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Assessing health care quality in adolescent clinics, implications for quality improvement

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Abstract

Purpose – Adolescents are more exposed to risky health behaviors. However, many adolescents do not seek health care due to the poor quality of care. The purpose of this paper is to assess health care quality in adolescent clinics in Tema, a suburb of Ghana.

Design/methodology/approach – Cross-sectional survey design was adopted to collect data from 365 adolescent respondents. Data were analyzed with the aid of Statistical Package for Social Science (version 20) using descriptive statistics and multiple linear regression.

Findings – The results demonstrate that adolescents perceived quality of care in adolescent clinics to be good. The significant predictors of adolescents' overall perceptions of quality of care were provider competencies ($\beta = 0.311$, $p < 0.01$), adolescent's health literacy ($\beta = 0.359$, $p < 0.01$), appropriate package of services ($\beta = 0.093$, $p < 0.05$), and equity and non-discrimination ($\beta = 0.162$, $p < 0.01$).

Research limitations/implications – The study was conducted in an urban setting. Therefore, the generalization of findings must be done with caution.

Originality/value – Adolescent health care quality in Ghana is below expectation. However, it has received little attention from researchers. This study provides empirical evidence for adolescent health care quality improvement in developing countries like Ghana.

Keywords Health care quality, Quality, Patient safety, Patient perspectives, Management of clinical performance, Patient education

Paper type Research paper

Introduction

Adolescents (10–19 years) are the world's future leaders and human resource (Ki-moon, 2016). However, according to the World Health Organization (WHO), many adolescents die prematurely, while others are living with diseases (WHO, 2015). This is partly because adolescents are more exposed to risky health behaviors like unsafe sex, alcohol and substance abuse (Bearinger *et al.*, 2007; WHO, 2015).

To promote the health, well-being and development of our future leaders, it is necessary that they are provided with quality health care (WHO, 2015). On the contrary, evidence from both high- and low-income countries show that adolescent health care quality remains poor (WHO, 2015). For instance, adolescents often find mainstream health care services unacceptable because of the perceived lack of privacy and confidentiality coupled with poor provider attitudes. Moreover, health care facilities usually lack adolescent-friendly resources like health information materials, essential drugs and supplies (WHO, 2015).

In this regard, global health organizations like WHO and Joint United Nations Programme on HIV/AIDS have called on countries to implement standards-driven approaches to improve adolescent health care quality. Prioritizing quality is a way of reinforcing human rights-based approaches to health care (WHO, 2015). Recognizing this, more than 25 countries have adopted national quality standards, while others have

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conducted surveys to measure the quality of care being provided to adolescents in order to inform action (Chandra-Mouli *et al.*, 2015; WHO, 2014).

In Ghana, efforts have been made toward improving adolescent health care quality. For example, in 1996 Ghana launched the Adolescent Health and Development (ADHD) program. In addition, Ghana has a National Adolescent Sexual and Reproductive Health Policy and a National ADHD strategic plan. In 2015, the Ministry of Health in collaboration with Ghana Health Service and non-governmental organizations refurbished and equipped adolescent clinics, also known as adolescent health corners with resources such as health information materials, logistics and trained health providers. According to Ghana Health Service's (GHS, 2015) annual report, there were 212 adolescent clinics spread across the country expected to provide adolescents with quality health care (GHS, 2015).

Despite these efforts, gray literature and anecdotal evidence have shown that adolescent health care quality is below expectation in Ghana (GHS, 2015). For instance, according to the annual reports of Ghana Health Service, adolescents perceived health providers as unfriendly, judgmental, discriminatory and untrustworthy. Also, health facilities environment were not welcoming to adolescents coupled with inadequate adolescent-friendly resources (GHS, 2014, 2015).

However, adolescent health care quality has received little attention from researchers in developing countries like Ghana (Villalobos *et al.*, 2017). Prior studies on health care quality were conducted in general health facilities and focused more on adults (Abuosi, 2015; Abuosi and Atinga, 2013; Ahenkan and Aduo-Adjei, 2017; Atinga, 2012; Atinga *et al.*, 2011). To the best of the authors' knowledge, no study has been conducted in Ghana to measure adolescent health care quality, especially from adolescents' perspectives.

To improve adolescent health care quality, studies focusing on measuring the quality of care in adolescent health facilities are needed. If stakeholders have a clear understanding of the gaps in adolescent health care quality, management or policy actions can be taken. Therefore, the aim of this study was to assess the quality of care in adolescent clinics in Ghana. The objectives were to assess perceive the quality of care and identify factors that are salient to gauging the quality of care.

Literature review

The WHO has developed eight global standards for assessing adolescent health care quality. The organization suggested some of these standards can be adopted for use depending on the context (Nair *et al.*, 2015). Since adolescent health care quality improvement has not received much attention in developing countries like Ghana, five of the standards which are applicable to our context were adopted. These include facility characteristics, adolescent's health literacy, appropriate package of services, provider competencies, and equity and non-discrimination (Nair *et al.*, 2015; WHO, 2015).

According to WHO (2015), adolescent health care quality can be assessed based on the characteristics of the health facility. This means that the health facility has convenient operating hours, a welcoming and clean environment and maintains privacy and confidentiality. Also, it has the equipment, medicines, supplies needed to ensure the effective service provision for adolescents (WHO, 2015). Evidence has shown that adolescents prefer health facilities that have convenient operating hours such as late afternoon and weekends, and convenient location (example, close to their school) where they can easily make an appointment or "drop-in"(Richter and Mfolo, 2006; Senderowitz *et al.*, 2003). Adolescents also prefer health facilities with a welcoming and clean environment coupled with basic facilities like washrooms (Sovd *et al.*, 2006). Geary *et al.* (2014) found that adolescents' visits to clinics were influenced by the cleanliness of the environment and the availability of washrooms.

For privacy purposes, adolescents prefer stand-alone clinics or health facilities with a separate waiting area for adolescents (Kennedy *et al.*, 2013; Richter and Mfolo, 2006;

Sogarwal *et al.*, 2013; Sovd *et al.*, 2006). Adolescents may not use health facilities if they perceive that it cannot provide adequate privacy (Ambresin *et al.*, 2013). Furthermore, ensuring that essential drugs and supplies like condoms are always available in adolescent clinics is also a significant determinant of quality of care. Studies have found that adolescents' dissatisfaction with quality of care were associated with the lack of resources in adolescent health facilities (Erulkar *et al.*, 2005; Schriver *et al.*, 2014).

Another standard for assessing adolescent health care quality is adolescent's health literacy. This implies that health facilities implement systems to ensure that adolescents are knowledgeable about their own health and they know where and when to obtain health services (WHO, 2015). Studies have shown that adolescents usually do not have adequate knowledge about their health and developmental changes (Lim *et al.*, 2012; Schriver *et al.*, 2014). Therefore, they prefer health facilities that provide age-appropriate health information or have health information materials like books, posters, magazines, leaflets among others (Sovd *et al.*, 2006). For example, Sogarwal *et al.* (2013) found that waiting areas of adolescent clinics were stocked with adolescent-friendly health education materials for adolescents to pick and read. However, their respondents could not borrow the materials to read at their convenience.

Apart from the physical structures, the package of services is another standard for assessing adolescent health care quality. This implies that the health facility provides counseling, diagnostic, treatment and care services that fulfill the needs of all adolescents. Services are provided in the facility and through referral linkages and outreach (WHO, 2015). Prior studies have shown that adolescents prefer "one-stop shop" kind of health facilities (Ackard and Neumark-Sztainer, 2001). Thus, they prefer health facilities that provide comprehensive care including promotive, preventive and curative. Also, adolescents prefer health facilities that provide tailored-made health care services such as pregnancy and sexually transmitted infections (STIs) testing and management, and counseling services on nutrition and mental health (Senderowitz *et al.*, 2003). It has been suggested that if health facilities provide a broad range of services under one roof, it can promote health care utilization among adolescents (Nath and Garg, 2008).

According to WHO (2015), adolescent health care quality can also be assessed based on the competencies of providers. This means that health care providers demonstrate technical competence required to provide effective health services to adolescents. Both health care providers and support staff respect, protect and fulfill adolescents' right to information, privacy, confidentiality and non-judgmental attitudes. Existing studies have found that positive provider attitude is a significant determinant of adolescent health quality (Geary *et al.*, 2014). Adolescents prefer providers who are friendly, respectful, non-judgmental, spend enough time with them, and value them seeking care (Gibson *et al.*, 2013; Richter and Mfolo, 2006; Schriver *et al.*, 2014; Sogarwal *et al.*, 2013).

Moreover, adolescents expect providers to have adequate knowledge about adolescent health issues, such as mental health, nutrition, sexual and reproductive health coupled with good communication skills (Mngadi *et al.*, 2008). Above all, providers' ability to maintain confidentiality and privacy is also a significant predictor of adolescent health care quality (Geary *et al.*, 2014; Mmari and Magnani, 2003; Schriver *et al.*, 2014; Senderowitz *et al.*, 2003; Tangmunkongvorakul *et al.*, 2012). Adolescents prefer providers who can uphold their privacy and would not disclose information to their parents. Adolescents are more likely to disclose sensitive information to providers if they are confident that providers will not disclose the information to their parents. Promoting a trustworthy relationship between providers and adolescents can promote the quality of care.

Finally, equity and non-discrimination mean that the health facility provides care to all adolescents, irrespective of their ability to pay, age, sex, marital status, education level, ethnic origin, sexual orientation or other characteristics (WHO, 2015). Adolescents prefer

providers who ensure fairness (Chandra-Mouli *et al.*, 2015) and do not discriminate in the delivery of care (Schriver *et al.*, 2014). However, prior studies established that adolescents are usually discriminated against in care delivery, especially in developing countries (Bankole *et al.*, 2007). For instance, Chilinda *et al.* (2014) found that health care providers in some developing countries were not comfortable providing family planning services to adolescent girls. In addition, Ahanonu (2014) found in Nigeria that providers were not willing to give contraceptives to unmarried adolescents. Providers argued that it would promote promiscuity and that adolescents should abstain from pre-marital sex because it was against their cultural and religious beliefs.

However, all these studies were conducted outside Ghana. Therefore, the findings may not be a true reflection of Ghana. This study sought to find empirical answers to the following research questions:

RQ1. How do adolescents in Ghana perceive quality of care in adolescent clinics?

RQ2. What factors are salient to gauging quality of care from the perspective of the Ghanaian adolescent?

Methods

Study setting

The study was conducted in Tema Metropolis. A coastal urban district situated about 30 km East of Accra, Ghana's capital city. According to Ghana's 2010 Population and Housing Census, the metropolis has a total population of 292,773. Adolescents represent 18.9 percent of the total population (Ghana Statistical Service, 2014). The metropolis has a high literacy rate of 91.1 percent. In terms of health care delivery, the public sector has a wider coverage (Ghana Statistical Service, 2014). The metropolis has 4 adolescent clinics and 19 adolescent health clubs. The clinics are operated by professional health providers who also oversee the activities of the various adolescent health clubs. In addition, there is a focal person who coordinated the activities of the adolescent clinics and clubs.

Design and sampling

A cross-sectional survey design was employed to collect data from 365 adolescent (10–19 years) respondents (Biddlecom *et al.*, 2007; Sogarwal *et al.*, 2013). According to Bowling (2014), the survey method is ideal for measuring attitudes, perceptions and behaviors and the collection of accurate and precise information as possible. Also, it is ideal for making statistical inferences to a broader population. At the time of the survey, the metropolis had four adolescent clinics only. In this regard, all the adolescent clinics were purposely selected, hence piloting was not done. Due to low attendance at the adolescent clinics, respondents who were available during the survey and consented were conveniently selected.

Questionnaire and data collection

A structured questionnaire was used to collect data from respondents. Items in the questionnaire were adopted from WHO's measurement tools. These tools have been tested in Benin, Latin America and the Caribbean countries (WHO, 2015). The questionnaire had three main sections. Section 1 comprised of respondent's demographics (i.e. age, sex and education), section 2 contained the independent variables used to measure adolescent health care quality. All the items were categorical variables (yes or no) categorized into five dimensions including provider competencies, which was measured with five items (i.e. did the provider treat you in a respectful manner?), equity and non-discrimination, which was

also measured with five items (i.e. were you denied any service because of your age?), adolescent's health literacy, which was also measured with five items (i.e. did the provider talk to you about how to stay healthy?). Last but not least, appropriate package of services was also measured with five items (i.e. does the clinic provide pregnancy test? and finally, facility characteristic was also measured with five items (i.e. is the clinic environment adequately clean?). Section 3 measured the adolescents' overall perceptions of health care quality (dependent variable) on a five-point Likert scale ranging from 1 = very poor to 5 = very good.

The questionnaires were administered using a face-to-face approach by two interviewers (the first author and a trained researcher assistant) within the premises of adolescent clinics. The interviewers approached adolescents who had finished receiving care and were leaving the clinic. The purpose of the study was made known to them and those who agreed to participate were kindly asked to consent either orally or by signing. After consenting, items on the questionnaire were read to the respondent by the interviewer. The questionnaire was designed and administered in English. For respondents who did not understand English, items on the questionnaire were translated orally into the local dialect (Twi language) by the interviewer. Translation was not a problem, because the interviewers were fluent in both languages. In all, 365 questionnaires were administered instead of 401. This is because attendance at the clinics was very low. However, this represents a 91 percent response rate. Data collection was done between January and March 2017.

As an academic paper focused on improving the quality of care for adolescents in developing countries, ethical principles in academic research were acknowledged. For instance, the purpose of the study was made known to the respondents before questionnaires were administered. In addition, confidentiality, informed consent among others was adhered to. Moreover, where possible, the consent of parents or guardians was sought for.

Analysis

Data analysis was done with the aid of Statistical Package for Social Science (SPSS) version 20. First of all, descriptive statistics were computed using frequency distributions. Finally, multiple linear regression analysis was computed to determine significant predictors of adolescents' overall perceptions of health care quality (dependent variable). The assumptions underlying multiple regression analysis such as normality, outliers and test for multicollinearity were all satisfied (Pallant, 2005).

Results

From Table I, it is shown that the majority of the respondents were females (69 percent), students (61 percent) and had junior high school education (72 percent). The mean age was 16 years and the majority of the respondents were between the age of 17 and 19 (53 percent). It was not surprising to find that the majority of the respondents were schooling. In addition, it was interesting to find that all the respondents had some level of formal education. Moreover, it was informative to find that the adolescent clinic at the health center recorded higher attendance than the other clinics. This may be as a result of its proximity to some junior high schools.

Table II presents results on adolescents' experiences at the adolescent clinics. Respondents were required to respond either "yes" or "no" to a set of 25 items measuring the quality of care. The majority of the respondents stated that health information materials were available at the waiting areas for them to pick and read. Also, the majority of the respondents indicated that providers educated them on healthy living, and informed them about the range of services available in the adolescent clinic. However, many of the

Characteristic	Mean (SD)	$n = 365$	n (%)
Gender			
Male			113 (31)
Female			252 (69)
Age (years)			
11–13			23 (6)
14–16			153 (42)
17–19	16 (1.9)		189 (52)
Education			
Primary school and below			49 (13)
Junior high school			263 (72)
Secondary/vocational			53 (15)
Occupation			
Schooling			224 (61)
Not schooling			141 (37)
Health facility type			
Hospital			62 (17)
Polyclinic			55 (15)
Health center			202 (55)
Clinic			46 (13)

Table I. Demographic characteristics

Source: Authors' field survey (2017)

respondents did indicate that they could not borrow the health information materials coupled with difficulty in locating the adolescent clinic.

In addition, a larger proportion of the respondents stated that the adolescent clinics had a welcoming environment and convenient operating hours. However, about six in ten respondents indicated that drugs and supplies like condoms were not always available at the adolescent clinics. That notwithstanding, the package of services was perceived to be appropriate for adolescents. Thus, the majority of the respondents stated that they could get sexual and reproductive care and counseling services at the adolescent clinics.

Furthermore, many of the respondents stated that the providers were friendly, competent, spend adequate time with them and guaranteed their privacy. Even though a larger proportion of the respondents stated they did not see any poster on anti-discrimination, discrimination was minimal. The majority of the respondents indicated that they were not denied care due to their socio-economic status, including age, gender, marital and financial status.

Table II also shows adolescents' overall perceptions of quality of care on a scale of 1–5, ranging from very poor to very good. It is observed that about half (49 percent) of the respondents rated the overall quality of care as very good. This implies that the quality of care was perceived to be good.

Multiple regression

To identify significant predictors of adolescents' overall perceptions quality of care, a multiple linear regression analysis was computed. All the items under each dimension were computed to generate an index for each independent variable. The five standards were used as predictors with overall perception of quality care as the dependent variable controlling for demographics. It is observed in Table III that adolescent's health literacy ($\beta = 0.359, p < 0.01$), provider competencies ($\beta = 0.311,\ p < 0.01$), equity and non-discrimination ($\beta = 0.162,$

Adolescent health care quality standards	*n*	No (%)	Yes (%)
Adolescent's health literacy			
Availability of signpost?	365	54.5	45.5
Availability of information materials to read?	365	40.0	60.0
Availability of information materials to borrow?	365	69.9	30.1
Did the provider inform you about services available at the clinic?	365	33.7	66.3
Did the provider talk to you about how to stay healthy?	365	10.4	89.6
Facility characteristics			
Convenience of location?	365	37.5	62.5
Convenience of working hours?	365	31.2	68.8
Enough privacy?	365	27.4	72.6
Welcoming environment?	365	7.7	92.3
Availability of drugs or supplies?	365	54.8	45.2
Appropriate package of services			
Does the clinic provide the following services			
Pregnancy test?	365	14	86
Counseling services?	365	14.8	85.2
Family planning services?	365	22.2	77.8
STIs tests?	365	13.4	86.6
Outreach services?	365	25.2	74.8
Provider competencies			
Did the provider do the following			
Spend adequate time to listen to you?	365	6.6	93.4
Treat you in a respectful manner?	365	4.4	95.6
Assure you of confidentiality?	365	14.8	85.2
Explain issues to your understanding?	365	10.1	89.9
Condemn your decisions?	365	85.8	14.2
Equity and non-discrimination			
Did you see any poster on anti-discrimination?	365	51.8	48.2
Were you denied any service because of			
Lack of money?	365	14.5	85.5
Your gender?	365	7.7	92.3
Your marital status?	365	9.3	90.7
Your age?	365	11.8	88.2
Overall perception of health care quality	*n* (%)	Mean (SD)	
Very poor	7 (1.9)		
Poor	13 (3.6)	4.27 (0.913)	
Fair	35 (9.6)		
Good	130 (35.6)		
Very good	180 (49.3)		

Source: Authors' Field Survey (2017)

Table II. Adolescents' perceptions of health care quality

Predictors	*B*	SE	*β*	*t*-value	*p*
Adolescent's health literacy	0.198	0.026	0.359	7.626	0.000*
Provider competencies	0.510	0.075	0.311	6.811	0.000*
Equity and non-discrimination	0.164	0.045	0.162	3.620	0.000*
Appropriate package of services	0.097	0.047	0.093	2.081	0.038*
Facility characteristics	0.027	0.033	0.037	0.842	0.400
(Constant)	1.357	0.292		4.642	0.000

Notes: $R^2 = 0.312$, adjusted $R^2 = 0.303$, F-value = 32.577, $P = 0.00$, $p \leqslant 0.05$. *Significance level

Table III. Multiple linear regression results on predictors of adolescents' overall perceptions of health care quality

$p < 0.01$) and appropriate package of services ($\beta = 0.093$, $p < 0.05$) emerged as the significant predictors. This implies that improvements in these areas can lead to a rise in adolescents' perceptions of quality of care.

Discussion and implications

Adolescents are more exposed to risky health behaviors than other age groups. However, adolescent health care quality is below expectation. Having evidence-based information on adolescents' perceptions of quality is essential for designing effective health care quality improvement interventions. Adopting WHO standards, this study assesses perceive the quality of care in adolescent clinics.

It was found that adolescents in this study perceived quality of care to be good. Adolescents' perceptions were significantly influenced by adolescent's health literacy, provider competencies, appropriate package of services, and equity and non-discrimination. Adolescents' positive perceptions of quality of care were significantly associated with the availability of health information materials or health information at the adolescent clinics. Consistent with prior studies, adolescents prefer health facilities that provide age-appropriate health information to help them improve their health literacy (Sovd *et al.*, 2006). However, the adolescents perceived that they could not borrow or own the health information materials (Sogarwal *et al.*, 2013). This practice is unacceptable because adolescents are more exposed to risk health behaviors and therefore need adequate health information to be able to make informed health decisions or modify risky behaviors (WHO, 2015).

Also, the majority of the respondents were students and may not be able to spend enough time at the adolescent clinic reading. Moreover, the adolescent clinics did not operate on weekends and late afternoon when adolescents were not engaged in school. For these reasons, we recommend that management of the adolescent clinics should print more health information materials so that adolescents can borrow or own them to improve on their health literacy. This would help adolescents to make informed health decisions or avoid risk health behaviors.

In addition, adolescents' positive perceptions of quality of care were influenced by the positive attitudes of health providers. The majority of the respondents in this study perceived providers to be respectful, competent, trustworthy and non-judgmental. This is commendable since good provider attitude is the "bedrock" of adolescent health care quality (Ambresin *et al.*, 2013; WHO, 2015). However, this finding contradicts with findings of previous studies (Geary *et al.*, 2014; Samargia *et al.*, 2006; Tangmunkongvorakul *et al.*, 2012). What might have accounted for the differences in findings is the difference in providers' level of training. Prior studies found that providers who were not adolescent-friendly lacked adequate training in adolescent health care (AlBuhairan and Olsson, 2014; Geary *et al.*, 2014; Mngadi *et al.*, 2008; Senderowitz *et al.*, 2003). However, in this study, the providers were trained nurses. This confirms that providers who are trained in adolescent health care demonstrate positive attitudes such as respectfulness and friendliness (Sogarwal *et al.*, 2013).

Apart from the fact that adolescents prefer providers who are friendly, they equally prefer providers who are fair or nondiscriminatory. In this study, equity and non-discrimination emerged as a significant predictor of perceived quality of care. The majority of the respondents perceived that the providers were fair and did not deny them health care. On the contrary, previous studies found that adolescents were discriminated against in health care delivery (Ahanonu, 2014; Chilinda *et al.*, 2014). The following reasons may explain the differences in findings. First, services in the adolescent clinics are supposed to be free or affordable. Second, adolescent health care in Ghana is supported by strong policies and protocols. For example, there is a national Adolescent Sexual and Reproductive Health policy that supports the adolescents' use of such services.

Third, providers in the adolescent clinics were professionals, and it is expected that they would demonstrate professionalism in their duties.

Furthermore, adolescents' positive perceptions of quality of care were associated with the package of services. Adolescents have special health needs and, therefore, need tailor-made services that can adequately address their health needs (Ackard and Neumark-Sztainer, 2001; Senderowitz *et al.*, 2003). It has been argued that health services for adolescents are mostly not tailor-made, even in facilities labeled adolescent-friendly (WHO, 2015). However, in this study, adolescents perceived services to be appropriate. The majority of the respondents did indicate that the adolescent clinics provide a wide range of services such as reproductive and counseling services. This is laudable and would help adolescents to have a "one-stop" for all their health care needs.

Apart from the above-mentioned factors, adolescents also prefer health facilities that have adolescent-friendly characteristics, such as essential drugs, supplies among others. The environment of the adolescent clinics was perceived to be convenient and welcoming. However, it was found that drugs and supplies like condoms were not always available for adolescents to pick up. Prior studies found that adolescents were dissatisfied with care because clinics lacked adequate resources (Erulkar *et al.*, 2005; Schriver *et al.*, 2014). Therefore, managers of the adolescent clinics need to give this finding the needed attention. This is because the majority of the respondents were not employed and may not have money to buy drugs or condoms. Moreover, many of the respondents were older adolescents (15–19 years) who are believed to be sexually active. Hence, the shortage of contraceptives at the adolescent clinics may expose sexually active adolescents to unprotected sex which may result in unintended pregnancies and STIs. In this regard, we recommend that managers of the adolescent clinics should innovate strategies to ensure the constant supply of adolescent drugs and supplies.

Limitations

Despite the practicality of these findings, the study was not devoid of limitations. Key among the limitations was the sampling. The sampling was not fairly distributed across adolescent clinics. This was largely due to low attendance in some of the adolescent clinics. This did not allow the authors to compared adolescents perceptions of quality of care across adolescent clinics. Subsequent studies should consider an equal sample size across adolescent clinics. In addition, generalization of the findings should be done with caution, because, it was not a nationwide study. The study was conducted in an urban setting which has different characteristics from the rural settings. Also, it would have been useful to combine both quantitative and qualitative methods. However, due to resource constraints the qualitative aspect was not explored. Future studies may consider adopting a qualitative research approach. For similar reasons, the study was limited to adolescents at the clinics only and did not include health providers and adolescents in the communities. Hence, future studies may consider including these populations.

Conclusion

The objectives of this study were to assess the quality of care in adolescent clinics and identify the factors that are salient to gauging the quality of care from the perspectives of adolescents. The findings revealed the respondents' perceived quality of care in the clinics to be good. Out of the five quality standards, four including adolescent's health literacy, provider competencies, appropriate package of services, and equity and non-discrimination were found significantly associated with adolescents' perceptions of quality of care. Thus, these are the salient factors that adolescents in Ghana look out for when determining the quality of care. In the quest to improve the quality of care for adolescents, more resources should be channeled into improving these standards.

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