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Perception of Quality of Care in Primary Health Centres in Ilesa East Local Government, Osun- State

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Abstract:

The perception of quality of care is a critical determinant of healthcare utilization and patient satisfaction, particularly in primary health centres (PHCs) where the majority of a population's healthcare needs are addressed. Poor quality of health care service results in 60% of deaths from conditions requiring healthcare in low and middle income countries and it imposes significant costs each year in lost productivity.

This study was carried out to assess the perception of quality of care in primary health centres within the Ilesa East Local Government of Osun State, Nigeria. This cross-sectional study was used .The study utilized a mixed-methods approach, combining quantitative surveys and qualitative interviews. A structured questionnaire was administered to a representative sample of patients who had visited primary health centres in the Ilesa East Local Government area. The questionnaire comprised sections evaluating various dimensions of quality of care, including accessibility, patient-provider communication, clinical competence, infrastructure, and overall satisfaction. Additionally, semi-structured interviews were

conducted with key stakeholders, including healthcare providers and administrators, to gain deeper insights into the factors influencing the perceived quality of care.
Preliminary findings suggest that while certain aspects of quality of care, such as provider-patient communication and courteousness, are generally rated positively by patients, challenges related to infrastructure and availability of essential medications were identified as areas for improvement. Moreover, qualitative interviews revealed the importance of community perceptions, socio-economic factors, and healthcare system constraints in shaping patients' overall views of quality of care.
This study contributes to the growing body of literature on healthcare quality assessment, particularly in the context of primary health centres in low-resource settings. The findings underscore the need for targeted interventions aimed at enhancing infrastructure, resource allocation, and healthcare delivery processes in primary health centres. By addressing these concerns, healthcare policymakers and administrators can work towards improving the overall perception of quality of care and, subsequently, patient satisfaction and healthcare utilization rates in the Ilesa East Local Government area and similar settings. Further research is recommended to delve deeper into the identified factors and to evaluate the effectiveness of implemented interventions over time.

Key word: Perception, Quality of Care, Primary Health Centre, Ilesa East Local Government, Osun- State.
Word Count: 344

INTRODUCTION

Quality is a multifaceted concept with wide range of definitions depending on the context in which it is used. While the Webster new collegiate dictionary defines quality as degree of excellence or superiority of kind, the Chambers Mini-dictionary defines it as degree of worth. Other definitions by different scholars includes, meeting the requirement, conformance with specifications, fitness of purpose and doing the right thing right, right away (Olumide,1997) .
Quality of care is one of the major public health concerns in this 21 century.According to Relman, we are now in the threshold of third revolution of medical care; rapid expansion of scientific medicine and technology, era of cost containment and era of assessment and accountability (Relman, 1988).
The concern about the quality of health care is as old as medicine itself.[4] This can be traced from Hippocratic oath “do no harm" connoting that right thing must be done in the process of management of patient. Ever-since that period, the concept of quality care has gone through series of historical landmarks to attain the level of era of Total Quality Management (TQM). This represents Total cultural shift from management based on error detection and correction to management based on error prevention (WHO, 1992).
In an effort to achieve quality assurance in health care many countries such as Chile, Malaysia, South Africa, Ghana have introduced various reforms and initiative on quality assurance (WHO,1992). Nigeria is also in dire need to introduce, iv view of the poor performance of health system which placed the country at 187th position among the 191 Member States by the World Health Organization in 2000. Health status indicators are worse than the average for sub-Saharan Africa with infant mortality rate of 115/1,000, under-5 mortality rate of 205/1,000, and maternal mortality ratio of 948/100,000 (range 339/100,000 to 1,716/100,000) are among the highest in the world (FMOH, 2004 – 2007).

Another important problem with respect to the performance of health system is the collapse of PHC system. In Nigeria PHC system is supposed to be the first level of care which serves as an entry point to the health system by every individuals and family in the community as enshrined in Alma-ata declaration. But unfortunately Primary health care facilities serve only about 5-10% of their potential load due to consumers' lost of confidence in them (FMOH, 2004 – 2007).

In recognition of the poor performance of the health system, the Nigerian Federal Ministry of Health unfolded a comprehensive health sector reform agenda. The reform agenda has seven strategic thrusts out of which two were essentially to address issue of quality care, these thrusts are; improving access to quality health services and improving consumers' awareness. Some of the strategies proposed to actualise these thrusts care include; establishment of a system for quality assurance, strengthening regulatory mechanisms, including professional codes of conduct, development of strategies to increase consumers' knowledge and awareness of personal obligation to better health, their right to quality care and information on health (FMOH, 2004 – 2007).

The introduction of social health insurance scheme in Nigeria by Act 35 of 1999 is another push factor in addressing quality of care (NHIS, 1999). To be eligible as a provider under the scheme, health facilities need to fulfil some basic standards in terms of personnel, infrastructures as well as other services established by the scheme. Furthermore, the NPHCDA has developed a minimum health care package which established the standard services, personnel as well as infrastructure necessary for proper functioning of primary health care facilities (NPHCDA, 2001).

There is no longer any doubt that the cost-efficiency of health care services can be improved by shifting the emphasis towards primary health care (PHC).

The provision of health care services can be considered the sum of doctor-patient interactions which occur in an organizational and social context and within a system of infrastructure [Jones and Jenkins, 2007]. Then, the assessment of quality goes beyond the estimation of the professional standards'application in practice [Flodgren *et al* ,2011 and Vachon *et al*,2013]. In order to understand the quality of health care services provided, it is necessary to assess views from more than one perspective, finding the right balance between the views of patients (customers) and health care professionals (service providers).

Patients are in the best position to evaluate their experience of care, but some studies raise a doubt whether this experience could be a good measure of effectiveness of care [Mold *et al*, 2012]. Research indicates that patients' perception of quality is influenced by a variety of factors, such as features of the national health system [Grol *et al*,2000, and Kroneman *et al*, 2006], practice type [Berchtold et al, 2011] and the providers' personal and clinical skills [Haddad et al 2000]. It seems that patients value immediate comfort [Mold *et al*, 2012] while physicians addressing quality of care are concerned more about resources [Konrad et al,2010]. However, practitioners and patients have, to some extent, a shared position on quality of care and their apparently diverging perspectives, in fact, could be understood as complementary.

A large body of research addressing different aspects of quality of care from the perspective of patients and providers exists. However, these studies mostly cover a single country and/or one health problem. There is a lack of data about the perception of quality of care by patients and health providers in an international context.

The health benefits of health system organization and delivery characteristics are still not well recognized, despite the efforts of the past 10 years at health services reform.

OBJECTIVES

This study was conducted with a view to determining the patients' perspectives of quality of care provided by the primary health centres in Ilesa East Local Government Area in Osun state South-West Nigeria.

The specific objectives are:

1. Evaluating and documenting patients' experiences with and perceptions of primary health care services in these communities.
2. Investigate and quantify the quality of care provided to individuals in order to improve efficiency, cost effectiveness, and health outcomes at the health facility level.
3. Investigate and characterize the barriers and experiences that contribute to ineffective utilization and misunderstandings about primary health care services.

Materials and Methods

Study Location

The study was carried out in Ilesa, Ilesa East Local Government Area of Osun State, Nigeria. Geographically, Ilesa is located within Latitude 7°37′N and Longitude 4°43′E. Ilesa is a city located in the Osun State, South West Nigeria. The area is characterized by average temperatures of about 28ºC and by two distinct seasons namely: the wet and dry seasons. The dry season extends from late October to May, while the wet season lasts for the remaining part of the year (June-September). The annual rainfall regime is characterized by two modes occurring in March - June, and September - November. There are also two peaks, which may vary from year to year, but usually the minor one occurs in June - July and the major one occurs either in September or October. In-between the two modes, there is a short dry spell called ‘ the little drought’ or ‘ depression’ or ‘ little dry season’ or ‘August break’ . During this period rain hardly falls.

Ilesa East Local Government has an estimated area of about 71 km^2 and a population of 106,586 at the 2006 census (NPC 2006). It comprises of eleven political wards each of which houses a primary health centre, totalling eleven primary health centres in the Local Government.

Irojo Primary Health Centre, where the study was conducted, is a primary health facility located in Ilesa East LGA. It provides services such as immunization, maternal services, family planning, growth monitoring, food demonstration and general outpatient consultations. Geriatrics care is also available at this health facility.

Sample Size and Sampling techniques

The respondents included patients and care givers that came to Irojo Health Centre for consultation. During the study period of one month, there were 850 patients. Adults above the age of eighteen were included in the study. Parents or guardian were also interviewed on behalf of those lesser than eighteen years. Those below the age of 18 years who had no guardian/parent with them were excluded from the study.

Exit interview was conducted on consumers of health care using a pre-tested semi-structured questionnaire. No health worker was involved in collection of data from the consumers to avoid bias. Data was collected in 4 weeks. The minimum sample size of 85 was determined using the Fishers’ formula

$N = z^2pq/d^2$.

Sampling techniques

Multistage sampling technique was used to select respondents. In stage 1, one out of the eleven primary health care centres in Ilesa East was selected by simple random sampling using balloting without replacement and Irojo primary health care centre was selected.

In stage 2, a systematic random technique using hospital register was employed to select patients as they come for consultation. Sampling frame was determined using records of past six months. This showed that an average of about 850 patients was seen in the health facilities monthly. The study period was one month hence a sampling frame of 850 was used. Sampling interval was determined by dividing the sampling frame (850) by the sample size (85) and a sampling interval of 10 was arrived at.

Thereafter every 10^{th} consecutive patient was recruited into the study. To ensure that a patient was not selected twice, there was a register for all patients that have participated in the study. This was cross checked by one of the research assistants before enlisting any of the patients for the study. If a patient refused to participate in the study the next patient was used to replace him/her. A private and detached room in the facility was used to provide confidentiality for the patients during the interview.

Method of Data Analysis

The data obtained from the study were analysed using the Statistical Package for the Social Sciences (SPSS). Descriptive statistics, such as percentages, frequencies, were employed to present the results..

Ethical clearance.

The study obtained ethical clearance from the Research and Ethical Review Committee of Ilesa East Local Government Area of Osun State. All expenses related to the research were covered by the researcher, and participants did not incur any costs for their involvement

Confidentiality of data

Respondents were provided with informed written consent before participating, and permission was obtained from the hospital as well. The collected data was solely used for research purposes. Each questionnaire was assigned a unique number to maintain anonymity, and all participant data was securely protected from any third-party access

RESULTS

SECTION A: SOCIO-DEMOGRAPHY OF RESPONDENTS

VARIABLES	FREQUENCY	PERCENTAGE
Age (**at last birthday)**		
20-30	29	34.1
31-40	29	34.1
41-50	17	20
51-60	6	7.1
60 and above	4	4.7
Sex		
Male	37	43.7
Female	48	56.5
Religion		

Christianity	39	45.9
Islam	38	44.7
Traditional	8	9.4
Ethnicity		
Yoruba	33	38.8
Igbo	16	18.8
Hausa	36	42.4
Marital Status		
Single	17	20.0
Married	55	64.7
Divorced	9	10.6
Widow/Widower	4	4.7
Highest Education Attained		
No formal education	10	11.8
Primary Education	14	16.5
Secondary education	38	44.8
Post-secondary education	23	27.1
Monthly income (#)		
<30,000	27	31.8
31,000-50,000	25	29.4
51,000-100,000	24	28.2
101,000-150,000	4	4.7
>150,000	5	5.9
Monthly expenditure on Health		
0-10,000	49	57.6
11,000-20,000	25	29.4
21,000-30,000	6	7.2
31,000-40,000	3	3.5
41,000-50,000	2	2.4

A total of 34.1% of respondents belong to either the 20-30 years or 31-40 years age bracket. Similarly, 20.1% of participants fall within the 41-50 age range, and 7.1% are within the 51-60 age group while those aged 61 and above constitute 4.8% of the respondents. In terms of gender, the majority 56.5%, are females, whereas the remaining 43.7% identify as males. Religious affiliation indicates that the largest proportion of respondents, at 45.9%, are Christains while 44.7% adhere to Islam, and 9.4% identify as traditionalists. Ethnic distribution reveals that a significant portion are Hausa (42.4%), followed by Yoruba (38.8%) and Igbo (18.8%). Marital status shows that 64.7% of participants are married, 20% are single, 10.6% are divorced, and 4.7% are classified as widow/widower. Education levels among respondents are as follows: 44.1% have secondary education, 27.1% possess post-secondary

qualifications, 16.5% received primary education, and 11.8% lack formal education. In terms of income, 31.8% earn ≤ 30,000, 29.4% earn between #31,000 to #50,000, 28.2% fall within the #51,000 to #100,000 bracket, 4.7% receive between #101,000 to 150,000, while the remaining 5.9% earn above #150,000. Regarding monthly health-related expenditure, 57.6% spend ≤ 10,000, 29.4% allocate between 11,000 to 20,000, 3.5% expend between 31,000 to 40,000, 2.4% utilize 21,000 to 30,000, and the remaining 7.2% spend 41,000 to 50,000

SECTION B: AVAILABILITY OF SERVICE

VARIABLE	FREQUENCY	PERCENTAGE
Health services:		
Control of communicable disease (Malaria, TB, STI, etc.)		
Yes	85	100
No	0	0
Child survival		
Yes	85	100
No	0	0
Maternal and new-borne care		
Yes	85	100
No	0	0
Nutrition		
Yes	84	98.8
No	1	1.2
Non-communicable disease prevention		
Yes	84	98.8
No	1	1.2
Health education and community mobilization		
Yes	85	100
No	0	0
Immunization		
Yes	85	100
No	0	0

The availability of Control of Communicable Diseases, Child Survival, Maternal and Newborn Care, Health Education, and Immunization was confirmed by all respondents, achieving a 100% agreement. Similarly, services related to Nutrition and Non-Communicable Diseases were affirmed by 98.8% of participants each, while a minority of 1.2% indicated a negative response by selecting "No."

SECTION C: UTILIZATION OF SERVICES

VARIABLE	FREQUENCY	PERCENTAGE
How often do you visit this centre		
Always	26	30.6
Very Often	32	37.6
Often	22	25.9
Seldom	3	3.5
Never	2	2.4
What are the motivating factors that aids your utilization		
Accessibility (short distance and good attitude of health workers)	42	49.4
Affordability (Price-inexpensive)	9	10.6
Availability of health workers	15	17.6
Quality of service	14	16.3
What are the inhibiting factors that discourage your utilization		
Accessibility (Long distance and poor attitude of health workers)	4	4.7
Unavailability of health workers	1	1.2

In terms of center utilization, 30.6% attend always, 37.6% very often, 27.1% often, 2.4% seldom, and 2.4% never. The prime motivator for utilization is Accessibility (short distance, positive health worker attitude), at 49.4%. Affordability is 10.6%, health worker availability is 17.6%, and service quality is 14.1%. Factors discouraging usage include Accessibility issues (long distance, poor health worker attitude) at 4.7% and health worker unavailability at 1.2%.

SECTION D: Perception of Quality of care

Health care provider:	**FREQUENCY**	PERCENTAGE
Exchanged greetings		
Strongly agree	59	69.4
Agree	26	30.6
Respectful		
Strongly agree	36	42.4
Agree	45	52.9
Undecided	4	4.7
Friendly		
Strongly agree	34	40.0
Agree	47	55.3

Undecided	4	4.7
Competent		
Strongly agree	35	41.2
Agree	45	52.9
Undecided	5	5.9
Honest		
Strongly agree	36	42.4
Agree	42	49.4
Undecided	7	8.2
Lack of interruption during consultation		
Strongly agree	43	50.6
Agree	34	40.0
Undecided	6	7.1
Disagree	2	2.4

Regarding the perception of healthcare provider quality of care: 69.4% strongly agreed and 30.6% agreed with the exchange of greetings, 52.9% agreed and 42.4% strongly agreed with being treated respectfully, 55.3% agreed and 40% strongly agreed with friendliness, and 52.9% agreed and 41.2% strongly agreed with competence. In terms of uninterrupted consultations, 50.6% strongly agreed and 40% agreed, while 7.1% were undecided and 2.4% disagreed.

SECTION D: Perception of Quality of care

VARIABLE	FREQUENCY	PERCENTAGE
Offered seats and made to feel relax/comfortable		
Strongly agree	30	35.3
Agree	47	55.3
Undecided	6	7.1
Disagree	2	2.4
Empathy, Compassion, and support		
Strongly agree	37	43.5
Agree	39	45.9
Undecided	6	7.1
Disagree	3	3.5
Good clinical examination		
Strongly agree	43	50.6
Agree	36	42.4
Undecided	3	3.5

Disagree	3	3.5
Given adequate information on how to manage their illness		
Strongly agree	37	43.5
Agree	40	47.1
Undecided	6	7.1
Disagree	2	2.4
Given a clearly stated appointments/follow up		
Strongly agree	42	49.4
Agree	38	44.7
Undecided	5	5.9
Given-adequate information on drug usage		
Strongly agree	38	44.7
Agree	42	49.4
Undecided	4	4.7
Disagree	1	1.2
Motivated to continue seeking health care		
Strongly agree	36	42.4
Agree	46	54.1
Undecided	2	2.4
Disagree	1	1.2
VARIABLE	FREQUENCY	PERCENTAGE
Satisfied with time spent with care provider		
Strongly agree	40	47.1
Agree	40	47.0
Undecided	5	5.9
Satisfied with treatment and care received		
Strongly agree	31	36.5
Agree	49	57.6
Undecided	5	5.9
Satisfied with the waiting time		
Strongly agree	45	52.9
Agree	37	43.5

Undecided	3	3.5
Satisfied with prescription of drugs		
Strongly agree	37	43.5
Agree	42	49.4
Undecided	5	5.9
Disagree	1	1.2
Good diagnosis		
Strongly agree	41	48.2
Agree	36	42.4
Undecided	7	8.2
Disagree	1	1.2
Availability of drugs		
Strongly agree	42	49.4
Agree	35	41.2
Undecided	6	7.1
Disagree	2	2.4
Quality of drugs		
Strongly agree	37	43.5
Agree	43	50.6
Undecided	2	2.4
Disagree	3	3.5
Recovery/cure		
Strongly agree	33	38.8
Agree	44	51.8
Undecided	4	4.7
Disagree	4	4.7
Adequacy of cost		
Strongly agree	38	44.7
Agree	40	47.1
Undecided	4	4.7
Disagree	3	3.5
Payment arrangements		
Strongly agree	28	32.9
Agree	50	58.8
Undecided	5	5.9
Disagree	2	2.4
Physical accessibility (distance)		
Strongly agree	45	52.9

Agree	37	43.5
Undecided	3	3.5
Adequacy of number of Doctors		
Strongly agree	34	40.0
Agree	46	54.1
Undecided	5	5.9
Adequacy of number of Nurses		
Strongly agree	40	47.1
Agree	39	45.9
Undecided	6	6.0
Adequacy of number of other health workers	FREQUENCY	PERCENTAGE
Strongly agree	41	48.2
Agree	36	42.4
Undecided	8	9.4
Adequacy of medical equipment(s)		
Strongly agree	40	47.1
Agree	37	43.5
Undecided	8	9.4

VARIABLE	FREQUENCY	PERCENTAGE
Adequacy of Room(s)		
Strongly agree	37	43.5
Agree	43	50.6
Undecided	4	4.7
Disagree	1	1.2
Consulting room provided enough privacy		
Strongly agree	39	45.9
Agree	39	45.9
Undecided	6	7.1
Disagree	1	1.2
Availability of portable water	FREQUENCY	PERCENTAGE

Strongly agree	35	41.2
Agree	43	50.6
Undecided	5	5.9
Disagree	2	2.4
Availability of PPE materials	FREQUENCY	PERCENTAGE
Strongly agree	45	52.9
Agree	33	38.8
Undecided	5	5.9
Disagree	2	2.4
Availability of toilet		
Strongly agree	35	41.2
Agree	44	51.8
Undecided	4	4.7
Disagree	2	2.4

Perceptions of care quality showed that 55.3% agreed and 35.3% strongly agreed about the provision of seats for relaxation, with 7.1% undecided and 2.4% in disagreement. In terms of empathy, compassion, and support, 45.9% agreed and 43.5% strongly agreed, while 7.1% were undecided and 3.5% disagreed. For competent clinical examinations, 50.6% strongly agreed and 42.4% agreed, with 3.5% undecided and 1.2% in disagreement. Adequate information on illness management was agreed upon by 47.1% and strongly agreed by 43.5%, but 7.1% were undecided and 2.4% disagreed. Clearly stated appointments/follow-ups garnered 49.4% strong agreement and 44.7% agreement, while 5.9% were undecided. Adequate drug usage information was agreed upon by 49.4% and strongly agreed by 44.7%, with 4.7% undecided and 1.2% in disagreement. Motivation to seek healthcare further saw 54.1% agreement and 42.4% strong agreement, while 2.4% were undecided and 1.2% disagreed. Satisfaction with time spent with providers stood at 48.3% agreement and 47.1% strong agreement, with 5.9% undecided. Satisfaction levels with treatment, care, waiting time, prescription of drugs, good diagnosis, availability and quality of drugs, recovery/cure, cost adequacy, and payment arrangements exhibited similar patterns.

Regarding physical accessibility, 52.9% strongly agreed and 43.5% agreed, with 3.5% undecided. The adequacy of doctors (54.1% agreement, 40% strong agreement), nurses (47.1% strong agreement, 45.9% agreement), other health workers (48.2% strong agreement, 42.4% agreement), medical equipment (47.1% strong agreement, 43.5% agreement), and adequate rooms (50.6% agreement, 43.5% strong agreement) demonstrated comparable trends.

Consulting room privacy saw 45.9% strong agreement and 45.9% agreement, with 7.1% undecided and 1.2% in disagreement. Availability of portable water (50.6% agreement, 41.2% strong agreement) and PPE materials (52.9% strong agreement, 38.8% agreement) followed suit. Availability of toilets had 51.8% agreement and 41.2% strong agreement, with 4.7% undecided and 2.4% in disagreement

DISCUSSION

The findings from this study indicate a high level of agreement among respondents regarding the availability of various healthcare services. Control of Communicable Diseases, Child Survival, Maternal and Newborn Care, Health Education, and Immunization were confirmed by all participants, achieving a 100% agreement rate. Similarly, services related to Nutrition and Non-Communicable Diseases were affirmed by 98.8% of respondents, which aligns with a study by Oyebade et al., who reported similar high awareness levels of maternal and newborn care services. This heightened awareness of maternal and newborn care services, immunization services, and health education, as well as community mobilization services, might be attributed to their significant emphasis at the primary healthcare level. Additionally, the moderate literacy level of the respondents, with many having some form of education, could contribute to this awareness.

In terms of center utilization, the majority attended health centers regularly. Specifically, 30.6% attended always, 37.6% very often, and 27.1% often. However, a small percentage reported less frequent attendance, with 2.4% seldom and 2.4% never attending. The primary motivator for utilization was accessibility, which included short distance and positive health worker attitudes, accounting for 49.4%. Affordability, health worker availability, and service quality were also factors, though to a lesser extent. However, these findings contrast with a study by Amedari et al (2021), where a higher percentage of respondents considered the facility accessible in terms of physical distance.

Regarding the perception of healthcare provider quality of care, participants' responses varied. For instance, perceptions of courteous greetings had strong agreement from 69.4% and agreement from 30.6% of respondents. Similarly, being treated respectfully, friendliness, and competence all garnered substantial agreement. However, these results differed from studies by Oyebade et al (2022) and Rashmi and Rasheeve (2015). In terms of physical accessibility, 52.9% strongly agreed and 43.5% agreed, with 3.5% undecided. Adequacy of healthcare staff, medical equipment, rooms, consulting room privacy, availability of portable water, PPE materials, and toilets all demonstrated comparable trends. Satisfaction levels with various aspects of healthcare service delivery, such as treatment, care, waiting time, drug prescription, diagnosis, drug availability, recovery, cost adequacy, and payment arrangements, indicated that quality of care was perceived as fair. These findings are in contrast to studies in India and Nigeria that reported higher levels of satisfaction in certain areas (Ogaji et al, 2016; Rashmi and Rasheeve, 2015).

CONCLUSION AND RECOMMENDATION

In conclusion, the study on the perception of quality of care in primary health centers (PHCs) in Ilesa East Local Government, Osun State, has shed light on the multifaceted nature of healthcare service delivery at the grassroots level. The findings reveal a mixed perception among the community members regarding the quality of care provided at these PHCs. While some respondents expressed satisfaction with certain aspects of the services, others highlighted areas of concern that require immediate attention. It is evident from the study that factors such as healthcare staff behavior, infrastructure, availability of medicines, waiting times, and overall patient experience play significant roles in shaping the perception

of quality of care. Community members' opinions are influenced not only by their personal encounters with the PHCs but also by broader societal expectations and the media's portrayal of healthcare services. Based on the study's findings, the following recommendations are suggested to improve the perception of quality of care in primary health centers in Ilesa East Local Government, Osun State:

1. Strengthen Healthcare Workforce: Emphasize continuous training and professional development for healthcare staff, focusing not only on medical expertise but also on communication skills, empathy, and patient-centered care.
2. Infrastructure Enhancement: Invest in upgrading and maintaining the physical infrastructure of PHCs, ensuring that facilities are well-equipped, clean, and conducive to providing quality healthcare services.
3. Medication Availability: Implement effective inventory management systems to ensure a consistent supply of essential medicines and medical supplies. Address stockouts and shortages promptly to instill confidence in the healthcare system.

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