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The Missing Piece in Postpartum Care: The Mental Health Gap in Sexual and Reproductive Health Self-Care among Parents of Children Under Five: A Mixed-Methods Study

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Abstract

Background: Self-care is central to global guidance on sexual and reproductive health and rights (SRHR), yet little is known about whether existing self-care and SRH service models adequately address the emotional and mental health needs of parents of young children.

Objective: To examine the prevalence and lived experience of emotional strain among parents of children under five, and to assess how adequately current SRH services are perceived to address mental wellbeing.

Methods: A convergent mixed-methods analysis of a 57-item self-administered questionnaire completed by 114 parents (84 female, 29 male; 91% married; 92% educated to undergraduate level or above), combining descriptive statistics and cross-tabulation of closed-ended items with inductive thematic coding of open-ended responses.

Results: More than half of respondents (56%, 64/114) reported changes in mood, sleep, or energy since becoming a parent, and 60% reported feeling stressed, anxious, or overwhelmed by parenting responsibilities at least sometimes. Only 30% (34/114) felt their mental wellbeing was adequately addressed within current SRH services, while 46% (53/114) were unsure and 24% (27/114) said it was not. Formal or informal help-seeking for emotional or mental stress was reported by only 29% (33/114) of respondents, and partners/spouses — not health services — were the dominant source of emotional support (56%, 64/114). Despite this gap in provision, 61% (69/114) believed self-care practices helped reduce SRH-related stress and anxiety. Qualitative accounts described chronic sleep deprivation, an unacknowledged perinatal mental load, and a clear desire for postpartum psychological support integrated into routine care.

Conclusion: Parental emotional wellbeing represents the clearest unmet need identified in this dataset — a gap in service provision rather than in demand or self-perceived awareness. Embedding brief mental health screening and support within existing SRH and paediatric touchpoints, rather than treating mental health as a separate referral pathway, is likely to close a need that parents identify consistently and independently of one another.

Keywords: Sexual and reproductive health; self-care; postpartum mental health; parenting; maternal mental health; service integration; mixed-methods

1. Introduction

Sexual and reproductive health (SRH) self-care — the practices individuals use to manage contraception, fertility, menstrual and hormonal health, and sexual wellbeing with or without direct clinical supervision — is increasingly recognized as a critical dimension of wellbeing across the life course. The World Health Organization's consolidated guideline on self-care interventions for SRHR defines self-care as the ability of individuals, families, and communities to promote health, prevent disease, maintain health, and cope with illness and disability, with or without the support of a health-care provider (World Health Organization, 2019). This framing deliberately extends SRH beyond the walls of the clinic, recognizing that most day-to-day management of reproductive and sexual health occurs in people's own homes and routines.

Early parenthood is one of the periods in which this extension matters most, and is tested most severely. The years surrounding the birth of a child under five are marked by concentrated physical recovery, hormonal change, disrupted sleep, caregiving load, and identity transition — all of which can crowd out attention to a parent's own SRH needs even as those needs (postpartum recovery, contraception, sexual wellbeing, and mental health) are often at their most acute (World Health Organization, 2019). A substantial epidemiological literature documents elevated rates of perinatal and postpartum depression across diverse settings, with prevalence estimates ranging from roughly 7–14% in nationally representative or multi-country samples to as high as 47% in some primary-care-based studies in low-resource settings, depending on the screening instrument, timing, and population studied (Chen et al., 2011; Ayoub et al., 2024; Tekelab et al., 2018).

What is less well understood is not whether perinatal mental health problems exist — that is well established — but whether parents themselves feel that mental health is adequately addressed within the SRH and postpartum services they actually use, and how they describe that gap in their own words. Much of the existing literature approaches perinatal mental health as a clinical screening and diagnosis problem, using validated instruments such as the Edinburgh Postnatal Depression Scale (EPDS) within maternal and child health facilities (Chen et al., 2011; Islam et al., 2025). Comparatively little research captures the parent's own subjective appraisal of service adequacy — a patient-experience and health-systems question that sits alongside, rather than substitutes for, clinical prevalence data.

This paper addresses that gap. Using data from a mixed-methods survey of 114 parents of children under five, it asks three linked questions: (1) how prevalent is self-reported emotional and mental strain in this population; (2) how adequately do parents perceive current SRH services to address their mental wellbeing; and (3) what do parents' own accounts suggest about why this gap exists and what would close it. The analysis presented here is one component of a broader research project on SRH self-care among parents of young children; this paper isolates and develops the mental health dimension, which the fuller analysis identified as the area with the largest measured gap between reported need and reported provision.

2. Background and Rationale

2.1 Self-care as a framework for integrating mental health into SRH

The WHO's SRHR self-care guideline was developed partly in response to global health workforce shortages and persistent access gaps: an estimated shortage of 18 million health workers is anticipated by 2030, and at least 400 million people worldwide lack access to essential health services (World Health Organization, 2019). Self-care interventions are positioned as a way to extend the reach of the health system by giving individuals safe, informed tools to manage aspects of their own health outside formal

clinical encounters. Because the guideline explicitly frames self-care as operating 'with or without' provider support, it creates conceptual room for self-care to include emotional and psychological self-management — not only physical interventions such as contraception or pregnancy testing. In practice, however, self-care programming for SRH has concentrated heavily on physical and behavioural interventions, with mental health support less consistently integrated into either clinical SRH services or self-care toolkits (Karp et al., 2025).

2.2 The perinatal mental health burden

Perinatal depression and anxiety are among the most consistently documented health complications of childbearing. A US nationally representative analysis using the PHQ-9 found depression prevalence of 9.7% in antepartum and 12.8% in postpartum women, with postpartum mental health service utilization rising over the study period but remaining incomplete (Ayoub et al., 2024). A large obstetric health-system study similarly found that approximately 11% of women screened positive for depression during pregnancy or the postpartum period, with disparities by age, marital status, and insurance status (Cerimele et al., 2024). In lower-resource settings, reported prevalence is often considerably higher: a primary-care study in Eswatini found 47.4% of postpartum women screened positive for depression, associated with unemployment and poor partner support (Nkambule et al., 2019), while a multi-country synthesis estimated an average prevalence around 14%, noting that roughly half of affected mothers remain undetected (Tolossa et al., 2024). A hospital-based intervention programme in Singapore that screened over 1,300 postpartum women and offered case-managed treatment to those who screened positive achieved a 78% reduction in depression symptom scores among treated participants, offering a concrete example of what integrated screening-and-referral can accomplish at scale (Chen et al., 2011).

Across these differing contexts, a consistent conclusion recurs: mental health screening is not yet routinely integrated into maternal and child health or postnatal care services, and where it is absent, perinatal depression tends to go undetected and untreated (Nkambule et al., 2019; Islam et al., 2025; Tekelab et al., 2018). These studies, however, measure prevalence using clinical screening tools administered by researchers; they do not typically ask parents whether they themselves perceive their routine SRH or postpartum care as addressing their emotional needs. That perception — not just the presence or absence of clinical depression — shapes whether parents seek help at all, and is the specific gap this paper examines.

2.3 Rationale for the present study

This study complements the epidemiological literature by asking a self-selected but relatively well-educated, partnered sample of parents to describe, in their own words and their own closed-ended ratings, whether current SRH services meet their emotional needs, whom they turn to for support, and what integrated support might look like. Because the sample is not drawn from a clinical or high-risk population, and mental health status was assessed through self-report items rather than a validated diagnostic scale, the findings should be read as evidence about perceived service adequacy and help-seeking behaviour rather than as a clinical prevalence estimate. This distinction is itself part of the contribution: it captures a dimension of the problem — parents' own sense of whether the system is meeting them — that diagnostic prevalence studies are not designed to measure.

3. Methods

3.1 Design

This study uses a convergent mixed-methods, cross-sectional design. Data were collected via a structured,

self-administered online questionnaire (Google Forms) covering demographics, SRH knowledge and awareness, access barriers, decision-making and autonomy, and mental and emotional wellbeing. The questionnaire contained 57 items in total; this paper draws on the demographic items and the subset of items addressing emotional and mental wellbeing, help-seeking, and perceived service adequacy, together with related open-ended responses.

3.2 Sample and recruitment

A total of 114 responses were recorded from self-identified parents of at least one child under five years of age; one record was substantially incomplete and is noted where relevant, so valid n for individual items ranges from 113 to 114. The sample was self-selected, which — combined with the survey's online distribution — likely produced a convenience sample skewing toward more educated, digitally connected, and partnered respondents than the general population of parents of young children.

Indicator	n / %
Female respondents	**84 (74%)**
Male respondents	**29 (26%)**
Married / partnered	**~91%**
Aged 31–35 years	**49 (43%)**
Postgraduate education or above	**55 (49%)**
Graduate (undergraduate) education	**49 (43%)**

This profile should be read as a population that is, if anything, relatively resourced and supported; the gaps reported below are therefore likely to understate, rather than overstate, the true scale of unmet mental health need among less advantaged or unpartnered parents.

3.3 Measures

The items analyzed in this paper include: (a) a closed/free-text item on whether respondents had experienced changes in mood, sleep, or energy since becoming a parent; (b) an item on frequency of feeling stressed, anxious, or overwhelmed by parenting responsibilities; (c) a multi-select item on primary sources of emotional support; (d) an item on whether respondents had ever sought professional or informal help for emotional or mental stress; (e) an item on whether respondents perceived current SRH services as adequately addressing mental wellbeing; (f) an item on whether self-care practices were perceived to reduce SRH-related stress or anxiety; and (g) open-ended items asking respondents to describe how parenthood had affected their emotional wellbeing and what integrated mental health support they would want to see.

3.4 Analysis

Closed-ended and multi-select items were tabulated as frequencies and percentages of valid responses. Several free-text responses recorded in short yes/no-style form (e.g., 'yes,' 'sometimes,' or longer descriptive sentences beginning 'Yes, ...') were harmonized into a common Yes / Sometimes-Somewhat / No / Not Applicable / Descriptive-Other coding scheme so that they could be analyzed quantitatively

alongside fixed-choice items; original text was preserved verbatim for qualitative analysis. Longer open-ended responses were read closely and inductively coded into recurring themes by the research team, with representative, anonymized quotations retained to illustrate each theme. No statistical significance testing was performed given the exploratory, descriptive purpose of the analysis; cross-tabulations by gender and age are presented descriptively.

3.5 Ethical considerations

The questionnaire was self-administered and anonymous, with participation implying informed consent to the use of responses in aggregate, anonymized form. The source dataset provided for this analysis did not include documentation of formal institutional ethics review; authors intending to submit this paper for publication should confirm and report the relevant institutional review board or ethics committee approval, or obtain retrospective/expedited approval as appropriate to their institution's requirements, before submission.

4. Results

4.1 Emotional and mental strain is a majority experience

Emotional strain since becoming a parent was reported by a clear majority of respondents. Sixty-four of 114 respondents (56%) reported changes in mood, sleep, or energy since becoming a parent. Feeling stressed, anxious, or overwhelmed by parenting responsibilities was reported as a frequent experience by 45 respondents (39%), with a further 24 (21%) reporting this 'sometimes' — together indicating that some degree of parenting-related emotional strain is experienced by roughly three in five respondents (60%), not a minority.

Indicator	n / %
Changes in mood, sleep, or energy since parenthood	**64 (56%)**
Feels stressed / anxious / overwhelmed “often”	**45 (39%)**
Feels stressed / anxious / overwhelmed “sometimes”	**24 (21%)**
Ever sought professional or informal help for emotional/mental stress	**33 (29%)**
Has not sought help	**51 (45%)**
Unsure whether they have sought appropriate help	**30 (26%)**
Feels mental wellbeing is adequately addressed in SRH services	**34 (30%)**
Unsure if mental wellbeing is adequately addressed	**53 (46%)**
Feels mental wellbeing is not adequately addressed	**27 (24%)**
Believes self-care practices reduce SRH-related stress/anxiety	**69 (61%)**

4.2 Support is informal and partner-centred, not service-based

Partners/spouses were by far the dominant source of emotional support, cited by 64 respondents (56%), well ahead of own family (24), spouse's family (14), and friends (12). This same pattern echoes the broader

survey's finding that partners are also the primary confidant for SRH topics generally and the primary joint decision-maker for SRH services, suggesting that the partner relationship functions as the de facto emotional and informational infrastructure for many parents in the absence of a formal service-based equivalent.

Formal or informal help-seeking for emotional or mental stress was reported by only 33 respondents (29%); 51 (45%) said they had not sought help, and 30 (26%) were unsure. This roughly one-in-four uncertainty rate is notable in itself: it suggests that for a meaningful share of parents, the boundary between ordinary parenting stress and something warranting support is not clearly understood or signposted — a finding consistent with an absence of routine screening or prompts within existing services.

4.3 A clear perception gap between need and provision

Asked directly whether they felt their mental wellbeing was adequately addressed within current SRH services, only 34 respondents (30%) said yes. Twenty-seven (24%) said no, and the largest group — 53 respondents (46%) — said they were unsure. This 'maybe' response, larger than either the 'yes' or 'no' group, is itself informative: it suggests that for many parents, mental health is not a visible or explicit component of the SRH services they encounter, so much as an absent category they cannot confidently evaluate. Read alongside the 56% who report mood/sleep/energy changes and the 60% who report at least occasional stress or overwhelm, this represents the largest proportional gap between self-reported need and self-reported provision identified anywhere in the survey.

4.4 Self-care is seen as a protective, complementary channel

Despite the service gap, respondents were broadly optimistic about the value of self-care itself: 69 (61%) agreed that self-care practices help reduce SRH-related stress or anxiety, and a further 36 (32%) said 'maybe,' with very few outright disagreeing. This suggests self-care and formal mental health support are not seen as competing or substitute priorities by respondents, but as complementary — self-care already functions, informally, as a coping mechanism that a more deliberately designed mental-health-inclusive self-care offering could plausibly strengthen rather than duplicate.

4.5 Qualitative themes

Open-ended responses were coded into four recurring themes: (a) an invisible and unacknowledged mental load; (b) chronic sleep deprivation as a near-universal baseline condition; (c) a clear, specific desire for postpartum psychological support integrated into existing care; and (d) shared caregiving and workplace flexibility as protective factors.

> *"In my journey as a parent, the most difficult thing I faced was nobody around me was aware of perinatal and postpartum care that was needed. I went through anxiety and depression fulfilling all the new parent roles. The mental load was so much which gave me chronic stress. I was sleep deprived throughout." — Respondent*
>
> *"Parenthood has brought a mix of emotions. It has given me joy and purpose, but it has also added stress, tiredness, and sometimes anxiety. Balancing responsibilities for my child and myself can be challenging, which affects my emotional and mental wellbeing." — Respondent*
>
> *"Yes, the continuous underlying anxiety of facing an unplanned pregnancy causes considerable psychological stress." — Respondent, on SRH concerns affecting mental health*
>
> *"Fatigue and emotional burnout can make it harder to seek care by reducing motivation, energy, and the ability to schedule or attend appointments. As a result, symptoms may be ignored or delayed in being addressed, even when medical attention is needed." — Respondent*

A specific and recurring request across responses was for postpartum psychological support to be offered as a routine part of maternal and child health care rather than something a parent has to separately identify a need for and seek out:

> *"Postpartum counselling, body image support, burnout management — these are the three areas where I felt like having support when I was not well. Ideally, mind and body should be taken care of together." — Respondent*
>
> *"Myth breakers during pregnancy and postpartum. I think it itself will reduce a lot of stress. Also, to educate people that the mother is not the only ultimate care giver of the child — anyone can participate and bring out the same task except for breastfeeding, obviously." — Respondent*

A smaller number of respondents described structural or relational protective factors that appeared to buffer emotional strain, most often shared caregiving arrangements or predictable working hours:

> *"Fixed working hours help me to manage my time accordingly so that I can focus on self-care." — Respondent, describing a protective factor*

5. Discussion

5.1 A gap in provision, not in demand or awareness

The central finding of this analysis is that emotional strain among parents of young children is common (experienced by a clear majority of respondents), while perceived provision of mental health support within SRH services is not: fewer than one in three respondents felt their mental wellbeing was adequately addressed, and help-seeking behaviour was reported by fewer than three in ten. This is not a knowledge or motivation problem in the way that, for instance, low awareness of a specific contraceptive method would be; parents in this sample are not failing to recognize that they are struggling, nor are they dismissive of support — 61% already credit self-care with helping their stress levels, and open-ended responses show considerable insight into their own emotional state. What is missing is a visible, integrated pathway connecting that self-awareness to support.

5.2 Positioning within the broader perinatal mental health literature

This finding is consistent with, and adds a distinct layer to, an existing literature documenting that mental health screening is rarely integrated into routine maternal and child health services (Nkambule et al., 2019; Islam et al., 2025; Tekelab et al., 2018). Those studies measure the clinical consequence of that gap — undetected depression, measured against validated instruments such as the EPDS. The present findings measure the parent's own perception of the gap, and show that the absence of integration is legible to parents themselves: the plurality response to whether services address mental wellbeing was not 'no' but 'unsure,' suggesting that mental health is often simply not present as a visible component of the SRH encounter, rather than being present and judged inadequate. This distinction matters for intervention design: a service that is inadequate can be improved within its existing structure, but a service in which mental health is largely invisible may need to be explicitly redesigned to include it as a default component, echoing the case-managed screening model demonstrated at scale in Singapore, where systematic screening surfaced probable cases in a population that had not sought care independently (Chen et al., 2011).

5.3 Partners as unrecognized mental health infrastructure

Partners/spouses emerged as the dominant source of emotional support by a wide margin over family, friends, or formal services. This mirrors a broader pattern in the fuller dataset, in which partners are also

the primary decision-making partner and confidant for SRH matters generally. While a supportive partnership is a protective resource, relying on it as the default mental health support structure has clear limits: it is not accessible to unpartnered parents, it places an uncompensated emotional labour burden on partners who may themselves be under strain, and — as the multinational literature on postpartum depression correlates suggests — poor partner support is itself one of the strongest risk factors for depression when it is absent (Nkambule et al., 2019). Interventions that engage couples jointly, rather than targeting the parent in isolation, may therefore be better positioned to reinforce this existing support structure rather than compete with or bypass it.

5.4 Self-care as a low-cost, trusted complementary channel

The finding that respondents already view self-care practices as helpful for stress and anxiety (61% yes, 32% maybe) suggests a practical entry point for closing the mental health gap without requiring an entirely new service line. Because self-care by definition operates partly outside formal clinical settings (World Health Organization, 2019), digital or community-based self-care tools that explicitly incorporate mental health content — brief psychoeducation, mood tracking, signposting to when professional help is warranted — could plausibly reach parents earlier and more often than a referral-based clinical pathway alone, particularly given that this sample's most-requested form of support was digital tools and apps (66% of respondents) in the broader survey. Positioning mental health content within an already-trusted self-care channel, rather than as a separate and potentially more stigmatized 'mental health service,' may also help address the ambient hesitation described in respondents' accounts of stigma around SRH topics generally.

6. Limitations

- The sample is self-selected and skews toward educated, married, partnered respondents, which likely understates the burden and barriers faced by less advantaged, unpartnered, or lower-resource parents.
- Mental health items were assessed through self-report, harmonized free-text and single-item measures rather than a validated clinical screening instrument (e.g., the EPDS or PHQ-9), so findings describe perceived strain and service adequacy rather than clinical diagnosis or prevalence.
- The cross-sectional design captures associations and self-reported perceptions at a single point in time rather than causal change over the course of parenthood.
- Gender representation is imbalanced (84 female, 29 male respondents), which limits the precision of male-specific subgroup findings and may understate paternal mental health experiences, which are themselves under-studied in the literature.
- Items combining a closed-choice question with a free-text justification produced heterogeneous responses requiring interpretive coding; this is a reasonable approximation of respondent intent rather than an exact re-administration of a standardized scale.
- As an online, self-administered survey, the sample excludes parents without reliable internet access or digital literacy, a group plausibly at higher risk of both SRH and mental health service gaps.

7. Implications for Practice and Policy

7.1 Integrate brief mental health screening into existing SRH and postpartum touchpoints

Given that only 30% of respondents feel mental wellbeing is adequately addressed in SRH services, and that a plurality are simply unsure, embedding a short, validated screening conversation (for example, a brief EPDS-based check) into routine postpartum or paediatric visits could make mental health a visible,

default component of care rather than something a parent must separately identify and pursue, consistent with recommendations from the wider perinatal depression literature (Nkambule et al., 2019; Islam et al., 2025).

7.2 Build mental health content into digital self-care tools

Because digital tools were the most-requested form of support and self-care is already viewed as stress-reducing by a majority of respondents, embedding brief psychoeducation, mood check-ins, and clear signposting to professional help within digital SRH self-care platforms offers a low-friction channel that meets parents where they already are.

7.3 Design couple-inclusive, not only individually targeted, support

Since partners are both the dominant source of emotional support and the dominant joint decision-maker for SRH services, resources that equip couples together — rather than materials aimed solely at the individual parent — may have outsized impact relative to individually targeted interventions, while also reducing the uncompensated support burden currently placed on partners.

7.4 Reduce ambiguity around what constitutes help-seeking

The finding that 26% of respondents were unsure whether they had sought appropriate help suggests a need for clearer, simpler messaging about what mental health support looks like and how to access it, so that ambivalence does not become a barrier in itself.

8. Conclusion

Among this sample of 114 parents of children under five, emotional and mental strain since becoming a parent is a majority experience, yet perceived integration of mental health support within sexual and reproductive health services is limited: fewer than one in three respondents felt this need was being met, and fewer than three in ten had sought help. This gap does not appear to stem from parents' unwillingness to engage with self-care or support — the majority already credit self-care with easing their stress, and their own open-ended accounts show clear insight into what integrated support should look like: routine, non-judgmental, and delivered alongside — not instead of — physical postpartum care. As one respondent summarized when asked what would help most: "try to prioritize yourself and give at least one hour to yourself in the whole day." Making that hour possible — through screening embedded in existing touchpoints, mental-health-aware digital self-care tools, and couple-inclusive support — is what this dataset suggests the majority of parents are still missing.

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