REPORT

PERINATAL DEPRESSION IN UGANDA:

Supporting Recovery Through Community-Based Care

2026

STRONGMINDS®

PERINATAL DEPRESSION IS ALL TOO COMMON. THE SOLUTION EXISTS.

Community-based group talk therapy is opening up access to mental health care for women in sub-Saharan Africa.

Few changes in life are as profound as becoming a parent. Pregnancy and the postpartum period can bring joy and anticipation, but they can also be exhausting, disorienting, and deeply stressful. For many women, this season of life also brings relationship strain, financial pressure, isolation, and, for some, grief and loss.

In low- and middle-income countries, up to a quarter of women experience perinatal depression, and most never receive care. Left untreated, perinatal depression can have serious consequences not only for women, but for the health and overall well-being of their children.

Urgent challenges require scalable solutions. That is why StrongMinds is partnering with governments across East and Southern Africa to expand access to community-based mental health care.

This report explores the benefits of community-based group talk therapy for women experiencing perinatal depression in Uganda. Their experiences make a powerful case for expanding community-based care for perinatal women at the local, national, and global levels.

Images by Karin Schermbrucker.

WHAT IS PERINATAL DEPRESSION?

Perinatal depression is depression that occurs during pregnancy or within one year of childbirth. Its symptoms — persistent sadness, loss of interest and energy, difficulty concentrating, impaired stress tolerance, and thoughts of self-harm — are the same as depression at any other point in life. But the timing makes it distinct, because its consequences extend beyond the mother herself.

Left untreated, perinatal depression shortens lifespans, reduces quality of life, and limits opportunity. For pregnant women specifically, it raises the risk of miscarriage, preterm delivery, preeclampsia, and suicide. It also increases the likelihood that depression will become chronic and recurrent, compounding its toll over time.

Children are affected too. Infants born to mothers with untreated depression face higher rates of low birth weight, prematurity, and stunted growth. As they develop, these children show higher rates of cognitive, emotional, and behavioral difficulties, and are more likely to struggle with stress regulation well into later life.

WHO DOES IT AFFECT?

Perinatal depression is a global phenomenon. Roughly one in four women worldwide will experience it. The WHO estimates that 10% of pregnant women and 13% of women who have recently given birth experience a mental disorder, predominantly depression, with rates rising to 15.6% and 19.8% respectively in developing countries (World Health Organization, n.d.).

Women in low- and middle-income countries bear a disproportionate burden, driven by elevated exposure to poverty, gender inequality, intimate partner violence, and HIV/AIDS, alongside severely limited access to mental health services. Stigma, shame, and low awareness of symptoms further reduce the likelihood that affected women will seek help.

Image by Karin Schermbrucker.

In sub-Saharan Africa, these pressures are acute. Uganda, where StrongMinds operates, reflects this pattern: a review of eleven studies found a postpartum depression prevalence of 29% there — more than 40% above the global rate of 17% (Wang et al., 2021).

Certain groups face even greater risk. Pregnant and parenting adolescents experience depression at rates ranging from 14 to 53% globally, significantly higher than both older mothers and their non-parenting peers (Eboreime et al., 2022).

This is a particular concern in sub-Saharan Africa, which has the world's highest adolescent pregnancy rate and elevated rates of suicidal behavior among pregnant teenagers. Women navigating acute crises — conflict, natural disasters, pandemics — also show consistently elevated rates, as emergencies amplify existing risk factors and further erode access to care.

COMMUNITY-BASED CARE FOR PERINATAL DEPRESSION

For perinatal women in low- and middle-income countries, the barriers to mental health care are substantial. Specialist services are scarce, costs are prohibitive, and stigma, compounded by guilt and a cultural expectation of resilience around motherhood, keeps many women from seeking help at all. Clinic-based care, even where it exists, rarely reaches women in the communities and circumstances where perinatal depression is most prevalent.

Community-based care addresses this gap directly. By embedding trained lay health workers within existing local health systems, and by delivering therapy in community settings rather than clinical ones, it brings treatment to women where they are. This is not a compromise on quality; it is a design choice that makes treatment accessible at scale.

The StrongMinds Model

StrongMinds treats depression using interpersonal group therapy (IPT-G), a manualized, time-limited talk therapy model delivered by trained lay counselors in communities and schools. Groups of approximately twelve participants meet once per week for six weeks, guided by a structured curriculum that helps people understand the connection between their interpersonal relationships and their depression, and take active steps to improve both.

The IPT-G framework identifies four common triggers of depression: grief, interpersonal conflict, life changes, and loneliness or social isolation. Each is addressed within the group through structured discussion, skill-building, and peer support. For perinatal women in particular, these triggers are acutely relevant: pregnancy and early motherhood are among the most significant life transitions a person can undergo, often accompanied by relationship strain, shifting roles, and social isolation.

THE EVIDENCE FOR IPT-G

IPT-G is recommended by the World Health Organization and is among the most rigorously tested therapeutic models available for community-level deployment in low-resource settings. Research consistently demonstrates that it can be effectively and safely delivered by lay providers. This finding is central to its scalability in contexts where trained mental health specialists are few.

The evidence base for IPT-G in perinatal populations specifically is growing. A 2020 systematic review by Bright and colleagues examined interpersonal psychotherapy across multiple study designs and perinatal populations, finding consistent reductions in psychological distress during both pregnancy and the postpartum period. The review noted that IPT is particularly well-matched to this population because it directly targets the relational and role-based stressors — relationship conflict, transition to parenthood, grief and loss — that are most salient during the perinatal period (Bright et al., 2020).

A 2024 pilot study by Shieh and Hsu further demonstrated the feasibility and effectiveness of a group IPT format with distressed pregnant women, finding meaningful reductions in distress and supporting the view that the peer dynamic of group delivery adds value for this population (Shieh & Hsu, 2024).

Image by Karin Schermbrucker.

VOICES OF WOMEN WHO HAVE RECOVERED FROM DEPRESSION

Results from focus group discussions

In any given StrongMinds therapy group, there are often pregnant and nursing women. Babies are passed around the circle while toddlers play nearby. These groups are safe, welcoming spaces where women can speak openly about what they are facing and learn that they are not alone. For perinatal women, who are navigating one of life's most significant transitions, often with limited support and under considerable stress, that sense of belonging can be transformative.

StrongMinds conducted focus group discussions and individual interviews with 28 former clients who were pregnant or had recently given birth when they participated in therapy. Many came to StrongMinds tired, anxious, and unsure of what to expect. Some described conflict with spouses and in-laws, rejection, loneliness, and overwhelming stress. With support from group leaders and peers, women began to manage stress differently, build confidence, and reconnect with hope. As one former group member in Uganda said, "I met people who loved me and shared the same challenges."

What follows is what they shared about the journey, from the depths of their depression, to the decision to seek help, to what happened inside the group, to what changed in their lives after.

Life before therapy

Many women had difficulty connecting with their infants. They wanted to be good mothers and to care for their children, but they didn't feel they had the emotional capacity to do so. They were stressed, in conflict with partners or family, and without enough support. Many felt inadequate and unprepared.

"At that time," one client said, "I felt bad because I felt I wasn't ready to become a mother."

They were often overcome with sadness, hopelessness, and irritability. They withdrew from their lives and struggled with intrusive thoughts, while some thought of suicide. Physical symptoms compounded the picture. "I didn't have sleep," said one participant. "I couldn't eat… I would just think too much and feel like there was no future for me."

Relationships were a recurring source of distress. "My husband wasn't supporting me with necessities," said one client. "When my child fell sick, he couldn't care… even my mother-in-law couldn't support me… they used to disassociate me from themselves." The women we spoke with often navigated pregnancy and childcare with minimal assistance — little financial help, little emotional support, and frequent conflict with partners and in-laws.

Perinatal-Specific Stressors

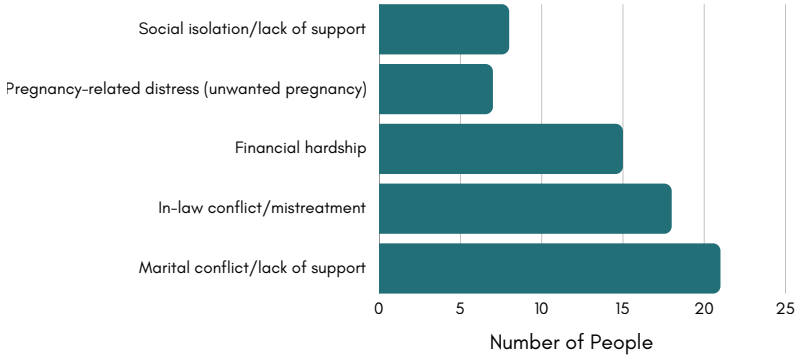


Image by Karin Schermbrucker.

The decision to participate

Women often cited a trusted community leader who encouraged them to try therapy. They had each reached a point where their symptoms had become too difficult to manage on their own, and fellow community members had taken notice. "What made me decide to join," one client said, "I had a lot of stress and didn't have anyone to talk to… I felt like it was the end of the world for me, so when I heard about it, I decided to register."

Household responsibilities made attendance challenging because there was always work to be done. But encouragement from family members, proximity to meeting locations, and belief in the benefits helped women remain committed. Many arrived expecting financial support as part of the program. When they learned that wasn't the case, they stayed anyway. "At first," one client said, "we thought maybe they would give us money or support us financially… but later we saw they were teaching us how to handle our problems."

> "I have regained my hope and I feel genuinely happy again. I feel courageous and empowered. Their encouragement kept me motivated to breastfeed safely and stay consistent with the baby's medication. Because of that support and the steps I took, my child is now HIV free." – Evelyn

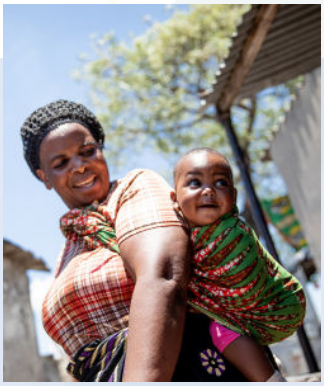
The benefits of therapy

Women described wide-ranging changes in the months after therapy. Improved communication skills helped them manage conflict in their relationships. They became more attentive to their own health and more engaged with their children. They learned to cope with stress, regulate their emotions, and respond to difficulty with greater calm.

At the therapy, they advised me how to talk to people," one client said. "Now even when there is a problem, I speak well and we understand each other." Before therapy, many women had felt unable to speak freely. That changed. "Before we would quarrel every day," said another. "But now we sit and talk and solve things."

Those skills extended to parenting. "They taught us not to put stress on children," one client recalled. "To play with them and have good relationships… and this changed how I treated my child." Another noted concrete gains in infant care: "After counselling, I learnt to feed, bathe and take care of the baby properly."

Many participants also developed greater financial independence — learning to run small businesses from others in their groups, gaining a sense of purpose alongside a source of income. "I learned to work, save, and support my family through small businesses," said one former client. For women who had come to therapy feeling helpless and overwhelmed, the ability to provide for themselves and their children was among the most meaningful changes of all.



Images by Karin Schermbrucker.

Experiences in group therapy

Many participants were apprehensive at the start of group therapy and uncertain whether they could share their challenges openly. Those feelings shifted as they watched others begin to speak, and as facilitators reinforced the importance of confidentiality. The group became a space they trusted. "We used to fear in the beginning," said one client. "But later we became free with one another and could talk about anything."

Visual tools like emotion cards and structured activities helped participants understand their own experiences and track their progress. Group discussions connected the concepts their facilitators introduced to the realities of daily life. Most importantly, women stopped feeling alone. "When everyone shared their problems and got solutions," one client stated, "I realised even mine could be solved."

Before therapy, many women had believed their struggles with pregnancy and motherhood were uniquely their own — a belief that had kept them from seeking help. The group dismantled that. "I thought I was the only one going through such things," said one participant. "When others shared," said another, "I saw I was not alone... and that made me feel better."

The shared experience was especially powerful among women at similar life stages. "Seeing other pregnant women made me believe in myself," one client said. "I realised I was not the only one." Advice exchanged within the group — about managing relationships, coping with stress, and handling daily challenges — had lasting practical value. "When we talked to others," one client said, "they advised us on what to do and that helped me feel peaceful."

ONE MOTHER'S JOURNEY THROUGH DEPRESSION

Evelyn said her life felt like she was drowning in a deep mire. She was newly pregnant, and she learned her husband had been unfaithful to her. She contracted HIV as a result, and she was afraid her baby might be born with HIV, too. "I was paralyzed by sadness and disappointment and was stuck on what I would do next, other than ending my own life."

She was four months pregnant when she met a StrongMinds volunteer. She was separated from her husband and isolated. "I didn't know how I would provide for my child," she said.

For Evelyn, group therapy was a turning point. Other women were walking similar paths. Together, they created roadmaps through their conversations. The friends she made took her to medical appointments and they taught her to save money so she could start a business.

Now, Evelyn says she makes her own decisions in life. She finds creative ways to solve problems. She says she sleeps much better at night and believes in her ability to mother her child.

"I have regained my hope and I feel genuinely happy again," she said. "I feel courageous and empowered."

With therapy over, Evelyn said the friends she made in the group have still not left her side. "Their encouragement kept me motivated to breastfeed safely and stay consistent with the baby's medication. Because of that support and the steps I took, my child is now HIV free."

CALL TO ACTION

The perinatal phase is one of the most consequential periods in a woman's life, and growing evidence suggests it is also one of the most important windows for intervention. Community-based group therapy has shown meaningful results in reaching women who would otherwise go without care, reducing depression, and strengthening families. When a mother recovers, her children are more likely to thrive. The evidence is compelling, the need is urgent, and the path forward is becoming clearer.

Policymakers at every level — global, national, and local — have an opportunity to make perinatal mental health a genuine priority. This means integrating mental health screening and treatment into maternal and child health systems, investing in community-based delivery models that remove barriers like cost, distance, and stigma, and ensuring that the women most at risk — including adolescents, those living in poverty, and those affected by conflict or climate displacement — have access to care designed for their circumstances.

Researchers and governments must invest in better data, particularly from sub-Saharan Africa, where perinatal depression is most prevalent and evidence remains thin. Stronger, localized data will sharpen policy decisions, direct resources where they are most needed, and build the case for sustained public investment in this work.

And we must all invest in normalizing the conversation. The women in this report came to therapy afraid to speak and left with the confidence to share their stories, support their families, and help others do the same. That transformation — from silence to voice, from isolation to community — is both the outcome of effective treatment and the foundation on which healthier communities are built.

Perinatal depression is not inevitable. Recovery is not exceptional. With the right policies, the right investment, and the right spaces for women to come together, it can become the norm — for every mother, in every community, everywhere.

Image by Karin Schermbrucker.

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