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## *CASE STUDIES*

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# Maternal Health Policies in Countries in Transition: Poland and Kyrgyzstan, 1990–2006

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**ABSTRACT.** Starting with the initiation of democratic and market economic transitions, unsupportive policies concerning women's reproductive health were implemented in Kyrgyzstan and Poland in the period 1990–2006. These policies were expressed by (1) political decisions limiting available funding to support medical practices protecting women's reproductive health, (2) diminishing or restricted dissemination of knowledge about family planning, and (3) the

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implementation of new contraception and abortion policies. Could these changes be perceived as combat between democratic liberalism, cosmopolitanism, and tolerance versus traditionalism, insularism, and fundamentalism? We use analyses of policies concerning women's reproductive and maternal health to manifest rivalry between economic crisis and the push toward modernity and between traditionalism and liberalism. We demonstrate that the return to traditional gender roles and gender policies, and their practical application expressed in maternal health policies, illustrates cultural backlash toward diffusing Western liberalism in countries in political and economic transition.

**KEYWORDS.** Democratization and women's health, market economic transition, maternal health policy

### ***COUNTRIES IN TRANSITION TO MARKET ECONOMY AND TO DEMOCRACY***

The main goal of family planning policy, including education and counseling, is to ensure low-risk pregnancies and safe motherhood; it strives to avoid complications due to inadequately spaced pregnancies and intends to reduce the incidence of sexually transmitted diseases (United Nations, 2003).

The disintegration of the Soviet Union and its centralized economy in the early 1990s and the transition of the Soviet bloc to a market economy and democracy brought positive changes to the lives of residents of prior countries of the USSR. Among these changes were the establishment of political freedom, free elections, elimination of censorship, an opening of opportunities for private entrepreneurs, and, in the more economically advanced countries, availability of both food and quality consumer products (Czapinski, 1994). In addition, the ongoing political and economic unification with Western Europe had exposed former Soviet bloc societies to the lifestyle of Western democracies and presumably to a higher standard of living (Brown, 1992; Dabrowski & Antczak, 1996; Wejnert, 1996; Wejnert & Spencer, 1996).

These transitions were coupled with changes in employment levels, the emergence of a new class system, and initial economic hardship and impoverishment of parts of the population. During the

transition, income and living standards drastically declined. For instance, in countries of the former Soviet Union, by the end of 1994 real wages were barely one-third of the average level for 1990 (UN Development Program [UNDP], 1995, p. 9) and by the end of the 1990s the real wages in some former Soviet Republics were only 40% of their average level for 1990 (among these states were Ukraine, Moldavia, and Georgia) (Kolodko, 2001). Though democracy and a global market economy were perceived as a guarantee of a high standard of living for all citizens, the democratic liberal ideology and economic liberty of a global market has led to substantial social inequality and social discomfort (Kolodko, 2001, 2002, 2003; Lissytukina, 1993; Wejnert, 2007; Wejnert & Spencer, 1996).

### ***MATERNAL HEALTH POLICIES IN COUNTRIES IN TRANSITION***

The implementation of democracy and a global market also brought changes in gender politics and women's health policies. These changes reflected new cultural perceptions of the role of women and mothers. In contrast to the communist period, democratic governments, religious institutions, and the media started campaigns propagating women's freedom to choose home and family instead of employment and encouraging mothers' return to home for the sake of families. From this perspective it seemed that the economic and political transitions brought an end to women's participation in the labor force and to previously encouraged models of working mothers. Childcare policies and supportive maternal health policies disappeared: Maternity leaves were terminated and sick child leave, daycare centers on company premises, and subsidies for child care disappeared (Wejnert, 2002). In sum, the communist model of "professionally working mother" was changed to that of "mother-homemaker" (Wejnert & Djumabaeva, 2004). Children's upbringing returned to families, and mother's role as an agent responsible for child/family care and for domestic duties was restored.

This change was especially illustrated in returned traditional gender politics and its practical application expressed in reproductive and maternal health policies. Analyses of policies concerning women's reproductive and maternal health manifest that the impact

of democracy, globalization, and a global market on societal development was met with a returned traditional culture leading to a combat between democratic liberalism, cosmopolitanism, and tolerance versus traditionalism, orthodoxy, and insularity. Many new policies, including gender and maternal health policies, demonstrate the rivalry between economic crises and a push toward modernity and between traditionalism and liberalism in countries in transition.

### ***CASE STUDIES OF POLAND AND KYRGYZSTAN IN 1990–2006***

Starting with initiation of democratic and market economic transition, unsupportive policies concerning women's reproductive health were implemented in Kyrgyzstan and Poland. These policies were expressed by (1) political decisions limiting available funds to support medical practices protecting women's reproductive health, (2) diminishing or stopped dissemination of knowledge about family planning, and (3) reforms in contraception and abortion policies.

#### ***Governmental Budget and Spending on Maternal Health Care***

Unlike most developed democratic countries, promotion of a concept of health in general and maternal health in particular as well-being, rather than the absence of disease as defined by the World Health Organization, was not instituted in new, post-Communist democracies. The meaning of health was misunderstood coupled with rapidly diminishing finances available to health care services, including maternal health care since 1990 (Romaniuk, 2002; United Nations, 2003).

In Kyrgyzstan in 1991, 3.8% of the gross domestic product was spent on health care; in 1992 it was 2.7%, and in 1993, 2.3%. By 2004 it was only 1%. Facing financial difficulties, Kyrgyz Ministry of Health began to redirect resources according to prioritized medical care sectors and maternal care was not considered a priority (Table 1). Financial resources were shifted from reproductive health programs and maternal medical units to general health services. Accordingly, within 6 years (from 1991 to 1997) the number of hospital beds for women and expectant mothers declined by approximately 25% (from 5,507 to 4,080), the number of beds for all gynecological illnesses also declined by almost 25% (from 2,115 to 1,616), and the number of

TABLE 1. Hospital and Prophylactic Help for Women in Kyrgyzstan

	1991	1992	1993	1994	1995	1996	1997
Number of gynecological and obstetrical doctors	1,072	1,052	1,040	1,080	1,135	1,253	1,227
Number of midwives	3,763	3,598	3,649	3,414	3,642	3,292	3,265
Number of beds for expectant mothers	5,507	5,335	4,801	4,473	4,216	4,165	4,080
Total number of beds for all gynecological illnesses	2,115	2,206	2,080	1,865	1,671	1,672	1,616

Source: Kyrgyz National Statistical Committee. (1998). *Women in Kyrgyz Republic*. Report. Bishked, Kyrgyzstan.

professional midwives declined by approximately 15% (from 3,763 to 3,265) (Kyrgyz National Statistical Committee, 1998, 2002). Women in rural areas more frequently delivered children without the assistance of medical staff, and maternal death rates drastically increased. As the UN Population Fund (UNFPA) (2003) indicated, more than 1.3% of registered deliveries occurred at home due to problems with transportation from remote villages and the number of deliveries at home increased by over 1% (not counting unregistered deliveries). The new policy plan on the health of women and newborn children (Manas Policy Plan of 2000) was implemented in a year when maternal death reached 110 women out of 100,000 live births (UNFPA, 2005). At least for a decade and half of democratic growth, visible decline of maternal health and reproductive health services was observed (Table 1) before the Kyrgyz government started to look for foreign grants and humanitarian aid. For example, based on credit received from the World Bank, medications were purchased and distributed among hospitals; governments of China and the United States provided humanitarian aid; and grants were received from the World Health Organization, the U.S. Agency for International Development (USAID), the UNDP, the UN Children's Fund (UNICEF), the UNFPA, and the Soros-foundation. The World Bank, Asian Development Bank, Islam Development Bank, and the Japanese government provided credits to Kyrgyz in support of medical services.

Similarly in Poland, the reform budgets of the early 1990s included cuts in the funding of the Ministry of Health and Social Welfare. Starting in 1991, over 2,500 beds and nearly 100 clinics and dispensaries were eliminated to achieve consolidation and efficiency of existing units. By 1992 Poland had 57 hospital beds per 10,000 citizens, much less than on average in other countries of the European Union. Additional targeted cuts of 10% to 20% were expected in clinics and hospital beds by 1994, but the number increased to 55 hospital beds by 2005. Lack of financial resources pushed the medical centers to add the costs of drugs and other needed materials to patients' expenses. Informal payments and gifts for medical treatment, especially for surgical operations, started to become normal practice, especially since the salaries of doctors and medical staff were very small (equal to about U.S.\$25–50 per month). The long-term goal of the Polish health policy was a complete conversion of socialized medicine supported by state budget to a privately administered health system supported by a universal, obligatory health insurance fee. Under such a system, fees were supposed to be shared equally by workers and enterprises. Introduction of private, pay-for-service medical care was unaffordable for most, however, except the highest income families. Small industrial enterprises were also reluctant to participate in this plan when needing to copay for medical insurance of their employees. Therefore, even after 1995, planners projected that the state budget would continue contributing to the national health care fund until the insurance system became self-sufficient.

The financial problems of the post-Communist health care system were additionally acute because the inherited communist system was also inefficient. The structure of the medical profession did not supply enough general practitioners and medical personnel; dentists and nurses were also in short supply. Treatment facilities were too few and crowded, preventive medicine received little attention, and the quality of care was generally poor. In rural areas the medical care was much worse.

In both countries there were cuts in the budget designated for maternal care, financial support from state-run daycare facilities was withdrawn, and many daycare centers had to be closed. From 1990 to 1992, the first 2 years of democracy, more than half of such centers had been closed in Poland. The culminations of these changes were political decisions that did not seem supportive to motherhood. For instance, in 1992 the Polish government closed the Office for Women

and Family Matters in the Polish Government (Pełnomocnictwo Rządu do Spraw Kobiet i Rodziny), the only office representing women's rights in the public and domestic spheres. Minister Anna Popowicz, who was released from the post as a director of this office, stated: "as soon as the right wing politicians win the election to the Polish government, women's role will be limited to that of mother, care giver, and homemaker . . .and nobody will invest in the education of women whose only role will be to bear children" (Paradowska, 1992, p. 5). Under such politics safe motherhood, health of women, and parenting (especially by working mothers) became more problematic.

### ***Limited Family Planning***

As our study revealed, under budgetary cuts and limited support for working mothers, family planning became imperative for Kyrgyz and Polish couples, especially because the economic difficulties required transition to a modern model of a small family. It appeared that democratic growth assisted by economic restructuring generated financial insecurity for many families, and Polish and Kyrgyz couples viewed family planning as increasingly important (Table 2).

In neither country were educational programs and dissemination of information about family planning and women's reproductive health included in health policies (United Nations, 2003). The Forum of Women's NGOs in Kyrgyzstan in its study of women's reproductive health conducted in rural regions of Kyrgyzstan concluded that 50% of these women never had a complete gynecological, general practitioner, pediatric, or ultrasound technician exam. Many of these women were not aware that they had diseases of reproductive organs, and 10% were not aware that they were pregnant. Because medical exams are expensive, almost none could see a doctor regularly. At the same time, these women did not have any knowledge about family planning and were uninformed about contraceptives. Research conducted by the Forum of Women's NGOs and the Winrock Agricultural Institute with over 100 women and children in four villages in the region of Kant in Kyrgyzstan found that in 2000 most women did not have any knowledge about family planning. Lack of emphasis on family planning led to limited use of contraception, with the contraception prevalence rate of 49% in comparison with neighboring Uzbekistan of 63% (UNFPA, 2005) (see Table 3).

TABLE 2. Need for and Availability of Education Concerning Reproductive Health and Contraception Before and During Democratization Period in Poland and Kyrgyzstan

Country	The Need for Family Planning Today vs. Past	Education Concerning Reproductive Health Today	Availability of Contraception Today vs. Past	Couples' Concern About Reproductive Health Today vs. Past
Kyrgyzstan	<b>61.7% more important</b>	<b>47.3% much more needed</b>	<b>45% increased</b>	<b>52.8% stronger concern</b>
	17.2% same	<b>16.2% more needed</b>	16.7% same	12.0% same
	16.4% less important	17.7% same	33.9% decreased	31.3% weaker concern
		5.5% less needed 12.7% much less needed		
Poland	<b>33.3% more important</b>	<b>38.6% much more needed</b>	<b>38.2% very increased</b>	<b>57.2% stronger concern</b>
	64.4% same	<b>34.6% more needed</b>	38.2% increase	31.0% same
	0.3% less important	15.0% same	12.1% some	9.5% weaker concern
		6.5% less needed 4.2% much less needed	9.2% decrease	

*Note:* In Poland  $n = 306$  (women), in Kyrgyzstan  $n = 100$  (women) and  $n = 100$  (men). The percent does not add up to 100% due to missing data. The most significant results are shown in bold.

*Source:* Data collected in Poland in 1999 by Wachowiak & Wejnert and in Kyrgyzstan in 2002 by Wejnert & Djumabaeva.

Limited contraception use not only led to a higher abortion rate, but it also had direct implications on spacing childbirths, spread of sexually transmitted diseases, teenage childbirth, teenage pregnancies, and safe motherhood (UNICEF, 2004). Hence, policies that are not supportive of family planning seem to contradict attempts to reduce maternal death.

### *Abortion Policies*

The abortion policies in these two countries were additional indicators of lack of support for safe motherhood. The policies in these two countries represented two extreme possibilities: In Poland abortion was banned, whereas in Kyrgyzstan it was unrestricted.

TABLE 3. Contraception Use by Polish Couples in 1997

Protection Used During Last Sexual Intercourse With In General (%) Husband/Wife or Steady Partner	Women (%)	Men (%)	
None	<b>30.1</b>	<b>28.3</b>	<b>32.1</b>
Calendar-based method	9.8	11.1	8.4
Billings and temperature method	1.8	2.4	1.2
Withdrawal	<b>15.1</b>	<b>16.2</b>	<b>13.9</b>
Oral contraception	8.3	9.0	7.6
Diaphragm	4.8	5.6	3.9
Foams, gels, creams	0.3	0.4	0.3
Other methods	1.4	1.8	1.0
Condom	<b>20.8</b>	<b>18.2</b>	<b>23.6</b>
Lack of data	7.6	7.1	8.0

The most significant results are shown in bold.

Source: Compiled from the result of the survey of the Polish national statistics. Główny Urząd Statystyczny (GUS) (General Statistics Office) (1997). *Stan Zdrowia Mieszkańców Polski* [The state of health of the inhabitants of Poland]. Warsaw, Poland [in Polish].

## Poland

In the early 1990s the ruling conservative party propagated the concept that the survival of the Polish nation required strengthening traditional family values and the devotion of mothers to child and family care even at the price of sacrificing professional development. In the late 1980s a national organization, called the Association of Ordinary Women, was established within the Catholic Church. The members contacted women in villages and small towns where they stressed the importance of family and women's roles as housewives and emphasized the need to support the Senate draft of a bill banning abortion. From 1956 into the 1990s abortion was legal and widely accessible, both on medical and social grounds, and was conducted in public hospitals (free of charge) and in private clinics as a paid service (Hauser, Heyns & Mansbridge, 1993). In 1991 the National Christian Parliamentary Club sponsored a bill for complete elimination of abortion. A year later this bill was supported by the National Assembly of Doctors (a medical professional organization) and adopted by the Medical Code of Ethics. This bill not only prohibited abortion on social grounds, but it also did not allow it when the pregnancy was a result of a criminal act.

After more than 3 years of discussions, the Polish Sejm (lower house of the Parliament) voted for the Family Planning, Protection of Human Fetus and Conditions for Termination of Pregnancy Act, commonly known as the Anti-Abortion Act of 1993. Different actions restricted access to abortion, making it almost impossible in public hospitals and more expensive in private clinics.

In 1996, the Sejm liberalized the Act, allowing for abortion until the 12th week of pregnancy if “a woman is in hard life conditions or in a difficult personal situation” due to social circumstances. Nevertheless, the provision regarding abortion on social grounds was withdrawn by the Parliament elected in 1997 because of the decision of the Constitutional Tribunal. Justifying its decision on the basis that Poland as a democratic state should protect life at its every stage, the Constitutional Tribunal stated that abortion on social grounds is unconstitutional. The provision of legal protection of the life of every human being (Article 38) was included in the Polish Constitution. Polish Sejm restricted the conditions once again, withdrawing the possibility of termination of pregnancy on social grounds. According to the law, abortion was legal only in cases

1. When pregnancy constitutes a threat to life or a serious threat to the health of the mother that is confirmed by two doctors other than the doctor involved in the abortion,
2. When prenatal examination, confirmed by two doctors other than the doctor involved in the abortion, indicates heavy, irreversible damage of the embryo,
3. When there is justified suspicion, confirmed by a prosecutor, that the pregnancy is a result of an illegal act.

Doctors who performed illegal abortion were subject to the punishment of up to 2 years of prison, and legal abortions could be only performed in a public hospital.

After the introduction of the Act in 1994, the official number of abortions conducted in public medical centers decreased to 782 cases, all for medical reasons. In 1997, the year when the regulations allowing for the termination on social grounds had been reintroduced, 3,047 abortions were conducted in public hospital and 2,534 (83%) were for social reasons. In 1997 there were 409 abortions, which decreased to 94 in 1999 because it threatened the life or health of the

TABLE 4. Number and Reasons of Legal Abortions Conducted in Poland in 1994–1999

Year	General Number of Abortions	Number of Abortions Conducted on Social Grounds	Number of Abortions While Pregnancy Was Threatening Life or Health	Number of Abortions Conducted Because of Heavy and Irreversible Damage of the Fetus	Number of Abortions Conducted When a Pregnancy Resulted From Rape
1994	782	—	689	74	19
1995	559	—	519	33	7
1996	505	—	457	40	8
1997	<b>3,047</b>	<b>2,524<sup>a</sup></b>	<b>409</b>	<b>107</b>	<b>7</b>
1998	310	—	211	46	53
1999	151 <sup>b</sup>	—	94	50	1

<sup>a</sup>Regulation allowing for abortion on social grounds was binding only in 1997. The most significant results are shown in bold.

<sup>b</sup>Data do not add up to 151 due to missing data.

*Source:* Compiled from the reports of the Council of Ministers for the Realization of the Family Planning, Protection of Human Fetus and Conditions for Termination of Pregnancy Act, Warsaw, 1999 [in Polish].

mother (Table 4). At the same time health indicators clearly showed no radical improvement in the health of Polish women in 1999 (Nowicka, 2000; Nowicka & Tajak, 2000). In 1999 it appeared that abortions were granted only when there was “heavy and irreversible damage of the fetus” or the pregnancy was the result of a criminal act. Most abortions due to social or medical conditions had to be conducted illegally. Abortion is still illegal and very rare in Poland. By 2003 there were no legal abortions reported, and only seven illegal abortions were reported per 1,000 women (Table 4).

Similarly peculiar seem to be data on abortions due to rape, which decreased from 53 to 1 over 1 year (1998–1999), although we could not find any report suggesting almost complete elimination of rape crime in 1999. There were actually 2,399 officially reported rape cases in 1999 (Nowicka & Tajak, 2000).

### *Kyrgyzstan*

In Kyrgyzstan abortion has been legal since 1955. It is authorized if performed by a licensed physician in a hospital or other recognized

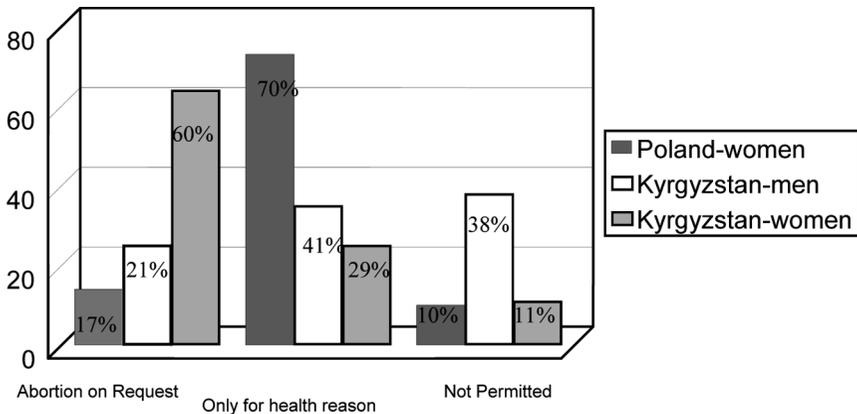
medical institution and is available on request during the first 12 weeks of gestation. An abortion requires only the consent of the pregnant woman. On judicial, genetic, vital, broad medical, social, and personal reasons, abortion is available within 28 weeks from conception if it is authorized by a commission of local physicians (United Nations, 2003).

Such a completely unrestricted abortion policy combined with limited knowledge about family planning results in high rates of abortion. Official reports in 1991 indicted that there were 63.1 abortions per 1,000 women of reproductive age. As a result of a diffusion of information about family planning initiated in Kyrgyzstan by the government and international organizations (e.g., World Health Organization), this number was lowered to 22.4 abortions per 1,000 women by 1999. The reported abortion rate was lower than for post-Communist Russia (93 abortions per 1,000 women of reproductive age in 1991 and 68.4 abortions by 1999) but much higher than for other post-Communist, Asian countries that are culturally similar to Kyrgyzstan, such as Uzbekistan (23.0/1,000 in 1991, 11.8/1,000 in 1999 of women of reproductive age) (Henshaw, Singh, & Hass, 1999).

It is estimated that Kyrgyz women had on average four or more abortions per lifetime (Kyrgyz National Statistical Committee, 1998; United Nations, 2001). Particularly alarming, however, was the age distribution of women who decide to terminate pregnancy—out of 55,000 to 66,000 pregnancies aborted each year, 10% of them were pregnancies of teen mothers (under 18 years of age). For these women the rate of abortion-related maternal death was also significantly higher than for any other age group (Kyrgyz National Statistical Committee, 1998; United Nations, 2003).

In both countries abortion policies challenge societal attitudes regarding abortion. As our research indicates, Poles on average have more liberal attitudes toward abortion, whereas Kyrgyz respondents opt for some restrictions in their abortion policies (Figure 1). Accordingly, in the predominantly Muslim, traditionally conservative culture of Kyrgyzstan, 11% of Kyrgyz women believed that abortion should be banned, whereas 38% of Kyrgyz men believed that it should be banned. In largely Catholic Poland (over 90% of Poles declare themselves as Catholics), only 10% of Polish women believed that abortion should be banned, 17% supported abortion for social and health reasons, and near 70% believed that

FIGURE 1. Attitudes toward Abortion in Poland and Kyrgyzstan in 1999 and 2002\*



*Note:* The numbers of cases included in each study were as follows: In Poland N = 306 (women), in Kyrgyzstan N = 100 (women) and N = 100 (men). \*In a case of Polish women the data do not sum up to 100% due to missing data. *Source:* Data collected in Poland in 1999 by Wachowiak & Wejnert and in Kyrgyzstan in 2002 by Wejnert & Djumabaeva (2004).

abortion should be available in cases of poor health of mother or infant (Figure 1).

These rather liberal attitudes prevail regardless of the high religiosity of Poles—such attitudes were expressed by 81% of Poles who were raised as Catholics and 42% of Poles who had continuous religious upbringing, as well as 22% of Poles irregularly and 5% who regularly attend church services supporting abortion on request. Over 90% of Poles who had some religious teaching and 43% of those who had continuous religious upbringing supported abortion on request but only after consultation with a physician. The absolute ban of abortion was supported by only 6% of Poles who had strong religious upbringing (1% with some religious upbringing) and 7% of regularly attending church service (only by 2% of those who attended church service irregularly). No Poles who did not attend church or did not have religious upbringing supported a complete ban of abortion (Wachowiak, 2002).

Results obtained in a national survey supported our finding of very limited public support for complete ban of abortion, showing consistency of this attitude over time. For example, according to the Polish

public opinion poll, in February 1992 only 11% of Poles supported an absolute ban of abortion, whereas 82% believed that abortion should be allowed (either offered whenever women request it [25%] or with some restrictions [35%], or only in cases of rape or when a women's health is jeopardized [22%]) (Polish Federation for Women and Family Planning, 1999).

The high rate of abortion suggests that due to limited use of contraception, couples use abortion as a substitute when controlling family size. Such practice endangers health of mothers (e.g., high rate of abortion-related maternal death) and in the future affects the safety and health of mothers and newborn children. Compared with the United States, where the maternal mortality ratio was 13 in 2004 (Minino, Heron, Murphy, & Kochanek, 2007), or with Canada, where maternal mortality was 6 in 2004 (Minister of Public Works and Government Services Canada, 2004), there were 110 maternal deaths per 100,000 live births in Kyrgyzstan in 2001 (increase from 65 in 1996), and about one-third of maternal deaths were related to abortions or complications after abortions and others were pregnancy related (United Nations, 2003; UNFPA, 2003). In Kyrgyzstan, the number of maternal deaths as a consequence of abortion was decreasing (during 1990 to 2000 abortion-associated deaths fell from 56% to 14%); however, for teen mothers (aged 12–19) the number of abortion-related deaths increased by 1.5 times (United Nations, 2003). Most deaths, 77% to 80% of all cases, were registered in rural areas of Kyrgyzstan, especially among young women and migrant workers, suggesting illegal abortion practices due to inaccessibility of abortion clinics or limited knowledge about available abortion services (United Nations, 2003). Causes of maternal deaths in Kyrgyzstan were as follows: abortions, 6 cases per 100,000 live births; late ketosis, 15 cases; bleeding, 6 cases; complications after delivery, 5 cases (United Nations, 2003).

In 2006 the maternal mortality rate of 8 in Poland was similar to the United States and Canada (UNICEF, 2008), but almost half of maternal deaths were pregnancy-associated deaths and between one-third to one-half were considered preventable (Troszynski, Chazan, Kowalska, Jaczynska, & Filipp, 2003). Accordingly, the main causes of direct maternal deaths were as follows: hemorrhage 33.6% (rate 3.1), sepsis 27.3% (rate 2.5), amniotic fluid embolism 22.4% (rate 2.0), and pregnancy-induced hypertension 16.7% (rate 1.5) (Troszynski et al., 2003).

Because many of the abortion-related deaths were preventable, did democratic governments of Kyrgyzstan and Poland overlook issues of safe motherhood, maternal care, and mothers' health? Could and did cultural norms counteract the negative effects of budgetary, family planning, and abortion policies on safety of motherhood?

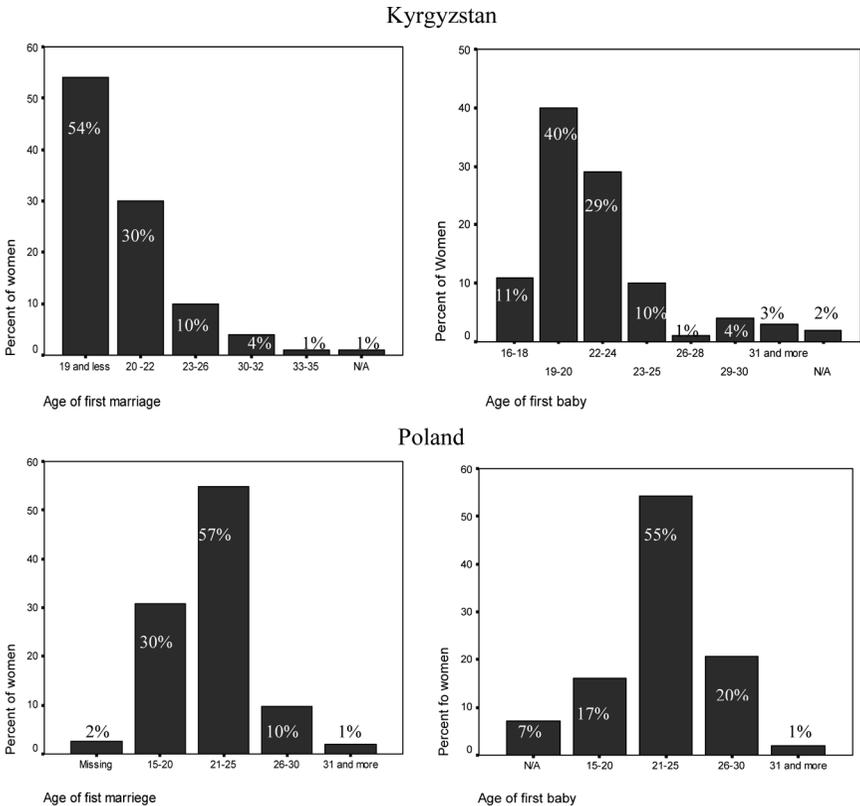
### ***IMPACT OF CULTURE ON SAFE MOTHERHOOD***

The emergence of modern liberal culture, similar to the Western countries, could lead to changes of conservative policies over time. At the times of democratization and globalization, new models of family diffused from Western to post-Communist countries. The new models included increased cohabitation, childlessness, divorce, single parenthood, extramarital and premarital sexual relations, and teenage sex. The new family arrangements were not always welcome and thus generated backlash to liberalism and democratic principles, establishing grounds for reintroduction of traditional gender norms.

Especially since 1998, ideological propaganda of the leading conservative party in historically traditional Poland affirmed that the survival of the Polish nation requires large families, strengthening of traditional family values, devotion of mothers to child and family, and sacrifice of women's professional development for the sake of family. Religious teaching emphasizing anti-birth control, antiabortion, and pre- and postmarital chastity reigned in Poland. Banned use of contraceptives, antiabortion laws, prohibition of sexual relations outside of marriage, and limited knowledge about modern contraception methods became the norm (Wejnert & Djumabaeva, 2004). In the predominantly Muslim, traditional society of Kyrgyzstan, customs of bride kidnapping, strict control of women's virginity, and the wearing of traditional *parandjas* (head-covering scarves) were reinstated (Kleinbach, Ablezova, & Aitieva, 2005; Wejnert & Djumabaeva, 2004). In both countries early marriage and early child-bearing had returned (Figure 2).

Procreation started at a very young age and, when combined with a higher number of children and short intervals between deliveries (30% of all deliveries and 44% of deliveries among women ages 20–29 years were during the 24 months after previous pregnancies)

FIGURE 2. The Age of Women's First Marriage and the First Child in Kyrgyzstan and Poland



Source: Data collected in Poland in 1999 by Wacho-wiak & Wejnert; in Kyrgyzstan in 2002 by Wejnert & Djumabaeva.

(UNDP, 2003), had a strong negative impact on mothers' health. One of the negative outcomes was alimentary anemia, which was experienced by 60% of pregnant Kyrgyz women (Kyrgyz Institute of Equal Rights and Opportunities, 1998).

Cultural traditionalism was initially believed to be an expression of personal freedom. A significant part of society saw political transformation as an appropriate time for women to return home full-time after communism that, as media propagated, had forced women into the workplace and weakened the family. By mid-1990s, however, with

unemployment rates rising above 16% in Poland and up to 50% in most former Soviet republics (an average much higher for women than men), economic crisis underway, and poverty on the rise, the public support for large families and women as homemakers ceased.

Nonetheless, the traditional perception of women's roles and of reproductive health policies had survived. For instance, The Law on Reproductive Rights of Citizens of Kyrgyz Republic, adopted in 2000, included Article 12, which stated that in the later term of pregnancy (after 12 weeks), "any medical interference during pregnancy is applicable based on consent of both parents as well as a woman herself." Therefore an unmarried woman needs to ask permission of her parents or, when married, her husband and/or his family before she is allowed to have an abortion. As nongovernmental organizations activists claimed, Article 12 weakens woman's position in families, makes them subservient to males, and expresses a traditional view that procreation is women's primary responsibility (CEDAW Committee, 2004). In Poland the traditional, influential, Roman Catholic church continued to teach in favor of natural, calendar-, and abstinence-based contraceptive methods as the only allowable contraceptive methods for Catholic families.

In a short time, the cultural image of mother-procreator and woman-homemaker replaced the prior image of the working mother, small nuclear family, and gender equality. Traditional models of womanhood and gender contradicted the notion of modernity and further jeopardized maternal psychological and physical health. In Poland the strict antiabortion policy led to a development of agencies organizing "abortion tourism" into neighboring countries of Ukraine, Lithuania, and Germany, as well as Austria, Belgium, and the Netherlands, to perform abortions (Council of Polish Ministers, 1999; Nowicka, 2000). During the strictest antiabortion law of 1997–1998, 1,200 abortions per year were facilitated by these agencies (Nowicka, 2000). In addition, during 1993–1999 the number of children being left in hospitals by most unmarried mothers almost quadrupled (an increase from 252 children in 1993 to 803 in 1997) and rates of pregnancy-related crimes committed by women also increased (Table 5). In 1997–1998, the years of reinstatement of abortion for social reasons, it was lowered by 30% (to 594 in 1998), but with the return of strict abortion policy it rapidly expanded to 737 per year in 1999.

TABLE 5. Crimes Related to Pregnancy According to Legal Qualifications in Poland

Legal Qualification	1995	1996	1997	1998	1999
Art. 149: Infanticide	42	44	43	38	31
Art. 149a: Causing the death of a fetus <sup>a</sup>	14	47	4	—	—
Art. 149b: Death of a child resulting from violence against a woman <sup>a</sup>	6	3	—	—	—
Art. 156a: Damage to the body or damage to the health of a fetus <sup>a</sup>	11	8	1	—	—
Art. 157: Causing the death of a mother <sup>a</sup>	2	1	—	—	—
Art. 152a, §1-2: Termination of pregnancy resulting from violence against a woman	—	—	2	3	2
Art. 152b, §1-3: Termination of pregnancy with a violation of legal regulations	—	—	2	5	—
Art. 152, §1-2: Termination of pregnancy with a consent from a woman <sup>b</sup>	—	—	—	1	92
Art. 152, §3: Damaging a fetus which is able to live <sup>b</sup>	—	—	—	7	3
Art. 153, §1: Termination of pregnancy as the result of violence <sup>b</sup>	—	—	—	1	2
Art. 154, §1-2: Causing the death of a pregnant woman <sup>b</sup>	—	—	—	—	—
Art. 152–154 KK (sum of all illegal abortions)	—	—	—	—	<b>99</b>
Total number of infanticide and Anti-Abortion Act	<b>75</b>	<b>103</b>	<b>52</b>	<b>55</b>	<b>130</b>
Only infanticide	<b>42</b>	<b>44</b>	<b>43</b>	<b>38</b>	<b>31</b>
Art. 210 KK z 1997 r.: abandonment of a child and abandonment resulting in a death of a child	55	54	77	63	46
Only abandonment resulting in the death of a child	<b>4</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>1</b>

Data in bold refer to a crime resulting in the death of a newborn child.

<sup>a</sup>Starting from 14.02.1997 registration of cases according to the Act of 30.08.96 on the change of the Family Planning Act was abandoned and the registration according to Art. 152a, §1-2 and Art. 152b, §1-3 was introduced.

<sup>b</sup>Legal qualifications according to Polish Criminal Code of 1997 (in force from 1.09.1998).

Source: Polish Police Headquarters (2000). *Statistics of the Police Headquarters*. Warsaw, Poland [in Polish]; Governmental Population Commission, *Demographic Situation in Poland*, reports 1993–2002; the Ministry of Health and Social Affairs, reports 1997–2000; Center of Information Systems of Health Care, report of Statistic Researches Program of Public Statistics 2001–2006; Governmental Population Commission, *Demographic Situation in Poland*, reports 1993–2002; the Ministry of Health and Social Affairs, reports 1997–2000; Center of Information Systems of Health Care, report of Statistic Researches Program of Public Statistics 2001–2006.

Similarly in Kyrgyzstan, during the legalized and free of charge abortion policy, the rate of abortions and infanticide increased. Media, ignoring the fathers' role, often blamed mothers for being irresponsible, clearly indicating patriarchal, unequal approach to

gender. A different image, however, could be equally propagated—an image of mothers abandoned by society and their male partners, desperate victims of rape, and at times of economic hardship and victims of unemployment, who are unable to take care of their newborn child.

All three effects, abortion, infanticide, and abandonment, intensified during democratic reform, resulting in part from an increased need for controlled procreation that collided with the limited prevalence of contraception.

### CONCLUSION

Prior studies indicated that democracy and global economic development protect the health of mothers (Shiffman & Garces del Valle, 2006); however, in post-Communist Poland and Kyrgyzstan the process of democratic growth was very costly to maternal health. Although the economic and social costs of transition seemed to be unavoidable for societies in general, the costs to women seem to be more extensive and long term than the costs to men.

Why do women pay harsher costs of transitions? This study suggests some explanations. *First*, the costs result from economic difficulties faced by countries during times of economic and political transition. They represent a response to the economic problems they experience resulting from an introduction of a market economic system coupled with the rise of materialism, commercialism, and the need for a rapid improvement in living conditions.

*Second*, diffusing democratic liberalism that allows for novel family forms, such as childless couples, professional singles, child-bearing out-of-wedlock, and—unheard of before the democratic era—cohabitation or gay/lesbian relations, meets with a corresponding backlash of a return to cultural traditionalism, including traditional models of womanhood and family structures, in the name of preservation of family. This cultural change of women's societal roles is characterized by a devaluation of women's professional development, increased domestication, and decreased employment, which many studies suggest counteracts improvement toward safe motherhood.

*Third*, the return to traditional gender roles is reinforced by limited and declining women's representation in governing and policymaking bodies, which leads to an easy dismissal of needs typical only to women (Ruschmeyer, 1998). Therefore, as the study demonstrated, maternal medical services and a progressive health policy and health care system that, before democratic transition, had been relatively well-established deteriorated in Poland and Kyrgyzstan during times of economic and political transition.

We conclude that regardless of the common assumption that democracy and a globalized economy protects the health of mothers and children, the costs of democratic and market economic transitions to safe motherhood are substantial. Democratic growth and globalization are not necessarily the magic remedy for improving maternal health and should not be used indiscriminately. A focus on cultural change valuing mothers' and women's roles in society and reinforcing women's societal position may lead to faster improvements in maternal health than economic and political reconstructions.

## REFERENCES

- Brown, J. F. (1992). The East European agenda. In J. F. Brown, R. Hormats, & W. Luers (Eds.), *Western approaches to Eastern Europe* (pp. 16–44). New York: Council on Foreign Relations Press.
- CEDAW Committee. (2004). *Alternative report. Report of the CEDAW Committee on the status of implementation of the UN Convention on elimination of all forms of discrimination against women in kyrgyz republic*. Bishkek, Kyrgyzstan: CEDAW.
- Council of Polish Ministers. (1999). *Report on realization of the family planning, protection of human fetus and conditions for termination of pregnancy act*. Warsaw: Author [in Polish].
- Czapinski, J. (1994). Uziemnienie Duszy Polskiej. *Kultura i Społeczeństwo*, 1, 19–37.
- Dabrowski, M., & Antczak, R. (Eds.) (1996). *Ukraińska droga do gospodarki rynkowej 1991–1995*. Warszawa: Wydawnictwo Naukowe, PWN [in Polish].
- Hauser, E., Heyns, B., & Mansbridge, J. (1993). Feminism in the interstices of politics and culture: Poland in transition. In N. Funk & M. Mueller (Eds.), *Gender politics and post-communism* (pp. 257–273). New York: Routledge.
- Henshaw, S. K., Singh, S., & Haas, T. (1999). Recent trends in abortion rates worldwide. *International Family Planning Perspectives*, 25, 44–48.
- Kleinbach, R., Ablezova, M., & Aitieva, M. (2005). Kidnapping for marriage [Ala Kachuu] in a Kyrgyz Village. *Central Asian Survey*, 24, 191–202.
- Kolodko, G. (2001). *From shock to therapy. The political economy of postsocialist transformation*. Oxford, UK: Oxford University Press.

- Kolodko, G. (2002). Nouveaux riches Vs nouveaux pauvres: Policy making in transition economies. In B. Wejnert (Ed.), *Transition to democracy in Eastern Europe and Russia: Impact on economy politics and culture* (pp. 185–221). Westport, CT: Greenwood Press.
- Kolodko, G. (2003). *Emerging market economies: Globalization and development*. London: Ashgate Publishing.
- Kyrgyz Institute of Equal Rights and Opportunities. (1998). *Kyrgyzstan's women after Beijing conference 1995. Situation analysis, actions conception and strategy up to 2000. Report of the Kyrgyz Institute of Equal Rights and Opportunities*. Bishkek, Kyrgyz Republic.
- Kyrgyz National Statistical Committee. (1998). *Report: Women in kyrgyz republic*. Bishkek, Kyrgyz Republic.
- Kyrgyz National Statistical Committee. (2002). *Women and men in kyrgyz republic. Gender-divided collection of statistics*. Bishkek, Kyrgyzstan.
- Lissyutkina, L. (1993). Soviet women at the crossroad of Perestroika. In N.Funk & M.Mueller (Eds.), *Gender politics and post-communism*. New York: Routledge.
- Minino, A., Heron, P. M., Murphy, S.L., & Kochanek, K. D. (2007). Deaths: Final data for 2004. *National Vital Statistics*, 55, 12–13.
- Minister of Public Works and Government Services Canada.(2004). *Health Canada. Special report on maternal mortality and severe morbidity in Canada—Enhanced surveillance: The path to prevention*. Ottawa. Retrieved March 10, 2008, from [www.phac-aspc.gc.ca/rhs-ssg/srmm-rsmm/pdf/mat\\_mortality\\_e.pdf](http://www.phac-aspc.gc.ca/rhs-ssg/srmm-rsmm/pdf/mat_mortality_e.pdf)
- Nowicka, W. (2000, September). The anti-abortion law in Poland. Report of the Polish Federation for Women and Family Planning (FEDERA). Warsaw, Poland.
- Nowicka, W., & Tajak, M.. (2000). *The anti-abortion law in Poland. The functioning, social effects, attitudes and behaviors*. Report of the Organization Federa. Warsaw, Poland.
- Paradowska, J. (1992). Kobieta do Domu. *Polityka*, weekly newspaper. March 21, 5 [in Polish].
- Polish Federation for Women and Family Planning. (1999). Independent report submitted to the United Nations Human Rights Committee on Gender Discrimination. NGO in Special Consultative Status with the Economic and Social Council of the United Nations. Retrieved October 15, 2007 from <http://www.federa.org.pl/english/english1.htm>
- Romaniuk, L. A. (2002). A country in transition: Health crisis in Ukraine, with a focus on tobacco and alcohol. In B.Wejnert (Ed.), *Transition to democracy in Eastern Europe and Russia: Impact on economy, politics and culture* (pp. 241–257). Westport, CT: Greenwood Press.
- Ruschmeyer, M. (1998). *Women in the politics of post communist eastern europe*. New York: Sharpe.
- Shiffman, J., & Garces del Valle, A. L. (2006). Political history and safe motherhood disparities between Guatemala and Honduras. *Population and Development Review*, 32, 1, 53–80.

- Troszynski, M., Chazan, B., Kowalska, B., Jaczynska, R., & Filipp, E. (2003). Four main reasons of maternal death in Poland between 1991–2000. *Ginekolog Poland*, 74, 1306–1315. Retrieved October 16, 2007 from <http://lib.bioinfo.pl/pmid:14669435.htm>
- United Nations. (2001). *The world's women 2000: Trends and statistics*. New York: United Nations.
- United Nations. (2003). *Report on realization of millennium declaration*. Bishkek, Kyrgyzstan.
- UNICEF. (2004). Child rights and poverty reduction in CEE/CIS and the Baltic States. *Innocenti social monitor: The Monee Project CEE/CIS/Baltic States*, 1. University of Sussex, Brighton: Innocenti Research Center.
- UNICEF. (2008). *At a glance: Poland. Statistics. Info by country*. Retrieved March 10, 2008 from [www.unicef.org/infobycountry/poland\\_statistics.html#0](http://www.unicef.org/infobycountry/poland_statistics.html#0)
- UN Development Program (UNDP). (1995). *Human development report 1995. Gender and Human Development*. New York: Author.
- UN Population Fund. (UNFPA). (2003). *Reproductive Health Sub-Program*. Bishkek, Kyrgyzstan. Retrieved October 21, 2007 from [www.unfpa.org/kg](http://www.unfpa.org/kg)
- UN Population Fund. (UNFPA). (2005). *State of the World Population Report*. United Nations, Population Fund, Kyrgyzstan. Retrieved October 21, 2007 from <http://kyrgyzstan.unfpa.org/rh.htm>
- Wachowiak, A. (2002). Religijność a życie rodzinne oraz planowanie rodziny (Religiosity, family life and family planning). In A. Wachowiak (Ed.), *Przemiany orientacji życiowych kobiet zameznych* (pp. 38–39). [*Change in married woman's orientation towards life*]. Poznan: Wydawnictwo Fundacji Humanitara.
- Wejnert, B. (1996). Political transition and gender transformation in the Communist and post-Communist periods. In B. Wejnert & M. Spencer (Eds.), *Women in post-Communism* (pp. 3–19). Greenwich, CT: JAI Press.
- Wejnert, B. (2002). *Transition to democracy in Eastern Europe and Russia*. Westport, CT: Praeger/Greenwood Press.
- Wejnert, B. (2007). Safe motherhood at times of democratization. Paper presented at the session of the Annual Meeting of the Society for the Advancement of Socio-Economics (SASE), Copenhagen.
- Wejnert, B., & Djumabaeva, A. (2004). From patriarchy to egalitarianism: Parenting roles in democratizing Poland and Kyrgyzstan. *Marriage & Family Review*, 3/4, 147–171.
- Wejnert, B., & Spencer, M. (Eds.) (1996). *Women in post-Communism*. Greenwich, CT: JAI Press.