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Availability and Accessibility of Health Information to Women in Rural Community, Elemere, Moro Local Government, Kwara State

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INTRODUCTION

Rural communities experience health disparities that are exacerbated by barriers to reliable health information.In the same way, access to this health information is critical for good health. However, residents of rural communities face more difficulties in accessing health information than residents in urban areas.This is whydwellers in the urban setting are far better than those in the rural areas in terms of information access, civilisation, poverty alleviation, and access to formal education and health care services (Obaremi and Olatokun, 2021). As opined by Ugboma (2010) that information is an important ingredient that is needed in every sphere of life endeavor especially in health matters. This is because information is key part in health improvement to individuals in provincial territories in Nigeria. By implication, getting cured of an illness is by being aware that you are sick and require treatment. In other words, information is needed to be healthy.

In Nigeria, about 65 million Nigerians are illiterate and live mostly in remote areas, thus, require urgent national attention. About 14 years after 2005 UNESCO report, the illiteracy rate in the country has remained on the increase, at 69.1% (Ann-Walker, 2019). This connotes a high inability of Nigerians, especially rural dwellers to identify, create and use printed materials (Amoo, 2018). If access to primary health care is truly a basic human right, primary health care must be brought to rural communities as are accessible to urban communities (World Health Organisation, 2020).

According to Wilson (2000), information-seeking behaviour is the purposive seeking for information as a consequence of a need to satisfy some goal. Informationseeking behaviour of an individual may be passive or active. Therefore, getting one's information needs satisfied is a function of information-seeking behaviour.According to Corragio, (2011) he stated that rural women have no time to seek information or to get into educational programs. However, even if those programs are available rural dwellersstill lack access to healthcare services generally; whereby women will have low or no information as to whom they see for treatment, and may be offered a more limited range of services than available elsewhere, one essential explanation of this observation is information poverty. The rural women are remained as unexploited national resources and the whole nation would be benefited if they are properly involved in the development activities in a planned way (Agriculture Information Service, 2004).

The uprising of providing information base on health issue to rural communities is a significant intervening with the potential to ensure that knowledge and information are very important for achieving health development. The relevance of this revolution is complemented by Balit (1996) who pointed out that the least price input for rural development is information. Also, health information to women in rural area has not been comprehensively studied in Nigeria. There is enough information to conclude that the magnitude of the problem is quite serious. In the light of this, it is imperative that we understand the nature, benefit and effect of information to health in Nigeria. The study is therefore an effort to reveal the availability and accessibility of health information to women in rural community of (Moro local government Elemere, Kwara state). This study area was chosen because it is far away from Ilorin city which is where better health services are concentrated.

Historical Background of Elemere Community

Elemere town is located at Moro Local Government Area in Kwara State, north central in Nigeria,and it is situated along Jebba road from Ilorin and at the intersection of roads from Shao. Elemere is one of the older towns in Kwara. It is traditionally said to have been founded about many years ago by two brothers (Odunbaku and Oyeyemi) that came from Oyo to Ilorin and were known as hunter warlord. The town is divided into two called Elemere oke and Elemere isale.Today, the community is been led by two leaders known as Mogaji which were Alhaji Ambali Akani and Alhaji Akani. The nearby towns includes; Shao, Asomu and Malete.

The name Elemere was derived from a strange river located in the town which was assume to be (“omi emere”) gene water, due to the scarcity of water and the hidden location which the water was found in the environment. Elemere is known for cassava produce. Cassava plantation occupies almost a quarter of the land mass, and the people of the community derive their livelihood from the business.Like in many rural regions in Nigeria (Elemere communities of Kwara state inclusive), the health status of rural families is tied to the health of the women. A woman inElemereis expected to know about primary health care, and be able to provide some first aid when the need arises, before the sick seek further assistance. Just one health centers exist in the communities. Given the large area which the individual communities (Elemere kwara state) covers and the relative large size of the population, the facilities are obviously insufficient.

fig1.Showing kwara state map in the national context

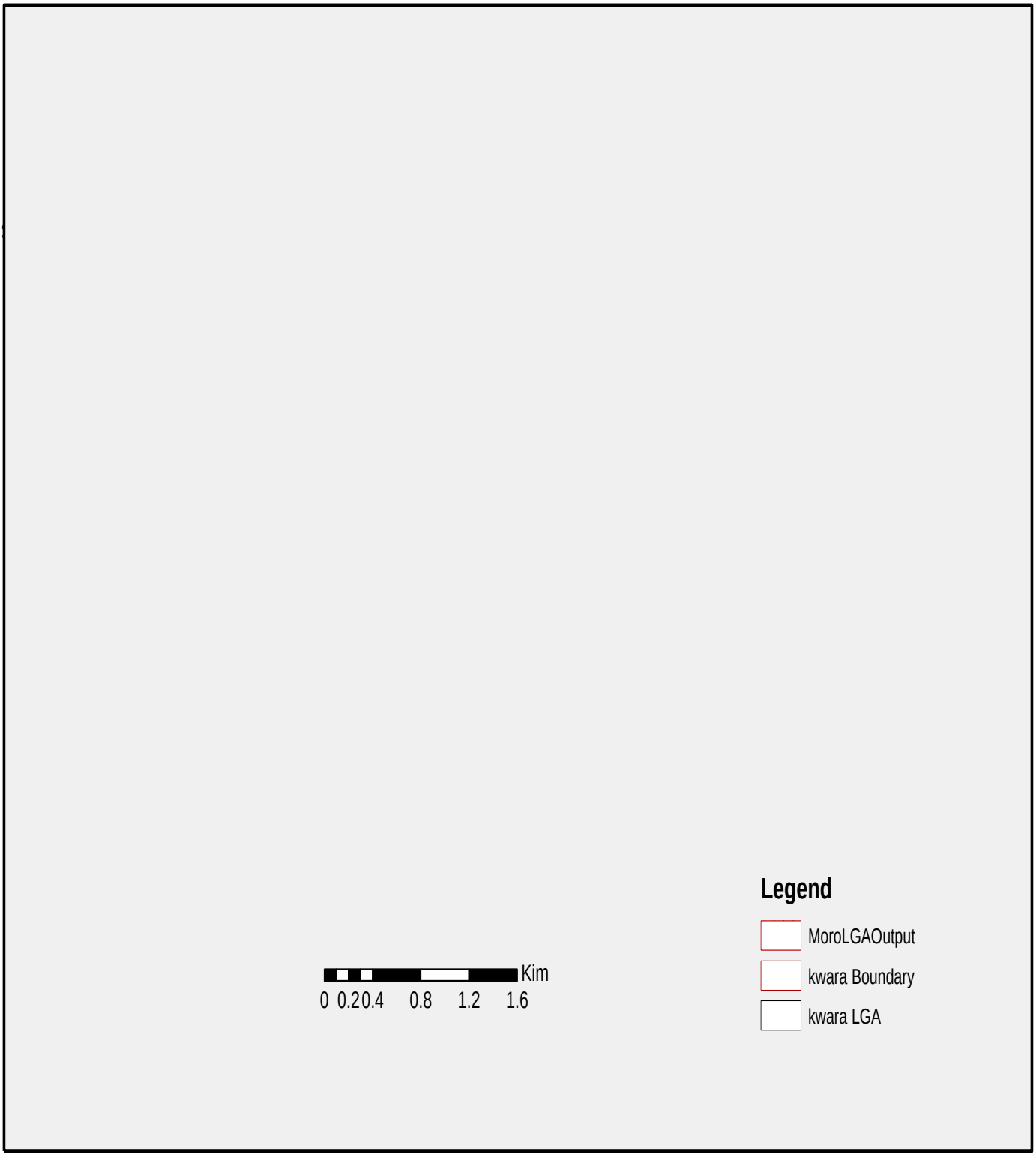

Fig2:Showing Moro local government in the context of Kwara state local Government area.

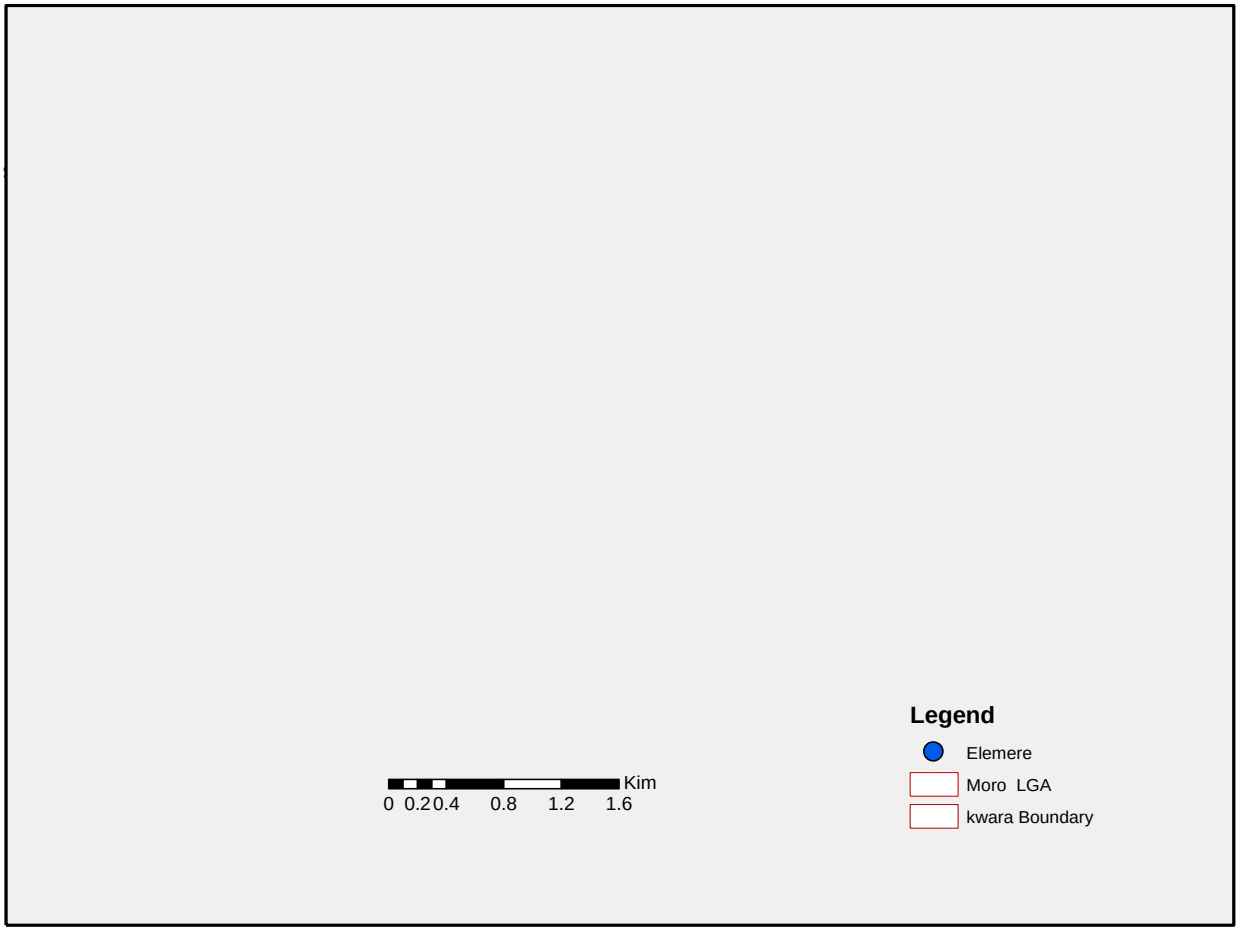

Fig 3: Showing the study area in Moro Local Government Kwara State.

Specifically, the objectives of this work are to:

1. To find out the health information needs of rural women in Elemere
2. To understand the health information seeking behavior of rural women in Elemere
3. To know the level of availability of health information to women in the study area
4. To find out how rural women in Elemere access health information
5. Identify the challenges they faced when obtaining health information
6. To find out the role of librarian and libraries in health information dissemination

REVIEW OF RELATED LITERATURE

Availability of health information to women in rural community

According to Ngozi and Ezeugwu (2003), primary health care information needs mean all the vital knowledge concerning primary health care matters, some of which man/woman does not have but which are necessary for his or her wellbeing. This means that such a person may have some knowledge of some aspects of primary health care matters but lack in some other desirable ones. Those areas where such a person does not have knowledgeor information but requires to have knowledge or information becomes the primary health care information needs. Adequate primary health care information among women is a veritable tool for prevention and cure of so many diseases and illnesses they will have. They will have excellent health and then be in a better position to effectively participate in education, employment, and other endeavours in the society.

Ochogwu (1993) cited in Ngozi and Ezeugwu (2003) stated that information materials are not much available to rural communities because of the cost of access to it. They further expressed that where some of the information materials may be available, they are unaffordable because of high cost of purchasing them. These include, for example, newspaper, magazines, and even books. Similarly, Voight (1995) cited in Ngozi an Ezeugwu (2003) pointed out that library and information materials/services are only used where they are available. He also maintained that library service/materials are mostly found in schools/institutions and are rarely found in communities. Also, Utor (2004) agreed that the non-availability of information materials is a barrier to effective information transfer to the grassroots and this problem is largely caused by high cost of information materials and services. On his part, Ngozi an Ezeugwu (2003) citing Adeyemi (1991) sees availability and timeliness of information as one of the factors which unable users in utilizing information

Accessibility of health information to women in rural community

Accessibility to and use of various information types and sources to urban and especially rural communities is a dire need and causes a bone of contention (Obaremi and Olatokun, 2021). Access to health care services is critical for rural residents (World Health Organisation, 2017). Also, while access to health care is critical to good health, residents of rural areas often experience barriers to health care (Rural Health Information Hub, 2020). This limits their ability to get the care they need.

A survey in the United States of America reported by Galvin (2019) submitted that rural communities which tend to be older, poorer, and sicker than urban areas can face a complex set of challenges in accessing health care and other services, as about 4 in 10 rural adults struggle to afford medical bills, housing or food in recent years. If rural communities in developed nation(s) such as the USA face health care access challenges, one is left to worry at the height of the bane to accessing health care services among rural communities in under-developed and developing nations in Africa, such as Nigeria, a nation with 4.14% budget allocation for the health sector in the year 2020 (Ann-Walker, 2019).Another study by Chen et al. (2019) investigated the differences in rural and urban health information access and use, and revealed that rural residents had lower access to health information from sources including primary care providers, specialist doctors, blogs, and magazines, and less use of search engines

Health information needs and information seeking behaviour of women in rural community

Adedoyin, and Oyewusi, (2015) citing Okigbo (2007) and Uta (2003) uncovers that very little efforts have been made by information researchers to investigate the health information needs and services among the populace. The increasing number of health-related problems among rural women in Nigeria requires urgent and special attention. Bearing in mind that information as discussed by Olatokun (2016), is that which clears doubt and reduces uncertainty, health information-seeking behaviour (HISB) can be described as the various ways in which individuals interact with information, mainly how people seek and use the information to clear their health doubts or uncertainty to achieve healthy living (Nielsen-Bohlman et al., 2004). Bates (2002) submits that health-seeking behaviour is a complex and dynamic phenomenon, not only to understand but also to respond to, at both the individual and the population level.

Michael, Murphy and Kanost (2003) citing (Rees & Bath 2000) indicated that in defining women's health information needs, several key issues or dimensions need to be considered. The first one is health status of information-seeker. For example, preventative health information is most relevant to well women, whereas information about diagnoses and treatments is most relevant to those who are ill and their families more specifically for the latter, the nature of the illness and the timing of information acquisition becomes important. In regard to an acute illness, for example, information needs to be gathered quickly, prior to or at diagnosis. In contrast, the

information needs of those with a chronic condition, or who are undergoing long term treatment, change over time.

So, what are women's major health concerns? Michael, Murphy and Kanost (2003) citing Astbury and White (2008) identified six key themes relevant to women's health information needs. These themes, based on a review of research findings, policy documents, and the content of women's common requests to health information services, were: Age-related issues; Emotional and mental health; Reproductive health; Violence and women; Women as careers. Olorunda, (2004) pointed out that Women's information needs on personal, religious, social, domestic, professional or medical are an important factor in determining the quality of life they live, their output professionally or socially, at home and to the world generally. Similarly, Momodu (2002) carried out a study on information needs of rural dwellers in Nigeria. He identified that women particularly needed information on pre- and post-natal care and current immunization facilities for their children and themselves. Murphy and Kanost (2003) revealed that there are a number of reasons why it is important to understand women's health information channels and preferences. First, women are the main decision-makers in terms of medical and treatment decisions; they are the main family careers, and the driving force behind health-information-seeking in the family.

In a study of 924 gastroenterology outpatients, undertaken by researchers at Duke University Medical Centre, United States of America (USA), demonstrated that those who sought health information were typically women in their early fifties (O'Connor and Johanson 2000). An Australian study of general practice patients similarly highlighted women as the main health information seekers (Charlton 2007). Indeed, women have been referred to as "health brokers" as they act on behalf of others in seeking health information and subsequently making health-related decisions, women clearly want information. Michael, Murphy, Kanost (2003) concluded that Information needs differ depending on the timing of the information and, in the case of both chronic or acute illness, the stage of the disease progression or treatment process

Barriers to meeting the health information needs of rural women

According to Almader-Douglas (2013), there are myriads of factors militating against health information access and use in developed and developing countries, urban and rural areas as the case may be. However, the rate at which these factors impinge varies from region to region.

These factors are great determinants of individual knowledge of health information and how to access them range from socio-economic, political, cultural, linguistic, etc. Socio-economic factors among others are such that are prominent in the talk of barriers and challenges of accessing health information and quality health care services. The place of culture in a typical African setting cannot be over-emphasised. Nigeria among other African countries is rich in culture and human moral values. Each ethnic group jealously guards its culture and would not for any reason jettison its stance. It was further stated that for people from different cultural backgrounds, health care is affected by belief systems, communication styles, and understanding and response to health information (Duranti, 1997).

Also, language is seen as an integral part of the culture and ways of life of people of diverse races. It is the natural gift given by the creator of human kind. It is said to be central to social life and mediates the acquisition of much cultural knowledge. Communication of thoughts, feelings, ideas and emotions are grossly made possible by language without which interaction and expression will be made impossible. Therefore, if there are barriers in the language used by two or more people, communication would be said not to have taken place, and this can lead to confusion and serious consequences as it may be in the case of health and well-being.

Sources of health information by rural women

The health information needs of individuals can be met through various information sources. As discussed by Olatokun (2016), information sources refer to the actual source from which information could be gathered. Information sources can either be formal or informal. Examples of formal sources of information are reference materials such as manuals, guides, almanacs, atlases, encyclopaedias, thesauruses, handbooks, and dictionaries and so on, books such as monographs, collection of articles and bibliographies, and periodicals such as journals, magazines, newspapers and so on, while examples of informal information sources are pamphlets, reports and grey literature among others (Olatokun, 2016). However, there are some prominent key health information sources that seekers and users of health information harness to meet their health information needs. (International Longevity Centre–UK, 2015). The research findings and data analysis through the five key health information sources, their ranking in terms of the level of patronage or access for health information and their roles in the health

informationseeking process as discovered by are (i) doctors or nurses; (ii) pharmacists, chemists or drugs stores; (iii) family, friends or colleagues; (iv) medical helplines; and (v) the Internet.

A study by Kassim and Katunzi-Mollel (2017) examined the sources of information used by women in rural Tanzania and revealed that women used different sources of information such as community health care workers (CHWs), traditional birth attendants (TBAs) and their immediate family members. Also, with a focus on interpersonal communication especially with traditional health care givers as sources of health information, a study by Maliwichi-Nyirenda et al. (2017) investigated the role of indigenous knowledge in the provision of health care in Malawi and revealed that trained traditional birth attendants (TBAs) were still using medicinal plants to assist pregnant women to deliver. This indicates that traditional health care providers serve as sources of information and through them, people access health information and health care services.

METHODS

The study adopted reconnaissance survey method. It is most appropriate for the study since it focused on a small population. The study population for the research work comprises of rural women, health workers and health information provider in Elemere community, Moro local government, Kwara State, Nigeria. Five health workers, five health information providers and forty rural women were randomly selected as sample for the research work.Questionnaires and interviews form the basic instrument adopted for the research work. The data gotten from the study area was further analysed with the use of descriptive techniques such as frequency tables and percentages using statistical package for social scientists (SPSS). Map was used to show the study area. In addition, photography was used to illustrate the operation system in the study area.

RESULT

Research Question One: what is the health information needs of rural women in elemere?

Research question one is investigated with two (2) sub-questions as shown on table 2.1 and 2.2.

Table 2.1 Available Health Information Provisions in the Area

DESCRIPTION	FREQUENCY	PERCENTAGE
Health information on	7	70.0

immunization		
Maternal and child health information	1	10.0
Prevention and treatment of communicable diseases	1	10.0
None of the above	1	10.0
TOTAL	10	100.0

Table 2.1 reveals that 70% health information on immunization, 10% maternal and child health information, 10% prevention and treatment of communicable diseases, while 10% of none of the information provided. This indicated that health information on immunization is the most available health information provided in the study area while other forms of information are not adequately provided for in the study area. The results provided positive relation to Momodu (2002) study on information needs of rural dwellers in Nigeria. He identified that women particularly needed information on pre and post-natal care and current immunization facilities for their children and themselves. Therefore; there is need for provision of pre and post-natal care in the study area.

Table 2.2 Health Information Needs of Rural Women

DESCRIPTION	FREQUENCY	PERCENTAGE
Health information on immunization	1	10.0
Maternal and health information	3	30.0
Environmental health services	3	30.0
Prevention and treatment of communicable diseases	3	30.0
Total	10	100.0

Table 2.2 shows that the following health information provisions are needed in the area; maternal and child health information (30% respondents), Environmental health services (30% respondents), prevention and treatment of communicable diseases (30%) while 10% respondents agree that health information on immunization is needed.From the study it can be deduced that health information on immunization is the most frequent health information provided in the area.Michael, Murphy, Kanost (2003) reveals that Information needs differ depending on the timing of the information and, in the case of both chronic and acute illness, the stage of the disease progression or treatment process respectively. Therefore, there is high and urgent need for the provision of other health information provision which includes Maternal and child health information, environmental health services and prevention and treatment of communicable diseases. This is needed in other to ameliorate the impact of diseases health issue on rural in Elemere.

Research Question Two: what is the information seeking behaviours of rural women in Elemere?

Research question two is investigated with two (2) sub-questions as shown on table 3.1 and 3.2.

Table3.1 How Often do the Rural women Seek for Health Information?

DESCRIPTION	FREQUENCY	PERCENTAGE
Always	5	50.0
Ones in a while	3	30.0
Never	2	20.0
Total	10	100.0

Table3.2 Does the Rural Women Value Health Information?

DESCRIPTION	FREQUENCY	PERCENTAGE
Yes	7	70.0
No	2	20.0
Partially	1	10.0

Total	10	100.0

Objectives 2 (two) of the study evaluate the health seeking behaviour of rural women in the area. With reference to table 3.1; 50% of the respondent shows that health information is sought often, 30% once in a while, also 20% never seek health information. Also, table 3.2 depict that 70% Women values health information, while 30% do not value information in the study area. The study implies that the available health information is very relevant in the area; women seek more of health information. Charlton (2007) study of general practice patients similarly highlighted women as the main health information seekers.

Research Question Three: what is the level of effectiveness of availability of health information to women in the study area?

Research question three is investigated with two (2) sub-questions as shown on table 4.1 and 4.2.

Table 4.1 How Effective is the Health Information in the Area

DESCRIPTION	FREQUENCY	PERCENTAGE
very effective	6	60.0
not effective	3	30.0
partially effective	1	10.0
Total	10	100.0

Table 4.2 Relevance of the Available Health Information

DESCRIPTION	FREQUENCY	PERCENTAGE
very relevant	7	70.0
not relevant	1	10.0
not sure	2	20.0
Total	10	100.0

The study depicts in Table 4.1 that 60% of the information available is very effective,30% are not effective while 10% of the information are partially effective, also Table 4.2 shows that health information for rural women is very relevant(70% respondent),10% are not relevant while 20% are not sure of its relevancy. Ochogwu (1993) cited in Ngozi and Ezeugwu (2003)

vehemently express that where some of the information materials may be relevant, they are unaffordable because of high cost of purchasing them.Therefore, it depicted that available health information are very efficient and highly relevant to the women in the area.

Research Question Four: how did women in Elemere access health information?

Research question two is investigated with four (4) sub-questions as shown on table 5.1, 5.2, 5.3 and table 5.4

Table 5.1 ***Medium through which Health Information is accessed***

DESCRIPTION	FREQUENCY	PERCENTAGE
Friends and relatives	4	40.0
Direct contact with health workers	3	30.0
Community show talk	3	30.0
Total	**10**	**100.0**

Table 5.2 ***what are the other means of obtaining health information by rural women***

DESCRIPTION	FREQUENCY	PERCENTAGE
Through religious leader	4	40.0
Community town crier	5	50.0
Newspaper	1	10.0
Total	**10**	**100.0**

Table 5.1 reveals that 40% of health information is accessed through friends and relative, 30% through direct contact with health centres and 30% through community show talk.

Table 5.2 above indicate other means of obtaining health information include through religious leader (40%), 50% through community town crier and 10% through newspaper.This implies that majority of health information in the study area are accessed through friends and relatives while other means of obtaining information by rural women majorly includes through religious leaders and community town crier. The internet is a relatively good channel for non-English speaking women, providing easy access to information in a range of languages; this is not the case for rural women. This is a directly proportional to Michael, Murphy and Kanost

(2003) vehemently express that Indigenous woman and those from diverse cultural backgrounds appear to have poorer access to health information, either written or through general practitioner.

Table 5.3 ***Have you ever receive sensitization on woman health?***

DESCRIPTION	FREQUENCY	PERCENGE
Yes	9	90.0
Not aware	1	10.0
Total	10	100.0

Table 5.3 reveals that 90% of the health workers receive sensitization on woman health, while 10% are not aware if sensitizations on woman exist in the study area.

Table 5.4: ***Medium for Sensitization for Health information***

DESCRIPTION	FREQUENCY	PERCENTAGE
public health official	7	70.0
Town crier	1	10.0
Librarian	-	-
Media	2	20.0
Total	10	100.0

Table 5.4 depict the medium of sensitization, it shows that the health information on rural women is made available through; public health officials representing 70%, 10% through the town crier and 20% are gotten through the media, while no respondent selected librarians. This implies that librarians are not part of health information dissemination in the study area.In reference to Obidike and Nkechi (2011) they opined that librarian collect and compile health information, store them in appropriate media which can be easily accessed by health information users. They have the role of reducing health information illiteracy in rural communities. Following the result gotten from the study area; librarian work has been neglected and or not involve in participation of health information dissemination in Elemere.

Table 5.5***How often is the Awareness / Sensitization?***

DESCRIPTION	FREQUENCY	PERCENTAGE
Once in a while	8	80.0
Once every 2 month	2	20.0
Total	**10**	**100.0**

Furthermore Table 5.5 shows the sensitization/awareness of the health information by public health official is once in a while as selected by 80% of the respondent and 20% of the respondent selected that the awareness is once every two months respectively.

Research Question Five: what are the challenges rural women faced when obtaining health information?

Table 6: Challenges faced when Seeking Information by Rural Women

DESCRIPTION	FREQUENCY	PERCENTAGE
Traditional belief on local drug and concoction	4	40.0
High illiteracy among rural women	4	40.0
Obsolete infrastructure and equipment	2	20.0
Total	**10**	**100.0**

Table 6 indicated that challenges rural women faced in obtaining information in the study area includes Traditional belief on local drug and concoction (40%), high illiteracy among rural women (40%), and obsolete infrastructure and equipment used by the health practitioners (20%). it can be concluded that the major challenges faced by rural women in obtaining health includes; traditional belief on local drug and concoction and high illiteracy among women.This result is

similar to Ada and Salihu the study was based on interview of 107 pregnant women; findings indicate 88% did not attend antenatal care, 96.3% had deliver to home without skilled attendant. Rural women choose high risk options leading to morbidity and even their own deaths (This may include traditional belief on local drug and concoction); this is a great challenge which is inimical to their health status.

RESULT OF INTERVIEWS

- **What is the name of your community?**

Responses: all respondent were from Elemere community, Kwara State.

- **How old are you?**

Responses: Out of the 40 respondents, 7 respondents were between the age of 12-19, 12 respondents are between the age of 20-34, 18 respondents are between the age of 35-59 while 3 respondents fall between 60 years and above

- **What is your marital status?**

Responses: Out of the 40 respondents, 25 respondents are currently married, 12 respondents are currently single while 3 respondents are widows.

- **What are your health challenges?**

Response: Out of the 40 respondents, 14 respondents' health challenge is malaria, 10 respondent health challenges is fever, 3 respondents health challenge is Cough, 2 respondents health challenge is Typhoid, 4 respondents health challenge is measles, 2 respondents health challenge is ulcer, 3 respondents health challenge is cholera while 2 respondents health challenge is hypertension.

- **Are you aware of the existence of primary health centre in your community?**

Responses: Out of the 40 respondents, 38 respondents are aware of the existence of health centre in their community while 2 are not aware.

- **Are you aware of the health information/services available in the primary health centre in your community?**

Responses: Out of the 40 respondents, 35 respondents are aware of the available health information and services in the health centre in their community while 5 respondents are not aware

- **In what form are you aware/access of the health information?**

Response: Out of the 40 respondents, 3 respondents said that they were aware of the available health information through Newspaper, 2 respondents said that they access the available health information through Mobile clinic, 5 respondents said that were aware of the available health information through Radio, 18 respondents said that they access the available health information by having direct contact with the health centres,8 respondents said that they were aware of the available health information through family and relations, 3 respondents said that they access the available health information through community show talk and poster, while only one respondent access health information by seeing television.

- **What is the health information available in the health centre in your community?**

Out of the 40 respondents, 2 respondents stated that maternal and child health services is a type of health information available in the health centres in their community, 11 respondents stated that Prevention and treatment of sickness and diseases is a type of health information available in the health centres in their community, one respondent stated that family Planning is a type of health information available in the health centres in their community, 3 respondents representing stated that Public health education is a type of health information available in the health centres in their community, 3 respondents stated that Environmental Health Services is a type of health information available in the health centres in their community also 16 respondents stated that Immunization is a type of health information available in the health centres in their community while 4 respondents are not aware health information available in their community.

- **How often do you use the health centre in your community?**

Response: Out of the 40 respondents,3 respondents said that they make use of the health centre in their community once in a while, 8 respondents said that they only make use of the health centre in their community during the time of sickness, 4 respondents said that they only make use of the health centre in their community during their antenatal period, 7 respondents said that they only make use of the health centre in their community during child delivery,4 respondents

does not make use of health centres in their community,14 respondent makes use of the health centre in their community always.

- **What are the factors that hinder you from accessing the available health information and services?**

Response: Out of the 40 respondents, 6 respondents said that the factor that hinders them from accessing the available health information is lack of adequate facilities, 7 respondents said that it is non-availability of health information.16 respondents said that it is unaffordable price of information materials, 5respondents said that it is the high rate of illiteracy another 11 respondents said that it is their own personal belief in herbs (concoction).

Conclusion

In reference to the findings above, the health information needed by rural women in the study area are only concentrated on immunization, maternal and child health information, prevention and treatment of sickness and communicable diseases; other forms of information are not adequately provided for in the study area. I.e., health information is available to rural women but limited. Most rural women are aware of the health information available to them but the accessibility means are unstable, inefficient and unreliable also librarians are not included in health information dissemination; government have totally look away from the provision of adequate libraries to the rural community which can affect the economic development of the country.

Recommendations

The following recommendations are made base on the findings of the study

1. There should be professional health workers and health information providers in rural communities so as to regularly provide rural women with health information needed.
2. Public libraries should be extended to rural community by Government so as to bring health information closer to the rural women. Thus, librarians will be part of health information provision by providing translation services in the local community in Yoruba language (indigenous language).

3. Adult schools should be organized to decrease the level of illiteracy among rural women so that they can easily and effectively access and understand the health information available to them.
4. The health information available to rural women should also include their environmental health service. For those that depend on local drugs, concoction and traditional herbalist for health information, there should be assistance from health workers and health information providers (librarian inclusive) to help them know the negative result of these acts and help improve their health information seeking behaviour

Elemere community health centre.

Source: Author's field work, 2019

PLATE 4.2 Bed space used in admitting rural patients

Source: Author's field work, 2019

PLATE 4.3 Elemere rural women

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