

1 CHAPTER

BACKGROUND

This report sets forth comparative reproductive health data collected in face-to-face interviews from representative household samples of women of reproductive age in 12 countries of Eastern Europe and the former Soviet Union. In this report, the countries are clustered in three sub-groups: a) the Eastern European group (Czech Republic, Romania, Moldova, Ukraine, and Russia); b) the Caucasus Region group (Georgia, Armenia, and Azerbaijan); and c) the Central Asian group (Kazakhstan, Kyrgyz Republic, Turkmenistan, and Uzbekistan). To better understand the similarities and differences among these countries in key reproductive health areas, this chapter includes a review of selected characteristics of the 12 countries profiled in this report.

1.1 Shared History

The countries of Eastern Europe, the Caucasus, and Central Asia studied in this report constitute a diverse group of nations, each having its own rich historical and cultural heritage, a distinct ethnic composition, and unique political and socioeconomic development. Their inclusion in a common group is rooted in relatively recent events. From the end of World War II until 1989, all of these nations had socialist governments and experienced similar political and economic situations. Their increasing isolation from Western Europe, and their inclusion into either the Soviet Union or its sphere of influence, added commonalities to a region already brought together by shared history and geographical proximity. The collapse of the Soviet Union loosened the old political systems in the region and triggered profound social, economic, and political changes. Since about 1990, most of the Eastern European countries and the former Soviet Union have made efforts to move from centralized totalitarian regimes under the influence of the Soviet Union, to

decentralized administrative, economic, political, and socio-cultural systems whose priorities are capacity building, transition to a democratic society, and development of a market economy. However, their progress on the road of post-communist transition has been uneven. At the forefront are some countries of Eastern Europe and the Baltic countries, more advanced in their transition due, in part, to preserved and renewed Western traditions. Other countries have been less successful, having economies still in the early stages of transition, facing severe economic hardships and, in a few instances, struggling with divisive ethnic disputes. All countries, however, have been subject to profound societal transformation, including rapid changes in the health status of their populations and in their health care systems.

1.2 Similar Demographic Profiles

Demographically and socially, the countries included in this report, as well as most other countries in the region, have much in common (Table 1.2). Between one-fourth and one-third of their populations are composed of women of reproductive age (15–49 years) (PRB, 2002a).¹ With the exception of the Central Asian republics, all countries studied in this report have fertility rates lower than those typically found in Western Europe and well below the replacement level of 2.1 births per woman (PRB, 2002a). Despite substantial differences in fertility between the European and Central Asian countries examined, rates of childbearing have fallen substantially in all places. Large actual or intended families are rare. Women tend to marry early, have their first child shortly after they marry, and achieve the desired family size of about one or two children soon after. Women tend to both begin

and end their childbearing at much earlier ages than in Western Europe and North America. The vast majority of childbearing takes place between the ages of 20 and 29, and it is concentrated in the early twenties. Mainly because of below-replacement fertility (with a small contribution from increased mortality and out-migration in some countries), population growth rates are around zero or even negative, excepting the countries in Central Asia. This situation has become a major social and economic concern in the region.

Compared to most of the major countries of Western Europe, life expectancy at birth in Eastern Europe and the Caucasus is, on average, 9 years shorter among men and 7 years shorter among women. The difference in life expectancy between the Central Asian countries and Western Europe is, on average, 10 years or more for both men and women (PRB, 2002a). Since 1990, life expectancy in most post-communist countries has declined—particularly in the Russian Federation, which has the lowest life expectancy among males in Europe—or has registered little change. One of the major direct contributors to the widening mortality gap between these countries and Western Europe is an increase in destructive health behaviors, especially among men. Previously existing health problems, such as alcoholism and tobacco use, have increased. Lack of physical activity and unhealthy diet have become more prevalent. Psychosocial stress factors, work-related stress and job insecurity, have amplified. Rising mortality from cardiovascular diseases—the leading cause of death in most countries of the region, accounting for more than one-half of the mortality gap—reflects, in part, the effect of these risk factors and the

¹ Note that the fertility rates presented in Table 1.2 are taken from the most recent official statistics available and do not necessarily coincide with the survey rates presented in Chapter 3 of this report.

Table 1.2 Comparative Demographic and Social Indicators for Selected Countries in Western and Eastern Europe, Caucasus, and Central Asia Eastern Europe and Eurasia: A Comparative Report												
Region and Country	Population (in millions)	Women Aged 15–49 (in millions)	Total Fertility Rate*	Rate of Natural Increase†	Life Expectancy		% Urban	GNI PPP per capita 2000‡	Health Expenditures per capita 1990–1998§		% Women Enrolled in Secondary School 1993–1997¶	
					Male	Female			1990–1998§	1990–1998§		
Western Europe												
Austria	8.1	2.0	1.3	0.0	75	81	54	24,600	2,108	2,108	102	
Belgium	10.3	2.4	1.6	0.1	75	82	97	25,710	1,812	1,812	151	
France	59.5	14.4	1.9	0.4	76	83	74	23,020	2,287	2,287	111	
Germany	82.4	19.5	1.3	-0.1	75	81	86	23,510	2,727	2,727	103	
Netherlands	16.1	3.9	1.7	0.4	76	81	62	24,410	1,988	1,988	129	
Switzerland	7.3	1.7	1.5	0.2	77	83	68	28,760	3,616	3,616	U	
United Kingdom	60.2	14.0	1.7	0.1	75	80	90	22,220	1,480	1,480	120	
Eastern Europe												
Czech Rep.	10.3	2.6	1.1	-0.2	72	78	77	13,780	384	384	100	
Moldova	4.3	1.2	1.3	-0.1	64	71	46	2,230	30	30	82	
Romania	22.4	5.8	1.2	-0.2	67	74	55	6,360	65	65	78	
Russia	143.5	39.3	1.3	-0.7	59	72	73	8,010	130	130	91	
Ukraine	48.2	12.7	1.1	-0.8	62	74	67	3,700	54	54	94	
Caucasus												
Armenia	3.8	1.1	1.1	0.2	70	74	67	2,580	27	27	79	
Azerbaijan	8.2	2.3	1.9	0.8	69	75	51	2,740	36	36	81	
Georgia	4.4	1.4	1.2	0.0	69	77	56	2,680	46	46	76	
Central Asia												
Kazakhstan	14.8	4.5	1.8	0.5	60	71	56	5,490	68	68	91	
Kyrgyz Rep.	5.0	1.4	2.4	1.3	65	72	35	2,540	11	11	83	
Turkmenistan	5.6	1.3	2.2	1.3	63	70	44	3,800	U	U	U	
Uzbekistan	25.4	6.9	2.7	1.7	68	73	38	2,360	U	U	88	

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

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

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

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

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

U = Unavailable.

Source: Population Reference Bureau, 2002 *World Population Data Sheet* and 2002 *Women of Our World*; World Bank, 2000 *World Development Indicators*.

inability of a deteriorating health system to provide adequate prevention services or treatment (e.g., low quality hypertension screening, lack of follow-up, poor emergency care, low access to proper medication) (Velkova A et al., 1997; Bobak M & Marmot M, 1996). Perhaps most of the mortality divide experienced by former Soviet bloc countries since 1990 could be attributed to economic changes, such as changes in gross domestic product and changes in income inequalities (Marmot M & Bobak M, 2000). The transition to a market economy has had a negative impact on the welfare of the population of these countries. The per capita gross national income (GNI PPP) is, on average, 6–9 times higher in Western Europe than in the other countries shown in Table 1.2 (PRB, 2002a). Furthermore, the health expenditures per capita are 13 times higher in Western Europe and at least 22 times higher than in the Caucasus and Central Asian countries (World Bank, 2001).

1.3 Common Reproductive Health Concerns

Unintended pregnancy and abortion

Given the relatively low usage of the more effective modern contraceptive methods in most countries of the region, the early start and completion of childbearing, and the small ideal family size, the proportion of pregnancies that are unintended is quite high in each of these countries. The vast majority of unintended pregnancies (over 80%) are unwanted (i.e., in excess of the number of children wanted), while mistimed pregnancies (i.e., occurring earlier than intended) are relatively infrequent. There is considerable evidence that women who are pregnant with an unintended pregnancy are more likely than those with intended pregnancies to seek an elective abortion, to enter prenatal care late

or not at all, and to experience pregnancy or perinatal complications (Brown SS & Eisenberg L, 1995). Typically, in Eastern Europe and the former Soviet Union most unintended pregnancies are not carried to term and end in elective abortions.

For several decades, one of the most outstanding demographic features of most of the former Soviet bloc countries has been the high reliance on abortion as a means of birth prevention. Abortion was the single most important determinant of fertility; contraception was much less significant. Until recently, abortion rates and ratios in many of these countries have been among the highest in the world. High reliance on abortion continues to play a role in Eastern Europe and the former Soviet countries at the current time although, since the mid-1990s, the use of modern effective methods of contraception has increased with a corresponding decrease in the abortion rates. Nevertheless, reliance on abortion as a means of fertility control is still high in many countries of the region. The official total abortion rates in the region are equal to or greater than the total fertility rates. Two Eastern European countries—Romania, with a rate of 2.3 abortions per woman and Russia, with a rate of 2.6 abortions per woman—have the second and third highest abortion rates in the world (Henshaw SK et al., 1999). By comparison, abortion rates in Western Europe are among the lowest in the world, typically not exceeding 0.5 abortions per woman.

Viewed as a basic reproductive right of women in the former Soviet Union and Eastern Europe, abortion was legalized in the region well before the Western European countries. Except for Romania and Albania—where abortion was illegal prior to 1990 and 1991, respectively—women in the other ex-Soviet bloc countries enjoyed broad access to free-

of-charge or affordably priced legal abortions. Currently, abortion without restrictions as to reason during the first 12–14 weeks of gestation is available in all countries presented in this report (Rahman A et al., 1998). Beyond this gestational age, abortion is available on medical or selected socioeconomic grounds. Abortion is typically performed by trained physicians either in public or private clinics or hospitals. In most countries, the official cost of a legal abortion in a state run facility is relatively low, but it is not covered by health insurance, and unofficial payments could increase the cost beyond what a low-income family may afford.

Although standard surgical abortion carries a very little health risk when compared to childbirth or other surgical procedures, it has an inherent risk of complications (Cates W Jr., 1982). Shortage of equipment, crowded facilities, poor hygienic conditions, and inadequate standards of care may increase the risk of post-abortion complications, even when the procedure is legal. In the countries included in this report, up to 16% of women experience post-abortion complications after legally performed procedures, mostly following procedures performed after more than 10 weeks of gestation. In contrast, complications following legal abortions range from less than 1% in the United States and from 3% to 6% in Western Europe (Hakim-Elahi E, et al., 1990; Heisterberg L & Kringelbach M, 1987; Thonneau P, et al., 1998).

Even though availability of legal abortion in Eastern Europe and Eurasia is almost universal, some women still obtain abortions outside the legal system. Lengthy waiting time between the first visit and hospital admission for obtaining a legal abortion, lack of sanitary conditions, privacy, and patient confidentiality in state run hospitals, and payments associated with the abortion procedure may

deter some women from obtaining abortions in authorized facilities. Mandatory abortion notifications (in several countries included in this report the employer and primary care physician are notified about the abortion procedure), parental consent (in Czech Republic parental authorization is required if the patient is a minor), and advanced gestational age (beyond 12 weeks) can often contribute to seeking an abortion outside the system. Obtaining abortions later in the pregnancy is independently associated with an increased risk of complications. All these barriers may influence some women to seek unsafe medical procedures performed by unskilled providers outside the legal system.

Unsafe abortion is one of the leading causes of maternal mortality and morbidity. Although the annual number of these abortions is difficult to estimate, vital statistics in Eastern Europe and Central Asia indicate that between 15% and 54% of maternal deaths are abortion-related, presumably most of them from illegally performed abortions. By contrast, abortion-related deaths constitute about 4% of maternal deaths in the United States (Chang J, et al., 2003). That unsafe abortion is a major cause of maternal death is dramatically exemplified by the levels and trends of maternal mortality in Romania, where abortion restrictions triggered a massive reliance on unsafe procedures. Between 1957 and 1966, abortion was legally available in Romania. Maternal mortality due to abortion was as low as 17 deaths per 100,000 live births. In an effort to stop the fertility decline, the government outlawed abortion and contraception and instituted various surveillance measures (such as mandatory pelvic exams in the workplace and the presence of security police personnel in maternity hospitals) to ensure compliance. Maternal mortality due to abortion skyrocketed, reaching its highest level in 1989 (142 abortion-related deaths per 100,000) and

contributing to over 85% of the maternal mortality ratio. At the end of 1990, the first year when abortion again became legal, abortion-related mortality fell to about one-third of its 1989 level (57.5 abortion-related deaths per 100,000) and continued to decrease in the following years (21 abortion-related deaths per 100,000 in 1997).

Since the mid-1990s, the use of modern methods of contraception has increased with a corresponding decrease in reliance on abortion. Nevertheless, reliance on abortion as a means of fertility control is still high in many countries and still an important determinant of fertility throughout the region.

Contraception

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

In the former Soviet Union countries, for example, oral contraceptives were officially prescribed principally for selected medical benefits rather than for contraceptive purposes; dissemination of correct information about the pill was actively discouraged; and, when the topic was addressed, potential health risks and side effects were overstated. As a result of the negative propaganda, actively

promoted by policy makers and the medical community, misconceptions about the pill's safety were universal (Popov AA et al., 1993). Throughout the region, the use of traditional contraceptive methods, particularly withdrawal, was widespread and constituted a major contribution to the high levels of unintended pregnancy

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

Although many couples are currently using birth control methods, the use of traditional

methods often exceeds the use of modern methods and women using less effective contraception continue to rely on legal abortion services when their methods fail. Thus, substantial reductions in their reliance on abortion and improvements in maternal mortality and morbidity will depend not only on further increases in contraceptive use but also on improvements in method selection and reductions in contraceptive discontinuation and failure rates. In these countries, inclusion of postabortion counseling in the standards of care is essential, both to avoid repeat abortion and to encourage use of more effective methods of contraception.

Maternal and Infant Mortality

Maternal and infant mortality are measures of a nation's health and worldwide indicators of social well being, but accurate estimates are often difficult to obtain. Although the vital registration systems in former Soviet bloc countries are quite comprehensive, they share a common history of under-reporting and misclassification of deaths. Thus, comparisons of mortality rates based on vital statistics alone—even when correction factors are applied—are often misleading and difficult to interpret, highlighting the need for more accurate data provided by population-based surveys or other special studies.

Maternal mortality rates in all the countries studied in this report, but especially in the Central Asian republics, are reportedly at least twice as high as the Western European maternal mortality average, according to recent WHO estimates (Hill K et al., 2001). As of 1995, the last year for which comparison data were available, the Russian Federation had the highest maternal mortality ratios among Eastern European countries (75 deaths per 100,000 live births), followed by Romania (60 deaths per 100,000 live births). Among Central

Asian republics, maternal mortality rates in 1995 ranged from 123 per 100,000 live births in Tajikistan (data not shown) to 80 per 100,000 in Kazakhstan and the Kyrgyz Republic, to 63 per 100,000 in Uzbekistan. Complications related to abortion, especially when it is performed under unsafe conditions, are among the leading causes of maternal death in many of these countries. Worldwide, abortion-related deaths account for about 20% of maternal deaths each year, but in some of the countries of Eastern Europe, they account for as much as one-half of maternal deaths (WHO, 1997).

As will be demonstrated in Chapter 13, the actual rates of infant mortality in most of the countries included in this report are considerably higher than the official rates reported by these countries. However, even those official rates are much higher than the rates in Western Europe. For example, as of 2000, the official infant mortality rate in Romania (18.6 infant deaths per 1,000 live births) ranked the highest in Central and Eastern Europe. Official rates in the Caucasus region and Central Asian republics ranged from 12.2 to 32.8 infant deaths per 1,000 live births. By comparison, the infant mortality rate for Western Europe was, on average, 5.0 infant deaths per 1,000 live births (PRB, 2002).

The magnitude of the difference in infant mortality between East and West, however, cannot be accurately described using unadjusted data provided by the vital statistics systems in ex-Soviet countries (Kingkade WW & Arriaga EE, 1997). Part of the underreporting of infant deaths in the former Soviet Union countries is due, in part, to a widespread reluctance to adopt the standard international definition of a live birth (any infant who exhibits at least one sign of life upon delivery). In several countries included in this report, the Soviet definition of a live

birth is still in existence. Misclassifications and delays or failures to register infants who die shortly after births are key contributors to under-reporting of infant mortality rates in the region. Recent RHS and DHS surveys conducted in the region estimate much higher infant mortality rates than the official reports, particularly in the Caucasus region and Central Asia. Survey estimates of infant mortality in the region exceed official rates by a factor of between 1.5 and 5.8 in 8 of the 12 countries included in this report (see also Chapter 13).

Use of Preventive Services

A substantial proportion of women in Eastern Europe and the former Soviet Union have limited access to preventive health services for women, mainly because of provider's failure to recommend them, a perceived lack of susceptibility to disease, and a lack of awareness about screening. Among these services, cervical cancer screening is particularly deficient. Risk factors for cervical cancer include a history of multiple sexual partners, early onset of sexual intercourse, smoking, infection with human immunodeficiency virus (HIV), and infection with a certain serotype of the human papilloma virus. Data from large screening programs have shown that frequent Pap smear screening (every 1–3 years) reduces the probability of developing invasive cancer by 91% to 93%. Most experts recommend that women who are sexually active or 18 years of age or older should have a Pap test at least every 3 years. Unfortunately, the data show that a significant proportion of women in Eastern Europe are not aware of cervical cancer screening or have never been tested. Severe underutilization of cervical cancer screening is associated with higher morbidity and mortality rates. The average cervical cancer rate for Eastern Europe of 21.6 cases per 100,000 is 33% higher than

the Western European average of 15.0 per 100,000. Mortality due to cancer of the cervix constitutes the third highest cause of death among women of childbearing age in Romania, while in Poland it ranked 5th, in Hungary 8th, in Ukraine 11th, in the Czech Republic 12th, and in the Russian Federation 16th (Parker SL et al., 1996).

STIs, Including HIV/AIDS

Since the early 1990s, many of the countries of Eastern Europe and the former Soviet Union have experienced major epidemics of sexually transmitted infections (STIs), particularly of syphilis. While the reported incidence of new cases of syphilis in several former Soviet countries increased by 45–165 times during 1990–1998—the steepest recorded increases were reported in Kazakhstan (from 1.4 to 231.4 new cases per 100,000), the Kyrgyz Republic (from 2 to 144.4 new cases per 100,000), Belarus (from 2.7 to 164 new cases per 100,000), and the Russian Federation (from 5.3 to 225.6 per 100,000)—the rates in the countries of the Caucasus region and in Romania, though higher than in 1990, remained low by comparison (Riedner G et al., 2000).

Most former communist countries have inherited a centrally controlled STI surveillance system based mostly on case-reports. The only STI with active screening is syphilis. In all these countries, STI surveillance systems are centered on dermatavenerology (DV) clinics. Official data on STI prevalence represent only the cases reported to the dermatavenerology network. Cases seen by gynecologists or other doctors are seldom reported. Like other health surveillance systems, STI reporting is seriously affected by the general lack of resources that has plagued health care services during the past decade. Because of

limited laboratory resources, very few DV clinics have the ability to provide a wide array of laboratory testing and treatment. Even when the laboratory resources are adequate, the STI surveillance reflects only patients who seek medical care, and thus under-reports those with asymptomatic STIs, those who get treatment from alternative providers, those who use self-treatment or no treatment, and those with limited access to medical care. Increasingly, owing to the lack of confidentiality and social stigma, patients with STI symptoms are seeking care in the private sector, although the private sector is still little developed. Thus, even though these rates are high, STI surveillance systems in these countries are substantially underestimating the real magnitude of the STIs.

Eastern Europe is one of the last regions of the world to be challenged by the HIV/AIDS epidemic. Until mid-1995, Eastern Europe and the former Soviet Union did not seem threatened by a substantial HIV epidemic. Of the 450 million residents in the region, fewer than 30,000 were estimated to be infected with HIV. However, between 1995 and 1997, the estimated number of cases of HIV increased more than fivefold in this region. At the end of 2001, Eastern Europe and Central Asia were estimated to have one million people infected with HIV, with intravenous drug use being the main mode of transmission (UNAIDS, 2001). HIV surveillance in most former Communist countries is separate from that for other STIs, with diagnostics, reporting, and treatment centered around the infectious disease clinics. Under the recent health care reforms, HIV testing is usually voluntary (with the exception of blood donors) and is offered free of charge to some high-risk groups.

1.4 Young Adult Sexual and Reproductive Health: A Growing Concern

Prior to 1990, under the climate of strong moralistic principles vigorously promoted by the Communist regimes in Eastern Europe and the former Soviet Union, sex education in school was largely prohibited, sexuality was a taboo topic, and knowledge of contraception was discouraged in order to promote more rapid population growth. Although most adolescents in Eastern Europe remain sexually abstinent for most of their teen years, recent social, economic, and cultural changes are likely to liberalize sexual behaviors at a faster pace than in the past. Young people, especially adolescents, are sexually active at earlier ages than were older cohorts. They are more likely to have experienced premarital sexual intercourse, a greater number of sexual partners, and exposure to unintended pregnancy and sexually transmitted infections. In addition to direct health consequences, these behaviors could have very serious long-term influences on their lives (lower level of education, reduced range of employment opportunities, greater risk of fertility impairment, and even shorter life expectancy since, in the last decade, AIDS has rapidly become a leading cause of death among men and women 25–44 years of age).

1.5 Women's Status and Gender Issues

Most countries of the region share similarities with regard to the legal status of women and gender roles; they all experienced the same Communist efforts in the past to promote gender equality, only to see them replaced by recent political and social changes aimed at relegating women to traditional roles.

In many of these countries, the Reproductive Health Surveys produced the first population-based information on violence against women available at a national level. Violence against women includes a wide range of behaviors and acts perpetrated against women, and most commonly occurs between men and their female partners. This form of violence occurs in all cultures and affects women of all ages and all socio-economic and educational backgrounds. Gender stereotypes, women's economic dependence on men, cultural acceptability, loose or nonexistent legislation to protect women's fundamental human rights, and lack of preventive measures for victims are some of most widely recognized factors that contribute to intimate partner violence.

Since domestic violence affects women's physical, sexual, psychological, economical, and social well being, it implicitly affects women's health, including their reproductive health. Women subjected to domestic violence may be unable to use contraception effectively and consistently, and may lack control or negotiation skills that will enable them to avoid sexually transmitted diseases, plan pregnancies, and attend preventive health services, such as prenatal care.

1.6 Health and Population Policies

Health

In the former Communist countries, health policies, practices, and facilities were modeled after the centralized, government-supported Russian health system that provided universal health services to all citizens. Typically, the system promoted hospital-based health care services - that created a surplus of hospitals and hospital-based specialized physicians - and an inadequate supply of primary health care services. In the recent years of transition to a market economy, the costly hospital-based

curative system has become impossible to maintain; most hospitals lacked the minimum equipment, drugs, and supplies necessary and could not afford the maintenance costs. Health care deteriorated rapidly, particularly in the area of reproductive health services, which is reflected in the worsening of several outcome indicators (e.g., maternal and infant mortality, STI prevalence, and utilization of preventive services).

In all the countries profiled in this report, governments are struggling with limited resources and emerging health problems. They have responded to demographic and reproductive health challenges to varying degrees by introducing a wide array of policies and programs. Currently, health care reforms are in various stages of development and implementation. All of the governments continue to support health care services but most are in the process of turning them over to national health insurance agencies or to the private sector, possibly leaving large parts of their populations uninsured or with minimum health benefits. The newly created insurance systems have a mandatory component - based on mandatory payroll taxes, specific earmarked taxes and funds, and governmental and municipal subsidies- and a voluntary component. The mandatory insurance covers a limited range of essential services for all citizens who do contribute as well as for some who do not (e.g., minors and students).

Population policies

Under the socialist regimes, policies aimed to increase the birth rate were a high priority and employed a wide array of pronatalist incentives. Currently, with population growth stagnated or even reversed, all 12 countries that are the focus of this report have increased their efforts to stimulate the birth rate.

1.7 Measurement Issues

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

Even when they are complete, vital records, census data, and program data often do not provide sufficient information to adequately

and reliably assess public health problems and to evaluate public policy and program initiatives. Furthermore, the data usually satisfy the needs of centralized decision-making but are less useful for describing the health status and the burden of disease of the population at sub-national levels.

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

