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Facilitators and Barriers to accessing antenatal care experienced by adolescents in Primary Health Care facilities at the City of Johannesburg district in the Gauteng Province

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Facilitators and Barriers to accessing antenatal care experienced by adolescents in Primary Health Care facilities at the City of Johannesburg district in the Gauteng Province

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A research report submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the degree of Master of Public Health (MPH) in the School of Public Health

Johannesburg, September 2025

DECLARATION

I, Hlubikazi Ntamehlo, declare that this research report is my original independent work conducted without external assistance. It is being submitted in fulfilment of the requirements for the Master of Public Degree at the University of the Witwatersrand, Johannesburg. I further confirm that this work has not been submitted previously, for any degree or examination at any other University.



_____

(Signature of candidate)

5th day of October 2025 in Ridgeway

DEDICATION

This research is devoted to my son, Lonwabo Ntamehlo, and my three daughters, Asemahle Ntamehlo, Amahle Ntamehlo, and Amilisa ‘Ami’ Ntamehlo. I appreciate your unwavering assistance and unconditional love. I feel privileged your mother. My husband, Andile Ntamehlo, whose love and strength have been instrumental in helping me reach this point. My sisters, Fundiswa Mpalala and Nonyameko Mpalala for being my constant support and foundation through every challenge. My mother has been the pillar of my strengthen.

In memory of

My father ***Mr. Mthombothi Mapapu***

1945-1986

My sister ***Ms. Nomtha Mpalala***

1979-1996

ABSTRACT

Introduction

One of the most important aspects of international efforts to accomplish the Sustainable Development Goals (SDGs) is the availability of antenatal care (ANC) services for adolescents who are pregnant. Due to the increased risks of mother and fetal morbidity and mortality, adolescent pregnancy is one of the numerous public health issues that exist both in South Africa and globally. Therefore, this study examined the experiences of pregnant adolescents in accessing ANC services in an urban setting in South Africa.

Aim

The aim of this study was to explore the factors that enable or hinder pregnant adolescents from accessing ANC services in two PHC facilities in the City of Johannesburg district, Gauteng Province.

Methods

An exploratory qualitative research design was employed. Semi-structured interviews were conducted with 15 pregnant adolescents aged 16 to 19 years, attending ANC services at the selected PHC facilities. A thematic analysis was used to analyse the data.

Results

On one hand, pregnant adolescents face both personal and systemic barriers to accessing ANC, such as: stigma, lack of family support, and negative interactions with healthcare staff. Structural issues like rigid clinic hours, absence of youth-focused education, and perceived low-quality services further hinder access. On the other hand, factors that encouraged ANC use included nearby clinics, free healthcare services, and individual motivation. The findings also noted that adolescent pregnancy often disrupts education, especially in cases of unsupportive families and restrictive school policies.

Conclusion

To improve ANC for adolescents, services must be more supportive and inclusive. This includes training healthcare workers, involving families and communities, and making health and education systems more adolescent-friendly. These steps are crucial for increasing ANC use and improving health outcomes for young mothers and their babies.

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LIST OF ABBREVIATIONS AND ACRONYMS

ANC	Antenatal Care
AAAQ	Availability, accessibility, acceptability, and quality of services
AA-HA	Accelerated Action for the Health of Adolescents
BANC	Basic Antenatal Care
CHW	Community Health Worker
CSE	Comprehensive Sexuality Education
HCW	Health Care Worker
LMICs	Low and Middle-Income Countries
MCH	Maternal and Child Health
NAFCI	National Adolescent-Friendly Clinic Initiative
NDoH	National Department of Health
NCCEMD	National Committee on Confidential Enquiries into Maternal Deaths
PHC	Primary Health Care
SADHS	South Africa Demographic and Health Survey
SDGs	Sustainable Development Goals
SHR	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
UHC	Universal Health Coverage
WHO	World Health Organization

LIST OF DEFINITIONS

Antenatal care (ANC) is the term for medical treatments provided to expectant mothers and teenage girls by qualified experts in order to promote the healthiest possible outcome for both the mother and the unborn child. Pregnancy-related or pre-existing health issues are managed, risks are identified, and health promotion as well as education, are provided**.**

National Adolescent-Friendly Clinic Initiative (NAFCI) is a South African program that aims to improve the quality and accessibility of primary healthcare services for adolescents by building youth-friendly environments and increasing public health sector responsiveness to their needs.

District Health Information System (DHIS) is a routine system that collects and manages critical health data for healthcare planning, monitoring, and reporting.

First Trimester: is the first stage of pregnancy, ranging from conception to the end of the 12th week.

National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD) is a government-appointed group of healthcare professionals responsible for confidentially reviewing maternal deaths across South Africa. The committee identifies systemic issues and provides recommendations to improve maternal health outcomes.

Maternal health refers to the overall health and well-being of women during pregnancy, childbirth, and the postnatal period.

In the context of the current study, **adolescents,** are young people aged 16 to 19 years.

CHAPTER ONE: INTRODUCTION

1.1 Background

Adolescent pregnancy remains a global public health challenge, with approximately 21 million girls aged 15 to 19 years becoming pregnant each year. This includes an estimated 12 million of them giving birth (Stephano et al., 2025). Of these, nearly 90% occur in low- and middle-income countries (LMICs), with disproportionately higher rates reported in sub-Saharan Africa (SSA), where adolescent pregnancy prevalence reaches approximately 4.4 per 1,000 women (Stephano et al., 2025). South Africa (SA) mirrors this challenge, where approximately 150,000 teenage girls become pregnant annually (Umubyeyi, 2024).

Adolescent pregnancy substantially contributes to global maternal morbidity, with an estimated 15% of the overall burden being due to health risks associated with pregnancy, biological immaturity, and social factors (Ndahimana et al., 2023). On a similar vein, maternal mortality amongst adolescent girls in SA accounted for 8% of all maternal deaths from 2011 to 2013. This proportion increased to 8.9% from 2014 to 2016, indicating a marginal but concerning rise in adolescent contributions to overall maternal mortality (Sewpaul et al., 2021). These challenges indicate the dire need for accessible antenatal care (ANC) and Sexual and reproductive health (SRH)-friendly services (Mazur, Brindis, and Decker, 2018).

Globally, multiple policy initiatives have been implemented to improve ANC access for pregnant adolescents (McIntyre and WHO, 2006). The World Health Organization (WHO) has emphasized the importance of universal health coverage (UHC) to eliminate health disparities and ensure that all individuals, including adolescents, have access to essential healthcare services without financial hardship (WHO, 2018). However, as Mason et al. (2020) highlight, UHC cannot be considered universal unless it effectively reaches women, children, and adolescents, particularly those in vulnerable situations (Mason et al., 2020).

The inclusion of Adolescent Sexual and Reproductive Health (ASRH) services in UHC programs has been recognized as a crucial step in addressing the unique healthcare needs of adolescent girls, ensuring they receive necessary care without financial barriers (Ndlovu, Ross, and Nirangu, 2020). This approach aligns with global commitments such as the Sustainable Development Goals (SDGs), particularly Goal 3 (good health and well-being), which prioritizes

bringing down maternal mortality and improving adolescent health by 2030 (Eckert et al., 2022).

Recognizing the critical issue of adolescent pregnancy as a public health challenge, initiatives like the Global Accelerated Action for the Health of Adolescents (AA-HA!) was established to offer policy guidance that includes adolescent perspectives and supports implementation at the national level (WHO, 2023). Prioritizing adolescent health is regarded as an essential approach to achieving lasting advancements in maternal and child health while enhancing economic and social development (WHO, 2024).

Much progress has been made in South Africa to increase accessibility to maternity healthcare services, especially for marginalized communities. However, historical inequities in healthcare access continue to impact adolescent maternal health outcomes (Majebi, Adelodun, and Anyanwu, 2024). In response, the National Department of Health (NDoH) introduced the White Paper on Healthcare Transformation in 1997, establishing a unified national healthcare system and prioritizing maternal and child health services (NDoH, 1997a). One key policy intervention to improve ANC access is providing free maternal healthcare services in public health facilities. While this initiative has alleviated financial burdens for many, indirect costs such as transportation remain a significant barrier for some pregnant adolescents, limiting their ability to attend ANC appointments (Nguyen et al., 2018).

To further improve adolescent-friendly healthcare, South Africa introduced the National Adolescent-Friendly Clinic Initiative (NAFCI), which adopts a youth-centered approach to make clinical care more accessible and acceptable to adolescents (James et al., 2018). This initiative addresses the structural and social barriers that discourage adolescent services (Sewpaul et al., 2021). In addition to healthcare interventions, the Department of Basic Education has implemented the Comprehensive Sexuality Education (CSE) program, integrated into the school curriculum to equip learners with knowledge about sexual health, pregnancy prevention, and responsible decision-making (Srikwan et al., 2024). However, despite these efforts, challenges remain in the effective implementation of the programs. The social stigma surrounding adolescent pregnancy continues to discourage young mothers from seeking timely ANC services, further delaying essential care (Shefer and Morrell, 2013). Furthermore, research suggests that despite South Africa's extensive range of interventions, adolescent ANC utilization remains low (Govender et al., 2018) . Strengthening adolescent-friendly healthcare services, addressing societal stigma, and enhancing Comprehensive Sexuality Education (CSE) programs are critical strategies for closing these gaps and improving maternal health outcomes

(Jochim et al., 2023). This study explores the facilitators and barriers to accessing ANC services experienced by pregnant adolescents in Primary Health Care (PHC) facilities in the Gauteng province.

1.2 Literature review

1.2.1 Overview of adolescent pregnancy and antenatal care services in low and middle-income countries

Adolescent pregnancy is a public health concern, particularly in low- and middle-income countries (LMICs). Roughly 44,000 births per day are reported globally. However, these rates are more pronounced in LMICs where each year about 16 million girls aged 15 to 19 years give birth, with approximately 1 million being younger than 15 years (Malunga et al., 2023). Moreover, the Sub-Saharan Africa region has been identified as having the highest adolescent birth rates. In 2021, approximately 6.1 million births were recorded among adolescents aged 15 to 19 years, while about 332,000 births occurred among those aged 10 to 14 years (Johnson and Moore, 2016; Stephano et al., 2025). Additionally, Sub-Saharan Africa is linked with a high maternal and child morbidity and mortality, contributing to elevated maternal mortality rates (Kumar et al., 2018).

Studies indicate that adolescent mothers face severe health complications due to their biological immaturity and restricted access to quality healthcare services (Kassa et al., 2018). Compared to older women, adolescent mothers are at a greater risk of pregnancy-related complications, including: anemia, preterm labor, unfavorable fetal outcomes, pre-eclampsia, prolonged labor, and sexually transmitted infections (STIs) (Nagandla et al., 2020).

These findings underscore the urgent need for accessible, adolescent-specific ANC services to mitigate these risks. Several variables, including inadequate ANC utilization, nutritional deficiencies, limited awareness of maternal health services, alcohol consumption, smoking, and financial constraints, induce poor maternal as well as fetal health outcomes (Singh et al., 2012) . Beyond physical health concerns, adolescents often experience emotional distress and psychological challenges during pregnancy, which may deter them from seeking or adhering to ANC services (Machoka et al., 2024).

Furthermore, structural and socio-economic barriers restrict adolescent ANC access, while low education levels, and the unavailability of nearby healthcare facilities are frequently reported as reasons for delayed or missed ANC visits (Singh et al., 2012). Moreover, Owolabi et al.

(2017) found that although many adolescents attend at least one ANC visit, few initiate ANC within the first trimester despite clinical guidelines recommending early engagement. The absence of timely and consistent ANC services deprives many adolescent mothers of skilled childbirth assistance and postpartum care, which are essential for reducing complications and improving maternal and neonatal health outcomes (Dairo and Owoyokun, 2010).

A holistic approach is necessary to address these challenges, taking into account both adolescents' healthcare-seeking behaviors and the systemic barriers that restrict access to ANC (Singh et al., 2012). ANC plays a pivotal role in shaping maternal and neonatal health outcomes by ensuring that pregnant individuals receive vital health interventions aimed at minimizing complications and enhancing pregnancy outcomes (Gulliford et al., 2002). According to the WHO (2018), effective ANC should be provided in a timely, continuous, and high-quality manner, enabling early risk identification, complication prevention, and comprehensive monitoring of both maternal and fetal health (Singh et al., 2012). Access to ANC is critical in determining maternal and neonatal health outcomes, ensuring that pregnant individuals receive essential health interventions that reduce complications and improve pregnancy outcomes (Gulliford et al., 2002). WHO (2018) emphasizes that effective ANC should be timely, continuous, and of high quality, facilitating early detection of risks, prevention of complications, and comprehensive maternal and fetal health monitoring.

1.2.2 Barriers and facilitators to accessing antenatal care for pregnant adolescents

While various facilitators enhance pregnant adolescents' access to ANC, multiple barriers limit their ability to seek and effectively utilize these services. Adolescents face unique challenges related to socio-economic status, cultural norms, stigma, healthcare system inefficiencies, and psychological barriers that lead to delayed initiation, inconsistent attendance, or complete avoidance of ANC (Dahab and Sakellariou, 2020). Adolescent girls who live in underprivileged areas, have a lesser degree of education, or live in rural areas, and are more probable to fall pregnant than their more affluent peers. There are also other obstacles that prevent them from getting information and health care (Dairo and Owoyokun, 2010). These barriers disproportionately affect adolescents in LMICs, where structural healthcare limitations and financial constraints further exacerbate disparities in maternal health outcomes (Nagandla, et al. 2020)

1.2.2.1 Socio-economic barriers

Economic insecurity presents a significant barrier to ANC utilization among adolescents in LMICs (Lateef et al., 2024). While some countries have implemented free maternal healthcare services, adolescents often face hidden costs, including transportation expenses and lost wages, which make ANC visits financially burdensome (Mweteni et al., 2021). In rural areas, where healthcare facilities are distant, the financial strain of transportation alone is a major obstacle, often leading to delayed or missed ANC visits (Shee et al., 2021).

Studies conducted in Bangladesh and Nigeria indicate that adolescents from low-income households are significantly less likely to attend ANC services compared to those from wealthier backgrounds, who can afford medical costs and transportation fees (Dairo and Owoyokun, 2010; Islam and Masud, 2018). Additionally, many adolescent mothers lack financial autonomy, relying on parents or partners to cover healthcare costs. In situations where parents refuse financial support or partners deny paternity, adolescent mothers face severe economic barriers that further restrict ANC access (Mweteni et al., 2021). Alem et al.'s (2022) findings indicate that adolescents with higher levels of education tend to be more autonomous in healthcare decision-making and more likely to attend ANC consultations (Alem et al., 2022).

1.2.2.2 Health system barriers

Availability of health care professionals and infrastructure

Resource constraints within public healthcare systems continue to limit adolescents' ANC access, particularly in settings with high patient loads and insufficient staffing (Gamberini, Angeli, and Ambrosino, 2022). Studies have shown that staff shortages, lack of medical equipment, and inconsistent service provision result in long waiting times, overcrowded clinics, and compromised quality of care (Young et al., 2024). Furthermore, Moucheraud et al. (2022) found that limited human resources and high demand for maternal care hinder provision of adolescent-responsive services as healthcare workers often prioritize older pregnant women, leading some adolescents to switch clinics in search of better treatment. This, in turn disrupts continuity of antenatal care and delayed timely interventions. This staffing imbalance contributes to fragmented care, where adolescents receive minimal attention during ANC visits and are left without adequate counseling or maternal health education (Mekwunyei and Odetola, 2020). Clinic backlogs further discourage early ANC engagement, leading to missed opportunities for risk screening and early pregnancy management (Hackett et al., 2019).

The COVID-19 pandemic further exacerbated existing ANC access barriers by redirecting healthcare resources away from routine maternal health services toward pandemic response efforts (Witter et al., 2019). In Zambia, reallocating medical staff and financial resources to COVID-19 management reduced ANC availability, led to shorter consultation times, and disrupted referral systems (Young et al., 2024). Mekwunyei and Odetola (2020) report that many maternal health clinics operated at reduced capacity during pandemic lockdowns, making it more difficult for adolescents to schedule ANC visits. Without adequate staffing and service availability, adolescents remain at risk of delayed pregnancy care, poor maternal health outcomes, and increased perinatal complications (Young et al., 2024).

Geographical distance and transportation costs pose significant financial and logistical barriers to ANC utilization. Adolescents in remote areas report that long travel distances and high transportation costs make regular ANC attendance challenging (Dahab and Sakellariou, 2020). Studies in Ethiopia and Zimbabwe highlight that women facing financial distress, particularly those dependent on male partners for income, often lack the means to afford transportation to ANC clinics (Dahab and Sakellariou, 2020). In addition, the unreliability of ambulance services in some regions further limits emergency ANC access, increasing maternal and neonatal risks (Dahab and Sakellariou, 2020).

Experiences of pregnant adolescents in healthcare facilities

Studies have shown that adolescents often feel judged, ridiculed, or dismissed by healthcare workers, discouraging them from seeking ANC services (Chikalipo et al., 2018). Chikalipo et al.'s (2018) findings indicate that in Malawi, adolescents are subjected to condescending remarks, inadequate emotional support, and a general lack of adolescent-friendly care at ANC clinics. The study reveals that healthcare providers failed to offer comprehensive ANC information, leaving adolescent mothers vulnerable to misinformation about pregnancy care (Chikalipo et al., 2018). Similar concerns have been reported in Nigeria. Banke-Thomas et al. (2017) found that healthcare workers often lacked training in adolescent-friendly services, resulting in dismissive treatment and inconsistent ANC consultation. Achieng, et al, (2025) further note that pregnant adolescents avoid ANC services due to a lack of confidentiality and fear of public humiliation.

In some healthcare facilities, adolescents must disclose personal health information in open spaces, heightening their fear of being judged or recognized by community members (Cumber et al., 2022). Health system constraints further exacerbate these challenges. Research reports

that adolescent mothers receive fewer ANC visits and lower-quality care than older pregnant women (Owolabi et al., 2024). Additionally, Young et al. (2024) found that shortages of healthcare professionals, prolonged waiting times, and inadequate medical supplies are major deterrents to ANC utilization.

Furthermore, some caregivers are reported to avoid encouraging ANC visits due to the fear of being criticized by healthcare providers for not preventing their daughter's pregnancies, leading to further delays in accessing maternal healthcare (Young et al., 2024). Studies in Malawi and Nigeria show that judgmental treatment by healthcare providers discourages adolescent mothers from seeking ANC services (Banke-Thomas et al., 2017; Chikalipo et al., 2018). Research findings from Nigeria also illustrate that breaches of confidentiality and a lack of adolescent-friendly services further hinder ANC utilization (Onukwugha et al., 2022). Without specialized adolescent-friendly training for healthcare providers and structural changes to ensure privacy, many adolescent mothers will continue to delay or avoid seeking ANC altogether.

Inflexible clinic scheduling and service accessibility

One key structural barrier to ANC access for adolescent mothers is the rigidity of clinic appointment schedules, which often fail to accommodate their educational, work, and household responsibilities (Shee et al., 2021). In many healthcare facilities, ANC services are only available on selected days and at fixed times, making it difficult for adolescents to attend visits without disrupting school or work obligations (Highet, 2022).

For adolescents who fear stigma at home, in school, or in healthcare settings, the lack of flexible or discreet appointment options creates an additional barrier (Shee et al., 2021). This forces some adolescents to delay or skip ANC visits altogether, increasing the risk of missed screenings, undiagnosed complications, and poorer pregnancy outcomes (Highet, 2022). The fragmented nature of ANC services further exacerbates this issue. Some facilities schedule different ANC assessments on separate days, requiring multiple visits instead of consolidated appointments (Shee et al., 2021).

Adolescents who lack autonomy over their schedules or depend on family members for transportation may find it difficult to return for follow-up appointments, leading to missed opportunities for early intervention in pregnancy-related risks (Mweteni et al., 2021). This challenge is particularly severe in rural areas, with sparse healthcare facilities and limited transportation options (Shee et al., 2021). Many adolescent mothers rely on friends, relatives,

or unreliable public transport to reach ANC clinics, which introduces additional logistical delays (Shee et al., 2021). The absence of mobile ANC services further marginalizes these adolescents, resulting in delayed ANC initiation, inconsistent attendance, and increased pregnancy-related health risks (Highet, 2022).

1.2.2.3 Health knowledge and beliefs

In several LMICs, the absence of targeted adolescent reproductive health education has been identified as a significant barrier to ANC access (Young et al., 2024). Limited reproductive health education further contributes to misconceptions about pregnancy care, with some adolescents believing that ANC is only necessary when complications arise (Kotoh et al., 2022). Despite global recognition that CSE is one of the most effective strategies for promoting adolescent sexual health and preventing STIs, stigma within school environments remains a major obstacle for pregnant learners (Chavula et al, 2023). Many pregnant adolescents feel compelled to keep their pregnancy a secret due to the fear of disrupting their education, experiencing discrimination, or being ridiculed by peers and teachers (Chavula et al, 2023, 2013). This secrecy often delays ANC attendance, exposing both the mother and unborn child to serious health risks associated with late or no maternal care (Haddrill et al., 2014).

Some schools also discourage the presence of pregnant learners, fearing that their continued enrollment may tarnish the school's public image or normalize adolescent pregnancy (Chavula et al 2023. In extreme cases, pregnant adolescents face direct or indirect exclusion from education, further limiting their access to school-based health information and ANC services (Machoka et al., 2024). Among those who leave school, some attempt to continue their education by pursuing alternative career goals, while others hesitate to return due to shame, stigma, and fear of judgment (Machoka et al., 2024).

Cultural beliefs and societal expectations influence ANC utilization among pregnant adolescents, often shaping their decisions to delay or avoid seeking healthcare. In some West African contexts, pregnancy among unmarried adolescents is viewed as shameful, leading to delayed disclosure and avoidance of ANC services due to fear of social judgment (Ziblim et al., 2018). In Ghana, early ANC initiation is discouraged by traditional norms, which prohibits public disclosure of pregnancy before certain cultural rituals are performed (Ziblim et al., 2018). This practice delays access to maternal healthcare, as adolescent mothers may wait until these rituals are completed before attending their first ANC visit. In Tanzania, legal requirements

dictate that pregnant women must attend ANC with their husbands, excluding unmarried adolescents or those whose partners deny paternity, further limiting their access to essential maternal healthcare (Mweteni et al., 2021). For unmarried adolescents or those with unsupportive partners, this legal requirement acts as a barrier to accessing maternal healthcare services, leading to missed opportunities for early interventions (Mweteni et al., 2021).

In Uganda, pregnant adolescents utilize the traditional health sector for seeking safety and empathy more than the modern health sector because it is geographically accessible and less costly, which further limits their success in ANC services (Atuyambe et al., 2009).The interaction between traditional restrictions, legal barriers, and societal judgment creates multi-layered challenges that limit adolescent mothers' ability to engage with maternal healthcare services (Mweteni et al., 2021). The lack of clear reintegration mechanisms for adolescent mothers reflects ongoing gaps in implementing CSE programs.

1.2.2.4 Family Reactions and Community Stigma

Family reactions and community stigma play a significant role in pregnant adolescents' decisions to delay or avoid ANC services. Fear of judgment from family members, community elders, and peers discourages early ANC initiation, particularly in social contexts where adolescent pregnancy is viewed as dishonorable (Hackett et al., 2019). Studies indicate that fear of parental reprimands, verbal abuse, and physical punishment prevents many young mothers from disclosing their pregnancies early enough to seek ANC (Young et al., 2024).

According to Machoka et al. (2024), some pregnant adolescents face extreme reactions from their parents, including social isolation, financial withdrawal, and being expelled from their homes (Machoka, Kabiru, and Ajayi, 2024). Others report psychological distress, grief, and thoughts of suicide or abortion due to the severe stigma and emotional alienation they experience (Machoka, Kabiru, and Ajayi, 2024).Financial dependence on parents further complicates ANC access. Some parents refuse to cover medical costs, transport expenses, or school fees, making it economically impossible for adolescents to seek ANC services (Machoka, Kabiru, and Ajayi, 2024).

Without family support or financial independence, adolescent mothers are left with few options for seeking maternal healthcare, delaying critical interventions that could prevent pregnancy complications (Apolot et al., 2020). Community norms around sexual purity and adolescent pregnancy also influence healthcare-seeking behaviours. Kotoh et al. (2022) found that

adolescent girls often face criticism, social exclusion, and judgment from their peers as well as local communities, and are labeled as irresponsible or immoral if they become pregnant (Kotoh et al., 2022). Additionally, legal requirements for male accompaniment in Tanzania create institutional barriers that discourage early ANC initiation (Mweteni et al., 2021). The literature reviewed demonstrates that traditional norms, legal restrictions, family rejection, and community stigma significantly impact adolescents' access to ANC services. Without mental health support, confidential counseling, and stigma-free healthcare environments, pregnant adolescents remain at risk of avoiding maternal care entirely, increasing the likelihood of complications.

1.3 Facilitators To Accessing Antenatal Care Services

Access to comprehensive ANC provides critical health education, risk screening, and maternal support that enhances pregnancy outcomes (Shee et al., 2021). Understanding factors facilitating ANC utilization is essential to improving early ANC initiation and adherence.

1.3.1 Supportive Family, Community, and Peer Networks

The presence of supportive family members, teachers, and peers plays a significant role in encouraging ANC attendance and reducing emotional distress among pregnant adolescents (Mathebula et al., 2022). In a study conducted by Akella and Jordan (2014), adolescents who received social and emotional support from friends reported higher levels of ANC engagement. The involvement of civil society in health systems with clearly defined and communicated roles and responsibilities within the legal framework was found to help ensure not only citizens' rights to participation but also their rights to remedy where appropriate and ensure that services are responsive to community needs (Jolivet et al., 2018).

Kotoh et al. (2022) found that community-based interventions help to reduce stigma and encourage earlier care-seeking behaviors through engaging families, schools, and local communities, enhancing maternal health outcomes. Furthermore, ANC awareness initiatives can improve maternal health outcomes (Kotoh et al., 2022). Beyond external support, individual health awareness and personal motivations influence ANC attendance. Young et al. (2024) found that pregnant adolescents living with HIV were more likely to seek early ANC, driven by their concern for their health and the well-being of their unborn child. Awareness of pregnancy risks and the benefits of early ANC monitoring contributed to increased self-motivation to seek care (Young et al., 2024).

1.3.2 Flexible Clinic Appointment Systems

Clinic flexibility is a key determinant of ANC accessibility for adolescents. Abuosi and Anaba, (2018) found that providing adolescent-friendly hours, such as evening or weekend clinics within healthcare facilities, where adolescents could receive confidential and nonjudgmental care from specially trained providers, made it easier for school-going adolescents to attend ANC appointments.

Bwalya et al. (2018) also report that adolescents preferred clinics with flexible hours and appointment scheduling, as rigid healthcare systems often clashed with school or work obligations (Bwalya et al., 2018). Brazil's National Digital Health Strategy provides pregnant adolescents with flexible scheduling options, improving ANC coverage (Haddad and Lima, 2024). Burundi's digitalized appointment system has also been linked to better ANC attendance rates (Misago et al., 2023).

1.3.3 Availability of health care with a patient-entered approach

A supportive and respectful clinical environment can significantly improve adolescent ANC attendance. In Zambia, Bwalya et al. (2018) found that pregnant adolescents who experienced respectful and compassionate care from healthcare workers (HCWs) reported higher satisfaction. Similarly, Sewpaul et al. (2021) found that adolescents who were treated with kindness and felt comfortable asking questions, were more likely to return for ANC services. These HCWs made them feel welcome, at ease, and supported. In the same study (Sewpaul et al., 2021), adolescents expressed gratitude for the opportunity to gain information and ask questions.

1.3.4 Proximity To well-maintained healthcare facilities and free health Services

Geographical access plays a crucial role in ANC utilization among adolescents. Young et al. (2024) found that pregnant adolescents living near healthcare facilities were more likely to initiate ANC early. The introduction of mobile ANC clinics has further enhanced access to maternal healthcare (Young et al., 2024). Harrison et al. (2014) found that mobile outreach programs provided comprehensive maternal care, mental health support, and peer-led group sessions (Harrison et al., 2014). These services allowed adolescents to attend ANC with friends in a stigma-free environment, encouraging higher attendance (Warri and George, 2020).

Enhancing health literacy is essential for increasing understanding of the benefits of ANC, the significance of its early initiation, and the value of comprehensive reproductive health

education (Tabiri et al, (2024). Healthcare services need to consider how their spaces can be designed to improve navigation and meet adolescent needs with teen-friendly clinic environment design within the framework of availability, accessibility, acceptability, and quality of services (AAAQ) (Namusana et al., 2022). Khan et al. (2022) found that adequate facilities, medical equipment, and well-maintained healthcare centers promoted higher ANC utilization rates.

1.3.5 Availability of Health Care Providers

The government must provide an adequate multi-skilled work health workforce, appropriate training, and regular in-service training, including adolescent-friendly training, for the provision of non-judgmental care (Kotoh et al., 2022). Sufficient numbers of health providers must be deployed to meet population needs to reduce long waiting times and improve the quality of care, and improve health provider morale (Mazur, Brindis, and Decker, 2018). Additionally, Kenyetao et al. (2023) found that employment, recognition of community healthcare workers, and their integration into the Mali National Health system have increased antenatal attendance through home visits by building trust, counseling, and promoting appointment attendance, as well as helping patients conquer any challenges to facility-level care (Kayentao et al., 2023).

1.4 The South African Context

1.4.1 Adolescent pregnancies in South Africa

Adolescent pregnancy remains a significant public health concern in South Africa, with approximately 30% of girls aged 10 to 19 years becoming pregnant, 65% of which are unintended (Mbongwa, Mpanza, and Mlambo, 2024). Early adolescent pregnancies are particularly troubling; in 2020, 660 of roughly 34,000 teenage pregnancies involved girls under the age of 13 years (Mbongwa, Mpanza, and Mlambo, 2024). The majority of cases were concentrated in KwaZulu-Natal (26,296), Limpopo (15,365), and the Eastern Cape (15,348), with Limpopo also reporting the highest number of terminations (Umubyeyi, 2024).

Between April 2020 and March 2021, over 23,000 births occurred among girls under 18, including 934 to those younger than 14, reflecting an increase from 14,577 births among adolescents under 19 in the preceding year (Umubyeyi, 2024). Gauteng's adolescent delivery rate rose sharply from 29,7 to 36,2 per 1,000 between 2019/20 and 2020/21, driving national trends, while most other provinces showed stable or gradually increasing rates, except for

Northern Cape's consistently high rate and Western Cape's spike in 2021/22 (Barron et al., 2022).

1.4.2 Antenatal care services in South Africa

Given that the ANC services are free in the South African public sector, pregnant adolescents must consult at least eight times during their gestational period (WHO 2018). Despite these policies, adolescent mothers continue to experience delayed ANC initiation due to social stigma, financial barriers, and limited healthcare access (Baxter and Moodley, 2015). A study by Govender et al. (2018) in KwaZulu-Natal found that younger adolescents, aged 13 to 15, were more likely to delay ANC initiation compared to older adolescents, aged 16 to 19 (Govender et al., 2018).The primary factors influencing late ANC booking included limited knowledge of pregnancy symptoms, lower decision-making autonomy, and financial dependency (Govender et al., 2018). Data from a study by Govender et al. (2018) in KwaZulu-Natal revealed that 86% of 13-year-olds, 74% of 14-year-olds, and 57% of 15-year-olds all booked late, while only 48% of 16-year-olds booked late. These findings suggest that older adolescent mothers initiate ANC earlier, potentially due to greater awareness of pregnancy symptoms, improved autonomy, and better financial resources (Govender, Reddy, and Ghuman, 2018).

A study in SA illustrates that family and social support networks, as well as the availability of youth-friendly clinics and positive patient providers improve ANC adherence (Mathebula et al., 2022). CHWs have played a key role in improving early antenatal booking (before 20 weeks) by reaching out to women who had not initiated ANC, following up on missed appointments, making referrals to clinics, and providing home-based education to promote positive health-seeking behavior and better maternal outcomes (Katzen et al., 2020). Moreover, evidence from South Africa highlights how digital health strategies and flexible scheduling enhance ANC accessibility (Sewpaul et al., 2021). For instance, the Teen Mom Connect messaging platform in South Africa has been identified as a promising intervention for improving ANC attendance (Sewpaul et al., 2021). It is reported to support pregnant adolescents, enrolled at their first ANC visits by providing stage-specific health messages, counselling, and referrals via WhatsApp, thus enhancing both antenatal and postnatal care while learners remain in school (Sewpaul et al., 2025)

The National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD) 2017-2019 Report NDoH documented a progressive decline in maternal mortality rates from 320 per 100,000 live births in 2010 to 120 per 100,000 live births in 2019 (NDoH, 2017b). The findings

underscore the importance of integrating ANC services with broader maternal health programs, including HIV prevention and treatment initiatives (NDoH, 2017b). Rejuvenating South Africa's PHC system has improved ANC service delivery (Dookie and Singh, 2012). Despite these advancements, the Saving Mothers Report NDoH (2017b) highlights, persistent gaps in early ANC initiation, and calls for further restructuring of ANC services within PHC settings, to ensure timely access after pregnancy diagnosis.

1.5 Problem Statement and Study Justification

Adolescent pregnancy continues to be a public health concern in South Africa, with high rates of teenage pregnancies contributing to increased maternal and neonatal health risks (Ogunwale and Rangiah, 2021). Despite policies promoting free ANC services, many pregnant adolescents delay or fail to attend ANC visits, which significantly increases the likelihood of pregnancy-related complications such as preterm labour, and pre-eclampsia (Govender et al., 2018). This is further compromised by the socio-economic development of any country (Moallemi et al., 2019).

In South Africa, the birth rate of adolescents is high, with at least 20 000 high school girls reported to be pregnant (Govender et al., 2018). Early and consistent antenatal care is critical for monitoring fetal growth, detecting high-risk pregnancies, and safeguarding maternal health. However, research indicates that adolescents face multiple barriers to accessing ANC services, including financial constraints, stigma, lack of adolescent-friendly healthcare services, and restrictive cultural norms (Machoka et al., 2024). While there is extensive literature on ANC utilization among adult pregnant women, studies focusing on adolescents remain limited, particularly in urban South African settings.

However, despite the availability of ANC services in SA, only 53% of ANC attendance occurred before 20 weeks, with almost 23% of adolescents failing to attend the minimum requirement of four ANC visits (Sewpaul et al., 2021). According to a 2022 District Health Information System (DHIS) report, the City of Johannesburg District, a district in the Gauteng province, only had 65% of pregnant women who had their first visit before or at 12 weeks of pregnancy as recommended by WHO, while the rate of adolescents in these bookings is not known[2]. It is for this reason that this remains a major public health imperative in South Africa (Sewpaul et al., 2021).

[2] https://gp.dhis.dhmis.org/dhis-web-pivot.

Existing research has largely been conducted in rural areas, leaving gaps in understanding how urban adolescents navigate maternal healthcare (Bwalya et al., 2018). The current study addresses this gap by exploring the facilitators and barriers to ANC access among pregnant adolescents in Sub-District G in the City of Johannesburg. Identifying these factors provides insights into the systemic, social, and psychological challenges that influence ANC utilization among adolescents in urban South Africa (Shefer and Morrell, 2013). Moreover, given the increasing urbanization of South Africa, understanding ANC utilization in urban settings is critical for shaping policies that address the specific challenges faced by adolescent mothers in these environments.

1.6 Study Aim

The aim of this study is to explore the facilitators and barriers to accessing antenatal care services amongst pregnant adolescents in two primary health care facilities in sub-district G in the City of Johannesburg, in Gauteng Province.

1.7 Study objectives

i. To describe the experiences of pregnant adolescents regarding antenatal care services in sub-district G in the City of Johannesburg.
ii. To examine pregnant adolescents' perceptions of the barriers to accessing antenatal care services in Sub-district G in the City of Johannesburg.
iii. To describe pregnant adolescents' perceptions of the facilitators to accessing antenatal care services in Sub-district G in the City of Johannesburg.

CHAPTER TWO: METHODOLOGY

2.1. Introduction

This chapter outlines the methodology adopted to explore the research questions of the study. It starts by detailing the research design and study setting. It further describes the research population and sampling strategy used for selecting the participants. It proceeds to discuss the data collection process, including the management and analysis. The chapter discusses the processes followed to ensure rigor in the research by addressing the trustworthiness of the data, followed by describing the researcher's reflexivity in undertaking this study. The chapter ends on discussing the ethical considerations that were acknowledged during the study.

2.2. Study design

This study employed an exploratory qualitative research design. Qualitative research focuses on gaining insight into social phenomena and exploring the reasons behind specific occurrences. It is particularly useful when understanding individuals' motivations, beliefs, desires, and thoughts regarding a subject (Austin and Sutton, 2014). A qualitative methodology was chosen for the study to allow for an in-depth exploration of the problem by employing a purposive sampling approach. An explorative study aims to investigate new areas of interest, akin to explore venturing into the unknown to uncover novel insights. As Casula et al. (2021) note, this type of research particularly emphasizes understanding and describing individuals' experiences with various phenomena (Casula, Rangarajan and Shields, 2021).

In South Africa, numerous policy interventions have been implemented to enhance access to ANC, especially for adolescents. Since this study aimed to explore pregnant adolescents' lived experiences in accessing antenatal care services in primary healthcare facilities and their perspectives as well as beliefs. An exploratory study design using a qualitative approach was deemed suitable, enabling participants to share their experiences with a relatively unexamined practice.

2.3. Study setting

This study was conducted in Sub-District G within two PHC facilities in the City of Johannesburg, Gauteng Province. The city is divided into seven sub-districts (fig 1). The City of Johannesburg is one of the six districts in the Gauteng Province. The sub-district was

purposively selected based on a high number of teenage pregnancies, with a total of 168 deliveries recorded for adolescents aged 15 to 19 years from April 2021 to March 2022[3] . This sub-district was also characterized by low ANC attendance, particularly in the first trimester, where only 60% of pregnant individuals attended ANC before 20 weeks, falling short of the national annual target of 74%[4]. Additionally, Sub-District G was selected due to logistical feasibility, as the researcher was based in the district as a district health manager, allowing for ease of access and coordination.

The sub-district in the deep south of Johannesburg faced significant healthcare access barriers and contained a high concentration of informal settlements with an unemployment rate of 28% (Abrahams and Everatt, 2019). The sub-district catered to both urban and peri-urban communities, many of whom faced socio-economic challenges that impacted maternal healthcare access (Abrahams and Everatt, 2019). Two PHC facilities were purposively selected based on their geographical characteristics, infrastructure, and the population served. This population was highly mobile, with high unemployment rates, posing challenges to consistent healthcare access. The first clinic (Clinic A) operated from a porta cabin in a peri-urban area, primarily serving residents from nearby informal areas. The second PHC facility (Clinic B) was in a township and mainly served residents from its local catchment area.

The researcher selected these clinics based on familiarity with their maternal health services and the extent of their utilization by pregnant adolescents. In addition, the PHC facilities were purposively selected on the basis of that they provided Basic Antenatal Care (BANC) services and had active community health workers (CHW) as well as health promoter teams, who play a crucial role in identifying pregnant adolescents within the local areas.

[3] https://gp.dhis.dhmis.org/dhis-web-pivot.
[4] https://gp.dhis.dhmis.org/dhis-web-pivot.

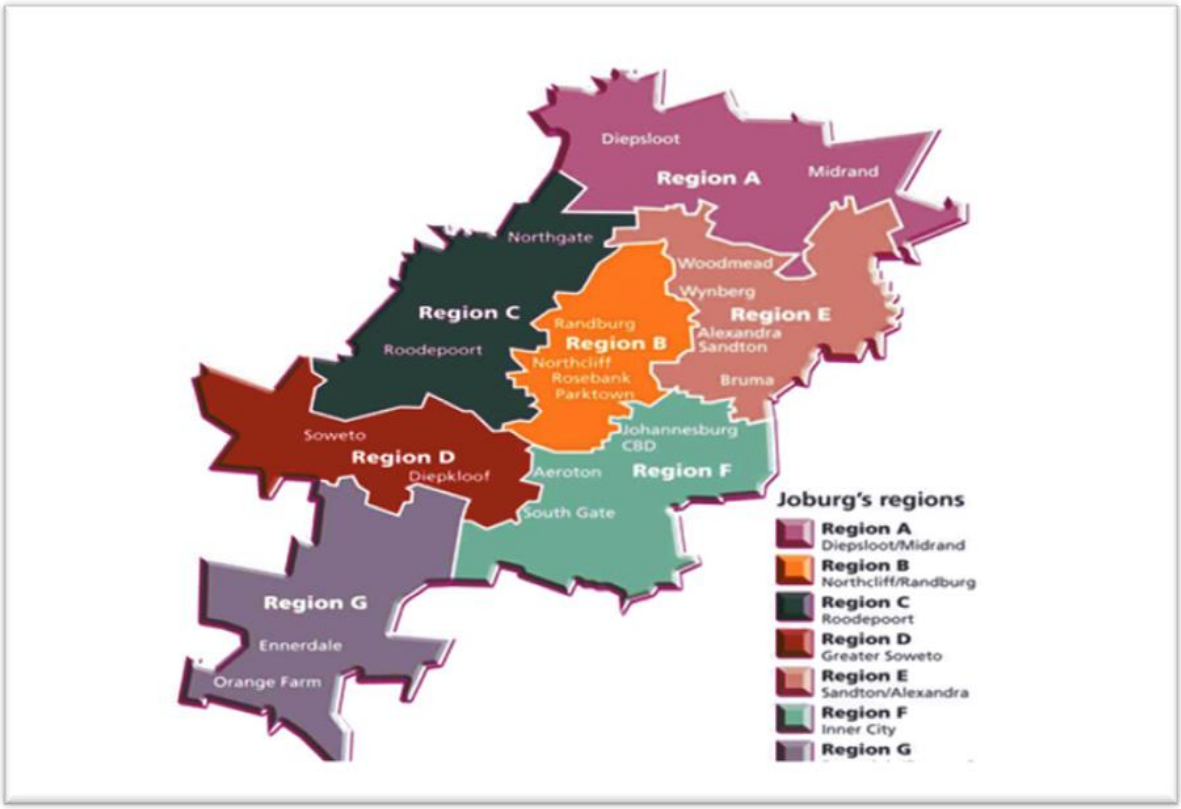


Figure 1 Map of the City of Johannesburg's seven regions (Abraham and Everatt, 2019)

2.4. Study Population

The study population consisted of pregnant adolescents. These participants were recruited from the two selected PHC facilities and the surrounding community within the facilities' catchment areas.

2.5. Study Sample

The study participants were purposively selected from the two PHC facilities. The decision to use purposive selection criteria was guided by the study's objectives and the specific areas of investigation being explored (Ritchie and Lewis, 2014). The sampling approach was to ensure that participants who had insights about the research objectives were selected. Purposive sampling operates on the principle that selecting information-rich participants provides a deeper understanding of the phenomenon under study (Gentles et al., 2015). A total of 15 participants were selected. This was informed by the achievement of data saturation, where interviews continued until no information was emerging (Vasileiou et al., 2018).

2.5.1. The inclusion criteria

The inclusion criteria for pregnant adolescents were firstly, that attend a follow-up visit after their ANC; secondly, they had previously attended ANC services but had discontinued. Thirdly, had never attended ANC but were traced and linked to a PHC facility by CHWs. Participants who met the inclusion criteria were selected through purposive sampling.

2.5.2. The exclusion criteria

Conversely, the exclusion criteria specified that pregnant females younger than 16 or older than 19 years and pregnant women from other regions were not eligible to participate in the study. Those that are between the ages of 10-15 were excluded on the basis that sexual activity in South Africa is legal from the age of 16 as individuals can give consent to engage in sex from this age[5] (DoJ & CD, 2007). Including this age group would have introduced legal implications as sexual activity within this cohort is regarded as illegal. Moreover, it was anticipated that discussing these legal implications and the sexual experiences with participants younger than 16 years of age would likely result in undue emotional distress from participating.

Table 1. Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Pregnant females between 16 and 19 years who were residing in the catchment area of the selected site.	Pregnant females younger than 16 or over 19 years old.
Participants who had not attended their first ANC visit	Pregnant women from other sub-districts/regions were not eligible to participate in the study
Pregnant females attended follow-up visits after their first antenatal visit.	
Participants who attended BANC services and stopped but were traced and linked to a PHC facility by CHWs	

[5] Sexual Offences Act 32 of 2007

2.6. Participant Recruitment and Data collection

Data collection was conducted from September to December 2024. In the initial process, the researcher engaged with facility managers in both health facilities to explain the purpose of the study. Pregnant adolescents who were successfully identified were referred to a PHC facility for antenatal initiation and invited to participate in the study upon their arrival at the PHC facility on the day of data collection. The researcher then explained the purpose of the research to the pregnant adolescents attending BANC. CHWs and health promoters played a vital role by directing interested participants to the researcher.

Before conducting interviews, participants were provided with an information sheet (Appendix G) detailing the purpose of the study. Informed consent was then obtained to conduct the interviews (Appendix D) and to audio record them (Appendix E) from participants above 18 years old, with additional consent from a parent or guardian for those under 18 (Appendix F). After receiving consent, the researcher conducted face-to-face, in-depth interviews, using a semi-structured interview guide (Appendix C). The interviews explored questions about the participants' perceived facilitators to accessing ANC, including the barriers. The interviews further explored their experiences with the healthcare services in Sub-District G. The researcher ensured that participants felt secure in sharing their experiences, particularly regarding sensitive topics like the attitudes of healthcare workers. Interviews were scheduled at convenient times and places, typically lasting 45 minutes to an hour. While most interviews were conducted in English, provisions were made for those more comfortable in other languages, as the researcher was familiar with the local languages.

Field notes are often used in qualitative research to capture important contextual details (Phillippi and Lauderdale, 2018). Therefore, the researcher also took field notes to document contextual factors, such as non-verbal communication, which enhanced the interpretation of the data. The emphasis on confidentiality helped foster trust, allowing participants to discuss their experiences.

2.7. Piloting

The pilot study was conducted at a PHC clinic not included in the main study but with similar characteristics to the selected participating clinics. Three pregnant adolescents aged 16 to 19 years were interviewed in various languages to assess their feasibility as well as clarity and to ensure linguistic inclusivity. None of the participants were included in the sample of the study.

The researcher addressed any aspects that were identified during and informed by lessons from the pilot study.

2.8. Data management and quality assurance

All audio recordings of the interviews were transcribed verbatim with no omissions. All audio recordings, transcripts, and field notes were labeled using a unique code to ensure anonymity. The transcripts were stored on a password-encrypted computer, accessible only to the researcher and her supervisor. Hard copies of transcripts, fieldnotes, and signed consent forms were stored in the researcher's locked cupboard. For quality assurance, the researcher read each transcript line by line while simultaneously listening to the audio recordings to ensure accuracy. Minor editing was conducted to enhance readability and coherence without altering the original meaning of the content. The audio recordings will be kept and destroyed five years after the study is completed

2.9. Data Analysis

Audio-recorded interviews were meticulously transcribed using Microsoft Word. Deductive and inductive codes were identified as the researcher read the transcripts line by line. A thematic analysis was then conducted, creating codes that were organized into main themes. The goal of a thematic analysis is to identify themes and patterns in the data that were important or interesting and use them to address the research question and objectives (Maguire and Delahunt, 2017).

For the coding process' reliability, the researcher and supervisor independently coded a sample of transcripts, so as to ensure inter-coder agreement. A final codebook was developed, outlining definitions for each code, which facilitated the identification of themes and sub-themes. The researcher cross-checked these themes against the original transcripts to confirm their accuracy, with the supervisor conducting a comprehensive review to provide guidance and validation throughout the process.

2.10. Rigour in research

Rigour in qualitative research was emphasized to maintain the integrity and quality of the findings, which is critical for establishing the study's trustworthiness (Gaglio et al., 2020). This involves a systematic inquiry, using an appropriate design and posing challenging questions,

ensuring that the findings are credible and reliable. According to Gill and Gill (2020) for the research to be rigorous, it must be systematic in its inquiry, employ an appropriate design, ask challenging questions, and the findings should be credible as well as trustworthy.

2.10.1. Trustworthiness

The concept of trustworthiness was a primary concern, with the research designed to uncover participants' insights and accurately reflect their lived experiences. Actions to achieve this included developing codes and themes through a collaborative coding process between the researcher and supervisor and rigorous checks to ensure the themes authentically represented the data. In qualitative research, the concept of truth is often considered subjective, reflecting individual perceptions and experiences (Busetto, Wick, and Gumbinger, 2020).

2.10.2. Consistency

Consistency was deemed essential for the credibility and dependability of the findings. This was accomplished by employing a comprehensive research methodology, ensuring the coding process was rigorously cross-checked, and incorporating feedback from the supervisor to refine the coding framework. Collectively, these efforts underscored the study's commitment to maintaining high standards of trustworthiness and rigour in qualitative research. Consistency in qualitative research is crucial to ensuring credibility, reliability, and trustworthiness in the findings. Polit and Back (2012) explain that consistency or dependability of data is the third criterion of trustworthiness, further citing that dependability is data consistency over similar contexts (Polit and Beck, 2010)**.** The following steps were taken to ensure overall trustworthiness for this study:

Credibility, which is understood as the extent to which findings are congruent with participants' realities (Anderson, Herr, and Nihlen, 2014), was ensured through detailed data gathering, purposive selection of participants, and supervisor debriefing. Moreover, to allow honest accounts of their experiences, participants were allowed to decline participation, providing opportunities to those who were most likely to be freely transparent.

Dependability, which refers to the reliability of the study while *confirmability* relates to objectivity (Korstjens and Moser, 2018; Shenton, 2004). I ensured these aspects by maintaining a detailed record of the process followed throughout the study, this including: sampling methods, the generation of the findings and procedures followed for data management. This

included a constant review of the data, coding details, while the interpretation of the data was checked through regular discussions with my supervisor. Furthermore, to ensure *transferability* – the extent to which findings of a study can be applied in other settings or circumstances (Shenton, 2004), I provided an extensive description of the research process, including details of the participants.

2.11. Researcher's reflexivity

Reflexivity is crucial for health care workers engaged in research, particularly in the public sector, where personal experiences and cultural backgrounds can shape data interpretation. Acknowledging these influences helps researchers maintain neutrality and rigor throughout the research process. Due to my position as a manager in the district, I have extensive knowledge regarding the health system dynamics and its constraints. This puts me in a favorable position to understand pregnant adolescent experiences with regards to accessing health care services. This means I could have brought preconceived notions and knowledge of the study environment. However, this was mitigated by holding regular discussions with my supervisor.

As noted by Berger (2015), reflexivity in qualitative research involves being aware of one's biases and positionality (Berger, 2015). For instance, as a researcher who is influenced by social constructs, I made an effort to recognize how my cultural and religious perspectives could affect participant interactions.

Furthermore, I informed the participants that permission to conduct the study had been obtained from the University of Witwatersrand and the Gauteng Department of Health. This transparency ensured that participants felt secure, as they were informed their discussions would be anonymous and confidential.

Moreover, I took steps to address power dynamics, especially since the study involved interviewing adolescents. By recognizing personal biases and maintaining a reflexive approach, I enhanced credibility and the overall quality of the study. (Bradshaw, Atkinson, and Doody, 2017). Ultimately, reflexivity proved invaluable in creating an environment where participants felt comfortable to freely express themselves. The credibility of the study was further supported by ongoing engagement with a supervisor to navigate these complexities throughout the research process.

2.12. Ethical considerations

Ethical approval was obtained from the University of the Witwatersrand Human Ethics Committee (Medical) (Clearance Certificate no.M230139 M231117-A-0001), (see Appendix A). Furthermore, a National Health Research Database (NHRD), approval was secured and granted by the JHB Metro Health District Research Committee (see Appendix H). The researcher arranged a debriefing meeting with pregnant adolescents to explain the study's purpose. Participants were provided with an information sheet (Appendix G) containing additional details about the study, available in the languages that are spoken in the sub-district. The researcher emphasized that participation was voluntary and that participants could withdraw at any time without fear of discrimination or consequences. Informed consent with details about the study was obtained from participants above 18 years old for the interview (Appendix D) and audio recordings (Appendix E). The researcher obtained guardian or parental consent for participants below the age of 18 years (Appendix F).

To ensure confidentiality, pseudonyms were assigned to both the healthcare facilities and participants. The facilities were referred to as ‘Clinic A’ and ‘Clinic B’, while participants were labeled ‘Participant 1’, ‘Participant 2’, and so forth. All data files and transcripts were stored on a password-protected computer, accessible only to the researcher and supervisor. Signed consent forms were kept in a locked and secure location. By data protection guidelines, all anonymized data will be destroyed after five years if the study findings are not published and after two years if they are published.

CHAPTER THREE: FINDINGS

3.1. Introduction

This chapter discusses the study's findings on the experiences of pregnant adolescents and their perceptions of accessing antenatal care services at PHC facilities. It firstly describes the characteristics of the participants. This is followed by a discussion of the themes that make up the findings, with some sub-themes related to each theme. These include personal experiences of pregnant adolescents, experiences of pregnant adolescents in accessing healthcare facilities, contrasting experiences of pregnant adolescents in accessing healthcare facilities, and the implications of pregnancy on education and future aspirations. A summary of the themes is described in table 2 below:

Table 2 Summary of Study Themes

MAIN THEMES	SUB-THEMES
Personal experiences of pregnant adolescents	▪ Initial emotions upon discovering pregnancy ▪ Reactions to pregnancy; rejection and support
Constraining factors to accessing antenatal care services by pregnant adolescents	▪ Attitudes of nurses ▪ Language barrier to accessing antenatal care ▪ Lack of education and inadequate quality of care ▪ Clinic operating hours and scheduling system ▪ Limited interfacility emergency transportation
Facilitators to accessing antenatal services by pregnant adolescents	▪ Geographical proximity to antenatal services ▪ Free antenatal care services ▪ Supportive and information-sharing of healthcare providers
The implications of pregnancy on education and future aspirations	

3.2. Participant characteristics

Fifteen participants were interviewed from September to December 2024.

3.2.1. Socio-demographic profile of the participants

The following table shows the age distribution, marital status, educational level, employment status, living arrangement, and planned or unplanned pregnancy of the participants:

Table 1: Age distribution of participants

Age	Number of Participants
19yrs	6
18 years	5
17 yrs	1
16yrs	3
Relationship status	
Married	2
Unmarried (In relationship with boyfriend)	11
Unmarried (No longer in a relationship with boyfriend)	2
Educational level	
Did not complete matric	8
Discontinued schooling without matric before pregnancy	5
Discontinued school upon discovery of pregnancy	3
Completed matric	4
Still in school	4
Employment status	
Completed matric and employed	1
Did not complete matric and unemployed	8
Living arrangement	
Residing with parents and siblings	5
Residing with father	1
Living with an aunt	1
Living with her boyfriend and mother of	1

boyfriend	
Cohabiting with boyfriend	5
Living with husband	2
Residing in an informal settlement	15
Planned pregnancy or unplanned pregnancy	
Planned pregnancy	3
Unplanned pregnancy	12

In terms of educational attainment, the majority of participants, eight (n=8), had discontinued schooling before completing matric (high school). Among the participants who had not completed matric, five indicated that they discontinued schooling before becoming pregnant. Three reported leaving school upon discovering their pregnancy. Four participants had successfully obtained matric. Three were still in school during the period of data collection.

Among the four participants who had completed matric, only one was employed at the time of the study. In contrast, all eight participants who discontinued schooling prior to completing matric reported being currently unemployed. Participants reported diverse household arrangements. Five resided with parents and siblings. One lived with her father and another one stayed with her aunt. In addition, one participant was living with her boyfriend and his mother, while five others were cohabiting with their boyfriends. Only two participants reported living with their husbands. Three participants reported planned pregnancies which were influenced by their boyfriends' desire for children. The remaining twelve described their pregnancies as unplanned. Each of the fifteen participants reported residing within an informal settlement.

3.3. Personal experiences of pregnant adolescents

3.3.1. Initial emotions upon discovering pregnancy

For most participants, discovering their pregnancy was an overwhelming and distressing experience of shock, fear, and anxiety. The immediate concern for many was how their families and communities would react. Adolescents feared rejection, disappointment, or punishment, particularly from strict or unsupportive family members. One participant described her initial reaction by saying:

> *"I was still shocked and didn't know how to tell my mother. I thought if I told her, she would tell my uncles, and I was scared because my uncle always shouted at me and beat*

me. I thought if she told my uncle, he would come and beat me as always" (Participant 11, 16 years old).

Beyond the immediate fear of disclosure, many adolescents struggled with the weight of familial expectations. They reportedly felt that they had let their parents down. One participant explained:

"*I felt so disappointed that I had disappointed my parents"* (Participant 8, 16 years old).

Some of the participants reflected on their future aspirations, feeling that pregnancy had disrupted their educational and career goals. One participant reflected on this as follows:

"I thought I had disappointed my parents because they expected me to find work and continue my studies. They were hoping I would complete my O-levels before I had a child" *(*Participant 1, 19 years old).

The emotional toll of an unplanned pregnancy was evident in many participants' reflections, with some admitting regret and considering abortion due to the pressure they faced. One participant candidly stated that:

*"I was not ready to have a baby at an early age. I thought of having an abortion, but I was not ready. I regretted what I did" (*Participant 11, 16 years old).

For many participants, the fear of family rejection led to them delaying to disclose their pregnancy. Many participants waited until several months into their pregnancy before informing their parents, fearing anger, punishment, or further disappointment. One participant described her struggle with disclosing her pregnancy, explaining as follows:

*"I just recently told my mother that I was seven months pregnant. I was scared of telling her. I thought she was going to shout at me because I was having a second baby, so it was not easy to disclose my pregnancy" (*Participant 10, 19 years old).

Similarly, another participant avoided her home altogether, hoping to conceal the pregnancy for as long as possible. She noted that:

*"When I discovered that my tummy was growing, I stopped sleeping at my place. I would sleep at my friend's place because I was afraid that my father and mother would see me" (*Participant 15, 18 years old).

On the contrary, one participant described how she immediately informed her boyfriend, who responded with excitement:

> *"My boyfriend was so happy. He told me that he had wanted a baby for a long time, and he would take me to his family to introduce me" (*Participant 13, 16 years old).

3.3.2. Reactions to pregnancy: rejection and support

3.3.2.1. Contrasting parental reactions

The discovery of pregnancy among adolescent participants was often met with mixed reactions from their families, ranging from complete rejection to reluctant support and, in some cases, unwavering encouragement. The responses of mothers and fathers followed distinct patterns, with fathers often reacting with silence or withdrawal, while mothers expressed disappointment but were more likely to remain involved. However, these reactions were not universal, as some participants experienced rejection and eventual support from different family members. This section explores these contrasting parental responses, examining cases of total family rejection and those where adolescents found support from other relatives or peers. Fathers, when present, were often the most emotionally distant figures in the adolescents' experiences.

Many participants reported that their fathers refused to speak to them for extended periods after learning about the pregnancy, one adolescent described how her father completely cut off communication with her:

> *"My father spent three months without talking to me. Even when I asked him something, he wouldn't respond" (*Participant 8, 16 years old).

For a few participants, fathers sometimes withdrew financial support, using economic means to express their disapproval and enforce consequences. One participant recalled how her father abruptly stopped funding her schooling, implying that she was distracted by boys at school:

> *"My dad said he won't pay for school transport again because I'm not going to school, but I'm going to see the boys" (*Participant 15, 18 years old).

For these participants, the withdrawal of both emotional and financial support intensified the already overwhelming experience of pregnancy. Fathers' reactions were often absolute and punitive, reinforcing the notion that pregnancy equated to failure and irresponsibility. However, the severity of rejection varied. While some fathers remained distant throughout, others

eventually re-engaged with their daughters and, in some cases, became sources of support. For instance, a few fathers responded with immediate acceptance, breaking the common pattern of rejection. One adolescent shared that her father was the first to know about her pregnancy and was actively involved in supporting her:

> *"My dad said he would be there for me and support me during the pregnancy". (*Participant 9, 19 years old).

Another participant experienced a father who took a proactive role, even involving extended family. She expressed the following:

> *"My dad bought a pregnancy test for me. I immediately showed him the results, and he showed my aunt. My aunt assured me that she would be there for me." (*Participant 9, 19 years old).

Unlike fathers, mothers rarely severed ties completely, but their initial responses were often marked by disappointment, frustration, and concern. Many participants recounted how their mothers expressed sadness or anger upon learning of the pregnancy. However, rather than withdrawing completely, most mothers continued to engage with their daughters, even if their support was reluctant or conditional. Unlike fathers, whose rejection often manifested through silence or financial cutoffs, mothers voiced their emotions openly, expressing their fears about their daughter's futures. However, this disappointment was often accompanied by continued caregiving, showing a complex emotional duality of a struggle between societal expectations and maternal instinct to provide support. One adolescent captured this tension in her mother's response:

> *"My mom said she was disappointed because I was pregnant, but she said she would continue doing things and support me" (*Participant 8, 16 years old).

Another participant shared a similar contradiction of emotions from a mother:

> *"My mother was shocked and shouted at me, she said I must not come back home where I was born, I must stay with the man that pregnant me, because my mother loves me, she always gives me a call and checks if I am okay with the baby, I don't know if she will change when I go home to Mozambique" (*Participant 2, 18 years old).

While some mothers gradually shifted from disappointment to acceptance, others initially refused to engage with their daughters' pregnancies, either discouraging antenatal visits or

refusing to take an active role in their care. One participant shared how her mother's refusal to support her through antenatal visits heightened her anxiety:

> *"My mother said she was not going to be part of my pregnancy; she was not going to come with me to the clinic" (*Participant 10, 19 years old).

These reactions suggest that while mothers were often the first to express disappointment, they also remained the most likely parental figures to provide eventual support, even if that support was strained or conditional.

For a few participants, pregnancy resulted in total rejection from both parents and extended family, leaving them without emotional or material support. This complete alienation often led to homelessness, financial instability, and deep emotional distress. One adolescent, unable to face her parents' disappointment, ultimately left home:

> *"I'm no longer staying with my parents. I'm staying alone. It was very difficult to face my parents' disappointment and let them down" (*Participant 10, 19 years old).

Another participant described how her father's rejection led to a deep sense of emotional neglect, intensifying the isolation that she felt:

> *"I was dealing with the emotions of being rejected by my parents. You know how it feels to be rejected by your parents. I felt neglected" (*Participant 7, 18 years old).

While some adolescents faced rejection from their immediate families, others found support in extended family members or peers, who became their primary sources of emotional reassurance and material assistance. One adolescent, whose father initially rejected her, found comfort in her aunts and uncles, who embraced her pregnancy with excitement. She reported as follows:

> *"I have my uncles and aunts and my mother around here in South Africa, and they are excited. They always ask me when I am due for delivery—they are waiting to see him" (*Participant 12, 19 years old).

Others turned to friends for emotional support, particularly when their parents refused to engage with them. One participant described how a friend played a crucial role in repairing her relationship with her family:

> *"I feel a new friend helped me a lot because if she didn't talk to my parents, I was going to give birth without my parents talking to me" (*Participant 15, 18 years old).

Overall, when adolescents faced both financial and emotional rejection, their options for coping with pregnancy became severely limited, often leading to delayed antenatal care, unstable living conditions, and increased stress. The divergent reactions of fathers, mothers, and extended family members highlight the complex emotional and social landscape of adolescent pregnancy. Fathers were likelier to react with silence or financial punishment, while mothers expressed disappointment but often remained engaged. In some cases, adolescents faced complete rejection, while others found support in extended family or peers.

These experiences reveal that while immediate family rejection was common, support was sometimes found elsewhere, allowing adolescents to navigate pregnancy despite initial adversity.

3.3.2.2. Community and peer reactions to adolescent pregnancy: judgment, stigma

While family reactions played a central role in shaping adolescents' experiences of pregnancy, the broader social environment, including community members and peers, also had a profound impact. For many participants, community responses were harsh, judgmental, and isolating, reinforcing the stigma attached to early motherhood. Some adolescents found partial acceptance, while others were met with outright hostility. Meanwhile, peer relationships emerged as a double-edged sword, while some friendships deteriorated under the weight of judgment, others became crucial sources of social support. This section explores the stigma, gossip, and scrutiny imposed by communities, followed by an examination of the complex role of peers in the adolescent pregnancy experience.

For many participants, pregnancy brought an immediate shift in how they were perceived within their communities. Instead of being treated with compassion, adolescents were often subjected to judgmental remarks, gossip, and a sense of social alienation. Pregnancy, particularly among unmarried adolescents, was viewed as a violation of moral and social expectations, and many pregnant adolescents were shamed for being irresponsible, immature, or reckless. One participant recalled how members of her community doubted her ability to care for her child and reflected on the expectation that they prioritize education and personal development over motherhood, hence reinforcing the belief that early motherhood equated to a loss of future potential. She noted that:

> *"Other community members were saying they would see how I was going to maintain my baby. Some said I was too young to have two babies, that I rushed to have children, and*

*that I should have gone to school, been educated, and become someone big first" (*Participant 12, 19 years old).

These sentiments were private thoughts and actively expressed through gossip and social exclusion. Expecting adolescents to follow the traditional route of having children, led to resentment and disappointment among some community members. One participant described how gossip followed her throughout her pregnancy, reinforcing her sense of shame:

*"The community is always gossiping, saying how can I have a second child when the first one is still young, and I'm not even married" (*Participant 10, 19 years old).

For most participants, pregnancy marked a symbolic loss of innocence, triggering disillusionment from those who once saw them as 'good girls'. One participant recalled how her return to the community was met with disappointment rather than acceptance:

*"Some people in the community didn't care; others didn't believe that I would have a baby. Some were saying I left with the virgin girls and came back with a child, and they were disappointed in me" (*Participant 11, 16 years old).

This form of public scrutiny and stigma created psychological distress, leaving many adolescents feeling isolated and unwelcome in spaces they once belonged to. Some adolescents avoided public spaces, community gatherings, and healthcare facilities due to the fear of being recognized, judged, or humiliated. One adolescent described how she actively avoided interacting with others due to fear of public shame:

*"I was scared of people who would look at me in a funny way" (*Participant 15, 18 years old).

The reactions of friends and peers were particularly complex. Some adolescents lost friendships due to judgment and social distance, while others found unexpected solidarity. In many cases, peers echoed the same societal stigma as the broader community, reinforcing the narrative of irresponsibility. One participant recalled how her closest friendship was irreversibly changed by her pregnancy, resulting in an unspoken distance between them:

*"She was no longer there like before… there was a distance of some sort" (*Participant 15, 18 years old).

Friendship loss was particularly painful because, for many adolescents, peers had been a primary support system before pregnancy. The sudden withdrawal of friends signified social

rejection and the loss of a trusted emotional outlet. This form of peer-based exclusion was especially damaging for those who had already faced family rejection, leaving them with no safe space for emotional expression.

3.3.3.3. Emotional well-being and coping strategies

For many pregnant adolescents, the emotional burden of pregnancy extends far beyond the initial shock and fear of disclosure. Feelings of stress, guilt, and emotional distress were commonly reported, with some participants describing persistent anxiety about their future, their families' disappointment, and the judgment they faced from their communities. These emotions were often exacerbated by uncertainty about how they would manage motherhood, continue their education, or financially support themselves. One adolescent described her overwhelming stress, noting how the realization of her situation weighed heavily on her:

> *"I was so stressed. To have a baby while I'm still young, and my first child is still young" (*Participant 10, 19 years old).

For some, guilt and shame became consuming emotions, particularly when they felt that they had let down their parents or defied societal expectations. This distress sometimes led adolescents to consider desperate measures to undo their pregnancy, as one participant recounted:

> *"I was always crying. I even asked my boyfriend to help me get an abortion because I wanted my parents to feel okay" (*Participant 15, 18 years old).

However, over time, many adolescents found ways to cope with their emotional distress. Some turned to trusted individuals for support, including friends, romantic partners, or extended family members who provided reassurance. One participant noted:

> *"My sister told me to stop blaming myself" (*Participant 1, 19 years old).

Others relied on personal resilience, attempting to adjust to their new reality despite ongoing challenges, as exemplified below:

> *"I ignored the community's comments because I didn't want to stress myself" (*Patient 8, 16 years old).

> *"I just kept quiet and calm myself down" (*Participant, 18 years old).

Others expressed determination to attend antenatal care for the health of their babies, with one expressing the following:

> *"What encourages me is that when I come to the clinic, they will check my stomach to see if my baby is moving and check my baby's heartbeat"(*Participant 10, 19 years old).

Another shared a similar sentiment:

> *"I want my baby to be healthy, that's why I come regularly here"(*Participant 12, 19 years old).

Many adolescents demonstrated personal motivation to prioritize their baby's health by keeping their appointment to collect HIV treatment to prevent mother-to-child transmission.

Another added:

> *"Because of my HIV condition, I have to come to collect pills to prevent my baby from getting an infection" (*Participant 6, 18 years old).

The presence or absence of a support system played a crucial role in determining how well adolescents managed the emotional impact of pregnancy. Those with understanding partners, supportive relatives, or close friends reported feeling more capable of handling their situation. In contrast, those who faced family rejection and social isolation experienced prolonged emotional distress and uncertainty.

3.4. Constraining factors to accessing ante-natal care services by pregnant adolescents

3.4.1. Attitudes of nurses

Most participants reportedly encountered significant challenges when seeking antenatal care, shaped by fear of judgment, misinformation, systemic inefficiencies, and inadequate support from healthcare providers. While antenatal care is a critical component of ensuring maternal and infant health, participants' experiences revealed multiple barriers that discouraged them from seeking timely and consistent medical attention.

A dominant theme in most participants' accounts was fear of judgment from healthcare workers, particularly nurses. Many of them perceived healthcare facilities as spaces of moral scrutiny rather than support, which made them hesitant to attend antenatal check-ups. Several participants expressed anxiety about how they would be treated, with one stating:

> *"I didn't want to go to the clinic because I feared the nurses would judge me" (*Participant 6, 18 years old).

Another participant shared similar concerns, explaining how she avoided clinic visits due to anticipated verbal reprimands from healthcare workers. She noted:

> *"I thought the nurses would ask me, 'As young as you are, you fell pregnant.' I was avoiding such talks" (*Participant 15, 18 years old).

These fears were not unfounded, as several participants experienced direct judgment from nurses, often in harsh remarks, scolding, or dismissive attitudes. One adolescent recounted an interaction that heightened her fears about her baby's health. She expressed as follows:

> *"The nurse shouted at me for attending the clinic late in my pregnancy and made me worry about the baby being crippled (disabled) because I started attending late and didn't take the pills at the beginning. The nurse said, 'What if your baby doesn't grow or becomes a cripple" (*Participant 8, 16 years old).

3.4.2. Language barriers to accessing antenatal care

Adolescents who cannot communicate in dominant local languages, such as Zulu or English, reported feelings of ridicule, exclusion, and diminished dignity, as well as confidentiality during clinic consultations. Such experiences act as a systemic barrier that promotes evidence of language mismatch between a patient and the health-care provider, limiting access to timely, patient-centered maternal care.

A different participant commented:

> *"I remember one woman who couldn't communicate in either Zulu or English but only spoke in Portuguese, the nurses laughed and made jokes about what she was saying instead of helping her. They even joked about the numbers she gave when explaining her pregnancies. She didn't realize they were laughing, but I could hear it, and it didn't sit well with me. In the end, I offered to interpret for the nurses. Still, I felt it was unfair because eventually I knew her personal issues"* (Participant 13, 16 years old).

3.4.3. Lack of health education and inadequate quality of care

Further factors influenced the extent of some participants' health-seeking behavior. Some participants delayed attending antenatal clinics due to false information from family members or the community. One adolescent recalled receiving misleading advice from her cousin:

> *"My cousin suggested that I stop going to the clinic and only go when my belly is visibly big. She said they would do an operation on me" (*Participant 2, 18 years old).

Similarly, a few participants were told that they needed specific documents, such as passports, to access healthcare, discouraging them from visiting clinics early in their pregnancy. One participant reported the following:

> *"My friend advised me to get a passport so I could access healthcare"* (Participant 14, 18 years old).

This apparent gap in health education further alienated adolescents. Many participants noted that they were simply handed pamphlets without explanation instead of active, personalized guidance. One participant expressed frustration at this lack of engagement:

> *"They only give us papers instead of teaching and explaining. They have never included any information about pregnancy in those papers" (*Participant 8, 16 years old).

Other participants reported receiving no health education at all, which made them feel uninformed and unprepared for pregnancy, while others feared attending clinics due to this limited knowledge about medical procedures. One participant noted as follows:

> *"They never gave me any information"* (Participant 10, 19 years old).

While another illustrated this lack of information and revealing how misconceptions about childbirth exacerbated her fear of seeking antenatal care. They noted:

> *"I was scared that when I went to the hospital, the doctors would cut my tummy and do an operation so that I could give birth. Then I thought I might die, and I was scared of that". (*Participant 11, 16 years old).

The absence of comprehensive antenatal education left adolescents feeling uncertain about how to navigate their pregnancy, reinforcing their dependence on unreliable sources of information from family or the community.

3.4.4. Clinic operating hours and scheduling system

Systemic barriers within healthcare facilities further exacerbated the challenges of accessing care. Many participants described long waiting times, inadequate scheduling systems, and inconsistent availability of nurses, all of which contributed to frustration and discouraged them for the return visits. One participant described being turned away after arriving late, which made her hesitant to return:

> *"The nurses turned me back because I came late, which made me feel so sad. I didn't want to come back again" (*Participant 12, 19 years old).

Other participants highlighted nurses' inattentiveness, explaining how some prioritized personal activities over patient care, leaving pregnant adolescents feeling neglected and unimportant. Some participants expressed this as follows:

> *"The nurse started attending to me from 9 am till 11 am. She would go up and down, busy with her phone. At that time, there were still other people waiting after me" (*Participant 9, 19 years old).

Another added:

> *"I saw one nurse who was busy with their WhatsApp while patients were waiting outside. She wasn't attending to them, just sitting there with her phone". (*Participant 11, 16 years old).

The lack of streamlined appointment systems was another commonly cited frustration. Several participants who missed their scheduled appointments, often due to family emergencies, school, or work obligations, were met with resistance when attempting to reschedule. One adolescent described how rigid scheduling forced her to miss work, highlighting the lack of flexibility for pregnant adolescents juggling multiple responsibilities:

> *"When you are working and can't come on the scheduled day, they tell you to tell your boss you're going to the clinic". I came here on Monday after informing my boss on Friday, but they turned me back, saying I was supposed to come on Tuesday (*Participant 12, 19 years old).

Another participant added:

> "*Like for instance when we come to the clinic for check-ups the nurses give the date for our next visit, if that date you are writing exams and you ask them to give you*

another date, they don't agree and tell you that they will give you a form to take it to school indicating that you started at the clinic, immediately after here you need to go to school and they tell you that they will not allow you to do as you wish by choosing your own appointment date " (Participant 13, 16 years old).

3.4.5. Limited interfacility emergency transportation

Financial and logistical barriers further complicated access to healthcare services. Some adolescents struggled to afford clinic transportation, particularly when referrals required them to travel to larger hospitals without formal transport arrangements. One participant expressed frustration about the lack of interfacility transport, which placed a financial burden on already vulnerable pregnant adolescents. She expressed that:

> *"The nurses said I must provide for my transport when I was transferred to Bara[5], and there was no money, so we had to hustle for transport money" (*Participant 8, 16 years old).

Other participants shared similar concerns, emphasizing how the absence of ambulance services or clinic- organized transport forced adolescents to make difficult decisions about seeking care:

> *"The issue of not calling an ambulance discouraged me a bit. I even thought of going to another clinic, but I said maybe things would be better"* (Participant 1, 19 years old).

The overwhelming challenges faced by pregnant adolescents in healthcare facilities reveal a system that is often unwelcoming and difficult to navigate. Fear of judgment and mistreatment by healthcare providers, misinformation from social networks, long waiting times, rigid scheduling policies, limited emergency transport services, and inadequate health education collectively discouraged pregnant adolescents from seeking timely antenatal care.

3.5. Facilitators to accessing antenatal services by pregnant adolescents

3.5.1. Geographical proximity to antenatal services

While many adolescents faced barriers to accessing antenatal care, some participants reported factors that made healthcare facilities more accessible and less burdensome, particularly regarding clinic proximity. These facilitators reduced the impact of transportation costs and financial constraints, which were major obstacles for many pregnant adolescents.

For most participants, the geographic location of healthcare facilities played a crucial role in determining whether they could regularly attend antenatal appointments. Participants who lived within walking distance of clinics found it easier to seek care, as they did not have to worry about transportation expenses or needing someone to accompany them. Several participants highlighted this convenience, explaining that proximity allowed them to attend check-ups without financial stress. They noted the following:

> *"I walk to the clinic; I don't need bus fare" (*Participant 10, 19 years old).

> *"I don't stay far from the clinic; I just walk" (*Participant 14, 18 years old).

> *"I don't need money to come to the clinic. I walk to the clinic because I'm not staying far from the clinic" (*Participant 2, 18 years old).

3.5.2. Free antenatal care services

Beyond clinic proximity, free antenatal care services alleviated financial stress for many of the participants, enabling them to seek care without worrying about out-of-pocket costs. Participants widely appreciated that healthcare services were provided at no charge, removing a potential financial barrier that could have discouraged clinic attendance. One participant noted that the services were free.

> "*The services are given for free here" (*Participant 2, 18 years old).

Another participant reinforced this point, explaining that she would have struggled to access medical attention if she had been required to pay:

> *"The services they give me are free, I don't pay. I wouldn't have money to pay. I would request that they rather refer me to a hospital that doesn't need me to pay" (*Participant 12, 19 years old).

Free antenatal care helped mitigate financial burdens. It ensured that pregnant adolescents could receive essential maternal health services.

3.5.3. Supportive and information sharing health care providers

Some participants described supportive, respectful, and reassuring nurses, encouraging them to engage with antenatal care. One participant shared how her first clinic visit set a positive tone, helping her feel comfortable despite arriving late. She said:

> *"The attitude of the nurses was good on the first day, even though they said I should be back tomorrow because I was late. The nurses are friendly, respond to me with respect when I ask questions, and make conversation, asking how I feel and if I'm ready to be a mother. That made me feel free and comfortable" (*Participant 1, 19 years old).

One participant shared that nurses treated them well and did not discriminate based on nationality, fostering a sense of comfort and trust. She mentioned that:

> *"The nurses are treating me very well, ever since I came here, they have been good to me, they did not discriminate against me because of my nationality, they were just friendly" (*Participant 14, 18 years old).

Several participants indicated the value of communication with the nurses and how the information provided allayed their fears. One adolescent shared how counselling helped her accept her HIV status and take control of her healthcare decisions:

> *"I was sad about my HIV status, but nurses gave me counselling sessions, and now I have accepted and am taking the HIV pills" (*Participant 6, 18 years old).

Others highlighted the practical knowledge nurses provided, including dietary guidance, fetal monitoring, and preparation for labor. One participant described how learning about fetal movement helped her feel reassured about her baby's well-being:

> *"Well, I learned a lot of things. The nurses taught me to check if the baby was kicking every day to show that the baby was alive" (*Participant 13, 16 years old).

Another adolescent recalled how nurses encouraged proper nutrition and early preparation for childbirth, offering practical advice that helped her feel more in control of her pregnancy. She noted that:

> *"They said we must eat fruits and vegetables, like spinach, and not eat soil or ice. They also told us that when we are seven months, we must start packing the baby's stuff because we can give birth from that month, and we must always be ready and prepared" (*Participant 15, 18 years old).

These positive interactions sharply contrast with the experiences of adolescents who felt belittled or unwelcome, showing that the quality of antenatal care largely depended on the attitudes of individual nurses rather than a consistent institutional standard.

3.6. The implications of pregnancy on education and future aspirations

One of the most significant long-term consequences of adolescent pregnancy was its disruptive effect on education. Many participants reported being forced to drop out of school, either due to financial constraints, lack of family support, or restrictive school policies that did not accommodate pregnant learners. For these adolescents, pregnancy not only brought immediate social and emotional challenges but also altered their prospects, limiting their ability to complete their education and pursue career aspirations.

For some, the financial burden of pregnancy meant that continuing school was no longer an option. In cases where parents already struggled with school-related costs, the discovery of pregnancy often led to the withdrawal of financial support, particularly for transport to school. One participant explained how her father's reaction to her pregnancy resulted in her inability to attend school:

> *"I dropped out of school because my father refused to pay for school transport after he found out I was pregnant" (*Participant 15, 18 years old).

A few faced institutional barriers, where school regulations required parental presence or additional care arrangements, making it difficult for pregnant adolescents to continue their education. One participant described how her school expelled her simply because her mother was unable to be present for her. She said the following:

> *"The teachers chased me away. They said I must stay at home because my mother was not available to look after me at school" (*Participant 8, 16 years old).

3.7. Conclusion

The findings from this study highlight the complex and multifaceted challenges that pregnant adolescents face in accessing antenatal care and maintaining their education. These challenges are shaped by family reactions, community stigma, healthcare experiences, and financial constraints, all of which influence their ability to successfully navigate pregnancy. However, the findings also indicate facilitators that encouraged and enhanced the experience of ANC services by adolescents. This included factors such as support from family, proximity, supportive healthcare professionals, and free healthcare services. The findings further illustrate

that pregnant adolescents' experiences in healthcare facilities are highly variable, with some receiving excellent care while others feel neglected, judged, or uninformed. The key differences between positive and negative experiences stemmed from respectful and engaging nurses who fostered trust, while judgmental ones discouraged clinic attendance. Adolescents who received clear information on pregnancy, fetal health, and nutrition felt more empowered, whereas those who received little guidance remained uncertain and misinformed. Finally, transportation costs, a lack of ambulance services, and rigid scheduling made it difficult for some adolescents to consistently access antenatal care.

CHAPTER FOUR: DISCUSSION

4.1. Introduction

This study explored the experiences and perceptions of pregnant adolescents regarding their access to antenatal care (ANC) services in primary healthcare facilities in the City of Johannesburg, Gauteng Province. The findings illustrate a range of complex barriers that participants encountered while accessing care. Some of these include adverse familial and community responses to their pregnancy, the fear of judgment and rejection, negative encounters within healthcare settings, financial and logistical hurdles, educational disruptions, cultural restrictions, and various socio-demographic factors. Despite these obstacles, the study also identified several facilitators that enhanced the experiences of pregnant adolescents with ANC services. These included supportive family and peer networks, and health interventions tailored specifically for adolescents.

This chapter discusses the main findings in relation to existing literature on pregnant adolescents' experiences of accessing ANC services in similar contexts and settings. It consolidates the key themes and sub-themes that encompass personal experiences, the challenges faced in accessing healthcare, the contrasting experiences within healthcare facilities, and the implications of pregnancy on education and future aspirations.

4.2. Personal experiences of pregnant adolescents

4.2.1. Pregnant adolescent's initial emotions upon discovering pregnancy

This study found that most participants experienced emotional distress upon discovering their pregnancy, characterized by shock, fear, and anxiety. These findings align with Olajubu et al. (2021), who report that pregnant adolescents commonly experience psychological stress and anxiety due to stigma, rejection, and feelings of failure. The fear of ostracism often compels young women to keep their pregnancies a secret, delaying their access to ANC and increasing the risk of complications.

A key theme that emerged from this current study was the reluctance of participants to disclose their pregnancy, mainly due to fear of family rejection and anticipated negative experiences in healthcare settings. A similar finding from a study by Smith et al. (2024) also illustrate similar emotional reactions experienced by pregnant adolescents. The study reported that participants described their initial reactions as shock, denial, and deep apprehension about how they would

be treated by both their families and healthcare providers (Smith, Leach, and Rossouw, 2024). Similarly, Govender et al. (2020) found that adolescent mothers in South Africa face significant psychological distress driven by stigma, isolation, and fear of rejection from their families and communities.

Beyond fear and anxiety, many participants in this current study reported guilt, despair, and feelings of unpreparedness for parenthood. Some considered abortion as a possible way to escape the responsibilities of early motherhood. This aligns with a study by Bah (2016), which noted that adolescent mothers frequently experienced emotional turmoil worsened by limited social support and uncertainty about their futures. They encounter several physical, psychological, mental, and social challenges (Bah, 2016).

In the current study, another critical concern among participants was disappointing their families, particularly their parents, who often held high expectations for their daughters' education and career aspirations. This fear of letting down their families contributed to guilt and shame, making it difficult for them to seek support or disclose their pregnancies. In a study by Mathebula et al. (2022), many adolescents reported that their families reacted with shock and disappointment, as they had expected them to prioritize education and future career goals.

4.2.2. Reactions to pregnancy: rejection, and support

4.2.2.1. Contrasting parental reactions

The reactions to adolescent pregnancy among families can vary significantly, highlighting a complex emotional landscape for the young individuals involved. Many participants in this study reported fears about disclosing their pregnancies due to anticipated negative responses from their parents, such as shame and rejection, which often stem from cultural and societal expectations. While some faced outright rejection and disappointment from their families, others received reluctant or even full support. Generally, parents, other family members, as well as neighbors blamed adolescents for becoming pregnant and were initially hesitant to offer assistance to them (Kotoh et al., 2022).

It was common for family members to attribute blame to the adolescents, with cultural perceptions framing teenage pregnancy as a violation of family honor. A similar sentiment was described in a study by Tyumre et al. (2020), which highlighted that those cultural expectations also played a role, with some parents not accepting or perceiving teenage pregnancy as a violation of family honor.

The findings in the current study indicate that initial reactions from parents involved anger and denial, sometimes transitioning into reluctant support as time passed. In this study, the findings show that in more extreme situations, some participants encountered severe familial conflict, including violence and financial withdrawal from their families, particularly affecting relationships with their fathers. Ilika et al. (2004) report that 97% of unmarried pregnant adolescents in Nigeria experienced violence, verbal abuse, or economic withdrawal from a family member.

Interestingly, the findings in this current study revealed that despite a prevalent trend of emotional and financial distancing, few participants reported instances where fathers provided immediate support, challenging the traditional view of paternal disengagement in such situations. According to Mabetha et al. (2022), this support was linked to better antenatal care attendance among pregnant adolescents, as social support from immediate networks, especially fathers, plays a significant role in fostering positive engagement with pregnancy-related changes. Ultimately, the findings in this study underscore the contrasting responses from families and the critical influence of parental attitudes in shaping the experiences of adolescents facing pregnancy. Research by Erasmus et al. (2020) also indicates that community stigma and parental rejection could intensify the emotional toll on pregnant adolescents, potentially leading to lower attendance at antenatal care due to the distress caused by parental disapproval.

4.2.2.2. Community and peer reactions to adolescent Pregnancy

The findings in this study reveal a significant influence of community stigma on adolescents experiencing pregnancy. Most participants frequently reported facing verbal abuse, such as gossip and exclusion from social circles. This aligns with the findings from a study by Erasmus et al. (2020), which highlights how stigmatization leads to feelings of isolation and psychological distress among young mothers.

Additionally, in the current study, the fear of judgment emerged as a primary factor contributing to delayed disclosure of pregnancy and attendance at antenatal care. Alemayehu et al. (2010) found similar sentiments among young mothers who believed that society held a negative view towards premarital pregnancy. The fear of judgment often prevented pregnant adolescents from openly discussing their situations or seeking necessary medical care (Alemayehu, Haidar, and Habte, 2010). Overall, these findings illustrate the emotional challenges faced by adolescents considering societal perceptions surrounding pregnancy.

4.2.2.3. Emotional Well-being and coping strategies

The findings in this study indicate that the participants experienced significant psychological stress due to their unpreparedness for pregnancy at a young age. This stress was compounded by the stigma associated with being visibly pregnant, which led some adolescents to withdraw from their social circles to avoid negative attention. The current study's findings show that community rejection was often internalized, prompting self-isolation as a protective mechanism, causing some participants to withdraw from their usual environments to escape negative attention. This suggests that community rejection was not always explicit but often internalized, causing adolescents to self-isolate as a defense mechanism. Research by Ntshayintshayi et al. (2022) supports this, noting that many participants in their study preferred to stay indoors during their pregnancies to escape judgment and mockery.

Participants in the current study commonly reported emotions such as guilt, self-blame, and disappointment, worsened by uncertainties surrounding motherhood and the fear of adding burdens to their families. These feelings created a heavy psychological strain, adversely affecting the mental and physical health of pregnant teenagers who struggled to cope with unexpected life changes. Despite these challenges, some participants demonstrated resilience by ignoring judgmental comments or seeking support from partners, family members, and friends. A study by Mabetha et al. (2022) emphasizes that supportive relationships significantly enhance feelings of comfort, joy, and positive self-awareness during pregnancy. Such support helped participants bond with their unborn babies and fostered increased acceptance of their pregnancies, ultimately promoting emotional well-being (Mabetha et al., 2022).

4.3. Experiences of pregnant adolescents accessing healthcare facilities

4.3.1. Constraining factors to accessing ante-natal care services by pregnant adolescents

4.3.1.1. Attitudes of nurses, lack of education, and inadequate quality of care

The findings in the current study identified multiple barriers that hinder pregnant adolescents from accessing ANC services, with negative interactions with HCWs emerging as a significant challenge. Most participants reported experiencing judgmental attitudes, dismissive behavior, and inadequate quality of care, discouraging them from seeking timely medical attention. These findings are supported by Erasmus et al. (2020), who report that healthcare workers' stigma and judgmental attitudes prevent adolescents from attending ANC. They reported that many

participants delayed their ANC bookings or avoided follow-up visits due to prior negative encounters with HCWs, who made them feel unwelcome, embarrassed, or morally judged. These findings highlight the critical influence of healthcare workers in shaping adolescents' perceptions of ANC services. When HCWs provide emotional support, engage in open dialogue, and offer non-judgmental care, adolescents feel empowered and more comfortable accessing services (Govender, Taylor, and Naidoo, 2020). Conversely, stigma and discrimination within healthcare settings create an environment of exclusion, making young mothers hesitant to seek the necessary care (Erasmus et al., 2020).

The presence of unsupportive or judgmental HCWs is particularly detrimental, as it reinforces feelings of shame and isolation, ultimately contributing to poor maternal health outcomes (Erasmus, Knight, and Dutton, 2020). Beyond interpersonal challenges, structural barriers also limit ANC access to pregnant adolescents. Most participants in this current study reported concerns about the lack of privacy in healthcare facilities and the absence of adolescent-friendly services, both of which deterred them from seeking care. These concerns are consistent with findings from a study in Uganda by Rukundo et al. (2015), who highlight that the lack of youth-focused clinics and insufficiently trained HCWs contribute to substandard service care and heightened stigma. Additionally, Tolossa et al. (2024) state that, due to a lack of privacy and confidentiality, many adolescents fear that their pregnancy status would be disclosed to their communities, discouraging them from attending ANC.

Overall, the findings in this study emphasize the urgent need for healthcare reforms that promote adolescent-friendly ANC services, including confidentiality, respectful quality care treatment, and HCW training on adolescent-sensitive care. Addressing these barriers would improve trust in healthcare systems and encourage more pregnant adolescents to seek essential maternal care.

4.3.2. Facilitators to accessing antenatal services by pregnant adolescents

4.3.2.1. Clinic proximity and free antenatal care services

Despite existing barriers, the current study’s findings highlight several key facilitators that enable pregnant adolescents to access ANC services. Notably, proximity to healthcare clinics and free antenatal care availability appeared to encourage appointment attendance. Most participants living closer to health facilities were more likely to utilize ANC services. Worku et al. (2016) highlight that the use of ANC was significantly influenced by factors such as: the

mother's age, the longer distance to the health facility, and the poor quality of ANC services provided at health facilities.

Most of the participants in the current study stated that free health services encouraged them to visit ANC services and that if they were compelled to pay, they would be unable to afford payment for obtaining ANC care. Conversely, high out-of-pocket expenses for prenatal care, including consultation fees, medications, and transportation, often deter women from seeking necessary maternal healthcare (Hackett et al.., 2019). Similarly, Abdiwali et.al. (2024) cited that affordable ANC services and the provision of nutritional supplements at MCH facilities were identified as key factors encouraging ANC use. Participants noted that reducing financial barriers could improve service uptake. However, findings in this study also identify encouraging factors that promote ANC attendance among adolescents.

Family support, flexible appointment schedules, the availability of emergency transportation, and positive attitudes from healthcare workers were highlighted as crucial facilitators. This aligns with research findings from Shee et al. (2021), which indicate that respectful and welcoming interactions with staff can lead to increased engagement in ANC among adolescents. Shee et al. (2021) also support that appointment flexibility and emergency transport assistance played a crucial role in ANC attendance.

In the current study flexible appointment options, positive staff attitude, and emergency transport assistance were emphasized as vital for improving attendance rates. In summary, while challenges in accessing antenatal services persist, supportive environments and logistical considerations play significant roles in enhancing the healthcare experiences of pregnant adolescents.

4.4. Contrasting experiences of pregnant adolescents in healthcare facilities

4.4.1. The role of healthcare workers in providing information and emotional support

The experiences of most participants in this study vary based on their interactions with HCWs. Some participants reported positive experiences, noting that supportive HCWs provided quick ANC services, emotional support, and essential health education. These positive interactions often increased ANC visit continuity and reduced the sense of isolation during pregnancy. In contrast, negative experiences were characterized by long wait times, delayed clinic opening hours, and feelings of being ignored or shamed, which discouraged some adolescents from

attending ANC. A study in South Africa by Smith et al. (2024) reinforces these observations, highlighting that factors like fear of verbal aggression, poor communication from staff, and extended waiting periods could hinder access to ANC services. Similarly, a study in Ethiopia by Alemayehu et al. (2010) indicates that adolescent mothers who received support from healthcare providers had higher rates of ANC attendance than those who encountered stigma.

In the current study, some participants reported nurses' practical expertise in ANC including nutritional and HIV counseling, fetal monitoring, and labor preparation played a critical role in promoting health literacy and alleviating anxiety among pregnant adolescents. Some participants emphasized that gaining awareness of fetal movement provided reassurance regarding their baby's well-being, while psychosocial counseling was instrumental in facilitating acceptance of their HIV status. Dewidar et al. (2023) reported that a balanced diet during pregnancy is crucial for the health of the mother, successful pregnancy outcomes, and healthy fetal development. The most effective interventions to reduce transmission from mother to child depend upon a woman knowing her HIV status, and that, in turn, depends upon the availability of information, counseling, and voluntary testing services (UNAIDS, 2001). Overall, the experiences of pregnant adolescents in healthcare settings are deeply influenced by the level of support and communication they receive from HCWs.

4.5. The implications of pregnancy on education and future aspirations

Pregnancy significantly impacts education and future aspirations for many young women. The findings in this study reveal that many participants experienced disruptions in their educational and career goals due to pregnancy, leading to heightened stress and uncertainty. Many participants faced the difficult decision of dropping out of school, often influenced by unsupportive family environments, restrictive school policies, and stigma from peers and educators. This reflects the conclusions of East and Barber (2014), who note that pregnant adolescents with high educational aspirations typically encounter considerable distress and parenting challenges arising from the conflict between their academic ambitions and the responsibilities of motherhood.

Most participants experienced the stigma surrounding teenage pregnancy as pervasive, emanating not only from peers but also from the educational system and society at large resulting in school dropouts. East and Barber (2014) highlighted that this stigma not only comes from peers but also from educators and society in general. Similarly, Willan (2013) notes that school policies are understood and carried out by principals, governing bodies, and teachers,

with community and family influences playing a role creating room for individuals to bring their morals and values into how the policies are applied. The policy environment generally supports allowing pregnant teenage girls to stay in school and return after giving birth, but poor implementation and subjective interpretations create significant barriers, making it difficult for them to do so in practice (Shefer and Morrell, 2013). The findings in this study illustrate the need for a more supportive and understanding approach within educational institutions to help pregnant adolescents navigate their challenges.

4.6. Limitations of the study

While this study provides valuable insights into the experiences of pregnant adolescents accessing ANC, several limitations should be acknowledged. Ethical and logistical challenges affected participant recruitment. Since many pregnant adolescents are minors, obtaining parental or guardian consent was difficult, leading to potential selection bias. Adolescents who lacked family support or who had particularly negative experiences may have been less likely to participate, potentially skewing the findings. Another limitation is the reliance on self-reported experiences, which introduces the possibility of recall and social desirability biases. Participants may have altered or downplayed their responses due to fear of judgment or difficulty of accurately recalling past experiences. To mitigate this limitation, the researcher reassured the participants that all that they expressed was confidential and that no harm was going to be posed to them.

In addition, the study primarily focuses on pregnant adolescents' perspectives without including the viewpoints of healthcare providers, policymakers, or educators. Understanding the challenges HCWs face in providing adolescent-friendly care could provide a more holistic view of the barriers within the healthcare system. Lastly, the study was conducted within a single sub-district, limiting its ability to capture regional variations in healthcare access and socio-cultural attitudes toward adolescent pregnancy. Despite this limitation, the findings provide empirical evidence of the layered experiences of pregnant adolescents which can be applied to similar settings.

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

5.1. Introduction

This chapter provides the conclusion as synthesized from the findings of this study. It further provides recommendations on ways to improve ANC services targeting pregnant adolescents in PHC facilities. The recommendations reflect aspects that have been drawn from the findings, including aspects that build on those factors. The chapter then discusses the implications for future research.

5.2. Conclusion

One of the key findings in this study reveals that despite the availability of free maternal healthcare services for ensuring positive maternal and neonatal health outcomes, pregnant adolescents face numerous challenges that hinder their access to timely and quality antenatal care. The study's findings are closely related to SDG Goal 3, which promotes healthy lives and fosters well-being for all people, regardless of age. Target 3.1 is primarily designed to reduce global maternal death rates and ensure that all women, including adolescents, have access to quality maternal healthcare services (Eckert et al., 2022). The findings in this study underscore the need for a more adolescent-responsive health system. In alignment with the WHO's (2018) ANC model, which recommends a minimum of eight ANC contacts during pregnancy, delivered in a respectful, person-centered manner, there is a clear gap in meeting international standards (WHO, 2018).

Secondly, this study illustrates health system-related barriers such as staff shortages, negative attitudes from healthcare workers, and prolonged waiting times significantly hinder adolescent ANC access. It was highlighted how overburdened healthcare workers often provide rushed consultations with minimal counseling, which discourages pregnant adolescents from regularly attending ANC services. This study further highlights that pregnant adolescents face structural barriers such as inflexible clinic hours and a clinic appointment system. Pregnant adolescents struggle to balance ANC visits with school or work commitments, as clinics often operate strict weekday schedules that do not accommodate adolescent needs. This correlates with Williams and Garrido (2016), who states that participants reported not being able to leave school to attend appointments, with inflexible attendance requirements and inflexible clinic hours serving as a

barrier to seeking care for school-age participants (Williams and Garrido, 2020). The interruption of schooling ultimately perpetuates socio-cultural and economic implications, where young mothers face future unemployment, contributing to barriers in accessing adequate maternal healthcare services (Banke-Thomas et al., 2020). In the context of the NHI, the goal of universal health coverage is undermined if marginalized groups such as pregnant adolescents continue to face structural and interpersonal barriers. The study's findings suggest that unless health system reforms incorporate youth-specific needs, the NHI's promise of equity and inclusivity will not be realized.

Thirdly, stigma and social barriers were indicated in this study by the adolescents who experienced family rejection and community stigma, which led to delayed pregnancy disclosure and low ANC attendance. This corresponds with the study conducted by Dahab and Sakellariou (2020), which found that adolescents face unique challenges related to socio-economic status, cultural norms, stigma, healthcare system inefficiencies, and psychological barriers that lead to delayed initiation, inconsistent attendance, or complete avoidance of ANC (Dahab and Sakellariou, 2020).

The findings in this study suggest that the immediate reaction of pregnant adolescents includes emotional distress such as shock, fear, denial, uncertainty, and social isolation. The reactions of pregnant adolescents correlate with those explained by Govender et al. (2020), who found that adolescent mothers in South Africa face significant psychological distress driven by stigma, isolation, and fear of rejection from their families and communities (Govender et al., 2020).These findings further align with those reported by Moganedi et al. (2024), who highlighted that adolescent mothers encounter psychological challenges, including social withdrawal and community rejection. The transition into motherhood is associated with various emotional and psychological distress factors, such as heightened anxiety and concern, feelings of regret and frustration, experiences of guilt and shame, and increased social isolation (Moganedi and Mudau, 2024). This is a stark indication of the need for mental health care services geared at pregnant adolescents in PHC settings.

South Africa's maternal health framework emphasizes adolescent-friendly services, integration of mental health support, and accessibility, which remain inadequately implemented at the PHC level (Mokgaola et al. 2022). Although tangible integration of mental health care at the community level remains incoherent in LMICs (Eboreime et al., 2021), efforts to strengthen the integration of services that cater to adolescents' unique needs have the potential to address the

mental health and well-being of pregnant adolescents. This has the potential to encourage their accessing of ANC services timeously.

However, the findings in this study also identified facilitators of ANC accessibility for pregnant adolescents. This includes factors such as supportive family networks, proximity to healthcare clinics, free antenatal care availability, and flexible clinic appointment systems, which significantly encourage appointment attendance for healthcare services. These findings are supported by Gitobu et al. (2018), who report that cost and lack of support structures are deterrents to health facility delivery service utilization in Kenya, transport being the main cost driver, and thus free delivery services are a key approach to encouraging the use of healthcare services.

5.3. Recommendations

This study's findings suggest a critical need for interventions that promote family acceptance to address family rejection, particularly among fathers and community figures who shape the adolescents' experience. Strengthening family communication, providing emotional counseling for parents, and fostering supportive networks for pregnant adolescents could mitigate the harmful effects of rejection and improve antenatal care engagement and mental well-being.

This study further highlights the urgent need for targeted interventions that address health system inefficiencies, socio-economic constraints, and societal stigma. In this regard, several recommendations could be considered to inform decision-makers on improving the experiences of pregnant adolescents in accessing ANC services.

5.3.1. Strengthening health system-related barriers

Findings from this study indicate that staff shortages and prolonged waiting times are significant barriers of ANC access in PHC facilities. The inadequate number of healthcare workers not only overburdens existing staff but also contributes to inefficient service delivery, ultimately discouraging pregnant adolescents from seeking timely ANC services. To address these challenges, it is recommended that the number of healthcare workers in PHC facilities be increased to reduce patient load and improve consultation times. By expanding the health workforce, facilities can enhance the quality of ANC services, allowing adolescents to receive adequate attention, counseling, and maternal health education during their visits.

This study further highlights the importance of training healthcare providers in adolescent-friendly service delivery. Many adolescents in this study reported experiencing judgmental attitudes and inadequate support from healthcare workers, which negatively impacted their willingness to seek ANC. Implementing specialized training programs focusing on respectful, non-judgmental confidentiality, psychosocial support, and youth-centered approaches can foster a more inclusive and welcoming healthcare environment for pregnant adolescents. As South Africa rolls out NHI, adolescent health must be a priority. This study calls for dedicated NHI funding for adolescent-friendly services, monitoring systems, and improved coordination between PHC and community structures to uphold the principle of universal access. The recommendations of this study directly support SDG 3.1, which aims to reduce maternal mortality and ensure universal access to reproductive and maternal healthcare. Ensuring that adolescent mothers receive respectful, accessible, and quality ANC services is fundamental to achieving these global commitments.

These interventions have the potential to improve ANC utilization rates and contribute to better maternal and neonatal health outcomes by ensuring that adolescent mothers receive the necessary care, guidance, and support throughout their pregnancy.

5.3.2. Flexible clinic hours and digital health solutions

The findings in this study demonstrated that many pregnant adolescents face difficulties balancing ANC attendance with demands of schoolwork, combined with the rigid operating hours of most PHC facilities, often leading to missed or delayed ANC visits. This challenge is particularly pronounced amongst pregnant adolescents who lack flexible schooling arrangements or who fear stigma from peers and educators when requesting time off for healthcare appointments. Considering these findings, flexible antenatal care appointment scheduling should be implemented to accommodate the needs of adolescents balancing pregnancy with the demands of schoolwork and the need to attend ANC visits. Additionally, it is recommended that PHC facilities implement extended clinic hours, including after-school and weekend services, to better accommodate the schedules of pregnant adolescents. By offering ANC services outside regular school hours, adolescents can access necessary ANC services without disrupting their education.

Moreover, leveraging digital health tools that resonate with younger people could be considered. Using SMS-based appointment reminders and mobile health applications can enhance adherence to ANC schedules, minimize waiting times, and improve service delivery.

5.3.3. Innovation to improve ANC access for pregnant adolescents

The existing innovative Teen Mom connect application could be better implemented so that it is accessible, particularly in scarcely resourced communities such as rural areas, to enhance health-seeking behavior and empower adolescents with vital maternal and child health information.

5.3.4. Educational reintegration programmes

The current study's findings demonstrate that adolescents face stigma and discrimination within school settings, leading to absenteeism or dropout. Therefore, it is crucial to provide training for teachers and school staff to foster non-judgmental and supportive learning environments for pregnant learners by allowing them to continue their studies without fear of exclusion. Additionally, literature reveal that by strengthening Comprehensive Sexuality Education (CSE) programs in schools (CSE) into the school curriculum, adolescents can make informed choices about their reproductive health, thereby reducing unintended pregnancies and improving ANC engagement (Srikwan et al., 2024).

5.3.5. Family, community rejection, and stigma

The findings in this study reveal that family rejection and societal stigma significantly contribute to delayed pregnancy disclosure among adolescents, which, in turn, leads to reduced ANC uptake. Many pregnant adolescents in the current study reported fear of judgment, discrimination, or punishment from their families and communities, resulting in prolonged secrecy about their pregnancy. To mitigate these challenges, community-based health education should address common misinformation about pregnancy and antenatal care, improving early healthcare-seeking behavior. These programs should emphasize the health benefits of early ANC engagement, dispel harmful misconceptions about adolescent pregnancy, and encourage families to provide emotional and financial support to pregnant adolescents.

By addressing these issues through targeted healthcare, educational, and community-based interventions, pregnant adolescents can receive the support they need to ensure better health outcomes for both them and their children. Community health workers can play a central role in linking pregnant adolescents to ANC services, while alleviating experiences of stigma in the community (Malapela, Mboweni and Risenga, 2024). Additionally, a lack of understanding about the risks associated with pregnancy and insufficient awareness of ANC services'

significance limit adolescents' knowledge and engagement with these health services. Therefore, there is a pressing need for improved awareness programs to educate young mothers about the importance of regular ANC.

5.4. Implications for future research

The findings in this current study highlight critical gaps in the accessibility, utilization, and quality of ANC services for pregnant adolescents. While existing research has explored the barriers and facilitators of ANC in LMICs, this study underscores the need for targeted interventions that address systemic, social, and economic constraints affecting adolescent mothers, hence contributing to evidence-informed policies and interventions that improve maternal and neonatal health outcomes for adolescent mothers.

Future research could mitigate reliance on self-reported experiences by participants, which introduces the possibility of recall and social desirability biases by triangulating data from multiple sources, such as healthcare workers, family members, or official clinic records. Expanding research to include multiple provinces, rural communities, sub-districts, and diverse healthcare settings would enhance the breadth and applicability of findings.

Furthermore, innovative qualitative methodologies that allow young participants to express their experiences in ways that resonate with them should be explored. This includes the use of diaries to document the pathways of accessing ANC services by pregnant adolescents can provide the nuances in their experience of the health care system from the perspective of younger people. Ethnographic methods, such as participant and non-participant observations, can provide context-based factors, lived experiences of pregnant adolescents as they attempt to access ANC services.

By acknowledging these constraints, future research can build on these findings, adopt more inclusive methodologies, and contribute to evidence-based interventions that improve healthcare access for adolescent mothers.

REFERENCES

Abrahams, C. and Everatt, D., 2019. City Profile: Johannesburg, South Africa. *Environment and Urbanization ASIA*, *10*(2), 255-270.

Abdiwali, S.A., Adesina, O.A., Fekadu, G.A., 2024. Barriers and facilitators to antenatal care services utilisation in Somaliland: a qualitative study. *BMJ Open,* 14:e085073. doi:10.1136/bmjopen-2024-085073

Abuosi, A.A., and Anaba, E.A., 2018. Barriers on access to and use of adolescent health services in Ghana. *Journal of Health Research, 33*(3), 197-207. DOI 10.1108/JHR-10-2018-0119

Achieng, A., Ajayi A.I., and Kabiru, C.W., 2025. "Trying not to be seen": a qualitative study exploring adolescent girls'experiences seeking antenatal care in a Nairobi informal settlement. *BMJ Open*,15:e093696. doi:10.1136/bmjopen-2024-093696

Akella, D. and Jordan, M., 2014. Impact of social and cultural factors on teenage pregnancy. *Journal of Health Disparities Research and Practice*, 8(1), 41-62. https://digitalscholarship.unlv.edu/jhdrp/vol8/iss1/3.

Austin, Z. and Sutton, J., 2014. Qualitative research: Getting started. *The Canadian Journal of Hospital Pharmacy*, *67*(6), 436-440.

Alem, A.Z., Yeshaw, Y., Liyew, A.M., et al., 2022. Timely initiation of antenatal care and its associated factors among pregnant women in sub-Saharan Africa: A multicountry analysis of Demographic and Health Surveys. *PloS One*, *17*(1), e0262411. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0262411

Alemayehu, T., Haidar, J. and Habte, D., 2010. Utilization of antenatal care services among teenagers in Ethiopia: a cross-sectional study. *Ethiopian Journal of Health Development*, *24*(3). https://www.ajol.info/index.php/ejhd/article/view/68389

Anderson, G.L., Herr, K. and Nihlen, A.S., 2007. *Studying your own school: An educator's guide to practitioner action research*. Thousand Oaks: Corwin Press.

Apolot, R.R., Tetui, M., Nyachwo, E.B., et al., 2020. Maternal health challenges experienced by adolescents; could community score cards address them? A case

study of Kibuku District–Uganda. *International Journal for Equity in Health*, *19*(1), 191. https://doi.org/10.1186/s12939-020-01267-4.

Atuyambe, L., Mirembe, F., Annika, J., et al., 2009. Seeking safety and empathy: adolescent health seeking behavior during pregnancy and early motherhood in central Uganda. *Journal of Adolescence*, *32*(4), 781-796. https://doi.org/10.1016/j.adolescence.2008.10.012.

Bah, Y.M., 2016. Teenage pregnancy: teenage mothers' experiences and perspectives: a qualitative study. *Journal of Health, Medicine and Nursing*, *29*(2), 118-136.

Banke-Thomas, O.E., Banke-Thomas, A.O., and Ameh, A.A., 2017. Factors influencing utilisation of maternal health services by adolescent mothers in Low-and middle-income countries: a systematic review. *BMC Pregnancy and Childbirth, 17,*65. doi 10.1186/s12884-017-1246-3

Barron, P., Subedar, H., Letsoko, M., et al., 2022. Teenage births and pregnancies in South Africa, 2017-2021–a reflection of a troubled country: Analysis of public sector data. *South African Medical Journal*, *112*(4), .252-258. https://doi.org/10.7196/SAMJ.2022.v112i4.16327

Baxter, C. and Moodley, D., 2015. Improving adolescent maternal health. *South African Medical Journal*, *105*(11), 948-951. https://doi.org/10.7196/SAMJ.2015.v105i11.10126.

Berger, R., 2015. Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative Research*, *15*(2), 219-234. https://doi.org/10.1177/1468794112468475.

Bradshaw, C., Atkinson, S., and Doody, O., 2017. Employing a Qualitative Description Approach in Health Care Research. *Global Qualitative Nursing Research*, 4, 2333393617742282. doi: 10.1177/2333393617742282

Busetto, L., Wick, W. and Gumbinger, C., 2020. How to use and assess qualitative research methods. *Neurological Research and Practice*, *2*(1), 14. https://doi.org/10.1186/s42466-020-00059-z.

Bwalya, B.C., Sitali, D., Baboo, K.S., et al., 2018. Experiences of antenatal care among pregnant adolescents at Kanyama and Matero clinics in Lusaka district, Zambia. *Reproductive Health*, *15*(1), 124. https://doi.org/10.1186/s12978-018-0565-9.

Casula, M., Rangarajan, N. and Shields, P., 2021. The potential of working hypotheses for deductive exploratory research. *Quality & Quantity*, *55*(5), 1703-1725. https://doi.org/10.1007/s11135-020-01072-9.

Chikalipo, M.C., Mipando, L.N., Ngalande, R.C., et al., 2018. Perceptions of pregnant adolescents on the antenatal care received at Ndirande Health Centre in Blantyre, Malawi. *Malawi Medical Journal*, *30*(1), 25-30. https://doi.org/10.4314/mmj.v30i1.6.

Dahab, R. and Sakellariou, D., 2020. Barriers to accessing maternal care in low-income countries in Africa: a systematic review. *International Journal of Environmental Research and Public Health*, *17*(12), 4292. https://doi.org/10.3390/ijerph17124292.

Dairo, M.D. and Owoyokun, K.E., 2010. Factors affecting the utilization of antenatal care services in Ibadan, Nigeria. *Benin Journal of Postgraduate Medicine*, *12*(1). https://www.ajol.info/index.php/bjpm/article/view/63387

Department of Justice and Constitutional Development. 2007. *Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 32 of 2007.* Pretoria: Department of Justice and Constitutional Development, South Africa.

Dewidar, O., John, J., Baqar, A., et al., 2023. Effectiveness of nutrition counseling for pregnant women in low- and middle-income countries to improve maternal and infant behavioral, nutritional, and health outcomes: A systematic review. *Campbell Systematic Reviews*, 19, e1361. https://doi.org/10.1002/cl2.1361

Dookie, S. and Singh, S., 2012. Primary health services at district level in South Africa: a critique of the primary health care approach. *BMC Family Practice*, *13*(1), 67. https://doi.org/10.1186/1471-2296-13-67.

East, P. L., and Barber, J. S., 2014). High educational aspirations among pregnant adolescents are related to pregnancy unwantedness and subsequent parenting stress

and inadequacy. *Journal of Marriage and Family, 76*(3), 652–664. https://doi.org/10.1111/jomf.12103

Eboreime, E., Ogwa, O., Nnabude, R., et al., 2022, Engaging stakeholders to identify gaps and develop strategies to inform evidence use for health policymaking in Nigeria. *Pan African Medical Journal, 43*(140). 10.11604/pamj.2022.43.140.36754

Eckert, N., Rusch, G., Lyytimäki, J., et al., 2023. Sustainable Development Goals and risks: The Yin and the Yang of the paths towards sustainability. *Ambio*, *52*(4), 683-701. https://link.springer.com/article/10.1007/s13280-022-01800-5

Erasmus, M.O., Knight, L. and Dutton, J., 2020. Barriers to accessing maternal health care amongst pregnant adolescents in South Africa: a qualitative study. *International journal of public health*, *65*(4), pp.469-476. Available at: https://doi.org/10.1007/s00038-020-01374-7.

Gaglio, B., Henton, M., Barbeau, A., et al., 2020. Methodological standards for qualitative and mixed methods patient-centered outcomes research. *BMJ*, 371. https://doi.org/10.1136/bmj.m4435.

Gamberini, C., Angeli, F. and Ambrosino, E., 2022. Exploring solutions to improve antenatal care in resource-limited settings: an expert consultation. *BMC Pregnancy and Childbirth*, *22*(1), 449. https://doi.org/10.1186/s12884-022-04778-w.

Gentles, S.J., Charles, C., Ploeg, J. and McKibbon, K.A., 2015. Sampling in qualitative research: Insights from an overview of the methods literature. *The Qualitative Report*, *20*(11), 1772-1789. https://doi.org/10.46743/2160-3715/2015.2373.

Gill, T.G. and Gill, T.R., 2020. What is Research Rigor? Lessons for a Transdiscipline. *Informing Science*, *23*. https://doi.org/10.28945/4528.

Gitobu, C.M., Gichangi, P.B. and Mwanda, W.O., 2018. The effect of Kenya's free maternal health care policy on the utilization of health facility delivery services and maternal and neonatal mortality in public health facilities. *BMC Pregnancy and Childbirth*, *18*(1), 77. https://doi.org/10.1186/s12884-018-1708-2.

Govender, D., Taylor, M. and Naidoo, S., 2020. Adolescent pregnancy and parenting: Perceptions of healthcare providers. *Journal of Multidisciplinary Healthcare*, 1607-1628. https://doi.org/10.2147/JMDH.S258576.

Govender, T., Reddy, P. and Ghuman, S., 2018. Obstetric outcomes and antenatal access among adolescent pregnancies in KwaZulu-Natal, South Africa. *South African Family Practice*, *60*(1), 1-7. https://doi.org/10.1080/20786190.2017.1333783.

Gulliford, M., Figueroa-Munoz, J., Morgan, M., et al., 2002. What does 'access to health care' mean? *Journal of Health Services Research & Policy*, *7*(3), 186-188. https://doi.org/10.1258/135581902760082517.

Hackett, K., Lenters, L., Vandermorris, A., et al., 2019. How can engagement of adolescents in antenatal care be enhanced? Learning from the perspectives of young mothers in Ghana and Tanzania. *BMC Pregnancy and Childbirth*, *19*(1), 184. https://doi.org/10.1186/s12884-019-2326-3.

Haddad, A.E. and Lima, N.T., 2024. Digital Health in the Brazilian National Health System (SUS). *Interface-Comunicação, Saúde, Educação*, *28*, .e230597. https://doi.org/10.1590/interface.240045.

Haddrill, R., Jones, G.L., Mitchell, C.A. and Anumba, D.O., 2014. Understanding delayed access to antenatal care: a qualitative interview study. *BMC pregnancy and childbirth*, *14*(1), 207. https://doi.org/10.1186/1471-2393-14-207.

Harrison, M.E., Weinstangel, H., Dalziel, N. et al., 2014. A collaborative outreach clinic for pregnant youth and adolescent mothers: Description of a pilot clinic and its patients. *Paediatrics & Child Health*, *19*(5), 247-250.

Highet, N., 2022. Emotional and mental health challenges of expectant and new parents-what can midwives do to improve outcomes in pregnancy, birth and early parenthood. *Women and Birth*, *35*, 24-25. https://doi.org/10.1016/j.wombi.2022.07.067.

Ilika, A. and Anthony, I., 2004. Unintended pregnancy among unmarried adolescents and young women in Anambra State, south east Nigeria. *African Journal of Reproductive Health*, 92-102. https://www.jstor.org/stable/3583396?seq=1

Islam, M.M., and Masu, M.S., 2018. Determinants of frequency and contents of antenatal care visits in Bangladesh: Assessing the extent of compliance with the WHO recommendations. *PLoS One*, *13*(9), e0204752. doi: 10.1371/journal.pone.0204752

James, S., Pisa, P.T., Imrie, J., et al., 2018. Assessment of adolescent and youth friendly services in primary healthcare facilities in two provinces in South Africa. *BMC Health Services Research*, *18*(1), 809. https://doi.org/10.1186/s12913-018-3623-7.

Jochim, J., Cluver, L., Sidloyi, L., et al., 2023. Improving educational and reproductive outcomes for adolescent mothers in South Africa: A cross-sectional analysis towards realising policy goals. *Global Public Health*, *18*(1), 2206465. https://doi.org/10.1080/17441692.2023.2206465.

Johnson, W. and Moore, S.E., 2015. Adolescent pregnancy, nutrition, and health outcomes in low-and middle-income countries: what we know and what we don't know. *Bjog*, *123*(10), 1589. https://doi.org/10.1111/1471-0528.13782.

Jolivet, R.R., Moran, A.C., O'Connor, M., et al., 2018. Ending preventable maternal mortality: phase II of a multi-step process to develop a monitoring framework, 2016–2030. *BMC pregnancy and childbirth*, *18*(1), 258. https://doi.org/10.1186/s12884-018-1763-8.

Katzen, L.S., Tomlinson, M., Christodoulou, J., 2020. Home visits by community health workers in rural South Africa have a limited, but important impact on maternal and child health in the first two years of life. *BMC Health Services Research 20*, 594 https://doi.org/10.1186/s12913-020-05436-7

Kassa, G.M., Arowojolu, A.O., Odukogbe, A.A. and Yalew, A.W., 2018. Prevalence and determinants of adolescent pregnancy in Africa: a systematic review and meta-analysis. *Reproductive Health*, *15*(1),195. https://link.springer.com/article/10.1186/s12978-018-0640-2

Kayentao, K., Ghosh, R., Guindo, L., et al., 2023. Effect of community health worker home visits on antenatal care and institutional delivery: an analysis of secondary outcomes from a cluster randomised trial in Mali. *BMJ Global Health*, *8*(3), e011071. https://doi.org/10.1136/bmjgh-2022-011071.

Khan, M.N., Akter, S. and Islam, M.M., 2022. Availability and readiness of healthcare facilities and their effects on long-acting modern contraceptive use in Bangladesh: analysis of linked data. *BMC Health Services Research*, *22*(1), 1180. https://doi.org/10.1186/s12913-024-10824-4.

Korstjens, I. and Moser, A., 2018. Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice*, *24*(1), 120-124. https://doi.org/10.1080/13814788.2017.1375092.

Kotoh, A.M., Sena Amekudzie, B., Opoku-Mensah, K., et al., 2022. Pregnant adolescents' lived experiences and coping strategies in peri-urban district in Southern Ghana. *BMC Public Health*, *22*(1), 901. https://doi.org/10.1186/s12889-022-13318-2.

Kumar, M., Huang, K.Y., Othieno, C., et al., 2018. Adolescent pregnancy and challenges in Kenyan context: perspectives from multiple community stakeholders. *Global Social Welfare*, *5*(1), 11-27. https://doi.org/10.1007/s40609-017-0102-8.

Lateef, M.A., Kuupiel, D., Mchunu, G.G. et al., 2024. Utilization of antenatal care and skilled birth delivery services in Sub-Saharan Africa: A systematic scoping review. *International Journal of Environmental Research and Public Health*, *21*(4), 440. https://doi.org/10.3390/ijerph21040440.

Mabetha, K., Soepnel, L., Klingberg, S., et al., 2022. Social Support during pregnancy: A phenomenological exploration of young women's experiences of support networks on pregnancy care and wellbeing in Soweto, South Africa. *MedRxiv*, 2022-04. https://doi.org/10.1101/2022.04.03.22273162.

Machoka, B.N., Kabiru, C.W. and Ajayi, A.I., 2024. "My father insisted that I have the baby but not in his house": Adolescent pregnancy, social exclusion and (dis) empowerment of girls in an urban informal settlement in Kenya. *PLOS Global Public Health*, *4*(9), e0003742. https://doi.org/10.1371/journal.pgph.0003742.

Maguire, M. and Delahunt, B., 2017. Doing a thematic analysis: A practical, step-by-step guide for learning and teaching scholars. *All Ireland Journal of Higher Education*, *8*(3). http://ojs.aishe.org/index.php/aishe-j/article/view/335.

Majebi, N.L., Adelodun, M.O. and Anyanwu, E.C., 2024. Maternal mortality and healthcare disparities: Addressing systemic inequities in underserved communities. *International Journal of Engineering Inventions*, *13*(9), 375-385.

Malapela, R.G., Mboweni, S.H. and Risenga, P.R., 2024. Evaluating counselling skills of community health workers for pregnant adolescents in Limpopo province. *South African Journal of Psychiatry*, *30*(1),1-9.

Malunga, G., Sangong, S., Saah, F.I. and Bain, L.E., 2023. Prevalence and factors associated with adolescent pregnancies in Zambia: a systematic review from 2000–2022. *Archives of Public Health*, *81*(1),27. https://doi.org/10.1186/s13690-023-01045-y

Mason, E., Sen, G. and Yamin, A.E., 2020. Universal health coverage provisions for women, children and adolescents. *Bulletin of the World Health Organization*, *98*(2), 79. https://doi.org/10.2471/BLT.19.249474.

Mathebula, R.N., Runhare, T. and Mafumo, T.N., 2022. Educational support for pregnant and parenting school girls in rural South African school settings. *Issues in EducationalResearch*, *32*(2),593-612. https://www.iier.org.au/iier32/mathebula.pdf

Mazur, A., Brindis, C.D. and Decker, M.J., 2018. Assessing youth-friendly sexual and reproductive health services: a systematic review. *BMC Health Services Research*, *18*(1), 216. https://doi.org/10.1186/s12913-018-2982-4.

Mbongwa, L., Mpanza, S. and Mlambo, V.H., 2024. The teenage pregnancy crisis in South Africa among high school students, causes, implications and possible solutions: A literature review. *Futurity Education*, *4*(3), 200-216. https://doi.org/10.57125/fed.2024.09.25.12.

McIntyre, Peter & World Health Organization (2006). Pregnant adolescents: delivering on global promises of hope. Geneva: World Health Organization. Available from: https://iris.who.int/handle/10665/43368 [Accessed 18 September 2025]

Mekwunyei, L.C. and Odetola, T.D., 2020. Determinants of maternal health service utilisation among pregnant teenagers in Delta State, Nigeria. *Pan African Medical Journal*, *37*(1). https://doi.org/10.11604/pamj.2020.37.81.16051.

Misago, N., Habonimana, D., Ciza, R., et al., 2023. A digitalized program to improve antenatal health care in a rural setting in North-Western Burundi: Early evidence-based lessons. *PLOS Digital Health*, *2*(4), e0000133. https://doi.org/10.1371/journal.pdig.0000133.

Moallemi, E.A., Malekpour, S., Hadjikakou, M., et al., 2019. Local Agenda 2030 for sustainable development. *The Lancet Planetary Health*, *3*(6), e240-e241. https://doi.org/10.1016/S2542-5196(19)30087-7.

Moganedi, S.E. and Mudau, T.S., 2023. Stigma and mental well-being among teenage mothers in the rural areas of Makhado, Limpopo Province. *Social Sciences*, *13*(1), 18. https://doi.org/10.3390/socsci13010018.

Mokgaola, I.O., Gause, G., Sehularo, L.A., et al., 2022. The status of integrating children and adolescents' mental health care services into primary health care in South Africa: scoping review. *The Open Public Health Journal*, 15. e187494452211240. https://doi.org/10.2174/18749445-v15-e221128-2022-75.

Moucheraud, C,. McBride, K., Heuveline, P., et al., (2022). Preventing, but Not Caring for, Adolescent Pregnancies? Disparities in the Quality of Reproductive Health Care in Sub-Saharan Africa. *Journal of Adolescent Health*, 71, 210-216. https://doi.org/10.1016/j.jadohealth.2022.02.012

Mweteni, W., Kabirigi, J., Matovelo, D., et al., 2021. Implications of power imbalance in antenatal care seeking among pregnant adolescents in rural Tanzania: A qualitative study. *PLoS One*, *16*(6), p.e0250646. https://doi.org/10.1371/journal.pone.0250646.

Cumber, S.M, Atuhaire, C., Namuli, V., et al., 2022. Barriers and strategies needed to improve maternal health services among pregnant adolescents in Uganda: a qualitative study. *Global Health Action*, *15*(1),2067397. https://doi.org/10.1080/16549716.2022.2067397.

Namusana, R., Namyalo, J.M., Otieno, E.D. et al., 2022. Experiences of Seeking Antenatal Care and Delivery Among Teenagers in Kibuku District, Uganda. *Journal of Research and Health*, *12*(4), 239-252. https://doi.org/10.32598/JRH.12.4.1970.2.

National Department of Health (NDOH), 1997a. *White Paper on the Transformation of the Health System in South Africa.* Pretoria: National Department of Health

National Department of Health (NDOH), 2017b. *Saving Mothers 2017-2019: Seventh triennial report on confidential enquiries into maternal deaths in South Africa. Technical Report.* Pretoria: National Department of Health

Nagandla, K., and Kumar, K., 2020. Prevalence of teenage pregnancy in 2015–2016 and its obstetric outcomes compared to non-teenage pregnancy at Hospital Tuanku Ja'afar Seremban (HTJS), Negeri Sembilan, Malaysia: A retrospective case-control study based on the national obstetric registry. *Malaysian Family Physician*, *15*(2), 2–9.

Ndahimana, R., Umutoni, N.J., Nteziryayo, J.P., et al., 2023. Prevalence, Trends in and Determinants of Teenage Pregnancies in Rwanda: Analysis of Rwanda Demographic and Health Survey (2010 to 2020). *J ISSN*, *2766*, p.2276. https://doi.org/10.37871/jbres1813.

Ndlovu, S.M., Ross, A. and Ndirangu, J., 2025. Young men's barriers to and facilitators of utilising HIV-testing services in South Africa. *Southern African Journal of HIV Medicine*, *26*(1), 1631. https://doi.org/10.4102/sajhivmed.v26i1.1631

Nguyen, H.T., Zombré, D., Ridde, V. and De Allegri, M., 2018. The impact of reducing and eliminating user fees on facility-based delivery: a controlled interrupted time series in Burkina Faso. *Health Policy and Planning*, *33*(8), 948-956. https://doi.org/10.1093/heapol/czy077.

Ntshayintshayi, P.N., Sehularo, L.A., Mokgaola, I.O. et al. , 2022. Exploring the psychosocial challenges faced by pregnant teenagers in Ditsobotla subdistrict. *Health SA Gesondheid*, *27*, 1880. https://doi.org/10.4102/hsag.v27i0.1880.

Ogunwale, O.I. and Rangiah, S., 2021. Profile and obstetric outcome of teenage pregnancies compared with pregnant adults at a district hospital in KwaZulu-Natal. *South African Family Practice*, *63*(1), 5290. doi: 10.4102/safp.v63i1.5290.

Olajubu, A.O., Omoloye, G.O,. Olajubu, T.O., et al., (2021). Stress and resilience among pregnant teenagers in Ile-Ife, Nigeria. *European Journal of Midwifery,* 5, 9. https://doi.org/10.18332/ejm/134181

Onukwugha, F., Agaba, P., Hayter, M. et al., 2022. Unmarried adolescents' experiences of using reproductive and maternal health services in Nigeria and Uganda: a qualitative study. *Social Sciences*, *11*(5), 203. https://doi.org/10.3390/socsci11050203.

Owolabi, O.O., Wong, K.L.M, Dennis, M.L., et al., 2017. Comparing the use and content of antenatal care in adolescent and older first-time mothers in 13 countries of west Africa: a cross-sectional analysis of Demographic and Health Surveys. *Lancet Child Adolescent Health, 1*(3),203-212. https://doi.org/10.1016/S2352-4642(17)30025-1

Phillippi, J. and Lauderdale, J., 2018. A guide to field notes for qualitative research: Context and conversation. *Qualitative Health Research*, *28*(3), 381-388. https://doi.org/10.1177/1049732317697102.

Polit, D.F. and Beck, C.T., 2010. Generalization in quantitative and qualitative research: Myths and strategies. *International Journal of Nursing Studies*, *47*(11), 451-1458. https://doi.org/10.1016/j.ijnurstu.2010.06.004.

Ritchie, J. and Lewis, J., 2014. *Qualitative research practice: A guide for social science students and researchers* (2nd ed.). London: Sage Publications.

Rukundo, G.Z., Abaasa, C., Natukunda, P.B., et al., 2015. Antenatal services for pregnant teenagers in Mbarara Municipality, Southwestern Uganda: health workers and community leaders' views. *BMC Pregnancy and Childbirth,* 15,351. doi 10.1186/s12884-015-0772-0

Sewpaul, R., Crutzen, R., Dukhi, N., Sekgala, D. and Reddy, P., 2021. A mixed reception: perceptions of pregnant adolescents' experiences with health care workers in Cape Town, South Africa. *Reproductive Health*, *18*(1),167. https://doi.org/10.1186/s12978-021-01211-x.

Sewpaul, R., Resnicow, K., Crutzen, R., et al., 2025. A Tailored mHealth Intervention for Improving Antenatal Care Seeking and Its Determinants Among Pregnant Adolescent Girls and Young Women in South Africa: Pilot Randomized Controlled Trial. *JMIR Mhealth Uhealth*, 13. https://mhealth.jmir.org/2025/1/e59144

Chavula, M.P., Zulu, J.M., Goicolea, I., et al., 2023. Unlocking policy synergies, challenges and contradictions influencing implementationof the Comprehensive Sexuality

Education Framework in Zambia: a policy analysis. *Health Research Policy and Systems*, 21, 97. https://doi.org/10.1186/s12961-023-01037-y

Shee, A.W., Frawley, N., Robertson, C., et al., 2021. Accessing and engaging with antenatal care: an interview study of teenage women. *BMC Pregnancy and Childbirth, 22,* 693. https://doi.org/10.1186/s12884-021-04137-1

Shefer, T., Bhana, D. and Morrell, R., 2013. Teenage pregnancy and parenting at school in contemporary South African contexts: Deconstructing school narratives and understanding policy implementation. *Perspectives in Education*, *31*(1), 1-10.

Shenton, A.K., 2004. Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, 22, 63–75. DOI: 10.3233/EFI-2004-22201

Singh, P.K., Rai, R.K., Alagarajan, M. et al., 2012. Determinants of maternity care services utilization among married adolescents in rural India. *PloS One*, *7*(2), p.e31666. https://doi.org/10.1371/journal.pone.0031666.

Smith, A., Leach, G. and Rossouw, L., 2024. The timing of antenatal care access for adolescent pregnancies in Cape Town, South Africa. *African Journal of Primary Health Care & Family Medicine*, *16*(1), 4192. https://doi.org/10.4102/PHCFM.V16I1.4192.

Srikwan, N., Klunklin, P., Sripichyakarn, K., et al., 2024. Implementation of Comprehensive Sexuality Education in Primary Schools in a Province of Northern Thailand. *Pacific Rim International Journal of Nursing Research*, *28*(1), 53-70. https://doi.org/10.60099/prijnr.2024.264799.

Stephano, E.E., Yusheng, T., Yamin, L. and Mtoro, M.J., 2025. A multilevel analysis of trends and predictors associated with teenage pregnancy in Tanzania (2004–2022): evidence from demographic and health surveys. *BMC Public Health*, *25*(1), p.2559. Available at: https://doi.org/10.1186/s12889-025-23752-7

Tabiri, J., Adzordor, P., Bawontuo, V., et al., 2024. Adolescent girls' and young mothers' knowledge and use of antenatal care in the Ahafo Region, Ghana: A cross-sectional study. *African Journal of Primary Health Care & Family Medicine, 16*(1), a4259. https://doi.org/10.4102/phcfm.v16i1.4259

Tolossa, T., Gold, L., Dheresa, M., et al., 2024. Adolescent maternal health services utilization and associated barriers in Sub-Saharan Africa: A comprehensive systematic review and meta-analysis before and during the sustainable development goals. *Heliyon*, 10, e35629. doi: 10.1016/j.heliyon.2024.e35629

Tyumre, A., 2020. Teenage pregnancy and Impact upon parents: A challenge to pastoral care. PhD Thesis, University of Pretoria

Umubyeyi, B.S., 2024. Curbing teenage pregnancy in South Africa's schools. *Dhaulagiri Journal of Sociology and Anthropology*, 18(2), 35–45. https://doi.org/10.3126/dsaj.v18i2.73315

Vasileiou, K., Barnett, J., Thorpe, S. et al., 2018. Characterising and justifying sample size sufficiency in interview-based studies: systematic analysis of qualitative health research over a 15-year period. *BMC Medical Research Methodology*, *18*(1), 148. https://doi.org/10.1186/s12874-018-0594-7.

Warri, D. and George, A., 2020. Perceptions of pregnant women of reasons for late initiation of antenatal care: A qualitative interview study. *BMC Pregnancy and Childbirth*, 20,70 https://doi.org/10.1186/s12884-020-2746-0.

Willan, S., 2013. A Review of Teenage Pregnancy in South Africa – Experiences of Schooling, and Knowledge and Access to Sexual & Reproductive Health Services. Partners in Sexual Health (PSH).

Williams, M.E. and Garrido, M., 2020. *Young Parents Logic Model: Selected Annotated Bibliography*. Healthy Teen Network. Available from: http://www.healthyteennetwork.org/resources/young-parents-logic-model/ [Accessed 27 September 2025].

Witter, S., Anderson, I., Annear, P., et al., 2019. What, why and how do health systems learn from one another? Insights from eight low-and middle-income country case studies. *Health Research Policy and Systems*, *17*(1),9. https://doi.org/10.1186/s12961-018-0410-1.

World Health Organization., 2018. *WHO Recommendations on Antenatal Care for a Positive Pregnancy Experience: Summary*. Geneva: World Health Organization

World Health Organization., 2023. *Global accelerated action for the health of adolescents (AA-HA!): Guidance to support country implementation*. Geneva: WHO. Available from: https://www.who.int/publications/i/item/9789241512340 [Accessed 228 September 2025]

World Health Organization., 2024. *Adolescents in a changing world: The case for urgent investment.* Geneva: World Health Organization.

Worku, E.B., Woldesenbet, S.A., 2016. Factors that Influence Teenage Antenatal Care Utilization in John Taolo Gaetsewe (JTG) District of Northern Cape Province, South Africa: Underscoring the Need for Tackling Social Determinants of Health. *International Journal of MCH and AIDS*, *5*(2), 134-145

Young, A.M., Okpara, N., Chelwa, N., et al., 2024. Navigating antenatal care: The lived experiences of adolescent girls and young women and caregiver perspectives in Zambia. *Women's Health*, *20*, 1-10. https://doi.org/10.1177/17455057241281482.

Ziblim, S.D., Yidana, A. and Mohammed, A.R., 2018. Determinants of antenatal care utilization among adolescent mothers in the Yendi municipality of northern region, Ghana. *Ghana Journal of Geography*, *10*(1), 78-97. https://doi.org/10.4314/gjg.v10i1.5.

APPENDIX A -Ethics clearance certificate

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

R14/49 Mrs Hlubikazi Ntamehlo

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M230139 M231117-A-0001

NAME: (Principal Investigator)	Mrs Hlubikazi Ntamehlo
DEPARTMENT:	School of Public Health Mountainview and Freedom Park Primary Healthcare Clinics
DEGREE:	Master of Public Health
PROJECT TITLE:	Facilitators and Barriers to accessing antenatal care experienced by adolescents in Primary Health Care facilities at the City of Johannesburg district in the Gauteng Province
DATE CONSIDERED:	27-Jan-2023
DECISION:	Approved unconditionally
CONDITIONS:	N/A
NOTE:	Application Number: MED 22-11-065
SUPERVISOR:	Dr Nonhlanhla Nxumalo
APPROVED BY:	Prof P. Ruff, Chairperson, HREC (Medical)
DATE OF APPROVAL:	17-Nov-2023 **EXPIRY DATE:** 16-Nov-2028

This clearance certificate is valid for 5 years from data of approval. Extension may be applied for.

DECLARATION OF INVESTIGATOR(S)

I/we fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report** in the month date of convened meeting each year until study is closed. Failure to submit annual report will result in ethics clearance certificate suspension. The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. Unreported changes to the application may invalidate the clearance given by the HREC (Medical). Email a signed copy of ethics clearance certificate to HREC-Medical.ResearchOffice@wits.ac.za

Signature of Principal Investigator

11/01/2024
Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

APPENDIX B - Plagiarism Declaration

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

FACULTY OF HEALTH SCIENCES

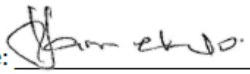
PLAGIARISM DECLARATION TO BE SIGNED BY ALL HIGHER DEGREE STUDENTS

SENATE PLAGIARISM POLICY: APPENDIX ONE

I Hlubikazi Ntamehlo (Student number: 2352292) am a student registered for the degree of Master of Public Health in the academic year 2020.

I hereby declare the following:

- I am aware that plagiarism (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong.
- I confirm that the work submitted for assessment for the above degree is my own unaided work except where I have explicitly indicated otherwise.
- I have followed the required conventions in referencing the thoughts and ideas of others.
- I understand that the University of the Witwatersrand may take disciplinary action against me if there is a belief that this is not my own unaided work or that I have failed to acknowledge the source of the ideas or words in my writing.
- I have included as an appendix a report from "Turnitin" (or other approved plagiarism detection) software indicating the level of plagiarism in my research document.

Signature:  Date: 03/10/2025

APPENDIX C: Interview Guide

Facilitators and Barriers to accessing antenatal care experienced by pregnant adolescents in at Primary Health Care facilities at a district in the Gauteng Province

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Introduction

Hello. My name is Hlubikazi Ntamehlo. I am a Master of Public Health student at the University of Witwatersrand. Thank you for agreeing to be interviewed. The interview should take about 45 to 60 minutes. Are you happy to start?

I am turning on the audio recorder to capture the interview.

Is that ok with you?

1. **Yes**
2. **No**

A. PARTICIPANT CHARACTERISTICS

First, I just want to ask you some questions about yourself.

How old are you?	
Who do you currently live with?	
Do you attend school/work or other?	
If you attend school, what grade?	
If you do not attend school, what grade did you finish?	
If no to school, why did you leave school?	

B: EXPERIENCES OF PREGNANT ADOLESCENTS

1. What were feelings or thoughts when you discovered that you were pregnant?

Probe:

- Can you tell me if there was anyone available when you found out?
- Can you explain the extent to which they were helpful in that experience?

2. What was your experience after disclosing your pregnancy to your parents/guardian/the person you told?

Probe:

- How long did it take you to inform someone?
- Why did it take you that amount of time?
- Who did you inform first and why?
- How did the way they responded make you feel?

3. Tell me about your perceived reaction of the rest of your family and community?

Probe:

- How did the reaction from family make you feel?
- To what extent was it easy to disclose to the rest of the family?

4. Can you explain the extent to which you receive support from family members?

Probe:

- Who do you think supports you the most?
- Can you describe how they support you?
- To what extent were you helped to decide about going to a clinic? Please explain how they helped.

C: PERCEPTIONS OF BARRIERS TO ACCESSING ANC SERVICES

5. Can you tell me whether you decided to attend antenatal care?

Probe:

- If you decided to come, who helped you with that decision?

6. What was your experience of attending antenatal care visits.

Probe:

- What was the attitude of the nurses during your clinic visits?

Tell me about the type of health information you received when visiting the clinic? (Adolescent specific guidance)

- Tell me about how you felt when you first visited the clinic? Why did you feel that way?
- To what extent did you feel judged by the health care professionals at the clinic?

7. What are some of the things that make it difficult for you to get to antenatal care clinic?

Probes:

- What are some of the challenges that you experience in visiting antenatal care clinic, if any?
- What would you consider as an unmet need for your age groups at antenatal services?
- What are your experiences of waiting before you are attended by nurses?

8. Tell me about any instances where you perceived the nurse's questions or comments as upsetting or made you nervous.

Probe:

- Can you give me an example of these questions or comments?

9. To what extent do you think the services rendered at antenatal clinic are beneficial to you? Give me an example.

10. Can you think of any incidences in the clinic, whether by nurses or other staff members that affected your clinic visit?

Probes:

- If you were ever demotivated or stopped attending, can you tell me the reasons? • To what extent did it have to do with the nurses' attitude/comments or treatment? Please tell me a bit more about what happened

11. Can you tell me about the extent to which you can afford to come to the antenatal care services?

Probes:

- To what extent do you sometimes have to pay for services rendered?
- To what extent have you sometimes been referred to private doctors? If it has happened, why were you referred?
- Who supports you financially currently?

What are your thoughts/feelings regarding money involving travelling to the clinic

D: PERCEPTIONS OF FACILITATORS TO ACCESSING ANC SERVICES

12. Can you explain what enables you to attend antenatal services regularly?

Probes:

- To what extent was the attitude of the nurse during your attendance at the clinic a motivation?
- To what extent are the nurses approachable when you need assistance at the clinic?
- To what extent do you feel that you were given enough information to understand your pregnancy?
- To what extent was the information that was given to you helpful to gain knowledge about your pregnancy?
- To what extent are the nurses reasonable in what you should do to promote health during your pregnancy? If not reasonable, please explain. What would make it reasonable?
- To what extent are you given an opportunity to give input into your concerns?

13. What would you suggest to the clinic to improve antenatal care services in this clinic?

Thank you for giving me your views and experiences.

APPENDIX D – Consent form (for in-depth interview)

Title of study: Facilitators and Barriers to accessing antenatal care experienced by adolescents in

Primary Health Care facilities at the City of Johannesburg (COJ) district in the Gauteng Province.

I have read the participant information sheet and the researcher has explained the study to me prior to the interview. The study is about exploring adolescent's experiences of accessing antenatal care (ANC) services in Primary Health Care facilities in the COJ district in Gauteng Province.

I understand that the researcher will be asking me questions related to the topic mentioned. I am aware that my responses will be written in a report which will be read in the future by those that are involved in the work of ANC care for adolescents, such as PHC nurses, those in the Department of Health, adolescents who seek ANC care services and other agencies. My responses may be used as part of a publication or report that documents the experiences of antenatal care services. The information gathered will not be used for commercial purposes.

I understand that the researcher/s involved in this study will make every effort to ensure confidentiality and that my name will not be used in the study reports, and that comments that I make will not be reported back to anybody else. I understand that the participation in the study is voluntary and I can withdraw at any stage. There will be no negative consequences if I decide not to participate or withdraw. I also understand that I do not have to answer any questions that I am not comfortable with and I can stop the interview at any time.

□ **Yes (***please tick)* **I agree to be interviewed**

□ **No** *(please tick)* **I do not agree to be interviewed**

Signature: **Date:**

Participant Name: **Time:**

(please print name)

I certify that S/he apparently understood the nature and the purpose of the study and consents to the participation in the study. S/he has been given opportunity to ask questions which have been answered satisfactorily.

Signature: **Date:**

Designee/investigator's name **Time:**

(please print name)

APPENDIX E - Consent Form (to be audio-recorded)

Title of study: Facilitators and Barriers to accessing antenatal care experienced by adolescents in

Primary Health Care facilities at the City of Johannesburg (COJ) district in the Gauteng Province

I have read the participant information sheet and the researcher has explained the study to me prior to the interview. The study is about exploring adolescents' experiences of accessing antenatal care services in Primary Health Care facilities in the COJ district in Gauteng Province. I am consenting to be audio recorded in the in-depth interviews.

I understand that the interview will be audio-recorded, and the audio will be destroyed two years after the interview. The audio recording will only be accessed by the researcher and her supervisor. I am aware that the information gathered will be written in a report which will be read in the future by those that are involved in the work of adolescents' antenatal care services.

I understand that the researcher/s involved in this study will make every effort to ensure confidentiality and that my name will not be used in the study reports. I understand that the audio recording will be heard by the researcher and her supervisors. I understand that the participation in the study is voluntary and I can withdraw at any stage. There will be no negative consequences if I decide not to participate or withdraw. I also understand that I do not have to answer any questions that I am not comfortable with and I can stop the audio recording at any time. I understand that I can change my mind at any stage, and it will not affect me in any way.

□ **Yes** please *tick* I **agree to be audio recorded during the interview**

□ **No** please *tick* I **do not agree to be tape recorded during the interview**

Signature: _____ **Date: _____**

Time: _____

I certify that s/he apparently understood the nature and the purpose of the study and consents to the participation in the study. S/he has been given opportunity to ask questions which have been answered satisfactorily.

Signature: _____ Date: _____

Designee/investigator's name: _____ Time: _____

APPENDIX F - Consent Sheet -Parent/Guardian of a Minor

Title of the Research Project: Facilitators and Barriers to accessing Antenatal Care Experienced by adolescents in Primary Health Care Facilities at the City of Johannesburg district in the Gauteng Province.

1. I have given a Participant Information Sheet which explains the nature and processes involved in this study, which is attached hereto;

2. I was given to read it, or had it read to me in a language I best understand;

3. I was given time to ask any questions I wanted to and found any answers given to me to be reasonable and satisfactory;

4. I believe I fully understand why the study is being conducted and what the intended outcomes will be;

5. I understand that there will be no immediate benefit to me or my child, should I agree to participate, nor will I receive any payment; conversely, participation will not cost me anything but my time.

6. I understand that, even if I initially consent to take part in the study, I may subsequently withdraw my child's participation at any time and would not be required to give any reasons; if that happened, any data collected about my child for the purposes of the study would immediately be destroyed, unless I give consent for it to be retained.

7. I have been given a range of contact details, listed below. If I require further information or become concerned about any aspect of this study, I am free to speak to any of these contacts.

Contact details:

NAME: Hlubikazi Ntamehlo ,Principal Investigator, **telephone no**:011 407 6868 **CELL NO**: 083 286 0388 or by **e-mail** at 2352292@students.wits.ac.za

NAME: Dr. Nonhlanhla Nxumalo ,Supervisor, on **telephone no**: 717-3432 **CELL NO:** 082 337-8573 or by **e-mail** at Nonhlanhla.nxumalo@wits.ac.za

Professor P Ruff, Chairperson of the Human Research Ethics Committee (Medical) at the University of Witwatersrand, who may be contacted via any one member of the secretariat.

The **telephone numbers** for the Committee secretariat are 011 717 2700/1234/2656/1252 and the **e-mail addresses** are Zanele.Ndlovu@wits.ac.za, Rhulani.Mukansi@wits.ac.za, Mapula.Ramaila@wits.ac.za and lain.Burns@wits.ac.za

[1] A minor in South African law is a person under 18 years of age.

Name of child: _____

Name of parent or guardian: _____

Date: _____

Place: _____

Signature or mark of parent: _____

Witnessed by:

Name of Witness: _____

Signature: _____

Date: _____

APPENDIX G - Participant information sheet for In -depth interview:

Title of the study: Facilitators and Barriers to accessing antenatal care experienced by adolescents in

Primary Health Care facilities at the City of Johannesburg (COJ) district in the Gauteng Province

Good day. Thank you for giving me some of your time to listen to me. My name is Hlubikazi Ntamehlo. I am a Master of Public Health student at the University of the Witwatersrand. I invite you to participate in this study.

What is this research about?

I am conducting a study to examine adolescents' experiences of accessing antenatal care (ANC) services.

Considering your experiences of ANC services at some point in your pregnancy, I have approached you because I feel that you have the relevant information regarding these experiences.

If you agree, the interview discussion will be audio-recorded to ensure that the information that I write later accurately represents your views. No-one will be identified by name on the audio recording.

Consent

Permission to carry out this project has been obtained from the Provincial Department of Health (Gauteng). Ethical approval for this study has been obtained from the University of the Witwatersrand Ethics Committee for Research on Human Subjects (Medical).

Will there be any harm from participating?

The level of risk to you as a participant is minimal as the likelihood and magnitude of possible harm are no greater than those imposed by daily routine. No harm will come to you from participating in the study. All information will be kept confidential and no one in the clinic or the Department of Health will know what you have said. Similarly, there will be no negative consequences if you do not want to be interviewed.

During the interview you have the right to decline to answer any of the questions or stop the interview at any time. The fact that you have done this will not be reported to anybody, will not be recorded in the research report and will not have any negative consequences for you.

The Interview

The interview will take about 45 to 60 minutes. It will be carried out in English unless you would prefer it to be in your own language. The interview will be carried out at a time and place that is convenient for you.

Voluntary Participation

As part of this study, I would like to invite you to take part in an interview and I will be using a questionnaire as a guide. Your participation is completely voluntary, and you may withdraw at any time or refrain from answering any question without any consequences.

Confidentiality

The information from the interviews will be used for research purposes. Anonymity will be protected by assigning codes to participants and data presentation will avoid specific individuals being identified. The knowledge gained from this research will be disseminated in summary form, without revealing the identities of the participants. I will therefore not disclose participants' identities or use names in any reports of this research. Audio recordings will be kept on a secure computer server or external drive, and participant codes will be kept in a locked filing cabinet under the care of the researcher for the duration of the data collection and analysis and will be destroyed once analysis is complete. The data collected from this research project will be stored in computer file under a secure encrypted password to ensure confidentiality. No one other than myself and the study supervisor will be allowed to see the records of the interviews.

Anonymized data will be digitized and stored in the researcher's data archive for at least two years after publication of the findings and for six years if there is no publication.

Permission for audio recording of the interviews

To make the interview easier for us, I will also ask if I can audio record the interview. If you do not want the interview to be audio recorded, I will write your responses manually. If you give me permission to audio record the interview I will listen to the recording and write down everything. Your name will not be recorded to ensure confidentiality. I will keep the audio recordings under lock and key for two years, after which they will be destroyed.

Approval for and benefits of this work

There will be no personal costs to you if you participate in this project. You will not receive any direct benefits from participation however, there are indirect benefits in that the study will

contribute to new ideas and insights regarding the experiences of adolescents in using antenatal care services at PHC. There are no disadvantages or penalties if you do not choose to participate or if you withdraw from the study. The study has been approved by the ethics committee of University of the Witwatersrand, and the Provincial Department of Health (Gauteng).

What if I have any questions?

If you have any questions during or afterwards about this research, feel free to contact the researchers by using the details below:

Hlubikazi Ntamehlo (Researcher): email address 2352292@students.wits.ac.za , Mobile number:083 286 0388

Dr Nonhlanhla Nxumalo (Supervisor): Nonhlanhla.Nxumalo@wits.ac.za , 011 717 3432

Contact details of Human Research Ethics Committee (Medical) (HREC) Administrator and Chair:

Please also find the contact details of the Human Research Ethics Committee (Medical) which oversees the ethical aspects of this study so that you may direct any queries and/ or complaints regarding research participation:

1. HREC Chair contact details:

Professor Clement Penny

Telephone: +11-717-2301

Email: clement.penny@wits.ac.za

2. Administrative Officers' contact details:

Ms. Zanele Ndlovu/Mr. Rhulani Mkasi/Ms. Lebo Moeng

Telephone: +11-717-2700/2656/1234/1252

APPENDIX H - City of Johannesburg District Approval



Research Committee of Johannesburg Health District

Enquiries: Prof S. Moosa |researchjoburg@gmail.com

DATE: 19 January 2024

ATT: Mrs Hlubi Ntamehlo

EMAIL: 2352292@students.wits.ac.za

Dear Sir/Madam

STUDY TITLE: Facilitators and Barriers to accessing antenatal care experienced by adolescents in Primary Health Care facilities at the City of Johannesburg district in the Gauteng Province

NHRD REF. NO.: GP_202312_029

OFFICIAL APPROVAL

The District Research Committee has reviewed your application. This letter serves as a final approval letter for this study.

The following conditions must be observed:

- The facilities in which the research will be conducted are listed below
- These facilities will be visited from: **2024/01/19 to 2028/11/16**
- Participants' rights and confidentiality will be maintained all the time.
- Neither the District nor the facility will incur any additional cost for this study.
- No resources (Financial, material and human resources) from the above facilities will be used for the study.
- The study will comply with Publicly Financed Research and Development Act, 2008 (Act 51 of 2008) and its related Regulations.
- You will submit a copy (electronic and hard copy) of your final report. In addition, you will submit an annual progress report to the District Research Committee.
- If this is academic research then your supervisor and the University will ensure that these reports are being submitted timeously to the District Research Committee.
- The District must be acknowledged in all the reports/publications generated from the research and a copy of these reports/publications must be submitted to the District Research Committee.
- You will liaise with the manager/s listed below as relevant before initiating the study.

We reserve our right to withdraw our approval, if you breach any of the conditions mentioned above. Please feel free to contact us, if you have any further queries.

On behalf of the District Research Committee, we would like to thank you for choosing our District to conduct such an important study.



Regards,

_____

Prof S. Moosa

Chairperson: District Research Committee

Johannesburg Health District

As delegated by Mrs M.L. Morewane, Chief Director, Johannesburg Health District, and Mr. Frans Moseane, Acting ED Health, City of Johannesburg

List of Facilities Approved

- Mountain View Clinic

List of Managers

Sub District/ Hospiital	Sub District Manager/ Area Manager	Contact No.	Cell phone	Email
CoJ Admin	Mr Frans Moseane	011 407 – 7513 / 011 407 - 7535		FransMos@joburg.org.za
CoJ Research	Dr Keshni Arthur	011 4076395	(060) 548-0940	KeshniA@joburg.org.za

APPENDIX I - Turn-it-in report

Draft three Chapter one_five_31 March _ 2025_ FINAL FINALFINAL updated 31 Mar 2025 RI.docx

ORIGINALITY REPORT

15%	12%	10%	5%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

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7	Motsieloa, Lifutso. "Training of Community Health Workers in Ward-Based Outreach Teams: Exploring Experiences and Perceptions in Tshwane District", University of the Witwatersrand, Johannesburg (South Africa), 2025 Publication	<1%