Original Article

A Qualitative Exploratory Study of the Continuity of Midwifery Care for the Adolescent Pregnancy in Indonesia

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Abstract

Background: Adolescent pregnancy poses serious biopsychosocial challenges and increases maternal and infant health risks. Continuity of Midwifery Care (CMC) is essential to ensure optimal outcomes, yet its implementation for adolescent pregnancies remains suboptimal. This study aims to explore gaps in CMC for adolescent pregnancies and provide recommendations for improvement. **Materials and Methods:** This qualitative study was conducted in Padang, West Sumatera Indonesia, from January to June 2022. Using purposive sampling, participants included adolescent pregnant women (n = 4), Private Midwifery Practices (n = 4), maternal and child health (MCH) program holders (n = 3), a maternal care coordinator midwife (n = 1), and a public health division head (n = 1). Data were collected through in-depth, semistructured interviews and analyzed thematically using an inductive approach with triangulation to ensure rigor. **Results:** Three key themes emerged: (1) Management continuity**;** care primarily focused on physical health, with limited assessment of psychological well-being. Diagnosis and care planning neglected adolescent-specific needs. Emotional support was minimal during implementation and follow-up. (2) Informational Continuity; Health information was general, lacking relevance to adolescent risks. Verbal explanations and the Maternal and Child Health Handbook were commonly used, with limited digital tools. Retention barriers included judgment, low confidence, and lack of adolescent-friendly materials. (3) Relational Continuity; Midwifery care lacked psychological support and was disrupted by staff rotation, reducing consistency. Family and partner support were often limited, affecting adherence and safety. **Conclusions:** To improve CMC for adolescent pregnancy in Indonesia, it is essential to integrated psychological support, develop adolescent-specific guidelines, provide personalized health education and strengthen midwife-client continuity.

Keywords: *Maternal health services, midwifery, pregnancy in adolescent*

Introduction

In the developing countries, approximately 21 million young girls get pregnant every year, increasing the risks of maternal and neonatal complications. Early pregnancy is closely linked to the elevated maternal and child morbidity and mortality.[1] Among *The Association Of Southeast Asian Nations* (ASEAN) countries, Indonesia has the second-highest rate of teenage pregnancies, with 45.10% of first-time pregnant women under 20 years. West Sumatra, particularly Padang City, records a high rate of the adolescent pregnant women seeking pregnancy care.[2-5] *The World Health Organization* (WHO) recommends *Continuous Midwifery Care* (CMC) for pregnant women under 20, encompassing pregnancy through childbirth.[5] The CMC model emphasizes establishing personal connections between midwives and expectant mothers, ensuring consistent care throughout pregnancy, childbirth, and postpartum. This model comprises of three main aspects: management continuity, informational continuity, and relational continuity.[6,7] Compared to standard maternity care, this approach leads to a higher satisfaction with childbirth experiences, fewer complications, and improved birth and neonatal outcomes.[7-9] Midwives play crucial roles in providing the CMC and assisting adolescent with healthy pregnancies.[6,7] However, there are challenges in providing CMC for the adolescent pregnancy. The previous study in Indonesia stated There is no standard for health care encounters for adolescent mothers related to maternal and babies'

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health.[10,11] The continuity of midwifery care is not consistently implemented, and sometimes it does not meet the standards. Midwives still face challenges in providing continuous midwifery care, especially for young pregnant women.[8] "Adolescents' experiences of the transition to motherhood and the factors influencing this process, including physical challenges, psychological aspects, baby care, social support, and healthcare provision, have been identified in previous studies.[11] This study focuses on the continuity of midwifery care CMC for adolescent pregnancy provided by the midwives in Indonesia. This study aims to explore gaps in CMC for adolescent pregnancies and provide recommendations for improvement.

Materials and Methods

This study employed a qualitative exploratory design to investigate the continuity of midwifery care for adolescent pregnancies in Padang, West Sumatera, Indonesia. The qualitative approach was chosen to obtain in-depth insights into the experiences and perspectives of various stakeholders involved in the care of pregnant adolescents. The study was conducted in Padang, a region with a high rate of adolescent pregnancies and an active network of healthcare practitioners and policymakers, making it an ideal location for this research. Participants were selected using purposive sampling, with a total 13 individuals involved. The study participants included adolescent pregnant women (n = 4), midwives from private practices (n = 4), maternal and child health (MCH) program coordinators (n = 3), a maternal and child care coordinator midwife (n = 1), and the head of the public health division (n = 1). The aim was to include individuals who could provide diverse and comprehensive perspectives on the continuity of midwifery care for adolescent pregnancies. Participants were recruited through direct contact at healthcare facilities, maternal and child health program offices, and midwifery practices in Padang. The research team approached healthcare professionals and administrators to identify potential participants who met the inclusion criteria. Written informed consent was obtained from all participants before data collection.

The inclusion criteria for the study participants were as follows: adolescent pregnant women aged under 20 years, experiencing their first pregnancy, and seeking antenatal care services at a healthcare facility in Padang; midwives practicing in private or public healthcare settings who actively provide midwifery care for pregnant adolescents, with a minimum of two years of professional experience in adolescent maternity care; Maternal and Child Health (MCH) program officers responsible for supervising and managing maternal and child health initiatives within the Padang area; Maternal and Child Health coordinator midwives tasked with coordinating maternal and child health services across multiple healthcare facilities and possessing at least one year of experience in program management within the maternal and child health sector; and the Head of the Public Health Division serving in a leadership capacity for developing and implementing public health policies related to maternal and child health services.

Data were collected through in-depth, semistructured interviews conducted between January and June 2022. Interviews allowed for flexibility in exploring key topics while ensuring consistency across participants. Each interview lasted approximately 45–60 minutes, was audio-recorded, transcribed verbatim, and analyzed to capture emergent themes. Field notes and memos were maintained to document nonverbal cues and additional contextual insights. Data collection continued until data saturation was achieved, which was defined as the point at which no new codes, categories, or themes emerged from the interviews. Saturation was monitored through ongoing analysis during the data collection process, with regular meetings among the research team to discuss emerging findings. Redundancy in participants' responses across diverse groups was used as an indicator that sufficient depth and variation had been captured to address the research objectives.

Some examples of the questions included in the interview guide are in Table 1.

An inductive thematic analysis was employed to analyze the data. Open coding was used to identify key phrases and concepts grouped into categories and themes. Triangulation methods, including methodological, data source, participant, and researcher triangulation, were employed to ensure the rigor and credibility of the findings.[12,13]

Credibility was ensured through methodological triangulation by employing multiple data collection

Table 1: Semi-structured interview questions guideline

Semi-structured interview questions asked to Adolescent Pregnancy and Midwife
1. How do you gather and assess data for adolescent pregnancies?
2. What challenges do you face in diagnosing and planning care?
3. How do you evaluate and follow up on the effectiveness of the care provided?
4. What types of health information do you provide to pregnant adolescents?
5. How do you deliver this information and through what methods?
6. How do you ensure the information is effective and followed up?
7. How would you describe your interactions with midwives or healthcare providers during your pregnancy?
8. What factors contribute to your sense of trust and comfort when receiving antenatal care?
9. In what ways do healthcare providers support you in maintaining your privacy and ensuring a safe pregnancy experience?

methods, such as interviews and document analysis, to obtain a comprehensive understanding of the subject. Transferability was achieved by providing detailed descriptions of the research context and participants, enabling readers to assess the applicability of the findings to other settings. Dependability was maintained by thoroughly documenting the research process and keeping an audit trail to allow replication of the study. Confirmability was strengthened through researcher triangulation, where multiple researchers were involved in the coding and analysis process to minimize bias and enhance the depth of interpretation.

Ethical considerations

This study received ethical approval from the Research Ethics Committee at the Faculty of Medicine, Andalas University (No. 736/UN.16.2/KEP-FK/2022, May 23, 2022). Additional approvals were obtained from the Padang City Health Department (No. 891/4382/DKK/2022, May 31, 2022), the Integrated Licensing and One-Stop Service Agency of Padang City (No. 070.1000/DPMPTSP-PP/VI/2022, June 7, 2022), and the Director of the Health Polytechnic of the Ministry of Health in Padang (No. DP. 02.01/03657/2022, June 8, 2022). All participants gave informed consent after being informed of the study's purpose, procedures, risks, and benefits. Participation was voluntary, data were anonymized and kept confidential, and all procedures ensured participants' safety and comfort in accordance with ethical research standards.

Results

The study identified three key themes in midwifery care continuity: Management Continuity, Informational Continuity, and Relational Continuity. A total of 13 codes were extracted from the data analysis it presented in Table 2. Here is the table, which contains the 13 participant codes, participant details, and their roles in this study.

The interviews categorized into key themes and subthemes. Table 3 presents an overview of these themes, subthemes.

1. Management Continuity

Management continuity refers to the structured and consistent approach in providing midwifery care, including data collection, diagnosis, care planning, implementation, and follow-up. However, the findings suggest that care remains predominantly focused on physical complaints rather than a holistic approach addressing psychological and social aspects.

Data collection and assessment

Midwives collect data through direct inquiries and observations. However, the assessment primarily focuses on physical health parameters, with limited attention to psychological and emotional well-being.

Table 2: The participants' details and roles

Informant code	Role/Occupation	Age (years)	Education level	Job
01a	Midwife from Private Practice 1	55	Diploma-III	Retired Civil Servant
01b	Midwife from Private Practice 2	56	Diploma-III	Civil Servant
01c	Midwife from Private Practice 3	54	Diploma-III	Civil Servant
01d	Midwife from Private Practice 4	65	Diploma-IV	Retired Civil Servant
02a	Mother and Child Health Program Holder 1	35	Diploma-IV	Civil Servant
02b	Mother and Child Health Program Holder 2	36	Diploma-IV	Civil Servant
02c	Mother and Child Health Program Holder 3	40	Diploma-IV	Civil Servant
03a	Maternal and Child Care Coordinator Midwife	39	Diploma-III	Civil Servant
04a	Adolescent Pregnancy 1	19	Junior High School	Housewife
04b	Adolescent Pregnancy 2	19	Junior High School	Housewife
04c	Adolescent Pregnancy 3	18	Junior High School	Housewife
04d	Adolescent Pregnancy 4	19	Elementary School	Housewife
05a	Head of Public Health Division	54	Magister	Civil Servant

Table 3: An overview of themes, subthemes

Respondent code	Subthemes	Theme
(01b, 01c, 01d, 04a, 04b, 04c)	Data Collection and Assessment	Management Continuity
(01a, 01 d)	Diagnosis and Care Planning	
01a, 01b, 01c, 01d	Implementation and Follow-up	
(01a, 01b, 01d, 04a, 04b, 04c)	Types of Health Information	Informational Continuity
(01a, 01b, 01d, 05 a)	Method of Information Delivery	
(04 a, 04b, 04c, 02a, 02 b, 03a, 01a, 01b, 01c)	Barriers in Information Retention	
(01a, 01b, 01c)	Comprehensive midwifery Care	Relational Continuity
(04a, 04b, 04c, 03a, 05a).	Continuity in Midwife-Mother Interaction	
01a, 01b, 02a, 02c, 03a, 04a, 04b, 04c	Ensuring Safety and Adherence	

A midwife from a private practice stated, "*Assessment includes inquiring about complaints during the examination." (Midwife from a private practice 1)*

Another midwife explained, *"Midwives ask about health issues in the Mother and Child Health room." (Midwife from a private practice 2)*

A Midwife shared, *"Data collected covers family history, marital status, pregnancy details, and family acceptance." (Midwife from a private practice 3)*

Diagnosis and Care Planning: After gathering data, midwives diagnose and create a personalized care plan based on the adolescent mother's needs. The diagnosis stage includes identifying pregnancy-related conditions, but there is a lack of standardized guidelines for addressing adolescent-specific concerns, such as mental health risks, nutritional needs, and socioemotional challenges. Care planning primarily targets symptom relief rather than preventive or holistic strategies tailored to adolescents.

A midwife expressed, "*Diagnosis includes details such as the mother's age, gestational age, and progress in pregnancy." (Midwife from a private practice 4)*

Another midwife describe how care is planned to respond to mothers' needs: *"Care plans address the mother's complaints, provide explanations, and suggest preventive measures." (01a, 01d).*

Implementation and Follow-up: This phase involves executing the care plan and conducting regular follow-ups to assess the effectiveness of interventions and adjust as needed. While follow-up is conducted regularly, it is largely focused on physical progress, with limited continuity in monitoring emotional well-being and psychosocial support. The documentation system is utilized but lacks integration of mental health screening or counseling records.

A midwife stated, *"Follow-up includes reviewing previous and current complaints and checking adherence to previous advice." (Midwife from a private practice 1)*

Another Midwife mentioned, *"Documentation is maintained in the Maternal and Child Health Handbook and other records." (Midwife from a private practice 2)*

2. Informational Continuity

Informational continuity ensures that adolescent mothers receive consistent and relevant health information throughout pregnancy and postpartum.

Types of Health Information: Midwives provide general information on pregnancy, childbirth, and postpartum care, but specific information related to adolescent pregnancy risks and psychological adaptation is rarely addressed.

A midwife from a private practice explained, *"Information provided includes causes, solutions, and risk reduction strategies for maternal complaints, as well as childbirth preparation and necessary supplies." (Midwife from a private practice 3)*

Method of Information Delivery: Verbal explanations are the primary mode of delivery, supported by the Maternal and Child Health Handbook. However, adolescent mothers often struggle to fully understand the content, highlighting the need for interactive and tailored educational approaches.

A midwife stated, *"Information is delivered orally and supported by the Maternal and Child Health Handbook." (Midwife from a private practice1, 3)*

Another midwife added*; "Information is presented orally and backed by the Maternal and Child Health book." (Midwife from a private practice 2,4)*

Head of Public Health Division explained, *"The guideline used for both young and other pregnant mothers is the Maternal and Child Health book." (05a)*

Barriers in information retention and utilization

Many participants reported feeling judged due to the stigma of adolescent pregnancy, leading to self-doubt and hesitation in seeking help.

An Adolescent pregnancy expressed, *"I feel judged by those around me, including healthcare workers, which makes me hesitate to ask questions."* (04 a)

Several adolescent mothers struggled with breastfeeding but felt too embarrassed to ask for help:

"I often lack confidence in breastfeeding but rarely seek support due to embarrassment." (04 b, 04c)

Health workers acknowledged that most educational materials are not adapted for adolescents. Participants highlighted the lack of adolescent-friendly health education materials.

A maternal health program holder mentioned, *"Most materials are general and not tailored to young mothers. They need specific guideline, interactive, digital content."* (02a, 02 b, 03, a)

Additionally, adolescent pregnancy reported difficulty in finding reliable information online. *Adolescent Pregnancy shared, "We searched online but wasn't sure what was trustworthy."* (04a, 04b, 04c)

3. Relational Continuity

Relational continuity emphasizes the importance of sustained and trust-based relationships between midwives and adolescent mothers. The findings indicate that adolescent mothers highly value emotional support and reassurance from midwives, yet structured efforts to establish a therapeutic relationship are lacking.

Comprehensive Midwifery Care: Midwives provide holistic care addressing adolescent mothers' physical,

psychological, and social needs throughout pregnancy and postpartum.

A midwife stated, *"Care follows the 10T standards, including various examinations and vaccinations, with support from family." (01a, 01c)*

Another Midwife described, *"Midwives explain results, provide family support, and remind mothers about medication and follow-ups." (01a, 01b, 01c)*

Midwives acknowledge the importance of providing psychological support but face time constraints and a lack of specific training in adolescent mental health.

Continuity in midwife-mother interaction

Adolescents prefer consistent midwifery care from the same provider to build trust and familiarity. However, staff rotations and limited availability of dedicated adolescent midwifery services disrupt continuity in care relationships.

An adolescent Mother expressed, *"When the midwife keeps changing, I have to repeat my story from the beginning, and that makes me reluctant to talk much." (04a, 04c)*

Another adolescent Mother shared, *"There are no specialized services for adolescent mothers, so we are often grouped with older patients. This can make us feel uncomfortable." (04 a, 04d.).*

A midwife noted, *"While resources are nearly complete, ultrasound is not available on-site, leading to referrals as needed." (01a, 01d)*

Ensuring safety and adherence to care

Safety is ensured by following evidence-based practices and maintaining strict privacy and hygiene protocols.

A midwife described, *"Privacy is upheld by controlling the examination environment, and hygiene practices include handwashing and PPE use." (01a, 01b)*

Another midwife emphasized, "Midwives follow COVID-19 protocols during procedures." (02a, 02c, 03a)

Ensuring adherence to care protocols among adolescent mothers requires a more engaging and supportive approach beyond standard ANC services. Adolescents may have higher dropout rates in follow-up care due to lack of motivation and external support.

An adolescent mother admitted, *"I often forget my check-up schedule because no one reminds me, and sometimes I feel too lazy to go alone." (04a, 04b)*

Another adolescent pregnancy added, *"Some adolescents stop attending prenatal check-ups due to a lack of support from their family or partner.(04c, 04d")*

A maternal coordinator midwife concluded *"We observe that adolescent mothers are more vulnerable to not completing their prenatal care, especially if they do not feel supported by their surroundings." (02c, 03a)*

Discussion

This study explores the Continuity of Midwifery Care (CMC) for adolescent pregnancies in Indonesia, focusing on three key aspects: management continuity, informational continuity, and relational continuity. The findings highlight several gaps in the current midwifery care model, particularly in addressing the holistic needs of adolescent mothers.[14]

The study identifies a lack of comprehensive management continuity in midwifery care for adolescent mothers. The care provided remains predominantly focused on immediate physical complaints, with limited attention to psychosocial and emotional aspects. This finding aligns with Fleming *et al*., who argue that adolescent mothers often receive care that fails to address their developmental and psychosocial needs.[15,16] Similarly, Laurenzi *et al*.[17] emphasized the necessity of integrating psychosocial support and daily routine assessments to improve maternal and infant health outcomes. The absence of standardized guidelines addressing adolescent-specific concerns such as mental health risks, nutritional requirements, and socioemotional challenges indicates a critical gap in current midwifery practices.[18,19] Prior research suggests that a holistic approach that incorporates psychological support and personalized interventions could enhance the overall quality of care for adolescent pregnancies.[17,20]

Additionally, the lack of structured follow-up mechanisms contributes to inconsistent care. While routine check-ups are conducted, they primarily focus on physical health indicators, with limited integration of emotional well-being assessments. Effective continuity of care requires systematic follow-ups that track both physical and psychosocial progress to ensure comprehensive support for adolescent mothers.[21,22]

This study finds that informational continuity is insufficient, as adolescent mothers often receive fragmented and generalized health education. Health information predominantly addresses immediate concerns, such as maternal complaints and labor preparation, rather than offering comprehensive, tailored education on adolescent pregnancy risks and long-term maternal well-being.

Ghiasi *et al*.[23] highlight that adolescent mothers frequently receive inadequate health information that does not cater to their specific developmental and educational needs. The reliance on standardized resources, such as the Maternal and Child Health Handbook, without additional adolescent-specific guidance, limits the effectiveness of health education efforts. Moreover, the study reveals that the predominant use of verbal explanations, without supplementary interactive or digital educational materials, further reduces information retention among adolescent mothers.[24,25]

Prior research underscores the importance of targeted health education that is accessible, engaging, and responsive to

adolescent learning preferences.[26] This study supports the growing call for adolescent-friendly educational resources, including interactive learning modules and peer-support initiatives, to improve informational continuity in midwifery care.[26]

The study underscores the importance of relational continuity, emphasizing that sustained and trust-based relationships between midwives and adolescent mothers are essential for positive care experiences. Adolescent mothers highly value emotional support and reassurance from midwives, yet structured efforts to establish therapeutic relationships remain inadequate.[27]

Existing literature supports the role of strong, ongoing relationships between healthcare providers and adolescent mothers in improving care quality and patient satisfaction.[27] However, this study finds that frequent midwife rotations and the absence of dedicated adolescent maternity care services disrupt relational continuity. The inconsistency in provider-patient relationships results in repeated information-sharing and a reluctance among adolescent mothers to disclose personal concerns.

Previous studies indicate that personalized and continuous midwifery care fosters trust and improves adherence to maternal health recommendations.[28] This study highlights the need for more structured relational strategies, including adolescent-friendly midwifery services, mentorship programs, and designated midwives for adolescent mothers, to strengthen relational continuity and enhance care engagement.

Future research should consider a mixed-methods approach, incorporating quantitative assessments of care outcomes alongside qualitative insights, to develop a more comprehensive understanding of continuity of midwifery care for adolescent with young mothers.

While this study provides valuable insights into continuity of care for adolescent pregnancies, several limitations should be acknowledged. First, the study is limited to a specific regional context, which may affect the generalizability of the findings to other healthcare settings. Second, the qualitative nature of the study relies on self-reported experiences, which may be influenced by recall bias or social desirability bias.

Conclusion

CMC improves maternal and infant health, but there is a room for enhancement, particularly in addressing psychosocial aspects and specific need. Specific guidelines and improved midwife training for adolescent pregnancy are needed. Adopting effective CMC and strategies to overcome relationship barriers is recommended. Addressing these limitations is vital for future research and an implementation of CMC implementation for the adolescent pregnancy in Indonesia.

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Conflict of interest

Nothing to declare.

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