Sexual and reproductive health rights are one of the most controversial and one of the most important rights. These rights are guaranteed by both the domestic law of the Republic of Armenia and a number of treaty documents that clearly delineate the State's obligations to protect those rights.

The often-cited use of rights at the regional level is conditioned by local socio-cultural traditions and customs that play a decisive role in the extent to which these rights violate individual rights and to what extent they are accepted, protected and enforceable.

When talking about human rights in general, it should be noted that it includes rights to holders and responsibilities for states. In this respect, the main bearers of responsibility are the states, and the right holders are the individuals.

Some of these responsibilities require states to refrain from encroachments on the exercise of their rights, others to take steps to ensure the gradual and full realization of human rights by individuals. In other words, states have an obligation to respect, protect, implement and promote human rights.

Speaking of the State's obligation to respect sexual and reproductive rights, it should be noted that it obliges the state to refrain from interfering with or directly violating or directly limiting the exercise of these rights. For example, the state should not impede access to health care for individuals, should not restrict access to contraceptives and abortion, should not discriminate against certain groups for access to and provision of such services, and etc.

The state's obligation to protect sexual and reproductive rights requires that state authorities prevent third parties from interfering with the exercise of sexual and reproductive rights. For example, the state is obliged to protect and control the quality of drugstores in pharmacies, to prevent the sale of dangerous drugs by providers, to impose sanctions on human rights abusers, such as forced abortion, etc.

As for the state's obligation to exercise its sexual and reproductive rights, it requires the state to adopt such legislative, administrative, judicial and strategic measures that will enable and promote the full realization of sexual and reproductive rights. In other words, the state must create an environment where every individual can fully exercise his/her rights. For example, the state should take measures to provide contraceptive services, establish appropriate health care services in rural areas, perform safe abortion services and post-abortion care, and etc.

It should be noted that those human rights responsibilities have been expressed by national human rights institutions still through the Amman Declaration and Action Plan, which was confirmed at the eleventh international conference of the International Coordination Committee on Human Rights Promotion and Protection. The focus of the

conference was “Human Rights for Women and Girls, Promoting Gender Equality: the role of national human rights institutions[1].

The concept of "reproductive health" in general has not yet been clearly and comprehensively defined by any international convention. Due to the above, the content of the term "reproductive health" remains controversial. We mainly outline two approaches to the issue: narrow and broad.

According to the narrow approach, the right to reproductive health is limited only by the recognition of reproductive choice, and therefore, from a legal point of view, the reproductive rights of a person are limited by Article 16.1 (e) of the UN Convention on the Elimination of All Forms of Discrimination against Women.

This relatively restricted view of reproductive rights includes the following basic rights:

- right to form a family;
- right to freely master the issue of the number of children and the time between their births;
- right to information and education about family planning;
- right to access to family planning methods and services.

From this point of view, however, the right to reproductive health is not in itself viewed as a fundamental human right.[2]

As for advocates of the second, broader approach, the latter claim that reproductive rights "include certain human rights already recognized in national law, international human rights instruments, and other relevant UN instruments."[3]

Proponents of this view regard reproductive rights as a fundamental human right.

In this study we consider the right to reproductive health as a fundamental human right. In this regard, we will discuss issues related to safe motherhood and childbirth, abortion, surrogate motherhood and reproductive health strategy and the 2016-2020 action plans discussing the right to reproductive health as a fundamental human right.

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1 https://nhri.ohchr.org/EN/ICC/InternationalConference/11IC/Background%20Information/Amman%20PoA%20FINAL%20-%20EN.pdf

2 C. Packer “Defining and Delineating the Rights to Reproductive Choice” (1998) 67 NJIL 77–95

3 § 7.3 Programme of Action of the International Conference on Population and Development [‘Cairo Programme of Action’]

I. SAFE MOTHERHOOD AND CHILDBIRTH

A number of international documents, ratified by the Republic of Armenia, guarantee the right to family planning. In particular, Article 10 of the UN Covenant on Economic, Social and Cultural Rights recognizes support for the family as a natural and fundamental unit of society. Article 10 (2) provides that mothers should be provided with special protection during prenatal and postnatal periods. For its part, Article 12 of the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) promotes the right to reproductive health, including family planning. The state authorities are urged to take all necessary measures to eliminate discrimination against women in the health sector to ensure access to health care, including equality of family planning services, on the basis of equality between men and women.

The CEDAW Committee, in its General Comment № 24[4], inter alia, addresses the issue of safe motherhood and childbirth, declare that states should take measures to ensure the accessibility of high quality health services by making those services accessible to women. These "acceptable services" are services that are provided to ensure that the woman has given her full informed consent to the service, that the service is respectful of the woman needs and prospects and guarantees her confidentiality and also that the service is accountable[5].

In general, when speaking about the exercise of the right guaranteed by Article 12 of the CEDAW Convention, it should be kept in mind that this article cannot be applied and fully secured independent of other provisions of the Convention. In doing so, the CEDAW Committee, in its same № 24 General Comment calls upon[6] states to report on the measures taken to comply with Article 12 of the Convention to recognize the interdependence of other provisions of the Convention which may affect the health of particular women.

Speaking of safe motherhood and childbirth, it is important to provide equal opportunities for all women living in the state, assessing as much as possible the needs of women in each group. It is important to realize that women living in rural areas face one group of problems, women with disabilities in another group, lesbian women and trans* people with other problems, so solutions to these problems in the field must also be multi-sectorial and interdependent.

Referring to the domestic legislative regulations on this issue, it should be noted that Article 16 of the Constitution of the Republic of Armenia stipulates that the family, as a natural and basic cell of society, is the basis for the protection and reproduction of the population, as

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[4] https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/1_Global/INT_CEDAW_GEC_4738_E.pdf
[5] § 22, https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/1_Global/INT_CEDAW_GEC_4738_E.pdf
[6] § 28, https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/1_Global/INT_CEDAW_GEC_4738_E.pdf

well as maternity and childhood are under the special protection of the state. Based on the content of the aforementioned constitutional norm, Article 6 of the RA Law on Human Reproductive Health and Reproductive Rights stipulates that motherhood and childhood are under the protection of the state and society and are entitled to assistance.

In the Republic of Armenia, women have the right to safe motherhood, which means that women have the right to receive assistance during pregnancy, childbirth, and postpartum health with the use of methods that minimize risk to the health of the fetus and the newborn. Women have the right to information about the benefits of breastfeeding, as well as healthy and safe nutrition for infants and young children.

At the same time, the law stipulates that the medical intervention desired during pregnancy is carried out with the consent of the woman. Although the legislature did not envisage the content of the notion of "medical intervention" in the law, it nevertheless stipulates that a woman has the right to refuse or request termination of a medical intervention. An exception to this rule is provided when, without the consent of the pregnant woman, by the decision of the medical commission, and if it is not possible, by the decision of the doctor, it is permitted to carry out medical intervention in cases of danger to the life of the pregnant woman, as well as to diseases that pose a threat to the environment in accordance with the legislation of the Republic of Armenia.

In addition to the above, the law also stipulates that a woman has the right to receive free or privileged medical and pregnancy care during pregnancy, within the framework of state targeted health programs.

According to the decree of the RA Minister of Health[7], the obstetric-gynecological medical care and service provided in the out-of-hospital conditions within the framework of free medical care and services guaranteed by the state is mainly provided by the principle of territorial service. At the same time, every resident has the right to choose the obstetrician-gynecologist serving within the administrative area of her place of residence, irrespective of prior site attachments.

In all cases where a woman resides in the primary health care service of a given health organization but chooses to consult in another medical organization, the latter must submit an extract from her regional medical organization that she is not registered there and/or is not pregnant or has been excluded from registration.

In this regard, it should be emphasized that the above-mentioned relocation can only be carried out within the province. In other words, in case of withdrawal from the registration of a medical institution located in one of the marzes of Armenia and being registered in another

[7] https://www.arlis.am/DocumentView.aspx?docID=114488

marz, including another medical institution located in Yerevan, the woman is deprived of the right to free maternity care and the latter is provided with paid care.

Such legal regulation is in fact quite problematic in terms of access to health care in the sense that in the whole territory of the Republic of Armenia medical services do not have the same level of quality development, which is why women often prefer to go to another region or come to Yerevan for more quality medical care. As a result of such a legal settlement, however, a situation arises when one of the two pregnant women in different regions/in Yerevan has to pay for higher quality medical care and services, and the same service for another woman already registered in Yerevan/in the same region is free.

Speaking of safe motherhood, the issue of maternal mortality should also be addressed. According to the World Bank, the maternal mortality rate in Armenia is 25 per 100,000 live births. It should be noted that this figure is almost five times higher than the European average.[8]

When talking about safe maternity and maternity care, it is also important to consider the options for maternity care available in the state. In general, domestic law is not fully regulated and does not fully meet the needs of women. For example, the issues of the most favorable position for a woman during childbirth, place of birth/conditions which is linked to the right to private and family life guaranteed by Article 8 of the European Convention for the Protection of Human Rights and Fundamental Freedoms, are not fully regulated, so the state should pay special attention to ensuring that the process meets the needs of women.

RECOMMENDATIONS:

1. Provide equal opportunity for all women living in the territory of the state to have access to health care by providing free maternity care throughout the country.
2. Improve legislation and services on delivery of maternity care, childbirth, by adapting it to women's needs and ensuring access to health care throughout the country.
3. Regularly and continuously carry out informational reporting activities on reproductive health in relation to their fundamental rights for women and couples.
4. Conduct information campaigns regularly and on a regular basis about free medical care and services guaranteed by the state in the area of reproductive health for women and couples.
5. Make the policy of the maternal and infant more targeted, which will help reduce maternal, prenatal and infant morbidity and mortality rates.
6. Legislate the content of the notion of "medical intervention".

[8] https://data.unicef.org/ wp–content/uploads/2015/12/Trends–in–MMR–1990–2015_Full–re- port_243.

II. ABORTION

The right of women to make independent decisions on their own bodies and reproductive functions is the basis of equality and the right to privacy. Equality in the context of reproductive health, among other things, also means a woman's right to make an unequivocal decision on abortion.

According to the RA Law on Human Reproductive Health and Reproductive Rights[9], every woman has the right to abortion. Abortion up to 12 weeks of pregnancy is carried out in accordance with the written request of the woman, and in the case of medical indications abortion up to 12 weeks of pregnancy is carried out with the written consent of the woman. As regards abortion at 12 to 22 weeks, it is performed exclusively by medical or social counseling with the written consent of the woman.

In the Republic of Armenia abortion is performed by:

1) by surgical method or
2) by the drug method.

Medical indications of abortion are caused by pathologies that are incompatible with the life of a pregnant woman or fetus or diseases that are not ameliorated.

Social indications for abortion are:

1) the death of the spouse during pregnancy;
2) serving the sentence of the spouse/pregnant woman in the place of imprisonment prescribed by law;
3) divorce during pregnancy as prescribed by law;
4) pregnancy as a result of rape.

It should be noted that in case of medical or social indications abortion up to 22 weeks of pregnancy in the Republic is performed within the framework of state order - free of charge.

Referring to the abortion process, the law stipulates that prior to performing an abortion doctor should provide free counseling on the potential neggative effects of a pregnancy, which he/she records in the medical records of the woman requesting an abortion, which is endorsed by the woman's signature. Although it is important to provide the appropriate consultation, it is nevertheless important that the consultation is not biased.

In general, abortion counseling and information is characterized as biased if it is intended to prevent or influence in any way the woman's decision to abstain from pregnancy.

[9] https://www.arlis.am/DocumentView.aspx?DocID=120799

Examples of biased consultation are cases where health care providers exaggerate the risk of having an abortion or describe abortion as the murder of an unborn child or force the woman to look at the fetus and explain to them the stage of development.[10]

Due to the above, it is problematic in the wording of the law *"… immediately prior to the medical intervention the doctor is obliged to provide free consultation on the possible negative effects of the abortion…"* in the sense that the law already guides the content and direction of the consultation; therefore, it is not possible to speak of impartial consultation in this case.

In this regard, it should be noted that the World Health Organization (WHO) clearly states that counseling on abortion should be voluntary, confidential and non-binding[11]. What this implies is that the woman making the decision to terminate her pregnancy or to continue her pregnancy should *"treat with respect and understanding and ... provide information so that she can make a decision without incitement, coercion and discrimination.[12]"*

It should always be kept in mind that an abortion is a fundamental right of every woman in the reproductive health sphere, and in the absence of legislative adjustments and/or formulations in any way there should be no opportunity to prevent or in any way restrict the woman's right to make decisions about their body and health.

The European Court of Human Rights has referred to the issue of abortion in a number of decisions and noted that the issues arising from abortion relate to the right to liberty and security of the woman's private life[13]. Moreover, the Court also noted that the rights of the woman who decided to apply for abortion should be taken into account first, even if the husband of that woman disagrees with her decision[14], and as to the rights of the unborn embryo in that process, then the Court noted that the rights of the unborn embryo during the abortion process are limited to the rights of the pregnant woman[15].

In accordance with the regulation stipulated in Article 10 (4) of the Law, the doctor is obliged, prior to the abortion, to provide the pregnant woman with a request for a final decision on abortion for a period of 3 calendar days, which is calculated from the time the woman first applied to the doctor for an abortion. The above mentioned 3 calendar days is also called

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[10] «Կանանց ռեսուրսային կենտրոն» ՀԿ, «Կանանց անտեսանելի իրավունքը ՀՀ-ում. վերարտադրողական առողջության եւ իրավունքի պատկերը կանանց տարբեր խմբերի շրջանում» իրավիճակի վերլուծություն, Երեւան 2018

[11] WHO, "Safe Abortion Guidance", 2012, WHO "Health Worker Roles In ProvIdIng Safe AbortIon Care and PostabortIon ContraceptIon", 2015

[12] WHO, "Safe Abortion Guidance", 2012

[13] «Tysiąc c. Pologne», 2007 mars 20, pourvoi № 5410/03, Aurélie Moriceau, «La Cour Européenne des Droits de l'Homme et la Garantie de l'Avortement Thérapeutique», Revue de Droit International et de Droit Comparé, 2007

[14] «Boso c. Italie», 2002 septembre 5, pourvoi № 50490/99

[15] «Vo c. France», 2004 juillet 8, pourvoi № 53924/00, Jean-Manuel Larralde «La Cour Européenne des Droits de l'Homme et la Promotion des Droits des Femmes», Revue Trimestrielle des Droits de l'Homme, 2007

"compulsory waiting period", which implies the minimum period from the moment a woman applies for abortion until the woman has legally aborted her pregnancy.

As a general rule, the "compulsory waiting period" applies when the woman applies for abortion. In other words, this statutory fixation does not apply to cases where, for example, abortion should be performed as a result of medical or social instructions. It follows that such legislation is an indirect intervention in the exercise of women's reproductive rights.

This requirement is certain challenge to the exercise of women's fundamental rights and impedes the process of access to abortion services, which inevitably result in a breach of access to medical services for women who live far and are not eligible for lengthy service.

In this regard, the CEDAW Committee clearly states that the state must *"ensure the availability of safe abortion without forcing the woman to receive compulsory counseling and without compulsory waiting period.[16]"* In its recommendations to Russia[17] and Slovakia[18] on the compulsory waiting period, the CEDAW Committee urged states to abolish such legislative arrangements and to ensure access to abortion.

In connection with the case, the European Court of Human Rights also stated that *"from the moment the legislature decides to allow abortion in the state, it should not build a legal framework in such a way as to limit its possibilities.[19]*" Moreover, the Court finds that states have *"a positive obligation to establish a procedure that would allow a pregnant woman to legally exercise the right of access to abortion.[20]"*

RECOMMENDATIONS:

1. Amend the RA Law on Human Reproductive Health and Reproductive Rights and revoke the three-day compulsory waiting period set forth in Article 10 (4) of the Law.
2. Amend the Government Decree № 180-N of 23 February 2017 and revoke the three-day compulsory waiting period set out in point 21 of the decision.
3. Amend the RA Law on Human Reproductive Health and Reproductive Rights and provide free counseling on the possible negative consequences of abortion only with the consent of the woman.
4. Amend the Government Decree № 180-N of 23 February 2017 and provide free counseling on the possible negative consequences of abortion only with the consent of the woman.

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[16] https://www2.ohchr.org/english/bodies/cedaw/docs/co/CEDAW.C.HUN.CO.7-8.pdf

[17] https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CEDAW%2fC%2fRUS%2fCO%2f8&,Lang=en

[18] https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CEDAW%2fC%2fSVK%2fCO%2f5-6&,Lang=en

[19] https://hudoc.echr.coe.int/eng#{%22itemid%22:[%22001-79812%22]}

[20] https://hudoc.echr.coe.int/eng#{%22itemid%22:[%22001-104911%22]})

5. Supervise pricing policies for gynecological care and services licensed hospitals and health facilities for providing access to abortion.
6. Regularly inform the population about ways to protect themselves from unwanted pregnancies.
7. Provide regular training to health care staff providers.

III. SURROGACY/SURROGATE MOTHERHOOD

The concept of surrogate motherhood is described as *"a process in which a woman carries a baby throughout her pregnancy, with the aim of transferring her parental rights and responsibilities to the child's biological parents after child's birth.*[21] [22] *"*

In general, the institution of surrogate motherhood has given rise to various opinions. In modern legal systems, dual and often contradictory approaches to surrogate motherhood as well as surrogate mother status have emerged.

In view of the multifaceted viewpoints on the issue, the international community has so far not come to an agreement to give a single legal assessment regarding the issue. This is partly attributable to the fact that the aforementioned arrangements for surrogate motherhood are highly contradictory and mutually exclusive.

Referring to the issue within the framework of the domestic legislation, it should be noted that the institute of surrogate motherhood in Armenia was established in 2002 with the adoption of the RA Law on Human Reproductive Health and Reproductive Rights.

Article 2 of the Law defines the concept of a surrogate mother, according to which *"the surrogate mother is the donor-bearing woman in her womb, from which the child born does not bear her genotype."*

According to the RA legislation, can be surrogate mother women of age 20-35 who have previously had at least one birth, who have been subjected to a medical genetic test in accordance with the established procedure, have been found to have no contraindications to being a surrogate mother. At the same time, can be as surrogate mother women of childbearing potential (from at least 20 births in the past) who wish to have an embryo-delivered pregnancy by their relatives and have also undergone medical-genetic testing with no evidence of contraceptive maternity. As for the spouse who is registered in the marriage as prescribed by the RA legislation, woman can be a surrogate mother with the consent of the spouse.

The Law also stipulates cases in which a woman cannot act as a surrogate mother. Accordingly, the surrogate mother cannot be the woman whose surrogate mother contradicts the medical instructions approved by the RA state health authorized body and who has been a surrogate mother at least twice in the past. It should also be noted that the surrogate mother cannot be an egg donor at the same time.

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[21] Avis № 30 du 5 Juillet 2004 Relatif à la Gestation pour Autrui, Comité Consultatif de Bioéthique

[22] Académie national de Médecine, «La Gestation pour Autrui» sous la direction de Georges David, Roger Henrion, Pierre Jouannet et Claudine Bergoignan Esper, ©Lavoisier, 2011

According to Law, a surrogate mother may receive financial compensation for pregnancy and childbirth in accordance with a contract previously signed by a person or spouse using the appropriate health facility or reproductive aids and the surrogate mother. The person (spouse) using the assisted reproductive technology contracted with the surrogate mother shall bear all the costs associated with the pregnancy, delivery, and medical complications.

The legislation also regulates the relationship between persons using surrogate technologies and the surrogate mother. According to Law, their relations are regulated by written agreements subject to notarial ratification. In this regard, it should be noted that the contract between a surrogate mother and persons using assistive reproductive technologies in general is itself problematic due to the fact that the law does not clearly set out the principles and norms that must be enshrined in the contract. As a result, the said contract is typically based on the protection of the interests of persons using assistive reproductive technologies and imposes a number of prohibitions and/or obligations on the surrogate mother thereby limiting her right to privacy.

According to the Law, the surrogate mother has no right to refuse to hand over the child born to the person or spouse using the assistive technologies of reproduction to the contractual persons. The surrogate mother does not have any rights over the child born to her and does not bear any obligation from the moment of handing over the child to the person or spouses who signed the contract. A child born to a surrogate mother is handed over to a person using the auxiliary reproductive technology who has signed a contract if the DNA verification confirms that:

1) at least one of the spouses spouse using the assistive technologies of reproduction are the child's biological parent(s); and
2) the surrogate mother is not the biological parent of the child.

It should also be noted that the Law does not address the question of what rights and/or responsibilities the surrogate mother has over the child prior to the child's surrender. At the same time, the Law does not specify what happens when a DNA decision does not confirm that the child is the biological parent of at least one of the spouses or if the surrogate mother is the child's biological parent. It can be inferred from the logic of the Law that the settlement of these matters was left to the discretion of the parties in accordance with the contract.

In general, from a feminist perspective, and from the experience of a number of European countries in examining the issue, it becomes clear that the best solution to the problem is to ban surrogate motherhood, but if the state has already opted for a policy of allowing surrogate motherhood, then a legal system should be established where all persons using substitute maternity services will be fully informed of possible limitations on their rights, and will be prevented the practice of motherhood for commercial purposes.

RECOMMENDATIONS:

1. Amend the RA Law on Human Reproductive Health and Reproductive Rights and stipulate that a woman can act as a surrogate mother only once.
2. Amend the RA Law on Human Reproductive Health and Reproductive Rights and stipulate that before applying for surrogate motherhood, and afterwards, the state is obliged to provide free information to all parties, including the surrogate mother, her spouse, and biological parents: on psychological, medical, and legal issues arising from surrogate motherhood.

IV. REPRODUCTIVE HEALTH STRATEGY AND ACTION PLAN FOR 2016-2020

The goal of the strategy is to improve the reproductive/sexual health of the population in the Republic of Armenia, reduce maternal and neonatal morbidity and mortality, as well as abortions and implement measures aimed at preserving reproductive potential and maintaining healthy reproductive potential.

Implementation of the strategy envisages reduction of maternal and infant morbidity and mortality, improvement of maternal potential, reduction of infertility and perinatal loss due to health factors.

When talking about reproductive health in general, it is first of all necessary to understand that reproductive health is not limited to increase birth rates alone and if fertility rates increase substantially, it will not prove that there has been a positive shift in the field of reproductive health.

The strategy's content is that it is aimed at *"preserving the reproductive potential and increasing the fertility conditioned by the health factor".* The above wording is very problematic in it and limits the notion of reproductive rights. Moreover, certain formulations of the Strategy even contradict the content of that notion. In particular, it is incomprehensible as a Strategy's goal to reduce abortion if abortion is a fundamental right of every woman's reproductive health.

It is also unclear the need to reduce the gender imbalance in the Strategy's objectives. It is not understandable how the state perceives this function and what steps it will take to resolve this issue.

In general, sexual and reproductive rights, including sexual and reproductive health, are an integral part of the human rights concept and it is essential that the state regulate access to those rights through its policy and in no way restrict the scope of those rights.

RECOMMENDATIONS:

1. Refine the strategy for improving reproductive health based on the interdependence of the term "reproductive right" with civil, political, economic, social and cultural rights, including but not limited to the right to health, the right to life, the right to be free from torture, etc.
2. Establish the principles of non-discrimination and gender equality in the framework of the realization of rights in reproductive health.
3. Include clear steps in the exercise of reproductive health strategies for exercising the right to sex education.