THE BARRIERS TO ACCESS FOR MATERNAL HEALTH CARE AMONGST PREGNANT ADOLESCENTS IN THE MITCHELLS PLAIN SUB-DISTRICT

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KEYWORDS

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ABBREVIATIONS

ART- Antiretroviral therapy

HCW- Healthcare Worker

HIV- Human Immunodeficiency Virus

MTCT- mother-to-child-transmission

MOU- Maternity and Obstetrics Unit

SRH- Sexual and Reproductive Health

UN- United Nations

UNESCO- The United Nations Educational, Scientific and Cultural Organization

UNFPA- The United Nations Population Fund

UNICEF-United Nations Children's Fund

WHO- World Health Organization

ABSTRACT

Background and aim: Adolescent pregnancy holds numerous health and social risks for mother and child. Adolescent access to maternal health services is of vital importance to ensure that pregnant adolescents receive timely and effective health care. Evidence suggests that adolescents tend to seek medical care late in their pregnancies and attend fewer than the recommended four antenatal visits. This results in missed opportunities to improve maternal and newborn health due to untreated sexually transmitted diseases and uninhibited mother-to-child HIV transmission, resulting in low birth weight among other poor pregnancy outcomes.

Sub-Saharan Africa has the highest rate of adolescent births worldwide, in keeping with evidence that low-to-middle income countries have the highest rates of adolescent pregnancy. Adolescent pregnancy in South Africa remains a public health concern, and the Mitchells Plain sub-district has a particularly high rate of adolescent pregnancy. The aim of this study was thus to explore the barriers to access for maternal health care services amongst pregnant adolescents in the Mitchells Plain sub-district.

Methodology: This study used an exploratory qualitative design to explore the views of participants. Purposive sampling was used to select participants. In-depth semi-structured interviews were conducted with 10 pregnant adolescents at the Mitchells Plain Maternity and Obstetrics Unit (MOU), as well as 2 nursing staff working at Mitchells Plain MOU. Interviews were recorded and transcribed by the researcher herself. The thematic coding approach was then used to analyse the data.

Results: Results showed that fear of disclosing pregnancy, negative response to pregnancy disclosure, and feelings of shock and disbelief in response to pregnancy served as barriers to access to maternal health care services amongst pregnant adolescents. Negative perceptions of maternal health care services also served as a barrier to access to maternal health care services amongst pregnant adolescents. Negative perceptions included expected mistreatment by nursing staff and expected long waiting times. Many participants also reported poor knowledge of maternal health care services, which was a barrier to access to maternal health care services. Facilitators to access to maternal health care services included support and advice from parents or guardians, as

well as positive interactions with nursing staff. The support from parents and guardians often occurred after an initial negative response to disclosure of the pregnancy.

Conclusion and recommendations: Access to maternal health care services amongst pregnant adolescents is influenced by numerous factors. Societal norms and expectations about adolescent childbearing and knowledge about maternal health care services stand out as key factors in facilitating or hindering access to maternal health care services amongst pregnant adolescents. It is recommended that an inter-sectoral approach be adopted in improving access to maternal health care services amongst pregnant adolescents. This includes incorporating maternal health education into school's life skills curriculum, a well-functioning referral pathway between schools and clinic to facilitate early access to maternal health care services, as well as involvement by the social development sector to facilitate pregnancy disclosure for pregnant adolescents who fear negative response to disclosure of the pregnancy from their parents or guardians.

DECLARATION

I, Michelle Olivia Erasmus, declare that *The barriers to access for maternal health care amongst pregnant adolescents in the Mitchells Plain Sub-district*, is my own work, that is has not been submitted before for any degree or examination at any other university, and that all sources I have used or quoted have been acknowledged.

Michelle Olivia Erasmus

Signature……

Date: November 2017

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DEDICATION

This work is dedicated to the memory of my departed grandparents, Edward Richards, Cupido Fransman and Sarah Fransman.

This work is also dedicated to my parents, Albert and Aloma Fransman, my grandmother Joan Richards, my husband Marcelino, and my siblings, Desiree, Gradwell and Ricardo. Your love and support are invaluable.

Finally, I want to dedicate this work to my daughters, Madison and Morgan, my niece Zoe, and my nephews Matthew and Kyler. May you be inspired to reach for your dreams.

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CHAPTER 1- INTRODUCTION

1.1 BACKROUND INFORMATION

An adolescent is defined as any person between 10 and 19 years of age (WHO, 2017). Of all annual births worldwide, 11% occur in girls aged 15 to 19 years of age (WHO, 2014). This amounts to approximately 16 million births amongst adolescents. Of these births, 95% occur in low to middle income countries. The highest birth rates amongst adolescents are found in sub-Saharan Africa, with 200 per 1000 births in sub-Saharan Africa occurring amongst the adolescent age group (UNICEF, 2016). Adolescent birth rates in developing countries are more than double the adolescent birth rates in most developed countries, with developed countries such as Japan showing adolescent birth rates of less than 1% annually (WHO, 2008).

Despite efforts to decrease maternal mortality, sub-Saharan Africa still has the highest maternal mortality rates worldwide (UN, 2014). In terms of maternal mortality, maternal disorders are the second leading cause of death amongst adolescent girls, with adolescent girls facing a higher risk of complications and death from pregnancy and childbirth compared to older women (AbouZahr, 2013; WHO, 2014). Annually approximately 15% of maternal deaths worldwide occur in adolescent girls. However, Africa has a higher maternal mortality amongst adolescents in comparison with the global average, with 26% of maternal deaths in Africa occurring amongst adolescents. Furthermore, sub-Saharan Africa also has the highest rate of unsafe abortions worldwide (AbouZahr, 2013). According to AbouZahr (2013), it is estimated that one out of every four unsafe abortions in sub-Saharan Africa occurs in the adolescent population. However, it is thought that many adolescent pregnancies, births and abortions in sub-Saharan Africa may be undocumented, resulting in difficulties in accurate data collection regarding adolescent pregnancies.

Though South Africa saw an initial decline followed by stagnation in adolescent pregnancy rates over recent years, it still has a relatively high adolescent birth rate, with 49 per 1000 births occurring amongst adolescent females in South Africa (World Bank, 2015). The percentage of females between the ages of 15 and 19 years who have started bearing children has remained at

16% in 1998 as well as in 2016 (Department of Health, 2017). Adolescent pregnancy in South Africa is most prevalent amongst the second poorest percentage of the population, and least prevalent amongst the wealthiest percentage of the population (Department of Health, 2017). In 2015, KwaZulu Natal had the highest number of births amongst females between the ages of 15 and 19 years, with 30 233 births recorded (Statistics South Africa, 2016). The Western Cape had had recorded 10 382 births amongst females between 15 and 19 years of age for 2015, the sixth highest rate amongst this age group in South Africa. The lowest number of births amongst females between 15 and 19 years of age for 2015 was found in the Northern Cape, with 4 157 births (Statistics South Africa, 2016).

Mitchells Plain sub-district in Cape Town, has a population of 310 485 (City of Cape Town, 2013). In 2012/2013, Cape Town in the Western Cape had a birth rate of 54.6 per 1000 amongst women under the age of 18 years, with Mitchells Plain sub-district showing a birth rate of 56 per 1000 deliveries for women under 18 years of age, relatively higher than the national average (Western Cape Government Provincial Treasury, 2013). The City of Cape Town had a maternal mortality ratio of 78.9 per 100 000 live births in 2012/2013, but there was very scanty data regarding maternal mortality amongst adolescents. It is suspected that maternal deaths, including amongst adolescents, are under-reported or misclassified on death certificates (Groenewald et al, 2008).

Adolescent pregnancy is a multi-faceted issue, and has been shown to have various negative consequences. Pregnant adolescents are more prone to premature labour, obstetric complications and HIV transmission (UN, 2014; AbouZahr, 2013; WHO, 2014; UNFPA, 2013). Children of adolescent mothers also have worse outcomes than children of older mothers, with issues such as low birth weight and higher mortality rates (WHO, 2014; Althabe et al., 2013).

Adolescent pregnancy in South Africa is indicative of the fact that adolescents are engaging in high risk sexual behaviours, which in turn puts them at risk of contracting sexually transmitted diseases such as HIV (Ehlers et al., 2000; Kanku & Mash, 2010). Pregnant adolescents are thus more likely to be exposed to HIV. In keeping with this, Christofides et al. (2014) report that early adolescent pregnancy is associated with increased incidence of HIV. Furthermore, adolescents have shown slower uptake of antenatal ART, as well as higher mother-to-child transmission of

HIV (Fatti et al., 2014). This makes early access to maternal healthcare services, amongst pregnant adolescents, a priority in the management of HIV.

The social and economic effects of adolescent pregnancy are also far-reaching (UNESCO, 2014). Adolescent pregnancies are more common in poorer communities with high rates of crime, violence, alcohol and drug abuse (Klein, 2005; UNESCO, 2014; Vundule et al., 2001; UNFPA, 2013). Adolescent mothers very often do not finish their schooling, leading to fewer work opportunities or a reliance on low-income work (UNFPA, 2013; UNESCO, 2014; Flanagan et al., 2013). This has an impact on the livelihood of the adolescent mother and child, the family unit, as well as the community as a whole, making it more difficult for individuals and communities to achieve economic growth and move out of poverty.

Given the physical, psychological, social, and economic implications of adolescent pregnancy, it is clear that adolescent pregnancy is a public health problem which requires collaboration between different sectors (UNFPA, 2013). This includes collaboration between health, education and social development sectors. Access to comprehensive care during pregnancy is thus imperative for this vulnerable group. However, adolescents are known to under-utilize sexual and reproductive health (SRH) care services, including antenatal care (Worku & Woldesenbet, 2016; Alli et al., 2012; Burack, 2000). Pregnant adolescents are also known to access maternal health care services very late in pregnancy and show poor attendance at antenatal clinics (Tsawe & Susuman, 2014; Atuyambe et al., 2008). This creates a missed opportunity for HIV counselling, testing and treatment, and prevents early detection of potential problems in preparation for labour. Access to maternal health care services is thus of utmost importance for the health of the adolescent mother and her baby.

The SRH rights of adolescents in South Africa are protected by law, yet adolescents still face numerous barriers to accessing SRH care services (Hoopes et al., 2015). Sexuality amongst adolescents is still a controversial topic in many communities, and adolescent pregnancy is seen as something shameful (James et al., 2012; Ilika & Anthony, 2004), creating an environment in which adolescents fear disclosing their pregnancy. This makes adolescent pregnancy and the provision of antenatal care to adolescents a complex issue for both patient and healthcare provider.

Access to healthcare is defined as "the opportunity to identify healthcare needs, to seek healthcare services, to reach, obtain or use healthcare services and to have healthcare needs fulfilled" (Levesque et al., 2013:8). This means that factors such as the ability to recognise that one has a particular health care need, seek health care, reach healthcare services, pay for health care services and engage with healthcare providers are important dimensions of access. When any of these elements are compromised, it acts as a potential barrier to access to healthcare services.

Keeping the above-mentioned definition of access in mind, I will be exploring the issue of adolescent access to maternal health care services from the perspective of pregnant adolescents as well as healthcare providers in the Mitchells Plain sub-district.

1.2 CONTEXT

In 2016, 16% of South African girls between the ages of 15 and 19 years had started childbearing (Department of Health, 2017). Cape Town in the Western Cape has a high rate of adolescent pregnancy, with a birth rate of 54.6 per 1000 amongst women under the age of 18 years in 2012/2013 (Western Cape Government Provincial Treasury, 2013). The Mitchells Plain sub-district in Cape Town, however, had a birth rate of 56 per 1000 deliveries for women under 18 years of age for 2012/2013, which raises concern about the rate of adolescent childbearing in Mitchells Plain.

Mitchells Plain sub-district in the Western Cape, Cape Town, has a population of 310 485 (City of Cape Town, 2013). Mitchells Plain sub-district in the Western Cape, Cape Town, has a population of 310 485 (City of Cape Town, 2013). The Mitchells Plain community is predominantly coloured, with 95% of households living in formal dwellings, 99% of dwellings with access to piped water and electricity and 96% of households with flush toilets connected to a public sewer system. Despite this, the Mitchells Plain community has high levels of crime, gangsterism, unemployment and poverty (Department of Provincial and Local Government, 2011). According to the Department of Provincial and Local Government (2011), approximately 48% of households in Mitchells Plain earn below the poverty line, and 43% of residents who fall within employment age ranges are employed. Furthermore, there are high levels of overcrowding in certain areas. Large numbers of residents make use of a well-established public transport

system, in the form of buses, taxis and trains (Department of Provincial and Local Government, 2011).

Mitchells Plain is divided into approximately 9 sub-areas, and each sub-area has a primary health care facility located within 2.5 kilometres (Department of Provincial and Local Government, 2011). It has one private hospital and a district hospital, as well as numerous private general practitioners (GP) and pharmacies. Contraceptives, HIV testing and pregnancy testing is available at primary health care facilities as well as private health care providers and pharmacies. Mitchells Plain MOU services residents from all sub-areas in Mitchells Plain, as well as residents from Khayelitsha, Philippi, Samora Machel and numerous informal settlements that have been erected around the Mitchells Plain area.

The City of Cape Town had a maternal mortality ratio of 78.9 per 100 000 live births in 2012/2013. However, there is very little available data about maternal mortality amongst adolescents in particular. This could be due to possible errors in classification of causes of death amongst pregnant women, including adolescents (Groenewald et al., 2008). In light of the above-mentioned challenges, it is evident that reproductive health and access to maternal health services amongst adolescents needs to be explored.

The high rate of unplanned adolescent pregnancy in Mitchells Plain is in keeping with literature in that communities with high rates of crime, violence and unemployment also have high rates of adolescent pregnancy (Brahmbatt et al., 2014; Thobejane, 2015).

1.3 PROBLEM STATEMENT

Adolescent pregnancy has many potential negative implications, including higher risk for maternal mortality, serious adverse reproductive health problems, higher risk of mother-to-child transmission of HIV, mental health problems including depression, poorer health outcomes for children born to adolescent mothers and high development costs for communities in perpetuating the cycle of poverty (UNFPA, 2013). Adolescent mothers also face an array of socio-economic difficulties such as pressure to leave school, difficulty finding gainful employment, strained relationships with family and stigma from community (Ehlers et al., 2000). It is thus imperative

that research be conducted into access to services amongst pregnant adolescents in order to improve their health, social, and economic outcomes.

Pregnant adolescents may initiate antenatal care late in pregnancy and are more likely to attend fewer than the recommended four antenatal visits (Atuyambe et al., 2008; Phafoli et al., 2007). This puts this group at higher risk of adverse outcomes due to pregnancy. It is thus important that adolescent mothers receive timely and accessible health care and social support. However, there is little research into factors which influence access to maternal health services amongst adolescents. Mitchells Plain sub-district has a particularly high adolescent pregnancy rate. The aim of this study is thus to explore the barriers regarding access to maternal health services amongst pregnant adolescents in Mitchells Plain sub-district.

1.4 RATIONALE

Mitchells Plain has a high rate of adolescent pregnancy (Western Cape Government Provincial Treasury, 2013). The pregnant adolescent population may have late access to maternal health care services (Phafoli et al., 2007). Poor access and underutilization of maternal health care services is linked to poorer outcomes amongst pregnant adolescents and their infants.

The purpose of this study is to gain a better understanding into the perspectives of adolescents regarding access to maternal health services, as well as to gain understanding into how healthcare workers experience providing care to pregnant adolescents. Once we have a good understanding of how adolescents perceive access to maternal health care, this knowledge can be used to find ways of improving utilization of reproductive health care services for adolescents. This will help reduce maternal mortality and improve health outcomes for the adolescent mother and child. This data could be particularly useful to facility managers at Mitchells Plain MOU, as well as other health care workers (HCW's) to improve reproductive health care services to adolescents.

1.5 OUTLINE OF THESIS

This thesis is arranged as follows:

Chapter 1 introduces the issue of adolescent pregnancy and explains the rationale behind pursuing this research. Chapter 2 contains the literature review, which gives an understanding into what literature is available about adolescent pregnancy and access to SRH services amongst adolescents. Chapter 3 contains details of the research aims, objectives and study design, and provides details about the research methodology of the study. Chapter 4 presents the findings of the study. Chapter 5 follows, which contains the data analysis, discussion, and interpretation of the results. Lastly, chapter 6 presents the conclusion of the study and provides further recommendations based on the findings of the study about improving access to maternal health care services amongst adolescents.

CHAPTER 2- LITERATURE REVIEW

2.1 INTRODUCTION

This literature review focuses on adolescent access and utilization of sexual, reproductive and maternal health care services. Further available literature regarding risks of adolescent pregnancy and perceptions amongst adolescents regarding access to sexual and reproductive health (SRH) care services is also explored. This includes inconvenient clinic hours and fear of disclosure of pregnancy. The relationship between health care workers (HCW's) and adolescents may influence adolescent utilization of health care services, and available literature regarding is therefore be reviewed.

Lastly, I will explore the literature about the knowledge regarding sexual and reproductive health amongst adolescents, as well as the decision-making power of adolescents in seeking out health services.

2.2 RISK FACTORS FOR ADOLESCENT PREGNANCY

Unplanned adolescent pregnancy is an issue that affects many countries across the world. Of all births worldwide, 11% occur amongst adolescents (WHO, 2014). Furthermore, data from the World Health Organisation (WHO) shows that 95% of adolescent births occur in low to middle income countries, with sub-Saharan Africa bearing the highest number of adolescent births. In South Africa, the birth rate amongst adolescents is 49 per 1000 (World Bank, 2015).

Studies have shown that poor socio-economic conditions are associated with higher risk for unplanned adolescent pregnancy. Factors such as high levels of crime and violence, high levels of unemployment and poverty are all associated with high rates of unplanned adolescent pregnancy (Brahmbatt et al., 2014). Thobejane (2015) conducted a qualitative study in Limpopo, South Africa to explore factors which may contribute to teenage pregnancy, and identified poverty and family struggles as risk factors to unplanned adolescent pregnancy. Nkani and Bhana (2016) further state that many adolescent mothers come from poorer families, and the financial implications of caring for a child places further stress on household finances. The high

rate of adolescent pregnancy as well as the high rates of poverty and unemployment in Mitchells Plain sub-district is thus in keeping with trends described in the literature.

Understanding the socio-economic circumstances of individuals and communities is vital when addressing the issue of access to health care services (Dookie & Singh, 2012). Poverty and poor socio-economic conditions are often associated with poor access to health services (Copland et al., 2011). Furthermore, the adolescent population often faces difficulties in accessing sexual and reproductive health services, particularly those from poorer socio-economic conditions (Ehlers et al., 2000; Alli et al., 2012). This consequently results in underutilization of SRH care services amongst adolescents (Chandra-Mouli et al., 2014; Ehlers et al., 2000).

High rates of unplanned pregnancies may be testament to the fact that adolescents underutilize SRH care services, amongst other social drivers of adolescent pregnancy such as poverty. An unplanned pregnancy means that the pregnant adolescent engaged in unprotected sex and either did not use or incorrectly used birth control measures. Pregnant adolescents may therefore continue the pattern of underutilization of SRH services during the pregnancy (Burack, 2000). It is thus of utmost importance that reasons for poor access and poor utilization of maternal health care services be further investigated (Chandra-Mouli et al., 2013).

2.3 POTENTIAL RISKS ASSOCIATED WITH ADOLESCENT PREGNANCY

Adolescent pregnancy poses numerous risks for mother and child (UNFPA, 2013). These include biological, psychological, social and economic risks. Complications that directly stem from pregnancy or childbirth are the second leading cause of death amongst adolescent girls globally, with adolescent girls facing a higher risk of complications and death from pregnancy and childbirth compared to other women (AbouZahr, 2013; WHO, 2014).

Adolescent mothers have a higher risk of going into premature labour, and have a higher risk of having low birth weight babies in comparison to women older than 20 years of age (Fraser et al., 1995; Althabe et al., 2015). This trend may result from poor prenatal care, poor access and poor utilization of maternal health care services, as well as risk behaviour such as smoking during pregnancy (Klein, 2005). Factors such as access to and utilization of maternal health care services, poor nutrition during pregnancy, risk behaviour such as consuming alcohol and

smoking and general poor prenatal care may therefore be underlying factors to premature labour and low birth weight amongst adolescent mothers, rather than maternal age alone (Taffa & Obare, 2004; Raatikainen et al., 2005). This highlights the importance of early access to and utilization of maternal health care amongst pregnant adolescents.

In a randomized control trial in the Eastern Cape exploring the link between HIV infection and adolescent pregnancy, Christofides et al. (2014) found that early adolescent pregnancy was associated with an increased incidence of HIV. Overall, the study found that women who acquired HIV over the two years of follow-up were more likely to report early adolescent pregnancy than adult women and adolescents older than 15 years. Those with early adolescent pregnancy were three times more likely to acquire HIV than adult women. This was due to high risk sexual behaviour, greater number of sexual partners as well as greater age difference between those who reported early adolescent pregnancy and their partners. Dellar et al. (2015) conducted a series of case studies and reviewed the literature to find that early sexual debut and early pregnancy were identified as risk factors for HIV infection among young women in South Africa. Regions where adolescent pregnancies are prevalent show high rates of HIV prevalence, and these two issues therefore appear to be interrelated (Rutenberg et al., 2003).

Research suggests that adolescent mothers have a higher rate of mother-to-child-transmission (MTCT) of HIV than adult women (Horwood et al., 2013; Fatti et al., 2014). In a study by Horwood et al. (2013) in KwaZulu Natal, as well as a study by Fatti et al. (2014) in the Eastern Cape, it was found that the increased rate of MTCT amongst adolescents were found to be related to poor access to maternal health care services and poor adherence with ART regimes, rather than biological factors. Poor access to maternal health care services means that many pregnant adolescents do not get tested for HIV early during the pregnancy, leading to delays in commencing treatment if the pregnant adolescent is HIV positive. Poor access to health services may also lead to poor adherence to ART regimes during pregnancy, which results in increased MTCT rates amongst HIV positive adolescents.

Given the available evidence, we can see that the adolescent population that is at risk for unplanned pregnancy is also at risk of HIV infection as well as MTCT. High rates of unplanned

adolescent pregnancy show that adolescents are engaging in unprotected sexual activity, which heightens the risk of HIV infection (Mchunu et al., 2012).

2.4 PERCEPTIONS CONCERNING ACCESS TO HEALTH SERVICES AMONGST ADOLESCENTS

2.4.1 INCONVENIENT CLINIC HOURS AND IMPACT ON SCHOOL ATTENDANCE

Despite efforts to improve SRH knowledge amongst adolescents, research shows that adolescents still tend to underutilize SRH services (Tegegn et al., 2008). Young people may encounter many difficulties when accessing SRH services, which leads to decreased utilization (Lesedi et al., 2011). In a study in Limpopo, Mushwana et al. (2015) found that pregnant as well as non-pregnant high school girls felt that health care services were not readily available. Respondents indicated that clinics were open at times when they were still at school, making access to clinics difficult. Young people of both genders reported dissatisfaction with opening and closing times of clinics. Newton-Levinson et al. (2016) conducted a systematic literature review in low and middle-income countries regarding barriers to access to health care services for STI's amongst adolescents of both genders, and found that adolescents identified inconvenient clinic hours as a barrier to access to services for treatment of STI's. Alli et al. (2012) had similar findings in a study in KwaZulu Natal, South Africa, highlighting the effect of inconvenient clinic hours on access to SRH services amongst adolescents. Even though the aforementioned studies focus on reproductive health care services in general and not particularly on antenatal care, it highlights the fact that clinic timings are critical for the adolescent population.

Due to opening and closing times of clinics, attending antenatal clinics means that pregnant adolescents will miss school. The rate of school leaving amongst pregnant adolescents is high, and perceived difficulties with balancing antenatal clinic attendance with school attendance may contribute to poor attendance at antenatal clinics amongst adolescents, especially in early stages of pregnancy (Pell et al., 2013; UNESCO, 2014). Adolescent mothers who miss class because of medical appointments or other issues related to pregnancy or motherhood do not usually receive

assistance from teachers at school to catch up with classwork, and there are no programs in South African schools to assist adolescent mothers (Chigona & Chetty, 2007).

Apart from opening and closing times, adolescents are also unhappy about spending long hours waiting for a consultation at clinics (Mayeye et al., 2010; Godia et al., 2014; Onokerhoraye & Dudu, 2017). Lengthy waiting times creates dissatisfaction with services and adds to adolescents' reluctance to visit health care facilities for sexual and reproductive health care needs.

2.5 FEAR OF DISCLOSURE OF PREGNANCY

In the South African context, adolescent pregnancy is often viewed as undesirable, and is often a stressful time for adolescents and their caregivers (Richter & Mlambo, 2005). In a study in Mafikeng, South Africa, Mwaba (2000) found that adolescents of both genders viewed adolescent pregnancy as a negative event, which tarnishes the reputation of the family. An expected negative reaction by family and the community may mean that adolescents conceal their pregnancy for as long as possible (Hill et al., 2015; Phafoli et al., 2007). In many cases, pregnant adolescents encounter violence, anger and breakdown in relationships with parents or caregivers (Hill et al., 2015; Phafoli et al., 2007; Ilika & Anthony, 2004). The delay in disclosure of pregnancy leads to a significant delay in seeking antenatal care.

In a qualitative study in Limpopo, Richter and Mlambo (2005) found that adolescents were reluctant to visit clinics for reproductive health services due to fear of being recognized by community members, who may then inform their parents or caregivers that they have accessed reproductive health care. Adolescents therefore forego accessing SRH services in order to conceal any sexual activity (Rukundo et al., 2015; Ekong, 2016; Onokerhoraye & Dudu, 2017; Woog et al., 2015).

Despite the fact that sexual activity amongst adolescents is not socially acceptable in many communities, many adolescents are still sexually active (Gevers et al., 2013). This creates a situation where adolescents feel compelled to hide their sexual experiences from parents and older community members. The pregnant adolescent may therefore ignore, deny or dismiss early signs of pregnancy, leading to late confirmation of pregnancy and late consultation for antenatal care (Rukundo et al., 2015).

2.6 RELATIONSHIP WITH HEALTH CARE WORKERS

The relationship between adolescents and HCW's regarding sexual, reproductive and maternal health services may be a contributing factor to access and utilization of these services amongst adolescents. In a cross-sectional, descriptive study in the Eastern Cape, South Africa, Mayeye et al. (2010) found that adolescent respondents of both genders were unhappy with staff attitudes towards them. Wood and Jewkes (2006) had similar results in Limpopo, with adolescent girls reporting that nurses spoke to them in a disrespectful manner, resulting in adolescents avoiding attending clinics for their SRH care needs. Fear of visiting clinics due to an anticipated negative reception by clinic staff as well as older women at clinics serves as a major barrier to utilization of reproductive health services amongst adolescent girls (Erulka et al., 2005; Mfono, 1998; Durojaye, 2009). Having specific adolescent clinics does not guarantee that adolescent perceptions of HCW's will be positive, as adolescents who attend accredited adolescent-friendly clinics still report feeling disrespected and judged by HCW's when seeking sexual and reproductive health care services (Mathews et al., 2015).

Healthcare workers also face difficulties when providing sexual and reproductive health services to adolescents. Service providers to adolescents have their own personal beliefs about sexual activity amongst adolescents, and this may influence the manner in which they engage with adolescents (Alli et al., 2012). When HCW's feel that adolescents should not be engaging in sexual activity, they may adopt a harsh approach towards adolescents as a way to discourage adolescents from engaging in sexual activity (Godia et al., 2013; Alli et al., 2012). Even though law in South Africa allows adolescents to freely access sexual and reproductive healthcare services, HCW's may act as gatekeepers to these services amongst adolescents based on religious and moral belief systems (Morwe et al., 2014). In situations where HCW's express their disapproval of the adolescent clients' pregnancy, it creates a divide between the HCW and adolescent (Wiemann et al., 2005). In other cases, HCW's are aware of the fact that pregnant adolescents face numerous challenges but feel that they do not possess the necessary expertise to address the needs of pregnant adolescents (Rukundo et al., 2015; Kibombo et al., 2008).

A cross-sectional study in Botswana by Lesedi et al. (2011) revealed that a positive relationship between adolescents and healthcare providers is often associated with increased utilization of

SRH care services. Furthermore, adolescents prefer to receive advice regarding SRH from service providers whom they deem to be relatable and up to date with current norms (Kibombo et al., 2008). The health care system thus has a potentially important role to play not only in providing health care services, but also in providing counselling, support and changing social norms with regards to the management of adolescent pregnancy.

2.7 KNOWLEDGE REGARDING SEXUAL AND REPRODUCTIVE HEALTH

In women of all ages, good knowledge of maternal health care services has been linked with increased utilization of maternal health care services (Nisar et al., 2003; Taffa & Obare, 2004). Higher level of education is also positively associated with increased utilization of antenatal services. Many pregnant adolescents, however, have lower levels of education, either dropping out of school due to pregnancy or leaving school prior to pregnancy (Maness et al., 2016). Many pregnant adolescents have also been found to have poor knowledge regarding SRH, including antenatal care (UNESCO, 2014; Phafoli et al., 2007; Tsawe & Susuman, 2014). This lack of knowledge is thought to contribute to late access to antenatal care amongst adolescents. Poor insight into the physical and emotional changes that they are experiencing during pregnancy, as well as poor knowledge regarding reproductive health in general, may also lead pregnant adolescents to inadvertently engage in harmful practices during pregnancy, such as smoking and unhealthy nutritional practices (Coinco, 2010; Richter & Mlambo, 2005).

Inaccurate information received concerning SRH may also lead to unintended pregnancy (Henry & Fayorsey, 2002). In a study in Cape Town, Vundule et al. (2001) found that receiving information regarding SRH appeared to assist in preventing unplanned adolescent pregnancies. Receiving information regarding SRH from a medical professional was also linked to increased use of these services. However, receiving sexual health information from schools seems to be associated with higher risk for adolescent pregnancy, leading to doubts with regards to the detail and quality of information given by educators (Henry & Fayorsey, 2002; Vundule et al., 2001). Though these studies are not specific to utilization of antenatal services amongst adolescents, it shows that level of knowledge as well as source of knowledge and quality of information may influence patterns of utilization of reproductive health care services amongst adolescents.

Knowledge regarding SRH on its own, however, may not be a strong enough pull factor towards utilization of reproductive health care services amongst adolescents (Thobejane, 2015). The complex nature of adolescent sexuality means that one factor alone does not predict utilization of SRH services, but accurate information regarding SRH is a crucial component in the decision to seek out these services (Haider, 2008; Wood & Jewkes, 2005).

2.8 DECISION-MAKING POWER TO ATTEND ANTENATAL CLINICS AMONGST ADOLESCENTS

Adolescent girls are commonly in a disadvantaged position in terms of decision-making power to attend antenatal services as well as use of contraception before becoming pregnant (UNPFA, 2013; Lenters et al., 2015). Even though the pregnant adolescent may wish to attend antenatal clinics early, the fact that family, friends and the community may react negatively to pregnancy means that pregnant adolescents are disempowered as a result of stigma (Lenters et al., 2015; Haider, 2008). Adding to this is the fact that adolescents typically are still in many cases financially reliant on parents, guardians or partners/spouses, which means that an expectation is created for the adolescent to conform to the rules and standards set by those who provide food, shelter and sustenance for them (Lenters et al., 2015). Many pregnant adolescents access maternal health care services only after pregnancy has been disclosed to parents, guardians or partners (Phafoli et al., 2007) which demonstrates the extent to which the decision-making power of pregnant adolescents become limited by societal expectations. It is widely thought that parents should monitor adolescents closely in order to ensure the best possible reproductive outcomes for adolescents, but an autocratic parental approach to sexual health may in fact serve as a barrier to access to sexual and reproductive care services amongst adolescents (Macleod &Tracey, 2010). Furthermore, fear of deviating from religious and societal norms plays a significant role in shaping health-seeking behaviour amongst adolescent girls (AbouZahr, 2013).

Research suggests that parents with lower levels of education are more reluctant to discuss SRH matters with their children (Nyarko et al, 2014). Low levels of parental education means that many pregnant adolescents are already in a socio-economically disadvantaged position with limited resources, and being unable to communicate honestly about pregnancy and other matters regarding sexual health further disempowers pregnant adolescents (Phafoli et al., 2007).

2.9 SUMMARY

Adolescent access to maternal health care services is a complex issue that involves many factors. Poverty has been identified as an important driver of both adolescent pregnancy and poor access to health care services. Lack of knowledge of maternal health care services is a barrier to access to reproductive and maternal health care services amongst adolescents. Due to unease with discussing sexual matters with elders, adolescents are fearful of disclosing of pregnancy to parents and partners. This causes a delay in disclosing their pregnancy, and a delay in seeking antenatal care. A negative perception of HCW's by adolescents in response to pregnancy is also a recurring theme in the literature. Adolescents feel that they are treated harshly by HCW's, and HCW's face difficulty reconciling their personal beliefs regarding adolescent sexual activity with professional responsibilities.

Inconvenient clinic hours are cited as a barrier to access to SRH care services amongst adolescents. Clinics are open at times when school is in progress, which means that school-going adolescents need to miss class time, with no support structures at school to assist them to catch up on missed class time. Lengthy waiting times were identified as a barrier to access to SRH care services. The decision-making power of adolescents in seeking out SRH care services is greatly limited due to societal pressures and expectations. Often, adolescents only attend antenatal clinics after disclosure of pregnancy to a parent, guardian or partner, which shows that the decision to seek antenatal care is not made by the pregnant adolescent alone.

CHAPTER 3- METHODOLOGY

3.1 INTRODUCTION

The section that follows focuses on the methodology used for this study. The aims and objectives, study design, research setting, study population, sampling procedure, data collection, data analysis, ethical considerations, and limitations of the study are presented.

3.2 AIM

To explore the barriers to access for maternal health care amongst pregnant adolescents in the Mitchells Plain sub-district.

3.3 OBJECTIVES

The study objectives are as follows:

•To explore experiences of maternal health services and reproductive health amongst pregnant adolescents

•To explore perceptions of healthcare providers regarding provision of antenatal care to pregnant adolescents

•To explore the perceptions amongst pregnant adolescents regarding factors which inhibit and facilitate access to maternal health care services.

3.4 STUDY DESIGN

The research approach I used to meet the aims of objectives of this study was a qualitative approach. This study looks at the issue of access to maternal health services from the perspective of pregnant adolescents, and explores perceptions, attitudes, and beliefs of pregnant adolescents regarding access to health care, which lends itself to a qualitative approach. I wanted to gauge how access to maternal health care services is perceived and experienced by the pregnant adolescent community (Patton & Cochran, 2002), as well as how the beliefs and attitudes towards maternal health services influences access to maternal health care services, and a

qualitative design allowed me to unpack these issues. Furthermore, in order understand the perspective of participants; the research should be context-specific, which a qualitative research design allows for (Draper, 2004 Jack 2006). There is limited research and knowledge concerning adolescent access to maternal health care services in South Africa, thus an exploratory qualitative design is best suited to meet the aims and objectives of this study (Manerikar & Manerikar, 2014).

I used semi-structured interviews, which allowed the participant to freely relay their experiences regarding access to maternal health care services to me, without me predetermining what the participants responses should be (Choy, 2014; Robson 2011). Using this open-ended, flexible technique, I was able to develop an understanding of the perspective of pregnant adolescents at Mitchells Plain Mitchells Plain Maternity and Obstetrics Unit (MOU) regarding how they experience and perceive access to maternal health care services. It also allowed nursing staff to recount their experiences of providing care to pregnant adolescents.

Data collection took place from 16 January 2017 until 20 January 2017. Interviews took place immediately after participants were recruited. The study was finalized in November 2017.

3.5 RESEARCH SETTING

This study was conducted at Mitchells Plain Maternity and Obstetrics Unit (MOU). The MOU is part of the Mitchells Plain Community Health Centre. Mitchells Plain was established in the 1970's during the apartheid regime as part of mass evictions and relocation of non-whites (Department of Local Government, 2011). The community was initially built to house a population of 250 000, but the population has since grown to 310 485 people (City of Cape Town, 2013). However, some literature reports the population of Mitchells Plain to be around approximately 700 000 (Haque, 2002) largely due to the establishment of informal dwellings. This means that the community healthcare centre and MOU has seen a dramatic increase in patient numbers over the years, with no corresponding increase in resources. This has created overcrowding, long waiting times and frustration for patients and staff alike.

The MOU is well situated close to the bus, train and taxi station, therefore increasing convenience for residents who use public transportation. Mitchells Plain MOU offers both

antenatal and postnatal care, including labour and delivery services. The MOU has an adolescent antenatal clinic every Tuesday. However, due to high patient numbers and lack of space at the facility, adolescents are seated in the same area as older women at the MOU, and women of all ages are accommodated on Tuesdays as a result of the high demand for services. Mitchells Plain District Hospital is the closest referral point for the MOU.

3.6 STUDY POPULATION

The participants I have chosen possessed specific characteristics that gave me the most information about the topic (Ritchie et al., 2003), namely that they were pregnant, fell within the adolescent age group and utilized Mitchells Plain MOU. The sample population consisted of pregnant adolescents attending Mitchells Plain MOU, as they were be able to give the most valuable information about which factors facilitated or inhibited their access to maternal health care. I would also made use of key informants, in this case nursing staff providing services within the facility to pregnant adolescents. Key informants are those with specific knowledge about the study population and topic at hand (USAID, 1996). In this case, the nursing staff gave me particular insight into access to maternal health care services by pregnant adolescents. The implications of my sampling strategy are further discussed in the limitations section.

The reason for the sample size is that this was a small-scale study for the purpose of a mini-thesis, therefore logistical and financial constraints necessitated a small sample size. The aim of this study is not to generalize, nor be representative as it is qualitative, which means a large sample was not needed.

3.7 SAMPLING PROCEDURE

For this study, I used purposive sampling to find my sample. This means that participants were chosen based on specific characteristics, which would enable me to gain as much information as possible concerning adolescent access to maternal health care services (Ritchie et al., 2003).

Inclusion criteria were pregnant females between the ages of 16 and 19 years, who used Mitchells Plain MOU services, and understood English or Afrikaans. All those below the age of 18 needed to have a parent/guardian present in order to give consent.

Exclusion criteria were pregnant women over the age of 19 years and those between 10-15 years, and anyone who did not understand English or Afrikaans. Though excluding anyone under the 16 years limited my sample, sexual intercourse is legal from the age of 16 and participation is thus less likely to cause undue stress for participants from the age of 16. Pregnant adolescents who were 16 and 17 years of age who did not have a parent or guardian present with them at the clinic at the time of the interviews were also excluded from the study.

The operational manager of the MOU briefed the nursing staff at the MOU about the research project. The nursing staff at the antenatal clinic then assisted to identify potential participants, and notified me when they were about to assess a potential participant, or when there was a potential participant in the waiting area. I was then able to approach the potential participants, explain the study, and commence the informed consent process.

3.8 DATA COLLECTION

To describe the experiences of pregnant adolescents, I conducted semi-structured interviews with 10 pregnant adolescents attending Mitchells Plain MOU. I also interviewed two nurses with at least 2 years' experience of work at Mitchells Plain MOU. This means that 12 participants were interviewed. The interviews with adolescents covered how they experience the maternal healthcare services at Mitchells Plain MOU, as well as identifying and exploring barriers and facilitators to access to maternal healthcare services amongst pregnant adolescents. The interviews with nursing staff explored how nursing staff experience providing healthcare services to pregnant adolescents and what healthcare workers feel the barriers and facilitators to access to maternal healthcare services are amongst pregnant adolescents.

Nursing staff at the MOU identified potential participants, and I then approached the participants as identified by nursing staff. A thorough informed consent process was followed with all participants. For participants who were 16 and 17 years of age, I gained parental consent, and assent from the participant. Once consent was obtained, I conducted interviews with participants at the MOU. Interviews were audio-recorded with the consent of participants. Two nursing staff members volunteered to be interviewed, and a thorough informed consent process was followed with the nursing staff as well.

A semi-structured interview guide was used to conduct the interviews. Semi-structured interviews allowed me to guide the interview with the aim and objectives of the study in mind, but also allowed the participants to express themselves freely without me predetermining their responses (Choy, 2014). I also took field notes throughout the data collection process.

3.9 DATA ANALYSIS

I personally transcribed the audio-recorded interviews, thus all the data was in textual format (Pope et al., 2000). All interviews took place in English, though certain participants used certain Afrikaans and slang phrases. These were translated to English by the researcher for analysis purposes.

The data was analysed manually, using the thematic coding approach. The thematic coding approach entails assigning codes to phrases, expressions or behaviours that have emerged from the data (Robson, 2011). Themes are then created from the codes by grouping together similar codes that have emerged from the data. The thematic coding data analysis approach allows themes to be modified as the data analysis process unfolds.

Using Robson's (2011) key steps in the thematic coding approach, I first became familiar with the data, which included transcribing the interviews and reading the transcripts numerous times. I then created initial codes for segments that were of particular interest. From the initial codes, I then proceeded to create themes from the initial codes. After creating themes, I read the themes multiple times to ensure that it was an accurate reflection of the data. Once I had created themes, common themes were grouped together to create thematic networks. These thematic networks mean that themes were linked together under a main theme or heading. The data was then interpreted to describe the emerging findings.

3.10 RIGOUR

Qualitative research should be an accurate reflection of the participants' experiences and thoughts, and should therefore be carried out in a systematic manner (Robson, 2011; Srivastava & Thomson, 2009). Rigour ensures that the research is carried out systematically and that the research is trustworthy and is true reflection of the participants' experiences.

To ensure rigour, I used triangulation of data sources by interviewing pregnant adolescents who utilize Mitchells Plain MOU as well as interviewing nursing staff who work at Mitchells Plain MOU. This assisted to systematically find common themes from more than one source, increasing credibility of data (Creswell & Miller, 2000).

Personal reflections on the process were kept in a diary, and these reflections were referred to whilst analysing data and writing up the discussion to gauge how the researchers' own experiences might have impacted how data was perceived and interpreted.

I kept track of all research activities and decisions in a research journal to provide an audit trail. I also provided a detailed description of the research setting, study participants, and themes that arose (Creswell & Miller, 2000). The process of the study as well as my findings and interpretation of data was checked and discussed with my supervisor for peer debriefing to minimise bias.

3.11 ETHICAL CONSIDERATIONS

Ethical clearance for this research was obtained from the University of the Western Cape Research Ethics Committee. Once ethical clearance for this project was obtained from the University of the Western Cape, I applied for permission from the Western Cape Provincial Health Research Committee to conduct the research at Mitchells Plain MOU. This included submission of ethical clearance letter from the University of the Western Cape.

The research project was approved by The Western Cape Provincial Health Research Committee. The Western Cape Provincial Health Research Committee forwarded the approval letter to the person in charge of Mitchells Plain MOU. Once approval was obtained, I contacted the person in charge of Mitchells Plain MOU to further discuss the research project, as well as to clarify best suitable dates for data collection to take place.

Before conducting the interviews, a thorough informed consent process was undertaken with each participant. This ensured that they fully understood the nature and purpose of the research, and that their participation in the study is voluntary. All the information required by them was included in the participant information sheet, and each participant was given a participant

information sheet to keep. It was made clear that they are free to withdraw from the study at any stage, without any negative consequences.

During the interview process, I asked the participant a series of questions in order to gain as much information from the participant as possible. This probing and questioning could have potentially caused feelings of anxiety and distress in the participant (Richards & Schwartz, 2002). However, I ensured that each participant was aware that all effort would be made to ensure their comfort during the interview, and that any feelings of distress or anxiety would be dealt with in a dignified manner and that the participants' health and safety would be held in the highest regard.

For those under the age of 18, consent was obtained from their parent/guardian, and the participant gave assent. Their well-being and wishes were respected at all times. Therefore, in cases where the parent or guardian consents to participation, but the participant did not wish to participate, their refusal to participate was accepted and respected.

Due to the sensitive nature of the topic at hand, confidentiality was held in utmost consideration. The autonomy and dignity of all participants was respected at all times. Their anonymity was protected, and no unauthorized access to the audio recordings, transcriptions of interviews and consent forms was allowed. In the event that I became aware of any other further support required by the participant, and in cases where participants requested further help or support, I was prepared to refer them to the relevant person at the MOU who was able to assist them. However, none of the participants required any additional help or support from me. Participation in the study or refusal to participate in the study had no negative effect in the treatment the participants received at the MOU.

CHAPTER 4 FINDINGS

4.1 INTRODUCTION

In this chapter, the findings of the interviews conducted with pregnant adolescents as well as two nursing staff at Mitchells Plain Maternity and Obstetrics Unit (MOU) are presented. The socio-demographic profile of participants is presented, followed by the main themes that emerged from the data.

The first primary theme is fear of disclosing the pregnancy, with the sub-theme negative initial response from parents and guardians to the pregnancy. Fear of pregnancy disclosure and negative initial response has been shown to be a barrier to accessing maternal health care services. The second primary theme is feelings of shock and disbelief in response to finding out about the pregnancy, which also inhibited pregnant adolescents from accessing maternal health care services. The third primary theme presented is perceptions and experiences of maternal health care services, with the sub-themes of rumours of rude nursing staff, interaction with nursing staff and expected long waiting times. Results from this study showed that pregnant adolescents have a negative perception of maternal health care services, and expected to encounter rude nursing staff. This acted as an inhibiting factor to access to maternal health care services, mainly because pregnant adolescent were reluctant to come to the MOU because of negative perceptions of the MOU. However, the experiences of many adolescents at the MOU were not the same as the perceptions and expectations they had had in terms of interactions with nursing staff. Many adolescents reported a positive experience when interacting with nursing staff, but still reported dissatisfaction with waiting times, which was an inhibiting factor to access to maternal health care services. The fourth primary theme is poor self-reported knowledge regarding maternal health care, which was a barrier to access to maternal health care services amongst pregnant adolescents.

4.2 SOCIODEMOGRAPHIC PROFILE OF PARTICIPANTS

The following table shows the age distribution of participants:

Age	Number of participants
16 years	3
17 years	1
18 years	1
19 years	5

Table 1: Age distribution of participants

The relationship status of participants is represented as follows:

Relationship status	Number of participants
Married	2
Engaged	1
In a relationship with boyfriend	4
Unmarried but relationship status not specified	3

Table 2: Relationship status of participants

All those who were married or engaged, were married or engaged to the father of their baby after learning that they are pregnant.

Concerning level of education, five participants left school before completing matric, two participants completed matric and three participants were still attending school.

Of the participants who left school before completing matric, three reported that they stopped attending school before becoming pregnant, and one reported that she left school after learning that she was pregnant. Only one participant reported being employed at the time of the interview.

Five participants reported that they live with their mother; two reported that they live with their grandmother; one reported that she lives with her husband; one reported that she lives with her fiancé and one reported that she lives with her boyfriend and his parents. Only one participant indicated that she lived with her parents and siblings in the household.

Only one participant reported that she had planned her pregnancy after her boyfriend expressed his wish to have children, and the remaining nine participants viewed their pregnancy as unplanned. Of the nine unplanned pregnancies, seven participants were very positive about the pregnancy, describing feelings of excitement and joy, and two participants were still coming to terms with an unplanned pregnancy and did not indicate if the pregnancy was wanted. However, both these participants expressed that they wanted to be sure that the baby was healthy.

4.3 FEAR OF DISCLOSING PREGNANCY

A common theme amongst pregnant adolescents in this study was fear of disclosing their pregnancy to those around them. Pregnant adolescents were fearful of the reactions of their parents or guardians as pregnancy in adolescence is seen as morally and socially unacceptable in many households and communities (Richter & Mlambo, 2005; Mwaba, 2000). Pregnant adolescents therefore delayed informing their parents or guardians about the pregnancy.

> *[I felt] sad… and guilty [when I found about the pregnancy] …because I am still young*. P3, 16 years old

Pregnant adolescents also feared judgment from others in the community and older women at the MOU.

> *[I felt nervous about coming to the MOU], nervous because everybody is like looking at me [because] I am so young and stuff. [I feel] nervous [and] uncomfortable also…*

[because] the young ladies sitting around me and…older people [are looking at me]. P4, 17 years old

As a result of trying to hide their pregnancy status, pregnant adolescents therefore delayed coming to the MOU for antenatal care. At the first visit to the MOU, pregnant women open a folder, and the expected due date is confirmed. They then know when to come to the MOU for delivery, and the first visit to the MOU is therefore commonly referred to as "booking".

Um…like, at first I was scared to tell them [my parents]…about my pregnancy. Then I did not want to come book [come to the MOU for initial visit] or anything. I wanted actually my mommy to come with me, like now. Just…I was scared to tell them that is why I did not book before the time. P4, 17 years old

Going to the MOU before disclosing the pregnancy to parents or guardians means that there is a risk that others may recognize the pregnant adolescent in the community, who may then inform the parents or guardians of the pregnant adolescents' attendance at the MOU. Due to fear of pregnancy being revealed to parents by others in the community, participants delayed coming to the MOU.

I was, um, still afraid [to come to the MOU], just to, someone walking past me that knows me, [is going to] tell my parents [that I am pregnant], so… [I am] actually hiding a bit. P8, 19 years old

Nursing staff at the MOU identified fear of disclosing the pregnancy, as a significant reason for delayed access to maternal health care services, amongst pregnant adolescents

Some of them [pregnant adolescents], they come to book [for delivery] late, just because they were hiding the pregnancy. But if you ask them then they will tell you that I did not want my mum to know, my mum didn't know. P10, nursing sister, 57 years old

Fear of disclosing the pregnancy to parents also meant that participants were unable to ask parents or guardians for transportation or money for transportation to the MOU, as asking to be taken to the MOU or for transport money to the MOU would lead to further questioning by parents or guardians. Participants who are still attending school would also have to explain why

they have missed a day of school if they plan to attend the MOU. Fear of disclosing their pregnancy to parents or guardians thus means that pregnant adolescents are unable to access transport and are unable to negotiate time off school to attend MOU appointments.

> [*I didn't come to the MOU before my mother knew about my pregnancy] Because…I wouldn't have a taxi fare and how would I explain if I don't go to school?* P7, 18 years old

Nursing staff interviewed also revealed that many pregnant adolescents are unable to access the MOU because of fear of disclosing their pregnancy at school as well as missing a day at school.

> *Some of them [pregnant adolescents] they are still at school, they miss their appointment and then when you ask why didn't you [come to the MOU]? [They say] "I was at school", [When you ask pregnant adolescents] But why didn't you ask [for time off school to come to the MOU]? [They say] "I was scared".* P10, nursing sister, 57 years old

Many adolescents are financially dependent on parents or guardians. Parents and teachers also often monitor school attendance. This means that pregnant adolescents are often unable to access the MOU independently without the help or knowledge of parents and guardians. Pregnant adolescents therefore delay seeking antenatal care due to fear of pregnancy disclosure.

4.3.1 NEGATIVE INITIAL RESPONSE FROM PARENTS OR GUARDIANS TO PREGNANCY

Fear of disclosing the pregnancy was also related to uncertainty about the response from parents or guardians to the pregnancy. One participant who had not disclosed the pregnancy to her parents yet and attended the MOU without her parent's knowledge, gave the following response when discussing why she had not disclosed the pregnancy to her parents yet:

> *My mother, she's a understanding person but my father, he's more, he's the strict one, so I don't know[what] his reaction [to the pregnancy will be], basically.* P8, 19 years old

This alludes to the fact that adolescents may anticipate negative responses to the pregnancy from parents, and therefore delay disclosing the pregnancy.

I was scared to tell my mommy and daddy about [the pregnancy]…and when I told my, my mommy saw that I got fat and that, so I told her [that I am pregnant] and then she got kwaad [angry], and afterwards she was happy. And my daddy didn't talk to me… at all. P3, 16 years old

From this, we can see that some adolescents wait until there are overt signs of pregnancy before disclosing pregnancy, and that adolescents are fearful of negative reactions from parents. These fears are often justified, as many respondents reported that their parents or guardians indeed initially responded negatively when learning about the pregnancy.

At first my mommy scold[ed] at me but then she overcame it, but…my daddy is still cross…a bit. P4, 17 years old

This negative response was often anticipated by the pregnant adolescent and contributed to their fear of disclosing their pregnancy. Participants were afraid that their parents or guardians would be angry or disappointed in them for becoming pregnant. Fear of the reaction of parents or guardians was a powerful deterrent to disclosing the pregnancy, and this caused them to delay disclosing the pregnancy and seeking antenatal care. One participant described feeling fearful of disclosing her pregnancy to her mother because of seeing negative responses of other mothers in her community to the pregnancy disclosure of their own daughters:

Maybe [other pregnant girls] mothers' abuse [them], other [mothers of pregnant girls say to them] ok, you are pregnant, and [still young, so] take all your clothes [and] go. Maybe you going to go where? Which place [are] you going to go? [The] only [place you have to live] is your home. Just imagine going outside, your, your, clothes is not in the suitcase, the way it was in the suitcase, it's just in a plastic bag, plastic bag outside. P12, 16 years old

Witnessing or hearing stories about negative reactions to pregnancy caused pregnant adolescents to expect physical or verbal abuse, and even expulsion from home in response to pregnancy disclosure, making them hesitant to inform parents or guardians about their pregnancy, and also hesitant to seek healthcare and risk disclosing their pregnancy.

Despite an initial negative response to the pregnancy in some cases from parents and guardians, this was often followed by support and advice given to pregnant adolescents to attend antenatal clinics as soon as possible. Most participants indicated that the negative response to the pregnancy was followed by support and advice, though one participant had not disclosed the pregnancy yet, and another participant indicated that her mother advised her to go the MOU, but did not indicate if her mother was supportive or accepting of the pregnancy after the pregnancy. The support and advice was frequently reported to come from mothers and grandmothers.

> *My ma [grandmother] was disappointed [about the pregnancy] but…she said that…she…can't do anything about it and that she will stand by me*. P2, 16 years old

Participants tended to attend the MOU after they had disclosed their pregnancy to parents or guardians, and were most often advised by their mothers or grandmothers visit the MOU as soon as possible.

> *My mother told me that I should come [to the MOU] because…you need vitamins, etc.* P5, 19 years old

Some participants expressed that even though they may have received advice from other sources such as friends regarding antenatal clinic attendance, they really only heeded the advice of mothers and grandmothers regarding antenatal clinic attendance.

> *I [knew I had to come to the MOU]…but I like, didn't really take it seriously until my grandmother talked.* P9, 19 years old

A feared or experienced negative initial response from parents or guardians thus contributed to delays in pregnancy disclosure and in antenatal clinic attendance, but pregnant adolescents were often encouraged by parents, guardians and partners to attend the MOU after their pregnancy was disclosed. It was noted that some participants appeared to be particularly concerned about how their father would react to the pregnancy, and that fathers tended to remain angry for longer than the mothers of pregnant adolescents did after disclosure of the pregnancy.

4.4 FEELINGS OF SHOCK AND DISBELIEF IN RESPONSE TO PREGNANCY

Another common theme was feelings of shock and disbelief when discovering that they were pregnant. The majority of participants viewed this as an unplanned event and did not expect to become pregnant.

> *It is very shocking actually cos…I didn't even know what to do, that [is why] I didn't even come early for the…to the clinic for some test, so ya [yes]. It was shocking* P7, 18 years old

Feelings of shock and disbelief meant that many participants were uncertain about how to go about seeking assistance to cope with pregnancy, and did not know how to initiate seeking healthcare. Along with shock and disbelief, some participants described feelings of denial.

> *Actually, I didn't want to come [to the MOU], you see…so they tell me, my fiancé, he did tell me I must come so that we can find out, you see, before it's too late. So I told him ok then… Because I was scared, I don't want to know [about my pregnancy] actually*. P6, 19 years old

For many pregnant adolescents, delaying seeking healthcare is a means of coping with the shock of an unplanned pregnancy and avoiding the reality of being pregnant.

> *[Some pregnant adolescents avoid coming to the MOU because they think] "I don't want this baby so if I don't book, I can still think it's not real, you know, it's not there, you know, I don't have to deal with it, it won't be quite as in my face as when I go [to the MOU] and the sister in the antenatal clinic confirms that I'm pregnant and that I have a baby"* P11, Nurse, 52 years old.

Some nursing staff, however, feel that many pregnant young people are not necessarily shocked at the pregnancy, but that many adolescents plan the pregnancy in order to access the child support grant offered by government.

> *I think maybe they do plan this, these children, I think they plan, maybe, the other thing that maybe can contribute is this SASSA thingy, because they must get the money, also for the grant…maybe…* P10, nursing sister, 57 years old

None of the pregnant adolescents in this study mentioned access to social grants and only one participant in this study indicated that her pregnancy was planned. It appears that for the majority of participants, feelings of shock and disbelief lead to difficulties in making decisions about seeking antenatal care early in pregnancy, leading to delays in accessing maternal health care services.

4.5 PERCEPTIONS AND EXPERIENCES OF MATERNAL HEALTH CARE SERVICES

Participants in this study generally had negative perceptions of the MOU. These perceptions were generated by word of mouth in the community according to most participants. This caused pregnant adolescents to feel apprehensive about attending antenatal clinics at the MOU.

> *You know what, sometimes the younger we are ne [hey]? Sometimes we scared to come to the clinic, you know, because nurses, doctors, they shout at us, [they ask us] why you having pregnancy as young you are? Why? So we are scared [to come to the MOU]*. P12, 16 years old

Many participants reported that they expected to encounter rude, impatient and judgmental staff, and this made them feel fearful of coming to the MOU.

4.5.1 RUMOURS OF RUDE NURSING STAFF

Rumours of rude and judgmental nursing staff came across strongly amongst participants. As mentioned above, many participants expected to encounter staff that would chastise or judge them, and thus felt fearful of coming to the MOU. Hearing rumours about rude nurses created the expectation amongst pregnant adolescents that they would encounter rude nursing staff, and these rumours made pregnant adolescents reluctant to seek antenatal care at the MOU.

> *I was scared [to come to the MOU] because, um, people thought, think that the nurses are very rude, but when I came here they were nice and they assisted me.* P7, 18 years old

However, once they attended services many participants found that the nursing staff were friendly, helpful and approachable.

The nurses is, the nurses is nice…and they speak nicely to you… [when the nurses are nice to me] it makes me feel more comfortable and… more relaxed, so…not so nervous anymore. P8, 19 years old

Nursing staff at the MOU also felt that many pregnant adolescents expected to find nursing staff to be rude and unfriendly, but that nursing staff at the MOU try to change these perceptions by treating all patients at the MOU with respect.

You know everybody have got that attitude that the sisters are shouting at people, so…otherwise, if you explain everything to them [pregnant adolescents], everything just goes right. P10, nurse, 57 years old

Nursing staff in this study were very aware of the negative perceptions in the community about maternal health care nurses. They recognized that this perception made pregnant adolescents reluctant to seek antenatal care and delay coming to the MOU.

Already they [pregnant adolescents] have the expectation that somebody's going to tell them what you are doing is wrong or somebody's going to point a finger at them, um, somebody's going to condemn them or judge them, you know. So they come [to the MOU] with that attitude. P11, nurse, 52 years old

4.5.2 INTERACTION WITH NURSING STAFF

Despite hearing rumours about rude nursing staff, the majority of participants were actually satisfied with their personal interaction with nursing staff.

Everyone is nice with you so…I like it. You see, they [nursing staff] handle you well, they explain to you everything so…yes, that's my experience. P6, 19 years old

Participants mostly reported that staff were friendly and understanding, and mentioned their interactions with nursing staff when asked about positive experiences at the MOU.

Actually [my experience at the MOU was] nice because they [the nursing staff], they also start, they can also start a conversation with you, they very nice, they talk to you, they ask you things that you can be comfortable to talk about. P7, 18 years old

Some participants in this study also indicated that they valued the education sessions at the MOU and provision of information by nursing staff, and that education by nursing staff was done in a manner that made pregnant adolescents feel comfortable. Education sessions took place in the waiting room in the form of talks and sometimes videos. Participants showed great interest in these talks and seemed willing to adhere to the advice given during these information sessions.

> *I like the explaining [education sessions], you see outside [in the waiting area] the time when you come [arrive at the MOU], I'm listening outside [to] the doctor there outside [in the waiting area], they[doctors and nurses are] talking about the baby, and the, with this baby, the first one [my first baby], maybe I wish I can take care of him [the baby] like the way the doctor he talk outside, I wish so*. P12, 16 years old

Nursing staff try to remain unaffected by negative perceptions about them, and report trying to reassure pregnant adolescents that they will not be judged or mistreated by any nursing staff. Furthermore, nursing staff explained that when they speak to pregnant adolescents in a respectful manner and make them feel at ease, there is a positive relationship between nursing staff and pregnant adolescents.

> *That was an old perception. Because that's what I used to tell them [pregnant adolescents] if they said now 'I was scared because I know that the sisters all skel [scold]" I said no, those sisters are dead, we the ones that are here now, we don't do skel [scold] anybody, all we need is to understand each other, that's all. If I ask you something you must just tell me so that I can also understand, that's it*. P10, nursing sister, 57 years old

Finding nursing staff to be approachable and friendly put the participants at ease during their visit to the MOU, and participants reported that they felt free to ask nursing staff for advice and guidance.

> *No, they [nursing staff] are friendly, they not rude, like the people outside [in the community] would tell me, they going to skel [reprimand me], they going to do this [reprimand] and shout at you but they not actually like that*. P5, 19 years old

Nursing staff at the MOU reported that they have positive interactions with pregnant adolescents at the MOU.

> *[My interaction with pregnant adolescents is] very good, very good, it's very good. They ask lots of questions, and because now there is this googling stuff, you tell them this and they say Sister I google this, is this right? So when they come, some of them, they come with information, and then you just add from what they know…It's very good. You can see that they are really responsible, because you see that is responsibility to hunt for information, it's very good.* P10, nursing sister, 57 years old

However, one nurse reported that she felt disconnected from many pregnant adolescents at times, and attributed this to advancing technology and numerous social stressors, such as severe poverty, exposure to abuse and child-headed homes. She also indicated that she sometimes feels a sense of hopelessness when faced with pregnant adolescents who have problems such as sexual abuse and poverty.

> *These kiddies [adolescents] have they've got so much happening out there [new technology and social stressors], and it's so different from our time. And fossils like myself, it's difficult to keep up with them, so when they [pregnant adolescents] come to you and they are all full of this [new technology and social stressors] it's like…the two[nurses and pregnant adolescents] doesn't meet.* P11, nurse, 52 years old

Despite this, she reported that she made extra effort to treat all pregnant adolescents with dignity and compassion.

> *There's a lot of patience involved [in providing healthcare to pregnant adolescents] and there's a lot of teaching, and a lot of, you know, sort of, just give comfort. Unfortunately we don't have the space where we can ask mom [mothers of pregnant adolescents] to come in [to the delivery room or consultation with the pregnant adolescent] so, um, some of us [nurses] will take that role, we will slip into that role [of mother]*. P11, nurse, 52 years old

Participants reported that they heard stories about rude nursing staff in the community, from friends and family members who have utilized the MOU for antenatal care in the past but actually had not experienced rude nursing staff themselves.

4.5.3 EXPECTED LONG WAITING TIMES

Participants also reported that they heard rumours about long waiting times at the MOU, which added to their reluctance to visit the MOU.

> *[I have heard] that… if we come here you must have patience because it's always full and you wait here the whole day and such stuff…It actually did, actually I didn't want to come here [to the MOU] when they [people in the community] said that but, when I came so it actually wasn't that bad.* P2, 16 years old

Apart from expecting long waiting times, participants also expressed dissatisfaction with the actual waiting times, and reported experiencing physical discomfort due to lengthy waiting times at the MOU.

> *[The long waiting time] it's not nice…I mean all of us we are pregnant here outside so, we can't sit the whole time on our bums and if you stand up and then you want to sit again and it's not nice*. P1, 19 years old

A common complaint about the long waiting time was experiencing back pain and hunger. Participants felt that because they are all pregnant and more prone to physical discomfort due to prolonged sitting in waiting areas, more consideration should be given to cutting waiting times.

> *We [patients at the MOU are] getting impatient [due to long waiting times]… moving around and…because our backs is paining, some are hungry, we came here early this morning, past six [o' clock]*. P8, 19 years old

Some adolescents felt that staff at the MOU work slowly, and that staff could do more to shorten the waiting time for patients at the MOU.

I think here are a lot of people [patients] here [at the MOU], so they [staff at the MOU] can work faster…because I've been here since six o' clock this morning [the interview took place at 09h25]. P1, 19 years old

Some participants showed empathy towards staff at the MOU. Even though they reported lengthy waiting times, these participants understood the reasons for the delay in consultation and were therefore less upset by the long waiting time.

[*The waiting time] was a little bit long, you know, because, but I understand because there are not lot of people [staff] here, so I understand why it was a little bit waiting and sitting and all that stuff, but it's fine.* P6, 19 years old

Participants also appreciated when staff came and explained reasons for delays to them, as they then had a better understanding into why they are waiting.

4.6 POOR SELF-REPORTED KNOWLEDGE OF MATERNAL HEATLH CARE SERVICES

Many pregnant adolescents reported that they have poor knowledge of maternal health care and maternal health care service.

I knew nothing about it [antenatal clinic attendance], I didn't even know about this clinic, so it was my first time coming here. P7, 18 years old

Many pregnant adolescents also came to the MOU mainly because their mother, grandmother or friends told them to do so, and had very little knowledge about the importance of attending the MOU.

My mother told me that I should come [to the MOU] because…you need vitamins, etc. P5, 19 years old

Having poor knowledge concerning maternal health care and maternal health care services means that pregnant adolescents do not know or feel that there is a need for them to attend the MOU, resulting in poor access and utilization of maternal health care services amongst pregnant adolescents.

Some respondents reported that they had basic knowledge about maternal and reproductive health, but still viewed this knowledge as minimal.

> *Yes, [I] actually [know] a little bit [about maternal health]. You must eat healthy food and you must drink a lot of water, and you mustn't move…you mustn't have heavy stuff on you when you pregnant you see, so not actually much about the baby*. P6, 19 years old

However, the knowledge they had about self-care during pregnancy did not include knowledge about maternal health care services and antenatal clinic attendance.

Nursing staff felt that adolescents are not utilizing reproductive health care services optimally, and that adolescents have good knowledge about reproductive health care services.

> *I won't say [adolescent pregnancy is due to] ignorance…I won't say because the family planning now is available to everybody, and nobody must bring the parents to come and sign for family planning…I really don't know [why the rate of adolescent pregnancy is high], because everything is available.* P10, nursing sister, 57 years old.

Nursing staff thus felt that adolescents have good knowledge about reproductive and maternal health services, and that poor knowledge of reproductive and maternal health care services is not a major contributor to poor access and utilization of reproductive and maternal health care services. However, pregnant adolescents in this study reported that they had poor knowledge regarding maternal health care and SRH services.

4.7 CONCLUSION

In this study, half of pregnant adolescents had not completed their schooling. Nine out of ten pregnant adolescents reported the pregnancy as an unplanned event. Furthermore, two adolescents got married after learning that they were pregnant, and one reported getting engaged after learning that she is pregnant.

Fear of disclosing the pregnancy came across strongly as a barrier to accessing maternal health care services amongst pregnant adolescents. Many pregnant adolescents reported negative initial response to their pregnancy from parents or guardians, but this was followed by support and advice in most cases. However, in some cases, fathers tended to remain angry for longer than

mothers of pregnant adolescents did after learning about the pregnancy. Participants in this study generally had a negative perception of maternal health care services before using these services, which acted as barrier to access to maternal health care services. Many adolescents heard rumours of rude nursing staff, and feared judgment and chastisement from nursing staff. In contrast to widespread beliefs and attitudes regarding rude nurses, it appeared that the majority of participants had positive interactions with nursing staff, and reported the nursing staff to be friendly and helpful.

Many participants were worried about long waiting times, and were dissatisfied with the waiting time at the MOU, and complained of physical discomfort whilst waiting for their consultation. Many participants also reported having poor knowledge of maternal health and maternal health care services, which was a barrier to access to maternal health care services. Mothers and grandmothers were most often cited as sources of information about maternal health and maternal health care services.

CHAPTER 5 DISCUSSION

5.1 INTRODUCTION

This chapter focuses on the findings of the study in relation to the available literature regarding adolescent pregnancy. The purpose of this study was to explore the perceptions and experiences of pregnant adolescents regarding access to maternal health services, as well as to identify barriers and facilitators to access to maternal health care services. The findings of this study showed that fear of disclosure of pregnancy is a major barrier to access to maternal health care services amongst pregnant adolescents. Pregnant adolescents feared a negative response to the pregnancy from their parents or guardians, and also experienced feelings of shock and disbelief when they first learned that they were pregnant. These feelings of shock and disbelief lead to difficulty with decision-making in terms of seeking healthcare.

Many pregnant adolescents in this study had negative perceptions about maternal health care services. Most of these perceptions were formed by hearing rumours about rude nursing staff, which made pregnant adolescents reluctant to go to the MOU. However, despite the rumours about rude nursing staff, the majority of participants reported that they experienced positive interactions with nursing staff at the MOU, contrary to their expectations. The majority of participants also reported dissatisfaction with long waiting times at the MOU. Lastly, many participants had poor knowledge with regards to maternal health care services, which contributed to poor access to maternal health care services amongst pregnant adolescents.

This chapter further unpacks the above-mentioned findings.

5.2 FEAR OF DISCLOSURE OF PREGNANCY

Many participants expressed fear and reluctance to disclose their pregnancy to their parents or guardians. This caused them to delay disclosing their pregnancy, and delay seeking health care due to fear that their pregnancy will be revealed to their parents or guardians. This is similar to findings by Chaibva et al. (2009), who found that pregnant Zimbabwean adolescents delayed seeking antenatal health care because of fear of pregnancy disclosure. Fear of pregnancy disclosure not only impedes pregnant adolescents' access to healthcare services, but also

negatively affects their access to other services, such as schooling and social support (Loxton et al., 2007; Combs-Orme, 1993).

Some participants in this study stated that they experienced feelings of guilt in response to the pregnancy, and viewed the pregnancy as a source of disappointment to their parents or guardians. This caused them to conceal the pregnancy from those around them for as long as possible. This is in-keeping with findings by Grietens et al. (2010), whose study in Burkina Faso revealed that pregnant adolescents often face feelings of shame, embarrassment and guilt when discovering that they are pregnant. Grietens et al. (2010) also found that attempts to conceal the pregnancy caused a delay in accessing maternal health care services amongst pregnant adolescents. Fear of disclosing their pregnancy is most commonly rooted in the belief that they will be judged by others and seen as immoral (Richter et al, 2006; Wiemann et al., 2005).

Ilika and Anthony (2004) found that pregnant adolescents in Nigeria who are still in school often fear the reactions of teachers and peers, and many fear punishment because of religious or cultural rules. In many communities, cultural and religious rules dictate that pregnancy should only occur after marriage. When unmarried adolescents become pregnant, they delay disclosing the pregnancy in order to conceal the fact that they have deviated from cultural or religious expectations. A culture of non-disclosure around adolescent pregnancy is thus a common occurrence in many households, with fear and shame guiding the decisions of many adolescents (Richter et al., 2006). Participants in this study at Mitchells Plain also revealed that they were concerned about the perceptions of their peers at school in response to the pregnancy, in-keeping with findings in the literature. Fear of disclosing pregnancy thus leads to delay in accessing maternal health care services amongst pregnant adolescents, as many pregnant adolescents attempt to conceal the pregnancy for as long as possible.

5.2.1 NEGATIVE INITIAL RESPONSE TO PREGNANCY FROM PARENTS

In this study, many pregnant adolescents encountered negative responses from parents and guardians when disclosing their pregnancy. These negative responses included anger and disappointment from parents. Furthermore, pregnant adolescents in this study often anticipated this negative response, which also contributed to fear of disclosing the pregnancy. These findings are supported by a study done by Van Zyl et al. (2015), who found that pregnant adolescents in

the Western Cape are often scolded and expelled from home when the pregnancy is revealed to their parents or guardians.

However, participants in this current study reported that the initial negative response was often followed by support and advice from parents and guardians. Mturi (2015) had similar findings in a study in the North West Province of South Africa. The initial anger that parents felt was short-lived and in keeping with findings in this current study, pregnant adolescents cited their mothers as pivotal in providing support and guidance through their pregnancy experience (Mturi, 2015). The manner in which parents respond to the pregnancy greatly influences the manner in which pregnant adolescents manages their pregnancy (Mumah et al., 2014). This includes the decision on when to seek health care for pregnancy, and self-care practices during pregnancy.

A possible reason for the initial negative response to the pregnancy by parents and guardians in this current study in the Mitchells Plain sub-district is that parents fear the negative impact that early pregnancy may have on future schooling and career prospects for the adolescent (Singh and Hamid, 2015). Early adolescent pregnancy in South Africa has been found to have negative implications on fulfilment of scholastic and career goals for young mothers, as well as placing financial strain on households. Many households in Mitchells Plain face financial hardship, and an unplanned pregnancy puts further financial strain on families, which contributes to parents and guardians responding negatively to initial news of an unplanned adolescent pregnancy in the household. However, Singh and Hamid (2015) suggest that becoming a mother is held in high regard in many cultures in South Africa, and families therefore tend to become supportive after the initial negative response.

Most of the participants in this study at Mitchells Plain MOU indicated that their parents or guardians offered support and guidance after the initial negative response. Some participants also reported that their parents strongly encouraged them to continue with schooling. Singh and Hamid (2015) as well as Van Zyl et al. (2015) found that adolescents who receive support from parents during their pregnancy and with child-rearing tend to have a more positive outlook on their future, and use their pregnancy experience as motivation to improve their lives for themselves and their child. The support and guidance of parents and guardians is thus important for positive outcomes for the adolescent mother and her baby.

5.3 FEELINGS OF SHOCK AND DISBELIEF IN RESPONSE TO PREGNANCY

Many adolescents in this study at Mitchells Plain MOU expressed feeling shocked when they discovered that they were pregnant, which contributed to a delay in seeking antenatal care. This is in keeping with findings by Atekyereza and Mubiru (2014) as well as Mturi (2015), who found that when pregnancy is unplanned, women often feel overwhelmed and shocked when pregnancy is confirmed. When pregnancy is deemed as unacceptable by society, such as adolescent pregnancy, the feelings of shock and disbelief are often amplified. The feelings of shock and disbelief means that pregnant adolescents delay seeking early antenatal care, as they first try to process the array of emotions they feel whilst simultaneously trying to avoid judgment from family and society (Singh & Hamid, 2015).

The shock and fear that pregnant adolescents experience not only prevents them from accessing health care, but often also causes them to isolate themselves from family and friends (De Villiers & Kekesi, 2004). The difficulty pregnant adolescents' face in coming to terms with an unplanned pregnancy may thus greatly hinder the amount of support they receive from the health care workers, family and friends. In many cases, the pregnant adolescent receives assistance and advice to attend antenatal clinic as soon as the family is made aware of the pregnancy (Pell et al., 2013). Thus, when feelings of shock and disbelief cause pregnant adolescents to isolate themselves from family, it causes a delay in access to antenatal care.

5.4 PERCEPTIONS AND EXPERIENCES OF MATERNAL HEALTH CARE SERVICES

For many women in low and middle-income countries, a negative experience of maternal health care services is a barrier to access to maternal health care (Finlayson & Downe, 2013). Pregnant adolescents in particular have the expectation that they will chastised by healthcare workers when seeking health care for sexual and reproductive health (SRH) care needs (Kennedy et al., 2013). Negative perception of maternal health care services is thus a significant deterrent to early access to maternal health care services. These findings are in keeping with this study at Mitchells Plain MOU, where numerous participants expressed that they expected to be scolded by nursing staff for being pregnant at a young age, and therefore feared seeking antenatal care. This caused participants to delay seeking antenatal care.

Some participants in this study at Mitchells Plain MOU expressed that they felt uncomfortable attending the MOU with older pregnant women. Similarly, adolescent participants in a study by Ehlers et al. (2000) revealed that they felt uncomfortable at the prospect of attending clinics with older pregnant women, and believed that older women attending the clinic may judge them.

One participant in this study at Mitchells Plain MOU reported that she had not yet disclosed the pregnancy to her parents, and that she was reluctant to come to the MOU out of fear that someone at the MOU may reveal the pregnancy to her parents. The literature shows that pregnant adolescents frequently report fears regarding confidentiality when accessing maternal health care services (Agampodi et al., 2008). They hold the perception that accessing maternal health care services will lead to their pregnancy status being revealed to their parents either by health care workers (HCW's), or through being recognized by community members. Concerns regarding confidentiality of maternal health care services thus act as a barrier to access to maternal health care services amongst pregnant adolescents.

When adolescents hold negative perceptions of maternal health care services, they are more likely to have poor attendance at antenatal clinics (Gross et al, 2012). As seen in this study at Mitchells Plain MOU, an expected negative experience of maternal health care services causes many pregnant adolescents to delay accessing maternal health care services.

5.4.1 RUMOURS OF RUDE NURSING STAFF

Many participants in this study at reported that they heard rumours about rude nursing staff at Mitchells Plain MOU. These rumours were heard in the community, or from friends and family. Silal et al. (2012) also found that in South Africa, word of mouth regarding judgment and harsh treatment by nurses towards pregnant adolescents served as a barrier to access to maternal health care services amongst adolescents.

Similarly, in a study by Bohren et al. (2017), it was found that many Nigerian women experienced mistreatment by nursing staff at maternal health care facilities, and pregnant adolescents were perceived to be particularly susceptible to mistreatment from nursing staff. In some cases, nursing staff treat adolescents harshly as means of discouraging sexual activity amongst adolescents (Wood & Jewkes, 2006). Nursing staff that treat adolescents who seek SRH

care with disrespect are often influenced by their personal belief that adolescents should not engage in sexual activity (Jonas et al., 2017). Adolescents have become aware of this treatment at health care facilities, and thus expect the same treatment when accessing maternal health care services.

Many pregnant adolescents who participated in this study at Mitchells Plain MOU have had very little experience with maternal health care services. This lack of experience of maternal health care services means that pregnant adolescents easily believe negative information they receive about the treatment they might encounter maternal health care facilities (Loxton et al., 2007). Attitudes of HCW's are thus an important influence on how easily pregnant adolescents feel they can access maternal health care services (Phafoli et al., 2007).

5.4.2 INTERACTION WITH NURSING STAFF

Despite rumours of rude nursing staff and expecting to be treated poorly at Mitchells Plain MOU, many pregnant adolescents in this study reported positive interaction with nursing staff. Participants described nursing staff as friendly and approachable, and reported that the friendly attitude of nurses made them feel at ease. Phafoli et al. (2007) had similar findings, with numerous pregnant adolescents in their study reporting that were happy with the manner in which nursing staff treated them. Positive attitudes of nursing staff towards adolescents are thought to encourage access to SRH services amongst adolescents (Jonas et al., 2017). However, in a study in South Africa, Alli et al. (2012) found that many adolescents still reported negative interactions with HCW's when seeking reproductive health care, though some adolescents were happy with the services they received.

Nursing staff at Mitchells Plain MOU reported that they had mostly positive interactions with pregnant adolescents at the MOU. An Ethiopian study by Tilahun et al. (2012) supports these findings. They found that many health workers had positive interactions with adolescents seeking SRH care services, and a smaller number of health care workers had a negative outlook on the provision of SRH care services to adolescents. Even though most of the HCW's had good interactions with adolescents, the negative actions of the smaller group of HCW's in their study acted as a barrier to access to SRH care amongst adolescents. Thus, even though many adolescents as well as HCW's report positive interactions, the negative experiences that a smaller

number of adolescents and HCW's have in the provision of SRH care services seem to filter into communities through word of mouth, creating the expectation amongst adolescents that they will be mistreated at health care facilities.

Bowser and Hill (2010) conducted study to investigate the occurrence of maltreatment of women at maternal health care centres in various countries. Contrary to findings in this study at Mitchells Plain MOU, Bowser and Hill (2010) found that HCW's frequently mistreat pregnant women and teenage mothers in particular. The authors suggest that mistreatment of vulnerable groups of pregnant women, such as pregnant adolescents, has become accepted practice in many institutions. Many pregnant adolescents thus do not report negative interactions or experiences at maternal health care facilities.

5.4.3 EXPECTED LONG WAITNG TIMES

Many participants in this study expressed dissatisfaction with waiting times at Mitchells Plain MOU. Furthermore, participants had heard about extremely long waiting times before coming to the MOU, and this caused many participants to be reluctant to go to the MOU. This is in keeping with findings by Resty et al. (2011), who conducted a mixed-methods study in Uganda to determine barriers and facilitators to utilization of maternal health care services amongst pregnant adolescents. They found that long waiting times was a barrier to access to maternal health care amongst pregnant adolescents.

Adolescents in the Eastern Cape, South Africa, also mentioned long waiting as a barrier to access to SRH services (Mayeye et al., 2010). When faced with the prospect of long waiting times, adolescents often delay accessing reproductive health care services, and will access health care services according whether or not they consider their condition to be serious enough to warrant attention from a health care professional (Onokerhoraye & Dudu, 2017). This means that pregnant adolescents may delay coming to the MOU due to expected long waiting times, and may feel that the delay in access to the MOU is acceptable because they do not feel physically ill. The prospect of long waiting times means that pregnant adolescents are not able to continue with other responsibilities they made have for the day, such as school, housework or other work responsibilities (Hokororo et al., 2015). This then further motivates pregnant adolescents to

either delay the first visit to the MOU, or default future appointments, particularly if they feel physically healthy and do not feel the need for consultation with a health care professional.

5.5 POOR SELF REPORTED KNOWLEDGE OF MATERNAL HEALTH CARE SERVICES

Participants in this study at Mitchells Plain MOU reported that they have very little knowledge about maternal healthcare services. Many reported that they received advice from their mother, grandmother or partner to attend the MOU and did not realize that early attendance at the MOU was important until they received advice to attend. Chaibva et al. (2009) also found that lack of knowledge about maternal health care services was a barrier to access to antenatal care for pregnant adolescents. Lack of knowledge concerning maternal health services is common amongst young pregnant women (Loxton et al., 2009). According to Loxton et al. (2009), the gap in knowledge includes knowing when to consult maternal health care centres, as well as knowing what services are available to be accessed.

Lack of knowledge about maternal health care services has an impact on the adolescent mother as well as her child (Combs-Orme, 1993). Often, adolescent mothers also show poor utilization of services after childbirth due to lack of knowledge of which healthcare services her baby now needs. Women who have good knowledge about maternal health care services tend to utilize maternal health care services earlier and as recommended, compared to those with poorer knowledge regarding maternal health care services (Nisar & White, 2003). Knowledge regarding maternal health care services is thus an important determining factor for access and utilization of maternal health care services, with poor knowledge acting as a barrier to access to maternal health care services.

Many participants in this study at Mitchells Plain MOU cited their mother or grandmother as sources of information concerning antenatal care and utilization of maternal health care services. Very often, mothers, grandmothers or aunts advise young girls about SRH matters such as menstruation and pregnancy prevention (Henry & Fayorsey, 2002). However, in most cases, it appears that education regarding antenatal care is only done after pregnancy disclosure. This could be because adolescent pregnancy is deemed unacceptable in many cultures and settings, or

that parents and guardians do not feel comfortable discussing pregnancy and antenatal care with adolescent girls.

5.6 LIMITATIONS

A limitation of this study is that adolescents who have not accessed the MOU were excluded. Finding those who are not accessing the MOU is extremely difficult as there was no feasible manner within the period and scope of a mini-thesis to find those who should be accessing the MOU but are not, making exclusion necessary. This means that the perceptions of pregnant adolescents who have not accessed the MOU are not known in this study. Sampling only those that have accessed the MOU means that they may be more likely to give positive feedback with regards to family support, access to services and healthcare workers.

Of the pregnant adolescents below the age of 18, only those with parental permission were included in this study, so the perspectives of pregnant adolescents below the age of 18 who did not have parental permission are unknown. Pregnant adolescents under the age of 16 years were excluded from this study due to the fact that sexual intercourse is illegal for anyone under the age of 16 years of age. The views of those below the age of 16 are thus unknown in this study, as participation will mean exploring legal issues regarding sexual activity in this group. Discussing the legal issues about their sexual history may cause undue emotional or psychological stress for participants under the age of 16. It is therefore in the best interest of those under 16 years old to be excluded.

Another limitation of this study is that I have only included participants who speak English and Afrikaans. The researcher herself funded this research, therefore budgetary constraints did not allow for the use of an interpreter or translator. As the researcher speaks only English and Afrikaans, it was not feasible to conduct the interviews in any other languages. This means that the experiences of pregnant adolescents utilizing the MOU but do not speak English or Afrikaans is not accounted for in this research.

Conducting the research at the MOU may also mean that participants could be reluctant to give a negative account of their experience at the MOU. Participants are still in the same vicinity as the nursing staff at the MOU during the interviews, albeit in a separate cubicle and out of immediate

sight. This may make it difficult for participants to give negative feedback about the MOU or staff at the MOU.

Nursing staff at the MOU may also be unlikely to report their own negative behaviour, which means that they could give a bias account of their interaction with pregnant adolescents.

The role of family planning and contraception, as well as the role of fathers in both planned and unplanned pregnancies amongst adolescents are relevant areas to explore in pregnancies amongst adolescents. However, the limited time and scope for this study did not allow for exploration of these topics.

5.7 SUMMARY

The findings of this research correlate with findings from the literature. Barriers to access to maternal health care services amongst pregnant adolescents include fear of disclosing their pregnancy, negative reactions to the pregnancy, as well as feelings of shock and disbelief. Many pregnant adolescents have negative perceptions about maternal health care services, and expect to encounter harsh treatment and judgement from nursing staff. These negative perceptions cause many pregnant adolescents to delay accessing the MOU. However, many pregnant adolescents report positive interaction with nursing staff, in spite of the negative perceptions they had about the MOU. Long waiting times served as another barrier to access to maternal health care services amongst pregnant adolescents, and poor knowledge about maternal health care services also inhibits early access to maternal health care services amongst pregnant adolescents.

CHAPTER 6- CONCUSION AND RECOMMENDATIONS

6.1 CONCLUSION

The aim of this study was to explore the barriers to access for maternal health care amongst pregnant adolescents in the Mitchells Plain sub-district. This study has shown that pregnant adolescents in the Mitchells Plain sub-district often fear disclosing the pregnancy to their parents or caregivers, and this has been identified as a major barrier to access to maternal health care services. Furthermore, adolescents often anticipate a negative response to the pregnancy from their parents or caregivers, and therefore try to hide the pregnancy for as long as possible. While trying to hide the pregnancy, pregnant adolescents avoid seeking care at maternal health care centres, because they then run the risk of their parents or guardians learning about the pregnancy if they attend antenatal clinics. Results of this study showed that most adolescents only started visiting the MOU after disclosing the pregnancy to parents or caregivers. Many pregnant adolescents at Mitchells Plain MOU reported that a negative response to the pregnancy from parents and guardians was followed by support and guidance from parents, which facilitated access to maternal health care services amongst pregnant adolescents. Advice from pregnant adolescents' mothers or grandmothers to attend the MOU was also a facilitator to access to maternal health care services amongst pregnant adolescents in the Mitchells Plain sub-district.

Many pregnant adolescents in this study had a negative perception of maternal health care services at Mitchells Plain MOU, which made them reluctant to attend the MOU. These perceptions were often created due to rumours that pregnant adolescents heard in the Mitchells Plain community about rude nursing staff prior to going to the MOU. However, the majority of adolescents in this study had positive experiences in terms of interaction with nursing staff at the MOU despite the negative rumours they heard. Nursing staff in this study were aware of the negative perceptions of nursing staff and services at the MOU, and had a desire to change that perception amongst pregnant adolescents. Nursing staff also reported that they had positive interactions with pregnant adolescents, but also felt helpless at times due to the difficult situations endured by pregnant adolescents in the Mitchells Plain community, such as poverty.

Most participants in this study were unhappy with the waiting time at Mitchells Plain MOU, which acts as a barrier to access to maternal health care services, and may contribute to pregnant adolescents defaulting future appointments at the MOU. Lack of knowledge about maternal health care services is another barrier to maternal health care services amongst pregnant adolescents in the Mitchells Plain sub-district. Very often, adolescents in this study received advice from their mother or grandmother to attend the MOU after disclosing the pregnancy, but had little or no knowledge of maternal health care services before receiving advice from their mother or grandmother. This gap in knowledge contributed to poor antenatal attendance at Mitchells Plain MOU prior to disclosure of the pregnancy.

Adolescent access to maternal health care services the Mitchells Plain sub-district is thus a complex issue. The perceptions, beliefs and attitudes that adolescents have towards maternal health care services are shaped by societal norms and expectations about adolescent childbearing, as well as rumours they have heard in the community concerning how pregnant adolescents are treated by healthcare workers. Negative perceptions, beliefs and attitudes as well as lack of knowledge about maternal health care thus hinder access to maternal health care services amongst pregnant adolescents.

6.2 RECOMMENDATIONS

Based on the findings of this research, it is clear that early pregnancy disclosure amongst pregnant adolescents should be encouraged. This will require safe spaces to be created in which adolescents can disclose their pregnancy and receive assistance to access maternal health care services. This should include inter-sectoral collaboration between the Department of Health, Department of Education as well as social welfare to ensure that pregnant adolescents receive the assistance they need in all spheres, and receive assistance to disclose the pregnancy to their parents or guardians if required. There should be a clear and well-functioning referral pathway between schools and local clinics, so that learners who suspect that they are pregnant can receive assistance from schools to get tested at local clinics, and in this way pregnant adolescents can access maternal health care services early in pregnancy. Schools should also have a clear referral pathway to social welfare departments to mediate in cases where learners are afraid to disclose the pregnancy to their parents or guardians. Parents and guardians should also be given tools on

how to cope with an unplanned adolescent pregnancy in the family, in order to better assist pregnant adolescents. This could be provided by the Department of Social Development. This interrelated pathway will require collaboration between the Department of Health, Department of Social Development as well as the Department of Education.

It may be beneficial to include education regarding antenatal care and maternal health care services in high schools' life orientation curriculum, so that all adolescents understand the importance of antenatal care, and know where and how to access maternal health care services. As part of inter-sectoral collaboration, representatives from the Department of Health may provide some of these education sessions to learners, so that the perception that adolescents are mistreated when seeking reproductive health care is addressed.

The South African Department of Health started the Integrated School Health Policy (ISHP) in 2012, which includes collaboration between the education, health and social development sectors to improve the health of school-going learners through all phases of primary and secondary education (Department of Health & Department of Basic Education, 2012). This includes SRH services, referral systems and collaboration between the relevant departments in formulating schools' life orientation curriculum. However, the ISHP has been gradually phased in since 2012, and thus is not uniformly and consistently implemented. The implementation of the ISHP thus needs to be leveraged, particularly in areas with high rates of adolescent pregnancy to ensure that inter-sectoral collaboration in the management if adolescent pregnancy.

To further address the perceptions of maternal health care services amongst adolescents, it is important that maternal health nurses receive training and education regarding the health care needs of pregnant adolescents. This training should include sensitization to the difficulties faced by pregnant adolescents when accessing maternal health care services, perceptions of maternal health care services amongst adolescents, as well as improving communication skills and professionalism towards pregnant adolescents. This may assist in bridging the communication gap that some nurses may feel when providing services to pregnant adolescents. Further research into adolescent access to maternal health care services is recommended. Further research into the role of family planning and contraception, as well as the role of fathers in adolescent pregnancy is also recommended.

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APPENDIX 1

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INFORMATION SHEET

Project Title: Knowledge, Attitudes, Beliefs and Perceptions Regarding Access to Maternal Health Care Amongst Pregnant Adolescents in the Mitchells Plain Sub-district

What is this study about?

This is a research project being conducted by Michelle Olivia Erasmus at the University of the Western Cape. We are inviting you to participate in this research project because you *are a pregnant adolescent using the Mitchell's Plain Maternity and Obstetrics Unit (MOU) for your maternal health care needs*. The purpose of this research project is to understand the perceptions and experiences of pregnant adolescents when accessing maternal health care services at Mitchells Plain MOU, in order to identify factors which may improve access to maternal health services by pregnant adolescents.

What will I be asked to do if I agree to participate?

You will be asked to give consent to participation. Once you have consented to participate, you will be asked to participate in an interview with the researcher. The interview will be audio recorded. The interview will take place at Mitchells Plain MOU, and should not take longer than one hour. This is a once off interview and you will not be required to do anything further regarding this research project on completion of the interview. You will be asked questions regarding your experiences of using Mitchells Plain MOU, your thoughts and opinions about what makes it easy and/or difficult to use Mitchells Plain MOU and how you perceive your interaction with the staff at Mitchells Plain MOU.

Would my participation in this study be kept confidential?

The researchers undertake to protect your identity and the nature of your contribution. To ensure your anonymity, your name will not be recorded on the interview guide. The answers you give will be given key codes which will give the researcher an indication of your key characteristics such as your age and stage of pregnancy, but only the researcher and the researcher's supervisor will have access to these codes. Furthermore, these codes will not allow anyone else to trace the information back to you personally. To ensure you confidentiality, all audio recordings and consent forms will be locked away, allowing no unauthorized access.

If we write a report or article about this research project, your identity will be protected.

In accordance with legal requirements and/or professional standards, we will disclose to the appropriate individuals and/or authorities information that comes to our attention concerning child abuse or neglect or potential harm to you or others. In this event, we will inform you that we have to break confidentiality to fulfil our legal responsibility to report to the designated authorities.

What are the risks of this research?

There may be some risks from participating in this research study. These risks include some discomfort or stress due to the sensitive nature of adolescent pregnancy.

All human interactions and talking about self or others carry some amount of risks. We will nevertheless minimize such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator learn more about the perspective and experiences of pregnant adolescents regarding access to maternal health care services. We hope that, in the future, other people might benefit from this study through improved understanding of the needs of pregnant adolescents.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

What if I have questions?

This research is being conducted by **Michelle Olivia Erasmus through the School of Public Health** at the University of the Western Cape. If you have any questions about the research study itself, please contact Michelle Olivia Erasmus at:

Tel: 073 177 8758 or 021 391 0555

E-mail: erasmusmichelleolivia@gmail.com

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

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This research has been approved by the University of the Western Cape's Senate Research Committee. (REFERENCE NUMBER: BM/16/4/5)

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What is this study about?

This is a research project being conducted by Michelle Olivia Erasmus at the University of the Western Cape. We are inviting your child to participate in this research project because she is a pregnant adolescent using the Mitchell's Plain Maternity and Obstetrics Unit (MOU) for your maternal health care needs. The purpose of this research project is to understand the perceptions and experiences of pregnant adolescents when accessing maternal health care services at Mitchells Plain MOU, in order to identify factors which may improve access to maternal health services by pregnant adolescents.

What will your child be asked to do if you and your child agree to participate?

You and your will be asked to give consent to participation. Once you and your child have consented to participate, your child will be asked to participate in an interview with the researcher. The interview will be audio recorded. The interview will take place at Mitchells Plain MOU, and should not take longer than one hour. This is a once off interview and you or your child will not be required to do anything further regarding this research project on completion of the interview. Your child will be asked questions regarding her experiences of using Mitchells Plain MOU, her thoughts and opinions about what makes it easy and/or difficult to use Mitchells Plain MOU and how she perceives her interaction with the staff at Mitchells Plain MOU.

Would my child's participation in this study be kept confidential?

The researchers undertake to protect your child's identity and the nature of her contribution. To ensure her anonymity, her name will not be recorded on the interview guide. The answers she gives will be given key codes which will give the researcher an indication of her key characteristics such as her age and stage of pregnancy, but only the researcher and the researcher's supervisor will have access to these codes. Furthermore, these codes will not allow anyone else to trace the information back to her personally. To ensure her confidentiality, all audio recordings and consent forms will be locked away, allowing no unauthorized access.

If we write a report or article about this research project, your child's identity will be protected.

In accordance with legal requirements and/or professional standards, we will disclose to the appropriate individuals and/or authorities information that comes to our attention concerning child abuse or neglect or potential harm to your child or others. In this event, we will inform you and/or your child that we have to break confidentiality to fulfil our legal responsibility to report to the designated authorities.

What are the risks of this research?

There may be some risks from participating in this research study. These risks include some discomfort or stress due to the sensitive nature of adolescent pregnancy.

All human interactions and talking about self or others carry some amount of risks. We will nevertheless minimize such risks and act promptly to assist your child if she experiences any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

What are the benefits of this research?

This research is not designed to help your child personally, but the results may help the investigator learn more about the perspective and experiences of pregnant adolescents regarding access to maternal health care services. We hope that, in the future, other people might benefit from this study through improved understanding of the needs of pregnant adolescents.

Do I have to be in this research and may I stop participating at any time?

Your child's participation in this research is completely voluntary. You may choose not to allow your child take part at all. If you decide that your child may participate in this research, you may withdraw the decision to allow your child to participate at any time. If you decide that your child may not participate in this study or if your child's participation at any time, your child will not be penalized or lose any benefits to which she otherwise qualifies.

What if I have questions?

This research is being conducted by Michelle Olivia Erasmus through the School of Public Health at the University of the Western Cape. If you have any questions about the research study itself, please contact Michelle Olivia Erasmus at:

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INFORMATION SHEET

Project Title: Knowledge, Attitudes, Beliefs and Perceptions Regarding Access to Maternal Health Care Amongst Pregnant Adolescents in the Mitchells Plain Sub-district

What is this study about?

This is a research project being conducted by Michelle Olivia Erasmus at the University of the Western Cape. We are inviting you to participate in this research project because you are a nurse working with pregnant adolescents at *the Mitchell's Plain Maternity and Obstetrics Unit (MOU*. The purpose of this research project is to understand the perceptions and experiences of pregnant adolescents when accessing maternal health care services at Mitchells Plain MOU, in order to identify factors which may improve access to maternal health services by pregnant adolescents. It would therefore be valuable to gain some insight from nursing staff working with pregnant adolescents at Mitchells Plain MOU.

What will I be asked to do if I agree to participate?

You will be asked to give consent to participation. Once you have consented to participate, you will be asked to participate in an interview with the researcher. The interview will be audio recorded. The interview will take place at Mitchells Plain MOU, and should not take longer than one hour. This is a once off interview and you will not be required to do anything further regarding this research project on completion of the interview. You will be asked questions regarding your experiences of being a caregiver to pregnant adolescents at Mitchells Plain MOU, your thoughts and opinions about what makes it easy and/or difficult to provide care to adolescents at Mitchells Plain MOU and how you perceive your interaction with pregnant adolescents at Mitchells Plain MOU.

Would my participation in this study be kept confidential?

The researchers undertake to protect your identity and the nature of your contribution. To

ensure your anonymity, your name will not be recorded on the interview guide. The answers you give will be given key codes which will give the researcher an indication of your key characteristics such as your age, but only the researcher and the researcher's supervisor will have access to these codes. Furthermore, these codes will not allow anyone else to trace the information back to you personally. To ensure you confidentiality, all audio recordings and consent forms will be locked away, allowing no unauthorized access.

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What are the risks of this research?

There may be some risks from participating in this research study. These risks include some discomfort or stress due to the sensitive nature of adolescent pregnancy

All human interactions and talking about self or others carry some amount of risks. We will nevertheless minimize such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator learn more about the perspective and experiences of pregnant adolescents regarding access to maternal health care services. We hope that, in the future, other people might benefit from this study through improved understanding of the needs of pregnant adolescents.

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Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

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APPENDIX 4

RECORD OF INFORMED CONSENT TO CONDUCT AN INTERVIEW

CONSENT FORM

Title of Research Project: Knowledge, Attitudes, Beliefs and Perceptions Regarding Access to Maternal Health Care amongst Pregnant Adolescents in the Mitchells Plain Sub-district

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

Participant's name……..

Participant's signature…….

Date……

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION

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APPENDIX 5

RECORD OF INFORMED CONSENT TO CONDUCT AN INTERVIEW

PARENTAL PERMISSION FORM

Title of Research Project: Knowledge, Attitudes, Beliefs and Perceptions Regarding Access to Maternal Health Care amongst Pregnant Adolescents in the Mitchells Plain Sub-district

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my child's participation will involve and I agree to allow my child to participate of my own choice and free will. I understand that my child's identity will not be disclosed to anyone. I understand that I may withdraw my child from the study at any time without giving a reason and without fear of negative consequences or loss of benefits to me or my child

Parent/guardian's name……..

Parent/guardian's signature…….

Date……

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APPENDIX 6

RECORD OF INFORMED CONSENT TO CONDUCT AN INTERVIEW

ASSENT FORM

Title of Research Project: Knowledge, Attitudes, Beliefs and Perceptions Regarding Access to Maternal Health Care amongst Pregnant Adolescents in the Mitchells Plain Sub-district

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be revealed to anyone. I understand that I may decide to no longer participate in the study at any time without giving a reason and without fear of negative consequences or loss of benefits to me.

Participant's name……..

Participant's signature…….

Date……

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION

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APPENDIX 7

Interview guide- Adolescent

- Introduce topic

The purpose of this research is to explore knowledge, attitudes beliefs and perceptions of pregnant adolescents regarding access to maternal health care services. The reason for this is that adolescents/young people often come to the MOU very late in pregnancy, so I want to find out reasons for this, and what makes it easier or more difficult for young people to come to the MOU. I hope that this research will then help to identify ways to improve services for young people.

- Gain demographic information (age, area of residence, school/employment, family background)

How old are you?

Where do you live?

Do you attend school/work/

If yes, what grade? If no, what grade did you finish?

Prompt for those who left school… Did you leave school due to pregnancy?

Who do you currently live with?

- Can you tell me about your experience of finding out that you were pregnant?

Probe: How did that make you feel? Can you tell me about whether anyone helped you with this and how?

- Can you tell me about why you came to the MOU?

Probe: Can you tell me about whether anyone helped you decide to come here?

Probe: Can you tell me about anything that happened that made you decide to come here?

- Can you tell me about what it was like coming here to the MOU for the first time?

Probe: How did you feel about coming to the MOU?

Can you tell me about any good experiences you had at the MOU? How did that make you feel?

Can you tell me about any bad experiences you had at the MOU? How did that make you feel?

- Can you explain if there is anything that made it easier for you to come to the MOU?

- Can you explain if there is anything that made it difficult for you to come to the MOU?

APPENDIX 8

Interview Guide: Nursing staff

- (Get demographic information: Age, years of experience)
- How do you feel about the high rate of teenage pregnancy in this community?

Probe: Can you tell me about things you think contribute to high rates of teenage pregnancy?

- Can you tell about why access to the MOU is important for pregnant teenagers?

- How do you feel about working with pregnant adolescents?

Probe: Can you tell me about any positive experiences/incidents when working with pregnant adolescents? How did that make you feel?

Can you tell me about any negative experiences/incidents when working with pregnant adolescents? How did that make you feel?

- How would you describe your interaction with pregnant adolescents at the facility?

Probe: Can you explain how you react to pregnant teenagers who miss appointments/don't comply with medical advice?

Probe: Can you explain how you react to pregnant teenagers who seem nervous/anxious when they come to the MOU?

- Can you tell me about reasons why adolescents make late bookings?

Probe: Can you explain if there is anything at the MOU that contributes to teenagers making late bookings?

- Can you explain what you think would help adolescents' access maternal health care?

Probe: Can you tell me about what you think staff can do differently to assist pregnant teenagers at the MOU?

Probe: Can you tell me about anything at the MOU you would like to see change to help you work more effectively with pregnant teenagers?