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With the title:

EXPLORATION OF FACTORS CONTRIBUTING TO THE NON-ATTENDANCE OF ANTENATAL CARE BY PREGNANT WOMEN AT KING CETSHWAYO DISTRICTIN KWAZULU-NATAL

FACULTY OF SCIENCE AND AGRICULTURE

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Declaration

This is to certify that this work is entirely my own and not of any other person. All sources have been explicitly acknowledged (including citations of published and unpublished sources). The work has not been previously submitted in any form to the University of Zululand or to any other institution for assessment or for any other purpose.

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Abstract

Introduction: Antenatal Care (ANC) along with family planning, skilled delivery care, is the key element of services aimed at improving maternal and child healthcare. According to the World Health Organization (WHO), attendance of ANC is significant for a routine follow-up care including screening to intensive life support during pregnancy up to delivery. During Antenatal Care (ANC) visits, a number of examinations such as taking of blood pressure to detect hypertension, urine analysis to detect any possible presence of proteins and measuring of weight are conducted to establish foetal growth restrictions. Most pregnant women do not attend scheduled ANC visits during their pregnancy, putting themselves and their unborn babies at risk of pregnancy- related complications.

Aim of the study: The study was aimed at exploring and describing factors contributing to non- attendance of Antenatal Care by pregnant women at King Cetshwayo District in KwaZulu-Natal.

Methodology

A qualitative, explorative, descriptive design was used to conduct the study. The study was guided by Nola Pender's Health Promotion Model. The study population consisted of 12 pregnant women attending ANC at King Cetshwayo health district in KwaZulu-Natal who were purposefully sampled. Data collection was determined by data saturation and analysed thematically.

Findings

The findings of the study revealed four major themes such as the location of PHC facilities, cultural beliefs, knowledge deficits and financial constraints. The study revealed several challenges hindering pregnant women from attending ANC visits which may pose risks to pregnant women and their unborn babies leading to increased maternal mortality rates.

Conclusion and recommendations of the study

The study findings revealed that most pregnant women are faced with various challenges regarding the attendance of the ANC. Therefore, the researcher

recommended that pregnant women should be taught about pregnancy and related complications including the prevention of maternal mortality by encouraging them to attend all ANC scheduled visits. More campaigns regarding pregnancy and the importance of ANC attendance by pregnant women should be organised and conducted in the district. Existing policies regarding the initiation of ANC attendance must be reinforced to ensure that they are implemented. Moreover, more research should be conducted regarding the phenomenon to include a wider range of populations and study areas and to broaden the scope of the research topic.

Dedication

First and foremost, I would like to give thanks to God because I made my request known to Him and He gave me strength and courage to realise my dream. I would like to express my most sincere gratitude to my parents Mr S.P. Nkonzo and Mrs J.P. Nkonzo for encouraging me to be academically rich. Thank you. To my siblings, let us continue to study.

'The Lord is not slow to fulfil his promise as some count slowness, but is patient toward you, not wishing that any should perish, but that all should reach repentance (2 Peter 3:9)'.

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List of Acronyms

Acronym	Full term
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARV	Antiretroviral Therapy
BANC	Basic Antenatal Care
DOH	Department Of Health
HIV	Human Immunodeficiency Virus
KZN	KwaZulu-Natal
MMR	Maternal Mortality Ratio
OSS	Operation Sukuma Sakhe
PHC	Primary Health Care
SDGs	Sustainable Development Goal
SSA	Sub-Saharan
STI	Sexually Transmitted Infection
UNICEF	United Nation Children Fund
WHO	World Health Organization

Glossary of Terms

- Antenatal Care – refers to the maternal healthcare service rendered to the pregnant women during pregnancy and delivery of the infant by a trained midwife or medical practitioner (Prothero 2010:39).
- First trimester – is the period in pregnancy from conception to 13 weeks pregnant.
- Foetus – an unborn child from the end of seventh week after gestation when all the internal and external organs are present and undergoing development until birth (Prothero 2010:229).
- Maternal mortality ratio – is defined as the number of women dying in the area, from conception to within 42 days (six weeks) after delivery per total number of live births for that area.
- Pregnancy – it is regarded as the period of foetus development in a woman during conception up to the delivery period (Prothero 2010:476).
- Primary healthcare – continued care of a healthcare consumer by the same individual or team; it stresses holistic care and includes identification, management and referral of health problems (Protheros, 2010:4).

CHAPTER 1

1.1 INTRODUCTION AND BACKGROUND OF THE STUDY

Antenatal Care (ANC) along with family planning, skilled delivery care, is the key element of services aimed at improving maternal and child healthcare. ANC was first established during the 20th century in Europe and North America and finally in all developed countries but underdeveloped countries are still lacking facilities (Amna 2015:1). The World Health Organization (WHO) (2012) indicated that ANC is a significant variable. It involves having one or more visits to a midwife during pregnancy, including routine follow up provided to all woman at primary care level from screening to intensive life support during pregnancy up to delivery (Amna 2015:1).

When pregnant women attend scheduled Antenatal Care visits, a number of examinations are done including taking blood pressure to detect hypertension, urine analysis to detect any possible presence of proteins and measuring of weight to establish foetal growth restrictions (DOH 2015:35). Pregnant women are counselled and tested for Human Immune Virus (HIV). Pregnant women who test positive for HIV are initiated with antiretroviral therapy (ART) to eradicate the passage of the virus to an unborn child (DOH 2015:8). According to Solarin and Black (2013:359), Antenatal Care visits are regarded as an important time to render health education to pregnant women regarding healthcare issues such as important diet, rest, exercise and breastfeeding during pregnancy. These Antenatal Care teachings are aimed at equipping women with knowledge about pregnancy. Antenatal Care is a key strategy for reducing maternal morbidity and mortality by affording increased chances of the timely identification of high risk pregnancies.

Regular Antenatal Care attendance does not only avoid complications associated with pregnancy but also educate women regarding how to prepare themselves for labour and post-natal period. This assists women in taking care of themselves during pregnancy and post-delivery, including caring for their babies. In most cases, women do not attend ANC on a regular basis as scheduled. Amna (2015:38) revealed the statistics regarding the prevalence of late ANC bookings which is approximately 71 % of women who had no past obstetrical complications, in relation to 76.6% of women who did not book ANC due to traveling distance to the healthcare centre. Moreover, there are millions of women in developing countries who are more likely to develop life-

threatening pregnancy-related complications because of the lack of access to adequate and good Antenatal Care (Hijazi, Alyahya, Sindiani, Saqan and Okour 2018:1). These complications range from anaemia, hypertension, and diabetes among others. Efforts and investment are needed to sustain and accelerate progress if countries and the international community are to prevent maternal and child morbidity in reaching the related Sustainable Development Goals (SDGs) (Lattof, Moran, Kidula, Moller, Jayathilaka, Diaz and Tuncalp 2017:927). These authors further state that the timing of the first Antenatal Care visits is paramount for ensuring optimal health outcomes for women and their unborn babies, and it is recommended that all pregnant women initiate Antenatal Care in the first trimester of pregnancy (Lattof, Moran, Kidula, Moller, Jayathilaka, Diaz and Tuncalp 2017: 927). Hence it is imperative that pregnant women attend ANC visits. Therefore, the researcher intended to explore and describe factors contributing to the attendance of Antenatal Care by pregnant women in King Cetshwayo Health district.

1.2 PROBLEM STATEMENT

ANC delivered at various PHC institutions is a key strategy of the National Department of Health to improve the mother and child healthcare. Worldwide, approximately 515,000 women die from pregnancy-related complications each year (Andrew, Pell, Angwin, Auwun, Daniels, Mueller, Phuanukoonnon and Pool 2014: 1). South Africa is one of the few countries in the world with poor performance regarding maternal health and faced with difficulty in improving the outcomes of maternal healthcare and perinatal care (Schoon and Molometsi 2012:784). In spite of the WHO (2012) recommendations that pregnant women must attend four ANC visits for the duration of a normal pregnancy, attendance varies greatly among pregnant women. Poor ANC attendance has a substantive impact as one missed ANC visit results in twofold risks of maternal and child deaths due to mis-diagnosed pregnancy complications. Various risk factors contributing to poor ANC attendance have been revealed including distances to the healthcare facilities, socio-economic factors, and language barriers in ANC. These factors are not exhaustive as many pregnant women still do not attend their scheduled ANC visits, increasing the number of maternal morbidities. In 2018, the Minister of Health in KwaZulu-Natal reported that there is a slight decrease in maternal deaths from 393 in 2010 to 220 in 2016 (Department of Health 2017:10). Therefore, healthcare workers, Operation Sukuma Sakhe (OSS) and Community Care Givers should work together to

assist in further decreasing the statistics (Department of Health 2017:10). Adequate ANC attendance can be considered as a cornerstone of maternal and perinatal healthcare. Hence the study intended to explore factors contributing to the attendance of ANC by pregnant women at King Cetshwayo District KwaZulu-Natal.

1.3 AIM OF THE STUDY

The study was aimed at exploring and describing factors contributing to non-attendance of Antenatal Care by pregnant women at King-Cetshwayo District in KwaZulu-Natal.

1.4 OBJECTIVES OF THE STUDY

The objectives of the study were to:

- Explore factors contributing to attendance of Antenatal Care by pregnant woman.
- Describe measures of improving Antenatal Care attendance by pregnant women.

1.5 SIGNIFICANCE OF THE STUDY

Significance of the study refers to the level of certainty in the result of the study, which means that the research study should have the potential to contribute to health sciences knowledge and the health of the community and profession in a meaningful way (Brink, Van der Walt and van Rensburg and 2012:64). In this study, the findings were recommended to be implemented by the Department of Health at King Cetshwayo District in KwaZulu-Natal. The findings can also be useful as a recommendation to review policies, guidelines for maternal healthcare and procedures rendering ANC services to pregnant women. The study findings might also assist in improving and encouraging pregnant women's attendance to ANC at King Cetshwayo District healthcare institutions. Moreover, the findings of the study could be used by other researchers to conduct more research regarding the phenomenon. The study followed the chapter outline as indicated in **Table 1**.

1.6 Table 1 represents the outline of the study chapters.

Chapter	**Title**	**Chapter outline**
Chapter 1	Overview and background of the study	Introduction, the background, problem statement, aim, objectives, significance of the study and conclusion
Chapter 2	Literature review	Introduction, Historical view of Antenatal Care attendance, Review of global, Sub-Saharan African countries and the South African context of Antenatal Care including factors contributing towards Antenatal Care attendance and theoretical framework
Chapter 3	Research methodology	Research paradigm, design and methodology, including the population, sampling, data collection, data analysis, ethical considerations and trustworthiness
Chapter 4	Presentation of the study findings	Presentation of study findings from data analysis
Chapter 5	Discussion of the findings, conclusion, limitations of the study and recommendations	Discussion of findings with the application of Health Promotion Model (HPM), conclusionabout the perceptions of pregnant women regarding the attendance of ANC at King Cetshwayo District in KwaZulu-Natal, and recommendations

1.7 CONCLUSION

This chapter provided an overview of the study, problem statement, aim, objectives of the study as well as an outline of chapters comprising the dissertation. The following Chapter 2 will discuss the literature review about the factors contributing to attendance of Antenatal Care and theoretical framework in order to gain a broader perspective regarding the phenomenon.

CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION

The study overview was discussed in Chapter 1. Chapter 2 reviews literature under the following headings: Global context of Antenatal Care, Antenatal Care in sub- Saharan countries, Antenatal Care in South Africa and Antenatal Care in KwaZulu-Natal. Nolar Pender's Health Promotion Model is discussed as a theoretical framework guiding this study. The researcher used the library to search for books and journals that are related to the topic. A set of keywords and concepts such as Antenatal Care, pregnant women, ANC visits were set aside for the use during literature search. The internet search engines such as Google Scholar, EBSCOhost and World Wide Web used to access articles, journals and eBooks, using the keywords. The inclusion criteria for literature search were publications less than five years old. While the exclusion criteria for literature sources was information from the publications older than five years unless the information was of value for the study. The literature used mostly was from the primary sources regarding the phenomenon.

2.2 GLOBAL CONTEXT OF ANTENATAL CARE

Worldwide, the World Health Organisation (WHO) stipulated the significance of pregnant women to attend Antenatal Care from early stage of gestation on a regular basis to determine and monitor their healthcare status and the foetus to enable early diagnosis and management of any childbirth complications (WHO 2012:1). The attendance of Antenatal Care further equips pregnant women with self-care knowledge during pregnancy and how to take care of themselves and their new-born babies after delivery. According to WHO (2012:1), it is recommended that pregnant women must at least attend a minimum of four antenatal visits during a normal pregnancy, whereasin an abnormal pregnancy with complications, women should attend high risk clinic for ANC visit for the entire duration of pregnancy.

In Netherlands, pregnant women without complicated pregnancies receive ANC from primary healthcare midwives, while in Belgium, pregnant women consult obstetricians directly for ANC (Broeck, Feijen de Jong, Klomp, Putman, and Beeckman 2016:2). This signifies that in other countries, maternal health is the priority and they make it effortlessly accessible. In the United Kingdom (UK), maternal mortality reports have

identified late booking for Antenatal Care as a significant risk factor for maternal death for all women, and particularly black and minority ethnic women (Haddrill, Jones, Mitchell and Anumba 2012:1). This is supported by Garcia, Ali, Papadopoulas and Randhawa (2015:2) who postulated that pregnant women of different ethnicities experience barriers in accessing antenatal services such as language barriers whereby women do not have access to properly skilled translators. Another barrier is unawareness of service provision and socioeconomic status including educational status. Language barrier is deemed to have influence on women; hence, they become reluctant to attend ANC fearing being exposed to humiliation by healthcare provider

2.3 ANTENATAL CARE IN SUB-SAHARAN COUNTRIES

ANC has been identified as pivotal in improving maternal and child healthcare across the world. ANC attendance provides pregnant women with an opportunity to ask questions and report their concerns to midwives regarding their pregnancies. Consultation during pregnancy enables appropriate screening, identification and management of risks earlier for the purpose of timely referral for further treatment. Tylor, Sealy and Roberts (2017:17) postulated that women rarely attend ANC during their first trimester of pregnancy despite the emphasis done on the importance of ANC attendance during pregnancy. These risky behavioural practices by women expose them to chances of undiagnosed conditions that can occur during pregnancy.

The ANC model which was recommended by WHO states that pregnant women should at least attend four ANC visits for the duration of their pregnancies. This model has been adopted in Malawi due to high maternal mortality rate (Tylor *et al.* 2017:17). Despite the adoption of this model, Malawi was reported among the highest maternal mortality rate with an approximately 574 women per 100, 000 live births who die during pregnancy in comparison to other industrialised countries (UNICEF 2012:2). Whereas, in countries such as Burundi, Tanzania and Kenya respectively, maternal mortality rates in 100, 000 live births cases are just under 400 deaths in the continent.

Poor attendance of ANC escalates maternal mortality rates contributed by preventable risk factors such as HIV screening, testing and treatment, poor nutritional status early detection, treatment and referral of complicated pregnancies. Fagbamigbe and Idemudia (2015:1) reported that in Nigeria, pregnant women raised poor financial status, long distances to the healthcare centres and unavailability of means of transport as major barriers from attending ANC despite their willingness. These risk factors postulated by pregnant women in Nigeria pose a risk to women with high blood pressure, diabetes mellitus and other chronic diseases that need to be monitored and controlled during pregnancy. Although the studies conducted in these countries revealed few factors contributing to poor ANC to pregnant women, these were not exhaustive as maternal mortality rates are still alarming.

2.4 ANTENATAL CARE IN SOUTH AFRICA

In 1994, South Africa became a democratic country with the inception of changes including in the healthcare sector whereby free and comprehensive ANC were provided to all pregnant women (Department of Health 2017:3). Although the ANC services are provided freely to pregnant women in this country, risk factors such as socio-economic factors, health condition of pregnant women, accessibility and availability of ANC are among barriers contributing to poor utilization of the service (Lau, Cassidy, Hacking, Brittain, Haricharan and Heap 2014:2). Compared to other middle-income countries, South Africa has 97% of ANC coverage" (Kaswa, Rupesinghe and Mbenza 2018:2). However, attendance is still obstructing the optimal benefits of ANC services. Sixth report on the confidential inquiries into maternal deaths highlights late booking as one of the patient-related avoidable factors" (Kaswa, Rupesinghe and Mbenza 2018:2). Because poor attendance of ANC has been specifically identified as a cause for concern, this study aimed to explore contributing factors to attendance of ANC by pregnant women at King Cetshwayo Health district in KwaZulu-Natal, South Africa.

According to Smith (2016:2) cited by WHO, in South Africa every 100,000 live births in the country about 138 women die due to pregnancy and childbirth complications compared to other developing countries. The National Department of Health (NDOH) gave an instruction in 2007 that all healthcare institutions providing ANC should implement Basic Antenatal Care (BANC) approach by the year 2008 (NDOH 2012:6). This approach was adopted by South Africa to improve maternal health during ANC. Ngxongo, Sibiya and Gwele (2017:12) concur with the notion that BANC implementation is regarded as a positive measure in improving quality of ANC in Primary Healthcare (PHC) clinics. Thus, the focus of this study is to explore factors contributing to the attendance of Antenatal Care by pregnant women.

2.5 PROVISION OF ANTENATAL CARE SERVICES IN KWAZULU-NATAL

In KwaZulu-Natal (KZN) some of the health facilities do not offer ANC services on a daily basis, they have specific days for ANC according to the findings of the study that was conducted in KZN eThekwini District (Ngxongo, Sibiya and Gwele 2016:8). This practice could contribute to the number of women not attending ANC on a regular basis. The Department of Health (DOH) classified 60% of maternal deaths to be

probably preventable indicating mostly poor quality of care during the antenatal, intrapartum and postnatal periods (Department of Health 2013:4). Proper ANC rendered to pregnant women could reduce the escalated number of unwanted maternal mortality rate (MMR).

KwaZulu-Natal province is one of the provinces with high number of MMR in South Africa due to poor ANC services provided to pregnant women. Ngxongo *et al.* (2017:6) revealed that approximately 90% of pregnant women in South Africa have access to maternal healthcare, but an estimated percentage of approximately 83.5% died during pregnancy and childbirth between year 2008 and 2010 with a history of not attending ANC according to the scheduled number of appointments. The increased numbers of maternal mortality deaths raise questions regarding the causes of deaths in maternal healthcare which might be due to poor attendance of ANC to detect complications at an early stage of pregnancy. Poor clinical assessment, delays in referral, not following standard protocols and not responding to abnormalities in monitoring of patients were the most common health care provider avoidable factors. Moreover, the lack of appropriately trained doctors and nurses has emerged as a significant contributory factor in maternal deaths being recorded as 15.6% and 8.8% for doctors and nurses respectively (Department of Health 2013:4).

2.6 FACTORS CONTRIBUTING TO POOR ATTENDANCE OF ANTENATAL CARE BY PREGNANT WOMEN

Nationwide, there are various factors contributing to poor Antenatal Care attendance by pregnant women leading to barriers for pregnant women to commence ANC visits before 20 weeks as recommended by the DOH (DOH 2015:9). These factors need to be taken into consideration because they have a detrimental effect on maternal health outcome and maternal mortality statistics in the country. These factors included the patient's confidentiality, travelling distances to the healthcare facilities, lack of transport, fear of testing positive for Human Immune Virus (HIV).

2.6.1 PATIENTS' CONFIDENTIALITY

According to the Department of Health Patients' Rights Charter (2014:3), every patient has the right to be treated with confidentiality. In the context of health services, this includes the obligation to ensure that patients' confidentiality is protected, information

on health status is not disclosed to the third parties without the consent of the individual. Amnesty International (2014:23) revealed that healthcare workers are trained to respect rights and privacy, and nobody is subject to a procedure or treatment without their full and informed consent.

Mannava, Durant, Fisher, Chersich and Luchters (2015:6) stipulate that attitude and behaviour of maternal healthcare providers are an important element of quality as they influence both positively and negatively how women, partners and their families perceive and experience maternal healthcare during ANC. The behaviour of healthcare workers has great effect on attendance of ANC by pregnant women, due to lack of respect and confidentiality. This is further supported by Mannava *et al.* (2015:6) who state that the lack of respectful care from the providers, such as doctors and midwives lead to dissatisfaction with the health system, diminishing the possibility of seeking ANC. Hence, most pregnant women decide not to attend their local healthcare providers fearing that their medical status information will be compromised by local healthcare workers due to lack of confidentiality.

2.6.2 TRAVELING DISTANCES TO HEALTHCARE FACILITIES

Amnesty International (2014:47) revealed that the South African Constitution indicates that it is the State's obligation to protect, respect and fulfil the right to health including to ensure that all healthcare facilities, goods and services are physically and economically accessible to all, without discrimination. This implies that all healthcare institutions should be affordable to all individuals and must be within safe physical reach for all sections of the population, especially for the marginalized groups such as pregnant women (Amnesty International 2014:47). Most pregnant women residing in rural areas are faced with challenges of having to walk a long distance to reach the healthcare facility during pregnancy to initiate Antennal Care and most of them are unemployed and having financial challenges. Fagbamigbe and Idemudia (2015:2) reveals that long distances to the healthcare facilities along with limited number of ANC providers at various ANC clinics including unavailability of transport negatively affect ANC attendance by pregnant women exposing them to various pregnancy risks. Cronje and Grobler (2009:682) supports this by indicating that adequate transport facilities are usually available in the urban centres but are generally grossly inadequate in rural areas in developing countries. Moreover, in most of these areas

pregnant women cannot travel on bare foot to the healthcare facilities because of long distances. Hence, most pregnant women do not attend scheduled ANC visits during their pregnancies.

2.6.3 FEAR OF TESTING POSITIVE FOR HIV

The manner in which most health workers communicate information about HIV testing process during pregnancy results in pregnant women to believe that the process of HIV testing is mandatory during pregnancy. Amnesty International (2014:56) indicated that most women are aware that HIV testing is part of the prevention of mother-to-child transmission (PMTCT) programme incorporated in ANC services during pregnancy. The study conducted by Kaswa, Rupesinghe and Mbenza (2018:4) revealed that most pregnant women reported that they purposefully book late for ANC because of the fear of testing for HIV. This was because of the fact that HIV testing has impact on the relationship of a pregnant woman because most of them do not receive necessary required support from their partners (Kaswa, Rupesinghe and Mbenza 2018:4). Hence, most women opt to book late in their gestational stage of pregnancy at ANC clinics or avoid attendance of ANC scheduled visits.

2.6.4 OVERBURDENED CLINICS AND SHORTAGE STAFF IN HEALTHCARE FACILITIES

According to Ngxongo *et al.* (2016:11), the practice of not accepting all clients that come to the clinic could potentially increase the number of clients who never initiate ANC, book late and attend ANC poorly, all of which have been identified as contributing to maternal and perinatal deaths. When there are many patients, most nurses feel that they are overworked and resort to instructing patients to go back home and give them certain dates to come for their ANC visits. Kaswa, Rupesinghe and Mbenza (2018:4) concur with the notion by stating that the overburdened public healthcare facilities with shortage of staff often causes barriers to effective ANC services. Furthermore, the authors stated that long ques at the clinics have a negative impact to the attendance of ANC visits by pregnant women due to limited number of staff rendering the service to pregnant women (Kaswa, Rupesinghe and Mbenza 2018:4). Hence, most pregnant women do not attend their ANC scheduled visits.

2.7 THEORITICAL FRAMEWORK

Schmidt and Brown (2009:110) indicate that a theoretical framework guides and provides the structure of the study by linking the abstract to the empirical. Burns and Grove (2007: 238) define a framework as an abstract, logical structure of meaning, such as a portion of the theory, which guides the development of the study and enables the researcher to link the findings to nursing's body of knowledge. The theoretical framework selected for this study was based on Nola Pender's Health Promotion Model (HPM). The HPM denotes that each person has unique characteristics and experiences that affect subsequent action, the HPM can be a useful guide to nursing care in relation to assisting the recipients of nursing care in choosing and carrying out behaviours to increase well-being (George 2010:531).

George (2010:545) states that the theoretical basis of the Health Promotion Model (HPM) is drawn from social cognitive theory, expectancy value theory, and the nursing perspective of human functioning. This theory emphasizes self-direction, and perceptions of self-efficacy. Self-direction is the ability to direct and control one's thinking and actions; perceptions of self-efficacy involve one's view of the personal ability to perform an identified set of actions (George 2010:545). In this study, Nola Pender's HPM five basic human capabilities, namely, symbolization, forethought, vicarious learning, self-regulation and self-reflection were used to guide the study. This framework is relevant to the study due to the fact that the attendance to ANC depends on women's capabilities to make an informed decision, which is self-regulated during pregnancy to attend ANC. Furthermore, the study discussion was informed by pregnant women's views on what ANC attendance symbolises to them, what are their thoughts regarding ANC attendance, what could be learned from ANC attendance, how they regulate their ANC attendance and their personal self-reflection regarding their experiences of attending ANC. Therefore, this theory of HPM will be applied in this study during the discussion of the findings of the study. **Diagram 1**: below represents the schematic Nola Pender's HPM five basic human capabilities.

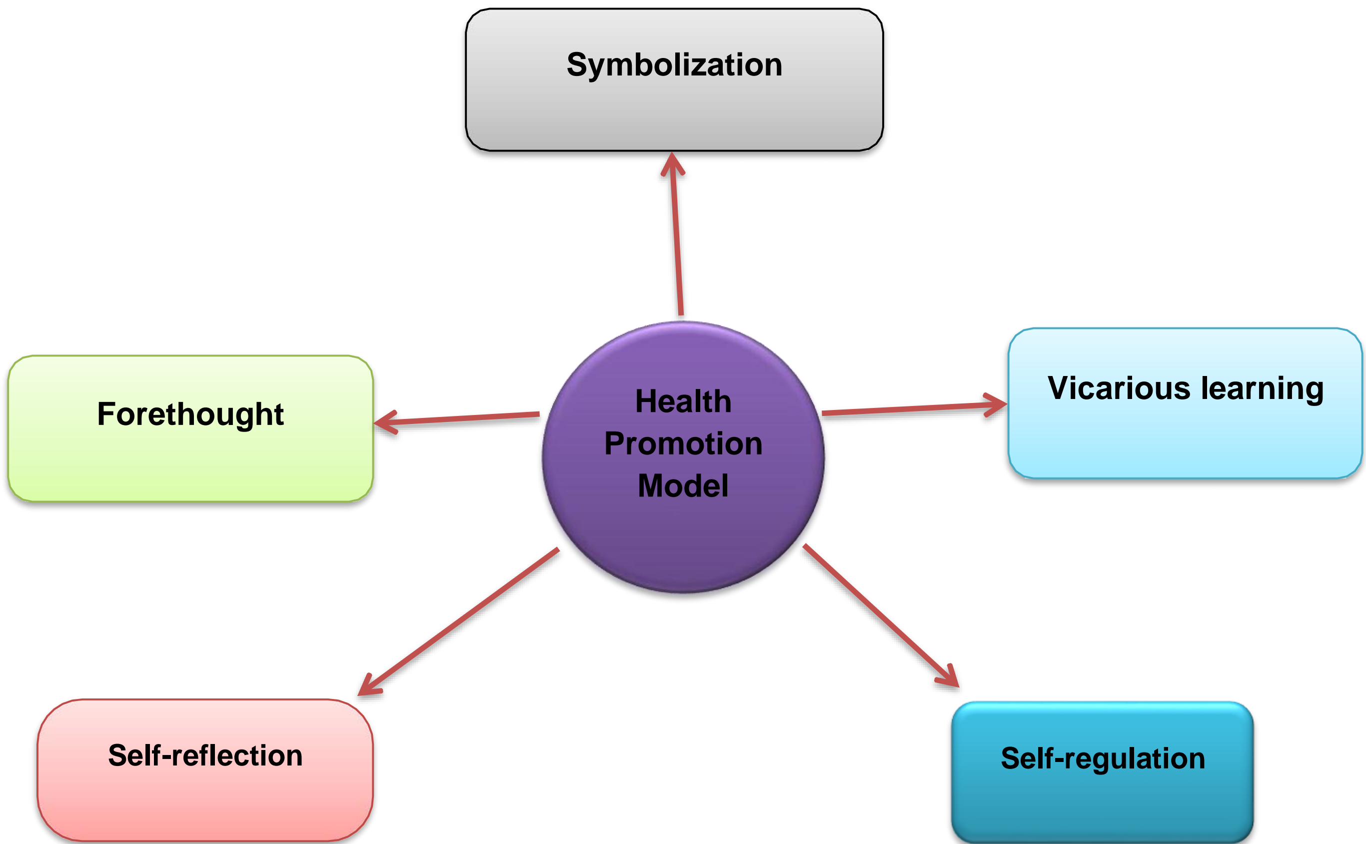


Diagram 1: Nola Pender's five basic human capabilities (George 2010)

Below, **Table 2** represents Nola Pender's HPM five basic human capabilities application to the study.

2.7.1 Table 2: Nola Pender's five basic human capabilities

Human Capabilities	Application to the study
Symbolization	The ability to process and transform experiences to create internal models to guide action in the future, in the study pregnant women will be asked what does Antenatal Care symbolises to them.
Forethought	The ability to anticipate possible consequences of potential actions and plan courses of action to achieve goals of value, for example what do they think they will benefit from attending Antenatal Care, why not use other models like traditional way of growing their unborn babies.

Vicarious learning	The ability to obtain rules for selecting actions through observation of others without having to use trial and error. Are they learning anything from attending Antenatal Care; does it help them; is there a difference attending and not attending?
Self-regulation	The ability to use internal standards and self-evaluation to inspire and adjust behaviour and to arrange the external environment to construct encouragement for action.
Self-reflection	The ability to consider one's own thought processes and change them, can they be able to make a conscious decision to start ANC and stick to all follow-up dates with the midwife.

2.8 CONCLUSION

In Chapter 2, literature was reviewed regarding the attendance of ANC by pregnant women globally, in sub-Saharan countries and in South Africa. Nolar Pender's Health Promotion Model was discussed as the conceptual framework that guided the study. The next chapter discusses the research design and methodology adopted to guide the study.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

Chapter 2 focused on the literature review and the theoretical framework that guided the study. Chapter 3 discusses the research paradigm, design and methodology applied in this study.

3.2 RESEARCH PARADIGM

Paradigm for human enquiry refers to ways in which people respond to basic philosophical questions. Polit and Beck (2017:113) describe paradigm as a worldview and a set of assumptions about the basic kinds of entities in the world, how these entities interact, and the proper methods to use for constructing and testing theories of these entities. According to Polit and Beck (2017:9), there are two main broad paradigmatic approaches relevant to sciences which are positivism and constructivism.

Positivism is a systematic research method which emphasise the importance of observable facts. It posits that reality exists and there is a real world driven by real natural causes and subsequent effects (Polit and Beck 2017:9). Constructivism paradigm believes that reality is multiple and subjective. Reality is mentally constructed by individuals, and there is simultaneous shaping, not cause and effect (Polit and Beck 2017:9). Therefore, due to the qualitative nature of the study, constructivism paradigm was chosen to guide the research study. The constructivism paradigm assumes that knowledge is maximised when the distance between the inquirer and those under study is minimised (Polit and Beck 2017:9). Therefore, the researcher's finding regarding the factors contributing to attendance of Antenatal Care by pregnant women at King Cetshwayo District in KwaZulu-Natal was the product of the interactions between the enquirer and the participants.

3.3 RESEARCH DESIGN

A qualitative explorative and descriptive research design was employed to conduct the study. Qualitative research is used when little is known about the phenomenon, or when the nature, context and boundaries of the phenomenon are poorly understood or defined (Brink *et al*. 2012:120).

Polit and Beck (2012:487) describe the following characteristics of qualitativeresearch:

- Often involves merging together various data collection strategies (triangulation of data obtained from different sources).
- Is flexible, capable of adjusting new information during the course of data collection.
- Tends to be holistic, striving for understanding of holistic phenomena.
- Requires the researcher to become intensely involved.
- Requires the researcher to become the research instrument.
- Involves ongoing analysis of data to formulate subsequent strategies and to determine when fieldwork is done.

3.3.1 Explorative research design

According to Brink *et al.* (2012:102) explorative research studies what has been previously studied and attempts to identify new knowledge, new insight, new understanding and new meaning, and to explore factors related to the topic. Polit and Beck (2012:15) state that an explorative study investigates the full nature of the phenomenon, the manner in which it is manifested and the other factors to which it is related. The current study's dimension was to explore contributing factors to attendance of Antenatal Care.

3.3.2 Descriptive research design

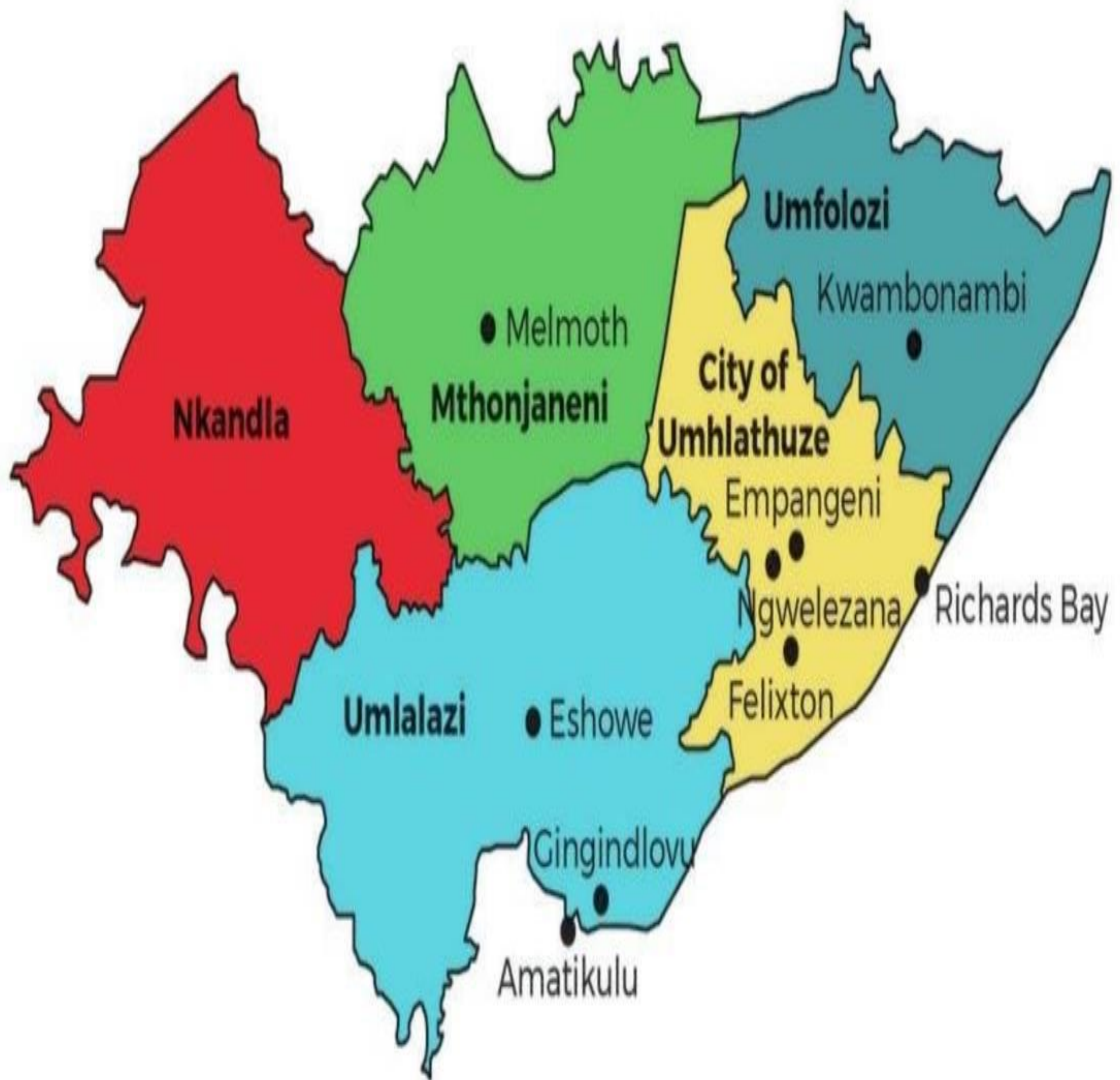
Descriptive design is used to identify a phenomenon of interest, identify variables within the phenomenon, develop conceptual and operational definitions of variables and describe variables (Burns and Grove 2015:502). According to Brink *et al.* (2012:112), a descriptive design uses the practice of that time to identify problems and to decide on what others with common situations were doing. Through descriptive studies researchers describe what exists, determine the frequency in which something occurs, discover new meanings and categorize information. The researcher in this study chose to use the descriptive design to describe measures of improving Antenatal Care attendance by pregnant women at King Cetshwayo Health district. Descriptive studies are usually conducted with large numbers of subjects in a natural setting with no manipulation of the situation (Burns and Grove 2007:34). Participantsof this study were

pregnant women who attended ANC in one of the facilities at King Cetshwayo health district.

3.4 AREA OF THE STUDY

The study was conducted at the PHC institutions situated in King Cetshwayo District where pregnant women were attending their ANC. KwaZulu-Natal consists of Amajuba, eThekwini, iLembe, Harry Gwala, Ugu, uMgungundlovu, uMkhanyakude, Umzinyathi, King Cetshwayo, Uthukela and Zululand Districts. King Cetshwayo District is situated in Northern East region of KwaZulu-Natal province. This District includes areas such as Gingindlovu in the South, Umfolozi river in the North and inland of iNkandla. King Cetshwayo health district has two regional hospitals, six district hospitals, 57 fixed clinics and one community health centre (CHC) serving approximately 917 315 rural people (Department of Health 2017). The study was conducted in the selected PHC institutions rendering ANC services to pregnant women within King Cetshwayo District in KwaZulu-Natal. **Diagram :2** below represents the map of King Cetshwayo Health District.

King Cetshwayo Health District map (municipalities.co.za).



3.5 STUDY POPULATION

The target population is the entire population in which a researcher is interested in and to which he or she would like to generalize the study findings (Polit and Beck 2012:744). For this study, the target population were the pregnant women from 18 years ofage attending a follow-up Ante Natal Care from 12 to 36 weeks of gestation at King Cetshwayo District healthcare institutions.

3.5.1 Identification of the study participants

According to Burns and Groove (2011:84), the researcher must enlist participants to take part in a study because of their particular knowledge, experience and views related to the study. Pregnant women attending ANC at the four PHC clinics at King Cetshwayo Health Districts were identified to participate in the study during their ANC classes in the waiting areas.

3.6 SAMPLING PROCESS

Polit and Beck (2012:250) explain the sampling process as the method of selecting study participants in a manner that will represent the entire population with an intention to permit inferences about the population. Population characteristics are specified using eligibility criteria. Eligibility criteria are the criteria designating the specific attributes of the target population by which people are selected for inclusion in a study (Polit and Beck 2012:274). In this study, pregnant women who met the inclusion criteria were purposively sampled.

3.6.1 Inclusion criteria

- Pregnant women from 18 years of age attending ANC at King Cetshwayo healthcare district.
- Pregnant women between 12 to 36 weeks of gestational age.
- Pregnant women who came for Antenatal Care for first time booking and for follow-up visit.
- Pregnant women with no obstetric emergency e.g., hypertension in pregnancy, or in pains.

3.6.2 Exclusion criteria

- Pregnant women less than 18 years of age and not attending ANC at King Cetshwayo healthcare district.
- Staff and female who are not pregnant.
- Women in labour.
- Mothers who came for their postnatal care and child well-being.
- Pregnant women who refuse to participate in the study.

3.6.3 Recruitment procedure

The recruitment took place in four clinics under King Cetshwayo health district during regular subsequent ANC visits of eligible participants. The researcher approached the participants to request their participation in the study. The participants were given information letter (Annexure 1) informing the purpose of the study and explaining that the study was not part of their routine antenatal care. They were informed that participation was voluntarily and an informed consent form (Annexure 2a) was signed by participants. The information letter and the informed consent form were issued to the participants according to their preferred language (English or isiZulu). All participants preferred to be interviewed in English. They were informed about withdrawal choice from the study at any point of time if they did not wish to continue. The participants were also assured that the information would be kept confidential, a confidentiality binding form (Annexure 3) was signed by the researcher,and also that the information would be used for scientific purposes. The researcher visited the four study areas from Monday to Thursday between January and February 2020.

3.6.4 Codebook for data definition

The codebook was developed following the sampling process. The codes, as detailed in the codebook, were used from data collection till the end of reporting the study findings in order to ensure that there was no link between the study data and the data sources. This was done in order to safeguard the study's participants' confidentiality and anonymity. The study areas were allocated alphabets A, B, C, D while the participants were identified by P1, P2 depending on the number of study areas and the number of participants. **Table 3** below represents the codebook.

Table 3: Codebook for participants

Study area code	Participants' code
A	AP1 AP2
B	BP1 BP2

3.7 PRE-TESTING

According to Pilot and Beck (2012:174), a pre-testing is done on small scale participants prior to the main study on a limited number of participants from the population at hand. In this study, two pregnant women were interviewed using unstructured interview as a pre-test of the study. The data collection tool was not changed. The researcher posed a grand tour question followed by probing sub-questions to ensure further clarity of the data collected. Data collected was audiotaped and field notes were taken during interviews which were analysed and interpreted. The participants' data and findings from pre-testing were not included in the main study.

3.8 SAMPLING TECHNIQUE

Sampling technique is the process of selecting participants to represent an entire population (Polit and Beck 2012:275). A purposive sampling method was used to select participants for the study. Polit and Beck (2012:517) define purposive sampling as a sampling method whereby the researcher selects participants based on his/her personal judgments about which participants would provide the most relevant information for the study. The researcher selected pregnant women from 18 years of age attending ANC at King Cetshwayo healthcare district institutions in KwaZulu-Natal. The nonprobability sampling technique was applied as each person or element has an opportunity to be selected for a sample and it increases the sample's representativeness of the target population (Burns and Grove 2015:257).

3.9 SAMPLING SIZE

Sampling size is a central consideration when it comes to minimizing the error of sample estimates and maximizing study value for a given cost; a qualitative research study does not conform to sampling size; therefore, the participants are recruited until

data saturation is reached (Schmidt and Brown 2009:161). There is no set sample size in qualitative research. In this study, sampling size was determined by data saturation. Data saturation is the point when the participants' information being shared with the researcher becomes repetitive and no new information emerges during subsequent interviews (Schmidt and Brown 2009:161).

Participants from all identified study areas were purposively sampled to ensure representation. Ten participants were interviewed from four different PHC facilities. Three pregnant women from each health facility participated in this study to make a total number of 12 participants. Data saturation was reached after interviewing participant number 10. However, the researcher continued to interview additional two participants to confirm data saturation.

3.10 DATA COLLECTION

According to Burns and Grove (2015:63), data collection involves the precise and systematic gathering of information relevant to the research purpose or objectives, questions or hypothesis of a study and was supported by Polit and Beck (2012:725) who stated that it is gathering of information to address a research problem. The data collection method used in this study was unstructured interviews which were conducted between April and May 2020 after the ethical clearances were obtained from the gate keepers of each facility. The interviews wereconducted in four different health facilities under King Cetshwayo health districts in a private consulting room. The interviews were conducted in the morning during ANC classes. Each interview lasted about 20 – 30 minutes depending on the participant engagement with the subjects. The researcher initiated each interview with a grand tour question followed by probing questions, encouraging pregnant women to talk freely about their experiences and perceptions regarding attendance of ANC. The interviews were recorded using audiotape recorder, with permission of each participant. Field notes were also taken and used to note certain points, moods and facial expression made by the participant during the interview.

3.11 DATA ANALYSIS

Data analysis in qualitative research is an active and interactive process with the purpose of organising, providing structure to, and eliciting meaning from data (Polit and Beck 2012:557).

The researcher read the field notes in conjunction with listening to the recorded responses from the pregnant women regarding their perception about attendance of ANC in order to gain a clear understanding of the collected data. The reasons, feelings and thoughts of the participants were explored. Each transcript was carefully read and field notes taken of any significant theme were correlated with specific interviews' information. The researcher organised data into themes and sub-themes in order to look for connections between them. The main aim was to end up with key themes that described the essence of the study. During the next step, the researcher combined and catalogued related patterns into sub-themes. Themes and sub-themes that emerged from the informants' perceptions about attendance of ANC were placed together to form a comprehensive picture of their collective experiences. The researcher had to find out how different ideas fit together in a meaningful way when linked together with the themes.

3.12 DATA MANAGEMENT AND STORAGE

Data management refers to conditions in which the identity of the subjects cannot be linked, even by the researcher, and the management of private data in research in such a way that only the researcher knows the subjects' identities (Burns and Grove 2007:535). Data collection tools were given codes so that there was no link between the participants' identities, facility unit used, place where the interviews were conducted and the information collected. The completed data collection tools were kept under lock and key in the researchers' office for a minimum of five years, and thereafter be destroyed by shredding. Electronic stored data are secured by using a protected secret password known only to the researcher and wiped off the electronic computer system after five years.

3.13 TRUSTWORTHINESS

Polit and Beck (2014:72) stated that qualitative research uses trustworthiness which encompasses several different dimensions outlined by the model of Lincoln and Guba (1985). Credibility, reflexivity, transferability, dependability and conformability were used as criteria for developing the trustworthiness of a qualitative inquiry.

3.13.1 Credibility

According to Polit and Beck (2014:323) credibility refers to confidence in the truth value of the data and interpretation on them. This is supported by Brink *et al.* (2012:172) who confirmed confidence in the truth of data and the interpretation thereof. In this study, credibility was ensured by prolonged engagement in the private consulting room with participants during data collection. The researcher ensured that participants were relaxed and felt safe throughout the interview. The researcher used a tape recorder to capture the participants' verbatim responses and took field notes during interviews. The researcher further used direct quotes from the participants' verbatim responses during the analysis of data to ensure credibility.

3.13.2 Reflexivity

Polit and Beck (2012:179) outlines reflexivity as a process of reflecting critically on the self-including scrutinising personal values that could affect interpretation of data. It is about the researcher's self-awareness as part of the research and the data they are collecting. The researcher did introspection and explored own biases, preferences, stakes in and fears about the research, made notes of reflexive thoughts in personal journals and was reflexive about every decision chosen during the inquiry as this enhanced the quality of the study.

3.13.3 Transferability

According to Lincoln and Guba (1985:321), transferability refers to the applicability of findings to other settings. It is attained through purposive sampling, where saturation of data applies, and thick description of the research strategy and method of the study which researcher intends to apply in the current study. Lincoln and Guba (1985:325) stipulate this as an applicability of findings to other settings. The researcher provides sufficient descriptive data in a research report such that other researchers could test its applicability to other contexts.

3.13.4 Dependability

According to Brink, Van der Walt and van Rensburg (2012:125), this refers to reliability of data over time and over various conditions. Lincoln and Guba (1985:320) stated that dependability is concerned with the stability of data over a period of time. The datathat was used in the study is own truthful perception regarding attendance of ANC. The

researcher captured the voice-recorded data collected from pregnant women and transcribed each interview verbatim; field notes were also coded, audited and archived. These are available if required for verification purposes.

3.13.5 Conformability

Brink *et al.* (2012:127) indicates that data have to be proven to be neutral and objective to conform to conformability. Therefore, conformability in this study was achieved by using direct quotations from the raw data in appropriate places in the research report to convey the participants' knowledge about attendance of ANC in their own words. Potential subjectivity and bias of the researcher was eliminated through the evaluation, relevance of the data by the supervisor and independent examiner.

3.14 ETHICAL CONSIDERATIONS

The researcher conducted this study in consideration of the participants' rights. The following ethical aspects were taken into consideration while conducting the study.

3.14.1 *Permission to conduct the study*. The study commenced after ethical clearance was granted by the University of Zululand Research Ethics Committee. Permission was requested from and granted by KwaZulu-Natal Department of Health Research Unit and the King Cetshwayo Health District before data collection commenced.

3.14.2 *Privacy*. It is a freedom to determine the time, extent and general circumstances under which private information will be shared with or withheld from others (Burns and Grove 2007:544). The participants were interviewed in a private room with a sign indicated as private to ensure that there are no interruptions during the interview.

3.14.3 *Informed consent*. This is an ethical principle that requires researchers to obtain people's voluntary participation after informing them of possible risks and benefits (Polit and Beck 2012:731). The researcher outlined the purpose and the process of the study to each participant on the information letter and the consent form without coercion and indicating the right to withdraw from the study. The researcher further requested each participant to sign a consent form. Permission was requested from each participant to audiotape unstructured interviews including capturing of field notes during data collection.

3.14.4 *Anonymity and confidentiality*. These are conditions in which the study participants cannot be associated with the findings, even by the researcher (Burns and Grove 2007:535). The interview guide used to collect data was identified by codes to ensure anonymity of the participant’s identities, facility unit used, place where the interviews were conducted and the information collected. This tool was kept in a secure locked office and the electronic data were password protected for a minimum period of five years, and thereafter field notes would be shredded and electronic data would be deleted.

3.15 CONCLUSION

This Chapter 3 discussed the methodology and processes used in the study. This also included maintaining trustworthiness and safeguarding ethical consideration. The next Chapter 4 focuses on the presentation of the study’s findings.

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CHAPTER 4

PRESENTATION OF THE STUDY FINDINGS

4.1 INTRODUCTION

The previous outlined the research methodology adopted to conduct the study.Chapter 4 presents the findings of the study obtained during individual unstructured interviews that were conducted face-to-face on 12 pregnant women attending ANC at King Cetshwayo Health district selected study areas during April and May 2020.

4.2 SAMPLE REALISATION

This study was conducted on four different PHC facilities situated in the Northern KZN King Cetshwayo Health district. The researcher conducted 12 individual face to face unstructured interviews. Data saturation was reached after the 10th interview and the additional two more interviews were conducted to confirm data saturation. **Table 4** below represents sample realisation based on the study area where participants were located.

Table 4: Sample realisation for the entire study (n=12)

Study Area	Participants	Total
Clinic A	AP1	03
	AP2	
	AP3	
Clinic B	BP1	03
	BP2	
	BP3	
Clinic C	CP1	03
	CP2	
	CP3	
Clinic D	DP1	03
	DP2	
	DP3	

4.3 DEMOGRAPHIC DATA

The demographic data were explored to determine the factors contributing to attendance of ANC by pregnant women. The researcher collected data from 12 pregnant women attending Antenatal Care at King Cetshwayo Health district facilities. The participant's age ranged from 18 to 40 years. All participants were African, seven single, five married, four belonging to Shembe religion and eight reported to be Christians. **Table 5** below represents the summary of the demographic data of the participants.

Table 5: Demographic data of the participants (n=12)

Participant number	Age	Race	Marital status	Gender	Religion	Parity
AP1	18	African	Single	Female	Shembe	01
AP2	26	African	Single	Female	Christian	02
AP3	31	African	Single	Female	Christian	04
BP1	29	African	Single	Female	Christian	01
BP2	33	African	Married	Female	Shembe	02
BP3	28	African	Single	Female	Christian	03
CP1	34	African	Single	Female	Christian	04
CP2	39	African	Married	Female	Shembe	02
CP3	40	African	Married	Female	Shembe	03
DP1	24	African	Single	Female	Christian	02
DP2	37	African	Single	Female	Christian	02
DP3	22	African	Married	Female	Christian	02

4.4 THEMES AND SUBTHEMES

4.4.1 Major themes

The following four major themes emerged during data analysis:

Theme 1: Location of PHC facilities

Theme 2: Cultural beliefs

Theme 3: Knowledge deficit

Theme 4: Financial constrains

4.4.2 Sub-themes

Several sub-themes emerged from major themes during data analysis are represented in **Table 6** below.

THEMES	SUB- THEMES
Theme 1: Location of PHC facilities	1. Availability of transport to PHC facilities
	2. Reliability of transport to PHC facilities
	3. Distance to the PHC facilities
	4. Mobile clinic stopping area
Theme 2: Cultural beliefs	1. Traditional beliefs during pregnancy
	2. Traditional practices during pregnancy
	3. Cultural support system
Theme 3: Knowledge deficit	1. Lack of knowledge about pregnancy
	2. Feeling of shame about pregnancy
Theme 4: Financial constrains	1. Unemployment of pregnant women and their partners

4.5 PRESENTATION OF THE STUDY FINDINGS

4.5.1 Theme 1: Location of PHC facilities

The participants raised several issues regarding the location of the facilities where they attended ANC as most of them were residing in remote areas. These issues included availability of transport to PHC facilities, distance to PHC facilities and mobile clinic stopping area.

Sub-theme 1.1: *Availability of transport to PHC facilities*

Most pregnant women were concerned about the availability of transport to PHC facilities based on the reason that they reside in remote areas where there are no taxis

or buses, and they only depend on hitch-hiking passing cars. This was captured in these verbatim responses:

> *"Sir…transport in this area is a problem as there are no taxis or buses that we can use on a regular base to attend ANC.'' [AP1]*
>
> *"…Eish … we are staying in a rural area where transportation to PHC facilities is problematic therefore this contributes to me not attending scheduled ANC appointments.'' [BP2]*

Sub-theme 1.2: *Reliability of transport to PHC facilities*

The participants alluded that there was no reliable transport from their residing area to PHC facilities. Most of them stated that they rely on a bus that does not pass their residing area on regular bases. This is what they had to say:

> *"Sir… I reside up in the mountain whereby the road is very bad, so there is no reliable bus where I stay for me to attend the clinic visits as the clinic is very far.'' [BP1]*
>
> *"The bus passes our area on alternative days, sometimes it does not pass at all especially on hard rainy days, and therefore I tend not to attend my clinic visits as regularly as I am supposed to attend them because of unreliable mode of transportation". [CP2]*

Sub-theme 1.3: *Distance to the PHC facilities*

Pregnant women verbalised that PHC facilities whereby they attend ANC are located far from their residing areas. Some participants stated that it is difficult to walk long distances to attend ANC. This was captured in this participant's response:

> *"The healthcare facilities where I attend clinic visits are far from home, so I only attend when I'm not feeling well by calling an ambulance or hiring a private car to come and pick me up as a sick patient.'' [CP3]*
>
> *"Sir… walking a long distance is a challenge for me, because I become very tired easily, so I tend not to attend scheduled clinic visits as proposed because the clinic is very far". [DP1]*

Sub-theme 1.4: *Mobile clinic stopping area*

Most pregnant women were concerned with regards to the mobile clinic stopping points. They stated that mobile clinic stopping points are situated far from their home, this affected their regular attendance of ANC scheduled visits. Their captions were as follows:

> *"In this area where I stay, mobile clinic comes on certain days, but mobile clinic stopping area is far from my home, sometimes I do not have energy to walk that long distance to the mobile clinic stopping area". [AP3]*

> *"Eh... the mobile clinic does come in our area, but sometimes, I do not attend my scheduled visits because the walking distance to mobile clinic stopping area is far and it is not safe to walk alone in the sugarcane area while pregnant". [DP2]*

4.5.2 Theme 2: Cultural beliefs

Several cultural beliefs that emanated from the interviews conducted on pregnant women hindered them from attending ANC scheduled visits on a regular basis. These included traditional beliefs during pregnancy, traditional practices during pregnancy and cultural support system.

Sub-theme 2.1: *Traditional beliefs during pregnancy*

The majority of pregnant women verbalised several cultural beliefs that affects their visitation to ANC especially during their first time of pregnancies. This was because of the fact that in certain rural areas, there were various cultural beliefs affecting pregnant women. This was evident in the following statements from the pregnant women:

> *"When I was pregnant with my first child, my grandmother told me that there is no need to go to clinic for antenatal because all her children are alive and she never attended any visits at the clinics, I only attended today because I was not feeling well". [DP2]*

> *"Sir… I come from a very culture sensitive family, my parents believe that during pregnancy a woman should not go outside the yard because she might catch*

bad spirits that will affect her and the unborn baby. This is my first visit to the clinic because my boyfriend insisted that I should come for a check-up''. [BP3]

"….. eh… I stay with my grandmother who told me that all her children were delivered at home and during pregnancy a woman should not leave the yard unnecessary as this might harm me and my child due to bad spirits out there, …. and beside I never got sick hence I saw no need to attend the clinic but Ijust came today as I was starting to feel sick lately''. [AP1]

"Going around when you are pregnant is culturally prohibited to avoid catching bad spirits that can severely affects you during delivery and your child too''. [DP3]

Sub- theme 2.2: *Traditional practices during pregnancy*

Most pregnant women indicated that they were practicing other traditional practices such as drinking traditional concoctions prepared for them by their parents, mothers-in-law or their grandmothers; hence, they did not attend the ANC scheduled visits on a regular basis. This is what they had to say:

"Once I become aware that I was pregnant, I notified my husband and his family, my mother-in-law prepared me traditional herbs for me to use instead of going to the clinic as she said that she was also using the same traditional herbal medication during her pregnancies". [CP2]

"My mother and my grandmother gave me this rope…. (Pointing at red rope on her waist) to wear around my waist. This is what protects me and my child from bad spirits that can harm us. She also prepares me herbs to drink on a regular basis. I only started attending clinic today just for check-up as I am now closer to delivery''. [AP2]

"I have been drinking some traditional herbs and I have been given a rope to wear around my waist which protects me and my baby. So…. Since I became aware that I was pregnant this is my first visit at the clinic because I will be delivering next month''. [AP1]

Sub-theme 2.3: *Cultural support system*

Several issues emanated during the interviews with pregnant women regarding cultural support system. The majority of pregnant women indicated that they were not supported by their partners during pregnancy that affected their visitation to clinics to attend scheduled ANC visits. This was captured as stated in these statements:

> *"Eh … to be honest with you, I feel alone in this pregnancy. My partner does not give me any support including encouraging me to attend the clinic for check-up. Sometimes I feel that he does not care about me and the baby hence I sometimes just stay at home". [BP1]*

> *"I stay with the father of my child, but when I ask him to accompany me to the clinic he tells me that he is busy, I cannot walk alone as the area is not safe. I feel that he is not supportive towards this pregnancy at all". [CP1]*

> *"Some pregnant women are accompanied by their partners or husbands when they are attending the clinic for check-ups. My partner declined that this child I am carrying was his. So I am all by myself…. I feel discouraged and demotivated most of the time to attend the clinic for check-ups because of no support". [DP3]*

4.5.3 Theme 3: Knowledge deficit about pregnancy

Knowledge deficit about ANC was a major concern raised by several pregnant women during their first time of pregnancy. Most pregnant women relied on knowledge received from their elders at home or their peers. The issues include lack of knowledge about pregnancy and feeling of shame about pregnancy.

Sub-theme 3.1: *Lack of knowledge about pregnancy*

Lack of knowledge about pregnancy was expressed as a reason not to attend ANC. Some pregnant women stated that they delayed starting ANC because they did not see the importance of attending the clinic scheduled visits. The following comments were captured during the interviews:

"If I knew early that attending clinic was this important and would benefit me this much, my first born will be still alive as during that pregnancy I never attended any clinic for check-up". [DP2]

"Sir… my perception about attending clinic was that it was meant for people who are sick during pregnancy. That is the main reason why I did not bother to attend my schedule clinic visits". [DP3]

"I did not have much knowledge why I should attend my clinic appointments on a regular basis as scheduled because I was not really sick hence it is my first time today to be here, …. I was not aware of the importance of attending ANC if I was not sick''. [AP3]

Sub-theme 3.2: *Feeling of shame about pregnancy*

Most pregnant women expressed the feeling of shame about being pregnant at the younger age while not married. Their expressions were based on the fact that they were still at school. The following comments were captured during interviews:

"Sir…I could not attend the clinic at an early stage of my pregnancy because I was ashamed to reveal pregnancy to my parents as I am still at school and not married". [AP1]

"Ehh….my parents are very strict and expected better things from me. I felt ashamed when I realise that I was pregnant and became afraid to tell my parents…… I was hiding this pregnancy hence I did not attend clinic at an early stage of my pregnancy". [BP1]

"Ey…Sir… I did not attend early at the clinic for scheduled check-up because I was so ashamed to reveal to my mother that I was pregnant as she is working very hard as a single mother for us to go to school". [DP1]

4.5.4 Them 4: Financial constrains

The participants raised financial constrains as a contributing factor towards their non-attendance to the scheduled ANC. These factors included unemployment of pregnant women and their partners, and lack of funds to attend ANC visits.

Sub-theme 4.1: *Unemployment of pregnant women and their partners*

The majority of the participants alluded that themselves and their partners were unemployed and it was difficult for them to make ends meet financially; hence, they were not honouring the scheduled ANC visits. This was captured in this verbatim response:

> *"Sir...we have been unemployed for months now me and my husband, financially we are struggling to make ends meet, we…. eh…. Rely on my mother-in-law's pension funds which are not enough to cover all the expenses".* [BP3]
>
> *"My husband lost his job and I have never been employed anywhere, and we found out that I am pregnant and I need to attend the clinic for check-up financially we are struggling".* [AP2]
>
> *"I do not have money to pay taxi or bus fare to attend ANC as I should, I am not employed and I don't have any source of financial support'' [AP3]*
>
> *"Eh… I would really like to attend ANC visits regularly like all other pregnant women does, but financially I am not able to do that as I am not working'' [CP3]*

4.6 CONCLSION

Chapter 4 presented the findings from data analysis. Four major themes and several sub-themes that emerged on data analysis from the interviews conducted with the study participants were presented. Discussion of the study findings is presented in the next Chapter 5.

CHAPTER 5

DISCUSSION OF FINDINGS

5.1 INTRODUCTION

The previous chapter presented the findings of the study regarding the factors contributing to the attendance of ANC by pregnant women at King Cetshwayo Health District. In Chapter 5, the findings of the study were discussed and supported with literature and the application of Nola Pender's Health Promotion Model as a theory guiding the study.

5.2 OVERVIEW OF THE RESEARCH STUDY FINDINGS

The main aim of this study was to explore and describe factors contributing to attendance of Antenatal Care by pregnant women at King Cetshwayo District in KwaZulu-Natal. The objectives of the study were to explore factors contributing to attendance of Antenatal Care, and to describe measures of improving Antenatal Care attendance by pregnant women. A qualitative explorative and descriptive research design was employed to conduct the study. Four major themes and several sub-themes emerged and were discussed with the purpose of achieving the study objectives.

5.3 DEMOGRAPHIC INFORMATION OF THE STUDY PARTICIPANTS

The demographic data were obtained to get a better understanding of the background, certain characteristics and possible commonalities amongst the participants. The data were collected from 12 pregnant women attending ANC in the four PHC facilities at King Cetshwayo health district in KZN which met the study inclusion criteria. Participants were all female and South African citizens. Religiously, the participants consisted of four (n=4) Shembe and eight (n=8) Christian religions. The ages of the participants ranged between 18 – 40 years old, and eight (n=8) participants who participated in the study were single and four (n=4) were married with a parity ranging from one to four.

5.4 DISCUSSION OF THE FINDINGS

5.4.1 LOCATION OF PHC FACILITIES

Antenatal care is described as a care given to pregnant women in order to experience a safe pregnancy and deliver a healthy baby (Sumera, Dero and Ali 2018:41). The findings of the study revealed several sub-themes that emerged which were based on the availability of transport to PHC facilities, reliability of transport to PHC facilities, distance to the PHC facilities and mobile clinic stopping area. Most participants raised several issues regarding the location of facilities where they attend ANC as most of them were residing in remote areas. The areas where the participants were residing do not have an available mode of transportation to be used by pregnant women to attend their booked ANC visits. Most of the participants indicated that they had to hitch-hike in order to reach the healthcare facilities due to unavailability of transport. This forms a barrier between the pregnant women and the healthcare facilities where pregnant women are expected to attend their ANC visits.

According to Issac, Mensah and Anyanful (2014:24) developing countries are yet to fully acknowledge and understand the role of transport and mobility in improving poor people's health and maternal health. Moreover, transportation plays a critical role in the effective and efficient delivery of maternal health services, it also enables people to access services and health workers to reach communities, especially in sparsely populated rural areas (Issac, Mensah and Anyanful 2014:24). Therefore, availability of transport is crucial for pregnant women to avoid hitch-hiking on passers-by vehicles which may pose dangers to them and their unborn babies. Nola Pender's HPM basic human capability indicates a forethought as the ability to anticipate possible consequences and plan courses of action to achieve goals of value (George 2010:545). Therefore, pregnant women use their forethought in anticipating the consequences of not attending the ANC visits due to barriers caused by unavailability of transport to the healthcare facilities; hence, they opt for hitch-hiking on passers-by cars as an alternative course of action to achieve their goals of reaching the healthcare facilities which might be dangerous for themselves and their unborn babies.

Reliability of transport to PHC facilities was raised as a concern by pregnant women. Most participants gave the reasons that they reside in remote areas where the roads were very bad, while others cited that the buses come on alternate days or do not come at all; hence, they miss their scheduled ANC visits. Gronje and Grobler (2009:682) revealed that adequate transport facilities are usually available in the urban centres but are generally grossly inadequate in rural areas in developing countries. This has a negative impact towards the movement of people living in remote areas including pregnant women who want to attend their scheduled ANC appointments in the health care facilities.

The distance between the participants and the healthcare facilities where they attend their ANC visits emanated as a barrier leading to most participants to delay or not to attend ANC. WHO, as cited by Dennil, King and Swanepoel (2012:17), recommendeda minimum distance of about five to ten kilometres to the health facility around each community. This was not the case with most of pregnant women residing in rural areas as they indicated that the walking distance was too long especially for them as they indicated getting tired easily. Kyei, Chansa and Gabrysch (2012:22) agree that the general healthcare utilisation for every kind of service is affected by distance between the healthcare user and the healthcare provider.

Similarly, the study conducted in Malawi revealed that people living in rural Malawi faced major challenges due to long distances between the community and the nearest health facility, be it a health centre, district hospital or central hospital (Varela, Young, Mkandawire, Groen, Banza and Viste 2019:2). Other participants stated that they only attend ANC when they do not feel well by calling an ambulance or hiring a private car to take them to the healthcare facility due to distance. Nola Pender’s HPM basic human capability indicates self-reflection the ability to consider one’s own thought processes and change them (George 2010:545). Hence, most pregnant women reflected on their thoughts of making other means of attending ANC by calling an ambulance as sick patients or hiring private cars to take them to the healthcare facilities due to long distances between their residing areas and the healthcare facilities.

The World Health Organisation (WHO) stipulated that it is significant that pregnant women should attend Antenatal Care from early stage of gestation on a regular basis to determine and monitor the healthcare status of the woman, and the foetus to enable

early diagnosis and management of any childbirth complications (WHO 2012:1). This can only be achieved through various strategies including the availability of mobile to areas where there are no healthcare facilities nearer to the community. Abbasi, Mohajer and Samouei (2016:4) stated that most countries of the world with widespread and diverse populations and remote or underprivileged locations try to provide mobile medical care and health services in various locations to improve the satisfaction of their citizens. Similarly, in South Africa, the Department of Health provides mobile clinics across widespread and underprivileged populations leaving in remote areas sothat they access healthcare services including ANC to pregnant women.

Most pregnant women were willing to attend ANC services rendered by mobile clinics, but most of them indicated that the mobile clinic stopping areas were far from their residential areas. The study conducted in Pakistan found that access to obstetric care depends on the transportation system and physical distance between the villages and the centres including the stopping point of a mobile clinic (Ali, Dero, Ali and Ali 2018:44). In the same vein, the study conducted by Amnesty International (2014:6) revealedthat the roads in some areas were of poor quality that they become impossible for ambulances when it rains or even when it is dry; mobile clinics go beyond a certain point. Pregnant women had to walk long distances in unsafe areas to reach the mobile clinics stopping areas. Hence most pregnant women do not attend ANC visits as scheduled.

5.4.2 CULTURAL BELIEFS

Cultural beliefs play an essential role in the decision-making process of pregnant women's starting to attend ANC (Chimatiro, Hajison, Chipeta and Muula 2018:6). Similarly, in this study the findings revealed several sub-themes that emerged, which were based on traditional beliefs during pregnancy, traditional practices during pregnancy and cultural support systems.

Most pregnant women revealed that their cultural beliefs hindered them from commencing ANC. They reported that they did not book early for ANC because they were advised not to attend by their elders or guardians because of their elders or guardians' previous pregnancy experiences of birth that went well despite not attending the ANC. Taylor, Sealy and Robert (2017:22) in their study revealed that some pregnant women delay attending ANC because they are told by their elders that they

are healthy with a belief that they will have a healthy pregnancy. The study conducted by Chimatiro *et al.* (2018:6) also established that some women do not start ANC early as they wait for marriage counsellors or their mothers-in-law to come and give them advice especially if it is the first pregnancy.

Some pregnant women attending ANC revealed that they were advised by elders to strictly stay indoors because the unborn baby will catch bad spirits. Studies in Zimbabwe, Mozambique and Tanzania have discovered that women at an early stage delay ANC attendance in order to protect the unborn against witchcraft and magical attacks from greedy neighbours (Maluka, Joseph, Fitzgerald, Salim and Kamuzora 2020:5). Pender's HPM basic human capability indicates a vicarious learning as an ability to obtain rules for selecting actions through observation of others without having to use trial and error; hence, pregnant women in this study were guided by their elders or guardians in deciding when to attend ANC (George 2010:545). This put pregnant women at risk of undiagnosed pregnancy related conditions that may pause danger to both pregnant women and their unborn babies.

Hajj and Holst (2020:3) are of the view that traditional herbal medicines may be used sometimes as part of maternal care to treat pregnancy related problems, and often to improve the well-being of the mother and/or the unborn child. It emanated from these study participants that they have to go through some traditional practices that become the bridge between them and attendance of ANC. Most pregnant women stated that when their elders realised, they were pregnant they prepared traditional herbal medicines for them to consume, and some were given robes to wear around their waists in view of protecting them and their unborn children from bad spirits. Therefore, their in-laws discouraged them from attending ANC. The study conducted in Bangladesh as cited by Simkhada, Porter and van Teijlingen (2010:3) revealed that older women, especially mothers-in-law, did not consider ANC essential during pregnancy and often discouraged their daughters-in-law from attending in rural Bangladesh.

Laelago, Yohannes, Lemango (2016:7) reported that during the first trimester of pregnancy in Ethiopia, women who had sufficient knowledge on herbal medicine use were 63 % less likely to use herbal medicine during pregnancy as those who had insufficient knowledge on herbal medicine and less attendance of ANC. Similarly, in

this study, most women were discouraged to attend ANC and were encouraged to use traditional medicines despite questionable knowledge regarding the safety use during pregnancy. Pender's HPM basic human capability indicates symbolisation as the ability to process and transform experiences to create internal models to guide action in the future (George 2010:545). The elders and the in-laws of pregnant women used traditional beliefs such as ropes worn around the waist during pregnancy as a symbol of cultural beliefs passed from generation to generation. This belief has an impact on pregnant women's actions and decisions of attending ANC.

The family, spouse or partner's support during pregnancy plays a crucial role for the expecting mother. Mlotshwa, Manderson and Merten (2017:1) agree with the notion that social relationships and support, both formal and informal, play critical roles in managing health and personal problems in pregnancy. This will encourage pregnant women to attend ANC. The study revealed that lack of support system during pregnancy is associated with the late booking of ANC. It became evident from the study that most pregnant women felt that they do not get support they need from their partners; hence, they lack motivation to attend ANC. This is supported by Gross, Alba, and Glass (2012:1) by stating that having a spouse or partner who is not supportive is associated with non-initiation or late attendance of ANC by pregnant women.

5.4.3 KNOWLEDGE DEFICIT ABOUT PREGNANCY

Health knowledge is an important factor as it enables women to be aware of their rights and health status in order to seek appropriate health services (Onasoga, Afolayan, Oladimeij 2012:3). Several sub-themes that emerged based on the lack of knowledge about pregnancy and feeling ashamed about being pregnant which contributed to non-attendance of ANC. Most participants reported that if they knew that ANC was going to benefit them this much during their previous pregnancies, which did not yield good outcome, they would have attended the ANC as scheduled.

Ali, Dero, Ali and Ali (2018:43) revealed that sufficient knowledge of the benefits of ANC and of the complications associated with pregnancy play an important role in the utilization of ANC services. This is supported by Ebonwu, Mumbauer, Uys, Wainberg and Medina-Marino (2018:2) who stated that women may not know the importance of attending ANC early or may not know how far long in their pregnancy should they be before attending their first ANC appointment. However, even with adequate

knowledge, socio-cultural determinants of health-seeking behaviours may negatively impact utilization of ANC services (Ebonwu *et al*. 2018:2).

Some of the study participants perceived ANC attendance as a service that is rendered for unhealthy pregnant women who have a history of being hospitalised or living with chronic conditions. Hence, it is important to alert pregnant women and their families to the fact that not all risks associated with pregnancy can be easily detected by pregnant women, early ANC attendance is important even when women feel healthy, in order to screen for high risk and early referrals to hospital care (Sychareun, Somphet, Chaleunvong, Hansana, Phengsavanh, Xayavong and Popenoe 2016:7).

This is in line with the study done by Ndidi and Oseremen (2010:47) in which they reported that most women booked antenatal care late because of the belief that there are no advantages of booking Antenatal Care in the first three months of pregnancy. Pender's HPM basic human capability indicates that self-reflection is the ability to consider one's own thought processes and change them (George 2010:545). Hence most pregnant women realised after the interviews the importance and benefits they would have had if they attended the ANC from the early stage of their pregnancies.

Pregnant women delayed ANC attendance due to stigma associated with pregnancy outside of marriage or being seen in public pregnant while they were not married. The study has shown that some pregnant women are faced with judgements and discrimination from their family and the community if they conceived outside wedlock. South Africa has a high rate of fertility outside of marriages and many womenmay still face judgement and stigma while attending ANC early (Erasmus, Knight andDutton 2020:474). This contributes negatively towards the early attendance of pregnant women at the ANC due to fear of shame from their families and thecommunity at large.

Other participants reported that they were afraid to disclose to their parents for fear of being rejected due to the disappointment they brought to the family. Similarly, in the study conducted in Uganda, pregnant adolescents were more likely to experience violence from their parents, rejection from their partners, being expelled from school and stigmatisation (Taylor, Sealy, and Roberts 2017:22). In Ghana, Kenya and Malawi, it was denoted that pregnancy disclosure influenced timing of ANC attendance. Across all sites, adolescents and unmarried younger women hid their pregnancies and delayed ANC to avoid expulsion from their natal home, partner abandonment,

stigmatization and gossip (Pell, Menaca, Were, Afrah, Chatio, Taylor, Hamel, Hodgson, Tagbor, Kalilani, Ouma and Pool 2013:6). This affects the ANC initiation by pregnant women which can pose risks of undetected pregnancy complications.

5.4.4 FINANCIAL CONSTRAINTS

The sub-theme that emerged from the study was based on unemployment of pregnant women and their partners. Some participants reported that they delayed ANC attendance because they did not have money for bus fare as they were not working.

Financial difficulties have been considered as an important barrier to Antenatal Care attendance specifically by most unemployed women including the immigrant women (Zhao, Huang, Yang, Pan, Smith and Xu 2012:12). Some participants reported that their partners whom they were depending on, have been unemployed for several months, so every cent they get they must consider using for basic needs for them to survive. Most of the studies revealed a positive association between socioeconomic status and the utilisation of ANC (Efendi, Chen, Kurniate, and Berliana 2016:7). This also emanated from the study done in Ethiopia which identified that women with higher income tend to start attending ANC earlier in their pregnancies, and the likelihood of utilising ANC decreases as the family income gets lower (Birmeta, Dibaba, Woldeyohannes 2013:13).

In South Africa, most women living in rural areas are unemployed and depend on their partners or grandmothers' pension funds for survival. This was also the case in this study as the participants alluded that most of them or their partners were unemployed which contributed to them either late booking or not attending ANC. Therefore, unemployment rate is still a major challenge in South Africa for pregnant women and their spouses leading to most pregnant women to be fearful to make financial decisions about their pregnancy.

Financially insecure women are often unable to make informed decisions on their own. When women depend financially on their parents, partners or guardians, the decisions about pregnancies are often determined by them (Kaswa, Rupesinghe and Longo-Mbenza 2018:7). Similarly, in the study conducted in Ethiopia, financial constraints

were amongst the most common reasons for late antenatal care booking (Warri and George 2020:2). Hence, most women delay or do not attend scheduled ANC due to financial challenges.

5.5 CONCLUSION

This qualitative study explored factors contributing to attendance of ANC by pregnant women at King Cetshwayo health district in KwaZulu-Natal to meet the objectives of the study. The Nola Pender's HPM Model was used to support and guide the study during the discussion of the findings. Pregnant women raised various issues of concern regarding their attendance of ANC which leads to four major themes and several sub-themes emerged based on the phenomenon. These issues ranged from location of PHC facilities, cultural beliefs and practices during pregnancy, to knowledge deficit about pregnancy and financial constraints. The information from the study confirmed that most pregnant women do not attend the ANC as required for the duration of their pregnancies. This may add to the numbers of undiagnosed pregnancy related complications leading to increased maternal mortality rates.

5.6 LIMITATIONS OF THE STUDY

The study was conducted on pregnant women attending ANC at four PHC facilities at King Cetshwayo District in KwaZulu-Natal. The study findings cannot be generalised based on its qualitative nature. The target population was pregnant women of ages from 18 years with the gestational stage of between 12 weeks to 36 weeks of pregnancy. The study could have yielded different findings

5.7 RECOMMENDATIONS

Based on the findings of the study, the following recommendations are made and presented in an attempt to address the gaps identified during the study: Recommendation to pregnant women and their families, district health managers, policy development and implementation:

5.7.1 Recommendation to pregnant women and their families

- Pregnant women should be taught about pregnancy and related complications including the prevention of maternal mortality by encouraging them to attend all ANC scheduled visits.
- Families and partners of the pregnant women should be taught about the importance and benefits of attending all scheduled ANC visits.
- Elders of pregnant women should be taught about the dangers of encouraging pregnant women to use traditional herbal medicines during pregnancy.

5.7.2 Recommendation to District Health Managers

- Conduct more campaigns regarding pregnancy and the importance of attendance of ANC by pregnant women.
- Encourage the inclusion of pregnant women's family members and their spouses in the importance of pregnancy and attendance of ANC by pregnant women.
- Increase the number of days in a week for mobile clinic visits in the community mobile stopping points.
- Recommend to the road and transport department to consider expanding and maintaining the roads in the rural areas for easy access of mobile clinics providing maternal health care to the community.
- Recommend more transport availability for the community residing in remote rural areas to be able to attend ANC during their pregnancies.
- Increase the number of mobile clinics or building more clinics within the rural community's reach rendering maternal healthcare services.

5.7.3 Policy development and implementation

- Review existing policies and develop new policies regarding reinforcement of early initiation of ANC and implement them.
- Develop policies that include family and partner's support to pregnant women during pregnancy and the importance of ANC attendance.

5.7.4 Further research

- The researcher recommends further research studies regarding the phenomenon to include a wider range of populations, study areas and to broaden the scope of the research topic.

6. REFERENCES

Abbasi, S., Mohajer, H. and Samouei, R. 2016. Investigation of mobile clinics and their challenges: *International Journal of Health System Disaster Management*, 4(1):1-5.

Ali, S.A., Dero, A.A., Ali, S.A. and Ali, G.B. 2018. Factors affecting the utilization of antenatal care among pregnant women: A literature review. *Journal of Pregnancy and Neonatal Medicine*, 2(2); 41-45.

Amna, A. 2015. Late antenatal booking, it barriers and maternal complication: *Israel Medical journal*, 7(1): 38-41.

Amnesty International. 2014. *Amnesty International Report 2014/15 - Bangladesh*, Available at: https://www.refworld.org/docid/54f07e187.html, (Accessed 20 March 2020).

Andrew, E.V.W, Pell, C., Angwin, A., Auwun, A., Daniels, J., Mueller, I., Phuanukoonnon, S., and Pool, R. 2014. Factors affecting attendance at and timing of formal antenatal care: Result from a qualitative study in Madang, *Papua New Guinea: PloS*, Available at: https://doi.org/10.1371/journal.pone.0093025 (Accessed: 15 February 2019).

Birmeta, K., Dibaba, Y. and Woldeyohannes, D. 2013. Determinants of maternal health care utilisation in Holeta town. Central Ethiopia: *Bio-Medical Central Health services*. Available at: https://doi.org/10.1186/1472-6963-13-256, (Accessed 15 July 2020).

Brink, H., Van der Walt, C. and Van Rensburg, G. 2012. *Fundamentals of research methodology for healthcare professionals*, 3rd edition. Cape Town, Juta and Co.

Broeck, J.V., Feijen de Jong, E., Klomp, T., Putman, K., and Beeckman, K. 2016. Antenatal care uses in urban areas in two European countries: Predisposing enabling and pregnancy related determinants in Belgium and Netherlands: *Bio-Medical Central Health services research*: Available at: https://doi.org/10.1186/s12913-016-1478-3, (Accessed 12 August 2018).

Burns, N. and Grove, S.K. 2007. *Understanding nursing research*, 5th edition. Saunders Elsevier.

Burns, N., and Grove, S.K. 2015. *Understanding nursing research: building and evidence based practice,* 6th edition. St Louis, Missouri, Elsevier.

Burns, N., Grove, S. and Grey, J. 2011. *Understanding nursing research building and evidence based practice*, 5th edition. St Louis, Missouri, Elsevier.

Chimatiro, C.S., Hajison, P. Chipeta, E. and Muula, A.S. 2018. Understanding barriers preventing pregnant women from starting antenatal clinic in the first trimester of pregnancy in Ntcheu District Malawi. *Reproductive health*. Available at: https://doi.org/10.1186/s12978-018-0605-5, (Accessed 12 May 2020).

Cronje, H.S., Grobler, A.A. 2009. *Obstetric in Southern Africa*. 6th edition, South Africa, Juta and Co.

Dennil, K., King, T. and Swanepoel, T. 2012. *Aspects of primary health care: community health care in southern Africa*, 2nd edition. Australia, Oxford University.

Department of Health. 2012. *Annual Report*. Available at: www.doh.gov.za (Accessed 15 June 2018).

Department of Health. 2013. Saving Mothers 2011-2013: Sixth report on the Confidential Enquiries into Maternal Deaths in South Africa, Available at: http://www.kznhealth.gov.za/mcwh/maternal/saving-mothers-2011-2013-executive-summary.pdf, (Accessed 10 June 2020).

Department of Health. 2014. Patient's Rights Charter, Available at: https://www.idealclinic.org.za/docs/Posters/PATIENTS%20RIGHTS%20CHARTER%20-%20E, (Accessed 10 May 2020).

Department of Health. 2015. *EThekwini district health plan 2014/2015*. Government printer. Pretoria, Available at: http://www.kznhealth.gov.za/Strategic/DHP/2015-16/eThekwini.pdf, (Accessed 19 June 2019).

Department of Health. 2017. Province of KwaZulu-Natal Annual performance plan 2015-2018.

Ebnwu, J., Mumbauer, A. Uys, M., Wainberg, M.L. and Medina-Marino, A.M. 2018. Determinants of late antenatal care in rural and peri- urban communities in South Africa: a cross sectional study, South Africa, *PLoS One*, 8;13(3): e0191903.

Efendi, F., Chen, C.M, Kurniate, A. and Berliana, S.M. 2016. Determinants of utilization of antenatal care services among adolescents' girls and women in Indonesia, *Women Health*. 57(5):614-629.

Erasmus, M.O., Knight, L. and Dutton, J. 2020. Barriers to accessing maternal health care amongst pregnant adolescents in South Africa: a qualitative study, *International Journal of Public Health* 65; 469–476.

Fagbamigbe, A.F., Idemudia, E.S. 2015. Barriers to antenatal care use in Nigeria: evidences from non-users and implications for maternal health programming. *Bio-Medical Central Pregnancy,* Available at: https://doi.org/10.1186/s12884-015-0527-y (Accessed 12 July 2018).

Garcia, R., Ali, N., Papadopoulos, C., and Randhawa, G. 2015. Specific antenatal intervention for black, Asian, and minority ethnic (BAME) pregnant women at high risk of poor birth outcomes in the United Kingdom: a scoping review: *Bio-Medical Central Pregnancy and childbirth*, Available at: https://doi.org/10.1186/s12884-015-0657-2, (Accessed 12 July 2018).

George, J.B. 2010. Nursing theories: *The base for professional practice*, 6th edition. Carlifonia, Pearson.

Gross, K., Alba, Stylor. and Glass, T.R. 2012. Timing of antenatal care for adolescent and adult pregnant women in south-eastern Tanzania. *Bio-Medical Central Pregnancy Childbirth*, Available at: https://doi.org/10.1186/1471-2393-12-16, (Accessed 15 June 2020).

Haddril, R., Jones, G., and Mitchell, C. and Anumba, D.O.C. 2012. Why do women attend late for antenatal booking? A qualitative interview study exploring the perspective of maternity health and social state holders. Part 1: The service users. *Archives of Disease in Childhood - Foetal and Neonatal Edition,* Available at: http://dx.doi.org/10.1136/fetalneonatal-2012-301809.370, (Accessed: 20 March 2020).

Hijazi, H.H., Alyahya, M.S., Sindiani, A.M., Saqan, R.S. and Okour, A.M. 2018. Determinants of antenatal care attendance among women residing in highly disadvantaged communities in northern Jordan: a cross-sectional study. *Reproductive Health*, 15(1):106.

Hajj, E.I.M. and Holst, L. 2020. Herbal Medicine Use During Pregnancy: A Review of the Literature with a special focus on Sub-Saharan Africa. *Frontiers Pharmacology*, Available at: doi: 10.3389/fphar.2020.00866, (Accessed 12 January 2021).

Issac, O.P., Mensah, C. and Anyaful, T. 2014. The role of transportation in accessing maternal health services: a case study of Sumbrungu health clinic, Accra Ghana: *European Journal of Logistics*.

Kaswa, R., Rupesinghe, G.F.D. Mbenza, B. 2018. Exploring the pregnant women's perspective of late booking of antenatal care services at Mbekweni Health Centre in Eastern Cape, South Africa, *African Journal of Primary Health Care and Family Medicine,* Available at: DOI: 10.4102/phcfm.v10i1.1300, (Accessed 17 February 2020).

Department of Health. 2017. *Budget speech delivered by MEC Dr S. Dhlomo*. KwaZulu-Natal legislature, Available at: http://www.kznhealth.gov.za/MEC-Dhlomo-Speech.asp, (Accessed 19 Aril 2018).

Kyei, N.N.A., Chansa, C. and Gabrysch, S. 2012. Quality of antenatal care in Zambia: a national assessment Zambia, *Bio-Medical Central Pregnancy and childbirth*, Available at: https://doi.org/10.1186/1471-2393-12-151, (Accessed 10 June 202).

Laelago, T., Yohannes, T. Lemango, F. 2016. Prevalence of herbal medicine use and associated factors among pregnant women attending antenatal care at public health facilities in Hossana Town, Southern Ethiopia: facility based cross sectional study, *Arch Public Health*, Available at: https://doi.org/10.1186/s13690-016-0118-z, (Accessed 23 February 2021).

Lattof, S.R., Moran, A.C. Kidula, N. Moller, A.N. Jayathilaka, C.A. Diaz, T and Tuncalp, O. 2020. Implementations of new WHO antenatal care model for a positive pregnancy experience: a monitoring framework, *British Journal of Global health*, Available at: 10.1136/bmjgh-2020-002605, (Accessed 20 November 2020).

Lau, Y.K., Cassidy, T., Hacking, D., Brittain, K, Haricharan, H, J, Heap, M. 2014. Antenatal health promotion via short message service at a Midwife Obstetrics Unit in South Africa: A mixed methods study, *Bio-Medical Central Pregnancy and Childbirth*: Available at: https://doi.org/10.1186/1471-2393-14-284, (Accessed 23 August 2018).

Lincoln, Y.S. and Guba, E.G. 1985. *Naturalistic inquiry*, San Francisco; Sage

Maluka, S.O., Joseph, C., Fitzgerald, S. Salim, R. and Kamuzora, P. 2020. Why do pregnant women in Iringa region in Tanzania start antenatal care late? A qualitative analysis, *Bio-Medical Central Pregnancy Childbirth*, Available at: https://doi.org/10.1186/s12884-020-2823-4, (Accessed 14 January 2021).

Mannava, P., Durrant, K., Fisher, J. Chersich, M. and Luchters, S. 2015. Attitudes and behaviours of maternal health care providers in interactions with clients: a systematic review. *Global Health*, https://doi.org/10.1186/s12992-015-0117-9, (Available 25 July 2019).

Mlotshwa, L., Manderson, L. and Merten, S. 2017. Personal support and expressions of care for pregnant women in Soweto, South Africa. *Global health action*, 10(1): 1363454.

National Department of Health (of South Africa). 2012. Strategic plan for maternal, new-born, child and women's health (MNCWH) and nutrition in South Africa 2012-2016 Available at: www.doh.gov.za/docs/stratdocs/2012/MNCWHstratplan.pdf, (Accessed 12 February 2018).

Ndidi, E.P. and Oseremen, I.G. 2010. Reasons given by pregnant women for late initiation of Antenatal Care in the Niger Delta, Nigeria, *Ghana Medical Journal*. 44(2): 47–51.

Ngxongo, T.S.P., Sibiya, M.N., and Gwele, N.S. 2016. Experiences and views of the pregnant women regarding the basic antenatal approach to healthcare services approach in eThekwini District, Kwa-Zulu-Natal: *Journal of Nursing and Health Sciences*, 3(1):5-14.

Ngxongo, T.S.P., Sibiya, N.M., and Gwele, N.S. 2016. Evidence of application of basic antenatal care principles of good care and guidelines in pregnant women's antenatal care records: *African Journal Primary Healthcare Family Medicine*, 8(2): 1-6.

Ngxongo, T.S.P., Sibiya, N.M., and Gwele, N.S. 2017. Implementation of basic antenatal care approach in Ethekwini district, KwaZulu-Natal, South Africa. *African Journal for Physical Activity and Health Sciences*, Available at: https://www.ajol.info/index.php/ajpherd/article/view/158772, (Accessed 15 May 2019).

Onasoga, O.A., Afolayan J.A, Oladimeij, B.D. 2012. Factors influencing utilization of antenatal care services among pregnant women in Central Lagos, Osun State Nigeria, *Advances in Applied Science Research,* 3(3): 1309-1315.

Pell, C., Menaca, A., Were, F., Afrah, N.A., Chatio, S., Taylor, L.M., Hamel, M.J., Hodgson, A., Tagbor, H., Kalilani, L., Ouma, P. and Pool, R. 2013. Factors affecting antenatal care attendance: Result from a qualitative study in Ghana, Kenya and Malawi, *PloS ONE,* 8(1): e53747*.*

Polit, D.F. and Beck, C.T. 2012. *Generating and assessing evidence for nursing practice*. 9th edition. Philadelphia, Lippincott Williams and Wilkins.

Polit, D.F., and Beck, C.T. 2014. *Essentials of nursing research: Appraising evidence for nursing practice*, 8th edition, Lippincott Williams and Wilkins, Philadelphia.

Polit, D.F. and Beck, C.T. 2017. *Nursing research: generating and assessing evidence for nursing practice*, Lippincott Williams and Wilkins, Philadelphia.

Prothero., S.E.M. 2010. *Blackwell's Nursing dictionary*, 2nd edition Southern Africa: Juta and Co.

Schmidt, A.A. and Brown, J.M. 2009. *Evidence based practice for nurses: appraisal and application of research*, London, Jones and Bartlett.

Schoon, M.G. and Motlolometsi, M.W.A. 2012. Poor maternal outcomes: A factor of poor professional systems design. *South African Medical Journal,* 102(10): 784-786.

Simkhada, B., Porter, M. and Van Treijlingen, E.R. 2010. The role of mothers in law in antenatal care decision making in Nepal: a qualitative study. *Bio-Medical Central Pregnancy childbirth*, Available at: https://doi.org/10.1186/1471-2393-10-34, (Accessed 16 July 2020).

Smith, A. 2016. Why mothers are not accessing antenatal care early in their pregnancies. *SATS*: May 2.

Solarin, J and Black, V. 2013. “They told me not to come back” women’s antenatal booking experience in inner-city Johannesburg. *Maternal and Child Health Journal* 17(2): 359-367.

Sumera, A.A., Dero, A.A., and Ali, S.A. 2018. Factors affecting utilization of antenatal care among pregnant women: A literature review Pakistan, *Pregnancy and neonatal medicine*, 2(2):41-45.

Sychareun, V., Somphet, V. Chaleunvong, K, Hansana, V. Phengsavanh, A. Xayavong, S. and Popenoe, R. 2016. Perceptions and understanding of pregnancy, antenatal care and postpartum care among rural Lao women and their families, Lao: Bio-Medical Central pregnancy and childbirth, Available at: https://doi.org/10.1186/s12884-016-1031-8,Accessed 10 October 2020.

Tylor, L.M., Sealy, D.A. and Roberts, J. 2017. Factors associated with delayed antenatal care attendance in Malawi: Result from a qualitative study, *Medical journal of Zambia*, 44 (1):17-25.

UNICEF. 2012. Committing to child survival: A promise renewed: A global movement to end preventable child deaths, progress support 2013. Available at: http://www.unicef.org/sowc2012/, (Accessed 25 July 2018).

Varela, C., Young, S. Mkhandawire, N. Greon, R.S. Banza, L. and Viste, A. 2019. Transportation barriers to access health care for surgical conditions in Malawi: a cross sectional nationwide household survey, Malawi: a cross sectional nationwide household survey, *Bio-Medical Central Public Health*, Available at: https://doi.org/10.1186/s12889-019-6577-8, (Accessed 20 April 2020).

Warri, D. and George, A. 2020. Perceptions of pregnant women of reasons for late initiation of antenatal care: a qualitative interview study, *Bio-Medical Central Pregnancy Childbirth*, Available at: https://doi.org/10.1186/s12884-020-2746-0, (Accessed: 15 January 2021).

World Health Organisation. 2012. *Early marriages, adolescent and pregnancies. Report by the secretariat,* Geneva, Available at: https://apps.who.int/iris/handle/10665/78901, (Accessed 10 February 2020).

World Health Organization. 2015. Recommendations-optimize MNH: Optimizing health worker roles to improve access to key maternal and new-born health interventions through task shifting, Available at: https://optimizemnh.org/, (Accessed 20 July 2020).

Zhao, Q., Huang, J. Yang, S. Pan, J. Smith, B. and Xu, B. 2012. The utilisation of antenatal care among rural to urban migrant women in Shanghai: A hospital based cross sectional study, *Bio-Medical Central public health*, Available at: https://doi.org/10.1186/1471-2458-12-1012, (Accessed 13 October 2020).

ANNEXURE 1: INTERVIEW GUIDE FOR PREGNANT WOMEN

Date: ………………… **Participant no**: ……………….

Institution code: ☐

SECTION A: DEMOGRAPHIC DATA

What is your age? ……………………… What is your religion? ……………………

Are you married? …………………….

What is your gender? ………………… What is your level of education? …………

Are you employed? ……………...

SECTION B: GRAND TOUR QUESTION

Tell me more about your views and experiences regarding non-attendance of antenatalcare at King-Cetshwayo District Healthcare institutions.

Any other probing questions following the participants' responses will be used to facilitate the discussion.

ANNEXURE 2A: PARTICIPANT INFORMED CONSENT

INFORMED CONSENT DECLARATION

(Participant)

Project Title: **Exploration of factors contributing to the non-attendance of antenatal care by pregnant woman at King-Cetshwayo District in KwaZulu-Natal.**

……………………. from the Department of Nursing Science, University of Zululand has requested my permission to participate in the above-mentioned research project.

The nature and the purpose of the research project, and of this informed consent declaration have been explained to me in a language that I understand.

I am aware that:

1. The purpose of the research project is to describe and explore factors contributing to the non-attendance of antenatal care by pregnant women in King-Cetshwayo District in KwaZulu-Natal.
2. The University of Zululand has given ethical clearance to this research project and I have seen/ may request to see the clearance certificate.
3. By participating in this research project I will be contributing towards adherence and attendance of antenatal care scheduled visits by pregnant women.
4. I will participate in the project by contributing by giving information on the topic to the researcher during interviews.
5. My participation is entirely voluntary and should I at any stage wish to withdraw from participating further, I may do so without any negative consequences.
6. I will not be compensated for participating in the research, but my out-of-pocket expenses will be reimbursed. (*there will be no compensation for the participants*).
7. There may be risks associated with my participation in the project. I am aware that the will be no risks associated with my participation and there is a 0% chance of the risk materializing.
8. The researcher intends publishing the research results in the form of articles,

However, confidentiality and anonymity of records will be maintained and that my name and identity will not be revealed to anyone who has not been involved in the conduct of the research.

9. I will receive feedback in the form of published article regarding the results obtained during the study.
10. Any further questions that I might have concerning the research or my participation will be answered by myself (***provide name and contact details***)
11. By signing this informed consent declaration, I am not waiving any legal claims, rights or remedies.
12. A copy of this informed consent declaration will be given to me, and the original will be kept on record.

I, ……………………………………………………………………………... have read the above information / confirm that the above information has been explained to me in a language that I understand and I am aware of this document's contents. I have asked all questions that I wished to ask and these have been answered to my satisfaction. I fully understand what is expected of me during the research.

I have not been pressurised in any way and I voluntarily agree to participate in the above-mentioned project.

…………………………………. …………………………………….

Participant's signature **Date**

ANNEXURE 2B: IFOMU LOKUZIBOPHEZELA

(obambe iqhaza)

Isihloko socwaningo:

.... ovela ku Mnyango wemfndo ephakeme eqeqesha abongikazi, University of Zululand ube nesicelo semvume yokuzibandakanya kulolucwaningo olulotshwe ngenhla.

Imvelaphi kanye nenhloso yalolucwaningo, nalolu lwazi nophawu lokwamukela ukuzibophezela ngichazeliwe ngalo ngolimi engilwaziyo.

Ngiyakuqonda ukuthi:

1. Inhloso yalolucwaningo uku ……………………………….

2. Inyuvesi yakwaZulu inikezele ngemvume kubenzi balolu cwaningo ukuba benze loluhlelo futhi ngiyibonile leyomvume/ngingacela ukubona isitifiketi semvume.

3. Ngokubamba iqhaza kulolucwaningo ngizonikezela iqhaza ngoku ……………………………… **(chaza ubungako obulindelekile noma inzuzo emphakathini noma abantu abangaphumelela ngalolucwaningo)**

4. Ngizobamba iqhaza kulolucwaningo ngoku... **(chaza imininingwane ephelele yokuthi ozimbandakanyile uzobe enzani)**

5. Ekuzibandakanyeni kwami angizukubheka nzuzo futhi akukho lapho engizotholakala ngihoxa ocwaningweni, umakwenzeka ngeke kube nemiphumela emibi ocwaningeni.

6. Mina angizukunxephezelwa ngokuzibandakanya kwami kulolucwaningo, kodwa izindleko ephume kwelami iphakethe zizokhokhelwa. (asikho isinxephezelo).

7. Kuzoba nezimo ezibucayi ekuzibandakanyeni kwami kulolucwaningo , ngiyakuqonda ukuthi:

   a. Lobu bungozi obulandelayo kuxhumene nokuzimbadakanya kwami ………………………… **(chaza imininingwane yonke ngobungozi okungaba khona kumuntu ozimbandakanye nalolucwaningo**)
   b. Lezi zitebhu ezilandelayo zithathiwe ukuvikela ubungozi: ……………………
   c. Angu.................% amathuba okuvela kobungozi.

8. Umphequluli uzoshicilela imiphumela yalolucwaningo ngohlelo loku………………………Nokho, ubhalomfihlo, nofihlo-gama lweminininingwane izobe igciniwe nokuthi igama lami nobutho kwami angeke kubonakaliswe kumona yimuphi umuntu obengayona inhlangano yocwaningo.

9. Angeke ngiyamukele imiphumela/ngizoyamukela imiphumela engaloluhlelo……………….. emayelana nemiphumela etholakale ngesikhathi sesifundo.
10. Eminye imibuzo ephathelene nalolucwaningo noma mayelana nokuzibandakanya kwami ingaphendulwa ngu …………………………………… **(bhala igama nemininingwane yokuxhumana)**
11. Ngokusayina lamafomu angiqubuli ubuthi noma amalungelo kwezomthetho
12. Ikhophi enolwazi oluphelele nophawu lokwamukela ukuzibophezela kwami ngizonikezwa, bese okungungqo kuyagcinwa.

Mina ………………………………ngilufundile loku okubhalwe ngenhla/ ngiyavuma ukuthi lolulwazi olungenhla ngichazelwe ngolimi lwami engiluqondayo futhi ngiyakuqonda okuqukethwe nokubhaliwe. Ngiyibuze yonke imibuzo engifunayo ukuyibuza, futhi yaphendulwa ngendlela engenelisayo. Ngiyayiqonda kahle ukuba kulindelekile ini kimi kulolucwaningo.
Angiphoqwanga nakancane ukubamba iqhaza kulokhu kulolucwaningo

------------------------------------ --

isishicilelo kobambe iqhaza **usuku**

UKUZIBOPHEZELA KOMCWANINGI

Mina .... ngiyavuma ukuthi

- Ngichazile ulwazi olukuleli bhuku ku

……………………………………………………………….
- Ngicelile ukuthi kubuzwe imibuzo uma kukhona la kungaqonakali khona ngizoyiphendula ngobuqotho
- Nginelisekile ukuthi u ------------------------------- uzwile indlela lolucwaningo oluzosebenza ngayo, lokhu okumenze wathatha isinqumo sokuthi alibambe yini iqhaza noma cha
- Ingxoxo yennziwa ngesiZulu
- Ngimsebenzisile noma/ angimsebenzisanga utolika

----------------------------------- -------------------------------

Isishicilelo somcwaningi **usuku**

ANNEXURE 3: RESEARCHER'S DECLARATION

I, Zolani Lucky Nkonzo declare that:

- I explained the information in this document to

  ……………………………………………………………..……………………..………..

- requested him/her to ask questions if anything was unclear and I have answered them as best I can.
- I am satisfied that s/he sufficiently understands all aspects of the research so as to make an informed decision on whether or not to participate.
- The conversation took place in isiZulu / English.
- I did not use an interpreter.

…………………………………	…………………………………
Researcher's signature	**Date**

ANNEXURE 4: ACCESS LETTER REQUESTING PERMISSION TO CONDUCT RESEARCH STUDY

University of Zululand
PO Box X1001
KwaDlngezwa
3886

The KwaZulu-Natal Department of Health Research Unit
………. Pietermaritzburg
Private Bag
……..

Date: ---------------

Dear Ms/Mr

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I am a registered Master Degree student in the Faculty of Science and Agriculture, Department of Nursing Science at the University of Zululand. My supervisor is Dr ST Madlala, co-supervisors are Mrs N Ngcobo, and Dr RM Miya.

The proposed topic of my research is: **Exploration of factors contributing to non-attendance of antenatal care by pregnant woman at King-Cetshwayo District in KwaZulu-Natal**

The objectives of the study are:

- To explore factors contributing to the attendance of antenatal care to pregnant woman.
- To determine measures to be taken to improve the attendance of antenatal care by pregnant women.

I am hereby seeking your consent to conduct the research study. To assist you in reaching a decision, I have attached to this letter:

(a) A copy of an ethical clearance certificate issued by the University
(b) A copy the research instruments which I intend using in my research

Should you require any further information, please do not hesitate to contact me or my supervisor.
Our contact details are as follows:

Mr Zolani Lucky Nkonzo, Cell number: 073 083 1082, email: znkonzo22@gmail.com, my Supervisor Dr ST Madlala, office number: 035 902 6512, email: madlalas@unizulu.ac.za and University of Zululand Research office **Professor G F De Wet, office number:** 035 902 6355, email: mashabax@unizulu.ac.za

Upon completion of the study, I undertake to provide you with a bound copy of the dissertation.

Your permission to conduct this study will be greatly appreciated.

Yours sincerely,

Signature: ……………………….

Name: Mr Zolani Lucky Nkonzo
Student number: 201860891

ANNEXURE 5A and B: UZREC ETHICAL CLEARANCE CERTIFICATE

UNIVERSITY OF ZULULAND
RESEARCH ETHICS COMMITTEE
(Reg No: UZREC 171110-030)

RESEARCH & INNOVATION
Website: http://www.unizulu.ac.za
Private Bag X1001
KwaDlangezwa 3886
Tel: 035 902 6731
Fax: 035 902 6222
Email: DlelanaM@unizulu.ac.za

ETHICAL CLEARANCE CERTIFICATE

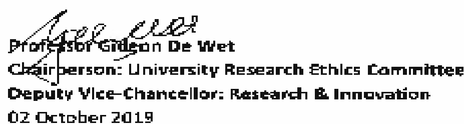
Certificate Number	UZREC 171110-030 PGM 2019/47						
Project Title	EXPLORATION OF FACTORS CONTRIBUTING TO THE ATTENDANCE OF ANTENATAL CARE BY PREGNANT WOMAN AT KING CETSHWAYO DISTRICT IN KWAZULU-NATAL						
Principal Researcher/ Investigator	Zolani L. Nkonzo						
Supervisor and Co-supervisor	Dr S.T Madlala						
Department	Nursing						
Faculty	Science and Agriculture						
Type of Risk	Med Risk – Data collection from people						
Nature of Project	Honours/4th Year		Master's	x	Doctoral		Departmental

The University of Zululand's Research Ethics Committee (UZREC) hereby gives ethical approval in respect of the undertakings contained in the above-mentioned project. The Researcher may therefore commence with data collection as from the date of this Certificate, using the certificate number indicated above.

Special conditions:

(1) This certificate is valid for 1 year from the date of issue.
(2) Principal researcher must provide an annual report to the UZREC in the prescribed format [due date-01 October 2020]
(3) Principal researcher must submit a report at the end of project in respect of ethical compliance.
(4) The UZREC must be informed immediately of any material change in the conditions or undertakings mentioned in the documents that were presented to the meeting.

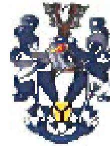
The UZREC wishes the researcher well in conducting research.



Professor Gideon De Wet
Chairperson: University Research Ethics Committee
Deputy Vice-Chancellor: Research & Innovation
02 October 2019

CHAIRPERSON
UNIVERSITY OF ZULULAND RESEARCH ETHICS COMMITTEE (UZREC)
REG NO: UZREC 171110-30
02 -10- 2019
RESEARCH & INNOVATION OFFICE

UNIVERSITY OF ZULULAND
RESEARCH ETHICS COMMITTEE
(Reg No: UZREC 171110-030)



RESEARCH & INNOVATION
Website: http://www.unizulu.ac.za
Private Bag X1001
KwaDlangezwa 3886
Tel: 035 902 6273
Email: ViljoenD@unizulu.ac.za

ETHICAL CLEARANCE CERTIFICATE

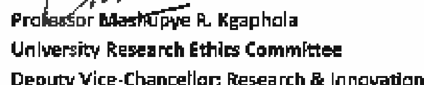
Certificate Number	**UZREC 171110-030 PGM 2019/47**
Project Title	**EXPLORATION OF FACTORS CONTRIBUTING TO THE ATTENDANCE OF ANTENATAL CARE BY PREGNANT WOMAN AT KING CETSHWAYO DISTRICT IN KWA-ZULU NATAL**
Principal Researcher/ Investigator	Z.L Nkonzo
Supervisor and Co-supervisor	Dr S.T Madlala
Department	Nursing
Faculty	Science and Agriculture
Type of Risk	Medium Risk – Data collection from people
Nature of Project	Honours/4th Year [ ] Master's [x] Doctoral [ ] Departmental [ ]

The University of Zululand's Research Ethics Committee (UZREC) hereby gives ethical approval in respect of the undertakings contained in the above-mentioned project. The Researcher may therefore commence with data collection as from the date of this Certificate, using the certificate number indicated above.

Special conditions

(1) This certificate is valid for 1 year from the date of issue.
(2) Principal researcher must provide an annual report to the UZREC in the prescribed format [due date-09 March 2022]
(3) Principal researcher must submit a report at the end of project in respect of ethical compliance.
(4) The UZREC must be informed immediately of any material change in the conditions or undertakings mentioned in the documents that were presented to the meeting.

The UZREC wishes the researcher well in conducting research.



Professor Mashupye R. Kgaphola
University Research Ethics Committee
Deputy Vice-Chancellor: Research & Innovation

09 March 2021

CHAIRPERSON
UNIVERSITY OF ZULULAND RESEARCH
ETHICS COMMITTEE (UZREC)
REG NO: UZREC 171110-30
09-03-
RESEARCH & INNOVATION OFFICE

ANNEXURE 6: HEALTH DISTRICT SUPPORT LETTER

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

DIRECTORATE

Physical Address: No2 Lood Avenue Corner of Chrome & Crescent Empangeni
Postal Address: P/Bag x20034, Empangeni Rail 3910
Tel: 035-787 6201 Fax: 035-7870044 Email: khenyc.hlaphe@kznhealth.gov.za
www.kznhealth.gov.za

Reference: Research Study

Date: 20 November 2019

To: Principal Investigator: Zolani L Nkonza
Student Number: 201860891
Masters of Nursing Science
Nursing Science
University of Zululand
Email: znkonzo22@gmail.com

Supervisor: Dr. ST Madlala

CC: Dr. E Lugte: Manager Research Unit ZN DOH

CC: Dr. SNT Vilakazi: CEO Nseleni CHC

RE: PERMISSION TO CONDUCT RESEARCH "EXPLORATION OF FACTORS CONTRIBUTING TO THE ATTENDANCE OF ANTENATAL CARE BY PREGNANT WOMEN AT KING CETSHWAYO DISTRICT IN KWAZULU – NATAL"

I have pleasure in informing you that permission has been granted to you by the King Cetshwayo District Director to conduct research on **"Exploration of Factors Contributing to the Attendance of Antenatal Care by Pregnant Women at King Cetshwayo District in Kwazulu – Natal"**

Please note the following:-

1) Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2) This research will only commence once this office has received approval of your study from the Provincial Health Research and Ethics Committee (PHREC) in the KZN Department of Health.
3) Please ensure this office is informed before you commence your research.
4) The District office/facility will not provide any resources for this research.
5) You will be expected to provide feedback on your findings to the District Office/Facility.
6) You are required to contact this office regarding dates for providing feedback when the research has been completed.

Sincerely,

Mrs. NE Hlophe
District Director:
King Cetshwayo District

Fighting Disease, Fighting Poverty, Giving Hope

ANNEXURE 7: KWAZULU-NATAL RESEARCH ETHICS CLEARANCE

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

DIRECTORATE:

Physical Address: 330 Langalibalele Street, Pietermaritzburg
Postal Address: Private Bag X9051
Tel: 033 395 2805/ 3189/ 3123 Fax: 033 394 3782
Email:
www.kznhealth.gov.za

Health Research & Knowledge Management

Ref: KZ_201910_003

Dear Mr Z Nkonzo
(University of Zululand)

Subject: Approval of a Research Proposal:

1. The research proposal titled **'EXPLORATION OF FACTORS CONTRIBUTING TO THE ATTENDANCE OF ANTENATAL CARE BY PREGNANT WOMAN AT KING CETSHWAYO DISTRICT IN KWAZULU-NATAL'** was reviewed by the KwaZulu-Natal Department of Health (KZN-DoH).

   The proposal is hereby **approved** for research to be undertaken at the selected clinics at King Cetshwayo District.

2. You are requested to take note of the following:

   a. *Kindly liaise with the facility manager BEFORE your research begins in order to ensure that conditions in the facility are conducive to the conduct of your research. These include, but are not limited to, an assurance that the numbers of patients attending the facility are sufficient to support your sample size requirements and that the space and physical infrastructure of the facility can accommodate the research team and any additional equipment required for the research.*
   b. *Please ensure that you provide your letter of ethics re-certification to this unit, when the current approval expires.*
   c. *Provide an interim progress report and final report (electronic and hard copies) when your research is complete.*

3. Your final report must be posted to HEALTH **RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Ms G Khumalo on 033-395 3189.

Yours Sincerely

Dr E Lutge
Chairperson, Health Research Committee
Date: 2/10/19

ANNEXURE 8: EDITING CERTIFICATE

PO Box 77214
Empangeni
3880

Mobile: 074 9211 480
Email: zanibaz@yahoo.com

Professional EDITORS Group | An association of editors in educational academic and general publishing

To whom it may concern

This serves to confirm that the document whose details appear below has been expertly proofread and edited.

Document Title: **EXPLORATION OF FACTORS CONTRIBUTING TO THE ATTENDANCE OF ANTENATAL CARE BY PREGNANT WOMEN AT KING CETSHWAYO DISTRICT IN KWAZULU-NATAL**

Author: ZL Nkonzo

Date: 2021/04/02

Professional EDITORS Guild

X

Dr Berrington Ntombela
Proofreader/Editor

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