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ASSESSMENT OF QUALITY OF CARE IN PRIMARY HEALTH CARE FACILITIES IN ILORIN WEST LOCAL GOVERNMENT AREA, KWARA STATE

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ABSTRACT

This study assesses the quality of care in Primary Health Care (PHC) facilities in Ilorin West Local Government Area (LGA), Kwara State, Nigeria, focusing on service delivery, infrastructure, and patient-provider dynamics. A mixed-methods approach was employed, combining cross-sectional surveys of 240 service users and focus group discussions with healthcare providers across six PHC facilities. Key findings reveal high patient satisfaction (81.7% rated care as "excellent"), attributed to courteous providers, short waiting times, and accessible services. However, challenges persist, including shortages of drugs, equipment, and staff (particularly during night shifts), inadequate follow-up care (40.4% reported no post-treatment follow-up), and gaps in emergency preparedness. The study highlights the critical role of government support, continuous training, and community engagement in strengthening PHC systems. Recommendations include increased funding, institutionalized audits, expanded staffing, and formalized patient feedback mechanisms to align services with Universal Health Coverage (UHC) goals and Sustainable Development Targets (SDGs).

***Keywords**: Primary Health Care, Quality of Care, Patient Satisfaction, Healthcare Accessibility, Nigeria.*

Introduction

Universal Health Coverage (UHC) aims to ensure all individuals access necessary healthcare without financial hardship, emphasizing equity and efficiency (Ranabhat et al., 2023). Primary Healthcare (PHC) serves as the cornerstone of health systems, advancing health equity and improving population health outcomes (van Weel and Kidd, 2018). In Nigeria, the National Primary Health Care Development Agency introduced the Ward Minimum Health Care Package to standardize PHC services, including maternal and child health, disease management, and health education (Abubakar et al., 2022). Patient satisfaction is a key indicator of healthcare quality, influencing health-seeking behavior and treatment compliance (Manzoor et al., 2019). Studies in Nigeria report low patient satisfaction due to poor communication, long waiting times, and inadequate infrastructure (Ndibuagu et al., 2020).

Despite PHC's critical role, concerns about care quality persist. In Rivers State, patients expressed dissatisfaction with medication communication (Ogaji et al., 2016). In Calabar, higher literacy and income correlated with lower satisfaction (Okeke et al., 2019). Globally, Community Health Centers in Vietnam play a central role in quality care, though integration with private clinics is needed (Hoa et al., 2019). Nigeria accounts for 19% of global maternal deaths, with only 36% of births occurring in health facilities (WHO, 2018). Therefore, assessing PHC quality is crucial.

The Donabedian model guides this study, assessing quality through structure (infrastructure, staffing), process (caregiver-patient interaction), and outcomes (patient satisfaction) (Ayanian and Markel, 2016). The Serviqual model adds tangibles, reliability, responsiveness, assurance, and empathy (Pakurár et al., 2019). PHC in Nigeria began with the Basic Health Services concept in 1975, with national policy launched in 1988 (Oluwasogo and Sebutu, 2020; Aregbesola and Khan, 2017). Availability refers to presence of essential services and personnel, while accessibility means obtaining services without cost, geographic, or cultural barriers (WHO, 2020).

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Essential services include preventive, curative, promotive, rehabilitative, and referral services (WHO, 2021).

Provider knowledge, attitudes, and practices significantly influence care quality. Studies found that 62% of Nigerian providers knew hypertension guidelines, but only 35% knew recommended treatments (Adamu et al., 2022). Provider attitudes matter: 72% demonstrated positive attitudes toward maternal health, but 28% expressed dissatisfaction due to resource constraints (Okeke et al., 2021). Regarding practices, 70% adhered to ANC guidelines, but 30% failed due to inadequate equipment (Eze et al., 2022). Challenges to quality include infrastructure deficits, equipment shortages, understaffing, inadequate funding, high out-of-pocket costs, limited health literacy, cultural beliefs, weak referral systems, lack of standardization, and poor accountability (Haq, 2016; Aregbeshola and Khan, 2020; Berkman et al., 2011; Tunis et al., 2018).

Empirical studies reveal mixed findings. Saric et al. (2021) found improvements in Albanian PHC following intervention. Ogah et al. (2024) reported promising practices in Nigeria but noted absence of assessment teams in 71.3% of facilities. Saka et al. (2020) found a gap between expectations and perceptions of quality in Kwara State. Oyebade and Oshineye (2022) found that good provider attitude was the most motivating factor for PHC utilization. Akinyinka et al. (2019) found a significant correlation between perceived quality and client satisfaction. Esomonu et al. (2022) reported high satisfaction following the Basic Healthcare Provision Fund in Nigeria. This study aims to assess the quality of care in primary health care facilities in Ilorin West LGA, Kwara State.

Methodology

Research Design

The study employed a qualitative and quantitative research design to evaluate the quality of care provided in primary health care facilities. This design was suitable for capturing the current status and perspectives of healthcare users at a specific point in time, enabling the identification of trends and gaps in service delivery.

Study Area

This study was carried out in Ilorin West Local Government Area (LGA) of Kwara State. Ilorin West LGA lies within 4°28′10″E, 8°34′28″N and 4°35′35″E, 8°24′09″N. It has a total land area of approximately 105 square kilometers and a population of 364,666 as at the 2006 census, with a population density of 3,501 per square kilometer. Ilorin West serves as the host for the state capital administrative headquarters. The LGA consists of twelve electoral wards: Adewole, Ajikobi, Alanamu, Badari, Baboko, Magaji-Ngeri, Ogidi, Oko-erin, Oloje, Ojuekun/Sarumi, Ubandawaki, and Wara/Osin/Egbejila (Oloko-oba et al., 2016). The LGA has twelve Primary Health Care Centres, including Agbaji Health Centre, Adewole Basic Healthcare Centre, Ubandawaki Primary Healthcare (Pakata), Oko-Erin Health Centre, Egbejila Health Centre, Osin-Aremu Health Centre, Magajingeri Health Centre, Ero-oma Health Centre, and Oloje Primary Healthcare Centre.

Target Population

The target population was divided into two main groups: healthcare providers and service users. Healthcare providers included doctors, nurses, community health workers, and other relevant staff working in the selected PHC facilities, as they directly influence the quality of healthcare services. Service users consisted of adults aged 18 years and older who accessed healthcare services at the PHC facilities during the data collection period, as their perspectives are essential for understanding overall satisfaction and service quality.

Sample Size Determination

The minimum sample size for this study was determined using the formula for sample size determination for descriptive studies (Araoye, 2003). The minimum sample size calculated was 219 respondents. After accounting for an anticipated non-response rate of 10%, the minimum sample size was 240 respondents.

Sampling Method

A multistage sampling technique was employed to select participants. In Stage 1, six wards (Adewole, Alanamu, Omoda, Pakata, Oloje, and Magaji Ngeri) were randomly selected by balloting without replacement. In Stage 2, PHC facilities within Ilorin West LGA were selected based on accessibility, operational status, and patient utilization rates. In Stage 3, questionnaires were allocated equally across the selected PHC facilities to ensure balanced representation. In Stage 4, a simple random sampling technique was used to select service users from each PHC facility using patient registers. In Stage 5, for healthcare providers, a qualitative approach using

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Focus Group Discussions (FGDs) was adopted, with at least 3–5 healthcare providers purposively selected from each of the six facilities. In Stage 6, service users were stratified based on the type of healthcare services accessed, including maternal health, child health, and general outpatient services.

Instrument for Data Collection

Data were collected using a structured questionnaire and a Focus Group Discussion (FGD) guide. The instrument was divided into five sections. Section A focused on socio-demographic characteristics. Section B assessed the availability and accessibility of healthcare services and infrastructure. Section C evaluated the knowledge, attitudes, and practices of healthcare providers through FGDs. Section D captured service users' perceptions of the quality of care. Section E focused on identifying challenges and barriers to providing quality care. The questionnaire and FGD guide were written in English and translated into Yoruba to accommodate local language preferences.

Inclusion Criteria

Healthcare providers were included if they were actively working at the selected PHC facilities in Ilorin West LGA, including doctors, nurses, community health officers, and other relevant staff, and had been employed for at least six months at the facility. Service users were included if they had visited a PHC facility within the past three months, received at least one healthcare service, were 18 years or older, and were able to provide informed consent.

Exclusion Criteria

Healthcare providers on leave or not actively working, as well as those with less than six months of service, were excluded. Service users who had not visited a PHC facility in the past three months, who visited for non-healthcare reasons, were under 18 years of age, or were unable to provide informed consent were also excluded.

Validity of the Instrument

The validity of the questionnaire and FGD questions was ensured through expert review. The instrument was reviewed by the researcher's supervisor and experts in public health, healthcare management, and healthcare quality, who provided feedback on relevance, clarity, and comprehensiveness. The questionnaire was revised accordingly to align with the study's objectives.

Reliability of the Instrument

Reliability was assessed through a pilot study conducted with 10% of the target sample size (30 respondents) in Ilorin South LGA, Kwara State. Cronbach's alpha coefficient was calculated, yielding a value of 0.85, indicating strong internal consistency and reliability for use in the main study.

Ethical Considerations

Ethical approval was obtained from the Ethics Committee of the Ministry of Health, Kwara State. Written informed consent was obtained from all participants, outlining the study objectives, their right to privacy and confidentiality, and the voluntary nature of participation. Participants were informed of their right to withdraw at any time without repercussions. All personal data were anonymized and securely stored in locked files and encrypted electronic devices.

Procedure for Data Collection

Data collection was conducted over six weeks by the researcher and trained research assistants. Separate spaces were provided for healthcare providers and service users to complete questionnaires without disruption. Service users were approached during routine outpatient visits, while healthcare providers completed questionnaires in a separate quiet area. Research assistants were trained to administer questionnaires neutrally, clarify questions without influencing answers, and ensure accurate data recording.

Method of Data Analysis

Data were entered into SPSS version 25.0 for analysis. Descriptive statistics (frequencies, percentages, means, and standard deviations) were used to summarize demographic characteristics. Inferential statistics, specifically the Chi-square test, were employed to examine associations between healthcare provider factors and quality of care. A p-value of ≤ 0.05 was considered statistically significant.

Results

Table 4.1: Socio-demographic Characteristics (For Service Users)

Variable	Category	Frequency	Percentage (%)
Age Group	18–25	31	12.9
	26–35	132	55.0

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	36–45	69	28.7
	46–55	7	2.9
	56 and above	1	0.4
Gender	Female	235	97.9
	Male	5	2.1
Highest Level of Education	No formal education	30	12.5
	Primary education	44	18.3
	Secondary education	120	50.0
	Tertiary education	46	19.2
Marital Status	Divorced	2	0.8
	Married	230	95.8
	Single	8	3.3
Occupation	Civil servant	20	8.3
	Farmer	3	1.3
	Others	38	15.8
	Student	8	3.3
	Trader	155	64.6
	Unemployed	16	6.7
Main Source of Income	Business	199	82.9
	Family support	15	6.3
	Farming	2	0.8
	Government assistance	1	0.4
	Salary	23	9.6
Health Insurance Coverage	No	212	88.3
	Yes	28	11.7
Frequency of PHC Visit	Monthly	148	61.7
	Occasionally	24	10.0
	Only when sick	46	19.2
	Weekly	22	9.2
Health Facility Attended	Adewole Basic Health Care Center	40	16.7
	Primary Healthcare Alanamu	40	16.7
	Basic Health Care Center Omoda	40	16.7
	Magaji Ngeri Primary Healthcare	40	16.7
	Primary Health Care Center Ubandawaki (Pakata)	40	16.7
	Oloje Basic Healthcare Center	40	16.7

The socio-demographic analysis of 240 service users showed that most respondents (55.0%) were aged 26–35 years, followed by those aged 36–45 years (28.7%). Females constituted the vast majority (97.9%). Half of the respondents had secondary education (50.0%), while 19.2% had tertiary, 18.3% primary, and 12.5% no formal education. Most were married (95.8%). Trading was the most common occupation (64.6%), and business was the primary income source (82.9%). The majority lacked health insurance (88.3%). Monthly PHC visits were most frequent (61.7%), and respondents were evenly distributed across the six health facilities (16.7% each).

Table 4.2: Availability and Accessibility of Essential Healthcare Services and Infrastructure

Variable	Category	Frequency	Percentage (%)
Availability of essential healthcare services	Excellent	200	83.3
	Fair	1	0.4
	Good	39	16.3
Healthcare facility easily accessible from residence	Maybe	6	2.5

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	No	2	0.8
	Yes	232	96.7
Adequate transportation to PHC facility	Maybe	3	1.3
	No	4	1.7
	Yes	233	97.1
PHC facility offers weekend services	Maybe	10	4.2
	No	3	1.3
	Yes	227	94.6
PHC facility open during evening hours	Maybe	9	3.8
	No	2	0.8
	Yes	229	95.4
Cleanliness and maintenance of PHC facility	Excellent	184	76.7
	Fair	3	1.3
	Good	52	21.7
	Poor	1	0.4
Adequate medical supplies and equipment at PHC facility	Maybe	33	13.8
	No	12	5.0
	Yes	195	81.3
Pharmacy available within PHC facility	No	9	3.8
	Yes	231	96.3
Laboratory service available at PHC facility	No	1	0.4
	Yes	239	99.6
Waiting time at PHC facility	Average	45	18.8
	Long	1	0.4
	Short	96	40.0
	Very short	98	40.8

Analysis of Table 4.2 shows favorable perceptions of healthcare availability and accessibility. Most respondents rated the availability of essential services as excellent (83.3%). Nearly all affirmed that facilities were easily accessible (96.7%), with adequate transportation (97.1%), weekend services (94.6%), and evening hours (95.4%). Cleanliness was rated excellent by 76.7%. Adequacy of medical supplies was confirmed by 81.3%. Pharmacy and laboratory services were available to 96.3% and 99.6% respectively. Waiting time was described as very short or short by 80.8%.

Table 4.3: Knowledge of the Service Users on the Available Services

Variable	Category	Frequency	Percentage (%)
Health education provided during consultations	No	2	0.8
	Yes	238	99.2
How healthcare providers assess health needs	By physical examination	10	4.2
	Through interviews	16	6.7
	Both	213	88.8
	None of the above	1	0.4
Receipt of follow-up services after treatment	No	97	40.4
	Yes	143	59.6
Perception of government support for healthcare provision	Neutral	11	4.6
	Supportive	90	37.5
	Very supportive	139	57.9

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PHC facility equipped for emergencies	No	64	26.7
	Yes	176	73.3
Frequency of referral to higher health institutions	Frequently	7	2.9
	Never	178	74.2
	Occasionally	20	8.3
	Rarely	35	14.6
Conduciveness of PHC work environment for quality care	No	34	14.2
	Yes	206	85.8
How healthcare providers stay up-to-date clinically	Attending training	145	60.4
	No specific strategy	74	30.8
	Peer review	12	5.0
	Reading medical journals	9	3.8

Table 4.3 shows high awareness of PHC services among respondents. Nearly all (99.2%) reported receiving health education during consultations. Most (88.8%) understood that health needs are assessed through physical examination and interviews. Follow-up services were received by 59.6%, while 40.4% did not. The majority viewed government support as very supportive (57.9%) or supportive (37.5%). Most (73.3%) believed PHC facilities are equipped for emergencies. Regarding referrals, 74.2% had never been referred. A majority (85.8%) agreed the PHC environment is conducive for quality care. On clinical updates, 60.4% reported providers attend training, while 30.8% indicated no specific strategy.

Table 4.4: Healthcare Provider Factors – Service Users' Perceptions of the Quality of Care

Variable	Category	Frequency	Percentage (%)
Overall quality of care received	Excellent	196	81.7
	Good	44	18.3
Healthcare providers are courteous and respectful	No	4	1.7
	Yes	236	98.3
Healthcare providers spend enough time during consultations	No	2	0.8
	Yes	238	99.2
Satisfaction with information received about health condition	Neutral	3	1.2
	Satisfied	32	13.3
	Very satisfied	205	85.4
Professionalism of healthcare providers	Excellent	228	95.0
	Good	12	5.0
Comfort discussing health concerns with providers	No	3	1.2
	Yes	237	98.8
Providers are attentive to concerns during visits	No	1	0.4
	Yes	239	99.6
Belief in effectiveness of treatments provided	Yes	240	100.0
Privacy and confidentiality at PHC facility	Excellent	232	96.7
	Good	8	3.3
PHC facility is equipped to provide quality care	No	22	9.2
	Yes	218	90.8

Table 4.4 shows overwhelmingly positive perceptions of care quality. The majority rated overall quality of care as excellent (81.7%), with the remainder rating it as good (18.3%). Nearly all respondents agreed that providers are

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courteous and respectful (98.3%) and that enough time was spent during consultations (99.2%). Most were very satisfied (85.4%) or satisfied (13.3%) with information provided about their health condition. Professionalism was rated excellent by 95.0%. Comfort during interactions was high (98.8%), and all respondents believed in treatment effectiveness (100%). Privacy and confidentiality were rated excellent by 96.7%. Most (90.8%) believed PHC facilities are adequately equipped for quality care.

Table 4.5: Challenges and Barriers to Providing Quality Care

Variable	Category	Frequency	Percentage (%)
Challenges faced in receiving quality care	Inadequate training	2	0.8
	Lack of medical equipment	14	5.8
	Lack of support from government	28	11.7
	Other	170	70.8
	Poor infrastructure	26	10.8
Challenges related to essential medicines availability	No	210	87.5
	Yes	30	12.5
Challenges from staffing shortages	No	199	82.9
	Yes	41	17.1
Infrastructural challenges affecting delivery of care	No	184	76.7
	Yes	56	23.3
Lack of adequate funding for the PHC facility	No	162	67.5
	Yes	78	32.5
Communication barriers with healthcare providers	No	229	95.4
	Yes	11	4.6
Challenges with access to technology or equipment	No	201	83.8
	Yes	39	16.3
Local community contributes to PHC challenges	No	211	87.9
	Yes	29	12.1
PHC adequately supported by local government	No	40	16.7
	Yes	200	83.3
Cultural/societal barriers to accessing healthcare	No	218	90.8
	Yes	22	9.2

Table 4.5 highlights challenges to quality care. The most reported challenge was "Other" issues (70.8%). Other barriers included lack of government support (11.7%), poor infrastructure (10.8%), lack of medical equipment (5.8%), and inadequate training (0.8%). Challenges with essential medicines were reported by 12.5%, staffing shortages by 17.1%, and infrastructural issues by 23.3%. Lack of adequate funding was noted by 32.5%. Communication with providers was not a concern for 95.4%. Access to technology challenges were reported by 16.3%. Most (83.3%) believed PHC facilities are adequately supported by local government. Cultural or societal barriers were identified by only 9.2%.

Test for Hypothesis

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Table 4.6: Association between Socio-Demographic Characteristics and Overall Quality of Care at PHC Facilities

Variable	Category	Overall Quality of Care at PHC Facilities		Chi-Square (χ^2)	P-value
		Excellent (n=196)	Good (n=44)		
Age Group	18–25	25 (80.6%)	6 (19.4%)	3.315	0.507
	26–35	110 (83.3%)	22 (16.7%)		
	36–45	56 (81.2%)	13 (18.8%)		
	46–55	4 (57.1%)	3 (42.9%)		
	56 and above	1 (100.0%)	0 (0.0%)		
Gender	Female	192 (81.7%)	43 (18.3%)	0.009	0.922
	Male	4 (80.0%)	1 (20.0%)		
Education Level	No formal education	21 (70.0%)	9 (30.0%)	3.249	0.355
	Primary education	36 (81.8%)	8 (18.2%)		
	Secondary education	100 (83.3%)	20 (16.7%)		
	Tertiary education	39 (84.8%)	7 (15.2%)		
Marital Status	Divorced	1 (50.0%)	1 (50.0%)	3.156	0.206
	Married	187 (81.3%)	43 (18.7%)		
	Single	8 (100.0%)	0 (0.0%)		
Occupation	Civil servant	14 (70.0%)	6 (30.0%)	5.686	0.338
	Farmer	2 (66.7%)	1 (33.3%)		
	Other	30 (78.9%)	8 (21.1%)		
	Student	7 (87.5%)	1 (12.5%)		
	Trader	132 (85.2%)	23 (14.8%)		
	Unemployed	11 (68.8%)	5 (31.2%)		
Main Source of Income	Business	164 (82.4%)	35 (17.6%)	3.247	0.517
	Family support	13 (86.7%)	2 (13.3%)		
	Farming	2 (100.0%)	0 (0.0%)		
	Govt assistance	1 (100.0%)	0 (0.0%)		
	Salary	16 (69.6%)	7 (30.4%)		
Health Insurance	No	172 (81.1%)	40 (18.9%)	0.347	0.556
	Yes	24 (85.7%)	4 (14.3%)		
PHC Visit Frequency	Monthly	119 (80.4%)	29 (19.6%)	12.056	**0.007**
	Occasionally	15 (62.5%)	9 (37.5%)		
	Only when sick	44 (95.7%)	2 (4.3%)		
	Weekly	18 (81.8%)	4 (18.2%)		
Facility Attended	Adewole Basic Health Care Center	30 (75.0%)	10 (25.0%)	71.020	**0.000**
	Primary Healthcare Alanamu	37 (92.5%)	3 (7.5%)		
	Basic Health Care Center Omoda	38 (95.0%)	2 (5.0%)		
	Magaji Ngeri Primary Healthcare	39 (97.5%)	1 (2.5%)		
	Primary Health Care Center Ubandawaki (Pakata)	37 (92.5%)	3 (7.5%)		

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	Oloje Basic Healthcare Center	15 (37.5%)	25 (62.5%)

P-values <0.05 showed statistically significance association

able 4.6 shows the association between socio-demographic characteristics and perceived quality of care. No significant associations were found for age (p = 0.507), gender (p = 0.922), education (p = 0.355), marital status (p = 0.206), occupation (p = 0.338), income source (p = 0.517), or health insurance (p = 0.556). Therefore, the null hypothesis was accepted for these variables.

However, frequency of PHC visits was significantly associated with quality of care (χ^2 = 12.056; p = 0.007). Respondents who visited only when sick reported the highest excellent care ratings (95.7%), leading to rejection of the null hypothesis. Facility attended was also highly significant (χ^2 = 71.020; p = 0.000). Magaji Ngeri (97.5%), Omoda (95.0%), and Alanamu and Ubandawaki (92.5%) had the highest excellent ratings, while Oloje had the lowest (37.5% excellent, 62.5% good).

Focus Group Discussion Results

Adewole Basic Health Care Center

Staff defined quality care as the consistent delivery of safe, effective, and patient-centered services guided by standard operating procedures (SOPs). Regular trainings, both clinical and interpersonal, were described as energizing rather than routine. However, persistent shortages of drugs, lab kits, and staff, especially during peak days required improvisational tactics such as borrowing supplies and personally assisting patients with transport. Formal feedback systems were lacking, though patient gratitude significantly boosted morale. Staff emphasized the need for institutionalized audits, improved cold-chain infrastructure, and expanded workforce capacity.

Magaji Ngeri PHC

Health workers demonstrated a deep commitment to procedural rigor, routinely practicing evidence-based hygiene and treatment protocols. Motivation stemmed from patient trust and health improvements, with one illustrative case of health rebound following renewed adherence. Cultural barriers sometimes hampered care delivery, requiring sustained community education and respectful family dialogue. Despite receiving some government support, the center's drug supply and infrastructure were inadequate. Respondents recommended deeper Ministry of Health engagement and stronger community-health partnerships.

Omoda PHC

Veteran staff stressed continuous adherence to evidence-based guidelines, reinforced by external seminars and mentorship. Patient feedback and positive outcomes motivated providers, while inadequate drug and diagnostic supplies remained persistent obstacles. Despite recognition of government supervisory visits, the absence of regular material support weakened service consistency. Staff advocated for more predictable logistics and infrastructure upgrades to translate their clinical dedication into dependable outcomes.

Ubandawaki (Pakata) PHC

Discussions emphasized protocol adherence, continuous training, and clear patient communication. Providers reported using clinical judgment and follow-ups to compensate for unavailable diagnostic tools. Gratitude from patients reinforced morale, while inconsistent supplies and inadequate staffing challenged care quality. Participants proposed enhancing audit systems, engaging community stakeholders, and prioritizing laboratory capacity-building.

Alanamu PHC

Quality was defined by patient satisfaction and outcome achievement, correct diagnoses, effective treatments, and respectful communication. Staff adhered to standard protocols supported by digital and in-person training. However, persistent staff shortages, especially at night, led to fatigue and safety concerns. Providers recommended institutionalizing peer reviews, strengthening monitoring, and improving infrastructure (e.g., cold-chain equipment, private consultation rooms).

Oloje PHC

Providers emphasized the accessibility, effectiveness, and safety of care, including ANC, immunizations, and lab diagnostics. Annual training (2–12 times) refreshed both technical and communication skills, reinforcing ethical responsibility. Nonetheless, chronic equipment and staffing gaps led to triaging or patient referrals. Clean

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environments, kind communication, and follow-ups helped sustain patient trust. Government support, while visible in staff postings, was inadequate for addressing supply deficits.

Discussion

This study assessed the quality of care in selected PHC facilities in Ilorin West LGA, Kwara State, Nigeria.

Socio-demographic characteristics showed that PHC utilization is highest among young and middle-aged adults (55.0% aged 26–35 years), with females representing 97.9% of respondents, reflecting women's predominant role in seeking reproductive health services. Half had secondary education, 95.8% were married, and trading was the most common occupation (64.6%). Only 11.7% had health insurance. Monthly visits were most frequent (61.7%). These findings align with Okeke et al. (2019) and Jimoh et al. (2019), who reported similar age and gender distributions in Nigerian PHC settings.

Availability and accessibility of services were rated excellent by 83.3% of respondents. Nearly all found facilities easy to reach (96.7%) with adequate transportation (97.1%). Extended hours, cleanliness, and medical supplies were rated highly. Waiting times were short for 80.8%. While earlier studies reported constrained PHC readiness (Garba et al., 2017; Adeoye & Olukoya, 2017), our findings suggest supply-side improvements in the surveyed facilities.

Service awareness and continuity: Nearly all respondents (99.2%) confirmed health education during consultations, and 93.5% understood comprehensive needs assessment. However, only 59.6% received follow-up care. Government support was viewed as supportive by 95.4%, and 73.3% acknowledged emergency preparedness. Referral frequency was low (74.2% never referred). These findings compare favorably with Adeusi et al. (2019) and Ogah et al. (2024).

Provider performance received exceptionally positive ratings, with 81.7% rating overall care as excellent. Courtesy and respect (98.3%), sufficient consultation time (99.2%), clear communication (98.7%), and treatment efficacy (100%) were highly rated. Privacy and confidentiality were rated excellent by 96.7%. These findings align with Umoke et al. (2020) and Jibril et al. (2024), though Ogunfowokan and Mora (2012) highlighted that long waiting times dampen satisfaction, contrasting with our efficient patient flow.

Barriers to quality care included unlisted issues (70.8%), lack of government support (11.7%), poor infrastructure (10.8%), and insufficient equipment (5.8%). While most did not report medicine shortages (87.5%) or staffing deficits (82.9%), 32.5% felt PHC facilities were underfunded. These barriers align with national assessments (The Guardian, 2025; Premium Times, 2025; Ajibade et al., 2023).

Focus group discussions revealed that staff define quality care as safe, effective, and patient-centered. Persistent shortages of drugs, equipment, and staffing were reported, leading to improvisational strategies. Formal feedback mechanisms were absent, though spontaneous gratitude boosted morale. Staff called for institutionalized audit loops, improved supply chains, and expanded human resources. Government support was described as inconsistent. These findings corroborate Owolabi, Oladejo, and Adeomi (2016) and Abdulraheem, Olapegba, and Adeoye (2024).

Conclusion

This study on the Assessment of Quality of Care in Primary Health Care Facilities in Ilorin West LGA, Kwara State, provides valuable insights into the strengths and weaknesses of the healthcare system. Service users generally rated the quality of care received at PHC facilities as excellent or good. Factors contributing to this positive perception included respectful and professional healthcare providers, effective treatment, short waiting times, clean facilities, and the availability of essential services such as health education, laboratory services, and pharmacy support. The study revealed that PHC facilities in Ilorin West are largely accessible, with most respondents reporting that the facilities are easy to reach and that transportation is adequate. Extended service hours during evenings and weekends further enhanced access, aligning with key objectives of primary health care. Service users demonstrated a high level of awareness regarding available services and how care is delivered. However, gaps were noted in areas such as follow-up care and emergency preparedness, suggesting a need for improvement in continuity and comprehensiveness of care. Healthcare providers were perceived as courteous, attentive, and competent. Focus group discussions further highlighted their commitment to quality care. However, recurring issues, such as shortages of drugs, medical supplies, staff (particularly during night shifts), and inadequate infrastructure continue to limit the full realization of high-quality service delivery.

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Despite visible efforts from staff, findings pointed to irregular and often inadequate support from government agencies. Formal systems for feedback, supervision, and performance auditing were largely absent, weakening mechanisms for continuous quality improvement. The study underscores the importance of institutionalizing regular training, improving supply chains, upgrading infrastructure (especially cold-chain and diagnostic equipment), increasing staffing levels, and integrating formal patient feedback and audit systems into PHC operations.

Recommendations

To the Government

1. The government should allocate more funds to the primary healthcare sector to ensure the steady provision of drugs, diagnostic equipment, and infrastructural upgrades. This includes cold-chain equipment, laboratory facilities, and private consultation rooms.
2. Institutionalize routine facility audits and supervisory visits to monitor quality indicators, adherence to protocols, and infrastructure conditions.
3. Address staff shortages, especially during night shifts and in laboratory services, by employing more skilled personnel and providing incentives to retain them.
4. Fund continuous professional development programs covering both clinical skills and soft skills to keep healthcare workers updated on best practices.
5. Launch and promote inclusive community health insurance schemes to reduce out-of-pocket spending and improve healthcare access among vulnerable populations.

To Healthcare Institutions

1. Implement mechanisms such as patient satisfaction surveys and suggestion boxes to gather and analyze service users' input and improve service delivery.
2. Develop more reliable and efficient procurement and distribution systems for drugs, consumables, and diagnostic tools to reduce frequent shortages.
3. Ensure that all PHC centers adhere to national SOPs and clinical guidelines for consistent care delivery.

To Public Health Authorities

1. Lead community sensitization campaigns to improve awareness and use of available PHC services, especially among underrepresented groups like men and the elderly.
2. Strengthen health education and promotion components of PHC by providing educational materials and training for staff on effective health communication.

To Healthcare Providers

1. Continue to uphold courteous communication, empathy, and respect for patients' privacy and dignity, as these factors strongly influence patient satisfaction and trust.
2. Take personal initiative to attend trainings, peer reviews, and access credible medical literature to stay current with clinical knowledge and innovations.
3. Document and follow up on treatments effectively and refer patients timely when higher-level care is needed.

To Community Leaders and Organizations

1. Community-based organizations should advocate for the use of PHC services and dispel myths or cultural beliefs that deter people from seeking care.
2. Collaborate with PHC centers to provide volunteer support, mobilize local donations, or facilitate transportation for patients in need.
3. Participate actively in health campaigns such as immunizations, antenatal care sensitization, and hygiene promotion to extend the PHC facility's outreach.

To Individuals (Service Users)

1. Individuals should adopt proactive health-seeking behaviors, attending facilities for routine check-ups and not just when sick.
2. Engage in health education sessions provided during visits and share knowledge within their households and communities.
3. Patients should offer feedback to PHC staff and management, when possible, to contribute to service improvement and accountability.

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