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Morbidity,mortality and reproductive health Facing challenges in transition countries

Morbidity, Mortality and Reproductive Health: Challenges in Transition Countries

I. Introduction

The Cairo + 5 process and its subsequent analysis and reflections have taken major steps forward by stressing the human rights perspective towards health, sexual health, choice, youth, etc. The Cairo Conference on Population and Development has paid great attention to Reproductive Health as a human right. It has mobilized the signatory countries for the compilation of policies in conformity with the POA.
The issues today remain: Where are we positioned? How we shall move forward? How shall we defend our achievements? What more shall we ask for?

While I believe this panel will put forth many questions for discussion, but it also will bring many answers to light. Touching on some of the issues addressed by this panel, I can say that the main questions to be discussed boil down to this: today we are talking about another level, another stage of development and health reforms. Changes in Central and Eastern Europe and in successor states of the former Soviet Union since the early 1990s were abrupt and ubiquitous, affecting every aspect of the politics, social life and economies of the region. While there is a great deal of diversity among the transition countries, some overall trends.

Most economic and social indicators show that, on the whole, the countries in the region are transitioning with a degree of success, however each is moving at a different pace[1].

Some Central and Eastern European (CEE) countries can be considered to have reached a high level of economic success some others medium or low level. The Human Development

[1] i. [b.i.–b.iii. are taken from *Demographic consequences of economic transition in countries of central and eastern Europe*, Council of Europe, May 2003, pp 47-8]

Report data shown that he Commonwealth of Independent States (CIS) (or Newly Independent States (NIS)) and those in the Central Asian Republics are still in the early stages of transition.
e.g.: GDP per capita in Czech Republic is 14.720 USD in Tajikistan 1170(HDR 2001)

* Transition has had a major impact on health infrastructures. Centralized, government-supported health systems that once provided universal health services to all citizens were impossible to maintain after transition. Thus healthcare, including the delivery of reproductive health services, deteriorated in many countries.
* Since the early 1990s, any address of health issues in the transition countries has met with a unique combination of challenges, including:

i. High incidence of unsafe abortion
ii. Low use of modern contraceptives, an increase in prevalence of infectious diseases such as sexually transmitted infections (STIs), including HIV/AIDS.
iii. High rates of infant and maternal mortality compared to the rest of Europe.
iv. Differences and gaps in women and men's life expectancy with high rates of males mortality.
v. Complex behaviour and norms and value changes contribute to this mix challenge as well.

But this distinctive set of challenges has led to ingenious solutions by governments, individuals, health providers and NGOs. For example, with very limited local, national and international funding, we have found ways to improve health conditions and services where:

- Entire health infrastructure have collapsed and governments were not yet able to fill the void (First Family Planning Clinic in Albania was set up by AFPA with the IPPF support)

- Where the breakdown of social norms and structures has occurred, it has lead to the introduction of problems and health concerns never before seen in the region. *(e.g. drug revolution, HIV infection rates etc)*
- And as we examine the conditions in the transition countries, we need to be aware that one of the greatest challenges is the lack of RELIABLE AND CONSISTENT DATA.

Successfully meeting the health needs of the populations in the region will depend in part on improving the monitoring and evaluation systems in all of the transition countries. Without the proper data, we cannot rationalize our need to prioritise reproductive health.

II. Health in the Region

Though the pace of transition and level of success differs across the region, the transition countries share several demographic trends related to Morbidity, Mortality and Reproductive Health[2]

1. "Since 1990, life expectancy in most post-communist countries has declined—particularly in the Russian Federation, which has the lowest life expectancy among males in Europe—or has registered little change."
2. "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."[3]
3. 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."[4]
4. Though morbidity data in much of the region is unavailable, unreliable or highly selective, we do know that people in central and eastern Europe and the former

[2] The following statistics are quoted from the background paper "Reproductive Health in Transition Countries in the European Context"
[3] From background paper "Reproductive Health in Transition Countries in the European Context," pp 2-3.
[4] Ibid.

> Soviet states can expect a shorter life than those in the West, and their time spent in full health will generally be shorter.[5]

Nevertheless, while in the early 1990s morbidity and mortality increased quickly throughout the region, during the last five years, some progress has been made. Economic level changes brought on further changes in lifestyle. The opening to democracy made information available, but also brought on phenomena such as drug and alcohol abuse, trafficking, conflicts etc. Data analysis shows that the age groups most affected by transition were youth and middle-aged adults, although patterns differ from one country to the next. However the way in which the analysis occurs, often means young people, especially young girls are often invisible to planners.

The discussion of morbidity leads us to today's primary topic—reproductive health—because we cannot discuss morbidity and mortality among women in particular without also addressing reproductive health.

III. Reproductive Health in the Region

During socialism, the size of families was influenced by overall population policy, which usually encouraged moderate and positive population growth. But with the transition, this changed:

1. Many positive changes have occurred at the country level in policy and legislation, but not always in practice. Anyway, parents have been granted the right to determine the size of their families in countries such as Romania and Albania.[6]
2. UNFPA and Family planning organisations developed and expanded their activities, with most family planning associations created and supported by the IPPF European Network.[7]

[5] From "Reproductive Health in Transition Countries in the European Context," from the European Centre on Health of Societies in Transition, authors: Ellen Nolte, Martin McKee and Anna Gilmore.
[6] Taken from *Demographic consequences of economic transition in countries of central and eastern Europe*, Council of Europe, May 2003.
[7] Ibid.

3. Abortion rates decreased as the usage and availability of modern contraceptives increased.[8]

However, overall reproductive health and rights in some parts of the region worsened as infertility, STI began to rise. As was mentioned yesterday, "with the exception of the Central Asian Republics, most transition countries have fertility rates that are lower than those typically found in Western Europe and well below the replacement level of 2.1 births per woman". And with population growth stalled or shrinking in many countries, some policymakers considered and still consider family planning programs unnecessary and counterproductive. They forget that reproductive health factors are major contributors to the morbidity and mortality of women.

Let's look at five key reproductive health areas that affect mortality and morbidity: Mother-child health, contraception, abortion, STIs/HIV/AIDS and violence against women.

1. Infant Mortality

Official infant mortality rates are considerably higher in the region than in Western Europe, and these official statistics are believed to be lower than the actual figures[9]

- In Western Europe=on average, 5.0 deaths per 1,000 live births
- The United Nations Population Division estimated infant mortality rates in Central European countries= around 10 infant deaths per 1,000 live births or less*
- Baltic region=between 11 and 16 infant deaths per 1,000 live births
- Central Asia=between 13 and 33 per 1,000

While the infant mortality rate has declined in many countries of the region, the differences are still very noticeable. Causes of

[8] Ibid.
[9] Taken from background paper "Reproductive Health in Transition Countries in the European Context,"

these differences include lifestyle, access to information and services, poverty etc.

2. Maternal Mortality and Morbidity

a. “Death rates related to pregnancy and childbirth in the region are estimated to be at least twice as high as those in Western Europe.” Some of the causes are:

i. [pg 12] A deficient health infrastructure that cannot afford to replace outdated obstetric equipment and facilities and a lack of essential supplies needed to provide basic emergency obstetric care.
ii. “Research has shown that early initiation of prenatal care and the presence of skilled birth attendants at delivery, reduces maternal and infant mortality, and can prevent obstetric morbidity.”
iii. In some parts of the region women cannot exam their right for modern contraceptives or safe abortion. However, lack of access to safe abortion services leads to reliance on unsafe abortion. This together with low use of modern methods of contraception to control fertility, is one of the most common causes of maternal death.

Despite liberal laws in most of the region, deaths from unsafe abortion account for between 15 and 54% of maternal mortality in Eastern Europe and Central Asia.

Reasons some women still obtain abortions outside the legal system include lengthy waiting times, unsanitary conditions in health facilities, lack of attention to privacy and confidentiality at state-run hospitals, and prohibitive costs. In most countries in the region, the official cost of a legal abortion in a state facility is relatively low, but the procedure is not covered by health insurance. Additional unofficial payments—fees women commonly pay to providers ‘under the table’—often increase the

cost of a safe abortion beyond what a low-income family may afford.

Governments must prioritise eliminating such barriers, in accordance with ICPD+5 paragraph 63iii calling for health systems to train and equip health service providers and take other measures to make abortion safe and accessible, particularly outside of urban centres.

Women's autonomy in their reproductive decision-making and their access to legal and safe reproductive health services are at the core of the right to reproductive self-determination, health, life and non-discrimination.

Signatories to international and regional human rights instruments that protect and promote these rights (such as the European Convention for the Protection of Human Rights and Fundamental Freedoms) should ensure that their laws and policies reflect and conform to international human rights standards. In the context of women's reproductive rights, this means ensuring that women have access to a full range of high-quality reproductive health services, including abortion.[i]

3 Contraception.

In many countries of the region information and education about modern contraception are still unavailable or inaccessible to women. Sometimes (like in my country) contraceptive methods are less available and more expensive than abortion because of a lack of public sector investment and regulation of the private sector in this area.

With those factors in mind, it is clear that we cannot talk about maternal health without also talking about contraception.

Although use of modern contraceptive methods has substantially increased in recent years, the use of traditional methods often exceeds the use of modern methods.

- In Albania, usage of modern contraception among married women ages 15-49 is 8%, and of all methods is 75%.
- By comparison, in France, the usage of modern contraception is 74%, and of all methods is 80%.

Because of different level of modern contraceptive usage, Europe has the highest and the lowest abortion rates in the world: while in the Netherlands, the abortion rate is 0.2; in Russia the rate is 2.6.
However, the rate does vary among transition countries as well.

The use of modern contraception is hampered by:

- Its high cost in relation to the average salary of people in the region. We are talking for countries some of them with high poverty level. High percentage of people living with less than 2 or 1 USD per day.
- Women have less access to income and they neglect their health to meet basic family living needs
- The relatively low cost of abortion compared to the cost of contraceptives.
- Negative attitudes among medical professionals and the general population, which are based on misinformation about the medical risks of contraception
- Social background and status of women. Women have not right to decide them self. The medicalisation of contraception and the notion of control and provider centred approach to service delivery.
- Poor infrastructure and availability of contraceptives in rural areas. In some countries number of population living in rural area is high (in Albania 57 % but not only there)
- Post-abortion counselling, which is essential to avoid repeat abortion and encourage the use of effective contraception, is rarely available.

4 **STIs/HIV/AIDS**

The rates of STIs and HIV/AIDS in some countries are rising
1. Since the early 1990s, some of the transition countries have seen epidemics of STIs, though rates vary:

- [pg 13] “The reported incidence of new cases of syphilis in several former Soviet countries increased by 45-165 times during 1990-1998.”

- [pg 13] "…the rates in the countries of the Caucasus region and in Romania, though higher than in 1990, remained low by comparison."

2. The rise in STIs has led to a rise in infertility; and the presence of STIs considerably increases the risk of contracting HIV.

3. Some of the transition countries are experiencing one of the world's fastest growing HIV/AIDS epidemics. [pg 13] "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."

This has been fuelled primarily by injecting drug use and STIs among young people but is not the case every were in all region. In some other countries trafficking and emigration has influenced as well.

5 Gender Based Violence

Though it is often left out of discussions about reproductive health, I contend that gender based violence is a major health issue.
Research on violence against women and trafficking, demonstrates that the abuse and exploitation of women is a complex and multidimensional problem. Cultural, social, and economic factors influence the probability that women will become victims of violence. Is important to understand the context of trafficking and to address properly since this fenomena has grown up in our region..
Trafficked persons, especially, women and girls, are particularly vulnerable to helth risks and exposed to highly risky situations. They suffer disempowerment, being subject to abuse and exploitation, stigma and discrimination. Victims of trafficking are exposed to a range of health related problems

including physical and psychological abuse and trauma, STI, and other diseases.
Social and economic upheaval is often accompanied by increased violence, and this is evident in some of the transition countries. Minorities also are more vulnerable to isolation, discrimination, and hence, to violence.
Violence also increases where women lack essential rights or choices to protect themselves.
The scale of response to trafficking has so far not been in conformity with the magnitude of reproductive health problems and social problems that trafficking causes. It is addresses more at present in terms of a policy matter to maintain order and protect borders. Trafficking needs to be addressed from the human rights perspective, including health protection and human security and giving priority to the prevention. As a regional problem, and now spread more widely, this terror must be addressed through programs with regional dimension and not by ones localized only in one country. It can no longer be left hidden behind the political agenda and requires collective response.

iv. Solutions: Improving Access, Quality of Care and Health Infrastructure, Integrating HIV/AIDS and Strengthening Surveillance

a**. <u>Improved Access</u> to information and services, is integral to improving reproductive health including women and young people**. There is still a gap between the diagnosis and the necessary therapy for solutions. It is not only an issue of problem analysis, but of developing effective solutions in the regional and local contexts since we are talking for differences from one to another country.

If we were talking about the huge differences between modern contraceptive use in Western Europe and the transition countries this are due primarily to differences in ACCESS, largely linked to issues of policy recognition. This means access to:

1. Prenatal and postnatal health services
2. Countries in Eastern and Central Europe must maintain their commitments to making modern contraception available, accessible and affordable and ensuring access to safe and legal abortion. Safe, legal abortion should be easily available and safe, using methods recommended by WHO in safe Abortion: Technical and Policy Guidance for Health Systems
3. HIV/AIDS information and services.
4. Sexuality education, counselling and services, especially for young people
5. Fostering women empowerment.

Improved access to all of these services works integrally

Access must be improved geographically and in its reach to:

1. People in rural areas. We have to take in to consideration much better demographic trends and socio- economic indicators in designing the health services: urban versus rural primary health care versus secondary health care services if we are decide to help people and create sustainability. (Rapid urbanisation and services)
2. Vulnerable and marginalized groups, minorities, Roma groups etc
3. Young people
4. Very important poverty alleviation. Country strategies on economic improvement and poverty reduction are in place but the question is impact that policy papers are giving. There is a gap in between good policy papers we formulate, some times as part of our good will and hurry to join Europe, and impact they give. We have to look carefully to the indicators.

<u>b. Quality of Care</u> must also be improved, including:

i. Training of healthcare providers with current information

iii. Women's empowerment enables women to participate effectively in program formulation and implementation as well.

iv. Training of healthcare providers and sexuality educators to be sensitive to the role of gender and bias in access and quality of care, which applies where:

1. Women are stigmatised for requesting contraceptives
2. Women have limited decision-making power in marital relationships
3. Those most in need of reproductive health services from vulnerable or socially-excluded groups, including injecting drug users, minorities, migrants and refugees, people living with AIDS, and young people, to name just a few.

c. Capacity-Building and development of health infrastructure

Family planning and reproductive health system reforms have been undertaken in many of the transition countries. However, the overburdened and outdated healthcare infrastructures of many countries make quality of care and access to services a challenge for many governments.

Some believe that reproductive health needs cannot be met by the public health systems of the transition countries alone.

1. NGOs and Governments both have key roles to play in improving access and quality of care. In this part of the world, NGOs are struggling to grow, to be accountable and sustainable so they still need support.
2. Creative collaboration between many of the organizations and individuals with the capacity and responsibility to provide reproductive healthcare in the region must be promoted.
3. Strengthening of local capacity building, cross cutting and inter-regional projects is more effective.

d. Integration of HIV/AIDS services into sexual and reproductive health services, to bring in the political agenda.

i. In response to the increasing rate of HIV infection in the transition countries, we must integrate HIV/AIDS into the discussion of overall reproductive health.

ii. Where HIV/AIDS services are available in the region, they are usually separated from sexual and reproductive health services, which is often due to:

- Stigma surrounding HIV and AIDS
- Misconceptions about who is at risk perception and disease prevention
- funding pattern as well(as yesterday panel has discussed)

iii. Experience in other areas of the world where HIV/AIDS has reached epidemic levels shows us that we can broaden the scope of HIV prevention by linking it to a range of topics, including contraception and unwanted pregnancy and among others to bring it in to the agenda of the policy and decision making by changing the mentality of the politicians and decision makers whom do not consider yet important(My Electoral campaign example). Is very important media involvement.

c. Improvements in research and data collection

i. The lack of reliable data regarding sexual and reproductive health in the transition countries is a major hindrance to improving programs and services. According to a UNICEF study in several CIS countries, infant mortality rates are two or three times higher than those reported officially.

1. Better monitoring and analysis of data does more than simply indicate the frequency of problems;
2. It helps us understand the most pressing needs and issues of people in the region and can bring public awareness and international attention to key problems related to sexual and reproductive health.
3. Sex disaggregated data is essential to understand the situation of women and girls.

ii. It is imperative that we improve the monitoring of mortality and morbidity data related to pregnant women and infants, abortion, STIs and contraception, if we are to develop effective sexual and reproductive health strategies.

iii. Moreover, the surveillance and analysis of data regarding additional topics is also needed, including gender sensitive and gender-based violence, behavioural health risks, trafficking of women and girls and other related issues.