

## ABSTRACT

**M**ental health is a neglected topic, and that of women's mental health even more so, with the latter receiving little attention within the South African public health sector. This chapter provides a selective, focused overview of women's mental health issues requiring public sector attention in South Africa. It reports global and South African prevalence rates and burden of disease estimates for common mental disorders in women, focusing on depressive and anxiety disorders. Several key factors which impact on the mental health status of South African women are discussed, namely gender disadvantage, poverty, gender violence, HIV and peripartum depression. Policy and programme implications of women's mental health issues are noted, and recommendations for effecting a comprehensive, multi-sectoral approach to improving the mental health status of women are outlined.

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## INTRODUCTION

Mental health is a neglected topic, and that of women's mental health even more so, with the latter receiving little attention within the South African public health sector. This chapter aims to provide a selective, focused overview of the key concerns in women's mental health which must inform improved public health attention to this issue. Very little relevant South African research has been published in this area. Where necessary, international research findings have been used to contextualise the issues and to assist in delineating the areas where further South African research is needed.

The permutations of 'mental illness' and its psychiatric counterpart, 'psychiatric disorders' are too extensive to accurately reflect in a short chapter of this nature, and this chapter reports on the most prevalent and potentially most disabling conditions where prevalence and / or burden of disease is significantly higher amongst females than amongst males. As women are significantly more likely than men to suffer from depressive disorders and most anxiety disorders,<sup>a</sup> as well as unspecified psychological distress,<sup>1-9</sup> this chapter will focus on these common mental health disorders. International and local research is used in considering pertinent social correlates of depression and anxiety in South African women, specifically poverty, gender violence and HIV. A brief review of current South African policies pertaining to women's mental health and some recommendations for addressing the issues raised within the public health context will be offered.

Extensive key-word searches of major data-bases of peer-reviewed literature were carried out. In addition, hand-searching for relevant journals was done. The web sites of the South African Department of Health, various South African non-governmental organisations and research institutes and the World Health Organization (WHO) were searched for relevant 'grey' literature and documentation. This information was supplemented with materials known to the authors from professional experience. Where South African data were not available, data from similar contexts (i.e. specifically from African and other developing countries) that would provide some indication of issues that may be relevant in the South African context, are presented.

a Anxiety disorders include obsessive-compulsive disorder, panic disorder, post traumatic stress disorder, social phobia, specific phobia, agoraphobia and generalised anxiety disorder.

## EPIDEMIOLOGY

### PREVALENCE OF PSYCHIATRIC DISORDERS

No representative South African population-based studies of prevalence rates for psychiatric disorders have been published to date; nor are reliable gender-disaggregated prevalence estimates currently available. The South Africa Stress and Health Study<sup>10</sup> was conducted several years ago using a nationally representative sample, but the results are still to be published. A recent consensus estimate of prevalence rates for selected mental disorders in the Western Cape Province, South Africa,<sup>11</sup> derived to inform local public health service planning for mental health, found an overall prevalence rate for mental disorders of 25.0% for adults and 17.0% for children and adolescents. Among adults, the highest unadjusted prevalence rate was for nicotine use (48.0%), followed by alcohol dependence and major depressive disorder / dysthymia (both 15.0%). The anxiety disorders were the next most frequent: 6.0% for generalised anxiety disorder and post traumatic stress disorder, and 5.0% for simple phobia. For further prevalence data, see the chapter on Morbidity and Mortality Trends in South Africa in this Review.

### BURDEN OF PSYCHIATRIC DISORDERS

The most reliable available estimates of the burden of psychiatric disorders in South Africa (SA) are the revised burden of disease estimates for SA 2000,<sup>12,13</sup> which are a revision and extension of earlier work.<sup>14</sup> These population-based best estimates (based on an extrapolation of models) provide some indication of the relative non-fatal burden of neuropsychiatric<sup>b</sup> diseases in SA (Table 1 and Figure 1).

b The category of 'neuropsychiatric' diseases is a combined category consisting of mental and nervous system disorders. The term was used in the South African burden of disease revised estimates<sup>12,13</sup> following its use in other international burden of disease studies. It is used here because disaggregated information on the specific category of 'mental / psychiatric disorders' is not currently available.



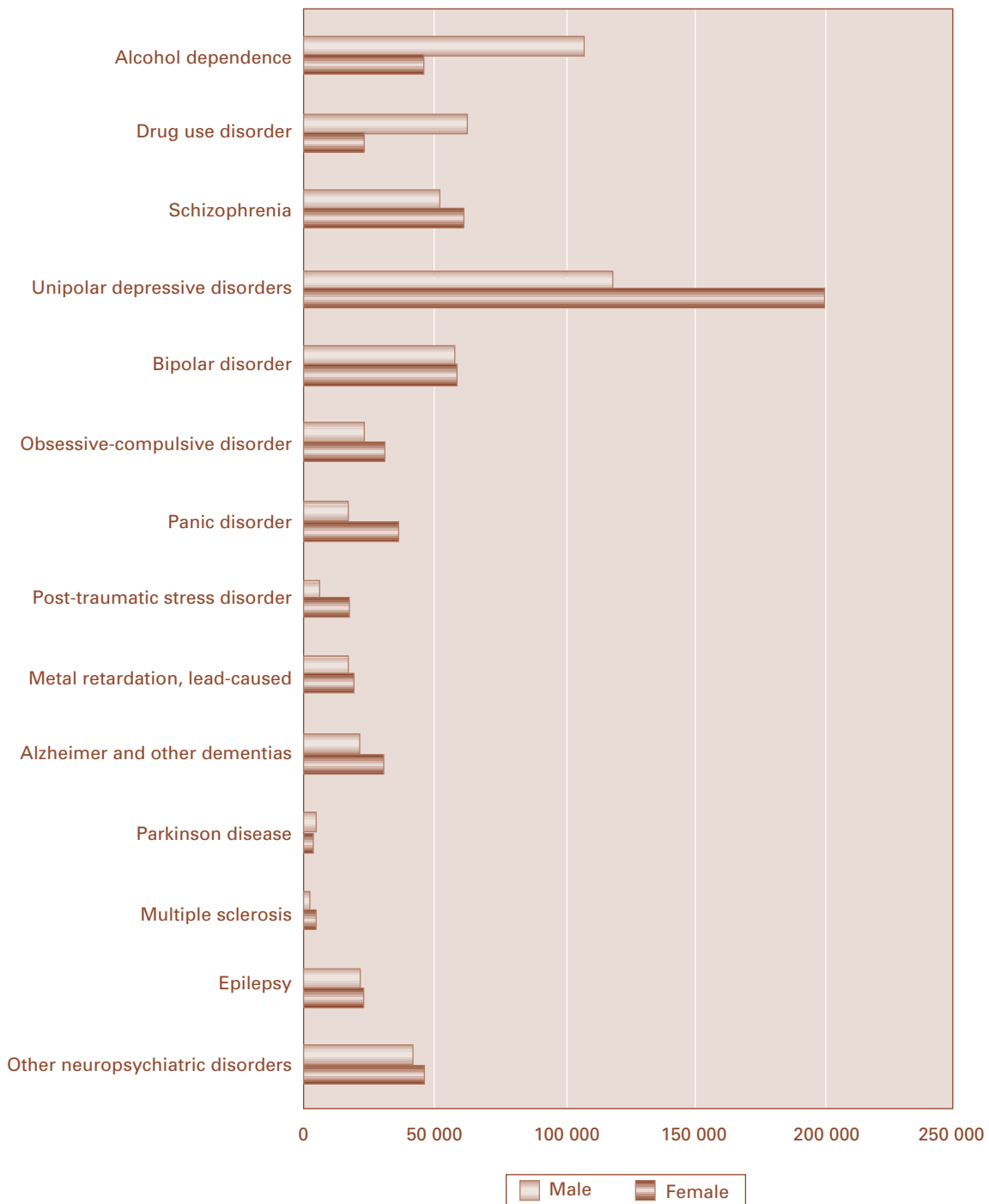
TABLE 1:  
Neuropsychiatric causes of years lost to disability  
(YLDs) in SA, revised estimates for 2000

Cause	% of total YLDs reported: females	% of total YLDs reported: males	% of total YLDs reported: persons
Unipolar depressive disorders	7.12	4.36	5.76
Schizophrenia	2.19	1.95	2.07
Bipolar disorder	2.08	2.14	2.11
Other neuropsychiatric disorders	1.66	1.55	1.61
Alcohol dependence	1.65	3.94	2.77
Panic disorder	1.27	0.63	0.96
Obsessive-compulsive disorder	1.10	0.87	0.99
Alzheimer and other dementias	1.10	0.79	0.95
Epilepsy	0.81	0.82	0.82
Drug use disorders	0.80	2.32	1.55
Mental retardation, lead-caused	0.65	0.65	0.65
Post traumatic stress disorder	0.63	0.22	0.43
Multiple sclerosis	0.14	0.07	0.11
Parkinson disease	0.11	0.18	0.14
Total neuropsychiatric conditions reported	21.32	20.48	20.91

Source: Adapted from Norman et al., 2006.<sup>13</sup>

Table 1 indicates that neuropsychiatric diseases account for an estimated 21% of the non-fatal disease burden experienced by South African women. Both Table 1 and Figure 1 show that whereas the estimated proportionate non-fatal burden of alcohol dependence and drug use disorders is higher for men, the estimated proportionate non-fatal burden of unipolar depressive disorders, panic disorder and post traumatic stress disorder is notably higher for women.

Figure 1:  
Neuropsychiatric causes by gender of years lost to disability (YLDs) in South Africa, revised estimates for 2000



Source: Adapted from Norman et al., 2006.<sup>13</sup>



## DEPRESSIVE DISORDERS

### PREVALENCE

Global and comprehensive reviews of general population studies concur that the lifetime prevalence of depressive disorders in women is significantly higher than in men.<sup>6,9</sup> Two recent systematic reviews of population-based studies in a range of countries found consistently and significantly higher rates of depression<sup>6,8</sup> and dysthymia<sup>6</sup> in women. In one review,<sup>6</sup> the female to male prevalence ratio varied between 1.2:1 and 4.8:1, with the conclusion that women are approximately twice as likely as men to suffer from major depression. Although intermittent depression and brief recurrent depression have received less research attention in population-based studies, the authors of one review<sup>6</sup> reported similar findings for these disorders. In the studies reviewed, no consistent gender differences were found in the prevalence rates of bipolar disorder.<sup>6,8</sup>

Üstün et al.<sup>15</sup> conducted a systematic review of population-based studies of depression in order to produce estimates of depression burden for the year 2000 for the WHO 2000 Global Burden of Disease study. Based on this review they estimated point prevalence (as opposed to lifetime prevalence) of major depressive disorder in 2000 for the WHO AFRO E region,<sup>c</sup> based on data from Zimbabwe,<sup>16</sup> Lesotho<sup>17</sup> and Ethiopia.<sup>18</sup> Regional point prevalence estimates were 2 173 per 100 000 (i.e. 2.2%) for females and 1 426 per 100 000 (i.e. 1.4%) for males. Chisholm et al.,<sup>19</sup> reporting on the same data set, reported the point prevalence rates reflected in Table 2. In the AFRO E region, prevalence was consistently higher for women than for men in all age groups over the age of 15 years.

TABLE 2:

Point prevalence of major depressive disorders in women for the WHO AFRO E Region

Age Group	Point Prevalence Rates (%)
15-29 years	2.1
30-44 years	3.4
45-59 years	3.2
60-69 years	2.6
70-79 years	1.1

Source: Chisholm et al., 2004.<sup>19</sup>

### BURDEN OF DISEASE

It is widely recognised that psychiatric disorders, and major depression in particular, contribute substantially to the non-fatal burden of disease.<sup>9,20</sup> According to the South African revised burden of disease estimates for 2000,<sup>13</sup> unipolar depressive disorder (major depression) was the second leading cause of years of life lost to disabilities (YLDs) after HIV, for South African women. Table 1 and Figure 1 indicate that unipolar depression accounts for the greatest proportion of neuropsychiatric disease burden measured in YLDs and that the proportionate burden of unipolar depressive disorder is much higher in South African women than in South African men.

### ANXIETY DISORDERS

Anxiety disorders constitute the most prevalent category of disorders in, for example, the US National Comorbidity Survey Replication.<sup>4,5</sup> No reliable representative South African prevalence estimates of anxiety disorders are available. Nevertheless, a recent systematic global review<sup>7</sup> found consistently higher prevalence in women than in men of each of the following: total anxiety disorder, panic disorder, phobic disorders and general anxiety disorders. There was little consistency observed for sex-specific prevalence rates of obsessive compulsive disorder.<sup>7</sup> Another recent evidence-based review of international research found that life-time prevalence of Post Traumatic Stress Disorder (PTSD) in women is higher than that in men.<sup>21</sup> The authors note that “women with PTSD arguably experience a greater symptom burden, longer

c The WHO AFRO E region includes the following countries: Botswana, Burundi, Central African Republic, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Uganda, United Republic of Tanzania, Zambia, Zimbabwe

course of illness and have worse quality-of-life outcomes than men”.

Table 1 and Figure 1 provide the available South African burden of disease estimates for anxiety disorders.<sup>d</sup> According to these estimates, panic disorder, obsessive compulsive disorder and post traumatic stress disorder each constitute a higher proportion of total YLDs for South African women than for South African men.

## COMORBIDITY AND COMMON MENTAL DISORDERS

International data indicate high prevalence rates of lifetime comorbidity of depression and anxiety, particularly in women.<sup>3,9,22</sup> Parker et al.<sup>22</sup> analysed data from the data-base of the United States (US) National Comorbidity Study<sup>3</sup> (conducted between 1990 and 1992) and concluded that “a proportion of the female preponderance in major depression and dysthymia in the general community appears determined by a primary sex difference in anxiety”.<sup>22</sup> No comparable South African data are available. Nonetheless, other authors are less than convinced of the usefulness of comorbid diagnoses from a public health perspective, particularly in developing countries. Patel<sup>23</sup> argues that “the diagnostic differentiation between depression and anxiety in general health care settings is not clinically valid”, especially in the light of the WHO multinational study<sup>24</sup> which found that “‘comorbidity’ of depression and anxiety exceeded 50%”.<sup>23</sup> Instead of studying these disorders separately, he and others chose to study a construct called “common mental disorders” (CMDs), defined as “non-psychotic”<sup>25</sup> mental disorders or “depressive and anxiety disorders that are classified in ICD-10 as: ‘neurotic, stress-related and somatoform disorders’ and ‘mood disorders’”.<sup>26</sup> In another article, Patel et al.<sup>27</sup> argue that “the concept of CMDs is valid in community settings because of the high degree of comorbidity between these categories and the similarity in their epidemiological profiles and treatment responsiveness”. In a recent review of the association between poverty and CMDs, Patel and Kleinman assert that there is “a consistent sex difference in risks for common mental disorders in all societies”.<sup>26</sup>

Although depressive and anxiety disorders have been called ‘common’ or even ‘minor’ mental disorders, this does not imply that their impact can not be severe. The range of psychiatric disorders is wide. Any specific disorder may have a mild, moderate or severe impact on psychosocial functioning. The course of a disorder may be restricted to one episode, comprise several discrete episodes, with the person functioning well between episodes, or in a smaller proportion of people, result in a lengthy or lifelong disabling condition.

## SOCIAL DETERMINANTS OF COMMON MENTAL DISORDERS IN WOMEN: GENDER DISADVANTAGE

### SOCIAL THEORIES OF MENTAL HEALTH AND ILLNESS

Social and gendered models of health recognise the roles of “both individual behavioural factors and material, economic and psychosocial factors, and their complex reciprocal relationships, in determining health and illness”.<sup>9</sup> From a public health perspective, social factors are particularly important. Desjarlais et al.<sup>2</sup> assert that there is substantial evidence of social determinants of women’s psychological distress: “poverty, domestic isolation, powerlessness (resulting, for example, from low levels of education and economic dependence), and patriarchal oppression, are all associated with higher prevalence of psychiatric morbidity (exclusive of substance disorder) in women”. Similarly, an evidence-based review<sup>9</sup> that explored social theories of depression in women emphasised the depressogenic effects of subordination and lower social ranking and found “ample evidence that depression in many women is a predictable response to severe events and difficulties in their environment and with those with whom they have ‘core ties’, that evoke a sense of humiliation, entrapment and lack of control over life”.

According to the same report, “common life stressors and events that are disproportionately experienced by women” include not only childbearing and reproductive events but “also include the impact of poverty, single parenthood, the ‘double’ shift of paid (often low paid) and unpaid work, employment status, lower wages, discrimination, physical, emotional and sexual violence

d No burden of disease estimates were reported for generalised anxiety disorder, social phobia, specific phobia or agoraphobia in this study.



and the psychological costs of childcare and other forms of caring work”.<sup>9</sup> Other reviews of the aetiology of women’s psychological distress have reported similar findings. Dennerstein et al.<sup>1</sup> claim that “stresses that have more impact on women and may contribute to a higher risk for depression include: physical and sexual abuse; sexual harassment; sex discrimination; unwanted pregnancy; divorce; poverty and powerlessness”.<sup>1</sup> Patel et al.<sup>25</sup> studied four low and middle income countries (Zimbabwe, Chile, Brazil and India) and found a consistent “association between CMD and female gender, older age, low education and economic deprivation” supporting several studies finding that the over representation of depressive and anxiety disorders in women is linked to multiple social roles, poor social and economic standing and consequent vulnerability to interpersonal, domestic and societal violence.

In SA, the lives of most women have been characterised by chronic social adversity and race / class and gender oppression and inequality of access to resources.<sup>28</sup> Below, we discuss key factorial issues identified as particularly aetiologically germane to depressive and anxiety disorders in South African women. These issues, which are partially constitutive of an overarching social context of gender disadvantage and discrimination,<sup>29</sup> are poverty, gender violence and HIV. They have emerged from international and local studies and reviews, particularly those focusing directly on SA or on low and middle income countries with similar contexts. A further issue that merits attention is peripartum depression.

## POVERTY

For epidemiological purposes, the relevant dimensions of poverty are socio-economic status, (un)employment and level of education.<sup>26,30</sup> Women, and especially African, Coloured and rural women, are over represented amongst the poor in SA. The rate of unemployment for females in all racial groups in SA is considerably higher than for males.<sup>31</sup> In September 2005, the highest rate of unemployment was amongst African females (37.1%). This was 10.3 times higher than that of White males (3.6%) and 1.4 times higher than that of African males (26.6%).<sup>31</sup>

More than half of all African women live in rural areas, and according to Kehler, African rural women are the

poorest 49% of South Africans.<sup>28</sup> Kehler<sup>28</sup> notes that “African rural women’s lack of access to resources and basic services are combined with unequal rights in family structures, as well as unequal access to family resources, such as land and livestock. This explains further why African rural women are not only poorer in society as a whole but also in their own families, and defines why their level and kind of poverty is experienced differently and more intensely than that of men”.

Patel and Kleinman,<sup>26</sup> in a comprehensive review of 11 population-based studies in six developing countries, found a consistently significant association between poverty and CMDs. Likewise, a meta-analytic review of population-based studies found that low socio-economic status (SES) individuals were significantly more likely to be depressed.<sup>32</sup> A systematic exploration of the reasons for this association is beyond the scope of this chapter. However, it is worth mentioning that poverty places severe constraints on personal choice in many dimensions<sup>2,33,34</sup> and that the resulting limitation in agency is likely to heighten the impact of other stressors. This is likely to be compounded by women’s relative lack of autonomy in decision making. Patel et al.<sup>27</sup> found that women’s limited autonomy in decision making was significantly associated with CMD. Furthermore, lower SES tends to be accompanied by higher levels of (often chronic) social adversity and severe life events, which pose major risks for depression.<sup>1,9,26,33-36</sup>

## GENDER VIOLENCE

The authors of an evidence-based review of women’s mental health<sup>9</sup> comment that “violence against women encapsulates all three features identified in social theories of depression – humiliation, inferior social ranking and subordination, and blocked escape or entrapment”. The prevalence of gender-based violence and abuse in SA has been increasingly studied in recent years, and there is convincing evidence of very high rates in girls and women of child sexual abuse,<sup>37-39</sup> rape,<sup>40-42</sup> forced first intercourse,<sup>43</sup> adult sexual assault by nonpartners,<sup>43</sup> sexual partner violence,<sup>43-45</sup> physical assault and / or abuse by current and ex-partners,<sup>40,44,45</sup> physical abuse during pregnancy<sup>40</sup> and emotional partner abuse.<sup>40</sup>

Whilst a systematic review of the social aetiology of gender violence is beyond the scope of this chapter, it is noteworthy that Dawes et al.<sup>44</sup> reviewed recent literature and found that significant “socio-cultural predictors of spouse abuse include the co-occurrence of low male SES, male approval of violence as a mode of conflict resolution, and support for male power over women”. They found that in a South African population-based sample (n = 1 198), significant correlates of partner violence were poverty (low income), being African or Coloured (although they acknowledged that in the South African context, race may be confounded with poverty), low levels of education, youth and cohabitation (as opposed to marriage).<sup>44</sup> Jewkes et al.,<sup>46</sup> who studied domestic violence in community based samples in three South African provinces (n = 1 306) and conducted extensive regression analyses, argued that their own findings “suggest that domestic violence is most strongly related to the status of women in a society and to the normative use of violence in conflict situations or as part of the exercise of power”. There is growing support<sup>9,44,47-50</sup> for this emphasis on the cultural influence of “ideologies of male superiority, supporting violence to women, particularly in economically stressed communities”.<sup>44</sup>

The WHO<sup>9</sup> asserts that “regardless of whether violence occurs during childhood or in adult life or is primarily physical, sexual or psychological, there is now incontrovertible evidence that women who have experienced violent victimisation, manifest greatly increased rates of depression, anxiety, PTSD and other psychological disorders in adult life compared with their non victimised counterparts”. Globally, depressive disorders and PTSD are significantly associated with male physical and sexual violence against girls and women, and are the most common psychiatric sequelae.<sup>9,51</sup> Comorbid diagnoses following gender violence are common.<sup>9</sup> In a cross-sectional survey<sup>27</sup> of women aged 18 to 45 years in Goa, India, marital sexual violence was a significant predictor of CMDs.

## HIV

Researchers have begun to explicate the common aetiology of the twin local epidemics of HIV and gender violence.<sup>50</sup> While gender violence has been found to

contribute to the prevalence of HIV in South African women, the rate of both is exacerbated by oppressive patriarchal cultural beliefs and gender (and other social) inequalities.<sup>44,49,50,52-55</sup> It is highly germane to note that much of women’s psychological distress is rooted in these same cultural patterns and social inequalities. Furthermore, women’s psychological distress is compounded by the effects of these epidemics.<sup>20</sup> Further local research into the interlinkages between these health issues is warranted.

In the South African context the prevalence of HIV sero-positivity is much higher in women than in men. In the latest 2005 national survey of the general population, HIV prevalence rates were 13.3% in females and 8.2% in males.<sup>56</sup> In younger females, the rates were significantly higher than for males.

**TABLE 3:**  
Prevalence of HIV sero-positivity in SA: males and females

Age Group	Female (%)	Male (%)
15-19 years	9.4	3.2
20-24 years	23.9	6.0
25-29 years	33.3	12.1

Source: Shisana et al., 2005.<sup>56</sup>

In the older age groups, prevalence was higher in men than in women. The Department of Health’s national HIV and syphilis sero-prevalence survey of pregnant women attending antenatal care for the first time during the current pregnancy in October 2005 in SA (n = 16 510)<sup>57</sup> found a rate for HIV sero-positivity of 30%.

Evidence-based reviews have reported significant correlations between HIV sero-positivity and a range of psychopathology and psychological distress.<sup>20,58-61</sup> Reported associated psychopathologies include delirium, dementia, personality disorders, mood disorders, PTSD, suicide and suicidal ideation.<sup>20,59,62-66</sup> Nevertheless, the mental health risks of HIV in developing countries and particularly with respect to female populations have received little research attention.<sup>20,61</sup> Morrison et al.<sup>67</sup> found a significantly higher prevalence of depression in a sample of HIV sero-positive US women than in a comparison sample of HIV



sero-negative women. High rates of depression (30% to 60%) in sero-positive women have been reported from community samples in the United States.<sup>67</sup> South African studies with clinical samples found significantly higher rates of depression and PTSD in HIV-positive women than in HIV-positive men.<sup>60,61,65</sup> However, it is noteworthy that whereas sexual violation was found to be a significant predictor of PTSD in seropositive women, PTSD was not significantly related to the diagnosis of HIV.<sup>65</sup> Similarly Freeman, in his paper on the potentially disastrous mental health implications of the HIV epidemic in SA,<sup>20</sup> points out that comorbidity between HIV and psychopathology does not imply that the psychopathology was caused by the presence of HIV (or vice versa). Nevertheless, comorbidity has important implications for prevention and treatment, both of HIV and AIDS and of the associated psychopathology.<sup>20</sup>

Poverty, adversity and HIV place considerable strain on social networks and particularly on women, who tend to carry the disproportionate burden of caring, not only for their own families but for others in their social networks, and may thus be especially vulnerable to stress 'contagion'.<sup>1,9,20,36</sup> A recent South African qualitative study of primary caregivers of people living with AIDS found that care giving, especially in the context of poverty, insufficient support and stigma, was highly stressful and debilitating.<sup>68</sup> Furthermore, Freeman highlights the vulnerability to secondary stress of "the formal caregivers, the health and social service workers, and even the community volunteers who work with people living with AIDS".<sup>20</sup> It is noteworthy that the majority of workers in these categories are women.

Freeman<sup>20</sup> comments on the stressors and grief experienced by the families of those who live with and die of HIV-related diseases. Grief after the death of a family member is often compounded by the associated loss of income, social and material support. Such material losses appear to be particularly distressing to women, who are more likely to be economically dependent on other family members. Furthermore, HIV-positive women's access to care and support for their own illness is constrained by their roles and by expectations:<sup>69</sup> they bear the greater burden of caring for the sick in the community, have limitations on their own access to care due to continuous nature of house-

hold work, limitations on how they may acceptably conduct their activities and cultural norms which discourage females from discussing sexuality. Fear of violence or abandonment may also prevent women from seeking treatment and support for their positive status.<sup>69</sup>

## PERIPARTUM DEPRESSION

Peripartum psychopathology, especially depression, is highly prevalent in women globally<sup>70</sup> and even more so in developing countries where, as Cooper et al.<sup>71</sup> point out, mothers are more likely to suffer from depression and socioeconomic stressors. Research in Khayelitsha found prevalence rates of 34% (approximately three times higher than international estimates) of maternal depression at 2 months postpartum.<sup>33,70-74</sup> Whereas postpartum psychosis is strongly linked to biological factors,<sup>1</sup> there is little evidence that the cause of postpartum depression is primarily biological.<sup>75</sup> Rather, available international evidence points to psychosocial aetiology.<sup>75</sup> According to evidence-based reviews, significant predictors include stressful life events, unemployment, poor interpersonal relationships and lack of social support.<sup>1,75</sup>

Stein et al.<sup>76</sup> also highlight the risks to mental health of the combination of pregnancy and HIV. They point out that "the relatively few studies of women with HIV have shown consistently that the psychological impact of being HIV-positive is profound and may be especially severe during pregnancy. Most women in Africa discover their HIV status during pregnancy. Thus, a mother is diagnosed with a life threatening condition, while at the same time preparing to bring a new life into the world. The studies that have been conducted suggest that a significant proportion of such women experience depression and suicidal ideation, as well as disruption of their social and material support networks".

In one study in Khayelitsha,<sup>33</sup> the following socio-economic predictors were found to be significant: "a lack of financial support from the father, the father being negative towards the infant, the mother describing herself as receiving no support or help, the infant being unplanned, and the infant being unwanted". The authors argued that the high absolute prevalence in a relatively homogenous sample of poor women indicated

that poverty was likely to be a risk factor. Rochat et al.<sup>77</sup> studying prevalence of depression among women undergoing first-time HIV testing in prevention of mother-to-child transmission programmes (PMTCT) in rural northern KwaZulu-Natal, found a point prevalence rate of depression of 41%. Participants did not know their HIV status when depression assessments were made. Factors significantly and independently associated with increased depression scores included an unplanned current pregnancy, absence of a regular household income and the perceptions of reduced access to household financial resources following an HIV diagnosis and of discrimination in access to health care. It appears likely that with a high prevalence of depression during pregnancy in this sample of poor women, poverty may have been a risk factor.

## LAWS, POLICIES AND PROGRAMMES TO ADDRESS WOMEN'S MENTAL HEALTH ISSUES

### 'HEALTHY' POLICIES

'Healthy' policies are non-health policies which indirectly promote (mental) health by improving the political, economic, social, cultural, environmental, and other factors which impact on health status.<sup>2</sup> Complete physical, mental and social wellbeing is best attained in an enabling environment which offers peace, shelter, education, nutrition, income, a stable ecosystem, sustainable resources, social justice and equity.<sup>78</sup> The literature reviewed in this paper suggests that to build an environment such as this for women, policy and practice must:

- ◆ Prioritise approaches which address the gendered inequalities which impact on women's wellbeing, in particular those aimed at improving women's social and economic base within society;
- ◆ Promote participation of women as agents of change in economic, social and political processes;
- ◆ Provide appropriate services and supports to prevent mental health problems in women; and
- ◆ Support the attainment of optimum recovery and functioning for women with mental health problems.

## THE NATIONAL LEGISLATIVE AND POLICY FRAMEWORK

South African gender equality provisions are enshrined in the Bill of Rights of the Constitution of the Republic of South Africa<sup>79</sup> and guided by international and regional treaties such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)<sup>80</sup> and the policy and institutional framework for gender mainstreaming in the Southern African Development Community.<sup>81</sup> The National Gender Machinery (NGM), comprising the Commission for Gender Equality, Parliamentary Joint Monitoring Committee for the Improvement of the Quality of Life and Status of Women, the Office on the Status of Women, and civil society, informs and monitors the inclusion of women's needs in activities of the state and broader society.<sup>82,83</sup> South Africa's gender policy framework<sup>84</sup> addresses women's needs for access to basic resources in society, and to the power and decision making processes within government, the workplace and the community. It provides sectors and government departments with a framework and process for promoting equal access to goods and services for women and men.<sup>83</sup> Many departments have gender units or gender focal persons, and a gender policy guideline in place. Within health, the gender policy guidelines for the public health sector<sup>85</sup> are available to guide public health sector progress towards implementation of South Africa's gender related commitments.

### IMPROVING WOMEN'S SOCIAL AND ECONOMIC BASE

#### Employment and social assistance

Women remain the poorest, lowest paid workers in SA, with gains in political rights not matched by gains in social and economic rights.<sup>82</sup> There is legislative and policy support for improving women's economic position, but the implementation of these laws and policies have not yet led to substantive improvement in the lives of poor working women. For example, the Employment Equity Act<sup>86</sup> prohibits unfair discrimination against, and provides for affirmative action to ensure that Previously Disadvantaged Individuals (PDI) are appointed, retained, developed and protected from barriers to employment, and where necessary, reasonably accommodated within the workplace. Yet this legislation has little impact on the



lives of women who are unemployed, working in low paying sectors such as the domestic, retail or informal trade sector, or within the home. For formally employed women, implementation gives little practical attention to “reasonable accommodation” of issues which may impede the progress of women, such as the impact of their multiple roles, their childcare needs, and sexual harassment in the workplace.<sup>87</sup>

Programmes to address the economic disadvantage of women are also offered by poverty alleviation strategies within the social welfare system, through programmes such as the community based public works programme, funded by the social security and welfare budget, and via social assistance grants.<sup>82</sup> Again, the constraints of available resources and competing priorities have not yielded satisfactory coverage by these programmes. For example, social grants provide assistance to poor girls and boys through the child support grant for children under-14 years, and the foster care grant for children less than 18 years. A care dependency grant is also available from 1 year to less than 18 years for disabled children requiring permanent care or support services. Mentally and physically disabled women and men who are unable to support themselves due to their disability may be eligible for a disability grant from 18 to 60 years (women) or 18 to 65 years (men). Women are eligible for an old age grant from the age of 60 years. As yet, these social assistance grants do not provide economic relief to poor women between the ages of 19 and 59.<sup>88-90</sup>

### Elimination of gender-based violence

Butchart et al.,<sup>91</sup> reviewing the changing ideological and policy perspective on violence in SA, describe a transition in the early 1990s from policy supporting state-entrenched violence, and violence as a means to political power, to policy which, in a rights based post-apartheid society, addresses the consequences of pre-democracy violence on the mental and social wellbeing of South African citizens. The pervasive impact of gender-based violence has placed it high on the political priority list.<sup>92-94</sup> The establishment of the NGM and the promulgation of the Prevention of Domestic Violence Act<sup>95</sup> are tangible expressions of South Africa's commitment to eradicating gender violence. The prevention of violence, and services for

redress, social and psychological support for victims of violence have been foregrounded in policy, with “child abuse, women abuse, assault and other forms of criminal violence as discrete sub-categories” requiring attention.<sup>91</sup> The National Crime Prevention Strategy, launched in 1996,<sup>96</sup> prioritised a focus on preventing gender violence and supporting victims of such violence within services provided by its victim empowerment programmes (VEP). Mental health services within this framework focused on providing counselling and support services for victims of violence, particularly women and children.<sup>91</sup> Still, despite this effort, there remains a gap between policy and practice which poses a significant barrier to the prevention of the abuse of women today. For example, Vetten<sup>94</sup> found little evidence for financial planning and resource allocation to implement the Domestic Violence Act. Furthermore, the health, social development and criminal justice sectors have limited resources for the development of support services, especially in rural areas, and where services exist, the judgemental attitudes of service providers may also impact on the protection of women from abuse.<sup>92</sup> Further, Jewkes<sup>93</sup> draws attention to the potentially disempowering effects of framing women exposed to gender violence as “victims of violence needing protection”. Butchart et al.<sup>91</sup> support this view and advocate a shift from broad-based conceptual strategies on “victimisation” to the development of local, evidence-based interventions, grounded in scientific analysis of the violence impacting communities, and in capacity for sustained implementation of interventions within the criminal justice, social, health and other systems.

It has been argued<sup>91</sup> that “effective policies for preventing violence must be firmly grounded in science and attentive to unique community perceptions and conditions. Scientific research provides information essential to developing such policies and prevention strategies and methods for testing their effectiveness”.

## PROMOTING WOMEN'S PARTICIPATION

The participation of women in policy and programme development, whether aimed at poverty alleviation, improving the mental health of women and men, boys and girls, reducing the impact of HIV, or any other priority public health concern, is also central to the success of these policies and programmes. Policy and programme developers should be mindful of power relations and cultural practices which separate available or preferred settings for the participation of men and women. The current practice of including women in traditionally male dominated settings is insufficient, and should be expanded to include settings in which women are already located, to maximise women's involvement in strategies geared towards improving their health. At the same time, programmes which support prosocial models of masculinity and discourage and ultimately eliminate anti-social, violent male behaviour are urgently needed.<sup>47,50,69,97</sup>

## HEALTH POLICIES IN SUPPORT OF WOMEN'S MENTAL HEALTH

While there is as yet no 'women's health policy' as such, the health sector has several policy directives which mandate the prioritisation of women's health concerns: The White Paper for the Transformation of the Health System in South Africa<sup>98</sup> identifies women, especially rural and urban poor women, as a priority group for consideration in health service provision, along with children, youth, the aged, the disabled and the poor. It provides for programmes vital to the wellbeing of women and their families, including programmes for nutrition, maternal, child and women's health, HIV and sexually transmitted diseases, environmental health, and mental health and substance abuse. In keeping with this, the Health Sector Strategic Framework, 2004-2009 (also known as the Ten Point Plan)<sup>99</sup> includes commitment to strengthen free health care for people with disabilities, programmes on women and maternal health, and programmes for survivors of sexual abuse and victim empowerment; to accelerate implementation of the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa;<sup>100</sup> and to improve mental health services, including the implementation of the Mental Health Care Act.<sup>101</sup> Similarly, the National

Health Act<sup>102</sup> prescribes that the best possible district based health services be equitably provided within available resources, mindful of "protecting, respecting, promoting and fulfilling the rights of vulnerable groups such as women, children, older persons and persons with disabilities". The Department of Health is mandated to consider these groups in the provision of available free health services, and to include services for sterilisation and termination of pregnancy, and social, physical and mental health care.

## MENTAL HEALTH POLICY

Within the mental health sector, almost ten years have passed since the Minister and Members of Provincial Executive Councils (MECs) for Health (MINMEC) approval of the National Health Policy Guidelines for Improved Mental Health in South Africa<sup>103</sup> in 1997. This policy focused on the involvement of all relevant governmental and civil partners in the development of an intersectoral mental health service framework at all levels of care and the integration of mental health care into general health care, deinstitutionalisation, rehabilitation and the development of a safety net of community based care. Although never formally disseminated for implementation, the policy was based on accepted international trends and national priorities for mental health care, and informed by public consultation regarding mental health needs. It set the tone for the principles and actions which drove National and Provincial Mental Health Offices' activities to transform mental health services, and provided a solid underpinning to guide the development of the Mental Health Care Act (MHCA).<sup>101</sup> The Act is now in force, Regulations have been developed, and provinces are currently in the process of developing capacity to come into compliance with the Act.<sup>e</sup>

Concerted action, however, is required to improve mental health care users' access to effective mental health services, and to work toward dismantling the fragmented services which have resulted from

e Other policies and guidelines developed include norms and standards for services for South Africans with severe psychiatric morbidity,<sup>104</sup> norms for community mental health services in South Africa,<sup>105</sup> policy guidelines for child and adolescent mental health<sup>106</sup> and norms for South African child and adolescent mental health services.<sup>107</sup> In keeping with the trend toward deinstitutionalisation, offering services which are least restrictive and which promote integrated community participation by persons with mental disability, a policy guideline for psychosocial rehabilitation<sup>108</sup> has also been developed.



the 'Cinderella' status<sup>109</sup> which has plagued mental health service provision to date.<sup>f</sup> Currently mental health services, for the most part, remain inequitably distributed geographically, with particularly poor access in rural areas.<sup>109,110</sup> The integration of mental health into primary health care services is still a struggle in many areas, with a poor 'fit' between traditional, medically-focused health service provision and the more appropriate biopsychosocial approach for mental health conditions.<sup>111,112</sup> Emsley<sup>110</sup> postulates that many men and women with anxiety, mood and other non-psychotic disorders are either not seeking help, are making use of alternative therapies such as those of traditional healers, or continue to be underdiagnosed and undertreated within primary health care settings. Mental hospital services are poorly developed in some areas, and overstretched in others, while community services remain underdeveloped and underfunded. Preventive and promotive mental health services remain few and far between.

De la Rey<sup>113</sup> and Orner<sup>114</sup> also highlight, respectively, the gender implications of mental health policy, and of legislative support for home and community based mental health care. They point out that it is mostly women, as primary caregivers, who will bear the psychosocial and economic impact of implementing this policy. The need to integrate people with mental disabilities into community life is incontestable, but requires concomitant resources to develop the necessary infrastructure, programmatic supports to community and household structures, and social assistance to implement this policy appropriately. This is essential to ensure that men and women with mental health problems and mental disabilities live dignified lives in society, and that people in their support system, the majority of them women, are positioned to provide support without any adverse impact to their own mental, physical and economic wellbeing. Freeman,<sup>115</sup> in response to Orner,<sup>114</sup> suggests that the gender-based implications of the MHCA<sup>101</sup> may more appropriately be addressed by mental health policy, plans and programmes which emerge in response to the provisions of the Act. The National Department of Health has prioritised the process of redrafting the

National Mental Health Policy this year,<sup>g</sup> providing an opportunity to effect these recommendations.

Although the process of drafting a mental health policy for women was initiated a few years ago,<sup>115</sup> this policy has not yet been finalised. The National Directorate: Mental Health and Substance abuse has supported projects which impact on women's mental health, such as a national project to prevent Foetal Alcohol Syndrome, launched in 1998, in collaboration with the Maternal Health Programme,<sup>83</sup> and a VEP funded pilot project to encourage positive interactions between at-risk mothers and their young children (The Mother-Child Bonding Project).<sup>116</sup> However, impact studies to measure the efficacy of the former are not yet available, and funding for the latter has not been allocated beyond piloting, again raising the question of the prioritisation of sustainable funding for effective programmes to address women's mental health issues.

#### Drafting an effective mental health policy

The WHO Mental Health Policy Project has produced a mental health policy and service package designed to assist governments with drafting and implementing national mental health policies, plans and programmes. The package can be accessed through the WHO Mental Health Service and Development web site.<sup>h</sup> Clear recommendations for developing a comprehensive policy are set out to inform both the development of a national mental health policy, and a women's mental health policy. As a first critical step, an extensive broad-based process of consultation is needed to inform a draft policy, followed by wide consultation to obtain consensus, to build political and resource support for the policy, and to support the development of a well-constructed strategic plan to effect the policy. To achieve this aim, WHO<sup>117</sup> recommends that it is realistic to allow one to two years for development of a mental health policy, and five to ten years for implementing and

<sup>f</sup> For example, the post of National Director for Mental Health within the National Mental Health and Substance Abuse Directorate has been vacant for more than 3 years.

<sup>g</sup> Personal communication, Mr Sifiso Phakathi, Acting National Director, Mental Health and Substance Abuse, May 2006.

<sup>h</sup> [http://www.who.int/mental\\_health/policy/en/](http://www.who.int/mental_health/policy/en/)

achieving changes.<sup>i</sup> Inclusion of the voices of women in the situational analysis, drafting and implementation of a (women's) mental health policy will be essential to incorporate women's own understanding of what leads to, constitutes and maintains their mental health or results in psychological distress or mental disorder in the South African context. Such an enquiry could focus attention on core interventions required to impact on the interpersonal, social and economic factors that influence women's mental health.

## BARRIERS TO IMPROVING WOMEN'S MENTAL HEALTH

The legislative, policy and programme environment in SA displays a strong commitment to the wellbeing of women. Despite this enabling policy environment, implementation has not reached sufficient scale to impact in practice on the physical and mental health and wellbeing of the majority of South African women. Women remain among the poorest of the nation and have limited access to available political, economic and social resources of society. Gender disadvantage, manifested, for example, in male violence against girls and women, and higher levels of poverty and HIV among women, continues to play a contributory role in the incidence of mental health problems experienced by South African women.<sup>118</sup> The above literature and policy review suggests several factors which may impact on this policy-practice gap, including:

- ◆ A lack of gender skills among policy makers and planners;
- ◆ Insufficient capacity and resources within the NGM;
- ◆ Insufficient staffing, power, authority and skills within departmental gender units to effect needed interventions;
- ◆ Insufficient prioritisation of government resources to programmes to enhance women's physical, mental, and economic well being, including mental

health and mental health-related programmes;<sup>118</sup>

- ◆ A lack of civil society organisation of the voices of poor women, including women with mental disability, to participate in national policy and budgetary debates on women's issues; and
- ◆ A lack of substantive political support, public health sector leadership and civil society action in foregrounding mental health as a public health priority.

## RECOMMENDATIONS

Several key areas require attention to impact on the improvement of women's mental health in SA:

**Policy developers and planners:** Women's health and mental health must be addressed within a gender-based framework of analysis. A review of economic policies and development strategies to ensure access of poor women to social and economic resources, such as networking capacity, education, training, employment, trade and social insurance, will have a direct impact on the mental wellbeing of women and their households. An assessment of implementation of progress and sustainability should be an essential aspect of such reviews.

**Government departments:** Mental health – and women's mental health – must be integrated as cross cutting intersectoral, departmental and programmatic issues. As resources are limited, women's mental wellness impact indicators should be integrated into all relevant public health efforts, including, housing, education, social development and labour. The needs of men and woman with mental disabilities should also be accommodated within the disability plans of these sectors.

**The mental health sector:** The integration of mental health care into general health must be stepped up. The Mental Health Care Act<sup>101</sup> provides a road map to inform policy and programme development, and low cost, effective treatments for common mental health disorders are available.<sup>26</sup> In order to most effectively utilise the limited resources dedicated to mental health, commitment to implementing a national plan of targeted (women's) mental health interventions is needed to guide action in the next period. Mental

i The Mental Health and Poverty project, a DFID-funded 5 year project (2005-2010) coordinated by the Department of Psychiatry, University of Cape Town, is currently undertaking an analysis of existing mental health policies and systems in four African countries, including South Africa. A key purpose of the project is to develop interventions which will assist mental health policy development and implementation in these countries, with a view to generating new knowledge on multisectoral approaches to breaking the negative cycle of poverty and mental ill-health in developing countries.



health programmes for women would need to target a variety of settings including the home, school, workplace, health care settings and other community institutions. For example, prevention programmes aimed at the early detection of psychosocial distress, postpartum depression or other mental disorders in young mothers in primary health care clinics<sup>116,119</sup> and community settings<sup>71</sup> suggest promising interventions for the prevention of postpartum depression.

We recommend that the mental health sector take the following steps to in order to foreground women's mental health:

- ◆ Firstly, a mental health perspective should be integrated into the National Women's Health Policy, when this is developed.
- ◆ Secondly, a gender-based analysis should be applied in order to clearly identify and respond to the gender implications of the implementation of the MHCA,<sup>114</sup> the redrafting of the National Mental Health Policy and of other mental health policies mentioned above.
- ◆ Thirdly, mental health and women's mental health could more clearly be integrated into the policies of other sectors, such as policies for inclusion in education, social security within the social development sector, special housing needs, criminal justice responses to violence against women, women as workers, etc.), and other health programmes (such as the health promotion, chronic care, care of the elderly and rehabilitation, HIV, reproductive health and the maternal health programmes).
- ◆ Fourthly, when human resources permit, it is crucial to complete the task of drafting a mental health policy for women. Such a policy should reflect and respond to the unique biological, psychosocial and economic issues which impact on women's mental health and their vulnerability to mental illness.

**Civil society:** National, provincial, district and community level opportunities should be available for advocacy activities by women, and persons with mental health problems. There is a need to rebuild a national women's lobby, and to strengthen the participation of people with mental disabilities within the national mental health and disability movements.

**Researchers:** There is a need for reliable population-based, gender-disaggregated information about prevalence, burden of disease and risk factors for mental illness in SA. The national health research agenda should include funded research to inform evidence-based public mental health interventions directed at improving the mental wellbeing of women, men, girls and boys. Greater collaboration between academic clinicians and researchers, on one hand, and public service planners and policy makers on the other, is needed to ensure that evidence based findings inform policy and programme development and implementation.

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