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Reproductive Health of the Population of Latvia

Evaluation and Recommendations

REPRODUCTIVE HEALTH IN LATVIA

EVALUATION AND RECOMMENDATIONS

Rīga
1998

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Latvia's development during the 1990s has been characterised by changes in societal attitudes and ways of thinking. People have experienced a sudden loss not only of guaranteed state jobs, but also of faith in themselves and a secure future – which undoubtedly has impacted the demographic situation in the country.

Between 1955 and 1968 demographers, along with health care system employees undertook extensive investigations into the research of fertility issues by surveying 23 thousand women. At the end of the 1980s demographers from the UN Economic Commission for Europe began a project comparing fertility and family development of European Union countries, with which the Centre for Demography of the University of Latvia became involved from 1994. In 1995, a family and fertility survey was conducted by the University's Centre for Demography in co-operation with the Central Statistical Bureau of Latvia.

In September 1994 at the International Conference on Population and Development (ICPD) in Cairo – which included Latvia among its 179 participating state delegations – new consensus was reached on the point that human development programmes must also be aimed at individual needs and rights. Special emphasis was placed on the status of women and the improvement of reproductive health, while also highlighting family planning.

In order to begin to address the ever mounting crisis situation in the reproductive health of the population, a strategy for reproductive heath must be developed. To do so, the actual situation in the country must first be evaluated and analysed, then followed by decisive plans for change.

I am very grateful to the United Nations Population Fund and to former United Nations Resident Coordinator in Latvia John Hendra personally for their significant contribution and investment, as a result of which the Ministry of Welfare/UNFPA technical cooperation project "Support to the Development of Reproductive Health Strategy in Latvia" came into being.

Vladimirs Makarovs
Minister of Welfare

At the International Conference on Population and Development (ICPD) held in Cairo in September 1994, delegates from all over the world - including Latvia - reaffirmed their commitment to provide information, resources and to independent policies to ensure that their populations could enjoy the highest quality of reproductive and sexual health possible. One of the most important elements was the development of an appropriate Government strategy to address these issues.

Now, almost three years later, countries all around the world are taking stock of what has been accomplished, what has been learned and what has fallen by the wayside since those days in Cairo. Undoubtedly, many changes have taken place in Latvia in the area of reproductive and sexual health since 1994. The amount of information available to the general public on questions such as contraception and the prevention of sexually transmitted diseases has certainly increased. Hot lines and counselling centres have started to appear around the country. Youth groups have become more active in peer education. Non-governmental organisations have acquired management and fund-raising skills to complement the Government in this challenging task.

Today, however, almost seven years after Latvia regained its independence, the demographic and reproductive health situation in Latvia has displayed signs of deterioration and decline. It is represented by the high rates of sexually transmitted diseases and unplanned pregnancies; unacceptable rates of infant and maternal mortality; increasingly reported incidences of sexual violence in the home and in the streets. It is no secret to any of us that much work still lies ahead.

The report "Reproductive Health of the Population of Latvia: Evaluation and Recommendations" is an outcome of the project "Support to the Development of Reproductive Health Strategy in Latvia" that was financed by the United Nations Population Fund (UNFPA). The project was developed in order to address the critical status of reproductive health in Latvia; to gain a better understanding

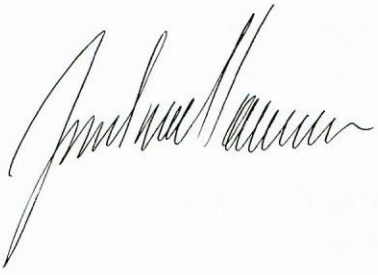
of the current situation; to gather, analyse and disseminate reliable data on the status of reproductive health in Latvia; and to develop solutions for adequately addressing these issues. UNFPA is very pleased with the opportunity to support this project and with the results achieved:

· the project has supported the contribution of non-governmental organisations and community-based organisations into assessment of health service needs;

· it has identified behaviours in reproductive health which are detrimental to good health; and

· it has prepared recommendations to the Government that would help to design a better strategy and target programmes for meeting the needs of the population.

I would like to acknowledge all the organisations, institutions and persons who contributed to various phases of the Report. Special thanks to all the participants and supporters of the National Working Group, to all who have dedicated their time, idea and efforts to create the report "Reproductive Health in Latvia: Evaluation and Recommendations".



Jan Sand Sorensen
United Nations Resident Coordinator in Latvia
UNDP/UNFPA Resident Representative in Latvia

"SUPPORT TO THE DEVELOPMENT OF REPRODUCTIVE HEALTH STRATEGY IN LATVIA" CONTRIBUTING AUTHORS

WORKING GROUP

Working Group Team Leader:

Laima Rudze, Deputy Director of Health Monitoring Division of the Medicine Department of the Ministry of Welfare

Working Group Participants:

Agnija Caunīte, Director of the Emergency Medicine Department of Riga Clinical Hospital; President of Latvia's Association of Obstetricians and Gynaecologists

Anitra Eiklone, Head of the Division of Youth Issues Education of the Department of Continuing of Education of the Ministry of Education and Science

Irēna Kondrāte, Head of Reproductive Health Division of the State Health Promotion Centre

Gunta Lazdāne, Lecturer at the Medical Academy of Latvia, Head of the Department of Obstetrics and Gynaecology; President of Latvia's Association for Family Planning and Sexual Health "Papardes Zieds"

Regīna Strautmane, Director of the State Family Health Centre

Daiga Štelmahere, Director of the Health Education Programme of the Environmental Science and Monitoring Study Centre of the University of Latvia; Vice-president of Latvia's Association of Family Planning and Sexual Health "Papardes Zieds"

Edvīns Vītoliņš, Senior Desk Officer of the Labour Resources and Labour Market Policy Division of the Labour Department of the Ministry of Welfare.

UNITED NATIONS DEVELOPMENT PROGRAMME (UNDP) TEAM:

Project Manager:

Mārtiņš Hildebrants, Programme Manager

Project Co-ordinator:

Agnese Štrodaha

Editor of the National Report "Reproductive Health of the Population of Latvia. Evaluation and Recommendations":

Dina Vjatere

Participants of the conference "Towards a Comprehensive Reproductive Health Policy in Latvia"

Translator:

Astrīda Neimanis

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PREFACE

CHARACTERISTIC DEMOGRAPHIC AND REPRODUCTIVE HEALTH TRENDS IN LATVIA

The demographic situation in Latvia in recent years could be considered very critical, with further deteriorating trends generally evident.

Natural growth – or the difference between birth and death rates – of Latvia's population has for quite some time now been negative, and is in fact one of the lowest in the world. In addition, birth rates in Latvia continue to decline reaching the lowest indicators in Latvia's history in 1996. Conversely, mortality rates are high indeed, and have only begun to slightly decline since 1995. Because of these low birth rates, effective generational replacement is not occurring – there are almost twice as few children as adults in their parents' generation, which indicates a trend towards the eventual extinction of the nation. Until 1994, life expectancy rates (which represent one of the most significant indicators of human development) continued to decrease, particularly among males. In Europe, male life expectancy rates were lower only in Russia.

Data characteristic of the reproductive health of the population are similarly alarming. The nation's abortion rates are very high – in 1996 reaching 46.1 abortions per 1000 women of reproductive age. While in absolute numbers abortions have somewhat declined in the recent past, in relation to live births these numbers continue to grow. Official statistics show that in 1996 only 20% of inhabitants between the ages of 15 and 44 were using some form of contraception. However, this data is not entirely reliable, as a comprehensive register of contraceptive use is not being compiled.

Incidence of sexually transmitted diseases (STDs) in Latvia continues to rise: STDs are second only to tuberculosis as the most threatening communicable diseases in Latvia. Incidence of syphilis in Latvia is among the highest in Europe, alongside the worrisome and dangerous increasing incidence of syphilis in new-borns, as well as in children and adolescents.

The poor level of awareness and lack of information on reproductive health issues remain a serious problem for Latvia's inhabitants. Nonetheless, health education remains outside of the compulsory school curriculum, and is rather taught as an optional subject. As a result, approximately half of Latvia's schoolchildren do not receive health education and thus an understanding of their own health – including reproductive and sexual health – remains insufficient.

ONGOING WORK IN LATVIA

The above-mentioned facts depict a very grim demographic situation in Latvia and testify to the serious reproductive health problems the population is facing. However, since Latvia regained its of independence, ongoing efforts to improve this situation continue to intensify. Key contributors to this process include various state and non-governmental institutions, professional organisations and community-based organisations – all of whom are active in various aspects of reproductive health care, family planning consultation, public information, improving standards of specialist work qualifications, and other aspects of improving the nation's reproductive health. With these goals in mind, the revamped State Family Centre, for example, has developed an updated workplan, and the privately-run Latvia's Family Centre continues to successfully work towards these ends after almost ten years of operation. Seven different youth health centres around the country are looking after the reproductive health care and information needs of adolescents, and have gained significant trust among the younger members of the population. The Emergency Clinic of Riga Hospital has

opened a birth control centre for young people, which offers quality counselling at prices affordable to young people. Various non-governmental organisations including Latvia's Association for Family Planning and Sexual Health "Papardes Zieds," Latvia's Breastfeeding Promotion and Protection Authority and Latvia's Contraception Association actively strive for improvements in public and professional education and awareness. The State Health Promotion Centre is now in its second year of effectively promoting public awareness. Professional qualification programmes for physicians continue to improve, promoted and implemented by various professional organisations including Latvia's Association for Women's Health and Birth Specialists and Latvia's Association of Urologists. Both The Environmental Study and Monitoring Centre of the University of Latvia and Latvia's Family Centre have invested significantly in the training of health education teachers. Furthermore, mass media have become far more responsive promoting awareness of family planning, sexual and reproductive health issues.

The most significant shorterming of these ongoing efforts is a lack of co-ordination across the country. Often, several organisations while striving to achieve similar goals will function in isolation, unaware of the achievements or ongoing efforts of their colleagues. A comprehensive national policy and strategy in the area of reproductive health that would inform society of national priorities and programmes while also providing the state with a comprehensive and co-ordinated framework through which to realise both short-term and long-term goals – remains to be developed.

THE RECOMMENDATIONS PROVIDED IN THIS NATIONAL REPORT COULD CONSTITUTE AN IMPORTANT BASIS FOR THE DEVELOPMENT OF A NATIONAL REPRODUCTIVE HEALTH STRATEGY IN LATVIA.

THE PROJECT "SUPPORT TO THE DEVELOPMENT OF REPRODUCTIVE HEALTH STRATEGY IN LATVIA"

One of the primary impediments to the development of national reproductive health strategy is the lack of high quality information that would assist in understanding and evaluating the real reproductive health situation. Therefore, in February 1997 the United Nations Population Fund (UNFPA) in Cupertino with Latvia's Ministry of Welfare began the implementation of the technical co-operation project "Support to the Development of Reproductive Health in Latvia."

Project Objectives

- the enhancement of both state and non-governmental capacity to develop and implement national policy in the area of reproductive health;
- the enhancement of the capacity of state and non-governmental organisations active in the area of reproductive health to evaluate the status of the reproductive health situation, while enhancing co-ordination and co-operation amongst these various organisations;
- the collection of information pertaining to the status of reproductive health in Latvia;
- the analysis of the above-mentioned data, as well as the dissemination of this information to the Government, relevant organisations, specialists and the general public;
- on the basis of this data, coupled with current situational analyses, the preparation of recommendations to be followed-up by the Government.

CHARACTERISTIC REPRODUCTIVE HEALTH INDICATORS IN LATVIA (1996)

Population (millions)	2.5
Division of population by gender (%)	
Males	46
Females	54
Structure of population by age (%)	
0 - 14 years	19.9
Employable age (15 - 59)	60.7
of those, reproductive age (15 - 49)	48.6
Over employable age	19.4
Birth rate of population (per 1,000)	7.9
Mortality rate of population (per 1,000)	13.8
Natural decrease (per 1,000)	–5.9
Summary birth rate coefficient (average number of children during a female life	1.16
Average life span (in years)	
Both genders	69.3
Males	63.9
Females	75.6
Mortality rate of infants (per 1,000 born)	15.6
Mortality rate of mothers (per 100,000 live births)	40.3
Number of abortions (per 1,000 births)	1,219
Infection with syphilis (per 100,000)	124.9
Government expenditure on health (% of all Government expenditures)	10.3
Total expenditure on health (% of the total national product)	3.9

1st

CHAPTER

REPRODUCTIVE HEALTH AND REPRODUCTIVE RIGHTS IN AN INTERNATIONAL CONTEXT

UN GLOBAL CONFERENCES

Latvia is firmly situated within the context of global processes and international standards, formulated through world-wide best practices. In light of this international experience and by learning through the mistakes of others, Latvia should be capable of providing its inhabitants with the best conditions for the promotion and strengthening of reproductive health.

Over the past ten years the UN has sponsored various global conferences on topics of relevance to all of humankind and each individual alike. Reproductive health and reproductive rights was one theme integral to many of these events. At these conferences, consensus was reached on certain international principles and plans of action to promote and secure reproductive health and rights for all. Programmes developed in the context of these conferences were accepted by all participating countries, including Latvia. As dictated by the principles of these conferences, it is the obligation of each participating country to implement the respective programmes of action, through the development of nationally appropriate strategies, the articulation of national priorities and the passage of relevant legislation in these areas. Therefore, more important than the conferences themselves is each nation's practical translation of the global consensus into action. Latvia's most pressing obligation remains the development and implementation of a national strategy for reproductive health.

UN GLOBAL CONFERENCES ADDRESSING ISSUES OF REPRODUCTIVE HEALTH AND RIGHTS

WORLD CONFERENCE ON HUMAN RIGHTS, VIENNA, 1993

INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT, CAIRO, 1994

WORLD SUMMIT FOR SOCIAL DEVELOPMENT, COPENHAGEN, 1995

FOURTH WORLD CONFERENCE ON WOMEN, BEIJING, 1995

Latvia participated in the Cairo, Copenhagen and Beijing conferences.

INTERNATIONAL PRINCIPLES

Several common principles related to reproductive health and reproductive rights are interwoven throughout the themes of all the above-mentioned conferences. These can be summarised as follows:

- Men and women have equal rights and possess equal human value. The main actions for translating this principle into reality include:
  - enhancing opportunities for women to enjoy their rights and freedoms;
  - encouraging the participation of men and promoting male responsibility.

- The family is the cornerstone of society.

- States must guarantee appropriate reproductive health care and social

services, as well as the right to comprehensive information and education for:

- young people
- elderly people
- people living in poverty
- people with disabilities
- vulnerable groups of society

• State and intergovernmental organisations must include non-governmental organisations (NGOs) in the decision-making process and must promote, NGO involvement in problem-solving.

GLOBAL CONSENSUS AT THE CAIRO CONFERENCE

Issues of reproductive health and rights were most comprehensively addressed at the **International Conference on Population and Development** (ICPD), in Cairo, 1994. A delegation from Latvia actively participated at this conference, at its conclusion approving the conference's programme for action.

The Programme for Action developed at Cairo is discussed in more detail below, highlighting the points most relevant to Latvia.

The chapter on Reproductive Health and Rights in the ICPD Programme for Action includes the following points:

1. The Definition of Reproductive Health and Rights

Reproductive Rights form one part of internationally recognised human rights, and are based on the recognition that every individual's and couple's rights include:

• the right to freely decide how many, when and at what intervals to have children, and to receive the necessary information and assistance to realise this right;

• the right to decide on having children free from discrimination, coercion or violence;

REPRODUCTIVE HEALTH IS THE COMPLETE PHYSICAL, MENTAL AND SOCIAL WELFARE OF AN INDIVIDUAL IN RELATION TO HIS OR HER REPRODUCTIVE SYSTEM, ITS FUNCTIONS AND PROCESSES.

• the right to use safe, effective , affordable and appropriate family planning methods, as well as other legal fertility regulation methods;

• the right to mutual respect and equality in sexual relations;

• the right, especially for young people, to receive the education and services that will provide them the opportunity to understand their sexuality, and to live their sexual life both constructively and responsibly the right to receive health care services which allow a woman to safely carry and give birth to a child.

2. A call to all states to make reproductive health care available as soon as possible to every individual in the context of the primary health care system. Amongst other services, this should include:

• counselling, information, education and services for family planning;

• information and services related to pregnancy, safe childbirth and postpartum care and breastfeeding;

• medical care for pregnant women; prevention and treatment of infertility; infant and women's health care;

• treatment for sexually transmitted diseases and other problems associated with reproductive health;

• information, education and counselling about sexual relations, reproductive health and parental responsibility;

• access to legal abortion, where this compatible with national legislation.

The abortion debate was the subject of great controversy at the Cairo conference. Several states were opposed to the section of the programme which referred to the termination of pregnancy other than by natural means, as it was in direct conflict with their national legislation prohibiting abortion. While abortion should not be a method of family planning, in

the event of an unwanted pregnancy, every woman should nonetheless be granted autonomous choice in accordance with the legislation of the given state.

Reproductive health care programmes should be designed with the needs of women and the youth in mind.

States are encouraged to implement new types of programmes – ones that make information, counselling and services available to young and adult men, such that men will have the opportunity to more fully participate in family planning, household affairs and child rearing, as well as taking on more responsibility for the prevention of STDs.

3. Family Planning Recommendations – The Development of Programmes which strive:

- **to reduce** the number of unwanted pregnancies and the level of maternal illness and mortality;
- **to improve** the quality of information, education, counselling and health care services;
- **to increase** male involvement in and responsibility for family planning.

4. Recommended Actions for the Prevention of Sexually Transmitted Diseases (STDs), including the human immunodefiency virus (HIV):

- to strengthen efforts in the prevention, diagnosis and treatment of STDs, other reproductive system infections and infertility;
- to provide special training for all health care workers in the prevention of STDs and patient counselling;
- to posit information and counselling on responsible sexual behaviour and the prevention of STDs and HIV as an integral component of health care services;
- to promote and distribute high quality condoms through the health care system.

5. Human Sexuality and Gender Relations. The objective is two-fold:

- to promote the development of responsible sexual relations based on equity and mutual respect between the sexes; and to ensure access to information, education and care services needed to achieve good sexual health and the attainment of reproductive rights and responsibilities.

Educational efforts for young people which promote parental support and involvement are encouraged, with an emphasis on promoting male responsibility for their own sexual health and behaviour.

6. Adolescent Reproductive Health and Rights:

- States must ensure that neither programmes nor the attitude of health care workers does not restrict young peoples' access to the information and services necessary for them;
- States are urged in co-operation with non-governmental organisations to develop necessary mechanisms to respond to the needs of young people;
- These services must guarantee young peoples' right to a private life, anonymity, confidentiality, respect and informed choice.

2nd

CHAPTER

SUPPORT TO THE DEVELOPMENT OF REPRODUCTIVE HEALTH STRATEGY IN LATVIA: PROJECT IMPLEMENTATION

SUPPORT FROM THE UNITED NATIONS POPULATION FUND

The project "Support the Development of Reproductive Health Strategy in Latvia" is being implemented through the collaborative efforts of the United Nations Population Fund (UNFPA) and the Ministry of Welfare of the Republic of Latvia.

UNFPA is the world's largest fund for the support of population issues, including issues concerning reproductive health. In 1996, UNFPA's contributions totalled 325 million dollars. UNFPA supports governments around the world to turn the Programme of Action from the International Conference on Population and Development in Cairo into action in a way appropriate for each individual nation. This includes both the promotion of human development and improvement in the quality of reproductive health care. Latvia's project, which is executed by the Ministry of Welfare of Latvia, is financed by a USD 92, 000 contribution from UNFPA.

THE NATIONAL WORKING GROUP

To begin, data on the reproductive health situation in the country were necessary for the implementation of the project. Further progress of the project was dependent upon the co-operation of both state and non-governmental organisations to perform both data and situational analysis, to outline and benchmark the progress of the project and to develop recommendations for a programme of action. Therefore, in the spring of 1997, UNFPA and the Ministry of Welfare invited various organisations active in different aspects of reproductive health to nominate a representative to be part of a national working group to oversee project implementation. As a result, a working group of eight people was formed (see Contributing Authors, pg. 6), which represented various state and non-governmental organisations.

One of the principle objectives of the project was conducting a national survey for the collection of high quality and reliable data that could provide an indication of the true status of the population's reproductive health. State statistics in this sphere were not sufficiently comprehensive to form the basis of a reproductive health strategy for Latvia. Furthermore, some state statistics are not sufficiently reliable. For example, statistics on contraceptive prevalence are not reliable, as this data is not comprehensively monitored and collected – official statistics only reflect contraceptive use amongst those individuals who visit state health clinics or centres, and thus ignore individuals consulting with private physicians or those who use contraception without consultation.

The first task of the working group was to develop a questionnaire that would reflect the population's opinions on, attitudes towards, awareness of and behaviour regarding various aspects of reproductive health. In total, the questionnaire contained 133 questions directed at women and 105 at men including questions on personal attitudes towards one's own health, psychological well-being, pregnancy, abortion, sexually transmitted diseases, level of awareness, and others.

THE SURVEY OF THE POPULATION

The survey, "On Reproductive Health and Behaviour" was sub-contracted to Baltic Data

House and fieldwork was conducted between 16 April and 5 May 1997. During the survey a total of 4, 568 individuals were interviewed, including 2, 990 women and 1578 men of reproductive age (15-45 years). Interviews were conducted at places of residence at 458 random interview points throughout Latvia – cities, towns, villages and rural homesteads. Selection was through an appropriate multi-tiered random selection method which guarantees the statistical significance for the designated survey population.

The survey was anonymous and guaranteed interviewees' complete confidentiality. Women were surveyed through the reliable survey method of the face-to-face interview. Men were asked to fill out questionnaires on their own, as it was suspected they may be uncomfortable if interviewed by women on questions of such an intimate nature, for, given the fact that men are generally not numerically well represented in the professions (teachers, librarians, medical workers, and others) which most commonly provide interviewers for the surveys, 95% of interviewers were female. However, this situation did not significantly impact the results of the survey, apart from the concern that men may have had help from others in completing the questionnaires.

The response of participants towards the survey itself was very positive, many of them understanding the importance of such a survey and recognising their own personal contribution to the development of a reproductive health strategy for Latvia. Only 17% of randomly selected participants declined to be interviewed, which falls within the average (15%-20%) for such surveys. This point highlights the misleading nature of stereotypical perceptions that suggest people may be reluctant to discuss their intimate lives. In fact, the reality is quite the opposite: interviewers reported that many women were in fact more than happy to be given the opportunity to openly discuss these issues which comprise such an important aspect of life.

ANALYSIS OF THE SURVEY RESULTS AND PREPARATION OF RECOMMENDATIONS

Following the compilation of data, Baltic Data House prepared a primary analysis, which the working group proceeded to analyse in more depth. During this process the data was subsequently divided into thematic areas, compared with existing national statistical indicators and evaluated in relation to the current health care system and legislation.

In September 1997, UNFPA and the Ministry of Welfare organised a three-day conference "Towards a Comprehensive Reproductive Health Policy for Latvia." Here, the data was further analysed and commented upon by a wide range of national specialists – medical workers, education specialists, demographers, sociologists, psychologists and representatives from other professions and non-governmental organisations. The participants divided into three working groups and on the basis of rigorous data analysis developed recommendations for further national action needed to develop and implement a national reproductive health policy for the population of Latvia.

INFORMING THE PUBLIC

Following the survey fieldwork and the primary data analysis, a press conference was organised where the data were given to journalists so that the greater public would be informed of the survey results and the major conclusions.

Other informative materials are being distributed within the context of the project, including this national report aimed at policy makers, specialists and a wider general audience, as well as an informative brochure and poster for the general public.

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CHAPTER

REPRODUCTIVE HEALTH: DEMOGRAPHIC AND SOCIAL ASPECTS

NATALITY AND MORTALITY

Reproductive health issues are integrally related to demographic processes: reproductive capacity determines the capacity for "regeneration." If the demographic situation in a country is critical, one of the potential sources which needs to be examined is the state of the inhabitants' reproductive health. At the International Conference on Population and Development in Cairo, one revelation was crystal clear: a nation will solve its demographic problems neither by imploring its inhabitants to conceive – nor, on the other hand, by telling them to not conceive. The responsibility to "regenerate the nation" means nothing to the individual. Governments must address demographic issues through careful situational analysis, removing impediments that may deter the optimal demographic development of the nation.

The demographic situation in Latvia is disturbing. **The greatest problem is low birth rates which have continued to decline over the last ten years, in 1996 reaching an all-time Latvian low of 19, 000 births.** Only nine years previously 42, 000 children were born in Latvia (see Figure 3.1). Alongside this, the death rate in Latvia began to increase in 1986, reaching a maximum of 41, 000 (in other words, 16.4 deaths per 1000 inhabitants) in 1994. According to demographers, Latvia has passed the most critical juncture, as in the last three years death rates in Latvia have been in decline (only 34, 000 deaths in 1996). However, when compared to its near neighbours in Scandinavia, Latvia lags behind in terms of natality and still significantly surpasses its neighbours in mortality rates

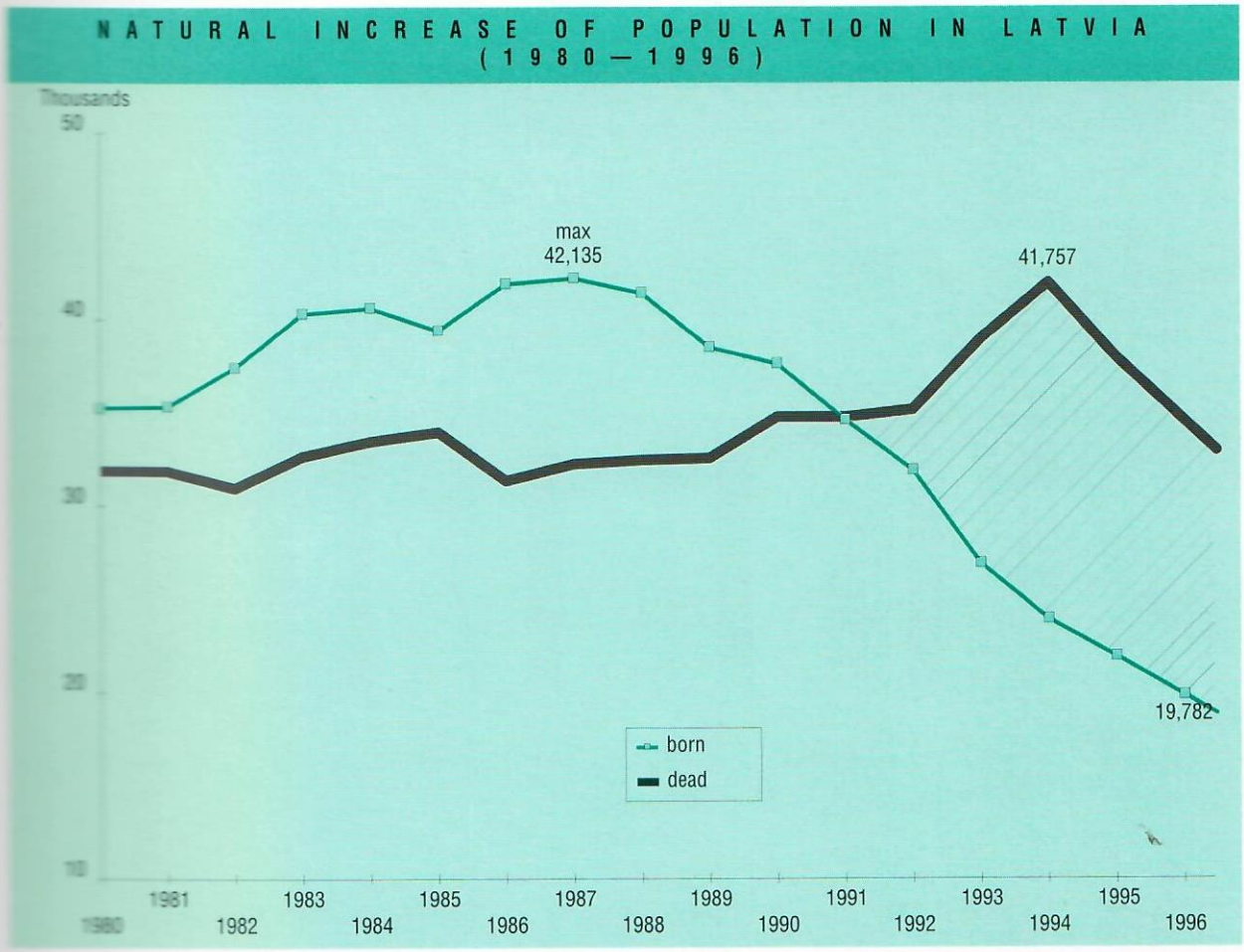
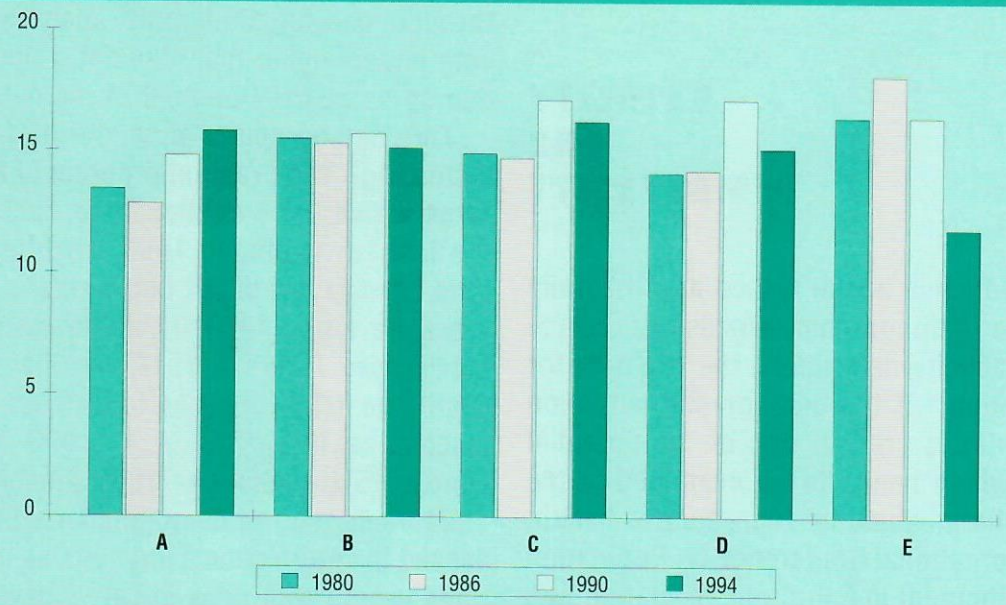


FIGURE 3.1.

FIGURE 3.2.1.

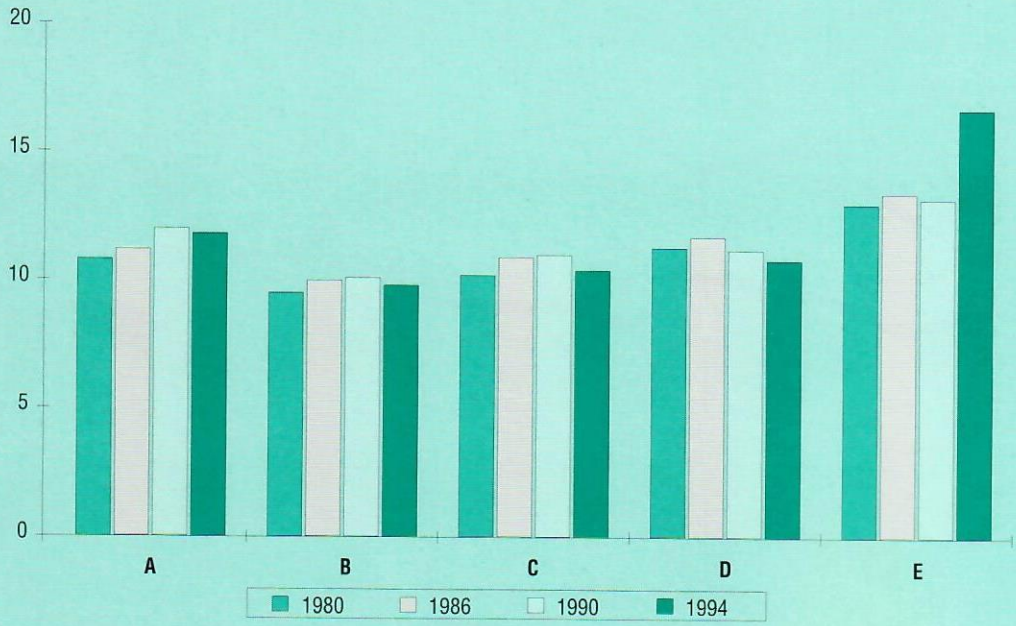
BIRTH RATE OF POPULATION
(per 1,000 inhabitants)



A – Denmark
B – Finland
C – Norway
D – Sweden
E – LATVIA

FIGURE 3.2.2

MORTALITY OF POPULATION
(per 1,000 inhabitants)



A – Denmark
B – Finland
C – Norway
D – Sweden
E – LATVIA

(see Figures 3.2.1., 3.2.2. and 3.3).

As death rates are overtaking birth rates, instead of a natural population growth the country is experiencing a decline – in 1996 by a total of 14, 500 inhabitants. This negative indicator of Latvia's natural progress (–5.9 per thousand inhabitants) is one of the worst in the world.

Due to low birth rates, Latvia is not experiencing full generational replacement:

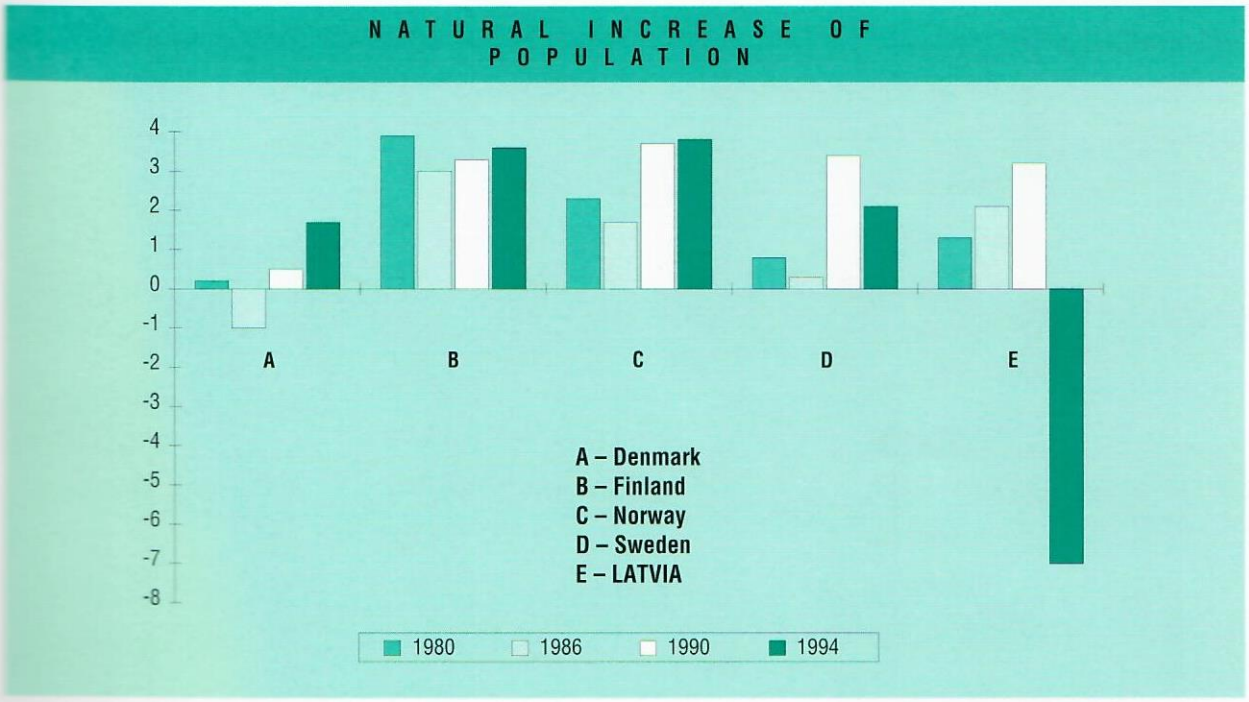


FIGURE 3.3.

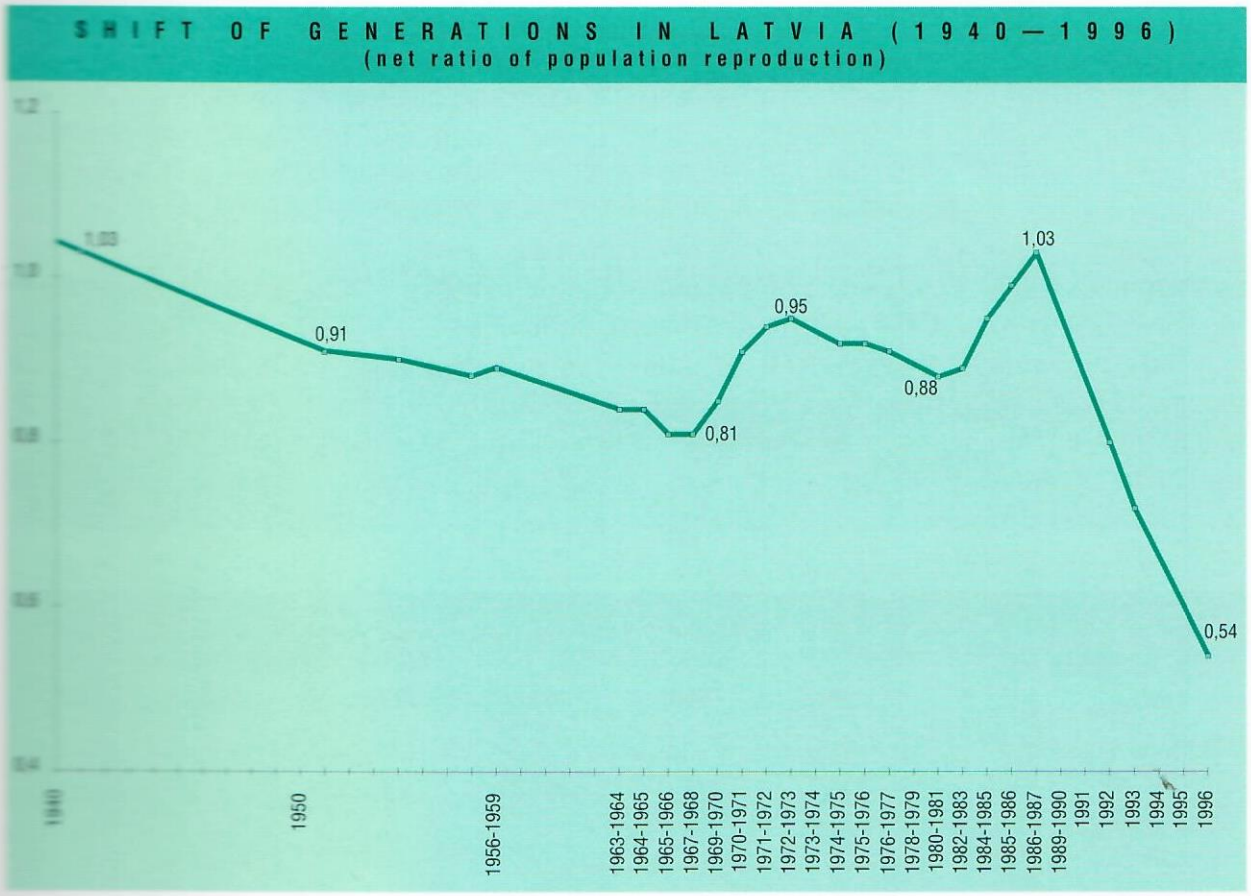


FIGURE 3.4.

FIGURE 3.5.

NET RATIO OF POPULATION REPRODUCTION
in different countries (1995)

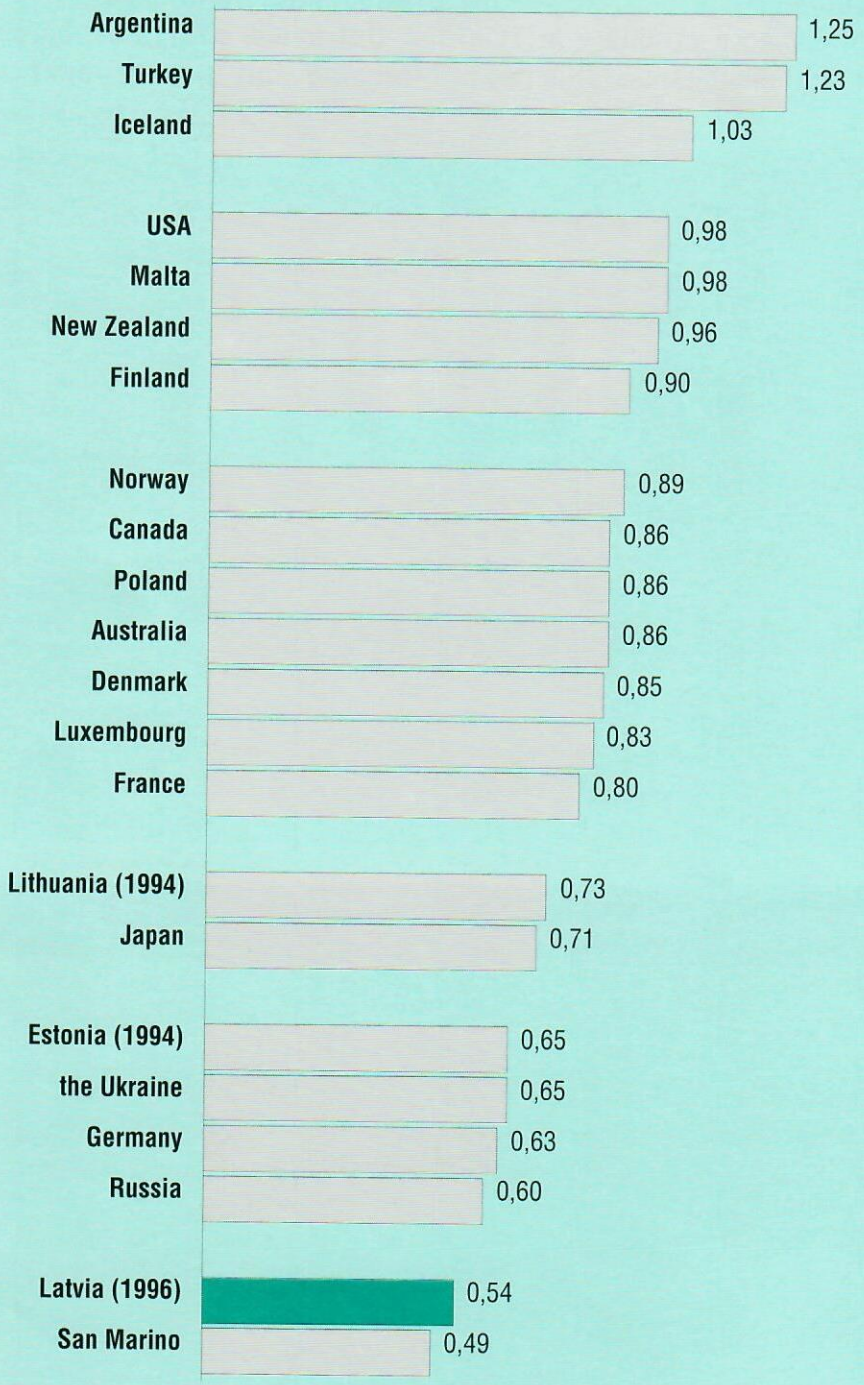


FIGURE 3.6.

MATERNAL AND INFANT MORTALITY

	1991	1992	1993	1994	1995	1996
Maternal mortality (per 100,000 live births)	31,8	41,2	29,9	57,7	37,0	40,3
Infant mortality (per 1,000 live births)	15,6	17,4	15,9	15,5	18,5	15,6

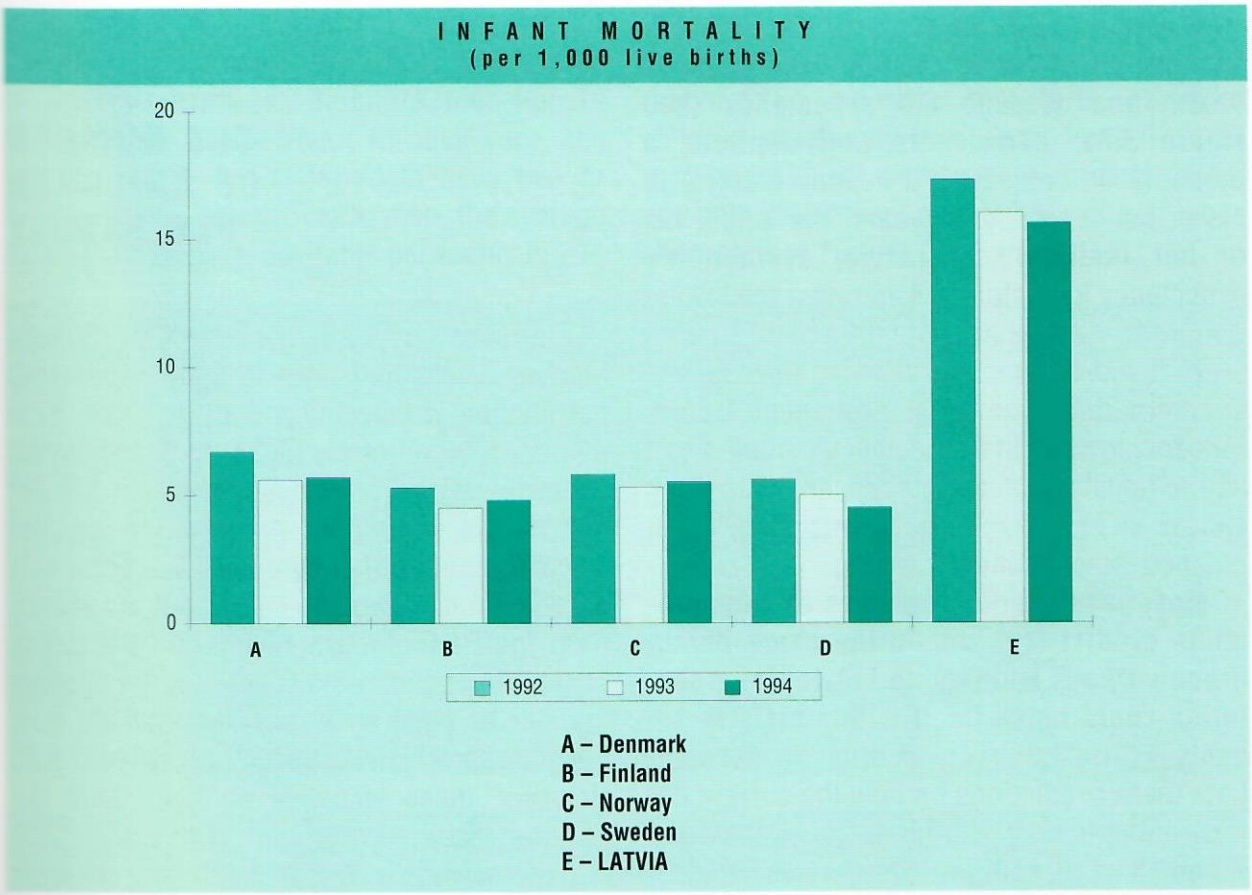


FIGURE 3.7.

There are almost twice as few children as adults in their parents' generation, which points to the nation's gradual extinction. The net coefficient of the population's natural replacement (illustrating the most recent generation's relationship to that of its parents) is almost half of that required for normal regeneration. For standard replacement to occur, this coefficient would need to be 1.0 – whereby both generations would be numerically balanced. Since attaining a maximum net coefficient of 1.03 in 1986-1987, this indicator in Latvia has dramatically slipped to a mere 0.54 in 1996 (see Figures 3.4 and 3.5).

Indicators of maternal and child mortality are also disturbing (see Figure 3.6). In absolute numbers, infant mortality (i.e. deaths up to one year of age) in 1996 was 315. Maternal mortality in Latvia is fluctuating somewhat – in absolute numbers between 14 and 8 maternal deaths per year. These mortality indicators should be understood as relatively high in comparison with countries of the developed world, yet almost insignificant compared to the developing world. For example, if compared to Scandinavian countries, infant mortality in Latvia is almost three times greater (see Figure 3.7).

AVERAGE LIFE EXPECTANCY OF POPULATION IN LATVIA

	1987	1990	1993	1994	1995	1996
Both sexes	70,9	69,5	67,2	66,4	66,6	69,3
Women	75	74,6	73,8	72,9	73,1	75,6
Men	66,3	64,2	61,6	60,7	60,8	63,9

FIGURE 3.8.

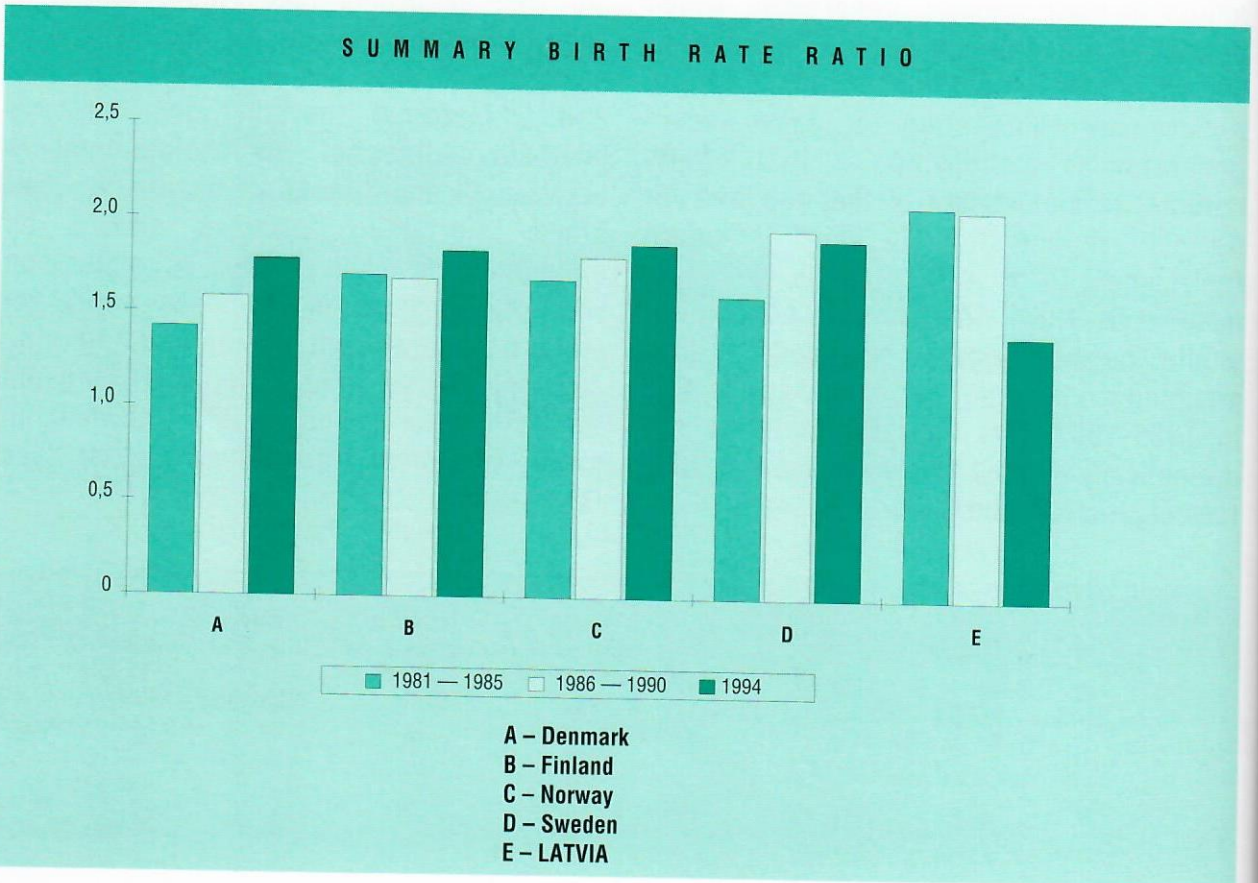
There is also an indirect relationship between the status of a nation's reproductive health and average life expectancy (see Figure 3.8). The more conscientious a person is in cultivating a healthy lifestyle in his or her reproductive years, the longer his or her lifetime. In Latvia, average life expectancy indicators are amongst the lowest in Europe, particularly among males, who on average die 12 years earlier than their female counterparts. The most prominent factors influencing male life expectancy include heart and circulatory disease, cancer (with lung cancer in first place), accidents such a car crashes, suicide and poisoning.

Most pessimistic prognoses of demographers predict that should the same demographic trends continue in Latvia, the population could halve itself within sixty to seventy years. However, in order to substantiate these predictions on how the current demographic processes may in fact impact the future, it is of course necessary to conduct serious scientific research and estimations.

THE NUMBER OF CHILDREN PER FAMILY

The summary birth coefficient or average number of children born to a woman during her lifetime in Latvia was 1.16 in 1996. This number is significantly higher in Scandinavian countries, where it fluctuates between 1.5 and 2.0 (see Figure 3.9). Information on the average number of children per family for this decade is unavailable in Latvia, yet the survey ("On the Reproductive Health and Behaviour of the Population") indicates that the average number of children in families that are now beyond reproductive capacity in currently 1.7. However, these statistics do not reflect the opinions and desires of inhabitants, as families express a wish to have more children. If families actually had as many children as

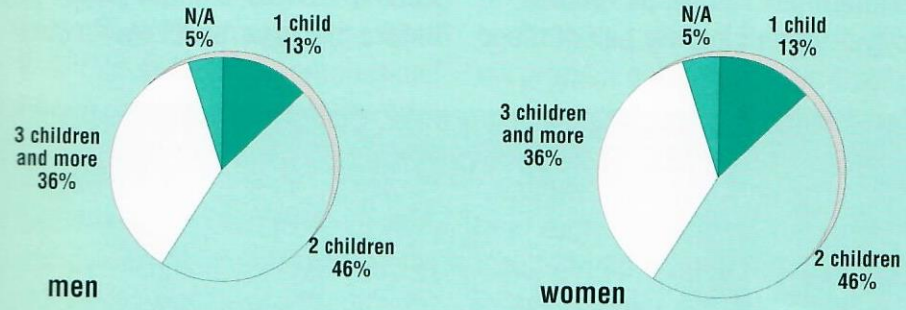
FIGURE 3.9.



they indicate to be desirable, birth rates in Latvia would aspire to the level deemed necessary from a demographic human development perspective. In such case, the average family in Latvia would have two or more children. According to men, the average number of children desirable per family is 2.3, whereas women indicate 2.2 as desirable. Despite the fact that more than a third of respondents indicated that three or more children per family is optimal, only 14% of men and 11% of women have three children, and only 3% of respondents have four or more children (see Figures 3.10 and 3.11).

FIGURE 3.10.

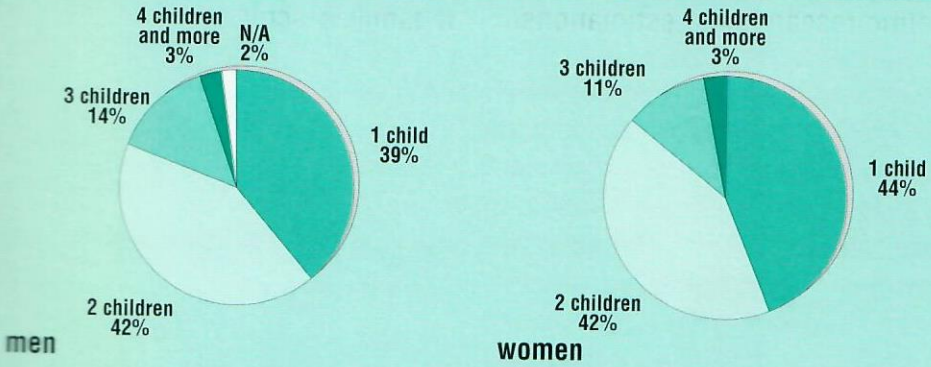
NUMBER OF CHILDREN CONSIDERED OPTIMAL IN A FAMILY LIVING IN LATVIA



Replied by all men (N=1578) and all women (N=2990)

FIGURE 3.11.

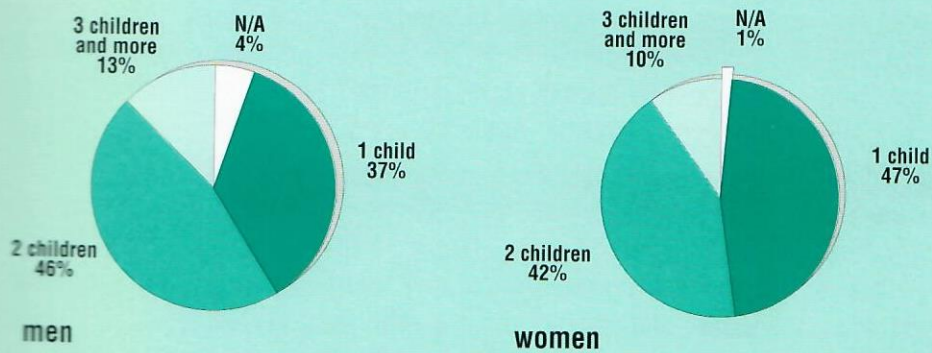
NUMBER OF RESPONDENT'S CHILDREN



Replied by men (N=888) and women (N=2093) who have children

FIGURE 3.12.

WISH TO HAVE CHILDREN IN THE FUTURE



Replied by men (N=968) and women (N=1555) who would like to have children

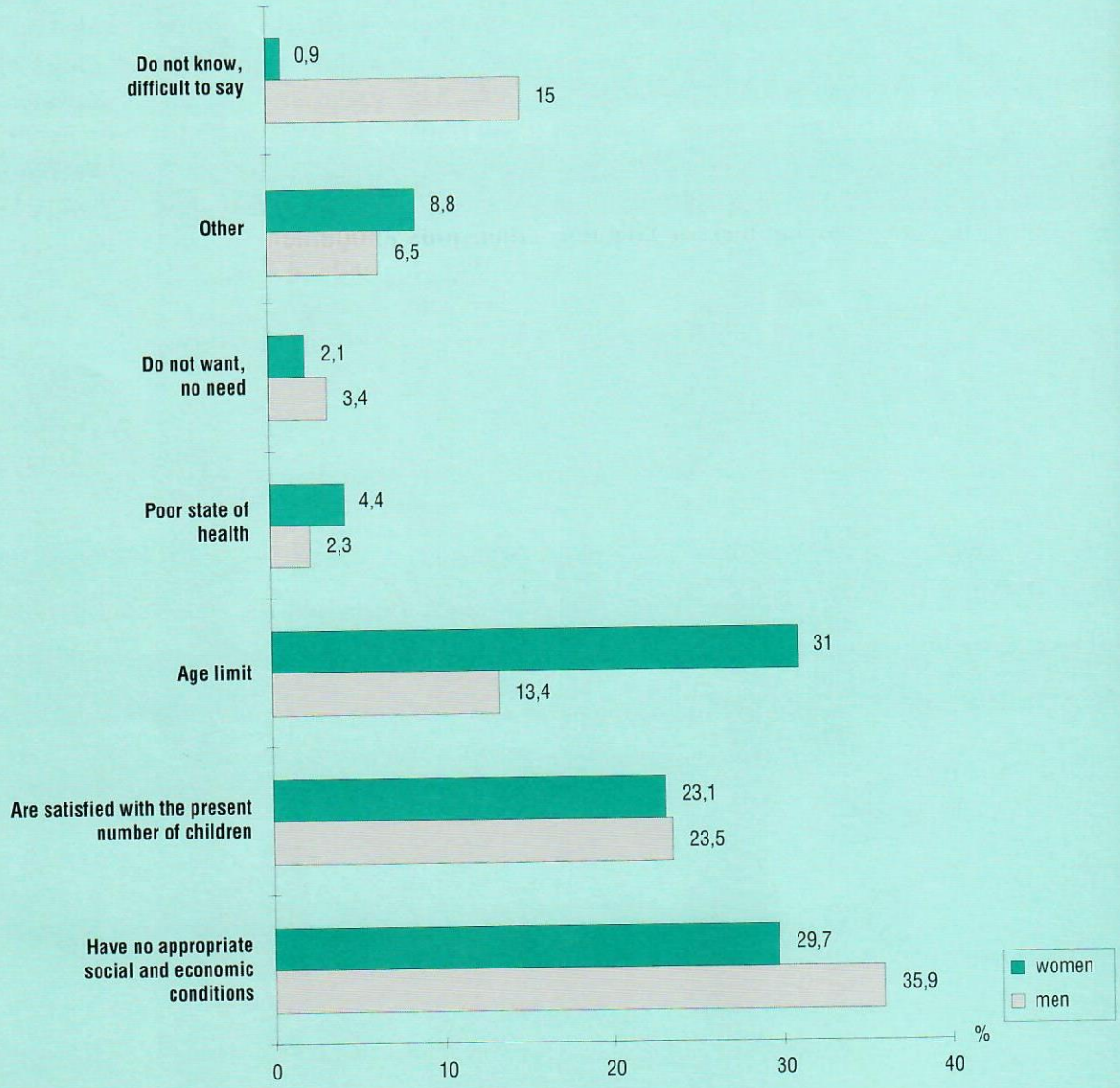
Of all respondents, 28% of men and 21% of women do not have any children, yet it must be taken into account that 13% of surveyed men and 11% of women have never been sexually active. 4% of surveyed women and 1% of men consider themselves to be infertile (this data is analysed further in Chapter 5). Only a small percentage of respondents (6% of men and 1% of women) have adopted children.

There are significant differences between the number of children per family in relation to where families live. Approximately half of those surveyed who live in Riga have only one child, and 35% have two. This is in contrast to those surveyed who live in rural areas, of whom 30% have one child yet almost half have two. Families with three or more children are also more common to rural areas (19% of men and 27% of women), while in Riga, this is only true of 12% of men and 7% of women.

The survey also indicates that children are born for the most part to young parents. **Almost half of women have their first child before the age of 21**, while first children are

FIGURE 3.13.

REASONS WHY PEOPLE DO NOT WANT TO HAVE MORE CHILDREN



Replied by those who do not want to have more children in the future (women N=1403; men N=554)

born to men most commonly between 22 and 26 years of age. The number of respondents who have their first child after 27 is comparatively small – only 18% of men and 13% of women. One potential reason for the young age of first time parents and mothers in particular is the common misconception in society that for a woman to have a child after 30 years of age is too late. Despite the fact that this age group faces an increased risk of health complications during pregnancy, this is not as serious a problem as is commonly perceived. Furthermore, it is not sufficiently emphasised that twenty-year old parents may not be adequately mature psychologically or emotionally which may affect their ability to raise children.

More than half of respondents (61% of men and 52% of women) still desire children in the future. Men in fact express a slightly greater interest in this than do women (see Figure 3.2). The most common explanations given by those who do not desire any more children are inappropriate socio-economic circumstances and an already adequate number of children (see Figure 3.13).

SOCIO-ECONOMIC SECURITY

Unsatisfactory material conditions are named as one of the most common reasons stated for why couples have not had as many children as they would consider optimal. Around 40% of men and women have protected against pregnancy because they could not financially afford a child.

This same motivator is often noted as a reason for terminating pregnancy: 36% of men and 24% of women mentioned poor material standing as the reason for ending pregnancy. Women increasingly state this reason with each successive pregnancy. The motivation for having an abortion also differs according to place of residence. While material instability is given as a reason by every fifth women living in Riga, every third rural woman provides this explanation. For men, material instability was a deciding factor for 71% of those in rural regions yet for only 30% of those in Riga or other cities. This corresponds to the reality of Latvia's economic situation, where rural dwellers experience higher rates of unemployment and less material security than their counterparts in Riga and other cities.

The interruption of career or studies is a far less frequent explanation, although one in six women and one if four male partners offer this reason for termination for the first pregnancy. In the case of second pregnancies, this frequency falls to only 5% of women and 7% of male partners. State labour legislation provides that women be reinstated in their former position of employ following a three-year maternity leave, yet reality shows that employers have little difficulty in finding ways to side-step this law – and new mothers either experience career restrictions or lose their jobs altogether.

Were the state to provide more financial and moral support to families, the number of children per family could increase – the fact that respondents state that the optimal number of children per family is 2.3 lends credence to this assertion. It follows that the number of children per family would indeed increase if people had more material stability and if employers were both more fair and understanding. The current support to families with children which is paid in the form of social benefits, does not prove sufficient to encourage increased birth rates. Many women, who in having children lose their wage income and in return receive a much smaller income in the form of benefits, yet on the other hand must absorb far greater expenses due to the addition to their family. However, this problem has yet another dimension: parents of financially-depressed families may often decide to have a child for the only reason that they may then claim the small state child-rearing benefit, which for these families is their only real income and may not be spent towards the needs of the child.

STATE SUPPORT TO FAMILIES WITH CHILDREN

Since 1992, the state has provided three types of social benefits to parents with children: a birth allowance, a child care allowance and a state family benefit. The state provides these benefits with the aim to support families who have incurred additional expenses in rearing and caring for children. In an effort to promote good health in children, the state has increased the birth allowance twice since 1994. Currently parents are eligible for the following types of benefits:

Birth Allowance in the sum of 98 Lats is paid for every child born. If, however, the mother visits a doctor within the first twelve weeks of term, thus indicating a concern for the health of the foetus, she receives twice as large a benefit - 196 Lats. Approximately 80% of mothers receive the full benefit.

Child Care Allowance is paid to the individual that cares for the child in the home and is neither employed full time nor part-time elsewhere. This allowance is 12 Lats per month for the first year and a half and then 7.50 Lats per month until the child's third birthday.

State Family Benefit is paid to parents immediately upon the birth of their child and until the child is either fifteen years old or until twenty if the child is studying in a general education school and is unmarried. The amount paid depends on the number of children in the family - 4.25 Lats per month for the first child; 5.10 Lats per month for the second and fifth child; 6.80 Lats per month for the third and fourth child; and 4.25 Lats per month for the sixth and additional children. An additional amount of 35 (before 1 april 1998 – 30 Lats). Lats per month is paid if the child is disabled. The Cabinet of Ministers intends to increase the State Family Benefit beginning 1 July, 1998: allowances for second children will be 5.10 Lats, but parents will receive 6.80 for the third and 7.65 for the fourth or subsequent children.

Unfortunately, these allowances have not been increased in proportion to average prices, which every year are on the rise. Furthermore, the state does not pay out as much as recommended by the European Union, which should total 1.5% of the GNP. Currently, benefits total only 1.16% of the GNP.

The fact that child care allowances are only awarded to those mothers that care for their children within the home and do not have other employment is not an optimal situation. Mothers who wish to care for their children but still wish or are forced to combine childcare responsibilities with other employment find ways of concealing their official employment. This results in both psychological and moral unease for women. The state should at the very least support families through appropriate legislation – particularly in the case where the state is unable to provide women who care for their children at home with adequate financial compensation.

PROPOSALS AND RECOMMENDATIONS

• The most crucial objective for improving and stabilising the demographic situation in Latvia is achieving quality and comprehensive generation replacement, which should be articulated as a priority. The state must therefore develop an appropriate strategy that would promote:

- an increase in birth rates,
- improved reproductive health,
- increased life expectancy,
- improved public health.

• To promote an increase in birth rates in Latvia, the state should strive to improve the material stability of parents through state social benefits. This would include:

- increased state family benefits such that each child would be allocated at lease 15% of state minimum wage;
- increased municipal social benefits;
- removal of restrictions on child care allowances relating to employment;
- increased benefits to children who are part of foster families or in the care of a guardian;
- a minimum pension for children who have lost their primary care-giver;
- a tax break for those being cared for that is equal to the amount of discount given to carers providers.

The state should be mindful and take measures to ensure that families do not become part of the most impoverished sector of society owing only to the fact that they have children.

• Social policy that is based on the understanding that the family is the cornerstone of society should be implemented.

The importance of both parents' role in childbearing and the value of strong families should be both strengthened and actively implemented.

• To enhance the participation of both parents in caring for and raising their children, legislation should guarantee equal rights and equal responsibilities for both parents in raising their children, including in the event of divorce.

• To prevent the attitudes of employers from discouraging families from having children, the development of a national framework that would prevent employers from restricting a woman's right to give birth and that would regulate employers' compliance with the labour rights of women should be considered.

The experience of Nordic countries should be adopted, by which fathers are entitled to child care leave after the birth of their children. This would enable willing fathers to act out their responsibility and choice to be an active part of their children's care and development.

• To improve the complicated and time-consuming process of adoption, necessary legislation should be developed.

• To encourage the raising of orphan and abandoned children in families as opposed to children's homes, it is crucial that the foster parent system in Latvia be supported and promoted.

4th

CHAPTER

REPRODUCTIVE HEALTH: PSYCHOLOGICAL ASPECTS

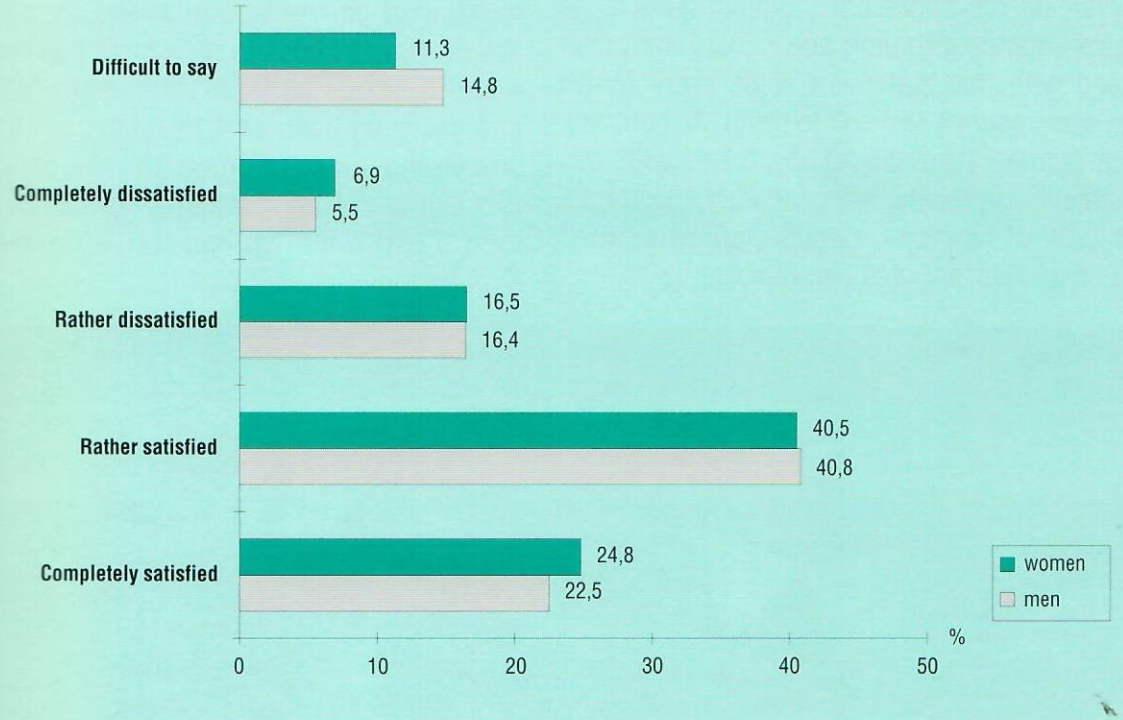
SEXUAL RELATIONS

In analysing the impact of sexual life on reproductive health, the survey revealed that the majority of respondents (around 60%) are content with their sex lives. However, there were also many individuals who were not satisfied: almost every fourth woman and every fifth man. More than 10% of respondents could not answer this question (see Figure 4.1).

Almost 90% of all respondents had been or are sexually active. Men began sexual activity at an earlier age than women; by the age of 18 almost half of the men had had sexual relations, while women for the most part (70%) had begun sexual relations after reaching 18. Seventy percent of women reported that their first sexual partner had been 20 or older, but 60% of men reported their first partner to be under the age of 20. One-third of men stated that sexual relations with their first partner lasted only one night, and just as many men reported curiosity to be the motivation to their first sexual encounter. Two thirds of the women, on the other hand, reported that their first sexual relationship lasted one year or longer.

There were notable inconsistency in men's and women's opinions when asked to evaluate their first sexual encounter: every fifth man described this as "fantastic and unforgettable" and 50% of men reported it to be "pleasant". However, 40% of women did not report any positive emotions concerning their first encounter, with 14% even reporting it as "unpleasant" – in contrast to the 1% of men of the same opinion (see Figure 4.2).

SATISFACTION WITH THE PRESENT INTIMATE LIFE

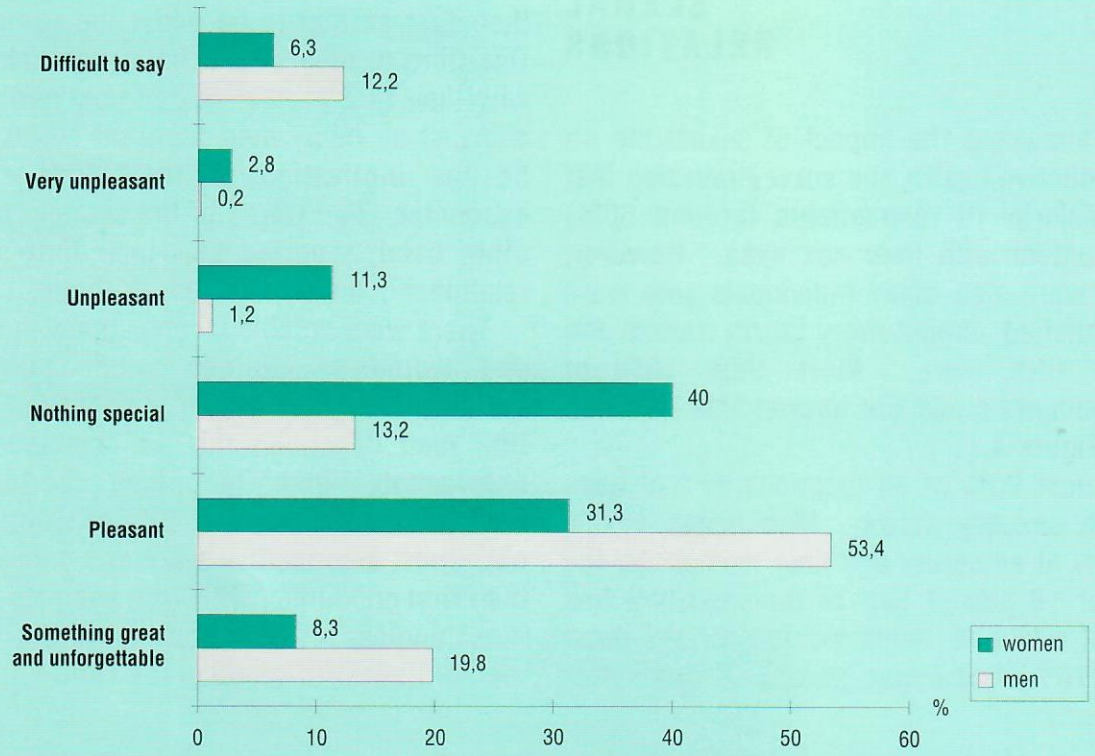


Replied by all respondents

FIGURE 4.1.

FIGURE 4.2.

EVALUATION OF THE FIRST SEXUAL EXPERIENCE



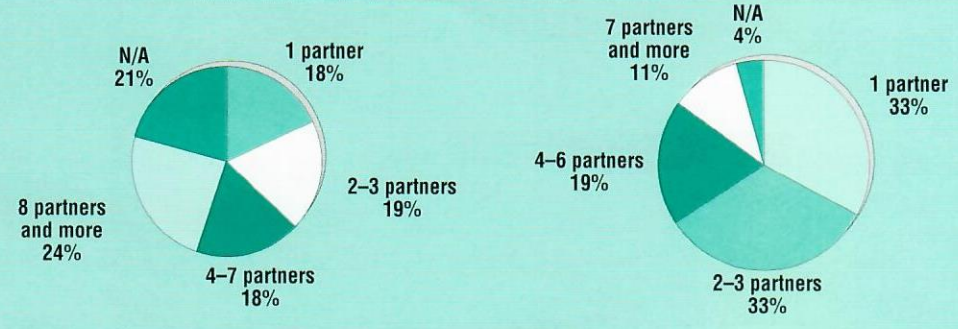
Replied by those who have had sexual relations (women N=2637, men N=1366)

A notable contradiction is evident between respondents' attitudes and actions when asked to evaluate the statement, "Women should be virgins entering into marriage". Every third man agreed with this statement while every fourth man was unsure ("Difficult to say"). In contrast, most women (two thirds) disagreed with this statement. In reality, however, only 7% of men and 19% of women had their spouse as their first sexual partner (see Figure 4.4).

Furthermore, there are apparent differences between men and women in terms of number of partners, with males as far more active. Around 40% of men have had between 4 and 8 sexual partners, and every fifth man has not even been able to report a number – something only common to 4% of women (see Figure 4.3). Similarly, twice as many men (20%) as women (10%) have two simultaneous sexual partners.

FIGURE 4.3.

NUMBER OF SEXUAL PARTNERS DURING LIFETIME



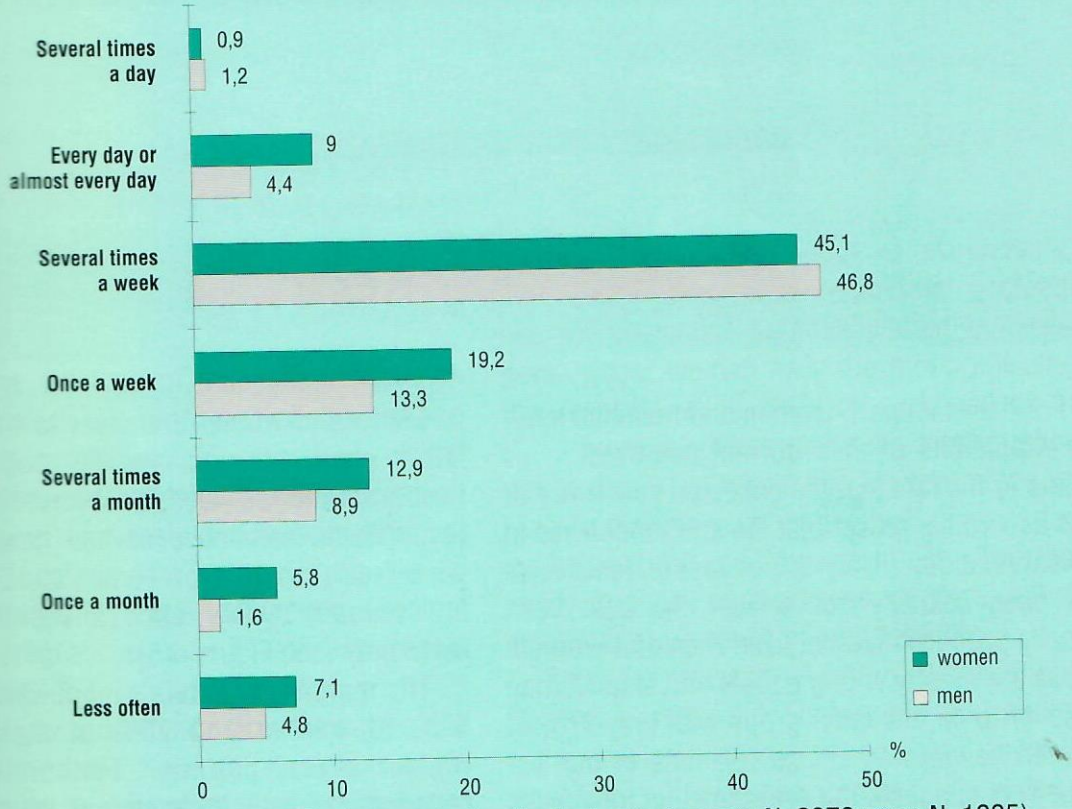
Replied by those who have had sexual relations (women N=2652, men N=1366)

RESPONDENT'S FIRST SEXUAL PARTNER

Replied by those who have had sexual relations (women N=2647; men N=1366)

FIGURE 4.4.

FREQUENCY OF SEXUAL ACTIVITY



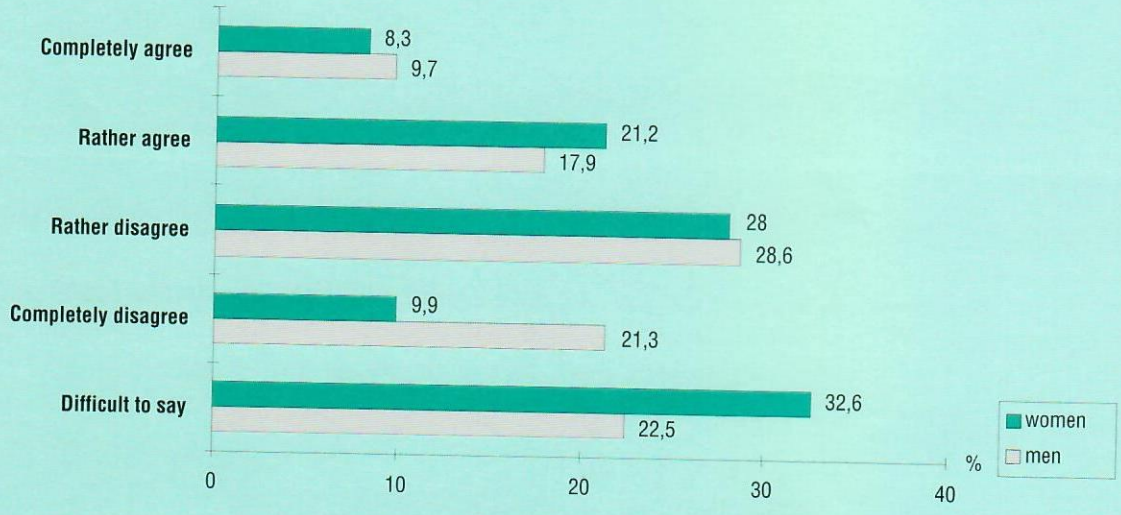
Replied by those who have had sexual relations during the last year (women N=2379; men N=1225)

FIGURE 4.5.

Differing opinions also surfaced in response to the statement "Condoms do not detract from sexual pleasure for males". Less than one third of men and women agreed with this statement, while half of men and 38% of women thought the opposite. It is very possible that the negative attitudes towards condoms held by men of the older generation are influenced by outdated stereotypes, as during the Soviet era only poor quality, thick and coarse rubber condoms were available in Latvia. Another potential reason for this attitude is male attempts to blame impotence problems on condom use. One would have to think that young men better understand the necessity of condom use, while also being more accustomed to using them, and therefore less commonly believing that condoms influence sexual pleasure. Many respondents had difficulty evaluating this statement (see Figure 4.6). The varied opinions of different generations of respondents underlines the fact that different strategies are necessary in designing sexual education programmes for different audiences of different age groups.

FIGURE 4.6.

EVALUATION OF THE STATEMENT — USE OF THE CONDOMS DOES NOT REDUCE MAN'S SEXUAL ENJOYMENT



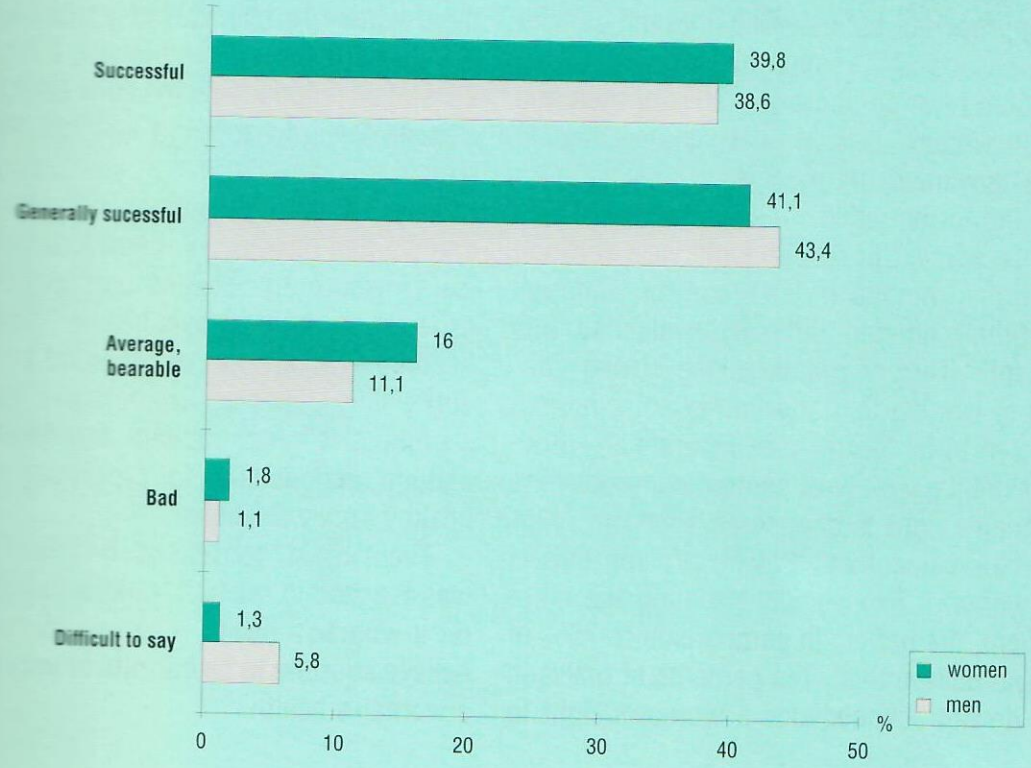
Replied by all respondents

For the most part, women and men had similar evaluations of their current sex lives. This points to the fact that the collected data more or less accurately reflect real life and tendencies in sexual relations. Only 9% of respondents have not been sexually active over the past year, equally proportioned between men and women. These are mostly young people and also women aged 41 to 45, the latter group with only 17% of women having had sexual relations in the last year. This suggests the prevalence of loneliness amongst this group of women.

Men's and women's answer to the question "How often are you sexually active?" were proportionate as well. Almost half of all respondents are active several times a week, while less than 13% of women and 7% of men are sexually active once a month or less frequently (see Figure 4.5).

The majority of Latvia's inhabitants (around 80% of women and 75% of men) have a regular sexual partner. Furthermore, most respondents rate their sexual relations with their partner as fulfilling (see Figure 4.7).

EVALUATION OF PERMANENT SEXUAL RELATIONS



Replied by those who have permanent sexual relations (women N=2177; men N=1029)

FIGURE 4.7.

EMOTIONAL RELATIONSHIP

UNPLANNED PREGNANCY

While the opinions of men and women on various aspects of reproductive health and behaviour generally match, responses of the genders differ noticeably when it comes to actual behaviour or actions. Around 80% of respondents believe that both partners should take responsibility for protecting against unwanted pregnancies; only 7% of respondents believe that this should be the woman's responsibility with an equal amount believing it to rest with the man. Similarly, in stating which partner should be using contraception, men and women are generally of the same mind: most believe that both should do so (see Figure 4.9). However, all couples do not openly discuss contraception issues between themselves, nor do they make joint decisions on use of birth control. There are couples who are not psychologically prepared to discuss contraception with one another. **Thirteen percent of all respondents of both sexes have never discussed protecting against unwanted pregnancy with their partners.** Older women have the most difficulty in this respect, which could be explained by outdated misconceptions that such matters should not be discussed with men. However, men least likely to discuss such matters with their partners are between 20 and 24 years of age. This could testify to a lack of awareness, careless attitudes or an immature sense of responsibility.

Attitudes toward abortion differ slightly. General questions on pregnancy and abortion were similarly answered by both men and women. Differences remain, however, in discussing a woman's actions in the event of

abortion. **Most respondents (around 70% of women and 60% of men) believe that in the event of an unwanted pregnancy, a woman should be free to follow the path of action most appropriate for her.** Only thirteen percent of women and 6% of men are convinced that she should have an abortion; 20% of men and 10% of women believe that women should resolve unwanted pregnancies by giving birth and caring for her child.

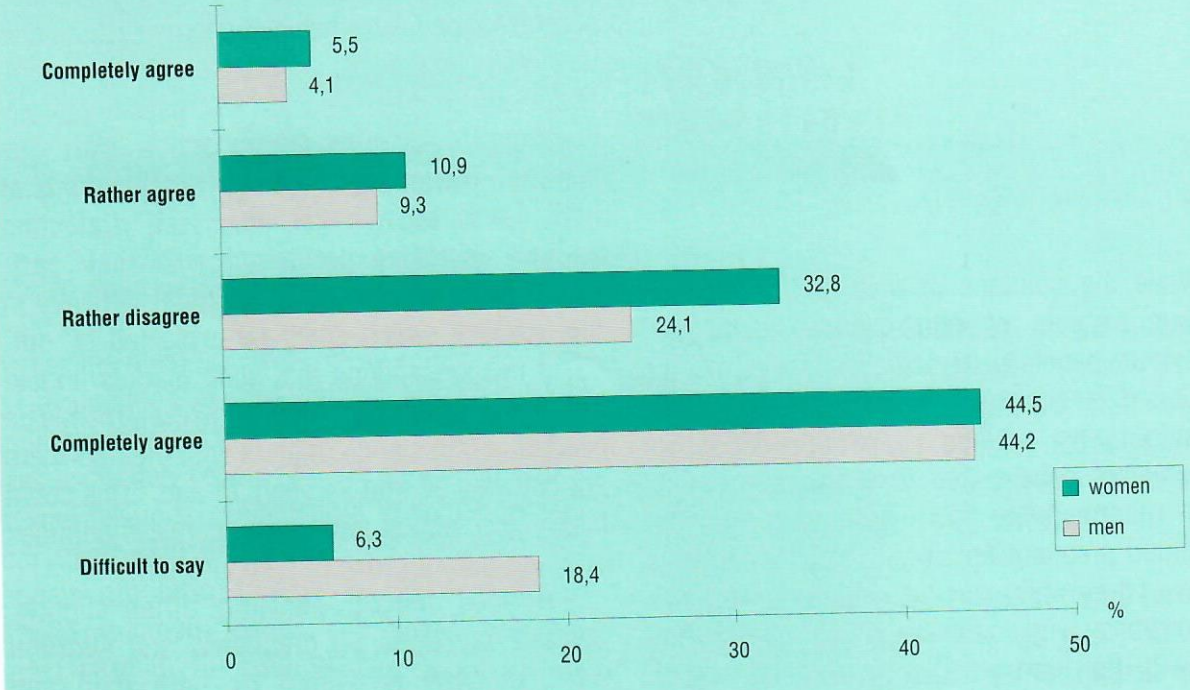
Fifteen percent of respondents view abortion as a normal method of birth control, although every fifth man had difficulty evaluating this statement. This contrasts to the strong conviction of women that abortion is not a normal method of birth control (see Figure 4.8). Both sexes exhibit a variety of contradicting opinions on women's right to choose an abortion: 93% of women agree that "Having an abortion is every woman's free choice, although the more infrequent, the better" in comparison to 75% of men who believe this. Ten percents of males in Latvia do not acknowledge a woman's right to choose an abortion. Men are far less decisive than women in evaluating whether abortion is "an unforgivable act similar to murder which should be prohibited". Men are also more likely than women to believe that access to abortion should be restricted (see Figure 4.10). Around 25% of all respondents in Latvia have a negative attitude towards abortion and feel that access should be restricted.

These differing opinions between the men and women on abortion point to a lack of sufficient discussion between partners on various aspects of reproductive health. Men do not become – or are not encouraged to become - sufficiently involved in decision making on reproductive health matters, nor do they accept enough responsibility for promoting strong and healthy family relations.

The largest consensus between the sexes was reached in relation to the effect of abortion on a woman's health – almost all respondents believe abortion to be harmful or very harmful to a woman's health.

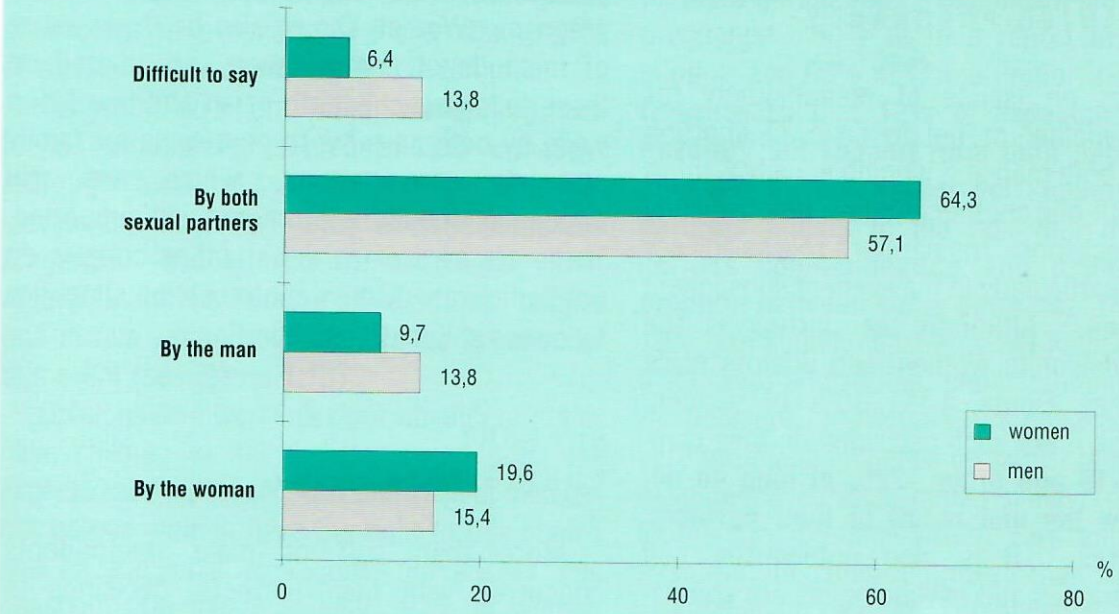
FIGURE 4.8.

EVALUATION OF THE STATEMENT – ABORTING IS A NORMAL METHOD OF REGULATING BIRTH CONTROL



Replied by all respondents

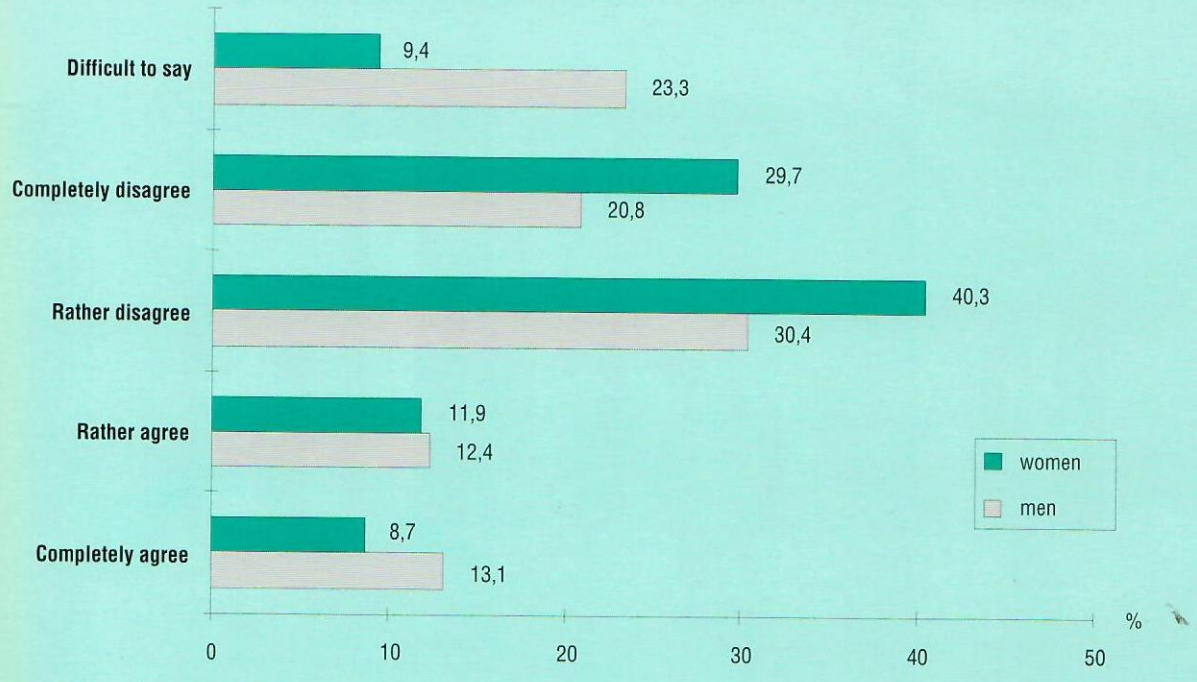
CONTRACEPTION SHOULD BE USED



Replied by all respondents

FIGURE 4.9.

EVALUATION OF THE STATEMENT – ABORTING IS AN UNFORGIVABLE DEED, EQUIVALENT TO MURDER, IT SHOULD BE PROHIBITED



Replied by all respondents

FIGURE 4.10.

RESPONSIBILITY IN CASE OF UNWANTED PREGNANCY

Answers on issues of responsibility for deciding whether or not to have an abortion show that both men and women equally want to consult with one another and take responsibility for such decisions. The partner's role as advisor increases particularly in the event of subsequent pregnancies. Although the partner is the primary advisor to women, and doctors place second (see Figure 4.11) 30% of women, nonetheless make such decisions on their own. **In the 15-19 age group, 22% of men do not even know the end result of their partners' pregnancies.** It is also noteworthy that mothers, friends and psychologists are comparatively rarely called upon for advice.

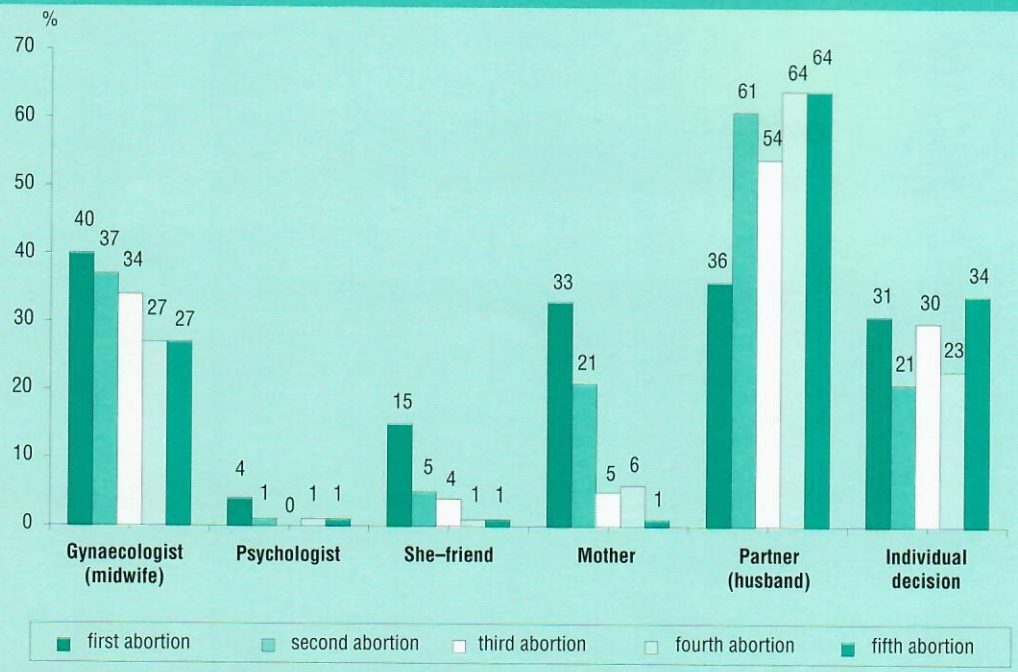
It is evident that a large amount of responsibility for advising women in the event of unwanted pregnancies rests upon the shoulders of doctors. Considering this trust that women place in their physicians, the responsibility of doctors in advising woman on birth control should be accordingly emphasised. Most importantly women should receive professional advice before she becomes pregnant. Women should also be made aware of methods of contraception and advised on these following childbirth or an abortion. Joint visits by both partners to physicians for family planning consultations, which are still unpopular, should be promoted and supported. These are particularly important as couples do not sufficiently discuss contraception strategies following childbirth and abortion.

SUPPORT DURING PREGNANCY

More than half of male respondents concurred with their partners' decisions to terminate an unwanted pregnancy, while also supporting this decision both morally and materially (see Figure 4.12). **Unfortunately, only 37% of women received support from their partners morally or financially in their decision to abort their first unwanted pregnancy,** 21% of women were supported

FIGURE 4.11.

WOMAN'S ADVISER BEFORE SHE MAKES A DECISION TO TERMINATE HER PREGNANCY



Replied by women who have had an abortion

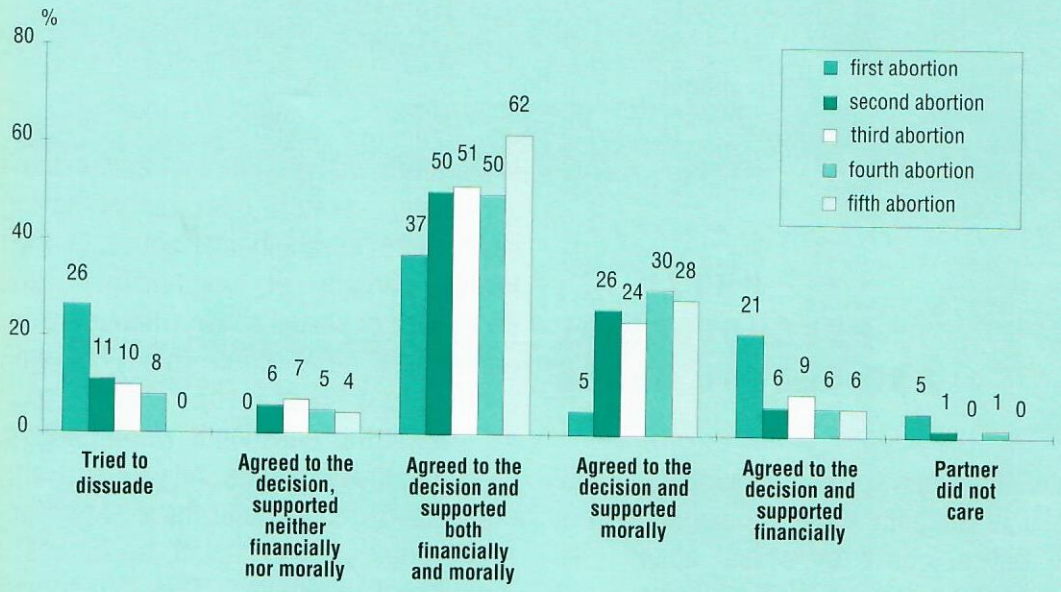
financially but not morally, and in the first event of pregnancy men most often (26%) attempt to talk their partners out of abortion. In the event of successive pregnancies these attempts at dissuasion came from only one in ten men.

Following abortion, most women reported feeling emotionally depressed and unhappy, although also relieved. Feelings of relief increased, however, with each successive pregnancy (and subsequent abortion). Still, regardless of the number of abortions, almost one in five women experienced no emotion at this event (see Figure 4.13).

Opinions on a woman's right whether or not to have children in her lifetime were both unexpected and surprising. Around 20% of men did not believe women have the right to this choice and an additional 15% could not answer this question. On the other hand, 92% of women believe this choice to be their right. Approximately 50% of men and 30% of women disagree with the statement "Caring for children is a woman's responsibility." However, it is possible that the statement was not precisely enough formulated and was misinterpreted by respondents to mean that "it is **only** a woman's responsibility."

It was reassuring that women do receive emotional support and understanding from their partners during such a significant life period as pregnancy. 90% of men report giving such support and 86% of women report receiving it. Nonetheless that **12% of expectant mothers have not felt support from their partners, yet only 3% of men report not supporting their partners attests to the fact that there is a serious communication and understanding problem between some partners.** This almost 10% gap acutely illustrates the insufficiency of discussion and mutual understanding in some relationships. Inadequate emotional contact is a very traumatic influence on family relations and in fostering parental responsibility. The development of prenatal health care and delivery systems in this country that focus on strengthening relations in families and between partners could be a significant investment in addressing this problem. Experience indicates that family deliveries provide a positive example for other families. It would also be useful to develop special education programmes for couples planning to start a family.

PARTNER'S REACTION WHEN LEARNING ABOUT THE POSSIBLE TERMINATION OF PREGNANCY

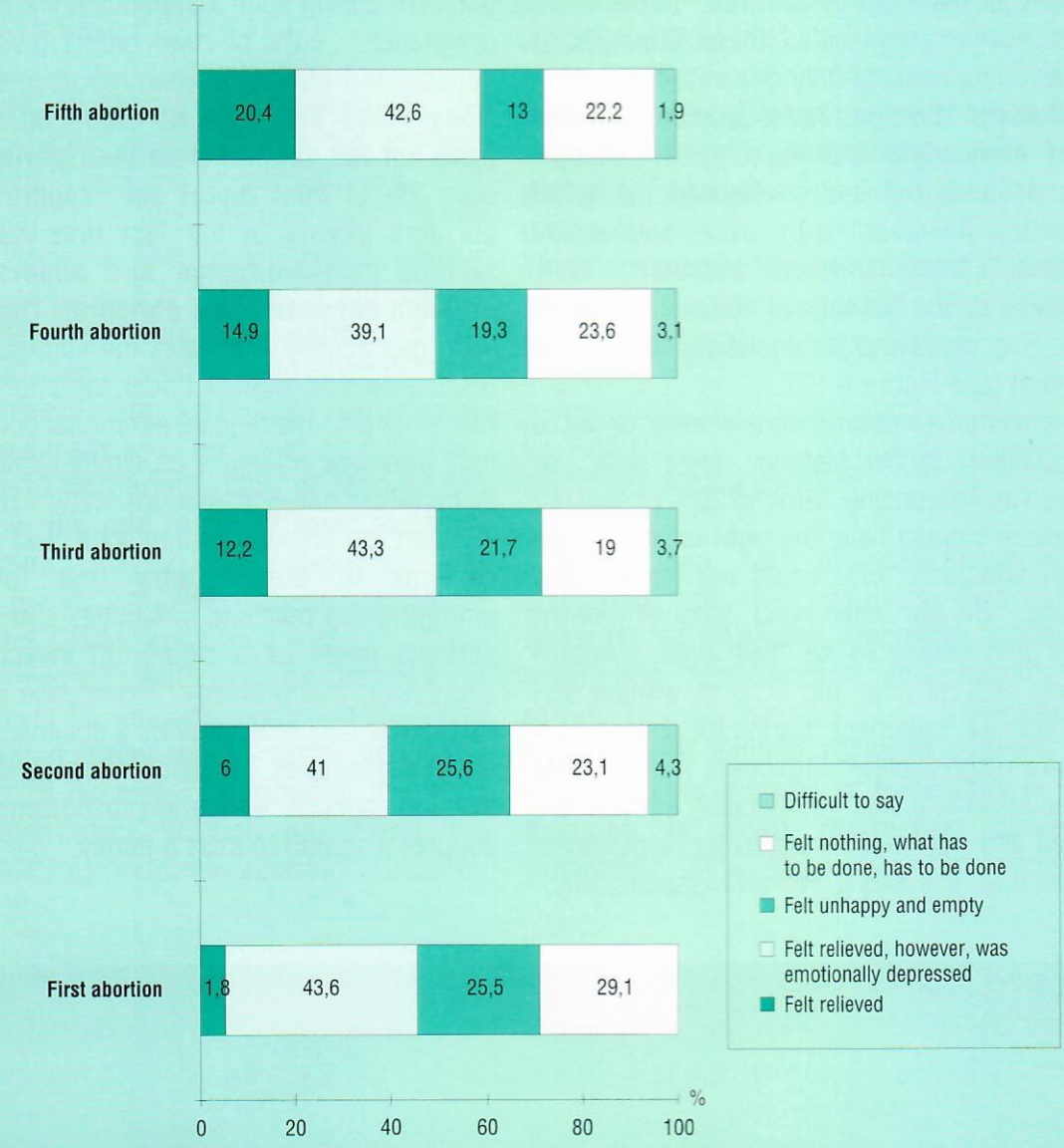


Replied by women who have had an abortion

FIGURE 4.12.

FIGURE 4.13.

HOW WOMEN FELT EMOTIONALLY AFTER ABORTION



Replied by women who have jad an abortion

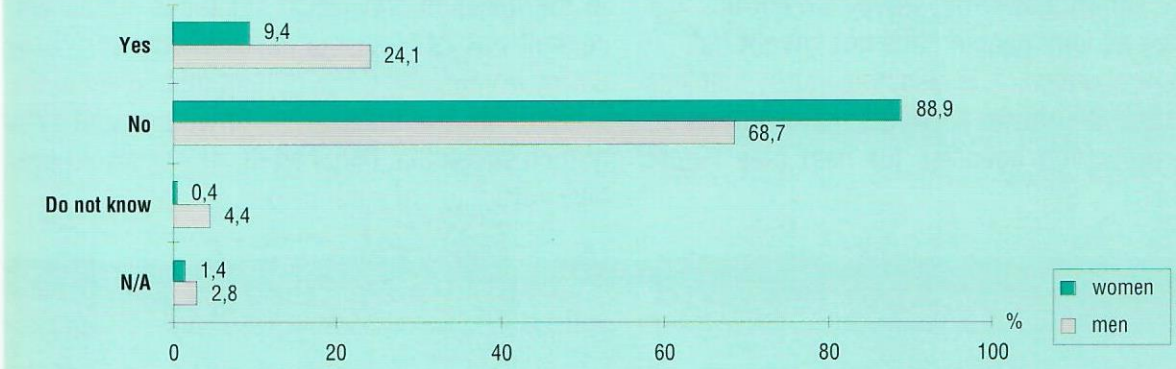
PHYSICAL, PSYCHOLOGICAL AND SEXUAL ABUSE

Results of the survey indicate that the majority of Latvia's inhabitants have not suffered from physical, psychological or sexual abuse (see Figures 4.14, 4.15 and 4.16). Nonetheless, men are most likely to suffer: one in four men has experienced physical violence, in contrast to every tenth woman. Almost every fifth woman and every seventh man report having been exposed to psychological abuse in their lives. Ninety percent of respondents report no experience of sexual abuse, although women still report this more often (6.6% of women in contrast to 0.4% of men). That 7% of men did not answer this question is worth pondering.

Although the results indicate that only small numbers of respondents have experienced violence, one suspects that these figures may be misleadingly optimistic. They beg consideration of the possibility that either individuals are not yet prepared to discuss violence or otherwise are not

familiar with the concept of "abuse". One must consider that the majority of the population lacks information on types of abuse and its consequences, particularly as regards psychological violence. Abuse suffered may translate into the sexual abuse of children, heartless behaviour towards children, violent attacks on others and even suicide.

HAVE YOU EVER SUFFERED FROM PHYSICAL VIOLENCE?



Replied by all respondents

FIGURE 4.14.

HAVE YOU EVER SUFFERED FROM PSYCHOLOGICAL VIOLENCE?

Replied by all respondents

FIGURE 4.15.

HAVE YOU EVER SUFFERED FROM SEXUAL VIOLENCE?

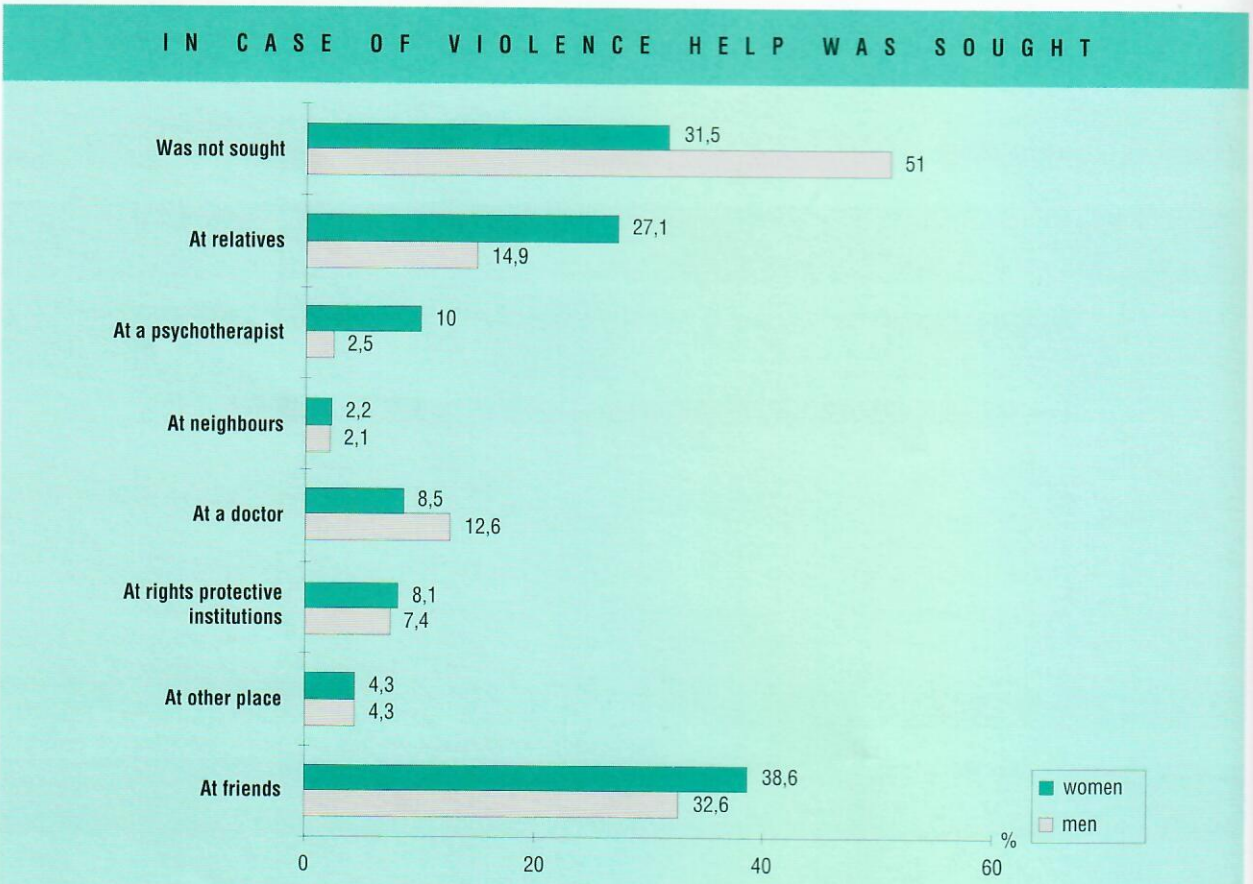
Replied by all respondents

FIGURE 4.16.

It is disturbing that only every other man and every third woman who has been the victim of abuse admits to seeking help. From this one can conclude that many people still suffer the consequences of abuse to a greater or lesser extent, which can influence both their mental and physical health, as well as their relationships with others. Unfortunately the survey did not uncover the reasons why people have not sought help in the event of abuse. It is also noteworthy that less than 10% of abuse survivors have turned to rights protection agencies for help (see Figure 4.17).

On average, every third victim of abuse sought help from friends, with family, physician and psychotherapist as the next most popular sources of help, respectively. In general, psychotherapists were thought to have partially or completely helped survivors overcome their abuse (in 92% of cases for men and 75% for women). In answer to the question, "In which situations would you consult a psychologist or psychotherapist?", only 8% of women and 0.8% of men mentioned in the event of abuse. In fact 12% of women and 17% of men stated that they had never nor would ever take advantage of such help.

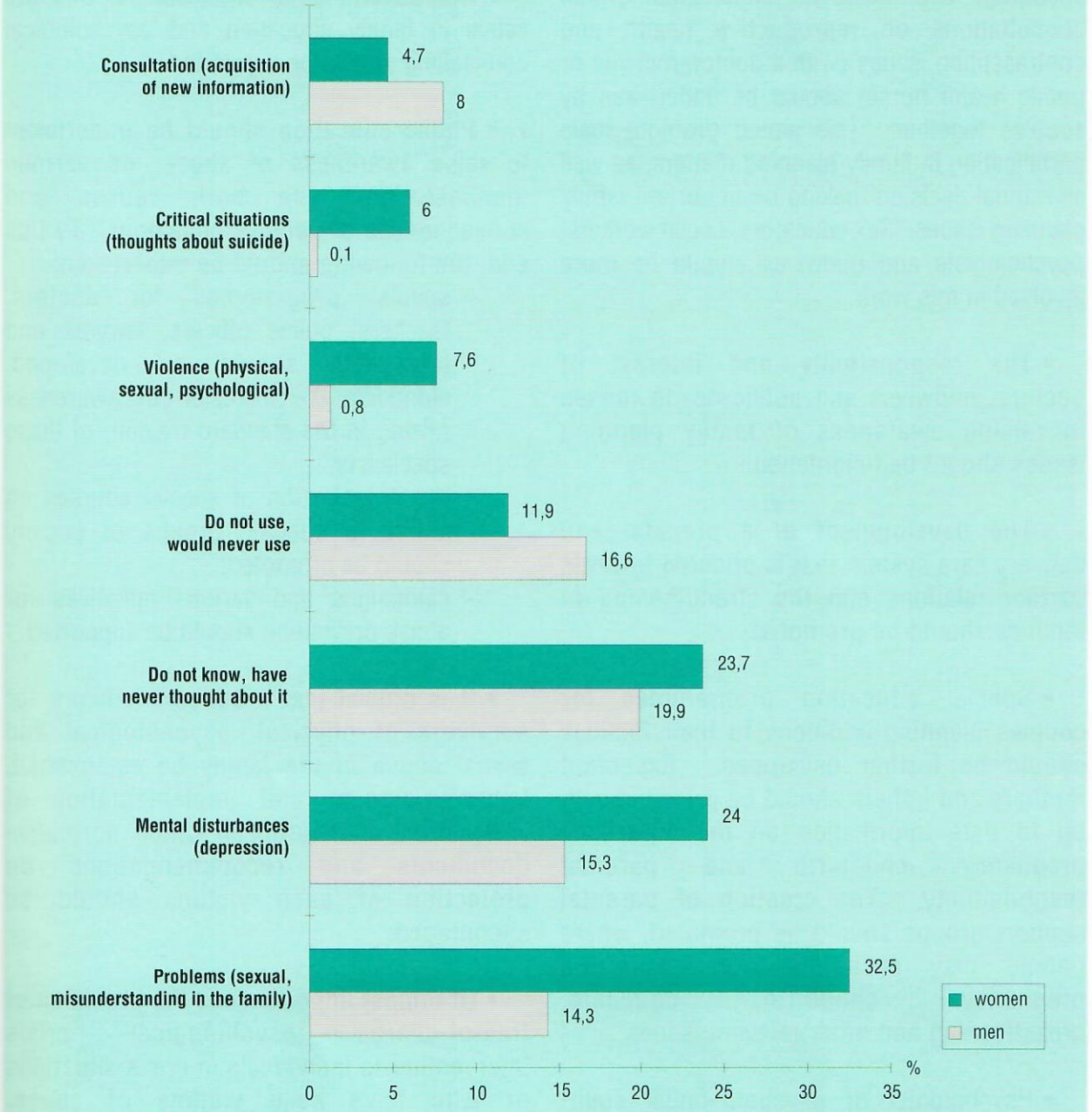
FIGURE 4.17.



Replied by those who have suffered from violence

The most common reason for seeing a psychotherapist was family conflict or sexual problems (see Figure 4.18). It is not inconsequential that women more often than men state that they would like to visit a psychiatrist or psychotherapist. This could be due to societal stereotypes concerning "femininity" and "masculinity", which propagate the idea that men must be strong, invincible and capable of solving their own problems as well as those of "weaker" people. These stereotypes which indicate that men are "not allowed" to experience emotional or psychological difficulties may deter men from either seeking help or even from admitting to the problems in the first place. This raises the question of whether men who suffer from emotional difficulties try to resolve these by other means. Doctors, health workers and psychologists should encourage men to consult with specialists when this is necessary.

IN WHAT CASES PEOPLE WOULD MAKE USE OF PSYCHOLOGIST OR PSYCHOTHERAPIST'S CONSULTIONS?



Replied by all respondents

FIGURE 4.18.

PROPOSALS AND RECOMMENDATIONS

• Raising awareness of individual responsibility for sexually healthy behaviour should be promoted. This should include encouraging the participation of both male partners and young people in taking responsibility for family planning and other aspects of reproductive health, ensuring that this idea is proliferated through mass media channels and included in sexual education programmes. In the same way, couples should be encouraged to openly and sympathetically discuss sexual behaviour, reproductive health and family planning concerns.

• Mass media, awareness raising seminars and regular interventions by physicians must encourage and create an understanding that consultations on reproductive health and contraception issues (with a doctor, midwife or public health nurse) should be undertaken by couples together. This would promote male participation in family planning matters, as well as mutual decision making on important family planning issues. Sex educators, social workers, psychologists and midwives should be more involved in this work.

• The responsibility and interest of doctors, midwives and public health nurses in raising awareness of family planning issues should be heightened.

• The development of a prenatal and delivery care system that is oriented towards partner relations and the strengthening of families should be promoted.

• Special education programmes for couples planning additions to their families should be further developed. Expectant mothers and fathers should be provided with up to date information on the course of pregnancy, childbirth and parental responsibility. The creation of parental support groups should be promoted, where people may exchange experiences on pregnancy, childbirth, childcare, breastfeeding and other relevant issues.

• Psychologist or psychotherapist counselling should be made more accessible (also in the financial sense) for women who feel they need to be counselled by a knowledgeable and understanding specialist both before and after an abortion. In the same vein, gynaecologists and family physicians should receive special training to be able to provide psychological counselling.

• Non-governmental organisations that are active in family education and psychological counselling should be supported.

• Public education should be undertaken to raise awareness of abuse, its various manifestations and both causes and consequences of abusive behaviour. To this end, the following should be undertaken:

- special programmes for doctors, teachers, police officers, lawyers and journalists should be developed, alongside the inclusion of awareness raising in the standard training of these specialists;
- the organisation of special courses on abuse in specific groups of society should be promoted;
- campaigns and various initiatives for abuse prevention should be supported.

• It is crucial that a support network for survivors of physical, psychological and sexual abuse in the family be established. Latvia's signing and implementation of various UN and European Union normative documents and recommendations on protection of such victims should be encouraged.

• Of utmost importance is the provision of free-of-charge psychological crisis intervention to individuals in crisis situations or who have been victims of abuse. Therefore, a sufficient number of crisis centres must be established. Health care workers and educators must encourage people, especially men, to turn to psychologists and psychotherapists for help when necessary.

5th

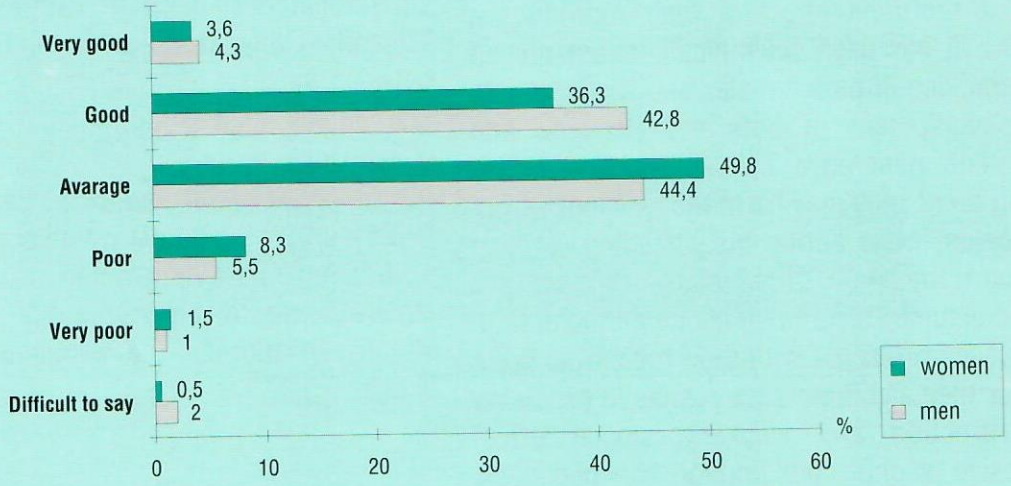
CHAPTER

REPRODUCTIVE HEALTH: MEDICAL ASPECTS

PERSONAL ATTITUDES TOWARDS HEALTH

Reproductive health is one aspect of an individual's overall state of health and is very closely connected to an individual's lifestyle, emotional, social and economic welfare. The survey revealed a rather bleak picture of Latvia's inhabitants' evaluation of their own state of health. **Only every other respondent rated their state of health as "good". Almost half of respondents viewed their state of health as mediocre, while 10% of women and 6% of men rated their own health as very poor.** This corresponds to people's evaluations of their emotional well-being: only around 60% of inhabitants are usually in a good mood, while every third person acknowledges that they more often than not feel depressed (see Figures 5.1 and 5.2). Furthermore, only half of respondents

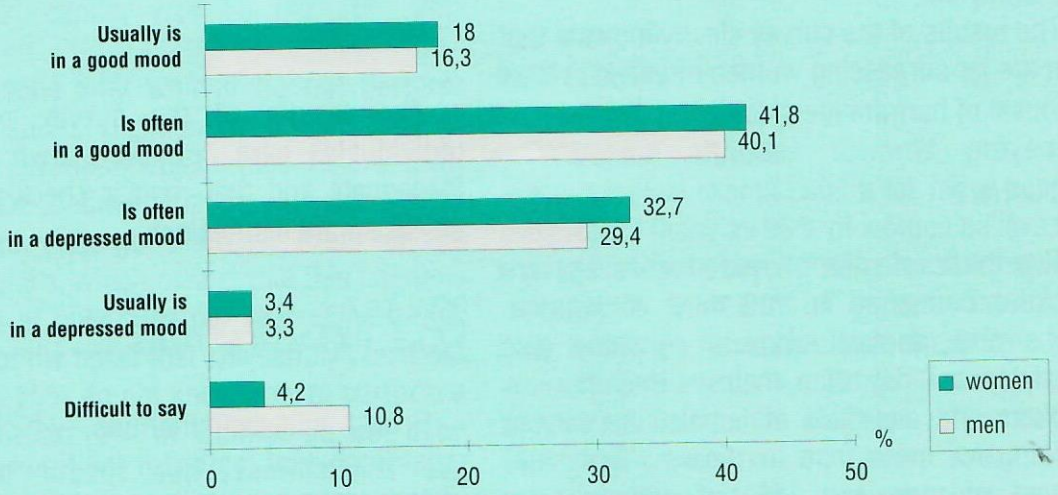
EVALUTION OF ONE'S OWN STATE OF HEALTH



Replied by all respondents

FIGURE 5.1.

EVALUATION OF ONE'S EMOTIONAL CONDITION



Replied by all respondents

FIGURE 5.2.

feel their current lifestyle to be satisfactory. Around 40% of people are more likely to see their lifestyle as unsatisfactory, and every tenth person is completely dissatisfied. Women rate their current emotional wellbeing and satisfaction with their lifestyle more positively than their male counterparts, yet rate their own state of health as lower.

HARMFUL HABITS

A person's lifestyle and harmful habits will have a profound effect of their reproductive health. It has been scientifically substantiated that smoking in both females and males effects the development of both the feminine and masculine generative cells. Nicotine intake during pregnancy may harm the development of the foetus, while during breastfeeding nicotine will harm the health of the infant. Women who have consumed alcohol for a long period of time experience problems with their menstrual cycle and for men alcohol excess results in problems with erection and weakens sexual drive. Excessive alcohol consumption can negatively influence sexual behaviour by encouraging carelessness, lack of responsibility and even violence. Alcohol abuse also has the power to create great stress and strife in couple relations and family life.

The results of the survey clearly indicate that men are far surpassing women in Latvia in their espousal of harmful lifestyles.

NICOTINE

Two-thirds of men of reproductive age are smokers compared to one-third of women. Furthermore, female smokers consume less cigarettes per day than males. Half of male smokers and one-third of females have been smoking for more than ten years. Forty-four percent of men and 18% of women have succeeded in quitting, although for the most part these were people who had been smoking for no longer than two years.

ALCOHOL

Men and women displayed similar behaviour in relation to alcohol. Only 7% of men and 6% of women completely abstain. The survey illustrates that the favourite alcoholic drinks of Latvia's inhabitants in descending order are beer, spirits and wine. Of those men who use alcohol weekly or more frequently, beer is most popular (33%), followed by spirits (11%) and wine (3%).

Fifteen percent of men and three percent of women have used other intoxicating substances such as narcotics or other chemical substances. Women in this group were for the most part between the ages of 15 and 19.

The survey data do not allow one to draw conclusions about the motivation behind all of the above-mentioned health-harming behaviours, for example whether alcohol use is a strategy for evading other problems. Such research would be necessary in order to effectively address the problem of harmful habits.

PERSONAL PREVENTIVE HEALTH MEASURES

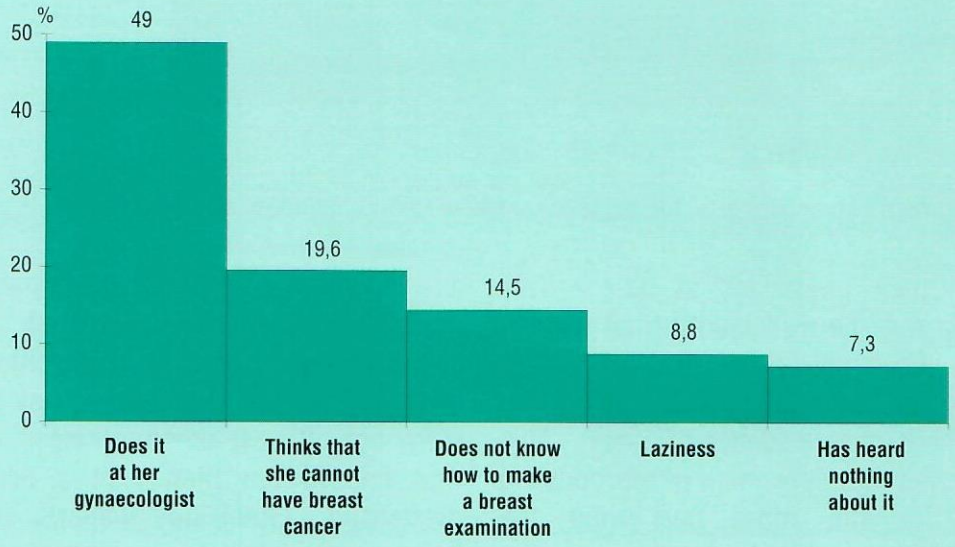
The results of the survey reveal that individuals' care for their own health is inadequate and that regular check-ups with a physician are insufficient.

BREAST SELF-EXAMINATIONS

Breast self-examinations, which are the most important factor for the timely detection of cancerous breast illness, are performed by only slightly more than every other woman

(56%). Of these women, only half perform examinations on a regular monthly basis. This leads to the conclusion that that only one in four women in Latvia is adequately caring for the health of her breast tissue. These statistics correspond to the Latvian register of cancer incidence: in 1996 40% of malignant tumours were discovered at the progressed or most critical stage, as women sought out a doctor too late. While in the US almost 90% of breast cancer is diagnosed in its early stage and in Europe such diagnosis is between 70% and 90%, in Latvia breast cancer is only diagnosed in its early stages in 59% of patients. In the last ten years incidence of breast cancer has increased: while 51 in 100, 000 cases were diagnosed in women in 1987, by 1996 the number had

REASONS WHY WOMEN DO NOT PERFORM BREAST SELF-EXAMINATION



Replied by women who have not done self-examination of their breast (N=1314)

FIGURE 5.3.

climbed to 64. In 1996, the rate of death from breast cancer was 16 per 100, 000 women.

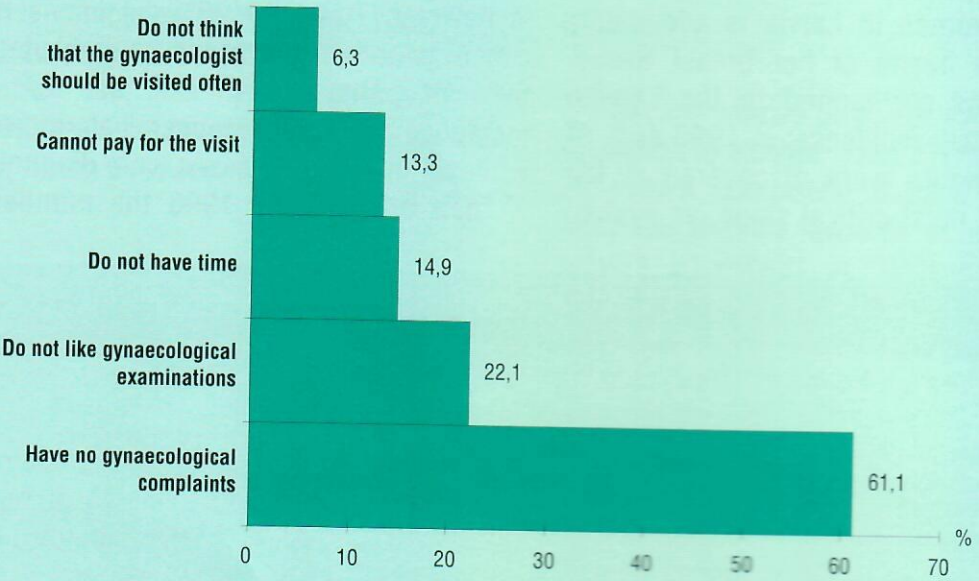
The reasons why women do not perform self-examinations highlight a critical lack of awareness on this subject (see Figure 5.3). Almost half believe that it is completely sufficient to undergo a breast exam at the gynaecologist's, which means that this happens on average of only once per year. One in five women is of the belief that she simply could not get cancer; 15% do not know how to perform a self-examination; **7% of women do not even know that breast self-examinations are necessary.** This data underlines a very dangerous level of ignorance.

VISITS TO GYNAECOLOGIST

Women's attitudes towards preventive gynaecological exams paint a far more positive picture. As many as 95% of women believe that a gynaecological check-up is necessary at least once a year, while 80% of women confirm that they in fact go for such check-ups once a year or even more frequently. This is in somewhat of a contradiction to the incidence of cancer, as statistics show that in almost every other women (44% in 1996) cervical cancer is only diagnosed at a progressed state, as women do

FIGURE 5.4.

REASONS WHY WOMEN DO NOT MAKE PROPHYLACTIC VISITS TO GYNAECOLOGIST



Replied by women who do not visit prophilactic gynaecological examinations (N=520)

not consult their physicians in time. This contradiction may be explained in that women visit the gynaecologist far less frequently after reproductive age, although it is this age group which has the largest incidence of cancer. This survey interviewed only women of reproductive age, who for the most part visit the gynaecologist on a regular basis.

Of the 17% of women who do regularly see a gynaecologist, most believe that visits are only necessary in the case of a specific complaint. Every fifth woman believes that these check-ups are unpleasant and 13% of these women state that they cannot financially afford to visit the gynaecologist regularly (see Figure 5.4).

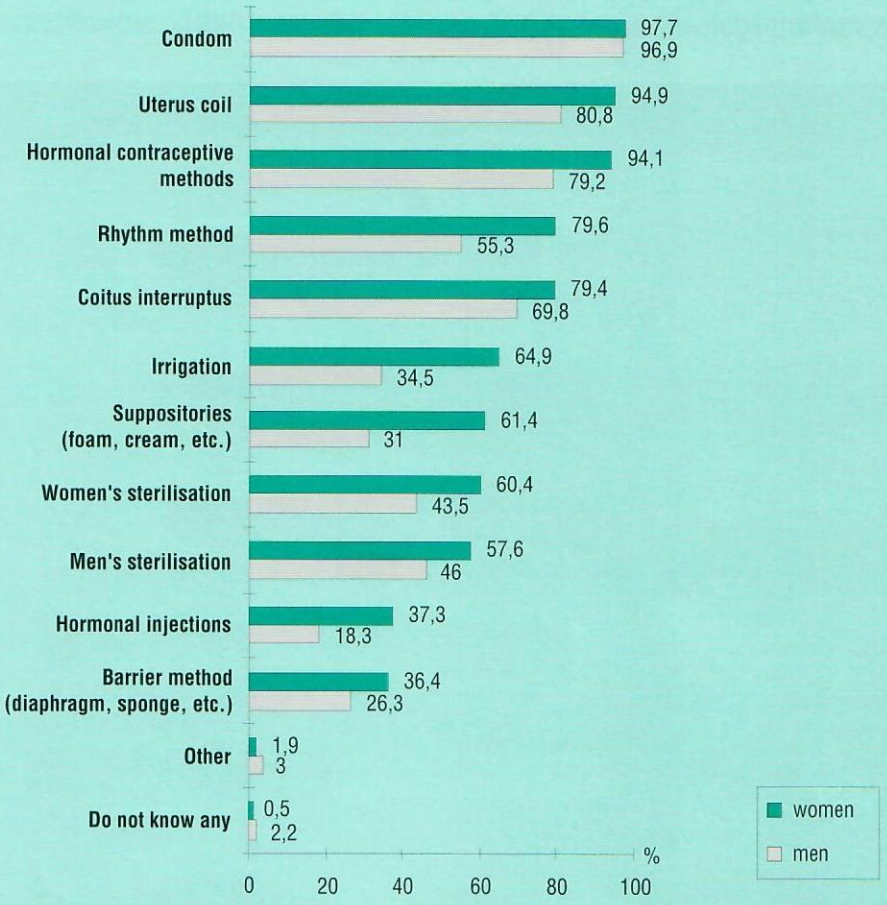
VISITS TO UROLOGIST

The survey data revealed that men are considerably ignorant about the need for reproductive health check-ups. Nine percent of men visit a urologist for preventive check-ups, which could be considered acceptable given that the men surveyed were 45 years of age or younger: preventive check-ups are necessary for men once in their teen years and then yearly starting from either age 50, or if the men are at increased risk for cancer, from age 40. It is nonetheless interesting that one in ten men visit a urologist for preventive check-ups, every third man believes such visits are necessary on an annual basis and 50% are unaware that such visits are even necessary. This highlights the low level of male awareness regarding under which circumstances and how often it is advisable to consult a urologist on a preventive basis.

CONTRACEPTION

Latvia lacks reliable and objective statistics on contraceptive methods and their prevalence (for further explanation, see Chapter 3), therefore the survey paid a great deal of attention to this question, including a great number of questions on family planning. As a result, the survey offers a very valuable information base on people's attitudes towards

CONTRACEPTIVE METHODS KNOWN BY RESPONDENTS



Replied by all respondents

FIGURE 5.5.

contraception, their level of knowledge and awareness, the kinds of myths prevailing in society, as well as the population's actual use of contraception.

AWARENESS OF CONTRACEPTION METHODS

The most commonly known contraceptive methods in Latvia are: condoms, intra-uterine device (IUD), and hormonal contraception (see Figure 5.5). Women are better informed than men about contraceptive methods and products. Men for the most part have difficulty evaluating both the reliability and efficacy of different contraceptive methods. Women as well had difficulty in evaluating modern contraceptive methods (injections, barrier methods, contraceptive vaginal suppositories, sterilisation) and for the most part those who can evaluate them are women who have used these methods themselves.

All in all, women's knowledge about various birth control methods is insufficient. Only half of women believe that oral contraceptives (the pill) are reliable (in terms of protecting against unwanted pregnancy) and one in four believes this method to be unsafe. It has been scientifically shown that oral contraceptives, with an efficacy rate of 99%, are the second most reliable method of birth control following sterilisation. Less than 50% of women feel that sterilisation is a reliable method of contraception and 36% feel that it is unreliable (see Figure 5.6). In reality, surgical sterilisation is virtually 100% effective. Every other woman believes that oral contraception is harmful to a woman's health (see Figure 5.7). This underlines the fact that

many myths – which came about several decades ago when the first oral contraceptives contained large doses of hormones and did in fact impact a woman's health negatively – are still prominent.

Currently, third generation oral contraceptives are being produced which contain comparatively tiny hormonal dosages and no longer have any negative health side effects. Thirty-six percent of

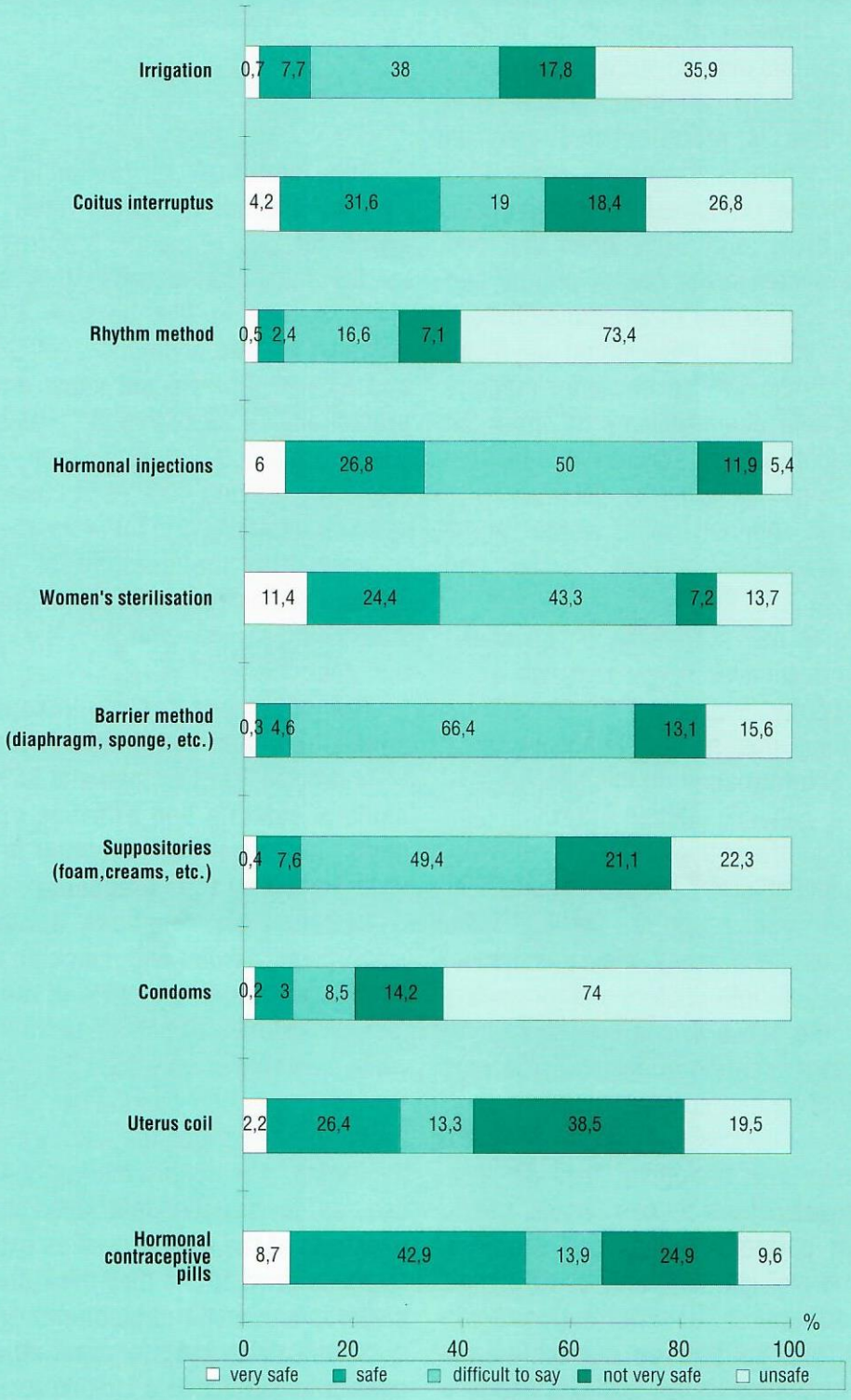
EVALUATION OF EFFICIENCY OF CONTRACEPTIVE METHODS (WOMEN)

FIGURE 5.6.

Replied by all women (N=2990)

the women surveyed also believed that sterilisation poses a health risk to women, although it is difficult to understand from where such misconceptions have arisen. Perhaps this can be explained be a complete lack of awareness, as the unknown has a tendency of breeding mistrust. Furthermore, only 36% of women felt that withdrawal (interrupted coitus)

EVALUATION OF INFLUENCE OF CONTRACEPTIVES ON WOMAN'S HEALTH



Replied by all women (N=2990)

FIGURE 5.7.

can be harmful to a woman's health. However, this method can indeed have negative effects on a woman's health, as it can cause frustration and stress during intercourse, and if used over prolonged periods of time, can lead to problems with both partners' nervous systems.

The survey data reveal that 95% of all women are aware of oral contraception as a method of birth control. However, responses to various statements about this method show that only half of all women know anything about oral contraception that is more detailed than its degree of efficacy and its advantages: only 40% of women know that combined pills can regulate the menstrual cycle; only 30% know that oral contraceptives decrease the risk of uterine and ovarian cancer; almost half of all women believe the myth that using oral contraception will result in weight gain. While 60% acknowledge that oral contraceptives help diminish fears of unwanted pregnancy, almost half also acknowledge that the effort to remember to take the pill daily is a source of stress. Almost half of women agree that oral contraception is easy to use and effective.

An analysis of men's answers on questions about oral contraceptives reveal that half of all men had difficulty evaluating these various statements about this method, showing their apparent lack of information on this subject.

Women are generally better informed than men are about contraceptive products, methods, their reliability and efficacy. The main sources for knowledge on contraception named were physicians, books and mass media channels. This underlines that both doctors and journalists must be far more active in challenging existing myths about contraception in society. The next most commonly named sources of information are friends, acquaintances and special booklets. As very few men visit urologists, they get their information mostly from books, mass media channels, their partners, friends and booklets. That men name their partners only as their third most common source of information again highlights the fact couples do not sufficiently discuss family planning issues with one another.

Only a small number of respondents reported their parents as a source of information on contraception. Only 11% of women and 15% of men (for the most part between 15-19 years of age) learned about birth control in health education classes at school, which makes sense given that health education has only been initiated in recent years (see Figure 5.8).

USAGE OF CONTRACEPTION

Only one-third of respondents protected against pregnancy during their first sexual encounter. The remainder reported not doing so for the most part because they did not think about it, one in five because they were not prepared for the encounter, **yet 9% of women and 6% of men did not know anything about protection.** Of those that did protect themselves from pregnancy during their first sexual encounter, around 40% used condoms, 30-40% withdrawal, and one in ten – the rhythm method. In answer to the question of which partner initiated protection methods, half reported that it was a joint decision and 20% said it was one or the other partner.

The most popular contraceptive method among both men and women is the condom.

In total, 60% of women and 56% of men use modern, reliable and effective methods (condoms, hormonal contraception or the IUD) in order to protect from pregnancy.

Unfortunately, methods as unreliable as withdrawal, rhythm and douching are still used by 25% of women and 40% of men (see Figure 5.9). Withdrawal has an efficacy rate of 70-80%, while douching is only 35 – 50% effective. Furthermore, the latter method can effect a woman's health, as it changes the natural environment in the vagina. The rhythm method is 40-97% effective, as it is dependent upon the conscientiousness of the user as well as external factors. Opposite to what one may think, these last three methods are used more commonly in Riga than in other Latvian cities or rural regions. This is more a testament to a lack of awareness about modern contraceptive methods, the power of myth and habit, than to a problem of

SOURCE OF INFORMATION
ABOUT CONTRACEPTIVES AND PREVENTIVE METHODS

Replied by all respondents

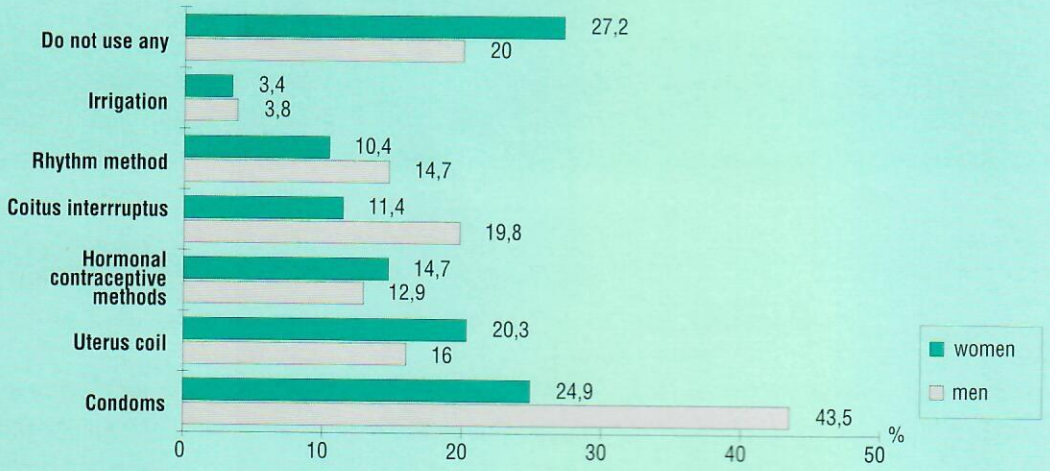
FIGURE 5.8.

accessibility: given that many rural dwellers must travel sometimes twenty or thirty kilometres to the nearest pharmacy often with infrequent public transport, modern contraceptives are in fact more difficult to obtain in rural regions.

The survey did not reveal that women have chosen sterilisation as a means of protecting against pregnancy, and only three percent are considering this as a method for the future. One of the main reasons for this may be the high cost of sterilisation which is not

FIGURE 5.9.

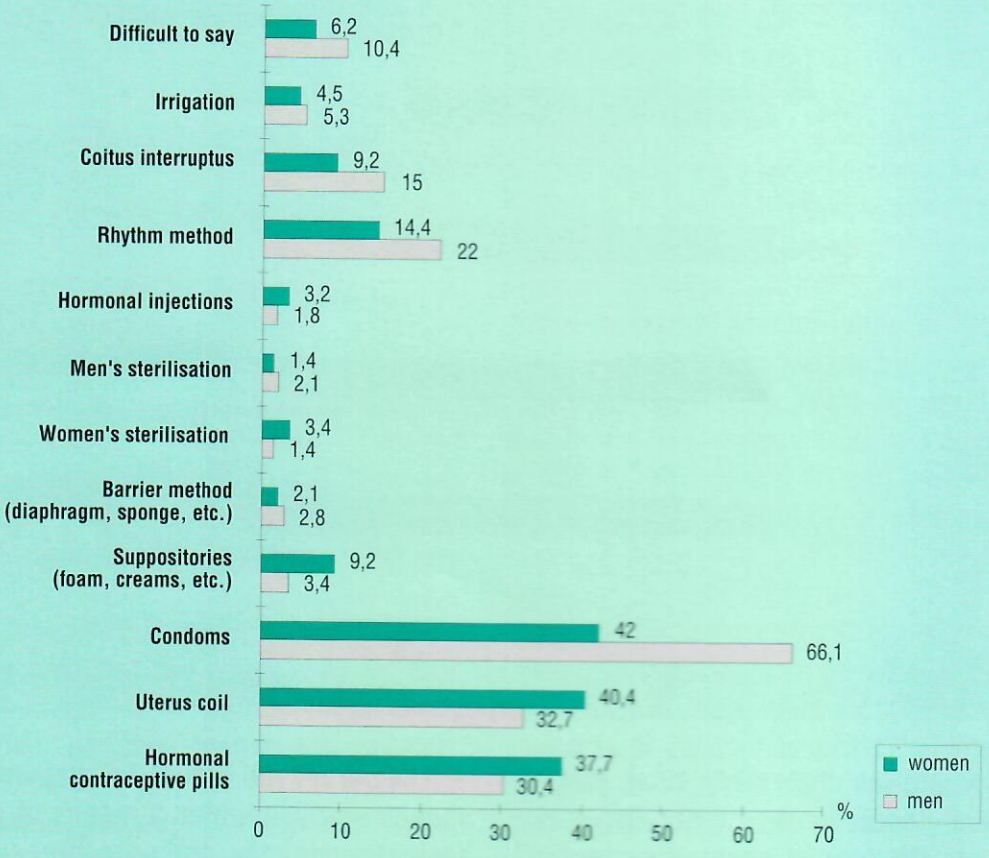
CURRENTLY USED CONTRACEPTIVES



Replied by those who have had relations (women N=2652, men N=1366)

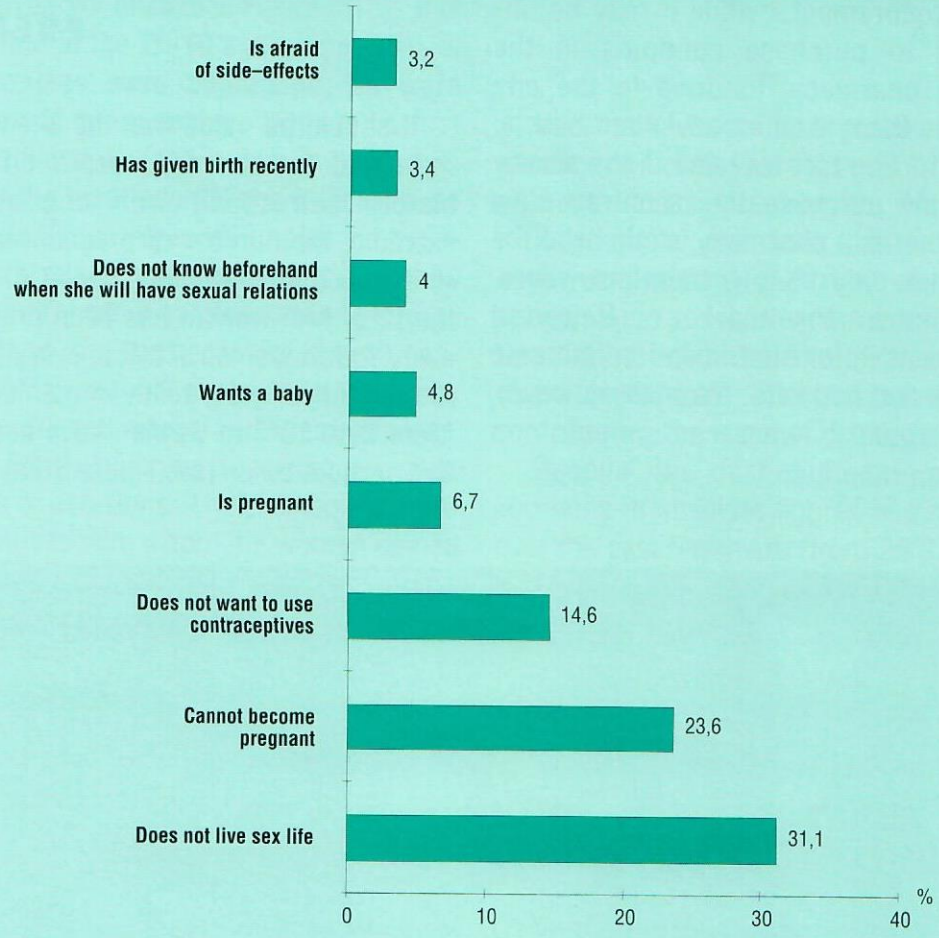
FIGURE 5.10.

CONTRACEPTIVE METHODS LIKELY TO BE USED IN THE FUTURE



Replied by all respondents

REASONS WHY WOMEN DO NOT USE ANY OF THE BIRTH CONTROL METHODS



Replied by women who currently do not use any contraceptive method

FIGURE 5.11.

included under state medical coverage. In 1996, sterilisation was designated as a fee service which would cost a patient more than 100 Lats. Most of the women who may want to choose this method simply cannot afford it. Another reason for its unpopularity is the lack of information about sterilisation as a method of contraception.

In the future, 75% of women and 65% of men wish to either continue or begin using some form of contraception. Every fourth man and every third woman of those who are currently using an unreliable form of contraception would like use a more effective method in the future. However, the most popular choice among women for a future means of contraception is again the condom. The next most popular preferences are the IUD and oral contraception (see Figure 5.10).

Ten percent of men and seven percent of women respondents have never used any form of contraception. Currently 27% of sexually active women and 20% of men are not using any form of contraception. One in every five of these women states that she is unable to become pregnant, 15% do not wish to use contraception and 5% are hoping for a child (see Figure 5.11).

The survey data leads to the conclusion that contraceptive prevalence among both men and women increases in accordance with the level of the individual's education, while social status or class appears to have no influence on contraceptive prevalence. Condom use is more common among inhabitants of Riga, while hormonal contraception and the IUD are used more in other cities, villages and rural regions.

It would make sense that rural dwellers do not use condoms given the complicated nature of procurement: while it may be uncomfortable to purchase condoms in the town's only pharmacy, to drive to the city centre to buy them is an inconvenient hassle.

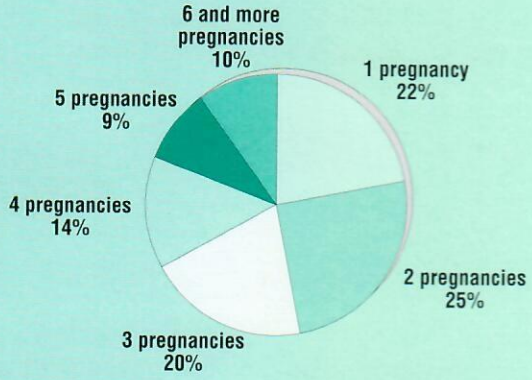
One comforting fact revealed in the survey is that people purchase their contraceptive products either in a pharmacy, clinic or at the doctor's, while only 1% buy them elsewhere, for example, in the market. Reported monthly expenses for contraception fluctuate between one and two Lats. Women, however, tend to spend twice as much on contraception than men.

PREGNANCY

It should be noted that the answers of both male and female respondents on pregnancy history correspond with one another, for example, the number of pregnancies a women (the man's partner) has had. Around every fourth or fifth woman has been pregnant once; every fourth women – twice; every fifth woman – three times; every tenth woman – four times. More than 10% of women have been pregnant five or more times (see Figure 5.12). More than

FIGURE 5.12.

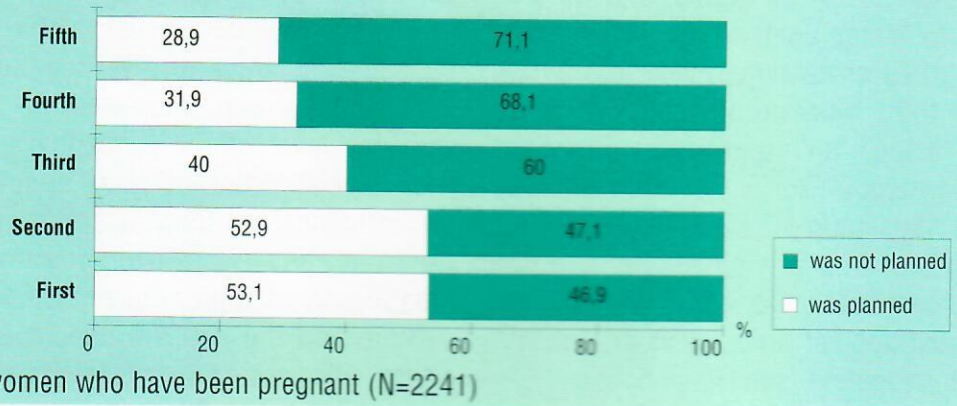
NUMBER OF PREGNANCIES



Replied by women who have been pregnant (N=2241)

FIGURE 5.13.

PLANNED/UNPLANNED PREGNANCIES



Replied by women who have been pregnant (N=2241)

half of all pregnancies were unplanned, and each successive pregnancy was less commonly planned than earlier ones (see Figure 5.13). **It is disturbing that in the 15-19 age group, 75% of first pregnancies were unplanned, as were 63% of second pregnancies.** Unplanned first pregnancies become less common with age, although as the respondents' age increases, so does the number of repeated unplanned pregnancies. This raises concerns about a woman and her partner's rather carefree attitude in relation to abortion and the necessity of birth control, although a second explanation could be that women do not receive sufficient information about family planning following repeated pregnancies or abortions. Gynaecologists, midwives and nurses with whom the woman comes in contact with after becoming pregnant should take more responsibility for this.

ABORTION

Because of the serious problem of repeated abortion in Latvia (see Figure 5.14), the survey paid particular attention to this issue and included many questions that would help to better understand the root causes of this phenomenon. However, the question of abortion turned out to be one of the topics which respondents were reluctant to discuss thus complicating the issue of detailed analysis.

Despite the fact that the numbers of abortions in absolute figures has slightly fallen over the past few years (from 25 933 abortions in 1995 to 24 227 abortions in 1996), the number of abortions in relation to 1000 live

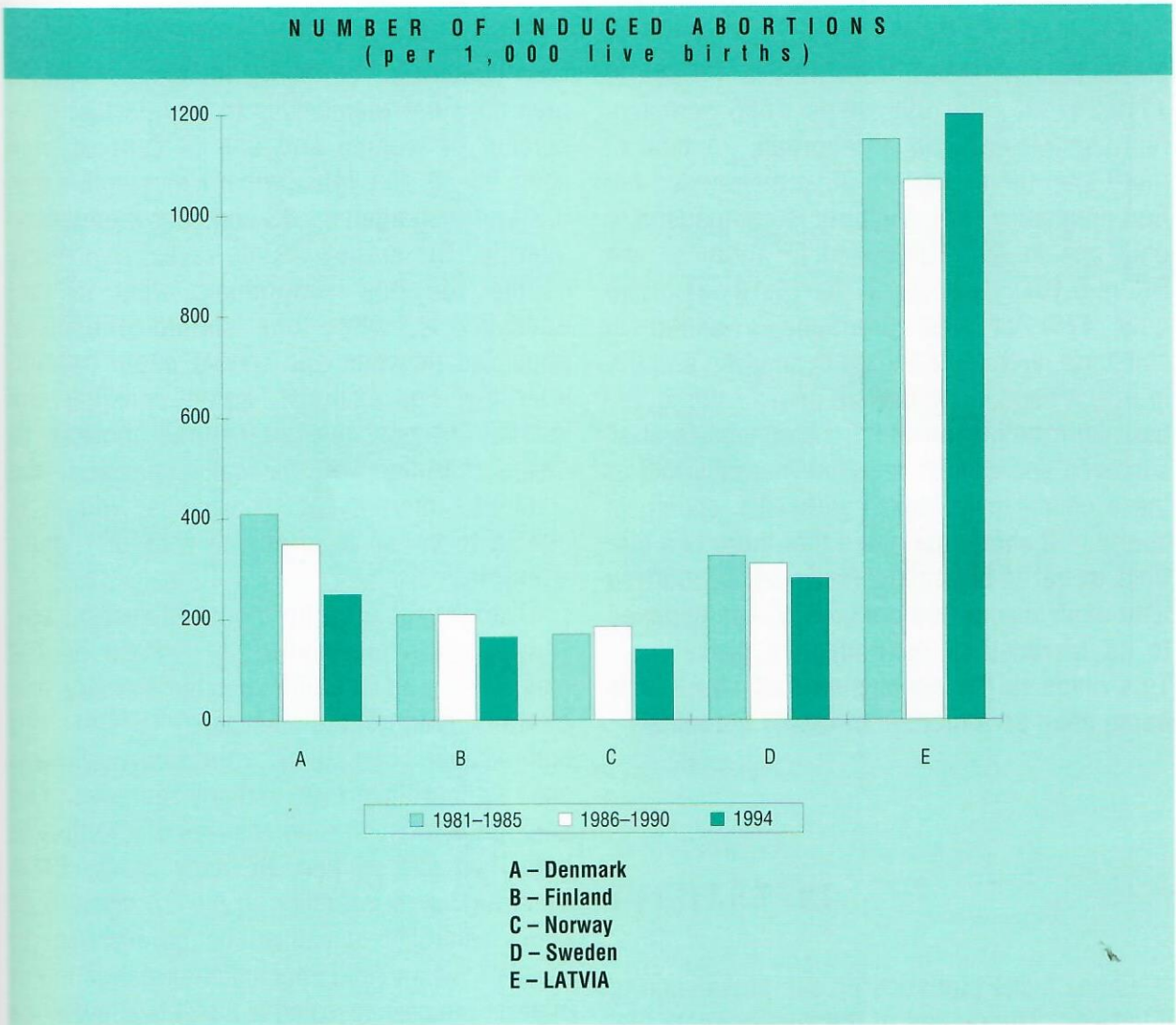
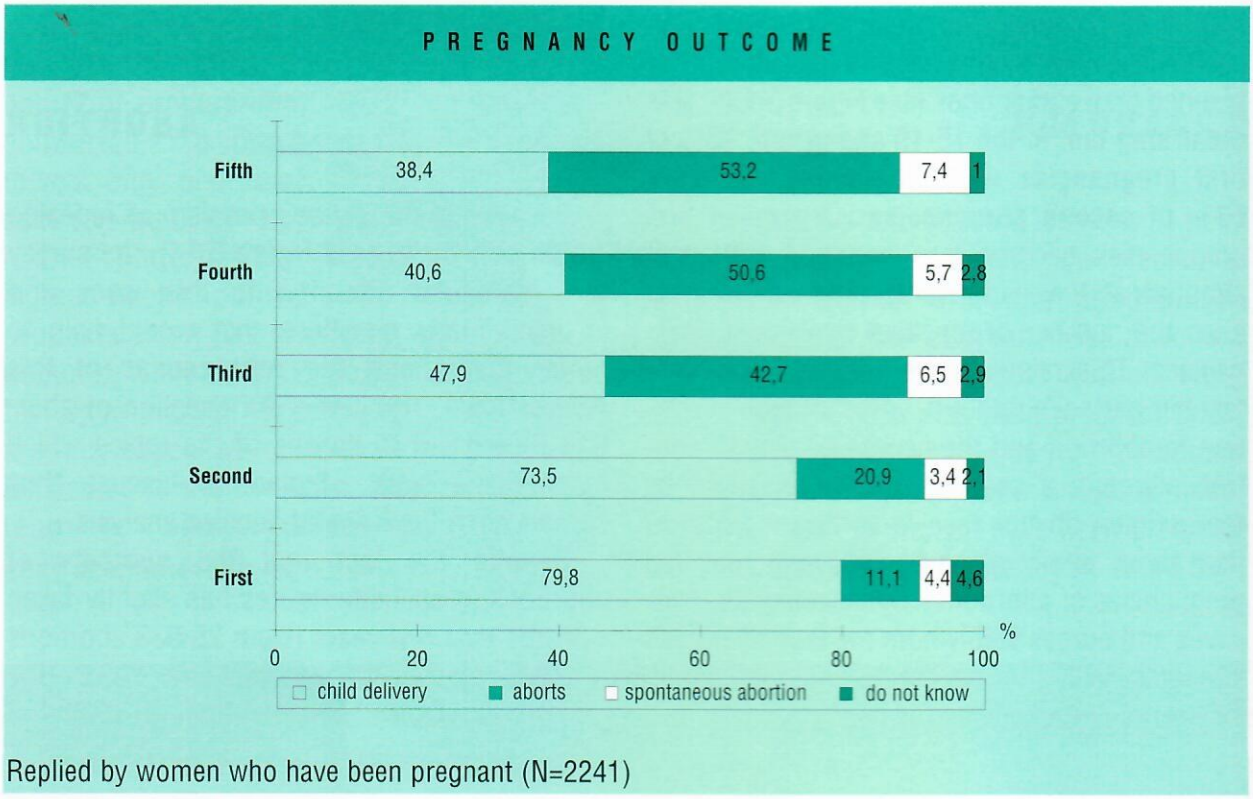


FIGURE 5.14.

FIGURE 5.15.



Replied by women who have been pregnant (N=2241)

births has increased from 1206.2 (1995) to 1219.3 (1996). In 1996, 46 per 1000 women of reproductive age had an abortion. A total of more than three quarters of women ended her first pregnancy with childbirth in comparison to only one in ten that ended in abortion (see Figure 5.15). However, in the 15-19 age group only 47% of first pregnancies ended in childbirth, with 28% ending in abortion and 9% in miscarriage. 16% did not answer this question. An examination of third pregnancies of all surveyed age groups revealed that only half of these ended in childbirth with 42% ending in abortion. **It should be noted that there is a distinct trend of increased recourse to abortion with each successive pregnancy – as opposed to an increase of contraceptive prevalence. This leads to the conclusion that abortion is being used as a method of family planning.**

INFERTILITY

Latvia lacks statistics on the prevalence of infertility. The results of the survey show that four percent of women and one percent of men consider themselves to be infertile: five percent of women and one percent of men aged 25-30 and four percent of women and 0.5% of men aged 31-43 consider themselves infertile. The survey results reveal that many couples do not comprehend what in fact infertility is, when one should consult a physician or when one should begin treating infertility. For example, some consider the inability to conceive after three months to mean infertility, yet medically speaking, the state of infertility occur when a woman is unable to conceive after one year of regular attempts.

Ovarian problems, hormonal imbalances and endometriosis are named by women as the main causes of infertility, despite the fact that sexually transmitted diseases (STDs) and complications resulting from abortion have been statistically proven in many countries to be among the most common causes of infertility in both men and women. In many cases, STDs cause women's infertility; in the US 40-50% of family infertility is caused be gonorrhoea; in Sweden, Finland and England an investigation of infertile couples revealed a 20-51% prevalence

of chlamydia. Considering the widespread incidence of STDs and the high number of abortions in Latvia, in would seem that the survey results do not reflect an objective reality. Furthermore, Latvia may in fact have a prevalence of infertility that matches the rest of the world – around 8%. As abortion complications and STDs were barely mentioned in the survey as causes of infertility, it would seem that these factors are not generally recognised in society as influencing infertility.

For men, infertility may take root already in their teen years. Since reversing this condition is possible with prompt diagnosis and treatment, it is crucial that teenage men see their family physician or a urologist for a preventive check-up. Unfortunately, as indicated in the survey results, only 5% of young men aged 15-19 have been to a urologist for a check-up. **It would seem that a lack of awareness of this problem in Latvia is the direct reason why young men do not go for this check-up.**

It must also be noted that infertility prevalence was almost twice as high among those who live outside of Riga. This raises the question of inconsistent accessibility, as well as quality, of medical services. One major problem surrounding infertility is the expensive diagnosis and treatment which furthermore tends to be for extended periods of time.

MORBIDITY WITH STD IN AGE GROUPS
per 100,000 inhabitants (1996)

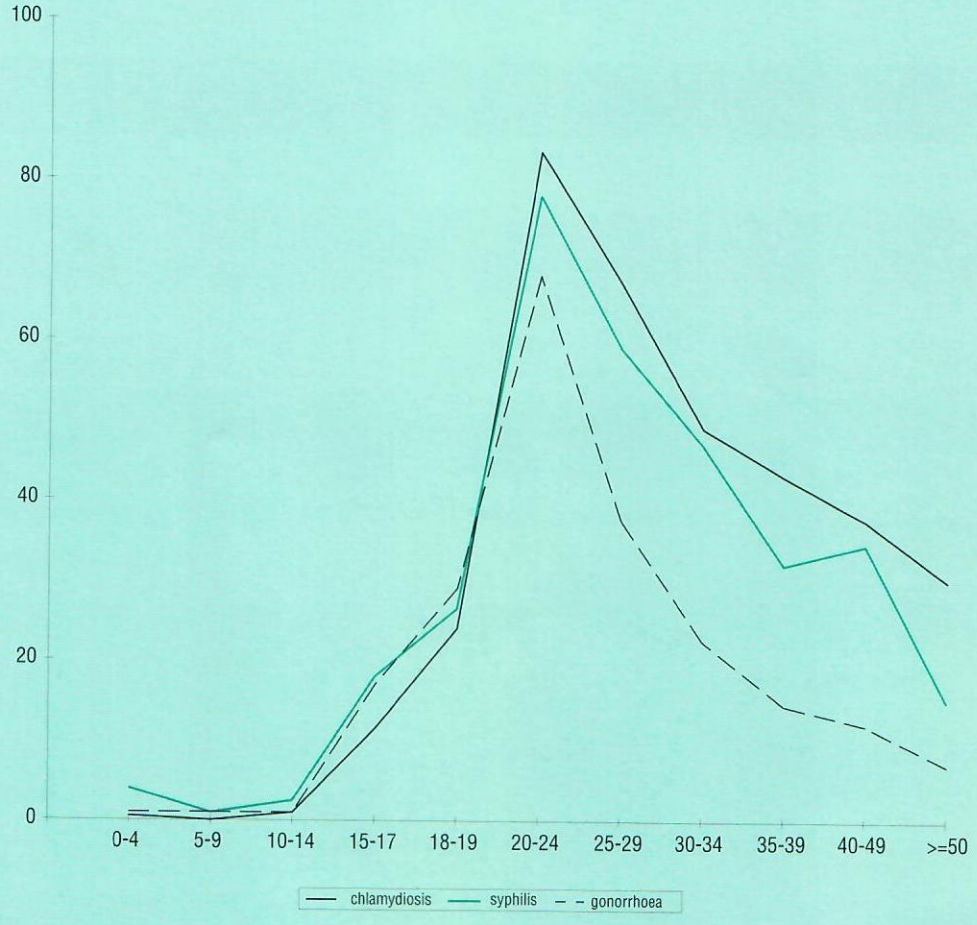


FIGURE 5.16.

SEXUALLY TRANSMITTED DISEASES

MORBIDITY

The incidence of sexually transmitted diseases (STDs) in Latvia is extremely high. In 1996, per 100, 000 inhabitants 125 had syphilis, 84 had gonorrhoea and 139 had urogenital chlamydial infection (see Figure 5.17). Since 1991, the incidence of syphilis has been unrelenting in its increase, most tragically amongst new-borns as well: in 1996, 25 children were born with syphilis. Child and adolescent STD incidence contracted through contact is also on the rise: in 1996, eight children contracted syphilis and 22 gonorrhoea. Furthermore, early diagnosis of syphilis is decreasing. While people of reproductive age most commonly suffer from STDs, the highest incidence is amongst people in their twenties (see Figure 5.16, 5.18 and 5.19).

With each year, the incidence of HIV (human immunodeficiency virus) is also increasing (see Figure 5.20). In 1997, a total of 76 people had been diagnosed with HIV. One-third of these people also suffered from other STDs.

Due to socio-economic circumstances several groups have come to show an increased risk of contracting STDs including HIV, for example prostitutes, young people from disadvantaged families or who do not attend school and are delinquent, prisoners and drug users. These groups have an increased risk because of a lack of information – it is difficult for them to glean information from the same channels as the rest of society, and they sometimes lack the desire to seek it out. For various objective or psychological reasons, medical care and means of STD prevention (for example,

FIGURE 5.17.

MORBIDITY WITH STD IN LATVIA
per 100,000 inhabitants (1989—1996)

MORBIDITY WITH SYPHILIS
per 100,000 inhabitants (1993)

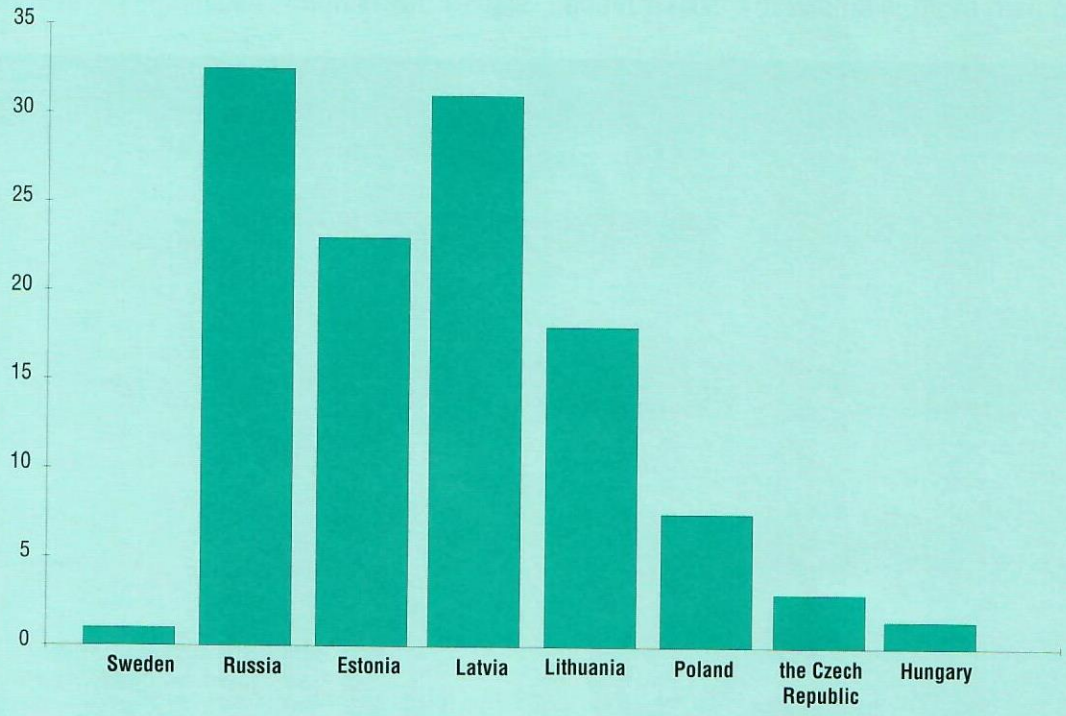


FIGURE 5.18.

MORBIDITY WITH GONORRHOEA
per 100,000 inhabitants (1993)

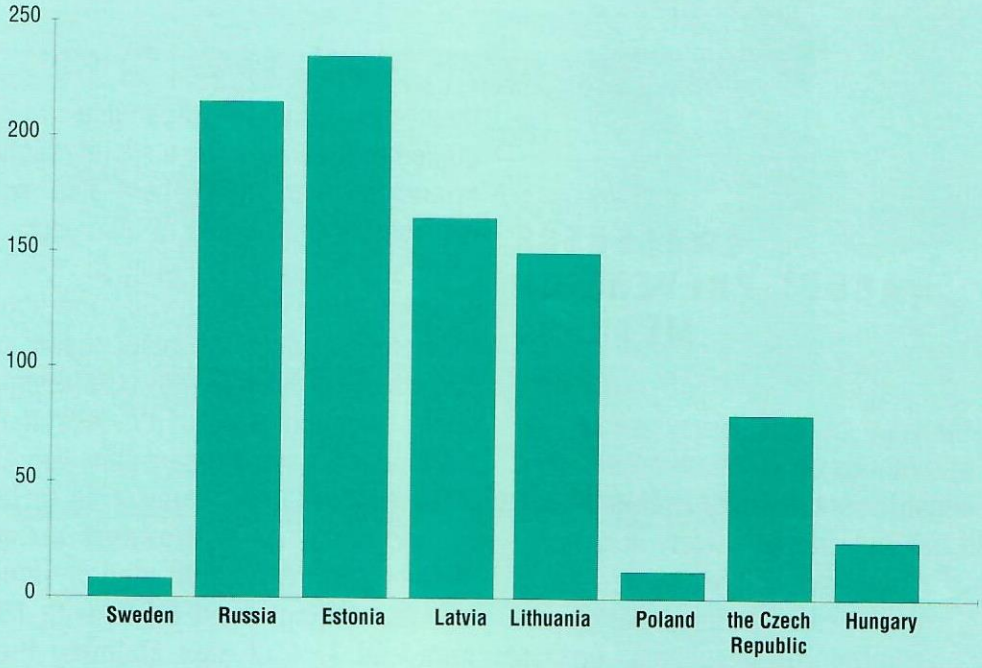
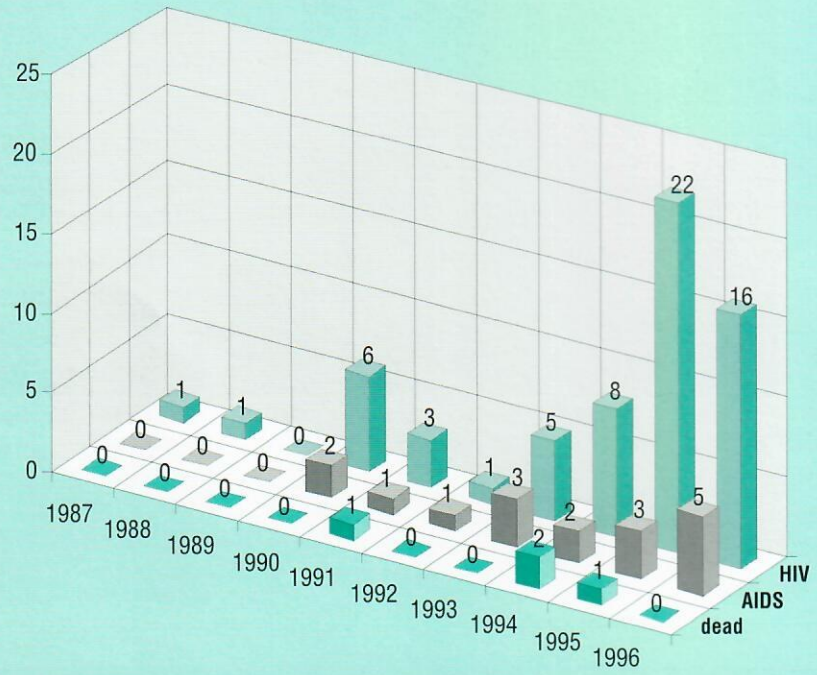


FIGURE 5.19.

condoms for young people) are not always easily accessible to these groups. However, despite the fact that certain groups face an increased risk of STD infection, this does not mean that a threat does not exist for all members of society.

FIGURE 5.20.

NUMBER OF CASES OF HIV/AIDS REGISTERED IN LATVIA ANNUALLY



AWARENESS ABOUT PREVENTION METHODS

As substantiated by the survey results, an awareness of methods of STD transmission and infection are insufficient not only among groups at increased risk but among society in general. Respondents' evaluations of their own levels of knowledge displayed rather dangerous tendencies: one portion of inhabitants consider themselves to be well-informed, yet in reality their knowledge is inadequate or even misguided. Women display a slightly higher level of awareness than men. There also exist discrepancies between levels of awareness on STDs, AIDS and HIV: for example, in response to the question "How much do you know about AIDS?" more than half of the respondents claim they know a great deal. However, in response to the same question about HIV, less than half of respondents gave this same answer. Around half of respondents feel themselves to be very informed about STDs. **However six percent of women and every tenth men claimed to know almost nothing about AIDS, with 15% of women and 17% of men claiming the same of HIV.**

Generally people understand that HIV is transmitted through sexual contact and by coming into contact with infected blood. Nonetheless a significant number of people believe that transmission can also occur through everyday contact (see Figure 5.21). There are also considerable gaps in people's knowledge about STDs. For example, more than one-third

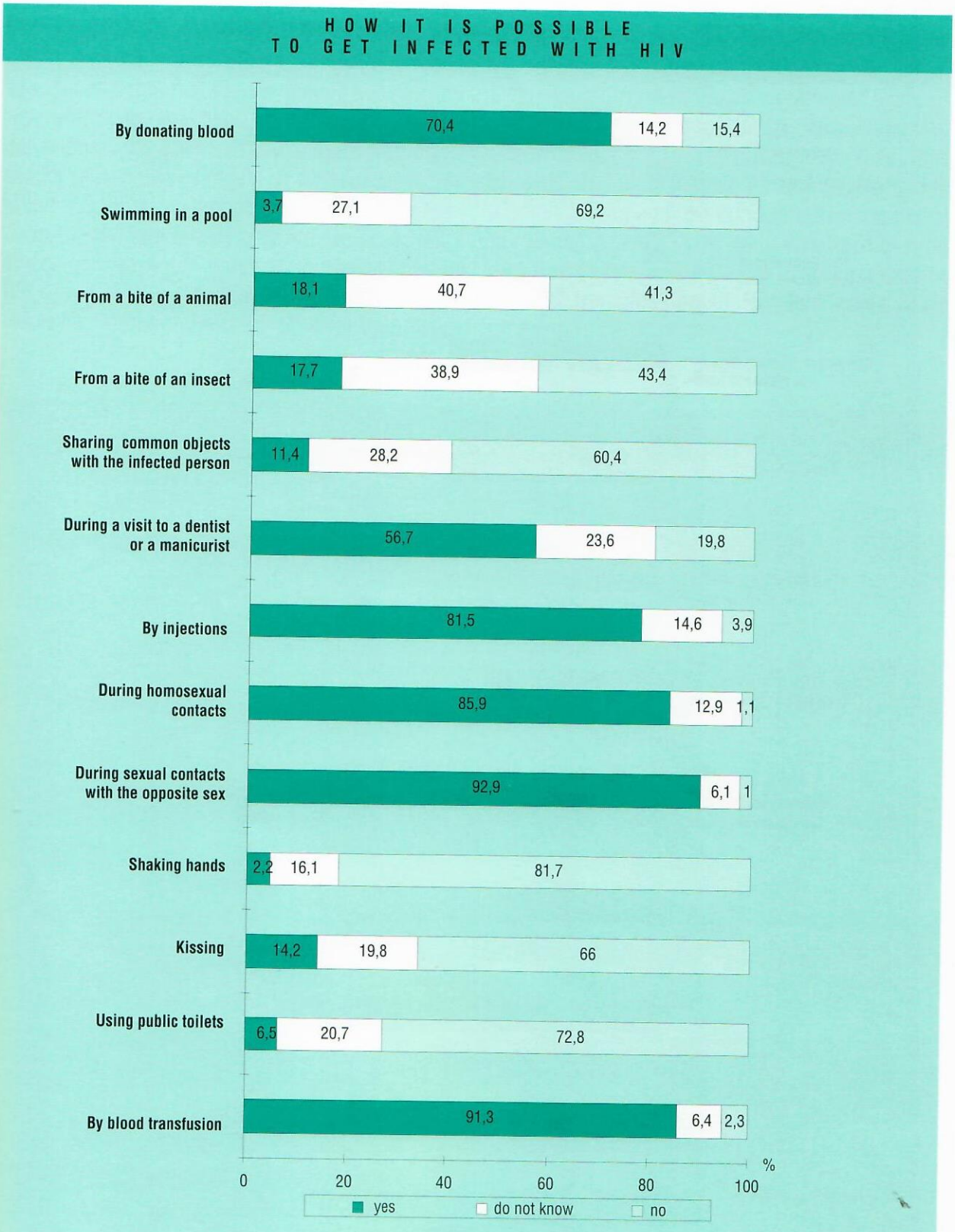


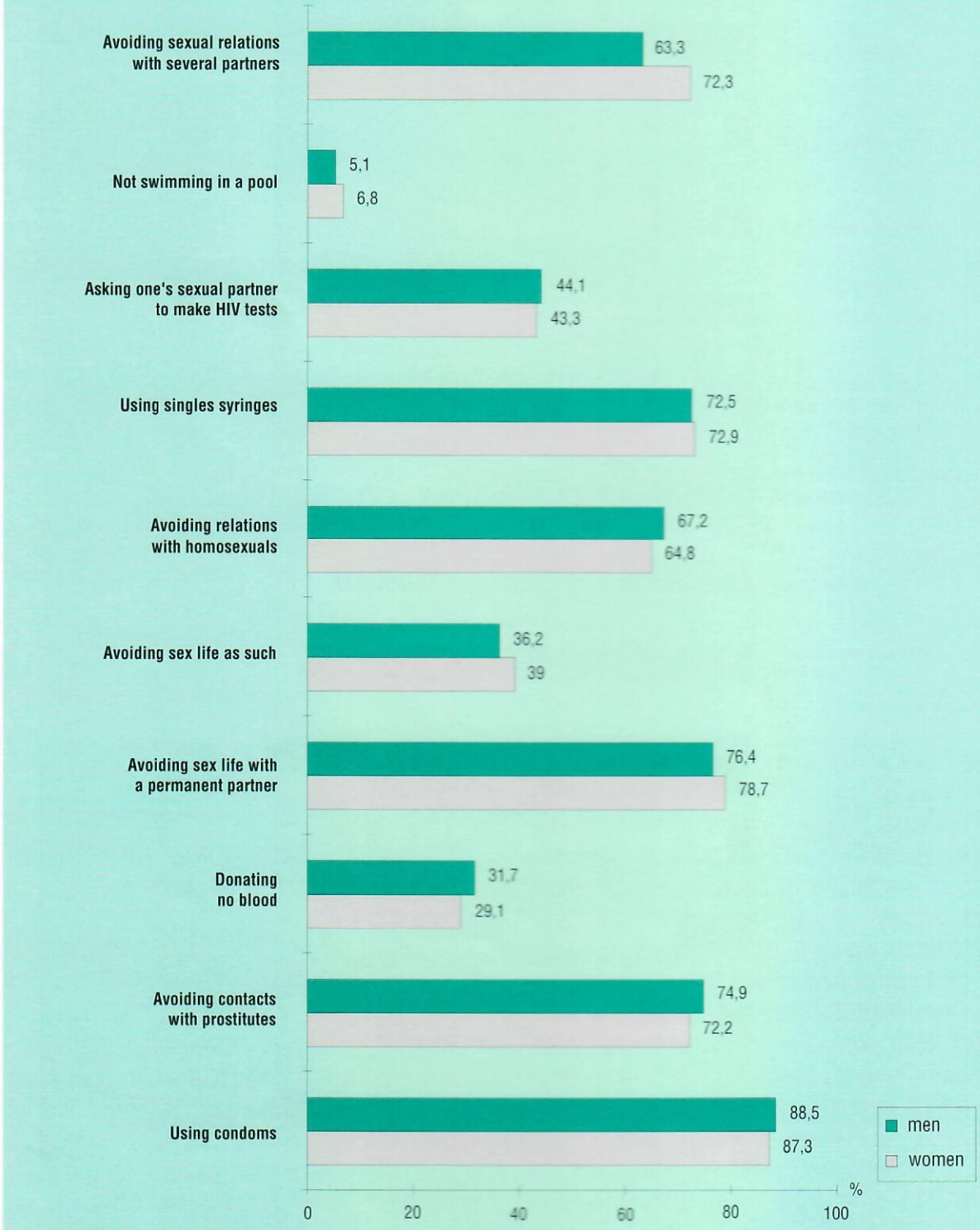
FIGURE 5.21.

Replied by all men

do not know whether it is possible to become infected through insect bites, animal bites or by swimming in a swimming pool. Additionally, one-third of men and almost every other woman believe that it is possible to become infected using public toilets, while one in five believes this is possible through shaking hands. It is scientifically proven that one cannot become infected with HIV, or STDs in a swimming pool, by shaking hands or using public toilets.

FIGURE 5.22.

HOW IT IS POSSIBLE TO REDUCE RISK OF GETTING INFECTED WITH HIV (an opinion)

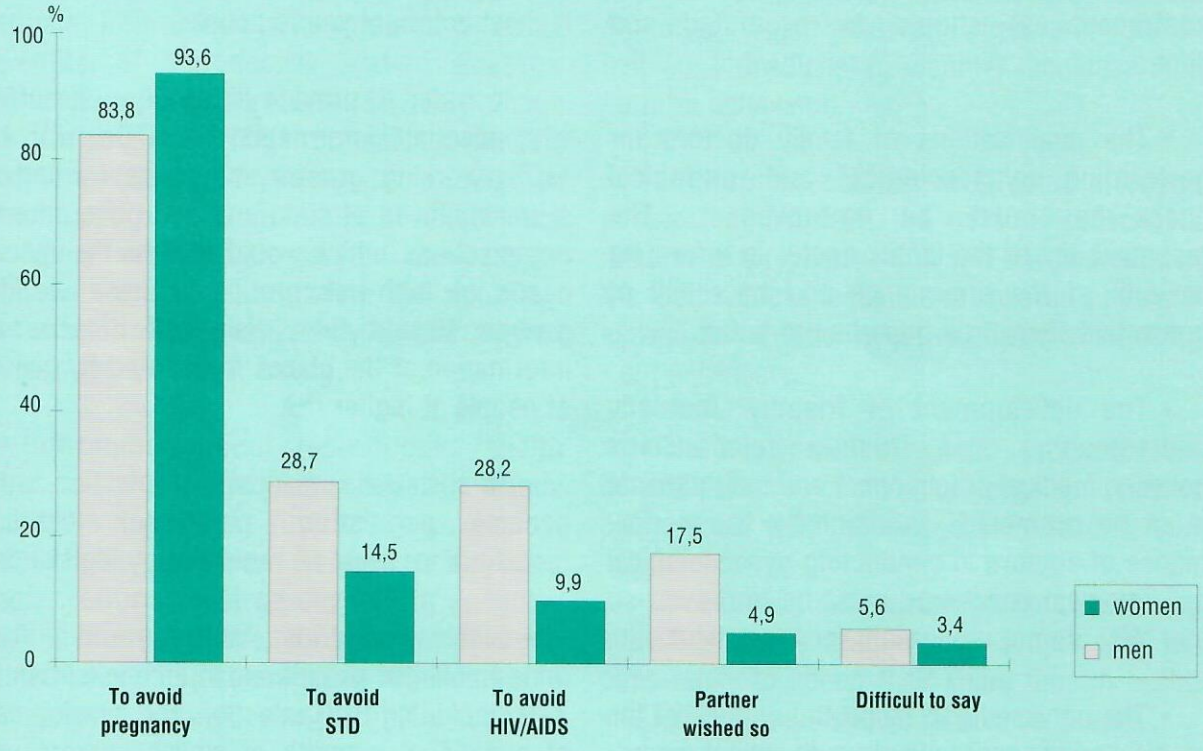


Replied by all respondents

In evaluating which social groups have the greatest risk of STD and HIV infection, almost half of respondents believe that lesbians face a high risk. These misguided statements are largely due to society's stereotypical attitudes towards homosexuals in general. In fact, the risk to lesbians is less than that facing heterosexuals and far less than the risk to homosexual men. However, the fact that there is a tendency to associate risk with social identities as opposed to sexual behaviour is dangerous in and of itself: a person's sexual behaviour – not his or her sexual orientation – is what will determine the degree of risk.

In theory, Latvia's inhabitants are sufficiently aware of means by which to lower the risk of STD and HIV infection (see Figure 5.22). However, almost one-third of men and every tenth woman was unable to rate his or her own risk of HIV infection. **Every fifth man and every third woman believe that they do not face any risk of infection.** Only one in ten people believes themselves to face a medium to high risk. It is precisely this surprising naivety of a significant portion of the population that constitutes their greatest risk factor: despite an awareness of how one can be infected with an STD, people do not translate this knowledge into action as they are convinced that they face almost zero risk of infection – and therefore only a small percentage use condoms as a means of protecting against STDs. **Only one-third of men and one in ten women have used condoms to prevent transmission of HIV and other STDs** (see Figure 5.23).

MAIN REASONS FOR USING CONDOMS



Replied by those who have used condoms

FIGURE 5.23.

PROPOSALS AND RECOMMENDATIONS

• It is crucial to improve and encourage the work of health care professionals (family physicians, gynaecologists, midwives, public health nurses) in providing the population with information on family planning. Particular care should be made in counselling people on means of protecting against pregnancy in the future following childbirth or abortion. It is necessary to develop a revamped system for counselling clients both prior to and following abortion.

• Awareness raising by medical practitioners on contraception and its various side effects (particularly regarding such myths as weight gain and the risk of cancer from using oral contraceptives) should be promoted and continued.

• The qualifications of family doctors for performing gynaecological and urological check-ups must be improved. The responsibility of the family doctor in informing patients of the importance and necessity of preventive check-ups must be promoted.

• The development of friendly, mutually understanding and trusting relationships between medical practitioners and their patients must be promoted. Additionally, the performance of doctors in conducting gynaecological or urological check-ups must be improved so that they are not unpleasant for the patient.

• The unbiased and respectful attitude of the medical practitioner towards each patient regardless of the nature of their illness, their lifestyle or social standing must be promoted, as behaviour towards STD patients is often judgmental.

• It is necessary to promote preventive check-ups for women on an annual basis, as well as mammographies annually after the age of 40. Promoting urological preventive check-ups for men once during adolescence and subsequently after the age of 50 on an annual basis (or from the age of forty if the patient is in a high-risk category for cancer) is also important.

• The state should make a provision for including surgical sterilisation within state-funded health care programmes for those for whom this is an appropriate and desirable method of family planning, yet cannot afford it. Contraception should be provided without cost or at discounted rates to young people, students, women for a year following childbirth and three months following an abortion, large families and disadvantaged members of the population.

• The work of youth health centres must be promoted and supported. This would help to curb the incidence of STDs which is currently highest amongst young people.

• In order to provide all sections of society with adequate information on STDs, HIV and AIDS, working groups should be formed by representatives of state and non-governmental organisations, which would address the specific needs of high-risk groups. These working groups should then visit and disseminate information at the places frequented by groups of people at higher risk.

• To curb the spread of HIV infection in the general population, paid sex services (prostitution) must be regulated by legislation.

• Since children and youth from underprivileged groups are at increased risk for STD (including HIV) infection, the development of a national network of social workers who would become familiar with the situation of homeless and unemployed children and teens, including underage prostitutes should be advocated. In order to provide these groups with accessible and quality health care, it is important that social rehabilitation centres,

which are staffed by medical practitioners, psychologists and social workers, be established.

• In order to provide accessible and good quality health care services and prevention means for all individuals in society, STD prevention centres must be established in large cities at places frequented by groups of people who are at greater risk of infection. Furthermore, condoms and information on how condoms should be used properly need to be made readily available to these groups of people. It would also serve to distribute condoms free of charge in prisons and in the army, where STD infection is particularly high.

• The further development of a health promotion network at both the state and community-based level is crucial for the improvement of environmental health in Latvia.

• Since all individuals in all age groups lack adequate information and knowledge about prevention of reproductive system illnesses, contraception, infertility and STD prevention and transmission, it is crucial to allocate maximum efforts to financing the introduction of health education programmes in schools as a mandatory subject. Doctors in co-operation with educators need to define the minimum level of information required by school children on reproductive health issues.

• Information about reproductive health issues must be made available in easily accessible locations such as pharmacies, health clinics and places frequented by young people. Efforts must be devoted to encouraging the interest of the management of medical institutions in disseminating information to their clients. Every medical establishment should be fitted with a display rack of information, and an appropriate quantity of information should always be ensured.

• The state should financially support the publication of professional quality informative materials by non-governmental organisations in their efforts to raise awareness in society on issues of reproductive health.

• The active and conscientious participation of mass media channels in raising awareness on reproductive health issues should be promoted.

• The support of non-governmental organisations that address health promotion issues – particularly amongst high-risk groups of people – would be a worthwhile investment in improving the health of the population.

• The development and implementation of national programmes to limit the demand for and consumption of tobacco, alcohol and narcotics would play an important role in helping individuals to counter addictive and harmful behaviour.

• Widespread campaigns targeted at young people that highlight the risks of tobacco in relation to pregnancy and the development of the foetus, breastfeeding and children's health – as well as the other negative effects of smoking - are necessary.

• The involvement of school-aged volunteers in anti-tobacco campaigns targeted at their peers would yield more successful results.

• Clubs or institutes that organise cultural and athletic activities that provide people with the opportunity to spend their spare time in health and fulfilling ways should receive tax breaks.

6th

CHAPTER

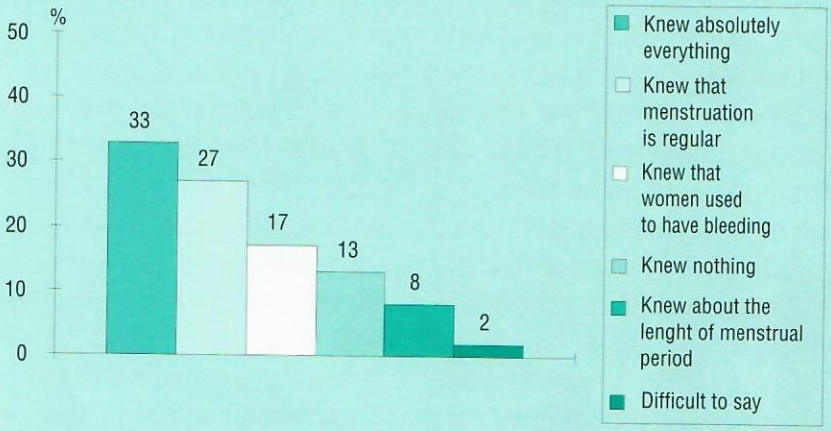
REPRODUCTIVE HEALTH: PREVENTION AND PUBLIC EDUCATION

PAUCITY OF KNOWLEDGE AND INFORMATION

One realisation and conclusion comes through in all aspects of the survey results: people in Latvia are lacking information and knowledge about reproductive health issues. This conclusion was undeniable not only in the gaps uncovered through data analysis, but also in respondents' clear admission of their need for information and knowledge.

For female respondents, this paucity of information was evident even on issues so elementary as a woman's physiology. Female knowledge about the menstrual cycle and its function was lacking, for example: **one in ten women knew nothing about the menstrual cycle before she began menstruating.** The remainder of women for the most part expressed approximate knowledge on these issues, and only one in three women believed herself to be completely informed (see Figure 6.1).

AWARENESS OF MENSTRUAL PERIOD AND ITS MEANING BEFORE THE BEGINNING OF MENSTRUATION



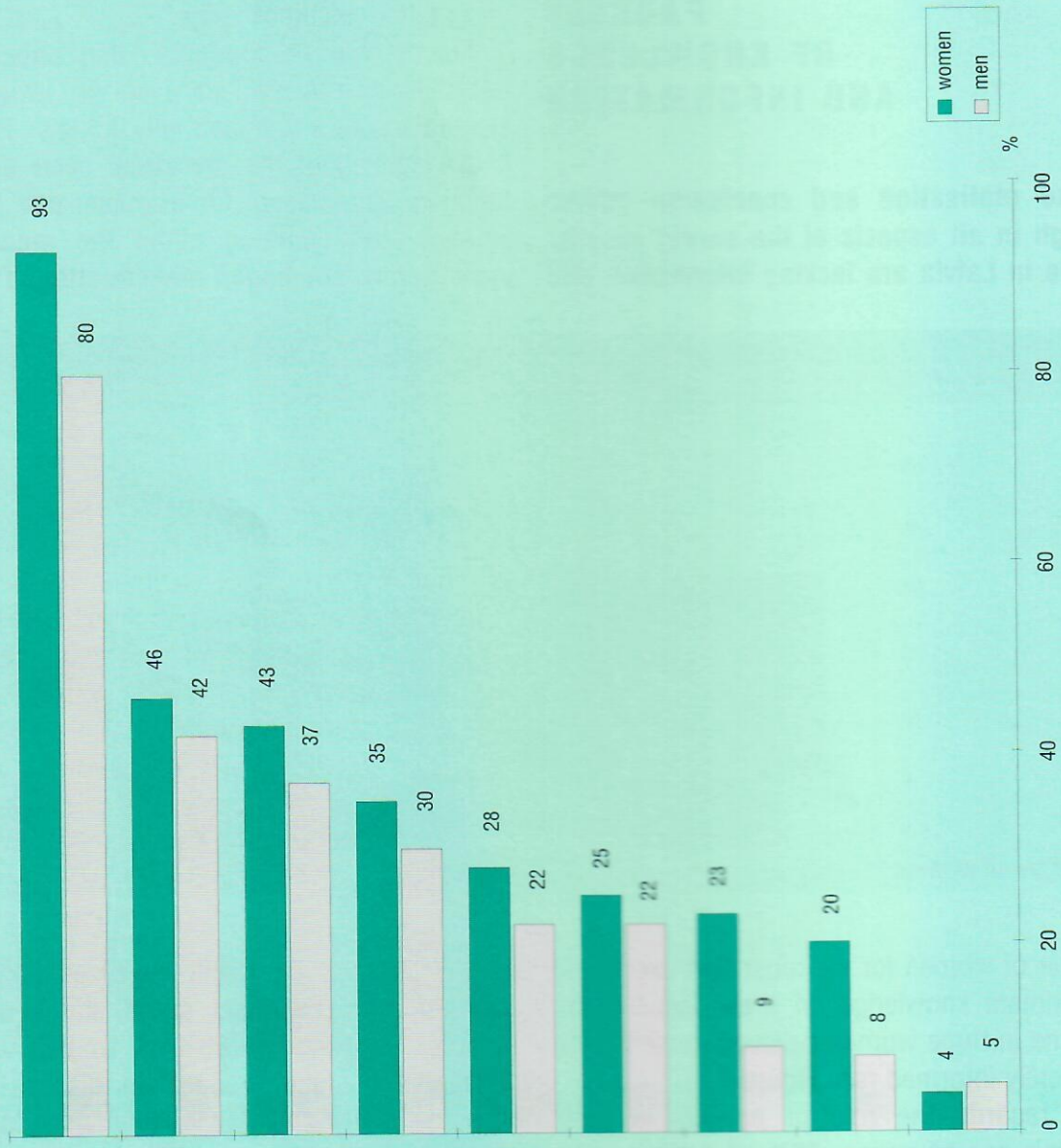
Replied by all women

FIGURE 6.1.

As regards the role of parents in their children's sex education, **60% of mothers discuss issues such as differences between the sexes, reproductive health and sexual behaviour with their children, but 40% admit to not doing so. Similarly, 60% of fathers do not discuss such issues with their children either.** If one considers the fact that traditionally, a mother will talk intimately with her daughters and a father with his sons, this could suggest that boys receive only half of the sex education from their parents that girls do. The survey revealed that city parents are more likely to discuss these issues with their children than are rural dwelling parents, and additionally, the extent to which these issues are discussed in the family increases alongside the education level and social status of the parents. For example, 60% of women with a vocational or higher education discuss such issues with their children, in comparison to 34% of women with only a middle school education. For men, this ratio is 45% to 21%. One half of fathers who are senior level specialists or managers by profession will discuss these issues compared to one in three labourers. The main reason for avoiding discussions on sexual behaviour and reproductive health with their children – given by 80% of respondents – was the rather young age of their children. Five percent admit that they are embarrassed and find it uncomfortable discussing such issues with their children, alongside being unsure of how to initiate such a conversation. Three percent of parents believe that children either should find

FIGURE 6.2.

ISSUES DISCUSSED AMONG PARENTS AND CHILDREN



Replied by those respondents who have discussed sexual behavior with their children

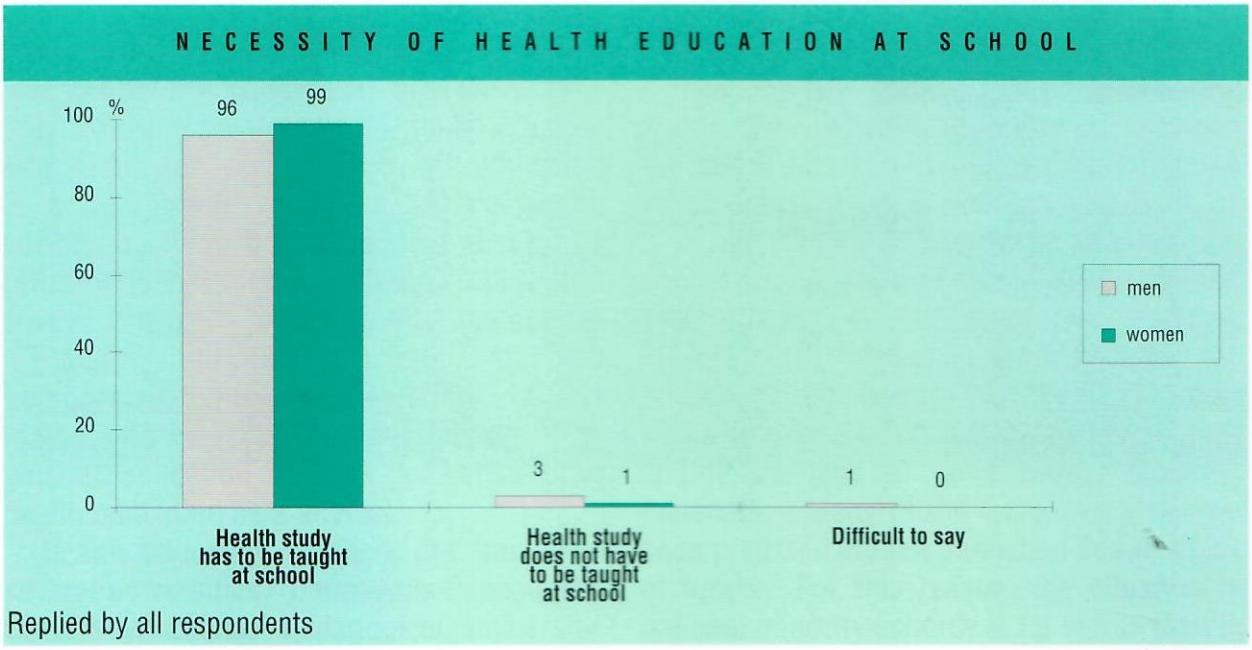
these things out on their own or are already aware of the issues, and the same percentage place their hopes on the school system, as they feel specialists should be responsible for this sort of education. Three percent again claim that there has been no need for such discussions – their children are not interested. An analysis of the topics covered in these parent-child discussions reveals that the most common conversation piece is genital hygiene (see Figure 6.2).

Significantly less popular topics include the functions of male and female reproductive organs, pregnancy and childbirth. **Prevention of STDs is covered by only one-third of parents and even less discuss the prevention of unwanted pregnancies.** Only one-fifth of parents discuss the need for gynaecological or urological check-ups – which could be due to parents' own ignorance in this subject.

Parents also play only a small role in advising on birth control issues. Only one in ten people stated that they had received information on contraception from their parents – although only 13% (mostly 15-19 year olds) state that this would be a preferred channel of information. Again, this may be explained by parents' own ignorance in this subject or by traditional social "norms of behaviour." Parents are also unaware of what would be an appropriate way and age at which to start talking about intimate issues with their children.

Both women and men state that their preferred channel of information on prevention of unwanted pregnancies would be their physician (see Figure 6.4). This once again highlights the significant authority of doctors and the fact that people feel their advice can be trusted. The second most preferred source of information include specifically designed booklets, mass media channels and books. Only one in five men and one in ten women mention health education classes in school as their channel of choice for information on contraception, as they feel this to be both a medically technical as well as extremely personal topic which should therefore be discussed with a physician.

Nonetheless, the survey question which was answered with the highest degree of consensus was in relation to health education in schools: **99% of women and 96% of men believe that the school curriculum should include health education as an obligatory subject** (see Figure 6.3). **This opinion is held by young people (98% of women and 94% of men in the 15-19 age group) and older people alike. However, reality is a far cry from people's stated preferences: of all young people surveyed who are currently in school, less than half (42% of females and 37% of males) are currently receiving health education** (see Figure 6.5). These responses correspond to those given by parents on their children's education.

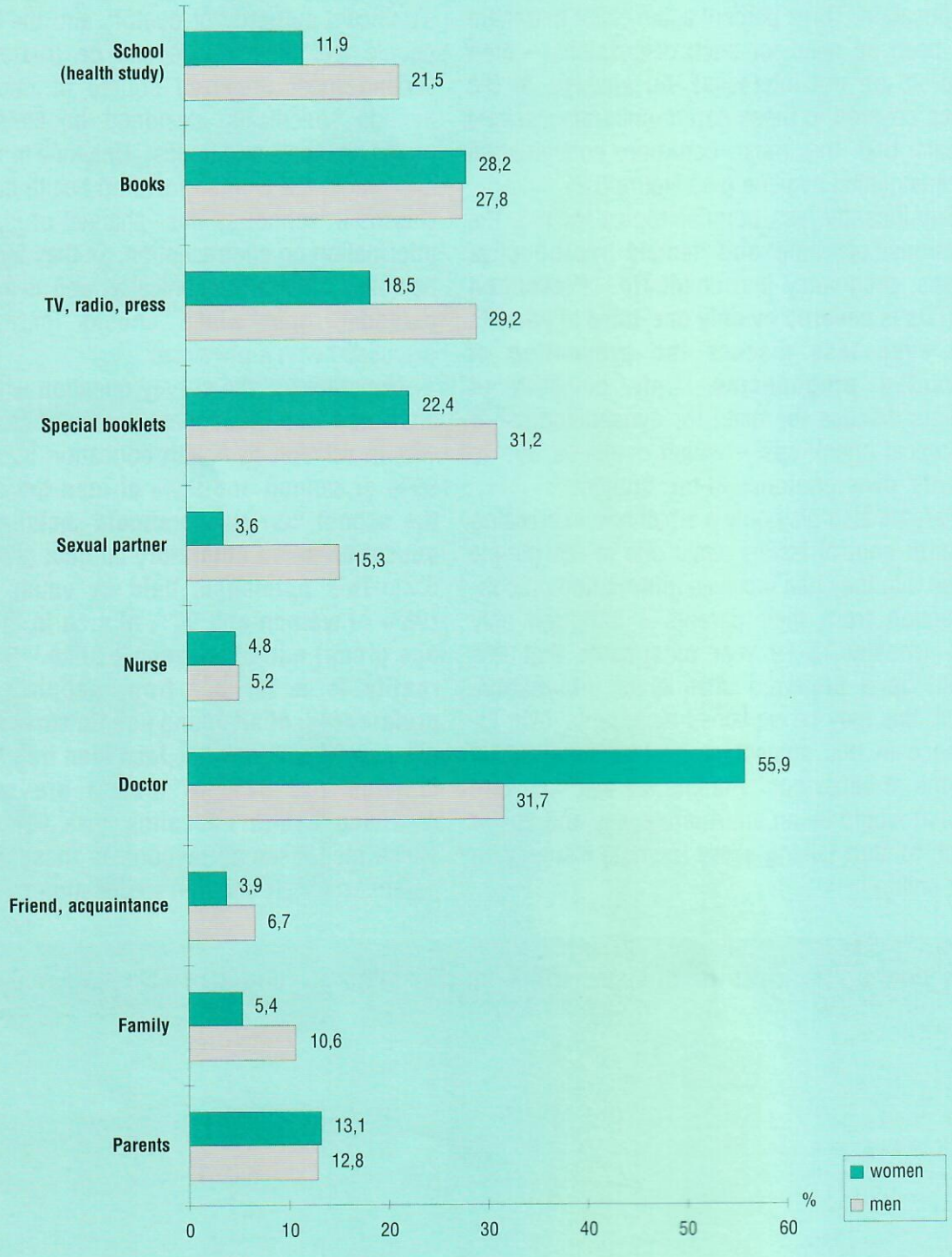


Replied by all respondents

FIGURE 6.3.

FIGURE 6.4.

SOURCES FROM WHICH PEOPLE WOULD LIKE TO RECEIVE INFORMATION ABOUT CONTRACEPTIVES AND PREVENTIVE METODS



Replied by all respondents

HEALTH EDUCATION IN ESTABLISHMENTS OF SECONDARY EDUCATION ATTENDED BY YOUNG PEOPLE

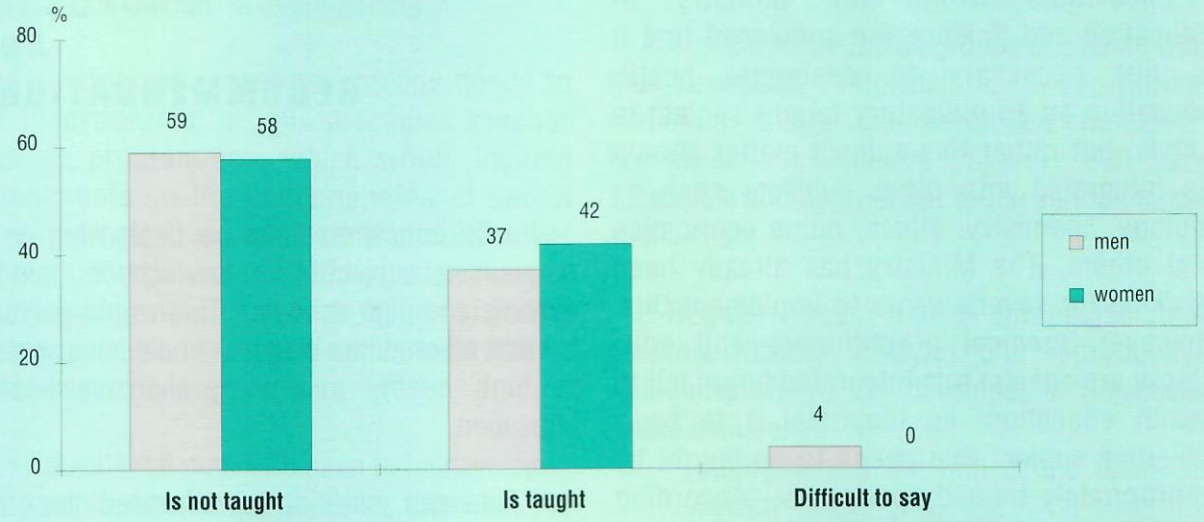


FIGURE 6.5.

Replied by respondents (15–18 years of age) who attend educational establishments of secondary education

HEALTH EDUCATION IN LATVIA

Currently in general education schools in Latvia, primary schools offer health education as an optional subject, while in high school it is considered an elective. The only exception is Grade 5 in public (general education) schools, where health education is a compulsory subject. Since health education is not considered mandatory for other classes, school directors are not always motivated to ensure that this subject is taught, and rather follow their own personal opinions and limitations in this matter. As a result, only around half of all general education schools in Latvia offer health education as a subject.

Health education teachers are trained in several universities: Daugavpils Pedagogical University, Liepaja Pedagogical University, The Athletics Pedagogical Academy of Latvia, the University of Latvia, as well as through specialised courses offered at Latvia's Family Centre and elsewhere. However, although there are not sufficient teachers for general education schools in Latvia, there are a number of qualified professionals that cannot find work, as school directors feel that health education in their schools is not necessary. However, it is within the directors' right to deny this, as health education is not mandatory according to the state curriculum.

The second factor that delays the introduction of health education in schools is the lack of a comprehensive state programme which would dictate national standards in levels of education required in this subject, similar to that of other compulsory subjects. The Ministry of Education and Science, however, has developed guidelines for the tuition of health education. The third reason which impedes health education is the lack and/or shortage of good quality teaching materials. Many of the textbooks that have been prepared are not published due to a lack of funds. For this reason, the situation in national minority schools is far worse than in

Latvian schools, as there are not any teaching materials prepared in the appropriate languages.

Specialists within the Ministry of Education and Science are convinced that it is not necessary to designate health education as an obligatory taught subject in Latvia, but rather this subject matter should be integrated into other subjects such as biology, chemistry, ethics, home economics and others. The Ministry has already been working for several years to implement this. However, medical practitioners and educators are against this integrated approach to health education, as they feel it to be a sensitive subject that needs to be taught by appropriately trained specialists. According to these practitioners, it is not possible to comprehensively address all aspects of health education through its integration into many other subjects, and thus high quality health education will not prevail.

Several alternatives to school-based health education are available to young people through youth health centres, which for the most part focus on reproductive health and mental well-being. When these centres were first opened, their work was financed by various international funding organisations such as the Eastern European Council in Stockholm. However, since this start-up period these centres have been for a large part dependant on municipal support which is of course limited. Currently, seven such centres exist in Latvia although a need for them exists in all of Latvia's twenty-six districts. In Estonia, for example, with a population of one million less that Latvia, 13 such centres are successfully operative.

High quality, comprehensive health education for young people should be put forward as a national priority for public education. This is additionally imperative given the fact that older people have much more difficulty accepting new principles and changing their opinions, altering their lifestyles or shedding bad habits to which they are accustomed.

PROPOSALS AND RECOMMENDATIONS

• Health education must be designated as a compulsory subject in primary schools, middle schools and high schools. This would guarantee that **all** students in Latvia would have access to high quality and comprehensive health education.

• Finances should be allocated for the introduction of health education in Latvia's schools which would include:
· the development and implementation of a post-graduate training programme for health promotion specialists;
· the development of certification requirements for health education teachers;
· the preparation and publication of teaching materials.

• In order to provide students with high quality information on health issues, health promotion courses should be implemented in higher education institutions and the programme for pedagogical students should be strengthened.

• It is imperative that the state promote the development of youth health centres and guarantee their appropriate financing from state and municipal budgets. These centres play an important role in education and promotion of reproductive health, utilizing the methodological base and professionals currently available in Latvia.

• Health education programmes that help young people develop skills to make responsible decisions that will positively impact their health and well-being – for example, abstaining from harmful habits or conversely quitting these habits - need to developed. For this purpose it

would be useful to develop training programmes for school nurses so that the necessary information and support would be available to children in every school.

• Child development psychology needs to be incorporated in all specialist teacher training programmes, which would include components on the understanding of sexual development. It is important that child development components of kindergarten teacher training programmes include issues of young children's sexuality and so-called behavioural problems.

• Educational materials need to be developed for parents which would advise them on the appropriate ways in which and age at which to discuss reproductive health and sexual behaviour issues with their children.

• In order to provide all interested parties in Latvia with high quality, comprehensive, up-to-date information on reproductive health issues, it would be useful to institute health promotion courses at adult education centres.

• The state needs to financially support the production of informative materials by non-governmental organisations that are active in reproductive health issues. The efforts of the community-based sector in contributing to public education should also be supported through extensive volunteer programmes.

• In order to ensure all groups of society with the necessary information, appropriate materials should be developed (booklets, brochures, informative flyers) that are accessible and appropriate to the various target audiences.

• Regular mass media campaigns that promote healthy lifestyles and reproductive well-being should be developed. Objectives would include:

- strengthening the role of the family in society;
- encouraging parents to educate themselves and their children;
- the development of individuals' under standing of responsible sexual behaviour;
- the dissemination of a wide range of information on family planning issues;
- awareness-raising on how to treat arious reproductive health problems;
- awareness-raising on sexually transmitted diseases and the prevention thereof;
- the promotion of preventive care in maintaining healthy reproductive systems and functions.

CONCLUSION

The national report, "Reproductive Health in Latvia: Evaluation and Recommendations" is the concluding component of the joint UNFPA/Ministry of Welfare project "Support to the Development of Reproductive Health in Latvia." This national report summarises the information collected throughout the course of the project and offers recommendations for further activities. The recommendations for the most part came out of a national conference "Towards a comprehensive reproductive Health Policy for Latvia" attended by a wide spectrum of reproductive health specialists including government officials, physicians, midwives, nurses, social workers, teachers, university lecturers, demographers, sociologists, psychologists and other state and non-governmental representatives. Their contribution collected here should be therefore understood as an independent and objective evaluation of the state of the nation's reproductive health and the health care system. This analysis was performed based on the results of the independent national survey "Reproductive Health and Behaviour," state statistics and a current situational analysis. The recommendations for improving the future reproductive health of the population were also rigorously developed on the basis of the experience of a wide and varied range of specialists. The analysis and recommendations contained in this report have also been commented on by both national and international experts. Such a comprehensive project along with this national report make the ensuing task of developing national reproductive health policy far more democratic.

The contributing authors and participants of both the national report and the project invite Latvia's politicians, government representatives, municipal government employees, community-based activists, specialists, students, journalists and other groups across society to become acquainted with this report, to critically evaluate its contents and to put forth their own recommendations or alternative proposals.

The recommendations and proposals compiled in this national report are primarily intended for the Government's further incorporation into the development and implementation of a national policy on reproductive health. However, the members of the national working group sincerely hope that these proposals will also be useful for the work of other state institutions, non-governmental organisations, professional associations, mass media channels, education centres and others. Improving the reproductive health of Latvia's inhabitants demands the dialogue, co-operation and conscientious efforts of many multi-faceted specialists and institutions, who, only together, will make a difference.

SOURCES AND BIBLIOGRAPHY

College of Social Work and Social Pedagogy "Attīstība". The Copenhagen Declaration and Programme of Action. Global Indicators of Social Development, Riga, 1996.
State Statistical Committee, Medical Statistics Bureau. Health and Healthcare of Latvia's Population: 1997 First Six Months. Riga, 1997.
State Statistical Committee, Medical Statistics Bureau. Latvia: Yearbook of Medical Statistics. 1996, Riga.
State Statistical Committee, Medical Statistics Bureau. Medical Aspects of Mortality in Latvia, 1996. Riga, 1997.
State Statistical Committee, Medical Statistics Bureau. Medical Support for Pregnant Women and New-borns. Riga, 1996.
State Statistical Committee. Statistical Yearbook 1996. Riga, 1996.
The Centre for Demography, University of Latvia. Family and Fertility in Latvia. Riga, 1996.
The Centre of Demography, University of Latvia. Unpublished data. Riga, 1995.
UNDP. Latvia: Human Development Report 1997. Riga, 1997.
United Nations. Department of Public Information. Fourth World Conference on Women, Beijing, China 4-15 September, 1995, The Beijing Declaration and the Platform for Action. New York, 1996.
United Nations. Report of the International Conference on Population and Development: Cairo, 5-13 September, 1994, Programme of Action. New York, 1995.

ABBREVIATIONS

UNFPA – United Nations Population Fund
STDs – sexually transmitted diseases
HIV – human immunodeficiency virus
AIDS – acquired immune deficiency syndrome
N/A - no answer (respondents did not answer the specific question)
N= - number of respondents

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The National Working Group:

Agnija Caunīte
Anitra Eiklone
Irēna Kondrāte
Gunta Lazdāne
Laima Rudze
Regīna Strautmane
Daiga Štelmahere
Edvīns Vītoliņš

Consultants:

Assia Brandrup-Lukanov
Astrīda Neimane
Anita Plūme
Aiga Rurāne

Participants of the Conference "Towards a Comprehensive Reproductive Health Policy in Latvia"

and

Brigita Zepa, Baltic Data House

Mārtiņš Sīmanis, Brand Sellers DDB

ANNOTATION

The information contained in the National Report reveals an alarming picture of the reproductive health of the Latvian population. A significant number of reproductive health indicators for the country show negative signs. However, one of the most important conclusions of the National Report, provided through a summary of analyses of different aspects of reproductive health, is the fact that the level of public awareness of reproductive health issues and disease prevention is insufficient. For this reason, many of the solutions proposed in the National Report imply a basic principle which must be implemented as part of the future reforms of Latvia's health care system - the importance of education and prevention. It is prevention of causes, rather than combating the consequences, which is of utmost importance.

Some of the reproductive health indicators for the Latvian population can be improved only after a lengthy period of the country's economic development, resulting in a general improvement in living conditions. However, many steps can be taken today in order to not only prevent a deterioration of the situation, but also achieve a stabilizing and positive trend.

Educating the public is extremely important, for that allows greater opportunities for the population - especially youth - to take care and responsibility for their own reproductive health on the basis of objective information rather than myths. Therefore, the first immediate task is to include health education in the curriculum of Latvian schools as a compulsory subject.

The reproductive health of the population is affected by many different factors, and the causes of problems are very diverse. In order to be able to resolve this situation, constructive cooperation not only between the Ministry of Welfare and Ministry of Education and Science, but among all Government and non-governmental organizations (NGOs) involved in the area of reproductive health of the population is essential. The work of public organizations and health centres which successfully perform public information and education functions should be promoted and supported.

Good health care is important in maintaining and strengthening the reproductive health of the population, therefore

many of the recommendations deal with the improvement and development of the health care system. Along with this work it is important to develop and establish other services - family consultations, psychological assistance, support centres - all of which can make a significant contribution to strengthening the reproductive health of the population.

The main recommendation for the Government is to work out and implement a national policy and strategy for the improvement of the reproductive health of the population in Latvia. By determining priorities and funding in this area, the Government could in a single consistent manner implement short and long term tasks in achieving its goal. A national policy in the area of reproductive health would give the Government an opportunity to more effectively attract assistance from international organizations using their support in the implementation of the country's priority projects. It is important that all costs of improving the nation's reproductive health are viewed not as a cost but rather as an investment in the improvement of public health and the development of the entire nation.