

4 Women's Health



The World Health Organization promotes the concept of good health as “a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity”. This prized state – an important measure of human development – is no less an aspiration of women and men living through the transition than are economic opportunity and political freedom.

In line with the social and economic hardship of the transition, the populations of most countries of the region have experienced a deterioration in health. The bluntest measure of this decline, presented in Chapter 1, is that life expectancy for women and men deteriorated during the first years of transition in most countries, although a recovery has subsequently been observed in some cases. There is also a growing disparity among different geographic areas, within countries, between countries or groups of countries, and between different population groups. In particular, the gap in women's health that existed between Western Europe and Central and Eastern Europe before transition has widened.

Access to good health is a basic element of women's equality in society, and the state of women's health is felt far beyond the well-being of individual women. There are important implications for family and child welfare because key determinants of health, such as education and income, are passed from generation to generation and because women are central figures in household health management, nutrition and care. By extension, women's health also has an important impact on broader society, both in the workplace and in the community. The Platform for Action of the Fourth World Conference on Women, held in Beijing in 1995, states that advancing women's equality in health involves not only addressing the biological differences between women and men, but the unequal access to health care resources and differences in the non-biological determinants that shape health.

Before transition, important investments had been made in health services across the region through the universal health care system. However, the return on that investment was less than might be expected for women's health in most countries of the region. For example, despite an emphasis on care for pregnancy, childbirth and infants, most countries experienced higher maternal mortality rates than those in Western Europe. In general, health awareness was very low across the region. The communist state appropriated the concept of health and defined it as the product of the state's health care system, so that individuals, employers and communities lacked a

sense of responsibility for, and the capacity to promote, good health.

The transition has not only weakened the state health system, but triggered changes in the socio-economic factors that shape women's health. Many of the immediate effects are adverse, including lower incomes, increased income disparity and greater social stress. Many countries are becoming more open societies, a shift that can bring both positive and negative changes in health – from improved access to family planning and promotion of healthy lifestyles to increases in the range and intensity of risk-taking behaviours such as drug use or unsafe sex. In most countries, lower levels of public spending limit the capacity of the existing health system to meet demand even if reforms raise quality and efficiency. It is important to realize that, while the health of women and the health of men will be affected, they may be affected in different ways and to different degrees.

One of the most dramatic examples of the different health responses and needs of women and men during the transition has been the mortality crisis (uncovered in earlier Regional Monitoring Reports and updated in Chapter 1) that has affected women and men, but that has been most pronounced among middle-aged men. This is consistent with worldwide patterns that men are more likely to experience premature death and women are more likely to experience sickness and poor health. This disparity simply underscores the reality that women's health issues are different from those of men in a number of ways. Women have particular health needs related to reproductive biology and beyond the reproductive sphere, for instance in terms of mental health. Their health problems tend to start earlier in life and to persist longer into old age. Biological and social factors, including subordination in society, influence women's health throughout their lives and have cumulative effects. Many of the health difficulties faced by women in their reproductive years originate in childhood or adolescence, confirming the importance of considering the health of women throughout the entire life cycle.

This chapter deals with selective aspects of women's health. Section 4.1 starts with the conventional focus on maternal and child health and expands to include reproductive health issues such as abortion and family planning. Section 4.2 reviews the way changes in economic and social determinants during the transition have affected women's health. The Conclusions summarize the challenges to women's health in the region. ■

4.1 Women's Reproductive Health: An Uneven Record

One of the main thrusts in improving the health status of women globally has been to emphasize the whole health of the woman at all ages and stages of life. This life-cycle approach means considering all aspects of female health – physical, mental and social – from birth to old age. Conventionally, medicine and health care have focused on the primacy of a woman's reproductive health and her childbearing years and, more specifically, on pregnancy and infant health. As a result, available data, especially in the transition region, tend to focus on these aspects of women's health. For this reason, the following section covers the more narrow view, but intends to point to a broader perspective which recognizes that women's reproductive health extends well beyond childbearing and is an integral part of women's overall health.

Large variances in maternal health

The overall stability or improvement of infant mortality rates across the region during transition, as presented in Chapter 1, attests to the inherited advantages of good health, education and health services for the mothers. However, during the transition, there has not been an adequate improvement in maternal mortality rates across the region. The level and quality of professional perinatal care have suffered in most countries surveyed, with implications for birth complications and outcomes. There also appear to be increasing differences in pregnancy complications between countries, between regions within countries and between various population groups.

Figure 4.1 presents information on the registered incidence of maternal mortality in the region – a total of about 1,700 deaths from pregnancy-related causes in 1997. The graph shows that 17 of 26 countries reporting document a decrease in the maternal mortality rate between 1989 and 1997. However, in the other nine countries, the rate has increased. Altogether, 17 countries

still have maternal mortality rates above the WHO target for Europe of 15 maternal deaths per 100,000 live births. In 11 countries, the rate is more than twice this target. Altogether, only 11 of the 26 countries have achieved or are about to achieve the goal set in 1990 at the World Summit for Children to halve maternal mortality rates over 1990-2000.

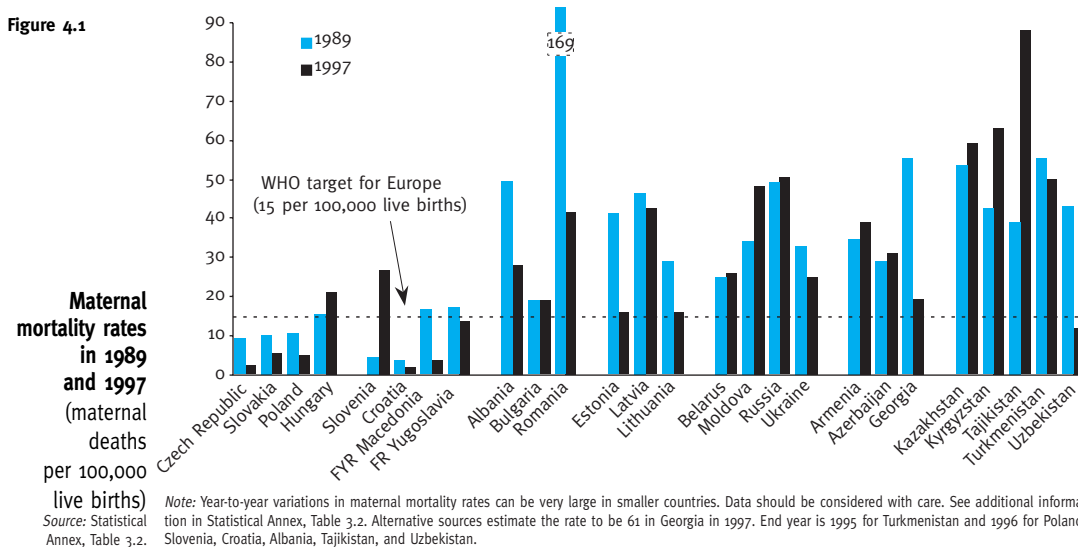
The situation varies significantly by sub-region. The graph clearly shows that maternal mortality is much lower in Central and Eastern Europe, the former Yugoslavia and the Baltics. The rate is generally decreasing and below or around the WHO target for Europe – with the exception of Hungary and Latvia. However, in these two countries the absolute numbers of maternal deaths are relatively small, so the rate can fluctuate greatly from year to year. (For example, the number of maternal deaths in Hungary was 12 in 1996 and 21 in 1997.) In FYR Macedonia, the reduction of the maternal mortality rate might reflect such a fluctuation. However, it should be noted that the share of births attended by professional health care providers rose from 89 percent in 1990 to 96 percent in 1996. In Albania and Romania, high maternal mortality rates in 1989 (49 and 169, respectively) were sharply reduced after the introduction of legal abortion. The rates are, however, still much higher than the WHO target, at 28 and 41 deaths per 100,000 live births, respectively.

The situation in countries of the Commonwealth of Independent States is quite different, with higher maternal mortality rates in most of the countries since transition. Figure 4.2 presents long-term trends in maternal mortality in Russia and Ukraine. It shows that the progress made in the 1980s has stopped or has even been reversed during the transition period of the 90s. As a result, in both countries the mortality rate has stabilized, but remains well above the WHO target for Europe. The trend is also worrying in Tajikistan, where the maternal mortality rate has sharply increased during transition and is about four times higher

than this target. Large variations in maternal mortality rates are also observed within countries, particularly where rates are high, such as in the Caucasus and Central Asia. For example, maternal mortality rates in the region of Karakalpakstan, bordering the Aral Sea, in Uzbekistan are significantly higher than in the rest of the country, 120 per 100,000 against a national average of less than 20 in 1994.

Even in some countries where the mortality rate has

Figure 4.1



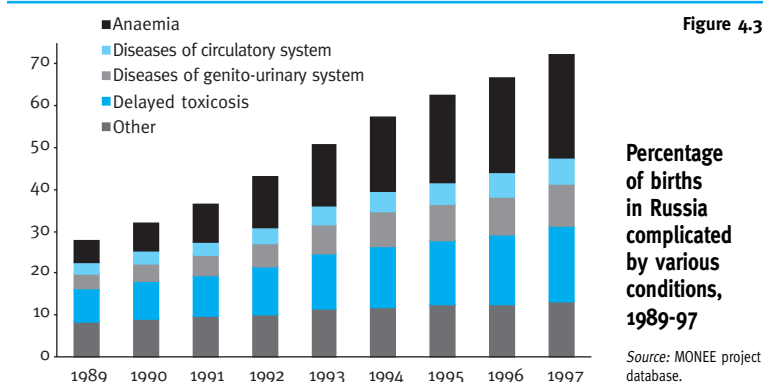
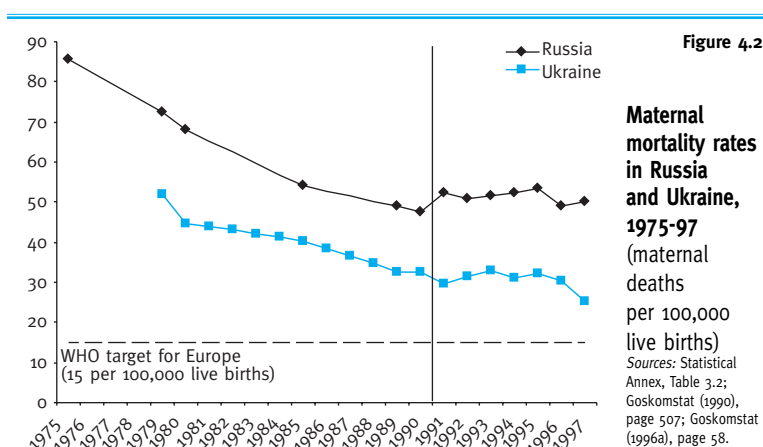
not risen, the incidence of complications during birth is growing. For example, in Belarus, the occurrence of hæmorrhage increased from 190 cases per 10,000 births in 1989 to 280 in 1995. Eclampsia cases rose from 6 per 10,000 births to 14 per 10,000 over the same period. Information for Russia, shown in Figure 4.3, also reveals a dramatic increase in complications, climbing from 23 percent of births in 1989 to as much as 67 percent in 1996. The prevalence of all conditions leading to complications has increased, with the incidence of anaemia growing especially rapidly. The share of births complicated by anaemia rose from 5 to 23 percent over the period. Part of the explanation may be linked to the demographic changes presented in Chapter 3. For instance, in most countries of the former Soviet Union, there is a higher proportion of young mothers, and younger women tend to have less successful birth outcomes, including higher incidence of stillbirth and low birthweight. However, the changes observed are greater than such structural shifts would suggest and point to an actual deterioration in outcomes.

In keeping with the increase in pregnancy and birth complications, the health status of newborns has also deteriorated. The number of stillbirths, low birthweights, congenital anomalies, and problems in the perinatal period has been rising in most of the countries surveyed, particularly in those hard hit during the transition, such as FYR Macedonia, FR Yugoslavia, Bulgaria, and Georgia. In Georgia, the country with the highest rate of stillbirths, the incidence increased from 7 per 1,000 births in 1989 to 18 in 1997.

In particular, the proportion of children born at low birthweight (under 2,500 grams) has been increasing in many countries – with the exception of countries such as Poland, Hungary, or Slovenia. (See Statistical Annex, Table 2.5 for details). A rise in the percentage of children born with a low birthweight may partly reflect improved perinatal and obstetric care that results in fewer stillbirths and more survivors with low weights. It can also reflect a deterioration in maternal health, such as poorer nutrition.

Low birthweight is an important indicator because it raises the probability of infant mortality, has a negative impact on the development of the child, carries financial and emotional stress for the parents, and has resource implications for health services. The situation of babies born to young mothers is of particular concern. For instance, in Bulgaria, the share of children born with low birthweights to women under age 20 increased from 10 percent in 1989 to 14 percent in 1997. Both the level and the deterioration are greater among this age group. Thus, the proportion for women of all ages rose from 7 to 9 percent over the same period. The reasons for this pattern include the fact that younger women tend to lack maturity, have lower socio-economic status and less access to health care, and are likely giving birth to first babies with the attendant higher risks.

Even in the Czech Republic, where there has been a general improvement in birth outcomes, disparity among social groups has been growing, in line with socio-eco-



omic changes. Over 1989-97, the mean birthweight in the Czech Republic increased (after an initial decline), while both infant and maternal mortality fell significantly. Figure 4.4 presents the mean birthweight of babies of mothers at various educational levels. It reveals that the differences among mothers with different levels of education are relatively large and have become greater during the transition. Babies born to women with less education showed larger decreases in birthweight during periods of deterioration and smaller increases during periods of improvement. The differences in mean birthweight and in post-neonatal mortality (after the first 27 days of life) were still found to be statistically significant and rising after controlling for other important determinants such as maternal age and the birth order and sex of the child.

Still, in the Czech Republic, the neonatal mortality rate fell over 1989-95, reflecting an improvement in the

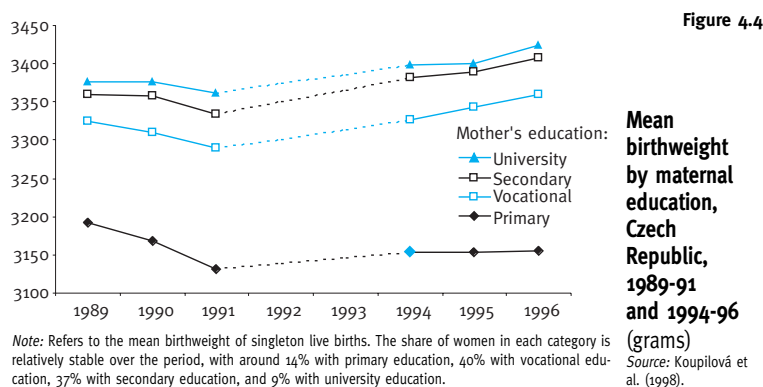
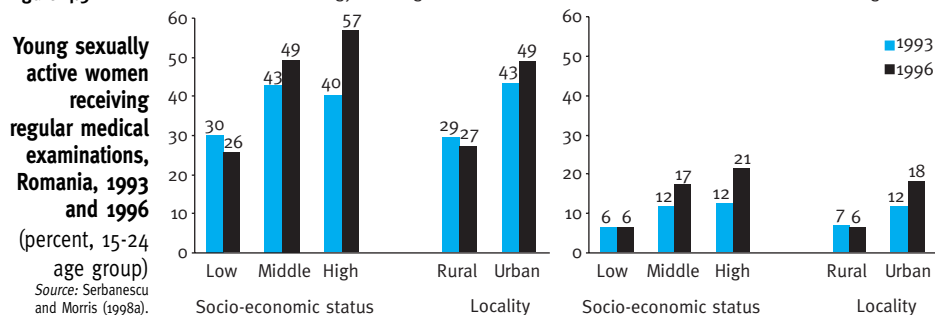


Figure 4.5



Young sexually active women receiving regular medical examinations, Romania, 1993 and 1996 (percent, 15-24 age group)

Source: Serbanescu and Morris (1998a).

ability of the health system to ensure the survival of low birthweight babies. However, regional analysis shows improvements have been much greater in Prague than in the rest of the country, confirming regional imbalances in the quality of neonatal care.

While the health status of women can partly explain changes in birth outcomes, the health system also plays an important role. Maternity care has traditionally been of high standard throughout the region, although emphasis was placed on number of visits, diagnostics and tests rather than on quality, counselling and education. Most women were followed regularly through their pregnancies, and the great majority of births took place in the presence of qualified staff and in health centres.

Evidence suggests that most of the advantages gained before transition in terms of birth care have been maintained, but that there are signs of decline, with important implications for the health of mothers and their children. The situation differs widely across the region.

Countries in Central Europe and the Baltics started with a better situation and have managed to maintain most of their achievements. There are, however, signs of inequality across population groups or regions that raise concerns about setbacks. For instance, big regional variations in the provision of maternity care were highlighted

by a large representative survey in the Czech Republic in 1993. Up to 10 percent of women were not receiving prenatal care during the first trimester in North Bohemia, compared to only 3 percent in South Bohemia. Similarly, 15 percent of women in North Moravia had not had an ultrasound exam during their pregnancy, compared to 2 percent in South Bohemia.

On the other hand, in Southeastern Europe, Central Asia, the Caucasus, and parts of western CIS and the former Yugoslavia, the initial conditions were usually less adequate, and the situation has deteriorated. This goes against the goal set by the World Summit for Children in 1990 to furnish universal access to prenatal care and to assistance during childbirth.

In Southeastern Europe, evidence indicates a decline in the provision of services for pregnant women. A large 1993 survey in Romania showed substantial inequality in access to prenatal care by age, education and economic status of the mother. The proportion of pregnant women without prenatal care ranged from 10 percent for those with primary education to 2 percent for those with post-secondary education. Both the number of visits and the timing of the first visit correlated with age, education and economic status. Information on changes in access to reproductive health services for young women (aged 15-24) over 1993-96 in Romania is presented in Figure 4.5. It shows an overall improvement in access to routine gynaecological examinations and to cervical cancer screening, but also reveals increasing inequality in access. Women from lower socio-economic groups and women in rural areas actually had reduced access during a period of general improvement.

In Bulgaria, the proportion of women with no prenatal care was 22 percent in 1996 and 17 percent in 1997, although births were still assisted by trained health professionals. In Albania, birth assistance decreased until 1992, when only 86 percent of births took place with professional attendance, but rose to 91 percent in 1997.

In countries of the former Yugoslavia, the range of services provided to pregnant women has likely diminished in areas where war has caused significant material destruction. In addition, large regional disparities were observed in FR Yugoslavia, especially between the region of strife-torn Kosovo and the rest of the country. Table 4.1 shows that more than one-fourth of deliveries (27.1 percent) were not assisted by professionals in Kosovo, against a national average of 8.3 percent, which is already high compared to neighbouring countries. Women in Kosovo averaged only 0.7 medical visits after birth, compared to a national average of 4.5. Similarly, infant and child mortality rates and the proportion of stunted children were significantly higher than in the rest of the country, while immunization coverage was lower. (These figures pre-date the 1999 conflict.)

In the Caucasus, the situation also appears to have deteriorated, especially in remote rural areas. In Armenia,

Table 4.1

Maternal and child health in FR Yugoslavia, 1995-96

	National average	Kosovo
% unattended births (without trained personnel) (1995) a, b	8.3	27.1
Average visits per woman after delivery (1995) c	4.5	0.7
Infant mortality rate (1995) b	16.8	23.6
Under-5 mortality rate (1995) b	19.4	27.7
% children aged 0-5 classified as stunted (1996) d	6.8	13.1
% children fully vaccinated in second year of life (1996) d	65.3	53.0

Sources: a. MONEE project database. b. UNICEF (1997b). c. Posarac (1998). d. IPHS, IPHM and UNICEF (1997).

Note: Children are classified as stunted when their height for age is two standard deviations or more below the median of a reference population. Full vaccination includes BCG, DPT, OPV, and measles vaccination.

the proportion of known home births increased and peaked at 7 percent in 1994 and 1995. Evidence suggests that up to half of deliveries take place at home in some areas of the country. The proportion of infant deaths occurring at home has risen, especially in rural areas, and represents about 30 percent of all infant deaths. The proportion of women without prenatal care has also grown. More than 40 percent of women in the city of Yerevan

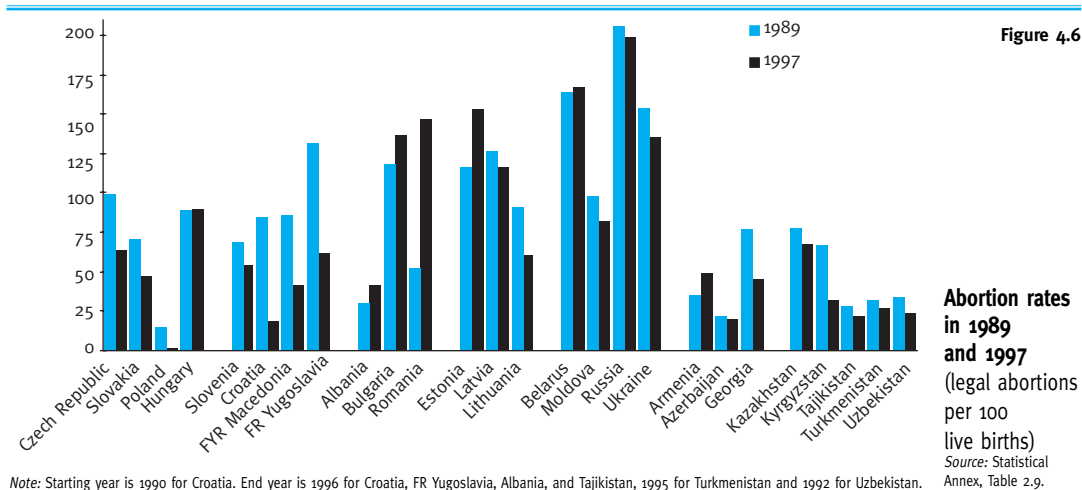
and 50 percent of women outside Yerevan are reported to attend their first medical consultation only after the initial trimester of pregnancy. In rural areas, the cost of transportation and health care, poor sanitary conditions and lack of supplies deter women from visiting health centres. The majority of facilities are reportedly in disastrous physical condition and lack drugs and other supplies.

The situation in Central Asia is also showing signs of decline and disparity. For example, in Kazakhstan, the share of women without prenatal care ranges from less than 1 percent in the northeast to up to 14 percent in the south (excluding Almaty). In Kyrgyzstan, the lack of timely transportation is reported to be a major factor. In the remote region of Talas, higher maternal mortality rates are partly attributed to the deterioration of transport facilities. The situation in Tajikistan, where civil war has destroyed health and transportation infrastructure, is particularly worrying, with an estimated 35 percent of infant deaths related to home births, which are often unassisted by professional help.

The care of pregnant women before, during and immediately after birth is fundamental to the health of mothers. A broader approach is also needed to fully address women's reproductive health. Family planning and abortion rates are two wider areas that merit particular attention in the region.

Abortion rates remain very high

Abortion rates in the region are very high relative to those in other industrialized countries. The average legal abortion rate in the region was more than 100 abortions per 100 live births in 1996, compared with an average of 20 abortions per 100 live births in the European Union in 1994. High abortion rates may be partly explained by two inherited conditions. There is a relative lack of promotion of family planning practices in the region, a situation in keeping with the pro-natalist policies pursued in many countries, as Chapter 3 notes. At the same time, universal access to legal abortions was generally guaranteed under the umbrella of basic women's health services. Lack of contraception, combined with the legal availability and



social acceptance of abortion, has contributed to high official rates of abortion.

Abortion rates do, however, vary greatly across countries. Figure 4.6 shows the legal abortion rate in 1989 and 1997 for all transition countries, grouped by geographic sub-region. Rates are particularly high in Southeastern Europe (except Albania), western CIS and the Baltics (except Lithuania). The only countries where the number of legal abortions per 100 live births is around or below the European Union average are Poland (see Box 4.1), Croatia, Azerbaijan, and Tajikistan. In particular, in Russia, there are two abortions for every live birth, that is, about 2.5 million abortions in 1997. Altogether, in seven countries, there were more legal abortions than live births in 1997, and in a further seven countries, there were 50-100 abortions for every 100 births.

The absolute number of legal abortions has declined in every country during the transition. Abortions declined by more than half in nine countries and by 20-50 percent in 10 countries. However, a look at the ratio of abortions to total number of live births shows that the decrease is less pronounced. The abortion rate actually rose in Hungary, Albania, Bulgaria, Romania, Estonia, Belarus, and Armenia. The cases of Poland and Romania are particular because of changes that took place in legislation. (See Box 4.1).

Figure 4.7 presents the legal abortion rate for women of all ages and for women under age 20 in 1997, compared to rates in 1989 (or 1991) for 15 countries. Abortion rates for women under age 20 increased more or decreased less than average, except in Albania, Belarus, Georgia, Azerbaijan, and Kazakhstan. The graph also shows that legal abortion rates for women under 20 have risen in nine of the 15 countries for which data are available in Central Europe, Southeastern Europe and the Baltics. The largest declines are found in the Caucasus and Central Asia.

The high overall numbers of abortions in these countries have important costs. Despite a cultural tolerance for abortion, a large proportion of women who have an abortion experience emotional trauma. Surveys in

Abortion legislation in the region

In all the countries covered by this Report, with the notable exception of Romania and Albania, abortion was legally permitted before transition. Women were free to have an abortion, irrespective of their health status and on their own initiative (no spousal consent). Often, employed women were even allowed to take a leave day from work for abortion. During the transition, several countries have made adjustments in their abortion laws. Two countries, Romania and Poland, have made major changes.

In Romania, the new abortion law, implemented one day after the fall of the previous regime in 1989, liberalized the very restrictive rules. After an initial spike in the abortion rate – up to 300 abortions per 100 live births, the rate has decreased, but is still high at 150 abortions per 100 live births. As a result of the liberalization, the registered number of maternal deaths caused by abortion declined from 545 in 1989 (out of

a total of 627 maternal deaths) to 51 in 1996, leading to a drop of 76 percent in the maternal mortality rate.

In Poland, since March 1993 (except for the period October 1996 to December 1997), abortion is only permitted in case of severe foetal damage or serious risk to the life or health of the woman, or when the pregnancy is a result of rape. The practice seems to be even more restrictive than the law, with many legally “eligible” women apparently denied abortions. Polish women are estimated to undergo 40,000–50,000 abortions annually either illegally, or abroad. The official number of legal abortions in 1997 was 3,200. Although covered in the abortion law, the provision of and education on family planning services have not significantly improved. The number of children abandoned in hospitals is also reported to have increased, more than doubling in four districts of the country between 1992 and 1993.

Latvia and Russia show around 70 percent of the women reported feeling depressed after an abortion or experiencing the abortion as psychological trauma.

Abortions also have serious physical complications, especially when the procedure is not performed in safe conditions. Abortions remain one of the leading causes of maternal mortality in the region, accounting for 20–25 percent of all maternal deaths. In Russia, for example, abortions are responsible for 25–30 percent of all maternal deaths, and an estimated 70–90 percent of abortions resulting in maternal death are performed illegally. In Romania, where maternal mortality is still high at 41 deaths per 100,000 live births, over half the maternal deaths follow abortions. In Kazakhstan, 19 percent of maternal deaths in 1995 were due to abortions, almost half of which were performed illegally.

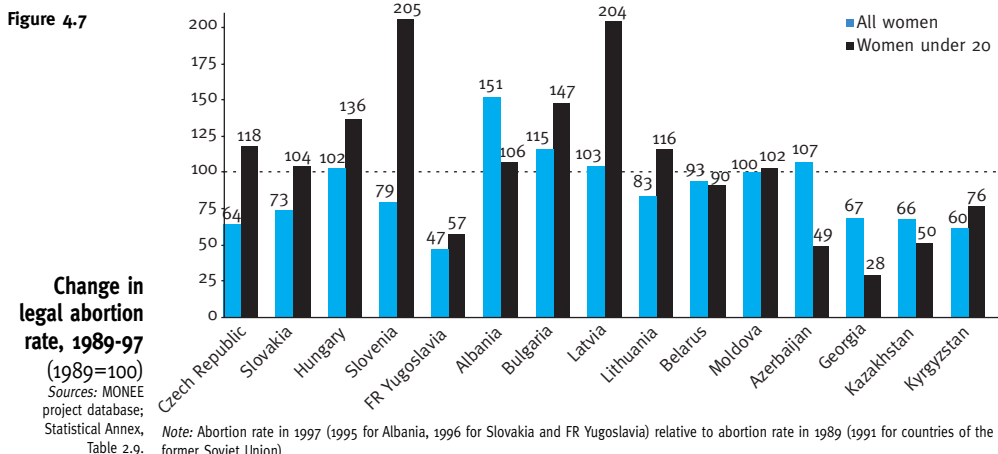
Abortions are also responsible for complications such as infection, hæmorrhage and anæmia, injury to internal organs, and long-term health problems, including chronic pelvic pain and disease, premature delivery, and infertility. In Ukraine, for example, abortions were found

to result in reproductive problems that contributed to sterility in 22 percent of couples and to inflammation of the reproductive organs among 30 percent of the women undergoing the intervention. In Kazakhstan, 20 percent of abortions led to complications, one-third of which required hospitalization. In Romania, 7 to 12 percent of abortions were followed by complications. In Russia, 13 to 17 percent of women had short-term complications – almost half leading to hospitalization, and 3 to 10 percent had long-term complications. The probability of complications increases when abortions are performed illegally. Adolescents are at higher risk of complications after abortion because their reproductive systems are more vulnerable to injury than are those of older women and because they are more likely to undergo illegal abortions.

Abortions, together with sexually transmitted diseases, are considered to be the leading cause of infertility, generating cervical trauma, cervical and uterine adhesions, pelvic infections, and other complications. The prevalence of infertility is relatively high throughout the transition region and increasing in some countries. For instance, the share of infertile women is estimated at 7 to 10 percent of married women in Estonia and Belarus, 15 percent in Moldova, and 10 to 15 percent in both Lithuania and Russia. In a special medical centre in Moscow, four in five of the women treated for secondary infertility had undergone induced abortions. In the Czech Republic in 1993, 13 percent of women who had been married or had cohabited had used infertility services.

The private reasons for abortion are many and include unwanted pregnancy as the result of sexual assault, opposition by the partner, or changes

Figure 4.7



in personal circumstances due to divorce, job loss, displacement, or war. However, the prevalence of abortions in the region has a public dimension, including lack of information and education about reproductive health and contraception and lack of access to affordable, effective birth control options. High abortion rates in the transition countries exact a high price from women's health, a burden that could be greatly alleviated through better access to family planning.

Inadequate access to family planning

The Beijing Platform for Action states that "the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health" and that women and men have the right to be informed and to have access to "safe, effective, affordable and acceptable methods of family planning of their choice". The universal availability of family planning education and services was also one of the goals set by the 1990 World Summit for Children.

Generally, women throughout the region, in particular young women, have relatively little knowledge of reproductive health issues. Surveys in Central Asia show that only 10 percent of women of reproductive age (15-49) in Uzbekistan in 1996 and 29 percent in Kazakhstan in 1995 knew when the fertile period of their menstrual cycles occurred. In other countries where reproductive awareness is generally higher young women still lacked this basic knowledge. In the Czech Republic in 1993, up to 61 percent of young women aged 15-19 and 41 percent of those 20-24 could not define the most fertile part of the menstrual cycle. In Hungary in 1995, over 40 percent of adolescents could not do so either.

Awareness of various contraceptive methods is usually more widespread, but still not universal. Also, awareness does not automatically entail understanding the proper use of the methods. In a 1993 survey of grade 10 students in St Petersburg, only 25 percent of girls and 35 percent of boys knew that condoms should be used only once; up to 38 percent thought they could be washed and re-used.

The combination of low awareness and inadequate access means use of contraception at first intercourse is low in most of the countries for which information is available. Table 4.2 presents contraceptive use by young women at first intercourse. In Moldova in 1997, less than 14 percent of unmarried women aged 15-24 used modern methods of contraception at first intercourse. However, with the exception of Poland, use of contraceptives seems to have increased during the transition period. For exam-

Contraceptive use at first intercourse

Table 4.2

	% women	Year	Type of contraception	Age at time of interview
Czech Republic	27.1	1993	Condoms	15-19
	20.2			20-24
Romania	15.0	1996	Modern methods	15-24, unmarried
	4.8	1993		15-24, unmarried
Moldova	13.5	1997	Modern methods	15-24, unmarried
Russia	30.5	1996	Modern methods	15-24, unmarried
Poland	50.0	1991	All methods	20-24
	49.8			25-29
Latvia	41.8	1995	All methods	18-19
	37.7			20-24
	26.3			25-29

Sources: CSO et al. (1995); Serbanescu and Morris (1998a), (1998b); VCIOM, CDC and USAID (1998); Holzer and Kowalska (1997); Zvidrins, Ezer and Greitans (1998).

Note: Modern methods include birth control pills and IUDs.

ple, in Latvia, use of contraception at first intercourse rose from 26 percent to 41 percent in less than a decade (comparing women aged 25-29 and those aged 18-19 at the time of the survey). In Romania, the percentage of unmarried women using contraceptives tripled in three years, from less than 5 percent in 1993 to 15 percent in 1996.

Most young women explained the non-use of contraception by saying they did not expect to have sex, wanted to get pregnant, or did not think they could get pregnant. Lack of access and the cost are rarely mentioned as reasons for non-protection; however, such responses assume an awareness of contraceptives.

In addition to the need for greater awareness and knowledge, access to the full range of modern contraceptive methods is important. This range of access is crucial because different methods suit different groups of users – for physical, philosophical, economic, and socio-cultural

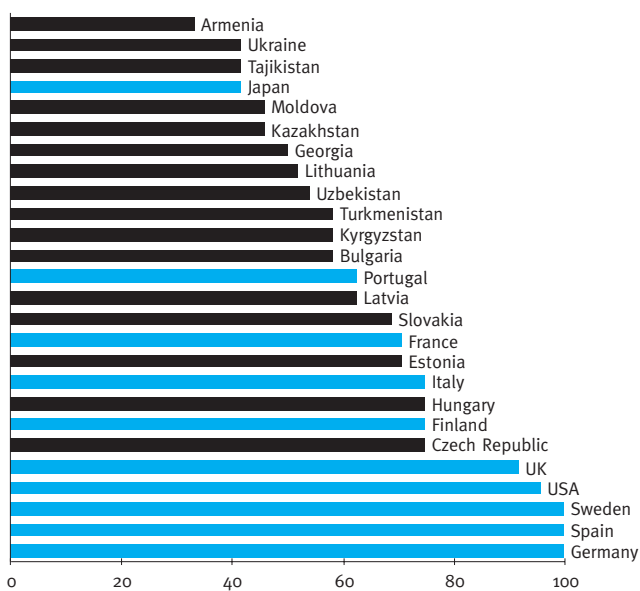


Figure 4.8

Note: The Contraceptive Choice Index measures the availability of six contraceptive methods: condoms, oral contraceptives, IUDs, injectable contraceptives, female voluntary sterilization, and vasectomy. The availability of each method is scored on a 20-point scale, with the maximum score reflecting essentially universal availability. The index converts the total score to a 100-point scale.

Contraceptive choice index, 1996
Source: PAI (1997).

reasons, and, from a health perspective, women need different approaches during their reproductive life cycle.

A Contraceptive Choice Index has been developed by Population Action International to reflect the availability of various means of contraception in a country. The 1996 index, presented in Figure 4.8, reports the availability of six modern contraceptive techniques in countries of the transition region. Choice appears to be less in Central and Eastern Europe and the former Soviet Union than in most Western countries. Availability is lowest in Central Asia, the Caucasus and western CIS.

Efforts have been made in several transition countries to improve access to modern contraceptives. Progress is, however, very slow in most cases. Figure 4.9 presents contraception-use levels for different years and countries. In Russia, there was a slight increase, from around 19 percent in 1991 to 24 percent in 1995 among women aged 15-49. In Belarus, after an initial rise in 1990, the rate declined again to just above pre-transition levels. In Slovenia, administrative data suggest that modern contraceptive prevalence actually declined over transition. A reduction in modern contraception use has also been observed in Lithuania and Poland, where the prevalence of contraception use may have dropped by more than half from 1992 to 1995, possibly as a result of changing values.

Cost and supply may not be major factors in the non-use of contraceptives at first intercourse, as shown in Table

4.2, but they are considerations for sexually active women later on. For instance, in Belarus in 1995, the top reasons given for non-use were fear of side-effects (39 percent), cost (27 percent) and difficulty in purchasing (11 percent). (It is important to note that contraceptive means are often of low quality in the region, which explains the predominance of concerns about side-effects.)

In most countries for which information is available, the prevalence of contraception use varies greatly with education, socio-economic status and place of residence. These variations may partly be linked to cost and availability of birth control, as well as awareness of methods. For example, in Moldova in 1997, less than 40 percent of women with low economic status, aged 15-44, and in marriage or non-marital unions were using modern contraception, compared to almost 60 percent of similar women of high economic status. Data from Kyrgyzstan show that about 10 percent of women with incomplete high school, compared to around 40 percent of women with complete higher education, were using contraception, with use lower in rural than in urban areas.

Figure 4.10 shows information for three countries on the share of sexually active women who use no or only traditional contraception and who need some or better methods. The extent of unmet needs is large. More than 50 percent of women aged 25-34 in Romania have contraception needs; even in the Czech Republic, more than 30 percent of women aged 25-44 have unmet needs for contraception.

In many countries, there are economic incentives to choose abortion over modern contraception methods. For example, in Bulgaria, the cost to the individual for an abortion in 1998 was less than 1 percent of the minimum wage, while modern contraceptives are imported and quite expensive. In some countries, the cost of abortion is subsidized by the state, or women can claim extra sick leave from work for an abortion.

In addition, both physicians and women in the region often have negative perceptions of the quality of modern contraception. Surveys in the 1980s and early 90s

showed that very few women considered the birth control pill or intra-uterine devices (IUDs) to be reliable and safe. Two surveys carried out in Russia, in 1982-84 and 1991, showed that less than 20 percent of women considered the pill reliable, safe and convenient. Even among gynaecologists, the pill was found to have a relatively low level of acceptance – only 62 percent considered it safe. As late as the mid-1980s, the Soviet Ministry of Public Health published instructions explicitly warning against the use of oral contraceptives. At times, the negative attitudes of providers towards modern contraception are a factor in the slow progress of contraceptive prevalence, along with high price and limited availability. The shift from abortion to

Figure 4.9

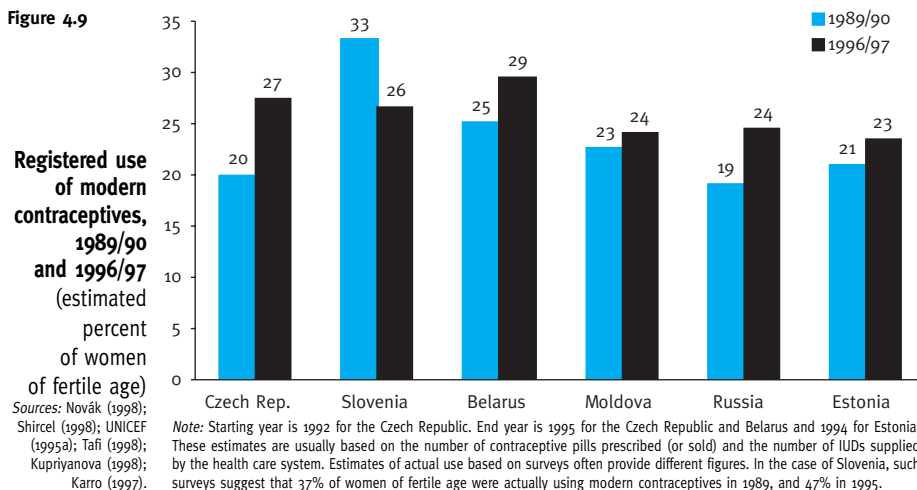
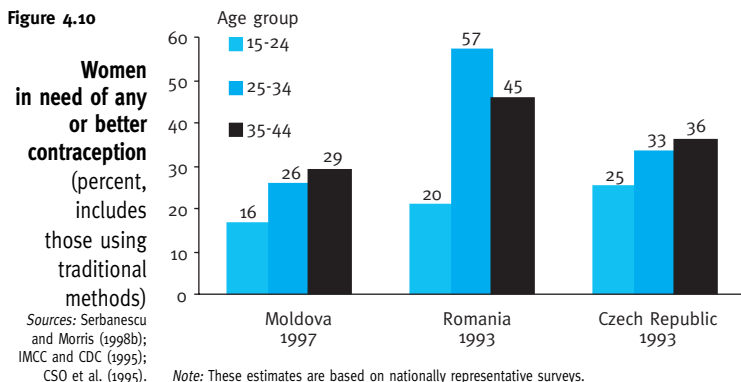


Figure 4.10



family planning calls for the training of physicians to encourage contraception and preventive care and to move away from abortion.

Some countries have taken initiatives to promote the shift from abortion to contraception as a primary means of family planning. For example, in the Czech Republic, the price of an IUD (effective for about two years) or birth control pills (for three months) is kept at around 3 percent of the average monthly wage, while an abortion costs more than 30 percent, except when it is medically required and therefore free. In Estonia, women have to pay half the cost of an abortion, with these funds applied to cutting the costs of contraceptive pills, to reducing the price by 90 percent for women in the first year after birth and for three months after an abortion, and to reducing the price by 50 percent for eligible students.

Public information and promotion campaigns can help improve access to family planning. In many countries, for example, pregnant women are seen regularly by health care providers during their pregnancies, but these visits are not exploited as opportunities to discuss family planning. In three Russian cities in 1996, health workers discussed or offered to discuss contraception with only 34 percent of women giving birth. Even following abortion, only 31 percent of women were offered contraceptive services or counselling.

In most of the countries covered by this Report, sex education is not provided at school. Even in Romania, where sex education is available, the topics of birth control and contraception are not often covered (see Box 4.4): more than 75 percent of teenagers learned about the reproductive system, but less than 25 percent of teenagers were taught about birth control. (Box 4.5 looks at how sex education can lower the risk of unwanted pregnancies and sexually transmitted diseases, or "STDs".) In many countries, non-governmental organizations and associations

have implemented information programmes. A student organization at the University of Tirana in Albania provides counselling, contraception and discussion of reproductive health topics. In Uzbekistan, local and international NGOs run a national family planning programme that provides both information and contraception alternatives. Such initiatives are limited in scope and cannot serve large populations. In contrast, the inclusion of sex education in schools reaches all children, including those from ethnic minorities or remote rural areas.

Finally, it is important to recognize that women's reproductive health has dimensions beyond fertility. The registered incidence of breast cancer appears to have increased during the transition period in most of the countries of the region. Part of this increase may be attributed to earlier detection through screening, even though screening is far from universal. For example, in Latvia, the incidence rose from 44 cases per 100,000 individuals in 1989 to 64 in 1996. The registered incidence declined in some countries, including Armenia, Azerbaijan, Tajikistan, Turkmenistan, and Uzbekistan, probably linked to reduced detection. The registered incidence of cervical cancer also fell in these five countries. However, cervical cancer increased in several other countries of the region, in keeping with improved detection. For example, in Bulgaria, the incidence of cervical cancer rose from 16 per 100,000 in 1989 to 23 in 1996. In Romania, the rate increased from 19 to 23 per 100,000 over 1989-94.

The available data suggest that women in the region would benefit from greater awareness, improved detection practices and better medical technology and treatments for these reproductive cancers. The existence of these diseases makes it clear that women's reproductive health embraces more than fertility and is an integral part of women's general health. ■

4.2 Increases in Lifestyle-related Health Risks

Medicine and health policies and programmes throughout the world tend to focus on biological aspects of well-being. Not only do the biological determinants of women's health need broader attention, but so do the social and cultural factors that affect women's health – factors that also have a gender dimension. This section reviews the extent to which women's health may have been exposed to greater risks during the transition because of economic recession, the rising incidence of poverty and overall societal changes. These changes in the social determinants of health have challenged the ability of women to access proper nutrition and health care and to develop and maintain healthy life skills.

Poorer nutrition

Populations in the region face three types of nutritional problems – undernutrition, micronutrient malnutrition, and

overnutrition (unbalanced intake of nutrients). In particular, it appears that micronutrient malnutrition is increasing in most countries. This is linked to a constellation of factors, including a drop in food consumption in some countries, a deterioration in the quality of the nutrients consumed, and the disruption of certain nutrition programmes such as the fortification of flour with iron or the distribution of specific food supplements for pregnant women and children. The impact of malnutrition is very important not only in terms of, for example, complications at birth or poor birth outcome (see Figure 4.3), but also in terms of greater risks of illness and death and reduced productivity.

Women are vulnerable to anaemia (iron deficiency) because of needs related to their reproductive biology. Girls' nutritional needs increase at adolescence with puberty and the onset of menstruation, while women have significant needs linked to both menstruation and child-

bearing. A large proportion of pregnancy complications or poor birth outcomes is a direct consequence of maternal malnutrition. Table 4.3 presents information on the percentage of live births complicated by anaemia in several countries of the former Soviet Union. Such reporting is not available for countries in Central and Eastern Europe, Southeastern Europe and the former Yugoslavia, where the prevalence of anaemia is likely to be lower. However, in light of the changes in nutrition patterns in some of

Table 4.3

Live births complicated by anaemia, 1989-97
(percent)

	1989	1997
Baltics		
Estonia	15	22
Latvia	13	22
Lithuania	6	35
Western CIS		
Belarus	5	18
Moldova	6	27
Russia	5	25
Ukraine	3	24
Caucasus		
Armenia	1	11
Azerbaijan	4	10
Georgia	2	4
Central Asia		
Kazakhstan	11	50
Kyrgyzstan	15	47

Source: MONEE project database.

Note: Data for Armenia refer to the number of women with anaemia before, at, or after birth per 100 live births. The starting year is 1992 for Estonia and 1990 for Lithuania, Armenia and Georgia.

these countries, an erosion in nutritional status can be expected.

A mother's lack of iron also affects the child not only because anaemia increases the risk of haemorrhage and complications during birth, but also because children born to anaemic mothers are more likely to be anaemic themselves. Anaemic children suffer from listlessness and a lack of concentration, and the onset of puberty may exacerbate the condition in girls.

The situation is particularly acute in Central Asia, where 60 percent of women aged 15-49 in Uzbekistan and just under 50 percent in Kazakhstan suffer some degree of anaemia. The severity of anaemia is higher among pregnant or lactating women. Studies in Kazakhstan point to a decline in the consumption of animal protein, essential vitamins and micronutrients over the last decade. The link between maternal and child anaemia is illustrated by a large health survey carried out in Uzbekistan in 1996. The results show that the anaemia status of children is strongly linked to that of their mothers (at the time of the survey, not at the time of birth): 41 percent of children born to mothers with moderate anaemia suffered severe or moderate anaemia themselves, compared to 15 percent of those born to non-anaemic mothers.

Iron deficiency and other nutritional deficiencies can be addressed in various ways. Nutrition education aimed at changing nutrition behaviour is a very cost-effective way to improve nutritional status. This includes general education for all members of the public, as well as specific information on proper nutrition for ill children and pregnant women. For example, it may be as simple as

learning not to drink tea and eat bread at the same time, a common habit in much of the region, because the tea prevents the body from absorbing the iron in the bread. Programmes that fortify common food such as bread with micronutrients or that supply vitamins and minerals separately are also inexpensive ways to reduce deficiencies.

Diets of people in the region have been subject to a variety of influences during transition. Some, such as higher prices and lower availability, may have a negative impact, while others, such as increased health promotion and awareness, may have a positive effect. Overall, evidence on the quality of diets is sparse, but there are signs in Russia of a decrease in the proportion of calories obtained from fat and proteins. Reduced fat consumption may have positive impacts for populations with unhealthily high intakes, but it can have adverse health effects for those who consume too little fat. Reduced protein consumption is also a concern. (See Chapter 1, Box 1.6.)

Worsening nutritional status is revealed by the rise in the proportions of adults who are overweight, obese or underweight. In Russia in 1996, 4 percent of women aged 18-59 were underweight, 28 percent overweight, and 24 percent obese, with underweight being more common among younger women, and overweight and obesity more common among older women. Still, a 1993 Russian survey of young children and their mothers in three cities and the surrounding areas showed a high prevalence of hunger: about 77 percent of the women, 70 percent of the households and 32 percent of the children were classified as hungry. The evidence suggests women may be less well fed than children or other household members. As Box 4.2 discusses, there is evidence that access to health care services has also been compromised.

Increased risk-taking behaviour

The upheaval of transition has created an environment that provides fertile ground for risk-taking behaviours. Increased poverty and social stress, greater travel and migration, changing values, and growing criminality all breed more substance abuse and unsafe sexual behaviour which raises the risk of sexually transmitted diseases.

While substance abuse has been less prevalent among women than men in the past, this pattern is changing across the region. Alcohol consumption and smoking are increasing among women and adolescent girls, raising new health risks. Women also suffer the consequences of men's substance abuse through, for instance, more domestic violence or the death of their partners. STDs pose a greater health risk to women than men. (See Box 4.3.)

It is important to note that some of these phenomena are relatively new to the region, as is the case for drug abuse and certain STDs. The impact of these emerging problems is compounded by the fact that they are occurring in an environment where there is often a lack of awareness, education, infrastructure, and programmes

Box 4.2

Deteriorating access to health care

In most countries of the region, poverty and economic hardship have reduced people's access to health care services, often linked to the decline in public spending on health. Households often have to contribute to the cost of drugs and medical supplies in countries where the health system faces shortages. Low wages have caused medical staff to request additional fees for services or to leave public health care, especially in rural areas, in order to set up private practices or take other employment.

This deterioration in medical services may affect women more than men, as women tend to have more contact with the health care system and are usually the managers of family health. The increased requirement to pay for medical services may also affect women disproportionately, since they have been more adversely affected economically during the transition. Single-parent families, most of which are headed by women, are especially vulnerable.

Evidence from various countries points to the increasing practice of informal payments for health services. For example, in Hungary, Bulgaria and Romania, such informal payments are reported to be widespread. In the Czech Republic, patients contributed 11 percent of total health care costs in 1997. There is also evidence that, in general, higher income groups benefit more from public health expenditures. For example, in Bulgaria, the poorest 20 percent of the population received less than 10 percent of public health spending in 1997, while the richest 20 percent received over 30 percent of the total – a gap that has widened since 1995.

In Russia, data from a large household survey for 1994-96 suggest that lack of money is emerging as the main reason for the inability to obtain medication. Table 4.4 shows that, among persons prescribed medication, the share able to comply decreased from 62 percent in 1994 to 45 percent in 1996. Among those unable to obtain medication, cost was the reason given by 48 percent of individuals in 1996 (up from 23 percent in 1994), while unavailability was cited by about 45 percent (down from 76 percent in 1994). Recent

reports note the difficulty the elderly and other groups entitled to free or subsidized drugs have in finding or acquiring medications. Russia's debt to foreign drug companies was estimated in 1998 to have reached US\$700 million.

In Moldova, a 1997 representative survey showed that payments are often made for medicine, medical visits and hospital treatments. More than 80 percent of women giving birth had to pay for the professional services provided. The survey also showed half the families interviewed could not buy prescribed medicine,

Table 4.4
Access to prescribed medicines in Russia, 1994-96

When medicine prescribed, % of persons	1994	1995	1996
Able to obtain medicine	62	70	45
Unable to obtain medicine	38	30	55
of which (%)			
because medicine is not available	76	59	45
because of cost	23	32	48
for other reasons (no time, no desire)	2	9	8

Source: Zohoori et al. (1997).

Note: Information is based on the Russia Longitudinal Monitoring Survey, a large nationally representative survey of Russian households.

mainly due to lack of money. Around 40 percent of low-income households had to borrow money or sell assets to cover health expenditures.

Substantial difficulties in acquiring medicines are also reported in the Caucasus and Central Asia. For example, in the Kuba district in Azerbaijan in 1994, 80 percent of households prescribed drugs could not find them. Two-thirds of those who paid for health care had to borrow or sell some goods in order to pay for them, with medicine representing 62 percent of all health care expenditure. For households where a member was ill during the month of the survey, total health care represented, on average, 20 percent of total household expenditure. Evidence from Kazakhstan shows that patient payments for medicines in hospitals made up 25-30 percent of the national health budget in 1996.

addressing the issues. Teenagers, though biologically healthy, are especially vulnerable to "social diseases".

The levels of alcohol consumption by adult men and of tobacco use by men and boys in the region have been similar to the prevalence in the West, but, until recently, girls and women smoked and drank relatively less. In particular, adolescent girls in the region used tobacco and alcohol less than their counterparts in Western Europe. Figure 4.11 shows, for selected countries, the percentage

of 15-year-olds who smoke. (Data refer to 1993/94, after the impact of transition had likely been felt already.) This relative advantage for women in the region mitigated against health problems such as lung cancer, which was already soaring among women in Western countries. Since the beginning of the transition, however, a deterioration of this advantage is observed in most of the countries covered in this Report.

WHO expects rising tobacco use to be the single

largest cause of increased disease and death in the region. It is estimated that more than 20 percent of the total adult disease burden will be attributable to tobacco by 2020 in the European part of the region, that is, excluding the

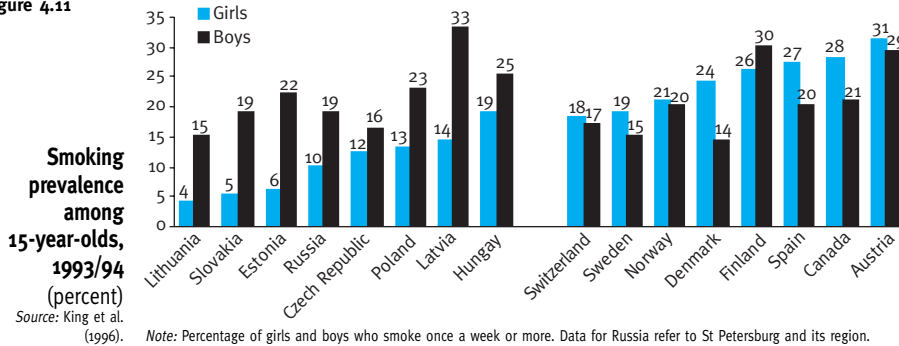
there has been an increase in the consumption of alcohol since the beginning of the transition and often a decline in the quality of the alcohol consumed. The resulting sharp rise in male mortality from alcohol-related diseases can be expected to affect the health of women and children in both direct and indirect ways – through the role model presented to children, the greater stress generated by drunkenness, domestic violence (often associated with drinking), growing poverty (loss of productivity), or the death of a partner or father. In Kiev, street children reported that 63 percent of their fathers and 55 percent of their mothers were abusing alcohol and that 12 percent of their fathers and 8 percent of their mothers were abusing drugs. It is important to note that, although the level of

alcohol-related mortality rates is much higher for men than for women in Russia, the increase in the rates since the late 1980s has been similar for both genders, showing that women have not escaped this negative trend. The death rate of adults aged 40-44 due to alcohol-related disease rose fivefold for men over 1987-94 and sixfold for women.

The growth in the incidence of certain STDs in Central and Eastern Europe and the former Soviet Union has also generated attention. The recent rise in HIV infections is staggering. The number of cases recorded jumped from about 30,000 infected persons in 1994 to about 270,000 at the end of 1998. (An estimated 80,000 new infections occurred in 1998 alone.) The biggest increases took place in Belarus, Moldova, Russia, and Ukraine. (Ukraine is currently the country most affected, with the estimated number of carriers soaring from about 1,500 in 1994 to some 110,000 in early 1998.) The transition region risks becoming one of the next areas of burgeoning HIV infections if the epidemic spreads to larger groups in the population.

Intravenous drug use appears to be behind this dramatic surge in the spread of HIV in western CIS, and drug use has been growing rapidly in parts of the region. About 70 percent of all HIV infections in Ukraine over the period 1995-97 occurred among drug users, especially among young people in cities bordering the Black Sea. For example, in the city of Mykolayev, the proportion of intravenous drug users infected with HIV swelled from 2 percent to 57 percent in 1995 alone. Similarly, in Russia, four out of five newly diagnosed infections are among intravenous drug users. Since most drug users are in the 15-24 age group, adolescents and young adults are the most affected. Experience in some Western countries has shown that the spread of HIV can be inhibited through programmes designed to encourage drug users to adopt safer practices. In Poland, initiatives to reduce needle sharing and to encourage sterilization of equipment have lowered the number of new infections among drug users since 1990.

Figure 4.11

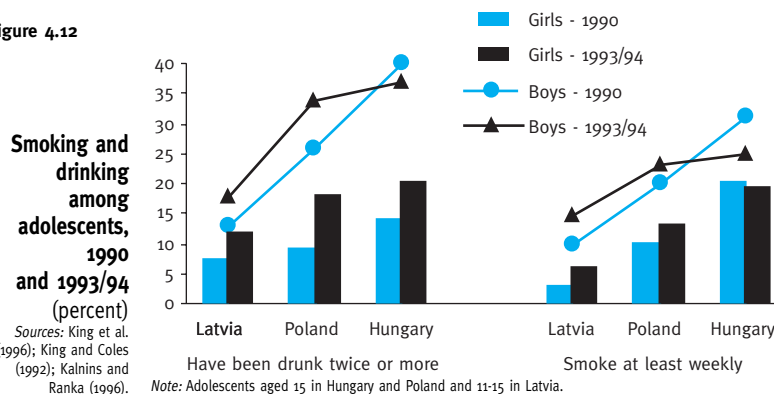


Caucasus and Central Asia. In a more liberalized marketplace, the concerted targeting of young people, particularly young women, in tobacco advertising and the relatively low price of cigarettes offered by companies to attract new customers are likely to play a pivotal role in the increase in smoking among young women. The absence of control and regulation on sales, advertising or quality standards and the growing influence of media will also conspire to promote smoking by young women. In terms of drinking and smoking, the gap between female teenagers in the region and those in Western countries is, unfortunately, narrowing.

Figure 4.12 presents estimates from surveys carried out in 1990 and 1993/94 in Poland, Hungary and Latvia. It shows increases in the consumption of alcohol and tobacco among teenagers (with the exception of tobacco consumption in Hungary) and the differences by gender. The proportion of girls reporting having been drunk at least twice doubled in Poland, from 9 to 18 percent, but remained well below the proportion of boys. In Latvia, the percentage of girls who smoked weekly also more than doubled over the period. Similar data from Romania reveal that the share of girls aged 18-19 who had smoked rose from 18 to 25 percent over 1993-96.

In terms of the overall population, evidence from some countries in western CIS and the Baltics suggests that

Figure 4.12



Women face higher biological risks of contracting STDs

In addition to social factors that increase the vulnerability of adolescent girls and women to STDs, biological realities place them at higher risk. Women's higher susceptibility to STDs transmitted through unprotected sex is based on biological particulars.

- Female reproductive systems expose a greater surface area of sensitive tissues to a greater variety of pathogens during intercourse. This is especially the case for young women, whose cervical mucus offers less protection from infections. Male-to-female HIV transmission appears to be two to four times as effi-

cient as female-to-male transmission.

- The consequences of STDs are broader for women than men, including pregnancy-related complications, septicæmia, spontaneous abortions, and stillbirths.
- STDs are less likely to produce symptoms in women and are, therefore, harder to diagnose until serious problems arise.

Women STDs also have important implications for children, since they are linked to premature births, low birthweights and congenital infections.

There is an important overlap between drug use and prostitution, and infection is likely to become more widespread among other social groups in the region in the near future. Evidence from the city of Kaliningrad in Russia reveals that about one-third of sex workers are intravenous drug users, while 80 percent of women treated for HIV-related health problems work as prostitutes. The potential growth in the spread of infections through unsafe sex could be dramatic in the region. Again, this is more likely to affect young persons than the rest of the

population and women more than men. (See Box 4.3.)

Some countries have also experienced a dramatic resurgence of syphilis, a more familiar disease in the region. This trend is particularly worrying since it indicates that a much broader swath of the population does not practice safer sex, and is, therefore, also exposed to HIV infections.

Syphilis had been practically eradicated in the region by the early 1990s, but the disease is fast re-emerging in many countries, with the exception of Croatia and Poland. The increase may be attributed in part to the collapse of STD management systems, which involved tracing, notifying and treating all infected persons and their partners. Table 4.5 presents the incidence of syphilis for selected countries from each sub-region and for selected countries of the European Union. There is a sharp contrast, with an average incidence of two cases per 100,000 in the European Union, 11 in Central and Eastern Europe and 221 in the former Soviet Union – the last more than 100 times the EU rate. The reported incidence is presented per 100,000 population; computing incidence rates relative only to the population most likely to be sexually active shows significantly higher rates. For example, the incidence rate per 100,000 persons aged 18-59 was 476 in Russia in 1997, meaning almost one adult in 200 became infected with syphilis in that single year.

Rates in Central Europe and the former Yugoslavia are comparable to those in Western Europe, but rates are much higher in Southeastern Europe. Within the former Soviet Union, countries in western CIS and the Baltics have a particularly high incidence, while countries in the Caucasus and Central Asia have a lower incidence, with the exception of Kazakhstan and Kyrgyzstan, where the incidence is similar to western CIS. (See also Statistical Annex, Table 6.4.)

The striking differences among sub-regions are in marked contrast with the situation of the late 1980s, when average sub-regional incidence rates were roughly similar across Europe – two cases per 100,000 in the European Union, six in Central and Eastern Europe and four in the

Table 4.5

Incidence of syphilis, 1997

(newly registered cases per 100,000 population)

Central Europe	Slovakia	3.5
	Hungary	3.0
Former Yugoslavia	Slovenia	1.3
	Croatia	0.4
Southeastern Europe	Bulgaria	87.4
	Romania	31.6
Central and Eastern Europe, average		11.2
Baltics	Latvia	121.8
	Lithuania	84.9
Western CIS	Russia	276.1
	Ukraine	147.7
Caucasus	Armenia	16.7
	Azerbaijan	7.6
Central Asia	Uzbekistan	35.6
	Turkmenistan	54.0
Former Soviet Union, average		220.6
European Union	Spain	2.1
	Italy	0.8
	United Kingdom	2.5
	Netherlands	1.4
European Union, average		1.6

Sources: MONEE project database; WHO (1998) for Croatia, Uzbekistan, Western Europe, and averages.

Note: Data refer to 1996 for Croatia, Romania, Uzbekistan, Western Europe (1995 for the UK), and averages.

Soviet Union in 1989. The sharp jump in the incidence of syphilis is illustrated by Figure 4.13, which presents incidence in seven selected countries for the period 1989-97. In 11 countries of the region, the number of new cases rose more than tenfold over 1990-96. The increase in the rate is

higher in the former Soviet Union, particularly in western CIS, the Baltics and Central Asia. Prevalence has been increasing in Bulgaria since 1993. In a number of countries, the rise in the annual number of new cases slowed in 1997.

Figure 4.13

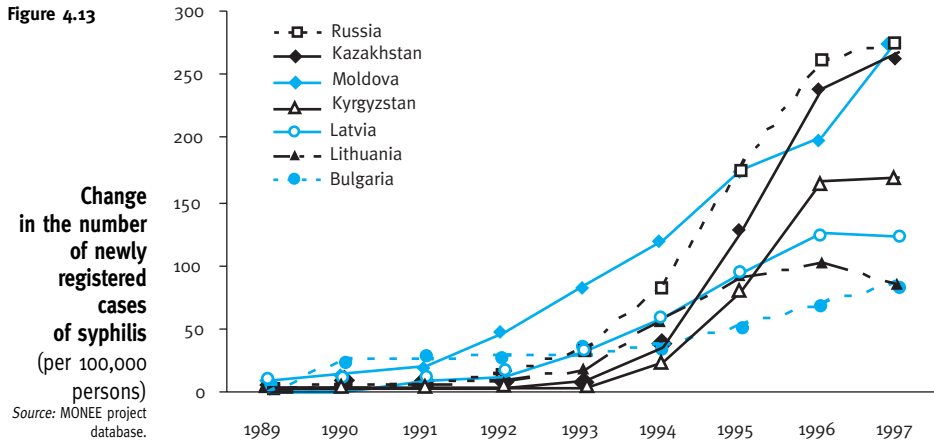
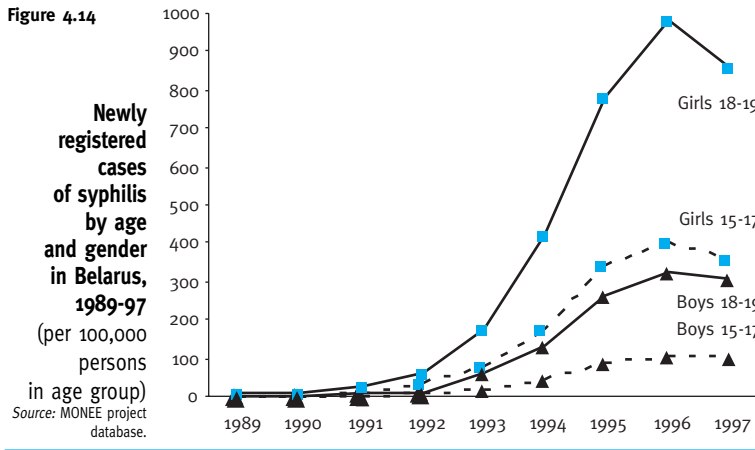


Figure 4.14



Breaking down the incidence of syphilis by age and gender underlines the vulnerable position of adolescents and young adults in general and of adolescent girls in particular. In Belarus, where the disease is spreading fast, incidence is significantly higher among the young. Figure 4.14 shows the incidence of syphilis for all teenagers. While the incidence rates follow a similar pattern for women and men who are older (190 new cases per 100,000 for women and 210 for men in 1997), the rate is much higher for female adolescents aged 15-19 than for their male peers. (See Box 4.3.) In 1996, almost 1 percent of females aged 18-19 were infected with syphilis (an incidence rate of 984 per 100,000), compared to 0.3 percent of males the same age. The situation is similar in Moldova and Ukraine, and slightly worse in Russia, where 1.3 percent of girls aged 18-19 were registered as new cases of syphilis in 1997.

At a time when public health services are experiencing greater financial constraints, they are also facing the immediate health demands of more cases of STDs, as well as the long-term health burdens, especially for young people, associated with the diseases. The issue of sexually transmitted diseases needs to be addressed urgently in the region through education campaigns aimed particularly at young people and through better access to reliable means of prevention. Adolescents' knowledge of STDs

Box 4.4

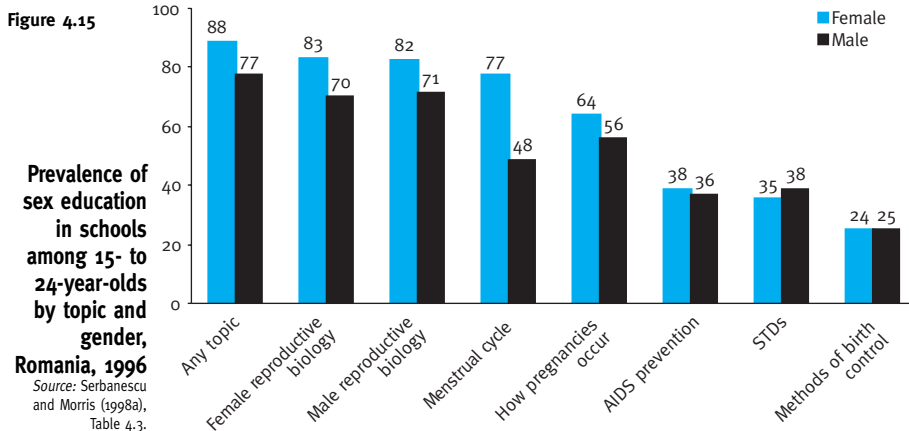
Adolescents' knowledge of STDs

Surveys of adolescents in different countries of the region reveal a lack of knowledge about sexually transmitted diseases and about the means of protection. As in other health areas, lack of information and awareness presents

a major barrier to healthy lifestyles among adolescents.

For example, in Romania, general sex education is widely available, with 88 percent of girls and 77 percent of boys aged 15-24 receiving some sex education at school. However, the topics of STDs and AIDS transmission are only rarely discussed – just over one-third of adolescents have received education on these topics, as reported in Figure 4.15. Families do not appear to provide an alternative information source, with parents discussing AIDS prevention with only 28 percent of girls and 16 percent of boys.

Figure 4.15



The low level of contraception prevalence among young persons, presented in Table 4.2, also points to the lack of knowledge about STDs and their transmission in countries, such as Moldova and Russia, where the incidence of infection is growing.

and of the modes of transmission remains very limited (Box 4.4), and sexual education can help boost awareness (Box 4.5).

Gender dimensions of stress and depression

As set out at the beginning of this chapter, health is not only the absence of disease or infirmity, but a state of physical and mental well-being. Epidemiological and anthropological surveys show gender differences in patterns of psychiatric disorder and psychological distress. It consistently appears that women more frequently experience depression, anxiety and psychological distress, while the prevalence of substance disorders and self-inflicted violence is greater among men. This is consistent with the observation in part of the region of a rise in mortality among men that is linked to alcohol abuse and suicides. The social conditioning of women, including their roles as mothers and caregivers and their greater reliance on social networks, may be a protective factor and may inhibit them from such extreme behaviours as substance abuse, violence and suicide.

Evidence on the emotional and mental health of people in the region before transition is largely absent. A few studies, however, have focused on the topic in recent years. They show that women are particularly at high risk of depression and emotional difficulties. Worsening living conditions in most of the countries of the region suggest this risk has increased during the transition. Certainly, many forms of psychological disorder are significantly influenced by environmental factors.

In 1990, the World Bank and WHO estimated the losses due to premature death and disability for different regions of the world. In the transition region, mental health problems accounted for about 14 percent of the total burden of disease and infirmity, and estimates suggest that the share will climb sharply over the coming decades. Table 4.6 shows the share that different conditions make up in the mental health problems of women and men.

Depressive and post-traumatic stress disorders account for one-third of disability from mental health problems for women, but only for 10 percent for men. On the other hand, substance dependence and self-inflicted injuries account for over 60 percent of the total for men, but for only 18 percent for women. Women also consistently report a lower subjective assessment of their health. Evidence from the region is similar to that from Western Europe, with the proportion of men reporting themselves to be in good health averaging 10 percentage points higher than that of women.

Research in countries around the world points to the social origins of psychological distress for women. Factors which put women at risk include lower social and economic status, physical or sexual abuse, stress generated by the "double burden" of paid and unpaid work, insecurity, isolation, dependence, unemployment and associated loss of support networks, or difficulties in providing for their households. A medical response to psychological distress is sometimes necessary, though largely overlooked by health care systems in the region, but the long-term improvement of women's health and equality requires

Box 4-5

Sexual health education lowers risks

Most individuals become sexually active during their teenage years. In addition, "partner turnover" is higher during younger years than later in life, both in terms of casual liaisons and stable, monogamous relationships. Thus, sex occurs with multiple partners even if the cumulative risk is sometimes hidden by the apparent monogamy and commitment of each discrete relationship. Higher risk of unprotected sex among young people is reflected in the disproportionately high rates of STD incidence and unwanted pregnancies among the young. The recent HIV/AIDS epidemic in the region creates new challenges and requires widespread sexual education on historically taboo sexual topics and practices. Sexual health education is needed to ensure healthy and responsible sexuality.

Sexual health education for children and adolescents is debated and often condemned as promoting early or increased sexual activity. A recent thorough review, based on studies carried out mainly in North America and Western Europe, shows that evidence does not support this argument. On the contrary, the survey

finds that sex education helps delay first intercourse and protect sexually active young people from HIV, STDs and unwanted pregnancies.

It is important to note that women's decisions on reproductive matters are directly influenced by their partners, whose responsibilities should not be neglected. Young women face particular risks, which arise out of both physical and social vulnerability. (See Box 4.3.) Responsibility for contraception or STD protection is often left to girls and women, while their status does not always give them the power to enforce their choices: a passive sexual role is traditionally prescribed for women; their male partners tend to be older, and girls are more likely than boys to consider their relationships stable and committed and, therefore, not requiring protection. In order to be successful, sex education programmes must also target boys and young men and address the context in which sexual relationships take place. This can help challenge gender roles in terms of sexuality, reproductive health and male-female relationships in general.

Table 4.6

Relative importance of different mental health problems in European transition countries, 1990

(percent of all mental health problems)

	Women	Men
Depressive disorders	25	7
Post-traumatic stress disorder	8	3
Total depressive and post-traumatic stress disorder	33	10
Alcohol and drug dependence	10	39
Self-inflicted injuries	8	25
Total alcohol and drug dependence and self-inflicted injuries	18	64
Alzheimer's and other dementia	27	11
Other	22	15
Total mental health problems	100	100
Mental health problems as a share of total losses	13	14

Source: World Bank (1993).

Note: The countries covered are those of Central and Eastern Europe, Southeastern Europe, the former Yugoslavia, the Baltics, and western CIS (19 countries).

that attention be focused upstream, on the causes of mental health problems.

Differences in subjective feelings between women and men are observed at a young age. Table 4.7 presents the percentage of children aged 15 who report various symptoms and feelings, based on large surveys of children in Central Europe, the Baltics and Russia. Young girls are much more likely than boys to report headaches, stomach aches, and feeling nervous, lonely, low, or depressed. Thus, 20 percent more girls, on average, report headaches, and 15 percent more report feeling depressed. This information is based on self-reported symptoms and feelings. It therefore reflects subjective feelings of health

Table 4.7

The health of 15-year-olds in Central Europe, the Baltics and Russia, 1993/94

(percent)

	Feeling very healthy		Headache		Stomach ache		Feeling nervous		Feeling lonely		Feeling low or depressed	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
Czech Republic	25	32	–	–	–	–	–	–	22	14	–	–
Slovakia	22	40	41	20	25	15	73	57	18	12	25	20
Hungary	16	19	41	19	17	11	61	49	25	14	54	34
Poland	13	25	33	14	13	6	69	51	19	7	29	12
Estonia	10	24	31	19	18	13	54	45	20	11	32	17
Latvia	17	32	36	14	22	9	53	31	25	14	31	17
Lithuania	18	33	42	22	22	10	57	39	29	17	31	17
Russia	14	29	41	19	14	11	54	34	26	15	35	17

Source: King et al. (1996).

Note: For headaches, stomach aches, feeling nervous, or feeling low or depressed, the questions asked whether the child had the characteristic once a week or more over the past six months. For feeling lonely, the question asked whether the child felt lonely very or quite often. Data for Russia refer to St Petersburg and its region.

Table 4.8

Estimated risk of social exclusion in Estonia, 1994

(percent)

Percentage with estimated	Women	Men
Low risk	25	43
Average risk	35	31
High risk	40	26
Total	100	100

Source: NORBALT survey of 4,550 individuals organized by the Estonian Ministry of Social Affairs, the Statistical Office and the Norwegian International Applied Social Research Institute, reported in UNDP (1997a).

Note: The risk of social exclusion is based on 15 indicators of deprivation, isolation and anomie (loss of norms): lack of regular income, reliance on social benefits, poor health, lack of medical insurance, difficulty in meeting housing expenses, lack of labour market participation, living without other adults, feelings of fear in public places or at home, non-participation in associations, no interest in politics, no trust in authorities, no understanding of politics, no faith in democracy, feelings of worthlessness, and lack of plans for the future. Individuals are classified according to the total number of conditions which apply to their situation: 0-6 is "low" risk, 7-9 "average" risk, and 10-15 "high" risk.

and does not necessarily reveal the actual medical/clinical incidence of problems. It still suggests that, irrespective of the actual incidence, girls are more likely to perceive themselves as having problems and, therefore, to have lower subjective perception of their health status.

The survey results emphasize the higher expression of the problems among girls, their different perceptions of their own health, and the impact of their social environments. These girls have yet to face some of the major challenges of life for women, such as raising a family and the cumulative effects of gender bias, but they already suffer a pronounced degree of emotional and mental stress.

A 1994 survey in Estonia evaluated the risk of social exclusion based on measures of deprivation, isolation and anomie (loss of norms). Table 4.8 shows the percentage of women and men who were classified as being at high,

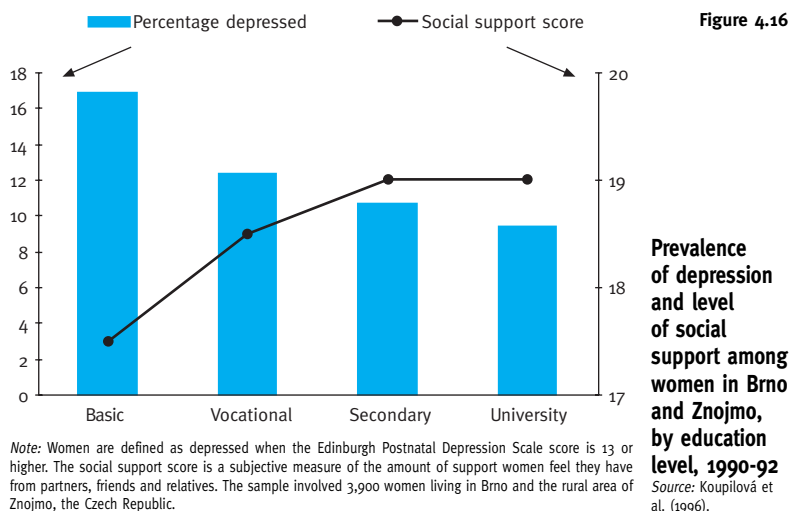
average, or low risk of social exclusion. It confirms that women are at greater risk of social exclusion – in other words, of weak participation in society. For example, 40 percent of women, compared to 26 percent of men, were found to be at high risk of social exclusion. The survey finds that this risk is linked to women's lower labour force participation, higher dependence on social assistance, lower capacity to generate income, and the prevalence of women among single parents. This higher risk of exclusion from the mainstream of society may well lead to higher risk of depression and stress.

Further evidence of the emotional difficulties experienced by women comes from a study of the emotional health of pregnant women. Pregnancy is a period with some potential for increased anxiety and depression and decreased emotional well-being. Stressful life events and limited social networks have been found to contribute to the development of emotional disorders during pregnancy. The study, carried out in four municipalities – Avon, England, Yaroslavl, Russia, and Brno and Znojmo, the Czech Republic – over 1990-92, allowed the simultaneous analysis of women's emotional status and the extent of their social networks and support during pregnancy. The level of clinical depression was found to be higher in England than in the Czech Republic or Russia. On the other hand, the average level of non-clinical depression was found to be somewhat higher in the Czech Republic than in England and significantly higher in Russia than in the other two countries, suggesting higher levels of general stress in families and society in the transition region.

Women in Russia and the Czech Republic had lower levels of support than women in England. For example, 30 percent of the British women, but only 18 percent of the Czech women and 8 percent of the Russian women had four or more persons with whom they could discuss "important decisions". Russian and Czech women were less likely than British women to know other pregnant

4.3 Conclusions

Overall, women in the region began the transition with relatively good health status and adequate access to basic health services. However, there were some particularly troubling traits in the general health picture of women, including relatively high infant mortality in many countries, high maternal death rates and extremely high abortion rates. The transition period has seen both a depreciation of existing health care assets for women and an inability to improve highly visible health problems such as maternal deaths. Countries with "higher" health status before transition have tended to lose less than those with a "lower" starting point. Within all countries, large and often growing disparities between different socio-economic groups have been noted.



women and more likely to doubt whether their neighbours would help out with a difficulty and whether the state would support them in case of problems. In the two Czech centres, where characteristics could be explored by maternal education, clear trends indicated that social support increases and clinical depression decreases with education level. Figure 4.16 presents the prevalence of depression and the "score" of social support from networks among women of different education levels in the Czech Republic.

The higher incidence of clinical depression and depressive disorders among women than men raises a host of questions about the differences between women's and men's health: Is there a biological basis for this gender gap in mental wellness? What are the reasons women and men respond to trauma and stress differently? How much does social and economic inequality influence women's emotional health, and how much does women's mental health affect their ability to participate in society? Most importantly, what range of responses is required?

Almost two-thirds of the countries in the region have reported declines in maternal death rates, and one-third have reported increases. Altogether 17 still have maternal mortality rates above the WHO target for Europe. Birth-related complications of all types have increased in many countries, as perinatal care has deteriorated. Abortion rates have long been high by international standards in these countries and have remained high throughout the transition – on average, five times greater than the average in the European Union. These high rates may result from a constellation of factors, including social acceptance of and universal access to medical abortions and lack of promotion of family planning techniques.

Family planning is an important way for women and men to exercise choice and responsibility in their personal lives. Generally, women throughout the region, especially younger women, show relatively poor understanding of reproductive health issues. There is evidence that the range of family planning techniques available is limited and that there are often problems with the availability, price and quality of contraception materials. However, for most countries for which information is available, use of contraception appears to be increasing during transition. The issue of family planning is being raised in a changing environment where fertility rates have plunged and social values are in a state of flux.

The transition period has brought many changes in both the living conditions and the lifestyles of women in the region, factors that are important determinants of health. For many women, these changes have challenged their ability to maintain proper nutrition and healthy behaviours. Evidence shows that populations have experienced micronutrient malnutrition linked to a drop in food consumption in some countries, a deterioration in the quality of the nutrients consumed and the disruption of certain nutrition programmes such as the fortification of bread with iron and the supply of vitamin and mineral supplements to pregnant women and children. Women, in particular, are experiencing more problems with anaemia.

The shifting influences around lifestyle during the transition also include increases in risk-taking behaviour. Alcohol consumption and smoking have risen among women and adolescent girls across the region during the transition period. The prevalence of drug abuse and sexually transmitted diseases, particularly HIV and syphilis, is also rising. Women, especially young women, are both biologically and socially vulnerable to STDs – a situation of major concern given the substantial growth in the sex industry in the region.

Specific dimensions of health, such as mental health, are still largely ignored throughout the region. This is especially troubling for women, as they tend to report more emotional health problems, including stress and depression, than men. In a study of 19 countries in the region, depressive and post-traumatic stress disorders account for one-third of the disabilities from mental health problems for women and only 10 percent for men.

Overall, the health of women is showing the strain of the transition. The system of universal health care, whatever its initial shortcomings, is suffering from the

reduced ability of the state to generate revenues. Infant mortality, maternal mortality and abortion rates remain high by international standards. The focus on women's health continues to be related to maternity, and so women's wider health concerns such as violence against women, depression and stress go under-recognized. At the same time, other health issues, particularly those shaped by social and economic factors, have emerged during the transition, including poorer nutrition, rising substance abuse and a higher incidence of STDs. Not only does this increased stress affect women's health directly, but it makes their role as health care managers in their families more difficult. The plunging fertility rates across the region, presented in Chapter 3, also suggest that, since women are making less use of the health care system for pregnancy-related reasons, they may be missing opportunities for more general health care.

A more complete understanding of the health of women requires a more complex understanding than that which underlay the health care system inherited from the communist years. However, it is evident that these curative-driven systems still need to be supported even while health care is being reformed – a step some countries have taken by directing more resources towards the health care system. This survey of women's health in the transition region makes clear that women's health would benefit from a broader approach to health both in terms of biology and in terms of the social determinants that shape health. It is also clear that women's health would benefit from a wider sharing of responsibility and initiative in society.

Under communism, health was considered the domain and the product of the state-run health care system. To improve the health of women in a manner which supports and advances women's equality requires a public policy approach that not only brings a gender lens to the health care infrastructure, but that brings a health perspective to other areas of public policy, including economic policy and social services. There are also many benefits to reap from an emphasis on public education, disease prevention and health promotion. Improving women's health requires the building up in the transition societies of a sense of responsibility and a capacity to contribute to health by individuals, families, communities, civil groups, and businesses. The achievement of optimum individual health is, in the final instance, the outcome of a healthy society. ■