



PREVENTING GENDER-BIASED SEX SELECTION BY CREATING A MORE RESPONSIBLE ATTITUDE OF MEDICAL WORKERS AND IMPROVING THEIR COUNSELLING SKILLS



EDUCATIONAL HANDBOOK

For Obstetrician-Gynecologists, Family Physicians,
Radiologists conducting ultrasounds, Midwives and Family Nurses

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This educational handbook on “Preventing Gender-biased Sex Selection by Creating a More Responsible Attitude of Medical Workers and Improving their Counselling Skills” was developed by a team of experts of the National Institute of Health named after academician Suren Avdalbekyan CJSC managed by the Ministry of Health of the Republic of Armenia (*from now on will be referred to also as the Armenia National Institute of Health*). It was developed within the framework of the “Addressing Gender Biased Sex Selection and Related Harmful Practices in the South Caucasus: Support for Regional, National and South-South Interventions” project implemented by the UNFPA in partnership with the OxYGen Foundation. The Project is funded by the European Union and UNFPA.

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ACRONYMS AND ABBREVIATIONS (In alphabetical order)

A

ADHS	Armenia Demographic and Health Survey
Arm SSR	Armenian Soviet Socialist Republic
ART	Assisted reproductive technologies
ATP	Artificial Termination of Pregnancy

B

BSRB	Biological level of sex ratio at birth
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C

CARA	Civil Acts Registration Authority
CRARA	Civil Residence Acts Registration Authority (ZAGS)
CPD	Continuous professional development

D

DHS	Demographics and Health Survey
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E

EECA	Eastern Europe and Central Asia
EU	European Union

F

FP	Family Planning
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G

GBA	Gender-biased abortion
GBSS	Gender-biased sex-selection
GBSSA	Gender-biased sex-selective abortion
CBV	Gender-based violence

I

IA	Induced abortion
ICHD	International Center for Human Development
IVF	In vitro fertilization

M

MoH	MoH - Ministry of Health
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MLSA	Ministry of Labor and Social Affairs
MD	Doctor of Medicine
N	
NSRB	Natural sex ratio at birth
NIH	National Institute of Health
NGO	Non-governmental organization
P	
PhD	Doctor of Philosophy
PGD	Preimplantation genetic diagnosis
R	
RA	Republic of Armenia
S	
SA	Spontaneous abortion
SC	Statistical Committee
SIA	Self-induced abortion
SIB	Sex Imbalances at Birth
SRB	Sex ratio at birth
SSA	Sex-selective abortion
SSPT	Sex-selective pregnancy termination
U	
UN	United Nations
UNFPA	United Nations Population Fund
USA	United States of America
USSR	Union of Soviet Socialist Republics
W	
WHO	World Health Organization

GLOSSARY DEFINITIONS OF KEY TERMS RELATED TO PREGNANCY TERMINATION

#	Key Terms	Definitions
1.	Termination of pregnancy	The expulsion of a fetus from the woman's womb (uterus) before it becomes capable of independent life outside of the mother's body. It can happen naturally or artificially.
2.	Artificial Termination of Pregnancy (also referred to as "Induced Abortion")	Intentional termination of an intrauterine pregnancy by medical stimulation, surgical intervention or unspecified means.
3.	Artificial Termination of Pregnancy on Woman's Request:	Intentional termination of an intrauterine pregnancy on the formal request of a woman without the need for explaining the reasons. This is usually legally permitted up to 12 weeks of gestation.
4.	Artificial Termination of Pregnancy on medical and/or social grounds	Intentional termination of an intrauterine pregnancy on medical, social or both grounds defined by the Government decision. This is legally permitted up to 22 weeks of gestation.
5.	Illegal abortion¹ (also referred to as "Clandestine abortion")	Termination of pregnancy performed in violation of order and requirements established by the Law is illegal. In the Republic of Armenia, any termination of pregnancy out of the hospital or by a person without appropriate professional qualification is considered illegal.
6.	Self-induced abortion	Self-induced termination of own pregnancy with the help of medication or other means.
7.	Sex-selective abortion (shortly: "Selective abortion")	The term refers to gender-biased sex-selective pregnancy termination. It can be considered legal only if performed on medical or social grounds up to the 22 weeks of pregnancy.
8.	Spontaneous termination of pregnancy (also referred to as "miscarriage")	The spontaneous loss of a nonviable intra-uterine pregnancy before 22 weeks of gestational age.

¹ *Note: It is well known that fetal sex can be reliably determined through an ultrasound examination starting from 14-15 weeks of gestation when the differences in the genital organs of the fetus are most clearly visible. In fact, according to RA legislation, induced abortion at the woman's request can be performed only up to 12 weeks of pregnancy, while in later periods, selective abortion can be legally performed only on the medical or social grounds defined by the medical commission, but not later than 22 weeks of pregnancy. Therefore, in all other cases, selective abortion is identical to illegal abortion (commented by the authors).*

DEFINITIONS OF GENDER-RELATED TERMS

#	Key Terms	Definitions
1.	Gender	The term “gender” refers to personal beliefs and societal perceptions about the identity of women and men, girls and boys, and their social, cultural and behavioral roles. These beliefs and prejudices lead to hierarchical power relations that can change over time.
2.	Gender-biased sex selection	The term refers to the practice of using medical techniques to choose the sex of offspring, such as selecting embryos for transfer and implantation following IVF, separating sperm, and selectively terminating a pregnancy. It can be measured using sex ratio at birth, a comparison of the number of boys born versus the number of girls born in a given period. The biologically normal sex ratio at birth can range from 104 to 106 males per 100 females.
3.	Gender equality	“Gender equality” means equal rights, duties and opportunities for all women and men, boys and girls, regardless of biological sex, gender identity and roles.
4.	Gender roles	Certain patterns of behavior dictated by society to biological sex.
5.	Preimplantation genetic diagnosis	This is a cutting-edge procedure to identify the presence of chromosomal abnormalities in embryos created with in vitro fertilization. The technique is also used for preimplantation sex selection, although it raises many ethical questions.
6.	Sex	The term primarily refers to biological sex, which defines people as female, male or intersex (hermaphrodite). This depends on the characteristics of their sex chromosomes and biological (anatomical or physiological) differences in external, internal or both genitalia.
7.	Sex ratio at birth	Ratio of male to female births in the population (normalized to 100).
8.	Sperm sorting technique	The sperm sorting technique aims to separate a sample of sperm with a higher proportion of either X-chromosome-bearing or Y-chromosome-bearing spermatozoa, thus increasing the chance of conceiving a child of the preferred sex. It is used with other assisted reproductive technologies (such as artificial insemination or in-vitro fertilization) to produce offspring of the desired sex.

The Sex-selective Pregnancy Termination (SSPT) is one of the main manifestations of discriminatory Gender-biased Prenatal Sex Selection (GBSS), leading to demographic imbalances in several countries across the regions and the world². In Armenia, the issue of prenatal sex selection was left out of the attention of policymakers until the UNFPA in 2011 alerted about this discriminatory practice³. Indeed, the birth registration data of Eastern European and Central Asian (EECA) region confirmed the existence of gender-biased prenatal sex selection in favour of boys in Azerbaijan (116.8 boys for 100 girls), Armenia (114.8), Georgia (113.6) and Albania (111.7). Eventually, in 2013 the High Commissioner for Human Rights of the Council of Europe highlighted this problematic phenomenon and assigned affected countries to take immediate measures to improve the situation⁴.

In recent decades, the issue of gender-biased sex-selective pregnancy terminations is becoming a continuous challenge for Armenia as well - a country with a demonstrated preference for having male children. The son preference, combined with the availability of fetal sex determination technologies in the early pregnancy stage, has led to a gross violation of the natural sex ratio at birth. The situation became more complicated due to the continuous decline in the birth rate. The son preference, combined with the availability of fetal sex determination technologies in the early pregnancy stage, has led to a gross violation of the natural sex ratio at birth. The situation became more complicated due to the continuous decline in the birth rate. Thus, according to the National Statistical Service of Armenia, the total fertility rate declined from an average of 2.62 children per woman in the early 1990s to 1.56 in 2021. Along with a declining number of births and the total fertility rates, the natural probability of having children of both sexes in the family is also decreasing. This factor further deepens the problem of gender-biased prenatal sex selection and related sex imbalances at birth in Armenia.

The skewed sex ratio at birth became obvious in Armenia in the 1990s, when an increase in the natural sex ratio at birth (NSRB) was observed (106 boys versus 104 per 100 girls). In the 2000s, this indicator reached 120 newborn boys per 100 girls, then relatively stabilized at 114 boys per 100 girls in the early 2010s, according to the National Statistical Service of Armenia.

In 2011, the UNFPA raised concerns about this growing problem. Besides, in 2013, the Government of Armenia, in partnership with international and local organizations, started large-scale preventive programmes with multi-level events towards combating sex-selective abortions. As a result of these measures, positive trends in the problem-solving process have been recorded. Thus, before starting sex-selective abortion prevention measures, the overall annual ratio of male to female newborns was 115 to 100 during 2008-2012, while it declined and reached 108.8 to 100 in 2021 following these measures⁵. Such ongoing situation improvement result is a silent witness to the success and effectiveness of cross-sectoral cooperation.

Nevertheless, the sex ratio at birth in Armenia is still skewed from the biologically normal level. There is still a lot to be done in this field, especially against the backdrop of the post-war human losses when the

2 UNFPA Asia-Pacific Regional Office (2012). *Sex Imbalances at Birth: Current trends, consequences and policy implications*. <https://www.unfpa.org/sites/default/files/pub-pdf/Sex%20Imbalances%20at%20Birth.%20PDF%20UNFPA%20APRO%20publication%202012.pdf>

3 International Centre for Human Development (2018). *Monitoring report of the state policy and programs aimed at preventing gender-biased sex selection in the Republic of Armenia*. UNFPA Technical Reports and Document, No. of pages: 44, Publication date: 2018, Yerevan, Armenia file:///C:/Users/USER/Downloads/333%20(3).pdf

4 Parliamentary Assembly of the Council of Europe (2011). *Prenatal sex selection (2011 - Fourth part-session)*. Resolution No. 1829 of the Parliamentary Assembly of the Council of Europe on discriminatory selection of the sex of the fetus, 03.10.2011 <https://pace.coe.int/en/files/18020>

5 Statistical Committee of the Republic of Armenia (2022). *The Demographic Handbook of Armenia, 2022*. <https://armstat.am/en/?nid=81&id=2535>

recovery will be psychologically oriented towards the preference of male children. And obviously, there is a need to continue programmatic measures for maintaining a significant reserve of positive results to recover the natural sex ratio at birth. To ensure further positive developments, it will be necessary to make additional efforts and invest resources towards the prevention of sex-selective abortions by changing the behaviour of health workers, increasing their role in family counselling and introducing approved legislative changes.

There is a need for an ongoing public awareness campaign to address the undervaluing of girls and maintain already achieved positive results. It is necessary to raise public awareness and dispel misconceptions about the current effort to normalize the skewed sex ratio at birth. This effort aims at increasing the number of female newborns by giving a chance to be born to girls who were unwanted because of their gender. It never aims at decreasing the number of newborn male children as wrongly understood by certain groups of society and some decision-makers (commented by authors).

Background

Within the framework of the “National Program on Prevention of Sex-selective Abortions: 2015-2017”, which was developed with the support of UNFPA and approved by the joint order of the Minister of Health and Minister of Labor and Social Affairs of Armenia, the number of activities have been carried out in Armenia to improve the professional skills of health care providers. In particular:

- ▶ The organization of 25 workshops on “The ethical aspects of using fetal sex determination technologies”, with the involvement of 100 prenatal counselling providers working at the maternity hospital services.
- ▶ Development and publishing, with the support of the UNFPA, a total of 300 copies of the thematic handbook for further distribution among medical staff of the Maternity Care Hospitals, including facility managers, obstetricians-gynaecologists, and radiologists conducting ultrasounds to determine the sex of the fetus.
- ▶ The organization of 15 workshop meetings on thematic issues for around 170 regional medical professionals and nurses.
- ▶ The organization of a one-day training course aimed at introducing the thematic manual to 30 obstetrician-gynaecologists and radiologists conducting ultrasounds at the primary health care facilities in Yerevan (in November 2017).

It is obvious that the volume of work performed in that period was insufficient for achieving desired quality counselling skills of health workers and expected behavioural changes. Moreover, in the years following 2017, the number of activities towards expanding educational programs for medical workers and public advocacy events gradually decreased, creating a risk from the point of view of maintaining achievements and securing further developments. Indeed, there is a negative trend in the sex ratio at birth, which reached 111 boys to 100 girls in 2018 from 110 boys per 100 girls in 2017. Furthermore, in 2022, the SRB worsened and increased to 111,9 boys per 100 girls, compared to 108,8 boys in 2021⁶.

Meanwhile, it is well known that healthcare workers providing effective counselling services can play an essential role in preventing gender-biased pregnancy termination. From this point of view, health providers working on the front line of contact with women in primary healthcare facilities can play a role of particular importance. However, according to expert assessments, the fight against selective abortions in maternity care institutions is still insufficient and needs further evaluation. The effectiveness of introduction into the national health care system of normative acts arising from legislative regulations and improvement of their implementation by medical personnel is especially problematic. Furthermore, the specific legislative components introduction process into the practice of maternity care institutions is not similarly organized due to different levels of knowledge about the approved procedures and, sometimes, the controversy of motivational mechanisms and conflict of interests.

Based on the above, one can conclude that the improved introduction of legal regulations and mechanisms for abortion prevention can contribute not only to the reduction of abortions in general but also to the decrease of gender-biased pregnancy terminations. Additional essential factors for the prevention of gender-biased sex selection and the achievement of expected positive results might become the implementation of the legislative procedures, as well as the creation of more responsible behaviour among

⁶ Statistical Committee of the Republic of Armenia (2022). *The Socio-Economic situation of the Republic of Armenia in 2022 January-December*, Socio-Demographic section, Demographic situation, https://armstat.am/file/article/sv_12_22a_510.pdf

health service providers and improving their knowledge and relevant consulting skills.

The achievement of program goals can be facilitated by introducing legal procedural issues on prenatal gender-biased pregnancy termination into the program of continuous professional education of medical specialists, including health providers working at maternity care institutions and the primary health care level. Nevertheless, apart from medical workers, the immediate and extended family of the pregnant woman play an important role in selective abortion prevention, as well as policymakers, clergy, social workers, influential people and other actors in society.

To ensure the continuation of the fight against GBSS, the preservation of the achievements, and further programmatic developments, the UNFPA and partner organizations developed “The Program on Prevention of the Gender-biased Prenatal Sex Selection and the List of Measures for Implementation in 2020-2023” approved by the joint order of the Minister of Health and Minister of Labor and Social Affairs of the Republic of Armenia. In the framework of this program, it is planned to “Develop relevant educational handbook to be included in the program of postgraduate education of the medical specialists” for more effective involvement of health workers in the gender-biased artificial pregnancy termination preventive processes.

Overview and Structure of the Handbook

The thematic educational handbook “Preventing Gender-biased Sex Selection by Creating a More Responsible Attitude of Medical Workers and Improving their Counselling Skills” (from now on will be referred to as Handbook) is designed for medical professionals working in women’s health, including obstetricians-gynaecologists, family physicians, radiologists conducting ultrasounds, and midwives. It is developed, introduced and planned to be institutionalized shortly through the national system of the continuous postgraduate education of medical specialists to create a more responsible attitude among health service providers and improve their counselling skills towards preventing gender-biased prenatal sex selection, thereby contributing to the reduction of selective abortions and the valuing of girl children in the family and society.

The Handbook consists of two parts: the Main Section and Appendices. The Main Section covers three professional topics presented in theoretical and practical interactive lesson format (20 in total). The theory is delivered by PowerPoint presentation, lecture, text reading and interpretation. Various toolkits are used during the practical lessons, including exercises, discussions around individual clinical cases or case studies, video-film demonstration, role-playing, interactive discussion/brainstorming, etc.

The Handbook incorporates some Appendices. The first one presents relevant articles of laws relating to Human Reproductive Health and Reproductive Rights and selected By-laws. The list of literature used for the Handbook development (References) is presented at the end.

MODULE 1. Topic: Gender-biased Pregnancy Termination and Sex Imbalances at Birth in International and National Contexts. Determinants of the Natural Movement and Reproductive Behaviour of Armenia Population.

Lesson N 1. Theoretical

- ▶ The Global Problem of Gender-biased Pregnancy Terminations and International Experience in Addressing this Issue.

The secret of conceiving a child of the desired sex has a thousand-year history. The ancient Greeks believed that man should tie his left testicle to have a male child because the right testicle produces semen which determines the male gender of the future child. According to the Jewish traditional belief, “if a woman emits her “semen” first, she will bear a male child; otherwise, she will give birth to a female child”⁷. Various other methods for sex preselection were also suggested, such as the timing of or position during intercourse, or a special diet⁸.

Some people believed that following sexual intercourse with a shallow penetration of the sperm, a girl is more likely to be born. Others were sure that food with rich content of potassium and sodium elements increases the probability of having a boy. Coming from the depths of centuries, this problem is more relevant nowadays.

One of the main manifestations of gender-biased sex selection (GBSS) is the sex-selective artificial pregnancy termination which led to demographic imbalances in several affected countries. In recent decades, it became a significant challenge for India, China, Vietnam, Korea, Balkan, and South Caucasus countries⁹. In the 90s and the following years, a gradual increase of disproportion in the sex ratio of newborns was observed in Armenia as well.

▶ The international experience of combating gender-biased pregnancy terminations

The problem of gender-biased pregnancy terminations and sex imbalances at birth, first of all, is highlighted by its consequences. For instance, there are about 100 million “missing women” globally, according to Western experts’ estimates, including 41 million in China and 40 million in India.

China: Before the introduction of the one-child policy by the Chinese government in 1980, the sex ratio at birth in the country was close to the biologically normal level. In the following years, however, the situation worsened progressively. According to a study conducted in 2000, the history of selective abortions was reported by 36% of Chinese women. Moreover, about 25% of all pregnancies were terminated if the fetus was of female gender, while termination of pregnancy with a male fetus was carried out only in 2% of cases¹⁰. According to the same source, in 3 relatively developed administrative regions of the country, the rate of SIB was 135-150 boys per 100 girls. China, perhaps, is facing much more serious consequences caused by this phenomenon than any other country in the world. Currently, China is talking about 30-40 million unborn girls.

The state of China has addressed this issue since the mid-2000s. The efforts have been aimed mainly at the legal regulation of selective abortion issues and the ban on telling the sex of the fetus by ultrasound

7 Shushan A, Schenker J.(1993) Prenatal sex determination and selection. *Hum Reprod* 1993;8:1545–49. <https://link.springer.com/article/10.1023/A:1016807605886>

8 Carson SA (1988). Sex selection: the ultimate in family planning. *Fertil Steril* 1988;50:16–19 <https://reader.elsevier.com/reader/sd/pii/S0015028216600006?token=0F0675AF24913D62D949C170243ABF66D22A885E56F28704A39ED78CC6512367883F44856067E5F1BF3AE8639807C058&originRegion=eu-west-1&originCreation=20230427161820>

9 OHCHR, UNFPA, UNICEF, UN Women and WHO (2011). Preventing gender-biased sex selection, An interagency statement, Geneva, Switzerland, 2011. https://www.unfpa.org/sites/default/files/resource-pdf/Preventing_gender-biased_sex_selection.pdf

10 Hemminki E., Zhuochun W., Guiyong C. and Kirsi V (2005). Illegal Births and Legal Abortions The Case of China. *Reproductive Health* 2(5). doi: 10.1186/1742475525. <https://reproductive-health-journal.biomedcentral.com/articles/10.1186/1742-4755-2-5>

examination. There was much less reference to public awareness measures aimed at changing people's perceptions and ideas fueling the preference for a boy child. Alternatively, the Chinese Government provides practical assistance only to families with a girl child.

In 2002, the Chinese government came up with a new "Family Planning" law, according to which it was forbidden to reveal the gender of the fetus during pregnancy. The doctor who performed selective abortion was fined, and the parents were deprived of the right to have children in the future¹¹. As a result of a violation of this law, several medical institutions were closed by the government in 2006¹².

Furthermore, following the state policy based mainly on legal restrictions, the scope of the consequences of the SIB phenomenon has grown so much that in 2015 the Chinese media began to discuss the possibility of polygamy as a solution to the problem of shortage of women of marriageable age. The issue has eased somewhat since the removal of the one-child policy, but there is no evidence of significant improvement so far.

China's experience indicates the ineffectiveness of restricting abortions and prenatal sex determination to combat the manifestations of this discriminatory practice. There is a need for more effective alternative measures focused on the roots of this phenomenon, such as the gradual improvement of the status of women and highlighting their roles in society, which may lead to the equal valuation of male and female children.

India: According to 2001 census data, there were only 93 women for every 100 men in India's population. These figures indicate the existence of a gender-biased selective abortion issue at the national level¹³. According to public opinion, sex-selective abortions help families cope with some challenges, such as the issue of "dowry" and its family consequences. Proponents of selective abortions also believe they help limit the country's population.

The government of India attempted to mitigate the problem by "banning" legislation; at the same time, it adopted the inheritance relations regulating laws with normative statements on the equal rights of girls and boys. The measures aimed at overcoming sex imbalances at birth included additional activities towards valuing the girl child in society and the provision of monetary incentives.

To prevent gender-biased sex selection and selective abortions, the Indian government passed a law in 1994 on pre-conceptual and prenatal sex determination¹⁴. The opinions about the effectiveness of this measure are controversial. According to some estimates, 106,000 girls aged 0 to 6 were granted a life thanks to the implementation of this law in their rural communities. On the other hand, this idea contradicts the common opinion that the law did not serve its purpose. This perception is based on the observation that the sex ratio of children throughout the country continued to deteriorate even after the adoption of this law. However, according to another opinion, the situation might be worse without the law.

There are also pessimistic ratings of the effectiveness of legislation enforcement with references to dire consequences. For instance, it is documented that the decomposed remains of more than 100 female

11 Ebenstein A. Y. and Sharygin E. J. (2009). *The Consequences of the "Missing Girls" of China*, *The World Bank Economic Review*, VOL. 23, NO. 3, pp. 399–425 doi:10.1093/wber/lhp012, Advance Access Publication - November 5, 2009. <https://academic.oup.com/wber/article-abstract/23/3/399/1730081?redirectedFrom=fulltext&login=false>

12 Joseph K. (2006). *China: Crackdown on Abortion of Girls*, *New York Times*, June 1, 2006 Retrieved from www.nytimes.com/2006/06/01/world/asia/01briefsbrief003.ready.html?_r=5.

13 Sharma BR, Gupta N, Relhan N. (2007) *Misuse of prenatal diagnostic technology for sex-selected abortions and its consequences in India*. *Public Health Journal of the Royal Institute of Public Health*. 2007. 0033-3506. doi:10.1016/j.puhe.2007.03.004. https://www.researchgate.net/profile/B-Sharma-7/publication/6226683_Misuse_of_prenatal_diagnostic_technology_for_sex_selected_abortions_and_its_consequences_in_India/links/5f4a4ed2299bf13c50504c74/Misuse-of-prenatal-diagnostic-technology-for-sex-selected-abortions-and-its-consequences-in-India.pdf

14 Rajan VJG (1996). *Will India's Ban on Prenatal Sex Determination Slow Abortion of Girls?* *Hinduism Today* Magazine, April 1, 1996. <https://www.hinduismtoday.com/magazine/april-1996/1996-04-will-india-s-ban-on-prenatal-sex-determination-slow-abortion-of-girls/>

fetuses were found in the area adjacent to one of the regional maternity.

India's experience demonstrates that the laws, which require several years and sometimes decades of campaigns and fight towards its adoption, do not act lonely. Otherwise, the struggle for such laws often ends with the search for those responsible and "guilty" for the situation and problems' continuation.

United States of America: Several qualitative studies testify that discriminatory prenatal sex selection phenomenon exists in the United States, though it is limited to some insignificant population segments. Moreover, the gender selection in the US includes both male and female children. Research shows that selective abortions are more common in states having populations of Asian descent, where preference is given to boys.

Following some studies on gender-biased prenatal sex selection published in 2008, several states banned selective abortions. Similar bills banning sex-selective and race-selective abortions have been debated in more than two dozen other US states and US Congress. Overall, during 2009-2013 more than 60 bills were suggested at the federal and state levels to criminalize physicians who perform sex-selective abortions.

Under State laws, physicians performing an abortion are subjected to varying degrees of liability, ranging from imprisonment and penalties to restrictions on professional practice and the need to pay damages claims made by the pregnant woman and her family. In some states, doctors and junior medical personnel are obliged to report to the authorities even about the mere suspicion that a pregnant woman is seeking a gender-biased abortion. Some bills impose liability even for simple assistance to pregnant women seeking a sex-selective abortion.

So far, state legislatures adopted eight similar laws. Several states have passed legal norms which require women seeking an abortion to get obligatory preabortion counseling in prenatal care institutions. Four of these states prohibit abortions for reasons of race and six - when the fetus may have a genetic anomaly. In conjunction with abortions based on a lethal fetal condition, three states require a woman to get preabortion counseling on perinatal hospice services available before she can undergo pregnancy termination. Moreover, Kansas requires counseling on perinatal hospice services before any abortion can be performed^{15, 16}.

Notably, the US states which banned gender-biased abortions have the fastest-growing largest Asian population. The researchers argue that while the gender ratio at birth in Asian families in the States has been slightly skewed in favor of boys, adopted legislation didn't affect the phenomenon elimination process at all. Based on these facts, analysts claim that the ban on sex-selective abortions has not significantly affected the practice of discriminatory sex selection. According to the researchers, one of the reasons for the lack of impact of banning legislation on the GBSS issue in the States is that it only bans sex-selective abortions without any provision referring to pre-implantation sex selection with the help of assisted reproductive technologies (sperm sorting, genetic testing of fertilized eggs, etc.), thus making it possible to use these technologies for choosing the sex of the child. Based on the above, experts conclude that legislative restrictions in the case of the USA hinder reproductive health and reproductive rights and deepen racial inequality.

There is an opinion that laws, which limit access to abortion while not prohibiting other means of sex selection and target mainly women of Asian descent, deepen gender inequality by curtailing women's fundamental and legal rights to make decisions about their reproductive health¹⁷. The researchers also

15 *Guttmacher Institute (2023). Abortion Bans in Cases of Sex or Race Selection or Genetic Anomaly. Published in the Guttmacher website as of 01.05.2023. <https://www.guttmacher.org/state-policy/explore/abortion-bans-cases-sex-or-race-selection-or-genetic-anomaly>*

16 *Seema Mohapatra (2013). Global Legal Responses to Prenatal Gender Identification and Sex Selection. Nevada Law Journal 13, no. 3 (2013): 690-721. <https://scholars.law.unlv.edu/cgi/viewcontent.cgi?article=1481&context=njl>*

17 *Jennifer Chou and Shivana Jorawar (2015). Silently Under Attack: AAPI Women and Sex-Selective Abortion Bans, 22 Asian Am. L.J.*

argue that banning sex-selective abortions is a burden on healthcare providers, not only because they have to interrogate every woman seeking an abortion about the motivation for her request to terminate the pregnancy but also due to the biased attitudes towards women of Asian descent and their communities.

According to analysts' conclusions, the ban on sex-selective abortions in the United States is ineffective since restrictions do not prevent them. On the contrary, they divert the public's attention from the real problematic issue, particularly: the existing attitude in society that values girls less than boys and the cultural pressures that feed this biased attitude, as a result of which couples and families resort to selective abortion¹⁸. The liability imposed for violating abortion banning regulations may prompt the health workers to refuse to provide the service in some cases to avoid the risk of being held liable. Consequently, some women may resort to unsafe/dangerous illegal abortion.

Israel: Although the most common reason for discriminatory prenatal sex selection is the preference for a boy child, there are several countries where some families prefer to have a girl child. Generally speaking, in Israel, couples usually resort to sex-selective abortion to balance the gender composition of the family. This issue has been partially solved through the use of assisted reproductive technologies¹⁹. Admittedly, Israel has the highest per capita rate of in vitro fertilization (IVF) per the world population²⁰.

However, the corresponding law concerning prenatal genetic diagnosis (PGD) does not exist in Israel. These issues have been regulated by the norms set by the Ministry of Health in 2005, which prohibit sex-selective abortions in general, except for those performed on medical grounds, as well as upon application with a request for balance family composition or termination of the pregnancy due to the sensitive (emotional) and, or religious reasons²¹.

Sex-selective abortions performed on medical orders are included in the basic package of healthcare services guaranteed by the state. The exceptional authority to give written permission to perform an abortion on medical grounds or to choose the sex of the fetus via ART is given to the 7-person Committee attached to the Ministry of Health, which consists of a psychologist, obstetrician-gynecologist, specialists in medical genetics and medical ethics, a social worker, and lawyer and clergyman. Spouses or single pregnant women can apply to the commission for permission to perform a gender-biased abortion if they justify that not performing it can cause significant damage to the mental health of their family members²².

Moreover, applicants must be married and have at least four children of the same sex and none of the opposite sex in their union. Prenatal genetic counseling of the applicants and written consent for the testing are mandatory requirements. IVF applicants should be aware of the rule that an additional IVF cycle will be allowed only after the couple has used all retained unselected embryos. There are also ethical and religious considerations in addressing the needs of some infertile Jewish clerical couples, which request sperm sorting during the artificial insemination procedure for conceiving a girl child. The reason for refusal to have a boy from a donor is based on Jewish tradition, according to which only a male child inheriting

(2015). <http://scholarship.law.berkeley.edu/aalj/vol22/iss1/4>

18 *Bela Ganatra (2008), Maintaining Access to Safe Abortion and Reducing Sex Ratio Imbalances in Asia*, 16: 31 *Supp. Reprod. Health Matters* 90, 96 (2008) <https://pubmed.ncbi.nlm.nih.gov/18772089/>

18a *Madhu Kishwar (1993), Abortion of Female Fetuses: Is Legislation the Answer? 1:2 Reproductive Health Matters* 113, 114 (1993). <https://reproductiverights.org/wp-content/uploads/2020/12/Statement-on-Sex-Selective-Abortion-Bans-FIN.pdf>

19 *Yael Hashiloni-Dolev (2010). Attitudes Toward Sex Selection: A Survey Among Potential Users in Israel*, 30 *PRENAT. DIAG.* 1019, 1019 (2010) : *Parents Queue to Select Baby Gender*, *B.B.C. NEWS*, Oct. 29, 2008, http://news.bbc.co.uk/2/hi/uk_news/7696698.stm

20 *Simonstein F, Mashiach-Eizenberg M, Revel A, Younis JS (2014). Assisted reproduction policies in Israel: a retrospective analysis of ivf-embryo transfer. Fertil Steril* 2014, 102(5):1301–1306:

21 *Ginoza M. and Isasi R.(2020). Regulating Preimplantation Genetic Testing across the World: A Comparison of International Policy and Ethical Perspectives. Cold Spring Harb Perspect Med.* 2020 May; 10(5): a036681. doi: 10.1101/cshperspect.a036681. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7197420/>

22 See Reference (20) *Simonstein F, Mashiach-Eizenberg M, Revel A, Younis JS (2014). Assisted reproduction policies in Israel: a retrospective analysis of -embryo transfer. Fertil Steril* 2014, 102(5):1301–1306:

the family's genetic line has the right to bless during a religious ceremony²³.

The review of the first seven years of activity of the Jewish Committee for sex selection by pre-implantation genetic diagnosis shows that all 411 applications met the primary criterion of the couple's having in their marriage at least four children of the same sex and none of the opposite sex. Most of the applicants wanted to have a boy. In 78.4% of applications, desired pregnancy did not require ART or any other infertility treatment intervention²⁴.

The national legal regulations on prenatal sex selection consider several issues of public concern, such as the gender balance approach in families with four or more children of the same sex, awareness of the risks associated with the procedures, as well as the limitation of the number of embryos, potentially deprived of the use, due to their sex, and some others. Such an approach limits the number of prenatal genetic diagnoses on non-medical grounds while leaving the "dream" achieving opportunity for some other families who meet the established criteria for PGD.

To conclude, it should be noted that the pre-implantation genetic test as part of ART for Infertility management is becoming more popular and widespread. This procedure helps to reveal the sex of the embryo from the first days of its formation and makes it increasingly easy to choose desired sex of the child on the non-medical ground. Therefore, along with the further development and spread of non-invasive accurate methods of prenatal sex determination at the early stage of pregnancy, there is a need to evaluate and monitor the impact of sex selection on the sex ratio at birth of the targeted countries, which became an issue of especial importance nowadays.

Lesson N 2. Theoretical

▶ The Problem of Sex Imbalances at Birth in Armenia and its Impact on Trends of the Population Composition by Age and Sex.

The retrospective analysis of the statistical data on the sex ratio at birth in Armenia proves that the sex imbalances caused by selective abortions appeared in the early 90s and deepened along with the decline in the birth rate and development of prenatal diagnostic technologies enabling women to know the sex of their child in advance of the birth. There are also several background factors of this problem, including the patriarchal structure of Armenian society and traditional beliefs that lead to patrilineal dominance in power relations and unequal status and opportunities of women and men in society. All the above are the prerequisites for the preference for male children. In the national values system, the role of boys is emphasized as the "Successors of Family Line", "Smoke-makers of Home's Hearth", etc.

The availability and accessibility of prenatal ultrasound examinations enable some couples to know the gender of the unborn child and avoid the birth of an "unwanted" baby girl. Thus, according to the survey conducted in 2011 among 368 Armenian women, the history of sex-selective abortions was reported by 4.6% of the respondents²⁵.

From the point of view of countering this phenomenon, increasing the role and motivating the behavior of medical staff, along with improvement of their counseling skills towards the prevention of sex-selective abortions, are highly important. The monitoring system regulations and existing legal procedures introduction processes are equally important.

23 Grazi RV, Wolowelsky JB (2006). *Addressing the Idiosyncratic Needs of Orthodox Jewish Couples Requesting Sex Selection by Preimplantation Genetic Diagnosis*. *J Assist Reprod Genet* 2006, 23:421–425. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3455094/>

24 Pessach N, Glasser S, Soskolne V, Barash A, Lerner-Geva L (2014). *The Israeli National Committee for sex selection by pre-implantation genetic diagnosis: a novel approach (2005–2011)*. *Isr J Health Policy Res* 2014, 3:33. <https://pubmed.ncbi.nlm.nih.gov/25396044/>

25 UNFPA, Armenia (2012). *Prevalence of and Reasons for Sex-Selective Abortions in Armenia, National Survey Report*. Published by UNFPA, No. of pages: 59, Publication date: 1 January 2012, Yerevan, Armenia. <https://eeca.unfpa.org/en/publications/prevalence-and-reasons-sex-selective-abortions-armenia>

► The Prevalence and Causes of Gender-biased Pregnancy Terminations

Research studies conducted in recent years demonstrate that there is a phenomenon of gender-biased pregnancy terminations in Armenia. The issue of sex imbalances at birth has been evaluated in several studies (conducted in 2010, 2011, 2013, 2015-2016, 2018, etc.), which aimed at estimating the prevalence and causes of selective abortions in Armenia. The women who applied to medical facilities for artificial pregnancy termination, including selective abortion, have been interviewed to reveal the reasons and circumstances for decision-making, the specifics of their obstetrics history features and reproductive behavior, and family composition by sex of children.

According to Armenia Demographic and Health Survey (ADHS) 2015-2016²⁶, the maximum number of births is recorded in the 20-24 age group of women, while the number of pregnancies that ended in an induced abortion rises dramatically with age and reached highest level in women age 35 and older. Armenian women usually request an abortion only after having at least 1 or 2 children. It was found that among women with a history of abortion, the sex ratio of children at the time of first birth is close to the biologically normal: 1.04 (51% and 49%). It is slightly changing in favour of boys at the time of last birth (51.7% and 48.3 %) but still is close to the biologically normal (1.07).

The same study (ADHS: 2015) shows that about two-thirds of abortions (65%) are performed because of a desire to stop childbearing. Other reasons include concerns about the mother's health (7%) and the risk of congenital malformations (8%). The proportion of women who mentioned sex selection as a reason for an abortion was 7.7%. This indicator decreased from 9% reported in ADHS: 2010.

⇒ Sex Imbalances at Birth in Armenia

The level of sex ratio at birth in Armenia is considered to be one of the highest levels of birth masculinity in the world. All three identified prerequisites for sex-selective abortion are present in the country^{27, 28}, particularly:

- ⇒ **Precondition 1:** Armenian society demonstrates a boy-child preference over girls.
- ⇒ **Precondition 2:** Invasive and non-invasive prenatal technologies, which allow future parents to know the sex of the fetus in advance and avoid the birth of unwanted girls, exist and are available in the country.
- ⇒ **Precondition 3:** Birth in Armenia is declining continuously, and couples prefer to have fewer children.

According to official statistical data from the National Statistical Service of Armenia, the country has witnessed a skewed sex ratio at birth starting from 1991 and peaking at 120 boys to 100 girls in the 2000s and stabilizing at 114 boys to 100 girls in 2012. During 2008-2012, before starting the national program towards combating gender-biased abortions, the 5-year average sex ratio at birth was 100:115 (girls/boys). In the following years, a significant declining trend of the SRB was recorded (100:113 in 2013; 100:113.4 in 2014; 100:112.7 in 2015; 100:111.9 in 2016; and 100/109.8 in 2017). In 2018, when fewer programmatic events aimed at the GBSS elimination were conducted, the SRB indicator worsened

26 National Statistical Service [Armenia], Ministry of Health [Armenia], and ICF, 2017. Armenia Demographic and Health Survey 2015-16. Rockville, Maryland, USA: National Statistical Service, Ministry of Health, and ICF. <https://dhsprogram.com/pubs/pdf/FR325/FR325.pdf>

27 UNFPA, Armenia, RA Ministry of Health (2013). Sex Imbalances at Birth in Armenia: Information booklet, Published by United Nations Population Fund, 2013. Yerevan, Armenia. <http://unfpa.am/publications-sex-imbalance-at-birth-2013>

28 UNFPA, Armenia (2013). Sex Imbalances at Birth in Armenia: demographic evidence and analysis: UNFPA Report by Christophe Z. Guilmoto IRD/CEPED Paris, Yerevan 2013. https://armenia.unfpa.org/sites/default/files/pub-pdf/Sex_Imbalance_report_Eng_final-with%20cover-final.pdf

(100:111:9). However, during the next three years, the SRB continued to decrease, approaching the natural level: 100:110.4 in 2019; 100:110,0 in 2020; and 100:108,8 in 2021. Unfortunately, in 2022, the SRB indicator returned to the level of 2018 (100:111,9 girls/boys), indicating the need for the program's continuation.

The assessment of registered births in Armenia during 2001-2010, presented in the UNFPA Report by Christophe Z. Guilmoto (see reference 28) revealed regional variations in birth masculinity (the SRB is ranging from around 110 to 124). In Syunik and Tavush provinces (marzes), the levels of SRB appear at a moderate level (100:110 and 100:112, respectively). In Aragatsotn and Gegharkunik provinces, the corresponding figures are higher than the natural levels of SRB (100:122 and 100:124).

The more in-depth analysis in the framework of the same study also revealed parity-wise variations in birth masculinity. Thus, the average SRB for the 1st birth order during 2008-2012 was at the level of 100:106, then it rose to 100:110 for the 2nd birth order and increased to 100:164 and 100:166 for the 3rd and 4th plus birth orders, respectively (highest ever registered SRB level in the world).

The recent publications of the Statistical Committee of the Republic of Armenia (SCRA) demonstrate a significant progress in reduction of birth masculinity by birth order²⁹. The Table below shows that gender disparity is more than halved in 2020 compared to 2015 in the case of the 2nd childbirth:

Year	Birth Order				
	First	Second	Third	Fourth	Fifth +
2015	100:106	100:108	100:143	100:141	100:118
2020	100:107	100:103	100:125	100:133	100:113

Furthermore, for the 1st and 2nd birth order, the SRB practically fits into the range of biologically determined average statistical norms. These data prove that in Armenia, gender-biased sex selection and selective abortions for the first and second birth order are uncommon, in contrast with many other countries experiencing the problem of birth masculinity.

On the other hand, gender-biased induced abortions are performed from the 3rd pregnancy onwards, which gives grounds to assume that artificial pregnancy termination in Armenia is the mean of the family composition regulation by sex of children. The assessment shows that Armenian families usually complete their reproductive plans if at least one child out of two is a boy. The continuous attempts to have a boy eventually led to the fact that in most families, boys are younger than girls. This, of course, contains potential demographic consequences in subsequent generations.

There was a clear positive trend in lowering birth masculinity during the last decade, reflected in the average SRB indicator decrease (from 100:164 in 2008-2012 to 100:143 in 2015 and up to 100:120 in 2020). However, despite these positive trends, the issue remains on the national agenda as a priority. Although the average SRB reduced by more than one-third (100:108,8 in 2021, versus 100:115 in 2008-2012), it continues to exceed the natural sex ratio at birth significantly. Moreover, a significant deterioration of the SRB indicator was recorded in 2022.

⇒ **Implications and Projections:**

The experience of countries facing the problem of gender-biased pregnancy terminations shows that this phenomenon can lead to undesirable implications, including demographic imbalance, increased emigration of men, and crime rising, including sexual violence. In Armenia, this phenomenon has already

29 Statistical Committee of the Republic of Armenia. Publications: 2019թ., 2020թ., 2021թ., 2022թ., <http://armstat.am>. Women and Men in Armenia 2022. <https://armstat.am/en/?nid=82&id=2439>

found its reflection in the main demographic indicators and population dynamics.

Thus, the number of male newborns exceeded the number of females by 9% during 1996-2001, but in 2001-2010 this difference was more than 26%. According to the Armenia Census: 2011, the number of boys under 15 exceeded the number of girls by almost 39,000 since 1996. The official reports of the RA Statistical Committee³⁰ show that as of January 1, 2022, the number of 0-19-year-olds boys exceeds the number of same-age girls by 52,800. The shape of the “Population Age-sex Pyramid” has also changed. A relative increase in the proportion of young men of early reproductive age (15-25 years) is recorded against the background of a decrease in the proportion of same-age young women.

According to expert estimates conducted in 2011-2017³¹, Armenia annually loses about 1400-2000 newborn girls as a result of sex imbalances at birth, which is a big blow to the demographic situation of the country, which is already in a critical state. According to the same sources, it was predicted that in the case of maintaining a similar sex ratio at birth, almost 93,000 girls will not be born by 2060, which, in turn, will lead to a decline in the number of births and decreasing in Armenia’s population size by another 80,000. This figure corresponds to the approximate number of births that Armenia has during two years.

It is predicted that apart from the demographic threats, many other social problems will also arise, such as the increase in crimes against sexual integrity and freedom, the increase in the number of single men, and related to celibacy consequences. The shortage of young women will affect the country’s so-called “marriage market”. The gender disparity can be an additional contributing “cause” for the marriage migration of men or delay in their family formation resulting in the rise of celibacy among those men who would prefer to stay in Armenia. Thus, despite some positive trends in the skewed sex ratio normalization, the demographic situation in the country, especially against the background of the current geopolitical crisis, is deteriorated. The joint effort for the solution to this ongoing problem and situation improvement is the imperative of the day.

30 *Statistical Committee of the Republic of Armenia (2022). The Demographic Handbook of Armenia, 2022, Yerevan, Armenia. <https://armstat.am/en/?nid=82&id=2535>*

31 *International Center for Human Development (2016) An Analysis of Policies and Current Practices to Prevent Gender Discrimination in Health Care. International Center for Human Development (ICHD), 2016. [https://ichd.org/download.php?f=822&fc=2_Health%20sector_Final%20\(2\).pdf](https://ichd.org/download.php?f=822&fc=2_Health%20sector_Final%20(2).pdf)*

Lesson N 3. Practical:

⇒ Sex Imbalances at Birth in Armenia: Thematic video presentation

<https://youtu.be/6YCAeIDqjRs>



The film watching and opinion sharing.

Lesson N 4. Practical:

▶ Family Composition Preferences and Attitudes towards Gender Stereotypes

▶ **Format:** Group work with interactive discussion around thematic issues.

▶ **Purpose:** Giving participants a chance:

1) to clarify and articulate their perceptions of gender roles and gender stereotypes of girls/women and boys/men, and

2) to share with others their personal experience of gender education of children, especially on the issues of gender equality and the inadmissibility of gender-based violence.

▶ **Training process:** Participants are divided into three groups:

- ▶ Those who don't have children,
- ▶ Those who have only one child or children of the same sex,
- ▶ Those who have children of different sexes.

The facilitator presents thematic issues for discussion, specifically developed for each group of participants.

⇒ **Group I: Participants who don't have children**

- 1) What are the advantages and disadvantages of being a girl or a woman?
- 2) What are the advantages and disadvantages of being a boy or a man?
- 3) How many and what gender of children do you prefer to have and what determines your preference?

⇒ **Group II: Participants who have only one child or children of the same gender**

- 1) What is the gender of your child/children?
- 2) Would you like to have another child of the opposite sex? If yes, then when? If not, then why?
- 3) Is there any difference between your personal preferences on these issues and the preferences of your husband and his parents?

⇒ **Group III: Participants who have children of different gender**

- 1) How many girls and how many boys do you have? What age are they?
- 2) Have you tried to instill in your young children the principles of gender equality and the inadmissibility of gender violence? If so, please share your experience. If didn't, then why?

- 3) Have you noticed discrimination towards your daughters or sons in the family and society? If so, then what kind of discrimination?
- 4) Are you planning to have a baby shortly? Of what gender?

- ▶ **Discussion in working groups and presentation of results:** The participants stand out from the general group and choose the group's Moderator/Host and Rapporteur. Moderators refer to the thematic issues for discussion and suggest participants write their answers on sticky notes and post them on the board. The Rapporteur of each group summarizes the group members' records and presents them to the general audience. Other participants of the group voluntarily share their personal stories and opinions. An interactive discussion is taking place in the classroom.
- ▶ **Evaluation:** The facilitator/instructor conducting the exercise summarizes group presentations concerning common perceptions of gender roles in Armenian families, preferences for the gender composition of the family, desired number of children, and family planning. The exercise concludes with the message on the need to eradicate discrimination against women and girl children and related harmful manifestations (see below):

“Every child, regardless of gender, is a personality and has the right to life and to be treated with dignity. In Armenian families and society, the principles of gender equality should be rooted, and childbearing, regardless of the unborn child's sex, should be encouraged”.

Lesson N 5. Theoretical:

- ▶ **Determinants of Natural Movement and Reproductive Behaviour of the Population: Background and Further Developments in Armenia.**

There are several problems in the healthcare sector of the Republic of Armenia that should be dissolved to prevent effectively gender-biased pregnancy terminations. Many healthcare providers lack information about Armenia's population dynamics and trends, as well as determinants and indirect factors of the reproductive behavior of women and men. Moreover, some healthcare providers demonstrate an irresponsible attitude towards gender-biased selective abortions and, sometimes, unintentionally or due to their motivation contribute to their implementation.

This training session aims to improve participants' awareness of trends and determinants of the natural movement and reproductive behavior of Armenia's population and to clarify the needs and importance of health workers' participation in the demographic challenges overcoming processes.

- ▶ **Population Reproduction and Natural Movement**

Population reproduction is the natural alternation and renewal of generations, which occurs as an outcome of births and deaths. As a result of this ongoing process, the population number is changing: it can increase or decrease in size.

This process of natural alternation and renewal of generations, which result in changes in the population size, is defined as a “Natural Movement”. The direct determinants of the Natural Movement are Birth Rate and Death Rate. The indicator of Natural Population Growth is the difference between the birth and death rates³².

³² Note: Populations' Natural Growth index is calculated both in absolute numbers and as a relative indicator {per cent (%) per 100 people or pre mille (‰) per 1000}.

Three main patterns of population Natural Movement exist: Stationary, Expansive and Constrictive. In the case of Stationary Reproduction, the birth and death rates are equal, that is, the population does not change and there is no natural increase. With the Expansive Reproduction Pattern, the birth rate exceeds the death rate, and the population is growing in size. The Constrictive Reproduction Pattern is defined when the death rate exceeds the birth rate, and the population is declining.

In countries where the death rate exceeds the birth rate for many years, and there is a negative somersault of the natural growth of the population, a situation of natural depopulation is arising. If such a situation persists for many years, it is considered a demographic crisis.

There are many factors influencing natural population growth, namely behavioral, demographic, medical, socio-economic, political, legislative, religious, psychological, cultural, epidemiological, ecological, etc.

► Reproductive Behavior of the Population

The reproductive behavior of the population, that is, the common behavior of the majority of women and men living in this country, plays a significant role in the processes of generation's alternation and renewal.

The reproductive behavior of cohabiting couples is an interrelated chain of preferences, capacities, abilities, knowledge and skills, as well as coincidences, events and circumstances, as a result of which they can have a child or be able to prevent pregnancy and childbearing.

Reproductive Behaviour incorporates the issues of sexual life and harmony between the partners, their gender roles and marital relationships, the number and sex preferences for children, the knowledge and practice of contraception and induced abortion, and the lifestyle during pregnancy, infant care and breastfeeding.

The reproductive behavior of the population is changing, along with the development of civilization and changes in people's living conditions. The basis of these changes is a new understanding and attitude towards life experience, traditional beliefs and behavioral norms of the previous generations, following the requirements of the time. As an outcome, some national traditions are no longer preserved or turn into stereotypes that indirectly affect reproductive behavior, gender relations, and the natural movement of the population.

► Family, as the Cornerstone of the Population's Sustainability

*"Strong is the nation that has empowered families.
The power of people is in their families³³".*

A strong and healthy family is the basis for the sustainable development of each nation. A family is a small group of people based on marriage union or consanguinity links, whose members are connected by the commonality of household duties, mutual help and moral responsibility. In the family, children are born, grow up and live with other family members: young people, adults and elderlies.

As a social phenomenon, family characteristics are changing, along with the economic development of society, maintaining at the same time relative independence. The family reflects the level of society's development, national traditions, public morals, and experienced crises over the centuries³⁴. The quite

33 Muratsan (1896), Gevorg Marzpetuni (historical novel). <https://en.wikipedia.org/wiki/Muratsan>

34 Hovhannisyan L (2021). Social science. The concept of family. <https://lalahovhannisyan.wordpress.com/2021/02/20/%D5%A8%D5%B6%D5%BF%D5%A1%D5%B6%D5%AB%D6%84>

conservative Armenian Family Traditions and Customs affect the reproductive behaviour of the entire population. To have a complete impression of these issues, one should observe and analyze the dynamics of the “family institution”, the past and the present of Armenian families.

► The Armenian Family and its Traditions

The Armenian family was nuclear originally. Later on, this family unit could survive in the framework of a larger family group, the so-called “Gerdastan”.

The traditional patriarchal Armenian family consisted of about 4-5 generations of children of one father with their wives and children living together under the same roof. The lineage continued on the principle of one man and one woman. The strong bond between relatives and generations was maintained. Special love and attention were shown to the ancestors, and their inherited values were strictly preserved.

Generations followed the laws laid down by their Patriarch (Nahapet) and were obliged to pass them on to their descendants³⁵. Such types of patriarchal families existed until the 30s of the 20th century. “Gerdastans” later began to disintegrate and split into several small families. However, living in the same apartment for 3-4 family generations is still common.

Although today’s youth often prefers living separately from their grandparents and parents, families still maintain strong ties between generations and follow family traditions. Respect for parents and elders and boundless love for children is considered of supreme value.

Typical Armenian families are still characterized by monogamy. Women having premarital relationships and children outside of marriage are condemned by society. Infidelity of a spouse is a common reason for divorce.

► The Patriarchal Family and the Mother’s Power

The Patriarch of the Family and the “Hidden” Matriarchy:

The head of Gerdastan or Patriarch was the eldest man in the family. All members of Gerdastan were accountable to the Patriarch for their actions, however, the Patriarch himself was not accountable to anyone. To solve family problems, the Patriarch consulted with other elderly men within his family. The second person in the family after the Patriarch was his wife, who helped him and preserved his high authority. The most important duty of a wife was to keep the fire in the house hearth. Even the death of a wife was often compared to an extinguished fire in the hearth. The main role of a wife was motherhood and raising children. The pregnant woman and the mother have been objects of worship in all timeframes. It was the duty of the Patriarch’s wife to teach the daughters-in-law and grandchildren the traditions and history of their Gerdastan, as well as the national culture, rituals and traditions. Although the power of the Patriarch’s wife extended mainly to women and children, all family members respected her. She was the Patriarch’s main adviser and the guardian of peace in the house. Moreover, in ancient times, Armenian queens and princesses had the right to give orders, take or release prisoners, organize feasts and attend royal meetings without informing their husbands³⁶.

35 Armenian Geographic Website, - Armenian traditional family. <https://www.armgeo.am/armenian-traditional-family>

36 Note: Same as reference 35 above

According to the traditions, Armenian families are patriarchal nowadays as well. The man is considered the Family Head (Main Breadwinner) and has the right to have the final word. However, so-called “hidden matriarchy” prevails in families because nothing is done without the knowledge and consent of the woman. And the opinion that married women in Armenia are not working, standing by the stove all day apart and forgetting about their leisure time is an absolute myth. Many Armenian women receive higher education, achieve great professional success, have a job and occupy high positions in State institutions and prestigious companies. Working does not reduce a woman’s role in the family: she is the guardian of the house hearth, family harmony and a comfortable home atmosphere. A woman is responsible for ensuring healthcare and education for children and their moral upbringing. However, nothing is done in these matters without the knowledge and consent of the man. Armenian women always find time for the organization of their family entertainment. Admittedly, retired elderly grandmothers support and help their daughters-in-law and daughters. It is also interesting that sisters are under the protection of their brothers as a rule. Even their age difference doesn’t matter. To conclude, we can say that Armenian family culture is full of mutual respect, care and love.

► **Desired Number and Gender of Children**

Families in Gerdastan usually had many children, so they always had the opportunity to have children of both genders. Special attention was given to boys because it was considered that male children continue the family tree branches. In the family tree, which was a testimony of the history of their clan for generations, only the names of the male representatives of the clan were mentioned. Girls were considered to become Lamp of someone else’s house and Hearth Keepers of a new family. Only the names of male members of the family were mentioned in the family tree, which was served as an evidence of the history of their Gerdastan for generations. Girls were considered to become the “lamp” of someone else’s house and hearth keepers of a new family. It was the newly married man’s purpose and responsibility to add new branches to his family tree (Note: same as reference 35 above).

Unfortunately, Armenian families nowadays limit their family size, and there is less chance of having children of both sexes. Meanwhile, son preference is still common for many Armenian families. This is evidenced by the results of several large-scale studies carried out in the last three decades (described below).

Within the framework of the first National Program on Reproductive Health, the RA Ministry of Health, in collaboration with the Republican Center of Perinatology, Obstetrics and Gynecology and the “For Family Health” NGO conducted in 1997-1998 the large-scale surveys among 6,000 women and 3,000 men of reproductive age ever been married or in the consensual union. It was found that before the (first) marriage, 60.5% of female respondents and 64% of male respondents considered having 3 or 4 children (2.5 on average) as an ideal, including at least 1 or 2 boys (1.7 on average). The majority (63.5%) at the time of the interview had 1 or 2 children (2.1 on average), and one quarter (25.1%) had (3) children {references 32 and 33 in the Bibliography: List of literature used section}.

According to the UNFPA-supported 2012-2013 study “Sex imbalances at birth in Armenia” demographic evidence and analysis conducted by Christophe Z. Guilmoto, the majority (65%) of Armenian women in 2011 were in favor of having sons and only around 25% preferred to have a daughter. Men unconditionally preferred to have male children. After having two children, the desire to have another one was three times higher in the absence of a male child {reference 24 in the Bibliography: List of literature used section}.

In the 2015-16 ADHS *{reference 18 in the Bibliography: List of literature used section}*, women and men were asked what they considered the ideal family size to be and what is their actual number of children. It was found that overall, the mean ideal number of children reported by female respondents is 2.6 and the corresponding number reported by male respondents is 2.7. The actual number of children that women have had at the time of the survey interview was less than 2 (1.4 on average). About 54% of married women and 48% of men stated that they do not want to have any more children. More than half of all the respondents (54% of women and 51% of men) had both male and female children. However, the gender ratio of children was significantly skewed in favor of boys. 24% of women and 23% of men had only sons, while the corresponding proportions of respondents who had only daughters were significantly smaller (16% of women and 17% of men).

Studies that were conducted by the International Center for Human Development (ICHD) during 2011-2016 helped to identify the reasons for the son's preferences *{references 14 and 18 in the Bibliography: List of literature used section}*. The common assumption is that "male children continue the family clan", "they are heirs of the property", "they protect the motherland", "they guarantee the family's material well-being", and, finally, "they personify authority and power".

In 2020-2021, Advanced Public Research (APR) Group NGO with the support of UNFPA conducted a randomized sociological survey among 3000 women and men of reproductive age living in urban and rural communities in Armenia. It was found that 78% of all respondents have at least one son and 70% have at least one daughter. The majority (86% of women and 81% of men) do not plan to have children in the near future. However, 36% of women have fewer children than planned, and 7% still have no children *{reference 5 in the Bibliography: List of literature used section}*.

The comparison of the published research data on son preferences conducted by the UNFPA during the last decade reveals positive changes. The share of families who prefer to have a boy decreased from 45% in 2011 to 13% in 2017. Another positive result is that for the majority of respondents (82%) surveyed in 2017, the gender of the desired child is unimportant. This is a significant increase compared to 47% in 2011.

In 2022, UNFPA repeated the previous study on the Prevalence and Causes of Gender-Biased Sex Selection in the Republic of Armenia using the same methodological approach, which aimed to identify the attitude and behavior of women and their family members concerning sex-selective abortions, as well as to assess the changes and trends in this field over the past five years³⁷. This study found that in the family and surrounding community, the share of community members who prefer to have a son exceeds the proportion of members in favor of having a daughter. In the 2022 study, fewer participants expressed an equal preference for children of both genders than in the previous (2017) study. However, more respondents in the 2022 study mentioned that the gender of the unborn child does not matter in deciding on pregnancy continuation. More than half (53%) of all participants of the study believed in the existence of son preference among the surrounding them people (compared to 38% in 2017), and 18% of them indicated evidence of son preference among their family members (compared to 13% in 2017). Unfortunately, only 11% of study participants reported evidence of female child preference in their families and communities.

► Fertility Regulation

37 UNFPA, Armenia (2022). *Prevalence and Causes of Gender-Biased Sex Selection in the Republic of Armenia*. Published by UNFPA, No. of pages: 75, Publication date: 11 January 2023. <https://armenia.unfpa.org/en/GBSSresearch2022>

The artificial surgical termination of the pregnancy by a medical professional was performed for the first time in 1750 and was called “Abortion”. Up to now, any pregnancy termination is defined as “Abortion” regardless of its motives and methods used. The first country that officially legalized abortion in 1920 was Soviet Russia. Following the legalization of abortion on the background of the absence of modern methods of contraception, the fertility level began to decline in several USSR Republics. To stimulate the birth rate in the USSR, abortion was banned in 1936. However, the ban did not increase the birth rate. Instead, it contributed to the rising number of women who died from illegal abortions or killed their unwanted newborn babies. About 20 years later, the policy of banning abortions in the USSR began to soften, and in 1955 abortions were legalized again. For several decades, due to insufficient knowledge about modern methods of contraception and lack of access to family planning services, abortion was often used as a method of birth control.

At all times, women have tried to avoid or terminate unwanted pregnancies. Some traditional means of pregnancy prevention, such as exclusive breastfeeding, withdrawal (interrupted sex), and voluntary abstinence, have been in use also nowadays. To get rid of unwanted pregnancies, women used various traditional means. However, these attempts were viewed by the church as “Infanticide”. The woman who tried to terminate the pregnancy and the person who carried it out were severely punished in the past (unfortunately, there is evidence of similar practices in some countries nowadays).

The Church’s ban on abortion had a biblical explanation, according to which even a newly formed fetus is endowed by God with a soul. It should be noted that the unique cases of unwanted pregnancy termination in peaceful and favourable living conditions did not affect the natural processes of births and population reproduction.

After the declaration of Armenia’s independence, the Constitution stipulated that Motherhood and Childhood are under the special protection and guardianship of the state, and the family is the basis of population sustainable development and reproduction.

In the early 1990s, ultrasound technologies and modern methods of early pregnancy termination were introduced and became available in Armenia. The emergence of the possibility of finding out the sex of the fetus at the early intrauterine stage contributed to the rise of gender-biased selective abortions due to the female sex of the fetus. This is evidenced by the state service statistics data, which revealed sex imbalances at birth starting in the 1990s.

The first National Program on Reproductive Health Improvement was launched in Armenia by the Ministry of Health in 1996-1997 and supported by the WHO, UNFPA, UNICEF, UMCOR, IPPF and other donors. Within the framework of this programme, 77 Family Planning Services were established countrywide, the service providers were trained, modern contraceptives were introduced and disseminated among the vulnerable population, and a large-scale public awareness campaign was carried out. Armenian women received fertility regulation and birth control opportunities that would enable them to have the desired number of children at their desired age and time intervals between births. By adjusting the period between pregnancies, women received possibilities to get a higher education, work and participate in public life, and devote more time to child care and education.

However, even with the availability of family planning services, many women continued to resort to abortion, mainly to fulfil the traditional preference for having a male child and sometimes also to limit the number of children. An extended surveys conducted in Armenia in 1997-1998 found that 51.2% of women’s pregnan-

cies ended in abortion *{references 32 and 33 in the Bibliography: List of literature used section}*.

According to results of 2015-16 ADHS *{reference 18 in the Bibliography: List of literature used section}*, 57% of married women of reproductive age are using some forms of contraception. After an initial decline from 22% in 2000 to 20% in 2005, use of modern methods increased to 27% in 2010 and 28% in 2015-16. The same study revealed a substantial decline in abortions: the average number of abortions per woman decreased from 2.6 in 2000 to 0.6. However, this figure might be underestimated since we suppose that not all respondents mentioned history of illegal abortions or self-induced pregnancy terminations. Another positive observation was that the proportion of women who reported sex-selective abortions decreased from 9% in the 2010 study, to 7.7% in the 2015-2016 study.

UNFPA-supported randomized sociological survey conducted by the APR Group NGO in 2020-2021 shows that 45% of ever-married or cohabiting women of reproductive age reported a history of at least one induced abortion. According to the responses of male participants, 31% of their spouses/partners performed at least one artificial termination of the pregnancy *{reference 5 in the Bibliography: List of literature used section}*. It can be assumed that men are often unaware of the termination of pregnancies by their spouses/partners. The evaluation of the outcome of this study once more confirms the assumption that the son's preference and possibility of prenatal sex selection are major background factors for pregnancy termination. Quite alarming data have been obtained regarding the attempts of women to self-induce abortion without medical counselling: about 24% out of 493 women with a history of abortion ever attempted to self-induce miscarriage, and in 16% of these cases, the attempt was successful.

► Armenia's Population Size and Natural Movement Trends

The irreversible consequences of geopolitical events, severe natural disasters, wars and invasions, with territorial and human losses, which have occurred in Armenia throughout its history, have disrupted the process of population growth and sustainable development. *{Information presented in this section is based on an overview of available historical literature, census data, and reports of the Statistical Committee of the Republic of Armenia}*.

The population of historical Western Armenia lived under the Ottoman Empire for about four centuries (1555-1923). According to historical literature data, the population has continuously decreased in size as a result of natural and human-made disasters, including the Armenian Genocide, as well as due to emigration. As a result of the persecutory policy of the Ottoman authorities towards Armenians, thousands of people were forced to leave their homeland, seeking refuge in other countries. About 100,000 refugees moved to the Russian Empire (Eastern Armenia and the Caucasus), and 200,000 - to the United States of America, Europe, and various countries in Africa and Asia. More than 1.5 million Armenians were brutally killed as a result of the genocide. As a result, the Armenian-inhabited areas of Western Armenia and the Ottoman Empire were deserted. Facts, evidence and testimonies of the violent Islamization of about 200 thousand Armenians and the torture and captivity of girls and women have been preserved. This great tragedy of Armenia's people further contributed to the preference to have a male child as the protector of the family and homeland.

From the beginning of the 19th century, after the Russo-Persian and Russo-Turkish wars, the territories of historical Eastern Armenia gradually joined the Russian Empire. The population of Eastern Armenia lived under the Russian Empire for about a century.

In 1831, around 161.7 thousand people lived in Eastern Armenia. The first Russian census was con-

ducted in 1897, according to which the total population size of the Yerevan province of Eastern Armenia counted 798 thousand, and of the Kars province - 73 thousand. In the following decades, the Armenian population increased in size more than six times and reached 1.01 million in 1913. During these peaceful and relatively favourable years, the birth rate was high, so there was a high probability of having children of both sexes.

In 1918, after the collapse of the Russian Empire, Armenian statehood was restored in Eastern Armenia. About 302 thousand Armenian people moved to Armenia from Western Armenia and various regions of the South Caucasus. The restoration of Armenian statehood and the rise of the economy created favorable conditions for the natural growth of the population. However, it did not last long. As a result of the Armenian-Turkish war in 1920, famine, and emigration to Russia, the population size of Armenia decreased again, reaching 720 thousand.

In the Soviet period, the population size of Armenia was rapidly increasing, mainly due to a high birth rate and a gradual decrease in the death rate. At the beginning of 1940, the population natural growth rate in the Soviet Armenia was quite high (27.4%). During the Great Patriotic War, the birth rate in Armenia considerably declined, but in the post-war period, it started to rise again. In 1987, the population size reached 3411,9 thousand.

Unfortunately, several dramatic events happened in Armenia over the past three decades, which had an irreversible impact on the demographic situation in the country. As a result of the earthquake in Armenia that happened in 1988, almost the entire northern part of the country was destroyed, where about 1 million people lived. The number of victims of the earthquake reaches about 25 thousand. About 120,000 people were evacuated from the disaster zone, including women and men, elderly people, and children; 75,000 were displaced outside Armenia. Thousands of young people and people of reproductive age died in Artsakh as a result of the Armenian-Azerbaijani conflict.

For more than 30 years of Armenia's existence as an independent state, it faced several socio-economic crises. The latest crisis, which began in 2020, was caused by the Covid-19 pandemic and the war in Artsakh with all their manifestations and demographic consequences. Due to the low standards of living, financial difficulties and the tense military-political situation in the country, a new flow of emigration of citizens of reproductive age began and the population of the Republic of Armenia decreased by about 800 thousand people. The decline in birth rate and increase in death rates contribute further to the decrease of the population size.

According to the 2011 census, the permanent population of Armenia was 3,213 thousand people, while in 1987, the country had 3,411.9 thousand people. As of 1st January 2022, the permanent population declined to 2,961.0 thousand (population size decreased by more than 450 thousand since 1987).

As a result of the losses caused by the war and the Covid-19 pandemic, against the background of the birth rate decline, Armenia recorded an almost zero level of natural growth rate in 2020. Furthermore, a negative natural growth rate was observed in some provinces, particularly in Lori, Tavush, Syunik, and Vayots Dzor.

In this situation, with a further reduction in the number of girls and women of reproductive age and continued emigration, the country may be on the verge of natural depopulation and a demographic crisis. Our assumption is based on analyzing the trends in the vital population statistics and demographic indicators of Armenia in the last decades.

In such a complex demographic situation, when families limit the number of their children, it becomes a challenge of higher priority the gender-biased prenatal sex selection, which results in a skewed sex ratio at birth and a decrease in the female population size.

APPEAL TO HEALTHCARE PROFESSIONALS

Healthcare workers can play a crucial role in gender-biased abortion prevention and overcoming depopulation challenges. In total, 683 family doctors, 877 obstetrician-gynecologists, 1680 family nurses, and 1041 midwives are working in Armenia, according to the RA MOH NIH 2021 Statistical Yearbook³⁸. If each of these healthcare workers would prevent at least five gender-biased abortions a year, then about 20,000 more girls would be born annually; the skewed sex ratio at birth would be gradually restored, and the challenges of natural depopulation would be mitigated.

38 MoH RA NIH Information Analytic Center (2021). *Health and Health Care: Statistical Yearbook*. Published by National Institute of Health named after Academician S. Avdalyan in 2021, Yerevan, Armenia. <https://www.nih.am/assets/pdf/atvk/46fd4a0a5c67d43d981ebc3f3ff4c443.pdf>

MODULE 2. Topic: Artificial Termination of Pregnancy, including Gender-Biased Clandestine Abortions and Self-induced Miscarriages. National Prevention Policy and Legislative Regulations, and their Ethical and Gender Aspects.

Lesson N 6. Theoretical

► The National Policies and Programs, their Effectiveness, and Current Challenges.

The issue of gender-biased pregnancy terminations in Armenia was raised for the first time by the UNFPA in 2011. Subsequently, in 2013, the Chief Commissioner of the Council of Europe on Human Rights rated this issue as problematic and approached the governments of Armenia and some other regional countries to take immediate measures to improve the situation³⁹.

Although public awareness was raised about the emerging problem of the disproportion of sex ratio at birth as an outcome of gender-biased sex selection in Armenia, its official recognition by policymakers and professional circles took about four years. Following the official recognition, the strategic plan for this problem-solving was included in the national programs on “Maternal and Child Health Care” and “Combating Gender-based Violence”.

In 2014, the Government of Armenia officially recognized the need to implement actions towards preventing gender-biased prenatal sex selection and related selective abortions, and the Prime Minister ordered relevant departments to take prompt measures to resolve the issue. In the same year, the Government of Armenia, under the framework of active intersectoral cooperation, developed and approved the problem-solving Action Plan for 2015-2017. As part of this plan, in June 2016, the National Assembly approved presented by the Government of Armenia a package of legislative amendments regarding the prohibition of sex-biased abortions. Thus, Armenia fulfilled the international obligation to develop a national policy to prevent discriminatory sex selection, following Resolution No. 1829 of the Parliamentary Assembly of the Council of Europe.

The monitoring reports of the state policy and the programs implemented by international and non-governmental organizations in this field include the statement indicating the adoption by the Government of Armenia of the comprehensive GSSS preventive policy that combines legislative restrictions and legal regulations with public awareness measures aimed at valuing the girl child and removing gender-based discrimination and stereotypes, as well as human resource development and institutional capacity building.

► **Activities in the Health Sector towards reducing induced abortions, including gender-biased pregnancy terminations in Armenia**

By the legislative initiative of the Ministry of Health in 2016 amendments were made to Article 10 of the Law of the Republic of Armenia: “On Human Reproductive Health and Reproductive Rights” (2002), in which the statement prohibiting sex-selective abortion was included. The law also established additional regulations and mechanisms for reducing selective pregnancy terminations.

To ensure the implementation of the above-mentioned legislative amendments and new regulations, the Government of the Republic of Armenia developed and approved Decision N180-N, dated 23.02.2017, on “Approval of the Order and Conditions for the Artificial Termination of the Pregnancy”. This document strictly clarifies medical and social indications for induced abortion, the details of the procedure, and the

39 *Parliamentary Assembly of the Council of Europe (2011) Resolution N 1829, 03.11.2011 on Prenatal Sex Selection, Parliamentary Assembly Fourth part session. <https://pace.coe.int/en/files/18020>*

conditions of its implementation. It includes additional mechanisms aimed at preventing GBSS, including instructions on written application procedure, conducting pre-abortion counseling, obtaining informed consent, waiting period, etc.

Following the new provisions of the Law and the Government's decision, several normative legal and departmental documents were developed and approved by the orders of the Minister of Health of the Republic of Armenia, aimed at implementing the mechanisms for the implementation of the Law and the Government's Decision.

The above documents have been forwarded by the RA Ministry of Health to all Maternity Health Care Services and their founders for taking necessary actions. The main provisions of the above-mentioned legal acts were presented to the medical service providers through the system for the postgraduate education of health workers.

In addition, several activities were carried out aimed at improving the professional skills of healthcare providers, particularly:

- ▶ Organization of seminars for physicians of maternity care institutions providing prenatal counseling for pregnant women on the ethical aspects of using sex-determination technologies,
- ▶ Publishing and disseminating a handbook for the medical staff of maternity hospitals, including gynecologists and radiologists conducting ultrasound examinations to determine the sex of the fetus.

Apart from the sectoral measures, other programmatic activities aimed at the prevention of gender-biased pregnancy terminations have been designed and implemented with the support of the United Nations Population Fund and intersectoral cooperation, including large-scale public awareness campaigns with the participation of medical workers and representatives of the state structures, international organizations, and local NGOs.

▶ Programmatic Outcomes and Current Challenges

As an outcome of the comprehensive set of activities implemented in Armenia within the scope of the GSSS combating program, significant positive achievements in reducing selective abortions have been recorded. Thus, the average sex ratio among those born during 2008-2012, which was at the level 100:115.0, started gradually reducing by approximately 1 unit on average every year (in 2014: 100:113.4, in 2015: 100:112.7, in 2016: 100:111.9, 2017: 100/109.8) and reached 100:108.8 in 2021. This implies that every year, compared to the previous, about 200 more girls were born, and the total cumulative number for the ten years is 6000⁴⁰.

In 2012 the assumption was made that it would take about 25 years for the sex ratio at birth (SRB) in Armenia to return to the natural level. Meanwhile, achievements recorded in 2022 significantly exceeded these expectations. At the same time, despite stable positive trends toward returning the sex ratio at birth to the natural level, there is much work to be done in Armenia in this direction since the current SRB (100:106) continues to exceed the upper limit of the natural SRB level by 3 points. In our opinion, recorded achievement can be lost shortly in case of the discontinuation of the programmatic activities. The proof of what was said is that 2022 SRB was at the level of 100:112, which is a retreat of another 3 points.

For sustaining positive achievements, additional efforts and resources are needed to improve the legislative environment and institutional infrastructure and implement public awareness activities. Without a doubt, inter-departmental and inter-sectoral cooperation is required.

40 Note: Expert assessment based on index backtracking

In addition, there is a need for healthcare workers' involvement in GBSS combating processes to ensure the sustainability of positive programmatic achievements. It can be done through programmatic measures towards improving their knowledge, counseling skills and professional performance, which finally will bring about behavioral changes.

Lesson N 7. Practical

▶ The Gender-biased Sex-selective Pregnancy Terminations: Perceptions Clarification

▶ **Activity 1:** Group work with interactive discussions around thematic issues, the outcome recording and summarizing:

▶ **Purpose:** To clarify through group work and interactive discussions the perceptions of healthcare workers about background factors of prenatal sex selection and sex imbalance at birth and their demographic consequences.

▶ **Format:** The course participants are divided into two groups. Each group discusses two thematic questions.

⇒ **Group 1:**

1. Is the ban on selective abortions appropriate? If yes or not, then with what justifications?
2. What demographic consequences might the gender disparity in newborns have?

⇒ **Group 2:**

1. What are the factors contributing to prenatal sex selection?
2. What are the reasons for the preference of male children in Armenia?

▶ **Sharing Perceptions:** A speaker chosen by each group writes down and presents to the general audience the ideas of the group on the topics under discussion. An interactive discussion takes place in the auditorium, the main results of which are summarized and recorded.

▶ **Activity 2:** Thematic video presentation: "If I were born..."

⇒ <https://armenpress.am/arm/news/885751/g-hayastanum-serov-paymanavorvats-hxiutyantarhestakan.html>



Participants watching a film and sharing opinions.

Lesson N 8. Theoretical

▶ The legislative regulations and normative legal acts of the Republic of Armenia related to artificially induced pregnancy termination, including sex-selective abortion.

There are no official statistics on selective abortions in the Republic of Armenia. Published data on this issue are available in the sample research reports. According to the results of the ADHS: 2015-2016, 7.7% of female participants mentioned the sex of the fetus among the reasons for terminating a pregnancy. The corresponding figure in the ADHS: 2010 was 9% (a decrease of 1.3%).

The official statistical reports on induced abortions are underreported because they don't include selec-

tive abortions prohibited by the law. Such kind of induced abortions usually are performed at 14-15 weeks of gestation when fetal sex determination is more accurate.

However, at this stage of pregnancy, its artificial termination is legally permitted only under medical conditions. Therefore, illegal selective abortions are registered in the graph “under medical grounds” or as abortions “on a woman’s request up to the 12 weeks of gestation” when an indication of its reason is not required.

Although the banning of the gender-biased terminations of pregnancy has been made only under current legal regulations and the ban was not previously established, the long-term consequences of sex-selective abortions are reflected in the indicators of gender disparity at birth. This makes it possible to monitor the manifestation of the GBSS phenomenon through evaluation of the official statistical estimates of its indirect indicator - the Sex Ratio of Newborns at Birth (SRB).

► **Legal Regulations on Artificial Pregnancy Terminations, including Gender-biased Abortions**

The legal regulations related to the GBSS related problems and/or their prevention are reflected in the following legal acts⁴¹:

1. The Law of the Republic of Armenia “On Human Reproductive Health and Reproductive Rights” of 2002, with the last amendment made in 2016.
2. The Law of the RA on “Amendments to the RA Code on Administrative Offenses⁴²”, 2016.
3. The Criminal Code of the Republic of Armenia, 2003, Article 122.
4. Decision N 180–Ն dated 23.02.2017 on approval of the “Terms and Conditions of the Artificial Pregnancy Termination”.

Moreover, the issues of artificially induced pregnancy terminations, including sex-selective abortions, are covered by several Departmental Acts and approved by the orders of the Minister of Health.

The implementation of these orders is mandatory for the medical facilities providing services to vulnerable people within the scope of the state orders⁴³ (see below):

- The Order of RA Ministry of Health number 2949–L, dated 27.12.2018: “On the organization of artificial pregnancy termination procedure, approval of the format of abortion medical card with instruction for the filling out, and content of the consultation sheet on the prevention of sex-selective abortions”⁴⁴.
- The Order of RA Ministry of Health No. 464–L, dated 06.02.2020, “On approval of the terms of the examination and counseling on Family Planning issues, within the scope of the national program on provision of the medical assistance and services to the population, under free and preferential conditions, guaranteed by the state”.
- **Amendments and additions in Article 10 of the RA Law “On Human Reproductive Health and Reproductive Rights” made in 2016:**

41 *Government of the Republic of Armenia (2016). The legal regulations related to the GBSS related problems and/or their prevention. Published in the Official Bulletin of Legal Acts of the Republic of Armenia. <https://www.arlis.am/>*

42 *National Assembly of the Republic of Armenia (2016). Amendments to the RA Code on Administrative Offenses. Published in the Official Bulletin of Legal Acts of the Republic of Armenia <https://www.arlis.am/documentview.aspx?docid=73129>*

43 *Ministry of Health of the Republic of Armenia (2017). Legal Acts. Published in the Official website of RA Ministry of Health: <https://moh.am/#1/900002>*

44 *Ministry of Health of the Republic of Armenia (2018). The Order of RA Ministry of Health number 2949–L, dated 27.12.2018. Published in the official website of RA Ministry of Health under Legal Acts section. <https://www.moh.am/uploads/2949havelvac.pdf>*

1. Sex-selective abortions have been legally banned⁴⁵,
2. Additional legislative regulations and mechanisms aimed at reducing abortions have been established (see Appendix 1).

▶ **Supplementary provision in Article 11 of the RA Law “On Human Reproductive Health and Reproductive Rights” concerning “Assisted Reproductive Technologies” established in 2021:**

When using assisted reproductive technologies, planning the sex of the unborn child is not allowed, unless there is a possibility of inheriting a sex-linked disease **or if there are 3 children of the same sex in the family.**

Article 11 was amended on March 21, 2012, by order № 85-N and supplemented on June 4, 2021 by order № 264-N.

▶ **A new provision established in the RA Criminal Code “On Administrative Offenses”:**

According to this new provision in the RA Criminal Code, administrative penalties have been set for non-fulfillment of the legal obligations related to the medical procedures of the artificial pregnancy termination, in particular if free pre- and post-abortion counseling was not provided to the client, and a waiting period for making a final decision on abortion was not sustained.

▶ **The decision of the Government of the Republic of Armenia N 180-N dated 23.02.2017⁴⁶ on “The Order and Conditions for Performing Artificial Termination of Pregnancy”**

The Government’s Decision clarifies the medical and social indications of artificial abortion, and its order, conditions, and implementation mechanisms. It also refers to the legal relationship between patient and doctor, their mutual responsibilities, and rights related to abortion.

▶ **The Decision of the RA Minister of Health N 3403–U dated 27.12.2018 on “The procedures for organizing artificial pregnancy terminations, the format of the abortion medical card and the instruction for filling it out, and an advisory sheet on preventing selective abortions”**

Attachment 1 of the Handbook includes “The procedures for organizing artificial pregnancy terminations, the format of the abortion medical card and the instruction for filling it out, and an advisory sheet on preventing selective abortions” approved by the Minister of Health.

It is assumed that the introduction of the latter into the unified electronic healthcare system will contribute to increasing the effectiveness of legally defined norms enforcement, improving the transparency of the process of organizing the procedures and registering artificial pregnancy termination, thus contributing to the quality of care and reducing corruption risks.

However, despite all these governmental decisions, the monitoring reports on the approved abortion procedure implementation at the level of the maternity healthcare facility or data on compliance with the requirements established by the legal acts and regulations and their effectiveness in preventing unsafe abortions are not available.

Lesson N 9. Theoretical (in interactive format)

45 *Note: The strengthening ban on selective abortion by law implies that the fact gender-based artificial termination of pregnancy is considered an illegal abortion, for which Article 122 of the Criminal Code stipulates the punishment: “...a fine in the amount of a maximum of one hundred times the minimum wage, or imprisonment for a maximum period of one month, or depriving the right to occupy certain positions or engage in certain activities for an maximum period of three years”.*

46 *Government of the Republic of Armenia (2017). Decesion N 180-N dated 23.02.2017 on “The Order and Conditions for Performing Artificial Termination of Pregnancy” <https://www.arlis.am/DocumentView.aspx?docid=111980>*

- ▶ The most frequently asked questions about gender-biased sex-selective clandestine abortions and self-induced miscarriages.

Healthcare professionals “play a key role” in preventing sex-selective abortions, their complications, and their demographic consequences. As primary informants on healthcare issues, they can provide reliable information and contribute to reproductive behavior transformation. Therefore, they should know their rights and responsibilities and the background factors of gender-biased pregnancy termination to provide correct answers to the questions asked by their clients.

⇒ Responding to the most frequently asked questions:

1. What is an Abortion and how is it different from a Miscarriage?

The English term “Abortion” (in Latine “Abortus”) refers to the expulsion of a fetus from the woman’s womb (uterus) before it becomes capable of independent life outside of the mother’s body. It can happen naturally or artificially.

The spontaneous loss of a nonviable intra-uterine pregnancy before 22 weeks of gestational age is defined as “Spontaneous termination of pregnancy “or “Miscarriage”. The short name for “Miscarriage” in the Armenian language is «Վիճում», in Russian - «Выкидыш»).

Intentional termination of an intrauterine pregnancy by medical stimulation, surgical intervention, or unspecified means defined as an “Artificial Termination of Pregnancy” or “Induced Abortion” (shortly “Abortion”). The short name for an “Abortion” in the Armenian language is «Աբորտ», in Russian - “Аборт”.

A woman’s self-inflicted abortion is also considered artificial, and although this type of medical abortion is common, it is rarely reported. Self-induced termination of own pregnancy with the help of medication or other means, referred to as a “Self-induced abortion” is a kind of artificial termination of pregnancy. Although this kind of induced abortion is common, it is rarely reported by women or healthcare providers.

2. Why do women terminate their pregnancies?

Women usually terminate their pregnancy if it is undesirable for them. Every woman in Armenia can get rid of unwanted pregnancy on request up to the 12th week of pregnancy. However, abortion can also be performed on social or medical grounds at a later gestational stage (up to the 22nd week). The technological possibilities of determining the sex of the fetus in the prenatal stage contributed to the rise of gender-biased terminations of pregnancies, which is prohibited by law and considered illegal in Armenia.

3. In what terms of pregnancy is it possible to determine the sex of the fetus and terminate the pregnancy legally?

It is well known that most pregnant women try to determine the sex of the fetus by ultrasound examination, but this can be accurately detected mainly at 14-15 weeks of pregnancy when the differences in the genital organs of male and female fetuses are most clearly visible. Meanwhile, according to the legislation of the Republic of Armenia, an abortion on a woman’s request is allowed up to the 12th week of pregnancy. Abortion at later gestational age can be legally performed only on medical or social grounds based on a commission decision, but not later than the 22nd week of pregnancy.

4. Which health service providers have the right to terminate a pregnancy, and under what conditions?

According to the procedure established by law, abortion, including medical abortion, can be performed exclusively at inpatient obstetrics-gynecology departments of maternity care institutions by obstetri-

cian-gynecologist with relevant qualifications. In other circumstances, an abortion performed in violation of the law (even by a physician) or after the 12th week of pregnancy without indications prescribed by law is considered “illegal”.

5. Who permits performing an induced abortion on medical grounds?

The decision regarding the authorization of an abortion on a medical ground is made by a commission of medical professionals, including the head of the obstetrics-gynecology service/department, the obstetrician-gynecologist managing the pregnancy, as well as the specialist whose field of activity deals with the disease or pathological condition of the pregnant woman. In the abortion medical card, there must be results of the medical examination confirming the justification of the protocol of the commission’s decision.

6. What is the state’s position on the discriminatory treatment of girls and women?

The equality of women and men and the prohibition of discrimination are enshrined in the RA constitution (Articles 29 and 30). In 1993, Armenia ratified the Convention on the “Elimination of All Forms of Discrimination against Women”. This Convention provides a clear definition of “discrimination” and points out the obligations of Member States to create a better legislative environment balancing individual and civic rights.

In 1994, Armenia has signed the Action Plan of the Cairo International Conference on Population and Development. This document demonstrates a global commitment to the elimination of all forms of discrimination against girl children, including the preference given to boys.

7. Who are the decision-makers in the family for performing sex-selective termination of the pregnancy?

According to the results of the sociological survey conducted in 2020-2021 by the Advanced Public Research Group NGO with the support of UNFPA, 54% of women decide on pregnancy termination together with their husbands/partners, 20% - take this decision alone, and 4% - at the behest of their mothers and or fathers in law.

8. What are the background factors of illegal abortions and self-induced miscarriages?

Due to legal prohibitions and/or with the purpose to ensure the privacy of their discriminatory sex selection, women with an unwanted pregnancy usually try to get rid of this with the help of private practitioners, often in unsafe conditions outside the hospital. Since abortion of this type is quite expensive, some women try to self-induce the miscarriage with the help of various methods, mainly medication use.

9. What are the consequences of illegal abortions or self-induced miscarriages?

Illegal or self-induced abortion is not only the loss of a fetus deprived of the opportunity to be born, but it also endangers the life and health of the woman. It is well known that an unsafe abortion can cause uterine wall rupture, heavy bleeding, acute pelvic or endometrial infection, internal organ injuries, and other complications. Its long-term consequences are chronic pelvic inflammatory disease and endometritis, secondary infertility, recurrent miscarriages and other disorders/dysfunctions of the female reproductive system.

10. What are the terms and methods of artificial termination of pregnancy in the first and second trimesters?

Sex-selective abortions are usually performed in the first trimester, at 13-14 weeks of gestation, and sometimes on medical grounds in the second trimester, but not later than 22 weeks. For termination of

the pregnancy, both medical and surgical methods are used.

11. According to RA Legislation, what are the social indications for performing an artificial pregnancy termination procedure?

The social indications for performing an artificial pregnancy termination procedure based on the RA Legislation are as follows:

- ▶ death of the husband during pregnancy.
- ▶ female or male spouse is serving the sentence as prescribed by law and stays in a place of imprisonment
- ▶ legal divorce during pregnancy
- ▶ pregnancy is a result of rape.

Lesson N 10. Practical

▶ Gender-biased sex-selective pregnancy terminations as a manifestation of discriminatory attitudes towards women and girls in the family and society. How to improve the situation?

▶ **Purposes:**

1. To improve the level of awareness of the participants that gender-biased pregnancy terminations are manifestations of discriminatory attitudes towards women and girl children in the family and society.
2. To reveal the ideas of the participants about the ways of changing the discriminatory attitude towards women and girl children in Armenian families and society.

▶ **Format:** Thematic video presentation and sharing opinions, followed by group work, interactive discussion, and summary.

▶ **Activity 1:** Watching the film “BAVAKAN” and sharing opinions

▶ **Description of activity 1:** Participants watching a film and sharing opinions on gender-biased sex-selective pregnancy terminations as a manifestation of discriminatory attitudes towards women and girls in the family and society. (*Note: Bavakan is the name of a girl, which means “enough”*)

<https://vimeo.com/91055855>

Password: Bavakan54321

▶ **Activity 2:** The group work: “How to improve the situation?”

▶ **Description of activity 2:** After watching the video, the participants should be distributed into five thematic groups. Each group receives a task to think about their surroundings and specify gender stereotypes in their communities that should be changed to eliminate gender-biased prenatal sex selection practices. The followings are 5 topics with issues suggested for the group discussions:

⇒ **Topic 1: Accepted cultural practices and beliefs:**

Examples to consider for discussion:

- ▶ Traditional belief that only men ensure the continuation of the generation and “Family Tree”,
- ▶ Accepted cultural practice of transferring all the family inheritance to men,
- ▶ Examples of common sayings: “She could not give birth to a son, the fire of the family hearth went

out” or “The boys ensure the survival of the homeland”.

- ▶ Accepted practice and belief that taking care of children and the house is the primary responsibility of a woman.

⇒ **Topic 2: Decision-making in the family:**

Examples to consider for discussion:

- ▶ A woman is submissive to both her husband and her mother-in-law.
- ▶ Men dominate in the family planning and decision-making processes.

⇒ **Topic 3: Economic opportunities for women:**

Examples to consider for discussion:

- ▶ Women are forced out of their jobs after childbirth, which limits their earning potential.
- ▶ Women are not seen as competitive or competent in the labor market as men.

⇒ **Topic 4: Influence of popular media:**

Example to consider for discussion:

- ▶ Possible influence of popular media on the formation of public opinion regarding the prevention of sex-selective abortions and prenatal determination of the gender of the fetus.

⇒ **Topic 5: Laws and developed policies:**

Examples to consider for discussion:

- ▶ Legislative norms that prohibit the announcement of the sex of the fetus or prenatal planning of its sex;
- ▶ Opportunity of taking parental leave by the father to encourage childbearing, etc.

After the presentation of all topics, groups begin to discuss their assignments. Based on the results of interactive discussions/brainstorming, each group develops its recommendations on how health workers can contribute to the eradication of discriminatory attitudes towards girls and women in families and societies and sex-selective abortion prevention processes.

Participants need to be informed that the brainstorming in groups should be based on the procedure of voicing and opposing opinions, but with the precondition of reaching a consensus on disputed issues. After agreeing on the best proposal for improving the situation, the rapporteurs share summaries of the group recommendations with other participants in the general auditorium.

- ▶ **Summarizing the Results:** Following group presentations and discussions in the auditorium, the trainer/facilitator interprets and summarises recommendations developed by the groups and clarifies that cultural traditions and stereotypes are an integral part of society’s identity.

At the same time, the trainer/facilitator notes that traditions and stereotypes are not identical. Stereotypes, unlike cultural traditions, are not static and change over time.

Finally, the trainer/facilitator explains that cultural traditions should not be considered negative phenomena. However, they are sufficient to bring up and challenge the beliefs and stereotypes that are harmful to men and women.

Lesson N 11. Theoretical

- ▶ The use of innovative laboratory and reproductive technologies for gender-biased prenatal sex selection from the medical ethics perspectives.

At the current stage of medical science development, issues of comparability of new reproductive technologies and ethics are relevant. Assisted reproductive technologies (ART) are developing at a faster pace. In recent years they are becoming more popular and increasingly affordable for couples willing to obtain more reliable information about the characteristics of their future child.

This is a cutting-edge procedure to identify the presence of chromosomal abnormalities in embryos created with in vitro fertilization. The technique is also used for preimplantation sex selection, although it raises many ethical questions.

One of these innovative technologies is the preimplantation genetic diagnosis (PGD) which was initially developed to reveal possible fetal malformations in pregnant women with a high risk of transmission of hereditary diseases to their children. This technique provided an opportunity to identify and prevent the birth of children with sex-linked inherited disorders. These diseases mainly affect boys and are caused by mutation of dominant genes on the X-chromosome. In such cases, the healthy Y-chromosome cannot balance the damaged X-chromosome, as a result of which the disease manifests itself in a male child.

PGD makes it possible to determine the sex of the fetus to avoid the birth of children suffering from many severe hereditary diseases caused by the mutation of the X-chromosome, including Duchenne muscular dystrophy, hemophilia, and color blindness.

To determine the gender of the child at the stage of preconception, Sperm Sorting technology or Flow Cytometry is also used, which allows for separating spermatozoa containing the X-chromosome from those containing the Y-chromosome since their masses differ by approximately 2.8%.

The ethical and gender aspects of fetal sex selection in the prenatal stage have been the subject of multi-level discussions in the international professional community in the last decade. The American College of Obstetricians and Gynecologists (ACOG)⁴⁷, the American Society for Reproductive Health (ASRM)⁴⁸, and the International Federation of Gynecologists and Obstetricians (FIGO)⁴⁹ are not in favor of the provision of requested services to persons seeking sex selection without a medical indication, as they believe that such a requirement can further worsen the valuing of women in the society. The mentioned organizations suggest providing fetal sex selection services only to prevent sex-linked hereditary diseases.

The Ethics and Law Committee of the European Society for Human Reproduction and Embryology⁵⁰ (ESHRE) defines: "The embryo should be treated with respect as a symbol of the future of human life."

By the way, amended RA legislation allows the pre-implantation genetic diagnosis for fetal sex selection in case of having at least 3 children of the same sex (Article 11 of the Law on Human Reproductive Health and Reproductive Rights, the addition was made on June 4, 2021).

However, despite the development of above mentioned modern ART technologies, globally, sex-selective abortion continues to be the most common mean of sex selection at the prenatal stage. Meanwhile, these reproductive technologies, mainly used for infertility management, can become alternatives for preventing sex-selective abortions.

47 American College of Obstetricians and Gynecologists <https://www.guidelinecentral.com/guidelines/ACOG/>

48 American Society of Reproductive Medicine <https://www.guidelinecentral.com/guidelines/ASRM/>

49 American Society of Reproductive Medicine <https://www.guidelinecentral.com/guidelines/ASRM/>

50 European Society of Human Reproduction and Embryology <https://www.eshre.eu/Guidelines-and-Legal>

Despite ongoing controversy over the ethical aspects of using assisted reproductive technologies for the purpose of prenatal sex determination of the fetus, the legislation of many countries around the world allows this procedure. The controversy on this issue is based on deep disagreements about the harm caused by prenatal sex determination of the fetus and its danger to the individual and society. Perhaps the debate on this issue will continue until reaching a consensus on which harm is more morally significant.

The knowledge of the ethical aspects of using the ART for fetal sex selection by healthcare workers and transferring this information to their clients will contribute at least to raising awareness of future parents about the determinants and consequences of gender-biased prenatal sex selection and the unacceptability of sex-selective abortions without any medical grounds.

To meet and overcome these challenges, all public groups and individuals in society, including politicians and decision-makers, community leaders, civil society representatives and opinion-makers, health workers and spiritual fathers, have a role to play in facing and overcoming described above challenges, in terms of ensuring the public resonance and maintaining spiritual/theological values.

Lesson N 12. Practical

▶ The anonymous case studies of unsafe clandestine abortion and/or self-induced pregnancy termination.

- ▶ **Format:** Presentation of individual cases, discussion of prevention possibilities, summary.
- ▶ **Description of the exercise:** The training facilitator and the participants share experiences on *unsafe clandestine abortion* and self-inflicted pregnancy termination cases that happened in their medical practice. Each story is followed by discussion and evaluation.
- ▶ **Summarizing the Results:** The facilitator makes notes write down and summarizes the main reasons for the presented pregnancy termination cases, who were the decision-makers, what methods/ measures were used, and what were the complications and consequences, if any. He concludes the lesson with the following statements:
 - ▶ Any surgical abortion performed by a person without sufficient knowledge and skills about the procedure and or under conditions that do not meet minimal required medical standards is considered unsafe.
 - ▶ The provision of medical abortion also requires special knowledge and skills. Termination of pregnancy based on advice and prescription given by an inexperienced person or self-administration attempts without the help of a licensed medical consultant can cause bleeding, severe pain, shock, and even death of the woman.
 - ▶ Performing gender-biased selective abortion in a maternity care institution without medical or social indications, even if performed by a skilled specialist, is considered illegal and may be prosecuted under the law.

MODULE 3. Topic: Prevention of gender-biased pregnancy terminations and their consequences by improving communication and counseling skills of healthcare providers and engaging them in community-based public awareness programs.

Today, the world is losing around 142 million women and girls, due to the gender-biased sex selection of children due to the preference for male children⁵¹. The role of healthcare workers in preventing these losses is great. This module aims to increase the awareness of health workers about the problem and consequences of sex imbalances at birth as a result of sex-selective pregnancy terminations, as well as to improve their professional counseling and communication skills on these issues and engage them in community-based public awareness programs participation and prevention processes as much as possible.

Lesson N 13. Theoretical

▶ Pre-abortion counseling for the prevention of gender-biased sex-selective pregnancy terminations and risk reduction.

▶ The role of healthcare workers in the prevention of gender-biased sex-selective pregnancy terminations and their risk reduction

The skewed sex ratio of newborns has become a challenge in our country. Medical workers are of great importance in the prevention of gender-biased sex selection⁵². The role of physicians in providing quality preabortion counseling is of particular importance. Therefore, medical counselors should be aware of gender stereotypes that are the background reasons for sex-selective abortions. These stereotypes sometimes condition personal behavior and lifestyle standards and, in a sense, determine their limitation circles. Gender stereotypes are created and constantly reproduced under the influence of propaganda, advertisements, and dissemination of various socio-political ideas.

Such stereotyping creates the basis for gender discrimination - a practice that acknowledges the preference of one gender over another. Meanwhile, discrimination is prohibited by the constitution of Armenia and the constitutions of most other countries in the world. Therefore, gender-biased pregnancy terminations are a reflection of hidden or indirect discrimination.

▶ Pre-abortion counseling

The provision of professional pre-abortion counseling and information about the possible complications and consequences of unsafe abortion by a physician may change the decision of a woman about termination of current pregnancy or prevent selective abortion cases in the future.

The main goals of pre-abortion counseling are reducing the risks and complications of unsafe abortion and preventing sex-selective pregnancy terminations.

Before making an informed decision on abortion, a woman should get comprehensive information concerning the medical procedure, its risks and consequences, and the advantages and disadvantages of the method. In this regard, it is important that the pre-abortion counselling will be free from psychological pressure and that information about possible health consequences and risks of the procedure will be reliable.

During pre-abortion counseling, it is recommended to be guided by (6) organizational principles, (6) top-

51 UNFPA (2020). *Gender-Biased Sex Selections Explained*, July 2020, UNFPA <https://www.unfpa.org/resources/gender-biased-sex-selections-explained>

52 UNFPA, Armenia (2017). *Prevention of sex-selective abortions, Handbook for health workers*, United Nations Population Fund, Yerevan 2017.

ics for the discussion, and (6) consecutive steps, described below⁵³.

► **Six principles of pre-abortion counseling:**

1. Be kind to every patient.
2. Collaborate with the patient.
3. Tailor the information to the patient's individual needs.
4. Avoid giving too much information.
5. Discuss the reasons for resorting to gender-based abortion, and highlight the role and importance of the girl child for the family and society.
6. Help the patient understand and remember the information provided.

► **Six topics to discuss during pre-abortion counseling:**

1. Making an informed choice.
2. Possible dangers of abortion.
3. Methods of birth control.
4. Legal requirements for an abortion procedure.
5. Women decide on their own.
6. Decisions on abortion should be weighed.

► **Six steps of pre-abortion counseling:**

1. Greet the patient with an open heart and respect, and listen to her with full attention.
2. Ask the patient how she is feeling.
3. Inform the patient about the ban on sex-selective pregnancy termination and the possible complications of illegal abortion at this gestational stage.
4. Help the patient make an informed choice within current legislation.
5. Encourage the patient to express opinions and ask questions. Answer their questions fully and openly.
6. Help the patient make an informed choice and consciously refuse the decision to terminate the pregnancy.

Lesson N 14. Theoretical

► **Post-abortion counseling on unwanted pregnancy prevention and basics of contraception.**

Despite some decrease in the abortion rate in the Republic of Armenia during the last decades, their number is still high. Thus, according to official statistics⁵⁴, in 2021, for 36,247 births, there were 11,214 induced abortions, including 6,113 on women's request. There were also registered cases of 2,214 spontaneous abortions and 609 medically induced abortions.

Meanwhile, abortion in Armenia is used traditionally for planning the number of children in the family. Besides, it is also one of the most frequently performed surgical interventions at the country level. Unfortunately, medical abortions are often performed illegally outside a medical facility with a high risk for a woman's health and are registered only in case of post-abortion complications.

53 UNFPA, Armenia (2018). *Six steps to prevent sex-selective termination of pregnancy with the help of counselling: Information sheet for healthcare workers. Published by UNFPA in Armenian language. No. of pages: 2, Publication date: 2018, Yerevan, Armenia.* <https://armenia.unfpa.org/hy/publications>

54 MoH RA NIH (2022). *Health and Health Care: Statistical Yearbook, Republic of Armenia, bu D. Andreasyan, A. Bazarchyan, published in 2022 by National Institute of Health named after Academician S. Avdalbekyan, 298 pages, Yerevan, Armenia.* <https://nih.am/assets/pdf/atvk/7b60e7d3520176ec109727456ba47eb0.pdf>

Therefore, it is not possible to estimate the actual number of unsafe abortions. It can be assumed that some of the registered spontaneous miscarriages are the outcomes of illegal abortions or women's self-attempts to terminate unwanted pregnancies.

Thus, it is justified why the issue of reducing abortions and increasing their safety remains today on the priority list of the National Reproductive Health Strategy despite some decrease in the abortion rate.

► The main goal of post-abortion counselling

Proper post-abortion counselling plays a significant role in the abortion prevention process. It can alleviate the psychological consequences associated with abortion, which are most often reported in sex-selective pregnancy termination cases. The main goals of post-abortion counselling are as follows:

- timely detection of possible complications of the early post-abortion period, provision of first aid, comprehensive care, and, if necessary, referral to an appropriate medical facility,
- providing medical supervision in the early post-abortion period to prevent further complications and consequences,
- mitigation of psychological outcomes of the abortion and underlying the value of the girl child, and
- providing advice on reliable methods of post-abortion family planning.

Depending on the method of pregnancy termination and course of the abortion process, as well as the psychosomatic characteristics of the woman, the post-abortion recovery period may have different manifestations and durations. Therefore, post-abortion counseling should be as individualized as possible. It should also include information about when to resume the normal rhythm of life, including sexual activity.

The woman should be properly informed that she can get pregnant again in the two-week post-abortion period and provided with the fullest possible counseling on modern methods of contraception. Regardless of the availability of abortion methods, the fact that abortion is not a method of family planning must be made clear to every woman. Even if the abortion was successful, it is necessary to explain to the woman how to distinguish the ongoing pregnancy symptoms that indicate the failure of the abortion, from other similar symptoms that are caused by the intervention and are temporary in nature.

The counselor must properly inform the woman that she can get pregnant again within the two-week weeks after an abortion and provide her with the fullest possible information about modern methods and means of contraception. Each woman needs to be made aware that abortion should not be used as a method of family planning, regardless of the availability and accessibility of the pregnancy termination services. Even if the abortion was successful, it is necessary to explain to the woman how to distinguish the ongoing pregnancy symptoms that indicate the failure of the abortion, from other similar symptoms that are caused by the intervention and are temporary in nature.

It is necessary to provide the woman with information about signs of dangerous post-abortion complications⁵⁵ (see below), as well as to explain to her the necessity and order of seeking medical help in case of their occurrence.

55 World Health Organization (2022). *Abortion Care Guideline*, WHO, Copenhagen, 2022 <https://srhr.org/abortioncare/>

⇒ **The signs of dangerous post-abortion complications:**

- ▶ Bleeding,
- ▶ Fever/increase in temperature,
- ▶ Pain, shivering, tremors,
- ▶ General weakness,
- ▶ Nausea, vomiting, bloating of the intestines,
- ▶ Signs of continued pregnancy,
- ▶ Continuous bloody discharge for two weeks or more.

Note: In case of any of these signs, woman should contact the physician who performed an abortion or request assistance from the nearest maternity facility.

Sex-selective abortions usually are carried out in violation of the law, as they are mainly performed at more than 12 weeks of gestation when termination of pregnancy on a woman's request is prohibited. Providing access to comprehensive post-abortion counseling services is particularly important in such cases.

⇒ **Guiding Principles for Provision of Post-Abortion Counseling**

The main guiding principles for the provision of post-abortion counseling are as follows:

- ▶ Ensure confidentiality and privacy of the counselling service.
- ▶ Communicate information respectfully and openly.
- ▶ Spend enough time listening to the woman to understand her needs and problems.
- ▶ Provide understandable for woman information without using medical terms.
- ▶ Present all the possible options arising from a woman's needs, avoiding at the same time imposing one's own opinion and values.
- ▶ Emphasize the need for other necessary services or counseling (for example, contraception after abortion).
- ▶ Make sure that woman got the answers to all her worrying questions.
- ▶ Check whether the woman understood the provided information correctly.
- ▶ Help the woman get informed about safe and effective means of contraception and use preferred by her family planning method.

In general, counseling is not just informing but a guided and interactive process through which a woman voluntarily receives support, information and impartial guidance from a health worker with appropriate knowledge and skills. Counseling should be provided in an environment that is private and conducive to honest sharing of feelings, thoughts, and perceptions.

To prevent sex-selective abortion, special attention should be paid to post-abortion family planning counseling services for married couples with two or more children of the same sex. This counseling should include an assessment of the likelihood of selective abortions for taking preventive measures timely and effective. For the implementation of effective family planning counseling⁵⁶, the health worker should:

- ▶ Enable the client to state her preferred contraceptive method,

⁵⁶ UNFPA, Armenia (2020). *For a Healthy Family: Effectiveness of contraceptive methods*. Published by UNFPA in Armenian language, Yerevan, 2020 <https://armenia.unfpa.org/sites/default/files/pub-pdf/Leaflet-Final-Web-Version.pdf>

- ▶ Demonstrate a client-friendly attitude,
- ▶ Listen to the client, ask relevant questions to assess the couple's reproductive goal and sexual behavior,
- ▶ Collect necessary anamnestic data,
- ▶ Help the client to make an informed decision on method of her choice,
- ▶ Explain the mode of method's application,
- ▶ Explain the benefits and possible side effects of contraceptives, as well as how to overcome them,
- ▶ Discuss the need to switch to the other method in case of side effects,
- ▶ Inform about dangerous signs of using contraceptives,
- ▶ Fill out related medical documents accurately, and
- ▶ Mark the next visit date.

⇒ **Medical eligibility criteria for using contraceptive methods to prevent unwanted pregnancies**

The Guideline for medical workers, approved by Order of the Minister of Health on August 14, 2015, under N2202 - A, describes in detail the general principles of family planning counselling and the procedure for providing individual consultation in choosing a most effective, convenient, acceptable, modern and safe method of contraception suitable for each couple⁵⁷.

Lesson N 15. Theoretical

- ▶ **Comprehensive care for women with complications of gender-biased sex-selective unsafe abortion, including first aid, health care management and referral.**

Despite achievements of modern medical science, which allow specialists with appropriate qualifications and expertise to safely perform an abortion on request or medical grounds to help women realize women's reproductive rights, it is not yet possible to avoid complications and situations with unfavorable outcomes. Therefore, health professionals and the public in general, including decision-makers, still have a lot to do to prevent induced abortions, especially sex-selective, and ensure the safety of abortion procedures. The experience shows that complications are rare if all required abortion procedures are followed.

Proper performed abortion procedure and postabortion management prevent unsafe abortions and their complications, which may contribute to reducing maternal mortality and disability. A medical facility of any level that provides abortion services should be equipped with the necessary equipment and qualified medical personnel who can recognize abortion complications, provide first aid, and, if necessary, refer to the appropriate medical facility of a higher level.

To reduce the complications and consequences of unsafe abortions, in 2020, by Order of the Minister of Health of Armenia, "Clinical recommendations on the organization and provisional procedures of comprehensive medical care for artificial termination of the pregnancy" was approved⁵⁸.

57 Ministry of Health of the Republic of Armenia (2015). *The Guideline for Medical Workers on Family Planning, approved by Order of the Minister of Health on August 14, 2015, under N2202-A.* <https://www.moh.am/uploads/2949havelvac.pdf> for English: <https://www.moh.am/#3/237>

58 Ministry of Health of the Republic of Armenia (2023). *Guidelines, Operating Systems, and Procedures. Official Website of the Ministry of Health of the Republic of Armenia* <https://www.moh.am/uploads/2949havelvac.pdf> for English: <https://www.moh.am/#3/237>

These recommendations are based on the WHO guidelines on “Safe Abortion” (version 2018), which aims at ensuring the safety, accessibility and quality of the abortion procedure through the organization and provision of comprehensive medical aid and care. It describes in detail safety approaches to the provision of surgical and medical abortion services, the principles of management of unsafe or complicated abortion cases, the post-abortion counselling procedure, as well as templates for patient consent and recommendations sheets.

The guide is intended for medical personnel providing abortion services, including obstetrician-gynaecologists, pre- and post-abortion counsellors, physicians working in specialized medical institutions providing abortion care services, and trainers involved in the provision of post-graduate health education who are interested in mastering the medical aspects of safe abortion. It contains practical recommendations on women’s rights counselling, obtaining informed consent for services, and ensuring high-quality abortion care.

The guidelines provide recommendations that include comprehensive, evidence-based measures for abortion. Here they are:

Improve the quality of abortion services, apply cost-effective technologies recommended by the WHO and integrate them into other reproductive health care services,

- ▶ Ensure the provision of safe, comprehensive, multifaceted quality abortion services, including post-abortion care,
- ▶ Increase the level of knowledge of medical workers on the prevention of unwanted pregnancy, the safety of the pregnancy termination procedure and its effective management.
- ▶ Ensure the safety of abortion by improving the skills of medical workers providing surgical and medical abortion services,
- ▶ Apply safe modern methods of the artificial pregnancy termination,
- ▶ Raise awareness and knowledge among service providers about the manual vacuum aspiration and medication methods of pregnancy termination,
- ▶ Refuse the dangerous scraping and curettage of the uterine cavity for pregnancy termination,
- ▶ Ensure the possibility for women to choose their preferred method of pregnancy termination, in particular by expanding the provision of medical abortion services by health care facilities,
- ▶ Conduct proper post-abortion counselling and provide information about the use of modern means of contraception,
- ▶ Reduce to a minimum the use of abortion procedures as a method of birth control by providing accurate information about modern means of contraception and dispelling myths about their harm,
- ▶ Contribute to an increase of women’s knowledge about the availability of safe abortion services and raise awareness of the dangers of unsafe pregnancy termination,
- ▶ Improve induced abortion registration and reporting processes in the service statistics system,
- ▶ Integrate the standards of provision of safe abortion services and comprehensive abortion care, including medical abortion, in the postgraduate education system for medical workers’ continuous professional development.

⇒ **Possible complications of sex-selective unsafe abortions**

Sex-selective abortions carry a greater risk of complications because they usually occur well after 12 weeks of gestation when the sex of the fetus can be more accurately determined. The likelihood of illegal, unsafe cases of medical abortion and associated post-abortion complications is higher in these circumstances since abortions on a woman’s request are allowed before 12 weeks of term. Such abortions are

usually performed through the self-use of pregnancy termination drugs without medical supervision and control.

Possible complications of unsafe surgical abortion include incomplete abortion, failed abortion, infection, bleeding, uterine perforation, damage to intra-abdominal organs, and complications related to the provision of analgesia.

The main complications of medical abortion are incomplete abortion, ongoing pregnancy, bleeding, and infection. Mental health issues are also possible.

In the case of medical termination of pregnancy, it is necessary to pay attention, differentiate and control the side effects of abortion drugs, the most typical of which are pain, bleeding, hyperthermia, and gastrointestinal system dysfunction. Described symptoms that occur during medical abortion are to be expected and are related to the termination of pregnancy, so the woman's sufficient awareness of their occurrence enables her to reduce and manage the risks of developing severe complications and psychological problems. When a woman approaches a physician for pregnancy termination, it is necessary to inform her about all possible complications of medical abortion and signs of danger at the stage of pre-abortion consultation.

Lesson N 16. Practical

▶ Improving pre-abortion and post-abortion counseling skills of service providers.

- ▶ **Purpose:** To improve the pre- and post-abortion counseling skills of the participants regarding the management of sex-selective abortion and/or its complications.
- ▶ **Format:** Work in 4 groups: discussion of situational problems and role plays.
- ▶ **Description of the exercise:** The participants of the course are divided into 4 groups, each of which is offered one thematic situational problem for evaluation and presentation of its solution by demonstrating the pre-abortion and/or post-abortion counselling skills through role-playing. The participants of each group are given roles: doctor giving advice, woman seeking advice, husband, and another family member of their choice. The trainer moderates counselling scenarios and their course. One of the facilitators conducts the timing of the role play and evaluates the quality of the counselling process using the Checklist.
- ▶ **The proposed scenarios:**
 - ▶ **Scenario 1:** the woman has sought pre-abortion counselling with her husband or mother-in-law, who instigates sex-selective abortion.
 - ▶ **Scenario 2:** the woman applied for post-abortion counselling after the gender-biased termination of the pregnancy.
 - ▶ **Scenario 3:** the woman visited a doctor alone with complaints after making an unsuccessful attempt to terminate the pregnancy by using medication on her own.
 - ▶ **Scenario 4:** a couple having three children of the same sex applied for counselling with the expectation

of having a child of a different sex. They mentioned a history of several sex-selective pregnancy terminations.

- ▶ **Summarizing results:** After the role-play, participants exchange their opinions about the correct and wrong aspects of provided counselling. The moderator summarizes the results of the exercise.

Lesson N 17. Practical



Watching and discussing thematic videos

- ▶ **Activity 1:** Say your word against violence:
<https://armenia.unfpa.org/en/video/speak-out-against-violence>
- ▶ **Activity 2:** Hidden by the Law Selective Abortion:
<https://m.mamul.am/am/video/26787617/p3668>
- ▶ **Format:** Watching films, discussing, reviews and recommendations.

Lesson N 18. Theoretical

- ▶ Paternity involvement and its impact on discriminatory fetal sex selection and gender inequality issues⁵⁹.

The problem of gender disparity at birth is more prevalent in countries where gender inequality and patriarchal values are spread. Global evidence shows that social norms of men having greater power and women being submissive are directly related to the level of gender-based violence (GBV) in society. Moreover, the manifestation of traditional patriarchal norms is correlated with a higher number of male newborns⁶⁰.

Sex-selective abortions are harmful to the family and society, they hinder the achievement towards gender equality and contribute to human rights violations in favour of male people. Gender-biased prenatal sex selection creates a culture of gender inequality, reinforces existing gender stereotypes and disrupts the natural proportion of infants by sex, which leads to long-lasting demographic and socio-economic consequences.

In Armenian reality, the roles of the sons in procreation, family income generation and caretaking of the ageing parents are often emphasized. Son is perceived as a family value and support, while daughter is often viewed with a different system of values and “ceases” to belong to the father’s family after marriage.

Fighting harmful gender stereotypes that favour boys and undervalue girls can contribute to addressing the issue of gender-biased artificial terminations of pregnancies and related sex imbalances at birth. The positive experience of programs implemented so far in this direction proves that one of the keys to success is the formation of a culture of respectful communication between spouses, joint decision-making and involvement of fathers in the process of child care and education. A significant role in this

59 UNFPA, Armenia (2022). *Papas Schools Manual*. Published by UNFPA (in Armenian language), Publication date: 2022, Yerevan, Armenia. https://armenia.unfpa.org/sites/default/files/pub-pdf/papa_schools_manual_in_armenian.pdf

60 World Vision Armenia (2015). *Caring for equality: A handbook on promoting gender equality and preventing sex-selective abortion for working with men, women and young people Promundo*: Washington, USA. World Vision, 2015. Yerevan, Armenia.

matter can play healthcare workers, particularly obstetricians-gynecologists, by encouraging young fathers in the processes of woman's care during pregnancy, childbirth and the postnatal period, providing the necessary information and contributing to attitude changes.

The involvement of fathers in the care, nutrition and upbringing of children, as well as spending their time on other parental duties and daily household chores, is essential.

When women become mothers, they are not the only ones who biologically can take care of their children. Studies show that fatherhood also causes hormonal changes in men. Such is the decrease in testosterone that helps them become better dads. Such a decrease in testosterone levels promotes a stronger father-child bond, makes the bodies of the father and child more communicative to each other, and develops biological, sensory and psychological attachment, which does not in any way negatively affect the sexual activity of the couple.

The benefits of father involvement in child care are more than obvious. When fathers are more actively involved in the lives of their sons and daughters, their children are more likely to have more achievements in their lives, such as better physical and mental health, educational and academic successes, better cognitive and social skills, and higher self-esteem. It is more likely that their children will have fewer behavioural problems and higher stress resistance⁶¹.

Teenagers whose fathers were involved in their upbringing are more likely than others to have better mental health, safer sexual behaviour, and less harmful habits. The benefit of fatherhood involvement is mutual. Studies have shown that men having warm, non-violent relationships with their children live longer, have fewer mental health and physical problems, and work more productively. Moreover, they are less prone to violence, alcohol or drug abuse⁶².

Dads' involvement in carrying a pregnancy is essential. The benefits are enormous when they are involved in the entire prenatal process, present at the birth and participate in the postpartum care of the mother and child⁶³.

⇒ **Everyone benefits from involved fatherhood.**

▶ **The mothers:**

- ▶ Reduces maternal stress during pregnancy and postpartum.
- ▶ Prenatal visits of pregnant women accompanied by their husbands to a women's counselling medical facility are more regular than women who visit the doctor alone. This circumstance contributes to favourable outcomes due to the early detection of problems or complications during the pregnancy and timely intervention.
- ▶ When the father is present in the delivery room and supports the mother during the childbearing process, the pains are alleviated since the woman's body produces natural pain relievers (endorphins) in labour.
- ▶ Psychological support provided by fathers contributes to shortening the duration of the 3rd stage of childbirth and reducing complications of the postpartum period.

61 Allen, S. and Daly, K. (2007). *The Effects of Father Involvement: An Updated Research Summary of the Evidence*. Guelph, Canada.

62 Barker, G., Greene, M.E., Nascimento, M., et al (2012). *Men Who Care: A Multi-Country Qualitative Study of Men in Non-Traditional Caregiving Roles*. Washington, D.C., International Center for Research on Women (ICRW). Rio de Janeiro, Promundo, 2012.

63 World Health Organization (2015). *Recommendations on health promotion interventions for maternal and newborn health*. https://apps.who.int/iris/bitstream/handle/10665/172427/9789241508742_report_eng.pdf

▶ **The fathers:**

- ▶ Fathers involved in their children's lives are much more satisfied and happy.
- ▶ Involved dads are healthier than others, both mentally and physically, have less harmful habits, and live longer.
- ▶ Some studies show that men who are involved in child care have more satisfying relationships and sex lives with their wives, are more attached to their children, and are more respectful and attentive to the older adults in the family as well.

▶ **The children:**

- ▶ Children of involved fathers benefit the most. Their cognitive abilities develop better.
- ▶ Children of involved fathers often grow up with high self-esteem and are able to resolve their conflicts without violence.
- ▶ Children of involved fathers tend to have fewer behavioural problems.

It should be noted that although research shows that most men want to be good fathers, traditional gender norms and the public's lack of a clear understanding of men's roles in the lives of women and children make it difficult to achieve this goal. In this regard, a positive role towards situation improvement can play the healthcare system and healthcare workers. The healthcare workers who participated in this course can contribute by supporting expectant fathers in acquiring new skills for conducting activities that will help them to become involved fathers and husbands/partners.

Fathers' involvement in caring for family members and establishing strong psycho-emotional ties between them contributes to family violence prevention, including gender-based violence. In such families, the probability of cases of domestic violence is much lower, and the risk of forced termination of pregnancy due to the sex of the fetus is also reduced.

▶ **Acquaintance:**

The RA Labor Code provides for paternity leave within 30 days after the birth of a child. In addition, a paid leave of five working days is provided at the request of the infant's father, for each day of which the employer pays in the amount of the employee's average daily wage.

▶ **Additional activity:**

Watch and discuss the videos below or one of them:



Video: Role of Fathers in Child Care and Education.

<https://www.youtube.com/watch?v=PzLZYKgK94g&t=779s>



Video: Impact of Violence on Child Development.

<https://www.youtube.com/watch?v=MN2QZq7txp0&t=2s>

Lesson N 19. Practical

- ▶ Position and Role of the Church in the prevention of artificially induced pregnancy terminations,

The journalist of Iravaban.net spoke with the director of the Information System of the Mother See Holy Etchmiadzin about the position of the Armenian Apostolic Church regarding artificial pregnancy terminations, particularly about gender-biased sex-selective abortions.

► **Format:** Reading and discussing published interview or video, and exchanging opinions.

1) *Father Isaiah, abortion has been commonly used since ancient times, and its prevalence has increased significantly nowadays. What are the main reasons for abortion in Armenia, according to you?*

The social problem is one of the first and most worrying reasons observed and dealt with in our society...

Although nowadays many people talk about the problem of sex-selective abortions, their number decreased significantly compared to the picture we had 5-10 years ago. It is obvious and for us in the Church. In the past, we often heard from newlyweds about their desire that the first child would be a boy, and if the first child was a girl, couples were praying for the second child would be a boy. Many resorted to artificial termination of pregnancy if their desires did not coincide with reality. Today, we rarely hear about gender preferences for children and rarely encounter such a problem...

2) *What is the position of the Church in this matter?*

Our Church always urges and calls never to go for artificial termination of the pregnancy and believes that abortion is a spiritual and moral disaster for our society.

3) *Are all types of abortion rejected by the Armenian Apostolic Church, regardless of circumstances? Are there cases when the Church does not condemn the artificial termination of pregnancy?*

It is not a question of permission or condemnation. When there is no other way out except for the pregnancy termination, our Church is not considered this a sin. For example, when the mother's life is in danger, and the fetus will not be viable even if the pregnancy is preserved, Church does not impose any prohibitions or restrictions because, from a spiritual point of view, it is not a sin. Church has another attitude towards the cases when parents terminate a pregnancy based on the congenital malformation of the fetus or the doctor's prediction that the child will be born with a birth abnormality, illness, or underdeveloped. Such cases are undeniably reprehensible...

4) *When performing an illegal abortion, the law punishes only the doctor. What about the church?*

According to Christianity and morality, sin is double-sided.

5) *Can contraceptives be used as an alternative and preventive measure? What is the position of the Church regarding the use of contraceptives?*

The Armenian Church does not have a clear, concrete position on this issue, not because it does not have its attitude. The question is that there are different dimensions to consider how the person should act in every particular case and whether this action is acceptable, less acceptable, or sinful. Therefore, the Church leaves this decision to the Christian consciousness and morality of the person. Generally speak-

64 IRAVABAN.NET (2021). Church's position on abortion: explained by priest Artenyan Ter Isaiah. <https://iravaban.net/352079.html> Church's position on abortion: explained by priest

ing, the Church does not address every issue and tries to determine what action is allowed or should be prohibited. Some individual manifestations are left to the conscience and morality of each human being.

6) And finally, concluding the conversation, let's talk about the intentions of the Armenian Apostolic Church concerning these issues. Does its position on abortions contribute to the reduction of their number?

In my opinion, our Church has done quite a lot in recent years to reduce selective abortions, but we will continue to work in this direction. When we say that the number of selective abortions has decreased compared to a particular year, this does not mean that the problem is already dissolved and the issue is closed. We still have work to do towards raising public awareness that performing a selective abortion is a big mistake for human beings. Our Church designed specific plans of action related to this issue, which have been implemented over the past few years.

Lesson N 20. Summary presentation and concluding remarks

- ▶ Perception and attitude of the public and professional community to the phenomenon of selective abortions and possible ways of their prevention

The perception and attitude of the public and the professional community regarding the legal regulations on selective abortions (presented in the sections above) is ambiguous. The disagreement among experts regarding the regulation of this issue by a legal ban has been recorded during the analysis of the policy and current practice in the healthcare sector on the prevention of discriminatory gender-biased prenatal sex selection⁶⁵. In general, the initiative to settle the problem was positively assessed as a clear state position and message that termination of pregnancy due to the sex of the fetus is reprehensible and legally impermissible. At the same time, it was noted that the regulation of the problem only through legislation cannot provide the expected results.

The doctors who participated in the expert surveys within the same research study found it difficult to say whether the problem-solving through legal punishments and restrictions would be effective. Moreover, according to the opinion of some specialists, bringing to legal responsibility for carrying out sex-selective abortions can lead to the problem becoming “hidden”. They believe the fight against this phenomenon should be focused on removing underlying causes. On the other hand, the progress in the development of medical technologies has made it possible to determine the gender of the fetus in the earliest terms through blood tests. In such cases, women can apply for abortion on request before the pregnancy reaches 12 weeks and do not specify the reason.

There were also discussions about the legal tool of giving a three-day waiting period before the abortion procedure to influence a woman's decision to terminate the pregnancy. This regulation was based on the successful experience of a similar practice in other countries. However, there are also opposing views that the three-day waiting period and potentially biased counselling risk increasing the stigma surrounding abortion. It is also noted that marginalized and poor women suffer the most from this regulation as it is a possible obstacle to accessing safe abortion services. Some experts believe that the three-day waiting period or doctor's consultation is unlikely to significantly influence women's decisions because most live in a family environment with psychological pressure for having a son.

On the basis of the expert's conclusion about the presence of various background causes of gender-bi-

⁶⁵ International Center for Human Development (2016). *Analysis of the policy and current practice on prevention of discriminatory gender-biased prenatal sex selection in the healthcare sector* © International Center for Human Development, 2016, Yerevan, Armenia.

ased discriminatory fetal sex selection in Armenia, the principle of close intersectoral cooperation was applied in the national program of fight against sex-selective abortions and the related phenomenon of sex imbalance at birth. During 2015-2017, the programmatic measures were focused simultaneously on the following strategic directions:

1. Raising public awareness on the issue and the value of girl children in society.
2. Improving indicators of the natality and encouraging the birth of female children.
3. Developing and introducing legislative regulations and mechanisms for reducing the problem of discriminatory prenatal sex selection.

The activities implemented so far have been effective, particularly in raising community awareness and gender stereotypes alleviation, including the valorization of girl children. However, following the approval of the sub-legislative legal acts arising from the RA Law “On Human Reproductive Health and Reproductive Rights”, no monitoring activities have been carried out to find out whether the given regulations are applied and what effects and or challenges have arisen as a result of their implementation.

In 2020, by joined decree of the Minister of Labor and Social Affairs and Minister of Health of the Republic of Armenia⁶⁶ the National Program on the Prevention of gender-biased prenatal sex selection (GBSS) and the list of measures for the program implementation during 2020-2023 was approved. The program aims at the prevention of GBSS and sex-selective pregnancy terminations, reduction of deviation of the natural sex ratio of newborns at birth, and increasing the role of the girl child/woman in society. The expected outcome indicator of the program is bringing SRB indicator closer to the natural level: 107 boys per 100 girls.

The programmatic activities of this comprehensive program are consolidated according to three priority strategic directions.

- ▶ **Priority 1. Evidence-based policy development.**
- ▶ **Priority 2. Capacity building.**
- ▶ **Priority 3: Raising public awareness.**

In 2022, the UNFPA started the process of adaptation of the GBSS global assessment and monitoring toolkit. We expect that this toolkit will enable us to measure accurately, monitor and evaluate the national indicators of the program’s success.

- ▶ **Doctors’ opinions about legal regulations and restrictions on abortion.**

In 2018, the Monitoring of the State Policies and Programs aimed at preventing discriminatory fetal sex selection in Armenia was conducted by the International Center for Human Development (ICHD)⁶⁷ to find out the position of the obstetrician-gynaecologists on these issues. According to the results of the anonymous interviews conducted within the framework of this investigation, all respondents were ever involved in the artificial abortion procedure implementation. They also conducted medical examination and research, provided counselling on abortion, and (or) managed other related procedures.

66 *Government of Armenia (2020). On approving the 2020-2023 program for the prevention of discriminatory selection of the sex of the fetus and the list of measures for the implementation of the program. Joyned order of the Ministry of Labor and Social Affairs of the Republic of Armenia (03.03.2020 No. 42-A) and the Ministry of Health of the Republic of Armenia (12.03.2020 No. 962-A)*

67 *International Center for Human Development (2018). Monitoring report of state policies and programs aimed at preventing discriminatory fetal sex selection in the Republic of Armenia © International Center for Human Development, 2018, Yerevan, Armenia.*

Attendance for artificial termination of pregnancy:

The general opinion was that although attendance with a request for artificial termination of pregnancy, particularly sex-selective abortion, decreased significantly, there are still requests for gender-biased pregnancy termination. Almost all obstetrician-gynaecologists stated that sex-selective abortion services are not performed in their institution. Interestingly, most participants said that they do not perform abortion procedures but had heard of physicians from other medical institutions known to be providers of late pregnancy termination services, including sex-selective abortions.

Access to safe medical abortion services:

The range of questions included an issue of medical abortion. Some respondents testified that even though the sale of Cytotec (Misoprostol) is permitted only by medical prescription, there are still cases where women obtain this medication “under the table” and use it at home to terminate unwanted pregnancies without counselling for indications and receiving instructions. There were opinions that improper use of Cytotec may lead to several complications, including heavy bleeding and incomplete miscarriage. It was noted that there have been registered life-threatening complications of self-induced abortions in Armenia, including women’s death cases.

Awareness of the legal regulations on abortion:

The doctors who took part in the survey were mainly aware of the legal regulations for performing artificial termination of pregnancy, established by the decision of the RA Government⁶⁸, including the woman’s application procedure (on her request or medical and social grounds), of permitted pregnancy terms for an abortion and three-day waiting period before the abortion procedure, as well as of the order of pre- and post-abortion counselling provision. It was also observed that physicians who exclusively conducted medical practice were less informed about the provisions of the above-mentioned legal regulations than respondents who were implementing administrative functions.

Among some practising gynaecologists, there was a lack of knowledge regarding social indications for artificial termination of the pregnancy and the order to fill in the woman’s application form. Thus, some respondents were aware of the requirement that women should sign the questionnaire before the abortion procedure but were not informed about the need for a written by her request for the pregnancy termination. Some physicians didn’t know about the legislative requirement to obtain an official decision from the committee with permission to terminate the pregnancy on medical grounds.

Content and scope of the pre-abortion counselling:

Awareness of participated obstetrician-gynecologists about the content and scope of the pre-abortion counselling was particularly ambiguous. All the physicians who participated in the interviews stated that they provide information about possible complications of sex-selective abortions; many of them added that they try to convince women not to have an abortion in a friendly, non-pressured way; and one physician said that she talks with the patient about the moral side of abortion, considering it a sin.

Post-abortion family planning:

Gynaecologists participating in the survey indicated that immediately after the abortion, they provide women with information on available methods of contraception and help them choose a suitable means of unwanted pregnancy prevention free of charge. However, many expressed scepticism about the effectiveness of such counselling. Some of them have reported cases of repeated abortions in their practice.

68 Government of the Republic of Armenia (2017). “On approving the order and conditions of abortion” the Government of the Republic of Armenia. Decision No. 180-N of February 23, 2017.

Another respondent had an opinion that there is a perception of the inefficiency of some methods or means of family planning, for example, hormonal contraceptives. There were also opinions on the importance of considering the financial motivation of obstetrician-gynaecologists, especially on the abortion issue. One of the gynaecologists frankly mentioned that he is not paid for the provision of the counselling to prevent abortion, while for performing the abortion procedures, he will be paid.

Opinions about legal restrictions on abortion:

Opinions among doctors about the effectiveness of preventing sex-specific abortions with legal restrictions are also controversial. Many mentioned that in their practice, although rare, there are cases when women do not return after the three-day waiting period to perform an abortion. According to some responses, many of these women decided to carry a pregnancy to the end and take pre-natal consultations at their maternity care institutions. However, there are also opinions that these women most likely turned to another abortion service provider.

► Brief Conclusions on Effectiveness of Measures to Combat GBSS in Armenia

1. The measures towards preventing sex-selective pregnancy terminations were excellently aimed at fulfilling the obligations of the Republic of Armenia in this field.
2. A comprehensive policy has been adopted by relevant state bodies and interested parties in Armenia, which combines legal regulation tools with measures aimed at raising public awareness and valuing the girl child, preventing all kinds of discrimination, as well as human resource development and institutional capacity building to achieve above mentioned goals.
3. Current legal regulations regarding gender-biased selective abortions had a positive impact. In particular, they at least testify determination of the state to fight against the phenomenon.
4. Significant improvement in the sex ratio of newborns was achieved in Armenia in a relatively short time and with limited financial resources. Thus, the sex ratio at birth decreased from 115 live-born boys per 100 live-born girls, in 2010, to 108.8 boys per 100 girls, in 2021.
5. On the other hand, the volume and content of the pre-abortion counselling largely depend on the motivation, values and approaches of abortion providers, which contains risks for maintaining program results and ensuring further developments.
6. According to the evidence noted by the experts, the registered achievements can be lost in quite a short time if complex activities are not continuous. The proof of this statement is the deterioration of the situation in 2022, when the deviation in sex ratio at birth increased by 3 points compared to 2021, amounting to 100:111.9.

Thus, evaluation of available data shows that fewer programmatic activities aimed at combating GBSS were conducted after 2018, especially public awareness measures, which is worrying from the point of view of maintaining achievements.

► Recommendations on Plan of Action Towards Prevention of GBSS

The plan of future actions, within the framework of national policy on gender-biased prenatal sex selection and sex-selective pregnancy terminations, should be focused on ensuring the continuity of program measures, monitoring the activities, and strengthening institutional cooperation. The authors recommend to conduct following measures for the GBSS prevention:

1. Monitoring of the implementation of the state policy towards the prevention of sex-selective pregnancy terminations, with the assessment of current abortion practices at healthcare institutions.
2. Evaluation of the effectiveness of legal regulations in human reproductive rights and reproductive health areas aimed at preventing sex-selective pregnancy terminations and improving performance.
3. On-going monitoring of the sex composition of newborns with the participation of interested state administrative bodies, representatives of public and international organizations and national experts.
4. Continuous implementation of round-table discussions on the prevention of sex-selective abortions and development of new situational recommendations.
5. Integration of issues of sex-selective pregnancy terminations, valuing the girl child in society, and professional and ethical aspects of using assisted reproductive technologies (ART) for fetal sex selection into the national system of the continuous professional development (CPD) of health-care workers. In particular, these thematic issues should be included in the post-graduate training sessions for the family physicians working at the primary health care level, obstetrician-gynaecologists, radiologists conducting the ultrasound, and mid-level medical staff.
6. Strengthening the effectiveness of the advocacy campaigns aimed at preventing gender-biased prenatal sex selection and selective abortions; publishing and disseminating informational, educational and communication materials in this direction.
7. Ensuring continuity of discussions around gender-biased sex selection and selective abortion prevention issues through commonly used social networks.
8. Active involvement in community awareness programs aimed at preventing sex-selective abortions of the health workers, particularly obstetrician-gynaecologists, midwives, family physicians, and radiologists conducting ultrasounds, as well as spiritual pastors, social workers, immediate and extended family members of the pregnant women, who are the most influential actors in that process.

THE LEGISLATION OF THE REPUBLIC OF ARMENIA ON HUMAN REPRODUCTIVE HEALTH AND REPRODUCTIVE RIGHTS

1. LAW OF THE REPUBLIC OF ARMENIA: ON HUMAN REPRODUCTIVE HEALTH AND REPRODUCTIVE RIGHTS

- ▶ Approved by the National Assembly of the Republic of Armenia on December 11, 2002.
- ▶ English Translation of this Law (as amended on 27-06-2022) is available at CIS-LEGISLATION Website, with the following Disclaimer: “This text was translated by AI translator and is not a valid juridical document. No warranty. No claim”.
- ▶ Link: <https://cis-legislation.com/document.fwx?rgn=26621>

2. DECISION OF THE GOVERNMENT OF THE REPUBLIC OF ARMENIA NO. 180-N: “ON APPROVAL OF THE ORDER AND CONDITIONS OF THE ARTIFICIAL TERMINATION OF PREGNANCY”, SIGNED ON FEBRUARY 23, 2017.

- ▶ Official English Translation of this Decision available in the Official Bulletin of Legal Acts of the Republic of Armenia. <https://www.arlis.am/>
- ▶ Link: <https://abortion-policies.srhr.org/documents/countries/08-Armenia-Government-Decision-on-the-Procedure-and-Conditions-of-Abortion-2017.pdf>

3. THE ORDER OF THE MINISTRY OF HEALTH OF THE REPUBLIC OF ARMENIA N 3403-A, SIGNED ON DECEMBER 27, 2022: “ON THE APPROVAL OF THE ORGANIZATIONAL PROCEDURE FOR ARTIFICIAL PREGNANCY TERMINATION, THE FORMAT AND INSTRUCTION FOR FILLING OUT OF THE OF ABORTION MEDICAL CARD AND THE ADVISORY SHEET ON GENDER-BASED ABORTION PREVENTION.”

- ▶ Available only in Armenian language in the Official Bulletin of Legal Acts of the Republic of Armenia.
- ▶ Link: <https://www.arlis.am/>

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