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Protection of Women's Sexual and Reproductive Health and Rights in Psychiatric and State Care Institutions

Special Report

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Introduction

This document reflects the results of the monitoring conducted by the Office of the Public Defender of Georgia in 2019 in the framework of the monitoring mechanism[1] under the UN Convention "on the Rights of Persons with Disabilities" and the project of the United Nations Population Fund (UNFPA) on "Assessment of the Situation of the Sexual and Reproductive Health and Well-being in the Country".

The report detects the conditions of sexual and reproductive health and protection of rights of women with mental health problems at in-patient psychiatric institutions, boarding houses for persons with disabilities, and community-based organizations.

Reproductive health care is one of the fundamental human rights, which implies support to reduction of maternal and child morbidity and mortality, quality reproductive health, including access to family planning services, prevention of sexually transmitted infections and cervical cancer, protection of women and girls from violence, meeting the adolescent sexual and reproductive needs and others.[2]

According to studies carried out worldwide, persons with mental health problems are more likely to have reproductive health issues than other members of the society. The problems are caused by a variety of factors: risky sexual behavior[3] increased risks of violence,[4] unwanted pregnancy, low use of contraceptives, avoidance of antenatal care and etc.

Universal spread of reproductive health services is one of the sustainable development goals.[5] In addition, many international documents impose an obligation on the state to protect and respect the rights of women with disabilities. Particular emphasis shall be made on the 2006 UN Convention on the Rights of Persons with Disabilities.[6]

Monitoring conducted by the Office of the Public Defender during May-September 2019 revealed that in spite of the state's obligations undertaken toward the protection of women's rights, protection of sexual and reproductive health rights of women with mental health problems at psychiatric and state care institutions constitutes one of the most important and so far unsolved challenges. Regulatory acts in the field and national guidelines, in fact, fail to address the issues of sexual and reproductive health of women with

[1] Information on the activities of the mechanism is available on the following website: https://bit.ly/2NSgzgW [last visited on 23.01.2020]

[2] Temmerman M, Khosla R, Say L. (2014) Sexual and reproductive health and rights: a global development, health, and human rights priority. Lancet. 2014 Aug 2;384(9941):e30-1.

[3] Chen LP, Murad H, Paras ML, Colbenson KM, Sattler AL, Goranson EN, Elamin MB, Seime RJ, Shınozakı G, Prokop LJ & Zırakzadeh A (2010) Sexual abuse and lifetime diagnosis of psychiatric disorders: systematic review and meta-analysis. Mayo Clinic Proceedings 85, 618–629

[4] Miller LJ (1997) Sexuality, reproduction, and family planning in women with schizophrenia. Schizophrenia Bulletin 23, 625.

[5] On September 25, 2015, 193 UN member states agreed on the Sustainable Development Agenda, under the title "Transforming Our World: The 2030 Agenda for Sustainable Development." This agenda includes 17 goals and 169 objectives. Information is available at: https://bit.ly/38cqllY [last visited on 23.01.2020].

[6] The Convention has been in force for Georgia since April 2014.

disabilities living at such institutions. Lack of services tailored to their needs and the inadequate attention to these issues are also problematic. So far no systematic monitoring has been conducted in this area.

Based on the monitoring conducted by the Public Defender, recommendations were elaborated addressing relevant state agencies and service providers, which will significantly contribute to the improvement of quality of protection of sexual and reproductive health and rights of a particularly vulnerable group of women with mental health problems in the country.

Monitoring methodology

In 2019 the Office of Public Defender of Georgia conducted monitoring with the support of the United Nations Population Fund (UNFPA), based on a specially developed "Methodology for Monitoring the Sexual and Reproductive Health and Rights of Women with Psychosocial Needs".

The document focuses on assessing the quality of consideration of sexual and reproductive health specifics and needs of female patients/beneficiaries of reproductive age (15 to 49 years) at psychiatric in-patient healthcare and state care institutions in the process of the delivery of psychiatric assistance or state care. Monitoring studied possible risks to the reproductive health of women under psychiatric treatment, the provision of sexual and reproductive health services (including necessary screening and examinations), pre- and post-natal care, and conditions of personal hygiene while being at the institution. Particular attention was paid to the study of the level of awareness of women on the above issues.

For the purposes of the monitoring, international documents and national legislation regulating the issue were analyzed. To study the issue on spot, visits to the sites were carried out at 12 psychiatric in-patient healthcare institutions[7], 3 boarding houses for adults with disabilities[8] and 6 community-based organizations.[9]

It shall be noted that the abovementioned institutions are specific in terms of their legal status, administration, funding and standards of care.

Psychiatric institutions provide stationery psychiatric care[10] within the State Health Care Program.[11]

Boarding houses for persons with disabilities are territorial bodies (branches) of the LEPL State Fund for Protection and Assistance of (Statutory) Victims of Human Trafficking under the Ministry of Internally

[7] Mental Health and Addiction Prevention Center Ltd; "Clinical Hospital No. 5" Ltd; Tbilisi City Center for Mental Health; JSC Evex Hospitals - Ivane Bokeria Tbilisi Referral Hospital; Kutaisi Mental Health Center Ltd; Batumi Medical Center Ltd; Rustavi Mental Health Center Ltd; "Dr. B. Naneishvili National Center for Mental Health" Ltd; Senaki Mental Health Center Ltd; East Georgia Mental Health Center Ltd; Surami Psychiatric Clinic; "Imereti-ImeretiRegional Medical Center" (Terjolmedi) Ltd.

[8] Boarding houses for persons with disabilities in Martkopi, Dusheti and Dzervi.

[9] These organizations are: (i) the "Union of Therapy of Socially Vulnerable in Sighnaghi Region"; "Generation Home 1", "Generation Home 2", "Brotsliani Mercy House", Charity Union "Temi", Clinic-Life.

[10] Group psychoeducation/therapy, occupational therapy, cognitive rehabilitation or daytime activities: art therapy/ergotherapy, integrated psychological therapy, restoring individual core skills, or sports/celebrations.

[11] Decree No. 693 of the Government of Georgia of December 31, 2018 "On the Approval of State Health Care Programs for 2019".

Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs of Georgia. The functions of the Fund include, among others, the creation of conditions close to the family environment for the beneficiaries and provision of treatment-rehabilitation activities.[12]

Community-based organizations are functioning under the sub-program of "Social Rehabilitation and State Child Care Program", which is annually approved by the Government of Georgia[13] and its target group includes persons with disabilities of 18 year and older, as well as the children of these beneficiaries under 18 if this does not contradict the interests of the child.[14]

The monitoring group[15] consisted of representatives of the Department of the Rights of Persons with Disabilities of the Office of the Public Defender of Georgia[16] and invited experts - a doctor psychiatrist[17] and a gynecologist.[18]

Information was gathered through interviewing beneficiaries, administration and staff, as well as studying/examining the conditions of their stay at the facility. The in-depth interviews were carried out with the patients/beneficiaries[19] of reproductive age (15 to 49 years) at the target institutions, as well as with the administration and staff[20] and agencies responsible for defining health policy in the country.[21] Research experts also analyzed medical records of up to 120 patients/beneficiaries.

Relevant medical documentation reflecting the treatment of patients/beneficiaries and reproductive health care at the target institutions was examined on spot. These included documents on placement, pharmacological treatment, treatment of somatic diseases, screening, analysis and other investigations, medication and hygiene supplies, as well as psychosocial rehabilitation activities.

Research experts have additionally studied the employment contracts signed with gynecologists at the institutions where they are employed, also documents proving their qualifications, their work schedules, and their records in the patient's/beneficiaries' medical history or records.

To verify findings of the visits (fieldwork), and to clarify some issues, focus group meetings were held with mental health field representatives - doctor psychiatrists and psychiatric facility managers and with the

[12] Resolution N146 of the Government of Georgia of February 13, 2014 "On the Approval of the Charter of the LEPL State Fund for Protection and Assistance of (Statutory) Victims of Human Trafficking" [as of 2019], Article 201, paragraph 3 "g".

[13] The State Program for Child Care and Social Rehabilitation for 2019 was approved on December 31, 2018, by Government Resolution No. 684.

[14] Resolution №684 of the Government of Georgia of 31 December 2018 on the Approval of the State Program for Social Rehabilitation and Child Care for 2019, Annex 1.12, Article 4, paragraph 1, subparagraph "a".

[15] Each facility was visited by a 4-member monitoring team.

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[17] Doctor-psychiatrist Marine Kuratashvili

[18] Doctor of Health Management/Administration, Public Health, Gynecologist Lela Shengelia.

[19] A total of 93 female beneficiaries/patients were interviewed in the in-depth interview format;

[20] Interviews were conducted with all psychiatrists (if any), physicians, nurses, senior nurses, care givers. A total of 103 in-depth interviews were conducted with the facility staff.

[21] 2 interviews in total: 1 with the representative of the Ministry of Internally Displaced Persons from the Occupied Territories, Labor, Health and Social Issues of Georgia and 1 with the representative of the Government of the Autonomous Republic of Adjara, respectively.

representatives of the organizations working on women with the psycho-social needs and disabilities at the Office of the Public Defender on September 11 and 13, 2019. Also, on December 6, 2019, a meeting was held with the representatives of the Ministry of Internally Displaced Persons from the Occupied Territories, Labor, Health and Social Issues of Georgia and the State Fund for Protection and Assistance of (Statutory) Victims of Human Trafficking. The purpose of the meeting was to get acquainted with the main findings of the research and to discuss ways of solving identified problems.

Main findings of the monitoring

The monitoring established a number of systemic and individual shortcomings, indicating that the reproductive health needs of women with mental health problems at the inspected institutions were not properly identified and acknowledged neither by the state on policy level nor by the institution, in practice. In particular, the monitoring revealed that:

- State-recognized clinical practice guidelines in the field of mental health, the so-called National Guidelines are outdated and need an update. Most of them, unlike international guidelines, do not contain a specific chapter that directly addresses a woman's sexual and reproductive health. There are no guidelines in place to promote the treatment and care of women with mental health problems during pregnancy. In addition, the medical staff apply minimum recommendations provided by the national guidelines on reproductive health in their work to a lesser extent.
- The examined institutions do not assess the conditions of sexual and reproductive health of the woman prior to the treatment with psychotropic medications and do not monitor her during the treatment. Access to the necessary laboratory research is problematic for both psychiatric and state care institutions. When the woman is admitted to a mental institution, she is not timely screened for the possible pregnancy. Gynecological services are not properly provided for women placed at the institutions for the long-term.
- Women with mental health problems are not included in the State Early Detection Screening Program (except for hepatitis C screening). Accessibility of studies under the State Program for Screening for Breast and Cervical Cancer is particularly problematic. Testing for HIV and syphilis lack a systemic character.
- Knowledge/awareness of the medical staff, in particular physicians, psychiatrists and gynecologists about the impact of psychotropic medications on sexual and reproductive health and ways of their rectification, is unsatisfactory. Also, the knowledge of patients/beneficiaries about their sexual and reproductive health and rights is extremely low. They have no information about the adverse side effects of prescribed psychotropic medications, including the effects of drugs on sexual and reproductive health.
- For most psychiatric hospitals and boarding houses, purchase of expensive, high-quality, modern psychotropic medicines that have minimal adverse effects on a woman's reproductive health is also problematic.
- Identification of cases of violence between patients, including alleged sexual abuse, by the administration and staff of the institutions, is challenging. The medical staff is indifferent to the "complaints" of patients about such facts and often ignores them.

- At one of the psychiatric establishments,[22] a case of deliberate decrease of libido through the use of non-prescribed medication was revealed.

1. International and national regulations and guidelines

The quality of women's needs-oriented health care service delivery is significantly influenced by the consideration of approaches of international and national regulations and guidelines by the specialists and staff in general, employed at the relevant institutions during the treatment process. Since the guidance documents are renewable and their provisions evidence-based, systematic tracking of the dynamic process specific to the field is essential. The following sections below discuss the international and national regulations on sexual and reproductive health of women with mental health problems, as well as the provisions set out in the guidelines.

1.1. International regulations and guidelines

According to the UN Convention on the Rights of Persons with Disabilities (UNCRPD), governments are obliged to ensure that persons with disabilities have access to reproductive health services.[23] Article 6 of the Convention particularly focuses on the risks of multiple discrimination against women with disabilitiesand calls on the authorities to take all appropriate measures to ensure the full development, advancement,and empowerment of women, for the purpose of guaranteeing them the exercise and enjoyment of the rights and fundamental freedoms. In its General Comment on the same article, the United Nations Committee on the Rights of Persons with Disabilities[24] explains that placement of women with disabilitiesat institutions and restriction of their sexual and reproductive rights are among the main challenges for theprotection of women with disabilities.

Patients' treatment recommendations are outlined in clinical practice guidelines. Guidelines are "a continuously updated set of policies that help physicians and patients to make the right decisions regarding the treatment of specific conditions".[25] These provisions are based on the best evidence from research. Furthermore, the National Clinical Practice Guidelines do not constitute a ready-made problem management recipe. It should be seen as the best evidence-based framework available to suit local needs, resources and individual cases.

The monitoring conducted by the Public Defender analyzed the mental disorder guidelines that most often require 24-hour care and treatment at mental health facilities.

One of these commonly accepted guidelines is Maxwell's Guide to Mental Disorders.[26] The document includes chapters specifically dealing with women's sexual and reproductive health. This issue is also found

[22] Surami psychiatric clinic.
[23] Convention on the Rights of Persons with Disabilities, Preamble and Article 25. Available on the following website: https://bit.ly/2tgUYrO [last visited on 23.01.2020]
[24] General Comment No. 3 on Women and Girls with Disabilities, 2016, Para. 10. Available on the following website: https://bit.ly/2NAdC4K [source last visited on 16.12.2019].
[25] Treatment and Management of Adult Schizophrenia, National Recommendations (Guidelines) of the Clinical Practice (Guidelines), P. 4. Source available on the following website: https://bit.ly/36XPkJw
[26] David Taylor, Carol Paton, Shitij Kapur "The Maudsley, Prescribing guidelines in psychiatry", (12th edition, 2015, Wiley Blackwell)

in other chapters of the textbook.[27] The guidelines recommend to precisely identify the cause of sexual dysfunction before treatment, eliminate somatic diseases, then to reduce/remove the medication causing dysfunction, or to replace it with another drug, or in case of hyperprolactinemia, to prescribe/add aripiprazole. In the case of no effect, the prescription of antidote is recommended.

These guidelines also discuss in detail the effect of specific medications on changing the prolactin level. The guidelines recommend pre-defining prolactin level in blood plasma before prescribing medications that are more likely to cause prolactin elevation.[28] Also, after 3 months, patients should be asked questions about the symptoms of hyperprolactinemia. The guidelines also set out specific measures to be taken in the event of adverse effects of the medication on the reproductive health.[29] Measures to be taken at different degrees of prolactin elevation are also described.

The Maudsley guide lists the forms of sexual dysfunction caused by various antidepressant medications (reduced libido, delayed orgasm, etc.). It is recommended that baseline sexual functioning is established through surveys prior to treatment and also, to reduce the dose of prescribed antidepressant during treatment of sexual dysfunction and/or to prescribe an antidepressant that has no such adverse effects.[30]

According to the guidelines, it is necessary for women of reproductive age to minimize the practice of potentially harmful medications for fetus, regardless of whether they are planning a pregnancy or not. In addition, monotherapy is preferable for women who plan pregnancy.

International guidelines contain detailed information on treatment strategies for pregnant and lactating women. The general principles for the prescription of psychotropic drugs in pregnant and lactating women are outlined and the new generation of psychotropic drugs are characterized by less teratogenicity. Recommendations for the treatment of psychotic conditions during pregnancy are defined.[31]

The document discusses in-depth depression in pregnant women and postpartum. The risks associated with taking antidepressants are described. Specific medication that cause stabilization of moods are characterized.[32] It is noted that consideration of these recommendations is especially important in the first 6 weeks of pregnancy when many do not yet know that they are pregnant. The guidelines also provide recommendations for the treatment of pregnant women with other mental disorders.

Other international guidelines also place great emphasis on the necessity and importance of psycho-education of women of reproductive age. An example of this is a guideline published by the German Bipolar

[27] David Taylor, Carol Paton, Shitij Kapur "The Maudsley, Prescribing guidelines in psychiatry", 12th edition, 2015 (pp.137–142; 133–136; 319–320; 324–327; 541–575).

[28] For example, risperidone, amisulpiride, sulpiride, first-generation psychotropic medications.

[29] For example, if prolactin level is high and symptoms are present, it is necessary to switch to another drug. According to the guidelines, high-risk medications for hyperprolactinemia should not be prescribed for young women under the age of 25 and for those with hormone-dependent breast cancer.

[30] Agomelatine, Bupropion.

[31] The guidelines state that it is not advisable to discontinue medication in pregnant women who are inclined toward severe exacerbations of psychosis. It sets medications that have minimal side effects (chlorpromazine, trifluperazine, haloperidol, olanzapine, quetiapine, clozapine).

[32] It is specifically stated that lithium salt shall not be prescribed. It is recommended that valproate, which is harmful to the fetus, shall not be prescribed to a woman of reproductive age, unless there are rare exceptions.

Disorder Society and the German Society of Psychiatry and Psychotherapy, Psychosomatics and Neurology, which states that "discussions shall be carried out with women of reproductive age about contraception and pregnancy in the framework of routine treatment and psycho-education".[33]

The guide provides detailed practical advice for managing all three trimesters of pregnancy, as well as for childbirth, postpartum, and lactation.[34] Besides the guidelines also provide recommendations for the safety of psychotropic medicines for pregnant and lactating women.[35]

The analysis of international guidelines reveals that for the protection of reproductive rights of women patients having psychological problems, guidelines reflect recommendations on prescription or non-prescription of particular medication at the particular stage in case of a particular diagnosis; it also provides means for reducing negative effects of the psychotropic medication. Therefore, for practitioners working in the field of mental health, practical clinical guidelines are very important.

1.2. National legislation and guidelines

Analysis of Georgian legislation shows that national regulations do not properly address the issues of sexual and reproductive health and rights of women with mental health problems.

The Law of Georgia on Psychiatric Care defines the legal and organizational basis for psychiatric care, forms of psychiatric care for persons with mental disorders, their rights, as well as the rules and conditions for the work of psychiatric workers.[36] Nevertheless, the law fails to address gender specificity in the provisionof necessary psychiatric care and the need to care for a woman's reproductive health.

The guiding principle of the Mental Health Development Strategy for 2015-2020 and the Action Plan[37] is to primarily consider the needs of the most vulnerable groups (for example, children, adolescents, women, the elderly, internally displaced persons, persons with disabilities and persons at penitentiary institutions). However, the plan does not include the obligation to take specific measures to protect the rights of women with mental health problems.

[33] Deutsche Gesellschaft für Bipolare Störungen DGBS, Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik, und Nervenheilkunde DGPPN "zur Diagnostik und Therapie Bipolarer Störungen" (pp. 330–342).

[34] It is said that birth shall be given at perinatal care because of the potential complications of exposure to psychotropic medications in infants; The recommendations also address other aspects of care. For example, it is recommended that during the first week after childbirth, the baby shall be taken care of by others during the night due to the care of sleep-wake rhythm of the mother; If the risk of exacerbation of the mental state of the mother is high, it may be desirable that she has an assistant, or be placed at a special facility, for those having infants, during the coming period.

[35] For example, it has been suggested that haloperidol and quetiapine are the safest of the neuroleptic drugs at this stage. For breast giving women, citalopram and sertraline are recommended from the SSRI group antidepressants, and amitriptyline and venlafaxine from other groups.

[36] Law of Georgia on Psychiatric Assistance, Article 2. Accessible on the following website: https://bit.ly/3ajRg1d [last visited on 23.01.2020].

[37] Decree №762 of the Government of Georgia of December 31, 2014 on the approval of the Strategic Document on the Development of Mental Health and Action Plan for 2015-2020. Accessible on the following website: https://bit.ly/37dT9KA [last visited on 23.01.2020].

The Action Plan of the Government of Georgia on the Protection of Human Rights (for 2018-2020 years),[38] foresees a number of objectives for the protection of women's mental health rights, as well as women's reproductive and sexual health rights; but the reproductive health is not considered with respect to women with mental health problems; these fields do not intersect and no concrete activities are foreseen in this regard.

National guidelines for the treatment of patients with mental health problems[39] also provide incomplete, fragmented and non-systematic information on the protection of sexual and reproductive health when treating female patients.

National Clinical Practice Recommendations (Guidelines) - "Treatment and Management of Adult Schizophrenia" is approved by the Minister of Internally Displaced Persons from the Occupied Territories, Labor, Health and Social Issues of Georgia in 2013.[40] The guidelines are quite extensive, but unlike international guidelines, they do not contain a specific chapter dealing directly with a woman's sexual and reproductive health. Some chapters contain, directly or indirectly, brief information on reproductive health.[41] Furthermore, it is well known that the term of revising guidelines amounts to 3 years. Thus, evidence-based research on this diagnosis would not be made available in the guidelines. Consequently, the guide definitely needs to be reviewed/updated.

Among the side effects of psychotropic drugs, the national guideline for the treatment of schizophrenia defines the rise in prolactin levels.[42] It also states that patients with schizophrenia believe that the most disturbing side effect of treatment, among others, is sexual dysfunction.[43]

According to Guideline's recommendation, prolactin should be screened according to the clinical need. The manual also describes the specifics of screening.[44] The guideline further recommends regular monitoring of the patient's somatic conditions, although there is no need to monitor sexual and reproductive health

[38] Decree №182 of the Government of Georgia of April 17, 2018 on the approval of the Action Plan of the Government of Georgia on the Protection of Human Rights (for 2018-2020). Accessible on the following website: https://bit.ly/2u34Cy5 [last visited on 23.01.2020].

[39] "Treatment and Management of Adult Schizophrenia", National Recommendations (Guidelines) of the Clinical Practice, Source accessible on the following website: https://bit.ly/36XPkJw [last visited on 23.01.2020]. "Treatment and Management of Adult Depression" National Recommendations (Guidelines) of the Clinical Practice, Source accessible on the following website: https://bit.ly/38g5r5y [last visited on 23.01.2020].

[40] "Treatment and Management of Adult Schizophrenia ", National Recommendations (Guidelines) of the Clinical Practice, Source accessible on the following website: https://bit.ly/373mQxY [last visited on 23.01.2020].

[41] For example, the chapter "Pharmacological Treatment", states: "Antipsychotic drugs also have an adverse effect on rise of blood serum levels of prolactin, which can lead to disorders in menstrual cycle, galactorrhea and sexual dysfunction, and later reduce bone mineral density."

[42] "Treatment and Management of Adult Schizophrenia", National Recommendations (Guidelines) of the Clinical Practice, p.64. Source accessible on the following website: https://bit.ly/2TuLyn6 [last visited on 23.01.2020].

[43] "Treatment and Management of Adult Schizophrenia", National Recommendations (Guidelines) of the Clinical Practice, p.64. Source accessible on the following website: https://bit.ly/2TuLyn6 [last visited on 23.01.2020].

[44] It is indicated that if hyperprolactinemia-related symptoms are at stake, the prescribed medication shall be changed into another medication (aripiprazole, olanzapine, quetiapine, clozapine) or aripiprazole shall be added. It is indicated that dopamine-agonists are added when needed.

separately. Nothing explicit is said about the recommendations for the treatment of pregnant and lactating women with psychotropic medications.

The National Clinical Practice Recommendations (Guidelines) - "Treatment and Management of Adult Depression" is also approved in 2013 and needs an update.[45] However, it better represents issues related to the woman's sexual and reproductive health. A special chapter is devoted to this topic, including recommendations for the choice of medication during pregnancy, and the risk factors associated with different drug use during pregnancy and lactation are provided.[46]

Thus, National Clinical Practice Recommendations contain some information about a woman's sexual and reproductive health, but compared to foreign guidelines, this information is one-sided and fragmented.

As already mentioned, Clinical Practice Recommendations are practical guidelines the recommendations of which are evidence-based and desirable to be applied in practice. These recommendations are necessarily considered in practical cases under dispute. At this time, the treatment recommended by the guidelines is considered to be correct and considered appropriate.[47] Consequently, it is important that practising physicians are well aware and follow the recommendations of the national guidelines.

It is noteworthy that those responsible for defining health policy in the country consider the guidelines as a starting point for the quality of medical care. Despite its recommendatory nature, it draws on many experiences and randomized research. National guidelines are drawn up on the basis of existing guidelines in the world, with the participation of professional associations that process them in the context of the country.[48]

1.3 Quality of implementation of recommendations provided by the guidelines

Monitoring of psychiatric hospitals and boarding houses revealed that there is a difference between the institutions and the medical staff of one institution in applying the recommendations provided in international and national guidelines. Some of the medical staff interviewed at the targeted monitoring facilities admit that they do not follow the recommendations foreseen by the guidelines on reproductive health, they rely on personal experience during treatment and primarily seek to remove symptoms of acute mental disorder. If the problem with sexual and reproductive health is revealed, they refer to a gynecologist and thereafter, the treatment for the problem is carried out according to the prescription of the gynecologist.

The second part of the interviewed personnel reported that they knew and use both national and international guidelines. However, they believe that the guidelines do not provide enough information on

[45] "Treatment and Management of Adult Depression" National Recommendations (Guidelines) of the Clinical Practice, Source accessible on the following website: https://bit.ly/2NwL8Je [last visited on 23.01.2020].

[46] For example, it is noted that in mild to moderate depression it is advisable to address to psychotherapy alone, and if there is a need for an antidepressant, lower risk medication shall be prescribed. These include amitriptyline, imipramine, fluoxetine during pregnancy; the breast milk has the lowest concentration of imipramine and sertraline.

[47] Interviews with individuals responsible for determining the health policy in the country.

[48] Interviews with individuals responsible for determining the health policy in the country.

the management of psychiatric pathologies and other reproductive health issues during pregnancy. They point to the need to establish such protocols.

Different attitudes have been identified toward the recommendations in the guidelines. In particular, it has been found that some of the interviewed medical staff do not fully follow the recommendations of the guidelines. For example, they do not carry out preventive examinations, unless they see an obvious need for it. It was thought that if all the recommendations foreseen by the guidelines were followed, the financial costs would increase significantly, whereas the current funding cannot cover these costs. Considering this view, "guidelines often constitute a barrier too". In other cases, they explain the failure to follow the recommendations under the national guidelines by saying that "they are rejected by psychiatrists." At one of the establishments,[49] it was identified that the medical staff was guided by the recommendations that consulting professors provide during periodic trainings.

Although some interviewed physicians confirm their knowledge of the recommendations on sexual and reproductive health outlined in the guidelines, the analysis of the medical records clearly indicates that this knowledge is not applied in practice. In particular, the woman's sexual and reproductive health status is not assessed prior to treatment with medication and her planned monitoring during the treatment. In case abnormalities in this area are revealed, recommended laboratory testing is not performed. Medications for women of reproductive age are not prescribed with due consideration of the reproductive health - preference is always given to the management of mental health, disregarding the possible adverse effects of this method of treatment on reproductive health.

Monitoring has shown that when identifying a problem with reproductive health, initially advice of a gynecologist is sought and the management of the identified condition is carried out as directed by the gynecologist, which in some cases fails to comply with the recommendations of national guidelines. In addition, consultations of the gynecologists employed at psychiatric hospitals largely carries formal character and is limited to an interview and superficial examination. Psychiatrists themselves are less likely to substitute prescribed medication with the medication recommended by the guidelines. One of the reasons for this may be that, due to the current procurement procedure and the limit in funding, mental health facilities do not always have access to the desired medication. It should also be noted, that drug side effects cannot be identified, and no substitution can be done because of a short stay of the patients at the facility.

As noted, inadequate funding is one of the possible reasons for the application of the recommendations foreseen by the guidelines. In this regard, health policymakers[50] in the country noted during the interviews, that to determine the cost of treatment when financing health care, multi-diagnosis and guidelines are considered as a whole, rather than individually. Nosologies are mostly considered during the “per case” financing methodology.

Considering all the issues mentioned above, it can concluded that national guidelines need to be updated and refined by devoting more space to the topic of sexual and reproductive health, based on the best

[49] Center for Mental Health and Prevention of Addiction.

[50] Interviews with individuals responsible for determining the health policy in the country.

international experience. It is also recommended that the budget of in-patient psychiatric institutions is in line with the financial costs required to comply with the recommendations of the guidelines. There is a need to improve the knowledge of the staff of psychiatric hospitals and boarding houses about the recommendations on sexual and reproductive health of women.

2. Considering the sexual and reproductive health needs of a woman during treatment

Effective care for women's health implies due consideration of their specific needs and issues related to reproductive and sexual health in the treatment process of physical or mental health problems. Monitoring team assessed consideration and prevention issues of the adverse effects of medicine on woman's sexual and reproductive health while prescribing them at the targeted institutions. As a result, it was found that the use of psychotropic medicines in women of reproductive age is a particular challenge at all types of institutions examined. Access to laboratory studies to protect reproductive and sexual health is also problematic for patients/beneficiaries of the examined facilities. Shortcomings have also been identified in reflecting issues related to women's reproductive health in medical documentation.

2.1. Assessment of the possible impact of psychotropic medications on a woman's sexual and reproductive health

The use of psychotropic medications for the treatment of mental disorders has a history of about 70 years. During this time, a great deal of data has been gathered on the side effects of these medications, including their adverse effects on a woman's sexual and reproductive health.

A number of recent studies have shown that sexual dysfunction is one of the side effects of psychotropic medications that causes the greatest distress and is a significant basis of impaired quality of life. This is also associated with a negative attitude toward treatment and a lack of consent to such treatment.[51] In women who take one or more psychotropic medications, the proportion of sexual dysfunction is very high and reaches approximately 68%.[52] The National Guidelines for the Treatment of Schizophrenia state that the sexual dysfunction is one of the most disturbing side effects of psychotropic medication.[53]

It is well known that an increase in prolactin levels in the blood serum is also a side effect of psychotropic medication; this can lead to disorders in menstrual cycle, lactorrhea and sexual dysfunction, and may later reduce bone mineral density.[54]

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[51] Anthony J. Bella[1] and Rany Shamloul Psychotropics and sexual dysfunction (Central europian journal of urology 2013; 66(4): 466–471)

[52] Veda N Shetageri, Govind S Bhogale, NM Patil, RB Nayak, SS Chate Sexual dysfunction among females receiving psychotropic medication: A hospital-based cross-sectional study (Indian journal of psychological medicine , 2016 , Volume : 38 , Issue : 5, Page : 447-454)

[53] "Treatment and Management of Adult Schizophrenia", National Recommendations (Guidelines) of the Clinical Practice, p.64. Source accessible on the following website: https://bit.ly/2R0utj4 [last visited on 23.01.2020].

[54] Haddad PM et al. (2004) Antipsychotic-induced hyperprolactinaemia: mechanisms, clinical features and management. Drugs; 64:2291–2314. Meaney, A. M., Smith, S., Howes, O. D., et al. (2004) Effects of long-term prolactinraising antipsychotic medication on bone mineral density in patients with schizophrenia. British Journal of Psychiatry, 184, 503–508

Comparison of the medical records obtained from the interviews with patients during the monitoring process revealed that menstrual cycle disorders in patients/beneficiaries were not considered as a possible side effect of the medication and they have been continuing to receive the same psychotropic drug prescribed for years. This clearly violates the patient's reproductive rights and points to the unprofessional, nonsensical attitude of the medical staff toward the patients.

According to the medical staff, most physicians evaluate the impact of psychotropic medication on reproductive health, however, in some cases, this consultation is considered to be a duty of a gynecologist. If side effects are revealed, alternatives to treatment include the substitution of the medication or reduction of the dose. Despite the validity of this tactic, the records of the studied medical records show that substitution with alternative medicine in practice does not always follow the recommendations. For example, haloperidol was replaced with risperidone because of a menstrual cycle disorder at one of the in-patient institutions, which is a wrong decision because risperidone constitutes one of the most active causes of hyperprolactinemia.[55]

Part of the interviewed staff noted that considering reproductive age and psychiatric conditions, patients are given less doses or more thrifty drugs as much as possible, although they were not able to name this medication accurately. A similar picture was revealed in pregnant patients. Pursuant to the doctors, prescribed medicines are changed or their dosage is reduced after determining pregnancy, however, doctors have also found it difficult to name safe medications for pregnancy.[56]

The monitoring team concluded that the facilities still use medicines that pose a risk to the patient and furthermore, sterilize them chemically. Although health care providers state that they do not use the drugs to suppress a patient's hypersexuality, as psychotropic medications themselves lead to reduced libido; the use of drugs that are no longer provided by guidelines has been identified.

Case No. 1

A tendency to use a specific drug against high libido of a patient women, that is not recommended by the guidelines and constitutes a method applied decades ago, was revealed at one of the psychiatric in-patient facilities for a long stay.[57] During the monitoring process, one ongoing case has been identified at the in-patient facility, when a woman was given a special medication called “Camphora Monobromata” for reducing libido, which patient's relatives made to be prepared at the pharmacy. As the nurse clarifies, the staff relied on their many years of experience in making the decision to prescribe the medication.

In the framework of the monitoring, during the meeting with the doctors-psychiatrists and a focus group of field experts, it was noted that although most psychotropic medicines have a negative effect on a woman's

[55] “Treatment and Management of Adult Schizophrenia”, National Recommendations (Guidelines) of the Clinical Practice, p.70. Source accessible on the following website: https://bit.ly/2TxjCyM [last visited on 23.01.2020].
[56] During the monitoring we studied the medical history of the pregnant patient, which fails to depict the consultation with a gynecologist and the effects of the medications on the fetus are not considered during their prescription.
[57] Surami Psychiatric Clinic.

reproductive function, drugs with less adverse effects are already available on the international market.[58] It is noteworthy that the existing consolidated state procurement procedure for these medicines creates certain barriers in the process of purchasing a new generation of appropriate quality medicines.[59]

2.2. Access to laboratory and other medical research

It is difficult for patients/beneficiaries of the examined institution to access laboratory studies. Some in-patient facilities do not even have their own laboratory. Laboratories do not operate at boarding houses, and despite agreements concluded with laboratories of various medical institutions, it is not possible for the boarding house beneficiaries to undergo a specific examination such as blood levels of prolactin, as no such examination is carried out at these laboratories. They also lack opportunities to collaborate with external sites.

For the same reason, most psychiatric establishments also lack the ability to determine prolactin levels in the blood. None of the studied medical histories confirm that such a study was carried out, nor did the staff recall when this study was utilized. Even a recommendation for this laboratory examination in the records of specialists in the medical history was found. As a result, it is difficult to associate the identified dysfunction with prescribed psychotropic medications and subsequently to correctly manage the condition.

These problems were also highlighted during the meeting with NGO representatives. Managing the somatic health of a patient at a mental institution has been identified as a challenge. Women's reproductive health issues are of particular importance in this regard. Similar problems occur at boarding houses of persons with disabilities and community-based organizations, as the institutions themselves do not have a doctor, whereas a therapist, providing services for them, is rarely able to pay a visit to the facility.

Monitoring has shown that the use of contraceptives in women with mental health problems to protect against unwanted pregnancy is associated with a certain challenge. At none of the targeted institutions talk the staff about contraception, family planning and birth control. Personnel of in-patient psychiatric institutions note that, as a rule, psychiatric clinics have strict control over patients' sexual relationships and therefore, there is no need of using contraceptives. As to the boarding houses and community facilities where sexual intercourse is allowed, the beneficiary is solely responsible for protecting against unwanted pregnancy.

[58] Clozapine, for example, has been found to be a drug that is less damaging to a woman's reproductive function but is not available in Georgia in its original form.

[59] According to the interviews with the medical staff, the quality of psychotropic drugs purchased in a consolidated manner is quite low and doctors have to increase their dose during treatment. It was also found that the quality of the inpatient and outpatient healthcare facilities differs, which puts patients in inpatient and outpatient settings in unequal conditions.

2.3. Keeping medical documentation

Lack of standards for keeping medical documentation is problematic. As a result, there is scarce information about the pregnancy of the patients in the medical records of the inspected institutions. Retrospective study of the pregnancy of a patient with a mental disorder according to medical records was made possible only at one multipurpose facility.[60]

Although part of the medical histories studied at the target institutions include records of the patient's prophylaxis by the therapist and the neurologist, they do not provide information on basic sexual and reproductive health conditions. Nor is such information available in the psychiatrist's daily records. It shall be noted that most medical histories contain records of the patient's physical condition at the time of hospitalization. In particular, all medical records provide information on the status of the genitourinary system, however, this data does not contain any information on the genital system. No medical record has any information on a woman's reproductive function, even when the woman's menstruation has been terminated for months.

3. Maternal health

Access to quality maternal health services, including antenatal and postnatal care, is part of women's right to access to the highest standard of health, equality and anti-discrimination, which is also linked to the right to life. Providing women with quality medical services during pregnancy, childbirth and after the childbirth is an important indicator of the development of the country's health system.

In line with the 2016-2030 Global Strategy for Women's, Children's and Adolescent's Health Strategy and Sustainable Development Goals,[61] the state is obliged to strengthen the managerial and leadership capabilities in relation to women, children and adolescents' health; strengthen multidisciplinary approaches and report to the public, especially on special needs, including those of women, children, and adolescents with mental health problems.

When managing a mental disorder, before and during pregnancy, and generally in women of reproductive age, the severity of the clinical condition, the risk of complications, and the termination of treatment, the benefits of its change or continuation, must be carefully considered.

Mental illnesses during pregnancy are associated with poor pregnancy outcomes, such as stillbirth, maternal death, or other pregnancy complications. There is also a high likelihood of complications of psychiatric illnesses during the postpartum. Consequently, the use of various risk substances is increasing during this

[60] №5 Clinical Hospital LTD.

[61] Information available on the following website: https://bit.ly/2R1aHEf [last visited on 23.01.2020].

period. The consumption of antenatal care services is also decreasing. The patient's negative attitude towards the fetus and the family, in general, is often noted.[62]

According to modern international approaches, all women of reproductive age should be screened for mental disorders before pregnancy, as early detection and appropriate treatment reduces negative pregnancy outcomes and negative attitudes towards the family.[63] However, there is no such practice settled in Georgia.

Progression of pregnancy is also particularly important in patients with mental disorders, as the use of neuroleptics and psychotropic medication usually reduces the timely detection of complications associated with pregnancy. For example, there is evidence suggesting that depression and high levels of excitement during pregnancy and postpartum period can severely impact family life, mother-infant relationships, and the child's future mental health.[64]

It is noteworthy that since 2018, in line with the Public Defender's recommendation, progressive steps have been taken by the state to increase access to antenatal program services. In particular, the number of antenatal visits increased from four to eight,[65] increasing the likelihood of timely detection and prevention of pregnancy-related complications. However, in order for a pregnant woman to receive the full package of services, she must be enrolled in the program until the thirteenth week of pregnancy.

The monitoring conducted by the Public Defender's Office at the state psychiatric care facilities revealed that patients or beneficiaries with mental health problems have limited opportunities to participate in the program during pregnancy, due to their state of health on the one hand, and on the other hand, because of neglecting their needs by the healthcare system. For example, women are not tested on pregnancy neither during admitting her to a psychiatric inpatient facility nor after a mental health problem is stabilized.[66] Consequently, no adverse effects of medication on fetus are considered during the treatment.

It is also noteworthy, that some positive steps have been taken by the state to improve the state program of antenatal monitoring. This program is more or less tailored to the needs of pregnant women.[67] However,

[62] Bennedsen BE, Mortensen PB, Olesen AV, Henriksen TB & Frydenberg M (2001) Obstetric complications in women with schizophrenia. Schizophrenia Research 47, 167–175.

[63] The clinical content of preconception care: women with psychiatric conditions Ariela Frieder, MD; Anne L. Dunlop, MD, MPH; Larry Culpepper, MD, MPH; Peter S. Bernstein, MD, MPH

[64] Burt VK, Hendrick VC. Clinical manual of women's mental health. American Psychiatric Publishing, Inc; 2005. Cohen LS, Nonacs RM. Mood and anxiety disorders during pregnancy and postpartum. Review of psychiatry, volume / Brockington I. Motherhood and mental health. American Psychiatric Publishing, Inc; 2005/ Ross LE, McLean LM. Anxiety disorders during pregnancy and the postpartum period: a systematic review. J Clin Psychiatry 2006; 67:8.

[65] Information is available on the following website: https://bit.ly/2uaZZlq [last visited on 23.01.2020].

[66] Facilities resort to pregnancy testing only after visible symptoms, such as bigger stomach, swelling of the legs, increased appetite or, on the contrary, toxicosis, are suspected.

[67] In particular, pregnant women who are diagnosed with anemia are given folic acid and iron medicine, which in itself should be considered as a positive dynamic. An important step forward has been the integration of the "High Risk Pregnancy, Maternity and Postpartum Care" component into the universal health program, which will further provide financial access to antenatal care services.

services for pregnant women temporarily or permanently stationed at psychiatric inpatient hospitals and those living in state care are inaccessible.

As a result of the information received in the framework of the monitoring, we can conclude that in the process of receiving antenatal, natal and post-natal services, barriers are created not only by the women's lack of knowledge of their own sexual and reproductive health, the influence of psychotropic drugs, and the severity of the disease but also by the lack of preparedness of the health system to provide high-quality antenatal, natal and post-natal services for women of reproductive age with mental disorder or other types of disabilities.

Although funding mechanisms for inpatient psychiatric institutions, boarding houses for the disabled and community-based organizations vary, it is clear that maternal health is not a priority at any of these institutions.

The monitoring revealed that the timely detection of pregnancy, and therefore consideration of the impact of the medication used during the treatment on the development of the fetus and on the maternal health is a particular problem at institutions. Pregnancy is not checked even if the woman is a first-time patient or transferred from another institution.

Part of the inpatient psychiatric service providers contractually employ gynecologists, however, the contract concluded with them is mainly formal in character. For example, according to the contract, a gynecologist paid a visit to one of the mental hospitals[68] once a month and tested an average of 10-15 patients. According to the gynecologist, he/she has problems during treating patients because management cannot purchase medication prescribed by her due to the fact that the budget does not cover such expenses.[69] It is noteworthy that the gynecologist assesses the health status of patients based on their complaints and in most cases, the patient is not visually examined.

Case No. 2

A case where it was not possible to establish the pregnancy of the patient was revealed at a psychiatric inpatient facility of a prolonged stay.[70] The medical personnel of the institution only learned about this fact after the woman had given birth without help during a 36-37 week gestational period in the toilet of the facility.

It is noteworthy that the patient received inpatient psychiatric care at 2 different mental hospitals during pregnancy, although no pregnancy was detected at these facilities, even though the contracted gynecologist is employed at these facilities. According to the record, the patient was consulted by a gynecologist, but the doctor failed to detect pregnancy, including in the last trimester of pregnancy. Pregnant woman was taking psychotropic medications throughout the entire pregnancy, which posed a high risk to the fetus.

[68] East Georgia Mental Health Centre LTD.
[69] In-depth interview with medical personnel and management of the facility.
[70] East Georgia Mental Health Centre LTD.

This case reaffirms the formal nature of the work of consultant-gynecologists employed at psychiatric inpatient facilities.

During the monitoring process, the medical history of one of the boarding-house[71] beneficiaries revealed that despite detected pregnancy, the woman was still given psychotropic drugs throughout her pregnancy.

Reproductive health care for a woman with a mental health problem is further complicated by the fact that there are no guidelines in the country to be applied by gynecologists for pregnancy management. Just as there is no guide in the field of psychiatry on how to manage a mental disorder in pregnancy.

The monitoring revealed that gynecologists often address psychiatrists with a request of a cesarean delivery during the childbirth by patients with mental disorders to prevent complications during vaginal delivery. Gynecologists try to use a diagnose of a mental disorder for a caesarean section.

International studies have shown that women with mental health problems need special care during the postpartum period.[72] However, the monitoring revealed that women in Georgia lack such care. Moreover, the mother most often is excluded from the infant or, after the childbirth, the mother with the infant is stationed in an environment that is not tailored to their needs. As a result, infants are cared for by the state and the child is transferred to the appropriate state service.

The problem of geographical access to obstetric-gynecological services by mothers living in disability boarding houses and community-based organizations has also been identified. In some cases, beneficiaries may need to be transported to the capital city, which is associated with additional costs, complexity of organization and risks of deteriorating health.

4. Use of state screening programs

Providing access to reproductive health for people with mental health problems is one of the key principles of the World Health Organization's Mental Health Action Plan for 2013-2020. According to the document, people with mental health problems need universal access to health and social care services, regardless of age, gender, socio-economic status, ethnicity or sexual orientation, to ensure their health and well-being. Mental Disability Management or Coordinated and Multidisciplinary Management of Disability-Related Health Problems is one of the approaches of the action plan.[73]

Georgia, as one of the member states of the World Health Organization, is obliged to take into consideration international recommendations. Consequently, women of reproductive age in mental or public health facilities should have access to state health programs as much as the rest of the population.

Although various state screening programs for the early detection of diseases have been introduced in the country, people with mental health problems who receive psychiatric care at appropriate institutions or

[71] Dusheti Boarding House for Persons with Disabilities.

[72] Ross LE, McLean LM. Anxiety disorders during pregnancy and the postpartum period: a systematic review. J Clin Psychiatry 2006;67:8

[73] WHO. Mental Health. Action Plan 2013-2020, the source is available on the following website: https://bit.ly/2RkAV3y [last visited on 23.01.2020].

live in state care are not enrolled in these programs. Out of all the screening programs, only the Hepatitis C program is implemented at all mental health facilities, disability boarding houses and community-based organizations, which is a significant and positive trend in itself. As for HIV and syphilis testing, it lacks systemic nature and is carried out only in some establishments per the decision of the management.

The monitoring revealed that no patients/beneficiaries of any of the inspected institutions were included in the state screening program for breast and cervical cancer.

The problem is particularly acute for psychiatric inpatient institutions where patients have been living for long periods, sometimes for decades. Consequently, they are deprived of the opportunity to use such services without the proper support of the administration. Unfortunately, the need for patients to be included in the screening program is not acknowledged by the management of these facilities despite the increased risk of developing breast and cervical cancer caused by psychotropic medications. The problem is further aggravated by the logistical and other difficulties associated with the transportation of patients stationed at inpatient institutions.

It shall also be noted that part of the medical staff of psychiatric institutions is cautious about providing unequivocal answer whether their patients should be included in the state cancer screening program or not.

Inclusion in the state screening program is also problematic for beneficiaries of boarding houses and community-based organizations as they often do not have the necessary information or are unable to get involved in the program due to the lack of support. Service providers are also unaware of the need for beneficiaries for cancer screening in boarding houses or community-based organizations.

The monitoring revealed that first of all, it is necessary to raise awareness of medical staff and patients about screening programs. It is important that the administration of psychiatric institutions, boarding houses and community-based organizations ensure the inclusion of patients/beneficiaries in screening programs, including through the provision of on-site services by mobile screening teams.

5. Qualification of staff and awareness on reproductive health

The relationship between the reproductive health of women and their mental health problems is complex, and much depends on how the disease is managed.[74]

The monitoring revealed that doctors' low awareness of reproductive health and rights significantly impedes access to quality medical care for women of reproductive age receiving psychiatric assistance and those under state care. It is precisely the low qualifications of the medical staff that lead to the failure to address patient's reproductive health needs even after the stabilization of the acute mental disorder.

Most of the interviewed medical staff report that both neuroleptic and psychotropic drugs affect reproductive function. However, for example, termination of the menstrual cycle in a patient of reproductive age for several months is not considered as a health problem and is deemed an inevitable

[74] Kocoglu D, B An Examination of Turkish Nurses' Attitudes, Awareness and Practices Regarding Reproductive Health Needs of Individuals With Schizophrenia. Issues in Mental Health Nursing 40(2):1-8 · January 2019

consequence of treatment. Hormonal imbalances, which are almost always associated with the treatment process, are also not recognized as a problem, which indicates to the low medical knowledge of staff and is due to the lack of a multidisciplinary approach of treating patients in the field of psychiatry.

It should be noted that the knowledge of medical staff about the impact of psychotropic medication on sexual and reproductive health is quite different even among the staff of one institution. More adverse situation is revealed in this regard at boarding houses and long-term inpatient facilities. Psychiatrists from some institutions also have no information about the clinical signs of adverse effects of medication on the reproductive health.

Part of the staff (doctor, nurse) believes that psychotropic medications do not affect sexual and reproductive health, they could not recall such a case from their own practice. According to one boarding house nurse, "patients get married, have healthy children if there was a deviation - it would show up".

Interviewed patients/beneficiaries identified reproductive health problems (menstrual cessation or irregular cycle, decreased libido) characteristic of psychotropic medications and which could have been a reflection of drug side effect. Some medical histories depict similar complaints, but it does not appear that the doctor-psychiatrist carried out recommended intervention according to the guidelines. For example, one medical history indicates to a patient complaining of galactorrhea and gynecomastia, which is a clinical manifestation of hyperprolactinemia. The patient was prescribed risperidone and chlorprothixene. According to guideline's recommendation, the blood levels of prolactin should have been determined first and the risperidone removed and/or replaced, for example, with aripiprazole.[75] The treating doctor had no doubt about the side effects of the medication, indicating that he/she did not have this information. The doctor's response to this problem was limited to prescribing the consultation with a gynecologist. The gynecologist rightly suspected that the ground for the complaint was the side effect of the medication, though other medication was considered as a cause of the complaint. At the same time, he/she did not recommend determining prolactin levels in the blood too.

It is clear from the example discussed above, that due to the lack of knowledge of the adverse effects of psychotropic medicines on the reproductive health, side effects are not properly analyzed and monitored. In general, monitoring revealed a tendency for doctor-psychiatrists prescribe the consultation with a gynecologist during sexual and reproductive dysfunction as they believe that such disorders are purely the competence of the gynecologist and do not consider them to be a manifestation of the possible side effects of the prescribed medication. In turn, consulting gynecologists also lack sufficient knowledge of the adverse side effects of psychotropic drugs and ways to correct them.

In addition to the psychiatrist, a doctor with a general profile provides services to a boarding house for persons with disabilities, but their knowledge of reproductive health issues is also problematic. In particular, according to a doctor at one of the boarding houses, he/she is not involved in the resolution of reproductive health problems and does not even think that his/her involvement in the issue is necessary.

[75] "Treatment and Management of Adult Schizophrenia", National Recommendations (Guidelines) of the Clinical Practice, p.69. Source accessible on the following website: https://bit.ly/2TsyRcx [last visited on 23.01.2020].

The situation in the community-based organizations is somewhat different in this respect. Services for them are provided mainly by psychologists and family doctors, or beneficiaries receive medical services largely from local primary care providers. According to the staff, mostly pills are used for treatment according to the nosology and mental condition, and the medicines taken by their beneficiaries do not affect the woman's reproductive health.

In-depth interviews at community-based organizations revealed that in case gynecological needs are detected, they often have to transport beneficiaries to Tbilisi as medical staff refuses to provide consultations to the patient at the municipal level. This can be explained by the stigma in the society and the lack of knowledge of local medical staff to manage mental health problems or various medical needs of persons with disabilities.

The low awareness of doctors is also confirmed by the fact that most of the interviewed specialists believe that women's reproductive rights are not violated at the institutions, although practically no measures are taken by them to enforce these rights.

6. Informing patients/beneficiaries about sexual and reproductive health and rights

Protection of reproductive health and rights includes universal access to reproductive health services, as well as information and education about it.[76] Awareness about reproductive health helps to reduce risky sex and sexually transmitted diseases and to avoid unwanted pregnancies.[77] Special attention is paid to the education of persons with disabilities, including those with mental health problems about reproductive health issues, especially on the safe sexual behaviour. This also helps to preserve their reproductive future.[78] Awareness about the reproductive health of beneficiaries of mental health institutions, boarding houses and community-based organizations is the responsibility of the medical staff and the management of the institutions.

The right of a patient with a mental health problem to access information is protected by an international act such as the Mental Health Act-2016. According to the document, patients have the right to receive accurate, timely and relevant information about their health; The patient should be given verbal clarification and be involved in key clinical decisions.[79]

According to the legislation of Georgia, any citizen of the country who applies to a health institution due to a health problem has the right to receive full information about his/her health. The Law of Georgia on Patient Rights is the guarantee for the protection of this right. According to this law, every citizen of

[76] Temmerman M, Khosla R, Say L.(2014) Sexual and reproductive health and rights: a global development, health, and human rights priority. Lancet. 2014 Aug 2;384(9941):e30-1.
[77] UNFPA (2019) Sexual & reproductive health. Source available on the following website: https://bit.ly/2w7jQmC [last visited on 25.01.2020].
[78] Higgins A, Barker P, Begley CM. Sexual health education for people with mental health problems: what can we learn from the literature? Journal Psychiatric and Mental Health Nursing (2006) Dec;13(6):687-97
[79] Mental Health Act 2016 Fact Sheet; the source is available on the following website: https://bit.ly/30uHd4P [last visited on 23.01.2020].

Georgia has the right to receive complete, objective, timely and comprehensive information on the factors that contribute to maintaining or adversely affecting his/her health.[80]

The law also protects the patient's right to have information about his/her diagnosis, planned and conducted treatment, and associated risks. In particular, according to the law, "the patient has the right to obtain a complete, objective, timely and understandable information from the medical service provider on: proposed preventive, diagnostic, treatment and rehabilitation services, and their associated risks and possible benefits, outcomes of the medical research, the planned medical service, alternative options, their associated risks and possible benefits".[81]

The right of a person with a mental disorder to be informed about his/her illness and treatment is protected by the Law of Georgia on Psychiatric Care. According to this law, the basic right of a patient is to receive complete, objective, timely and understandable information about his/her illness and intended psychiatric care. If the patient does not have the capacity to make a decision, the information is provided to the patient's legal representative.[82]

Obviously, the right to information also refers to awareness of the possible effects on the sexual and reproductive health of prescribed medication. In addition, as stated in the law, this information shall be provided to the patient in an understandable manner.

Although informing the patient is guaranteed by many international or domestic acts, the real situation is quite problematic in this regard.

According to the monitoring, patients'/beneficiaries' knowledge of their sexual and reproductive rights is significantly low. Patients do not pose questions to the staff about their sexual function. They especially avoid talking about intimate topics, which on the one hand is explained by their disinterest in the subject, and on the other hand, due to shyness, embarrassment, a desire not to over-burden staff with awkward questions, thereby demonstrating low self-esteem and self-stigmatization.[83] Doctors also explain that patients generally avoid talking about intimate topics with staff.

It is clear that patients are influenced by stereotypical beliefs that are typical of their social environment with regard to sexual and reproductive health. This impact was particularly evident with one of the boarding house beneficiaries. It was difficult to agree with them for an interview because they did not want to talk about sex and intimate matters as they consider it unacceptable and shameful.

[80] Law of Georgia on Patient Rights, Article 16, available on the following website: https://bit.ly/2NycdM4 [last visited on 23.01.2020].
[81] Ibid, Article 18.
[82] Law of Georgia on Psychiatric Care, Article 5, available on the following website https://bit.ly/38aGcRS [last visited on 23.01.2020].
[83] For example, one patient at the long-term inpatient institution said, she does not ask questions about prescribed medications ("I do not want to bother them, for them not to think that I feel bad").

Most patients and beneficiaries are also unaware of their diagnosis and the name of the medicine they take, especially their possible side effects in terms of sexual and reproductive health. Unusually, they are less interested in these topics and most of them never ask staff questions about these topics.

Only a small proportion of patients interviewed at psychiatric institutions were able to speak freely about the impact of psychotropic medicines on women's sexual and reproductive health and some knowledge of the issue was revealed. They had obtained information on the side effects of the drugs from other sources before being placed at the facility. It should be noted that knowledge around this topic was not revealed within the beneficiaries of the boarding house for persons with disabilities.

In some cases, patients' awareness of some of the side effects of the drugs did not include information on the effects of the medication on a woman's reproductive function. Patients/beneficiaries reported a number of sexual and reproductive health problems that they were experiencing at the moment or that they have experienced in the past (menstrual cycle abnormalities/its termination, decreased libido, and others), but they denied, they could not realize the possible association of these problems with the effects of the prescribed drugs.

During individual interviews, some of the beneficiaries expressed their desire to have a child in the future. Only a small proportion of them think that psychotropic drugs can have harmful effects on the fetus.

It should be noted that almost all inpatient psychiatric institutions and boarding houses employ a psychologist or a social worker, which is a very positive fact. Their relationships with patients are limited to individual conversations and group activities. Individual conversations are not systematic in nature and do not deal with a woman's sexual and reproductive rights, since, as mentioned above, this topic is primarily tabooed by the patients themselves, and the staff, for their part, do not properly understand the importance of the issue. Psychologist is primary left with the responsibility to evaluate patients' mental functions and to discuss with the patient topics of her interest if the patient so requests, but because they are reluctant to ask questions about intimate topics, discussing this subject during individual interviews is practically out of the question. The interviewed patients also confirm that no one talks about these topics with them.[84]

The monitoring reaffirmed the need to review the responsibilities of psychiatric staff and to organize systematic group and individual psycho-educational meetings with patients at the facilities, where they are provided with information, including on sexual and reproductive health issues.

7. Violence

The General Comment on Article 6 of the UN Convention on the Rights of Persons with Disabilities[85] states that the subordinate condition of women at institutions places them at particular risk of violence and exploitation.[86]

[84] According to the one patient at the inpatient department, she has a shortage of individual conversations with clinic specialists, which in itself eliminates the possibility of talking about privacy issues.
[85] General Comment No 3 of The Committee on The Rights of Persons with Disabilities on Women and Girls with Disabilities, 2016, Para. 10, available on the following website https://bit.ly/2TxlzLC [last visited on 23.01.2020].
[86] Ibid, Para. 29

Violence against persons with mental health problems is one of the most important issues in both public health and clinical settings, as victimization is associated with poor quality of life for patients with mental disorders and with treatment-resistant attitudes.[87] Patient with severe mental disorders can particularly often be subjected to violence.[88] The doctor plays a great role in identifying and managing violence.

The monitoring conducted by the Public Defender focused on the study of cases of violence against women of reproductive age with mental health problems at inpatient psychiatric institutions, community-based organizations and boarding houses, as well as on identifying cases of violence among patients/beneficiaries themselves and evaluating response methods.

During the in-depth individual interviews conducted during the visits, patients and beneficiaries generally indicated that violence against them, including sexual abuse, had occurred prior to their placement at the institution. For example, several patients reported being victims of sexual assault before being placed at a psychiatric inpatient facility. The named abusers were family members as well as strangers. They believed that the violence was due to their mental state and that the abuser took advantage of their vulnerability. However, medical staff believe that talking about violence by patients is more a consequence of their diagnosis than a reality.

The study revealed that medical staff is neglecting patients' complaints about alleged facts of violence and often ignores them. When consulting a patient, psychiatrists do not study the violence as a cause of the disease, even when violence against the patient may be systemic in nature. Violence against women of reproductive age with mental disorders is linked to the abuser's desire to benefit and/or subordinate a woman and manage her. Often, family members resort to the violence against women with mental disorders, to curb their sexual needs.

This was also confirmed during a meeting with a focus group of NGOs working on persons with disabilities, where violence against women with mental health problems and its exposure was named as one of the most pressing issues.

The monitoring also revealed that in cases of prolonged hospitalization, as well as at boarding houses for persons with disabilities, facts of violence among patients/beneficiaries are frequent, although the institution does not take care of preventing violence, identifying alleged facts and responding appropriately. There have also been cases of neglecting sexual assaults among the same-sex individuals. It is also worth noting that sexual violence is not separated from other forms of violence among patients, and institutions usually perceive them as physical violence, psychological pressure, etc.

[87] Mueser KT, Rosenberg SD, Goodman LA, Trumbetta SL. Trauma, PTSD, and the course of severe mental illness: an interactive model. Schizophr Res. 2002 Jan 1; 53(1-2):123-43; Assaultive trauma and illness course in psychotic bipolar disorder: findings from the Suffolk county mental health project. Neria Y, Bromet EJ, Carlson GA, Naz B. Acta Psychiatr Scand. 2005 May; 111(5):380-3

[88] Hiday VA, Swartz MS, Swanson JW, Borum R, Wagner HR. Criminal victimization of persons with severe mental illness. Psychiatr Serv. 1999 Jan; 50(1):62-8.

Latalova K, Kamaradova D, Prasko J.Violent victimization of adult patients with severe mental illness: a systematic review. Neuropsychiatr Dis Treat. 2014; 10():1925-39.

Case No. 3

During the monitoring process, the case was revealed,[89] where patients were sexually assaulted by a patient, which was often accompanied by conflict between patients. Due to the harsh conditions and narrowness of the facility, the patient could not be separated, resulting in inflicting damage on other patients, and also on the allegedly abusive patient, as the medical staff chained her to an iron bed for a long time. It should be noted that despite the medical records, where the patient openly stated her sexual orientation, the administration considered this fact only in the context of physical violence against other patients.

It should be noted that patients also have problems with mixed-type psychiatric inpatient facilities. For example, a woman at a mixed-type institution did not feel comfortable. She feared that the men in the same unit would sexually have assaulted her. However, the medical staff did not take her condition seriously and did not consider her separation or transfer to another department necessary.

The issue of alleged sexual violence among beneficiaries is even more acute at the boarding houses for persons with disabilities. Often one group of beneficiaries tries to oppress and influence the other. One of the beneficiaries stated in an in-depth interview that she had been "married" against her will at the boarding house. This reaffirms that the lives of people at large institutions imply increased risks of violence and preclude the proper protection of fundamental human rights.

8. Hygienic conditions and dignified environment

The United Nations Committee on the Rights of Persons with Disabilities considers neglecting hygiene procedures, menstrual and sanitary management by daycare services as widespread forms of violence against women with disabilities.[90] Such forms of violence often amount to torture, inhuman or degrading treatment and violate international human rights standards.[91]

During the monitoring, the physical environment of the target institutions was examined, and the hygienic conditions of the institutions were assessed.

The study of the environment and the process of service delivery during monitoring women's right to sexual and reproductive health served to examine the impact of existing living conditions and quality of service on women's health and well-being. In this regard, the monitoring team generally assessed the infrastructure, sanitary-hygienic conditions, temperature (heating and cooling system), issues of using bathrooms, access to hygienic materials (soap, women's hygiene pads, shaving means, toilet paper, etc.), and issues related to provision of women with clothes and private items (individual linens and underwear), as well as, protecting privacy/private space. The amount of item supplies listed above was checked, and personnel in charge of hygiene were questioned about the rules and procedures in this area.

[89] East Georgia Mental Health Center LTD.
[90] General Comment No 3 of The Committee on The Rights of Persons with Disabilities on Women and Girls with Disabilities, 2016, Para. 31
[91] Ibid, Para. 32

The monitoring revealed that the approach to hygiene is not unified at the target institutions. There is an unpleasant situation at the psychiatric departments of multi-profile hospitals, where due to the bureaucracy, those in charge at the department have difficulty to justify to the management the necessity to purchase women's hygiene pads and other hygienic items (such as toothbrushes and toothpaste or shaving means); this is due to the fact that here mainly acute cases are managed and patients do not stay for long-term. This is particularly problematic for female patients who do not have the support of family and relatives or when they do not arrive on time at the facility and are unable to provide the necessary supplies to the patient. In this case, it is up to the doctors to purchase hygiene items. It is also a common practice to cut/divide hygienic pads in the absence of such pads.

There have also been cases where the facility has a stock of women's hygiene pads, but patients themselves lack information about it and ask family members to provide the necessary items.

Patients often reported to water becoming cold soon in the bathroom, which makes it difficult for patients to properly maintain their personal hygiene. Women often have to use cold water for their daily hygiene. At the same time, the fact that a solid soap is available at the toilets of some institutions shall be assessed negatively, as this increases the risk of the spread of contagious diseases.

Patients still lack personal clothing or linen at some inpatient psychiatric establishments and have to choose the desired clothing (including underwear) from the general single/common supplies in the facility. Mostly there are large common washing machines where everything is washed together, including underwear. In some cases, at the request of the patient, it is possible to wash her private items separately, although this is usually the advantage of patients who are able to proactively express their desire to wash their individual items separately.

Although most of the laundry is washed once a week at most of the facilities, patients do not have the ability to fully maintain their personal hygiene, and adequate support is not provided in this regard.

An additional problem for women at mental health institutions is the fact that the toilets are not closed. In some cases, the facilities have gender-neutral toilets that both men and women use, though the toilet door is not locked from the inside. The administration explains this for security reasons, but patients explain that staff does not control the door and there is a high likelihood of someone entering an occupied toilet.

Quality of access to toilets is also problematic at psychiatric inpatient institutions, that almost never provide full access to wheelchair users. These include newly renovated facilities the bathrooms of which are not accessible to wheelchair users, or such possibility exists, but not completely.[92]

The situation at the boarding houses for persons with disabilities is different. The quality of bathrooms adapted at these facilities is satisfactory. Cold and hot water are available. Beneficiaries have individual means of hygiene. There are sufficient supplies of hygiene products, including women's hygiene pads, and beneficiaries are provided with all the necessary items. Yet it remains challenging to ensure the protection of the dignity of beneficiaries during hygiene procedures. In particular, during the staff interview at one of

[92] There is a pedestal, but it is impossible to reach the wheelchair to the bathroom, for example, because of a staircase.

the boarding houses,[93] it was revealed that in case of persons who cannot take care of themselves due to their health condition, the nurse of the institution assists them in bathing and maintaining personal hygiene, who, to ease the work, might shower two beneficiaries together.

Conditions at the community-based organizations in terms of hygiene are satisfactory. Due to the specifics of the institution, beneficiaries have more opportunities to maintain their personal hygiene. Linen is mostly changed as needed. However, necessary supplies of hygienic pads for women are problematic at some community-based institutions. Using cut pads is also a common practice here. Consuming a solid and common soap at organizations is also problematic since it increases the risk of contagious diseases.

The monitoring identified that the situation of complying with hygienic norms is slightly diverse at different types of institutions, however, the analysis of the general situation reveals that the quality of hygiene and existing living conditions largely fail to provide a high standard of care for women's health and well-being.

Recommendations

To the Ministry of Internally Displaced Persons from the Occupied Territories, Labor, Health and Social Affairs of Georgia

- Take all necessary measures to update the national guidelines for mental disorder to ensure that they appropriately reflect women's sexual and reproductive health issues in the light of the latest international practice. Ensure that comprehensive, clearly understandable, systematic information is provided on the topic mentioned in the updated guidelines, with particular emphasis on describing methods of intervention to protect the right to reproductive health
- Develop guidelines/protocols according to the diagnosis to manage pregnancy during mental disorder based on best international practice
- Study the compliance of the state budget for the Mental Health Program with the financial costs under the recommendations of the Guidelines on Mental Disorders
- Reflect the recommendations on sexual and reproductive health rights in standards on psychiatric health services and treatment
- Periodically monitor the implementation of recommendations for the protection of sexual and reproductive rights of women with mental health problems reflected in the guidelines, standards of treatment or strategies on mental health development, by analyzing relevant medical documentation and on-site visits
- Provide access to the respective laboratory research before commencing treatment with psychotropic medication, including to testing serum prolactin levels and pregnancy tests, through establishing an obligation to carry out laboratory tests for women of reproductive age at psychiatric and state care institutions and through allocating relevant resources to this end

[93] Dzevri Boarding House for Persons with Disabilities.

- Ensure that appropriate steps are taken to standardize the keeping of medical documentation
- Take into account the quality of psychotropic medicines in relation to reproductive health during consolidating purchases
- Facilitate the development and implementation of a protocol on medical testing of reproductive health of women aged 15-49 and living at boarding houses and community-based organizations
- Define an obligation of the staff to inform patients about their sexual and reproductive health rights and the potential impact of medication on this function through updated mental disorder guidelines
- Ensure that all women of reproductive age are tested during pregnancy while being placed at a psychiatric inpatient institution, through defining the obligation of the institution to carry out relevant testing
- Organize the development of the guidelines to be applied by gynecologists to manage pregnancy and postpartum periods of women with mental disorders
- Ensure integration of gynecologists in mobile groups under psychiatric institutions to monitor women with mental disorders during pregnancy, childbirth and postpartum
- Ensure involvement of patients/beneficiaries of mental health and state care institutions in the screening programs of cancer and sexually transmitted diseases, including through reflection of an obligation for screening on sexually transmitted infections in rules and procedures on issuing licenses for medical activities and permits of in-patient institutions
- In the framework of continuous education of doctors, facilitate:
  - Development of accredited training programs to address sexual and reproductive health issues of women during their treatment at psychiatric institutions
  - Development of a training module for the medical personnel of the psychiatric institutions on the impact of psychotropic medication on the sexual and reproductive health and its management
- Provide trainings for medical staff of psychiatric institutions, boarding houses and community-based organizations on:
  - Reproductive health issues, including the development of accredited training programs that focus on the psychoeducation of patients, sexual and reproductive health and rights of women, and strategies for their protection
  - On the mechanisms for prevention of violence against patients/beneficiaries, including sexual violence, detection and evaluation of alleged facts of violence and relevant response mechanisms
- Supervise referral of cases of violence by target institutions

To the Administration of Psychiatric Institutions, Boarding Houses of the Persons with Disabilities, Community-Based Organizations:

- Take concrete steps to increase the knowledge, motivation, and accountability of medical personnel in the treatment process of women with mental health problems in order to manage mental disorders in accordance with the recommendations of national and international guidelines

- Supervise the inclusion of data on the sexual and reproductive health conditions of a woman in the medical records of the facility according to the national guidelines
- Provide appropriate training on the reproductive health of a woman and its management for consultant-gynecologists of psychiatric and state care institutions
- Facilitate the increase of qualification of the staff of the institution to ensure that through various training courses they acquire knowledge and skills for psychoeducational work with patients
- Give systemic character to the individual and group psychoeducation work with patients/beneficiaries on sexual and reproductive health, and to add relevant function to the job descriptions of respective employees
- Facilitate the provision of information to the beneficiaries/patients about the screening programs in the country
- Ensure the inclusion of patients/beneficiaries in screening programs, including in on-site services provided by the mobile screening teams
- Provide training for facility staff on the prevention of violence against patients/beneficiaries, on the identification and evaluation of alleged facts of violence, and on the response mechanisms
- Supervise the staff of the institutions to ensure general sanitation and personal hygiene standards, to provide a dignified living environment and personal space for patients/beneficiaries
- Ensure that there is enough supply of personal hygiene products at the facilities and that patients/beneficiaries have access to them
- Strengthen work toward teaching the patients/beneficiaries self-care skills and to maintain personal hygiene.