What are the MNH counselling needs of Pregnant and Parenting Adolescents?

Background and Rationale

Why focus on pregnant and parenting adolescents and their babies?

Approximately 12 million adolescent girls aged 15-19 years and 2.5 million girls aged less than 16 years give birth each year in low and lower-middle income countries (LLMIC)[i]. Uganda is one of the Low- and Middle-Income Countries with a high rate of teenage pregnancies. Twenty-five per cent of Ugandan teenagers become pregnant by the age of 19 and close to half are married before their 18th birthday (DHS, 2016). By the end of 2021, the DHIS in Uganda recorded a total of 378, 790 teenage births, which was seven percent (7%) higher than the annual average that was registered in the previous five years[ii].

Why are pregnant and parenting adolescents and their babies more vulnerable?

Almost half of adolescents do not attend the acceptable number of antenatal care visits in Uganda[iii]. A study in a Rural Community in Uganda found that more than half of adolescent mothers who went for ANC made their first visit after the first trimester[iv]. Barriers to timely care seeking and receiving quality services among adolescents are shaped by their characteristics including biological, social, and cognitive factors, cultural and social norms. Systems issues like health providers' attitudes affect adolescents service use and contribute to poor outcomes during pregnancy, childbirth and in the postnatal period.

Why focus on MNH counseling for pregnant and parenting adolescents?

Pregnant adolescents often do not receive sufficient pregnancy and childbirth related information from Health Care providers. Many are uncomfortable asking for information, some are rebuked and most have lower health literacy and little knowledge of pregnancy, labor, and postpartum period[v]. MNH (Maternal and Newborn Health) counselling provides women including pregnant and parenting adolescents and their companions[1] with information that helps them to make decisions, design a plan and take action to improve their health and wellbeing[vi]. Pregnant and adolescent mothers are often navigating pregnancy experience for the first time, may not have the needed support from families and communities, and are still young and vulnerable.

Objectives

The main objective of the assessment was to understand the MNH counseling needs of pregnant and parenting adolescents (PPAs) and considerations for the design of a scalable MNH counseling approach.

Specific Objectives: Confirm priority context-specific barriers (including gender barriers) to access to and use of MNH services among pregnant and parenting adolescents and their partners in Uganda, and **a**ssess the extent to which current MNH counselling is tailored to the needs of pregnant and parenting adolescents and their companions, and Understand health providers' challenges in providing MNH services and counselling to pregnant and parenting adolescent mothers across the continuum of care, and Engage pregnant and parenting adolescents to determine characteristics of an adolescent responsive MNH counselling approach.

Methodology

Assessment Setting and target population: The formative assessment was done in 2023, in Kasese, one of the districts in Uganda with a high number of teenage pregnancies (7319 in the year 2020) targeting catchment areas of two geographically distinct, purposively selected public health facilities of Bwesumbu HCIII and Kyabumba HCIII which serve peri-urban and rural populations. The assessment engaged 72 pregnant and parenting adolescents, 40

[1] Male partners, mothers, other female relatives.

companions comprising 14 older women and 26 male partners, 16 health care providers and 12 key stakeholders (including MoH, NGO, District health team, community-based organizations, health programs and development partners).

Assessment Design and Sampling: The assessment utilized an exploratory mixed methods design to understand the MNH counselling needs of pregnant and parenting adolescents (PPAs) and considerations for the design of a scalable counselling approach. The process included desk review and qualitative methods to answer the specific objectives. We used purposive sampling for households with pregnant and parenting adolescents and convenient sampling for companions, health care workers and key stakeholders.

Data Collection: Data collection took place between September and November 2023. Separate interview guides for focus group discussions (FGDs) for health care providers, pregnant and parenting adolescents, companions, and key informants' guides were pretested before actual data collection. Each FGD group comprised 6 to 12 participants and lasted about one hour. Audio-recorded data was transcribed directly into English.

Data Analysis: All qualitative data was collected in English or suitable local languages, transcribed, and then translated into English by the interviewers. The interviewers were trained medical and social scientists and wrote notes in addition to the audio recordings. Transcriptions were done verbatim. Data was analyzed using the Thematic Content Analysis.

Results

Pregnant and parenting adolescents MNH counselling needs.

PPAs MNH counselling needs are enormous. Their counselling needs span from self-care, what to expect across the continuum of care and how to care for the baby. They are often navigating this experience for the first time, may not have the needed support from families and communities, and are still young and vulnerable hence need detailed MNH counselling.

Content of MNH counselling: Pregnant and parenting adolescents (PPAs) need counselling on how to prepare for delivery, requirements for themselves and the baby, work options to get money, how to prevent and manage other diseases (like HIV and malaria) and how to support themselves while pregnant. They would like to be prepared on how to provide newborn cord care, breastfeed the baby and how to keep the baby clean and warm; what to do in case of bleeding after delivery, requirement for immunization of the baby, importance of postnatal clinic, post-partum family planning, and maternal care such as nutritious diet, hygiene, rest, and exercise.

Method of MNH counselling: PPAs want a blend of individual and group MNH counselling. Both individual and group counselling in respective gestational age were reported to be acceptable for health care providers and clients where feasible. Individual counseling may be more responsive to the needs of the parenting and pregnant adolescents if it is more detailed and more open and group counselling can help build self-confidence *"…and you know when they are sharing in a group, ……. they share common things then it might help them to really come out and have self-confidence ……." (KI, MOH)*

Providers of MNH Counselling: PPAs prefer getting MNH services from government health facilities because they are free. They also preferred well trained peer mothers/younger counsellors who they could easily listen to and share information with freely; and health care providers to be facilitators of MNH counselling sessions. Male partners pointed out the parents and grandparents could also support with MNH counselling at the community level *"Need counseling from the parents who are experts in the area like if a woman if pregnant, you are supposed to keep this and this…how to support the wife during her pregnancy…" (FGD, Male partners)*

Pregnant adolescents reported a preference for special days as opposed to special corners and engagement with health care providers for longer periods. They suggested a focal person for MNH counselling is identified at the health facility for adolescents to coordinate their sessions.

Health care provider MNH counselling skills and knowledge: Informants revealed that pregnant and parenting adolescents do not open up if counselling is provided by person who is not knowledgeable or who cannot package the information in easy ways to understand and make them comfortable. Some health workers have the necessary skills to provide counselling to PPAs although they do not have the necessary tools to use. Some have skills and knowledge that have not been updated for quite a long time and are therefore not able to provide information relevant to the current times.

Health care providers also reported having little or no free time to give detailed MNH counselling packages to PPAs. They recommend innovative counselling approaches with appropriate technology to attract the adolescents and suggest cascading the counselling at communities and schools. *"… difference is when you are counselling these pregnant adolescents, they are very reluctant and anxious and don't pay much attention, they are anxious of outcome of the pregnant....." (KII, Health care provider)*

Challenges that pregnant and parenting adolescents experience and contribute to delays in accessing MNH counselling.

Fear, shame, and discrimination: Pregnant and parenting adolescents experience fear, shame, and discrimination. When a girl gets pregnant at a young age, they tend to hide their pregnancy first until they are detected, that is when they start ANC. The community perceives early pregnancy to be shameful, and pregnant and parenting adolescents experience discrimination and stigma. This causes some pregnant girls to hide from their community and be rejected by male partners. Some pregnant and parenting adolescents are mistreated by parents, relatives, and the community which forces the pregnant and parenting adolescents into hiding and not visiting the health facility for ANC to receive MNH counselling on time. *"… what you see is young pregnancy has a lot of discrimination, more stigma at the community level… being young in Uganda, the expectation is that you should not get pregnant. But of course, when it happens, this raises a lot of stigma to this younger ones. (KII, IP)*

Weak social support systems: Parents are not willing to support young adolescents when they get pregnant. They feel ill-equipped to communicate with adolescents. Current counselling initiatives do not include parents, making parent-adolescent communication about MNH to be weak. Equally partners of PPAs are not willing to support them when they come for services at the facility. There is also, lack of psychological support and guidance *"There's an adolescent who came with the baby she got impregnated as a housemaid. They chased her away back home. And she came when she was very sick, the baby was sick and the peer educator the fellow adolescent brought her, and she said the parents have denied this girl." (FGD, HCP)*

Inadequate space at health facilities: Respondents reported that the space provided at the facilities is too small to accommodate the increasing numbers of young mothers. It is challenging to provide counselling and convey information that take consideration of the needs of the different categories of young mothers in a crowded space.

Negative health care providers attitudes: PPAs feel discouraged by poor nurses' attitudes which prevent them from accessing ANC.

Recommendations

- Develop standardized and integrated tools and protocols for MNH counselling for PPAs for use by health care providers and peer mothers. Make MNH counselling package comprehensive to cover FP, Nutrition, Delivery, ANC, PNC integrating key issues along the continuum of care to cater for MNH counselling needs of PPAs.

- Train health care providers, peers, Village Health Teams, and parents in MNH counselling for PPAs for complementarity at facility and community levels Train health providers to improve their ability to communicate with adolescents and be more responsive to adolescent mothers' needs.
- Review the health facility service delivery system and agree on an approach that could work without creating parallel systems that are not sustainable. Disseminate the client charter.
- Review and re-structure the peer educator approach for relevance, appropriateness, skill set need to be reviewed. How are they prepared and by whom? Peer educator, if trained could link pregnant and parenting adolescents in health care seeking.
- Counselling approach should consider the needs of non-pregnant and non-parenting adolescents to address teenage pregnancy and cascading counselling sessions to community level.
- Incorporate adolescent disaggregated MNH data into the health management information systems to enable assessment of the coverage, quality, and impacts of adolescent MNH counseling and services.

Conclusion

The results highlight the need for appropriate information and messaging on MNH among adolescents. There is need for a MNH counselling approach for PPAs that takes advantage of the first ANC visit, to build a positive rapport to encourage continuity, and to provide clear information about when and why adolescents should return for future services along the continuum of care. The MNH counselling approach needs to address the unique needs of pregnant and parenting adolescents which would contribute to reducing their social exclusion.

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