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Implementation of Patient Service Standards at Tawiri Community Health Center, Ambon City: A Qualitative Study of Medicine Availability, Waiting Time, and Patient Experience

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ABSTRACT

This study examined the implementation of patient service standards at Tawiri Community Health Center, located in Laha, Teluk Ambon District, Ambon City, Indonesia. A descriptive qualitative approach was used, with interviews, observations, and document review involving 14 informants: one center head, three health workers, and ten outpatients. The original fieldwork was reported in January 2026. Findings indicated that health workers generally provided courteous explanations and sought to maintain patient safety, while medicine availability, peak-hour queues, limited medical staffing, and uneven workloads constrained service consistency. Administrative records described 42 personnel, including one general practitioner, and a network of community-based service points. Positive patient experiences were associated with respectful communication, but favorable impressions did not eliminate delays or medicine shortages. The findings suggest that the implementation of service standards depends on the alignment of frontline conduct with staffing, pharmaceutical supply, work scheduling, and facility readiness. Targeted improvements in inventory coordination, patient-flow management, workforce deployment, and routine feedback are recommended. The study does not provide statistical waiting-time or satisfaction estimates.

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INTRODUCTION

Primary healthcare centers (Puskesmas) translate Indonesia's commitments to accessible public services into routine encounters between residents and health workers. The quality of those encounters depends both on the behavior of staff and on institutional conditions that make reliable care possible. A clinic may have formal hours, personnel assignments, and written procedures yet still be unable to deliver predictable services when essential medicines are unavailable, patients arrive in concentrated periods, or too few clinicians are available for urgent and routine needs. Evaluating service standards therefore requires attention to the relationship between administrative arrangements and the patient experience.

In Indonesia, public service standards form part of the government's responsibility to provide clear procedures and accountable services. Law Number 25 of 2009 sets out the broader public-service framework. For primary healthcare, Ministry of Health Regulation Number 19 of 2024 governs the organization of Puskesmas and emphasizes infrastructure, health personnel, service delivery, management, and quality improvement. These regulatory expectations establish the importance of

adequate organizational arrangements but do not, by themselves, establish that every individual clinic consistently meets its service commitments.

The community-health-center setting poses distinct organizational challenges. In one facility, outpatient consultations, emergency responses, maternal and child health activities, preventive outreach, pharmacy functions, and reporting responsibilities may compete for the same people and space. Patient flows fluctuate by hour and day, while medicine procurement and distribution may depend partly on decisions above the facility level. A service standard must remain operational across these different circumstances, not only when staffing, supplies, and demand are favorable.

Empirical research has linked patients' assessments of healthcare to responsiveness, interpersonal communication, physical facilities, and the reliability of service processes. An Indonesian study of outpatient service quality at Puskesmas Kabanjahe found relationships between SERVQUAL dimensions and patient satisfaction (Sirajuddin et al., 2026). A separate primary-care study reported that waiting time and perceived staff competence were associated with patient satisfaction and loyalty (Hapsari et al., 2026). These studies help frame questions about the patient experience, but their quantitative findings cannot be transferred directly to a small qualitative case study in Ambon.

Operational resources are an equally important element of service quality. Fanda et al. (2024), using national facility evidence, documented challenges in the availability of essential medicines across Indonesian primary healthcare centers. Their subsequent study emphasized the role of local pharmaceutical systems in explaining variation in medicine availability (Fanda et al., 2026). These findings indicate that medicine stockouts should be examined as management and supply-system problems rather than attributed automatically to the attitude or competence of a single health worker.

Previous studies also suggest that quality improvement relies on the organization of work. Limato et al. (2019), in qualitative research at three Indonesian Puskesmas, highlighted the importance of teamwork, shared purpose, and institutional support for improvement activities. Lewis et al. (2023) found that better-performing facilities in several low- and middle-income health systems were associated with stronger management and community engagement. The two studies differ in scale and design, but both draw attention to the organizational conditions under which frontline staff can provide competent care.

Tawiri Community Health Center serves coastal communities in the Teluk Ambon area, including Tawiri, Laha, and Hative Besar. The underlying thesis reported complaints about medicines, waiting times, staffing distribution, and equipment, alongside accounts of courteous personnel and useful medical explanations. This combination is analytically significant: positive service encounters may coexist with resource shortages and uneven service continuity. An examination limited to patient satisfaction could obscure these operational constraints, while an examination limited to staff numbers could undervalue the role of respectful communication.

The present article converts a 2026 undergraduate qualitative study by Nur Intan into an academic manuscript focused on three empirical dimensions: medicine availability, waiting time, and patient experience. It asks how patient service standards are implemented at Tawiri Community Health Center, what factors support implementation, and which organizational constraints limit consistency. The contribution is a bounded account of the interaction between personnel practices, service flow, and material resources in one municipal primary-care facility. It does not claim a statistically representative assessment of all Ambon Puskesmas or a formal regulatory compliance audit.

RESEARCH METHODS

The research employed a descriptive qualitative design. The original study was conducted at Tawiri Community Health Center, located in Negeri Laha, Teluk Ambon District, Ambon City, Maluku Province, Indonesia. Its empirical focus was the application of patient service standards in everyday care. The underlying material consisted of interview accounts, field observations, documentary descriptions of service facilities and personnel, and the researcher's narrative interpretation. No experimental intervention, standardized patient-satisfaction scale, or quantitative waiting-time audit was reported.

The source thesis specified 14 informants: one community health center head, three health workers, and ten outpatient service users. Selection was based on their involvement in the service process and familiarity with the clinic. Interviews discussed medicine supply, the responsiveness of care, work allocation, queue experiences, communication, and perceived satisfaction. Several quoted interviews were dated 15 January 2026. Because the published manuscript is derived from the thesis rather than a new round of fieldwork, no additional participants or observations have been introduced.

Qualitative analysis followed the stages described in the thesis: data collection, reduction, display, and conclusion drawing or verification. For manuscript development, reported evidence was organized under three patient-facing themes and a cross-cutting institutional theme. The three themes—medicine availability, waiting time, and perceived service quality—were treated as the operational indicators used by the original research, rather than being incorrectly represented as the four-variable implementation model of Edward III. The article distinguishes direct interview accounts and administrative figures from analytical interpretations.

Triangulation in the source study was described as comparison between interviews, observation, and documentary materials. However, complete interview transcripts, a time-stamped observation log, and formal ethics documentation were not supplied with the two Word files. Accordingly, this article does not claim independent verification of each account or statistical saturation. Interview excerpts are translated from Indonesian into English and attributed only by the participant codes available in the source. Any ambiguous reference to another facility was excluded from the facility-specific interpretation.

The original thesis includes staff-composition and facility-network tables. These descriptive figures are reproduced selectively because they provide context for service capacity. They should not be interpreted as staffing-adequacy ratios: the documents do not contain the patient volume, clinical workload by profession, or coverage indicators required to assess staffing standards comprehensively. Similarly, patients' descriptions of waiting do not establish average, median, or maximum waiting times for the clinic.

Table 1 Composition of Research Informants

Informant category	Number	Role in the research
Community health center head	1	Management and oversight perspective
Health workers	3	Frontline service delivery and workload
Outpatient service users	10	Experiences of medicines, queues, and communication
Total	14	Qualitative informants

Source: Informant table in the 2026 undergraduate thesis; translated and reformatted for this article.

RESULTS AND DISCUSSION

Facility profile and capacity context

The original research places Tawiri Community Health Center within the Ambon municipal primary-care network. Its service area includes coastal settlements with different geographic and social characteristics. The institution reportedly provides outpatient care, emergency care, maternal and child health services, immunization, nutrition and environmental-health programs, disease prevention, and community outreach. This scope creates multiple service pathways requiring both scheduled and unscheduled staff availability.

Administrative figures in the thesis recorded 42 employees: six men and 36 women. By professional or educational category, the records listed one general practitioner, 12 bachelor-qualified nurses, 11 diploma-qualified midwives, five diploma-qualified nurses, three public-health graduates, three nutrition personnel, three higher-diploma midwives, two pharmacy graduates, one dental nurse, and one laboratory analyst. Rows for dentists, pharmacists, and sanitarians contained dashes rather than positive counts. These figures describe a particular reported staffing inventory and should not be treated as an independently audited roster or as proof that every listed role was available in every shift.

The facility network table also identified two auxiliary health posts, two village maternity posts, one village health post, nine Posyandu, and one mobile health unit. Although these service points

support outreach, their presence also implies coordination needs across the health center's catchment area. The thesis does not document the operational readiness or service coverage of each unit. This distinction matters when interpreting the adequacy of the available workforce: an aggregate number of staff gives less information about service capacity than the distribution of specific competencies across clinical hours and locations.

Table 2 Staff Composition Reported for Tawiri Community Health Center

Staff category or qualification	Reported number
General practitioner	1
Bachelor-qualified nursing personnel	12
Diploma-qualified nursing personnel	5
Bachelor-level public health personnel	3
Bachelor-level pharmacy personnel	2
Higher-diploma midwifery personnel	3
Diploma-qualified midwifery personnel	11
Diploma-qualified nutrition personnel	3
Dental nursing personnel	1
Laboratory analyst	1
Dentist, pharmacist, environmental health officer	No positive count reported
TOTAL (categories with counts)	42

Source: Tawiri Community Health Center staffing table reproduced in the thesis (2026). A dash in the original was retained as "no positive count reported."

Table 3 Community-Based Service Points Reported in the Study Area

Type of service point	Reported number
Auxiliary community health center (Pustu)	2
Village maternity post (Polindes)	2
Village health post (Poskesdes)	1
Integrated community health post (Posyandu)	9
Mobile health center unit	1

Source: Facility-network table in the source thesis; figures are descriptive, not an audit of functionality.

Medicine availability: service commitment under supply constraints

Medicine availability emerged as a central difficulty in the source interviews. The head of the community health center described the supply as sometimes incomplete and explained that staff contacted the Health Office when particular medicines ran out. This statement indicates an established escalation channel, but it does not show whether requests were fulfilled within a specified period or whether stockout events were systematically recorded. The original thesis did not provide commodity-level stock cards, replenishment intervals, or the proportion of prescriptions fully dispensed.

Patients did not describe all parts of the service negatively. One patient indicated that the doctor explained the illness but that medicine shortages remained a problem. This account distinguishes the quality of the consultation from the capacity to complete treatment at the point of service. A clinical encounter can therefore be informative and respectful while still leaving patients uncertain about whether the prescribed medication will be available. In service-standard terms, adequate information and adequate supply are complementary rather than interchangeable achievements.

Frontline staff also recognized the interaction between supplies and equipment. A health worker involved in urgent care reportedly tried to provide quick, safe treatment but referred to incomplete instruments and inadequate space as constraints. In the context of emergency care, readiness depends on what is available at the time of patient arrival, not merely on whether an equipment inventory or request procedure exists. The evidence does not establish frequency or clinical consequences of these shortages, and it should not be read as an estimate of adverse events.

National research provides a useful comparison without replacing the local evidence. Fanda et al. (2024) documented uneven availability of essential medicines across Indonesia, showing that the Tawiri concerns belong to a wider policy domain of primary-care pharmaceutical access. Fanda et al. (2026) further examined how facility- and district-level pharmaceutical-system features relate to medicine availability. Their findings support interpreting supply continuity through the interaction of planning, inventory management, local coordination, and distribution, but this case cannot determine which of those mechanisms explains each Tawiri stockout.

An actionable implication is to monitor medicine availability with more precise indicators than a general judgment of "complete" or "incomplete." The center and relevant Health Office could track essential items unavailable at the dispensing point, dates of requisition and delivery, and the number of patients referred elsewhere for medicines. None of these metrics was collected in the supplied thesis, so they are proposed administrative improvements rather than results. Monitoring them would make it possible to distinguish sporadic disruption from recurring supply-system failure and prioritize corrective action.

Waiting time: uneven demand and staff deployment

Waiting time was the second recurring theme. Several respondents described longer queues in the morning and quicker service later in the day. One patient reported arriving around 08:00 and waiting approximately half an hour because many people came at once. Another observed that personnel were already present when morning queues formed. These accounts suggest that the concentration of arrivals, rather than late staff attendance alone, sometimes produced delay. They do not establish the facility's average waiting time, because no systematic time-and-motion measurements were reported.

Other accounts pointed to intermittent staff readiness and access to clinicians. A patient described an instance when the relevant health worker had only just arrived; another said that obtaining a doctor or nurse could require an additional call. In contrast, a respondent described arriving at approximately 07:45 and being examined shortly after 08:00. These contrasting reports are analytically useful because they indicate variation by circumstance and service point. They should not be flattened into either a universal claim of punctuality or a universal claim of delay.

Management respondents discussed clearly distributed tasks and shift arrangements for evenings, weekends, and emergency cases. Yet frontline workers described covering multiple responsibilities and assisting colleagues when demand rose suddenly. Midwifery services, in particular, were described as requiring rapid response to unplanned deliveries at night or on holidays. The existence of a formal shift schedule did not necessarily eliminate the need for additional work during peaks. The source accounts therefore point to a mismatch between predictable administrative allocations and variable clinical demand.

Workload was not solely clinical. A health worker explained that attending to several patients while completing daily reports divided attention and reduced time for individual care. Reporting is necessary for public accountability, but it can create operational pressure when administrative tasks are scheduled during the busiest service periods. A distinction is needed between inadequate total staffing and suboptimal distribution of available staff: the thesis provides evidence of perceived overload but lacks service-volume and workload measurements sufficient to isolate either cause.

Comparable empirical research reinforces the importance of patient flow. Ariska et al. (2025) reported that registration waiting time and access to online services were among the weaker components of satisfaction at a public health center. Istiqamah and Dahlan (2026) documented persistent waiting-time problems in a separate Puskesmas. Hapsari et al. (2026) showed significant relationships between waiting time, perceived competence, and patient satisfaction in another Indonesian primary-care setting. Because these investigations used other samples and designs, they illuminate possible mechanisms rather than providing numerical estimates for Tawiri.

Service improvement should therefore begin with simple measurement: arrival time, registration completion, entry to consultation, pharmacy completion, and the reason for exceptional delays. The center could then identify which process contributes most to waiting during morning peaks. Staff reassignment or staggered clinic sessions may be useful, but recommendations should be tested against actual hourly arrivals, professional competency requirements, and emergency readiness. Installing a digital queue by itself would not solve a shortage of clinical capacity or essential medicines.

Patient experience: satisfaction and the limits of positive encounters

The interviews also contained favorable assessments of frontline conduct. One patient described prompt care for a feverish child and valued the nurse's explanation of the illness and home management. Another reported that staff answered medicine-related questions patiently even when the queue was

long. A further respondent emphasized regular checks and explanations about how to take medication. These narratives are consistent in identifying understandable communication, courtesy, and responsiveness as valued features of the service.

Positive experiences, however, did not imply uniformly adequate service conditions. A patient could be satisfied with explanations and respectful treatment while still experiencing delayed consultation or incomplete medicine supply. The underlying thesis frequently described satisfaction in qualitative terms, but it did not administer a validated satisfaction instrument or provide a response distribution for the 10 outpatient informants. Accordingly, this article uses "positive patient accounts" rather than claiming a measured satisfaction rate or a statistically high level of satisfaction.

The distinction accords with broader healthcare-quality research. Sirajuddin et al. (2026) identified associations between reliability, responsiveness, assurance, empathy, tangibles, and satisfaction in an Indonesian Puskesmas sample. Bustamante et al. (2024) examined service-quality gaps in Ecuadorian primary care, illustrating that the quality patients perceive encompasses both interpersonal and structural elements. The Tawiri material offers qualitative support for examining these domains together but cannot estimate their relative statistical importance.

Professional conduct was likewise described in terms of effort and commitment. A nurse reported continuing to prioritize patient comfort and safety despite operational limitations. Another health worker described trying to explain procedures slowly and clearly while becoming overwhelmed when many patients arrived at once. These narratives show a potential tension between professional motivation and system constraints. Staff dedication may help protect patient experience temporarily; it cannot replace a reliable medicine supply or sustainable task distribution.

This distinction matters for management. A positive attitude should be recognized as an organizational asset, but administrators should avoid using positive patient feedback as evidence that shortages have been resolved. Conversely, the presence of a queue or medicine shortage should not automatically be interpreted as neglect by frontline staff. Meaningful service evaluation requires paired information about the patient's encounter and the institutional conditions affecting that encounter.

Cross-cutting factors: leadership, coordination, and operational resilience

The study identified experienced personnel, established task descriptions, teamwork, and basic government support as potential implementation strengths. Interviews referred to mutual assistance among health workers during heavy demand. This informal flexibility helped continue care when unexpected patient arrivals or urgent events placed pressure on scheduled staffing. However, repeated reliance on additional shifts could also become a sign of a capacity problem if it occurred regularly. The source did not supply overtime, fatigue, or staffing-compliance records, so the longer-term sustainability of these practices remains uncertain.

Leadership appeared through decisions about task assignments, service opening times, and requests for supplies. These managerial actions connect institutional arrangements with service quality. Limato et al. (2019) similarly emphasized collective engagement and teamwork in primary-healthcare improvement, while Lewis et al. (2023) associated stronger facility management with better clinical performance across several countries. The Tawiri evidence is narrower, but it illustrates how local managerial processes can shape the reliability of otherwise well-intentioned frontline practices.

A recurring implementation challenge was the relationship between an internal facility and external support systems. Medicine distribution, referral arrangements, training opportunities, and financing cannot all be decided by the staff serving patients at the point of care. When accountability for quality remains concentrated at the frontline while key inputs depend on higher-level actors, improvement requires clear escalation, tracking, and feedback arrangements. This is an institutional interpretation supported by the reported requests for medicines and by the division of service responsibilities; it is not a claim that a particular external agency caused any documented delay.

The reported staffing profile also suggests why a headline count may be misleading. Forty-two employees were recorded, but the professional categories included only one general practitioner. Availability for a particular clinical service depends on specialty, shift, leave, simultaneous

emergencies, and service-network demands. A workforce study should therefore estimate staff hours and required tasks before concluding that recruitment alone will solve a problem. For Tawiri, the documents establish reported staffing composition and narratives of overload, not a validated staffing-deficit calculation.

Synthesis of qualitative evidence and managerial responses

Table 4 synthesizes the field accounts into practical questions for service managers. It deliberately separates the reported observations from proposed corrective measures. This approach avoids presenting recommendations as if they had already been implemented or evaluated at the facility.

Table 4 Qualitative Findings and Potential Service-Management Responses

Domain	Reported observation	Potential management response
Medicine supply	Some prescribed medicines were unavailable; the center reportedly requested replenishment from the Health Office.	Track stockouts, requests, deliveries, and unresolved prescriptions.
Waiting time	Morning queues and variable staff readiness were described; no complete time series was reported.	Measure patient-flow stages and adjust workload distribution during peaks.
Patient experience	Patients valued clear explanations and respectful staff; complaints about delays and medicines persisted.	Combine patient feedback with process and resource indicators.
Workforce and readiness	42 employees reported, including one general practitioner; staff described overlapping duties.	Review competency coverage, shifts, emergency readiness, and administrative workload.
Facility environment	Some staff described limited equipment or space in particular service encounters.	Prioritize a documented equipment and room-readiness assessment.

Source: Analytical synthesis of interview accounts, facility tables, and conclusions in Nur Intan's 2026 thesis. Responses are proposals, not observed interventions.

The three patient-facing themes point to a common implementation problem: formal service standards must be matched to the resources and operational processes that allow personnel to meet them consistently. Patients encounter the clinic as a sequence of interactions—arrival, registration, examination, medicines, and sometimes referral. Weakness at any point can compromise the practical value of otherwise appropriate professional conduct. For this reason, a service-standard evaluation should consider both the conduct of individual encounters and the continuity of the entire pathway.

First, pharmaceutical continuity requires joint attention to inventory data, prescribing needs, and the timing of distribution. A periodic report that simply labels stocks adequate or inadequate is less useful than a record of how long each essential medicine was absent and what alternative arrangements were made for patients. The national evidence from Fanda et al. (2024, 2026) provides a rationale for examining local supply systems, but Tawiri-specific improvement should be based on its own verified stock data.

Second, the service schedule should be evaluated against demand by hour and type of consultation. The qualitative evidence points to more congestion in the morning and additional pressure during unscheduled emergency and maternal-care events. Separating emergency, routine, and administrative workloads for planning purposes could help prevent the accumulation of tasks in the same time window. Yet a schedule adjustment should be judged through actual wait-time observations and staff availability, not on the assumption that all delays have the same cause.

Third, patient information and feedback should be incorporated into operational evaluation. The interview material illustrates how carefully delivered explanations influence patients' impressions, including when resources are constrained. A simple and consistent method for recording whether patients understood treatment, obtained medicines, and experienced an unresolved delay would allow management to recognize positive interpersonal conduct while detecting problems that satisfaction comments alone might conceal.

Fourth, continuous improvement requires shared ownership. Staff should be able to report equipment or supply constraints without treating such reports as individual failure. Managers need sufficient information to prioritize action, and relevant government units must receive follow-up feedback on requests that exceed the center's authority. Shahnazi et al. (2021) showed that communication and self-efficacy training could support service quality in primary healthcare; however,

training should complement rather than substitute for adequate physical resources and operational coordination.

Finally, any policy claim should remain proportional to the evidence. This study is a single-site qualitative account based on a limited number of informants. The source material does not establish the frequency of shortages, the statistical distribution of patient waits, a formal patient-satisfaction score, or clinical outcomes. Some descriptive passages in the original thesis contain inconsistent location references and were not used to infer additional facts about Tawiri. These limits do not invalidate the narratives, but they mean that the article's recommendations should be tested and monitored locally before generalized to other facilities.

The administrative implications are particularly relevant to coastal primary-care settings where routine services coexist with outreach, emergency events, and fluctuating patient flow. The case suggests that "compliance" cannot be inferred solely from the presence of a standard operating procedure or from broadly favorable patient attitudes. Effective implementation requires a service organization capable of handling variable demand, responding to resource constraints, and generating data that can guide specific improvements rather than general expressions of commitment.

Operationalizing service-standard monitoring in a municipal clinic

An important practical lesson of the case is that a qualitative judgment such as "the service is good" needs to be tied to observable dimensions before it can guide management. Different actors may reasonably apply different criteria. A patient who receives a clear explanation may evaluate the encounter favorably, while a pharmacist may focus on whether the full prescription can be dispensed and a manager may consider whether all service units opened according to schedule. These perspectives are complementary. A monitoring framework that aggregates them without preserving their differences risks overlooking recurring problems.

For pharmaceutical access, service managers could establish a small operational dashboard based on the essential medicine list, periodic physical stock verification, prescription fulfillment, and the duration of stockouts. Recorded data should be linked to the date a request was sent and the date new supplies arrived. Such a record would distinguish a delayed order, an unexpectedly high level of use, and a mismatch between demand and forecasting. It would also create an evidence base for discussing operational problems with the Health Office without asserting that any specific actor was responsible before the process was documented.

For patient-flow monitoring, each service stage requires an unambiguous definition. The duration between arrival and registration is different from the duration between completed registration and examination, which in turn differs from the time required to obtain medicines. The thesis does not provide a time-series dataset, and a patient's recollection of a queue cannot substitute for one. A small observational audit across ordinary mornings, less busy sessions, and selected weekend or emergency periods would provide a stronger basis for comparing staffing schedules with the times at which demand arises.

For workforce deployment, an assessment should consider simultaneous tasks rather than the aggregate headcount alone. Even when a facility has many employees, a clinical service may depend on a limited number of people with specific authority or qualifications. Administrators can map service obligations against available staff hours, including outreach, documentation, pharmacy tasks, and the coverage required for urgent cases. Where repeated overlap is identified, the response may involve better scheduling, task redistribution within professional scopes, administrative simplification, or a documented request for additional personnel. The source material does not allow one of these options to be identified as sufficient on its own.

Patients should also have an accessible way to report concerns that are distinct from general satisfaction. A short feedback form or structured service conversation could ask whether instructions were understood, medicines were received, waiting was acceptable, and a follow-up pathway was clear when the service could not be completed. Quyen et al. (2021) examined outpatient satisfaction using health-facility assessment data from Vietnam, demonstrating the value of explicit patient-experience

measurement. The Tawiri interviews suggest relevant questions, but their small purposive sample should not be presented as an estimate of the broader patient population.

A useful management cycle would review these indicators regularly with staff, identify one limited corrective action, specify who is responsible, and examine whether the problem changes afterward. This cycle should allow patient narratives and administrative data to challenge each other. If staff report an equipment shortage but stock records suggest equipment is present, the next question concerns location, usability, or shift-level access. If patient waiting is long despite timely staff attendance, arrival patterns and bottlenecks deserve closer attention. Such learning is more actionable than concluding that all shortcomings arise from insufficient commitment.

Finally, evaluations of service standards should consider the institutional context in which the facility works. Staff may be accountable for patient communication and safe practice, whereas procurement, staffing authorization, and major renovation are not necessarily fully under their control. Zakkar et al. (2021) described how healthcare providers and administrators interpret patient-experience evidence within wider institutional priorities. The Tawiri case similarly demonstrates why performance dialogue must separate actions within the clinic's direct authority from issues that require decisions elsewhere in the municipal health system. Improved documentation can make both categories visible and support proportionate accountability.

CONCLUSION

The qualitative evidence indicates that Tawiri Community Health Center had functioning elements of patient service standards, especially professional commitment, respectful communication, defined responsibilities, and attempts to maintain routine and emergency services. Patients reported positive interactions with health workers, including explanations of illness and medication, but also described prolonged queues and occasional problems obtaining medicines. Interview accounts and administrative records pointed to constraints in supply continuity, clinician availability for particular services, equipment, space, and the distribution of workload across peak hours and shifts. These findings support a balanced assessment: valued interpersonal care and uneven operational capacity existed simultaneously. Improvement priorities are systematic medicine-stock monitoring, evidence-based patient-flow management, competency-sensitive staff scheduling, facility-readiness reviews, and routine feedback linking the health center with the relevant Health Office. Future studies should complement these qualitative findings with direct time measurements, medicine-availability records, and broader patient-satisfaction data.

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