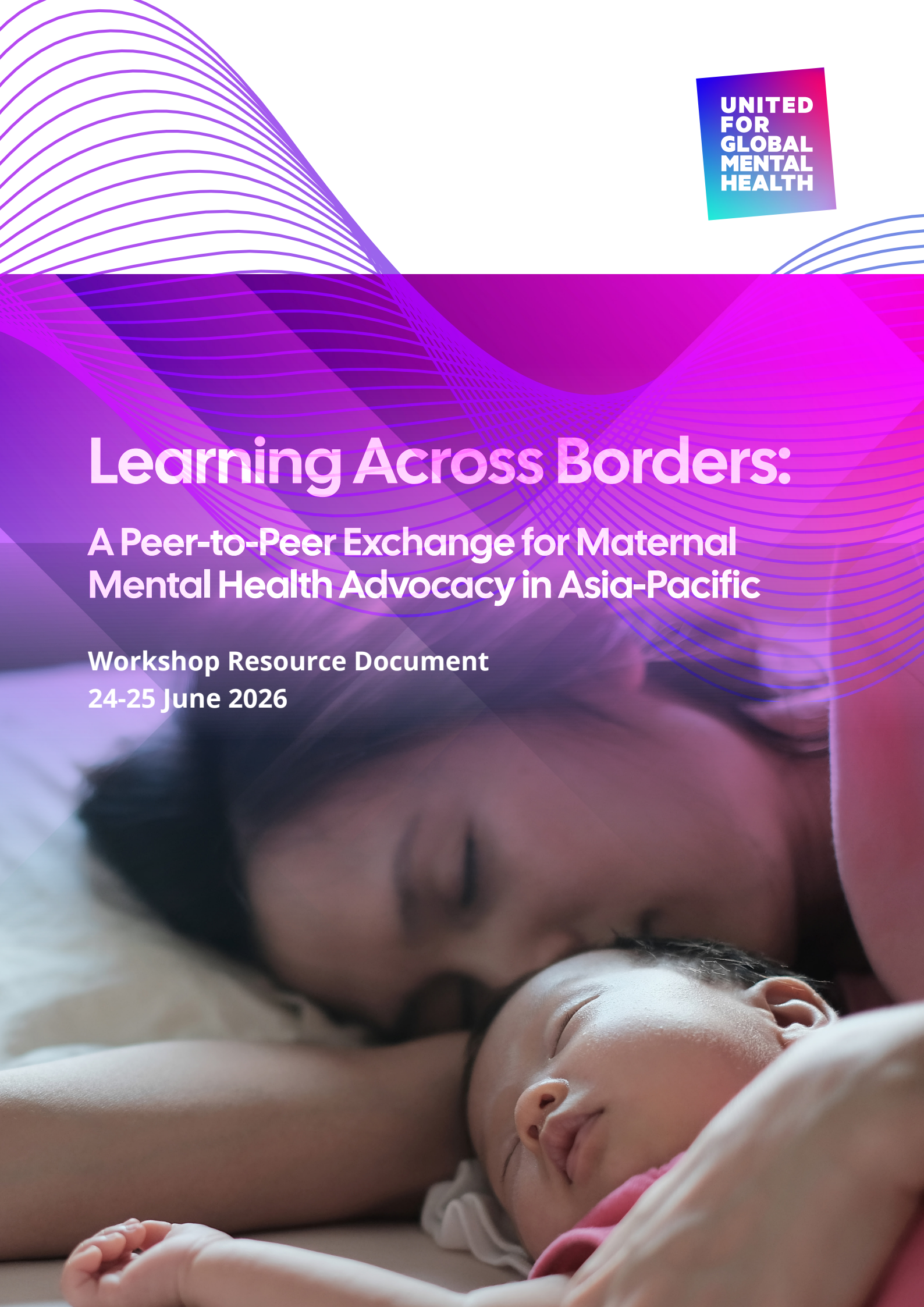
UNITED FOR GLOBAL MENTAL HEALTH

Learning Across Borders:

A Peer-to-Peer Exchange for Maternal Mental Health Advocacy in Asia-Pacific

Workshop Resource Document
24-25 June 2026



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Executive Summary

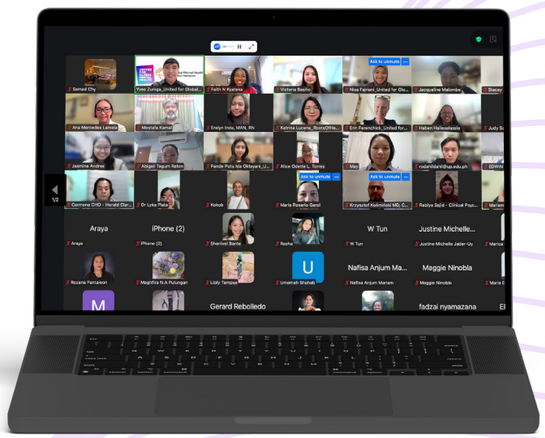
Every year, millions of women worldwide face maternal mental health problems during pregnancy or up to one year after giving birth. This silent mental health crisis has huge repercussions for mothers and their children, with consequences that could ripple down the generations – unless we act now.

Maternal mental health care is fundamental to the wellbeing of mothers, babies, families and whole communities. It must be a routine part of health systems, not an afterthought. That was the one message that most resonated at UnitedGMH's two-day workshop, *Learning Across Borders: A Peer-to-Peer Exchange for Maternal Mental Health Advocacy in Asia-Pacific* on 24 to 25 June 2026.

The workshop and its findings come at a pivotal moment. As moves to integrate maternal mental health into maternal and primary care systems across Asia-Pacific gather pace, we have an opportunity to build on that momentum and make a profound difference to the lives of mothers and babies in the region and beyond.

Recognising that many countries face similar implementation challenges, the workshop highlighted the opportunity to accelerate progress through regional collaboration. It brought together more than 140 participants from across 30 countries in the Asia-Pacific region and beyond to strengthen regional advocacy, exchange practical lessons and foster new partnerships. Participants included policymakers, civil society leaders, health professionals, researchers, development partners and people with lived experience.

There was strong consensus that maternal mental health should be integrated into primary health care – specifically reproductive, maternal, newborn, child, and adolescent health (RMNCAH) services. Participants emphasised that integration must move beyond isolated pilots and become part of routine antenatal and postnatal care, community health visits, and trusted services women already use. All participants agreed that achieving this at scale requires political commitment, financing, workforce capacity, and advocacythat connects data with lived experiences.



Group photo taken during the Asia-Pacific Regional Maternal Mental Health Advocacy Workshop on June 25, 2026

Key facts

This is a crisis on a massive scale – but one that rarely hits the headlines.

1. Globally, around 1 in 5 women experience maternal mental health problems during pregnancy or within the first year after childbirth.[1]
2. Poverty, gender inequality, violence and isolation all fuel the prevalence of maternal mental health problems.[2]
3. Depression is the most common complication of pregnancy and childbirth, while suicide is a leading cause of maternal death.[3]
4. Children of mothers with poor perinatal mental health are at greater risk of developing suboptimal growth and development.[2]
5. Untreated perinatal mental health conditions are estimated to cost around US$2 billion per country, per annual birth cohort.[4]

The region's top four suggestions

Participants in the Asia-Pacific workshop identified the following key steps to better maternal mental health:

1. **Move beyond screening to delivering care**

   Several countries have introduced maternal mental health screening during and after pregnancy. Yet according to many participants, women who were identified as needing mental health support often did not receive it. In numerous countries, the priority should not only start the screening, but also strengthen referral pathways, workforce capacity, supervision and access to evidence-based psychosocial interventions, such as the WHO *Thinking Healthy Programme*.

2. **Frame maternal mental health as an investment**

   Participants repeatedly stressed the need to position maternal mental health as an investment that strengthens health systems, early childhood development, and economic productivity. Several country experiences, including PAM Foundation's work in Thailand, demonstrated that this broader framing is more effective for securing political and financial commitment.

3. **Build advocacy around local evidence and lived experience**

   Drawing on lessons from partners leading maternal mental health advocacy in Africa, the workshop reinforced that the most successful advocacy efforts combine robust local evidence with the voices of women and families with lived experience. Participants highlighted that this combination helps decision-makers understand both the scale of the problem and its human impact, making it more effective in building political commitment and securing sustainable financing for maternal mental health.

4. **Sustain regional learning beyond the workshop**

   Many participants described remarkably similar implementation challenges and expressed strong interest in continuing regional exchange through:

   - a shared resource repository
   - regular peer learning
   - country case studies
   - an ongoing Asia-Pacific working group to accelerate implementation.

   United for Global Mental Health, under Global Mental Health Action Network (GMHAN), will create a Maternal Mental Health Working Group to continue fostering collaboration and accelerate progress on maternal mental health across the Asia-Pacific region and beyond.

Introduction

The perinatal period – from pregnancy through the first year after childbirth – is often a physically, emotionally and socially vulnerable time for mothers. The physical risks of pregnancy and childbirth are widely recognised. However, the mental health challenges millions of women experience at these critical times receive far less attention – especially across many countries in Asia and the Pacific.

Globally, around 10% of pregnant women and 13% of women after childbirth experience a mental health condition, predominantly depression. The burden is significantly higher in low- and middle-income countries (LMICs), where an estimated 15.6% of women experience mental health conditions during pregnancy and 19.8% after childbirth.[5]

Across the Asia-Pacific region, many pregnant and postpartum women do not get the mental health care they need due to workforce shortages, inadequate financing, stigma, gender inequities, humanitarian crises, and weak integration of mental health within maternal and child health services. Young mothers and women from underserved and marginalised communities are often at even greater risk of poor mental health outcomes during the perinatal period.[6]

Maternal mental health significantly influences a mother's wellbeing, her ability to provide nurturing care, and broader maternal, newborn, and child health outcomes. Yet despite its importance for women, children, families and communities, maternal mental health remains insufficiently prioritised within health systems. It receives both insufficient political attention and funding across much of the region. Mental health support is still inadequately integrated into primary health care – specifically routine reproductive, maternal, newborn, child and adolescent health (RMNCAH) services. This leaves many women without access to timely, affordable, and culturally appropriate care.

These challenges are being further compounded by shifting global financing. Humanitarian and development assistance is being cut, putting essential health and social services – including maternal mental health – under increasing strain.

Our three-year initiative

In this evolving landscape, we urgently need to strengthen advocacy, regional collaboration, and integrated approaches that embed mental health within maternal and newborn care systems.

United for Global Mental Health is launching a three-year maternal mental health initiative to strengthen advocacy for integrating maternal mental health into existing RMCAH services. Building on the success of the inaugural Africa regional workshop in 2025, the initiative has expanded to the Asia-Pacific region to foster regional learning, strengthen partnerships, and support country-led advocacy efforts.

As part of this initiative, the *Learning Across Borders: A Peer-to-Peer Exchange for Maternal Mental Health Advocacy in Asia-Pacific* workshop was held on 24–25 June 2026. The workshop brought together policymakers, multilateral agencies, civil society organisations, researchers, healthcare providers, funders, and advocates from across the region. It provided a platform to:

- exchange evidence and implementation experiences
- identify opportunities for stronger regional collaboration
- explore practical approaches to advancing policies, financing, and service delivery that better integrate maternal mental health into existing RMNCAH services.

This report captures the key discussions, lessons, and recommendations from the workshop. By documenting these collective insights, it aims to support continued collaboration and contribute to strengthening maternal mental health across the Asia-Pacific region.

[5] WHO website, Perinatal Mental Health. https://www.who.int/teams/mental-health-and-substance-use/promotion-prevention/perinatal-mental-health
[6] Howard, L. M., & Khalifeh, H. (2020). Perinatal mental health: a review of progress and challenges. World psychiatry: official journal of the World Psychiatric Association (WPA), 19(3), 313–327. https://doi.org/10.1002/wps.20769

Regional consensus: key advocacy messages

Integrate maternal mental health within routine care.

When maternal mental health is presented as part of quality maternal and child health, governments can use existing platforms, supervision structures, indicators, and budgets. Mental health screening, psychosocial support, referral and follow-up should be embedded in primary health care. This includes antenatal care, postnatal care, community platforms, and child health contacts. Integration also reduces stigma, allowing women to receive support through routine care rather than being referred into a visibly separate mental health pathway.

"It is not about creating a new system, but about making better use of the systems that already exist. Maternal mental health should become a part of routine, quality antenatal and postnatal care." Ruth O'Connell, UNICEF.

Keynote remark by Ruth O'Connell, Mental Health and Psychosocial Support (MHPSS) Specialist, Global Programme Division, UNICEF Asia-Pacific Office.

Task-sharing is essential, but supervision is non-negotiable.

The region faces a shortage of specialist mental health professionals, particularly outside urban centres. Country examples showed that trained midwives, community health workers, and lay counsellors can deliver mental health care when backed by rigorous training, clear protocols, referral pathways and supportive supervision. The lesson is not simply to add work to already stretched frontline workers. Task-sharing must be designed with adequate training time, refresher sessions, mentoring, referral options, and attention to the wellbeing of providers themselves.

"Many of the midwives that we work with say, 'I wish I had these skills."
Shanon McNab, UNFPA Asia-Pacific Regional Office

Keynote remark by Shanon McNab, Regional Advisor for Sexual and Reproductive Health and Rights (SRHR) at UNFPA's Asia-Pacific Regional Office.

Keynote remark by Dr Vasoontara S. Yiengprugsawan, Senior Universal Health Coverage Specialist (Service Delivery) at the Asian Development Bank.

"We want to look at how to support the frontline workers, because they are really the one that the mother is going to meet during check-ups, and oftentimes they're the one that can see what's happening before and after birth."
Dr Vasoontara Yiengprugsawan, Asian Development Bank

Family and community engagements are necessary.

Women rarely make decisions about care in isolation. Husbands, mothers-in-law, community leaders, faith leaders, and peers can either support disclosure and care-seeking or reinforce silence and stigma. Effective maternal mental health advocacy therefore needs an understanding of the community, strategies to reduce stigma, and family-sensitive communication. Programmes must also give frontline workers the support to manage privacy, family conflict and safety concerns.

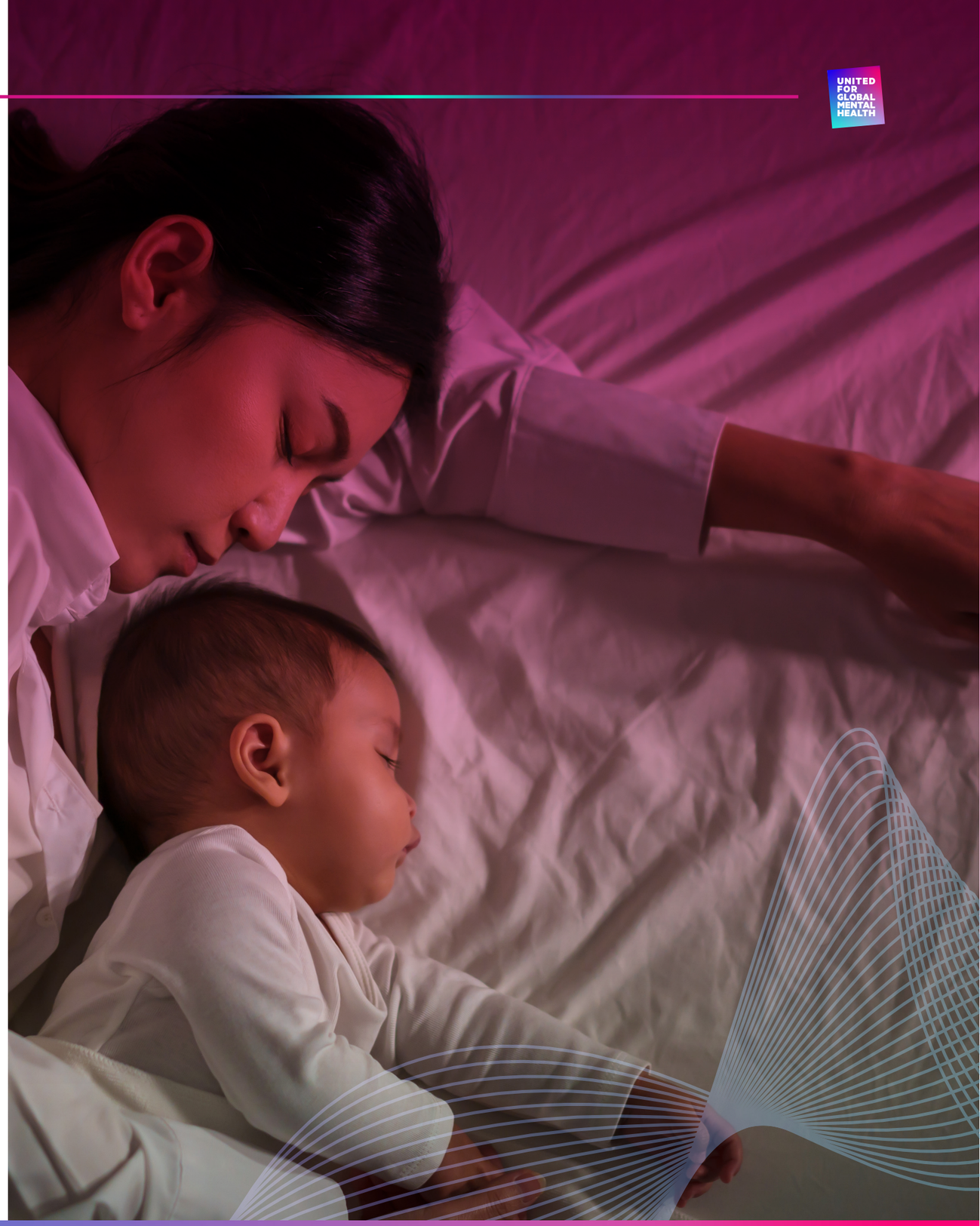
The investment case is both human and economic.

Untreated maternal mental health conditions carry large social and economic costs. Maternal mental health affects survival, wellbeing, responsive caregiving, child development, educational outcomes, productivity, and health-system costs. The workshop repeatedly positioned maternal mental health as an investment in human capital, not only a clinical service need. Thailand's presentation and workshop summary cited an estimated 200,000 women per year affected by perinatal mental health problems and an economic cost of about US$2 billion per annual cohort.

"There is a story behind every statistic. Perinatal mental health problems do not discriminate, they can affect everyone, everywhere."
Hamish Magoffin, PAM Foundation

"Maternal mental health is not merely a health sector responsibility. It is an investment in human capital, family resilience, and sustainable development." - Dr Imran Pambudi, Ministry of Health Indonesia

Keynote remark by Dr Imran Pambudi, Director of Vulnerable Group Health Services, Ministry of Health Indonesia.



Lived experience turns evidence into action.

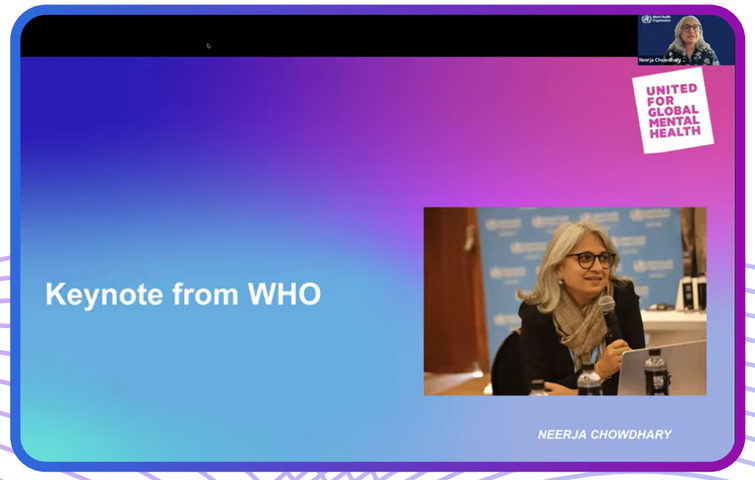
Data opens doors; stories move people to act. Maternal mental health advocacy should centre mothers and people with lived experience, taking care to protect dignity, consent and safety. Storytelling should be strategic: tailored to the audience, consistent across platforms, and connected to a concrete policy or financing ask. UnitedGMH's campaign experience pointed to a practical communications journey, from awareness to understanding, commitment, and then ultimately into action.

Regional collaboration is a force multiplier.

Participants valued the workshop as a rare space for Asia-Pacific maternal mental health advocates to learn from one another. The exchange with our partners in the Africa region who have built an alliance, community of practice, and national-level advocacy showed that peer learning can accelerate adaptation, reduce duplication and give advocates a stronger collective voice with funders and policymakers.

"So, what do we need at this moment? We need global leadership to advocate for change. That's why we are all here. We need regional collaboration to share knowledge and strategies. And we need national commitment to integrate mental health into every layer of maternal care." Neerja Chowdhary, WHO

Keynote remark by Dr. Neerja Chowdary, Technical Officer at Department of Noncommunicable Diseases and Mental Health, World Health Organization.



Lessons from perinatal mental health interventions across asia-pacific: country spotlights

The country examples below show how maternal mental health advocacy can be advanced in practice from different starting points:

Thailand: PAM Foundation

Using economic evidence and coalition-building to make perinatal mental health a national policy and investment priority

Hamish Magoffin presented PAM Foundation's work on adapting the economic case for perinatal mental health to Thailand context, demonstrating how locally generated evidence can support policy advocacy and investment in maternal mental health.

Intervention design and implementation

The Perinatal Alliance for Mental Health (PAM) Foundation and PAM Thailand presented a systems-strengthening and advocacy model organised around three pillars:

- awareness and education
- care
- research.

The work was grounded in lived experience after the loss of Pranaiya and Arthur Magoffin to postpartum depression in 2021. It expanded into a wider effort to reduce stigma, strengthen care pathways, and build an evidence base for investment.

The Thailand case worked because it began by mapping assets, not only gaps. The country has universal health coverage, high use of antenatal care services, existing mental health infrastructure, antenatal depression-screening guidelines, and increasing public awareness of mental health. PAM Foundation uses these entry points to make the case for stronger perinatal mental health pathways, including screening, referral, professional training, peer and group support, and locally adapted guidance for providers.

Advocacy strategy

The investment case was a turning point for advocacy. Working with the London School of Economics and Thai partners, it estimated the cost of untreated perinatal mental health conditions at about US$2 billion, or 68 billion Thai baht, per annual cohort. Of these costs, 97% fall outside the health system, which means ministries of health cannot see the full price of inaction if they look only at clinical expenditure. This evidence helps frame perinatal mental health not only as a clinical concern, but as an economic and social investment issue. Through PAM Thailand and alliance-building efforts, the foundation is also working to bring together professionals, researchers, civil society actors, and policymakers around a shared national agenda.

Challenges encountered during implementation

Perinatal mental health remains under-recognised and under-treated in Thailand. Screening and referral systems are inconsistent, and specialist mental health services remain concentrated in Bangkok and other urban centres. There are also gaps in national standards, validated screening, specialist training, and clear care pathways. Stigma continues to discourage disclosure and help-seeking, particularly among women in rural areas, migrant populations, and informal-sector workers.

Factors that supported success

Thailand has several conditions likely to promote progress: strong antenatal care, universal health coverage, existing mental health services, and increasing public openness to mental health conversations. PAM Foundation's three-pillar model also creates a clear structure for action: awareness can reduce stigma, care pathways can improve access, and research can strengthen the investment case. The use of economic evidence is especially important for engaging ministries and decision-makers who may not respond to health arguments alone.

Recommendations and learnings

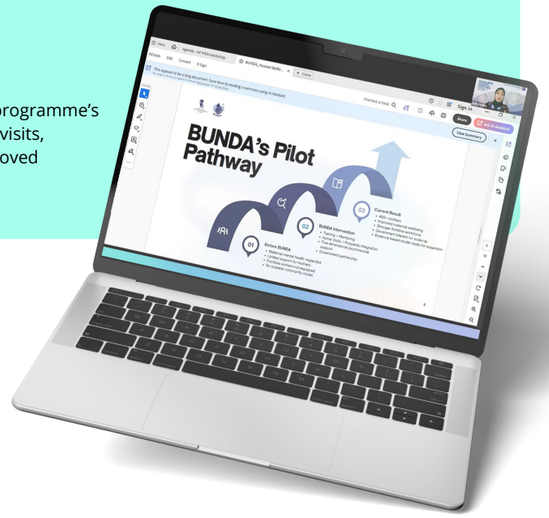
PAM Foundation's case shows that advocacy can be strengthened by linking lived experience with data and economic analysis. Countries should map existing care systems, identify structural gaps, develop national guidelines, pilot referral pathways, create practical toolkits for frontline providers (e.g. obstetricians, paediatricians, and nurses), and invest in local research. PAM Thailand's model connected the pieces: public awareness made the problem discussable, research made it fundable, and alliance-building created a platform for guidelines, pilots, training, and policy engagement.

Further information:

1. PAM Foundation's core activities: www.pamfoundation.org
2. PAM Thailand's PMH cost calculator tool and other research outputs: https://www.pamthailand.org/en/research

Indonesia: BUNDA - FMCH Indonesia
Integrating psychosocial support into maternal and child health services through midwives, community health workers, and family engagement

Syifa Andina, chairwoman of FMCH Indonesia, showcased BUNDA programme's model, demonstrating how integrated psychosocial support, home visits, mentoring, and government partnerships have contributed to improved maternal wellbeing and created a scalable model for expansion.



Intervention design and implementation

Foundation of Mother and Child Health (FMCH) Indonesia presented the country's 'first community-based maternal mental health programme'. BUNDA – which means *Bersama Mendukung Ibu Sehat dan Bahagia* or 'Together Supporting Healthy and Happy Mothers' – supports pregnant and breastfeeding mothers by integrating mental health support into existing community health services.

In rural, underserved, climate-vulnerable, and disaster-prone communities, BUNDA works through midwives and community health workers, combining training, mentoring, home visits and community-service integration. Its five-dimensional psychosocial approach includes:

(1) cognitive support based on WHO's Thinking Healthy Programme
(2) active listening
(3) physical wellbeing
(4) social support from husbands and family members
(5) spiritual wellbeing.

The pilot has reached more than 400 mothers, trained 40 midwives, and generated government interest in scale-up.

Advocacy strategy

UNDA's advocacy strategy: demonstrate maternal mental health support can be delivered through systems communities already trust. The programme has engaged local government, community leaders, midwives and families to increase awareness and reduce stigma. FMCH Indonesia is also working with the Ministry of Health to explore national scale-up, including options for integrating BUNDA training into existing health-worker training systems.

Challenges encountered during implementation

Implementation also revealed important challenges. A short five-day training period is not enough for midwives and cadres to feel fully confident – they require continued mentoring, coaching and refresher support. Mental health remains taboo in many rural communities, making disclosure difficult. Midwives may also find it challenging to manage the full scope of service delivery during home visits, especially when women need more time, privacy or referral support. Cost is another concern for national scale-up, particularly if training is not embedded within existing systems.

Factors that supported success

Several factors supported BUNDA's delivery. First, the programme builds on FMCH Indonesia's long-standing experience in maternal and child health. Second, it uses existing community platforms, making support more accessible and affordable for mothers. Third, home visits respond to mothers' preferences and reduce barriers to care. Fourth, the programme recognises that husbands and family members play an important role in maternal wellbeing, and therefore includes family engagement.

Recommendations and learnings

The BUNDA experience shows that community-based maternal mental health models should be low-cost, culturally acceptable, and integrated into routine maternal and child health services. Scale-up should prioritise sustained training and supervision for frontline workers, practical tools for family engagement, and strong links with government systems. BUNDA also shows that culturally acceptable care may look less like a formal mental health appointment and more like a trusted visit that begins with ordinary maternal and child health concerns. The mental health component becomes acceptable because it is wrapped in relationships, practical support, family explanation, and repeated contact.

A community health worker conducts a home visit as part of the BUNDA Programme, which integrates maternal mental health support into the existing primary health services. Photo credit: Foundation for Mother and Child Health (FMCH) Indonesia.

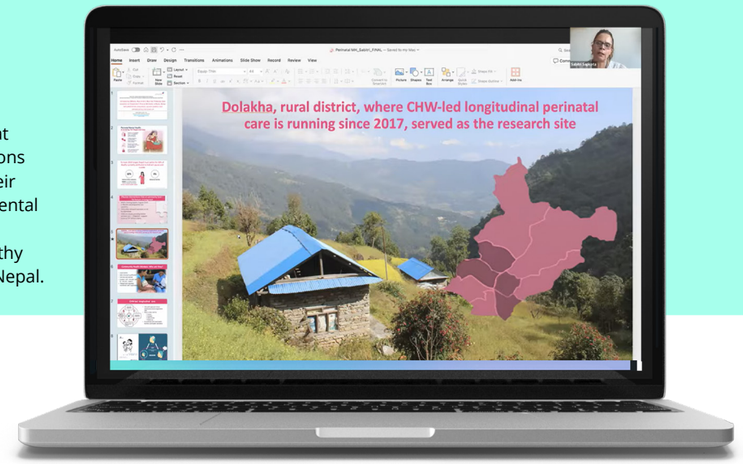
Further information:

1. FMCH Indonesia's BUNDA programme: https://fmch-indonesia.org/program-bunda/
2. Story of the midwives and cadres in BUNDA program can be accessed here
3. Story of mothers in BUNDA programme can be accessed here

Nepal: Possible

Embedding the Thinking Healthy Programme into routine community health worker-led perinatal care to reach mothers at home with trusted support

Dr. Sabitri Sapkota, Executive Director and Senior Scientist at Possible, shared lessons and findings from their CHW-led maternal mental health services using WHO's Thinking Healthy programme in rural Nepal.



Intervention design and implementation

Possible Nepal presented a hybrid effectiveness-implementation study in Dolakha district, where community health workers have delivered longitudinal perinatal care since 2017. The model integrates WHO's Thinking Healthy Programme into routine home-based antenatal and postnatal care, delivered by local, salaried, full-time community health workers provided with mHealth decision support and regular supervision. They conduct door-to-door screening, counselling, referral and follow-up, coordinating with local health facilities and health volunteers.

The intervention used EPDS screening within routine workflows. Of 915 women who were screened, 57 women were positive for perinatal depression using EPDS score 10 or above, and 56 received the Thinking Healthy Programme. Mean EPDS score fell from 12.6 at baseline to 3.9 at three months and 4.4 at six months. Suicidal ideation declined from 8 women at baseline to 1 at three months and 3 at six months, while CHWs referred 3 cases to higher care.

Implementation lessons were equally important: confidentiality, domestic distractions, family dynamics, the emotional burden on community health workers (CHWs), and the time required for deep conversations all need active management.

Advocacy strategy

Possible's advocacy value lies in demonstrating that evidence-based psychosocial support can be integrated into an existing community health worker platform. The programme generates evidence – on feasibility, effectiveness, supervision, confidentiality, family dynamics and referral – to help policymakers understand what it takes to integrate maternal mental health into routine household perinatal care.

Challenges encountered during implementation

Women were often comfortable discussing physical symptoms with community health workers, but emotional distress was different. Because CHWs lived in the same community, some women feared confidentiality breaches or exposure of family conflict. Family members could be supportive allies, but they could also become barriers, particularly when women needed privacy to speak. Delivery was also time-intensive, and CHWs required support to manage emotional burden, domestic distractions, and referral for more complex cases.

Factors that supported success

Ensuring the service is delivered in a private and convenient place is key. CHWs used practical strategies, such as meeting family members before or after sessions, creating a more comfortable environment, inviting a colleague to engage with a family member while the session continued, and using supervision to manage emotionally difficult situations. As a result, women were more willing to open up. The integration of mental health into physical perinatal care also made it easier for people to use the service without feeling stigmatised.

Recommendations and learnings

Possible's example shows that integration at household level can reduce stigma and reach women who would not seek facility-based care. However, programmes must be carefully designed. They should strengthen confidentiality safeguards, build CHW capacity to address stigma at the point of care, ensure supportive supervision, and connect women to higher-level care when needed. Family engagement is an important source of support, but women's privacy and safety must remain central.

Nepal's example also showed why provider wellbeing belongs in the model. CHWs were hearing stories of distress, family conflict, isolation, suicidal thoughts, and domestic pressure. Supportive supervision improved their confidence and helped them carry that emotional responsibility without being left alone with it.

Strengthening CHWs capacity, supportive supervision, and confidentiality safeguards are essential to improve mental health service uptake among pregnant and postpartum women. Photo credit: Possible.

Further information:

1. Possible's core activities: https://possiblehealth.org/
2. Possible's full implementation study result can be accessed here

Transferable cross-country lessons

Country example	Primary entry point	Advocacy strength	Transferable lesson
Thailand - PAM Foundation	Policy, professional, and research platforms	Economic evidence, alliance building and public awareness	Use costing and coalition-building to move maternal mental health from concern to budget priority.
Indonesia - BUNDA/FMCH	Midwives, community health workers, home visits and community health services	Government partnership and a low-cost, family-sensitive model	Embed psychosocial support into trusted community platforms and design training for scale.
Nepal - Possible	CHW-led longitudinal perinatal care	Implementation evidence from routine household care	Integrate evidence-based psychosocial support into existing CHW workflows with supervision and confidentiality safeguards.

Across the examples, the most promising models used existing touchpoints, trained trusted frontline workers, adapted tools to context, involved families carefully, and generated evidence that could be used for advocacy. The main barriers were also shared, including stigma, workforce constraints, training costs, weak referral path-ways, confidentiality risks and insufficient financing.

FROM KNOWLEDGE TO ACTION: ADVOCACY FOR PERINATAL MENTAL HEALTH

Lesson #1: Build coalitions that can carry a united message

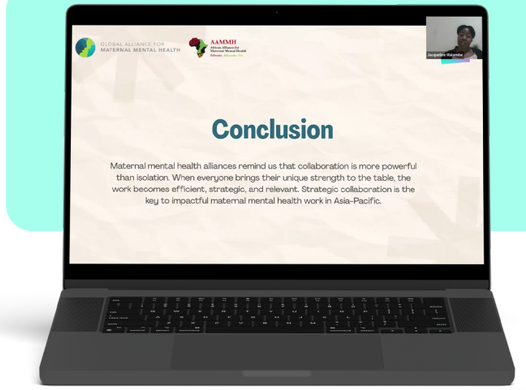
The African Alliance for Maternal Mental Health showed how alliances can act as centres of coordination, knowledge exchange, and policy influence. For Asia-Pacific, the immediate task is not to copy one model, but to start where countries are:

- map existing governance and professional structures
- identify champions
- choose a feasible advocacy goal
- build shared ownership among civil society, professional associations, researchers, and people with lived experience to grow the alliance sustainably.

An example from THRIVE PMH Community of Practice also shows how a coalition can act as a peer learning community to support practitioners in the field.

"The best thing about this field is that we do not have to reinvent the wheel in every country. We just have to find each other."
Stacey Ann Pillay, Healthy Brains Global Initiative

Stacey Ann Pillay introduced the Perinatal Mental Health Community of Practice (PMH CoP) as a global platform for shared learning and action.



"Partnership is the name of the game when it comes to building alliances. Don't think about how we do things differently, but how we do them together."
Jacqueline Malombe, AAMMH

Jacqueline Malombe shared lessons learned from African Alliance for Maternal Mental Health and how it can be replicated to Asia-Pacific region.

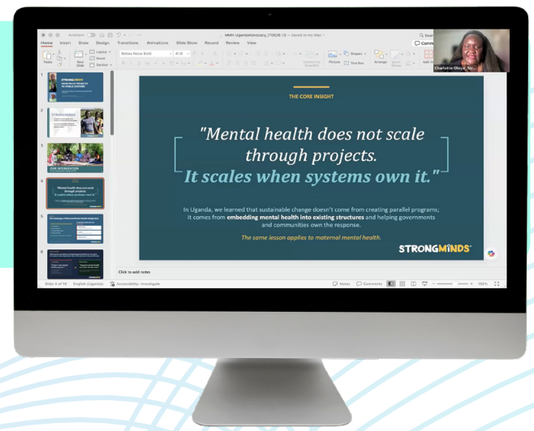
Lesson #2: Speak the language of decision-makers

Advocacy messages should be translated for the audience. Use evidence and related data from perinatal mental health that is tailored to the audience to inform budget cycles, quality improvement and policy briefs. Ministries of Health may respond to messages about primary care integration, maternal and newborn morbidity, and service standards. Ministries of Finance may respond to messages about productivity, avoidable long-term costs, and return on investment. Education and child-development actors may respond to messages about learning outcomes and early childhood development. Community leaders may respond to messages about family wellbeing, dignity, and practical support.

Advocacy is not about convincing governments to do more, it is about showing them they already have platforms. For maternal mental health, those platforms include antenatal clinics, immunisation visits, CHWs, schools, women's groups, faith communities, nutrition programmes, and social protection contacts.

"Maternal mental health does not scale through projects. It scales when systems own it."
Charlotte Oloya, StrongMinds Uganda

Charlotte Oloya shared advocacy strategies at the national level from StrongMinds Uganda's experience.



Lesson #3: Use stories ethically and strategically

The storytelling session underlined that communication is part of how policy change happens. Campaigns should begin with audience analysis: who do we need to convince, who influences them, what do they already believe, which channels do they trust, and what action is being requested.

United for Global Mental Health and African Alliance for Maternal Mental Health show that campaign moved from awareness to understanding, commitment and action. Along the campaign journey, advocates need to keep in mind that ethical storytelling requires consent, safeguarding, clear purpose, and a refusal to extract pain for visibility. It should also include varied perspectives from mothers, adolescent mothers, health workers, families, education professionals, protection systems, community leaders, and people facing poverty, violence, or other intersecting risks.

"Stories turn evidence into emotion and action."
Faith N. Kyateka, United for Global Mental Health

Faith Kyateka from United for Global Mental Health explained how the power of storytelling can support maternal mental health advocacy and shared practical ways to do it.

Participant Reflections

"For many women, especially in low-income settings, the perinatal period is shaped by poverty, stigma, and the sheer weight of caring for a family without support. In places like these, where there are no screening tools and too few mental health professionals, maternal mental health conditions go unnoticed and untreated."

"We know what works — community-based care, peer support, and proven models from across Asia and Africa. The task now is to share what we already know and make sure resources flow to the women who need them."

"Thank you to United for Global Mental Health and all the facilitators for organizing such an inspiring and informative workshop. I look forward to staying connected with this regional network and contributing to ongoing efforts to improve maternal mental health."

Recommendations

For governments:

- Recognise maternal mental health as an essential component of quality primary health care, specifically maternal, newborn, child, and adolescent health services.
- Integrate screening, brief psychosocial support, referral and follow-up into ANC, PNC, and community health platforms for families.
- Create budget lines or protected financing for workforce training, supervision, referral pathways, and service monitoring.
- Add maternal mental health indicators to routine health information systems with safeguards for privacy, confidentiality, and safety.

For development partners and donors:

- Fund integrated public-system models rather than parallel pilots, with transition plans for government ownership.
- Invest in task-sharing, underpinned by rigorous training with supportive supervision, and provider wellbeing as core implementation costs.
- Support economic analysis, implementation research, and open-access tools that countries can adapt.
- Use grant requirements and technical assistance to strengthen accountability for lived experience, equity, and stigma reduction.

For civil society and professional organisations:

- Build coalitions that align maternal health, mental health, child development, gender, youth, disability, and community actors around a shared ask.
- Centre mothers and people with lived experience in advocacy design, messaging and accountability.
- Translate evidence into simple policy messages, community campaigns and professional guidance.
- Work with families, community leaders and frontline providers to reduce stigma and strengthen support for women.

For researchers and academic institutions:

- Prioritise implementation research that answers what works, for whom, at what cost, and under what conditions.
- Validate and adapt screening tools and psychosocial interventions for local contexts.
- Generate evidence on adolescent mothers, climate-affected communities, migrants, rural women, and other underserved groups.
- Share protocols, briefs and data-use tools in formats that advocates and ministries can apply.

WORKSHOP RECORDINGS

Day 1 – Country Implementation Spotlights

Day 2 – Turning Knowledge into Action: Advocacy Strategies

REFERENCES

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