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**REASONS FOR LATE INITIATION OF ANTENATAL CARE AMONG PREGNANT
WOMEN IN TSHWANE: A NARRATIVE INQUIRY**

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Dedicated to my late father and mother Simeon and Dinah who instilled the spirit of learning and perseverance

MAFALO

Declaration

I, Eunice B Sihlangu, declare that this thesis, entitled, “**REASONS FOR LATE INITIATION OF ANTENATAL CARE AMONG PREGNANT WOMEN IN TSHWANE: A NARRATIVE INQUIRY**” is my own work, and that all the sources used or quoted in this research study have been indicated and acknowledged by means of complete references. Furthermore, I declare that this work has not been submitted for any other degree at any other institution.

Researcher's signature

Witness's signature

Date signed

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Abstract

Background

The incidence of late initiation of antenatal care in South Africa remains high, despite the reported benefits of early initiation of antenatal care and free antenatal care services since 1994. Antenatal care is a crucial strategy to reduce maternal and perinatal morbidity and mortality. Whenever antenatal care is initiated late, the opportunity to prevent, detect and treat pre-existing medical conditions and pregnancy-related complications becomes limited hence contributing to maternal and perinatal mortality.

Aim of the study

The study aimed to explore and describe the reasons for late initiation of antenatal care among pregnant women at a selected community health centre in Tshwane.

Research design and method

A narrative inquiry was conducted. Participants belonged to the same community. Data was collected using semi-structured interviews among ten pregnant women who initiated antenatal care after 20 weeks of gestational age at the selected community health centre. Interviews were recorded, transcribed, and analysed according to thematic analysis.

Results

Individual stories were analysed to get the content of their accounts, then the meaning of all the stories was collated to bring about the broad story of the reasons contributing to the late initiation of ANC. Four central themes and ten sub-themes were identified. These are namely unplanned pregnancy (unaware of pregnancy, contraceptive failure), work circumstances (lack of opportunity to attend ANC and stress from work), dilemma of reporting (fear of reporting and embarrassment) and service delivery issues (pregnancy confirmed somewhere else, service delivery flow, shortage of staff and misdiagnosis of pregnancy).

Conclusion

Regarding the ANC received, participants were satisfied. None complained about nurses' attitudes. The need for women empowerment concerning their reproductive health and rights is very fundamental. There is a great need for motivating the use of Long Acting Reversible Contraceptives among women in their reproductive ages, to prevent unplanned pregnancies. ANC services should be extended to after hours and weekends to reach women struggling with socioeconomic circumstances or disadvantages. Lastly, there should be regular reinforcement and monitoring the implementation of existing policies to improve quality care.

Keywords: Antenatal care, late initiation, midwifery, midwife obstetric units, pregnancy.

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List of Abbreviation

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
BANC	Basic Antenatal Care
CHC	Community Healthcare Centre
DoH	Department of Health
HIV	Human Immunodeficiency Virus
LARC	Long Acting Reversible Contraceptive
MOU	Midwife Obstetric Unit
NCCEMD	National Committee for Confidential Enquiry into Maternal Death
TB	Tuberculosis
USA	United States of America
UK	United Kingdom
WHO	World Health Organization

1. Orientation to the study

1.1 INTRODUCTION

Chapter one orientates the reader to the study, concentrating on the background and problem statement, the significance of the study, research aim and the research question. It also outlines concept clarification, research design and research methods used to address the aim. Ethical considerations adhered throughout the study process are delineated then the layout of chapters is presented, and lastly the summary.

1.2 BACKGROUND

It is estimated that globally, there is approximately 289 000 maternal deaths and nearly 2,8 million neonatal deaths that occur each year (WHO 2014:2; Oza et al. 2015:19). These deaths may be caused by several factors such as delivery conducted by unskilled persons, lack of transport, incorrect referral of high-risk pregnancies and the late initiation of antenatal care (Pattinson 2013:12; National Committee For Confidential Enquiry into Maternal Death 2014:57). Antenatal care (ANC) refers to the care given to women during pregnancy from the time the pregnancy is confirmed until the beginning of labour (Pattinson 2007:2). It is an essential section of primary health care and mainly utilised for preventive, promotive and minor curative care (Balogun 2007:80; Azuogu 2011:75). Within the continuum of care, antenatal care (ANC) provides a platform for critical healthcare functions. Thus, timely implementation and appropriate evidence-based practices during ANC can improve maternal and foetal health (WHO 2017:860).

According to Unicef (2018: On line) 86% of pregnant women access antenatal care with skilled health personnel at least once, only three in five (62%) attend at least four antenatal visits. In regions with the highest rates of maternal mortality, such as sub-Saharan Africa and South Asia, only 46% to 52% of women attended four or more antenatal. The antenatal care coverage in South Africa for at least one visit and four visit are 94% and 76% respectively in 2016 (Unicef 2018: Online). In the Republic of South Africa, the statistics for the prevalence of late initiation of ANC are not clear as no data has been captured in the WHO statistics. However (Ebonwu, Mumbauer, Uys, Wainberg, Medina-Marino 2018:4) indicated that 34% to 43% of women initiate ANC late in districts in Limpopo South Africa.

1 2.1 DEVELOPMENT OF ANC

Development of ANC was discussed in view of the developed, developing countries and in South Africa. SUBSTANTIAL

1.2.1.1 DEVELOPED COUNTRIES

Antenatal care was initially designed from developed countries to reduce maternal mortality. The first ANC programme was considered in Europe in the first decade of the 20th century (Lindmark, Berendes & Meirik 1998:4). The programme focused mainly towards women living in socially challenging conditions. Further, the need for maternal health programme came up in 1920. Consequently, the USA obstetricians indicated the need for identification of behavioural causes of maternal deaths, which could either be from the woman, family, midwife or physician (Lindmark et al. 1998:4). The reason that made these countries to want to reduce maternal mortality is that the problem was acknowledged by both the politicians and the community. According to De Brouwere, Tonglet and Van Lerberghe (1994: 771), the political and social strategies that made the dramatic reduction of maternal mortality were the recognition of the magnitude of the problem and the professionalisation of midwifery care. The establishment of ANC in developed countries was challenged by countries with most favourable maternal and perinatal indicators (Lindmark, Berendes & Meirik 1998:4-5). The reason for the challenge was because ANC was acknowledged for the reduction of maternal and perinatal deaths without much evidence of its specific benefits. Further, the countries demanded scientific evidence for medical interventions, and it was realised that there was a significant lack of substantive explanation for many procedures that have been introduced successively into ANC (Lindmark, Berendes & Meirik 1998:4)

1.2.1.2 DEVELOPING COUNTRIES

In developing countries, professionals knew about the technologies to reduce maternal mortality since they were developed. However, the progress in knowledge and technical knowledge had little impact due to failure to mobilise resources adequately (De Brouwere, Tonglet & Van Lerberghe 1994: 775). According to Abou- Zahr and Wardlaw (2003:2) “most antenatal care programmes in developing countries were established along the lines of those used in developed countries, with little adjustment for local conditions”. Maternal mortality was not a matter of public concern despite its increased levels (De Brouwere, Tonglet & Van Lerberg

1994:775). Further, this was because most women were dying at home and their lives were poorly valued. The visibility of perinatal deaths attracted funding and planning agencies, who decided to have more of an impact on child mortality than women mortality. Moreover, De Brouwere Tonglet and Van Lerberghe (1994:776) indicate that the failure of professionals and decision makers among the concerns of the population, caused the development of ill-informed strategies which did not achieve results. In 1950, the WHO introduced a package of measures to reduce maternal mortality which focuses on ANC and the education of mothers.

Like other developing countries, South Africa adheres to the WHO's recommendations concerning ANC in the reduction of maternal mortality. The Minister of Health Dr Nkosazana Dlamini -Zuma declared free ANC services as well as improved access to primary health care since 1996, and that improved women's health. Focused ANC was implemented in South Africa since 2008 according to the WHO's recommendations for reducing the number of ANC visits in developing countries. Evidence suggested that having fewer ANC visits do not affect the outcomes of care, other than women's satisfaction levels (Mametja 2009:1). In South Africa, the focused ANC package is called Basic Antenatal Care programme (BANC). Pattinson (2007:2) describes BANC as a simplified process of providing ANC where only interventions that are effective during ANC are performed.

BANC suggest that pregnant women need to attend ANC within the first 20 weeks of their pregnancy to benefit from the services offered such as health education, recognition and management of pregnancy-related complications and screening for underlying medical conditions (Pattinson 2007:5). The National Committee for Confidential Enquiry into maternal deaths (2014: v) reveals that between 2002-2004 and 2011-2013 maternal deaths have doubled due to pre-existing medical conditions and previous surgeries. Therefore, pregnant women initiating ANC late, fail to fully utilise the available health care services during their antenatal period resulting in maternal and perinatal complications and mortalities (Phaladi-Digamela 2014:4; Mametja 2009:1).

According to Pattinson (2013:17), late initiation of ANC increases the risk of stillbirths in view of pregnant women's inadequate knowledge on how to respond to weak foetal movements. Also, the burden of Human Immune Deficiency Virus (HIV) remains high. Since pregnant woman initiate ANC late, they miss opportunities for early diagnosis and treatment.

Furthermore, when a pregnant woman who is HIV positive initiates ANC at 35 weeks of gestation, the possibility of a mother transmitting HIV to the child becomes very high. The antiretroviral treatment would have commenced late and the viral load not sufficiently decreased by the time of delivery. Furthermore, the time for the mother to deal with the psychosocial factors of being diagnosed with HIV may be reduced and affect the adherence to antiretroviral treatment (Mametja 2009:12).

Feijen-de Jong et al. (2011:904), report that ANC had contributed mainly to the decline of perinatal and infant mortality in high-income countries during the last century. However, the late initiation of ANC remains a global concern. The ANC utilisation in the European American regions ranges from 80-86% (WHO 2013:104). A study conducted in the United Kingdom reports that 37,5% of pregnant women initiate ANC late (Creswell et al. 2013:6). In the Sub-Saharan region of Africa, 69% of pregnant women attend ANC at a minimum of once compared to the 54% in Asia (Zeidan, Idris & Bhairy 2010:590). In Kenya, Delva et al. (2010:584) found that 52.2% of pregnant women in rural areas attend ANC at least once while 49.2% from their urban counterparts also attend ANC once. Furthermore, it was found that 30% from the same sample initiated ANC around 28 weeks' gestation and this is regarded as the late initiation of ANC (Delva et al. 2010:584). In South Africa, 92% of pregnant women attend ANC at a minimum of once during their pregnancy. However, the initiation time of ANC was not measured in the same study conducted by Solarin and Black (2013:365).

1.2.1.3 Benefits of ANC

According to WHO's focused approach, the following benefits are achieved during ANC: (Lincetto, Mothebesoane-Anoh, Gomez, Munjanja 2010:51):

- Through the classification of pregnant women in the first visit of ANC, midwives can recognise and treat underlying or coexisting illness to prevent complications.
- Preventative measures, including tetanus toxoid immunisation, iron and folic acid and calcium commence during the first visit then throughout the pregnancy.
- Through history taking and assessment on every follow-up visit, the midwives can identify and observe complications of the pregnant woman and her expected child.
- Pregnancy-related complications, mainly pre-eclampsia are recognised and managed timeously during ANC.

- Further, screening for conditions and diseases such as anaemia, STIs (particularly syphilis), HIV infection, mental health problems, and symptoms of stress or domestic violence is made every ANC visit. Appropriate treatment or management is undertaken accordingly.

The pregnant woman and her family are advised and supported for developing healthy home behaviours and a birth and emergency preparedness plan. Through education, both pregnant women and families develop increased awareness of maternal and new-born health needs and self-care during pregnancy and the postnatal period (Pattinson 2005:5), including the need for social support during and after pregnancy. Healthy behaviours are promoted, including healthy lifestyles and diet, safety and injury prevention. Further, the prevention, support and care in the home is undertaken, such as advice and adherence support for taking preventative interventions such as iron supplementation and condom use (Heaman 2014:11).

1.2.1.4 Provision of ANC in South Africa

Since South Africa decided to take a stand in reducing maternal and perinatal mortality, the National Department of Health identified maternal health as a priority area requiring urgent action (NDOH 2015:4). The decision has been taken to implement the WHO recommendations for implementing focused ANC. Therefore, Pattinson (2007:6) recommends that all primary health care facilities should provide BANC, grabbing every opportunity when the pregnant woman presents herself in the facilities. In ideal circumstances each time when a pregnancy is confirmed, the initiation of ANC is supposed to be implemented the same day.

Through BANC since 2008, pregnant women attended four follow up visits, rather than the 12 previously proposed particularly when they started before 20 weeks' gestation. During the first ANC visit, history is taken, observations, physical examination and screening for diseases is done to classify the pregnant woman using a clinical checklist. Those with special conditions are referred for high-risk ANC, to an appropriate level of care facility for the duration of the pregnancy. However, pregnant women who are considered as low risk are followed-up at the local clinic at 20, 26, 32, and 38 weeks' gestation provided that they have initiated ANC in the first trimester (Pattinson 2007:10).

Furthermore, after the commencement of the WHO recommended model for ANC (BANC) in 2008, quality investigations were done. Studies conducted by Hofmeyr and Mentrop (2015: 902); Tuncalp et al. (2017: 861), revealed that the BANC model resulted in increased ANC utilisation in developing countries. However, increased perinatal mortality due to increased risk of foetal death between 32 and 36 weeks' gestation was cited by these authors.

The authors recommend that for a middle-income country such as South Africa, a reasonable compromise would be to continue to implement the WHO BANC model with reduced, goal-orientated visits up to 32 weeks' gestation. Thereafter, they need to return to routine visits every 2 weeks to 36 or 38 weeks, followed by weekly checks (Hofmeyr & Mentrop 2015:903; Tuncalp et al. 2017:86). Consequently, the model has been changed to "BANC plus" and has been rolled out since April 2017 in Tshwane.

1.2.1.5 Challenges of ANC

In ideal circumstances each time when a pregnancy is confirmed, the initiation ANC is supposed to be implemented the same day. However, many challenges are encountered in South Africa. According to Amnesty International (2014:19), South African women are still experiencing barriers to accessing ANC, especially the marginalised ones. These are people with HIV, the adolescence and the poor. Women living with HIV do not access ANC properly due to lack of privacy in the facilities (Biza et al. 2015:6). Lack of privacy and confidentiality could either be due to structural barriers or health system procedures revealing their status such as individual queues or individual file numbering, hence limited confidentiality is experienced.

Women's education is a barrier to accessing ANC. Owing to their low-level of education, pregnant women depend on males for survival. Therefore, it is assumed that they are unable to make their choices concerning their pregnancy. Further, because of their level of education, they can only work in farms or other insecure jobs where they cannot exercise their rights for getting an off day with pay. These circumstances predispose to pregnant women to delay or not attending ANC at all. Wright, Biya and Chokwe (2014:2) also indicate that due to the low level of education (low literacy level) most of the pregnant women using public health facilities, cannot access ANC early and even to react appropriately to danger signs of pregnancy.

Transport affects ANC utilisation mainly because in South Africa, women with low socioeconomic status cannot afford travelling costs to their preferred ANC clinic. Pregnant women may choose to travel to a clinic further away from their homes due to many reasons such as stigma of HIV status. Since 1994, most primary health care clinics are easily accessible but there are other costs such as childcare services which could become a barrier for ANC in cases where there is a lack of a support system (Heaman et al. 2014:8). In some provinces, the roads are so poor that women cannot reach ANC clinics during rainy days (Origlia et al. 2017:592; Amnesty International 2015:32). Furthermore, some pregnant women do not go for ANC because some do not have food to eat while awaiting to be seen and also due to the lack of assertiveness (Amnesty International 2015:32, Boerleider, Wieggers, Manniën, Francke & Devillé 2013:6).

Infrastructure caused challenges in ANC because of an overburdened health care system with a shortage of staff and increased waiting time. Overcrowding creates women's reluctance to attend ANC because they feel unvalued because in such environments, there is lack of privacy (Amnesty International 2015:32; Manyosi 2014:3, Origlia et al. 2017:592). Migration, on the other hand, causes a significant challenge in ANC because most immigrants or refugees are unable to speak the local language or English hence cannot follow orders about their care. Some immigrants will initiate ANC late because they were waiting for someone to assist with translation, while others arrive in the new country with their pregnancies that has progressed to above 20weeks (Origlia et al. 2017:592 Amnesty International 2015:42; Boerleider et al. 2013:6).

Lack of training among health care workers contributes a lot in challenges that are established in ANC which include lack of privacy in dealing with women's' sensitive issues such as HIV and STI's due to the lack of knowledge of new guidelines and protocols or even resistance in following procedures (Biza et al. 2015:5). Amnesty International (2015:32) indicated that women's perception of healthcare workers being gossipers about their information make them reluctant to go to ANC clinic. The struggle for maternal health among the youth and women with low socioeconomic status is a challenge to ANC because these women practice incorrect use of modern contraceptives hence predisposing them to an unplanned pregnancy with a significant challenge for ANC (Amnesty International 2015:40; Biza et al. 2015:7).

1.3 PROBLEM STATEMENT

Late initiation of ANC, was established as one of the avoidable factors responsible for the deaths of mothers and babies (The National Committee for Confidential Enquiry into Maternal Deaths (2014:45). Late initiation of ANC results in missed opportunities for screening and treatment of underlying conditions that exist independently of pregnancy or as a result of pregnancy (Pattinson 2013:7, Solarin & Black 2013:359).

The National Committee for Confidential Enquiry into Maternal Deaths (2014:12) reports that the majority of mothers die from preventable conditions such as non-pregnancy related infections, severe bleeding in pregnancy or labour and delivery and complication of hypertension in pregnancy. The National Committee for Confidential Enquiry into Maternal Deaths reported that a total of 809 (62.1%) of maternal death occurred in 2014 only was due to as non-pregnancy related infections, severe bleeding in pregnancy or labour and delivery and complication of hypertension in pregnancy (DOH (2014:15).

Initiating ANC after the first 20 weeks of pregnancy is considered late initiation of ANC and women are expected to initiate ANC before 20 weeks' gestation (Pattinson 2007:2). According to National Committee for Confidential Enquiry into Maternal Deaths (2014:23) and Pattinson (2013:16), late initiation of ANC is regarded as a likely avoidable factor for both maternal and perinatal deaths. However, if ANC could be initiated early as recommended by WHO, deaths from the non- pregnancy related infections, severe bleeding in pregnancy or labour and delivery and complication of hypertension in pregnancy would be reduced

The researcher practices as an advanced midwife at the Community Healthcare Centre (CHC). While providing ANC, she observed increased numbers of pregnant women initiating ANC after 20 weeks' gestation. Approximately six out of ten pregnant women initiating ANC on a daily basis are more than 20 weeks pregnant. This number also includes women with first and previous pregnancies. According to the yearly stats on average of 2100 pregnant women initiate ANC late in the selected CHC (Selected CHC 2016 stats). It is not clear as to what the reasons are for late initiation of ANC for the women attending at this specific CHC. Therefore, this motivated the researcher to explore and describe the reasons for late initiation of ANC to better understand the experiences of a pregnant woman.

1.4 SIGNIFICANCE OF THE STUDY

The study may assist healthcare workers to understand the reasons for late initiation of ANC. The recommendations made could initiate healthcare workers caring for pregnant women to seek alternative and more creative ways of providing ANC. Healthcare institutions where the pregnant women are cared for may experience better patient satisfaction rates and a decrease in costs incurred as a result to intensive care required by mothers and babies due to birth complications and litigation. Results of the study may contribute to finding feasible solutions of preventing late initiation of ANC by pregnant women. Furthermore, the dissemination of findings may influence changes in policy and practice.

1.5 RESEARCH QUESTION

What are the reasons contributing to the late initiation of antenatal care by pregnant women at the selected community health centre in Tshwane?

1.5.1 Aim

This study aimed to explore and describe the reasons for late initiation of antenatal care among pregnant women at the selected health centre in Tshwane.

1.6 CONCEPT CLARIFICATION

This study's following concepts are clarified:

1.6.1 Antenatal care:

Antenatal Care (ANC) means health care provided to a woman in the antenatal period (Pattinson 2007:2). According to Berhan and Berhan (2014:93), antenatal care is the service provided to mothers and unborn babies throughout pregnancy in an attempt to ensure early identification of problems and to decrease complications during pregnancy and childbirth. For this study, ANC refers to the care provided to women during pregnancy from the time the pregnancy is confirmed until the beginning of labour. The pregnant woman and the foetus are monitored to observe any signs of danger early in pregnancy to treat them timeously and prevent complications.

1.6.2 Late initiation of antenatal care:

Late initiation of antenatal care refers to when a pregnant woman initiates antenatal care after 20 weeks of pregnancy (Pattinson 2007:8; National Department of Health 2015:34). For this study, late initiation of ANC is when a pregnant woman fails to initiate ANC within the first 20 weeks of pregnancy.

1.6.3 Community Health Centre:

A CHC is a 24-hour comprehensive health service with a maternity unit managed by midwives. More often, the maternity section in a CHC will run alongside other services such as emergency care, minor ailments, chronic diseases, and promotive services (National Department of Health 2015:20). For this study, a CHC is considered the first level of care according to the National Health Plan as applied in obstetrical services and renders a variety of services to a specific community such as the promotion of health, prevention and treatment of diseases and rehabilitation. Maternity services form part of these comprehensive services.

1.7 DELINEATION

The study was conducted in an antenatal clinic in a CHC in Tshwane with women who have initiated ANC late. Considering that the initial visit for ANC forms the baseline of care for pregnant women, hence reasons for late initiation of ANC were explored.

1.8 RESEARCH DESIGN AND METHODS

Qualitative research is an 'inquiry process of understanding based on a distinct methodological tradition of enquiry that explores a social or human problem' (Creswell 2007:240). Qualitative research design involves an interpretive, naturalistic approach to the world, which means that 'qualitative researchers study things in their natural settings, trying to make sense of, or interpret phenomena regarding the meanings people bring to them' (Hickson 2016:381). By using qualitative research methods, the researcher was able to explore the phenomenon of interest in an in-depth fashion through the collection of rich narrative materials using a flexible research design (Polit & Beck 2012:739). Qualitative data are rich narrative descriptions classified in themes in the processes of understanding the participants' experiences of the phenomenon (Polit & Beck 2012:739). The reasons for pregnant women who initiated ANC late was explored and interpreted through narrative inquiry.

1.8.1 Narrative inquiry

Narrative inquiry is a way of understanding people's experiences (Lindsay et al. 2016:219). Also it is a method that explores and interprets personal experiences as lived and told by participants in a study. According to Clandinin, Caine and Steeves (2013:45), the stories are told through the three dimensions of experience, namely temporality, sociality and place. Temporality refers to the individual experiences over time, while sociality takes the participants' values, emotions and culture into consideration during storytelling. The dimension of place pertains to where the experience took place as well as the setting for the interview (Clandinin & Caine 2008:544). The method allows for the close study of individual's experiences over time, and in context. Narrative inquiry is marked by its emphasis on relational engagement between the researcher and participants, and its aim is understanding and making sense of experiences through conversations, discussions and partaking in the current lives of the participants (Clandinin & Caine 2008:542). The rationale for using narrative inquiry in this study is that it focuses on gaining understanding and meaning on the life of individuals who need to tell the stories of their experiences. Narrative researchers look for ways to understand personal stories and then present real-life experiences through the stories of the research participants. Inquiring narratively allows for a rich description of these experiences, and an exploration of the meanings that the participants derive from their experiences (Wang & Geal 2015:196). In this study, the stories of the pregnant women who initiated ANC late were narrated to gain an understanding of their specific reasons.

1.8.2 Context

The study was conducted in a CHC in Tshwane. The description of the CHC in Tshwane is provided for one to understand events within the concrete, the natural context in which it occurred (Polit & Beck 2012:743). The CHC is located in one of the urban areas in Tshwane. Services provided are chronic care, TB, casualty, mental health, expanded programme on immunisation, integrated management of childhood illness, contraceptive and fertility planning, male medical circumcision, adolescence and youth-friendly services, minor ailments, ANC and Midwife Obstetric Unit (MOU). The services specified are rendered from Monday to Friday from 07:30 -16:00 except the MOU which operates 24 hours a day and seven days a week. The unit consists of 1 (one) admission room, 2 (two) delivery rooms, 1(one) nursery room and 1(one) postnatal room comprising of 4 (four) beds.

The researcher is an advanced midwife working at the MOU in a selected CHC. Services provided to mothers and babies in the MOU include ANC, deliveries and postnatal care within a week after delivery. The total number of nurses operational in the MOU is 11. Advanced midwives are 4(four) in total and acting as team leaders on every shift day and night, 6 (six) midwives, and 1 (one) enrolled nursing assistant. ANC and postnatal care are provided from Monday to Friday from 07:30 to 16:00 with approximately ten women initiating ANC daily. The blood testing is performed daily only during the week from 07:00 to 12:00 and collected by courier services to laboratory. However, this becomes a challenge when pregnant women report at the ANC clinic for the first time after 12: 00 because the procedures for ANC initiation will not be completed. Hence the pregnant women are requested to return for blood tests.

Deliveries are conducted every day including weekends and holidays (24-hour service). All mothers who delivered in the MOU and those who delivered in the referral hospitals are seen again within a week together with their babies or any day if there is a concern within six weeks. After six weeks, babies and their mothers are seen in the primary health care services. The CHC in Tshwane was selected for this study to understand events within the actual, usual setting in which it occurred (Polit & Beck 2012:743).

1.8.3 Population

Polit and Beck (2012:375) refer to population as “the entire set of individuals or objects having some common characteristics, sometimes called universe or it is called the aggregation of the case in which a researcher is interested” (Polit & Beck 2012:273). The target population for this study was pregnant women aged between 18-40 years of age who initiated ANC after 20 weeks’ gestation.

1.8.4 Sample and sampling

Polit and Beck (2012:275) describe sampling methods as a subset of the population elements which are the most basic units about which data is a process of selecting a sample to represent an entire population so that conclusions about the population can be made. Purposive sampling was followed to select participants who were most informative and best contribute to the information required (Polit & Beck 2012:739). The sample size was ten women between ages of 18-40 years, who initiated ANC after 20 weeks at the selected CHC.

1.8.5 Data collection

Data collection refers to “the gathering of information to address a research problem” (Polit & Beck 2012:725.). For this study, data were collected through semi-structured interviews. The semi-structured interviews followed a guide to ensure that the same questions were asked of all the participants (Polit & Beck 2012:537). See Annexure B.

1.8.6 Data analysis

Data analysis is “the systematic organisation and synthesis of research data, a process of reducing, structuring and giving meaning to the collected data” (Polit & Beck 2012:725; Burns & Grove 2009:695). Thematic analysis of data was followed using the framework of Clarke and Braun (2013:120-123) as it is primarily a method for identifying and analysing patterns in qualitative data.

1.9 ETHICAL CONSIDERATIONS

Several ethical issues were considered in this study. The ethical issues were articulated by the World Medical Association’s Declaration of Helsinki and the Belmont Report. The World Medical Association (2001:1) developed the Declaration of Helsinki as a statement of ethical principles for medical research involving human participants, including research on identifiable human material and data. The Belmont Report (Polit & Beck 2012:151) articulates three primary ethical principles that should be considered namely beneficence, respect for human dignity and justice. Prior to data collection permission was sought from the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria for ethical approval (See Annexure G). Permission to conduct the study was also obtained from the Gauteng Provincial Ethics Committee, District Director and primary health care facilities’ operational managers. (See Annexure C). The ethical principles and how it was adhered to in this study follows:

1.9.1 Beneficence

The principle of Beneficence requires that researcher makes all effort to minimise harm and maximise benefits to protect the safety and interests of the participants. According to Terre Blanche, Durrheim and Painter (2006:67), researchers should attempt to maximise the benefits the research will contribute to the participants in the research study. Harm in social sciences includes emotional, physical, social and financial (Polit & Beck 2012:153). The principle covers

several dimensions such as the right to freedom from harm and discomfort including protection from exploitation (De Vos, Delport, Fouché & Srydom 2011:115).

- *Right to freedom from harm and discomfort:* Polit and Beck (2012:152) and de Vos et al. (2011:115) emphasise the responsibility of the researcher to avoid or prevent exposing participants to avoidable harm or distress within all possible limits. Risk assessment was performed to identify possible harm or risks to participants to maximise benefits of the study to the participants (Terre Blanche 2006:67). During the information session, participants were assured that they have the right to discontinue the interview session when feeling distressed (Burns & Grove 2009:154). A knowledgeable counsellor was arranged before the interview to be available if the need arose. The researcher made sure that data collection took place with minimal to no disruption of the service to prevent the participants' emotional discomfort. Debriefing was provided after interviews to minimise possible unintended emotional harm as suggested by De Vos et al. (2011:122).
- *Right to protection from exploitation:* To maintain the right to protection from exploitation, the study was conducted after approval had been received from appropriate review boards for permission and ethical clearance (De Vos et al. 2011:126). During participants' selection, vulnerable patients were excluded to protect them from exploitation as discussed in section 2.4.2.2. The purpose and benefit of the study were adequately disclosed beforehand as well as the methods to be followed. Participants in the study were made aware that they would not benefit as individuals but, their input would contribute to the changes in the ANC services. Participants were reassured that the information provided would not be used against them (Polit & Beck 2012:153).

1.9.2 Human dignity

This principle specifies the need to respect participants' rights during the research study. The researcher protected participants' human dignity by considering the following procedures namely, the right to self-determination and the right to full disclosure and the right to informed consent (Mossing 2014:20).

- *Right to self-determination:* Polit and Beck (2012:154) state that "humans are autonomous agents capable of controlling their actions". Participants have the right to be fully informed of the study so that they can decide voluntarily to take part or refuse to participate in the study without being prejudiced. Participants' self-determination involves freedom from coercion in the form of threats or even excessive incentives. In

this study, all participants took part in the study voluntarily. Participants were informed before the study commenced about their right to ask questions, to refuse to give information and to withdraw from the study at any stage without any consequence (De Vos et al. 2011:117).

- *The right to self-disclosure and informed consent:* The right to the full disclosure includes people's rights to make informed, voluntary decisions about participating in a study (Polit & Beck 2012:154). Full disclosure means potential participants should obtain comprehensive information of the study from the researcher. Participants should have comprehended the information and be allowed to ask questions before they make an informed decision (De Vos et al. 2011:119). During the pre-briefing, the researcher provided adequate information to the participants through the information leaflet and informed consent. Participants signed a consent form before interviews. However even after signing consent, participants were reminded of their right to withdraw from the study whenever they felt uncomfortable to continue.

1.9.3 Justice

The principle of justice denotes that research should be fair and impartial (Terre Blanche, Dur & Painter 200:68). According to Polit and Beck (2012:155), the principle of justice includes the right to fair treatment and the right to privacy.

- *Right to fair selection and treatment:* Right to fair selection and treatment is concerned with the equitable distribution of benefits and burdens of research (Polit & Beck 2012:155). The right to fair selection and treatment in this study was observed. Selection of participants was executed in such a way that the participants were selected from the same community where the CHC is situated as they would benefit from the inquiry (Terre Blanche et al. 2006:68). Fair selection of participants was achieved according to the discussed inclusive criteria section (2.4.2.1). Vulnerable patients were not selected. In this study, participants were treated the same. No one was given preference over others; all participants were given time to ask questions and the time limit was the same. No participant withdrew from the study, all of them received their ANC check up on time.
- *Right to privacy and confidentiality:* Polit and Beck (2012:162) indicate that participants expect that information provided be kept in strict confidence to protect their right to privacy. In narrative research, ethical dilemmas are intensified because of its interactive and relational nature. Summer (2006:53) cited in Holloway and Freshwater (2007:53)

indicate the difficulty in assuring informed consent, privacy, autonomy, and confidentiality. Hence one should balance the need to obtain valid data against the right of the individuals to privacy and confidentiality (Holloway & Freshwater 2007:53). Clandinin and Connelly (2000:171) confirm Summer's assumption and recommend that narrative researchers use their integrity and consider their responsibilities with participants. Narrative inquiry, unlike another method of qualitative inquiry, obliges researchers to apply ethics in all narrative research components, which includes research element and the therapy element derived from narrating unpleasant emotions (Coghlan & Brydon-Miller 2014:10; Holloway & Freshwater 2007:56). To maintain confidentiality and anonymity in the narrative inquiry is challenging as some participants may feel disadvantaged of the opportunity to have their voice heard (Clandinin & Connelly 2000:174; Holloway & Freshwater 2007:57). The researcher as the instrument, began data collection after obtaining approval from review boards. To protect participants' rights, ethical matters were discussed throughout the research process as the inquiry moved to temporality. Participants voluntarily gave both verbal and written informed consent before participating in the study. Participants were assured that they would not be discriminated upon even if they decided to withdraw from the study at any stage of the study process. A knowledgeable counsellor was pre-arranged to be available in case a need arose for the duration of interviews. However, privacy and confidentiality were also maintained throughout the study processes. Participants' narrative was written in such a way that their identities were not revealed. The records were kept in a safe place throughout the inquiry.

1.10 LAYOUT OF THE CHAPTERS

The layout of the chapters that set out the research journey is captured in Table 1.3.

Table 1.3 Layout of the chapters

Chapter 1	Introduction(orientation to the study)	This chapter gives an outline of the complete study, presenting an introduction and background, aim and research question. Concept clarification and the summary of research design, and methods undertaken. Ethical considerations followed as well as the layout of the chapters are presented
Chapter 2	Research design and methodology	An overview of the research methodology used is discussed, including the research design, research method. The paradigm, philosophical assumptions and the maintenance of the ethical considerations are elaborated in this section
Chapter 3	Orientation to the data analysis, Introduction to participants narratives and themes of the participants' collective narrative	Data analysis was done Using thematic analysis according to Clarke and Braun (2013:120-123). Individual narratives were outlined as well as how collective narratives were collated to form themes and subthemes
Chapter 4	Research findings and discussions, conclusions recommendations, limitations and the researcher as an instrument are outlined.	The findings of the study are discussed about the literature supporting and constructing the findings. In this chapter, the conclusions drawn from the study are outlined and recommendations to improve early initiation of ANC. Limitations encountered in the study are outlined. The researcher reflects on her experiences on the study in full.

1.11 SUMMARY

This chapter offered the introduction and background of the study, the problem statement followed by the significance of the study and research aim. The research question, concept clarification, research design, and research methods were explained in the same chapter. Lastly, ethical consideration and layout of the chapters were outlined. The following chapter focuses on the methodology followed in the study.

2 Research design and Methodology

2.1 INTRODUCTION

Chapter one gave the introduction and orientation of this research study through delineating the background and the rationale of the research. This chapter offers a detailed discussion of the research design and methods followed in the study. The research methods are discussed together with the principle of trustworthiness. In this chapter, an overview of paradigmatic perspective and the philosophical framework underlying the research process is presented.

2.2 THE RESEARCH PARADIGM

Polit and Beck (2012:11) describe paradigm as general perception that people have about the world they live in and, therefore, also the world they study. The constructivist paradigm was chosen to guide the study. Constructivism is ideal, natural, holistic and based on subjectivity (De Vos et al. 2011:311). Constructivists believe that reality is created and understood by the mind of the knower based on his perceptions. How individuals create knowledge, depend on the previous experiences, mental organisations and beliefs that one uses to interpret events, but it does not deny the existence of external reality (Jonassen1991:10). Constructivism embraces that the researcher is obliged to rely as much as possible on the participants' views of the occurrence (Creswell 2007:20).

The constructive paradigm influenced the participant selection because with this paradigm the participants should be able to describe their experience, and the findings from the comprehensive study should be typically grounded in real life experiences of people with genuine knowledge of an event (Polit & Beck 2012:15).

2.2.1 Ontological assumptions

According to Creswell (2007:17) ontology describes that reality is subjective and multiple as seen by participants in the study. According to Denzin and Lincoln (2011:103), this subjective reality is imperative in research as every participant experiences it in various ways. The researcher wanted to understand how participants

interpret reality. In this study, the researcher conducted the research anticipating more than one answer and was prepared to accept whatever the participants provided as the reasons for late initiation of ANC because she embraces the idea of multiple realities.

2.2.2 Epistemological assumptions

Denzin and Lincoln (2011:104) describe constructivist researchers assuming a subjective epistemology as they and their participants co-create understandings of the world. The truth of the generated knowledge is determined by the interaction between the researcher and the participant. Constructivists interact with their participants directly in a natural setting (Creswell 2007:17). In this study, the researcher was directly involved in the data collecting, taking into consideration the culture, language and beliefs of the participants as advised by Polit and Beck (2012:14). Participants' narratives and the field notes were recorded and compiled from the selected CHC, which was a familiar and non-frightening setting to the participants to allow them to narrate their experiences comfortably. Rapport was created by the researcher before the beginning of the study to maintain a relationship with the participants. The researcher maintained an open and honest relationship with the participants by informing them of all processes of the study. During the semi-structured interviews, appropriate interviewing skills were applied to allow participants to elicit all the reasons for their late initiation of ANC.

2.2.3 Methodological assumption

Methodology indicates strategies followed to generate knowledge or it can be described as what tools were used to know the reality (Creswell 2007:19). In the study, the researcher applied inductive reasoning whereby logic is from specific observations to a general theoretical explanation (De Vos et al. 2011:49). Narrative inquiry as one of the five approaches to qualitative research was chosen for the study because the reasons for the late initiation of ANC was unknown. The purpose was to gain an understanding of the phenomenon by constructing a meaningful reality (De Vos et al. 2011:66).

2.3 RESEARCH DESIGN

A research design is the comprehensive plan for collecting and analysing data (Polit & Beck 2012:741; De Vos et al. 2011:143). According to Creswell (2007:5) research design refers the entire process of obtaining answers to the research problem starting from conceptualisation of a problem, writing of the research question, data collection, analysis, and interpretation and writing a report. It provides guiding principles and directions to be followed when addressing the research problem. By thoroughly planning the research design which is the 'architectural backbone' of the research, it predicts what suitable research decisions should be taken to increase the integrity of the study and minimise bias (Polit & Beck 2012:58). The researcher's research question and curiosity to ask another question as answers are found, guided the researcher's choice to follow a qualitative research design. Creswell (2007:240) refers qualitative research as the inquiry process of understanding founded on a discrete methodological practice of inquiry that explores a societal or human problem.

2.3.1 Qualitative research design

The qualitative research design was used as contrasting to a quantitative research design in this study. It is an approach that is systemic and subjective when describing life experiences and giving them meaning as well as a way of gaining insight into discovering meaning (Polit & Beck 2012:490). The qualitative research design was preferred in the study because the reasons for the late initiation of ANC were unknown and the purpose was to gain an understanding of the phenomenon by constructing a meaningful reality (De Vos et al. 2011:66). Qualitative researchers study human actions from the insider's perspective aiming at describing and understanding the meaning it has for the participants (Merriam 2009:34). Different qualitative research methods can be used to understand human experiences which are phenomenology, ethnography, grounded theory, historical analysis, case study and narrative inquiry. In this study, a narrative inquiry was employed to achieve the aim of the study.

2.3.2 Narrative inquiry

According to Clandinin and Connelly (2006:477) cited in Clandinin, Pushor and Oor (2007:22) narrative inquiry refers to the study of experience as a story. Narrative inquiry is a way of thinking about and understanding experience. It is a method of inquiry that involves interpretation of a phenomenon. In practice, researchers adopt a narrative understanding of a phenomenon under study. To conduct research

narratively indicates co-operation between the researcher and participants over time in a place or series of places and social interaction with settings (Clandinin & Connelly 2000:20). Learning to think narratively is engaging in a narrative inquiry where existed and expressed stories become the ground for learning to inquire into stories (Tarahar 2011:37) narratively.

Narrative inquiry development was influenced by John Dewey, an educational theorist and philosopher whose focus was to understand how individuals teach and learn. According to the Deweyan theory of experience, we understand experience as “the fundamental ontological classification from which all inquiry proceeds” (Tarhar 2011:33).

Dewey also wanted to answer questions such as “how placing things in the context of time connect with change and learning and of how institutions frame our lives” (Clandinin & Connelly 2000:1). Other authors such as Geertz indicated that he turned to the narrative inquiry because in his study in anthropology, it was impossible to look at one event or one time without seeing both nested within the wholeness of his figurative display (Clandinin & Connelly 2000:16). The stories of narrative methodology allow participants to speak of their experiences and the construction of their identity (Wang & Geale 2015:196; Bamberg 2012:206). The same authors indicated that through narrative inquiry, nursing researchers understand patients, or other issues such as personal identity, life course development and the cultural and historical worlds of the narrator.

Furthermore, Andrews et al. (2013:240) conclude that self-narration offers ‘transitory forms of power’, it allows the narrator to recall, control, transform reimagine events to reclaim and create chosen personalities, social interactions and communities. Holloway and Beck (2007:23-24) expressed that narrative inquiry started because nursing had become more and more technical at the expense of human qualities of empathy. Nurses were disillusioned by the loss of meaning and relationships in their everyday practices hence they turned to narrative research as it is centred on the person.

The researcher used narrative inquiry which is a qualitative methodology to understand the reasons for pregnant women who initiated ANC late. Narrative inquiry differs from other qualitative methodology because of its progressiveness and

consistency. Narrative inquiry was chosen as the best method for this study because it addressed an individual's experience with late initiation of antenatal care and can be constructed into stories that could reveal recommendations' development. The stories were all-inclusive and based on the reconstruction of experience over time, considering individual and social dimensions of experience and discerning new choices of participants' lives.

2.3.3 The conceptual framework of narrative inquiry

Narrative inquiry differs from other qualitative research methods because of its relational inquiry process within a three-dimensional narrative inquiry space (Clandinin, Caine & Steeves 2013:43). The three-dimensional narrative inquiry space (commonplace) was identified by Clandinin and Connelly (2006) cited in Clandinin, Pushor and Orr (2007:23) and was based on Dewey's theory of experience, which based his principles on interaction, continuity and situation. The theory specifies that to understand people researchers need to examine their personal experience as well as their interaction with other people (Wang & Geale 2015:196). In this study, the three- dimensional narrative inquiry space was discussed as well as their application. The Commonplace in narrative inquiry refers to features or traits of narrative inquiry that includes dimensions of temporality, sociality and place.

2.3.3.1 *Dimension one: Temporality*

Temporality denotes that "events under study are in temporal transition" (Connelly & Clandinin 2006 cited in Clandinin, Pushor & Orr 2007:23). This dimension demands researchers to consider that events and people always have the past, present and the future. According to Trahar (2011:34) the narrative inquirer should always try to understand people, places and events, "as in process, and always in transition". Throughout the interview phase, researchers' probing allowed the conversation to proceed backwards and forward, to allow the participant to remember everything involved in the experience of reasons for the late initiation of ANC as suggested by Denzin and Lincoln (1994:417). However, while analysing the researcher took into consideration the past, the present actions of the participants as those actions are likely to occur in the future (Wang & Geale 2015:196). Therefore, the researcher undertakes to develop a plan to educate the pregnant women on the benefits of early initiation of ANC.

2.3.3.2 *Dimension two: Sociality*

Connelly and Clandinin (2006) cited in Clandinin, Pushor and Orr (2007:23) indicate sociality as a dimension characterised by both the personal and the social circumstance of the participants and to the relational aspect of the inquirer and participants. According to Dewey's theory, sociality signifies interaction and indicates the intersection of internal (personal) and existential (social) circumstances in humans' experience (Denzin & Lincoln 1994:417). Dewey's notion of interaction inquiry focuses on four directions in an inquiry, and in sociality, the focus is on the inward and outward. The inward circumstances of the participant include the "feelings, hopes, desires, imaginative reactions and moral dispositions." The existential circumstances include "environment, surrounding factors, and forces, people and otherwise, that form each's context" (Connelly & Clandinin 2006 cited in Clandinin, Pushor & Orr 2007:23 & Green 2013:64). Therefore, it is imperative that researchers consider these circumstances simultaneously during data collection and analysis. In this study, the researcher used her field notes to bring about the personal circumstances of participants. The recorded and transcribed interviews allowed the researcher and the supervisors to find themes through analysis of data. Relationships during the inquiry were maintained by avoiding judgements and by encouraging participants to relate their own stories concerning reasons for the late initiation of ANC.

2.3.3.3 *Dimension three: Place*

The place is the third dimension of the three- dimensional narrative inquiry space that means the "specific concrete, physical and topological boundaries of or sequence of places where the inquiry take place" (Connelly & Clandinin 2006 cited in Clandinin, Pushor & Orr 2007:23; Wang & Geale 2015:196). According to these authors, all events occurred in places and emphasised the importance of specifying the settings or locations where events took place in the study. The narrative inquirer should think of the impact of each place on the experience, and that place may change as the inquiry investigates into temporality (Connelly & Clandinin 2006 cited in Clandinin, Pushor & Orr 2007:23). In this study, a specific setting was considered when analysing the data so as to understand where the experience occurred as well as how events that took place in that specific setting affected their experiences (Wang & Geale 2015:196).

Clandinin and Connelly (2000 cited in Clandinin, Pushor & Orr 2007:24) developed a framework of elements for designing, living out, and representing narrative inquiries. These elements should be considered when designing a narrative inquiry, in living in the field and when composing field texts and in interpreting and writing research texts. These elements guided the conversations. The researcher thought about these elements as a set of questions to ask herself at each phase of narrative inquiry. As the researcher worked through the elements, it was essential to remember the commonplaces and how they shaped each response. The following elements were considered during the study.

Justification

Justification is the central element in the narrative inquiry which is the reason why the study is essential. Narrative inquirers need to attend to three kinds of justification: the personal, practical and the social (Clandinin, Pushor & Orr, 2007:24; Clandinin & Connelly 2000:124; Green 2013:65).

The personal justification comes from the importance, in narrative inquiries of situating oneself in the study. Inquirers write a narrative beginnings that speaks to the researcher's relationship and interest in the inquiry. The *practical justification* is when the researcher justifies how the research will be insightful to changing or thinking differently about the researcher's own and others' practices. The *social justification* requires that the researcher thinks about the broader social and educational issues that the study might address, practical and social justifications point researchers towards an inquiry's endpoint to be able to answer the "So what?" and "Who cares?" questions (Clandinin, Pushor & Orr, 2007:25; Schwind, Fredericks, Metersky & Porzuczek 2015:4)

Naming the phenomenon

The second element is the need to name the phenomenon; the "what" that is being inquired. The phenomenon became clear as the research puzzle and personal justification were developed. A narrative inquirer always adopts a narrative view of the phenomenon through living, telling and retelling their stories (Clandinin, Pushor & Orr 2007:25). A narrative view may extend over time, shaped by personal and social conditions, and situated, correspondingly in a multiplicity of places (Clandinin & Connelly 2000:125).

Method used

The third element is to consider and to describe the specific methods used to study the phenomenon. Narrative inquirers address this in two ways: By engaging in imaginatively thinking about the chosen puzzle, “along with possible participants, as existing in an ever-shifting space” (Clandinin, Pushor & Orr 2007:27). The first task for the narrative inquirer is to think of the inquiry phenomenon, topic, puzzle, and participants as occurring in a multidimensional, ever-changing life space. To plan a narrative inquiry is to be self-consciously aware of everything happening within that living space. The second thing about the method is figuring out and describing the kind of field text (data) to be collected and composed. Thinking at the beginning of the inquiry about the collection and composition of data needed, helped the researcher to make decisions at each phase. However, these decisions need to be undertaken with care on how the kinds of data are attentive to all three commonplaces, that is, temporality, sociality and place (Clandinin & Connelly 2000:128).

The analysis and interpretation process

The fourth element to be described in research texts is the analysis and interpretation process. Moving from field text to research texts, all forms of narrative inquiry emphasise that considering the contextual and relational is important (Clandinin, Pushor & Orr 2007:28). This element draws attention to the importance of defining and balancing the commonplaces, that is, how the researcher examined, described, and specify the commonplace features built into the study. The process of analysis used was the thematic analysis, which drew deeply on the narrative inquiry commonplace as a framework for the interpretation of data. Thematic inquiry according to Riesman (2005:2) highlights the content of the writing more than how it is said.

Positioning of the study

A fifth element is the positioning narrative inquirers conduct as they position their studies in relation to other research on a phenomenon, to related programmes of research, and to research undertaken using different epistemological and ontological assumptions. This is the first way of positioning, and it is what all researchers do in their literature reviews. The second way of positioning is to see that, for example, there are multiple programs of research within each area, and narrative inquires has to position their work in relation to other programmes of research on a particular phenomenon. Third positioning is to position our narrative inquiry about other forms of

inquiry. The positioning is essential for narrative inquirers even if they do not want to explore the philosophical assumptions in detail. These multiple ways of positioning the researcher's work about other work are all critical (Clandinin, Pushor & Orr 2007:29; Clandinin & Connelly 2000:128).

Uniqueness of the study

A sixth design element, the uniqueness of each study. This element allows narrative inquirers to propose some sense of what it is that can be known about a phenomenon that could not be known, at least in the same way, by other theories, methods, or lines of work (Clandinin, Pushor & Orr 2007:30). In this study through narrative inquiry, the voice of pregnant women who initiated ANC late is heard through them telling their stories for the reasons contributing to their late initiation of ANC. The uniqueness of the study involved a different way of conceptualising and representing pregnant women's knowledge. The research thus presented researchers' stories of pregnant women who initiated antenatal care late, rather than stories about pregnant women who initiated ANC late.

Ethical considerations

The seventh design element, ethical considerations, are central in narrative inquiries. The relational ethics of narrative inquiry needs special consideration. In the narrative inquiry, inquirers must deepen the sense of what it means to live in relation to an ethical way. Ethical considerations instil narrative inquiries from start to finish: "at the outset as ends –in- view is imagined; as inquirer-participant relationships unfold, and participants are represented in research text" (Connelly & Clandinin 2006 cited in Clandinin, Pushor & Orr 2007:30). During inquiry, relationships develop, trust is formed, experiences are shared, stories are told, and the way lives are connected with one another suggests an "ethic of care". Participants were protected from harm, informal processes and signed commitments. The negotiation of research text with participants was done to ensure their voices and stories were represented in a productive way (Clandinin, Pushor & Orr 2007:30).

The process of representation

The eighth element for consideration deals with the process of representation and the kinds of research text intended. For the research to be more compelling, the narrative researcher should work from a set of ontological and methodological assumptions and

the question of representational form follow from those assumptions (Clandinin, Pushor & Orr 2007:31). It is important to note that at the onset of the inquiry, narrative inquiry texts require evidence, interpretative, plausibility, and disciplined thoughts. However, some aspects of research text writing are specific to narrative inquiry and are discussed below.

Firstly Connelly and Clandinin (2006 cited in Clandinin, Pushor & Orr 2007:31) note that as one writes, one must continue to think narratively, crafting the research text with careful attention to the narrative inquiry's familiar places. The text needs to reflect the temporal unfolding of people, places and things within the inquiry, the personal and social aspects of the inquirer's and participants' lives, and the places in the inquiry.

Secondly, the inquirer needs to consider the possibilities of a range of written forms, as inquirers think of many different textual forms reflective "of the shapes lives take" (Clandinin, Pushor & Orr 2007:31). In the researcher's reflexive notes, her feelings are highlighted, as well as hopes, desires, aesthetic reactions, and moral dispositions and those of the participants.

Thirdly the writing of a research text is a narrative act. However, it also suggests that in a different time and in a different social situation, and for different purposes, a different research text might be written (Clandinin, Pushor & Orr 2007:32).

Fourthly, the questions of the audience are significant for narrative inquirers. There are multiple audiences, the inquirer himself or herself, other participants, and an imagined reading audience to be considered when writing a research text. The researcher must write in such a way that the inquirer, participants, and the audience are included, to answer the questions "who cares?" and "so what?" The research text that emphasises on one, to the exclusion of others, loses impact. According to Connelly & Clandinin (2006 cited in Clandinin, Pushor & Orr 2007:32), "Inquirers who forget their participants and their readers and write only to themselves, become selfish. Inquirers who write for imagined audiences and neglect their participants could be unethical; and inquirers who write only for self and /or participants may be unable to answer the questions "who cares" and "so what?". During report writing the researcher always kept the various audiences in mind.

The fifth aspect is that the researcher needs to be aware of the criteria by which her work may be judged when composing research text. Connelly and Clandinin (2006 cited in Clandinin, Pushor & Orr 2007:33) suggest that the three familiar places and the eight design elements will be helpful in setting criteria for readers. It was also indicated that a good narrative has authenticity, as having adequacy and credibility (Clandinin & Connelly 2000:185). These are criteria that emphasize recognisability of the field in research text. Others suggest meaning as a criterion for judgement as readers gain a way of illuminating new ways of thinking about the experience (Clandinin, Pushor & Orr 2007:33).

The sixth aspect is about the narrative inquirer's need to be always "attentive to and make explicit the social significance of their work and the larger body of literature to which their inquiry contributes". This sixth consideration takes the researcher back to questions of "so what" and who cares?" (Clandinin, Pushor & Orr 2007:33). It is important that narrative inquirers attend closely to these matters and think carefully about the research and practice conversations they want to join in with their work. Considering the work of other researchers in these conversations, their standpoints and the theoretical frameworks, and what is already known about a topic is also crucial work that narrative inquirers need to do in their research texts if they want to occupy a significant place in shaping the discourse of policy and practice in an area. (Clandinin & Connelly 2000:137)

2.4 RESEARCH METHODS

Research methods refer to procedures used to organise a study and to gather and analyse information in a systematic way (Polit & Beck 2012:741). The research methods were established as the researcher made choices and acted to answer the research question. The population, selection of participants, sampling criteria, researcher as an instrument, data collection and data analysis are described in the subsequent sections.

2.4.1 Population

The target population for this study were pregnant women aged between 18-40 years that initiated ANC after 20 weeks gestation. The participants were selected from this specific population because they have the experience of late initiation of ANC. Polit and Beck (2012:738) describe population as "the entire set of individuals or objects

having some common characteristics, sometimes called universe or it is called the aggregation of the case in which a researcher is interested". Many of these participants were within this age group and attending the ANC clinic at the selected CHC.

2.4.2 Sample and sampling

A sample is a subset of the population elements which are the most basic units about which data is collected. On the other hand, sampling methods are the process of selecting a sample to represent an entire population so that conclusions about the population can be made (Polit & Beck 2012:275). The research method commended the researcher to find a homogeneous sample to obtain rich information for enhancing the validity of the inquiry (Holloway & Freshwater 2007:70). Homogeneous sample refers to individuals having similar characteristics for the study with limited disparity (Polit & Beck 2012:729; Holloway & Freshwater 2007:72)

To locate a homogeneous sample, a purposive sampling as a form of non-probability sampling method was undertaken. Purposive sampling denotes selecting participants who will be most informative and best contribute to the information required (Polit & Beck 2012:739). The researcher chose purposive sampling as she wanted to collect data from pregnant women who experienced late initiation of ANC after 20 weeks only, based on the inclusion criteria. The sample size comprised of 10 pregnant women between the ages of 18 to 40 years, who initiated ANC after 20 weeks at the selected CHC.

Sampling in narrative inquiry relies on a tiny number of participants as this type of inquiry follows the constructivist paradigm, where the depth rather than breadth of data collection is required (Holloway & Freshwaters 2007:70; Lindsay et al. 2016:15). Therefore, data saturation was not used as a criteria to stop sampling. Saunders et. al (2017:5) support the view and said "It is less straightforward to identify a role for saturation in qualitative approaches that are based on a biographical or narrative approach to analysis". The authors added that in narrative inquiry, analysis tends to focus more on elements within individual descriptions rather than on analytical themes. The stories of the people involved in the narrative inquiry are unique but also share many elements of common experience in a specific context (Holloway & Freshwater 2007:74).

Participants were recruited by placing an approved poster in the waiting area to inform the prospective participants of the study. The researcher then conducted a face to face recruitment by approaching pregnant women in the waiting area who initiated ANC after 20 weeks gestation. The purpose of the study was explained in a non-threatening way. During the conversation, the researcher enquired whether the pregnant women who initiated ANC after 20 weeks were willing to participate in the study voluntarily. Only those who agreed to taking part in the study were included.

2.4.2.1 *The Inclusion criteria*

Inclusion criteria was the measure used by the researcher to select the specific attributes of the target population, and by which participants were selected for participation in the study (Polit & Beck 2012:726). The inclusion criteria for this study were:

- Pregnant women attending ANC at the selected CHC who initiated ANC after 20 weeks gestation;
- The pregnant women had to be willing to give informed consent and to disclose information regarding their experiences with reasons of late initiation of ANC;
- The pregnant women had to be conversant in English. The researcher believed that oral communication between herself and participants in English would allow for in-depth information about their experiences; and
- The pregnant women had to be able to express their feelings and thoughts because of the narrative nature of the study.

2.4.2.2 *The exclusion criteria*

Polit and Beck (2012:727) describe the exclusion criteria as characteristics not desirable or applicable to the population. The criteria prevents distortion of the study which could nullify credibility. The exclusion criteria for this study were:

- Pregnant women who initiated antenatal care early before 20 weeks gestational age.
- Pregnant women from foreign countries are classified as vulnerable people due to their unique circumstances, and they may have felt pressured into participating (Holloway & Freshwater 2007:74; Polit & Beck 2012:164).
- Pregnant women under 18 years of age as they are regarded as minors.

2.5 THE RESEARCHER AS AN INSTRUMENT

According to Polit and Beck (2012:492) and Creswell (2007:38), the researcher is considered as the primary instrument for data collection, data analysis and data interpretation in qualitative research. The researcher as a human being has personal biases which must be acknowledged and identified. Biases can emanate from the study at any stage of the research process. Researcher bias can inhibit the participants from feeling free to share their experiences of the phenomenon of interest in the study and can influence the researcher in the data analysis process, thereby affecting the credibility of the findings of the study.

To limit biases and to enhance the credibility of the study, self-reflection, unconditional positive regard, empathy, facilitative communication skills, and reasoning strategies were applied. The following aspects were taken into considerations about the researcher as an instrument.

2.5.1 Self-reflection / Reflexivity

Self-reflection denotes that the researcher is conscious of the biases, values and experiences that she brings to a study (Creswell 2007:243). It involves a continuous self-examination and asking, how might the researcher's previous experiences, values, background and prejudices be shaping her methods, analysis and interpretations (Polit & Beck 2012:597). According to Given (2008;4), the enquirer begins by inquiring into his or her own stories of experience, and because the narrative inquiry is an on-going reflexive and reflective methodology, narrative researchers need to continually inquire into their experiences before, during, and after each inquiry. Also, Hickson (2016:386) reiterates that reflexivity is a foundational aspect of narrative research and it involves being aware of how the researcher interprets actions, perceptions and responses. In this study, the researcher considered self-reflection through continuously reviewing her assumptions and thoughts about how she influenced the study, what it is about the researcher that influenced this study, how did her past experiences affect the situation.

2.5.2 Unconditional positive regard

Holloway and Freshwater (2007:150) refer unconditional positive regard as acceptance. It involves being non-judgemental towards participants, accepting them and their stories for who and what they are. Further, the key to achieving acceptance

in any relationship is linked to the ability of the researcher to differentiate between the person's behaviour and the person, as behaviour, in any case, depends upon the current circumstances or difficulties which a person experiences. Throughout interviews, the participants were encouraged to express their thoughts and feelings, while the researcher was listening in a non-judgemental manner, ensuring that the depth and richness of data were collected.

2.5.3 Empathy

Empathy is the ability to see the world from another individual, through their frame of reference, which means the ability to enter into real feelings of the other person (Holstein & Gubrium 2012:69; Holloway & Freshwater 2007:149). In this study, the researcher ensured empathy to create a safe and an enabling relationship, to maximise both the potential of data collection and the therapeutic potential of storytelling for the participants. Empathy was expressed through active listening to both the words and the feelings conveyed by participants. Reflecting back on the emotional content of the message from the storytellers in their own words enabled them to feel that their message was heard and understood. However, relatively relationships were formed rapidly as empathic responses were the vital feature during data collection.

2.5.4 Facilitative communication skills gradation

The facilitative communication skills implemented in this study included listening skills, probing, paraphrasing, and reflecting feelings and meaning.

Listening skills: Holloway and Freshwater (2007:151) suggest that to establish a good rapport in the initial stages of the research relationships, requires skills of active and accurate listening. There are three phases to listening in narrative inquiry, which is: receiving and understanding, communication of that understanding, and awareness in the other person that they have been heard and understood. Further, they described the levels of listening as listening for facts, for feelings and intentions.

Listening is an active process which requires a purposeful and a systematic response to messages including being silent (Holloway & Freshwater 2007:151). Nonverbal communication skills used during the listening process included head nods, open gestures and positive facial expressions that encouraged the participants to keep on

talking. Minimal verbal responses such as “Umm” and “Uh-hh” and silences were also used (Polit & Beck 2012:543; De Vos et al. 2011:345).

Throughout each interview, the researcher consciously tried to listen to the participant’s words, watched their body language and became perceptive to their communication to foster open communication between herself and the participant. The researcher remained silent when the participant spoke. Through the silence, participants were given time to collect and organise their thoughts and increase their awareness of their experiences of late initiation of ANC. Listening however, became an active process in which the researcher had to respond to the communication of the participants. The researcher encouraged participants to talk though maintaining eye contact and the sensitive use of nonverbal communication skills (Holloway 2007:151). By making use of minimal verbal responses such as “Umm”, head nods, open gestures, and silences, the researcher encouraged the participants to describe their reasons for late initiation of ANC.

Probing: Probing brings about detailed information from the participants in an interview that volunteered in the first reply (Polit & Beck 2012:738). Probes can either be a question or a statement with the aim of getting the participant to clarify or elaborate on previously made points. The probe is the researcher’s tool for rectifying inadequacies in the initial response to a question, thus encouraging the participant to give additional information that is needed. The researcher probed to get additional information from participants on their reasons for initiating ANC late after 20weeks. Both verbal and nonverbal probes were used when participants were required to think and gather their thoughts as a response to the researcher’s probes. An example of a probe used was “what do you mean?”

Paraphrasing: Paraphrasing means a summarised interpretation that includes underlying feelings and meanings (De Vos 2011:345). Holloway and Freshwater (2007:155) note that paraphrasing can be used to gain clarification and understanding, but it is a dominant element in a supportive or an empathic response. The researcher paraphrased the participant’s description of her reasons for late initiation of ANC in the researcher’s own words to clarify the meaning as she interpreted it from her descriptions.

Reflecting meaning and feelings: Holloway and Freshwater (2007:152) describe reflecting meaning as involving reflecting back what the participant has said. This facilitative skill was used by the researcher to let the participants know that the listener had understood the critical message. The researcher can use a question or selective “echoing” and can be used to highlight crucial words or points. Selective echoing encourages the participants to expand upon their earlier statement.

Reflecting feelings aims at focussing attention on the feelings of the narrative rather than on content alone (Holloway & Freshwater 2007:152). The feelings may be concluded from the participant’s verbal or nonverbal behaviour. It can help to raise awareness of vague unexpressed feelings that are not readily acknowledged, but essential in the context of the narrative. Reflecting back feelings can sometimes elicit a release expression of intense emotions, especially in situations where distress has been contained for some time. Using reflection in this study had two advantages; indicating an understanding of what was said by the participant, and trying to facilitate a situation for open communication during interviewing.

Reasoning strategies: According to Polit and Beck (2012:11) reasoning refers to the process of concluding. In research, these conclusions are the outcomes of the data collection and data analysis processes. The reasoning strategy implemented in this study was inductive reasoning. According to Polit and Beck (2012:730), inductive reasoning is the process of reasoning from specific observations to more general rules. This is where conclusions are developed from specific observations, a sample of participants is observed and the conclusions drawn about the population from which the sample has been selected. Following the inductive approach in the study, the researcher applied inductive reasoning whereby the conclusions that developed through narrative interviews, observations and field notes were drawn from the participants’ shared experiences of the phenomenon and then re-contextualised to the population (pregnant women who initiated ANC late) using literature control.

2.6 DATA COLLECTION

Data collection refers to the collecting of information in response to the research problem (Polit & Beck 2012:725). According to Henning (2005:60), the methods for data collecting may also be called “data sources” meaning that the sources are the method or the way in which the data “travels”.

The data collection methods utilised in this study were narrative interviews (semi-structured) and field notes. According to Holloway and Freshwater (2007:75), the primary source of data for the narrative inquiry is oral stories from participants through interviews. These consist of the unique and individual accounts of peoples' experiences. Further narrative research depends solely on spoken, written and occasionally visual data. The participants' stories are organised in a chain of causation (the plot); which dictates that events are somehow linked and that they are therefore to be described in relation to each other. Emplotment is central to the building and development of a story; it is the structure through which sense is made of events and the way things are connected. Holloway and Freshwater (2007:12) describe three significant elements in a plot; temporality, causation, and human interest. Temporality implies that the story evolves sequentially, meaning that the story should be linked in three sequences: the beginning; when the story unfolds - the middle; when the story is resolved, then the end.

A story often contains causal relationships which listeners and readers perceive even though they are often assumed. Holloway and Freshwater (2007:12) suggest that narrative itself distributes events in an orderly, consecutive way, very often giving the impression of a sequence of cause and effect. To gratify the basic need during interviews, the researcher was continually searching for causation. Human interest is another element in the story. For listeners to have interest in the story, the story of experience should include crisis and turning points as well as justification for the story teller's actions and behaviour that is a response to the interpretation of experience.

There are various ways to approach interviews including structured, unstructured and semi-structured. Data were collected through semi-structured interviews. Conducting semi-structured interviews required the researcher to have a list of topics to be covered rather than a specific sequence of questions to ask (Polit & Beck 2012:537). Semi-structured interviews were selected because they offer a compromise between the structured and unstructured, and allowed the researcher to explore stories as they arose (Hickson 2016:38). The author further quantified that, interviews should be minimally structured for flexibility and being able to explore the research topic thoroughly. In this study, similar semi-structured questions were asked, with all questions focused on the participants' experiences on reasons for late initiation of ANC.

2.6.1 Advantages of semi-structured interviews

Semi-structured interviews according to De Vos et al. (2011:351-352) have advantages, and has the ability to assist the researcher to gain detailed representation of participants' beliefs or perceptions about a specific topic. Further, the interviews gave the researcher and participants' flexibility during the interaction. Semi-structured interviews aided the researcher to follow up specific interesting trails that developed in the interview process, and the participants could give fuller representations. The semi-structured interviews benefited the inquiry because the issue was personal and controversial.

2.6.2 Challenges of semi-structured interviews

The semi-structured interviews have a set of predetermined questions which channels the interview and limits the inquiry even when new issues emanate throughout the study (De Vos et al. 2011:352). The challenge of deviation from the topic throughout the interview was encountered, and the researcher had to occasionally bring the conversation back on track to get the specific information required for the interview.

2.6.3 Preparation for the interview

Management and the staff working in the MOU of the selected CHC were informed of the process of the study during an information session. They were reassured that interviews would not interfere with nursing care. A private room was requested to ensure confidentiality during the interviews and to encourage participants to talk freely. According to Holloway and Freshwater (2007:76), the use of the private room is morally appropriate to help participants to recall the past without unnecessary distress. An audio recorder was tested for readiness before the commencement of the interview. The general setting of the room was therapeutic for participants to provide experiences concerning the study freely. Before the interview participants were given information relating to the study using the participant leaflet and the informed consent form. The information empowered the participants to determine the ideal time to be interviewed, either before or after their routine check-ups.

2.6.4 Conducting the interview

During the commencement of the interview, the researcher focused on establishing collaborative relationships. Both researcher and participants had a voice (Connelly & Clandinin 2015:4). Through the inquiry, both researcher and participant continued to

live the story whereby their narratives became, in part, a shared narrative construction and reconstruction through the inquiry.

The researcher conducted face to face individual interviews. Interviews commenced after the participants signed an informed consent form (see Annexure A) and lasted for approximately 30 to 45 minutes. Audio-recordings were utilised as per participants' permission through verbal consent. Semi-structured interviews were conducted to allow participants to describe their experiences fully (see Annexure B). The questions included one broad, open-ended question and follow-up questions. The follow-up questions were organised to build on previous questions to allow participants to clarify themselves fully (Braun & Clarke 2006:85).

The researcher, as an instrument, performed two interviews for the pilot study. The researcher discovered that she needed to improve her listening skills to allow her to obtain all information provided by the participants. Listening skills were implemented to facilitate participants to elicit detailed information about the study (Merriam 2009:101-102; Polit & Beck 2012:310). Probing was performed for clarity. Paraphrasing was affected by repeating what the participant had said and by using synonyms or shortened sentences to gain understanding. After the interviews, participants were thanked and there was time permitted for questions and clarifications (De Vos et al. 2011:531). Being attentive to the relational aspects of working with participants within the conceptual frame of the commonplaces required that the researcher and participants acknowledge that they are always interpreting their pasts from their present vantage points. In this way, narrative inquirers actively attend to and listen to participants' stories knowing that they "give shape to what they hear, making over participants' stories into something of their own" (Coles, 1989)

2.6.5 Field notes

Mouton (2001:108) explains that keeping extensive field notes of observations and other forms of data collection is vital to capturing the context of such an observation. Polit and Beck (2012:728) define field notes as notes that are taken by the researcher to record the unstructured observations made in the field and the interpretation of those observations. The researcher's field notes contain a narrative account of what was taking place in the field, and they served as the data for analysis. The descriptions included enough contextual information about the time, place, and actors to

adequately portray the situation. Clandinin and Cain (2008:6) mandate that field notes should be composed with attention to the three-dimensional narrative inquiry space:

Temporality which comes into play in two ways: First is that field notes are composed of multiple interactions with participants. Then, through participants' reflection on earlier life experiences. *Sociality* directs attention inwards towards the participants' thoughts, emotions, and moral responses, then outwards to events and actions. *Place* directs attention to places where lives were lived as well as to the places where inquiry events occurred.

According to Polit and Beck (2012:548), field notes are both descriptive and reflective. Descriptive notes are known as observational notes which are an objective description of observed events and conversations, information about actions, dialogue, and context are recorded as thoroughly and objectively as possible. Reflexive notes document the researcher's personal experiences, reflections, and progress while in the field. Polit and Beck (2012:737) maintain that personal notes are comments about the researcher's feelings during the research process. This includes the researcher's personal experiences, reflections and progress in the field. Throughout the research, the researcher evaluated herself continuously and was sensitive towards her biases, judgements and feelings regarding the phenomenon of late initiation of ANC.

2.7 DATA ANALYSIS

Data analysis denotes "the systematic organisation and synthesis of research data, a process of reducing, structuring and giving meaning to the collected data" (Polit & Beck 2012:725; Creswell 2012:179). According to Lieblich (1998) cited in Holloway and Freshwater (2007:83) narrative analysis is a way of viewing the narratives in its completeness not merely to concentrate on the content or and form. They further specify that narrative analysis includes extracting smaller sections of text which can then be classified into categories.

Thematic analysis was used for data analysis utilising the framework of Clarke and Braun (2013:120-123) as it is primarily a method for classifying and analysing patterns in qualitative data. Thematic analysis is one of the broad approaches and is perceived as the building block of all narrative analysis.

2.7.1 Advantages of thematic analysis

Thematic analysis has advantages such as the deconstructing the participants' talk, showing the reader the "what" of the narrative frames of lived experiences (Given 2008:4). The aspects of the narrative are selected thematically rather than drawing them randomly. Abbot (2002) in Holloway and Freshwater (2007:84) associates thematic analysis to repetition and interpretation, an idea that is closely related to analysis. According to Braun and Clarke (2006:97) the advantages of thematic analysis are:

- Flexibility;
- Relatively easy and quick method to learn and do;
- Accessible to researchers with little or without experience of qualitative research;
- Results are accessible to educated general public;
- Useful method for working within participatory research paradigm, with participants as collaborators;
- It can usefully summarise critical features of a large body of data, and offer a 'thick description' of the data set;
- It can highlight similarities and differences across the data set.
- Can generate unanticipated insights;
- Allows for social as well as psychological interpretations of data; and
- Can be useful in producing a qualitative analysis suited to inform policy development.

2.7.2 Disadvantages of thematic analysis

Thematic analysis does not attend to how the story was composed to converse communicative aims (Given 2008:4). Thematic analysis is superficial in itself and not able to do justice to the narrative form being studied (Coghlan & Brydon-Miller 2014:8). According to Braun and Clarke (2006;96), disadvantages of thematic analysis depend on poorly conducted analyses or inappropriate research questions than on the method itself. The disadvantages according to Braun and Clarke (2006:97) are outlined as follows:

- The flexibility of the method can be a disadvantage, in that it makes developing specific guidelines for higher-phase analysis difficult.

- A thematic analysis has limited interpretive power beyond mere description if it is not used within a theoretical framework that anchors the analytic claims that are made.
- Other disadvantages appear when the thematic analysis is considered about some of other qualitative analytic methods.
- The simple thematic analysis does not allow the researcher to make claims about language use, or the fine-grained functionality of talk.
- Thematic analysis currently has no credibility as an analytic method because it is poorly defined and demanded, yet widely used.

The researcher decided to use thematic analysis despite of its disadvantages, considering its advantages for inexperienced researchers. Further, the researcher developed an appropriate research question and was able to conduct the analysis well through the assistance from supervisors.

2.7.3 Data management

Data management is the designed structure of systematizing and filling the materials to make them to efficiently retrievable and duplicable (Merriam 2009:172; De Vos et al. 2011:408). The management of data started early when collecting data. Data was organised into folders for easy retrieval and coded by using age of participants. Organising data in that manner enabled researcher to get the sense of the whole for analysing purposes. The interviews were transcribed to aid interpretation to answer the research question. This helped the researcher to immerse herself in the data before actual analysis. Back up copies of all data were made and placed in safe place where it can not be burned or lost. Field notes and transcripts were protected by having one master copy put away.

2.7.4 Data analysis process

Thematic analysis was followed using the framework of Clarke and Braun (2006). Each phase is discussed as follows:

Familiarisation with the data:

The researcher transcribed the verbal data into a written form to conduct a thematic analysis. The researcher listened to audio tapes and transcribed interviews into written

form, in such a way that the 'verbatim' account of all verbal utterances remains true to its original nature. During the process of transcription, the researcher listened to the tapes several times and recorded her impressions of what was going on with the participant, for herself. The researcher familiarised herself with the data by repeatedly reading all field notes and transcripts. In this phase, meaning was created, and initial analytic observations notes were made. The researcher engaged in interpretive process by reading and re-reading the transcripts together with field notes until the main points and initial topics were identified.

Coding of the data

Construction of initial codes from the data extracts occurred in this phase. The researcher indicated potential patterns using highlighters, organising data into meaningful groups manually. Relevant and similar preliminary topics (codes) about reasons contributing to the late initiation of ANC from all individual transcripts were shortened and grouped. The researcher, as an instrument, tested her coding practice by having her supervisors co-code the data. Throughout coding, the researcher ensured that the codes correlated the data and the research question.

Searching for themes

The researcher grouped different codes into potential themes. Using tables, different codes were combined to form a leading or universal theme about how participants experienced reasons contributing to the late initiation of ANC. At the end of the phase, the researcher developed general themes and sub-themes and all the extracts of data that were coded. Because the inquiry is narrative, the participants' quotes were highlighted early in the process to assist in developing themes.

Reviewing themes

The researcher evaluated general themes by reading all combined extracts for each theme to see if they told a convincing story about the reasons for late initiation of ANC. The nature of individual general themes was defined and as well as their relationships. Themes were refined to accurately reflect the implications of the information given by the participants. Any additional data missed in the early stages was coded into existing themes.

2.7.5 Data interpretation

In qualitative research, the descriptive data interpretation is a way of “giving meaning to the raw data and providing the reader with the reasonable understanding that was not obvious at first glimpse” (Polit & Beck 2012:576). Interpretation and analysis of qualitative data occur simultaneously in an interactive process hence creativity plays a vital role in discovering meaning in the data. The researcher, as an instrument, interpreted the data throughout the analysis process. The interpretation of data depended on the researchers’ engagement in and closeness to the data and also the researcher’s self-awareness and the ability to reflect on their world view and perspective (reflexivity).

Reflection through the analysis and interpretation process was ensured by guarding the researcher’s stereotypical views that she held as a midwife, which she could have brought into the interpretation of data. Further, the researcher continually requested the participants to confirm her interpretation in all stages of the study by using good listening skills (Trahar 2011:93). Transcripts of the interviews and the data analysis were discussed and examined by the researcher’s supervisors to examine whether interpretations gave similar meaning with the data.

2.8 TRUSTWORTHINESS

In qualitative research, trustworthiness refers to the “degree of confidence qualitative researchers have in their data” (Polit & Beck, 2012:745). To measure the quality of the inquiry in qualitative studies, validity and reliability are replaced by trustworthiness. The strategies to improve trustworthiness, according to the model of Lincoln and Guba (1985:289-311), include credibility, transferability, dependability and confirmability. Guba and Lincoln (1994) cited in Polit & Beck 2012:584) added the criteria of authenticity that is more specifically within the constructivist paradigm. The concepts are defined, and the application thereof is described.

2.8.1 Credibility

Credibility refers to “the confidence in the truth of the data and its interpretation” (Polit & Beck 2012:484), and it includes taking steps to make sure that the experiences and circumstances of the participants are represented in the research report (Holloway & Freshwater 2007:112). In this study, credibility was ensured by persistent observation, reflection, triangulation, audit trail and verisimilitude.

Persistent observation involves the qualitative researcher's intense focus on the characteristics of circumstances that are relevant to the phenomenon being studied (Polit & Beck 2012:737). Lincoln and Guba (1985) indicate that persistent observation provides "depth" in a study. In this study, persistent observations were ensured by pre-briefing and debriefing the selected participants. Pre-briefing involved informing participants about the study and its progress (Lavoie; Pepin & Cossette 2015:18). Participants received pre-briefing and became aware of what was to be included in the study hence contributed to the credibility of the study.

The debriefing was done after the interviews by informing the participants about the end product of the research. Further, they were encouraged to ask questions. Debriefing is described as "communication with participants after participation is complete regarding aspects of the study" (Polit & Beck 2011:725; Lavoie; Pepin & Cossette 2015:18). All queries as asked during and after interviews were answered appropriately, For example, one patient asked a question about labour and delivery, and she was given information.

2.8.1.1 Reflection

Reflection refers to the process of critically reflecting on self as well as analysing and making a note of personal values that could affect collection and interpretation of data (Polit & Beck 2012:179). In the study, the researcher enhanced the credibility of the study by acknowledging and identifying personal biases which could have arisen at any stage of the research process. During data collection, the researcher avoided criticisms, opinion and paid strict attention to the descriptions that participants gave on the phenomenon under investigation. After interviews, the researcher kept reflexive notes to evaluate her biases.

2.8.1.2 Triangulation

Triangulation refers to the use of multiple methods to collect and interpret data about a phenomenon to converge to the truthful illustration of reality (Polit & Beck 2012:745; Creswell 2007:208). In narrative inquiry, triangulation is concerned with the representation of a multiplicity of voice and signatures which are reflected in the data (Given 2008:8). Investigator and communication triangulation was conducted to achieve credibility of the findings. Methodological triangulation is not appropriate in narrative research because the narratives are the only source of data collection

(Holloway & Freshwater 2007:113). However, because the study is narrative a vast range of participants with different age groups (18 – 40 years) were interviewed to achieve the study's credibility. The researcher, throughout analysis, triangulated participants' narratives through merging the multiple and different information to form themes.

The communication skills were applied throughout the interview process to achieve communication triangulation (Huber-Warring 2010:424). The researcher applied different communication skills during the interviews to draw information from the participants to gain an in-depth understanding of their experiences such as probing, paraphrasing and reflecting meaning and feelings.

Investigator triangulation refers to the use of more than one person to analyse or interpret results to prevent personal biases and increase accuracy (Polit & Beck 2012:563). In this study, investigator triangulation was ensured by utilising supervisors of the study during data analysis and interpretation. During report writing, the researcher represented the social reality and the meaning she gave to the participants' reasons contributing to the late initiation of ANC (Holloway & Freshwater 2007:112). Member checking was not done in this study because in narrative inquiry, the report is the researchers' understanding or interpretation of text (Clandinin 2012:16; Holloway & Freshwater 2007:106)

2.8.1.3 *Audit trail*

Audit trail refers to "the systemic documentation of material that allows an independent auditor of a qualitative study to conclude trustworthiness". Holloway and Freshwater (2007:115) indicate that an audit trail is a significant way of showing transparency in the research process. In this study, an audit trail was maintained by giving a detailed presentation of all strategies, procedures followed during data collection and the data analysis process. The researcher's supervisors acted as independent coders and repeated the analysis to verify and to enhance the credibility of findings. The meaning and intentions of the participants' reasons for late initiation of ANC were described when writing the report.

2.8.1.4 *Verisimilitude/truth:*

Verisimilitude is the criterion with which the value of narrative inquiries is judged (Creswell 2007:250). For the study to have trustworthiness it must "ring true" it must

have believability, whereby audiences must experience a similarity with their own experiences in similar, parallel, or analogous situations. Verisimilitude is the principle for good literary study, in which writing seems 'real and alive', bringing readers directly into the world of study (Loh 2013:9).

In this study, verisimilitude was ensured throughout report writing. The findings were written in such a way that the results were the accurate reflection of the information given by the participants. The utility is the second criterion speaking to the significance of a study that looks at narrative truth. Loh (2013:10) quotes Riessman (2008) who considered utility as the "ultimate test". Three criterion listed by Eisner (1998) to test usefulness or utility were considered when writing the report:

- Comprehension: can the study help readers understand the situation that is mysterious or confusing.
- Anticipation: study provides descriptions and interpretations that go beyond the information given to them.
- Guide or map: study highlights, explains or provides directions that the reader can consider; deepens and broadens their experience and helps them understand what they are looking at.

To gain trustworthiness in this criterion according to Loh (2013:10) peer validation and audience validation was necessary. Thick description contributed to creating the criteria.

2.8.2 Transferability

Transferability represents the generalisability of the study results to other settings (De Vos et al. 2011:420). However, Polit and Beck (2012:585) refer to transferability as "the extent to which the findings from the data can be transferred to other settings or groups." In narrative inquiry, the context is central (Holloway & Freshwater 2007:112).

For this study, the researcher ensured transferability by providing sufficient details about the context and the participants, for the readers to decide whether the findings could be acceptable to be applied to their settings. Transferability was ensured during sampling and by thick description. The thick description refers to "rich, detailed description of the research setting, the transactions and the process observed during the inquiry" (Polit & Beck 2012:526; Creswell 2007:209; Holloway & Freshwater 2007:98-99).

In this study, the context of the inquiry and the participants were described, including their demographic profiles and information about each participant indicating characteristics which were essential for the study. The participants' social world and experiences were also portrayed. During report writing, coherence was maintained by thoroughness so that readers and reviewers developed confidence in the data. The researcher wrote the report in such a way that it looked exactly as how the participants narrated by indicating the beginning, middle and the end (Holloway & Freshwaters 2007:99).

2.8.3 Dependability

In qualitative research, dependability is the criterion for evaluating the truthfulness of the study results (Polit & Beck 2012:725). Dependability of the study is measured by its consistency and accuracy (Holloway & Freshwater 2007:112). These authors further affirm that credibility is attained whenever there is a replication of results if the study is repeated, and without dependability one cannot attain credibility just as validity in quantitative research.

In this study dependability was improved by a persistent observation, investigator triangulation, independent checking, dense description and audit trail. The measures mentioned above of enhancing dependability were discussed in section 2.8.1.

Furthermore in order to show dependability the researcher provided a comprehensive description of research processes involved in all the phases of the study, the research design, and methods, including the sample and the data analysis. The dense description can also contribute to establishing utility because answers can be raised and meaning be transferred to a different yet similar setting (Loh 2013:10).

2.8.4 Confirmability

Confirmability refers to the neutrality of data and interpretations, signifying the potential for congruence between two or more independent people about the data's accuracy, relevance or meaning (De Vos et al. 2011:420; Polit & Beck 2012:585). Confirmability is also concerned with establishing that the researcher represents the information provided by the participants.

In this study, confirmability was enhanced by involving the supervisors to check if the transcription and interpretation of data were accurate as well as acting as co-coders

during data analysis. During report writing, the themes were supported by quotes from verbatim transcribed interviews to reflect participants' voices. The researcher demonstrated that the findings emerged from the data not from the researcher's own bias, and by re-checking the data throughout the study. Confirmability was also enhanced by using audit trail, triangulation and reflection during the study (Holloway & Freshwater 2007:113). These strategies to ensure confirmability were discussed in section 2.8.1.

2.8.5 Authenticity

Botma , Greef and Mulaudzi (2010:234) describe authenticity as the truthfulness and the impartiality of the research. Polit and Beck (2012:720) indicate that authenticity refers to the extent to which qualitative researchers fairly and faithfully show a variety of realities in the collection, analysis, and interpretation of data. The criteria of authenticity emerged as a result of critique against the other four measures of trustworthiness, namely credibility, dependability, confirmability and transferability (Polit & Beck 2012:584). Holloway and Freshwater (2007:113) describe Lincoln and Guba's criteria of authenticity as an extent of trustworthiness. They further indicate that a study is authentic when the process is adequate, when the ideas of the participants are appropriately presented and when participants and readers have better insight into their problems and can improve their situation. In this study, authenticity of the study was established through strategies such as the development of an audit trail and reflexivity as described in section 2.8.1 (Holloway & Freshwater 2007:116). The measures for authenticity as described by Holloway and Freshwater (2007:113) include fairness, ontological authenticity, educative authenticity, catalytic authenticity and tactical authenticity.

Fairness: The researcher demonstrated fairness by being non-discriminatory and just to the participants and taking their social context into account. Fairness was applied when purposive sampling was applied during the selection of participants, as well as gaining informed consent throughout the narrative inquiry.

Ontological authenticity: Ontological authenticity describes that this study may help the participants to understand their social world and their human condition through the research. The pre-briefing and the debriefing that was conducted in the interview process made participants look deeply at the reasons contributing to the late initiation

of ANC. By the end of the study, the participants were empowered on early initiation of ANC.

Educative authenticity: Through the intersubjective understanding, participants improved their understanding of others. Participants in this study were able to understand how ANC in the public sector is provided as well as the challenges.

Catalytic authenticity: Decision making by participants was enhanced by the research. Through the study, the participants were empowered to plan their pregnancies by choosing the best contraceptives especially the Long Acting Reversible Contraceptive's because it is very effective and does not require adherence.

Tactical authenticity: This research empowered the participants. In this study, strategies to improve early initiation of ANC were discussed with management so that all women who suspect pregnancy should be referred to any ANC clinic to confirm pregnancy and prevent delays in initiation of ANC.

2.9 SUMMARY

Chapter two outlined the constructivist paradigm followed through the study as well as the research design which was qualitative and narrative inquiry, the research method which was followed during fieldwork, the measures to ensure trustworthiness and the ethical considerations employed during the research process. The chapter also explored the familiar places of narrative inquiry which guided the inquiry, which was the temporality, the sociality, and the place. The next chapter will provide an overall orientation to data analysis, introduction to participant narratives as well as the results, in the form of themes, of the participants' collective narratives.

3 Findings from Participants' Narratives

3.1 INTRODUCTION

Chapter 2 focused on the research design and methods used to answer the research question. The research methods focussed explicitly on the setting, population, sampling, and the data collection technique and data analysis. Strategies to enhance rigour and ethical considerations were discussed as well as the researcher as an instrument for data collection. Chapter 3 offers the findings from the participants' narratives first the individual narrative is presented followed by the collective narrative in the form of themes.

3.2 ORIENTATION TO THE DATA ANALYSIS

Participants in this study initiated ANC after 20 weeks of pregnancy. They had unplanned pregnancies which made most of them delay confirming their pregnancies. Even those who confirmed their pregnancies earlier delayed to start attending ANC due to a variety of reasons. The participants in this study missed the benefits of early initiation of ANC, and this could have resulted in maternal and perinatal mortality and morbidity which could have been prevented if they had initiated ANC early. Sub-Saharan Africa is grappling with the burden of mistimed and unwanted pregnancies, that is associated with the unwanted conception that has been shown to be a cause of late initiation of ANC and less frequent visits compared to pregnancies that were planned (Ochako & Gichulu 2016:8).

3.3 INTRODUCTION TO PARTICIPANTS' NARRATIVES

Individual participants narratives are discussed in this section that included their demographic data. The individual narratives are introduced to demonstrate how participants experienced reasons contributing to the late initiation of ANC. The narratives of all study participants were outlined in this section.

3.3.1 Participant no. 1

Demographic Data	
Age	39 yrs
Race	Coloured
Marital status	Married
Highest qualification	Grade 10
Parity	G5 P3 Miscarriage (1)
Gestational age (first visit)	24 Weeks
Planned pregnancy	No
Occupation	Unemployed

The participant said that the reasons for late initiation of ANC was because she did not experience early signs of pregnancy until she felt movements which made her suspicious. She went to the clinic to seek healthcare for a headache and ulcer pains she was experiencing the pain over a period, which was not responding to over the counter medication. Because she was suspicious, she requested a pregnancy test. She expressed shock when she was told that she was pregnant. The participant explains this situation as follows:

“Because there was no signs of pregnancy, morning sickness, ok with other children I experienced serious morning sickness. During that month that I came to the clinic, I got suspicious, could feel that was something in my belly. However, I thought maybe it is my womb but still didn’t make me suspect that I’m pregnant. Yes on that date they said I’m pregnant. It was a big shock hey, it did come to mind to do the termination of pregnancy, and it was like don’t tell your husband, just keep quiet go clinic and do it.”

The participant revealed that before she fell pregnant, she did not use family planning at all. She indicated that she used the three months injection and experienced side effects and decided to stop the method and did not use protection. For nine months she postponed going for her next injections. Since then her menstrual cycle did not resume. The previous experience that she had with the same type of contraception made her think that she would not fall pregnant. In between the other children, the injection took time to clear from her system hence her other children are 21 years, 16years and 7 years. She indicated that the support received from her family made her accept the pregnancy even though the pregnancy was not planned.

3.3.2 Participant no. 2

Demographic Data	
Age	36 yrs
Race	Coloured
Marital status	Widow
Highest qualification	Grade 11
Parity	G6 P4 Miscarriage (1)
Gestational age (first visit)	25 Weeks
Planned pregnancy	No
Occupation	Unemployed

The participant indicated that her reason for late initiation of ANC was because she was not aware that she was pregnant. She decided to go the clinic to do a pregnancy test when she started experiencing late signs of pregnancy. The participant had an Implanon NXT but had problems with the contraceptive. She reported that she had breakthrough bleeding (side effects), which was never corrected and did not use condoms. She indicated that they gave her treatment for the bleeding, but she conceived while on treatment. She said the following:

“The reason why I started clinic late is that I didn’t know that I was pregnant at that time. It was because of the I implant, so every month when I menstruate, I came and ask sisters, but why you said this thing is 100% or 99% but why am I bleeding every month so this thing “mos” is not helping. I started feeling funny, my breasts were getting bigger, and I was getting a little weight, So I said to myself, no man this not right and I was feeling something moving inside, so I came to the clinic and ask them that side, to see if maybe I’m pregnant or maybe I’m not and is that where I found out I was pregnant”.

The participant was affected by the side effects of the implant. She also mentioned that she changed from the three month injection because she did not want to menstruate. She accepted the pregnancy and started attending ANC the same day after confirming pregnancy. However, she was already 24weeks pregnant.

3.3.3 Participant no. 3

Demographic Data	
Age	19 yrs
Race	Coloured
Marital status	Single
Highest qualification	Tertiary
Parity	G1 P0 Miscarriage (1)
Gestational age (first visit)	24 Weeks
Planned pregnancy	No
Occupation	Employed

This participant always experienced irregular menstrual cycles and because of this problem, she took time to discover that she was pregnant. She thought the menstrual cycle would resume again until she noticed signs of pregnancy. When she went to the doctor for pregnancy confirmation, she was already 20 weeks pregnant. After confirmation the pregnancy, she delayed initiation of ANC because she encountered many problems. She indicated that she fought with her mother, who chased her out of the house, and she stayed with friends and also was afraid to disclose the pregnancy to her boss and the nurses. Because she was employed, she did not get off during the week, and that caused another delay. She stated the following:

“Ok due to my circumstances I found out ok, it was like late due my periods – having period pains and all that stuff I do not get pains, so monthly the period pains come and go maybe skipped two months or so. I didn’t know that I was pregnant but afterwards, obviously, I notice the swelling on my breasts my nipple and all those stuff, and I needed someone to talk to before I can go. I asked my mom... tell my mom obviously it was shock for her and, I had a pregnancy test and then went to the doctor. Afterwards I started coming to the clinic instead. Because of certain reasons we had complications obviously we had fights, She was disappointed it was complicated, and then I told my boyfriend now I have to start coming to clinic because it is monthly treatment. And ja I came started clinic and it was first time”.

What made her gain confidence was the support from friends and the nurses. She indicated that she had never been at the clinic before and was embarrassed because of her age and thought the nurses would judge her. She was surprised by the support

and instruction she received at the antenatal care clinic. She apologised to her mother who forgave her and took her back home. The boyfriend was supportive, and together they believe in God, and that kept them going.

3.3.4 Participant no. 4

Demographic Data	
Age	28 yrs
Race	Black
Marital status	Married
Highest qualification	Tertiary
Parity	G2 P1
Gestational age (first visit)	24 Weeks
Planned pregnancy	No
Occupation	Employed

The participant was not aware that she was pregnant because she was using oral contraceptives, and she had a menstrual cycle every month. When she became suspicious, she did a home pregnancy test, and it was positive. She then attended with the private doctor and discovered that she was pregnant; around 18-20 weeks. After confirming the pregnancy at the private doctor's practice, she still delayed initiating ANC because she had a lot of problems at work. She could not concentrate on the pregnancy until the problem was resolved. She ended up by losing her job. She initiated ANC when she was 24weeks pregnant. The participant stated that:

“By then I was taking my contraceptives at the same time, then after a month that’s when I realised that ...no man I’m pregnant. I was also going through some hearing [disciplinary] issues from work, so those were the things that were delaying me to focus on my pregnancy. Ja I was focussing on this hearing situation and to defend myself and clear my name because I was accused of things that I didn’t do and was such a short period-to go through having appeal, CCMA, and labour –you know such things. So there was not enough time for me to focus on the pregnancy”.

As it is known that stress may cause forgetfulness, there is a high possibility that she forgot to take the pill. The participant encountered contraceptive failure because she was under a lot of pressure meanwhile the pill needs much devotion.

3.3.5 Participant no. 5

Demographic Data	
Age	25 yrs
Race	Coloured
Marital status	Single
Highest qualification	Grade 12
Parity	G1 P0
Gestational age (first visit)	36 Weeks
Planned pregnancy	No
Occupation	Employed

The participant confirmed her pregnancy at the doctor's practice immediately after she missed her period. She said she was not aware how ANC operated in the public sector. Hence she continued to do her check-ups with the doctor until the third trimester of her pregnancy. The doctor advised her to visit the ANC clinic to get maternity case record to be able to use the public health care centres when in labour and delivery. She said she was shy to go to the ANC clinic, but she was surprised because the nurses made her feel comfortable and gave her health education. She then decided to follow-up at the clinic because it is free and the service was excellent as compared to services received from the doctor. She expressed the following:

"I know people go to clinic when they are pregnant of some people don't have funds, money to go to GP so I preferred myself to go to GP – You know sometimes you are shy.– so when things started to be hectic at the doctor he referred me to the clinic because I needed a book, because if I go government to give birth there, they won't help me without the maternity case record, so I came to the clinic here the other sister told me they can help me I can start coming here, from now on I never went to GP or Gynaecologist ever again so I came here. It is safe to be at the clinic than to be at a GP because sometimes you don't have that money to go to the GP all the time mm! It's better to come to clinic because they do everything, every check-up like they give you good support".

The participant was impressed by the antenatal care received in the public sector. She appreciated the support she received from the nurses and could compare the better services received from the public sector with the one in the GP's rooms.

3.3.6 Participant no. 6

Demographic Data	
Age	40 yrs
Race	Black
Marital status	Single
Highest qualification	Grade 11
Parity	G2 P1
Gestational age (first visit)	27 Weeks
Planned pregnancy	No
Occupation	Employed

The participant initiated ANC late; she said she did not use contraceptives, and she was getting her menstrual cycle every month. She visited the clinic to confirm pregnancy immediately when she missed her menstrual cycle, but the pregnancy test was *negative*. She was bothered by the results but accepted them. Two months later, pregnancy signs manifested. She went back to the clinic to check again and then the pregnancy test was positive. After confirmation of the pregnancy, she delayed initiating ANC because after the pregnancy confirmation from the primary health care side, she reached the ANC clinic late in the day. The participant could not be seen on the same day because of the shortage of staff at the clinic and was given a date to return. She was unable to come on the appointment date because she was working. When she started to attend ANC, she was already 27 weeks pregnant. The participant said:

“Ok, the first time I didn’t see my period I came here at the clinic tolike [banteste] [to be tested] for pregnancy, and they find that I’m not pregnant –I’m negative. I stayed at home like relaxing that I knew that I’m not pregnant –but seeing that my stomach and my breast is changing I came back to the clinic to test again. I found out that I’m positive “you see” and then I was surprised that why being negative at the first time. When I came here the sister was working alone ne --they gave me the pills, they checked me the BP, and then they said come for the other things.”

The participant did not ask for alternative tests such as ultrasound or blood tests (BCHG) for pregnancy confirmation, which could have been done in the same facility. There is a great need for women empowerment because if she knew about these procedures, she could have demanded them and enhanced early initiation of ANC.

3.3.7 Participant no. 7

Demographic Data	
Age	22 yrs
Race	Coloured
Marital status	Single
Highest qualification	Grade 11
Parity	G1 P0
Gestational age (first visit)	20 Weeks
Planned pregnancy	No
Occupation	Unemployed

The participant had an irregular menstrual cycle that made her not to worry when she missed her menstruation cycle since she was using condoms for contraception. She was not aware that she was pregnant. She started to be alarmed when she experienced signs of pregnancy. Her boyfriend suggested they must go to the private doctor to do a pregnancy test, the pregnancy was positive, and she was 17 weeks pregnant already. She delayed coming to the antenatal clinic because she was afraid to tell her aunt since her aunt was her guardian since the time when her mother passed on. She wondered what her aunt would think of the pregnancy, but her aunt was shocked and excited at the same time. Her aunt advised her to start attending antenatal care. She was afraid to attend ANC in the public sector because she thought of the long waiting time and that people will judge her. Another problem she had was that she did not want the baby because she was young and the fact that she was not independent yet. She described her reasons for late initiation of ANC as:

“Then I went to the doctor to find out if I’m pregnant or not before I came to clinic and I found out, I was pregnant 17 weeks already. I was scared of my aunty the thing is, since my mother passed away she is the one who basically mm! Raised me so I was scared of what she will think of this pregnancy. The thing is I didn’t want the baby because I wasn’t ready and I felt that I was still too young to have a baby and that I’m not independent yet. I wasn’t independent yet but my aunt said it wouldn’t be a problem they will help me everywhere so in that I gain my confidence into keeping the baby. The thing is I didn’t really recover from my mother’s death and that made me in some way didn’t want the baby because I

felt like I had some unresolved issues with myself, that is why I didn't want the baby at first but when my aunt made me realise that I have to accept the baby".

The participant indicated that with the support she received from her aunt, she was able to accept the pregnancy, even though it was unplanned, she started to attend ANC. The fear of reporting the pregnancy led to the late initiation of ANC hence she started it when she was already 20 weeks pregnant; which is late initiation of ANC.

3.3.8 Participant no. 8

Demographic Data	
Age	26 yrs
Race	Coloured
Marital status	Single
Highest qualification	Grade 11
Parity	G3 P2
Gestational age (first visit)	27 Weeks
Planned pregnancy	No
Occupation	Unemployed

This participant did not use any contraceptive method. She was used to getting her menstrual cycle every month. When she realised that she missed her menstrual cycle, she suspected pregnancy and was in denial. She indicated that she started to worry thinking that she was pregnant then she thought of terminating the pregnancy. Before she came to the clinic, she decided to allow the pregnancy to continue because of her religious beliefs; she believes that termination of pregnancy is killing the baby. Later she came to the ANC clinic to confirm the gestational age, and she was already 27 weeks pregnant. The participant had a lot of stress, was not working and she was afraid of her mother because she knew that her mother would be unhappy. Indeed her mother was upset and shouted at her at the time of reporting, but she eventually accepted the pregnancy and supported her daughter. She mentioned that her sister and boyfriend supported her from the beginning of the pregnancy. The participant narrated her reasons contributing to the late initiation of ANC as follows.

"I didn't prevent –if I found out eish! I have lot of stress and I say yo!, Now I don't know what is happening with me. Maybe I'm pregnant or maybe aa! Maybe I must go to abortion or must keep the child. I keep it –abortion is not

say you must kill the child –you see because God say you must not kill- the child is a blessing, why must you go to abortion to do just everything. I came here by the clinic to find out what is happening”.

According to the demographic data, this participant had the lowest educational level compared to all the other participants coupled with the lowest socioeconomic status. This could be the reason that contributed to her late initiation of ANC. Poverty may lead women to exercise unprotected sex hence unplanned pregnancy.

3.3.9 Participant no. 9

Demographic Data	
Age	27 yrs
Race	Black
Marital status	Married
Highest qualification	Tertiary
Parity	G2 P1
Gestational age (first visit)	20 Weeks
Planned pregnancy	No
Occupation	Employed

The participant delayed initiating ANC because she delayed in confirming the pregnancy since it was not planned. She was using condoms as her contraceptive method hence did not know how it happened that she fell pregnant. However, she denied the pregnancy, although she missed her menstrual cycle until her sister asked her about the number of sanitary pads that she was having. She did a home pregnancy test, and it was positive. She then confirmed her pregnancy at the GP’s rooms during the weekend. Then she went to the primary health care centre to see the midwife, where she was seen by the registered nurses who referred her to the ANC clinic after twelve midday. At the ANC clinic, there was only one sister who could only see her later that afternoon. She then decided to come the following week because it was already late. She also had another week’s delay when she went home to look after her sick mother. She then initiated ANC at 20 weeks of pregnancy. She said the following:

“My sister asked me why is your pads still the same –is when I started realising [laughing]. Normally when we buy pads, on special, we buy like maybe 5 (five) or 10 (ten) packs then...then I looked at them and said ee! I don’t know why -

then I decided to buy a pregnancy test. Moreover, that's when I found that I was pregnant. It was on a Friday I was supposed to go home in Mpumalanga, and then when I came back that's when I started to come to the clinic. When I came there was only one sister and they said they still has to take my blood before they can open the white file for me—I said its ok no problem then the sister did inject me with the prevention –the mother to child and then they said to me I can come back after on Monday the following week. I took, I think a week because I was in Mpumalanga to look after my mom and that's when I came back to the clinic.”

The midwife could not do the ANC initiation procedure because it takes about half an hour to an hour to examine one pregnant woman during the first contact because of the paperwork that has to be filled in as well. Because it was late and the clinic was overcrowded, the participant was told to return on another date. However, the participant was glad because she was given tetanus toxoid injection before she left because she believed it was for the prevention of infections for the baby and herself.

3.3.10 Participant no. 10

Demographic Data	
Age	28 yrs
Race	Black
Marital status	Married
Highest qualification	Tertiary
Parity	G3 P2
Gestational age (first visit)	27 Weeks
Planned pregnancy	No
Occupation	Employed

The participant delayed initiating ANC because she was not aware that she was pregnant as there were no signs of pregnancy. She started to be suspicious when she felt foetal movements. She said since she has used the three month injection for contraception for two years, she experienced amenorrhea (an expected side effect). Since she had problems with the injection, she stopped it and did not use protection. However, she thought that since she does not get her menstrual cycle, she will not conceive. When she felt the movement, she bought a pregnancy test and the results were positive. She confirmed the pregnancy at the clinic and went to the doctor to

confirm the gestational age. She could not initiate ANC because she was on training for two months and could not get time off during the week. She then continued to see the doctor until she finished the course. After the two months of training, she then went to the clinic to initiate ANC as she would be able to be off during the week. By the time she initiated antenatal care, she was already 27 weeks pregnant. She expressed the following.

“I only find out that I was pregnant when I was 5months –ja because I had a problem with” Depo” –I didn’t have any signs of pregnancy I didn’t show- there was no changes, I bought a pregnancy test and discover that I’m pregnant. So I came here and confirmed but even though was not sure of the months I have to go to the private doctor to confirm for the months. Ja so that is why I come here and started late. Luckily is not the first time I’ve been pregnant, so if I wasn’t pregnant before I wouldn’t have known the movements.—I will just say my tummy is acting up, whatever. I will only discover when I was giving birth. Even if i couldn’t come to the clinic I took other way to make sure to have a save pregnancy. So even if you can’t come to clinic use ways...go GP do something! Ja but now I’m done I’m working –so during the week I get some offs –so now I can come to the clinic.”

Unemployment also contributed to the late initiation of ANC because the participant could not afford to lose an opportunity for training due to her pregnancy. However, the participant demonstrated a sense of responsibility by seeking help from the private sector until she was able to initiate ANC.

3.4 THEMES OF THE PARTICIPANTS’ COLLECTIVE NARRATIVE

In Section 3.3, the participants and their narratives were introduced to generate a deeper understanding of the collective narrative for the reasons that contributed to the late initiation of ANC among pregnant women in a selected CHC in Tshwane. Four themes were generated based on the individual narratives. This uncovered the shared experiences as; unplanned pregnancy, work circumstances, dilemma of reporting and service delivery issues. Themes are supported by quotes from the narratives and the quotes are ordered according to relevance and significance to the theme under discussion. All verbatim quotes of participants were carefully selected to become the voice of the participant and are reflected in italics and serve as evidence of the

participants' experiences of reasons contributing to the late initiation of ANC. See Table 3 for a summary of the themes and sub-themes.

Table 3: Summary of findings for the collective narrative

THEMES	SUB-THEMES
3.4.1 UNPLANNED PREGNANCY	Unaware of pregnancy
	Contraceptive failure
3.4.2 WORK CIRCUMSTANCES	Lack of opportunities to attend ANC
	Stress from work
3.4.3 DILEMMA OF REPORTING	Fear of reporting
	Embarrassment
3.4.4 SERVICE DELIVERY ISSUES	First consultation at the GP's
	Shortage of staff
	Service delivery flow
	Mis-diagnosis of pregnancy

3.4.1 THEME 1: Unplanned pregnancy

Unplanned pregnancy was one of the reasons for late initiation of ANC among the participants. Unplanned pregnancy could result in a mistimed or unwanted pregnancy. According to Bexhel, Guthrie, Cleland and Trussel (2016:233-234), unplanned pregnancies cause a lot of stress to the women and the family if the pregnant woman is still young and even in the relationship. Unplanned pregnancy is associated with adverse consequences for both mother and child such as high rates of abortion resulting in increased medical costs and mortality and morbidity (Trussel et al. 2013:155). Women who experience unplanned pregnancy have a tendency to delay initiating ANC. The reason given by the participants for late initiation of ANC was, among others, unawareness of the pregnancy and contraceptive failure.

3.4.1.1 Unaware of pregnancy

The participants said that their reason for late initiation of ANC was because they were not aware of the pregnancy until when they felt movements which made them to be

suspicious because they did not experience early signs of pregnancy. Not expecting to be pregnant caused women to miss the early signs of pregnancy, because they did not recognise them as pregnancy, especially because the signs were masked by irregular periods and other symptoms which may be manifested from other diseases.

“I didn’t even notice I was just like maybe is, no the periods it’s just skipping but I wondering why it took so long” [P3].

“Ok, actually I was not sure whether I was pregnant or what because I got sick often (ulcer pains), so on...that day I decided to come to clinic and to test myself, because there was no signs of pregnancy.” [p1]

Another participant who was not aware of her pregnancy indicated that she always experienced irregular menstrual cycles. Because of that problem, she took time to discover that she was pregnant. She thought the menstrual cycle would resume until she noticed pregnancy signs. When she went to the doctor for pregnancy confirmation, she was already 20 weeks pregnant. Not expecting pregnancy may have caused these women to miss early signs of pregnancy. The following narratives revealed this:

“Like usually with me it maybe come this month for 3 – 4 days and next month it skips like the following months I get two times a month, but I followed it up with the doctor and say now the doctor, he said no, he gave me medicine it worked but due to that time I was ignorant, I didn’t even notice I was just like maybe is, no the periods it’s just skipping but I wondering why it took so long” [p3].

3.4.1.2 Contraceptive failure

The participants indicated that they experienced contraceptive failure. Women who intend to use contraceptives should understand how the chosen method works and its side effects to achieve its maximum efficacy and prevent unplanned pregnancy. Some participants skipped taking their contraceptives due to the fear of side effects; others reported that they were lazy to go to the clinic to change the method. Contraceptive failure could have resulted from the inconsistent use or the effectiveness of the chosen method itself.

Participants had an unplanned pregnancy owing to the inconsistent use of contraceptives. They were not aware that they were pregnant until they felt foetal movements. They alleged that their experience with the previous pregnancy helped

them to discover the foetal movements and then suspected pregnancy. Since they stopped taking their injections, they experienced amenorrhoea, which made them think that they would not fall pregnant even if they did not use protection. A participant clarified this by the following narrative.

“I skipped for 9 months but still didn’t suspect that I could get pregnant, ja with other children, it was like three months’ injection took long to work out yes. Actually, why I skipped the injection, it was making me feel sick, and I was too lazy to come to clinic for something else every time I will say I will go tomorrow then I don’t come.” [P 1]

The lack of reproductive knowledge was evident when the participants indicated that they stopped using contraceptives on their own because they usually take time to conceive after stopping the three month’s injectable. These women did not use any protection after stopping the injectable for up to nine months. Another participant said this:

“has been using it for two years and quitted and only then I discovered when the child started kicking that I’m pregnant.” [P 10]

It is common for women to experience unplanned pregnancy due to contraceptive failure especially when using the modern contraceptives; short-acting reversible contraceptives (SARC) (Brooke et al. 2016:2004). The short-acting reversible contraceptive such as the pill, injection, condom, spermicides, patch, ring and diaphragm need much adherence as compared to long-acting reversible contraceptive (LARC). Whenever there is the inconsistent or incorrect use of the SARC, the women may become pregnant without being aware (O’ Brien 2016:21). There are many things or situations that can cause the women to fall pregnant while using the SARC, such as forgetting to take the tablet, using antibiotics and having diarrhoea while on oral contraceptives. One participant said she does not know how it happened because she was taking her pill the same time, but she indicated that she had a lot of stress. Maybe the woman forgot to take the pill due to high-stress levels. She said the following:

“Ok, the first few weeks 6 weeks, I was not aware because I was going through much stress from work. So I had my period, so I never thought I was pregnant.” [P 4]

One participant who did not expect to fall pregnant she thought that she was protected because she had an implant (Implanon NXT) which is one of the LARC's and is 99%-100% safe. Though she had an implant, she had breakthrough bleeding which is a known side effect of the implant. She indicated that she was given treatment but the side effect did not resolve. However, the woman was not aware of the possibility of conceiving with the implant and that she should use condoms for dual protection while experiencing the side effects to prevent pregnancy. Contraceptive failure was described by the participant as follows:

“ Every time when I came back they gave me box of white tablets they say I must drink tablets ja, when I drink the tablets no sign of menstruation but when I finish the tablets then it's when the menstruation come again, so I didn't know that I was pregnant at that time.” [P 2]

The participant was sad about the side effects of the implant; she also remarked that she changed from the three month injection because she did not want to menstruate. However, she accepted the pregnancy and started attending ANC the same day after confirming pregnancy, by then she was already 24 weeks pregnant.

Contraceptive failure coupled with denial contributed to the late initiation of ANC. Some participant indicated to have used condoms as a contraceptive method hence did not know how it happened that she fell pregnant. The participants denied the pregnancy. Although they missed their menstrual cycles for several months, they indicated that they were not aware of the pregnancy. One woman said her sister made her realise that the amount of the sanitary pads she had were still the same. She tested herself and confirmed she was pregnant. Then she confirmed the pregnancy with a private doctor and ended up initiating ANC late. The type of contraception (condom) used is ranked as the least effective contraceptive and has a failure rate of 18 % or higher according to O'Brien (2016:21). Her experience was explicated as follows:

“Ok the last time I saw my period it was in May, and June-July I didn't notice anything up until I think it was in August.” [P 9]

Another participant who had an irregular menstrual cycle did not worry when she missed her menstruation since she was also using condoms for contraception. She denied the pregnancy even when she experienced early signs of pregnancy. Her boyfriend suggested that they must go to the private doctor to do a pregnancy test.

The test came out positive, and she was 17 weeks pregnant already. Her denial is evident from the following comment.

“Ja I missed my period bit I didn’t see it strange because I missed ja I got it I miss it. Vomiting – I was not feeling well I was eating too much but some things didn’t want to go down. I was always tired gaining weight, and then my boyfriend suggested that we go to the doctor. I don’t know what happened to the contraceptives [Laughing]. We didn’t miss the condom. I didn’t miss it.” [P7]

“Actually I’m lying in that month, during that month that I came to the clinic, I got suspicious, I could feel that was something in my belly, but I thought but still not maybe It’s my womb” [P1].

The above statement reflects a situation in which some of the participants in this study initiated ANC late due to denial. They became ambivalent when they suspected their pregnancies, hence the delay in initiation of ANC.

3.4.2. THEME 2: Work Circumstances

The second theme of the collective narratives was work circumstances. Lack of opportunities to attend ANC and stress from work was described in this theme.

3.4.2.1 Lack of opportunities to attend ANC

Some of the participants in this study pointed out that they lacked opportunities for attending ANC. They found it difficult to initiate ANC after confirmation of pregnancy because they could not get time off from work during the week. This is evident when pregnant women went to General Practitioners (GP) for their ANC. The following narratives revealed the problem of lack of opportunities to attend ANC:

“Ja ok after finding out I had to go to the doctor for two months because I was busy with my training couldn’t come to the clinic. But I didn’t sit –went to GP because I was only available on weekends.”[10]

One participant also indicated lack of an opportunity to attend ANC after confirming the pregnancy because she was not given time off from work during the week until she went on maternity leave. This is her comment:

“The thing is this when I was still working I didn’t have off days, so now obviously they have to plan or if I have to come to clinic my dates and stuff. They gave me maternity leave last week I’m at home now.”[p 3]

Another participant explained her situation of failing to come to the clinic for initiation of ANC because she could only get time off work once per month. When she came to the clinic to initiate ANC and she was not assisted, she was told to return on another date. She then decided to come to the ANC clinic when she comes for her ARV’S that added up to a month’s delay. This was manifested in her narrative when she said:

“When I came here, they say I must come back and come back at Friday but Friday I was going to work I can’t be at clinic.”[P 6]

3.4.2.2 Stress from work

Stress from work was another reason which contributed to the late initiation of ANC. One participant confirmed her pregnancy early but could not initiate ANC on time because she had a lot of the problems at work. She had to put all her effort and time to defend herself in such a way that there was not enough time to concentrate on the pregnancy. Her circumstance was different from other participants because she could get days off at work. Astonishingly, she was aware of the benefits of early initiation of ANC. However, she had to go through a disciplinary hearing and initiated an appeal at the Commission for Conciliation, Mediation and Arbitration (CCMA), and there was not enough time to focus on her pregnancy. She related her experiences when she said:

“I said I had stress from work, because when I found out that that I’m pregnant I was also going through some hearing issues from work, so those were the things that were delaying me to focus on my pregnancy. Ja I was focussing on this hearing situation and to defend myself and clear my name because I was accused of things that I didn’t do and was such a short period.”[P 4]

3.4.3 THEME 3: Dilemma of reporting

The third theme from the collective narratives was the dilemma of reporting the pregnancy. Some participants initiated ANC late because they had a problem in reporting their pregnancies. They were afraid to tell their partners, parents, registered

nurses at the clinic and even their superiors at work. The leading cause of the dilemma was the fear of reporting and embarrassment. The participants said they needed to gain confidence first before they could report their pregnancies.

3.4.3.1 Fear of reporting

Participants had a fear of judgement. They did not know how the community would perceive them because of the knowledge that they violated the social norms. This was evident in the following comments:

“The thing is this before I came to clinic I was scared. Because I was supposed to come with my aunty the thing is, since my mother passed away she is the one who basically mm! Raised me so was scared of what she will think of this pregnancy. I had to gain confidence to tell my aunt about the pregnancy”. [P 7]

The above statement indicates the embarrassment the younger participant in this study had to go through before she could report her pregnancy. The participants thought people would judge them, thus because of their fear they ended up initiating ANC late. Another participant also confirmed the embarrassment incurred before they could initiate ANC.

“Ja obviously you think people will judge you of your age and stuff like that. So it was like still I know I have to go to clinic, and I have to tell my manager at work that I’m pregnant, shy about it but I’ve got over – I spoke to them Ja and it was over and done.”[P 3]

Another young woman said she was afraid of what people would say about her pregnancy; this was a problem to her in such a way that she decided to go to the general practitioner (GP) for her ANC. The GP had to refer her to the ANC clinic in her third trimester, as she did not have funds to deliver her baby in a private hospital. She indicated that she was also afraid of the nurses. She said:

“ I know you know sometimes you are shy.-They just look at you but in the end, it’s not about people is about you and your baby that you putting in danger.”[P 5]

Participant number eight also delayed reporting the pregnancy to her mother because she was afraid of being scolded. She even thought of terminating the pregnancy. This was highlighted from in this quote:

“No I didn’t prevent –if I found out eish! I have lot of stress and I say yo! Maybe must go to abortion or must keep the child, but eish!” My mom, she was shouting at me first.” [P 8]

3.4.3.2 Embarrassment

It is clear that even older participants were embarrassed by their pregnancies because they were not planned, they did not want people to know that they were pregnant. This feeling of embarrassment was manifested in the following account:

“ My breast were getting bigger, and I was getting a little weight, so I said to myself, no man this not right and, I ask them to just test my “pee” to see if maybe I’m pregnant or maybe I’m not”. [P2]

One participant was afraid to report her pregnancy. She waited until she gained confidence before she could tell her aunt about the pregnancy, and this was evident when she said:

“Ja I had to gain confidence to tell my aunt about the pregnancy, I was scared of what will she think of this pregnancy” The thing is since my mother passed away, she is the one who basically mm! Raised me.” [P 7].

The youngest participant in the study indicated that she was distressed when her mother told her to go to the clinic for ANC because she had to visit the clinic for the first time. She also indicated that her distress was exacerbated by embarrassment due to the pregnancy mainly because she did not have any idea of what would happen at the clinic. She related her situation by this quote:

“Afterwards my mother told me I should come to clinic, I never been to clinic before so it was like kind I can say I was embarrassed because it’s like something that, I was not use to. I didn’t know what to do and where to start, how to tell them that I’m pregnant. First of all I’m still young and I just ask the friend of mine who went the same situation, she helped me through it, she came with me and tell me what to do.”[p 3]

3.4.4 THEME 4: Service delivery issues

Service delivery issues emanated from the common stories of participants in this study. Several service delivery issues emerged during the participants' narratives which included, participants' delay to initiate ANC because their first consultation was with the general practitioner (GP), shortage of staff, service delivery flow, and health care worker-related problems.

3.4.4.1 First consultation at the general practitioners

Participant who consulted the general practitioner first were reluctant to initiate ANC early. The reason for taking so long before initiating ANC was because they belonged to their parents' Medical Aid, later in their pregnancy, their GP's or their parents referred them for ANC at the clinics to be able to deliver in the public hospitals. This was brought into actuality in this narrative:

"I went to doctor for like to make sure, I was in the Medical Aid that time. And my mom told me I shouldn't use Medical Aid anymore because by that time I already went for sonar, could see the baby and after that everything was fine and then she said that I have to come to clinic instead of going to the doctor because it's her Medical Aid. Afterwards, I started coming to the clinic instead."

[P 3]

One participant initiated ANC in her third trimester. Her reason for coming to the clinic was to get the obstetric book, but she was amazed to discover what important services she missed while consulting with the GP. She discovered the support from the midwife, and never went back to the GP. She said this:

"I went to the GP just to confirm am I really pregnant so when I went and the GP told me yes you are pregnant and I started from there from March to go to GP – You know sometimes you are shy, so when things started to be hectic at the doctor he referred me to the clinic because I needed a book, because if I go government to give birth there, they won't help me without a book – the maternity case record. So I came to the clinic here the other sister told me they can help me I can start coming here, from now on I never went to GP or Gynaecologist ever again so I came here".[P 5]

Another participant adopted a similar approach and ended up initiating ANC late. This was evident because when she confirmed her pregnancy, she was 17 weeks but initiated ANC at 20 weeks.

“I went to the doctor late I don’t know when, it is started when I was vomiting then I went to the doctor to find out if I am pregnant or not, before I came to the clinic and I found out when I found out I was pregnant 17weeks already.”
[P 7]

Some participants went to the GP because they were sick. The GP confirmed their pregnancies early but initiated ANC at 24 and 20 weeks respectively. This was narrated as follows:

“Then after certain weeks after a month that’s when I realised that no man I’m pregnant I felt so sick, I had flu, and I went by June to see the doctor and took a pregnancy test, and he told me that I am pregnant its early stages because the test wasn’t clear, the lines were not dark enough”. [P 4]

“It was on a Friday I was supposed to go home in Mpumalanga and then was not feeling very well then I went to the doctor –he did a scan he did confirm that I was pregnant .”[P 9]

3.4.4.2 Shortage of staff

One participant indicated that owing to the shortage of staff, she ended up confirming her pregnancy at the GP while waiting to go to the clinic because she was sick and the pregnancy was also confirmed there. However, because of the poor service, she visited the antenatal care clinic late and could not be assisted on the same day. The other thing that made things worse is that when she reached the ANC clinic was that the midwife was working alone. She said:

“I have to go to Mpumalanga, when I came there was only one sister, and they said they still has to take my blood before they can open the white file for me—and then it was getting late so I said can I please come the following week, they said ok no problem they won’t give me the file until I do all the blood test. I said its ok no problem then the sister did inject me with the prevention –The mother to child and then they said to me I can come back after on Monday the following week”. [P 9]

Another participant indicated that due to the shortage of staff, she had to come back for ANC. She ended up coming to the ANC clinic after a month because she could not get an off day on the date that was suggested by the midwife. This contributed to the delay in initiation of ANC. The following was said:

“When I came here – (yes) the sister was working alone ne!-they say I must come back on Friday but Friday was going to work I can’t be at clinic--they gave me the pills yes, they checked me the BP and then they said come for the other things? And they gave me date of 8 November to continue my clinic.” [P 6]

3.4.4.3 Service delivery flow

Participants’ experiences of being referred from the primary health care side to the ANC clinic after pregnancy confirmation by registered nurse intensified the delay in the initiation of ANC. Usually when pregnant women reach the ANC clinic after 12:00, there are some procedures that cannot be done such as collecting blood samples, hence participants were told to return on a different date. If patients were triaged well in the waiting area, the duplication of duties could be prevented and the pregnant women would be seen the same day for pregnancy confirmation and ANC initiation. A participant’s comment connected her experience of delay of ANC initiation to service delivery flow and was identified as follows:

“so I came to the clinic there by chronic people I ask them to just test my “pee” to see if maybe I’m pregnant or maybe I’m not and is that where I found out I was pregnant. Because they test my pee and the pee came out positive so they send me that side, you must go that side and open a file”.[p2]

3.4.4.4 Mis-diagnosis of pregnancy

On the contrary, participant number six had a different experience with reference to reasons of initiating ANC late. Her story varied from those of other participants. She was not using any contraceptive and became aware of her pregnancy. Immediately when she missed her menstrual cycle, she talked to the registered nurse who performed a urine pregnancy test. Regrettably, the registered nurse told her that the pregnancy test was negative. She was not satisfied but had to stay at home until she observed pregnancy signs. When she went back after eight weeks to check, the pregnancy test was positive. Due to the delay caused by service delivery issues, she

ended up initiating her ANC at 27 weeks. The concern was explained in the following narrative:

“Ok the first time I didn’t see my period I came here at the clinic to…… Like [banteste] to be tested and that they find that I’m not pregnant –I’m negative. I stayed at home like for two months relaxing that I knew that I’m not pregnant, –but I see that my stomach and my breast is changing I came back to the clinic to test again, I found out that I’m positive you see and then I was surprised that why being negative at the first time, I was positive and I say ok but see that I’m changing [my body].” [P 6]

3.5 SUMMARY

This chapter described the themes that emerged from the individual participants’ narratives. The participants experienced different reasons contributing to late initiation of ANC. According to the narratives, the reasons contributing to late ANC included unplanned pregnancy, work circumstances, dilemma of reporting and service delivery issues. Findings indicated the participants’ lack of reproductive health knowledge and the need for health services to improve service delivery. In the next chapter, the discussion of study’s findings, conclusion and recommendations are presented.

4 Discussion, conclusions and recommendations

4.1 INTRODUCTION

The previous chapter focused on the orientation to this study's data analysis, introduction to participants' narratives as well as the themes of the participants' collective narratives and summary. Chapter 4 presents the discussion of the findings, conclusions and recommendations based on the findings. The chapter ends with a personal reflection regarding the researcher as an instrument.

The data comprising of ten participants' (women who initiated ANC late 20weeks and after) responses were collected through semi-structured interviews. Data were analysed using a thematic analysis by Clarke and Braun (2013:120-123). Throughout data analysis, the focus was on the content. Henceforth, the thematic meanings and understanding of reasons contributing to the late initiation of ANC among pregnant women at a selected CHC in Tshwane were emphasised over language and form. The discussion pertains to the findings of this study with regard to the current literature on the research phenomenon.

4.2 DISCUSSION OF FINDINGS

Late initiation of ANC has been blamed for deaths of mothers and babies. Improving maternal care by improving early ANC initiation could reduce maternal and perinatal mortality and morbidity (NCCEMD 2014:12; Tekelab & Berhanu 2014:108; Kondale et al. 2016:3). Several studies have been conducted to examine factors associated with the late initiation of ANC. The late initiation is in high, middle as well as in low-income countries, the explicitly UK (Haddrill et al. 2014:9), Nigeria (Lamina 2015:195), Malawi, Kenya and Ghana (Pell et al 2013:1) as well as in Southern Ethiopia (Tekelab & Berhanu 2014:110).

The study investigated reasons contributing to the late initiation of ANC among pregnant women in a selected CHC in Tshwane. On the basis of the information provided by the selected pregnant women, there seem to be multiple reasons contributing to the late initiation of ANC. Among the reasons that the women reported

were, unplanned pregnancy, work circumstances, the dilemma of reporting and service delivery issues.

4.2.1 Unplanned pregnancy

Unplanned pregnancies are pregnancies which were either unwanted (when childbearing had been completed or when there was no desire for children) or mistimed (when childbearing came earlier than desired) at the time of conception (Bexhell 2016:233). The results of this study demonstrates that none of the women who participated planned their pregnancies. However, the women indicated that they accepted the pregnancies. To some women, accepting an unplanned pregnancy was easy. Perhaps it was mistimed pregnancies, but to others, it was challenging because the pregnancies were not wanted as they indicated that they concealed their pregnancies before and they even had thoughts of terminating them. Similar findings have been reported in the literature and state that unplanned pregnancy was associated with late initiation of ANC (Ochako & Gichuhi 2016:13; Tekelab & Berhanu 2014:114; Gebremeskel, Dibaba & Admassa 2015:4).

The pain associated with unplanned pregnancy may lead pregnant women to delay the initiation of ANC or even to hide the pregnancy. This was manifested when some women considered termination and later decided to allow the pregnancy to progress, hence the late initiation of ANC. Palamuleni and Adebawale (2014:552) studied the prevalence and determinants of unplanned pregnancy in Malawi and indicated that the level of unplanned pregnancy in the society could serve as an indicator of the state of the women's reproductive health, resulting in a high number of abortions. Eight of the ten women who participated in the study initiated ANC late and indicated that they did so because they were not aware of their pregnancies.

4.2.1.1 Unaware of pregnancy

From the study sample of ten participants, there were six single women and seven were young between 19 to 28yrs. They indicated that because their pregnancies were unplanned, they delayed recognising their pregnancies and that contributed to their late initiation of ANC. Not knowing about the pregnancy may contribute to late initiation of ANC, as some women may not be aware of their pregnancies for many weeks or even months after conception (Solarin & Black 2013;361)

Being unaware of a pregnancy had a wide variety of causes in this study such as the inability to recognise the cardinal signs of pregnancy, due to irregular menstruation cycles, and lack of acknowledgement of the symptoms. Similar results were found in a study by Haddrill et al. (2014:3). Unawareness of pregnancy could be an indication of poor reproductive health knowledge, lack of expectation of becoming pregnant and denial. Women who reported being unaware of pregnancy in this study included both the young (19yrs) and older (39yrs) women. Findings were furthermore corroborated by Murano (2014:1) who said that unplanned pregnancy is common among young and overweight as well as women approaching menopause. The author also revealed that these groups of women who are not expecting to be pregnant, would miss signs of pregnancy and even the baby's kicks may be mistaken for indigestion.

Women's unawareness or inadequate knowledge about early signs of pregnancy was also reported by Haddrill et al. (2014:9; Hagey et al. 2014: 100), from both developed and developing countries. They indicated that being unaware of pregnancy was due to lack of knowledge or self-awareness and the anxiety of conceiving outside of ideal conditions. Their findings are similar to the results of this study because the majority of women who reported being unaware of pregnancy were young and unmarried. Another study revealed that 20% of women whose pregnancies were diagnosed in the emergency department were unaware of their pregnancies (Mammen 2013:1).

Participants in this study indicated knowledge about benefits of early initiation of ANC, but the reason that contributed to their late initiation of ANC was the unawareness of the pregnancy. Findings of this study are in contrast with the findings from a study in Rwanda and North Western Ethiopia because women in these studies were found to have limited knowledge about the timing of ANC (Hagey 2014:98; Gudayu 2015:97). However, in the Southern part of Ethiopia Tekelab and Berhanu (2014:114) woman who presented themselves early for ANC were not registered for ANC and were told to come back for initiation when they started feeling foetal movements.

During the study, it was discovered that there were pregnant women who were in denial of their pregnancy. These particular women reported that they were aware of pregnancy but what made them delay initiation of ANC was because they were not sure if they wanted to allow the pregnancy to progress or to terminate. One participant said she was not ready to have a child because she was still young and not

independent yet. Another said she wanted to go for an abortion but because of her religious beliefs, she decided to allow the pregnancy to progress. The support received from their families assisted them to accept their pregnancies. The findings of this study mostly confirm those of Haddrill et al. (2014:7). The women in their research postponed initiation of ANC because initially, they wanted to terminate the pregnancy and hence led to late ANC initiation.

Similar findings were reported in several studies in South Africa by Muhwava (2014:78) and Muhwava, Morojele and London (2016:7). The feelings about the pregnancy (wanted or unwanted) especially if unplanned may cause the woman to delay in initiating ANC. This could be a result of resentment of the pregnancy or the difficulty in accepting and coming to terms with the unwanted pregnancy. Haddrill et al. (2014:9); Heaman et al. (2014:6) and Kawungezi (2015:139) confirm the results of Muhwava and Muhwava et al. and further indicate that young and unmarried women, in particular, have been observed to be affected by this psychological factor of resentment.

4.2.1.2 Contraceptive failure

The study, furthermore, revealed contraceptive failure as another reason for unplanned pregnancy that contributed to the late initiation of ANC. The results of this study are comparable with studies conducted in many countries with both high and low socioeconomic status such as the United Kingdom (Bexhell et al. 2016:234; Winner et al. 2012:1999), Malawi (Haddrill et al. 2014:9), Ethiopia (Birhanu & Dida 2015:27) and America (The Oregon Health Plan 2014:10). The results of these studies report approximately 50% of women experiencing unplanned pregnancy due to contraceptive failure.

The study uncovered that some women used contraceptives and others did not use contraceptives at all before the conception of their current pregnancies throughout the study period. However, in this study, unplanned pregnancy following contraceptive failure is discussed considering the following: inconsistent use of contraception, the effectiveness of the contraceptives used and counselling received on contraceptives.

- **INCONSISTENT USE OF CONTRACEPTIVES**

This study revealed that some participants (pregnant women) did not take their contraceptives as required. The pregnant women indicated that they skipped their

injections (Medroxyprogesterone) for many months. One woman indicated that she skipped for nine months. These women thought that they were still protected from pregnancy especially because they continued to experience amenorrhea even after discontinuation of injections. Similar findings were described by Palamuleni and Adebowale (2014:558); Berhanu and Dida (2015:270) and Bexhell et al. (2016:9) They alleged that the lack or inconsistent use of contraceptives resulted in unplanned pregnancy and thus led to late initiation of ANC. The reason for the inconsistent use of Medroxyprogesterone in this study was due to the unwanted side effects and the lack of belief in the possibility of becoming pregnant, more especially because of amenorrhea.

This study also suggested that there were fallacies about contraceptives hence women decided to stop using them, without consulting the health care workers when experiencing side effects. They alleged that they deliberately skipped taking the injectable due to the fear of side effects, and they were lazy or postponed to change the method until they conceived. One woman alleged that she skipped the injection for nine months. Beksinska, Rees and Smit (2001) cited by Lince Deroche (2016:99) pointed out temporary discontinuation as a compliance issue in injectable users and said: "In Gauteng Province, in a cohort of 189 new injectable users, 78 (41.3%) discontinued use before one year". Their study also reported that the women said they were "taking a break"; whereby the length of the break was seven months during which no other contraceptive method was used.

Similar findings were cited by Haddrill et al. (2014:9) and indicated that women with inconsistent use of contraceptives were shocked when they discovered that they were pregnant. The author alleged that it was due to a "combination of lack of knowledge about conception and the risks of pregnancy while using contraceptives". These findings call for women empowerment on their reproductive health, changing perceptions about contraceptives and reducing barriers for using other contraceptives.

- **CONTRACEPTIVE EFFECTIVENESS**

The study found that the type or effectiveness of contraceptives used by women may result in unplanned pregnancy. Most of the women who used contraceptives in this study used modern contraceptives or the Short Acting Reversible Contraceptives

(SARC's) except one woman who used an implant (Implanon NXT). However, they conceived while they thought they used the contraceptives correctly. These women reported that they did not know how it happened that they became pregnant while using contraceptives. According to O'Brien (2016:21), modern contraceptives (SARC's) need adherence and are ranked as less efficient compared to Long Acting Reversible Contraceptives (LARC's). A study conducted by Winner et al. (2016:2004) revealed that participants "using oral contraceptive pills, a transdermal patch, or a vaginal ring have a risk of contraceptive failure that is 20 times as high as the risk among those using Long Acting Reversible Contraceptives". For that reason, there is a huge need for healthcare workers to advocate the use of LARC's to all women in their reproductive ages, including adolescents. Trussell et al. (2013:159) recommend that the provision of LARC's should be done in all primary health care facilities as "This will benefit women as well as the state in cost savings". The LARC's do not need much adherence, and their failure rate is less than one percent.

- ***TYPE OF COUNSELLING ON THE CHOSEN CONTRACEPTIVE***

Contraceptive failure was also influenced by the type of counselling women received from the nurses because the women were not aware of the possibility of conceiving while using contraceptives. Bexhell et al. (2016:9) revealed in their study that reasons of unplanned pregnancy were among others, the lack of knowledge about conception and the risks of pregnancy while using contraceptives. Moreover, the same was established in this study. In this study, the woman who reported breakthrough bleeding did not indicate using a condom while experiencing the side effects of the implant. Although it is ranked as highly effective, she conceived.

Another challenge was that most of the younger women in this study reported that they used condoms for contraception which is classified as the least effective contraception with a failure rate of 18 per cent or higher. This could be because condoms are easily accessible over the counter and the fact that young women do not access a Contraception and Fertility Planning (CFP) clinic appropriately due to the stigma attached and the lack of knowledge about contraceptives. Palamuleni (2014:561) pointed out in her study that non- use of contraceptives by teenagers may be due to the limited access to family planning services or they find it difficult to practice the correct contraceptive usage.

According to Lince Deroche et al. (2016:102) in a study conducted in South Africa, young women, HIV-positive women and unmarried women are at risk of discrimination by health care workers when they come for counselling on contraceptives. The same results were cited in the study done in Nigeria where Iyoke et al. (2014:1050) concluded that there is a low level of knowledge of contraceptives among young people and a high dependency on peer information which could lead to reduced uptake of contraceptives. Therefore, there is a need to encourage the youth to utilise the available youth-friendly services in the clinics and CHC's. The South African law entails that anyone aged 12 years and older has the right to receive contraception without parental consent (NDOH 2012:44)

The characteristics of the study participants in this study were a combination of women with a level of education ranging from grade nine up to those who acquired tertiary education. These women had some knowledge about contraceptives but did not use it correctly hence unplanned pregnancy. Possible reasons that could have distracted the women's attitude change towards using contraceptives in this study included the fear of experienced side effects. This may indicate a gap between knowledge about contraceptives and their use. Similar findings were also stated in a study conducted from both urban and rural areas in Nigeria and Malawi. The authors concluded that knowledge about contraceptives did not translate to change of attitude for usage. They alleged that "both unwanted and mistimed pregnancies were more common among women who were knowledgeable and had ever used contraceptives" (Lamina 2015:129; Palamuleni et al. 2014:558).

A study conducted in North West Ethiopia also indicated that method failure and lack of knowledge on avoiding unplanned pregnancies are responsible for unplanned pregnancies despite increased awareness of contraceptives (Gebreamlak, Aragaw, Lemma & Demilew 2014:266). Bexhell et al. (2016:9) describe that the lack of knowledge about conception and the risks of pregnancy while using contraceptives caused unplanned pregnancy.

Dual protection (the use of condoms while women are using other forms of contraceptives) was not mentioned in this study and is very significant when enhancing protection from pregnancy. Condom use should be emphasised to all sexually active women to prevent contracting sexually transmitted infections such as HIV (Lince-

Derochei 2016:103). Furthermore, the DOH (2012:9) also emphasised 'the need to adhere to the WHO's specified directive about the cautionary statement advising women at risk of HIV to use dual protection'.

Other studies pointed out that there are countries where contraceptives are paid for (Malawi and USA). This means that the underprivileged women suffer unplanned pregnancies compared to their counterparts (Palamuleni & Adebawale 2014:562; McNicholas et al. 2014:635). These findings contrast this study because contraceptives are free and unplanned pregnancy occurs in both the employed and those who are unemployed. Oddly, women in this study did not mention issues such as not being able to obtain contraceptives because clinic hours conflicted with work or any barrier as it was discussed in the study conducted in East Yorkshire England (Bexhell et al. 2016:235). This then calls for research on the barriers for access to contraceptives.

4.2.2 Work circumstances

For some women in this study, work circumstances contributing to the late initiation of pregnancy meant that they lacked opportunities to attend ANC.

4.2.2.1 *Lack of opportunity to attend ANC*

Women in this study found it difficult to initiate ANC even after confirmation of pregnancy because they could not get time off of work during the week. The study displayed two groups of women who had the issue of not getting off during the week to attend ANC. Both groups demonstrated different coping strategies. One group used their experience and engaged in the self-care process and decided to consult with the General Practitioner (GP) to monitor their pregnancy while waiting for the opportunity to initiate ANC. These women indicated that regardless of their situation, they wanted to be up-to-date with the progress of their pregnancy in order to make their own choices about their pregnancies and to know that they are well. The other group, however, decided to accept the circumstances and did not initiate ANC until very late. Some initiated ANC during their maternity leave. Similar results were established in a study conducted on women presenting in the emergency department. The study revealed that 38.9% of women were aware of their pregnancies but sought care in the emergency department when they were ill because of lack of time to initiate ANC (Mammen 2013:1). Studies done by Matyukira (2014:126), and Kussule et al. (2013:2)

also confirmed that women initiated ANC late due to work circumstances such as the inability to get off from work.

Late initiation of ANC due to inability to get off from work could indicate that women are not aware of the code of good practice on the protection of employees during pregnancy and after birth as stipulated in the Basic Conditions of Employment Act No 11 of 2002 (The South African Department of labour 2004:15). There is a grave need for women empowerment about their rights during regular health talks in the ANC clinics. There is a need to expand health care services, by providing ANC during weekends and after hours to reach all pregnant women with different socioeconomic circumstances. The study exposed that for the latter group, there were other reasons which made them accept the delay such as stress from work.

4.2.2.2 *Stress from work*

These findings indicated that stress caused the pregnant women to delay initiating ANC. Stress causes emotional strain hence some women in the study pointed out different causes of their stresses that contributed to their late initiation of ANC. One woman in this study indicated that though she confirmed her pregnancy early, stress from work kept her busy and she neglected her pregnancy, and initiated ANC only after the problem was fixed. The findings further indicated that the particular woman was consumed by the problem in such a way that she kept everything on hold to concentrate on solving that problem. However, other stressful personal circumstances such as being chased out of the house, being scolded and being young without family support were described in the study and were also related to the late initiation of ANC.

This could mean that women were experiencing pregnancy within the context of other psychosocial or personal challenges and they tolerated the challenges to play a more significant role in their decision about initiating ANC. Similar findings were established from studies conducted in the UK, Canada and Southern Ethiopia. The studies allege that women who were struggling to cope with stressful personal circumstances were particularly likely to delay initiation of ANC (Heaman et al. 2014:6); Bexhell et al (2016:234) and Darega & Dida (2015:22) . Haddrill et al. (2014:10) confirmed the findings when they said: “many women simply had other priorities in their lives which impacted on their ability and willingness to engage with the public property of their pregnancy and the accompanying care.”

4.2.3 Dilemma of reporting

Some participants in the study highlighted the reasons that contributed to the late initiation of ANC equally linked to the dilemma of reporting their pregnancies, because of fear and embarrassment.

4.2.3.1 *Fear of reporting*

The women were afraid of reporting the pregnancy to their parents and at their workplaces and this led to a delay in initiation ANC. Fear of reporting was indicated by both young and older women in this study demonstrating the dilemma they faced before they could initiate ANC. The study revealed that for the younger women, fear of reporting was due to lack of preparedness regarding their pregnancies and the consequences such as abortion, mainly because the pregnancies were unplanned. The same findings were cited by Tekelab and Berhanu (2014:113) and Kawungezi et al. (2015:139), who indicated that fear of disclosure of pregnancy was related to shame and unplanned pregnancy. However the older women reported the fear of being pregnant while they were approaching menopause and were afraid of what people would say. Similar findings were cited by Palamuleni and Adebawale (2014:562) in Malawi and their study has shown that the higher the age of women, the higher the probability of having an unintended pregnancy. Ironically, women in this study did not indicate the fear of an abnormal baby because of their age. This calls for intensive education about the risk of related chromosomal abnormalities to babies born from mothers above 35 years, and encourage the use of permanent contraception or to consider LARC's (NDOH 2015:34).

The women's psychological state and social conditions incited fear of reporting their pregnancies until they perceived support from their families; this contributed to a delay in the initiation of ANC. Literature supported similar results. Haddrill et al. (2014:10) indicated that where support was lacking, women were reluctant to reveal their pregnancies.

Fear of witchcraft was recognised from other studies; this meant that women could not disclose their pregnancies to other people only after it was apparent due to fear of miscarriages (Pell et al. 2013:9). The fear of witchcraft was not cited in this study. This could be due to different demographics because this study was conducted in an urban area as compared to the rural areas of Malawi and Kenya.

4.2.3.2 Embarrassment

Women in this study demonstrated knowledge about the importance of ANC. However, they were embarrassed to report their pregnancies to their parents or at the ANC clinic. Their knowledge of the social norms governing their society or group of people around them made them feel guilty and were afraid that people would judge them. They did not know how people (the community) would perceive them because of the knowledge that they violated the social norms. The perception that they failed these social norms and their experiences with their mothers who did not approve of the pregnancy made them delay initiation of ANC. For instance, one young woman was chased from home after disclosing her pregnancy. The results of this study were confirmed by Smith et al. (2016:8) who indicated that friends may reject women who experienced unplanned pregnancy and family members hence they often keep their pregnancy secret for fear of criticism.

Similar findings were reported by Pell et al. (2013:9) that young women are afraid to report their pregnancies because of concerns about gossip which led them to hide their pregnancy and delay ANC. The results of this study indicated that women in the study also lacked preparation for the pregnancy which steered them to feeling embarrassed and resulted in the late initiation of ANC. Smith et al. (2016:13) as well as Muhwava, Morojele and London (2016:7) confirmed the results and indicated that embarrassment caused a delay in ANC initiation due to the social stigma associated with pregnancy among young and unmarried women.

In countries such as Malawi, pregnancy out of wedlock is severely punished in such a way that if the young woman is still a scholar, her studies are terminated (Palamuleni 2014:561; Pell et al. 2013:8). This act of punishment is different in South Africa. The policies of the country encourage teenage girls to use contraceptives, and in case of pregnancy, they are allowed to continue with school (DOH 2012:59).

On the contrary, a study by Pell et al. (2013:9) indicated that women do not disclose their pregnancies because they do not want to be embarrassed if the pregnancy does not reach term. The same study by Pell et al. (2013:8) pointed out that women do not disclose their pregnancies in their first trimester even to health care workers due to their cultural beliefs. When they are not feeling well, they will seek care at the healthcare facility rather than at ANC clinic. That practice could be hazardous when

medication is prescribed as some medication has a teratogenicity effect on the developing foetus in the first trimester of pregnancy. However, in South Africa, all women who are sick and are still in their reproductive age are tested for pregnancy before treatment is prescribed (NDOH 2015:330). In Ghana, there is social pressure to initiate ANC early (Pell et al. 2013:9). This is a commendable recommendation that if the community as a whole is adequately educated about the requirement and the benefits of early initiation of ANC, this could prevent late initiation of ANC.

4.2.4 Service delivery issues

As it was indicated earlier in this study, most women confirmed their pregnancies after the first trimester. Service delivery issues inflated their delay in initiating ANC. Some women in the study experienced administrative and professional failures such as shortage of staff, healthcare worker knowledge and service delivery flow. However, women's issues such as the first consultation with the GP were established to have contributed to the late initiation of ANC.

4.2.4.1 *Pregnancy confirmed somewhere else*

Several women in the study confirmed their pregnancies from the GP, while others confirmed their pregnancy and continued to follow-up until they initiated ANC. These women gave numerous reasons for consulting somewhere else as an alternative of ANC. Reasons such as the clinic's opening hours which were not suitable because they were working, others were covered by parents' medical aid and could afford payment at the GP. One woman indicated not being aware of the ANC system in the public sector. However, these pregnant women initiated ANC, and their pregnancies had already progressed to second and third trimester. Studies conducted in KwaZulu Natal South Africa and Ethiopia corroborate these findings and indicated that women delayed initiation of ANC because they started with the GP, either for confirmation or consultation (Matyukira 2014:66; Kusuule et al. 2013:6). Improved communication between GPs and ANC nurses could ensure early referral of pregnant women for ANC because presently, pregnant women are referred for ANC very late mostly without a blood test. If blood tests are performed during the third trimester, it does not serve the purpose, and it may be expensive to treat any infection to the baby (DoH 2011:6). The existing policy which requires communication between doctors in the community who are rendering ANC services and the facility in ensuring referral of women in early

pregnancy should be monitored by the maternal and child directorate to ensure the implementation of this directive (DoH 2011:6).

However, if women confirm pregnancy at the ANC clinic, the likelihood of initiating ANC on the same day is high as mandated by the policy on ANC (DoH 2011:6). However, this study indicated that even those who confirmed ANC at the selected community health centres encountered administrative failures which prevented them from initiating ANC the same day.

4.2.4.2 *Service delivery flow*

The service delivery flow was one of the administrative failures which were described as the reason contributing to the late initiation of ANC in this study. Women who faced this kind of failure described their situation as not knowing where to go for pregnancy confirmation. Confirmation of pregnancy was done in other areas in the same facility such as chronic area, acute, family planning then they were referred to the ANC clinic. The service delivery flow caused a delay because when the women reached the ANC clinic, it was already late in the day. Hence women were told to return to do blood tests the next day since the blood test can only be done before 12 o'clock midday. Heaman et al (2014:6); Matyukira (2014:106) and Kawungezi et al (2015:9) reported similar administrative failures and indicated that these failures were due to health care workers' attitudes as they fail to communicate with each other since pregnant women were not aware where to go for ANC.

4.2.4.3 *Shortages of staff*

The study also indicated that due to the shortage of staff, some women were turned back come the following day or given an appointment date, while others alleged that they saw that the nurse was working alone and the long queues they decided to return at a later date. Some women in this study supposed that they realised that the ANC clinic was full and decided to come back on another day because they had other things to do such as going back to work. Similar findings were revealed from studies conducted in Canada and South Africa. Heaman et al. (2014:6); Matyukira(2014:66) indicated that the pregnant women perceived a poor quality of care due to a shortage of staff, but they did not do anything about it. This could have transpired due to the lack of empowerment to demand care, or because of the trust they placed on the health care system. Acceptance of delay according to Haddrill et al. (2014:11) could

be an indication of the women's lack of empowerment, whereas passive acceptance of delays could be associated with other important factors such as the "value and the priority" placed on ANC.

Raising awareness on the importance of ANC, to dismiss misconceptions to achieve maximum benefits of ANC would be appropriate in this community as mandated by the health service framework (DoH 2014/15-2018/19:24).

4.2.4.4 *Mis-diagnosis of pregnancy*

Another professional failure was revealed such as mis-diagnosis of pregnancy, leading to late initiation of ANC. One woman in this study indicated that she went to the ANC clinic for confirmation of pregnancy and the healthcare worker told her that the urine test was contrary. In the meantime, she was experiencing cardinal signs of pregnancy. She went back to the clinic after two months because the pregnancy signs were persistent, and only then was the pregnancy test positive. By then, the gestational age was 27 weeks. The mis-diagnosis of pregnancy could be due to faulty test kits or due to the health care worker's knowledge or lack of about the pregnancy test procedure.

However, this mis-diagnosis of pregnancy could have been prevented when other means for pregnancy confirmation were performed such as a blood test or ultrasound. If the woman was empowered to seek an opinion from other health care workers, she would have initiated ANC earlier. Similar findings were established in the study by Haddrill et al. (2014:11) and disclosed that professional's failures related to mis-diagnosis of pregnancy might lead or worsen other delays for initiation of ANC. Findings from the study by Kondale et al. (2015:4) indicated that pregnant women who confirmed their pregnancy by a urine test were about five times more likely to initiate ANC within the first trimester of pregnancy.

These study findings are in contrast with a study conducted in Malawi, Ghana and Kenya where the urine test is not performed at primary care level but only in hospitals. Pregnant women in their study depended only on the second-trimester pregnancy cardinal signs such as foetal movement for pregnancy confirmation (Pell et al. 2013:9).

4.3 RECOMMENDATIONS

The indication of a large number of women not being aware of their pregnancy and the increased number of unplanned pregnancies calls for an intensification of

community engagement to improve the women's reproductive health knowledge. Families should be empowered on the issues of women's reproductive health rights to support and encourage contraceptive use and early initiation of ANC. Embarking on campaigns to promote public awareness about the importance of early initiation of ANC its benefits for the baby and mother's health, may address late initiation of ANC and dismiss misconceptions. Considering the failure rate of modern contraception, there is an urgent need for healthcare workers to be familiar with the LARCs. To motivate their use as it does not need adherence, hence prevent the costs incurred from unplanned pregnancies by the country. Family planning services are to be extended to schools and to the community (by mobile clinics) to reach those women who are underprivileged. The reduction of barriers to family planning may enable young women to access the services. Empowering women on the Basic Conditions of Employment Act that protects employees during pregnancy or after giving birth to a child, would assist working women to demand a day off with pay when attending ANC.

A community health care centre should have proper signage to indicate where women should go for pregnancy-related issues. The healthcare workers should be conversant on how different programmes in the CHC operate to redirect women appropriately. A pregnancy test should be performed at the ANC clinic to prevent duplication of duties, and therefore enhance initiation of ANC the same day as a requirement from the Department of Health maternal guidelines (DoH 2011:6).

The implementation of existing policies should be reinforced and regularly monitored to improve quality care. Group health education on how ANC is provided and the use of the existing social media such as 'Mom connect' may provide a sense of personal empowerment, also address some other obstacles discussed above and to be able to demand better care. All centres offering pregnancy test like pharmacies and GPs to offer MOM Connect also. ANC services should be extended to after hours and weekends to reach women struggling with socioeconomic circumstances or the disadvantaged women. Communication between midwives and GP's working in the community should improve to help ensure conveying appropriate information about early initiation of ANC and the early referral of pregnant women after confirmation of pregnancy for ANC at the CHC.

4.4 LIMITATIONS

This study is not free from limitations that should be considered while interpreting the results. This study was carried out in one CHC hence the results cannot be generalised to the general population. The study could have been strengthened further by increasing the sample size and expanding the study sites. The period between the beginning of the study and data collection had an impact on the results because early initiation of ANC has much improved at present compared to what it was at the beginning of the study.

4.5 SUGGESTION FOR FURTHER STUDY

A similar study that is community-based with a larger sample size should also be conducted. Future research should focus on effective interventions to encourage and enable pregnant mothers to engage with the ANC services early, especially in the first trimester.

4.6 RESEARCHER AS AN INSTRUMENT: REFLECTION

The researcher while working in the antenatal care clinic and observed late initiation of ANC. She also discovered that pregnant women who came to deliver in the MOU who initiated ANC late encountered problems such as late initiation of ARVs. Prevention of mother to child transmission of HIV (PMTCT) is compromised, and this could cause morbidity to the infant. What triggered the researcher to investigate the late initiation of ANC was when she realised that this phenomenon was the trend in the community. Meanwhile, there is a recommendation from the Saving Mothers' Report to reduce maternal death. According to the report, late initiation of ANC is one of the avoidable factors that causes maternal death. The researcher endeavoured to contribute to preventing maternal deaths by discovering the challenges encountered by the pregnant women in the community she is serving.

The researcher thought that pregnant women lacked knowledge about when to initiate ANC. Another thing that the researcher assumed was that women would say they were afraid to initiate ANC early due to health care workers' attitudes, especially because the majority of the nurses come from the same community. The ANC clinic hours were one of the concerns the researcher had in mind that they were responsible for late initiation of ANC. The community served has people with high, middle and low

socioeconomic statuses hence the researcher thought that only women with the low economic status were experiencing the phenomenon.

However, the researcher was astonished at what the participants narrated during the interviews because they gave a different picture to what she supposed. Participants indicated the reasons that contributed to the late initiation of ANC as the following: unplanned pregnancy due to contraceptive failure and that they took time to be aware of pregnancy because they were not expecting the pregnancy. Work circumstances such as the inability to get time off and stress from work was described. Other reasons were the fear of reporting and embarrassment which made them hide their pregnancy first before they could disclose it to the family or even to the public. The problems regarding the administration issues of the community health centre were also stated such as operating hours not suitable hence some working women confirmed their pregnancy at the GPs. Service delivery flow (lack of signage) affected the service, shortage of staff and mis-diagnosis of pregnancy were implicated.

Since the beginning of the research, the researcher developed a better understanding of the reasons contributing to the late initiation of ANC. The reasons for late initiation of ANC emanate from different origins such as from the woman herself when the women are not empowered enough to plan their pregnancy, and the deficiency in reproductive health knowledge. The community needs a change of attitude towards supporting women in using contraceptives and during pregnancy regardless of marital status and age. The healthcare service needs to be operated in such a way that barriers for initiation of ANC are avoided by following all the recommendations by the NDoH (2014:52).

The researcher would want to improve early initiation of ANC in the community she is serving by undertaking the following steps. The short-term initiative would be negotiating with the management that pregnant women should be triaged at the reception area, so that they reach the ANC clinic before 12 o'clock to initiate ANC the same day. Health education about the benefits of early initiation of ANC will be given in the primary health area to reach everyone in the community. Campaigns will be held in the community yearly to educate the community about the benefits of ANC and risks of late initiation.

To carry out the recommendations by the department (NDOH 2014:52) such as:

- Making sure that the existing Ward based outreach teams (WBOT)team in the facility is skilled so that the correct message about pregnancy, maternity and postnatal care is conveyed in the community such as early initiation of ANC.
- Making sure that all pregnant women are able to use MomConnect to receive appropriate pregnancy messages.

4.7 CONCLUSION

The study displayed unplanned pregnancy related to being unaware of pregnancy and the contraceptive failure as the main reasons contributing to the late initiation of ANC. Participants indicated an increased knowledge on the importance of ANC to the mother and foetus. However, unplanned pregnancy was established as the significant reproductive health problem in the study area. Contraceptive failure, related to its side effects, and inconsistent use caused unplanned pregnancy. Therefore, there is a need for motivating the use of LARCs among all women within the reproductive years.

Other reasons given by pregnant women who initiated antenatal care late were work circumstances, the dilemma of reporting and service delivery issues. Based on the findings that late ANC initiation was high in the study area, it is essential to provide health education on the timing of ANC among women within reproductive ages. Priority should be given to young women and women with unplanned pregnancies

The Department of Health should monitor the execution of recommended guidelines to improve public health such as preventing duplication of duties. There should be women empowerment on the Basic Conditions of Employment Act protecting employees during pregnancy or after giving birth to a child, for working women to demand a day off with pay when attending ANC. However, the vulnerable women, who are still underprivileged, could benefit once the services are extended to late afternoons and weekends.

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