Achieving ICPD commitments for abortion care in Eastern and Central Europe: The unfinished agenda
Achieving ICPD commitments for abortion care in Eastern and Central Europe: The unfinished agenda
Achieving ICPD commitments for abortion care in Eastern and Central Europe: The unfinished agenda.
# Table of Contents

Acknowledgements .......................................................... 4  
Executive Summary .......................................................... 5  
The ICPD Baseline for Abortion Care ................................. 7  
Ten Years On…Evaluating Progress in Eastern and Central Europe ........... 8  
Changes and Challenges in Women’s Reproductive Health Care in the Region ........ 8  
  Recovering from the Soviet model .................................. 8  
  Declining populations ................................................. 8  
  Low motivation to encourage contraceptive use .................. 9  
  Restrictive U.S. government policies ............................... 10  
  Widespread availability of abortion ................................. 10  
  Increasing conservative trends ..................................... 11  
A Regional Assessment of Progress .................................... 12  
Country Profiles .............................................................. 13  
  Russia ................................................................... 13  
  Poland .................................................................. 15  
  Romania ................................................................. 17  
  Slovakia ................................................................. 20  
  Albania ................................................................. 22  
The Unfinished Agenda ....................................................... 24  
Notes ........................................................................... 26  
Statistical Definitions .......................................................... 26  
Sources ......................................................................... 27
Acknowledgements

Ipas would like to thank the many colleagues who helped make this document possible. In particular we thank the following individuals who spoke with us about progress since ICPD in the area of abortion in their countries: Adriana Baban, Emanuela Bello, Vladimir Cupanik, Eglantina Gjermen, Inga Grebesheva, Danielle Hassoun, Mihai Horga, Michal Kliment, Françoise Laurant, Elena Loukovitskaya, Olga Pietruchova, Alexandra Solik and two respondents from Romania who wish to remain anonymous. Wanda Nowicka offered the assistance of staff members from the Polish Federation of Women and Family Planning. Other colleagues who provided guidance and review of the document in its various stages include Traci Baird, Barbara Crane, Sarbaga Falk and Entela Shehu. Reed Boland provided important information regarding the abortion laws of the countries included in this survey. Sarah Packer and Jenn Kiefer helped gather statistical information referenced in the document, and Ellen Mitchell provided guidance in the survey design. Additionally, we appreciate the efforts of Daniela Draghici, who not only conducted the interviews but also participated in the review of the final document. Finally, we want to acknowledge the work of Leila Hessini, Senior Policy Advisor at Ipas, whose initial vision and guidance made this document possible. The document was written by Irene McFarland, Marty Michaels and Charlotte Hord.
Executive Summary

The International Conference on Population and Development (ICPD) in 1994 offered the world a new paradigm that moved countries away from a narrow focus on population control and family planning and toward a framework that emphasizes individual rights, a comprehensive approach to reproductive health, and the involvement of women in decisions that affect their health and rights. Many countries in Eastern and Central Europe, which experienced widespread political, economic and societal changes in the early 1990s following the fall of the Soviet Union, have struggled to expand reproductive-health programs to meet the ICPD definition. Reliance on abortion for fertility control is widespread and well-accepted, and, although it has increased significantly, the use of modern contraceptives remains low. Fertility rates have fallen below replacement level in most countries in the region, leading some policymakers, health-care providers and NGOs to call for limitations on comprehensive contraception and abortion programs. Pressures from conservative forces have led to restrictions on approved methods of safe abortion and legal indications for terminating pregnancies. Meanwhile unsafe abortion remains high in the region, causing 24% of maternal deaths annually (World Health Organization, 1998).

In Russia, for example, under a 2003 proposed change to the abortion law, the number of circumstances under which a woman can obtain a legal abortion after 12 weeks has been reduced from 13 to four. In Slovakia, the government and the Holy See have drafted an international treaty that would allow health-care providers to refuse to perform abortions and allow teachers to refuse to teach sexuality education under the aegis of “conscientious objection.” Although purported to support the fundamental rights of the individual relating to thoughts and conscience, this treaty could infringe on the equally fundamental rights of women and youth to receive accurate, high-quality information and care related to their sexual and reproductive health.

Romania has experienced significant improvements since the early 1990s when abortion and contraception were legalized following the lengthy reign and pro-natalist policies of Nicolai Ceausescu. While the abortion rate remains high, the negative health consequences from unsafe procedures have been dramatically reduced. Ministry of Health statistics show that the maternal-mortality rate due to abortion changed from 149 in 1989 before the law change to 9 in 2002. Nevertheless, women living outside urban centers experience serious difficulties obtaining comprehensive reproductive-health care, and there are very few links between contraception and abortion. The outdated sharp curettage technique is still used for over half of all abortions.

Poland is an anomaly in the region in terms of reproductive health due to its restrictive laws and policies governing access to abortion and contraception. After decades of legal abortion under Communist rule, Poland’s new government passed a near-total ban in 1993, which was overturned in 1996. The more liberal law was again overturned in 1997 after the courts found it unconstitutional. Women’s groups believe that the current law, which is the most restrictive in Eastern Europe, has led to as many as 200,000 illegal abortions a year in Poland. They cite as evidence of the law’s impact on access to safe abortion care the fact that there were 11,700 legal registered abortions in 1992, but only 124 in 2001, eight years after Poland’s restrictive law came into effect. The dominance of Roman Catholic Church teachings regarding reproductive-health issues has limited progress in this area since ICPD.

Reproductive-health specialists from Albania note that while access to care is more limited for women living outside urban areas, Albanian families have broader access to various family-planning
methods, including emergency contraception, since ICPD. Although abortion rates are decreasing due to the increased use of contraceptives, abortion still represents the main method of fertility control in Albania. Abortion techniques are improving; however, sharp curettage is still used in some public facilities and most private ones. Gynecologists view abortion as an income-generating procedure and are not interested in providing contraception to their abortion patients, making the link between abortion and postabortion contraception weak.

In this review of post-ICPD developments, one can see how the political and economic needs of a country, combined with the presence of vocal and powerful religious entities, can lead to infringements on the rights of women to manage their fertility. Yet, despite the political and economic changes in this region, there have been some areas of progress since 1994. For example, new methods of fertility control, such as emergency contraception, have been introduced even in countries as conservative as Poland. Unfortunately, these new methods of fertility control are not yet widely available or affordable, and services continue to be lacking, especially in rural areas. Many reproductive-health specialists agree that much remains to be done before ICPD commitments will truly be achieved.
The concept that “…all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education, and means to do so”—first agreed to at the World Population Conference held in 1974 in Bucharest—is still an unrealized ideal for many women. While abortion is legal to protect women’s physical health and for other indications in 118 of the world’s 192 countries (Center for Reproductive Law and Policy, 2002), these laws often do not translate into government commitments to provide safe, accessible services. When performed under proper conditions, abortion is one of the safest of all medical procedures. However, the pervasiveness of unsafe abortions has made what should be a safe procedure a leading cause of maternal death and injury: Of the total number of abortions that take place each year, close to half, or 20 million, are unsafe [note 1], contributing to nearly 70,000 deaths and countless injuries. Most of these deaths and injuries occur in the developing world. In Eastern Europe, although the total number of maternal deaths is low compared to other regions, the proportion of deaths caused by unsafe abortion is extremely high—24 percent—a rate nearly double that of Africa and comparable to that in South America (WHO, 1998).

The international community first recognized unsafe abortion as a major public-health concern at the International Conference on Population and Development (ICPD) held in 1994 (see box below). In 1999, country delegates to the United Nations special session reviewing implementation of the ICPD Programme of Action—commonly known as ICPD+5—called on health systems to increase women’s access to services where abortion is not against the law by training and equipping health-care providers and taking other measures to safeguard women’s health (paragraph 63iii).

ICPD paragraph 8.25.

In no case should abortion be promoted as a method of family planning. All Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women’s health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services. Prevention of unwanted pregnancies must always be given the highest priority and all attempts should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counseling. Any measures or changes related to abortion within the health system can only be determined at the national or local level according to the national legislative process. In circumstances in which abortion is not against the law, such abortion should be safe. In all cases women should have access to quality services for the management of complications arising from abortion. Post-abortion counseling, education and family planning services should be offered promptly which will also help to avoid repeat abortions.

ICPD+5 paragraph 63iii

…In circumstances where abortion is not against the law, health systems should train and equip health service providers and should take other measures to ensure that such abortion is safe and accessible. Additional measures should be taken to safeguard women’s health.
Ten Years On … Evaluating Progress in Eastern and Central Europe

To help gauge the improvement in abortion care since the ICPD and its five-year review in 1999, Ipas undertook a modest review of the current reproductive-health status in the region, with a focus on abortion. The review included published literature, organizational experience in the region and a survey of key stakeholders in selected countries in Eastern and Central Europe to see what has been done to implement relevant recommendations from the ICPD Programme of Action. Our final survey results reflect responses from 12 key informants from Albania, Poland, Romania, Russia and Slovakia who represent a variety of sectors, including multilateral and government organizations, family-planning associations and women’s groups. The interviews were conducted from May – August 2003. Survey results are used to illustrate the types of issues and concerns felt at the country level and to supplement data from a number of other sources.

Changes and Challenges in Women’s Reproductive Health Care in the Region

Recovering from the Soviet model

Until a decade or so ago, many Eastern and Central European countries — having formerly been part of the Soviet Union or within its sphere of influence — had health-care systems modeled on the Soviet Union’s centralized system. Under this system, which provided universal health care, hospital-based care was emphasized, creating a surplus of hospitals and specialists and a dearth of primary-care services. Since the transition in the 1990s to market-based economies, the health-care systems in most of these countries have deteriorated precipitously. Hospitals often lack modern equipment and supplies, and the imposition of fees for services has led to lowered use of preventive care, including contraceptive and other reproductive-health services (Population Reference Bureau (PRB), Measure Communication, 2003).

Declining populations

During the 1990s, many countries in the region reported substantial declines in fertility rates. In fact, by 2000, fertility rates in most countries were lower than replacement level. For example, according to the most recent data available, in both Slovakia and Romania the total fertility rate was 1.2 children per woman. Poland and Russia each have total fertility rates of 1.3 children per woman. Based on this and other factors, there is a negative projected population change in many countries in the region over the next five decades (see box, page 9). The only country surveyed that defied this trend was Albania, which has a
total fertility rate of 2.0 children per woman and a projected population increase of 16% between 2003 and 2050 (PRB, 2003).

Vocal family-planning and abortion opponents in the region and from other countries, notably the United States, have tried to draw particular attention to these population trends as evidence for why contraceptives and abortion services are not necessary or good for the region (Mosher, 1997). Falling population rates have led policymakers in some countries to consider contraceptive programs to be unnecessary or negative. This trend represents an ominous development for women seeking to regulate their fertility and clearly moves away from the ICPD agenda, which emphasizes access to high-quality care, the right to determine one’s own fertility and the means to do so. The ICPD Programme of Action highlights reproductive-health care and fertility control as basic rights of the individual, not as privileges that a country can rescind depending on its desired rate of growth.

Low motivation to encourage contraceptive use

This trend is exacerbated by the fact that there is generally low motivation among health-care providers to encourage contraceptive use. For various reasons — including a lack of training, financial gain from providing abortions and a historical reliance on abortion to regulate fertility — policymakers and medical professionals often do not promote modern contraceptive methods. Contraceptives are often inferior in quality and difficult to obtain on a regular basis, particularly for adolescents, low-income women and women living outside urban areas. In most countries in the region (except Poland), most modern contraceptive methods are available in urban settings but use is lower than the need and use of contraception following abortion is very low. Many women are unable to afford methods that are not subsidized by their government.

Various family-planning initiatives in the region — including efforts run by nongovernmental groups (NGOs), donor agencies, and some government agencies — have attempted to address this lack of services, with varying degrees of success. In most countries, contraceptive use is increasing and the number of abortions is decreasing. For example, between 1988 and 2001, modern contraceptive use increased in Russia by 74%, while the abortion rate decreased by 61% (Deschner and Cohen, 2003) (see graph, page 10). Despite this, however, in virtually all countries in the region postabortion contraception and related counseling services remain inadequate or nonexistent. This lack of client education and access to modern contraceptive methods continues to contribute to women’s reliance on abortion as a means of controlling their fertility.
Restrictive U.S. government policies

These trends must also be viewed within the framework of the policies of the current U.S. administration of President George W. Bush, which threaten some of the advancements that have taken place over the past decade involving women’s reproductive health and rights. On the second day of his presidency, in January 2002, President Bush reinstated the Mexico City policy, also known as the Global Gag Rule (GGR). Through this policy, the U.S. administration mandates that NGOs that receive U.S. family-planning funds cannot perform, advocate or provide medical counseling or referrals for abortion services, even when those activities are supported with their own (non-U.S.) funds and are lawful under their national sovereign legislation. In this manner, the United States is controlling what NGOs can accomplish, both with their own and with other donors’ money. This policy affects a wide range of non-governmental organizations globally, particularly harming those that provide contraceptive services necessary to prevent unwanted pregnancies and decrease abortion.

In Eastern and Central Europe, the GGR is not a major factor in access to contraceptive methods, as most United States Agency for International Development (USAID) assistance is through governments or family-planning associations that have agreed to the GGR requirements. However, the U.S. government’s decisions have affected these countries to some degree by providing encouragement to conservative factions that oppose women’s reproductive rights. In many of these formerly Communist countries, these are rights that have been guaranteed to women for decades.

Widespread availability of abortion

In general, abortion rates are high in countries where the desire for small families is coupled with low rates of effective contraceptive use (Alan Guttmacher Institute, 1999). In most countries in Eastern and Central Europe, abortion is available on broad legal grounds, is free or low-cost, and is usually performed by trained health-care providers. The region has some of the highest abortion rates in the world: In Romania, the abortion rate per 1,000 women aged 15-44 is believed to be 78.0 [note 2] and in Russia the rate is estimated at 68.4. In comparison, the rate in Sweden is 18.7 per 1,000 and in the Netherlands is 6.5 abortions per 1,000 (Henshaw, et al., 1999). Despite widespread legal and available services, unintended pregnancy and abortions performed under unsafe conditions continue to represent major public-health problems in some countries. According to WHO estimates, unsafe abortions account for 24 percent of maternal deaths in Eastern Europe (WHO, 1998). In many countries sharp curettage, an outdated technique that is less safe than vacuum aspiration, is still used for most first-trimester abortions, and women do not regularly receive adequate pain management. This is compounded by other factors; for example, in Russia the rate of abortion among adolescents is particularly high; abortion is
widely used instead of contra-
ception; and unprotected sex is 
commonplace, leading to high 
rates of sexually transmitted 
infections (STIs) and a rising 
HIV-infection rate (Inter-
national Planned Parenthood 
Federation (IPPF), Russia 
country profile).

Attention is being paid to 
this substandard treatment in 
some countries, particularly 
in Romania, where a national 
standards and practice docu-
ment has recently been pro-
duced for elective pregnancy 
termination (Romanian 
Ministry of Health and Family, 
et al., 2003). The document is 
in keeping with new technical 
and policy guidance from 
the WHO for safe abortion, 
which was developed to aid 
implementation of paragraph 
63iii recommendations from 
ICPD+5 regarding the need 
for health systems to train and 
equip health providers to offer 
safe abortion services (WHO, 
2003). The Europe office of the World Health Organization recognizes the importance of 
ensuring that abortion services remain safe and that techniques be updated, and, in accor-
dance, is taking the lead in disseminating the new guidance in the region.

Increasing conservative trends

It is also important to consider the negative impact that the Catholic and Orthodox churches 
and conservative forces increasingly have on the availability of reproductive-health services 
in countries in the region. This trend is particularly apparent in Poland, where a 1996 law that 
permitted abortion in the cases of “difficult family and living conditions” was found unconstitu-
tional and was amended to remove the option of abortion for socio-economic reasons (Polish 
Federation for Women and Family Planning, 2000). This change was made following intensive 
lobbying by the Roman Catholic Church, whose influence also stymies access to family planning 
and sexuality education. According to IPPF, organized Roman Catholic opposition to family 
planning is also strong in Slovakia and elsewhere, and a well-financed anti-choice group of 
Russian Orthodox and other organizations has emerged in Russia, contributing to restrictions 
being put on second-trimester abortion. Other sources report that the Orthodox Church in 
Russia is also working to limit access to specific methods used for abortion. Furthermore, 
the region’s declining population rates, combined with civil and ethnic strife, have contributed 
to pro-natalist and pro-nationalist climates in some countries (IPPF, Russia, Poland, and Slovak 
Republic country profiles).
A Regional Assessment of Progress

Despite the great diversity within Europe with regard to ethnic composition, economic status, language, religion and other issues, several consistent messages emerged from the interviews with representatives from the five Central and European countries. One message is that even where abortion is legal, services may not be universally available to women because of poor access outside urban centers. Survey respondents frequently mentioned the lack of options for women, both in terms of contraceptive methods as well as with methods of abortion. Another consistent message is that few government departments or NGOs — other than a few women's groups — have prioritized abortion care as an issue of major importance. According to survey respondents, many governmental and nongovernmental organizations do not believe that abortion is an issue that affects all women, and accordingly do not consider it an important public-health issue.

Survey respondents also clearly felt that governments and organizations working on the issues of contraception and abortion-related care need to publicize their work better. The often different, and sometimes conflicting, knowledge regarding services and activities held by reproductive-health professionals in a given country, as reflected in contradictory survey responses, suggests that sharing information could greatly increase the ability of stakeholders to build on each other’s work. For example, respondents had widely varying responses to questions regarding whether health-care providers receive training in abortion while in medical school, whether they get any practical on-the-job training, and even who is being trained and is permitted to perform abortions. Responses to questions about the accessibility and affordability of abortion services also varied widely.

Still, as the following country profiles indicate, while there have been some setbacks in the past decade, noteworthy improvements and advances have also been made in meeting ICPD obligations regarding contraceptive services and abortion care. In one clear sign of progress, the question that survey respondents seemed to be most engaged in answering was not how to introduce abortion-care and family-planning services to the women in their countries, but how to protect, improve and expand existing services so that more women can receive high-quality services.
In the mid-to-late 1990s certain territories of Russia had among the highest abortion rates in the world (IPPF, Russia country profile). Under Russian law, a pregnant woman may obtain an abortion on request during the first trimester. Between the 12th and 22nd weeks of pregnancy, an abortion may be performed for selected social indications, as set by ministerial decree. This decree has recently been revised (see below). An abortion may be performed at any time during pregnancy for health reasons. All abortions must be carried out by a physician.

A number of legislative actions have been taken over the past few years that have the potential to greatly limit women’s access to care. A 1996 Governmental Decree concerning the social indications in which induced abortion is permitted after 12 weeks was voided in 2003 and replaced by a new decree that significantly limits the number of circumstances that are permitted. Permissible social indications were reduced from 13 to four: 1) rape, 2) imprisonment, 3) the death or severe disability of the husband or 4) a court ruling stripping a woman of her parental rights. The decree was approved in September 2003 and the Ministry of Health has been instructed to review its rules and regulations to make them consistent with it, but as of November 2003 the decree had not yet been approved by the legislature. This action builds on several recent changes that are not in keeping with ICPD.
principles, including the government’s decision to cease supply of contraceptive methods in 1997 (Deschner and Cohen, 2003), a proposed amendment to the family code and children’s rights law in May 2003 that would grant the fetus a right to life, and an amendment to the public health-care law imposing mandatory counseling prior to abortion (Zampas, 2003). As Russia is the most populous and influential country in the region, these actions to restrict reproductive choice could be a harbinger of changes in the region that could make abortion and contraceptives less accessible over the coming years.

In a survey of reproductive-health indicators in Russia in 1999 in three urban areas, 73% of married women aged 15-44 were found to use some form of contraception, most commonly the IUD. The survey also found that 66% of all pregnancies are unwanted and that the lifetime number of abortions per woman is 2.3 (PRB, Measure Communication, 2003). Since abortion was legalized in Russia in 1955 it has commonly been used as a method of birth control. Despite this, the abortion rate has been falling in recent years, dropping by 45% from 1992 to 2001. According to one recent report, health experts believe that approximately 13% of Russian married couples experience fertility problems and that 75% of these problems relate to the woman’s health, mostly due to complications from one or more previous abortions. (LaFraniere, 2003).

Survey respondents reported that while a variety of contraceptive services are available to all men and women of reproductive age, the cost of modern methods prevents them from being widely used. Instead, many lower-income families rely on abortion as their family-planning method because abortion services are seen as more cost effective. Abortion appears to be less expensive because it is necessary only twice a year for many women, while contraceptives must be purchased for use year-round. In a related comment, one survey respondent stated that Russia has a 40% repeat abortion rate.
It is difficult to gain access to modern contraceptives and practically impossible to obtain safe abortion services in Poland. There is a strong pro-natalist and Catholic fundamentalist atmosphere in the country, and, while contraceptives are available, only 19% of married women aged 15-49 are estimated to be using modern methods (PRB, 2003). Many methods are not subsidized by the government, making them too expensive for much of the population. According to one respondent, sex education has not improved since ICPD, and the Ministry of Education continues to support the use of manuals that provide inaccurate, gender-biased information. Under Poland’s current abortion law, abortions are permitted under three circumstances: 1) when the pregnancy endangers the life of the pregnant woman or seriously jeopardizes her health, as attested to by three physicians; 2) when a prenatal diagnosis has demonstrated the presence of a serious and irremediable defect in the fetus, as attested to by three physicians; and 3) when there are valid reasons for suspecting that the pregnancy resulted from an unlawful act (as confirmed by an attestation on the part of the Office of the Public Prosecutor). Despite the conservative climate for abortion, a public-opinion poll cited by the IPPF found

**Polish Statistics**

Population Indicators:

- Population: 38.6 million
- Population growth rate: 0.0%
- Infant mortality rate: 7.7 deaths per 1,000 live births
- Fertility rate: 1.3 children per woman
- Contraceptive prevalence rate, modern methods (% of married women 15-49): 19

Socio-economic Indicators:

- Percentage of total population under age 15, 2001: 18.6%
- Gross domestic product (GDP) per capita, 2001: US $9,450
- Public expenditure on health (as % of GDP), 2000: 4.2

“\textit{No measures have been taken to improve the quality of the reproductive-health services and to promote women patients’ rights in the area of reproductive health. Access to family planning methods is limited. Women’s rights to legal abortion are commonly ignored by the doctors and the authorities. The rule of informed consent is not being respected by reproductive-health providers.}”
- respondent from Poland
that 60% of the population supports the availability of abortion for social-economic reasons (IPPF, Poland country profile).

Treatment for complications of unsafe abortion is also compromised by the conservative atmosphere in the country. According to a respondent from the Polish Federation for Women and Family Planning, women who face complications from an unsafe abortion and end up in the hospital for care often face inquiries from the police. According to a survey respondent, information collected by authorities in the case of an illegal abortion include who performed the abortion, where, how, and the names of people who helped the woman obtain the procedure.

In February 2003, representatives from more than 150 international reproductive-rights, religious and women's groups from 46 countries signed a letter addressed to Polish President Aleksander Kwasniewski that asked him to ease restrictions on abortion access. Women's groups believe that Poland's law, the most restrictive in Eastern Europe, has led to as many as 200,000 illegal abortions a year in Poland. They cite as evidence of the law's impact on access to safe abortion care that there were 11,700 legal registered abortions in 1992, but only 124 in 2001, eight years after Poland's restrictive law came into effect (Catholics for a Free Choice, 2003).

The divisiveness of the abortion issue in Poland can be seen in the country's debate as to whether to join the European Union. In January 2003, in response to pressure from Roman Catholic officials in Poland, the Polish government sent a letter to the European Union that sought assurances that “no E.U. treaties or annexes to those treaties would hamper the Polish government in regulating moral issues or those concerning the protection of human life.” The Cardinal of the Polish church, Cardinal Jozef Glemp, called for a special clause in the E.U. membership treaty that recognized Poland's position on abortion. However, despite this pressure from the Church, the left-wing government of prime minister Leszek Miller did not choose to raise the abortion issue when negotiating Poland's membership to the E.U. (Traynor, 2003).

**Socio-economic indicators:**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women in government at ministerial level (as % of total), 2000</td>
<td>18.7%</td>
</tr>
<tr>
<td>Physicians (per 100,000 people), 1990-2002</td>
<td>233</td>
</tr>
<tr>
<td>Health expenditure per capita, 2000</td>
<td>US $575</td>
</tr>
</tbody>
</table>

**Reproductive-health indicators: 1995-2000**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of women aged 15-44</td>
<td>8,674,848</td>
</tr>
<tr>
<td>Maternal-mortality ratio, 1985-2001</td>
<td>8 per 100,000 live births</td>
</tr>
<tr>
<td>Pregnancies</td>
<td>8,396,989</td>
</tr>
<tr>
<td>Births</td>
<td>2,453,026</td>
</tr>
<tr>
<td>Abortions</td>
<td>4,684,418</td>
</tr>
<tr>
<td>Maternal deaths</td>
<td>294</td>
</tr>
<tr>
<td>Maternal abortion-related deaths</td>
<td>368</td>
</tr>
<tr>
<td>Unintended pregnancies</td>
<td>5,444,856</td>
</tr>
<tr>
<td>Unintended births</td>
<td>760,438</td>
</tr>
</tbody>
</table>

* PRB, 2003
** UNDP, Human Development Indicators, 2003
*** Global Health Council, 2002
See Notes for definitions.
According to a 1999 survey of reproductive health in Romania, the most-common method of contraception used was the withdrawal method and 55% of all pregnancies were unintended. Researchers also found that, on average, women had 2.2 abortions during their lives (PRB, Measure Communication, 2003). Survey respondents from Romania were equally divided as to whether reproductive-health services have improved in their country since ICPD. Those who felt that services have improved pointed to increased numbers of trained providers in abortion care and the expanded availability of modern contraceptive methods.

First-trimester abortion on request was legalized in Romania in 1990 following decades of draconian restrictions, including extremely limited availability of safe abortion services. "The Ministry of Health cannot ignore the fact that Romania has a maternal-mortality rate that places it second in Eastern and Central Europe, although it has decreased significantly. If we compare to '89, then we can say the situation has improved considerably. But we should no longer compare, but rather think that even if five young women die because of a legal or illegal abortion in the 21st century, then the Ministry of Health is bound to take targeted action to address this issue, especially when these deaths are due to abortions performed in clinics." - respondent from Romania

Changes in abortion-related mortality in Romania

---

access to contraception or abortion and the invasive monitoring of women’s pregnancies (Hord et al., 1991; Johnson, et al., 1993; Kligman, 1998). Following the legalization of abortion, abortion rates increased to three abortions for every live birth, but maternal deaths dropped precipitously and immediately from 1990-1992. Abortion rates have since declined, correlating with the increased availability and use of contraceptive methods (IPPF, Romania country profile). The most recent report from the Ministry of Health shows that the maternal-mortality rate due to abortion has decreased from 149 deaths per 100,000 women of reproductive age in 1989 to 9 deaths per 100,000 women in 2002 (Horga, 2003).

The Penal Code now permits a pregnant woman to obtain an abortion on request during the first 12 weeks of pregnancy. After the first trimester, an abortion may be performed if it is necessary for therapeutic reasons. Although the law does not define the term “therapeutic reasons,” the 2003 Standards and Practice Recommendations for Performing Elective Pregnancy Termination provides guidance in this area. An abortion may be performed at any time during pregnancy if necessary to save the pregnant woman’s life, health or bodily integrity from serious danger that is imminent and cannot be prevented by any other means. An abortion must be carried out by a gynecologist in an authorized medical institution.

A strategic assessment of abortion and contraception in Romania conducted by the Romanian Ministry of Health and Family, local partner institutions, the WHO and Ipas in 2001 confirmed that, despite improved indicators of abortion rates and contraceptive use, there are still many unresolved issues related to the availability, access and quality of abortion and contraceptive services. Ob/Gyn units, private abortion clinics and family-planning clinics are located almost exclusively in urban areas, significantly limiting access to those services for women who live in rural areas. This limited physical access, combined with financial hardship, has contributed to a relatively high number of illegal and unsafe abortions among rural women.
The strategic assessment also revealed that sometimes abortion was provided under minimal standards of care, even in tertiary-level hospitals. Sharp curettage, an outdated method according to the WHO, was the most widely used method (used in more than 50% of all cases) for abortion on request up to 12 weeks of gestation, in both public and private facilities. Abortion was also sometimes performed in inappropriate spaces without adequate pain management and infection-prevention measures.

There are very few, if any, links between abortion and contraceptive services. The assessment found that availability and access to contraceptive services is also limited by the fact that such services are not provided by family doctors at the primary-care level (WHO, 2002). Contraceptive methods and services are provided free of charge at government facilities, but costs can be prohibitive in the private sector and when women have to pay to travel to urban settings to obtain services.

### Reproductive-health indicators: 1995-2000 ***

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Births</td>
<td>1,425,349</td>
</tr>
<tr>
<td>Abortions</td>
<td>2,357,152</td>
</tr>
<tr>
<td>Maternal deaths</td>
<td>855</td>
</tr>
<tr>
<td>Maternal abortion-related deaths</td>
<td>214</td>
</tr>
<tr>
<td>Unintended pregnancies</td>
<td>2,741,996</td>
</tr>
<tr>
<td>Unintended births</td>
<td>384,844</td>
</tr>
</tbody>
</table>

* PRB, 2003  
** UNDP, Human Development Indicators, 2003  
*** Global Health Council, 2002  
See Notes for definitions.
Slovakia formed in 1993 after the Czechs and the Slovaks separated into two states following 75 years of functioning as the nation state of Czechoslovakia. The IPPF reports that since 1990 abortion rates have more than halved in Slovakia while the use of oral contraceptives has increased five-fold. Abortion services are provided free of charge (IPPF, Slovak Republic country profile). Respondents report that the country’s increased availability of contraceptive services has been a major factor in Slovakia’s lowered abortion rates, although survey respondents describe contraceptive services as still limited either because of cost or method choice. Sterilization is restricted under Slovakian law.

Slovakia has permitted access to abortion through the first trimester since 1986. Vacuum aspiration is available but the registration of the drugs required for medical abortion has not yet been obtained and is currently under debate by the Constitutional Court. Survey respondents expressed the opinion that while the range of abortion methods has remained the same since ICPD, the number of abortion providers has decreased as a result of pressure from the Roman Catholic Church.

Under the Law on Abortion, a pregnant woman may obtain an abortion on request during the 20 weeks of pregnancy. The law requires a waiting period of at least 24 hours and the establishment of a financial responsibility of the father. "Under the cover of ‘protection of life and moral revival of society,’ [conservative political forces led by the Christian Democratic Movement (KDH)] try to enforce their views on abortion on all Slovak society and do not hide their goal to ban artificial abortion, regardless of the views of those most affected — women themselves.” - respondent from Slovakia

### Population indicators: *

- **Population:** 5.4 million
- **Population growth rate:** 0.0%
- **Infant mortality rate:** 6.2 deaths per 1,000 live births
- **Fertility rate:** 1.2 children per woman
- **Contraceptive prevalence rate, all methods (% of married women 15-49):** 74%

### Socio-economic indicators: **

- **Percentage of total population under age 15, 2001:** 19%
- **Gross domestic product (GDP) per capita, 2001:** US $11,960
- **Public expenditure on health (as % of GDP), 2000:** 5.2%
- **Women in government at ministerial level (as % of total), 2000:** 19%
first trimester of pregnancy provided there are no medical contraindications. After 12 weeks, an abortion may be performed if the woman’s life or health or the healthy development of the fetus are endangered, or if fetal development manifests genetic anomalies.

Despite this broad framework, there are several limitations to the law. A physician in a health establishment designated by the pregnant woman’s gynecologist must perform the abortion, eliminating the possibility of authorizing other health professionals to carry out the procedure. Before she can obtain an abortion, a pregnant woman must be informed of the possible health consequences of abortion and be instructed on the use of contraceptive methods. Mandatory information of this sort can be biased and coercive. A woman under the age of 16 must have the consent of her legal representative or of the person who has been assigned responsibility for her upbringing, thus creating challenges for those young women who do not feel they can involve their parent or guardian. If the woman is between the ages of 16 and 18, her legal representative must be notified. If a woman’s physician denies her request for an abortion after the 12th week of pregnancy, she may appeal the decision to a committee of three physicians.

An amendment to the abortion law that would allow women to have an abortion up to 24 weeks in the case of fetal impairment has been presented to the Slovak National Parliament. Although this was already the common practice through a regulation enacted by the Ministry of Health, this exception had not been included in the abortion law. This proposed expansion of abortion access resulted in strong opposition from the conservative Christian Democrats and from the Church, which pressured members of parliament and the president of Slovakia to prevent the law from coming into effect. The amendment has not yet been passed.

The Church has also been involved in pushing adoption of a treaty between the government and the Holy See that would allow judges to refuse to grant divorces and health professionals to refuse to carry out abortions because of their religious beliefs. Under the terms of the treaty, health-care providers would be able to refuse to conduct abortions or prescribe contraception, and teachers could refuse to teach sex education. The Justice Ministry considers the treaty to have the status of an international treaty, thus requiring parliamentary approval. Such approval has not yet been obtained.
By 1992 Albania had broken free of 46 years of Communist rule and created a multi-party democracy. Health care began to improve for Albania’s women and, soon after the founding of the Albanian Family Planning Association in 1992, the Ministry of Health (MOH) began working to expand family-planning services. Some of the work of the MOH included integrating family-planning services into women’s and maternity centers.

At present, reproductive-health care in Albania includes access to first-trimester abortion upon request. Between the 12th and 22nd weeks of pregnancy an abortion may be carried out in cases of pregnancy resulting from rape or other sexual offenses, and for social reasons, which the law leaves unspecified. An abortion may be performed at any time during pregnancy in cases of risk to the life or health of the pregnant woman and in cases of fetal deformity or handicap. A commission of three specialists — including a physician, a social worker and a lawyer — must approve abortions performed between the 12th and 22nd weeks of pregnancy. Abortions performed for medical reasons or in cases of fetal deformity or handicap must be approved by a commission of three physicians.

Although abortion rates are decreasing due to the increased use of contraceptives, abortion

---

**Albanian Statistics**

**Population indicators:**

Population: 3.1 million

Population growth rate: 1.1%

Infant mortality rate: 12 deaths per 1,000 live births

Fertility rate: 2 children per woman

**Socio-economic indicators:**

Percentage of total population under age 15, 2001: 29%

Gross domestic product (GDP) per capita, 2001: US $3,680

Public expenditure on health (as % of GDP), 2000: 2.1%

Women in government at ministerial level (as % of total), 2000: 15%

Physicians (per 100,000 people), 1990-2002: 133

---

“Abortion is performed in both public and private facilities, but when talking about the private sector, providers perceive the procedure as an income-generation procedure and they are not very much in favor of counseling and pre- or post-abortion care.” - respondent from Albania
still represents the main method of fertility control in Albania. Over the past several years, abortion provision has increasingly shifted from public hospital settings to private care settings. This shift has been accompanied by an underreporting of abortion procedures. While electric vacuum aspiration is the standard procedure in the greatest number of hospitals, sharp curettage is still used in some public facilities and in most private ones. The link between abortion and postabortion contraception is still weak, because ob-gyn doctors see abortion as an income-generating procedure and are not necessarily interested in providing contraception to their abortion patients. Recently there have been efforts to improve the quality of abortion services and increase postabortion contraception, as well as efforts to provide family-planning services at the primary-care level by training family physicians. However, these efforts have yet to become national in scope.

Men and women can gain access to non-prescription contraceptives at pharmacies at regulated prices. The IPPF states that Albania’s movement towards democracy has improved family planning in the country and has led to an increase in contraceptive use and reductions in maternal and infant mortality rates. (IPPF, Albania country profile).

Respondents from Albania felt that while access to care is more limited for women residing outside urban areas, Albanian families in general have broader access to various family-planning methods, including emergency contraception, since ICPD. As with other surveyed countries, respondents were split on whether contraceptive services are affordable to the average household.

---

**Socio-economic indicators: **

Health expenditure per capita, 2000: US $129

**Reproductive-health indicators: 1995-2000***

Number of women aged 15-44: 812,975
Contraceptive prevalence rate, all methods (% of women 15-49): 58
Pregnancies: 646,546
Births: 416,887
 Abortions: 132,677
Maternal deaths: 129
Maternal abortion-related deaths: 4
Unintended pregnancies: 195,211
Unintended births: 62,533

---

* PRB, 2003
** UNDP, Human Development Indicators, 2003
*** Global Health Council, 2002
See Notes for definitions.
The Unfinished Agenda

While access to contraceptive information and services has clearly increased in much of Eastern and Central Europe over the past decade and abortion remains widely available except in Poland, there is much still to do to ensure that women have access to the high-quality information and services they need to manage their own fertility. The ICPD conference came on the heels of massive political and social changes in the region, and certainly underscored the importance of prioritizing reproductive health and rights as a key element in development. Yet it is clear from this modest analysis that NGOs and governments can and must make changes in order to fully implement the ICPD recommendations from paragraphs 8.25 and 63iii.

Priority actions through which governments and NGOs can fulfill the commitments of ICPD regarding reproductive health and abortion include the following:

Access to care, training and public awareness

- Increase affordability, accessibility and types of modern contraceptive methods, including emergency contraception.
- Ensure that the safest methods of abortion are used, according to the most recent WHO recommendations.
- Register and approve drugs needed for medical abortion.
- Develop or update standards and guidelines for the provision of abortion care and contraceptive services.
- Expand access to reproductive-health services, including contraception and abortion, beyond urban centers by offering these services at the primary-care level.
- Incorporate training in comprehensive reproductive-health care, particularly abortion services, into pre-service programs for a wide range of health professionals and into refresher training for current providers.
- Educate the public regarding where they can access contraceptive and abortion services and on the services and methods available to them.

Advocacy for policy change

- Identify new models for delivering reproductive-health services, including abortion, within the region’s economic systems so that all women, regardless of their socio-economic status, have access to high-quality care and the means to manage their fertility.
- Organize NGOs to counteract conservative forces that are attempting to curtail women’s access to family planning and abortion care, including conservative arguments that link low fertility rates with the use of contraception and legal abortion.
- Encourage governments to avoid pro-natalist policies that could impede women’s access to family-planning and abortion services.
- Overturn the restrictive abortion law in Poland and make modern contraceptives widely available.
Reproductive health is a critical part of every woman’s life, and access to modern contraception and safe abortion is the cornerstone of each woman’s ability to make her own fertility decisions. ICPD’s recognition of the importance of making legal abortion safe and of addressing unsafe abortion as a major public-health problem were vital first steps in highlighting the importance of this issue. At this significant juncture in the region’s development, Eastern and Central European countries must revisit their commitment to women’s rights and health and rededicate efforts to ensuring that all women can fully exercise their right to decide whether and when to have a child. Until women’s sexual and reproductive rights are truly fulfilled, they will be unable to fully exercise their basic human rights.
Notes

1. Unsafe abortion is defined by the World Health Organization as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards or both (WHO, 1992).

2. Reported abortion rates vary based on the source and how the data are compiled. For example, according to the Romanian Reproductive Health Survey conducted jointly by a number of Romanian agencies, the Centers for Disease Control and Prevention in the U.S., USAID, the United Nations Population Fund (UNFPA), and Unicef, the abortion rate per 1,000 women aged 15-44 between 1996-1999 was 74, while the background paper for a strategic assessment conducted by the Ministry of Health in partnership with WHO, a number of Romanian government and NGO agencies, and Ipas in 2000 reported an abortion rate of 45 per 1,000 women. The official government rate for 1996-1998 is quoted as 62/1,000.

Statistical Definitions

**Abortions:** Calculated from abortion rate and number of women aged 15-44.

**Births:** Calculated from population and birth rate.

**Fertility rate:** Average number of children born to a woman during her lifetime.

**Health expenditure per capita:** The sum of public and private expenditure, divided by the population. Health expenditure includes the provision of health services (preventive and curative), family planning activities, nutrition activities and emergency aid designated for health, but excludes the provision of water and sanitation.

**Maternal Abortion-Related Deaths:** Calculated from births and unsafe abortion mortality ratio per 100,000 live births.

**Maternal Deaths:** Calculated from births and maternal mortality ratio (MMR).

**Maternal mortality ratio reported (per 100,000 live births):** The annual number of deaths of women from pregnancy-related causes per 100,000 live births.

**Physicians (per 100,000 people):** Includes graduates of a faculty or school of medicine who are working in any medical field (including teaching, research and practice).

**Population:** As of mid-2003.

**Population growth rate:** The birth rate minus the death rate, implying the annual rate of population growth without regard for migration.

**Pregnancies:** Abortions + fetal wastage + births.

**Public expenditure on health (as % of GDP):** Current and capital spending from government (central and local) budgets, external borrowings and grants (including donations from international agencies and non-governmental organizations) and social (or compulsory) health insurance funds. Together with private health expenditure, it makes up total health expenditure.

**Unintended Births:** Births x percentage of unintended births.

**Unintended Pregnancies:** Unintended births + abortions.
Sources


