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Exploring Indonesian adolescent women's healthcare needs as they transition to motherhood: A qualitative study

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A R T I C L E I N F O

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A B S T R A C T

Background: Marriage and underage childbirth is a phenomenon of increasing incidence globally. Adolescent mothers simultaneously encounter multiple developmental challenges related to transition into adulthood, marriage, pregnancy and mothering responsibilities. Despite this, studies investigating postpartum care needs for adolescent mothers are limited.
Aims: The aim of this study was to explore adolescent mothers' postnatal inpatient experiences and healthcare needs as they moved towards their maternal roles.
Methods: A descriptive qualitative design was adopted to better understand experiences of adolescent mothers during their transition to becoming mothers. Data were collected using in-depth interviews with eleven adolescent mothers in hospital settings in South Sulawesi, Indonesia and analysed using thematic analysis.
Results: Four major themes emerged: (1) breastfeeding problems, (2) disempowerment in caring for the baby, (3) health care encounters, and (4) health care needs for adolescent motherhood transition.
Discussion: Breastfeeding problems and feeling disempowered in caring for their babies after birth was experienced by all adolescent mothers in this study. Furthermore, the health care provided was limited to mandatory hospital tasks with staff failing to recognize adolescent mothers' broader needs. The findings suggest that adolescent mothers need compassionate health education, support and psychological care from midwives in the postpartum ward before hospital discharge.
Conclusion: The results highlight important issues in postnatal care provision for adolescent mothers in improving their maternal roles during the transition period. Specific, appropriate interventions for adolescent mothers are needed to support their transition and adaptation to their new roles.
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Statement of significance

Problem or issue

Adolescent mothers may simultaneously encounter multiple developmental challenges related to transition into adulthood, marriage, pregnancy and mothering responsibilities. However, there is lack of research on healthcare needs of adolescent women for their transition to motherhood.

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What is already known

Adolescent mothers' experiences of inpatient postpartum care have been shown to contribute to their transition to motherhood. Assessing and supporting a woman's progress during the transition to motherhood is an essential component of postpartum care.

What this paper adds

Breastfeeding problems and feeling disempowered in taking care of their baby are challenges of Indonesian adolescent girls transitioning to motherhood. Postnatal hospital care for new adolsecent mothers in Indonesia was sometimes limited to mandatory interventions and staff may fail to recognize other needs. Adolescent mothers need more than mandatory interventions (physical care) during their postpartum hospitalisation, including health education and psychological support.

1. Introduction

Marriage and childbirth underage is a phenomenon of increasing incidence.[1] The International Human Rights defined this as a minimum age of marriage of 18 years.[2] However, complications from pregnancy and childbirth continue to be the leading causes of death among girls aged 15–19 years globally.[2] Approximately 16 million girls aged 15–19 years or one in five girls have given birth by the age of 18 years globally.[2] The number of child marriages in Indonesia is declining.[3] However, when compared with other countries in the Association of South East Asia Nations (ASEAN), Indonesia still has the second highest rate of adolescent girls giving birth.[3] Approximately 48 out of every 1000 Indonesian adolescent girls (15–19 years old) are reported to have given birth.[3]

The transition to motherhood period is a period of two to four weeks after giving birth where the mother will adapt to her new role.[4] After giving birth, common changes occur in the mother's life, including changes in roles, relationships, abilities and behaviour.[5] The changes require the mother's adaptation to her new role and this situation may be particularly challenging for adolescent mothers,[6] as they face physical, mental, psychological and social challenges.[7] Adolescent mothers aged 15–19 years simultaneously encounter multiple developmental challenges related to transition into adulthood, marriage, pregnancy and mothering responsibilities.[8] Furthermore, they need to manage their schooling and economic stability.[8]

The multiple developmental challenges of adolescent mothers should be considered by health care providers in order to offer comprehensive and age-appropriate health services for successful transition to the role of mother.[8] Appropriate health care services should be offered to the mother as part of care during pregnancy, labour and postpartum periods.[9] Midwives and postpartum nurses have important opportunities to assess adolescent mothers' knowledge, address all identified needs, and educate them including appropriate skills to improve the health of themselves and their babies.[10]

Furthermore, problems faced by mothers in the postpartum period, such as tiredness and short length of stay in the postpartum ward, pose a challenge for midwives, especially in providing health education, motivation and support mothers' self-confidence.[11] One study on adolescent mothers' satisfaction with inpatient postpartum nursing care has shown that care qualities can contribute to satisfactory experiences, or unsatisfactory experiences when nurses are not friendly, care is limited to the tasks required, is different to care provided for adult mothers, or when nurses fail to recognize individual needs.[10] Assessing a woman's progress during the transition to motherhood is an essential component of postpartum and infant care.[12] However, studies about the health care needs of adolescent mothers for successful transition are limited.

In Indonesia, many women are married at a young age and subsequently become mothers very early in their lives, making them less prepared for motherhood than if they had more life experiences.[6] Culture and social stigma are causes of high rates of early marriage, for example, an unmarried 20-year-old girl can make their parents feel embarrassed if their daughter is not married.[13] Furthermore, economic factors and low education contribute to the high rate of underage marriages in Indonesia.[14] Adolescent pregnancy in unmarried girls is widely considered to be culturally unacceptable and has negative consequences for the young woman.[15] Therefore, fear that a pregnancy is known to others in cases of unwanted pregnancy may limit adolescent women utilizing antenatal care.[16] Another barrier to accessing antenatal care is socioeconomic status. One study has shown that low income limited antenatal care access for teenage mothers and young mothers in Indonesia.[17] Taken together, these factors makes it difficult for midwives and nurses to provide health education or preparation for childbirth during pregnancy. Therefore, to improve the clinical care of adolescent mothers, more information is needed about their experiences of healthcare and needs in transition to becoming young mothers. The purpose of this study was to explore adolescent mothers' postnatal inpatient experiences and care needs regarding their maternal roles, specifically as adolescent mothers.

2. Method

2.1. Design

This study was undertaken in a large womens' and childrens' hospital in Makassar, Indonesia. Makassar is main city of South Sulawesi and one of the biggest cities in Indonesia with the largest population in eastern Indonesia. The number of marriages under the age of 18 years in South Sulawesi has been reported as high as 33.98%, higher than the Indonesian average of around 25.71%.[3] The setting for this study had the highest number of adolescent mothers birthing in hospitals in South Sulawesi. Postpartum maternal health services in Makassar are based on a government program of health care standards for postpartum mothers which are carried out at least three times according to a recommended schedule, including at six hours and up to three days after delivery, on the fourth day to the 28th day after delivery, and between the 29th and 42nd days postpartum.[18] Length of hospital stay for postpartum mothers averages one to three days after birth depending on birth method. This government program depends upon collaboration between hospitals and community-based health care facilities.[19] However, the follow-up system in the community after hospital discharge is still in need of attention, as presently there is no referral system in place between hospitals and community health care.[18]

A qualitative design was adopted to explore the experiences of adolescent mothers during their transition to becoming mothers, the problems they faced and care they sought while in hospital. Descriptive phenomenology was considered the most relevant approach for this research as rich data could be produced through exploring and interpreting the essence of experiences of adolescent new mothers.[20]

2.2. Participants and setting

Homogenous purposive sampling was used, meaning participants were chosen with specific considerations and objectives.[21] In accordance with the purpose of this study, participants were adolescent mothers meeting the inclusion criteria: primiparous

mothers aged <20 years at the time of giving birth, and mothers living with their babies at home. Prior to the interviews, the researchers obtained research approval from the hospital's research and development department. During their inpatient stay in the postpartum ward, midwives approached adolescent mothers to determine their willingness to be participants in the study. Those adolescent mothers who agreed were put in contact with the first author to arrange their interview at a mutually convenient time. There were no specific exclusion criteria applied.

The first author undertook a home visit and provided information about the study to the potential participant. This included information regarding confidentiality and the right to withdraw participation at any time. Informed oral and written consent was obtained prior to the interview. A total of 11 adolescent mothers aged 16–19 years took part in the study. Ten women were married and one was unmarried. All were living with or near their parents or parents-in-law. In qualitative research the sample size is not usually a focus as is the case in quantitative research. As this study was practice-based, there was no specification of the sample size and data saturation determined sample size. This was achieved after eleven (11) interviews when no new information from previous informants was obtained.

2.3. Data collection

In-depth interviews using a semi-structured questionnaire developed by the researchers, and probing questions were asked in accordance with the participants' reponses. The focus of questions included exploring the experiences of adolescent mothers, challenges faced after birth, the health care received during their hospitalisation in the postpartum period and their health needs during early motherhood. Interviews were conducted by the first author (Nursing PhD Candidate) in Bahasa (Indonesian language), between March and August 2018. The interviews were 45–60 min in duration, digitally recorded and transcribed verbatim. Initial data analysis was undertaken in Bahasa and transcripts translated into English and back-translated into Bahasa to ensure meanings were not lost.

2.4. Ethical consideration

The research received ethics review and approval from relevant institutional review boards in Indonesia. Permission to conduct the study was obtained from the Research and Development Agency of South Sulawesi, Indonesia as the government department responsible for conducting research in the region and from the Director of the regional hospital where was the study was conducted.

2.5. Data analysis

Thematic analysis was conducted to analyse data. In a holistic approach, each interview was transcribed verbatim and the transcript was prepared and simultaneously analysed. Each was read and re-read to enable familiarisation with the entire body of data. Using the software Open Code 3.6 for qualitative data management, we coded each segment of data that was relevant to or captured something relevant to the research aim. Then, similar codes were grouped and examined for each meaningful unit. The same meaning units were interpreted and grouped into sub-themes, which were then clustered into themes. Through interaction and understanding, the data was analysed by members of the research team to enable accurate themes and sub-themes to emerge. Where there were differing intepretations in the data coding process, the team discussed these until consnensus was reached.[22]

Several strategies were used to improve trustworthiness of findings. According to Lincoln and Guba (1985), four principles of trustworthiness of qualitative study are credibility, transferability, dependability, and confirmability.[23] Credibility in this study was achieved through a number of strategies. Firstly, the strategy of member checking was used, whereby interpretations were checked with participants. Credibility within the interviewing process was established by checking information based on the results of previous interviews and ideas being revisited with subsequent participants.[23] coding, sub-themes and themes were checked verbally with two participants to ensure these reflected the participant perspectives and experiences.

Transferability was attained as the authors worked to provide detailed descriptions of findings and comparison with related studies. Dependability and confirmability were strengthened through peer review among the research team to verify the essential meanings of the findings and achieve consensus through discussions and modification of the themes. To maintain integrity of translations, initial data analysis was conducted in Bahasa and then translated into English and back-translated into Bahasa to ensure original meanings were not lost. Moreover, concepts and themes were cross-checked and compared during the data analysis to enhance the rigor of the study.

3. Results

Eleven adolescent mothers participated in interviews. Two were aged 16 years, four aged 17 years, two aged 18 years, and three were aged 19 years when they gave birth. Four mothers were students when they became pregnant and seven were housewives.

Table 1
Themes and subthemes.

Themes	Sub-themes
Breastfeeding problem	Feeling stress related to breast feeding Pain Not having opportunity to breastfeeding
Disempowerment in caring for the baby	Fears related to meeting their physical needs of their babies Pain related to the birthing process Less engagement with the baby
Health care encounters	Contraception counseling Physical care Not understanding adolescent mothers' needs Short interaction with midwives
Health care needs for adolescent motherhood transition	Health education on breastfeeding and taking care of the baby Empowered to care for the baby Support from staff

Five of the eleven participants experienced unwanted pregnancies. The majority ($n = 9$) had low education backgrounds, and only two participants had graduated from senior high school. All participants were primiparous. The majority ($n = 10$) were married and lived with their husbands, parents and others family members. One participant was unmarried and lived with her parents. Eight mothers had given birth vaginally, and three had caesarean births.

Mothers' postpartum hospital length of stay ranged from one to three nights. The majority of mothers roomed in with their infants ($n = 8$) and three infants from teenage mothers were cared for in the neonatal intensive care unit due to prematurely and low birth weight (LBW). The majority of adolescent mothers' initiation breastfed their babies while inpatients in the postpartum ward ($n = 8$), but they mixed this with bottle feeding in the early postpartum period because of a variety of breastfeeding problems. Three mothers ($n = 3$) did not initiate breastfeeding during their inpatient stay because their babies were premature and/or LBW.

All of the mothers were interviewed within one to two months after giving birth to their infants. All were privately interviewed in their homes. At the time of interview, the majority ($n = 8$) had continued to breastfeed their babies, were mainly formula feeding and three mothers did not breastfeed their babies.

Four themes emerged from the analysis of mothers' experiences**:** '*Breastfeeding problems*', '*Disempowerment in caring for the baby*', '*health care encounters*', and '*health care needs for adolescent motherhood transition*'. Indicative quotations from these themes are shown in Table 1.

3.1. Breastfeeding problem

Breastfeeding was the main problem faced by adolescent mothers. The theme, breastfeeding problems, was described by adolescent mothers in relation to their feeling stressed related to breastfeeding, pain including nipple pain and pain related to having given birth, and not having an opportunity to breastfeed. Four of the mothers interviewed expressed feelings of sorrow, feeling guilty for giving formula milk, feeling stressed and feeling that their breast milk was not enough, or with the baby rejecting the mother's nipple due to early bottle feeding soon after birth.

> *"...If I want to breastfeed, I am still lacking. I also feel stressed. My breast milk hasn't come in so I give formula milk. But the thing, if it is helped by formula milk, I am afraid my child will be more interested in formula milk and when given breastfeeds, he (the baby) don't want to"* (Participant 11, 19 years old).

Additionally, one mother commented *" . . . when I was breastfeeding, my baby was not satisfied so my baby cried. The second week I gave formula milk because my baby was not satisfied with breast milk"* (Participant 5, 17 years old).

All participants reported not having commenced full breastfeeding while inpatients in the postpartum ward. Most reported mixing breastfeeding and formula, with three just offering bottle feeding. Some participants reported experiencing nipple pain and pain after surgery. Common problems with nipples were experienced by several mothers. Problems with nipples included pain or inverted nipples making it difficult for the baby to suckle, and causing the baby to become distressed. As a result, some mothers chose to give formula, as expressed by the following:

> *"Usually my nipples hurt but over time it does not hurt anymore. When I give birth, there is no milk from my breast so I give my baby bottle feeding. But now, I have so much breast milk. But now my baby does not want to breastfeed in right breast, my baby only wants to breastfeed on the left breast so my breasts look bigger on the left "(*Participant 1, 16 years old).

Furthermore, the mothers also expressed having pain related to the birthing process. Adolescent mothers who gave birth via caesarean section reported being in pain after surgery. They reported that this pain led them to be unable to breastfeed in a lying position and caused difficulties with breastfeeding their babies.

> *" . . . usually I want to breastfeed but my pain from the surgery was hurting, it's no longer. Usually at night I was giving my baby a bottle. Because I can't move, I was very sick, move a little as if the intestines inside are pulled up. I am afraid if I move the stitches and the wound will be broken"* (Participant 11, 19 years old).

Adolescent mothers who had undergone caesarean sections want to quicker postpartum recoveries so they could become healthier and better able to breastfed their babies.

> "*The postpartum ward was good but I want to be taught how to breastfeed. They only ask me to breastfeed but I had caesarean surgery, so I cannot move"* (Participant 4, 17 years old).

Not having the opportunity to breastfeed their babies while in the hospital was also revealed by three participants, one who gave birth prematurely and two who had LBW babies. The responses they provided during the encounters caused them to feel sadness as they could not breastfed their babies.

> "*I have never breastfed my baby. I was never called to breastfeed my baby although my breastmilk is already in. So, for three days I never met my baby. I never breastfed my baby . . .* " (Participant 2, 16 years old)

Separate care with babies caused these teenage mothers to not have the opportunity to breastfed their babies. This was revealed by a mother whose premature baby was treated in the NICU. *"I never saw my baby after birth and never breastfed my baby because I was treated separately because of low birth weight and my baby's doctor said it was born at not enough months"* (Participant 3, 16 years old).

3.2. Disempowerment in caring for their baby

In addition to breastfeeding problems, teenage mothers also expressed feeling disempowered in caring for their babies, verbalising fears related to meeting the physical needs of their babies, pain related to giving birth, and less engagement with their baby. All eleven mothers described feelings of fear. These arose when caring for their babies after birth and being unable to provide care independently. They felt newborn care such as bathing, taking care of the umbilical cord, swaddling the baby and breastfeeding should be done by the mother with support from the midwives. Most mothers felt fear in caring for their babies as they were still very small, they were afraid that when carrying the baby it might fall, and feared that something might happen with the baby's umbilical cord. One participant, who was still a student when she was pregnant, described her fear in taking care of the baby.

> *" . . . usually I am still afraid to wear clothes, I also don't know how to carry, not too much to carry. I am afraid that later my baby will fall because he is still small. I also do not know how to bathe, do not dare, especially as the umbilical cord has not broken."* (Participant 6, 18 years old)

Additionally, another comment by one mother indicated: *"I was still afraid to bathe my baby, afraid that the way to bathe the baby was wrong and something bad would happen to my baby."* (Participant 9, 17 years old)

Feeling disempowered was expressed by three participants because they did not know how to take care of a crying baby: *"Sometimes I confused whenmy baby is crying, I don't understand*

what causes her cry, I'm confused how to make her to stop crying, sometimes I can only sigh." (Participant 10, 19 years old).

Childbirth pain was felt by all women, iresspective if they had birthed vaginally or by caesarean section. Postpartum pain was expressed by the adolescent mothers as an obstacle in caring for their babies, especially after surgery and due to lack of knowledge about how to care for babies.

"When my surgical wound had not healed it felt very painful, if I move, it feels very painful, I want to take care of my child. After the pain is gone, I begin to learn little about carrying my baby, as I am still sick, usually I am helped by my husband or mother-in-law, after the wound is healed I just managed everything" (Participant 4, 17 years old).

Mothers reported lack of opportunity for engagement with their babies and not participating in taking care of the babies. The nurses reportedly provided care for the babies, for example bathing them, but they did not empower the mothers to provide this care while in hospital.

"When I was at the hospital, the nurse took my baby and I was banned from bathing because there was a nurse." (Participant 6, 18 years old)

3.3. Health care encounters

Adolescent mothers said their experiences of health care primarily focused on contraceptive counseling and physical examination. Overall, they shared negative reflections about the services provided, revealing that staff did not seem to understand their needs and they complained about short interactions with midwives. Contraceptive counseling is a mandatory hospital task that is provided for all postpartum mothers before discharge in Indonesia and aims to help mothers to choose appropriate contraception for the future. This counseling is given to postpartum mothers before discharge from the hospital.

" . . . before discharge from hospital, we came to the counseling room, were given information about family planning, given contraception counseling, given a leaflet about the types of contraception." (Participant 5, 17 years old)

In the interviews, cultural expectations about using contraception were expressed by two adolescent mothers who revealed they would use birth control only after 40 days postpartum. They believed that using contraception in the early postpartum period would inhibit the lochea (blood flow after giving birth).

"I was given counseling about family planning but I did not want to use it. I will use injected implant when it passed 40 days. I won't use family planning before 40 days, later my blood won't come out if I use contraception, it will be clean after 40 days, then I want to use contraception" (Participant 2, 16 years old).

One adolescent mother said that she was given contraception counseling but she did not want to use it before two weeks after giving birth: *"In the hospital I was given family planning counseling when I did not want to have family planning, because my husband allowed me to get family planning when I was discharged from hospital. Two weeks after giving birth I started using a family planning implant"* (Participant 1, 16 years old)

Other routine activities carried out by the staff included postpartum maternal physical examinations such as blood pressure checks and distributing medicines. "*Every morning, midwives checked my blood pressure*" (Participant 3, 17 years old).

Four mothers stated that the staff gave physical care but did not give any counseling or advice for taking care of the baby. " . . . *the staff usually check my blood pressure, distribute the medicine, ask our name. There has never been any counseling."* (Partcipant 7, 19 years old).

Adolescent mothers' descriptions of the care experienced during their inpatient postpartum stays illustrate limitations in the care they received. Some participants described that staff did not understand their needs and there was lack of time for nurses or midwives to interact with them. When participants discussed experiences relating to health education, the majority expressed dissatisfaction with services provided. Health education about baby care was generally not provided. Key areas of concern were cord care, breastfeeding and physical care, for example, bathing methods.

"I was not taught about way to breastfeed. [they] just checked my breast milk is in. They say that I have a lot of milk . . . .my baby was taken by the nurse for bathing and I didn't see my baby being bathed." (Participant 7, 19 years old)

In addition, some participants also revealed that information given by health workers was incomplete and staff tended to only interact briefly with them.

" . . . usually midwives only asked me where my baby, then it was taken for a bath. When I breastfeed, they only told me to breastfeed my baby, two days hospitalized, the midwives ask me to breastfeed my baby. I was told to learn, they just said "mom, feed your baby" (Participant 1, 16 years old).

Four adolescent mothers considered that the attention given by nurses and midwives was insufficient and they had short interactions with midwives. One participant expressed: "*The midwife often visits, she asks what the complaint is, and distributes the medicine, usually it is only a short time because maybe many other patients will be served*" (Participant 10, 19 years old).

3.4. Health care needs for adolescent motherhood transition

All participants expressed information needs about baby care and breastfeeding. Information about umbilical cord care, bathing the baby and how to hold a baby was information they required to be managed in the room, and postpartum care before returning home.

"*Well, I want that, I'm still young, so I want you to teach me how to bathe my baby, this is how to hold a baby, so my aunt teaches me. When I breastfeed I can't go, especially if I want to urinate I put my baby in bed and my baby must cry. I want to know how to breastfeed with a lying position, I want to breastfeed my baby while lying down but I can't . . .* " (Participant 8, 18 years old)

In addition to needing information about breastfeeding, mothers also needed information about how to care for the umbilical cord. As previously stated, the mothers experienced fear of caring for their babies because of fear that something would happen with the baby's umbilical cord. One participant revealed that her baby had an umbilical cord infection after discharge from hospital because she had never taken care of the cord. This was due to lack of knowledge of the mother about baby care.

"...I need to be taught how to care for umbilical cord, how do I do it? Because, I didn't see my baby when bathed in the hospital so I also do not know how to take care of the umbilical cord . . . " (Participant 5, 17 years old)

Adolescent mothers' wishes to be empowered in caring for their babies were conveyed in this study. They wanted to participate in the care of their babies while in the hospital so that when they returned home they could care for their own babies safely and effectively.

"I want to know how to bathe the baby. When I was at the hospital, the nurse took my baby and I was banned from bathing because there was a nurse" (Participant 6, 18 years old).

"I hope to be involved when bathing the baby and caring for the umbilical cord, I hope the midwife says 'come with me, I'll show you how to bathe the baby'" (Participant 1, 16 years old)

In addition to physical needs, adolescent mothers also needed psychological support from health workers, both nurses and midwives, who are assigned to the postpartum care ward. One unmarried participant who was a student at senior high school expressed her feelings after giving birth:

"In the morning, I felt sad, the midwife said nothing, I cried when after giving birth, I was thinking why I ended up like this, it's my fault so I have to take care of my child, but the midwife just said, "I will check your blood pressure" (Participant 3, 17 years old)

One mother wanted to get more support from the staff but she found that midwives and nurses did not give her attention: " *. . . just checked it, after that, abandoned, they leave the room*" (Partcipant 10, 19 years old).

4. Discussion

Adolescent motherhood is associated with poor outcomes for mothers[24] and infants.[25–27] Providing targeted care for adolescent mothers as a high-risk group may increase maternal and infant health. This study contributes new information that can inform care for adolescent mothers based on experiences of their health care needs as young mothers. These results demonstate that breastfeeding problems and feeling disempowered to take care of their babies were issues these Indonesian adolescent mothers experienced after birth. This is a different finding to studies exploring adolescent mothers from western countries where mothers reportedly faced psychological problems.[7,28] Our results confirm feelings expressed by adolescent mothers during the postnatal period, and they were focused on breastfeeding and care for their babies, rather than psychological problems. They believed breastfeeding was the most important role of a mother that could not be replaced by another family member. In addition, they received good support from their familes because almost all participants were living with their families, and most were married by theirs or their parents' choice in line with Indonesian culture. Furthermore, the healthcare they received was limited to mandatory hospital tasks and there seemed to be an inability of staff to recognize the young mothers' needs. These findings suggest that adolescent mothers need targeted health education and psychological care from nurses and midwives in the postpartum ward before hospital discharge.

In addition to benefits for their infants including as the best source of nutrition for infants, support on child health and growth, protection from infectious disease and certain chronic diseases,[29] adolescent mothers may derive significant benefits from breastfeeding. These include financial savings and associated positive health outcomes such as reduced risk of breast cancer.[30] Maternity care practices a mother experiences during her inpatient hospital stay can influence initiation of breastfeeding and breastfeeding duration.[31] However, in this study, the adolescent mothers who initiated breastfeeding were not provided supportive care and all faced breastfeeding problems. The majority breastfed their babies but mixed this with bottle feeding early postpartum because of challenges. This study identified feelings of stress, nipple pain, pain related to giving birth and not having opportunities for breastfeeding were associated with lowered rates of breastfeeding. Unpreparedness to becoming a mother was one of the causes of psychological changes. In a wider context, feeling stressed because of difficulty latching and insufficient milk are often reasons cited by new mothers for not initiating breastfeeding.[32]

Furthermore, critical analysis of the data revealed that feeling pain was a barrier to breastfeeding including nipple pain. In line with other studies, common barriers to breastfeeding initiation of adolescent mothers included nipple pain and insufficient milk.[33] Adolescent mothers in this study were faced with difficulty breastfeeding their babies immediately after birth. This was commonly expressed by mothers who gave birth by caesarean section. Emotional and psychological effects felt by the mother during childbirth and anaesthesia are reasons why mothers may have difficulty breastfeeding after surgery.[34] Furthermore, having no opportunity to breastfeed was felt by adolescent mothers who had LBW and premature babies. In some contexts, care of babies in the neonatal intensive care unit (NICU) causes separation in care between the mother and baby so that they cannot maximize breastfeeding. Other researchers have reported barriers to early initiation of breastfeeding as the absence of mothers at the bedside, insufficient kangaroo care, inconsistent professional support of breastfeeding, and family dysfunction.[35] This research also found that nine out of eleven mothers still breastfed their babies at the time of interview including one mother who had a LBW baby, but all were partially breastfeeding, and mainly formula feeding and two mothers did not breastfeed their babies. Breastfeeding becomes an important issue for young mothers. They are faced with problems with exclusive breastfeeding and require follow-up after discharge.[32,36] As a result, it is important for adolescents to transition into motherhood with as much preparation and support as possible so that the transition works as well as possible.[37]

In general, adolescent mothers in this study revealed feeling disempowered both physically and psychologically. Disempowerment in taking care of the baby included fears related to meeting the physical needs of their babies, pain related to the birthing process, and less engagement with the baby. The majority of adolescent mothers in this study felt fear in taking care of their babies. The most stressful experiences were learning how to take care of a crying baby.[38] They can experience fear, worry, regret, frustration, guilt, shame, depression, and disruption in relationships as couples.[39] Adolescent mothers simultaneously encounter multiple developmental challenges related to transition into adulthood, marriage, pregnancy and mothering responsibilities.[8,40] Furthermore, several of the mothers in this study reported that physical problems consistently challenged them in caring for their babies including pain after birth and discomfort, which has been reported elsewhere.[41] This is an important consideration for health care support during the postpartum stay in being able to carry out maternal roles such as breastfeeding and taking care of babies.[42]

The health care encounters valued by adolescent mothers in this study, particularly in provision as a mandatory care task, included contraception counseling and physical care. Postpartum contraception counseling in a significant aspect for teenage mothers.[43] However, adolescent mothers face barriers to using contraception during the postpartum period including misinformation, high cost and social stigma.[44,45] However, negative experiences about health care during their inpatient stay were also reported in this study. Adolescent mothers felt that short interactions and interventions provided by nurses and midwives were limited to physical care. This study confirms previous findings around what contributes to general sense of mistrust and fear, care that was provided in a manner perceived to be too serious and rushed inhibited mothers' interactions with health providers.[10,46]

Limited interaction with nurses and midwives are perceived as negative by new adolescent mothers during postpartum

hospitalization. In the case of adolescent mothers, effective communication skills contribute to the ability of nurses or midwives to assess the needs of adolescent mothers.[10] Moreover, adolescent mothers in this study revealed that health workers were not sensitive to the inability of adolescent mothers to breastfeed their babies. Nurses and midwives only recommended breastfeeding without providing further assistance. In addition, the health workers often did not involve adolescent mothers in caring for their babies in the postnatal ward. The results of this study support previous research that adolescent mothers feel that postnatal wards were 'an alien environment'; 'feeling exposed and judged'; and 'miscommunications' and most mothers not being satisfied with the information they receive.[47]

This study contrasts with previous international findings that adolescent mothers expressed positive experiences during inpatient care, nurses sharing information and anticipating unstated needs, mutual respect, good staff attitude and communication.[10,48] In the current study, inability of adolescent mothers to care for and feed their babies at birth suggests that skilled support and assistance should be provided for these women following birth. Lack of staffing for effective communication and limited scope of care focused on physical care contributed to negative experiences during hospitalization. Positive supportive care will help mothers to better prepare before discharge and care for their babies at home.

An important finding in this study that was adolescent mothers needed health education and empowerment to care for their babies, and receive psychological support from nurses and midwives during their inpatient stays. The treatment of young mothers postnatally impacts on their caring behaviour and feeding decisions by reinforcing feelings of disempowerment and helplessness.[47] As women in the liminal states of both adolescence and new motherhood, young mothers are particularly vulnerable and require additional support and validation in order to build identities as confident and capable breastfeeding mothers.[49]

Furthermore, other studies have found that educational programs related to adolescent mother-friendly care were insufficient, and policies for health care for mothers were not necessarily available to them. A minority of perinatal care has reported mother-friendly adolescent care.[50] Therefore, developing interventions, including managing breastfeeding problems, empowering mothers to care for their babies and staff support, that are appropriate to the needs of adolescent mothers in Indonesia in accordance with the results of this study are important to help adolescent mothers undergo the transition process and adaptation to their new roles.

5. Limitations

There are limitations to this current study that require acknowledgement. Firstly, the study was undertaken at a single location. However, this hospital had the highest numbers of adolescent maternal giving birth in the region so may represent broader experiences of Indonesian adolescent mothers. Secondly, care provided may differ across settings so there may be other experiences elsewhere. Despite the qualitative design, new insights were provided into the experiences of adolescent mothers during inpatient care after birth and thus contribute to understanding their needs for support.

6. Implications for practice, policy and future research

The results of this study identify a number of important recommendations. The current evidence of effective interventions for management of adolescent mothers in achieving their roles is still very limited, especially in Indonesia. Therefore, the results have implications for stakeholders in clinical settings and health care providers to develop interventions for adolescent mothers tailored to specific health care needs during the postpartum period. The concept of health care needs for Indonesian adolescent mothers provides guidance in design of a discharge planning model to improve maternal role of adolescent mothers after discharge from hospital. Moreover, these results will help nurses and midwives to understand how to provide best care for adolescent mothers during the postpartum period.

The themes generated by this study may form the basis for new empirical research and inform clinical policy and practices about postpartum care for adolescent mothers. Further research needs to focus on assessing the ability of breastfeeding for adolescent mothers because this is an important issue and the design, implementation and evaluation of interventions to improve maternal competence and role attainment based on an analysis of the needs of adolescent mothers.

7. Conclusion

This research revealed themes of importance to adolescent mothers and outlined problems that need addressing. Findings included breastfeeding problems, disempowerment in caring for the baby, health care encounters, and health care needs for adolescent motherhood transition. These results highlight important issues about postnatal care of adolescent mothers to improve their maternal roles during the transition period. Overall, descriptions of the adolescent mothers' experiences about postnatal care and their health care needs provide knowledge and awareness of an important area in postnatal care in the clinical setting in the Indonesian context.

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Conflict of interests

The authors declare they have no competing interests.

Ethical statement

This study was approved by the Hasanuddin University Medical Faculty Ethics Committee (admission number: 175/H4.8.4.5.31/PP36-KOMETIK/2018). This research conforms to the provisions of the Declaration of Helsinki in 1995 (as revised in Edinburgh 2000).

All study participants provided informed consent, and their anonymity was preserved.

CRediT authorship contribution statement

Erfina Erfina: Conceptualization, Methodology, Investigation, Data curation, Visualization, Writing - original draft. **Widyawati Widyawati:** Methodology, Data curation, Visualization, Writing - review & editing. **Lisa McKenna:** Data curation, Visualization, Writing - review & editing. **Sonia Reisenhofer:** Data curation, Visualization, Writing - review & editing. **Djauhar Ismail:** Methodology, Supervision.

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