POLICY PRIORITIES IN PUBLIC HEALTH

REPRODUCTIVE RIGHTS AND HEALTH IN ARMENIA: KEY CHALLENGES

INTERIM RESEARCH PAPER (DRAFT)

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INTERNATIONAL POLICY FELLOW 2003

YEREVAN 2003

ABBREVIATIONS

ABA/CEELI	American Bar Association/Central European and Eurasian Law Initiative
FGM	Female genital mutilation
FWCW	4th World Conference on Women
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
PHC	Primary health care
STD	Sexually transmitted diseases
TAR	Total abortion rate
UNFPA	United Nations Population Fund
WHO	World Health Organization

ACKNOWLEDGMENTS

Preparation of this Research Paper would not have been possible without the support and valuable contribution from different organizations and individuals.

The author would like to express special gratitude and appreciation to my mentors- CEU Prof. Judit Sandor, for the conceptual approaches and advice provided especially during the working group sessions in Budapest, as well as to the local mentors Prof. Razmik Abrahamyan, Vahe Gyulkhasyan, M.D. and Gayane Avagyan, M.D. for encouraging support and valuable recommendations.

Special thanks are due to the IPF staff-Csilla Kaposvari, Krisztina Bakos, Olena Sidorenko, Mladen Momcilovic and Merril Oates, and some of outgoing IPF Fellows from the Public Health group.

Recognition is due to the Department of Maternal and Child Health Care, Ministry of Health, Ministry of Education, Center of Perinatology, Obstetrics and Gynecology, and different international organizations as UNFPA, UNICEF, UNDP and WHO Liaison Office in Armenia, American Bar Association/Central European and Eurasian Law Initiative (ABA/CEELI), Medecins Sans Frontiers (Belgium), Intrah Prime II, "For Family and Health" Association, International Center for Human Development (ICHD), American University of Armenia, Center for Health Services Research and Center for Policy Analysis.

The Research Paper also benefited from a wide variety of resources obtained from the Central European University (CEU) library, Budapest-based NGOs "Hungarian Civil Rights Union", "Human Rights Students Initiative" and ordered publications kindly delivered from external contributors.

Thankful for all the support, the author would also appreciate any comments on the paper.

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METHODOLOGY

The research has been conducted on two concurrent levels: international and local.

The overview of the reproductive rights and human rights applicable to the reproductive health internationally has applied desk research methodology using printed and on-line resources by prominent authors and organizations on reproductive rights and health internationally and regionally: press releases, publications by WHO, Planned Parenthood, International Planned Parenthood Federation, Sexual Health and Family Planning in Europe, Entre Nous. On this level of research I have been guided by:

- *World Health Organization,* "Advancing Safe Motherhood through Human Rights" (2001), Transforming Health Systems: Gender And Rights In Reproductive Health (2001), Considerations For Formulating Reproductive Health Laws (2000)
- *ASTRA,* "The Application Of Human Rights To Reproductive And Sexual Health: A Compilation Of The Work Of The European Human Rights System", March 2002
- *International Programme on Reproductive and Sexual Health Law,* Faculty of Law, University of Toronto and Action Canada for Population and Development*,* The Application of Human Rights to Reproductive and Sexual Health: A Compilation of the Work of International Human Rights Treaty Bodies, 2001

Analysis of the present situation of reproductive rights protection in Armenia is made via the *de jure* assessment of all binding legal authority of Armenia relating to reproductive rights and *de facto* estimate analysis using all recently conducted surveys, sociological and epidemiological studies, polls and researches on reproductive health, demographic and health survey, official health, development reports and publications by local and international governmental and non-governmental agencies, the national school health and human rights education curricula and out- of- school programs, governmental documents, market researches, statistical reports, feasibility studies, situation analyses, as well as based on informal meetings and discussions with a variety of stakeholders.

The *de facto* part of the research will be complemented by an illustrative self-administered survey on reproductive rights among two groups of respondents: in-patient women and health care providers Center of Perinatology, Obstetrics and Gynecology, one of the biggest maternity hospital of c. Yerevan.

INTRODUCTION

The goal of this Project is to explore the reproductive rights and human rights related to reproductive health internationally and to evaluate the current situation with reproductive rights in Armenia; to contribute to the discourse of the reproductive rights promotion and improvement in Armenia; to increase the knowledge of professionals and society at large on the reproductive rights as well as to provide policy recommendations for relevant policy-makers and agencies.

The current research focuses on women's reproductive rights since it is predominately women whose reproductive rights are abused and require more consideration. Given the pioneer nature of such research in Armenia it has been considered appropriate to divide it into Parts: international and local. In order to get adequate understanding of the study of reproductive rights and health situation in Armenia it is critical for readers to read Part I and then go to Part II.

Part I: Part I is designed to examine the basic legal concepts and core elements of reproductive rights, overview human rights applicable to the reproductive health, their sources and articulations in international human rights law and major developments of reproductive rights on international and regional agendas.

The understanding of the concept of reproductive rights, their scope and articulations in international human rights instruments is of paramount and critical importance for their realization. This section relies both on the specific provisions of legally binding and non-binding and non-enforceable human rights instruments. It is important to note that singling out of some major human rights treaties illustrates merely some of the diversity and by no means exhausts the breadth of human rights relating to sexual and reproductive health.

Part II: The analysis applies a human rights and gender-sensitive approach to the status of reproductive health and rights in Armenia via wide-ranging analysis of *legal* and *factual* protection of reproductive rights. The research focuses on the reproductive rights and strengths and weaknesses of the commitment to reproductive rights in Armenia today as reflected in the country's laws and the degree to which women, in practice, enjoy the reproductive rights and other human rights affecting their reproductive lives. The *de facto* analysis identifies not only the deficiencies of the legislative framework but also reveals the social, economic, political and cultural causes of failure to enforce reproductive rights in Armenia.

The research also reveals the extent to which reproductive rights have been subject of study in Armenia, how much they are part of policy-making process on reproductive health and what they mean for women in Armenia.

This research paper is intended as one step in a series of steps under the project to contribute to national policy-making on reproductive rights and health, promote compliance with human rights principles relating to reproductive health, as well as local and international collaboration with knowledge of how a human rights approach can be applied to improve reproductive health.

It is anticipated that the work provides a clear and comprehensive illustration of the current situation and trends in the promotion of reproductive rights and gives distinct justification for the actions to be taken in implementing corresponding actions and measures.

Part I

Reproductive Rights: International Concern

Overview

PART I

CHAPTER I UNDERSTANDING REPRODUCTIVE RIGHTS

1.1 Why Human Rights? Pros and Contras

Procreation and reproduction represent one of the intimate and unique experiences of mankind. In this context to some the use of rights-talk may sound strange or eccentric since procreation is something taken for granted and a matter of privacy. However, rights-approach is a very useful tool in asserting one's entitlements and legitimate expectations.[1]

Although reproduction has until recent decades been heavily a private matter, it has always had clear public implications.[2] The procreation of individuals is a matter, which also affects the community interests, raising such legitimate concerns as guaranteeing minimum standards of life for everyone in community, enough resources and geographical space, and involving state intervention in form of family and population policies, public health, public good, morals and so forth.

International human rights law proclaims inalienable rights and freedoms of every human being and constitutes helpful machinery for defining the relations between the state and individuals. In matters of reproduction and procreation, limitations on permitted actions of the state and obligations are equally important. These limitations and obligations are stipulated in terms of concrete proscriptions and prescriptions in international human rights documents. Thus, the state has both positive and negative obligations: while it has the responsibility to ensure an enabling environment, to respect, protect and fulfill3 reproductive rights, it must also refrain from compromising reproductive rights in any way by resorting, for instance, to any form of coercion.

During the past decades the concept of rights has laid a ground for debates in women's movements for reproductive self-determination and freedom, empowerment, gender equity and equality. Its value is further emphasized with novelties and advances of medical technologies, which, on one hand, expand the scope of reproductive choice and autonomy, and on the other hand, cause conflicting interests. The introduction of third parties to procreative process has multiplied areas of potential conflict (surrogate mothers, egg and sperm donors).[4] This may be also a conflict between the rights themselves (right to life of a fetus and right to reproductive autonomy of a pregnant woman) and the rights of two individuals (wife's right of decision with respect to childbearing and husband's right to family life in the birth of his child). Despite genuine concern over "rhetoric of rights" in framing reproductive policy issues, one of the ways of analyzing and balancing these conflicting interests is also in terms of rights.
In the disadvantaged environments in which many women live, some find the apparently lofty ideals to which human rights appeal to be unrealistic to improve their circumstances or protect them against the neglect of their basic health care needs. The challenge is to improve women's and their families' lives and

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[1] Athena Liu, *Artificial Reproduction and Reproductive Rights,* University of Hong Kong, Dartmouth, Publishing Company Limited, 1991, p. 23.
[2] Robert Blank, Janna C. Merrick, *Human Reproduction, Emerging Technologies, and Conflicting Rights,* University of Canterbury, University of South Florida, A Division of Congressional Quarterly Inc., Washington D.C., 1995, p. 2.
[3] COMMITTEE ON THE ELIMINATION OF DISCRIMINATION AGAINST WOMEN, GENERAL RECOMMENDATION 24: WOMEN AND HEALTH (ARTICLE 12)
CEDAW, *General Recommendation 24*, UN GAOR, 1999, UN Doc. A/54/38/ Rev.1.
[4] Robert Blank, Janna C. Merrick, *Human Reproduction, Emerging Technologies, and Conflicting Rights,* University of Canterbury, University of South Florida, A Division of Congressional Quarterly Inc., Washington D.C., 1995, p. 7.

health, to avoid preventable deaths by applying human rights principles. This ideal underlies the human rights contained in the constitutions upon which governments plan their futures, and in international treaties designed to make respect for human rights universal.

1.2 Rationale for Reproductive Rights

It is critical to understand that reproductive health is not alienated and does not concern only individuals but also behaviors and relations between individuals and society as a whole. Though being in the domain of intimate human experiences, human sexual and reproductive practices are constructive and dependant on social relations, customs, traditions and taboos established in the society. Degree of empowerment and capacity for decision-making and choice by individuals determines the share of burden of ill health resulting from such behaviors and relationships.

The major burden of death and disability relating to sexuality and reproduction falls on women. It has been revealed that among women of reproductive age in developing countries, over 36% of healthy years of life are lost due to three conditions associated with sex and reproduction: maternal mortality and morbidity, sexually transmitted diseases (STD) and AIDS.[5]

Informed decisions and choices involved in the reproduction are closely related to life with dignity and interference with them would represent intimate attack on dignity and nature of human existence as such. The women's ability to choose the number and spacing of pregnancies plays a significant role in the general health and well-being primarily for women, but has implications that go beyond the women's lives to children, families and society as a whole. For women it implies that women cannot endure unlimited pregnancies and resulting complications but also the ability to determine their own personal development in terms other than childbearing. Equally, the status of women is greatly reduced in the absence of reproductive choice. Empowering adolescents to choose healthy sexual behaviors implies empowering them to make appropriate choices and decision-making. For society, individual choice can result in increased prospects for economic and social development.

A nurturing environment– in form of policies, laws and practices promoting reproductive health- is a necessary precondition that enables people to promote and protect their own and their partners' health, as well as permits them to take control of factors determining their health, appropriate use of services.[6] It is precisely in this area of promotion of ability to choose and improvement of women's reproductive health that human rights instruments, particularly reproductive rights, play a central role.

1.3 Formation of Right to Reproductive Choice

The right to reproductive choice has evolved over the years and from its early developmental stages was principally hortatory in nature[7] and then it gradually gained legal support. In 1966, UN Resolution on Population Growth and Economic Development reformulated the right of individuals to found a family by stressing that it may be of whatever size they desire, thus providing an additional important element of right to reproductive choice, however it also emphasized the state's power to encourage or discourage certain choices to control population growth.[8]

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[5] Tomris Turmen, *Reproductive Rights: How to Move Forward?* Health an Human Rights, International Journal, Special Focus: Reproductive and Sexual Rights, Vol. 4, No. 2, 2000, p. 32.
[6] *Ibid.*
[7] See generally Johnson, Stanley P., World Population and the United Nations, Cambridge, Cambridge University Press, 1987.
[8] UN General Assembly Resolution 21/2211 of 17 December 1966.

For the first time the right to reproductive choice was enunciated as a human right in the 1968 Proclamation of Tehran9, which recognized the parents' right to determine freely and responsibly the number and spacing of children and by its character as a basic inalienable human right contributed significantly to the shift of priority of individual choice of the state's power over population policy. The right of parents to decide on matters of procreation was further advanced in the Declaration of Social Progress and Development10 by complementing the prior emphasis on individuals' right to found a family of their choice with a responsibility of the couple not to have more children than they can support, an early articulation of parents' duty to guarantee their children a life with dignity (later included in the rights of the child).

Further steps forward were made by 1974 World Population Conference in Bucharest11 and importantly, 2nd International Conference on Population in 1984 in Mexico City[12], 'Recommendation 25'[13] and Nairobi Forward-Looking Strategies for the Advancement of Women[14], which built on the previous conferences and advanced the work on the subject to foster women's status and equal enjoyment of their human rights.

1.4 Advancement of Reproductive Rights: Cairo and Beijing Conferences

In 1993 the 2nd World Conference on Human Rights[15] in Vienna set the stage for what happened first in 1994 at the International Conference on Population and Development (ICPD) in Cairo and one year later at the 4th World Conference on Women (FWCW) in Beijing. These events, with the resultants as the Programme of Action[16] (hereinafter Cairo Programme of Action) and the Platform for Action[17] (hereinafter Beijing Platform for Action) adopted respectively, for the first time set out a comprehensive framework for realizing reproductive rights.

They marked a key decade in linking the provisions in existing human rights treaties and women's reproductive rights, where women's reproductive health began to be viewed and monitored through the lens of human rights in contrast to previous approaches, which treated women instrumentally as tools for population programs and policies. The consensus documents also focused on women's empowerment to exercise personal autonomy in relation to their sexual and reproductive health. They further recognized the strong link between reproductive health and social, economic and demographic factors, in particular women's standing in society and gender equality.

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[9] International Conference on Human Rights, which concluded with unanimous adoption of Proclamation of Teheran on 13 May, 1968.
[10] UN General Assembly Resolution 24/2542 of 11 December 1969.
[11] First inter-governmental conference on the subject, but also it adopted a 10-year World Population Plan of Action (WPPA), though it stipulated poor family planning provisions.
[12] Served a big advance on Bucharest Conference by determining that the most effective means via which a couple can responsibly found a family is modern family planning methods.
[13] UN, Report of the International Conference on Population, Mexico City, 6-14 August 1984, UN doc. E/CONF.76/19.
[14] UN, Report of the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women: Equality, Development and Peace, Nairobi, Kenya, 15-26 July 1985, UN doc. A/CONF.116/28/Rev.1, para. 156-159. It elaborated empowerment of women with the ability to control freely their fertility through family planning information and services.
[15] It affirmed that women's rights are human rights; that eradication of all forms of discrimination on the basis of sex should be a priority for governments; and finally, that women have a right to the enjoyment of the highest standard of physical and mental health throughout the life cycle, and it includes a right to accessible, adequate health care and to a wide range of family planning services.
[16] UNITED NATIONS POPULATION FUND, INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT (ICPD), *PROGRAMME OF ACTION*, CAIRO, 5-13 SEPTEMBER 1994, NY, 1996, UN DOC. A/CONF.171/13.
[17] United Nations Population Fund, Fourth World Conference of Women, Platform for Action, Beijing, October 17, 1995, UN Doc. A/CONF.177/20.

However, the feat of consensus at ICPD should not be taken for granted and easy to achieve, since it was a process of negotiations and compromises among 180 states on issues inherently involving deeply rooted views on family, gender, and other related values.[18]

1.5 Progress Since Cairo

While the two above-mentioned consensus documents advance the existence of reproductive rights, however, it is of fundamental importance to acknowledge that they express political will, are non-binding and cannot be invoked to secure legal protection.[19] Despite the limitations of legal invocation, these instruments represented important contributions to the genesis of treaty law, raised public awareness and consciousness, and served as starting points for advocacy movements stimulating positive changes by the participating states. The ICPD+5 Hague review of ICPD implementation showed many encouraging signs but also revealed challenges in achieving the Cairo goals.[20]

Among the positive shifts are substantial and comprehensive policy changes made by at least 27 out of the 114 developing countries; legislative changes with regard to reproductive rights protection; some African countries outlawing female genital mutilation (FGM); training programs targeted at improving quality of services, communication and counseling; development of protocols and guidelines in reproductive health, and shifting focus from service providers to clients; positive actions in the area of gender equality, equity and empowerment of women by 98 out of 114 countries; progress in protection of women from harmful traditional practices and ensuring rights to education, basic health and reproductive health; inclusion of adolescent reproductive health in youth and national health plans and development of policies and guidelines by some 55 countries; increased guarantee of reproductive health for women and adolescents in emergency situations, etc.[21]

Despite this, the survey revealed that the legal environment for women is still unsatisfactory; there is resistance to recognize the concept of rape within marriage; topic of adolescents' sexuality and reproductive health and education remains a sensitive domain and hard to reconcile; there is a high incidence of unwanted pregnancies, illegal or unsafe abortions, STDs, including HIV/AIDS and high rate of maternal mortality and morbidity; a large number of men and women throughout the world are unable to exercise the right to reproductive choice and have limited access to family planning and contraceptive methods.[22]

The ICPD+5 review confirmed the strong commitment of countries to the Cairo Programme of Action and urged them to reconsider their actions in several aforesaid categories.

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[18] For critical evaluation and interpretations of ICPD standards see article by Rosalind P. Petchensky, *Rights and Needs: Rethinking the Connections in Debates over Reproductive and Sexual Rights,* Health an Human Rights, International Journal, Special Focus: Reproductive and Sexual Rights, Vol. 4, No. 2, 2000. See also R. Joseph, *Flawed Human Rights-Based Approach to Health,* Vivant! Pro-Family News from the United Nations, 23 March 1999.

[19] For commentaries claiming such texts to be legally binding see Freedman and Isaacs, *Human Rights and Reproductive Choice,* 24 *Studies in Family Planning* (1993); Dixon-Mueller, *Population Policy and Women's Rights: Transforming Reproductive Choice* (1987); and IPPF, *The Human Right to Family Planning* (1984).

[20] UNFPA, A Five-Year Review of the Progress Towards the Implementation of the Programme of Action of the International Conference on Population and Development: A Background Paper Prepared by UNFPA, for the Hague Forum, NY, 1999. For the progress made in Armenia, see Chapter III.

[21] Nafis Sadik, *Progress in Protecting Reproductive Rights and Promoting Reproductive Health: Five Years Since Cairo,* Health and Human Rights, International Journal, Special Focus: Reproductive and Sexual Rights, Vol. 4, No. 2, 2000, p. 8.

[22] *Ibid,* see also *supra* note 19.

CHAPTER II ARTICULATIONS OF REPRODUCTIVE RIGHTS IN INTERNATIONAL LAW

2.1 Sources of Reproductive Rights

Reproductive rights are not new rights and embrace certain human rights that are already recognized in national laws, international human rights and consensus documents.

Non-binding human rights instruments

For the first time the focus on reproductive rights was affirmed and the paradigm shift made at the international governmental level in Cairo, 1994. However, as mentioned above Cairo and Beijing conference resultants do not establish legal obligations for states and thus there is no duty of performance and therefore, no possibility of breach. Despite the hortatory nature, they have helped to identify the constellation of rights from within the existing human rights documents, and consequently solidify the content of reproductive rights. They also stressed that reproductive rights are entitled to protection for their own sake, but also because they are essential as a precondition for the ability to exercise other rights without discrimination. Reproductive rights also means considering state obligations under the human rights documents in a whole new light, as for instance considering the rights to education, health and social services in relation all of the well-known causes of maternal mortality.[23]

The Cairo Programme of Action defined reproductive health and rights as follows:

> Reproductive health is a state of complete physical, mental and social well-being…in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex and that they have the capability to reproduce and the freedom to decide if, when and how often to do so… (Para. 7.2)
> …Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights and consensus documents. These rights rest on the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children and to have information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also includes the right to make decisions concerning reproduction free of discrimination, coercion, and violence… (Para. 7.3)

Beijing Platform for Action reiterated the new paradigm of ICPD and in addition, referred to inequalities and inadequacies in access to health care through the women's life cycle and further expounded women's human rights related to sexuality:

> …A major barrier for women to the achievement of the highest attainable standard of health is inequality both between men and women and among women in different geographical regions, social classes and indigenous and ethnic groups (Para. 89).

The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality including sexual and reproductive health, free of coercion, discrimination and violence (Para. 97).

Legally Binding Human Rights Instruments

Sources of human rights applicable to reproductive health are found in all national constitutions and in international and regional human rights treaties[24] based on the Universal Declaration of Human Rights.[25]

[23] *Transforming Health Systems: Gender And Rights In Reproductive Health*, A Training Curriculum for Health Programme Managers, World Health Organization, 2001, p. 151.
[24] See Annex 1 for provisions of different international instruments relevant to the protection and promotion of reproductive interests.

The primary modern human rights treaty concerning women's rights is the Convention on the Elimination of All Forms of Discrimination Against Women (the CEDAW).[26]

2.2 Core Elements of Reproductive Rights: Sources and Scope

"REPRODUCTIVE RIGHT" DOES NOT EXIST *EXPRESSIS VERBIS* AND AS A COMPOSITE RIGHT CONSISTS OF FOUR CORE INTERRELATED ELEMENTS:
RIGHT TO FOUND A FAMILY,
RIGHT TO DECIDE FREELY AND RESPONSIBLY THE NUMBER AND SPACING OF ONE'S CHILDREN,
RIGHT TO FAMILY PLANNING INFORMATION AND EDUCATION, AND
RIGHT TO HAVE ACCESS TO FAMILY PLANNING METHODS AND SERVICES (FACILITIES).[27]

Right to found a family

The international human rights law at the universal[28] and regional[29] levels is relatively clear on the scope of the right to found a family, which is not absolute and implies a fairly unrestricted possibility to found a family, with which the state practically cannot interfere, but at the same time does not oblige the state to provide medical technology to assist procreation.

Whether the right to procreate or right to assisted procreation is established under the right to found a family has been contested during few decades.[30] Despite the arguments of the proponents of the right to reproduce, the logical reasoning taken from the Cairo Programme of Action and broad interpretations of the existing applicable provisions, inter alia, reference to the *travaux preparatoires* of Article 23(2) of the Political Covenant[31] give no support and show lack of real foundation for the right to assisted procreation.[32]

> *It is recognized that there is a significant scope for the right to marry and to found a family to be applied to advance safe motherhood. The right to marry and to found a family, available to persons of "marriageable age," can be applied to achieve the desirable result of adolescent girls marrying later, giving them more choice over the age at which they have children. While the expression "marriageable age" in Article 23(2) of the Political Covenant needs to be interpreted in light of the Children's Convention. Article 1 of that Convention explains, "a child means every human being below the age of eighteen unless, under the law applicable to the child, majority is attained earlier."*

Right to decide on the number and spacing of children

At the universal level only CEDAW Convention expressly provides for "the right to decide freely and responsibly on the number and spacing of children."[33] Insofar as this right is also considered a matter of privacy, decisions regarding the number and spacing of children are protected by the right to privacy to

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[25] 10 December 1948, G.A. Res. 217A (III), UN Doc A/810. The UDHR originally was not proposed as a legally enforceable instrument, but it has gained legal acceptance and enforceability through a series of international human rights instruments.
[26] 18 December 1979, 1249 UNTS 13, *entered into force* 3 September 1981.
[27] Corinne A.A.Packer, *The Right to Reproductive Choice, A Study in International Law,* Abo Akademi University, Institute for Human Rights, Turku/Abo, 1996, p. 18.
[28] CEDAW Article 16(1)(e); the Political Covenant, Article 23(2); UDHR, Article 16(1), Genocide Convention, Article 2(d).
[29] ECHR, Article 12; American Convention, Article 17(2); the Protocol of San Salvador, Article 15;
[30] Among others see: Athena Liu, *Artificial Reproduction and Reproductive Rights,* University of Hong Kong, Dartmouth, Publishing Company Limited, 1991; Judit Sandor, *Reproductive Rights in Hungary: A New Right to Assisted Procreation?* Health and Human Rights, International Journal, Special Focus: Reproductive and Sexual Rights, Vol. 4, No. 2, 2000; For contrary position see: Cook and Dickens, *Ethics and Values in Family Planning: Legal and Legislative Aspects,* in: Bankowski et al (eds), *Ethics and Human Values in Family Planning,* 1989; and Cook, *International Human Rights and Women's Reproductive Health,* 24 Studies in Family Planning, 1994, No. 2.
[31] For recent changes to the institute of traditional family unit within of European Communities see Tomasevski, *European Approaches to Enhancing Reproductive Freedom, 44 The American University Law Review,* 1995, No. 4, pp. 1037-1051; For views of the Steering Committee on Human Rights, Council of Europe see Council of Europe, Progress of Medicine, Biology and Respect for Private and Family Life, doc. DH-DEV (91) 1 (1 March 1991).
[32] See Bossuyt, *Guide to the Travaux Preparatoires of the International Covenant on Civil and Political Rights,* 1987, p. 441-444.
[33] CEDAW Article 16(1)(e).

the extent that such decisions "do not interfere with the liberty of others."[34] Since too close spacing of children impacts the maternal health, this right may be protected under the right to health[35] and with the same analogy, the adolescents may be protected.[36]

At the regional level there is no such expressed right. On the aforesaid basis, this right is ensured through the right to privacy[37] and right to health.[38] Thus, the right to private and family life and the right to decide on the number and spacing of one's children become basis for the right to free choice of maternity. Accordingly, women may in principle protect their health in maternity by determining whether and when to plan pregnancy. All pregnancies and births carry some health risks, but these are higher when pregnancies are ill-timed (too early or too late in a woman's reproductive life, or too closely spaced) or unwanted.

There is though absence of consensus or clear answer to problematic questions raised by term "responsibly", which coupled with notion of "freely" is central to the notion of reproductive autonomy. Its meaning was influenced, on the one hand, by the population movement with underlying population growth concerns and, on the other hand, the women's rights movement with its focus on the right to bodily integrity. One thing is clear though that the need for responsible reproductive conduct of individual does not free the state from its obligation to ensure access to family planning information and services to enable the individual to behave "responsibly".[39]

Right to have access to family planning information and education

The right to obtain information on family planning is expressly provided in the CEDAW in the groupings of rights in Article 16(1)(e). While the right to family planning information is secured relatively straightforwardly in the universal human rights instruments, there was concern over potential problems in harmonizing the right to obtain information or education specifically relevant to family planning in at least one treaty and provisions of the right to information (in general) in others.[40] Notwithstanding this concern, there is no apparent reason why information sought and received could not be related to family planning.[41] As the information on family planning is key to good health, the right to health may also be invoked to obtain family planning information.[42]

On the regional level again the right to information does not expressly specify information on family planning (as under CEDAW), but provisions are broad enough to be interpreted to cover the information on family planning, including invocation of the right to health.[43]

The essence of the right is the freedom to impart and receive information, with which the state should not a *priori* interfere, should not generally refuse private initiatives or hinder NGOs or donor organizations' assistance in providing information. The claim that state has also positive duties to ensure access to

[34] The Political Covenant, Article 17(1).
[35] The Economic Covenant, Article 12.
[36] The Children's Convention, Article 24(2)(f).
[37] ECHR, Article 8(1) and ACHR, Article 11(2).
[38] European Charter, Para 11, Part I and Article 11, Part II; European Code of Social Security (Revised), Article 10(3); the Protocol of San Salvador, Article 10(1); and African Charter, Article 16.
[39] Fincacioglu, *Contraception, Family Planning and Human Rights,* in: UN, *Population and Human Rights: Proceedings of the Expert Group Meeting on Population and Human Rights, Geneva, 3-6 April, 1989,* 1990, p.90.
[40] The Political Covenant, Article 19(2); Children's Convention, Article 13; the Economic Covenant, Article 13(1).
[41] Corinne A.A.Packer, *The Right to Reproductive Choice, A Study in International Law,* Abo Akademi University, Institute for Human Rights, Turku/Abo, 1996, p. 65.
[42] CEDAW Article 10(h); the Economic Covenant, Article 12(1); Children's Convention, Article 24(2)(f).
[43] ECHR, Article 10(1); European Social Charter, Part I, Para 11, Article 11; ACHR, Article 13(1); the Protocol of San Salvador, Article 10(1); African Charter, Article 9 and 16.

information necessary for individuals to protect their health is increasingly supported by decisions of human rights tribunals and international treaty provisions.[44]

Right to have access to family planning methods and services

> *The right to access to family planning is provided specifically in the CEDAW and Children's Convention. Insofar as upon international consensus in Cairo the reproductive health is one aspect of health in general and the right to obtain means of family planning is an essential component of the right to health, on the universal level the right to family planning services can be also inferred from provisions on the right to health.*[45]

This link is again underlined in the regional instruments, none of which expressly makes a provision on the right to access to family planning services, as inferred from the right to health insofar as the absence of family planning services is detrimental to health.[46] CEDAW's General Recommendation on Women and Health observes that, "… the high maternal mortality and morbidity rates worldwide and the large numbers of couples who would like to limit their family size but lack access to or do not use any form of contraception provide an important indication for States parties of possible breaches of their duties to ensure women's access to health care." [47]

Importantly, women's lack of effective means of birth spacing and fertility control endangers their survival and health. Safe motherhood would be assisted through comprehensive reproductive health care, including contraceptive services (38), and, on women's request, lawful, safely conducted terminations of ill-timed or high risk pregnancies.

2.3 Select Illustrations of Reproductive Rights

The rights addressed below are not exhaustive, but indicative of rights that protect and promote reproductive interests. These rights can be applied individually or combined with others to advance reproductive health.

Right to life and survival

Historically, this right generally was applied legally only to ensure freedom from arbitrary deprivation of life (i.e. capital punishment). However, the right to life is applied in a variety of ways to matters relating to health by addressing the positive nature of the right, requiring positive measures to reduce infant mortality and to increase life expectancy and to protect a woman at risk of dying in childbirth due to lack of obstetric care.[48] Some national courts are giving an expanded meaning to the right to life that could be applied to require ministries of health to address the causes of preventable maternal deaths, a claim might be brought on behalf of women whose lives and health are at risk because of denial or neglect of life-saving obstetric care.

Right to liberty and security

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[44]See Coliver S, ed. *The Right to Know: Human Rights and Access to Reproductive Health Information*. Philadelphia, University of Pennsylvania Press, 1995.

[45] CEDAW, Article 16(1)(e), Article 12(1), Article 14(2)(b); Children's Convention, Article 24(2)(f); the Economic Covenant, Article 12(1) and (2)(a).

[46] European Social Charter, Part I, Para 11 and Article 11; European Code of Social Security (Revised), Article 10(3); the Protocol of San Salvador, Article 10(1); African Charter, Article 16.

[47] Committee on the Elimination of Discrimination against Women, General Recommendation 24: Women and health (Article 12), para 17.

[48]United Nations, Human Rights Committee. *General Comment 6, Article 6 (Right to Life)*. In: United Nations, *International Human Rights Instruments: Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*. HRI/Gen/1/Rev.4, 7 February 2000.

The right to liberty and security is one of the strongest defenses of individual integrity and the right of women to free choice of maternity. The right is being applied beyond its historical prohibition of arbitrary arrest or detention, to include security from sexual violence and assault, require the state to provide health services when the lack of services jeopardizes liberty and particularly health security of the person or the state fails to provide conditions necessary for safe motherhood, population programs that compel sterilization or abortion.

Right to privacy

While traditionally this right was understood to refer to privacy with regard to home and correspondence, now it is also directly related to sexual and reproductive health. Privacy and confidentiality are of critical concern regarding sexual and reproductive health, because sexual and reproductive matters are of particular sensitivity and are not freely discussed in many families, communities and cultures or between the sexes.

The common approach now is that choices on reproductive practice and health, including maternity, are private decisions between consenting partners, not governmental decisions. Courts respecting women's choices on pregnancy and childbirth have relied on rights to private life to prevent potential fathers, whether married or unmarried, from forcing women to bear children against their will. Claims by women to autonomous reproductive choices against their partners' attempted vetoes have been consistently upheld by national courts in countries of all regions of the world,[49] and by the European Commission of Human Rights.[50] The argument behind is that the state has no greater interest in the birth of a child than a husband or biological father and as a result, the state should have no right to prevent women's full exercise of their right to private and family life.[51]

Right to health

Traditionally understood to refer to the right to the highest attainable standard of physical and mental health, increasingly this right brings increased attention to women's health issues. Substantive elements of the right to health services are their availability, accessibility, acceptability and quality. Thus, laws and policies that unreasonably restrict health services according to these criteria would not comply with this right. For instance, a law or policy requiring excessive qualifications for health service providers to perform caesarean deliveries will limit the availability of a service that contributes to safe motherhood, or a state controlled reproductive health program existing for some population groups but excluding certain marginalized communities from their consideration and outreach.

Right to the benefits of scientific progress

Traditionally understood to relate to technology transfers between countries of the North and the South, now can play a vital role in the reduction of maternal mortality and morbidity rates. The right includes a recognition that a woman's entitlement to plan the number and timing of her pregnancies and to control her own reproduction will be enhanced by: birth control technologies, advantages of better and more acceptable means of fertility control, access to safe abortion, etc. The goal of safe motherhood can be also pursued through sponsorship and support of appropriate scientific studies on affordable methods, controlled by women, to prevent HIV and other STDs, on strategies empowering women to protect themselves from STDs, but also epidemiological or public health research, health systems research and social science research that could expose and remedy social causes of unsafe motherhood. However, need to note that the benefits of such technology cannot be interpreted as to be guaranteed under the right to found a family.

[49] Boland R., *Population Policies, Human Rights, and Legal Change*. American University Law Review, 1995, 44:1257-1278. Cook RJ, Maine D. Spousal Veto Over Family Planning Services. American Journal of Public Health. 1987, 77: pp.339-344.
[50] *Paton v. United Kingdom* (1980), Eur. Comm. H.R., 3 E.H.R.R. 408.
[51] Cook RJ. International Protection of Women's Reproductive Rights. New York University Journal of International Law and Politics, 1992, 24:645- 727 at 706.

Right to non-discrimination

> *While traditionally the right to non-discrimination applied to equal treatment and opportunity, for example providing equal access of all to health care, now it also entails the idea of substantive equality, i.e. distinctions are necessary to promote rights for people differently positioned but based on objective and reasonable criteria and objective to promote rights. Application of different approaches to girls and boys in reproductive health policy must be grounded on valid recognition of gender specific differentials, which should be determined by minimizing the impact of gender roles and cultural norms. National courts and international tribunals yet to apply the right to non-discrimination to protect women's distinct interests in safe pregnancy and childbirth.*

States are required to act against discrimination in all fields of civil and political rights and also of economic, social and cultural rights, including health, obliging the states to eliminate laws, policies and practices that discriminate on specified and unspecified ("other status") grounds (Article 26[52] of the Political Covenant). Important to note that the latter would include other prohibited grounds of discrimination, such as age, rural residence and poverty, which can affect women's ability to exercise their rights regarding safe motherhood.

Right to receive and to impart information

By tradition understood only with regard to media and free press, now exercise of this right is critical to reproductive health, for instance, reproductive decision-making, a woman's ability to make a full informed choice about her reproductive live, to receive information and have access to family planning methods and services and protect herself from sexual exploitation, abuse or infection. The rights to information itself and regarding access to reproductive health services in particular are two of the most vital reproductive rights. The European Court has emphasized the connection between access to information and health risk, finding that an injunction preventing the provision of information on where to find abortion services violated the right.[53]

While traditionally, the right to information was understood to guarantee freedom to seek, receive and impart information and ideas free from government interference. Now it is argued that government has concrete and immediate obligations to provide information necessary for the protection and promotion of reproductive health and choice, not just to refrain from interfering with its provision.[54]

Right to education

Previously understood only in relation to literacy, now critical to reproductive health. There is a strong relation between girls' access to education and literacy, and reduced maternal mortality. The right to education is particularly important for the promotion and protection of health. Research has consistently shown that women's education strongly influences improved reproductive health, including infant survival and healthy growth of children.[55] For example, the ECHR addressed the human rights dimensions of a state requiring a sex education course in its schools and while required sensitivity to parents' views, upheld a compulsory sex education course in the state's schools.[56]

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[52] Article 26, ICCPR "All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."

[53] *Open Door Counselling and Dublin Well Women* v. *Ireland* (1992), Eur. Ct. H.R. Ser. A, No. 246, 15 E.H.R.R. 244.

[54] Coliver S., The Right to Information Necessary for Reproductive Health and Choice Under International Law. In: Coliver S, ed. The Right to Know: Human Rights and Access to Reproductive Health Information. Philadelphia, University of Pennsylvania Press, 1995.

[55] Hobcraft JN. Women's Education, Child Welfare and Child Survival: a Review of the Evidence. Health Transition Review, 1993, 3(2): p.50-175.

[56] *Kjeldsen v. Denmark* (1976), Eur. Ct. H.R. Ser. A, No. 23, 1 E.H.R.R. 711 at para. 53.

Part II

Reproductive Rights and Health in Armenia: Key Challenges

PART II

CHAPTER III COMMITMENT TO REPRODUCTIVE RIGHTS IN ARMENIA

Laws are essential tools to promote women's reproductive health, to facilitate their access to health care services and to protect their human rights as consumers of such services. However, among other obstacles, poorly constructed and inconsistent legislation can also hinder women from achieving optimal reproductive health. The 'de jure' part of the review seeks to provide a general background to the legislation profile with respect to the four core elements of reproductive rights.

3.1 Right to found a family

De Jure

Without examination of historic development of the legal protection to family in Armenia, worth to mention that ancient Armenian law provided some status for the women-wives, at the same time providing the supremacy and powerfulness of the man. Both ecclesiastical and secular legal documents were based on the principles of the patriarchal structure of the society with provisions regarding the status of women but without a firm guarantee of their implementation.[57]

As of today, the *Constitution*[58] safeguards the equal rights, freedoms and obligations regardless of sex and other characteristics (Article 15), equality of all before the law and equal protection of the law without discrimination (Article 16), equal rights of men and women (emphasis added) when entering into marriage, during marriage, and in the course of divorce (Article 32). The family is declared the natural and fundamental cell of society. Family, motherhood, and childhood are placed under the care and protection of society and the state (Article 32).

Under *the Marriage and Family Code*[59] inherited from the Soviet era with minor amendments in 1998, the legal regulation (rights and obligations) of marriage and family relations is the exclusive responsibility of the State. According to article 1 of the Marriage and Family Code, the Code's purpose is to contribute to the building of family relations based on the free and full consent of the spouses, free of any financial motivation, and on love and respect. Men and women in Armenia are afforded the same legal rights to enter freely into marriage and to freely choose a spouse and marriages may be concluded only by mutual consent and the attainment of nuptial age (Article 14). Citizens have equal rights in family relations without any consideration of origin, social condition, race, nationality, sex, education, language, religious beliefs and residence. No explicit or implicit limitation of rights, direct or indirect imposition of advantages is allowed in marriage or family relations (Article 4). On contracting marriage the spouses freely choose the family name of one spouse as their joint surname, or else each spouse has the right to keep the family name he or she held before marriage (Article 18).

According to the Code only marriages registered in State Registry Offices are recognized as valid and church marriage, like other religious rites, do not have legal force (Article 6), while only the registered marriages entail rights and obligations for the spouses (Article 12). Marriage takes place with man's and

[57] The First codification of the canonical law was made in 8th century under the supervision of Hovhannes Imastaser (the Erudite) in 717-728, which then served as basis for the creation of 'Armenian Statute-Book'.
[58] RA Constitution, adopted 05.07.1995. A series of amendments to the Constitution reflecting requirements flowing form the membership to the Council of Europe (January 2001) were proposed at the national referendum on May 25, 2003 along with the Parliamentary Elections, however were not passed.
[59] Marriage and Family Code, in force 01/01/70, amendments made in 11/01/98.

woman's mutual consent at marriageable age (Article 14), which is 18 years for men and 17 years for women (Article 15). A marriage contracted by a person below marriageable age may be considered invalid if the interests of the person below marriageable age so require (Article 46).

Article 12 of the Marriage and Family Code provides that "registration of marriage shall be effected in the light of national and public interests as well as for the protection of the personal and property rights and interests of spouses and children. Only a marriage registered in a registry office shall entail rights and obligations for the spouses". Article 62 states that "The father and the mother have equal rights and duties with respect to their children. The parents also have equal rights and duties after divorce."[60]

The recently adopted *Law on Reproductive Health and Rights*[61] in Article 4 (2) stipulates the right to found a family. While according to Article 118 of the old Criminal Code anyone who forces a woman to marry against her will or forces her to stay married (or abducts her for the purpose of marriage), can be sentenced to prison for up to two years or corrective work up to one year, but except the penal sanction on the offender, the Code provision does not nullify coerced or forced marriages. Note that the new Criminal Code purports to fit to the new realities of the Armenian society, but it still does not contain provision on forced marriages and any sanctions against such. The transformation from the old Criminal Code inherited still from the Soviet era to the new Criminal Code took a long time and will need time to see how it matches to the new social and political order.[62]

Under Armenian law, the age of majority is 18. Civil competence is acquired at the age of 18, but article 11 of the Civil Code provides that, when the law permits marriage before the age of 18, a citizen who is below that age becomes legally competent to work from the date of marriage.

De Facto

As a start, one of the most important achievements towards safeguarding all core rights under the current analysis and improvement of reproductive health in the country was the adoption of Law on Reproductive Health and Reproductive Rights by the National Parliament in November 2002, which was drafted to enshrine the internationally accepted human rights in general, and sexual and reproductive rights in particular. However, at this stage with one month of the law in force, it would be erroneous to take for granted the drastically positive changes to come, since it first needs to be harmonized with the existing other laws regulating the reproductive health and the mechanisms for application of this law at local, regional and national levels still need to be developed.

While the right to found a family is guaranteed by the Armenian legislation and freedoms and rights are secured by the national Constitution, however the contradictions between legislative safeguards and underlying reality cannot be suppressed.

Though the family law reflects the changes of recent vintage, amendments to the Marriage and Family Code introduced upon the Parliament decision in 1992, as mentioned above, majority of the Code provisions still reflect the Soviet regime's ideology and are not in line with new political and economic realities and trends in changes experienced by present-day Armenian families.

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[60] RA Marriage and Family Code, Article 62. See also, RA Marriage and Family Code, Articles 19, 63, 65, and RA Law on Children's Rights, Article 14.
[61] Adopted 11.12.02, in force 07.08.03.
[62] Old Criminal Code of the USSR, adopted 07.03.1961 and enforced on 01.07.1961. New Criminal Code of RA, adopted 18.04.2003, enforced 01.08.2003.

Marriageable age

This age first coincided with the general age of majority- 18. With amendments to the Marriage and Family Code the marriage age for women was lowered from 18 to 17. It is to be noted that the new Law on *Reproductive Health and Rights* in Article 14 defines the reproductive age as 18 and not 17. As the age of majority is 18 in Armenian law, this leads to a situation when females are by the family law allowed to marry when they have not reached the legal majority age. While marriage with minors is forbidden under Armenian law,[63] marriage between minors sometimes takes place, most often in rural areas. The City Council is legally entitled to lower the age requirement for women by one year in certain exceptional cases an with the permission of the parents.

Recent years observe certain changes in the sexual and reproductive behavior among Armenians, e.g. incidence of premarital sexual relations has relatively increased, and selection of spouses has become freer from parents' pressure. In 1991-1999 the average age of first marriage among young women was 21.7-22.7, and for men 24.4-26.8, which shows growth tendency for both sexes- evidencing the delay in marriage, which is also an outcome of not adequate socio-economic prerequisites.[64] According to the Demographic and Health Survey 2000 among women age 25-49, the median age of first marriage and first sexual intercourse was 20.5 years and it was higher among urban (21.1) than rural women (19.7). There is also a positive correlation between education and age at first marriage (and first intercourse).

Having said this, the recent gender-specific comprehensive studies reveal that in Armenia there are instances that the dearth of young men in the society and the intense social pressure to marry at a young age led some women to consent to marriages which, while not technically "forced" marriages, were not completely "free" either.[65]

Health-wise, marriages should not be undertaken before adolescent girls have achieved sufficient physical maturity to bear pregnancy and deliver safely, and the emotional and intellectual maturity for self-care, child-care, and resort to necessary assistance. Physical maturity can be approximately related to a chronological age, but this age may not be as reliably related to emotional and intellectual maturity.[66]

In this context, notice should be taken of content and meaning to an understanding of "marriageable age" further explained in CEDAW's General Recommendation on Equality in Marriage and Family Relations[67] based on Article 16(1)(a) and (b) of the Women's Convention. *Human Rights Committee's General Comment 28 Equality of Rights between Men and Women*[68] explains, "States are required to treat men and women equally in regard to marriage in accordance with Article 23…. Men and women have the right to enter into marriage only with their free and full consent, and States have an obligation to protect the enjoyment of this right on an equal basis. Many factors may prevent women from being able to make the

[63] See RA Marriage and Family Code, Article 14, "Mutual consent of the marrying persons is necessary for marriage and their attainment of nuptial age." See also, the UN Convention on the Rights of the Child.
[64] "Kananc aroghjutyan urvagitc" (Women's Health Profile, Country Report), Ministry of Health, Department of Maternal and Child Health Care, Yerevan, 2000, p. 12.
[65] CEDAW Assessment Tool Report, Armenia, July 2002, American Bar Association/Central European and Eurasian Law Initiative (ABA/CEELI), p. 9.
[66] World Health Organization, *Advancing Safe Motherhood through Human Rights*, 2001.
[67] United Nations, Committee on the Elimination of Discrimination Against Women. *General Recommendation 21, Equality in Marriage and Family Relations*. In: United Nations. *International Human Rights Instruments: Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*. HRI/Gen/1/Rev.4, 7 February 2000.
[68] *Human Rights Committee's General Comment 28 Equality of Rights between Men and Women.*

decision to marry freely. One factor relates to the minimum age for marriage. That age should be set by the State on the basis of equal criteria for men and women." [69]

Equality

Legally, women enjoy all guarantees against discrimination and equality mandated by the Armenian Constitution. Interestingly, gender-sensitive legal analysis reveals that in addition to general equality clauses (with references to 'all', 'every citizen', 'everyone') only one provision in the Constitution (Article 32) *expressly* provides equality between men and women with regard to family and marriage relations.

The overwhelming majority of provisions of the old Criminal Code does not contain differentiation and refer equally to both men and women (new Code has just come into force and is characterized by de-criminalization of offences, e.g. provision on illegal abortion). While these rights are declared in the legislation, they are not, however, used or applied in practice.

Family law frequently expresses communities' basic cultural values. Cultures resistant to women's equality with men have unselfconsciously perpetuated women's subordination as a 'natural' condition of family life and social order so profoundly as to render women's disadvantage invisible.

Impact of Culture

As a matter of a brief historical overview, in the Armenian family under the Turkish rule before 1914 women had a 'respected and protected status", but it was mainly a male-dominated community and was regulated by the traditions and customs. During the Soviet era even with the official stance of gender equality and enshrined equality rights in legislation, the promises were still unfulfilled in the daily lives of women, which also contributed to the *de facto* asymmetry of women's equality, rights and freedoms in today's Armenian society as well.[70]

Historically, in dealing with the issue of sexual activity and sexuality the Armenian society is faced with a wide variety of sensitivities. The concept of womanhood remains very traditional. Virginity and taboos on premarital sex widely remain rooted as a traditional cultural value of the Armenian society. Sexual abstinence before marriage is considered a moral norm for young women and therefore only marriage is seen for them as an acceptable sexual and reproductive union. The survey conducted in 1997 shows that the expectation of both genders is that a woman should be a virgin when she marries (78% of women, 90% of men respondents).[71]

Another recent study among adolescents revealed that nearly 48% of young men and 9% of young women under the age of 25 had first sexual relation before marriage, which is almost 5 times different. Since traditionally women have to enter into marriage as virgins, so to avoid societal condemnation the young women who were sexually active in premarital period, are prompt to reject the fact, thus the data may not reflect the reality. In addition, 14 young women (3%) and 2 young men (1%) were married in their early

[69] World Health Organization, *Advancing Safe Motherhood through Human Rights*, 2001.
[70] See more in Women Status Report, Impact of Transition, Armenia, 1999.
[71] Mary Khachikyan, *Gender Issues in Family Planning and Reproductive Health,* In: Exploring Gender Issues in the Caucasus, Civic Education Project, Yerevan, Armenia, 2003, p. 53.

adolescence, which shows that the number of women ever married in their early teens threefold exceeds the number of young men.[72]

Separately, the specific stereotypes about women's role in the Armenian society boil down to the following tenets. Men are viewed as the main breadwinners, providers for the family and his activism should be realized in society. They are therefore the main job seekers, and the fact that women play the primary role in the family should not be seen as disparaging. They should be authoritative and strong leaders in their family. A man is expected to act in a somewhat aggressive manner.

Women are responsible for the upbringing of children and housekeeping. This responsibility does not stem from a concept of the superiority or inferiority of either sex, but rather from a male explanation of Armenian traditions where women enjoy the noble role of mother and all the responsibilities this description entails. Traditions and customs involve domination of a man over a woman. This is the reason why in spite of legal norms ensuring equality of the sexes in labor and social life, family relations still remain quite unequal. The scope of men's rights in the family is considerably larger than that of women, while their obligations are considerably less.[73]

However, during the 1990s these traditional stereotypes on gender and familial roles of men and women underwent certain changes: firstly, women started to play a more active role in financial, educational and other spheres; secondly, out-migrating men in search of employment to close-by or distant overseas left families without any source of financial support, which put enormous physical and psychological burden on women's shoulders and required assuming new non-traditional roles, thirdly, in rural areas the nuclear families become predominant though the extended family retained its significance, fourthly, there has been observed some democratization of family relations, with grown importance of mother and wife roles, relaxation of stereotypes of women's role, etc.[74]

There are a series of factors perpetuating the vicious circle. Society's opinion and expectations pull and drive women to conform to the rigid scheme of cultural and traditional mores, especially in rural territories than in the capital Yerevan. The lack of young men in the society and the strong social pressure to marry at a young age led some women to consent to marriages which, while not technically "forced" marriages, were not completely "free" either. Women are expected to focus primarily on family matters, while career and civic activities should be of secondary importance. They should be caring and loving mothers and wives and in case of active civic involvement they are seen as of masculine type and perceived not feminine. Similar sentiments do not however refer to men. Consequently, the traditional patriarchal model causes women to follow conservative and traditional values that limit their public lives and reinforce stereotypes as mother and wife. Moreover, this reliance on "custom" is often used to justify or rationalize discriminatory behavior toward women.[75]

The Human Rights Committee observed that de facto discrimination against women persists as a matter of custom and stresses that this problem should be addressed in the light of Armenia's obligations under the Political Covenant. The Committee noted cultural stereotypes, which overemphasized the traditional role of women as mothers in a protective and restrictive way.[76]

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[72] "Derahasneri aroghjutyan pahpanumy geraka khndire hajastanum" ("*Protection of Adolescents' health Is a Priority in Armenia")*, For Family and Health Association, Report within framework of UNFPA Project "Improvement of Reproductive Health of Women, Men and Young People", 2002, p. 63.
[73] Women Status Report, Armenia 1999: Impact of Transition, p. 28.
[74] *Ibid*, p. 30.
[75] CEDAW Assessment Tool Report, Armenia, July 2002, American Bar Association/Central European and Eurasian Law Initiative (ABA/CEELI), p. 10.
[76]Concluding observations of the Human Rights Committee: Armenia. 19/11/98. CCPR/C/79/Add.100. (Concluding Observations/Comments).

In its Concluding Observations the CEDAW Committee particularly expressed concern on deeply rooted patriarchal attitudes in the family and society despite the high level of education of women and recommended that Armenia take urgent and wide-ranging measures, such as the revision of curricula and textbooks and the implementation of awareness-raising programmes, including specific programmes targeting men and boys, to change stereotypical and discriminatory attitudes and perceptions about the roles and responsibilities of women and girls and men and boys in the family and in society.[77]

3.2 Right to decide freely and responsibly the number and spacing of one's children

De Jure

This right is expressly provided under Article 9 on Reproductive Health of the Law on *Health Care and Services to the Population*[78], which envisages that each couple or individual has the right (a) to decide on the number and spacing of children (b) in order to avoid unwanted pregnancy and artificial termination of pregnancy, use family planning efficient and safe means and methods, as well as receive necessary information on them.

Again Article 4 (2) of *Law on Reproductive Health and Rights* clearly provides the choice over the number and spacing of children. The provision expressly qualifies the right by the term 'autonomously' (can be also translated as 'independently'), which are not exactly synonymous with 'freely and responsibly'[79]- the core language endorsed in most treaties. Still, the concept of 'autonomy' is to be found at the roots of human rights philosophy and is especially relevant for decisions regarding reproduction. Autonomy requires certain degree of distance from the larger society in order to choose an individual action or conduct. Here, a link is implied between autonomy and privacy, since the choice over number and spacing of children is also a private matter. A question may arise though: whether 'autonomously' in this provision implies 'freely or without coercion'?

Freedom from arbitrary or unlawful interference with privacy and family from unlawful attacks on honor and reputation is proclaimed in the Basic Law of Armenia. In this legal review provisions specifically on inviolability of home and correspondence and consequences of their infringements will not be considered.

Articles 20 and 38 of the Constitution are relevant to the right under analysis. Article 20 states, "Everyone has the right to defend his or her private and family life from unlawful interference and to defend his or her honour and reputation from attack."; and according to Article 38, "Everyone has the right to defend his or her rights and freedoms by all methods not prohibited by law. Everyone has the right to defend in court his or her rights and freedom enshrined in the Constitution and the laws."

Article 3(1) of the Civil Code[80] stipulates the principles of equality, autonomy of will, impermissibility of arbitrary interference by anyone in private affairs, the necessity of the unhindered exercise of civil law rights, the guarantee of restoration of violated rights and their judicial protection and Article 162 protects, *inter alia,* the family honor and reputation, personal dignity, personal immunity, personal and family privacy and private life.

[77] CEDAW Concluding Observations, A/52/38/Rev.1 (1997).
[78] Adopted 04.03.96, in force 16.05.96, last amendment made on 28.11.02.
[79] Only Forward-Looking Strategies adopted by the Women's Conference in Nairobi in 1985 used the terminology 'a right to decide freely and informedly', possibly in the belief that an informed choice is a responsible choice. See more UN, Report of the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women: Equality, Development and Peace, Nairobi, Kenya, 15-26 July 1985, UN doc. A/CONF.116/28/Rev.1, para. 156-159.
[80] Civil Code of RA, adopted 05.05.98, enforced 01.01.1999.

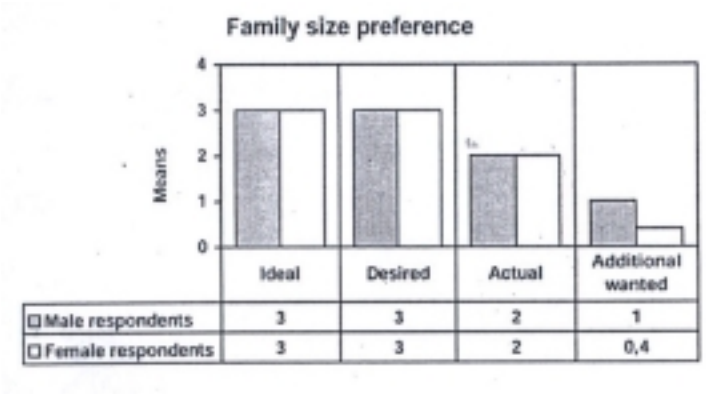
The right to decide on number and spacing of one's children can be protected under the right to health as the Constitution entitles everyone to the preservation of health (Article 34).

De Facto

The nation-wide study within framework of the National Program on Reproductive Health in 1998 showed that cultural traditions and moral norms still have significant influence on the attitudes of Armenian women and men toward gender-related sexual and reproductive rights.

According to the nation-wide epidemiological survey conducted in Armenia, both men and women of reproductive age consider as an ideal family size at least three children, and also desired at marriage to have three, on average. However, the actual number of living children was about 2 and most of couples among one-child families have no intention to have more. Important determinant reducing the desired c number children is the socio-economic factors, chiefly family income and housing conditions (Figure 1).[81]

Figure 1



Determinants of family size

Reasons for stopping childbearing	Male respondents	Female respondents
Lack of income	54%	47%
Inadequate housing	21%	13%

Source: Exploring Gender Issues in the Caucasus, Civic Education Project, Yerevan, Armenia, 2003

While most sexually active couples of reproductive age are using family planning methods (with high reliance on abortion), they essentially use them for spacing children and not for postponing the first birth, because they cannot afford to have the number ideally wanted.

Birth intervals or spacing of children affects the health of women and children- the short birth intervals may adversely impact maternal health and children's chances for survival, or risks of health problems and the longer birth intervals contribute to the improved health status of both mother and child. Having this in mind, spacing patterns in Armenia vary by regions and are related to birth order, residence and education. The longest spacing has been observed in Yerevan (41 months) and the shortest in Aragatsotn, Gegharkunik, Lori and Kotayk (27 months). It has been revealed that spacing among mothers with higher

[81] Mary Khachikyan, *Gender Issues in Family Planning and Reproductive Health,* In: Exploring Gender Issues in the Caucasus, Civic Education Project, Yerevan, Armenia, 2003, p. 49.

education is 10 months longer than birth intervals among mothers with secondary school education and 14 months longer than birth intervals among women with a primary/middle school education.[82]

To this end, factors relevant to the realization of the right to decide on number and spacing of children are decision-making powers of man and woman, their involvements in deciding on family planning methods, autonomy in (reproductive) health issues, tendency for son preference and involvement of other family members and physicians in the decision-making.

A finding of the study conducted in Gavar region of Armenia shows that the majority of women stated that the couple makes decisions about family size, but in cases of disagreement, the husband has the final say. The same conclusion was drawn from the men and older women respondents' groups. Mothers-in law were also mentioned as influential decision-makers, especially when no grandson is born, however the influence of financial situation in family was agreed among all as most determining factor. It also reveals that almost all women respondents agreed that in cases when a couple decides to have more than 2 children, it is usually linked to the desire for a son in the family.[83]

According to the Demographic and Health Survey, 2000, about four-fifths of men believe that a wife should have at least an equal say in certain household decisions, including the number and spacing of children.[84]

Another important factor in exercise of this right is that Armenian culture also stresses privacy of such matters within family, which can have serious implications for women, particularly when there is a need for consulting health care professionals, when they are in troubled marriages or are victims of domestic violence. Thus, because women face social pressure to keep "family matters" private they do not report such matters to the police.[85]

3.3 Right to family planning information and education

De Jure

Constitution provides every citizen with the right to education (Article 35) and entitlement to the preservation of health, provision of medical care and services (Article 34).

The *Law on Education*[86] affords the right to education irrespective of nationality, race, sex, language, religion, political or other views, social origin, property or other status[87] and states that in secondary schools the education aims at providing basic knowledge necessary for ensuring, among others, healthy life style. Article 18(5) education in the middle school is aimed to provide minimum necessary knowledge about healthy lifestyle, environment protection and world learning, and skills necessary for individual work and learning".

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[82] Demographic and Health Survey, 2000, National Statistical Service, Armenia, Ministry of Health, Orc Macro, Calverton, Maryland, USA, p. 60.

[83] Michael E. Thompson, Tsovinar L. Harutyunyan, Gayane G. Ghukasyan, *Feasibility Study: The Strategic Introduction of the Standard Days Method of Family Planning In Armenia, Formative Research Final Report,* American University of Armenia, Center for Health Sciences Research, Yerevan, Armenia, February 2001, p.7.

[84] Demographic and Health Survey, 2000, National Statistical Service, Armenia, Ministry of Health, Orc Macro, Calverton, Maryland, USA, p. 42.

[85] CEDAW Assessment Tool Report, Armenia, July 2002, American Bar Association/Central European and Eurasian Law Initiative (ABA/CEELI), p. 24.

[86] Law of RA on Education, adopted 14.04.1999, enforced on 14.05.1999.

[87] Law of RA on Education, Article 6, part 1, "The laws of the RA ensure the right to education irrespective of nationality, race, sex, language, religion, political or other views, social origin, property or other status."

Article 9 of the *Law on Provision of Health Care Services to the Population* provides that everybody, including adolescents, has the right to receive information on protection of their sexual health, diseases communicated by means of sexual intercourse, their after-affects and consequences. As mentioned earlier, Article 9 assembles the right to decide on number and spacing of children, use of the family planning methods and information thereon.

Relevant to this and below-stated rights under analysis, Article 4(1) of *Law on Reproductive Health and Rights* provides for the right to independently control one's sexual and reproductive life, provided it does not endanger others' health. While Article 4 (2) groups the right to found a family, choice over number and spacing of children and access to fertility regulation services, Article 4 (4) goes further to provide 'the right to receive reliable and complete information on matters of sexual and reproductive health, including advantages, efficiency and possible harm of existing methods of fertility regulation.'

Article 5 stipulates the preservation of adolescents' rights to "sexual upbringing, sexual and reproductive health, being informed on sexual maturity, issues of sexual and reproductive health, possess pertinent knowledge on artificial termination of pregnancy, sexually transmitted diseases, including modern preventive methods of HIV; youth-friendly and confidential accessible and complete medical counseling, if necessary, also medical aid, on puberty and matters related to sexual and reproductive health." The Article also stipulates the sexual upbringing of adolescents in secondary schools and other educational establishments and educational programs related to adolescents' sexual and reproductive health are to be implemented by the executive bodies in the health care and education sectors with the active participation of interested non-governmental and other organizations, young people, taking into account national customs, moral values and international experience, in conformity with adolescents' age, psychological and physical development.

In addition, Article 8 on contraceptive methods in Clause 2 further stipulates that the health care providers ensure reliable/accurate information on the use, efficiency and safety of available contraceptive methods in order to ensure informed choice on fertility regulation method.

Article 11 of *Law on Children's Rights*[88] stipulated for the right of the child to education, however does not expressly provide for a right to seek, receive and impart information per se. Taking into account that the rights to health and family planning information are quite interrelated, Article 7 can be also cited in this context; it stipulates the child's right to maintenance and strengthening of his/her health.

De Facto

There is wide evidence that education promotes and enhances harmonious, healthy, responsible and proper relationships and helps to recognize and respect each other's rights. "Access to reproductive health information and services affects women and adolescents in many ways- among the most significant benefits are improvements in health status, in personal decision-making, in employment opportunities, and in access to economic resources."[89]

Awareness on family planning

Among adolescents

While the 1996 Survey conducted by "For Family and Health Association" among adolescents of 10-19 age shows that 22% of adolescents of 13-19 age were entirely unaware of family planning methods. The

[88] Law of RA on Children's Rights, adopted 29.05.1996, enforced on 27.06.1996.
[89] WHO, "Progress in Human Reproduction Research", No 30, 1994.

traditional mechanisms of support to adolescents on raising their awareness of sexual and reproductive health as parents, family and community, are not sufficient and effective in the new fast changing realities.

Among population

As shows the Reproductive Health Survey of 1997, 96% of respondents knew at least one fertility regulation method and 60% were currently using birth control, the majority though were using low-reliability methods. The survey indicated that several factors impact women's knowledge on modern contraceptive means: women's age, education, urbanization, place of residence, and socio-economic status. From the index of awareness on family planning, the scores followed a bell curve distribution with the lower scores among women of adolescent age, rural women and among those of only primary level of education or low socio-economic status.[90]

According to family planning physicians participating in survey of another study in 1999 their clients are well aware of such matters, noting that younger women demonstrate more awareness of family planning than older clients. However, it does not necessarily mean that such awareness indicates deep or even accurate knowledge. There is also limited number of printed materials on family planning at their disposal to distribute to their clients. There is also lack of adequate knowledge on family planning among gynecologists and pharmacists, while the former are also in charge of counseling on family planning and the latter also sell contraceptives in the drug stores. While majority of the respondents had no formal training on family planning and contraceptives, they all give advice to clients on the selection of contraceptives.[91] In the same study women obtain information from their physicians, friends and family, but the preferred source of information is clinics and physicians. They exhibited higher level of awareness on family planning than any other group in the study, except for physicians.

As of 2000 knowledge of contraception (including traditional and folk methods, as well as modern methods) was nearly universal- with 94% of women having heard of at least one method, the highest awareness being among married women (99%) at the time of the survey, however even 84% of women with no sexual experience know at least one method.[92]

Sources of information on family planning

There is a lack of modern health education materials and current information on family planning contraceptives in Armenia available to the public. As highlighted by the Commercial Market Strategies assessment, the family planning patient education literature is stocked out in some family planning cabinets and is not being replaced.[93]

Concurrently, mass media provide wide exposure of such information to a broad spectrum of the population. Television is the most common source of messages on family planning: 87% of all female respondents in Demographic and Health Survey 2000 saw such messages on the television, 42% heard on radio, and 38% read in newspapers. Similar results on the contribution of these sources were received also earlier by the Reproductive Health Survey 1997.

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[90] *Highlight on Women's Health, Armenia,* WHO Regional Office for Europe, 2000, p. 24.

[91] Sosig Salvador, Lucig H. Danielian, *Report on Qualitative Research: John Hopkins University/Population Communication Services Project on Reproductive Health in Armenia,* Information, Education and Communication Campaign, American University of Armenia, Center for Health Sciences Research, Yerevan, Armenia, August 1999.

[92] Demographic and Health Survey, 2000, National Statistical Service, Armenia, Ministry of Health, Orc Macro, Calverton, Maryland, USA, p. 65.

[93] S. Sulzbach, W. Winfrey, S. Scribner & F. Armand, *Contraceptive Security in Armenia: Segmenting the Family Planning Market,* Commercial Market Strategies, New Directions in Reproductive Health, Country Research Series, No. 7, October 2002, p. 24.

Information, education and communication (IEC) campaigns were undertaken to promote family planning and led to some positive shifts. By the evaluation of USAID supported *Green Path* campaign 2000, which aimed to promote greater awareness, knowledge acceptance, and adoption of modern contraception through increased utilization of counseling and related services provided at the then-underutilized Family Planning Cabinets, visits to local family planning cabinets increased by more than 4% as a result of the campaign.[94]

Since 1997 the Ministry of Education, Ministry of Health, Family Planning Association of Armenia, For Family and Health NGOs and Association of Medical Students (with support of UNFPA and UNICEF) implemented projects and trainings designed to increase the public and particularly, adolescents' awareness about family planning, reproductive rights and women's health, including some undertakings to hold lectures and advisory sessions on reproductive health issues.

Sexual Health Education

New global data clearly indicates the existence of a myriad of risk factors affecting reproductive health resulting from the improper education and hindered access to information on sexual and reproductive health and rights. Furthermore, the argument that proper education "will just awake the sleeping dog" and will promote sexual activity among youth is now a fallacy.[95] A worldwide WHO analysis of 35 studies of sexual education in schools demonstrated that proper sexual education leads to delay of sexual activity and an increased use of safer sex practices.[96]

Researches and epidemiological studies in Armenia support that there is a correlation between the education level/educational attainment and marriages age, early childbearing, birth intervals, use of family planning methods, decision-making and reproductive health autonomy, all of these varying by urban and rural characteristics.[97]

Today, as for many years in the past, health information is supplied to the public from two main sources: the health education bodies established (hygiene apparatus that almost stopped to operate at present) within the Ministry of Health system, and secondary schools within the educational system. The capacity of both is limited. In neither system does the information provided on health and hygiene meet today's requirements.

The sexual and reproductive health epidemiological surveys conducted in 1996 and 1998 by the Armenian Family Planning Association showed that provision of sexual health education has been largely neglected, even until now.[98] A number of studies by the National Health Institute have found that school-leavers are completely ignorant of elementary medical and hygiene matters. In addition, withholding or neglecting to provide clear information on issues related to sexual health and sexuality-related matters forces the children to mixed messages from other sources. The information vacuum is filled with the help of informal sources (peers, video films, books, etc.). Interestingly, school as a source of information on

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[94] *A Pre-Post Panel Evaluation of the Green Path Campaign for Family Health, Armenia, 2000*, American University of Armenia Center for Health Services Research, May 2001. p. 1.

[95] Evert Ketting, "Meeting Young People's Sexual and Reproductive Health Needs Worldwide", ", International Planned Parenthood Federation, CHALLENGES, Empowering Youth, 1995/1, p. 31.

[96] WHO, Global Programme on AIDS , "Sex Education Leads to Safer Behavior", Global Aidsnews, No. 4:1-2, 1993.

[97] See more Demographic and Health Survey, 2000, National Statistical Service, Armenia, Ministry of Health, Orc Macro, Calverton, Maryland, USA.

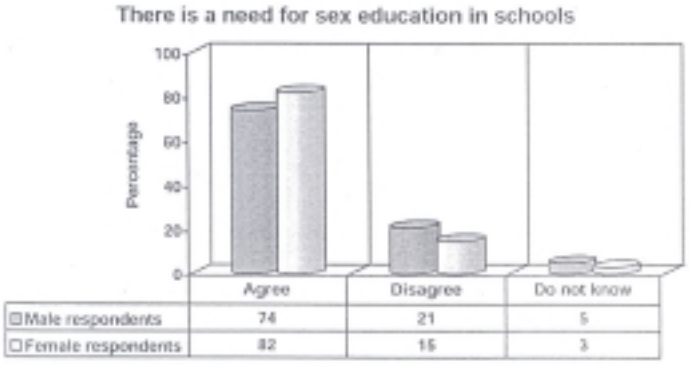
[98] Mary Khachikian, "Armenian FPA: New but Already Well Established", Choices, IPPF, Vol. 28 No 1, 2000.

topics HIV/AIDS/sex was reported only by 37% of the young people surveyed in 2000.[99] This information is interpreted without assistance and often incorrectly, the main danger being that it may eventually become deep-rooted and manifested in action.[100]

Traditionally for the majority of the Armenian society sex and sexual education have been difficult issues to discuss openly. One of the dominant and commonly heard statements in the Armenian society with regard to the sex education is that introducing it on the formal national level will lead to sexual activity and promiscuity. And such is the conservatism in the Armenian society leading to a firm reluctance by the policy-makers to initiate sexual health education on a formal school level. Such resistance to sex education in schools, however, did not prevent Armenian youth from engaging in sexual behaviors: in a sample of 442 university students (aged 17-21), 78% of the males and 7% of the females reported being sexually active, with an average age of the first sexual intercourse around 15-16 years, while increase in a number of sexual partners is an important risk factor for HIV infection.[101]

The need for sexual health education is reinforced by the findings of other studies suggesting poor level of awareness on sexual and reproductive health and transmission modes of HIV and other STDs.[102] Another nation-wide survey on family planning, sexual and reproductive health and rights revealed the common view of most of respondents that there is a need for sex education in schools (Figure 2).[103]

Figure 2



Recent epidemiological study re-emphasized the need for the inclusion of sexual education in the secondary school curriculum (88%): 87% are in favor of it as a separate course, 11% prefer such topics to be incorporated in other courses. Case study shows that 92% of respondents' opine that inclusion of sexual education in schools will not negatively impact adolescents' sexual activity.[104]

Health education as a separate course is not covered generally in schools of Armenia. On September 1, 1999, the "Life Skills" Pilot Project was launched in 1st and 5th grade of 16 schools throughout Armenia.

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[99] Babikian T. *AIDS and Youth in the Republic of Armenia: An Application of a Risk Behavior Model*. Master Thesis submitted to Loma Linda University.

[100] State Party Report to the Committee on the Rights of the Child, Armenia, CRC/C/28/Add.9, 30 July 1997.

[101] Gayane Ghukasyan, 2002 IPF Fellow, Research Paper, Fellowship Topic: Integrating HIV/AIDS/STI education program in the school curriculum. Source: Babikian T. *AIDS and Youth in the Republic of Armenia: An Application of a Risk Behavior Model*. Master Thesis submitted to Loma Linda University.

[102] A Report of the Knowledge and Attitudes of STDs, AIDS, and Condom Use: *A Study of University Students in Yerevan, 1996*. American University of Armenia Center for Health Services Research, 1996.

[103] Mary Khachikyan, *Gender Issues in Family Planning and Reproductive Health,* In: Exploring Gender Issues in the Caucasus, Civic Education Project, Yerevan, Armenia, 2003, p. 50.

[104] "Derahasneri aroghjutyan pahpanumy geraka khndire hajastanum" ("*Protection of Adolescents' health Is a Priority in Armenia")*, For Family and Health Association, Report within framework of UNFPA Project "Improvement of Reproductive Health of Women, Men and Young People", 2002, p. 83.

Since then supported by the UNICEF and implemented by the Center for Educational Reforms this course has been introduced in grades from 1 throughout 7 grades in about 300 schools across Armenia (the Center itself trains the school teachers). Inclusion of the "Life Skills" course is not compulsory and is left to the discretion of school administrators, who upon wish can apply for including the course in their curriculum.

It touches upon several elements of health education instruction and adds up on its complexity level according to the age and capacities of the students. The aim of teaching this subject in the school is to make students acquainted with the philosophy of major life skills, such as decision-making, problem solving, critical thinking, communication, interpersonal relationships, self- learning, etc. Curriculum for the health related topics focus on general hygiene, healthy life style, infectious diseases, basic information on AIDS, and barely touches upon topics related to sexual and reproductive health, reproductive rights.

At present, driven by the need to continue this course throughout 8-11 grades, with the support of UNICEF the Center for Educational Reforms is conducting a tender for interested NGOs and individuals to propose curricula for the course "Healthy Life Style", which will supposedly include some sexual education topics at more depth and complexity according to students' age and developmental peculiarities. However, according to the preliminary information obtained from the Center it will take approximately 2 years till the curriculum is approved, textbooks prepared, and specialists trained to teach the subject.

Human Rights Education

The very process of educating people about their rights generates awareness of the gap that exists between the proclaimed rights and the reality of their lives. Effective human rights education can empower people with various groupings to work together and campaign efficiently towards social change. As promoted by the International Planned Parenthood Federation (IPPF) Charter on Sexual and Reproductive Rights[105], based on twelve rights envisaged in core international human rights instruments and additional rights implied by them, human rights education is an essential element of efforts to promote and protect sexual and reproductive health and rights.

Human rights education has been a novel concept in the independent Armenia. Some organizations ventured to introduce it directly as a school course and only since September 2001 following the efforts of the organization *Junior Achievement* that experimented with it in the larger context of civic education, the Ministry of Education released a decree placing a compulsory three-year course into the secondary school curriculum all over Armenia. Each year is assigned a separate course as follows: 8th grade- "Human Rights", 9th grade- "Civic Education", 10th grade- "State and Law". To this end, the specialists from *Junior Achievement* trained 300 teachers (majority are history major teachers) all over the country, 40 of whom received training in the United States. All three courses have chapters covering gender issues along with basic principles of democracy, organization and function of different branches of government, diplomacy and so on. The cornerstone to their approach in encouraging equality between sexes is providing information and knowledge.[106]

Relevant in this context is the course on Human Rights allocated for 12 hours at 8th grade as follows:

[105] *Charter on Sexual and Reproductive Rights*, International Planned Parenthood Federation (IPPF), London: IPPF, 1996.
[106] Armine K. Hovannisian, *Gender Issues in Civic Education,* In: Exploring Gender Issues in the Caucasus, Civic Education Project, Yerevan, Armenia, 2003, p. 101.

Section I	
1st hour	Introduction, individual, society, state; General nature of human rights and freedoms
2nd hour	Origin and developments of human rights; three generations of human rights
3rd hour	Human rights: rights and obligations of citizens; Classification of human rights and freedoms
4th hour	Basic human rights documents, necessary conditions for civil society, norms and values, law, Constitution
Section II	
5th hour	Civil and political rights
6th hour	Freedom of religion and belief, speech, right to trade unions, manifestations, demonstrations, right to participation in government, free and fair elections
7th hour	Right to property, work, vacation and leisure, marriage and family, social security, health, housing, education, art freedom and participation in art life
Section III	
8th hour	Right to family; children's rights
9th hour	Women's rights
10th hour	Rights of refugees, disabled people and national minorities
Section IV	
11th hour	Means and mechanisms of human rights protection
12th hour	Summary

Despite the training of teachers by Junior Achievement specifically for these courses, throughout research-driven queries in a series of schools in Yerevan for these course textbooks it turned out that though compulsory, these courses are not properly taught in schools either because of lack or absence of specifically trained teachers or improper administration and enforcement. Further investigation and research is necessitated to monitor and evaluate the effectiveness of operation of human rights education in Armenian schools.

3.4 Right to have access to family planning methods and services

De Jure

The *Constitution* provides equality of all before the law and equal protection of the law without discrimination (Article 16), as such equal access to men and women in the field of health care. According to Article 34 everyone is entitled to the preservation of health and the provision of medical care and services is prescribed by law. Additionally, the government is obliged to ensure the implementation of state policies in the areas of science, education, culture, health, social security and environmental protection (Article 89).

As mentioned earlier, the right to access to safe and efficient services of fertility regulation is provided in the groupings of rights of Article 4 (2) of *Law on Reproductive Health and Rights*. The law also has comprehensive provisions on volunteer medical sterilization (Article 9), artificial termination of pregnancy (Article 10), prohibition of forced abortion (Article 4), such assisting reproductive technologies as surrogacy, in vitro fertilization, artificial insemination, donor egg and sperm donation (Articles 11-19). Article 5 provides for the rights of adolescents for preservation of their sexual and reproductive health and the right to receive accessible and complete counseling and if necessary the treatment under youth-friendly and confidential conditions. Article 4 (5) reiterates the right to receive medical counseling and services on sexual and reproductive health issues with provision of privacy and confidentiality. Article 18 guarantees the confidentiality of information on the use of assisting reproductive technologies.

With respect to legal regulation of abortion, in addition to Article 10 of newly adopted *Law on Reproductive Health and Rights*, the Decree on Artificial Termination of Pregnancy[107] regulates in detail the abortion services. Legalized since 1955, abortion should be performed only by licensed obstetrician-gynaecologist, in licensed health facilities. Termination of pregnancy is legal upon request up to the 12th week of pregnancy and is widely available in obstetric-gynecological health facilities (maternity hospitals or hospital-based gynecological departments). In case of pregnancy above the 15th week, it is legal to perform an abortion for medical reasons, and in case of pregnancies up to 22 weeks, it is legal if the woman has valid social reasons. Besides for the stipulated medical and social grounds, in the period of up to 22 weeks abortion can be carried out upon the decision of the relevant hospital committee.

Punishment for the illegal termination of pregnancy is regulated by the newly adopted Criminal Code. If performed by a qualified physician with higher medical education, the penalty includes a fine at most in the size of hundredfold minimum salary or community work of one to two years, or imprisonment at most for one month and suspension of right for certain positions or practice for up to three years. An abortion performed by an unauthorized individual without higher medical education is punishable by a fine at most in the size of two-hundredfold minimum salary or detention of one to three months, or imprisonment at most of up to two years. Should an abortion be committed by a physician or an unauthorized individual, or a person accused of performing an illegal abortion in the past, that by negligence resulted in the serious harm to health or death, the penalty includes a prison term of up to five years and suspension of right for certain positions or practice at most for three years.[108]

Article 4 of Law *on Provision of Health Care Services to the Population* provides, "Any person, regardless of one's nationality, race, sex, language, religion, age and health condition, political or other views, social origin, property or other status, in the Republic of Armenia is entitled to the provision of health care services." Article 7 regulates the informed consent, particularly, "the right to receive information in a comprehensible form on the health status, results of examination, methods of diagnosis and treatment, related risks, alternative means of medical intervention, consequences and treatment results." Article 10 states that every child is entitled to free medical care and assistance within framework of state target programs.

The law on the "Prevention of Diseases Caused by Human Immunodeficiency Virus" is in force since 1997. The deliberate contamination of another person with HIV and sexually transmitted diseases is criminally prosecuted by Article 131 and 132 of the new Criminal Code respectively.

There is no specific law on domestic violence, and separate provisions in different legislation pieces are applied. From the Soviet times criminal[109], administrative[110] and family laws[111] have been and continue to be applied for most instances of domestic violence, majority dealing with assault, criminal hooliganism and divorce.

[107] Decree by the Ministry of Health on "Artificial Interruption of Pregnancy", Clauses 6, 7, enacted 25.12.97.
[108] Criminal Code, Article 122, enacted 18.04.03, to come into force 01.08.03.
[109] New Criminal Code provisions relevant to domestic violence include: Articles 110-115, 117-126, 129, 131-132, 134, 138-145, 148, 149, 286-288.
[110] Code of Administrative Violations, Articles 172. adopted 06.12.1985, in force 01.06.1986.
[111] Marriage and Family Code, Articles 31-39.

De Facto

Right to health and health care services

Though the legislation is inductive in terms of right to preservation of health and provision of health care services, in reality access to health care services is limited, unaffordable, discriminatory and unequal with regard to poor and wealthy population. In addition, while as health care as well as family planning facilities and services must be respectful of medical ethics, culturally appropriate, gender sensitive and designed to respect confidentiality, they are not such in Armenia.

As far as health care is concerned, while the record prior to the 1990s was good in providing more access to all levels of health care there was no right to choose a physician and register with a polyclinic other than the assigned by the state according to the place of residence. With the guarantee of free medical assistance and access to a comprehensive range of secondary and tertiary care, the Soviet health care system was characterized by the lack of personal responsibility of health care consumers towards their health status and lack of incentive on part of health care providers to control costs and deliver quality services.[112] In the aftermath of the collapse of the Soviet Union, in Armenia installing democracy was accompanied by making profound changes in the economic and sociopolitical map of Armenia and putting an overwhelming pressure on the health care system.

With increasing pressure on state budget, more funding is sought from private sources, which became possible by the Law on "Medical Aid and Medical Services for the Population", which legalized alternative financing schemes, including private out-of-pocket payments and by the 1997 government decree providing out-of-pocket payments for a majority of health care services to all non-vulnerable and non-targeted population groups. Free-of-charge services to targeted population segments are provided since 1998 to cover a publicly-funded package of services, including hygiene and anti-epidemic control, primary health care, medical care of children, obstetrics-gynecology, emergency health care program and etc.

Despite this, the healthcare system worked only at half of its capacity. In 2000, hospital bed occupancy amounted to 35% (in case of some regions it is 10-15%). Compared to 1990s, the referrals to polyclinics decreased by 45%, home calls decreased by 53% and the number of emergency ambulance calls decreased by 60%. All this is undoubtedly a result of high prices, insolvency of the population and a decline in the quality of health care rather than an indicator of improved health.[113]

The enforcement of rights related to health and health care is further hindered by the radical nature of health care reforms with privatization, optimization and decentralization, which negatively affected the general quality and access to health care, leading to more corruption, expansion of informal payments, unequal health outcomes, institutional obstacles and funding scarcity. Many issues that vitally affect the health care area are still decided at the state level, which primarily comes from the former Soviet regime centralization and state control.

[112] S. Hovhannisyan, E. Tragakes, S. Lessof, H. Aslanian, Ararat Mkrtchyan, *Health Care Systems in Transition, Armenia,* European Observatory on Health Care Systems, 2001, p. 6.
[113] *10 Years of Independence and Transition in Armenia*, UNDP, Armenia, 2001, p. 97.

Availability, accessibility and acceptability

The CESCR General Comment on Health[114] and other general recommendations, such as the CEDAW General Recommendation on Women and Health, and those arising out of the Cairo Programme and the Beijing Platform significantly develop the understanding of what is required to implement the right to health, "the right to health in all its forms and at all levels contains the following interrelated and essential features-availability, accessibility, acceptability and quality".

Integral to the exercise of the right to health is securing the right to confidentiality. Under the Women's Convention, CEDAW has made a General Recommendation reiterating the importance of confidentiality, observing that, although lack of confidentiality affects both men and women to a certain degree, "it may deter women from seeking advice and treatment and thereby adversely affect their health and well-being. Women will be less willing, for that reason [unreliable confidentiality], to seek medical care for diseases of the genital tract, for contraception or for incomplete abortion and in cases where they have suffered sexual or physical violence."

In Armenia family planning services and counseling are provided in a variety of settings through the gynecological and obstetric care facilities and family planning cabinets. The family planning counseling is provided by gynecologists at the cost of equivalent of 10% of an average monthly salary. The average cost of a gynecological consultation ranges from 2-20 USD.

The public sector is the primary source of contraceptive supplies in Armenia (67% of modern method users), while pharmacies (61% of condom users) and shops also merchandize them.[115] The contraceptives in the public sector are free but the costs of medical examination and laboratory analyses range from 1 to 20 USD. The major consignments of free contraceptives were supplied to maternal hospitals and family planning cabinets within framework of family planning campaign in 1997 and later also during donor organization projects as humanitarian assistance. Informal inquiries show that while the contraceptive supplies are without charge, at present majority have expired and are not distributed to clients.

The findings of field assessment by Commercial Market Strategies in 2001 reveal that though the consultation and donated supplies are free of charge in the family planning cabinets, the initiation of family planning methods may not be free and some require prior laboratory tests for which the facilities are allowed to charge. The IUDs (price is 5USD, insertion cost is about 20-25 USD) and sterilization (250 USD) follow the pattern of reliance on public sector. The sources of supply for oral contraceptives (800-1000AMD=1.4-1.8USD) are more uncertain because this method is much less popular among Armenian women. The low frequency usage of oral contraceptives comes from the Soviet time anti-pills propaganda. The fear of side effects or complications (46.8%) and the high cost of modern contraceptives (34.5%) were the most common reasons for not using them as revealed by the Reproductive health survey 1997. Though the least expensive oral pills can compete with cost of commercially available condoms are commercially, the oral contraceptives have their hidden cost, since a woman should get a blood test, for which she is charged additionally. Condoms (each- min. 0.08USD, max. 1.8USD) are by far the most important method where commercial sector plays an important role. Though condoms are sold in pharmacies, supermarkets and shops and are accessible, for many couples they are not affordable.

[114] Committee on Economic, Social and Cultural Rights, General Comment 14: The right to the highest attainable standard of health (Article 12), CESCR, *General Comment 14*, UN Doc. E/C.12/2000/4, 11 August 2000.
[115] Demographic and Health Survey, 2000, National Statistical Service, Armenia, Ministry of Health, Orc Macro, Calverton, Maryland, USA, p. 78.

Besides economic accessibility, another concern is their physical accessibility. Rural access is an important issue. Despite the legal equality afforded to, *inter alia*, access to health care the situation is quite different for urban and rural areas. Due to financial constrains (formal and informal payments) and geographic remoteness of centralized district health centers and facilities for women in rural areas it is much more expensive and inconvenient to travel for counseling and treatment, with the result that their access to such services is limited. The nation-wide population-based survey in 1997 revealed the range of travel time for prenatal care from 1 minute to 5 hours, where 5% of women had to travel more than 1 hour to get to the site. Those women, who cannot by the above-mentioned reasons, make therefore less frequent use of medical services and resort to self-treatment, home deliveries, no prenatal care or unsafe abortions.

As for the right to privacy and confidentiality, there is almost no empirical data on the observation of this right in Armenia. One of the striking examples of violation of right to privacy and its negative impact to enjoyment of sexual and reproductive health is the disadvantages of adolescents in Armenia in resort to reproductive health/family planning counseling and services, since they may fear that they will not be afforded the same confidentiality as adult women seeking the same services. Given the impact of failures to respect confidentiality, the absence of confidentiality is also a contributing factor to violation of a woman's right to health and wider aspects of security.

Family Planning Use

Armenia commenced the implementation of a national family planning campaign in 1997 within framework of the National Reproductive Program funded by the government, WHO and UNFPA, when 77 family planning centers were established and supplied with free contraceptives. Several other institutions also provide family planning services: maternity hospitals, women's consultancies, polyclinics, private practices and sometimes PHC facilities.

Despite the availability of a myriad of family planning service providers now compared to the past, the family planning practices in Armenia raise concerns. Although the knowledge of modern contraceptive methods is relatively high, actual use of these methods is low. While current legislation limits provision of family planning services to gynecologists-obstetricians it is unclear whether family practitioners are permitted to prescribe hormonal contraceptives or insert IUDs.

Attitudes Towards Family Planning

It is known that use of effective contraceptive methods is facilitated by the positive attitudes towards family planning and conversely, widespread disapproval of contraception can be a barrier to the adoption of methods. Approval also correlates strongly with the educational level- the Demographic and Health Survey 2000 revealed that approval ranged from 73% of women with a primary/middle education to 90% of women with a higher education.

Despite this, family planning is a sensitive issue in Armenia. The nationwide advertising television campaign in 2000 conducted to increase the public awareness of family planning clinics and services available triggered a negative reaction among some strata of the Armenian society, who claimed that family planning is dangerous for health and leads to a decrease of Armenian population. With a deteriorated birthrate and high migration, there is a feeling among some people and politicians that the

State should promote high birth rates and increases in population rather than contraception and family planning.[116]

Other determinants and background characteristics

As for the decision-making autonomy related to health, Demographic and Health Survey, 2000 indicates that one-third of married women make decisions on their own about their own health care, while one-fourth of married women have no say in such decisions and for 20.2% of married women their husband makes the decisions about their health care. Among unmarried women, approximately half (49.3%) have no say in decisions related to their health.[117]

A general opinion persisted among nurses and physicians in one of studies has been that men do have a dominant role in decision-making regarding family-planning and are not very communicative with their wives on the selection of family planning methods[118], the latter being also indicated by the DHS where more than half of all currently married women (55.4) have never discussed family planning with their husbands.[119] Another study revealed the men's belief that decisions on contraceptive methods are mainly the responsibility of their wives.[120] In the same study the gynecologists believed that family planning consulting constitutes the important part of their practices, and they are also participants along with their clients in making family planning decisions.

The above-stated barriers also limit the woman's ability to make decisions about her own heath and reduce the frequency of visits for family planning and health counseling. In Armenia due to the enshrined traditional norms and practices, the studies on family planning show that women in selection of family planning methods are affected by their husbands' decisions and her ability to use contraceptives to control her fertility is also affected by her status and degree of empowerment. There are more stereotypes about the role of men and women, more prejudice against modern contraception methods and visiting family planning among rural women, causing them to rely on traditional and folkloric contraceptive methods with higher failure rates.

On the other front, while legally the woman is entitled to exercise informed choice and decision on contraceptive method after being furnished with full information on various methods and associated side effects. Whereas virtually women are provided with some information on side effects of methods and different methods available at a health care facility or family planning cabinet, the study in 2000 shows that there is still a gap necessary to bridge and both public and private health and family planning workers in Armenia need to provide women with more information about contraceptive methods in order to help them make informed choices.[121] The Cairo Programme and the Beijing Platform affirm that "the principle

[116] CEDAW Assessment Tool Report, Armenia, July 2002, American Bar Association/Central European and Eurasian Law Initiative (ABA/CEELI), p. 63.
[117] Demographic and Health Survey, 2000, National Statistical Service, Armenia, Ministry of Health, Orc Macro, Calverton, Maryland, USA, p. 39.
[118] Michael E. Thompson, Tsovinar L. Harutyunyan, Gayane G. Ghukasyan, *Feasibility Study: The Strategic Introduction of the Standard Days Method of Family Planning In Armenia, Formative Research Final Report,* American University of Armenia, Center for Health Sciences Research, Yerevan, Armenia, February 2001.
[119] Demographic and Health Survey, 2000, National Statistical Service, Armenia, Ministry of Health, Orc Macro, Calverton, Maryland, USA, p. 84.
[120] Sosig Salvador, Lucig H. Danielian, *Report on Qualitative Research: John Hopkins University/Population Communication Services Project on Reproductive Health in Armenia,* Information, Education and Communication Campaign, American University of Armenia, Center for Health Sciences Research, Yerevan, Armenia, August 1999.
[121] See more Demographic and Health Survey, 2000, National Statistical Service, Armenia, Ministry of Health, Orc Macro, Calverton, Maryland, USA, p. 78.

of informed free choice is essential to the long-term success of family planning programs [and that] any form of coercion has no part to play".[122]

Use of contraceptive methods

In 1997 the Reproductive Health Survey showed that the lack of information on family planning led about 25% of women to continue using the contraceptive methods they were not happy with.[123] The most popular contraceptive choice is withdrawal method, which though has definite value as a birth control, is characterized by high failure rate. In fact, heavy reliance on the withdrawal method in Armenia contributes to the high abortion rate.[124] The use of contraceptives is low with the reliance on abortion especially among commercial sexual workers in specific regions of Armenia bordering Georgia and Turkey.[125]

According to the Commercial Market Strategies research, in Armenia the majority of women (63%) consider as having their family planning needs met are traditional method users, which explains also the high contraceptive failure rates, i.e. more likely to result in unwanted pregnancies. 45.4% of women currently use no method, 33.1% rely on traditional methods (withdrawal, vagina douching, breast-feeding) and 20.2% modern methods. The above-said 20% of Armenian women use modern contraceptives, varying from 14% of the poorest quintile to 27% of the wealthiest quintile. Wealth and buying power affects the use of a modern method- 40% of poor respondents use traditional methods, whereas only 25% of the wealthiest does so.[126]

As of year 2000 94% of women in Armenia heard of at least one method, awareness ranges from 99% among currently married women, 95% of women who have had sex, to 84% of women with no sexual experience.[127]

Challenges for Adolescents

Though by newly adopted Law *on Reproductive Health and Rights* adolescents are legally entitled to receive information and youth-friendly consultation on family planning with ensuring confidentiality, adolescents are less likely than adults to receive information and to have access to family planning services for reasons of cultural morals and fear of negative reaction to their active sexual life. Providers' own attitudes often confirm adolescents' fears about them. Though adolescents do not need authorization to receive family planning services, the access to such services is limited for them due to financial scarcity and the cultural mores of reproach for early sexual activity.

While there are a few youth-friendly health care services for adolescents, under societal pressures they are deprived of information, in clinics they do not have access to written materials, which divests them of necessary knowledge and skills to make informed choices on their sexual and reproductive life. For

[122]The Cairo Programme of Action and the Beijing Platform for Action (para. 7.12, Beijing paras. 106(g) and (h), 107(e)).
[123] A Situation Analysis of Children and Women in Armenia, 1998, p. 108.
[124] Westoff, Charles F., Jeremiah Sullivan, Holly A. Newby and Albert R. Themme, *Contraception-Abortion Connections in Armenia.* DHS Analytical Studies No. 6. Calverton, Maryland: ORC Macro, 2002, p. 9. In: S. Sulzbach, W. Winfrey, S. Scribner & F. Armand, *Contraceptive Security in Armenia: Segmenting the Family Planning Market,* Commercial Market Strategies, New Directions in Reproductive Health, Country Research Series, No. 7, October 2002.
[125] Tido von Schoen-Angerer, Medecins Sans Frontieres-Belgium, *STD-HIV Harm Reduction at the Bagratashen/Sadakhlo Cross Border Trading Market*, January 2001.
[126] S. Sulzbach, W. Winfrey, S. Scribner & F. Armand, *Contraceptive Security in Armenia: Segmenting the Family Planning Market,* Commercial Market Strategies, New Directions in Reproductive Health, Country Research Series, No. 7, October 2002, p. 10.
[127] Demographic and Health Survey, 2000, National Statistical Service, Armenia, Ministry of Health, Orc Macro, Calverton, Maryland, USA, p. 66.

adolescents the contraceptives are not easily acceptable either, because they are by tradition are ashamed to purchase them from merchants and/or cannot afford them.[128]

Consequently, the lack of awareness, education on family planning, limited access and affordability of family planning, contraceptive supplies and medical assistance, the sexually active adolescents face the risk of unwanted pregnancies, induced abortion, STD/AIDS and other social and medical consequences thereof. This is especially harmful for adolescents in the risk group.

Abortion

Clear-cut line should be drawn between the law and the practice. In Armenia abortion has been the primary means of fertility regulation since the Soviet era, interestingly mainly for spacing children and not for postponing the first birth. Despite an obvious tendency in decrease of abortions (in 1995 - 686 cases per 1000 births; in 1997 - 562.2; in 1999 – 350 cases) and improvements in family planning use in recent years, there is still a high incidence of induced abortions[129] and hundreds of Armenian women still face unwanted pregnancies, unsafe abortions[130], self-induced abortions[131], a major concern in Armenia contributing to one of causes of conditions leading to infertility, reducing further childbearing, and finally contributing to maternal and perinatal mortality. In Armenia induced abortions account for a significant portion of maternal mortality (between 10 and 20%).[132]

The 2000 survey found that three-fourths of respondent women had more than one abortion, 43% had 2-3 abortions, 18% reported four to five abortions and 14% had six or more abortions and thus confirmed the findings of a nation-wide survey conducted in 1998 that the majority (65%) of married women had had an induced abortion, and among women who had ever had abortion, 79% had had more than one. In the year 2000, each woman had 2.6 abortions, and according to study conducted within "Improvement of Reproductive Health of Women, Men and Young People in Armenia" in 2001-2002, only in Yerevan and the Ararat region, the figure was more than 3 abortions per woman.[133]

Important to note that there is a self-evident gap what concerns the registration and statistics of abortion. Though by 1971 WHO recommendation to include a provision on compulsory registration of each abortion case Armenian legislatures incorporated such provision in the Decree on Artificial Interruption of Pregnancy[134], there are discrepancies in the official statistics in Armenia. This is particularly true for self-induced abortions when most women, who have experienced self-induced abortion, are never referred to a health facility for medical care, therefore these kinds of unsafe abortions are not officially registered.[135] In Armenia, for example, the reported rate in a recent national survey, conducted by the WHO Regional Office for Europe, exceeded the rate reported to the Ministry of Health five times.[136]

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[128] "Derahasneri aroghjutyan pahpanumy geraka khndire hajastanum" ("*Protection of Adolescents' health Is a Priority in Armenia")*, For Family and Health Association, Report within framework of UNFPA Project "Improvement of Reproductive Health of Women, Men and Young People", 2002, p. %.

[129] Mini-abortion officially defined as a termination of early pregnancy by vacuum aspiration no later than 20 days after the expected menstruation and considered as induced abortion.

[130] "Unsafe abortion" is defined by the World Health Organization as a procedure of terminating the unwanted pregnancy either by persons lacking the necessary skills or in environment lacking the minimal medical standards or both.

[131] "Self-induced abortion" refers to the termination of pregnancy through a deliberate intervention by a woman intending to end her own pregnancy.

[132] Demographic and Health Survey, 2000, National Statistical Service, Armenia, Ministry of Health, Orc Macro, Calverton, Maryland, USA, p. 87.

[133] Interview with Meri Khachikyan, 6 April 2002. In: CEDAW Assessment Tool Report, Armenia, July 2002, American Bar Association/Central European and Eurasian Law Initiative (ABA/CEELI), p. 67.

[134] Decree by the Ministry of Health on "Artificial Interruption of Pregnancy", Clauses 6, 7, enacted 25.12.97.

[135] Reproductive Health Survey, 1997, by WHO, UNFPA and UNICEF, Yerevan, 1998, p. 23.

[136] *WHO Regional Strategy on Sexual and Reproductive Health*, WHO Regional Office for Europe, Reproductive Health/Pregnancy Programme, Copenhagen, Denmark, November 2001, p. 3.

While Armenia does not have restrictive laws on abortion, even under the liberal stance the women in reality face numerous obstacles in the access to safe abortion. The cost of abortion varies across Armenia between 10 and 80 USD depending on the hospital, the procedure, and the use of anaesthetic means. Though legally permitted only in maternity or hospital-based gynecological facilities and for most of uncomplicated cases, including mini-abortions, it is an outpatient procedure and patients are discharged from the clinics one or two hours after the abortion, due to financial constraints women often resort to unsafe and unhygienic self-induced abortions or abortions performed in unsafe environments (feldscher-obstetrical posts, rural ambulatories, private houses) with high risk of complications, some requiring immediate hospitalization and some leading to death. Lack of access to and affordability of essential obstetric care, as well as resort to low quality abortion lead to otherwise preventable maternal deaths.

In circumstances when abortion is legal as it is in Armenia, such abortion should be safe. Though by law the abortions must be provided by vacuum aspiration, there is still reliance by abortion providers on the dilation and curettage (D&C) method, while this has been virtually replaced in Western Europe by the quicker, easier and safer aspiration techniques.

The 1997 Reproductive Health Survey and 2000 Demographic and Health surveys found a number of determinants, as women's age, level of urbanization, residence, level of education, and socio-economic status of women influencing use of induced abortion. Whereas in 2000 the total abortion rate (TAR) was 2.6, rural TAR was more than 60% higher than urban rate.[137] This results, *inter alia*, from the high cost of abortion services, hindered access to quality services and poor educational level in rural areas.

While Armenian legislation regulates the provision of abortion services by woman's consent and prohibits any pressure or coercion in having abortion, the dominating traditional norms regulating family relations and values impact the woman's freedom in deciding on termination of her pregnancy, and men, particularly in rural areas or in less educated families, often have disproportionate influence over the decision of whether to have an abortion.

Nation-wide Reproductive Health Survey in 1997 showed that a one of reasons for abortion use has been sex preference: for the first abortions 9 abortions (1.2%) and for last abortions 6 cases (0.9%). Connected to this is another finding that significant proportion of women surveyed had the opinion that a woman has no right to terminate her pregnancy if her husband objects (43%) (Figure 3). It would be important to see statistics on the scope of the practices across the country.

Figure 3

[137] Demographic and Health Survey, 2000, National Statistical Service, Armenia, Ministry of Health, Orc Macro, Calverton, Maryland, USA, p. 87-90.

As seen from the findings of surveys conducted, the low level of awareness of reproductive health issues, lack of awareness and education, poor availability of family planning services and economic accessibility account for high incidence of abortions and are a barrier to moving from abortion to contraception.

Sexually transmitted diseases, including HIV/AIDS

Sexually transmitted infections (STIs) contribute both to infertility and to pregnancy-related complications, thus ensuring access to information and services geared to preventing sexually transmitted infections in women and men is an important part of making motherhood safer. In Armenia there were 161 cases of HIV registered between 1988 and 2001 and as of September 2002, the number of confirmed cased of HIV infection totalled 198 persons, however these may be the underestimate because the real number may exceed the officially registered ones.

Although the incidence rate is not high, the lack of awareness and education is a barrier to knowing the extent of the HIV/AIDS problem in Armenia. While as of 1997 survey the majority of respondents were aware of syphilisis (93%) and AIDS (96%), the remaining women did not have any notion of these diseases or had false ideas about infection transmission. As confirmed by the 2000 survey almost all respondents (94% of women and 97% of men) heard about HIV/AIDS, but only 62% of women and 73% of men believe there is a way to avoid HIV/AIDS, supporting a strong positive correlation between the educational level and such opinion.

Adolescents, residents of rural areas and never-married individuals are less likely to believe there is a way to avoid. Confidentiality is also critical in dealing with HIV/AIDS cases, and since fear, denial and shame that others may know about the condition may discourage the individuals to seek information and women are particularly vulnerable. The right to receive information and education on such matters is hampered in Armenia with the lack of formalized sexual education. Additionally, while entitled to equality to heath care services without discrimination on any grounds, people with STDs and HIV/AIDS bear the stigma and society's condemnation and have limited access.

Domestic Violence

It is recognized that health and reproductive rights of women are very closely linked to their social and legal status, and violence against women is a dangerous threat to their rights and health. CEDAW's General Recommendation 19 on violence against women calls "to ensure that measures are taken to prevent coercion in regard to fertility and reproduction."[138]

For the recent years in Armenia the domestic violence has become to be publicly discussed, especially by international donor or non-governmental organizations. While numerous studies and surveys revealed that domestic violence is a widespread and serious problem in Armenia, government officials at all levels either minimized the problem or consider it a matter of private concern within families outside of the reach of legal system.[139] Government of Armenia until now failed to acknowledge and address the matter of violence against women, which traditionally is a subject of taboo in Armenian society, although there have been many indicators of it being as serious a problem as in other societies.[140]

There are deficiencies in legal penalizing of domestic violence due to the sporadic and scattered nature of provisions in the different laws. There is no definition of domestic violence and in general, the legal

[138] United Nations, Report of the Committee on the Elimination of Discrimination Against Women (11th session) Doc. A/47/38 (1992).
[139] Domestic Violence in Armenia, December 2000, Minnesota Advocates for Human Rights, p. 6.
[140] CEDAW Concluding Observations, A/52/38/Rev.1 (1997).

system focuses on reconciling spouses in cases of domestic violence, rather than on penalizing the acts of abusers.[141] The domestic violence cases are charged under the criminal and administrative provisions carrying the lightest punishment and thus diminishing the weight of domestic assaults. Though divorce serves in many cases as escape from abuse, divorce procedures fail to take into account the domestic violence.

Women have hindered access to the legal system in cases of domestic violence and encounter difficulties through societal, institutional and traditional cultural pressures, discouraged from bringing claims, since the domestic violence is still perceived and enshrined in the Armenian mentality as a private matter and not in the public domain.

Survey by the Center for Women's Rights in 1998 revealed that with respect to autonomy in family planning issues 15% of women were imposed the decision to become pregnant, primarily by their mothers-in-law because they feared being subjected to violence by their husbands. The decision to terminate unwanted pregnancy was taken alone by husbands in 19% of cases, where 10% of women were afraid that their husband would resort to violence.[142]

As for the attitudes toward refusing sexual relations a more recent study showed that one-third of respondent men believed to have the right to get angry and reprimand wife, 20%- right to have sex with someone else, 6%-right to refuse financial support, and 3%-right to use force and have sex with wife against her will. Same survey went further to demonstrate the attitudes justifying wife beating for possible reasons as burning the food, arguing with him, going out without telling him, her neglecting the children, and refusing to have sexual relations. Whereas 22% of urban and 49% of rural women believe in one of justified reason for beating wife the men are more likely to agree with one reason for beating- 35% of urban and 52% of rural men.[143]

[141] Domestic Violence in Armenia, December 2000, Minnesota Advocates for Human Rights, p. 27.
[142] Women Status Report, Impact of Transition, Armenia, 1999, p. 39.
[143] Demographic and Health Survey, 2000, National Statistical Service, Armenia, Ministry of Health, Orc Macro, Calverton, Maryland, USA, p. 45-50.

CHAPTER IV CHALLENGES TO REALIZATION OF REPRODUCTIVE RIGHTS IN ARMENIA

4.1 Awareness of reproductive rights

The discourse on human rights is at a nascent stage in Armenia, especially rights related to reproduction. As examined by 1998 Survey "Do you really know your rights?" associated with domestic violence conducted by the Center for Women's Rights. Among respondent women (62% of the surveyed of reproductive age) only 1% were familiar with the Universal Declaration of Human Rights, 74% never heard of it and 25% had rather inadequate information about human rights. About 63% of the surveyed had no idea about their reproductive rights, however every third woman believed that her reproductive rights were protected, 28%- only partially protected, and 23% held the opposite opinion. 84% of women opined that it was necessary to know about their rights and 39% expressed wish to learn about methods of self-defense and resisting violence. Another recent sociological survey by the Center as part of the study of domestic violence in Armenia examined also the knowledge about women's rights and family life and revealed that the main sources of such information is books (10.9% and 5.1% respectively), mass media (10.6% and 7.01%), talks with friends (10.5% and 7.5%), whereas school was the least occurring source of information (2.7% for women's rights and 1.81% for family life). Concurrently, within 3 groups of women according to possessing sufficient knowledge of family and women's rights, the women who are satisfied with their knowledge consult books regularly in contrast to women who are dissatisfied with their knowledge and resort mostly to TV programs and conversations with friends.

In addition, knowledge about women's rights and marital relations different among 3 groups of respondent women-from smaller cities, smaller cities and villages and the capital Yerevan. For the first group TV is more frequent source of information, for the second group prefer to enhance their knowledge by special TV programs and the group from the capital prefers to consult special services free of charge. Interestingly, women without higher education believe they have become more deprived of their rights, more unprotected and more oppressed by men.[144]

Lack of awareness on reproductive rights is revealed by a number of epidemiological surveys and studies on reproductive health issues as discussed in the previous Chapter. Awareness of women's rights however has increased over the past decade. This is contributed to the emergence of autonomous activities mainly by the international and local non-governmental organizations focused on a set of issues of women's rights, empowerment and gender equality that have never been discussed openly. The contributing factors to this increase include the ratification of the CEDAW in 1993, filing country report to the CEDAW Committee, World Conference on Human Rights, Vienna in 1993, participation of Armenian delegation in the Beijing Conference on Women in 1995 and Fifth Asian and Pacific Population Conference, Bangkok in 2002, as well as activities of different NGOs focusing on women's rights.

4.2 Conglomerate of Underlying Factors: Legal, Economic, Social and Cultural

As shown, transition to a democratic society and market economy has had adverse effect on women. The important barriers to the implementation of reproductive rights, among others, are the economic constraints to access and afford the reproductive health services, disproportionate effect of unemployment on women, decline of living standards, lack of women's empowerment, self-perpetuated discrimination and lack of legal culture of recourse to the legal system, etc, all this stronger, in particular, in rural areas.

[144] A. Adibekyan, A. Davtyan, *Violence Against Women in Armenia*, Yerevan, 2001, Women's Rights Center and Sociometer Sociological Center.

The immediate effect of the competitive politics introduced as a result of democratization in Armenia had also high burden on the position of women.[145]

Social mores of the population make it difficult to achieve true equality in Armenian society. The traditional customs, practices and socio-cultural norms, which still maintain discrimination against women within family, stereotypes of social roles and customary beliefs in male privilege and female inferiority are still prevalent in Armenia and serve to the detriment of exercise of women's reproductive rights. Customs and culture are of particular concern with respect to the reproductive choice exercised by Armenian women, since the reproductive behavior of couples and individuals is in practice traditionally shaped by implicit societal signals and rules.

Indeed, even in instances when by law the rights are safeguarded, the custom holds firm in many aspects of Armenian life. As a former Soviet country, Armenia still carries the legacy of the past in terms of controversial assortment of gender norms "woman-worker-mother" and stereotypes of "Armenian noble woman in the role of mother", where the gender culture of equal rights is yet not achieved. To this end, the CEDAW Committee stressed cultural stereotypes, which overemphasized the traditional role of women as mothers in a protective and restrictive way. While involved, lack empowerment shown also in family power dynamics, where women are not the main decision makers with regard to family size, spacing of children and fertility, but have to consider other kin members.

The extent to which a free decision can be in fact made in light of the socio-economic hardships and social pressures is a valid concern. However, the Armenian government by adhering to the binding international human rights treaties has the obligation, regardless of political, economic and cultural systems, to promote and protect all human rights and fundamental freedoms.

Though the recognition of the value of patient autonomy has gained strength in Armenia the reproductive health services are still rendered with paternalistic approach towards women and reproductive decisions, including choice of family planning methods, are made with the full involvement of health care providers as legacy from the Soviet regime.

4.3 Reproductive rights: subject of studies

The past decade has witnessed increased concentration on women's issues, women's health and their status and role in the society. Recently the number of researches and studies on Armenian women in transition, their standing and needs has been growing. As basis for the current research paper, the recent researches and studies provide more data on the status of women, including statistics disaggregated by gender, as well as a series of reports, surveys and analyses of women's situation conducted with support of the United Nations Agencies, other international and local non-governmental organizations.
According to the recommendations of Bali Declaration[146] and ICPD Programme of Action the Armenian government supports the National Statistical Service to produce comprehensive statistical data on key aspects of population and socio-economic development. Mainly, cooperation among research institutions, international organizations, and NGOs supported the data collection on poverty related, reproductive health/family planning issues to design policy interventions in these areas.[147]

[145] Concluding observations of the Human Rights Committee: Armenia. 19/11/98. CCPR/C/79/Add.100. (Concluding Observations/Comments).
[146] Bali Declaration on Population and Sustainable Development, Fourth Asian and Pacific Population Conference, 1992 Bali, Indonesia, United Nations.
[147] *Country Report on Population, Poverty and Development*, Republic of Armenia, Fifth Asian and pacific Population Conference, Bangkok, 11-17 December 2002.

Reproductive health has also become an issue of major concern in Armenia. However, comprehensive investigation into the issue of reproductive rights, correlation of human rights and reproductive health remains an uncharted area on the map of the current national reproductive health policy of Armenia.

The first nation-wide population-based Reproductive Health Survey 1997 serves as one of primary reference points for studies and assessments in the field of reproductive health in Armenia providing data on knowledge, attitudes, beliefs, and current practices by Armenian population with an overview also of select survey results with important implications for reproductive health promotion. In Chapter VII it mentions 'reproductive rights' and provides a short assessment of the awareness, basically focusing only on the right to abortion, right to have or not to have children, along with the awareness and knowledge of sexuality, family planning and reproductive health.

The representative Demographic and Health Survey 2000 as a single integrated set of demographic and health data at nation-wide level also provides useful epidemiological data in almost all reproductive health components and indicates main trends in reproductive health behavior, variables according to different primary and background characteristics (level of education, place of residence, urban vs. rural, age, etc.), and per its objectives can be used to provide information needed to evaluate existing social programs and to design new strategies to improve health programs.

Though record and information on status of rights, including those related to reproduction, in Armenia can be found also in a series of documents as Health Profile Report 2000, Women 2000, Women Status Report 1999, Human Development Report 2000, Situation Analysis of Children and Women in Armenia 1998, which cover to different extent the status of women in Armenia. The adequate understanding and knowledge of concept of reproductive rights, their safeguards in international human rights instruments to which at least Armenia has acceded to, the consequences of their condone or violation as to the women's reproductive health and empowerment and coverage and application of human rights framework is absent.

In defining priorities most of research has been limited by the analysis of mortality, morbidity and disability.[148] The preliminary finding of this research is the surveys and researches all focused on reproductive health rather than the rights involved in reproductive life. For instance, while the studies in Armenia have mostly focused on identifying abortion trends, determining the incidence of unsafe abortions and self-induced abortions, none of researches or surveys addressed the violation of human rights in abortion cases. Most of researches and studies have concentrated on reproductive health statistical indices, percentages, rates and ratios and are lacking sound and targeted research aimed to patients' rights in general, and in particular those to identify the situation on reproductive rights and their connection to reproductive health status, and to systematize the revealed underlying social, cultural and behavioral factors. There have been no research or studies that can shed light on the extent to which laws are known among whose lives are most affected by them. The RA Law on Reproductive Rights and Health is in place but its practical significance for its beneficiaries is unknown.

As shown, though the Armenian legislation is supportive to reproductive rights to some extent, among barriers to improving women's reproductive rights enforcement are often social, economic, cultural and related conditions that transcend health considerations. Under such conditions, targeted social-science rights researches can disclose gaps between rights that Armenian government claims that women enjoy and the reality of neglect of women's rights related to reproductive choice, to assess the practical implications of underlying impediment factors for reproductive health and choice and to focus on obligations undertaken by the Armenian government in agreeing to implement various human rights

[148] R.B. Saltman & J. Figeyras, *Reformi Sistemi Zdravokhranenia v Evrope, Analiz Sovremennikh Strategiy (European Health Care Reforms: Analysis of Current Strategies),* World Health Organization Regional Office for Europe, 'Geotar Medicine', Moscow, 2000, p. 174.

instruments that have a bearing on reproductive rights, to help to provide an understanding of the potential and the limitations of the law to empower women, rather than of the law solely as an instrument for protecting the *status quo* or for seeking social change. Especially when adopting new laws related to reproductive rights and health debates about what that law on women's health is and what it should be allow to explore the contested visions of women's roles and identities in personal, family and public lives.

This imperative bases upon universal recognition that social science and legal researches, particularly with a gender approach, have been helpful to understanding how these underlying socio-legal-cultural causes affect women's reproductive status and autonomy, to afford a more complete understanding of women's experiences of reproductive health and illness. Social science research findings are critical to the rights framework since they provide scientific evidence to assess the realization of reproductive rights and can a basis for public action in areas of sexual and reproductive health and choice.[149]

4.4 Inadequate national machinery: laws and institutional framework

There is an intimate relationship between the general human rights observance in the country and the status of women's rights protection. Though Armenia made considerable progress in bringing its legislation in line with its international obligations, in most spheres Armenia still applies the legislation inherited from the Soviet times with modifications to eliminate the contradictions between the old legislation and newly developing democratization.

What concerns the available human rights guarantees in Armenia, there is a new Constitution yet there seems to be no constitutionalism; there are new laws, yet the rights float in a normative vacuum appearing as mere political promises or declarations toward a democratic society and the courts do not have experience in directly applying the constitution. The Constitutional Court cannot ensure effective compliance with constitutional human rights safeguards, cannot accept individual complaints but only cases proposed by the President, by two-thirds of all parliamentary deputies. In addition, the judiciary is subject to political pressure and does not enforce constitutional protections effectively. Authorities do not respect constitutional protections regarding privacy and due process, the independence of the judiciary is not fully guaranteed.[150]

Though the legislation is indicative of the recent development of emphasis on the patients' rights and reproductive rights, however as shown by the analysis it lacks enforcement mechanisms and practically is abstracted from the realization of rights in practice, with lack of complaints, appeal and other procedural safeguards. In existing legislative statutes and acts stipulated rights and national norms are introduced with the main emphasis on the standards and not the legitimate rights, which means that the success of such provisions will depend upon the quality of mechanisms and procedures. Procedures appear "formalities"- therefore less important, whereas consideration of procedures and mechanisms leads to serious consequences. Especially for the recently adopted "Law on Reproductive Health and Rights" the success of statutes will depend upon the quality of mechanisms and procedures for executing the envisaged rights.

There is no a specific national machinery/special institution responsible for the protection of women's rights, for the advancement of women and the elimination of discrimination against women. The existing Women's Council at the Prime Minister's, composed of mostly female politicians and NGO leaders, possesses solely advisory capacity. Related to this is the operation of the Government Commission on

[149] Jejeebhoy S.J. The Importance of Social Science Research in the Promotion of Sexual and Reproductive Choice of Adolescents. *Medicine and Law*, 1999, 18:255-275 at 256.

[150] Country Reports on Human Rights Practices- 2001, Released by the Bureau of Democracy, Human Rights, and Labor March 4, 2002, URL: http://www.state.gov/g/drl/rls/hrrpt/2001/eur/8221.htm.

Development of Gender Policy[151] mandated to develop multi-sectoral gender policy in Armenia and promote inter-agency cooperation.

The Human Rights Commission at the President's Office currently headed by Mr. Vahan Asryan, has been established since 1998. The commission exists essentially as a reference bureau and has no formal legal powers; however, it has had a modest impact in persuading authorities to review official actions on problems ranging from apartment allocations to police behaviour, in some cases winning official reconsideration. The Commission refers such cases to the appropriate agency, but it does not follow up on specific issues.[152] It is not particularly popular among the public, and though it receives claims by citizens there was no any lawsuits on women's rights.

The Human Rights Department within the Ministry of Foreign Affairs does not deal with citizens' complaints. The draft law on establishment of the Office of Ombudsperson[153] the human rights is still under review and it is not clear yet what powers the Ombudsperson is entrusted with and what mechanisms of protection and remedies will be available in practice and whether it will take a lead in dealing not only with general human rights cases but with gender-specific and patients' rights as well.

Concurrently, in Armenia there is a low level of legal culture within the population, lack of understanding for the modern concept of liberal democracy, legal nihilism, the highly political and ideological approach to the law and legal process, and the fact that the law is still considered as an expression of one's ideology. In relation to the legal culture, there has been no litigation or claims of reproductive rights violation. There are no specific programs on reproductive rights or patients' rights for practicing legal professionals to take on such cases either.

There are two interrelated conditions to the advancement of reproductive health through human rights. First, it must be recognized that simply describing a claim as human right does not per se give it the legal force, but gathers legitimacy from national law and obligations undertaken by acceding to binding international human rights treaties. Second, it must be also recognized that claims to human rights arise from within their own culture, traditions and national law and state's duties are not an imposition from outside.[154]

4.5 Moving Forward

While the preliminary research presents the context, in light of all of these challenges, in which to evaluate reproductive health and rights situation and enforcement of reproductive rights in Armenia, it has hopefully drawn attention to the legitimacy of reproductive rights and importance of human rights dimension to women's health. However, it does not purport to leave the discussion without mentioning the major positive signs demonstrated in Armenia with respect to reproductive health.

In 1995, the Government of Armenia with UNFPA assistance developed and adopted the first National Programme on Reproductive Health on the basis of the ICPD Cairo Programme of Action recommendations, as well as other relevant programmes, laws and decrees of the Government. The

[151] Established by Prime Minister's Decree No. 360, August 6, 1997.
[152] Human Rights Watch Report 2001, URL: http://hrw.org/wr2k2/europe2.html.
[153] Ombudsman- a mediator between the particular structures including consultation provided to patients on the issues of the compliance with the law, their rights and assistance in filing complaints or applications for compensation. For more information, see Appendix on Ombudsman.
[154] Rebecca Cook, *Advancing Safe Motherhood Through Human Rights,* In: Planned Parenthood, Challenges, "Save Motherhood", 1998/1.

Government has established an institutional framework to deal with the RH issues through the National RH Coordination Committee.

A number of documents, action plans, programs, creation of institutions and other national initiatives were approved to improve the status of women and define mechanisms for the realization of opportunities for women since accession to the Women's Convention, including the following. The first two documents constitute framework for implementation of Beijing commitments and as of 1999 number of activities endorsed by them have been achieved and/or were being implemented.[155]

- "National Platform on Improvement of Women's Status in the Republic of Armenia", No. 242 of 15 April 1998;
- "National Plan of Action on Improvement of Women's Status and their Empowerment, for the years 1998-2000", No. 406 of 26 June 1998;
- National Program of Reproductive Health Improvement, Perinatal Medical Aid Program, 2000-2005;
- National Parliament adopted new Law on Reproductive Health and Reproductive Rights, November 2002;
- Council on Women in the Prime Minister's Cabinet, created in December 2000, Presidential Decree no. 862;
- Commission on Human Rights at the President's Cabinet, established in 1998;
- Department of Women, Children and Family at the Ministry of Social Security.

In 1995 UN Inter-agency Theme Group on Gender was established (UNDP, UNHCR, UNICEF, WFP, UNDPI, and UNFPA). Other Theme Groups bring together the Government, UN Agencies, donor community and NGOs and serve as a main tool for coordination, strengthening of existing and building of new partnerships.

UNFPA in particular has been mandated to focus on improvement of reproductive health in Armenia. Among its framework the main projects are: ARM/95/P01 "Strengthening of Reproductive Health Services in Armenia", ARM/01/P01 "Improvement of Sexual and Reproductive Health of Women, men and young people" (2001-2004), as well as separate initiatives funded by UNFPA aimed at strengthening preventive programs promoting women's health, gender-sensitive campaigns, promoting research and information on women's health, increasing resources and monitoring follow-up for women's health, etc.

On the front of adolescents' reproductive health, the Ministry of Health of Armenia has undertaken three-prong strategy to meet the needs of adolescents:

- To promote most positive attitudes and support from the civil society and mass media towards sexual education of adolescents and consulting;
- To improve the awareness, communication and counseling skills with respect sexuality and sexual and reproductive health among teachers, students and health care providers;
- To increase opportunities for young people to use accessible means of information on sexual and reproductive health, education, friendly consultations and treatment, prevention of unwanted pregnancies, abortion, STDs and AIDS/HIV.

[155] *UNFPA Support to Implementation of the Beijing Platform of Action*, UNFPA Report, Yerevan, 1999. However, due to financial constraints and malfunctioning of monitoring mechanisms the implementation of Plan of Action has been slowed down, with little follow-up and no final report.

To this end, UNFPA-supported project on “Improvement of Sexual and Reproductive Health of Women, men and young people” aims to improve the accessibility of information and education on sexual and reproductive issues for the young people.

In April 2002 the Government of Armenia approved the National Strategic Plan to serve as a basis for the National Programme on HIV/AIDS Prevention 2002-2006 and began its implementation.

The civil sector community has been also growing and there is a number of NGOs specializing in sexual and reproductive health and gender issues, education, domestic violence, etc. and representing a rich resource for building partnerships for implementation of the commitments towards improvement of women’s status and lives in Armenia.

CONCLUSIONS AND RECOMMENDATIONS

The current research has shown lack of proactively mainstreaming human rights and gender aspects into and applying those frameworks when designing reproductive health policy, during provision of reproductive health services and implementing all-national or regional surveys/studies.

1) The reproductive rights are not thoroughly analyzed in Armenia and lack systematic examination. Reproductive health and poverty-related researches and statistics with underlying medical factors, as opposed to rights-related data, are discussed and analyzed more in Armenia. In particular, there is lack of statistics, research and studies on perception and awareness of reproductive rights and their application in the day-to-day lives, including not only rights involved in family planning, decision-making, but also safe motherhood.

- A necessary step towards applying human rights to advance reproductive health is to examine the research infrastructure in Armenia to improve upon and strengthen capacity to establish a sound knowledge basis for reproductive health and rights policy and practice.
- Social science rights-oriented researches should be encouraged and funded to reveal discrepancies between rights, by which Armenia binds itself and the real choices women can, in practice, make, and to inform on the duty to provide effective remedies for violations of reproductive rights.

2) Abortion is one of major concerns in reproductive health of Armenia and remains the most popular method of fertility regulation and unsafe abortion is one of causes contributing to maternal mortality. There is no data on how injuries, negligence or professional misconduct in abortion cases bringing maternal death or health injuries are addressed, what approaches (regulatory, disciplinary, civil law, criminal law, alternative dispute resolution) in practice are more applied to protect a woman's right to liberty and security, right to life and right to health.

- More disintegrated data is needed on the resort to execution of the rights applicable to abortion in Armenia through judicial and non-judicial means, as well as claims to remedy accountable for maternal deaths.

3) Despite the Armenian legislature's stance characterized by the adherence to legally binding provisions on right to education, in practice there is resistance to a general overall policy and unified practice regarding sexual health and reproductive rights education. Particular non-governmental organizations and associations conduct individual programs in this field but their work is fragmented and is not regulated on the national level. It is not clear whether the "Life Skills" Course in select schools will incorporate sexual health or family planning education elements. The human rights education lacks efficient implementation in schools.

- Given the proven interrelation between the education and reproductive choice, the education at the national school level should include the sexual health components.
- The government should consider exert special and systematic efforts in ensuring that the compulsory human rights education in schools is effectively implemented and establish monitoring and evaluation procedures.

4) As shown by the research there is lack of awareness among health care professionals, supporting health care personnel, pharmacists, teachers, researchers and general public on reproductive rights, benefits of the sexual health, human rights education and family planning information respectively.

- The government should promote the reproductive rights among reproductive health care providers and encourage efforts to include those in the training curricula of health care professionals, to make clear the connection between the human rights language and reproductive health programs issues.
- Proper awareness, education and training on reproductive rights among general public, both women and men, on reproductive rights is dictated as necessary, considering the increasing number of studies/researches by independent NGOs in Armenia on issues, which indirectly or directly involve reproductive rights.

5) Analysis of the existing legislation applicable to the reproductive health demonstrates a mix of the Soviet legacies and new Armenian laws passed and separate provisions amended since the independence. While not overtly contradicting international human rights norms with respect to women, they do not contain strong equality between men and women and anti-discrimination clauses and lack the definitions of discrimination and domestic violence.

- Reconsider the law provisions inclusive of reproductive rights to fit to the new realities of Armenia and comply with the international human rights treaties.
- With respect to family law code, based on implications revealed by the research, the marriageable age 17 set for women should be in line with other law provisions (e.g. on legal majority age).

6) Deep-rooted traditional practices, gender stereotypes, cultural beliefs and conservative social mores sometimes hinder the reproductive rights even when they are in principle protected by law and often constitute the causes of *de facto* discrimination and distorted power dynamics in own health care decisions, marriage, family life, use of family planning services, as well as inadequate understanding of shared rights and responsibilities between men and women.

- Although cultural and traditional barriers to reproductive choice are significant in the Armenian reality, they are not insurmountable and can be overcome by the appropriate education and awareness campaigns at least to the extent that cultural norms though influence reproductive rights may be freely accepted by individuals, but cannot be imposed on those who choose not to act according to them.

7) In view of dimensions of the reproductive health problems in Armenia, a multifaceted and interdisciplinary strategy, rather than merely medical one, can lead to improvements. In Armenia there is a need for development of appropriate rights-oriented and gender-sensitive reproductive health policy.

- Reproductive health professionals and human rights activists should coordinate and intensify their efforts to work more effectively to achieve an advance towards application of human rights framework to reproductive health.
- Information activities should not be part of merely reproductive health sector, including projects implemented by funds of international donor organizations, but involve the education and human rights sectors. Health education authorities should cooperate closely with the media to maintain continuous and intensive distribution and coverage. Such efforts should also take into account the rural context and special needs.

8) Legislation and reproductive health services are not appropriate to needs of all strata of population. The rural context- with the lack of financial viability and resources, disadvantaged quality of health care services compared to the urban areas, lack of training of health care providers and lower level of awareness on family planning and sexual/reproductive health and rights in general- demands additional considerations for rural population, especially vulnerable or marginalized groups, which are not covered by the current legislation and practices.

9) Legal safeguards for reproductive rights are in practice inadequate to protect reproductive autonomy, choice and safe motherhood. The secured rights are not backed up with efficient enforcement mechanisms, which due to other factors hinder the exercise of these rights in practice. As shown the real issue is not the inclusion but the reinforcement offered for rights. The enforcement of the reproductive rights remains rudimentary.

- Development of adequate national machinery to deal with women's rights, including reproductive rights in compliance with international human rights standards and to oversee implementation of Armenia's obligations with respect to reproductive rights.
- There is a need for non-judicial mechanisms for the protection of human rights (Ombudsman or the Patients' Rights Advocate), strengthening the existing national human rights institutions and bodies responsible for women's issues.
- Government should pay more attention to the obligations undertaken by Armenia when acceding to CEDAW and core international human rights instruments relevant to reproductive health.

ANNEX 1

International Instruments Relevant To The Protection And Promotion Of Reproductive Interests.

Derived from the Universal Declaration are:

- International Covenant on Civil and Political Rights (the Political Covenant) [156]
- International Covenant on Economic, Social and Cultural Rights (the Economic Covenant)[157]
- International Convention on the Elimination of All Forms of Racial Discrimination (the Race Convention)[158]
- Convention on the Rights of the Child (the Children's Convention)[159]

Regional human rights conventions of legal force also inspired by the values of the Universal Declaration include:

- European Convention for the Protection of Human Rights and Fundamental Freedoms (the ECHR),[160]
- European Social Charter - Revised (the European Charter),[161]
- American Convention on Human Rights (the American Convention),[162]
- Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (the Protocol of San Salvador),[163]
- Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women (the Convention of Belém Do Pará),[164] and
- African Charter on Human and Peoples' Rights (the African Charter).[165]

[156] 16 December 1966, 999 UNTS 171, *entered into force* 23 March 1976.
[157] 16 December 1966, 993 UNTS 3, *entered into force* 23 March 1976.
[158] 21 December 1965, 660 UNTS 195, *entered into force* 4 January 1969.
[159] 20 November 1989, 1577 UNTS 3, *entered into force* 2 September 1990.
[160] 4 November 1940, 213 UNTS 222, *entered into force* 3 September 1953, as amended by Protocol Nos. 3, 5 and 8, *entered into force* 21 September 1970, 20 December 1971 and 1 January 1990, respectively.
[161] (1996) E.T.S. No. 163, *entered into force* 1999.
[162] (1969) O.A.S.T.S. 1, *entered into force* 18 July 1978.
[163] O.A.S.T.S. No. 69 (1988), signed Nov 17, 1988. Reprinted in: Basic Documents Pertaining to Human Rights in the Inter-American System, OEA/Ser. L. V./II.82, doc. 6 rev. 1 at p. 67 (1992).
[164] Known as the *Convention of Belùm do Paŕo* for the place of its adoption, opened for signature June 9, 1994, *entered into force* March 5, 1995, OAS Treaties Register A 61; 33 I.L.M. 1534 (1994).
[165] 27 June 1981, O.A.U. Doc. CAB/LEG/67/3 Rev. 5, 21 I.L.M. 58 (1982), *entered into force* 21 October 1986.

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