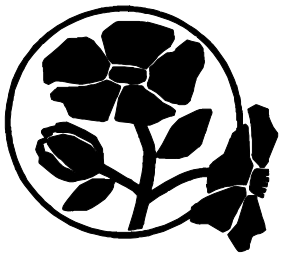
Third edition 2000
(first edition1995, second edition 1997)



From abortion to contraception

Family Planning and Reproductive Health in Central and Eastern Europe and the Newly Independent States

UNFPA
Division for Arab States and Europe

WHO
Regional Office for Europe
Women's and Reproductive Health Programme

Abstract

The profound and rapid changes that have taken place in recent years in the countries of central and eastern Europe (CCEE) and the the newly independent states (NIS) has revealed a particularly disadvantaged group in these countries: women.
The growing health problems and particularly the widening gap between women's health in western and eastern Europe require the rethinking of social and health policies.
With limited resources available, reproductive health services are increasingly being viewed as one appropriate mechanism for improving women's health. Although most countries in the CEE and NIS report a growing interest in contraceptives, limited availability and cost remove them as viable options for many people.
The level of reproductive health services to be provided should be determined on a case-by-case basis, taking into account the client and community needs and programme capabilities. As a minimum, reproductive health programmes should provide a broad range of family planning choices, STI prevention, safe abortion, safe perinatal, postnatal and antenatal care. This document is the third update of reproductive health data for the region since 1995.

Targets for HEALTH21

Target 1: Solidarity for Health in the European region
Target 2: Equity in Health
Target 3: Healthy Start in Life
Target 7: Reducing Communicable Diseases
Target 8: Reducing Noncommunicable Diseases
Target 15: An Integrated Health Sector
Target 16: Managing for Quality of Care

Keywords

FAMILY PLANNING
REPRODUCTIVE HEALTH
ABORTION
CONTRACEPTION
MATERNAL MORTALITY
INFANT MORTALITY
WOMEN'S HEALTH
BIRTH RATE
FERTILITY RATE
HUMAN DEVELOPMENT INDEX

World Health Organization
Regional Office for Europe
Women's and Reproductive Health
8, Scherfigsvej
DK-2100 Copenhagen
Denmark

Telephone: **+45 39 17 14 26**

Telefax: **+45 39 17 18 50**

Electronic mail: **ABR@who.dk**

This working document was funded by UNFPA Division for Arab States and Europe and was prepared by Dorte Jepsen, consultant; Dr Nese Savas, consultant; Nadia Redman, assistant; Ken Legins, Technical Adviser, Health Information and Communications; and Dr Assia Brandrup-Lukanow, Regional Adviser for Women's and Reproductive Health, WHO Regional Office for Europe.

Acknowledgements are hereby extended to all the Ministries of Health and their collaborative partners in the countries included in this working document, different United Nations agencies, including the statistical unit of the World Health Organization Regional Office for Europe and consultants who have given their time and efforts to make this working document as complete as possible with the available data.

Contents

Introduction

Reproductive health

In September 1994, at the International Conference on Population and Development in Cairo, 185 participating countries endorsed the Programme of Action which states that reproductive rights rest on "the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health". Also included is "their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents".

At the conference it was also decided that to provide a full picture, which takes reproductive rights into account, research and data are needed on such topics as:

- The extent of unmet demand for safe and effective methods of fertility regulation;
- The extent of unmet need for the information necessary to make free and informed choices about childbearing;
- Levels of reproductive morbidity in women of all ages, including conditions such as reproductive tract infections, uterine prolapse and cancer;
- Quality of care in the provision of family planning and reproductive health services;
- Legal and ethical standards relating to reproductive rights and the extent to which those standards are observed in practice;
- The extent to which individuals are aware of their reproductive rights and the means of redress available if rights are violated.

Initiatives have begun to collect better information on these topics, but much more work is needed to develop methods for measuring more directly the implementation of reproductive rights.

Women's health

Profound and rapid changes are underway in the countries of central and eastern Europe (CCEE) and the newly independent states (NIS), of the former USSR. These changes have led to social and economic hardship and, in some cases, to war. The result is a widening gap in health indicators between the eastern and western halves of the WHO European Region: a serious inequity. The leading causes of death in the CCEE and NIS are the same as in most other European countries: cardiovascular diseases, malignant neoplasms and external causes. A closer look at the CEE and CIS reveals a particularly disadvantaged group in these countries: women. While women bear more of the burdens imposed by change, they also comprise an invaluable, largely untapped resource for the response to change. Studies by the United Nations and the World Bank have shown that

investments in women yield high returns in the form of faster growth, higher efficiency, greater savings, and reduced poverty.

Healthy mothers have an increased chance of having healthy new-borns and children, while a woman's ill health or death affects not only her own opportunities and potential, but those of her children. Women's health is, therefore, an issue that crosses borders, political systems and cultural differences and it is an excellent investment as it guarantees an improvement in the health of the next generation.

The World Health Organization (WHO), as well as UNFPA and UNAIDS, fully support the charter on sexual and reproductive rights by the International Planned Parenthood Federation (IPPF). WHO will cooperate with the Member States on all the principles contained in the charter, particularly in the implementation of the activities concerning sexual and reproductive health, and encourages Ministries of Health to:

- Recognize the importance of protecting reproductive health and placing it high on the list of priorities of public health. Many countries in the eastern part of the European Region are now in the process of finalizing national policies on reproductive health;

- Respect sexual and reproductive rights and to revise, if necessary, the respective legislation particularly regarding abortion and homosexuality;

- Apply an intersectoral approach and cooperate in particular with the educational, social, private and mass media institutions in order to strengthen public information and education on reproductive health;

- Support non-governmental organizations (NGOs) activities and initiatives in reproductive health, including the prevention and treatment of HIV/AIDS related diseases, taking into account the financial and organizational constraints to the public sector;

- Promote breastfeeding through appropriate legislation and activities of health professionals;

- Upgrade the skills of health professionals in reproductive health by implementing training activities in postgraduate training (on the job), pregraduate training and curriculum revision;

- Shift focus on health service provision from the curative to health promotional and preventive measures (for example from mandatory mass HIV screening, as has been the practice in some countries, to promotion of condom use and information);

- Broaden the approach to reproductive health to include prevention of cancers of the reproductive tract and the care of women of perimenopausal age.

Comparison of the data between west and east shows great differences in women's health indicators. Though women generally live longer than men both in western (5–7 years) and eastern (7–13 years) Europe, the greater mortality rates of men often draw attention away from the problems that women face. Women have more years of unhealthy life in terms of higher rates of chronic illness and disability, associated to some extent with their longer survival. Women are also more vulnerable than men at a younger age, in that a large burden of women's ill health occurs during the reproductive years, whereas the main burden of disease on men tends to occur later.
Women's economic situation, a prerequisite for health, is generally less favourable than that of men. The most fundamental and universal difference between households headed by women and those headed by men is the relative poverty of female-headed households in all countries.

Poverty is a general determinant of ill health. For old women living alone, poverty often reaches extreme levels that threaten survival.

Food shortages and economic difficulties prevent many people from eating healthy diets. Malnutrition is a growing problem in many countries in the Region. The prevalence of anaemia among young women is growing, reaching levels of up to 40–50% in the central Asian republics, and 17% among pregnant women in Europe in general.

The issue of security and women`s health and safety in the home, the workplace and the community, applies to women worldwide. In 1999 the United Nations Population Fund declared violence against women ”a public health priority”.

The effects of violence can be devastating to a woman`s reproductive health as well as to other aspects of her physical and mental well-being.

Women with the history of a physical or sexual abuse are also at increased risk for unintended pregnancy, STIs, and adverse pregnancy outcomes.

Violence in the home effects family planning as well as it restricts a woman’s reproductive and sexual autonomy.

Physical abuse during pregnancy has been recognised as an important risk to the health of both mother and infant. Still it is an issue that has received far too little study in spite of the evidences that violence often begins or escalates during pregnancy.

WHO/EURO currently maintains a number of projects related to this issue, which have been incorporated into several overall program workplans. One of them addresses directly the violence and pregnancy issue.

Pregnancy gives a window of opportunity for violence assessment, as it is one of the rare situations where healthy women have regular contacts with the health care system (numerous studies show that missing prenatal visits is one of the signs of the abuse, and it should alert health professionals).

Violence against women has never been addressed before in the region, and as it is mentioned in the UNICEF Regional Monitoring Report, Women in Transition (N6, 1999), “…one of the serious barrier to women’s equality is the blanket of silence over violence against women that still covers the region.” .
Preliminary data from the WHO comparative study on violence against women including violence during pregnancy show much higher prevalence of domestic violence in eastern Europe than in western Europe.

There is a need for developing services for victims of violence, including assistance through the legal system and assistance in finding ways to leave a violent situation.

Action within the health sector is just one part in tackling domestic violence. A major step in primary prevention of violence and mental health problems can be achieved by working together with other institutions fighting violence generating conditions (such as a low level of education, unemployment, lack of reproductive rights and unjust gender relationship).

The growing health problems, and particularly the widening gap between women's health in western and eastern Europe, require the re-thinking of social and health policies and above all, the increased participation of women in the decision-making process concerning policies deciding over their health and future.

Family planning and reproductive health

With limited resources available, family planning services are increasingly being viewed as one appropriate mechanism for improving women's reproductive health. Some key reasons for providing a broader array of reproductive health services, inclusive of family planning, are that:

- medical research has proven that too early, too late, and too frequent pregnancies negatively affect the health of women, as well as affecting the health of a previously born and subsequently born child;

- many of the safe modern methods of contraception can also prevent anemia, sexually transmitted infections (STIs) and some forms of benign and malignant neoplasms;

- unwanted pregnancies are a serious threat to women's health, and even where abortion is legal, its potential side effects account for a major proportion of maternal mortality and morbidity;

- the incidence of induced abortions is inversely linked to access and availability of safe and effective contraception.

Contraceptive prevalence rates range from about 60 to 70 percent in some countries of western Europe, to less than 10 percent in some countries of eastern Europe. In many countries, the financial resources or the political will are lacking to make the necessary changes.

Non-governmental organizations concerned with women's reproductive health are increasingly active in their countries in order to bring about changes, and the growing social respect for these organizations was reflected in the fact that many women belonging to family planning or other women's health organizations were members of the national delegations attending the recent International Conference on Population and Development (ICPD) in Cairo in September, 1994 and as such directly influencing the decision-making process concerning global women's health issues.

Although most countries report a growing interest in contraceptives, limited availability and cost remove them as viable options for many people. Getting an abortion for very little money or for free, but having to give one third of one's salary for contraceptives denies choice.

In some countries, the lack of sex education in the presence of changing social and moral values has led to an increase in teenage pregnancies, which vary widely between countries, with the UK reporting one of the highest, and the Netherlands the lowest rates in Europe. Many countries of CEE report increasing abortion in teenagers.

Dramatic rises in sexually transmitted infections (STIs) occurred during the first half of the nineties in all the NIS, eg. in the Russian Federation, the incidence of syphilis increased 15–60 fold, from 5–15 per 100 000 population in 1990, to 200–500 per 100 000 population by 1996, with proportionally larger increases occurring among young women.

The incidence of congenital syphilis has doubled since 1996 in many countries reflecting an increase in the prevalence of untreated syphilis among young women. During 1998–1999 the number of notified cases of syphilis, an indicator for other STIs, remains at a very high level.

The alarming rise in STIs may reflect changes in sexual behaviour towards more risky sex, including growing prostitution. An equally important factor is a delay or shift in health seeking behaviour. Patients try to avoid the stigma and coercive sanctions attached to the state service and seek treatment in the growing private sector or, alternatively, treat themselves, in both cases with no quality control of the treatment.

In the NIS, HIV continues to spread among injecting drug users. This part of the region, which until the mid-1990s appeared to have been spared the worst of the epidemic, now holds an estimated 270 000 people living with HIV, with an estimated half of the cases transmitted through sex. For the moment Ukraine remains the worst-affected country, though the Russian Federation, Belarus, Kazakhstan and Moldova have all registered enormous increases in the past few years. With the rapid and wide spread of HIV, the potential for continued spread through drugs and sex is undeniable given the known overlap between drug-injecting and sex-worker populations and the dramatic rises in other STIs.

To enable early diagnosis and effective treatment of STIs, STI case management based on syndromic approach should be available to the patient at the first encounter with health care services. Integration of STI diagnosis and treatment in reproductive health services is an important first step in this direction.

Also, many countries report increasing rates of sexually transmitted diseases, including HIV infection. The dire economic situation in many eastern European countries has lead to an increase in prostitution/sex work, and though the number of AIDS cases is still generally low, there is an increase in female cases, mainly only due to sexual transmission. The cumulative total number of AIDS cases in the WHO European region was reported to be 179 955 as of 30 September 1996. (HIV&AIDS Surveillance in Europe, no.51, September 1996). Ultimately, therefore, integrated reproductive health services are required which would consist of preventive care, family planning, STI diagnosis and treatment and cancer screening. WHO has developed a cost-effective care-based management strategy, therefore, the level of reproductive health services to be provided should be determined on a case-by-case basis, taking into account the client and community needs and programme capabilities. As a minimum, family planning programmes should provide a broad range of contraceptive choices, STI prevention and linkages in a functioning referral system of safe birth and abortion care.

The abortion issue

Due to the lack of appropriate contraceptives and counselling services, abortion was and still remains the principal means of fertility regulation in the CCEE and NIS, sometimes equalling the number of live births, and sometimes even exceeding this by two or three times. However, it is generally agreed that vacuum aspiration in the first trimester, performed by an experienced and skilled specialist, is a safe procedure with few, if any, long-term adverse effects, i.e. secondary infertility, ectopic pregnancy, pre-term delivery etc.

As a possible result of the economic difficulties that these countries are encountering in their transition period, where women in CCEE and NIS do not think they can afford to give birth to and to bring
up children, some governments are extremely concerned about the rapid decline of fertility rates to levels below replacement.

The question of the price paid by society for abortion has several aspects, such as the health consequences and cost of induced abortion. Maternal mortality connected with induced abortion and following it, the social drama and sometimes tragedy of the family involved is the most serious price paid for abortion. Maternal morbidity after induced abortion (especially illegal) and connected with it, inflammatory diseases of the genital tract, could be reasons for long suffering, temporary disability or even partial invalidity.

Since many women who are terminating an unwanted pregnancy intend to have a child later, it is extremely important to identify possible adverse effects of induced abortion on subsequent reproductive function. Cervical trauma, cervical and uterine adhesions, pelvic infections, to

mention only a few, are several complications which could potentially adversely affect future pregnancy. A review of available information concerning the long-term impact of induced abortion and subsequent reproductive outcome shows no consensus because some studies were conducted in countries where abortion was illegal, while others did not adequately control for confounding factors.

There are also several safety issues (abortion in nulliparous women, multiple pregnancy terminations, second trimester abortion) which have not been addressed adequately and need special attention, not to mention the psycho-social effects of multiple abortions and possible secondary infertility, and the growing interest and practice of assisted reproduction techniques, such as in vitro fertilization (IVF).

The Third Symposium on Bioethics arranged by the Council of Europe in December 1996 in Strasbourg addressed, among others, the issue of multiple pregnancies being an inevitable consequence of assisted reproduction techniques, and the higher incidences of pre-term births and low birth weight following IVF which can result in developmental difficulties for the child. In view of the existing evidence (specifically in CCEE and NIS) of maternal-fetal risk deriving from multiple pregnancies, it is incumbent on clinics working with assisted reproduction techniques to provide suitable prophylaxis to limit the incidence of multiple pregnancies, however, presentations at the symposium showed that studies conducted to date indicate that full-born children conceived by IVF are no more at risk for congenital abnormalities than naturally conceived children and evidence also suggests that full-born IVF children do not experience problems in intellectual development.

Child health

Infant and child health indicators are accepted excellent indicators of the general level of the health of the nation. They permit an evaluation of the problems that we face. As children's health is strongly tied to their mothers' health, they reflect among other factors, conditions during pregnancy and at birth.

Profound and rapid changes are underway in the countries of central and eastern Europe and the newly independent states of the former USSR. These changes have led to social and economic hardship and, in some cases, to war. The result is a widening gap in health indicators between the eastern and western halves of the WHO European Region: a serious inequity.

Between 1950 and 1975 the health status of children improved rapidly in most countries due to reduction of poverty, better nutritional status, the control of major infectious disease and expanded health services. In this period, infant mortality rate dropped substantially in all European countries. However, with few exceptions, improvements in infant mortality rates over the past 15 years have been smaller than during 1950–1975 period. It is noticeable that in some eastern European countries, the infant mortality rate has not declined any further during the past decade. This has led to wide differentials between the countries. The main causes of infant mortality in eastern Europe are acute respiratory infections, perinatal conditions, diarrhoeal diseases and congenital malformations. In western Europe the main causes of infant mortality are perinatal conditions, sudden infant death syndrome, congenital malformations and malignant diseases. In many countries between 40 and 60 percent of infant mortality occurs in the first four weeks of life, the majority occurring during the first week. This relationship, however, varies greatly depending on the level of social and economic development of a country and on coverage and quality of its health services.

Usually, neonatal and perinatal mortality decline more slowly than infant mortality. There are two main reasons for this: the first is that infant deaths after the neonatal period are more sensitive to

general social changes and more easily affected by preventive activities and appropriate case management; the second is that more efforts have been made to decrease the post-neonatal components of infant mortality.

In 1959 the United Nations adopted a *Declaration of the Rights of the Child*. Finally in 1989, the *United Nations Convention on the Rights of the Child* was accepted. The convention secures the fundamental minimum needs of the child. It includes three categories of articles:

1. the right to fulfil basic needs:

    - the basic needs are the right to food, health care and education i.e. the most fundamental needs for survival and normal development.

2. the right to be protected from exploitation and discrimination:

    - this means that the child has to be protected from sexual and economical exploitation; to be protected from wars and other similar situations; and to be protected from military recruitment. Special protection is needed for the vulnerable child, such as the child refugee and the disabled child, also protection against traditional customs that may injure the child (such as female circumcision).

3. the child's personal views are to be heard in matters that concern personal life, according to maturity and development.

The First World Summit for Children was held at the United Nations on 30 September 1990. More than 70 world leaders pledged to fight the hunger, poverty, disease, exploitation, neglect and illiteracy that afflict children in both developing and industrialised countries. The International Community identified a strategic set of technically achievable goals and targets in the health, nutrition, education and water supply and sanitation fields.

Selected Health Goals endorsed by the World Summit for Children.

1. Major goals for child survival, development and protection:

(a) Between 1990 and the year 2000, reduction of infant and under-five child mortality rates by one third or to 50 and 70 per 1000 live births, respectively, which ever is less;
(b) Between 1990 and the year 2000, reduction of maternal mortality rate by one half;
(c) Between 1990 and the year 2000, reduction of severe and moderate malnutrition among under five children by one half;
(d) Universal access to safe drinking water and to sanitary means of excreta disposal;
(e) By the year 2000, universal access to basic education and completion of primary education by at least 80 percent of primary school-age children;
(f) Reduction of the adult illiteracy rate to at least one half of its 1990 level, with emphasis on female literacy;
(g) Improved protection of children in especially difficult circumstances.
In most European countries, all the above goals (a-f) have been met before in-depth

2. Supporting health goals.

A. Women's health and education:
(a) Special attention to the health and nutrition of the female child and to pregnant and lactating women;
(b) Access by all couples to information and services to prevent pregnancies that are too closely spaced, too late and too many;

(c) Access by all pregnant women to prenatal care, trained attendants during childbirth, and referral facilities for high-risk pregnancies and obstetric emergencies.
All three health goals have still to be met in CCEE/NIS

B. Nutrition:
(a) Reduction of iron deficiency anaemia in women by one third of the 1990s levels;
(b) Virtual elimination of iodine deficiency disorders;
(c) Virtual elimination of vitamin A deficiency and its consequences, including blindness;
(d) Empowerment of all women to breast-feed their children exclusively for four to six months and to continue breast-feeding, with complementary food, well into the second year while ensuring effective family planning methods.
Of the above the recommendations relevant to CCEE/NIS are: a, b, and d.

C. Child health:
(a) Global eradication of poliomyelitis by the year 2000;
(b) Elimination of neonatal tetanus by 1995;
(c) Reduction by 95 per cent of measles deaths and reduction by 90 per cent of measles cases, compared to pre-immunisation levels, by 1995, as a major step towards the global eradication of measles in the longer run;
(d) Maintenance of a high level of immunisation coverage (at least 90 per cent of children under one year of age by the year 2000) against diphtheria, pertussis, tetanus, measles, poliomyelitis and tuberculosis and against tetanus for women of child-bearing age;
(e) Reduction by 50 per cent in deaths caused by diarrhoea in children under the age of five years and 25 per cent reduction in the diarrhoea incidence rate;
(f) Reduction by one third in deaths caused by acute respiratory infections in children under five years of age.
All the above, but particularly recommendations a, c, d, e, and f are still relevant to CCEE/NIS.

The implications of the International Conference on Population and Development (ICPD)

The International Conference on Population and Development (ICPD), held from 5–13 September, 1994 in Cairo, adopted a Programme of Action for the next twenty years that is generally viewed as the start of a new era in thinking about population and development by explicitly placing human beings in the centre of all our population and development activities. The Programme of Action encourages the international community to address the macro problems by meeting the micro needs in taking into account individual perspectives and needs in policy formulation and implementation. Investing in people, in their health and education, is the key to sustained economic growth and sustainable development.

A critical element of the Programme of Action is the notion to place the concept of family planning within the wider context of reproductive health. An essential component of such strategy is the basic right of all people, couples and individuals alike, to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so.

Cairo was not the end, but rather the beginning of a new phase in dealing with population issues. The challenge is immense, but achievable. The significance of the ICPD now depends on the willingness of governments, local communities, the non-governmental and private sectors, the international community and all other concerned organizations and individuals to turn the recommendations of the conference into real action.

The implications of the ICPD for future population policies and programmes are far-reaching. As a direct consequence, population policies and programmes that were previously oriented towards meeting demographic targets need to be redefined, as the focus has shifted to human development and addressing the needs of individuals. In order to achieve the goals and objectives set out in the ICPD Programme of Action, in many cases a reorientation of national policies and programmes is needed in order to bring about the three key areas of the ICPD Programme of Action, namely the integration of population issues in all development planning policies, the empowerment of women and the integration of family planning activities into the broader framework of reproductive health care.

Follow-up at the national level would inevitably entail the formulation of national ICPD Action Plans which would translate the ICPD Programme of Action into the national context. The formulation of national ICPD action plans will involve setting national ICPD goals and objectives in conjunction with the ICPD Programme of Action, establishing intermediate outputs and activities required to reach those goals, determining the costs and identifying the required financing and dividing the responsibilities for implementing the plan among the country's various national counterparts.

Specific challenges are faced by the countries of eastern Europe and the newly independent states, whose economies and political systems continue to undergo a dramatic transition. For example, abortion is widely used as a method of family planning. At the same time, it is one of the leading causes of maternal morbidity and mortality in the region. Lack of information and knowledge on the part of medical professionals, as well as the general public, seriously hampers the promotion and use of modern family planning methods. The breakdown of the Communist regimes has resulted in an alarming increase in sexually transmitted diseases, particularly among teenagers and adolescents. Prostitution and trafficking in women and young girls to western European countries are on the rise and causes great concern among Governments. Internal and international migration, both legal and increasingly illegal, poses serious threats to the stability in the region.

On the other hand, most of these countries possess some critical advantages in pursuing population and development goals. An emphasis on education at all levels, with equal access for women and men, has resulted in enviable levels of literacy and produced a well-trained medical and paramedical profession. The health infrastructure is generally also well-developed, yet in need of revitalization. Consequently, there is the potential to advance fairly quickly to self-sufficiency in regard to reproductive health and family planning.

To advance the transition "from abortion to contraception" the ICPD has recognized, for the first time in any UN document, the need for countries with economies in transition to receive temporary assistance from the international community for population and development activities in light of the difficult economic and social problems these countries face today. In view of its mandate, the United Nations Population Fund (UNFPA) is committed to assist governments in developing and implementing policies and programmes that address the most pressing population and development problems, notably in the area of reproductive health and family planning. UNFPA will be a partner in building the national capacity in these countries to implement national reproductive health programmes.

Experts Group Meeting, Copenhagen, September, 1998

The UNFPA Division for Arab States and Europe and the WHO Regional Office for Europe in Copenhagen, co-organized and hosted an important expert meeting on 28–30 September 1998, within the subject of reproductive health. The purpose of the meeting was to bring its conclusions and recommendations for action to the Regional Population Meeting in Budapest in December

1998 in preparation for the International Forum in The Hague in February of 1999. The following recommendations and key actions on reproductive and sexual health policies were put forward:

Nationally
Governments should ensure that:

- There is a national consensus, whether in legislation or in a national policy, on reproductive health care to serve as a basis for a comprehensive national programme for reproductive health;
- Reproductive health policy is developed and implemented within the scope of broad social development;
- Stakeholders (NGOs, other public organizations and relevant health and educational professionals) are invited to contribute through participation in the development of policy and programmes;
- Existing laws supporting reproductive health are enforced;
- Guidelines are developed to assist governments monitor the implementation of reproductive health care to ensure that ministries take a continued interest in their performance;
- Their capacity to learn from NGOs how to incorporate the latter's successful approaches into national reproductive health programmes is reinforced;
- Awareness is raised of the need to create sustainability and ensure the cost-effectiveness of reproductive health programmes;
- Standards for the quality of care in public and private reproductive health services are laid down and updated on the basis of data collection and research on health and quality indicators.

Regionally

A regional reproductive health care strategy should be developed in support of national strategies. Participation by a wide range of ministers in regional meetings on reproductive health policy should be ensured.

Internationally
International agencies should:

- Offer support in terms of a framework for a reproductive health strategy and programme development;
- Support governments in exercising their role to regulate and set norms and standards for reproductive health care, and support NGOs.

Integration of reproductive health components

- Client-oriented integrated core reproductive health services should be secured.
- Incremental health care reforms should be based on experience from pilot or demonstration projects.

- A basic reproductive health care package should be developed and integrated into primary health care.
- Multisectoral working groups should be set up to secure central and local standards for implementation of reproductive health policies.

Information, education and communication

- Interministerial communication and coordination in development of client-oriented public information materials and health education curricula to be ensured.

- The use of the mass media for public information, education and counselling should be promoted and people working in the media should be educated on the benefits of reproductive health care.

- Governments should cooperate and set up joint initiatives with NGOs to develop national information, education and counselling programmes, promote and introduce sex education at an early age, and secure parents' support.

Adolescents' reproductive health and reproductive rights

- Government commitment to reproductive health care for adolescents should be secured in reproductive health policy and programmes.

- Policy-makers, officials and the media should be sensitized as to adolescent health and development issues.

- Adolescents should be involved in the design and implementation of information, education and counselling and reproductive health service programmes for adolescents.

- Health professionals, service providers and teachers should be trained and sensitized to adolescents' health needs.

- Data should be obtained on cultural, religious and socioeconomic conditions as well as qualitative research carried out on adolescents' reproductive health situation and needs.

- Sex education should be available both in school and outside.

- Education and counselling programmes should provide adolescents with skills relating to their personal and social lives in addition to those concerned with sexual and reproductive health issues.

- Access to good quality, "youth-friendly" confidential services should be improved.

- Use should be made of innovative and popular channels of communication such as the internet, music and theatre.

- Governments and NGOs should cooperate with the private sector as the basis for good adolescent health programmes.

Reproductive rights

- Training in ethical and clients' rights issues in the area of reproductive health should be integrated into the education of all health professionals.

- Information on clients' rights and on negotiating and solving conflicts should be made available in reproductive health services (ombudsman system).
- Information should be provided to the public about existing reproductive health care services, referrals and clients' and patients' rights.

Reproductive health services

- Cost recovery programmes should be developed (social marketing).

- Disadvantaged and under-served people, including adolescents, should have free access to services and contraceptives.

- New contraceptive and fertility-regulating technologies should be introduced when services are set up.

- Access to quality care and multidisciplinary reproductive health services should be improved.

- MIS training in reproductive health care should be introduced or improved among reproductive health care administrators at every level.

- Reproductive health care and services should be integrated at the administrative and managerial levels.

- Reproductive health service providers should be trained in client-oriented service provision and counselling, including referral procedures.

- Protocols for reproductive health care and services should be updated to meet clients' needs, including on counselling and on postgraduate education for health professionals.

- The job descriptions of reproductive health care personnel should be reviewed with the aim of introducing midwives and nurses into reproductive health counselling as health structures evolve.

Reproductive health in emergency situations

- Emergency preparedness should be built into national reproductive health programmes, especially in countries likely to suffer civil or political unrest, social and economic transition, war or disaster.

- Each country should have a strategy for reproductive health in emergencies.

- Adequate reserves of contraceptive supplies and devices should be ensured, reproductive health should be a priority in emergency situations, and contraceptives (including condoms) should be added to the list of essential drugs.

- Primary health care level (emergency deliveries and septic abortions) should be ready to respond to emergency situations at the level of personnel and resources.

- Needs should be assessed and agencies' activities coordinated before the introduction of aid for reproductive health.

- The concept of reproductive health kits should be promoted and supported.

- Aid organizations should establish networks and contacts with NGOs working in areas of refugee crisis.
- Sexually transmitted infection (STI) epidemics should be seen as an emergency needing a public health response.

- Adolescent reproductive health needs should be seen separately from those of adults. Particular emphasis should be placed on assuring that young people are informed and educated about their reproductive and sexual health choices.

- Information, education and communication should be integral component of any family planning and reproductive health initiative.

The role of civil society and the private sector

- NGOs in reproductive health, including those serving young people, should facilitate the building of networks and initiate consensus-building among civil society stakeholders.

- NGOs should find innovative ways to mobilize civil society, including establishing fora or promoting the democratization of the health sector.

- NGOs and civil society groups should monitor ministries' programmes and implementation by the health system of programmes on good quality client-oriented services.

- NGOs serving young people and family planning associations should serve as centres of excellence on information, education and counselling and services and should institute innovative pilot projects.

- NGOs should develop their capacity for advocacy and information to parliamentarians.

- NGOs should develop their skills in acquiring funding from private foundations and the private sector.

- Appropriate work to prepare for setting up private sector reproductive health care services and securing standards should be undertaken.

The future of reproductive and sexual health services

- A strategic regional framework and national strategies should be developed for reproductive health, with a special focus on adolescents.

- Prevention of unwanted pregnancies and abortion should be intensified.

- Reproductive health services should focus on the psychological, emotional and social development of adolescents, including their reproductive health needs.

- The meaning to be given to sex education in the region should be clarified.

- Standards and norms for care during pregnancy and delivery should be laid down in the reproductive health services' management and information systems.

- Domestic violence against women and violence in families should be addressed as a public health issue.

- Reproductive rights and reproductive health should be addressed in the context of a greater alliance for information, education and counselling.

- Reproductive health services should address the STI epidemic, including HIV (of which syphilis is an indicator), syndromically.

- Reproductive health services should address the needs of under-served and vulnerable groups who are socially unprotected (e.g. the unemployed, disabled, drug users, sex workers and homosexuals) and ethnic minorities.

Beijing declaration of the UN Women's Summit

The Fourth World Conference on Women in September 1995 in Beijing was the largest ever international meeting of women. The resulting Declaration and Platform for Action in the product of long debate among 5000 government delegates from 189 countries.

In the final hour of the conference, notwithstanding reservations expressed by several countries and the Holy See, the Declaration and Platform for Action were adopted unanimously. The Platform provides a broader understanding of women's health than previous documents. The challenge ahead is to implement the recommendations.

The Platform for Action strongly affirms women's rights, stating that "the human rights of women and of the girl child are an inalienable, integral and indivisible part of universal human rights" (paragraph 2). Delegates have committed themselves, their countries and organizations to the defence of the human rights and fundamental freedoms of all women and girls.

The Beijing Conference provided WHO with an opportunity to draw attention to the challenges now facing the health community as it strives towards "health for all by the year 2000" (paragraph 1). The Platform affirms many of WHO's goals for the health of women and girls. Progressive commitments were made for women's health in several areas:

- women's empowerment
- the girl child, including adolescent girls
- human rights and violence against women
- reproductive and sexual rights.

The health community, along with all other actors are urged to focus their attention and resources on strategic actions. Several activities are emphasized:

- health education;
- health research;
- decision making;
- access to services.

The following outlines critical areas of concern. Each area has been defined in the context of women's health and underlying factors, outlining actions to be taken:

- Women's right to health;
- Reproductive and sexual health;
- Violence against women;
- Childhood and adolescence;
- Female genital mutilation;
- HIV/AIDS and sexually transmitted diseases;
- Other health problems affecting women;
- Poverty and nutrition;
- Workplace and environmental hazards;
- Women and armed conflict.

WHO health strategy for Europe

The health policy for Europe, as expressed in the *Targets for Health for All* by WHO Regional Office for Europe (1992), unites the 870 million people of the European Region. Since it was introduced in 1980, Health for All (HFA) has provided a comprehensive framework for health improvement within the European Region of WHO and has had a major impact on health development. The present major revision, HEALTH21, gives effect to global Health for All values, targets and strategies. It also reflects the Region's ongoing health problems, as well as its political, economic and social changes, and the opportunities they provide. HEALTH21 gives an ethical and scientific framework for decision-makers at all levels to assess the impact on health of their policies, and to use health to guide development actions in all sectors of society.

HEALTH21 builds on the collective experience of the European member States with their regional HFA approach, which for the past 15 years has made "health outcomes" in the form of aspirational targets the cornerstone of policy development and programme delivery. Refining the previous 38 regional HFA targets in the light of past achievements and new challenges, HEALTH 21 defines 21 targets for the 21st century. They are not meant as a prescriptive list, but together they make up the essence of the regional policy. They provide the framework for action for the Region as a whole, and an inspiration for the construction of targets at the country and local levels.

Four main strategies for action have been chosen to ensure that scientific, economic, social and political sustainability drive the implementation of HEALTH21:

- Multi-sectoral strategies to tackle the determinants of health, taking into account physical, economic, social, cultural and gender perspectives, and ensuring the use of health impact assessments;

- Health outcome-driven programmes and investments for health development and clinical care;

- Integrated family- and community-oriented primary health care, supported by a flexible and responsive hospital system;

- A participatory health development process that involves relevant partners for health at home, school and worksite, local community and country levels, and which promotes joint decision-making, implementation and accountability.

Of the 21 targets, those particularly relevant to women and child health are:

EUROPEAN HEALTH21 TARGET 1 – SOLIDARITY FOR HEALTH IN THE EUROPEAN REGION: *By the year 2020, the present gap in health status between Member States of the European Region should be reduced by at least one third.*

EUROPEAN HEALTH21 TARGET 2 – EQUITY IN HEALTH: *By the year 2020, the health gap between socioeconomic groups within countries should be reduced by at least one fourth in all Member States, by substantially improving the level of health of disadvantaged groups.*

EUROPEAN HEALTH21 TARGET 3 – HEALTHY START IN LIFE: *By the year 2020, all newborn babies, infants and pre-school children in the Region should have better health, ensuring a healthy start in life.*

EUROPEAN HEALTH21 TARGET 4 – HEALTH OF YOUNG PEOPLE: *By the year 2020, young people in the Region should be healthier and better able to fulfil their roles in society.*

EUROPEAN HEALTH21 TARGET 7 – REDUCING COMMUNICABLE DISEASES: *By the year 2020, the adverse health effects of communicable diseases should be substantially diminished through systematically applied programmes to eradicate, eliminate or control infectious diseases of public health importance.*

EUROPEAN HEALTH21 TARGET 8 – REDUCING NONCOMMUNICABLE DISEASES: *By the year 2020, morbidity, disability and premature mortality due to major chronic diseases should be reduced to the lowest feasible levels throughout the Region.*

EUROPEAN HEALTH21 TARGET 15 – AN INTEGRATED HEALTH SECTOR: *By the year 2010, people in the Region should have much better access to family- and community-oriented primary health care, supported by a flexible and responsive hospital system.*

EUROPEAN HEALTH21 TARGET 16 – MANAGING FOR QUALITY OF CARE: *By the year 2010, Member States should ensure that the management of the health sector, from population-based health programmes to individual patient care at the clinical level, is oriented towards health outcomes.*

Donor assistance to CCEE and NIS

As expressed in earlier documents, and discussed in Cairo, the needs of the Region are enormous and will require concerted action of the donor countries in order to help to resolve reproductive health problems in the CCEE and NIS.

The main areas of support should be the following:

- Providing at least sufficient contraceptives to cover risk groups;
- Assisting in data collection on fertility and reproductive health and promoting Regional research projects;
- Providing basic medical equipment for obstetric, antenatal, perinatal and family planning services and services to treat abortion complications;
- Providing training in country and fellowships for abroad;
- Assisting in the production of education materials and client information;
- Working with governments to ensure that despite the privatization of the health system, contraceptives remain affordable to all population groups;
- Assisting in setting up services for young people.

Over the past four to five years, awareness of the problems and needs of the CCEE and NIS has grown, and assistance is now being provided not only to the economic sector, but also increasingly to the social and health sectors. However, the unmet needs are still enormous, and during the period of transition it is unlikely that countries will be able to meet these needs themselves.
The main organisations actively assisting at present are:

- UNFPA, in providing contraceptive supplies and basic medical equipment, assisting with data collection and training of health professionals;
- WHO, providing technical assistance in the safe motherhood initiatives, reproductive health, AIDS & STI prevention, and quality of care. Many countries of the Region are participating in the research programmes (East-West initiatives) coordinated by the WHO-HRP programme, as well as in the collection of national data on Women's' Health), coordinated by the WHO-EURO office;
- UNICEF, providing vaccine supplies and essential drugs and contributing to projects of safe motherhood and child health;
- The ECE is conducting family and fertility surveys (FFS) in the Region in order to obtain a baseline of reliable data. The CCEE and NIS participating at this stage are: Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, and Slovenia;
- EU-PHARE and EU-TACIS are providing technical assistance, equipment and medical supplies to the Primary Health Care and MCH sector in Albania and Bulgaria, and to the MCH and family planning sector in Romania, Hungary, the Czech & Slovak Republics, and Poland through NGO support;
- The World Bank, providing loans for health sector reform and infrastructure;
- IPPF is providing technical assistance, training, financial support and contraceptive supplies to all CCEE and NIS
- Medecins Sans Frontieres, providing humanitarian assistance in countries with particular needs, as well as primary health care and some family planning services;
- USAID is providing technical assistance and contraceptive supplies in small quantities, mainly to the Central Asian Republics and Kazakhstan, Ukraine, the Russian Federation and Romania.
- Family Health International (FHI), providing clinical training in the CARK in cooperation with UNFPA;
- German Ministry of Cooperation, through GTZ and KFW, providing mainly technical and financial assistance to the Central Asian Republics and Kazakhstan, the Baltic States and

Albania in Family Planning and MCH projects, and contraceptive supplies to Uzbekistan and Kyrgyzstan;

- DANIDA, providing assistance mainly to the Baltic States in Primary Health Care and training of Health Professionals;
- SIDA, providing assistance to Estonia in family planning and reproductive health;
- UK-ODA providing assistance to MCH/FP projects in the Russian Federation. Furthermore, ODA has identified Kyrgyzstan and Kazakhstan as priority countries for assistance to MCH and family planning;
- The Government of the Netherlands (Ministry of Foreign Affairs) providing assistance to Women's' Health and Family Planning projects in the Central Asian Republics and Kazakhstan through IPPF and UNFPA;
- The Government of Italy, committed to provide assistance to MCH and family planning in Armenia and in Albania;
- The Government of Switzerland, providing assistance to training in Albania and to STD/AIDS prevention programmes in the Czech and Slovak republics;
- JICA, committed to provide assistance to reproductive health in the NIS;
- The SOROS Foundation is supporting Women's Development Projects in the whole region.

(Many other organizations who are active in individual countries only are mentioned in the introduction to the sub-regions.)

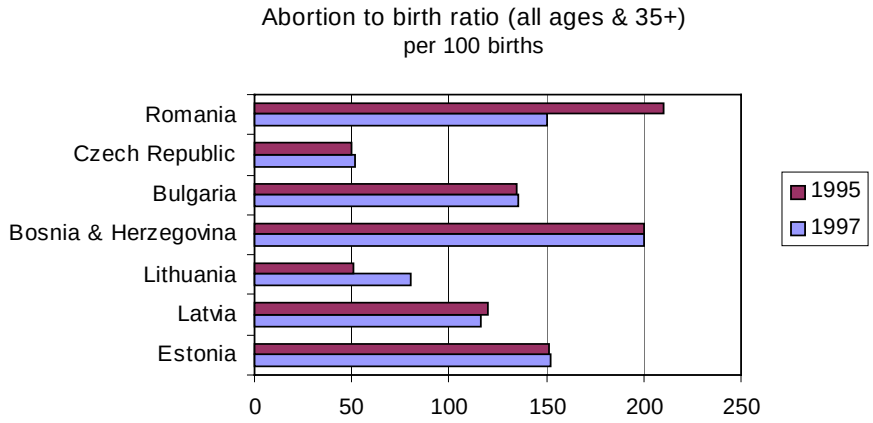
Notes on data collection and analysis

This report will constitute basic background information needed for policy makers and donors to identify main needs in the area of family planning in the CCEE and NIS. (Further in-depth information may be found in the reference materials listed at the end of this report).

All country information and data has been obtained through answering the questionnaire contained in annex no. 1 in the latter quarter of 1998.

Morbidity and mortality

Maternal deaths from eclampsia and haemorrhage during pregnancy and delivery indicate the need for better monitoring of pregnant women, as well as the need for functioning referral systems and good quality obstetric care. Furthermore, it is most unfortunate that woman family providers often have to resort to abortion as the main mean of family planning, thereby exposing themselves to greater health deterioration.



During the course of a lifetime, and following problems related to adolescence and maternity, women have other unique problems related to their reproductive function and menopause. The most important of these are breast- and cervical cancer, which, if detected early can be prevented from spreading or treated appropriately. The rates for cervical cancer in the CCEE are the double of the European average and about three times as high as the EU average. This is largely due to lack of screening services and cervical cancer prevention/early detection programmes.

It appears that the situation for breast cancer is reversed, and further research is needed to investigate the reasons for the higher morbidity from breast cancer in western Europe. In most CCEE and NIS clinical breast cancer screening was previously promoted.

Data validity and comparability

When analysing perinatal, neonatal and infant mortality rates the quality of data must be evaluated. Reliable data is essential for good care. It is also important to compare statistics with other countries. Incomplete reporting of perinatal and neonatal deaths is common in many countries and the underestimation of the problem surely contributes to the lack of priority being accorded to neonatal health. In addition varying interpretation of the definitions lead to different results.

The World Health Assembly (resolutions WHA20, 19 and WHA13, 24) under Article 23 has adopted these definitions:

Live Birth
Live birth is the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached: each product of such a birth is considered liveborn.

Fetal death (deadborn fetus)
Fetal death is prior to the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy; the death is indicated by the fact that after such separation the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

Birth weight
The birth weight is the weight of the new-born infant obtained before significant post-natal weight loss has occurred, that is no more than 1-2 hours after birth.
Low birth weight
Less than 2500 g (up to, and including 2499 g)
Very low birth weight
Less than 1500 g (up to , and including 1499 g)
Extremely low birth weight
Less than 1000 g (up to, and including 999 g)

Gestational age
The duration of gestation is measured from the first day of the last normal menstrual period. Gestational age is expressed in completed days or completed weeks.
Pre-term
Less than 37 completed weeks (less than 259 days) of gestation.
Term
From 37 completed weeks to less than 42 completed weeks (259 to 293 days) of gestation.
Post-term
42 completed weeks or more (294 days or more) of gestation.

Perinatal period
The perinatal period commences at 22 completed weeks (154 days) of gestation (the time when birth weight is normally 500 g), and ends seven completed days after birth. The *perinatal mortality rate* is the sum of all such deaths in relation to the sum of all stillborn and liveborn infants. All fetuses and newborn infants who are 22 weeks of gestational age (approximately 500g) should be reported in a country statistics. WHO has recommended that mortality statistics reported for purposes of international comparison should include only those new-borns 28 weeks of gestational age approximately 1000g or more), since in some countries it would be difficult to obtain reliable data on the very small babies.

Neonatal period
The neonatal period commences at birth and ends 28 completed days after birth. Neonatal deaths (deaths among live births during the first 28 completed days of life) may be subdivided into *early neonatal deaths,* occurring during the first seven days of life, and *late neonatal deaths,* occurring after the seventh day but before 28 completed days of life. The early neonatal mortality rate is defined as the number of dead infants occurring 0-7 days after birth, expressed per 1000 livebirths. Late neonatal death refers to the death of a liveborn infant after 7 completed days, but before 28 completed days, after birth.

Infant mortality

Infants born alive independently of the duration of gestation, who die before the completion of their first year of life.
The definition of infant mortality used in the Republics of the former USSR included only infants born alive after the 28th week of pregnancy, whereas the WHO definition of infant mortality also includes infants born alive independently of the duration of gestation, who die before the completion of their first year. The practised differences of these two definitions resulted in an underestimation of the actual rate of infant mortality in the former USSR.

The definition of **maternal mortality** was different in the former USSR compared to the WHO definition. The former USSR definition indicated that a woman's death during pregnancy and till 42 days after termination was only acknowledged as maternal mortality beginning with 28 weeks of pregnancy. Also, there was a differentiation between deaths occurring linked to pregnancy, and deaths occurring during, but not because of, pregnancy. In WHO-terms, these would both be "maternal deaths".

With the adoption of the *WHO definition*, which indicates that a death which occurs at *any time while a woman is pregnant or within 42 days of termination of the pregnancy*, is a "maternal death", irrespective of the duration and the site of the pregnancy, CCEE and NIS will see a significant increase of maternal mortality.

In United Nations Population Division terms, the definition of **total fertility rate** is the number of children that would be born per woman if she were to live to the end of her child-bearing years and bear children at each age in accordance with prevailing age-specific fertility rates.

Improving women's status must include ways to diminish their vulnerability to **AIDS** and its impact. The challenge is to empower women to avoid exposure to infection, and to support them to cope with AIDS. In all cases, it means that men must take on their fair share of the responsibility for AIDS care and for preventing transmission. In many societies, there is an important inequity between men and women, supported by social and cultural systems that are dominated by men. Some societies expect women to adhere strictly to monogamy and mutual fidelity while tacitly condoning that men have extra-marital relations. Women are also vulnerable to coerced sex, including rape, forced sex work and other sexual abuse. In virtually every society, women face discrimination in education, employment and social status, resulting in economic vulnerability to HIV/AIDS.

The data on AIDS (in the data box), specifically avoids any mention of the number of persons diagnosed with HIV. This is to avoid encouragement of mass screening for HIV in a population, as advised by the former Global Programme on AIDS of the WHO Regional Office for Europe. Other STDs as such are only mentioned as rates increasing or decreasing.

The **Human Development Index (HDI)** mentioned as one of the indicators in the data box of each country, reflects a measure of development that goes beyond per capita GNP.

The HDI is a contribution toward a better, more comprehensive socio-economic measure of national progress and will permit more instructive and meaningful comparisons across countries. The index offers an alternative to GNP value, because it takes into account, not only monetary income but also education measured in literacy years of schooling and health, measured in terms of life expectancy, and enables people and their governments to evaluate progress over time, and to determine priorities for policy intervention.

The HDI, although hardly ten years old, has already had a major impact on policy-making on human development. So far, the HDI has been used in five main ways:

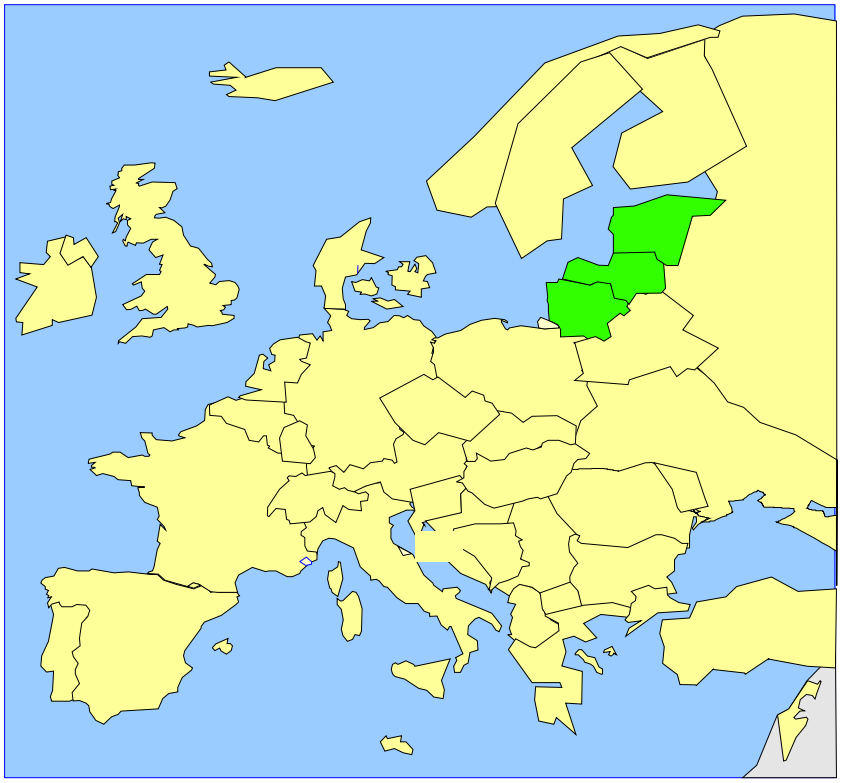
4. *to stimulate national political debate*
5. *to give priority to human development*
6. *to highlight disparities within countries*
7. *to open new avenues for analysis and*
8. *to stimulate dialogue on aid policy.*

The HDI will remain subject to further improvements, amongst others, the need for gender-disparity-adjusted HDI. There are significant differences within the overall HDI score for any country between men and women. Men generally fare better than women on almost every socio-economic indicator. One way to illustrate this difference is to adjust the HDI ranking for gender disparities, expressing the female value of each component as a percentage of the male value.

The **contraceptive choice index** is the sum of the access scores for each of the methods of condoms, oral contraceptives, IUDs, injectable contraceptives, female sterilization, and vasectomy, converted to a 100-point scale. The access scores are estimates of the extent to which couples in a given country have access to that method and were copied from *The Report on Progress Towards World Population Stabilization -"Contraceptive Choice: Worldwide Access to Family Planning"* by Population Action International, 1997. Four categories are used: excellent (90 points or more); very good (70-89 points); good (50-69 points) and fair (less than 50 points). The first category is labelled "excellent" rather than "very good" because a maximum score reflects essentially universal access to contraception.

In this revised edition of the first document published in 1995 and the second published as a working document in 1997, the data boxes include both previous and updated data, with symbol indicators of ⇑⇓, depending on the trend. Most of the information in this revised edition stems from answers given to the questionnaire in ANNEX 1. Few countries (Azerbaijan, Georgia, Croatia, FYROM, Kyrgyzstan) have, for unknown reasons, been unable to return the requested data in time for this publication. For these countries the information has mainly been obtained from different sources: UN, National Institutes of Statistics, Ministries of Health, NGOs, unpublished WHO duty travel reports and correspondence and the previous document. It is furthermore estimated that abortion data are not always calculated in the same manner.

The Baltic States



The region

The effects of the transition on the social and economic conditions and status of women and children in the three, small Baltic States are rather similar. Their demographic structure is that of northern Europe and their social and human development levels are similar to each other.

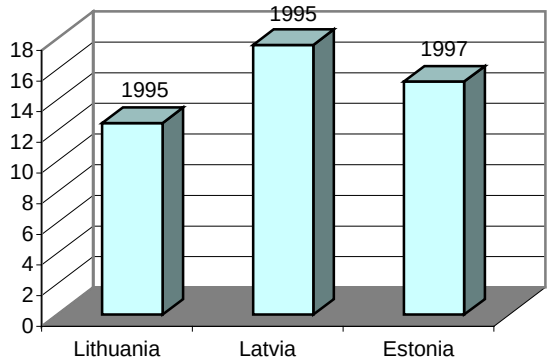
Mother and child health is the major concern of the Governments in the Baltic States. Since 1991, the calculation of infant mortality was done according to WHO criteria. All three Baltic countries rank below other eastern European countries in infant mortality.

The maternal health problems of all three Baltic States are a valid indicator of a faltering system of preventive care. There has been a long-standing emphasis on curative care.

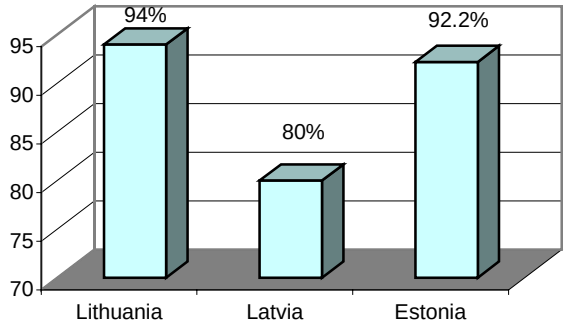
As for reproductive health and fertility, the major concern of the governments in the Baltic States is the present low rate of population growth.

Statistics on perinatal mortality, average immunization coverage and contraceptive prevalence rate

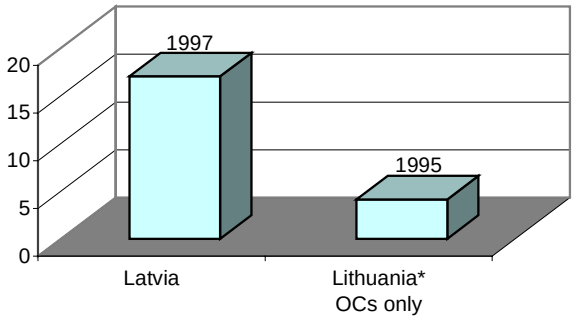
Perinatal mortality rate (per 1000 live births)



Average immunization coverage % (Diphtheria-Tetanus/Pertussis/Measles/Polio/Tuberculosis) Latest available data (1996)



Contraceptive prevalence rate in % (Latest available data)



Follow-up of ICPD, Cairo 1994

By order of the Lithuanian Government, a group of leading specialists has been formed in Lithuania, to develop a document on the implementation of Programme of Action of the ICPD. The document " The conception of the family policy and the main direction for actions in that field in Lithuania" has been developed. The document has been criticised by Conference of Bishops of Lithuania and anti-choice groups for promotion of modern family planning methods, and for liberal family conception, "because homosexual couples, unmarried cohabiting people or single women could be encouraged to have children, and unacceptable forms of cohabiting could be promoted or encouraged". A new and more conservative version of the document was developed, but information on implementation of the document by the new Lithuanian Government is presently not available.

Estonia

VARIABLES	PAST DATA	PRESENT DATA (1997)	⇧ ⇩
Population estimate (millions)	1.476 (1995)	1.46	⇩
HDI (Human Development Index) value	0.749 (1993)	0.776	⇧
HDI (Human Development Index) rank	68 (1995)	71	⇩
GNP US$ (per capita)	2290 (1994)	3117	⇧
Women of fertile age (age 15-49)	367 100 (1995)	364.832 (1998)	⇩
Total fertility rate (per woman)	1.32 (1995)	1.24	⇩
Maternal mortality ratio (per 100 000 live births)	51.6 (1995)	15.84	
Perinatal mortality rate (per 1000 births)	9.6	15.2	
Infant mortality rate (per 1000 live births)	14.8 (1995)	10.06	⇩
Contraceptive methods used	Mainly IUDs	IUD's,OC's,condoms	
Contraceptive prevalence rate	No data	No data	
Contraceptive choice index	No data	70.8/very good	
Abortion rate (per 1000 women age 15-49)	69.6 (1995)	45.5	⇩
Abortion:birth ratio < age 20	1.31:1 (1995)	1.37:1	⇧
Abortion:birth ratio age 20-34	No data	1.12:1	
Abortion:birth ratio age 35+	3.89:1 (1995)	3.66:1	⇩
Abortion:birth ration, all ages	1.51:1 (1995)	1.52:1	⇧
Birth rate (per 1000 population)	9.14 (1995)	8.66	⇩
Maternal mortality from abortions (per 100 000 live births)	7 (1995) = 14%	0	
Immunisation coverage : Diphtheria-Tetanus/Pertussis/ Measles/Polio/Tuberculosis	(1996) 93% / 90% / 86% / 93% / 99%	87% / 85% / 88% / 86% /100%	
STD/AIDS rates	4 AIDS cases (1995)	17 AIDS cases (1998)	⇧

Health services

The health sector in Estonia is financed 88% by public sources, and 12% by private sources. International donor organisations are involved in education and financing.

Various professionals have an active role in the provision of reproductive health service, with the gynaecologists and midwives performing most of the services.

It is estimated that 98% of the population is covered by the present national health insurance. Sick funds under the health insurance law administer the health insurance tax. Health care providers are contracted by sick funds in cooperation with the local government health care division.

Estonia has adopted the Essential Drug Policy recommended by WHO, and has included contraceptives on the Essential Drug List.

Pharmacies in Estonia are mainly privately run. 94% of the national pharmacies are estimated to be private, and 6% public. Data suggests that drugs are generally available in the major regions of the country, covering 100% of the estimated need.

Family planning

Estonia does not have an adopted national programme of family planning. However, family planning services are provided in the following institutions: maternity hospitals, consultancies of obstetrics and gynaecology, polyclinics, general practitioners, private practices and primary health care facilities.
The Estonian Family Planning Association (FPA) plays an active role in the country. The board of the organization make up part of a national advisory body orienting family planning in the country.
Family planning counselling is offered free of charge for the part of the population covered by health insurance. Counselling is provided by general practitioners, gynaecologists and midwives.
Adolescents do not need to have an authorization to receive Family Planning services in Estonia.

Contraception

The main method of fertility regulation is by the use of IUDs and oral contraceptives (OC). There is a reliable continuity of these two contraceptives in Estonia.

Contraceptives are not free of charge. Certain groups of women can obtain 90% subsidy if they fall into one of the following categories:

1) full-time students
2) within the first three months following an abortion
3) within the first year after delivery

This practice leans on the lessons learned in a project (1993–1995) which showed a significant decrease in the number of abortions and in the percentage of repeat abortions, when sufficient contraceptives had been effectively distributed to three high risk groups (the same categories as above).
The proportion of a woman's monthly salary used on contraceptives is 1–2% for one cycle of OC; 2–3% for one IUD; 0.5–1% for one injection of injectable contraceptive.

Pharmacies sell hormonal contraceptives incl. pills, IUDs, condoms, implants, spermicides, all on prescription only.

Youth services hand out (emergency) contraceptives free of charge.

Abortion

Clinical abortions are performed in licensed health care institutions. Data suggests that the estimated prevalence of unsafe abortion is only 0.03%

The technique for performing abortions is mainly by vacuum aspiration. Curettage is sometimes used and amniocentesis is used in rare cases, when gestation is more than 12 weeks.

Clinical abortion is available free of charge for medical reasons, mini-abortions included. For non-medical reasons, 50% of the price for a clinical abortion will be covered by health insurance (for those insured).

Pre- and post abortion counselling is performed by gynaecologists.

Recent trends in reproductive health

There is no public policy specifically on women's health. Some parts of the reproductive health care has been privatised in Estonia. This applies for 27% of births (1997) and 17.4% of clinical abortions, as well as the antenatal and gynaecologists' services.

Adolescents are offered reproductive health care services among other services. A study to analyse the trends of adolescent fertility rates and abortion rates in Estonia, and to describe the changes in health care and the availability of services and contraceptive methods 1992 – 1996, concluded that improved availability of contraceptives and better access to services has a positive impact on teenage pregnancy rates. Successful strategies included improving sex education, initiating open discussions about sexual and reproductive health matters in mass media and educational campaigns.

As yet, Estonia has not implemented social marketing into the national reproductive health care services, however, plans are being discussed to have the FPA implement social marketing projects. At present the organization does not offer actual services, but they do support the existing services and they are involved in IEC activities at national level.

A Swedish funded project begun in 1994 to strengthen family planning services in Estonia, is particularly emphasizing aspects of sexual and reproductive health and the cost-effectiveness of the project strategies in collaboration with WHO Regional Office for Europe.

Antenatal care

Health services for pregnant women are organized according to a medicalised model with numerous specialized visits during the antenatal period. In 1997, 97.6% of women were given antenatal care.
On average, women visits outpatient antenatal care facilities 6–12 times during each pregnancy. Some reforms are being implemented to counteract the financial constraints of these excessive visits.
Routine checks include: blood count and blood pressure; urine; body weight; ultrasound examinations (recommended), one scanning at 15–19 weeks of gestation. However, there is no data showing what percentage of pregnant women show a positive syphilis serology.

Estonia has developed **comprehensive** essential obstetric care in 6.7 facilities per 500 000 population.
It is not known what percentage of obstetric and gynaecological admissions are due to abortions.

Breast and cervical cancer

Breast cancer is found in 20% of all cancer cases in women. This is an increase to previous data, when breast cancer accounted for 17% of all new cases.

The incidence of cervical cancer remains rather high: 6% of all new cancer cases. Estonian women are not regularly screened for cervical cancer and the awareness of this cancer form is low.

Child health

Estonia has signed and ratified the Convention on the Rights of the Child.

Children's health and well-being are being adversely affected by environmental hazards and the socio-economic situation. Part of the respiratory problems are attributed to pollution from the oil shale industry in the northern part of the country, among other things. There are an estimated 600 cases of asthma annually in Tallinn area. High ingestion of heavy metals, particularly in the north-east, is one reason for increased baldness among children in kindergartens.

Mortality from infectious and parasitic diseases has remained fairly constant due to serious shortages of vaccines and antibiotics. Hepatitis is often not diagnosed owing to lack of diagnostic equipment and materials.

Adolescent Health[1]

While the youth of Estonia are engaging in sexual activity at an earlier age (See Table 1E), research indicates that younger people are more likely than the youth of the past to use condoms. Over 50% of youth in the 1956-1960 birth cohort who had more than one sexual partner said they never used a condom (60% male and 64% female) while the birth cohort of 1976-80 revealed that only 20% of men and 33% women did not use a condom.

In the WHO Health of School Aged Children Study (HBSC), 1997/98, 10% of 15 year girls and 21% of boys reported drinking once a week, the lowest of the CEE and NIS countries surveyed, except Lithuania.

Table 1E. Number of sexual partners during last 12 months (%)

Birth cohort	No sexual partners	One sexual partner	Two sexual partners	More than three sexual partners
Females				
1971–1975	3.8	79.9	13.3	3.2
1976–1980	5.3	66.0	17.0	11.7
Males				
1971–1975	5.1	48.4	15.3	31.2
1976–1980	9.1	38.6	23.9	28.4

*Source: Estonian Health Interview Survey, 1996**; cf: UNICEF ICDC, MONEE Country Reports, 1999.***

Areas for action and policy changes

- Providing technical assistance, training, supplies and education in the area of reproductive health and neonatal care;
- Breast-feeding practise should be extended. Early and exclusive breast-feeding should be promoted for all infants;
- Introducing a broader choice of effective long-term reversible contraceptive methods and ensuring access to an uninterrupted supply of low-cost contraceptives;
- Essential equipment for obstetric care (MOH);
- Equipment needed for intensive care units in perinatal care and obstetrics;
- Ensuring that training is given alongside donations of equipment and drugs;

[1] UNICEF ICDC, MONEE Country Reports, 1999.

- Assistance to adolescent health projects needed, particularly health promotion and youth counselling and education services.
- Training in skills of counselling and communication;
- Information, education, communication (IEC) activities needed;
- Research: Need to conduct a Knowledge, Attitude and Practice (KAP) survey among health staff to assess their knowledge and use of contraceptives;
- Improving women's health services in relation to antenatal care, reduction of risk factors leading to maternal deaths and the general well-being and health of women;
- Breast and cervical cancer screening and health-promoting behaviour specifically aimed at women.

Latvia

VARIABLES	PAST DATA	PRESENT DATA 1997	⇧ ⇩
Population estimate (millions)	2.5 (1995)	2.5	
HDI (Human Development Index) value	0.820 (1993)	0,711	⇩
HDI (Human Development Index) rank	55 (1993)	92	⇩
GNP US$ (per capita)	2290 (1995)	2238	⇩
Women of fertile age (age 15-49)	529 837 (1995)	606.292	⇧
Total fertility rate (per woman)	1.3 (1995)	1.11	⇩
Maternal mortality ratio (per 100 000 live births)	37.2 (1995)	42.5	⇧
Perinatal mortality (per 1000 births)	17.6 (1995)	14.79	
Infant mortality rate (per 1000 live births)	18.8 (1995)	15.2	⇩
Contraceptive methods used	IUDs, (1995)	OCs, IUDs, condoms	
Contraceptive prevalence rate	18.9% (1995)	17% (IUDs 52%, OC 47,7% sterilisation 0.3%)	⇩
Contraceptive choice index	No data	62.5 /good	
Abortion rate (per 1000 women age 15-49)	48.9 (1995)	35.8	⇩
Abortion:birth ratio < age 20	1.06:1 (1995)	1.4:1	⇧
Abortion:birth ratio age 20-34	0.96:1 (1992)	1:1	⇧
Abortion:birth ratio age 35+	2.83:1 (1995)	2.3:1	⇩
Abortion:birth ratio, all ages	1.2:1 (1995)	1.16:1	⇩
Birth rate (per 1000 population)	8 (1995)	7.6	⇩
Maternal mortality from abortions (per 100 000 live births)	9.3 (1995) = 25%	10.6 = 24.9%	⇩
Immunisation coverage : Diphtheria-Tetanus / Pertussis Measles/Polio/Tuberculosis	(1996) 77% / 64% 82% / 77% / 100%	75% / 77% / 97% / 76% / 96%	
STD/AIDS rates	0 AIDS cases (1995)	21 AIDS cases (1998)	⇧

Health services

The main part of the health sector - 96% - is privately financed in Latvia. Despite this, hospitals and polyclinics are still defined as either public or private. The coverage needs of public hospitals in Latvia is estimated to be 93.5% and of public polyclinics to be 44.8%. Private hospitals and polyclinics cater for the rest of the population. Private family planning clinics, started in 1992, target 20% of the society.
There does not appear to be sufficient health insurance coverage.

Latvia has adopted the Essential Drug Policy and has included contraceptives on the Essential Drug List.

89.1% of pharmacies are privately run, the rest being run by public sources. There is no present data on the general availability of drugs in the major regions of Latvia.

Family planning

Latvia does not have a national programme of family planning, however, family planning services are provided in maternity hospitals, consultancies of obstetrics/gynaecology, polyclinics, general practitioners, private practices and PHC facilities.

Family planning counselling services are not offered free of charge in Latvia. It is estimated that the cost of counselling is equivalent to 0.6% of an average monthly salary. General practitioners, gynaecologists and midwives all provide family planning counselling.

Adolescents do not need an authorization to receive family planning services in Latvia.

Contraception

The main method of fertility regulation in Latvia appears to be the use of condoms, followed by the use of IUDs and oral contraceptives. There is a reliable continuity of availability of the three mentioned methods in the country. One cycle of OCs cost the equivalent of 1–3% of an average monthly salary, one IUD 4–6%, condoms 0.2% per piece and one shot of injectable contraceptives approximately 4% of an average monthly salary. All the mentioned contraceptives are sold in pharmacies. Emergency contraceptives have been made available to the population.

Abortion

Clinical abortions are performed at various places in Latvia: in out-patient units; in one-day hospitals, and generally in hospitals and clinics. Three methods of clinical abortion are used: curettage, vacuum aspiration and amniocentesis.

It is estimated that approximately 2.7% of abortions are unsafe abortions. A clinical abortion varies in price being from 17–57% in proportion of an average monthly salary. Pre and post abortion counselling is performed by gynaecologists.

Recent trends in reproductive health

Latvia does not have a reproductive health policy, however, reproductive health care services are offered through private clinics and projects funded by international organisations. Social marketing projects are organized by IPPF and the Latvian Association of Family Planning and Sexual Health. Reproductive health care services are offered to adolescents by the Youth Centre Coordination Board through Youth Centres and Youth Health Clinics.

Since 1998, the privately run Latvian Family Centre has been directing education projects at teachers, midwives, nurses, doctors and psychologists, and family planning services at 65% of the population. Of these, 35% are from the Latvian capital of Riga. The poorer parts of the population are offered services by government centres.

Several associations are actively involved in activities of reproductive health care services: the Latvian Association of Family Planning and Sexual Health; the Association of Contraception; the Association of Gynaecologists and Obstetrician; the Association of Perinatologists; the Association of Breast Feeding.

Antenatal care

Approximately 35.5% of women are given antenatal care in Latvia. 6–7 visits are recommended. During these visits various checks are made: blood pressure, urine tests, PAP smear, ABO, WAR, HbAg, weight, fetal heart rate, one obligatory ultrasound examination at 16–18 weeks of pregnancy. Despite these various checks there is as yet no data on the percentage of pregnant women showing positive syphilis serology.

It is estimated that 59% of obstetric and gynaecological admissions are due to abortions. 33.6 facilities per 500 000 population have functioning basic essential obstetric care. Only 1 per 500 000 population have comprehensive essential obstetric care.

Breast and cervical cancer

There is a breast cancer prevalence of 65 per 100 000 women in Latvia and a cervical cancer prevalence of 12.5 per 100 000 women.

Child health

Bad environmental conditions have an especially serious effect on children's health. Regional variation in the number of congenital anomalities is alarming, particularly in the regions of the country known to be ecologically hazardous such as Ventspils, Jurmala and Olaine. Children who live in polluted cities tend to fall ill eleven times more often than do children in unpolluted control cities, particularly with laryngitis and allergic diseases.

Mortality from infectious and parasitic diseases is higher than in Lithuania or Estonia. Major concerns relating to infectious diseases include acute shortages of vaccines and antibiotics.

Adolescent Health[2]

Latvia is progressing in the area of youth health and, at present, is a society tolerant of open discussions concerning sexual responsibility. At the close of 1998 health education lessons are held in 60% of Latvia's schools. However, health education has not been included in a listing of compulsory subjects, and pupils can choose this subject voluntarily.

60% of mothers and 40% of fathers discuss with their children topics related to reproductive health and sexual behaviour. In urban areas parents discuss such topics more often compared with rural areas, and the educational level and status in the society of parents have an impact on such talks.

In order to avoid undesirable pregnancy adolescents use contraception. Condoms are used the majority of the time. (See Table 1LA)

In the WHO Health of School Aged Children Study,1997/98 12% of 15 year girls and 28% of boys reported drinking once a week, lower than all CEE and NIS countries surveyed, except Lithuania and Estonia.

[2] UNICEF ICDC, MONEE Country Reports, 1999.

The number of cases of Syphilis among 15-19 year olds has shown some decline (See Figure 1LA), but further research is needed to better understand the STIs among young people.

Table 1LA.

USE OF CONTRACEPTION (only couples) (%)

	Females			Males		
	All	18-19	20-24	All	18-19	20-24
Use contraception	46.6	42.9	61.8	48.6	40.0	54.7
Of which use condom	9.6	20.0	19.4	12.4	20.0	24.0
Does not use contraception	8.3	14.3	11.3	12.0	0.0	9.3`

Family and Fertility Survey data.

Areas for action and policy changes

- Providing technical assistance, policy advice, training, supplies and education in the areas of reproductive health;
- Ensuring that training is given alongside donations;
- Epidemiological investigation of maternal death causes is needed in order to design intervention programmes. This involves evaluating and improving women's health services in relation to antenatal care, reduction of risk factors leading to maternal deaths and the general wellbeing and health of women;
- Breast and cervical cancer screening and health promoting behaviour specifically aimed at women need to be evaluated;
- Assistance in the development of a health insurance system;
- Equipment needed for intensive care units;
- Training in the skills of counselling and communication;
- Assistance to adolescent health projects needed, particularly health promotion and youth counselling and education services;
- Information, education and communication (IEC) activities needed;
- Health education programmes for children in schools on alcoholism, drug abuse and sexuality.

Lithuania

VARIABLES	PAST DATA	PRESENT DATA (1997)	⇧ ⇩
Population estimate (millions)	3.7 (1995)	3.7	
HDI (Human Development Index) value	0.719 (1993)	0.761 (1999)	
HDI (Human Development Index) rank	81 (1993)	62 (1999)	
GNP US$ (per capita)	3771 (1994)	2570	⇩
Women of fertile age (age 15-49)	929 100 (1995)	935 224	⇧
Total fertility rate (per woman)	1.49 (1995)	1.39	⇩
Maternal mortality ratio (per 100 000 live births)	10.7 (1995)	23.8	⇧
Perinatal mortality (per 1000 births)	12.5 (1995)	7.69	⇩
Infant mortality rate (per 1000 live births)	12.4 (1995)	10.3	⇩
Contraceptive methods used	Mainly IUDs	IUD, OC, Condoms, IJ	
Contraceptive prevalence rate	5.5% (1995)	OC 4.1% (1995)	⇩
Contraceptive choice index	no data	52.1/good	
Abortion rate (per 1000 women age 15-49)	40.5 (1995)	32.7	⇩
Abortion:birth ratio < age 20	0.32.1 (1995)	0.37:1 (1997)	⇧
Abortion:birth ratio age 20-34	No data	no data	
Abortion:birth ratio age 35+	1.38:1 (1995)	1.58:1 (1997)	⇧
Abortion:birth ratio, all ages	0.9:1 (1995)	0,8:1	⇩
Birth rate (per 1000 population)	11.1 (1995)	10.2	⇩
Maternal mortality from abortions (per 100 000 live births)	2.43 (1995) = 23%	no data	
Immunisation coverage: **Diphtheria-Tetanus/Pertussis** **Measles/Polio/Tuberculosis**	(1996) 92% / 91% 96% / 93% / 98%	 94% / 90% / 96% / 95% / 98%	
STD/AIDS rates	2 AIDS cases (1995)	14 AIDS cases (1998)	⇧

Health services

94.9% of the health services are funded from central and municipal budgets and obligatory health system insurance. The remaining parts of the health services are privately funded. There are few in-patient private clinics with a few beds in Lithuania. The number of small, private out-patient clinics is increasing. An estimated 4% of the physicians in the country are also employed at private clinics and 1.5 % are employed at private clinics only.

The main function of obstetricians and gynaecologists is in offering antenatal care service, in providing family planning services and screening for cancer (breast, ovary, cervical etc).

In Lithuania, all employees, retired people, children, unable people, jobless persons registered at labour exchange are covered by the national health insurance.

An Essential Drug Policy has been adopted by the country, however, contraceptives are not included on the Essential Drug List.

It is not known what percentage of the national pharmacies are public or private. It is estimated that all indispensable drugs are available in every region of Lithuania.

There were 825 ob/gyn doctors equivalent to 2.2 per 10 000 population in 1997.

Family planning

Lithuania has a national programme of family planning. It was approved by the government in 1995, but as it has been criticised and opposed by anti-choice groups and the Catholic church, the programme has hardly been implemented.

A guide for doctors on family planning is planned to be published in 1998–1999 by the national family planning programme. A short handbook for doctors on reproductive endocrinology was developed by staff of the National Family Planning Promotion Centre and printed in 1998.

There is no national advisory group orienting the programme of family planning. Family planning services are provided in out-patient departments for primary obstetrics and gynaecology care, free of charge, and in private practices. Services provided in the National Family Planning Promotion Centre cost an average of 0.5% of an average monthly salary.

According to the existing regulations of health care funding, patients applying to the second and third level health care institutions without written reference from the primary health care institutions have to pay their own way. As family planning clients visit the National Family Planning Promotion Centre without reference, they have to pay for the counselling themselves and for the prescription of contraceptives.

In Lithuania, gynaecologists are the main providers of family planning counselling. Adolescents need authorization to receive family planning services.

Contraception

The main method of fertility regulation is by use of IUDs, OCs and condoms. It is estimated that there is a reliable continuity of availability of the mentioned fertility regulation methods. Contraceptives are not free-of-charge. One cycle of OC costs the equivalent of 2% of an average monthly salary, one IUD 4%, and a package of 3 pieces of condoms 0.3%.

The National Family Planning Promotion Centre promotes, as well as provides services, on emergency contraception in Lithuania. Furthermore, the centre distributes the information on emergency contraceptives to doctors.

The Family Planning and Sexual Health Association of Lithuania is actively involved in the national programme of family planning.

Abortion

Clinical abortions are performed at in-patient departments in hospitals. The techniques of curettage and vacuum aspiration are used for the performance of clinical abortions. There is no available data on the estimated prevalence of unsafe abortion in Lithuania. Clinical abortions cost 10–20% of an average monthly salary.

Pre-abortion and post-abortion counselling is not performed everywhere in Lithuania. When counselling does take place, it is performed by obstetricians/gynaecologists. Statistics reveal a decline, but still a high rate of abortions, especially among girls.

Recent trends in reproductive health

The Lithuanian Government has approved a perinatal care programme, an STI prevention programme, and AIDS/HIV prevention programme and partly a national family planning programme.

Reproductive health care has not been privatised in Lithuania, however, there are small, private clinics in almost every town where primary reproductive health care is being provided by obstetricians/gynaecologists.

There are no specific reproductive health care services for adolescents. The services are offered at the primary out-patient obstetric/gynaecologic departments for women and at the primary out-patient clinics for children.

There is presently no available data on steps taken to implement social marketing into the national reproductive health care services.

The Family Planning and Sexual Health Association of Lithuania and the Society of Doctors are actively involved in the national reproductive health care services

Antenatal care

It is estimated that approx. 100% of women are given antenatal care in Lithuania. 14 visits are recommended during the entire period of pregnancy. Checks undertaken routinely are: blood tests, urine tests, vaginal smears, syphilis tests, and genetic consultations for those over age 35.

In 1997, there were 1863 beds for basic and comprehensive essential obstetric care at hospitals, equivalent to 5 beds per 10 000 population.

Despite routine antenatal care checks on syphilis, there is no available information on the percentage of pregnant women showing a positive syphilis serology. Neither is there available information on the percentage of obstetric and gynaecological admissions due to abortions.

Pregnant women undergo both obligatory and voluntary ultrasound examinations. Two examinations are recommended during the period of pregnancy.

Breast and cervical cancer

In 1997 there were 1143 cases of breast cancer in Lithuania, equivalent to a rate of 58.4 per 100 000 population. During the same year, 429 cases of cervical cancer were registered, equivalent to a rate of 21.9 per 100 000 population.

Child health

Lithuania has signed and ratified the Convention on the Rights of the Child.

Children’s morbidity in urban areas is almost double that found in rural area. It might be due to heavy pollution, high rate of traffic accidents, or better recording system in the cities, however, the trend indicates that this gap is narrowing.

Tuberculosis is one of the primary infectious disease problems. The incidence of this disease is increasing and among children has almost doubled between 1986 and 1990. Although vaccination coverage is high against tuberculosis, this increase might be due to using the low quality vaccine or breaking the cold chain.

Adolescent Health[3]

The Commission of Young People's Affairs has been established in the Seimas of the Republic of Lithuania. The Commission cooperates with the State Council of Young People's Affairs under the Ministry of Social Security and Labour. The Council members are represent various youth organizations.

In regards to reproductive health and family planning, the number of extra-marital births formed only 6-7% of births. Presently, it has moved up to18%. Extra marital births are most common (50-70%) among mothers aged 15 years and younger. On the other hand, more extra-marital children are born by women aged 16-19 and 20-24 years. In 1998, 34% of births to 16-19 year olds and 16% of 19-24 year olds were to single mothers. The number of abortions, although declining among girls, still remains high.

According to the results of the survey on Lithuanian young people conducted by Sociology Laboratory of Vilnius University in 1997, young people mainly (57%) drink strong alcoholic beverages during celebrations. The percentage of young people who do not drink strong alcohol at all was 22%, of which were mainly women and people under 23 years old. As far as propaganda against alcohol usage is concerned, young people consider detailed information about drinking results to be mostly effective and acceptable.

There are 165 HIV infected persons registered at the moment (as of 1 August 1999), in Lithuania. 4 of them are under the age of 19, 27 of them are 20-24 year-old. 87% of the infected youths under the age of 24 are intravenous drug addicts. The largest number (52%) of the infected at the moment are from the port, Klaipeda town.

Young people aged 15-29 years account for approximately two thirds of all STIs. Although incidence of syphilis per 100 000 young people aged 15-29 years in 1995 decreased more than twice, in 1998 there were registered 1295 syphilis cases, 1033 cases of acute gonorrhoea and 111 cases of chronic gonorrhoea among young people of the same age. Boys tend to become sick with venereal diseases more often than girls. Among the youth, every fifth incident of an STI was among a 15-19 year old.

Areas for action and policy changes

- The appropriateness and impact of women's health services in relation to the antenatal care process, reduction of risk factors leading to maternal deaths, and the general health and well-being of women should be assessed;
- Improved education and access to safe contraceptives are required to reduce the reliance on abortion as a means of family planning. This can be achieved in Lithuania through health promotion and education aimed at changing the attitudes of the population and health care providers;
- Promote access to effective methods of fertility regulation;

[3] UNICEF ICDC, MONEE Country Reports, 1999.

- Improve the capacities of the professionals involved in family planning and fertility programmes;
- Further support needed to the Government in developing and finalizing the national family planning and reproductive health programmes;
- Assistance to adolescent health projects needed, particularly health promotion and youth counselling and education services.
- Assisting to extend breastfeeding practises;
- Increasing vaccination rate of tuberculosis.

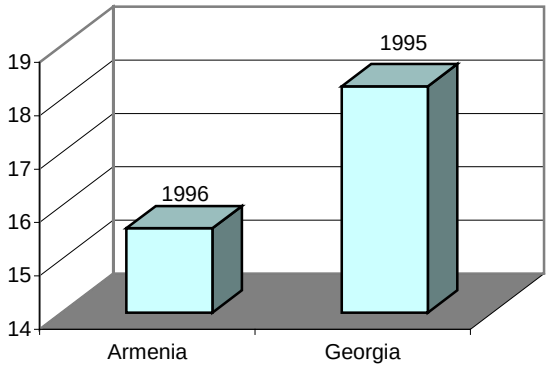
Caucasian Countries

The region

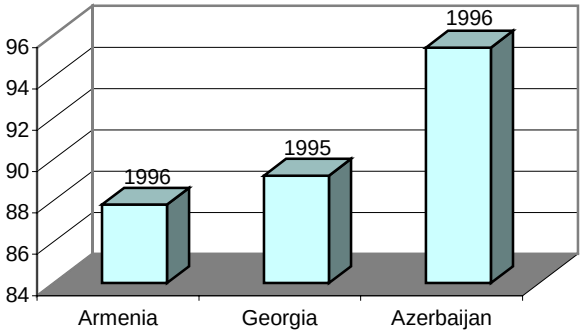
These countries have similar characteristics, however, they display a varying range of conditions in mother/child health issues. In 1995, infant mortality rates ranged between 16–26 per 1000 live births in the three countries. Also main causes of infant mortality differ from country to country. Acute respiratory infections are the main cause of infant mortality in Azerbaijan. Perinatal conditions take first place in Armenia and Georgia, however, the definition of infant death used in these countries was different from the WHO definition, resulting in underestimation of infant mortality. Actual rates might be higher than these rates. Although they have financial problems they have been trying to transit to the WHO definition.

Statistics on perinatal mortality, average immunization coverage and contraceptive prevalence rate

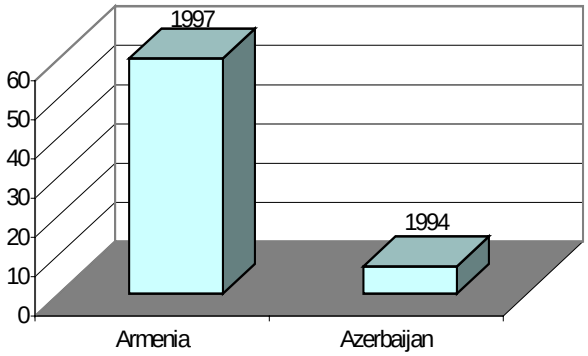
Perinatal mortality rate (per 1000 live births)



Average immunization coverage (Diphtheria-Tetanus,/Pertussis/Measles/Polio/Tuberculosis). % Latest available data



Contraceptive prevalence rate in % (Latest available data)



Follow-up of ICPD, Cairo 1994

Armenia has taken several steps to implement the endorsed Programme of Action developed at the ICPD in Cairo in 1994. The country has developed and implemented a national programme for reproductive health, established collaborative links with local and international NGOs and professional organizations and has made substantive legislative changes.

Armenia

VARIABLES	PAST DATA	PRESENT DATA (1997)	⇧ ⇩
Population estimate (millions)	3.166 (1995)	3.7	⇧
HDI (Human Development Index) value	0.568 (1994)	0.607	⇧
HDI (Human Development Index) rank	90 (1992)	103	⇩
GNP US$ (per capita)	365 (1994)	560	⇧
Women of fertile age (age 15-49)	1 mill (1995)	925.000	⇩
Total fertility rate (per woman)	1.7 (1994)	1.45	⇩
Maternal mortality ratio (per 100 000 live births)	30.6 (1995)	38.6	⇧
Perinatal mortality (per 1000 births)	15.58 (1996)	17.54	⇧
Infant mortality rate (per 1000 live births)	14.2 (1995)	15.4	⇧
Contraceptive methods used	natural methods	IUD	
Contraceptive prevalence rate	17% (1991)	60%	
Contraceptive choice index	No data	33.3/fair	
Abortion rate (per 1000 women age 15-49)	30.5 (1995)	24.3	⇩
Abortion:birth ratio < age 20	No data	0.12:1	
Abortion:birth ratio age 20-34	No data	No data	
Abortion:birth ratio age 35+	No data	2.1:1	
Abortion:birth ratio, all ages	0.62:1 (1995)	0.57:1	⇩
Birth rate (per 1000 population)	13.3 (1995)	11.6	⇩
Maternal mortality from abortions (per 100 000 live births)	1.25 (1995)	4.5	⇧
Immunisation coverage: **Diphtheria-Tetanus / Pertussis** **Measles/Polio/Tuberculosis**	(1996) 86% / 85% 89% / 97% / 82%	 89% / 87% / 92% / 94% /72%	
STD/AIDS rates	0 AIDS cases (1995)	13 AIDS cases (1998)	⇧

Health services

There is no data showing the percentage of the health sector financed by private sources, however, from public sources, 1.3% of GNP is allocated to the health sector. The coverage needs met by public hospitals and public polyclinics is estimated at 64% and 36% respectively.

The health professionals have various roles in the provision of reproductive health service. Obstetricians-gynaecologists provide counselling and care. Midwives and nurses give attendance to birth, assist physicians and undertake various measurements and procedures. STI professionals provide counselling and care for patients with major STIs. Paediatricians provide neonatal care.
The country does not provide a national health insurance system for the population as yet. Armenia has adopted the Essential Drug policy as recommended by WHO, but has not, as yet, included contraceptives in the Essential Drug List.

The majority of pharmacies - 95% - are privately run. There is no present data indicating the general availability of drugs in the major regions of Armenia.

Family planning

Armenia commenced the implementation of the national family planning programme in 1997. The programme is implemented by 1) the administrative office of the national programme on reproductive health 2) a Coordination committee 3) a scientific advisory committee 4) information-analytical centre in the Ministry of Health.

Several institutions provide family planning services: maternity hospitals, consultancies of obstetrics and gynaecology, polyclinics, private practices and sometimes PHC facilities.

The family planning counselling services offered cost the equivalent of 10% of an average monthly salary and are provided by gynaecologists.

Adolescents in Armenia do not need an authorization to receive family planning services.

Several national NGOs are actively involved in the programme of family planning.

Contraception

The main method of fertility regulation is as yet clinical abortion, following the use of natural methods including withdrawal. There appears however to be a reliable continuity of IUDs and condoms free of charge in 77 specific sites of the country. Overall, access is insufficient, mainly due to the lack of awareness and the lack of motivation by the providers. Apart from the areas where contraceptives are given free of charge, the cost of one cycle of oral contraceptives and one injection of injectable contraceptive is equivalent to 20% of an average monthly salary; one IUD costs an average monthly salary; one condom the equivalent of 1–2% of an average monthly salary.

Recently the national programme on reproductive health introduced the availability of emergency contraceptives to the population.

Abortion

Clinical abortions are performed in hospitals. The technique of curettage and vacuum aspiration are used. Certain medical methods also appear to be in use with no definition of the type. There are no official estimates of the prevalence of unsafe abortion but recent survey data indicate that the admitted rate of attempted self-induced abortion is 13%. The immediate complications after abortion is 11% and long-term consequences 4%.

A clinical abortion costs the equivalent of one average month salary. Pre-and post-abortion counselling can be performed by gynaecologists, but is rarely done.

Recent trends in reproductive health

Armenia commenced the implementation of a reproductive health policy in 1995. The services are mainly covered by the public sector but there are a few private out-patient facilities. In Yerevan, a centre offering reproductive health care services to youth has recently been established (1998). As yet no such services exist for the youth in rural settings.

Social marketing has yet to be implemented into the national reproductive health care services. The Armenian Family Health Association is actively involved in the national reproductive health care

services. Several international organizations are involved in humanitarian aid and development programmes.

Antenatal care

It is estimated that 58% of women are given antenatal care in Armenia. 8–12 visits are recommended during which various checks are routinely undertaken including three voluntary ultrasound examinations. The official estimates of the percentage of women attending antenatal care and showing a positive syphilis serology is 0.43%.

There are 6 facilities per 500 000 population that have functioning basic essential obstetric care and 7 facilities per 500 000 that have functioning comprehensive essential obstetric care.

The data on obstetric and gynaecological admissions being due to abortion indicates a level of 82%.

Breast and cervical cancer

The breast cancer prevalence in Armenia is 29.6 per 100 000 population and the prevalence of cervical cancer is 9.1.

Child health

The leading causes of perinatal deaths appear to be congenital malformations, infections, asphyxia and hypoxia. The leading causes of neonatal deaths appear to be asphyxia, respiratory distress syndrome, trauma, congenital malformations and infections.

Rooming-in and early breast-feeding have been introduced country wide. The number of home births is increasing.

Acute respiratory infections and diarrhoeal diseases are the contributing factors to child morbidity. Neonatal tetanus is no longer considered a risk in Armenia. No cases have been reported over the past 20 years.

Adolescent health

As of 1998 the first youth centre offering reproductive health services opened. This facility provides reproductive health medical services, family planning counselling and distributes condoms and information.

However, youth living in the rural areas do not have access to reproductive and family planning services. Condoms are available at pharmacies, but the cost and the stigma associated with buying them, especially for girls, is a significant barrier.

At a WHO/UNESCO/UNAIDS Regional Seminar on youth, Armenia noted that, it needed improved capacity of the government to address the needs of youth. Additionally, increased efforts need to be made to establish links between NGOs and the government.

Areas for action and policy changes

- Action needed for the short and medium term includes comprehensive reproductive health programmes and the upgrading of maternal and child health services;
- Efforts should focus on improving perinatal health and on preventing diarrhoeal diseases, being the third cause of infant mortality;
- Strengthening the programme against acute respiratory tract infections;
- Urgent provision of contraceptives,
- Training of health professionals in counselling skills,
- Assistance to adolescent health projects needed, particularly health promotion and youth counselling and education services.

Azerbaijan

VARIABLES	PAST DATA	PRESENT DATA	⇧ ⇩
Population estimate (millions)	7.39 (1994)	7.5 (1995)	⇧
HDI value	0.730 (1992)	0.665 (1993)	⇩
HDI rank	71 (1992)	96 (1993)	⇩
GNP US$ (per capita)	870 (1992)	500 (1994)	⇩
Women of fertile age (age 15-49)	1.78 mill (1994)	2.0 mill. (1997)	⇧
Total fertility rate (per woman)	2.7 (1994)	2.1 (1996)	⇩
Maternal mortality ratio (per 100 000 live births)	34.4 (1993)	31.0 (1997)	⇩
Perinatal mortality (per 1000 births)	18.02	14.11	⇩
Infant mortality rate (per 1000 live births)	26.2 (1994)	20.0 (1997)	⇩
Contraceptive methods used	IUDs, condoms	IUD's,OC's,condoms	
Contraceptive prevalence rate	7 % (1994)	20% (1997)	⇧
Contraceptive choice index	no data available	no data available	
Abortion rate (per 1000 women age 15-49)	239 (1993)	130 (1997)	⇩
Abortion:birth ratio < age 20	6.3 (1993)	0.073:1 (1997)	⇩
Abortion:birth ratio age 20-34	no data available	no data available	
Abortion :birth ratio age 35+	0.16:1 (1993)	0.54:1 (1997)	⇧
Abortion : birth-ratio, all ages	0.23:1 (1993)	0.15:1 (1995)	⇩
Birth rate (per 1000 population)	26 (1994)	17.26 (1998)	⇩
Maternal mortality from abortions (per 100 000 live births)	6.3 (1994)	1.51	⇩
Immunisation coverage: **Diphtheria-Tetanus / Pertussis** **Measles/Polio/Tuberculosis**	(1996) 96% / 95% 97% / 99% / 90%	96% / 92% / 97% / 98% / 94%	
STD/AIDS rates	1 AIDS cases (1995)	10 AIDS cases (1998)	⇧

Health services

The health care system is elaborate, but suffers from acute shortages in vaccines, medication and equipment. Azerbaijan is trying to reorient the system towards progressive economy and management, and towards primary health care and an increased number of family physicians, however, since independence there have been no significant changes in the organization of services, which still follows the traditional Soviet model in which the Ministry of Health is responsible for certain central, typically specialist, institutions, and the regions and cities are responsible for all other services. In addition there are several parallel health systems run by other ministries.

Pregnant women would normally have free access to services, including referral services for high-risk pregnancies and trained attendants during childbirth. In the present crisis condition caused by war and transition, these services cannot always be provided.

There is presently a transition from large-size families to medium-sized ones.

Family planning

The absence of modern family planning methods is felt mostly in the rural areas, where families are the largest and facilities the least. The increasing rate of poverty and unemployment among women

and the growing trend toward exploitation of girls and young women in prostitution and sex trafficking are likely to increase sexually transmitted diseases and HIV incidence, especially among the young women.

A national programme of family planning has been prepared for the period of 1994–1997, but has not yet been implemented due to poor economic conditions.

Contraception

Sex education does not exist and birth control is culturally presumed to be only the women's responsibility.

Contraceptive devices are still scarce and expensive. In 1991, IUD needs were being met by local production and condoms were supplied from other countries. In 1992, less than 2% of women used contraceptives. Virtually no contraceptives of any kind were available in 1993.

Abortion

Due to the unavailability of contraceptives, abortion continues to be the primary method of fertility regulation. There appears to be an increase in the use of abortion among young women under 19 years, despite the overall decrease in abortion:birth ratio.

Recent trends in reproductive health

Despite the lack of recent available data, it is important to point to the 27% increase in the maternal mortality ratio in just one year, reflecting women’s vulnerability in the present crisis in Azerbaijan. As many women in the Azerbaijanian society are sole providers during periods of emergency, maternal mortality may reflect large-size to medium-sized families of children with no mothers to provide immediately for them.

Antenatal care

(Maternal mortality --- see databox)
(Infant mortality ---see databox)
(Birth and fertility rate --- see databox)

Breast and cervical cancer

The mortality rates for both breast cancer and cervix uteri cancer are below the average European rates.

Child health

Among children, respiratory system diseases account for nearly half of all morbidity, followed by infectious and parasitic diseases with 13%. Heavy pollution causes high incidences of allergy, asthma and respiratory problems in children.

Adolescent health[4]

The Ministry of Sport and youth was established the 26th of July 1991 and deals with youth problems in the country and makes efforts to coordinate the activity of youth organizations.

From 1991 to 1999, 110 child and youth organizations were started, a third of which stopped their activities because of the lack of funding and technical expertise.

In regards to reproductive health and family planning, in 1998, 340 individuals aged 15-29 were diagnosed with gonorrhoea for the first time, over half of all patients had had gonorrhoea before. 577 cases, or 61 %, of all diagnosed cases of gonorrhoea were among those aged 15-29.

Of the 24942 registered abortions approximately 25% were among girls 15 -24 years old. 520, or 8%, of them were first time pregnancies.

In 1998, 5707 women aged 15-24 reported using the IUD, 0.4% of the female population aged 15-24. Hormonal contraceptives were used by 8490 women aged 15-24 year old, 0.6% of the corresponding population.

Of 92.8 babies born alive to young mothers aged 15-24, half were under-weight (less than 2500gr).

During 1998 there were no individuals under the age of 14 were infected by HIV. As of mid-1999, 3 individuals under 14 years of age were HIV infected.

Areas for action and policy changes

- There is an urgent need for contraceptive devices;
- Among the medium- and long-term needs is technical assistance to implement WHO standard protocols for family planning and safe motherhood;
- Long-term exchanges are needed to facilitate training of local staff in maternal and child health;
- Assistance to adolescent health projects needed, particularly health promotion and youth counselling and education services.

[4] UNICEF ICDC, MONEE Country Reports, 1999.

Georgia

VARIABLES	PAST DATA	PRESENT DATA	⇧ ⇩
Population estimate (millions)	5.4 (1994)	5.5 (1995)	⇧
HDI value	0.747 (1992)	0.645 (1993)	⇩
HDI rank	66 (1992)	101 (1993)	⇩
GNP US$ (per capita)	850 (1992)	363 (1994)	⇩
Women of fertile age (age 15-49)	1.34 mill (1991)	1.33 mill (1992)	⇩
Total fertility rate (per woman)	2.2 (1994)	1.9 (1997)	⇩
Maternal mortality ratio (per 100 000 live births)	20.5 (1990)	46.8 (1995)	⇧
Perinatal mortality (per 1000 births)	18.24 (1995)	24.08	⇧
Infant mortality rate (per 1000 live births)	16 (1994)	21.4 (1995)	⇧
Contraceptive methods used	Mainly IUDs	Condoms, IUDs	
Contraceptive prevalence rate	19 % (1992)	no data available	
Contraceptive choice index	no data available	50.0 / good	
Abortion rate (per 1000 women age 15-49)	41.1 (1992)	24.0 (1995)	⇩
Abortion:birth ratio < age 20	no data available	* 3%	
Abortion:birth ratio age 20-34	no data available	* 53.6%	
Abortion :birth ratio age 35+	no data available	* 17.3%	
Abortion : birth-ratio, all ages	0.59:1 (1994)	0.59:1 (1995)	
Birth rate (per 1000 population)	no data available	11.8 (1992)	
Maternal mortality from abortions (per 100 000 live births)	10% (1993)	3.3% (1995)	⇩
Immunisation coverage: Diphtheria-Tetanus / Pertussis Measles/Polio/Tuberculosis	(1994) 83% /81% / 83% / 88% / 56%	(1995) 92% / 89% / 84% / 95% / 86%	
STD/AIDS rates	3 AIDS cases (1995)	22 AIDS cases (1998)	⇧

***** *% of abortions in each age group - No information available on births by age group, therefore indicator is not calculable.*

Health services

Previously, prenatal care services reached virtually all pregnant women in Georgia. Presently, transportation problems and the need to partially pay for health services are excluding an unknown percentage of women from prenatal care and about 10% of pregnant women from assisted delivery in hospitals.

Georgia has one of the highest rates of doctors and nurses in the world and midwives still play a central role in providing health care to pregnant women.

The government is keen to reform the health care system (insurance, privatization, etc.), but the economic situation obstructs this, as does the threat of unemployment for medical staff. While the dispersal of maternity hospitals make for relatively easy access, many of them are under-equipped. Only a few of the maternity hospitals have intensive care units. Sanitary conditions in hospitals are poor and therefore health risks resulting from abortions are high.

The government aims to compromise, e.g. by allowing state care to coexist with the private sector and elements of insurance, and by cutting support to research apart from a few priority projects. Apart from the transition from centralized planned to market economy, Georgia also suffered an earthquake in April 1991 and important disruption due to the civil war of the past years.

Some health trends are clear, i.e. rising mortality rate, declining birth rate, and steady increase in infant mortality.

Family planning

Only half of the 20 established family planning clinics are functioning. Supplies of donated contraceptives are generally present in the country, but the distribution and utilization is less than ideal. This is due to transportation problems and to the lack of training and motivation of gynaecologists/obstetricians to make the modern methods of contraception available to the population. However, the government policy is to expand family planning services and there is a growing appreciation that family planning is not a device to limit population size, but a means to allow couples to decide under what circumstances to have children. Emphasis on family planning is thus shifting from treatment of infertility to contraception. The family planning strategy comprises three components:

1. Family planning promotion through health education, particularly in patient–physician context;
2. Abortion by vacuum extraction performed by medical staff (replacing traditional methods);
3. Research on family planning issues and infertility.

Contraception

In recent years, family planning programmes have shown some success; use of oral contraceptives or IUDs has risen from 5% to 19% (1992) of fertile-aged women, despite the fact that the availability of contraceptives has been greatly restricted by the past emergency situation.

UNFPA and IPPF are providing contraceptives, which are distributed in clinics.

Abortion

Similar to the rest of CEE and CIS, abortion is the principal method of fertility regulation. A campaign to reduce abortion showed decreases from 61 100 reported in 1990 to 32 016 incl. mini abortions reported in 1995.

The current level is relatively lower than average for the CEE and CIS. Although abortion is still legal and officially free of charge, it is common to pay health professionals, making illegal abortions a large problem and abortion statistics unreliable.

At an international conference entitled **From Abortion to Contraception** in Tbilisi, in October 1990, the 170 participants representing 19 countries from CEE and CIS issued a declaration which has been used as a basis for developing forthcoming activities in the CEE and CIS.

Recent trends in reproductive health

Due to the present economic situation in Georgia, the data obtained is not fulfilling, maybe due to underreporting. For example, the drastic increase in the maternal mortality ratio of 128% over five years and the high abortion rate, despite an apparent decrease over three years, is not reflected in the data on maternal mortality from abortions.

Furthermore, maternal mortality is expected to further increase, as a result of the rise in unprepared home deliveries (estimated to be around 10% of all deliveries), non-functional referral systems, as well as of the diminishing capacity of health services to deal with obstetric complications.
The abortion:birth ratio is a repetition of previous years' data.

Antenatal care

(Maternal mortality --- see databox)
(Infant mortality ---see databox)
(Birth and fertility rate --- see databox)

Breast and cervical cancer

No data available on breast and cervical cancer.

Child health

Respiratory system disease and digestive system diseases account for more than 67% of the childhood morbidity. In the 0–14 age group the main causes of respiratory diseases are acute respiratory infections. Chronic tonsillitis is one to show the highest percentage of all the chronic diseases of respiratory system.

Most of the cases of digestive system diseases are acute diarrhoea. Oral rehydration treatment packets have been provided by UNICEF and other donors.

The prevalence of infectious and parasitic diseases was low in both 1991 and 1992, however, due to current political and economic conditions it is difficult to obtain data for making reliable health policy and management decisions. Information has not been received from many areas due to the lack of communications, fuel shortages and security problems.

The immunisation coverage was just below 60 % in 1993. More recent data on immunisation coverage are not available. Antibiotics and anti-asthmatic drugs are in short supply.

Adolescent health[5]

According to the survey of the State Department for Youth Affairs, 38,6% of young respondents consider their parental relations satisfactory, 11,3% think that they cannot rely on their parents. This tendency is more notable among boys, (16%), than among girls, (6%). 34,6% are tightly linked to their parents and scared to live without them.

According to Georgian State Statistic Department data 46841 children were born in 1998, among them, mothers aged 15-24 gave birth to 25291 children (54% of new births). 59,6 % of children whose mothers are 15 years old or less were born in urban area and 40,6%-in rural. 64% of children that were born to women 15 years old and less are Georgian children, 28,5% - Azerbaijanians, 4,5 - Kurds, 1,1% - Armenians, 04% - Russians.

[5] UNICEF ICDC, MONEE Country Reports, 1999.

During 1995-1998, the number of STIs among young people aged 15-19 increased. Particularly, in 1995 in this age group the number of ill with syphilis was 84 and it reached to 181 in 1998 (it increased for 2,2 times)[6]. In the same period the number of people ill with HIV in 1995 increased from 126 cases to 154 in 1998. There were no cases of AIDS in this age group.

Table 1G. STIs among boys in Georgia, 1995-1998

	1995	1996	1997	1998
Syphilis	877	953	2172	2379
Gonococcus infection	1201	947	1245	1602
AIDS	0	8	21	25
15-19 age				
Syphilis	84	86	152	181
Gonococcus infection	126	65	136	154
AIDS	--	--	--	--

Source: Statistic and Information Centre data under Georgian Ministry of Health; cf: UNICEF ICDC, MONEE Country reports, 1999.

According to data from the Scientific Research Institute under the Ministry of Health, drug abuse is widely spread among young people and adults. In 1995 there was no registered cases of drug abuse among youth aged 15-19. But in 1997 there were 23 cases of drug abuse, and in 1998, 43 cases; a 86,9% rise in one year. (see Table 2G).

Table 2G. Drug and alcohol abuse among youth, 1995-1998

years	number of drug addiction	age		location		alcoholism	age	location	
		0-14	14-19	urban	rural		15-19	urban	rural
1995	5031	-	-	3207	1824	9241	10	3620	5621
1996	5734	-	-	3744	1990	9338	-	3710	5628
1997	6323	-	23	4159	2164	9428	11	3785	5643
1998	6868	4	43	4558	2310	9841	13	3805	6036

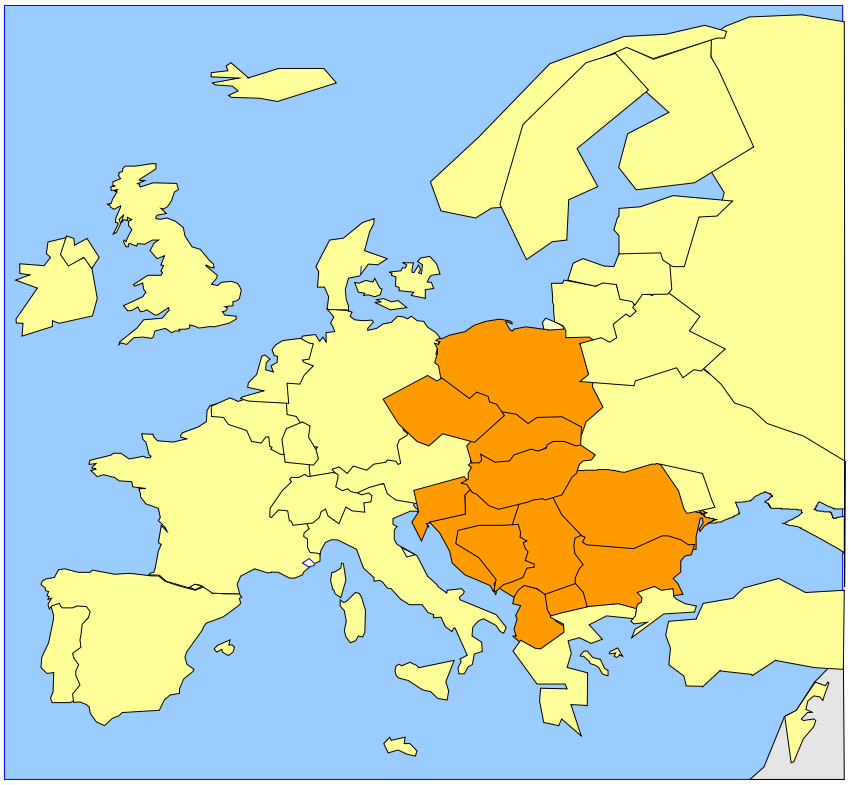
Source: Drug abusing Scientific Research Institute data under Georgian Ministry of Health; cf: UNICEF ICDC, MONEE Country Reports, 1999.

Areas for action and policy changes

- Further evaluation of actual conditions is needed to identify specific action;
- Technical assistance in human reproduction is needed through the continuous support supply of contraceptives, by means of raising funds and thus strengthening family planning promotion;
- Strengthening MCH services and training health staff, thus strengthening family planning promotion;
- Future projects should include medical equipment and supplies, primary health care services, training in public health, issues on healthy infants and mothers, issues on AIDS;
- Antenatal and perinatal care and the management of respiratory diseases should be examined in order to reduce avoidable deaths in infants;
- Safe Motherhood equipment to be sent to Georgia;
- Assistance to adolescent health projects needed, particularly health promotion and youth counselling and education services.

[6] Source: Georgian Ministry of Health. Center for Scientific Information and Statistics data

Central and Eastern Europe (CEE)



The region

The effects of transition on women and children, while varying in degree from country to country, have generally been severe. Access to and availability of health, education, child care and other previously free social services has, in effect, declined as restructuring of these services along market lines has begun. In many countries, such basic supplies as drugs and text books have become scarce.

Sharp falls in the birth rate have been recorded throughout the region, caused by both the economic hardships being experienced by the population and an apparent lack of confidence in the future. Continuing reliance on abortion as a major means of fertility regulation poses a major threat to women's health. Death from unsafe abortion is an indicator of failure to reach all women with family planning services.

Infant mortality rate varies from country to country in this region. The leading causes of infant mortality are also different in the countries in this region. While perinatal conditions are the leading causes of infant mortality where infant mortality rate is below 15 per 1000 live births,

respiratory infections are the leading causes of infant mortality where infant mortality rate is higher than 15 per 1000 live births.

In Romania, the age pyramid shows a young population and reflects the pro-natalist policies of the previous regime. The birth rate will probably fall in the next few years following the legalisation of abortion – still the primary method of fertility regulation.

The Former Yugoslav Republic of Macedonia - FYROM - suffers from the side-effects of the international embargo and the more direct effects of the separate Greek blockade.

Slovenia suffers least from the side-effects of the embargo, but the influx of political and economic refugees is an ever-present burden.

In all the countries of ex-Yugoslavia with the possible exception of Slovenia, the overwhelming preoccupation of the national authorities and the people is the struggle to survive, and to deal with the current emergencies.

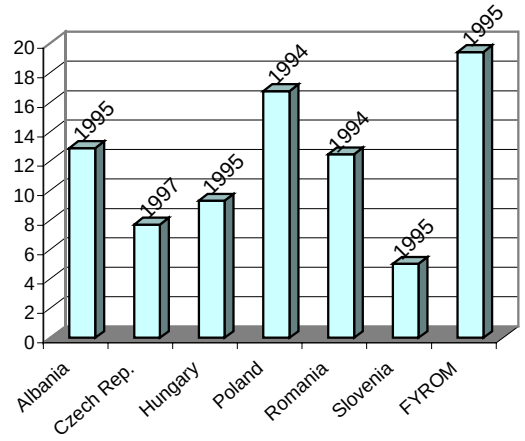
Women were the bearers of the major burden of the effects of war and civil strife.

Some 81% of children interviewed in 1993 in a survey in Sarajevo, reported having been in a situation during the war where they thought they would be killed.

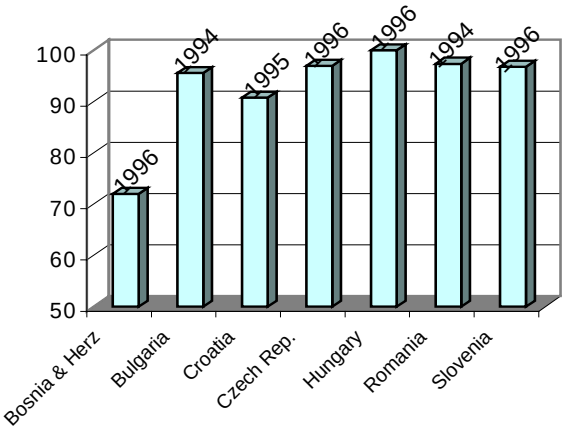
There is presently not enough data available to calculate a Human Development Index for the countries of former Yugoslavia.

Statistics on perinatal mortality, average immunization coverage and contraceptive prevalence rate

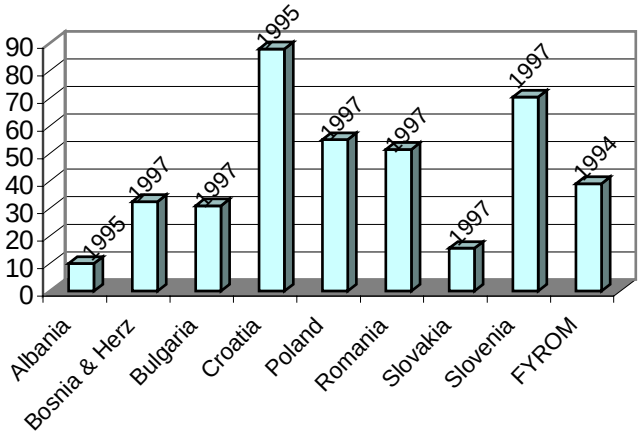
Perinatal mortality (per 1000 live births)
Latest available data



Immunisation coverage % (Diphtheira-Tetanus/Pertussis/ PolioMeasles/Tuberculosis)
Latest available data



Contraceptive prevalence rate in %
(Latest available data)



Follow-up of ICPD, Cairo 1994

Despite the national crisis in 1996/97, which caused a major set back in all health programmes and activities, Albania has been able to adopt several policy document related to the endorsed programme of Action developed at the ICPD in Cairo in 1994:

- Primary health care document, including reproductive health care;
- National reproductive health country programme;
- Public health policy (in process).

Bulgaria has taken various steps to implement the endorsed Programme of Action developed at the ICPD in Cairo in 1994. Among the actions taken have been:

- Increasing the participation of women in the political, social and economic life;
- The start of reforming the health care system with the main objective of decentralising PHC and improving the quality of care, and the quality of pre-/postgraduate training and education of health professionals;
- Implementing a nation-wide family planning project (PHARE programme);
- Developing and strengthening the NGOs sector;
- Adopting a National Environmental and Health Action Plan (NEHAP); and
- Adopting a law on labour conditions.

The Czech Republic has taken steps to implement the endorsed Programme of Action developed at the ICPD in Cairo in 1994, as yet only at the level of NGOs and the professional medical associations. Steps taken concern sex education and prevention of STI/AIDS with the main goal being “from abortion to contraception”.

Romania has taken steps to implement the endorsed Programme of Action developed at the ICPD in Cairo in 1994 by organizing a national family programme and reproductive health services as well as by monitoring the reproductive rights of women.

Despite the recommendations from the ICPD (and the Slovak Family Planning Association) the Slovak Parliament have not accepted proposals for liberation of the sterilization law. A deteriorating economic situation is specifically felt in the health sector, resulting in government and health insurance companies not supporting modern contraception.

In Slovenia, an intersectoral national committee on population and development was founded before the ICPD in Cairo, and a draft for a national plan of action on population and development for all sectors was prepared at the Ministry of Work, Family and Social Affairs. After a change of ministers in the ministry, all activities have stopped. Independently of that, the government has adopted a reproductive health strategy as part of the national health care plan until year 2000, however, this has yet to be approved by the Slovenian Parliament.

Albania

VARIABLES	PAST DATA	PRESENT DATA (1997)	⇧ ⇩
Population estimate (millions)	3.249 (1995)	3.283.000	⇧
HDI (Human Development Index) value	0.633 (1993)	0.699	⇧
HDI (Human Development Index) rank	104 (1995)	100	⇧
GNP US$ (per capita)	762 (1994)	760	⇩
Women of fertile age (age 15-49)	812 000 (1995)	835.000	⇧
Total fertility rate (per woman)	2.6 (1995)	2.6	
Maternal mortality ratio (per 100 000 live births)	29.1 (1995)	27.5	⇩
Perinatal mortality (per 1000 births)	11.5 (1992)	12.9 (1995)	⇧
Infant mortality rate (per 1000 live births)	30.0 (1995)	43.2	⇧
Contraceptive methods used	OC, IUDs (1995)	OC,IUD's, condoms	
Contraceptive prevalence rate	10% (1995)	3%	⇩
Contraceptive choice index	No data	No data	
Abortion rate (per 1000 women age 15-49)	39.7 (1995)	263.8	⇧
Abortion:birth ratio < age 20	No data	* 3.6%	
Abortion:birth ratio age 20-34	No data	* 64.4%	
Abortion:birth ratio age 35+	No data	* 32.0%	
Abortion:birth ratio, all ages	0.44:1 (1995)	0.39:1 (1999)	⇩
Birth rate (per 1000 population)	22.2 (1995)	20.8	⇩
Maternal mortality from abortions (per 100 000 live births)	14.3% (1995)	1.6 = 5.8%	⇩
Immunisation coverage : **Diphtheria-Tetanus / Pertussis** **Measles/Polio/Tuberculosis**	(1995) 97% / 97% 91%/ 98% / 97%	(1996) 98% / 98% 92% / 100% / 94%	
STD/AIDS rates	5 AIDS cases (1995)	10 AIDS cases (1998)	⇧

** Abortions per age group in % compared to overall number of abortions. As information on birth rate per age group is not available, the indicator is not calculable.*

Health services

The health sector is mainly financed by public sources: 80%, and by private sources: 20%. It is estimated that the public hospitals cover the entire needs of the population. The various professionals in reproductive health service provide mainly counselling.

Albania's national health insurance covers the needs of 93.4 % of the total population. The country has adopted the Essential Drug Policy as recommended by WHO, including contraceptives on the Essential Drug List, however, there is no data to indicate the general availability of drugs in the major regions of Albania.

Family planning

The national programme of family planning was commenced in August 1998. The programme is implemented through the primary health care sectorate, coordinated with the UNFPA country programme.

A national advisory group composing of obs/gyn, GP, midwives, UNFPA orient the national programme of family planning.

Albanian Family Planning Association (AFPA), Albanian Social Marketing Organization (ASNA) and the Contraceptives Social Marketing Unit (CSMU/MSI) are all active partners in the implementation of the national family planning programme.

Family planning counselling services are offered free of charge and are provided by gynaecologists and midwives.

Adolescents do not need to have an authorization to receive family planning services in Albania.

Contraception

Contraceptives are free of charge through the public sector institutions. Costs have to be foreseen by the users when obtaining contraceptives through the private sector or through social marketing. Pharmacies sell oral contraceptives (OC) IUDs, injectables, condoms and spermicides. Despite the situation in the country, it has been estimated that the country does have a reliable continuity of availability of IUDs, OCs, and condoms. Emergency contraceptives are mainly available through the private sector and in a few cases through family planning clinics.

Abortion

Clinical abortions are performed in maternity hospitals and in IPPF funded family planning clinics. Most institutions use the curettage method for the performance of clinical abortions. In a few cases, the vacuum aspiration technique is used. In one clinic the syringeal method is used.

Clinical abortion is not available free of charge in Albania. The estimated cost in proportion of a monthly salary is approximately 15%.

Pre- and post abortion counselling is performed by midwives, social workers and nurses.

Recent trends in reproductive health

Albania does not have a specific public policy aimed at women's health. Nor have the services provided relating to reproductive health been privatised. Among the services are counselling, contraceptive services and abortion services directed at adolescents.

Social marketing is an active element of the services provided in reproductive health. In 1994, a condom social marketing project was launched by PSI and in 1997 KFW/MSI implemented a contraceptives social marketing project.

International donor organisations are specifically involved in the following activities related to reproductive health in Albania: family planning; mother and child health; social marketing of contraceptives; IEC; distribution of contraceptives free of charge.

Antenatal care

An estimated 85% of women are given antenatal care in Albania. Four visits are recommended. Two ultrasound examinations are recommended during pregnancy. The checks routinely taken during antenatal care are: blood pressure measurement, weight, ECHO, Wasserman (syphilis),

other laboratory examinations, however, there is no data on the percentage of women attending antenatal care showing a positive syphilis serology.

There is no available data on the number of facilities that have functioning **basic** and/or **comprehensive** essential obstetric care.

It is estimated that 28 000 women admitted to obstetric and gynaecological examinations are due to abortion.

Breast and cervical cancer

There is a lack of data on breast and cervical cancer, due to the general lack of knowledge of women's health.

Child health

Respiratory diseases, especially pneumonia are responsible for 42% of all deaths in children 1–4 years of age. Diarrhoeal diseases including dysentery and salmonellosis account for 11.5% of under-five deaths and a large part of total morbidity in this age group. One third of children under five years of age have parasitic infections. The incidence of diseases is reduced in later ages due to better personal hygiene.

Viral hepatitis is a particularly serious problem in Albania. About half of the cases are hepatitis A, occurring mainly among children in day care centres. The hepatitis B cases are transmitted by excessive recourse to blood transfusions, especially among dystrophic children and by injections administered with inadequately sterilised equipment.

Adolescent health

49% of the Albanian population is under that age of 25, as large numbers of adults left the country after 1987. Young people have been slowly mobilising in Albania and are securing their voice in the health sector. Increased funding for the region after the Kosova war has contributed to efforts to improve young people's reproductive health. The Albanian Family Planning Association has developed youth centres which provide counselling and peer education. However, continued efforts are needed to reach rural populations and young women who are socially isolated.

There was only 36 reported cases of syphilis and 5 cases of gonorrhoea in 1998. This data is only from the urban areas. Further development of testing and treatment will need to be made if a true picture of STDs in Albania is to become clear. (*Source: Albanian Institute for Public Health*)

Of individuals arrested for prostitution, 3% were 18-19 years olds and 58% were 20-24 years old. Prostitution has become a main source of income for some families in Albania, as their daughters trafficked and the money is given to the parents. After girls return they often bring STDs and other infections across the border. (*Source: Albanian NGO, Useful to Albanian Women, 1997*).

During 1997, 5% of all births were to mother 19 years old and younger.

At a WHO UNFPA information, education and communication (IEC) Conference in 1999, youth participants stated that the highest health priorities for youth are: abortion, nosocomial infections, HIV/AIDS and STIs.

Areas for action and policy changes

- Lack of information on women's health, which makes a statistics index of accurate data a priority;
- Need for major changes and improvements in safe motherhood services, especially at community level;
- Decrease hypothermia in newborn babies;
- Monitor growth and development;
- Efforts should be made to boost couple's knowledge of family planning methods, increase the demand for those services and ensure their availability;
- Need to educate the public that abortion is not a contraceptive method and is always associated with risk;
- Need for urgent improvement in abortion equipment and training in new techniques in order to decrease maternal mortality;
- Mobilization of the mass media to inform couples about the choice and right in practising family planning;
- Assistance to adolescent health projects needed, particularly health promotion and youth counselling and education services;
- Better understanding of the health issues caused by the trafficking of women.

Bosnia and Herzegovina

VARIABLES	PAST DATA	PRESENT DATA (1997)	⇧ ⇩
Population estimate (millions)	3.4 (1995)	4.390.000	⇧
HDI (Human Development Index) value	No data	No data	
HDI (Human Development Index) rank	No data	No data	
GNP US$ (per capita)	No data	1810	
Women of fertile age (age 15-49)	No data	2.230.000	
Total fertility rate (per woman)	No data	2.48	
Maternal mortality ratio (per 100 000 live births)	No data	10.7	
Perinatal mortality rate	No data	no data	
Infant mortality rate (per 1000 live births)	No data	14.5	
Contraceptive methods used	No data	IUDs, OC's, condoms, spermicide	
Contraceptive prevalence rate	No data	32.5%	
Contraceptive choice index	No data	No data	
Abortion rate (per 1000 women age 15-49)	No data	No data	
Abortion:birth ratio < age 20	No data	No data	
Abortion:birth ratio age 20-34	No data	1:1	
Abortion:birth ratio age 35+	No data	4:1	
Abortion:birth ratio, all ages	No data	2:1	
Birth rate (per 1000 population)	No data	11.6 (1998)	
Maternal mortality from abortions (per 100 000 live births)	No data	25 (absolute number)	
Immunisation coverage : **Diphtheria-Tetanus / Pertussis** **Measles/polio/tuberculosis**	(1994) 82% / 67% 69% / 57% / 85%	 79% / 79% 86% / 80% / 97%	
STD/AIDS rates	2 AIDS cases (1995)	17 AIDS cases (1998)	⇧

Health services

The health sector is financed mainly by public sources: 80%. Private sources finance the difference: 20%. There is no data on the coverage met by public and private hospitals and polyclinics. The health facilities have suffered severe damage during the recent war. There is marked deterioration in the quality and availability of primary health care and health facilities are highly overloaded. The effect of this is indicated in women's health needs as largely unmet in Bosnia.

In most areas, hospital records indicate that therapeutic abortions have increased while birth rates have decreased during the war. Pregnancy complications have also increased significantly for various reasons.

The present national health insurance covers an estimated 83% of the population.

The Essential Drug Policy has been adopted as recommended by WHO. Contraceptives are included in the Essential Drug List.

Nearly two-thirds of the national pharmacies are still public. Private pharmacies account for 37%. The general availability of drugs in the major regions of the country is estimated to cover approximately 70%. Data does not indicate which drugs are /are not generally available.

Family planning

Bosnia & Herzegovina has a national programme of family planning. Implementation of this programme was commenced in 1995. The Minister of Health is supported by an advisory committee and through the executive office, by a management support group (MSG) when implementing the programme.

Family planning services are provided in maternity hospitals, consultancies of obs/gyn, polyclinics, primary health care facilities and private practices. Counselling services are not offered free of charge. Depending on the service, costs range from 10DM–300 DM, equivalent to 2%–60% of an average monthly salary. Gynaecologists are the main provider of family planning counselling services.

Adolescents up to the age of 18 cannot receive family planning services without an authorization. Marie Stopes International is one of the most active NGOs involved in the national programme of family planning.

Contraception

The main method of fertility regulation is the use of IUDs. There appears to be a reliable continuity of availability of IUDs in the country, however, natural methods are also regarded as another main method. Emergency contraceptives have not been made available to the population.

Contraceptives have to be bought by the user. The cost for one cycle of OC is 10 DM, equivalent to 2% of an average monthly salary. One IUD costs 20 DM (4% of an average monthly salary) and a condom 2 DM (0.4% of an average monthly salary).

Pharmacies sell Oral Contraceptives (OC), condoms, IUDs and diaphragms.

Abortion

Clinical abortions are performed in hospitals and polyclinics. The techniques used for performing clinical abortions are the curettage and the vacuum aspiration. Clinical abortions cost 300 DM, equivalent to 60% of an average monthly salary. Despite this high cost, the prevalence of unsafe abortion is estimated only at 3–5%.

Pre- and post abortion counselling is performed by gynaecologists.

Recent trends in reproductive health

A reproductive health policy from 1945 has been the basis of the reproductive health care services offered in the country. The services aimed at preventive measures have been privatised, but as yet no steps have been taken to implement social marketing into these services.

Reproductive health care services to adolescents are offered through juvenile counselling services.

Although a number of women organized themselves into support groups in response to the violence they became victims to during the war, there are as yet no national NGOs actively involved in the national reproductive health care services. A number of international organizations are present in

this respect: UNFPA, CARE, IRC, WHO and others. Their activities are mainly within rebuilding the infrastructure of the country and education and supplies.

Antenatal care

An estimated 80–90% of women are given antenatal care. They are recommended to visit for checks 8 times during their pregnancy. Checks routinely taken are: BT, GTT, Urin, Wasserman (syphilis), Mantoux, ultrasound (5 scannings per pregnant woman is recommended) . It appears that data has been collected on pregnant women attending antenatal care with regard to a positive syphilis serology: 0.3%.

For obvious reasons, the country has a shortage of basic and comprehensive essential obstetric care. It has been estimated that there is one unit per 500 000 population.

There is no data on the percentage of obstetric/gynaecological admissions due to abortion.

Breast and cervical cancer

There is no data on the prevalence of breast and cervical cancer in the country.

Child health

The burden of the war to all children under the age of seven was severe. In total, 17 000 children died during the war and 39 712 were wounded. Of the total number of over 1.25 million displaced persons within the Federation, over 40% were children. Furthermore, thousands of children were orphaned or were left with only one parent.

Adolescent health

Adolescents and young married women are most concerned about defining sexuality on their terms and obtaining necessary information and supplies if desired. Most women believe that a double standard exists be6tween the socially acceptable sexual practices of young men and young women. On the one hand, women should remain virgins until marriage while men are expected to be sexually experienced. The norms place limits on women's public behaviour as evidenced by the limited access adolescents and women have to contraceptive methods when compared with access afforded to men.

Men, not boys, have access to contraception. Men can purchase condoms in newspaper shops, while an adolescent girl would be stigmatised if she did the same thing. In addition, young men reportedly pressure young women to have sex early in an relationship.

Continued efforts are needed to expand reproductive health services to the youth population.

Areas for action and policy changes

- Women's health services, particularly family planning programmes need to be expanded;

- Support is needed for the ongoing health-related activities organized by the informal network of women's groups;
- Pre- and post abortion counselling skills needed at all levels of health professionals;
- Support for abortion services using adequate technology;
- A broader choice of contraceptive supplies are urgently needed;
- Breast and cervical cancer prevention programmes needed;
- Assistance to adolescent health projects needed, particularly health promotion and youth counselling and education services.

Bulgaria

VARIABLES	PAST DATA	PRESENT DATA (1997)	⇧ ⇩
Population estimate (millions)	8.7 (1995)	8.283.200	⇩
HDI (Human Development Index) value	0.773 (1993)	0,774	⇧
HDI (Human Development Index) rank	62 (1995)	67	⇩
GNP US$ (per capita)	1543 (1995)	1190 (1996)	⇩
Women of fertile age (age 15-49)	1.75 mill (1994)	2.036.334	⇧
Total fertility rate (per woman)	1.24 (1995)	1.09	⇩
Maternal mortality ratio (per 100 000 live births)	12.59 (1994)	18.71	⇧
Perinatal mortality rate (per 1000 birth)	11.81 (1995)	13.1	⇩
Infant mortality rate (per 1000 live births)	16.3 (1994)	17.5	⇧
Contraceptive methods used	Mainly condoms	Mainly condoms	
Contraceptive prevalence rate	22% (1992)	31%	⇧
Contraceptive choice index	No data	58.3 /good (1996)	
Abortion rate (per 1000 women age 15-49)	No data	43.1	
Abortion:birth ratio < age 20	0.68:1 (1995)	0.81:1	
Abortion:birth ratio age 20-34	0.96:1 (1989)	1.33:1	
Abortion:birth ratio age 35+	5.1:1 (1995)	4.69:1	
Abortion:birth ratio, all ages	1.35.1 (1995)	1.36:1	
Birth rate (per 1000 population)	No data	7.7	
Maternal mortality from abortions (per 100 000 live births)	5.04 (1994) = 40%	3.11 = 16.6%	⇩
Immunisation coverage : Diphtheria-tetanus/Pertussis Measles/Polio/Tuberculosis	(1995) 93% / 96% 94% / 97% / 98%	94% / 94% 93% / 96% /97%	
STD/AIDS rates	1 AIDS case (1995)	55 AIDS cases (1998)	⇧

Health services

The health sector in Bulgaria is as yet nearly 100% financed by public sources. The private sector is being established and parts of the health sector is slowly becoming privatised.

Public hospitals cover 100% the needs of the population, whereas public polyclinics only covers 95% of the need. The difference is covered by private polyclinics.

Health professionals have different roles in Bulgaria. The reproductive health care services are the obligation of the obstetricians, the gynaecologists and the midwives. In rural areas the follow-up of pregnant women, counselling and other prophylactic measures are the obligations of the general practitioner. The health professionals of the hygiene epidemiological inspectorates also participate in promoting family planning.

A national health insurance system has recently been developed and adopted by the Bulgarian Parliament, and remains to be implemented.

Bulgaria has also adopted the Essential Drug policy as recommended by WHO, but has not included contraceptives on the Essential Drug List.

More than two-thirds of the pharmacies are privately run. It is estimated that the availability of drugs can cover 100% of the coverage needs.

Family planning

A draft for a national family planning programme was developed in early 1998 and presented to the Authority of the Ministry of Health for discussion in agreement with other ministries. The programme will eventually be adopted by the Council of the Ministers. The draft is based on lessons learned in a large-scale reconstruction of the health system involving a multi-component family planning project financially launched in 1995 and technically supported by PHARE-EU and WHO-IPPF, respectively.
A family planning team was established at the Ministry of Health for the implementation of the PHARE project. Following termination of the project, experts have been given areas of responsibility within the on-going family planning activities. A national advisory groups orients the on-going activities. It consists of representatives from the Ministry of Health, Ministry of Education, Ministry of Finance, Ministry of Defence, Ministry of Labour and Social Policy, representatives from the Medical University, the Committee of Youth, Physical Education and Sport, the National Centre for Health Information, the National Centre for Health Education and the Bulgarian Family Planning Association (BFPA).

Family planning services are provided in a number of institutions: maternity hospitals, consultancies of obs/gyn including private practices, polyclinics, general practitioners and PHC facilities.

Family planning counselling services are offered free of charge in Bulgaria. The counselling is provided by gynaecologists and midwives.

Adolescents under the age of 16 cannot receive family planning services without an authorization.
Apart from BFPA a number of women NGOs are actively involved in the on-going family planning activities.

Contraception

The main method of fertility regulation in Bulgaria is as yet clinical abortion. The PHARE project provided sufficient supplies of contraceptives within the project. Data indicates a reliable continuity of availability of the contraceptives sold in the pharmacies: hormonal contraceptives (OC) IUD, condoms, spermicides and diaphragms. Likewise, emergency contraceptives have recently been made available to the population in both private and public pharmacies through UNFPA assistance.

The cost of one cycle of oral contraceptives varies from 5–9 US$, one IUD from 12–15 US$ and a condom from 0,12–1,2 US$.

Abortion

Clinical abortions are performed in the obstetric/gynaecological departments of the existing public hospitals. The techniques of curettage and vacuum aspiration are both used.

The prevalence of unsafe abortion in Bulgaria is estimated at 52.3 per 100 000 women.
As from 1991, the Ministry of Health has imposed a tax on abortion services, based on the woman’s income, but ranging at approximately 33% of her monthly salary. Women under the age of 18 and abortions performed for medical reasons are exempted from this. The law also provides for post-abortion counselling and contraceptive advice, performed by midwives.

Recent trends in reproductive health

Bulgaria does not have a public policy specifically aimed at reproductive health, however, elements of reproductive health services are offered by public institutions (obstetric/gynaecological departments/offices). These institutions also offer reproductive health care services to adolescents. The Bulgarian Family Planning Association with support from IPPF is actively involved in all the reproductive health care services.

Steps to implement social marketing into reproductive health care services have not yet been taken.

Antenatal care

It is estimated that almost 100% of women in the country are given antenatal care through a high frequency of visits both at home by obstetricians/gynaecologists and midwives. Pregnant women visit consultancies of obstetrics and gynaecology: one visit monthly by the end of month V, one visit every two weeks in month VI, VII, VIII and one visit weekly in the last 45 days before delivery.

The checks that are undertaken routinely are: blood pressure, body weight urine, measurement of pelvis and two obligatory ultrasound examinations at the end of month V.

Although check up of blood sample for syphilis of pregnant women is obligatory, there is no data available at national level. The positive syphilis serology cases are included in the positive syphilis serology cases of the total population.

An average of 8.3 facilities have functioning comprehensive essential obstetric care per 500 000 population.

37.7% of obstetric and gynaecological admissions are estimated being due to abortion.

Breast and cervical cancer

The prevalence of breast cancer is estimated at 713.7 per 100 000 women and the prevalence of cervical cancer is 237.2 per 100 000 women.

Child health

The structure of registered diseases shows that accidents and poisoning are the major cause of child mortality. Pneumonia, followed by malignancies, takes second place.

There have been three polio outbreaks since 1960. All three outbreaks occurred after long periods of stability, and all three affected immunised or only partially immunised children mainly from the Gypsy ethnic minorities.

Adolescent health[7]

A state institution responsible for administering state policy in the field of youth and children's activities is the Committee of Youth, Physical Education and Sport (The Council of Ministers, 2 April 1997). According to the same Decree the main functions of the Committee of Youth, Physical Education and Sport is to form state policy concerning the activities related to youth, including:

- Participation in the working out a national strategy on young activities and coordination of putting it into practice.
- Development of acts and programs' projects connected with youth; offering these documents to the Council of Ministers and coordination of the realization.
- Cooperation for joining this country as a full member of international programs related to youth and coordination of activities connected with execution of country's duties on these programs.
- Presentation of this country at governmental authorities of other countries and intergovernmental institutions as well as international organizations in the field of youth activity and children's problems, physical education and sports.
- Assistance to national organizations in the field of physical education and sports, youth activities and children's problems particularly in the field of international cooperation.

In regards to reproductive health and family planning, the percentage of abortions among women under that age of 20 has increased from 9.1% in 1989 to 12.1% in 1998 (See Table 1B).

Table1B. Percentage of abortions among women under 20 years old, 1989-1998

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Abortions	9.1	9.9	9.2	10.6	11.6	11.2	11.4	11.6	11.4	12.1

Source: UNICEF ICDC, MONEE Country Reports, 1999.

During the first half of 1999 the government adopted a draft law on which prohibits the sale of spirits to persons under the age of 18 years. Data from 1995 indicated that alcohol abuse is widespread among the secondary school students. 8.0 % of respondents reported that they used spirits frequently, 56.8 % reported using sprits rarely and 35.2 % declared they do not use spirits.

The Areas for action and policy changes

- Need for development of a comprehensive reproductive health policy;
- Need for affordable contraceptives;
- Need for condom promotion,
- Support to IEC in reproductive health,
- Assistance to adolescent health projects needed;
- National interventions for the reduction of infant mortality should be directed towards the most frequent causes for death: asphyxia, pneumonia, prematurity related conditions, and congenital anomalities;
- Special attention to children from minority groups and children in difficult circumstances;
- Monitoring the effect of environmental pollution on child health;
- Acute respiratory infections control programmes should be considered.

[7] UNICEF ICDC, MONEE Country Reports, 1999.

Croatia

VARIABLES	PAST DATA	PRESENT DATA	⇧ ⇩
Population estimate (millions)	no data available	4.8 (1995)	
HDI value	no data available	0.773 (1999)	
HDI rank	no data available	55 (1999)	
GNP US$ (per capita)	no data available	3786 (1995)	
Women of fertile age (age 15-49)	1.149 mill (1994)	1.17 mill (1995)	⇧
Total fertility rate (per woman)	1.4 (1994)	1.5 (1995)	⇧
Maternal mortality ratio (per 100 000 live births)	10 (1993)	12 (1995)	⇧
Perinatal mortality (per 1000 births)	9.71 (1994)	8.82	⇩
Infant mortality rate (per 1000 live births)	11.1 (1994)	8.9 (1995)	⇩
Contraceptive methods used	75.8% OC	64.4% OC	⇩
Contraceptive prevalence rate	no data available	87.8% (1995)	
Contraceptive choice index	no data available	no data available	
Abortion rate (per 1000 women age 15-49)	27.2 (1993)	17.0 (1995)	⇩
Abortion:birth ratio < age 20	no data available	0.196:1 (1997)	
Abortion:birth ratio age 20-34	no data available	no data available	
Abortion :birth ratio age 35+	no data available	0.83:1 (1997)	
Abortion : birth-ratio, all ages	0.65:1 (1993)	0.4:1 (1995)	⇩
Birth rate (per 1000 population)	10 (1994)	11.2 (1995)	⇧
Maternal mortality from abortions (per 100 000 live births)	no data available	none reported (1997)	
Immunisation coverage: **Diphtheria-Tetanus / Pertussis** **Measles/Polio/Tuberculosis**	(1996): 91%, 91% 91%, 91%, 90%	 92% / 92% 93% / 92% / 98%	
STD/AIDS rates	16 AIDS cases (1995).	124 AIDS cases (1998) .	⇧

Health services

In previous years, the well developed health care system was relatively good compared with other countries of CEE and CIS, i.e. infant mortality was one of the lowest in the region, however, the situation has deteriorated due to the past war. Of particular concern are the immense numbers of displaced persons and refugees, constituting 15–18% of the total population. They present a huge challenge to the health system, which is already compromised because of war damage.

The health budget has been radically reduced and no new major items of equipment have been purchased for five years. Following the endorsement of a new health care act and health insurance act in 1993, the process of privatization of primary health care facilities has started.

The constitution of the Republic of Croatia provides for a special financial and legal protection of women and children.

A new system of professional supervision has been introduced, which is expected to result in improved quality of medical care.

Furthermore, special measures are being taken for preventing HIV transmission through blood and human plasma derivates.

Family planning

Within the framework of health care, citizens have the right to be informed on family planning methods and their effects and side effects.

Contraception

Oral contraceptives, IUDs and condoms are available in pharmacies. Oral contraceptives and IUDs are given on prescription and the cost is usually covered by the health insurance. Condoms must be purchased.

Abortion

The number of induced abortions has declined considerably in the time period 1987–1995, but is still very high. In 1995, there were 17 legally induced abortions per 1000 women of fertile age, compared to the 1987 figure of 49.92 legally induced abortions.

Recent trends in reproductive health

With an increase in the number of women of fertile age, a 37% decrease in abortion rates (1993 to 1995), a high contraceptive prevalence rate of 87.8% (1995), Croatia is witnessing an increase in the total fertility rate and birth rate, and possibly reflecting success in the family planning services within the framework of health care. Unfortunately, a trend of a 20% increase in maternal mortality ratio has been observed simultaneously with no specific reason given.

Antenatal care

(Maternal mortality --- see databox)
(Infant mortality ---see databox)
(Birth and fertility rate --- see databox)

Breast and cervical cancer

In the Republic of Croatia, every fifth death is caused by cancer, with lung cancer being the largest single contributor to total cancer death. The latest comprehensive data available from the National Cancer Register dates back to 1989. Mortality figures from 1993, show that malignant neoplasm of the breast rated 30.74 and malignant neoplasm of the cervix uteri rated 4.62 per 100 000 population.

Child health

In 1995, the most frequent causes of death in 1–4 years old are accidents and injuries (1/3 of total deaths at this age). This has been the predominant cause of death of small children for years. The second leading cause of death are congenital anomalies. The most frequent among them are cardiac

anomalies. Third leading cause of death in this age group are malignant neoplasm mostly of lymphatic and haemopoietic tissue.

Acute respiratory infections are the major causes of morbidity among pre-school children.
Among school children, the most frequent causes of death are injuries and poisoning, followed by neoplasm.

Compulsory immunisations in Croatia are against diphtheria, tetanus, pertussis, measles, rubella, parotitis and tuberculosis. Systematic immunisation has resulted in eradication of poliomyelitis and diphtheria, reduction of tetanus.

Adolescent Health[8]

The First Croatian Health Project, includes a sub-project named *Promoting of Health*, and is carried out in co-operation with teachers of biology and physical education, and covers a lot of children in basic and secondary schools. Some issues covered are: nutrition, smoking, responsible sexual behaviour and bodily activity. The Project *Health Promoting Schools* has been supported by UNICEF in co-operation with the Croatian Public Health Institute, the School of Public Health "Andrija Štampar" and the Ministry of Education and Sports. It comprises about 40 schools and was implemented 4 years ago.

In school curricula of basic and secondary schools there is no basic family planning or health education curriculum. As in most CEE and CIS countries, reproductive health issues are normally taught by biologists,

The average age when young people in Croatia have their first sexual experiences is 17. Their knowledge about sexuality is extremely low and most of young people consider sex education as a necessary class in school. One fourth of young people are not sexually active, and those who are active frequently use a condom, while 20% of them do not use any method of contraception.

Alcohol beverages are taken (often or sometimes) by 57% young people, while only 12% never drink alcoholic beverages. Soft drugs are taken by 14% young people, and 62% of them never took anything. Hard drugs are taken by 2% of young people, while 90% of them never tried any.

Areas for action and policy changes

- Strengthening of the professional supervision in the quality of medical care to prevent maternal deaths;
- Updating of medical equipment;
- Data collection;
- Needs assessment.

[8] UNICEF ICDC, MONEE Country Reports, 1999.

Czech Republic

VARIABLES	PAST DATA	PRESENT DATA (1997)	⇧ ⇩
Population estimate (millions)	10.3	10.3	
HDI (Human Development Index) value	0.872 (1993)	0.833 (1999)	⇧
HDI (Human Development Index) rank	37	36 (1999)	⇧
GNP US$ (per capita)	4190 (1994)	5240 (1997)	⇧
Women of fertile age (age 15-49)	2.25 mill (1995)	2.651.777	⇧
Total fertility rate (per woman)	1.28 (1995)	1.18	⇩
Maternal mortality ratio (per 100 000 live births)	11.57 (1995)	6.71 (1999)	⇩
Perinatal mortality (per 1000 births)	No data	7.7 (1995)	
Infant mortality rate (per 1000 live births)	7.7 (1995)	4.62 (1999)	⇩
Contraceptive methods used	OC, Condoms (1994)	Mainly condoms, IUD	
Contraceptive prevalence rate	No data	69% (1997)	
Contraceptive choice index	No data	75 /very good (1996)	
Abortion rate (per 1000 women age 15-49)	21.4 (1995)	16.4	⇩
Abortion:birth ratio < age 20	0.49:1 (1995)	0.1:1	⇩
Abortion:birth ratio age 20-34	0.57:1 (1993)	0.05:1	⇩
Abortion:birth ratio age 35+	2.46:1 (1995)	0.62:1	⇩
Abortion:birth ratio, all ages	0.5:1 (1995)	0.05:1	⇩
Birth rate (per 1000 population)	9.5 (1995)	8.8	⇩
Maternal mortality from abortions (per 100 000 live births)	0	1.12 (1999)	⇧
Immunisation coverage: **Diphtheria-Tetanus/Pertussis** **Measles/Polio/Tuberculosis**	(1996) 97% / 97% 97% / 98% / 96%	 98% / 98% 96% / 97% / 97%	
STD/AIDS rates	13 AIDS cases (1995)	112 AIDS cases (1998)	⇧

Health services

The Ministry of Health is responsible for health care legislation and manages regional hospitals. At a more local level, accessibility of the health services is the responsibility of the district authorities. An accreditation project aimed at enhancing quality standards in all hospitals and other health care facilities was initiated in 1995 by the Ministry of Health, health insurance companies and the associations of hospitals and health professional chambers.

91% of the health sector is financed by public sources and 9% by private sources. The estimated coverage needs met by public hospitals is 72% and 28% by private. Public polyclinics cover 25% of the needs and private polyclinics 75%.

Gynaecologists play a main role in the reproductive health services given in the Czech Republic. There are 2094 gynaecologists, compared to 5006 general practitioners.

100% of the population are covered by the present national health insurance system.
The country has adopted the Essential Drug Policy as recommended by WHO and have included contraceptives on the Essential Drug List.

95% of the national pharmacies are privately run, only 5% are public pharmacies.

It is estimated that there is a 100% general availability of drugs in the major regions of the Czech Republic.

Family planning

There is no national programme of family planning in the Czech Republic. Nor is there a national advisory group oriented toward such a programme, however, Health Order no.149/1994 prescribes the extent of services that must be provided by health institutions for women. Family planning services are provided by maternity hospitals, consultancies of obstetric/gynaecology, polyclinics PHC facilities and private practices of gynaecologists. The Czech Family Planning Association (SPRSV) is actively involved in family planning services.

All family planning counselling services are offered free of charge, covered by the national health insurance system. Gynaecologists and midwives are the health professionals that provide family planning counselling.

Adolescents do not need authorization to receive family planning services in the Czech Republic. Furthermore, the Ministry of Health and the Ministry of Education have developed a comprehensive sexual education programme for schools throughout the country.

Contraception

The main method of fertility regulation in the country is by the use of oral contraceptives (OC) followed by IUDs and condoms, all of which there is a reliable continuity of availability.
Contraceptives are not free of charge. One cycle of OC cost 2% of the average monthly salary, one IUD costs 5%, an implant is estimated at 70% and a condom at 0.08%. Injectable contraceptives are covered by health insurance.

All means of contraceptives are sold in pharmacies. A good availability of emergency contraceptives to the population are found in the gynaecological departments of the country.

Abortion

Clinical abortions are performed in the gynaecological departments in all hospitals. The techniques used for the performance of clinical abortions are curettage and vacuum aspiration. It is estimated that no unsafe abortions take place in the country. Clinical abortions made free of charge are only provided for health reasons, all other abortion requests must be paid for by the client. The price of an abortion is approximately 30% of an average monthly salary.

Both pre- and post abortion counselling is provided and performed by gynaecologists

Recent trends in reproductive health

In 1984, the Ministry of Health implemented a reproductive health policy: “Conception of Gynaecologic and Obstetric Care”.
Reproductive health care in most of the out-patient obstetric/gynaecology departments has been privatised. Adolescents are offered the same services in reproductive health care in the same manner as adults.

Social marketing is being implemented into the reproductive health care services by the Czech Family Planning Association. The financial aspects of this are covered by the national health insurance system.
Several international donor organisations are presently supporting special programmes in reproductive health care at both government and non-government level.

Antenatal care

Approximately 100% of women are given antenatal care in the Czech Republic. They are recommended ten visits altogether. The checks routinely undertaken at these visits are: vaginal examinations, various laboratory tests and three obligatory ultrasound examinations. 39 women showed a positive syphilis serology in 1997.

There are 130 obstetric/gynaecologic wards with 8152 beds in the country. All of these offer comprehensive essential obstetric care.

It is estimated that 6% of obstetric and gynaecological admissions are due to abortion.

Breast and cervical cancer

During 1976-1995, 29.018 cases of breast cancer and 12.083 cases of cervical cancer were registered by the National Cancer Register.

Child health

The Czech Republic has a very good record regarding perinatal care coverage, which has become almost universal.

Adolescent health[9]

The Czech Republic has established an innovative social prevention units focused on children and young people. They are aimed at reducing negative social phenomena and are situated in social services, district courts and local authorities.

The social prevention units are addressing many problems. Some problems revealed by statistics are a reported increase in STIs. This rise has been document in relation to a rise in street prostitution, hidden prostitution in erotic clubs and sexual tourism. The group most at risk are men and women aged 15-24. Statistics indicate that syphilis rates increased 10% between 1995 and 1997 and the number of congenital syphilis reached the highest level in the last 15 years.

A permanent increase in the use of drugs is reported from the beginning of the 1990s. Supply and availability of drugs has been on the rise, often at places where young people meet. The most frequently used addictive substance remains to be pervitin, but the use of heroine is growing significantly. The number of difficult drug addicts rose by 26% in 1997, compared with 1995. Alarming is the decreasing gap between male and female drug use and the declining age of users.

[9] UNICEF ICDC, MONEE Country Reports, 1999.

Youth aged 15-19 make up nearly half of all drug addicts. Approximately 55% of addicts use syringes, according to a study, *Public Health and Addictions in the Czech Republic*.

A 1996 sample survey found that 14.1% of men and 23.2% of women aged 15-24 were teetotallers for life. Among 15-24 year olds, 9% of men and 4% of women could be described as "excessive drinkers". However, there has been no statistical increase in alcohol use since 1993 among 15-24 year olds.

Areas for action and policy changes

- Integrated reproductive health programmes are needed;
- Further development of sex education in general;
- Strengthening the gynaecological care service;
- Assistance to adolescent health projects needed;
- Counselling for mothers on taking care of baby.

Hungary

VARIABLES	PAST DATA	PRESENT DATA	⇧ ⇩
Population estimate (millions)	10.2 (1996)	10.13 (1998)	⇩
HDI (Human Development Index) value	0.855 (1993)	0.795 (1999)	⇩
HDI (Human Development Index) rank	46 (1993)	47 (1999)	⇩
GNP US$ (per capita)	3840 (1994)	4402 (1996 GDP)	⇧
Women of fertile age (age 15-49)	2.2 mill (1994)	2.570.000 (1998)	⇧
Total fertility rate (per woman)	1.57 (1995)	1.38 (1997)	⇩
Maternal mortality ratio (per 100 000 live births)	10.38 (1994)	20.9 (1997)	⇧
Perinatal mortality (per 1000 births)	9.32 (1994)	8.16 (1995)	⇩
Infant mortality rate (per 1000 live births)	11.55 (1994)	9.9 (1997)	⇩
Contraceptive methods used	No data	38% OC, 18% IUD, 8% condoms	
Contraceptive prevalence rate	62% (1992)	73% (1993)	⇧
Contraceptive choice index	No data	75.0 /very good	
Abortion rate (per 1000 women age 15-49)	33.3% (1992)	28.9 (1997)	⇩
Abortion:birth ratio < age 20	No data	1.05:1 (1997)	
Abortion:birth ratio age 20-34	No data	No data	
Abortion:birth ratio age 35+	No data	2.16:1 (1997)	
Abortion:birth ratio, all ages	No data	0.76:1 (1997)	
Birth rate (per 1000 population)	11 (1994)	9.9	⇩
Maternal mortality from abortions (per 100 000 live births)	3.46 (1995) = 33%	4.0 (1997) = 19%	⇩
Immunisation coverage : Diphtheria-Tetanus/Pertussis Measles/Polio/Tuberculosis	(1996) 100% / 100% 100% / 100% / 100%	100% / 100% 100% / 99% / 100%	
STD/AIDS rates	31 AIDS cases (1995)	287 AIDS cases (1998)	⇧

Health services

The Hungarian Health Insurance Act is a basis for the development of a progressive financial and management mechanisms.

According to 1996 data, 80% of the pharmacies are privately run.

Hungary does not appear to have adopted the Essential Drug Policy as recommended by WHO. There is no systematic data on the general availability of drugs in the major regions of the country.

Family planning

Hungary does not have an actual national programme of family planning, but a Ministry of Family Protection was established in 1998. A national advisory group is oriented to activities of family planning. Family planning services are integrated into the national health service.

General practitioners, midwives and gynaecologists all have the authorization of providing family planning counselling to the population of Hungary. Family planning counselling is offered free of charge.

Contraception

The main methods of fertility regulation in Hungary are clinical abortion and the use of oral contraceptives, despite the fact that the law on legal abortion stipulates that abortion is not a family planning method. OCs are not free of charge, but the availability is reliable. Emergency contraceptives are also made available to the population, however, no systematic data on this exists as yet.

Abortion

It is estimated that the clinical abortion method of vacuum aspiration is used seven times as often as the curettage method.

Clinical abortion is available free of charge for women referred on medical indications. For social indications the price of a clinical abortion is approximately 20% of an average monthly salary of a woman.

Pre-abortion counselling is performed in Hungary by the Family Welfare Services. There is no indication that post abortion counselling takes place.

Recent trends in reproductive health

Hungary has no public policy specifically on women's health, even though some activities related to reproductive health are ongoing in the country. E.g. adolescents are offered reproductive health care services and the Family Welfare Services offer a range of activities.

In 1997, a Parliamentary Act on Health Care was adopted. The Act mainly addresses the extraordinary treatment of human reproduction, research on human embryos and gametes, and sterilization. The number of maternal mortalities from abortions indicate that reproductive health should become a priority in Hungary.

Nagycsaladosok Egyesulete and the Merce Association are both actively involved in reproductive health care services in Hungary.

Antenatal care

It is estimated that 99 % of women are given antenatal care. Altogether four visits are recommended, but data on the scope of these visits have not as yet been made available.

Breast and cervical cancer

All women examined by gynaecologists are screened for cervical cancer, as the gynaecologist is obliged to take a cytological smear. This has helped to recognise the disease in an early stadium, even in symptom-free patients. The mortality rate of cervical cancer in 1996 was 7.04 per 100 000 population.

Child health

Accidents and malignant neoplasm are the major causes of childhood mortality. The Debrechen hospital was the first "Baby-Friendly Hospital" in Europe.

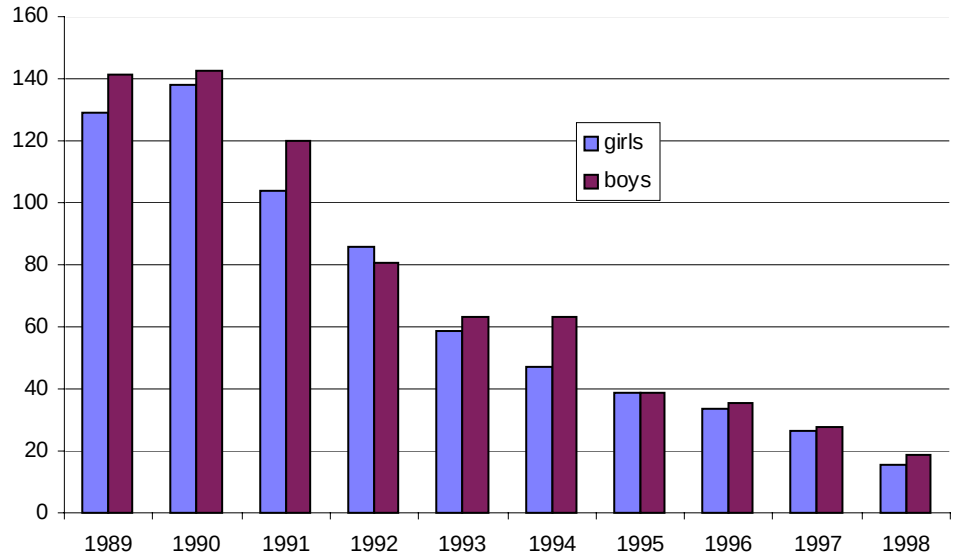
Adolescent health[10]

In the previous term of government, Youth Co-ordination Committee headed by a secretary of state was set up which was required to report to the Parliament annually. However, due to the reorganisation of ministries in 1998, a separate Youth and Sports Ministry was set-up whose responsibilities and authority concerning youth has not been fully developed.

In regards to reproductive health and family planning, for youth aged 20-24, the number of abortions per birth was higher than the average. In 1997 the abortion/birth ratio was one in women under 19 while women aged 20 to 24 had 35 thousand births and 19 thousand abortions. 68% of women 19 or under had their first abortions but nearly 70% of those 20 to 24 had been pregnant before.

As one tool to reduce the higher than desirable number of abortions, the "education for family life" program was introduced in the educational curriculum of schools. However, the degree of implementation and its successfulness have not been assessed. Other initiatives include the establishment of pilot teenager gynaecological clinics and emergency clinics where women can get an emergency contraception free of charge. Over 50% of the patients are under the age of 25 and can not afford regular contraceptive drugs.

Figure 1H. Gonorrhoea rates (per 100,000) for 15-19 year olds in Hungary, 1989-1998.



Source: UNICEF ICDC, Country Statistical Reports, 1999.

Drinking alcohol is a socially accepted behaviour. According to the survey slightly more than half of boys aged 15 to 19 and 37% of girls drink alcohol while 75% and 59% of males and females aged 20 to 29 do so.

[10] UNICEF ICDC, MONEE Country Reports, 1999.

According to an international comparative survey (ESPAD 99) in 1999, 36.8% of 16 year olds, as compared to 21% in 1995, have used prohibited substances or legal ones without a doctor's prescription, such as sedatives or sleeping pills sometimes combined with alcohol. The frequency of drug use significantly increases during the four years of secondary school. In Pest twice as many fourth grade pupils have tried one kind of drug or another than first year pupils, and in Budapest the rates are one fourth and one third, respectively.

Areas for action and policy changes

- Support to integrated reproductive health programmes;
- Strengthen the commitment to women's and infants' health by developing, improving and implementing health promoting policies and friendly health services to enhance sexual health and avoid unwanted pregnancies;
- Reduce maternal and infant mortality and increase maternal and infant safety;
- Introduce health education programmes with an emphasis on antenatal care/services and the promotion of healthy lifestyles;
- Assistance to adolescent health projects needed;
- Introduce health education programmes with an emphasis on antenatal care services and promoting healthy lifestyles;
- Strengthen the commitment to women's and infants' health by developing, improving and implementing health promoting policies and friendly health services to enhance sexual health and avoid unwanted pregnancies;
- Promote early and exclusive breastfeeding.

Poland

VARIABLES	PAST DATA	PRESENT DATA (1997)	⇧ ⇩
Population estimate (millions)	38.5 (1994)	38.64	⇧
HDI (Human Development Index) value	0.819 (1993)	0.851 (1995)	⇧
HDI (Human Development Index) rank	49 (1992)	52 (1995)	⇩
GNP US$ (per capita)	2470 (1994)	3 230 (1996)	⇧
Women of fertile age (age 15-49)	8.65 mill (1994)	10.17 mill	⇧
Total fertility rate (per woman)	1.8 (1994)	1.508	⇩
Maternal mortality ratio (per 100 000 live births)	11.1 (1994)	4.8 (1996)	
Perinatal mortality (per 1000 births)	No data	16.77 (1994)	
Infant mortality rate (per 1000 live births)	13.3 8 (1995)	12.21 (1996)	⇩
Contraceptive methods used	Mainly IUDs	OC, condoms, IUDs	
Contraceptive prevalence rate	11% (1995)	55%	⇧
Contraceptive choice index	No data	no data	
Abortion rate (per 1000 women age 15-49)	14 (1992)	no data	
Abortion:birth ratio < age 20	No data	no data	
Abortion:birth ratio age 20-34	No data	no data	
Abortion:birth ratio age 35+	No data	no data	
Abortion:birth ratio, all ages	0.22:1 (1992)	0.001.1(1995)	⇩
Birth rate (per 1000 population)	14.5 (1993)	11.3	⇩
Maternal mortality from abortions (per 100 000 live births)	3.332 (1994) =30%	no data	
Immunisation coverage: Diphtheria-Tetanus/Pertussis Measles/Polio/Tuberculosis	(1994) 96% / 95% 96% / 96% / 94%	98% / 97% / 98% /98% / 96%	
STD/AIDS rates	120 AIDS cases (1995)	627 AIDS cases (1998)	⇧

Health services

Deteriorating income levels and high inflation have reduced people's socio-economic status and living standards.

The need to protect the health of both young women and those after climacterium is not recognized by the state authorities. Only women of child bearing age are subject to special care. There is a lack of paediatric gynaecologists.

The deteriorating economical situation of the state of health care has affected the supposedly free services, forcing patients to use paid consultancies. (The situation of women in Poland, NGO paper, 1995)

Family planning

Family planning services are available through public hospitals, health centres and private clinics.

At present, family planning is constrained by a powerful conservative lobby in the Catholic church, influencing politicians. Government pronatalist policy seeks to maintain fertility levels through maternity leave, child benefits and child care.

Sex education is non-existent in schools, although the anti-abortion act obliged the subject to be entered into school curricula. The mass media are not publishing information material on safe sex and informed childbirth. Among the married couples who practice birth control at all, the most popular way is the natural rhythm method, the least reliable, but often recommended by doctors in rural areas. (The
Situation of Women in Poland, NGO paper, 1995)

Contraception

Contraceptives are available in pharmacies and the social insurance reimburses the cost of the contraceptives.

Information suggests that there is no guarantee of wide availability of contraceptives and that contraceptives on sale in pharmacies are too expensive for the average citizen. A representative study of fertility in 1991 revealed that 80% of mothers did not use any contraceptive measures at all before having their first two children.

Modern and highly effective contraceptives (oral contraceptives and IUDs) are used by no more than 11% of the Polish adult population, a decline in use of more than 50%. (The situation of women in Poland, NGO paper, 1995)

Abortion

The February 1993 anti-abortion law deprived women of the right to control fertility by abortion; all the more serious with the regular contraceptive shortages. Some hospitals have ceased performing abortions, further constraining poor women, forcing women to visit expensive private gynaecologists or to seek abortion abroad, and risking women's health. This explains the lack of available abortion data.

Recent trends in reproductive health

The 1993 anti-abortion law appears to be taking its toll. A drop in contraceptive prevalence rate of 57% from 1992 to 1995, a 15% decline in fertility rate, and 30% of maternal mortalities from abortion reflects a women’s health care service, that by law has deprived women of the right to control fertility, and in need of obstetrical/gynaecological care services.

In the time period of 1990-1995 infant mortality rate fluctuated between 15.9 to 13.3. So despite an increase from 1993 to 1995 the overall trend is a decrease in infant mortality rates.

Antenatal care

Over 99 % of births are medically attended. The maternal mortality ratio has been stable at 11 per 100 000 live births in the period of 1992–1994, however, in rural areas increasing maternal mortality reflects limited access to services. 30% of all maternal mortalities in 1994 were due to abortions.

Breast and cervical cancer

An estimated 8000 women per year suffer from breast cancer, half of these die, mainly due to late diagnosis. Half as many women died from cancer of the cervix uteri as of cancer of the breast. (The situation of women in Poland, NGO paper, 1995)

Child health

Ninety-nine percent of deliveries take place in institutions and four out of five are performed by obstetricians-gynaecologists. The remainder are performed by professional midwives. Higher infant mortality rates in rural areas reflect limited access to services.

Insufficient nutrition, avitaminoses, infectious diseases, high prevalence of dental caries, psychological problems and accidents are the main health problems of children

Most infectious diseases are under control. The immunisation programme is comprehensive, however, Hepatitis B is still endemic in Poland (1% of the population), and its incidence among children is abnormally high due to negligence of health staff in sterilizing materials or reusing of disposables. Tuberculosis meningitis still occurs in children less than five years of age.

Adolescent health[11]

The transition from youth to adult life is easier for those who get some support from their family and parents in the adaptation to the changing life conditions and changing socio-economic and political roles. Being close to Germany, the effects of the West have contributed to Poland economically advancing quicker than its neighbours and introduced many problems associated with open borders.

The problem of prostitution among minors has not been extensively studied. During the transition period there has been a growing number of minor girls entering prostitution as a lifestyle or additional source of income. These girls attend schools or work on week days and sell sex on weekends and holidays. There is even a phenomenon known as occasional weekend prostitution.

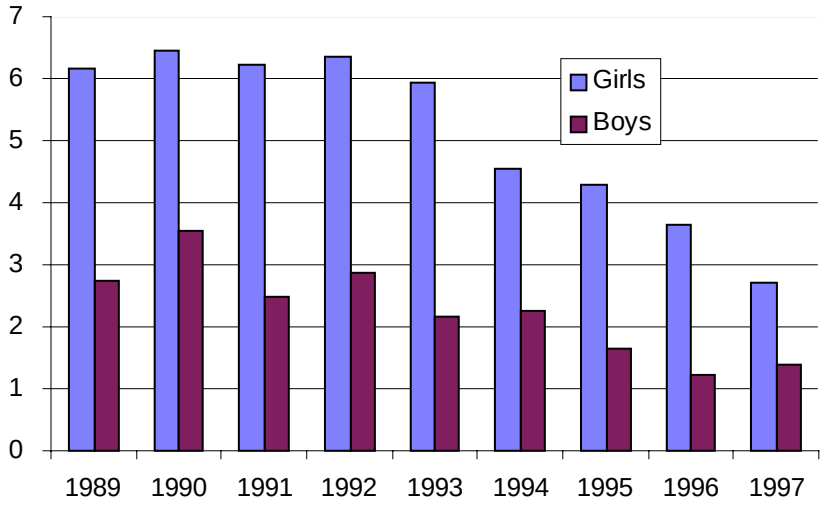
It is difficult to get information regarding the sexual and reproductive health of youth in Poland given the cultural values and strict Catholic mores. However, some data is presented. Young women, more so than young men, are the parents of children. (See Table 1P).

Table 1P Live births from parents under the age of 25. Poland (%)

		Total Births	Father's age		Mother's age	
			19 years and under	20-24 years	19 years and under	20-24 years
Total	1990	100,0	1,7	21,5	8,0	36,5
1995		100,0	1,5	21,4	8,0	36,1
1998		100,0	1,3	20,1	7,7	35,3

[11] UNICEF ICDC, MONEE Country Reports, 1999.

Figure 1P. Syphilis rates (per 100,000) for 15-19 year olds in Poland, 1989-1997.



Source: UNICEF ICDC, Country Statistical Reports, 1999.

The respondents are not willing to decline drinking alcohol. In 1988, 13% of respondents aged 15 years admitted that they had drunk alcoholic beverages 1-4 days before the survey, while in 1992 the respective figure was 20%. According to the survey carried out in 1996, 38.2% of men and 47.3% of women at the age of 25 and under did not drink any alcohol during one year preceding the survey.

Drug addiction affects people from adolescence to forty year-olds. The initiation of drug use is most frequently noted at the age of 15 and over.

Areas for action and policy changes

- Strengthen the commitment to women's health by developing, improving and implementing health promoting policies and friendly health services to enhance sexual health and avoid unwanted pregnancies;
- Promotion of early and exclusive breastfeeding;
- Identification of possible contributing factors to the high incidence of premature births and low birth weight rate is needed;
- Improving perinatal and neonatal care, including upgrading emergency transportation system for new-borns;
- Increase information on family planning in the population;
- Make contraceptives widely available;
- Strengthen youth services;
- Assistance to adolescent health projects needed.

Romania

VARIABLES	PAST DATA	PRESENT DATA (1997)	⇧ ⇩
Population estimate (millions)	22.8 (1995)	22.545.925	⇩
HDI (Human Development Index) value	0.738 (1993)	0.752 (1999)	⇧
HDI (Human Development Index) rank	74 (1993)	68 (1999)	
GNP US$ (per capita)	1230 (1994)	3975	⇧
Women of fertile age (age 15-49)	5 mill (1994)	5.819.541	⇧
Total fertility rate (per woman)	1.4 (1994)	1.30	
Maternal mortality ratio (per 100 000 live births)	47.8 (1995)	41.4	⇩
Perinatal mortality (per 1000 births)	12.48 (1995)	12.63	
Infant mortality rate (per 1000 live births)	21.2 (1995)	22.0	⇧
Contraceptive methods used	Mainly natural methods	Mainly condoms, OC	
Contraceptive prevalence rate	11% (1992)	51.5 %	⇧
Contraceptive choice index	No data	41.7 /fair (1996)	
Abortion rate (per 1000 women age 15-49)	100.6 (1995)	59.6	⇩
Abortion:birth ratio < age 20	0.98:1 (1993)	0.03:1	⇩
Abortion:birth ratio age 20-34	2.5:1 (1992)	0.1:1	⇩
Abortion:birth ratio age 35+	No data	0.3:1	
Abortion:birth ratio, all ages	2.1:1 (1995)	1.5:1	⇩
Birth rate (per 1000 population)	10.4 (1995)	10.5	⇧
Maternal mortality from abortions (per 100 000 live births)	24.9 (1995) = 52%	21.1 = 50.9%	⇩
Immunisation coverage : **Diphtheria-Tetanus / Pertussis** **Measles/Polio/Tuberculosis**	(1996) 98% / 98% 94% / 97% / 100%	 97% / 97% 97% / 97% / 98%	
STD/AIDS rates	686 AIDS cases (1995)	5280 AIDS cases (1998)	⇧

Health services

Virtually all the health sector is financed by public sources, with the exception of 1% private sources.
The various health professionals relate to reproductive health services as follows: general practitioners and obstetric/gynaecology specialist nurses take care of family planning services; general practitioners, specialist doctors and nurses take care of the other elements of reproductive health care services.

Romania has not implemented a health insurance system as yet. Neither has the country adopted the Essential Drug Policy as recommended by WHO.

95% of the national pharmacies are privately run, with the state only running 5%. The general availability of drugs in the major regions are estimated to be good.

Family planning

The national programme of family planning commenced implementation in Romania in 1992. The programme is implemented through the family planning and sex education unit in the Department

for Mother and Child Care in collaboration with other departments such as the National Centre for Health Promotion, the National Centre for Post-graduate Training, etc.
Family planning services are provided in maternity hospitals, consultancies of obstetric/gynaecology and polyclinics. Some, but not all, general practitioners, PHC facilities and private practices also provide family planning services. The Romanian Family Planning Association is actively involved in the national family planning programme. Some NGOs aiming at youth are also cooperating the national family planning programme.

Family planning counselling are offered free of charge and are provided by some general practitioners, gynaecologists and midwives.

Adolescents do not need an authorization to receive family planning services in Romania.

Contraception

The following methods of fertility regulation are regarded as likewise feasible in Romania: clinical abortions, IUDs, oral contraceptives (OC), condoms and natural methods. Abortions and contraceptives are regarded as being available in a reliable continuity.

Contraceptives are not free of charge for the general population, but are free for certain specific groups such as women with chronic diabetes and female students.

The charge is nominal and based on a cost recovery scheme for those contraceptives that are of high quality (WHO standards) and are procured by the Ministry of Health using public sector funds (World Bank loan). The cost in proportion to monthly salary is based on the above cost recovery scheme. The prices are affordable, however, contraceptives sold in pharmacies and directly supplied by pharmaceutical companies are very expensive from 3.5–8 times the cost of the ones supplied by the Ministry of Health.

OCs, IUDs, injectable contraceptives and condoms are sold by pharmacies. Emergency contraceptives have been made available to the population through the family planning facilities and through some private facilities.

Abortion

Clinical abortions are performed in maternity hospitals and in some private clinics. The main technique used for clinical abortion is vacuum aspiration. In some facilities the technique of curettage is used.
It has been estimated that 50% of maternal mortalities are due to unsafe abortions, but the actual data on unsafe abortion is not available. Clinical abortions performed on the grounds of medical (health) reasons (RU486) are as yet not available for women in Romania.

Clinical abortions are not free of charge, the cost being approximately 5% of the average monthly salary.

Both pre- and post abortion counselling is provided in Romania by family planning doctors and nurses.

Recent trends in reproductive health

Romania has an implicit policy on reproductive health encountering the organized family planning programme, a maternal care programme and a STI programme. Certain parts of the privatized health sector provide abortion services, contraceptives and STI detection.
The country offers reproductive health care services to adolescents through all specific facilities.
Social marketing has been introduced via contraceptive products distribution through both governmental and NGO family planning clinics - Romanian Family Planning Association.
The international donor organizations active in Romania are mainly involved in contraceptive supply, IEC and training activities.

Antenatal care

It is estimated that approximately 60% of urban women and 40% of rural women are given antenatal care. A minimum of 6 visits are recommended. The checks routinely undertaken are: general check-up, weight, blood pressure, various laboratory tests and ultrasound examinations on a voluntary basis. There are no standard recommendations for ultrasound examinations. There is no available data on the percentage of women attending antenatal care showing a positive syphilis serology.

Data has been unobtainable as to what percentage of obstetric and gynaecological admissions are due to abortions.

Breast and cervical cancer

The prevalence of breast cancer in Romania in 1996 was 35.3/10.000 women equivalent to 4073 women in absolute numbers. The prevalence of cervical cancer in 1996 was 22.6/ 10.000 women equivalent to an absolute number of 2610 women.

Child health

Hospitalisation of children with minor illnesses is common.

Environmental factors worsen the health of children by increasing the incidence of enteric and respiratory diseases due to problem of quality of water and control of pollution.

The main causes of mortality between 1.4 years of age are acute respiratory diseases, accidents and trauma, and neoplasm.

Rubella and mumps and routinely reported. A high prevalence of acquired immune deficiency syndrome (AIDS) is found among young children in orphanages due to virus contamination via blood transfusions and the failure to use sterilized needles and syringes.

Adolescent health[12]

The position of youth in Romania has changed dramatically in the last years as increased efforts have been made to assess the health and well-being of young people. A survey on youth reproduction health (1996) was carried out with a sample of people aged 15-24 years. Data analysis showed that 77% of women stated they have been pregnant at least once, that almost a quarter were pregnant before 18 years old. The percentage of undesired pregnancies was higher for women in urban area and for those aged 20-24 years. The percentages among both variables were significantly higher for unmarried women.

Since 1993, the time of the last survey, the level of accidental pregnancies was practically unchanged for women aged 15-19 years and slightly decreased for those of 20-24 years old.

The survey also revealed that among both men and women, the age of initial alcohol consumption was low. For men, 45% started before 13 years of age and 84% before 18 years of age. For women 7% and 38% initiated alcohol consumption, respectively. Women had a lower rate of "frequent drinking" as compared to men (2% versus 19%). Alcohol consumption is much higher in rural than in urban area.

Areas for action and policy changes

- A further development and improved efficiency of the family planning programme;
- Development of a national reproductive health policy;
- Strengthening obstetrical care services;
- Reducing maternal mortality by taking actions on reducing abortions, haemorrhage and infections;
- Developing and improving the prevention action and care of children's health, including ante- and post natal care;
- Restructure and re-equip child institutions and retrain staff;
- Reduce low-birth weight to 6% by 1999;
- Strengthen consumer demands for contraceptives rather than for abortions;
- Assistance to adolescent health projects needed, particularly health promotion and youth counselling and education services.

[12] UNICEF ICDC, MONEE Country Reports, 1999.

Slovakia

VARIABLES	PAST DATA	PRESENT DATA (1997)	⇧ ⇩
Population estimate (millions)	5.8 (1995)	5.387.000	
HDI (Human Development Index) value	0.864 (1993)	0.813 (1999)	⇩
HDI (Human Development Index) rank	41 (1995)	42 (1999)	⇩
GNP US$ (per capita)	2230 (1994)	2695 (1996)	⇧
Women of fertile age (age 15-49)	1.2 (1995)	1.246.846 (1996)	⇩
Total fertility rate (per woman)	1.66 (1995)	1.47 (1996)	⇩
Maternal mortality ratio (per 100 000 live births)	10 (1995)	3.37 (1997)	⇩
Perinatal mortality (per 1000 births)	No data	7.76 (1997)	
Infant mortality rate (per 1000 live births)	15.6 (1994)	8.66 (1997)	⇩
Contraceptive methods used	Mainly natural methods	OC (10.2%) IUD (5.4%)	
Contraceptive prevalence rate	34% (1992)	74% (1999)	⇧
Contraceptive choice index	No data	68.8 /good (1996)	
Abortion rate (per 1000 women age 15-49)	23.5 (1995)	15.2	⇩
Abortion:birth ratio < age 20	No data	0.307:1	
Abortion: birth ratio age 20-34	No data	0.305:1	
Abortion: birth ratio age 35+	No data	1.41:1	
Abortion:birth ratio, all ages	0.57:1 (1995)	0,373:1	⇩
Birth rate (per 1000 population)	14 (1994)	10.86	⇩
Maternal mortality from abortions (per 100 000 live births)	No data	1.68 (1997)	
Immunisation coverage : **Diphtheria-Tetanus/Pertussis** **Measles/Polio/Tuberculosis**	(1996) 99% / 98% 98% / 99% / 97% (1993)	 99% / 98% / 98% / 98% / 90%	
STD/AIDS rates	2 AIDS cases (1995)	18 AIDS cases (1998)	⇧

Health services

The Slovak health sector is mainly financed by public sources (94%). The other 6% stem from private sources. With the exception of two hospitals and two polyclinics in the whole of Slovakia, all hospitals and polyclinics are publicly run.

The health professionals take up different functions in reproductive health service provision. Gynaecologists, sexologists, genetologists and urologists work in out-patient departments or in hospitals, diagnosing and treating reproductive health problems. This includes infertility, prenatal genetic diagnosis, prenatal and obstetrics care. Psychologists work in counselling centres providing psychological support for men and women with partnership problems.

Health insurance is obligatory in Slovakia, covering the entire population.

Although the country has adopted the Essential Drug Policy as recommended by WHO, the Essential Drug List does not include contraceptives.

The main proportion of the pharmacies in the country are privately run. Only 5% are run by public sources.

There is a general availability of drugs in the major regions of the country, however, economical problems, such as the insufficient cash flow of health insurance companies, do at times cause a problem of sufficient supply.

Family planning

The implementation of the national programme of family planning was commenced in 1992. However, family planning does not appear to be a priority programme of the government as yet. There is no specific advisory group oriented toward the programme of family planning. There is, however, an advisory group oriented toward the national programme of health support works.

Family planning services are provided by maternity hospitals, polyclinics, PHC facilities and private practices. Family planning counselling is offered free of charge in Slovakia by gynaecologists.

Adolescents under the age of 15 need an authorization to receive family planning services in Slovakia. The Slovak Family Planning Association is actively involved in the national programme of family planning.

Contraception

The main method of fertility regulation in Slovakia is as yet clinical abortion. Oral contraceptives and IUDs are growing in popularity, but natural methods is still seen as a widely used method. There appears to be a reliable continuity of availability of oral contraceptives and IUDs.

Most contraceptives are not free of charge in Slovakia. Injectable contraceptives are free of charge and IUDs cost very little. It is estimated that the cost of one cycle of oral contraceptives is equivalent to 1.2% of an average monthly salary. Condoms (estimated to be seldom used) cost 5Sk per one piece.

The contraceptives sold in pharmacies are oral contraceptives, IUDs, diaphragms and spermicides.

There appears to be an availability of emergency contraception in the obstetric and gynaecologic departments. But the public have seemingly not been well informed about this possibility.

Abortion

Clinical abortions are only performed in hospitals at an average cost of 36% of a monthly salary. The curettage and vacuum aspiration techniques are used, as well as the method of prostaglandin in the second trimester on the basis of genetic indications.

It has been estimated that there no unsafe abortion takes place in Slovakia. Pre- and post abortion counselling is not obligatory in Slovakia. The gynaecologists provide the counselling at the first visit after an abortion.

Recent trends in reproductive health

The implementation of the Slovak reproductive health policy was commenced in 1992. The parts of the reproductive health care that has been privatised in the country are primary gynaecological care in out-patient departments. Both these institutions and special services in hospitals offer reproductive health care services to adolescents.

As yet no steps have been taken to implement social marketing into the national reproductive health care services.

Due to good and sufficient official networks, it is estimated that there is no need for the active involvement of NGOs in the Slovak national reproductive health care services.

International donor organisations are a part of this official network. UNICEF supports a hotline for abused children. The SOROS Foundation, USAID, EU PHARE/TACIS programme sponsor various activities. IPPF gives technical and financial support to the Slovak Family Planning Association.

Antenatal care

It is estimated that 98% of women in Slovakia are given antenatal care. 10 visits are recommended. During these visits checks such as blood pressure, blood count and group, BWR, HbsAg, HIV on request, alfa-feto protein in blood and amniotic fluid, rubella, three obligatory ultrasound examinations, PAP smear, urine and cultivations from the vagina are done.

There is, however, no systematic data on what percentage of obstetric and gynaecological admissions are due to abortion. Neither is there any systematic data on what percentage of women attending antenatal care show a positive syphilis serology.

There does not seem to exist data on the number of facilities that have functioning basic and comprehensive obstetric care per 500 000 population.

Breast and cervical cancer

There appears to be no present systematic data on the prevalence of breast and cervical cancer of women in Slovakia, despite the increase of overall cancer mortality. The latest data of 1993 indicates a breast cancer mortality rate of 14.4 per 100 000 population.

Child health

Accidents are the main causes of childhood mortality.

Breastfeeding is supported by all hospitals by a programme which introduced rooming-in system and educates the public about the benefits of breastfeeding.

Adolescent health[13]

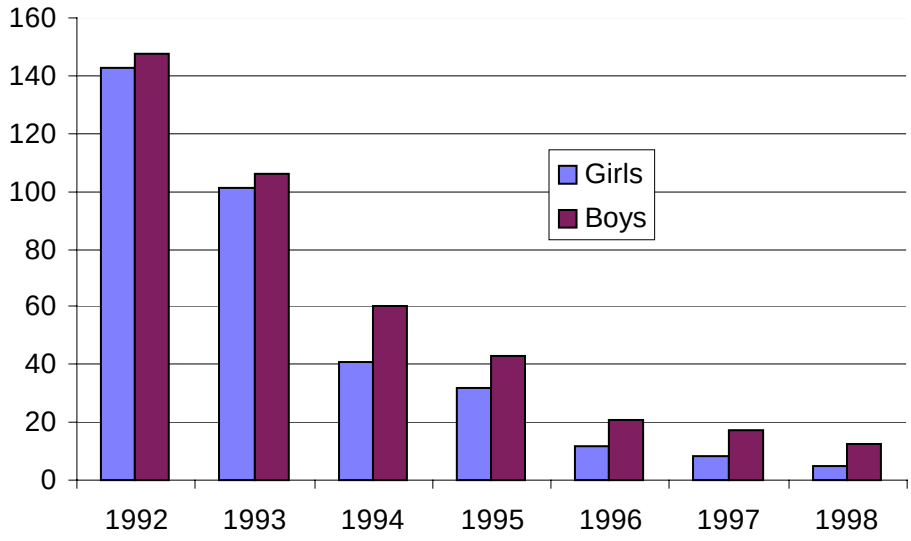
The new socio-economic situation in Slovakia after 1989 has brought many changes in the reproduction behaviour of young people. On the one hand, the economic transformation, development of entrepreneurial activities, reconstruction of economics and other facts have led to the creation of an increased economic independence of families; on the other hand, the risk of economic instability has increased among young persons and families due to the decline of their living standard and rise of social dependence.

The Ministry of Education deals with the problems of young people within the frame of its competence. There are also centres of diagnostics that take care of problem juveniles and those with mental or physical handicaps. The Slovak Radio and Slovak TV regularly present various educational programs and discussions about the problems of the young people.

Marriage at a very young age (16, 17 years) and childbirth up to 15 years are not widespread in Slovakia. Since 1989 till the end of 1998 there were 384 live births, on the average 38-39 children a year among 12-14 year olds, one live-birth per 1.000 girls.

Data on STIs is limited, however data from the UNICEF ICDC indicates a dramatic drop in gonorrhoea, but mentions the problems associated with reporting such illness to the physicians. See Figure 1SL.

Figure 1SL. Gonorrhoea rates (per 100,000) for 15-24 year olds in Slovakia, 1992-1998



Source: UNICEF ICDC, Country Statistical Reports, 1999.

The total consumption of alcoholic drinks in Slovakia decreased in 1998 in comparison with 1997 by 6.9l/inhabitant/year and is 110 litres per person. The decrease was attributable to beer consumption which decreased by 7.7%.

[13] UNICEF ICDC, MONEE Country Reports, 1999.

In 1997, 38 patients (26 males, 12 females) up to 14 years old, were treated for drug addiction (Source: Health Statistics Yearbook of the Slovak Republic 1997, UZIS Slovakia). This group of patients constituted 1.8% of all drug addict patients. 20 to 24 year olds were the largest group, 646 males and 166 females.

Areas for action and policy changes

- Comprehensive policies to promote the health of women need to be developed involving all stages of a woman's life;
- Advocacy for legal reforms on abortion and sterilisation;
- Information, Education and Communication activities needed;
- Assistance to adolescent health projects needed, particularly health promotion and youth counselling and education services;
- Acute respiratory infections control programme and acute disease control programme should be extended;
- Antenatal and perinatal care services should be strengthened.

Slovenia

VARIABLES	PAST DATA	PRESENT DATA (1997)	⇧ ⇩
Population estimate (millions)	1.99 (1996)	1.98	⇩
HDI (Human Development Index) value	No data	0,886 (1994)	
HDI (Human Development Index) rank	No data	38th place (1994)	
GNP US$ (per capita)	9348 (1994)	9161	⇩
Women of fertile age (age 15-49)	454 257 (1995)	518 307	⇧
Total fertility rate (per woman)	1.4 (1995)	1.25	⇩
Maternal mortality ratio (per 100 000 live births)	8.4 (1995)	26.7 (1996)	⇧
Perinatal mortality (per 1000 births)	5.04 (1995)	5.6	
Infant mortality rate (per 1000 live births)	5.2 (1995)	4.76	⇩
Contraceptive methods used	Mainly IUDs, OC.	OC, IUD, condoms	
Contraceptive prevalence rate	40% (1993)	70.5%	⇧
Contraceptive choice index	No data	no data	
Abortion rate (per 1000 women age 15-49)	27.4 (1995)	18.7	⇩
Abortion:birth ratio < age 20	No data	1.6:1	
Abortion:birth ratio age 20-34	No data	0.4:1	
Abortion:birth ratio age 35+	No data	1.8:1	
Abortion:birth ratio, all ages	0.65:1 (1995)	0.5:1	⇩
Birth rate (per 1000 population)	10 (1994)	9.2	⇩
Maternal mortality from abortions (per 100 000 live births)	0 (1995)	no deaths registered	
Immunisation coverage: Diphtheria-Tetanus/Pertussis Measles/Polio/Tuberculosis	(1994) 98% / 98% 91% / 98% / 99%	94% / 92% / 82% / 91% / 97%	⇩
STD/AIDS rates	14 AIDS cases (1995)	66 AIDS cases (1998)	⇧

Health services

The health services in Slovenia are financed mainly by public sources: 88%, and 12% by private sources. It is estimated that the population needs for hospitals and polyclinics are fairly well covered by the present number of institutions. There are as yet no private hospitals in Slovenia, however, one or two polyclinics are in progress to function on a private basis.

The provision of reproductive health services is covered mainly by gynaecologists working at community health centres or at private clinics. At times gynaecologists working in ob-gyn departments are asked by the patient to provide reproductive health service. In rural settings, the general practitioner provides the services.

The Slovenian population is covered by a compulsory health insurance. It is estimated that 97% of the population have an additional health insurance.

Slovenia has not adopted the Essential Drug Policy as recommended by WHO, but has instead a broader assortment of drugs grouped in three to offer. The first group of drugs are free of charge and covered by the compulsory health insurance and are defined as essential drugs. The second group are drugs free of charge for those who pay the additional health insurance. The third group consists of drugs free on the commercial market, to which the full price has to be paid.

An estimated 75% of the pharmacies are public run and 25% privately run.

There is no data indicating a shortage of drugs in the major regions of Slovenia.

Family planning

The national family planning programme in Slovenia dates back to the 60's, when routine family planning and contraceptive counselling were implemented at primary and secondary health level. According to a new health law from 1992, National Guidelines for Implementation of Preventive Reproductive Health Care were adopted by the government in March 1998.

There is no advisory group orienting the programme of family planning in Slovenia.

The following institutions provide family planning services in Slovenia: consultancies of obstetrics and gynaecology, polyclinics, some private practices and PHC facilities and sometimes general practitioners. The main professional providing these services are gynaecologists.

Family planning counselling services are offered free of charge by her personal gynaecologist, who in most cases have a contract with the national health insurance.

Adolescents do not need an authorization to receive family planning services in Slovenia.

There are no NGOs involved in family planning activities in Slovenia

Contraception

The main method of fertility regulation in Slovenia is the use of oral contraceptives. It is estimated that there is a reliable continuity of oral contraceptives available in the country. Most contraceptives are free of charge with the exception of condoms and diaphragms. The cost of these compared to an average salary are respectively 1% per 20 condoms and 2.5 % .

IUDs and implants cannot be purchased in pharmacies. The IUDs are purchased directly by the health services and refunded by the compulsory health insurance.
Emergency contraceptives are available in Slovenia at family planning clinics in community health centres, gynaecological consultancies and ob-gyn hospitals.

Abortion

Clinical abortions are mainly performed at ob-gyn hospitals and in some consultancies. The vacuum aspiration and prostaglandin are the main techniques used for the performance of clinical abortions.
According to present hospital statistics and mortality statistics, there is no indication that unsafe abortions are performed in Slovenia.

Clinical abortion is free of charge for those who have an additional health insurance. For the rest, the women have to pay an average of 5% of a monthly salary. It is estimated that a clinical abortion would cost a woman 50% of a monthly salary, if she did not have a health insurance.

There is no surveillance mechanism that ensures women are given pre-abortion counselling, but it is reckoned to be common practice. This also applies for post-abortion counselling, which is done at a regular check-up four weeks after the abortion.

Recent trends in reproductive health

Slovenia has a reproductive health policy included in the national health plan to year 2000, which has been adopted by government, but not yet approved by the Parliament. There are a few private gynaecologists practising at primary health level in Slovenia. The country offers reproductive health care services to adolescents through the outpatient consultancies at community level, spread evenly throughout the country. No steps have been taken in Slovenia to implement social marketing into the national reproductive health care services. There are no NGOs actively involved in the national reproductive health care services.

Antenatal care

It is estimated that 98% of women are given antenatal care in Slovenia. Usually ten visits are recommended for a normal pregnancy by in average around seven are actually performed. There is no data on the number of facilities which have functioning basic essential obstetric care per 500 000 population, however, it is estimated that 14 maternity hospitals per 500 000 women in reproductive age have functioning comprehensive essential obstetric care. There is no obligatory registration of pregnant women attending antenatal care showing a positive syphilis serology.

It is estimated that the percentage of obstetric and gynaecological admissions due to the incidence of abortion is very low in Slovenia.

Two ultrasound examinations are recommended to pregnant women, paid by the health insurance. The examinations are voluntary for the women to undergo.

Breast and cervical cancer

It is estimated that the incidence of breast and cervical cancer in Slovenia is increasing. In 1995, there were 77 breast cancer cases per 100 000 women, and 21 cervical cancer cases per 100 000 women.

Child health

The greatest decline of infant mortality has been observed in respiratory diseases. The major causes of infant mortality are now perinatal conditions and congenital anomalies.

Adolescent health[14]

In 1991 the Office of the Republic of Slovenia for Youth was established within the Ministry of Education and Sport. The office is responsible for the informal sector education of youth. It supports youth organisations and other non-governmental organisations in implementing projects

[14] UNICEF ICDC, MONEE Country Reports, 1999.

intended for the young; it educates and trains youth in managing youth organisations and implementing projects; it helps in establishing youth centres and lodging; it co-operates with the Centre for Social Psychology at the Faculty of Social Sciences, and is the co-editor of the Juventa series which publishes academic research. The advisory body of the Office of the Republic of Slovenia for Youth is the Joint Commission for Youth Issues, which includes representatives of the Youth Council. This assures the influence of non-governmental structures on the formation of the youth policy.

In regards to reproductive health and family planning, almost three quarters of youth were using contraceptives at first intercourse. Adolescent girls had higher rates at first intercourse than their male counterparts. Secondly, those that were not using contraception at first intercourse started using contraception soon after. The median age at first contraceptive use is also 16 years, the same as their median age at first intercourse (Kožuh et al., 1998).

Abuse of alcohol has been cited as one behavioural risk. A survey in 1995 showed that young people in Slovenia have a high level of abuse which may be attributed to the social acceptability of drinking at a young age.

Areas for action and policy changes

- Strengthen the pre- and post abortion counselling;
- Improve the knowledge, attitude and behaviour of adolescents through the introduction of family planning/reproductive health services and the provision of IEC (information, education, communication);
- Strengthening acute respiratory infections control programme.

The Former Yugoslav Republic of Macedonia (FYROM)

VARIABLES	PAST DATA	PRESENT DATA (1997)	⇧ ⇩
Population estimate (millions)	1.5 (1994)	2.1 (1995)	⇧
HDI value	no data available	0.746 (1997)	
HDI rank	no data available	73 (1999)	
GNP US$ (per capita)	no data available	1,100	
Women of fertile age (age 15-49)	462 000 (1994)	no data available	
Total fertility rate (per woman)	1.9 (1994)	2.1 (1997)	
Maternal mortality ratio (per 100 000 live births)	12 (1991)	15.62 %	
Perinatal mortality rate (per 1000 births)	20.20 (1994)	19.42 (1995)	⇩
Infant mortality rate (per 1000 live births)	24.5 (1994)	20 (1997)	⇩
Contraceptive methods used	Mainly OC, IUDs	no data available	
Contraceptive prevalence rate	39 % (1994)	no data available	
Contraceptive choice index	no past data	no present data	
Abortion rate (per 1000 women age 15-49)	54.4 (1994)	no data available	
Abortion:birth ratio < age 20	no data available	no data available	
Abortion:birth ratio age 20-34	no data available	no data available	
Abortion :birth ratio age 35+	no data available	no data available	
Abortion : birth-ratio, all ages	0.85:1 (1994)	0.48:1 (1997)	⇩
Birth rate (per 1000 population)	16 (1994)	no data available	
Maternal mortality from abortions (per 100 000 live births)	no data available	no data available	
Immunisation coverage **Diphtheria-Tetanus/Pertussis** **Polio/Measles/Tuberculosis**	(1995): 95% / 94% 95% / 97% / 95%	 97% / 97% / 98% / 97% / 96%	
STD/AIDS rates	2 AIDS cases (1995)	25 AIDS cases (1998)	⇧

Health services

Health authorities report that there is an urgent need for contraceptive supplies. The status of antenatal care appears to be much lower than many other countries in the region. Less than half of all pregnant women are covered by regular antenatal care. There is concern that the quality control of blood safety is not always assuring.

Family planning

About 17% of women's visits to health centres and doctors are related to family planning. The counselling of individuals regarding contraception is at present almost exclusively the responsibility of obstetricians and gynaecologists, who practice in specialized family planning units set up in almost all health centres.

Contraception

Oral contraceptives have been the most frequently used contraceptive measure, although they are not popular, partly due to the expense that has to come from the women themselves and partly due to negative publicity in the media. The IUD is cheaper and more frequently used. Condoms are available, but hardly used as a birth control method. Although contraceptive use has increased in the older age-groups, it seems to have decreased in the under 20 age group.

Abortion

In 1977, a liberal abortion law was passed allowing abortions on medical and non-medical grounds. Since then, the abortion rates have risen. Currently, for every 100 live births about 80–90 abortions take place. 75% of all induced abortions were performed on urban women (1992). Abortions are paid for by the women themselves.

Recent trends in reproductive health

It has been difficult to obtain recent data on reproductive health from the former Yugoslav Republic of Macedonia.

Antenatal care

See data box.

Breast and cervical cancer

No data available.

Child health

In the FYROM, mass media campaign was implemented to create awareness among health care practitioners and mothers on the importance of breastfeeding.

Adolescent health

Youth in FYROM are organizing themselves and are significant contributors to the non-governmental sector. Although unemployment is their main concern, many also refer to the problems of prostitution and drugs.

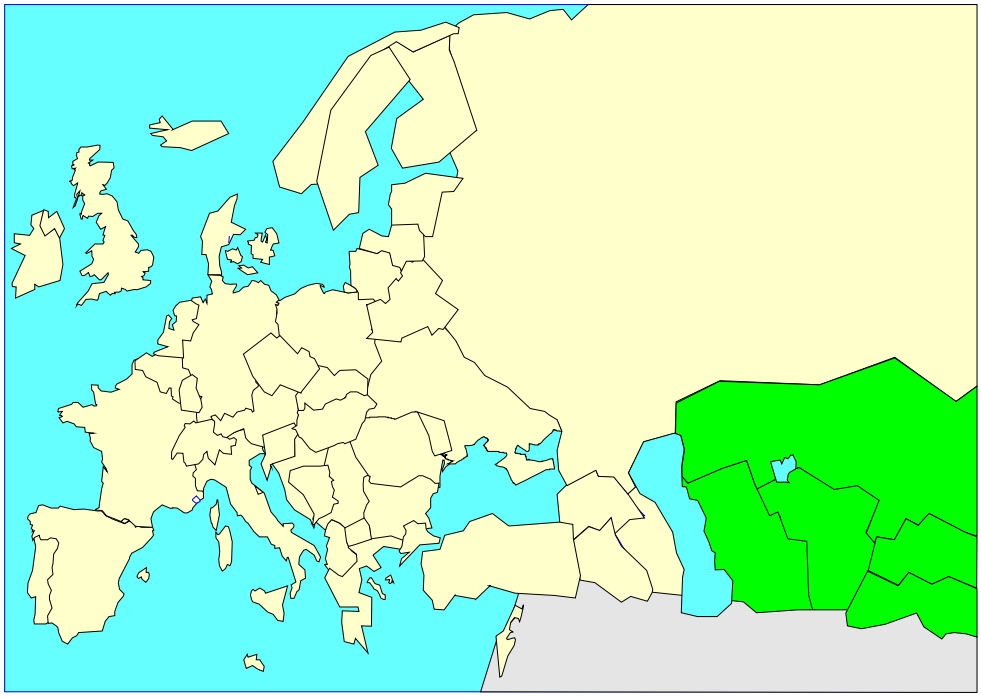
A youth group has formed at Healthy Options Project Skopje (HOPS). This group works with drug addicts in the predominantly Albanian sections of Skopje, providing needle exchange options, condoms counselling and education. One of the programs implemented by HOPS, under the motto "You and Me Closer", oversees education and training of pupils, students in primary and secondary schools regarding HIV/AIDS.

Continued efforts in reproductive and family planning need to be expanded to the rural areas to accommodate the needs of youth, especially young women.

Areas for action and policy changes

- Training of health professionals;
- Management of acute respiratory infection;
- Prevention of acute diarrhoeal diseases;
- Improvement on perinatal health;
- Implementing baby friendly hospitals and promoting breastfeeding;
- Establishing family planning services and providing contraceptive supplies;
- Assistance to adolescent health projects needed, particularly health promotion and youth counselling and education services in the rural areas.

Central Asian Republics and Kazakhstan (CARK)



The region

Due to the economic crisis of 1998 and the limited support from the former USSR, all the five countries in the region are severely limited in their ability to purchase goods in general and drugs in particular. Where it existed, the local production of drugs has virtually ceased due to the shortage of raw materials, equipment or spare parts, which was previously provided by other parts of the former USSR.

Among other countries of the former USSR, these countries stand out demographically for their significantly higher fertility. In all five countries, there are substantial differences in demographic behaviour between rural and urban dwellers and between the ethnic groups of Asian and European origin.

Life expectancy at birth is between 65 and 70 years. Infant mortality rates range from 24 (Kazakhstan) to 40 per 1000 live births in Turkmenistan, with considerable regional variation within countries. Although there is a universally literate population and high number of medical personal in the region, children suffer from easily preventable diseases. The leading causes of

infant mortality are the same in all five countries. They are respiratory, parasitic and infectious diseases. Maternal mortality ratios are high for developed countries and low for developing countries within CARK.

All the five countries have initiated family planning programmes for birth spacing in view of preventing high maternal and infant mortality and morbidity owing to repeated pregnancies, and reducing the number of abortions.

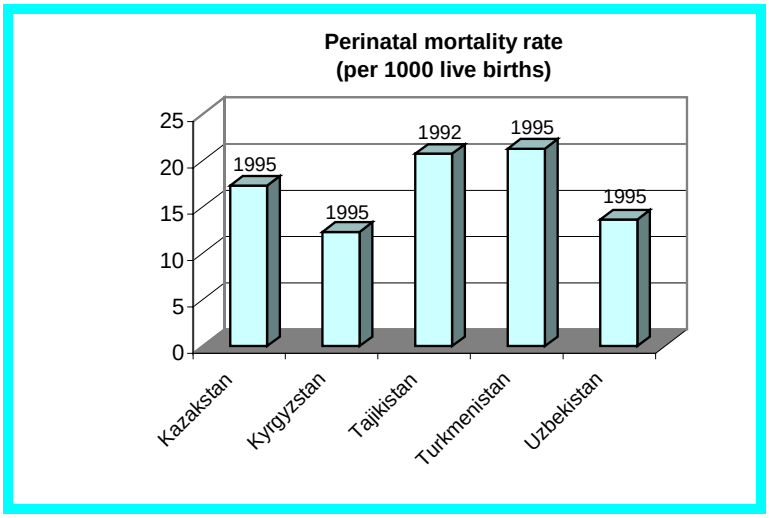
Follow-up of ICPD, Cairo 1994

Following the ICPD, a Council for Women, Family and Demographic Policy Issues was set up under the president in Kazakhstan. A concept of the state policy to improve women's position in Kazakhstan has been developed, and a law on joining the convention on the elimination of all forms of discrimination in relation to women has been adopted. A national policy on reproductive health care in Kazakhstan has also been developed.

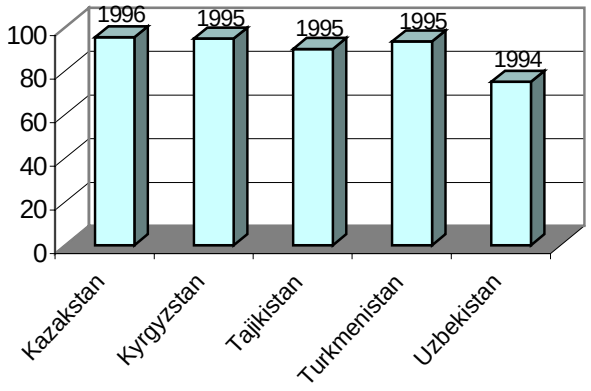
Tajikistan has taken several steps to implement the endorsed Programme of Action developed at the ICPD in Cairo in 1994. Reproductive health centres have been established in each district of the Republic, running the services. Programmes to improve these services are being implemented and family planning services have become more accessible for the population, despite the difficult socio-economic situation of the country.

To follow up on the programme of action of the ICPD, Turkmenistan has opened family planning cabinets, reproductive health centres, provided contraceptives to all regions, and implemented preventive measures of AIDS/STI.

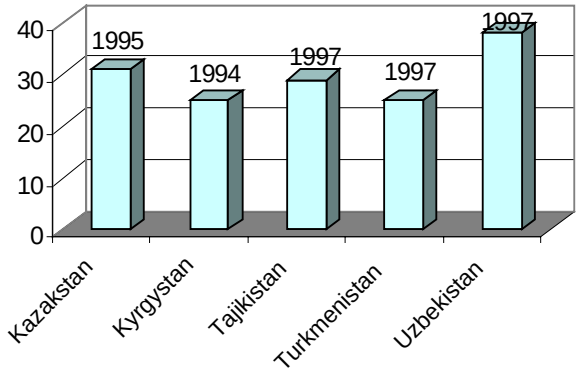
Statistics on perinatal mortality, average immunization coverage and contraceptive prevalence rate



Average immunization coverage (diphtheria-Tetanus/Pertussis/Measles/Polio/Tuberculosis) %
Latest available data



Contraceptive prevalence rate in %
(Latest available data)



Kazakhstan

VARIABLES	PAST DATA	PRESENT DATA (1997)	⇧ ⇩
Population estimate (millions)	16.5 (1995)	15.671	⇩
HDI (Human Development Index) value	0.685 (1995)	0.740 (1999)	⇩
HDI (Human Development Index) rank	100 (1995)	76 (1999)	⇧
GNP US$ (per capita)	2760 (1995)	2296	⇩
Women of fertile age (age 15-49) (millions)	4.08 mill (1995)	3.88	⇩
Total fertility rate (per woman)	2.7 (1995)	2.6 (1999)	⇩
Maternal mortality ratio (per 100 000 live births)	69.4 (1996)	76.9	⇧
Perinatal mortality rate (per 1000 births)	17.3 (1995)	18.01	
Infant mortality rate (per 1000 live births)	25.3 (1996)	24.2	⇩
Contraceptive methods used	Mainly IUDs	IUD's,OC's,condoms	
Contraceptive prevalence rate	31% (1995)	59% (1999)	⇧
Contraceptive choice index	No data	45.8 /fair (1996)	
Abortion rate (per 1000 women age 15-49)	54.7 (1995)	40.2	⇩
Abortion:birth ratio < age 20	0.5:1 (1995)	0.56:1	⇧
Abortion:birth ratio age 20-34	No data	0.6:1	
Abortion: birth ratio age 35+	1.1:1 (1995)	0.77:1	⇩
Abortion: birth ratio, all ages	0.77:1 (1996)	0.25:1 (1999)	⇩
Birth rate (per 1000 population)	16.8 (1995)	14.7	⇩
Maternal mortality from abortions (per 100 000 live births)	23% (1995)	24.9%	⇧
Immunisation coverage : **Diphtheria-Tetanus / Pertussis** **Measles/Polio/Tuberculosis**	(1996) 95% / 94% 98% / 97% / 93%	 97% / 97% 97% / 100% / 99%	⇧
STD/AIDS rates	1 AIDS case (1995)	14 AIDS Cases (1998)	⇧

Health services

90% of the health sector in Kazakhstan is publicly financed and 10% is financed by private sources. It is estimated that 98% of hospitalisation needs are met by public hospitals and 2% by private hospitals. The coverage needs met by polyclinics are respectively 95% for public polyclinics and 5% by private polyclinics.

Kazakhstan has a health insurance law (No.2329), that theoretically should give 100% coverage of the population. The country has adopted the Essential Drug Policy as recommended by WHO and contraceptives are included on the Essential Drug List. All pharmacies in Kazakhstan are privately run. It is estimated that the general availability of drugs in the major regions of the country is 60–70%.

Family planning

Kazakhstan has a national programme of family planning to which a national advisory group, the coordinating Committee on Reproductive Health within the Health Committee, is oriented. Family planning services are provided in maternity hospitals, in consultancies of obstetrics and gynaecology, in polyclinics, by general practitioners, in private practices and in village health posts. The family planning services are free of charge. Family planning counselling is mainly

provided by gynaecologists. Adolescents do need to have an authorization to receive family planning services in Kazakhstan.

There are three NGOs actively involved in the national programme of family planning:

- National Family Planning Association
- Youth Organisation “Zhas-Tolkyn”
- Business Women Association

Contraception

The two main methods of fertility regulation in Kazakhstan are by clinical abortion and the use of IUDs. It is estimated that there is a reliable continuity of availability of IUDs in Kazakhstan. Contraceptives are not free-of-charge. One cycle of oral contraceptives, one IUD and one injection of injectable contraceptive are each estimated to cost the equivalent to 0.1% of an average monthly salary. Condoms are estimated to cost the equivalent to 0.005% of an average monthly salary.

Oral contraceptives, injectable contraceptives, IUDs, spermicides and condoms are all sold in pharmacies.

Abortion

Clinical abortions are performed in hospitals. The techniques used for the performance of clinical abortions are by curettage and vacuum aspiration. It is estimated that 13.7% of abortions are made outside hospitals. Clinical abortions are free-of-charge in Kazakhstan. Both pre- and post- abortion counselling are performed by gynaecologists

Recent trends in reproductive health

Kazakhstan has recently endorsed a reproductive health policy. The reproductive health care has not been privatised, and the services are offered to adolescents as well. These services include contraceptives. UNFPA and USAID are specifically involved in the reproductive health care services.

Antenatal care

It is estimated that 95% of women are given antenatal care in Kazakhstan. Altogether 12 visits are recommended. Ultrasound examinations are obligatory and pregnant women are recommended to undergo two examinations.

An average of 22 facilities per 500 000 population have functioning basic essential obstetric care and 1.7 facilities per 500 000 population have functioning comprehensive essential obstetric care.

It is estimated that 1% of pregnant women attending antenatal care show a positive syphilis serology.
40–44% of obstetric and gynaecological admissions are estimated to be due to abortions.

Breast and cervical cancer

The prevalence of breast cancer in Kazakhstan is estimated to be 14.4 per 100 000 population and the prevalence of cervical cancer is 6.3 per 100 000 population.

Child health

Acute respiratory infections and pneumonia are the main reasons of child morbidity. They are treated with injectable antibiotics and a wide array of symptomatic medicines. Unnecessary and excessive antibiotic administration is the norm (BASIC).

Diarrhoeal diseases are the second reasons for morbidity in children under 14 years of age. The incidence peaks occur during the months of October through to May each year.

The incidence of most vaccine preventable diseases have steadily declined over the last years, due to increased coverage of immunisation. However, tuberculosis and hepatitis incidences are increasing.

Adolescent health

Kazakhstan is facing an epidemic of HIV/AIDS. The number of registered HIV-infected patients has increased almost ten-fold. The vast majority of these HIV/AIDS cases are among IVDU; and a significant percentage of IVDU are under the age of 25. In 1996, 50% of HIV diagnosed HIV cases were among individuals under 20 years of age. Comparable increases in STIs have also been noted among this population. HIV/AIDS prevalence has also been recorded among 10-50% of commercial sex workers, who are usually young women.

The British KFH program which supported the development of reproductive health and sex education programs saw a decrease in abortions, and teen pregnancies after 18- month program of training health care workers and working with young people in social settings.

Although, as mentioned earlier, reproductive health services are being established in the urban areas, continued emphasis needs to be placed on reaching youth in rural areas, IVDU, and sex workers.

Areas for action and policy changes

- Establishing comprehensive systems of maternal and child care, including family planning at district level;
- Assistance to adolescent health projects needed, particularly health promotion and youth counselling and education services;
- The practise of taking care of newborn babies should be revised;
- Acute respiratory infections and diarrhoeal diseases must be reduced.

Kyrgyzstan

VARIABLES	PAST DATA	PRESENT DATA	⇧ ⇩
Population estimate (millions)	4.5 (1994)	4.48 (1995)	⇩
HDI value	0.689 (1992)	0.663 (1993)	⇩
HDI rank	82 (1992)	99 (1993)	⇩
GNP US$ (per capita)	810 (1992)	610 (1994)	⇩
Women of fertile age (age 15-49)	0.9 mill (1994)	1 mill (1995)	⇧
Total fertility rate (per woman)	3.7 (1994)	3.2	⇩
Maternal mortality ratio (per 100 000 live births)	43 (1994)	44.3 (1995)	⇧
Perinatal mortality rate (per 1000 births)	12.33 (1995)	20.84	⇧
Infant mortality rate (per 1000 live births)	31 (1994)	27.7 (1995)	⇩
Contraceptive methods used	Mainly IUDs	Mainly IUDs	
Contraceptive prevalence rate	25 % (1994)	60%	⇧
Contraceptive choice index	no past data	58.3 / good	
Abortion rate (per 1000 women age 15-49)	58.8 (1994)	31.429	⇩
Abortion:birth ratio < age 20	no data available	0.21:1	
Abortion:birth ratio age 20-34	no data available	0.36:1 (1995)	
Abortion :birth ratio age 35+	no data available	0.19:1	
Abortion : birth-ratio, all ages	0.5:1 (1994)	0.21:1	⇩
Birth rate (per 1000 population)	26.9 (1993)	17.8 (1995)	⇩
Maternal mortality from abortions (per 100 000 live births)	16% (1994)	6.8 (1995) = 15%	⇩
Immunisation coverage **Diphtheria- Tetanus/Pertussis** **Polio/Measles/Tuberculosis**	(1995): 93% / 92% 96% / 97% / 96%	 98% / 97% / 99% / 98% / 97%	⇧
STD/AIDS rates	0 AIDS cases (1995).	0 AIDS cases (1998)	

Health services

The Ministry of Health has evolved from the former regional ministry, undertaking all responsibilities and functions that were formerly performed in Moscow. The transition to a market economy has inevitable consequences for all social sectors including health, education and the social security system. The health sector has suffered from chronic under-financing. The share of GNP decreased to 2.6% in 1993 from 4.2% in 1990, further exacerbated by a fall in overall GNP. It subsequently rose to 3.9% in 1994. The health care service is characterized by a severe shortage of vaccines, drugs and medical supplies.

At present, the entire population is still covered by the state health delivery services, but this will gradually be changed into a system of health insurance, enterprise-level provision of pensions and targeted family allowances.

Kyrgyzstan has adopted a population policy which states that child spacing (family planning) is justified as a contribution to improving maternal and child health and to reducing abortion. This policy has also been publicly supported by the Republic's highest religious official, the Kadi. The Ministry of Health realizes it needs to give priority to improving its reproductive health services.

Family planning

Since 1989 family planning services have functioned. A programme called the worker's social patronage offers the services of one family planning worker per 30 families at risk of unwanted pregnancy.

Contraception

Almost no oral contraceptives or condoms are available through government facilities. Supplies have mainly consisted of IUDs, distributed through government health care facilities. The contraceptives available in pharmacies are too expensive for consumers, thus contraceptives are basically supplied through humanitarian aid. The supply has made access to contraceptive choice good.

Abortion

A total of 60.000 abortions were performed in 1993, 30% of these were first pregnancy abortions, 16% were in women under 19 years of age.

Recent trends in reproductive health

Women in the age group 35+ appear to be resorting to abortion twice as much as other age groups. These women are the carers of the family often consisting of other children, and having to resort to abortion increases their risks of health deterioration.

Antenatal care

See databox on infant and maternal mortality.

Breast and cervical cancer

According to the Ministry of Health, the incidence of malignant neoplasm of the female breast was 15.7 per 100 000 women in 1992. The incidence of malignant neoplasm of cervix uteri was 10.5 per 100 000 women.

Child health

Childhood malnutrition, acute respiratory infections, diarrhoeal diseases, and vaccine- preventable diseases are major health problems of children in Kyrgyzstan. According to the Ministry of Health data, 30–50 % of children seen by feldscher stations complained of respiratory problems. There is not standard acute respiratory infection treatment guideline, and antibiotics are excessively prescribed.

Rural feldschers report that about 10% of children presented to their clinics are " malnourished". The prevalence of malnutrition is due to a combination of infectious diseases, short breastfeeding, and dietary constraints.

Among diarrhoeal diseases, acute diarrhoea predominates.

Vaccine preventable diseases have been greatly reduced through systematic immunisation programmes over the past 30 years. Coverage is over 80 % for the 6 basic antigens. However, no significant progress has been made in reducing incidence of vaccine preventable diseases over the last decade, despite the reported high immunisation coverage. The latest available data on infectious diseases show increasing incidence of tuberculosis, diphtheria and measles.

Adolescent health[15]

As in many of the CARs, youth reproductive health services are limited. The study cited in this section provides an insight into the reproductive health situation of youth in the CARs.

Youth in rural area, IVDU and sex workers are at highest risk for negative health outcomes.

30% of the population is 10-24 years old; and 37% is below the age of 15. Adolescent fertility is officially estimated at 46 per 1000. Almost one quarter (22.7%) of females aged 19 are mothers.

According to the demographic and health survey, 11.1% of 15-19 year old women were sexually active in the previous four weeks, while 85.7% have never had sex. Among 20-24 year olds, 59.1% were sexually active in the previous four weeks, while 19.5% have never had sex. Studies in Bishkek indicate that while only 3% of girls aged 13-17 reported having sex, at least 14% of boys reported having sex.

6.5% of girls aged 15-19 reported using contraception, and only 4% were using some kind of contraception at the time of the interview.

In Osh, one-third of female drug users report that they are periodically or constantly engaged in prostitution to earn their living or to purchase drugs. An estimated 90% of these commercial sex contacts take place without the use of condoms (UNAIDS, 1999).

According to the NGO Sanitas, whereas five years ago the average age of beginning drug use was 16-18 and the age of dependence was around 20-22, now young people begin using drugs between ages 13-14 and are dependent by age 15-16.

An assessment of reproductive health services in Osh and Jalal-abad oblasts was conducted in 1997 (AVSC and KRIOP, 1998). It noted that "*practically no information is available for adolescents , although providers and school teachers realise the importance of working with the population on RTI/STI and contraceptive issues.*"

[15] Reproductive Health Alliance Europe, *An assessment of the reproductive health needs of young people in Kyrgyzsta*n, 1999.

Areas for action and policy changes

- Curriculum review, development of training of teaching staff in medical and paramedical institutions;
- Establishing family planning NGOs;
- Family life education;
- Training school doctors;
- Improving the quality of care in all levels of MCH services;
- Assistance to adolescent health projects needed, particularly health promotion and youth counselling and education services in rural areas.

Tajikistan

VARIABLES	PAST DATA	PRESENT DATA (1997)	⇧ ⇩
Population estimate (millions)	6.1 (1995)	6.066.000	⇩
HDI (Human Development Index) value	0.616 (1993)	0.665	⇩
HDI (Human Development Index) rank	105 (1993)	108	
GNP US$ (per capita)	350 (1994)	330	
Women of fertile age (age 15-49)	1.2 mill (1994)	1.300.000	⇧
Total fertility rate (per woman)	5 (1994)	3.4	⇩
Maternal mortality ratio (per 100 000 live births)	87.2 (1996)	64.6	⇩
Perinatal mortality rate (per 1000 births)	20.74 (1992)	22.43 (1996)	
Infant mortality rate (per 1000 live births)	30.2 (1996)	27.6	⇩
Contraceptive methods used	Mainly IUDs	IUD, OC, injectable, condoms, female sterilisation	
Contraceptive prevalence rate	16% (1996)	29.5%	⇧
Contraceptive choice index	No data	41.7 /fair	
Abortion rate (per 1000 women age 15-49)	214.88 (1993)	181.5	
Abortion:birth ratio < age 20	0.3:1 (1992)	* 4.61%	
Abortion: birth ratio age 20-34	0.23:1 (1992)	* 51.29%	
Abortion: birth ratio age 35+	0.6:1 (1992)	* 44.1%	
Abortion: birth ratio, all ages	0.2:1 (1996)	0.18:1	⇩
Birth rate (per 1000 population)	24.5 (1996)	25.0	⇧
Maternal mortality from abortions (per 100 000 live births)	3.6 (1995)	7.5	⇧
Immunisation coverage : Diphtheria-Tetanus / Pertussis Measles/Polio/Tuberculosis	(1995) 96% / 95%(1994) 80% / 85% / 94%	95% / 95% / 95% / 92% / 90%	
STD/AIDS rates	0 AIDS cases (1995)	0 AIDS cases (1998)	

*No information is available on births by age groups, therefore indicator is not calculable.

Health services

The health sector is 100% publicly financed and there are no private hospitals or polyclinics in the country at present. 7% of the pharmacies are estimated to be privately run, the rest are public.
The role of the various professionals in reproductive health service provision appear to be that of consultation and dissemination of information to the population.

There is as yet no national health insurance system in Tajikistan.

The country has adopted the Essential Drug Policy as recommended by WHO and has included contraceptives on the Essential Drug List, however, with the difficult socio-economic situation in the country, there appears only to be an estimated 20% coverage of the availability of drugs in the major regions.

Family planning

The implementation of a national family planning programme was commenced in 1996, supported by the law on protection of reproductive health (Article N33). An advisory group – the Committee on Population and Development – is orienting the programme of family planning.

Family planning services are provided in maternity hospitals, consultancies of obstetrics and gynaecology, polyclinics, by general practitioners, PHC facilities and village health posts.

Family planning counselling services are offered free of charge to the population and are provided by general practitioner, gynaecologists and midwives.

Adolescents do not need an authorization to receive family planning services in Tajikistan.
The committee “Women in Development” is actively involved in the national programme of family planning.

Contraception

As yet the main method of fertility regulation in Tajikistan is clinical abortion and by the use of IUDs. Contraceptives are supposedly free of charge but the emergency contraceptives made available to the population have to be purchased by the user. A variety of modern contraceptives are sold in pharmacies to the extent that they are accessible.

It is generally believed that condoms are highly unpopular with Tajik men and that condoms are only used to an insignificant degree.

Abortion

Clinical abortions are performed free of charge in the abortion departments of clinical hospitals and in the gynaecological departments of regional and central hospitals. Three different techniques are used for clinical abortion: curettage, vacuum aspiration and intra-amnion insertions of hypertonic solutions.

Pre-abortion counselling is performed by doctors in women consultations, in reproductive health centres and post-abortion counselling is performed by family doctors and doctors in health care facilities where the clinical abortion was performed.

Recent trends in reproductive health

The implementation of the national reproductive health policy was commenced in 1996. Adolescents are offered reproductive health care through a comprehensive service in the centres, offering information and contraceptive supplies. The NGO “Bovary” is actively involved in these activities. Other NGOs actively involved in reproductive health care services are the committee “Children of the Street” and the committee “Women in Development”.

Three surveys concerning reproductive health care services have been conducted within the last couple of years.

Several international organizations are involved in activities such as upgrading of clinics, research on STIs, education of personnel, supplies of medical equipment and contraceptives.

Antenatal care

It is estimated that 70% of urban women and 50% of rural women are given antenatal care. 2–4 visits are recommended for checks routinely undertaken such as the full analysis of blood and medical examinations including two obligatory ultrasound examinations. It is estimated that 1% of pregnant women attending antenatal care show a positive syphilis serology. An estimated 18% of obstetric and gynaecological admissions are due to abortion.

192.8 facilities per 500 000 population have functioning basic essential obstetric care and 7 facilities per 500 000 population have comprehensive essential obstetric care.

Breast and cervical cancer

The prevalence of breast and cervical cancer appear to be very low in Tajikistan. The estimated prevalence of breast cancer was 2.1/100 000 population in 1997 and the estimated prevalence of cervical cancer was 1.3/100 000 population in the same year.

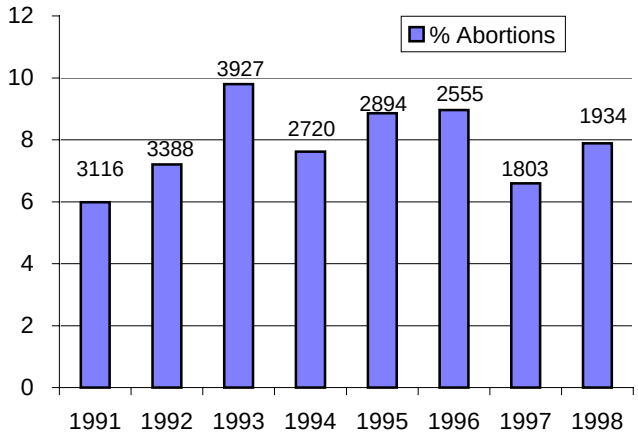
Child health

Among children under five years of age, the most important causes of morbidity and death are acute respiratory infections, diarrhoeal diseases, vaccine-preventable diseases, malnutrition and malaria.

Adolescent health

The youth of Tajikistan face many of the same concerns as their CAR neighbours. STDs and abortion is high among the general population, suggesting that attention should be paid to youth. Youth living in rural areas should also be given special consideration. (See Figure 1T and Table 1T).

Figure 1T. Number and Percentage of Abortions to women <20 years old, Tajikistan



Source: UNICEF ICDC, Country Statistical Reports, 1999.

Table 1T. Number of registered STI cases among 0-17 year olds, Tajikistan

	1992	1993	1994	1995	1996	1997	1998
Cases	56	67	93	90	86	97	89

Source: UNICEF ICDC, Country Statistical Reports, 1999.

Areas for action and policy changes

- Strengthening of an integrated concept of Safe Motherhood and Family Planning urgently needed at all levels;
- Establishing family planning NGOs;
- Train primary health care personnel for diarrhoeal diseases, and provide oral rehydration solutions;
- Provide vaccine supply;
- Malaria control programme should be considered;
- Weight and growth charts should be used and reported;
- Assistance to adolescent health projects needed, particularly health promotion and youth counselling and education services.

Turkmenistan

VARIABLES	PAST DATA	PRESENT DATA (1997)	⇧ ⇩
Population estimate (millions)	4.36 (1995)	4.6	⇧
HDI (Human Development Index) value	0.695 (1993)	0.671	⇧
HDI (Human Development Index) rank	80 (1992)	90 (1995)	⇩
GNP US$ (per capita)	1230 (1992)	2683	⇧
Women of fertile age (age 15-49)	926 000 (1994)	1.109.598	⇧
Total fertility rate (per woman)	4.1 (1994)	3.6	⇩
Maternal mortality ratio (per 100 000 live births)	93 (1996)	105.0	⇧
Perinatal mortality rate (per 1000 births)	21.3 (1995)	17.11	⇩
Infant mortality rate (per 1000 live births)	42.9 (1994)	40.3	⇩
Contraceptive methods used	Mainly IUDs	No data	
Contraceptive prevalence rate	19% (1994)	25%	⇧
Contraceptive choice index	No data	58.3 /good (1996)	
Abortion rate (per 1000 women age 15-49)	31.4 (1994)	No data	
Abortion:birth ratio < age 20	No data	No data	
Abortion:birth ratio age 20-34	No data	No data	
Abortion:birth ratio age 35+	No data	No data	
Abortion:birth ratio, all ages	0.22:1 (1996)	0.33:1	⇧
Birth rate (per 1000 population)	33.1 (1994)	21.6	⇩
Maternal mortality from abortions (per 100 000 live births)	1.4 (1994) = 3%	5.79	⇧
Immunisation coverage : **Diphtheria-Tetanus/Pertussis** **Measles/Polio/Tuberculosis**	(1995) 93% / 92% 97% / 92% / 93%	 98% / 98% 100% / 99% / 96%	⇧
STD/AIDS rates	0 AIDS cases (1995)	1 AIDS case (1998)	⇧

Health services

Hospitals, polyclinics and pharmacies are all publicly financed. The present national health insurance system covers approximately 74% of the population. Turkmenistan has adopted the Essential Drug policy as recommended by WHO, but as yet contraceptives are not included in the Essential Drug List.

There is no data at present on the general availability of drugs in the major regions of the country.

Family planning

Turkmenistan has implemented a national programme of family planning. An advisory group is orienting this programme. The family planning services are provided by maternity hospitals, consultancies of obstetrics and gynaecology, polyclinics, sometimes by general practitioners, PHC facilities and village health posts.

Family planning counselling services are not offered free of charge in Turkmenistan. It is estimated that the cost of these services range between 4–14% of an average monthly salary. The counselling services are provided by general practitioners, gynaecologists and midwives.

Adolescents have to have an authorization to receive family planning services in Turkmenistan.
Women's and youth organizations are actively involved in the national programme of family planning.

Contraception

The main method of fertility regulation in Turkmenistan is as yet clinical abortion followed by the use of IUDs, oral contraceptives, condoms and natural methods. Contraceptives are free of charge and the continuity of availability is estimated to be reliable. Emergency contraceptives have been made available to the population through the reproductive health centres.

Abortion

Clinical abortions are performed in hospitals. The techniques used are the curettage method and vacuum aspiration. There is at present no systematic data on the prevalence of unsafe abortion in Turkmenistan. Clinical abortion cost the equivalent of 54% of an average monthly salary. Women are offered pre- and post abortion counselling performed by gynaecologists.

Recent trends in reproductive health

It appears that Turkmenistan has a reproductive health policy, but it remains unclear as to the extent of this policy. Adolescents are not offered reproductive health care services. Apparently, women's bureau and youth organizations are involved in activities related to reproductive health care.

International organizations are involved in activities of financial support and information dissemination.

Antenatal care

It is estimated that all women in Turkmenistan are given antenatal care. 14–15 visits are recommended with checks routinely undertaken of blood sampling for syphilis, urine sampling for protein, blood pressure, minimum two ultrasound examinations and other obligatory examinations of the pregnant woman. Despite the routine blood sampling for syphilis, there is no systematic data on the percentage of women attending antenatal care showing a positive syphilis serology.

There are 427 facilities per 500 000 population that have functioning basic essential obstetric care and 147 per 500 000 that have functioning comprehensive essential obstetric care.
It is estimated that 3–4% of obstetric and gynaecological admissions are due to abortion.

Breast and cervical cancer

Data indicates that 1063 women have breast cancer and 918 women have cervical cancer.

Child health

Among children the main cause of morbidity and mortality are respiratory system diseases followed by infectious and parasitic diseases. 75% of infectious and parasitic diseases are attributed to intestinal infections.

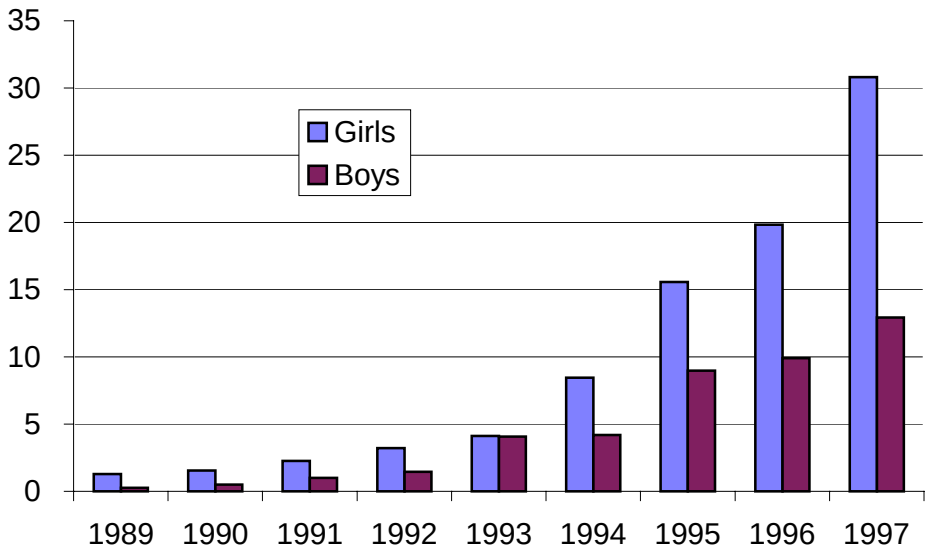
The frequency of intestinal infections is contributed to by the shortage of potable water and poor sanitation, increasing poverty and malnutrition. The incidence of tuberculosis is very high and particularly affects children. Brucellosis is also widespread in the rural areas.

Adolescent health

The youth in Turkmenistan are caught between cultures and politics. Not only have they lived through the transition from a communist to a capitalist economy, their culture is on the border of the Muslim—Christian world.

Condom use is next to none. IUD remains the number one form of contraception among older women, yet younger women's contraceptive practices are not as well documented. Syphilis rates have made a substantial increase among young people aged 10-19, especially among girls, during the last 9 years. Given the tendency for under-reporting in the CARs, this data expresses the need for a better understanding of youth reproductive health and behaviour. (See Figure 1TU).

Figure 1TU. Syphilis rates (per 100,000) among 10-19 year olds, Turkmenistan.



Source: UNICEF ICDC, Country Statistical Reports, 1999.

Areas for action and policy changes

- Strengthening the quality of care at all levels of MCH and family planning;
- Strengthening human resources in reproductive health care services;
- Curriculum review, development of training of teaching staff in medical and paramedical institutions;
- Establishing family planning NGOs;
- Implementation of integrated management of childhood diseases in order to improve perinatal and neonatal care, improve the treatment of respiratory tract infections and diarrhoeal diseases, and use/report growth charts;
- Assistance to adolescent health projects needed, particularly health promotion and youth counselling and education services.

Uzbekistan

VARIABLES	PAST DATA	PRESENT DATA (1997)	⇧ ⇩
Population estimate (millions)	22.8 (1995)	23 (1996)	⇧
HDI (Human Development Index) value	0.679 (1993)	0.720	⇧
HDI (Human Development Index) rank	94 (1993)	92	⇧
GNP US$ (per capita)	950 (1994)	1020	⇧
Women of fertile age (age 15-49)	5.2 mill (1995)	5.7 million	⇧
Total fertility rate (per woman)	No data	3.4	
Maternal mortality ratio (per 100 000 live births)	24.1 (1994) 32.4 (1995)	32.2 (1996) 28.5	⇩
Perinatal mortality rate (per 1000 births)	13.67 (1995)	12.11	⇩
Infant mortality rate (per 1000 live births)	32.7 (1994)	26.0 (1995) 22.5	⇩
Contraceptive methods used	Mainly IUDs	Mainly IUDs	
Contraceptive prevalence rate	39.2% (1995)	38.3 %	⇩
Contraceptive choice index	No data	54.2 / good	
Abortion rate (per 1000 women age 15-49)	20.7 (1995)	12.4	⇩
Abortion:birth ratio < age 20	1.31:1 (1995)	No data	
Abortion:birth ratio age 20-34	No data	No data	
Abortion:birth ratio age 35+	3.89:1 (1995)	No data	
Abortion:birth ratio, all ages	0.15:1 (1995)	0.118:1	⇩
Birth rate (per 1000 population)	29.8 (1995)	25.8	⇩
Maternal mortality from abortions (per 100 000 live births)	No data	(1995) 1.5	
Immunisation coverage: **Diphtheria-Tetanus/Pertussis** **Measles/Polio/Tuberculosis**	(1994) 67% / 65% 71% / 79% / 93%	 96% / 96 % 88% / 97%/ 97%	
STD/AIDS rates	0 AIDS cases (1995)	5 AIDS cases (1998)	⇧

Health services

Data from 1997 indicates that 80% of the health sector is financed by public sources. The remaining 20% is financed by private sources. There is no data available of the estimated percentage of coverage needs that are met by public and private hospitals and polyclinics.

Nor does there exist any reliable data on the percentage of the country's population covered by the present national health insurance.

Uzbekistan has adopted the Essential Drug Policy and contraceptives are included in the Essential Drug List, as recommended by WHO.

It is estimated that 15% of the national pharmacies are publicly run, the remaining 85 % are private. There is no reliable data on the general availability of drugs in the major regions of Uzbekistan.

The Government of Uzbekistan is developing a strategy based on strengthening primary health care through the creation of rural medical centres (RMCs).

Family planning

In 1993, the Cabinet of Ministers adopted a national programme of family planning. Implementation is executed from the ministerial level to the primary level. There is no advisory group orienting the programme of family planning.

Family planning services are provided in maternity hospitals, consultancies of obstetrics and gynaecology, polyclinics, by general practitioners, through private practise, primary health care facilities and village health posts. The counselling services are provided by general practitioners and gynaecologists.

Adolescents do not need authorization to receive family planning services in Uzbekistan.

There are no national NGOs actively involved in the national programme of family planning.

Contraception

The main method of fertility regulation in Uzbekistan is by use of the IUD, oral contraceptives and condoms. It is estimated that the country has a reliable continuity of availability of the methods. The contraceptives are free-of-charge. Oral contraceptives, injectable contraceptives and condoms are all sold in pharmacies.

Emergency contraceptives are made available to the Uzbek population through foreign donors and state funds.

Abortion

Clinical abortions are performed at stationary clinics. The techniques of curettage and vacuum aspiration are used for the performance of clinical abortions.

It is estimated that the prevalence of unsafe abortion in Uzbekistan is 0.02%.

Clinical abortions are available free-of-charge. Pre- and post abortion counselling is performed by obstetricians/gynaecologists.

Recent trends in reproductive health

Uzbekistan has a reproductive health policy, the implementation of which was commenced in 1991. Reproductive health care services have not been privatised.

Adolescents are offered reproductive health care counselling and medical aid if necessary.

No steps have been taken to implement social marketing into the national reproductive health care services.

There are no national NGOs actively involved in the national reproductive health care services.

Antenatal care

It is estimated that 98% of the women in Uzbekistan are given antenatal care. 14–16 visits during the pregnancy are recommended. Data is not available on the checks taken during the antenatal visits.

There is no data available on the number of facilities which have functioning basic and comprehensive essential obstetric care.

Uzbekistan has data on the number of cases of the whole population showing positive syphilis serology, being 47,3 per 100 000 population (1997).

There is no data on the percentage of obstetric and gynaecological admissions that are due to abortions.

Pregnant women undergo ultrasound examinations in Uzbekistan. The examinations are obligatory and it is recommended to attend at least twice during a pregnancy.

Breast and cervical cancer

The prevalence of breast cancer in Uzbekistan is estimated to be 11.4 per 10 000 population, and cervical cancer to be 7.7 per 10 000 population.

Child health

Pneumonia and other respiratory infections are the major causes of childhood mortality. During the summer months particularly, diarrhoea is very common among children due to the lack of safe drinking water.

Especially in rural areas, children suffer from Brucellosis transmitted by animals.

Tuberculosis, diphtheria and viral hepatitis are reported to be on the increase (1995).

Adolescent health

Adolescents in Uzbekistan face many of the same problems as their CAR neighbours. Findings from the WHO/UNESCO/UNAIDS meeting on youth in the CARs revealed several areas of action in regard to adolescent health in Uzbekistan. There is a lack of preventive health interventions aimed at youth and a lack of technical expertise to implement prevention programs.

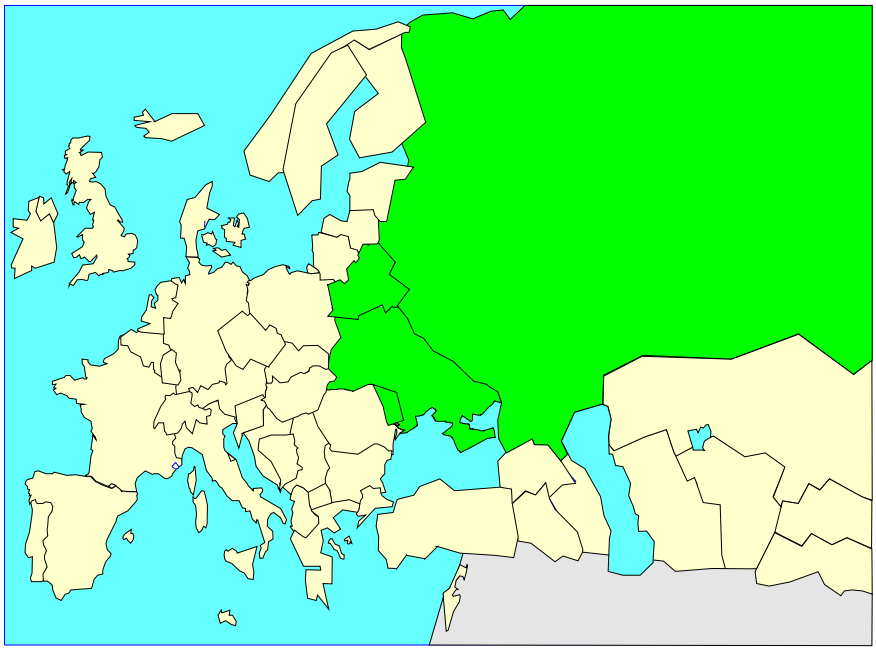
The government of Uzbekistan screened adolescent girls in school for health risks. However, STI testing was not part of the screening.

Future efforts in the country will focus on developing youth centres throughout the country to address the specific needs of young people.

Areas for action and policy changes

- Establishing Family Planning NGOs;
- Strengthening the quality of care at all levels of MCH and family planning;
- Assistance to adolescent health projects needed, particularly health promotion and youth counselling and education services;
- Training of primary health care personnel for the treatment of respiratory infections, pneumonia and diarrhoeal diseases.

Belarus, Republic of Moldova, the Russian Federation and Ukraine



The region

These countries are very closely linked to each other, economically socially and politically, in their trading and generally in their interdependence.

When thinking of the Russian Federation, it is important to remember that the country consists of 16 autonomous republics and 6 autonomous regions with a total area of 1.7 million hectares. It is the largest country in the world. Consequently, statistics for Russia as a whole present a picture which is very misleading as they portray the average situation of a very diverse country that masks deprived areas and groups which may be as badly or even worse off than neighbouring smaller and more homogeneous countries.

As in many other countries in CEE/NIS, poor mother and child health is not due to poor access to health services. Women of reproductive age are examined annually, pregnant women visit health services as many as 12 times, even for normal pregnancies, and regular prenatal care includes at least two ultrasound tests. All deliveries take place in hospital. After the mother and baby are discharged from the hospital, they are visited by a midwife and doctor regularly. The problem of the poor health of mothers and children rather lies in the fact that health professionals are inadequately trained in this subject, and in the extreme scarcity of drugs, supplies and equipment, as well as the lack of capital to update the system's infrastructure. The Ministries of Health depend

heavily upon humanitarian assistance and aid funds to supply even the essential drugs such as vaccines.

For example, anti-D globulin is often not available, so Rhesus factor-incompatibility cannot be treated prophylactically. Cases of Rhesus factor-incompatibility in a desired pregnancy are treated by haemo-filtration, an operation which poses additional threats to the mother's and the child's health.

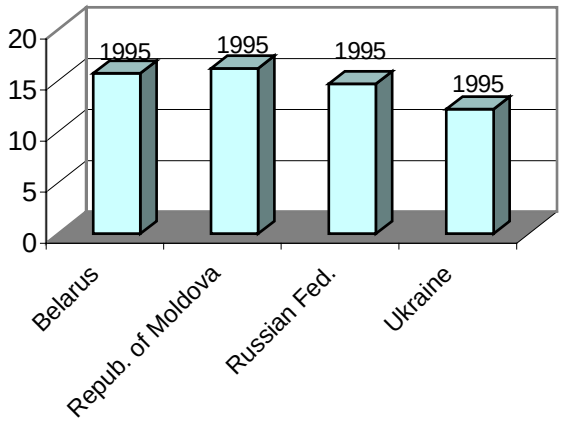
Infant and maternal mortality is high compared to other countries of western Europe, yet the definition of infant death used in these countries is different from the WHO definition, resulting in underestimation of infant mortality rates. Excess fertility, unwanted pregnancies, unsafe abortion and low quality of prenatal and delivery care including poor emergency obstetric care, are among the important factors of maternal mortality. WHO considers that rising ratios may also be partly due to better reporting systems.

Breastfeeding practise is not common enough. Current policies are not very effective in promoting longer duration of breastfeeding.

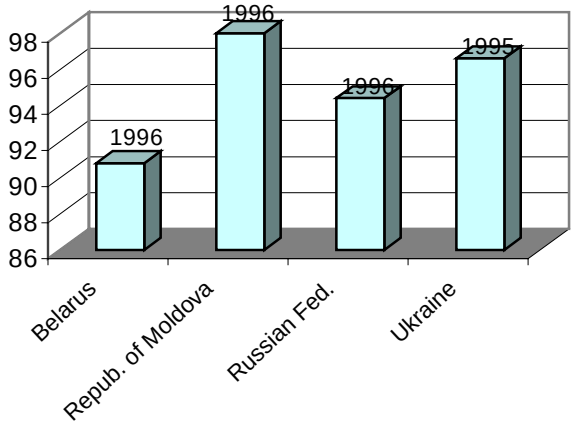
To varying degrees, induced abortion has been one of the main methods of managing fertility, although it has high health and economic costs.

Statistics on perinatal mortality, average immunization coverage and contraceptive prevalence rate

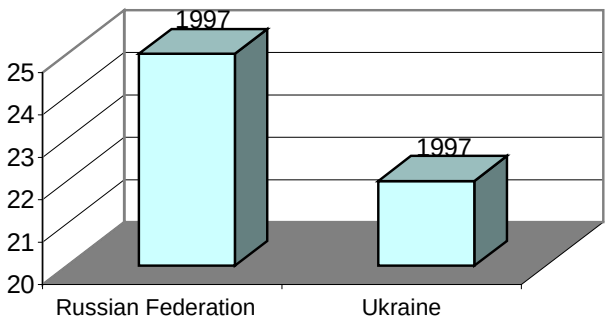
Perinatal mortality rate
(per 1000 live births)



Average immunization coverage (Diptheira-Tetanus/Pertussis/Measles/Polio/Tuberculosis). %
Latest available data



Contraceptive prevalence rate in %
(Latest available data)



Follow-up of ICPD, Cairo 1994

Belarus has taken several steps to implement the endorsed Programme of Action developed at the ICPD in Cairo in 1994:

- created a national committee on population;
- organized a conference on "Three years Post Cairo"; and
- adopted a resolution of the Cabinet of Ministers on "The Conception of the State Demographic Policy and Main Trends of the Demographic Policy Implementation Considering the Sustainable Development of the Economy in Transition", 24th June 1998.

To implement the endorsed Programme of Action developed at the ICPD in Cairo in 1994, the Republic of Moldova has set up the Republican Centre of Family Planning, in which several activities take place:

- coordination of the national programme for family planning
- coordination of a project on health education of the population
- training of health workers and
- provision of contraceptives free of charge

The Russian Federation has taken steps to elaborate on the implementation of the National Programme of Measures for the ICPD Programme of Action.

In Ukraine, several national programmes have been adopted and commenced - on family planning, on women's health protection and on maternity and childhood care.

A batch of national laws have been adopted on the issues of reproductive health care

Belarus

VARIABLES	PAST DATA	PRESENT DATA (1997)	⇧ ⇩
Population estimate (millions)	10.1 (1993)	10.2	⇧
HDI (Human Development Index) value	0.787 (1993)	0.763 (1997)	⇩
HDI (Human Development Index) rank	61 (1993)	60	⇧
GNP US$ (per capita)	2160 (1994)	2150	⇩
Women of fertile age (age 15-49)	2.29 mill (1993)	2.65 mill	⇧
Total fertility rate (per woman)	1.7 (1994)	1.5	⇩
Maternal mortality ratio (per 100 000 live births)	26 (1994)	25.7	⇩
Perinatal mortality rate (per 1000 births)	No data	15.7 (1995)	
Infant mortality rate (per 1000 live births)	14.8 (1994)	12.4	⇩
Contraceptive methods used	Mainly IUDs	OC, IUD, condoms	
Contraceptive prevalence rate	30% (1992)	50%	⇧
Contraceptive choice index	No data	No data	
Abortion rate (per 1000 women age 15-49)	85.9 (1992)	56.0	⇩
Abortion:birth ratio < age 20	No data	1.1:1	
Abortion:birth ratio age 20-34	No data	1.5:1	
Abortion:birth ratio age 35+	No data	5.7:1	
Abortion:birth ratio, all ages	0.8:1 (1995)	1.6:1	⇧
Birth rate (per 1000 population)	12 (1994)	8.8	⇩
Maternal mortality from abortions (per 100 000 live births)	25% (1995)	2.2 = 8.5%	⇩
Immunisation coverage : **Diphtheria-Tetanus/Pertussis** **Measles/Polio/Tuberculosis**	(1996) 95% / 95% 74% / 94% / 96% (1995)	 98% / 97% 98% / 98% / 98%	⇧
STD/AIDS rates	3 AIDS cases (1995)	17 AIDS cases (1998)	⇧

Health services

The health sector in Belarus is financed totally by public sources. At present only a few private practices at polyclinics (stomatology) have been introduced. Otherwise public hospitals and public polyclinics meet the total coverage needs of the population.

The main role in reproductive health care is taken by obstetrician-gynaecologists and venereologists. Lately, adolescent therapeutists, paediatricians and urologists have been actively involved in reproductive health care.

The national health insurance system covers 100% of the Belarus population. The country has adopted the Essential Drug Policy as recommended by WHO and has included contraceptives on the Essential Drug List.

Pharmacies are mainly run by public sources - 70%. The rest, 30%, are privately run. It is estimated that there is a 55–60% coverage need met in the general availability of drugs in the major regions of Belarus.

Family planning

The implementation of the Belarus national family planning programme was commenced in 1996. A programme on specifically reproductive health care was developed and republican and regional consulting centres on reproductive health and family planning have the role of advisory groups oriented toward the programme of family planning.

Family planning services are provided in maternity hospitals, through consultancies of obstetrics and gynaecology, in polyclinics and through the PHC facilities. The services are free of charge and are provided by gynaecologists and midwives.

Adolescents do not need an authorization to receive family planning services, but in the case of having a clinical abortion, they do need to have their parents' consent.

The national NGO "Association of Reproductive Health and Family Planning" is actively involved in the national programme of family planning.

Contraception

The two main methods of fertility regulation in Belarus is clinical abortion and the use of IUDs. Other methods in use are oral contraceptives, condoms and natural methods. There appears to be a reliable continuity of availability of IUDs, OCs, and condoms, however, the high price on OCs makes the contraceptive less affordable by most women. One cycle of OCs is estimated to cost the equivalent of 20% of an average monthly salary, as does one injection of injectable contraceptive. One IUD costs the equivalent of 5% and one condom 0.9% of an average monthly salary. All the mentioned contraceptives are sold in pharmacies.

Belarus has made emergency contraceptives available to the population. Post-coitus tablets (Rostinol) are sold and there is a possibility of inserting an IUD.

Abortion

Clinical abortions are performed in hospitals. The techniques of curettage and vacuum aspiration are used. Clinical abortions are free of charge, which may explain the extremely low estimated prevalence 0.02% - of unsafe abortions in Belarus.

Pre- and post abortion counselling are performed by the obstetrician-gynaecologist of antenatal clinics.

After the adoption in Poland of the law prohibiting abortions, women of Poland therefore apply to the medical preventive establishment of Belarus for cessation of their pregnancy. This may affect the abortion data, unless the nationality of the woman is stated in the data.

Recent trends in reproductive health

The implementation of a reproductive health policy was commenced in Belarus in 1997. Adolescents are presently being offered reproductive health care services in special consulting rooms of each antenatal clinic (polyclinic). Social marketing has been introduced into the national reproductive health care services through a joint UNICEF/UNFPA information-communication project.

Other international organizations have been involved in the training of specialists, providing information and methodical material and by making participation in international conferences possible for relevant health professionals.

Antenatal care

It is estimated that 99.5% of women are given antenatal care in Belarus. A total of 12 visits is recommended, in which various checks are routinely undertaken, including two obligatory ultrasound examinations. An estimated 0.2% of pregnant women attending antenatal care show a positive syphilis serology.

There are 323 facilities in Belarus that have functioning comprehensive essential obstetric care. It is estimated that up to 25% of obstetric and gynaecological admissions are due to abortions, including complications of abortions.

Breast and cervical cancer

Women are regularly screened for breast and cervical cancer in Belarus. In 1997, the prevalence of breast cancer was 25.2 per 100 000 population and 7.8/100 000 for cervical cancer. The breast cancer prevalence indicates a significant decrease from the 1994 prevalence rate of 36.9, however, information collected does not indicate the reason for this decrease.

Child health

The most influential factor on perinatal health is the state of maternal health. Due to unstable and undesirable environmental factors, the economic situation, inadequate nutrition, frequent induced abortions and heavy labour in the workplace, maternal health is deteriorating.

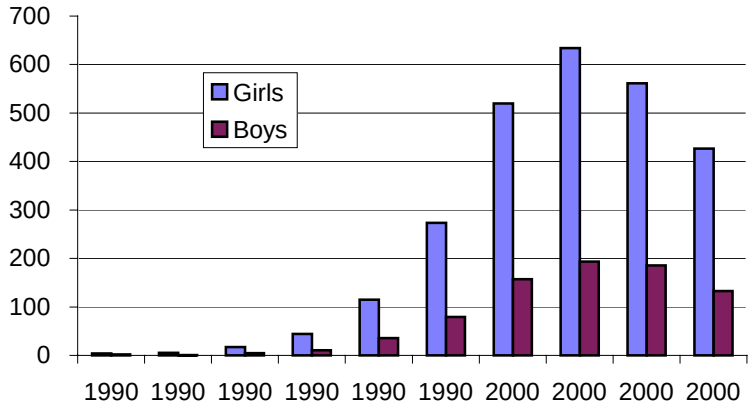
The largest contributors to infant mortality are conditions occurring during the perinatal period, followed by congenital disorders and, to lesser extent, respiratory diseases, infectious diseases and external causes.

There has been a sharp rise in infant and child morbidity since the Chernobyl accident in neighbouring Ukraine. An increase in thyroid cancer cases has been observed, particularly in the Gomel region.

Adolescent health

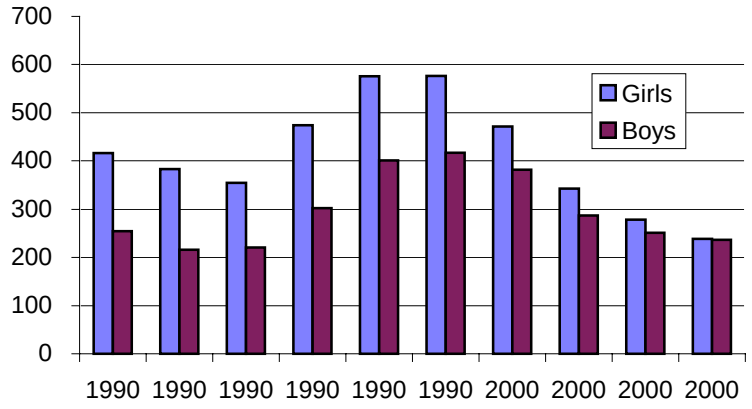
Of particular concern in Belarus is the high rates of STIs among young people, 15-19 years old. (See Figures 1BE and 2 BE). Additionally, 2228 cases of HIV were diagnosed from 1996-1998 among all age groups.

Figure 1BE. Syphilis case rate (per 100,000) among 15-19 year olds, Belarus.



Source: UNICEF ICDC, Country Statistical Reports, 1999.

Figure 2BE. Gonorrhoea case rate (per 100,000) among 15-19 year olds, Belarus.



Source: UNICEF ICDC, Country Statistical Reports, 1999.

Areas for action and policy changes

- Reduction in induced abortion and improvements in family planning services will further help to reduce maternal mortality and the risks of complications;
- Review and support for relevant health practices/programmes; for example technical assistance, supplies and education for family planning to eliminate abortion as the most common means of fertility regulation;
- Perinatal care strategy should be elaborated;
- Training of health professionals in family planning and reproductive health;
- Assist in developing in-country production of basic pharmaceuticals, including contraceptives,
- Assistance to adolescent health projects needed, particularly health promotion and youth counselling and education services;
- The origin and nature of thyroid cancer in children should be determined;
- Urgent need for further and more precise information on health impact of radioactive contamination.

The Republic of Moldova

VARIABLES	PAST DATA	PRESENT DATA (1997)	⇧ ⇩
Population estimate (millions)	4.3 (1995)	4.3	
HDI (Human Development Index) value	0.663 (1993)	0.629 (1996)	⇩
HDI (Human Development Index) rank	98 (1993)	113 (1998)	⇩
GNP US$ (per capita)	870 (1994)	460 (1997)	⇩
Women of fertile age (age 15-49)	1.132 mill (1995)	1.003.224	⇩
Total fertility rate (per woman)	1.95 (1994)	1.6	⇩
Maternal mortality ratio (per 100 000 live births)	40.8 (1995)	48.3	⇧
Perinatal mortality rate (per 1000 births)	15.46 (1996)	14.08	⇩
Infant mortality rate (per 1000 live births)	21.2 (1995)	19.8	⇩
Contraceptive methods used	Mainly IUDs	Mainly IUDs	
Contraceptive prevalence rate	24% (1993)	IUD 25.1%	
Contraceptive choice index	No data	45.8 /fair (1996)	
Abortion rate (per 1000 women age 15-49)	101.3 (1995)	32.3	⇩
Abortion:birth ratio < age 20	0.47:1 (1995)	0.46:1	⇩
Abortion:birth ratio age 20-34	No data	No data	
Abortion:birth ratio age 35+	3.0:1 (1995)	2.7:1	⇩
Abortion:birth ratio, all ages	1.01:1 (1995)	0.7:1	⇩
Birth rate (per 1000 population)	13 (1995)	14.3	⇧
Maternal mortality from abortions (per 100 000 live births)	13% (1995)	10.9 = 22.5%	⇧
Immunisation coverage : Diphtheria-Tetanus/Pertussis Measles/Polio/Tuberculosis	(1996) 98% / 97% 98% / 99% / 98%	98% / 97% / 99% / 98% / 99%	
STD/AIDS rates	2 AIDS cases (1995)	17 AIDS cases (1998)	⇧

Health services

The health sector is financed 97% by public sources. There is only one private hospital in Moldova offering cosmetology to the citizens. All other hospitals and polyclinics are publicly run.
A health insurance system is presently under way in Moldova. The law of medical insurance is expected to come into force in 1999.

The Essential Drug Policy as recommended by WHO has been adopted in Moldova, and the Essential Drug List includes contraceptives.

65% of pharmacies are privately run and 35% publicly run. It is estimated that there is a general availability of drugs in the major regions of the country.

Recently, a national action plan has been developed to promote a new approach to perinatal care.

Family planning

The Republic of Moldova commenced the implementation of their national programme of family planning in 1994. The programme has been implemented by the principal specialist coordinator in family planning through the division of mother and child care section of primary medical care in

the Ministry of Health. There is a national advisory group orienting the programme of family planning.

The services of family planning are provided in various institutions throughout the country in: maternity hospitals, consultancies of obstetrics and gynaecology, polyclinics, general practitioners, private practices, PHC facilities and village health posts.

Family planning counselling services are offered free of charge by gynaecologists, general practitioners and midwives.

Adolescents do not need an authorization to receive family planning services in the Republic of Moldova. The Moldavian Family Planning Association is actively involved in the national programme of family planning.

Contraception

The main method of fertility regulation in Moldova is as yet clinical abortion. IUDs, oral contraceptives, condoms and natural methods are also methods of fertility regulation used, but less often. The price of one cycle of oral contraceptives is equivalent to 5.3% of an average monthly salary, one IUD to 8.8%, one injection of injectable contraceptive to 10.6% and one condom to 1.7%. All contraceptives are sold in pharmacies.

The country relies on donations of emergency contraceptives for the population, being distributed from the family planning centre.

Abortion

Gynaecological hospitals perform clinical abortions using the technique of curettage (74.6% of all clinical abortions). Municipal polyclinics perform clinical abortion using the technique of vacuum aspirations (25.4% of all clinical abortions).

The estimated prevalence of unsafe abortions in the Republic of Moldova is 19.9%, despite the fact that clinical abortions are available free of charge.
Pre-abortion counselling is performed by gynaecologists. Post-abortion counselling can be performed, upon request, by gynaecologists and midwives.

Recent trends in reproductive health

The implementation of a reproductive health policy was commenced in 1997. Adolescents are offered counselling, contraceptive supplies and information. Steps have been taken to implement social marketing into the national reproductive health care services by undertaking several related activities.

Several NGOs are actively involved in the national reproductive health care services: the Republican Association of Mother and Child Health, the Anti-AIDS Association, the 3rd-Millenium, DRAGS etc.

International organisations have been involved in the training of health workers, provision of contraceptives, provision of material for training, etc.

Antenatal care

Approximately 96% of women are given antenatal care. 10–14 visits are recommended. During these visits clinical examinations are undertaken as well as blood analysis of urine, sugar, blood group, syphilis, the PAP smear, and for 60% of the women obligatory ultrasound examinations. It is estimated that in 1997, 0.38% of pregnant women attending antenatal care showed a positive syphilis serology.

As much as 85% of obstetric and gynaecological admissions are due to abortion.

There are 34.8 beds per 500.000 population offering basic essential obstetric care and 200 beds per 500 000 population offering comprehensive essential obstetric care in the Republic of Moldova.

Breast and cervical cancer

Previously, women over 30 years of age were screened on a yearly basis, but due to budget constraints this practice has been minimised .

In 1997, the breast cancer prevalence was 297.3/100 000 women and the cervical cancer prevalence was 227.1/100 000 women. It would be important to find out the incidence rates of breast and cervical cancer, so as to assess the effectiveness of early detection and treatment.

Child health

The patterns of child morbidity reflect worsening socio-economic conditions, and in particular, the shortage of vaccines. Major causes of child morbidity are respiratory diseases, infectious and parasitic diseases, accidents and poisoning. Due to the lack of vaccines, the number of children vaccinated against diphtheria, pertussis, tetanus, tuberculosis and poliomyelitis have decreased.

According to the report of the paediatric referral hospital in Kishinau, an increase in allergies, iodine deficiency and cancers in recent years, including deaths from thyroid cancer, have been seen. Despite an almost 100% success rate with breastfeeding after birth, breastfeeding practices after discharge seem to require further evaluation.

Adolescent health[16]

Data collected from a 1997 Reproductive Health survey illuminated the reproductive health and family planning needs of young women. Today, the youth of Moldova, 15 to 24 years of age, are 0,7 million in number and represent 17% of the total population.

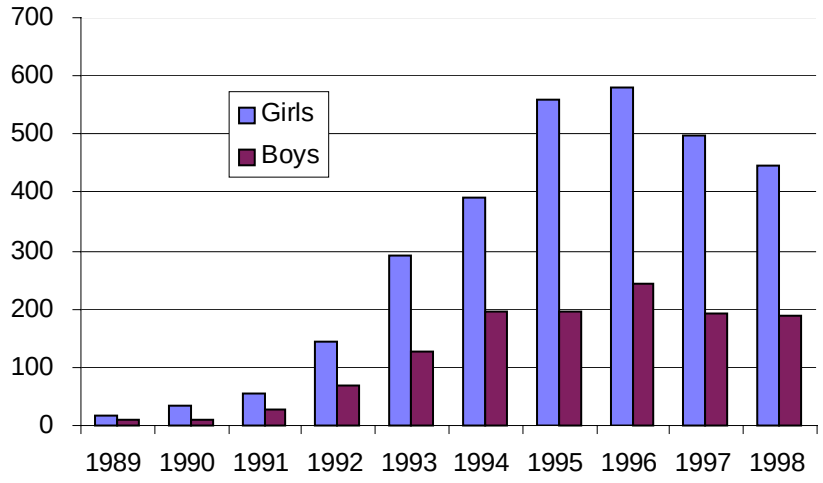
Half of the 15-24 year olds surveyed reported that they have had sexual intercourse: 21% of 15-19 year-olds and 83% of 20-24 year-olds. Among these young adults, 52% (26% of the total) said that their first intercourse was premarital: two-thirds of 15-19 year-olds and slightly less than one-half of 20-24 year-olds. Premarital sexual experience was related to residence, 37% of young adults in the four municipalities reported premarital sexual experience, compared with 25% in other urban areas and 19% in rural areas. Only one-third of young adults with premarital sexual intercourse used contraception at first intercourse, primarily condoms (13%) and withdrawal (16%). Russian

[16] Reproductive Health Survey Moldova, 1997 CDC Atlanta.

and Ukrainian youth were more likely to use contraception at first premarital intercourse than were Moldavians. The principal reasons for non-use at first premarital relation were that sexual intercourse was not expected or "she did not think about using a method." Only 18% of young adults who first had sexual intercourse after marriage used contraception; 60% of non-users said that "they wanted to get pregnant," again showing the pressure to have a child soon after marriage in a traditional society. Contraceptive use improves dramatically after unmarried women are pregnant or enter into a more stable relationship, 66% (40% modern methods, primarily condom) of women in this category said they or their partner used contraception during their most recent sexual intercourse.

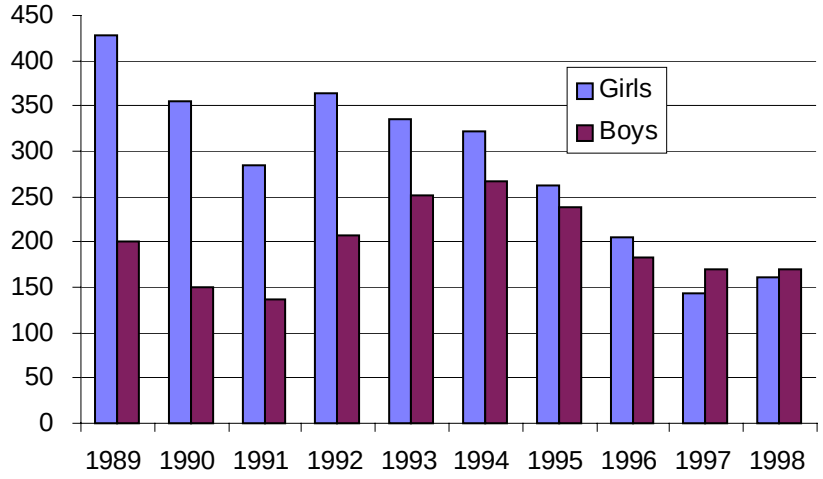
Data from the study indicates that only 15% of girls aged 15-24 were satisfied with their family planning services. The data on STDs reveals a trend which requires attention. (See Figures 1M and 2M).

Figure 1M. Syphilis rates (per 100000) among 15-19 year-olds, Moldova



Source: UNICEF ICDC, Country Statistical Reports, 1999.

Figure 2M. Gonorrhoea rates (per 100000) among 15-19 year-olds, Moldova



Source: UNICEF ICDC, Country Statistical Reports, 1999.

Areas for action and policy changes

- Urgent need for bilateral and multilateral support to the MCH/FP/RH sector, to include technical and material assistance;
- Implementation of the perinatal care strategy;
- Urgent need for maternal health drugs and material;
- Need to develop specific strategies based on regional needs in the area of education, counselling and service provision programmes;
- Provision of adequate quantities of contraceptives;
- Further assistance should be given to review all family planning and reproductive health care activities in order to comply with the needs of women in the Republic of Moldova;
- Need for upgrading the quantity and quality of existing abortion equipment to meet safety requirements in order to prevent complications and unnecessarily late abortions;
- Assistance to adolescent health projects needed.

The Russian Federation

VARIABLES	PAST DATA	PRESENT DATA (1997)	⇧ ⇩
Population estimate (millions)	147.9 (1995)	147.5	⇩
HDI (Human Development Index) value	0.804 (1993)	0.747	⇩
HDI (Human Development Index) rank	57 (1995)	71	⇩
GNP US$ (per capita)	2680 (1992)	2650 (1994)	⇩
Women of fertile age (age 15-49)	37.8 mill (1995)	38.58 mill	⇧
Total fertility rate (per woman)	1.03 (1995)	1.23	⇧
Maternal mortality ratio (per 100 000 live births)	53.3 (1995)	50.2	⇩
Perinatal mortality rate (per 1000 births)	14.56 (1996)	14.48 (1997)	
Infant mortality rate (per 1000 live births)	18.1 (1995)	16.9	⇩
Contraceptive methods used	Mainly IUDs	Mainly OC,IUD	
Contraceptive prevalence rate	23.8% (1995)	24.6%	⇧
Contraceptive choice index	No data	66.7 /good (1996)	
Abortion rate (per 1000 women age 15-49)	69.1 (1995)	64.2	⇩
Abortion:birth ratio < age 20	1.1:1 (1995)	1.2:1 (1996)	⇧
Abortion:birth ratio age 20-34	No data	No data	
Abortion:birth ratio age 35+	6.4:1 (1995)	5.9:1 (1996)	⇩
Abortion:birth ratio, all ages	1.9:1 (1995)	1.8:1 (1996)	⇩
Birth rate (per 1000 population)	9.3 (1995)	8.6	⇩
Maternal mortality from abortions (per 100 000 live births)	23.2% (1995)	154 (absolute number)	
Immunisation coverage : **Diphtheria-Tetanus / Pertussis** **Measles/Polio/Tuberculosis**	(1996) 96% / 87% 95% / 97% / 97%	 - / 71% / 85% 85% / 58% / 97%	
STD/AIDS rates	39 AIDS cases (1995)	325 AIDS cases (1998)	⇧

Health services

The growing economic difficulties have made it hard to implement universal access to health and social services in the Russian Federation. Significant cuts in the public health care budget have resulted in a decrease of state-guaranteed health services for women and children. Lack of modern equipment, of accessible medicine and qualified personnel have led to deteriorating health among the population, particularly among women and children.

There are some private medical establishments, but as yet no data illustrates how the health sector is financed altogether. This applies for pharmacies as well. The main role of the various professionals in reproductive health services is providing information and counselling. The entire population in Russia is covered by a national health insurance. The country has adopted the Essential Drug Policy but has not included contraceptives in the Essential Drug List.

The present economic situation in Russia has made the availability of drugs in the major regions of the country an uncertain issue.

Family planning

During the period 1993–1997 a national programme of family planning has been implemented. As of 1998, the family planning programme became an integrated part of the Safe Motherhood Programme, to which investments have yet to come.

A national advisory group orients the programme of family planning. The services are provided in maternity hospitals, consultancies of obstetrics and gynaecology, polyclinics, private practices, PHC facilities and village health posts.

All state institutions provide family planning counselling free of charge. Fees may have to be paid for the same service in private practices. Gynaecologists and midwives provide the family planning counselling.

Adolescents need to have an authorization to receive family planning services in Russia. The Russian Family Planning Association is actively involved in the national family planning programme.

Contraception

The main method of fertility regulation is as yet the use of clinical abortions. The supplies of modern contraceptives in Russia is for the most either unavailable in sufficient quantities or unaffordable for the majority of the population, although data does indicate that the price of contraceptives is equivalent to 3–5% of the average monthly salary. The contraceptives sold in pharmacies are oral contraceptives, condoms, spermicides and IUDs.

Abortion

Clinical abortions are performed in medical establishments. The techniques of curettage and vacuum aspiration are used. There is no present data on the prevalence of unsafe abortions in Russia, but it is assumed that the prevalence is high, as the medical establishment have many cases of post-abortion complications that have no previous records.

Clinical abortions are by law supposedly free of charge for all in the Russian Federation, but the present socio-economic situation has triggered a growing habit of charges made for clinical abortions.
Pre- and post abortion counselling are seldom performed.

Recent trends in reproductive health

The Russian Federation has adopted a reproductive health policy, but the investment level for implementing the activities is estimated to be too low for optimal effect.

Adolescents are offered reproductive health care services in youth centres and in family planning centres. Social marketing has been introduced into a few projects of reproductive health care in various regions of the Federation. The Russian Family Planning Association and its affiliates in the country are actively involved in reproductive health care activities. Several international organisations are involved in activities of education, training, upgrading quality of services and strengthening the Family Planning Association.

Antenatal care

It is estimated that approximately 80% of women in the Russian Federation are given antenatal care. 5–7 visits are recommended. Despite various checks routinely undertaken of pregnant women attending antenatal care, including ultrasound examinations, there is no systematic data on the percentage of pregnant women showing a positive syphilis serology. From other data sources it is recognized that STI rates are rising, particularly syphilis and gonorrhoea.

The present data indicates that there are 14.1 beds for obstetric-gynaecological admissions per 10 000 women in the country.

Increasing infant and maternal mortality are causing concern and many women die of abortion-related complications.

Breast and cervical cancer

The leading cancer cases in the Russian Federation are those associated with breast cancer. Incidences are far above the European average of 19 per 100 000, being 50.1/100 000 in 1996. Uterus and placenta cancer rates are 33.1/100 000 in 1996. This is not comparable to the European average cervical cancer rate, as the Russian data combines uterus and placenta.

Child health

The main cause of morbidity among children are diseases of the respiratory system, followed by diseases of the nervous system and sensory organs, infectious and parasitic diseases and diseases of the digestive system.

Adolescent health[17]

Relatively few 15 year-olds (7%-9%) reported being sexually experienced, but the percentages rose sharply from age 16 to 19. Roughly one-fourth of 16 year-olds were sexually experienced, more than half of 18 year-olds reported having had intercourse.

Among 15-24 year-olds sexually experienced respondents, only 7% to 17% said they did not have premarital sex. The first experience of those who had sex before age 18 was more likely to have been non-marital.

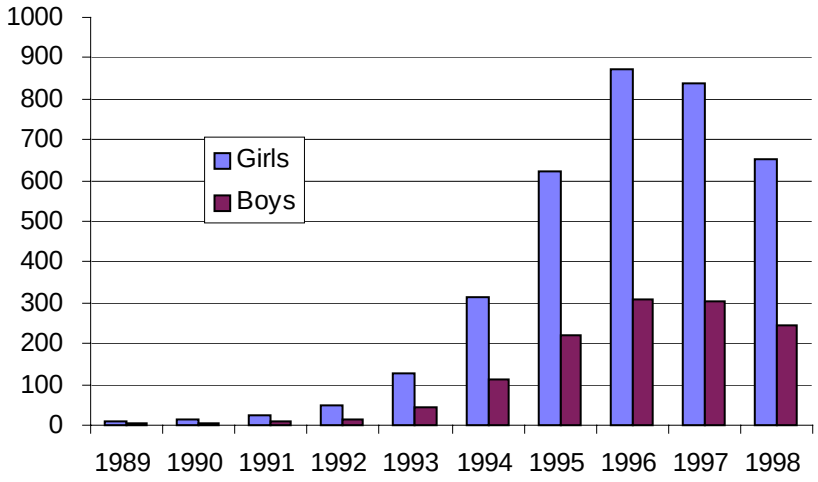
Between 39% and 48% of sexually experienced young respondents reported that they used some form of contraception the first time they had intercourse. Condoms and withdrawal accounted for most of this contraception. Respondent who first had sex at age 18 or older were slightly more likely to have used contraception than those who started younger.

The study results indicated that age at first intercourse has been decreasing. Growing proportions of women have had sex by the time they turn 16, 18, and 20 years old. About two-thirds of all respondents had had sexual intercourse in previous 30 days.

[17] 1996 Russia Women's Reproductive Health Survey: A study of Three Sites; Published in 1998 by CDC Atlanta.

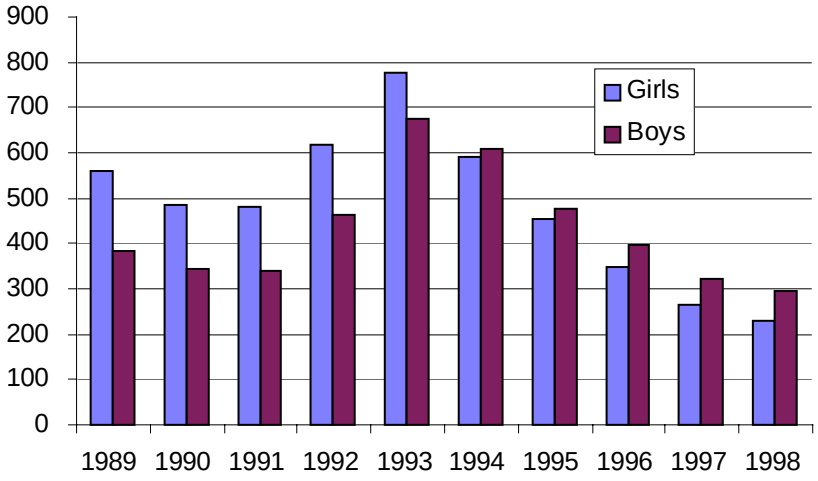
Between 19% and 28% of respondents, who were of all ages, reported that health care provider had ever talked with them about how to prevent the spread of STIs.

Figure 1RU. Syphilis rates (per 100000) among 15-19 year-olds, Russian Federation



Source: UNICEF ICDC, Country Statistical Reports, 1999.

Figure 2RU. Gonorrhoea rates (per 100000) among 15-19 year-olds, Russian Federation



Source: UNICEF ICDC, Country Statistical Reports, 1999.

Areas for action and policy changes

- Improving technology and quality of care in gynaecological/obstetric and perinatal services aiming at improving women's and child health;
- Breastfeeding promotion: provide technical assistance and material support to initiate national and regional campaigns involving both professional reorientation and major media coverage;

- Development of appropriate policies in the hospitals (baby-friendly hospitals);
- Assist in improving in-country production of basic pharmaceuticals, including contraceptives and basic equipment;
- Further financial support to the local production of contraceptives;
- Strengthening human resources in reproductive health care services;
- Need for an analysis of the situation of women and children by oblast or at least by region, particularly to identify the most disadvantaged areas and groups, as this should be the standard approach in the future;
- Strengthening of the primary health care system:
    - in education regarding modern birth control and ensuring its adequate distribution
    - in perinatal care
    - in high-risk assessment
    - in referral and care
    - in the quantity and quality of the visits by the specialists to the outlying feldsher posts on a regular basis;
- AIDS/STI prevention programmes are urgently needed;
- assistance to adolescent health projects urgently needed.

Ukraine

VARIABLES	PAST DATA	PRESENT DATA (1997)	⇧ ⇩
Population estimate (millions)	51.4 (1995)	50.9	⇩
HDI (Human Development Index) value	0.736 (1994)	0.665 (1998)	⇩
HDI (Human Development Index) rank	80 (1993)	102 (1998)	⇩
GNP US$ (per capita)	1570 (1994)	1040 (1997)	⇩
Women of fertile age (age 15-49)	11.3 mill (1994)	12.6 million	⇧
Total fertility rate (per woman)	1.38 (1995)	1.32	⇩
Maternal mortality ratio (per 100 000 live births)	32.1 (1996)	30.9	⇩
Perinatal mortality rate (per 1000 births)	No data	12.2 (1995)	
Infant mortality rate (per 1000 live births)	14.7 (1995)	14.1	⇩
Contraceptive methods used	Mainly IUDs	IUD, OC	
Contraceptive prevalence rate	20.5% (1995)	22.1 %	⇧
Contraceptive choice index	No data	41.7 /fair (1996)	
Abortion rate (per 1000 women age 15-49)	51.5 (1996)	44.2	⇩
Abortion:birth ratio < age 20	No data	*14.76%	
Abortion:birth ratio age 20-34	No data	No data	
Abortion:birth ratio age 35+	No data	4.3:1	
Abortion:birth ratio, all ages	1.4:1 (1995)	1.44:1	⇧
Birth rate (per 1000 population)	9.2 (1996)	8.8	⇩
Maternal mortality from abortions (per 100 000 live births)	17% (1996)	23%	⇧
Immunisation coverage : Diphtheria-Tetanus/Pertussis Measles/Polio/Tuberculosis	(1995) 98% / 96% 97% / 97% / 95%		
STD/AIDS rates	35 AIDS cases (1995)	498 AIDS cases (1998)	⇧

** No information available on births by age group, therefore indicator was not calculable.*

Health services

Several national programmes have been adopted and commenced on the issues of family planning, women's health protection, maternity and childhood care. A number of national laws have been adopted on the issues of reproductive health care.

The health sector in Ukraine is financed 100% by public sources. Family planning and reproductive health services are provided by various professionals. The major role is taken by physicians of family planning centres. Medical consultations, training and methodology support is also provided by obstetricians and gynaecologists, as well as adolescent gynaecologists, psychologists, midwives, nurses and volunteer professionals.

There is no national health insurance system in Ukraine at present. The transition to a health insurance system is a process that requires time not available at present as the current status of the health care system demands immediate organisational and structural reconstruction. In introducing a health insurance system, it is the aim that a minimum basic package of health services is guaranteed for all and equity in the provision of health care services will be sought.

There is a need for health care services to be re-organised nationally to provide cost-effective health care. A system of primary, secondary and tertiary level care needs to be established with requirements for equipment and supplies linked to the function within each institution.

The country has adopted the Essential Drug Policy, as recommended by WHO. Contraceptives have been included on the Drug List for certain categories of people.

At present, the 30% of the national pharmacies are run by public sources and 70% are privately owned. Drugs are estimated to be commercially 100% available in Kiev and the major cities, with an unknown availability in rural areas.

Family planning

Ukraine has a national programme of family planning. A national advisory group is attached to the programme of family planning.

Implementation of this programme was commenced in 1995 in cooperation with several international donor organizations, supporting specific projects of the programme. Family planning centres have been created, training has been provided for specialists and contraceptives have been supplied. NGOs are actively involved in the programme, mainly the Ukrainian Family Planning Association (UFPA) and the Association of Natural Family Planning Methods Teachers.

General family planning services are being provided in maternity hospitals, consultancies of obstetrics and gynaecology, polyclinics, village health posts and in private clinics. The state run services are free of charge for the public. Costs in the privately run services varies.

Family planning counselling is provided by gynaecologists and midwives. Adolescents do not need authorization to receive family planning services in Ukraine.

Contraception

The main method of fertility regulation in Ukraine is still by clinical abortion, however, IUDs, oral contraceptives (OC) and condoms are said to be available on a reliable basis. Apart from OCs, condoms, and IUDs, pharmacies sell postcoital pills, spermicidal foams and gels.

Contraceptives are free of charge for certain groups of the population, but in general women have to spend 10–15 % of their monthly salary to obtain one cycle of OCs . IUDs cost a similar proportion of a woman’s monthly salary. Condoms are estimated to cost 0.2–0.5% of a monthly salary.

Consultations on emergency contraception are available to all free of charge.

Abortion

Abortion is still seen as the basic method of fertility regulation. The number of abortions in Ukraine today is one of the highest in the world.

Clinical abortions are performed in obstetric/gynaecological clinics, polyclinics and in women’s consultations. Both techniques of curettage and vacuum aspiration are used, however, the main cause of death is still connected with abortion (both safe and unsafe), accounting for 23% of all maternal deaths. It is estimated that over 5% of abortions are performed illegally outside medical institutions.

There is an estimated prevalence of unsafe abortion in Ukraine of 11%. These unsafe abortions lead to death three times more often than the safe abortions.
Clinical abortion is free of charge for the poorest of the lower income groups. For higher income groups, the average price for a clinical abortion is equivalent to 30US$.

Gynaecologists perform both pre- and post abortion counselling.

Recent trends in reproductive health

Ukraine has adopted a reproductive health policy, implemented since 1992. The UFPA is actively involved in the reproductive health care services. UNFPA is involved in "Support to the National Family Planning Programme (1995–2000)", USAID is involved in Perinatal Technologies Project and UNAIDS is involved in "Prevention of STI/AIDS Projects".

Social marketing has not yet been implemented in the national reproductive health care services.

Reproductive health care has not officially been privatized in Ukraine, however, specialists are allowed to run private practices.

Reproductive health care services are being offered to adolescents by means of sexual education provided by paediatricians and adolescent gynaecologists.

Despite these efforts , analysis of morbidity rates according to data from women's consultations shows that recent years have witnessed a persistent tendency toward the worsening of women's health. This situation can be explained by the inadequate system of information on all aspects of family planning, the low level of the population's sexual culture, its lack of knowledge concerning reproductive behaviour, irresponsible parenthood and an inadequately developed family planning service. Adoption of contemporary methods of contraception would foster a lower number of abortions, prevent unwanted pregnancies and optimize the selection of the best time for women to be pregnant during their lifetime.

Antenatal care

It is estimated that 99,3 % of women are given antenatal care in Ukraine. Women are recommended to make 14–16 visits. The following checks are routinely undertaken: CBC, urinalysis, AIDS/RW, HBsAG , vaginal cultures, PAP smear, 2 ultrasound scannings (obligatory), internist's, dental checks, ophthalmology. However, there is presently no data on what percentage of pregnant women attending antenatal care shows a positive syphilis serology.

There are 62.5 obstetric stations per 500 000 population running **basic** essential obstetric care.
250 obstetric hospital beds per 500 000 population are offering **comprehensive** essential obstetric care.

It is not known what percentage of obstetric and gynaecological admissions are due to abortion.

The leading causes of maternal mortality in recent years are illness related to pregnancy, loss of blood, gestosis, and septic complications.

Child health

Acute respiratory infections are a major cause of avoidable deaths in children.

After the Chernobyl accident, children aged 0–3 years experienced health problems of some sort in both contaminated and uncontaminated areas. Almost all children in the older age groups living in the contaminated areas had health problems (respiratory problems, allergic diseases) compared to children living in uncontaminated areas. It is estimated that the prevailing iodine deficiency before the Chernobyl disaster increased the serious effects of these health problems.

Adolescent health

Reproductive health care of children and adolescents is a component of the child and maternal health care with its main principles of a prophylactic orientation and accessibility of medical assistance. Medical assistance to children and adolescents in the area of reproductive health is provided in Ukraine through family planning centres, centres for adolescents, which are mostly organized within maternity advice bureaus and children's consultations, and children and adolescent gynaecological rooms.

Youth sexual education centres have also been established. These centres produce materials for young people by young people. Many young people are trying to prevent pregnancy but have never spoken to anyone about how or about their options (See Tables 1U and 2U).

Table 1U. Response to the question," If you have a sexual relations, do you try to prevent pregnancy?"

Response to questions	15-18 years		19-20 years	
	Boys	Girls	Boys	Girls
Yes	76.1	53.4	78.2	49.8
No	23.9	20.5	21.8	21.6
Sometime		26.1		28.6

Source: UNFPA, et.al, Adolescent Reproductive and Sexual Health in the Ukraine.

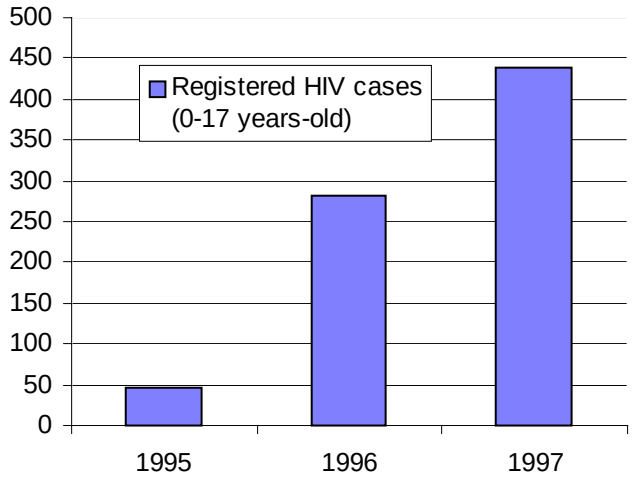
Table 2U. Response to the question," Have you ever asked anyone for information about sexual life"

Response to questions	Age	
	15-18	19-20
Yes	32.8	34.5
No	67.2	65.5

Source: UNFPA, et.al, Adolescent Reproductive and Sexual Health in the Ukraine.

The Ukraine has one of the highest rates of HIV and AIDS in the transitional countries (See Figure 1U). Concerted efforts have been focused on the Ukraine by UNICEF, UNAIDS, UNFPA, and the WHO to confront the rising incidence of HIV. The major mode of transmission is IVDU followed by heterosexual sex with IVDUs.

Figure 1U. Registered HIV cases among 0-17 year-olds, Ukraine



Source: UNICEF ICDC, Country Statistical Reports, 1999.

Breast and cervical cancer

It is estimated that 53.7 per 100 000 women develop breast cancer and 18.2 per 100 000 women develop cervical cancer. The standardized mortality rate in 1996 per 100 000 women for breast cancer was 28.9 and 9.7 for cervical cancer.

Areas for action and policy changes

- Improvement needed in infant health care;
- Family planning services need to be strengthened and availability of contraception need to be increased. Needs include: providing technical assistance, training, supplies and education in the area of family planning;
- Improvements in laboratory and technical equipment for diagnosis of prenatal and perinatal conditions are necessary;
- Assistance to adolescent health projects needed, particularly health promotion and counselling services;
- Investigate the breast cancer incidence rates so as to assess the effectiveness of early detection and treatment;
- AIDS/STI prevention programmes are urgently needed.

References

Albania National Report: *Action for Development, Equality and Peace*, 1993.

Armenia : *National report on the Conditions of Women*, 1995.

Bengt Lindström, Nick Spencer: *Social Paediatrics.* Oxford University Press, 1995.

Estonia Family Planning Association: *From abortion to contraception: Strengthening family planning in two centres in Estonia.* Final project evaluation by Dr Evert Ketting. December 1997

International Foundation for Children and Families, National Institute for Mother and Child Health Care, and National Commission for Statistics: *Young Adult Reproductive Health Survey Romania. Preliminary Report, April 1997*, by Florina Serbanescu MD and Leo Morris PhD, Bucharest 1997.

Ministry of Health, Society of Paediatricians in Lithuania,
Mother and Child Health Care Programme, Lithuania, 1994

Ministry of Health in Bosnia Herzegovina
Federation Health Programme, February 1996.

Ministry of Health, Republic of Uzbekistan: *Population Health in the Republic of Uzbekistan in 1994-1995 and some stages of Health Protection Reform*, Tashkent 1996

Ministry of Welfare, Latvia: Reproductive Health of the Population of Latvia. Evaluation and recommendations. Riga 1998

Moldovan Ministry of Health, Division of Reproductive Health CDC-Atlanta, United Nations Population Fund, USAID, UNICEF: *Reproductive Health Survey, Moldova, 1997. Preliminary Report.* Prepared by Dr F.Serbanescu & Dr Leo Morris. May, 1998.

National Preparatory Committee for the UN Fourth Conference on Women, Latvia: *National Report on the Situation of Women in Latvia*. Latvia, 1995.

Population Reference Bureau Inc.: *World Population Data Sheet, 1994*; Washington, 1994.

Population Division of the Department for Economic and Social Information and policy Analysis of the United Nations Secretariat: *World Population Monitoring, 1996. Selected aspects of reproductive rights and reproductive health - Draft, January 1996.*

The situation of women in Poland, **NGO paper**, 1995.

Reproductive Health Alliance of Europe: An assessment of the reproductive health needs of young people in Kyrgyzstan, 1999.

Republic of Albania: *Sector of Statistics of the Ministry of Health*, 1994.

Republic of Bosnia and Herzegovina, Government: *Survival Programme for the population of the Republic of Bosnia and Herzegovina during the period from 1 November to 30 June 1993;* Sarajevo, 1 November 1992.

United Nations Children's Fund (UNICEF): *Children and women in Kazakhstan, A Rapid Assessment;*Alma Ata, 19-25 October 1992.

United Nations Children's Fund (UNICEF): *Preparation and Methodology for a Situation Analysis on Children and Women in Bulgaria.*1991

United Nations Children's Fund (UNICEF)&Government of the Republic of Albania;
Children and women in Albania, 1993

United Nations Children's Fund (UNICEF)&Government of the Republic of Armenia
Children and women in Armenia, 1994

United Nations Children's Fund (UNICEF)/World Health Organisation (WHO) Mission with the participation of United Nations Development Programme (UNDP), United Nations Populations Fund (UNFPA) and World Food Programme(WFP)
Belarus; Human needs, crisis and transition.20-23 February 1992
Independent Republic of Kazakhstan, Alma Ata, 17-26 February 1992.
The looming crisis of children and women in Kyrgyzstan, Bishkek, June 1995.
Health in the Russian Federation ; with emphasis on children and women, 17February-2March 1992
Republic of Turkmenistan, Askhabad, 17-21 February 1992.
Republic of Uzbekistan, Tashkent, 21 February-2 March 1992

United Nations Children's Fund, International Child Development Centre (UNICEF ICDC): Country Statistical Reports, 1999**.** http://www.unicef-icdc.org/

United Nations Children's Fund, International Child Development Centre (UNICEF ICDC): Country Reports, 1999.

United Nations Development Programme (UNDP): *Human Development Report 1994,* New York, 1994.

United Nations Populations Fund (UNFPA)/ World Health Organisation (WHO)/ International Planned Parenthood Federation (IPPF) and Dr Assia Brandrup-Lukanow, Janet Jackson, 2-8 June 1994. *Maternal & Child Health and Family Planning , Basic needs assessment mission in Moldova.*

United Nations Populations Fund (UNFPA), World Health Organisation Regional Office for Europe: *Family Planning and Reproductive Health in CEE/NIS.* Copenhagen,1995.

United Nations Population Fund (UNFPA), World Health Organisation Regional Office for Europe, Ministry of Health of Ukraine, Ukranian Family Planning Association: *Adolescent Reproductive and Sexual Health in Ukraine,* 1995.

Children and Women of Belarus-**UNICEF** 1995.

United Nations Development Fund (UNDP): *Human Development Report 1996,* New York, 1996.

United Nations Development Fund (UNDP):*Human Development Fund, 1999*, New York.

United Nations Population Fund (UNFPA):(unpublished) *Recommendation by the Executive Director. Assistance to Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan. Support for a population programme.* New York, 1994.

United Nations Population Fund (UNFPA): Review and needs assessment report (unpublished): *Executive summary. Trip to five Central Asian Republics, by P.M. Jesse Brandt of UNFPA country support team, Office for South and West Asia;* Kathmandu, August 1994.

United Nations Population Fund (UNFPA): *Maternal Mortality in Romania. Trends and differences 1989 to 1995***.** Study by Prof. Vasile Ghetau, Bucharest, October 1996.

United Nations Population Fund (UNFPA): *Population and Reproductive Health in th Russian Federation.* Needs Assessment Report. ISBN:0-89714-475-9. E/500/1998.

United Nations Population Fund (UNFPA), **WHO, Ministry of Health of Ukraine, Ukrainian Family Planning Association:** Adolescent Reproductive and Sexual Health in the Ukraine: situational analysis, 1999.

World Health Organisation, Regional Office for Europe,
Copenhagen: *Highlights on Health in:*
Azerbaijan, November 1992
Georgia, December 1992
Kyrgyzstan, November 1992

World Health Organisation, Regional Office for Europe and Patricia Stephenson:*Women's and Children's Health in Georgia*.February, 1995.

World Health Organisation, Regional Office for Europe: Health and Health Behaviour Among Young People, WHO Policy series: Health policy for children and adolescents, Issue 1, International Report, 1999.

World Health Organisation, Child and Adolescent Health and Development Programme: Young people: in Armenia Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Mongolia, Tajikistan, Turkmenistan, Uzbekistan. A project report, 10 October 1998.

World Bank (WB)/World Health Organisation (WHO)/Ministry of Health of Kyrgyzstan. *Maternal and Perinatal Health,* Bishkek, June 1995.

World Bank: Draft of *Reproductive Health in transition Economies. A four countries study*, by Joana Godinho, WB consultant, Washington, November 1994.

World Health Organization, Regional Office for Europe, Sexuality and Family Planning Unit: Background Document (Table, Paper) on *International Activities in CEE/NIS* prepared for Working Meeting/Interagency; Copenhagen, March 1993.

World Health Organization, Regional Office for Europe: *Targets for health for all. The health policy for Europe.* Summary of the updated edition, Copenhagen, September 1991.

World Health Organization, Regional Office for Europe: *Health in Europe. The 1993/1994 health for all monitoring report*, WHO Regional Publications, European Series, No.56.

World Health Organization, Regional Office for Europe: *HEALTH21 - The Introduction to the Health for All Policy for the European Region*, Copenhagen, EUR/RC 48/9, 22 July 1998

World Health Organization, Regional Office for Europe, Copenhagen: *Cooperative Medium-Term Programmes for 1996-97* with the Ministries of Health (or their equivalent) of all the countries in the CEE and CIS.

World Health Organization, Regional Office for Europe, and Dr Tatjana Harito (Ministry of Health, Albania): *Women's Health Profile in Albania* (unedited document); Copenhagen, January 1994.

World Health Organization Regional Office for Europe: Various unpublished *Duty travel reports*; Copenhagen, 1993–97.

World Health Organization Regional Office for Europe: *Highlight on Women's Health* (all countries in CEE and CIS) , Copenhagen, 1997.

World Health Organization Regional Office for Europe: *Elaboration of an Institutional Framework for the Family Planning Programme in Bulgaria.* Report on Final Evaluation. Copenhagen, Family Planning BG9301/03/01

World Health Organization, Division of Reproductive Health, Geneva: *Monitoring Reproductive Health: Selecting a shortlist of national and global indicators*. WHO/RHT/HRP/97.26

World Health Organization Regional Office for Europe: AIDS case reported to WHO by Country/territory. Based on reports received through 20 June 1998.

World Health Organization Regional Office for Europe: *Population and Reproductive Health in the Russian Federation.* UNFPA needs assessment mission 12-30 May 1997. Preliminary report. EUR/FMLY 04 23 06.

World Health Organization Regional Office for Europe: *The Epidemiology of Induced Abortions in Russia: Pilot trial***.** Copenhagen, 1997, EUR/RUS/FMLY 04 23 04

World Health Organization, Geneva, and Health Perfect International: *Report on Training Health Professionals in reproductive Health with Emphasis on Birth Spacing Methods in Turkmenistan*.prepared by Dr H.B.Schaap, 1997

ANNEXES TO

Family Planning and Reproductive Health in central and eastern Europe and the newly independent states

Updated edition, 2000

Sources of annexes are from the Ministries of Health in CEE and CIS, Health for All database, United Nations Development Fund and Population Action International.

From abortion to contraception

Questionnaire

1 What steps has your country taken to implement the endorsed Programme of Action developed at the ICPD in Cairo in 1994?

HEALTH SECTOR IN GENERAL

2 How does your country finance the health sector ?
By public sources ……. (estimated percentage)
By private sources ……. (estimated percentage)

3 How does your country meet the coverage needs of
Public hospitals …….. (estimated percentage)
Private hospitals …….. (estimated percentage)
Public polyclinics …….. (estimated percentage)
Private polyclinics …….. (estimated percentage)

4 What is the role of the various professionals in reproductive health service provision? ..……..

5 What percentage of your population is covered under your present national health insurance ? …….

6 Has your country adopted the Essential Drug Policy ?

Yes …….. No ……..
If yes, are contraceptives included on the Essential Drug List ?
Yes …….. No ……..

7 What percentage of your national pharmacies are
Public …… (estimated percentage)
Private …… (estimated percentage)

8 What is the general availability of drugs in the major regions of your country (estimated percentage of coverage need) ?
……

FAMILY PLANNING

9 Does your country have a national programme of Family Planning ?

Yes …….. No ……..
If yes, please state the year implementation of the programme was commenced ……..

10 How is the programme implemented on Ministry of Health level (please attach an organigramme) ? …….
……
……

11 Is there a national advisory group orienting the programme of Family Planning? …….

12 In which institutions are Family Planning services provided ?
(tick the appropriate)

Maternity hospitals ……
Consultancies of obstetrics and gynaecology ……
Polyclinics ……
General practitioners ……
Private practice ……
Primary Health Care facilities ……
Village Health Post ……

13 Are Family Planning counselling services offered free-of-charge ?

Yes …….. No ……..
If not, what is their cost (in proportion of monthly salary) ?
……..

14 Who provides the Family Planning counselling ? (tick the appropriate)
General practitioner ……..
Gynaecologists ……..
Midwife ……..

15 Does an adolescent need authorization to receive Family Planning services in your country ?
Yes ……. No ……..

16 What is the main method of fertility regulation in your country?
(tick the appropriate)
Clinical abortion ……
IUD ……
Oral Contraceptives ……
Condoms ……
Natural methods ……

17 Do you have a reliable continuity of availability of the first four mentioned methods ?

Yes ……. No ……..
If not, can you state the reason ……...
…….

18 Are contraceptives free-of-charge ?

Yes …….. No …….

If not, what is their cost (in proportion of monthly salary):

One cycle of oral contraceptives ……..
One IUD ……
Implant ……
One injection of injectable contraceptive ……
Condom ……

19 Which contraceptives are sold in pharmacies ? ..……...

20 How has your country made emergency contraceptives available to your population ? …….

21 Where are clinical abortions performed? ……..……
…….

22 What techniques are used for the performance of clinical abortions ?
(tick the appropriate)
Curettage ……
Vacuum aspiration ……
Other methods (please describe) ……..…….
……

23 What is the estimated prevalence of unsafe abortion in your country ?
…….….

24 Is clinical abortion available free-of-charge in your country?

Yes ……. No ……..
If not, what is the average price (in proportion of monthly salary)
……..

25 Is pre-abortion counselling performed and by whom ? ……..……
……..……

26 Is post-abortion counselling performed and by whom ? ……
……..……

27 Which national NGOs (non-governmental organisations) are actively involved in your national programme of Family Planning ?
……..
……..

REPRODUCTIVE HEALTH

28 Does your country have a Reproductive Health Policy (a public policy specifically on women's health) ?

Yes …..……. No ……..
If yes, please state the year implementation of the Policy was commenced
…….

29 Has Reproductive Health care been privatised in your country?

Yes ……. No …..……..
If yes, please state to what extent (the entire or certain parts of the Reproductive Health care) ……
……

30 Does your country offer Reproductive Health care services to adolescents?

Yes ……. No …..……..
If yes, please state in what manner the services are offered ……..…
……...

31 What steps have been taken in your country to implement social marketing into the national Reproductive Health care services ?
…….
…….

32 Which national NGOs (non-governmental organisations) are actively involved in your national Reproductive Health care services ?
…….
…….

33 Which major donor organisations are presently active in your country ? (tick the appropriate)
UNFPA …….
UNICEF …….
EU-PHARE …….
EU-TACIS …….
World Bank …….
IPPF …….
Medecin Sans Frontieres …….
USAID …….
Family Health International (FHI) …….
GTZ/KfW …….
DANIDA …….
SIDA …….
UK-ODA …….
NORAD …….
JICA …….
SOROS Foundation …….
Govt. of Netherlands ..……
Govt. of Italy …….
Others ……
…….……

34 What activities in relation to Reproductive Health are the above mentioned donor organisations involved in? …….
……..……..

ANTENATAL CARE

35 What percentage of women are given antenatal care in your country ?
……..

36 How many visits are recommended ? ..…….
…….

37 Which checks are undertaken routinely ? ……..
…….

38 What number of facilities have functioning **basic** essential obstetric care per 500 000 population ? ……..……
……

39 What number of facilities have functioning **comprehensive** essential obstetric care per 500 000 population ? ……

40 What percentage of pregnant women attending antenatal care show a positive syphilis serology ? ……..……

41 What percentage of obstetric and gynaecological admissions are due to abortion ? ……..……

42 Do pregnant women in your country undergo ultrasound examinations?

Yes ……. No ……..
If yes, are the examinations:
Obligatory …….
Voluntary …….
for the women to undergo ?

43 How many ultrasound examinations are recommended a pregnant woman in your country to undergo? …… not less than two times …….
…….

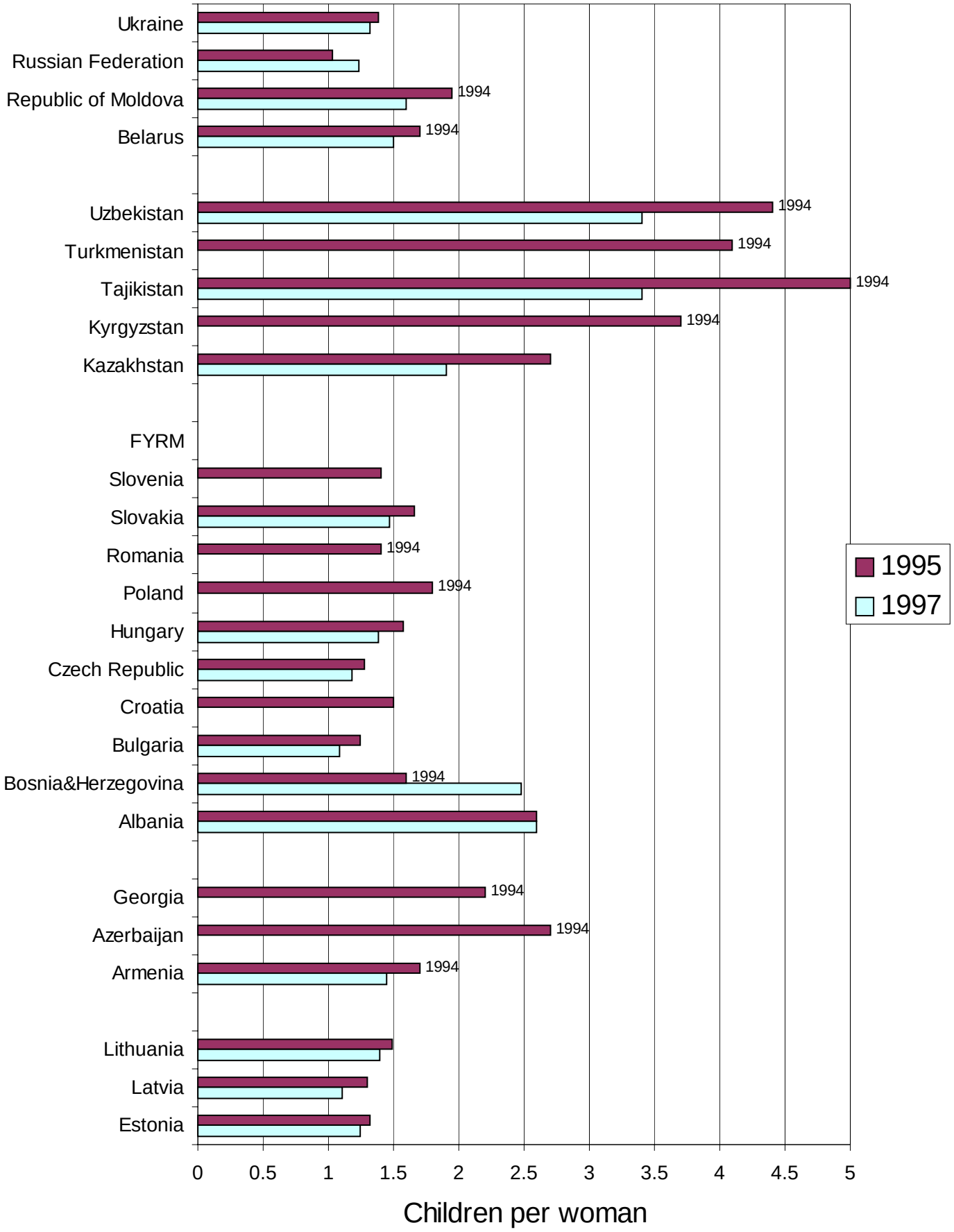
44 How prevalent is breast cancer in your country ? ……..……

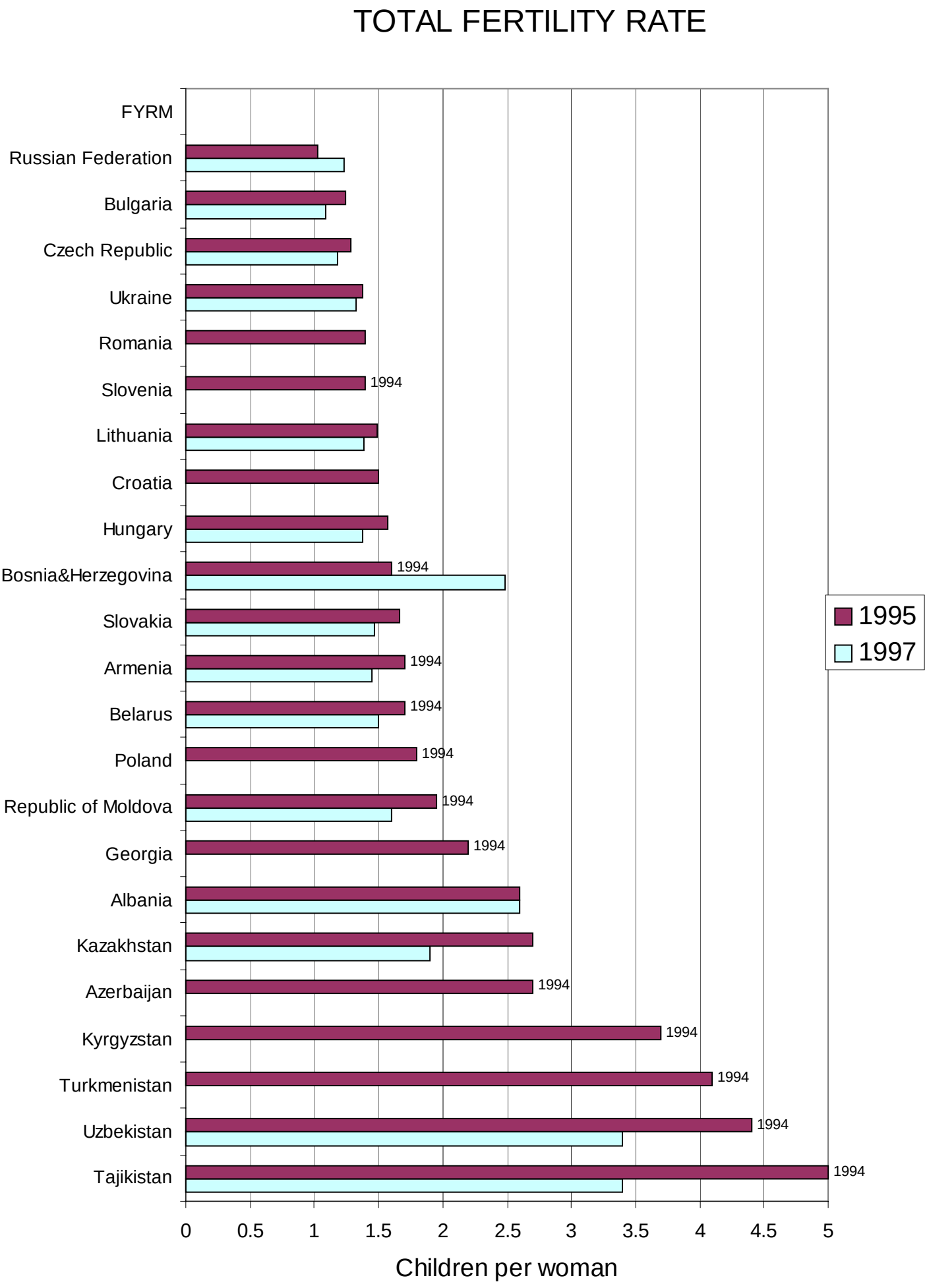
45 How prevalent is cervical cancer in your country ? ……..……

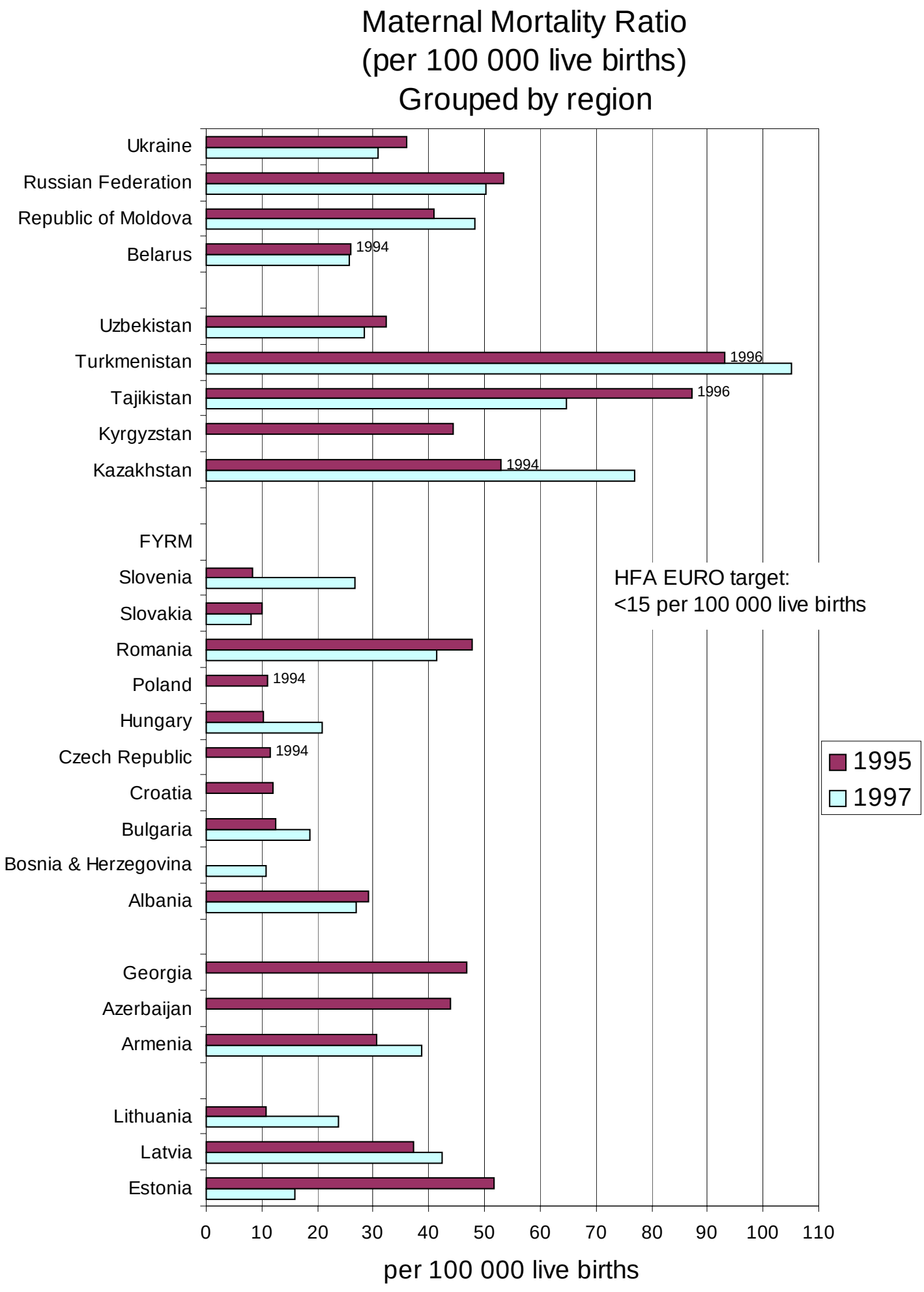
COUNTRY:

VARIABLES	PRESENT DATA
Population estimate (millions)	
HDI (Human Development Index) value	
HDI (Human Development Index) rank	
GNP US$ (per capita)	
Women of fertile age (age 15-49)	
Maternal mortality ratio (per 100 000 live births)	
Infant mortality rate (per 1000 live births)	
Contraceptive methods used	
Contraceptive prevalence rate	
Contraceptive choice index	
Abortion rate (per 1000 women age 15-49)	
Abortion:birth ratio < age 20	
Abortion:birth ratio age 20-34	
Abortion:birth ratio age 35+	
Abortion:birth ration, all ages	
Birth rate (per 1000 population)	
Maternal mortality from abortions (per 100 000 live births)	
STD/AIDS rates	

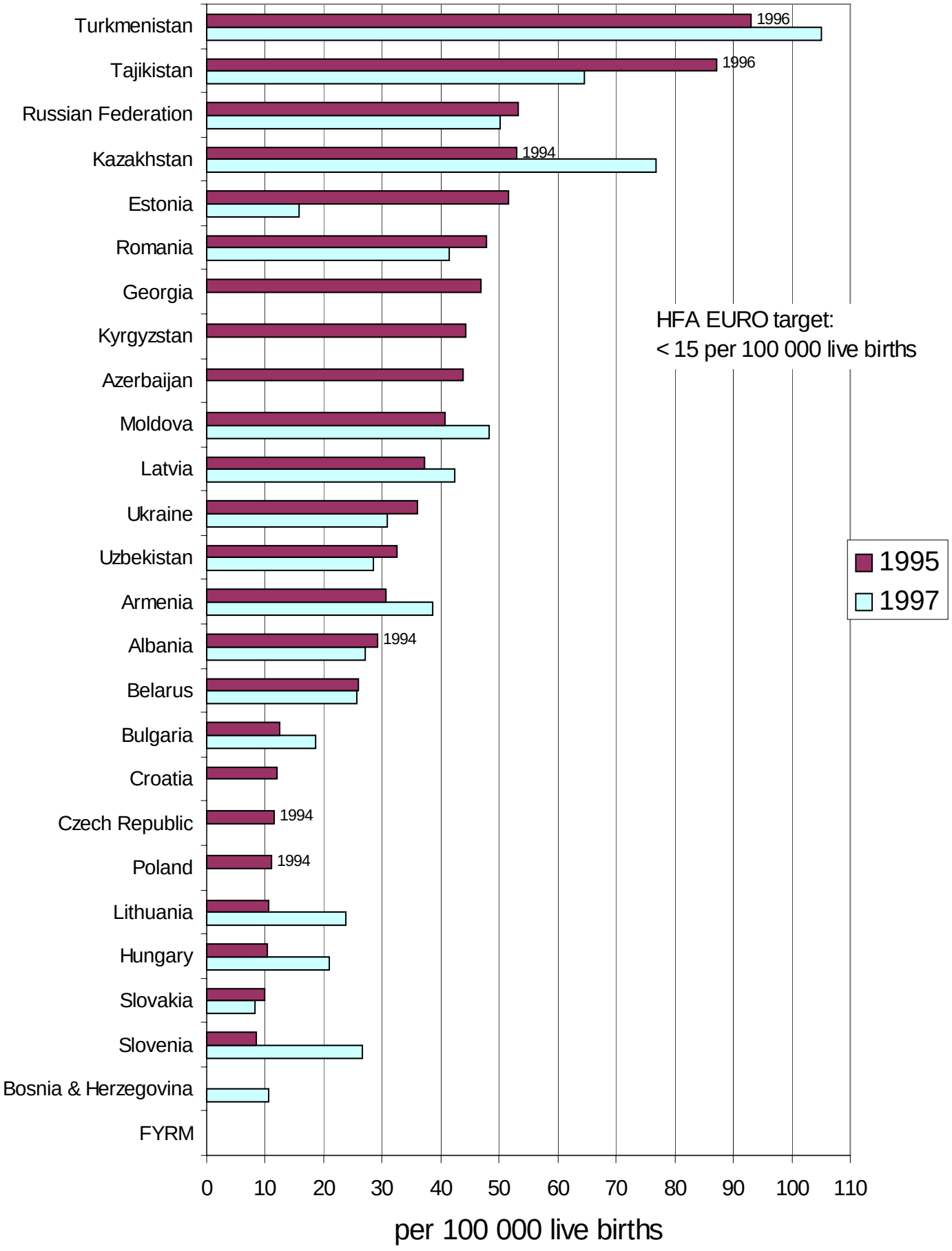
TOTAL FERTILITY RATE
(Grouped by region)

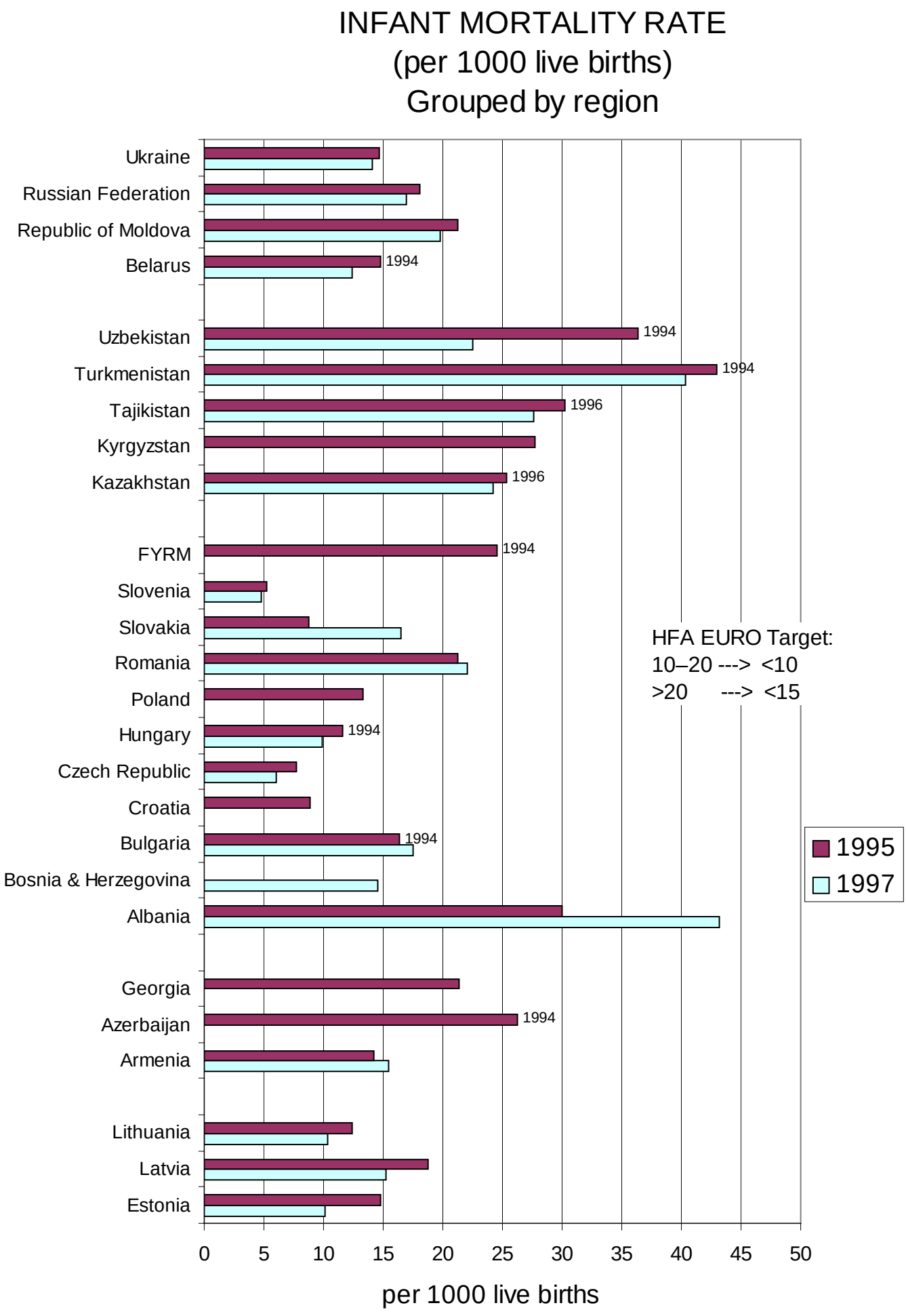



TOTAL FERTILITY RATE
FYRM
Russian Federation
Bulgaria
Czech Republic
Ukraine
Romania
Slovenia
Lithuania
Croatia
Hungary
Bosnia&Herzegovina
Slovakia
Armenia
Belarus
Poland
Republic of Moldova
Georgia
Albania
Kazakhstan
Azerbaijan
Kyrgyzstan
Turkmenistan
Uzbekistan
Tajikistan
1994
1995
1997
0
0.5
1
1.5
2
2.5
3
3.5
4
4.5
5
Children per woman

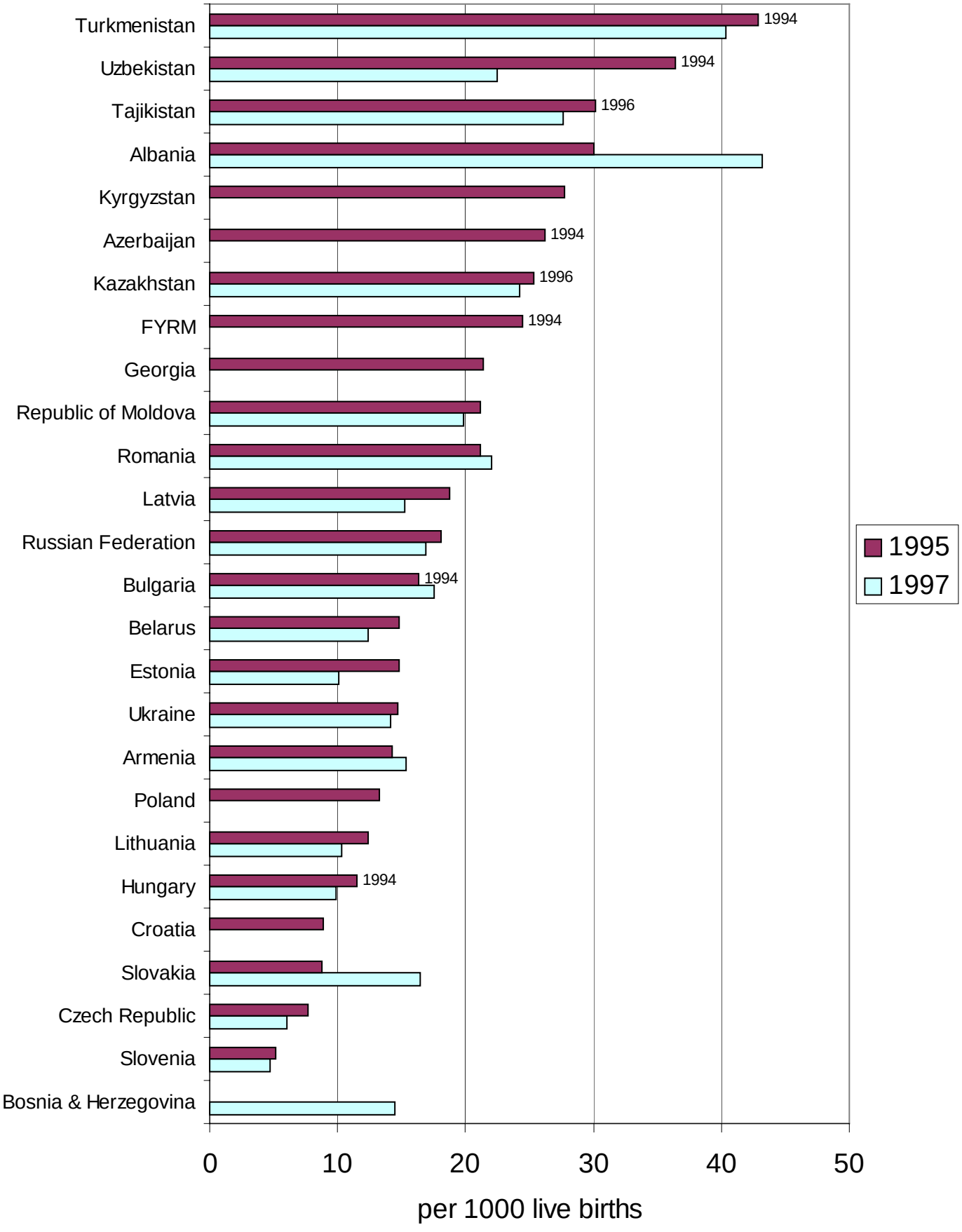

Maternal Mortality Ratio
(per 100 000 live births)
Grouped by region
Ukraine
Russian Federation
Republic of Moldova
Belarus
1994
Uzbekistan
Turkmenistan
1996
Tajikistan
1996
Kyrgyzstan
Kazakhstan
1994
FYRM
Slovenia
Slovakia
Romania
Poland
1994
Hungary
Czech Republic
1994
Croatia
Bulgaria
Bosnia & Herzegovina
Albania
Georgia
Azerbaijan
Armenia
Lithuania
Latvia
Estonia
HFA EURO target:
<15 per 100 000 live births
1995
1997
0
10
20
30
40
50
60
70
80
90
100
110
per 100 000 live births

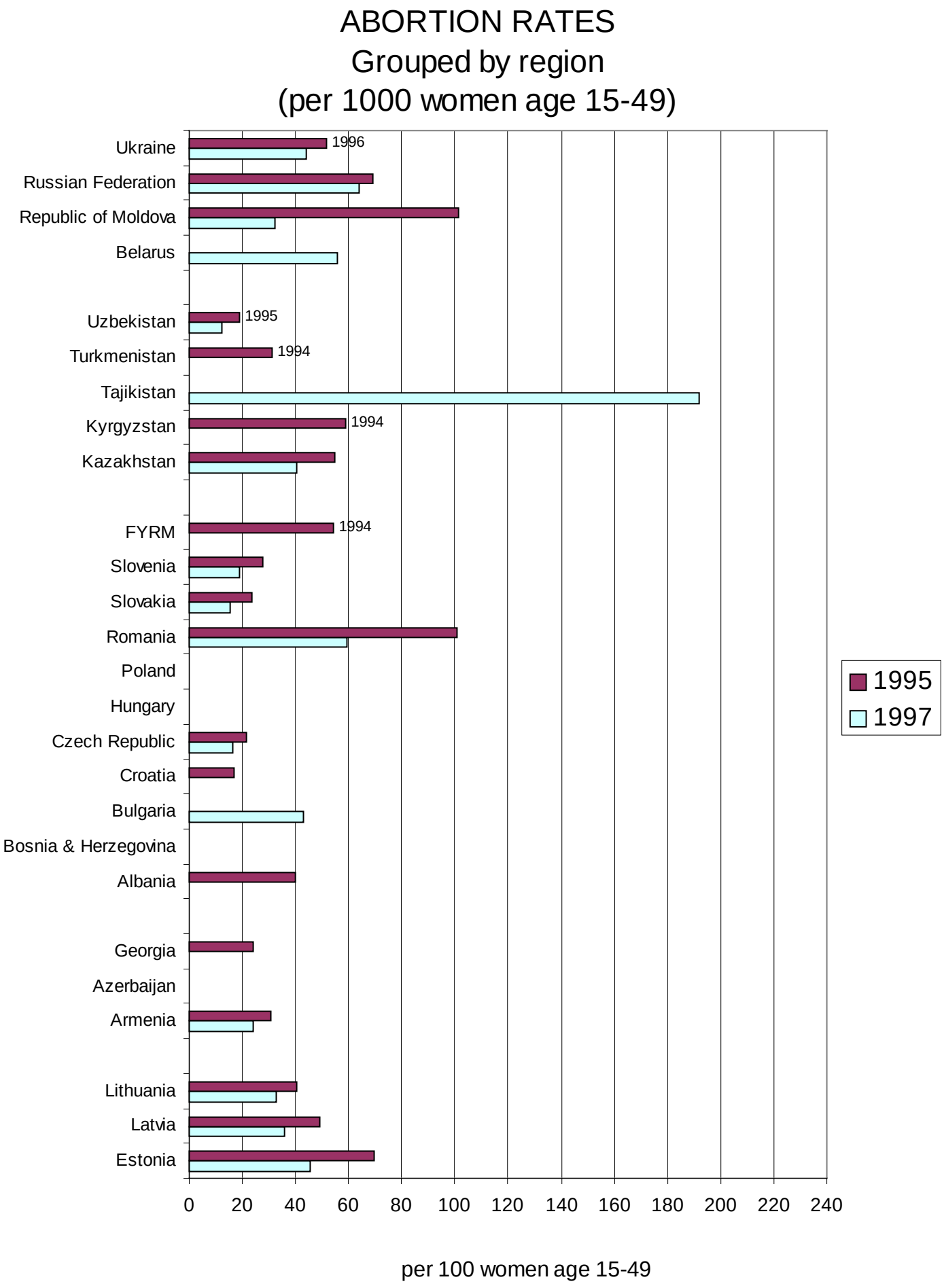
Maternal Mortality Ratio
(per 100 000 live births)




INFANT MORTALITY RATE
(per 1000 live births)
Grouped by region
Ukraine
Russian Federation
Republic of Moldova
Belarus
1994
Uzbekistan
1994
Turkmenistan
1994
Tajikistan
1996
Kyrgyzstan
Kazakhstan
1996
FYRM
1994
Slovenia
Slovakia
Romania
Poland
Hungary
1994
Czech Republic
Croatia
Bulgaria
1994
Bosnia & Herzegovina
Albania
Georgia
Azerbaijan
1994
Armenia
Lithuania
Latvia
Estonia
HFA EURO Target:
10–20 ---> <10
>20 ---> <15
1995
1997
0
5
10
15
20
25
30
35
40
45
50
per 1000 live births

INFANT MORTALITY RATE
(per 1000 live births)




ABORTION RATES
Grouped by region
(per 1000 women age 15-49)
Ukraine
Russian Federation
Republic of Moldova
Belarus
Uzbekistan
Turkmenistan
Tajikistan
Kyrgyzstan
Kazakhstan
FYRM
Slovenia
Slovakia
Romania
Poland
Hungary
Czech Republic
Croatia
Bulgaria
Bosnia & Herzegovina
Albania
Georgia
Azerbaijan
Armenia
Lithuania
Latvia
Estonia
1996
1995
1994
1994
1994
0
20
40
60
80
100
120
140
160
180
200
220
240
1995
1997
per 100 women age 15-49

ABORTION RATES