Diagnostics and biomarkers

PO - (8248) - DETERMINANTS OF ACCEPTABILITY OF MALARIA RAPID DIAGNOSTIC TEST AMONG HEALTH WORKERS IN KINTAMPO NORTH MUNICIPALITY, GHANA

Anaba, Michael (Ghana)¹; Ae-Ngebisi, Kenneth (Ghana)¹; Owusu Agyei, Seth (Ghana)²; Ibisomi, Latifat (South Africa)³

1 - Kintampo Health Research Center; 2 - University of Health & Allied Sciences; 3 - University of Witwatersrand

Background: Ghana rolled-out the policy in 2013 with malaria rapid diagnostic test (mRDT) use promoted to facilitate diagnosis. However, Health Workers who are at the centre of mRDT implementation still treat half of febrile patients with negative mRDT results with antimalarial drugs suggesting limited or lack of acceptability of the innovation.

Methods: We conducted a cross-sectional study to examine determinants of mRDT among HWs in Kintampo North Municipality (KNM) in Ghana. Data were collected from 110 HWs in KNM involved in malaria management from February to April, 2017. The survey tool was based on two frameworks – the Technology Acceptance Model (TAM) and Normalization Process Theory (NPT). Acceptability was measured by ease of use, perceived usefulness and intention to use. We hypothesised that acceptability was influenced by coherence, cognitive participation, collective action, reflexive monitoring and respondent characteristics. A composite acceptability score was computed from a 21-item questionnaire for each respondent. The respondents were divided into three groups of low, moderate and high acceptability for ordered logistic regression to examine the relationship between acceptability and its determinants.

Results: The median acceptability score was 84(Q1, Q3:68, 103). About 34% of HWs had low acceptability while 37% and 29% had moderate and high acceptability respectively. In the multivariable analysis, coherence (OR=1.23, 95%CI=1.11-1.37), cognitive participation (OR=1.35, 95%CI=1.10-1.66), HWs in rural health facilities (OR=6.99, 95%CI=1.82-26.84) and HWs with more than three years’ experience (OR=5.53, 95%CI=1.98-15.42) were more likely to have high mRDT acceptability.

Conclusion: Acceptability of mRDT was moderate among majority. This can be improved by enhancing HWs coherence on the benefits of mRDT through policy building or dissemination of information, promoting HWs cognitive participation in the mRDT implementation process through recruitment of local “champions” to promote “buy-in” and providing incentives to HWs to embed and sustain the use of the health technology.