



REPORT

PUBLIC INQUIRY INTO ENJOYMENT OF SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN ARMENIA

Yerevan
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The public inquiry has been conducted within the framework of the United Nations Population Fund Strengthening of Sexual and Reproductive Health Services project in collaboration with Staff of the Human Rights Defender of the RA.

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LIST OF ABBREVIATIONS

ADHS	Armenia Demographic and Health Survey
ANC	Ante-natal care
CAT	Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
CEDAW	Convention on Elimination of all forms of Discrimination against Women
CRC	Convention on the Rights of the Child
FAPs	Feldsher Midwifery posts
FGD	Focus Group Discussion
FP	planning services
GoA	The Government of Armenia
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development-Cairo
IDI	In-Depth Interview
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
MDG	Millennium Development Goals
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
NGO	nongovernmental organizations
OB/GYNs	Obstetritian-Gynecologists
SRB	skewed sex ratio at birth
SRH	sexual and reproductive health
SRHR	sexual and reproductive health and rights
STI	sexually transmitted infections
UNECE	United Nations Economic Commission for Europe
UNFPA	United Nations Population Fund
WHO	World Health Organization

EXECUTIVE SUMMARY

1. Maternal Health Care to Ensure Safe Pregnancy and Childbirth

Ante-natal care, delivery assistance, emergency obstetric care, and post-natal care are among critical components required to reduce maternal mortality recognized by the International Conference on Population and Development.

According to the Armenian National Statistics Service, Maternal Mortality Ratio Armenia on a 3-year average basis was 18.5 in 2014. The ratio has declined over the last decade. However, the progress is slower than it was projected by the Government of Armenia and the MDG 5A target by 2015.

Our Inquiry shows that Armenia made considerable progress in addressing factors behind maternal morbidity and mortality. The main achievements include introduction of the “State Maternity Certificate” offering free of charge maternal health care services, availability of skilled medical care for almost all pregnant women and appropriate referral system in place, as well as favorable laws and policies. The introduction of continuous professional development for medical personnel provides another opportunity to continuously improve their practice and care of patients.

However, there are still major issues of quality of care to be addressed. Although the Ministry of Health started to develop standards and guidelines on provision of medical services from 2011, the available clinical guidelines on maternal health care, on the national level, do not cover the whole field. Also, the current practices on defining medical malpractice and negligence are not well-defined, and leave loopholes for avoiding liability in cases of maternal morbidity and mortality.

Evidence from the Inquiry also demonstrates that not all maternity centers in the regions of Armenia have renovated buildings and facilities, and most importantly, updated diagnostic equipment. There is a lack of neonatologists and anesthesiologists in regions. Additionally, maternity centers generally receive the cheapest drugs, which cause concerns

from the medical community. The Inquiry also reports excessive use of caesarian section operations in Armenia with an upward trend during the last five years.

Our Inquiry obtained information regarding discriminatory attitudes toward HIV positive pregnant women. We also received public submissions indicating that accessibility of reproductive medical services is generally inadequate for women with disabilities in Armenia. The cases of violation of the patient's right to receive consultation in private environment, not providing comprehensive information to make informed decisions and discrimination against poorer patients who use State sponsored "Maternity Certificate" vs. those who pay out of pocket is also very disturbing.

2. Access to Family Planning: Access to Contraceptive Information and Service

The World Health Organization includes access to family planning services in its definition of what constitutes the universal access to SRH services. In its definition, WHO defines universal access to SRH services to include prevention, diagnosis, counseling, treatment and care services related to: ante-natal, prenatal, postpartum and newborn care; family planning services including infertility and contraception; elimination of unsafe abortions; prevention and treatment of STIs, HIV/AIDS, cervical cancer etc. and the promotion of healthy sexuality.

During the last 5 years indices of the uptake of contraceptive methods have changed. In contrast to 53.0% in 2005, ADHS 2010 results show that only 55.0% of married women (15-49 years old) use any contraceptive method. But in 2010 the contraceptive prevalence rate among married women has been fallen in comparison with ADHS 2000 results (61.0%). During the last 10 years the rate of the uptake of traditional contraceptive methods has been decreased from 38.0% in 2000 to 28.0% in 2010.

Evidence gathered during the public inquiry indicates that despite of definite changes in the levels of use of family planning in the past decade, there are major barriers in accessing family planning services. It is notable that family planning services are not universally accessi-

ble, available and affordable across the country. Evidence suggests that gender inequities, cultural norms and beliefs, lack of accurate information about FP, lack of routine supplies of FP commodities, unavailability of comprehensive FP services in lowest levels of health care system, the low level of the state budget allocations for health care, non-sufficient financing of family planning, non-sufficient accessibility of health care services and professional medical aid regarding family planning for rural population, non-sufficient level of material and technical saturation are some of the commonest barriers to accessing family planning services.

Although the majority of the physicians who participated in our interviews noted that many of the women who came for consultation were informed about contraceptive methods and their use, our interviews revealed that in some cases this information doesn't come from physicians.

Our Inquiry revealed that long distances between their homes and the reproductive health service centers are a serious problem for obtaining family planning services. Moreover, it is easier for citizens with education and enough financial resources to obtain modern contraception information and services than for women who live in villages in poverty or with little family income.

The inquiry also revealed that sometimes men hindered the uptake of family planning services. In other words, it emerged that among women who desire to use contraception; most were denied of the access to the mentioned services by their spouses.

3. Abortion and Post-abortion Care

Each year, almost 20 million unsafe abortions take place. This leads to the death of 47,000 women worldwide and causes disabilities due to complications to another 5 million. Unsafe abortions and associated morbidity and mortality in women are avoidable. Safe abortion services and post-abortion care should be available and accessible for all women of all ages, to the full extent of the law.

The Inquiry established that while the state has made some positive achievements in the context of abortion services, more efforts are

needed. The rate of abortion in Armenia has decreased in Armenia, but it still remains high. Induced abortion has a prominent place in the regulation of fertility in Armenia, with a total abortion rate of about 0.8. From the period of 2007 to 2010, approximately 3 out of 10 pregnancies (29%) resulted in abortion. The high rates of induced abortions and its use as a family planning method in Armenia is related to the limited access to family planning services and information (including misinformation and prejudice), and the non-affordability of modern contraceptive method.

The Inquiry also established that the rate of drug induced unsafe abortions using Cytotec (Misoprostol) is very high. Although its sale is banned without a doctor's prescription, the drug is readily available at pharmacies. The improper use of Cytotec has led to many cases of complications such as hemorrhage and incomplete abortions.

The most serious issue facing Armenia in the context of abortions is the sex-selective abortions, which finds its roots in a culture of gender inequality and reinforces the climate of violence against women. Every year, almost each year, over 1400 girls are not being born in Armenia due to this phenomenon. By the year 2060 nearly 93,000 women will be missing in Armenia if the trend of sex-selective or pre-natal sex selection remains unchanged. Sex-selective abortions in Armenia are closely related to forced abortions. Women are sometimes forced by their husbands and their families to abort female fetuses.

4. Adolescents Sexual and Reproductive Health Rights including Comprehensive Sexuality Education

According to the UN Population Fund estimates, today's adolescents comprise approximately one quarter of the world population. Among others, reproductive ill health is included in the major cause of morbidity and mortality among adolescents. It is noted that adolescents face significant challenges in accessing good quality reproductive health services and comprehensive sexuality education worldwide.

Despite certain improvements in the access to health care facilities significant barriers still remain. Such barriers include limited physical accessibility at some facilities and schools, financial costs associated

with transportation, treatment (for some segment of adolescents) and lack of accurate sources of factual information on reproductive health for adolescents.

During the conduction of this inquiry we were unable to depict the specific mechanisms that help the professionals assure the confidentiality of the adolescents. No institutional or nationally approved mechanisms were identified. Absence of such mechanisms may enable violations of the right of an individual to confidential and private services.

The mode and depth of delivery of the reproductive health education section somehow varied depending on the values and attitude of the teacher regarding the subject matter. The teachers often adopted the content of the materials for children with mental disabilities. However, criteria for such adaptations were not uniform and often depended on the experience and the views of the teachers.

1 | INTRODUCTION

Under the overall guidance and direct supervision of the inquiry panel representatives from the Office of the Human Rights Defender of Armenia and the United Nations Population Fund (UNFPA), the team of national consultants conducted a public inquiry into the enjoyment of sexual and reproductive health rights (SRHR) in Armenia, including preparatory analyses of data and human rights obligations of Armenia.

The Inquiry was conducted on the basis of UNFPA’s Concept Note in line with the UNFPA “Guide in support of National Human Rights Institutions; Country assessments and national inquiries on Human Rights in the context of sexual and reproductive health and well-being”.

This report presents the findings of the Public Inquiry into enjoyment of SRHR in Armenia. The Inquiry was conducted to enable the Office of the Human Rights Defender to review the status of sexual and reproductive health and rights issues in a comprehensive manner through a public inquiry and, subsequently, to provide appropriate recommendations for positive change.

The general aim of this Inquiry was to gather and assess existing data and the evidence base from the public inquiry for informed policy making and media campaigns concerning SRHR in Armenia. The objectives of this Inquiry include:

- ✓ Assessment of the availability, accessibility and quality of sexual and reproductive health services in Armenia
- ✓ Evaluation of the extent to which the government is complying with its obligations relating to sexual and reproductive health rights in Armenia;
- ✓ Identification and documentation of sexual and reproductive health rights violation cases in Armenia

Provision of appropriate recommendations based on the Inquiry findings.

Contextualizing Sexual and Reproductive Rights: Various definitions of sexual and reproductive health rights have been profiled.

However, there is no agreed definition of what encompasses SRHRs as their realization is premised upon the realization of those rights already recognized. For purposes of this inquiry however, the definition of the United Nations International Conference on Population and Development-Cairo (ICPD) of 1994¹ was adopted: “Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other relevant United Nations consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right of all to make decisions concerning reproduction free of discrimination, coercion and violence as expressed in human rights documents.”¹

The ICPD 1994 further elaborates that reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.²

Reproductive Health Care is also further defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases.

Rights related to sexual and reproductive health which are provided in various treaties and conventions are: 1) the right to life, 2) the right to education and information, 3) the right to equality and non-discrimination, 4) the right to health (mentioned as part of the right to adequate standard of living in the Universal Declaration of Human Rights in

¹ International Conference on Population and Development (ICPD) Programme of Action, available at: <http://www.un.org/popin/icpd/conference/offeng/poa.html>

² *Ibid*

1948)³, 5) the right to decide the number and spacing of children, 6) the right to consent to marriage and equality between the spouses, 7) the right to privacy, 8) the right to be free from torture or other cruel, inhuman, or degrading treatment or punishment, 9) the right to be free from practices that harm women and girls, 10) the right to be free from sexual and gender-based violence, 11) the right to an effective remedy.⁴

³ The Universal Declaration of Human Rights, available at: <http://www.un.org/en/universal-declaration-human-rights/>

⁴ *Ibid*

2 | METHODOLOGY

Public hearings and inquiries can be defined as investigations conducted by governmentally mandated bodies to assess important social issues or technologies.⁵ The public hearing or inquiry process emerged in Great Britain in the 18th to 19th centuries.⁶ “A national inquiry is a transparent, public participatory investigation of systematic human rights problems the purpose of which is to identify the factors underlining human rights violations and make recommendations for positive change.”⁷ The specific scope of the inquiry was the investigation of Human Rights Violations pertaining to sexual and reproductive health in the following four thematic areas: Access to contraceptive information and services, Maternal Health Care: Ensuring Safe Pregnancy and Childbirth, Abortion and post Abortion Care, Adolescent Sexual and Reproductive Health including Comprehensive Sexuality Education. Within each thematic area the following subthemes will be mainstreamed: gender, disability and social vulnerability.

2.1. Conceptual framework

The investigation in each thematic area evolved around factors that enable human rights violations. The three-part (human rights) framework⁸ that includes state obligations of respect, protect and fulfill was embedded in enabling factors as a further expansion of the conceptual framework. The obligation of the state to *respect* a person’s civil and political rights requires the government to refrain from directly violating the human rights. The obligation to *protect* civil and political rights implies that the government should take steps to prevent others (individuals or organizations) from violating human rights. This means that the government establishes regulatory environment and actively enforces laws and policies that prohibits human rights violations. The

⁵ Salter, L., & Slaco, D. (1981). *Public inquiries in Canada*. Ottawa: Science Council of Canada.

⁶ Kemp, R. (1985). Planning, public hearings, and the politics of discourse. In J. Forester (Ed.), *Critical theory and public life* (pp. 177–201). Cambridge: MIT Press.

⁷ <http://bit.ly/1OIU0aP>

⁸ Office of the United Nations High Commissioner for Human Rights, Fact Sheet No. 33, “Frequently Asked Questions on Economic, Social and Cultural Rights”, (2008), p. 16.

obligation to *fulfill* human rights requires the government to take steps to create an environment in which each person's rights can be fully realized.⁹ The domains for each factor were developed based on the guide for conducting social enquiry developed by UN Population Fund.

2.2. Overarching Methodology

The present methodology defined the overall scope of the conduction of public inquiry on Human Rights in the context of Sexual and Reproductive health and Well-being. Within the overarching theme the study has four separate thematic areas. The present section first describes the overall methodological approach deployed for the present inquiry and then describes each thematic area separately.

2.3. Study design and approach

For the purposes of the present investigation a multisite, cross-sectional descriptive qualitative study was conducted. The present investigation was deductive¹⁰ in nature as a conceptual framework was used with predefined categories.

2.4. Study Participants

While the public inquiry was open to all, the fieldwork for each of the section had its own specific group of participants. No children under legal age were included in the fieldwork. The field work was conducted with health care professionals, teachers and school principals, patients and stakeholders from nongovernmental organizations (NGO). In addition to field works, the inquiry had opened a call for submissions of relevant stories and anyone willing to share their stories regarding the mentioned four thematic areas were welcomed to submit either through e-mail, drop paper copies of their letters at special boxes placed at Ombudsman's offices in Yerevan and in marzes (namely; Gegharkunik, Shirak and Syuniq) or call hotline opened for the purposes of this inquiry. Overall, 45 interviews were conducted among health

⁹ Jessica C. Lawrence, Human Rights. Course materials. University for Peace

¹⁰ Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of advanced nursing*, 62 (1), 107–115

care professionals, 25 among pregnant women or among those who delivered within the last two years, six teachers and two representatives of nongovernmental organizations.

2.5. Study setting and sampling

For investigation in each thematic area the study setting varied. For the public inquiry we deployed various sampling techniques to ensure richness and heterogeneity of the data collected throughout the inquiry. The investigation consisted of two major simultaneous data collection stages: open call for submissions and a purposeful multisite fieldwork. The public inquiry was launched after the first stakeholder meeting the purpose of which was to present study scope and research questions to various stakeholders and collect opinions on the relevance of the research questions and amends them if needed. The open call implied submission of human rights violation cases in form of written materials, blog posts, articles, videos and etcetera. The multisite fieldwork was conducted in Gegharkunik, Shirak and Syunik regions. The fieldwork was consisted of local stakeholder meetings/forums, focus group discussions, in-depth interviews, field observations and public hearings. As the study had predefined target groups the study team deployed purposeful sampling¹¹ with snowball technique for the field research. The regions chosen for the field work were selected by the Human Rights Defenders' office in Armenia in consultaion with the UN population Fund country office in Armenia. The in depth interviews mostly conducted at health care facilities. Exceptions were; 1) focus group discussions which were held at the end of a training course organized by the UNFPA Armenia team, 2) in-depth interviews with representatives of NGOs; and 2) in-depth interviews with teachers which were conducted at public schools.

2.6. Interview Guide development

The Focus Group Discussion (FGD), In-Depth Interview (IDI) guides were developed based on the guide prepared by the UN Population Fund. For each section the interview guides and observation cards are presented separately.

¹¹ M. Sandelowski, *Research in Nursing & Health* , 2000, 23, 334±340 <http://bit.ly/1Y8cFvZ>

2.7. Data collection

The data was collected through the review of related documents (e.g., policy papers, laws and national strategies, NGO reports and local researches etc.), open call submissions, focus group discussion, stakeholder forums, in-depth interviews, field observations and public hearings. Data collection was stopped after a thematic saturation was achieved. The decision of thereof was made by the team of consultants.

2.8. Data management and analysis

For the purposes of the present investigation directed content analysis of the collected data was conducted. Other themes that emerged during the analysis were carefully analyzed and labeled and included in the report. The analysis followed steps of qualitative data analysis described by Elo and Kyngäs.¹² The mentioned steps included: *preparation*, *organizing* and *reporting*. During the *preparation* phase the research team first grouped the written submissions according the thematic areas. Afterwards, the research team expanded their field notes, prepared transcripts of the interviews and focus group discussions. After the preparation of the row data the consultant assigned to each thematic area carefully read each file paragraph by paragraph until reaching data familiarization. During this phase the consultants identified preliminary recurring and contradicting patterns in the data. During the *organizing* phase the consultants started coding the data and grouping them by the categories and themes embedded in the selected theoretical framework. During the *reporting* phase the consultant described the analysis and the main findings.

2.9. Study rigor

To ensure the study rigor and trustworthiness¹³ such measures as credibility, dependability, conformability and transferability were considered. The credibility was insured through peer review process (i.e., consultants reviewed and provided feedback on the analysis prepared

¹² Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of advanced nursing*, 62 (1), 107–115

¹³ A.K. Shenton / Strategies for ensuring trustworthiness in qualitative research projects: available at <http://bit.ly/1kp2Q84>

by each consultant), triangulation of data sources and document check (whenever possible the research team asked the study participants to provide them with any relevant or supportive documents or reports). The study team attempted to achieve dependability through detailed description and reporting of each step of the inquiry thereby enabling future researchers to repeat the work and enable the readers of the report understand the appropriateness of the deployed strategies and techniques. The conformability of the findings was ensured through triangulation of data sources. To address the transferability concerns the consultants attempted to thoroughly describe the context the work was conducted in, which enables the readers to judge the applicability and relevance of the findings (i.e., transferability) to other groups.

2.10. Ethical considerations

The study methodology was endorsed by the Human Rights Defenders Office in Armenia which is legally mandated to conduct public inquiries. The consultants proceeded with the involvement of study participants only after obtaining their oral consent which aimed to protect the participants' rights. The informed consent (see appendix 1) included the study purpose, the terms of participation, the principle of volunteerism, confidentiality of shared information, the possible risks and benefits of participation and non-participation. No identifiable information was presented in the reports. Any information that might potentially lead to identification of study participants was blurred. The audio records, transcripts and field notes were destroyed after the submission of the final report of the inquiry.

2.11. Implementation challenges

Throughout the conduction of the inquiry there were several challenges that are important to highlight. The team of consultants attempted to organize public hearings in the selected marzes. The public hearings implied a dissemination of the information about the time and place of the hearings among the communities in the selected regions, as a result of which it was expected that people whose rights were violated would come and voice them during the hearings. The information was disseminated through Ombudsman's regional offices. Despite the

efforts no residents came for the hearings. This might be due to a number of reasons including the sensitivity of the topic and that people might have felt uncomfortable to talk about it in public. In addition people might not be aware of their reproductive health rights and thus they would neither be aware of the violations of thereof. These are assumptions that should be checked and challenges that should be considered during the conduction of similar public inquiries. Finally, the team has attempted to involve journalists in the actual implementation of the inquiry. Within the scope of this inquiry the team organized a media breakfast and invited active journalists and sensitized them about the inquiry and the specific role they could play. Even though the journalists expressed great interest during the media breakfast no active involvement was observed since then. Despite above mentioned challenges the data collection aimed at involving as many participants as possible through focus group discussions and in depth interviews.

3 | LEGAL FRAMEWORK

The International Obligations of Armenia: Sexual and reproductive health rights are among the most sensitive and controversial issues in international human rights law, but are also among the most important. These rights are guaranteed in various treaty documents and other instruments which clearly delineate government obligations to protect these rights. Implementation of these rights at the regional level is shaped by the socio-cultural beliefs and practices that determine the extent to which the rights are respected, protected and realized. These beliefs either violate or protect individual's rights. The key international and regional human rights treaties and other instruments, that Armenia is a party to, that provide for SRHR are outlined in the sections below.

International Treaties: 1) International Covenant on Civil and Political Rights, 2) International Covenant on Economic, Social and Cultural Rights, 2) Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 4) Convention on the Rights of the Child, 5) Convention on the Elimination of all forms of Discrimination against Women, 6) Convention on the Rights of Persons with Disabilities, 7) International Convention on the Elimination of All Forms of Racial Discrimination.

All of the aforementioned International treaties are ratified by Armenia, without any reservations or declarations regarding sexual and reproductive rights.

Regional Treaties: 1) European Convention on Human Rights, 2) The European Social Charter.

Human Rights includes rights holders and duty bearers. In international human rights law, the main duty bearers are States, while the right holders are persons. States have both negative and positive obligations when it comes to human rights. Some require states to refrain from encroaching the enjoyment of rights, while others require states to take steps to achieve the gradual, and eventually full realization and enjoyment of the individuals of their human rights. Thus, states have an

obligation to respect, protect, fulfill, and promote human rights.

The obligation to respect human rights requires states to refrain from interfering or violating directly or indirectly the enjoyment of human rights, in this case sexual and reproductive rights. This is sometimes called negative obligation, because it requires the government *not* to do something. For example, the state must not prevent individuals from accessing health services, limit access to contraceptives and abortion procedures, and discriminate against certain groups in terms of access and distribution of services.

The second part of the obligations of the state actors is the obligation to protect. The obligation to protect requires state actors to prevent third parties from interfering with the realization of sexual and reproductive rights. For example, the state must protect and control the quality of pharmaceutical drugs, prevent suppliers from marketing unsafe medicines, and punish those who violate human rights such as forced abortion or forced sterilization.

The third part of the obligation of the state is the obligation to fulfill. This requires the state to adopt legislative, administrative, budgetary, judicial and promotional measures to enable and facilitate the full enjoyment of sexual and reproductive rights. That is, the state must create an environment where each person's rights can be fully realized. For example, the state must take measure to deliver contraceptive services, build clinics in rural areas that provided safe abortion services and post-abortion care, subsidize doctors' visits and provide prenatal care.

According to UN Treaty Monitoring Bodies, the human rights standards applicable in the area of sexual and reproductive health are: a) availability, b) accessibility (physical, economic, and information accessibility), c) acceptability, and d) quality. Moreover, human rights treaties are underpinned by a core set of principles that guide development in all sectors of development, including sexual and reproductive health policies and interventions. These are: a) the principles of non-discrimination and equality, b) the principle of participation, c) the principle of accountability.¹⁴

¹⁴ *Id* 3

National Human Rights Institutions expressed their commitment to reproductive rights in the Amman Declaration and Programme of Action, which was approved at the Eleventh International Conference of the International Coordinating Committee of National Institutions for the Promotion and Protection of Human Rights. The focus of the Conference was “The human rights of women and girls: Promoting gender equality: The role of national human rights institutions”.¹⁵

It is also important to state that there are also non-state duty-bearers with no less important responsibilities in relation to the rights and needs of rights-holders. In the context of the right to health, and specifically SRHR, such actors include most importantly service providers, pharmaceutical companies, which may sometimes hinder the full and effective realization of SRHR.

¹⁵ Amman Declaration and Programme of Action, available at: <http://bit.ly/1Q7dne5>

4

MATERNAL HEALTH CARE TO ENSURE SAFE PREGNANCY AND CHILDBIRTH

Access to quality maternal health care is recognized as a human right and lack of access to such care is an issue involving the right to be free from discrimination and other human rights deprivations. This is well recognized by multiple resolutions passed by the United Nations Human Rights Council.¹⁶

Ante-natal care (ANC), delivery assistance, emergency obstetric care, and post-natal care are among critical components required to reduce maternal mortality recognized by the International Conference on Population and Development (ICPD).¹⁷ Reduction by three quarters, between 1990 and 2015, the maternal mortality ratio is agreed by countries as Millennium Development Goal 5A.¹⁸ The SDG goal 3 targets to reduce the global maternal mortality ratio to less than 70 per 100,000 live births, by 2030.¹⁹

This chapter will present the Inquiry's findings regarding maternal health rights in Armenia. The chapter begins with reporting the current status of maternal health care in Armenia. It further discusses the challenges that the system faces and factors that contribute to maternal morbidity and mortality. It also presents the international treaties that Armenia participates and analyzes the local legal and policy framework. The chapter concludes with recommendations on maternal health care system in the country to ensure safe pregnancy and childbirth.

¹⁶ United Nations, Human Rights Council. Resolution 11/8, Eleventh Session, Preventable maternal mortality and morbidity and human rights. New York, 2011. Available from <http://bit.ly/1UcECIZ>

¹⁷ United Nations. International Conference on Population and Development (ICPD) Programme of Action. Cairo, 1994, para. 8.22. Available from <http://www.unfpa.org/publications/international-conference-population-and-development-programme-action>

¹⁸ United Nations. Millennium Development Goals and Beyond 2015, Goal 5: Improve Maternal Health. Available from <http://www.un.org/millenniumgoals/maternal.shtml>

¹⁹ Sustainable Development Goals. Goal 3: Ensure healthy lives and promote well-being for all at all ages. Available from <http://www.un.org/sustainabledevelopment/health/>

4.1. Trends in Maternal Health Care

According to the Armenian National Statistics Service, Maternal Mortality Ratio (maternal deaths per 100.000 live births) in Armenia on a 3-year average basis was 18.5 in 2014.²⁰ The Maternal Mortality Ratio (MMR) in Armenia is similar to the region of Europe and Central Asia including countries with all income levels (18.0 in 2013); however it is higher than in European Union (8.0 in 2013).²¹

The ratio has declined over the last decade. International organizations data showed annual 3.0% decrease in MMR from 2000 to 2013.²² However, the progress is slower than it was projected by the Government of Armenia²³ and the MDG 5A target by 2015 (10.0%).²⁴

There is no reliable statistical data on complications and long-term medical conditions resulting from ante-natal, delivery, emergency obstetric, and post-natal care in Armenia. However, there is data regarding secondary infertility²⁵, which was declared by the Government of Armenia a core issue in 2003-2015 in the Strategic Plan for Mother and Child Health Preservation.²⁶ Data presented by the Ministry of Health (MOH) of the Republic of Armenia, report 10.6% secondary infertility form 2014.²⁷ A 2009 study reported 11.4% secondary infer-

²⁰ National Statistics Service of Armenia. Socio-Demographic Situation in the Republic of Armenia during January-December 2014. Yerevan, 2015. Available from http://www.armstat.am/file/article/sv_12_14a_520.pdf

²¹ The World Bank. Maternal mortality ratio (modeled estimate, per 100,000 live births). Geneva, 2014. Available from <http://data.worldbank.org/indicator/SH.STA.MMRT/countries/EU-Z7?display=graph>

²² WHO, UNICEF, UNFPA, The World Bank, and United Nations Population Division Maternal Mortality Estimation Inter-Agency Group. Maternal mortality in 1990-2013. Available from http://www.who.int/gho/maternal_health/countries/arm.pdf

²³ UNDP in Armenia. Improve maternal health: Where we are. Yerevan, 2013. Available from <http://www.am.undp.org/content/armenia/en/home/post-2015/mdgoverview/overview/mdg5.html>

²⁴ Government of Armenia, United Nations Country Team in Armenia Office of the UN Resident Coordinator. Armenia: MDG National Progress Report. Yerevan, 2010. Available from <http://bit.ly/1ITYyOz>

²⁵ Secondary Infertility is defined by the WHO as a condition when a woman is unable to bear a child, either due to the inability to become pregnant or the inability to carry a pregnancy to a live birth following either a previous pregnancy or a previous ability to carry a pregnancy to a live birth

²⁶ RA Ministry of Health. 2003-2015 Strategic Plan for Mother and Child Health Preservation. Yerevan, 2003. Available from <http://bit.ly/1QAATP1>

²⁷ Ministry of Health of the Republic of Armenia. Response to the 01.09.2015 #01/13.3/4366-15 information inquiry by the Human Rights Defender of the Republic of Armenia. Yerevan, 2015

tility and 5.4% primary infertility, among respondents.²⁸ In this regard, 2003-2015 Strategic Plan for Mother and Child Health Preservation states that high rate of secondary infertility in Armenia is due to high prevalence of sexually transmitted diseases and induced abortions.²⁹

4.2. The Status of Maternal Health Rights in Armenia

States have an obligation to develop laws, policies, programs and practices to ensure women's and girls' health and well-being throughout pregnancy, delivery, and the postpartum period.³⁰ Such rights will be fulfilled only if women and girls have access to ante-natal care services, emergency obstetric care and delivery services, including caesarean section where necessary, essential newborn care services, and post-partum care within two days of delivery.³¹⁻³²⁻³³

This section discusses the status of realization of maternal health rights in Armenia by analyzing key indicators on accessibility, availability, quality, and affordability of maternal health care services.

4.2.1. Ante-natal care

According to the 2010 Armenia Demographic and Health Survey (ADHS) data, almost all women in Armenia (99.0%) received ANC,³⁴ This indicator showed a positive change from 93.0% recorded in the

²⁸ Ministry of Health of the Republic of Armenia, National Statistical Service of the Republic of Armenia, Unites Nations Population Fund and Institute of Perinatology, Obstetrics and Gynecology. Clinical and Epidemiological Survey on Etiology, Prevalence of Infertile Marriages. Yerevan, 2009. Available from <http://bit.ly/1NmKmVC>

²⁹ RA Ministry of Health. 2003-2015 Strategic Plan for Mother and Child Health Preservation. Yerevan, 2003. Available from http://www.moh.am/?section=static_pages/index&id=214&sub-ID=91

³⁰ Committee on Economic, Social and Cultural Rights, General Comment No. 14: The right to the highest attainable standard of health, 12(a) (2000), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I), at 78, 2008

³¹ Convention on the Elimination of All Forms of Discrimination against Women, art. 12(2), G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46, 1981

³² ESCR Committee, General Comment No. 14, supra note 1, 43(d). The WHO Model List of Essential Medicines includes misoprostol for obstetric purposes. WHO, WHO Model List of Essential Medicines 29, 2011.

³³ International Covenant on Economic, Social and Cultural Rights, art.10(2), G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316, 1966.

³⁴ National Statistical Service of Armenia, Ministry of Health of Republic of Armenia, and ICF International. Armenia Demographic and Health Survey 2010. Calverton, Maryland, 2012. Available from <http://dhsprogram.com/pubs/pdf/FR252/FR252.pdf>

2005 ADHS.³⁵ The proportion of women who saw doctor during their ANC is very high (99.0%), and most of the women (93.0%) saw a gynecologist. However, there is a small variation in the latter number. In Shirak region the percentage of women who received ANC from a gynecologist was 86.0% (12.0% of pregnant women saw family doctor), in Lori it was 76.0% (5.0% saw a family doctor and 13.0% went to see internist for ANC), and in all other regions the number was more than 90.0%. The role of nurse, midwife, or feldsher in providing ANC is gradually decreasing; in 2010 it was less than 1.0%, compared to 3.0% in 2005.

Our field interviews with physicians and pregnant women showed that almost all of the pregnant women make more ANC visits, than the minimum 4-6 recommended visits by WHO and Ministry of Health, and the majority of them have their first visit by 12 week of gestation. This is documented by ADHS as well, according to which 93% of women who had a live birth from 2005 to 2010 had 4 or more ANC visits during pregnancy for the most recent child (urban-rural difference was 96.0% and 89.0%, respectively), and 80.0% of women made their first ANC visit in the first trimester.

During the Inquiry, interviewees raised 2 major issues regarding ANC services as follows:

- ✓ Almost all interviewed Obstetrician-Gynecologists(OB/GYNs) mentioned that they receive low quality drugs, under the state sponsored free care, due to the current mechanisms of the cheapest drug purchase dictated by state regulations.
- ✓ MOH provided us with 12 guidelines and standards on the organization and provision of ANC, delivery and post-natal care. Many of the interviewed OB/GYNs rated currently available guidelines and standards, as helpful but not covering the whole field. Also, the majority of them raised the issue of not having detailed clinical guidelines and protocols. They also stated that lack of the protocols regarding patients with complications and emergencies keeps them in fear that in cases of unfavorable outcomes they will not be able to prove that they took a right course of treatment.

³⁵ National Statistical Service of Armenia, Ministry of Health of Republic of Armenia, and ORC Macro. Armenia Demographic and Health Survey 2005. Calverton, Maryland, 2006. Available from <http://dhsprogram.com/publications/publication-fr184-dhs-final-reports.cfm>

It would be better if all hospitals worked with same protocols. We might prescribe one drug to a patient and when she goes to another hospital in Yerevan, she could be told that such prescription is wrong and dangerous for the life of her baby.

Gynecologist, Syunik

I would like to have detailed clinical guidelines that would tell me what to do in specific situations, especially when patient presents with complications.

Gynecologist, Shirak

International Experts also report issues of quality of care such as lack of key clinical guidelines at national level and, clinical protocols at facility level, based on international standards.³⁶

Two out of six regional maternity centers we visited had old buildings and facilities. In these two centers, doctors also reported that they use outdated diagnostic equipment. One of such centers, Gyumri's maternity home, was relocated to a polyclinic building after the 1988 earthquake. Doctors in this center mentioned that they are in need of modern equipment. In spite of the need, the hospital was not offered any major assistance over the past several years. Sevan's maternity center had also outdated facilities and equipment; however a new building is being built for the hospital. The rest of maternity homes were renovated and well equipped.

Physical, sensual and socio-cultural accessibility of reproductive medical services has been described as generally inadequate for women with disabilities in Armenia.³⁷ Women and girls with disabilities overcome physical inaccessibility with help of others and depend on others' help when receiving reproductive care.³⁸ There are 8,585 women with

³⁶ United Nations Armenia Country Team Report prepared in accordance with paragraph 15(B) of resolution 5/1 of the Human Rights Council For the Second Universal Periodic Review of the Republic of Armenia. Available from <http://www.refworld.org/pdfid/54c0f8634.pdf>

³⁷ Sensual accessibility refers to the adjustments of the environment for people with hearing and visual full or partial impairments. Socio-cultural accessibility refers to the awareness of the members of the society and to the attitude towards people with disabilities.

³⁸ Zaruhi Batoyan, Center for Gender and Leadership Studies. Inclusion and Accessibility of Reproductive Medical Services for Women and Girls with Disabilities in Armenia. Yerevan, 2014. Available from <http://bit.ly/21UKQfe>

disability aged 18–40 in Armenia, as of July 2014.³⁹ However, medical personnel in primary health care facilities and maternity homes, who interviewed with us, either had difficulty remembering cases of women with disability receiving maternal care or mentioned singular cases in their practice. When describing those cases, doctors mentioned that their communication with their patients was generally accompanied by another person.

As a recent media report mentions, there are cases when additional money is requested from an HIV positive woman for purchasing single used instruments and supplies⁴⁰In the same report, another case is described when HIV positive woman was advised to terminate the pregnancy due to her HIV positive status. Our interviews with medical personnel revealed that they either never provided medical care to an HIV positive pregnant woman, or when learned about the woman’s status, they referred her to continue care at hospitals in Yerevan.

We learned from our interviews that the right of pregnant women to receive consultations in a private manner is sometimes violated. As one of the interviewees, described:

During my ante-natal consultations, there are at least 3-4 other pregnant women and their family members in the doctor’s room, and they can clearly listen to my conversation with the doctor.

Woman who recently gave birth, Yerevan

In addition, some of the women who interviewed with us rated the information regarding their pregnancy and delivery care, given by the physician, not enough to make informed decisions, and therefore used Internet to obtain needed information. Others did not know about the availability of “Mothers’ school” services at their local maternity center. They also added that they would certainly have used such services, if they knew. These schools are intended to educate future mothers re-

³⁹ National Statistic Service of the Republic of Armenia. The Number of People with Disability Registered in January-June 2014. Yerevan, 2014. Available from http://www.armstat.am/file/article/sv_06_14a_540.pdf

⁴⁰ Petrosyan A. (2015, November 11). HIV Positive Pregnant Women bare faced to Discriminatory Attitude. *Medialab.am*. Available from <http://blog.apastyle.org/apastyle/2013/04/how-to-cite-a-news-report.html>

garding pregnancy care, nutrition, post-natal care, and newborn care, among other issues.⁴¹

4.2.2. Delivery care

Assistance at delivery by a health professional is universal in Armenia. 2010 ADHS reported that almost all births (99.4%) in Armenia occur in health facilities. A doctor attended 97.0% of live births during the five years preceding the survey.⁴²

The role of a nurses or a trained midwives has declined from 14.0% in 2000 to 2.0% in 2010. There is a variation in the later number across the regions; the role of nurses and midwives in assisting deliveries is considerable in Aragatsotn (13 percent) and Lori (8 percent).

According to the 2010 ADHS data, 60.0% of women, who gave birth in a health facility in the five years preceding the survey, reported that they received free hospital care delivery; 49.0% received free medicine during the delivery, as opposed to 43.0% of women, who were charged for the delivery services they received.⁴³

Pregnant women, who interviewed with us in regional maternity homes⁴⁴, stated that they receive free hospital delivery care and were not subjected to additional charges. It is worth stating that medical personnel were always trying to be a part of those interviews, which could have affected the responses of interviewees. Interviews conducted outside of medical facilities identified women who had chosen paid delivery services. Among those are women who had their registration in region, but received delivery care in the capital and those who chose to have delivery assisted by their designated gynecologist and submitted the official payment for that.

⁴¹ RA Ministry of Health. Expansion of Ante-Natal Care Services. News release July 15, 2010. Available from <http://www.moh.am/?section=news/open&id=143&nid=1200>

⁴² National Statistical Service of Armenia, Ministry of Health of Republic of Armenia, and ICF International. Armenia Demographic and Health Survey 2010. Calverton, Maryland, 2012. Available from <http://dhsprogram.com/pubs/pdf/FR252/FR252.pdf>

⁴³ National Statistical Service of Armenia, Ministry of Health of Republic of Armenia, and ICF International. Armenia Demographic and Health Survey 2010. Calverton, Maryland, 2012. Available from <http://dhsprogram.com/pubs/pdf/FR252/FR252.pdf>

⁴⁴ 25 interviews were conducted among pregnant women or among those who delivered within the last two years

I live in Yerevan with my husband but I did not yet change my registration from Marz/region. I was told that I should pay for all diagnostic tests and the delivery assistance because I am from marz

Woman who recently gave birth, Yerevan

Initially I went to the local physician for ANC and was very disappointed by the quality of the care and conditions of the polyclinic. Then, without changing my registration, I changed the health care provider and paid for all services in full.

Woman who recently gave birth, Yerevan

Our interviews indicate that the culture of providing monetary gifts to medical personnel is not eliminated. Moreover, there is generally higher level of attention from medical staff towards the women who pays for the services out of pocket, compared to one who uses the “State Maternity Certificate”.

My husband gave money to the doctor as “thank you”.

Woman who recently gave birth, Ararat

I just gave a symbolic amount of money to the nurse who brought the baby to me, when checking out

Woman who recently gave birth, Yerevan

During the Inquiry, health care professionals who we interviewed raised the following issues regarding assistance at delivery:

Maternity homes in remote regions of Armenia are understaffed with neonatologists and anesthesiologists. Physicians were relating this issue to the low pay they receive, the diminished respect towards them and constant accusations from media outlets.

There are still maternity homes in Armenia that are in need of modern equipment. Also, majority of interviewed physicians raised the issue of being underfinanced by the state budget.

We need modern machine for general anesthesia and assisted breathing. Until now we use machine produced during Soviet years

Physician, Shirak

Although, generally, maternal mortality cases in Armenia widely receive media coverage and undergo investigation from relevant state bodies⁴⁵, there is no evidence that evaluation of such cases result in development and implementation of new guidelines in the national level and protocols in the facility level. In general, our enquiries to MOH, interviews at hospitals and review of reports by international organizations⁴⁶ also revealed that there is a need for development of a good information system.

In regards to promotion of evidence-based learning, Ministry of Health, with its 17.08.2015 N2209-A⁴⁷ executive order, provided regulations on analyzing and recording critical cases that were successfully managed in maternity hospitals. This could be a perfect opportunity for physicians to learn via information exchange on critical case management. When talking to physicians, we learned about aspects that could be improved. For example, an OB/GYN practitioner mentioned:

Many doctors don't even know that there is a committee where they can present critical cases that they successfully managed. Also when such cases are discussed, head of the health department from Marzpetaran (Governor's office) is present. He is not an OB/GYN. His presence is just an obstacle to a normal discussion. He is just looking for problems to pinpoint

Physician, Gegharkunik

Almost all physicians that we interviewed were engaged in continuous professional development trainings and events; majority of the events that they participated were organized by international organizations. All interviewed OB/GYNs rated these trainings as helpful and mentioned

⁴⁵ Ministry of Health of the Republic of Armenia. Response to the 05.11.2015 information inquiry by the Human Rights Defender of the Republic of Armenia. Yerevan, 2015

⁴⁶ United Nations Armenia Country Team Report prepared in accordance with paragraph 15(B) of resolution 5/1 of the Human Rights Council For the Second Universal Periodic Review of the Republic of Armenia. Available from <http://www.refworld.org/pdfid/54c0f8634.pdf>

⁴⁷ Ministry of Health, Executive Order N2209-A, 17.08.2015. Available from http://www.moh.am/?section=static_pages/index&id=587

that they would like to be more involved in continuous professional development events. Some doctors also mentioned that sometimes the topics of offered trainings are repetitive and they would like to have seminars regarding the new guidelines and standards that are being prepared by MOH. On the other hand, nurses and midwives were not actively involved in such trainings and attended; they would attend only the mandatory 3-5 week courses held once in 3 or 5 years.

4.2.3. Emergency Obstetric Care

A good indicator regarding access to emergency care for childbirth complications is the availability of caesarean section operations.⁴⁸ According to World Health Organization, acceptable rates for deliveries with caesarean section are between 5 and 15%.⁴⁹ Caesarean section rates above 15% are considered excessive, while rates below 5 percent indicate that not all woman in need of caesarean section receive it.⁵⁰⁻⁵¹ According to MOH statistical data, the caesarean section rates were increasing in the last 5 years, and currently are considerably higher, than the 15% threshold (25.7% in 2014, 23.7% in 2013, 22.4 in 2012, 21.7% in 2011, 18.9% in 2010).⁵²

Our qualitative investigation revealed that all maternity homes that we visited in regions were equipped to handle emergency deliveries. Also, if the maternity center does not have the necessary equipment or personnel to handle emergency obstetric cases, there are working procedures in place to refer/transport the patient to higher grade maternity center.

⁴⁸ World Health Organization. The Global Numbers and Costs of Additionally Needed and Unnecessary Caesarean Sections Performed per Year: Overuse as a Barrier to Universal Coverage. 2010. Available from <http://www.who.int/healthsystems/topics/financing/healthreport/30C-sectioncosts.pdf>

⁴⁹ World Health Organization. The Global Numbers and Costs of Additionally Needed and Unnecessary Caesarean Sections Performed per Year: Overuse as a Barrier to Universal Coverage. 2010. Available from <http://www.who.int/healthsystems/topics/financing/healthreport/30C-sectioncosts.pdf>

⁵⁰ Althabe, F., and J. M. Belizan. Caesarean Section: The Paradox. 2006. *Lancet* 368(9546):1472-1473. doi:10.1016/S0140-6736(06)69616-5.

⁵¹ United Nations Children's Fund (UNICEF), World Health Organization (WHO), and United Nations Population Fund (UNFPA). 1997. *Guidelines for Monitoring the Availability and Use of Obstetric Services*. New York: UNICEF, WHO, and UNFPA.

⁵² Ministry of Health of the Republic of Armenia. Response to the 05.11.2015 information inquiry by the Human Rights Defender of the Republic of Armenia. Yerevan, 2015

4.2.4. Post-natal Care

According to the standard adopted by the Ministry of Health, postnatal period is defined 42 days after delivery.⁵³ 2010 ADHS reported that 3.0% of women, who gave birth in the two years preceding the survey, did not receive a postnatal checkup. In total, 8.0% of women did not receive postnatal care during 2 days after giving birth, which is the recommended timeline.⁵⁴

The inquiry did not record any complaints regarding post-natal care services from women who recently gave birth.

However, it is noteworthy that during our visits to some maternity centers in regions, we were offered to enter maternal wards with no hospital coats for visitors. In one case, a member of our team who had a common cold and was staying outside of the premises of the Obstetric-Gynecological Department, was told that “it is fine” for her to enter in that condition, since she is “an inspector”. Although an infection-control study was not a part of our Inquiry, we did find these observations as concerning.

4.3. The Legal and Policy Framework

Reproductive health rights are guaranteed in various international treaties and documents that clearly define government obligations to protect these rights. Armenia is party to all nine United Nations human rights treaties and most of additional protocols.

4.3.1. National Legal and Policy Framework

Armenia has a favorable national legal framework providing universal access to maternal health care services. The basis of national legal framework is laid out in the Constitution of Armenia. The Constitution states “Everyone shall have the right to benefit from medical aid and service under the conditions prescribed by the law. Everyone shall have the right to free of charge benefit from basic medical aid and services. The list and the procedure of the services shall be prescribed by the

⁵³ Executive order of the Minister of Health N 77-N, 28 November, 2013. Available from <http://www.arlis.am/documentview.aspx?docID=89318>

⁵⁴ National Statistical Service of Armenia, Ministry of Health of Republic of Armenia, and ICF International. Armenia Demographic and Health Survey 2010. Calverton, Maryland, 2012. Available from <http://dhsprogram.com/pubs/pdf/FR252/FR252.pdf>

law.”⁵⁵

The Law of the Republic of Armenia on “On human reproductive health and reproductive rights” defines that a woman has a right of safe motherhood. Such right entitles a woman to receive medical care that poses minimal risk to the health of pregnant woman, fetus and newborn during ante-natal, delivery and post-natal period. The article also states that a woman has a right to receive medical care and services related to pregnancy and delivery, under the framework of state sponsored programs, free of charge.⁵⁶

The Law of the Republic of Armenia on “On medical assistance and services to the population” states that each individual has a right receive easy-to-understand information regarding their health status, results of diagnostic tests, diagnoses, treatment methods, risks associated with treatment procedures, possible choices of treatment procedures, their consequences and prognoses. The law also defines provisions of assuring patient medical information privacy.⁵⁷

The Parliament of the Republic of Armenia has also passed laws to assure access and prevent discrimination against people with disabilities, live with HIV/AIDS, or belong to racial and ethnic minorities.

The Government of Armenia declared its commitment to providing quality reproductive health services as one of the main priorities for the health sector. The issues of reproductive health and maternal health care have been reflected in Government strategic documents, including the 2003-2015 Strategic Plan for Mother and Child Health Preservation⁵⁸, National Plan for Improvement of Reproductive Health⁵⁹, among others.

⁵⁵ Constitution of Armenia. Article 38. Available from <http://www.parliament.am/parliament.php?id=constitution&lang=eng>

⁵⁶ The Law of the Republic of Armenia on “On human reproductive health and reproductive rights”, Article 6. Accepted on 11/12/2002. Available from <http://www.parliament.am/legislation.php?sel=show&ID=1339&lang=arm>

⁵⁷ The Law of the Republic of Armenia on “On medical assistance and services to the population”, Articles 7 and 19. Accepted on 4/3/1996. Available from <http://www.parliament.am/legislation.php?sel=show&ID=1688&lang=arm>

⁵⁸ Government of the Republic of Armenia. N1000-N Decision: 2003-2015 Strategic Plan for Mother and Child Health Preservation. Approved on August 8, 2003. Available from http://www.moh.am/?section=static_pages/index&id=214&subID=91

⁵⁹ Government of the Republic of Armenia. N29 decision. Approved on July 26, 2007. Available from <http://www.moh.am/AzgCragir/Reprod.pdf>

There are some important issues to be addressed. In particular,

- ✓ Until now, the term “medical error” has not been defined by law in Armenia. Also, the available standards and guidelines on maternal health care do not cover the field in whole.

The Ministry of Health started to develop standards and guidelines on provision of medical services from 2011. However, the process is slow and needs to be accelerated. Also, some of these standards and guidelines are of recommendatory nature.

- ✓ The current protocols regulating state purchase of drugs, under the framework of state sponsored medical care, consider the cost of drugs as the main priority and the quality and efficacy of the drugs being purchased is not prioritized.

As a result, maternity centers generally receive the cheapest drugs, which causes concerns from the medical community. The problems regarding state drug purchase regulations were also raised in 2014 Annual report of the Armenian Ombudsman.⁶⁰

4.4. Conclusions

Our Inquiry indicates that Armenia made considerable progress in addressing factors behind maternal morbidity and mortality. The main achievements include introduction of the “State Maternity Certificate” offering free of charge maternal health care services, availability of skilled medical care for almost all pregnant women and appropriate referral system in place, as well as favorable laws and policies. The introduction of continuous professional development for medical personnel provides another opportunity to continuously improve their practice and care of patients.

However, there are still major issues to be addressed. Although the MOH started to develop standards and guidelines on provision of medical services from 2011, the available clinical guidelines on maternal health care, on the national level, do not cover the whole field. Evidence from the Inquiry also demonstrates that not all maternity centers in the regions of Armenia have renovated buildings and facilities, and most importantly, updated diagnostic equipment. Also, there is a lack of neo-

⁶⁰ Human Rights Defender of the Republic of Armenia. 2014 Yearly Report. Yerevan, 2015

natologists and anesthesiologists in regions. The above mentioned factors are among the main causes for lacking consistency of medical services across the various levels of health services providers in Armenia.

The Inquiry also reports excessive use of caesarian section operations in Armenia with an upward trend during the last five years.

The cases of violation of the patient's right to receive consultation in private environment, not providing comprehensive information to make informed decisions and discrimination against poorer patients who use State sponsored "Maternity Certificate" vs. those who pay out of pocket is also very disturbing.

The Inquiry revealed that accessibility of reproductive medical services is generally inadequate for women with disabilities in Armenia. We also received submission on discriminatory attitudes toward HIV positive pregnant women.

The legislative gaps identified by the Inquiry include lack of mechanisms defining medical malpractice, and inadequate practices adopted for drug purchase, under the government sponsored care.

The inquiry also concludes that there is lack of procedures ensuring learning from maternal mortality cases, need for development of a good information system, as well as need for introduction of evidence based medicine into practice.

4.5. Recommendations

Clinical Guidelines: The MOH should accelerate its work toward developing clinical guidelines and standards at national level, which would be compulsory for practitioners, as well as encourage usage of clinical protocols at facility level, based on international standards and evidence-based medicine. The medical providers should be continuously informed regarding those guidelines and standards via discussions and trainings.

Updated Equipment at All Levels: The government shall periodically review and enforce the licensure requirements for health services organizations that provide gynecological services, in order to ensure that those facilities are equipped with required equipment and personnel and the infection control norms are preserved. Availability of updated

equipment and clinical guidelines would assure that women receive medical care that poses minimal risk to the health of pregnant woman, fetus and newborn during ante-natal, delivery and post-natal period, as defined by State law.

Accountability Mechanisms: The current practices on defining medical malpractice and negligence are not well-defined, and leave loopholes for avoiding liability in cases of maternal morbidity and mortality. On the other hand, many OB/GYNs are in fear for being unfairly accused in cases of complications, due to lack of clear diagnostic and therapeutic guidelines and protocols. The term “medical error” shall be defined by law. Also detailed and impartial mechanisms on investigation and reporting of medical malpractice cases shall be defined. Such changes would provide accountability mechanisms in cases of malpractice and would offer clear regulatory system for the medical practitioners.

Better State Drug Purchase Mechanism: The purchase of drugs for the state needs is conducted under the same mechanism as other state purchases, and the main criteria of choice is often the price. The MOH should pay attention toward addressing this issue. Additionally, better oversight from the MOH on quality of purchased drugs should be ensured. This would assure that the right of pregnant women to receive quality medical care is fulfilled.

Access to Maternal Health Care Services: Medical institutions should improve their accessibility of reproductive medical services for women with disabilities. On the other hand, medical personnel should be continuously trained on to the ethics of communicating with people with disabilities. Medical personnel should be well informed on rights of HIV positive patients and trained on ethical conduct on providing services to them. Also, measures should be taken to ensure that the existing mechanisms actually work in regards to holding accountable those practitioners who discriminate patients based on their HIV/AIDS status or those who do not preserve confidentiality of personal health information.

Continuous Professional Development: Provision of continuous professional development trainings to OB/GYNs were reported to be effective in regards to keeping physicians well informed on certain topics. The topics of these events should be further diversified and cover modern,

evidence based practices. On the other hand, training of midwives and nurses with right skills mix, via continuous medical education events, should not be overlooked. This would ensure the provision of quality care, mandated by State standards, to pregnant women, newborns and women in postpartum period.

Financial Incentives for Physicians in Regions: Due to limited number of births in regional maternity centers and current mechanism of pay, highly trained specialists, including anesthesiologists and neonatologists, prefer to practice in Yerevan. The Government should create financial incentives that would encourage trained physicians to work in remote regions of Armenia in order to guarantee the accessibility of specialized care for all women and newborns in Armenia.

Rights and Roles of the Patients: The MOH should provide better oversight to ensure that the same high quality standard of care is offered to both patients who use “State Medical Certificate” and those who pay out of pocket. Medical practitioners should be well informed and trained regarding their core obligations to preserve patients’ privacy and provide comprehensive information to make informed decisions. Effective mechanisms should be developed regarding circulation of medical documents containing patient information. Better oversight should be provided to ensure that existing provisions in the law, regarding medical secret, are acted.

Caesarian Sections: The MOH should investigate root causes of the upward trend in caesarian section operations in Armenia. If the over-use of such operations has no objective causes, mechanisms should be developed to control the situation.

5 | ACCESS TO FAMILY PLANNING: ACCESS TO CONTRACEPTIVE INFORMATION AND SERVICE

Reproductive health is the basis for wellbeing and prosperity of every family, the whole society and the country. The proper level of the reproductive health is a guarantee for stable economic and social development. Investments in this field are perceived as towards future-looking. Family planning is the main constituent part of reproductive health. It is also the optimal development planning of one's life and the society. The government and the society are obliged to create proper conditions and to take appropriate measures which would result in healthy childbirth and create prerequisites for complete upbringing of the growing generation and provision of the reproductivity of the society.

Family planning has wide-ranging benefits for sexual and reproductive health (SRH), including enabling women to exercise choice and control over their fertility; reducing maternal and prenatal morbidity and mortality; reducing the risk of Sexually Transmitted Infections (STI), including HIV transmission.

The World Health Organization (WHO) includes access to family planning services in its definition of what constitutes the universal access to SRH services. In its definition, WHO defines universal access to SRH services to include prevention, diagnosis, counseling, treatment and care services relating to: ante-natal, prenatal, postpartum and newborn care; family planning services including infertility and contraception; elimination of unsafe abortions; prevention and treatment of STIs, HIV/AIDS, cervical cancer etc. and the promotion of healthy sexuality.⁶¹

This chapter analyzes the status of the fulfillment of the right to uptake of effective contraceptive methods and means in the Republic of Armenia. It begins with an analysis of the trends in family planning, discusses the various barriers to accessing family planning services and discusses the international, regional and national policy and legal frameworks, while identifying the gaps. The chapter outlines recommendations which will help to realize the Article 8 of the RA Law on

⁶¹ Who.int

“Reproductive health and reproductive right” which underlines the right to uptake of effective contraceptive methods and means to provide women safe maternity and prevent from unwanted pregnancies and unsafe abortions.

5.1. Trends in family planning

Since Independence in 1991 notable changes have taken place in the field of health services provision, including reproductive health services and family planning.⁶² There are 75 family planning cabinets, 22 of which are established in Yerevan, the rest in other regions of the country, are cooperating with maternity hospitals, policlinics and women consulting centers. These cabinets are established with the support of UNFPA. In recent 10 or more years UNFPA has provided some reserves of combined hormonal pills, intrauterine copper devices, condoms, and medroxyprogesterone injections.⁶³ During the last 5 years indices of the uptake of contraceptive methods have changed. In contrast to 53.0% in 2005, ADHS 2010 results show that only 55.0% of married women (15-49 years old) use any contraceptive method. But in 2010 the contraceptive prevalence rate among married women has been fallen in comparison with ADHS 2000 results (61.0%). During the last 10 years the rate of the uptake of traditional contraceptive methods has been decreased from 38.0% in 2000 to 28.0% in 2010. Especially the proportion of withdrawal has decreased (32.0% in 2000 and 25.0% in 2010). The decrease in the proportion of the use of withdrawal method is more vivid among rural women: 40.0% in 2000 and 28.0% in 2010. On the other hand, the percentage rate of the married women who use modern contraceptive methods has been increased reaching from 22 % in 2000 to 27% in 2010. Particularly, one may observe an increasing trend in the proportion of condom use among married women, reaching from 7.0% in 2000 to 15.0% in 2010.⁶⁴

Unmet need for family planning can be calculated as the proportion of women who have regular sexual intercourse without using any contraceptive method, but do not want to get pregnant. According to the

⁶² Health face in transition report, 2013

⁶³ “Contraceptive market segmentation survey” report, UNFPA, 2014

⁶⁴ National Statistical Service [Armenia] et al, 2012.

2013 UN Economic Commission for Europe (UNECE) Regional Report, the value of the unmet need for family planning indicator is 10.0%-15.0% in Armenia.

The limited use of modern contraception and the high unmet need for family planning could be explained by 2 major factors: misconceptions and lack of knowledge about hormonal contraceptives; and non-affordability of modern contraceptive methods. As a result, abortion becomes a “method” for family planning.⁶⁵

2014 ASTRA network factsheet mentions the low contraceptive usage rate in Armenia, combined with high abortion rate. It mentions several reasons for this situation, among them: lack of political will and commitment to reproductive health, a limited range of available modern forms of contraceptives and information about them, costs which make contraception difficult to access and prevailing social norms.⁶⁶It should be mentioned that it is the first time that State budget 2015 includes allocations for purchase of modern contraceptive means for distribution to socially vulnerable couples.

5.2. Barriers to accessing Comprehensive Family Planning

A number of factors hinder access to family planning services in the Republic of Armenia. This section presents the factors identified by the course of the analysis of the data obtained during in-depth interviews with medical personal. The factors are categorized into commodity insecurity, socio-cultural barriers, and costs.

5.2.1. Unavailability of Family Planning Commodities

This inquiry established that unavailability of family planning commodities, unaffordability of taking necessary examinations before deciding which kind of contraceptive to use (especially modern pills), and the lack of accurate and complete information on modern contraception are the main barriers to accessing family planning in the Republic of

⁶⁵ RA National Statistic Service, RA Health ministry and ICF International. Demographic and Health Research, Armenia, 2010, Calverton, Meryland. RA National Statistic Service, RA Health ministry and ICF International.

⁶⁶ ASTRA Network (2014) *Status of Sexual and Reproductive Health and Rights in Central and Eastern Europe*. Warsaw, Poland. Available from <http://www.astra.org.pl/publications.html>

Armenia. Particularly, the majority of doctors who participated in the inquiry gave similar responses, like this one:

We used to give free pills to women who could not afford paying for them. All of them used the contraceptives with pleasure. But now we don't get any, so they can't afford them...

Health care professional, Gegharkunik

As to the next issue, i.e. the lack of accurate and complete information on modern contraception among the population, one of the doctors noted:

It doesn't matter what information we give, they always do as they have heard. There is an opinion that the pills fatten and make overgrown with hair, or that after using an intrauterine device getting pregnant becomes a problem, etc. Though people have become more informed about the contraception, misconceptions still do exist

Health care professional, Gegharkunik

We explain how the pills should be used. We call them up a few times and ask how they're doing. And ouch! they come to the hospital already expecting a baby. When we talk to them, we realize that they have used the pills in a wrong way.

Health care professional, Gegharkunik

The above mentioned is also confirmed by the results of other reports. For example, according to survey carried out with the support of the UNFPA⁶⁷: 'The costs are one of the main hindrances to uptake of modern contraceptives. The survey revealed that the majority of the women would like to use modern contraceptives, but they haven't:

Not because of the value of the contraceptive, but the costs for the necessary treatment before up taking the contraception

A rural woman has noted:

⁶⁷ "Giving voice to women: The conceptions and experience on contraception and abortions in the village communities of Armenia 2015", Survey, UNFPA, 2015

One should have money for coming to the nearest town, that's why the uptake of modern contraceptives is hindered.

The report stated the problem of misinformation:

Some women have controlled their fertility by means of methods which are not contraceptive. At the same time both the women inquired, and the medical staff have told about misuse of contraceptives.

The report has learnt about another problem which was discovered during the survey. Many of the participants were afraid that some contraceptives may cause health problems, for example, infertility, overgrowing with hair, loss of memory, etc.

Almost all the reports, that we have accessed⁶⁸, mention that the safety of modern contraceptive methods is a big concern for Armenian men and women. This misperception of modern contraceptives being harmful to health is present among both married and unmarried, rural and urban population, young and older generations, etc. It seems to be a result of the experiences with high-dose contraceptive pills of the Soviet period passed down generation to generation. This could also be further reinforced with modern focus on “healthy is natural” movement.⁶⁹

Such fears and prejudice is documented in a 2012 qualitative study by UNFPA and International Planned Parenthood Federation (IPPF). The study mentions that they recorded many comments that depict the level of concern regarding the safety of modern contraception in Eastern Europe and Central Asia, including in Armenia. Some of the comments from the study are worthy to quote, such is this comment from a single, rural woman from Armenia, saying:

⁶⁸ “Giving voice to women: The conceptions and experience on contraception and abortions in the village communities of Armenia 2015”, Survey, UNFPA, 2015, ‘Contraceptive market segmentation survey’ report, UNFPA, 2014, RA National Statistic Service, RA Health ministry and ICF International. Demographic and Health Research, Armenia, 2010, Calverton, Maryland. RA National Statistic Service, RA Health ministry and ICF International

⁶⁹ USAID (2008) *Fact Sheet: Family Planning in Europe and Eurasia*. http://www.usaid.gov/locations/europe_eurasia/health/technical_elements/family_planning.html

My friend told me that hair growth may occur on the face of women who use hormonal contraceptive pills

They conclude that there is little doubt that concerns about safety contribute significantly to the non-use of modern contraception in the region.⁷⁰

US Department of State Bureau of Democracy, Human Rights, and Labor in its 2014 Country Reports on Human Rights Practices cites the UN Committee on Economic, Social and Cultural Rights July report, expressed concern that availability of contraception was limited.⁷¹

The survey has also revealed that it is considered not necessary to inform the youth about contraceptives who are expected to have babies. For example, during one of the interviews medical facility noted:

Why should they use contraception? If they are married, let them have babies. If I'm present at the visit, I say-Shame on you, why do you want to use contraception? Go and have babies.

Health care professional, Gegharkunik

In this region another big problem exists: when adolescent girls already 15 years old undergo screening, their mothers forbid doctors to speak about contraception to their daughters. Some of the doctors confirmed this assertion (see more in chapter six).

A family doctor of a polyclinic in this town also stated that no information is given to population, including adolescents about contraception, they are merely referred to women consulting units. A doctor from adolescent mobilization examination cabinet noted that no information on contraception is given to boys, they are only referred to take necessary examinations.

Though all the participants (health care professionals, mothers) of the inquiry said that women are given information on contraception in a

⁷⁰ UNFPA EECARO, IPPF European Network (2012) Key Factors Influencing Contraceptive Use in Eastern Europe and Central Asia. Available from <http://eeca.unfpa.org/publications/key-factors-influencing-contraceptive-use-eastern-europe-and-central-asia>

⁷¹ US Department of State Bureau of Democracy, Human Rights, and Labor (2015) *2014 Country Reports on Human Rights Practices*. Washington, DC. Available from <http://m.state.gov/md236496.htm>

private manner, it was established that after birth, few women are given consultation in the same hospital room simultaneously.

Another problem is the absence of emergency contraceptive services/methods. Inquiry at the primary level family physicians and specialists of family planning showed that they do not apply for emergency contraception or are going to pharmacies to buy the means for it. But they also point out that there are no guidelines provided, that will define which is an urgent case, what type of documentation should be kept. Legal analysis also showed that there are no regulations on the use of emergency contraception methods.

5.2.2. Structural Barriers

Since Independence in 1991, notable changes have taken place in the field of health services provision, including reproductive health services and family planning. According to family planning services are usually provided at reproductive health centers. Family planning cabinets are cooperating with maternity hospitals, policlinics and women consulting centers. There are 75 family planning cabinets, 22 of which are in Yerevan, the rest are located in the regions of Armenia. They all were established with the support of UNFPA.⁷²

The unmet need for family planning services is high – 21.3 %. But it is higher if we take into account the uptake of traditional contraceptive methods, in that case the unmet need for modern contraception will be 49 %.⁷³

According to the participant of the inquiry, long distances between their homes and the reproductive health service centers are a serious problem for obtaining family planning services. Moreover, it is easier for citizens with education and enough financial resources to obtain modern contraception information and services than for women who live in villages in poverty or with little family income. It is especially difficult for those women who live in village communities with high men migration rate. Men, especially those who live in villages, very rarely or never attend women centers that provide family planning consultation

⁷² “Contraceptive market segmentation survey” report, UNFPA, 2014.

⁷³ RA National Statistic Service, RA Health ministry and ICF International. Demographic and Health Research, Armenia, 2010, Calverton, Meryland. RA National Statistic Service, RA Health ministry and ICF International.

and services. Hence, men or adolescent boys living in the suburbs and regions have to go the capital to access the services⁷⁴, even though even in Yerevan there are very few sexual health services which are intended for men or adolescent boys.

We have come to the same conclusion while talking to doctors. To the question, “whether the contraceptive methods choice is made taking into account the most expedient one for one’s health (after being consulted by a doctor)”, or “the most affordable one”, the doctors answered that if asked consultation is given, but the most affordable and cheapest method is chosen.

5.2.3 Cultural and Social Barriers

The cultural beliefs and practices around child bearing and decision making authority in Armenian society were cited as impacting the access to family planning services. The inquiry revealed that sometimes men hindered the uptake of family planning services. In other words, it emerged that among women who desire to use contraception, most were denied of the access to the mentioned services by their spouses. Doctors, who participated in the inquiry, stated that they had never been asked for consultation by both spouses, only women came. Men have never visited a doctor to get information on various contraceptive methods. The same is stated in the survey, according to which “in some cases the women cited that it were a mutual decision whether to use or not a contraceptive. But their stories showed that in fact the decision maker was the husband”⁷⁵.

Another issue that doctors reported as a hindrance to family planning, was the seasonal labour migration of husbands (Gegarqunik marz, Shirak marz). Doctors told that when they began talking about contraception, many women answered:

To use contraception? But why? Nearly no men are here. We are lonely most of the time of the year.

Gynecologist, Shirak

⁷⁴ “Contraceptive market segmentation survey” report, UNFPA, 2014.

⁷⁵ “Giving voice to women: The conceptions and experience on contraception and abortions in the village communities of Armenia” 2015

In-depth interviews conducted during the inquiry have revealed another stereotype which hinders family planning: very often family planning is perceived as something that “should be practiced after having children”. In addition, the viewpoint of mothers of adolescent girls that their daughters shouldn’t be talked to about contraception, very often make problems for the youth itself.

Cultural beliefs were also cited to have an influence the provision of family planning services. It was noted that within the scope of family planning services and information, men are positioned as passive actors, resulting in lack of information and knowledge among men on family planning. Noteworthy, as inquiry has shown most family planning clinics do not see men as potential clients and thus design their services/programs exclusively for women. Existing social barriers are also an obstacle to the availability of modern contraceptive methods. During our in-depth interviews we asked the participants whether women from socially vulnerable families refer to them for contraception. The answers of the doctors of family planning cabinets were nearly the same:

Many women refer to us. Previously, we had contraceptives, mainly condoms. Sometimes we had also intrauterine devices, pills. But now we don't have any.

Doctors of family planning cabinets, Gegharkunik

The above mentioned statement is confirmed by the Contraceptive market segmentation survey: “During the survey the following segments of population were revealed which cannot afford buying regularly modern contraceptives and should be involved in groups provided free contraception or in groups which are to pay a part of the price. These segments include: those who have the smallest 40.0% income, villagers, young people at the age of 15-24, the regions which the ADHS 2010 stated to have the smallest uptake of family planning, groups having right to social aid with their MLSI 30 points and women who have practiced abortions”.⁷⁶

⁷⁶ “Contraceptive market segmentation survey” report, UNFPA, 2014

5.2.4. Lack of Accurate Information on Family Planning

Although the majority of the participants noted that many of the women who came for consultation were informed about contraceptive methods and their use, the interviews indicated lack of information among the doctors. So we can come to the conclusion that the society needs some professional information as well. Many of the doctors stated that they had regularly passed professional trainings regarding reproductive health, particularly contraception and reproductive rights (nearly all of them mentioned courses organized by UNFPA in September–November 2015). Nevertheless, when being asked whether they know that they and the medical facility are obliged to provide reliable information to the patients on accessibility, effectiveness and security of contraceptive methods, and whether they know that, by law, the obstetrical-gynecological aid at the first level medical organizations includes provision of information on preventing the unwanted pregnancies and provision of modern contraceptives within the free medical aid and services guaranteed by the government; equivocal responses were given. Some of them said yes, but when asked to present the procedure, it became obvious that there are no mechanisms in place at the facility. For example, the prevailing majority of the participants confirmed that they had no information leaflets for clients on their rights, including reproductive rights. According to doctors no records are made in dispensary cards about contraceptive information and consulting. No record of people seeking family planning services is made. One of the doctors said:

Previously, when we distributed condoms, pills, a compulsory record was made. But now-nothing is done

Family planning doctor, Gegharkunik

To the question how many women seek for a gynecological consultation after childbirth, the answer was: “Approximately, half of them”.

To the question whether there are information materials about contraception given to people seeking family planning services or gynecological consultation, the doctors gave a negative answer, at the same time underlining the unmet need for such didactic materials. They noted that they had professional books/booklets but of their own use. One of the doctors added:

There is no information material, that's why young people refer to the Internet. But very often they get wrong information and face many problems. For example, they use contraception, but suddenly find out that they are pregnant.

Gynecologist, Gegharkunik

2012 UNFPA and IPPF study revealed that rural women with migrant husbands, urban parents with limited income, and young people with only primary and secondary education are more likely to have less knowledge about modern contraception in Armenia compared to married men and women in urban areas.⁷⁷

The 2010 ADHS reports more optimistic data. It suggests that knowledge of contraception is high among both women and men in Armenia. All of their survey respondents knew at least one contraception method (among those, withdrawal is the most widely known traditional method, 91.0%). Also, on average, married women, knew almost eight methods. More than 90.0% of married women involved in the 2010 survey have heard about pills, male condom and Intrauterine Device (IUD). The survey participants were less familiar with other modern contraceptive methods; such as, female sterilization and injectables; foam/jelly and the fertility wheel calculator. Respondents were also less aware of emergency contraception, male sterilization, and implants.

2010 ADHS provides insights on where women obtain modern contraceptives. The survey showed that six in ten users of modern methods received their method from the private sector, mostly from pharmacies. The public sector remained the primary source for almost all users of the IUD (96.0%), the second most common modern contraceptive method in Armenia. Condoms and pills were generally obtained from pharmacies (96.0% and 94.0%, respectively).⁷⁸

This inquiry also revealed that in pharmacies the pharmacists and/or pharmacologists gave information on how to use contraceptives,

⁷⁷ UNFPA EECARO, IPPF European Network (2012) Key Factors Influencing Contraceptive Use in Eastern Europe and Central Asia. Available from <http://eeca.unfpa.org/publications/key-factors-influencing-contraceptive-use-eastern-europe-and-central-asia>

⁷⁸ National Statistical Service [Armenia], Ministry of Health [Armenia], and ICF International (2012) Armenia Demographic and Health Survey 2010. Calverton, Maryland: National Statistical Service, Ministry of Health, and ICF International. Available from <http://dhsprogram.com/pubs/pdf/FR252/FR252.pdf>

including the “Cytotec” without referring the clients to a doctor. In addition, despite the recently introduced ban on the over the counter sell of “Cytotec” such cases were recorded in pharmacies of different regions. The latter was also confirmed during the field trips.

5.2.5. Un-affordability of Family Planning

Abortions play a notable role in the control of birthrate in Armenia.⁷⁹ The general indicator of abortions was approximately 0.8 (in 2010). Abortion is being used as a method of birthrate control. Moreover, one of three pregnancies was ended with an abortion. Very often abortion was considered to be more available, safe and affordable than modern contraceptive methods. Two women of five (37.0%) have had an abortion in Armenia. They have stated that they have not used modern contraception⁸⁰ because of the lack of comprehensive information (60.0%) and the lack of financial means or high price (15.0%) of modern contraceptive methods.

The financial strain associated with family planning methods and services was raised during the inquiry as an issue of concern. Despite of the high number of abortions, many of the men and women, also adolescents would prefer to prevent unwanted pregnancies. But they underlined that it was difficult to find a reliable method and that the unwanted pregnancy was often a consequence of failure of contraceptives.

According to the above mentioned survey, women in villages complained that there were practically no consultation and post abortion contraception.⁸¹ We came to the same conclusion while talking to doctors who participated in this inquiry.

According to survey the high cost for modern contraception methods is a great barrier to their uptake. One of the men participants from the target group told:

⁷⁹ RA National Statistic Service, RA Health ministry and ICF International. Demographic and Health Research, Armenia, 2010, Calverton, Meryland. RA National Statistic Service, RA Health ministry and ICF International.

⁸⁰ USAID, Global health initiative strategy, Armenia, March, 2012. <http://www.ghi.gov/whereWe-Work/docs/ArmeniaStrategy.pdf>

⁸¹ “Giving voice to women: The conceptions and experience on contraception and abortions in the village communities of Armenia 2015”, Survey, UNFPA, 2015

The minimum salary in Armenia is 30,000 dram [less than 100 dollars]. Men with a regular sexual life should pay for condoms approximately 3000 dram per month. In case of early pregnancy the abortion cost varies from 12 000 to 18 000 dram. Many people in Armenia do not have a job or any source of income and are financially dependent on their relatives living abroad. They visit public health centers only when there is an emergency. I have no more comments.⁸²

There is lack of information about reproductive health issues especially among the youth. And they are not eager to visit reproductive health centers. Nearly half of the young people admit the need for additional information on modern contraception methods. In their opinion there are serious problems concerning the accessibility to modern contraception methods. The fourth of them outlines the high cost as a serious barrier.⁸³

While talking about the affordability, the doctors also noted that:

When we prescribe contraceptives, especially pills, we are concerned, because it would be more correct to take some hormonal tests beforehand. But they are very expensive and we don't have any state order in that regards. So we give prescriptions without taking any tests. And this is wrong.

Gynecologist, Shirak

5.3. Legal and Policy Frameworks on Family Planning

The world community has continuously confirmed the importance of issues related to the protection of children and mothers. After the independence Armenia, being a state member of the United Nations Organization, has joined the commitments within the implementation of which the issues related to women and children are given a national importance. Underlining the priority of this sphere, the Armenia has emphasized the supremacy of the protection of mother and child health and the reproductive health.

⁸² “Contraceptive market segmentation survey” report, UNFPA, 2014.

⁸³ RA National Statistic Service, RA Ministry of Labor and Social Affairs, National Institute for Labour and Social Surveys. RA Population Reproductive Behavior Selective Survey. Analysis of Results. UNFPA, Yerevan, 2009.

Armenia has committed to fulfilling the right to family planning through a number of international, regional and national legal and policy frameworks. This section discusses the provisions referring to family planning.

5.3.1. International and Regional Legal and Policy Frameworks

The ICPD vision includes equality between men and women in reproductive health decision making, voluntary choice in determining the number and timing of one's children, and freedom from sexual violence, coercion and harmful practices⁸⁴. It further recognizes the rights of men and women to information and access to safe, effective, affordable and acceptable methods of family planning and of their choice. The Beijing Platform of Action on the other hand noted that lack of sexual and reproductive health education, including family planning, has profound impact on women and men.⁸⁵

The Convention on Elimination of all forms of Discrimination against Women (CEDAW) in Article 12 promotes the right to health, including family planning. State parties are called upon to take all appropriate measures to eliminate the discrimination against women in the field of health care to ensure, on the basis of equality of men and women, access to health care services, including those related to family planning. The CEDAW Committee in its concluding observation (2009) has stated /General Recommendation 21/: “In order to make an informed decision about safe and reliable contraceptive measures, women must have information about contraceptive measures and their use, and guaranteed access to sex education and family planning services, as provided in article 10 (h) of the Convention”.⁸⁶

The Article 10 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) recognizes the assistance to be given to the family which is the natural and fundamental unit of society. Article 10(2) provides that special protection should be accorded to mothers during the period before and after childbirth.

The Committee on the Rights of Persons with Disabilities speaks about

⁸⁴ https://www.unfpa.org/sites/default/files/pub-pdf/icpd_and_human_rights_20_years.pdf

⁸⁵ <http://www.un.org/esa/gopher-data/conf/fwcw/off/a--20.en>

⁸⁶ <http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom21>

the issue of accessibility in its General Comment 1:” For example, women with disabilities are subjected to high rates of forced sterilization, and are often denied control of their reproductive health and decision-making, the assumption being that they are not capable of consenting to sex. Certain jurisdictions also have higher rates of imposing substitute decision-makers on women than on men. Therefore, it is particularly important to reaffirm that the legal capacity of women with disabilities should be recognized on an equal basis with others”.⁸⁷

The Committee against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment has found that abuses against women in reproductive health facilities may constitute torture or ill treatment.⁸⁸

The Report to the Commission on Human Rights: The Rights to Sexual and Reproductive Health points out the following:

Many of the numerous obstacles to sexual and reproductive health are interrelated and entrenched. They operate at different levels: clinical care, the level of health systems, and the underlying determinants of health. In addition to biological factors, social and economic conditions play a significant role in determining women’s sexual and reproductive health. The low social status of girls and women frequently contribute to their sexual and reproductive ill health. Many women experience violence during pregnancy, which may give rise to miscarriage, premature labour and low birth weight.

The right to health also demands accountability. Without mechanisms of accountability, the obligations arising from the right to health are unlikely to be fully respected”.

According to the Report to the General Assembly: Criminal laws and other legal restrictions that reduce or deny access to family planning goods and services, or certain modern contraceptive methods, such as emergency contraception, constitute a violation of the right to health. For example, some States have criminalized the distribution and use of emergency contraception, justifying such laws with claims that emergency contraception is abortifacient. WHO, however, confirms that emergency contraception is a valid form of contraception. Women who

⁸⁷ <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf?OpenElement>

⁸⁸ http://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Reproductive_Rights_Violations_As_Torture.pdf

carry an unplanned pregnancy to term as a result of such laws also might face adverse physical and mental health outcomes. At the same time, women who lack access to emergency contraception as a result of criminal prohibitions may ultimately be forced to seek clandestine abortions, thus exposing themselves to the associated health risks.”

According to State Report 2013: National Program for Reproductive Health Improvement (2007) approved the development concept for population’s reproductive health sector for 2007-2015, as well as relevant strategies, schedule of activities and timeframes of their implementation. Strategies of the program include: a) The goal of improving contraceptive services: to extend the accessibility of quality contraceptive services for all strata of population. Currently, Armenia has a favorable institutional and legislative framework for introduction and promotion of family planning programs. In 2002 the National Assembly of the Republic of Armenia adopted the Law “On Human Reproductive Health and Reproductive Rights”. According to this Law, use of contraceptive methods is legal in Armenia.⁸⁹

And the State Report 2015 notes that: Although the legislation is rather favorable in this sector, however, the analysis of women’s situation prove the existence of some restrictions concerning issues of preservation of women’s reproductive health, particularly, with regard to affordability of effective contraceptives and some medicine (necessary for medical termination of pregnancy), limited opportunity for both women and men to use assisted reproductive technology.⁹⁰

In essence therefore, under the international human rights framework, the government has an obligation to *respect, protect* and *fulfill* human rights relevant to family planning. The government is also obligated to ensure a range of family planning goods and services are available, accessible, acceptable and of good quality. The table below summarizes the government’s obligations with regards to family planning.⁹¹

⁸⁹ <http://bit.ly/1Ng8lYK>

⁹⁰ <http://bit.ly/1OX7AnR>

⁹¹ RA Ministry of Health. 2003-2015 Strategic Plan for Mother and Child Health Preservation. Yerevan, 2003. Available from http://www.moh.am/?section=static_pages/index&id=214&sub-ID=91

Availability

The State must ensure that all needed family planning services are made available to boys, girls, men and women. All boys, girls, men and women must be able to access information and services at all times and plan when to have children.

Accessibility

The services must be accessed by women, men and the youth (adolescent boys and girls) as a whole irrespective of any difference including disability, sexual orientation among others. The State must ensure that there are no restrictions whatsoever to access the services. The information on costs of FP must be readily be available. The FP services must be affordable, thus eliminating any fee barrier to access to contraception.

Acceptability

The existing policies and programmes must be sensitive to all categories of people seeking the services- these include women, men and adolescent boys and girls. The policies must address the needs of the most vulnerable within the community

Quality

The information that is given at health facilities must be scientifically accurate and respect human rights. The different family planning methods must be made available for all clients to choose from. In cases of conscientious objection, the health providers must be able to refer patients to places where they can get the services so as not to infringe on girl, woman, boy or man's right to contraceptive information and the services.

5.3.2. National Legal and Policy Framework

The Article 38 of the RA Constitution promotes that everyone has right to medical aid and services as defined by the law, and that everyone has right to receive the main medical services free of charge, the list and the order of provision of which is defined by law.⁹²

The right to medical aid and health preservation is also a general norm of international law which is stated in the Universal Declaration of Human Rights (Article 25)⁹³, as well as in the International Covenant on

⁹² <http://parliament.am/legislation.php?sel=show&ID=1&lang=eng>

⁹³ <http://www.un.org/en/universal-declaration-human-rights/>

Economic, Social and Cultural Rights (Article 12).⁹⁴

The Article 23 of the RA Constitution recognizes that everyone has a right to private and family life and no information can be collected, maintained, used or spread without one's consent but for the cases legally provided.

It is prohibited to use and spread information about someone if it contradicts the goals of gathering information or is not provided by law. The above mentioned article ensures the citizens' right to medical aid, privacy to health status and diagnosis. So the constitutional basis for medical secret information is stated. Among the international documents including these principles are the Universal Declaration of Human Rights (Article 12) and the European Convention on Human Rights (Article 8)⁹⁵.

Article 9 of the RA Law on "Medical aid and population services"⁹⁶ states that every couple or everyone has a right to decide the number and times of one's children, uptake effective and secure family planning methods and means to prevent unwanted pregnancies and abortions, to receive necessary information on the issue, and get medical aid and services regarding pregnancy and childbirth within the annual target health care programs guaranteed by the State.

Everyone, including adolescents, has a right to get information on one's sexual health preservation, STIs, on latter after-effects and consequences.

Even though the RA Law on "Medical aid and population services" defines person's rights regarding reproductively, but the general concept of 'reproductive right' is not defined.

In December, 2002 the RA National Assembly adopted the RA Law on "Reproductive health and reproductive rights"⁹⁷ which includes sexual and reproductive rights internationally recognized, paying special attention to adolescents' rights. This law regulates the relations connected to reproductive health preservation, reproductive right provision, the order and conditions of implementation of technologies in repro-

⁹⁴ <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>

⁹⁵ http://www.echr.coe.int/Documents/Convention_ENG.pdf

⁹⁶ <http://pharm.am/index.php/en/laws/86-on-medical-aid-and-population-services>

⁹⁷ Adopted 11.12.02, in force 07.08.03.

duction sphere, and other matters with this regard. The law presents provisions on human's right regarding reproductivity, adolescent reproductive health preservation, abortions, contraceptives, reproductive auxiliary technologies.

Particularly, the following articles of the mentioned law refer to contraception methods and means defines that “every woman has right to safe maternity and to use effective contraception methods and/or means in order to prevent unwanted pregnancies and abortions. Health care services provide reliable information on the safety, effectiveness and security of contraception methods and means to exercise an informed choice of fertility control. The prescription of this right presumes also provision of availability to effective contraception methods and/or means, which is no doubt a big problem especially for socially vulnerable families”.

The RA Government has confirmed “The order of implementing medical sterilization” in yet 1998 according to the Article 9 of the RA Law on “Medical aid and population services”.

The public inquiry also indicated that this order is out of practice due to some reasons: absence of culture, non-sufficient awareness of population and specialists, incompleteness of mechanisms for some provisions and lack of correspondence to development trends in the field of reproductive health and rights. For example, the order doesn't define the procedure of providing precautionary information and/or getting informed consent, neither contains a provision which will reserve their definition for an authorized body. The conditions of medical sterilization are defined practically only for women, one of which is for woman to be 40 or more years old, which is illogical from point of view of reproductive activity and unwanted pregnancy risks.

The RA Government decision N 1000-Ն made on 8 August, 2008 on “Confirming the national strategy 2003-2015 on mother and child health preservation”⁹⁸The strategy has emphasized the implementation of programmes regarding the preservation of the health of mother and child, reproductive health and the provision of health care education, as

⁹⁸ RA Ministry of Health. 2003-2015 Strategic Plan for Mother and Child Health Preservation. Yerevan, 2003. Available from http://www.moh.am/?section=static_pages/index&id=214&sub-ID=91

well as the need for creating favorable health care services. Goals were defined to improve reproductive health of mothers and adolescents and the main strategic directions to achieve them were prescribed. The measures to be taken to promote modern contraception uptake, safe sexuality, the provision of modern contraceptives and the doubling the number of women practicing contraceptives were underlined.

The RA Government decision N 29 made on July 26, 2007 on “Defining the national program on reproductive health promotion” is an comprehensive document which reflects the situation that exists in Armenia regarding the reproductive health, which considers the trends of 1990-2007 related indicators. The documents describe the achievements, reveals the main problems and outlines the strategic directions by realizing the need for improving the reproductive health for the sake of making progress in this field.⁹⁹

The decision N 77- Ն made by the RA minister of health on 28 November, 2013 on “Confirming the criteria of organizing outpatient obstetrical-gynecological aid and services within the free of charge medical aid and services guaranteed by the State” states that: “The brief description on volume of organizing the prenatal care of a pregnant woman” section of the mentioned order involves the following in the volume of work of a midwife or a nurse re-qualified as a midwife in women consulting cabinets, rural medical districts, rural outpatient clinics:

“preventive work on unwanted pregnancies, STIs, pre-cancer and cancer diseases of reproductive organs (knowledge and informing on family planning, premenopausal and postmenopausal osteoporosis, STIs, urogenital disorders, accessible methods of preventing neoplasms).

The volume of work of a family doctor involves: “knowledge and informing on family planning, STIs, urogenital disorders, osteoporosis...”. The volume of work of an obstetrician-gynecologist involves: “prevention of unwanted pregnancies (teaching of family planning methods, including implementation of intrauterine mechanical means, modern hormonal preparations, etc)”.

⁹⁹ Arlis.am

The above mentioned order defines also the volume of outpatient obstetrical-gynecological aid and services within the free of charge medical aid and services guaranteed by the State which includes: “the provision of consulting about family planning and prevention of abortions”.¹⁰⁰

The evidence gathered during the in depth interviews indicates that doctors at the medical centers (obstetrician-gynecologists, family doctors) were aware of their duties prescribed by the RA Health minister order and of involving the family planning constituent in their work volume. But the inquiry among family doctors showed that they didn't provide such consultations.

The analysis of in-depth interviews indicated that despite of the presence of certain legislative field, there are definite problems from point of view of realization of right to family planning and uptake of contraception.

5.4. Conclusions

Evidence gathered during the public inquiry indicates that despite of definite changes in the levels of use of family planning in the past decade, there are major barriers in accessing family planning services (FP) services. It is notable that family planning services are not universally accessible, available and affordable across the country. Evidence suggests that gender power inequities, cultural norms and beliefs, lack of accurate information about FP, lack of routine supplies of FP commodities, unavailability of comprehensive FP services in lowest levels of health care system, the low level of the state budget allocations for health care, non-sufficient financing of family planning, non-sufficient accessibility of health care services and professional medical aid regarding family planning for rural population, non-sufficient level of material and technical saturation are some of the commonest barriers to accessing family planning services. Nevertheless, the implementation of steps corresponding to international, regional and national legal approaches revealed during the analysis of this inquiry is an imperative to the realization of family planning rights. Based on the findings of this inquiry the following recommendations are made on how to work towards the realization of family planning rights in the Republic of Armenia.

¹⁰⁰ Arlis.am

5.5. Recommendations

The government and medical professional's fulfill their obligations to ensuring access to family planning services through appropriate planning, adequate resource allocation and implementation of family planning related programs. The government should ensure equal and consistent distribution of commodities to all healthcare institutions, both private and public, by streamlining procurement, stock management and distribution of FP commodities. For that purpose it is necessary:

- ✓ To carry out structural reforms – to assess the present FP services and to create legal basis for formation of family planning cabinets, their allocation and functioning.
- ✓ To define the provisions of organizing the activity of a family planning cabinet doctor, clearly mentioning the main directions and principles of his/her activity.
- ✓ To define qualification characteristics for a family planning cabinet doctor, prescribing the necessary borders of knowledge and capabilities.
- ✓ To envision the possibility to include first level medical workers (not only obstetrician-gynecologists) in the process of family planning consultation and contraception measures prescription.
- ✓ To review the provisions of organizing family doctors' activity (the RA Government decision N 539-Ն made on 8 April, 2004) strengthening family planning component, and define the implementation mechanisms creating a viable system of family planning referrals.
- ✓ To expand the accessibility of qualitative contraceptive services to all social strata adding modern contraceptive means to the list of main medicines (making changes and amendments to the RA Health minister's order) expanding choice in FP. Long acting and permanent methods need to be promoted and made readily available in lower levels of health care delivery such as dispensaries and health centers where most couples seek health care services.
- ✓ To take measures to provide the accessibility to effective contraceptive methods/or means, especially for socially vulnerable families, to streamline procurements from state budget to distribute them to family planning centers.

- ✓ To create legal basis for provision of emergency contraceptive process, establish guidelines for health workers
- ✓ To review the RA Government decision on “Confirming the order of implementing medical sterilization”, taking into account that the order is out of practice due to some reasons: absence of culture, non-sufficient awareness of population and specialists, incompleteness of mechanisms for some provisions and lack of correspondence to development trends in the field of reproductive health and right. It is necessary to define the procedure of providing precautionary information and/or getting aware consent, and provisions which will reserve their definition for an authorized body. The conditions of medical sterilization are defined practically only for women, one of which is for woman to be 40 or more years old, which is illogical from point of view of reproductive activity and unwanted pregnancy risks.
- ✓ The offer that Ministry of Health to optimize the system of monitoring, assessing and reporting in the field of family planning services.
- ✓ Address the socio-cultural barriers to family planning with a view to ensure that all persons, including adolescents, persons living with HIV and AIDS, unmarried persons, can access family planning services without discrimination. Specifically, government and stakeholders must support all initiatives seeking to transform the socio-cultural and legal barriers women and men face in accessing family planning services and information.
- ✓ Family planning initiatives must involve men to ensure that they receive the necessary education and information to be able to make informed choices. As such, the programs and services need to be reoriented to visibly capture men as actors in the family planning interventions.
- ✓ In order to obtain accurate information on family planning information leaflets should be prepared, confirmed and distributed to medical centers, in which the principles, methods and right to family planning would be mentioned. This will enable men and women make informed choices.

6

ABORTION AND POST ABORTION CARE

Abortion is the medical or surgical termination of an unwanted pregnancy. Abortions and post abortion care are part of the sexual and reproductive health rights, which are fundamental human rights. Sexual and reproductive rights encompass rights which are embedded in various international human rights conventions, treaties and norms such as the right to: a) life, b) health (recognized as part of the adequate standard of living in the Universal Declaration of Human Rights 1948), c) education and information, d) equality and non-discrimination, e) privacy, f) the right to decide the number and spacing of children, g) right to consent, h) the right to be free from torture or cruel, inhuman or degrading treatment, i) the right to be free from sexual and gender-based violence, and j) the right to an effective remedy. The fulfillment of sexual and reproductive health is also dependent on underlying social and economic factors, such as the right to water and sanitation, the right to food, the right to education, etc.¹⁰¹

As mentioned in the Introduction of the Report, human rights have right holders and duty-bearers. Under international human rights law, the rights holders are the individuals, while the duty-bearers are primarily the state actors and institutions at various levels of government. States have the obligation to respect, protect and fulfill human rights.¹⁰²

In the implementation of policies and program aimed at the realization of sexual and reproductive rights, states must ensure that they are grounded in human rights standards and principles, such as: Availability, Accessibility, Acceptability, and Quality.

¹⁰¹ OHCHR. (2014). Reproductive Rights are Human Rights: A Handbook for National Human Rights Institutions. Geneva: OHCHR.

¹⁰² Lawrence, J. C. (2012). Human Rights. Williamsburg: Peace Operations Training Institute.

6.1. Legal framework of abortion services in the Republic of Armenia

Abortions are legal in Armenia according to Article 10 of the Law on Reproductive Health and Reproductive rights (December 11, 2002).¹⁰³ According to the law, every woman has the right to perform an abortion. Abortions of up to the 12th week of pregnancy are performed with the women's consent, while abortions between 12th and 22nd week of pregnancy are performed if women satisfy the socio-medical indicators/conditions mentioned in the government decision N 1116-Ն.¹⁰⁴

According to the law, before and after abortions, health institutions are required to provide women medical advice and consultation about the methods and means of protection from unwanted pregnancies.¹⁰⁵

In case of minors, abortions are only performed when the consent of the parents or legal representatives are obtained; or in cases where the obtainment of such a consent is not possible, through the decision of the medical committee.¹⁰⁶ Whereas, the World Health Organization states that third-party authorization should not be required for women to obtain abortion services.¹⁰⁷ To protect the best interests and the welfare of minors, and taking into consideration their evolving capacities, policies and practices should encourage, but not require, parents' engagement through support, information and education.

The Criminal Code of Armenia contains a provision on illegal abortions. According to Article 122 (1) of the Criminal Code, the "Performing illegal abortion by a person with appropriate higher medical education is punished with a fine in the amount of up to 100 minimal salaries, or corrective labor for 1-2 years, or with arrest for the term of up to 1 month, or with deprivation of the right to hold certain posts and practice certain activities for the term of up to 3 years." The second part of the Article mentions that "conducting illegal abortion by a person with no appropriate higher medical education is punished with a fine in the

¹⁰³ Law on Reproductive Health and Reproductive Rights] of Dec.11, 2002, available at: <http://www.arlis.am/>

¹⁰⁴ Decision N1116-Ն, available at: <http://www.arlis.am/DocumentView.aspx?docid=12781>

¹⁰⁵ *Id* 101

¹⁰⁶ *Ibid*

¹⁰⁷ World Health Organization. (2012). Safe Abortion: Technical and Policy guidance for Health Systems. Geneva: World Health Organization.

amount of up to 200 minimal salaries or with arrest for the term of 1 to 3 months, or with imprisonment for the term of up to 2 years”. If the performing of an illegal abortion results in the death or grave damage to the woman, or is performed by a person previously convicted with the same offence, it may result in imprisonment for up to 5 years.¹⁰⁸

Also of note, in its State Report (2012) to the Committee on the Rights of Persons with Disabilities, Armenia stated that The Criminal code of Armenia provides for relevant punishments for illegal or forced abortion, as well as forced sterilisation whether the person concerned (woman, girl, man) is with disabilities or not.¹⁰⁹

The MOH has submitted a draft on the amendments to Article 10 of the Law on Reproductive Health and Reproductive rights, according to which sex-selective abortions will be banned by the law.

6.2. Trends in Abortion and post Abortion Care and Issues

The International Conference on Population and Development Program of Action (ICPD Program of Action) calls upon governments to take appropriate steps to help women avoid abortion “which in no case should be promoted as a method of family planning”¹¹⁰

Induced abortion has a prominent place in the regulation of fertility in Armenia, with a total abortion rate of about 0.8. From the period of 2007 to 2010, approximately 3 out of 10 pregnancies (29%) resulted in abortion.¹¹¹ Although the tendency of pregnancies ending in induced abortion has declined over the past 10 years, it still remains high in Armenia. The data on the decrease in the rates of abortions can be interpreted in two different ways. The first explanation can be the increased use of modern contraceptive methods as opposed to more traditional methods, while the second plausible explanation could be the increased rate of self-prescribed abortions using Cytotec (Miso-

¹⁰⁸ Criminal Code of Armenia, available at: https://www.unodc.org/res/cld/document/armenia_criminal_code_html/Armenia_Criminal_Code_of_the_Republic_of_Armenia_2009.pdf

¹⁰⁹ CRPD State report Armenia 2012, available at: <http://bit.ly/1QABkJ1>

¹¹⁰ ICPD Programme of Action, available at: http://www.unfpa.org/sites/default/files/event-pdf/PoA_en.pdf

¹¹¹ National Statistical Service of Armenia, Ministry of Health of Republic of Armenia, and ICF International. Armenia Demographic and Health Survey 2010. Calverton, Maryland, 2012. Available from <http://dhsprogram.com/pubs/pdf/FR252/FR252.pdf>

prosto).¹¹² During the Inquiry it was established that the later was the more probable cause.

The “Report of Contraceptive Market Segmentation Research”, conducted under the auspices of the United Nations Population Fund (UNFPA), mentions that from the period of 2008 to 2012 the number of medically induced abortions per 1,000 women has increased slightly from 12.5 in 2008 to 13.7 in 2012.¹¹³

The **root cause** of abortion and its prevalence in Armenia is the limited access to family planning services and information (including misinformation and prejudice), and the non-affordability of modern contraceptive methods.¹¹⁴ Often, women resort to traditional methods of contraception. According to DHS 2010, around 55% of married women reported that they were using a contraceptive method: 27% were using modern methods of contraception, while 28% were using traditional methods. The most common traditional method used was withdrawal, followed by male condoms and IUDs. The traditional methods of contraception, such as withdrawal and periodic abstinence have high rates of failure, resulting in unwanted or unintended pregnancies.¹¹⁵

There is also the issue of unmet need of family planning. Currently married fecund women who either want no more children or want to wait at least two years before having another child, but who are not using contraception, are considered to have an unmet need for family planning.¹¹⁶ According to the UNECE Regional Report “ICPD Beyond 2014: The UNECE Region’s Perspective”, the value of the unmet need for family planning indicator is 10%-15% in Armenia.¹¹⁷

Often abortion is thought to be more accessible, safer and cheaper than modern contraceptive methods. Two out of five (37%) women in Armenia have had an abortion. Women who have had an abortion report that the lack of comprehensive information (60%) and unavailabil-

¹¹² Guilamoto, C. Z. (2013). Sex Imbalances at Birth in Armenia. Yerevan

¹¹³ Walker, G. (2014). Report of Contraceptive Market Segmentation Research. Yerevan: UNFPA.

¹¹⁴ ASTRA Network (2014) Status of Sexual and Reproductive Health and Rights in Central and Eastern Europe. Warsaw, Poland, available at: <http://www.astra.org.pl/publications.html>

¹¹⁵ *Id* 109

¹¹⁶ WHO, Unmet Need for Family Planning, available at: http://www.who.int/reproductivehealth/topics/family_planning/unmet_need_fp/en/

¹¹⁷ United Nations Economic Commission for Europe. (2013). ICPD Beyond 2014: The UNECE Region’s Perspective. Geneva: United Nations.

ity or high cost (15%) deterred them from using modern methods of contraception. For these reasons, abortions has become a “method” of family planning.¹¹⁸

Most men and women, including young people, would prefer to prevent unwanted pregnancy. But they have reported that access to reliable methods is an issue and unwanted pregnancy is often an outcome of contraceptive failure.

*If women would have access to effective and safe methods of contraception, they would never choose an abortion.*¹¹⁹

Moreover, the Inquiry established that women are not always well informed about abortion services and post-abortion care. For example, not all women know when abortion is legal, safe abortion guidelines, what complications may arise, and when to seek post-abortion care.

Other factors that affect abortions among Armenian women are:

- a) **Age:** the proportion of pregnancies (in general) increases dramatically with the woman’s age.
- b) **Education:** There is a negative correlation between education and abortion. The percentage of pregnancies that end in abortion decreases as educational level increases.
- c) **Wealth status:** Although there is no clear relationship between wealth status and abortion, mothers in the lowest and middle wealth quintiles have the highest proportion of pregnancies resulting in abortion. For example in rural areas, socio-economic reasons and poor living conditions are the main reason for terminating unplanned pregnancies.
- d) **Number of children:** There is a positive relationship between the number of living children and having had an induced abortion. Less than 1 percent of women with no living children have had an abortion, compared with 17 percent of women with one child, 58 percent of women with two to three children, and 56 percent of women with four or more children.¹²⁰

¹¹⁸ Walker, G. (2014). Report of Contraceptive Market Segmentation Research. Yerevan: UNFPA.

¹¹⁹ *Ibid*

¹²⁰ *Id* 111

Despite the high abortion rates, women in Armenia tend to have a negative attitude towards abortion, but would resort to it if they become pregnant unintentionally.¹²¹

6.3. Access to Family Planning Information and Services, and Modern Contraceptives

As mentioned earlier in this section, the root cause of abortion and its prevalence in Armenia is the limited access to family planning services and information (including misinformation and prejudice), and the non-affordability of modern contraceptive methods. Whereas human rights treaties and treaty monitoring bodies such as CEDAW, Convention on the Rights of the Child (CRC), International Covenant on Economic, Social and Cultural Rights (CESCR) and their respective committees have stated the importance of access to family planning services and information, including modern contraceptive methods in their General Comments and Concluding Observations to Armenia.

The inquiry established that while doctors and health workers regularly received training about family planning and modern methods of contraception, however, the information is not accessible to the population. For example, health centers and hospitals in Gegharkunik Marz do not have booklets on family planning and modern methods of contraception to distribute to the population. Moreover, a segment population is misinformed and prejudiced against modern contraceptives (there is the fear of stigmatization for using contraceptives)

The inquiry in Gegharkunik Marz also established that a segment of the population resort to receive information about sexual and reproductive health from the internet, thus leading to misinformation.

As mentioned earlier in this section, there is also the issue of non-affordability of modern contraceptives. Modern methods of contraception is not affordable to low-income couples, the rural population (who must add on the cost of travel to get contraceptives and visit clinics), and young couples who are financially dependent on their parents (financial barriers). For example, in 2010 the median cost of an induced

¹²¹ Westoff, Charles F., Jeremiah M. Sullivan, Holly A. Newby and Albert R. Themme. 2002. Contraception– Abortion Connections in Armenia. DHS Analytical Studies No. 6. Calverton, Maryland: ORC Macro.

abortion was around 29 US Dollars, which is significantly less than the annual costs required to purchase commercially most types of contraception.¹²²

6.4. Drug Induced Abortions and Unsafe Abortions

The WHO defines **unsafe abortion** as a procedure for terminating an unintended pregnancy either by individuals without the necessary skills or in an environment that does not conform to minimum medical standards, or both. Unsafe abortions mainly endangers women in developing countries, where there are restrictive abortion laws, and/or abortion services are not easily accessible to women.¹²³

Each year 22 million unsafe abortions are estimated to take place in the world, which result in the death of approximately 47,000 women annually, and causes disabilities to an additional 5 million women.¹²⁴ Moreover, the number of unsafe abortions has increased from the period of 2003 to 2008 by 2 million. Unsafe abortions account for nearly 13 per cent of maternal mortalities worldwide, which makes unsafe abortion the third-largest cause of maternal deaths.¹²⁵ Unsafe abortion is a public health issue which can be prevented through the promotion of sexuality education and information, family planning, safe abortions and post abortion care.

According to reports, women in Armenia have been using Cytotec (the brand name for Misoprostol), which is an anti-ulcer medication but can also be used as an abortifacient, to induce abortions at home without any medical supervision. It is used in combination with another drug called Mifpristone.¹²⁶ The improper use of Cytotec as an abortifacient can sometimes lead to complications such as hemorrhage, post-hemorrhage anemia, incomplete abortions and sometimes even death.¹²⁷

¹²² *Id* 111

¹²³ *Id* 105

¹²⁴ *Ibid*

¹²⁵ United Nations Population Fund. (2015). A Guide in Support of National Human Rights Institutions: Country Assessments and National Inquiries on Human Rights in the Context of Sexual and Reproductive Health and Well-being. New York: United Nations Population Fund.

¹²⁶ Grigorian, M. "Armenia: At-Home Abortion Pills Readily Available, Despite Ban", 2014, available at: <http://www.eurasianet.org/node/69836>

¹²⁷ Jilozian, A. (2015). Giving Women a Voice: Perceptions and Experiences with Contraception and Abortion in Rural Armenia. Yerevan: UNFPA.

Although as of August 1, 2014 the sale of Cytotec is banned without a doctor's prescription by the government of Armenia, women are still able to buy them over-the-counter without a doctor's prescription. The inquiry established that the ban on the sale is ineffective and women have easy access to Cytotec.

During the Stakeholder Meeting conducted in the UN House in Yerevan, a representative of an NGO mentioned that pregnant women are buying Cytotec from pharmacies without a doctor's prescription, and are using the pills without knowing the exact dosage needed, which is leading to complications. This was also proven later on during the field trips conducted during this Inquiry.

During the visit to Shirak Marz, a health worker mentioned that unsupervised medical abortions were her biggest concern. She stated that almost always women try to have an abortion by taking pills in their houses, and if that does not work, then they come to the clinic. She went further by declaring that she knew a case where a woman almost died because she had taken an improper dosage of Cytotec. She also stated that this issue was her biggest concern. When the inquiry team was in a clinic in Shirak Marz, a woman entered to receive treatment because she had taken Cytotec without a doctor's supervision. A health worker in Syunik Marz stated that almost 90% of women who want to abort a fetus first try to do it by taking Cytotec and only visit a hospital when the abortion fails.

Moreover, since the need of an induced abortion is a more acute and urgent need compared to the use contraceptives, people tend to find the funds to finance an abortion or purchase Cytotec rather than to regularly purchase preventive contraceptives.

Women living in rural areas, where the use of Cytotec is high, tend to identify abortions with Cytotec as an artificial or spontaneous miscarriage instead of an abortion. For them, abortions require the use of medical equipment and tools. Moreover, a high percentage of women are not aware of the risks associated with Cytotec. Health workers in rural areas have mentioned that symptoms and complications range from incomplete abortions, excessive bleeding, infection, abdominal pain, nausea, polyps, and infertility.¹²⁸

¹²⁸ *Ibid*

The reasons why women living in rural areas choose to use Cytotec rather than having a surgical abortion include: 1) Cheaper cost, 2) fear/psychological stress/shame of surgical abortions, and 3) the fear that confidentiality is not kept.¹²⁹

Among the consequences of unsafe abortions is secondary infertility. Armenia's infertility rate is 17% (the critical level defined by WHO is 15%). Primary infertility comprises 5% of the total rate, while the secondary infertility is almost 12%. Thus, one in six couples in Armenia want to have children, but are unable to because of infertility. The second major cause of secondary infertility is sexually transmitted infections (STIs).¹³⁰

Moreover, women attempting to have abortions by hitting and punching their abdomen is also common, which can be attributed to a lack of information about unsafe abortions. A gynecologist in Yerevan stated that almost every month there is a case where a woman visits the hospital having a hemorrhage because she has had an attempt of an abortion in her house (by hitting her abdomen).

6.5. Pre-Abortion Counseling

During its visits to the Marzs, the Inquiry established that in most cases the abortion counseling for women takes place in the same area as the pregnancy care, which is filled with pictures and brochures of newborns and mothers, and messages encouraging women to have children. These may induce feelings of guilt and deteriorate the mental health of the women who are going to have an abortion, especially if they are not there by their choice and are forced by their husbands or mothers-in-law.

Although states should aim at decreasing the rates of abortions and its use as a method of family planning, this should not come at the expense of the mental and psychological wellbeing of the concerned women.

¹²⁹ *Ibid*

¹³⁰ Reed, S. (2015). Independent Country Programme Evaluation. Yerevan: UNFPA.

6.6. Post-Abortion Care

The ICPD Program of Action states that “women should have access to quality services for the management of complications arising from abortion. Post-abortion counseling, education and family-planning services should be offered promptly, which will also help to avoid repeat abortions.”¹³¹

Following an induced or spontaneous abortion, women should receive post-abortion care. This is specifically important for women who have undergone unsafe abortions, where the post-abortion care is used as a strategy to attenuate the morbidity and mortality associated with complications; offer of contraception to prevent future unintended pregnancies; and linking women with other needed services in the community. For women who have undergone safe induced abortions, follow-up visits may not be required if the woman has enough information about when to seek care for complications. Moreover, all women should receive contraceptive information, and be offered counseling about methods of post abortion contraception, including emergency-contraception.¹³²

Regardless of the legal status of the abortion, the state must ensure access to confidential post-abortion care, free from discrimination, coercion and violence. States should ensure the confidentiality of the women and girls is protected, and eliminate any requirements for health care providers to report patients to law enforcements or relevant authorities who have undergone or are suspected to have undergone an illegal abortion.

As mentioned above, performing illegal abortions are punishable under the Criminal Code of Armenia. Those who perform illegal abortions are subject to fines and even imprisonment. The law does not punish the women who have undergone illegal abortions

However, during its research in the marzs, the inquiry established that health care providers are required to report to the law agencies women or girls who have undergone an illegal abortion. A gynecologist interviewed in Aghveran mentioned: “If we decide that the criminal code has been violated, we have to report them”. This was also confirmed in

¹³¹ *Id* 108

¹³² *Id* 105

Gegharkunik, Shirak and Syunik Marzs. This forms a barrier to accessing post-abortion care, because women and girls will be thwarted from seeking post-abortion care in case of complications because of fear from punitive measures and stigmatization.

During the Inquiry in the marzs, women in rural areas mentioned that they do not receive consultation on post-abortal contraception.

Treaty monitoring bodies, such as the Committee on the Rights of the Child, have recommended that States should ensure access to safe abortion and post-abortion care services, irrespective of whether abortion itself is legal.¹³³ The CAT Committee has criticized laws and requirements that oblige or entail health care workers to report women who seek post-abortion care.¹³⁴ The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has stated that such laws and requirements restrict and create barriers to the realization of women's right to health.¹³⁵

The health care workers interviewed during the inquiry mentioned that they provide post-abortion care to women even if they had had illegal abortions (reporting them to the relevant authorities later), especially if the case is an emergency like hemorrhage.

6.7. Human Rights Education and Reproductive Health Care

The enjoyment of human rights is a pre-condition for the protection, promotion and the enjoyment of human health, including sexual and reproductive health. Health services and health workers are key agents in this process, where they can either enhance the protection and enjoyment of the health rights or hinder them.¹³⁶

The inquiry established that in most cases health workers do not have a good, if any, understanding of human rights laws and principles and their correlation with sexual and reproductive health. The health work-

¹³³ CRC Committee General Comment 15, available at: <http://bit.ly/1M7h2k6>

¹³⁴ CAT Committee, Concluding Observations Peru, available at: <http://bit.ly/1OIUUUI>

¹³⁵ Special Rapporteur on the Right to Health, Report to the General Assembly: Criminalization of sexual and reproductive health, available at: <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N11/443/58/PDF/N1144358.pdf?OpenElement>

¹³⁶ OSCE/ODIHR.(2013). Guidelines on Human Rights Education for Health Workers. Warsaw: OSCE/ODIHR

ers interviewed in the Marzs mentioned that they do not receive any specific instruction or preparation about human rights/patients' rights related to health during their trainings. In one case, when asked about the human rights to health of his patients, a health worker responded:

The rights of my patients? I do not even know my rights

A health care professional, Gegharkunik Marz

Knowledge of human rights norms, principles and values and their integration in the work of health workers improves their interaction with patients, improves their professional practice, and helps them recognize human rights violations that need to be documented and remedied. This importance is highlighted in human rights conventions, declarations, treaty monitoring bodies, and Special Rapporteurs. These include the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), the CEDAW Committee, The Special Rapporteurs on the right to health and on torture.¹³⁷

6.8. Conclusions

Health Centers: During the field visits, the Inquiry team visited hospitals, health centers and clinics in the different marzs. As mentioned earlier, health services, good and facilities should be available, accessible (physically, economically), acceptable, and of good quality. While some health centers were modern, fully equipped and hygienic, the Inquiry team noted some problems.

For example, a health center in Gegharkunik Marz (Sevan) was in an appalling condition. The building was in a dire state, and the rooms and bathrooms were seemingly unsanitary. These conditions hinder the effective realization of the right to health, including sexual and reproductive health. A problem was also noted in Shirak Marz. The concerned health center was modern, equipped appropriately and appeared sanitary. The Inquiry team was required to put on the smocks before entering the maternity ward, however, every other visitor to the ward entered freely without being asked to wear them. Also, a street cat was witnessed entering the ward from the nearby garden.

¹³⁷ *Ibid*

Socially Vulnerable Persons and Women Living in Rural Areas: During the field visits to the marzes, the interviewed health workers reported that the yearly budget allocated for socially vulnerable persons is not enough to cover for the whole year. A health worker mentioned that the entire budget is sometimes spent in the first two months. He also stated that the health center still provides abortion services free of charge once the budget has been spent, but it is not compensated later by the government.

There is also the issue of access to health services, including sexual and reproductive health, in rural areas. In its Concluding Observations to Armenia 2009, the CEDAW Committee stated that it was concerned about “the insufficient access to adequate general health-care services as well as reproductive health-care services for women especially those living in rural and remote areas.”¹³⁸

The use of anesthesia or painkillers during abortion in rural areas depend on their availability in the health centers, personal preference, and whether women were presented with the choice by health care workers. The primary barrier for anesthesia or painkiller use is the cost.¹³⁹

An NGO representative in Syunik Marz stated that there are cases of discrimination against socially vulnerable persons. She mentioned that health workers treat patients from diverse social classes differently; “There was a case where a poor woman visited a doctor for pregnancy care, and the doctor told her that poor families should not have children”.

Moreover, due to the shortage of resources, An NGO member stated that the medications available to socially vulnerable persons, including women living in rural areas, is limited and there are shortages. Therefore, women who want to have an abortion or receive post-abortion care do not obtain the relevant medication, or they do not receive it for free (sometimes including the abortion).

Training of Health Workers: Although health workers regularly receive trainings, they are not available to all health workers in different Marzes. A health worker in Shirak Marz mentioned that they do not receive

¹³⁸ CEDAW Committee Concluding Observations 2009, available at: <http://bit.ly/1TFofgW>

¹³⁹ *Id* 125

“invitations” for trainings and requested it to be available to all health workers in all the Marzes.

Confidentiality: The importance of the confidentiality of patients seeking reproductive health care, including abortion counseling and services and post-abortion care, is highlighted in international human rights treaties and declaration, and by treaty monitoring bodies and Special Rapporteurs. The Inquiry established that violation of privacy and confidentiality occur in health care settings in Armenia. The problem is more serious in remote and rural areas, then in the Yerevan or bigger cities. Health workers and NGO representatives interviewed mentioned that women in rural areas prefer to have abortions in health centers that are outside their living areas, sometimes even preferring to go to the Yerevan. Also, when the Inquiry team was visiting one of the Marzs, two members of the team were invited to have an interview with a doctor in a room where a woman was receiving consultation from a health worker.

Efforts taken by the State: Article 2(1) of ICESCR underlines that States have the duty to progressively realize the rights in the Covenant, including right to sexual and reproductive health.¹⁴⁰ The rationale behind this idea is the recognition that States have financial and resource constraints, and giving them time to realize the Covenant provisions. However, States are still required to demonstrate that they are making an effort and taking appropriate measures to realize the Covenant rights even with limited resources. Moreover, retrogressive measures taken in relation to the right of health are impermissible.

In its Concluding Observations 2014 to Armenia, the ESCR Committee stated that “the maximum available resources are not used by the State party to progressively achieve the full realization of the rights recognized in the Covenant.”, emphasizing that the State should “improve the capacity of line ministries for public finance management, facilitate the dialogue between line ministries and the Ministry of Finance, ensure that resources are effectively allocated according to program budgeting criteria, and increase political awareness of the need to allocate substantial additional resources to health and education, and regularly

¹⁴⁰ International Covenant on Economic, Social and Cultural Rights, available at: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>

assess whether the maximum available resources have been used to progressively achieve the full realization of the rights recognized in the Covenant”¹⁴¹

During an interview, an NGO representative mentioned that the State has actually taken measures to improve effective access to quality abortion services and post-abortion care, but due to the high rates of corruption, they have little or no effect.

Remedies for Rights Violations: The obligation to protect requires States to enact remedies (administrative and judicial) and to redress violations of human rights related to sexual and reproductive rights, including violations of rights related to abortions and post-abortion care. This is a core requirement of the principle of accountability, which ensures that policies and program are appropriately implemented, thus preventing human rights violations.¹⁴²

The inquiry established that there are mechanisms which give the possibility to protect violations of rights in the context of abortion and post-abortion care, and reproductive rights in general. However, an NGO representative stated these mechanisms are not very effective and women do not have much confidence in them. Moreover, the society is not much informed about their existence, which means that the possibilities are not utilized in most cases.

Participation of Women and Girls in the Formulation, Implementation and Monitoring of Health Strategies related to Abortion and post-Abortion Care: All stages of decision-making, implementation and monitoring requires the active participation of women, girls, stakeholders, and the civil society representing them. This is an important step in the process of enhancing accountability and empowering women.

An NGO representative stated that that there are procedures and mechanisms to ensure such participation, but they “were not working or not working effectively enough”.

¹⁴¹ ESCR Committee Concluding Observations 2014, available at: <http://bit.ly/1wWxfrM>

¹⁴² United Nations Population Fund. (2015). A Guide in Support of National Human Rights Institutions: Country Assessments and National Inquiries on Human Rights in the Context of Sexual and Reproductive Health and Well-being. New York: United Nations Population Fund.

6.9. Persons with Disabilities

Women and girls often face discrimination, violence, gender inequality and are stereotyped, especially in patriarchal societies. However, there are cases where women and girls face double or multiple discrimination, and are more vulnerable due to disabilities (physical or mental), social status, race, etc.

Article 23(1b) of the International Convention on the Rights of Persons with Disabilities (ICRPD) mentions that State parties “shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others, so as to ensure that: The rights of persons with disabilities to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family planning education are recognized, and the means necessary to enable them to exercise these rights are provided.”, while Article 25 (a) states that State parties should provide persons with disabilities the same range, quality, and standard of free and affordable health care, including in the area of sexual and reproductive rights.¹⁴³ Moreover, the ICPD Programme of Action makes a specific reference to persons with disabilities and their reproductive rights.¹⁴⁴

As of 2015, there are approximately 198,600 persons with disabilities¹⁴⁵, of which almost 94,000 are women, currently living in Armenia, which makes up almost 6% of the population.¹⁴⁶ Despite the fact that Armenia is a State party to the ICRPD, discrimination against persons with disabilities is a serious issue, where women face an intersectional form of discrimination based on gender and disability.¹⁴⁷

An NGO representative confirmed that women with disabilities face discrimination by health workers, while seeking abortion services or post-abortion care, although he stressed that he did not know of cases

¹⁴³ International Convention on the Rights of Persons with Disabilities, available at: <http://www.un.org/disabilities/convention/conventionfull.shtml>

¹⁴⁴ *Id* 108

¹⁴⁵ Office of the Human Rights Defender of Armenia.(2015). Annual report 2014. Yerevan (Armenian)

¹⁴⁶ Batoyan, Z. (2014). Inclusion and Accessibility of Reproductive Medical Services for Women and Girls with Disabilities in Armenia. Yerevan: YSU Center of Gender and Leadership Studies.

¹⁴⁷ *Id* 143

of forced sterilizations or forced abortions, which are punishable under the Criminal Code of Armenia. Moreover, it was confirmed that women with disabilities or the NGOs and the civil society that represent them do not have a meaningful participation in the formulation, implementation, and monitoring of strategies or programmes on the prevention of unsafe abortions, access to safe abortion and post-abortion care. This fact furthers the discrimination faced by women with disabilities and erodes accountability.

Furthermore, the visits to the health centers and facilities during the Inquiry confirmed that not all of them are physically accessible (partially or totally) to women with disabilities, thus forming obstacles and barriers for their reproductive health rights, including abortion and post-abortion care. This issue is compounded by the fact that some health care workers do not treat women with disabilities positively or treat them in a discriminatory manner.¹⁴⁸ This problem is more evident in regional or rural health centers and institutions. The Inquiry further established that health workers do not have specific guidelines on how to deal with women with disabilities seeking abortion or post-abortion care, which explains the gaps concerning knowledge about the special needs of persons with disabilities.

As mentioned earlier in this chapter, not all women are fully and adequately informed about abortion and post abortion care. The seriousness of this issue is compounded in the case of women with disabilities, since within the scope of the inquiry, the team was unable to find didactic health promotion material for people with visual impairments. To have adequate access to such information, they require the assistance of family members or acquaintances, which may violate their right to privacy and confidentiality.

The discriminatory treatment of women with disabilities regarding sexual and reproductive rights, including abortion and post-abortion care rights is also related to the stereotypes, assumptions and the pervasive false beliefs that consider persons with disabilities as being asexual, especially those who have mental disabilities. During the Inquiry, most health workers interviewed mentioned that they have had only a few patients with disabilities or not at all.

¹⁴⁸ *Id* 144

6.10. Sex-Selective Abortions and pre-natal Sex Determination

Sex-selective abortions or pre-natal sex determination is a serious issue in Armenia and its severity is getting worse (Armenia now ranks third in the world in the prevalence of sex-selective abortions, being behind only China and Azerbaijan). Each year, over 1400 girls are not being born in Armenia due to sex-selective abortions.¹⁴⁹ By the year 2060 nearly 93,000 women will be missing in Armenia if the trend of sex-selective or pre-natal sex selection remains unchanged.¹⁵⁰ According to Garik Hayrapetyan, from 1993 onward the number of men aged till 20-21 is 50,000 more than women in Armenia. The ratio of son preference to daughter preference in Armenia is 5 in Armenia.¹⁵¹ Sex-selective abortion is a form of discrimination and violence against women, and is an unethical and harmful practice.

The ICPD Program of Action called upon States to tackle the issue of sex-selection. Moreover, international bodies have taken notice of the seriousness of the issue and have made recommendations to Armenia. The Human Rights Committee, in its concluding observation 2012, expressed its concern in the rising practice of sex-selective abortions.¹⁵² The ESCR Committee stated its distress about the “fact that Armenia has one of the highest levels of male births compared with female births observed anywhere in the world as a result of sex-selective abortions.¹⁵³ The parliamentary Assembly of the Council of Europe passed a resolution (Resolution 1829) in 2011, condemning sex-selective abortions. In it the Parliamentary Assembly condemned “the practice of prenatal sex selection as a phenomenon which finds its roots in a culture of gender inequality and reinforces a climate of violence against women”. Furthermore, the resolution called the authorities in Armenia to investigate the causes of sex-selection, collect reliable data, step up efforts to raise the status of women in society, etc.¹⁵⁴

¹⁴⁹ *Id* 110

¹⁵⁰ Hayrapetyan Garik, available at: <http://eeca.unfpa.org/news/93000-women-be-missing-armenia-2060-if-high-pre-natal-sex-selection-rate-remains-unchanged>

¹⁵¹ *Id* 110

¹⁵² HRC Committee Concluding Observations 2012, available at: <http://bit.ly/1NKvbcl>

¹⁵³ *Id* 139

¹⁵⁴ Parliamentary Assembly of the Council of Europe Resolution 1829, available at: <http://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=18020&lang=en>

Sex-selective abortions result in a skewed sex ratio at birth (SRB). The normal biological SRB is 102-106 boys per 100 girls, whereas in Armenia it has reached almost 114.5 per 100 female births. The SRB also varies between different Marzes. For example, in Syunik Marz, pre-natal sex determination remains moderate, while Gegharkunik Marz has a birth masculinity that is even higher than China.¹⁵⁵

For sex-selective abortions to take place, three preconditions or factors should exist; 1) son preference (demand side), 2) availability of reproductive technology (supply side), and 3) low fertility (the squeezing effect).¹⁵⁶ All of these three preconditions exist in Armenia.

Son preference is deeply embedded due to the patriarchal structure of the Armenian society. The main reason for the inequity between men and women is the prevalent patriarchal culture which is based on a patrilineal kinship system. Armenian families prefer to have a son six times more than having a female child. In this system, families revolve around the male line, while girls cease to belong to their native family once they get married.¹⁵⁷

Son preference is also a manifestation of gender inequality and the low status accorded to women in society. Gender inequality is expressed in the form of unequal access of women to employment opportunities, wages, access to resources (feminization of poverty) and political representation (both on the local and national level). Women in Armenia also suffer from an unequal power situation, where masculine value norms have aggravated their vulnerable situation.¹⁵⁸

During the Inquiry such sentiments came to the fore. When asked about the prevalence of sex-selective abortions, a health worker stated:

I think that is a good thing. After all, we need men for our army

A health care professional

¹⁵⁵ Guilмото, С. Z. (2013). *Factsheet on "Sex Imbalances at Birth in Armenia: Demographic Evidence and Analysis" Report*. Yerevan: UNFPA.

¹⁵⁶ UNFPA Asia and Pacific regional Office. (2012). *Sex Imbalances at Birth: Current trends, consequences and policy implications*. Bangkok: UNPA Asia and Pacific Regional Office.

¹⁵⁷ *Id* 110

¹⁵⁸ *Id* 110

As mentioned above, the other two preconditions for sex-selective abortions are the availability of reproductive technology and low fertility. Low fertility is correlated with economic conditions, especially in rural areas.¹⁵⁹ As a result of poor living conditions, women in Armenia have few children, sometimes even fewer than desired. The likelihood of having male children in families that have two or fewer children, therefore this has become a primary driver of sex-selective abortions, since repeated pregnancies are no longer the preferred solution to ensure the birth of a son.

The Inquiry established that gravity of sex-selective abortions is getting worse. While women used to have sex-selective abortions mostly during their third pregnancies, nowadays they are also performing it during the first or second pregnancies as well (while the first and second births represented less than 9% of the extra male births from 1996-2001, the number has increased 26.1% of all extra male births from 2001-2010).¹⁶⁰ A health worker interviewed in Shirak Marz mentioned that nowadays some women are performing sex-selective abortions even during their first pregnancies. She stated that since sex-selective abortions take place after the 12th week of pregnancy (when abortions can be performed only according to the socio-medical indicators), the health workers performing such abortions either change in their report the date the abortion took place, or state that the concerned woman had a miscarriage.

The phenomenon of sex-selective abortions in Armenia is correlated with forced abortions. Forced abortions are violations of the right to health, and according to the Human Rights Committee, can be considered a violation of Article 7 of the ICCPR which states that “No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment”.¹⁶¹

In Armenia, the husbands and their parents (specifically their mothers) oftentimes intervene and have an influence in the reproductive decision making of women. Son preference by the husbands and their parents are a significant factor in the disproportionate ratio of male-to-female

¹⁵⁹ *Id* 125

¹⁶⁰ *Id* 153

¹⁶¹ HRC General Comment 28, available at: <http://bit.ly/ISScmE7>

births, and has resulted in psychological and physical abuse of women. The psychological abuse have included pressure and threats to divorce, oust from the house, cut financial means, etc., while the physical abuse includes battery and beatings to force women to have an abortion or to cause the abortion.¹⁶² A health worker in Shirak Marz mentioned that she had witnessed cases where women did not want to abort the female fetus, but they were forced by their mother-in-laws. Furthermore, when a birth of a child is registered by the father the SRB is higher (116.8) then when the birth is registered by the mother (single mothers), which is barely above from the normal SRB (106.3).¹⁶³

Other reasons given to justify sex-selective abortions are: 1) Desire of the parents for their male children to have brothers, and 2) the perception that male children provide security for the aging parents.¹⁶⁴

To counter this phenomenon, the MOH has prepared a draft law that will make sex-selective abortions illegal. This said, Abortions are provided upon a woman's request up to the 12th week of pregnancy, a period during which the sex of the fetus may not be determined yet, which makes sex-selective abortions illegal already (being performed after the 12th week).

To sum up, women are subjected to gender-based psychological and physical violence to have male children, and are forced to undergo consecutive abortions which may have consequences on their physical and mental health. Moreover, sex selection reinforces the culture of gender inequality and discrimination and the low value placed on girls. On the long run, sex-selective abortion will further distort the sex-imbalance and create a surplus of men, which in turn will affect their marriage prospects, decrease in birth rates, increase in human trafficking, crime, gender-based violence and political unrest.

¹⁶² US Department of State. (2014). Armenia 2014 Human Rights Report. Washington: US Department of State

¹⁶³ *Id* 153

¹⁶⁴ *Id* 125

6.11. Recommendations

Although efforts are being taken by the State to improve Abortion services and post-abortion care, more is required. Unless gender discrimination and inequality, women's role and status in society are not addressed and improved, efforts to improve sexual and reproductive health rights, including abortion services and post-abortion care would be ineffective and fruitless.

Recommendations:

- ✓ In order to reduce the rate of abortions and to stop its use as a family planning method, the government should step up efforts to change the negative perception concerning modern contraceptives by segments of the population and even health care workers. Moreover, despite difficulties, the government should step up its efforts in making modern contraceptives available and accessible to all segments of the population.
- ✓ The State should make the existing ban on the over-the counter purchase of Cytotec effective. At the same time, it should raise public awareness of the dangers and consequences of unsafe abortions and of using Cytotec without a health worker's supervision
- ✓ Health care centers should provide abortion counseling to women in areas outside the maternity ward.
- ✓ Remove the requirement for health care workers to report women who have undergone illegal abortions to the police or relevant authorities. This requirement can act as a barrier for women trying to effectively access post-abortion care.
- ✓ Provide mandatory human rights training to all health workers, specifically to those who work in the field of sexual and reproductive health.
- ✓ Improve the physical conditions of some of the health centers in the Marzs, making them more hygienic and sanitary
- ✓ Revise the budget allocated for socially insecure persons to ensure that it covers for the whole year. Insure that there is adequate access to reproductive health care in rural areas. Insure that anesthesia, painkillers and medications are available accessible and affordable to all women undergoing abortion.

- ✓ Eliminate all forms of discrimination in the provision of health care services, including discrimination based on disabilities and social status
- ✓ Ensure that trainings are available to all health care workers.
- ✓ As stated in the Concluding Observation 2014 of the ESCR Committee, the State should use the maximum available resources to ensure the realization of the right to health, including sexual and reproductive health.
- ✓ The State should enact effective remedies for violations of rights in the context of sexual and reproductive health, including abortion and post-abortion care.
- ✓ The State should ensure the effective participation of women and girls, civil society and various stakeholders in the formulation, implementation, monitoring of health strategies related to abortions and post-abortion care.
- ✓ The State should step up its efforts in eliminating discrimination against persons (mainly women) with disabilities in the reproductive health care setting. Health care workers should receive training and specific guidelines on how to treat and deal with women and girls with disabilities. Furthermore, the State should insure that all health care facilities are physically, psychologically and economically accessible for women with disabilities.
- ✓ The State should ensure that all women and girls have adequate access to accurate information regarding abortions and post-abortion care.
- ✓ The State should refrain from requiring third-party authorization for minors to obtain abortion services. It should encourage the parents'/guardians' participation and engagement but not require it.
- ✓ To combat sex-selective abortions and to halt the increasing sex-ratio imbalances, the State should, in addition to passing laws which are ineffective in isolation, take broader measures to address the underlying social and gender inequalities that are at the root of sex-selection. Measures can include: a) Mandatory gender-sensitivity training for family planning officials, b) collection of more reliable data on sex-selection and its causes, c) promoting gender equality and women's right in a coherent legal framework, d) adopt legis-

lation criminalizing domestic violence(either as part of the Criminal Code or a separate legislation), e), design advocacy and public awareness raising campaigns and programs to change the mindset of the population and to increase the recognition of the value of women and girls in society, f) involve in a more rigorous oversight of the conduct of health care workers regarding the phenomenon of sex-selection, g) engage women, girls and various stakeholders in the formulation and implementation of laws and policies designed to combat sex-selection.

7 | ADOLESCENTS SEXUAL AND REPRODUCTIVE HEALTH RIGHTS INCLUDING COMPREHENSIVE SEXUALITY EDUCATION

According to the UN Population Fund estimates, today's adolescents comprise approximately one quarter of the world population. Among others, reproductive ill health is included in the major cause of morbidity and mortality among adolescents.¹⁶⁵ It is noted that adolescents face significant challenges in accessing good quality reproductive health services and comprehensive sexuality education worldwide.¹⁶⁶ Most young people still have limited access to good quality education, decent employment, and recreational facilities, as well as limited access to sexual and reproductive health program, information, skills, Sexual and reproductive health (SRH) and HIV-related services.¹⁶⁷ Very often reproductive health needs of adolescents are reported to be unmet. Policies aligned to international conventions and treaties create an enabling environment conducive to the enjoyment of sexual and reproductive health rights. The present qualitative investigation aimed to reveal and discuss the compliance of the policies and regulations present in Armenia with the international treaties and conventions the National Assembly of the Republic of Armenia ratified. Additionally, the team of investigators aimed to collect information on the factors impeding the effective execution of laws and policies pertaining sexual and reproductive health and rights of adolescents.

¹⁶⁵ Sexually Transmitted Infections Among Adolescents, Karl L Dehne, Gabriele Riedner: available at: <http://bit.ly/1IZWda6>

¹⁶⁶ UNFPA: Available at <http://www.unfpa.org/resources/adolescent-sexual-and-reproductive-health#> accessed on 8/23/2015

¹⁶⁷ Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS, 2011.

7.1. Situation in Armenia

A comparative analysis of results of adolescent reproductive health surveys¹⁶⁸ conducted in Armenia, Azerbaijan and Georgia reveals that the respondents in all three countries, more often in Armenia, have insufficient knowledge about the physiological and pathological processes taking place during puberty. Other studies confirm the lack of factual knowledge and indicate prevailing misconceptions about the modern contraceptives and shame to request reproductive health (RH) services.^{169, 170}

Over the past five years the age at first sexual intercourse among both female and male respondents at the age of 25–49 has slightly increased (from 20.7 in 2005 to 21.1 in 2010 for the male population and from 19.8 years in 2005 to 20.2 in 2010 for the female population). In case of Armenian women the age at first sexual intercourse coincides with the age of marriage (20 years old). The age of first sexual intercourse varies depending on demographic characteristic. The median age at first sexual intercourse is higher among the urban women compared to that among the rural women. It also varies depending on the years of education completed. The median age of first sexual intercourse is lower among women with lower level of education. The highest median age was recorded in Yerevan (22.7 years) and the lowest in Gegharkunik (19.5 years).¹⁷¹ The opposite picture is observed among Armenian male population. The age tends to be lower in urban areas compared to rural areas and decreases depending on wealth and education level. Adolescents' pregnancies start at the age of 17 and tend to increase with the increase in age. In the age group of 17 the proportion of pregnancy cases constitutes 1.4% followed by 6.7% among 18 year olds and reaching 13.5% among 19 year old adolescent women.¹⁷² Additionally, over the past 20 years, adolescent fertility decreased from 69.1 live

¹⁶⁸ Reproductive Initiative For Youth in the South Caucasus: Comparative Analysis of Results of Adolescents Reproductive Health Surveys Conducted in Armenia, Azerbaijan and Georgia; Tbilisi 2009

¹⁶⁹ *Ibid*

¹⁷⁰ The Adolescents' Health Protection is a Problem of High Priority in Armenia: Results of the National Survey and Case Studies on Sexual and Reproductive Health Knowledge, Attitude and Behavior; Yerevan 2009

¹⁷¹ DHS 2010, Armenia: available at <http://dhsprogram.com/pubs/pdf/FR252/FR252.pdf>, accessed at 8/03/2015

¹⁷² *Id* 136

births per 1,000 women aged 15-19 years in 1990 to 22.7 live births per 1,000 women aged 15-19 years in 2013¹⁷³. The number of legally induced abortions in the same age group was 5.0 per 1000 women aged 15-19, in 2013.¹⁷⁴

The Armenian Demographic and Health Survey (ADHS) 2010 indicates that 65.0% of women and 80.0% of men have heard of sexually transmitted diseases among which Syphilis (90.0%) and HIV/AIDS (70.0%) were mentioned most frequently. Unfortunately, no disaggregated information is available for adolescents making it difficult to exhibit the situation specific to adolescents. The DHS 2010 recognizes the potential underreporting of sexually transmitted diseases during the survey and thus recommends considering those statistics with caution. The proportion of men reporting common symptoms of Sexually Transmitted diseases (STI) constituted 2.0%. Meanwhile, the proportion of women reporting common symptoms was estimated to be 3.0%. At the same time, in the period of June 1998 and 2015, 2,194 cases of HIV infection has been recorded among the Armenian citizens.¹⁷⁵ From which 334 cases were registered in 2014, which exceeds the yearly registered number of cases recorded previously. Proportion of male registered cases (69.0%) surmounts that of the female cases (31.0%). Fifty three percent of people at the moment of registration of HIV status were in the age category of 25 to 39.¹⁷⁶ The number of urogenital diseases has slightly increased over time (46.4 cases per 100,000 populations in 2009 to 55.1 in 2013). The number of cases of urogenital diseases among the age group of 0-14 also increased (from 4,576 in 2009 to 6,286 in 2012).¹⁷⁷

¹⁷³ United Nations Population Fund (2015) Country programme document for Armenia. New York. Available at http://www.unfpa.org/sites/default/files/portal-document/DP.FPA_.CPD_.ARM_3-LF-HR-FINAL-30Mar15.pdf

¹⁷⁴ TransMonEE and World Bank 2013, UNICEF. Available at <http://www.transmonee.org;http://data.worldbank.org/indicator/and> <http://data.worldbank.org/indicator/SP.ADO.TFRT>

¹⁷⁵ http://www.armmaids.am/main/free_code.php?lng=2&parent=3, accessed at 8/03/2015

¹⁷⁶ *Ibid*

¹⁷⁷ <http://armstat.am/file/doc/99489203.pdf>

7.2. Laws and Regulations Pertaining to Reproductive Health and Comprehensive Sexuality Education

The Government of Armenia (GoA) in its strategy on the protection of rights of children for the years of 2013-2016 recognized the lack of knowledge among youth pertaining to reproductive health and noted dearth of youth friendly health services. In addition, it highlighted the difficulties regarding the organization of such services, particularly the assurance of confidentiality. In the law (Article 2) on reproductive health and reproductive rights N-474-Ն the adolescents are referred to as individuals from 10 to 18 years old. Even though the RA law on the reproductive health and reproductive rights defines adolescence, nevertheless, in other legal document the term is not clearly defined. Very often, adolescents are categorized under the term “child/ren” or are generally stated as “all individuals”. Clear definition of “adolescence” will provide opportunity to precisely define this category and individuals belonging to thereto and hence will allow better operationalization of legal and regulatory frameworks.

According to the Article 5 of the law on reproductive health and reproductive rights of the Republic of Armenia the adolescents have the rights to:

- ✓ Sexuality education, including the right to preservation of sexual and reproductive health
- ✓ Be informed of matters pertaining to sexual development, sexual and reproductive health
- ✓ To have necessary/essential knowledge on abortion, sexually transmitted diseases, including modern means of prevention of HIV
- ✓ Obtain full and affordable medical counselling in private and friendly conditions, if necessary, to get medical help on matters pertaining to sexual development and sexual and reproductive health.

The present law on reproductive health and rights *respects* adolescents’ right to access to reproductive health information and services. The Article 7 and Article 8 of the RA law on “Provision of Medical Aid and Population Services” delineate the scope of autonomy and access of adolescents to reproductive health information and services. More specifically, according to Article 7 of the corresponding law the infor-

mation pertaining to the health status of individuals less than 18 years old is provided to their legal guardians. In addition, the Article 8 states that the consent to medical interventions for adolescents is also given by their legal guardians. Thus, the current law potentially fails to *protect* the full realization of the reproductive health rights of adolescents. In those cases where the legal guardian is not present the decision on medical interventions is made by the medical consilium or if not, the decision is made by the assigned doctor.

Article 8 might also limit the scope of the provision of confidential and private reproductive health counseling to adolescents stated by Article 5. Furthermore, there are certain shortcomings in the successful implementation of Article 8, which is the absence of standardized documentation of the legal guardian accompanying the adolescent. The latter enables bypassing the law and may thus risk the full and effective execution of the SRH rights of adolescents.

Article 18(5) of the law on Education of the Republic of Armenia states that: “In the middle school, the education is directed for the sake of preservation of health; for the formation of scientific understanding of the world and the nature; and for the assurance of provision of essential knowledge for an independent life”. In 2008 by the decree of the Minister of Education N637-Ս/Ք, Healthy Lifestyle education curriculum was introduced in the state education program which incorporates reproductive health section. In the present time, all of the schools are obliged to implement the nationally approved curriculum.

7.3. Availability, Accessibility, Acceptability and Quality of Reproductive Health Services and Comprehensive Sexuality Education for Adolescents

Availability: Reproductive health services are provided in a variety of health care facilities and diagnostic centers including primary health care facilities, specialized clinics and hospitals.

Primary health care is provided by a network of first-contact outpatient facilities involving urban polyclinics, health centres, rural ambulatory facilities and Feldsher Midwifery posts (FAPs), depending on the size of

the population in a particular community.¹⁷⁸ In 2013, there were over 514 ambulatory facilities and polyclinics in the country.¹⁷⁹

The responsibility of provision of health care services in the regions (marzes) is put on the shoulders of the local health care facilities. Based on the medical indications the primary health care professional is in charge for the referrals and the organization of the treatment of the patients (in this case the adolescents), based on the guidelines/protocols approved by the Ministry of Health.

According to the decree N-70 of the RA Minister of Health, the provision of medical aid and services to adolescents is delivered by the primary health care doctor or adolescents' doctor at the level of regional or municipal polyclinic. According to the same decree the adolescents have the right to receive the following free of charge services:

- ✓ Continuous monitoring and evaluation of the health status of adolescents, including psychosocial examination and assessment of their sexual development based on Tanners scale. In addition, if necessary receive medical assistance and services.
- ✓ The provided medical services also include the provision of youth friendly health services in private and confidential environment. Those services also include counseling on matters pertaining to reproductive health, harmful habits etc.

During the interviews conducted in the scope of this public inquiry, when asked about the services the health care facilities provide to adolescents, the participants most frequently mentioned about two preventative programs. One program is based on the Governments' decision N748-Ն made in 2008 and calls all 14-15 years old male adolescents for a mandatory pre-military and military examination, and if necessary for a medical assistance. The second program is conducted by the guidelines approved by the decree N77-Ն made in 2013 of the Ministry of Health and targets female adolescents at the age of 15 to 18. These programs include mandatory assessment of physical and sexual development, specialized counseling and laboratory tests. It is important

¹⁷⁸ Health Care in Transition, 2013: available at https://www.ecoi.net/file_upload/1788_1386770750_hit-armenia.pdf

¹⁷⁹ National Statistical Service of the Republic of Armenia: <http://armstat.am/file/doc/99489203.pdf>

to note that when asked about visits other than those within the mentioned two mandatory programs the health care professionals often reported rare visits of adolescents to their health care facilities with an inquiry for reproductive health services.

For female adolescents the school nurse or a teacher assigned to the class accompanies the students to the local primary health care clinic or health care facility for the mandatory check-ups. As such, the results of the check-ups are delivered to the adult (teacher or the nurse). Afterwards, in case of problems identified the school reports to the parents. In case of male adolescents, the military units the adolescents are assigned to organize the required check-ups. Some of the check-ups are conducted at the military rallying points while the others are referred to primary health care units the adolescents are registered at.

In regards to child marriage, the international human rights bodies have called on States to eliminate this phenomenon and make the legal minimum age for marriage 18 for both men and women.¹⁸⁰ The UN CEDAW and CRC recommendations highlight that the minimum age of the marriage should not allow exceptions even with consent. The state has relinquished the gender inequity pertaining to the age of marriage noted in the CRC state party report in 2011. Presently, the chapter three (Article 10) of the Family Code¹⁸¹ of the Republic of Armenia states that the legal age for marriage for both male and female is 18. However, there are sub conditions that allow marriages at an earlier age. Accordingly, an individual may enter marriage at 17 years of age, if there is the consent of the legal guardian. An individual may also enter the marriage at 16 years of age, if there is consent of the legal guardian and the marriage partner is at least 18 years old.

The curriculum on healthy lifestyle education introduced in 2008 includes a section on sexual development (puberty, and reproductive health). The curriculum is designed for 8-11 grades. The section on reproductive health covers such topics as gender roles, puberty, hygiene and topics related to love, family as a value, casual sexual relationships and risk behavior, sexually transmitted diseases and HIV/AIDS, unwanted pregnancies, sexual harassment and discrimination,

¹⁸⁰ Committee on the Rights of the Child. General Comment No. 4, para. 20; CEDAW Committee. General Recommendation No. 21, para. 36.

¹⁸¹ <http://www.arlis.am/documentview.aspx?docid=83374>

family planning (including modern contraceptives). The curriculum is not directed solely for the sake of dissemination of factual knowledge among students but also for the development of values and attitudes around matters pertaining to their sexuality, relationship and family. Along with the school based curriculum there have been extensive peer education, outreach programs, and services delivered to young people across the country since 2009 by various non-governmental organizations.¹⁸²

Accessibility: The accessibility in this chapter is discussed in terms of four defined categories: 1) geographic accessibility; 2) physical accessibility; 3) economic accessibility; and 4) information accessibility.

The analysis of the focus group discussions and in-depth interviews revealed that the level of *geographic accessibility* varied between cities and villages. In fact, health care professionals working in villages and small communities mentioned that many patients have to travel long distances to access health care facilities for more specialized care or diagnostic tests that are unavailable in their local facilities. Meanwhile, the professionals from cities described the opposite picture.

...we refer the adolescent to ultrasound examination. And here we have a barrier. We live 12 kilometers away from the marz health care center. We refer and the mother says that she will certainly take the child to ultrasound examination. Later, when you ask her [referring to the mother] if she took the child she says: "no I am waiting until my husband sends money from Moscow." The ambulatory does not have ultrasound equipment and there is a financial strain associated with the transportation.

Health Care Professional, Focus Group Discussion, Gegharkunik

It is completely different in my case [in the city], our health care facility is fully equipped and we have specialized professionals".

Health Care Professional, Focus Group Discussion, Gegharkunik

Most of the health care facilities visited during this investigation were newly renovated and the entrances were accessible for people with physical disabilities. However, few of them had elevators (general) or

¹⁸² https://www.unfpa.org/sites/default/files/pub-pdf/maternal_health.pdf

special equipments for wheelchairs enabling the access to stairs. Two of the doctors mentioned that they made home visits to few patients living with physical disabilities as they had limited access to the local health care facility. The same is true about the schools. Even though some of the schools had a ramp for wheel chairs none of the schools had an elevator to enable access to upper floors. At some schools friends would help to access upper floors while in the others the school administration would rearrange classes in such a way that the sessions are conducted on the first floor. Thus, it became evident that the *physical accessibility* for children with disabilities might be limited to schools and health care facilities.

The *economic accessibility* is somewhat improved for several population groups. According to the Article 10 of the law on reproductive health, the provision of reproductive health counseling and services are free of charge and are included in the basic benefit package (BBP). The lists of services included in the BBP are either fully or partially subsidized by the Government. The population groups receiving full coverage for the services under the BBP include: "...children (less than 18 years old) living with disabilities, in single-parent households, identified as orphans, or in care; large families (four or more children less than 18 years of age); and households living in poverty".¹⁸³ Those not included in the specified list are obliged to pay user-fees for hospital services and pay for outpatient pharmaceuticals directly and in full.¹⁸⁴ The mentioned two preventive programs for adolescent girls and boys are also free of charge. Even though the BBP ameliorates to some extent the financial strain associated with the acquisition of the health care services, nevertheless, some financial burden still remains for a large segment of adolescents who are not fully covered under the BBP and do not have independent financial sources. More specifically, in such cases the financial source for those adolescents would be the primary caregivers. In fact, adolescents might feel reluctant to approach adults, given the sensitivity of topics related to the reproductive health issues. Hence, this may postpone the visit to a health care professional which may in turn result in a medical complication due to a late treatment.

¹⁸³ Health Care in Transition, 2013: available at https://www.ecoi.net/file_upload/1788_1386770750_hit-armenia.pdf

¹⁸⁴ *Ibid*

The predominant majority of the interviewed health care professionals highlighted dearth of accurate sources of information for adolescents on the matters of sexual and reproductive health. They have reported lack of awareness and misconceptions on such matters. Many of them further emphasized the need of sources of factual information given the increased access to inaccurate and sometimes confusing information available on web.

... They [referring to adolescents] need factual information that should be acquired at schools and educational institutions

Health Care Professional, Focus Group Discussion, Gegharkunik

Now they have internet... and they access information. But they do not access the information that is essential for them

Health Care Professional, Focus Group Discussion, Gegharkunik

... and, sometimes it has the contrary effect, in a way that they have wrong interpretation or understanding of those things... they need factual, professional information

Health Care Professional, Focus Group Discussion, Lori

Acceptability: Within the scope of this investigation we attempted to portray the environment in which the adolescents receive counseling and services pertaining to their reproductive health. As mentioned in the law on reproductive health and reproductive rights, the adolescents have the right to “obtain full and affordable medical counselling in private and friendly environment”. The analysis of the in-depth interviews and focus group discussions confirm the stigma associated with the visits of single girls to “women counseling”, particularly in small marzes and regions where the residents know one another.¹⁸⁵

¹⁸⁵ Decisions related to family planning and selection of contraceptives among Armenian women; Cross-sectional qualitative study. Mkhitarian Samvel, *UNFPA internal*, 2014 Yerevan, Armenia

... Most of the time they say that if I go to a doctor they will see and question why is she going to a doctor, it means she is sick that she goes. It is very widespread.

Young female, Mardouni¹⁸⁶

There was such a case when we referred the adolescent to echo-sound test and this information was disseminated and interpreted in a way that the child is pregnant.

Health Care Professional, Focus Group Discussion Gegharkunik

We did ultra-sound to an adolescent at the age of 15, do you know what kind of reaction it triggered. 15 years old... they went to a consultation, and abortion. The entire village was talking about it.

Health Care Professional, Focus Group Discussion, Gegharkunik.

In addition to the stigma pertaining to visits of women consultation cabinets, concerns related to the patients' confidentiality often make the families take their child to health care facilities located in another region or in the capital.

... they do not visit doctors [referring to small villages] if they have the option they go to the closest nearby region where no one knows them. From Spitak they would go to Vanadzor, from Vanadzor they would come to Yerevan...

Health Care Professional, In-depth interview, Yerevan

During the conduction of this inquiry we were unable to picture the specific mechanisms that help the professionals assure the confidentiality of the adolescents. When asked about such mechanisms, the professionals would often refer to the medical code of ethics. However, no institutional or nationally approved mechanisms were mentioned. Absence of such mechanisms enables violations of the right of an individual to confidential and private services. On one hand the privacy of the adolescent might be violated by the presence of the adult (parents

¹⁸⁶ *Ibid*

or the teacher/nurse from school) during the counseling and medical examinations, and on the other hand the people sitting in the waiting area can easily recognize the patients entering and exiting the consultation room. Hence, in small villages where residents know one another may, by virtue of prevailing stigma associated with such services, incorrectly perceive and disseminate information about the patients they met there.

It was a young girl 15-16 years old. She had a rash on her skin. But when I looked there was nothing. She was with her mother. Her mother received a call and left the room for one minute. During that 1 minute the girl managed to say that she had a relationship with a guy and she had complaints and asked me to examine her and not to tell her mother.

Health Care Professional, In-depth interview, Yerevan

They [referring to adolescents] come with their mothers, they say that they have complaints, but I usually talk to the child. I ask the child to tell herself about her complaint. I have not had a case where the presence of the parent would disturb the process.

Health Care Professional, In-depth interview, Vanadzor

The analysis of the in-depth interviews indicates that the structure and the content of the counseling remain random and varied from one professional to the other. Several professionals mentioned that they provide comprehensive information regardless of the inquiry of the adolescent while the others would chiefly focus on the specific matter of the visit.

They usually do not raise other questions and I proceed with their inquiry.

Health Care Professional, In-depth interview, Vanadzor

This may predominantly be due to the absence of counseling guidelines approved by the Government.

The mode of delivery of the reproductive health classes at schools also

varied from school to school and no common pattern was observed. General observation was that the teachers were reluctant to mention challenges associated with the delivery of the sessions. However, when asked about the appropriateness of the topics and the depth of the information some of the teachers mentioned that the parts on physiology and condoms are not appropriate for children at that age.

Quality: Within the scope of this qualitative investigation we have attempted to reveal the specific training of 1) health care professionals in delivering youth friendly health services at health care facilities, and 2) teachers in delivering reproductive health education at schools.

A client exit research¹⁸⁷ conducted in reproductive health facilities by the “For family and Health pan Armenian Association” in 2004 revealed that the majority (61.0%) of the respondents reported lack of youth friendly approach. When asked about youth friendly approach no unified definition was articulated among health care professionals. Only two of the interviewed health care professionals mentioned that they underwent a special training on delivering youth friendly reproductive health services. Those two trainings were within the scope of one of the program aiming to open youth friendly cabinets in Armenia. Since then, the participants did not mention any other specialized training on this matter. In addition, within the course of the document review we were unable to find any specific guideline approved by the Government on delivery of youth friendly services. Hence, the mode of delivery of the youth friendly services mentioned in the current law is mainly left upon the professional.

The professionals, prior to delivering the classes on reproductive health education receive a specialized training organized by the National Institute of Education. Within the course of the interviews conducted with teachers it was hard to determine the level to which they comply with the curriculum approved by the Ministry of Education. Notwithstanding, we were able to identify several challenges. In one case, a teacher said that if she was to choose she would eliminate some parts from the curriculum (e.g., anatomy and physiology and contraceptives) the reason for which is that she thought that those things are impertinent

¹⁸⁷ Ministry of Health of the Republic of Armenia, Youth Friendly Health Services: Concept Paper, Yerevan, 2006.

for children at that age. In addition, she felt uncomfortable delivering sessions on such matters. In contrast, in another school, one of the teachers stated that all of the mentioned subjects are important and he makes sure that the students understand the topic. He also mentioned that he talks to the students like an elder friend or as a parent. One may observe that the practice the teachers employ is somehow determined by the values and attitude of the teacher regarding the subject matter and not their professional responsibilities or job description. In regards to children with mental disabilities, the teachers mentioned that they usually adopt the content of the materials. When asked about the criteria or a guideline for adapting the materials the teachers very often referred to their experience and the individual capacities of those children.

Another observation was that the collaboration between the teachers for the sake of effective delivery of the “healthy lifestyle” classes was limited. This was, particularly true about those schools where the biology teacher or the school administration were convinced that the gym teacher is not the one who should deliver the subject. For instance, in one school there was a very strong collaboration between the school nurse and the gym teacher. During those classes that included very private and sensitive matters they would split the class and the school nurse would help to handle sensitive questions. Whereas in another school, despite the presence of a very skilled biology teacher there was no cooperation between the two in that regards. Such collaborations may in fact increase the quality of the delivery of reproductive health sessions.

7.4. Conclusions

The Government of Armenia recognized the need for preservation of reproductive health and for implementation of health education projects. It committed to develop and implement projects pertaining to adolescents’ physical, mental and psychological development, promotion of healthy lifestyle and preservation of reproductive health through improving the access to reproductive health information and services. The present law on reproductive health and rights *respects* adolescents’ right to access to reproductive health information and services.

However, due to certain discrepancies and incoherence the current policies potentially fail to *protect* the full realization of the reproductive health rights of adolescents.

In addition, the legal age recommended by the international human rights bodies are not firmly embodied in the RA Family Code which enables child marriages.

The law on Education of the Republic of Armenia recognizes the preservation of health as one of its functions and towards realization of which it introduced the healthy lifestyle education curriculum for 8-11 grades. The curriculum incorporates reproductive health section which provides comprehensive sexuality education to students at all schools in Armenia.

Despite certain improvements in the access to health care facilities significant barriers still remain. Such barriers include limited physical accessibility at some facilities and schools, financial costs associated with transportation, treatment (for some segment of adolescents) and lack of accurate sources of factual information on reproductive health for adolescents.

The prevailing stigma associated with the acquisition of reproductive health services and counseling by adolescent girls might significantly hinder the access to health care facilities. On the foreground of the prevailing stigma, the lack of institutional and state mechanisms for assuring the confidentiality of the adolescents may further exacerbate the situation and result in delays in diagnosis and treatment. In addition, the lack of guidelines on the delivery of youth friendly reproductive health services stated in the respective law puts the effectiveness of the practice of such approach under a question.

Certain reluctance was identified in regards to the delivery of some of the thematic parts included in the school based curriculum. Moreover, the extent to which and the form in which children with mental disabilities receive the planed subject may vary from one professional to another. Nevertheless, it was difficult to judge upon the quality of the delivery of the reproductive health sections incorporated in the curriculum.

7.5. Recommendations

- ✓ There is a need for clear definition of “adolescence” for legal and regulatory frameworks which will provide ground for operationalization of this term.
- ✓ The law on the provision of medical services and counseling should reconsider the aspects of parental consent in order to respect the right of adolescents to information pertaining to his/her health status, and decision pertaining to their reproductive health.
- ✓ The state should reconsider the sub-conditions that enable marriage at an age less than the one recommended by the international human rights bodies.
- ✓ Mechanisms should be developed to increase the geographic, physical, and economic accessibility of adolescents (particularly those living with disabilities) to health care facilities and schools.
- ✓ Guidelines and protocols should be developed to insure effective delivery of youth friendly health services and protection of confidentiality of patients.
- ✓ National and institutional mechanisms should be created in regards to assurance and protection of confidentiality of adolescents at health care facilities.
- ✓ There is a need for a comprehensive evaluation of the implementation of the reproductive health curriculum at schools in order to reveal barriers for successful delivery of classes.
- ✓ There is need for thorough consideration of the content of the material of school based reproductive health curriculum for children with mental disabilities.

APPENDICES

Appendix 1: Public poll on exercising the right to reproductive and sexual health in the RA

Informed consent form

Dear Participant,

I _____, work as a consultant within the framework of the public poll conducted in the area of reproductive and sexual health rights organized at the initiative of Human Rights Defender's office staff and the United Nations Population Fund's Armenian Office.

The objective of this poll conducted within the framework of the research carried out first time in Armenia, is to investigate the instances of violation of human rights to sexual and reproductive health care in Armenia, which would help to identify the existing issues and develop appropriate recommendations for improvement in this area. Your opinion, knowledge and experience are highly important to us. We strongly believe that your professional experience will help us form a comprehensive picture of the issues existing in this sphere. The interview will take approximately 45 minutes, during which you will be asked questions related to reproductive health sphere. The results will be publicized in form of generalized data, hence making it impossible to disclose the identity of the interviewee providing the information.

Participation in this poll is voluntary. You are free to decline your participation in it, not to respond to any of the questions or at any time stop the interview. Your participation to the poll is not compensated.

Should you have questions, recommendations or concerns at any time within the scope of the study, you may address them by email to iravunq@ombuds.am or call 010 50 60 01.

Do you agree to participate? (Yes or No):

Do you give your consent for the interview to be recorded? (Yes or No):

Thank you.

Project team implementing Public poll on exercising the right to reproductive and sexual health in the RA

Appendix 2: Interview guide: Maternal Health Care to Ensure Safe Pregnancy and Childbirth

a) for the medical personnel

1. How long do you work in your community?
2. Do you have the equipment and supplies required to ensure quality prenatal care, delivery assistance and post-delivery assistance to the pregnant women?
3. Do you have the drugs required to provide quality prenatal care, delivery assistance and post-delivery care to the pregnant women?
4. What guidance and standards are available to you related to prenatal care, delivery assistance and post-delivery care?
5. Do you have access to guidance or standards which you may use for complicated pregnancies, as well as delivery and post-delivery complications?
6. According to you, are the abovementioned guidance and standards useful and applicable?
7. According to you which should be treated as priority – the life of pregnant woman or the fetus.
8. Have you ever encountered instances of complicated pregnancy where qualified medical assistance was necessary, which was not available in place and it was required to refer the pregnant woman to relevant medical institution? If yes, do you have an effective referral system in place?
9. How do you inform pregnant women of pregnancy complications?
10. How frequently do you have pregnant patients with disabilities?
11. Is your medical institution adapted to provide medical care to pregnant women with disabilities? If yes, please describe.
12. How do you interact with pregnant women with disabilities and how do you provide medical services to them?
13. Do you demonstrate special treatment towards pregnant women with disabilities?
14. What are the difficulties that you encounter in the course of providing medical assistance to pregnant women with disabilities?
15. How frequently do you receive professional qualification enhancement training?
16. Is the level of your involvement in the continuous professional trainings / training courses, self-education, practical skills/ satisfactory to you?

17. Would you like to discuss any topic which we did not cover?

b) for the interviews with pregnant women and women who have had deliveries during the past two years

1. Could you please indicate your address of residence and your age?
2. Where and when have you had your delivery. Is this your first childbirth?
3. On which week of your pregnancy you have applied to medical institution?
4. Approximately how many visits to medical institutions you have had for pre-natal care. Was your consultation carried out by a medical doctor/gynecologist?
5. Was your pregnancy accompanied with any complications?
6. Were you provided with clear and comprehensible information to be able to make informed decisions on medical intervention during the pregnancy.
7. Was your right to confidential service retained during your medical consultations and assistance?
8. Were you able to use free of charge examination, medical care and medicaments guaranteed by State? If no, please provide details.
9. Were you or members of your family requested to pay additional money to receive more “careful treatment” in the course of delivery assistance?
10. [In the event of a post-delivery case] After delivery, how long have you stayed under medical care in the delivery medical institution as well as after being released home.
11. [If a woman has a disability]. Have you ever encountered any limitations to accessibility of maternal and delivery medical assistance? Please provide details.
12. Would you like to discuss any topic which we did not cover?

Appendix 3: Interview guide Access to Family Planning: Access to Contraceptive Information and Service

1. When was the last time when you passed professional training?
2. Who conducted the training (international organizations, state bodies (medical university, national institute of healthcare)).
3. Did you cover issues related to reproductive health, in particular – contraception methods?

If your response is “Yes, I passed a training” , please indicate some of the issues covered with respect to contraception, which you have memorized.

If your response is “No, I did not pass a training”:

Would you like to pass a training?

If your answer is “No” please go to Question 8.

4. During the training were you provided with information materials? If “Yes”:
5. Was the information materials easy to understand /fully comprehensible/ or you would need some clarification on a part of the information provided in relation to modern contraception methods?
6. Per your estimates – were such trainings sufficient for you to further support you in your job in terms of your consultation activities with population regarding contraception means and methods?
7. Did the training topics cover subject such as reproductive rights, in particular, related to the right to use effective contraceptive methods, or was the training limited to purely professional /medical/ subjects.
8. Throughout your professional activity, do you perform female consultations on issues related to fertility regulation, sexually transmitted diseases and protection from unwanted pregnancy.
9. Are there criteria for such consultations or the consultations are provided within the limits of the knowledge you obtained?
10. Do you provide information materials related to contraceptives to the citizens during your consultations. If “Yes”, who supplies you with these materials,
11. In the medical institutions are there informative leaflets related to patients’ rights, and are the questions related to reproductive health, in particular, to contraceptives covered in these leaflets.
12. Do you provide modern means of contraception?

To whom: Men, Women... : If “Yes”, then:

Who supplies you with these materials :

13. Are males made aware of effective contraception methods?
14. Are you aware that by law you/the medical institution represented by you/ is obliged to provide reliable information on the safety, effectiveness and security of available means and methods of contraception, to enable an informed choice of fertility regulation.
15. Are you aware that within the scope of free-of-charge medical assistance and service guaranteed by State, the obstetric-gynecological medical assistance and service in health institutions also includes provision of female consultations on protection from unwanted pregnancy and ensuring availability of modern contraception methods?

If “yes” – do you perform the said function? What procedures do you follow/ especially related to ensuring availability of modern contraception methods/.

16. Do people apply for follow –up consultation? How frequently?
17. Do people with disabilities, mental disorders, HIV-positive, socially vulnerable people apply for consultations?
18. Based on your experience, please indicate whether in your marz/city the selection of contraceptive methods is made based on what is most appropriate for health (determined based on the consultation with health care professional) or the “most affordable” option is selected?
19. Does the population, including adolescents, receive sufficient information on the availability, accessibility of modern contraceptives, and on their right to use appropriate health care services

Appendix 4: Interview Guide Abortion and post Abortion Care

1. Are there cases of abusive treatment of women and girls seeking legal abortion services?
2. Do women who have undergone illegal abortions have to denounce the provider of the abortion procedure?
3. Are you aware of cases of forced abortion? Were they sex-selective abortions?
4. Are adolescents prone to seek clandestine unsafe abortions because of the fear of stigmatization?
5. What are the efforts taken by the state to ensure effective access to quality, respectful post-abortion care, irrespective of the legality of the abortion?
6. Are the effected groups consulted during the process of the formulation of policies, laws, and program?
7. Do you have the equipment and drugs to provide abortion and post-abortion care? Are they of good or high quality?
8. Do doctors check for signs of physical violence when a woman requests an abortion after the 12th week? (in case of suspicion of sex-selective abortion)
9. Do you follow the WHO guidelines on safe abortion?
10. How accessible is to have an abortion in rural areas?
11. If a women has undergone an illegal abortion and requests a post-abortion care, do doctors provide it? Do they have to report it to the police or the relevant authorities?
12. Are their barriers of access to abortion and post-abortion care for persons with disabilities? Do doctors receive training?
13. Is patient confidentiality guaranteed?
14. Does the definition of health encompass both physical and mental health in accordance to WHO's definition of health?
15. Are abortion services available, accessible, acceptable and of good quality?
16. Are there cases of the practice of conscientious objection by health workers? Does the state regulate it?
17. Is post-abortion care (confidential, free from discrimination, coercion and violence) provided?
18. Is post-abortion care provided irrespective of the legality of the abortion procedure?

19. Do the abortion laws reflect WHO guidelines on safe abortion? Do the state collect data on unsafe and/or illegal abortion?
20. Has the state allocated enough budgetary, human and administrative resources to of strategies and plans ensuring that lawful abortion is accessible and affordable for all women?
21. Are there practices conditioning access to post-abortion care on confessing to having undergone an illegal abortion or denouncing the abortion provider?
22. Has the state taken efforts to ensure effective access to quality, respectful, post-abortion care irrespective of the legal status of the abortion?
23. What types of administrative or judicial remedies has the state provided in case a woman is denied an abortion or post-abortion care or when her confidentiality has been breached? Are such remedies accessible and time sensitive?
24. Are there mechanisms to ensure the participation of women and girls in the formulation, implementation and monitoring of health strategies?

Appendix 5: Interview guide Adolescents Sexual and Reproductive Health Rights including Comprehensive Sexuality Education

a) for the medical personnel

1. According to you which are the needs related to adolescents' reproductive health (Prob.: According to you, which are the obstacles to maintaining adolescents' reproductive health)
2. Per your estimates, does the primary health care unit provide all required services for adolescents' reproductive health (Prob.:Do the primary health care units have all the required main medical materials and skills required for providing reproductive health care services to adolescents with physical or mental disability. Do the primary health care specialists undergo special training for working with adolescents (including those with physical and mental disabilities).
3. Please describe the type of consultation received by adolescents in the primary health care units. (Prob.. Are the adolescents accompanied during the consultations? What topics are discussed during the consultations? How are these topics selected? How are the specialists providing adolescent consultation selected? In which conditions are the consultations carried out? How the confidentiality of provided services is maintained?).
4. Please describe how the consultations to adolescents with special needs (mentally or physically disabled) are carried out? (Prob.: Are the adolescents accompanied during the consultations? Which are the obstacles/challenges that arise during the consultations provided to adolescents).
5. Please advise what types of services related to adolescents' reproductive health are provided specifically by your medical institutions (Prob.: Are there services for which the adolescents should visit other institutions? If yes, which are these services. In the instances when the adolescent should visit other institutions, how are the adolescents directed? Are there additional payments for using such services?).
6. Please describe the procedure where there is need for medical intervention in relation to adolescents' reproductive health (Prob.: How is the necessary medical intervention presented/clarified to the adolescent? Who can accompany the adolescent during the medical intervention?).
7. According to you which are the obstacles (financial, physical etc.) to accessibility of services related to adolescents' reproductive health (including – for adolescents with both physical and mental disabilities)

8. According to you how the community population's opinion affect the access to services related to adolescents' reproductive health?
9. Are there issues which we did not cover during the interview, and which are important to better understand this subject?

b) for the school teachers

1. Please describe how the subject "Healthy lifestyle" was implemented in your school?
2. How was the selection made in your school for the specialist who would teach this subject?
3. Please describe the section "Reproductive health" which is a part of "Healthy lifestyle" curriculum (Prob.:What topics are included in this section? How do you organize the teaching of this section? What is the proportion of involvement of boys and girls in this course? What materials are provided to students on this subject. What challenges exist with respect to implementation of this course. How do the parents treat this course?)
4. What types of children with special needs are educated in your educational institution?
5. Please tell us how the section "Reproductive health" is taught to children with special needs (Prob.:Are the training courses/materials adapted to the capabilities of pupils with special needs? What are the challenges in teaching this section to pupils with special needs?).
6. How would you improve the section "Reproductive health" which is a part of "Healthy lifestyle" curriculum both for healthy pupils, and for those with special needs?
7. Are there issues which we did not cover during the interview, and which are important to better understand this subject?