

# Adolescent and Young People SRHR Agenda Central and Eastern Europe Brief

## Introduction

Youth and adolescents aged 15-24 constitute almost 11% of the population, which means there are **over 30 million young people** in the region. Along with women, they remain the most affected by this situation and yet their needs and challenges are not understood, recognised and addressed – young people disappear somewhere in the wider group of citizens. This brief is going to present the **interlinked and cumulative barriers** youth and adolescents experience in accessing basic sexual and reproductive health services and in exercising their sexual and reproductive rights.

ICPD Programme of Action calls for the promotion “to the fullest extent” of the health of young people and provision of services that are of good quality and sensitive to their needs and “safeguarding the rights of adolescents to privacy, confidentiality, respect and informed consent”. However, the process of its implementation in Central and Eastern Europe remains far from finished.

In year of the 20<sup>th</sup> anniversary of Programme of Action, taking into account findings from the review processes and PoA's broad mandate on interrelationships between population, sustained economic growth and sustainable development, economic status and empowerment of women, it is now time to reflect and adjust it to the current global reality. **It is time to recognize and guarantee the full package of sexual and reproductive health and rights, with particular focus on young people, as fundamental part of the reaffirmed and expanded Programme of Action and post-2015 agenda.**

Developed by ASTRA Youth  
in cooperation with ARROW



<sup>1</sup> ICPD Programme of Action, paragraphs 6.7(a), 6.7(b), 6.15, 7.45

## Context

Locating Central and Eastern Europe (CEE) somewhere between Global North and Global South might at first appear as a surprise. However, this brief proves that the situation remains far from Western reality. The **political and economic transformation** took place over 20 years ago. The progress has been uneven with **some sectors left far behind** and the Soviet heritage is still visible. The region incorporates some European Union member states, countries that aspire to join the EU and countries that are none of the above, and the vast disparities within Central and Eastern Europe and among different social groups within the individual countries result in such **diversity and complexity** of this part of the world.

The region has experienced a **growing wave of radicalisation**. Catholic, Orthodox and Muslim religious leaders engage deeply in political discussions. They powerfully affect the public discourse and have a **strong influence on the decision-makers**. As a result, this is reflected in a **heavy backlash** throughout the region, especially regarding state policies concerning gender equality and sexual and reproductive health and rights of women and young people. The gap of growing socioeconomic inequalities, widespread stigma and discrimination, consequences of financial crisis from 2008, the **withdrawal of major donors** and **lack of political will** to change this picture add into the challenges. Yet CEE (sometimes even referred to as a “Non-Region”) somehow disappeared from the world’s view, which lead to marginalization of the region’s struggles in the global agenda.

## Lack of comprehensive sexuality education (CSE)

Lack of comprehensive sexuality education is the most burning issue for young people in Eastern Europe. Sexuality remains a taboo and the decision-makers, under the powerful pressure of the religious institutions, treat sexuality education not as gaining crucial knowledge and life skills, but as sensitive issue and prefer the families to take care of it. **Inadequate or non-existing sexuality education programmes** along with the lack of time, knowledge and ability of parents, carers, teachers and healthcare practitioners to provide the necessary information leave the burden of filling this gap on the few volunteer groups and NGO initiatives whose capacities and outreach are limited.

This **denial of the basic right** to understand and thus control one’s own fertility has numerous consequences for young people. They are left alone to struggle with the increasing pressure regarding sex along with conflicting norms and widespread misconceptions, fears, discrimination and gender stereotypes. Additionally the lack of youth-friendly sources of reliable information on matters of sexuality, protection from sexually transmitted infections and sexual violence prevention often results in unwanted parenthood and causes intersectional discrimination. Young people are not able to prevent unwanted pregnancies, plan to provide for their families or themselves, reduce the risks of work or school dropout or protect themselves from

**Table 1: Sexuality Education component in the school curriculum**

Country	Term used	Age at which SE officially begins	Minimum standards for SE	Voluntary organisations involved	Is the SE curriculum comprehensive according to WHO standards?	Staff
Armenia	Healthy Lifestyle	13	Yes	N/A	N/A	Q
Azerbaijan	Life Skills	6	Yes	Yes	N/A	Q
Bulgaria	Sexuality Education	11	No	Yes	No	N/A
Croatia	Health Education (suspended due to the pressure of the Church)	9	N/A	Yes	No	N/A
Georgia	Integrated in biology subject of reproductive health issues and importance of healthy life style	12	No	Yes	N/A	N/A
Hungary	Education for Family Life	7	No	Yes	No	Q
Poland	Preparation for Family Life	12	Yes	Yes	No	Q
Russian Federation	Integrated in biology subject and Basics of Life Safety	7	Yes (integrated in specific subjects)	Yes	N/A	N/A
Romania	Education for Health	7	No	No	No	Q
Ukraine	Basics of Health (+ other selective subjects)	7	Yes (as a part of general standards of education)	Yes	No	Q

Source: WHO, UNESCO, IPPF  
Q - questionable

sexually transmitted infections, including HIV. Unintended pregnancies may lead to gaps in education and drastically increase the risk of poverty, often accompanied by stigma and social exclusion. In far too many cases they also lead to unsafe abortions that threaten girls' and young women's health and life. The suffering of young people from vulnerable groups is even more dramatic. **This reality and its harmful consequences are preventable to a large extent.**

**Comprehensive sexuality education is recognised by the UN Treaty Bodies as having a valuable role in realising the right to education, health, equality and non-discrimination. Limiting access to or allowing for withdrawal from CSE classes undermines full realisation of these human rights.**

*UNESCO International Technical Guidance on Sexuality Education* recognises that withholding information about safe and healthy expressions of sexuality makes children and young people potentially vulnerable to coercion, abuse and exploitation, unintended pregnancy and sexually transmitted infections (STIs), including HIV<sup>2</sup>. This key document aims to assist States in implementing comprehensive sexuality education programmes at the national level. Additionally, *WHO Standards for Sexuality Education in Europe. A framework for policy-makers, educational and health authorities and specialists*<sup>3</sup> are available. The WHO Standards were developed in order to provide step-by-step instructions and a detailed matrix to support health and education professionals in their efforts to guarantee children accurate and sensitively presented information about sexuality. In spite of availability of guidelines and assistance, the countries failed at their implementation.

The table 1 presents the existing programmes and describes the situation in ten countries of the region, regarding the WHO standards. Armenia and Ukraine are among the countries which have a strongly incorporated sexuality education component in their school curriculum. However, these programmes are mostly influenced by the HIV prevention agenda. In Croatia sexuality education was introduced, but due to the pressing influence of the Church the law was eventually withdrawn. In Georgia until 2009 the funding was available exclusively to abstinence-only curriculum – recently the number of evidence-based programmes has increased but they remain a minority. The sexuality component in Poland is strongly influenced by the Catholic Church which condemns any use of contraception and non-marital sex and imposes traditional gender roles and stereotypes. Bulgaria has failed to implement already developed educational programmes into the school curriculum.

<sup>2</sup> International Technical Guidance on Sexuality Education. An evidence-informed approach for schools, teachers and health educators. UNESCO in collaboration with WHO, UNAIDS Secretariat, UNFPA and UNICEF. Paris, December 2009.

<sup>3</sup> Standards for sexuality education in Europe – A framework for policy makers, educational and health authorities and specialists. WHO Regional Office for Europe in cooperation with the Federal Centre for Health Education (BZgA), 2010.

The **lack of comprehensive sexuality education is the most burning issue of the region** and is closely related to other challenges of the region's young people such as adolescent pregnancy rates and high HIV/AIDS prevalence among them.

On 22 January 2014 Azerbaijani LGBT right activist Isa Shakhmarli was found dead. He committed suicide by hanging, using a rainbow flag. In his last message to the world that he posted on his Facebook page, Isa, whose name meant Jesus in Arabic, said: *„This world is not strong enough to bear my colours. Farewell. I am leaving. Forgive me for everything. This country and this world are not for me. You are all guilty for my death. This world cannot handle my true colours. Goodbye.“*

Isa was the chairman of Azad (Free) LGBT, the first group in the country to encourage lesbian, gay, bisexual, and transgender Azerbaijanis to openly acknowledge their sexual orientation and advocate for their rights. Homosexuality remains stigmatized in Azerbaijan. Shakhmarli's family condemned the fact that he was gay. Homosexuality was decriminalized only in 2001, yet the oppression and harassment of LGBT people in the Muslim society remains widespread. There are no legal provisions for same-sex unions and no laws protecting LGBT citizens from discrimination. Hate crimes or hate speech are not recognized as legal concepts, and no data on pervasive violence against LGBT people have been collected as it is not considered an issue. Sadly, assaults, humiliation, life threats, unfair job losses, social ostracism, rejection by the family and even forced heterosexual marriages are not uncommon. Gay and lesbians, particularly youth and adolescents suffer heavily from various forms of violence on a daily basis.

## Contraceptive use among adolescents and young people

Young people face multiple challenges in accessing modern contraception, even in EU countries such as Bulgaria, Hungary, Poland and Romania. Structural, legal, social, economic and other barriers make it hardly possible for the region's youth and adolescents to effectively protect themselves from unwanted pregnancies and sexually transmitted infections including HIV. High cost of modern contraceptives and lack of subsidies from health insurance systems along with age restrictions and/or requiring parental consent for obtaining prescription are the key factors that extremely limit young people's effective access to pregnancy prevention methods. In countries such as Poland the misuse of conscientious objection by doctors and pharmacists further obstructs access to modern contraceptives, including emergency contraception. Throughout the region, lack of sexuality education pushes young people to turn to alternative, often unreliable sources of information like the Internet and their peers. Apart from modern contraception being unachievable out-of-pocket expense for young people, widespread misinformation, stereotypes and lack of knowledge (regarding health professionals as well) also contribute towards low contraceptive use. In the Caucasus lack of gender equality is an additional determining factor, particularly in relationships in which women experience difficulties with negotiating condom use with their partners.

**There is a pressing need for research on young people's and adolescents' contraceptive use in Eastern Europe.** The data available is very scarce and incomplete, making it almost impossible to provide a bigger and more comprehensive picture.

## Adolescent pregnancies

The ICPD PoA calls for reduction in adolescent pregnancies. Reasons for early pregnancies vary across the region and follow two unique trends: where pregnancies occur within marriage and the other being a marker for early sexual debut. The adolescent birth rates remain high throughout the region, averaging 23.4 births per 1000 girls aged 15-19.

The largest numbers of adolescent pregnancies are observed in the Caucasus countries of Georgia and Azerbaijan (the only country in the region where the numbers have remained stagnant over the years) and Bulgaria – with the rates of 48, 40 and 37 births per 1,000 women aged 15-19 respectively. Also in Armenia, Romania, Russian Federation and Ukraine the number of adolescent pregnancies are high and above the regional average. Cumulatively, lack of CSE in schools

and multiple barriers in accessing modern and effective contraceptives described earlier contribute heavily towards this phenomenon.

## Access to abortion information and services among adolescents and young women

Abortion rates remain high in Eastern Europe compared to the western part of the continent. According to the Guttmacher Institute, **Eastern Europe has the highest subregional abortion rate in the world.** The annual regional estimate of unsafe abortion is 360,000 and even though 30% of all pregnancies in Europe are terminated with abortions, a higher proportion of abortion procedures occur in Eastern Europe. Poland leads in the number of unsafe abortions due to the criminalization of the procedure.

Liberal abortion laws remain in place in almost all countries of Eastern Europe and these recognize a woman's right to abortion without restrictions up to 12 weeks of pregnancy. The striking exception is Poland where the law criminalises abortion unless the woman's life is in danger, the foetus incurably deformed or the pregnancy resulted from criminal fact. Poland has **one of the most restrictive abortion regulations** in Europe and even within the legal framework, access to abortion services is difficult. As a result, many women are forced to rely on underground abortion services or travel to get the procedure in other countries. According to the recent survey, more than every fourth woman in Poland terminated pregnancy within her lifetime. Despite liberal grounds on which abortion is permitted in other countries in the region, women face significant barriers in accessing safe abortion services. Due to lack of gender equality, the phenomenon of sex-selective abortions can be observed in countries like Azerbaijan and Armenia. However, the lack of available and well disaggregated data regarding the rates of youth and adolescent abortions, originating from the inconsistency of methodological approaches towards data collection, makes it very difficult to describe in detail current developments.

Adolescents experience even greater challenges in accessing abortion services, among which are age restrictions and/or regulations requiring young girls to have parental consent for the procedure prior performing it. This is generally the case for all countries of Eastern Europe. Additionally, in many states termination of pregnancy is also a huge out-of-pocket expense for young people. If this wasn't enough, in recent years the initiatives to restrict access to safe abortion were conducted in many states, including Azerbaijan, Bulgaria, Hungary, Ukraine, Russian Federation, Macedonia, Lithuania and Poland.

## HIV/AIDS

Unemployment, poverty, lack of sexuality education and increased substance use, especially among adolescents and young people, contribute to the spread of HIV/AIDS.

Eastern Europe is one of two regions in the world where the incidence of new HIV infections is on the rise – despite the fact that until 10 years ago the HIV rate was almost nonexistent. However, the number of people living with HIV has almost tripled since 2000 and reached an estimated 1,4 million in 2009 (1.3 million - 1.6 million with the incidence rate below 0,1). New infections in Ukraine and Russian Federation constitute 90% of new infections in the region. HIV positive youth and adolescents account for around 0,1% in Armenia, Azerbaijan, Bulgaria, Croatia, Georgia, Hungary, Poland and Romania. However, in the Russian Federation and Ukraine the rates are 0,5% among young women and 0,4% among young men, with the upper estimates of 0,7% and 0,5% respectively. This constitutes an **alarming sign of an upcoming epidemic**, if nothing changes.

Feminisation of the HIV epidemic is yet another regional characteristic, with the proportion of women living with HIV growing rapidly. By 2009 women represented 45% of people living with HIV in Ukraine when in 1999 the number was estimated at 37%.

## Homophobia and transphobia

The recognition of diverse sexual and gender identities and expressions is still problematic in the region, and homophobia and transphobia starts as early as primary school. In society and in public discourse, homophobia and transphobia are generally accepted and common, therefore there is a need for promoting tolerance towards LGBTQI communities including young people.

References to „traditional values” to justify homophobic and transphobic actions as well as support of patriarchal values and stereotypical gender patterns of behaviour are widely used in the media and reinforced at the political level all over the region. This has a negative impact on the lives and everyday experience of LGBTQI youth in the region. Additionally, instead of promoting diversity, fake and/or biased sexuality education classes replicate harmful stereotypes and misinformation, what puts LGBTQI youth at greater risk of experiencing violence.

**Table 2: Grounds on which abortion is permitted under 12 weeks of pregnancy**

Country	To save woman's life	To preserve physical health	To preserve mental health	Rape or incest	Foetal impairment	Economic or social reasons	On request
Armenia	+	+	+	+	+	+	+
Azerbaijan	+	+	+	+	+	+	+
Bulgaria	+	+	+	+	+	+	+
Croatia	+	+	+	+	+	+	+
Georgia	+	+	+	+	+	+	+
Hungary	+	+	+	+	+	+	+
Poland	+	+	+	+	+	-	-
Russian Federation	+	+	+	+	+	+	+
Romania	+	+	+	+	+	+	+
Ukraine	+	+	+	+	+	+	+

Source: *World Abortions Policies. United Nations Department of Economic and Social Affairs Population Division*

P was a 14-year old girl living in Lublin, her hometown, going to school, thinking of going to the university. Her life changed when she was raped by a classmate. She reported it to the police with her mother S the next day and was referred to a health clinic for an examination. Despite her youth and the fact that she was raped, she was not provided with emergency contraception. When few weeks later P found out she was pregnant, after careful consideration and with the support from her mother, she decided to terminate pregnancy. **Neither P nor her mother could have ever imagined what came later.**

Although P qualified for a legal abortion under restrictive Polish law, her access to the procedure was severely obstructed. She experienced a continuous harassment and denial of timely and professional medical attention, facing cumulative barriers in accessing the basic health service she was entitled to.

After interrogation by the Family District Court, P obtained certificate confirming that her pregnancy resulted from unlawful sexual intercourse, required in order to undergo the legal termination, but without any information on how to proceed. P and her mother S visited three different hospitals, receiving deliberately distorted information about the requirements for obtaining an abortion. They were told that a medical referral was necessary and that only a few specialists could provide it. However, all these specialists refused to do so. At one of the hospitals P and her mother were told that P needed a priest, not an abortion, and facilitated an unrequested meeting between P and a Catholic priest. P's confidential personal and medical information had been disclosed to the priest, hospital staff and the press without her consent. Desperate, P and her mother travelled to Warsaw to seek support of the Federation for Women and Family Planning.

Although P did receive a referral, the doctor who was to perform the abortion expressed reservations when the priest and other anti-choice activists contacted the hospital in Warsaw where he worked, falsely claiming that P was being coerced by her mother and did not want an abortion. The priest organised a group of people who were praying in front of the hospital, who stalked P and repeatedly tried to convince her not to terminate the pregnancy. Her name and address leaked to the media and the case became public in the whole country. Hospital staff, the priest and anti-choice groups tried to manipulate the relationship between P and S, in order to force P not to have the abortion.

After leaving the hospital, P and her mother were again harassed by anti-choice activists and sought police protection. The Warsaw police responded by interrogating them for over six hours. State authorities removed P from her mother's custody and detained her in a juvenile centre for a week. P's mobile phone was taken away, she was locked in a room, and was not provided with timely medical treatment when she suffered from severe pains and bleeding. Eight hours after she first complained, she was finally taken to the hospital for treatment, where she again faced harassment by journalists and anti-choice activists.

Weeks after the rape occurred, and only a few days before the 12 week cut off for abortions in cases of rape, the Ministry of Health intervened and P was able to get an abortion in a hospital 500 km away from her home. Although the abortion was legal, the hospital refused to register P as a patient and the abortion was conducted in a clandestine atmosphere. P was given anaesthesia without warning and was not given information about the procedure or post-abortion care. P was also told to leave the hospital immediately after the procedure. *The procedure was also not reported in the official data on number of legal abortions conducted that year.*

Unable to gain recognition of wrongdoing and receive an effective remedy in the Polish legal system, P and S, with the support of the Federation for Women and Family Planning and in cooperation with the Center for Reproductive Rights, filed an individual complaint before the European Court of Human Rights in May 2009.

**In case P and S versus Poland the Court stated the violations of articles 3, 5 and 8 of the European Convention of Human Rights, which are: Right to be Free from Torture and Cruel, Inhuman and Degrading Treatment (CIDT), Right to Liberty and Security and Right to Respect for Private and Family Life.** Among the most important issues highlighted by the Court were: Women legally entitled to abortion must be able to exercise their right and have effective access to the procedure. States must respect adolescents' personal autonomy in the sphere of reproductive health. There was no proper regard for P's vulnerability, young age and her own views and feelings. **Abuse and humiliation of adolescents within the reproductive health sector amounts to inhuman and degrading treatment.**

P moved to another city, where she is now studying. She welcomed the Court's decision with a great satisfaction but she wishes that nobody will ever have to go through what she and her mother experienced.

# Interlinked barriers in accessing health services for youth and adolescents

Young people experience multiple, interlinked and cumulative barriers in accessing health services: parental and/or spousal consent/age restrictions; lack of reliable information or confusing and harmful misinformation; lack of dedicated centres for young people and youth friendly services; administrative/procedural obstacles. Socioeconomic barriers and other challenges all form an overwhelming snowball effect. This already high vulnerability of youth and adolescents is further multiplied by interlinkages with other factors. Social marginalisation, stigma and discrimination on various grounds and lack of comprehensive sexuality education further limit access to evidence-based knowledge, key life skills and conscious decision-making processes. Migration and poverty to far extent exclude young people from the formal health system and the high out-of-pocket cost blocks their already narrow access to services. This results in increased inability of vulnerable young people to understand and control their own fertility and thus plan their lives, what puts them at greater risk of being trapped in dramatic spiral of poverty, stigma, social exclusion, school dropout, poor health and living conditions and further multilevel marginalisation.

## Recommendations

**We, adolescents and young people of Central and Eastern Europe and Balkan and Caucasus countries, call upon the governments to:**

1. Put young people at the centre of the future post-2015 development agenda.
2. Recognize that sexual and reproductive health and rights of youth and adolescents are a fundamental part of universal human rights package.
3. Fulfill the rights of adolescents and young people to universal access to a continuum of quality care and comprehensive sexual and reproductive health services, supplies and information, through all levels of healthcare, with particular focus on youth and adolescents from vulnerable groups, including but not limited to HIV positive, with disabilities, LGBTQI, migrants, out-of-school, outside the formal health system and other.
4. Provide mandatory, non-discriminatory, non-judgemental, rights-based, gender-sensitive health education including youth-friendly, evidence-based comprehensive sexuality education which meets WHO standards and is provided accordingly with evolving youth capacities, in formal and non-formal education system. CSE should be developed in partnership with young people and include information on sexual orientation and gender identities and expressions that is free from religious intolerance.
5. Provide, monitor and evaluate universal access to a basic package of youth-friendly health services (including mental health care and sexual and reproductive health services) that are high quality, integrated, equitable, comprehensive and affordable, needs and rights based, accessible, acceptable, confidential and free of stigma and discrimination for all young people. As part of this basic package governments must provide comprehensive sexual and reproductive health services that include safe and legal abortion, maternity care, contraception including emergency contraception, free of charge HIV and STI prevention, care, treatment, and counseling to all young people.
6. Remove obstacles and barriers in accessing sexual and reproductive health services, including requirements for parental and spousal notification, consent and age of consent, that infringe on the sexual and reproductive health and rights of adolescents and youth.
7. Ensure young women have effective and timely access to safe and legal abortion, pre and post-abortion services by decriminalizing abortion, creating and implementation of policies and programmes that remove mandatory waiting periods, requirements for parental and spousal notification, consent and/ or age of consent and all other legal barriers.
8. Ensure effective access to a wide range of family planning methods and information for youth and adolescents, including free of charge modern contraception and over-the-counter emergency contraception. Guarantee emergency contraception and HIV post-exposure prophylaxis (PEP) as a part of basic, free of charge care for sexual violence survivors.
9. Guarantee youth meaningful participation at all stages and at all levels of decision-making concerning youth and adolescents.
10. Address the impact of religious extremism on sexual and reproductive health and rights of women, young people, LGBTQI persons and other vulnerable groups by removing legal, policy and other barriers pertaining to young people's SRHR based in political and cultural conservatism.

### **Resources:**

Bali ICPD Global Youth Forum Declaration, 2012

Central and Eastern European Network for Sexual and Reproductive Health and Rights (ASTRA and ASTRA Youth). Reclaiming and Redefining Rights: Setting the Adolescent and Young People SRHR Agenda Beyond ICPD+20, 2012

Guttmacher Institute and World Health Organisation. Facts on Induced Abortion Worldwide. New York, 2012

ICPD Programme of Action

UNAIDS Report on the Global AIDS Epidemic, 2013

UNESCO in collaboration with WHO, UNAIDS Secretariat, UNFPA and UNICEF. International Technical Guidance on Sexuality Education. An evidence-informed approach for schools, teachers and health educators. Paris, 2009

United Nations Department of Economic and Social Affairs. World Population Prospects [Data File]. New York, 2012

United Nations Development Programme, Human Development Report 2013

United Nations, The Millennium Development Goals Report, New York 2012

United Nations, Millennium Development Goals Indicator Database

WHO Regional Office for Europe in cooperation with the Federal Centre for Health Education (BZgA). Standards for sexuality education in Europe – A framework for policy makers, educational and health authorities and specialists, 2010

World Health Organisation. Unsafe abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality, 6th edition, 2008



**This factsheet was prepared by ASTRA Youth**

ASTRA Youth - Network of young advocates for sexual and reproductive health and rights from Central and Eastern Europe (CEE) and Balkan countries

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