



Ghana's community-based primary health care: Why women and children are 'disadvantaged' by its implementation

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ABSTRACT

Policy analysis on why women and children in low- and middle-income settings are still disadvantaged by access to appropriate care despite Primary Health Care (PHC) programmes implementation is limited. Drawing on the street-level bureaucracy theory, we explored how and why frontline providers (FLP) actions on their own and in interaction with health system factors shape Ghana's community-based PHC implementation to the disadvantage of women and children accessing and using health services. This was a qualitative study conducted in 4 communities drawn from rural and urban districts of the Upper West region. Data were collected from 8 focus group discussions with community informants, 73 in-depth interviews with clients, 13 in-depth interviews with district health managers and FLP, and observations. Data were recorded, transcribed and coded deductively and inductively for themes with the aid of Nvivo 11 software. Findings showed that apart from FLP frequent lateness to, and absenteeism from work, that affected care seeking for children, their exercise of discretionary power in determining children who deserve care over others had ripple effects: families experienced financial hardships in seeking alternative care for children, and avoided that by managing symptoms with care provided in non-traditional spaces. FLP adverse behaviours were driven by weak implementation structures embedded in the district health systems. Basic obstetric facilities such as labour room, infusion stand, and beds for deliveries, detention and palpation were lacking prompting FLP to cope by conducting deliveries using a patchwork of improvised delivery methods which worked out to encourage unassisted home deliveries. Perceived poor conditions of service weakened FLP commitment to quality maternal and child care delivery. Findings suggest the need for strategies to induce behaviour change in FLP, strengthen district administrative structures, and improve on the supply chain and logistics system to address gaps in CHPS maternal and child care delivery.

1. Introduction

Health systems constantly seek better ways to make health services accessible, affordable, equitable and responsive to disadvantaged populations. Such efforts resonate with the Alma Ata Primary Health Care (PHC) philosophy of 'health for all' (WHO, 1979) underpinned by the implementation of close-to-community health programmes to end health disparities, social injustices, tackle disease burden of the poor, reduce deficits of hospital services and minimise risks factors of the social determinants of health (Kruk et al., 2010; Lawn et al., 2008; McCollum et al., 2016).

In Low- and Middle- Income Countries (LMICs) PHC programmes are widely implemented (Lewin et al., 2008; Rosato et al., 2008) with priority given to maternal and child care (Bhutta et al., 2010), primarily because these populations often lack access to, and face difficulties

interfacing with complex hospital systems to have their health needs and challenges adequately addressed (Goroll and Hunt, 2015). Thus, PHC adapted to local conditions and relying on cost-effective local resources and community mobilisation can improve access and use of health services and ultimately maternal and child health (Rosato et al., 2008). PHC is shown to contribute to better overall population health in LMICs (Marmot et al., 2008; Rifkin, 2014). However, the poor maternal and child health and survival (Alkema et al., 2016; You et al., 2015), coupled with weak micro-health systems resilience and responsiveness to health shocks in these countries (Gilson et al., 2017; Kienny et al., 2014), have generated questions around the effectiveness of these programmes scale up (Rosato et al., 2008).

Additionally, despite PHC programmes implementation in low- and middle-income settings, women and children are still disadvantaged by access and use of health services (Kruk et al., 2016). The gaps in

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implementation have been diagnosed as: poor community participation in delivering health benefits, and in promoting choices, social accountability and uptake of health services (Marston et al., 2016; Rosato et al., 2008); weak inter-sector collaboration leading to human, physical and material resources being poorly harnessed for delivering health services at scale (Lawn et al., 2008; Lewin et al., 2008); and poverty, economic marginalisation and entrenched socio-cultural norms shaping decisions around health service use (Atun et al., 2007; Rosato et al., 2008). And although the literature continues to proliferate, little efforts have been made to broaden understanding of other factors underlying the gap. Moreover, an understanding of whether and how the implementation processes and structures themselves generate the gap has received limited focus. Analysing the gap from a policy perspective, however, is crucial to enable policy makers benefit from more nuanced and expanded set of alternative solutions for health systems strengthening. Drawing on the bottom-up policy implementation literature, this study sought to provide further in-depth explanation to the problem.

Bottom-up literature attribute implementation outcome success or otherwise to the influence of implementers at the operational level (Matland, 1995). Because these implementers work remotely from the sight of central bureaucrats, it becomes difficult to maintain perfect hierarchical control over their routine activities (Buse et al., 2012), thus, giving them more discretion and control over how policy is administered (Erasmus, 2014). Usually policy-practice divergence occur because of implementer's flexibility in making choices. A range of evidence attest to these. In South Africa, a free care policy was poorly delivered as nurses' discretionary decisions dominated normative prescriptions (Walker and Gilson, 2004). A maternal care subsidy policy implementation in Burkina Faso was altered as health providers used their own discretion to charge unapproved fees (Ridde et al., 2013). And in Liberia, a key barrier to implementation of a Basic Package of Health Services programme was nurses attitudinal obstacles to health service use (Petit et al., 2013).

Reflecting these implementation experiences, is Ghana's Community-based PHC known as Community-Based Health Planning and Services (CHPS) to be referred to as such in this paper. Despite decades of scaling up to improve maternal and child health, women and children are still faced with multiple barriers accessing care as are opportunities to have their needs and concerns adequately addressed (Engmann et al., 2016). There is also evidence of women delivering at home despite CHPS proximal distance, particularly where this study was conducted (Rishworth et al., 2016). Unpublished reports have attributed these gaps in part to Frontline Providers (FLP) attitudes and practices, and weak governance and administrative structures nested within the district health systems (Agongo, 2014; Ministry of Health, 2009). This call for empirical evidence situated within the policy lens to understand the scale of the problem. Accordingly, this study sought answers to two research questions: how and why do FLP attitudes and practices influence access and use of health services by women and children and with what consequence? What health systems factors hinder quality maternal and child health service delivery and with what effect on women and FLP practice?

To explore the underlying research questions, the study drew on Lipsky's (1980) street-level bureaucracy theory. Lipsky (1980) framed the term street-level bureaucrats to describe public servants who routinely interact with citizens and have discretion performing their functions. Although work requirements for street bureaucrats are often scripted to achieve specified goals (Scott et al., 2014), they have relative autonomy and exercise discretion and power in discharging their duties to the extent that such prescriptions are hardly followed (Erasmus, 2014). The lack of adherence to rules sometimes produce unintended policy outcomes (Lipsky, 1980).

Street bureaucrats typically work amidst constraints, tight schedules, heavy client demands and poor working conditions (Erasmus, 2014). They get around these by establishing routines and coping

mechanisms (e.g. service rationing, misuse of resources, lacklustre attitude to work, poor commitment to policy goals) in order to have more control over their work (Lipsky, 2010). Elements of the routines and coping methods typically override bureaucratic prescriptions of policy requirements and become implementation in practice. Clients are also important in understanding implementation processes and outcomes. Clients are non-voluntary usually faced with limited control over street bureaucrats' actions and alternative services they provide (Erasmus, 2014).

2. The Ghana community-based primary health care programme

The CHPS programme emerged from a trial of a community health service model (CHSM) implemented between 1994 and 2001. The CHSM was driven by failure of vertical primary care interventions implemented between the 1970s and 1980s. At the time, Ghana implemented the Village Health Worker and Community Health Nurse programmes as part of broader primary care strategy to make health services accessible and affordable (Lamptey et al., 1980). Both programmes, however, failed to survive the test of time due to poor implementation structures and technical problems (Agyepong and Marfo, 1992). The CHSM programme was subsequently piloted to provide family planning, immunisation and maternal and child care taking into account community participation, voluntarism, social mobilisation, clinical outreaches, home visits and resident community health nursing (Nyonator et al., 2005).

Evaluation of the pilot programme showed that deploying health services to the community provided by resident nurses stimulated utilisation and improved maternal health and child survival (Phillips et al., 2005). The pilot programme was expanded and replicated in other communities with proven similar positive results (Awoonor-Williams et al., 2004). The CHSM programme was subsequently adopted and integrated into the health system known as CHPS (Nyonator et al., 2007). CHPS became a national primary health care policy with nationwide scale up in 2002. There is detailed information about CHPS elsewhere (Awoonor-Williams et al., 2013; Nyonator et al., 2005; Phillips et al., 2006). CHPS Implementation and management is bottom up. Community members, Frontline Health Providers (FLP) and District Health managers are the key implementing stakeholders.

Frontline providers (trained and salaried community health officers, midwives and enrolled nurses) are reoriented to the community to perform four broad spectrum of tasks (Fig. 1) (Ghana Health Service, 2005). Cases beyond their clinical capacity are referred to health centres and district hospitals. They are assisted by Community Health Volunteers (CHVs) to deliver family planning, reproductive health services, immunisation and more, depending on local needs. District health managers perform supervisory and other roles (Fig. 1). The community provides social mobilisation, voluntary services and needed support systems to aid care delivery. The community also provides local administrative oversight by instituting Community Health Management Committees (CHMC) to serve as watchdog of CHPS affairs (Ghana Health Service, 2005).

3. Study context

The study was conducted in the Upper West Region (UWR) of Ghana. The region is one of 3 savannah regions north of the country. It has the least national population (702,110), population density (38.0), urban population rate (16.3%) and population growth rate (1.2%) (Ghana Statistical Service, 2012). At the time of the study, the region was divided into 11 administrative districts: 1 municipality and 10 district assemblies, well below the national average of 6 and 15 respectively (Local Government Service, 2013).

Although poverty incidence in the 3 savannah regions is marginally higher than the national average (24.2%), the UWR has the highest poverty incidence. About 71% of the population are living below the

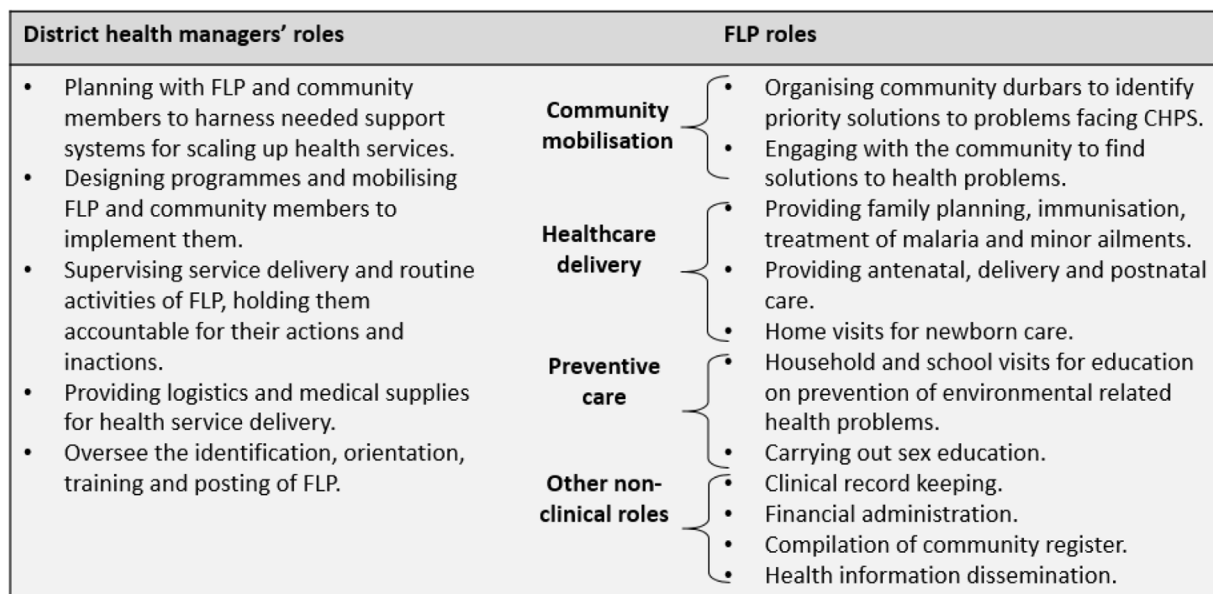


Fig. 1. District health managers and FLP roles on CHPS implementation.

Table 1
Numbers of participants sampled.

Community key informants (n = 43)				
Chiefs	Land Priest	Assembly members	CHVs	CHMC
4 (13.3%)	2 (6.7%)	5 (16.7%)	21 (33.3%)	11 (30.0%)
Clients (n = 73)				
Women	Parents			
39 (53.4%)	34 (46.6%)			
FLP (n = 9)				
Enrolled Nurses	CHO	Midwives		
3 (33.3%)	4 (44.4%)	2 (22.2%)		
District health management (n = 4)				
DDHS	CHPS Coordinators			
2 (50%)	2 (50%)			

Key: CHVs: Community Health Volunteers; CHMC: Community Health Management Committee; CHO: Community Health Officer; DDHS: District Director of Health Services.

annual poverty line of GH¢1314 (Ghana Statistical Service, 2014) (exchange rate: GH¢3.7 to US\$1 as of June 2015). Access and use of health services is constrained by the combined effect of poverty and most households being distant from a walking radius of 8 km to the nearest health facility (Ghana Health Service, 2008).

Critical health human resources such as doctors, nurses and midwives are lacking in most parts of the region. A doctor in the region attends to about 10 times the patients that the counterpart in Greater Accra and Ashanti regions handle (Ministry of Health, 2015). In terms of health infrastructure, the region is the least developed. Primary care facilities, CHPS, health centres and district hospitals are under the national average (Agongo, 2014; Ghana Health Service, 2014). Ghana implemented a national health insurance scheme in 2005 to protect the poor against financial difficulties when accessing healthcare. In theory, the insured do not pay for cost of care at the point of service use. At the time of the study, the scheme covered about 60% of the region's population (NHIA, 2013).

4. Materials and methods

4.1. Study design

This paper presents part of the qualitative findings of a mixed method case study executed between June and November 2015 to explore how and why district health system, community and frontline provider factors shape CHPS implementation in relation to service delivery; access and use of maternal and child health services; and community participation in the programme.

4.2. Sampling

To draw perspectives across rural urban settings, the sole municipal district of the UWR was purposively sampled together with a ballot selection of 1 rural district. In each selected district, simple random sampling was used to select 2 CHPS communities. Study participants comprising community informants (traditional authorities, Assembly members, CHVs and CHMC), FLP (community health nurses, enrolled nurses and midwives) and district health managers (district directors of health services and district CHPS coordinators) were sampled purposively because of their critical roles linked to CHPS implementation (Awoonor-Williams et al., 2013). Women who previously used antenatal and/or postnatal care, and parents who ever sought care for a child under-5 years in the CHPS facility more than once within six months to this study, were selected using snowballing contact (Patton, 2002). Sampled participants and their numbers are shown in Table 1.

4.3. Data collection

In-depth interviews and focus group discussions (FGD) were used to collect data. Five (5) FGD with membership ranging between 9 and 11 were held with community informants to elicit shared experiences on the CHPS implementation dynamics. Seventy-three (73) in-depth interviews were held with the women and parents of sick children. Interview topics for both the FGD and in-depth interviews included: FLP approach to maternal and child care delivery; attitude and relations with clients; nature and quality of work related behaviours; responsiveness of care; and use of resources. Interviews were conducted in the most dominant languages spoken in the study communities – Waale and Dagaare.

Thirteen (13) in-depth interviews were held with FLP and district

health managers to explore issues pertaining to knowledge of the CHPS policy; administrative capacity to enforce service delivery standards; medical supplies and logistics; clients and care delivery; conditions of service; coping with challenges and other issues that emerged as the interviews proceeded. All in-depth interviews took the form of discussions; allowing participants to direct the course as much as possible. Saturation was reached when further inquiry to a question yielded no new substantive information. All interviews were jotted and tape-recorded in agreement with participants. Interviews were complemented by two week observations of service delivery sites to better understand FLP behaviours, relations with clients, approach to work and service provision.

4.4. Analysis

To ensure rigour and quality of the data, audio recordings in the local languages were double transcribed directly into English. The transcripts together with the observational, field and reflective notes were read multiple times to correct errors. Transcripts for in-depth interviews with women and parents of children were assigned numbers serially for referencing purpose. Data were managed and coded with the aid of the Nvivo 11 software (QSR International Pty Ltd, Victoria, Australia). RAA (the first author) and a qualitative expert person analysed the data. Analysis followed deductive and inductive approaches. Conceptual dimensions of the interview guides guided preliminary coding of texts based on Hsieh and Shannon (2005) deductive coding approach. As coding proceeded, new codes emerging and describing any of the existing codes were nested appropriately. In working our way through the data, we used the Nvivo function “memo” to capture unique opinions, poignant experiences and relevant quotations illustrating themes.

4.5. Ethical approval

The study was approved by the Ghana Health Service Ethics Review Committee (Ethical approval ID No. GHS-ERC: 14/07/15). Informed consent was sought from each individual participant who provided verbal or written consent prior to participation in interview which was voluntary: the right to participate and withdraw from the interview process at any time.

5. Results

Findings are presented thematically. The first set of themes describes FLP negative work related behaviours: absenteeism and discretionary care delivery including being at post but denying children care and its consequences. We then discuss the factors underlying FLP behaviours that hampered care seeking for children. The final set of themes describes how deficient medical logistics and supplies elicited various client responses, FLP coping strategies of the logistical and supplies deficits and conditions of service.

5.1. FLP negative work related behaviours

5.1.1. Absenteeism behaviours

Systematic problems of FLP attitude to work threatened access to care for children. All the communities were relying on CHPS as their main source of care. Community participants, therefore expected reliable, timely and responsive care from CHPS, especially in emergency situations. The interview and observational data, however revealed the contrary. Interview participants' comments pointed to FLP frequent absenteeism behaviours, which to varying degree prevented clients from obtaining care as and when they needed it.

“... last week for example, my child was running and vomiting and I went there thinking I can get urgent treatment for him, but nobody was around

and the facility was locked up.” (In-depth interview 04)

“I can say that it is some particular days that we get treatment in the clinic, because sometimes if people need treatment, they don't get it. Some days you don't see any nurse around when you come.” (In-depth interview 44).

5.1.2. Discretionary care delivery

Care delivery was at the discretion of FLP. They controlled working hours, and determined when and how to administer care. Reporting to work late and closing before traditional scheduled working hours was becoming a norm to some of them. In one of the facilities, it was observed that clients were entitled to care for only 2–3 hours a day. This was because FLP routinely reported to work at noon and by 3 p.m., care delivery was over even if clients were waiting.

“They usually report to the clinic late and after attending to few clients they tell the rest waiting in queue that they have closed work. If your child's condition is severe, it is up to you to decide what do.” (FDG, Male)

Provisions of the CHPS programme requiring that FLP task-shift basic non-clinical duties to CHVs was technically hindered by the latter's low literacy levels and training exposure. Caught up with the burden of routine tasks, FLP adopted strategies to navigate their practice system. They sometimes blocked off working hours to accomplish clinical data entry, report writing and complete insurance claims. This often worked out to deny clients care as illustrated in these experiences.

“... the second time my baby was having high temperature and I went there [CHPS]. The nurse said she was preparing reports and can't attend to me. I asked for common paracetamol for the child but she drove me away. Because of that behaviour I have made up my mind not to go there anymore.” (In-depth interview 09).

“For me I went to the clinic twice with my child and felt being ignored. The second time the nurse said she was busy writing reports and therefore refused to attend to my daughter. I asked why clients cannot be treated when the clinic is opened but she did not mind me.” (In-depth interview 30)

5.2. Why FLP can be at post but refuse clients care

Reasons for which some FLP sometimes refused clients care or reluctantly attended to them were in two-fold. First, and as illustrated in the quote below, they tried to resist treating clients who refused referrals and repeatedly presented to CHPS with conditions they think are supposed to be treated in higher facilities.

“When the condition worsens and you refer them, they will not go, and when the situation is bad they come back to us again expecting treatment. In that case we refuse them care so that they will go to the referral place.” (FLP, Female)

Second, they reported being overwhelmed by high client load because about 99% of cases presenting to CHPS were card bearing members of the health insurance scheme. FLP felt the high client numbers was a deliberate abuse of the scheme. Hence, they reluctantly attended to seemingly trivial conditions in order to conserve resources.

“We can't use the little we have to treat people who will come with a small problem today and a different thing tomorrow because of the health insurance.” (FLP, Female)

This FGD participant's narrative, however, illustrates how FLP sometimes misrepresent clients.

“One day my wife went there with the child and was given drugs. But there was no relief after the drugs were taken. When she sent the child back to the clinic, the nurse was angry saying because of health insurance

we bring a child here for drugs today and before daybreak we are here again, and that we would not have behaved that way without insurance.” (FGD, Male)

5.3. Consequences of FLP behaviours

5.3.1. Financial hardships of seeking alternative care

Actions of the FLP had ripple effects on the poor. Most households depended on small scale farming and *pito* (local beer) brewing, which according to participants brought little income to adequately support livelihood, let alone medical care. Therefore, as many participants' explanations suggested that community members experienced financial hardships whenever actions of FLP called for seeking basic alternative care. Notable examples were:

“You need not less than 100 cedis to send your child to the hospital if the nurse is not around ... it is always a burden when you think of having to cough out that money.” (In-depth interview 31)

“... last time I had to borrow money and take my child to another clinic, when they were not around. I am even still paying the debt.” (In-depth interview 20)

5.3.2. Recourse to informal care to manage children symptoms

The financial hardships associated with seeking alternative care encouraged recourse to home remedies, traditional medicine and traditional healers for illness episodes in children.

“When you go there with the sick child and they [FLP] are not around, will you sit down and look at the child to die? No! you have to get him herbs or take him to the healer who is not far from us.” (In-depth interview 67)

“If you go there to meet their absence or they fail to give you care, there are herbal mixtures that the child can take and get fine.” (In-depth interview 56)

Nonetheless, recourse to informal remedies described above were not without problems. When asked whether home and herbal therapies posed further health problems to children exposed to them, the responses were almost affirmative, such as “some have their sickness becoming severe after taking concoctions”; “constituents of some herbal mixtures are too strong for children”; “my child nearly lost his life because of concoctions”. This, then, produced reinforcing effects. Children who developed complications were usually sent back to CHPS for treatment, which FLP have no other choice but to prescribe referral. Such referrals, however, were often resisted. This client, for example, reported resisting referral and insisting on care from CHPS.

“Last time I sent my daughter there only to meet the nurse absence. I gave her herbal medicine and she became fine. But in the evening the condition worsened. Fortunately, I met the nurse the next day and explained the situation. She wrote a referral and blamed me for giving the child herbal medicine. I told her I don't have money to go anywhere because if she was around that will not happen.” (In-depth interview 21)

Many other participants' narratives demonstrated how FLP behaviours at times deprived care for children, resulting in children being subjected to informal treatment, with a reinforcing effect on repeat visits to CHPS and resistance to referrals (Table 2).

5.4. Underlying causes of FLP attitudinal barriers to care access

5.4.1. Lodging infrastructural deficits

Each of the CHPS facilities was staffed with at least 2 FLP, who were expected to be accommodated in a room designed for single occupancy. Some FLP felt that was discomforting and therefore self-arranged lodging in towns. Commuting to and fro, partly caused the lateness.

“We are supposed to be pairing in one room which is not comfortable enough. The room has one bed and the hall is not furnished yet the three of us are expected to stay there. That is why some of us have to look for accommodation elsewhere and go there every day. By the time you arrive you are late for work but they should understand us.” (FLP, Female)

5.4.2. Weak district health administrative structures for implementation

District health managers complained about lack of funds as a factor that weakened purchasing power for transport logistics to aid routine monitoring and supervision. As a result, their work was somewhat removed from the sight of health delivery points. They could not enforce service delivery standards by holding FLP accountable for their actions, and ensuring that services were delivered according to the needs and preferences of women and children.

“The office currently has no means of transport for official duties or for CHPS. So in fact there is no regular monitoring and supervision. What we want is good healthcare for the women and children, but without visiting the people frequently how can we know whether they are receiving quality care.” (CHPS Coordinator)

Consequently, supervision was delegated to sub-district health centre managers to prescribe sanctions against FLP exhibiting dissenting behaviours. In practice, however, it was not enforced. It was discovered FLP and their sub-managers had established strong informal social networks, and that eventually undermined the latter's control over the former. This weak control created space for behaviours that eluded punitive actions. This FGD participant comment highlights how community members were unhappy with FLP behaviours believed to be driven by poor supervision.

“... they (health managers) need to always be around so that we can tell them our problem with the nurses. If they were coming regularly some of their behaviours will stop” (FGD, Male).

5.5. Medical logistics and supplies

5.5.1. Limited obstetric facilities

FLP were confronted with inadequate, and in some instances, lack of essential medical logistics and supplies to provide quality obstetric care. They had to work without basic obstetric facilities such as labour room, beds for deliveries, detention and palpation, and infusion stand. Yet they were directed to deliver all pregnancies except primigravida and obstetric complications. These constraints also affected postpartum care. Families of mothers had to provide a mattress or mat for postpartum care. But this arrangement according to FLP was detrimental to newborns due to heat and dirt.

“When a woman delivers the family has to bring a mat for the woman to rest before breast feeding. But here is a bit dirty and there is heat, so lying or sitting on a mat to breastfeed gives the child health problems.” (FLP, Female)

Lack of essential obstetric facilities encouraged unattended home deliveries. Some of the FLP launched educational campaigns, and together with the CHVs and traditional authorities established fines to deter women who deliver at home. For example, if a woman delivered at home, a fine of GH¢10 was imposed on the couple or family. In spite of this, the practice persisted because women found it discomforting to deliver in the CHPS facility. Home deliveries were further fuelled by information from the grapevine about how unpleasant it is to deliver in CHPS.

“We educate them about the importance of delivering in the facility. But you know when women come to deliver and they don't find the place comfortable, they tell others. Women deliver at home with the excuse that the CHPS facility is not comfortable.” (FLP, Female)

Table 2
How FLP behaviours influenced recourse to informal care for children and the consequences.

Client	Condition of child	FLP available	Action taken and consequences
In-depth interview 03	Not sure	No	Traditional healer diagnosed and prescribed herbal medicine, but the sickness persisted. Initially resisted referral from CHPS, but later borrowed money and sent the child to the hospital.
In-depth interview 08	Diarrhoea and vomiting	Yes, but could not be contacted	Child was given home-made herbal mixture. The condition got better but intensified the next day. Child was taken back to CHPS. FLP prescribed referral but it was resisted.
In-depth interview 15	Cough and vomiting	No	Child was given herbal medicine but the severity level increased. Parents lacked money for hospital care and sought another traditional remedy. As the condition persisted, the child was sent back to CHPS. Referral was prescribed but parents resisted for lack of money.

FLP concerns seemed buttressed in how this participant concealed a certain perception about the lack of essential obstetric equipment.

“Anywhere you go for antenatal, the nurses normally put something around your stomach and listen to the baby, but I went to the clinic [CHPS] twice and they did not do that to me. Since then I have stopped going there, they can't take care of pregnancy.” (In-depth Interview 28).

5.5.2. Deficient drug supplies

Frequent stock-outs of essential drugs was raised as an obstacle to meeting basic care needs of women and children. A community participant remarked that “clients sometimes felt reluctant going to CHPS because needed drugs run out frequently”. This was confirmed in observation. Dispensary shelves were sparsely stocked, labelled without accompanying drugs, and FLP were uncertain when supplies will arrive. And while lack of essential drugs had caused decline in health seeking, a top-level directive to cease supply of essential antibiotics to CHPS facilities aggravated the situation.

“... because of the directive, when they come with the children with conditions that require antibiotics, we refer or prescribe for them to buy. Because of that we are experiencing a drastic decline in outpatient attendance at the moment because antibiotics are not available.” (FLP, Female)

5.6. Coping with the limited obstetric facilities and supplies

FLP endured the enormous constraints of obstetric care delivery by devising a number of coping mechanisms. One of them held the view below that the usual bureaucratic rhetoric of “just manage with what you have” meant they had to adopt improvised techniques to conduct deliveries in order not to disappoint clients.

“If we are to deliver a woman, someone has to be upstanding holding the infusion stand. ... first we move clients out of the consulting room when conducting deliveries, but now we use a cloth to partition so that they don't feel we are sacking them. The women still feel uncomfortable but it is better than not doing anything.” (FLP, Female)

In some facilities, deliveries were conducted on improvised beds which FLP decried it posed health risk as they constantly crouched down suturing to repair episiotomy and tears after birthing. To cope with the unpleasant experiences and discomfort during birthing, FLP mostly referred cases within their clinical capacity.

“It is not easy to deliver a woman under this condition. Sometimes by the time you finish with one case, you are so tired because of the bed. So when another woman arrives, you have no option than to refer. Even though we can handle the case, we have to rest.” (FLP, Female)

Such referrals, however, produced incentives for home deliveries. Women unable to afford cost of transportation and medical bills conveniently delivered at home unassisted. Some women were also reported to deliver by the roadside during referrals. The challenge of meeting competing demands with limited drugs also generated a coping

method whereby some FLP apportioned oral suspension medications for children, as for example:

“For the drugs they normally pour some. They will not give you a full bottle. When you give it to the child and the condition is not better and you return to the clinic, they are always annoyed saying that you did not handle it well otherwise the child would have been okay.” (FGD, Female)

5.7. Conditions of service

FLP described their conditions of service as a disincentive to work. They felt slighted that their salary did not measure up to nascent and current task volume in which they worked for longer hours than other health professionals, attended to clients at all times and performed multiple non-clinical roles. A notable demotivated comment was:

“In fact we are left behind. We overwork ourselves for the community because we are here all the time, people wake you up anytime of the night and by early morning you start work again yet our pay is nothing to write home about.” (FLP, Female)

Some of the responses obtained from FLP further suggested that the low salaries and benefits partly detached their commitment from CHPS, as for example:

“You have to find something else doing in town if you are to survive. The small allowances we used to get are cancelled. Should you sit here all the time and suffer for that.” (FLP, Male)

“Our conditions of service are poor. I must be honest to say it affects the commitment to give your best.” (FLP, Male).

FLP were discouraged that their work was less prioritised and lip service paid to addressing medical supplies and logistics deficits. They also pointed out that they were poorly recognised and supported by health leaders and managers and that killed morale. This participants' comment is noteworthy:

“Both hands wash each other. If the right hand washes the left, the left must also do same. But where we find ourselves and work, things are not like that. They don't care about us, they don't appreciate us and that is discouraging.” (FLP, Female).

6. Discussion and conclusion

This paper analysed first, how and why FLP attitudes and practices influence access and use of CHPS health services by women and children, and second, health system factors impeding quality CHPS maternal and child health service delivery with consequential effect on maternal care seeking and FLP practice. By employing the street-level bureaucracy theory, our findings draw policy makers' attention to how FLP actions on their own and in interaction with health system factors undermine CHPS objective of meeting the health needs of disadvantage populations. As noted elsewhere, clients care seeking and encounters were adversely affected by FLP poor attitudes and practices driven by

the implementation context, limited resources, personal values and weak administrative control (Aniteye et al., 2013; Petit et al., 2013).

Overall, our findings resonate with Lipsky's (1980) assertion about the power of street-bureaucrats to transform policy implementation focus and processes in ways that align with their parochial interest (Erasmus and Gilson, 2008). FLP possessed relative autonomy, discretionary power and flexibility of making choices, and exercised them directly or indirectly to the disadvantage of clients seeking care (Lehmann and Gilson, 2013). They responded to pressure and persistent challenges embedded in their work by, for example, using their discretionary power to determine children who do not deserve care (such as turning away some children or stereotyping them and their conditions), while the relative autonomy provided them more control over time allocated to work (Erasmus, 2014). Lipsky noted that street-level bureaucrats' actions will almost always have ripple effect on service beneficiaries. This was brought to light as families experienced financial hardships in seeking alternative care for children, and avoided that by managing symptoms with care provided in non-traditional spaces by native and herbal doctors when FLP could not be contacted (Sato, 2012). This is seen as a threat to CHPS key objective of improving under-5 health outcomes in underserved environments (Awoonor-William et al., 2013).

It was clear that district health managers were administratively constrained and functioned with limited decision space (Kwamie, 2016), and that partly fuelled the zero-sum elements of FLP attitudes and manoeuvres. In line with Hill et al. (2014), routine supportive supervision crucial for providing motivators, sanctions and feedback mechanisms was lacking, as were systems for determining adherence to service delivery standards. The weak control enabled FLP enact attitudes and practices that dominated their obligations. Moreover, it was apparent that weak control enabled FLP make choices governed by their own discretionary decisions rather than the CHPS implementation requirements (Nyonator et al., 2005). This finding is consistent with others (Aniteye et al., 2013; Petit et al., 2013; Ridde et al., 2013), and parallel Ridde et al. (2013) that ineffective supervision enabled health providers' discretionary decisions to override bureaucratic orders in the implementation of a maternal care programme in Burkina Faso. Both the present and existing findings mirror theory. Elmore (1979), for example, theorised that in the absence of tighter administrative control mechanisms, street-bureaucrats are free to develop routines that compromise policy intentions.

Good quality maternal care delivery was impeded by deficient essential medical and obstetric infrastructure (Rishworth et al., 2016), prompting FLP frustrations. Such frustrations were further heightened by the adoption of a patchwork of improvised delivery methods which exposed FLP and clients to discomfort. This in turn prompted unnecessary referrals as FLP sought ways by which to protect their own health, giving rise to home deliveries, as clients were averse to referrals owing to the monetary cost involved (Jithesh and Ravindran, 2016). This finding contrasts those attributing home deliveries to geographical distance (Gabrysch and Campbell, 2009; Mrisho et al., 2007). CHPS was close by, and available at community door-steps, yet limited obstetric facilities and constrained care options, made unassisted home deliveries a default option for simplifying these constraints (Rishworth et al., 2016). Although this study did not investigate maternal mortalities attributable to home deliveries, the high rate of maternal mortality in the UWR (Ministry of Health, 2015), means that link cannot be discounted.

Dissatisfaction with conditions of service was shown to scale back FLP commitment to, and morale for care delivery. The feeling that financial rewards less compensated for the multiple tasks and routine stress they endured corroborate Kok et al. (2015) review, and empirical evidences by Rahman et al. (2010) and Mpembeni et al. (2015) that lack of, or perceived meagre financial remuneration, performance-based incentives and related economic rewards lowered community health providers' motivation to provide high quality care. FLP concerns

about poor leadership recognition and support to overcome complexities embedded in the rapidly changing work is consistent with Sakeah et al. (2014) and Adzei and Atinga (2012) perspectives on the role of supportive leadership machineries in improving peripheral health worker motivation, and with the analysis showing community health provider motivation is highly correlated with supportive health leadership (Alhassan et al., 2013). FLP desired to have a kind of transactional leadership, who demonstrate the elixir of human problems, by balancing personal needs with performance, and by providing rewards for greater accomplishment.

The findings have implication for policy decisions. Foremost, strong administrative structures within the district health system are needed for effective monitoring to control FLP actions with detrimental effect on care delivery. In addition, strong community engagement should be present at the interface between FLP and clients. Effective community engagement can promote shared problem solving, improved relationships, and in enabling the community hold FLP accountable for their actions (Tindana et al., 2007). FLP need to be recognised for their crucial roles in rural, remote and deprived communities. This can take the form of competitive financial rewards as is the case elsewhere (Manongi et al., 2006) combined with opportunities for further schooling, good career progressing path and good quality lodging facilities. Finally, infusion stands, delivery and detention beds, and the building of conductive labour rooms are urgently needed to aid quality obstetric care delivery.

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Conflicts of interest

None.

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