

**CONTRIBUTORY FACTORS LEADING TO NON-ATTENDANCE
FOR ANTE-NATAL CARE BY PREGNANT WOMEN IN A SELECTED
PUBLIC HOSPITAL IN LIMPOPO PROVINCE, SOUTH AFRICA**

by

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DISSERTATION

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DECLARATION

I declare that the *Contributory Factors Leading to Non-Attendance for Ante-Natal Care by Pregnant Women in a Selected Regional Hospital in Limpopo Province, South Africa* (dissertation) hereby submitted to the University of Limpopo, for the degree of master of nursing has not previously been submitted by me for a degree at this or any other university; that it is my work in design and in execution, and that all material contained herein has been duly acknowledged.

A handwritten signature in black ink, appearing to read 'Kgorane MR', is written over a dark, textured rectangular area.

Kgorane MR (Ms)

08/04/25

Date

DEDICATION

This dissertation is dedicated to my family, whose support, prayers and encouragement sustained me throughout this journey. I appreciate all that you have done.

To my parents Dennis and Selae Kgorane, thank you for your endless motivation and belief in me. You have made this achievement possible.

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ABSTRACT

Background: Ante-natal care, especially early booking, is key to ensuring that pregnant women receive optimum care during pregnancy and delivery. It is essential in preventing pregnancy-related complications. However, the frequency of pregnant women presenting at the selected regional hospital for delivery with no prior history of ante-natal care remains high. This study aimed to identify and evaluate the contributory factors leading to non-attendance for ante-natal care.

Objectives: The study explored and described the contributory factors leading to non-attendance for ante-natal care by pregnant women in a selected regional hospital in Limpopo province, South Africa.

Methods: The study was conducted in a selected regional hospital. A qualitative research approach and exploratory, descriptive, and contextual design were adopted. Non-probability purposive sampling was used to select participants. The data were collected through in-person semi-structured interviews and analysed using a thematic analysis technique. A total of 16 participants were interviewed until data saturation was reached. Measures to establish trustworthiness—credibility, conformability, dependability and transferability—were implemented and ethical principles adhered to.

Results: The current study found that the most reported factors contributing to non-attendance for ante-natal care were linked to the following themes that emerged from the study's findings: socio-demographic factors, personal barriers, and system provider factors. Inaccessible healthcare, financial constraints, a low level of education, lack of knowledge of ante-natal care, lack of support, and poor nurse-patient relationships were identified as sub-themes of the current study. The least frequently reported factors—initial denial of pregnancy, late recognition of pregnancy symptoms, considered abortion, long queues/slow service, and operating hours—were also sub-themes emerging from the study.

Conclusions: Although maternal services are offered free of charge, women persistently reach full term without seeking ante-natal care. Factors such as

insufficient funds, inadequate support from family members, attitudes of healthcare personnel, and denial of pregnancy had a negative impact on attendance for ante-natal care by pregnant women. To mitigate these factors, the study recommended mass media outreach initiatives (TV, radio, newspaper, and social media) to educate the public on the importance of ante-natal care and spousal support. With the help of home-based carers, women can be tested for pregnancy at their homes and encouraged to attend ante-natal care.

Keywords: Ante-natal care, non-attendance, non-adherence, unbooked, determinants

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DEFINITION OF CONCEPTS

Ante-natal care

The World Health Organization defines ante-natal care as multiple interventions that a pregnant woman receives from qualified healthcare providers during the course of pregnancy (WHO 2018). In this study, ante-natal care means the care that a pregnant woman receives during pregnancy.

Contributory factor

A contributory factor is defined as bringing about the creation of something (Oxford Dictionary of English 2010). In the context of this study, contributory factors are those that lead to non-attendance for ante-natal care by pregnant women who presented at the selected regional hospital during labour.

Leading

Leading is defined as being the cause or motivation behind something (Oxford Dictionary of English 2010). In this study, leading will mean motivations for non-attendance of ante-natal care.

Midwife

A midwife is a trained healthcare professional who oversees a pregnant woman throughout her pregnancy, and assists in childbirth and post-birth care (Bloxsome, Bayes & Ireson 2019). In this study, a midwife refers to a healthcare professional trained in providing ante-natal care services, as well as intrapartum and postpartum care services.

Non-Attendance for Ante-natal Care

Non-attendance for ante-natal care is defined as a pregnant woman's failure to be present at a clinic to seek ante-natal care services (Tufa, Tsegaye & Seyoum 2020). In this study, non-attendance for ante-natal care means a pregnant woman who has no prior history of ante-natal care and presents herself to the healthcare institution for delivery.

Pregnancy

Pregnancy is defined as the period from conception to birth when a woman nurtures a developing fetus in her uterus (Tiran & Redford 2022). In this study, pregnancy means the period in which a fetus develops inside a woman's uterus.

Pregnant Woman

A pregnant woman is defined as a woman whose fertilised egg has implanted in the wall of her uterus (WHO 2016). In this study, a pregnant woman refers to a woman carrying a fetus in her uterus.

LIST OF ABBREVIATIONS

ANC	Ante-natal care
DoH	Department of Health
HIV	Human immunodeficiency virus
PMTCT	Prevention of mother-to-child transmission
SASSA	South African Social Security Agency
SDG/s	Sustainable Development Goal/s
TREC	Turfloop Research Ethics Committee
WHO	World Health Organization

CHAPTER 1: OVERVIEW OF THE STUDY

1.1 Introduction and background

The World Health Organization (WHO) defines ante-natal or prenatal care as multiple interventions that a pregnant woman receives from qualified healthcare providers during the course of pregnancy (WHO 2018). Ante-natal care, especially early booking, is key to ensuring that pregnant women receive optimum care during pregnancy and delivery. It is essential in preventing pregnancy-related complications (WHO 2018). Research studies have proved that women who attend ante-natal care (ANC) have a lower risk of encountering pregnancy-related complications (Jain, Tikkas, Jain & Tikkas 2023; Okojie, Ogboghodo & Omoijuanfo 2022). Therefore, pregnant women are encouraged to book as early as 12 weeks of gestation or as soon as they miss a menstrual period (WHO 2018).

The WHO guidelines (2018) on ANC for a positive pregnancy experience established that eight or more ANC visits can reduce perinatal deaths by up to eight per 1 000 births when compared to four visits. However, women continue to reach term (38–40 weeks of gestation) and experience labour pains without seeking pre- or ante-natal care, despite healthcare facilities being affordable, accessible, and staffed with midwives daily (Magqadiyane 2020). Ante-natal booking allows midwives to detect pregnancy-related problems that may affect both the fetus and the mother during the course of her pregnancy (WHO 2016).

The WHO (2016) estimated that 303 000 women died from pregnancy-related complications globally in 2015. These mortality rates were highest among women who did not attend ante-natal care throughout their pregnancy (WHO 2016). In the same year, an additional 2.7 million babies died within their first month of life, and 2.6 million were stillborn, with inadequate ante-natal care being a significant contributing factor (WHO 2016).

Despite these worrying statistics, many pregnant women still do not utilise ANC services on time, with others failing to attend ANC at all and only presenting

during delivery. A study among booked and unbooked pregnant women in Pakistan (Ghafoor, Irum, Soomro, Shah, Mughis & Maqsood 2022) revealed that pregnancy-related complications were much higher among unbooked patients (16.6%) than booked patients (8.6%).

Maternal and neonatal mortalities are associated with the unbooked pregnant mother (Suleiman & Pappan 2020). As such, the rate of unbooked cases in Sharjah, a city in the United Arab Emirates, was 74% as evidenced by a study undertaken concerning the obstetric and foetal outcome among unbooked mothers (Suleiman & Pappan 2020). This makes it challenging for low and middle-income countries to achieve the millennium development goal for improving maternal health (Magqadiyane 2020).

Ashraf, Momina and Shahid (2022) conducted a study in Pakistan on the frequency of maternal and perinatal complications among 900 booked and unbooked ante-natal pregnant women, 450 (50%) of whom were unbooked. Similarly, a study in India on 1 004 women who were admitted during labour found that 508 (51%) of the admitted women were unbooked (Jain et al 2023).

In South Africa, a study conducted in KwaZulu-Natal on non-utilisation of ante-natal healthcare services indicated that of the 60 000 deliveries performed, 56% (33 600) were unbooked pregnant women (Magqadiyane 2020). Non-utilisation of ante-natal healthcare services occurs despite the fact that maternal healthcare services are free in the country.

According to Alanazy and Brown's (2020) study on individual and healthcare system factors influencing ante-natal care in Saudi Arabia, ante-natal care attendance was associated with maternal healthcare literacy, personal barriers, and healthcare system factors. Their study revealed that 17.6% of pregnant women who attended ANC services late (first ante-natal care visit after 20 weeks of gestation) were between the ages of 18 and 24, while 56.3% were between the ages of 25 and 34. This demonstrated that younger pregnant women were less likely than older pregnant women to attend ante-natal care late or not attend at all.

Religious beliefs, cultural practices, and educational background also affect ante-natal care utilisation, as evidenced by a study conducted in Southwest Ethiopia on prevalence and factors affecting the utilisation of ante-natal care (Belay, Astakle, Abebaw & Wegayehu 2022).

According to a study conducted in 2020 on factors associated with underutilisation of ante-natal care services in Limpopo, Mulondo (2022) identified unplanned pregnancies as a contributory factor to non-attendance at ante-natal care clinics. Mulondo's study attributed this to the fact that unplanned pregnancies led to denial of the baby's imminent arrival; consequently, women resorted to risky behaviours including drug and alcohol abuse. Furthermore, women avoided ANC services due to mandatory human immunodeficiency virus (HIV) testing, as a positive result was perceived as taboo and led to stigmatisation and bullying (Mulondo 2020).

The researcher identified that women present at the selected regional hospital without history of ante-natal care attendance. This trend resulted in complications such as low birth weight, low apgar scores, low haemoglobin levels and eclampsia. No previous studies have investigated non-attendance for ante-natal care in the selected regional hospital in Limpopo province. Based on the researcher's observed trend of women arriving for delivery without seeking ante-natal care, this study identified and evaluated contributory factors to unbooked cases among pregnant women in a selected regional hospital in Limpopo province who arrived for delivery without accessing ante-natal care services.

1.2 Problem statement

As a midwife at the selected regional hospital, the researcher had observed that several pregnant women presented at the hospital for delivery with no prior history of ANC attendance. In 2021 and 2022, the regional hospital's birth register recorded that 38 and 35 pregnant women, respectively, gave birth without a history of ANC attendance. At the time of this study, from January 2023 to April

2023, 10 pregnant women had already presented to the selected regional hospital without a history of ante-natal care visits.

Unbooked pregnancies are frequently linked with adverse outcomes, particularly stillbirths, low Apgar scores, and postpartum haemorrhage (Ago & Ekanem 2022). According to Oguejiofor, Okafor, Eleje, Okafor, and Ezeigwe (2023) 80% of unbooked pregnant women experience complications of pregnancy, labour, and delivery, often requiring urgent management. These complications include obstructed labour, uterine rupture, and pre-eclampsia.

Healthy pregnancy behaviours promoted at ante-natal care clinics (e.g. avoidance of drinking and smoking) are frequently disregarded by pregnant women who do not receive ante-natal care, posing a threat to the fetus. Similarly, the delayed discovery of diseases such as HIV/AIDS prevents women's enrolment in a prevention of mother-to-child transmission (PMTCT) programme, increasing strain on the mother and putting the fetus at risk of contracting the virus and other infectious diseases. Therefore this study aimed to identify and evaluate the contributing factors leading to non-attendance for ante-natal care services.

1.3 Aim of the study

The study aimed to identify and evaluate the contributory factors leading to non-attendance for ante-natal care by pregnant women at a selected regional hospital in Limpopo province, South Africa.

1.4 Research objective

The study's objective was to explore and describe the contributory factors leading to non-attendance for ante-natal care by pregnant women in a selected regional hospital in Limpopo province, South Africa.

1.5 Research question

What are the contributory factors leading to non-attendance for ante-natal care by pregnant women in a selected regional hospital in Limpopo province, South Africa?

1.6 Overview of research methodology

The researcher adopted a qualitative research approach, which is a systematic approach used to explain events and circumstances based on the experiences of the participants involved in the research (Grove, Gray & Burns 2015). The researcher followed an exploratory, descriptive, and contextual design.

1.6.1 Study setting

The study was conducted at a selected regional hospital under the Limpopo Department of Health in Limpopo province, South Africa.

1.6.2 Population of the study

The study population was pregnant women who presented at a regional hospital for delivery with no history of ante-natal care attendance.

1.6.3 Sampling technique and sampling size

Non-probability purposive sampling was used to sample participants and the target population was 16 participants. Permission to conduct the study was sought from various parties.

1.6.4 Data collection

Data were collected through in-person semi-structured interviews. All interviews were recorded using a voice recorder and field notes were taken by the researcher to keep track of observations that might be forgotten over time.

1.6.5 Data analysis

Data were analysed using the thematic analysis technique. Bias was minimised and ethical considerations adhered to.

1.7 Significance of the study

The study's findings were anticipated to benefit the following:

1.7.1 Patient

Increasing awareness of the value of ante-natal care attendance would be promoted. Pregnant women would be equipped with lifesaving knowledge about pregnancy-related complications and be encouraged and motivated to attend ante-natal care. This might help reduce pregnancy-related complications and encourage healthy pregnancy behaviours that are beneficial for both the mother and the fetus.

1.7.2 Healthcare workers

The study could be beneficial to healthcare workers in hospitals because initial assessments would have been performed in ante-natal care clinics, providing them with a thorough history of the woman, thus aiding in future healthcare management.

1.7.3 Department of Health

Preventing complications from failure to attend ante-natal care could lead to healthier babies and a reduction in maternal and neonatal morbidity and mortality rates. This research could assist the Department of Health, as policymakers, in developing programmes and implementing actions to improve the provision of maternal health services in the future.

1.7.4 Nursing education

In focusing on the factors contributing to non-attendance for ante-natal care, this study could add to the body of knowledge. Exploring and documenting the factors that contribute to non-attendance for ante-natal care services could assist policymakers, healthcare planners, and other health stakeholders in developing innovative strategies and programmes to improve maternal health services.

1.7.5 Research priority

This study could assist future researchers in conducting other studies in similar contexts.

1.8 Bias

According to Polit and Beck (2022), bias is a component that leads to a distortion in a study's findings and can threaten the study's trustworthiness. In this study, bias was minimised by presenting the participants' opinions and not the researchers' viewpoints or experiences. The researcher evaluated findings in their original, unaltered form, regardless of the outcome of the study.

1.9 Arrangement of chapters

Chapter 1: Overview of the study

Chapter 1 outlined the overview of the proposed study and stated the study's aim and significance.

Chapter 2: Literature review and theoretical framework

Chapter 2 reviews the literature on the contributory factors leading to non-attendance for ante-natal care, organised under various headings along with the theoretical framework.

Chapter 3: Methodology

Chapter 3 discusses the research methodology used in the study. It considers how the data were analysed and ethical considerations adhered to.

Chapter 4: Results, interpretation and discussion of findings

Chapter 4 discusses the results of the study and the interpretation thereof. It also discusses the findings of the study supported by literature and theoretical framework.

Chapter 5: Summary, recommendations and conclusion

Chapter 5 summarises the methods, findings and provides recommendations from the study.

1.10 Conclusion

In Chapter 1, the researcher presented the overview of the study, which included the introduction and background, the problem statement, an overview of the literature review, the theoretical framework, aim of the study, objectives of the study, research questions, an outline of research methodology, and the significance of the study. The next chapter presents a review of the literature.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

A literature review provides an in-depth evaluation of the literature on a subject, theory or methodology and synthesises earlier research to expand the body of knowledge (Paul & Criado 2020). A literature review's primary objective is to identify major research gaps based on the ideas, theories, and methodologies frequently used in various settings, and the contexts in which studies have been conducted (Paul & Criado 2020).

Both primary and secondary sources were used to compile the literature review in this study. Primary sources of literature are compiled by the individual who proposed or was responsible for developing the concepts or information, whereas secondary sources paraphrase the work of other researchers or theorists by summarising the main components or quoting them, and are based on the interpretation of another person's work (Brink, van der Walt & van Rensburg 2018).

To address the complexities of the topic of this dissertation, this literature review introduces the concept of ante-natal care (ANC), maternal health and discusses the importance of ante-natal care. It then explores factors contributing to non-attendance for ante-natal care globally, in international countries, sub-Saharan Africa, and South Africa. This is followed by a discussion of the impact or consequences of not attending ante-natal care and, lastly, strategies to facilitate ante-natal care attendance.

2.2 Ante-natal care and maternal health

Ante-natal care involves the support and medical attention a pregnant woman receives from skilled healthcare professionals (midwife or doctor), throughout pregnancy (Denny, Laksono, Matahari & Kurniawan 2022). It is one of the four pillars of safe motherhood initiatives, which helps to ensure that pregnancy-related complications are identified as soon as feasible and dealt with suitably (Ali, Ali, Adnan, Asif, Memon, Barkat, Soofi, Hussaini & Karmaliani 2023).

Ante-natal care has been associated with reduced maternal and perinatal morbidity and mortality. Reducing the maternal mortality ratio continues to be a global health concern as it remains particularly high in low- and middle-income countries (Herwansyah, Czabanowska, Kalaitzi & Schröder-Bäck 2022). The new global maternal mortality ratio target to be achieved by 2030 is less than 70 deaths per 100 000 births. One strategy to lower maternal mortality is to increase women's access to care during pregnancy and delivery. Ante-natal care has proven to save lives if implemented promptly and appropriately. A minimum of four ante-natal care visits is recommended to improve maternal health (WHO 2018).

2.3 Importance of ante-natal care

The Saving Mothers Report—a South African publication that examines maternal mortality rates and causes—identified non-pregnancy-related infections, obstetric haemorrhage, and hypertensive complications as contributing to up to two-thirds (66.7%) of maternal preventable deaths (Moodley 2018). By identifying and recommending strategies to prevent or manage the causes of maternal deaths, the Saving Mothers Report seeks to decrease maternal mortality rates (Department of Health 2017).

While Sustainable Development Goal (SDG) 3 aims to reduce the global maternal mortality ratio to less than 70 per 100 000 and achieving universal access to reproductive health (Shaikh, Asghar, Jafri, Islam, Ali & Ramzan 2022), numerous barriers and difficulties impede its achievement. The primary reasons for maternal fatalities include the social determinants of health, cultural variety, the socio-economic position of women and their families, health policy, and the availability of sufficient maternal health services (Herwansyah et al 2022).

According to the 2024 guidelines for maternity care in South Africa (National Department of Health (2024), ante-natal care strives to provide women and their babies with the best pregnancy experience through:

- Screening for pregnancy-related complications.
- Treatment of any problems that may arise during pregnancy.

- Administration of medication that could enhance pregnancy outcomes.
- Empowering women with valuable information through health education.
- Preparation for childbirth and motherhood on a physical and psychological level.

The first ante-natal care visit recommended within 12 weeks of gestation (WHO 2018) is crucial in the identification of risk factors and estimation of gestational age. During the first ante-natal care visit, a qualified healthcare provider (such as a midwife) takes a full history, which includes: current and previous pregnancies; present and past medical conditions; family and genetic disorders; allergies; experience of violence; lifestyle habits; and social and family circumstances (National Department of Health 2024).

A general physical examination is performed during the first ante-natal visit. It includes measurement of height, heart rate, and blood pressure, an examination of the colour of mucous membranes, and palpation of the lymph nodes. Following a physical examination, the following essential screening investigations are carried out (National Department of Health 2024):

- Mid-upper arm circumference to assess the risk of pre-eclampsia and maternal diabetes
- Estimation of gestational age
- A rapid HIV test – important for (PMTCT)
- Tuberculosis (TB) screening for both HIV-positive and HIV-negative women
- Syphilis serology
- Rhesus blood group, haemoglobin level, urine dipstick for protein, and glucose testing
- Mental health screening.

The pregnant woman is given supplements: folic acid and ferrous sulphate to prevent anaemia, calcium tablets to prevent pre-eclampsia complications, and tetanus toxoid to prevent neonatal tetanus. Essential information regarding five danger signs and symptoms of pregnancy, nutrition, HIV, substance use, fetal movements, self-care in pregnancy, a delivery plan, postpartum contraception,

and newborn and infant care are provided. In addition, midwives help prepare the woman, her family, and her partner emotionally, physically, and psychologically (WHO 2016).

At the end of the first ANC visit, the pregnant woman is regarded as booked and is given a follow-up return date for continuation of care to improve her pregnancy experience, as well as maternal and fetal outcomes (National Department of Health 2024). Should a complication be detected during the first ANC visit, the pregnant woman will be referred to a hospital for further management.

2.4 Ante-natal care globally

According to United Nations Children’s Fund data, the percentage of pregnant women who receive at least four ante-natal care visits varies widely, from 13% in Sub-Saharan African nations to over 90% in other Latin American, Caribbean, and European nations. The poorest women in low and middle income countries frequently still lack access to high-quality ante-natal care, despite improvements in the global coverage of early ante-natal care during the past 20 years (Anumba & Jayasooriya 2022). The United States has fewer obstetricians and other health care providers that provide maternity care than other high-income nations (with the exception of Canada). Four midwives are present for every 1000 births, compared to 25–68 midwives for every 1000 births in similar countries (Sonenberg & Mason 2023).

In the United States, ante-natal care access is a significant problem, since increasingly more areas lack even the most basic services for maternity care. As general hospitals’ obstetrics departments and rural hospitals close, even those with access to maternity care frequently struggle to receive respectful treatment. Many expectant mothers have to travel more than half an hour to get to the closest hospital providing obstetric services (Bianchi, Clayton & Zenk 2023).

2.5 Factors contributing to non-attendance for ante-natal care by pregnant women in international countries

Distance, along with financial constraints, plays a major role in the use of ANC services. A study conducted in Pakistan in 2022 found that income levels influenced pregnant women's use of ANC services, with higher-income women seeking care early while lower-income women delayed or avoided attending ANC altogether (Ashraf et al 2022). The study also identified an association between distance and the utilisation of ANC services. Distance can pose a barrier to healthcare services, particularly in deep rural areas (Ashraf et al 2022). Therefore, women residing near ANC clinics utilised the services more than those who have to walk or catch two or more taxis to reach ANC clinics (Ashraf et al 2022).

The study found that women with high parity (number of births after 24 weeks' gestation) were unlikely to seek ANC services due to their increased level of experience. However, Ashraf et al (2022) noted that women who had experienced a loss via miscarriage or stillbirth were more likely to seek ANC services than a woman who had never experienced a loss. The authors emphasised women's knowledge regarding ANC as a high predictor of utilisation of ANC services. The study also revealed that women who were equipped with sufficient knowledge regarding the dangers of pregnancy were three times more likely to utilise ANC services.

Another study conducted in rural Pakistan reported that 41.2% of pregnant women did not make use of ANC services owing to insufficient knowledge of its importance (Aziz Ali, Aziz Ali, Feroz, Saleem, Fatmai & Kadir 2020).

2.6 Factors contributing to non-attendance for ante-natal care by pregnant women in African countries

According to a study conducted in Ethiopia, fewer than 80% of women access ANC services. In 2016, a national report showed that 62% of pregnant women in Ethiopia had at least one ANC visit (Tekelab, Chojenta, Smith & Loxton 2019). While the reasons for not attending ANC services vary, the Ethiopian study

concluded that women's level of education played a major role in their use of ANC services, followed by the level of their husband's education and whether the pregnancy was planned. Lastly, satisfaction with previous ANC visits was linked to subsequent attendance, with a larger portion of women who were satisfied with previous visits (76.3%) seeking care than women who were dissatisfied (23.6%) (Tekalab et al 2019).

Shibre, Zegeye, Idriss, Wheeler and Yaya (2021) identified socio-economic, geographic, and personal factors as strong markers for utilisation of ANC services. In this study, older women (aged 44–49 years) were found to disregard the importance of utilisation of ANC services compared to younger women (15–35 years). They attributed this to their experience of previous pregnancies.

Religious beliefs, cultural practices, and educational background were among other factors affecting ante-natal care utilisation, as evidenced by a study conducted by Belay et al in 2022 in Southwestern Ethiopia on prevalence and factors affecting the utilisation of ante-natal care. Women who practised Orthodox (43%), Catholic (4.2%), and Protestant (37.6%) religions used ante-natal care services more frequently than women who practised Muslim (4.2%) and traditional (7%) religions. Furthermore, women with an educational background, who were literate, and had once attended school (34.1%) used ANC services more regularly than women who were illiterate (21.9%).

Corroborating Shibre et al's (2021) Pakistan study, Belay et al (2022) determined that the likelihood of using ANC services was 76% higher among married women with decision-making power on health issues than married women with limited power or no decision-making power. This echoes Tekalab et al's (2019) finding that giving women greater autonomy in healthcare decisions correlates directly with increased ANC service utilisation.

Shibre et al (2021) highlighted that even though ANC services are offered free of charge, distance plays a major role, with factors such as extra transport costs hindering their utilisation and attendance. The study revealed that women who

lived nearer to ante-natal clinics were 7.58 times more likely to attend ANC services than women who lived further away.

A study conducted in Uganda by Steele, Patterson, Berrang-Forf, King, Kulkani, Namanya, Kesande, Batwa Communities, Twesigomwe, Asaasira and Harper (2021) reported that interactions with healthcare providers were identified as a barrier to ANC attendance. Numerous Batwa and Bakiga women noted unsatisfactory treatment from healthcare providers, describing them as rude, unfriendly, and inconsiderate of their feelings. Consequently, these women feared attending ANC services (Steele et al 2021).

Furthermore, the authors identified lack of spousal support as a barrier to ANC attendance. Several Batwa and Bakiga women indicated that the role of a man during pregnancy was non-existent, as they were absent for most of the pregnancy. Although these men did not offer any support during the pregnancy, the women reported that they traditionally had decision-making power in their households regarding health, often limiting the woman's ANC attendance (Steele et al 2021). The use of traditional medication was recognised as a barrier to ANC attendance. Several women indicated their belief in consuming herbs, which was prohibited in the clinics, thus demotivating them from accessing ANC services (Steele et al 2021).

Dahab and Sakellariou (2020) conducted a study to determine barriers to accessing maternal care in low-income countries in Africa. They identified transportation as a significant barrier to accessing maternal care. Women in South Sudan, Ethiopia, and Mali involved in farming reported that their continuous search for greener pastures for their livestock required them to travel long distances for ante-natal care services (Dahab & Sakellariou 2020).

The authors noted that during rainy seasons, women in South Sudan, Togo, Mozambique, and Zimbabwe were unable to seek services due to muddy roads and unreliable modes of transportation, with walking being the only means of accessing an ante-natal care facility (Dahab & Sakellariou 2020). Emergency services in African low-income countries were unreliable, further hindering

access to health facilities (women reported that an ambulance would not arrive even in emergency situations). Additionally, emergency services' telephone lines were frequently out of service for extended periods or went unanswered (Dahab & Sakellariou 2020).

Moreover, traditional beliefs and cultural practices influenced the utilisation of ante-natal care services (Dahab & Sakellariou 2020). Women in South Sudan and Ethiopia were inclined towards home delivery and viewed pregnancy and delivery as a natural occurrence that did not require medical interventions. They expressed the need for religious practices that involved a religious leader to bless their newborns.

In some Muslim countries such as Mali, men were viewed as the decision makers of the family and women were not permitted to seek ante-natal care services without their male counterpart. Often men were too busy working to accompany their wives to healthcare facilities or force their wives to deliver at home (Dahab & Sakellariou 2020).

Quality of care was linked to the utilisation of maternal care services. Reports from Ethiopia revealed that hospitals were unable to accommodate women due to a lack of bed capacity and private birthing space in maternity sections (Dahab & Sakellariou 2020). A number of women in South Sudan pointed out that they were reluctant to seek ante-natal care services because of the lack of well-equipped clinics, shortage of equipped healthcare providers, and the absence of essential medications in some primary healthcare facilities. Healthcare provider attitude was associated with ante-natal care insufficiency. Women in Malawi viewed vaginal examination without prior notice as an invasion of privacy, as it was an uncomfortable procedure that was occasionally performed in the presence of numerous healthcare providers, other patients, or male providers (Dahab & Sakellariou 2020).

Communication barriers gave rise to poor quality of care (Pandey, Kamrul, Michaels & McCarron 2022), with language barriers causing distress, particularly for women with speech impairments. Al Shamsi, Almutairi, Al Mashrafi and Al

Kalbani (2020) found that when a healthcare provider and patient spoke the same language, a positive working relationship was established.

Women in Malawi and Ethiopia highlighted that they were subjected to verbal and physical abuse, reporting that they were often shouted at, insulted, judged, and even slapped on the thighs during ante-natal care attendance (Dahab & Sakellariou 2020).

Lastly, a study in sub-Saharan Africa found a close link between intimate partner violence (emotional, physical, and sexual) and ante-natal care visits (Aboagye, Seidu, Asare, Adu & Ahikorah 2022). Women who experienced intimate partner violence were unlikely to seek ante-natal care services, unlike women who did not experience intimate partner violence (Aboagye et al 2022). The same study found only a slight difference in ANC service utilisation between cohabiting women (40%) and married women (37%) (Aboagye et al 2022).

2.7 Factors contributing to non-attendance for ante-natal care by pregnant women in South Africa

A Gauteng study by Tshivhase, Mukwevho, Moyo and Moloko (2022) among ante-natal women identified long waiting times and service providers' attitudes as hampering the utilisation of ANC services. The same authors highlighted the judgemental attitudes of service providers (specifically nurses), particularly towards teenage pregnancy as a factor that deterred women from attending ANC services.

Furthermore, a study by Nxiweni, Oladimeyi, Nanjoh, Banda, Apalata, Mbokazi and Oladimeji (2022) showed that only 79% of pregnant women used ANC services in South Africa, with the highest in Western Cape (88.6%), followed by KwaZulu-Natal (82.8%), Northern Cape (80.5%), and North West (80.5%). The study revealed that the utilisation of ANC services was particularly high among women between the ages of 25 and 34 years and women who were either cohabiting or married. Nxiweni et al (2022) identified age, marital status, tertiary education, availability of electricity, media exposure, and socio-economic factors

as elements that influenced the utilisation of ANC services. Some women mentioned that they did not attend ANC services due to their family responsibilities such as chores, cooking or taking children to school.

A study by Mulondo (2020) on factors associated with the underutilisation of ante-natal care services revealed that women did not utilise ANC services because they were rebuked and abused by midwives experiencing work-related stressors. Additionally, fears of disclosing their pregnancy to loved ones and language barriers among immigrants from Zimbabwe were among the factors that led to the underutilisation of ANC services. Fear of tubal ligation by women of high parity was also noted as one of the factors leading to non-attendance at ante-natal care.

A study carried out in the province of Limpopo by Marabele, Maputle, Ramathuba and Netshikweta (2020) noted that cultural factors were a determinant of ante-natal care service utilisation. The women in this study reported that culture influenced their decision-making regarding health matters, particularly in rural areas. Culture also often shaped South African women's perspectives on diseases and pregnancy (Marabele et al 2020). When pregnancy was suspected, care was first sought at churches and traditional healers. This was particularly true among women who believed that pregnancy was a spiritual or natural phenomenon that did not require medical interference. According to Lestari, Frilasari and Nugroho (2020), a commonly held belief was that traditional medication was stronger than Western medication. If a woman became ill during the course of a pregnancy, a traditional healer would provide church tea and herbs, or a pastor would pray for the woman. Medical help would only be sought if the woman's condition worsened (Marabele et al 2020).

2.8 Impact or consequences of not attending ante-natal care

The care of the mother, fetus, and neonate is associated with diverse health and developmental outcomes. Numerous factors, both modifiable and non-modifiable, have an impact on the outcome (Ago & Ekanem 2022). Modifiable factors can help in reducing maternal and neonatal deaths (Jain et al 2023). A

pregnant woman's ability to access ante-natal care is essential for the effectiveness of PMTCT initiatives—a substantial risk of vertical HIV transmission exists when pregnant women do not receive ante-natal care during pregnancy (Mandima, Schaay, Ngara & Lembani 2022).

Research has proven that women who do not attend ante-natal care often require a Caesarean section because of complications during normal labour. This could be due to lack of assessments during ante-natal visits, which would determine the probability of a normal delivery (Jain et al 2023). Complications of hypertensive disorders are more prevalent among women with no history of ante-natal care. Hypertension in pregnancy can complicate to eclampsia and, according to Jain et al (2023), pregnant women with unbooked eclampsia are 13 times more likely to die in the hospital than those with booked eclampsia.

Another study confirms that Caesarean sections and hypertensive complications are prevalent in unbooked pregnant women (Ashraf et al 2022). Complications such as anaemia in pregnancy can be treated with follow up ANC visits. Unbooked women are at a higher risk of being anaemic, as a result of lack of supplement intake provided at ANC clinics (Ashraf et al 2022). This places significant pressure on public health facilities, as anaemic mothers often require emergency blood supplies, originally allocated for other cases, potentially compromising both maternal and fetal health.

Adenaya, Ibrahim, Ojo, Grillo, Ade-Onojobi and Odelola (2022) stated that low birth weight is more common in women with no history of ante-natal care attendance. This is due to lack of supplement intake, fetal growth measurements, and health education regarding diet provided at ANC clinics, resulting in intrauterine growth restriction. Low birth weight leads to increased admissions in neonatal units, which contributes to early neonatal deaths (Adenaya et al 2022).

According to Setia and Meheshwari (2020), intrauterine deaths occur more frequently in unbooked pregnant women. This may be due to underlying infections the pregnant woman is unaware of or pregnancy-related complications

such as diabetes, hypertension, and congenital abnormalities, which could have been detected and managed at ANC clinics.

2.9 Strategies/recommendations to improve ante-natal care attendance

Studies from various countries have highlighted the importance of adequate ANC attendance. For instance, a study conducted in Ethiopia established that empowering women with the information they need through health education, mass media, and communication awareness can enhance ante-natal visits and attendance (Tekelab et al 2019). Expanding their decision-making power and improving accessibility to ANC services would encourage more pregnant women to make use of these services (Tekelab et al 2019).

Belay et al (2022) indicated that both partners' level of education, satisfaction with previous ANC visits, and sufficient knowledge about ANC visits during pregnancy were the key factors affecting their attendance for ante-natal care. Therefore, they recommended that these should be taken into consideration when formulating guidelines to increase the number of ANC visits during pregnancy.

Another study emphasised the implementation of educational programmes in communities to empower women with sufficient knowledge regarding women's health (Nxiweni et al 2022). The study emphasised that equipping the girl child with essential knowledge and skills during primary and secondary education would enhance women's empowerment. Similarly, Mgata and Maluka (2019) stated that empowerment should not only be limited to women but should include the entire community. In addition, they noted that actively promoting spousal accompaniment to ANC services could promote attendance.

A study conducted in Southern Ethiopia by Tufa et al (2020) indicated that increased community awareness before and during pregnancy could be achieved through community outreach, group discussions, and proper education to enhance early ANC booking.

Bobo, Asante, Woldie and Hayen (2021) suggested that more public health campaigns need to be held with the support of community leaders to enhance community engagement. These campaigns should focus on maternal and neonatal health issues and empower women to make informed decisions that are beneficial to their health and wellbeing through health education and promotion programmes.

Ahinkorah, Ameyaw, Seidu, Odusina, Keetile and Yaya (2021) expressed the significance of the formation of alliances between ministries of finance and ministries of health. Financing programmes such as conditional cash transfers, where women are compensated for their transportation costs, would encourage utilisation of maternal services and reduce the financial burden on women.

Sufficient budget should be devoted to the improvement of maternal services by employing staff that are more experienced, equipping facilities with the necessary resources, and renovating infrastructure (Ahinkorah et al 2021). Okedo-Alex, Akamike, Ezeanosike and Uneke (2019) proposed that healthcare workers be equipped with updated information and skills through workshops and skills training.

Mulondo (2020) suggested that women should be given intensive health education during ANC visits. The importance of ANC visits, family planning, as well as information about common pregnancy-related disorders, such as hypertension, diabetes and urinary tract infections, should be communicated before ANC visits. Community-based awareness through social media, messaging platforms (such as WhatsApp), outreach, and distribution of flyers could also encourage the utilisation of ANC services.

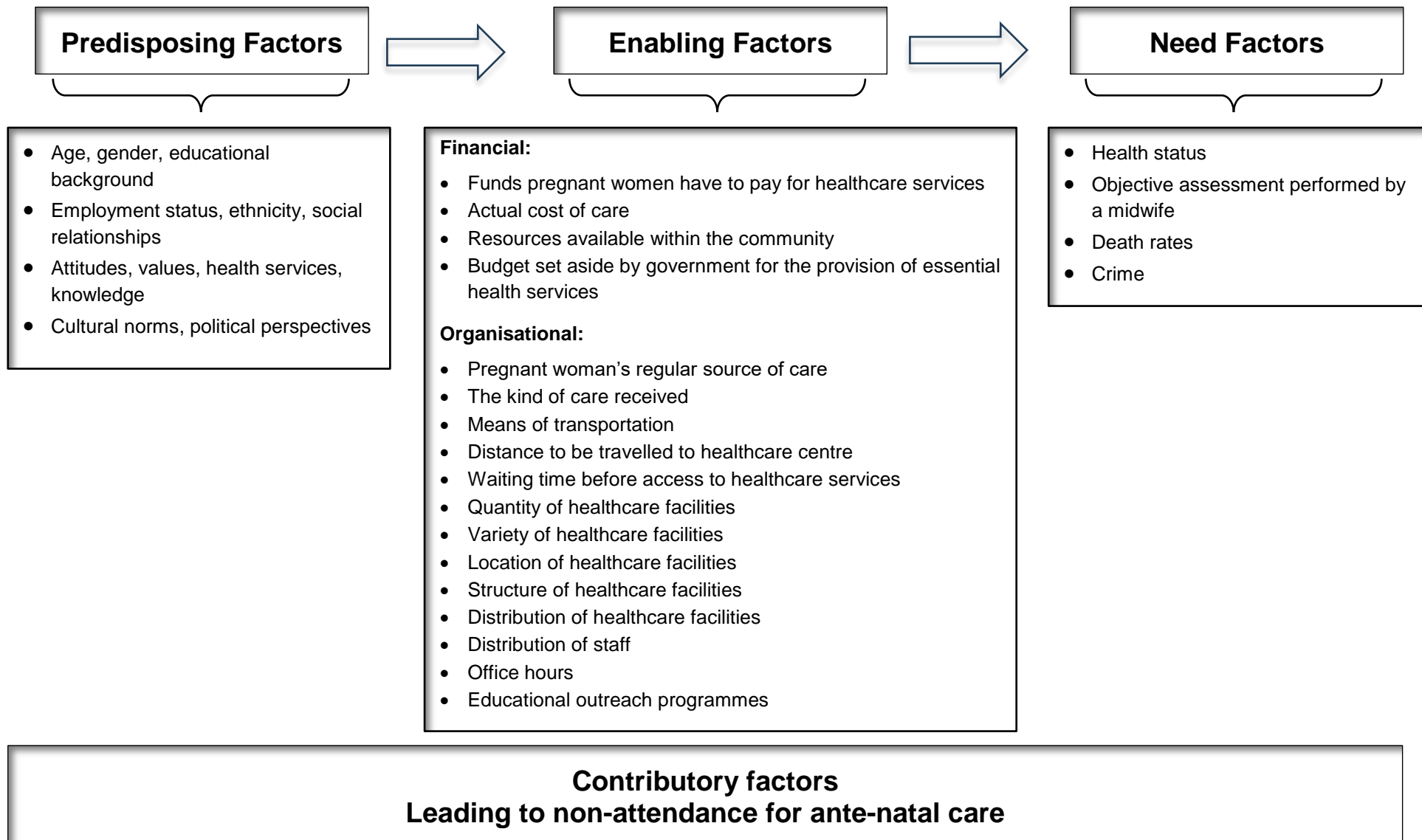
Lastly, training of midwives and doctors through workshops and seminars should be conducted on a regular basis to improve the quality of ante-natal care and to reinforce newly developed policies and guidelines on maternal and child health (Mulondo 2020).

2.10 Theoretical framework

A theoretical framework determines how concepts are organised and operationalised based on a theory (Polit & Beck 2022). In this study, Andersen's behavioural model of health services utilisation was applied (Travers, Hirschman & Naylor 2020). The behavioural model is a system of multiple levels that considers both personal and environmental variables affecting how people use healthcare services. The researcher adopted Andersen's behavioural model and linked it with the contributory factors that lead to non-attendance for ante-natal care by pregnant women. Predisposing factors, enabling factors, and need factors form part of the three major components of Andersen's behavioural model, as illustrated in Figure 2.1.

2.10.1 Predisposing factors

Predisposing factors can expose a person to a certain situation or condition that might impact the decision-making process for planned or intended behaviour (Travers et al 2020). In the current study, predisposing factors included characteristics such as age and gender. They also referred to social factors such as educational background, employment status, ethnicity, and social relationships, as well as mental factors such as attitudes, values, health, and services-related knowledge, all of which may affect ante-natal care attendance. Moreover, cultural norms and political perspectives were considered, as they can predispose pregnant women to using maternal healthcare services.



Adapted from Andersen's behavioural model (Travers et al 2020)

Figure 2.1: Theoretical framework for studying contributory factors leading to non-attendance for ante-natal care in a selected regional hospital in Limpopo province, South Africa

2.10.2 Enabling factors

Enabling factors constitute having the proper resources at an individual and community level. It is crucial that resources are accessible and available where people live and work (Travers et al 2020). In this study, enabling factors were those that influenced utilisation and encourage or motivate pregnant women to seek ante-natal care services.

Enabling factors are subdivided into financing and organisational factors. The funds a pregnant woman has available for healthcare services, along with the actual cost of care, are considered individual financing factors (Travers et al 2020). Given that ante-natal care is offered free of charge at public clinics, financing factors would include resources available within the community and the budget set aside by the government for the provision of essential health services.

Organisational factors refer to the quantity, variety, location, structure, and distribution of healthcare facilities, as well as staff (Travers et al 2020). Office hours, educational outreach programmes, means of transportation, distance, and waiting times for healthcare services are also organisational factors. This study considered factors that could have negative or positive outcomes for the utilisation of maternal healthcare services by pregnant women. They included the accessibility of healthcare facilities in terms of distance, availability of midwives, their receptiveness or attitudes towards pregnant women, and the facilities' operating hours.

2.10.3 Need factors

Need is the relationship between an individual's perception of their own health and functioning status and how another person, such as a healthcare worker, defines their health and functional needs (Travers et al 2020). In this study, need factors referred to the health status of the pregnant woman, whether she has accepted her pregnancy or not, what her pregnancy means to her health, and what she must do to keep herself healthy. Needs factors include the objective assessments performed by a midwife when rendering maternal healthcare

services (Travers et al 2020). Environmental needs were also considered. Environmental characteristics refer to the health-related conditions of the environment where the women live, such as crime and death rates (Travers et al 2020). This could also affect the pregnant woman's decision to attend ante-natal care.

2.11 Conclusion

This chapter presented a literature review of the factors contributing to non-attendance for ante-natal care by pregnant women across the globe and the impact or consequences of not attending ante-natal care. It also discussed strategies to facilitate ante-natal care attendance. The researcher has reviewed several studies to identify gaps in understanding the factors that contribute to the lack of ANC attendance. Most studies suggest that religious beliefs, cultural practices, and the pregnant woman's knowledge of the importance of ANC attendance are key factors. However, the purpose of this study was to determine the contributory factors leading to non-attendance for ante-natal care by pregnant women in a selected regional hospital in Limpopo province, South Africa. Having established the theoretical foundation through this literature review, the study proceeded with its methodological approach, which is detailed in the next chapter.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

Research methodology refers to the plans and processes the researcher intends to follow in conducting research. It incorporates the general hypothesis, and the technique for gathering and analysing data (Grove et al 2015). The research methodology also includes the study site, population, sampling, data collection, and data analysis (Polit & Beck 2022).

3.2 Research method

The researcher employed a qualitative research approach, which systematically explains events and circumstances based on the experiences of participants involved in the research (Grove et al 2015). This method entails interpreting the participants' words, assessing their significance, and providing a descriptive account of the experiences, which deepens understanding (Grove et al 2015).

A qualitative research approach is characterised by the requirement for researchers to be fully engaged, frequently remaining in the field for extended periods of time. The researcher was of the opinion that a qualitative research approach was the most pertinent because it would enable her to obtain comprehensive insights into participants' experiences and delve deeply into the factors that contribute to non-attendance for ante-natal care by pregnant women.

3.3 Research design

Brink et al (2018) asserted that research design acts as the framework for a study, serving as a guide for data collection, measurement, and analysis. It comprises a breakdown of the steps the researcher will follow, starting with drafting the hypothesis and its operational implications, all the way through to the final data analysis. According to Polit and Beck (2022), research design is a comprehensive strategy that aids in finding answers to the research question. The research

design of a study outlines the fundamental methods that researchers use to address their research questions and test their hypotheses (Majid, 2018). A good design mitigates bias and increases the accuracy of the data collected and processed (Polit & Beck 2022).

An exploratory, descriptive, and contextual design was used to collect data.

3.3.1 Exploratory research design

Finding new ideas and insights is the main focus of exploratory studies, sometimes incorporating experience surveys of those with first-hand knowledge of the problem statement (Polit & Beck 2022). An exploratory design was used to explore the possible contributory factors that led to non-attendance for ante-natal care by pregnant women in a selected regional hospital. The exploratory design helped the researcher in obtaining more information about the study through probes, seeking clarity, and interacting with participants.

3.3.2 Descriptive research design

Descriptive researchers frequently do not delve deeply into data interpretation in descriptive qualitative studies (Polit & Beck 2022), focusing instead on characterising the features of a certain person or group (Majid 2018). Such studies include thorough, plain-language accounts of a phenomenon or of occurrences. This study adopted a descriptive design because it aimed to identify and evaluate the contributing factors leading to non-attendance for ante-natal care in a selected regional hospital. After the researcher explored the factors with the participants, she described their reasons for not seeking ante-natal care.

3.3.3 Contextual research design

Contextual research design focuses on specific occurrences in their natural environments (Grove et al 2015). Participants were selected from a regional hospital where the researcher had identified the problem. The researcher interacted with participants in their natural setting—specifically, when they came

to give birth—fostering a deeper understanding of their feelings towards ante-natal care.

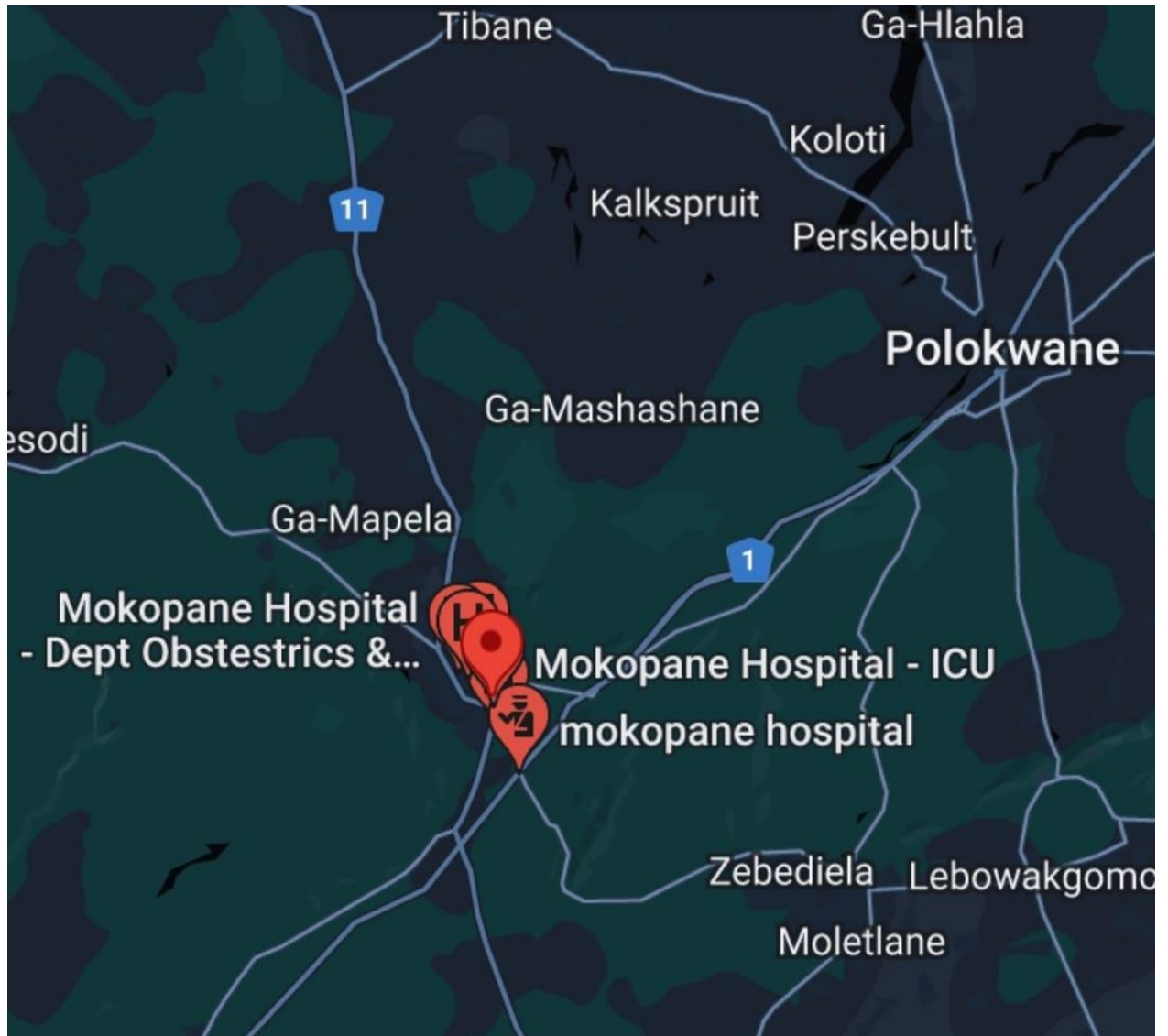
3.4 Study setting

The research setting refers to the actual location and circumstances under which data collection occurs in a study (Polit & Beck 2022). In qualitative research, data are typically gathered in the field where participants experience the problem under study (Polit & Beck 2022). Such research does not entail sending out instruments for people to complete or bringing people into a laboratory. Instead, qualitative researchers usually obtain their data in a real-world naturalistic environment (Polit & Beck 2022).

The study was conducted at a selected regional hospital, under the Limpopo Department of Health in Limpopo province, South Africa. Mokopane is located 59 km south-west of Polokwane and 92 km north-east of Modimolle, as illustrated in Figure 3.1. The selected regional hospital is situated in the Waterberg District, along Dudu Madisha Drive, Mahweleng Zone-A. It is a public referral regional hospital and supports primary healthcare in the district. Neighbouring hospitals referring to the selected regional hospital are Voortrekker, Thabazimbi, Lephalale, Elisras, and FH Odendaal.

The study took place in the selected regional hospital's maternity ward, which comprises ante-natal (bed capacity 6), labour (bed capacity 6), operating theatre, postnatal (bed capacity 30), and neonatal sections. The type of pregnant women served in the selected regional hospital include teenagers, youth, and women of advanced maternal age ranging from 14 to 47 years. At the time of the study, the majority of the pregnant women had not completed their high school studies, while those who had completed their high school studies and had not pursued any further education and training. Most of these pregnant women were unemployed, with very few employed as casual workers earning below the national minimum wage. Majority of pregnant women were not married. The population served by the selected regional hospital is diverse and comprises

Black Africans, Whites, and Coloured women. Included in this population are a number of foreign nationals, most of whom are Black, from Zimbabwe, Kenya, Somalia, Pakistan, and Mozambique. The dominant race served is black South Africans.



Google maps

Figure 3.1: Area map of research site

3.5 Population of the study

All elements (people, objects, events, or substances) that satisfy the sample requirements for research inclusion are referred to as the population (Grove et al

2015). According to Grove et al (2015), a study's specific expertise, experience, or viewpoints are taken into consideration when the researcher selects participants. The population in this study was pregnant women who presented for delivery with no history of ante-natal care attendance. Each month, two to three pregnant women who had not attended ANC reported labour pains and delivered their newborn babies at the selected regional hospital.

3.6 Sampling technique and sampling size

Sampling is the process of choosing a portion of the population to represent the complete population (Brink et al 2018). The study employed a non-probability purposive sampling design, with individuals intentionally selected for inclusion in the sample based on the researcher's understanding of the population (Brink et al 2018). According to Brink et al (2018), non-probability samples are those in which the likelihood of selecting any particular subject is unknown. This sampling design enabled the researcher to select participants who could provide rich, in-depth information. Data saturation determined the final sample size of this study.

The sample size entails the number of participants included in a research study to represent the target population (Polit & Beck 2022), which, in this study, was 16 participants and was guided by data saturation.

Some participants were sampled in the postnatal ward after delivery. Other participants who presented to the selected regional hospital with a history of preterm labour, false labour, and latent phase labour (a period of contractions and cervical dilatation of less than 5 cm) but had no history of ANC attendance were sampled in the ante-natal ward. The aim of the study was explained and the researcher obtained consent from the participants.

3.6.1 Inclusion criteria

Inclusion criteria are the qualities a potential subject must possess to be included in a study (Grove et al 2015). The following were included in the study:

- Pregnant women who presented at the selected regional hospital for delivery without a prior history of ante-natal care attendance.
- Pregnant women who provided informed consent given that they have no prior history of ante-natal care attendance.

3.6.2 *Exclusion criteria*

Exclusion criteria are those qualities that restrict potential subjects from being included in a study (Grove et al 2015). The following were excluded from the study:

- Pregnant women who were eligible to participate in the study but refused to provide informed consent.
- Pregnant women who presented at the selected regional hospital for delivery without a prior history of ante-natal care attendance but were not physically and mentally fit to take part in the study.

3.7 **Data collection method**

Data collection is the systematic gathering of data related to a study's aims, questions, or hypotheses (Grove et al 2015). Most researchers gather unique data created specifically for their study, while flexible techniques are used to collect self-reported data (Miles, Huberman & Saldana 2018). With the use of an interview guide, the researcher conducted in-person semi-structured interviews and posed open-ended questions. According to Grove et al (2015), a semi-structured interview includes a fixed set of questions. It enabled the researcher to interact with the participants directly and to obtain detailed, accurate information from them.

In a semi-structured interview, the researcher is able to use probes to gather information. Probes are questions asked to elicit additional details regarding a particular interview question (Grove et al 2015). The researcher used probing questions to elicit additional information from participants. Probes were used if

the researcher was of the opinion that the participant withheld important information about questions asked.

3.7.1 Preparation of the research field

Upon receiving the ethics clearance certificate from the Turfloop Research Ethics Committee (TREC/1706/2023: PG), the researcher requested permission to collect data electronically from the Department of Health (DoH) in Limpopo. The research proposal and TREC certificate were submitted electronically on the National Health Research Database website. Following approval from the DoH, the researcher contacted the Waterberg District Manager, who requested the approval letter from the DoH and granted permission to conduct the study. Thereafter, all approval letters were submitted to the CEO of a selected regional hospital and the maternity ward's operational manager. Permission to collect data was granted.

3.7.2 Pre-Test

A pre-test is a smaller version of the proposed study (Grove et al 2015). It aims to validate the feasibility of the study by reproducing each main aspect, including evaluating the inclusion and exclusion criteria, as well as the storage and testing of the measurement tools. The researcher identified two participants who met the inclusion criteria, interviewed them to test the effectiveness of the interview guide, and identified errors. This process assisted the researcher in allocating adequate time for the interviews and testing probing techniques. The interviews were recorded to test the functionality and reliability of the voice recorder. The participants in the pre-test were excluded from the main study's data collection process to reduce bias, and the results from the pre-test were excluded from the final study's results.

3.7.3 Data collection process

After participants in the post-natal and ante-natal wards were sampled and their consent obtained, onsite interviews were conducted in a consultation room in the selected regional hospital's maternity ward. The aims and objectives of the study

were explained to participants, who were informed that the interviews would be recorded but that their identities would remain anonymous. Participants were made aware that they had the right to withdraw from the study at any point without fear of repercussions. Written consent forms were provided for participants to sign.

The researcher then proceeded with the interviews while voice recording and taking field notes. The researcher used probes to elicit additional information from participants (Appendix F). Most interviews were conducted in Sepedi, as it is the most commonly spoken language in Mokopane. For participants unfamiliar with Sepedi, interviews were conducted in English. Recordings were played back to participants to give them the opportunity to add any information they felt they had left out.

Each interview took between four and 52 minutes. The data were collected until data saturation was reached. Data saturation is reached when sampling continues until duplication occurs and no new information is obtained from participants (Polit & Beck 2022). Data saturation occurred on the 15th participant. The 16th participant was interviewed to confirm saturation. The recordings were then stored on the researcher's laptop and encrypted so that no unauthorised person could access them. The data were transcribed and translated into English to allow for smooth analysis. The recordings will be deleted after five years.

3.8 Data analysis

Miles et al (2018) referred to the term analysis as the computation of specific metrics and the search for relationships between data-groups. Conducting qualitative research relies heavily on transcription because it enables the researcher to decode behaviour, processes, and cultural meanings related to people's viewpoints. It also captures the participant's own words, language, and expressions (Grove et al 2015). Thematic analysis, which was used to analyse the data, involves the identification of themes, patterns, regularities, and inconsistencies (Polit & Beck 2022). The following phases were used, as cited in Clarke and Braun's approach to reflective thematic analysis. (Byrne 2022).

Phase 1: Becoming familiar with the data

This involves transcribing the data. The researcher repeatedly read the data actively while searching for meanings and patterns and taking notes for coding.

Phase 2: Creating initial codes

Codes identify characteristics of the data that the researcher finds interesting. To do this, the researcher organised the data into meaningful groups.

Phase 3: Identifying themes

The codes were then sorted into different themes, and the relevant codes extracted within the themes were grouped together. Relations between codes, themes, and sub-themes were identified.

Phase 4: Reviewing themes

Themes were reviewed and refined, and were analysed until they formed a coherent pattern. The validity of individual themes in relation to the data was considered.

Phase 5: Defining and naming themes

The essence of what each theme captured was identified. Each theme was analysed in detail.

Phase 6: Writing the report

The final report provided a concise, logical, and non-repetitive account of the data.

After data and themes had been analysed in detail, the researcher identified areas for improvement and proposed ways to enhance ante-natal care attendance by pregnant women. Recommendations that may reduce factors contributing to non-attendance for ante-natal care by pregnant women were drawn from the data collected.

3.9 Measures to ensure trustworthiness

Polit and Beck (2022) defined trustworthiness as the integrity of research. A qualitative study's trustworthiness establishes the extent to which it is rigorous and of high quality. Criteria used to ensure trustworthiness include credibility, dependability, transferability, and confirmability, as suggested by Lincoln and Guba's framework (cited in Polit & Beck 2022).

3.9.1 Credibility

Credibility is the reader's confidence in the degree to which a researcher's findings accurately represent the participants' opinions (Grove et al 2015). The researcher ensured credibility by purposively sampling participants who met the selection criteria. The following elements were taken into consideration to ensure credibility:

- *Prolonged Engagement*

Prolonged engagement is essential in establishing the integrity of research. Investing sufficient time in data collection is crucial in gaining in-depth knowledge of participants' beliefs, language, or culture, to check for errors and deceptions, and to guarantee that key themes are saturated (Polit & Beck 2022). The researcher prolonged engagement by spending more time with the participants to gain their trust.

- *Member Checking*

According to Brink et al (2018), member checking entails having participants review, validate, and verify the researcher's findings. The researcher replayed the audio recordings to the participants, allowing them to provide feedback on any inaccuracies or misunderstandings, and to add any information they had left out.

- *Triangulation*

Triangulation is the use of multiple methods to collect data from participants to ensure confirmability of the results (Miles et al 2018). The researcher utilised semi-structured interviews, field notes, and audio recordings to collect data.

- *Peer Debriefing*

Peer debriefing involves conversations with peers concerning various aspects of research (Brink et al 2018). The researcher continuously sought guidance from supervisors and individuals who had obtained their master's degree.

3.9.2 Transferability

According to Lincoln and Guba's framework (as cited in Polit and Beck 2022), transferability is the degree to which qualitative findings can be applied to different contexts or populations. The researcher outlined clearly all the methods used in this study in conducting the research to enable future researchers to replicate the study in similar contexts. This included details about the population, methods of sampling, and the research design, as well as data collection and analysis methods.

3.9.3 Dependability

According to Lincoln and Guba's framework (as cited in Polit and Beck 2022), dependability refers to the consistency and reliability of data over time and under various conditions. The researcher ensured dependability through a pre-test to determine whether the findings were similar to those of the main study. The data collected from the participants in the pre-test did not form part of the main findings of the study.

3.9.4 Confirmability

The Lincoln and Guba framework (as cited in Polit and Beck 2022) defines confirmability as the capacity for two or more independent parties to reach a consensus on the accuracy and significance of the data. Furthermore, the data must accurately reflect what the participants said, rather than what the researcher thinks. The researcher ensured confirmability by making voice recordings and transcripts accessible to supervisors to verify the findings. The researcher analysed the data and sent it to the supervisor for confirmation of the results.

3.10 Ethical considerations

In any research study, it is crucial to protect participants by applying appropriate ethical principles (Arifin 2018). These principles of ethics serve as a practical guide for determining the behaviours, motives, and intentions that are valued in research. These principles focus on decision-making processes as well as right and wrong behaviour. Among these principles are several key practices that researchers must follow to uphold ethical standards, such as obtaining permission, ensuring informed consent, and respecting participants' autonomy, as outlined below.

3.10.1 Permission to conduct the study

The researcher presented the research proposal for approval to the Department of Nursing Sciences, the School Research Ethics Committee and the Faculty of Health Sciences Higher Degrees Committee.

The research proposal was then submitted to the Turfloop Research Ethics Committee (TREC) for ethical clearance (TREC/1706/2023: PG).

Permission to conduct the study and collect data was obtained from the Limpopo Department of Health, the Waterberg District Manager, the CEO of a selected regional hospital, and the maternity ward's Operational Manager.

3.10.2 Informed consent

Informed consent is a written agreement signed by a participant and researcher concerning the terms and conditions of voluntary participation in a study (Polit & Beck 2022). The researcher first explained the aim, objectives, and significance of the study to participants and ensured that they understood the concepts. Participants had the opportunity to ask questions regarding any aspects they did not understand, and clarity was provided so that they could give their informed consent. Consent was obtained from all participants verbally through a voice recorder as well as through the signing of consent forms (Appendix K).

Participants were informed that they could withdraw from the study at any point during the research without fear of punishment.

3.10.3 Principle of respect for persons

The right to self-determination applies to every person. As such, participants are free to decide not to take part in a study without fear of punishment or unfair treatment (Brink et al 2016). The researcher obtained verbal and written consent from each participant. Concepts were explained where participants did not understand. No information was withheld from participants, nor were they deceived.

3.10.4 Principle of beneficence and non-maleficence

Researchers have an obligation to reduce risks and increase benefits. Participants have the right to safety from discomfort and harm, whether physical, psychological, emotional, economic, social, or legal (Brink et al 2018). This study intended to benefit participants by spreading awareness about the importance of ante-natal care attendance. This would maximise the utilisation of health facilities and therefore reduce pregnancy-related complications.

During one of the interviews that took place after working hours, a participant displayed signs of distress (started crying). The interview was stopped and the participant was given time to calm down. Onsite counselling was provided by the researcher until the participant displayed no signs of distress. The researcher requested permission to proceed with the interview and the participant provided consent. The participant consulted with the selected regional hospital psychologist the following morning. Interviews were conducted in a clean consultation room, free from hazards such as slippery floors and sharp objects. COVID-19 protocols were adhered to, and sanitiser and hand-washing equipment were available in the consultation room.

3.10.5 Principle of justice

A participant's right to justice includes their right to privacy and fair treatment (Polit & Beck 2022). Participants' privacy was maintained throughout the study;

their names were kept confidential, and no information would lead back to them. The researcher ensured that all participants were treated fairly and without judgement. Participants were selected to partake in the study according to the selection criteria.

3.10.6 Confidentiality and anonymity

Polit and Beck (2022) defined confidentiality as a pledge that information provided by participants will not be disclosed to the public in a way that identifies them or be made available to others. The most secure method of preserving confidentiality is through anonymity (Polit & Beck 2022). Confidentiality was adhered to by restricting access to collected data to only the researcher and supervisors. Recordings and field notes were safeguarded and accessed solely by individuals directly involved in the research, such as supervisors. In this study, the researcher maintained anonymity, assigning each participant a number rather than using their real names. These numbers were used when discussing the data, so that participants remained anonymous. Participants were also promised that their private information would only be shared with individuals directly involved in the research, such as supervisors. Recordings and transcripts will be kept safe for five years.

3.10.7 Privacy

In this study, participants were not compelled to share their private information with the researcher. Neither videos nor photographs of participants were used as a means of data collection. Onsite interviews were conducted in a private consultation room at a selected regional hospital's maternity ward, out of sight of other patients and healthcare workers.

3.11 Bias

According to Polit and Beck (2022), bias is a factor that can distort a study's findings and threaten its trustworthiness.

3.11.1 Sampling bias

Sampling bias is the systematic overrepresentation or underrepresentation of a certain segment of the population regarding a trait that is pertinent to the research problem (Brink et al 2018). In this study, the researcher minimised bias by selecting participants using purposive sampling. The study reached its sample size when data saturation was achieved.

3.11.2 Interviewer bias

Interviewer bias refers to the systematic variation in how information is collected, recorded, and analysed (Gerson & Damaske 2020). In this study, interviewer bias was minimised by presenting the participants' opinions rather than the researcher's viewpoints or experiences. The researcher maintained objectivity when interviewing participants.

3.11.3 Citation bias

According to Gerson and Damaske (2020), citation bias refers to the reluctance of researchers to publish unfavourable results because they believe it may negatively affect the perceived success of a study. In this study, the researcher evaluated findings in their original, unaltered form, regardless of the outcome.

3.12 Conclusion

This chapter discussed the researcher's selection of a quantitative research approach. This method was chosen because it allowed the researcher to obtain in-depth information from participants regarding their experiences and to explore the factors contributing to non-attendance for ante-natal care by pregnant women in a selected regional hospital in Limpopo province, South Africa. The chapter highlighted the study area, population, and design. Non-probability purposive sampling was employed to select participants, and semi-structured interviews served as the means of data collection. The data were analysed using thematic analysis. The next chapter will present the findings and provide an interpretation and discussion of the data.

CHAPTER 4: RESULTS, INTERPRETATION AND DISCUSSION OF FINDINGS

4.1 Introduction

Chapter 3 discussed the methods, design, and data analysis applied in this study. This chapter analyses the study's results, supported by the literature and quotes from participants. The study's objectives were to explore and describe the contributory factors leading to non-attendance for ANC by pregnant women and to propose recommendations that may reduce factors contributing to non-attendance for ante-natal care by pregnant women in a selected regional hospital in Limpopo province, South Africa. The researcher presented participants' demographic data, followed by three themes and eleven sub-themes.

4.2 Data management and analysis

The researcher received an ethics clearance certificate from the university and requested permission to collect data in the selected regional hospital. Following data collection, the researcher transcribed the data and analysed it using thematic analysis. Similar data were grouped together to form themes and sub-themes. The researcher analysed the data and sent the analysis to the supervisor for confirmation.

4.3 Research results

4.3.1 Participant demographics

The researcher interviewed 16 participants in total, aged 16 to 38. As depicted in Table 4.1, the majority of participants were unemployed, with two being casual workers and three high school learners. One participant was married. The age distribution reveals that both older adults and younger individuals (including teenagers) do not attend ante-natal care.

Table 4.1: Participant demographics and descriptive data

Participant	Age	Race	Occupation	Marital Status
1.	16	Black	Learner	Single
2.	29	Black	Piece jobs	Single
3.	17	Black	Learner	Single
4.	29	Black	Unemployed	Single
5.	20	Black	Unemployed	Single
6.	33	Black	Unemployed	Single
7.	26	Black	Unemployed	Single
8.	27	Black	Piece jobs	Single
9.	30	Black	Unemployed	Single
10.	33	Black	Unemployed	Single
11.	23	Black	Unemployed	Single
12.	32	Black	Unemployed	Single
13.	19	Black	Learner	Single
14.	29	Black	Piece jobs	Single
15.	28	Black	Unemployed	Single
16.	38	Black	Unemployed	Married

4.3.2 Presentation of themes and sub-themes

Table 4.2 depicts the three themes and eleven sub-themes from data collected from women who did not attend ante-natal care throughout their pregnancy, but only presented during labour. These themes were aligned with the theoretical framework of Andersen's behavioural model of health service utilisation, which formed the basis of this study (Travers et al 2020). The themes have been integrated below the table with the discussion of each sub-theme.

Table 4.2: Themes of factors contributing to non-attendance for ante-natal care

Themes	Sub-Themes
1. Socio-demographic factors related to predisposing factors	1.1 Inaccessible healthcare services 1.2 Financial constraints 1.3 Low level of education
2. Personal barriers related to enabling factors	2.1 Purpose or importance of ante-natal care unknown by pregnant women 2.2 Initial denial of pregnancy 2.3 Late recognition of pregnancy symptoms 2.4 Considered abortion 2.5 Lack of support system
3. System/provider barriers related to need factors	3.1 Long queues/slow service 3.2 Operating hours 3.3 Poor nurse-patient relationship

4.4 Theme 1: Socio-demographic factors related to predisposing factors

The researcher presented the first theme on the factors contributing to non-attendance for ante-natal care and its sub-themes, as indicated in Table 4.2.

Table 4.3: Socio-demographic factors

Theme	Sub-Themes
1. Socio-demographic factors related to predisposing factors	1.1 Inaccessible healthcare services 1.2 Financial constraints 1.3 Low level of education

The study's findings indicate that participants' socio-demographic factors played an important role in non-attendance for ante-natal care by pregnant women. Some participants reported that they stayed far from their nearest clinic and could not afford transport to the clinic to attend ante-natal care. The majority of participants reported that they were unemployed and survived on their children's social grants. Consequently, they could not afford a taxi to the clinic to attend ante-natal care. While it was evident that most participants were from poor backgrounds, most had dropped out of school, with only a few having completed their matric. Three sub-themes emerged from this theme, as presented in Table 4.3.

4.4.1 Sub-theme 1.1: Inaccessible healthcare services

Participants reported that they were unable to attend ANC because they lived too far from the clinic. They stated that because they could not walk to the clinic and had to use taxis, they decided only to come to the hospital when it was time to deliver their babies. This was supported by the following quotes:

"I did not come to book [meaning attend an ante-natal clinic] because I am staying far from the clinic. From our village to the clinic, one must take a taxi. I failed to come. Today, I came to the hospital because I was in pains." (Participant 2)

"Eish, I stay far from the clinic; I could not attend the clinic until today where I started to feel the pains." (Participant 7)

"It is a bit far. It can take up to 45 minutes when on foot. It is the only clinic that is a bit closer." (Participant 12)

Other participants reported that they could not visit the local clinic without transport, as illustrated in the following quotes:

“It is not that far if you have transport; I take a taxi when I go to Sekuruwe Clinic.” (Participant 9)

“It is far; it is a big distance. I can say the distance from here to town. You cannot go by foot. You have to take a taxi which costs R10.” (Participant 11)

“Eish I have to take a taxi. It is far. It is in another village. There is no clinic in Ga-Mokaba. We use the clinic in Tshamahansi.” (Participant 14)

“It is a bit of a distance because I have to catch a taxi when I go there. It is the distance from here to town.” (Participant 16)

One participant referred to another clinic in their area, but stated that the roads were not well taken care of, making it dangerous for residents to travel:

“There is one next to a mine but the road is very dangerous. The road is not well taken care of; there is big grass. There is no way that a car can pass. You cannot see where you are going when you use that road.” (Participant 11)

Another stated that she had to walk for approximately 45 minutes before reaching her local clinic:

“I don’t know the name of the local clinic. It is a bit far. It can take up to 45 minutes when on foot.” (Participant 12)

During the interviews, the researcher learned that clinics were allocated by sections, with residents permitted to attend only certain clinics. Some participants indicated that despite living within walking distance of some clinics, they were not permitted to attend these due to demarcations, and would be refused assistance. Consequently, they could not attend ante-natal care:

“My nearest clinic is in Hospital View, but we go to the clinic in town because the clinic in Hospital View makes us return home without getting help. They say that we fall under Mokopane Voortrekker.”

(Participant 2)

“I am from Millennium Park; we use the clinic in Sekuruwe.”

(Participant 9)

One participant confirmed that she once took her younger child for immunisation and had to go through two villages to arrive at the clinic because of demarcations put in place. This demotivated her from going to the clinic throughout her pregnancy:

“I once took my baby for immunisation, arrived home at 7 pm. I carried the baby on my back. I went through Sekgakgapeng, then Polar Park. It was late at night, and I had a baby on my back. I got demotivated to go to clinics because you leave early but arrive home late.”

(Participant 10)

A teenage participant stated that she had to attend classes at school and could not access clinics because the local clinic closed at 4 pm. Consequently, she did not attend ante-natal care at all until she started to experience abdominal pains, indicating labour:

“I was going to school. School knocks off late. It starts at 6 am and knocks off at 4 pm. We also attend on weekends. There was no way I could have attended ante-natal care clinic. I was scared of missing school.” (Participant 3)

The findings of this study indicate that some participants resided far from their designated clinics and had to either take a taxi or walk for long hours to reach them, leading to non-attendance for ante-natal care. Additionally, the limited operating hours of local clinics, which did not offer a 24-hour service, made it difficult to access healthcare services after hours, further contributing to non-attendance for ANC.

Similarly, Nigatu and Birhan (2023) conducted a study on the magnitude and determinants of delayed initiation of antenatal care, where women residing in rural areas were prone to non-attendance for ANC. The reason was that women in rural areas often had low socio-economic status, minimal exposure to the media, and restricted access to healthcare (Nigatu & Birhan 2023).

As revealed from the study, pregnant women failed to attend ante-natal care due to stipulated political demarcations. A study conducted by Myburgh, Qwabi, Shivambo, Ntsie, Sokani, Maixenchs, Choge, Mahtab, Dangor and Madhi (2024) on factors affecting antenatal care attendance in Soweto corroborates these findings. Women in their study reported that facilities were allocated according to demarcations and that healthcare providers refused to assist them if they sought care elsewhere. This system prevented women from seeking ANC services.

The findings of this study showed that distance to healthcare facilities contributed to failure in ANC attendance. Similarly, a study by Palamuleni (2024) on factors associated with late antenatal initiation revealed that the distance to an ANC clinic could either encourage or discourage attendance. Palamuleni (2024) noted that women who resided in regions far from clinics failed to attend ante-natal care. According to the theoretical framework on which this study was based, Travers et al (2020) pointed to inaccessible healthcare as a predisposing factor leading to non-attendance for ANC, often resulting in women presenting themselves for the first time when in labour. This delay in seeking care could result in complicated home deliveries and, consequently, an increased rate of maternal mortality.

4.4.2 *Sub-theme 1.2: Financial constraints*

Most participants reported using their children's grants as a means of survival, although for some, this was not the primary reason for not attending ante-natal care. This was supported by the following quotes:

"I did not have money to come to the clinic for ante-natal care. At home I am surviving using money for the children from the grant."
(Participant 4)

"I don't work. I support myself with my children's SASSA [the grant paid by the South African Social Security Agency] money." (Participant 15)

"At home, we survive with SASSA money mostly because their father does not have a government job. He is self-employed and does not get enough." (Participant 6)

Other participants corroborated this information, indicating that families rely on children's grant to meet their basic needs:

"No one is working, so we are using SASSA money, so I failed to attend ante-natal care." (Participant 10)

"I am not married. As such, I support myself and my children with SASSA money." (Participant 9)

Some reported that they were not permanently employed and either survived off piece jobs or contracts, or with the help of other family members:

"I sometimes work contracts. They offer us contracts here at home to clean at schools or other environments. I sometimes work there. Currently I am not working because the contract has ended. They did not renew the contracts. We are still waiting. I do piece jobs sometimes. If there is someone who needs me to do laundry or clean, I can help out." (Participant 14)

"I get some piece jobs here and there and my mother helps out. My mother provides the food and my sisters also work and help out." (Participant 11)

"I stay with my husband. He supports the children and me. He is the one working." (Participant 16)

Another participant reported that her brother sometimes helped her with money, but was not consistent in doing so:

“My brother sometimes helps with the children, but you know a person has their own responsibilities. When things are going well for him, he gives me money to help out.” (Participant 12)

One participant reported that she made use of her grandmother’s pension grant to survive:

“I did not come for booking because I don’t work and I am not married, so at home we utilise my granny’s pension fund for food and other things.” (Participant 7)

One participant reported that although she had previously attended ante-natal care, she did not attend during her current pregnancy because of the long hours she had spent during previous clinic visits. These long hours involved waiting in a queue without having anything to eat, and she did not have money to buy lunch:

“I sat the whole day; I was starved the whole day. That is why I stopped attending ante-natal care. Some people take out their food and eat in front of you. Some of us are poor; we cannot call people to bring us food when we are on the queue.” (Participant 10)

The same participant noted that ANC follow-up dates were assigned without considering whether patients had sufficient funds to attend:

“I had nothing. They do not consider whether you have money or not at ante-natal care clinic.” (Participant 10)

The findings of this study indicate that some participants faced financial difficulties and relied on SASSA grants for survival, which contributed to their non-attendance for ante-natal care. This finding is supported by a study conducted in Ghana by Duodu, Bayuo, Mensah, Aduse-Poku, Arthur-Holmes, Dzomeku, Dey, Agbadi and Nutor (2022) on trends in antenatal care visits and associated factors from 2006 to 2018. The study indicated that women from financially secure families were more likely to attend ante-natal care than those from poor households. Furthermore, although ANC services were offered free of charge,

women from low-income households were less likely to attend due to insufficient information and transport costs (Duodu et al 2022).

In line with the findings of this study, another study conducted in Togo by Kota, Chomienne, Geneau and Yaya (2023) on socio-economic and cultural factors associated with the utilisation of maternal healthcare services established that unemployed women did not attend ANC. Additionally, women from the poorest wealth quintile had a significantly higher likelihood of non-attendance for ante-natal care (Kota et al 2023).

In accordance with the theoretical framework used in this study, Travers et al (2020) suggested that organisational and need factors, such as financial constraints, unemployment, and transport issues, played a role in non-attendance for ANC. This was particularly concerning for HIV-positive mothers, as their non-attendance could potentially lead to vertical transmission of HIV due to a lack of access to PMTCT initiatives. Furthermore, this situation would put a strain on government resources, as both mother and child would require lifelong antiretroviral treatment.

4.4.3 Sub-theme 1.3: Low level of education

The level of education influences individuals' understanding of the importance of attending ANC. Some participants reported that they had not furthered their studies beyond matric level, while others had not completed matric. The teenagers interviewed by the researcher were too young to fully comprehend the purpose of ANC, as attested to in the following quotes:

"I am 16 years old. I am in grade 10. I had no knowledge of ante-natal care and did not see the need to go" (Participant 1)

"I am 17 years old. I am in grade 11. I go to school. I knew nothing about ante-natal care attendance. I don't know what they do at ante-natal care" (Participant 3)

One participant reported that she was failing at school and had repeated grade 11 three times:

“I dropped out of school. I was failing. I repeated grade 11 three times. I dropped out when I was supposed to repeat it for the fourth time. I just decided to quit. I had difficulties understanding what was being taught at school. I never really understood why one should go to the clinic when pregnant.” (Participant 14)

The findings of this study indicate that participants with inadequate educational backgrounds failed to attend ante-natal care, only presenting themselves when in labour. These findings align with those of Duodu et al's (2022) Ghana study, which determined that sufficient ANC attendance is linked to a higher level of education, suggesting that greater educational attainment corresponds with a better understanding of obstetric difficulties.

A study conducted in Togo by Kota et al (2023) on socio-economic and cultural factors associated with the utilisation of maternal healthcare services supports the findings of the Ghana study. Their study revealed that women who completed secondary school and higher education were more likely to attend ANC than those with no formal education (Kota et al 2023). Education empowers women to make better decisions regarding their health by providing them with essential information on the significance of ANC services (Girotra, Malik, Roy & Basu 2023).

In accordance with the theoretical framework underlying this study, Travers et al (2020) cited predisposing factors such as educational background and ethnicity as contributors to poor attendance or failure to utilise ante-natal services. This lack of attendance could prevent women from understanding the importance of ANC, thus predisposing themselves to pregnancy-related complications.

4.5 Theme 2: Personal barriers

Table 4.4 presents personal barriers as one of the factors contributing to non-attendance for ante-natal care in a selected regional hospital in Limpopo province.

Table 4.4: Personal barriers

Theme	Sub-Theme
2. Personal barriers related to enabling factors	2.1 Purpose or importance of ante-natal care unknown by pregnant women 2.2. Initial denial of pregnancy 2.3. Late recognition of pregnancy symptoms 2.4. Considered abortion 2.5. Lack of support system

Some participants reported that they did not know the importance of ante-natal care. While others were aware of its importance because they had attended during previous pregnancies, they were unaware that they were pregnant. They recognised pregnancy symptoms late and could therefore not attend ANC. Some women reported that they were initially in denial about the pregnancy and did not have anyone to support them. Others were considering abortion, which led to their failure to attend ANC.

4.5.1 Sub-theme 2.1: Purpose/importance of ante-natal care unknown by pregnant women

A few participants stated that they were unaware of the importance of ANC, which is why they did not attend. One foreign resident interviewed stated that she had no knowledge of ANC or of the importance of visiting the clinic when pregnant:

“No I do not know the importance. I am 20 years old; I do not have child. It is my first baby.” (Participant 5)

Another acknowledged that before she came to the hospital, she had no knowledge of ANC but had learned about its importance there. The participant had not attended ANC because of her lack of knowledge:

“At first I did not know. It is because I did not know, I did not know that you are supposed to go to the clinic to check and monitor the baby. I did not know anything; that is why I did not go.” (Participant 1)

Another concurred, reporting that her lack of knowledge about ANC and its importance had prevented her attendance:

“I do not know anything about the importance of ante-natal care and I did not come.” (Participant 3)

One participant suffered an intra-uterine fetal death and acknowledged that only now did she fully appreciate the importance of ANC:

“Yes, it is only now that I fully understand the importance and that as a woman you need to attend ANC but now I do not know that prevented me...”

Another stated that while women in the villages were aware that they should visit the clinic when pregnant, they did not fully understand the importance of ANC:

“I do not think most know the importance because someone will stay home and listen to what other people say. I think they should be made aware of the importance of attending and maybe they will attend. There will be changes if the importance of attending ante-natal care clinic is emphasised.” (Participant 8)

From the findings of this study, it was evident that some participants had no knowledge of ANC or its purpose. This lack of understanding led to non-attendance for ANC, as participants were not fully aware of what ANC visits involved. Similarly, Tessema, Kassu, Teshome and Abdo (2023) conducted a study on timely initiation of antenatal care and its associated factors among pregnant women. They found that women with no knowledge of maternal healthcare services did not attend ANC because of their limited understanding of their health (Tessema et al 2023).

A study by Awoke, Ababulgu, Hanfore, Gebeyehu and Wake (2024) on regional disparities in antenatal care utilisation established that women with no knowledge of maternal and neonatal health did not attend ANC. Jassey (2023) indicated that inadequate understanding of the benefits of ANC is the leading cause of maternal and neonatal mortality.

Lack of knowledge about the importance of ANC, one of the predisposing factors cited by Travers et al (2020), played a crucial role in non-attendance for ANC. This potentially led to increased morbidity and mortality rates, as pregnancy-related complications would be left untreated due to failure to seek care while pregnant. This was evident from the findings of the current study where the researcher identified the implications of not attending ante-natal care. Some participants only discovered their HIV-positive status after delivery. These participants had never taken treatment throughout their pregnancies and had to anxiously await their babies' polymerase chain reaction test results. The mothers felt guilty and regretted not attending ante-natal care.

4.5.2 Sub-theme 2.2: Initial denial of pregnancy

One participant reported initially having trouble accepting her pregnancy, as she had a 15-month-old baby who still needed her care. She explained how her mother struggled to understand the news of her pregnancy:

“Yes, I explained to her as soon as I found out that I was pregnant, but she did not understand at first because it came as a surprise also to me. I have a child, and by the time I found out I was pregnant, that child was one year and three months old. I then felt like what I did was wrong. Why would I get pregnant while my child is still young? The child still needs my care. That issue stressed me and my mom did not understand when I explained to her.” (Participant 6)

The same participant indicated how her mother blamed her for not protecting herself from becoming pregnant while her baby was still young. The participant finally accepted the pregnancy, although she then felt it was already too late to attend ANC:

“She asked why I did not protect myself from the beginning. Then, as time went on, I started accepting that I was pregnant. By the time I accepted, I was far along in my pregnancy and came to the realisation that I would deliver without any knowledge of what is happening with my baby. The baby was playing, but I knew that could not just sit and

tell myself that the baby was alive and playing. I never attended because I thought it was too late” (Participant 6)

Another participant revealed that although she could see that her belly continued to grow, she refused to believe she was pregnant. She explained that she did not have a loving and respectful home to offer a child:

“I felt something moving inside my belly. I saw that my belly got bigger, and I told myself that it was not a baby. I thought it was just clotted blood in my belly. Sometimes you need to assess your home situation and see if it is suitable to raise a child. Looking at my home situation – eish, it is not conducive to raise a child. At home we are uncontrollable. I wish my child can be raised in a home where there is respect and love. I feel like I cannot provide that. I have two other children at home.”
(Participant 12)

Another indicated that despite feeling movement inside her body, she did not want to believe that she was pregnant. She admitted that nothing prevented her from visiting the clinic as she was not busy:

“I was going on my period but felt that there was something in my tummy, but I did not want to believe that I was pregnant.” (Participant 15)

From the findings of this study, it was noted that women with unplanned pregnancies initially denied their condition, which led to non-attendance for ANC. Similarly, Blessing, Zainab, Markus and Olabisi (2023) conducted a study on factors associated with the timing of first antenatal care. The authors determined that ANC booking was slightly lower among women with unplanned pregnancies because they lacked support from their spouses and families.

A study by Ahinkorah, Seidu, Budu, Mohammed, Adu, Agbaglo, Ameyaw and Yaya (2022) on factors associated with the number and timing of antenatal care visits among married women supports the findings of the current study. Their findings established that the probability of ANC attendance was higher in women who had intended falling pregnant than those with unplanned pregnancies.

According to Travers et al's (2020) theoretical framework, the potential implications of denial of the current pregnancy included postpartum depression and psychosis, as mothers would not have received proper counselling at the ANC clinic. This resulted in negligence and failure to attend to the baby's needs.

4.5.3 Sub-theme 2.3: Late recognition of pregnancy symptoms

A few participants reported being initially unaware of their pregnancy, which affected their ANC attendance. Although familiar with the signs and symptoms from previous pregnancies, they noted that their current pregnancy presented differently:

"Yes, I went for ANC with the other two children. I was not aware of this pregnancy at all. Even the baby was not playing. I just felt normal. I did not feel anything in my stomach. I have a big belly, so after giving birth, I do not tie my stomach. So there was no sign of me being pregnant until on Sunday when I started feeling pains." (Participant 4)

The same participant confirmed that she was aware of the signs of pregnancy:

"One could be nauseous, dizzy, and the body will change to show that something is wrong. Then, when you go to the clinic, they will test you for pregnancy. But with this one, I was on depo [Depo-Provera] contraceptives, then I stopped. So, after stopping, I did not menstruate at all. That is what also contributed to me not knowing about the pregnancy." (Participant 4)

Another participant admitted to drinking alcohol while pregnant because she experienced no signs and symptoms of pregnancy:

"...I saw my period and felt fine. I had no symptoms, and I drank beer because I did not know." (Participant 10)

Another explained that she only noticed that she was pregnant a month before giving birth because her period stopped:

“I found out I was pregnant not so long ago, about last month when I no longer noticed my periods.” (Participant 2)

One participant mentioned that she had irregular periods and had searched for signs and symptoms of pregnancy on Google but had none of the signs. She maintained that because she had not experienced signs of pregnancy, she did not attend ante-natal care:

“I never felt any signs of pregnancy at all, such as fatigue and vomiting. I never experienced those. I felt like my normal self. I did not vomit and had no mood swings. My period was irregular; I would see my menses this month and not the following month. I searched the signs of pregnancy on Google when I missed my period but I never had any of those signs. Then one month my period was unusual, I had brown discharge but never thought it would be pregnancy. I also started feeling a ball-like mass moving under my belly button. I knew something was wrong. I then bought a pregnancy test at Clicks and it was positive. I did not go to the clinic. I decided to come to the hospital.” (Participant 8)

At the hospital, the participant was found to be 31 weeks pregnant. She was then referred to a local clinic for continuation of care and ANC attendance.

A teenage participant indicated that she did not attend ante-natal care because she had only recently discovered her pregnancy while at a school camp. Shortly after this discovery, the participant experienced ruptured membranes and was taken to the hospital:

“I did not know that I am pregnant. I found out yesterday. I was at school; we were at camp. After eating, I drank juice. I felt water coming down from my legs. I thought there was something wrong with the juice but my teacher said that she suspected that it was a baby. The teacher called my mother. My mother came and I was taken to Thabazimbi Clinic. They tested me at Thabazimbi Clinic. My mom was very surprised. I was also surprised and scared.” (Participant 13)

The same participant indicated that she knew the signs of pregnancy:

“Swollen feet and vomiting. Your body changes. Everything felt normal. I was going on my periods.” (Participant 13)

Another participant revealed that she only noticed that she was pregnant after six months:

“I found out I was pregnant when I was six months along – five or six months. I started sleeping a lot at work and I was going on my period.”
(Participant 14)

The findings of this study indicate that some participants were unaware of their pregnancy. Despite knowing the typical signs of pregnancy, they reported experiencing no symptoms, resulting in non-attendance for ANC. These findings are supported by Tengera, Meharry, Nkurunziza, Rugema, Babenko-Mould, Rulisa and Nyirazinyoye (2024), who explored perceptions about enablers of women’s attendance and adherence to recommended antenatal care visits. Their study indicated that women who recognised pregnancy symptoms early were encouraged to attend ANC and honour follow-up dates (Tengera et al 2024).

A study by Otiso, Alhassan, Odhong, Onyango, Muturi, Hemingway, Murray, Ogwang, Okoth, Oguche and Doyle (2024) on exploring acceptability, opportunities, and challenges of community-based home pregnancy testing for early antenatal care initiation corroborates Tengera et al’s (2024) findings. The study noted that early detection of pregnancy improved ANC attendance. The women participating in the study indicated that they failed to seek health education due to late recognition of pregnancy symptoms (Otiso et al 2024).

Conforming to the theoretical framework underlying this study, Travers et al (2020) indicated that factors such as a woman’s self-perception of her health could lead to non-attendance for ANC. Being unaware of one’s pregnancy potentially increased the risk of home deliveries in an unsterile environment with unsterile equipment.

The results of this study enabled the researcher to identify the implications or outcomes of not attending ante-natal care. Some participants had home deliveries due to late recognition of pregnancy symptoms. Others delivered at home because they were aware that they should have attended ante-natal care and were afraid that they would be reprimanded for not producing a maternal care record.

4.5.4 Sub-theme 2.4: Considered abortion

One participant revealed that she had not attended ANC initially because she had considered an abortion but ultimately could not proceed, as her pregnancy was too far along:

“It was already late. I was not aware I was pregnant because I was going on my period. I felt fine. I went to the hospital to get an abortion and was told that it is already late and was far along in my pregnancy. My last two children are not too far apart in terms of age. They explained clearly that I could not get an abortion. If I had noticed early that I was pregnant, I would have had an abortion...” (Participant 10)

Another reported that she initially wished for an abortion because she was financially unstable:

“I asked the nurse for abortion pills if I was pregnant. The nurse asked if I would have an abortion if I was pregnant and I said I would. I was asked the reason for an abortion and I said that I was not financially stable. If I couldn’t support even myself, what would I then offer the baby.” (Participant 12)

One participant confessed that she had not attended ante-natal care as she wanted an abortion. She had been unfaithful, and the child was not her boyfriend’s:

“The father is not the same as my other children. I was cheating. I actually wanted money for an abortion before everyone could notice that I was pregnant. I was stressed about what could happen if they

found out I was pregnant. My boyfriend was not aware that I was pregnant, and on the other hand, he is not even the father. I just wanted money to go to the doctor for an abortion. That is the only thing that was on my mind. That is why you can see that I never attended ante-natal care. Abortion was the only thing on my mind.”

(Participant 14)

Another participant indicated that she did not attend ante-natal care because she wanted an abortion but did not know where to seek help and was afraid to go to the hospital:

“The reason why I did not attend ante-natal care is because the first months from 3–6 months I wanted to get an abortion. I didn’t know where to go and was afraid to come to the hospital.” (Participant 11)

One participant indicated that she did not attend ante-natal care because her husband wanted her to get an abortion. However, she was not comfortable with the idea as she had never done it before and was scared of dying and leaving her children behind. The participant was pregnant with twins:

“I told my husband about the pregnancy after finding out. He said that he does not want a baby and that I should get an abortion. I told him that I was not comfortable with it and could not do it because I had no experience of such things. I asked him what if I ended up dying. He gave me money and told me to go to the hospital. I came and went back home. I then told him that I did not find the person who was supposed to help me. My conscience would not allow me. I don’t know how abortion is. I was scared of dying and leaving my children behind.”

(Participant 16)

The same participant later reported that she had decided to give her babies up for adoption after birth:

“I just lost hope and decided that I would give the babies up for adoption and not take them home.” (Participant 16)

Another first-time mother reported searching on Facebook for information about abortion pills. Although she indicated that she did not pursue termination, she expressed significant interest in understanding more about issues around abortion:

“What happens if I wanted to terminate the pregnancy? I want to know more about the abortion pills that they sell on Facebook and if hospital termination pills are free. I am just curious and wanted to know more.”

(Participant 3)

The findings of this study reveal that some participants had considered an abortion, contributing to their failure to attend ANC. Similarly, Nigatu and Birhan (2023) conducted a study on the magnitude and determinants of delayed initiation of antenatal care among pregnant women. Their study indicated that women failed to attend ANC because they had initially considered terminating the pregnancy.

Another study conducted by Mare, Wuneh, Awol, Ibrahim, Hiluf, Aychiluhm, Mohammed and Sabo (2022) on factors affecting non-adherence to the World Health Organization’s recommended antenatal care visits supports the results of this study. The authors determined that women who initially considered terminating their pregnancies did not attend ANC (Mare et al 2022).

According to Travers et al (2020), considering abortion was an enabling factor that prevented some pregnant women from attending ante-natal care. The absence of care may lead to low birth weight or deformities in the newborn, as some women might attempt unsafe termination methods. Additionally, congenital malformations could result from the lack of supplements provided at ANC clinics.

The findings of this study enabled the researcher to identify outcomes associated with not attending ante-natal care. Some participants gave birth to babies with low birth weights, which led to neonatal admissions. One participant was unaware that she was pregnant with twins as she had never had a sonar. The twins were delivered prematurely, experienced respiratory distress, and were admitted to the neonatal ICU.

4.5.5 Sub-theme 2.5: Lack of support system

Some participants reported receiving no support from their partners. Others stated that they lacked a strong support system and had no one to confide in when facing difficulties. As a result, they had no encouragement to attend ANC. One participant explained that the father of her child worked far from home while she was unemployed. She added that she constantly faced financial challenges:

“Eish, I stay alone; I do not have a partner so I do not really have money. I separated from the father of my child. He only found a job this month; he was not working all along.” (Participant 9)

One participant commented that although she stays with her family, she barely speaks to them about her problems. She mentioned that as an introvert, she rarely spoke to people:

“I stay with my family but I don’t really speak to them. I found out that I was pregnant not so long ago, about last month but did not tell anyone. I keep to myself. I barely speak to people.” (Participant 2)

Another participant mentioned that, although she stayed with her aunt, she did not disclose her pregnancy. Furthermore, the participant had no knowledge of ANC. She reported that she disclosed the pregnancy to her boyfriend; however, he neither supported nor encouraged her to attend ANC:

“I did not tell my aunt about my pregnancy, but my boyfriend knew from the onset that I was pregnant, but never mentioned anything about going to the clinic nor show any support.” (Participant 1)

One participant reported that she disclosed the pregnancy to the father of the baby, but he did not comment much on it. She stated that she had no support from the father and that she found the whole experience distressing:

“I disclosed the pregnancy to the father of the child. He did not say much about the pregnancy. He did not support me even financially. This was painful. I went through the pregnancy alone.” (Participant 7)

Another declared that, following an argument, she was not on speaking terms with the father of her child. She stated that he showed no support, even though he had fathered another baby with her:

“He did not support me whatsoever. He did nothing. I kicked him out. We had a fallout. The problem started when he did not support my fifth child; he did not buy nappies, when we started fighting. We had some disagreements. After our fight, he stopped everything and just became a regular person. He would lock the gates when I was supposed to visit. I left him because I have been raising my children all by myself. We started talking recently, two weeks back. He has never supported me ever since my pregnancy. You know what they say that a baby is the responsibility of the mother.” (Participant 10)

One participant reported that she confided in her sister during her visits, as they did not live together. She stated that she currently had no one to talk to as she lived with her strict mother and was afraid of her:

“I have an older sister but the problem is that she doesn’t stay here with us. I only speak to her when she is visiting us. I don’t confide in anyone unless I have a phone and call her. I do not have a phone now. I have no one to speak to about my problems. It hurts me a lot because right now I stay with my mother. I cannot confide in her because I am scared of her. She is strict.” (Participant 11)

The same participant indicated that, despite living with her mother, she had never disclosed the pregnancy and continued to hide it. She had also refrained from telling her sister for fear that she would inform the entire family:

“I did not tell my sister that I am pregnant. I hid the pregnancy from her. I could not bring myself to tell her. I was scared that she might tell the whole family. After my last pregnancy, I promised my mother that I wouldn’t disappoint her by having another baby until at least my child goes to school. I made a mistake by falling pregnant. My mother told me that she would die from a heart attack if she found out that I was

pregnant. That is why I was afraid to tell her that I am pregnant. I stay with her. I stay with her and she was always suspecting that I was pregnant and I lied that I was pregnant. I did not disclose the pregnancy to anyone because I was scared of my mom.”
(Participant 11)

Another participant indicated that she did not disclose her pregnancy to the father of her child because he had shown no interest when informed of the possibility of having a baby:

“He is not around but I did not tell him that I am pregnant. I once mentioned it in passing but never revisited the topic again. Ah, I just decided to leave him alone. He never followed up when I first told him that I suspected I was pregnant. He showed no interest and never asked what was actually happening.” (Participant 12)

One participant confessed that she had been unfaithful to the father of her other children and could not disclose to the father of her current child that she was pregnant:

“No, I did not because I do not want him to find out. I don’t want him to know he is the father. I think he will get out of control if he learns that I have a boy child. I will tell my child who his real father is after he turns 15 or 16. People will talk and I think that other people already know and they will talk.” (Participant 14)

Another indicated that her mother had never supported her relationship with her husband, believing it would not work out. This stance compromised her relationship with her mother. The participant also reported feeling unhappy at home and only staying for the sake of her children:

“Eish there is no life in my home. It is just that, eh. Actually I move in with him even though my family was against it. Eventually, my mom told me that since I chose him, there is nothing she can ever help me with. I could not see the things they saw in him at the time. They saw

that he was not good for me. He liked things. They could see that he was not someone that I could have a future with.” (Participant 16)

“He likes alcohol and to party. He also likes women. I tried to talk to him about that but he goes back to his old habits after two to three weeks. It is like he changes for the better for a short period of time just to please me. I am not happy. I only stayed because of the children and there is nowhere I can go.” (Participant 16)

Another confirmed that she had passed matric with admission to a bachelor's degree and wanted to study teaching at university. She explained that she could not further her studies because she fell pregnant twice and was currently looking for a job:

“I went to school and completed my matric. I want to study teaching at the University of Limpopo. I passed with a bachelor. I am looking for any type of job now as long as it brings in an income. I got disturbed by my child who is at home. There is no one to look after my child when I am at school. I had the child in 2021. I decided not to further my studies to raise the child. Then I thought I would apply when she is 3 years old but got pregnant now again.” (Participant 11)

This study's findings reveal that some participants lacked a strong support system, both financially and emotionally, contributing to non-attendance for ANC. Some participants did not disclose their pregnancies to those they lived with and had no one to encourage them to attend ANC. Although some participants disclosed their pregnancies to their male counterparts, they received no support, which further led to their non-attendance for ANC.

The results of this study align with a study conducted by Palamuleni (2024) on factors associated with the late initiation of ante-natal care, which found that unmarried women failed to attend ANC. This study revealed that a lack of support from male partners discouraged women from seeking ANC services. Even though these services were free, women still required financial assistance from a partner (Palamuleni 2024).

In contrast to the findings of the current study, a study conducted by Bhosale (2023) in the Eastern Cape on the determinants of mothers' access to antenatal healthcare found no correlation between women's marital status and ANC attendance. The author determined that women attended ANC, even without the support of their male counterparts.

According to Travers et al (2020), a lack of a support system was a social factor related to predisposing factors that significantly contribute to non-attendance for ANC. This situation may lead to unidentified risk factors associated with complications of pregnancy, such as hypertensive disorders. These disorders can further result in eclampsia as a complication of untreated gestational or chronic hypertension, as the woman did not receive the necessary care during ANC.

The results of this study enabled the researcher to identify the implications of not attending ante-natal care. Some participants were admitted to high care for uncontrolled hypertension post-delivery. One participant experienced an intra-uterine death due to undiagnosed hypertension.

4.6 Theme 3: System/provider barriers

Table 4.5 below represents system or provider barriers as one of the factors that contributed to non-attendance for ante-natal care in a selected regional hospital in Limpopo province.

Table 4.5: System/provider barriers

Theme	Sub-Theme
3. System/provider barriers related to need factors	3.1 Long queues/slow service 3.2 Operating hours 3.3 Poor nurse-patient relationship

Participants reported that they did not attend ANC because of the clinic's operating hours and the long waiting periods. Other participants reported that they were afraid of the nurses at the clinic.

4.6.1 Sub-theme 3.1: Long queues/slow service

One participant reported that she did not attend ANC because she arrived early in the morning, only to leave late. She complained that because she spent so much time in the queue, she became hungry but had no money to buy lunch. Additionally, she still had to go home and care for her other children. She added that clinic employees took lunch breaks, while patients were left hungry as they waited for their turn:

“I got demotivated to go to clinics because you leave early but arrive home late. If you don't have lunch money. If you arrive early, you need to be helped early. You cannot leave the clinic at 7 pm when you arrived at 6 am or leave at 5 pm when they close. Do you see that it is a problem? We are scared of the long waiting period. You can ask anyone in the village why they do not attend ante-natal care and they will tell you that they sit at the clinic the whole day. Nurses do not care that you have been on the queue for long, they will still go and eat. We are not sick; they should stop being on their phones and help so we leave early and focus on our homes.” (Participant 10)

The same participant noted that only elderly people and those collecting medication were prioritised. She added that pregnant women, especially those making their first ANC booking, were assisted last, often spending the entire day at the clinic without food:

“They help old people first, then those who are collecting medication. They help pregnant women last. Previously, I went for my first ante-natal booking; they helped everyone first. They helped all the pregnant women and I was last because it was my first booking. I had not eaten anything the whole day. There were no nurses. Some nurses were at schools registering for their children; it was in January. I sat the whole

day; I was starved the whole day. That is why I stopped attending ante-natal care. Some people take out their food and eat in front of you.”

(Participant 10)

Another participant reported that after being told that she was not pregnant at the clinic, proceeded to the hospital. Upon arriving at the outpatient department, she found the queue to be too long and decided to go home and return the following day. She mentioned that she was number 182 in the queue and waited for more than 30 minutes before deciding to leave:

“When I suspected that I was pregnant, I went to the clinic and they tested my urine. I was told that I wasn’t pregnant by the nurse. The urine came out negative. Afterwards, I went home and never went back to the clinic again because I was told that I am not pregnant. I came to the hospital and found a long queue at outpatient department. I stayed for a bit, for more than 30 minutes, then decided that I would return another day because I wasn’t feeling well. I was number 182 on the queue. I arrived at around past 9 and left at around 12.”

(Participant 12)

From the findings of this study, it was noted that participants failed to attend antenatal care because of the long waiting periods at the clinic or hospital. Although clients arrived on time at the clinic or hospital, they were delayed and often spent the entire day there. Similarly, Vasilevski, Graham, McKay, Dunn, Radelaar, Vuillermin and Sweet (2024) conducted a study on barriers and enablers to antenatal care attendance for women referred to social work services. The women reported becoming impatient after waiting for an hour, and as a result, left before their consultations (Vasilevski et al 2024).

Aligning with the findings of the current study, another study by Escañuela Sánchez, Linehan, O’Donoghue, Byrne and Meaney (2022) on facilitators and barriers to seeking and engaging with ANC in high-income countries found that women avoided attending ante-natal care because of administrative delays. These women reported that the ANC system was inflexible and the process too

slow, hindering them from attending to their other responsibilities (Escañuela Sánchez et al 2022).

The findings of the current study indicated that long queues caused by slow service were organisational factors that hindered pregnant women from attending ANC. This contrasts with the enabling factors identified by Travers et al (2020), which were found to facilitate women's attendance for ANC. The lack of attendance might lead to an increase in maternal mortality rates due to preventable conditions that could be detected early if women attended ANC.

4.6.2 Sub-theme 3.2: Operating hours

Participants reported that they did not attend ante-natal clinics because they had to go to school and some to work, and by the time they returned, it would have closed for the day. One participant stated that she did not want to miss out on schoolwork and even attended classes on weekends:

"I was going to school. School knocks off late. It starts at 6 am and knocks off at 4 pm. We also attend on weekends. There was no way I could have attended ante-natal care clinic. I was scared of missing school." (Participant 3)

A participant who was in matric attended school during the week. Her local clinic closed at 3 pm on weekdays and did not operate on weekends, making it impossible for her to attend ANC, as school finished after 4 pm:

"I am in grade 12. We sometimes attend classes during the weekend. The clinic opens the whole week. It closes at 3 pm. I knock off from school after 4 pm. They do not operate during the weekend." (Participant 13)

Another participant reported that at 5 pm, the queues are cut off, and clients are instructed to return the following day:

"...You were at the clinic seated listening to workers telling we will be helped but sometimes cut the queue. They cut the queue at around 5 pm and tell you to come back the following day, I did not go back. As

such, I only reported to the hospital now because I was feeling pains.”
(Participant 10)

This study found that some ANC clinics had inflexible operating hours, which prevented some participants from attending ANC, as the clinics either closed early or queues were cut and clients were instructed to return the following day. Similarly, Vasilevski et al (2024) conducted a study in which women reported that ANC clinic hours were inflexible, making it difficult to fit appointments around their commitments. Some working-class women noted that by the time they finished work, the clinic was closed and no after-hours appointments were available (Vasilevski et al 2024).

Similarly, Hailu, Weret, Adasho and Eshete (2022) conducted a study on quality of antenatal care and associated factors in public health centres. Women reported that ANC clinics closed early and by the time they finished work, the clinics were already closed (Hailu et al 2022).

The current study, along with previous literature, reveals that the inflexible operating hours of healthcare facilities contributed to non-attendance for ANC. This inflexibility could potentially lead to obstructed deliveries, as the mothers lacked an ANC history, and no pelvic assessments would have been performed. In this study, two mothers lost their newborn babies due to non-attendance for ANC. The conditions that led to these deaths might have been detected or prevented by attending ANC early.

4.6.3 Sub-theme 3.3: Poor nurse-patient relationship

A few participants reported that they were afraid of the nurses at the clinic, which discouraged them from attending ANC. Although some participants had no first-hand experience of this, they mentioned hearing about nurses' rude attitude through informal sources.

One participant reported that clinic nurses had a negative attitude and did not explain things in a polite manner. She confirmed that she had experienced this treatment first-hand:

“Nurses do not explain things in a polite manner and they must change their attitude. People at the clinic have attitude... “I have first-hand experience. This other time I visited the clinic and did not come with urine. I told them that I did not know that we were supposed to bring urine. They then told me not to get too familiar with them.”

(Participant 3)

Another participant reported that nurses became angry when asked questions about their service delivery. The participant even suggested that the researcher should wear casual clothes and pretend to be a client to observe what is happening in public clinics:

“I do not know how they work. When you ask the nurses, they will tell you not to be forward and that they know their work. If you continue questioning them, you will have a problem. If you think you talk at the clinic, nurses will give you a nasty look and they will hate you because you speak a lot. They will tell you that they do not have a thousand hands. If you wear casual and go to those clinics, you will see things. You will see that we do not get assisted. Nurses will tell you that they are aware that clients post them on Facebook.” (Participant 10)

The same participant complained that clients could not express their concerns in the consultation rooms at the clinic, as they were afraid that the nurses would reprimand them harshly:

“Sometimes, nurses reprimand clients harshly. People go to the clinic scared and cannot speak out their problems. If I was scared when you interviewed me, I wouldn't have told you anything. What would I tell you? If you speak to me nicely like you did, then I will be free to go to the clinic and explain my problems. Sometimes they tell us where to get off. We make mistakes but don't be harsh. Tell me nicely.”

(Participant 10)

Another participant revealed that she did not attend ANC because she had heard that the nurses shouted at those who booked late:

“I am scared that nurses shout at people who book late. So I just decided to go to the hospital when I give birth. I heard people on the streets talking.” (Participant 7)

One participant suggested that people in the villages spread rumours that the nurses at the clinics were rude and reprimanded clients harshly. She also reported that nurses gave clients medication without explaining its purpose and that clients influenced each other not to attend ANC:

“People in the rural areas tell each other that nurses are rude. Many people, especially in the villages, have this stigma that nurses will reprimand you, take you up and down and give you a lot of pills. Some nurses give patients pills but not explain what they are for, so they end up piling up in people’s homes, especially the ones with acid. Yaa..., people influence others into not going by telling others that they were reprimanded by nurses, so people end up thinking that they too will be reprimanded, so they would rather be reprimanded at the hospital.”
(Participant 8)

Another reported that even though she visited the clinic every month to collect her medication, no measures were taken to ensure that she was not pregnant. She indicated that she would lie if asked whether she was pregnant, but added that she wished someone had spoken to her on a deeper level instead of believing everything she said:

“At the clinic, they don’t take extra measures to ensure that we are not pregnant. It’s like they don’t care. I went to the clinic every month to collect medication, but no one could tell that I was pregnant. When they asked me if I was pregnant, I said no, and they just believed me. My belly was big, and they didn’t care. I wanted someone to speak to me on a deeper level and not just believe everything I told them.”
(Participant 11)

A participant who delivered at home expressed her fear of visiting a clinic for her first ante-natal care appointment because she was far along in her pregnancy.

She confirmed that she anticipated being asked about her maternal case record and feared being reprimanded. She also mentioned hearing rumours that nurses physically punished and turned patients away. This participant eventually presented at the hospital after delivering at home and stated that she knew she would not be turned back home:

“I was starting to feel scared that they were going to ask me why I do not have a maternal case record. I was scared that you were going to reprimand and shout at me. I heard people saying that nurses even give patients a hiding. I got scared. They say that they even turn patients away. They tell you to stay at the gate and not enter the premises. I figured that they won’t turn me away when it is time to give birth.” (Participant 12)

This study determined that some participants complained of healthcare providers’ attitudes. Some participants had been previously reprimanded or perceived nurses as rude, discouraging their attendance for ANC. Similarly, Escañuela Sánchez et al (2023) conducted a study in which women reported dissatisfaction with ANC services, which dissuaded them from attending. They attributed this to healthcare providers being judgemental and lacking empathy and compassion. The same study revealed that women felt disrespected by healthcare providers and sensed a disparity between themselves and the healthcare providers (Escañuela Sánchez et al 2023).

In a study conducted in Soweto, women reported being verbally abused and treated with disrespect by nurses at an ANC clinic. They stated that they were given medication without any explanation of its purpose and that nurses took long, extended lunch breaks (Myburgh et al 2024).

In contrast to the findings of the current study, another study found that the majority of women were content with healthcare providers’ attitudes, which positively influenced ANC attendance. These pregnant women reported that they were treated with kindness and respect (Blessing et al 2023).

In accordance with the theoretical framework underlying this study, Travers et al (2020) noted that enabling and organisational factors, such as the quality of care received, may contribute to non-attendance for ANC. The findings of this study align with this, as the pregnant women reported unpleasant attitudes from healthcare providers, which led to their failure to attend ANC. This could result in severe anaemia in pregnancy, as no baseline blood tests were conducted due to non-attendance. Furthermore, women might experience postpartum haemorrhage and require emergency transfusions.

4.7 Conclusion

The results of this study highlight the contributory factors leading to non-attendance for ante-natal care. Most participants failed to attend ANC due to inaccessible health services, as many health facilities were not within walking distance and participants lacked the financial means to reach them. Furthermore, the absence of support from family members and partners negatively impacted ANC attendance. Some participants lacked knowledge of the importance of attending ANC, while others had considered terminating their pregnancies. Numerous people who participated in this study complained that a poor relationship with healthcare providers prevented them from attending ANC. Additionally, some mentioned that they were unaware of their pregnancies.

CHAPTER 5: SUMMARY, RECOMMENDATIONS, AND CONCLUSION

5.1 Introduction

Chapter 4 discussed the findings of the study. This chapter presents the summary, limitations, conclusions, and recommendations of the study, which focused on the contributory factors leading to non-attendance for ANC in a selected regional hospital in Limpopo province, South Africa.

5.2 Aim of the study

The aim of the study was to identify and evaluate the contributory factors leading to non-attendance for ante-natal care by pregnant women at a selected regional hospital in Limpopo province, South Africa.

5.3 Research design and method

This study adopted a qualitative, exploratory, descriptive, and contextual research design to collect and analyse data. A qualitative research approach is a systematic approach used to explain events and circumstances based on the experiences of the participants involved in the research (Grove et al 2015). A qualitative research approach was selected because it assists in obtaining thorough information from participants' experiences and delves deeply into the factors that contribute to non-attendance for ante-natal care by pregnant women. This study was conducted in a selected regional hospital in Limpopo province.

The population for this study was pregnant women who presented at the selected regional hospital for delivery with no history of ante-natal care attendance. Non-probability purposive sampling was used to sample participants, and a total of 16 participants were interviewed until data saturation was reached. The data were collected through in-person semi-structured interviews and analysed using thematic analysis.

5.4 Summary of the study findings based on the research objective

This study answered the research question: What are the contributory factors leading to non-attendance for ante-natal care by pregnant women in a selected regional hospital in Limpopo province, South Africa?

By answering the question, the study accomplished the following objective:

- To explore and describe the contributory factors leading to non-attendance for ante-natal care by pregnant women in a selected regional hospital in Limpopo province, South Africa.

Aligned with the above-mentioned objective, three themes emerged from the findings of the study.

5.4.1 Theme 1: Socio-demographic factors

This theme comprised three sub-themes in which participants explained why they did not attend ante-natal care. The researcher noted that clinics were allocated according to sections, and clients were turned back if they did not visit their designated clinic. Participants reported that because they lived far from their designated clinics, they either had to walk long distances or catch a taxi. Some participants reported that they lacked the financial means for transport as they were unemployed, with some depending on their children's social grants to meet their basic needs. Other participants had a limited educational background, therefore making it difficult to fully comprehend the importance of ANC. All the above factors led to non-attendance for ANC.

5.4.2 Theme 2: Personal factors

This theme comprised five sub-themes in which participants explained factors that contributed to non-attendance for ANC. Several participants acknowledged that they were not aware of the importance of attending ANC. While others knew the importance, they still did not attend, with a few initially denying their pregnancy. Some participants reported that they initially were not aware that they

were pregnant—although they had knowledge of pregnancy symptoms, their present pregnancies presented with unusual symptoms.

A number of participants reported that they did not attend ANC owing to the fact that they considered terminating the pregnancy. Some did not receive support from their relatives or partners after disclosing that they were pregnant. Others did not disclose their pregnancies to the people closest to them.

One participant reported that she had no one to take care of her children when she attended ANC and was afraid that people would assume she neglected them.

5.4.3 Theme 3: System/provider factors

This theme comprised three sub-themes in which participants explained their reasons for not attending ANC. Participants pointed out that inflexible clinic operating hours did not accommodate school-going mothers. Long queues and slow service at the clinic were identified as factors hindering ANC attendance, with several participants remarking that they were told to return home without being assisted after the 5 pm cut-off time. A foreign national explained that she failed to attend ANC because she could not speak the local language. Several participants complained of negative healthcare provider attitudes, noting that healthcare providers were perceived as being rude.

5.5 Conclusion

The findings from this study identified several factors contributing to non-attendance for ANC. Many participants reported financial burdens that made it difficult to afford taxi fares to the clinics, with some clinics being inaccessible by foot. Additionally, participants' low levels of education led them to underestimate the importance of attending ANC. Some individuals initially denied their pregnancies, having considered abortion and recognising pregnancy symptoms late, which resulted in their non-attendance for ANC. Two mothers lost their newborn babies due to non-attendance. A lack of an adequate support system demoralised some participants, further discouraging them from attending ANC.

Furthermore, long queues and inflexible clinic operating hours were identified as significant barriers to attendance. Lastly, some participants cited a poor relationship with healthcare providers as a reason for not attending ANC.

5.6 Recommendations of the study

5.6.1 Recommendations to community (partners, home-based carers, and community leaders)

- Community leaders should organise community meeting outreach programmes to educate the community about the importance of ante-natal care.
- The community must be involved in pregnancy matters so they can encourage one another to attend ante-natal care.
- Home-based carers should routinely conduct pregnancy tests at women's homes.
- Husbands/partners should be encouraged and advised to support women during and after pregnancy.
- Teachers and nurses should organise awareness campaigns to educate schoolchildren about ante-natal care and contraceptives.
- Healthcare workers should communicate with patients in a respectful and compassionate manner to enable unrestricted access to clinics/hospitals.

5.6.2 Recommendations to the Department of Health/government

- Utilise different forms of media (TV, radio, social media platforms, newspapers, and magazines) to spread awareness about ante-natal care.
- Allocate adequate funds to repair public roads for easy access to clinics/hospitals.
- Allocate funds to hire more nurses at clinics to improve quality of care.

- Offer nurses opportunities for further education and professional development to enhance their ability to deliver quality ante-natal care.
- Hire more home based-carers to raise awareness in the community about ante-natal care.
- Hire an occupational health nurse in all schools to provide ante-natal care to school going women, as well as reproductive health education to all learners.
- Ensure that funds allocated towards improving healthcare services are utilised accordingly.
- Ensure that emergency contraceptives are available in all public clinics.
- Provide incentives (maternity bag with nappies, pads, baby clothes, etc.) to women who attend ante-natal care.
- Construct clinics in every village for effortless access to care.
- Provide mobile clinics that offer ANC services to alleviate the burden of transportation costs.
- Consider offering a 24-hour operating service at all clinics and hire adequate security personnel to protect workers in clinics.
- Allocate more funds towards job creation to empower community members.
- Conduct client and staff satisfaction surveys monthly to identify areas of improvement.
- Implement interpersonal communication training to address nurses' attitudes.

5.6.3 *Recommendations to clinical practice*

- Nurses should hold meetings with the community in the morning before work and teach about the importance of ante-natal care.
- Nurses should teach the community about emergency contraceptives and where they can be obtained.

- Client and staff satisfaction surveys should be conducted monthly to identify areas of improvement.
- Interpersonal communication training should be implemented to address nurses' attitudes.

5.6.4 Recommendation to nursing education institutions

In order to prepare future nurses to deliver quality ante-natal care, nursing education institutions should allocate more practical time at clinics to expose students to ante-natal care services.

5.6.5 Recommendations for further research

- Future qualitative studies determining and exploring factors contributing to non-attendance for ante-natal care in other public facilities need to be conducted within the Waterberg district.
- A follow-up study should be conducted in the same regional hospital after three years to assess any improvements in ante-natal care attendance.

5.7 Limitations of the study

- Initially, the researcher traced 12 participants who delivered in 2023, with the intention of interviewing them at their homes. However, no traced participants took part in the study. Three participants' cell phone numbers went to voicemail multiple times; two participants agreed to be interviewed but did not answer their phones when called again; and seven participants refused to take part in the study.
- The researcher's inability to speak Shona led to a communication barrier in interviewing one of the participants. This participant had no visitors during her stay at the selected regional hospital.
- The researcher only sampled participants from one regional hospital, which might have limited information obtained, as geographical area can influence ante-natal care attendance.

5.8 Concluding remarks

This was a qualitative, exploratory, descriptive, and contextual study aimed at identifying and evaluating the contributory factors leading to non-attendance for ante-natal care by pregnant women at a selected regional hospital in Limpopo province, South Africa. Non-probability purposive sampling was used to sample participants. The data were collected through in-person semi-structured interviews and analysed using thematic analysis. Three themes and eleven sub-themes emerged from the findings of this study. Factors contributing to non-attendance for ante-natal care were described comprehensively.

The findings of this study indicate that women continue to avoid ante-natal care throughout their pregnancy, highlighting the significant challenges that remain in achieving the Sustainable Development Goal 3 by 2030 which is reducing the global maternal mortality ratio, and achieving universal access to reproductive health. This study's findings underscore the urgent need for targeted interventions at community, institutional, and policy levels to improve ante-natal care attendance.

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APPENDICES

Appendix A: Ethics certificate TREC (Turfloop Research and Ethics Committee)



University of Limpopo
Department of Research Administration and Development
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 3935, Fax: (015) 268 2306, Email: tukiso.sewapa@ul.ac.za

TURFLOOP RESEARCH ETHICS COMMITTEE
ETHICS CLEARANCE CERTIFICATE

MEETING: 04 December 2023

PROJECT NUMBER: TREC/1706/2023: PG

PROJECT:

Title: Contributory factors leading to non-attendance of ante-natal care by pregnant women in a selected public hospital of Limpopo province, South Africa.
Researcher: MR Kgorane
Supervisor: Prof TI Ramavhoya
Co-Supervisor/s: Dr MG Mathebula
School: Health Care Sciences
Degree: Master of Nursing

PROF D MAPOSA
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: REC-0310111-031

Note:

- i) This Ethics Clearance Certificate will be valid for one (1) year, as from the abovementioned date. Application for annual renewal (or annual review) need to be received by TREC one month before lapse of this period.
- ii) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee, together with the Application for Amendment form.
- iii) PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

Appendix B: Approval letter from Limpopo Department of Health



LIMPOPO

PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF
HEALTH

Ref : LP_2023-12-010
Enquires : Legodi P
Tel : 015-293 6028/6410
Email : Malesela.Legodi@dhsd.limpopo.gov.za

MAKGAKA REBECCA KGORANE

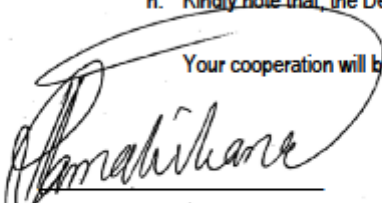
PERMISSION TO CONDUCT RESEARCH IN DEPARTMENTAL FACILITIES

Your Study Topic as indicated below;

CONTRIBUTORY FACTORS LEADING TO NON-ATTENDANCE OF ANTE-NATAL CARE BY PREGNANT WOMEN IN A SELECTED PUBLIC HOSPITAL OF LIMPOPO PROVINCE, SOUTH AFRICA

1. Permission to conduct research study as per your research proposal is hereby Granted.
2. Kindly note the following:
 - a. Present this letter of permission to the Office of District Executive Manager a week before the study is conducted.
 - b. This permission is **ONLY** for Mokopane Hospital
 - c. In the course of your study, there should be no action that disrupts the routine services or incur any cost on the Department.
 - d. After completion of study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
 - e. The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
 - f. **The approval is only valid for a 1-year period.**
 - g. If the proposal has been amended, a new approval should be sought from the Department of Health
 - h. Kindly note that the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated.


pp Head of Department

5/2/2024

Date

Private Bag X9302, Polokwane 0700
Fidel Castro Ruz House, 18 College Street, Polokwane 0700
Tel: 015 293 6000. Fax: 015 293 6211. Website: www.doh.limpopo.gov.za

The heartland of Southern Africa - *development is about people!*

Appendix C: Approval letter from Waterberg District



LIMPOPO

PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF
HEALTH
WATERBERG DISTRICT

ENQ: Ramalivhana M.C
EMAIL: Mukhethwa.Ramalivhana@dhsd.limpopo.gov.za
TEL: 014 718 0623

TO: MAKGAKA REBECCA KGORANE


RE: PERMISSION TO CONDUCT RESEARCH: YOURSELF.

The above bear's reference:

The office of the District Executive Manager, hereby confirm receipt of your request to conduct research on **CONTRIBUTORY FACTORS LEADING TO NON-ATTENDANCE OF ANTE-NATAL CARE BY PREGNANT WOMEN IN A SELECTED PUBLIC HOSPITAL OF LIMPOPO PROVINCE, SOUTH AFRICA.**

1. Permission is hereby granted as per approval by the acting HOD.
2. You are further requested to notify this office on when you are going to start with the research and make sure that there is no action that disturbs service delivery.
3. This permission is **ONLY** for Mokopane Hospital.
4. The approval is only valid for a 1-year period.
5. If the proposal has been amended, a new approval should be sought from the Department of Health.
6. During your study, there should be no action that disrupts the routine services or incur cost on the Department.
7. After completion of study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
8. Kindly note that, the Department can withdraw the approval at any time.

Your support and cooperation in terms of the above will be highly appreciated.


Ms. Bulannga N.G.
DISTRICT EXECUTIVE MANAGER

29/02/2024
DATE

100 Nelson Mandela Drive & Thabo Mbeki Street Modimolle 0510, Private Bag X 1026 Modimolle 0510
Tel: 014 718 0500. Fax: 014 718 0675 Website: www.doh.limpopo.gov.za

Appendix D: Approval letter from Hospital CEO



DEPARTMENT OF HEALTH

OFFICE OF THE CHIEF EXECUTIVE OFFICER

Enquiries : Maila M.J (Acting P.A to the Chief Executive Officer)
Contact number : 015 483 4170/4166
Cell number : 078 153 9791
Email address : Malesele.Maila@dhsd.limpopo.gov.za

Date: 08 March 2024

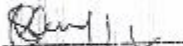
TO: MAKGAKA REBECCA KGORANE

RE: PERMISSION TO CONDUCT RESEARCH: YOURSELF

GREETINGS

1. The above matter has reference.
2. Kindly be informed that the office of the Chief Executive Officer hereby confirms the receipt of your request to conduct research on: **conduct research based on contributory factors leading to non-attendance of ante-natal care by pregnant women in a selected public hospital of Limpopo Province, South Africa.**
3. Permission is hereby granted for Mokopane Hospital only as per approval by the District Executive Manager and the acting HOD.
4. Your request has been forwarded to Nursing Managers office, please call 015 483 4174/4274 for further arrangements.

Yours cooperation will be highly appreciated.

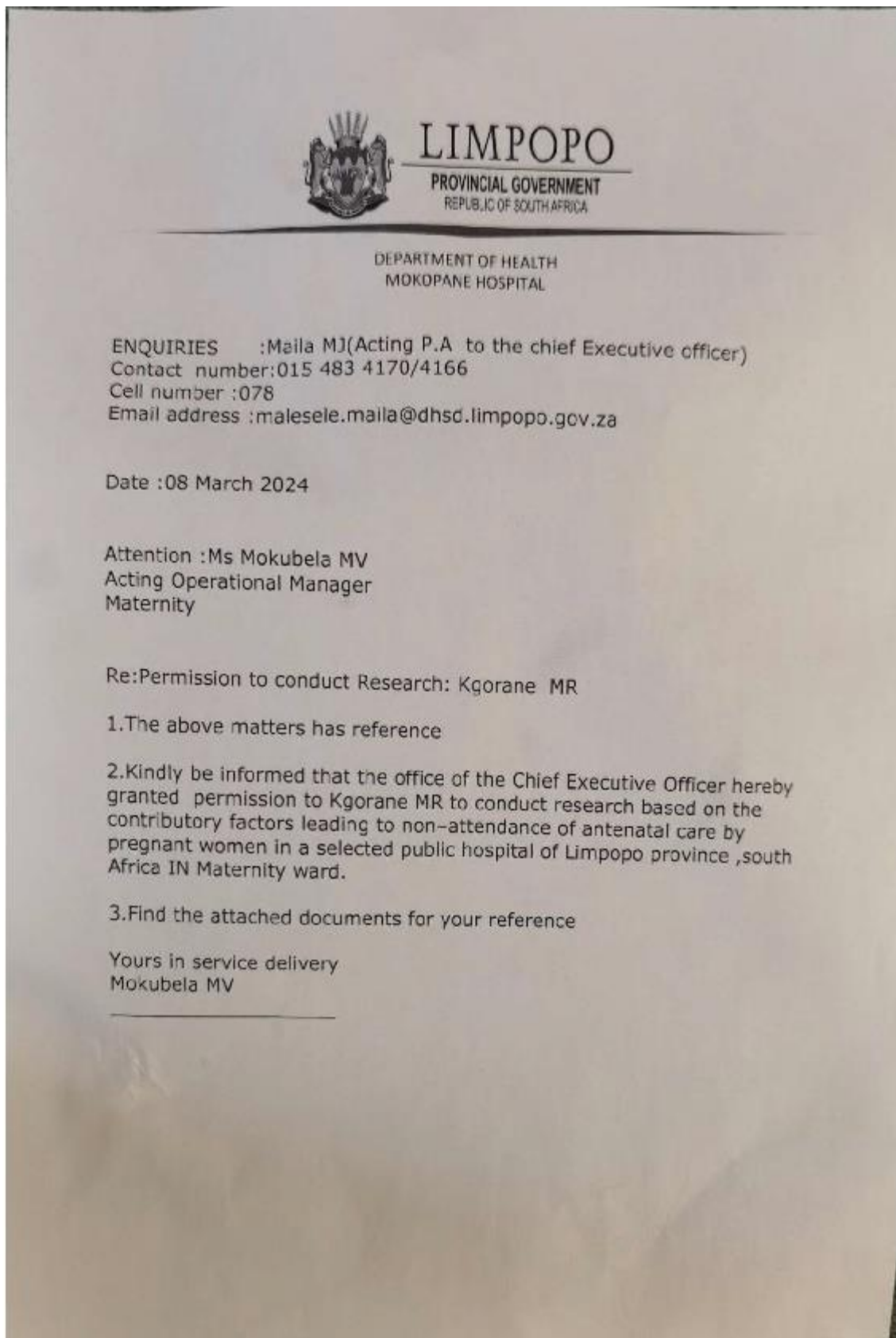

Ms. Magagane S.L.
Chief Executive Officer



WATERBERG DISTRICT
DIEDU MADJENA DRIVE MOKOPANE REGIONAL HOSPITAL PRIVATE BAG X2466 MOKOPANE, 0660 TEL (015) 483 4000 FAX (015) 483 2405
Website: <http://www.limpopo.gov.za>

The Department of Health, Limpopo Province

Appendix E: Approval letter from Operational Manager



Appendix F: Interview guide

Central Question

What are the contributory factors that made you not attend ante-natal care throughout your pregnancy?

Probing Questions

Where do you stay around Mokopane?

How do you support yourself?

Who are the people that you go to for support?

What do you know about ante-natal care?

Appendix G: Consent form

DEPARTMENT OF NURSING SCIENCE ENGLISH CONSENT FORM

Statement concerning participation in an academic research project/ study

Name of project/study: CONTRIBUTORY FACTORS LEADING TO NON-ATTENDANCE FOR ANTE-NATAL CARE BY PREGNANT WOMEN IN A DELECTED REGIONAL HOSPITAL IN LIMPOPO PROVINCE, SOUTH AFRICA.

I have read the information and heard the aims and objectives of the proposed study and was provided the opportunity to ask questions and was given adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear to me. I have not been pressurized to participate in any way.

I am aware that this material may be used in scientific publications which will be electronically available throughout the world. I consent to this provided that my personal information such as names and surname will not be revealed.

I understand that participation in this study is completely voluntary and that I may withdraw from it at any time and without reasoning.

I know that this study has been approved by the Turfloop Research Ethics Committee (TREC). I am fully aware that the results of this study will be used for scientific purposes and may be published. I agree to this, provided my privacy will be guaranteed.

Access to the records that pertain to my participation will be restricted to persons directly involved in the research.

Any questions that I may have regarding the research or related matters, will be answered by the researchers.

I indemnify the University of Limpopo and all persons involved with the above study from any liability that may arise from my participation in the above study or that may be related to it, for whatever reasons including negligence on the part of the mentioned persons.

I hereby give consent to participate in this Study / Project

Signature of researched person.....

Signature of researcher.....

Signed at..... this.....day of..... 2024

Appendix H: Foromo ya tumelelo ya Sepedi

Polelo mabapi le go tšea karolo mo protšekeng/ thutong ya nyakišišo ya thuto.

Leina la projeke/thuto: MAKGOLO A GO TŠEA SEBELETŠO A ITŠETŠEGO GO SE BEGO TLHOKOMELO YA PELE GA PELEGO KE BASADI BA BAIMAMO SEPEPELO SA MOKOPANE SA PROVINCE YA LIMPOPO, AFRIKA BORWA.

Ke badile tshedimošo gomme ke kwele maikemišetšo le maikemišetšo a nyakišišo ye e šišintšwego gomme ka fiwa sebaka sa go botšiša dipotšišo gomme ka fiwa nako ye e lekanego ya go nagana gape ka taba ye. Maikemišetšo le maikemišetšo a nyakišišo ye di molaleng ka mo go lekanego go nna. Ga se ka gatelelwa gore ke tšee karolo ka tsela le ge e le efe.

Ke a tseba gore sedirišwa se se ka šomišwa ka dikgatišong tša mahlale tšeo di tlogo hwetšagala ka mokgwa wa elektroniki lefaseng ka bophara. Ke dumela se ge fela tshedimošo ya ka ya motho ka noši go swana le maina le sefane e ka se utollwe.

Ke kwešiša gore go tšea karolo nyakišišong ye ke ga boithatelo ka mo go feletšego le gore nka ikogogela morago go yona nako le ge e le efe le ntle le go bea mabaka.

Ke a tseba gore nyakišišo ye e dumeletšwe ke Komiti ya Boitshwaro ya Nyakišišo ya Turfloop (TREC). Ke tseba ka botlalo gore dipelo tša nyakišišo ye di tla šomišetšwa merero ya mahlale gomme di ka phatlalatšwa. Ke dumela se, ge fela sephiri sa ka se tla kgonthišetšwa.

Pihlelelo ya direkhoto tšeo di lebanego le go tšea karolo ga ka e tla lekanyeletšwa go batho bao ba amegago thwii nyakišišong.

Dipotšišo dife goba dife tšeo nka bago le tšona mabapi le nyakišišo goba ditaba tše di amanago le yona, di tla arabja ke banyakišiši.

Ke šireletša Yunibesithi ya Limpopo le batho ka moka bao ba amegago ka nyakišišo ye e lego ka mo godimo go tšwa go maikarabelo afe goba afe ao a ka

tšwelelago ka lebaka la go tšea karolo ga ka mo nyakišišong ye e lego ka mo godimo goba ao a ka amanago le yona, ka mabaka afe goba afe go akaretša le go se šetše ka lehlakoreng la batho bao ba boletšwego.

Ke fa tumelelo ya go tšea karolo Thutong / Protšeke ye.

Mosaeno wa motho yo a nyakišišitšwego.....

Mosaeno wa monyakišiši.....

E saennwe ka..... letšatši le..... la.....

2024

Appendix I: Transcript

Researcher: Kgorane MR

Date: 24/08/2024

Duration: 25 minutes and 56 seconds

Participant 16

Researcher: My name is Rebecca. I work in labour ward. I am doing my Masters degree. I have permission from the university, department of health and hospital to collect data from women. I am doing research. The research is based on women who do not attend ante-natal care when they are pregnant. I want to find out their reasons for not attending ante-natal care and what they can suggest to be done so they can attend ante-natal care. Maybe there is a gap that needs to be filled. Do you understand?

Participant: Yes I understand

Researcher: I am going to ask you a few questions that will help me understand why you did not attend ante-natal care. Do you understand?

Participant: Yes I do

Researcher: I am asking to record you for transcription purposes. The recordings will be deleted. I am not going to use your name. Do not tell me your name. This will be private. Please don't answer with a yes/no or nod your head. Speak loudly. Explain your answers in full. Feel free. Do you allow me?

Participant: Yes I do

Researcher: How old are you?

Participant: 38 years

Researcher: How many times have you been pregnant?

Participant: This was the eighth pregnancy

Researcher: How many children do you have at home?

Participant: I have seven children at home

Researcher: How many children do you have now?

Participant: I have nine children now. I got twins now

Researcher: Tell me your children's ages in their order

Participant: The first born is 17 years old. The second is 14, the third is 12, the fourth is 10 year old. The fifth is seven years. The sixth is five years. The last is two years old and I have the twins now

Researcher: Do you work?

Participant: No I do not

Researcher: How do you support yourself and your children?

Participant: Their father at home supports them. I stay with my husband. He is the one working

Researcher: Where do you stay?

Participant: I stay in Armoed

Researcher: Which clinic do you use in Armoed? The nearest clinic

Participant: We use Armoed clinic, it falls under Mapela

Researcher: How far is the clinic from where you stay?

Participant: It is a bit of a distance because I have to catch a taxi when I go there. It is the distance from here to town. The taxi fare is R12. It is far by foot but I usually go by foot.

Researcher: Do you have someone that takes care of your children when you go to the clinic?

Participant: Yes I do. It is my aunt. She doesn't stay far from where I live. I take my children there when I go somewhere

Researcher: Did you go to school?

Participant: Yes I did. I ended in grade 11

Researcher: Why didn't you continue?

Participant: I got pregnant in 2007 when I was supposed to do my matric. There was no one to take care of my child. I was still living at home by the time. My mom was working so I decided to just leave it.

Researcher: Why didn't you ever go back?

Participant: Ah I cannot even say that I have a reason but I was a top student. I can read and write

Researcher: Have you ever worked somewhere else before?

Participant: Yes I have worked before in Kempton Park Pick n Pay. I was doing stock taking. They retrenched people

Researcher: Is there someone in your life that you can talk to when you have problems or when you are overwhelmed?

Participant: I do not have anyone

Researcher: What about your husband?

Participant: I cannot talk to him. He shouts at me. I only speak to him when he has had alcohol to drink. Other than that he cannot sit down and talk to me.

Researcher: What about your aunt?

Participant: My aunt does not stay at her house now because she recently found a job. She only comes back month end

Researcher: Are you and your husband civil towards each other? Is there peace in your home?

Participant: Eish there is no life in my home. It is just that eh. Actually I moved in with him even though my family was against it. Eventually my mom told me that since I chose him there is nothing she can ever help me with. I could not see the things they saw in him at the time.

Researcher: What did they see in him?

Participant: They saw that he was not good for me. He liked things. They could see that he was not someone that I could have a future with.

Researcher: What is it that he does that you do not like?

Participant: He likes alcohol and to party. He also likes women. I tried to talk to him about that but he goes back to his old habits after 2-3 weeks. It is like he changes for the better for a short period of time just to please me

Researcher: Are you happy?

Participant: I am not happy. I only stayed because of the children and there is no where I can go. I took a new stand now somewhere but haven't told him the honest reason. I told him that it for the children since they are growing

Researcher: Do you speak to your mom about your problems?

Participant: No I don't. She does not even know that I was pregnant and have given birth. She never understood why I was having all these children. She asked why I would have children with a man whose life was not in order. My husband is the one driving a wedge between us

Researcher: Does he give you money for the children?

Participant: Yes he gives me money month end to buy food and other things for the children. The children do not lack anything. He is just not emotionally supportive towards me

Researcher: Are you on speaking terms with your mother?

Participant: We do talk but I cannot share my problems with her. I do not consider her as a parent because I have wronged her so much. It is only now that I realise that I wouldn't be where I am if I had listened to her

Researcher: How did you wrong her?

Participant: I dropped out of school after getting pregnant. She told me to go back to school. I pretended as if I didn't hear her. She asked me what I was going to achieve by not going back to school. She told me I would have no future and get no job without going to school. She said she did not want me to end up like her. I realise that I'd be something now if only I had listened to her.

Researcher: Don't you have siblings

Participant: I have a younger brother. We are only two

Researcher: I want to know why you never attended ante-natal. Why did you give birth without attending ante-natal care clinic?

Participant: I cannot really say that I have a reason. I told my husband about the pregnancy after finding out. He said that he does not want a baby and that I should get an abortion. I told him that I was not comfortable with it and could not do it because I had no experience of such things. I asked him what if I ended up dying. I asked what would happen with our children since he does not have a good relationship with my family. He told me that since I was making the decision to keep him, he would not provide for him or help with anything whether during or after pregnancy. I told him that I knew that it is not like he does not want the baby, it is about the money. He always complains about money. So I cannot really say I have a reason for not attending ante-natal care. I just lost hope and decided that I would give the babies up for adoption and not take them home. He gave me money and told me to go to the hospital. I came and went back home. I then told him that I did not find the

person who was supposed to help me. My conscience would not allow me. I don't know how abortion is. I was scared of dying and leaving my children behind.

Researcher: Have you ever attended ante-natal care?

Participant: Yes I attended in my previous pregnancies

Researcher: When did you find out that you were pregnant?

Participant: It was in February. My last period was on the 14th of December. My belly does not usually show when I am pregnant and a sometimes go on my period

Researcher: Why didn't you go the clinic and get a maternity booklet?

Participant: I do not have a reason. There is a home based carer in our area. She is my husband's family. She came to my house to ask me but on that day my husband and I had fought. I did not speak to her nicely. I did not even want to hear what she had to say to me.

Researcher: Do you know the importance of attending ante-natal care?

Participant: Yes I do

Researcher: Tell me about it

Participant: The importance is that sometimes especially in my case, let me give an example about myself. This was my eighth pregnancy. There are a lot of things that could happen that I do not know of. Sometimes they say there is a high risk but I do not know what actually happens there. What if I do not attend ante-natal care and give birth at home and the baby dies or I lose a lot of blood. I would cause a lot of problems for the people at home. I wasn't thinking of all that at the time. I started feeling pains yesterday and sat at home. I was aware that it was not period pains. Eventually I gave birth. I had no guilt that I gave birth to twins. My husband got back from work, saw what had happened and said nothing.

Researcher: Who delivered the babies?

Participant: I delivered them. I cut the cord. My children were not home at the time. They were visiting my aunt.

Researcher: What happened when your husband arrived?

Participant: He could not look at me. He called for a car that took me to the clinic

Researcher: What happened at the clinic?

Participant: They shouted for me at the clinic. They asked why I never attended ante-natal care because it was not the first pregnancy. I could not answer them because I have no reason.

Researcher: How did you feel delivering at home? Did you know that you were carrying twins?

Participant: I did not know that it was twins. I delivered the first one. When the second one came I thought it was the placenta so I took the first one and covered him with a towel. Then I took the second one and covered him with a towel. I then pushed out the placenta. I cut the cords. There were two cords. I was so embarrassed thinking what if the children were around. They would have seen things they aren't supposed to. I am embarrassed.

Researcher: Did they cry?

Participant: Yes they did but they are small

Researcher: Did you accept your situation?

Participant: Yes I did because there is nothing that I can do. They are my babies and I am glad that they are alive. I am going to show them love and go home with them

Researcher: Where are the babies now?

Participant: They are in ICU.

Researcher: What do you think can be done to encourage women to attend ante-natal care?

Participant: Eish I can't really say that I know because usually home based carers in the community visit our homes to check on us when they don't see us at the clinic. I do not know what other option there is..

Researcher: What do you think would have made you attend ante-natal care?

Participant: You asked me if there was someone I speak to about my problems. If that person was there I would have explained my problems to them. I would have told them that I do not want the baby and they'd advice me accordingly.

Researcher: Do you want to ask or add anything?

Participant: No I do not have anything to ask

Researcher: Thank you for your input.

APPENDIX J: SENGWALWA SA GO NGWALWA

Monyakišiši: Leina la ka ke Rebecca. Ke šoma ka Ward ya pelego. Ke dira masters degree ya ka. Ke na le tumelelo go tšwa go Yunibesithi, Kgoro ya Maphelo le Sepetlele go kgoboketša data go tšwa go basadi. Ke dira nyakišišo. Dinyakišišo di theilwe godimo ga basadi bao ba sa tsenego tlhokomelo ya pele ga pelego ge ba imile. Ke nyaka go hwetša mabaka a bona a go se be gona tlhokomelong ya pele ga pelego le seo ba ka se šišinyago gore ba dirwe gore ba kgone go tsenela tlhokomelo ya pele ga pelego. Mohlomongwe go na le sekgoba seo se swanetšego go tlatšwa. Na o a kwešiša?

Motšearolo: Ee ke a kwešiša .

Monyakišiši: Ke ya go le botšiša dipotšišo tše mmalwa tšeo di tlogo go nthuša go kwešiša gore ke ka lebaka la eng o se wa tsenela tlhokomelo ya pele ga pelego. Na o a kwešiša?

Motšearolo: Ee ke a dira

Monyakišiši: Ke ya go le botšiša dipotšišo tše mmalwa tšeo di tlogo go nthuša go kwešiša gore ke ka lebaka la eng o se wa tsenela tlhokomelo ya pele ga pelego. Na o a kwešiša?

Motšearolo: Ee ke a dira.

Monyakišiši: Ke kgopela go go rekota ka mabaka a go ngwalolla. Direkoto di tla phumolwa. Ga ke ye go šomiša leina la gago. O se ke wa mpotša leina la gago. Se e tla ba sa poraebete. Hle o se ke wa araba ka ee/aowa goba nod hlogo ya gago. Bolela ka go hlaboša. Hlalosa dikarabo tša gago ka botlalo. Ikwe o lokologile. O ntumelela?

Motšearolo: Ee ke a dira .

Monyakišiši: O na le mengwaga ye mekae?

Motšearolo: Mengwaga ye 38.

Monyakišiši: O imile ga kae?

Motšearolo: Ye e be e le boimana bja seswai.

Monyakišiši: O na le bana ba bakae ka gae?

Motšearolo: Ke na le bana ba šupago ka gae.

Monyakišiši: O na le bana ba bakae bjale?

Motšearolo: Ke na le bana ba senyane bjale. Ke na le mafahla bjale.

Monyakišiši: Mpolelele mengwaga ya bana ba gago ka tatelano ya bona

Motšearolo: Motho wa go belegwa ka leitšibulo o na le mengwaga ye 17. Ya bobedi ke 14, ya boraro ke 12, ya bone ke ya mengwaga ye 10. Ya bohloko ke mengwaga ye šupa. Ya botshelela ke mengwaga ye mehlano. ya mafelelo e na le mengwaga ye mebedi gomme ke na le mafahla bjale.

Monyakišiši: Na o a šoma?

Motšearolo: Aowa ga ke dire.

Monyakišiši: O iphediša bjang le bana ba gago?

Motšearolo: Tatago bona ka gae o a ba thekga. Ke dula le monna wa ka. Ke yena a šomago.

Monyakišiši: O dula kae?

Motšearolo: Ke dula ka Armoed.

Monyakišiši: Ke kliniki efe yeo o e šomišago go Armoed? Kliniki ya kgauswi.

Motšearolo: Re diriša armoed Clinic, e wela ka tlase ga Mapela.

Monyakišiši: Kliniki e kgole gakaakang le moo o dulago gona?

- Motšearolo: Ke bokgole bjo bonyenyane ka gobane ke swanetše go swara thekisi ge ke eya moo. Ke sekgala go tloga mo go ya toropong. Tefo ya thekisi ke R12. E kgole ka maoto eupša gantši ke sepela ka maoto.
- Monyakišiši: O na le motho yo a hlokomelago bana ba gago ge o eya kliniki?
- Motšearolo: Ee ke a dira. Ke rakgadi wa ka. Ga a dule kgole le moo ke dulago gona. Ke iša bana ba ka moo ge ke eya felotsoko.
- Monyakišiši: O ile sekolong?
- Motšearolo: Ee ke dirile. Ke ile ka fela ka Mphato wa 11.
- Monyakišiši: Ke ka lebaka la eng o se wa tšwela pele?
- Motšearolo: Ke ile ka ima ka 2007 ge ke be ke swanetše go dira marematlou a ka. Go be go se na motho yo a bego a ka hlokomela ngwana wa-ka. Ke be ke sa dula ka gae ka nako yeo. Mma o be a šoma ka fao ke ile ka tšea sephetho sa go no e tlogela.
- Monyakišiši: Ke ka lebaka la eng o se wa ka wa boela morago?
- Motšearolo: Ah ga ke kgone le go bolela gore ke na le lebaka eupša ke be ke le morutwana wa godimo. Ke kgona go bala le go ngwala.
- Monyakišiši: Na o kile wa šoma felotsoko pele?
- Motšearolo: Ee ke šomile pele ka Kempton Park pick n pay. Ke be ke dira go tšea setoko. Ba re ke tsamaye batho.
- Monyakišiši: Naa go na le motho bophelong bja gago yo o ka bolelago le yena ge o na le mathata goba ge o imetšwe?
- Motšearolo: Ga ke na motho.
- Monyakišiši: Go thwe'ng ka monna wa gago?

- Motšearolo: Ga ke kgone go bolela le yena. O a nkgoeletša. Ke bolela le yena feela ge a be a e-na le bjala bja go nwa. Ntle le seo a ka se kgone go dula fase gomme a bolela le nna.
- Monyakišiši: Go thwe'ng ka rakgadi wa gago?
- Motšearolo: Rakgadi ga a dule ntlong ya gagwe bjale ka ge a sa tšwa go hwetša mošomo. O boa fela kgwedi e fela.
- Monyakišiši: Naa wena le monna wa gago la setšhaba le lebile go yo mongwe le yo mongwe? Na go na le khutšo ka gae ga gago?
- Motšearolo: Eish Ga go na bophelo ka gae ga gešo. Ke feela eh eo. Ge e le gabotse ke ile ka hudugela go yena le ge lapa lešo le be le le kgahlanong le yona. Mafelelong mma o ile a mpotša gore ka ge ke mo kgethile ga go na selo seo a ka nthušago ka sona. Ke be ke sa kgone go bona dilo tšeo ba di bonego go yena ka nako yeo.
- Monyakišiši: Ba bone eng go yena?
- Motšearolo: Ba bone gore o be a se botse go nna. O be a rata dilo. Ba be ba kgona go bona gore e be e se motho yo nka bago le bokamoso le yena.
- Monyakišiši: Ke eng seo a se dirago seo o sa se ratego?
- Motšearolo: O rata bjala le go dira monyanya. Gape o rata basadi. Ke lekile go bolela le yena ka seo eupša o boela morago mekgweng ya gagwe ya kgale ka morago ga dibeke tše 2-3. Go swana le ge a fetoga go ba yo mokaone ka nako e kopana ya tome e le feela go nkgahla.
- Monyakišiši: O thabile?
- Motšearolo: Ga ke thabe. Ke ile ka dula feela ka baka la bana gomme ga go na moo nka yago gona. Ke tšere boemo bjo bofsa bjale

felotsoko eupša ga se ka mmotša lebaka la potego. Ke mmoditse gore it for the children since ba gola.

Monyakišiši: O bolela le mmago ka mathata a gago?

Motšeakarolo: Aowa ga ke dire bjalo. Ga a tsebe le gore ke be ke imile e bile ke belege. Ga se a ke a kwešiša gore ke ka lebaka la eng ke be ke na le bana ba ka moka. O ile a botšiša gore ke ka baka la'ng ke be ke tla ba le bana le monna yo bophelo bja gagwe bo bego bo se gona ka thulaganyo. Monna waka ke yena a otlelago wedge magareng ga rena.

Monyakišiši: O go fa tšhelete ya bana?

Motšeakarolo: Ee o mpha tšhelete kgwedi end go reka dijo le dilo tše dingwe tša bana. Bana ga ba hloke selo. O no ba a sa nthekgga maikutlong go nna.

Monyakišiši: O ka go bolela mareo le mmago?

Motšeakarolo: Re a bolela eupša ga ke kgone go abelana mathata a ka le yena. Ga ke mo tšee e le motswadi ka gobane ke mo fošeditše kudu. Ke feela bjale ka ge ke lemoga gore nka se be mo ke lego gona ge nkabe ke ile ka mo theeletša.

Monyakišiši: O mo fošitše bjang?

Motšeakarolo: Ke tlogetše sekolo ka morago ga go ima. O ile a mpotša gore ke boele sekolong. Ke ile ka itira eka ga se ka mo kwa. O ile a mpotšiša gore ke be ke tla fihlelela eng ka go se boele sekolong. O ile a mpotša gore nka se be le bokamoso gomme ka se hwetše mošomo ntle le go ya sekolong. O rile ga a nyake gore ke feleletše ke swana le yena. Ke lemoga gore I'd be something now ge nkabe ke mo theeditše.

Monyakišiši: O se ke wa ba le bana babo rena.

Motšearolo: Ke na le ngwanabo rena yo monyenyane. Re ba babedi feela.

Monyakišiši: Ke nyaka go tseba gore ke ka lebaka la eng o se wa ka wa tsenela tlhokomelo ya pele ga pelego. Ke ka lebaka la eng o belege ntle le go tsenela tlhokomelo ya pele ga pelego?

Motšearolo: Ga ke kgone go bolela e le ka kgonthe gore ke na le lebaka. Ke ile ka botša monna wa ka ka boimana ka morago ga go hwetša seo. O ile a bolela gore ga a nyake ngwana le gore ke swanetše go ntšha mpa. Ke ile ka mmotša gore ga se ka phuthologa ka yona gomme ke be ke sa kgone go e dira ka gobane ke be ke se na phihlelo ya dilo tše bjalo. Ke ile ka mmotšiša gore ke eng ge e ba ke feleletša ke e-hwa. Ke ile ka botšiša gore go tla direga eng ka bana ba rena ka ge a se na tswalano e botse le lapa lešo. O ile a mpotša gore ka ge ke be ke dira phetho ya go mo boloka, o be a ka se mo nee goba go thuša selo le ge e le sefe e ka ba nakong ya boimana goba ka morago ga bjona. Ke ile ka mmotša gore ke be ke tseba gore ga go bjalo ka ge eka ga a nyake ngwana, e mabapi le tšhelete. O dula a ngongorega ka tšhelete. Ka gona nka se kgone go bolela e le ka kgonthe ke na le lebaka la go se be gona tlhokomelong ya pele ga pelego. Ke no lahlegelwa ke kholofelo gomme ka tšea sephetho sa gore ke tla gafa masea gore a godišwe gomme a se a iše gae. O ile a mpha tšhelete gomme a mpotša gore ke ye sepetlele. Ke ile ka tla gomme ka boela gae. Ke moka ke ile ka mmotša gore ga se ka hwetša motho yo a bego a swanetše go nthuša. Letswalo la-ka le be le ka se ntumelele. I don't know gore go ntšha mpa go tla bjang. Ke be ke tšhogile go hwa gomme ka tlogela bana ba ka.

Monyakišiši: Na o kile wa ba gona tlhokomelong ya pele ga pelego?

Motšearolo: Ee ke ile ka ba gona go boimana bja ka bja peleng.

- Monyakišiši: O hweditše neng gore o imile?
- Motšearolo: E bile ka Hlakola. Nako ya ka ya mafelelo e bile ka la 14th la December. Mpa waka gantši ga o bontšhe ge ke imile gomme ka dinako tše dingwe ke tšwela pele ka period ya ka
- Monyakišiši: Ke ka lebaka la eng o se wa ya kliniki gomme wa hwetša pukwana ya pelego?
- Motšearolo: Ga ke na lebaka. Go na le mohlakomedi wa ka gae mo tikologong ya rena. Ke lapa la monna wa ka. O ile a tla ntlong ya ka go tlo mpotšiša eupša ka letšatši leo nna le monna wa ka re be re lwetše. Ga se ka bolela le yena gabotse. Ke be ke sa nyake le go kwa seo a bego a swanetše go se bolela go nna.
- Monyakišiši: Na o tseba bohlokwa bja go tsenela tlhokomelo ya pele ga pelego?
- Motšearolo: Ee ke a dira.
- Monyakišiši: Mpolelele ka yona.
- Motšearolo: Bohlokwa ke gore ka nako ye nngwe kudu tabeng ya ka, e re ke fe mohlala ka nna. Ye e be e le boimana bja-ka bja seswai. Go na le dilo tše dintši tšeo di ka diregago tšeo ke sa di tsebego. Ka nako ye nngwe ba re go na le kotsi ye kgolo eupša ga ke tsebe gore go direga eng ge e le gabotse moo. Go thwe'ng ge e ba ke sa tsenele tlhokomelo ya pele ga pelego gomme ka belega ka gae gomme lesea le a hwa goba ke lahlegelwa ke madi a mantši. Ke be ke tla baka mathata a mantši go batho ba ka gae. Ke be ke sa nagane ka tšeo ka moka ka nako yeo. Ke thomile go kwa bohloko maabane gomme ka dula ka gae. Ke be ke lemoga gore e be e se dihlabi tša nako. Mafelelong ke ile ka belega. Ke be ke se na molato wa gore ke belege mafahla. Monna wa ka o

ile a boa mošomong, a bona seo se diregilego gomme a se bolele selo.

Monyakišiši: Ke mang yo a ilego a neela masea?

Motšeakarolo: Ke di beile. Ke ile ka sega thapo. Bana ba-ka ba be ba se gona gae ka nako yeo. Ba be ba etela rakgadi wa ka.

Monyakišiši: Go diregile eng ge monna wa gago a fihla?

Motšeakarolo: O be a sa kgone go ntebelela. O ile a bitša koloi yeo e ilego ya nkiša kliniki.

Monyakišiši: Go diregile eng kliniki?

Motšeakarolo: Ba ile ba nkgoeletša ka kliniki. Ba ile ba botšiša gore ke ka baka la'ng ke se ka ka ka ba gona Ante-Natal Care ka gobane e be e se boimana bja mathomo. Ke be ke sa kgone go di araba ka gobane ga ke na lebaka.

Monyakišiši: O ile wa ikwa bjang o belega ka gae? Na o be o tseba gore o be o rwele mafahla?

Motšeakarolo: Ke be ke sa tsebe gore ke mafahla. Ke ile ka tliša ya pele. Ge ya bobedi e fihla ke ile ka nagana gore ke placenta ka fao ke ile ka tšea ya mathomo gomme ka mo khupetša ka toulo. Ke moka ka tšea ya bobedi gomme ka mo khupetša ka toulo. Ke moka ke ile ka kgoromeletša ka ntle placenta. Ke ile ka sega dithapo. Go be go e-na le dithapo tše pedi. Ke be ke le dihlong kudu ke nagana gore go thwe'ng ge nkabe bana ba le gona. Ba be ba tla bona dilo tšeo ba sa swanelago go di dira. Ke hlabja ke dihlong.

Monyakišiši: Ba lla?

Motšeakarolo: Ee ba dirile eupša ke tše nnyane.

Monyakišiši: O amogetše seemo sa gago?

- Motšearolo: Ee ke dirile ka gobane ga go na selo seo nka se dirago. Ke masea a ka gomme ke thabela gore a a phela. Ke ya go ba bontšha lerato ke ye gae le bona.
- Monyakišiši: Masea a kae bjale?
- Motšearolo: Ba ka baneng ba go lwala.
- Monyakišiši: O nagana gore ke eng seo se ka dirwago go hlohleletša basadi go tsenela tlhokomelo ya pele ga pelego?
- Motšearolo: Eish I can't really say that I know because gantši bahlokamedi ba gae ba go thewa ka gae ba etela magae a rena go re lekola ge ba sa re bone kliniki. Ga ke tsebe gore ke kgetho efe e nngwe yeo e lego gona.
- Monyakišiši: O nagana gore ke eng seo se bego se tla go dira gore o be gona tlhokomelong ya pele ga nako ya pele ga nako?
- Motšearolo: O mpotšišitše ge e ba go na le motho yo ke boelago le yena ka mathata a ka. Ge nkabe motho yoo a be a le gona nkabe ke mo hlaloseditše mathata a ka. Nkabe ke ba boditše gore ga ke nyake ngwana and they'd advice me aspally.
- Monyakišiši: O nyaka go botšiša goba go oketša selo?
- Motšearolo: Aowa ga ke na selo seo ke se botšišago.
- Monyakišiši: Ke leboga ditšhupetšo tša gago.

Appendix K: Letter from editor



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TO WHOM IT MAY CONCERN

I, Erica Jean Webster, hereby confirm that I have provided a language editing service to Makgaka Rebecca Kgorane (Student No. 201703302) for her Master of Nursing dissertation: *Contributory Factors Leading to Non-Attendance for Ante-Natal Care by Pregnant Women in a Selected Public Hospital in Limpopo Province, South Africa.*

I have a BA Degree from the University of the Witwatersrand, majoring in English and Industrial Psychology. I have approximately 15 years' freelance writing experience and, over the past seven years, have assisted many students and academics with language editing, formatting, and proofreading proposals, research reports, dissertations/theses, and journal articles.

Please feel free to contact me should you require further information.

Yours sincerely

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