Stigma and utilization of treatment for perinatal depression among adolescents in Nigeria

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Abstract

Background. Depression is a common and serious disorder among low-income adolescent mothers in low-and middle-income countries where resources for treatment are limited. We wished to identify, among adolescents with perinatal depression and their health providers, factors influencing health service utilization for the condition in Nigeria to inform new strategies of care delivery.

Methods. Focus group discussions (FGDs) were carried out among low-income adolescent women with a history of perinatal depression and separately with primary care clinicians treating this condition in Ibadan, Nigeria. Semi-structured interview guides were used to obtain views on the factors that promote or hinder help-seeking and engagement. FGDs were conducted until saturation of themes was achieved. Transcripts were analyzed using content analysis framed by the Behavioral Model for Vulnerable PopulationsModel and triangulation between patients and providers.

Results. A total of 17 women and 25 care providers participated in 6 FGDs. Perceived benefits of treatment received for perinatal depression were strong motivation for service utilization. Significant stigma regarding adolescent pregnancy and perinatal depression created obstacles to care. Providers expressed negative stereotypes associated with adolescent pregnancy. However, individual patient resilience was a major enabling factor facilitating service engagement. Older and more experienced care providers were perceived to deliver more tolerant and supportive care that adolescent mothers valued.

Conclusions. Participants identified an unsupportive and stigmatizing clinic environment as a major barrier to accessing available care. Interventions to reduce stigma among healthcare providers may improve services for this vulnerable population.

Background

Maternal health care for adolescents is complex and involves a range of psychosocial issues while also requiring attention to both the developmental needs of the child-parents and medical issues related to the pregnancy (UNFPA, 2013). Approximately 95% of all births to girls under age 18 occur in low- and middle - income countries (LMICs), where supporting infrastructure for healthcare is limited (UNFPA, 2013). Perinatal depression (PD), occurring during pregnancy and in the year postpartum, is common among adolescent mothers than older women of childbearing age (Salazar-Pousada et al, 2010; Dinwiddie et al, 2017). The occurrence of PD among adolescents complicates their unique age-and development-related challenges and thus demands services attuned to the special needs of this age group. Unfortunately, healthcare delivery systems in LMICs, are limited by a lack of adequate numbers of trained care providers as well as appropriate infrastructure to support high quality primary maternal care for adolescents (WHO, 2018).

Several factors may potentially constitute a barrier to adolescents with PD accessing care and adhering to treatment. For example, adolescent mothers in LMICs report a high degree of stigmatizing attitudes regarding adolescent sexual activity from healthcare providers that reflects broader social and cultural

forces to healthcare participation (Baryamutuma, 2011; Mbeba et al, 2012; Kennedy et al, 2013; WHO, 2017). Stigma is a fundamental cause of health inequities (Hatzenbuehler, Phalen, and Link, 2013) and stigmatizing attitudes from clinic staff may lead to dissatisfaction with the health system, reduce the likelihood of help-seeking, and eventually compromise maternal and infant health outcomes (White Ribbon Alliance, 2011; Holmes 2012; Mannava et al 2015).

We wished to explore factors associated with care for adolescents with PD in an urban setting in Nigeria and identify potential interventions to improve care utilization. Specifically, using the Behavioral Model for Vulnerable Populations (Gelberg et al, 2000) which provides a systematic framework for exploring how vulnerable individuals engage with the health service, we examined how predisposing, enabling, and need factors affect the health service utilization experiences of perinatal adolescents with depression.

Methods

Subjects and study setting. The study was conducted in Ibadan, southwest Nigeria. Using a qualitative method of inquiry, we carried out 6 Focus Group Discussions (FGDs) among twenty-seven (27) women and twenty-five (25) primary care providers between 6th March and 29th April, 2018. Participants were purposively selected from our database of respondents who participated in a previous randomized control trial (RCT) which was conducted between 2014 and 2016 (Gureje et al 2015). In the RCT non-specialist maternal and child health clinicians (MCHC) delivered psychosocial interventions for PD using the Nigerian adapted WHO mhGAP intervention guide (mhGAP-IG) (Gureje et al, 2019).

Interviews. The interview guide was semi-structured and designed to explore the views of study participants on healthcare utilization patterns of perinatal adolescents. This removed the restriction implicit in the use of closed-ended questions (Pope & Mays, 1995; Nyumba et al, 2018) and allowed for the use of probes for necessary explorations. The questions in the guide draws on the experiences of participants during the trial and form the basis of this paper. The interview guide was originally written in English and later translated to the Yoruba language. The Yoruba version of the interview guide was necessary to ensure a better understanding of the concept under study by participants.

Data Collection. Identified participants were contacted on the phone. They were briefed about the aims and purpose of the study and invited to participate in the FGDs. We contacted 24 women (who were adolescents during our RCT) and even though all accepted our invitation to participate in the FGDs, only a total of seventeen showed up eventually on the days the FGDs were scheduled. Besides, one out of the 26 care providers we invited declined our invitation to participate at the last minute because of an emergency work commitment.

We conducted the FGDs until saturation of themes was achieved as determined by the interview facilitator. The participating women (mothers during our RCT) were selected to maximize variation for the adolescent groups along treatment engagement using the criteria in table 1 from the RCT study database. The FGD sessions were conducted in a seminar room at the University of Ibadan for three

weeks. LK, facilitated the FGDs and DA a research supervisor with 4 years of experience in qualitative study was the timekeeper and notetaker. In all the group discussions LK declared to participants that she was not from a medical background and this proved valuable because participants were able to let down their guards and were unpretentious during the discussions, hence the data was rich and the bias minimal. The FGDs lasted between 70 - 90 minutes and all were tape-recorded and transcribed. Transcribed interviews were later translated back to the English.

Conceptual Models. The Behavioral Model for Vulnerable Populations (Figure 1; Gelberg et al, 2000) guided the exploration during the FGDs, and the analysis. This was also based on the assumption that several factors determine the use of services (Andersen, 1995; Aday & Andersen 2014). In Table 2, we present the main features of this Model.

Data Analysis. All transcripts were analyzed using content analysis of themes that emerged from the FGDs (Downe-Wamboldt, 1992). Subjective interpretation of the text data was achieved through the systematic classification process of coding, the identification of themes, and avoidance of preconceived categories (Kondracki & Wellman, 2002). This allowed for inductive categorization development and the emergence of new insights into the data (Mayring, 2000; Kondracki & Wellman, 2002). Initial primary codes were created by LK from the interview guide under the thematic headings and then applied to the transcriptions. LK and DA independently coded the texts that reflect the utilization pattern of the then adolescents. Dissenting codes were resolved through consensus. Emerging recurrent themes were managed to avoid repetition. LK who holds a Ph.D. in medical sociology, and currently a senior research fellow, and an adjunct associate professor of Sociology, with years of experience in the conduct and analysis of qualitative interviews carried out the data analysis. Her social science background influenced the entire process of analysis. This analysis led to the development of a descriptive account focused on identifying key variables, and bringing out the range and diversity for each subject heading (Ritchie, Lewis, Nicholls & Ormston, 2013).

Results

Seventeen of the invited 24 women (71%), and 25 of the 26 care providers (96%) participated in the 6 FGDs (3 with RCT women and 3 with care providers); All 42 participants gave their consent to participate in the study. The results are organized below according to the constituent factors of the Behavioural Model.

Predisposing factors

The *demographic details* of participants are shown in table 3. The mean age of the women was 22 ± 1.1 years and their mean years of education was 11.2 ± 1.7 years. Most of the women (11) and their partners (13) were low-income earners. However, the mothers reported an average of over 10 years of prior education. The Maternal and Child Health care (MCHC) providers had a mean age of 49 ± 4.8 years; the

majority were female and married. Analysis of the FGD transcripts revealed some key findings to support, illustrate and illuminate the ideas and experiences of participants (Sandelowski, 1994).

Health beliefs.

All FGD participants (patients and providers), reported that the primary reason women attended clinic appointments for treatment of PD was the perceived usefulness of the care received for the condition. All of the mothers reported no *knowledge of their illness* before they visited antenatal clinic (ANC) where they were recruited into the trial following screening for depression.

Enabling Factors.

We present the enabling factors of healthcare utilization of the FGD participants with a focus on the women's experiences as they interacted with service and clinic staff. *It was reported that the* availability of care for PD at the primary care level was an important enabling factor in healthcare utilization for the adolescents. All the women rated the *perceived usefulness of treatment* they received for depression as high.

"I met nurse [Name] and she gave me hope. She told me I had a sickness of the mind that made me sad... and that I will get better with time and I did. I like her a lot" (FGD Women group 1).

The women described how they overcame self and social stigma relating to their early pregnancy to access available care. They reported that increased visits to the health facility resulted in improved clinical conditions, which encouraged their continuing use of healthcare services.

"...I was in a bad state when I went to the clinic... I thought my life was over. However, the more I visited the clinic and talked to the nurse, the better I felt." (FGD, Women group 1).

Social support. Many of the women reported low social support which was however still an enabler to use of service.

"My mother showed me very little support and was not happy about my pregnancy...but she would make sure I go the clinic..." (FGD, Women group 1)

"My mother followed me to the clinic only once" (FGD, Women group 3)

About half of the providers expressed openly disparaging views about their adolescent patients, and endorsed a justification for the low social support adolescents received from relatives during their pregnancies.

"Many of these girls are irresponsible and promiscuous and do not listen to parents ...it is no wonder that they receive very little support from relatives. They need to learn the hard way" (FGD, Care

provider group 2)

Informational support the women received from the care providers was rated as very helpful to their understanding of the symptoms of depression. The providers, in turn, attributed the skills to manage their patients to the training they had received before the commencement of the trial.

A majority of the women expressed appreciation for available health care services for PD at the primary care clinic level. Their appreciation notwithstanding, they reported stigmatizing attitudes of some clinic staff towards pregnant adolescents. Stigma, experienced mainly from junior nurses with fewer years of experience, was in some cases subtly manifest through negative attitudes and behavior; receiving sharp answers to questions asked during a physical examination, or overt statements of negative stereotypes such as a clinic staff telling a patient she is too young to get pregnant. The women reported passive and active strategies of coping with the negative attitudes of the healthcare providers. They sometimes ignored negative actions or actively responded to such behavior by calling it out directly. At other times they insisted on seeing a different provider or resorted to visiting the clinic only when it was very necessary, to avoid unpleasant stigmatizing situations. A participant recounted:

"I had a very bad experience one day with a nurse [name]. She was the one that checked if the baby was breathing, Nurse [name] was always rude to young people. She told me that I got pregnant when my mates were in school... I felt very worthless ..., yet I answered back and told her she was a bad person. I refused to let her attention to me after that day"

(FGD, Women group 2).

FGDs with providers reflected a lack of sympathy and frustration in caring for adolescents with PD. They described adolescents with PD as more "annoying" because of the symptoms of depression that made them socially withdrawn.

Both the women and care provider groups pointed to difficulties with clinic structure, particularly on ANC days when the women made appointments for both routine prenatal and depression care to reduce the frequency of travel to the clinics. Most women reported ANC days as difficult, with long waiting times. They described as "awful" some records clerks who created unnecessary tension by calling out patient's names for consultation with clinicians only once and without a microphone, making it difficult to hear when to come forward and risk losing your place in line.

"Going for ANC was a big problem. The lines were long and the record clerks called our names only once. If you missed when your name was called then you might have to wait a long time..." (FGD, Women group 3).

Although the reports of the providers corroborated systemic care delivery shortcomings relating to human resource limitations, they attributed aspects of poor care quality to the difficulties of working with adolescents.

"Those young girls are very rude and difficult to attend to. They are very disrespectful" (Care provider group 1).

Despite significant examples of stigmatizing behaviors, the women reported *positive patient and clinician relationships with the providers who managed their depression*. They indicated a general preference for the older and more experienced providers whose descriptions of the girls suggested a more accommodating attitude.

"You see, these are children that got pregnant...and depression made their cases even worse... one needs to be patient with them" (FGD Care provider group 1).

"Proximity of care facility to their homes. All the women lived within walking distance to the primary care centers, and reported easy access to the clinics.

Need factors

The women reported perceived heightened need to continue in treatment after the diagnosis of their depression. This was facilitated by the support they received from their MCHC providers.

Health behavior.

The providers' accounts depicted most of the adolescents as having poor personal hygiene practices that sometimes made physical examination unpleasant. One care provider noted,

"Many of those girls are very dirty. When you want to examine them, they smell." (FGD Care provider group 3).

The women reported relatively few recommended health practices although health talks were given to them regularly by their providers. About half of the women indicated being aware of the need to have adequate *sleep*. Four reported walking about an hour per day not intentionally for *exercise* but mainly to run errands. Many reported having very few food choices as a result of poor social and economic circumstances. The MCHC clinicians in their account also related that generally, adolescents have poor health practices because of lack of autonomy:

"...it can be difficult for someone young to enforce anything at home because they are not autonomous." (FGD Care Provider Group 1)

Outcome following the receipt of care.

There was consensus across the women's FGD groups on *satisfaction with the care, and engagement with health care services*. All women interviewed had *recovered from their depression*.

Discussion

In this study, we have explored factors that may promote or hinder the use of health care services by adolescents experiencing PD. We used a framework, the Behavioral Model for Vulnerable Populations that allows for a systematic exploration of developmental and contextual issues that may be of particular relevance when considering adolescents' engagement with the health service in a resource-constrained setting. In a setting with health care services to support the mental health of adolescent mothers, we identified evidence of stigma which had the potential to reduce service use of perinatal adolescents.

The main predisposing factor to engaging with service by the adolescents was pregnancy. This finding is in line with the observation that most women from southwest Nigeria access antenatal care during pregnancy (Shambe et al, 2018). The mothers were generally unaware of their depression before being screened in the clinic and found to be depressed. The subsequent interaction with the providers led to an informed health belief about depression and the need to receive care for the condition.

The service environment was often discouraging, with long queues and stigmatizing attitude by many of the providers. In the clinic, the stigma was both about their early pregnancy as well as their depression. Some clinic staff labeled, devalued, stereotyped, and degraded adolescents thereby undermining the primary goal of the provision of high-quality patient-centered health services by healthcare professionals. The social stigma of adolescent pregnancy described in the study is rooted in cultural values and negative stereotypes which translate adolescent pregnancy into a stigmatized identity (Kyla Ellis-Sloan, 2013; Rendell and Whitehead, 2001). We found that family resources like parental support were often absent, and family members conveyed disapproval for the unplanned and unwanted pregnancies by providing little support for young girls during the perinatal period. However, despite the vulnerability and demanding personal circumstances of many adolescents, they employed different coping strategies to use available health care services and deal with social stigma at the care facilities. Individual resilience was an important enabling factor which facilitated their continued use of treatment facilities (SmithBattle 2013; Kumar et al, 2018).

Adolescents' personal hygiene was an example of a health behavior that generated negative attitude from the providers and was associated with difficult patient-clinician interaction. Thus, this healthy behavior as a potential barrier to health care utilization.

Overall, despite the negative experiences associated with the receipt of care, adolescents persevered with help-seeking because of personal resilience, supportive attitude of more senior providers and perceived benefit or effectiveness of the treatment, which led to overall satisfaction with care.

Limitations

This exploratory study has several limitations. First, the sample size is small which limits the ability to generalize the findings to other settings. We believe, however, that the purposeful sampling strategy we

utilized increased the likelihood that salient themes underlying the utilization of care for PD emerged.

Conclusion

This study identified factors mitigating against and facilitating service utilization by adolescent mothers. We found that even though negative attitudes were pervasive at home and in the treatment facilities and the care conditions in the latter were often tasking, adolescent mothers nevertheless displayed a commendable level of resilience to cope with both their adverse social circumstances and the less than optimal service environment. We found that providers who are mature, senior professionally and well trained in the delivery of care for depression were needed to ensure service engagement by depressed adolescent mothers. Our results highlight the need for improvement and more supportive health care delivery environments for pregnant adolescents to reduce barriers to care.

Abbreviations

PD: Perinatal Depression; RCT: Randomised Control Trial; LMICs: Low and Middle Income Countries; ANC: Antenatal Clinic; FGD: Focus Group Discussion; MCHC: Maternal and Child Health Care Clinician

Declarations

Ethics approval and consent to participate

All procedures performed in studies involving human participants were in accordance with the ethical standards of the Helsinki declaration and its later amendments or comparable ethical standards. The approval for the study was given by the University of Ibadan/University College Hospital Institutional ethics review committee (FWA 00002499). All participants were above the age of 18years at the period of the interview and all gave written informed consent to participate in the study.

Consent for publication

Not applicable. This article do not contain any individual person's personal information.

Availability of data and materials

The data that support the findings of this study are available from the corresponding author but restrictions apply to the availability of these data, which were used under license for the current study, and so are not publicly available. Data are however available from the authors upon reasonable request and with permission of the corresponding author.

Competing interests

All contributing authors declare that they have no conflict of interest.

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Authors Contribution

LK and IB designed the work and LK wrote the first draft of the manuscript. LK and DA collected the data, LK led the analysis of the results, and IB, DA, AB, PYC and OG contributed to interpretation of the results. LK, IB, PYC, OG contributed to the production of the drafts of the manuscript. AB, IB, PYC, OA and BDO critically reviewed the article. All authors have read and agreed to the content of the final draft and are accountable for all aspects of the accuracy and integrity of the manuscript.

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Tables

Table 1: Study participants according to groups

Women group 1 (n=5)	those who completed 8 sessions of treatment
Women group 2 (n=7)	those who completed 6 sessions of treatment
Women group3 (n=5)	those who completed ≤ 2
Provider group 1 (n=8)	Heads of ANC facilities who are midwives
Provider group 2 (n=9)	Intermediate level clinicians
Provider group 3 (n=8)	A mix of the various cadres of clinicians including junior, intermediate and heads of facilities

Table 2: Conceptual themes and definitions (derived from theBehavioral Model for Vulnerable Populations)

Conceptual themes	Definitions
Predisposing factors	Demographic, health beliefs and other factors prompting their utilization of health facilities
Enabling factors	Personal, family and health care resources available to the women during their pregnancy
Need factors	Perceived and evaluated health
Health behavior	Personal health practices
Outcome factors	Satisfaction with care and other effects of service use

Table 3: Demographic characteristics of FGD Participants (N=42)

<i>Women participants</i>	
Variable	N (%)
Marital status	
Married	14(82.4)
Cohabiting	3(17.6)
No of Children	
	<u>Total</u>
1	3 (17.6)
2	13 (76.5)
3	1 (5.9)
None	0 (0)
Occupation	
	<u>Participants</u>
Apprentice	1 (5.9)
Artisans	11 (64.7)
Traders	4 (23.5)
Housewife/unemployed	1(5.9)
	Mean±SD
Age of women participants	22±1.1
Years of education of women participants	11.2±1.7
<i>Care provider participants</i>	
Variable	N (%)
Sex of care providers	
Male	3(12.0)
Female	22(88.0)
Total	25 (100.0)
Marital status	
Married	25(100.0)
	Mean±SD
Age of care provider participants	49±4.8

Figures

Figure 1

Behavioural model of health service use by adolescents with perinatal depression

Supplementary Files

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- [COREQ32ItemchecklistBMC.docx](#)