Investing in Women's Health: Central and Eastern Europe
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Investing in Women's Health: Central and Eastern Europe
WHO Library Cataloguing in Publication Data

Investing in women's health: central and eastern Europe

(WHO regional publications, European series; No. 55)

1. Women's health  2. CCEE  3. NIS  1. Series

ISBN 92 890 1319 2
ISSN 0378-2255

(NLM Classification: WA300)

Figures and tables: Rafael Paz Fernandez (Epidemiology, Statistics and Health Information), and Dr Ashot Hovanesian (WHO consultant)

Text editing: M.S. Burgher (Publications)

Layout and desktop publishing: Shirley Harelle (Text Processing: Systems and Training)

Thanks to Dr Agis Tsouros (Project Coordinator, Healthy Cities project) for his contribution of the photograph Hygeia as the symbol for the Investing in Women's Health Initiative
Investing in Women's Health: Central and Eastern Europe
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PRINTED IN DENMARK
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Acknowledgements

Gratitude is due to the people and organizations that contributed to this publication. *Investing in women's health: central and eastern Europe* was prepared by Dr Kathryn Dean, WHO consultant, with the technical support of Isabel Yordi Aguirre, Short-term Professional, Sexuality and Family Planning unit, WHO Regional Office for Europe. The publication was made possible by the financial support of the World Bank.

This book is based on reports on women's health, prepared by 11 pilot countries and one pilot city that joined the Investing in Women's Health Initiative launched by the Regional Office. Nine of these reports were compared for the first time in the working document *Highlights on women's health in CCEE/NIS* (January 1994), prepared under the direction of Dr Ilona Kickbusch, who was, at that time, the Director of the Lifestyles and Health Department and focal point for women's health of the Regional Office. The World Bank provided financial support for assembling a research team to prepare the highlights and analyse the reports. The team comprised: Kathryn Dean, Senior Researcher; Mirvet Shabanah (Technical Officer, Epidemiology, Statistics and Health Information unit, WHO Regional Office for Europe), team leader of the information component; and Isabel Yordi Aguirre. Mary Bussell and Claudia Heinle prepared literature reviews. The highlights were presented as a background document at the Conference Women's Health Counts, held in Vienna in February 1994.

Appreciation is due to the coordinators of the pilot countries and pilot city, whose enormous efforts resulted in excellent reports on women's health.

Special thanks are due to the Government of Norway, which provided the initial support for the Initiative, and to the governments of Finland, the Netherlands and Sweden for their contributions to the Initiative. Likewise, recognition and thanks are due to the Government of Austria and the City of Vienna for hosting the Conference.

The encouragement and support provided by the WHO Global Commission on Women's Health are highly appreciated.

Finally, thanks are due to all the units in the Regional Office that have actively contributed to the Investing in Women's Health Initiative. The commitment and continuous encouragement provided by Dr Jo E. Asvall, WHO Regional Director for Europe, were invaluable.

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9 Dr Kickbusch recently assumed the position of Director of the Division of Health Promotion and Education at WHO headquarters.
The WHO Regional Office for Europe launched the Investing in Women's Health Initiative in 1993 in pursuit of its commitment to improving the health status of women in the WHO European Region. This commitment is embodied in target 8 of the regional strategy for health for all; endorsed by all the Member States of the Region, the target details the most important improvements needed to secure sustained improvement in the health of all the women in their populations. The commitment focuses particularly closely on the women living in the difficult circumstances faced by the countries of central and eastern Europe and the newly independent states of the former USSR.

These countries are undergoing fundamental political, economic and social changes. The current challenges range from poverty and population migration to ethnic and social conflict, and they have had important consequences for the Region in general and for women in particular. Investing in women's health: central and eastern Europe will increase the understanding of the effects of the changes on the health of women.

The Investing in Women's Health Initiative is exploring ways to encourage politicians to cooperate with people in the arenas of public health and public policy by building and using networks to improve the health of women in the European Region. I am confident that this handbook will be very useful to policy-makers, academics, students of public health and health professionals in their work for better health for women, as part of their contributions towards achieving health for all.

J.E. Asvall
WHO Regional Director for Europe
The WHO Regional Office for Europe chose Hygeia, the Greek goddess of health, as a symbol to show that the principles of health that she represents are as relevant today as they were many centuries ago. It seems appropriate that the female deity of health watch over an initiative that places women at the centre of analysis, and that seeks to focus attention on the diversity of women's needs over the life cycle.

The Investing in Women's Health Initiative

The Initiative builds on proposals generated in a conference on women, health and public policy, held by the WHO Regional Office for Europe in Vienna in 1991. These proposals included a recommendation that a European Forum on Women's Health be established. The idea received further stimulus from the 1992 World Health Assembly resolution on women, health and development. A generous contribution from Norway and additional support from Finland, the Netherlands and Sweden made the Initiative possible. It also benefited from the continuous support of the WHO Global Commission on Women's Health.

To establish and launch the European Women's Health Network, the Initiative began with 11 pilot countries and one pilot city. The coordinators selected for each provided the background information for country profiles on women's health that could also serve as the basis for the analysis in Investing in women's health: central and eastern Europe.

The comparative analysis of the country profiles forms the core of this publication, for which the World Bank provided additional support. A first comparative analysis, as well as detailed country-based women's health profiles, were presented as working documents at Women's Health Counts: Conference on the Health of Women in Central and Eastern Europe, which was held in Vienna in February 1994. Both comparative analysis and country profiles will be presented as part of the WHO contribution at the United Nations 4th World Conference on Women, to be held in Beijing in September 1995.

Diversity - of people, cultures and traditions - is the keyword to describe the part of the European Region considered in this analysis: the countries of central and eastern Europe (CCEE) and the newly independent states (NIS) of the former USSR. The Investing in Women's Health Initiative aimed to reflect this diversity when approaching and selecting pilot countries for the first phase.

The analysis of women's health started at a difficult time. One of the pilot countries, Georgia, was at war. Another, Ukraine, was experiencing extreme economic decline. Most were facing enormous problems of reconstruction. The coordinators reported their difficulties with finding data on women and women's health, but asking the questions often led to changes, to intersectoral contacts, to media contacts and to the building of new networks to address the issues raised: to make women's health visible.

The future and the past sometimes merge

The optimism felt after the fall of the Berlin Wall and so many other walls and régimes is overshadowed by harsh economic realities and the brutality of war. The current picture of the CCEE and NIS shows them fraught with problems.

But there is also the shadowed legacy of the past. The health gap between the western and eastern halves of the European Region is not the product of a few short years. The downward epidemiological trends can be followed from the 1960s, through the 1970s and 1980s. This deterioration resulted from a range of social, economic and political factors, which have hit men particularly hard in some countries.

The rapid changes of the last few years have partly accelerated the downward trends in health, reinforced through lack of medicines, the collapse of health systems, unemployment, insecurity, poverty and war. The data indicate a need to look for far more complex explanations than conventional risk factors, prominent as they might be.
The figures shown in this publication reflect a tremendous pressure and need for change and an enormous opportunity for reform. They also highlight that all the countries have a great unrecognized and untapped human resource for innovation to meet the challenges ahead: women. Women in these societies are on the whole well educated and familiar with the labour market, and have shown tremendous skills and strength to survive in a very difficult period of history. Their exclusion from the transition process will lead to great long-term costs.

In applying a gender-specific approach, the comparative analysis considers both the similarities and the differences between women and does not mistake some women's health for all women's health. It states that, to improve the health of women, the nature of the gender relationship and the inequality of power inherent in it must be understood and changed. It recognizes gender inequality as an epidemiological fact. Inequality is also a social reality of women's everyday lives, and therefore a health policy that is beneficial to women cannot be developed without an understanding of their contributions and needs in the social, political and economic arenas.

**Social epidemiology of women's health**

WHO's main task is helping countries develop comprehensive health policies. A key element of this is to broaden the view of women's health from a perspective considering only issues in reproductive and maternal and child health. Policies should address women as they develop through a lifetime, and should see them as important in their own right, not just as the bearers and carers of the next generation.

The Investing in Women's Health Initiative expresses the need for a new social epidemiology of women's health, the need to define the notion of risk factors for women's health and to look at the policy consequences that will arise from it. The following analysis may be seen within the framework of three issues that reflect the immediate reality of women's health in the CCEE and NIS: emergency, security and choice.

**Emergency**
The concepts of emergency and disaster need new definitions. They tend to be understood in physical terms, such as earthquakes, floods or wars, and do not include social disasters. The extreme deterioration of women's and children's health in the CCEE and NIS, the maternal mortality rates in some of these countries and the effects of the impossible demands of daily life on women's health are social disasters.

A social epidemiology of women's health would help to identify such social disasters and emergencies. The investments to turn them around are simple, cost-effective and easily made, but the political will worldwide is not yet strong enough to invest significantly in women and children.

**Security**
The leaders of the world are calling for a new definition of human security. But even where this point is made strongly, as in the 1993 Human Development Report of the United Nations Development Fund (UNDP), it does not include the concept of security for women.

A social epidemiology of women's health is challenged with documenting the lack of security in women's lives: particularly the security to feel safe within one's own body, one's own home, one's own city. The violence against women, expressed through rape and attack on civilian populations in the wars in the Region, shows that women have become targets.

Epidemiological research on violence is needed to map the threats to women's security and identify the processes that create patterns of violence against women in everyday life. This will help to move from the atrocity of a single event in a woman's life - such as being raped - to a systematic assessment of effects on female population health. This would then stimulate the formulation of public health policies and the development of interventions to increase female security.

**Choice**
The move to democracy should increase women's choices. Being able to get an abortion for free, but having to give one third of one's income for contraceptives denies choice, denies women the chance to act responsibly and to move from abortion to contraception. It also denies them freedom from bodily harm. Many of the numerous maternal deaths are linked to a high abortion rate and its consequences. Being uneducated about one's body, its sexuality and the joys and the dangers involved, denies a woman choices, risks her security and causes her bodily harm. Women forced to sell their bodies for economic reasons are also denied choices. Comparisons are needed between the level of control women have over their bodies and over their reproductive health in different societies. This could then be related to health outcomes and health gains. There is also a need to look closely at the choices
women have within the health care system itself. Finally, comparisons should be made of the effects on choice of women's social status, colour, ethnic background and age.

A new social epidemiology of women's health is essential to change policies and professionals' perspectives. Risk reduction includes the improvement of basic education, housing, child care and the creation of jobs. All of these are eroding in most of the CCEE and NIS. Investing in human resources, as the data show, would be one of the most cost-effective investments for societies in crisis. But at present only 6.5% of total aid goes to human priority concerns such as health. The UNDP Human Development Report suggests a minimum of 20% in order really to make a difference. The 1993 World Bank report gives the same message: donor money must be redirected from hospitals and specialist training to public health programmes and essential primary health care.

A political tool: a women's health index

These three issues — emergency, security, choice — also show how important it is to perceive women's health risks within the larger problems of their lives: unemployment, divorce, lack of health insurance, lack of services, lack of child care. It could be a challenge to a social epidemiology of women's health — and maybe the Initiative — to develop an index for the quality of women's health, including perhaps 10–12 key indicators such as maternal mortality, life expectancy, and levels of choice (including contraceptive use, rate of abortions, level of prostitution, etc.), education, income and employment, security (rape, domestic violence, civilian victims of war), services, political participation, cancer, cardiovascular diseases, and drug abuse. With such an index, the context of health would shift from being a control variable to being an integral part of the index. Such an information base could complement and improve the world development index.

The Vienna Statement

It was one of the challenges of Women's Health Counts: Conference on the Health of Women in Central and Eastern Europe to consider both similarities and differences, between women and between countries. Based on Conference deliberations, the Vienna Statement on Investing in Women's Health in the Countries of Central and Eastern Europe was adopted. It comprises Annex 1.

The Statement reflects the consensus of the participants at the Conference. It sets out principles to advance women’s health, establishes priorities for action and describes policy mechanisms to strengthen the commitment to women's health in policy reform throughout the WHO European Region.

The Conference, co-sponsored by the World Bank, brought together 270 participants (of which 31 were officially nominated country coordinators and focal points) from 40 countries. Several ministers of health attended, including three from the CCEE and NIS. The Regional Office is grateful to the Government of Austria and the City of Vienna for hosting the Conference, and to our partners, who made possible the 1991 meeting on women’s health, for again inviting us to Vienna: Minister Ausserwinkler, Minister Dohnal and Stadtrat Rieder.

Women's health agenda

The work at the Vienna Conference should be seen as a significant step along the way to creating a women's health agenda. Public health advocates must constantly insist on a health focus and must be able to argue for a long-term population health perspective based on hard data. To allow the women's health agenda to move ahead, the Investing in Women's Health Initiative proposes that the countries wishing to join take 10 steps. They should:

1. prepare a women's health report
2. prepare a women's health country profile
3. improve the statistics on women's health
4. set targets for women's health
5. determine the cost of reaching the targets
6. clarify the responsibilities for implementation
7. clarify who will pay
8. design a national women's health strategy
9. seek external cooperation
10. build political alliances.

Since the Initiative started, at the beginning of 1993, 35 WHO Member States have nominated country coordinators/focal points for women's health, and most have started to prepare their reports on women's health.

At present, the reports can only be schematic overviews, but they highlight the need to approach women's health improvements systematically. This is crucial in the light of challenges as formidable as
reorienting systems to agree that women count and that women’s health counts.

Power relationships influence and sometimes determine women’s health issues. The health sector alone cannot break this pattern. But through involving women in health policy-making, it can contribute significantly to women’s feeling of self-worth and give visibility and acknowledgement to women’s role in protecting health and wellbeing in society. Women must not be seen just as victims. They contribute significantly to society, raise the next generation, care for the old and the sick, take care of husbands and lovers – in short, do most of the work and most of the caring on this planet. In return, most women earn little money and own next to no property.

The European Region has many women in positions of influence, who can start the process of change. They can bring women in their countries together as a women’s health forum, to initiate the ten-step process.

“To be friends we could not be before”

The Initiative and the Conference in Vienna celebrated the opportunity of bringing together women from different parts of the Region who could not work together a few years ago. It echoed the words of Anna Akhmatova, one of the great poets of this century. From her life in St Petersburg – having lived through a revolution and two world wars – she describes what it means to be denied access to the full potential of life:

Oh how many fine sights I have missed
how many curtains have risen without me
and fallen too. How many of my friends
I have met not even once in my life,
how many city skylines
could have drawn tears from my eyes,
I, who know only one city.

The Investing in Women’s Health Initiative faces the opportunity to bridge some of these historical gaps in understanding, even though the harsh age mentioned in the poem has not yet ended. For many, it seems to have returned with new, brutal force in a century that has seen too many civilian deaths from violence, most of them in women and children.

The words of Anna Akhmatova express the dream we all carry within us:

And still it seemed to her a flame
Was close ... In her hand a tambourine . . .
And she was like a white flag,
And like the light of a beacon.

Ilona Kickbusch
Introduction

The rapid political, economic and social changes occurring in the countries of central and eastern Europe (CCEE) and the newly independent states (NIS) of the former USSR have created new political, social and economic conditions that fundamentally affect the population. With responsibility for promoting the health of populations, WHO is concerned with the impact on health of these developments.

Circumstances unique to females intensify the impact of the changes on women's lives. Conditions that are specific to the lives of women may be expected to affect their health. The major goal of the Investing in Women's Health Initiative of the WHO Regional Office for Europe is to expand knowledge about the state of women's health and social conditions in the CCEE and NIS, to facilitate the informed development of policy and programmes to address their needs. To attain this goal, baseline assessments of health status and the forces that affect health must be made.

To begin the process of identifying the health problems that women face, 11 countries joined the WHO European Women's Health Network in its first phase. The countries were: Albania, Belarus, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Poland, Romania and Ukraine. St Petersburg participates as a pilot city from the WHO Healthy Cities project. The Initiative is evolving to its second phase. By July 1994, a total of 35 countries had nominated focal points, expanding the Network by an additional 24 countries (see Annex 2). The process of expansion and revision to improve knowledge about women's health in the European Region will continue. The Network, initiated by WHO, has undertaken the important task of establishing the foundations of a knowledge base that can be used by its members for informed policy development, and that can be improved as experience and resources are gained.

This book is based on the working paper prepared for Women's Health Counts: Conference on the Health of Women in Central and Eastern Europe, which was held in Vienna from 16 to 18 February 1994. It provides the first overview and comparative analysis of women's health conditions in the CCEE and NIS. It is based on information submitted by the 11 pilot countries and St Petersburg. Country coordinators and their teams expended great effort in the preparation of their reports. When population data were unavailable, relevant country experts provided descriptive summaries of the situation. The range of subjects covered in the reports varies from country to country, and the data on many subjects are not comparable. Further, problems arose that affected the quality of the data. Indeed, one of the common problems reported by the members of the Network was the lack of information on women's health issues.

Some countries reported basic needs for data on a broad range of subjects that are central to the development of health policy and services, including morbidity, disability, employment conditions, lifestyle variables, violence, prostitution, occupational diseases and the impact of the deterioration of the environment on women's health. While some new databases on population health are already being established, the development of health information systems was a priority concern in most of the reports received from the Network members. For these reasons, the comparative analysis presented below is based not only on comparative data, but sometimes also on information from one or more of the countries that is parallel, but not directly comparable. The report is supplemented with published information when sources relevant to the subjects discussed are available.

The importance of focusing on women's health is not immediately obvious to all. On average, women live longer than men and have lower mortality rates at all ages and for all causes of death. In some of the CCEE and NIS, the excess of male mortality is especially severe, and concerted effort is needed to understand the gender differences in health and longevity. The greater mortality rates of men often draw attention away from the health problems that women face. The impression is often given that women are healthier. This is an unwarranted conclusion. Death rates give a false picture of health and wellbeing. A few years' differential in average survival time can draw attention away from
the greater burdens of chronic illness and disability associated with longer survival – problems that are more prevalent among women.

Economic and social upheavals greatly increase the burden of women's health problems. Nowhere do women enjoy equal status with men. Fig. 1 shows the difference between the human development index (HDI) and the gender-adjusted HDI presented in the Human Development Report of the United Nations Development Programme (UNDP, 1993). The HDI moves beyond the simple measures of gross national product (GNP) usually seen to include three powerful indicators of development: longevity, knowledge and income. The HDI measures people's ability to live a long and healthy life, to communicate and participate in the life of the community, and to have sufficient resources to obtain a decent living. It combines indicators of real purchasing power, education and health, providing a measure of development that is more comprehensive than GNP.

It was found that, when the HDI is adjusted for gender disparity (UNDP, 1993):

... no country treats its women as well as it treats its men, a disappointing result after so many years of debate on gender equality, so many struggles by women and so many changes in national laws.

For example, the HDI for Sweden is 0.977, but the gender-disparity-adjusted HDI is 0.921. The gender-adjusted HDI shows that, even in those countries where gender equality is most advanced, women maintain negative human development scores relative to men (Fig. 1) – a powerful illustration of the dimensions of inequality women face.

The relative disadvantage of women makes them more vulnerable when populations suffer the types of economic adversity and social conflicts that characterize the transition period in the CCEE and NIS. This is reflected in all of the country reports, but the materials provided by the country coordinators also allow the identification of some strong foundations for advancing women's interests.

In work on the HDI, the CCEE and NIS were found to have very high levels of human development. Two thirds of the 15 NIS fall into the category of high human development, with the other third falling in the medium category. This means that the relatively strong positions of women in education and employment in the CCEE and NIS are sources of great potential. According to data available in 1990/1991, the CCEE and NIS have some of the highest worldwide percentages of women in the workforce. The former Czechoslovakia (52%) and Latvia (50%) rank highest, closely followed by Estonia, the Russian Federation, Romania, Hungary and Poland. By comparison the western countries with the highest proportions of women in the workforce are: Sweden (48%), Finland (47%), Denmark (46%) and Norway (45.3%). All other countries are at or below 45%. Unfortunately, the country reports indicate that this strong foundation is being eroded by the greater disadvantages experienced by women in the current social and economic transformation.

Since the focus of this project is the health and wellbeing of women in the CCEE and NIS, the report naturally starts with a comparative overview of statistics related to health. The relevant comparisons are between women in the CCEE and NIS and the female averages for the European Union.
EU and 27 WHO European Member States (see note on page 5). The reader should remember that this is a comparison of averages, and that averages hide differences within groups. In some cases, health indicators of some of the CCEE and NIS are better than those of some EU and EUR countries.

It must be emphasized that the information available on women's health is quite limited. In the past, the collection of gender-specific data was uncommon everywhere. Only in recent times have the fundamental differences in the health of men and women been formally recognized. A 1993 World Health Assembly resolution (WHA45.25) underscored the importance of rectifying this problem by calling for the disaggregation of health data by gender.

Further, a great deal of the available data is uncertain. Not only do systems of data collection vary greatly in quality and comprehensiveness, the types of data collected and the methods of analysis are often quite limited – problems that are by no means limited to the CCEE and NIS. The most widely available data are mortality statistics. Mortality rates, however, have severe limitations in creating an understanding of health status, and the forces that protect health or contribute to its deterioration.

The gender differences in health, disease and disability that lead to the mortality differentials are poorly studied and not understood. Most of the diseases that are major threats to the health of populations in the CCEE and NIS develop over long periods of time. Causal factors interact with other influences in complex ways. Many health problems are related to the life situation, to conditions of work and to patterns of behaviour, all of which tend to vary in gender-specific ways.

New types of data and research on health are needed. The factors and processes related to the onset of morbidity, and the nature of symptoms and their progression to disease need to be studied in research that can elaborate the complex processes that determine health over time. It may be expected that the consequences of the massive changes occurring in the CCEE and NIS will appear in unexpected ways and sometimes over long periods of time.

The initial work in the project must be recognized as the establishment of baseline information. The teams working to collect, synthesize and interpret the information on women's health are using limited and uncertain information that can help to explain only some parts of the subject. This information, however, will certainly point out the directions in which efforts should be focused.

Since the work must start with the available information, the comparative analysis of health status must rely predominantly on mortality data, in spite of their limitations. As new types and methods of data collection and analysis are used, a broader range of information, which is more relevant for policy and planning, will become available. The comparison of data on mortality shows that the rates for the CCEE and NIS – which have about half of the population of the Region (415 million) – are greater than those in the rest of the Region. The death rates are reflected in the differentials in life expectancy found for these countries in relation to the Region as a whole. The reduction of the differences in health between countries and between groups within countries in the European Region is the goal of target 1 of the WHO regional policy for health for all.
Data comparing life expectancy at birth provide an overview of differences in survival for the female populations of the CCEE and NIS in relation to the EU and the EUR averages (Fig. 2). In 1990, average life expectancy for women in the NIS was 6 years less than the average for women in the EU. The difference for women in the CCEE was 5 years.

Life expectancy also varies within the CCEE and NIS. There is a six-year average difference in life expectancy between the countries with the lowest and highest figures.

In some countries, life expectancy fell. In Lithuania, female life expectancy dropped from 76.3 years in 1990 to 75.86 in 1991. The figure for Poland decreased from 75.6 to 75.4 in 1991, and that for St Petersburg dropped from 74.3 in 1990 to 74.0 in 1992.

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**Fig. 2. Life expectancy at birth, females**

- **Latest year, 1990/1991**
- **Trend 1981–1991**

*Source: Health for all database, WHO Regional Office for Europe, 1994*

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EUR average (avg.) includes 27 WHO European Member States, excluding Monaco, San Marino, Turkey and the former USSR. The CCEE includes Bulgaria, the former Czechoslovakia, Hungary, Poland, Romania and the former Yugoslavia. EU includes the 12 member countries. The NIS comprise the former USSR.

The sources for illustrations include the following: the health for all database of the Regional Office, the database of the Tobacco or Health unit of the Regional Office and the Investing in Women's Health Initiative. The last of these comprises a combination of: country reports, the health for all database, and data from the Council of Europe and UNDP (1993).
The health gap between the CCEE and NIS and the rest of the European Region widened in all respects between 1981 and 1990 (Fig. 3), and new data for 1991/1992 show an even greater difference as the economic crisis deepens. The increases in the mortality statistics for all major causes of death highlight the seriousness of the problems faced in these countries.

Infant mortality is a particularly sensitive indicator of economic deprivation. Increasing rates of infant mortality after a period when infant deaths have fallen progressively throughout most of the Region illustrate the impact of the social and economic disruptions.

Even for those diseases for which the women in the CCEE and NIS have relatively favourable statistics (cancer of the breast and lung), the recent data suggest a deteriorating situation. Perhaps the greatest cause for concern is the rapidity of the increases in female mortality seen for a period of less than a decade.

Since a large proportion of the differences in life expectancy is due to the increases in infant and maternal mortality, it is hoped that attempts to improve knowledge and availability of contraception will reduce mortality from abortion and the recent positive developments in the economies of some of the countries will help to reverse the negative trends. It is not possible, however, to assess how current developments will change the trends. This is why close monitoring of these developments and expanding the sources of information are so important.
Diverging trends between CCEE and NIS and the rest of the Region in the two main causes of overall mortality for males and females (cardiovascular diseases and cancer in the group aged 0–64 years) give rise to concern. Particularly worrying, as seen in Fig. 4, are the death rates for cardiovascular disease for females. The lowest female rate in the CCEE and NIS (Lithuania: 72.95 per 100 000) is more than one and a half times the EUR average and more than twice the EU average. The highest rate is more than three times the EUR average and five times the EU average.

Subregional variations in cardiovascular mortality are particularly large. While mortality from cardiovascular diseases (mainly ischaemic heart disease, seen in Fig. 5, and cerebrovascular disease, seen in Fig. 6) in females has been decreasing since 1980 in western Europe, no progress was made in the CCEE and NIS. Hence the gap between the two halves of the European Region has steadily widened.
The gap in cancer mortality for females (Fig. 7) is less dramatic than that for cardiovascular diseases, but growing larger. The CCEE and NIS have not enjoyed the consistent decline in mortality from cancer in females aged 0–64 years that has been found in other countries of the Region since 1975.

The standardized death rate for female lung cancer in the CCEE (Fig. 8) is similar to the EUR and the EU averages. As in the western countries of the Region, the rate in the CCEE rose in the 1980s. Female lung cancer rates in the NIS, however, were low and stable in the decade.
Mortality from cancer of the breast, in contrast to most other major causes of death among women, is lower in the CCEE and NIS than the rest of the Region (Fig. 9). It appears, however, that breast cancer may more often reach an advanced stage before being detected. Estonia has reported that 30–40% of all new cases of breast cancer are advanced.

The rates for cervical cancer in the CCEE are among the highest in the Region: 7.02 per 100 000, compared to the EUR average of 3.55 and the EU average of 2.3 (Fig. 10). The rates for several of the NIS are lower. Cervical cancer is decreasing in the rest of the Region, mainly as a result of effective early detection and treatment.

Most of the countries reported a lack of screening services and prevention programmes for both types of cancer.
For the category of mortality classified as external causes (Fig. 11)—accidents, trauma, poisoning, traffic accidents and suicide (Fig. 12)—the NIS average is highest. This category of female mortality is particularly high in Latvia, Estonia and the Russian Federation.
The highest average rate of diseases of the respiratory system (acute respiratory infections) for females is seen in the NIS (Fig. 13). The average for the CCEE is closer to those for EUR and EU.

In general, disease-specific patterns of mortality in the CCEE and NIS are following trends seen earlier in the western countries: declining mortality from infectious diseases paralleled by increases in mortality from diseases of the circulatory system, followed by reductions in cardiovascular mortality and corresponding increases in cancer mortality. The relatively low rates of circulatory disease mortality along with the relatively high rates of death from cancer in Estonia, Latvia and Lithuania reflect this pattern.

**Maternal mortality**

Maternal mortality rates in the NIS are about twice those in the CCEE and about four times the average for the Region (Fig. 14). Maternal mortality in Romania and Albania fell dramatically after the legalization of abortion in 1989. Nevertheless, abortion remains a major cause of maternal mortality in both countries.
In Kyrgyzstan, the maternal mortality rate was 62.88 per 100,000 live births in 1990, the second highest rate in the Region. During the 1980s, the rate had hovered around 50 per 100,000, but began to increase in 1989. The maternal death rates were 62.9, 76.4 and 70.1 per 100,000 live births in 1990, 1991 and 1992, respectively. These exceptionally high rates were reportedly due to socioeconomic difficulties. The most vulnerable group is women aged 20-24 living in urban areas. Regional variations within Kyrgyzstan ranged from the extremely high rate of 112.9 reported for the Tchu region to 51.1 for the Issyk-Kool region.

Other NIS have also witnessed this doubling of maternal mortality. Compared with the rates seen in Fig. 14, those reported for 1992 were 49.8 in Georgia and 44.0 in Lithuania. St Petersburg reported a similar development. A portion of the increases is probably due to better reporting systems, but real increases in maternal mortality arise from deteriorating socioeconomic conditions, limited access to safe and effective health services and other factors.

The population health statistics that are available clearly document the large differentials in women's survival in the CCEE and NIS compared with other countries in the European Region. These differentials cannot be understood without understanding the conditions of women's daily lives, and the gender-specific impact of the social and economic upheavals in these countries.
Women in the social structure

Population size and distribution

The size and geographic distribution of the populations of the CCEE and NIS are changing. Regardless of the size of the country, women constitute the majority of the population in all of the countries reporting, except Albania (Table 1).

Relatively high birth rates paralleled by somewhat lower death rates in Kyrgyzstan and Albania result in higher rates of natural increase in these two countries, especially in Kyrgyzstan (Fig. 15). Four of the countries and St Petersburg show declines in population size due to low birth rates coupled with relatively high death rates.

### Table 1. Network members: population statistics

<table>
<thead>
<tr>
<th>Member</th>
<th>Total population (thousands)</th>
<th>Percentage of women in the total population 1991/1992</th>
<th>Percentage of rural population 1991/1992</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1980</td>
<td>1992</td>
<td></td>
</tr>
<tr>
<td>Albania</td>
<td>2 731.0</td>
<td>3 353.1</td>
<td>48.5</td>
</tr>
<tr>
<td>Belarus</td>
<td>9 621.8</td>
<td>1 028.8</td>
<td>53.0</td>
</tr>
<tr>
<td>Estonia</td>
<td>1 472.2</td>
<td>1 562.1</td>
<td>53.2</td>
</tr>
<tr>
<td>Georgia</td>
<td>5 052.8</td>
<td>5 447.1</td>
<td>52.0</td>
</tr>
<tr>
<td>Kazakhstan</td>
<td>16 899.0</td>
<td>16 899.0</td>
<td>52.0</td>
</tr>
<tr>
<td>Kyrgyzstan</td>
<td>3 523.0</td>
<td>4 484.0</td>
<td>51.0</td>
</tr>
<tr>
<td>Latvia</td>
<td>2 534.0</td>
<td>2 693.0</td>
<td>53.5</td>
</tr>
<tr>
<td>Lithuania</td>
<td>3 404.2</td>
<td>3 746.9</td>
<td>52.6</td>
</tr>
<tr>
<td>Poland</td>
<td>35 734.9</td>
<td>38 309.2</td>
<td>51.3</td>
</tr>
<tr>
<td>Romania</td>
<td>226 451.0</td>
<td>22 786.0</td>
<td>50.9</td>
</tr>
<tr>
<td>St Petersburg</td>
<td>–</td>
<td>4 955.7</td>
<td>54.7</td>
</tr>
<tr>
<td>Ukraine</td>
<td>–</td>
<td>51 999.0</td>
<td>53.7</td>
</tr>
</tbody>
</table>

*Source: Investing in Women’s Health Initiative, WHO Regional Office for Europe, 1994*
Aging female populations

As in other parts of the Region, increases in life expectancy, along with declining birth rates in many countries, have resulted in an aging of the populations of the CCEE and NIS. Women account for much larger proportions of people over 65 years of age in all of the countries (Fig. 16), with the proportion of elderly females double that of males in Kazakhstan, Belarus, Estonia, Ukraine and Latvia. In the last three countries, more than 15% of the female population is over 65 years of age. The enormous loss of men in the Second World War is one reason for the large proportion of older women.

The country reports indicate that the vulnerability of elderly women is increasing. Growing proportions of aged women are in danger of severe deprivation and are frequent victims of crime. In urban areas with severe housing shortages, old women are the group most vulnerable to the growing criminal takeover of private homes by swindle or, in extreme cases, by murder or injury.

Most of the country reports highlight the lack of specific programmes for elderly people as a serious problem. The lack of community support services, combined with the rapid deterioration of the few established homes for the elderly, means that the chronically ill and the aged with reduced functional capacity experience hardship in daily life that frequently threatens their survival.

Urbanization and migration

Table 1 showed that the tendency towards urbanization seen in most of the countries has progressed more rapidly in Belarus, Ukraine and the Baltic countries.

Pressures towards urbanization arising from changing social and economic structures are drastically complicated in the CCEE and NIS by the massive migrations due to political and economic upheavals. An existing refugee problem has escalated sharply during the period of transition. In the Russian Federation alone, 2 million displaced persons are registered. Official figures seriously underestimate the extent of the problem. It is estimated that 1–2 million people who returned to the Russian Federation between 1988 and 1992 did not register with the authorities. The highest concentrations are in major cities, especially Moscow and St Petersburg (Radio Free Europe/Radio Liberty, 1993).

The refugee problem grew explosively at the same time that indigenous populations were experiencing severe economic decline and growing disadvantage. Since immigrants are often used for cheap labour, resentment from local residents and potential social conflict increase as the economic situation worsens.

Migration from rural to urban areas or to another country, because of the socioeconomic situation, political oppression or war, creates disadvantaged circumstances with special risks for women. Very often they are left alone when men migrate in search of jobs. One country under the burden of extreme poverty emphasized the health risks and damage to social and family structures.
brought about by the extensive migration of the male working population to illegal labour markets in other countries. Women are left in charge of single-parent households with extremely limited resources and frequently ill children. The emigration of health care personnel and reductions in social benefits intensify the hardship.

In countries with a massive influx of illegal labour, women are more vulnerable to losing their jobs to the large numbers of people willing to work for low pay. The risks of exploitation and violence also increase for women in these countries.

Changing family structures

Changing family structures parallel general changes in the larger social structure. The rate of marriage is highest in Kyrgyzstan. Belarus, Kazakhstan, Lithuania, St Petersburg and Ukraine have marriage rates hovering around 9 per 1000 population (Fig. 17). Albania, Estonia, Georgia, Latvia, Poland and Romania all have marriage rates below 8 per 1000.

Fig. 17. Marriage and divorce rates, 1991/1992

<table>
<thead>
<tr>
<th>Country</th>
<th>Marriages</th>
<th>Divorces</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kyrgyzstan</td>
<td>10.6</td>
<td>2.6</td>
</tr>
<tr>
<td>Ukraine</td>
<td>9.4</td>
<td>1.2</td>
</tr>
<tr>
<td>Belarus</td>
<td>7.4</td>
<td>1.3</td>
</tr>
<tr>
<td>St Petersburg</td>
<td>7.1</td>
<td>1.4</td>
</tr>
<tr>
<td>Kazakhstan</td>
<td>6.8</td>
<td>1.1</td>
</tr>
<tr>
<td>Lithuania</td>
<td>9.1</td>
<td>1.1</td>
</tr>
<tr>
<td>Romania</td>
<td>7.1</td>
<td>1.3</td>
</tr>
<tr>
<td>Latvia</td>
<td>7.3</td>
<td>1.5</td>
</tr>
<tr>
<td>Estonia</td>
<td>6.9</td>
<td>1.4</td>
</tr>
<tr>
<td>Poland</td>
<td>6.9</td>
<td>1.4</td>
</tr>
</tbody>
</table>

Source: Investing in Women’s Health Initiative, WHO Regional Office for Europe, 1994

Latvia and St Petersburg have the highest divorce rates, followed by Lithuania, Estonia and Belarus. The low marriage rate in Poland is paralleled by the lowest divorce rate of the countries reporting. Romania and Georgia, with relatively low marriage rates, also have low divorce rates. In Kyrgyzstan, the high marriage and birth rates, coupled with the low divorce rate, explains its vastly greater rate of natural increase (Fig. 15) in comparison with the other countries reporting.

Higher divorce rates, especially when coupled with lower marriage rates, as in Estonia, result in more households headed by females. While the data on this subject are limited, over 10% of households with dependants are reported to be headed by women in Estonia and Belarus, and the proportion reaches 20% in St Petersburg. Households headed by women differ in many ways from those headed by men. The most fundamental and universal difference is the relative poverty of female-headed households in all countries (United Nations, 1991a).

These changes in family structure and living situations are more prevalent in urban than in rural areas. In the rural areas, relatively higher marriage and birth rates, along with lower divorce rates, mean that women are caring for larger families, often under disadvantaged conditions, including very limited access to health and social services, if any are available.

The country reports indicate that the general trends do not hold for certain ethnic groups that maintain their traditional family structures, regardless of the trends in the country in which they live.

Education

Education is the most important component of the foundations on which life chances are built. Fig. 18 indicates that, while relatively large proportions of children have not completed primary school in some countries, high levels of education have in general been achieved. The CCEE and NIS have high literacy rates both for the overall population and for women. Women have achieved higher levels of educational attainment than in most other parts of the world, as reflected when the HDI (see p. 2) is adjusted for gender. There are signs, however, that the educational gains could be threatened by the economic collapse in some of the countries.

A country reporting a 97% literacy rate expressed this concern, pointing out that the renovation of schools has been discontinued and no additional schools can be built. It also reported that a substantial proportion of the teaching staff has left the educational system to find employment in other areas or to set up private businesses. About 30% of the teaching staff in institutions of higher education were reported to have left the field of education.

Even though the reports indicate that only relatively small proportions of the population have the opportunity for higher education, women are well represented at the higher levels of educational achievement. Georgia and Estonia report that more than 10% of women attain higher education.

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Women in the social structure

In some fields requiring high levels of education, women are overrepresented. For example, in contrast to other parts of the world, in the CCEE and NIS most physicians are women. A major reason for this appears to be that the medical profession did not have the same status or receive the same high salaries as in the western countries (Malysheva, 1992).

Relatively large proportions of women in the CCEE and NIS, in comparison to other countries, have received training for skilled jobs in industry. Women are found in larger numbers in the manufacturing sector than anywhere else in the industrial world (Shapiro, 1992). It is reported, however, that managerial and high-level technical training is less available to women.

Women in paid employment

In 1990–1992, in all of the countries reporting, women accounted for roughly half of the labour force. In 1991 in St Petersburg, for example, 56.6% of employed persons were women. The full participation of women in the labour force, with the correspondingly wide range of experience and expertise involved, is not reflected in the distribution of women in managerial and other positions of influence.

When documented, it appears that women comprise not more than 2% of the workers in the administrative and managerial sectors in many of the CCEE and NIS. This dismal discrepancy is not always so extreme, differing from country to country and across sectors within countries. One report stated that the proportions of women among high-ranking managers in 1991 was 9.3% in industrial production, 6.3% in agriculture and only 0.4% in civil construction. In some areas, it was pointed out, women dominated even the higher positions, reaching 85.6% in the trade and public catering sector and 62.4% in planning, bookkeeping and accounting. These figures indicate the gains that are possible, and highlight areas of potential on which to build. The same report, however, pointed out that, in other sectors where women constitute the majority of the workforce, such as medicine and education, they are seriously underrepresented in positions of leadership.

Women’s employment in the industrial sector is significantly higher in the CCEE and NIS than in most other countries. The 1989 census data revealed that women constitute 48% of the industrial workforce (Shapiro, 1992). Still, they have been held in a restricted range of jobs that are less well paid. The earnings of women are 1.5–2 times lower than men’s. In some of the countries reporting, over 70% of the low-paid workers are women.

One country reported that, in 1991, 64.8% of women took home less than the average monthly salary, compared with 39.7% of men. Correspondingly, only 24% of full-time employed women, compared with 60% of men, earned salaries above the average for the country. The proportion falling in the highest income category was 1.5% of women and 6.1% of men. The greatest sex differences in earnings were found in people aged 30–49 years. These figures highlight the serious problems encountered in female-headed households, and point to one of the major causes of female poverty and deprivation in old age.

Over the past four to five decades, rising wages in industry enticed many farm workers to migrate to cities. In Belarus, Estonia, Latvia, Lithuania, the Russian Federation and Ukraine, this urbanization of the workforce had dramatic proportions (Brider, 1992). The exodus had negative consequences for the food supply, stimulating a movement “back to the land”. Women, caught in these developments, found few opportunities open to them upon returning to rural areas. With work on agricultural machinery not available to them, they were largely held to unskilled manual jobs. In one of the poorest countries, with 73% of the women working full time, 54.3% were reported to be working in the agricultural sector, with most of the work performed by hand.

The information provided in the reports indicates that, as elsewhere, the income of women is only about 70% of the income of men in almost all
the participating countries. This inequality in compensation for work exists even though it has been documented that women in many of the countries have responsibility for some of the most burdensome work. It is estimated that women perform 44% of the dangerous work and more than their share of night shifts (Shapiro, 1992). The situation is not significantly better for women in white-collar work. Research has shown that in office jobs in the service sector, another traditionally female area of work, women are held at low levels in the hierarchy.

Double burdens of work

As in other parts of the world, women in unpaid work, as in paid employment, provide most of the caring work in the CCEE and NIS. The high rates of female labour market participation are not associated with corresponding reductions in responsibilities for family care and housework. The country reports show that women carry far greater burdens of work in the home. Thus, women have the same official working hours as men plus responsibility for running households and caring for the family.

Research in one country showed that women worked an average of 9.3 hours, including lunch break and transportation time, in their paid jobs, then needed 48 minutes for shopping and 6.2 hours for housekeeping. Thus, the total work demand was 16.3 hours of daily work inside and outside the home. In another country, it was shown that women spend three times as much time on weekday housework as men and twice as much time at weekends. Yet another study found that 42% of the men take no part in family life, and they rarely share maternity leave benefits.

The excessive burdens of work in the daily lives of women was one of the more common themes highlighted in the country reports. It has been estimated that, if unpaid family care and housework were counted in national economic assessments of production, global output would increase by 20–30% (UNDP, 1993). The double burdens of work that women bear in all countries are made especially heavy in the CCEE and NIS by the severity of the economic crisis.

Positions of influence

The position of women in the social structure, and the life chances and opportunities available for health protection and promotion, are both reflected in and influenced by their representation in the institutions and organizations that establish the laws and priorities determining the social order.

In 1987, the highest representation of women in the parliaments of the world was in eastern Europe (Table 2). This was due to quotas for female representation. With the advent of glasnost, Soviet and eastern European women began to protest the "cosmetic" quality of their legislatures. Even women holding political office had little or no decision-making power (United Nations, 1991b).

Recent elections show a significant drop in the proportions of women in the parliaments of the CCEE and NIS. Women are being nominated far less often than men, and voters show a greater tendency to vote for men. The result is a decline in female elected officials.

Buckley (1992) reported that, in the NIS, female representation had dropped from an average of 50%,

<table>
<thead>
<tr>
<th>Country</th>
<th>Women in parliament (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1987</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>21</td>
</tr>
<tr>
<td>ex-Czechoslovakia</td>
<td>30</td>
</tr>
<tr>
<td>ex-German Democratic Republic</td>
<td>32</td>
</tr>
<tr>
<td>Hungary</td>
<td>21</td>
</tr>
<tr>
<td>Poland</td>
<td></td>
</tr>
<tr>
<td>Senate</td>
<td></td>
</tr>
<tr>
<td>Lower House</td>
<td>20</td>
</tr>
<tr>
<td>Romania</td>
<td>34</td>
</tr>
<tr>
<td>ex-USSR</td>
<td></td>
</tr>
<tr>
<td>Congress of People's Deputies</td>
<td></td>
</tr>
<tr>
<td>Soviet of Nationalities</td>
<td>31</td>
</tr>
<tr>
<td>Supreme Soviet</td>
<td>35</td>
</tr>
</tbody>
</table>

Source: United Nations, 1991a

Investing in Women's Health
to 35% in Latvia, 34% in Lithuania, 30% in Kazakhstan, 29% in the Republic of Moldova, 25% in Turkmenistan, and 23% in Estonia. All indications point to poor prospects for improvement. Indeed, with fewer women being nominated and the increased tendency to vote for men, even among women, the situation has continued to deteriorate.

In spite of the greater proportions of women in the population of the CCEE and the NIS, their full participation in the official labour force of their countries and their greater responsibility for the total burden of work in society, their representation in legislative bodies has continued to fall. Fig. 19 shows the information provided in the country reports.

Fig. 19. Seats in parliament occupied by women, 1992/1993

- Latvia has the highest percentage of women elected to parliament. In Estonia, Poland and Ukraine, over 10% of the parliamentarians are women, while in the remaining countries the proportions are under 9%.

- Elected office, while of fundamental importance, is only one of many areas of power and influence that determine the relative position of women. Even when citizens can elect their leaders in regular, free and fair elections, women have seldom achieved full political participation (UNDP, 1993). There are many levels of influence between political representation and the equal opportunity necessary for people to have control over their own lives. In public administration, as in political parties and trade unions, women are concentrated in the lower echelons.

Women are also largely absent from other types of positions with high prestige and status, and are underrepresented in economic decision-making. Very few women are found in high positions in finance ministries, central banks or foreign trade departments (UNDP, 1993; United Nations, 1991a). At the time of this study, only two health ministers in the CCEE and NIS were women.

**Differential impact of the economic crisis**

The economic reforms in the CCEE and NIS are directed towards a complete restructuring from planned to market economies. Between 1988 and 1992, industrial production fell more than 40%. Official figures on unemployment often underestimate the extent of the problem. For example, the official 1992 unemployment rate in Poland was 12%, but the statistics for induced early retirement and other forms of unofficial joblessness suggest that 20% was a more realistic figure. The CCEE are experiencing mass unemployment and it is felt that rates well over 15% could last for years (UNDP, 1993).

The transition has created economic insecurity and hardship for millions of people. The developments reported in one country illustrate the magnitude of the problems in many areas. With one of the lowest real gross domestic products (GDP) per head in 1990, the country launched an ambitious privatization programme in 1992, but this was hindered by the near collapse of the economy. During that year, industrial and agricultural production declined by 20% and food output fell by 40%. GDP fell by 20%, and inflation was 2000%. Another country reported a 60.7% decline in industrial production and the same inflation rate.

Ethnic conflicts, migrating male populations in search of jobs and growing crime all contribute to reducing the possibilities for economic recovery. Even the better-off countries face severe economic crisis. The richest of the central Asian republics, with large reserves of natural resources, found that trade with the other republics came to a virtual standstill after the rapid transformation to a market economy. A major problem in most of the countries is the lack of commercial and transport infrastructures to support trade and development.

Agricultural production has fallen severely in most countries, increasing the share of family income that must be spent on food. One traditionally well-off country reported that almost 100% of household income is now spent on food.
The economic crisis does not affect men and women equally. The differential impact is graphically illustrated in Fig. 20, which shows that women represent roughly half of the employed labour force, but far higher proportions of the total unemployed.

**Fig. 20. Proportions of employed and unemployed women, 1992/1993**

<table>
<thead>
<tr>
<th>Country</th>
<th>Employed</th>
<th>Unemployed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ukraine</td>
<td>52.9</td>
<td>47.0</td>
</tr>
<tr>
<td>Kyrgyzstan</td>
<td>54.8</td>
<td>45.2</td>
</tr>
<tr>
<td>Kazakhstan</td>
<td>54.9</td>
<td>45.1</td>
</tr>
<tr>
<td>St. Petersburg</td>
<td>56.3</td>
<td>43.7</td>
</tr>
<tr>
<td>Belarus</td>
<td>57.2</td>
<td>42.8</td>
</tr>
<tr>
<td>Lithuania</td>
<td>58.3</td>
<td>41.7</td>
</tr>
<tr>
<td>Romania</td>
<td>55.5</td>
<td>44.5</td>
</tr>
<tr>
<td>Latvia</td>
<td>54.5</td>
<td>45.5</td>
</tr>
<tr>
<td>Poland</td>
<td>53.4</td>
<td>46.6</td>
</tr>
<tr>
<td>Estonia</td>
<td>52.3</td>
<td>47.7</td>
</tr>
<tr>
<td>Georgia</td>
<td>50.9</td>
<td>49.1</td>
</tr>
</tbody>
</table>

*Source: Investing in Women's Health Initiative, WHO Regional Office for Europe, 1994*

The shaded bars show the 44–57% of women in the labour force, while the black bars show the quite different picture that emerges when newly unemployed women are considered as a percentage of the total unemployed population. The extreme inflation in the economies of the CCEE and NIS severely increases the burdens created by the high and disproportionate share of unemployment that women must bear. The cost of food and other necessary goods has increased drastically while less income is available to purchase them. The consequences are especially severe for the growing numbers of female-headed households, especially for many elderly women living alone.

The increasing number of households dependent on a woman’s income needs greater recognition. The numbers of fathers living alone with their children and of elderly men living alone are small. The difficulties experienced by single parents on the labour market fall almost entirely on women. In the EU, divorced and widowed women, the very women with the greatest need for the means to sustain a household on their own, experience the highest unemployment rates (EUROSTAT, 1992). In the CCEE and NIS, women living alone with their children are likely to be equally vulnerable.

The daily lives of women carrying heavy burdens of double work are made even more stressful by long waiting lines and limited availability of food and services, poor sanitation and limited household time-saving devices.

The CCEE and NIS have traditionally provided a broad range of social benefits and maternity support. Sometimes quite extensive, the benefits may include prenatal and maternity allowances, paid maternity leave and allowances for the care of sick children. One country reported that family allowances at the level of the minimum wage are paid for working women who care for a child under 18 months old, and monthly benefits at 50% of minimum wage for single mothers with children under the age of 16. Another country reported that 100% of the average wage is paid for 14 days to care for sick children and 120% of minimum wage is provided for care of a child up to age 3.

Social benefits that support families help to ameliorate the impact of economic need, but since most benefits are tied to minimum wages, high inflation rapidly erodes their purchasing power. One country reported that welfare benefits were raised substantially to reduce the impact of the transition for the most vulnerable groups, but the increases have not kept pace with the inflation in the cost of living. Several countries reported that the future status of the maternity, child-care and sickness leave benefits are uncertain. These are other consequences of the transition that will have greater impact on the lives of women.
Daily life

Ways of daily living shaped by cultural and structural opportunities and barriers

The impact of ways of living on the health of individuals arises from the effects of patterns of daily behaviour. Patterns of behaviour are shaped in social settings that determine options for learning and for making healthy choices. The cultural and structural forces that influence daily behaviour are often not adequately recognized. Ways of living that can damage health often spring from barriers that deny access to information, goods or services that support choices conducive to health.

Heavy burdens of double work and growing economic disadvantages place severe limits on viable options for women to choose healthy lifestyles. Even when time and resources allow, lack of knowledge and skills for making healthy choices may interfere with patterns of behaviour in daily life that protect and promote health.

The health consequences of patterns of individual behaviour have usually been ignored in traditional health and health education programmes. This leads to a lack of public awareness of the role of lifestyles in the preservation of health.

Family planning

A fundamental prerequisite for women to have control over their lives is to be able to maintain control over their reproduction.

Policies promoting motherhood in some CCEE attempted to increase birth rates by making contraception and abortion illegal. These policies failed. Instead of achieving their purpose, these policies led to extremely high maternal mortality in some countries. After the policies were abolished, the situation began to improve. For example, the very high abortion-related mortality for Romania in 1990 actually represents a fall from earlier figures and the improvement appears to be continuing. Nevertheless, as shown in Fig. 21, abortion is still a major cause of maternal death.

Only in Georgia, Kyrgyzstan and Kazakhstan, where most birth-related deaths are due to haemorrhage, is abortion not the primary cause of female deaths associated with pregnancy and birth. Socio-economic deprivation and the functioning of the health services (see page 29) exert greater influence on deaths due to haemorrhage.

In general, abortion remains the principal means to control reproduction in the CCEE and NIS. The country reports indicate that, in some areas, abortion rates equal or exceed birth rates. In one country, personal accounts found an average of 5 abortions among women reporting. The consequences of this tradition are reflected in the extremely high maternal mortality rates relative to the European Region as a whole.

Because the reliance on abortion limited family planning to the domain of the health services (a subject taken up on page 30), awareness of family planning alternatives to abortion remains quite limited. Although most countries report a growing interest in contraceptives, limited availability and cost remove them as viable options from many people, as reflected in Table 3. Information available from St Petersburg shows that almost 34% of women use no contraception, as shown in Fig. 22. It appears that, thus far, only intrauterine devices (IUDs) are becoming a more widely used form of reproductive control than abortion in the CCEE and NIS.

Fig. 21. Proportion of maternal mortality due to selected cause, around 1991

<table>
<thead>
<tr>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Romania</td>
</tr>
<tr>
<td>Kyrgyzstan</td>
</tr>
<tr>
<td>Kazakhstan</td>
</tr>
<tr>
<td>Georgia</td>
</tr>
<tr>
<td>Ukraine</td>
</tr>
<tr>
<td>Estonia</td>
</tr>
<tr>
<td>Albania</td>
</tr>
<tr>
<td>Latvia</td>
</tr>
<tr>
<td>Lithuania</td>
</tr>
<tr>
<td>Belarus</td>
</tr>
<tr>
<td>Poland</td>
</tr>
</tbody>
</table>

Source: Investing in Women's Health Initiative, WHO Regional Office for Europe, 1994
Table 3. Methods of contraception used by women aged 15–44 years, 1992/1993

<table>
<thead>
<tr>
<th>Area reporting</th>
<th>Abortions per 1000 live births</th>
<th>Percentage of women using:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>hormonal contraceptives</td>
</tr>
<tr>
<td>Albania</td>
<td>582</td>
<td>3.2</td>
</tr>
<tr>
<td>Belarus</td>
<td>1 578.9</td>
<td>3.9</td>
</tr>
<tr>
<td>Estonia</td>
<td>720</td>
<td>–</td>
</tr>
<tr>
<td>Georgia</td>
<td>975.49</td>
<td>–</td>
</tr>
<tr>
<td>Kazakhstan</td>
<td>606.6</td>
<td>–</td>
</tr>
<tr>
<td>Kyrgyzstan</td>
<td>1 270</td>
<td>2</td>
</tr>
<tr>
<td>Latvia</td>
<td>483.65</td>
<td>–</td>
</tr>
<tr>
<td>Lithuania</td>
<td>141.49</td>
<td>–</td>
</tr>
<tr>
<td>Poland</td>
<td>3 150</td>
<td>–</td>
</tr>
<tr>
<td>St Petersburg</td>
<td>1 550.57</td>
<td>3.7</td>
</tr>
</tbody>
</table>

Source: Investing in Women’s Health Initiative, WHO Regional Office for Europe, 1994

The consequences for family functioning and healthy lifestyles of barriers to effective family planning are made more serious by the eroding rights for maternity leave and child care. One country identified the lack of efficient and well coordinated social assistance programmes as one of the most important barriers to options for women to choose healthy lifestyles.

Breastfeeding

There are significant differences in the proportions of women who breastfeed in the countries reporting. The largest proportions are found in Kazakhstan, followed by Ukraine and Kyrgyzstan (Fig. 23). Variations in breastfeeding between countries are not related to family structure or fertility rates, but breastfeeding is more common in rural areas. This suggests that family structures and working conditions in urban areas are less conducive to breastfeeding.

The low proportions of breastfeeding in some countries were considered to be influenced by conditions in hospitals that contribute to early cessation of breastfeeding, such as providing supplementary bottle feeds and separating the baby from the mother.
Health damaging behaviour

The reports provided by the members of the Network indicate that quite limited information, if any, is available about the prevalence of behaviour that is detrimental to health in the CCEE and NIS. It is clear, however, that choosing healthy patterns of eating is not an option for large segments of the population.

In general, the country reports indicate that the change from planned to market economies brings problems of balancing the supply of and access to food, with the major limiting factor being price. A gap has developed between recommended and actual consumption of protein and vitamins. The nutritional status of the population has worsened considerably. Families with many children, the elderly, the disabled and other vulnerable groups are at high risk of infections and deficiency diseases, whose incidence is increasing.

Where information is available, the evidence shows that the prevalence of smoking is still far lower for females than for males (Fig. 24). The relatively greater rates of death attributed to smoking among men than women reflect the usually lower smoking prevalence among women in all countries for which data are available (Fig. 25).

Programmes developed to promote patterns of behaviour conducive to health are uncommon, but health promotion initiatives were reported in several countries. It has been found that programmes based on the experience of countries in western Europe may founder on cultural differences in ways of living and understanding. When programmes are not grounded in the customs and traditions of the local people, they will not be understood.

At the same time that health promotion programmes are not widely available, other forces encourage health damaging practices. For example, concerns were raised regarding the introduction of tobacco and alcohol advertising with the privatization of television. It is feared that the targeting of young people, particularly young women, in tobacco advertising will lead to higher smoking rates among women. A study in one country found that the prevalence among ninth-grade students of daily smoking had increased to 42% among boys and 21% among girls.

Increased smoking and alcohol consumption among women would add new dimensions of lifestyle threat in the form of increased direct risks to health from smoking, along with the consequences of using already extremely limited economic resources on health damaging practices. The sharp increases in female lung cancer mortality from 1980 to 1989 in the Region as a whole illustrate the danger (Fig. 26).

While little is known about the consumption of alcohol, the information that it is available suggests that, as in other areas of the Region, consumption by males is much greater than that by females. The proportions of documented cases of alcoholism are far smaller for women than for men. One country reported that, while the total consumption of alcohol...
had fallen considerably, the incidence of illness related to alcohol abuse has continued to increase. Alcohol-related violence against women, as noted below, is increasing.

The reports indicate that drug abuse is increasing and that its prevalence is lower in women than men.

The sex industry

In the past, the existence of prostitution was officially denied in the CCEE and NIS. Today, it is recognized that prostitution and sex workers are increasing significantly. In some areas, prostitution and crime related to it are virtually out of control. Factors increasing prostitution include social need, the lure of "easy" money and the inflow of visitors from western countries who are able to exchange money at highly advantageous rates (Radio Free Europe/Radio Liberty, 1993).

Female sex workers are stigmatized, discriminated against, treated as criminals and often blamed for spreading sexually transmitted diseases such as AIDS. The term sex industry is used to underscore the fact that prostitutes are only a minority of the people involved. First and foremost, the industry exists because of clients, but hotel and bar managers, pimps, taxi drivers, police and others are also involved (Morgan-Thomas, 1991).

As with any other industry, this industry responds to market forces. Failure to acknowledge this marginalizes sex workers, leaving them open to even greater exploitation than other disadvantaged workers. Relatively few women freely choose sex work to earn money. For many, it is the only realistic way to survive. Some of the country reports mention young women leaving the rural areas to practise prostitution in the cities; cross-border prostitution has also been reported to be increasing. Many women are swindled or literally forced into the sex industry.

There are important health promotion implications for all involved. For example, if clients continue to demand unsafe sex (and research indicates they do), then unsafe sex will continue to be sold. When sex workers are unaware of the danger of sexually transmitted diseases, or lack the options or resources to protect against it, they alone cannot be held responsible for the unsafe sex demanded by clients (Morgan-Thomas, 1991).

Sexually transmitted diseases and HIV

Although the numbers of people with AIDS in the CCEE and NIS are small, they are increasing. While the reporting of AIDS cases is standardized, there is little knowledge about the prevalence of HIV infection. Fear, denial and lack of information are barriers to knowing the extent of the HIV and AIDS problem in the CCEE and NIS. Excluding figures from Romania, infection via contaminated blood had begun to fall in 1987. According to the country reports, 100% of the blood units taken from blood donors is tested.

Lack of sex education, one-sided approaches to the sex industry and an increasing number of intravenous drug users increase the dangers of spreading HIV infection. The countries reported very low numbers of HIV-positive women. There is a lack of services and programmes for women on sexually transmitted diseases and HIV. Young girls, who are specially vulnerable, should be taught how to protect themselves from HIV infection. The introduction of programmes in secondary school on safe sexual life and the prevention of sexually transmitted diseases and HIV is an important achievement reported by some of the pilot countries. In many countries, however, sex education is not yet part of health promotion activities.

Violence against women

Domestic violence is a serious threat that many women face in their daily lives. Reluctance to
discuss the problem, or even acknowledge its existence, means that little is known about this form of violent behaviour. In contrast to the relatively well documented incidence of other forms of violence, violence against women is often hidden and undocumented. Most data on this subject are compiled from small studies, with the result that no systematic and representative information is available on the nature and extent of the problem in most places (United Nations, 1991a).

Studies that have explored violence against women and its health consequences indicate that it is widespread in all cultures. The country reports give indications that domestic violence and rape are increasing in the CCEE and NIS. One country reported an increase in the number of rapes and attempted rapes since 1985, paralleled by a decrease in the number of convictions for these crimes.

Violence is exacerbated by alcohol and drug abuse, economic difficulties and crowding. One country reporting an increase in the incidence of rape estimated that 80–90% occurred while the perpetrators were under the influence of alcohol. Another country reported that crimes committed while intoxicated had almost doubled between 1987 and 1992, with women and children being the principal victims. It was pointed out that, because women do not contact the police in such cases, the official statistics covering violence against women do not correspond with the real extent of the problem.

The physical and psychological health consequences, always present, can be severe. Violence against women represents a hidden obstacle to female economic and social development because it saps the energy and confidence of its victims (WHSQ, 1993).

Domestic violence occurs in all social classes, the vast majority of victims being women and children. It appears that girls may more often be victims of child abuse. One country reported results from a study finding that violence against children led to the deaths of six girls but only one boy.
Environment

Impact of dangerous and deteriorating environments

Physical environment

The environment in which people live their daily lives has a great influence on their health (World Bank, 1993). Serious air, water and soil pollution have become major threats to health in many of the CCEE and NIS. A bewildering array of environmental problems, including deforestation, desertification, soil degradation and loss of biodiversity, were inherited from the former system.

There has been considerable speculation among scientists and the public as to how much of the health gap between the eastern and western halves of the Region is attributable to environmental pollution. Very little research has focused directly on the health consequences of environmental pollution in the CCEE and NIS, and this is a priority area for concerted effort. The forces exacerbating the environmental crisis are considered among the chief dangers of the transitional period.

According to the country reports, the industrial sector is the main source of contaminated air. Low-quality and poorly maintained cars and massive use of low-quality coal for heating are also major contributors.

The failure to consider environmental protection in industrial development policy has severe consequences for future health and development. In most areas, pollution exceeds recommended standards for environmental protection. Only in some areas, where industrial production was reduced, have levels of pollutants decreased. Although less polluting industrial production is possible, the economic crisis makes it difficult or impossible to close plants or undertake fundamental conversions to more efficient and environmentally sound production in most places.

Water supplies are contaminated with untreated sewage and industrial waste dumped directly into rivers and lakes. Serious changes have been reported in the quality of major sources of urban water supplies. For example, the water supply for the 5 million people of St Petersburg is in jeopardy from the contamination of Lake Ladoga, the largest lake in Europe (Radio Free Europe/Radio Liberty, 1993). Fertilizers and pesticides are major sources of both water and soil pollution. Pollutants simultaneously in air, water and soil create parallel sources of risk that can have interactive effects on human health.

One country reported that in 1990, 7% of food supplies did not meet chemical standards and 9% did not meet bacteriological regulations. Children are especially vulnerable. Blood level concentrations of both lead and nitrates are higher than recommended standards for children and teenagers in many areas. Table 4 shows blood lead levels in Poland.

The nature of the environmental problems reported are similar for the CCEE and NIS. Radiation from Chernobyl, as well as chemical and bacteriological pollutants in air and water, cross national borders and defy national solutions. The health consequences are manifest in increasing rates of anaemia and kidney disease, and increasing mortality from respiratory disease.

All aspects of environmental pollution contribute to the dangers to health in the daily lives of women, but the environmental threats to health for women working in agriculture are especially dangerous due to the synergetic effects of multiple sources of exposure to pollutants in daily life. One country reported an increase in cancer in women of all ages, but particularly those aged 20–39 years. Infant mortality is also higher in more polluted areas, as are premature births, low birth weight and birth defects.

Occupational environment

The concentration of women in manufacturing and unskilled jobs in agriculture and the service sector means that large proportions of women are exposed to health risks at work. In some countries, it is forbidden for women to work in jobs involving serious occupational risks. Owing to their relatively disadvantaged position in the job market, women find the higher salaries paid for dangerous work attractive.

Lack of enforcement of occupational safety standards and rules is a general problem. The country reports point out that hazards in the workplace are made more dangerous by poor maintenance of equipment, inadequate investment

Investing in Women's Health

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Table 4. Blood lead in children and mothers in the Katowice region, Poland, 1990

<table>
<thead>
<tr>
<th>Place</th>
<th>Children</th>
<th></th>
<th>Mothers</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean blood level (μg/dl)</td>
<td>Level &gt;35 μg/dl (%)</td>
<td>Mean blood level (μg/dl)</td>
<td>Level &gt;35 μg/dl (%)</td>
</tr>
<tr>
<td>Szopienice</td>
<td>26.7</td>
<td>17.8</td>
<td>21.1</td>
<td>12.2</td>
</tr>
<tr>
<td>Miasieckzo Slaskie</td>
<td>24.7</td>
<td>16.6</td>
<td>21.6</td>
<td>14.7</td>
</tr>
<tr>
<td>Zyglin</td>
<td>26.1</td>
<td>21.8</td>
<td>20.1</td>
<td>9.7</td>
</tr>
<tr>
<td>Lubowice*</td>
<td>12.7</td>
<td>0</td>
<td>10.6</td>
<td>0</td>
</tr>
<tr>
<td>Zabrze</td>
<td>18.9</td>
<td>3.2</td>
<td>15.9</td>
<td>3.5</td>
</tr>
<tr>
<td>Toszek</td>
<td>17.9</td>
<td>13.2</td>
<td>13.1</td>
<td>4.5</td>
</tr>
<tr>
<td>Bytom</td>
<td>15.2</td>
<td>10.0</td>
<td>15.5</td>
<td>5.1</td>
</tr>
<tr>
<td>Bojszow*</td>
<td>12.3</td>
<td>0</td>
<td>11.5</td>
<td>0</td>
</tr>
<tr>
<td>Brzeziny Slaskie</td>
<td>22.4</td>
<td>13.0</td>
<td>17.6</td>
<td>6.9</td>
</tr>
<tr>
<td>Brzozowice</td>
<td>23.4</td>
<td>7.8</td>
<td>16.8</td>
<td>4.8</td>
</tr>
</tbody>
</table>

*Relatively far from a source of contamination.

Note: 15 μg/dl is the lowest adverse effect level; levels over 25 μg/dl require medical investigation.


in pollution control devices and failure to develop measures and procedures that increase work safety.

Exposure to dangerous chemicals is one of the more serious risks. The exposure to pesticides in agricultural work is perhaps the greatest occupational risk faced by women. Women have to do the more labour-intensive manual work in the fields, which constantly exposes them to heavy doses of pesticides from the soil, surface water and the products they handle. The unskilled jobs, often involving direct and concentrated exposures to dangerous chemicals, in picking and other forms of hands-on work that women more often perform, are a serious threat to both their health and that of the infants they produce.

The content and organization of work in many jobs where women are concentrated also affect health. It is estimated that about 4 million women in the NIS work night shifts, a figure greatly in excess of the male rates. Calculations indicate that 800,000 women are officially exposed to excess noise and vibration; 400,000 are doing heavier than legal manual labour, and 1.23 million are said to be exposed to excessive dust. Between 20% and 50% of women’s workplaces do not meet safety requirements (Shapiro, 1992). One estimate places 12% of female workers at risk from work requiring monotonous, constant and intensive tasks (Kroupova, 1991). This type of work causes damage to muscles and joints. Permanent disability is often the result.

Occupational diseases, it was reported, develop mainly among women between 31 and 50 years of age, with between 11 and 20 years of work in the dangerous job. The implications of these figures are that future rates of cancer, skin diseases, stress-related conditions and diseases of the muscles and joints, as well as infant mortality, will continue to increase, widening the health status differences between the CCEE and NIS and the rest of the Region if the conditions of work are not improved.

**Household environment**

As discussed above, women have the responsibility for most of the work in the home in addition to their paid jobs. The household environment exposes poor people to the greatest risks to health. Thus, millions of women must bear the burden not only of double work but also of double exposure to occupational health risks.

Poor sanitation, inadequate water supply, inadequate waste disposal, heavy indoor air pollution and crowding create serious and interactive risks to health in the household environments of poor people. Indoor air pollution contributes to acute respiratory disease, chronic lung disease, cancer and adverse outcomes of pregnancy. Crowding is associated with increased airborne infection and violence (World Bank, 1993)
Health care services

The health service systems of the CCEE and NIS struggle to provide health care to their populations under deteriorating conditions, with increasing shortages of staff and supplies. Historically, the health systems have been a government responsibility, with health care expenditures financed from general revenues. In principle, the population received services free of charge in government clinics and hospitals. In practice, "informal payments" were routinely required to obtain needed services (World Bank, 1993).

The CCEE and NIS have more hospital beds and physicians per 100,000 population than the other countries of the Region. The health systems, developed on the basis of quantitative norms, thus have exceedingly high levels of hospital capacity and health care personnel (Fig. 27), which the country reports say are now too expensive to maintain.

![Fig. 27. Numbers of hospital beds and physicians per 100,000 population, 1990](image)

<table>
<thead>
<tr>
<th>Country</th>
<th>Hospital beds</th>
<th>Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Romania</td>
<td>1014</td>
<td>422</td>
</tr>
<tr>
<td>Poland</td>
<td>1296</td>
<td>706</td>
</tr>
<tr>
<td>Kyrgyzstan</td>
<td>630</td>
<td>356</td>
</tr>
<tr>
<td>Belarus</td>
<td>598</td>
<td>315</td>
</tr>
<tr>
<td>Kazakhstan</td>
<td>506</td>
<td>252</td>
</tr>
<tr>
<td>Ukraine</td>
<td>397</td>
<td>228</td>
</tr>
<tr>
<td>Lithuania</td>
<td>397</td>
<td>228</td>
</tr>
<tr>
<td>Estonia</td>
<td>369</td>
<td>203</td>
</tr>
<tr>
<td>Latvia</td>
<td>352</td>
<td>185</td>
</tr>
<tr>
<td>Georgia</td>
<td>536</td>
<td>287</td>
</tr>
</tbody>
</table>

Fig. 27. Numbers of hospital beds and physicians per 100,000 population, 1990

Health services were previously focused on the employed segment of the population. Services developed specifically for women were essentially limited to reproductive needs, especially childbearing. Services for other groups were underdeveloped or nonexistent. Thus children, the elderly, the disabled, people confined to their homes, the unemployed and others with special needs, still have limited options for obtaining needed services.

Women as providers of health care

Health care services in the CCEE and NIS, medical and nonmedical, are essentially provided by women. As illustrated in Fig. 28, a large majority of physicians are women. It appears, however, that women seldom have the power to determine the type of services provided or their organization. As pointed out earlier, even though the majority of physicians are women, they are seriously underrepresented in leadership positions in the health sector. This may be a constraint to providing services that better meet the general needs of women.

Many rural health services are provided by fieldshers: auxiliary health personnel, most often women, with a professional education level between a nurse and a physician. A large proportion of the work involves maternal and infant care.

![Fig. 28. Proportion of women among physicians, 1990/1992](image)

Many of the country reports emphasized that health facilities are outdated and in poor repair. One country reported that 40% of hospitals are located in buildings that were originally constructed for another purpose, and that hospitals are often used irrationally. A shortage of supplies in many areas complicates the problems. These deficiencies may contribute to the high maternal death rates from haemorrhage seen in Fig. 21.

![Fig. 29. Proportion of women among physicians, 1990/1992](image)
Unmet needs of women

Even though women constitute the majority of patients and have special needs, health services frequently do not respond adequately to their needs. The most outstanding example is the widespread availability of abortion free of charge while contraceptives, when they are available at all, are usually not reimbursed. This problem is reflected in the widespread differentials in both contraception rates and abortion rates between the CCEE and NIS and other countries in the European Region (Fig. 29 and 30).

Fig. 29 shows the prevalence of contraception use, but must be read with caution, as standardized data on contraception use are not collected. Traditional methods such as withdrawal and the calendar method may or may not be included. For example, a study in Romania showed that the most prevalent method of contraception is withdrawal (34%) followed by the calendar method (8%). Only 14.5% of the women studied used “modern contraception” (CDC, 1994).

Modern contraception is difficult to obtain owing to the lack of supplies, the resistance of physicians, and the lack of consumer pressure groups to emphasize demand. In general, therefore, contraception is seldom used and does not reach the women in greatest need. Level of education is an important factor in awareness about methods of contraception.

Abortion, as mentioned above, remains the most frequently used means of family planning. In many of the CCEE and NIS, the rate is as high as one abortion for each live birth. Data from 1992 show three abortions for each live birth in Romania. In Lithuania, when counting “mini-abortions” during early pregnancy, the ratio of abortions to live births doubles: 903 per 1000 live births in 1992. In St Petersburg, the ratio rose from 2005 in 1990 to 2482 in 1992.

In addition, most country reports note that the type of maternity services available also illustrates the limited range and development of health care options. Fathers are generally not allowed to be present during labour and delivery. Newborn babies are usually not kept with their mothers, but are kept tightly swaddled, in nurseries. The role of midwives is not well defined, limiting the services they can provide.

Disease prevention and health promotion services focused on the health needs of women are usually not available. Services for sexually transmitted diseases need to be integrated into the general range of services. Several country reports mentioned the need for services to prevent violence against women and to treat the victims.

The limited array of services available for the elderly has a relatively greater impact on women than men. The growing proportion of older women living in communities where elderly women are losing their traditional roles in the family means that neglected and vulnerable older female populations are being created. The reports indicate that community options for their support and care are usually lacking. The limited number of old age facilities that exist are overcrowded, short of sanitary equipment and lack medical treatment.
facilities. One country reported that elderly people often unnecessarily prolong their stays in hospital because of the lack of living facilities and care in the community.

A major source of women's dissatisfaction with health care services is being left out of decisions about their treatment and care. In a study made in one of the pilot countries, only one third of the women responding considered health services helpful to women. Another frequently mentioned area of dissatisfaction was insufficient information about causes of diseases and treatment options. In several studies, women complained about physicians making decisions for patients.

**Barriers to better care**

Many physicians and pharmacists are leaving the government health services for private practice on a fee-for-service basis. Medicines and medical services have become more expensive and most patients are unable to afford them. The problems of limited access to services have grown at the same time that the harmful effects on health of increasing poverty have expanded.

It is reported that the balanced geographic distribution of physicians in some countries is being lost as physicians increasingly move to urban areas.

Many rural areas now suffer severe shortages of personnel. One country reported that a fourth of all patients had to be rejected owing to overloaded facilities and personnel.

According to the country reports, a problem affecting patient care is the frequent expectation of payment "under the table" to obtain better services. In a deteriorating socioeconomic situation, this problem may intensify. One country reported the results of a study showing that 60% of patients questioned reported the impossibility of getting help in maternity departments without tipping the personnel. Low-income women, especially single mothers, suffer more from this barrier to needed care.

Several countries report initiatives focused on women's needs. Main areas targeted include: family planning, healthy lifestyles, maternal and child care, health at the workplace, the needs of the elderly, accident prevention and prevention of HIV and AIDS.

Substantial resources are needed to repair and modernize health facilities, develop a broader range of services, and retrain health professionals, but the severe financial constraints mean that little investment has been made since the start of the transition. This is a key challenge facing health ministers throughout the CCEE and NIS.
Future directions

The health needs of women cannot be separated from an understanding of their place in the social structure, and their access to the opportunities and resources that enable people to live health-enhancing lives. The 1990s are a critical decade that could turn into an era either of advancement for women or of missed opportunity (United Nations, 1991b). The CCEE and NIS must grapple with old problems and the new threats that have emerged. Embedded in the crisis, however, as in all periods of transition and renewal, are new opportunities.

Women in the CCEE and NIS have achieved high levels of education and integration into the workforce, in comparison with women in other regions of the world. These achievements are threatened both by the economic crisis, and by a transition process that thus far has not valued the achievements of women or built guarantees of equal opportunity into the development process. The current situation for millions of women in the CCEE and NIS can only be characterized as an emergency. Effective solutions involve building security and ensuring choices in women's daily lives.

Dimensions of the challenges

For the women trapped in war zones, the emergency is acute and life threatening. Ethnic conflicts have created terrible conditions of deprivation, danger and violence for huge numbers of women. Violence against women, including systematic rape as a means to oppress and conquer populations, damages not only the health of the victims but also their basic human rights.

The economic crisis has created a chronic emergency in the lives of women living in and outside war zones. Women driven into prostitution by force or extreme deprivation must live daily lives that not only threaten their health, but may also be void of options for personal and social development and meaningful family life. Their options are further limited by exposure to multiple sources of danger and limited rights for personal safety and legal protection.

For the general population of women, the economic crisis has removed options for healthy choices from daily life, intensifying the burdens of double work. Economic vulnerability is especially harsh for female-headed households and for growing numbers of old women.

These new threats have compounded the inequalities that women traditionally face, the discrimination in the job market, the unequal pay, the excessive responsibility for the formal and informal caring work in society, and the double burdens of paid and unpaid work. The acute and chronic dimensions of disadvantage and deprivation help to continue the deterioration of the health of women in the CCEE and NIS.

Facing the challenges

Prerequisites for promoting the health of women in the CCEE and NIS are securing safety and creating options for healthy ways of living. The definition of crises and emergencies that stimulate protective responses from the community must be broadened to include the threats that are specific to women. The health of women has often been considered narrowly in terms of reproduction. A view of women's health that covers the whole life-span and recognizes the multiple dimensions of human development and functioning must be used to form the health and social policy developed for women.

Crimes and discrimination against women must be made culturally and socially unacceptable. They must be clearly forbidden and swiftly punished when they occur. Women victims of violence must be provided with protection and effective health and social services to heal not only their physical but also their psychological wounds.

Safety for women involves protection not only from the raw, violent acts of battering and rape but also from the socially constructed dangers inherent in unnecessary, inappropriate or dangerous treatments, whether they be in the form of drugs, procedures or equipment.
Securing the health of women involves economic and social options for a healthy daily life. The foundation on which this must be built is the availability and affordability of nutritious food. The security to control one's reproduction is also basic to healthy ways of living. Comprehensive information needs to be made available on options for family planning. The information is useless, however, if safe and affordable contraceptives are not available.

Women cannot protect and promote health in stressful living situations characterized by excessive work demands that do not allow viable options for rest and personal development. The burdens of work in society need to be distributed fairly between men and women. Shared family care will enhance the physical, psychological and social health of all members of the family.

When disease and/or functional decline develop, safe and flexible services are needed to protect and expand the reserves of health that remain. Resources need to be directed to developing a range of services that support and improve health and functioning.

**Priorities for action**

Effective investment in women's health can only be achieved by building policies and programmes appropriately around the needs of women as they live their daily lives. In general, health research has not focused on either women or daily life. New types of knowledge are needed for the health promoting investment of resources. The knowledge needed can only be obtained by new forms of research: epidemiology that recognizes that health is protected or destroyed in the complex realities of daily life, and health services research that studies the range of caring for health. A priority for action is the stimulation of scientifically sound research on the processes that protect or damage women's health.

Policy and programmes can be developed on a sound knowledge base only if the relevant regional and local information is available. The general data deficiencies documented in all of the reports submitted point to the need for new and expanded information systems.

Knowledge and information are useful only if they are used. Existing health and social policy needs to be evaluated and revised in the light of existing and newly obtained knowledge about women's health and health needs.

The people can use knowledge and make healthy choices only if they are educated about health protection and the service options available to them. A priority for action is to report what is known (and not known) in the range of formats needed to inform policy and practice. This report is a step in that process. It can only be considered a snapshot of the deteriorating health status and living conditions of the women in the Network countries at this time. It is not possible to predict how the countervailing forces in the daily lives of women in the CCEE and NIS will affect their health in the future. Many new health and social initiatives will have positive effects, but social upheaval and economic crisis are likely to confound the gains. The developments must be monitored to provide information on which to base effective health promoting action.
References


Annex 1
Vienna Statement on Investing in Women’s Health in the Countries of Central and Eastern Europe

In support of the WHO Global Commission on Women’s Health

Introduction

The 1992 World Health Assembly stated that: “women’s health must be given the highest level of visibility and urgency”. This encouraged the WHO Regional Office for Europe to launch the Investing in Women’s Health Initiative. This Initiative builds on a network, first established in 1991 at a WHO workshop in Vienna, for women from the countries of central and eastern Europe. In 1994, each Member State of the WHO European Region was requested to nominate a focal point for women and health. These counterparts will form the first European Women’s Health Forum.

As a result of the widening health gap between the eastern and western halves of the Region and the WHO commitment to equity, the first phase of the Initiative focused on 11 countries, and 1 city in the WHO Healthy Cities project. The results of the first year of work on the Initiative—a comparative analysis called “Highlights on Women’s Health”, as well as detailed country profiles—were presented at Women’s Health Counts: Conference on the Health of Women in Central and Eastern Europe. The Conference was held in Vienna, Austria from 16 to 18 February 1994. Its 270 participants from 40 countries agreed on the following consensus statement.

The Vienna Statement sets out six principles to advance women’s health throughout the WHO European Region, and establishes six priority areas for action. While these are particularly important for women in the countries of central and eastern Europe (CCEE) and the newly independent states (NIS) of the former USSR, they are also priorities for women in the rest of the Region. Finally, the Statement describes six policy mechanisms to strengthen the commitment to women’s health in policy reform throughout the WHO European Region.

Principles

The Investing in Women’s Health Initiative is guided by six principles. These principles form the basis of an approach to women’s health that builds on WHO’s commitment to equity, human rights and primary health care. These six principles include:

- investment in health;
- human rights;
- life-span health;
- empowerment;
- woman-friendly and appropriate services; and
- gender relationships.

1. Investment in health

Women are a key resource to societies. As the human development index clearly shows, however, no country treats its women as well as its men, or according to women’s contribution to the economy. A range of studies by the United Nations and the World Bank clearly shows that investments in women yield high returns in the form of faster growth, higher efficiency, greater savings and reduced poverty. Through improvements in women’s health, governments can make significant contributions to economic and social development. Investments in women’s health are beneficial in their own right. They lead to healthier children, improved household and community welfare, lower health care costs, and greater productivity. The
education of girls and women, child support, housing and primary health care for women, as well as their children, must become important priorities for policy-makers.

2. Human rights

The WHO Constitution defines health as "one of the fundamental human rights". This principle has not been sufficiently applied to women and their health needs.

Gender inequality is an epidemiological fact. Public health intervention must aim to redress this imbalance. A woman must have the right to sexual and reproductive choice. A woman's right to control her own sexuality and fertility must be recognized and accorded the status of a fundamental human right. Legislation on reproductive rights should be consistent with the United Nations Convention on the Elimination of All Forms of Discrimination Against Women and protect women's rights to sexual and reproductive choice.

3. Life-span health

Approaches to women's health must be based on the WHO definition of health, which encompasses physical, social and mental wellbeing. A health policy that is beneficial to women must consider the quality of their health throughout the entire life-span, and respond to the social, political and economic realities of women's lives.

4. Empowerment

The empowerment of women results from their ability to join together to promote change. Women need to be leaders in formulating health policy, making decisions, and carrying out programmes. This is a prerequisite for moving the women's health agenda forward.

5. Woman-friendly and appropriate services

Health strategies and services must respect and protect the dignity of women, while ensuring their right to privacy. No individual or group should suffer discrimination or stigmatization because of gender. Health services must be gender-sensitive and appropriate for the special needs of women.

6. Gender relationships

Significant change in women's health implies a shift in the relationship between men and women. Women and men need to share responsibility for family planning and child-rearing.

**Priorities for action**

Most societies in the CCEE and NIS are facing a deterioration in the health of their populations. For example, the difference in life expectancy between women in eastern and western Europe is on average 5 to 10 years. The most sensitive indicator today is the maternal mortality rate. It is rising in many of the CCEE and NIS; the rates in some countries are up to 10 times higher than those in many western countries of the Region. Both an emergency response and a long-term investment strategy are needed to reverse these trends.

There is an enormous range of challenges for reforming the health systems in the CCEE and NIS. The Conference participants identified six priority areas in women's health. While these priority areas focus on the concerns raised by the participants from the CCEE and NIS, they are relevant to women throughout the WHO European Region. These priorities include:

- reduced maternal death and increased maternal safety;
- promotion of sexual and reproductive health;
- the introduction of woman-friendly reimbursement policies;
- promotion of programmes for healthy lifestyles;
- reducing violence against women; and
- improving the situation of women working in the health care system.

1. Reduced maternal death and increased maternal safety requires:

   - upgraded maternal and child health services;
   - more cost-effective prenatal intervention;
   - updated women-centred delivery practices;
   - the promotion of breastfeeding;
   - updated knowledge and skills of midwives;
   - protection against inappropriate medical technology;
   - reduced unsafe abortions; and
   - high quality of care in abortions.

2. Promotion of sexual and reproductive health requires:

   - more sex education for girls and boys;
   - wider availability of contraceptives;
   - a variety of contraceptives from which to choose;
integrated family planning services in the community;
confidential testing and counselling for sexually transmitted diseases;
treatment for sexually transmitted diseases;
confidential counselling for people with HIV and AIDS; and
counselling for sex workers.

3. The introduction of woman-friendly reimbursement policies requires:

- supporting reimbursement of the cost for contraceptives;
- giving priority to comprehensive primary care services;
- giving priority to preventive services and health promotion programmes, particularly for heart disease and stroke; and
- providing screening for breast and cervical cancer.

4. Promotion of programmes promoting healthy lifestyles would:

- promote healthy nutrition;
- promote psychological and mental health;
- support tobacco-free lifestyles;
- provide treatment for substance abuse; and
- promote healthy aging.

5. Reducing violence against women requires:

- recognizing domestic violence and rape as public health issues;
- enacting and enforcing laws against battering and rape;
- acting against forced prostitution and traffic in women; and
- providing counselling and shelter to women in need.

6. Improving the situation of women working in the health care system requires:

- ensuring better pay, better working conditions, and higher status for women health workers;
- appointing more women to leadership positions; and
- providing high quality continuing education.

Political commitment to women's health policy

The Conference documented the wide range of policy initiatives already under way. But much remains to be done to strengthen the commitment to women's health in policy reform. This means appointing more women to leadership positions, and ensuring the full involvement of women's groups and nongovernmental organizations in an interactive policy process. Six policy mechanisms were recommended.

1. Countries should establish an office for women's health, charged with developing an intersectoral women's health policy and action plan.

2. National women's health forums should be created in each country.

3. Countries should develop a reliable information base for an intersectoral women's health policy, including sectors such as education, labour, welfare and housing. This requires reporting and monitoring systems that use gender-specific, disaggregated data on women's socioeconomic and health conditions.

4. Countries should publish comprehensive reports on women's health at regular intervals, and present them to parliaments, the media and the general public.

5. Countries should develop research strategies for women's health that specify priority areas for investigation and outline subsequent action. Research should be multidisciplinary and support the development of a new social epidemiology of women's health.

All countries should increase their research efforts in women's health.

6. All Member States of the European Region should produce women's health reports in the context of the Regional Office's women's health initiative. This material will be part of the materials presented at the United Nations 4th World Conference on Women, to be held in Beijing in September 1995. This material will also be presented at the forthcoming Economic Commission for Europe Regional Preparatory Meeting, to be held in Vienna in October 1994, as well as the preceding forum for nongovernmental organizations.
Annex 1

Coordination of effort

Initiatives in women’s health throughout the Region should be well coordinated. Investors and donors – multilateral and bilateral – should review their priorities and pay greater attention to the health of women. They should ensure that women experts are actively included as part of the consultant teams working with the CCEE and NIS.

WHO should explore the feasibility of establishing a network of centres for women’s health to support research and training in women’s health for the European Region, and continue to monitor women’s health through regular comparative highlights and country profiles.

Community involvement and women’s empowerment

Mechanisms must be established for listening to women’s views on their own needs and the issues they confront. Social and cultural differences must be recognized and respected. People need to be informed about research findings that relate to women’s health in ways that are both understandable and relevant. Most important, these mechanisms must empower women to care for their own health.

Meeting the challenge together

Women’s health is an issue that crosses borders, political systems and cultural differences. International cooperation is essential. WHO should seek alliances with other organizations to support the Investing in Women’s Health Initiative.
Annex 2

Investing in Women’s Health Initiative: Country Coordinators and Focal Points

Dr Tatjana Harito
Director, Public Health Department
Ministry of Health
Tirana
ALBANIA
Tel: +355-4234672
Fax: +355-4234672

Dr Kanine Saribekian
Head of Maternity and Child Health Department
Ministry of Health
Toumanian Street 8
001 Yerevan 375 001
ARMENIA
Tel: +7 8852 56 43 15

Dr Alida Aleeva
c/o Ministry of Health
Kickik Daniz str.4
Baku, 370014
AZERBAIJAN
Tel: +7-8922 932977
Fax: +7-8922 988559

Dr Beate Wimmer-Puchinger
Direktor, Ludwig Boltzmann Institut für Gesundheitssoziologie der Frau
Stumpergasse 56
A-1060 Vienna
AUSTRIA
Tel: +43-1-47615362
Fax: +43-1-47615307

Dr Dimitri Mikhnyuk
Chief Obstetrician/Gynaecologist
Ministry of Health
39 Miasnikov Str
220097 Minsk
BELARUS
Tel: +7-0172-204548/96256
Fax: +7-0172-296297/206673

Dr Nadija Volcic
c/o Ministry of Health
Marsalo Tito 7
Sarajevo
BOSNIA AND HERZEGOVINA
Tel: +387-71 663742
Fax: +387-71 664898

Dr Tania Cholakova
National Centre for Health Information
D. Nestorov Bld 15
Sofia 1431
BULGARIA
Tel: +359 259 50 22
Fax: +359 259 01 47

Dr Vlasta Deckovic-Vukres
Head, Workers’ Health Protection
Public Health Institute
Rockefellerova 7
Zagreb
CROATIA
Tel: +385 41 272822
Fax: +385 41 432688

Dr Vit Unzeitig
Clinic of Obstetrics and Gynaecology LFMU
Obilni trh 11,
65677 Brno
CZECH REPUBLIC
Tel: +42-5-2194

Dr Ene Tomberg
Head, Health Office of Tallinn
Toompuiestee
5 EE-Tallinn
ESTONIA
Tel: +372-2-448609
Fax: +372-2-442009
Ms Eeva-Liisa Vakkilainen  
Senior Counsellor  
Ministry of Social Affairs and Health  
00171 Helsinki  
FINLAND  
Tel: +358-0-160530  
Fax: +358-0-650-442

Dr Tengis Asatiani  
Chief Obstetrician/Gynaecologist  
Ministry of Health  
K. Gamsakhrurdi Avenue 30  
380060 Tbilisi  
GEORGIA  
Tel: +7-8832-3897071  
Fax: +7-8832-998108  
Telex: 21-22 23 lazer su

Dr Cornelia Helfferich  
Albert-Ludwig-Universität Freiburg  
Abt. Medizinische Soziologie  
Stefan-Meier-Str. 17  
79104 Freiburg  
GERMANY  
Tel: +49-761-203 5518  
Fax: +49-761-203 5516

Nina Kajupova  
Director, Public Research Centre on Health of Women and Children  
Ministry of Health  
Ablaihan Str. 63  
Almaty 480003  
KAZAKHSTAN  
Tel: +7-3272-644684  
Fax: +7-3272-331719

Dr Joomabubu Doskeeva  
Chief, Health of Women and Children  
Ministry of Health of Kyrgyzstan  
Bishkek  
KYRGYZSTAN  
Tel: +7-3312-223771  
Fax: +7-3312-228424

Dr Aiga Rurane  
Department of Maternal and Child Health  
Ministry of Welfare, Labour and Health  
Skolav str 28  
LV-1331 Riga  
LATVIA  
Tel: +371-2-271713  
Fax: +371-2-276445

Dr Vande Vainauskiene  
Head, Department for Mother and Child  
Ministry of Health  
Gedimino pr 27  
2326872 Vilnius  
LITHUANIA  
Tel: +370-2-621625  
Fax: +370-2-224601

Dr Miriam Camilleri  
The Commission for the Advancement of Women  
c/o Ministry of Home Affairs and Social Development  
“Casa Leon!”  
476 St Joseph High Road  
Santa Venera-HMR 18  
MALTA  
Tel: +356-446524  
Fax: +356-447228

Dr Johanne Sundby  
Adviser, Institute of Medical Anthropology  
Faculty of Medicine  
University of Oslo  
PO Box 1130  
N-0138 Oslo  
NORWAY  
Tel: +47-22-850598

Mrs Jolanta Lozinska  
Adviser to the Minister of Health  
Ministry of Health and Social Welfare  
Miodowa 15  
Warsaw  
POLAND  
Tel: +48-2-313441  
Fax: +48-2-6359245

Dr Maria Helena Matos Neves  
Director, Primary Health Care Services  
Directorate-General of Health  
Alameda D. Afonso Henriques, 45  
P-1065 Lisbon Codex  
PORTUGAL  
Tel: +351-1-847-5515  
Fax: +351-1-847-66 39

Dr Eugen Gladun  
Director, Research Institute of Maternal Health and Children’s Care  
Str Burebista 93  
Chisinev 277030  
REPUBLIC OF MOLDOVA  
Fax: +373-2521171
Dr Anna-Maria Tinu
Romanian Focal Point on Women's Health
c/o WHO Liaison Office
Str Pitar Mos 7-13
Bucharest
ROMANIA
Tel: +40-1-6116440
Fax: +40-1-2100173

Dr L.V. Gavrilova,
Deputy Chief, Board on Maternal and
Child Health
Ministry of Health of the Russian Federation
Rahmanovskij pereulok 3
101431 GSP Moscow K-51
RUSSIAN FEDERATION
Tel: +7-095-9251140
Fax: +7-095-2000212

Dr D.I. Zelinskaya
Chief, Department of Maternity and Child Health
Ministry of Health
Rahmanovskij pereulok 3
101431 GSP Moscow K-51
RUSSIAN FEDERATION
Tel: +7-095-9251140
Fax: +7-095-2000212

Dr Lidia Simbirtseva
Head, Lifestyles and Health Department
Institute for Women and Management
MAPO Saltycova-Shedrina 41
St Petersburg
RUSSIAN FEDERATION
Tel: +7-812-5422655
Fax: +7-812-2730039

Dr Eva Siracka
President, League against Cancer
Spitalska 21
811 08 Bratislava
SLOVAK REPUBLIC
Tel: +42 7 321735

Dr Dunja Obersnel Kveder
Institute of Public Health
Trubarjeva 2
61000 Ljubljana
SLOVENIA
Tel: +386-61-1323-245
Fax: +386-61-323-955

Dr Annika Strandell
Director, Sex, Gender and Health
Swedish National Institute of Public Health
P.O. Box 27848
S-115 93 Stockholm
SWEDEN
Tel: +46-8-783-35-00

Dr T. Stutz Steiger
Bundesamt für Gesundheitswesen
Abteilung Gesundheitsförderung
CH-3097 Liebefeld
SWITZERLAND
Tel: +41-31-970-8728
Fax: +41-31-970-8789

Dr Eugenia Narzulaeva
Director, Institute of Obstetrics, Gynaecology
and Paediatrics
Tursun-sade 31
Dushanbe 738058
TAJIKISTAN
Tel: +7-3772-232456
Fax: +7-3772-278038

Dr Katica Zafirovsua
Chief, Department of Nephrology
University of Skopje
Vodnjausue 17
94000 Skopje
THE FORMER YUGOSLAV REPUBLIC OF MACEDONIA
Tel: +389-91-206505

Mrs Nina Kerimi
Chief, Department of Physiology
State Medical Institute
c/o Ministry of Health
Mahtumkuli pr.95
744000 Ashgabat, GSP-19
TURKMENISTAN
Tel: +7-363-2251063/2254697
Fax: +7-363-2255032/2255173

Dr Arzu Köseli
General Directorate of Mother & Child Health
and Family Planning
Ministry of Health
Sihhiye Ankara
TURKEY
Tel: +90-312-4314824
Fax: +90-312-4314879
Annex 2

Dr Boris Ventskovsky
Chief Obstetrician/Gynaecologist
Ministry of Health
M. Hrushevsky str. 7
252021 Kiev
UKRAINE
Tel: +7-044-2936194
Fax: +7-044-2936975

Dr Delia Fahritdinovna Karimova
Head, Department of Obstetrics and Gynaecology
Tashkent Advanced Medical Training Institute
51 General Petrov str.
Tashkent
UZBEKISTAN
Tel: +7-3712-782576

Dr Eileen Rubery
Senior Principal Medical Officer
HP(M) Division, Department of Health
Room 522, Wellington House
135/155 Waterloo Road
London SE1 8UG
UNITED KINGDOM
Tel: +44-71-9724421
Fax: +44-71-9724319

Investing in Women's Health
Profound and rapid changes are under way 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 between the eastern and the western halves of the WHO European Region: a serious inequity. A closer look at the CCEE and NIS 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.

Recognizing both the problem and the opportunity, the WHO Regional Office for Europe created the Investing in Women's Health Initiative. Its goal is to provide governments in the CCEE and NIS with information and policy options, through a European Women's Health Forum. Governments can then use these tools to address women's needs throughout life, and make use of women's strengths in this difficult period of transition.

This book is one of the first fruits of the Initiative. Coordinators from 11 pilot countries and 1 pilot city in the eastern half of the Region gathered data for the first-ever “country profiles” on women's health and the factors that influence it. This book makes a comparative analysis of the profiles. It takes a broad view of women's health, extending beyond the traditional focus on reproductive issues to embrace the whole life cycle. It describes not only health status and health care services but also women's position in society and the influences of daily life and the environment on their health. It concludes by indicating the directions for future action, which should include improving the amount and quality of the data on women.

This book makes gripping and vital reading for anyone interested in women's health, health in the CCEE and NIS, equity, healthy public policy, or the opportunities for beneficial change in the eastern countries of the European Region.

ISBN 92 890 1319 2

Sw.fr.11.–