Health Status of Women in CEE and the NIS

The rapid political, economic and social changes occurring in the countries of central and eastern Europe (CEE) and the new independent states (NIS) of the former USSR have created conditions that fundamentally affect the population. These changes have lead to social and economic hardship and, in some cases, to war. The result is a widening gap in health between the eastern and western halves of Europe, a serious inequity. A closer look at CEE and the NIS reveals that while women bear more of the burdens imposed by change, they also comprise an invaluable, largely untapped resource for improving their communities and their health.

It must be emphasized that the information available on women's health is quite limited. In the past, the collection of gender-specific data was uncommon globally. Only in recent times have the fundamental differences in the health of men and women been formally recognized. Further, a great deal of the available data is uncertain. Not only do the systems of data collection vary greatly in quality and comprehensiveness, the types of data collected and the methods of analysis are often quite limited.

Most of the diseases that are major threats to the health of populations in CEE and the NIS develop over long periods of time. Causal factors interact with other influences in complex ways. Many health problems are related to the life situation, to conditions of work and to patterns of behavior, all of which tend to vary in gender-specific ways.

Life Expectancy

Data comparing life expectancy at birth provide an overview of differences in survival for the female population of CEE and the NIS in relation to European Union (EU) averages. In 1993, the average life expectancy for women in the NIS was six years less than the average for women in the EU. The difference for women in CEE was five years. Within CEE and the NIS, there is a seven-year average difference between the countries with the lowest and highest figures, from 69.3 years in Turkmenistan to 76.5 years in the Republic of Georgia.

In the 1980s, life expectancy in CEE and the NIS showed a very gradual increase. But for most of the countries, life expectancy fell from 1990 to 1993. Life expectancy at birth in the Russian Federation decreased from 74.4 years to 72. Latvia fell from 74.5 to 73.3 years.

Cardiovascular Disease and Cancer

Diverging trends between CEE and the NIS and the rest of the region in the two main causes of overall mortality for males and females (cardiovascular disease and cancer under the age of 65) give rise to concern. Particularly worrisome are the death rates for cardiovascular disease for females. The lowest female rate in CEE and the NIS - Lithuania at 72.95 per 100,000 - is more than one and a half times the European average of 47 per 100,000 and more than twice the EU average. Subregional variations in cardiovascular mortality are particularly large - Turkmenistan has 165 deaths per 100,000 women, while Estonia has 81. While mortality from cardiovascular disease (mainly ischemic heart disease and cerebrovascular disease) in females has been decreasing since 1980 in western Europe, no progress was made in CEE and the NIS.

The gap in cancer mortality rates for females is less dramatic than that for cardiovascular diseases, but growing larger. CEE and the NIS have not enjoyed the consistent decline in mortality from cancer in females under 65 that has been found in other countries of the region since 1995.

The standardized death rate for female lung cancer in CEE is similar to the EU average of 6.48 deaths per 100,000 women under 65. As in the western countries of the region, the rate in CEE rose in the 1980s. Female lung cancer rates in the NIS, however, were low and stable, with 3 deaths per 100,000 in Tajikistan and 5 per 100,000 in Russia in 1991, possibly because of a lower smoking rate among women.

Mortality from cancer of the breast, in contrast to most other major causes of death among women, is lower in CEE and the NIS than the rest of the region. The EU average is 20 deaths per 100,000 women under 65, but the CEE average is 16 and the NIS average is 14.5. It appears, however, that breast cancer may more often reach an advanced stage before being detected. Estonia has reported that 30 to 40 percent of all new cases of breast cancer are advanced.

The rates for cervical cancer are among the highest in Europe: 7 per 100,000, compared with the EU average of 2.3. The NIS average is slightly lower than that of CEE. Cervical cancer is decreasing in the rest of Europe, mainly as a result of effective early detection and treatment.

Maternal Mortality

Maternal mortality rates in the NIS are about twice those in CEE and about four times the average for the region. Maternal mortality in Romania and Albania fell dramatically after the legalization of abortion in 1989. Nevertheless, abortion remains a major cause of maternal mortality in both countries.

In 1990, the maternal mortality rate in Tajikistan was 42 per 100,000 live births; two years later it leapt to 83. In Georgia, the rate rose from 20.5 in 1990 to 50 in 1992. A portion of the increases is probably due to better reporting systems, but real increases in maternal mortality arise from deteriorating socioeconomic conditions, limited access to safe and effective health services and other factors. Still, it is important to note that at the same time, several nations report decreases in maternal mortality, such as Kyrgyzstan, whose rate went from 73 in 1990 to 43 in 1994.

Only in Georgia, Kyrgyzstan and Kazakstan, where most birth-related deaths are due to hemorrhage, is abortion not the primary cause of female deaths associated with pregnancy and birth.

Family Planning

Because of the reliance on abortion, awareness of family planning alternatives remains quite limited. Although most countries report a growing interest in contraceptives, limited availability and cost remove them as viable options for many people. In a 1993 survey of St. Petersburg women, almost 34 percent said they use no contraception. A 1994 Centers for Disease Control study in Romania found that the most prevalent method of contraception is withdrawal (34 percent) followed by the calendar method (8 percent). Only 14.5 percent of the women studied used "modern contraception" such as birth control pills or intrauterine devices (IUDs).

Abortion remains the most frequently used means of family planning. In many CEE and NIS nations, the rate is as high as one abortion for each live birth. Data from 1992 show three abortions for each live birth in Romania. In St. Petersburg, the ratio rose from 2:1 in 1990 to 2.48:1 in 1992. Estonia's rate rose from 1.13:1 in 1990 to 1.5:1 in 1994. But in several Central Asian nations, the ratio of abortions to live births is dipping slightly: In Kyrgyzstan, the ratio dropped from .606:1 in 1990 to .588 in 1994. In Kazakstan, the ratio was .975:1 in 1990 and .88:1 in 1994.

Lifestyles

Where information is available, the evidence shows that the prevalence of smoking is still far lower for women than for men. The relatively greater rates of death attributed to smoking among men as compared to women reflect the usually lower smoking prevalence among women. In Albania for example, 7 percent of women smoke, whereas 50 percent of men smoke. In Belarus, 37 percent of deaths of males ages 35 to 69 are attributed to smoking; only 1 percent of women in that age group died of causes related to smoking. However, it is feared that the targeting of young people, particularly young women, in tobacco advertising will lead to higher smoking rates among women.

While little is known about the rate of consumption of alcohol, the information available suggests that proportions of documented cases of alcoholism are far smaller for women than for men. Alcohol-related violence against women is increasing.

In contrast to the relatively well-documented incidence of other forms of violence, violence against women is often hidden. Domestic violence and rape are increasing in CEE and NIS. One country reporting an increase in the incidence of rape estimated that 80 to 90 percent occurred while the perpetrators were under the influence of alcohol. In the Czech Republic, a woman who is raped is held responsible for her assault. In Slovenia, police statistics show that in 99 percent of cases of violence involving women, the perpetrators are men. Violence in the form of "light physical injury" within the family is not defined as a criminal act.

Health Care System

Even though women constitute the majority of patients and have special needs, health services frequently do not respond adequately. Services developed specifically for women are essentially limited to reproductive needs, especially childbearing.

Although a large majority of physicians are women, it appears, that they seldom have the power to determine the type of services provided or their organization. Women are seriously under-represented in leadership positions in the health sector. This may be a constraint to providing series that better meet the general needs of women.

The health needs of women cannot be separated from an understanding of their place in the social structure, and their access to the opportunities and resources that enable people to live health-enhancing lives. CEE and NIS must grapple with old problems and the new threats that have emerged.

Women in CEE and NIS have achieved high levels of education and integration into the workforce in comparison with women in other regions of the world. These achievements are threatened both by the economic crisis and by a transition process that thus far has not valued the achievements of women or built guarantees of equal opportunity into the development process. A view of women's health that covers the whole life span and recognized the multiple dimensions of human development and functioning must be used to form the health and social policy developed for women.

Excerpted from "Investing in Women's Health: Central and Eastern Europe," World Health Organization, 1995 and WHO's "1995 Highlights on Women's Health in Europe."