WHO CARES?

MOTHERHOOD, MENTAL HEALTH, and the INVISIBLE WEIGHT OF EXPECTATIONS

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Motherhood, Mental Health, and the Invisible Weight of Expectations

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‘If a physician of high standing, and one’s own husband, assures friends and relatives that there is really nothing the matter with one but temporary nervous depression - a slight hysterical tendency - what is one to do? My brother is also a physician, and also of high standing, and he says the same thing.

So, I take phosphates or phosphites, whichever it is, and tonics, and journeys, and air, and exercise, and am absolutely forbidden to “work” until I am well again.

Personally, I disagree with their ideas.

Personally, I believe that congenial work, with excitement and change, would do me good.’

Charlotte Perkins Gilman,
The Yellow Wallpaper

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1. Introduction

Depression and anxiety are among the most common mental health disorders globally, contributing significantly to the overall burden of disease. Prior to the COVID-19 pandemic, prevalence estimates reached up to 20.8% for depression and 28.8% for anxiety *(University Clinic of Psychiatry – Skopje, 2023)*. Gender-disaggregated data from the Institute of Public Health (2024) show that women in North Macedonia are diagnosed with these conditions at higher rates than men, reflecting broader patterns of gendered vulnerability *(Institute of Public Health of the Republic of North Macedonia, 2024)*.

These include, but are not limited to, postpartum depression and perinatal anxiety. While the causes are multifaceted—ranging from hormonal shifts to psychosocial stressors—there is broad consensus that social and psychological factors play a central role. Addressing these factors can reduce both the severity and duration of perinatal mood disorders.

In 2022, postpartum depression manifested in 27.6% of young mothers in North Macedonia, while 27.8% were affected by moderate to extreme anxiety (University Clinic of Psychiatry et al., 2023).

Perinatal mental health refers specifically to mental health conditions that arise during pregnancy or within the first year after childbirth.

Despite the recognized importance of maternal mental health, national policies in North Macedonia remain insufficient to address the widespread needs of mothers. With only one maternal mental health support group in the country, access to care is severely limited, particularly for women outside the capital[1].

Evidence consistently shows that stigma, limited-service availability, and the absence of regular postpartum mental health screening prevent many women from receiving timely support. Access to affordable, humanistic psychotherapy is limited, while inadequate childcare options further exacerbate psychological distress among new mothers. Research and expert insights also highlight that policies enabling shared, non-transferable parental leave contribute to a fairer distribution of caregiving responsibilities, improve women's labour market participation, and reduce mental health strain on mothers *(Bojchevska Mitrevska, 2024)*.

While public government discourse increasingly emphasizes the need to raise birth rates, this policy focus has not been matched by meaningful investment in maternal health and well-being. Women are encouraged to bear children, yet the structural conditions that shape their reproductive experiences—mental health support, accessible care, social protection—remain largely unaddressed. The country's transitional health system, uneven access to services, and lack of gender-sensitive policy frameworks compound the problem. With only one maternal mental health support group nationwide, most women—especially those outside the capital—are left without meaningful options.

This pattern of neglect is not unique, however the disconnect between policy ambitions to increase birth rates and the lack of structural support for women's mental and general health speaks volumes. Without sustained investment in maternal well-being, calls for higher natality ring hollow.

Addressing perinatal mental health is not a matter of individual resilience or private responsibility, but rather a question of public accountability, and of whether institutions are willing to center women's needs in the policies that so often depend on their unpaid labor and reproductive capacity.

1 Findings from key expert interview with representative from the University Clinic of Psychiatry – Skopje (2025)

2. Methodology

This contextual analysis was conducted using a qualitative, mixed-method approach combining desk research, expert consultation, and policy analysis. The aim was to generate an evidence-based overview of the determinants, current practices, and systemic gaps in perinatal mental health care in North Macedonia and to situate these within global and regional policy trends.

Literature review

A comprehensive review of psychological, psychiatric, sociological, and feminist literature was conducted to examine risk factors, screening practices, treatment approaches, and the gendered dimensions of perinatal mental health. Sources included peer-reviewed journal articles, books, institutional reports, and grey literature. The review provided the theoretical and empirical foundation for understanding perinatal mental health as both a clinical and social phenomenon.

Expert Consultations

Semi-structured meetings were held with practitioners and institutional representatives who work directly or indirectly with women during pregnancy and the postpartum period.

Consultations included:			
II	two gynecologists working in maternity wards,	I	one representative from a civil society organization providing mental health services and participating in drafting the national SRH strategy,
II	two psychiatrists,	I	one representative from the Institute of Psychology engaged in doctoral research on the concept of matrescence[2].
II	two representatives from UNFPA,		

Policy and Guidelines Review

The analysis included a review of national legal and policy documents relevant to mental health and sexual and reproductive health, including the Law on Mental Health, the National Strategy for the Advancement of Mental Health (2018–2025), and the draft Strategy for Sexual and Reproductive Health. Global and regional guidelines, including WHO's perinatal mental health guidance and comparative analyses of policies across the WHO European Region, were examined to assess the alignment of national systems with international norms.

Analytical Approach

The analysis followed a qualitative, thematic approach. Literature, policy documents, and expert interviews were reviewed for recurring patterns related to perinatal mental health, with particular attention to structural, relational, and gendered dimensions of mothers' experiences. Themes were identified both inductively (emerging directly from expert conversations and policy texts) and deductively (informed by existing feminist scholarship on motherhood, medicalization, and gender inequality). The integration of these two approaches allowed for organizing the material into coherent thematic clusters without predetermining the content in advance. A feminist analytical lens was used throughout the process, guiding attention toward how institutional arrangements, cultural norms, and power relations shape women's emotional and psychological wellbeing during pregnancy and postpartum. Evidence from literature, policies, and expert consultations was triangulated to ensure that the analysis captured not only clinical and theoretical perspectives but also the realities of service provision and the broader sociopolitical context in which maternal mental health is situated.

Limitations

The methodology is subject to limitations inherent to qualitative research and contexts with limited available data, including the limited number of consulted experts and the absence of comprehensive national indicators on perinatal mental health. These constraints informed, but did not restrict, the scope of the analysis.

2 Matrescence is a term introduced by Dana Raphael in the 1970s to capture the complex physical, emotional, and social transition of becoming a mother.

3. Risk Factors, Screening, and Psychological Interventions for Perinatal Mental Health Disorders

One of the most common contributors to poor perinatal mental health outcomes is perinatal depression.

> ***Perinatal depression is typically defined as a nonpsychotic depressive episode of mild to major severity that occurs either during pregnancy or postnatally (Gelaye, Rondon, Araya, & Williams, 2016).***

These depressive episodes may last from 4 weeks to more than 6 months and may be a recurring disturbance. Although postpartum depression receives more attention, depression can also affect mothers during the antepartum period. Antepartum depression may go underreported, as its symptoms are often attributed to discomfort and emotional adjustment associated with pregnancy.

It is also common to see people who suffer from perinatal depression share this diagnosis with one or more comorbid psychiatric conditions. The most frequently observed comorbidities include anxiety disorders, such as generalized anxiety disorder, panic disorder, social phobia, and obsessive-compulsive disorder.

There are varying numbers in literature regarding the incidence of perinatal depression. Some research posits that perinatal depression affects one in seven perinatal individuals *(Moore Simas, Whelan, & Byatt, 2023)*, while other studies estimate the prevalence to be as high as one in five women *(Gelaye et al., 2016)*. Additional sources report that major depression in the postpartum period may occur in 8%–15% of all new mothers *(Clark, Tluczek, & Wenzel, 2003)*.

The difficulty in establishing a consistent prevalence rate lies in the fact that perinatal depression often goes undetected, unreported, and untreated. More than 75% of those who screen positive receive no treatment *(Moore Simas et al., 2023)*.

These numbers also vary depending on the socioeconomic status (SES) of research participants. The incidence of postpartum and antepartum depression appears to be higher in lower- and middle-income countries—affecting approximately 20% of women in LAMICs compared to 10% in high-income countries *(Gelaye et al., 2016)*.

3.1. Risk Factors

In most research, interviews, and memoirs, a few common factors accompany the heightened risk of developing perinatal depression and any number of comorbidities that may come along with it.

Lack of social support

Raising a child takes a village.

Generally speaking, social support may reduce the extent to which situations are seen as stressful. Research into maternal support has found that those mothers who have good support networks cope better than those without one. The social support, specifically that of other women who provide a non-critical intimate relationship, may help mediate stress in times of change and difficulty which motherhood tends to bring. Collins et al. *(1993, as cited in Arnold-Baker, 2023)* found that mothers who had good social support during their pregnancy experienced better progress through labour.

A prime example of the effects of social isolation during and after pregnancy can be seen thanks to studies conducted following the global COVID pandemic. A study done by Rokicki (2024) found that women from across racial and socioeconomic backgrounds experienced social isolation as a result of the pandemic, which acted as a significant predictor of perinatal depression. The pandemic magnified underlying symptoms, increased stress and social isolation, and disrupted access to mental health care. In this study majority of women shared that the pandemic prevented their friends and family from visiting them during pregnancy and the postpartum period. This reduced social support had a major impact on their ability to manage their PPD symptoms.

Poverty/low SES

Furthermore, as a result of the COVID-19 pandemic, financial strain was magnified and acted as extra stress for new parents. This loss of income had a major impact on the mental wellbeing of new mothers and parents in general. For example, one woman who experienced homelessness during her pregnancy and postpartum period expressed how COVID-19 exacerbated the already substantial challenges in finding affordable housing *(Rokicki, 2024)*.

Due to systemic and structural factors, minoritized groups experience a higher burden of stress which contributes to higher rates of perinatal mental health symptoms and conditions. It does not help that treatment rates for perinatal mental health conditions are often inequitable across racial and ethnic patient groups, particularly for perinatal depression. *(Deichen Hansen et al., 2023)*

A few studies have reported culture-specific factors contributing to perinatal depression. In some cultures, notedly Asian cultures, but also including our own eastern European culture, a gender bias exists where there is preference for a male first-born child. This gender-preference has been reported to be a stressful experience for some women, as men are seen as having inherent value in that they continue the family name and legacy. Subsequently, mothers who give birth to a female child are often blamed for the birth with increased risk of depression compared to mothers who give birth to a male child *(Gelaye et al., 2016)*.

Partner relationship satisfaction

Evidence from recent studies underscores the relationship between partner relationship quality and perinatal mental health. Schwarze et al. (2024) report that general marital instability and poor interpersonal functioning during the transition to parenthood are associated with increased maternal depressive symptoms. Relationship quality was found to decline significantly over this period. Although the study does not establish a clear causal direction, these findings suggest that diminished partner support may exacerbate perinatal depression and anxiety.

Complementing this, Carona et al. (2024) show that higher partner relationship satisfaction is linked to lower postpartum psychological distress and higher levels of positive mental health, with maternal self-efficacy and psychological flexibility functioning as sequential mediators. These results indicate that supportive partner relationships may enhance maternal confidence and capacity to cope, thereby contributing to improved mental health outcomes during the perinatal period.

Childhood & subsequent IPV

Early life abuse is a predictor of both physical and mental repercussions in later life. In their 2015 study of pregnant Mexican women, Lara et al. found that a history of sexual abuse in childhood was associated with 2.49-fold increased odds of antepartum depression.

Intimate partner violence (IPV) includes physical, psychological and sexual abuse. As people who have a history of abuse in childhood are more likely to go on to experience IPV later in life, the combination of these two factors plays a role in the likelihood that one will face poor perinatal mental health. Exposure to IPV results in social, emotional and physical isolation, separation, loss, and an unpredictable/unsafe home environment, all of which significantly worsen perinatal depression.

History of depression/Depression and anxiety during pregnancy

Moreover, women who have previously experienced bouts of depression, whether chronic or episodic, are at an increased risk of experiencing perinatal depression. Past experiences with the psychiatric system and subsequent stigmatization may also provide a barrier to further treatment of poor perinatal health, either due to fear of stigma or to avoid further disappointment and trauma from poor psychiatric interventions. Cooper & Murray (1995) found that women whose first onset of depression was in the postpartum period were at increased risk for future PPDs but not for depressive episodes that occurred outside of the postpartum period.

Unintended pregnancy

Even with planned pregnancies, the disruption of the normal course of life may leave new mothers at a loss *(Arnold-Baker, 2021)*. In unplanned or unwanted pregnancies, additional stressors can further increase the risk of postpartum depression. Women experiencing unintended pregnancies often face psychosocial stress related to unexpected interruptions in their education, career, or other life plans. Moreover, the internal conflict associated with deciding whether to continue or terminate the pregnancy can create further emotional strain *(Qiu, Zhang, Sun, Li, & Wang, 2020)*.

As we later will discuss in this analysis, preventative prenatal care provides an opportunity to diagnose and address pre-existing mental health conditions that may intensify during the postpartum period. However, compared with women with intended pregnancies, those with unintended pregnancies often begin prenatal care later and have fewer opportunities to address these issues. Some may also live in environments that are not conducive to pregnancy, such as unstable family situations, insecure housing, or economic stress, which can contribute to nervousness, emotional fluctuations, and reduced psychological resilience during pregnancy.

Hormonal shifts (biological basis)

Some women may be particularly susceptible to depression in the postpartum period due to a biological sensitivity to changing levels of hormones.

Research done by Bloch et al. (2000) suggests that changes in gonadal steroid levels during childbirth may contribute to depressive symptoms.

Emerging research into gene expression profiles has shown potential in distinguishing depressed from nondepressed individuals, with some studies reporting classification accuracies around 84%. However, perinatal psychiatric conditions are multifactorial, and current evidence does not support the view that genetic factors alone are responsible for their incidence *(O'Hara, 2013)*.

In a practical sense, many of these risk factors can be readily identified, and health care providers can monitor these women more closely during the postpartum period to prevent or intervene early in the development of PPD. One does not have to wait for the postnatal period to prepare for any mental health struggles that may come with childbirth. The period before delivery may be key to setting up safeguards and building a support system for the coming times.

Therefore, screening and early detection are essential.

However, ***PPD often cannot be predicted.*** Even mothers with no past incidences of depression, no obstetric complications and easy deliveries may develop antepartum or postpartum depression. It may also occur after a second or third child, while the first pregnancy may have passed with no incidents.

This is why universal screening using standardized tools is needed - at least once during pregnancy and again postpartum (American College of Obstetricians and Gynecologists [ACOG], n.d.).

3.2. Screening of Perinatal Mental Health Challenges

Motherhood is often portrayed as a time when women are expected to be happiest, to take on their new identity in stride and deal with any problems that may arise as though they have been training for the role of mother their entire life. Additionally, motherhood and any parenting choices are seen as public domain, where everyone's opinion and criticism of one's parenting is free to be shared.

During this period, when society expects women to cope well and appear content, the perceived stigma surrounding mental illness tends to increase. Across perinatal populations, barriers to accessing mental health care include psychosocial complexity, history of trauma, fear of stigma, affordability of care, and limited knowledge - both among patients and providers - of how to navigate the mental healthcare system.

To address these perinatal mental health issues, interventions are needed at the patient level, a clinical and practical level, and most importantly- a community-level.

So why does screening prove so challenging?

In a study by Gemmill and colleagues (2006) researchers surveyed women about their experiences with perinatal mental health screening programs, asking whether they found the process comfortable and necessary. Of the 472 respondents, only 18.8% reported some discomfort, and 97% agreed screening was a good idea.

By contrast, a qualitative study done in the United Kingdom found that 46% of interviewed women reported low acceptability of depression screening *(Shakespeare, Blake, & Garcia, 2003)*. Those who expressed discomfort often attributed it to the clinical setting and their sensitivity to the demeanor of the person conducting the screening. Many preferred to discuss their mood and symptoms in a conversational format rather than through a questionnaire.

Training programs in screening, when regularly and systematically used, may improve the comfort providers have in administering screening. However, this process of training needs follow-up and continuing supervisor support to ensure ongoing revision around acceptable and effective screening implementation.

Numerous perinatal depression screening instruments exist. The two most widely studied and used are the Patient Health Questionnaire (PHQ-9, 9 questions) and the Edinburgh Postnatal Depression Screen (EPDS, 10 questions). These are self-administered, easy to score, include self-harm questions, and are standardized in numerous languages. As with any self-administered mental health questionnaire, openness and honesty is needed to ensure that proper screening and subsequent care are provided.

3.3. Treatment of Perinatal Mental Health Challenges

Though there are a myriad of ways to approach the treatment of PPD, four major approaches have been commonly tested: general counseling (also referred to as Listening Visits), interpersonal psychotherapy, cognitive behavioral therapy (CBT), and psychodynamic therapy.

LISTENING VISITS

Listening Visits are a non-directive form of counseling recommended by the National Institute for Health and Care Excellence (NICE) 2007 guidelines for women experiencing mild to moderate depression during the perinatal period. Delivered by health visitors in the home, these sessions provide screening and treatment even for professionals with little formal mental health training (Milgrom & Gemmill, 2015).

E-MENTAL HEALTH

Alongside traditional interventions, **E-mental health** is a rapidly growing field. Online screening and treatment programs can monitor clients' progress and provide tailored support, potentially increasing detection of perinatal depression and awareness of available resources.

INTERNAL RESOURCES AND SOCIAL SUPPORT

Internal resources and social support also play a critical role in recovery. Women with PPD often experience self-criticism and feelings of moral weakness, compounded by societal stigma surrounding emotional illness (This Isn't What I Expected). Psychotherapeutic interventions that validate these experiences and provide opportunities to process grief, losses in autonomy, and changes in partner relationships are essential. Social support is especially crucial in complex cases, such as women who have experienced birth-related trauma, previous pregnancy loss, or ambivalence about an unwanted pregnancy. Unfortunately, social support often diminishes during these periods as friends and family may feel uncertain about how to provide assistance *(Arnold-Baker, 2021)*.

PSYCHOTHERAPY

Psychotherapy provides a structured context in which women can receive emotional support and develop competence in their maternal role. Evidence suggests that individual or group psychosocial interventions can reduce PPD symptoms effectively. Approaches that also include the mother–infant relationship, such as Mother-Infant Therapy Groups (M-ITG), combine maternal peer support, infant developmental interventions, and mother-infant interactive activities. Involving infants and spouses in treatment has been shown to reduce stress and enhance maternal competence, which can protect against recurrent depressive episodes *(Clark, 2003; NICHD, 2006)*.

PHARMACOLOGICAL TREATMENTS

Pharmacological treatments remain the most common intervention for PPD, although women often prefer psychotherapy *(Pearlstein et al., 2006)*. Selective serotonin reuptake inhibitors (SSRIs) and serotonin/norepinephrine reuptake inhibitors (SNRIs) have been shown to be effective, including during breastfeeding, with nortriptyline, paroxetine, and sertraline considered preferred options (Simas, 2023; Scalea & Wisner, 2009; O'Hara, 2014). While pharmacotherapy can be highly effective, access to psychotherapy and supportive interventions is often limited, particularly in lower- and middle-income countries (LAMICs).

One of the main barriers in LAMICs is the low recognition of mental health disorders by primary care providers, compounded by a shortage of specialists. The World Health Organization recommends integrating mental health

services into primary care to close this treatment gap. Community-based approaches, including nonspecialist health and community workers delivering mental health interventions, have demonstrated significant improvements in mother–child outcomes during the first two years postpartum *(Rahman et al., 2013)*. These interventions are particularly effective when adapted to local circumstances and integrated into routine work, reducing stigma compared with stand-alone programs.

Such approaches suggest that *talk therapy, peer support, and community-based interventions can be highly effective for PPD and PPA*, but accessibility remains a challenge in many countries, including North Macedonia.

4. Maternal Mental Health as a Gendered Issue

4.1. Perception of Motherhood Within Patriarchal Systems

> ***Even though motherhood is defined differently by everyone that experiences it, motherhood cannot be understood separately from the society in which it occurs***
> ***(Ehrenreich and English, 1978).***

Motherhood has existed as long as humanity, but both the perception and the practice of motherhood and its many forms has changed throughout the centuries. Gender studies and sociological theories of motherhood, to a large extent, deal precisely with the issues of the influence of social context and social aspects of motherhood as an institution, but also as an experience.

In her work *The Myths of Motherhood*, Shari Thurer *(1994, as cited in Borovska, 2022, p. 15)* provides a historical overview of how the position of women and the practice of maternal roles have changed over time. The Neolithic period, or the New Stone Age, is often seen as an era of greater gender equality, since lineage and inheritance were traced through the mother, and concepts such as fatherhood and monogamy were unknown until the emergence of patriarchy

toward the end of this period. The social position of women thus directly influenced how motherhood was perceived and practiced.

With the rise of patriarchal social organization, the previously egalitarian relations between men and women began to deteriorate. Female chastity and fidelity became enforced virtues, and women were increasingly treated as material property used for exchange between tribes. These developments laid the foundation for women's subordination. Consequently, the status of mothers also changed: lineage, once traced through the mother, began to be defined through the father. Within this new order, the mother and her children became socially confined to the domestic sphere, while the father assumed the role of the absent provider and external authority.

The ideal of the "good mother" remains one of the most pervasive and psychologically demanding ideologies shaping women's identities.

As Douglas and Michaels describe in *The Mommy Myth (2004)*, contemporary motherhood is governed by the logic of "new momism"—a set of cultural norms and practices that appear to celebrate women's freedom to choose motherhood, yet in reality impose impossible standards of perfection. This ideology frames motherhood as the ultimate and most fulfilling life experience for women, one that demands complete selflessness, emotional devotion, and professional-level competence. Within this framework, the only "right" choice for women is to become mothers, and to perform that role with tireless enthusiasm and moral purity. Douglas and Michaels argue that this new momism functions as a subtle backlash against feminism, reinstating traditional gender hierarchies under the guise of empowerment.

Motherhood has become a psychological police state.

Similar ideological mechanisms operate in the Macedonian context, where motherhood continues to be deeply tied to a woman's moral worth and social identity. As Borovska notes in her 2022 book, myths about the "good mother" are grounded in cultural assumptions about maternal instinct and women's innate biological capacity for caregiving.

Motherhood is idealized as a woman's highest purpose, while those who do not conform to this model—whether by not having children, expressing ambivalence, or struggling emotionally—are often stigmatized.

The ideology of hegemonic motherhood (Goodwin & Huppatz, 2010, as cited in Borovska, 2022, p. 33) reinforces this pattern, prescribing intensive, all-consuming mothering as the only legitimate form of maternal care. It constructs motherhood as a moral hierarchy that measures women's value by their sacrifice, patience, and ability to conceal "negative" emotions such as anger, exhaustion, or regret.

These cultural ideals create a psychological environment in which many mothers feel constant guilt and self-doubt. The rhetoric of maternal guilt positions mothers as personally responsible for every outcome in their children's development and wellbeing. As Adrienne Rich (1976) argues in *Of Woman Born*, this guilt is not inherent to the maternal experience but is a product of motherhood as an institution—a patriarchal construct that dictates what mothers should feel and how they should behave. Rich distinguishes between motherhood as an institution, which disciplines and constrains women, and motherhood as an experience, which can be empowering and relational. However, the institutionalized ideal of the "perfect mother" leaves little space for authentic emotional complexity, creating a state of constant self-surveillance and internal conflict.

> ***As Thurer (1994, as cited in Borovska, 22, p.42-43) further observes, these expectations pressure mothers to not only perform well but to enjoy motherhood unconditionally—to suppress ambivalence, frustration, or fatigue in favor of a socially acceptable image of maternal bliss.***

The result is what she calls a "turbulent inner war," in which women struggle to reconcile their lived experience with the unattainable ideals imposed upon them. This conflict often leads to feelings of inadequacy and personal failure, which can manifest as depression, anxiety, or burnout. In clinical settings, these symptoms are frequently medicalized as postpartum depression, detached from their social and cultural origins. Yet, as both feminist theorists and practitioners argue, such distress is not merely a personal pathology but a reaction to the oppressive demands of idealized motherhood and the lack of structural and emotional support for mothers.

Furthermore, one of the most persistent myths sustaining the ideal of the "good mother" is the belief in a natural, universal maternal instinct. This notion assumes that women possess an innate, biologically determined capacity for caregiving and emotional attunement toward their children. As Borovska (2022) notes, maternal behavior is frequently interpreted as a manifestation of this instinct, presumed to emerge spontaneously in the moments following childbirth. Such an idea reinforces the essentialist view that women are naturally predisposed to motherhood, and that maternal love and competence arise effortlessly from biology rather than being shaped through social, psychological, and contextual factors. The myth of maternal instinct therefore serves a powerful ideological function: it naturalizes women's caregiving roles and masks the structural and emotional challenges of motherhood under the guise of biological inevitability.

Research on becoming a parent consistently reveals that mothers and fathers experience the transition in markedly different ways. While mothers often derive profound satisfaction and meaning from their new role, they are also more likely to face a wider array of challenges, particularly in the early months following childbirth. These differences largely stem from traditional gender norms, which position women as the primary caregivers. Mothers typically take longer parental leave, spend more time with the infant, and carry the main responsibility for daily care and domestic tasks.

This unequal distribution of labor exposes mothers to greater physical, emotional, and social strain, while limiting opportunities for rest, social engagement, and personal development.

Several studies have highlighted the emotional consequences of this unequal division of labor. Ross and Van Willinger (1996, as cited in Borovska, 2022) found that parenting-related responsibilities significantly increased levels of anger and frustration among mothers—almost twice as much as fathers—with the effect intensifying with each additional child. These feelings were linked primarily to two sources: economic stress and the unequal allocation of childcare responsibilities. In households where mothers carried a larger share of child-rearing duties, they reported higher levels of emotional strain and perceived injustice, suggesting that parental frustration is closely tied to structural inequalities rather than individual shortcomings.

4.2. Feminist Perspectives on the Ideological Construction of Perinatal Depression

Although motherhood is often idealized as instinctive and universally fulfilling, feminist scholarship highlights how such cultural myths obscure the social, economic, and political conditions that shape women's perinatal experiences and emotional well-being. Mainstream psychology and psychiatry often conceptualize perinatal difficulties as pathology – an individual failure to cope - rather than as a reasonable response to the intense changes and challenges that accompany becoming a parent. This framing contributes to stigma, leaving women feeling that they are defective rather than supported. As van Deurzen (1998) points out, society tends to assume that people should be immune to the difficulties their lives expose them to and that if they do not cope, there must be something wrong with them, rather than with the situation itself.

British psychologist Paula Nicolson (1999-2, as cited in Borovska, 2022, p.49) critically examines the myth of the 'good mother' through her research on postnatal depression, arguing that the widespread assumption of maternal instinct distorts our understanding of mothers' emotional realities.

According to Nicolson, postpartum depression should not be seen as a pathological deviation from "normal" motherhood, but rather as a common and understandable response to the profound life changes and social isolation that often accompany the early postpartum period.

She suggests that such emotional distress is, in fact, a more natural maternal experience than the absence of any difficulty. However, within the cultural framework that idealizes motherhood as an exclusively joyful and fulfilling experience, mothers who experience ambivalence, sadness, or exhaustion feel as though they are failing to achieve a biological and moral standard.

Nicolson's analysis highlights a central paradox: if a natural maternal instinct truly ensured that women seamlessly adapted to motherhood, then the high prevalence of postnatal depression would imply a widespread failure of this instinct—a claim that is both empirically and conceptually untenable. Instead, Nicolson (1998, 1999) argues that postpartum depression reflects not an individual pathology but a psychosocial response to the contradictory expectations of contemporary motherhood. Women become depressed, she notes, not because they lack instinct, but because the transition to motherhood often entails a loss of autonomy, identity, and social recognition (as cited by Borovska, 2022, p. 51).

In patriarchal and capitalist societies, mothers are celebrated rhetorically while being deprived of genuine structural support. This dissonance—between the glorified image of maternal bliss and the lived reality of isolation and disempowerment—creates conditions ripe for psychological distress.

In this sense, the myth of maternal instinct operates as both a social control mechanism and a source of guilt. By framing caregiving as instinctual, it delegitimizes the need for support, learning, and community, and transforms maternal struggle into personal failure.

Within the Macedonian context, where gender norms continue to emphasize women's primary responsibility for childcare, the absence of shared parental leave, limited access to affordable childcare, and insufficient perinatal mental health services reinforce the idealization of motherhood and the notion of the "ideal mother."

Coupled with a dominant public discourse that celebrates fertility while implicitly blaming women for low birth rates, these expectations create immense social pressure on mothers. Within this framework, the belief in a natural maternal instinct further isolates women by framing struggles in motherhood as personal failings rather than as reflections of systemic gender inequality and lack of structural support.

From a feminist perspective, the terminology surrounding women's emotional and psychological experiences in the perinatal period—especially the term *postpartum depression*—has long been a subject of critique. Ann Oakley (1980, as cited in Borovska, 2022, p.77) was among the first to argue that this term, while seemingly clinical and objective, carries deep ideological weight. Rather than being a neutral medical descriptor, "postpartum depression" reflects and reinforces dominant patriarchal norms that define successful motherhood as the ability to embody a particular ideal of femininity: nurturing, self-sacrificing, and emotionally fulfilled. Within this framework, any deviation from this ideal—sadness, exhaustion, ambivalence, or disconnection—is interpreted as a form of failure or pathology. Oakley points out that the medicalization of these experiences, constructed largely by male experts, disguises an ideological judgment beneath a "technical" scientific label: it frames the struggling mother as "defective" rather than questioning the social structures and expectations that contribute to her distress.

Lee (2006, as cited in Borovska 2022, p. 83-84) expands this critique, describing the "unprecedented medicalization of women's social experiences," where the everyday struggles of motherhood are reframed as symptoms of illness rather than reflections of cultural, economic, and political conditions.

Paula Nicolson (1998; 1999, as cited in Borovska, 2022, p. 86) offers a more nuanced and empathetic understanding of postpartum depression.

> ***Rather than treating it as a pathological condition rooted in female biology, she proposes that perinatal depression should be viewed as a normal and often healthy emotional response to the immense losses and changes that accompany motherhood.***

She describes these as "potentially healthy mourning reactions to loss," arguing that the expectation of unbroken happiness in new motherhood silences women's real experiences. Nicolson identifies several forms of loss that commonly emerge in the transition to motherhood: the loss of autonomy and personal time, changes in body image and sexual identity, the loss of professional identity or career continuity, and a broader sense of losing one's previous self. Although motherhood brings recognition and a valued social role, it simultaneously strips women of freedoms and identities that previously defined them—a paradox that lies at the heart of many mothers' distress.

Nicolson also highlights how the internalization of medical and cultural narratives encourage women to interpret their struggles as biological failings rather than as consequences of social inequality or structural neglect. The dominance of biomedical

discourse has positioned women as inherently vulnerable, irrational, and unstable, which is contrasted with the rational, self-controlled male subject. This framing discourages women from recognizing the sociocultural dimensions of their suffering: the isolation of nuclear family life, the unequal distribution of care work, and the lack of institutional support for mothers. In this sense, perinatal depression is not simply a medical issue but a profoundly political one. It reflects the collision between the lived reality of motherhood and the socially constructed ideals that define how mothers *should* feel and behave.

Building on these feminist perspectives, Borovska (2022) furthermore emphasizes that perinatal depression, when viewed through the lens of social sciences and feminist theory, should be understood as a consequence of the loss of identity, autonomy, independence, power, and income that often accompanies motherhood. Historically, women lived in extended family structures and tight-knit communities where childbirth and the transition into motherhood were surrounded by collective rituals and shared female support, easing the adjustment to the maternal role. In contemporary societies, however, women experience motherhood in conditions of social isolation, nuclear family structures, and increased individual responsibility, often without comparable communal or systemic support. While some narratives suggest that women's emancipation and participation in public life have contributed to higher rates of postpartum depression, Borovska argues that blaming women's freedom for their suffering is both regressive and dangerous. Such reasoning implies that restricting women's rights and confining them once again to domestic roles would serve as a "solution" to perinatal depression—an idea echoed in pronatalist policies that valorize motherhood as women's primary role.

In reality, research shows that reducing women's identities to caregiving roles and denying them personal and professional self-realization often exacerbates depressive symptoms. True prevention, Borovska concludes, lies not in reversing women's emancipation but in evolving the broader social context of parenthood—through equal parental involvement, community support, and systemic measures that redistribute the emotional and practical labor of childrearing across families, partners, and society.

4.3. Implications for Therapeutic Practice: Feminist-Informed Approaches

Although motherhood can be a profoundly meaningful experience, the many factors that may influence it do not leave space for any "normative" belief about what motherhood *should* be. In any therapeutic setting, therapists should be able to challenge the often-idealized assumptions about 'good mothering' and the supposed sufficiency of maternal instinct. These unrealistic expectations of mothers and motherhood often lead to feelings of failure, self-doubt and the perception that a newborn's normal behavior reflects maternal inadequacy and are common factors in many new mothers' negative postnatal experience *(Donaghy, 2001)*.

Central in these debates is the key issue of how women's experiences of mental health are culturally framed and interpreted as personal troubles, rather than as "public feelings" that are deeply entwined with historical, sociocultural, economic and political conditions *(Cvetkovich, 2012)*.

> ***We cannot separate the institutional practices, cultural contexts and affective relations that shape the diversity of women's lives and directly impact their experience when attempting to get help for perinatal mental health.***

A more well-rounded approach is necessary. Feminist-informed therapeutic interventions rely on the belief that the psychological distress experienced by women within these situations cannot be understood without reference to the political contexts in which women and girls live their lives. Feminist-informed therapeutic interventions pay particular attention to the influence of the patriarchy on violence and healing, with an understanding that the violence women and girls experience- as well as the feelings of self-blame and many other reactions that follow exposure to violence are rooted in structural gender inequality. These therapeutic interventions, ones that do not shy away from the political and social realities we operate within, have been found to be of particular value in alleviating women's sense of loneliness, shame and guilt. In this sense, feminist informed therapeutic interventions can help women in ways that other mental health interventions cannot.

5. Global overview

5.1. Global Prevalence of Maternal Mental Health Disorders

As noted earlier, perinatal mental health disorders—most commonly depressive and anxiety disorders but also severe conditions such as bipolar disorder and postpartum psychosis—are widespread and under-treated.

> ***The World Health Organization (WHO) estimates that roughly 10% of pregnant women and 13% of women in the first year after birth experience a mental disorder, with higher rates in low- and middle-income countries (approximately 15.6% antenatally and 19.8% postnatally).***

Recent systematic reviews and meta-analyses report wide variation by setting and measurement method, but pooled estimates indicate that antenatal and postnatal depressive symptoms affect a substantial proportion of women, often exceeding 15–25% in many studies and rising further in vulnerable populations and during crises such as the COVID-19 pandemic. These figures understate the problem because many studies use screening instruments rather than diagnostic interviews and because service contact and case ascertainment are low in many settings *(WHO; (Howard & Khalifeh, 2020; Woody et al., 2017)*.

The human consequences extend beyond individual suffering: perinatal mental disorders carry demonstrable effects on maternal functioning, mother–infant interaction, infant development and behaviour, and family wellbeing. Untreated maternal depression and anxiety are associated with poorer obstetric outcomes, reduced breastfeeding duration, delays in cognitive and emotional development in children, and increased risk of behavioural problems later in childhood. At the population level these effects translate into increased demand on health, social and educational services and into longer-term losses in human capital. The intergenerational dimension, in which maternal mental health challenges alter caregiving capacity and early child development, means that the impact compounds over time rather than resolving when the perinatal period ends. *(Stein et al., 2014; Bauer et al., 2016)*.

The economic burden is substantial and measurable.

Country-level and sectoral studies show that untreated perinatal mood and anxiety disorders generate direct health-care costs (additional consultations, specialist care, pharmacotherapy, inpatient care in severe cases) and indirect costs through lost productivity, social services use, and increased expenditures related to child health and special education.

Estimates from high-income settings and recent modelling applied elsewhere indicate that the societal cost of perinatal mental disorders runs into hundreds of millions or billions of dollars per country when productivity losses and longer-term child impacts are included. Cost-of-illness studies also consistently show that the costs of inaction far exceed the investment required to deliver basic, evidence-based perinatal mental health interventions at scale *(Luca et al., 2020; Margiotta et al., 2022)*.

Addressing perinatal mental health is therefore both a health priority and a development imperative.

Stronger perinatal mental health (PMH in further text) services contribute directly to SDG 3 (ensure healthy lives and promote well-being for all at all ages), by reducing maternal morbidity and mortality and improving early childhood outcomes, and they have cross-cutting relevance for SDG 1 (poverty reduction), SDG 4 (quality education, via early childhood development), and SDG 5 (gender equality, by addressing women's health and agency). Integrating PMH into routine maternal and child health platforms, through validated identification, stepped care, task-sharing, and clear referral pathways, offers a high-value route to lower the human and economic costs summarized above and to make progress on multiple SDG targets.

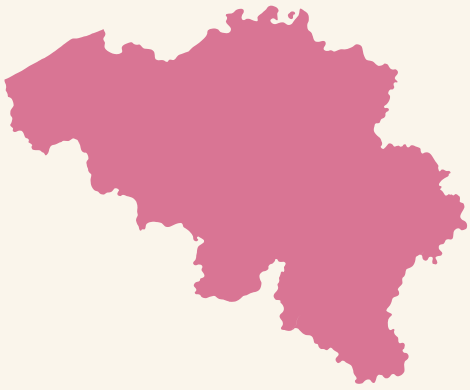
5.2. Global Policy and Guidelines

Despite the high incidence of perinatal mental health challenges and their substantial impact on maternal and infant outcomes, the integration of perinatal mental health (PMH) care into national health systems remains uneven across the WHO European Region. A recent comparative analysis sought to map existing gaps in PMH care and identify regional leaders in service provision *(Horakova et al., 2024)*. The study employed a five-point scoring system to assess each country's mental health-care infrastructure, awarding one point for the presence of: (1) a general national mental health policy; (2) a specific PMH policy; (3) a nationally implemented PMH screening service; (4) evidence-based treatment options for PMH conditions; and (5) official guidelines for PMH care, including diagnostics, prevention, treatment, screening, or pharmacotherapy.

Out of 53 countries assessed, only seven achieved the maximum score, indicating comprehensive and integrated PMH systems[3]. Conversely, five countries scored zero, reflecting a complete absence of formal PMH infrastructure[4]. While 48 countries reported having a general mental health policy, only 25 had developed a specific PMH policy. Screening services were present in just 10 countries, and only 11 offered any form of PMH-specific treatment. Furthermore, fewer than half (23/53) had published guidelines addressing any aspect of PMH care.

Leading countries in perinatal mental healthcare have implemented structured, evidence-based approaches that emphasize early identification, standardized screening, and integrated care pathways.

BELGIUM



Belgium employs a multi-stage screening process led by midwives using validated tools such as the Whooley questions[5], GAD-2[6], EPDS[7], and GAD-7[8], with referrals to mental health professionals embedded within maternity services.

3 Belgium, Finland, Ireland, Malta, the Netherlands, Sweden, and the United Kingdom

4 Kazakhstan, Kyrgyzstan, San Marino, Tajikistan, and Turkmenistan

FINLAND

Finland integrates mental health assessments into routine prenatal and postnatal care, using instruments like the EPDS and Beck Anxiety Inventory[9], and ensures continuity of care through strong collaboration between prenatal and child

IRELAND

Ireland has established a central role for perinatal mental health (PMH) midwives, who provide screening, psychoeducation, and referrals to general practitioners, who then coordinate access to tiered mental health services.

5 A brief two-item screening tool for depression in primary care, assessing depressed mood and anhedonia over the past month.

6 A two-item questionnaire derived from the Generalized Anxiety Disorder-7 (GAD-7) scale, used to screen for core symptoms of generalized anxiety disorder

7 Edinburgh Postnatal Depression Scale: A 10-item self-report questionnaire designed to identify symptoms of postnatal depression in women, focusing on emotional and cognitive aspects rather than somatic symptoms.

8 Generalized Anxiety Disorder-7: A 7-item self-report scale that measures the severity of generalized anxiety disorder symptoms over the past two weeks.

9 A 21-item self-report instrument assessing the intensity of anxiety symptoms, emphasizing somatic manifestations.

NETHERLAND

In the **Netherlands,** primary care midwives use standardized digital screening tools developed by the National Knowledge Centre for Psychiatry and Pregnancy to monitor maternal mental health and facilitate referrals.

SWEDEN

Sweden offers universal access to perinatal care through antenatal and child health services, with comprehensive screening protocols and follow-up counselling for women identified as at risk.

THE UNITED KINGDOM

The United Kingdom, guided by NICE clinical guidelines[10], recommends routine screening during early pregnancy and the postnatal period using tools such as the Whooley questions, GAD-2, EPDS, and PHQ-9[11], followed by referral to primary or specialist care depending on the severity of symptoms. Across these systems, common strategies include repeated use of validated screening tools, integration of mental health within maternity and primary care, and multidisciplinary care models to ensure timely intervention and support.

10 Evidence-based recommendations from the UK's National Institute for Health and Care Excellence on best practices in health and social care, including perinatal mental health.

11 A 9-item self-report questionnaire used to screen for depression and assess its severity over the past two weeks.

While these examples illustrate effective national practices, the Horakova et al. (2024) study highlights that many countries still lack formal policies, screening services, or treatment guidelines. The Guide for Integration of Perinatal Mental Health (2022) developed by WHO provides a comprehensive framework to address these gaps, offering evidence-based recommendations for integrating PMH into maternal and child health services. Central to the WHO approach is a stepped care model, which ensures that interventions are proportionate to the severity of women's needs and feasible within existing health system resources. The model organizes interventions into different levels of intensity, with women "stepping up" or "stepping down" in care depending on their response to treatment.

Supportive environments

According to the this guide, the creation of **supportive environments** is fundamental for safe and effective perinatal mental health (PMH) care. The guide stresses that women must feel **respected, listened to, and safe** in order to openly discuss their mental health and access available services. Without such an environment, stigma, fear, or mistrust can prevent women from seeking help.

Reducing stigmatization

Therefore, one of the most important aspects is **reducing stigmatization**. Mental health conditions are often heavily stigmatized, with women facing stereotypes of being "bad" or "unfit" mothers. This discourages disclosure and engagement with services. By integrating PMH into maternal and child health (MCH) services and discussing mental health at every point of contact, providers can help normalize mental health concerns, making them a routine part of care rather than a source of shame.

Respectful care

Equally vital is **respectful care**, which guarantees women's rights to **privacy, dignity, autonomy, and recognition of their preferences and beliefs**. Respectful maternity and mental health care involves obtaining informed consent, ensuring confidentiality, and fostering trust between women and providers. Abuse and disrespect, whether physical, verbal, or through neglect, discrimination, or non-consensual procedures remain common in maternity care globally. WHO emphasizes that such practices must be actively prevented, with mechanisms for accountability in place. Women should also be made aware of their rights and have **safe, anonymous ways to report mistreatment.**

This guide also propositions a plan to integrate mental healthcare during the perinatal period into maternal and child health services, which includes 1) screening of all women for PMH conditions, 2) identification of women who would benefit from mental health support, and 3) referrals to other services that can offer additional working support.

Once the needs and the possibilities are identified, the WHO guide notes that successful integration of perinatal mental health (PMH) into maternal and child health (MCH) services depends on careful implementation as well.

Adaptation to context and culture is essential.

Existing MCH services, local practices, and the attitudes of women, families, and providers all shape how care can be integrated. Cultural norms may determine when and where women can access services (for example, restrictions on movement after childbirth in some cultures), or who makes health decisions in the household. Stigma toward mental health can delay or prevent women from seeking help. Implementation must therefore be informed by situational analysis and adapted to the specific cultural, legal, and policy environment.

Workforce development is a second core requirement.

Dedicated PMH providers can strengthen continuity of care, but recruitment is often limited by funding and by the small number of staff trained in mental health. WHO recommends task-sharing, where non-specialist workers such as community health staff or peers provide health promotion, psychoeducation, and screening, and task-shifting, where certain responsibilities are redistributed from specialists to providers with shorter training. These measures require consultation with staff to ensure feasibility and acceptability.

Training should be competence-based and matched to the interventions chosen and the skills of the workforce.

Training needs to cover detection, psychosocial support, basic psychological interventions, prescribing (where relevant), referral, and monitoring. Participatory approaches—such as case studies, role-play, and supervised practice—are recommended, with standardized methods used to assess competence. Training should be integrated into pre-service education where possible, and **cascade models** can be used for scale-up, with specialists training health professionals who then train community workers. Continuous learning opportunities, supervision, and refresher sessions are necessary to sustain skills.

Supervision and support are integral to implementation.

Clinical supervision provides space for providers to review cases, receive feedback, and manage the stress of working with women in distress. Mentoring supervision pairs less experienced workers with senior clinicians, while supportive supervision, usually delivered by managers, focuses on improving practice, teamwork, and accountability. Where specialists are limited, supervision can be organized in cascades.

Finally, effective implementation requires **coordination of care**.

Women with PMH conditions often need services beyond MCH, including social protection, employment, housing, gender-based violence support, and specialized mental health care. Clear care pathways should be established in advance, with defined referral mechanisms and case management responsibilities. Referrals must be reliable to maintain women's trust and engagement. Case management done by midwives, nurses, doctors, or trained mental health specialists will ensure women are supported across different services and are not left to navigate the system alone.

A well-designed care pathway is therefore central to WHO's recommendations. This involves mapping the points of entry into care - whether antenatal visits, maternity wards, child health clinics, or community health services - and ensuring that women can be identified and supported at each of these points.

From there, the stepped care model provides the structure for intervention: universal health promotion and prevention for all, low-intensity psychological interventions for women with mild difficulties, and referral to specialist mental health services for those with moderate to severe conditions. Each level of care must be connected through clear referral and back-referral systems, supported by user-friendly directories of available services and regular communication among providers. Without such pathways, women risk falling through the cracks of a fragmented system. With them, perinatal mental health care becomes predictable, accessible, and responsive to need, rather than dependent on chance encounters with individual providers.

6. National Situational Analysis

6.1. Gender Equality in the National Context

In 2024, there were 400,502 women of reproductive age (15–49) in North Macedonia, representing 22% of the total population. That same year, 16,040 children were born to mothers in this age group. Although around half of all births take place in the capital, two-thirds of the children born in 2024 were born to parents residing outside of Skopje. This corresponds with the fact that two-thirds of women of reproductive age live outside of the capital (State Statistical Office, 2024).

Economic inequality between women and men in the Republic of North Macedonia remains high. According to official state statistics, 38% of women of working age are employed, compared to 56% of men. The majority of women of working age in the country are neither employed nor unemployed but are classified as economically inactive. Among economically inactive women, 41% are officially recorded as housewives. In comparison, 0% of economically inactive men are listed as househusbands *(State Statistical Office, 2024)*.

Household and childcare responsibilities continue to be "exclusive" obligations of women and remain the main reason why women of working age are excluded from the labor market.

Accessible and high-quality early childcare and education provided through kindergartens and day-care centers can enable a redistribution of caregiving responsibilities and increase women's employment opportunities.

Greater availability of systemic solutions for quality and affordable early childcare and education would create equal opportunities for both women and men to establish a balance between private and professional life.

This would also contribute to improving women's career prospects and reducing gender pay and pension gaps. Numerous studies and reports worldwide confirm a (causal) relationship between access to quality and affordable early childcare and education, and women's economic empowerment and improved employment opportunities *(Leshoska & Bojchevska Mitrevska, 2024)*.

Furthermore, the discussion on shared parental leave has been ongoing for more than a decade, without any concrete efforts being made by any of the ruling governments. The importance of introducing parental leave models that include both parents in the right to paid leave after childbirth is recognized in key international conventions and declarations on the advancement of women's rights and gender equality, such as the Beijing Declaration and Platform for Action (1995) and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1979) of the United Nations (UN). The need for policies such as shared parental leave, aimed at redistributing unpaid domestic labor (childcare and household activities) and balancing the work–life responsibilities of women, is also part of the United Nations Sustainable Development Goals (2015–2030), specifically Goal 5 – Gender Equality. In addition, the International Labour Organization (ILO) highlights in its research and recommendations the need to introduce maternity, paternity, and parental leave as measures for improving work–life balance, increasing women's access to the labor market, and reducing gender-based discrimination *(Reactor – Research in Action, 2019)*.

Finally, it is important to note that including fathers in child-rearing through shared parental leave policies has substantial benefits that contribute to the overall mental well-being of new mothers.

These benefits include more equitable household responsibilities, shifts in gender norms, and increased participation of women in the workforce, which promotes economic growth and reduces gender wage and pension gaps while decreasing discrimination against women. It also supports both parents in maintaining their attachment to the labor market while fostering a better work–life balance, which can reduce stress. Moreover, fathers who take at least two weeks of leave immediately following the birth of a child are more likely to remain actively involved in childcare and household responsibilities thereafter. One of the most immediate benefits of shared parental leave is the reduction of stress associated with the imbalance of household responsibilities. This shared responsibility allows mothers to recover physically and emotionally from childbirth, which is essential for preventing postpartum depression and other mental health issues. Shared parental leave also improves marital relationships and allows time for self-care and personal pursuits, which are critical for maintaining mental health during the demanding early months of parenthood *(Bojchevska Mitrevska, 2024)*.

From a societal perspective, non-transferable shared parental leave shifts gender norms by involving men in caregiving and reducing the traditional perception of mothers as primary caregivers. This normalization of paternal involvement helps alleviate societal pressure on women and creates a more supportive environment for mothers. Additionally, in countries where paternity leave is common, there is less workplace discrimination against women and a narrower gender pay gap. Research from Sweden shows that for every month of paternity leave taken, a woman's salary increases by 7% *(Johansson, 2010, as cited in Reactor – Research in Action, 2019)*.

In North Macedonia, a proposed Labor Relations Law that included shared, non-transferable parental leave was drafted with the aim of promoting gender equality and supporting both parents in their child-rearing responsibilities. However, the legislation faced significant resistance from the private sector and from conservative forces opposed to gender equality, who sought to limit women's roles outside the household. As a result, the law was never brought to a vote and was returned to the drafting process (Bojchevska Mitrevska, 2024).

6.2. Perinatal mental health context

In 2022, postpartum depression was present in 27.6% of young mothers in North Macedonia, while 27.8% experienced moderate to severe anxiety (University Clinic of Psychiatry, 2023). Despite the recognized importance of maternal mental health, national policies in North Macedonia remain insufficient to meet the widespread needs of mothers. With only one maternal mental health support group operating in the entire country, access to care is severely limited, particularly for women outside the capital. Additionally, the absence of comprehensive parental leave policies that promote shared responsibility further exacerbates the mental health burden on mothers.

Findings from interviews with gynecologists working in maternity wards in Skopje, conducted for the purposes of this analysis, highlight significant gaps in the formal mechanisms for identifying and supporting women with perinatal mental health issues in North Macedonia. Insights from one expert reveal persistent shortcomings in the recognition and support of psychological wellbeing during pregnancy and postpartum. Emotional distress is common, particularly among first-time mothers, with fears surrounding labor and pain frequently reported. However, these concerns are rarely addressed within routine care. Mental health remains a marginal topic in maternity services, and conversations about psychological wellbeing are often silenced by stigma.

No formal systems exist to identify or refer women who are struggling, and mental health professionals are typically not present in or near maternity wards.

Staff such as midwives and nurses receive little to no training in supporting mothers emotionally, and their capacity to do so is further constrained by administrative pressures. Coordination between gynecologists, general practitioners, and pediatricians is minimal, and referrals often rely on informal networks rather than structured protocols.

Another gynecologist working in a maternity ward in the capital highlighted that women are often discharged very quickly (24–48 hours after vaginal births and 4–5 days after cesarean sections) and are typically advised to seek psychiatric help independently, with minimal guidance or follow-up. This situation leaves many women, particularly those outside the capital, without accessible support. They noted that a substantial proportion of women enter pregnancy with pre-existing psychological vulnerabilities, with estimates suggesting that around 15–20% of women may experience some level of psychological difficulty from the outset of pregnancy. These challenges are

frequently under-recognized, as the healthcare system lacks systematic screening during antenatal visits. Consistent assessment during pregnancy is limited, and existing checklists, questionnaires, and awareness guides for gynecologists and primary care doctors are relatively new and unevenly implemented across clinics. As a result, antenatal mental health support remains inadequate, and the first structured contact for mental health care often occurs postpartum.

Both clinicians emphasized the urgent need for national screening programs, dedicated training for maternity staff, clear referral procedures, and stronger interdisciplinary collaboration through joint workshops and education.

Social stigmatization of non-traditional views and experiences of motherhood remains deeply entrenched in Macedonian society and is frequently internalized by mothers.

A qualitative study conducted by Borovska in 2018 with 27 mothers of children of different ages from Skopje found that a significant characteristic of motherhood among the interviewed women, who come from a context that is more patriarchal than democratic in terms of private life, was their resistance to speaking about the difficulties of motherhood. The term "difficulty" itself was extremely hard for mothers to "swallow" and integrate into their personal narratives. The reasons for this unease lie in the myths of the "good" and "bad" mother. For the "good" mother, whom all strive to be, it must not be difficult even when it truly is, because admitting hardship would imply that she has not properly or adequately incorporated motherhood within herself—or worse, that she harbors negative feelings toward her child or does not fully enjoy the maternal role, which is seen as completely unacceptable for a "good" mother. However, despite their initial resistance, it was precisely the difficulties that mothers spoke about in more depth, as emphasizing the challenges they face gave additional meaning and value to their maternal engagement.

At the national level, discourse on perinatal mental health has expanded in recent years, though it remains dominated by a medicalized perspective that limits broader understanding of the experience. The discussion continues to pathologize the condition, leaving little space for existential approaches that normalize this critical transition to a new role that lacks systemic support. According to Lee (2016, as cited in Borovska, 2022, p.84), a large number of women globally are diagnosed with some type of disorder, or, as she puts it, "*the lives of these women are subject to the unprecedented medicalization of a social experience*." The same can be observed nationally, in a context that does not encourage discussion of the transformations that accompany parenthood and the need for systematic, accessible, and affordable support.

6.3. National mental-health policies

North Macedonia's current political approach to perinatal mental health is characterized by systemic neglect of this issue within national health planning and policy.

North Macedonia's mental health legislation is anchored in the Law on Mental Health (2005), which primarily emphasizes the protection of human rights for individuals with mental illness, their diagnosis, and access to treatment. However, the law does not prioritize preventive care, psychosocial support, or mental hygiene—elements critical to PMH.

The National Strategy for the Advancement of Mental Health (2018–2025) represents a more progressive policy document. It calls for the deinstitutionalization of psychiatric care and the development of community-based mental health services, drawing on both domestic and international best practices. The strategy promotes a diversified treatment model, including individual and group psychotherapy, occupational therapy, rehabilitation, and psychosocial support for individuals and families. It also advocates for a redefinition of psychiatric institution financing and the establishment of updated diagnostic and therapeutic protocols. Despite its ambition, the strategy lacks a dedicated budget for implementation, rendering its execution contingent on shifting political will and institutional priorities.

A new draft strategy on sexual and reproductive health marks a tentative shift toward recognizing perinatal mental health needs[12]. While the draft includes a brief mention of perinatal mental health, it lacks concrete measures or implementation plans. Nonetheless, its inclusion signals a departure from previous strategies, which omitted perinatal mental health entirely, and aligns with broader efforts to comply with international standards for perinatal care. The draft strategy is part of the Government's commitment to the Master Plan for Effective Perinatal Care, and its development has been supported by the UNFPA office in North Macedonia.

12 The draft National Strategy on Reproductive and Sexual Health referenced here is unpublished and not yet finalized. The version cited was made available for public comment and contribution, which is where the information for this analysis was obtained.

This institutional recognition of perinatal mental health, absent in previous SRH strategies, reflects a growing awareness catalyzed by the COVID-19 pandemic and offers a strategic framework for future action.

The absence of a coherent perinatal mental health framework in North Macedonia is compounded by several entrenched barriers. First, there is minimal public and professional awareness of the psychological needs of mothers during the perinatal period. Mental health remains heavily stigmatized, and frontline health workers, including obstetricians, pediatricians, and family doctors, often lack the training to recognize and respond to PMH concerns. Even where awareness initiatives are introduced, their effectiveness is undermined by structural deficiencies in service provision. UNFPA has begun addressing this gap through targeted training for gynecologists and obstetricians, in collaboration with the Macedonian Association of Gynecologists and Obstetricians. These sessions aim to build capacity among gynecologists and should soon expand to include family doctors and pediatricians, supporting a multidisciplinary approach to perinatal mental health care. Furthermore, the University Clinic of Psychiatry has developed a handbook for health professionals on recognizing and detecting mental health difficulties, which is being distributed to healthcare workers who have direct contact with new mothers during the postpartum period[13]. However, these trainings do not address the absence of a clear care pathway, as recommended by the WHO, and despite increased sensitivity among doctors regarding the mental health of new mothers, there remain no systematic referral options or services to which these women can be directed.

Insights from a psychologist working in the civil society sector further highlight systemic gaps in the availability and visibility of mental health services. While primary healthcare is supposed to include psychologists, in practice these positions are often nominal or politically appointed, and patients are typically referred directly to psychiatry, receiving pharmacological treatment rather than psychosocial support. Existing mental health centers, although promoted as functional, frequently operate below standard, often resembling day hospitals rather than counseling services. There is a need to systematically map available resources, strengthen existing capacities, and establish sustainable referral pathways, including ones for preventive and psychosocial care. Civil society organizations, universities, and hospital counseling centers could contribute to a network of trained providers able to deliver continuous support to women during the perinatal period.

One of the most critical gaps is the lack of patronage nurses and home-based care for women during the perinatal period. In countries with robust perinatal mental health systems, such as Sweden and the United Kingdom, midwives and patronage nurses play a central role in early identification, psychosocial support, and referral. In North Macedonia, however, these professions suffer from chronic under-recognition,

13 https://www.agom.org.mk/2025/10/22/mentalnozdravjevoperipartalenperiod/

ambiguous legal status, and systemic undervaluation. Based on national standards, the country would require at least 367 patronage nurses to adequately cover the population, yet in 2023 only 258 were employed across all units *(Institute of Public Health of the Republic of North Macedonia – Skopje, 2024)*. Legislative and regulatory reforms are underway to address these issues, but progress remains slow and uneven.

The interviews done for the purpose of this study also stressed that sustainable perinatal mental health services require integration with existing health mechanisms, including primary care and home-visiting services. Resources must be mapped, capacities strengthened, and referral pathways clearly established so that health professionals who identify mental health needs have accessible points of care. Group support initiatives for mothers could be launched alongside the implementation of protocols, but without state-backed coordination, these are in danger of remaining fragmented and unsustainable.

Additionally, physicians who routinely interact with new mothers - particularly gynecologists, family doctors, and pediatricians - are burdened by high patient volumes and administrative demands. These high demands under a capitalist system do not align with the conception of giving each patient the time and care needed for quality observation and treatment. This leaves little room for preventive care or mental health counseling, further marginalizing perinatal mental healthcare within routine clinical practice. While UNFPA's efforts have improved early detection capacity, they also noted that there is no systematic follow-up once a PMH issue is identified, leaving a critical gap between screening and treatment.

The mental health professionals consulted additionally note that psychologists themselves require training to provide effective psychosocial support and that advocacy is needed to ensure they are embedded in the health system rather than marginalized. The mapping and strengthening of these services, combined with clearly defined referral mechanisms, are essential to ensure women identified with mental health needs can access appropriate care.

Addressing these deficiencies requires not only legislative and institutional reform but also a cultural shift toward destigmatizing mental health and recognizing the psychosocial dimensions of maternal wellbeing. Mental health remains highly stigmatized, and psychological support (for all citizens, including mothers) is rarely recognized as a healthcare need. Health professionals in close contact with women during pregnancy and postpartum still lack training to identify and respond to mental health difficulties. Moreover, the limited availability of services compounds these challenges: the only specialized mental healthcare for mothers is located in the capital, Skopje, despite the fact that approximately 70% of women of reproductive age reside outside the city. This geographic concentration of care leaves the majority of women without access to timely or appropriate support. Financial barriers further restrict access, as mental health services are not consistently integrated into primary healthcare and often require high out-of-pocket payments. For many women, especially those in rural or economically disadvantaged areas, these costs are prohibitive, effectively excluding them from care. The result is a system that not only overlooks maternal mental health but actively reinforces inequities in access and outcomes.

7. Conclusions

In 2022, postpartum depression affected 27.6% of young mothers in North Macedonia, while 27.8% experienced moderate to extreme anxiety.

Perinatal mood disorders can affect anyone, but their emergence is shaped by a combination of physical, psychological, relational, and structural factors. Difficulty adjusting to the new role may relate to previous mental health challenges, yet one of the strongest predictors of perinatal mood disturbances is the lack of social support and sense of community.

Modern society often leaves women isolated from the networks that could ease this transition. Individualistic lifestyles and the erosion of collective care deepen this isolation. Patriarchy remains a pervasive structural force shaping the conditions under which maternal mental health

difficulties arise and persist. In the perinatal period, its influence operates through cultural norms, institutional practices, and interpersonal dynamics that undermine women's autonomy, devalue emotional labor, and restrict access to care. The idealized image of the selfless, joyful mother, rooted in patriarchal expectations, creates a narrow framework for acceptable maternal experience. When women deviate from this ideal through depression, anxiety, ambivalence, or trauma, they are often met with stigma or dismissal, which intensifies their distress.

One of the most damaging effects of patriarchy in this context is the medicalization of maternal experience, where emotional, relational, and existential dimensions of pregnancy and early motherhood are reframed as clinical disorders. Rather than recognizing perinatal distress as a response to social, structural, and relational pressures, dominant biomedical frameworks often reduce it to individual pathology. This approach interprets women's suffering through the lens of dysfunction rather than context, concealing the systemic forces that contribute to it.

Clinical systems, shaped by patriarchal logics of control and efficiency, tend to prioritize diagnosis and pharmacological intervention over relational care and structural change. This risks transforming the perinatal period into a site of surveillance and correction, where deviations from normative emotional responses are quickly medicalized. The effects are particularly harmful for women from marginalized communities, whose expressions of pain or resistance are more likely to be pathologized or dismissed. Framing perinatal mental health as a disorder to be managed, rather than a signal of unmet needs or structural violence, allows institutions to avoid accountability for the conditions that shape maternal suffering.

> ***The absence of trauma-informed, culturally responsive, and socially embedded care reflects a broader devaluation of reproductive labor.***

When maternal distress is treated as a disorder rather than a consequence of unsupported caregiving, economic precarity, or gendered expectations, the burden falls on the individual. This isolates mothers and justifies the withdrawal of structural support such as paid leave, affordable childcare, and community-based services under the guise of clinical containment. In this way, the pathologization of the perinatal experience upholds patriarchal norms and conceals systemic neglect behind the language of diagnosis.

In North Macedonia, these dynamics are particularly visible within a context marked by economic inequality, weak social protection, limited access to care services, and lack of inclusion of men in caregiving responsibilities. Despite the country's alignment with international gender equality frameworks, policies that could alleviate the structural roots of maternal distress, such as shared parental leave, affordable childcare, and accessible mental health support, remain largely absent or unimplemented. The persistence of high female economic inactivity, coupled with the cultural ideal of the self-sacrificing mother, reinforces women's dependence on unpaid care work and constrains their social and psychological autonomy. At the same time, the lack of systemic support for mothers outside the capital deepens territorial inequalities

and leaves the majority of women without access to quality services. Within this context, the medicalization of postpartum suffering obscures the gendered and structural nature of maternal distress, framing it as an individual pathology rather than a collective social issue. This process isolates mothers and perpetuates a cycle in which care work is undervalued, emotional labor remains invisible, and the mental health of women continues to be treated as secondary to their reproductive function. Ultimately, maternal mental health in North Macedonia reveals the intersection of gendered expectations, socioeconomic precarity, and institutional neglect, exposing how the failure to support mothers reproduces broader patterns of inequality.

The situation in North Macedonia reflects a broader global pattern in which maternal mental health remains undervalued and insufficiently integrated into health and social policy. Around the world, perinatal mental health disorders are among the most common complications of pregnancy and childbirth, yet they continue to be underdiagnosed and undertreated. The World Health Organization estimates that roughly one in five women in low- and middle-income countries experiences depression or anxiety during or after pregnancy, with profound effects not only on the mother but also on child development and family well-being. The consequences extend across generations, affecting children's emotional and cognitive growth and perpetuating cycles of inequality and poor health. These outcomes are not inevitable but stem from systemic failures to recognize and support the psychological and social dimensions of motherhood. Globally, as in North Macedonia, perinatal mental health policies remain fragmented, with only a small number of countries offering comprehensive screening, referral, and treatment systems. The WHO's stepped care model and emphasis on respectful, culturally responsive, and integrated care provide a blueprint for progress, but implementation requires political will and sustained investment.

Addressing maternal mental health is not solely a health issue; it is a question of gender justice. It demands recognition of reproductive labor as essential social infrastructure and investment in policies such as shared parental leave, affordable childcare, and accessible psychosocial care that affirm women's rights and well-being as a collective social responsibility rather than an individual struggle.

8. Recommendations

Improving perinatal mental health in North Macedonia requires coordinated action across health, social, and community systems. Guided by the WHO Guide for Integration of Perinatal Mental Health into Maternal and Child Health Services, the following recommendations outline the key steps toward building an equitable, trauma-informed, and gender-sensitive system of care.

1. POLICY LEVEL

- **Integrate maternal mental health into the national health strategy (high priority)**: Perinatal mental health should be explicitly recognized within national health and gender equality strategies as a public health and social justice priority. Policies, budgets, and institutional mandates should reflect the importance of psychological well-being alongside physical maternal care. The National Mental Health Programme should be revised to include measurable provisions for maternal mental health, and a national protocol for maternal mental health support, including postnatal support groups, should be developed and adopted. Alignment with the WHO stepped-care model will allow differentiated responses according to the severity and type of distress.

- **Ensure insurance coverage for psychosocial support (high priority)**: Mental health services for mothers should be included in public health insurance packages, reducing financial barriers and improving equitable access across urban and rural areas.
- **Promote task-sharing and intersectoral collaboration (medium priority)**: Encourage collaboration between the Ministry of Health, Ministry of Labour and Social Policy, and civil society organizations to coordinate care pathways, service provision, and policy development. Civil society organizations should be recognized as official service providers under preventive health programs.
- **Map and strengthen the mental health workforce (high priority):** Conduct a national mapping of psychologists and mental health professionals in primary care to identify existing resources and gaps and ensure visibility and accessibility of services for women during pregnancy and postpartum. Include psychologists and psychotherapists in the official systematization of all primary health centers to formalize their role in service delivery and create sustainable care pathways.

2. SERVICE LEVEL

- **Introduce universal perinatal mental health screening (high priority)**: Maternal mental health screening should become a standard part of antenatal and postnatal care. Screening should include mothers and, where possible, partners, be repeated across key perinatal stages, and be paired with clear referral pathways to ensure timely care. Clear referral pathways should be developed from family doctors and patronage nurses to mental health services to avoid unnecessary referrals to psychiatry.
- **Strengthen capacity of healthcare providers (high priority)**: All healthcare workers involved in maternal and child health, including general practitioners, gynecologists, midwives, and nurses, should receive competence-based training in recognizing, responding to, and referring cases of perinatal mental distress. Training should be ongoing, include supervision and mentoring, and follow WHO guidelines for culturally responsive care. Existing mental health professionals should be supported to provide therapeutic (not only diagnostic) services. Patronage nurses should be trained to perform basic triage for maternal mental health and guide mothers toward appropriate support.
- **Ensure availability and accessibility of psychosocial support services (medium priority)**: Conduct a national mapping of existing services to identify gaps and inequities. Based on this, develop new community-based, multidisciplinary services staffed by professionals trained in perinatal mental health, trauma-informed approaches, and gender-sensitive care. Services should be accessible to all women, including those in rural areas. Pilot maternal mental health counseling services in selected primary care centers, with the goal of scaling nationally. Services should be accessible to all women, including those in rural areas, and sustainably funded through the national health budget or integrated programs.

3. COMMUNITY LEVEL

- **Develop and implement stigma-reduction campaigns (high priority)**: Public campaigns should normalize the emotional complexity of pregnancy and early motherhood, challenge idealized patriarchal norms of motherhood, and encourage help-seeking as a sign of strength rather than failure.
- **Establish peer support programs for mothers (medium prirority)**: Peer support groups should be accessible to all women, including those living in rural areas. Groups should be organized in health centers, local communities, and online platforms, and supervised by mental health professionals according to WHO guidance to ensure safety and effectiveness.

4. RESEARCH AND IMPLEMENTATION

- **Pilot programs for high-need populations (high priority)**: Initiate pilot projects targeting populations identified, such as mothers in rural areas or those experiencing economic precarity.
- **Collect data and monitor outcomes (high priority):** Integrate maternal mental health indicators into national health information systems to guide policy, resource allocation, and service improvement.
- **Evidence-informed scale-up (medium priority)**: Use data from pilots and research to inform national policy, service expansion, workforce planning, and resource allocation, ensuring the creation of a sustainable, culturally adapted, and gender-sensitive perinatal mental health system.

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