



IDOM
INSTITUTUL PENTRU
DREPTURILE OMULUI

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REPORT

on the practical exercising of sexual and reproductive rights of women and girls, residents of the Temporary Placement Centers for Persons with Disabilities (adults) and of the Psychiatric Hospitals of the Republic of Moldova

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Introduction

Moldovan Institute for Human Rights (IDOM) is a non-governmental, independent, non-profit organization aimed at defending and promoting human rights, as well as monitoring the implementation of obligations assumed by the Republic of Moldova in the field of human rights, including on the international level.

IDOM carries out monitoring activities to ensure the respect for human rights in the Republic of Moldova, advocacy at national and international levels, strategic litigation, and it contributes also to informing specific groups, international organizations, as well as the society about the most serious human rights violations. Since 2007, IDOM has been elaborating human rights reports, comparative analyzes on the national legal framework and international acts in the field of human rights, providing conclusions and recommendations in order to improve the situation with regard to the respect for human rights in the Republic of Moldova. One of IDOM's strategic areas of intervention is monitoring, defending and promoting the rights of persons with mental disabilities residing in psychiatric and psychoneurological institutions. In this regard, since 2007, IDOM members have been conducting numerous unannounced monitoring visits to all psychiatric and psychoneurological institutions from Moldova, preparing reports on each institution, describing the findings and developing recommendations with a view to improving the situation of persons with disabilities. At the same time, the lawyers of IDOM took over numerous cases, on behalf of the patients, residing in these institutions, and defended their interests at national and international levels in cases where violations of their rights have been found. All relevant information about IDOM can be accessed on the website <https://idom.md/ted-wells/>.

As a national human rights organization, IDOM works to promote and defend the rights of persons with disabilities who are being institutionalized and found themselves in the case of the state authorities. In recent years, following the ratification by the Republic of Moldova of the UN Convention on the Rights of Persons with Disabilities, and its entry into force on 21 October 2010, but also following the Universal Periodic Review¹ on the way in which the Republic of Moldova implements its assumed obligations, IDOM intensified the monitoring of residential institutions and psychiatric hospitals. One aspect, which is analysed in recent years, is how the respect of and practical realization of sexual and reproductive rights

¹ Universal Periodic Review (UPR) is a unique mechanism which involves a review of human rights progress by the UN Human Rights Council in all those 193 UN member states and it takes place every 4-5 years.

of persons with disabilities are ensured, and how the prevention of all forms of violence and discrimination against women and girls with disabilities is secured.

The present report was elaborated using a mixed methodology: interviewing the employees and beneficiaries of the Temporary Placement Centers for Persons with Disabilities (adults) from the country and psychiatric hospitals, processing information obtained from the questionnaires filled in by the institutions and from analysing the personal and medical files, using the accumulated statistical data.

This research is based on the understanding that the state owes to institutionalized persons with disabilities the insurance of autonomy and bodily integrity, self-determination, equality and inclusion in the realization of sexual and reproductive rights. In the light of these principles, this report aims to address openly and honestly the critical situations existing in residential institutions and psychiatric hospitals. Recommendations are also proposed for redressing the situation and returning to an environment in which human dignity and fundamental rights of persons with disabilities are respected.

Research approach and perspective on respecting sexual and reproductive rights of persons with disabilities in residential institutions and psychiatric hospitals

Today, the UN Convention on the Rights of Persons with Disabilities (CRPD) is the most comprehensive tool for understanding the dignity and fundamental rights of persons with disabilities, as well as the obligations of the state to respect, protect and realize these rights. In particular, the Convention articulates very clearly the sexual and reproductive rights of the persons with disabilities, including:

- Respect for human dignity and individual autonomy;
- Freedom to make one's own choices, and independence of persons;
- Non-discrimination and equality, both formal and substantive,
- Effective participation and social inclusion;
- Accessibility;
- Gender equality.

Once the Convention was ratified, the state undertook obligations to ensure that persons with disabilities have equal access to health services, including the sexual and reproductive health services, on the basis of free and informed consent.² The Convention also protects the rights of persons with disabilities to non-discrimination relating to family, marriage, relationships and parenthood.³ The latter includes the ability to decide on the number of children, access to reproductive health services and to information about family planning and education, as well as the right to control fertility on an equal basis with others.⁴

Therefore, the approach of this research is based on the understanding that the rights of people with disabilities are interspersed with sexual and reproductive rights in an interdependent and indivisible manner. At the heart of this approach, is the concept of individual autonomy and the objective of full participation in social, economic and political life. Sexual and reproductive rights are focused on a simple legal principle – everyone has the right to make informed decisions – without discrimination, violence or coercion – about their reproductive health and sexuality. And indeed, once deprived of the ability to make important decisions regarding their sexual and reproductive lives, persons with disabilities face many violations of

² CRPD, Art. 25 (a) and Art. 25 (d);

³ CRPD, Art. 23;

⁴ CRPD, Art. 23 (1) (b) and Art. 23 (1) (c);

their rights, which persons without disabilities do not face, such as *improper use of contraceptives and bearing the adverse consequences, lack of information about sexual and reproductive health, lack of ability to decide on the birth of a child and/or the formation of relationships, denial of individual autonomy regarding their sexuality, medical services not adapted for women with disabilities, denial of the right to family life, discrimination* and others.⁵ Let us not forget that women and girls with disabilities face barriers in exercising their sexual and reproductive rights unique to them, such as *sexual abuse and forced sterilization*. There are no cases, known so far to IDOM, when men and boys with disabilities have been sexually abused or subjected to forced sterilization.

In its 2017 Concluding Observations, the UN Committee on the Rights of Persons with Disabilities indicated, as its principal area of concern, the fact that the medical model is still used to define disability. This fact is reflected in the legal framework and the medical assessment of disability.

Social Model *versus* Medical Model

The UN Convention on the Rights of Persons with Disabilities⁶ adopts the “social model” for defining disability, which emphasizes the unadapted social environment in which the person with disability encounters barriers in the realization of his or her rights in full. In contrast to the “medical model”, which sees disability as a problem in itself, offering treatment or rehabilitation to return to “normal”, the social model recognizes that negative attitudes in the society, lack of resources and multiple barriers are the causes of oppression of persons with disabilities.

We regret to note that this issue has remained unchanged, especially for residential institutions. The sexual and reproductive rights of persons with disabilities are viewed exclusively through the prism of the medical model. For this reason, the disability of the beneficiary of the institution is seen as an impediment to the full and autonomous realization of the right to intimate and family life, but also a justification for deciding instead of the person.

⁵ Article 9 of CRPD calls on ensuring accessibility, including to medical institutions and information; Article 16 of CRPD calls on the States Parties to take measures to protect persons with disabilities from all forms of violence and abuse, including gender-based violence and disability; Article 22 of CRPD recognizes the rights of persons with disabilities to privacy, including the protection of health information on an equal basis with others; Article 23 of CRPD calls on the States Parties to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, relationships, parenthood, especially in matters of family planning, fertility and family life; Article 25 of CRPD calls on the States Parties to ensure non-discriminatory access to health services for persons with disabilities, in particular sexual and reproductive health services;

⁶ Article 1 of CRPD “Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others”.

A. The exercising of sexual and reproductive rights of women and girls in Temporary Placement Centers for Persons with Disabilities (adults) in the Republic of Moldova

I. Access to reproductive health information and services

Contraceptives

Condom is the contraceptive widely distributed in residential institutions. Some of them are purchased, some are received through donations from civil society organizations. From discussions with the staff in charge, condoms are distributed mainly to women known to be sexually active⁷. The use of condoms is not common. Access to them is given through the medical office where the inquirer must go and ask for them.

Two institutions claimed that they also have oral and injectable contraceptives, stating that they are used only at the request of the patient. Examples, however, when these have been requested and used by any beneficiary, were not provided. There was also no data made available on the available quantity of these contraceptives.

None of these institutions mentioned the use of IUDs as a method of contraception. It was stated that this contraceptive is not currently used. The use of IUDs has been a common practice of psycho-neurological internat, applied without obtaining an informed consent of the patients, and left in their body unmonitored for years. One case was documented where a deinstitutionalized patient of such an internat⁸ (today called a temporary placement center), suffers from infertility due to the incorrect placement of the IUD, about which she did not even know.

Access to specialist examination

Beneficiaries of residential institutions are regularly examined by a gynecologist, in the form of routine checkups, upon request by the beneficiary or in case of an illness. Not all temporary placement centers have on staff a gynecologist, therefore the services of a midwives are used. Neither in institutions nor in the family doctor centers, where the beneficiaries are periodically brought, are there any gynecological chairs adapted to the needs of women with locomotor disabilities.

It has been stated that the gynecologist provides patients (!) with information about the contraceptives, personal hygiene, treatment, sexual life, sexually transmitted diseases. No statistics were provided

⁷ Nu e tradus...

⁸ nu e tradus

on the number of monthly visits to the gynecologist, as not all institutions have one. Nor were quantitative data provided on the number of patients who received this information. Nor was there any information provided on ensuring that men and boys have access to the same information on sexual and reproductive health, contraception, sexual life, personal hygiene.

Based on the statements made by the employees of the interviewed institutions, gynecological examination is done only if requested, and mainly for the sexually active women.

Informed consent

The institutions insisted on stating that there is a signed informed consent in each beneficiary's medical record and on the basis of this agreement she benefits from medical examination and treatment. Under the same consent form, the beneficiary is examined by a gynecologist and tests are performed and treatment is provided if necessary.

Once checking the medical records of the beneficiaries, we had studied this informed consent form. It is a common form, approved by the joint Order of the Ministry of Health and the Ministry of Justice no.303 from 06.05.2010, signed by the beneficiary, which does not contain anything specific with reference to interventions and treatments for reproductive health. So a generalized consent, is used as a lifelong informed consent, offered by the beneficiary and used as a legal basis for medical staff to intervene. No institution has confirmed that the beneficiary signs a new informed consent each time she is examined by a gynecologist and biological materials are taken for testing, unless she is transported to the family doctor center or to the another medical institution.

Communication between gynecologist - patient (person with disabilities resident of the placement center) is sporadic and usually takes place through intermediaries - nurse, midwife or psychiatrist. In the absence of a gynecologist among the staff of the institution, the beneficiary either receives little information or none at all. The latter situation is often encountered because after living for a lifetime in residential institutions as a person with disabilities, women have become accustomed to the negative attitude towards themselves. They do not have basic skills to exercise individual autonomy to request and manage information. Staff is accustomed to guarding the beneficiaries and taking decisions on their behalf under the strong conviction that they are acting in their best interest.

The information on the results of the gynecological examination are noted in the medical record of each patient, and is not communicated

and explained in simple terms to her. When asked, the patient can communicate that she indeed visited a gynecologist, but she cannot communicate what the visit ended with because she was not informed. She was only taken and brought back. Some pills are administered, prescribed by the doctor, however what they are, and what they are for, she does not know.

Communication tailored to the needs of the beneficiary, does not exist. The beneficiary's right to know about her health, to be involved in the making decisions about her sexual and reproductive health and to know the side effects of medication, is flagrantly violated on a daily basis. It is a medical approach to disability, which contradicts current national and international law.

Access to information on sexual and reproductive health

Residential institutions insisted that all beneficiaries have access to sexual and reproductive health information through informational leaflets and communication. No example of such a leaflet or other informational material, adapted to the needs of a person with cognitive or perceptual disabilities, has been shown. It is known that reading and counting are rare skills among the vast majority of the institutions' beneficiaries. An employee who was asked directly if she demonstrates to the beneficiaries how to use a condom, had a long moment of silence, then stated that they were probably shown before. Another employee insisted on stating that she does not leave condoms at the beneficiaries' disposal because they "inflate" them, that's why she prefers that the beneficiaries come to ask for them and she then personally hands them out. And even in those situations, she does not explain how the condom should be used correctly. The conclusion is self-evident, the beneficiaries of residential institutions do not benefit from any information about methods of contraception, sexual life, sexually transmitted diseases and other aspects of sexual-reproductive health essentials to lead an independent way of life.

The institution is keeping records of the menstrual cycles. Written in a special register, accessible to anyone. Beneficiaries are not taught to keep track of their own cycle, which diminishes their autonomy and ability to make informed decisions about their own health.

Hygiene products,⁹ needed by women, are kept by nurses who distribute the products upon request. The products purchased do not always take into account the physiological needs of women with disabilities. The amounts allocated, in the budgets of residential

⁹ They are purchased through the Center for Centralized Public Procurement in Health and from Donations;

institutions, for the purchase of these products vary significantly from one institution to another.¹⁰

Pregnancy and abortion

Two out of three residential institutions stated that at least in the last four years no beneficiary has become pregnant, although they do have beneficiaries living in couples. The third institution had pregnant beneficiaries, and currently has a patient on her second pregnancy in the last two years.

Abortion is not used as a method of contraception, at least that is what residential institutions say. In only one case, the pregnancy was interrupted "according to medical indications" with the diagnosis "pregnancy in evolution". The real reason for the abortion was the disability of the institutionalized woman, the latter being on the list of medical indications for abortion¹¹. Regarding the voluntary aspect of this medical intervention, it should be noted that the lack of adapted information and experience leaves the pregnancy of the woman with mental or intellectual disabilities from residential institutions in the hands of staff "who know best". The second beneficiary of the residential institution¹² who completed two full-term pregnancies (she gave birth in 2019¹³ and then in November 2020) did so because she had chronic mistrust of the institution's staff. Refused any recommended medication, including prenatal vitamins.

Family planning

After the birth of the child by a beneficiary of the residential institution, the mother is separated from the child. She returns to the institution, and gradually removed from the child who is subsequently offered the status of adoptable child. The child is placed in the Temporary Placement Center for Children. Although the National Program for deinstitutionalization of persons with intellectual and psychosocial disabilities in residential institutions managed by the National Agency for Social Assistance for 2018-2026 is approved, the decision of the authorities is not helping to keep the family by

¹⁰ 2,500 lei Temporary placement center for people with disabilities (adults) v. Brînzeni r. Edineț, 136,350 lei Temporary placement center for people with disabilities (adults) mun. Bălți to which are added products donated in the amount of 59, 644 lei;

¹¹ nu este tradus

¹² The first beneficiary T. gave birth to a boy in 2017, was deinstitutionalized with her child but without being offered social care services, she eventually died and the child was adopted by a family;

¹³The beneficiary was returned to the residential institution after giving birth, separated from her child, and will most likely be separated from her second child as well after giving birth;

desinstitutionalizing the woman with disabilities to live with her child/children in a safe house or community housing.¹⁴.

The lack of information, the lack of support in decision making, the lack of empathy of the social care services and the application of the medical model for defining disability resulted in abandonment, abuse and violation of the right to family life, both for mother and child. The authorities' argument that "she agreed to place the child in the Center" hides behind it the despair of the woman who was convinced that she has no place to live with the child (the residential institution does not receive beneficiaries with children), has nothing to support the child with and that the child would be better off in another family. It is this approach of the situation of women with disabilities who have become mothers that constitutes abuse.

Access to the family doctor

The beneficiaries are registered with the family doctor from the territorial area of the residential institution. The costs for the necessary medical services are covered by the compulsory medical insurance policy and by the budgets of the residential institutions.

Training the staff of residential institutions on the sexual and reproductive rights of persons with disabilities

There is no systematic training of staff on the rights of people with disabilities, even less on the sexual and reproductive rights of people with disabilities. Some employees referred to the training provided by IDOM and those given by the family doctor. With regard to the latter, the employees could not communicate when they were last organized, on what topic the training was and for whom.

The massive fluctuation of staff, including of unskilled employees, coupled with the lack of systematic training results in the widespread use of prejudices about the sexual lives of people with disabilities, which surfaced abundantly in conversations with employees for the entire duration of this research.

IN CONCLUSION: Analyzing the gathered information as a whole, it became obvious that women with disabilities from residential institutions face multiple barriers in exercising their sexual and reproductive rights. These include:

- Lack of adapted information;

¹⁴ See p. 48 from the National Plan for deinstitutionalization of persons with intellectual and psychosocial disabilities in residential institutions managed by the National Agency for Social Assistance for the years 2018-2026;

- Lack of empowerment activities and development of personal autonomy;
- Negative attitudes of employees of the institution, community and family;
- Lack of reasonable accommodation of medical procedures and language;
- Untrained medical staff;
- Application of the medical model of disability;
- Discrimination;
- Extensive application of prejudices regarding the sexuality of people with disabilities, their vulnerability and their ability to be a parent.

II. Prejudices regarding disability, sexuality and reproduction

People with disabilities in residential institutions face different forms of discrimination due to stereotypes, assumptions and fears about disability. Last but not least, the application of the medical model for defining disability, transforms the beneficiaries from holders of rights and freedoms into patients dependent on medical treatment and recovery services.

Discrimination against people with disabilities also intersects with other protected grounds, such as gender, sex, ethnicity, race and other status. These have a disproportionate impact on women and girls with disabilities, making them targets of abuse and violence.

Direct discrimination

includes the existing practices of unjustified differential treatment based on the disability of the person, including those contained in normative acts such as, for example, point 3, in Annex no.1 to Order no.WHO647 / 2010 of 21.09.2010 on the voluntary termination of pregnancy in safe conditions, which indicates mental and intellectual disability as medical indications for abortion. This provision is enough for employees of the medical sector and those of residential institutions to insist on terminating the pregnancy of a woman with disabilities rather than offer an alternative to institutionalization - life in the community with the child, with her family.

Systemic discrimination is reflected in the biased behavior of officials who resort to stigma and stereotypes, resulting in impunity for rape and sexual abuse cases of women with disabilities.

Discrimination by association

of the partner of the person with disabilities from the residential institutions, the creation of impediments for obtaining the recognition of the relationship, the denial of access to information and sexual-reproductive health services.

Discrimination against people with disabilities in exercising sexual and reproductive rights is rooted in stereotypes and prejudices. The vast majority of them refer to their sexuality, among which are the following:

- *People with disabilities are asexual:* which assumes that people with disabilities are not sexually active or have no interest in sex. A completely erroneous prejudice based on the medical model of disability that treats the person's condition as a defect. People with disabilities have the same sexuality, desires, relationships with other people as do those without disabilities. However, they may encounter some difficulties in exercising their sexuality due to the environment not being adapted to their disability. This preconception about the sexuality of the person with disabilities leads to the denial of access to sexual and reproductive health services because it is based on a misunderstanding that people with disabilities do not need these services.¹⁵
- *People with disabilities are hypersexual:* at the opposite pole of the first preconception, the latter comes to say that people with disabilities, especially those with intellectual or psychosocial disabilities, have an out-of-control libido that endangers them and those around them. This “vision” leads to the denial of access to information and education about sexuality and sexual-reproductive health for people with disabilities - and in some cases to the application of contraceptive methods without appropriate informed consent (IUD planting, oral contraceptives, sterilization) - in order to control sexual behavior seen as unacceptable by employees of residential institutions.
- *People with disabilities should not reproduce or are incapable of being parents:* because people with disabilities are seen as asexual, it is believed that they cannot reproduce and when they do reproduce, they are socially condemned for doing so. The preconception that disability is genetically transmitted is widespread, although there is no scientific data to support this. On the other hand, the births, in recent years, of perfectly healthy children by the beneficiaries of residential institutions, claim once again that preconception is wrong.¹⁶ Last but not least, people with disabilities are considered to

¹⁵ see General Comment no.3: Article 6 (Women and Girls with Disabilities) 2016 of the UN Committee on the Rights of Persons with Disabilities, paragraph 40;

¹⁶ Ibidem, paragraph 39;

be incapable parents due to their disability, believed to be an impediment in the proper care of the child. The latter is in fact an institution-resulted “disability” in people with disabilities, who living in a health facility for so long have never received assistance in learning basic life skills that would have later allowed them to use in full their parental rights and obligations. This is not available even when a person with disability in the residential institution becomes a parent. Both, the employees of the institution and the officials of the social care system, vehemently deny the idea that with a little help and support a new family could be created.

- *Women and girls with disabilities are unable to make decisions about their sexual and reproductive health:* the state of affairs, documented during this research, and not only, shows that health care providers and employees of residential institutions are the most versed in what “is best” for the woman / girl with disabilities. For this reason, the institution keeps track of their menstrual cycle in a special register. The women are not educated about their menstrual cycle or how to keep a track of it. Employees of the institution (everyone from nurse to director) know better whether or not a pregnancy should be continued and what methods of contraception should be used and whether to make them available, whether or not to provide information about sexuality and reproduction and to what extent.¹⁷
- *People with disabilities are vulnerable and need protection:* this preconception is also very widespread, through it, people with disabilities are seen as helpless and dependent human beings. This stereotype comes to justify the interruption of pregnancy, sterilization or the application of contraception without the informed consent of the person, often used as methods to protect women with disabilities from a pregnancy resulting from rape or sexual abuse.
- *Women with disabilities lie about rape and sexual abuse:* this is the most harmful prejudice, for the dignity and safety of women with disabilities. This, unfortunately, is still rooted in the practices of residential institutions. As a consequence, resident women and girls with disabilities are vulnerable to attack, abuse and rape known to take place both within the walls of residential institutions and outside. There have been cases, documented in the past, when male employees raped and sexually abused women and girls with disabilities in residential institutions, and escaped responsibility due to this prejudice. The most disturbing is the fact that the female employees of residential institutions share these prejudices, which cause distrust

¹⁷ Ibidem, paragraph 44;

in women and girls with disabilities who become reluctant to report sexual abuse.

B. The exercising of sexual and reproductive rights of women and girls in Psychiatric Hospitals in the Republic of Moldova

Contraceptions

Psychiatric institutions in the country claim that they do not purchase contraceptives and respectively do not distribute them to patients. The average duration of treatment in the ward of the psychiatric hospital, today, is about 21 days, and patients are hospitalized in spaces separated by sex, which is why contraceptives are not on the list of drugs purchased by these institutions. If patients bring contraceptives with them, they are still made available for the patient to administer while being on psychiatric treatment.

Access to a specialist exam

The patients of the psychiatric hospitals are examined by the gynecologist when it is necessary or when the patient requests the consultation or when the results of the tests indicate that a consultation and treatment is needed. There were cases when the gynecologist's consultation was requested by the family (*the mother of a patient with a disability requested the termination of her daughter's pregnancy*) and by criminal investigation bodies in a case of sexual abuse (*for collecting biological samples and treating disease, injuries*).

Each hospital has a gynecologist on staff, who provides consultations and prescribes treatment as needed. Treatment, investigations and medications are covered by the budget of each hospital. Patients receive free treatment, whether or not they are medically insured.

We have not received confirmation whether gynecological chairs are adapted to the needs of women with locomotor disabilities are installed in the gynecologist's office in hospitals.

The pregnancy test is not mandatory when women and girls are admitted to psychiatric hospitals. Only if the patient, being in the inpatient ward, indicates that she is pregnant, she will take the test and will be referred to the gynecologist. Even if the female patient is hospitalized in an acute psychotic state and cannot communicate all the information about her condition, in a few days her condition improves, and the medical psychiatrist has an additional discussion with the patient who can thus communicate to them a possible pregnancy. Specialists report that during the first trimester of the pregnancy, the administered psychiatric medicine do not harm the fetus and when a pregnancy is confirmed in the hospitalized patient, priority is given to the psychiatric treatment. The new generation of drugs, administered today to patients in psychiatric hospitals, affect

their sexual and reproductive health. While some claim that they only lower libido, others say that the medication has a contraceptive effect because it directly affects the female patient's fertility (for example, some drugs affect directly the hormone responsible for prolactin levels in blood which in turn disrupts the menstrual cycle in women). A common view, however, has been shared that there is no up-to-date scientific research to confirm or disprove the negative influence of psychotropic drugs on the sexual and reproductive health of people with disabilities in treatment in psychiatric hospitals.

Informed agreement

The hospitals explained that in the medical record of each patient there is a signed informed consent form and based on this agreement the patient benefits from medical examination and treatment. Under the same agreement, the patient is examined by a gynecologist, tests are performed, and treatment is provided, where necessary.

The signed informed agreement is in fact a common form approved by the joint Order of the Ministry of Health and the Ministry of Justice no. 303 of 06.05.2010 and does not contain anything specific with reference to interventions and treatments for reproductive health. So a generalized agreement, used as an informed consent offered by the patient and valid throughout the stay in the ward of the psychiatric hospital. Hospitals have not confirmed that the patient signs a new informed consent each time she is examined by a gynecologist and biological materials are taken for tests, unless she is transported to the other medical institution.

The informed consent form does not contain information on the harmful effects of psychiatric medication on sexual and reproductive health. They are communicated only verbally to the patient and not to all of them.

The results of the test performed on the biological samples taken from the patients, are registered in the medical file. An informative entry is also included in the medical file, released to the patient at discharge. Some of the patients are informed verbally as well.

Access to information on sexual and reproductive health

Psychiatric hospitals do not hold and do not distribute, in a targeted manner, information on the sexual and reproductive health of people with disabilities. The information leaflets received by hospitals, with reference to various social and health topics, are made available to patients and employees.

Hygiene products needed only for women, are purchased by two out of three hospitals or received through donations¹⁸, and are kept by nurses, who distribute the products upon request. The products purchased do not always take into account the physiological needs of women with disabilities. The amounts allocated, in the budgets of psychiatric hospitals, for the purchase of these products vary significantly from one institution to another.

The psychiatric hospital in Bălți claims that they cannot buy personal hygiene products necessary for women during their menstrual cycle because these are not included in the "parapharmaceuticals" category, and the 4 patients who are undergoing coercive psychiatric treatment buy their products from their disability pension.

Pregnancy and abortion

The officials from the psychiatric hospitals interviewed for this study, could not tell us how many pregnant patients have been hospitalized in the last 2-3 years. But they did confirm that such cases took place.

Pregnancy termination did not take place in psychiatric hospitals or on the instructions of a psychiatrist, although there was a situation when the mother of a patient with disabilities asked doctors to terminate the pregnancy against the will of the young woman. This did not happen during her treatment in the psychiatric hospital, as stated by the hospital.

Training the staff of residential institutions on the sexual and reproductive rights of persons with disabilities

There is no systematic training of staff on the rights of people with disabilities, especially on the sexual and reproductive rights of people with disabilities.

In order to report cases of violence or sexual abuse, the psychiatric hospital in Chisinau sends information to the police and the Ombudsman Office, which is in direct contradiction to Order no.77 that imposes the obligation on the institutions to report cases of abuse to the district prosecutor's office.

¹⁸ Spitalele de psihiatrie din mun. Chișinău și or. Orhei;

CONCLUSION: Analyzing the information gathered as a whole, it became obvious that women with disabilities in psychiatric hospitals face the same barriers in achieving sexual and reproductive rights. These include:

- Lack of adapted information;
- Lack of reasonable accommodation of medical procedures and language;
- Untrained medical staff;
- Applying the medical model of disability;
- Discrimination;
- Extensive application of prejudices regarding the sexuality of people with disabilities, their vulnerability and their capacity to be a parent.