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The Influence of Primary Health Care Training on Health Workers and the Community: A Case Study of Esan West Local Government Area, Edo State

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Abstract

The rate of poor health care delivery services in Nigeria has been a major problem in the Nigerian Health Sector consuming so much thoughts and rigorous policies that have been set in place to curb its trending limitations. The sermons of development have become so ear irritating as so much has been said, discussed on the news, platforms, name it, but yet the problems are still persistent and on daily basis land mosquito-like bites on the minds of those who struggle daily to cope and still hope for development somewhere, somehow. This was a study intervention to determine the awareness level of Primary Health Care (PHC) training in Esan west L.G.A of Edo state, Nigeria. This study also investigated the influence of these training both previous and present on the quality of health care services provided in the health care centres also assessing the problems and providing possible tackling mechanisms to curbing these problems in the Esan West Local Government Area. This study involved the use of questionnaires to assess the individual perception of the PHC training. 300 questionnaires were randomly handed out to the respondents present at the PHC training and analysed afterwards. This study however highlighted some of the distinctive problems tail dragging the delivery services in the primary health care centres in Esan West Local Government area of Edo state, Nigeria. Evaluating from majority opinion carried out in this study, the primary health care trainings had not been really conducted/felt in the community, as commencement of these health care programs will bring about an improvement in the health care delivery services as well as improve the rate of tackling diseases conditions in the community.

Keywords: Health care training; Limitations; Tactical approach; Health care delivery

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Introduction

Primary Health Care (PHC) is an important and fundamental aspect of the health programmes and institutions present in Nigeria. However, it has had the worse attention and consideration, and man power for a very long time. In 2008, the World Health Organization (WHO) [1] suggested a reasonable redeployment and reorganization of responsibilities as well as duties among the available health workforce teams. They also suggested the increment in the strength of health workers in all aspects of health facilitating as they are short on manpower [2,3]. In the Nigeria, these duties have been restricted to just the doctors and nurses and sometimes the lab scientists. This has even spread as far as the entire black continent, Africa limiting if not excluding the functional capabilities and capacities of other health practitioners such as the physiologists, the pharmacists, the biochemists among others. This eye sore in the black continent had become a major concern of three studies as nurses had problems even administering their skills in the prescription realms of health service whereas the Nursing Act meant to secure their rights to maximum utilization of their skills remains overwhelmingly indecisive and capsuled by fear

of the unknown [1,4,5]. Together with the indecisive nature of the Nursing acts as well as other legal functions of other health care personnel, the issue of slow or no accreditation processes seems to wrap the thorn lace around the necks of the health sector in general. Surely progress is seen with the ambient control of the doctors and the nurses, but this progress I say is "irritatively" slow with little or no impact on the general health welfare of the community. When it boils down to the treatment of diseases, in Africa, only quantified calibres of health care givers are readily available. This could be due to deprivation from active participation by some conniving forces or personalities or the poor educational prowess of these larger faction of health care givers. Majority of the town folks would grumble endlessly about the active participation of the governments of Africa in the restructuring of the health care sectors, but surely grumbles land on plain stone. Concerned and affected folks have voiced and agitated for government intervention putting forward letters, appeals and petitions, but still they only get the end of the box reply. The educational system set aside for training health care providers at the basic and tertiary levels have put in their possible best to produce the quality but frustration had yielded most of the results and graduates who pool out of these institutions are inadequately equipped. In many other countries, we observe that lower-level nursing and clerical tasks, health education, as well as counselling and testing have been farmed out to an array of community caregivers, whether volunteers, workers or even patients themselves.

The ball and chain question further arises, we have poorly equipped health personnel in Nigeria, who then do we adapt or perhaps inculcate into the health sector? Stakeholders have insistently dwelt endlessly on this issue culminating in a series of PHC trainings for these poorly equipped PHC personnel. The PHC training had promised to proffer multi-skilling techniques which would enable PHC personnel become pro-active and competent in their delivery services, regardless of the PHC levels they operate in. However, another bone of contention had sprung up as PHC personnel are not even aware of these trainings and have not had the ample opportunities to benefit from such many PHC training programmes.

More so, there is still the prevalence of PHC personnel shortages consequently due to the factors mentioned above (poorly equipped PHC personnel and inadequate awareness) which limits efficiency in PHC sectors of Nigeria. In 2000, an extensive study carried out by the Department of Health had made provision for revisions regarding the entitlement of a large number of professional groups including the nursing assistants as well as a whole herds of other levels of PHC personnel [6].

Aim of the Study

The purpose of this study was to ascertain the awareness of health care training in the community as well as the influence of these trainings on both the health workers and the quality of services they render towards the community in Esan West Local Government Area, Edo state, Nigeria. This study also carried out an extensive study on some of the problems facing PHC as well as limitations and possible solutions to making PHC service delivery an enjoyable and feasible aspect of the Nigerian economy.

PHC standards in Nigeria

Over the years now, the requisite of standard and even though not too unique settings in the PHC services has become a round table concern. "According to the World Health Organization" Heidemann [7] reported that the purpose of setting up PHC standards as an indelible instrument in PHC services management was to instinctively attempt to attain the highest and premier quality of PHC within the constraints of available resources. In their words, standards should provide a degree of competency in practical and acceptable ways in villages, rural areas and even in urban settlements.

Loads of comprehensive documents have been endlessly produced for PHC in Nigeria, but still, the standards for PHC is not making head ways. However, an overview of Ogundeji's [8] work, that the first ever methodical attempt at formulating as well as determining some articulate objective system to develop the standards for establishing the status of PHC services in Nigeria as earlier stated by the Regional Office for Africa [9]. Among his records were:

- The WHO Minimum District Health Package document [10].
- The Basic Health Services Scheme contained in the Nigerian experience document [10].
- The Draft plan of action for the delivery of the Ward Minimum Health Care Package in Nigeria [11].
- The FMOH/NPHCDA Operation Training Manual and Guidelines for PHC in Nigeria [12].
- The background and status of PHC activities by 2000 in Nigeria document [13,14].
- The NPHCDA Ward Minimum Health Care Package in Nigeria [15].
- National Strategic Health Development Plan 2010–2015 [16].

Limitations of PHC implementation in Nigeria

Briefly, I would like to note that PHC centres have been established everywhere at least if only one per town/village, yes, indeed in both rural and urban areas in Nigeria. But as Abdulraheem et al. [3] had also noted that despite the availability of PHC centres, the rural populations have been deprived of so much the benefits PHC centres promises when comparing them with those in the urban environment. From this the limitations experienced per hour basis in properly implementing PHC procedures is like an elephant's obstructing corpse.

Taking aback by the role of governments in PHC, it had been observed that they too had found it futile consequently due to lack of political desires or interest in facilitating PHC [17,18] unless it makes them noteworthy figures in the eyes of the public. There is also the common problem with the Nigerian economy, that is, inadequate funding or misappropriation of funds. The financing of for public PHC is strappingly fastened to

the flow of funds from the federal accounts. According to the Budget office of the Federation [19], funds are shared between levels of government by modus operandi scarping these funds; quarter to the 36 states in Nigeria as well as another quarter to the 774 LGAs, leading to poor productivity in the services of the PHC sectors [20]. Omoleke [21] noted in a study to inspect and further examine the management of PHC services in Nigeria, noted that the PHC was not allocated the relevant funds and this had consequently culminated in the poor performance of PHC centres as well as their utilization of these PHC facilities. There is also poor cooperation between sectors of the Nigerian economy [22] to both climb the success ladder, and last but not the least of these problems is the cat and rat relationship between the state and local governments [23]. The people as a community in general had also served as a limiting factor to the implementation of PHCs in Nigeria, by their ridiculously stagnant perception of what poor PHC provisions refer to, under-utilization of the PHC facilities even provided for them as a surrogate to pass the PHC recession time.

At community gatherings to discuss issues pertaining to their own wellbeing, the people of Nigeria are more reluctant than the snail in labour, but would instantly delve into uproarious and chaotic nuisance they religiously term “riot or protest” mostly, against the unknown. The Alma-Ata declaration acknowledged and encouraged community participation as this was the only possible or available medium families can take responsibilities for their own health and welfare as well as develop their community through their tangible contributions [24].

In an era of severe/chronic motivation ruling the world and building positive minds, there is still the coughing issue of decreased motivation in workplaces especially in the health centres due to excusable non-payments of salaries forgetting the fact that Karl Max had extensively stated that man can never be satisfied, it’s just so impossible. Even with salaries been paid extensively full, what has been the positive yield at the time? Health workers engage in unhealthy competition enshrining the workplace with the capitalist mentality which rings out a lot of limiting factors in promoting PHCs in Nigeria. It is also observed that the ‘I don’t care attitude’ (illitero-feudo-capitalist mentality) of the private health institutes have also contributed to the limiting factors of PHC growth in Nigeria. The ideology that the public health and public issues belong to the government has indeed become so fallaciously inherent that it frustratingly leads to quenching fires with gasoline. Who is the government? Bodies are not made in a day, I say confidently as the Nigerian PHC sectors have so depended on foreign donors like the UNICEF and USAID as well as other Nigerian-god-figure bodies. We can build can’t we? Common diseases that can be combated in weeks or months in Nigeria will often take decades to solve due to this extreme dependence. It is just simply pitiable and regrettably ludicrous.

Tactical approaches for improving PHC services in rural communities

Operational strategy: A comprehensive baseline survey using rapid assessment techniques should be planned, initiated and completed.

Reviewing and restructuring of PHC services: Some of the restructures and reviews include:

- Accessibility can be improved by either relocation of the existing PHC centres, or adding more centres.
- It is essential that PHC personnel are trained and re-trained to orientate people towards the concept and principles of PHC.
- The establishment of health centres to serve remote populations would be a better strategy.
- Guiding laws and regulations should be enacted for special services like immunization and reproductive health.
- Village health committee should be restructured and revitalized to include health personnel, community members, including nomadic people, and women.
- Periodic evaluation of PHC centres with regards to the impact of new health programmes and policies.
- The secondary health facilities should also have some disciplinary authority on erring PHC centres.

Community participation and involvement: It is almost universally acknowledged by national and international health planners that community participation is the key to the successful implementation of Primary Health Care (PHC). The 1978 Declaration of Alma-Ata identified community participation as 'the process by which individuals and families assume responsibility for their own health and welfare and for those of the community, and develop the capacity to contribute to their community's development [25]. This is necessary because health begins at home and in the work place. It is where people live and work that health is made or neglected. So the involvement of the community in devising health plans cannot be over-emphasized [3].

Advocacy and political support/commitment for health equity: A concern for health equity is not new in global health. Equity was central to the World Health Organization (WHO) constitution, and to the work that culminated in the Declaration of Alma Ata in 1978. Despite this, the health agenda has mostly focused on securing progress on priority challenges. Lucas and Gilles studies [26] in low and middle income countries in Africa and Asia show a stepwise increase in under-five mortality across households by wealth, with children from the poorest fifth of households more likely to die before their fifth birthday than the next poorest and so on across the distribution. Political commitment is a crucial factor in the process of policy formulation and implementation to ensure adequate services to the neglected sections of society [27]. There is the serious need for a national and premeditated approach to health education in Nigeria. Currently, the unit within the PHC responsible for health promotion needs to be supported and strengthened to discharge her responsibilities effectively. This need as noted by Morley et al. [28] can be maximally experienced when the health care centres start to envision themselves as valuable. For this, a follow up study conducted by Lucas and Gilles [26], noted that the primary health care centres need adequate, scientific and health information. The language

also for communication should be the same as that of the local people, audiovisual aids used must be produced locally and be appropriate, and finally the educational programme should be carried out by trained and experienced personnel from the locality [27].

Collaboration and partnership with other agencies: Collaboration in PHC focuses on how to create conditions for health care providers everywhere to work together in the most effective and efficient way with the aim of producing the best health outcomes. Collaboration with other related sectors in the improvement of PHC as part of total socioeconomic development is very important [3]. It has been emphasized that no sector involved in socioeconomic development, especially the health sector, can function properly in isolation [29]. Many social factors such as education, housing, transport and communications influence health [30], and so does economic factors too. Therefore, collaboration with the relevant sectors is especially important for worthwhile mutual benefits. Literacy programmes have been shown to have a great impact on equity-oriented development in rural areas [27]. The educational status of the mother plays a pivotal role in the health of the family. As maternal education among rural and nomadic groups is relatively lacking, adult educational programmes would be of great help. The mass media can contribute effectively to the dissemination of health messages to the population at large. The health sector must play a leading role in health supportive public policies. Health activities should be undertaken concurrently with such measures as the improvement of nutrition, particularly that of children and mothers. Coordination of health-related activities should be devoid of duplication [29]. Concerted efforts according to the World Health Organization [27] should be made to express how ill health and diseases are directly correlated to the prevalence of illiteracy, ailments of poverty, ignorance of poor sanitation and environmental conditions.

Supervision: The PHC centres should they were "frequently left undirected, with few or no milestones to help assess their performance, until the next supervisory visit, and motivation was hard to maintain in such an atmosphere" [31]. While most primary health care services acknowledge the need for some form of supervision, we maintain that effective (traditional) supervision has been an abject failure in most primary health care settings in developing countries. The maximizing access and quality initiative (MAQ) described supportive supervision as "a process that promotes quality at all levels of the health system by strengthening relationships within the system, focusing on the identification and resolution of problems, and helping to optimize the allocation of resources-promoting high standards, teamwork, and better two-way communication [27]." By 2001, the move away from traditional supervision had begun. Decisions were made by WHO to re-write the training modules [27]. This guideline clearly laid out the new principles of supportive supervision. While we believe these guidelines provide the basis for improving supervision in most of the developing world, there is also scope for yet more innovative approaches to supervision.

Design/Methodology/Approach

A total of three hundred (300) questionnaires were administered to randomly selected respondents consisting of both health workers and town folks in Esan West Local Government Area (EWLGA). All three hundred (300) questionnaires were finally collected from the respondents and analyzed.

Data Analysis/Discussion

From the **Table 1**, 14.7% of the respondents agreed that primary health care training had been conducted in EWLGA, while the very large majority (85.3%) of respondents either did not know what PHC training was all about or had never heard of such training in EWLGA. From the analysis above, it can then be said that primary health care training had not been conducted various parts of the local government area.

Table 2 showed that 53.3% of the respondents' interest in health care program improved and will improve after the training (if any were to be provided). However, 46.7% of the respondents' interests were not improved or will not be improved basing their arguments on actions rather than lectures. These 46.7% of the respondents argued that when there were no financial backups or provisions, these trainings will only equip the health workers with dormant skills and information that may never be put to use. They also complained that many lectures and trainings without the available resources will only make things in the health care centres shoddier.

Table 3 revealed that 93.3% of the respondent believed that primary health education affect the rate of awareness on diseases, while 6.7% did not agree. From the analysis above, it is obvious that the rate of enlightenment and campaign programmes on diseases is greatly affected by primary health education.

Table 4 indicated that 88.67% of the respondents believed that diseases are rampant in their communities due to lack or poor PHC services. On the other hand, only 11.33% did not believe that poor PHC services had increasingly persist the prevalence of diseases in their communities.

Table 5 indicated that only 27% of the respondents pointed out that there were enough qualified and experienced health care personnel in the PHCs. Whereas, 73% of the respondents implied

Table 1 Has the primary health training been conducted in your *EWLGA?

Options	No. of Respondent	Percentage %
Yes	44	14.7
No	256	85.3
Total	300	100

*EWLGA: Esan West Local Government Area, Edo State, Nigeria

Table 2 Did/Will your interest in health care improve after the training?

Options	No. of Respondent	Percentage %
Yes	160	53.3
No	140	46.7
Total	300	100

that there were not enough qualified and experienced health care personnel in the PHCs. They also argued that though there were some PHC personnel with wealth of experiences, they were not much in the PHCs and if they were much, the health care would be a better place. They also complained that even these experienced health care personnel operate their own private centres thus devoting more time to their profit based centres leaving the PHCs to the supervision of inexperienced health care personnel.

Table 6 showed that 54% of the respondents felt that the lack of equipment for effective health care delivery services in government hospitals made them treat health problems in private hospitals while some often used orthodox medications like *agbo* (a boiled concoction of mango leaves, guava leaves, cashew leaves and *dogoyaro* leaves, believed to revitalize the body's physiologic activities), *orerhio* or *oriorhio* (usually white, made from palm kernel extracts, believed to inhibit cough), *uden* (an oily cream made from palm kernel extracts, can also be warmed and taken orally for sore throat or cough) and black soap (made from palm kernel extracts, believed to disinfect the body during successive baths). There is also the use of bitter leaves *(Vernonia amygdalina)* believed to inhibit cough receptors as well as act an analgesic syrup, anti-inflammatory fluid and anticoagulants. **Table 7** showed that 57.3% of the respondents agreed that the cost of drugs and hospital bills are responsible for treating their ailments with alternative methods while 42.3% did not agree. They believed that regardless of the costs from the hospitals getting genuine drugs was ideal for their health and safety. They also argued that they'd not risk their health for petty excuses. However the 57.3% argued that alternative methods especially local and traditional methods (i.e., the use of herbs or local tinctures) were more reliant. However, most of them resorted to buying drugs on the road side from road drug sellers.

Table 3 Would you say that primary health care training programme has affected the rate of enlightenment and campaign programme on diseases?

Options	No. of Respondent	Percentage %
Yes	280	93.3
No	20	6.7
Total	300	100

Table 4 Do you think diseases are common in your communities because of poor PHC services?

Options	No. of Respondent	Percentage %
Yes	266	88.67
No	34	11.33
Total	300	100

Table 5 Are there enough qualified and experienced health care personnel in the Primary Health Centres in *EWLGA?

Options	No. of Respondent	Percentage %
Yes	81	27
No	219	73
Total	300	100

*EWLGA: Esan West Local Government Area, Edo State, Nigeria

Table 6 Do lack of equipment and facilities for effective health care delivery service in government hospitals make you treat health problems in private hospitals or use orthodox medications?

Options	No. of Respondent	Percentage %
Yes	162	54
No	138	46
Total	300	100

Table 7 Is the cost of drugs and hospital bills responsible for you treating ailments with alternative methods?

Options	No. of Respondent	Percentage %
Yes	173	57.3
No	127	42.3
Total	300	100

Table 8 indicated that a large percentage of the respondents (96.67%) agreed that lack of political desires or interest in facilitating and promoting PHC has resulted in the insistent poor delivery services in EWLGA as discussed by Olise [17] and Magawa [18]. However, 3.33% thought otherwise. **Table 9** revealed that 93% of the respondents agreed that inadequate funding as well as misappropriation of funds by the government or stakeholder had been a major cause of poor health care delivery services in EWLGA this complementing Omoleke's [21] study as well as Abimbola's [20], while 7% did not agree.

Table 10 showed that the largest number of respondent representing 67% agreed that the public has also played a role in poor health care delivery services in EWLGA. They complained that these were mainly as a result of the poor awareness programmes in the LGA as well as the illiteracy and ignorance rates amongst people of EWLGA. 33% disagreed and argued that the public had always played a role or two in promoting health care delivery services in EWLGA. Though their influence had not been excessively felt didn't mean that they had not contributed or even raised an eyebrow at the poor performances and services of the PHC in the local government area. However, **Table 11** showed that 90.3% of the respondent agreed that community participation and involvement will help promote PHC delivery services in Esan West local government area presenting a key solution to this limitation in Primary health care delivery services. They believed that when the general public contribute their own quota either as complains, suggestions and attendance in community development meetings will go a long way to improving the health care services in the community. However, 9.7% disagreed. They argued that even with their recent contributions to the health care services in the form of complains and suggestions, that only deaf ear had been the result of their efforts. They insisted that though it is very important to hope as well as cope, but they do not strongly believe their contributions mattered. This is in line with the 1978 Declaration of Alma-Ata which acknowledged community participation as 'the process by which individuals and families are able to assume total responsibility for their own health and welfare schemes as well as for those of the community, thus improving and developing the capacity to contribute to their community's health developmental strides [24]. Lately, there have been several governmental projects to

Table 8 Can you say that lack of political desires or interest in facilitating PHC has resulted in poor health care delivery services in *EWLGA?

Options	No. of Respondent	Percentage %
Yes	290	96.67
No	10	3.33
Total	300	100

*EWLGA: Esan West Local Government Area, Edo State, Nigeria

Table 9 Has inadequate funding or misappropriation of funds by the government or stakeholders led to poor health care delivery services in *EWLGA?

Options	No. of Respondent	Percentage %
Yes	279	93
No	21	7
Total	300	100

*EWLGA: Esan West Local Government Area, Edo State, Nigeria

Table 10 Has the general public played a role in poor health care delivery services in *EWLGA?

Options	No. of Respondent	Percentage %
Yes	201	67
No	99	33
Total	300	100

*EWLGA: Esan West Local Government Area, Edo State, Nigeria

Table 11 Will community participation and involvement improve PHC delivery services in *EWLGA?

Options	No. of Respondent	Percentage %
Yes	271	90.3
No	29	9.7
Total	300	100

*EWLGA: Esan West Local Government Area, Edo State, Nigeria

strengthen community participation to further improve health services in the world [32]. Community participation however was institutionalized in Nigeria via the creation of urban development committees and the rural development committees [32], bringing about evidential improvements of the types of services offered at these PHCs [3,33].

Table 12 showed that 68% agreed that less motivation in workplaces in the health centres had led to poor delivery services in the local government area. They complained that when the rewards are low they tend to work less quoting the common phrase "work like an elephant and eat like an ant", they wouldn't want to be victims of this phrase or any other similar phrases like "the monkey works hardest while the baboon eats the fattest". Others also complained that adequate facilities served as a motivation factor which was scarce in the PHC centres. This too contributed to the decreased motivation by health workers in the health centres in Esan west local government area. While they complained about scarce or little facilities, they also complained about bosses' and chief medical directors' contribution to lack of motivation. They argued that they also contributed to the reduced morale in the health centres when all they usually do was boss workers around and nag as well. However, 32% disagreed with these facts that even at that there are dedicated health workers who were hard working despite all these remuneration factors which poised a serious problem. Besides bosses were set in place to make PHC centres work despite the toes they'd step on to do so. These 32% argued that laziness on the part of the workers would compel them to argue bluntly. "What do you know? Everyone to his or her own opinions". **Table 13** indicated that 98.7% agreed that reviewing and restructuring PHC services will go a long way to help promote and improve PHC delivery services in Esan west local government area. However, 1.3% disagreed, basing their arguments on previous review and restructuring plans by the governments as well as stakeholders that have failed in previous times.

Table 14 showed that 99% of the respondents believed that the intervention of the government as well as though in political offices, monarchs and those in position of governments will help improve the PHC delivery services in the community. 1% of the respondents disagreed. They had decided to reserve their comments on why they had disagreed. Health outcomes are most likely concurrent to position in social hierarchies, illustrated by income, occupation and education, by ethnic group or by gender and to geographic location mostly prevalent in rural and urban areas. Lucas and Gilles, in an older study [26] expressed that low and middle income earning countries in Africa and Asia showed a stepwise increase in mortality rates across households whether or not they had been blessed with wealth.

Table 15 showed that 99% of the respondents believed that coordination as well as supervision by special bodies such as the UNESCO, UNICEAAF, WHO, OAU as well as the Nigerian government at both Federal, state and local levels will better improve the PHC delivery services in the community and the

Table 12 Has decreased motivation in workplaces especially in the health centres led to poor PHC delivery services in *EWLGA?

Options	No. of Respondent	Percentage %
Yes	204	68
No	96	32
Total	300	100

*EWLGA: Esan West Local Government Area, Edo State, Nigeria

Table 13 Will reviewing and restructuring of PHC services help improve PHC delivery services in *EWLGA?

Options	No. of Respondent	Percentage %
Yes	296	98.7
No	4	1.3
Total	300	100

*EWLGA: Esan West Local Government Area, Edo State, Nigeria

Table 14 Will advocacy and political support/commitment for health equity improve the PHC delivery services in *EWLGA?

Options	No. of Respondent	Percentage %
Yes	297	99
No	4	1
Total	300	100

*EWLGA: Esan West Local Government Area, Edo State, Nigeria

Table 15 Will coordination of health related activities by special bodies or the government improve PHC delivery services in *EWLGA?

Options	No. of Respondent	Percentage %
Yes	297	99
No	3	1
Total	300	100

*EWLGA: Esan West Local Government Area, Edo State, Nigeria

nation at large. 1% of the respondents had disagreed arguing that continuous dependence on the government or external or foreign bodies would rapidly increase her reliance on these bodies, thus slowing down the nation's growth process. Though biased, this 1% made some sense. Besides it was the opposition from the American government to assist Nigeria cure a deadly virus (Ebola) that Nigeria was finally able to quarantine and cure the disease in 2016. Social factors including education, housing, transportation and communications influence the health care delivery system [30]. Hegazy et al. [29], emphasized that no sector of a country's economy that indulges in socioeconomic development, especially in the health sector per se, can function appropriately on its own. Collaboration with other related sectors as noted by Abdulraheem et al. [3] in the enhancement, development and promotion of PHC as part of total socioeconomic development is indeed very imperative. They were "frequently left undirected, with few or no milestones to help assess their performance, until the next supervisory visit, and motivation was hard to maintain in such an atmosphere" [31]. This study recommends that efforts should be put in place to improve the quality and use of primary health care in Nigeria by focusing not only on providing better resources, but also on low-cost, cost-effective measures that address the process of service delivery such as supervision as stated by Ehiri et al. [34].

In this study, **Table 16** revealed that 93.7% of the respondents agreed that awareness and enlightenment programmes will contribute to improving the PHC delivery services in Esan west local government area. Whereas 6.3% of the respondents disagreed, owing to the fact that much of these programmes have been carried out but no tangible improvements thus far.

Conclusion

The PHC has a long way to go from where it is currently bench warming. Though there have been policies put in place to relieve the stress and problems faced in the health care centres in Nigeria, they appear to be snailishly implemented or sluggishly observable. This study has however highlighted some of the problems facing the primary health care centres in Esan West Local Government area of Edo state, Nigeria. Judging from public opinion, the primary health care trainings had not been really felt in the community as initiations of these health care programs will bring about an improvement in the health care delivery services as well as improve the rate of tackling diseases conditions in the community. This study recommends that more qualified and experienced health care personnel be employed and or assigned to PHC centres in the community. This study also recommends that; adequate equipment and facilities to PHC centres be provided, governments and stakeholders increase the interest in the health centres as well as look into the prices of drugs as well as the hospital bills, the public join in the movement of the PHC centres to greater heights through their voluntary supports and that the policies of the health sector nationwide be reviewed and restructured.

Table 16 Will awareness and enlightenment programmes improve the PHC delivery services in *EWLGA?

Options	No. of Respondent	Percentage %
Yes	281	93.7
No	19	6.3
Total	300	100

*EWLGA: Esan West Local Government Area, Edo State, Nigeria

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