



Policy brief 15

Maternal mental health: addressing key vulnerabilities



Perinatal Mental Health Project

Caring for mothers, caring for the future

The vision of the Perinatal Mental Health Project (PMHP) is for all women to have access to routine mental health care during and after pregnancy as part of the package of maternal care. The Project develops, implements and evaluates maternal mental health models aimed at increasing the capacity of health workers and existing services. The PMHP partners with the public health system to address maternal mental illness among pregnant women in South Africa.



Introduction: Why the perinatal¹ period?

- Studies have found an increased rate of onset of depression in the perinatal period.
- Women have a significantly higher risk than men of developing depression and anxiety disorders. Pregnancy further increases the risk of mental illness, especially for women living in poverty.
- Postnatal depression affects 10% to 15% of women in developed countries. However, studies in KwaZulu-Natal and Cape Town report rates of 41% antenatal depression and 35% postnatal depression respectively.
- The national prevalence for common mental disorders (depression and anxiety) is 16.5%.
- Poverty is a very strong risk factor for mental illness: in South Africa, poor women are particularly at risk due to a range of related socio-economic factors.
- The antenatal period presents a unique opportunity to prevent postnatal mental health disorders. Research shows that only 3% of women who suffer from postnatal depression or anxiety did not have depression and/or anxiety during pregnancy.
- Pregnancy is often a time of increased contact with health professionals. In South Africa, most women will access antenatal services at least once during pregnancy.

1. The perinatal period refers to the time from pregnancy through to the end of the first year of life.

In 2002, a multi-disciplinary team at Mowbray Maternity Hospital, Cape Town, founded the Perinatal Mental Health Project.

The primary focus was to deliver a screening, counselling and psychiatry service to the midwife unit at the Hospital. Since then, the Project has expanded considerably, offering training to health workers and community-based workers, conducting research towards best practice care and engaging in advocacy work.

In 2008, the Project formalised a collaborative partnership with the Mental Health and Poverty Project (MHaPP), based in the Department of Psychiatry and Mental Health at the University of Cape Town. This has seen the reach of the work extend into other countries in Africa.

The Project also partners with the Western Cape Department of Health with expansion planned to Hanover Park, a high-risk community, in 2010.

Vulnerability during pregnancy

HIV/AIDS: Almost half (43.7%) of all people living with HIV/AIDS in South Africa have an identifiable mental illness which requires an intervention. Most women find out about their HIV-status during pregnancy. This can have a significant impact on their mental health. Mental illness has been proven to have a negative impact on a woman's HIV treatment and on her ability to access proper antenatal care during her pregnancy. Mental illness is also a significant factor in AIDS-related mortality among women. *I have been going through hell. I am so worried about my baby. I am afraid the baby will get the virus. And what if I get sick? Who will support this child?* ZUKISWA

Violence: In South Africa, there is an extraordinarily high level of violence against women. HIV is a proven risk factor for violence against women and mental illness, while mental illness is a risk factor for HIV infection and often a consequence of violence. Experiences of rape or physical, sexual or emotional abuse all increase the risk for mental illness. Of women who attend PMHP counselling services, 69% experience some form of abuse, either previously or currently. *I can't get the pictures out of my mind. I wake up with my heart beating, sweating. I keep seeing his face laughing...right now I just want to die.* BONGI

Lack of social support: South African women consistently report overwhelming feelings of isolation during pregnancy. Many women do not have a supportive partner, mother, family or community, or access to necessary social services. Of the women attending the PMHP's counselling service, 69% report an unsupportive partner while 39% report an unsupportive family. This is contrary to the popular notion that African women 'live in community'. *At home they are not supportive...I don't interact with others. Even if others are interacting freely, I am not free.* ZODWA

Mental illness in the mother can:

- limit access to proper antenatal care which may lead to obstetric complications
- cause her to default on PMTCT or other ARV regimes
- increase vulnerability to both communicable and non-communicable diseases, as well as infections, in both mother and child leading to increased hospitalisation
- impact on foetal brain development, e.g. poor motor and cognitive skills
- prevent her from finishing her baby's immunisation programme
- disrupt the mother-baby bond
- impact on infant development, e.g. stunted growth, behavioural and emotional problems which may last into childhood and adolescence
- lead to infant mortality
- lead to suicide or other conditions which increase maternal mortality

Refugee status: Findings indicate that African refugee women are particularly vulnerable to poorer general health. Psychological trauma, associated with political conflict, displacement, violence, loss of loved ones, torture, rape, dispossession and poverty are contributing factors. The lack of family and other support structures contributes to social isolation or exclusion. Discrimination and xenophobia can further exacerbate existing traumas and mental anguish.

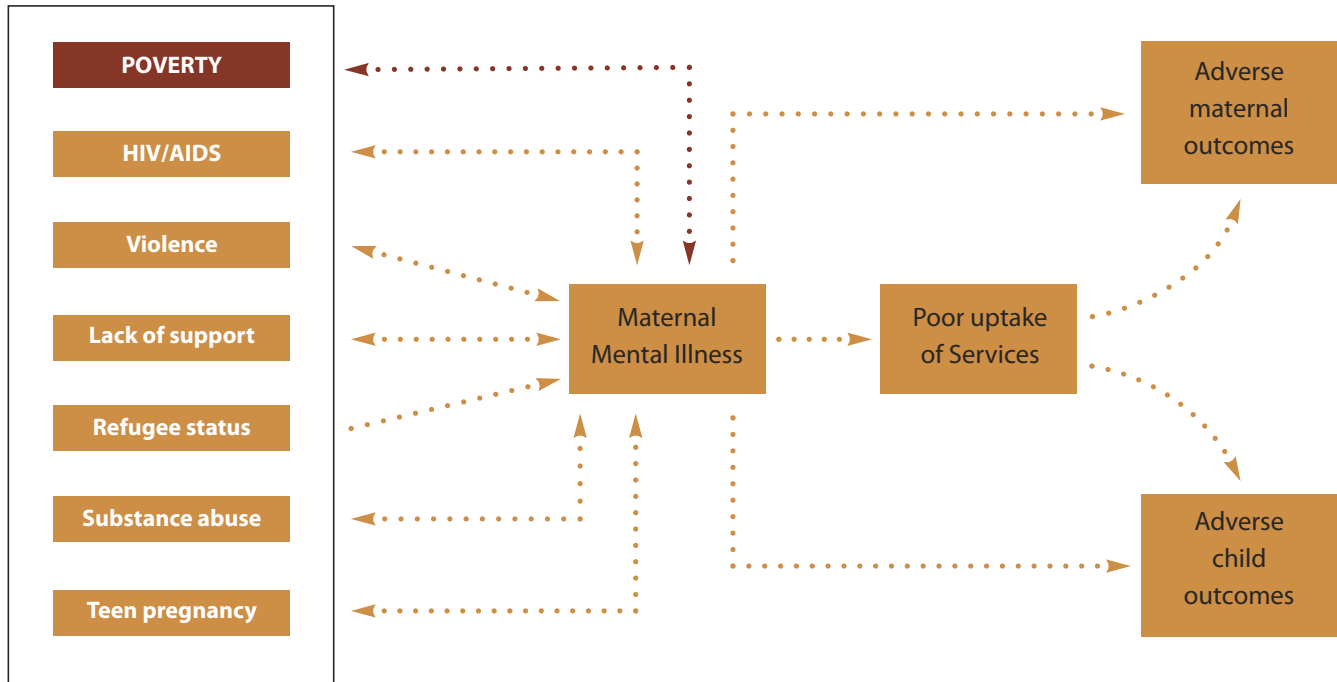
I can't let myself think about what happened at home. Nobody speaks about it. You can't trust anyone. Where can I go for help? FRANCINE

Substance abuse: Mental illness can lead to substance abuse, while substance abuse may trigger mental illness. The South African Community Epidemiology Network on Drug Use (SACENDU) indicates that substance abuse is on the increase in South Africa. Nationally, alcohol is the primary substance of abuse. In the Western Cape, Tik is ranked the second highest substance of abuse, however elsewhere in South Africa, Dagga is more commonly abused. Multiple drug use is common. Increasing numbers of people are seeking treatment and mortality rates linked to substance abuse have risen.

Teenage pregnancy: In developed countries, 26% of teen mothers develop postnatal depression. It is believed that the rate is twice as high in South Africa. Audit on suicide-related maternal mortality has shown adolescents to be the most at-risk group. They are often treated in a punitive or abusive manner by health workers.

Maternal mental health: Vulnerable groups and adverse outcomes

The diagram below outlines the relationship between some of the risk factors for maternal mental illness. Poverty has a compounding effect on these risks. Poor uptake of services is associated with adverse outcomes for both mother and child. The diagram arrows indicate where interventions can be made for positive effect.



PMHP Research

Evidence from over 1000 pregnant clients:

- One third (34%) of women who are screened qualify for counselling.
- Women who qualify for counselling are more likely to:
 - have no partner – 11 times more than those with a partner
 - have an unsupportive partner – 13 times more likely than those with a supportive partner
 - have experienced domestic violence – 24 times more likely than those without the experience
- Women who attend counselling:
69% experience significant problems with their primary support relationships
- Women who attended psychiatric services:
 - 45% reported unsupportive partners or families
 - 53% reported current or past abuse (any of the following: physical, sexual, or emotional)
 - 86% suffered from Major Depressive Disorder
 - 34% suffered from disorders in the Anxiety spectrum

Consequences of mental illness during pregnancy

Women experiencing perinatal mental illness have higher rates of disability and are compromised in their ability to care for their own needs or the needs of their children. Addressing the mental health needs of vulnerable mothers can have positive implications for women's, children's and social development. Yet, maternal mental health is missing from relevant policy and service planning. In contexts of social adversity, women's vulnerability to mental illness is higher. Thus, not addressing mental health problems actively, poses obstacles to achieving several Millennium Development Goals².

Current situation

One in three women in South Africa experience a mental health problem related to her pregnancy – three times the prevalence of developed countries. Primary care providers are generally not trained to detect psychiatric disorders. Therefore, access to treatment is severely compromised. Comparative studies across other developing countries show South Africa to have significantly higher prevalence, with a higher level of unmet need.

² Further information on Millennium Development Goals in: Mental Health and Poverty Project (MHaPP) Policy Brief 14 "Mental health and development".

Recommendations

- **Partnerships** developed with, and between, health managers and relevant stakeholders, incorporating regular feedback. This will ensure a responsive service which is supported, and championed, by those who deliver it and those who use it.
- **Staff capacity** increased by providing basic mental health training. Many health workers in South Africa feel overwhelmed by their workload. Mental health training leads to feelings of relief, increased morale, job satisfaction and empowerment. In addition, addressing the mental health needs of health workers leads to more empathic care for patients.
- **Mental health screening tools** developed which are informed by the local context, such as busy clinical settings, language needs of patients, including refugees, and variable levels of literacy and numeracy among health workers.
- **Mental health screening** incorporated within antenatal booking procedures helps to de-stigmatise mental health and improve uptake of services. This can:
 - **prevent** progression of mental health disorders, or the development of postnatal disorders
 - **promote** overall health of women and their children. Women who are mentally well have better physical health, are more likely to use health services appropriately and have improved treatment adherence.
- **Dedicated, on-site counsellors at maternity facilities** are required to make mental health integration a success. This allows for counselling appointments to coincide with antenatal appointments, thereby maximizing access for low-income women, and minimizing defaulting of appointments.
- **Social support** integrated with mental health interventions. These may include microfinance schemes, income-generating skills development and social networking.
- **Intimate partner violence** management protocol integrated into routine obstetric and mental health care.
- **Psychiatric services** should, where necessary, augment counselling. In non-urgent cases, the locus of care should remain with the counsellor.

Where can I read more about this issue?

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MHaPP website: www.psychiatry.uct.ac.za/mhapp

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