Exploring perceptions of maternity services for pregnant adolescents in Indonesia: a qualitative study

Abstract

Background/Aims **Adolescent pregnancies are prevalent in Indonesia. This study aimed to explore perceptions from healthcare workers and pregnant adolescents of maternity services for pregnant adolescents.**

Methods **This qualitative exploratory study involved two policymakers, 10 midwives, five doctors, and 10 pregnant adolescents. Data were collected through structured interviews in public health centre consultation rooms. The data were analysed thematically to explore factors that promoted or hindered use of maternity services for pregnant adolescents.**

Results **The identified barriers included a lack of tailored directives, challenges in engaging adolescents, insufficient numbers of skilled healthcare professionals, adolescents' fears and compromised confidentiality. Opportunities for improvement included enhancing service quality through strategic planning and specialised training for midwives and psychologists.**

Conclusions **The study underscores the need to improve maternity services offered for pregnant adolescents by creating a conducive working environment and sensitising healthcare workers and the community to adolescent mothers' needs.**

Implications for practice **There is a need for guidelines in Indonesia specifically on providing care for pregnant adolescents. Healthcare professionals require specialised training and facilities should be made adolescent friendly.**

Keywords

Adolescent pregnancy | Indonesia | Maternal service

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There are approximately 21 million adolescent pregnancies per year, 50% of which are unintended and result in an estimated 12 million births around the world (World Health Organization (WHO), 2019). In Indonesia, the age-specific fertility rate of female adolescents aged 15–19 years is 26.6 per 1000 women of childbearing age (National Family Planning Coordinating Board, 2024). Data from the Indonesian demographic health survey show that 93% of mothers received adequate antenatal care, 84% gave birth at a healthcare facility and 71% received postnatal care (Kemenkes, 2018). However, looking specifically at adolescents, it has been reported that 25% of pregnant adolescents attend less than four antenatal care visits and one-third choose to give birth accompanied by traditional birth attendants (Gayatri et al, 2023).

Pregnant adolescents aged 10–19 years face higher risks of eclampsia, puerperal endometritis and systemic infections than women aged 20–24 years, and babies of adolescent mothers are at greater risk of low birth weight, preterm birth and severe neonatal conditions (WHO, 2024). There are also negative psychosocial outcomes associated with adolescent pregnancy and motherhood (Bostancı Ergen et al, 2017), including perinatal distress (Hipwell et al, 2016), financial difficulties and school dropout (Astuti et al, 2020).

In Indonesia, the use of maternal healthcare services is determined by sociostructural and intermediary determinants, such as maternal age, education, household wealth index, husbands' occupation, number of children, access to healthcare facilities and residential area (Aji et al, 2021). The Indonesian government has implemented interventions focused on adolescent pregnancy prevention, but there are no national maternity services or guidance targeted specifically for pregnant adolescents. Evidence from the UK shows that specific services for pregnant adolescents can meet their and their partners' needs and improve opportunities for young parents and their children (Public Health England, 2019). Offering these services may contribute to national targets to provide early access to maternity care, reduce

infant mortality and morbidity, promote a healthy lifestyle during pregnancy, prevent perinatal mental health disorders, support young parents and increase breastfeeding (Public Health England, 2019). It may also contribute to preventing adverse effects of adolescent pregnancy, such as preterm birth and prolonged labour (Aba and Kömürcü, 2017; Laurenzi et al, 2020). Supporting adolescents in this way would simultaneously promote safe and healthy pregnancy and childbirth and increase use of professional maternal healthcare services (McLeish et al, 2020; Agampodi et al, 2021).

This qualitative study explored perceptions of maternity services for pregnant adolescents in Indonesia, through the lenses of policymakers, midwives, doctors and pregnant adolescents. The aim was to report their experiences of barriers to and facilitators of providing and attending specific maternity services for pregnant adolescents in Indonesia.

Methods

An exploratory qualitative design was used for this study, as it draws on the strengths of established qualitative methodologies, enabling flexible adoption of techniques (Percy et al, 2015). It seeks to understand a phenomenon, process or perspectives and worldviews of the people involved (Creswell and Poth, 2017). Given that the overarching study aim was to gain an in-depth understanding of the situation through the eyes of policymakers, midwives, doctors and pregnant adolescents, an exploratory qualitative study was deemed appropriate.

The study was based on the Model of Access to Personal Health Care Services, a theoretical lens proposed by Millman (1993). The model highlights that timely use of healthcare services is needed to achieve better health outcomes and identifies barriers and opportunities for healthcare service delivery.

Setting and participant recruitment

Participants were purposively sampled from two public health centres with the highest number of adolescent pregnancies in the Bantul Municipality working area. The participants included directors of public health centres, midwives, doctors and pregnant adolescents seeking maternal health services. The eligibility criteria for healthcare professionals were those with more than 2 years' experience working in public health centres. For adolescents, those who were pregnant or had been pregnant in the year preceding the study. A detailed explanation was sent by mail or email to potential participants (two directors, 10 midwives, eight doctors and 15 pregnant adolescents). A total of 27 participants responded positively (two directors, 10 midwives, five doctors and 10 adolescents); three of the doctors were not available to participate because of other work commitments and five pregnant adolescents did not respond within 14 days.

Data collection

One-on-one, in-person interviews were conducted using topic guidelines. The interviews explored the following broad topics:

- Policies/programmes implemented with the aim of providing maternal services for adolescents
- Programmes that have been effective or ineffective at accessing adolescents
- Facilitators and barriers to implementation, adoption, uptake and effectiveness of policies/programmes aimed at adolescents, especially maternal health services
- Recommendations to improve provision of specific maternity services for adolescents.

All interviews were conducted in a private room at each public health centre during daytime working hours. The data were collected between January and September 2022, and each interview lasted approximately 1 hour. All interviews were audio-recorded and transcribed verbatim.

Interviews were conducted in Bahasa, and data were initially analysed in the same language. All quotes, codes, sub-themes and themes were translated to English by a professional translator. Forward and back-translation were carried out to ensure accuracy and minimise errors.

Data analysis

The data were analysed thematically, using Braun and Clarke's (2006) six steps: becoming familiar with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and producing the reports. NVivo 10 was used to facilitate data management, (Hoover and Koerber, 2011). Throughout the execution of the study and analytical process, a reflexive approach enabled the authors to think about and discuss potential personal influence from their own biases (Galdas, 2017).

Rigour

To maintain the study's rigour, strategies were used to ensure credibility, transferability, dependability and confirmability (Lincoln and Guba, 1985). A digital audio voice recorder was used to produce high-quality audio records, interviews were transcribed verbatim and the accuracy of the transcripts was checked against the recordings. The analysis process was recorded to enable the researcher to perform iterative analysis and audit trials, and a reflective journal was kept.

Researcher characteristics and reflexivity

Exploring the barriers and facilitators in relation to maternal services for pregnant adolescents was the focus of this study because of AWW's personal experience

Table 1. Pregnant adolescent participants

Participant	Age (years)	Profile
Adolescent 1 (2 interviews)	18	Mother of 2-month-old, left school and married at 30 weeks' gestation, unemployed, missed antenatal care in first trimester because concealing premarital pregnancy
Adolescent 2 (2 interviews)	18	Pregnant (32 weeks' gestation), graduated high school, married 2 weeks later, unemployed, missed antenatal care in first trimester because concealing premarital pregnancy
Adolescent 3 (2 interviews)	19	Mother of 7-month-old, graduated high school, earning minimum wage, pregnancy occurred after marrying, missed antenatal care in first trimester because of work commitments and busyness
Adolescent 4 (2 interviews)	17	Pregnant (30 weeks' gestation), left school and married at 20 weeks, unemployed, missed antenatal care in first trimester because concealing premarital pregnancy
Adolescent 5 (2 interviews)	18	Pregnant (24 weeks' gestation), graduated high school, married at 20 weeks', earning minimum wage, missed antenatal care in first trimester because concealing premarital pregnancy
Adolescent 6	19	Mother of 8-month-old, graduated high school, pregnancy occurred after marrying, unemployed, missed antenatal care in first trimester as unaware of pregnancy
Adolescent 7	18	Pregnant (38 weeks' gestation), left school and married at 24 weeks, unemployed, missed antenatal care in first trimester because concealing premarital pregnancy
Adolescent 8	17	Pregnant (24 weeks' gestation), left school and married at 20 weeks, unemployed, missed antenatal care in first trimester because concealing premarital pregnancy
Adolescent 9	19	Mother of 11-month-old, left school and married at 28 weeks, unemployed, missed antenatal care in first trimester because concealing premarital pregnancy
Adolescent 10 (2 interviews)	17	Pregnant (28 weeks' gestation), left school and married at 20 weeks, unemployed, missed antenatal care in first trimester because concealing premarital pregnancy
Adolescent 11	19	Mother of 2-month-old, graduated high school, married at 20 weeks, earning minimum wage, missed antenatal care in first trimester because concealing premarital pregnancy
Adolescent 12	18	Pregnant (8 weeks' gestation), graduated high school, pregnancy occurred after marrying, unemployed
Adolescent 13 (2 interviews)	19	Mother of 2-month-old, graduated high school, pregnancy occurred after marrying, unemployed, missed antenatal care in first trimester as unaware of pregnancy
Adolescent 14	18	Pregnant (32 weeks' gestation), left school and married at 24 weeks, unemployed, missed antenatal care in first trimester because concealing premarital pregnancy
Adolescent 15	19	Mother of 7-month-old, graduated high school and married at 28 weeks, unemployed, missed antenatal care in first trimester because concealing premarital pregnancy

that the number of pregnant adolescents was increasing in their neighbourhood and because of their previous research into the psychosocial experiences of pregnant adolescents and their partners (Astuti et al, 2020).

Ethical considerations

Ethical approval was granted by the Unisa Yogyakarta Research Ethics Commission (reference number: 1772/KEP-UNISA/IV/2021). Permission was also obtained from the local authorities. In Indonesia, it is permitted for an approved researcher to access patients' medical and maternity records to determine names, phone numbers and addresses of pregnant adolescents who visited the health centre during the data collection period. All participants provided written informed consent and participation was voluntary. Parents were not asked for consent in the case of adolescents under the age of 18 years, as in Indonesian law, married adolescents under the age of consent are legally permitted to consent to participate in research themselves.

Results

Characteristics of the adolescent participants are outlined in *Table 1*. Most of the adolescents were unemployed, with some having left high school before graduation because of their pregnancy. The majority (93.3%) had not attended antenatal care in their first trimester, most because they were concealing a premarital pregnancy (73.3%). The participants who were midwives had between 5 and 20 years' experience; those who were general practitioners had between 4 and 15 years' experience, and the two directors/heads of the community health

centres were public health specialists with 3 and 5 years' experience respectively.

Three main themes were identified: barriers to providing specific maternity services for pregnant adolescents, opportunities to provide these services and expectations of care.

Barriers to providing services

The healthcare professionals who participated (directors, midwives and doctors) were aware that pregnant adolescents have unique needs compared to adult women accessing services, particularly for those who become pregnant as a result of premarital sex. However, no special training or processes had been developed to deliver maternity services to pregnant adolescents. In principle, pregnant adolescents received the same treatments as adults.

> ***'Pregnant adolescents have a higher risk of experiencing complications, especially those who are pregnant before marriage … Unfortunately, there has been no special training for us midwives, and the guidelines for providing services are still generally given to pregnant women'. Midwife 1***

Pregnant adolescents were afraid to visit healthcare services when they discovered that they were pregnant. Some were concerned that visiting the community health centre may be reported to their parents or school. As a result, they frequently attended antenatal care late in their pregnancy.

> ***'I came to the community health centre when I was almost 5 months late for my period, after my mother determined that I was pregnant. Before that, I was afraid of being determined. I wasn't ready, I was afraid of being scolded'. Adolescent 4***

Adolescents were unprepared for the reactions of their parents, friends, teachers and surrounding environment. All adolescent participants highlighted feeling stressed and confused about their pregnancy, and some considered abortion.

> ***'I didn't dare to tell anybody since my parents would be angry. At the time, I was confused and stressed about who should be told. I wanted to tell my friends, but I was frightened of being found, especially in my community, so I waited until my mother determined before going to the midwife'. Adolescent 1***

> ***'Many pregnant adolescents came in extremely distressed, frustrated and wanting to terminate their pregnancy'. Doctor 7***

Some were worried about being looked down on because they were unmarried. Consulting with midwives at the community health centre meant it was likely that the wider community would find out about the pregnancy.

> ***'There are many people at the community health centre. If I go there, they will ask me why I want to meet the midwife, and all my neighbours will know my pregnancy'. Adolescent 6***

As a result of delays accessing antenatal care and a lack of preparation, some midwives highlighted that adolescents may be uncooperative during childbirth and that they may not follow advice given by healthcare professionals during birth or the postpartum period.

> ***'Adolescents who experience unwanted pregnancy, mostly they do not want to breastfeed'. Midwife 5***

One midwife stated that a lack of family support was a barrier to providing health services.

> ***'Her family did not support her and even prohibited her from going to the community health center because of feeling embarrassed'. Midwife 2***

Adolescents' lack of knowledge and the geography of the area were also barriers to providing health services.

> ***'They are still adolescents and lack information and experience. They may believe that checking their pregnancy is unnecessary'. Midwife 1***

> ***'When her house is on the slope of a mountain, preventing communication over long distances, they cannot be contacted directly. We have her cellphone, we call them, but there is no network'. Midwife 4***

Opportunities to provide services

The healthcare professionals who participated in the study noted that a programme for maternal services that was already ongoing may be beneficial for pregnant adolescents. The mobile antenatal care service for early detection of high-risk of pregnant women targeted all pregnant women in the community health centre domicile area, including pregnant adolescents.

> ***'At the beginning of 2019, a programme called mobile integrated antenatal care was launched … examining pregnant women for all targets in the Piyungan Community Health Centre domicile area … Well, this can actually be integrated to serve pregnant adolescents too, but unfortunately, there is no specific***

programme for them yet'. Head of community health centre 1

The participants noted that frequent monitoring and evaluation programmes had been implemented, and all pregnant women were observed, including pregnant adolescents.

'We have reactivated monitoring through the cadres who help pregnant women. If there is a birth or pregnancy, whether it is an out-of-wedlock pregnancy or not, we must still observe it as closely as possible because if it is not checked, it is quite risky'. Midwife 4

The head of one community health service felt that special resources were needed to provide maternal services to adolescent mothers, including trained midwives and psychologists.

'I think [human resources] readiness regarding numbers has been sufficient … Recently, we have psychologists involved in the integrated antenatal care psychology services. However, the problem is that psychologists have not been specifically trained to serve pregnant adolescents'. Head of community health centre 2

However, although the services provided to adults and adolescents were procedurally similar, healthcare professionals also offered special assistance services to adolescent mothers by approaching their parents and close family.

'Adolescents are more intense because we are not only alone, but we involve parents, husbands or closest family'. Midwife 3

'The service procedure is almost the same. It's just that for service assistance to adolescent mothers, thus far there are parents who accompany our [midwives]. It is more intense [for adolescent mothers]'. Midwife 5

Some adolescents had positive perceptions of the attitudes of healthcare professionals who provided healthcare services. Many stated that the healthcare professionals had been kind, friendly and responsive.

'[When conducting an examination at the community health centre] the midwives' attitudes are good, friendly, always supportive, quick to respond. They guide the patient for the future, and the services provided are already appropriate'. Adolescent 6

In addition, they also described receiving support from their families.

'How come it hurts so much? …At first I felt the pain to walk, I panicked, I thought I was going to give birth … then the family came, then I was taken to the community health centre. The bleeding got heavier. It is truly painful'. Adolescent 1

In addition to support from husbands and families, healthcare professionals at the community health centre gave support by providing information related to maternal nutrition during pregnancy and emotional support, such as attention and encouragement.

'Midwives encourage mothers to eat green vegetables such as spinach and broccoli and consume high amounts of protein such as eggs and fish'. Adolescent 4

'I was told not to feel insecure if I was young but already become a mother. She [the midwife] said all mothers are good … this motivation is enough to keep me going during the transition'. Adolescent 8

Expectations of care

The participants shared their expectations of care in the future, in relation to infrastructure and implementation of training. Healthcare professionals hoped that non-governmental organisations could provide facilities and services, such as special rooms for adolescent mothers, counselling and targeted guidelines. They wanted support in handling conditions for adolescent mothers and providing a more structured approach.

''We hope there is support from non-governmental organisations to be more focused and accustomed to handling this condition. The approach should be more structured and collaborative. Children like this usually have problems with social and family'. Head of community health centre 2

Healthcare professionals' expectations related chiefly to the infrastructure needed to support adolescent mothers, such as the provision of specific facilities.

'Actually, we need a counselling room. They need privacy, especially for adolescents. When we ask, it must be from the heart to heart, right? If there are other people, sometimes they are uncomfortable'. Midwife 10

Healthcare professionals wanted to use more attractive media, such as videos, flip sheets and leaflets, to enable

adolescents to better understand the information provided during pregnancy.

> ***'We hope to make an interesting video. If it is integrated with only PowerPoint material, they will definitely become bored. Maybe it would be better and more interesting if a video were made. They think about many things, they cannot even concentrate … An interesting video can make them understand well. Especially for quiet adolescents'. Midwife 8***

Participants felt that it was important to separate services for adolescents and adult women, to provide more targeted care. They hoped to create WhatsApp groups specifically for adolescents and provide separate classes at the community health centre.

> ***'Yes, hopefully, there will be a WhatsApp group, but a WhatsApp group specifically for adolescent mothers because thus far the existing ones have merged with the adults'. Midwife 9***

> ***'It will be great if the class of pregnant adolescents and the class of adult pregnant women can be held separately'. Adolescent 14***

Adolescents wanted support from healthcare professionals and for their family to be involved.

> ***'The need for support. Support is important because when parents have restrictions and health workers provide education to parents, parents start to feel sympathy. The role of parents and health workers is significant. For example, parents receiving counselling from health workers will not participate in health-related myths'. Adolescent 11***

> ***'She only explained everything to me, even though she can also explain it all to my husband. In my opinion, the husband's role is crucial, especially after giving birth and breastfeeding. One of the success factors of breastfeeding mothers is support from the environment and the husband'. Adolescent 6***

Key points

- Pregnant adolescents in Indonesia face significant barriers because of social stigma and a lack of tailored antenatal care.
- Maternity services for adolescents are not differentiated from those provided to adult women, highlighting a gap in specialised support.
- Parental influence often leads adolescents to marry after becoming pregnant, despite feeling unprepared, to maintain social standing.

Discussion

The participants in the present study highlighted barriers to providing or receiving maternity care as a pregnant adolescent, and suggested opportunities for care provision. They also reported on their expectations and hopes for future services.

Barriers

Although all pregnant adolescents who participated in the study had accessed maternity services, almost all had not attended antenatal care during their first trimester. Adolescents highlighted that they feared being judged by healthcare professionals and their communities, which led them to delay accessing care. Most participants were pregnant as a result of a premarital sexual relationship, which is seen as taboo in the Indonesian context. Indonesian social norms place importance on maintaining family honour and reputation (Jannati et al, 2022). Pregnancy outside of marriage is viewed as tarnishing the family's name and damaging their standing in the community (Astuti et al, 2020). After a family is made aware, pregnant adolescents are often encouraged to marry (Astuti et al, 2021).

In Indonesia, initiation of marriage to avert social judgement and secure community respect is a prevalent phenomenon (Erfina et al, 2019; Astuti et al, 2021). The findings highlighted that while premarital pregnancy served as a catalyst for adolescent marriage, parental influence was often an important factor. Adolescents have reported feeling unprepared for marriage, but their parents' influence meant they felt coerced into it, with no viable alternatives (Astuti et al, 2021). The findings underscore the control that parents wield in shaping and enforcing family values, which tend to mirror broader sociocultural expectations in Indonesia.

Despite being coerced into marriage, all pregnant adolescents received substantial support from their parents in terms of nutrition, financial assistance, childcare and accommodation. This contrasts with evidence from other low-and middle-income countries, where premarital pregnancy often results in single parenting (Lambonmung et al, 2022). The present study's findings in the Indonesian context highlight the dual role of parents as both enforcers of sociocultural norms (in encouraging adolescents to marry) but also providers of essential support to pregnant adolescents. Inadequate family support can hinder access maternal services, compounded by social stigma, fear and embarrassment (Biaggi et al, 2016). During pregnancy, women who do not receive consistent support have been found to experience a longer labour than those who receive social support (Wang et al, 2018).

Adolescent pregnancies often stem from limited knowledge and awareness regarding contraception and

pregnancy prevention, a situation that is particularly prevalent in the Indonesian context (Erfina et al, 2019). Discussing sexual matters is generally considered taboo, contraception is predominantly perceived as a resource for married couples, and sexual and reproductive health education tends to focus on anatomical, biological and physiological aspects, rather than pregnancy prevention (Agampodi et al, 2021). Consequently, adolescents typically acquire knowledge about contraception through informal channels, such as friends, which can lead to misconceptions (Panda et al, 2023).

A lack of education for adolescent mothers, especially regarding the perinatal period, directly impacts pregnant adolescents use of health services. Socioeconomic factors and a scarcity of health information exacerbate this issue, emphasising the critical role of health education in bridging these gaps (Abuosi and Anaba, 2019). Health education for adolescent mothers is essential to address pregnancy, childbirth, the postpartum period and newborn care (Mwilike et al, 2018). Adolescent mothers who have had interpersonal communication with healthcare professionals are twice as likely to attend the recommended number of antenatal care appointments than adolescents who have never been in contact with healthcare professionals (Singh et al, 2014).

Geographic obstacles exacerbated issues accessing appropriate care, as the distance and insufficient transportation options impeded timely access to maternal health interventions. This is in line with previous research that reported difficulty accessing health services as a result of distance and a lack of transportation (Aji et al, 2021). This challenge is acutely felt in low-income regions, where inefficient transport systems significantly hinder healthcare access (Afari et al, 2014), underlining the necessity for effective referral systems for high-risk situations (Magwaja et al, 2021).

When adolescents were able to access care, healthcare professionals were not equipped with training to meet the distinct needs of pregnant adolescents. This shortfall significantly impacted the comprehensive delivery of maternal services, echoing previous research that linked the availability of skilled service providers with increased patient satisfaction and timely access to care (Ferreira et al, 2023). The lack of specialised staff led to a cascade of delays in providing essential psychological support to this vulnerable group, as has been highlighted in other forms of care, such as for those with HIV (Erasmus et al, 2020; Mbuagbaw et al, 2024).

The lack of standard operating procedures for adolescent maternal care was a barrier to the provision of high-quality services. Current standard operating procedures (Indonesian Ministry of Health, 2020), calibrated for the adult maternal population, do not encapsulate the adolescent experience, underscoring a demand for tailored protocols that align with the unique needs of this demographic (Astuti et al, 2020). There is a need for procedural guidance to ensure that the healthcare framework is responsive to adolescent maternal health needs (Gayatri et al, 2023). Developing targeted standard operating procedures would mark a significant step towards equitable health provision.

The absence of privacy in healthcare facilities, along with a pronounced lack of empathy and understanding from healthcare workers, are formidable barriers that limit the use of maternal services by adolescent mothers (Sarker et al, 2019). Adolescent mothers may be embarrassed of or anxious about their pregnancy, particularly if they are unmarried (Kola et al, 2020). This may deter them from seeking essential healthcare services, affecting both their own and their babies' health. Therefore, it is vital that healthcare professionals do not judge or stigmatise pregnant adolescents, instead fostering an environment where they feel empowered to seek care with dignity (Astuti et al, 2021). The present study highlighted that some healthcare professionals expected adolescents not to follow their guidance during birth and postpartum. Adolescents being perceived as failing to follow recommendations can lead to a lack of quality services (Bałanda-Bałdyga et al, 2020).

Opportunities

The participants identified several pathways to enhance access to maternal care for adolescents, such as mobile antenatal care services to overcome transportation issues. This initiative highlights the potential of using technology and community health platforms to enhance service delivery and patient engagement beyond traditional settings (Quinn et al, 2021).

Interprofessional collaboration was highlighted as a key strategy for providing comprehensive care, with the aim of healthcare professionals and psychologists working together to cater to the multifaceted needs of pregnant adolescents. Healthcare professionals must be empathetic and attentive to create a supportive environment for adolescents (Dassah et al, 2023).

The importance of a robust support network for pregnant adolescents, including midwives, family, colleagues and interprofessional collaboration, was emphasised. This aligns with previous findings that midwives' attitudes can significantly affect maternal health, especially for adolescent mothers (Firrahmawati, 2017; Huong et al, 2021). Backing from key stakeholders is also vital to ensuring the continuity and efficacy of maternal service programmes, and multiple studies have underscored the significance of community involvement in managing pregnancies and childbirth, particularly among high-risk groups (Camara et al, 2017). The use of community-centred

strategies has been shown to significantly bolster health-seeking behaviour among adolescent mothers (Sarker et al, 2019), highlighting the role of the community in managing adolescent pregnancy.

Expectations

The participants discussed their expectations for future care provision, emphasising the need for effective counselling and a suitable environment for adolescent mothers. Developing educational materials and specialised training for healthcare professionals is vital to provide tailored maternal services (Hasanah and Musyafak, 2018). Educational materials, such as booklets, leaflets, videos and flip sheets were highlighted as possible alternative formats for pregnant adolescents. This aligns with Nugroho et al (2017), who noted that counselling for adolescent mothers requires alternative media in varied formats. Additionally, healthcare professionals are highlighted the need for training on providing services to pregnant adolescents. Frequent training would equip midwives and doctors with the necessary skills and knowledge to support this group (Rumsey et al, 2017).

The participants recognised that social media had potential as a support and information dissemination tool, with recommendations for creating dedicated online platforms for pregnant adolescents. Virtual interactions with healthcare professionals play a substantial role in mitigating anxiety and fear among pregnant adolescents, fostering improved self-management (Monaghesh and Hajizadeh, 2020). Establishing bespoke antenatal classes was also identified as a critical resource for pregnant adolescents, to provide them with the knowledge to navigate pregnancy effectively. The participants also felt it was important to integrate family and partners into the care process, highlighting the need for a holistic support system (Tokhi et al, 2018).

Implications for practice

This study highlights the need for specialised maternity care for adolescents, including tailored guidelines, enhanced midwife training and community involvement. It underscores the importance of addressing social stigma and providing accessible services, such as mobile antenatal care, to improve adolescent pregnancy outcomes in Indonesia.

Limitations

The study focused on two public health centres in Indonesia, limiting the generalisability of the findings. Additionally, the small sample size and reliance on qualitative data may restrict broader applicability. Further research across diverse regions and with larger samples is needed to validate these findings.

CPD reflective questions

- How can existing maternity services be adapted to meet the unique needs of pregnant adolescents more effectively?
- In what ways can parental influence be balanced with adolescent autonomy in managing premarital pregnancies?
- What strategies can be implemented to reduce the stigma and social barriers faced by adolescent mothers when accessing healthcare services?
- How can midwife training and community involvement be used to improve the delivery of specialised care for adolescent pregnancies in rural settings?

Conclusions

This study explored the views of policymakers, healthcare professionals and pregnant adolescents in order to explore maternity care provision for pregnant adolescents in Indonesia. The findings highlighted existing barriers to providing specific services for adolescents, which are needed as the current healthcare system does not provide guidance on targeted care for this population. Healthcare professionals need to be sensitive to the needs of pregnant adolescents, and community support is vital. BJM

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