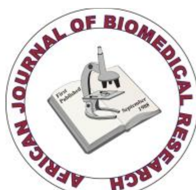

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Research Article

Pregnant Teenagers' Perception And Access To Focused Ante Natal Care Services in a Ghanaian Government Hospital

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ABSTRACT

This study was aimed at assessing the perception of pregnant teenagers of focused ante natal care (FANC) and their challenges in accessing care in Suntreso government hospital, Kumasi, Ghana. A cross sectional descriptive survey design was utilized whereby a purposive sampling technique was used to recruit 50 pregnant teenagers who met the inclusion criteria. A pre-tested structured questionnaire was employed to obtain information from the study participants after obtaining due consents. Obtained data were analyzed using SPSS version 21. Majority ended at the junior high school level 30(60%); 44(88%) not married; majority 40(80%) started attending FANC in their first trimester; 24(48%) were students; 22(44%) earned 6-10 Ghc a day and 20(40%) of them were responsible for their healthcare. Distance 18(36%) and finance 18(36%) influenced their decision to attend FANC. On the whole, only 22(44%) had good perception of interpersonal care, 18(36%) of staff efficiency, 25(50%) of comfort with care, 34(68%) of information they received, and 21(42%) of service environment. Those with strong family support, married and with higher income had good perception of ANC services. Stressful service environment 46(92%) and dissatisfaction with services rendered rated very high 30(60%) among the challenges faced by pregnant teenagers in accessing FANC services. Short waiting time 50(100%), availability of staff 50(100%) and good healthcare providers' attitude 40(80%) were rated highest among the respondents' opinion on measures to improve access to ANC services. The study recommended a user friendly healthcare environment through the provision of a separate space for pregnant teenagers and re-training of care providers with emphasis on care of teenagers among others.

Keywords: *Pregnant teenagers, perception, antenatal care services, access, challenges, Ghana*

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INTRODUCTION

Ante Natal Care (ANC) refers to the regular medical and nursing care recommended for women during pregnancy with the goal of providing regular check-ups that allow for prevention, early detection as well as treatment of potential health problems that may arise in pregnant women (WHO 2005). Moreso, it serves as the entry point for the care of pregnant women to ensure a positive outcome of childbirth (Woyessa and Ahmed, 2019; Abou-Zahr and Wardlaw, 2003). Focused antenatal care emphasizes not attendance alone but the quality of ANC (Abou-Zahr and Wardlaw, 2003; USAID, 2007). Furthermore, FANC is different from the traditional ANC in that it is individualized, client centered, comprehensive. It is intended to reduce waiting time during ANC visits, while time for direct contact to share information is increased. Care is provided by the same midwife and there is focus on involvement of client's partner or support persons in the process of birth preparedness and complication readiness (WHO,2001; Nyarko *et al*, 2006; USAID,2007; Nsemo, 2016). The Government of Ghana adopted the World Health Organization's (WHO) focused antenatal care (FANC) approach in 2002 in an attempt to address the comparatively high maternal mortality rate and to improve access, quality and continuity of antenatal care (ANC) to pregnant women (Ghana Health Service, 2012).

Teenage pregnancy occurs in all societies, and the magnitude and consequences vary among different countries and regions (WHO 2005), with economic and social factors playing a great role. For instance, in some cultures, girls are forced into early marriage and are expected to begin their families during adolescence, while in others pregnancy outside marriage is very common (WHO 2005; Bonso, 2015). Teenagers are faced with pregnancy-related complications which evidence has shown to be the second cause of death among fifteen (15) to nineteen (19) year in sub-saharan Africa

(Fatusi and Hindin,2010; Ziblim, Yindana and Mohammed,2018). In low and middle income countries, babies born to mothers under twenty (20) years of age face the highest risk of being still born or dying in the first few weeks. The younger the mother, the greater the risk to the baby. Newborn to teenage mothers are more likely to have low birth weight, with the risk of long-term effects (WHO 2005; Bonso, 2015). Teenage pregnancies are more likely in poor, uneducated and rural communities (Bonso, 2015). More so, some girls do not know how to avoid getting pregnant as sex education is lacking in many countries, they may feel too ashamed to seek contraception services, it may be too expensive or not legally available and even when available, sexually active teenage girls are less likely to use them than adults (WHO 2005).

The relevance of Focused Antenatal Care (FANC) services to ensure the health and wellbeing of young mothers and new born cannot be understated, and FANC should be started in the first trimester (WHO 2005; Bearinger, Sieving, Ferguson and Sharma, 2007;WHO,2016). Attendance at ANC becomes very necessary for pregnant teenagers as studies confirm that they are exposed to several pregnancy-related complications (James,Van Rooyem and Strumpher, 2010; WHO/UNFPA,2016). Accordingly, Nsemo *et al*, (2016); Seller (2006); James, Rall and Trumpher (2012); Mgbekem *et al*., (2020), submitted that through FANC, there is overall supervision of maternal health for early detection of problems and interventions to correct them, education on birth preparedness and complication readiness, for better pregnancy outcome for mother and child.

ANC usually is the first comprehensive health assessment that most pregnant teenagers go through, and this serves as an opportunity to sensitize them on identifying signs of obstetric complications since they may likely have limited knowledge and experience about them (Nsemo and Offiong, 2016). Furthermore, ANC services provides young mothers with immunization, prevention and treatment for malaria, anemia and sexually transmitted infections (STIs) including HIV/AIDS. They are also educated on birth spacing, family planning and use of institutional delivery which improves pregnancy and delivery outcome. (Brown, Smith, Mori and Noma, 2015; Reynolds, Wong and Tucker 2006; WHO 2003; Bonso,2015).

Many countries in sub-saharan Africa were not able to achieve the Millennium Development Goal 5 by the year 2015, Ghana inclusive. Adolescents in developing countries constitute approximately 70% of all adolescents globally (UN, 2012). According to a report by Ghana coalition of NGOs on Health (GCNH in Ziblim *et al*, 2018), an estimated number of 750,000 teenagers became pregnant annually. In recognition of the significance of ANC services to maternal and child health, several national policies and programmes in Ghana have been put in place including Patient's Rights and Patient's Responsibilities Charter implemented by the Ghana Health Service, the introduction of the National Health Insurance Scheme (NHIS) and free maternal care policy which are all geared towards improving the quality of care for pregnant women in Ghana.

As a follow up, the Suntreso Government Hospital in seeking to improve access to quality maternal, neonatal, child and adolescent health services, prioritized areas such as safe motherhood, focus Antenatal care, as well as home visits and health promotions activities to educate the masses and trace defaulters (GHS, 2013).Yet adolescents still have limited access to information and health services that will improve their health. In some rural districts in Ghana, there was an increase in maternal mortality rate from 518 to 748 deaths per 100,000 live births in 2010 (GCNH, 2010 in Ziblim *et al*, 2018). Furthermore, the Ghana statistical services (2014) has indicated that ANC sought from skilled providers is an important tool used to monitor pregnant women to reduce morbidity and mortality associated with it. Studies have also shown that pregnant women who utilize ANC Service are more birth prepared and complication ready hence positive pregnancy outcome for both mother and child (Nsemo *et al*., 2016; Nsemo,2016).

However, evidence shows that encouraging pregnant teenagers to attend ANC is thought to be unsuccessful, as they are less likely than older women to receive good ANC and skilled care at delivery due to personal, social and institutional factors which stems from misguided perceptions. Acording to Thaddeus and Maine (1994), delays leading to maternal morbidity and mortality due to delayed access to care are often multifactorial. These can be prevented by reducing delays at three points; in the decision to seek are, in reaching the healthcare facility and in receiving care at the facility. These in one way or the other affect pregnant teenagers' health seeking behavior (Matua, 2004; Ziyaniet *et al*., 2004; James, Rall and Trumpher, 2012). Numerous internal and external challenges also hamper teenage mothers' access to FANC as they often complain about poor quality of services in public healthcare facilities (GHS 2005), especially poor client care, unhealthy environment and apathy of health care providers (Boadu, 2011; Kwarteng, 2012).

Against this background, this study sought to answer the following questions; How do teenage mothers perceive Focused antenatal care services in Suntreso government hospital? Are they satisfied with the ante-natal care services rendered? What are the challenges faced by pregnant teenagers in accessing ante-natal care in Suntreso government hospital?

MATERIALS AND METHODS

Setting: Suntreso government hospital is located at the North-Suntreso area central in Kumasi, the capital city of Ashanti region of Ghana (Plate 1). The hospital was established in 1963 as an urban health Centre to provide primary healthcare to residents of the Bantama metropolitan area and its environs. In January 1964, the Centre began operations after it had been commissioned on the 22nd of November, 1963 with one medical officer and an assistant, five nurses, a dispensary technician and other administrative staff. The Centre became a poly clinic in 1980 due to the massive expansion in its activities and the enormous increase in patients' turnout. In 1996, the Ghana health services upgraded the clinic to a District hospital to cover health issues in the area. The hospital has the following department; Obstetrics and Gynecology, Sexually Transmitted Diseases, out-patient, Dental, Ear, Nose and Throat (DENT), Mother and Baby Unit, Surgical, Public

Health, Pharmacy, Diagnostic, Administrative and Finance Departments. The total staff strength stands at 159 currently.

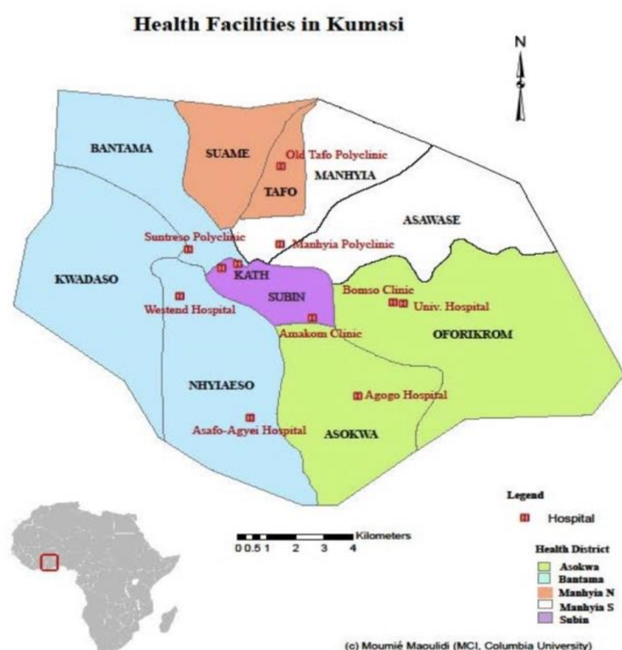

Plate 1
Map showing the location of Suntreso Government Hospital, Kumasi

Study design: The study adopted a cross-sectional descriptive survey using a pre-tested structured questionnaire to assess the pregnant teenagers' perception and access to antenatal care services in Suntreso Government hospital, Kumasi, Ghana. The Study targeted pregnant teenagers aged 13 -19 years registered at the Suntreso Government Hospital.

Population of study and sampling technique: Purposive sampling was used to recruit 50 pregnant teenagers who were attending clinic at the study setting during the period of the study. The inclusion criteria was pregnant teenagers in their 3rd trimester who have been registered and are attending Antenatal clinic in Suntreso government hospital. Out of 114 of them, 50 who were available and consented to the study were recruited.

Data collection and analysis: Structured questionnaire which was pre-tested using a similar population of 20 in Manhyia hospital, Kumasi and yielded a reliable co-efficient of 0.85 was used to elicit responses from the respondents. Those who could not read nor write were assisted by the researchers who speak the local dialect. The instruments were in sections A to D covering socio-demographic data, perception of ANC services and challenges to access ANC services, as well as opinions on measures for improvement, comprising both closed and open-ended questions. This enabled the researchers to obtain relevant, reliable and accurate data for the study. Data collected was collated, coded using SPSS Version 21 and analyzed using both descriptive and inferential statistical tools. Same presented in frequency tables and pie charts.

Ethical consideration: Prior to the initiation of the research activities, ethical clearance was obtained from Ghana health service, followed by written permission from the authorities of the Suntreso Government Hospital. Each participant gave their consents and were reminded that participation was voluntary and the discussion would remain confidential. No information pertaining to participant's identity was recorded

RESULTS

Demographic characteristics of pregnant teenagers:
The section demographic characteristics of the pregnant teenagers are presented in Table 1.

Table 1:
Demographic characteristics of respondents by selected variables. (n=50)

Variable	Number	Percentage (%)
Age (Years)		
12 - 15	12	24
16 – 19	38	76
Marital Status		
Married	6	12
Single	44	88
Residence		
Rural	36	72
Urban	14	28
Educational Status		
Primary	16	32
JHS	30	60
SHS	4	8
Tertiary	0	0
Employment Status		
Students	24	48
Petty Traders	10	20
Not Employed	16	32
Religion		
Christianity	38	76
Muslim	12	24
Delivery Status		
Nulliparous	42	84
One previous pregnancy	8	16
Daily Income		
GH¢ 1.00 – 5.00	20	40
GH¢ 6.00 – 10.00	22	44
GH¢ 20.00 – 50.00	6	12
GH¢ 60.00 and Above	2	4
Responsibility of Medical Expenses		
Self	20	40
Spouse	6	12
Parents	20	40
Relatives	2	4
Others	2	4
Influences on Decision to Attend ANC		
Financial	18	36
Distance	18	36
Superstition / Religion	0	0
Others	14	28

The majority of respondents were residing in rural areas 36 (72%), while 14 (28%) of them resided in the urban area. 12 (24%) of them were younger than 16 years old and more than half 44 (88%) were single. 16 (32%) attended primary school, 30 (60%) attended JHS, 4 (8%) attended SHS and none had tertiary education. Those employed were 16 (32%), petty traders 10(20%) and 24 (48%) were students. Out of the 50 respondents 38 (76%) were Christians and 12 (24%) were Muslims. 42 (84%) were in their first pregnancy (nulliparous) and 8 (16%) had had 1 previous pregnancy. Out of the 50 respondents, 20 (40%) earn GH¢1.00 – 5.00, 22 (44%) earn GH¢ 6.00 – 10.00, 6 (12%) earn GH¢20.00 – 50.00 and 2 (4%) earn GH¢60.00 and above in a day. 20 (40%) were responsible for their medical expenses, 6 (12%) said their spouses were responsible, 20 (40%) said their parents were responsible while 2 (4%) said other non-relatives. On influences of their decision to seek ANC services, 18 (36%) indicated financial reason, 18 (36%) indicated distance and 14 (28%) indicated other reasons not specified.

Antenatal Registration and Attendance

Regarding first engagement at the antenatal clinic, 40 (80%) of them registered during the 1st trimester, 4 (8%) during the 2nd trimester and 6 (12%) during the third trimester, while as at the time of study, 28 (56%) of the respondents had made over 4 visits, 12 (24%) made 4 visits, 6 (12%) made 3 visits, 2 (4%) made 2 visits and 2 (4%) just registered during the 3rd trimester (Table 2).

Table 2:
Respondents' FANC attendance in Suntreso government hospital, Kumasi.

Variable	Number	Percentage (%)
ANC Registration		
1st Trimester	40	80
2nd Trimester	4	8
3rd Trimester	6	12
No. of ANC visits		
Once	2	4
Two Times	2	4
Three Times	6	12
Four Times	12	24
More than 4	28	56

Pregnant Teenager's Perception of FANC Services

The findings from this study as shown in Table 3, revealed that 22 (44%) had good perception of the interpersonal care between them and the care providers; while a greater number, 28 (56%) had poor perception. This aspect covered friendly attitude towards the pregnant teenagers and maintenance of individual respect and involvement of family and relative. On efficiency, 32 (64%) had poor perception while 18 (36%) had good perception. This aspect covered care providers attending to participants without delay, enough numbers of caregivers available for their care, maintenance of good coordination with other staff, waiting time and willingness to attend to all their questions. On the aspect of Comfort, 25 (50%) had good perception and 25 (50%) had poor perception. This had to do with ensuring privacy and attending to them in a private section without mixing up with the adult pregnant women. Concerning information, 34 (68%) had good perception and 16 (32%) had poor perception. This aspect covered amount of information given at first booking, education on birth preparedness and complication readiness. Regarding the service environment, 21 (42%) had good perception while 29 (58%) had poor perception. This covered space, cleanliness and ventilation of the ANC area, information displayed on the walls and stress from medical procedures.

Table 3:
Respondents' Perception of FANC Services in Suntreso government hospital (n=50)

S/No.	Aspect	Good Perception		Bad Perception		Total
		No.	(%)	No.	(%)	(%)
1	Interpersonal Care	22	44	28	56	100
2	Efficiency	18	36	32	64	100
3	Comfort	25	50	25	50	100
4	Information	16	32	34	68	100
5	Environment	21	42	29	58	100

Responses not mutually exclusive

Perception of FANC Services based on Selected Demographic Variables

Respondents' perception of FANC services based on selected demographic variables as shown in Table 3 revealed that only 3 (19%) and 1(5%) of respondents with primary school education and JHS had good perception of FANC services respectively, while 3 (75%) of respondents with SHS had good perception. Those that have strong family support for instance, sponsored by spouse 5 (83%) and parents 11 (55%) had good perception of FANC services. Married respondents 5 (83%) had good perception and respondents with daily income of GH¢ 60.00 and above 2 (100%), GH¢ 20.00 – 50.00, 5 (83%), GH¢ 6.00 – 10.00, 12 (55%) and GH¢ 1.00 – 5.00, 16 T(80%) had good perception of FANC services (Table 4).

Table 4:
Respondents' perception of FANC Services based on selected demographic variables

Variables	Label / Category	Perception				
			Good Perception		Poor Perception	
		N	No.	(%)	No.	(%)
Educational Status	Primary School	**16**	3	19	13	81
	JHS	**20**	1	5	19	95
	SHS	**4**	3	75	1	25
Family Support	Self	**20**	8	40	12	60
	Spouse	**6**	5	83	1	17
	Parents	**20**	11	55	9	45
	Relatives	**2**	1	50	1	50
	Others	**2**	0	0	2	100
Marital Status	Married	**6**	5	83	1	17
	Single	**44**	8	18	36	82
Daily Income	GH¢ 1.00– 5.00	**20**	16	80	4	20
	GH¢ 6.00– 10.00	**22**	12	55	10	45
	GH¢ 20.00– 50.00	**6**	5	83	1	17
	>GH¢ 60.00	**2**	2	100	0	0

Respondents' reasons for not attending FANC in their communities

On respondents' reason for not attending FANC in their communities as shown in figure 1, out of the 50 respondents, 16 (32%) of them perceived that providers' attitude hindered them from attending FANC in their communities, 26 (52%) linked it to stigmatization and 8 (16%) claimed ignorance.

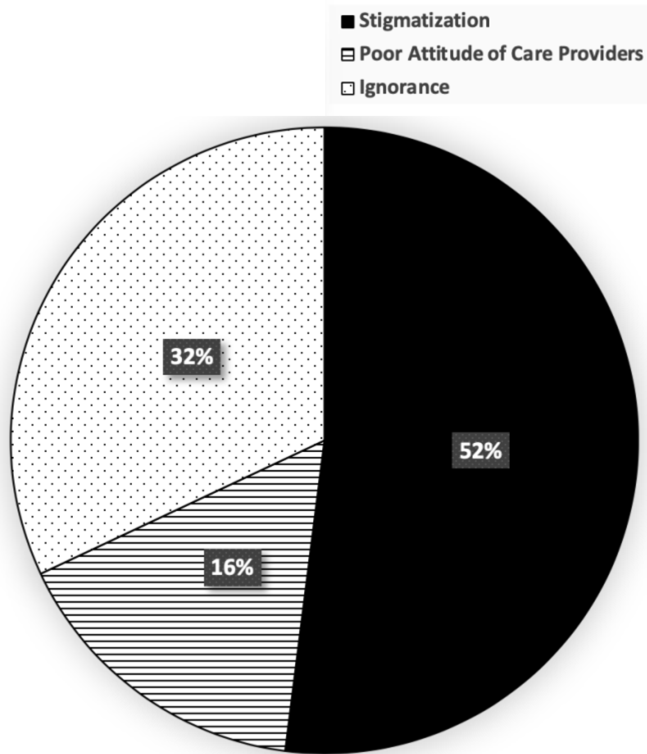

Figure 1:
Pie Chart showing respondents' reasons for not attending ANC in their communities

Challenges faced by pregnant teenagers in accessing FANC services

Regarding challenges faced by pregnant teenagers in accessing FANC services, Table 5 shows that 20 (40%) and 28 (56%) of the respondents indicated long distance and high cost of transportation to the facility respectively. 40 (92%) indicated stressful hospital procedures and long waiting time at the clinic, and 24 (48%) and 30 (60%) indicated poor attitude of the care providers and dissatisfaction with services rendered respectively**.**

Table 5:
Showing challenges faced by pregnant teenagers in accessing FANC services in Suntreso government hospital.

S/N	Variables	Number	Percentage (%)
1	Long distance to facility	20	40
2	High Cost of Transportation	28	56
3	Stressful Service Environment (Long waiting time)	46	92
4	Poor Attitude of Care Providers	24	48
5	Dissatisfaction with Services Rendered	30	60

Note: Responses not mutually exclusive

Respondents' opinion on areas for improvement to facilitate access to FANC

Response on respondents' opinion on areas for improvement to facilitate access to FANC care as shown in table 6 below, good service providers' attitude rated 40 (80%), short waiting time and availability of clinic staff rated 50 (100%), flexibility of clinic schedules rated 32 (64%) while male involvement initiation rated 28 (56%).

Table 6:
Showing respondents' opinion on measures to improve access to FANC in Suntreso government hospital, Kumasi.

S/N	Variables	Number	Percentage (%)
1	Good service providers' attitude	40	80
2	Short waiting time and availability of Staff	50	100
3	Flexibility of clinic schedules	32	64
4	Male involvement initiation	28	56
5	Teenage-friendly environment	50	100

Note: Responses not mutually exclusive

DISCUSSION

From the results of the analysis of the respondents' demographic characteristics, majority of them, 38 (76%) were within the ages of 16-19 years. As stated by WHO, (2005), in some societies girls are forced into early marriages and are expected to begin their families during adolescence, while in others becoming pregnant outside marriage is very common. Findings further confirms that 44 (88%) were single. According to Mac Donald *et al*, (2012), unmarried teenagers are less likely to have planned pregnancy and to access FANC. Also, according to WHO (2013), as cited by Chaibra (2008), unmarried pregnant teenagers are less likely to seek antenatal care services due to lack of economic and social support. However, in the study, the respondents sought ANC services even though most of them perceived services as being poor due to various challenges.

Majority of the respondents, 36 (72%) were rural dwellers, but they came from far to attend FANC at the Suntreso government hospital. The reasons they were avoiding ANC in healthcare facilities in their communities due to stigmatization (52%), poor attitude of the care providers (32%), and ignorance about existence of FANC services (16%). Otherwise, their reasons may also be linked to the fact that services rendered by Suntreso government hospital include home visits to educate and encourage pregnant women to attend FANC for skilled attendance and prevention of complication, as well as tracing defaulters. According to Banda (2013); Naariyong *et al* (2012), these are strategies that promotes FANC utilization irrespective of location.

Majority of the respondents only had primary education 16 (32%) and JHS 30 (60%). Teenagers without formal education may be reluctant in utilizing FANC, and even if she does, may perceive quality of service as being poor (Harrison 2008; Briggs 2013). Franke and Chasin (2012); Nsemo (2016), also stated that education of women improve utilization of FANC, maternal health and increased perception of quality of service as being good. Accordingly, Matua (2014); Irinoye, Adeyemo and Ellujoba (2011) observed that lack of education negatively affect the girl's comprehension of important health information, ability to make informed decision and dissatisfaction with service rendered. Majority of the respondents were not employed 24 (48%), students 10 (20%), and only 2 (4%) had the highest daily income of GH₵60.00 and above. These account for the major influence 18 (36%) on the respondents' decision to seek ANC services. Some could not access nor pay for some services rendered while majority 30 (60%) depends on parents, spouse or other relatives for support. According to World Bank (2013), a high percentage of rural women in the world live in poverty of which 90% are in Africa and Asia. Poverty levels in Africa and Asia are very high and in Ghana particularly, it has been estimated that fourty-nine (49) percent of Ghanaians earn less than a dollar a day (UNICEF, 2014). To comfirm this, Bour (2014); Nsemo (2016), stated that finance was a major challenge in accessing maternal health services especially by the poor rural dwellers. In support of this, study by Yeboah (2012), observed that depending on extended family for support to afford ANC services yield negative perception of service rendered. On the contrary, study by Alema Yehu, (2010) revealed that single pregnant teenagers may feel so responsible in taking charge of their own pregnancy compared to their married counterparts. The survey revealed that 42 (84%) of the respondents were in their first pregnancy, 40 (80%) registered at the antenatal clinic in the 1st trimester while 4 (8%) and 6 (12%) registered in the 2nd and 3rd trimester respectively. This is in consonance with GHS/CRS (2006), who stated that the first antenatal care should take place during the first trimester of pregnancy. Those who registered late made less than 4 visits in their 3rd trimester as at the time of visit. They traced their reason to financial and distance challenges 18 (36%). Studies by Banda (2013) and Reisty (2011) corroborate these findings as they observed in their respective studies that long distances and transport cost limits participants' access to ANC services as well as satisfaction with services rendered.

Perceived quality of care was generally low among the respondents. This finding agrees with that of a study in Kenya where almost a third of women complained about inadequate services (Van Eijk *et al*, 2006; Gross *et al*, 2012). In this study, pregnant teenagers' perception of FANC services based on interpersonal care, efficiency, efficiency, comfort, information and environment was assessed, and these play a crucial role in determining a pregnant teenager's perception, access and satisfaction with services provided (tables 3 and 4), and needs to be improved but also better understood.

A good number of pregnant teenagers (56%) had poor perception of interpersonal aspect of FANC services rendered in Suntreso Government Hospital. This covered friendly provider-consumer relationship and attitude, maintenance of individual respect and involvement of partner or relatives. This could be linked to young age of the pregnant teenager and fear of the unknown. Studies have shown a strong association between age of an expectant mother and their perception and satisfaction with FANC services (Bonso, 2005). The reason might be with the stigma associated with the younger teenagers assessing FANC. Ghanaian society frowns at young teenagers who become pregnant. This stigma usually comes in the form of mockery, public insult, disgrace to family name, social isolation and rejection, which limits their participation in social activities. This also restricted their attendance of FANC in their communities (Fig 3). This agrees with the findings of study by James, Rall, Strumpher (2012), who observed that participants perceive themselves as inferior and as being treated as such at the clinic because of the age difference and the older women attending the clinic. More so, nurses and midwives prioritize the completion of job related tasks rather than spending time to talk with the clients, work overload due to shortage of staff and lack of concept of patient-centered care (Bonso 2005; Negussi, 2018). Low educational background could also be a factor, as the pregnant teenager may feel inferior before the care givers; hence information with good intention may be misunderstood or misconceived (Nsemo, 2016). Also, lack of social support they are exposed to since the society disapproves of their pregnancy, has a negative impact on their perception and satisfaction with FANC services rendered (Yeboah, 2012). Invariably, access to support (social and financial) is significant to early ANC registration and number of ANC attendance (Bonso, 2005).

Majority of the respondents (64%) had poor perception of the efficiency of FANC services rendered. This dimension covered prompt attention to participants without delay, availability of care givers, maintenance of good coordination with other staff, waiting time and willingness to attend to all questions. This finding is contrary to the findings of a study by Negussie, (2018) whose study revealed that participants perceived good the efficiency of services rendered as treatment was given without delay and maintained good coordination with other staff. This finding is also lower that that conducted in Jordan 66% (Al-hussami *et al*, 2017). This could have explained lack of understanding of specific information or poor communication within the staff. Long waiting time which posed a challenge to access and dissatisfaction with FANC services could be traced to shortage of staff and lack of individualized care as emphasized in FANC.

Regarding the respondents' comfort with ANC services rendered, it was 50:50 for good and bad perception. This had to do with efforts taken to ensure privacy during examinations and consultations, attending to pregnant teenagers in a private section without mixing them up with adult pregnant mothers to avoid stigmatization. FANC emphasizes one on one contact between care consumers and care providers to ensure individualized care (WHO,2016). Similarly, other studies also confirms this findings. Pregnant teenagers frowns at the practice of receiving care together with the older pregnant women. They found this embarrassing and recommended having their own waiting area and additional midwives at the clinic so that they would not be subjected to humiliating

scrutiny and disapproval from older pregnant women (James, Rall, Strupher, 2012).

In relation to information, 34 (68%) of the respondents had good perception of the amount of information they recovered at their first booking, education on birth preparedness and complication readiness as well as other aspects of mother craft education. This is an indication that the caregivers exhibited these important qualities in the provision of care. The fact that a greater number of respondents were from the rural setting presumably with little or no access to information and health services could enhance good perception and appreciation of information they got in Suntreso Government Hospital.

Regarding service environment, 29 (58%) of them had poor perception. This covers space, cleanliness and ventilation of the FANC area, information displayed on the walls and stress from medical procedures. This perception may be greatly linked to their educational background. A good number of them only attended primary education (32%) and JHS (60%), so reading and understanding of health posters, fliers and literature may be a challenge. Studies done in Sri Lanka (69%), North Ethiopia (94%) and Nepal (66.4%) of respondents had good perception on the care environment (Muraleeeswaran, 2016; Teferi, 2017; Negash, 2014) but this study revealed less. This difference may be due to the variations in staff strength and inadequate equipment in our study setting.

Our study revealed that socio demographic variables such as education level, family support, marital status and daily income greatly influenced respondents' perception of FANC services. This finding agrees with the findings of various studies (Dikem *et al*, 2016; Eyasu *et al*, 2014; Tuayana *et al*, 2015; Zhao *et al*, 2011). This may not be far from differences in socio economic level and level of understanding on quality of service.

Studies by (Dikem *et al*, 2016; Eyasu *et al*, 2014; Merde *et al*, 2017) revealed that age and level of education has significant association with patient perception of care. In this study, educational level was significantly associated with perception of FANC services, as 75% of those with SHS had good perception. This finding agrees with the study in Turkey, North Ethiopia and Addis Ababa (Dikem *et al*, 2016; Molla *et al*, 2014). Also studies done in Gamo Gofa and Mekelle indicated that respondents who attends colleges and universities are more likely to be satisfied with nursing care service provided than the low or uneducated ones (Merde *et al*, 2017; Molla *et al*, 2014).

Respondents who had strong support had good perception of FANC; spouse (82%), parents (55%), relatives (50%), compared to those who were self-sponsored (40%). This is in line with the findings from study by Negussie, (2018). In contrast, study done in Turkey (Ali *et al* 2018) revealed that there is no association between family support and patient perception of nursing care. This may be linked to variations in levels of caring and assurances at the hospital. Study by Alemayehu (2010) also contradicts this finding, as single pregnant teenage mothers felt so responsible in taking charge of their own pregnancy compared to married ones.

This study provides evidence for the influence of lack of strong financial support on pregnant teenagers' perception of FANC services. Respondents with daily income of GH₵20.00 – 50.00 (83%) and those earning GH₵60.00 and above (100%) had good perception of FANC. Also those who are married (83%) have good perception. Some countries like Tanzania encourage greater spouse involvement in maternal health issues (Ministry of Health and Social Welfare, Tanzania 2008). Although some may be able to pay for services rendered, there are those who could not pay for some ANC services. Lack of strong financial backings tend to deter access to services (Akin *et al* 1999; Uzochukwu *et al* 2004). This could exclude the poor from accessing FANC services. This could also cause late registration for FANC. Thus, fee exemption and subsidies for the pregnant teenagers with low socio economic background to be introduced to enhance quality care and user satisfaction with services.

Furthermore, satisfactory FANC services for pregnant teenagers may entail the reconstruction of clinic spaces to ensure individualized consultation, privacy and confidentiality, and to permit providers to see each pregnant teenager in a defined location at each visit (Chege 2005; Von Beth 2006). This is the focus of Focused Antenatal Care to improve client ease, their ability to obtain adequate information they require and get familiar with the care provider (Baldo 2001; Birungi and Onyango-Ouma 2006; Nyarko *et al*, 2006).

This study revealed challenges faced by pregnant teenagers in accessing FANC to include long distance to facility, which translated to high cost of transport, stressful service environment due to long waiting time and stressful hospital procedures, poor attitudes of care givers and general dissatisfaction with service rendered (table 5). It is evident from the study that majority of them (72%), came from the rural areas with long distances to access FANC in Suntreso Government Hospital. Their reasons could be traced to fear of stigmatization (52%), poor attitude of care providers (16%) and ignorance about availability of service (32%) in healthcare facilities nearer to them (**Fig. 3**). It could as well be linked to the policies in Suntreso Government Hospital to make FANC affordable and accessible to all pregnant teenage mothers irrespective of their socio-demographic status such as age and location. Health promotion activities are upheld through community promotion, home visits and tracing of defaulters (Banda, 2013; Naariyong *et al*, 2012). Distance could be a problem in the midst of lack of finance stemming from low or no income as well as lack of financial support. Hence, Band (2013) and Reisty (2011) in their respective studies confirmed that long distances to ANC services is challenging to accessing such services.`

Among the challenges to access of FANC which might be a reflection of perception of quality care is the shortage of care providers which translated to long waiting time and stressful service environment. Speizer and Bollen, (2000) found that shortage of healthcare providers was perceived as an indicator of low quality of care. Additionally, Newman *et al*, (1998) and Uzochukwu *et al*, (2004), found that dissatisfaction with care were due to long waiting time and stressful care environment. Majority of the respondents were not employed, with very low income per day and were dependent on financial support from spouses, parents and relatives (Table 1). This could have accounted for the few FANC visits despite the fact that majority registered in their first trimester (80%). According to

Bour, (2014) finance poses a huge challenge in accessing maternal healthcare services. Teenage pregnant women have been reported to most likely either not attend ANC or to attend late and infrequently (Who, 2006; Bearinger *et al* 2007; Magadi *et al*, 2007: Van Eijk 2006) due to lack of money, ignorance or other social factors. Contrary in this study, we found no evidence of late registration and majority made 4 visits and above as at the time of study (Table 2). A study from Uganda comparing ANC attendance in pregnant teenagers and adult first time mothers found no difference in the timing of the first visit but a lower number of subsequent ANC visits in teenagers (Atayambe *et al*, 2008; Gross *et al*, 2012). A high percentage of rural women in the world live in poverty of which 90% are in Africa and Asia (World Bank, 2013). Poverty levels in Africa are very high and in Ghana particularly, it has been estimated that 49% of Ghanaians earn less than a dollar a day (UNICEF, 2014). Pregnant teenagers therefore may require additional financial support to enable them access ANC services. Chibava *et al*, (2009) in their study also confirm that socio-economic issues limit expectant mothers' access to FANC services.

Attitude of care providers also posed a challenge to accessing FANC by pregnant teenagers. Similarly, Matua, (2014) reported that pregnant teenagers have reported negative attitudes of healthcare providers. Same author also advanced that pregnant teenagers are sometimes reluctant to use maternity care services because healthcare providers are perceived to be rude, insensitive and threatening to the teenagers. Pregnant teenagers can also base their judgment on previous negative experiences and perceptions of care received (Matua 2014; Starrs 2017; Ziyani *et al*, 2004). On the whole, pregnant teenagers expressed dissatisfaction with the services provided. This perception may not be far from the fact that accessing services was stressful and not very comfortable due to long waiting time, stressful medical procedures and not having a separate private space for pregnant teenagers.

Among the respondents' opinions on measures to improve pregnant teenagers' access to FANC to enhance satisfaction with services rendered were; good service provider's attitude, teenager-friendly service environment, availability of staff to prevent long waiting time, flexibility of clinic schedules and male involvement in care. This is in line with study by (James, *et al*, 2012), who observed that pregnant teenagers' recall of their experiences of the ANC clinic environment suggests that they perceive themselves as not being adequately cared for, as judged, and as forced to be in an environment that is insensitive to their needs as they were not given their private space but mixed up with the older pregnant women in the course of care. As a result some of their peers stayed away from the clinic and at times they contemplated the same action. Therefore, the authors recommended a well-managed ANC clinic environment which has midwives who are empowered with the necessary skills in terms of dealing with the needs of youth has been requested by the pregnant teenagers (James *et al*., 2012). These recommendations conforms with the FANC approach which was originally intended to reduce waiting time during antenatal visits and subsequently increase the time for individualized, client-centred care (WHO, 2001), and continuous care provided by the same midwife and focusses on the involvement of the client's partner or support person in the process of care and preparation for delivery (Nyarko *et al*, 2006).

In conclusion, evidence from the study shows that perception and access to FANC by pregnant teenagers emanated from various factors which were related to pregnant teenagers' socio-demographic background, providers and facility. This conforms to the three phase delay model of Thaddeus and Maine (1994), which is the conceptual framework that directed the study.

FANC emphasizes that a woman's contact with her ANC provider should be more than a simple 'visit' but rather the provision of care and support throughout pregnancy. This implies an active connection between a pregnant woman and health provider (WHO, 2016). Thus this study recommends the following:

- FANC services should be teenage-friendly with good provider-client relationship to promote access among teenagers.
- Supporting income generating activities for teenagers such as revolving loans might serve as an intervention to reducing delay and poor perception and dissatisfaction with FANC services caused by lack of finances needed for FANC or other maternal health services especially among those pregnant who lack support.
- Involving partners in FANC will enhance support.

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