Journal of Management and Science

13(3) 2023 42-48

OPEN ACCESS

RESEARCH ARTICLE

DOI: https://doi.org/10.26524/jms.13.33

Health information needs of rural women in ilorin east local government area of Kwara State, Nigeria

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Abstract

The study assessed the health information needs of the rural women in Ilorin East Local Government Area of Kwara State, Nigeria. The study used primary data. The primary data were collected using structured questionnaire. Multistage sampling technique was use to select respondents for the study. A total number of eighty rural women were selected for the study. Data were analyzed using frequency, percentage, mean and Likert type rating scale. The result of the study revealed that the mean age of the respondents was 37.7 years, their average income was 27,637.50 Naira. The result revealed that majority (98.8 %) of respondents' source of health information were radio/television (98.8%), Neighbors and friends (92.5%), drug hawkers (90.0%), family members (77.5%), local chemist shops (75.3%) and Doctors/Nurses (67.5%). The common health challenges in the study area are typhoid fever (40.0%), malaria (43.8%) and (28.8 %) miscarriages. Also, the result identified that First aid treatment with a mean score (2.21), Drug/Pharmaceutical care information (2.20) and infant's health care (2.10) were areas where the respondents highly needs health information. The result also reveals that Illiteracy (2.51) and low level of income (2.08), communication barrier (1.93), poor electricity (1.91) and poor attitude of health personnel (1.91) were some of problems preventing rural women from getting health information. The study concluded that there is information need among rural women in the study area. The study therefore recommends that for government to achieve its vision of good health for all, there is need for targeted policies in the areas of health information needs of rural women and there should be provision of health facilities in the rural areas by the government and donor agencies.

Keywords: Health Information, Needs, Rural Women.

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How to cite this article: S.A. Ahmed, J.O. Ifabiyi, I.K. Banjoko, Health information needs of rural women in ilorin east local government area of Kwara State, Nigeria, Journal of Management and Science, 13(3) 2023 42-48. Retrieved from https://jmseleyon.com/index.php/jms/article/view/684

Received: 19 July 2023 **Revised:** 21 August 2023 **Accepted:** 18 September 2023

1. Introduction

Information is a major resource that is needed in every sphere of life and particularly in health matters [1]. Information is crucial to the success of any business or activity. According to Corragio (2011), [2] lack of information results in the denial of choices and opportunities for living better life. Therefore, the quality of information people have access to, enhances their ability to make informed choice. Information and knowledge had been reported to fuel innovation and increase productivity and competitiveness[3]. Consequently, information need is described as the feeling of lacking something and the desire to fill the gap. Health information is therefore a vital resource for individuals who according to BIREME/PAHO/WHO, (2008) [4] seek information for varying reasons as mere curiosity, self-diagnosis, analyzing and evaluating treatment for health. Health information are data or statements on health that are needed to achieve healthy living. This could be facts on the current health status, available rural health care facilities, health personnels` information on drugs prescription and use, immunization, medical treatment and information on nutrition.

Health is a major form of human capital and there exists substantial agreement in the literature on the relationship between health and economic development through its relationship be-tween capability and poverty [5]. Furthermore, sound health is a fundamental requirement for living a socially and economically productive life. Poor health inflicts great hardships on households, substantial monetary expenditures, loss of labour and sometimes death [6]. Access to health information is key to achieving health information for all and the set Millennium Development Goals (Godlee,2004). However, in many rural populations particularly in Africa, the access to

health information is still a major challenge [7]. Women constitute about half of the total world population (WHO,2007) [8]. Despite playing key role in the rural economy, Nigeria is by tradition a patriarchal society in which women are discriminated against from infancy. In the rural setting, gender disparity has been observed with women generally receiving less attention than men. Poorer access to medical services is compounded by socio- cultural, economic and demographic factors including the behavior of families and communities, social status, education, culture, income, health decision making power, age, access to health facilities, and availability of health services played a vital role in causing maternal mortality [9]. Researchers have found that the disparity is more noticed in rural areas than urban areas [10]. Accessibility of health services has been shown to be an important determinant of Utilization of health services in developing countries. In most rural areas in Africa, one in three Women lives more than five kilometers from the nearest health facility (Nigerian Central Bank, 2004) [11]. The Scarcity of vehicles, especially in remote areas, and poor road conditions can make it extremely difficult for women to reach even relatively nearby facilities. Walking is the primary mode of transportation, even for women in labour [9].

The program of action of the international conference on population and development, the millennium development Goal (MDGs) and Maputo Declaration and Action plan call for concerted action to reduce maternal mortality, promote maternal health and empower women with knowledge so that they are more useful to themselves, their families and communities (WHO,UNFPA,UNICEF 2004) [12]. In order to achieve this goal, adequate knowledge of maternal health is a prerequisite. It is well known that higher education is strongly correlated with improved maternal health knowledge [13]. This shows how vital health information is in determining the quality of life one live, the output professionally or socially, at home and to the world generally [14]. Poor health affects agricultural production [6]. This implies that the present health conditions of rural women will have influence on their total productivity as women play an important role in the Nigerian rural economy. Agricultural production is the main occupation of women after domestic activities in the rural areas, women are involved in planting, harvesting, agro-processing activities, keeping backyard poultry, rearing sheep and goat among several others.

The health care and concern aimed at the rural population raise interest since the beginning of the 20th century, focused especially on rural endemic diseases. However, they attract the commitment and work of few researchers (Hochman,2010).Health status of rural women in Nigeria is poor and are more likely to suffer from lack of access to health-care and health information. However, in most of the rural areas in Nigeria there are inadequate health facilities. There is dearth of information on the health needs of rural women in Kwara State, Nigeria. This creates a great lacuna in knowledge that this is study seeks to fill. It was on this note that this study sought to investigate the health information needs of rural women in Ilorin East Local Government Area of Kwara State, Nigeria. The specific Objectives were to;

1. Describe the socio-economic characteristics of the rural women in the study area;
2. Identify the respondents` perceived health status in the study area;
3. Describe the health challenges of the respondents;
4. Sources of health information available to the respondents; and,
5. Assess the health information needs of the respondents;

2. Materials and Methods

Study area

This study was conducted in Ilorin-East Local Government Area of Kwara State. Ilorin is the capital city of Kwara State. It is located in the transition zone between the forest belt and the grassland of Nigeria. It is centrally located in the country. The implication of this is that, it is easily accessible from all parts of the country. Ilorin East LGA. is located between Latitudes 80 and 150 N and Longitudes 40 and 50E and shares boundary with Ilorin South, Ilorin West, Moro and Ifelodun Local Government Areas (Kwara State Government, 2013) [15]. According to the 2006 population census Ilorin East LGA has a population of 207,462 (Federal Republic of Nigeria Official Gazette, 2009) [16]. Majority of the people in the area are farmers who engage in the production of crops like melon, groundnuts, beans, pepper, cassava, yams, Soyabean, maize, locust bean and Shea nuts. There are thirty three primary health centres in the LGA. Seven of these health centres are located within Ilorin metropolis while the remaining twenty-six centres are spread across the other parts of the LGA. As is generally the case in Kwara State the rural parts of the LGA are grossly deficient in provision of infrastructural facilities. For instance, the problem of deficiency of rural road transport in the state has been noted (Aderamo, 2007). Most of the available roads in the study area are in deplorable condition resulting in difficulty of movement of people.

3. Data Source

Primary data was used for the study. The data was elicited using questionnaire. The questionnaire solicited information from the respondents on issues that bother on the set objectives of the study.

4. Sampling technique and Sample size

The population for the study consist of eighty rural women which were randomly selected from four rural communities in Ilorin east local government area of Kwara State. The communities are Oke-oyi, Oke- ose, agbeyangi and Agbede. Twenty rural women were selected from each of the communities.

5. Analytical technique

The study used both descriptive statistics and Likert Rating Scale. To determine the source of information of the respondents, a scale of Yes and No were used where Yes = 2 and No = 1. To measure the health challenges of the respondents, a 3-point likert type scale were used where always =3, rarely = 2 and never = 1. To determine the areas of health information needs of the respondents, a 3-point likert type scale were used where highly needed = 3, moderately needed = 2 and not needed = 1. To measure the problem encountered by the respondents in getting health information, a 3-point likert type scale were used where always =3, rarely = 2 and never = 1.

6. RESULTS AND DISCUSSION

The result in Table 1 reveals that more than half of the respondents (55%) were below the age of 40 years while their mean age was 37.7 years. 77.5% of the respondents were married while 22.5% were single. The average income of the respondents was N27,637.5. This indicates that the majority of the respondents earns below the national minimum wage of N30,000. The results in Table 1 also shows that 61.3% had tertiary education while 33.8 % had secondary education, majority of the respondents (82.5%) were Muslims, 60.0 % of the respondents were civil-servants while 15% were artisans and 75% were members of rural association while 25% does not belong to any association.

The result in Table 2 reveals that the majority of the respondents (98.8 %) got health information from radio/television and family members. Also, 92.5% of the respondents gets health information from their neighbours and friends. This indicates that radio, television and family members were the most important source of information to the respondents on health matters. The finding corroborate the position of (McGuffin and Wright,2004; Andreassen et al.,2005) that the most commonly used health information media was magazines, newspapers televisions, radios and other printed material like leaflets, pamphlets, flyers and books.

The result in Table 3 reveals that majority of the respondents (88.8%) rated their present health status as fair while only 11.3 % of the respondents rated their present health status as good. Consequently, 71.3% of the respondents frequently visits Nurses/Doctors when having health challenge while 21.3 % of the respondents visits traditional healers. 37.5% covers less than or 1 kilometer to the nearest health centre while 35.0% covers 1.1-3km. The result in Table 3 also reveals that 73.8 % of the respondents were not satisfied with the health care providers while 26.3 % had low level of satisfaction. The result of the study is consistent with the findings of Ezeh and Ezeh (2017), that reported in both the developed and developing world, many rural residents must travel substantial distances for primary medical care, requiring significantly longer travel time to reach care than their urban counterparts. Evidence indicates that rural residents have limited access to health care and that rural areas are often under-served by primary health practitioners.

The result in Table 4 reported that 43.8% always have Malaria, 40.0% of the respondents always have typhoid fever, 42.5% of the respondents always have Cough and cold, 28.8% reported having Miscarriage as their major health challenge.

The result in Table 5 reveals that First Aid treatment (mean score= 2.21), Drug/ pharmaceutical care information (mean score= 2.20) and infants health care information (mean score= 2.10) were the highly needed areas of health information needs while Immunization, Family planning and reproduction health, hygiene and sanitation practices, information on medical diagnosis center, traditional health care information and information on nutrition were areas where the respondents needs moderate information. This result is in agreement with the study of Momodu (2002), [17] and Saleh and Lasisi (2011) [18] who reported that women particularly needed information on pre and post-natal care and current immunization information for their children and themselves.

The utilization of health services by the communities is determined and affected by a variety of factors. The result in Table 6 reveals that illiteracy (mean score= 2.51) and low level of income (mean score= 2.08) were more severe challenges encountered by the respondents in getting health care services. Other challenges encountered by the respondents in getting health care services were Communication/ language barriers (mean score= 1.93), Lack/poor electricity supply and poor attitude of health workers to patients (mean score= 1.91) and Lack of health centres/personnel (mean score= 1.29). The result of the study is consistent with Bernstein et al (2003), [19] the study indicated that good roads, newer technology or insurance, availability of health care facilities and health care personnel all influence individual use of health services. This position is also consistent the findings of Odunbanjo, Badejo & Shokunbi, (2009), [20] Ajala, Sanni & Adeyinka, (2005), [21] that lack of basic equipment hinders the utilization of health care. It is important that health centers and personnels be provided with facilities and tools to carry out their duties effectively without harm to the client or the staff. Rural health policy, in countries face major challenges in the areas of service delivery, human resources, governance, transportation, financing, communication, and in some regions corruption (Anyamele,2009) [22].

Table 1: The socio-economic characteristics of the respondents

Personal Characteristics	Frequency (N=80)	Percentage (100%)	Mean
Age			
20-30	24	30.0	
31-40	20	25.0	
41-50	20	25.0	37.7 years
51-60	14	17.5	
≥61	2	2.5	
Total	80	100	
Marital status			
Single	18	22.5	
Married	62	77.5	
Total	80	100	
Monthly Income			
10,000-20,000	39	48.8	
21-000-30,000	10	12.5	₦27,637.50
31,000-40,000	11	13.75	
≥ 41,000	20	25	
Educational level			
Primary	4	5.0	
Secondary	27	33.8	
Tertiary	49	61.3	
Total	80	100	
Household			
1-2	34	42.2	
3-4	38	47.5	3.0
≥ 5	8	10.0	
Total	80		
Religion			
Christian	13	16.3	
Islam	66	82.5	
Traditional worshipper	1	1.3	
Total	80	100	
Primary Occupation			
Food processor/vendor	4	5.0	
Trading	7	8.8	
Farming	9	11.3	
Artisan	12	15.0	
Civil servant	48	60.0	
Member of Association			
Yes	60	75	
No	20	25	

Sources: Field Survey 2017

Table 2: The Respondents' Source of Health Information

Source of health information	Yes		No	
	Frequency	Percentage	Frequency	Percentage
1. Doctor/Nurses	62	67.5	18	22.5
2. Radio/Television	79	98.8	1	1.3
3. Local chemist shop	57	75.3	23	28.8
4. Family member	79	98.8	1	1.3
5. Newspaper/magazine	72	77.5	18	22.5
6. Herbs hawkers	74	90.0	8	10
7. Neighbours/friend	62	92.5	6	7.5

Source: Field Survey 2017

Table 3: The Health-Care Status of the Respondents

Health Care Status	Frequency	Percentage
1. The present health Status of the respondents		
Fair	71	88.7
Good	9	11.3
2. Health care personnel seen/visited frequently		
Nurses/Doctors	57	71.3
Traditional healers	17	21.3
Herb hawkers	6	7.5
3. Distance to the nearest health centre in kilometer(s)		
≤ 1 Km	30	37.5
1.1-3Km	28	35.0
≥ 3	22	27.5
4. Level of satisfaction with the health care provider		
Never	59	73.8
Low	21	26.3

Source: Field survey 2017

Table 4: The Health Challenges of the Respondents

Health challenges	Never %	Occasionally %	Always %
1.Back/general body pain	98.8	1.3	-
2.Skin disease	47.5	52.5	-
3.Typoid fever	70.0	-	40.0
4.Malaria fever	75.0	1.3	43.8
5.Miscarriage	71.3	-	28.8
6.Asthma	10.0	33.8	20.0
7.Menstrual pain	72.5	16.3	11.3
8. Cough and cold	52.5	27.5	42.5
9.Diabetes	80.0	-	20.0
10.Infertility	42.5	48.8	8.8
11.Cancer	53.8	18.8	27.5
12.Ulcer	45.0	55.0	-
13.Hypertension	36.3	47.5	16.3
14.Tuberculosis	45.0	11.3	23.8

Source: Field survey 2017

Table 5: The Health Information Needs of the Respondents

Health Information Needs	Mean	Rank	Remark
1.Immunization	1.95*	4	Moderately needed
2.Family planning and reproduction	1.08*	12	Moderately needed
3.Hygiene and sanitation practices	1.83*	6	Moderately needed
4.information on health personnels	1.38*	10	Moderately needed
5.Disease prevention information	1.65*	8	Moderately needed
6. Information on medical diagnosis center	1.21*	11	Moderately needed
7.Information on nutrition	1.79*	7	Moderately needed
8.Information on health insurance schemes	1.84*	5	Moderately needed
9.Infants health care information	2.10**	3	Highly needed
10.First Aid treatment	2.21**	1	Highly needed
11.Traditional health care information	1.44*	9	Moderately needed
12. Drug/ Pharmaceutical care information	2.20**	2	Highly needed

Source: Field survey 2017, Note: ≥ 2 is Highly Needed, ≤ 2 is Moderately Needed**

Table 6: The Problem Encountered by the Respondents in Getting Health Care Services

Problems	Not Severe %	Less Severe %	Highly Severe %	Mean	Rank
1.Communication/ language barriers	48.3	20.0	36.3	1.93	3
2. Low level of income	36.3	25.32	36.3	2.08**	2
3. Illiteracy	11.3	26.3	62.5	2.51**	1
4. Lack of health centres/ personnels	68.8	28.8	2.5	1.29	6
5.Lack/poor electricity supply	45.0	18.8	36.3	1.91	4
6.Poor Attitude of health workers towards patients	45.0	18.8	36.3	1.91	4

Source: Field survey 2017, Note: ≥2 are More Severe Problems, ≤ 2 are Less Severe Problems**

7. Conclusion

There is increasing evidence that the health systems in rural areas still fall short of providing accessible, good-quality and integrated care. The study concluded that if the provision of access to qualitative rural health care would be a reality, there is the need for a better understanding of rural health information needs for effective planning of health care systems for proper health system interventions that can address health and health-related problems in rural areas. The finding of the study shows some of the prevailing health challenges in the study area include Malaria, Typhoid and cough/cold. The result of the study revealed there is information need among the respondents and some of the areas of information needs include first aid treatment, drug/pharmaceutical care information, infant care, immunization, health insurance schemes, hygiene and sanitation practices, Nutrition information and disease prevention related information. The major problem encountered by the respondents in getting health care services include that of illiteracy, poor income level, Communication/language barriers, poor attitude of health workers towards patients, poor state of the infrastructure and poor attitude of the health care personnel. The study recommend that to help government realize it vision of good health for its citizens, there is the need to identify the health information needs and to identify the health and health-related challenges associated with rural dwellers` access to health care.

Acknowledgement

Nill

Funding

No funding was received to carry out this study.

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