

Access-related Barriers to Early Antenatal Booking by Pregnant Mothers in South Africa: An Exploratory Design

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Abstract

Background

The primary health care system is accessible to all communities globally. Each provides specialized skills to address the antenatal care needs of pregnant women across all communities. Antenatal care is defined as the routine care of pregnant women provided between conception and the onset of labour. However, Antenatal clients seem not to access care early, before 12 weeks of confirmed pregnancy.

Subject and Methods:

The study followed a qualitative, exploratory, descriptive, contextual design and a descriptive phenomenological method to allow in-depth exploration of pregnant women's experiences of access-related barriers to early antenatal booking. The population is pregnant women visiting the facility for care first time in this pregnancy. Purposive sampling was done to gather information from the participants as they experienced the phenomenon under study. Data was collected through unstructured interviews, and responses were audiotaped and transcribed. Data analysis followed a thematic approach based on Colizzi six steps.

Results

Three themes and Nine sub-themes emerged from the study: Literacy and Knowledge Barriers to Early ANC Attendance, with five sub-themes; Lack of understanding of the early booking, English medium is a barrier to communicating ANC messages to pregnant women, antenatal clients do not know the signs of pregnancy they associate it with illness, Failure to comply with test results given by midwives at the clinic, and Multiparas use their experiences to learn and confirm the signs; Socio-Economic Barrier with two sub-themes; Transport money a reason for late booking, Traveling long distances to the clinic; and Health System Barrier with two sub-themes; Health professionals' attitudes, a barrier to early antenatal booking, health Facilities Conditions Reasons for failing to attend ANC. Trustworthiness and Ethical principles were adhered to.

Conclusion

The study results may inform policy-making, nursing practice, and further research.

Key Concepts:

Accessibility, Client-related barriers, Early Antenatal booking

BACKGROUND

The primary health care system is accessible to all communities globally. Each has the specialized skills to address the antenatal care needs of pregnant women across all communities (Khatri et al., 2024). The Primary Health Care stands firm on six key building blocks of the health care system service delivery, health labour force, health information systems, health financing, medications, leadership, and governance, which are crucial to strengthening PHC to meet community health needs (Rai et al., 2024). Apart from the six key building blocks, primary Health care is more effective when delivered through a comprehensive, integrated approach and community active participation (Cooper et al., 2026).

An international study defines Antenatal care as the routine care of pregnant women provided between conception and the onset of labour. Antenatal care is an opportunity to prevent and manage existing and potential causes of maternal and newborn mortality and morbidity (Bowden, Chang & McCallum, 2023). However, antenatal care can only take place when antenatal clients show up at the facility at their earliest convenience before 12 weeks of confirmed pregnancy. The new World Health Organization (WHO) antenatal care model recommends that the first antenatal care visit occur within the first trimester (gestational age < 12 weeks), with an additional 7 visits (Lee et al., 2024).

Studies in developing countries show that the national antenatal coverage of clients attending antenatal clinics late is high (Abuhay et al., 2025). One district in Sub-Saharan Africa (2023–2024) data indicate that over 90% of pregnant women initiate antenatal after 20 weeks of gestation, well beyond the WHO recommendation of booking within the first trimester (Krischer, et al 2026). Furthermore, another study shows that the burden of unintended pregnancy is substantial in sub-Saharan Africa, with estimates ranging from 11.2% to 30% across the region (Tiruneh., et al 2026). This burden reflects structural and behavioural determinants, including non-use or discontinuation of contraception, contraceptive failure and sexual violence (Sibanda, Khozah, & Moyo, 2026). Facility and population-based studies from Ethiopia and other African settings consistently reported prevalences of approximately 30% among pregnant women, with higher levels among adolescents, women of low socio-economic status, and those with limited knowledge or autonomy regarding reproductive health (Yoseph., et al 2025).

Seven national surveys were conducted to evaluate the coverage of ANC services at the national level, which included two national maternal health care coverage surveys and five Ethiopian Demographic and Health Surveys (EDHS) studies. Furthermore, three reports from WHO/United Nations International Children's Emergency Fund (UNICEF) and three administrative reports from Ethiopian Federal Ministry of Health (FMOH) were examined (Tiruneh., et al 2026). These studies and reports suggest that the use of ANC services in Ethiopia has recently increased. The most recent mini-EDHS 2019 report indicates that the overall ANC utilization coverage in the country rose from 28% in 2005 to 74%, while the proportion of women attending four or more ANC visits grew from 12% in 2005 to 43% in 2019. However, significant regional disparities in Ethiopia have continued since 2005, with pastoralist regions consistently showing very low ANC utilization rates (Abuhay et al., 2025).

A national study suggest that pregnancy is viewed as an honour by the family. However, it is also considered a sacred event that should be kept confidential due to fears of bewitchment. The underlying belief is that malevolent spirits may affect the pregnant woman if exposed in the first trimester, potentially leading to fetal malformation. Within this belief framework, women tend to remain at home during the first trimester of pregnancy (Ngomane & Mulaudzi, 2012). The findings of a recent study conducted in South Africa revealed that delays in seeking antenatal care were influenced by several factors, including unawareness of pregnancy, the tendency to wait for observable signs of pregnancy, and apprehension regarding HIV testing. Furthermore, structural and healthcare system barriers, such as transportation challenges, considerable distances to healthcare facilities, and suboptimal facility conditions, further hindered timely access to antenatal services.

Late initiation of antenatal care was also associated with efforts to avoid prolonged waiting times, inadequate healthcare infrastructure, language barriers, and perceived mistreatment by nursing staff (Myburgh et al., 2024). Another study identified a range of factors influencing the timely initiation of antenatal care, including healthcare workers' conduct, negative provider attitudes, deficiencies in operational management, and the socio-economic circumstances of pregnant women. The findings suggest that strengthening staff counseling, providing ongoing professional development and training in comprehensive maternal healthcare, and delivering accurate, standardized, and consistent health education that is culturally sensitive and responsive to prevailing beliefs and practices may enhance the early uptake of ANC services (Mlambo & Ibeziako, 2025). This study seeks to share results of barriers to early antenatal booking in the context of Mpumalanga Province, South Africa.

SUBJECTS AND METHODS

This study adopted a qualitative design to gain an in-depth understanding of antenatal clients' experiences of barriers to accessing early antenatal care. Qualitative research methodology provides strengths that offset the weaknesses of collecting data that may not be able to answer the research question and provides a more comprehensive understanding of the research problem than other research methodologies in the participants' natural setting (Berkovich & Grinshtain, 2023).

Research Design

Exploratory, descriptive, and contextual designs were applied to answer the research question.

Exploratory Design

An exploratory design was employed to explore antenatal clients' experiences without relying on preconceived assumptions (Faulkner, Faulkner, & Faulkner, 2025). The study aimed to gain a deeper understanding of early antenatal experiences as described by the participants themselves.

Descriptive Design

The descriptive design was used to obtain detailed accounts of participants' experiences and identify recurring patterns and themes (Tisdell, Merriam, & Stuckey-Peyrot, 2025).

Contextual Design

A contextual design complemented the descriptive approach by exploring early antenatal booking within the natural consulting environment of antenatal clients coming for their first antenatal booking in this pregnancy (Steen, 2025). This ensured that findings and recommendations were grounded in the realities of clinical practice.

Research Method

The study used a descriptive phenomenological approach to explore the lived experiences of antenatal clients coming for their first antenatal booking in this pregnancy (Lindqvist & Forsberg, 2023). This approach focused on describing participants' experiences as they were lived and understood, rather than interpreting them through theoretical frameworks. It provided valuable insights into participants' experiences that may not be captured through more structured research methods (Creswell, 2019).

Descriptive phenomenology was considered appropriate because it enabled the collection of rich, detailed accounts from antenatal clients coming for the first antenatal clinic in this pregnancy (Taylor, Benson, & Hendon, 2025).

Research Setting

This study was conducted in the rural Bushbuckridge sub-district of the Ehlanzeni District in Mpumalanga Province, South Africa. Bushbuckridge has an estimated population of 639,635 and is served by 40 Primary Health Care (PHC) facilities, including five 24-hour community health centres and 35 daytime clinics providing antenatal care services. The sub-district experiences a high rate of late antenatal bookings (34%), exceeding the World Health Organization target and contributing to adverse perinatal outcomes. The research setting was considered important because contextual factors can influence study outcomes and access to quality antenatal care (Carr, 2026). The selected PHC facilities were purposively chosen due to their large patient volumes, high numbers of antenatal bookings, extended operating hours, and their service to culturally and ethnically diverse populations, making them suitable sites for exploring antenatal care practices (Yihune et al., 2025).

Study Population

The population of this study was multipara antenatal clients presenting for their first antenatal clinic visit in this pregnancy. The participants were sampled using criterion purposive sampling as they possessed the ability to answer the research problem under this study (Pitard & Pitard, 2026). According to DePoy (2024), the population is the entire set of participants, including participants that have comparable features and meet the inclusion criteria of this study. The population was more than Para two antenatal clients coming for their first antenatal booking in this pregnancy in Primary Health Care facilities of Bushbuckridge sub-district, Mpumalanga Province. The population is comprised of Tsonga, Sotho, Coloured and Swazi ethnic groups staying in the same villages and utilising the same Primary Health Care facilities.

Sampling method and sample size

Non-probability purposive sampling was used to select all pregnant multiparas coming for their first antenatal visit in this pregnancy, as they have experience of attending antenatal visits which are under study (Flanagan & Beck, 2024). According to Creswell and Báez (2020), purposive sampling is known as judgmental, selective, or subjective sampling, depending on the researcher's judgment in choosing the participants who experience the phenomenon under study. Primary Health Care facilities of the Bushbuckridge sub-district in Mpumalanga were purposely selected. Twenty-two antenatal clients were sampled and interviewed until saturation was reached (Hossain, Alam, & Ali, 2024). The setting of the current study was Bushbuckridge, where five Primary Health Care facilities were selected purposely for their known easy access to antenatal clients from several indigenous community settlements.

Inclusion criteria

The criteria included different generations of antenatal clients of all languages and ethnic groups residing in Bushbuckridge who were coming for their first antenatal booking in this pregnancy. The selection was based on the availability of daily antenatal services. Only 22 antenatal clients who are gravida 2 or more, and attending their first antenatal visit for this pregnancy, were included in the study.

Exclusion criteria

The study excluded antenatal clients attending follow-up care, or gravida one antenatal clients. Participants who met the inclusion criteria but did not consent to the study were excluded from the study.

Data Collection And Organisation

Before data collection, Ethics approval was obtained from the University of Pretoria (Ethics number: 45/2021). Data were collected by the researcher, with support from an assistant researcher, using unstructured open-ended interviews to enable an in-depth exploration of the phenomenon under study (Hossain, Alam, & Ali, 2024). The interviews were conducted in a private room at the Primary Health Care facilities where antenatal clients received care. The interviews were conducted face-to-face with each

participant, and service disruptions were avoided by ensuring that clients were examined in the same room where they were interviewed. Each interview lasted approximately 45 minutes, and the researcher needed three months to collect data. The main opening question was, "What are your experiences of early antenatal booking?" A follow-up question was posed by the researcher to facilitate in-depth discussions and to document the exploration of in-depth knowledge (Xu, Wang, & Qian., 2025). Transcripts and voice recordings were used to gather rich qualitative exploratory data from participants. During the interview, the researcher used good communication skills to ensure the capturing of all responses without losing the meaning. Verbal and non-verbal cues were documented to guarantee the completeness of the data. The researcher used probing to encourage more information sharing from participants. Antenatal clients were interviewed until saturation was reached at the 22nd participant. Paraphrasing and follow-up questions were used to confirm understanding of the meaning of the information.

Data Analysis

Data analysis was conducted using Colaizzi's method of data analysis as described below (Sapountzi-Krepia, 2026).

The orientation phase.

Prior to writing down what was in the audio recordings, the researcher carefully listened to the audio recordings to gain a better understanding. The researcher listened to the tape recorder three times to confirm what was written in the transcripts. The researcher attempted a thorough analysis of the data's meaning during the listening phase. The researcher also reviewed the original research objectives and determined which questions the data could address. The researcher made a summary of the readings after concluding the interviews.

The coding stage.

By examining similar and distinct data, the data was divided into multiple fragments through the process of coding (Sapountzi-Krepia,2026). The researcher then created a framework in which major concepts and ideas were noted and assigned codes. The data was coded to organise and label it. Following the data coding, the researcher carefully examined the codes to find patterns that could be gathered again. A revision was conducted to identify data that did not fall under that category (Myers., 2025).

Identifying the themes

Data was presented in the form of themes and sub-themes for objective one by organising the qualitative data into key themes and patterns that have been perceived (Roseveare, 2023). The research questions guided the development of the themes, which then emerged from the data as the study was being completed. The identified themes were then organised into thematic groups, their significance was examined, and their relationship to the research objectives was established. Next, the researcher

assessed the themes, eliminating any that lacked sufficient evidence to support them and combining any that were connected (Streelman 2023).

Examining themes

The basic themes discovered in the previous stage were reviewed, improved, and enhanced throughout this phase (Komane 2023). To determine whether each theme made sense, the researcher gathered information pertinent to each theme. Following Colaizzi's method of data analysis, the data associated with each topic were color-coded and then read to determine whether the data supported the theme, whether too much material was crammed into the theme, and whether overlapping themes were distinct (Colaizzi et al., 1969) as cited by Sapountzi-Krepia (2026). After the review, the researcher had a fair understanding of the many themes, how they interacted, and the overall narrative they conveyed about the data.

Defining and naming themes

The concepts that would be given for analysis were then outlined and improved. At this point, the researcher determined which aspects of the data each theme captured. The organised data extracts for each theme were then compiled into an understandable explanation with a story to go along with it. The story that each theme communicated was identified through a thorough analysis produced concurrently for each topic (Magnani & Gioia, 2023).

Combining and interpreting

The researcher then used a concise and persuasive extract relating to the topics, research question, and literature to transform the analysis into a piece of interpretable writing. The data were combined and analysed by the researcher to draw conclusions on the causes of pregnant women's delayed antenatal booking (Sapountzi-Krepia, 2026.).

TRUSTWORTHINESS

According to Lincoln & Guba (1985), Trustworthiness is a quality criterion in qualitative research. In this study, the following were ensured: credibility, conformability, transferability, dependability, and authenticity.

Credibility

To ensure credibility, the researcher engaged in prolonged interviews to develop an understanding of customs and culture. This approach aimed to ensure that information captured was representative of antenatal clients seeking antenatal booking. During interviews, the researcher made cautious observations to ensure that verbal cues and non-verbal cues were captured to represent the meaning of the information captured (Ivey, 2023). Member checking was done to improve the reliability and validity of this qualitative study (Riazi, Rezvani, & Ghanbar, 2023). Additionally, probing inquiries were utilised to confirm their statements. This tactic was employed to guarantee the accuracy of the gathered data.

Confirmability

To satisfy this requirement, the researcher ensured that credibility, dependability, and transferability were achieved and that the interpretations and findings were of high quality (Enworo, 2023). Lastly, the researcher ensured that a confirmability audit was conducted to examine the study results and confirm that the research findings, interpretations, and recommendations were supported by the raw data (Gunbayi, 2024).

Transferability

The researcher encouraged participants with follow-up questions to elicit in-depth, rich descriptions as they responded to open-ended questions. The researcher ensured that detailed descriptions of results, interpretations, and recommendations were provided to facilitate the transferability of the findings to other potential research sites (Polit & Beck, 2010), as cited by (Petersson et al., 2023).

Dependability

In qualitative research, reliability and dependability are related. Dependability is the degree to which a study can be replicated by a different researcher and yield identical results (Lincoln & Guba, 1986, as cited in Enworo, 2023). To ensure dependability, the researcher ensured that the study followed a consistent, easy-to-follow, and clearly documented process to facilitate auditing of the research.

Authenticity

The researcher applied the fairness principle to ensure the findings represented all cultures, ethnic groups, or social classes. The researcher ensured that all participants expressed their understanding and interpretation of the views presented in the study results and that all participants had equal learning opportunities (Yanti, Dwi, Putri, & Zulfani, 2025).

ETHICAL CONSIDERATIONS

The rights, welfare, and dignity of study participants and other stakeholders were all protected in accordance with the Declaration of Helsinki. According to (Wang et al., 2026), ethical considerations were selected because participants are human beings with the right to safety, respect, and anonymity. Due diligence was considered when dealing with them throughout the research project (Atenas, Havemann, & Timmerman, 2023).

RESULTS

Description Of Demographic Data

Table 1.1 indicates that antenatal clients who participated in the qualitative strand of Phase One came from different ethnic groups. They were all females of childbearing age coming for their first antenatal visit in this pregnancy. In the first objective of Phase One, the population size purposively sampled was 22 antenatal clients. Amongst the 22 antenatal clients that participated in the qualitative strand, 55%

(12) were in the age group 21 to 30 years. Amongst these participants, 36% (8) were between 31 and 40 years old, and 9% (2) were between 41 and 45 years of age. Furthermore, 77% (17) were gravida two, 14% (3) were gravida three, and 9% (2) were gravida five. Out of the 22 that participated in this study, 60% (13) were para one, 20% (04) were para two, 13% (03), and 7% (02) were para four.

ANNEXURE A: Table 1.1 Demographic Information of the Sample (N=22)

STUDY FINDINGS

In this study, three themes with nine sub-themes emerged from an exploratory descriptive and contextual qualitative design that interviewed 22 antenatal clients coming for first antenatal visit in this pregnancy.

ANNEXURE B: TABLE 1.2 THEMES

ANNEXURE C: Table 1.3 Theme 1: Literacy and knowledge barrier

THEME 1: LITERACY AND KNOWLEDGE BARRIERS TO EARLY ANC ATTENDANCE

The first theme of this study showed that clients were reluctant to attend the antenatal clinic early due to client-related factors, such as a lack of understanding. From the statement of clients, it was evident that multipara women used their experience to learn and confirm the signs of pregnancy, which might cause their delay in showing up for early antenatal visits. In this study, multipara women confirmed that they already knew what was done at the antenatal service; hence, there was no need for them to present early before 12 weeks. This finding was analysed from the statements below:

1.1 Sub-theme 1: Lack of understanding of the early booking.

Participants verbalised that they did not understand why they had to present early at the clinic because the pregnancy was still invisible. They wondered what the sisters would see during the examination and did not wish anyone to see it at this early stage.

"I do not understand why I should start coming for an antenatal check-up this early because my pregnancy is not yet visible, and I do not understand what the sisters will see on the examination. Secondly, I do not want anyone to see it this early" (P 6).

Another participant added that early ANC would add to the number of times they had to visit the clinic, and they felt it was exhausting.

"I'm not sure why I have to book early before 12 weeks because it will just add the number of times I come to the clinic; it is exhausting" (P 21).

In the interviews, one participant said she does not know why she has to show up this early at the clinic, as it is exhausting to start so early.

"Participants confirm that she did not know the signs of pregnancy , what she knows is that she missed a menstrual period. She further says she just felt miserable and sick because of nausea and vomiting." (P 5).

One participant confirmed that she did not know the signs of pregnancy. She only knew that she had missed her menstrual periods. She further said that she just felt miserable and sick because of nausea and vomiting, which usually happened in the morning, and it disturbed her usual routine.

"I do not know the positive signs of pregnancy except that I missed my period, and I feel miserable because the things that I used to like make me pour out very bitter stuff. Yes, it happens more in the morning, and it disturbs my routine" (P 10).

In this study, participants stated that whether they came early or late for the first antenatal booking was the same. These results are supported by Adulo and Hassen (2022), whose study showed challenges of early antenatal booking as a lack of information regarding the timing of antenatal appointments, the value of making early reservations, a hostile nurse-patient relationship, and a staffing shortage. The assumption that they were not at substantial risk related to pregnancy, as well as family and economic activities, also contributed to late booking by these women. The responses of antenatal clients showed that a lack of information or assurance on the advantages of prompt and frequent ANC was the most common knowledge-based hindrance. Penman et al. (2023) support these findings in their study, where seven clients spoke of hindrances that could be understood as consequential to a lack of knowledge.

1.2 Sub-theme 2: English medium as a barrier to communicating ANC messages to pregnant women

Some participants could only read vernacular language to a certain extent, and some could not even read in vernacular. They needed an explanation of what was written on the notice board.

"I am able to read in the vernacular to some extent, and not in English. But I need explanation on what is written on the notice board" (P 12.)

A participant said she could not read or write in vernacular or English. Yet, at the facility, they were given pamphlets written in English.

"I cannot read or write in vernacular and even English, they give us pamphlets written in English, but I am not able to read what is written" (P 18).

Another said that she could see the pictures on the wall but could not understand what they meant because she could not read what was written, as she was uneducated. She said she could read vernacular to a certain level. She further expressed that she was from another country, and it wasn't easy to catch up with school when you were from another country.

Sister, I can see the pictures on the wall, but I cannot read what is written because I am uneducated. I can read my vernacular language to a certain extent, Aah! Sister, you know that when you come from another country, it is difficult to get an opportunity to go to school” (P 20).

One participant showed frustration in not progressing far with her education. She knew how to write her name and surname. She said that she came from another country with her husband, who was coming to work in a hotel. The husband agreed to assist her in pursuing her education so she could learn to read and write, as being unable to read is a problem for her.

“Yhoo! I did not go far with my school. I only know how to write my name and surname. I just came into the country with my husband, who is working at the hotel. Yes, if he agrees, I can pursue find a school where I can learn because it is a problem not to be able to read” (P3)

Findings in this study show that participants lack knowledge due to their literacy level, which poses a barrier to reading and writing. Battu et al. (2023) concur with these results, noting that 86.6% of late antenatal bookings were due to insufficient knowledge. The median age (IQR 25.7–27.1) was 26.4 years. In multivariate logistic regression analysis, age, marital status, and parity were also predictors of late antenatal booking. Studies conducted by Lungu et al. (2023) confirmed that, even though all pregnant women had access to free antenatal care services, late-booking rates remained high due to a lack of knowledge. The value of early antenatal care booking to expectant mothers might be increased with the support of public awareness and health education. In a study by Edessa, Dida, and Teferi (2023), facility factors were confirmed to be barriers to early antenatal care. Eleven (50%) of the antenatal clients who participated in the study were at the primary level, three (13,6%) of the antenatal clients were at the secondary school level, five (23%) were at the high school level, while three (13,6%) were at the graduate and or postgraduate level. The low number of graduate and postgraduate attendance created room for more research to determine why graduates and postgraduates were not attending government antenatal facilities in numbers.

1.3 Sub-Themes 3: Antenatal clients do not know the signs of pregnancy;

they associate it with illness

From the 22 interviews conducted it is learned that antenatal clients do not know the signs of pregnancy. They came to the clinic only when they missed one menstrual period because they thought they are sick and needed intervention.

“I missed one menstrual period and went to the clinic where urine was tested for pregnancy test positive, Staff advised that I am starting antenatal care and must return monthly.”

This confession from antenatal clients confirms that when the body presents with ailments that the client does not understand, they present early at the facility. However, when they realize they are pregnant, they recess only to come back late.

"I do not know the positive signs of pregnancy except that I missed my periods and I feel miserable because the things that I used to like, make me pour out very bitter staff. Yes, it happens more in the morning, and it disturbs my routine."A similar thing happened with my first and second children, which is why I suspect that I may be pregnant"(P11)

After interviewing 22 antenatal clients, it was discovered that it is a challenge for most antenatal clients to realize that they are pregnant using signs and symptoms of pregnancy, based on the following quotes:

"I missed one menstrual period and went to the clinic, where urine was tested for a pregnancy test positive. Staff advised that I am starting antenatal care and must return monthly."I felt sick with nausea and vomiting, dizziness, and fatigue, but I did not associate it with pregnancy as I did not know the positive signs of pregnancy. I do not know the positive signs of pregnancy except that I missed my periods and I feel miserable because the things that I used to like to make me pour out very bitter staff. Yes, it happens more in the morning, and it disturbs my routine. A similar thing happened with my first and second children, which is why I suspect that I may be pregnant."(P13).

Some antenatal clients have no knowledge of the positive signs of pregnancy. This is confirmed by statements like

"I felt sick with nausea and vomiting, dizziness, and fatigue, but I did not associate it with pregnancy as I did not know the positive signs of pregnancy." This category resulted in four sub-categories during analysis:

From the statement below, it is evident that multipara women use their experience to learn and confirm the signs of pregnancy, which may cause their delay in showing up for early antenatal visits. In the qualitative strand, which is the first objective of this study, multipara women confirmed that they already know what is done at the antenatal service; hence there is no need for them to present early before 12 weeks. This is confirmed by the statement below,

The research findings confirm that Antenatal clients visit the clinic when they miss one monthly menstrual period because they suspect pregnancy; however, they are not sure if they are pregnant or not. It is evident from these findings that Antenatal clients do not know the signs of pregnancy; they associate it with illness; hence, they present at the clinic with illness. Some present with illnesses, including Suspicion of pregnancy; however, they are not sure, according to the results of this study. Ndomba, et al (2023) support this finding in their study that found factors associated with likelihood for late antenatal care booking during the initial visit, including tertiary education [AOR= 10.174, 95%CI: 1.002-103.301] and primigravida [AOR=0.101, 95%CI: 0.170-0.605]. These results are supported by a study conducted in Limpopo Province, where 37% of antenatal clients did not start antenatal care early, before twelve weeks, because of a lack of knowledge (Molokomme, Matlala & Ntuli 2021).

1.4 sub-theme 4: Noncompliance with test results given by midwives at the clinic

Some participants verbalised that when they missed their period, they did visit the clinic, but after a positive pregnancy test, they did not comply with the advice given by the midwife because they do not see why they must start antenatal clinic early. This participant confirmed that the sisters ran tests at the clinic verifying her pregnancy. She was shocked to discover she was pregnant because it was unplanned, and she didn't go back on the day that her sister had given.

"I missed one menstrual period and went to the clinic where urine was tested for pregnancy test positive and I was shocked, Staff advised that I am starting Antenatal Care and must return monthly but never came back to the clinic on the given date" (P 3).

A participant confirmed that she had missed her menstrual period and consulted the PHC facility, where a pregnancy test was done, which was positive. After she was advised to continue coming for antenatal, she refused. Another participant also said that she was shocked by the positive pregnancy test.

"After the sister tested my urine, she confirmed pregnancy, of which I was shocked" (P 12).

"I went to the clinic, and sister checked my urine with a long paper and showed me that it had two lines which means I am pregnant, and I was very shocked" (P 16).

This participant confirmed that she was given an antenatal card as evidence that antenatal booking was initiated on the day of the positive pregnancy test. Still, she did not honour the return date because she wanted to return after three months.

"She said this is a book I will bring along on every visit when I come to the clinic. But I'm only one month pregnant and do not understand what I am coming to do in the clinic before I complete three months" (P 11).

Another client confirmed that the sister at the clinic had advised her to return for a subsequent antenatal visit after one month. However, she did not go because her pregnancy was still not visible, and she did not know what her sister wanted to see at that point.

"I do not understand why I should start coming for an antenatal check-up this early because my pregnancy is not yet visible, and I do not understand what the sisters will see on the examination because my pregnancy is still small" (P 2).

One participant stated that starting antenatal visits early would only add to the number of clinics visit days. Her understanding was that the sisters in the clinic would not see anything even if she could go early. She felt that it would be better for her to go only when the pregnancy was visible and when the sister in the clinic could see something during the examination.

"I'm not sure why I have to book early, before three months, because it will just add the number of times I come to the clinic; it is exhausting" (P9).

In the statements above, antenatal clients confirmed that nurses had conducted tests on them if they had missed one or more monthly menstrual periods when they visited the facilities. The tests would include urine testing, blood pressure checks, weight, and other pregnancy-related issues, determining pregnancy risk, educating expectant mothers, and supporting women to have happy pregnancies and childbirth life experiences. Psaila, Schmied, & Heath (2023:5) concurred with these findings as their study found that nurses conducted several tests during a first antenatal visit and in a subsequent visit. The patient's experiences showed that nurses were also willing to share their knowledge and support the patients when they were open to learning. Pesantes, Palacios, Hewlett, and Maake's (2023) study supported these results as their research confirmed that nurses invested time advising patients to seek medical care early to prevent complications. The above statements from antenatal clients confirmed that each time they consulted the clinic, Primary Health Care nurses conducted relevant tests to determine their health needs. Sundermann et al., (2026) supported the results of this study, as their research confirmed that pregnancy was detected early through pregnancy tests. Still, pregnant women did not respond as advised based on their different perceptions, needs, and experiences that shaped who they were and defined how they understood health.

1.5 Sub-Theme 5: Multiparas use their experiences to learn and confirm the signs and symptoms of pregnancy

This sub-theme showed that clients were reluctant to attend the antenatal clinic early due to client-related factors like past experience. From the statement of clients, it was evident that multipara women used their experience to learn and confirm the signs of pregnancy, which might cause their delay in showing up for early antenatal visits. In this study, participants confirmed that they already knew what was done at the antenatal service; hence, there was no need for them to present early before 12 weeks. After interviewing 22 antenatal clients, the majority voiced that the health facility's condition discouraged them from initiating ANC early. Participants emphasised that a lack of staff forcing them to attend early in the morning and depart late in the afternoon was a major barrier in prenatal clinics. This finding was analysed from the statements below:

"A similar thing happened with my first and second children, which is why I suspect that I may be pregnant".

From the statement below, it is evident that multipara women use their experience to learn and confirm the signs of pregnancy, which may cause their delay in showing up for early antenatal visits. In this study, multipara women confirmed that they already know what is done at the antenatal service; hence, there is no need for them to present early before 12 weeks. This is confirmed by the statement below,

"It is the same; whether you come early or not, it doesn't change anything. In my first pregnancy, I came early, and it did not mean anything."

Ummah, Rosdiana, & Utami 2026. support this finding through their study, which found 85.1% of multipara women presented late on their first antenatal visit. This finding is supported by Heri, Mselle, and Malqvist, (2023), whose study found that multipara women described signs of labour based on their

past experiences, which contributed to late presentation at the maternity ward rendering them vulnerable to perinatal risks. According to the multivariate regression analysis results, individuals' educational background and familiarity with antenatal care services were important predictors of late antenatal booking. Ndomba et al., (2023) support the result from their finding, which shows women who are primigravida have a 90% lower risk of making early reservations than women whose parity is between 1 and 2. The chance of a late ANC booking is considerably higher for pregnant women who are three or more parities than for those with one or two births (AOR=0.101, 95% CI: 0.170-0.605, $p = 0.012$). In their study, Mohan, et al., (2023) confirms that Multipara women pitched late at first antenatal booking than primigravida.

ANNEXURE D: Theme 2: Socio-Economic Barrier

THEME 2: SOCIO-ECONOMIC BARRIER

2.1 Sub-theme 6: Transporting money a barrier for early Antenatal booking

The responses from some participants showed that lack of transport contributed to delayed antenatal booking. Participants reported that having transport money for many clinic visits was impossible. Additionally, if they started early, everyone would know they were pregnant. Furthermore, participants indicated that they have to walk a long distance to the facility; hence, they are reluctant to start the antenatal clinic early.

"Sister Mara, it is impossible for me to have transport money for many clinic visits. Despite if I start clinic check-ups now, everyone will be aware that I am pregnant, which I do not prefer to disclose at this early stage" (P 18).

One participant stated that her husband was working in Rustenburg and not coming home every month. She felt it would be better if her husband came earlier to give her money for transport.

"You see, my husband works in Rustenburg, and he is not coming home every month. Maybe it would have been better if my husband came back early so that I could have money to come early" (P 4).

Another participant said that she did not have money for transport, and it would be better to start after three or four months to save on transport money.

"Furthermore, I did not have money to start clinic this early; it is better to start at three or four months so that I save money and time" (P 2).

This participant verbalised that she could not show up for an early antenatal clinic visit because of a lack of transport money. She further explained that her mother had no money, and no one was at home to assist her.

"Finances are a contributory factor to my not being prepared to start early I have no one to support me financially because my mother had no money to give me for transport, and I have no job" (P5).

Another participant said she did not work and depended on her mother for transport money. She said her mother got her grant at the beginning of the month, and her budget was tight.

"Sister, I am not working, and I depend on my mother for transport money. She is only getting her grant at the beginning of the month, and her budget is very tight. If I begin to come to the clinic earlier than after three months, it will cost me more visits than necessary due to the early prenatal booking" (P 20).

Lack of transport money to visit Primary Health Care facilities contributed to late antenatal booking. As such, the antenatal clients' responses indicate that they are not working, possibly leading to a lack of transport money to attend early antenatal clinics (Ali, et al 2025). 33% of antenatal clients were not married, possibly contributing to the number of those whose partners were older. Studies found that all clients whose pregnancies were anticipated came in earlier for their antenatal visit than those whose pregnancies were not anticipated due to factors such as marital status (Alex-Ojei, Odimegwu & Ntoimo 2023).

2.2 Sub-theme 7 : Travelling long distances to the clinic

A participant in this study said she did not have money to start early antenatal booking, and she would have to save money because the clinic was far away.

"Furthermore, I did not have money to start clinic this early; it is better to start at three or four months so that I save money because the clinic is far and time"(P 14).

One participant said that the clinic was too far and that she had to catch an early morning bus to arrive at 7h00 as there was no car at their home.

"Sister, the clinic is far. I have to catch a 5 o'clock bus to arrive at the clinic at 7o'clock because there is no one with a car at home" (P 11).

One participant said that because she was vomiting during early pregnancy, she could not go to the clinic because it was not practical for her to be on public transport in her situation. Another participant said that the first month, she had to stay home because she was vomiting and was not fit to walk to the clinic because she lived across the river.

"In the first few months, I was vomiting and was not fit to walk to the clinic because I stay across the river, it is far" (P 3).

The statements from antenatal clients showed that the antenatal clinic was accessible to only a few research participants within less than 30 minutes of walking distance. making it more practical and feasible to access ANC earlier than 12 weeks of confirmed pregnancy. These results were not surprising considering that the study was based on women in deep rural communities who mostly did not have a job and relied on spouses for financial support. Khanna, Patel, Akhtar, and Mehra (2023) confirmed that most women attending antenatal clinics either commuted by public transport or drove their own vehicles

to travel more than five kilometres and back, which posed a financial obligation. Dramile, (2025) found that antenatal clients travelled long distances to the clinic, negatively impacting early antenatal booking.

3. ANNEXURE E: Health Systems Barrier

THEME 3: HEALTH SYSTEM BARRIER

Participants in this study voiced their fear of being ridiculed and shamed by health professionals at the facility. Some says sister would shout at them and judge them for being pregnant again. Some were afraid of ridicule from their own peers who would shame theme them for being pregnant. Participants are scared to ask clarifying questions during consultations because the sisters become irritable and impatient due to long queues. Most participants are scared sitting on long queus for a long time, because even if they arrive early, the allocated clinic staff are so few that it takes long to clean the queus.

3.1 Sub-theme 8: Health professional attitudes, a barrier to early antenatal booking

One participant verbalised fear of being shouted at by clinic sisters, judging her that if she was not breastfeeding, she was pregnant.

"Sisters will shout at me to say if I am not breastfeeding, I'm pregnant" (P 5).

Another one said that she hated to see peers ridiculing her for seeing her pregnant again.

"I did not want my peers to ridicule me when they see me pregnant again" (P 12).

The fear of being shouted at by sisters at the clinic was articulated by another participant. She said sisters would scold her and say she was wasting their time while she knew the queue was long.

"I am afraid to ask because the sisters will scold me and say I am wasting their time while I know that the queue is long" (P 11).

Another participant was surprised that the sister expected her to come to the clinic for antenatal booking within one month of a missed menstrual period. She said she could not imagine the pain of having her pregnancy disclosed to strangers in the clinic because the sister called them in public to follow her to the place, they were going to receive care. She further said she was scared of the sisters, which is why she could not start antenatal booking early because she would be persevering ridicule for a longer period.

"Staff, do you mean coming to the clinic just after a one-month missed menstrual period? Yhii!!! I cannot imagine the pain of my pregnancy being disclosed to strangers in the clinic because the sisters call us in public to follow them where they will help us. "KKKK!!! Me, I am scared of the sisters; if I start antenatal clinics early, I will have to persevere ridicule for a longer period" (P 22).

Participants from the interviews indicated that they opted to delay disclosure because parents and relatives would force them to go to the clinic earlier than they were emotionally prepared for. They saw the delay as a defence or a way to postpone disrespect, shouting, and exposure at the clinic by nurses. Magunda et al (2023) supported these results through their study that found that nurses yelled and disrespected clients at the clinic.

3.2 Sub-theme 9 Health facilities conditions as reasons for failing to attend ANC

From the interviews, one participant said the clinic was always full, and they sat in long queues for the whole day. A participant said that the facilities were always full, and sitting in queues was not what she wanted to do because she would be embarrassed when the sisters disclosed her pregnancy in public. She felt embarrassed when people she did not know would learn about the pregnancy in the facility.

“The challenge is that the clinic is always full, and sitting in a long queue is not what I want to do because it is embarrassing for people you do not even know to learn about your pregnancy in public” (P 11).

Another participant stated that it was not understandable for her to come to the clinic for her first antenatal visit after one month of a missed menstrual period. She said this would lead to the disclosure of her pregnancy to strangers because sisters called them in public by the name of their ailment when they ran the fast queue. Additionally, she would have to persevere ridicule from clinic staff for a long time.

“The sisters call us in public to follow them where they will help us. “KKKK!!! Me, I’m scared of the sisters; if I start antenatal clinics early, I will have to persevere ridicule for a longer period” (P 22).

Another participant confirmed that she was terrified of going to the clinic this early, only to endure humiliation from clinic staff for a long time.

“I’m terrified of the sisters, If I start antenatal clinics early, I will have to endure humiliation for a longer duration” (P 9).

The findings under this category confirmed that antenatal clients did not enjoy waiting in long queues at the clinic. Hence, they found waiting times to be a substantial cause of frustration. One woman shared an incident where she waited more than six hours without seeing a Primary Health Care midwife. Baron & Kaura (2021) confirmed that the use of the early antenatal service was negatively impacted by Long Wait Times (LWTs) in the antenatal clinic. LWTs were considered a major barrier to using antenatal clinics and required further research and intervention. Two main reasons surfaced in another study, explaining why respondents were unsatisfied with antenatal services. The reasons were LWTs (n=196, 65.3%) and congested medical facilities (n=110, 36.7%). This dissatisfaction emphasised the critical need to solve infrastructure and service delivery challenges in antenatal facilities to guarantee that pregnant women would receive prompt and effective treatment (Nwabueze, et al 2023).

DISCUSSIONS

This results of this exploratory descriptive design shows that antenatal clients from deep rural areas had no opportunities to learn to read and write hence they have insufficient knowledge about the importance of early antenatal booking. Participants confirms that they see pictures on the clinic wall, but they cannot read. Some says that after clinic staff took a pregnancy test they advice clients to come back the subsequent month for follow-up care, but partciapnts do not adhere to the return data because it is still very early to start antenatal clinic. Penman et al. (2023) supports this finding, showing that primigravida women have a 90% lower risk of making early reservations than women with parity between one and two. The chance of a late antenatal booking is considerably higher for pregnant women with three or more parties than for those with one or two births (AOR = 0.101, 95% CI: 0.170–0.605, $p = 0.012$). In their study, Mohan et al., (2023) confirm that Multipara women presented late for their first antenatal booking than primigravida. Some women are delayed even after showing positive pregnancy symptoms, such as nausea, vomiting, and missing periods. While some people were experiencing pregnancy symptoms, they were unaware of what those symptoms represented due to ignorance. These results are supported by (Tukisi, Dlakude, Hlatshwayo, & Dlamini, 2025), who confirm that most women delayed prenatal scheduling because they believed they were ill and had other health issues, rather than understanding the signs of a positive pregnancy.

Gebremariam et al (2023) support these results through their study, which found that Age, marital status, occupation, literacy rate, and ethnicity all had significant associations with their thorough knowledge, according to this study. Additionally, statistically significant correlations between their level of gravidity and parity and their knowledge and practice were found, confirming primigravida to have less knowledge than multipara. These results are supported by Battu et al (2023), who confirm that in their study, there were 86.6% of late ANC bookings due to insufficient knowledge. The median age (IQR 25.7–27.1) was 26.4 years. Age, marital status, and parity were also found to be factors in multivariate logistic regression analysis that predicted late ANC booking. A study conducted by Magunda (2023) confirms that despite the fact that all pregnant women have access to free ANC services, late booking rates remain high due to a lack of knowledge. The value of early ANC booking to expectant mothers may be increased with the support of public awareness and health education.

Studies found that there is a lack of insight into health and well-being among low-literacy clients, and that their education level affects early antenatal uptake associated with the level of knowledge (Worku, Mekonnen, Gebremedhin, & Egata, 2025). A similar result was found from this current study, which is confirmed by the statement, *"It is the same; whether you come early or not, it does not change anything. If your baby lives, he will live even if you come late."* In this statement, the researcher discovered a lack of insight into one's health in low literacy level antenatal clients. This is supported by another study, which identified literacy level as one of the contributing factors to late antenatal booking (Battu et al., 2023). Similar to this, participants with an adequate understanding of antenatal services had lower odds of making late presentations for antenatal booking than those with inadequate information (Estifanos et al., 2025). Some presented with illnesses, including suspicion of pregnancy; however, they were not sure, according to the results of this study. Ndomba et al. (2023) found that factors such as tertiary education were associated with the likelihood of late antenatal booking. This is confirmed by a statement from

antenatal clients: *"It is the same; whether you come early or not, it doesn't change anything."* A comprehensive assessment of care competence and maternal experience of first antenatal care visits in Mexico: Insights from the baseline survey of an observational cohort study. Doubova (2024) supports this finding through their study, which found that 85.1% of multipara women presented late for their first antenatal visit. This finding is supported by Heri, Mselle, and Malqvist, (2023), whose study found that multipara women described signs of labour based on their past experiences, which contributed to late presentation at the maternity ward rendering them vulnerable to perinatal risks.

The results of this study show that clients have difficulty transporting money because they are unemployed and depend on their husbands, who earn too little. Another study conducted in Mahama Refugee Camp in Nigeria stated lack of money as a contributory factor to low early antenatal uptake, showing that, among the refugees, adolescent pregnant girls and young moms had been exposed to unprotected sex due to socio-economic status Izuka et al., (2023). In this study, around 68% of participants were identified to have used at least one ANC service during their most recent pregnancy. Of these, just 13 (62%) had to travel more than five kilometers to reach the closest clinic, using buses and taxis depending on affordability. Two participants (9,5%) out of 22 (90%) reported traveling for less than 30 minutes to the nearest antenatal clinic, which is a much lower percentage of women who said they took longer to get to the closest health facility. This finding is supported by Matladi, Maluleke-Ngomane, and Jacobs (2025) in another study, affirming that antenatal clients travelled long distances through public and personal transport to access basic health care services.

In a study by Edessa, Dida, and Teferi (2023), facility factors were confirmed to be barriers to early ANC. The study also demonstrated that unpleasant ANC experiences from previous pregnancies, including overcrowding, being shrieked at by clinic staff, staying too long at the facility due to long queues, and lack of support, particularly for single women and those with health issues that needed attention were significant barriers to early ANC attendance among older women. To avoid having to cope with the emotional stress at facilities, women frequently booked late appointments for ANC to reduce the time and frequency that they would have to endure this stress if they had to book early. They expressed fear of the sisters' attitude, as supported by Penman, et al., (2023).

The participants saw the midwives' unfavourable views as obstacles to facility-based antenatal services. Most participants complained about being treated rudely by clinic staff. When pregnant ladies presented themselves at facilities, nurses were disrespectful and shouted at them. The way nurses treated great multiparous women was horrible. They continually claimed that the language used by the nurses during care had an emotional impact on them (Mlotshwa & Sibiya, 2023). In interviews with 22 antenatal clients, 67% reported that the health facility's condition discouraged them from initiating ANC early. Participants emphasised that a lack of staff forced them to arrive early in the morning and depart late in the afternoon, which were major barriers in prenatal clinics. Based on these results, antenatal clients experience access barriers to early antenatal booking in Mpumalanga, South Africa.

Conclusion

This study provides valuable insights into the factors influencing the phenomenon under investigation, with important implications for healthcare policy, nursing practice, and future research. The findings may inform the development of evidence-based, contextually relevant interventions, support the delivery of person-centered care, and guide policy initiatives to improve healthcare outcomes. Furthermore, the study contributes to the existing body of knowledge by identifying areas for further investigation and strengthening the evidence base for Primary nursing practice and health system improvement.

Declarations

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The author's contributions

S.H.M.-N was responsible for the methodology, conceptualization, data collection, data analysis, and compilation, discussion of the results, and editing and approval of the final version for submission and publication. The author has considerably read previous drafts of the manuscript and approved the final version.

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Data availability

The datasets generated and analysed during the present study are not publicly accessible in order to safeguard the privacy, confidentiality, and anonymity of the participants. However, the data may be obtained from the corresponding author upon reasonable request and subject to appropriate ethical considerations.

Declaration of Helsinki

This study was conducted in accordance with the ethical principles outlined in the *Declaration of Helsinki*, and its subsequent amendments. Ethical approval was obtained from the **University of Pretoria ethics review committee** prior to the commencement of the study (**Ethics Reference No: 45/2021**). All participants were provided with comprehensive information regarding the purpose, procedures, potential benefits, and possible risks associated with the research and voluntarily provided informed consent

before participation. Participants' autonomy, dignity, privacy, confidentiality, and right to withdraw from the study at any stage without penalty were respected and protected throughout the research process.

Consent to Participate Declaration

Written informed consent was obtained from all participants before their inclusion in the study. Participation was voluntary, and participants were informed of their right to withdraw from the study at any time without prejudice.

Consent for publication

Not applicable.

Competing Interests

The author, **S.H.M-N**, declares that no financial, professional, or personal relationships exist that could have inappropriately influenced the conduct, interpretation, or reporting of this research. The review and editorial evaluation of this manuscript were conducted independently and in accordance with the journal's established procedures for managing potential conflicts of interest. The author had no involvement in the peer-review process, editorial assessment, or final publication decision regarding this submission. No other competing interests, whether financial or non-financial, are declared by the author.

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 61. ANNEXURES.
 62. ANNEXURE A.

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