

MENTAL ILLNESS & REFUGEE WOMEN

Refugee women are particularly vulnerable to maternal mental illness.

Psychological trauma, associated with political conflict, displacement, violence, loss of loved ones, torture, rape, dispossession and poverty contribute to poorer general maternal health. The Perinatal Mental Health Project (PMHP) has, in its 8 years of experience, found that refugee status is a key factor contributing to mental illness in pregnant women.

Discrimination and xenophobia can further exacerbate existing traumas and mental anguish. Cultural norms surrounding pregnancy and the lack of family and other support structures at this vulnerable time contributes to social isolation, exclusion and psychological distress.

*The United Nations Refugee Agency (UNHCR) estimates that there are currently about **470,000** documented refugees and asylum seekers in South Africa.*

*Local experts believe that the actual number of refugees currently in South Africa could be as high as **8 million**.*



In South Africa, **one in three women** experience a mental illness related to her pregnancy.

The long-term negative consequences of maternal mental illness require urgent attention. The PMHP proposes preventative interventions for vulnerable groups of women, such as refugees, which include screening, counselling and providing psychiatric services.

Christine meets Charlotte

Christine arrived in South Africa from the Democratic Republic of Congo four years ago.

Christine struggled to get work and stay employed due to language difficulties. When Christine became pregnant for the second time, her partner did not want the child. He became verbally and emotionally abusive and was controlling with finances. She was forced to live on his meagre handouts.

Eight hours after giving birth to her second daughter, Christine was discharged from hospital and returned home. Despite her pain and exhaustion, she had to continue, alone, with her domestic obligations – washing clothes, cleaning the house, and cooking for her partner and children.

Maybe it wasn't a wise decision to bring this child into the world. I am a failure. How am I going to take care of this baby?

Christine's relationship with her partner deteriorated, and without any friends or family to support her, Christine felt completely alone. She became increasingly sad and stressed.

Feeling despondent, isolated and helpless, Christine found it difficult to bond with her new baby and had no energy to meet the demands of her 2 year old daughter. She wanted to 'run away from it all', but then was consumed with guilt for having such thoughts.

Cultural norms added to Christine's desperation. At the time of her pregnancy, her partner's parents had not yet paid lobola (dowry) for her. She was therefore not recognised as being married. Consequently, her baby could not be named, making it more difficult to bond.

Christine's stress and depression caused her breast milk to dry up. She was referred to Charlotte, the PMHP's French-speaking counsellor. At the time, she was 31 years old, and unemployed. Her daughters were 2 years and 2 months old.

Charlotte worked with Christine on acknowledging her feelings, and building a sense of her own self-worth and capabilities. Christine started to develop solutions to some of her problems, and felt empowered to negotiate a healthier way to communicate with her partner. She also accepted the help of a breastfeeding advisor.

Today, Christine loves being a mother. She is more able to manage stress effectively and to care for her own and her children's physical and emotional needs.

At first, help was like a slap in my face. But with counselling I recognised that I had a problem and that it was not my fault. I now have time with my children and the milk is flowing. The heavy cloud over my head has been swept away. I now take things one step at a time.

IMPACT

Mental illness causes the greatest decrease in health status of any chronic disease, and when present with other chronic illnesses, such as HIV, mental illness can worsen health outcomes more than any other disease combination.

Emotional distress in pregnant women can have long-term physical and psychological impacts on the foetus, infant and child. Maternal mental illness has been identified as a major obstacle to social development and achieving the Millennium Development Goals.

Loneliness, loss of identity, poverty and trauma are the main stressors that we see. Many refugee women have no one to talk to, and pregnancy makes them more vulnerable.

Charlotte Mande-Ilunga
French-speaking counsellor
PMHP

That is why the PMHP believes that **caring for mothers is caring for the future.**

Mental illness in the mother can:

- limit access to proper antenatal care which may lead to obstetric complications
- cause her to default on HIV and mother-to-child prevention treatments
- impact on foetal brain development, e.g. increased future risk of Attention Deficit Disorder
- increase vulnerability to both communicable and non-communicable diseases in both mother and child leading to increased hospitalisation
- prevent her from accessing immunization services for her baby
- disrupt the mother-baby bond
- impact on infant development, e.g. stunted growth, behavioural and emotional problems in her baby which may last into childhood and/or adolescence
- lead to infant mortality
- lead to suicide or other conditions which increase maternal mortality

The Perinatal Mental Health Project

The good news is that **mental illness is identifiable and treatable.**

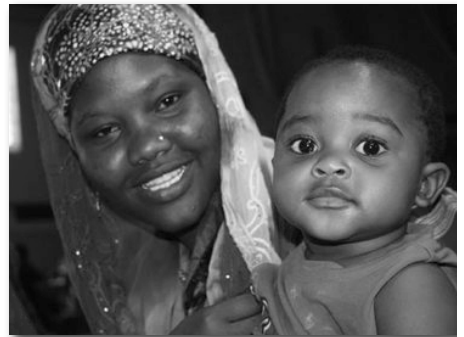
The innovation of the PMHP is its preventative approach. The Project does not only address women in crisis. Instead, screening large populations of at-risk women identifies those who are vulnerable. Therapeutic counselling then provides support and empowerment for women so that crises may be

The PMHP has received formal commendation from the World Health Organisation.

prevented or managed more effectively. Self esteem and a sense of agency may be restored in a safe and therapeutic environment.

In South Africa, there is an excellent uptake of maternity care services – 92% of pregnant women will go to a clinic. The PMHP has optimised this opportunity: mental health care is routinely integrated into maternal care. Poor women need not spend extra resources nor deal with issues of stigma. While they are attending for their pregnancy care, they can access mental health care **on-site.**

The PMHP model is based on proven interventions which have positive impacts for mother, child and long-term social development. It is also feasible for the local, resource limited context. In addition, the model advocates for partnerships within the public health sector, gaining buy-in from health workers and health managers.



The PMHP continues to provide this intervention within its resources, currently at 3 sites in the Cape Town area. The ultimate vision is to provide a proven model for use by the national Department of Health. The PMHP will continue to advocate for integrated maternal mental health services in accordance with the Mental Health Act of 2003.

**Read more about the PMHP at www.pmhpa.za.org
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