WHO CARES?

MOTHERHOOD, MENTAL HEALTH, and the INVISIBLE WEIGHT OF EXPECTATIONS

CONCLUSIONS AND RECOMMENDATIONS

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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.

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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Who Cares Motherhood, Mental Health, and the Invisible Weight of Expectations

Beyond Symptom Reduction: A Mixed-Methods Evaluation of a Postpartum Group Intervention and Perceived Emotional Change