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Reproductive Health in Transition Countries in the European Context

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Reproductive Health in Transition Countries in the European Context

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Introduction

The International Conference on Population and Development (ICPD) held in Cairo in 1994 adopted the first normative definition of reproductive health which incorporates the World Health Organization (WHO) concept of health as “a state of physical, mental, and social well-being and not merely the absence of disease and infirmity” in all matters relating to the reproductive system and at all stages of life. It also recommends that the state of reproductive health should be considered within a broad social and environmental context and that adequate provisions of appropriate services are integral part of reproductive health. In the last decade, countries in Central and Eastern Europe and the Commonwealth of Independent States (CIS) have undergone major economic and social transformations that have affected virtually every aspect of life, including health. By some measures, women’s health has improved—for example, women in the region today are more likely to use modern contraception and less likely to have an abortion to prevent unplanned births. On the other hand, rates of maternal and infant deaths, although lower than in the past in most countries, are still unacceptably high, the use of preventive health services is low, and awareness about some important issues such as how to prevent HIV/AIDS is generally lacking. Regional and socio-economic disparities within countries are large and sometimes have worsened compared to the pre-transition period.

This paper provides a broad overview of various aspects reproductive health in the region, covering a wide range of women’s health topics and providing in-depth information on attitudes and behaviors related to reproductive health. For 13 countries, data are derived from CDC-assisted Reproductive Health Surveys (RHS) and ORC Macro-assisted Demographic Health Surveys (DHS) conducted in the region since the mid-1990s. These surveys were conducted in several countries in Eastern Europe (Albania, Czech Republic, Moldova, Romania, Russia, and Ukraine), the Caucasus (Armenia, Azerbaijan, and Georgia), and Central Asia (Kazakhstan, Kyrgyz Republic, Turkmenistan, and Uzbekistan) (Centers for Disease Control and Prevention [CDC] and ORC, Macro, 2003). With the exception of Russia, where the sample was drawn from three urban areas only, all surveys consisted of interviews with large nationally representative samples of women of reproductive age. For other countries of the region, reproductive health data included here come from official statistics, when available. The results give program officials, researchers, and policymakers an opportunity to view the characteristics of women that have the greatest health needs and the factors associated with increased contraceptive use, reduced reliance on abortion, and to other changes in reproductive health behavior.

The Context for Reproductive Health

Shared history

The transition countries of Central and Eastern Europe and the CIS constitute a diverse group of nations, each having its own rich historical and cultural heritage, a distinct ethnic composition, and unique political and socioeconomic development. Their inclusion in a common group is rooted in relatively recent events. From the end of World War II until 1989, all of these nations

had socialist governments and experienced similar political and economic situations. Their increasing isolation from Western Europe and their inclusion in either the Soviet Union or its sphere of influence, added commonalities to a region already brought together by shared history and geographical proximity. The collapse of the Soviet Union loosened the old political systems in the region and triggered profound social, economic, and political changes. Since about 1990, most of the Eastern European countries and the former Soviet Union have made efforts to move from centralized totalitarian regimes under the influence of the Soviet Union, to decentralized administrative, economic, political, and socio-cultural systems whose priorities are capacity building, transition to a democratic society, and development of a market economy. However, their progress on the road of post-communist transition has been uneven. At the forefront are the countries of Central and Eastern Europe and the Baltic countries, more advanced in their transition due, in part, to preserved and renewed Western traditions. Other countries have been less successful, having economies still in the early stages of transition, facing severe economic hardships and, in a few instances, struggling with divisive ethnic disputes. All countries, however, have been subject to profound societal transformation, including rapid changes in the health status of their populations and in their health care systems.

Similar Demographic Profile

Demographically and socially, the transition countries have much in common (Table 1). Between one-fourth and one-third of their populations are composed of women of reproductive age (15–49 years) (Population Reference Bureau [PRB], 2002a).¹ With the exception of the Central Asian republics, most transition countries have fertility rates lower than those typically found in Western Europe and well below the replacement level of 2.1 births per woman (PRB, 2002a). Despite substantial differences in fertility between the European and Central Asian countries examined, rates of childbearing have fallen substantially in all places. Large actual or intended families are rare. Compared to women in Western Europe, women in transition countries tend to marry early, have their first child shortly after they marry, and achieve the desired family size of about one or two children soon thereafter. Women tend to both begin and end their childbearing at much earlier ages than in Western Europe and North America. The vast majority of childbearing takes place between the ages of 20 and 29, and it is concentrated in the early twenties. Fertility of 15-19-year-olds is at least twice as high as in Western Europe. Mainly because of below-replacement fertility (with a small contribution from increased mortality and out-migration in some countries), population growth rates are near zero or even negative, excepting the countries in Central Asia. This situation has become a major social and economic concern in the region.

[Table 1]

Compared to most of the major countries of Western Europe, life expectancy at birth in Central and Eastern Europe and the Caucasus is, on average, 9 years shorter among men and 7 years shorter among women. The difference in life expectancy between the Central Asian countries and Western Europe is, on average, 12 years for men and 10 years for women (PRB, 2002a). While life expectancy in Western Europe have steadily increased, life expectancy in many post-

¹ The fertility rates presented in Table 1 and 2 are taken from the most recent official statistics available.

communist countries has declined in the mid-1990s—particularly in the Russian Federation, which has the lowest life expectancy among males in Europe—or has registered little change. T the end of 1990s, life expectancy for women ranged from 68 years in Turkmenistan and 77 years in Slovenia, with countries in Central Europe having female life expectancies above 75 years. Male life expectancy varied between 62 years (Turkmenistan) and 70 years (Albania, FYR Macedonia, and Bosnia-Herzegovina). As of 1995, female life expectancy decreased in 14 of the in the 27 transition countries, and male life expectancy decreased in 20 (UNICEF, 2003). Although this decline was followed by a significant improvement in the late 1990s, in several transition countries (Belarus, Moldova, Russian Federation, Ukraine) women and men still experienced lower life expectancies at birth in 2001 compared to 1989 (UNICEF, 2003). The reasons for higher mortality levels in the transition countries compared to Western Europe are complex and subject to substantial variation at the sub-regional levels (Nolton E et al., 2003). In the absence of reliable and representative data in many countries in transition, firm conclusions for the mortality divide cannot be drawn. However, one potential major direct contributor to the widening mortality gap is a high prevalence of destructive health behaviors, especially among men. Alcohol and tobacco use, lack of physical activity, and poor nutrition could explain in part the mortality gap. Psychosocial stress factors, work-related stress and job insecurity, which have been amplified by transition, are also important contributors (Bobak M & Marmot M, 1996). Rising mortality from cardiovascular diseases—the leading cause of death in most countries of the region for both men and women, accounting for more than one-half of the mortality gap—reflects, in part, the effect of these risk factors and the inability of a deteriorating health system to provide adequate prevention services or treatment (e.g., low quality hypertension screening, lack of follow-up, poor emergency care, low access to proper medication) (Velkova A et al., 1997; Bobak M & Marmot M, 1996). Perhaps most of the mortality divide experienced by former Soviet bloc countries since 1990 could be attributed to economic changes, such as changes in their gross domestic product and widening gaps in income inequalities (Marmot M & Bobak M, 2000). The continuing transition to a market economy has had a negative impact on the welfare of the population of these countries. Compared to Western Europe, the per capita gross national income (GNI PPP) in 2000 was, on average, 2-3 times lower in Central Europe and the Baltic region, 5 times lower, on average, in Eastern Europe, and at least 8 times lower in Caucasus and Central Asian countries (Table 1) (PRB, 2002a). Furthermore, the health expenditures per capita are at least 10 times higher in Western Europe than in Central and Eastern Europe and at least 22 times higher than in the Caucasus and Central Asian countries (World Bank, 2001).

Common Health Concerns

The health of mothers and their children are important measures of well-being in all transition countries, but verifiable estimates of maternal and infant mortality are hard to obtain. The vital registration systems in the former Soviet-bloc countries are comprehensive, but they share a common history of underreporting and misclassification of deaths. With several notable exceptions (Czech Republic, Poland, Slovakia), death rates related to pregnancy and childbirth in the region are estimated to be at least twice as high as those in Western Europe (Table 2) (Hill K et al., 2001). Widespread reliance on abortion rather than use of modern methods of contraception to control fertility is one of the most common causes of maternal deaths in many countries in transition. Complications from abortions, especially those performed under unsafe

conditions, are among the leading causes of maternal death. Vital statistics in Central and Eastern Europe and Central Asia indicate that between 10% and 54% of maternal deaths are abortion-related, presumably most of them from illegally performed abortions (World Health Organization [WHO], 1998). By contrast, abortion-related deaths constitute about 4% of maternal deaths in the United States (Chang J, et al., 2003). Advanced gestational age, shortage of equipment, crowded facilities, poor hygienic conditions, and inadequate standards of care may increase the risk of post-abortion complications, even when the procedure is legal. In several transition countries, 8% - 16% of women experience post-abortion complications after legally performed procedures, mostly following procedures performed after more than 10 weeks of gestation (CDC and ORC Macro, 2003). In contrast, complications following legal abortions range from less than 1% in the United States to 3% - 6% in Western Europe (Hakim-Elahi E, et al., 1990; Heisterberg L & Kringelbach M, 1987; Thonneau P, et al., 1998).

[Table 2]

As the health of mothers and their infants is linked and they depend on similar health services, infant mortality rates are also considerably higher in the region than in Western Europe, although this is not always reflected in the official statistics. However, even the official rates are much higher than the rates in Western Europe, in all but two countries (Czech Republic and Slovenia). For example, as of 2000, the official infant mortality rate in Romania (18.6 infant deaths per 1,000 live births) ranked the highest in Central and Eastern Europe. Official rates in the Caucasus region and Central Asian republics ranged from 12.2 to 32.8 infant deaths per 1,000 live births (data not shown). The United Nations Population Division estimated infant mortality rates around 10 infant deaths per 1,000 live births or less in Central European countries, between 11 to 16 infant deaths per 1,000 live births in the Baltic region, between 13 to 33 per 1,000 in Eastern Europe and Caucasus, and between 45 to 57 infant deaths per 1,000 in Central Asia (Table 2) (United Nations Population Fund [UNFPA] and PRB, 2003). By comparison, the infant mortality rate for Western Europe was, on average, 5.0 infant deaths per 1,000 live births (PRB, 2002b). On a positive note, however, the infant mortality rate has declined in many countries since the start of transition. The regional average IMR based on official data declined by one third (UNICEF, 2003). But the good news, however, have to be interpreted with caution. Alternatives estimates derived from population-based reproductive and demographic health surveys show that the actual rates of infant mortality in most countries where these studies have been implemented are considerably higher than the official rates reported by the official statistics (CDC and ORC Macro, 2003) (Table 3).

Women throughout the transition countries usually marry and begin having children earlier than women in Western Europe; childbearing peaks between ages 20 and 24 and drops off sharply after that. Little childbearing occurs after age 30 in these countries; women typically spend the rest of their reproductive years trying to avoid pregnancies. Although the use of modern contraceptive methods has substantially increased in recent years, the use of traditional methods often exceeds the use of modern methods and women using less effective contraception continue to rely on legal abortion services when their methods fail. However, inclusion of postabortion counseling in the standards of care, essential to avoid repeat abortion and to encourage use of more effective methods of contraception, is seldom institutionalized. With population size stalled or shrinking, some policymakers consider family planning programs unnecessary and

counterproductive and instead advocate for measures to encourage women to have more children.

Increasingly, women in countries in transition are faced with the risk of contracting sexually transmitted infections (STIs), including HIV/AIDS. Currently, in most countries in the region, between one-fifth and one-third of adults living with HIV/AIDS are women of childbearing age. The HIV epidemic is known to be spreading quickly in the Baltic countries, Ukraine, Moldova, and the Russian Federation, primarily fuelled by high rates of injecting drug use. As in Western Europe, the burden of HIV infection is higher among men than women, but due to rising STI rates that precede and can facilitate HIV transmission? in the region, an increasing number of women may become infected in the near future in the absence of sustained prevention efforts.

Women's Status and Gender Issues

Most countries of the region share similarities with regard to the legal status of women and gender roles. Women in transition countries had traditionally benefited from the Communist principles of gender equality in access to education and the work force. Although women are generally paid equally with men for equal work, they increasingly face discrimination both at the workplace and at home. The labor force participation rate is lower for women than for men. The share of women's participation in parliament is less than 11% in 15 out of 25 transition countries and does not exceed 26% (UNFPA and PRB, 2003). The average salary for women is generally lower, reflecting the fact they are more likely to hold lower paid jobs. The share of household tasks is distributed unequally, leaving working women with the double burden of working full time at the workplace and completing most of the household chores at home. Inequity in women's status in countries of the region is perhaps nowhere more clearly manifested than in women's limited access to modern contraceptive methods and corresponding high rates of unintended pregnancy and induced abortions (CDC and ORC Macro, 2003).

Impact of Transition on Health and Health Care

In the former Communist countries, health policies, practices, and facilities were modeled after the centralized, government-supported Russian health system that provided universal health services to all citizens. Typically, the system promoted hospital-based health care services—that created a surplus of hospitals and hospital-based specialized physicians—and an inadequate supply of primary health care services. In the recent years of transition to a market economy, the costly hospital-based curative system has become impossible to maintain at an effective level; most hospitals lacked the minimum equipment, drugs, and supplies necessary and could not afford the maintenance costs. Health care deteriorated rapidly in a number of areas, including reproductive health services, which is reflected in the worsening of several outcome indicators (e.g., maternal and infant mortality, STI prevalence, and utilization of preventive services).

In many countries in transition, governments are struggling with limited resources and emerging health problems. They have responded to demographic and reproductive health challenges to varying degrees by introducing a wide array of policies and programs. Currently, health care reforms are in various stages of development and implementation. Many health care systems (e.g. Albania, Czech Republic, Croatia, Estonia, Lithuania, Georgia, Hungary, Poland, Russia,

and Romania) are undergoing financial reforms meant to insure a transition from a fully financed by the state system to a mixed public and private financing. While some governments continue to play a major role in supporting the health care services, others are in the process of turning them over to national health insurance agencies or to the private sector, possibly leaving large parts of their populations uninsured or with minimum health benefits. The newly created insurance systems have a mandatory component—based on mandatory payroll taxes, specific earmarked taxes and funds, and governmental and municipal subsidies—and a voluntary component. The mandatory insurance covers a limited range of essential services for all citizens who do contribute, as well as for some who do not (e.g., minors and students) (Center for Reproductive Law and Policy [CRLP], 2000).

Measurement Issues

Many former Soviet bloc countries collect extensive vital statistics information. However, the health information systems during the Soviet times were often flawed by overreporting of “positive” results, which could bring rewards, and underreporting of undesired statistics, which could lead to disciplinary actions. Although the old systems are no longer in place, some of their characteristics may have persisted. In addition, with the emerging private health sector and the shifting of health costs from the state to the individual, official data may be less complete than previously (Bladen C et al., 1998). For example, vital record data in several countries have indicated that abortion rates have been in decline. The availability of abortion services from private practice providers, however, has increased in most countries and abortions carried out by these providers are usually not included in official figures, placing the completeness of these figures in some doubt.

Even when they are complete, vital records, census data, and program data often do not provide sufficient information to adequately and reliably assess public health problems and to evaluate public policy and program initiatives. Furthermore, the data usually satisfy the needs of centralized decision-making but are less useful for describing the health status and the burden of disease of the population at sub-national levels.

Until recently, population-based data on most areas of reproductive health, including sexual activity, pregnancy intentions, contraceptive knowledge, and attitudes did not exist. While periodic sample surveys have been used for many years to evaluate national maternal and child health needs in many developing and developed countries, they had been infrequently used in former Soviet bloc countries. National population-based representative surveys of women of childbearing age with a nationally representative sample are considered to be the best and most timely way to collect information on fertility, the planning status of pregnancies, contraceptive use, health behaviors and use of women’s health services, knowledge and attitudes about contraception, knowledge about HIV/AIDS transmission and prevention, and other reproductive health issues.

While fertility data obtained through DHS and RHS surveys recently conducted in the region may compare well with the vital records, other data are quite different (e.g. abortion levels, infant mortality levels), or not covered by official statistics (e.g. contraceptive prevalence, unmet need for contraception, health behaviors and use of women’s health services) illustrating how

critical it is to monitor key reproductive health indicators through periodic population-based sample surveys (Table 3). The differences in induced abortion reporting, for example, are probably largely due to the inability of the official registration systems to record the increasing number of abortions performed in private health facilities or the early-term abortions (“mini-abortions”) performed in ambulatory facilities. These trends may have affected the completeness of abortion reporting in the government systems but they should have little effect on the reporting of events by survey respondents. As shown in Table 3, in all but one country the survey estimates exceed government rates by at least 20%. In the Caucasus, the survey estimates are several times higher than official rates? indicating a more severe breakdown in the government system for collecting abortion statistics than in other countries. Similarly, the surveys showed that rates of infant mortality are substantially higher than the official rates—four times higher in Azerbaijan, and more than 1.5 times higher in Romania, Georgia, and Uzbekistan. The differences are due to weaknesses in reporting systems as well as to differences in how a live birth is defined. The DHS and RHS surveys used standard World Health Organization definitions that many governments in the region have been slow to adopt or implement. Governments may fear that adopting the WHO definition will make it appear that infant mortality has been rising.

[Table 3]

While the official data can be less complete, inherent problems with survey data can also exist. Because surveys count events experienced by a randomly selected probability sample of the population rather than the entire population, the resulting estimates of the parameters intended to be measured are subject to a certain degree of sampling error. Thus, the estimates based on a probability sample may differ by chance variation from the statistics based on the entire population. Standard errors can be used to calculate 95% confidence intervals around the survey estimates; consequently, we can say with confidence that the true value of a statistic lies within the boundaries of the 95% confidence interval. The true value could be higher or lower than the sample estimate. Figure 1 shows that in the case of survey estimates of IMR, the lower boundary of the confidence interval is well above the official estimate in all but one country (Romania), suggesting that the official counts are subject to significant undercounting (Serbanescu et al., 2003).

[Figure 1]

Selected Reproductive Health Issues

Abortion and Contraception: Trends and Relationships

Abortion rates and trends

Given the relatively low usage of the more effective modern contraceptive methods in many countries of the region, the early start and completion of childbearing, and the small ideal family size, the proportion of pregnancies that are unintended is quite high in each of these countries. The vast majority of unintended pregnancies (over 80%) are unwanted (i.e., in excess of the

number of children wanted), while mistimed pregnancies (i.e., occurring earlier than intended) are relatively infrequent. There is considerable evidence that women who are pregnant with an unintended pregnancy are more likely than those with intended pregnancies to enter prenatal care late or not at all, and to experience pregnancy or perinatal complications (Brown SS & Eisenberg L, 1995). Typically, in Eastern Europe and the former Soviet Union most unintended pregnancies are not carried to term and end in elective abortions (CDC and ORC Macro, 2003).

Prior to the breakup of the Soviet Union in 1991, a characteristic feature of the countries under Soviet influence was their heavy reliance on abortion as a means of fertility control. In these countries, abortion has long been readily available while effective means of contraception have not. Viewed as a basic reproductive right of women in the former Soviet-bloc countries, abortion was legalized in the region well before the Western European countries. Except for Romania—where abortion was illegal prior to 1990—women in the other ex-Soviet bloc countries had broad access to free-of-charge or affordably priced legal abortions. Currently, during the first 12–14 weeks of gestation abortion is available without restrictions in all countries in transition, excepting Poland (Rahman A et al., 1998). Beyond this gestational age, abortion is available on medical or selected socioeconomic grounds. Abortion is typically performed by trained physicians either in public or private clinics or hospitals. In most countries, the official cost of a legal abortion in a state run facility is relatively low, but it is not covered by health insurance. However, in many places unofficial payments or payments for “extra” services, such as anesthesia, can increase the cost beyond what a low-income family may be able to afford.

The widespread use of abortion in the former Soviet Union resulted from many factors. Chief among these were the liberal government policies toward abortion, centralized medical systems that focused more on curative than on preventive care, and limited access to high quality methods of contraception. Before 1990, the medical establishments of these countries were relatively isolated from advances in Western contraceptive technology such as the low-dose pills, which have reduced the serious side effects of oral contraceptives. These factors continue to play a role in the former Soviet-bloc countries and until recently abortion rates and ratios in some of these countries were among the highest in the world. Since the mid-1990s, however, the use of modern effective methods of contraception has increased with a corresponding decrease in the abortion rates (Popov AA & David HP, 1999). Nevertheless, reliance on abortion as a means of fertility control is still high in many countries of the region. With the exception of Central Asia, Albania, Czech Republic, Slovakia, Croatia and Slovenia, countries in transition have total abortion rates (TARs) equal to or greater than the total fertility rates. It should be noted however, that official abortion rates represent conservative estimates in most countries. In several Eastern European countries—e.g. Georgia, Russia, Azerbaijan and Romania—population-based surveys have revealed some of the highest abortion rates in the world (CDC and ORC Macro, 2003; Henshaw SK et al., 1999). By comparison, abortion rates in Western Europe—where complete data exist—are among the lowest in the world, typically not exceeding 0.5 abortions per woman (Table 2).

Population-based surveys have documented considerable variation in the total abortion rates in the region. The highest rates are in the Caucasus where, at current age-specific rates, a woman would have more than three abortions during her lifetime in Azerbaijan and Georgia and more

than two abortions in Armenia. The TAR for Georgia (3.7 abortions per woman) is probably as high as anywhere in the world. In Eastern Europe, the rates are variable, being higher in Romania and Russia (2.2 and 2.3 abortions per woman) than in Moldova and Ukraine (1.3 and 1.6). Abortion levels also differ among the Central Asian Republics. In Kazakhstan and the Kyrgyz Republic, where the cultural influence of Russia has been stronger and larger proportions of the population are ethnically Russian, levels of abortion are distinctly higher (1.4 and 1.5 abortions per woman) than in Turkmenistan or Uzbekistan (0.8 and 0.6).

In several transition countries, DHS and RHS data have documented a decline in the level of abortion in the most recent years. The declines are substantial, amounting to between 0.3 and 0.6 fewer abortions per woman in Moldova, Russia, Armenia, Kazakhstan, and Uzbekistan and about 1.0 less abortion per woman in Romania and Georgia. These figures represent declines of between 15% and 38% over a 6-year interval. In Ukraine, the Kyrgyz Republic, and Turkmenistan, however, there is little or no change in the abortion rates. In the case of Azerbaijan, there has been a clear increase in the abortion level from 2.3 to 2.9 abortions per woman (Figure 2).

[Figure 2]

Contraceptive Use and Unmet Need for Contraception

In all of the countries highlighted in this paper, except for Romania and Albania, modern contraceptive use during the communist years was legal and contraceptive services were offered through women's health centers. Legality, however, did not insure wide access to and availability of effective, modern contraception. The range of modern contraceptive methods available was often limited to locally produced supplies and the quality of contraceptive services was generally poor. In addition, provider resistance, fear about possible side effects (particularly associated with the use of hormonal methods), cultural norms, and partners' opposition, made it difficult for many women to obtain modern contraception.

In the former Soviet Union countries, for example, oral contraceptives were officially prescribed principally for selected medical benefits rather than for contraceptive purposes; dissemination of correct information about the pill was actively discouraged; and, when the topic was addressed, potential health risks and side effects were overstated. As a result of the negative propaganda, actively promoted by policy makers and the medical community, misconceptions about the pill's safety were universal (Popov AA et al., 1993). Throughout the region, the use of traditional contraceptive methods,² particularly withdrawal, was widespread and constituted a major contribution to the high levels of unintended pregnancy

Among married women, use of contraception in the transition countries, whether modern or traditional methods, ranges from a low of 41% in Georgia and Bulgaria to 77% in Hungary, with the highest rates found in Central and Eastern European countries (Table 4). Although the use of

² In this paper, the term "traditional methods of contraception" refers to withdrawal and periodic abstinence. The term "modern methods" includes the pill, the IUD, condom, male and female sterilization, injectables, implants, and vaginal methods.

modern contraceptive methods has substantially increased in recent years, the prevalence of oral contraceptives continues to be low? with the exception of selected countries in Central Europe- mainly because of widespread misinformation about their health risks and side effects. Few couples in the region employ long-term or permanent contraceptive methods, except for IUDs, despite the fact that a large majority do not intend to have more children. Permanent methods of contraception are not currently promoted, at least in part because of the continuing concern about a negative rate of population growth. Legal provisions to support voluntary sterilization are absent or restrictive. Female sterilization was illegal until recently and even today women younger than 30 years of age do not have access to sterilization unless they have three or more children (Popov AA, 1996). Legal provisions to support vasectomy are not yet in place. The availability of contraceptive sterilization (especially laparoscopic sterilization and vasectomy) is also limited because of a lack of adequate training of providers, government perception of low interest in these methods, and little knowledge among family planning clients. Withdrawal and periodic abstinence continue to be widely used. Because of widespread use of traditional, less effective methods, the overall rates of contraceptive failure and discontinuation are very high, contributing significantly to unintended pregnancies.

[Table 4]

Modern methods account for a higher share of contraceptive use in most Central European countries than elsewhere, where the pill is the most used method. They are also more prevalent in Belarus, the Baltic countries, and Central Asia where intrauterine devices (IUDs) are popular. As in other parts of the world, the higher the level of women's education, the more likely they are to use a modern contraceptive method.

A standard approach to forecasting the contraceptive needs in a population is to assess the potential demand for family planning. The total potential demand for contraception is generally defined as the sum of current contraceptive use (met need) and the additional contraceptive use that would be required to protect women from unintended pregnancies (unmet need). Thus, the unmet need for contraception is a very specific estimate that measures the gap between desired fertility and the contraceptive practices adopted to ensure that fertility preferences are met in a population. The conventional definition of *unmet need* includes women currently married or in consensual unions who are currently sexually active, currently exposed to the risk of pregnancy (women who are not sexually active, currently pregnant women, and women in postpartum abstinence or amenorrhea are excluded), fecund (neither they nor their partners have any subfecundity conditions), not wanting to become pregnant, and not using any form of pregnancy prevention (Bongaarts J, 1991). In countries with high use of traditional methods, the standard definition of unmet need masks the real need for more effective contraception because these methods tend to have higher failure rates. For these countries it is more useful to estimate the unmet need for modern contraception, despite the small risk of overstating the unmet need in some cases in which traditional methods are used effectively. For international comparisons, however, both indicators are shown for all women and currently married women (Table 5).

[Table 5]

The unmet need for contraception cannot be routinely estimated from the official statistics. Among all countries in Central and Eastern Europe and the former Soviet Union where population-based Reproductive Health, Demographic and Health, or Fertility and Family Surveys have recently been conducted, the level of unmet need for any method among married women ranged from 1% in Albania to 30% in Bulgaria while the unmet need for modern methods varied between 18% in Uzbekistan to 68% in Albania (CDC and ORC Macro, 2003; Klijzing, 2000). Albania and Azerbaijan have a relatively low need for any contraception (1% and 15% of married women, respectively) but the highest unmet need for modern contraception (68% and 53% of married women, respectively) (Figure 3). Thus, the levels of unmet need in the region are usually several times higher than in Western Europe, particularly the unmet need for modern methods.

[Figure 3]

Links between Contraception and Abortion

Generally, there is a clear relationship between abortion and use of traditional contraceptive methods: the greater the ratio of traditional methods to all methods used, the higher the level of abortion (Figure 4). A simulation using data from Armenia, Azerbaijan, Georgia, Kazakhstan, the Kyrgyz Republic, Romania, Russia, Turkmenistan, Ukraine, and Uzbekistan showed that if women using traditional methods (an average of 15% of all women of reproductive age) were to switch to modern methods of contraception with their lower failure rates, abortion rates could be reduced by an average of 24%. If women with an unmet need for any contraception (about nine percent of all women) were to adopt modern contraception, abortion rates would be reduced by an average of 33%. Abortion rates could be reduced by as much as 57% on average if both traditional method users as well as women with an unmet need for family planning were to become users of modern methods (Westoff CF, et al., 2003).

[Figure 4]

Reducing women's reliance on abortion will require increasing contraceptive use overall, shifting to more effective contraceptive methods, and encouraging more consistent use of methods by improving the information and services provided. Women's attitudes about contraception lend support for these changes. About three-fourths of women in Azerbaijan, Moldova, and Romania say they want more information about contraception; in Georgia, more than half want more information. A greater proportion of young women, never-married women, and women using condoms want more information, emphasizing a need for educational efforts among young adults. In much of the region, young unmarried women have less access to family planning and reproductive health services than married women do.

During the past decade, several countries in the region had developed comprehensive national family planning programs with detailed training agenda, aiming to increase the number of physicians and nurses that are involved in family planning activities. In Romania, for example, family planning training had been extended to primary health care providers, in an effort to educate a critical mass of providers and improve reproductive health services at the primary health care level.

Safe Motherhood

Maternal mortality in Central and Eastern Europe and Central Asia is, on average, several times as high as in Western Europe, with abortion, obstetric hemorrhage, sepsis, and toxicosis accounting for the majority of maternal deaths. Factors contributing to high maternal mortality include: a high reliance on abortion rather than usage of modern methods of contraception to control fertility; a deficient health infrastructure that cannot afford to replace outdated obstetric equipment and facilities; a lack of essential supplies needed to provide basic emergency obstetric care; insufficient or inadequate transportation of high risk cases to the referral centers; and delays in adopting evidence-based protocols in medical practice and in training of the medical personnel. Although the medical care infrastructure in these countries comprises the full range of facilities and medical personnel, in reality, however, health care services are often ill equipped to provide quality prenatal and postnatal care, timely diagnostic and referral of high risk pregnancies, and emergency obstetric care, especially in rural areas. This situation may explain the coexistence of relatively high maternal mortality levels with almost universal skilled attendance at birth and relatively high utilization of prenatal care services.

Research has shown that early initiation of prenatal care and the presence of skilled birth attendant reduces maternal and infant mortality and can prevent obstetric morbidity. Under the USSR health guidelines, women's access to perinatal care was free of charge and consisted of three components: preconception care, prenatal care, and postnatal care. (US DHHS, 1999). Changes in the health care systems and the financing available for health care since the fall of communism may have affected perinatal care services significantly. The RHS and DHS surveys conducted in the region contained considerable amounts of information regarding women's experience during pregnancy, delivery, and the postpartum period (Table 6). In the absence of reliable official statistics, these data can be used to identify problems and to help set program priorities, goals, and strategies related to improving the health of mothers and infants and pregnancy outcomes.

[Table 6]

Use of Prenatal Care Services (initiation and frequency of prenatal care, quality of care)

Survey data showed that the vast majority of pregnant women in the region receive prenatal care, with the exception of women in Azerbaijan. There was a strong correlation between whether women received prenatal care and when the first visit for care took place. In the Czech Republic, 94% of women began receiving care during their first trimester of pregnancy. At the other extreme, in Azerbaijan, only 45% started that early. In almost all countries, prenatal care began sooner among better educated women, though the relationship was weakest in Central Asia. In those countries where there was a relationship between start of care and birth order, prenatal care tended to start earliest for first births.

Intranatal and Postpartum Services

Except in the Caucasus countries, deliveries outside of health facilities are relatively uncommon. In Azerbaijan, 26% of births occurred outside of health facilities, a figure more than three times

higher than in Georgia and Armenia, the countries with the next highest rates. Such births are the least common in Central and Eastern Europe, where generally only about 1% of deliveries take place outside of health facilities. Use of postpartum care, however, is substantially lower than use of other maternity services. In three of five countries for which data were available, less than 50 percent of women—and only 11 percent in Georgia—reported receiving a postpartum exam following their most recent birth.

HIV/AIDS

STI and HIV/AIDS Levels and Trends

Since the early 1990s, many of the countries of Eastern Europe and the former Soviet Union have experienced major epidemics of sexually transmitted infections (STIs), particularly of syphilis. The reported incidence of new cases of syphilis in several former Soviet countries increased by 45–165 times during 1990–1998; the steepest recorded increases were reported in Kazakhstan (from 1.4 to 231.4 new cases per 100,000), the Kyrgyz Republic (from 2 to 144.4 new cases per 100,000), Belarus (from 2.7 to 164 new cases per 100,000), and the Russian Federation (from 5.3 to 225.6 per 100,000). The rates in the countries of the Caucasus region and in Romania, though higher than in 1990, remained low by comparison (Riedner G et al., 2000). In addition to direct reproductive health consequences, the presence of one or more STIs increases the risk of becoming infected with HIV considerably (Wasserheit JW, 1991).

Countries in transition are also facing one of the world's fastest growing HIV/AIDS epidemics. Until 1994, Eastern Europe appeared to have been spared the worst of the AIDS epidemic. While the region as a whole reported about 30,000 infections among its 450 million people, at that time Western Europe had over 15 times as many infected individuals. The pattern of transmission, however, changed after 1994, fueled primarily by injecting drug use and sexually transmitted infections among young people. Between 1995 and 1997, the estimated number of HIV cases in Eastern Europe increased more than five-fold across the entire region, and as much as 70-fold in the worst affected areas (Dehne et al., 1999). The UNAIDS estimated that, at the end of 2002, 1.2 million people in Eastern Europe and Central Asia were living with HIV, of which 250,000 were infected in the previous year (UNAIDS and WHO, 2002). This compares with 570,000 adults and children living with HIV/AIDS at the end of 2002 in Western Europe. Intravenous drug use had been the main mode of transmission in countries in transition, but infection through sexual contact is increasing, particularly among young people and the growing number of commercial sex workers. International AIDS experts are warning that the epidemic may quickly spread from these subgroups to the general population.

Worldwide, half of all new HIV infections occur among young adults and one-third of those currently living with HIV/AIDS are between 15 and 24 years of age. In Eastern Europe and Central Asia, 430,000 young people 15–24 years (35% young women and 65% young men) were living with HIV/AIDS at the end of 2001, compared to 240,000 in the industrialized countries (UNICEF, 2002). UNAIDS estimates that, on average of five young people in the region become infected with HIV/AIDS every minute.

HIV/AIDS Awareness and Knowledge of Transmission and Prevention

At the same time, young people in the region are particularly under-served by most reproductive health programs. Several RHS and DHS surveys showed that most young people lack correct knowledge of HIV transmission and do not know what can they do to protect themselves from getting infected. In Romania, for example, 31% of young women and 21% of young men could not spontaneously mention any AIDS prevention measure; only about half of young women and two thirds of men spontaneously mentioned that using condoms could effectively protect against AIDS; less than one fourth knew that using clean needles could prevent HIV infection. Most young adults do not consider that they have any risk of HIV infection.

Access to Information and Services

Access to correct and adequate information on HIV transmission has been particularly limited for young adults. For one thing, young people seldom have conversations about sex education topics with their parents and teachers are often uncomfortable about discussing reproductive health topics with their students. In the absence of formal training, they tend to obtain information on these topics from their equally ill-informed peers. Many transition countries had been slow in introducing comprehensive sex education in schools, especially courses that include information on contraception and STIs, including HIV/AIDS. Reproductive health surveys conducted in several countries in Eastern Europe are a rich source of information about young adult's exposure to sex education. Overall, the majority (89%–94%) of young women in Romania and Moldova had had at least one school-based course or class on sexuality education, but less than one in two women in Azerbaijan and Georgia had had such lectures. Generally, all young adults were more likely to have received lectures on female and male reproductive biology, the menstrual cycle, and how pregnancies occur than lectures on HIV/AIDS, other STIs, and methods of contraception. Between 50% and 54% of young women in Moldova and 39% and 42% of young women in Romania, but less than 7% in Azerbaijan and Georgia reported lectures on HIV/AIDS and other STIs. Similarly, only 36%–38% of young women in Moldova and Romania and 1%–2% in the Caucasus countries received school-based lectures on contraception. The fact that most sexuality lectures were offered during the high school years—particularly in countries with school-based lectures on contraception and STIs (e.g. Moldova and Romania)—points to the need for out-of-school education for those students who never enter secondary school.

Limited access to reproductive health services is another factor that can contribute to risky sexual behaviors. Studies had shown that few sexually active youths in the region protect themselves and their partners from STIs by using condoms. Condom use at the first sexual intercourse ranged from less than 1% in the Caucasus countries to 23% in the Czech Republic. In Ukraine and Russia 27% and 33% never married young adults had used condoms at the first intercourse. Even fewer obtain condoms from family planning services, thus missing the opportunity for counseling regarding behavioral changes.

Sex Education on HIV/AIDS and other STIs

In recognition of the young adults' critical need for correct information about HIV/AIDS and other reproductive health topics, the 2001 United Nations General Assembly Special Session on HIV/AIDS (UNGASS) recommended that by 2005 at least 90% of young men and women aged 15 to 24 years should have access to information, education, and services necessary to develop

the life skills required to reduce their vulnerability to HIV infection, “in full partnership with youth, parents, families, educators, and health care providers” (UNGASS, 2001). Additionally, the 2001 UNGASS endorsed the “ABC” approach? Abstinence or delay in having sex, Be faithful, and use Condoms? as a key component of HIV prevention strategies.

UNFPA and its partners joined efforts to strengthen sex education programs in the region, using school-based, clinic-based, or peer-education approaches. Starting with 1998, USAID and other international donors in Romania teamed up with the Ministry of Education to help design the first school-based sex-education program in Romania. In 2002, UNFPA partnered with the Ministry of Education in Turkmenistan to implement a sex-education curriculum for ninth-graders and develop age-appropriate information resources for teachers and doctors. In the same year, UNFPA collaborated with the Russian Ministry of Health to distribute materials on user-friendly approaches to prevent HIV to health clinics and youth centers. In the past two years, UNFPA helped trained 165 peer education trainees in 27 countries of the region reaching more than 30,000 young people that participated in national peer education-training workshops on HIV prevention and gender issues. The project also created the first web-based resource training tool for peer educators (Youth Peer Education Electronic Resource or Y-PEER), illustrating how information technology could be applied in HIV prevention strategies (UNFPA, 2003a).

Marketing campaigns like “What’s Your Excuse?” supported by UNFPA and implemented by Population Services International (PSI) in Yugoslavia and Bulgaria, represent another innovative approach to comprehensive HIV prevention. The campaign, aimed at 15–25-year-olds, uses ads, posters, T-shirts, TV and radio commercials, and condom distribution to bring about behavior changes. In addition to information, promoting healthy sexual behaviors among young adults also requires access to youth-friendly services (UNFPA, 2003b). In Ukraine, UNICEF, working with its partners, supported the Young People’s Development Programme in creating youth-friendly clinics and information centers for out-of-school youth (UNICEF, 2002).

HIV/AIDS Prevention in the Context of Reproductive Health Care

Reproductive health services are also ideal means for carrying out HIV and other STIs prevention activities among women of reproductive age. Among them, family planning and STI clinics, maternal health services, and outreach delivery services for high-risk groups could provide an ideal environment to provide information on HIV prevention. Information in these settings should include counseling on HIV transmission and prevention, voluntary testing, promotion of safer sexual behaviors (e.g. correct and consistent use of condoms, avoiding sex with high-risk partners or multiple partners), and early management of STIs. Maternal health clinics and services provide an excellent opportunity for HIV prevention strategies since pregnancy is often one of the few times when the majority of women in the region access the health care system. The UN General Assembly Special Session on HIV/AIDS recommended that by 2005, “...80% of pregnant women accessing antenatal care should receive information, counseling, and other HIV prevention services” in order to reduce the proportion of infants infected with HIV.

The training of military personnel represents one of the newest initiatives in the HIV prevention efforts in the region. Because members of the military are usually young, sexually active and separated from their partners, they face a higher risk of exposure to STIs, including HIV, compared to the civilian population. Their risk of STI infection is usually 2-5 times higher during peacetime and can increase to over 50 times higher in times of conflict (UNAIDS, 1998). With UNAIDS funding, UNFPA has collaborated with the Ministry of Defense in Ukraine in a series of HIV prevention courses. The training aims to provide the military and their families with the knowledge of STIs, and HIV/AIDS prevention, condom use, and gender equity in reproductive health.

Reproductive Health among Vulnerable Groups

Young Adults

Although most adolescents in Eastern Europe remain sexually abstinent for most of their teen years, recent social, economic, and cultural changes are likely to liberalize sexual behaviors at a faster pace than in the past. Young people, especially adolescents, are sexually active at earlier ages than were older cohorts. They are more likely to have experienced premarital sexual intercourse, a greater number of sexual partners, and exposure to unintended pregnancy and sexually transmitted infections. In addition to direct health consequences, these behaviors could have very serious long-term influences on their lives (lower level of education, reduced range of employment opportunities, greater risk of fertility impairment, and even shorter life expectancy since, in the last decade, AIDS has rapidly become a leading cause of death among men and women 25–44 years of age). In many countries, young people are seldom prepared with the information, skills, and resources needed to make a healthy transition to adulthood. Inadequate programs and lack of sex education leave youth at the mercy of mass media and misinformation from peers.

Several RHS surveys conducted in Eastern Europe and the Caucasus region included young adult modules designed to explore several issues of great concern for the youth in the region: exposure to sex education, first sexual experience, and current sexual behavior including contraceptive use. There are distinct differences between Eastern Europe and the Caucasus region. At least one-half of young adult women in the Eastern European countries report sexual experience (from 50% in Moldova to 75% in Russia) compared with approximately 30% of women in the countries of the Caucasus region. In Eastern Europe, the majority of young adults that report sexual experience have had premarital sexual intercourse compared with less than 5% in the Caucasus. Only 3% to 33% of women with premarital sexual experience used a modern method at the time of first intercourse. In Eastern Europe, 40% to 66% of unmarried women who are sexually active used modern contraception at last intercourse, indicating an improvement in use since the first sexual experience. In Romania, modern contraceptive use increased from 36% in 1996 to 47% in 1999, particularly because of a 50% increase in condom use (from 22% to 32%).

Young people often lack access to health services that are appropriate for their needs. Barriers to such services include constraints related to age and marital status, lack of privacy and confidentiality, fear to be seen attending clinics, embarrassment to seek advice, lack of

knowledge about available services, inconvenient locations or hours, and high costs. To overcome these obstacles and provide appropriate reproductive health services to young people, programs targeting youth need to provide youth-friendly services. These includes treatment services in adequately equipped and staffed clinics, peer outreach and social marketing of condoms at non-traditional outlets, mobile clinics, and programs in schools and workplaces (UNFPA, 2003b).

Ethnic Minorities

Many countries in transition are facing greater disparities in the health of the minority populations compared to the main ethnic groups. In Romania, for example a Roma (Gypsy) woman would experience 2.5 more abortions during her reproductive lifetime than a Romanian woman and 3.5 times more than a Hungarian woman. Similarly, Azeri women residing in Georgia report, on average, 2 abortions more per woman than Georgian women. Generally, in several transition countries minorities have less access to health care than the population at large. They may experience discrimination in accessing the health care services either directly (e.g. language barriers) or indirectly (e.g. inconvenient location of clinics, no service provisions for nomadic populations). Their general health status is likely to be worse than in the general population because of poverty, lower education levels, and worse housing and living conditions. Women are more likely than men to experience the effects of discriminatory or inadequate care. In order to promote substantial improvements in their health, countries of the region need to specifically target these populations in their reproductive health policies and programs.

Violence against Women during War

Women who survive armed conflict and displacement represent a particularly vulnerable group. Women and girls are considered to be especially vulnerable to gender based violence due to targeted sexual violence, separation of families, and the breakdown of social norms and structures during and after conflict. Although wars throughout history had heightened the risk of violence against women, contemporary conflicts seemed to have affected unprecedented number of women and girls and have reached new levels of brutality. Common aspects of violence against women in modern conflicts include rape, sexual mutilation, human trafficking, sexual slavery, enforced prostitution, forced pregnancy, and enforced sterilization. In a dramatic attempt to provide better accountability and legal recourse for the war crimes against women, these forms of gender and sexual violence had been recently included in the definition of crimes against humanity (ICC, 2002).

Estimates of the number of women raped in Croatia and Bosnia-Herzegovina range from 14,000 to 50,000 (Olujic MB, 1998). Another study based on examining clinical records in a women's health center in Zenica, Bosnia-Herzegovina, revealed a history of rape among 3% of clients during one year.

Internally Displaced Populations and Refugees

Modern conflicts are more often accompanied than in the past by forced displacement of the civilian population. Rather than being an indirect effect of the conflict, driving people out of their homes through intimidation, terror, murder and sexual violence had become a direct

objective of war. Displacement also leaves women more vulnerable than men. They are more likely to be affected by poverty, disruption of basic services, loss of family support, and the breakdown of social norms. Often they have to cope with becoming heads of household and may be forced to provide sexual services in exchange for food, shelter, or protection. Violence against refugee or displaced women and girls may be more common than violence against women in settled population. However, the RHS surveys conducted in Georgia and Azerbaijan? countries where the internally displaced persons represent a sizable proportion of the population? did not show any positive association between the displacement and lifetime experience of sexual violence or domestic abuse.

Trafficked Women

Trafficking in persons is one of the most critical forms of gender-based violence (GBV) today. It is also the greatest manifestation of slavery in the 21st Century. It is estimated that between 700,000 and 4 million persons, are trafficked within or across international borders each year, including 175,000 in Central and Eastern Europe. Many of these persons are trafficked into the international sex industry or forced labor, often by force, fraud, or coercion. The primary target of trafficking is constituted by women and girls, who are disproportionately affected by poverty, unemployment, discrimination, and the lack of economic opportunities in countries of origin. Typically, women and girls are either lured into traffic networks through false promises of legitimate employment or improved working conditions (e.g. nannies, maids, dancers, factory workers, restaurant workers, sales clerks, or models), sold by a family member, or even kidnapped (such is the case in Albania, but less common in other countries). Those from poor families, migrants, ethnic minorities, runaways, those with little or no education, and those from broken families, are typically at a higher risk of being trafficked. Victims of trafficking are often rendered defenseless and vulnerable because they are taken away from their home environment of family and friends, legal institutions, and other sources of protection and support, to unfamiliar destinations, including foreign countries. Because victims of trafficking are frequently unfamiliar with the laws, cultures, and languages of the countries into which they have been trafficked, they often find it difficult or impossible to report the crimes committed against them. Furthermore, trafficked women and girls are often subjected to physical violence? that includes rape and other forms of sexual abuse, torture, physical detention? and coercion through threats, psychological abuse, and financial dependence. In addition to GBV, women and girls trafficked in the sex industry are exposed to serious health risks, such as unintended pregnancy, HIV/AIDS and other sexually transmitted diseases, and drug and alcohol addiction. Because victims are often illegal immigrants in the destination country, they lack access to adequate health care services, housing, education, and legal assistance.

Typically, there is little information regarding the number women and girls trafficked into or through the countries in transition. An assessment conducted by the Ministry of Public Order in Albania, known as one of the most active sources and transit countries for women and children in the region, estimated that more than 5,000 Albanian women and girls were trafficked into prostitution in the last decade (U.S. Department of State, 2003). Some of the poorest ex-communist countries in the region (Albania, Romania, Bulgaria, and Moldova) and countries recently affected by conflict (Bosnia and Herzegovina, Serbia, and Montenegro) represent the largest source of trafficked women in Europe.

Gender Equity in Reproductive Health

Gender-based Violence

Millions of women around the world are subjected to physical, sexual, and emotional abuse every day. Violence against women includes a wide range of behaviors and acts perpetrated against women, but its most common form occurs between men and their female partners. Often referred to as domestic violence, battering, or intimate partner violence (IPV), this form of violence occurs in all cultures and affects women of all ages and all socio-economic and educational backgrounds. Gender stereotypes, women's economic dependence on men, cultural acceptability, loose or nonexistent legislation to protect women's fundamental human rights, and lack of preventive measures for victims are some of most widely recognized factors that contribute to IPV. We know from some small, localized studies that domestic violence is a rampant public health problem around the world. But little information is available on the burden of domestic violence in Eastern Europe, its impact on reproductive health, and how effectively to respond to one of the most critical violation of women's human rights today.

The two most basic measures of prevalence of domestic violence are lifetime abuse in adulthood by a formal or consensual partner and similar abuse in the last 12 months as a measure of "current" violence. In most countries in transition with population based data, prevalence of domestic violence is comparable with the prevalence documented in the U.S. For example, between 15% - 30% of women in Eastern Europe report ever having been abused by their partners and 8%- 10% report such abuse during the past 12 month (Figure 5). Similarly, women who are subjected to IPV in this region have the same characteristics as women who report this type of abuse in the US: they are more likely to be young, separated or divorced, less educated, and from low socio-economic backgrounds. Findings from several surveys conducted in Eastern Europe suggest that domestic violence is associated with unintended pregnancy, induced abortion, and low use of contraceptive methods. For example, data from a reproductive health survey conducted in Romania in 1999 show that women reporting current physical abuse by a partner are twice as likely to have a current unmet need for contraception compared with women who do not experience domestic abuse. Despite these similarities, the consequences of domestic violence in developing countries are more severe and may result in worse health outcomes because of limited resources and poor infrastructure.

[Figure 5]

Male participation in RH decision-making

Improving reproductive health through a gender-based approach is a key component of the Programme of Action (POA) from the ICPD in 1994 and the ICPD+5 Forum review in 1999. Since 1994, a wide variety of programs and interventions strived to address the male participation in reproductive health decision making. Some strategies are designed to accommodate gender differences (e.g. community based distribution of contraception, educational programs for men, condom programming) while others seek to change gender norms to promote gender equity (e.g. programs that seek empowerment of women or increased

assertiveness in partner communication). In several countries in transition these strategies have been particularly applied in programs that address reducing unintended pregnancies and the STI and HIV/AIDS infection.

Gender Integration in Access to Reproductive Health Services

The few population based studies conducted in the region that had included men samples documented that nearly all male respondents marry and have children; they have similar fertility preferences with their partners; many have discussed family planning with their partners and currently practice contraception to space or limit births; and have similar levels of unmet need for contraception. In addition, the survey conducted in Romania showed that young adult men, although reported having more sexual partners than young adult women, seldom had sexual intercourse with more than three sexual partners during their lifetime. The RHS in Romania had also shown that, although two-thirds of married men were currently using contraception, less than half of them were using modern contraceptives; less than one in five married men aged 15-49 obtain their methods from the public health sector; and about one third have an unmet need for modern contraception. Almost two of three men wanted to have more information about contraception and one in two believed that abortion is not always acceptable for fertility control. The majority of men believed that family planning decisions should be taken jointly with their partners. In spite of their reproductive health needs, many men lack the information and services required to maintain an optimal sexual and reproductive health.

Key Challenges to be addressed:

Prevention

In order to achieve tangible improvements in sexual and reproductive health, equity, and the well being of women in the countries of Central and Eastern Europe and CIS, multifaceted and interdisciplinary strategies are required. To obtain further reduction of maternal and infant mortality and morbidity, the rates of unintended pregnancy and induced abortion, the risk of STI infection, and the risk of gender based violence, the governments of these countries need to increase their investments in health, particularly in the area of health education and prevention. Such efforts should particularly target high risk groups, such as young adults, rural residents, ethnic minorities, migrant, refugee or internally displaced populations, and victims of gender based violence.

Substantial reductions in women's reliance on abortion and improvements in maternal mortality and morbidity in the region will depend not only on further increases in contraceptive use but also on improvements in method selection and reductions in contraceptive discontinuation and failure rates. Women in many countries of the region generally know that specific contraceptive methods exist, but they often do not know where to obtain them, how to use them, or how effective they are at preventing pregnancy. Although more women use modern contraceptives today than a decade ago, relatively few women use oral contraceptive pills, mainly because of widespread misinformation about health risks and side effects, even among health providers. Education and health promotion efforts are needed to overcome women's lack of awareness about other important reproductive health topics: the need for preventive medical care before and

after a birth; follow-up care after an abortion; ways to prevent STIs and HIV; and where to go for help if they are abused. Special emphasis should also be placed on meeting the reproductive health needs of young adults.

Many governments are in process of introducing family life education curricula in schools. Several efforts had been made to promote safer sex practices through information, education, and communication (IEC) messages and condom programming, using clinic-based and peer-education approaches. These efforts need to intensify and reach all the high risk groups.

Increase Access to and Quality of Services

Updating the existing health infrastructure, particularly at the primary health care level, continues to be a priority in many countries. Primary health care facilities need to be able to diagnose high risk pregnancies, refer those pregnancies to more specialized levels, and address selected obstetric emergencies.

The availability of modern contraceptive methods continues to be an issue of great concern in some countries. In the poorest countries in the region, the newly opened family planning clinics have very few, if any, contraceptive supplies, and their main source is international donors. Although large quantities of contraceptive supplies (condoms, IUDs, pills, and barrier devices) have been imported or donated, the absence of contraceptive logistics and managerial skills often contributes to shortages and uneven distribution of these supplies. Effective steps toward increasing access to and the quality of family planning services should include: improvements in the family planning supply and distribution system; strengthening of the private sector delivery; expansion of the availability of a wide array of effective, high quality, affordable methods, including long-term and permanent methods; training of family planning providers; establishment of standards and guidelines to ensure quality of reproductive health care; institutionalization of family planning counseling; integration of family planning services with STI, and maternal and child health care services at the primary health care level; and increased participation of men in reproductive health decision making.

Monitoring and Evaluation

Surveillance of maternal and infant mortality, abortion, HIV/AIDS, STIs and behavioral risk factors, is essential in evaluating the impact of newly developed reproductive health strategies and programs. Surveys like the DHS and RHS provide valuable data for developing new programs, evaluating existing programs, and reforming health care systems. In the future, more periodic sample surveys and smaller facility-based studies will be needed to monitor not only traditional demographic, family planning, and MCH indicators but also other reproductive health topics such as maternal morbidity, gender-based violence, health risk behaviors, and the impact of a gender in reproductive health programming.

Beyond estimating the prevalence of the problem, survey data could also be used to raise the levels of awareness about selected reproductive health problems. An excellent example is provided by the RHS conducted in Romania. At the end of 2002, survey findings have been used to launch a nationwide public campaign to raise general awareness on domestic violence and its consequences. The campaign, sponsored by the Ministry of Health and UNFPA, ran for

two months and consisted of radio, TV, and newspaper messages. In addition, the Ministry of Health also distributed educational materials to the public health community for mounting support against domestic violence among health professionals (Romanian Ministry of Health, 2002).

Very little is known about trafficking of women and girls because of its clandestine nature. Special studies are needed to better understand the nature, magnitude and trends in trafficking; to identify areas and subgroups with the highest risk; to provide an inventory of existing anti-trafficking activities; and to document and community awareness.

Capacity Building

In the aftermath of the ICPD, most countries with economies in transition started to reform their family planning and reproductive health programs in order to re-align them to the principles of the Cairo Programme of Action. The Programme of Action recommends that programs should have the dual goal to cover all reproductive health needs of their clients and promote gender equity to be truly successful in reaching the objectives set out at the ICPD in 1994. The Programme also describes several basic principles aimed at optimizing reproductive health services: develop dynamic policies and processes that includes all major stakeholders; strategize interventions based on priorities and availability of resources; restructure the organization and funding of the health systems in the context of a multisectoral approach to reproductive health.

Many countries of the region took steps toward reforming their reproductive health policies and programs, particularly in the area of family planning and adolescent reproductive health. Currently, health care reforms are in various stages of development and implementation. Although all of the governments continue to support health care services, national health insurance agencies, which generally provide a limited range of essential services for all citizens, are increasingly defining the service delivery systems. Increasingly, efforts have been made to devise effective strategies for sustainability and cost-recovery, promote social marketing, improve management of service delivery, and introduce contraceptive tracking and forecasting systems.

Development of new legislations has occurred in several countries, particularly in relation to women's basic human rights. In Romania, for example, survey-based evidence that most forced sexual intercourse is perpetrated by a partner was first made available to the public health community immediately preceding a Penal Code revision that allowed women to press charges against their sexually abusive husbands (Romanian Constitutional Court, Decision 211, November 2000). The same revision included preventive measures for victims of domestic violence, such as restraining orders against abusive husbands and their exclusion from the family home.

The crimes committed against women during the recent conflicts in Balkans had just recently begun to be addressed. The establishment of the International Criminal Court (ICC) and the International Crime Tribunals of the Former Yugoslavia, as well as national reforms of the judicial systems that aim to protect victims of conflict and trafficked victims, mark a new era of increased accountability of violence against women.

Collaborative Efforts

Sexual and reproductive health needs in a population cannot be met just by the health sector system; collaboration and coordination between various sectors that deal with the social, economic, and political aspects of reproductive health is actively needed. Several countries in the region started to develop the collaboration and coordination between the governmental sector, private sector, and local non-governmental organizations (NGOs). Partnerships need to be also formed outside the health sector and at the community level. External partnerships are also needed to ensure good quality of FP supplies and commodities, assistance with technological development of local production of contraceptives, and assistance in training of providers, development of guidelines and education materials, and development of policy issues.

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Table 1
Comparative Demographic and Social Indicators
for Selected Countries in Several European Regions and Central Asia

Region and Country	Population (in millions)	Women Aged 15–49 (in millions)	Total Fertility Rate	Rate of Natural Increase (%)	Life Expectancy Male	Life Expectancy Female	% Urban	GNI PPP per capita 2000 [†]	Health	% Women
									Expenditures per capita 1990–1998 [§]	Enrolled in Secondary School 1993–1997 [¶]
<u>Western Europe</u>										
<i>Austria</i>	8.1	2.0	1.3	0.0	75	81	54	24,600	2,108	102
<i>Belgium</i>	10.3	2.4	1.6	0.1	75	82	97	25,710	1,812	151
<i>France</i>	59.5	14.4	1.9	0.4	76	83	74	23,020	2,287	111
<i>Germany</i>	82.4	19.5	1.3	-0.1	75	81	86	23,510	2,727	103
<i>Netherlands</i>	16.1	3.9	1.7	0.4	76	81	62	24,410	1,988	129
<i>Switzerland</i>	7.3	1.7	1.5	0.2	77	83	68	28,760	3,616	U
<i>United Kingdom</i>	60.2	14.0	1.7	0.1	75	80	90	22,220	1,480	120
<u>Central and Eastern Europe</u>										
<i>Albania</i>	3.1	0.8	2.1	1.2	72	76	46	3,600	73	38
<i>Belarus</i>	9.9	2.8	1.3	-0.5	63	75	70	7,550	82	95
<i>Bosnia&Herzegovina</i>	3.4	1.1	1.4	0.4	65	72	40	U	U	U
<i>Bulgaria</i>	7.8	1.9	1.3	-0.5	68	75	69	5,560	59	76
<i>Croatia</i>	4.3	1.1	1.7	-0.2	70	77	54	7,960	431	83
<i>Czech Republic</i>	10.3	2.6	1.2	-0.2	72	78	77	13,780	384	100
<i>Hungary</i>	10.1	2.5	1.4	-0.4	67	76	64	11,990	290	99
<i>Macedonia</i>	2.0	0.5	1.9	0.6	70	75	59	5,020	171	62
<i>Moldova</i>	4.3	1.2	1.3	-0.1	64	71	46	2,230	30	82
<i>Poland</i>	38.6	10.2	1.3	0.0	70	78	62	9,000	242	97
<i>Romania</i>	22.4	5.8	1.2	-0.2	67	74	55	6,360	65	78
<i>Russia</i>	143.5	39.3	1.3	-0.7	59	72	73	8,010	130	91
<i>Serbia&Montenegro</i>	10.7	2.6	1.8	0.2	70	75	52	U	U	64
<i>Slovakia</i>	5.4	1.5	1.4	0	69	77	57	11,040	255	96
<i>Slovenia</i>	2.0	0.5	1.2	0.0	72	79	50	17,310	768	93
<i>Ukraine</i>	48.2	12.7	1.3	-0.8	62	74	67	3,700	54	94
<u>Baltic Countries</u>										
<i>Estonia</i>	1.4	0.4	1.3	-0.4	65	76	69	9,340	230	108
<i>Latvia</i>	2.3	0.6	1.2	-0.6	65	76	68	7,070	168	85
<i>Lithuania</i>	3.5	1.0	1.3	-0.3	68	78	67	6,980	240	88
<u>Caucasus</u>										
<i>Armenia</i>	3.8	1.1	1.7	0.2	70	74	67	2,580	27	79
<i>Azerbaijan</i>	8.2	2.3	2.9	0.8	69	75	51	2,740	36	81
<i>Georgia</i>	4.4	1.4	1.7	0.0	69	77	56	2,680	46	76
<u>Central Asia</u>										
<i>Kazakhstan</i>	14.8	4.5	2.1	0.5	60	71	56	5,490	68	91
<i>Kyrgyz Rep.</i>	5.0	1.4	3.4	1.3	65	72	35	2,540	11	83
<i>Tajikistan</i>	6.3	1.6	3.7	1.4	66	71	27	1,090	U	74
<i>Turkmenistan</i>	5.6	1.3	2.9	1.3	63	70	44	3,800	U	U
<i>Uzbekistan</i>	25.4	6.9	3.3	1.7	68	73	38	2,360	U	88

* The average number of children that a woman would have during her reproductive lifetime, given present age specific fertility rates.

† Rate of natural increase is the birth rate minus the death rate, implying the annual rate of population growth without regard to migration.

‡ GNI PPP per Capita, 2000 (US\$) is the gross national income in purchasing power parity (PPP) divided by midyear population. GNI PPP refers to gross national income converted to international dollars using a purchasing power parity conversion factor; expressed in US \$.

§ Represents the sum of public and private expenditures on health divided by the country's population.

¶ Percent enrolled in secondary school refers to the ratio of the number of students enrolled in secondary school to the population in the applicable age group (e.g. 12 to 17 years of age) for the country (gross enrollment ratio). It can exceed 100 when number of students enrolled exceeds the population of the relevant age group.

U Data are unavailable

Source: United Nations Population Fund and Population Reference Bureau, 2003 *Country Profiles for Population and Reproductive Health: Policy Development and Indicators*; Population Reference Bureau, 2002 *World Population Data Sheet* and 2002 *Women of Our World*; World Bank, 2000 *World Development Indicators*.

Table 2
Comparative Reproductive Health Indicators
for Selected Countries in Several European Regions and Central Asia

Region and Country	Total Fertility Rate	Total Abortion Rate [*]	Percent of Married Women 15–49 Currently Using Contraception		Maternal Mortality Ratio [§]	Infant Mortality Rate [¶]	Percent of Women Among Population Aged 15–49 with HIV/AIDS
	Rate	Rate [*]	Total [†]	Modern [‡]	Ratio [§]	Rate [¶]	
<u>Western Europe</u>							
<i>Austria</i>	1.3	U	68	65	11	4.9	22
<i>Belgium</i>	1.6	0.2	78	74	8	5.3	35
<i>France</i>	1.9	0.4	80	74	20	4.5	27
<i>Germany</i>	1.3	0.2	75	72	12	4.4	20
<i>Netherlands</i>	1.7	0.2	79	76	10	5.1	20
<i>Switzerland</i>	1.5	0.3	82	78	8	5.0	32
<i>United Kingdom</i>	1.7	0.5	77	73	10	5.6	22
<u>Central and Eastern Europe</u>							
<i>Albania</i>	2.1	0.8	75	8	31	28.3	U
<i>Belarus</i>	1.3	2.0	50	42	33	12.5	25
<i>Bosnia&Herzegovina</i>	1.4	U	48	16	15	15.0	U
<i>Bulgaria</i>	1.3	1.6	41	26	23	15.2	U
<i>Croatia</i>	1.7	0.4	40	26	18	10.1	U
<i>Czech Republic</i>	1.2	0.6	67	58	14	5.8	23
<i>Hungary</i>	1.4	1.1	77	68	23	9.6	11
<i>Macedonia</i>	1.9	0.9	74	50	17	18.2	U
<i>Moldova</i>	1.3	1.3	49	19	65	20.5	22
<i>Poland</i>	1.3	U	64	30	12	10.0	U
<i>Romania</i>	1.2	2.2	73	53	60	22.1	38
<i>Russia</i>	1.3	2.6	58	33	75	16.7	25
<i>Serbia&Montenegro</i>	1.8	1.6	74	41	15	14.8	U
<i>Slovakia</i>	1.4	0.6	71	57	14	8.6	13
<i>Slovenia</i>	1.2	0.7	68	38	17	6.1	25
<i>Ukraine</i>	1.3	1.6	68	38	45	15.3	30
<u>Baltic</u>							
<i>Estonia</i>	1.3	1.6	70	56	80	11.1	20
<i>Latvia</i>	1.2	1.3	48	39	70	15.6	21
<i>Lithuania</i>	1.3	1.0	45	30	27	10.7	20
<u>Caucasus</u>							
<i>Armenia</i>	1.7	2.6	61	22	29	16.9	20
<i>Azerbaijan</i>	2.9	3.2	55	12	37	32.5	20
<i>Georgia</i>	1.7	3.7	41	20	22	19.4	20
<u>Central Asia</u>							
<i>Kazakhstan</i>	2.1	1.4	62	55	80	44.8	1
<i>Kyrgyz Republic</i>	3.4	1.5	60	50	80	43.2	U
<i>Tajikistan</i>	3.7	1.5	34	27	120	56.6	U
<i>Turkmenistan</i>	2.9	0.8	55	47	65	54.8	U
<i>Uzbekistan</i>	3.3	0.6	57	53	60	41.0	U

* The number of abortion that a woman would experience during her reproductive lifetime, given present age specific abortion rates. Based on official statistics for 1996 except for: France (1995), Moldova (1997), Romania (2000), Ukraine (1999), Georgia (2000), Azerbaijan (2001), and Central Asia where TAR was provided by RHS and DHS. The TAR for UK excludes Scotland. Source for official statistics: Henshaw et al., 1999.

† Includes modern and traditional methods.

‡ Includes supplied methods such as the pill, injectables, implants, IUD, condom, diaphragm, and contraceptive sterilization.

§ The annual number of deaths to women per 100,000 live births that result from conditions related to pregnancy, delivery, and related complications.

Excepting MMR in Western Europe, ratios represent consensus estimates for 1995 by WHO (Hill K et al., 2001), UNICEF and UNFPA.

¶ The annual number of deaths of infants under age 1 year per 1,000 live births. Rates reported by the United Nations Population Division, 2001 in *World Population Prospects: the 2000 Revision*.

U Data are unavailable

Table 3
Selected Reproductive Health Indicators from the DHS and RHS and from Government Sources
from the Demographic and Reproductive Health Surveys and from Government Sources

Region and Country	Time Period	Total Fertility Rates* (per woman)		General Abortion Rates† (per 1,000)		Infant Mortality Rates‡ (per 1,000)	
		Survey Estimates (women 15-44)	Government Sources (women 15-49)	Survey Estimates (women 15-44)	Government Sources (women 15-49)	Survey Estimates (5-year period before survey)	Government Sources (5-year period before survey)
<i>Eastern Europe</i>							
<i>Moldova, 1997</i>	1994–1996	1.8	1.7	43	43	U	U
<i>Romania, 1999</i>	1997–1999	1.3	1.3	74	62	32	21
<i>Russia, 1999</i> [§]	1996–1998	1.3	1.3 [¶]	80	U	U	U
<i>Ukraine, 1999</i>	1997–1999	1.4	1.3	55	42	U	U
<i>Caucasus</i>							
<i>Armenia, 2000</i>	1998–2000	1.7	1.3	81	17	36	16
<i>Azerbaijan, 2001</i>	1998–2000	2.9	2.0	116	10	74	17
<i>Georgia, 1999</i>	1997–1999	1.7	1.3	125	18	42	15
<i>Central Asia</i>							
<i>Kazakhstan, 1999</i>	1997–1999	2.1	1.9	47	32	62	24
<i>Kyrgyz Rep., 1997</i>	1995–1997	3.4	3.1	45	31	61	29
<i>Turkmenistan, 2000</i>	1998–2000	2.9	2.9	26	U	74	32
<i>Uzbekistan, 1996</i>	1994–1996	3.3	3.4	20	16	49	30

* The average number of children that a woman would have during her reproductive lifetime, given present age specific fertility rates.

† General abortion rate is the annual number of abortions per 1,000 women of reproductive age. General abortion rates from official government sources expressed per 1,000 women aged 15–49 are slightly lower than general abortion rates expressed per 1,000 women aged 15–44, since very few women aged 45 years or older reported any abortions.

‡ The probability of dying in the first year of life per 1,000 live births.

§ Data for Russia pertain to three primarily urban areas

¶ National Data

U = Unavailable.

Source: CDC and ORC Macro, 2003. *Reproductive, Maternal, and Child Health in Eastern Europe and Eurasia: A comparative Report.*

Table 4
Percent Distribution of Current Use of Specific Methods of Contraception
Among Women Aged 15–44 Years Currently Married*
for Selected Countries in Several European Regions and Central Asia

Region and Country	Modern Method							Traditional Method			% Using Modern	Most Used Method
	Any Method	Any Modern Method	Pill	IUD	Condom	Female Sterilization	Other Modern[†]	Any Traditional Method[‡]	Periodic Abstinence	Withdrawal		
Western Europe												
<i>Austria, 1996</i>	68	65	40	9	10	4	2	3	2	1	96	Pill
<i>Belgium, 1991-92</i>	78	74	46.7	5	5	11	7	4	2	2	95	Pill
<i>France, 1998</i>	80	74	38	21.2	5	9	1	6	U	U	93	Pill
<i>Germany, 1992</i>	75	72	59	6	4	1	2	3	1	1	96	Pill
<i>Netherlands, 1993</i>	79	76	49	4	8	5	11	5	2	2	96	Pill
<i>Switzerland, 1994-95</i>	82	78	34	6	14	14	10	5	1	5	95	Pill
<i>United Kingdom, 1998-99</i>	77	73	24	5	18	11	15	4	1	3	95	Pill
Central and Eastern Europe												
<i>Albania, 2002</i>	75	8	1	1	2	4	0	67	0	67	11	Withdrawal
<i>Belarus, 1995</i>	50	42	7	29	5	1	0	8	3	5	84	IUD
<i>Bosnia&Herzegovina, 2000</i>	48	16	5	8	3	0	0	32	4	27	33	Withdrawal
<i>Bulgaria, 1997-98</i>	41	26	7	7	11	0	1	15	3	13	62	Withdrawal
<i>Czech Rep., 1997</i>	67	58	23	14	13	7	1	9	2	7	86	Pill
<i>Hungary, 1992-93</i>	77	68	38	17	8	5	1	9	3	6	88	Pill
<i>Moldova, 1997</i>	74	50	2	38	6	3	0	24	2	22	68	IUD
<i>Poland, 1991</i>	49	19	2	6	9	0	2	30	19	11	39	Periodic Abs.
<i>Romania, 1999</i>	64	30	8	7	9	3	3	34	6	29	47	Withdrawal
<i>Russia, 1999§</i>	73	53	7	25	16	2	3	20	13	7	73	IUD
<i>Serbia&Montenegro, 2000</i>	58	33	5	8	17	0	3	26	14	11	57	Condom
<i>Slovakia, 1991</i>	74	41	5	11	21	4	0	32	U	U	55	Condom
<i>Slovenia, 1994</i>	71	57	22	22	8	6	0	15	7	8	80	Pill
<i>Ukraine, 1999</i>	68	38	3	19	14	1	1	30	10	20	56	IUD
Baltic Countries												
<i>Estonia, 1994</i>	70	56	4	36	16	0	1	14	8	5	80	IUD
<i>Latvia, 1995</i>	48	39	8	20	10	2	0	9	5	3	82	IUD
<i>Lithuania, 1994-95</i>	45	30	3	14	13	0	0	15	9	6	68	IUD
Caucasus												
<i>Armenia, 2000</i>	61	22	1	10	8	2	0	39	5	35	36	Withdrawal
<i>Azerbaijan, 2001</i>	55	12	1	6	3	1	0	44	3	41	22	Withdrawal
<i>Georgia, 1999-2000</i>	41	20	1	10	6	2	1	21	10	11	49	Withdrawal
Central Asia												
<i>Kazakhstan, 1999</i>	62	55	3	44	5	3	1	8	5	3	89	IUD
<i>Kyrgyz Rep., 1997</i>	60	50	2	39	6	2	1	9	3	6	83	IUD
<i>Tajikistan, 2000</i>	34	27	1	25	1	0	0	7	3	4	79	IUD
<i>Turkmenistan, 2000</i>	55	47	1	41	2	2	1	8	2	6	85	IUD
<i>Uzbekistan, 1996</i>	57	53	2	47	2	1	2	4	1	3	93	IUD

* Includes women in consensual unions.

† Includes methods such as injection, vasectomy, diaphragm, spermicides, Norplant, female condom.

‡ Excludes folk methods.

§ Data for Russia pertain to three primarily urban areas.

Source: Population Reference Bureau (PRB), *Family Planning Worldwide, 2002 Data Sheet* and the CDC-assisted RHS conducted in Albania in 2002.

Table 5
Unmet Need for Any Contraception and Unmet Need for Modern Contraception
Among All Women and Currently Married Women of Reproductive Age*
for Selected Countries in Several European Regions and Central Asia

Region and Country	Source[†]	All Women		Currently Married Women	
		Any Method	Modern Method	Any Method	Modern Method
<u>Western Europe</u>					
<i>Belgium, 1991-92</i>	FFS	2	6	3	7
<i>France, 1994</i>	FFS	6	10	7	14
<i>Italy, 1995-96</i>	FFS	7	23	12	33
<i>Spain, 1994</i>	FFS	3	12	5	18
<u>Central and Eastern Europe</u>					
<i>Albania, 2002</i>	RHS	1	43	1	68
<i>Bulgaria, 1997-98</i>	FFS	23	36	30	46
<i>Czech Rep., 1997</i>	FFS	10	31	15	39
<i>Hungary, 1992-93</i>	FFS	4	12	7	16
<i>Moldova, 1997</i>	RHS	7	23	6	29
<i>Romania, 1999</i>	RHS	5	29	6	39
<i>Russia, 1999‡</i>	RHS	11	28	12	33
<i>Slovenia, 1994</i>	FFS	7	19	9	24
<i>Ukraine, 1999</i>	RHS	15	37	18	47
<u>Baltic Countries</u>					
<i>Latvia, 1995</i>	FFS	11	17	17	25
<i>Lithuania, 1994-95</i>	FFS	12	23	18	34
<u>Caucasus</u>					
<i>Armenia, 2000</i>	DHS	10	34	15	52
<i>Azerbaijan, 2001</i>	RHS	7	31	12	53
<i>Georgia, 1999</i>	RHS	15	27	24	44
<u>Central Asia</u>					
<i>Kazakhstan, 1999</i>	DHS	10	16	14	22
<i>Kyrgyz Rep., 1997</i>	DHS	9	15	13	22
<i>Turkmenistan, 2000</i>	DHS	12	17	19	27
<i>Uzbekistan, 1996</i>	DHS	10	13	14	18

* Considered to be 15–44 years in RHS and 15–49 years in DHS survey.

Table 6
Selected Maternal and Child Health Indicators from Demographic and Reproductive Health Surveys
Selected Countries in Eastern Europe and Central Asia

<u>Region and Country</u>	Type of Survey	Mothers Receiving Any Prenatal Care (%)	Mothers Receiving Prenatal Care Beginning with 1st Trimester (%)	Births Outside Medical Facilities (%)	Deliveries Attended by Skilled Medical Personnel	Postpartum Care (%)
<u>Eastern Europe</u>						
<i>Albania, 2002</i>	RHS	81	59	5.9	U	U
<i>Czech Republic, 1993</i>	RHS	99	94	U	U	U
<i>Moldova, 1997</i>	RHS	99	73	0.9	U	74
<i>Romania, 1999</i>	RHS	89	60	2.0	98	32
<i>Russia, 1999[†]</i>	RHS	96	83	1.8	U	U
<i>Ukraine, 1999</i>	RHS	90	66	0.9	U	58
<u>Caucasus</u>						
<i>Armenia, 2000</i>	DHS	92	54	8.5	97	U
<i>Azerbaijan, 2001</i>	RHS	70	45	26.3	88	25
<i>Georgia, 1999</i>	RHS	91	63	7.8	98	11
<u>Central Asia</u>						
<i>Kazakhstan, 1999</i>	DHS	95	60	1.6	U	U
<i>Kyrgyz Rep., 1997</i>	DHS	97	72	3.8	99	U
<i>Turkmenistan, 2000</i>	DHS	98	72	4.2	98	U
<i>Uzbekistan, 1996</i>	DHS	95	73	5.9	97	U

[†] Data for Russia pertain to three primarily urban areas

Source: CDC and ORC Macro, 2003. *Reproductive, Maternal, and Child Health in Eastern Europe and Eurasia: A comparative Report.*

Figure 1

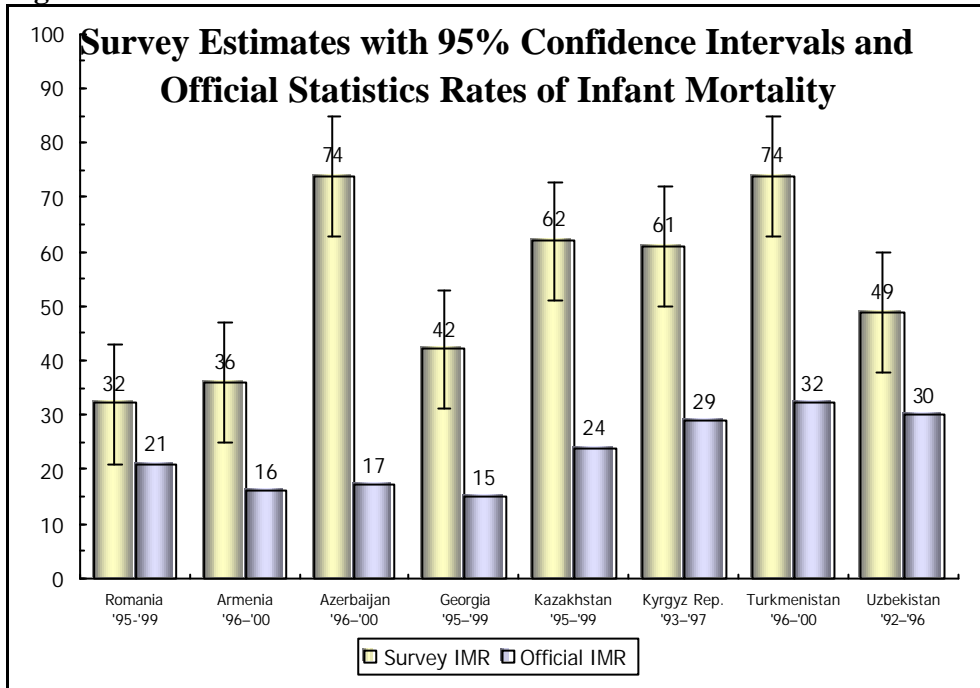


Figure 2

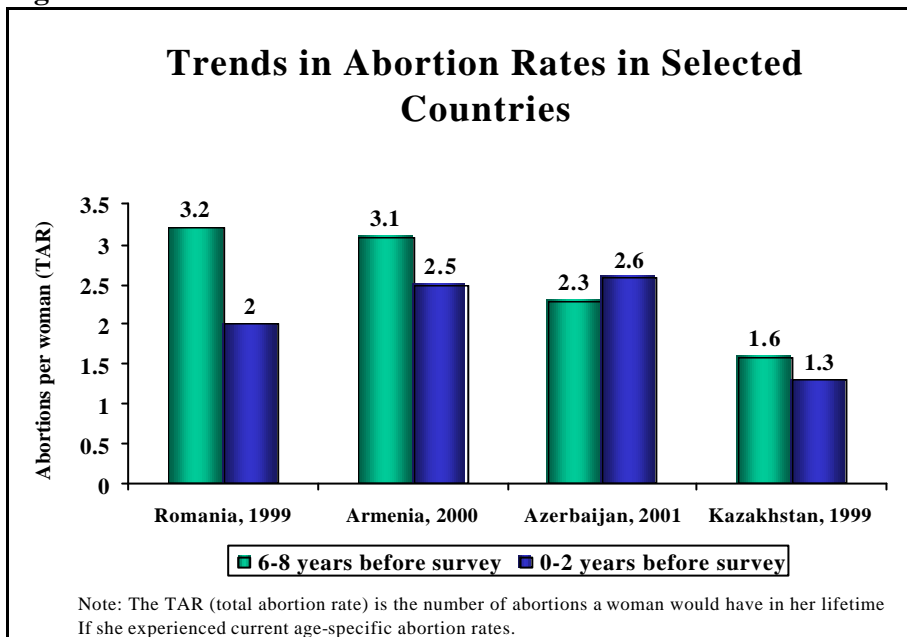


Figure 3

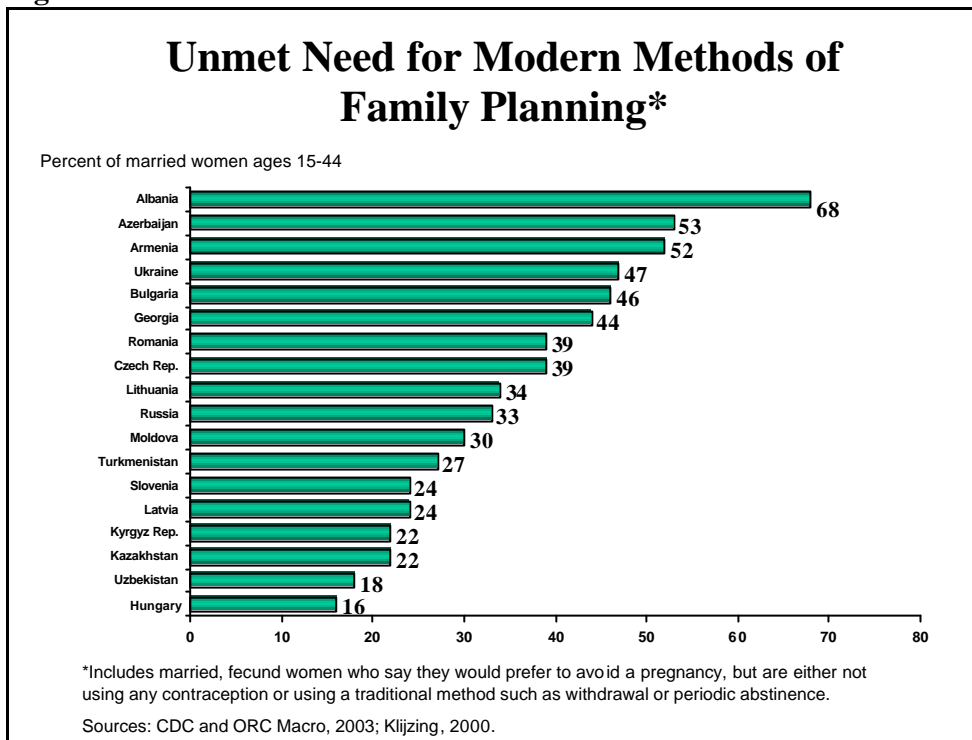


Figure 4

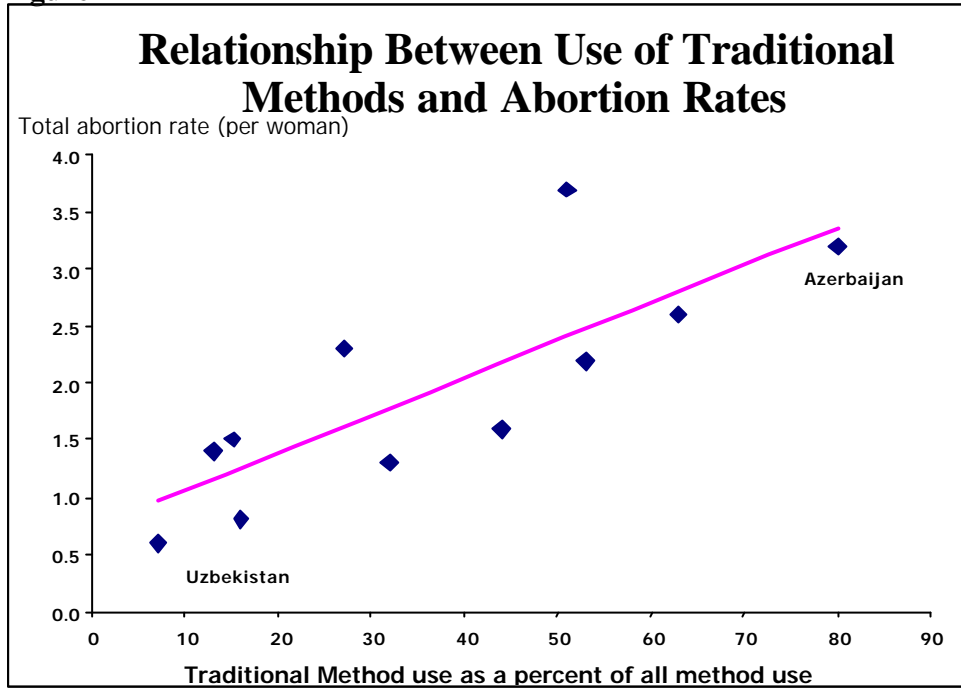


Figure 5

