

Reproductive Health in the Baltic Sea Area

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Abstract

This paper aims to compare the reproductive health situation in the selected Baltic area countries – Estonia, Latvia, Lithuania, Finland, Sweden, and in St. Petersburg. The analyses focus on the trends and incidence of induced abortions, family planning, contraception, and STDs.

National data were obtained by sending questionnaires to the medical statistics bureaus of Estonia, Latvia, Lithuania, and the Russian Family Planning Association. Also, annual official statistical reports and the annual statistics from Estonian, Finnish, and Swedish abortion registers were used.

The different reproductive health situations in the Baltic area countries prove that the cornerstones for improved reproductive health (low incidence of abortions, teenage pregnancies, and STDs) are comprehensive family planning and sex education programs, new health promotion strategies, and openness in society concerning sexuality.

Keywords: reproductive health, abortion, contraception, sexually transmitted diseases, Baltic Sea Area

Introduction

Reproductive health is defined in the Program of Action of the ICPD in Cairo and it

“implies that people are able to have a responsible, satisfying and safe sex life and that they have the capacity to reproduce and freedom to decide if, when, and how often to do so. Implicit in the last condition are the right of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice as well other methods of their choice for the regulation of fertility which are not against a law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and child birth and provide couples with the best chance of having a healthy infant” (ICPD 1994).

Reproductive health includes antenatal care, childbirth, and prevention of unwanted pregnancies and sexually transmitted diseases (STDs). Family planning is the most important part of women's reproductive life, having a great impact on women's health. To improve reproductive health, one has to prevent unwanted pregnancies by providing good family planning services and effective contraception as well as safe abortion services. Abortion practices, attitudes, frequency, and quality varies in different countries, but there is no country where abortions do not occur. Different studies have proved that in countries where the use of modern reliable

contraceptive methods is widespread, the need for induced abortion is low (Henshaw 1990; Ketting 1993; Ketting and Visser 1994; Segest, 1994).

The aim of the current study is to compare the reproductive health situation in selected Baltic area countries – Estonia, Latvia, Lithuania, Finland, and Sweden as well as in St. Petersburg. There are a lot of studies describing the situation in Finland and Sweden, but little has been published about the situation in other Baltic area countries. The analyses focus on the trends and incidence of induced abortions, family planning, contraception, and the STD situation, showing differences between countries and giving possible explanations for them.

Data and methods

National data on live births, abortions, number of women in fertile age, contraception, and STDs were obtained by sending a questionnaire to the medical statistics bureaus of Estonia, Latvia, Lithuania, and the Russian Family Planning Association. Also, annual official statistical reports were used for analyses (EMsB 1997; ESA (Statistical Office of Estonia); Estonian Abortion Register; Health in the Baltic countries 1993, 1994, 1995, 1996; Latvian MsB 1996, 1997; Lithuanian HIC 1996). The annual statistics from Finnish and Swedish abortion registers, from NOMESCO, and from the Council of Europe have been used for comparison (Council of Europe 1996; NOMESCO 1997; Socialstyrelsen 1997; STAKES, 1993, 1996; Gissler et al. 1996).

Abortion rates and ratios were calculated. The abortion rate is calculated as the estimated number of abortions per 1,000 women of fertile age. In Estonia, Lithuania, St. Petersburg, and Finland fertile age is defined as age 15 to 49 years; in Latvia and Sweden as age 15 to 44. The abortion ratio is defined as the estimated number of abortions per 1,000 live births. Registered pregnancies are analyzed by type in Estonia, Latvia, and Lithuania as the number of deliveries, legally induced abortions (up to 12 weeks and therapeutic abortions), and miscarriages per 100 total number of pregnancies. Age-specific data was calculated on the basis of existing data. Estonian vital statistics and the number of women in the age groups were obtained from the Estonian State Department of Statistics. Age-specific data is presented as percentage distributions of induced abortions in three age groups (15–19, 20–34 and 35+), and as abortion rates per 1,000 women in each age group. To analyze teenage pregnancies, abortion rates and fertility rates have been calculated for the period 1992–1996. The fertility rate was calculated by dividing the annual number of live births in the age group 15–19 by the mean population in that age group and the abortion rate correspondingly using the annual number of induced abortions. The Estonian Abortion Register was established in 1994, age-specific data and information about the distribution of induced abortions by gestational age and previous pregnancies were drawn from the register.

Routinely collected data from the medical statistics bureaus of the Baltic countries concerning use of oral contraceptives (OCs) and intrauterine devices (IUDs) were collected to compare contraception prevalence. No official data is available concerning the use of other methods. To give a picture about the family planning situation in Estonia, data was obtained from the Estonian Family and Fertility Survey, where the use of family planning methods is expressed as the percentage of the respondents' ever-used method in different birth cohorts (Katus, Puur, and Sakkeus 1995).

The manner in which data about abortion and contraception is collected and reported varies, therefore comparison of Baltic area data was not easy. Finland and Sweden have long experience with computerized data and abortion registers (Gissler et al. 1996a; NOMESCO 1997; Socialstyrelsen 1997), whereas in the Baltic countries and St. Petersburg only aggregated data were collected previously. Existing data does not make it possible to carry out detailed analyses. Until 1991 only the total number of abortions (sum of induced and spontaneous abortions) was collected and age-group selection was made differently in different years, therefore age-specific abortion data is available from the year 1992. Hopefully, the Estonian Abortion Register will make detailed study feasible in the future.

Reliability of the data. When comparing abortion statistics one has to consider how completely abortions are registered. David (1992) has claimed that the reported statistics from some European countries (Germany, Italy, France) are not complete. Popov (1993) expressed the opinion that the real number of abortions in Russia is higher than what the official statistics state as the total of abortions performed in departmental health services and commercial clinics and, in addition, notification is not made of most miniabortions. The assessment of the Finnish Abortion Register affirmed the reliability of register data (Gissler, Ulander, Hemminki, and Rasimus 1996a). According to the abortion law in Finland the abortion register must be notified of every induced abortion carried out in a hospital or private clinic. One can assume that official statistical data on abortions is reliable in Estonia: the number of illegal abortions has been small and reporting of abortion data has been compulsory for all institutions, including private health care. In Latvia, it has been assumed that official abortion statistics underestimate the real number of abortions, as a number of abortions performed in private practice may be unreported (Melngailis 1995). In Lithuania there is very strong influence from the Catholic Church (Cepaite 1995), which on the one hand can have the effect that women are less willing to terminate their pregnancies, but on the other hand they do not want abortions officially registered; there is an anecdotal evidence about so-called "night abortions", performed in hospitals. Therefore, it can be assumed that in Lithuania the real number of abortions is probably underestimated.

Legal status of abortions

Abortion has been legal in all three Baltic countries since 1955 under the USSR constitution, which allowed abortion on request up to 12 weeks and for medical and social reasons up to 28 weeks of gestation. No new abortion law has been passed yet, but abortion is legal in the Baltic countries and regulated by various decrees. In Estonia, termination of pregnancy is regulated by decrees from the Ministry of Social Affairs of 1992 and 1993. Abortion on request is allowed up to 12 weeks, and abortion for medical reasons up to 20 weeks of gestation. In Latvia, a revised law concerning the regulation of fertility is currently being discussed. In Lithuania, a draft for a family health law was announced in the summer of 1996 to be considered in Parliament in 1997. This law draft was attacked by the anti-choice movement. In Finland, abortion has been legal since 1970, up to 12 weeks of gestation on request for women under 17 or over 40 years of age and for women with 4 or more children; others with pregnancies of this gestational period need the consent of two doctors. In Sweden abortion has been legal since 1975 and women living in Sweden are entitled to induced abortions on demand, after a counseling visit, up to the 18th week of gestation.

Abortion: incidence and trends

Abortions and live births. Table 1 shows the number of live births, the total number of abortions (in the Baltic countries), the number of induced abortions, and the abortion ratio in Estonia, Latvia, Lithuania, Finland, and Sweden for 1987–1996. The number of live births, abortions, and induced abortions decreased considerably in Estonia and Latvia, while in Lithuania the decrease is less obvious. In Sweden the number of live births and induced abortions has remained almost stable during the period 1987–1996, while in Finland live births have increased slightly and induced abortions have decreased. Despite the fact that the decrease of the number of abortions is more evident in Estonia and Latvia, the abortion ratio remains high and the number of abortions exceeds live births by about 1.2 times. Among selected Baltic area countries the highest abortion ratio was in St. Petersburg (2092.0 in 1996) and the lowest in Finland (156.4 in 1996).

Table 1. Abortions, live births, and the abortion ratio in selected Baltic area countries, 1987–1996

	Number of live births	Number of abortions	Number of induced abortions	Abortions per 1,000 live live births	Induced abortions per 1,000 live births
Estonia					
1987	25,086	34,713	*	1383.8	*
1988	25,060	30,702	*	1225.1	*
1989	24,292	28,216	*	1161.5	*
1990	22,308	29,410	*	1318.4	*
1991	19,320	29,406	26,470	1552.0	1370.1
1992	18,006	28,403	25,803	1577.4	1433.0
1993	15,170	25,587	23,284	1686.7	1534.9
1994	14,178	22,450	19,784	1583.4	1395.4
1995	13,560	20,518	17,671	1513.1	1303.2
1996	13,291	19,464	16,887	1471.0	1257.9
Latvia					
1987	42,135	56,918	*	1351.0	*
1988	41,275	56,233	*	1362.0	*
1989	38,922	47,277	*	1212	*
1990	37,918	45,360	*	1095	*
1991	34,633	44,886	38,837	1296.0	1121.4
1992	31,569	40,494	34,325	1282.7	1087.3
1993	26,759	37,273	31,348	1392.9	1171.5
1994	24,256	32,535	26,795	1342.1	1104.7
1995	21,595	31,324	25,933	1450.5	1200.9
1996	19,748	29,653	24,223	1501.6	1226.6
Lithuania					
1987	59,360	37,783	*	636.5	*
1988	56,727	34,845	*	614.3	*
1989	55,782	30,775	*	551.7	*
1990	56,868	27,504	*	483.6	*
1991	56,219	45,904	40,764	816.5	725.1
1992	53,617	48,400	40,947	902.7	763.7
1993	46,727	42,023	35,211	899.3	753.4
1994	42,826	36,893	30,351	861.5	708.7
1995	41,180	37,655	31,273	914.4	759.4
1996	39,169	34,019	27,829	868.5	710.5
St. Petersburg					
1994	...	...	76,113	...	2224.0
1995	...	...	68,737	...	2081.0
1996	...	...	64,074	...	2092.0
Finland					
1987	59,827	...	12,995	...	217.2
1988	63,316	...	12,749	...	201.4
1989	63,348	...	12,658	...	199.8
1990	65,549	...	12,232	...	186.6
1991	65,359	...	11,747	...	179.6
1992	66,731	...	11,071	...	164.8
1993	64,826	...	10,342	...	159.0
1994	65,231	...	10,013	...	153.5
1995	63,067	...	9,884	...	156.4
Sweden					
1987	104,699	...	34,707	...	331.5
1988	112,080	...	37,585	...	335.3
1989	116,023	...	37,862	...	326.8
1990	123,938	...	37,489	...	302.5
1991	123,737	...	35,788	...	289.2
1992	122,848	...	34,849	...	283.7
1993	117,998	...	34,169	...	289.6
1994	112,257	...	32,293	...	287.7
1995	103,422	...	31,391	...	303.5

Source: Council of Europe. Recent demographic developments in Europe, 1996.

Health in the Baltic countries 1993, 1994, 1995, 1996; Statistical Yearbook of Estonia, 1997.

* data not available

Figure 1. Rates of induced abortion in selected Baltic area countries per 1,000 women in fertile age, 1991.

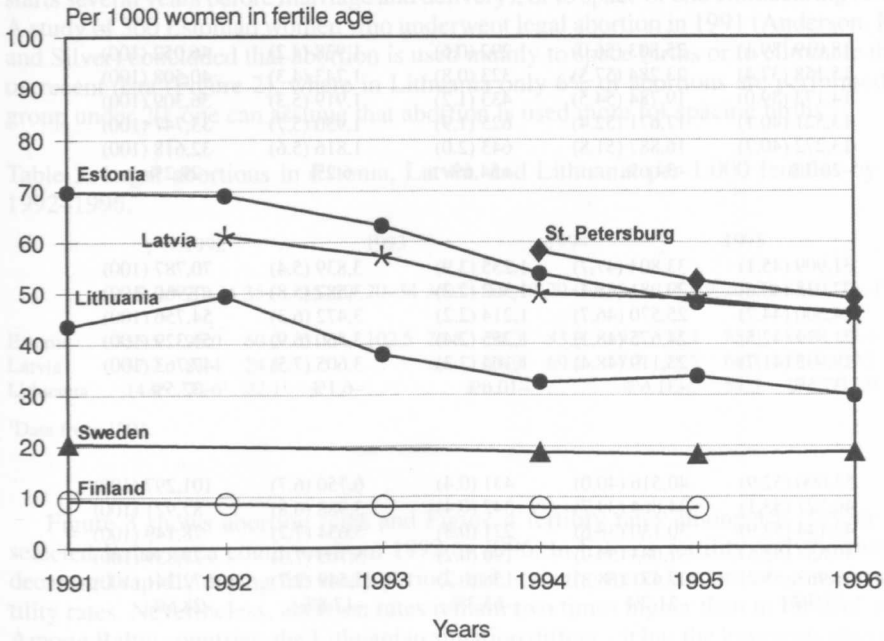


Figure 1 shows the abortion picture in Estonia, Latvia, Lithuania, St. Petersburg, Finland, and Sweden, comparing abortion rates during 1991–1996. There is the same trend – the lowest abortion rates are found in Finland and Sweden, the highest in St. Petersburg, with the most rapid decrease occurring in Estonia (from 69.8 in 1991 to 46.1 in 1996).

Table 2 presents registered pregnancies by type in Estonia, Latvia, and Lithuania in 1992–1996. During this five-year period the total number of pregnancies has decreased in all three countries, with the number of deliveries decreasing most noticeably in Latvia and the number of legal abortions (up to 12 weeks) in Estonia. Deliveries constitute approximately 41 percent of all registered pregnancies in Estonia and Latvia; in Lithuania the proportion of deliveries is higher and constitutes 55%. The proportion of legal abortions is higher in Estonia (51.8% in 1996), while at the same time the proportion of miscarriages is higher in Latvia and Lithuania (7.5% and 7.7% in 1996). The higher incidence of miscarriage in Latvia and Lithuania can be explained by the registration practice (some legal abortions are registered as spontaneous abortions) or by some other factors. The considerable increase of therapeutic abortions in Estonia during the last three years can be explained by the new regulation concerning abortions – legal abortions must be paid for, but therapeutic abortions are free of charge. Earlier a therapeutic abortion was only registered when the gestational age was over 12 weeks.

Table 2. Registered pregnancies by type in Estonia, Latvia, Lithuania, 1992–1996.

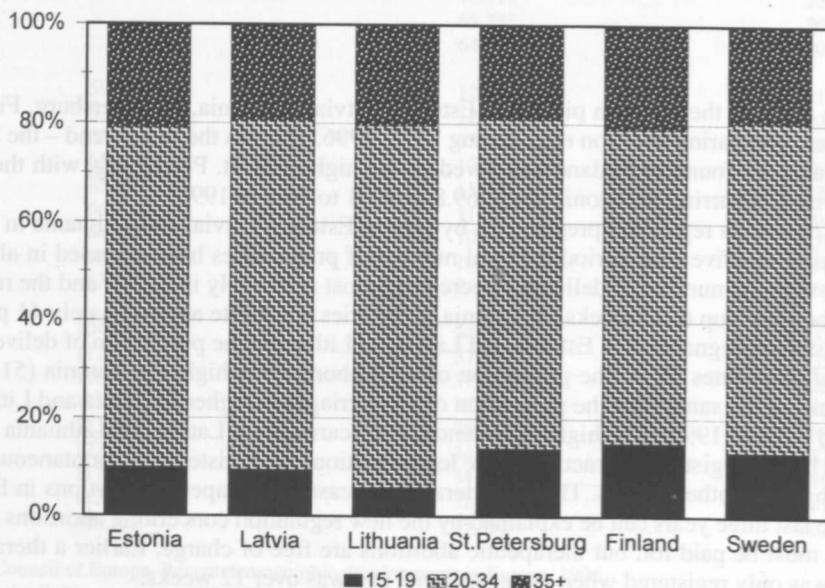
	Deliveries (%)	Legal abortions (%) ¹	Therapeutic abortions (%) ²	Miscarriages (%)	Total (%)
Estonia					
1992	18,019 (39.1)	25,803 (56.0)	292 (0.6)	1,938 (4.2)	46,052 (100)
1993	15,158 (37.4)	23,284 (57.5)	323 (0.8)	1,743 (4.3)	40,508 (100)
1994	14,173 (39.0)	19,784 (54.5)	433 (1.2)	1,919 (5.3)	36,309 (100)
1995	13,521 (40.1)	17,671 (52.4)	625 (1.9)	1,930 (5.7)	33,747 (100)
1996	13,272 (40.7)	16,887 (51.8)	643 (2.0)	1,816 (5.6)	32,618 (100)
Change 1992–1996	-26.3%	-34.6%	+54.6%	-6.2%	-29.2%
Latvia					
1992	31,909 (45.1)	33,804 (47.7)	1,235 (3.9)	3,839 (5.4)	70,787 (100)
1993	27,035 (43.6)	29,981 (48.4)	1,362 (2.2)	3,582 (5.8)	61,960 (100)
1994	24,500 (44.7)	25,570 (46.7)	1,214 (2.2)	3,472 (6.3)	54,756 (100)
1995	21,839 (42.5)	24,675 (48.1)	1,255 (2.4)	3,560 (6.9)	51,329 (100)
1996	19,935 (41.7)	23,119 (48.4)	1,104 (2.3)	3,605 (7.5)	47,763 (100)
Change 1992–1996	-37.5%	-31.6%	-10.6%	-6.1%	-32.5%
Lithuania					
1992	53,600 (52.9)	40,516 (40.0)	431 (0.4)	6,750 (6.7)	101,297 (100)
1993	46,727 (53.1)	34,864 (39.7)	342 (0.4)	5,988 (6.8)	87,921 (100)
1994	42,144 (53.9)	30,130 (38.6)	221 (0.3)	5,654 (7.2)	78,149 (100)
1995	40,857 (52.5)	31,083 (39.9)	190 (0.2)	5,709 (7.3)	77,839 (100)
1996	38,963 (55.2)	27,671 (38.3)	158 (0.2)	5,549 (7.7)	72,341 (100)
Change 1992–1996	-27.3%	-31.7%	-63.3%	-17.8%	-28.6%

¹ Legally induced abortions up to 12 weeks of gestation

² Legally induced abortions for medical reasons up to 20 weeks of gestation

Age-specific data. Fifteen percent of all induced abortions in Finland and 14% in St. Petersburg are carried out in the age group 15–19, and only 6% in Lithuania, where the proportion of abortions among women aged 35 and more is highest (Figure 2). The age-specific abor-

Figure 2. Distribution of induced abortions in selected Baltic area countries by age groups, 1995.



tion rates peaked among women aged 20–34 (in Estonia, Latvia and Lithuania 75.8, 61.7 and 49.2, respectively, in 1996) compared to the abortion rate for all women of fertile age (Table 3). Abortions can be needed for different reasons – to delay childbearing (where sexual activity starts several years before marriage and delivery), or to space or end childbearing (David 1992). A study of 360 Estonian women who underwent legal abortion in 1991 (Anderson, Katus, Puur and Silver) concluded that abortion is used mainly to space births or to eliminate them. Based on recent data (Figure 2), where in Lithuania only 6% of abortions are performed in the age group under 20, one can assume that abortion is used more for spacing births.

Table 3. Legal abortions in Estonia, Latvia, and Lithuania per 1,000 females by age group, 1992–1996.

	1992			1993			1994			1995			1996		
	15–19	20–34	35+	15–19	20–34	35+	15–19	20–34	35+	15–19	20–34	35+	15–19	20–34	35+
Estonia	55.5	95.0	60.2	51.2	102.5	26.8	34.3	83.9	19.2	32.1	85.0	21.4	27.4	75.8	22.4
Latvia	37.2	81.4	24.1	...	...	...	26.9	69.1	17.7	28.7	66.3	18.1	29.2	61.7	18.4
Lithuania	14.9 ¹	71.6 ¹	22.1 ¹	...	...	...	...	...	...	13.0	54.5	17.2	13.9	49.2	14.2

¹Data from 1991.

Figure 3 shows abortion rates and Figure 4 fertility rates among 15–19-year-old girls in selected Baltic area countries from 1992 to 1996. In Estonia fertility and abortion rates have decreased rapidly during the study period, in Latvia the trend is more obvious concerning fertility rates. Nevertheless, abortion rates remain two times higher than in Finland and Sweden. Among Baltic countries, the Lithuanian situation differs – it has the lowest abortion rate but the highest fertility rate and there is less change in both figures.

Figure 3. Induced abortions per 1,000 women aged 15–19 in selected Baltic area countries, 1992–1996.

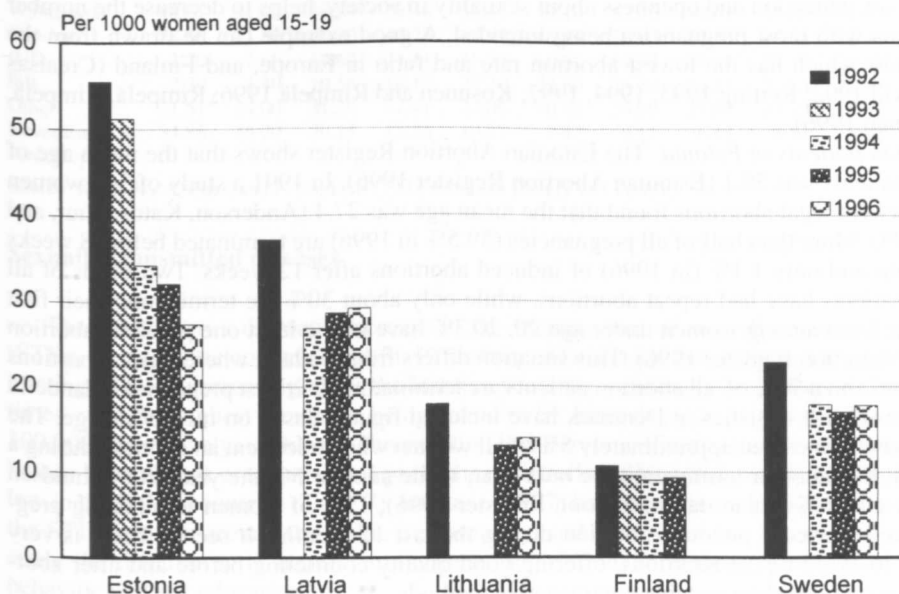
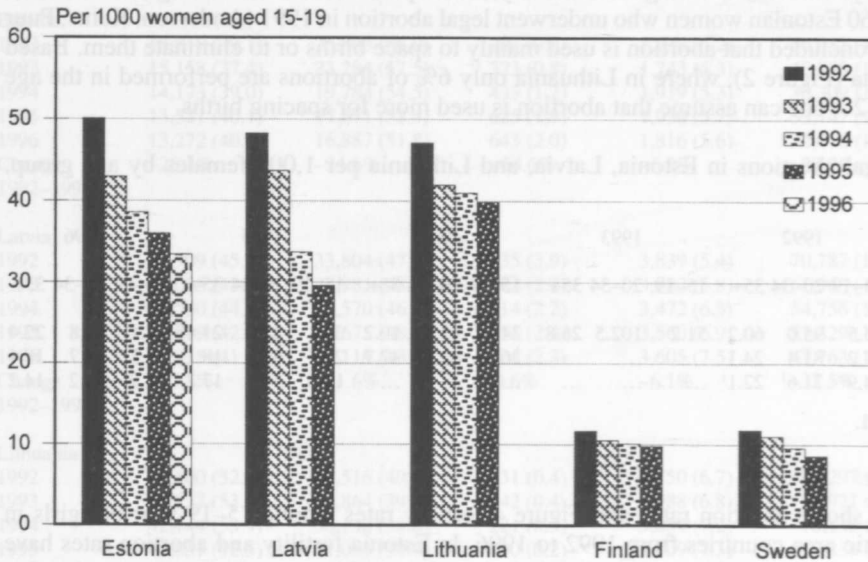


Figure 4. Fertility rates per 1,000 women aged 15–19 in selected Baltic area countries, 1992–1996.



Finland has succeeded in reducing teenage pregnancies and abortions by more than half since the mid-1970s. The downward trends in teenage abortions were similar for the Nordic countries up to the mid-1980s, but then they ceased, whereas in Finland the decline continues. Kosunen and Rimpelä (1996) have shown that with increasing use of contraceptives the first effect can be seen on the fertility rates of teenagers and later, with wider use of contraceptives, on the abortion rates. The high abortion ratios among teenagers indicate that teenage pregnancies are very often unintended. It has been evident that during the last decades the proportion of women starting sexual life earlier is increasing. However, it is well-known that a liberal approach to sex education and openness about sexuality in society, helps to decrease the number of abortions with most pregnancies being intended. A good example can be drawn from the Netherlands, which has the lowest abortion rate and ratio in Europe, and Finland (Creatsas 1995; David 1992; Ketting 1993, 1994, 1997; Kosunen and Rimpelä 1996; Rimpelä, Rimpelä, and Kosunen 1996).

Abortion patients in Estonia. The Estonian Abortion Register shows that the mean age of abortion patients was 28.1 (Estonian Abortion Register 1996). In 1991 a study of 360 women who underwent legal abortions found that the mean age was 27.4 (Anderson, Katus, Puur, and Silver 1993). More than half of all pregnancies (59.5% in 1996) are terminated before 8 weeks of gestation and only 1.1% (in 1996) of induced abortions after 12 weeks. Two-thirds of all abortion patients have had repeat abortions, while only about 30% are terminating their first pregnancy. Even among women under age 20, 20.3% have had at least one previous abortion (Estonian Abortion Register 1996). This situation differs from Finland where repeat abortions are rare, and about 70% of all abortion patients are terminating their first pregnancy (Mandelin 1997). The routine statistics in Denmark have included figures based on record linkage. The linkages have shown that approximately 5% of all women who underwent an abortion during a given year, had another termination the next year, while another 5% the year after (Knudsen 1997). Based on Estonian data (Abortion Register 1996), 12% of women terminating pregnancy have reported a previous abortion during the last 12 months. It seems that it is very important to avoid repeat abortions, offering good quality counseling before and after abortions, and recommending suitable contraceptive methods.

Contraception

It is difficult to compare national data about contraceptive prevalence. Ketting (1993a) has put forth reasons for the cross-national incomparability of data, which are the following: different years of study (changing use-patterns), different sample definitions, different definitions of women at risk of unplanned pregnancy (excluding infertile and pregnant women and those not having sexual intercourse), and different survey methods.

The use of effective contraception is relatively low in all three Baltic countries and there are no relevant statistics about it. According to the data from the medical statistics bureaus the prevalence of oral contraceptives has increased in all Baltic countries and in St. Petersburg but it is still low (in Estonia, Latvia, Lithuania, and St. Petersburg, accordingly 69.7, 86.6, 19.9 and 67.0 per 1,000, respectively, in 1996). The IUD use has slightly decreased and varies from 83.0 in Lithuania to 179.3 in Estonia (per 1,000 women of fertile age in 1996) (Table 4). The Estonian Family and Fertility Survey from the year 1994 shows that among younger women the percentage never having used contraception is lower. In the birth cohort of 1964–1968 31.7% had used the pill and 64.7% an IUD, but a still high percentage had used ineffective methods, such as rhythm (54.4%) and withdrawal (46.8%) (Table 5).

Table 4. Registered use of contraceptives per 1,000 women of fertile age in Estonia, Latvia, Lithuania, and St. Petersburg, 1990–1996.

	1990		1991		1992		1993		1994		1995		1996	
	OC	IUD	OC	IUD	OC	IUD	OC	IUD	OC	IUD	OC	IUD	OC	IUD
Estonia	26.2	182.7	39.1	196.8	38.6	204.7	37.4	198.6	47.3	186.7	69.5	191.6	69.7	179.3
Latvia					19.6	166.3	32.3	148.5	52.3	136.3	61.9	127	86.6	119.9
Lithuania			11.9	10.8	16.2	107.1	11.6	100.8	13.8	99.0	19.9	92.0	19.9	80.8
St. Petersburg									36.2	90.1	51.0	86.0	67.0	83.0

OC = oral contraceptives, IUD = intrauterine device

Table 5. Methods of family planning in Estonia by birth cohorts.

Respondent ever-used,%	1924– 1928	1929– 1933	1934– 1938	1939– 1943	1944– 1948	1949– 1953	1954– 1958	1959– 1963	1964– 1968	1969– 1973
Rhythm	27.89	36.80	48.59	54.88	57.51	59.18	56.28	56.28	54.43	52.64
Withdrawal	46.61	51.00	56.69	59.48	51.37	50.10	52.02	52.02	46.80	51.03
Condom	28.88	31.80	42.00	43.28	44.82	46.19	50.00	57.89	64.74	72.41
IUD	1.20	2.60	12.62	24.31	46.72	60.62	64.37	62.55	57.32	28.05
Pill	2.39	4.40	10.55	14.18	20.30	22.89	26.32	29.55	31.75	25.98
Other	21.51	24.00	31.26	32.41	27.06	30.72	24.90	24.09	23.30	18.62
Never used contraception	34.86	26.20	20.15	13.26	10.57	7.42	9.11	6.68	4.54	5.75

Source: Katus K., A. Puur, and L. Sakkeus. 1995. Estonian Family and Fertility Survey

Sexually transmitted diseases

There has been a dramatic increase in the transmission of sexually transmitted diseases (STDs) in the Baltic countries and St. Petersburg. Alarmingly, the average age of people contracting STDs is decreasing. Over the last five years the incidence of syphilis has increased 10 times, with the highest incidence being found in St. Petersburg and Latvia (239 and 125 per 100,000, respectively) (Table 6). The situation is different in Finland and Sweden where syphilis has been almost eradicated and gonorrhea controlled. The incidence of HIV/AIDS is still low in the Baltic countries (Table 7). Lazdane (1997) has found that it is impossible to analyze the STD situation around the Baltic Sea properly, and to solve the problem it is important to study the differences in health care systems, legislation, screening, contact tracing, sexual behavior, and sex education.

Table 6. Registered cases of gonorrhoea and syphilis per 100,000 population in Estonia, Latvia, Lithuania, St. Petersburg, and Finland, 1994–1996.

	1994		1995		1996	
	Gonorrhoea	Syphilis	Gonorrhoea	Syphilis	Gonorrhoea	Syphilis
Estonia	206.0	56.8	194.2	69.7	165.9	66.2
Latvia	147.1	159.3	111.2	91.9	83.9	124.9
Lithuania	147.9	57.6	111.0	90.8	77.7	101.4
St. Petersburg	341.5	173.0	237.2	267.8	163.4	239.1
Finland	9.7	1.2	6.5	2.4	3.4	0.7

Table 7. Registered cases of HIV carriers and AIDS per 100,000 population in Estonia, Latvia, Lithuania, Finland, and Sweden, 1994–1996.

	1994		1995		1996	
	HIV	AIDS	HIV	AIDS	HIV	AIDS
Estonia	0.7	0.07	0.7	0.2	0.5	0.5
Latvia	0.3	0.1	0.9	0.04	0.7	0.3
Lithuania	0.6	0.05	0.9	0.08	1.1	0.3
Finland	1.4	0.9	1.4	0.8	1.3	0.4
Sweden	2.9	2.1	2.8	2.2	2.5	1.7

Differences in reproductive health

Practices and attitudes toward termination of pregnancy and contraceptive use vary considerably in Europe as well as in the Baltic area countries. David (1992) has pointed out that legal, religious, and cultural constraints vary widely in countries, making interpretation of data more complex. The figures presented in this article indicate the huge differences between the Baltic area countries – reproductive health is greatly improved and it is on a high level in Sweden and especially in Finland, where the number of abortions and teenage pregnancies has decreased, and the incidence of STDs and HIV/AIDS is low. The reasons for the favorable situation in Finland are a combination of the public health and preventive medicine approaches, a well-functioning infrastructure of the health and education sector, and the professional attitude of doctors and nurses (Rimpelä, Rimpelä, Kosunen 1996).

Why is the reproductive health situation less favorable in Estonia, Latvia, Lithuania, and St. Petersburg? To comment on the high abortion figures and low use of modern contraceptive methods in Estonia, Latvia, Lithuania, and St. Petersburg, one has to go back in history. In the Soviet Union abortion was legalized before modern contraception was available. The availability and diversity of modern and reliable methods of contraception were insufficient. Moreover, critical public opinion towards oral contraceptives (concerning their reliability and health risks) also played an important role. Even nowadays some people feel that contraceptives are more risky than abortion and they see abortion as a family planning method. During the Soviet period family planning was treated predominantly as a medical but not as a social problem. Nowadays, when birth rates are falling, family planning seems for some politicians and organizations to be a low priority issue and is equated to controlling the population.

Sex education. People are having sex for the first time at an increasingly young age, having changing relationships, and multiple partners, therefore they have put their reproductive health at high risk. The same trend exists in the Baltic countries, especially in Estonia and Latvia, where a delayed “sexual revolution” has taken place – sexual messages are everywhere, and pornography and prostitution are widespread. To respond to young people’s needs, new counseling and education strategies are required, giving adequate information about sexuality. Finland’s and Sweden’s success proves that the cornerstones of improved reproductive health (low incidence of abortions, teenage pregnancies and STDs) are comprehensive family plan-

ning and sex education programs, new health promotion strategies, and openness in society about sexuality.

Estonia. Sexual education is included in the framework of the health education component of the school curricula for the fourth, seventh, and tenth grades. Health education lessons are conducted by teachers from various disciplines, health workers, and psychologists. Family education has been in secondary schools since 1980s, but earlier the programs dealt more with preventing sexual activities and the negative consequences of sexual life. Nowadays the level of sexual education differs in different schools, being at a high level in some schools and still unsatisfactory in others due to the lack of teaching materials and/or the insufficient training and preparedness of teachers. The abortion rate has decreased considerably in Estonia among young people. One possible explanation could be in activities carried out during the last years. In Estonia the funds obtained from paid abortions are used as subsidies to make contraceptives affordable for certain groups (who pay only 10% of the real price) – full-time pupils and students, women in their first year after delivery, and women three months after an abortion. A special counseling center was established in Tallinn in 1993 and now there are 13 youth counseling centers in Estonia. The Estonian Family Planning Association is networking with them, providing information, education materials, and training.

Latvia. Approximately 500 teachers have sought training. Sex education is not yet incorporated as a comprehensive part of the school sex education programs, but it is being taught in about one-third of all Latvian schools. Information, education, and communication work is carried out by the Latvian FPA and the Health Education Teachers' Association (Melngailis 1995).

Lithuania. Sexual education is included in the framework of the health education program and lessons are conducted by teacher of various specialities. Teachers are insufficiently prepared and they have different views about the subject. The Catholic Church has curbed the introduction of a family planning education program, and in many cases education is limited to a discussion of "saving life and moral values in society". Sex education is carried out by the national AIDS Prevention Center, the National Family Planning Center, and the Lithuanian FPA (Klimas 1996). In Lithuania the abortion figures are the lowest in the Baltic countries. It is difficult to see what the real reasons for this are – whether it is because of the influence of religion, a later start to sexual life, a nonacceptance of induced abortion, or the unreliability of the statistics. Basing on the available information it seems that there is no ground for considering that lower abortion figures can be explained by more widespread modern contraception or sex education.

The positive change is that the role and influence of nongovernmental organizations (Family Planning Associations of Estonia, Latvia, and Lithuania) are growing in all Baltic countries.

Conclusions

This article, based on available information cannot give answers to all questions related to reproductive health in the Baltic Sea area countries. It is clear that the figures presented in this article indicate a real need for improvement in the Baltic countries and in St. Petersburg and the possibility to learn from the positive experiences of Finland and Sweden. To improve the situation in the Baltic countries, what is needed is advocacy and political lobbying for sexual and reproductive health information, education, and communication in matters related to reproductive health, particularly for young people, and easy access to good-quality youth counseling services.

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