CENTRAL AND EASTERN EUROPEAN WOMEN'S NETWORK FOR SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

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ASTRA Central and Eastern European Women's Network for Sexual and Reproductive Health and Rights consists of 31 organizations from 19 countries of Central and Eastern Europe and Central Asia (Albania, Armenia, Azerbaijan, Belarus, Bulgaria, Croatia, Georgia, Hungary, Kazakhstan, Latvia, Lithuania, Macedonia, Moldova, Poland, Romania, Russian Federation, Slovakia, Ukraine, Uzbekistan) and Eastern European Alliance for Reproductive Choice (EEARC) has 11 member organizations from Armenia, Azerbaijan, Georgia, Kyrgyzstan, Lithuania, Moldova, Poland, Romania, Russia, Ukraine, and Uzbekistan. We jointly work towards transforming gender power relations in our societies so that women, girls, men and boys can enjoy their sexual and reproductive rights, and are equal, free and live in dignity. Our shared mission is to prioritize access to sexual and reproductive health and rights (SRHR) on international, regional and national agendas, in particular in the EU, CoE and UN institutions.

ASTRA Network and EEARC advocate for the importance of SRHR in the region, focusing also on the health necessities of women, of people living with HIV/AIDS, of Roma communities, of youth, of LGBTQI, of migrants and of internally displaced persons. The health concerns, especially those of sexual and reproductive health, of these communities are often overlooked by national governments as well as neglected by global development donors. Health is central to development, as a precondition for, as well as indicator and an outcome of sustainable development, and our common goal is to ensure that health, including reproductive and sexual health, is meaningfully included in the post 2015 development framework**.**

This report is the outcome of a consultation process that included an online consultation targeting the ASTRA Network, ASTRA Youth and Eastern European Alliance for Reproductive Choice member organizations, extensive outreach to partners, the review of written submissions as well as an important input from 20 experts invited to consultation meeting in Moscow (26-27 January, 2013).

Regional overview:
Central and Eastern Europe and Central Asia is a very heterogeneous geopolitical region bringing together countries with a common state socialist past, a common history in relation to the social organization of health and health concerns and yet with very different developmental trajectories in the past two decades.
One of the most general indicators of the significant differences between different parts of the region are large economic differences between the countries in our region- the richest among them- Slovenia- had a per capita gross domestic product (GDP) in 2004 that was more than 17 times (adjusted for ppp) that of the poorest, Tajikistan (World Bank 2006). The uneven development of the region is also closely tied with political circumstances. Several countries benefited from relative political stability and strategically positioned themselves toward European Union integration, either by becoming full members or by signing different protocols with the EU (such as ENP or accession treaties). On the other hand, for countries of Central Asia and the Caucusus, Russia remains a key partner together with China, the US or Iran. The bulk of these countries experienced severe and prolonged periods of economic downturns, some underwent conflicts (ethnically or politically motivated), political unrest (Orange revolutions). More recently, some countries of the region such as Russia, Azerbaijan or Kazakhstan ripped the benefits of having access to natural resources especially with the soaring of oil prices, thus becoming important economic partners and increasing state revenues.

In spite of these different developmental paths, it seems that there is a consensus that throughout the past two decades socio-economic inequalities between different social groups have grown alarmingly while access to public resources and services has increasingly declined. Income differentials have grown with a small hyper-affluent elite benefiting substantially, while large sections of the population have suffered and become marginalized. The size of vulnerable populations has grown, with migrants, ethnic minorities, the homeless, and people working in the informal economy being particularly at risk. Moreover, the entire region underwent dramatic changes in regards to its demographic and health indicators, which compare unfavorably with the indicators in Western Europe. Numerous high-risk behaviors that were minimal prior to 1990 become widespread such as selling sex, alcoholism and drug use.

In respect to SRHR and the demographic crisis affecting differently yet all countries in the region it must be said numerous political forces as well as religious leaders are pushing for pronatalist policies often reflected in attempts to restrict access to abortion and contraception. Additionally, the issue of sex selective abortion has started to trigger attempts to restrict access to abortion (Albania, Armenia, Azerbaijan, Georgia). Attempts to restrict access to legal abortion appeared in Hungary, Macedonia, Poland, Romania, Russian Federation, and Ukraine. In

Uzbekistan, forced sterilization are increasingly being documented as way to decrease family size and ensure economic resources.

Unemployment and poverty further negatively impacted the health indicators in the region such as low life expectancy especially for men, high maternal and infant mortality, HIV epidemics in Ukraine/Russia, high rates of cervical and breast cancers and more generally on the well being of the populations in question. The state of national health care systems, chronically underfunded and in a state of constant change also contributed to poor health indicators.

Before the collapse of communism, countries under the influence of the Soviet Union shared a similar model for their health system[1]. The system sought to provide universal access through an extensive network of facilities. The health-care systems were publicly financed, through general taxation, with the state owning the facilities and providing all health services. Access to care was free at the point of use. The formal private sector was nonexistent. The system was labor-intensive, largely because it was possible to keep the wages of health professionals in the health sector low when the state was the monopoly employer. Moreover, the Soviet-style health system placed emphasis on curative rather than preventive services, allocated funding according to the number of hospital beds, relied on too many hospitals and hospital-based, specialised physicians, and did not maintain adequate primary health care services. With the end of the centralised Soviet administration and post-communist economic decline, the costly hospital-based curative system became impossible to maintain. Most hospitals lacked minimal equipment, drugs, and supplies, and could not afford maintenance costs. Extensive health care sector reforms started all over the region as early as in mid 1990s yet its outcomes are still of questionable quality. At the turn of the XXI Century, in many places the system collapsed in the face of serious financial shortages, triggering a huge increase in out-of-pocket payments, privatization of services, lack of essential medical interventions and reducing coverage to different social groups. International development assistance for the health sector in the region if existent still remains low in relation to health needs.
In addition to the poor condition of the medical system, the recent global economic downturn further took its tool on the health situation in the region. Lack of funding for health in national budgets implementing austerity measures as well as a decrease in individual incomes place many people at risk of not accessing even emergency health care.

Since the fall of state socialist regimes, all our member organizations have had to

[1] Stillman, S. (2006). Health and nutrition in Eastern Europe and the former Soviet Union during the decade of transition: A review of the literature, Economic and Human Biology 4 (2006) 104-146.

work against the consequences of severe financial slashing to national health systems. Neoliberal health policy implemented across the board tends to transforms patients who have rights to health into consumers who can (or cannot) pay for their health Moreover the lack of funding for health is often times doubled by a lack of adequate support and resources for civil society organizations including those advocating for SRHR or women's rights. A demographic crisis is also politically instrumentalized towards restricting access to abortion, contraception, HIV testing or forced sterilization. These three features can be regarded as trademark of the region.

While the Millennium Development Goals (MDGs) remain relevant, new global realities and trends are factors which cannot be ignored and any review process should account for this changed reality. We hope to inform this debate whilst at the same time to underline the importance of tackling the growing burden of problems related to lack of access to SRHR.

Three of the main Millennium Development Goals refer to health: Reduce Child Mortality (MDG 4), Improve Maternal Health (MDG 5) and Combat HIV/AIDS, Tuberculosis and Malaria (MDG 6) while another important goal targets gender equality Promote Gender Equality and Empower Women (MDG 3). These are the main reference points for our discussion, as they relate to our area of interest and expertise – gender equality, women's health, sexual and reproductive health and rights.

ASTRA Network and Eastern European Alliance for Reproductive Choice Recommendations regarding future development framework:

"*it takes all the running you can do, to keep in the same place. If you want to get somewhere else, you must run at least twice as fast as that!*"
(Red Queen in L. Carroll's *Alice in Wonderland*)

Lessons learnt from the MDGs framework:

The MDGs have influenced health policies in multiple ways. The MDGs raised awareness on health and galvanized support from donors, national governments, CSOs, public opinion on specific social and human development issues. Several of low income countries from our region integrated MDG 5 in their development policies, strategies and plans and adopted country-specific strategies on reproductive health, mother and child health.
Furthermore, the MDGs served as a benchmark for national governments in setting up their poverty reduction strategies and for donors in outlining their development

cooperation policies. According to the estimated from the IMF, OECD, United Nations and the World Bank, absolute aid spending on social sectors including health and education has increased twofold between 1990 and 2000[2]. However, this increase from $ 6.1 billion to $ 17.4 billion in 2009, and then dropped to $ 13.8 Billion in 2010 due to the global economic crisis[3].

Last but not least, the indicators introduced within the MDGs framework strengthened the system of data collection. For instance, MDG 5 indicators improved the availability of data on maternal mortality ratio; the proportion of births attended by skilled health personnel; the contraceptive prevalence rate; the adolescent birth rate; the antenatal care coverage and the unmet need for family planning. This reinforced accountability and was used by CSOs for advocacy and monitoring purposes at both global and country levels. Equally, MDGs created a framework for European NGOs to track ODA levels and encourage policy change. As a result better financial data on European governments' ODA to reproductive health is now available.

On the other hand, the series of problematic issues accompanied the realization of targets indicated within the MDGs framework.

Most importantly, the Millenium Development Goals were not set as a result of a broad consultation with all actors including grassroots organizations and CSOs, which led to a lack of ownership in the implementation. From the point of view of realization, lack of clear financing targets/indicators resulted in heavy underfunding of goals and obstructed the process of monitoring the realization of goals.

Furthermore, the MDGs fail to acknowledge the links between health and other key areas such as education, income generating activities, youth and women empowerment, and fail to stress the role of human rights approach in promoting sustainable development. The perspective imposed by MDGs separates development areas from each other and ignores their inter dependence. For instance, by separating HIV/AIDS, gender, maternal and child health, the MDGs have created a multiple track policy approach to the same problem hindering integration and horizontal approaches.

Moreover, the MDGs framework fails to address causes of poverty such as the violation of key human rights principles of non-discrimination, meaningful participation and accountability. The current development agenda has not highlighted inequity and inequalities, notably in access to health care. These hide vulnerable and marginalized groups from the statistics. Similarily, the current framework failed to address the existing differences between countries and acknowledge the different starting level of development between and within countries. The countries started out at very different levels in 2000 but had the

[2] IMF, OECD, United Nations, World Bank (2000), *A Better World for All: Progress towards the international development goals*. Available at: http://www.paris21.org/sites/default/files/bwa_e.pdf

[3] The United Nations Development Strategy Beyond 2015 United Nations June 2012 : www.un.org/en/development/desa/policy/.../2012cdppolicynote.pdf

same timeline- this weakened the impact of the current framework and jeopardised the goals, that were not perceived as realistic and achievable at the very beginning of the process.

The limited and fragmenting perspective on health that is embedded in the MDGs framework fails to acknowledge that health outcomes are also and greatly influenced by behavioural change, socio and cultural barriers, education, etc. For instance, while 15% of all pregnancies result in complications, most of these complications are curable and preventable through a strengthened health system but also through an overall approach to sexual and reproductive rights. One lesson that can be drawn from implementation of the MDGs in our region is that the post -2015 development framework must address the high incidence of unsafe abortions as a leading cause of maternal mortality and morbidity that affects vulnerable women in developing countries. Governments should implement policies and programs to ensure that women, especially adolescents and young women, have access to safe and legal abortions without mandatory waiting periods or requirements for parental and spousal notification and/or consent based on the woman's age, as well as adequate , pre - and post -abortion services including contraceptive counseling and information on HIV and sexually transmitted infections (STIs).

The existing references to SRHR in current MDGs framework are problematic, because they only target "mothers" and not women in general – focusing therefore mainly on the reproductive health side and leaving out the specific sexual aspects of the issues, and ignoring key target groups, mainly women and young people.

Finally, while MDGs fostered consensus on top developmental priorities, they failed to appropriately address human rights issues in general and sexual and reproductive rights specifically. This leaves out some of issues that have critical importance for achieving sustainable development in our region like violence against women and early marriage. Important aspects of maternal health which impact greatly on maternal morbidity and mortality such as unsafe abortion were also discarded. Indicators also left out the social and economic determinants of maternal health. From a policy perspective this has meant a narrow approach to sexual and reproductive health and rights which seriously hampered progress in improving maternal health. The MDG 5 b target on universal access to reproductive health was only added 7 years later. Also how SRHR-related goals were formulated reflected lower ambitions compared with other more comprehensive agendas, such as the International Conference on Population and Development Programme of Action. This has negatively impacted reproductive health policies and slowed down progress.

Summing up, one of the overarching benefits of the current framework and structure has been the spotlight the MDGs have placed on the importance of health for achieving development and overcoming poverty. Having 3 of the 8 goals focus on health emphasises this central importance. On the other hand, however, the

MDGs' agenda was proved deficient as it hasn't addressed appropriately issues related to human rights, social protection, inequalities, social exclusion, reproductive health and violence against women.

We recommend that the future agenda covers the following issues ignored by the MDGs framework:

- Human rights based approach in line with the WHO constitution stating that "*enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religious or political belief, economic or social condition*"[4]. The post-2015 development agenda should include a clear reference to the right to health under international law, and linkages with the relevant UN human rights conventions and mechanisms, such as in the case of sexual and reproductive health and rights, the Programme of Action of the International Conference on Population and Development (ICPD) in 1994 in Cairo.
- The notion of equity should be the core of the future framework, ensuring for instance, that gender equality is reflected through the lens of the right to health and the right to control one's body, including sexual and reproductive health; and placing obligations on governments to ensure that measures are put in place to secure equality.
- Specific health needs of people from vulnerable groups including women, youth, victims of domestic violence, internally displaced people, LGBTQI, sex workers, people living with HIV/AIDS, migrants, ethnic minorities, particularly Roma, disabled people, drug users. Two thirds of the world's poorest still live in middle-income countries. People from vulnerable groups experience poorer levels of health than the general population, face a range of barriers in accessing health care services and information and are more vulnerable to catastrophic health expenditure, as typically many people from vulnerable groups face higher health costs. The MDG framework failed to address the needs of young people in any substantive way, despite the fact that today almost half of the world's population is under the age of 24. The new development framework should include specific indicators that measure equality and progress made in reaching vulnerable and marginalised populations. The importance of setting clear targets is derived from the analysis of progress in achieving those of MDGs that lacked specific targets (especially MDG7 and MDG8). The targets in the new framework should be monitored and evaluated with disaggregated data to focus on different social-demographic groups and not only low income countries. Economic crude data cannot give a full picture of human development.
- Taking into account specific need of men and formulating comprehensive care and prevention programmes addressing men's health needs.

[4] http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf

- Putting SRHR in the center of future development agenda. MDG 5b, "*Achieve universal access to reproductive health*" was only added as a goal in 2005, and indicators were only assigned in 2007. Family planning and sexual and reproductive health and rights (SRHR) services are not adequately emphasized in the current framework. As a result, MDG5b is one of the worst performing MDGs, while over 200 million women who wish to avoid or delay a pregnancy do not have access to modern contraceptive methods. In in some countries of Eastern Europe and Central Asia (Albania, Armenia, Bosnia and Hercegovina, Macedonia and Serbia) the usage rate of modern contraception is below the average of 22% for the least developed countries and in another 10 countries it is lower than the average of 55% for less developed regions[5]. Moreover, the MDGs related to SRHR (MDG5 and MDG6) strongly target "mothers", rather than women in general – focusing mainly on reproductive health and ignoring the specific sexual aspects of the issues as well as the essential enabling conditions such as women and girls empowerment and self-agency.
- Promoting holistic approach to health, taking into account intersectionality of health outcomes and full spectrum of social determinants of health. In some of the countries of the region the traditional disease-specific interventions driven model of health services predominate. It is necessary to promote health systems based on recognition that good health outcomes rely on a variety of health and non -health inputs. This should include investment in the social determinants of health (including access to sanitation, employment, housing) which are critical to improving people's health outcomes and well-being. Furthermore, in order to be truly effective, the post-2015 agenda must take into consideration that while patterns of disease, care and treatment are changing, the health systems must be able to continually respond to these changing needs and priorities.
- The new goals should be linked to specific indicators, like performance-based funding indicators, facilitating measuring the progress towards their realization and specifying the sources of financing the process of realization. The last 15 years experience proves that many developmental strategies failed because they were not backed up by adequate resources and it was not clear which financial responsibilities each party had. This still holds true for many MDGs and particularly for MDG 5. The targets in the new framework should be monitored and evaluated with disaggregated data.
- The future framework should be a global framework which can be tailored to meet individual country needs and situations. It is important that the post-2015 framework take into account the context in which action will be taken, are founded on guiding principles that are adaptable at the national level, and flexible for local implementation**.** They should also be

5 http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITIONANDPOPULATION/EXTPHAAG/0,,contentMDK:22546157~pagePK:64229817~piPK:64229743~theSitePK:672263,00.html

based on shared, coherent understanding that enables global level solidarity and differentiated accountable action where necessary and appropriate. The scope should be global but take into account national situations and this should be reflected in the ways in which progress is measured. Not all countries have the same resources, or the same capacity, to implement measures needed.

- The future framework must be agreed upon by all stakeholders.
- Regarding the structure of the framework it is important that the new framework retain the positive aspects of the previous framework, i.e. time-bound, goals and targets with common indicators for transparency and accountability.

Health in post-2015 agenda. Priority health agenda for the 15 years after 2015- key issues:

Health is a precondition for and an outcome and indicator of all three dimensions of sustainable development: environmental sustainability, economic sustainability and sociopolitical sustainability. Health is, therefore, an indispensable part of economic growth and remains a major determinant for productivity; and, in an ageing society, health also becomes an economic necessity. The primary purpose of any future framework should be a consistent and measurable improvement in the living conditions of the millions of people in countries currently in process of development. Global health challenges cannot be addressed effectively without addressing social, economic and environmental determinants and challenges. We now have a great opportunity to shape the policies and practices that recognize this intersectorality by focusing on social determinants of health, including through integration of the social protection approach.

We recommend that future agenda focuses on following priorities:

- Realization of the "*Right to the highest attainable standard of physical and mental health*" for all people, in all countries. This ought to include marginalised and vulnerable populations such as women, youth, victims of domestic violence, internally displaced people, LGBTQI, sex workers, men having sex with men, people living with HIV/AIDS, migrants, ethnic minorities, disabled people, drug users. The post-2015 development agenda on health should include a clear reference to the right to health under international law, and linkages with the relevant UN human rights conventions and mechanisms.
- Holistic approach to health- It is necessary to promote health systems based on recognition that good health outcomes rely on a variety of health and non -health inputs. This should include investment in the social determinants of health (including access to sanitation, employment, housing) which are critical to improving people's health outcomes and well-being.

- Strengthening health systems- The strategic importance of strengthening health systems is crucial. While a well-performing health system can help to increase equity in health care access, improve health outcomes and improve health equity, poorly performing health systems can be a major barrier to health care and a critical social determinant of health. Many of health systems in the region fail to support people in realising their right to health and limit access to health services. Inequalities in the distribution of health services persist and translate into limited access to health services and the burden of ill health, according to socioeconomic status, geographical location, gender, ethnicity and age, including an unfair burden of out-of-pocket expenses and a high proportion of catastrophic household spending on health. The reforms of health systems should enable them to take into account the diversity and the social determinants of health, so the delivery of health services is responsive, inclusive, accessible and equitable services.
- Investing in health systems. In our region, many health systems are chronically under-resourced and financed, with many people paying catastrophic out-of -pocket payments to access health care. Evidence demonstrates that while the MDGs have led to significant increases in aid flows to health (from 2000 to 2006 development assistance to health rose from US$6.8 billion to US$16.7 billion[6]) and a proliferation of global health initiatives, this has not led to the significant investment in, or strengthening of, health systems as was initially envisaged. Furthermore, resource distribution has been uneven with most of the increases in development assistance directed at disease-specific interventions under MDG6. This vertical programming and subsequent financing in health has seriously undermined the capacity of many health systems to deliver primary health care and often to meet the most basic needs of the population. To mitigate this fragmentation, targeted, effective investment in health systems is required.
- Securing sustainable funding. The post-2015 framework is being developed and negotiated in an era of global economic crisis. In order for the post-2015 development goals to be met, long-term sustainable and predictable funding needs to be identified and secured. The goals set in the future development framework should be closely linked to funding modalities, with clear accountability mechanisms for donors and governments. Special funding approaches need to be considered for countries with high economic dependency such as least-developed countries, fragile states and small developing states. The private sector needs to share the responsibility to improve public health and access to affordable goods and services. National governments have a responsibility to work hand in hand with donors, allocate their own financial resources to health and development responses, and to stimulate private-public partnership to increase access to SRHR. The new

[6] WHO 2008

framework should include mechanism in order to secure government's accountability for allocation of funds. The new framework should serve as an opportunity to go beyond the false dichotomy between "horizontal" and "vertical" interventions (addressing the overall health systems versus disease-specific approaches). Strong and effective health systems that achieve universal coverage need both horizontal and vertical components with community systems strengthening at their core.

- Universal Health Coverage[7] that can only be achieved within the framework of effective health system with effective primary health care services, a well-performing workforce, strong health management information systems and governance, access to essential medicines and an effective health financing system; and must be funded on long-standing political, technical and financial resources at international level in order to support national efforts to remove user fees or payment -for-service and progress towards UHC. Moreover, UHC will ensure that large migrant populations will benefit from access to health wherever they will be (sometimes forced by circumstances) working.
- Removing inequalities in access to health. A principle of equity in health needs to address equity of opportunity and outcomes - equity of outcomes means not just providing the essential institutions – such as within a health system – that provide quality services (equality of opportunity), but taking into account the diversity of people's needs, such as women, youth, LGBTQI, migrants, ethnic minorities, internally displaced people, people living with HIV or with disabilities, and developing processes that enable people to participate in decision -making in services that affect them and policies that facilitate better health outcomes.
- Inter-sectoral approach to health. Health policy generally, and health equity in particular, to a large extent depend on decisions made in sectors other than health, and are fundamentally linked to several interrelated issues such as governance, environment, education, employment, social security, food, housing, water, transport and energy. It means that health outcomes cannot be achieved by taking action in the health sector alone, and that actions in other sectors are critical.
- Prioritizing SRHR - unequal access to sexual and reproductive health information, education and services exacerbate the poor health, poverty and other inequalities experienced by marginalised groups including women and girls, adolescents and the poor. In developing countries an estimated 222 million women have an unmet need for contraception, meaning that they face risk of an unplanned pregnancy and are not using modern contraception. Human health, including SRHR, is a critical aspect of human development and sustainable development and *'the enjoyment of the highest attainable*

[7] *„practical expression of the concern for health equity and the right to health. UHC is a "system in which everyone in a society can get the health care they need without having to incur financial hardship" (WHO).*

standard of physical and mental health' is a recognized human right. Poor health, poverty and social inequities are inextricably linked, and lack of access to SRHR is a key driver of poor maternal and child health and gender inequality.

Future health goals & indicators:

HEALTH GOAL PROPOSAL 1- UNIVERSAL ACCESS TO HEALTH

Health services must be accessible to all, including vulnerable and marginalised populations, available in sufficient quantity, respectful of medical ethics and of high quality. Universal access to health should ensure that all services are responsive to the needs of patients, particularly the most vulnerable and marginalized, and address a wide range of social and structural barriers. People should have access, without discrimination, to nationally determined sets of the needed preventive, curative and rehabilitative basic health services and essential, safe, affordable, effective and quality medicines, while ensuring that the use of these services does not expose the users to financial hardship, with a special emphasis on the poor, vulnerable and marginalized segments of the population. In order for universal access to health to be equitable and meaningful, it also requires that several social determinants of health are addressed, including at the levels of differential socioeconomic position, differential exposure to risk factors, differential vulnerability to diseases and health conditions, differential health outcomes and differential consequences of diseases and health conditions.

Universal access to health must cover sexual and reproductive health and rights (SRHR) services, including family planning, which are not emphasized in the current MDGs. In order not to let reproductive health to be subsumed under broader social development or become a mainstreaming theme that could easily become neglected, reproductive health must be identified as a priority in its own right within the health goal.

Indicators: population, life expectancy at birth (M/F, and by social and demographic group), healthy life expectancy (M/F), birth rate, death rate, under-5 mortality rate, modern contraceptives prevalence, maternal mortality rate, HIV prevalence, ART coverage, unmet need in ART coverage, tuberculosis incidence, immunization coverage, cancers (registered cases, mortality), communicable and non-communicable diseases incidence/prevalence, malnutrition, improved sanitation facilities (urban/rural), % of people covered by health insurance (M/F), unemployment rate and number of unemployed, self-reported unmet need for health care (M/F), out-of-pocket health expenditure, health expenditure per capita, health expenditure (total/public), etc.

HEALTH GOAL PROPOSAL 2- SRHR Goal (Universal Access to Sexual and Reproductive Health and Rights)

Promotion of sexual and reproductive health and rights necessarily encompasses promotion of gender equality and equity and measures to combat gender -based violence and violence against women, which assists in facilitating the social inclusion of vulnerable groups in development efforts. When laws and policies are in place to further gender equality, including regulations to ensure that girls are not forced into early marriages and that women and girls can inherit and own land and property, provide food for their families by growing and selling food, attend educational institutions of their choice, and control their own fertility , their participation in social development is enhanced. Thus, women and girls must be enabled to take voluntary, autonomous decisions about whether and when to have children so that they can take full advantage of educational and employment opportunities and be able to participate in community and civic decision -making and activities.

Formulating specific targets related to reproductive health and inserting it to the post-2015 agenda will help galvanizing political leadership, funding and accountability - which also will result in important gains in broader health. This needs to be built upon in the post-2015 framework by including strong and comprehensive reproductive health-related targets and indicators. They should be based on paradigm of focusing on the needs and rights of individuals and that having control over their sexuality and fertility allows people to choose how to live their lives. Key aspects of the SRHR agenda are derived from the ICPD PoA and include the following: contraception and family planning, post abortion care and safe abortion services, maternal health services, adolescent and youth-friendly SRH information and services including comprehensive sexuality education, reducing maternal morbidity, prevention, screening and treatment for reproductive cancers, reproductive tract infections, sexually transmitted diseases.

Furthermore, the SRHR- related targets and indicators must take into consideration that SRHR is heavily impaired by poverty-related diseases, especially HIV/AIDS and TB. The linkages between HIV and SRHR are well-known since the growing number of HIV infections are sexually transmitted or associated with pregnancy, childbirth, and breastfeeding. In addition, sexual and reproductive ill-health and HIV share root causes, including poverty, gender inequality and social marginalization of the most vulnerable populations. TB meanwhile is the third leading cause of death globally among women in their reproductive years.

As it regards developing countries with high fertility, like Tajikistan, by avoiding unwanted pregnancies, we can significantly reduce the number of women experiencing problems in pregnancy and childbirth, the leading cause of death

amongst young women as well as a major cause of morbidity through unsafe abortion or delivery-related problems. Enabling women to space their pregnancies and choose a time that suits them will improve maternal health. Having smaller families will make it easier for women to look after their children in terms of both time and household resources. Smaller families will also make it easier for health systems in low resource contexts to service their populations. Over forty per cent of the world population is under thirty years of age, meaning that demand for family planning is rising.

Reduced population growth reduces pressure on limited resources and the environment and relieves pressure on society and services. Enabling people, especially women, to limit their family size gives them control over their lives and is a basic human right. With that control, they are better able to participate in society, including formal employment. This gives women an independent income and empowers them. The ability of younger women to avoid pregnancy enables them to complete secondary education, empowering them by giving them the skills to participate in employment where education is a requirement and to play a full role in society.

Helping people to prevent unwanted pregnancies by promoting access to sexual and reproductive health information and services, including voluntary family planning, improves the health and well-being of women, men, and young people. At the same time, it helps to increase educational and employment opportunities, particularly for women and girls. Ultimately, it helps countries make savings and gains that enable them to reduce poverty and to reach their development goals. It is therefore essential that health, including sexual and reproductive health and rights, is at the centre of the post-2015 decision making processes to ensure that position of health, including reproductive health, remains as ambitious in the future framework as it is in the current framework.

It is our view that the best indicators for health are those which can be tracked and measured. In order to ensure full realization of the right to health, the new development framework should include specific indicators that measure equality and progress made in reaching vulnerable and marginalised populations. The importance of setting clear targets is derived from the analysis of progress in achieving those of MDGs that lacked specific targets (especially MDG7 and MDG8).

With regards to SRHR the main indicators should be: comprehensive sexuality education; non -coercive sexual and reproductive health counseling; a wide range

of short - and longer –term modern contraceptives that are available without requirements for spousal or parental consent; assisted conception measures; prevention of sexually transmitted infections and diseases that can affect healthy pregnancies (e.g., malaria); satisfaction with level of services, adequate and accessible antenatal, delivery and post -natal care; and prevention and management of unwanted pregnancies through easily accessible and legal emergency contraception and safe abortion care.

In addition, targets and indicators should be formulated regarding the implementation of laws and policies and fulfillment of obligations assumed with the ratification of international treaties that promote access to all evidence-based reproductive health services. This would include revision of laws that criminalize or impede access to comprehensive sexuality education, modern contraceptives including emergency contraception, and safe abortion care. In this context, attention should also be given to monitoring mechanisms at the community level, as well as the implementation of national human rights bodies, such as human rights commissions and ombudspersons, and redress mechanisms for persons denied sexual and reproductive rights.

Development Goal: "Universal Access to Sexual and Reproductive Health and Rights"

Target 1:"Achieve universal access to Sexual and Reproductive Health"

Specific indicators on Maternal Health, access to contraceptives, modern contraceptives prevalence rate, prevention on unintended pregnancies and STIs, youth friendly services, HIV/AIDS, (regional) free access to contraception(including emergency contraception, zero unmet need in effective contraception.

Target 2: "Achieve universal recognition of Sexual and Reproductive Rights"

Specific indicators on: Protection of sexual and reproductive rights, Protection from violence, free safe abortion, comprehensive sexuality education in schools, ban of sexual discrimination (granted LGBTQI rights).

Target 3: "Achieve strengthened systems for Sexual and Reproductive Health Financing"

Specific indicators on: SRH financing (divided in specific areas: sex

ed financing, contraception financing, abortion services financing, etc)

Indicators should allow for disaggregation by age, sex, urban/rural, social status and income status in order to unmask the inequalities hidden behind generalized statistics.

HEALTH GOAL PROPOSAL 3

Improve Women's Health

This particular goal aims at improving the lives of women around the world. As mentioned previously, women are often and in many contexts victims of gender-based discrimination, victims of violence (including sexual), poor, underrepresented in decision making bodies. Moreover, women may be faced with multiple discrimination based on their race, ethnicity, religion, age, income, state of health, sexual orientation. At the same time, women are important agents of development and their well-being is a significant indicator of the well being of their communities and families. Therefore, we call on the global community to ensure that women enjoy the highest attainable standard of physical and mental health.

HEALTH GOAL PROPOSAL 4

Promote Sexual and Reproductive Health and Rights

Policy-makers and politicians often overlook the importance of sexual and reproductive health as it is tied up with societal and religious taboos over sexuality. Nonetheless, the double standard of narrowly conceived morality should not impede on the health rights of people.

Sexual and reproductive health deals with an area of human life closely connected to one's sense of self and self-fulfillment as it is tied to reproduction and intimacy. Moreover it is a field where prevention and education can make important gains against some cancers and communicable diseases.

Recommendations:

Building on over 20 years of experience of ASTRA Network and EEARC members in

advocating for sexual and reproductive health and rights (SRHR)[8] we call for post-2015 agenda that will be founded on recognition of sexual and reproductive health and rights being a prerequisite for individuals' well-being and for the achievement of social and economic development, both at the individual and societal level.

Gender, class, ethnicity and age are important determinants of individuals' ability to decide over matters related to their body and health, as well as their access to services, commodities and information related to health, including sexual and reproductive health. Lack of access to sexual and reproductive health and rights reinforces social, and economic, inequities, particularly those experienced by women, youth, poor people and other vulnerable and marginalized groups. Furthermore, sexual and reproductive health and rights are essential for the achievement of sustainable development, by addressing population dynamics and the interrelationships between population, health and the environment in ways that respect and protect human rights, and particularly women's rights. Lack of access to sexual and reproductive health and rights constitutes a significant barrier to enabling everyone to contribute fully to the achievement of inclusive sustainable development, and to the full realization of human rights and achieving gender equality. It is now time to ensure universal access to sexual and reproductive health and rights, and to seize the opportunities this would offer to drive progress towards addressing the root causes of gender inequality, poverty and the realization of sustainable development.

The Millennium Declaration, affirming the "*collective responsibility to uphold the principles of human dignity, equality and equity at the global level*" remains relevant in many aspects. However, the current MDGs' framework fails to address the centrality of human rights for sustainable development. Human rights, including sexual and reproductive health and rights and equality, need to underpin the new post-2015 development framework to ensure that vulnerable and marginalised populations are not excluded from services and that health, including reproductive health, is recognised as a universal human right.

The new development framework should include, but not be limited to ensuring universal access to health and universal access to reproductive health, advancing health research, strengthening health financing, introducing the rights-based approach, targeting vulnerable and marginalized communities.

The future health goals should work toward access to equitable and quality health services to all, and they should be guided by the following principles: equality,

[8] SRHR is defined in the Programme of Action from the UN Conference on Population and Development (ICPD PoA) in Cairo in 1994 as "*a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so*." Further, the definition states: "*Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.*"(ICPD PoA)

human rights, quality, solidarity, efficiency and an integrated approach to achieving better health outcomes.

The recommendations are focused on the four major areas where urgent improvement is necessary in order to press forward to achievement of sustainable development through improving health outcomes: strengthening health systems; health financing; continued, committed and sustained governmental and donor investment in health, including women's sexual and reproductive health; policy change with respect to reproductive rights and sexual rights; universal access to health, including sexual and reproductive health; and the concretisation of sexual and reproductive health and rights for adolescents and other marginalised groups. Furthermore, the recommendations seek to express the specific needs of the countries of Central and Eastern Europe and Central Asia as identified by regional experts.

POLICY CHANGE UNDERPINNED BY COMMITMENT TO HUMAN RIGHTS

The political will of governments is essential to improving health outcomes in our region. In all areas where progress has been noted in realization of the current MDGs framework, government policies and implementation were critical for success. Now, as the new development agenda is being decided upon, it is imperative that governments become more cognizant of their obligations stemming from international human rights treaties, with special attention paid to underserved groups (women, youth, migrants, Roma, ethnic minorities, LGBTQI, internally displaced people, disabled, living with HIV/AIDS), who are disproportionately affected by human rights violations, and whose wellbeing should be viewed as critical to government efforts to achieve sustainable development and reduce poverty.

The human rights must be put in the center of the new transformative agenda. The post-2015 development agenda on health should include a clear reference to the right to health under international law, and linkages with the relevant UN human rights conventions and mechanisms.

STRENGTHENING HEALTH SYSTEMS

1. Strengthen health systems in order to achieve universal access to high quality primary (preventive and curative) care that is financially sustained through more appropriate roles for the public and private sectors and more efficient allocation of resources.

2. Fund adequately medical services and pharmaceutical products in order to abide by the principle of equal access to health care as well as to guarantee the individual right to non-discriminatory access to health care.
3. Guarantee the implementation of SRHR policies by: ensuring the functionality of health systems, allocating adequate budgets for that purpose, providing updated training for health professionals;
4. Inform health policies with an intersectional analysis; to base these policies on data using reproductive rights indicators; to include marginalized groups, in these policies; and to use qualitative research input in order to ensure that these policies are continually relevant.
5. Take into account the diversity and the social determinants of health, so the delivery of health services is responsive, inclusive, accessible and equitable services.
6. To introduce targeted, effective investment in health systems in order to mitigate the fragmentation caused by vertical programming and subsequent financing in health which has seriously undermined the capacity of many health systems to deliver primary health care and to meet the most basic needs of the population.
7. To identify and secure long-term sustainable funding. The goals set in the future development framework should be closely linked to funding modalities, with clear accountability mechanisms for donors and governments. Special funding approaches need to be considered for countries with high economic dependency such as least-developed countries, fragile states and small developing states. The private sector needs to share the responsibility to improve public health and access to affordable goods and services. National governments have a responsibility to work hand in hand with donors and also allocate their own financial resources to health and development responses. The new framework should serve as an opportunity to go beyond the false dichotomy between “horizontal” and “vertical” interventions (addressing the overall health systems versus disease-specific approaches). Strong and effective health systems that achieve universal coverage need both horizontal and vertical components with community systems strengthening at their core.

ADDRESSING INEQUALITIES BETWEEN THE COUNTRIES AND WITHIN THE COUNTRIES AND RESPONDING TO NEEDS OF UNDERSERVED GROUPS

The notion of equity should be the core of the future framework, ensuring for

instance, that gender equality is reflected through the lens of the right to health and the right to control one's body, including sexual and reproductive health.

The new development agenda needs to be in line with existing international Human Rights such as in the case of sexual and reproductive health and rights, the Programme of Actions of the International Conference on Population and Development (ICPD) in 1994 in Cairo. This should include safe abortion, fight against violence and discrimination against women and reducing unmet need for family planning among the people most in need – youth and women living in rural areas.

More specific goals are needed, that can be different for the countries and can be adjusted according to their specific conditions. For example if the decrease of the cases of female genital mutilation (FGM) could not be added as an indicator globally, but for sure it is very important for the countries where it is present as a practice.

More specific goals (or related to) for young people are needed. The current MDGs framework includes goals related to children which is a very important area that should be covered. . But there are situations where countries prioritize children but do not include young people. Which means they become a marginalized group.

Greater focus on men's health is needed.

REALISATION OF THE HIGHEST STANDARD OF SEXUAL AND REPRODUCTIVE HEALTH

Lack of access to SRH services and information contributes to high levels of morbidity and mortality for largely preventable SRH problems, particularly in developing countries. Every year, 300 thousands women die during childbirth because they are not able to access life-saving emergency obstetric services. Lack of information and education on HIV/AIDS and condoms, as well as insufficient provision of condoms have contributed to the spread of STIs, including HIV. Restricted access to abortion services, contraceptives, and information on sexuality and reproductive health has led to unwanted pregnancies, botched abortions, women's impaired health and wellbeing and women's deaths. Policy formulation must be backed up by service provision ensuring universal access to sexual and reproductive health. In addition, it is very important that in the future development framework there is understanding for the importance of SRHR for achieving the sustainability in general. Through new data and research the linkages between SRHR and poverty reduction or climate change should be made clear. This data will support the need for a stronger focus on SRHR.

1. Population policies continue to be driven by state interest rather than by

meeting women's needs. Policies pertaining to women's sexual and reproductive health need to be under-pinned by the ICPD PoA and the underlying concepts of reproductive rights and sexual rights. Policies on sexual and reproductive health and rights need to be mainstreamed into already existing national machineries, national policies and national plans in a cohesive manner.

2. Policies that determine sexual and reproductive health and reproductive rights should be aligned to provide access to a range of contraceptive methods, abortion services, pregnancy-related mortality and morbidity interventions, addressing STIs and HIV/AIDS, reproductive cancers, and male responsibility in sexual and reproductive health. Policies should also enunciate measures against stigma and discrimination.

3. Policies should be implemented and backed by functional health systems, adequate budgets, trained human resources and updated training and curriculum for health professionals. Policies that determine SRHR must recognise the need for inter-sectoral coordination and cooperation. Existing policies which are progressive must be publicised, especially to service providers and to women, and must be translated into programme and project implementation.

4. Policies and policy review should be informed by robust data, should measure new indicators of reproductive rights, should include groups (beyond the traditional one of married women aged 15-49 years) such as unmarried single women, and include input from qualitative research in order to ensure that these policies are continually relevant. Intersectional analysis would enable governments to understand differences in policy implementation for different marginalised groups. It is important to develop data collection systems based on internationally comparable methodology.

5. Policies and policy reviews that determine SRHR need to be created and implemented in secular spaces, free from the influence of fundamentalisms and other doctrines that restrict human rights.

6. Policy review efforts should be integrated into CEDAW, ICCPR and ICESCR reporting mechanisms in order to put pressure on governments to meet international commitments regarding SRHR. NGO cross-movement collaborative efforts would help initiate policy review.

7. Policy reviews should be underpinned by human rights paradigms. These can build on the 2009 call by the UN Human Rights Council to recognise preventable maternal mortality and morbidity as human rights violations, and on the 2009 NGO Berlin Call to Action by the SRHR community to address deaths resulting from unsafe abortions also as a human rights issue. This would ensure that sexual and reproductive health are framed and treated as issues of human rights, and that governments are held accountable for fulfilling them, regardless of economic climate or political change. Legislative initiatives that expand the grounds for abortion, for instance, or which repeal laws that punish women for procuring an abortion, should be introduced.

8. Policy review efforts should integrate the good practices of neighboring countries as performance benchmarks, and engage in knowledge-sharing and learning between countries.

9. Comprehensive SRH services need to be made available, affordable, and acceptable at all levels starting from the primary healthcare level. The primary healthcare level is the one which is most accessible to most of the population and, hence, the essential sexual and reproductive health services should be made available at this level. There needs to be renewed commitment to making available the full range of contraceptive methods (including emergency contraception and the promotion of condoms as a dual protection method); the full range of abortion services and post-abortion care; the full range of services that prevent maternal deaths, especially emergency obstetric care services and adequately equipped facilities; and the full range of services to identify and to treat victim-survivors of violence including counselling. Counselling services, especially to ensure informed choice, should also be provided. Contraceptives, anti-retroviral drugs, antibiotics, and other supplies ought to be adequately stocked in health facilities or other centres where younger and older women and men are able to gain access to them. Information and education campaigns are important, but behavioral change communication strategies have been shown to alter health-seeking behavior significantly in many cases.

10. There needs to be renewed commitment to staffing health facilities with skilled and trained human resources. Service providers should incorporate gender-sensitive approaches and be receptive to differences in sexual orientation and gender identities. Service providers should also mitigate misconceptions on all aspects of sexual and reproductive health. Service

provision should also include accountability mechanisms and redress mechanisms for patients and clients.

11. There is a dire need to integrate services, especially RH and HIV services, which have generally been funded separately and operated vertically, meaning that clients see a different provider for each health service. Yet, with the growing number of HIV infections being sexually transmitted, addressing RH and HIV together would better serve the needs of clients and health care providers in a more comprehensive, cost-effective, and efficient manner than it is envisioned under current MDGs framework. Integration is a feasible means to achieve multiple key goals: prevent new HIV infections among women and girls; reduce HIV transmission from mother to child; prevent more AIDS orphans; and support HIV-positive women's reproductive rights and fertility choices. From the perspective of ethics and programme operations, women and girls who access HIV testing, counseling, and treatment through HIV/AIDS programmes have a compelling need for RH and FP services, especially relating to their fertility choices, just as much as women and girls accessing RH and FP services have a critical need for HIV information and services. In this aspect we need to:
    - Develop more effective strategies to help HIV-positive women prevent unwanted pregnancies and access contraception. This underscores the need for comprehensive SRH services where providers do not judge their clients and for the provision of safe spaces for young, HIV-positive women to access services. Responses are needed to address negative, judgmental attitudes of service providers toward HIV-positive women, especially those wanting children.
    - Strengthen the ability of local government units and NGOs to reach adolescent girls, including married adolescents, with RH and HIV information and services. Adolescent girls have poor access to confidential and affordable reproductive health and HIV services, making it difficult for them to protect themselves from HIV and unwanted pregnancy. This is an area that demands greater innovation and attention, both through facility-based approaches and other activities to reach young people.
    - Develop programmes that integrate RH/FP programmes in HIV/AIDS prevention strategies. This is critical: programmes that help prevent women from acquiring HIV but do not help women prevent pregnancy are not sufficient. Women need to use dual protection – contraception and condoms – to prevent unwanted pregnancy and HIV.

ENSURE CONTINUED, COMMITTED AND SUSTAINED INVESTMENTS IN HEALTH, INCLUDING WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS BY GOVERNMENTS AND DONORS

Until 2011, aid had been steadily increasing for more than a decade and net official development assistance (ODA) rose by 63% from 2000 to 2010. However, a drop in ODA registered in 2011 shows that donor countries need to move more aggressively to meet the 0.7% aid target by 2015.

1. There needs to be advocacy for political support and to encourage donors and governments to meet the agreed funding requirements to ensure universal access to sexual and reproductive health services beyond 2015:
    - At the global level – by influencing the allocation of ODA to sexual and reproductive health and rights (SRHR) by forging partnerships with global inter-government agencies and international NGOs;
    - At the regional level – by impressing the central role of SRHR in the achievement of the sustainable development upon EU institutions, UN agencies and regional offices of other UN agencies such as UNDP and UNAIDS;
    - At the national level – by prioritising SRHR in national development plans and legislative initiatives, by ensuring that SRHR is supported by funds stipulated in the national budget, and by incorporating SRH service components, especially important country specific SRH issues.
    - At the sub-national or local level – by prioritising SRHR in local or provincial investment health plans at the local level, i.e., local government units, and by ensuring that funds are invested in interventions and activities that support and sustain efforts to achieve the sustainable development.

2. It is important to advocate that governments track expenditure on SRH. There is a compelling need to create national health accounts' (NHA) sub-accounts on RH programmes. This is a crucial tool for setting priorities, allocating budgets, and advocacy as well as for increasing transparency and drawing accountability from governments tasked with providing RH services.

3. The capacity of partners and their constituencies needs to be strengthened, to engage effectively in policymaking and political decision-making processes. They need to: appreciate the context and understand the processes of policymaking such as setting priorities and drafting policies and engaging in health sector-wide approaches; to strategically apply political and technical tools, e.g., national health accounts' sub-account for RH to influence priorities and budgetary allocations; to forge alliances and coalitions; and to

demonstrate results.

4. Donors should fulfill their commitments to the vision set out by the Millenium Development Goals and other international frameworks, especially ICPD PoA, by funding all components of SRHR and health system strengthening from primary healthcare levels. Vertical funding mechanisms for components of SRH services need to be reviewed, putting them under the same umbrella.

CONCRETISE THE RIGHTS TO SEXUAL AND REPRODUCTIVE HEALTH AND THE SEXUAL AND REPRODUCTIVE RIGHTS, ESPECIALLY THOSE OF ADOLESCENTS, MARGINALISED GROUPS OF WOMEN AND THOSE WITH DIVERSE SEXUAL ORIENTATION AND GENDER IDENTITIES

Across the region, there is a tendency to restrict women's access to SRHR services and supplies. Moreover, women who are poor, less educated, who live in remote areas, rural areas, and less developed parts of the country face greater difficulties in accessing services and realising the autonomy of their bodies. This happens regardless whether the service they require access to is contraception, maternal health services, safe abortion services, prevention and treatment of reproductive cancers, HIV testing and anti-retroviral therapy or sexual health services. Sexual and reproductive health and rights are issues of socio-economic equity as well as gender equity.

1. Adolescent-friendly policies and services need to be created, because this group faces the greatest barriers in accessing information, education and services for sexual and reproductive health. Barriers of consent and discrimination which prevent adolescents from accessing all sexual and reproductive health services including contraception, abortion and post-abortion care and counseling need to be eliminated.

2. It is important to ensure that comprehensive sexuality education is available, to inform and empower adolescents with choices regarding safe-guarding their sexual and reproductive health and enable them to realise their sexual and reproductive rights.

3. Comprehensive programmes need to be created, with policies and plans to address marginalised groups. Ethnic minorities, elderly, disabled, and migrants will require more than one intervention to improve their sexual and reproductive health and rights. Barriers that impede their access must be

understood, and these must be deliberately and systematically removed. It is important to ensure that national resources are also allocated to these marginalised groups. Sexual and reproductive health needs of these groups must be understood in a non-judgemental manner, and service provisions created if previously non-existent.

4. Policies need to be created which will include sex-workers and people with diverse sexual orientation and gender identities within service provision, which will ensure they are entitled to equal, fair, non-discriminatory sexual and reproductive health services, care and treatment. Legislation needs to be created and enacted, which will enable these groups to also realise their sexual and reproductive rights to the fullest.

5. Communities must be empowered, especially marginalised communities, to recognise their rights to sexual and reproductive health, and build their capacities to claim these rights from duty-bearers. Spaces need to be created for the participation of different marginalised communities in policy and programme formulation, encouraging their leadership at all levels.

6. Policies and programmes need to be implemented with an understanding of the different aspects of vulnerability: exposure to risks and danger as well as lack of the capacity to cope with the negative consequences of risks and threats of these marginalised groups. In situations of emergencies and disasters, it is important to fully understand the increased risk for marginalised groups and incorporate SRH into the formulation and implementation of disaster-preparedness, response and recovery plans.

In conclusion, we urge governments, donors and international organisations in the region to understand the critical need for pressing forward on the agenda of sexual and reproductive health and rights in this region.

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The report was edited by Katarzyna Pabijanek, ASTRA Network Coordinator.