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Assessing The Challenges Affecting Quality and Effective Planning and Management of Primary Healthcare Services in Health Facilities in The Bono Region of Ghana

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Abstract:
Background*: The quality of the medical care given determines the health of a community. Challenges in the efficient administration and delivery of healthcare affect the health of the community. Assessing the challenges of efficient and quality healthcare planning and management and ways of addressing these challenges at Catholic Health facilities in the Bono Region, Ghana, is the aim of this study.*
Materials and Methods*: A mixed methodology was employed in the study, using both quantitative and qualitative data. The information was gathered via a questionnaire and semi-structured interviews. This investigation employed the nested case study design approach. A select number of Catholic Health facilities in the Bono Region were used for the study. There were 331 individuals from the facilities in the sample. Data analysis, both descriptive and inferential, was performed on the respondents' information.*
Results*: The findings revealed poor health workers' communication and high staff attrition rates as health worker-based challenges respondents' face. Lack of community ownership of the facility projects and late reporting of cases by the community members to the facility were also found to be community-based challenges respondents faced. The findings finally revealed that addressing the issues of community lack of ownership of facility programs, community entry and engagement, and medicine availability, strongly and positively correlated with improvement in health service planning and delivery. Inadequate or non-availability of CHOS/CHNs at posts when needed, lack of staff accommodation, disrespect for clients, and poor motivation for staff were challenges the study concluded on.*
Conclusion: *It is concluded that health service planning and delivery is improved through; equitable distribution of human resources for health, patient management, customer service, and conflict resolution and management skills in healthcare facilities. It's recommended that Diocesan Health Service should capitalize on the flagship programme on the application of the Network of Practice Concept rolled out by the Ghana Health Service to utilize resources to provide high-quality healthcare.*
Key Word*: Perception; Perspective; Effective; Health Service; Planning.*

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I. Introduction

In the past, the process of evaluating clinical quality and effectiveness did not take patient opinions and feedback into account; however, in modern times, emphasis is placed on the value of patients' opinions in evaluating the effectiveness and quality of services, and sole reliance on clinical effectiveness is not strongly supported (Smith et al., 2009). Providing quality healthcare is therefore challenging as patient feedback needs to be implemented with little resources. Addi et al., (2021) found that the main determinants of healthcare quality at the local and district levels were similar, and were related to the enthusiasm and dedication of different stakeholders. Some of the obstacles to healthcare quality included lack of stable funding, strict and unclear regulations, high turnover of staff, limited skills of health workers in family and community-oriented care, limited involvement of non-health institutions in cross-sectoral responses, and limited community participation (Mosquera et al., 2014).

Despite an expanding economy in prior decades, according to the Catholic Health Service's Annual Reports, the healthcare system struggles to provide basic healthcare services. For health service providers,

particularly at the Catholic Health facilities in the Bono Region, providing efficient public and clinical health services is a challenging endeavor that has never been simple.

Kweku et al's. (2020) study revealed that, the provision of health services at the primary, secondary, and tertiary levels of the health system can be improved with the use of effective and high-quality planning strategies. The methods assist in identifying various service provision gaps, generate solutions to fill those gaps, and reduce the likelihood of service delivery bottlenecks. The study further revealed that, it is commonly known that using quality and efficient health service planning methods has improved care in areas including HIV/AIDS, TB/Malaria programs, maternity, neonatal, and child health. A national policy on CHPS was introduced by the Ghanaian government in 2016 through the MoH (Awoonor-Williams et al., 2016). In order to attain Universal Health Coverage and close the access equity gap by 2030, the policy seeks to realize its goals of offering a fundamental bundle of necessary health services to every community. After ten years of extending CHPS across the country, CHPS Policy, 2016, was released. According to the authors, the revised CHPS implementation will be made more thorough, useful, and integrated with other national health systems with the help of the new strategy. The National CHPS Policy's implementation is guided by five policy directives that are anticipated to provide direction and guidance on the scale up of CHPS across the country (Kolbila, 2019). This study therefore seeks to assess the challenges of efficient and quality healthcare planning and management and ways of addressing these challenges at Catholic Health facilities in the Bono Region, Ghana.

II. Material And Methods

This study was carried out in the Bono Region of Ghana at the Catholic Diocesan Health Service of the Catholic Diocese of Sunyani from December 2022 to October 2023. A total population of 2480 participants who were academics, administrative employees, patients, and healthcare workers (both male and female) were considered for this study of which 331 were sampled.

Study Design: The study included quantitative and qualitative data using a mixed-methodology approach. Qualitative data aims to provide a subjective and comprehensive understanding of social realities, whereas quantitative data provides statistical description and prediction (Yilmaz, 2013). When combined, these two methods often counterbalance each other in terms of gathering comprehensive and detailed data.

Study Location: This study was conducted in a few selected Catholic health services facilities in the Bono Region of Ghana (Holy Family Hospital Berekum, St. Mary's Hospital Drobo, St. Mathew's Hospital Ampenkro, and St. James Clinic Abesim). The target population consisted of the management, staff, and users of these Catholic health facilities. The participants were chosen using the simple random sampling technique. The researcher used this technique because it uses simple natural methods of selection that are not constrained by any conditions of a research design.

Study Duration: November 2022 to November 2023.

Sample size: 331 administrative employees, patients, and healthcare workers.

Sample size calculation: The sample was made up of 331 people who represented academics, administrative employees, patients, and healthcare workers to achieve the objectives specified and prevent unclear interpretations along with time restrictions, proximity, and cost. The sample was chosen using a straightforward random sampling procedure. Krejcie and Morgan's 1979 sample size determination table was considered in determining the sample size.

Subjects & selection method: A simple random sampling process was used to select the sample. The sample size was determined by taking into account the sample size determination table developed by Krejcie and Morgan (1979).

Inclusion criteria:

The target population was the persons who were carefully chosen from some facilities of the Catholic Health Service in the Bono Region. Only the target respondents who know the issues under the study were included in this study.

Exclusion criteria:

1. Staff who were less than 6 months in the facility were excluded
2. Users with little knowledge of the issues under discussion were excluded.

Procedure methodology

After written informed consent was obtained. Data were gathered through the use of questionnaires and semi-structured interviews with key informants (KI) who included academics, administrative personnel, patients, and healthcare professionals. This study adopted the multiple embedded or nested case study design approach (Creswell, Plano Clark, Gutmann, & Hanson, 2003). A questionnaire constituted the primary data-gathering method employed by the researcher.

The research included primary and secondary sources for data collection. Semi-structured interviews and questionnaires were used to collect data from key informants (KI), which included academics, staff members, patients, and medical professionals. The numerous embedded or nested case study design approach was used in this investigation (Creswell, Plano Clark, Gutmann, & Hanson, 2003). The major data collection method utilized by the researcher was a questionnaire. A questionnaire was given to a cross-section of respondents from different categories to gather the data. The responders were instructed to finish the questionnaire while the researcher waited. This decreased the number of non-responses. Additionally, the questionnaire was dropped off and later found. Follow-ups via phone calls, emails, and in-person interviews were carried out to guarantee a sustainable response rate for the study. Errors and omissions were checked, as well as ambiguity, legibility, and relevancy.

III. Result

Challenges Affecting Quality And Effective Planning And Management Of Primary Healthcare Services

The researcher wanted to know the challenges affecting the quality and effective planning and management of Primary Healthcare Services. This is presented in Tables 1 to 13.

The Multinomial logistic regression below indicates the model summary which represents the Iteration Log, Log-likelihood, Number of obs, LR chi2(3), Prob > chi2, and the Pseudo R2.

Iteration Log – This is a listing of the log likelihoods at each iteration.

Log Likelihood – This is the log-likelihood of the fitted model

LR chi2 (3) – This is the Likelihood Ratio (LR)

Prob > chi2 – This is the probability of getting a LR test statistic as extreme

Pseudo R2 – This is McFadden's pseudo R-squared

Number of obs – number of cases used for multinomial logistic regression.

The Coefficient magnitude shows how big the effect of the independent variable is on the dependent variable. The Coefficient sign (+/-) shows whether the effect is positive or negative. Calculating variables at a 0.5% confidence interval for each predictor in the model, the Coefficient tells you the expected increase in the dependent variable when the independent variable increases by one, while other variables stay the same (Nathans et al., 2012). Nathans, Oswald, and Nimon (2012) claim that regression analysis is used to create an equation that uses one or more independent variables to forecast a dependent variable. The dependent variable Y is what you are trying to forecast, and the independent variables X1, X2, and so on are what you use to estimate it. The coefficients or multipliers b1, b2, and so on define the magnitude of the effect the independent variables have on the dependent variable Y, and A is what you would expect to happen when all the independent variables are equal to zero.

From table 1, the researcher wanted to know the health worker-based challenges in quality and effective health service (The healthcare service I receive from this facility is to the best of my satisfaction).

Table 1 Health Worker-Based Challenges.

Iteration 0: log likelihood = -150.46944
Iteration 1: log likelihood = -145.65462
Iteration 2: log likelihood = -145.52193
Iteration 3: log likelihood = -145.52186
Iteration 4: log likelihood = -145.52186

Multinomial logistic regression Number of obs = 331
LR chi2(3) = 9.90
Prob > chi2 = 0.0195
Log likelihood = -145.52186 Pseudo R2 = 0.0329

The healthcare service I receive from this facility is to the best of my satisfaction	Coef.	Std.Err.	z	P>|z|	[95% Conf.	Interval]
YES						
There is poor Health workers' communication.	-.0737355	.1203348	-0.61	0.540	-.3095873	.1621163
There are high attrition	-.0738004	.111217	-0.66	0.507	-.2917818	.1441809

rates of Community Health Officers/Community Health Nurses (CHNs) (through transfers, further studies, death).						
Inadequacy and/or unavailability of CHOS/CHNs at post when needed.	.4748067	.1545814	3.07	0.002	.1718327	.7777806
_cons	-2.318638	.4666167	-4.97	0.000	-3.23319	-1.404086
NO	(base	outcome)				

Researcher's field work 2023

From table 1 above, the prediction equation in the Multinomial regression shown below is: The healthcare service I receive from this facility is to the best of my satisfaction =-2.318638 -.0737355(There is poor Health workers' communication) -.0738004(There are high attrition rates of Community Health Officers/Community Health Nurses (CHNs) (through transfers, further studies, death) + .4748067(Inadequacy and/or unavailability of CHOS/CHNs at post when needed.) This equation tells you whether there is an increase or decrease in the dependent variable when the independent variable is increased by one unit.

Poor health workers' communication is indicated by a coefficient of -.0737355. When poor health workers' communication is increased by one unit, the satisfaction level of healthcare service respondents receive from the facility declines by .0737355 units holding all other factors constant. Again, high attrition rates of Community Health Officers/Community Health Nurses (CHNs) (through transfers, further studies, death and resignations) are indicated by a coefficient of -.0738004. with one unit increase in high attrition rates of Community Health Officers/Community Health Nurses (CHNs) (through transfers, further studies and death), the satisfaction respondents derive from the healthcare declines by .0738004. Also, Shortage and/or absence of CHOS/CHNs at post when needed, is indicated by a coefficient of .4748067. With one unit increase in Inadequacy and/or unavailability of CHOS/CHNs at post when needed, results an increase in the satisfaction level of healthcare service respondents receive by .4748067.

The researcher also wanted to know the health worker-based challenges in quality and effective health service in relation to systems available to address complaints. This is presented in table 2 below:

Table 2: Health Worker-Based Challenges.

Iteration 0: log likelihood = -168.09815
Iteration 1: log likelihood = -156.76718
Iteration 2: log likelihood = -156.2547
Iteration 3: log likelihood = -156.25319
Iteration 4: log likelihood = -156.25319

Multinomial logistic regression Number of obs = 331
LR chi2(3) = 23.69
Prob > chi2 = 0.0000
Log likelihood = -156.25319 Pseudo R2 = 0.0705

There are systems available to address complaints	**Coef.**	**Std.Err.**	**z**	**P>|z|**	**[95% Conf.**	**Interval]**
YES						
There is poor Health workers' communication.	-.4806329	.1309576	-3.67	0.000	-.7373051	-.2239606
There are high attrition rates of Community Health Officers/Community Health Nurses (CHNs) (through transfers, further studies, death).	-.2000833	.1026843	-1.95	0.051	-.4013407	.0011742
Inadequacy and/or unavailability of CHOS/CHNs at post when needed.	.0830557	.1599909	0.52	0.604	-.2305206	.396632
_cons	.1778985	.4069733	0.44	0.662	-.6197546	.9755516
NO	(base	outcome)				

Researcher's fieldwork 2023

From Table 2 above, the prediction equation in the Multinomial regression is: There are systems available to address complaints = .1778985 -.4806329 (There is poor Health workers' communication) - .2000833 (There are high attrition rates of Community Health Officers/Community Health Nurses (CHNs) (through transfers, further studies, resignation, vacation of post, death) + 0830557 (Inadequacy and/or unavailability of CHOS/CHNs at post when needed)

A value of -.4806329 indicates that communication among healthcare professionals is poor. The systems available to resolve complaints decrease by .4806329 units when bad health workers' communication increases by one unit while all other factors remain constant. Additionally, the significance level (0.000) is shown. The statistically significant difference in the degree of freedom of systems available to resolve complaints and Poor health workers' communication can be seen when the significance value is below 0.05, or when "p" is less than .05.

A coefficient of -.2000833 once more indicates that Community Health Officers and Community Health Nurses (CHNs) have substantial attrition rates (via transfers, further education, resignations, vacation of post and death). The systems available to resolve complaints fall by.2000833 for every unit rise in the high attrition rates of Community Health Officers/Community Health Nurses (CHNs) (via transfers, higher education, resignation and death). Additionally, the significance level is denoted by 0.051. The degree of freedom of the systems available to address complaints and the high attrition rates of Community Health Officers/Community Health Nurses (CHNs) (through transfers, further studies, resignation and death) are statistically significant, as shown by the significance value being below 0.05, or "p" equal to.05.

A value of .0830557 further indicates inadequacy and/or unavailability of CHOS/CHNs at post when needed. When CHOS/CHNs are inadequate or unavailable at the post when needed, the healthcare service respondents obtain from the facility increases by.4748067, to the best of their satisfaction. The significance level is given by 0.604 for further verification. This indicates that there is no statistically significant difference in the degree of freedom of systems available to resolve complaints and inadequacy and/or unavailability of CHOS/CHNs at post when needed. The significance value is above 0.05, i.e. "p" is more than 0.05.

The researcher also wanted to find out what other health worker based challenges respondents know. This is presented in table 3 below:

Table 3: other health worker-based challenges respondents' face

What other health worker-based challenges do you face?	Freq.	Percent	Cum.
Poor customer satisfaction	11	3	3
Disrespect to clients	40	12	15
Inadequate specialists	6	2	17
Lack of staff accommodation	41	12	30
Failure to explain procedures to patient	35	11	40
Poor working conditions	17	5	45
Inexperienced staff	45	14	59
Poor motivation to staff	36	11	83
Autocratic leadership style by nurse manager	8	2	72
Lack of teamwork in the facility	36	11	83
No essential equipment to work with	25	8	91
No clear understanding of responsibilities	31	9	100
Total	**331**	**100**	

Researcher's fieldwork 2023

From the table above, the total number of respondents were 331. Out of the total of 331, 11(3%) respondents indicated poor customer satisfaction as worker-based challenges faced in the facilities. 40(12%) mentioned disrespect to clients as a health worker-based challenge faced in the facilities. 6(2%) respondents claimed inadequate specialist is a worker-based challenge faced in the facilities. 41(12%) indicated a lack of staff accommodation as a worker-based challenge. 35(11%) of respondents mentioned failure to explain procedures to patients is a challenge. 17(5%) respondents indicated poor working conditions as a challenge. 45(14%) indicated inexperienced staff in facilities as a challenge. 36(11) of respondents claimed poor motivation of staff is a challenge. 8(2%) respondents mentioned autocratic leadership style by nurse managers as a challenge. 36(11%) revealed a lack of teamwork in the facility as a challenge. 25(8%) respondents revealed no essential equipment to work with as a challenge. The remaining 31(9%) indicated no clear understanding of responsibilities as a health worker based on challenges in the facilities. This therefore shows that the majority of respondents claim inexperienced staff in facilities, lack of staff accommodation, disrespect to clients, lack of teamwork in the facility, poor motivation to staff and failure to explain procedures to patients are some of the health worker-based challenges they mostly face in the facilities.

The researcher also wanted to know the community-based challenges of quality and effective health service, taking into consideration the satisfaction level of healthcare service respondents receive from the facility. This is presented in Table 4.

Table 4: Community Based Challenges.

Iteration 0: log likelihood = -150.46944
Iteration 1: log likelihood = -145.55915
Iteration 2: log likelihood = -145.41034
Iteration 3: log likelihood = -145.41026
Iteration 4: log likelihood = -145.41026

Multinomial logistic regression Number of obs = 331
LR chi2(3) = 10.12
Prob > chi2 = 0.0176
Log likelihood = -145.41026 Pseudo R2 = 0.0336

The healthcare service I receive from this facility is to the best of my satisfaction	Coef.	Std.Err.	Z	P>|z|	[95% Conf.	Interval]
YES						
There is lack of community ownership of the facility projects and ownership.	-.014895	.1181944	-0.13	0.900	-.2465517	.2167617
There is lack of security at facility compounds	.2553393	.1147583	2.23	0.026	.0304172	.4802613
There is late reporting of cases by the community members to the facility	.175504	.1156458	1.52	0.129	-.0511576	.4021655
_cons	-2.697599	.491939	-5.48	0.000	-3.661782	-1.733416
NO	(base	outcome)				

Researcher's field work 2023

From the table above, the prediction equation in the Multinomial regression can be stated as: The healthcare service I receive from this facility is to the best of my satisfaction = -2.697599 -.014895 (There is lack of community ownership of the facility projects and ownership.) + .2553393 (There is lack of security at facility compounds) + .175504 (There is late reporting of cases by the community members to the facility.)

The lack of public ownership of the facility projects and ownership is indicated by a coefficient of -.014895. When a Lack of community ownership of the facility projects and ownership is increased by one unit, the healthcare service respondents receive from the facility to the best of their satisfaction declines by .014895 units holding all other factors constant.

Again, the lack of security at facility compounds is indicated by a coefficient of .2553393. With one unit increase in high attrition rates of Community Health Officers/Community Health Nurses (CHNs) (through transfers, further studies, and death), the satisfaction level of healthcare service respondents received from the facility also increased by .2553393.

Also, late reporting of cases by the community members to the facility is indicated by a coefficient of .175504. One unit increase in late reporting of cases by the community members to the facility, results in an increase in the satisfaction level of healthcare service respondents receive from the facility by .175504.

The researcher again probed further to know the community-based challenges of quality and effective health service, taking into consideration the systems available to address complaints. This is presented in Table 5.

Table 5: Community-Based Challenges.

Iteration 0: log likelihood = -150.46944
Iteration 1: log likelihood = -145.55915
Iteration 2: log likelihood = -145.41034
Iteration 3: log likelihood = -145.41026
Iteration 4: log likelihood = -145.41026

Multinomial logistic regression Number of obs = 331
LR chi2(3) = 10.12
Prob > chi2 = 0.0176
Log likelihood = -145.41026 Pseudo R2 = 0.0336

There are systems available to address complaints	Coef.	Std.Err.	Z	P>|z|	[95% Conf.	Interval]
YES						
There is lack of community ownership of the facility projects and ownership.	-.2014511	. 1103195	-1.83	0.068	-.4176733	.0147711
There is lack of security at facility compounds	.0496793	.1073528	0.46	0.644	-.1607283	.2600869
There is late reporting of cases by the community members to the facility	.1085396	.1137677	0.95	0.340	-.1144411	.3315203
_cons	-1.187852	.420928	-2.82	0.005	-2.012856	-.3628481
NO	(Base	outcome)				

Researcher's field work 2023

From Table 5 above, the prediction equation in the Multinomial regression is: There are systems available to address complaints = -1.187852 -.2014511 (There is lack of community ownership of the facility projects and ownership) + .0496793 (There is lack of security at facility compounds) + .1085396 (There is late reporting of cases by the community members to the facility)

Lack of community ownership of the facility projects and ownership is indicated by a coefficient of -.2014511. When the lack of community ownership of the facility projects and ownership is increased by one unit, the systems available to address complaints decline by -.2014511 units holding all other factors constant. Also, the significance level is indicated by 0.068. The significance value is above 0.05 ie "p" is greater than 0.05, this shows that there is no statistically significant difference in the degree of freedom of systems available to address complaints and Lack of community support of the facility projects and ownership.

Again, the lack of security at facility compounds is shown by a coefficient of -.2000833. With one unit increase in lack of security at facility compounds, the systems available to address complaints decline by .2000833. The significance level is also indicated by 0.644. The significance value is above 0.05 ie "p" is greater than 0.05, this shows that there is no statistically significant difference in the degree of freedom of systems available to address complaints and lack of security at facility compounds.

Also, late reporting of cases by the community members to the facility is indicated by a coefficient of .1085396. With one unit rise in late reporting of cases by the community members to the facility, results in an increase in the systems available to address complaints by .1085396. The significance level is indicated by 0.340. The significance value is above 0.05 ie "p" is greater than 0.05, this shows that there is no statistically significant difference in the degree of freedom of systems available to address complaints and late reporting of cases by the community members to the facility.

The researcher also wanted to know what other community-based challenges respondents know of and this is represented in table 6 below:

Table 6: Other Community-based Challenges respondents face.

Mention other community-based challenges you face?	**Freq.**	**Percent**	**Cum.**
Inadequate support from community members	17	5	5
High rate of drug abuse	36	11	16
Teenage Pregnancy	12	4	20
Lack of trust for health workers	42	13	32
Inadequate education on health issues to community members	49	15	47
Road Traffic Accidents	23	7	54
Presence of Traditional healers	53	16	70
Expensive Healthcare	61	18.43	88.52
Lack of coordination between hospital and community members	20	6	95
No free health screening	18	5	100
Total	**331**	**100**	

Researcher's fieldwork 2023

From the table above, the total respondents were 331. Out of the total of 331, 17(5%) indicated inadequate support from community members as community-based challenges they face. 36(11) respondents indicated a high rate of drug abuse as a challenge. 12(4%) respondents claimed teenage pregnancy is a challenge. 42(13%) respondents indicated a lack of trust in health workers as a challenge. 49(15%) respondents mentioned inadequate education on health issues to community members as a challenge. 23(7) respondents revealed road traffic accidents as a challenge. 53(16%) respondents revealed the presence of traditional healers as a challenge. 61(18%) respondents indicated expensive healthcare as a challenge. 20(6%) claimed lack of

coordination between hospital and community members is a challenge. 18(5%) respondents indicated no free health screen in the community is a challenge.

This therefore indicated that the majority of respondents mentioned failure to explain procedures to patients, presence of traditional healers, inadequate education of health issues to community members, lack of trust for health workers, high rate of drug abuse, road traffic accidents, and lack of coordination between hospital and community members as community members and the hospital are not coordinated enough.

The researcher wanted to know the Health System Based Challenges in Quality and Effective Health Service taking in to consideration the satisfaction level of healthcare service respondents receive from this facility. This is presented in table 7.

Table 7: Health System-Based Challenges.

Iteration 0: log likelihood = -150.46944
Iteration 1: log likelihood = -140.40286
Iteration 2: log likelihood = -139.78167
Iteration 3: log likelihood = -139.78028
Iteration 4: log likelihood = -139.78028

Multinomial logistic regression Number of obs = 331
LR chi2(5) = 21.38
Prob > chi2 = 0.0007
Log likelihood = -139.78028 Pseudo R2 = 0.0710

The healthcare service I receive from this facility is to the best of my satisfaction	Coef.	Std.Err.	Z	P>|z|	[95% Conf.	Interval]
YES						
There are always late referrals to the facility and to other facilities.	-.0364544	.1299601	-0.28	0.779	-.2911716	.2182628
There is lack of proper community entry and engagement	-.4939051	.1352803	-3.65	0.000	-.7590496	-.2287606
There is non-availability of essential logistics for running the facility	-.5010989	.1751147	-2.86	0.004	-.8443175	-.1578803
There is too much distance of facility from communities	.0307116	.1469042	0.21	0.834	-.2572154	.3186386
There is inadequate funding/lack of resources	.3776294	.1712561	2.21	0.027	.0419736	.7132852
_cons	-.0728943	.5470218	-0.13	0.894	-1.145037	.9992487
NO	(base	outcome)				

Researcher's fieldwork 2023

From table 7 above, the prediction equation in the Multinomial regression is: Satisfaction level of healthcare service respondents receive from this facility = -.0728943 -.0364544 (There are always late referrals to the facility and to other facilities.) -.4939051 (There is lack of proper community entry and engagement) -.5010989 (There is non-availability of needed logistics for running the facility) + .0307116(There is too much distance of facility from communities) + .3776294(There is inadequate funding/lack of resources).

From the table above, late referrals to the facility and to other facilities is indicated by a coefficient of -.0364544. When late referrals to the facility and to other facilities is increased by one unit, the level of satisfaction healthcare services respondents receive from the facility declines by -.0364544 units holding all other factors constant. Also, the significance level is showed by 0.779. The significance value is above 0.05, i.e., "p" is greater than 0.05, indicating that there is no statistically significant difference between the respondents' level of freedom with regard to their satisfaction with the healthcare services they receive from the facility and their late referrals to the facility and to other facilities.

Again, a coefficient of -.4939051 indicates that improper community entry and involvement are present. The level of satisfaction with the healthcare services respondents receive from the facility drops by.4939051 for every unit more of improper community entry and involvement. Additionally, the significance level is shown by 0.000. The statistically significant difference between the degree of freedom of the level of satisfaction of healthcare services respondents receive from the facility and the lack of appropriate community entry and participation may be shown when the significance value is below 0.05, or when "p" is less than 0.05.

Additionally, a value of -.5010989 indicates the absence of necessary logistics for maintaining the facility. The level of satisfaction with the healthcare services respondents receive from the institution declines by -.5010989 for every unit rise in the non-availability of critical logistics for operating the facility. The significance level was also examined, and it is represented by the number 0.004. The statistically significant difference in the degree of freedom of the level of satisfaction of healthcare services respondents receive from the facility declines and non-availability of essential logistics for running the facility is shown by the significance value being below 0.05, i.e. "p" is less than 0.05.Furthermore, too much distance of facility from communities is indicated by a coefficient of .0307116. When there is an increase in too much distance of facility from communities, the level of satisfaction of healthcare services respondents receive from the facility also increase by .0307116.

Finally, from table 7 above, inadequate funding/lack of resources is indicated by a coefficient of .3776294. A unit increase in inadequate funding/lack of resources results in an increase in the level of satisfaction of healthcare services respondents receive from the facility by .3776294.

Table 8: Health System Based Challenges.

Iteration 0: log likelihood = -168.09815
Iteration 1: log likelihood = -167.21382
Iteration 2: log likelihood = -167.21018
Iteration 3: log likelihood = -167.21018

Multinomial logistic regression Number of obs = 331
LR chi2(5) = 1.78
Prob > chi2 = 0.8792
Log likelihood = -167.21018 Pseudo R2 = 0.0053

There are systems available to address complaints	Coef.	Std.Err.	Z	P>|z|	[95% Conf.	Interval]
YES						
There are always late referrals to the facility and to other facilities.	.0689846	.1151398	0.60	0.549	-.1566853	.2946544
There is lack of proper community entry and engagement	-.0214635	.1113262	-0.19	0.847	-.2396589	.1967319
There is non-availability of essential logistics for running the facility	-.1112259	.1523929	-0.73	0.465	-.4099105	.1874587
There is too much distance of facility from communities	.1187705	.1369446	0.87	0.386	-.1496359	.3871769
There is inadequate funding/lack of resources	-.0278158	.1475007	-0.19	0.850	-.3169118	.2612802
_cons	-1.450163	.4736871	-3.06	0.002	-2.378572	-.5217528
NO	(base	outcome)				

Researcher's fieldwork 2023

From table 8 above, the prediction equation in the Multinomial regression is: There are systems available to address complaints = -1.450163 + .0689846 (There are always late referrals to the facility and to other facilities) -.0214635 (There is lack of proper community entry and engagement) + -.1112259 (There is non-availability of needed logistics for running the facility) + .1187705 (There is too much distance of facility from communities) -.0278158 (There is inadequate funding/lack of resources)

Late referrals to the facilities is indicated by a coefficient of .0689846. When late referrals to the facilities is increased by one unit, the systems available to address complaints also increase by .0689846 units holding all other factors constant.

Again, lack of proper community entry and engagement is indicated by a coefficient of -.0214635. With one unit lack of proper community entry and engagement, the systems available to address complaints declines by -.0214635.

Also, non-availability of needed logistics for running the facility, is shown by a coefficient of -.1112259. With one unit increase in non-availability of essential logistics for running the facility, results in decline of the systems available to address complaints by .1112259 unit

Further on table 21, too much distance of facility from communities, is indicated by a coefficient of .1187705. With one unit increase in too much distance of facility from communities, results in increase in the systems available to address complaints by .1187705 unit.

Finally, from the table above, inadequate funding/lack of resources is indicated by a coefficient of -.0278158. When inadequate funding/lack of resources is increase by one unit, the systems available to address complaints also declines by -.0278158.

The researcher also wanted to know if there are other health system based challenges respondents know. This is presented in table 9 below:

Table 9: other health system challenges respondents face

Mention other Health System challenges you face?	Freq.	Percent	Cum.
Charges for services to clients are very costly	14	4	4
Corruption happening in health facilities	26	8	12
Delay in service delivery by healthcare providers	16	5	17
Poor channel of communication	61	18	35
Price hikes of medicines	36	11	46
Government do not prioritized the health sector	44	13	59
High attrition rate of skilled workers	16	5	64
Inadequate CHIPS Compound	19	6	70
Inadequate equipment	14	4	74
Inadequate knowledge about the health system	13	4	78
Inadequate logistics and some technical personnel in facilities	15	5	83
Lack of commitment from leaders	17	5	88
Poor network service in communities	14	4	92
Shortage of vaccines and no isolation rooms available	26	8	100
Total	**331**	**100**	

Researcher's fieldwork 2023

From the table 9 above, the total respondents were 331. Out of the total of 331, 14(4%) respondents claimed Charges for clients' health care service are very Costly and this is a health system challenge they face. 26(8%) indicated corruption as a challenge. 16(5) indicated delay in service delivery by healthcare providers as a challenge. 61(18%) respondents indicated poor channel of communication as a challenge. 36(11%) respondents claimed price hikes of medicines is a challenge. 44(13%) respondents indicated Government not prioritizing the health sector is a challenge. 16(5%) respondents indicated high attrition rate of skilled workers is a challenge. 19(6%) respondents claimed inadequate CHIPS compound is a challenge. 14(4%) indicated inadequate equipment as a challenge. 13(4%) respondents claimed inadequate knowledge about health systems is a challenge. 15(5%) respondents claimed inadequate logistics and some technical personnel to deliver healthcare is a challenge. 17(5%) revealed lack of commitment from leaders is a challenge. 14(4%) respondents indicated poor network service in communities is a challenge.26(8) remaining respondents revealed shortage of vaccines and no isolation rooms available in facilities is a challenge.

This therefore indicates that, majority of respondents revealed poor channel of communication, Government not prioritizing the health sector, price hikes of medicines, corruption, shortage of vaccines and lack of commitment from leaders as health system challenges they face.

Improving Health Services Planning And Delivery

The researcher needed to know the ways in which Health Services planning and Delivery can be improved. This is presented in table 10 below:

Factor analysis/correlation Number of obs = 331
Method: principal factors Retained factors = 12
Rotation: orthogonal varimax (Kaiser off) Number of params = 162

The parameters in the tables are described below:

Eigenvalue; refers to the factor's variations. According to the table below, the first factor will explain the greatest amount of variance. The next largest amount of variance will be explained by the second factor, and so on.

Difference: the distinctions between the current and subsequent eigenvalues are revealed.

Proportion: shows the percentage of variance that the factor is responsible for explaining.

Cumulative: shows the fraction of the total variation that is explained by this factor plus all of the previous ones.

Factor loadings represents how the variables are weighted for each factor but also correlated between variables and the factor.

Uniqueness indicates the percentage of the variable's common variation that is not related to the factors. Therefore, uniqueness is equal to 1.

Rotated factor loadings reflects the correlation between the variables and the factor as well as how the variables are weighted for one another.

Table 10 Improving health service planning and delivery

Factor	Eigenvalue	Difference	Proportion	Cumulative
Factor 1	2.83622	0.39556	0.2311	0.2311
Factor 2	2.44066	0.07834	0.1989	0.4301
Factor 3	2.36232	0.17880	0.1925	0.6226
Factor 4	2.18352	0.80928	0.1780	0.8005
Factor 5	1.37424	0.19421	0.1120	0.9125
Factor 6	1.18003	0.81493	0.0962	1.0087
Factor 7	0.36510	0.11697	0.0298	1.0385
Factor 8	0.24814	0.10369	0.0202	1.0587
Factor 9	0.14444	0.06576	0.0118	1.0705
Factor 10	0.07868	0.05489	0.0064	1.0769
Factor 11	0.02379	0.00790	0.0019	1.0788
Factor 12	0.01589		0.0013	1.0801

LR test: independent vs. saturated: chi2(171) = 4449.97 Prob>chi2 = 0.0000

From the table above, principal factor analysis was performed and rotated. Factors with positive Eigenvalues were retained. 12 factors were retained and explained the acceptable level of variance. According to the Kaiser Criterion, you should employ factors with eigenvalues greater than 1. The first four elements in the table, which have variances greater than 1, appear to account for the majority of the total variability. The remaining variables only contribute a very little amount to the variability and are probably not significant.
Again, varimax rotation was also than using the rotated factor loadings. This is presented in in table 11 below:

Table 11: Factor loadings (pattern matrix) and unique variances

Variable	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6	Factor 7	Factor 8
Addressing the challenge of community lack of ownership of facility programmes	0.0998	0.1340	0.1294	**0.7141**	0.0745	0.0712	0.0188	-0.0165
Addressing the lack of community entry and engagement	0.3126	0.2546	0.1529	**0.6599**	-0.0026	0.3126	0.2546	0.1529
Addressing the non-availability of medicines	0.2275	0.1347	0.1071	**0.6087**	0.3001	0.1765	-0.1268	0.0639
Communities support for health workers in healthcare delivery, planning and implementation	0.4790	0.1379	0.2488	0.5360	0.2675	0.0615	-0.0691	-0.0324
Equitable distribution of human resource for health	**0.5731**	0.1499	0.3497	0.2349	0.1896	0.0965	0.2404	0.0344
Addressing the infrastructural deficit	0.3010	0.2724	0.2549	0.3085	0.0089	0.4456	0.0238	-0.0167
Capacity building for staff to improve communication and customer service	**0.6521**	0.1785	0.2144	0.2401	0.2320	0.2055	0.0155	-0.0369
Improve Logistics management	**0.7286**	0.2147	0.3155	0.2232	0.0320	0.2220	0.0245	0.1032
Enhance community entry and engagement Emergency delivery	0.3950	0.2879	0.3853	0.2096	0.1058	0.4627	-0.0241	0.2338
Build capacity in communication skills	0.3746	0.2710	0.1189	0.2170	0.2088	**0.5857**	0.0842	-0.0440
Develop conflict resolution and management skills	**0.5042**	0.1438	0.4786	0.2177	0.1419	0.1782	0.0140	-0.1902
Data management capability	0.1876	0.3268	**0.7352**	0.1854	0.1374	0.2051	-0.0204	-0.0345
Develop management and leadership skills	0.3836	0.2427	**0.7305**	0.1030	0.2096	0.0321	0.1017	0.0996
Train staff in integrated management of neonatal and childhood illnesses	0.4214	0.4198	0.4046	0.0810	0.3004	0.0651	0.0622	0.3371
Improve management of non-communicable and communicable diseases	0.1974	0.3850	0.3095	0.1986	**0.6538**	0.1005	-0.0241	-0.0032

Build capacity of managing referrals at CHPS level	0.2404	**0.7189**	0.2494	0.1942	0.2345	-0.0287	-0.0310	0.0771
Managing neglected tropical diseases in the communities	0.0977	**0.7605**	0.2754	0.1365	0.0958	0.3600	0.0177	-0.0284
Integrated diseases surveillance and response.	0.2017	**0.5909**	0.1478	0.1702	0.2288	0.1034	0.4060	0.0144
Resuscitation of newborns	0.1213	0.1863	0.1756	0.0884	**0.5868**	0.1217	0.1670	0.0588

Variable	Factor 9	Factor 10	Factor 11	Factor 12	Uniqueness
Addressing the challenge of community lack of ownership of facility programmes	-0.0192	-0.0554	-0.0086	0.0053	0.4306
Addressing the lack of community entry and engagement	0.0073	0.0922	0.0095	0.0318	0.2617
Addressing the non-availability of medicines	-0.0054	-0.0882	0.0061	-0.0613	0.3951
Communities support for health workers in healthcare delivery, planning and implementation	0.1840	0.1042	-0.0028	0.0203	0.2761
Equitable distribution of human resource for health	0.1584	0.0508	-0.0857	0.0125	0.3322
Addressing the infrastructural deficit	0.2589	-0.0364	0.0132	-0.0064	0.4069
Capacity building for staff to improve communication and customer service	0.0448	-0.1352	-0.0057	0.0065	0.3213
Improve Logistics management	-0.0759	0.0292	0.0223	-0.0204	0.2046
Enhance community entry and engagement Emergency delivery	-0.0119	-0.0465	0.0360	0.0317	0.2835
Build capacity in communication skills	-0.0394	0.0378	-0.0200	--0.0065	0.3260
Develop conflict resolution and management skills	0.0508	0.0616	0.0728	0.0228	0.3482
Data management capability	-0.0244	-0.0579	-0.0143	-0.0417	0.2148
Develop management and leadership skills	0.0599	0.0475	0.0045	0.0385	0.1770
Train staff in integrated management of neonatal and childhood illnesses	0.0005	0.0263	-0.0015	-0.0046	0.2633
Improve management of non-communicable and communicable diseases	0.0097	-0.0397	-0.0508	0.0049	0.2352
Build capacity of managing referrals at CHPS level	0.0226	0.0680	-0.0060	0.0582	0.2543
Managing neglected tropical diseases in the communities	0.0294	-0.0407	0.0079	-0.0415	0.1734
Integrated diseases surveillance and response.	-0.0156	-0.0281	.0089	-0.0086	0.3301
Resuscitation of newborns	0.0078	0.0556	0.0745	-0.0032	0.5128

From the results above, a varimax rotation was performed on the data. Using the rotated factor loadings. Eigenvalues close to -1 or 1 as considered to have an effect. The findings revealed that equitable distribution of human resources for health (**0.5731**), Capacity building for staff to improve communication and customer service (**0.6521**), and develop conflict resolution and management skills (**0.5042**) have large positive loadings on factor 1, so this factor describes the improvement of Health Service Planning and Delivery in facilities. This therefore indicated that equitable distribution of human resources for health, capacity building for staff to improve communication and customer service, and development of conflict resolution and management skills in healthcare facilities have a positive moderate relationship with the improvement of health service planning and delivery.

Building CHPS-level referral management capacity (0.7189), controlling neglected tropical disease outbreaks in local communities (0.7605), and integrated disease surveillance and response (0.5909) all have significant positive loadings on factor 2. Therefore, factor two explains how the facilities' planning and delivery of health services need to be enhanced. This proves that improving health service planning and delivery at the facilities is strongly positively correlated with increasing CHPS's capacity to manage referrals, manage neglected tropical diseases in the communities, and integrate disease surveillance and response.

The findings indicate that building the capacity of managing referrals at the CHPS level (**0.7189)** and managing neglected tropical diseases in the communities (**0.7605)** have a strong positive relationship with health service planning and delivery improvement in the facilities. However, integrated disease surveillance and response (**0.5909)** revealed a moderate positive relationship with health service planning and delivery improvement.

The findings from the table above further revealed that data management capability **(0.7352), and** developing management and leadership skills (**0.7305)** also have large positive loadings on factor 3 describing the ways of health service planning and delivery improvement in health facilities. This therefore indicates that data management capability **(0.7352), and** developing management and leadership skills (**0.7305)** have a strong positive relationship with health service planning and delivery improvement in healthcare facilities**.**

Again, according to the results from the table above, addressing the issues of community lack of ownership of facility programs (0.7141), community entry and engagement issues (0.6599), and medicine availability (0.6087) have significant positive loadings on factor 4. This also shows that addressing the issue of community lack of ownership of facility programs (0.7141), addressing the issue of community entry and engagement, and addressing the issue of medicine non-availability are all strongly and positively correlated with improvement in health service planning and delivery. This is because their factor loadings are nearly 1.

Improved management of non-communicable and communicable diseases (0.6538) and neonatal resuscitation (0.5868) show significant positive loadings on factor 5. Improved non-communicable and communicable disease management and neonatal resuscitation are related in this factor. Improvements in healthcare planning and delivery are strongly correlated with improvements in the management of communicable and non-communicable diseases. Additionally, resuscitation of babies is positively and moderately correlated with better planning and provision of healthcare services.

The findings also revealed building capacity in communication skills (**0.5857)** to have large positive loadings on factor 6. This indicates that, the factor describes a moderate positive relationship between building capacity in communication skills and improvement in health service planning and delivery.

The researcher also wanted to know if there are other ways to improve health services planning and delivery in health facilities. This is presented in table 12 below:

Table 13: respondents' views on other ways to improve health services planning and delivery in facilities.

Explain other ways to improve health services planning and delivery in the facility.	Freq.	Percent	Cum.
Train workers on patient management	27	8	8
Involve community members in healthcare delivery decisions	20	6	14
Make healthcare affordable	19	6	20
Intersectoral collaborations among stakeholders	33	10	30
Improve health infrastructure	26	8	38
Effective communication system among staff and patients	18	5	43
Eradicate corruption in the health system	24	7	50
Stop interference in operation by high authorities	14	4	54
Extensive patient adherence to drug administration	21	6	60
Accept other people's views	6	2	62
Addressing the issue of inadequate equipment in facilities	10	3	65
Strengthening health financing (NHIA)	14	4	70
Involve various department in decision making	11	3	73
Coordinated healthcare systems	19	6	79
Educating the public about health related issues	21	6	85
Effective communication system between nurses and patients	18	5	90
Equitable distribution of human resource for health	20	6	96
Teamwork among management and staff in facilities	10	4	100
Total	**331**	**100**	

Researcher's fieldwork 2023

From the table above, 13 respondents indicated training of workers on patient management is a way to improve health services planning and delivery in the facility representing 8% of the total respondents of 331. 20 of the respondents also indicated they involve community members in health care delivery as ways to improve health services planning and delivery in the facilities representing 6% of respondents' response rate. 19 respondents also indicated making health care affordable can improve health service and delivery representing 6%. 33 of the respondents also indicated intersect oral collaborations among stakeholders as ways to improve health services planning and delivery in the facility representing 10% response rate. 26 respondents mentioned that improving health infrastructure can improve health services planning and delivery representing 26% response rate. 18 respondents indicated effective communication systems among stakeholders are key in improving health services planning and delivery representing 5% response rate. 24 respondents representing 7% indicated eradication of corruption in the health system will improve health service planning and delivery. 14

(4%) respondents indicated stopping interference in healthcare operations by high authorities will improve health service planning and delivery. 21(6%) respondents mentioned extensive patient adherence to drug administration will improve health service planning and delivery. 6(2%) respondents explained accepting other people's views will improve health service planning and delivery. 10(3%) respondents indicated addressing the challenge of inadequate equipment will improve health service planning and delivery. 14(4%) respondents claimed strengthening health financing such as NHIA and others will improve health service planning and delivery. 11(3%) of respondents mentioned involving various departments in decision-making in facilities will improve health service planning and delivery. 19(6%) respondents explained a coordinated healthcare system and removal of inequalities in the service will improve health service planning and delivery. 21(6) respondents claimed educating the public about health-related issues will improve health service planning and delivery. 18(5%) mentioned effective communication between nurses, administrative staff, and patients will improve health service planning and delivery. 20(6%) respondents claimed equitable distribution of human resources for health will improve health service planning and delivery. The remaining 10(3%) respondents revealed that teamwork among management and staff in the facility will health service planning and delivery. The majority of respondents therefore indicated intersect oral collaborations among stakeholders, training of workers on patient management, improving Health Infrastructure, eradicating corruption in the health system, extensive Patient adherence to drug administration, educating the public about health related issues, equitable distribution of human resource for health and involving Community members in healthcare will facilitate health service planning and delivery.

IV. Summary And Discussions

Challenges Affecting Quality And Effective Planning And Management Of Primary Healthcare Services

Health Worker-Based Challenges

When poor health workers communication is increased by one unit, the satisfaction level of healthcare service respondents receive from the facilities declines. An increase in high attrition rates of Community Health Officers/Community Health Nurses (CHNs) (through transfers, further studies, resignations, vacation of post and death), declines the healthcare service respondents receive from the facility to the best of their satisfaction. Increase in Inadequacy and/or unavailability of CHOS/CHNs at post when needed, results in increase of the healthcare service respondents receive from the facility to the best of their satisfaction. When poor health workers communication is increased by one unit, the systems available to address complaints declines. One unit increase in high attrition rates of Community Health Officers/Community Health Nurses (CHNs) (through transfers, further studies, death), declines the systems available to address complaints. The results of this study support the findings of Kweku et al.'s (2020) study, which found that the primary challenges faced by health professionals were their negative attitudes, the high attrition rates of community health workers (CHOs/CHNs), and the insufficient and/or non-availability of CHOS/CHNs at the post when needed. In their respective FGDs, health professionals and community members both regularly identified high attrition rates as a major barrier to the effective deployment of CHPS (Woods, 2016).

Inadequate and/or unavailability of CHOS/CHNs at post when needed, results in increase of the healthcare service respondents receive from the facility to the best of their satisfaction. Majority of respondents claim inexperienced staff in facilities, lack of staff accommodation, disrespect to clients, lack of teamwork in the facility, poor motivation to staff and failure to explain procedures to patients are some of the health worker based challenges they mostly face in the facilities. The research by Addi et al., (2021) showed that the important variables that were determined at the district and local levels all followed a similar pattern and were related to the zeal and commitment of different players. The lack of a dependable funding source, the strict and unclear regulations, the high turnover of human resources, the lack of skills among health workers regarding family focus and community orientation, and the limited involvement of institutions outside the health sector in generating intersect oral responses and fostering community participation were among the obstacles (Mosquera et al., 2014). National policies and a health system based on neoliberal principles were also among the obstacles. The above studies also supports the present study conducted in the Catholic Health facilities.

Community based challenges

When lack of community ownership of the facility projects and ownership is increased by one unit, the systems available to address complaints declines. With one unit increase in lack of security at facility compounds, the systems available to address complaints declines. With one unit increase in late reporting of cases by the community members to the facility, results in increase in the systems available to address complaints. When Lack of community ownership of the facility projects and ownership is increased by one unit, the healthcare service respondents receive from the facility to the best of their satisfaction declines. With one unit increase in high attrition rates of Community Health Officers/Community Health Nurses (CHNs) (through transfers, further studies, death), the satisfaction level of healthcare service respondents receive from the facility

also increase. Increase in late reporting of cases by the community members to the facility, results in increase of satisfaction level of healthcare service respondents receive from the facility. Majority of respondents mentioned failure to explain procedures to patients, presence of traditional healers, inadequate education of health issues to community members, lack of trust for health workers, high rate of drug abuse, road traffic accidents and lack of coordination between hospital and community members as lack of coordination between hospital and community members. According to Addi et al.'s study from 2021, late case reporting by community members, a lack of community ownership of the CHPS program, and a lack of security at CHPS compounds are more pervasive challenges healthcare providers face. The aforementioned study supports Woods' (2016) study, which found that community-based difficulties are obstacles that arose in the communities and stalled the effective implementation of CHPS.

Health system-based challenges

When late referrals to the facility and to other facilities is increased by one unit, the level of satisfaction healthcare services respondents receive from the facility declines. There is statistically significant difference in the degree of freedom of the level of satisfaction of healthcare services respondents receive from the facility and lack of proper community entry and engagement. There is statistically significant difference in the degree of freedom of the level of satisfaction of healthcare services respondents receive from the facility and non-availability of essential logistics for running the facility. Also, when there is an increase in too much distance of facility from communities, the level of satisfaction of healthcare services respondents receive from the facility also increase. A unit increase in inadequate funding/lack of resources results in an increase in the level of satisfaction of healthcare services respondents receive from the facility. When late referrals to the facility and to other facilities is increased by one unit, the systems available to address complaints also increase. With one unit increase in lack of proper community entry and engagement, the systems available to address complaints declines. With one unit increase in non-availability of essential logistics for running the facility, results in decline of the systems available to address complaints. Majority of respondents revealed poor channel of communication, Government not prioritizing the health sector, price hikes of medicines, corruption, shortage of vaccines and lack of commitment from leaders as health system challenges they face. This supports the key concerns stated in Tiiga's (2018) FGDs, which were: late referrals, improper community access and participation, a lack of essential logistics for operating CHPS, a distance between communities and CHPS Compounds, and a lack of financing or resources.

A system thinking approach, which considers stakeholder interactions and interventions while creating and evaluating reforms, could assist in anticipating obstacles to the implementation of health changes (De Savigny & Adam, 2009).

Improving Health Services Planning And Delivery

Equitable distribution of human resource for health, capacity building for staff to improve communication and customer service, and developing conflict resolution and management skills in healthcare facilities have a positive moderate relationship with improvement of health service planning and delivery. Building capacity of managing referrals at CHPS level, managing neglected tropical diseases in the communities integrated diseases surveillance and response have large strong positive relationship with health service planning and delivery improvement in the facilities.

The findings indicate that, building capacity of managing referrals at CHPS level and managing neglected tropical diseases in the communities have strong positive relationship with health service planning and delivery improvement in the facilities. However integrated diseases surveillance and response revealed a moderate positive relationship with health service planning and delivery improvement.

Data management capability, developing management and leadership skills have strong positive relationship with health service planning and delivery improvement in healthcare facilities. Addressing the challenge of community lack of ownership of facility programmes, addressing the lack of community entry and engagement, addressing the non-availability of medicines are strongly and positively correlated with improvement in health service planning and delivery. Improve management of non-communicable and communicable diseases has a strong positive relationship with improvement in health service planning and delivery. Resuscitation of newborns also have a positive moderate relationship with improvement in health service planning and delivery.

There is moderate positive relationship between building capacity in communication skills and improvement in health service planning and delivery. Majority respondents therefore indicated intersect oral collaborations among stakeholder, training of workers on patient management, improve Health Infrastructure, eradicate corruption in the health system, Extensive Patient adherence to drug administration, educating the public about health related issues, Equitable distribution of human resource for health and involve Community members in healthcare will health service planning and delivery.

According to Kweku et al. (2020) study, using efficient and superior planning strategies can enhance the delivery of health services at the primary, secondary, and tertiary levels of the health system. The techniques aid in locating various gaps in service delivery, produce solutions to close those gaps, and lessen the possibility of service delivery bottlenecks. The study also found that it is well known that employing effective planning techniques for health services has enhanced treatment for patients in areas including HIV/AIDS, TB/Malaria programs, maternity, neonatal, and child health. The present findings support the above findings.

The above findings support the national policy on CHPS which was introduced by the Ghanaian government in 2016 through the Ministry of Health (Awoonor-Williams et al., 2016). In order to attain Universal Health Coverage and close the access equity gap by 2030, the policy seeks to realize its goals of offering a fundamental bundle of necessary health services to every community. After ten years of extending CHPS across the country, CHPS Policy, 2016, was released. According to the authors, the new approach is predicted to help in readjusting the CHPS implementation to make sure it is more detailed, useful, and integrated with other national health systems and hence managing neglected tropical diseases in the communities. The present study confirms the above studies.

V. Conclusion

Challenges affecting the quality and effective planning and management of primary health care services.

Health worker-based challenges

The findings in objective two concluded that, Health worker-based challenges affect the quality and effective planning and management of primary health care services. These include; poor health workers communication, low satisfaction of healthcare service respondents receive from the facilities, high attrition rates of Community Health Officers/Community Health Nurses (CHNs) (through transfers, further studies, resignations, vacation of post, death), inadequate and/or absence of CHOS/CHNs at post when needed, inexperienced staff in facilities, lack of staff accommodation, disrespect to clients, lack of teamwork in the facility, poor motivation to staff and failure to explain procedures to patients.

Community based-challenges

The findings further concluded that, Community based challenges affect the quality and effective planning and management of primary health care services due to: lack of community ownership of the facility projects and ownership, lack of security at facility premises, late reporting of cases by the community members to the facility, high attrition rates of Community Health Officers/Community Health Nurses (CHNs) (through transfers, further studies, death), failure to explain procedures to patients, presence of traditional healers, inadequate education of health issues to community members, lack of trust for health workers, high rate of drug abuse, road traffic accidents and lack of coordination between hospital and community members as lack of coordination between hospital and community members.

Health system-based challenges

The findings also concluded that, Health system challenges affect the quality and effective planning and management of primary health care services through; late referrals to the facility and to other facilities, lack of proper community entry and engagement, non-availability of vital logistics for running the facility, too much distance of the facility from communities, inadequate funding/lack of resources, the poor channel of communication, Government not prioritizing the health sector, price hikes of medicines, corruption, shortage of vaccines and lack of commitment from leaders.

Improving Health Services Planning and Delivery

From the findings in objective three, it is concluded that health service planning and delivery can be improved through; equitable distribution of human resources for health, capacity building for staff to improve communication and customer service, and developing conflict resolution and management skills in healthcare facilities. The findings concluded that, building the capacity to manage referrals at CHPS level, and integrating disease surveillance and response into the management of neglected tropical diseases in the communities has a strong, positive association with the planning and implementation of improved health services in the facilities.

The findings again concluded that, data management capability, and developing management and leadership skills, have a strong positive relationship with health service planning and delivery improvement in healthcare facilities. Addressing the challenge of community lack of ownership of facility programmes, addressing the lack of community entry and engagement, and addressing the non-availability of medicines are strongly and positively correlated with improvement in health service planning and delivery.

The findings in objective three finally concluded that health service planning and delivery can be improved through; improving the management of non-communicable and communicable diseases, resuscitation of newborns, building capacity in communication skills, intersectoral collaborations among stakeholders,

training of workers on patient management, improving health Infrastructure, eradicate corruption in the health system, extensive patient adherence to drug administration, educating the public about health-related issues, equitable distribution of human resource for health and involving Community members in healthcare.

Recommendations

Networks of Practice Concept

From the findings, there are health worker, health systems and community based challenges in the provision of quality and effective health care planning and delivery. It's recommended that, Diocesan Health Service should capitalize on the flagship programme on the application of the Network of Practice Concept rolled out by the Ghana Health Service to utilize resources to provide high-quality healthcare.

Increasing Access to Responsive Clinical and Public Health Emergencies

It is also recommended that; management should concentrate on increasing access to responsive clinical and public health emergencies through the networks of practice concept.

Training of Health care staff on National Health Strategy and the Sustainable Development Goals

It is again recommended that, healthcare managers and staff be trained on the National Health Strategy and the Sustainable Development Goals which seek to ensure that all people have access to higher-quality, more effectively managed health services, and increase access to timely clinical care and public health emergencies while decreasing unnecessary maternal and child health with disabilities.

Holistic Health Financing Approach

Additionally, it is advised that the government, together with stakeholders, consider a comprehensive health financing approach to help healthcare providers sustain their facilities in order to give quality care.

Future Research

Based on the results, the study recommends that, a similar study is conducted in selected Ghana Health Service facilities to validate the users perspective of quality and effective health service planning and delivery in the service (GHS).

Reference

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