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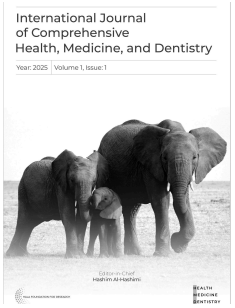

Original Article

Addressing Sexual and Reproductive Health Needs of People with Mental Illness: Evidence-Based Approaches from High-Income Countries for Low- and Middle-Income Settings

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Abstract

Objective: This study reviews inclusive SRH intervention programs from high-income countries (HICs) to guide the development of similar programs for people with mental illness in low- and middle-income countries (LMICs), with a focus on LIMCs.

Methods: A literature review was performed using databases such as PubMed and Google Scholar, focusing on articles from 2010 to 2024. The review examined peer-reviewed articles and credible reports on SRH services for people with mental illness.

Results: Findings indicate that integrating SRH services with mental health support is effective in HICs. LMICs face challenges like stigma and limited-service integration. Successful strategies from HICs, including legal protections and specialized services, offer valuable lessons.

Conclusion: Adapting successful SRH intervention models from HICs to LMICs, incorporating multisectoral approaches and legal reforms, is essential to improving SRH service access for people with mental illness.

Keywords: Mental health, Mental illness, Access, Sexual, Reproductive, Health, Services, Program, Intervention, Inclusion, and Stigma.

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Introduction

Stigma and discrimination associated with mental illness, fueled by cultural and social norms and values, continue to create barriers leading to the social exclusion of people with mental illness. This remains a serious challenge for achieving Sustainable Development Goals (SDGs) [1]. The World Health Organization (WHO) defines exclusion and inclusion in social terms as "dynamic, multi-dimensional processes driven by unequal power relationships interacting across four main dimensions—economic, political, social, and cultural—and at different levels, including individual, household, group, community, country, and global levels" [2, 3]. Conversely, social inclusion is defined by the International Conference on Population and Development (ICPD) and the Convention on the Rights of Persons with Disabilities (CRPD) as the right to full community participation [4]. Thus, social inclusion involves the societal acceptance and participation of individuals, families, and the community [5, 6].

Stigma itself is a social-dynamic process affected by the level of education and influenced by attitudes, beliefs, behavior, and cultural norms [7]. Common but highly stigmatizing beliefs about people with mental illness—such as being considered dangerous, unproductive, asexual, unintelligent, and dependent—impact their social inclusion [8, 9]. These beliefs are key determinants in excluding people with mental illness from health and social intervention programs and are responsible for the denial of their rights and justice [10]. The exclusion of people with mental illness from health and social interventions affects their livelihood, well-being, and self-esteem [10], and influences their social support, help-seeking, and access to health services [11]. For people with mental illness, accessing sexual and reproductive health (SRH) services is affected by double stigma due to beliefs that they are asexual and face unequal treatment [12].

Ensuring social inclusion and the right to equal treatment for people with mental illness is critical to achieving the SDGs and the success of inclusive mental and sexual health programs and interventions [13]. Health interventions that promote social inclusion tend to address challenges related to beliefs, attitudes, subjective norms, and behavioral factors, which remain major drivers of social exclusion [14]. These factors are common barriers to accessing SRH services for people with mental illness in low- and middle-income countries (LMICs) [15]. Surprisingly, there is limited research available on the health and social inclusion of people with mental illness in LMICs due to high stigma, poor understanding of the consequences of mental illness, and a lack of explanatory models, theories, and evidence-based interventions [6, 16].

However, in developed and high-income countries (HICs), the inclusion of people with mental illness has been addressed through community-based mental health service approaches. These approaches involve adopting and institutionalizing legal frameworks for protection, promoting economic independence, and implementing stigma reduction interventions [17, 18]. Evidence shows that effective inclusive intervention programs and best practices in HICs support people with mental illness by reducing stigma and promoting access to health services [19, 20].

This study aims to identify, discuss, and share insights from inclusive health intervention programs and best practices in high-income countries (HICs). The goal is to guide the design of similar SRH interventions or enhance existing programs targeting people with mental illness in LMICs.

Methods and Analytical Framework

***Methodology**:* This study employs a literature review to analyze SRH programs and interventions from high-income countries (HICs) aimed at addressing stigma and promoting access for individuals with mental illness in LMICs. The review synthesizes information from existing literature to provide an overview of inclusive SRH programs and best practices.

***Search Strategy**:* A comprehensive search was conducted across academic databases such as PubMed, Google Scholar, and the WHO library. Keywords included "Mental health," "Mental illness," "Access," "Sexual," "Reproductive," "Health," "Services," "Program," "Intervention," "Inclusion," and "Stigma." The search was restricted to English-language articles published between 2010 and 2024 to ensure the relevance and timeliness of the data.

***Selection of Sources**:* Sources were selected based on their relevance to the research questions and objectives. Inclusion criteria were peer-reviewed articles, government reports, and credible publications on mental illness and inclusive SRH services. The selection involved an initial screening of titles and abstracts, followed by a full-text review of the shortlisted articles.

***Data Extraction**:* Data extraction used a standardized form to ensure consistency. Key information included the main findings and their relevance to the study.

***Data Synthesis**:* The extracted data were synthesized to identify common themes, patterns, and gaps. A narrative synthesis approach integrated findings from various studies to provide a comprehensive overview.

***Justification for Literature Review**:* The literature review method was chosen to synthesize existing knowledge comprehensively, identify themes and gaps, and inform future research. It provides a broad overview and helps understand the complex nature of the study.

***Inclusion Criteria**:*

- Studies published between 2010 and 2024
- Peer-reviewed articles, government reports, and credible organizational publications
- Focus on mental illness and access to inclusive SRH services

***Exclusion Criteria**:*

- Studies published before 2010
- Non-peer-reviewed articles, opinion pieces, and anecdotal reports without empirical data

***Analytical Framework**:* The study uses a modified version of DFID's theory of change for disability inclusion to explore key factors such as attitudes, behaviors, gender differences, stigma, and norms affecting the design and implementation of inclusive SRH programs. It examines best practices related to laws and regulations for stigma reduction and improving access to SRH services for individuals with mental illness [21]. The framework is based on the principles of the Convention on the Rights of Persons with Disabilities (CRPD) and the Sustainable Development Goals (SDGs). It addresses gender, mental health, stigma and discrimination, and assistive technology. The aim is to ensure that individuals with mental illness are engaged, empowered, and enjoy equal rights and access to services [21].

Figure 1. United Kingdom model for disability inclusion [21].

Results

The review presents available SRH challenges for people with mental illness, alongside evidence-based interventions from HICs. International conventions on disability have reaffirmed global commitments to improving SRH service access for people with disabilities including those with mental illness [22, 26]. Enhanced SRH service provision is a top priority of most counties and focus is been given to ensuring access and utilization throughout the life cycle based on population needs [27].

The conventions emphasize the need to integrate disability care into the design, implementation, monitoring, and evaluation of SRH programs. Strategies include strengthening health services to address SRH issues like gender inequality and promoting engagement with civil society organizations [23]. Despite these efforts, there remains a gap between available interventions and the specific SRH needs of people with mental illness in LIMCs [24, 23].

1. **Mental Health Service, Stigma, Discrimination, and Gender Issues:** Globally, high-income countries often integrate SRH services for individuals with mental illness into mental health and psychosocial services [28, 29]. However, in low- and middle-income countries, mental health care is frequently limited and primarily provided through primary health centers, posts, and municipal hospitals [30]. Studies have indicated that individuals in rural areas face challenges accessing specialized mental health services, especially when referrals to hospitals are required [31]. Some of these challenges can be mitigated by integrating basic and essential health packages into mental health services [32]. Additionally, other studies highlight the lack of dedicated female health workers in government mental health facilities [33].

   The lack of standardized and integrated SRH interventions for people with mental illness contributes to information inconsistency [34]. Research has shown that varying SRH intervention programs lead to different patterns of information regarding causes, barriers, and enablers related to SRH issues [34]. Data reliability is also challenged by non-harmonized data reporting systems, resulting in a gross underestimation of the incidence of mental illness and the associated health

service needs [35, 36]. This underestimation affects the system's ability to effectively plan and address these issues.

Although SRH services have traditionally prioritized women of reproductive age and young girls, studies consistently report challenges for women and girls with mental illness in accessing these services [37]. Moreover, women and girls with mental illness are often victims of sexual and gender-based violence, with some facing the risk of involuntary sterilization in extreme cases [38]. These issues are attributed to the stigma surrounding mental illness, marginalization, discrimination against women, and a lack of inclusive or integrated mental health service packages [38].

Despite these challenges, significant progress has been made in some developed high-income countries where SRH and mental health policies and interventions are designed inclusively, offering equal opportunities to all beneficiaries [39]. For example, in the United States, an integrated service approach has been adopted to facilitate easier access to SRH services for people with mental illness [40]. Public health clinics providing SRH services allocate specific hours for people with mental illness, allowing health workers to focus on clients requiring both mental health and SRH services [41]. Additionally, to reduce stigma at the point of seeking services, civil society organizations are empowered to support SRH services for people with mental illness within community health services [41]. The approach also addresses challenges related to referral systems and the distance to health facilities for people with mental illness residing in rural areas [41].

2. **Assistance, Empowerment, and Equal Rights:** The review highlights various factors affecting access to SRH services for people with mental illness, including poor knowledge of mental health and SRH barriers, lack of specific mental health empowerment, and inadequate prevention policies [42]. In developed countries, governments are establishing mental health centers for sex education and providing specialized SRH services specifically targeting people with mental illness [43]. For instance, the United Kingdom has implemented a national campaign on the health and well-being of people with mental illness during pregnancy and sexually transmitted diseases [44]. These initiatives focus on the right of people with mental illness to reproduce and access SRH services. Additionally, the initiatives offer economic empowerment opportunities and promote behavioral changes related to stigma reduction [45].

   In LMICs like Nigeria, low school enrollment for young people with mental illness is attributed to cultural beliefs and socio-economic barriers [46, 47]. Lessons from the United Kingdom's campaign strategy could address barriers related to societal attitudes and lack of support through comprehensive sex education and behavioral change programs [48].

3. **Equal Access to Services:** In Sweden, centers have been established to offer counseling, medical examinations, treatment, and therapy for people with mental illness [49]. These centers provide multi-professional services and are strategically located to enhance access. Staff are trained to maintain positive attitudes and confidentiality, contributing to improved SRH access for people with mental illness [50].

   This contrasts with the situation in LMICs, where efforts to establish counseling and psychosocial support centers for victims of sexual and gender-based violence among people with

mental illness have been hindered by inconsistent data on gender-based violence cases due to underreporting [51]. Reasons for underreporting include poor knowledge of reporting mechanisms, fear of stigma and discrimination, and denial or delay of justice for victims and their families [52]. Conversely, Australia has established a commission against violence targeting people with mental illness, enforcing laws to protect and support victims [53]. The Council of Australian Governments has enacted national policies to prohibit non-consensual sterilization and improve SRH commodity provision [54, 55].

Conclusion

Currently, there is no singular standard interventional approach to improve access and utilization of sexual and reproductive health (SRH) services. Different countries have adopted various methods to enhance access and address inequalities. A persistent approach in many countries is integrating SRH services with mental and psychosocial services. This method has proven effective, particularly in developed countries like those in Europe, the UK, the US, and Canada. Another intervention involves improving the skills, attitudes, and knowledge of healthcare staff regarding basic SRH services, such as contraception, emergency contraception, and delivery. These services are crucial for people with mental illness in LMICs.

The rights of people with mental illness to healthcare, including SRH services, are also a significant area for intervention. Efforts are underway to pass a mental illness bill into law, and the benefits of such legislation are evident from examples in other countries. For instance, Australia's government law enforcement agencies collaborate with the community to ensure the sexual and reproductive rights of people with mental illness. Finally, a multisectoral approach has been found most effective, as it involves various stakeholders in SRH care and people with mental illness.

LMICs have also been working to implement SRH interventions for people with mental illness, often adopting strategies similar to the UK model. Some countries have reported increased SRH service availability, improved provider attitudes, and better community support.

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