An Investigation into the Sociocultural Influences on Adolescent Maternal Healthcare Utilisation in Nigeria

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Introduction

Adolescent pregnancy is a common occurrence in Nigeria, with nearly a quarter of adolescent girls being either currently pregnant or having given birth, and an adolescent fertility rate of 122 births per women aged 15-19 (NPC & ICF International, 2014). Pregnant adolescents are susceptible to anaemia, pregnancy complications, obstructed labour due to an incompletely developed pelvis, and other pregnancy-related morbidity and mortality, and they are more likely to have low birth-weight, preterm and stillborn babies (Banerjee et al., 2009; Bearinger, Sieving, Ferguson, & Sharma, 2007; Conde-Agudelo, Belizan, & Lammers, 2005; Ibrahim & Owoeye, 2012; Ogu, Agholor, & Okonofua, 2016; Olusanya & Ebuehi, 2012; Onoh et al., 2014; Wall, 1998). Pregnancy-related mortality is the major cause of death among girls aged 15-19 globally (World Health Organization, 2017), and in Nigeria, 30.5% of deaths among girls aged 15-19 are from maternal causes (NPC & ICF International, 2014).

Despite the risks associated with pregnancy at a young age however, adolescent mothers have the lowest utilisation rates of maternal health services in Nigeria (Babalola & Fatusi, 2009; Dairo & Owoyokun, 2010; Idowu, Olowookere, Abiola, Adebowale, & Adegbenro, 2017). The few studies which have focused exclusively on adolescent maternal healthcare utilisation in Nigeria have mainly been quantitative in nature, and have examined the socioeconomic and demographic determinants of maternal healthcare utilisation among this group of mothers (Kupoluyi & Oyinloye, 2014; Olusanya & Ebuehi, 2012; Rai, Singh, & Singh, 2012). This study instead used a qualitative method to investigate the sociocultural factors which informed adolescent mothers' choice of maternal healthcare, as well as to understand the enablers of and barriers to their use of modern maternal healthcare services. The study examined the individual, household and community factors which could influence adolescent mothers' maternal healthcare utilisation.

Objectives

1. To explore adolescent mothers' pregnancy experience across Nigeria.

2. To identify factors that serve as barriers and enablers of maternal healthcare utilisation among adolescent mothers in Nigeria.

Theoretical framework

The study used the Andersen's Behavioural Model of Healthcare Utilisation, which examines the factors that influence healthcare use in a population. The 2008 revision of the theory examined predisposing, enabling and need factors at both individual and contextual levels. The individual predisposing factors are healthcare preferences, health worker attitudes, marital status, and pregnancy intention, while contextual predisposing factors include cultural attitudes and norms towards adolescent pregnancy, ethnicity, gender and power relations, prevailing healthcare preferences, health policy provisions, place and region of residence. The individual enabling factors include ability to afford healthcare costs, and health facility accessibility, while contextual enabling factors include health facility accessibility, presence of social support for adolescent mothers and positive health worker attitudes. The individual need factor is the recognition for necessity of healthcare during pregnancy, and the contextual need factor is the prevailing belief system concerning the necessity of maternal healthcare for adolescents.

Methods

The study used qualitative methodology, and extracted information from adolescent mothers, their mothers and guardians, health workers and community leaders. Urban research sites were Akure in the South West, Owerri in the South East and Katsina in the North West, while rural sites were Aponmu in the South West, Assa in the South East, and Majigiri in the North West. Study locations were selected using the enumeration area framework of the 2013 Nigeria Demographic and Health. Fifty-five in-depth interviews were conducted among adolescent mothers; nineteen in-depth interviews were conducted among mothers whose adolescent daughters had had a pregnancy; five key informant interviews were conducted among community leaders in all research sites except one; and six key informant interviews were conducted among senior health workers, one each from each research site. The inclusion criterion was all girls who were either currently pregnant or had been pregnant between ages 15 and 19. All of the interviews were conducted using a semi-structured interview guide. The primary language of the interview guides was English, and questions were translated into Yoruba and Hausa in the South West and North West zones where people were more comfortable being interviewed in those languages, by the principal investigator and two female field assistants. Interviews were audio-recorded where consent was given, and transcribed

directly where consent was not given. All audio-recorded interviews were translated where necessary and transcribed in English, and data were analysed using thematic analysis with NVivo 12.

Results

The study found that pregnancy intention was very low among unmarried adolescent mothers, with a large number of them reporting that their pregnancies were unplanned, while married mothers majorly reported having planned and expected pregnancies. Also, unmarried adolescent pregnancy was stigmatised, as many respondents reported being verbally abused or harassed by their community members or even complete strangers. Most married and cohabiting mothers regardless of their age reported no stigma, showing that being in a recognised union had a protective effect against stigma for adolescent mothers in Nigeria. Generally, cultural perceptions supported adolescent pregnancies in married adolescents but frowned on non-marital pregnancies. However, in contrast to existing literature, there was little reporting of negative health worker attitudes by adolescent mothers. Also, it was discovered that the major enablers of maternal healthcare use were maternal economic and financial support for unmarried adolescents, and partner and family support for married adolescent mothers. Additionally, maternal and community healthcare preference influenced the type of providers adolescent mothers used, as their healthcare decision makers were usually their mothers, mothers-in-law or other family members, and they conformed to these decision makers' preferred healthcare types.

Conclusion

The role of maternal and partner support must be emphasised in programmes concerned with increasing maternal healthcare utilisation among adolescent mothers. Also, as community healthcare preferences influenced choice of healthcare provider for young mothers, healthcare interventions must strive to be culturally sensitive so as to be acceptable to young mothers.

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