Strengthening perinatal mental health is a requirement to reduce maternal and newborn mortality

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Estimates of global prevalence of poor perinatal mental health (PMH) range from 13 to 30 percent, with higher prevalence in low- and middle-income countries.[1] Defined as the period between pregnancy through two years postpartum, PMH includes clinical depression, anxiety, and psychosis, among other conditions. Myriad biological, socioeconomic, political factors, and gender inequalities can magnify the risk of poor PMH outcomes.[2]

Girls and women disproportionately experience poverty, limited educational opportunities, stigma associated with unmarried status, and sexual and gender-based violence, all of which influence the likelihood and severity of poor PMH. Socio-cultural constructs stigmatise mental illness and expect perinatal girls and women to be primary caregivers. Unequal social conditions limit girls' and women's autonomy to make care-seeking decisions, particularly when they experience marginalisation including migrants, people living with disabilities, and ethnic minorities.[3] Non-binary people and trans men also face elevated risk due to gender dysphoria, isolation, and anticipatory discrimination within communities and healthcare settings.[4] These intersecting factors contribute to an increased risk of poor PMH while diminishing its perceived importance and hindering PMH care seeking.

Increasingly, the evidence demonstrates the harmful impacts of poor PMH on maternal and infant outcomes, and the ripple effects on families, societies and economies. Perinatal girls and women with poor PMH are less likely to attend antenatal and postnatal care and are more likely to experience obstetric complications such as preeclampsia and preterm birth, or experience self-harm.[2] Suicide is the leading cause of death in the year following birth and accounts for up to 20 percent of maternal deaths globally.[5] Infants of mothers who experience poor PMH are also at higher risk of experiencing inadequate growth, more childhood illnesses, and early cessation of exclusive breastfeeding.[2] They are also more likely to experience worse cognitive, behavioural, social-emotional, and motor development outcomes.[6] These neurodevelopmental interruptions in infancy can influence long-term development and have been associated with poor academic performance, lower earning potential, and poor health in adulthood.[7] Early childhood exposure to maternal depression also increases the longitudinal risk for depression during adolescence, with the risk extending through adulthood. Pre-existing mental illness is a risk factor for poor PMH, which in turn can lead to poor mental health in offspring perpetuating intergenerational cycles of the harmful sequelae of poor PMH.[8] At a societal level, untreated PMH can present significant economic issues. A modelling study in South Africa examining the impacts of poor PMH for women and their infants for 10 years in women and 40 years in children, estimated the lifetime costs of perinatal depression and anxiety per annual cohort was 2.8 billion U.S. dollars.[9]

USAID aims to optimise PMH for perinatal girls, women, and their infants and families. This aligns with the Agency's vision of a world in which all perinatal girls and women, regardless of their circumstances, can enjoy the highest standard of mental health, so they and their newborns and families can all reach their full potential and contribute to the development of their communities and countries. USAID is currently working to achieve this in diverse global contexts through implementation research and bringing evidence-based models of PMH services to scale. Country-level stakeholders and implementing partners express high levels of interest in addressing PMH to improve maternal and newborn outcomes and reduce mortality. USAID's recently released Mental Health Position paper provides valuable guidance to bring this vision to fruition. It promotes the use of human rights and 'do no harm' practices, locally tailored and contextualised approaches developed in partnership with communities, addressing barriers including multi-level stigma and discrimination, while prioritising sustainability.

PMH intervention planning, implementation, and monitoring and evaluation activities must systematically include individuals who experience elevated risk for poor PMH, including adolescents, girls and women with disabilities and with HIV/AIDS, migrants and

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refugees, and other marginalised groups, to ensure interventions are effective. Strengthening the availability of high-quality and disaggregated data for decision-making is also foundational to reaching diverse subpopulations. Given the majority of the global healthcare workforce comprises women who work within gendered health systems,[10] activities that address systems challenges and strengthen the mental health and well-being of healthcare providers should be gender-transformative to position them to provide respectful maternal and newborn care which is inextricably linked to PMH.

USAID cannot achieve this vision alone. It requires collective action and sustained commitments from donors, governments, global and local partners, academia, the private sector, community and faith organisations, and advocacy groups to enable whole-of-society approaches that shift the underlying factors that influence PMH risk and optimise outcomes. Raising awareness of poor PMH across all segments of society will lead to greater investment and action. This collective work can strengthen the health of perinatal girls and women, their newborns, and their families, while interrupting the intergenerational impacts of poor mental health, reducing maternal mortality, and contributing to stronger societies.

Contributors

MD: Conceptualization, writing original draft.
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Declaration of interests

We declare no competing interests.

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