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**“They often take us for granted”: perceptions of Community Health Workers attitudes and discretionary power affecting implementation of Ghana’s close-to-client health delivery programme**

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Background: In 2002 Ghana scaled up a community-based heath delivery programme to mitigate health access difficulties by peripheral communities. Community Health Workers (CHWs) are trained and reoriented to communities to among others provide clinical sessions, domiciliary care, clinical outreaches as well as promotive and preventive care. In principle, CHWs are socially accountable to the community and policy bureaucrats at the district level. In practice however, they enjoy relative autonomy in terms of choices and hold considerable discretionary power often exercised to the benefit or detriment of programme implementation. Drawing upon Likpsky’s street-level bureaucracy theory we aim to explore and analyse how and why implementation of the programme is affected by factors embedded in the actions of CHWs.

Methods: We conducted a qualitative study in northern Ghana on four communities. In each community, we conducted in-depth interviews with CHWs (n = 10) and focus group discussions with a purposefully sampled community key informants: traditional authorities, district assembly members, community health volunteers and clients. Interviews were tape-recorded, transcribed verbatim and exported to Nvivo 10 for analysis. Two researchers independently coded the text deductively but allowing new codes emerging to be nested into existing ones. The final set of codes were aligned, organised into a hierarchical structure and reported.

Results: Findings demonstrate that regular access to health services was punctuated by CHWs skiving behaviour, lateness at work and use of discretionary authority to determine when and how care should be administered and who receives them. Furthermore, community members shared their experience about problems associated with CHWs relational orientation, courtesy, cultural respect and personal commitment to the programme scale up. Such attitudes played out in undermining the ethos of broad-based social mobilisation and participation in the programme. Clients reported lack of opportunity to ask questions concerning diagnosis and treatment as frequent cause of diagnostic and prescription errors. Factors behind attitudinal shortfall of the CHWs were identified as excessive caseload, insufficient staffing, poor motivation and weak bureaucratic control resulting in CHWs formulating discretionary decisions that compromised community care needs.

Conclusion: Findings extend the utility of bottom-up theories to the implementation of community-based health programmes. The results suggest that for community-based health programmes to survive and become sustainable, CHWs have to model the way and act as agents of social change at the interface with the community to influence participation.