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# Perceptions of Antenatal Care among Ghanaian Mothers

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**Abstract:** In Ghana, some pregnant women may not seek antenatal care due to the unavailability of such services in their communities, although preventive service can help reduce maternal mortality with high-quality care. This study aimed to understand the antenatal care opinions of Ghanaian mothers who sought antenatal care, the barriers they faced, and their suggestions for improvement in antenatal care in Ghana. This study's data were collected in the Central and Ashanti regions in Ghana from June 2023 to January 2024. Four hundred and fifty mothers in Ghana who indicated that they had given birth within the last 10 years of the data collection period took part in the study. Our findings revealed that 93.6% of Ghanaian mothers perceived their antenatal care to be of good quality due to proper examinations, friendly provider–patient interactions, reassurance, fair treatment, and proper education, whereas 6.5% of Ghanaian mothers perceived their care to be of poor quality due to long wait times, impersonal interactions, inadequate facility resources, and barriers to communication. For Ghanaian mothers to receive better outcomes for themselves and their children, it is worth improving healthcare facilities, healthcare provider preparedness, local transportation, and addressing financial constraints to go from suboptimal to optimal health services.

**Keywords:** antenatal care (ANC); prenatal care; Ghanaian mothers; maternal mortality; perceived quality of care; healthcare inequities; healthcare accessibility



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## 1. Introduction

### *1.1. Antenatal Care (ANC) as It Relates to Maternal Mortality Reduction*

Maternal health refers to the period of pregnancy, childbirth, and postnatal time [1]. Globally, childbirth represents a significant event for a pregnant woman and her family. It also represents a time of susceptibility for the unborn babies and their mothers [1–3]. The literature on maternal health and childbirth indicates that, worldwide, approximately 140 million births occur annually, and that the proportion of health professionals helping women through this journey has increased by about 23% (from 58% to 81%) between 1990 and 2019 [1,4].

The World Health Organization (WHO) sees maternal and child health issues as human rights linked to universal health coverage [2]. It emphasizes the core care involving maternal and child health, families, communities, and health professionals' quality improvement efforts. The WHO's goal is to ensure that a woman's journey during this period is a positive experience, maximizing the health and well-being of both the baby and their mother [1]. In the last two decades, progress has been made in pregnancy and childbirth in several countries; however, on a global scale, there were 223 maternal deaths per 100,000 births [4,5]. This high number of deaths is preventable (WHO, 2023) [1,6–8]. The common causes of these mostly preventable deaths are unsafe abortions, infection, excessive bleeding, high blood pressure, and obstructed labor, which could be prevented through timely and skilled medical care [7–9]. Studies have found respectful maternal care interventions to reduce maternal and neonatal deaths [10,11].

"Antenatal care is defined as the routine care of pregnant women provided between conception and the onset of labor" [12]. According to the WHO, "Antenatal care (ANC) coverage is an indicator of access and use of health care during pregnancy" [13]. The Sustainable Development Goals (SDGs) still consist of achieving comprehensive reproductive health and maternal and child healthcare by 2030, cutting down the maternal death ratio to 70 deaths per 100,000 births, and achieving universal health coverage, which relies on comprehensive reproductive, maternal, newborn, and child healthcare [1]. With this in mind, many scientists nationally and globally have begun to investigate factors that lead to complications and/or increase the likelihood of maternal mortality. Specifically, some scientists have begun to explore ANC and the quality of care that pregnant women are suggested to be receiving to reduce some of common causes of preventable deaths associated with maternal mortality.

### *1.2. Why Does ANC Matter?*

ANC is considered a type of preventive service where expectant mothers can become well informed about healthy behaviors (social, emotional, and psychological) as well as warning signs to watch out for during their pregnancy [14–16]. It is important for pregnant women during the antenatal period to seek healthcare and have access to ANC services because it is vital to their well-being, which impacts them and their unborn children [13,17]. The Center for Disease Control and Prevention suggests that expectant mothers start prenatal care (also known as ANC) early and encourages them to stay connected to a healthcare provider (HCP) throughout pregnancy to reduce and manage pregnancy complications [18]. The benefits of ANC are that it reduces maternal mortality, and ANC can provide expectant mothers with the necessary skills and birth preparedness that are need for birth delivery/labor [14–16,18]. Prenatal experiences tremendously influence a woman's birth and postpartum journey. Positive experiences from professionals and family could help the woman throughout her pregnancy and the postpartum period. Negative experiences of care such as professionals not paying attention to them, however, could cause further health problems, especially related to physical and emotional health [6,19–21]. The quality of ANC has the ability to influence the expectant mothers and their babies specifically during and after pregnancy [6]. "Quality ANC could also enable early detection and management of obstetric and non-obstetric complications and thereby minimize maternal mortality [14,22,23] and it helps to alleviate preventable stillbirths and newborn deaths" p. 38 [14,24,25]. Overall, the quality of ANC encourages women's health-seeking behaviors and the unitization of facilities helps to provide skilled birth [6].

### *1.3. History of Sub-Saharan African Countries and ANC*

Although the past two decades have seen maternal mortality decrease by 38% throughout the world, Sub-Saharan Africa and Southern Asia continue to have the highest maternal mortality [1]. Unsurprisingly, "the lowest levels of ANC are observed in Sub-Saharan Africa and Southern Asia" [1,26]. There are numerous reasons for high maternal mortality in Africa, with research in Sub-Saharan Africa on maternal mortality listing a lack of skilled birth attendants, ANC, and postnatal care [26]. For years in developing countries, there seems to have been a lack of interest or perhaps a lack of perceived benefits/knowledge among some pregnant women [27]. Specifically, there is a lack of research available on what women in "sub-Saharan African Low and Middle-Income Countries" perceive as "quality intrapartum care" that can be applied to create guidelines, prompting this study to focus on this topic [28]. However, even when skilled healthcare is provided, the quality can differ depending on the interactions between the patient and provider and overall perceptions [28].

### *1.4. Ghanaian Maternal Mortality*

Ghana has a higher average of maternal mortality than Africa's average [29]. Research has been conducted that identified the factors (wealth, age, and demographics) that are

associated with ANC visits, and other studies have looked into ways to improve health literacy during ANC visits. Very few studies have investigated the quality of ANC services in Ghana. For example, Azanu identifies that 90% of women in a facility in Ghana reported inadequate pain control 6–12 h after a c-section [30–32]. This was found to be due to a discrepancy between what was being prescribed by the doctor and what was served by the nurse. These discrepancies in pain control management may be due to the same misguided beliefs held by the midwives in D-Zomeku's 2020 [33] study that downplayed the severity of the patient's suffering. However, both studies [30,33] illustrate, ultimately, that even skilled providers can provide subpar and inadequate healthcare when patients' needs are not being taken into account. If behaviors, such as the aforementioned abuse and disrespect, dissuade women from seeking ANC in the future, then this could lead to the patient experiencing low birth weight and other complications in future pregnancies.

Banchani's study [34] argues that the quantity of ANC visits and the quality of care during these visits were equally relevant to reducing the prevalence of low birth weight in Ghana. This study's findings revealed that determining what constitutes quality care for women is a necessary step toward preventing low birth weight and infant mortality. Therefore, our study seeks to understand the lived experiences of Ghanaian mothers receiving ANC to understand their perceptions regarding quality ANC to advocate and suggest guidelines based on the collective voices who share in the identity of being a Ghanaian mother in the twenty-first century.

### *1.5. Research Questions*

This study investigates mothers who attended ANC in Ghana to understand their experience. The following research questions guided this study:

(1) What are the ANC opinions and experiences of Ghanaian mothers?
(2) What are the barriers to usage of antennal care services among Ghanaian mothers?
(3) Which areas do Ghanaian mothers suggest for improvement in ANC in Ghana?

## 2. Materials and Methods

This study uses a convergent mixed methods design where qualitative and quantitative data were collected simultaneously and merged to describe the research issue comprehensively.

For the closed-ended questions on the survey, descriptive statistics were run to generate frequencies and percentages using Microsoft Excel software, version 2406.

The open-ended questions were posed for survey participants to share their experiences and opinions. These responses were transcribed and systematically coded to highlight the issues addressed by each research question following the six-step thematic analysis procedure proposed by Braun and Clarke [35] including familiarization, generating codes, generating themes, reviewing themes, defining and naming themes, and creating the report.

We used both qualitative and quantitative approaches because we realized that numbers alone do not tell a full story. Therefore, our goal was to hear from patients directly impacted by ANC in Ghana. Additionally, hearing the perspectives of women who sought ANC care can illuminate blind spots that providers and policymakers have regarding this issue.

### *2.1. Feminist Theory*

This study was framed in feminist theory, which was developed in the 1970s. Feminist theory is a framework to understand human behavior that arose in the 1970s, and emerged as a movement in response to the societal gender system that was challenging and that undervalues women [36–38]. The theory focuses on the lived experiences of all individuals, with an emphasis on the oppression they face [36–38]. Feminist theory includes diversity and incorporates the intersectionality of women based on factors such as race, class, sexuality, and various forms of oppression [36–38].

The aspect that was used in the conceptualization and development of the questions for this study was the part that applies to making changes in women's experiences that are challenging in societies [37,38]. Feminist theory was used in this study to discover the experiences of mothers and the challenges they face in receiving maternal care.

### *2.2. Study Site*

The study data were collected from June 2023 to January 2024 in the Central and Ashanti regions in Ghana by three of the authors. These regions were chosen because of the metropolitan areas within each region which afforded the researchers an opportunity to meet women from both urban and rural dwellings. This also helped the researchers to collect rich data from Ghanaian women from diverse backgrounds.

### *2.3. Population and Sampling*

In total, 450 mothers took part in the study and 400 were included in the analysis. The sample (50) that was not included in the analysis were those who had incomplete surveys and did not answer some of the main questions.

The recruited participants for this study were mothers of a wide range of ages and educational backgrounds. Although the population sample was diverse in terms of age and educational background, the most important "qualification" for this study was that the participants were women who had been pregnant and attended a clinic or hospital in Ghana. We used a purposeful sampling approach for the data collection method to select participants [39].

### *2.4. Data Collection*

All procedures and materials were approved by an Institutional Review Board in March 2023 before the study began.

The items on the survey consisted of both quantitative and qualitative questions that were formulated after reading several articles on the subject matter [10,25,26,30–34,40–46]. The senior author's (C.O.) experience in the field also shaped the survey. We were also guided by the existing discrepancies that already existed in Ghana, such as the following:

- Perceptions of quality of ANC provided.
- Cultural perceptions regarding what is appropriate to share in medical settings.
- Communication barriers (i.e., being disrespectful and not clear); language barriers (i.e., not speaking their native language); and barriers to clarity (i.e., using complicated jargon that patients may not understand).
- Health-seeking behaviors as related to ANC.

Our mixed-methods questions consisted of open- and closed-ended questions administered by the researchers in Ghana. The research team comprised three individuals from a Midwestern University in the US and a person from the University of Cape Coast.

The questions that sought to obtain the mothers' experiences with ANC are the following:

- What type of prenatal care did you receive?
- Have you received maternal care?
- Can you describe a time when you had difficulty communicating or interacting with a doctor?
- Have you ever felt uncomfortable sharing information with your doctor?

The questions to identify the barriers to the usage of ANC are the following:

- Has there ever been an instance where you did not want to visit the doctor? Can you describe a time when you had difficulty communicating or interacting with a doctor?

One question was asked for participants to suggest ways to improve maternal and child care in Ghana:

- What are the things you think must be done to improve maternal and child care in Ghana? Why?

### *2.5. Data Analysis*

For the closed-ended questions on the survey, descriptive statistics were run to generate frequencies and percentages using Microsoft Excel software. Thematic analysis was manually performed using the six steps proposed by Braun and Clarke [35], which include familiarization, generating codes, generating themes, reviewing themes, defining and naming themes, and creating the report.

## 3. Results

The results of this study are presented in the following order: demographic characteristics of respondents, Theme 1: ANC opinions and experiences of Ghanaian mothers, Theme 2: barriers to usage of ANC service, and Theme 3: suggestions for improvement in ANC in Ghana.

### *3.1. Sociodemographic Characteristics of Respondents*

Table 1 presents the sociodemographic characteristics of the respondents. The majority of the mothers who participated in this study were within the age range of 20 to 39 years. The majority had at least completed Senior High School. The respondents were evenly distributed in terms of their area of residence or location. The majority had one local language and English as their first language. The majority used English as their language for communication with health providers.

**Table 1.** Sociodemographic characteristics of respondents.

| Sociodemographic Variable | Frequency | Percentage |
|---|---|---|
| **Age** | | |
| 19 and below | 37 | 9.3 |
| 20–39 | 249 | 62.2 |
| 40 and above | 114 | 28.5 |
| **Highest level of school completed** | | |
| University | 95 | 23.7 |
| Technical/Vocational School | 28 | 7 |
| Senior High School | 134 | 33.5 |
| Junior High School | 74 | 18.5 |
| Primary School | 46 | 11.5 |
| No School | 23 | 5.8 |
| **Location** | | |
| Urban | 201 | 50.2 |
| Rural | 199 | 49.8 |
| **First Language (Ghanaian) One Speaks** | | |
| Fante | 50 | 12.5 |
| Twi | 48 | 12 |
| Ewe | 5 | 1.25 |
| Ga | 3 | 0.75 |
| Dagbani | 2 | 0.5 |

**Table 1.** *Cont.*

| Sociodemographic Variable | Frequency | Percentage |
|---|---|---|
| Frafra | 1 | 0.25 |
| Nzema | 1 | 0.25 |
| Two Local Languages | 30 | 7.5 |
| Local Language and English | 260 | 65 |
| **Language Used in Interacting with Healthcare Professionals** | | |
| English | 143 | 35.7 |
| Twi | 116 | 29 |
| Fante | 84 | 21 |
| Local Language and English | 42 | 10.5 |
| Ewe | 10 | 2.5 |
| Ga | 4 | 1 |
| Frafra | 1 | 0.3 |

N = 400.

### *3.2. Theme 1: ANC Opinions and Experiences of Ghanaian Mothers*

The mothers' responses to the questions on their ANC experiences are presented in Table 2. The frequency of ANC perceptions and services received by Ghanaian mothers are followed by their reasons for their responses (see Table 3).

**Table 2.** Frequency of ANC perceptions and services received by Ghanaian mothers.

| Questions | Yes Frequency (%) | No Frequency (%) |
|---|---|---|
| If you received ANC during your pregnancy/pregnancies, do you think the ANC you received was good? | * 359 (93.5) | * 25 (6.5) |
| Have you received maternal care (care for yourself as a mother) before? | 342 (85.5) | 58 (14.5) |
| Have you ever felt uncomfortable sharing information with the/your doctor? | 6 (1.5) | 394 (98.5) |
| What type of prenatal care (a care given to the mother before giving birth) did you receive? | **Prenatal care received by participants**<br>Urine, blood, and lab tests<br>Ultrasound examination<br>Physical examination<br>Health education and counselling<br>Blood pressure checks<br>Medication<br>Body temperature checks<br>Checking of the fetal heart rate<br>Pelvic examination<br>Weight check | |

* N = 384 participants who responded that they had received ANC.

**Table 3.** ANC opinions and experiences of Ghanaian mothers.

| **Theme 3.2 ANC opinions and experiences of Ghanaian mothers.** | |
|---|---|
| **Description** | **Participants Excerpts (3.2)** |
| **(3.2A) and (3.2B):** Regarding whether their ANC was good, 93.5% of the mothers responded yes and 6.5% of the participants indicated no. For most participants, one theme was identified: good antenatal service. Some of the reasons assigned to why participants believed they received good ANC. | **Excerpt (3.2A)** The ANC service was good because proper examination was conducted concerning the baby and me. Medications pertaining to the pregnancy was also given (40 years and above, Primary School graduate, Urban resident). |
| | **Excerpt (3.2B)** The staffs were friendly and nice and I was also well educated about the do's and don'ts of pregnancy (40 years and above, University graduate, Urban resident). |
| **(3.2C) to (3.2E):** A few of the participants who were not so impressed with the ANC received | **Excerpt (3.2C)** There were times you will have to wait for a long time before the doctor comes and anything could happen while waiting (40 years and above, University graduate, Urban resident).<br>**Excerpt (3.2D)** The level of treatment and medications were not enough to handle some of the issues. I even had to purchase some of the medicines and go to a private laboratory for some tests (between 20 and 39 years, University graduate, Urban resident).<br>**Excerpt (3.2E)** I was not treated the way I was expecting. The nurses were treating me as a stranger (between 20 and 39 years, No School, Urban resident). |
| **(3.2F) and (3.2G)** excerpts: The mothers also generally shared their positive experiences when they received maternal care. | **Excerpt (3.2F)** My experience was really good especially when the doctor was able to tell me my child [the fetus] was doing well (40 years and above, Senior High School graduate, Urban resident). |
| | **Excerpt (3.2G)** My experience was really good especially when the doctor was able to tell me my child [the fetus] was doing well (40 years and above, Senior High School graduate, Urban resident).<br>**Excerpt (3.2G)** My prenatal was good because though a lot of pregnant women complain about unfair treatment they receive from their doctors, I faced none of such (between 20 and 39 years, University graduate, Urban resident). |
| **(3.2H) and (3.2I)** excerpts: Most of the participants had not faced a situation where they had difficulty communicating with a doctor. However, few who have had such experiences shared them. | **Excerpt (3.2H)** I found it difficulty ones, because my English was not great and the doctor could not speak Ga [a Ghanaian language] (between 20 and 39 years, Senior High School, Urban resident). |
| | **Excerpt (3.2I)** The doctor was not an Ewe [an ethic group in Ghana who speak the Ewe language], so any time she mentioned certain things in English I found it difficult to understand (between 20 and 39 years, No School, Rural resident). There was a time when I was communicating with a doctor and he was using jargons, so I was finding it difficult to understand (between 20 and 39 years, Senior High School, Urban resident). |
| **Theme 3.3 Barriers to usage of ANC service for Ghanaian mothers.** | |
| **Descriptions** | **Participants Excerpts (3.3)** |
| **(3.3A) and (3.3B)** excerpts: | **Excerpt (3.3A)** |
| When asked if there had been an instance where they did not want to visit the doctor, twenty-five percent (n = 101) of the participants indicated yes and 75% (n = 299) indicated "No". The theme identified as the main reason for participants not wanting to visit the doctor was money and distance problems. | Money was the problem. I was not having any money on me then (between 20 and 39 years, Senior High School graduate, Rural resident). |
| | I was not having money to take car, pay the hospital bills and even the money to use to buy food (between 20 and 39 years, Primary School graduate, Rural resident). |
| | **Excerpt (3.3B)** |
| | Even though the mothers generally shared positive experiences, distance to the antenatal facility was mentioned as a barrier. Below is what a participant shared. |
| | My visit to the hospital during my pregnancy was good but distance served as a barrier (40 years and above, Junior High School graduate, Rural resident). |

**Table 3.** *Cont.*

| **Theme 3.4. Suggestions for Improvement in ANC in Ghana.** | | |
|---|---|---|
| **Descriptions** | **Participants Excerpts (3.4)** | **Implications (Suggested Next Steps)** |
| **(3.4A) and (3.4B) excerpts:** | **Excerpt (3.4A)** | **Increase the health personnel-to-population ratio so that more healthcare personnel can attend to pregnant women when they access/use the healthcare facilities.** |
| The mothers involved in this study suggested several ways in which maternal and child health can be improved in Ghana. Their suggestions were grouped under five broad themes: provision of more health personnel, provision of more specialized health personnel, provision of more facilities, provision of improved services, and provision of more education.<br>**Provision of more health personnel**<br>Participants indicated that, for maternal and child health to be improved in Ghana, there is a need for more health personnel. They shared these in excerpts (3.4A) and (3.4B). | Provision of enough personnel because the place [health facility] I used to attend, the health professionals were inadequate (40 years and above, University graduate, Urban resident).<br>**Excerpts (3.4B)**<br>There should be enough health workers, because when you visit there [the health facility the participant attended], it is only two people taking care of about 80 people, so it slows or delays us (between 20 and to 39 years, Junior High School graduate, Urban resident). | |
| **(3.4C) and (3.4D)** excerpts:<br>**Provision of more specialized health personnel**<br>Some of the participants emphasized the need for health personnel with specialized training. | **Excerpt (3.4C)**<br>I think we need more specialized health workers in the system. This is because sometimes in the hospitals, they will ask you to wait for the specialist from either Accra or Takoradi [cities in Ghana other than where the participant is seeking healthcare] (between 20 and 39 years, University graduate, Rural resident).<br>**Excerpt (3.4D)**<br>There should be training of more skilled professional to assist in maternal and child care in the country (40 years and above, Junior High School graduate, Rural resident). | **Providing more specialized training. This may encourage women to use ANC services frequently.** |
| **(3.4E), (3.4F) and (3.4G)** excerpts:<br>**Provision of improved services**<br>Participants also suggested a need for improved services. | **Excerpt (3.4E)**<br>The government should equip the hospitals with modern equipment to aid in treatment (between 20 and 39 years, Senior High School graduate, Rural resident).<br>**Excerpt (3.4F)**<br>Technology is fast growing and the hospital in the country needs to grow along and adopt these technologies to help save the lives of the mothers and babies (between 20 and 39 years, Senior High School graduate, Urban resident).<br>**Excerpt (3.4G)**<br>The government should supply the health service with drugs. At times, they will always say there are no drugs, so go and buy (between 20 and 39 years, Junior High School graduate, Rural resident). | **Increasing the number of healthcare facilities to reduce patient wait times and improve service delivery. Equipping healthcare facilities with modern technology and ensuring the availability of essential medications to provide better services** |

**Table 3.** *Cont.*

| | | |
|---|---|---|
| **(3.4H), (3.4I) and (3.4J)** excerpts:<br>Provision of more education<br>Participants also suggested that, to im-prove maternal and child health in Ghana, there should be more education. | **Excerpt (3.4H)**<br>More public education should be organized to create public awareness about this [maternal and child health] service (40 years and above, Senior High School graduate, Rural resident).<br>**Excerpt (3.4I)**<br>There should be good educational system on maternal and child health to help reduce ignorance (between 20 and 39 years, Junior High School graduate, Rural resident).<br>**Excerpt (3.4J)**<br>Empowering women by providing education, employment opportunities and resources for family planning which can positively impact maternal and child health (between 20 and 39 years, Senior High School graduate, Urban resident). | **Increasing awareness and enhancing public health education regarding maternal health benefits specifically, as it relates to the utilization of antenatal services.** |

## 4. Discussion

Our research shows that 93.6% of Ghanaian mothers reported that their ANC was "good", with descriptions of their care that allowed the researchers to identify and glean what women perceived as contributing factors for good and quality care. Our findings revealed that the perceptions of good-quality ANC consisted of (1) proper examination being given, (2) friendly patient–provider interactions, (3) reassurance that the baby was doing okay, (4) fair treatment, and (5) education on how to properly manage their pregnancies. Ahmed's [28] findings echo the perspectives of the women in our study that described their idea of "good" ANC with these qualities. Ahmed [28] found that women-centered care, which includes "effective communication, respect and dignity, and emotional support", is necessary for a good childbirth experience [40] (as quoted in Rishard M, 2021). Also, Banchani's study [34] found that the quality care indicators of clinical interventions (health information and advice) and highly qualified healthcare providers (doctors and nurses) were positive indicators of birth weight.

Additionally, 6.5% of Ghanaian mothers from our study indicated that they did not have "good" ANC. Adu-Bonsaffoh [1] found that ineffective patient–provider communication, disrespectful treatment, and inappropriate provider attitudes negatively impacted the quality of care perceived by patients. Adu-Bonsaffoh [41] affirms our study's perspective that women's healthcare experiences are necessary to listen to in order to improve the healthcare system and quality of care. Additionally, Ahmed [28] found poor communication between the patient and provider, non-consensual care, and a lack of female involvement in care. Poor communication was also found in our study, as previously mentioned, due to language barriers. When abuse and disrespect are practiced, this impacts the patient's dignity and may hinder women from wanting to seek ANC in future pregnancies.

An authoritative or paternalistic model of healthcare refers to communication in which the provider directs the care of the patient without input from the patient in the process or treating them as a stranger [47] his leads to a lack of patient education and understanding, a lack of respect for patients, and restricted patient autonomy [47]. This method of communication is not limited to the realm of ANC, as shown by Houphouet's study [42] findings on psychiatric care in Ghana, which found a similar model of healthcare professionals directing the care without input from the patient. Additionally, code-mixing, a practice of combining Akan and English in the same sentences, was found to be performed commonly to fill gaps in difficult translation, particularly of medical terms that do not have a direct Akan equivalent. This practice is especially detrimental for patients who primarily speak Akan, since this hinders the patient–doctor relationship, the patient's understanding of their own health, and the overall quality of care provided (as cited in Koh 2010) [43].

Language barriers due to the provider's inability to speak in plain language without jargon or due to the doctor not being familiar with the patient's preferred language were present in our study's findings and led to the patient not feeling fully aware of what their provider was saying.

As previously mentioned, ANC services are necessary for the health of the mother; however, our research found that 25% of participants said that there had been an instance when they did not want to go to the doctor. The most commonly expressed barriers were financial issues and long distances to healthcare facilities. Our findings are similar to evidence from Adu-Bonsaffoh [41], who found reports of significant delays to healthcare provision [44,48] (reported in Osungbake 2011 and Danso 2010), which could result in preventable deaths and complications [49] (as cited in Knight 2013). Long distances to healthcare facilities are detrimental to the mother's and child's health, as shown in Bawuah's study [45], which found that women who report distance to healthcare facilities as a problem were more likely to have fewer and later antenatal visits. Also, Bawuah's study [45] findings revealed that a unit increase in health personnel per 1000 of the population ratio is associated with early ANC initiation and frequent visits.

According to Abuosi, [16] some of the commonly cited reasons why women in Ghana are not seeking maternal health services were identified as the lack of transportation, lack of money, and overall lack of urgency regarding the importance of the attending the first appointments during the first trimester. The lack of transportation and lack of money were two significant factors that were present in our own study, highlighting just how prevalent this issue appears to be in accessing ANC.

## 5. Limitations

Our research surveyed women who had accessed a healthcare facility for ANC, which excluded women who never received ANC in the first place. By placing this qualification, the perspectives of these women were excluded, which could have provided information on why women may not access antenatal healthcare services. This could have clarified barriers and perspectives that were not present for the women surveyed, since the women surveyed all accessed antenatal healthcare services. While there was wide variety of age, educational status, location, and languages spoken among the participants, the data were collected in the Central and Ashanti regions of Ghana. While collecting data in these regions allowed us access to metropolitan areas that gave ample opportunities for the researchers to survey both urban and rural participants, there are fourteen other regions of Ghana that were not included. Considering that each region is composed of different majority ethnic groups, religions, and practices, there may be other barriers and perspectives that are present in these other regions that were not addressed by our study. Additionally, ANC providers were not surveyed. If these perspectives were included, they could give insight into the provider's bedside style and possible reasoning providers may have for performing behaviors that hinder the provider–patient relationship.

## 6. Future Research

Ongoing studies should consider investigating the authoritative model in healthcare [47], i.e., the authoritative/paternalistic model of healthcare that has the provider dictate the patient's healthcare decisions [47]. This model has been seen specifically among midwives who use disrespect and abuse toward women giving birth [33]. There have been frequent accounts of disrespect and abuse in healthcare facilities, which is treatment that can reduce the patient's motivation to access these services [33] (as cited in 6–10 of article D-Zomeku). The practice is justified among midwives by blaming their actions on the patient's attitude or by holding the belief that, if the woman is coddled too much during birth, the woman will not comply and the baby could die. The WHO determines respectful maternal care, "care organized for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and

mistreatment, and enables informed choice and continuous support during labor and childbirth" (definition), to be the solution [46] (as quoted in the WHO 2018).

## 7. Implications

Patient–provider interactions can largely influence the quality of care provided and the health outcome of the patient. Our study sought to understand Ghanaian women's experiences after receiving ANC services and learn about their perceptions as they relate to the quality of care and interaction with providers. Though there are existing challenges in providing optimal healthcare to women in Ghana, including delays in care, paternalistic approaches, communication gaps, and healthcare provider skill gaps, based on our study findings, we suggest the following to public health leaders to improve ANC services:

(1) Increasing the health personnel-to-population ratio for more healthcare personnel to attend to pregnant women when they access/use the healthcare facilities. Participants expressed at their healthcare facility that there were two people taking care of 80 people, demonstrating inadequate patient–provider ratios. Bawuah 's study [45] found that a unit increase in health personnel per 1000 of the population ratio is associated with early ANC initiation and frequent visits. An increase in the health personnel-to-population ratio implies that there are more healthcare personnel available to pregnant women when they access/use healthcare facilities. This may encourage women to use ANC services frequently.

(2) Providing more specialized training. Our findings revealed that Ghanaian mothers lacked access to skilled healthcare providers and had to wait for specialists from other cities. Therefore, providing more specialized training may decrease the delay in treatment time and may provide a more optimal ANC visit, which may encourage Ghanaian mothers to use ANC services frequently.

(3) Increasing the number of healthcare facilities to reduce patient wait times and improve service delivery. The results indicated that travel time was a barrier for Ghanaian mothers seeking frequent ANC services, especially in rural areas. It was also noted that some labor wards did not have sufficient available beds and space. Therefore, we suggest that leaders in Ghana consider establishing more healthcare facilities, especially in rural areas, to reduce travel distance and improve Ghanaian mothers' access to ANC services.

(4) Equipping healthcare facilities with modern technology and ensuring the availability of essential medications to provide better services. The results indicated that patients experienced issues in the quality of facilities that prevented exceptional ANC care. Hospitals not having the proper medication required creates a burden where patients must travel to private pharmacies to purchase medications. Additionally, respondents reported facilities having outdated technology. Having up-to-date facilities with the proper technology and services may improve the quality of care able to be provided and, ultimately, allow for optimal ANC for Ghanaian mothers.

(5) Increasing awareness and enhancing public health education regarding maternal health benefits specifically as it relates to the utilization of antenatal services. Our results revealed that Ghanaian women lack health literacy regarding the appropriate number of ANC visits, which is a minimum of four ANC visits [22]. Therefore, we suggest increasing awareness and enhancing public health education regarding the maternal health benefits related to ANC services. The provision of public health education has the potential to empower and equip Ghanaian mothers with sufficient resources and data to make wise family planning decisions and adequate preparations for their new child.

These suggestions align with global health strategies aimed at improving maternal health outcomes. The World Health Organization emphasizes the importance of comprehensive healthcare services, including sufficient healthcare personnel, infrastructure, and public health education, to achieve sustainable improvements in maternal health.

## 8. Conclusions

Overall, this preliminary and comprehensive study identified the expected mothers' perceptions and experiences as they related to receiving ANC services. Our study results showed the importance of addressing the perspectives of women to examine personal barriers and barriers within the existing healthcare system. For Ghanaian mothers to receive better outcomes for themselves and their children, it is worth improving healthcare facilities, healthcare provider preparedness, and local transportation and addressing financial constraints to go from suboptimal to optimal health services taking care of the whole person (a mother) and the person who is yet to be born (a baby).

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