2 Young Lives: mentoring teenagers for safer pregnancy and birth

Project report 2020

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Background

Sierra Leone has an estimated maternal mortality ratio (MMR) of 1100 maternal deaths per 100 000 live births, the highest in the world [1]. However, for teenagers the risks are exacerbated, with an increased MMR for young women under twenty, and when disaggregated further by age, an even higher risk for the younger age group [2]. This was borne out in a rapid household survey conducted by Lifeline Nehemiah Projects (LNP) in the Kuntorloh area of Eastern Freetown in July 2015.

Of the 150 adolescents aged seventeen and under who had given birth in the previous two years, twenty (13 %) had died of maternal causes.

This led to a qualitative study by Lucy November, a midwife researcher from Kings College London, funded by the Wellbeing of Women's International Midwifery Fellowship, which examined the causes of this high incidence of maternal death in teenagers [3].

Among the key findings was that pregnant girls are often abandoned or neglected by their families, particularly when being cared for by a non-parental adult, a common scenario in Freetown. It is common for pregnant girls to then stay with a more distant relative or with her boyfriend's family, sleeping on bare ground without a mosquito net, and being fed once a day in exchange for heavy domestic duties such as water collection and laundering.

This lack of adult care or support often leads to delays in care seeking or complete lack of antenatal and delivery care, putting girls at high risk of death from untreated infections and anaemia, lack of birth preparation, and common obstetric risks.

It was hypothesised that having a mentor could mitigate against the risks of maternal and infant mortality and morbidity in pregnant adolescents and their babies. A review of the determinants of delivery service use identified low maternal age as a determinant for not accessing skilled care for delivery [4], and evidence from other community projects in Freetown indicate that having an advocate when accessing health care helps to reduce some of the barriers such as disrespectful care and informal charges.

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There is strong evidence that connectedness with an adult, be it a parent or a non-parental adult, appears to be foundational for adolescent health and well-being more generally [5-8], including delaying rapid second pregnancies [9].

The mentoring scheme: 2 Young Lives

History so far

Lifeline Nehemiah Projects, a local non-governmental organisation which trains and mentors young people in vocational and life skills, started a mentoring scheme for pregnant teenagers in October 2017 in Kuntorloh, Eastern Freetown, with a team of three mentors mentoring nine teenagers. In October 2018, a second team was established in Kuntorloh. In April 2019, the project expanded to the district town of Port Loko, and in November 2019 a fourth team was trained in Bumpe, a small town in Bo district. Plans are in place to start a fifth team in a rural village in Kenema district. These five teams span the range of settings from urban to rural.

How does 2 Young Lives work?

Mentor recruitment / training

Mentors work in teams of three, with a team co-ordinator. They are recruited based on their reputation in the community for kindness and care of others. They are taken on as volunteers and given a monthly stipend. A three-day training programme includes LNP's safeguarding training, the use of scenarios and role play, and the use of the pictorial maternal and infant health resource developed by the Welbodi Partnership.

The mentoring model

Mentors initially take on three pregnant teenagers and are expected to provide at least weekly opportunities for confidential 1:1 discussion. Each team of three mentors is supported by a co-ordinator who communicates regularly with the mentors by phone and carries out monthly face-to-face visits. Once a month, the co-ordinator, mentors, and mentees gather to cook and eat together, with input from a visiting speaker. Each mentee is also given a small business start-up fund and supported to run a small business to allow her to eat well and prepare for birth. Mentees stay on the programme until their baby is around a year old, with new mentees taken on when the first cohort of babies are around 6 months old.

The mentor's role

The role of the mentor is four-fold

- helping mentees to re-establish family connection and support
- encouraging health seeking behaviours and advocating for respectful care at clinic, in labour and in the postnatal period
- providing practical advice and support with parenting
- providing support and training in a small business and to re-enter education or vocational skills training

Project outcomes: quantitative data

Data collection

Data is collected for each participant on three occasions:

- On registration to the scheme (age, schooling reached, orphan status, who she lives with)
- After birth (# ANC visits, # tetanus injections, did she use a bed-net, did she have malaria in pregnancy, place of birth, birth complications, mother alive, baby alive at 7 days)
- At 1-year post-birth (baby alive at 28 days, baby alive at 1 year, breastfed exclusively for 6 months, age of baby when stopped breastfeeding, mother using family planning, second pregnancy, mother in school or training)

Mortality data

Maternal and infant mortality

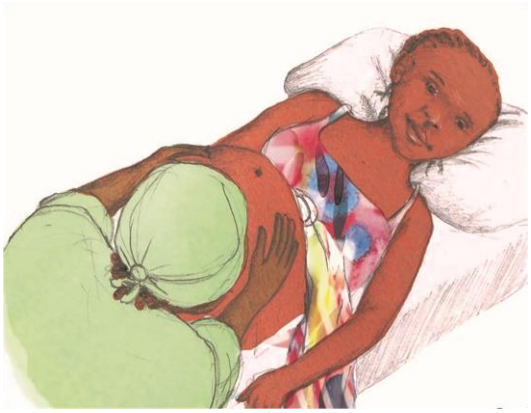
The following table compares data collected in a survey in 2015 with data from 2 Young Lives beneficiaries from October 2017 to May 2020 (80% from Kuntorloh, 20% from Port Loko).

	Maternal mortality	Neonatal mortality	Infant mortality
Data from 2015 survey	13%	16%	26%
Data from 2YL in 2020	0%	6%	11%

For each of the 6 infant deaths, a team discussion was held to understand what happened and if lessons could be learned for future reference. For example, one baby died at 6 days old after the mother was subjected to sustained fundal pressure in labour in a non-government private clinic. The mentors agreed to encourage all the mentees to register at established government clinics where there are strong relationships between staff and the 2 Young Lives team.

Skilled birth attendance

Of the 2YL births for which there is birthplace data, (61), three were at home but two of these were with a local nurse. Only one birth (2%) happened in the absence of a skilled birth attendant.



Other quantitative data

Malaria in pregnancy by use of bed net

The use of bed nets in pregnancy is encouraged for all pregnant women, and free bed nets are part of antenatal care. This table emphasises the importance of mentors encouraging their use.

Use of bed net in pregnancy	Used bed net in pregnancy 65% (n=32)	Did not use bed net in pregnancy 35% (n=17)
Malaria in pregnancy	12.5% (n=4)	70% (n=12)

Use of family planning

The data in the DHS 2019 only breaks down use of contraception by age for married women, so a comparison is problematic. For unmarried women, the all-age data shows a 52% use of any modern method, but this is likely to be very much lower for teenagers. Though take-up is fairly low before 1 year post-partum, **70% of mothers whose babies were over 1 year were using contraception in May 2020** (although it is not clear if they were all using by 1 year postpartum), and there were no second pregnancies in the whole cohort for mothers for whom this is known. It can be assumed that 0% were using contraception effectively at conception.

Small businesses, training, and education

All girls ran a small business throughout pregnancy and in the first postnatal year. Though they varied in their success, at a minimum this allowed all the girls to eat well every day. Most girls had been at school when they became pregnant, and due to the previous ban on visibly pregnant girls attending school or sitting exams (until 2020), had to leave [10]. A change of government policy in 2019 means that secondary schooling is now officially free, although expenses such as uniform and equipment still present barriers to some.

Of the mothers for whom this data is known (n=25), in the second postnatal year, 9 were back at school, 2 were on a vocational training course subsidised by 2YL, 2 were continuing to expand their business, and 12 were doing 'nothing'. This is an aspect of the programme which the team are looking to improve.

Mentor/mentee contacts

Mentors are required to provide at least one opportunity per week for a 1:1 meeting. However, co-ordinators report almost daily contact. Even at one contact per week antenatally and one per fortnight postnatally, this equates to an average of 22 antenatal contacts and 26 postnatal contacts per mentee, or over 4000 mentor/mentee contacts in total since the project commenced.

Orphan status

The following table shows data for orphan status including whether, for girls whose mothers were still alive, they were living with their mothers or with another family member.

Predictably, more girls from the Freetown cohort were orphans, and were not living with their biological mothers. Girls are often sent to the city if their mother is widowed or to attend secondary school, living with a relative.

	Both parents alive	Mother alive	Living with mother	Living at boyfriend's family home	Married (living with husband)	% whose mother is alive who are living with their mother
Freetown (D=55)	67% (n=38)	76% (n=42)	24% (n=14),	16% (n=9)	0% (n=0)	26% (n=11)
Port Loko (D=18)	83% (n=15)	94% (n=17)	50% (n=9),	11% (n=2)	11% (n=2)	59% (n=10)

Project outcomes: qualitative data

Recruitment methods and criteria

Girls are recruited to the scheme by word of mouth, with the senior project co-ordinator as the gatekeeper regarding eligibility. Different mentors have different strategies for recruitment. For example, one lives near to a water pump and can see the queue of young people waiting to fill containers from her veranda. When she sees a girl who is pregnant, she speaks to her about the project and invites her to come and meet the co-ordinator.

Eligibility

The main criterion for recruitment to the programme is that the girl is under 18 years of age or under 20 if disabled. **Five disabled girls have been mentored; 3 have been profoundly deaf, and 2 have had a pronounced learning disability**. Deaf awareness training was added to the training package for mentors, as deafness appears to be a common disability.

High levels of poverty and vulnerability

The majority of girls (90% in Freetown) were told to leave the home where they were staying when they revealed their pregnancy, and mentors felt that even when girls initially came from a home with some financial security, they were still very vulnerable due to this situation. As examples of girls being recruited with high levels of vulnerability; one girl was sleeping at night in a vacant market stall but had to leave at dawn and not return until dusk; one girl had lost both parents in the mud slide of August 2017; one girl whose mother and stepfather were both blind and relied on begging had never been to school; and one girl whose mother was dead was being sold for sex with older men by her father.

'Being driven' and reconciliation

Although having a mentor was not a magic bullet for family reconciliation, mentors try to meet all the girls' families as a gesture of respect and to try to build a relationship which might then allow the girl to re-enter the family home after the birth. For several girls, the persistent gentle intervention of the mentors throughout the pregnancy meant that the girls were allowed home after the birth.

Monthly gatherings and peer support

Once a month, all the mentors, the co-ordinator and all the mentees gather to cook and eat together, and to discuss health topics. This has proved to be an extremely popular aspect of the programme. When asked what they liked most about being mentored, most girls identified this monthly gathering, with eating and having fun together and playing with each other's babies as the main factors. The friendships develop and resulting peer support is a significant benefit of the programme. Mentors gave several examples of where girls had given each other sound health advice as they shared what the mentors had taught them with each other.

Accessible health education

Prior to starting the pilot, the authors came across pictorial health education resources which had been developed and tested locally by the Welbodi Partnership, who agreed to share them with LNP. These laminated picture cards portray common health issues and are designed to be used in a facilitated discussion with community members. They are used in this way as part of the monthly gatherings and then again 1:1 between mentors and mentees to reinforce the message.

Improving confidence and self-efficacy

Despite some of the challenges already discussed, most girls manage to run a successful business for the first time, which allows them to eat well every day and save for their babies' needs. Having been part of the health discussions throughout their pregnancy, girls become confident in their understanding of basic health advice, such as the need to breastfeed exclusively for 6 months, and what to do if their baby had a fever or diarrhoea. Several girls go on to do the health talks at the monthly gatherings as they grow in confidence. The sense of solidarity and friendship amongst the girls is strong, with a significant benefit being the increase in social capital engendered by these relationships, an unexpected positive outcome of the scheme. This benefit is equally true for the mentors who express high levels of satisfaction in the role and in the friendships developed by being part of the programme.

Wider community impact

The health messages are effective not just for the young women being mentored, but for the community more generally as mentors share them more widely.
For example, one mentor reported that she now tells all pregnant women that carrying very heavy water containers could lead to bleeding and miscarriage, and another that she now understands that the common advice for pregnant women to restrict their food intake to ensure their baby is small and easy to deliver is wrong, and she is encouraging all pregnant women to eat well. This is an encouraging finding as it indicates a wider impact for the community than just the mentees of the scheme.

Supporting small businesses

It was recognised that an important factor in determining birth outcomes in this group is their lack of economic capital. This resulted in most girls not eating adequate quantity or quality of food and having no means to purchase medicines prescribed in pregnancy, or items for their births or babies. Having a small start-up fund to enable them to engage in petty trading was identified as a key element of the scheme.

The role of the mentor as business advisor

The role of mentors in relation to these small businesses is to help the girls identify a suitable business that will be sustainable and profitable, and help with issues such changing what the girl sells depending on seasonal supply and demand (for example if a girl sells lunch to school children, the mentor helps her to flex during school holidays).

Effectiveness and sustainability

The small business aspect of the project has been very successful. Though the girls differed in their business skills, almost all of them have made enough money to eat well every day and buy items for their babies, and in addition to repaying the initial amount, some girls also saved significant amounts of money. Challenges to the scheme are that the girl can be called upon to support other family members, even when they have been thrown out of home. One girl who had saved a significant amount of money gave half of what she had saved to her mother to pay for a hospital bill; medical care is only free for pregnant women and under 5's, so a sudden sickness can be disastrous for a family's economic security.

Next steps

2 Young Lives is a robust intervention which not only saves the lives of teenagers and infants but provides vulnerable teenagers with an opportunity to develop confidence and self-efficacy, and to move on with their lives; encouraging girls to consider their options for education and training, as well as discouraging a second pregnancy. It also benefits the community more generally as simple and effective health messages are widely dispersed. Using an iterative process of co-production with local teenagers and mentors, new learning has been gradually embedded into the programme.

The programme is currently being manualised, including the thorough training scheme which has been developed for mentors and co-ordinators. Training, supervision, and monitoring processes will be clearly described to ensure fidelity to the programme as it is scaled up. New partnerships and funding are currently being sought to further develop this project's reach and impact.

Click here to see a short documentary about the 2 Young Lives project.

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