated with prejudices, which make them absolutely unfit for investigating crimes of this kind. The victim-blaming attitudes and the resulting lack of action and malpractice on the part of professionals dealing with domestic violence (police, lawyers, social workers, psychologists, child custody officers, etc.) are widespread and prevalent in all the region.

Spousal rape is not specifically recognised in Armenia, Azerbajian, Georgia, Poland, Russian Federation nor Ukraine, while Hungary criminalises maritial rape.

SEXUAL HARASSMENT

In Azerbaijan, a research on the Status of Sexual Harassment Issue found that 33% of women determined themselves as victims of sexual harassment in 2007.[95]

Of the cases where women were harassed or treated in this way, 53% of the time it was by a supervisor (mostly in the private sector), with 26.3% occuring in the education sphere and 5.6% of the time from colleagues. Around 80% of these women acknowledged a dependance on the insulter at the time of the incident. The women who refused indecent proposals said it impacted negatively on their employment (17%) , or on their education (33%).[96] Informants from other surveyed countries stated that recognition of sexual harassment as an offence prevails in society.[97] However, victims of sexual harassment are often reluctant to take their cases to court because it may lead to rumours, because of a difficulty proving sexual harassment, plus fear of further discrimination or losing their job.

SEX WORK

As in most other countries of the world, state policies addressing issues of sex work in the region are rarely driven by pragmatism, scientific evidence, and human rights concerns; instead, they are often restrictive and based on moral prejudice.

Even when sex work is not technically illegal, it is frowned upon and its practitioners discriminated against and shunned by much of society. These attitudes greatly impede sex workers' access to public health services, including treatment for drug dependence as well as HIV prevention and treatment information and services. They also place sex workers in a position where their basic human rights can easily be violated and protection of these rights becomes difficult if not impossible. Nearly all countries in the CEE region have experienced an increase in sex work, largely stemming from economic necessity, in the wake of the collapse of the Soviet Union.

The rise in explicitly commercial sex work has occurred concurrently with a growing emphasis on the economic value of sexual relations in general, a development that reflects widening differentials in wealth. The sex industry appears to be growing especially rapidly in the countries of the former Soviet Union. In the region, existing legislation is much more restrictive toward organised prostitution, even in countries where prostitution itself is quasi-legal (Hungary, Poland) or not regulated.

Pimping is prohibited in all countries of the CEE region, with punishments varying from a fine to imprisonment. Prostitution in general is not subject to criminal liability. In Hungary, there are relatively new regulations in effect concerning both prostitution and human trafficking. However, as regulations were amended and/or drafted without any deeper knowledge about the social reality of either prostitution or human trafficking, a strange situation has developed where Hungarian regulations deal with the two questions totally independently, without any regard to the close relationship between the two and in different thematic environments. The wording of the regulations poses many theoretical and interpretational problems. Because of this, and ignorance about the close relationship between human trafficking and prostitution, there are also severe shortcomings with regards to implementation. Hungarian regulation about human trafficking does not even mention prostitution or sexual exploitation among the possible aims of human trafficking. Possible purposes – and also aggravating circumstances – listed in the statute might be work, unwanted physical contact with a sexual organ or intercourse, or illegal use of the human body.[98]

TRAFFICKING

Trafficking is an important problem of the region, but most of the existing laws are gender-blind and ignore the fact that women and children are the trafficking victims in most of the reported cases. Armenia is a main source and transit country for women and girls trafficked primarily for sexual and, to a lesser extent, labour exploitation to the United Arab Emirates and Turkey. This problem is being recognised and addressed by the Armenian government. Azerbaijan adopted its Law on the Fight against Human Trafficking in 2005. The law aims to combat trafficking in human beings by introducing a firm legal and organisational basis for the fight against trafficking, by giving legal protection and support to victims of trafficking. Although states

recognise the problem of trafficking, little is done to prevent trafficking and protect women from falling victims of this procedure. This is especially alarming when we take into consideration that the **former Soviet Union** and **Central** and **Eastern Europe** have replaced Asia as the main source of women **trafficked** to Western Europe. The majority of existing regulations are gender-blind.

THE STATUS OF DIVERSE SEXUAL AND GENDER IDENTITIES AND RECOGNITION OF THEIR RIGHTS

The recognition of diverse sexual and gender identities is still problematic in the region. The HIV/AIDS pandemic has revealed many issues affecting people of diverse sexual and gender identities. However, this has not led to the overall recognition of their rights. On the level of society, homophobia and transphobia are generally accepted and there is need for general action to promote tolerance towards LGBT communities. Statistics of hate crimes against LGBT people, as well as other violations of the rights of this group of people and discrimination against them, are not kept. References to "traditional values" to justify homophobic and transphobic actions, as well as support of patriarchal values and gender-stereotypical patterns of behaviour, are widely used in the media and reinforced at the political level all over the region. Deeply rooted homophobia and transphobia in public and political discourse are used to justify the limitation on most attempts to introduce relevant issues in public space. Meetings or demonstrations are forbidden, in many cases there is a refusal to register LGBT organisations, or there are obstacles to holding cultural events, with arguments on the inadmissibility of "propaganda of homosexuality" being widespread.

Table 27: LGBT situation in the region

	Armenia	Azerbaijan	Georgia	Hungary	Poland	Russian Federation	Ukraine
Anti-discrimination	Discrimination on the basis of sexual orientation and gender identity is not prohibited in any areas.	Discrimination on the basis of sexual orientation and gender identity are not prohibited in any areas.	Discrimination on the basis of sexual orientation is prohibited in the area of employment.	Discrimination on the basis of sexual orientation and gender identity is prohibited in the areas of employment, and provision of goods and services.	Discrimination on the basis of sexual orientation is prohibited in the area of employment.	Discrimination on the basis of sexual orientation and gender identity are not prohibited in any areas.	Discrimination on the basis of sexual orientation and gender identity are not prohibited in any areas.

Legal gender recognition of trans people	No administrative procedures for legal gender recognition.	No administrative procedures for legal gender recognition.	Administrative procedures to obtain legal gender recognition exist; however, only after compulsory sterilisation and compulsory divorce.	Administrative procedures to obtain legal gender recognition without compulsory genital surgery.	Administrative procedures to obtain legal gender recognition without compulsory genital surgery, however with compulsory divorce.	Administrative procedures to obtain legal gender recognition without compulsory genital surgery however with compulsory divorce.	Administrative procedures to obtain legal gender recognition - however only after compulsory sterilisation [and] compulsory divorce.
Partnership recognition	Does not provide any legal recognition of same-sex partnerships	Does not provide any legal recognition of same-sex partnerships.	Does not provide any legal recognition of same-sex partnerships.	Hungarian same-sex couples are able to enter into a registered partnership.	Does not provide any legal recognition of same-sex partnerships.	Does not provide any legal recognition of same-sex partnerships.	Does not provide any legal recognition of same-sex partnerships.
Parenting rights	Neither joint nor second parent adoption is available to same-sex couples.	Neither joint nor second parent adoption is available to same-sex couples.	Neither joint nor second parent adoption is available to same-sex couples.	Neither joint nor second parent adoption is available to same-sex couples.	Neither joint nor second parent adoption is available to same-sex couples.	Neither joint nor second parent adoption is available to same-sex couples.	Neither joint nor second parent adoption is available to same-sex couples.
Criminal law on hate speech/crime	Laws on hate and violence do not refer to sexual orientation or gender identity, and do not recognise sexual orientation nor gender identity as aggravating factor.	Laws on hate and violence do not refer to sexual orientation or gender identity, and do not recognise sexual orientation nor gender identity as aggravating factor.	Sexual orientation and gender identity are included in the law on hate and violence, and are recognised as aggravating factor.	Laws on hate and violence do not refer to sexual orientation or gender identity, and do not recognise sexual orientation nor gender identity as aggravating factor.	Laws on hate and violence do not refer to sexual orientation or gender identity, and do not recognise sexual orientation nor gender identity as aggravating factor.	Laws on hate and violence do not refer to sexual orientation or gender identity and do not recognise sexual orientation neither gender identity as aggravating factor.	Laws on hate and violence do not refer to sexual orientation or gender identity and do not recognise sexual orientation neither gender identity as aggravating factor.
Freedom of assembly/ Pride events	Pride events have never taken place / never been applied for.	Pride events have never taken place / never been applied for.	Pride events have never taken place / never been applied for.	Pride events have taken place with authorisation.	Pride events have taken place with authorisation, however LGBT public events were banned in 2004, 2005 and 2006.	No Gay Parade has ever been officially permitted in Russian Federation.	The first Gay Pride took place in 2012.

Source: ILGA-Europe, http://www.ilga-europe.org/home/guide/country_by_country

According to the newest ILGA Europe report ("Rainbow Europe Index 2011"),[99] Ukraine is the worst violator of LGBT rights in the continent, with a score of -4. The LGBT community falls victim of homophobic and transphobic prejudice all over the region. In Azerbaijan, where homosexuality was decriminalised in 2001, ILGA reported cases of police harassment and brutality, including bashings, blackmail, intimidation, bribery and invasions of privacy. LGBT people risk eviction from their homes and dismissal from their jobs. They have no legal protection against discrimination. Amnesty International is concerned about a climate of intolerance in Poland and Hungary against the LGBT community. This is characterised by the banning of public events organised by the LBGT community, openly homophobic language used by some highly placed politicians, and incitement of homophobic hatred by some right-wing groupings.

THE STATUS OF LAWS RELATED TO SAME-SEX SEXUAL PREFERENCES AND RELATIONS

Hungary was the first of the surveyed countries to allow same-sex partnership, but currently this regulation is jeopardised by the new Constitution (2012) which defines family as the union of a man and a woman. Same sex marriages are not outlawed in the Russian Federation, but when two women attempted to get married in Moscow in 2009, they were refused. The rest of surveyed countries' legislation fails to recognise same-sex unions.

THE STATUS OF TRANSGENDER PEOPLE

Legal regulation in the field of gender reassignment is underdeveloped and unsystematic in all of the countries that participated in the survey.

In general, the legislation is not adapted for addressing problems of changing documents for transgender people. Despite medical recommendations for social adaptation of transgender men and transgender women, they often can not change their documents of identity to reflect their desirable gender identities. Without suitable documents, it is almost impossible for transgender people to live as full members of a society. Some of them experience serious violence if the identity on their passport is found out. Transgender people are not able to secure employment because their gender representation and their official documents do not correspond. With such documents, transgender people cannot find employment according to their qualifications, as they have encountered a lack of understanding and intolerance from employers.

Although in the Russian Federation and Ukraine no legislation or regulation requires surgery for changing vital records, it is common practice that civil registry offices override their competencies and make the successfulness of an application dependant on the "completeness" of the applicant's gender reassignment – accordingly, surgical intervention is required and one surgical procedure is regarded as not sufficient. International research also shows that transgender people are over-proportionally avoiding access to healthcare services, which are not transgender-related, because of perceived or experienced transphobia by medical staff. Thus, transgender people are exposed to suffer from adverse effects on their health. Transgender people report about the complete absence of a professional understanding of transgender issues by general practitioners and other medical staff, leading to degrading and partly false treatment.

OVERVIEW REGARDING SEXUAL RIGHTS

The challenge for sexual health and sexual rights in the region is positioned within non-reproductive functions and expressions of sexuality.

All countries recognise the rights of women to freely choose their partners and enter into consensual marriages. In some countries in CEE, traditional practices may interfere with this choice and the exercising of this choice. All countries also recognise the rights of women and girls to bodily integrity and to live lives free from sexual violence: rape and sexual harassment. Marital rape is still a problematic concept in the region, but the idea to criminalise it seems to be gaining acceptance. All countries recognise the need to address trafficking of women and girls.

CONCLUSIONS

Reviewing the sexual health and sexual rights indicators across the seven countries, the following conclusions can be made.

Sexual health is still being framed in limited paradigms across the region. With the possible exception of some countries in Central Europe, a lack of political leadership and HIV-related stigma and discrimination are major impediments to the development and implementation of effective HIV/AIDS policies and strategies in CEE/CA. HIV/AIDS sets the defining framework for both STIs intervention and HIV/AIDS intervention, although the population vulnerable to STIs is larger and more diverse. This means that groups whichmayneed screening and treatment interventions are not receiving them. The impact of STIs on the sexual and reproductive lives of people is not being given the rightful recognition it deserves. Interventions framed within a "disease prevention" paradigm create access to services based on targeting risky behaviours instead of recognising the rights of marginalised groups (for example male and female sex workers) to services. However, this has opened the door for discussion and negotiation of these rights. There is a still a long way to go before the issues of sexual health and rights are framed in a paradigm of pleasure, autonomy and self-determination in all seven countries.

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