


## Sexual and reproductive health of women with mental disorders: health professionals' perceptions

Saúde sexual e reprodutiva das mulheres com transtorno mental: percepção dos profissionais de saúde (resumo: p. 16)

Salud sexual y reproductiva de las mujeres con trastorno mental: percepción de los profesionales de salud (resumen: p. 16)

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This study's objective was to identify health workers' perceptions concerning the sexual and reproductive health of women with mental disorders and the consequences of their perceptions on care practice. This exploratory and qualitative study addressed 17 health professionals working in primary healthcare and Psychiatric services. Data were collected using semi-structured interviews, and thematic analysis was used to interpret data. The reductionist perceptions of health workers concerning the sexual and reproductive health needs of women with mental disorders reflect on their practice, in which sexual and reproductive health is dissociated from mental health. Therefore, professionals from both sexual/reproductive health and mental health care services need to work together to provide effective integral health care.

**Keywords:** Sexual health. Reproductive health. Women. Mental disorder. Health professionals.



## Introduction

Sexual and reproductive health is acknowledged as an integral part of human health and is essential for human development. For this reason, it constitutes a global concern<sup>1</sup>. Thus, historical and timeless documents emphasize a concern with safeguarding sexual and reproductive rights together with human rights, advocated by the 1994 International Conference on Population and Development (ICPD) convened under the auspices of the United Nations in Cairo, 1995 Beijing Platform for Action, Committee on Social Economic and Cultural Rights (CESCR) in 2016, United Nations Population Fund (UNPFA), and the Sustainable Development Goals (SDGs) to be achieved by 2030<sup>2</sup>.

These documents evoke the freedom of women and men to decide whether and when to reproduce, the right to access reliable information, and effective, accessible, and adequate family planning methods, in addition to healthcare services<sup>2</sup>. However, even though these rights are well established in international documents, women with mental disorders are considered unable to make decisions regarding these matters and enjoy these rights.

The United Nations Conventions on the Rights of Persons with Disabilities (CRPD) ensure these women have the same rights to access quality and accessible healthcare services, including sexual and reproductive health services, as people with disabilities. However, in practice, this population is still marginalized and socially excluded in many countries, including Cape Verde<sup>3</sup>.

International studies suggest that sexual health services are dissociated from reproductive health services provided to women with mental disorders. As a result, health services neglect and often fail to screen the sexual and reproductive health of these women<sup>4,5</sup>. These studies usually associate the neglect of services to stigma and discrimination, considered the primary barriers preventing health services from recognizing the sexual and reproductive health needs of women with mental disorders<sup>6</sup>.

Stigmas confer a negative connotation to the sexual and reproductive health of women with mental disorders, denying that these women are sexually active, have the ability to marry, have children or constitute a family. When it comes to their sexuality, it is seen as a manifestation of their mental illness<sup>7</sup>. Health workers may also share this stigmatizing perception, which shapes their perceptions of these women's sexual and reproductive health needs, possibly compromising care delivery<sup>6</sup>.

In general, women with mental disorders perceive these stigmas and avoid seeking health services. Consequently, their quality of life and self-esteem may decrease, compromising their physical and mental health and delaying diagnoses and treatment when necessary<sup>6,7</sup>. Therefore, women with mental disorders may not acknowledge health services as a resource they can use or consider them inappropriate and with little problem-solving capacity.

To understand how women with mental disorders are assisted in health services, we need to identify workers' perceptions regarding these women's sexual and reproductive health and understand how these perceptions influence their practice.



Likewise, it is essential to identify the feelings, beliefs, and attitudes of workers toward mental health, as their perceptions may prevent the provision of integral and effective healthcare to these women.

This study's objectives were twofold: (1) identify the perceptions of workers regarding the sexual and reproductive health of women with mental disorders, and (2) identify how the workers' perceptions influence their practice performed among women with mental disorders.

## Method

### Study design

This qualitative study was based on the Cultural Care Theory of Diversity and Universality (CCTDU) proposed by Madeleine Leininger. This theory considers that the provision of care should be sensitive, responsive, and culturally congruent to individuals, families, groups, communities, and institutions, paying attention to the fact that values, the way care is provided, beliefs, actions, and cultural lifestyles influence the delivery of care<sup>8</sup>. From this perspective, identifying the beliefs and values of patients and families is essential for health workers to plan care actions that meet the patients' needs according to their cultural context.

The model proposed by the CCTDU to generate new knowledge and support the analysis of the meaning of care in diverse cultures is called *Sunrise*. This model presents a set of technological, religious, philosophical, familial, and social factors, cultural values, and political, legal, economic, and educational ways of life that are interconnected and enable observing the sociocultural factors that permeate the lives of individuals and may influence their health<sup>8</sup>.

Based on this model, Leininger proposed decision-making and actions based on three types of cultural care: (1) preservation and maintenance of cultural care when providing care and support, and facilitating and enabling actions, helping cultures to train, preserve or maintain beneficial care ideas and solutions, or to cope with disadvantages and death; (2) accommodation and/or negotiation of cultural care, which concerns care, facilitating or creative actions, which enable actions or decisions that help cultures to adapt or negotiate with others to obtain culturally congruent, safe and efficient care to promote health, well-being, or cope with illnesses and death; and (3) re-patterning and/or restructuring, which refers to professional, auxiliary, facilitating or enabling actions and mutual decisions that help people to reorder, change, modify or restructure ways of life, and institutions to obtain better (or beneficial) standards, practices or results<sup>8</sup>.

In this sense, efficient, culturally congruent care is necessary to approximate care delivery to the patients' cultural contexts.



## Study setting

This study addressed health professionals working in primary healthcare and Psychiatric services in São Vicente/Cape Verde/Africa. Cape Verde is an archipelago with few resources. It is composed of ten islands with approximately 4,033 Km<sup>2</sup> and is located in the central region of the Atlantic Ocean on the African coast, at 455 km from Senegal<sup>9</sup>.

São Vicente/Cape Verde was chosen because it presents several problems in the context of sexual and reproductive health. Even though many women with mental disorders face these problems, this field is seldom explored locally, and there are gaps of knowledge. Additionally, the primary author has a Cape Verdean nationality.

The country's health system is organized at three levels. Primary healthcare is provided at the municipal level and is the entrance door to the National Health Service. The São Vicente Island's primary healthcare structure comprises a Health Station, five Health Centers, three Basic Health Units, one Reproductive Health Center, and one Occupational Therapy Center, connected to each other and two other care levels, secondary and tertiary<sup>9</sup>.

The regional level groups and reorganizes the cities' closest sanitary structures in an island, emphasizing secondary and hospital care. However, there is no regional level in São Vicente, as there are no regional hospitals and the health centers do not have hospitalization wards. The central or referral level is national broad and provides tertiary care, mainly differentiated hospital services. One of the country's two central hospitals is located in São Vicente<sup>9</sup>.

Sexual and reproductive health is governed by the Reproductive Health Program, the activities of which are integrated into the actions of various structures within the National Health Service at the various levels<sup>9</sup>. Primary healthcare is primarily intended to provide prenatal and contraception care, while hospital services complement differentiate hospital functions, including childbirth, surgeries, gynecological medical consultation, and complementary exams. These actions are regulated by the National Health Policy (2007/2020).

Mental health is governed by the Strategic Plan for Mental Health (2009/2013) and National Health Policy (2007/2020). Even though the country is working to formulate a new Strategic Plan for Mental Health, data have not been published yet. The country has a Psychiatric hospital and a referral Psychiatric hospitalization service, while these structures are of national scope.



## Participants and selection criteria

Twenty health professionals working with sexual and reproductive health were invited to participate in the study, all of whom worked in some primary healthcare or Psychiatric service located in São Vicente. The potential participants were first contacted in July 2017, when they received clarification of the study's objectives and an invitation. Seventeen workers met the inclusion criteria: working in primary healthcare or Psychiatric service for at least one year. Three workers were on leave or vacation, and for this reason, were excluded from data collection.

## Data collection

Data were collected through semi-structured interviews held between September and October 2018 via videoconference between Brazil and Cape Verde. The primary author conducted the interviews from Brazil, and two research assistants in Cape Verde provided technical support. The participants were individually interviewed in a private room in their workplace premises on previously scheduled dates and times. Each interview lasted 50 minutes on average.

A four-part script was used. The first part contained questions intended to characterize the participants such as age, sex, marital status, religion/beliefs, occupation, education level, time since graduation, area of training, and length of service. The second part addressed the participants' conceptions regarding the sexuality and reproductive life of women with mental disorders and the care provided to patients. The third part addressed knowledge regarding the strategies and resources used by health workers to meet these women's needs. Finally, the fourth part investigated the professionals' knowledge regarding official documents and references of cultural, academic, and institutional nature to guide the care provided to the sexual and reproductive health of women with mental disorders. The instrument was previously tested and adequately adapted.

## Analysis and treatment of data

The interviews were recorded and later transcribed verbatim. Empirical categories emerged from repeated readings, and the material was submitted to content thematic analysis<sup>10</sup>, following the three steps recommended: pre-analysis (floating reading to establish the corpus of analysis, objectives, and category units, and prepare the material for the following phases); exploration of the material (the categories were established, and the units, units of meaning and context were identified). Finally, data were interpreted. The thematic categories were based on CCTDU.



## Ethical aspects

The study was approved by the Institutional Review Board at the Federal University of Rio Grande CEPAS/FURG, opinion report No. 86/2018, and the Ministry of Health in Cape Verde, by deliberation No. 34/2018, place where data were collected. Considering that the study is linked to a Brazilian institution, the guidelines provided by Resolution 466/12, National Council of Health, were complied with<sup>11</sup>. In addition, a code composed of the letter “P” followed by the number of the order of interviews was used to ensure confidentiality of the participants’ identities.

## Results

Three categories emerged from data analysis. The first category refers to health workers’ perceptions of the sexual and reproductive health of women with mental disorders; the second was “invisibility of the competencies of women with mental disorders”, and the third category was “fragmentation of sexual and reproductive care provided to women with mental disorders”.

### Health workers’ perceptions of the sexual and reproductive health of women with mental disorders

When asked about the sexual and reproductive health of women with mental disorders, most participants revealed a narrow-minded perspective of these women’s health needs, which essentially focused on birth control. This reductionist perception shows an association with stigmas; i.e., these women would be less competent due to their mental diseases.

The mental and reproductive health of women with mental disorders is a complex subject because we don’t know the mind of a woman [with mental disorders]. There are women with mental disorders who have an exacerbated sexuality, while others don’t even think about it. (P14)

P1, P2, P3, P5, P6, P7, P9, P10, P11, P12, P13, P14, P15, and P17 showed greater sensibility when talking about the sexual and reproductive health of these women, mainly when they associated these individuals to groups that are vulnerable to sexual violence. In the reports of P3, P6, P9, P11, P14, and P15, pregnancy gained a connotation of sexual abuse.

I explained to the family the importance of keeping the contraceptive medication because she wandered a lot around the community, sort of abandoned, and sometimes she was a victim of sexual abuse. (P6)



Sexual violence was reported as something that may occur within these women's own families. Homeless women with mental disorders are considered the most vulnerable for not having the support of a family, social or health services to protect them from sexual abuse. In these cases, tubal ligation, or a long-term contraceptive method, is suggested as a means to prevent pregnancy.

In my experience, many pregnancies occur within the family, or with a very close friend. Then, the family protects itself and solves the problem internally. (P14)

She was wandering on the streets, so I say that they abused her because even if she consented, she was with decompensatedschizophrenic and was not aware of her actions and got pregnant after having fortuitous intercourse. (P11)

The participants' perception is that the care provided in health services to women with mental disorders that focuses on active birth control is a protective practice to ensure the women's and their families' wellbeing, who usually live under vulnerable social and financial conditions.

We don't know whether this is the correct course of action, but we tend to look for what is best for these women. Thus, if a woman has a mental disorder, is unemployed, doesn't know who the father is... it's simply a matter of preventing a child because a child is a responsibility, and the disease is often genetic, so the mother has no conditions, let alone with a child, and another one, I guess that anyone can see the problem. (P14)

Undoubtedly, helping the family and women to acquire greater control of their sexual lives is a way to protect them. However, this concern cannot become a barrier, preventing the delivery of integral care, which is a right advocated in official national and international documents.

### **Invisibility of the competencies of women with mental disorders**

In this category, the participants revealed a view that women with mental disorders are incapable of self-care, caring for their children, keeping an affective relationship, or taking contraceptives regularly.

Is she able to protect herself to the point of wearing a condom? We cannot expect it from the men who will abuse her... Usually, it is important to understand that a woman with a mental disorder will hardly be able to keep a stable relationship. I don't know, I don't know whether the literature says it, but there are situations of people with disabilities who form a family, but there is no mental disorder. (P14)



Data show that this perception of workers regarding women with mental disorders influences their practice when working in primary healthcare services or services specifically providing sexual and reproductive healthcare. According to P1, P2, P7, P8, P9, P12, P13, P14, P15, P16, and P17, the care provided to the sexual and reproductive health of women with mental disorders is deficient, infrequent, and restricted in time. Note that the focus is to prevent pregnancy using family planning resources actively, and in the case of pregnancy, health workers provide follow-up during the pregnancy-puerperal period.

She goes [to health services] or because she's got pregnant already, or because the family is concerned with the possibility of her becoming pregnant. She never seeks the service like the average person, for the services and her rights. (P2)

Most of the time, it is the family who brings her, and it's never, let's say, a regular consultation; she already has the intention to take a contraceptive. (P16)

The health workers report that the behavior of the families toward women with mental disorders influences both the search for services and the care provided to this population. Thus, according to the participants, the families deny these women's sexual and reproductive health, keeping them isolated at home to prevent pregnancy and consequently, avoid the burden of providing care to a new family member. The workers also note that the few times a family seeks a health service are to ask for a long-term or definitive contraceptive, or when a pregnancy has been confirmed, they only take her to follow-up consultations. The workers report that the reasons for this behavior include values, cultural beliefs, and socioeconomic aspects.

There is a taboo surrounding mental diseases, so that is why I said that the families don't bring them or believe that because a woman has a mental disorder, she doesn't have a sexual life or that it is not necessary to bring her to a reproductive health service. And, these women are often dependent... and because they less frequently seek health services, they are less frequently assisted. (P8)

The participants' reports blame the families for the (lack of) care provided to women with mental disorders. It is a perception that makes it impossible for workers to see these women's competencies that can be preserved or recovered with the help of workers and the family.





## Fragmentation of the sexual and reproductive care provided to women with mental disorders

As reported by P3, P7, P10, P11, and P14, fragmentation of the sexual and reproductive health care provided to women with mental disorders results from a perception that these women are under the Psychiatric service's responsibility. Additionally, these same participants noted that because the Psychiatric service is a crisis management ward, it has no conditions to address the sexual and reproductive health of these women, a task for which the primary healthcare services should be responsible.

One of the participants, P13, reported that the primary focus of the care provided to the sexual and reproductive health of women with mental disorders in the case of a pregnancy is to ensure that the baby is born healthy. This report suggests that the care provided to these women is restricted in time, i.e., greater attention is provided during the pregnancy-puerperal phase, and the most significant concern is with reproductive issues.

This woman progressed well, did not have any complications during the pregnancy. Only that I don't know how the postpartum goes, because they don't come back, the concern is more focused on the baby. You see that she is not attending follow-up, so the family feels obliged to at least bring her to ensure the baby is healthy. Now, regarding the woman, I can't always ensure that she is adequately assisted. (P13)

P3, P5, P6, P7, P11, and P16 report that fragmentation of care is inherent to the health system itself, resulting in women with mental disorders becoming invisible in the current sexual and reproductive program. This situation reflects the organization of primary healthcare services providing sexual and reproductive health care and Psychiatric services. All the participants reported that the lack of protocols with specific care to be provided to the sexual and reproductive health of women with mental disorders is a weakness of the service affecting the professionals' practice.

I don't understand; even though we have all the resources and good indicators of sexual and reproductive health care – we are even a reference in Sub-Saharan Africa –, when it comes to women with mental disorders, it's as if they don't have the same rights. The Health System itself... even though it includes sexual and reproductive healthcare, it does not include women with mental disorders. (P5)

P3, P5, P7, P9, P10, P11, P12, P13, P15, P16, and P17 also reported that communication problems between the primary healthcare services providing sexual and reproductive health care and Psychiatric services are one of the factors contributing to the fragmentation of care.

We don't have a counter-reference system here. I may make a referral, but then we don't know what happens after. When it comes to women with mental disorders, I guess that multi- and interdisciplinary care should be provided. We often fail when making referrals. (P7)



P2, P3, P4, P5, P6, P7, P9, P10, P12, P13, P14, P16, and P17 reported that the distance between sexual and reproductive health from mental health is an aspect that dates back to academic training and prevents these fields to cooperate with each other and provide integral care to this specific population. In addition, P4, P7, P13, and P15 noted that even continuing education programs promoted by healthcare structures do not approximate these two fields.

To be honest, I don't think that we're prepared for this, perhaps we should have a course addressing this subject during our academic training, so we'd have the competence to work with it on our routine... (P5)

The professionals' discourse evidences the urgent need for health professionals to work together with existing services, current policies, and society to sensitize people about the sexual and reproductive health needs of women with mental disorders to provide integrate care to this group of women.

## Discussion

This study's results suggest that the perception of health workers concerning the sexual and reproductive health of women with mental disorders may be closely linked to their perception of mental health, affecting the delivery of care. Mental diseases are usually seen as a predictor of disability, and therefore, women with mental diseases are considered incapable of performing daily living activities such as self-care, treatment adherence, or being financially independent, among others<sup>12</sup>.

Mental health in Cape Verde is a field that lacks visibility and investments in infrastructure and training of human resources, in addition to official documents providing updated guidelines to regulate care delivery. In addition, current cultural stigmas are identified in the health services, which may hinder the inclusion of women with mental disorders in the primary healthcare services providing sexual and reproductive health.

In this study, this perception is manifested through cultural expressions that characterize women with mental disorders as aggressive, neglectful, incompetent, and unpredictable, all labels that portray these women as being incapable of caring for their sexual and reproductive health. Additionally, the participants manifested stereotypes, denying the sexual urges of women with disabilities, presenting a discourse and attitudes that end up neglecting these women's sexual and reproductive health<sup>13</sup>.

Even though these workers are aware that women with mental disorders are more likely to suffer sexual abuse, the participants did not suggest preventive actions or actions emphasizing their safety; rather, they show a concern with pregnancy, which would burden the families. It is important to implement actions intended to protect these women from rape, violent sexual abuse, or coercive reproductive control<sup>14</sup>.



Even though the participants' concerns with women with mental disorders becoming pregnant is understandable, especially among those with families facing socioeconomic vulnerability, this study draws attention to the reductionist view of these women's sexual and reproductive health, mainly focused on birth control. This practice prevents integral care from being provided to these women and neglects their rights, considering that birth control does not solve the vulnerability to which they are exposed.

The participants' discourse is based on a view that does not acknowledge the competencies of women with mental disorders. Therefore, they resort to economic, political, familial, educational, and cultural factors to support the way these women's sexual and reproductive health is assisted in Cape Verde. Even though these factors indeed influence care delivery, it is noteworthy that the professionals resort to these factors to justify the omission or fragmentation of the care provided to these women.

Enjoying sexual and reproductive health is closely linked to safeguarding basic human rights, that is, the right to non-discrimination, privacy, freedom from violence and coercion, and access to information and health services<sup>1,2</sup>. Women with mental disorders are among the most vulnerable groups, most likely to have their rights denied, which are explained by factors such as culture, stigmas, discrimination, and social exclusion, which may compromise the quality of care delivery<sup>15</sup>.

Even though international guidelines were adopted in this study context to safeguard human, sexual, and reproductive rights, care delivery revealed a discrepancy between theory and practice, whereas culture strongly interfered with the delivery of integral care to these women. Adopting international guidelines and conventions may not suffice to achieve the goals proposed in these documents if there is not an effort to guarantee the rights of the most vulnerable populations<sup>2,16</sup>.

Accommodating and/or negotiating cultural care enable facilitating or creative care activities, which define care actions or decisions that facilitate the adaptation or negotiation with others to provide culturally congruent, safe, and efficient care<sup>8</sup>. This study reveals the participants find it difficult to negotiate care and promote the ability of women with mental disorders to care for their sexual and reproductive health due to stigmas that nullify their skills and competencies.

This is a critical point, considering that Leininger recommends care be based on the relationship between nurse-patient, established to create a new lifestyle, and health care, resorting to the accommodation and/or negotiation of cultural care as a way to achieve these objectives<sup>8</sup>. A difficulty in negotiating care based on stigmas that nullify the competencies of women with mental disorders may result in care practices that do not consider the autonomy of these women; rather, it only meets the workers' expectations.

The results evidence that the capabilities of women with mental disorders in care practice are disregarded, suggesting that the guidance of workers is focused on birth control, promoting the use of long-term or definitive contraceptive methods, and



ensuring non-procreation. It reveals that the care provided to these women's sexual and reproductive health fails to prevent sexually transmissible infections and HIV so that the vulnerability of these women becomes a concern.

The participants' reports suggest that sexual health is dissociated from reproductive health, and these two axes are dissociated from mental health. The results reveal that the greatest difficulty is not providing sexual and reproductive healthcare but the presence of mental disease. A study developed in Australia revealed a lack of preparation of health professionals in dealing with the sexual and reproductive health of women with mental disorders, suggesting that, in the face of a care model that focuses on the biological symptoms of mental disease, their sexual and reproductive health may be neglected<sup>17</sup>.

These results suggest that a negative perception of the sexual and reproductive health of women with mental disorders makes their competencies invisible, leading health workers to perform fragmented and inconclusive actions, impeding these women from meeting their health needs. In this sense, there is an urgent need to invest in training and recycling health professionals with actions that enable them to stop providing care based on mental disease stigmas, promoting the sexual and reproductive health of these women. Continuing education by itself does not suffice, and pertinent actions intended to sensitize workers to change their perception of the problem under study are also needed.

A dissociation between sexual from reproductive health became apparent in the participants' discourses, suggesting that this dissociation is also inherent to the organization of the health services; there are communication problems between primary healthcare services providing sexual and reproductive care and Psychiatric services. In addition, inefficient referral processes among health services may compromise the quality of the care provided to these women's sexual and reproductive health and preventive and specialized care, constituting an omission of fundamental care<sup>18</sup>.

This study shows that providing integral care to the sexual and reproductive health of women with mental disorders is a challenge in terms of the universality of care and to the achievement of the goals proposed by international documents such as ICPD, CERSCR, CRPD, ODS, which call for the fulfillment of the sexual and reproductive rights of these women. In line with this study's results, a study developed in Uganda reports that integral and patient-centered care indicates the responsiveness of a health system. Additionally, having prior knowledge about the interpersonal, cultural, and psychosocial aspects influencing health supports the quality of the services provided and the achievement of international goals<sup>19</sup>.

Facilitating actions and mutual decisions can support cultural care that meets the needs of these women, contributing to demystify preconceptions rooted in the Cape Verdean culture that deny women with mental disorders the ability and right to enjoy a pleasant and risk-free sex life; manage an affective relationship; exercise maternity; and the ability to decide on these aspects.



In this study's context, changing care practices, recognizing these women as the subject of sexual and reproductive health care can be the beginning of an overdue change, recovering and preserving these women's human, sexual and reproductive rights, necessary to ensure human dignity.

### **Contributing to care practice and Public Policy**

To the best of our knowledge, this is the first study in São Vicente, Cape Verde, to address the care provided to the sexual and reproductive health of women with mental disorders. For this reason, this study is expected to contribute to sensitize health workers in their practice and encourage competent entities to review public policies, ensuring these women's sexual and reproductive rights.

### **Study's limitations**

This study was developed with data concerning the island of São Vicente, Cape Verde. Thus, the results cannot be generalized to the entire country, and comparisons are restricted. Therefore, new studies conducted in the remaining islands of Cape Verde addressing this subject are needed.

### **Final considerations**

This study's results are similar to those reported in the literature and add information concerning the Cape Verdean context. The participants' worldviews resort to familial, social, cultural, political, legal, economic, and educational factors to justify the care provided to the sexual and reproductive health of women with mental disorders. However, data suggest that their view is based on a stigmatizing perspective of mental diseases, which compromises these women's integral health and well-being, fragmenting sexual and reproductive health from mental health. Therefore, the services need to cooperate and connect these three axes.

This study reveals the iniquities and gaps in universal health coverage, showing these women's sexual and reproductive rights are neglected, even though these rights are enshrined in international documents. More than public health, women with mental disorders are entitled to integral care. Health inequalities and actions that were never implemented to ensure the health rights to the most vulnerable populations may be the reason why the goal "Health for all in 2000" was not achieved.



## Authors' contributions

All authors actively participated in all stages of preparing the manuscript.

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## Conflict of interest

The authors have no conflict of interest to declare.

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## References

1. Alarcão V, Stefanovska-Petkovska M, Virgolino A, Santos O, Ribeiro S, Costa A, et al. Fertility, Migration and Acculturation (FEMINA): a research protocol for studying intersectional sexual and reproductive health inequalities. *Reprod Health*. 2019; 16:140. Doi: <https://doi.org/10.1186/s12978-019-0795-5>.
2. Pizzarossa LB, Pehudoff K. Global survey of national constitutions: mapping constitutional commitments to sexual and reproductive health and rights. *Health Hum Rights*. 2017; 19(2):279-93.
3. Upadhaya N, Regmi U, Gurung D, Luitel NP, Petersen I, Jordans MJD, et al. Mental health and psychosocial support services in primary health care in Nepal: perceived facilitating factors, barriers and strategies for improvement. *BMC Psychiatry*. 2020; 20:64. Doi: <https://doi.org/10.1186/s12888-020-2476-x>.



4. Montejo AL, Montejo L, Baldwin DS. The impact of severe mental disorders and psychotropic medications on sexual health and its implications for clinical management. *World Psychiatry*. 2018; 17(1):3-11.
5. Harrison ME, Zanten SVV, Noel A, Gresham L, Norris ML, Robinson A. Sexual health of adolescent patients admitted to a psychiatric unit. *J Can Acad Child Adolesc Psychiatry*. 2018; 27(2):122-9.
6. Wainberg ML, Cournos F, Wall MM, Pala NA, Mann CG, Pinto D, et al. Mental illness sexual stigma: implications for health and recovery. *Psychiatr Rehabil J*. 2016; 39(2):90-6.
7. Ganle JK, Otupiri E, Obeng B, Edusie AK, Ankomah A, Adanu R. Challenges women with disability face in accessing and using maternal healthcare services in Ghana: a qualitative study. *PLoS One*. 2016; 11(6):e0158361. Doi: <https://doi.org/10.1371/journal.pone.0158361>.
8. Leininger MM. *Culture care diversity and universality: a theory of nursing*. New York: Wiley; 1991.
9. Cabo Verde. Ministério da Saúde. Política Nacional de Saúde. Reformar para uma saúde melhor. Praia: Ministério da Saúde; 2007-2020.
10. Bardin L. *Análise de conteúdo*. Lisboa: Edições 70; 2015.
11. Brasil. Ministério da Saúde. Conselho Nacional de Saúde. Comissão Nacional de Ética em Pesquisa. Resolução nº 466, de 12 de Dezembro de 2013. Diretrizes e normas regulamentadoras de pesquisa envolvendo seres humanos. Brasília: Ministério da Saúde; 2013.
12. Badu E, O'Brien AP, Mitchell R. An integrative review of potential enablers and barriers to accessing mental health services in Ghana. *Health Res Policy Syst*. 2018; 16:110. Doi: <https://doi.org/10.1186/s12961-018-0382-1>.
13. Rugoho T, Maphosa F. Challenges faced by women with disabilities in accessing sexual and reproductive health in Zimbabwe: the case of Chitungwiza town. *Afr J Disabil*. 2017; 6:252. Doi: <https://doi.org/10.4102/ajod.v6i0.252>.
14. Tarzia L, Thuraisingam S, Novy K, Valpied J, Quake R, Hegarty K. Exploring the relationships between sexual violence, mental health and perpetrator identity: a cross-sectional Australian primary care study. *BMC Public Health*. 2018; 18:1410. Doi: <https://doi.org/10.1186/s12889-018-6303-y>.
15. Keet R, Mahon MV, Shields-Zeeman L, Ruud T, Weeghel JV, Bahler M. Recovery for all in the community; position paper on principles and key elements of community-based mental health care. *BMC Psychiatry*. 2019; 19:174. Doi: <https://doi.org/10.1186/s12888-019-2162-z>.
16. Bekker LG, Alleyne G, Baral S, Cepeda J, Daskalakis D, Dowdy D. Advancing global health and strengthening the HIV response in the era of the Sustainable Development Goals: the International AIDS Society-Lancet Commission. *Lancet*. 2018; 392(10144):312-58. Doi: [https://doi.org/10.1016/S0140-6736\(18\)31070-5](https://doi.org/10.1016/S0140-6736(18)31070-5).
17. O'Dwyer CA, Tarzia L, Fernbacher S, Hegarty K. Health professionals' experiences of providing care for women survivors of sexual violence in psychiatric inpatient units. *BMC Health Serv Res*. 2019; 19:839. Doi: <https://doi.org/10.1186/s12913-019-4683-z>.
18. Miyoshi NSB, Azevedo-Marques JM, Alves D, Azevedo-Marques JM. An eHealth(eHealth-Interop): development of an interoperability platform for mental care integration. *JMIR Ment Health*. 2018; 5(4):e10129.
19. Waweru E, Sarkar NDP, Ssengooba F, Grue'nais M, Broerse J, Criel b. Stakeholder perceptions on patient-centered care at primary health care level in rural eastern Uganda: a qualitative inquiry. *PLoS One*. 2019; 14(8):e0221649. Doi: <https://doi.org/10.1371/journal.pone.0221649>.



Este estudo teve por objetivos: conhecer a percepção dos profissionais sobre a saúde sexual e reprodutiva das mulheres com transtorno mental; e identificar a repercussão da percepção dos profissionais acerca da prática que desenvolvem com as mulheres com transtorno mental. Trata-se de um estudo exploratório, de abordagem qualitativa, realizado com 17 profissionais de saúde que atuam na rede de cuidados primários e serviços de Psiquiatria. Os dados foram coletados utilizando entrevistas semiestruturadas e, após, submetidos à técnica de análise temática. A percepção reducionista das necessidades de saúde sexual e reprodutiva das mulheres com transtorno mental pelos profissionais de saúde reflete, na prática, um cuidado que dissocia a saúde sexual e reprodutiva da Saúde Mental. Assim sendo, para a efetivação do cuidado integral à saúde dessas mulheres, faz-se necessário maior horizontalidade entre a saúde sexual/reprodutiva e mental.

**Palavras-chave:** Saúde sexual. Saúde reprodutiva. Mulheres. Transtorno mental. Profissionais de saúde.

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Los objetivos de este estudio fueron: conocer la percepción de los profesionales sobre la salud sexual y reproductiva de las mujeres con trastorno mental e identificar la repercusión de la percepción de los profesionales sobre la práctica que desarrollan con las mujeres con trastorno mental. Se trata de un estudio exploratorio, de abordaje cualitativo, realizado con 17 profesionales de salud que actúan en la red de cuidados primarios y servicios de Psiquiatría. Los datos se colectaron utilizando entrevistas semiestruturadas y que después se sometieron a la técnica de análisis temático. La percepción reducionista de las necesidades de salud sexual y reproductiva de las mujeres con trastorno mental por parte de los profesionales de salud refleja, en la práctica, un cuidado que disocia la salud sexual y reproductiva de la salud mental. Por lo tanto, para que el cuidado integral a la salud de esas mujeres sea efectivo, es necesaria una mayor horizontalidad entre la salud sexual/reproductiva y mental.

**Palabras clave:** Salud sexual. Salud reproductiva. Mujeres. Trastorno mental. Profesionales de salud.