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SCHOOL OF INFORMATION AND COMMUNICATION STUDIES

DEPARTMENT OF INFORMATION STUDIES

HEALTH INFORMATION SEEKING AMONG WOMEN IN A PERI-URBAN COMMUNITY: A STUDY OF MARKET WOMEN IN MADINA.

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A RESEARCH THESIS PRESENTED TO THE DEPARTMENT OF INFORMATION STUDIES, UNIVERSITY OF GHANA, IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTER OF PHILOSOPHY DEGREE IN INFORMATION STUDIES

JULY, 2019
DECLARATION

I do hereby declare that this thesis is my own original work and has not been submitted either in whole or in part to any institution for any degree. Where references are made to works of other researchers, due acknowledgements are given.

Finally, I wish to state that, I take full responsibility for all shortcomings, misinterpretations and weaknesses that may be identified in this work.

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ABSTRACT

This study is focused on exploring the health information-seeking behaviour of market women at Madina. The objectives of the study were to determine health information needs of respondents, examine the sources of health information, examine how market women evaluate the content and sources of health information and find out the barriers market women face seeking health information.

The study adopted a survey design. The population for the study was 1020 and a sample size of 102 of market women who sells in shops and market leaders were used. The research adopted convenience sampling technique and snow-ball technique to collect data from market women and market leaders respectively. The mixed methods approach was employed for the study. The personal interview and questionnaire were used to collect data from market leaders and market women. The Statistical Package for Social Sciences (SPSS) software was used to analyse the quantitative data and the content analysis was used to analyse the qualitative data that was gathered from interviews.

The findings showed that among the 102 respondents, 27.5% of them are 31-40 years of age, 24.5% are between the ages of 41-50 years of age, 11.8% of the respondents are above 60 years of age among others. The study also revealed the majority of the market women have Junior High School (JHS) education with 36.3% of them admitting that they are JHS certificate holder and followed by Senior High School with 24.5%. The study also revealed that health information needs of market women in the top rank are cure with 90.2% of respondents and treatments with 89% of respondents and the least specialists or specialise facilities. The study clearly indicates the major sources of health information with radio/television recorded the highest and Newspaper/magazine
recorded the lowest. The study show that the major use of information by respondents was to cure sickness. It is clear from the study that the barriers to health information seeking includes; illiteracy, finances, among others.

Recommendations were put forward to enhance health information-seeking behaviour among Madina market women which included; teach-back technique and regular health campaign in market centres by authorities. In conclusion, there was a marginal level of awareness of health information awareness among market women in Madina and there is a need to increase the level of awareness through a campaign.
DEDICATION

I dedicate this work to my brother, Mr Elvis Sarfo and GETfund for their financial support and scholarship respectively.
ACKNOWLEDGEMENT

I wish to express my deepest appreciation to God Almighty for giving me the strength to successfully complete the study. I would like to express my sincere gratitude to my supervisors Dr Emmanuel Adjei and Dr Musah Adams for their continuous support and guidance throughout my graduate studies.

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To all and sundry who contributed to the success of this study, I doff my hat to you. May God richly bless you.
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>CHI</td>
<td>Consumer Health Information</td>
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<tr>
<td>HIS</td>
<td>Health Information Seeking</td>
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<td>HISB</td>
<td>Health Information Seeking Behaviour</td>
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<td>HIL</td>
<td>Health Information Literacy</td>
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<tr>
<td>HIV</td>
<td>Human Immune-deficiency Virus</td>
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<td>US</td>
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CHAPTER ONE

INTRODUCTION

1.1 Background to the study

Everybody needs information, literate or illiterate needs information, from the president of a nation to a farmer in the village or ordinary street person. Information is very vital and in these modern information overload society as it is considered as the first factor of production. In recent times information has become a vital and essential tool that no category of people can easily ignore. Human beings are basically active and goal-oriented and willing to get information about themselves and the world around them (Folitse, Osei, Dzandu & Obeng-Koranteng, 2016).

According to Case (2007), noticing a change in the weather, deciding to visit another city, finding out about travel schedules, choosing a departure date, and buying an airline ticket are examples of a range of activities known as “information behaviour.” These include encountering, needing, finding, choosing, and using information. Research in information needs and seeking behaviour has occupied a niche at the intersection of psychology, management, communication and information science (Case, 2007; Reddy, Krishnamurthy & Asundi, 2018). Adequate knowledge about the information needs of users is important for organisations to re-orient their products, services and activities to be in synchrony with the information-seeking behaviour of their clients. For health organisations to provide any meaningful service, it is pertinent that the users’ information-seeking behaviour to be taken into consideration.

The provision of Consumer Health Information (CHI) to the general public is recognized politically and economically as being important. It enables the public to take responsibility for
maintaining their health and to make informed decisions regarding their health care. There are arrays of health information sources available in print and non-print format. These information services are just one way of providing consumer health information. The varieties of services include telephone helplines, websites and public education for specific health problems (King, 2001). Health centres and hospitals have leaflets available on coping with illnesses and health promotion. In many countries, the citizens subscribe to database and website developed to help educate people on health conditions, symptoms and first aid knowledge. Libraries are traditionally seen as sources for information most especially the Public and Medical libraries provide their users with health literacy (Gillaspy, 2000).

Health information is defined as the information relating to a person’s medical history or symptoms of diseases, diagnoses, prevention, and management of any pandemic diseases (Centre for Disease Control and Prevention, 2012). Zarcadoolas, Pleasant & Greer (2003) defined, health literacy as the evolving skills and competencies needed to find, comprehend, evaluate, and use health information and concepts to make educated choices, reduce health risks, and improve quality of life. Health information literacy is also further defined as the extent to which individuals in general and patients, in particular, have the capacity to access, process and understand relevant health information that is needed to make appropriate health decisions (Engqvist-Boman et al., 2017; Schardt, 2011). Two important elements of health information literacy are recognizing health information needs and identifying appropriate health information sources. A health literate person is able to apply health concepts and information to novel situations. A health literate person is able to participate in ongoing public and private dialogues about health, medicine, scientific knowledge, and cultural beliefs (Schardt, 2011).
The internet has become one of the most popular sources of health information in recent years. Worldwide, 4.5% of all Internet searches are health-related (Eysenbach & Kohler, 2003). The Internet provides increasingly easy access to health information for the general population. A vast and increasing amount of health-related information is readily available on the Internet. Further, sources of health information are provided by electronic information systems designed for public access. These systems may supply health information alone or as one component of a larger community information package. These systems seek to provide comprehensive health information on conditions, treatments, self-help groups and relevant literature. There are many examples of public access community information systems, usually managed by local governments, which provide health information as part of a larger community information service.

Health information seeking has its foundation from information-seeking behaviour. Information seeking is defined as being able to recognize when information is needed and have the ability to locate, evaluate, and use information effectively (America Library Association, 1989). Information literacy is rapidly gaining importance in every aspect of our lives. Knowing how to find, understand, manage, and use information gives us power for success in academic environments, workplaces, and personal lives. Improvements in information technology and the Internet have changed the ability to produce, use, and communicate available information. As the world moves towards being more information-centric, having adequate information skills becomes valuable in public and private organizations, businesses, and governmental agencies. Information literacy is considered to be an essential element in educational practice as well as in various academic and professional environments.

According to La Trobe University (2013), peri-urban communities or areas are largely defined as the areas that surround our metropolitan areas and cities – neither urban nor rural in the conventional
sense. Peri-urban is the fastest growing community in the country or region. These areas are often contested space, largely regarded as being in transition and most vulnerable to burgeoning demands on health, transport and education services. ‘Peri-urban’ and peri-urbanisation are generally loose definitions, often they are used to describe newly urbanised zones at the fringes of cities, especially in developing countries, which are then called the ‘peri-urban interface’ (McGregor, Simon & Thompson, 2006). The Council of Europe defines the peri-urban as a transition area moving from strictly rural to completely urban, related to a high pressure towards urban development (Bertrand 2007).

Madina is a fast-developing suburban settlement situated on the Accra plains some 16.0934 kilometres northeast of Accra on the Accra - Aburi Road and some 3.21869 kilometres north of the University of Ghana, Legon. The historical background to the founding of Madina in 1959 by Muslims from Northern Ghana and elsewhere, and its subsequent development as a 'mixed' suburb with residents of many different ethnic and widely different occupational and educational backgrounds (Beery, 1967).

1.2 Problem statement

The literature on user studies in Ghana is deficient in information needs and seeking behaviour of market women. Ofosu- Tenkorang (2011) investigated the information needs and information-seeking behaviour of the legal profession in Ghana. Appiah (2016) conducted a study on information-seeking behaviour of visually challenged students in public universities in Ghana. Dzansi (2008), also researched on information needs and information-seeking behaviour of students of the University of Ghana Medical School.
Of the many user studies research that has been conducted on various user groups, none has centred on the market woman in the country. No study has been conducted to determine the information-seeking behaviour of market women. Women and children are more vulnerable when it comes to disease outbreak because most women are less health literate in African communities (W.H.O., 2002). Research has indicated that Africans rely heavily upon interpersonal sources for information, especially family and the older people in society; rarely used the appropriate sources for health-related information; and desired information beyond the infant and maternal health, such as finding jobs and accessing community/government resources. The appropriate health information sources include: books, journals, magazines, audio-visuals and the internet.

Notwithstanding the presence of smartphones, laptops and other portable computing devices, people mostly women are not using these devices to seek health information. They are more interested in perusing social media platforms like Whatsapp and Facebook only to chat with friends on matters mostly not relating to women and family health or emerging diseases. Technologies such as the Internet could conceivably enhance the health knowledge of consumers but have not adequately reached socioeconomic groups at highest risk for poor health (Birru & Steinman, 2004).

So many women die of communicable and non-communicable diseases because of the lack of knowledge as a result of poor health information-seeking behaviour. This can be attributed to illiteracy and poor information literacy as to seeking appropriate information sources that will educate them on the treatment and management of diseases. Patients’ participation is fundamental to the treatment and management of chronic diseases such as diabetes, HIV/ AIDS and breast cancer and reproductive health. Patients, therefore, have considerable information needs and how they access and use information significantly impact on their prognosis (Engqvist Boman et al., 2017). Research shows that patients themselves contribute profoundly to the treatment and self-
management of disease outbreak through the kind of information they seek and where they seek such information (Afzal, 2017; Schardt, 2011).

The problem is even worse in African countries where there are high levels of illiteracy and low engagement in active information search. Thomas et al., (2017) and Zaid et al., (2016) studies have shown that knowledge of diseases among women on health is very limited compared to those in advanced countries.

In Africa, Ghana especially, the majority of women diagnosed with mental illness and pregnancy and reproductive health and cancer still engage in some practices such as visiting the shrine or prayer camps that further worsen their conditions all because of poor health literacy (Boadi, 2018). This is due to inadequate knowledge or market women unawareness of sources of health information so they turn to rely on churches, mosques and spiritual centre which end up complicating their problem.

Preliminary studies at the Madina market revealed that the market women spend most of their time in the market trading, therefore, do not have the luxury of time to visit the hospital for medical check-ups, they only go to hospitals when they are sick to the extent that they cannot come to walk before visiting hospital. They mostly rely on drug peddlers who sell drugs at the market. Market women especially are being deceived by drug peddlers that one medicine can cure so many diseases.

Quake doctors and drug peddlers are found selling drugs in the Madina market and lorry (tro- tro) stations that one medicine can cure numerous diseases, which are not scientifically proven therefore endangering market women’s live. These unscrupulous, quack doctors and herbalist sell even fake drugs to Madina market women and take advantage of these vulnerable market women
to enrich themselves. According to Acquah (2018), “Peddlers of these products, claim that the supplements could cure high blood pressure, diabetes and cancer; but such products, he explained were only supplements hence they could not heal. He also condemned the high cost at which those products were sold and explained that their only interest was to make money at the expense of people’s health”. Acquah (2018) also said most of those peddlers could hardly explain scientifically how those medicines worked and recalled how some patients had lost their lives because they were deceived into patronizing a particular medicine rather than using prescribed medications.

In Ghana, there is limited research on health information seeking among market women. The sources of information on health available to market women and information on the wellbeing of women in the technological age have left most Ghanaian women in the dark especially the traditional market woman.

Moreover, many gaps remain in literature. It has not been established if poor health-seeking is associated with the many types of disease outbreak international (Sentell & Braun, 2012).

1.3 Purpose of the Study

The purpose of this study is to investigate the health information-seeking behaviour among market women in Madina market.
1.4 Objectives of the Study

The specific objectives are:

1. To find out market women’s level of health information seeking competency.
2. To determine the health information needs of market women.
3. To examine the sources of health information available to market women.
4. To examine how market women evaluate the content and sources of health information.
5. To find out the challenges or barriers market women face in seeking health information.

1.5 Theoretical Perspectives

According to Khan (2014), a theoretical framework holds the theory of research work by presenting the theory responsible for explaining the existence of the problem under study. He further stated that the purpose of a theoretical framework is to aid the researcher in identifying the variable of the study and also give the researcher a general structure of the study.

One of the most widely used models to explain information literacy and information-seeking behaviour is Wilson’s Model of Information Seeking Behaviour (Tewell, 2015). Several studies across different parts of the World have used this model to explain information-seeking behaviours of different groups including students, teenagers, women, teachers and different social groups (Lloyd, 2010). The popularity of this model is based on its simplicity in assumptions and yet robust nature of the model to explain critical elements of people’s information-seeking behaviours (Mackey & Jacobson, 2014).
Wilson’s (1981) information behaviour model suggests that information-seeking behaviour arises as a consequence of a need perceived by an information user, who in order to satisfy that need, makes demands upon formal and informal information sources. Which result in the success or failure to find the relevant information, if successful, the individual then makes use of the information found and may either fully or partially satisfy the perceived need or fail to satisfy the need and therefore have to reiterate the search process.

1.5.1 Wilson’s 1996 Information Seeking Model

For this study, the research used Wilson’s 1996 model, which is a major revision of that of 1981, shows the cycle of information from the beginning of information need to the phase when information is used. The basic framework of the 1981 model persists in that the person in context remains the focus of information needs, the barriers are represented by intervening variables, which have a significant influence on information behaviour and the mechanisms that activate it, and information-seeking behaviour is identified. According to Niedzwiedzka (2003), Wilson proposed that information needs are secondary needs caused by primary needs which in accordance with definitions in psychology can be defined as physiological, cognitive or affective. Cognitive needs arise in an attempt to find sense and order in the world, and are the realization of a need to explain and make sense out of phenomena but which can also be simulated by common, non-utilitarian curiosity. The rise of a particular need is influenced by the context, which can be the person himself or herself or the role the person plays in work and life, the social, political, economic, technological environments, etc.

Individual features form a unique personality and strongly determine the information behaviour of a person. Personal characteristics seriously influence the choice and hierarchy of information
needs. In spite of character, the information needs of a market woman may differ from that of a banker or that of a police officer and the needs of the same person may vary depending on the challenges in circumstances. The role a person plays in life is the effect of the behaviour patterns established in society for a particular role. Therefore, a father, student or librarian has some specific roles, which are connected with their occupied positions, job, character or place in the professional hierarchy. Certain roles demand specific information needs.

Lastly, the environment within which the life and work of the information seeker take place encompasses a social environment with organizational structure include information services and system, economic situations, technology, location, culture and tradition. The environment conditions are the occurrence of certain needs, but they also affect the perception of information barriers and the ways in which the need is satisfied. Factors conditioning behaviour can be supportive or preventive and this, Wilson calls intervening variables.

While drawing upon research from various fields like psychology and sociology, Wilson points out numerous significant determinants of information behaviour, which can be of personal, role-related or of environmental nature. He uses the term “intervening variables” to suggest that is the value of an intervening variable that determines the support or prevention of information behaviour. The intervening variables are psychological, demographic, role-related or interpersonal, environmental or source characteristics.

In between what he calls “person in context” and the decision to seek information, Wilson inserts a concept of activating mechanism and rightly notes that not every need gives an incentive or motivation to undertake activities leading to information seeking. Wilson looks for what will motivate information seeking and comes up with three theoretical ideas: - stress or coping theory (Folkman, 2010) which offers possibilities for explaining why some needs do not invoke
information-seeking behaviour, the risk or reward theory. According to Murray (1991) and Simões, & Soares (2010) explain which sources of information may be used more than others by a given individual and lastly, the social learning theory which embodies the concept of self-efficacy, the idea of conviction that one can successfully execute the behaviour required to produce the desired outcome.

Lastly, Wilson differentiates the types of searches. Passive attention is that type of absorption of information from the environment as in when a radio is on without the person’s intention to seek attention. However, it is not a purposeful information behaviour it is still an important way of assimilating information. Passive search is when a particular type of behaviour results in the acquisition of information that is relevant. The active search takes place when an individual actively searches for the information and on-going search only means a continuing search carried out to expand or update an area of information.

Information obtained by a user is then processed and it becomes part of a person’s knowledge which can be used directly or indirectly to influence and consequently create new information needs. The cyclic process is formed in which the individual elements of a context determine a person’s behaviour at all stages and where information that is arrived at becomes a new element in a dynamic system.
However, there are also changes: the use of the term ‘intervening variables’ serves to suggest that their impact may be supportive of information use as well as preventive; information-seeking behaviour is shown to consist of more types than previously, where the ‘active search’ was the focus of attention; ‘information processing and use’ is shown to be a necessary part of the feedback

loop, if information needs are to be satisfied; and three relevant theoretical ideas are presented: stress/coping theory, which offers possibilities for explaining why some needs do not invoke information-seeking behaviour; risk/reward theory, which may help to explain which sources of information may be used more than others by a given individual; and social learning theory, which embodies the concept of ‘self-efficacy’, the idea of ‘the conviction that one can successfully execute the behaviour required to produce the desired outcomes’.

Thus, the model remains one of macro-behaviour, but its expansion and the inclusion of other theoretical models of behaviour make it a richer source of hypotheses and further research than Wilson’s earlier model.

1.6 Scope and limitation of the Study

The study will be undertaken in the Madina Market and will be limited to market women who sell in shops and the market leaders who can speak either English, Twi or Ga only. The researcher will focus on women health information-seeking behaviour in the Madina market, determine factors that influence their information needs on health, identify sources of health information, examine how market women evaluate the sources of health information, the challenges Madina market women face when seeking health information, recommend ways of improving their health information search and therefore, the findings cannot be generalised for all market in Accra, because the study is limited to just one market in the Greater Accra Region.
1.7 **Significance of the Study**

Adequate knowledge of health information-seeking behaviour of market women is imperative for health directorates as it will re-orient their services to synchronise their activities to meet health behaviour and needs of market women. The significance of the study lies in the fact that it would add to the already existing knowledge in the area of study.

Any findings from this study may serve as a noteworthy reference that can benefit health authorities, hospital authorities, women health specialists, doctors, nurses, women and policymakers in establishing strategic decisions to improve health promotion much better in the country. Such findings may also contribute to the understanding of the new and challenging role of telemedicine in the digital era, particularly in the developing country like Ghana.

1.8 **Research Setting/ Research Environment**

The study will be carried out at the La Nkwantanang-Madina Municipality, which is located in the Greater Accra Region. It is one of the 16 Metropolitan, Municipal and District Assemblies in the region and was created in 2012 as part of the newly created Assemblies aimed at deepening decentralization and bringing development to the doorstep of citizens. The La Nkwantanang-Madina Municipal Assembly was established by Legislative Instrument (L.I.) 2131 and inaugurated on June 2012. It was carved out of the Ga East Municipality. The La Nkwantanang-Madina Municipality is located at the northern part of the Greater Accra Region. It covers a total land surface area of 70.887 square kilometres. It is bordered on the West by the Ga East Municipal, on the East by the Adentan Municipal, the South by Accra Metropolitan Assembly and the North
by the Akwapim South District (see Figure 1.1). La Nkwantanang-Madina Municipality is generally urban (84%). The political administration of the Municipality is based on the local government structure. The Municipality is headed by the Municipal Chief Executive and supported by the Municipal Coordinating Director who is the administrative head of the Municipality. The highest decision-making body of the Assembly is the General Assembly comprising of all elected and appointed Assembly members. This body performs the deliberative and decision-making functions of the Assembly. This body consists of the elected representatives 70% of the various Electoral Areas and appointed representatives 30% (2010 Population and housing Census report).

1.8.1 Madina

Madina is a fast-developing suburban settlement situated on the Accra plains some 16.0934 kilometres northeast of Accra on the Accra-Aburi Road and some 3.21869 kilometres north of the University of Ghana, Legon. The historical background to the founding of Madina in 1959 by Muslims from Northern Ghana and elsewhere, and its subsequent development as a 'mixed' suburb with residents of many different ethnic and widely different occupational and educational backgrounds (Beery, 1967).

1.8.2 Madina Market

This market is not as large as Makola but is similar in content with respect to food products and household goods. Access to this market is not child’s play, parking is almost impossible so it’s best to Uber your way there or picks a local taxi. The frenzy of hawkers, truck pullers, female
porters “kaya yei”, and irate “tro-tro” and taxi drivers are multiplied in this market which has less defined structures in comparison with Makola. Delve into the inner parts of the market and you will find more organised stalls.

Produce from Koforidua, Aburi and Somanya, popular farming districts in Ghana often ends up at Madina before other markets especially on their market day, which are Wednesdays and Saturdays. A market day is when abundant truckloads of fresh produce arrive at a particular market straight from the farm, it’s a day to find almost any desired vegetable or fruit in its best state.

Madina is a slightly pricier market as compared to Makola, which could be attributed to most merchants sourcing their products from the main Makola markets where imported Chinese products are mostly offloaded. Food vendors at the main entrance to the market also price higher due to their favourable position so you are better off entering the market itself for the best price.
Figure 1.2: Map of La-Nkwantanang-Madina Municipality

Source: Ghana Statistical Service, GIS
1.9 Organisation of Chapters

The study is organized into six main chapters as follows:

**Chapter One:** This contained the introduction aspect of the entire study with the background to the study; statement of the problem, the purpose of the study, objectives, theoretical framework, scope/limitation of the study; significance of the study, and chapter description.

**Chapter Two:** This chapter reviewed pertinent literature of concepts and related empirical studies on health information literacy which consist of the world view, African view and Ghanaian view.

**Chapter Three:** This contains the research methodology of the study by discussing the research design, target population, sample size, sampling technique and instrumentation and also provides the procedure for data collection.

**Chapter Four:** This chapter will deal with the presentation of data and analysis

**Chapter Five:** Discussions of findings in relation to the objectives.

**Chapter Six:** Contains the summary of findings, conclusion and recommendations of the study
2.1. Introduction

A literature review is a carefully summary of recent studies conducted on a topic that include the key findings and methodology used while making sure to document the sources. It is based on the assumption that knowledge accumulates and that people learn to build on what others have done. It is, however, not a chronological list of all the sources, but an evaluation, blending the previous research together and also explaining how it integrates into the proposed research. The study implemented the integrative form of literature review where reviews are basically summaries of past research (Creswell, 2013). The essence of reviewing literature is to reveal what other studies have said. The understanding of other related studies enables the researcher to tackle the problem being investigated. According to “Jesson, Matheson and Lacey (2011), a literature review is where a researcher shows that he or she is aware of and can interpret what is already known and where eventually the researcher will be able to point out the contradictions and gaps in existing knowledge. The purpose of reviewing relevant literature is to help the researcher fill gaps and establish research and academic areas that are of importance to the research.

This section reviewed the literature on related works on the topic under study from the World, African and Ghana perspectives under the following thematic areas:

1. The concept of health information literacy.

2. Health information need
2.2. The concept of health information literacy

Health literacy is an area of study that has been developed through the mounting research findings over the past two decades connecting low literacy with decreased health status and poor health outcomes (Berkman et al., 2004; Berkman, Davis, & McCormack, 2010). The area of health literacy originated principally from the field of literacy. The term literacy was defined by the Department of Education via the National Library Act in 1991 as “an individual’s ability to read, write and speak in English, and compute and solve problems at a level of proficiency necessary to function on the job and in society, to achieve one’s goals, and develop one’s knowledge and potential” (Kirsch, Jungeblut, Jenkins, & Kolstad, 2002). Considered a recent field of study, health literacy was defined in the year 2000 as the “capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions” (Ratzan & Parker, 2000). This definition was published in the National Network of Libraries of Medicine (2000) and later included in the 2004 Institute of Medicine (IOM) report (Berkman et al., 2010; Parker & Ratzan, 2010; Ratzan & Parker, 2000).

The concept of health literacy was first introduced in 1974 in relation to health education and health policy issues (Simonds, 1974, as cited in Ratzan, 2001, p. 210). Health literacy began to be conceptualized in the 1980s (Eadie, 2014; Nutbeam, 2009), and theories and research about health
literacy emerged in the 1980s and 1990s (Eadie, 2014). In the 1990s, researchers began working
to identify and provide Americans with “the currency patients need to negotiate a complex health
care system” (Parker & Ratzan, 2010)—that is, the knowledge and understanding that allows
patients to make wise health care choices. The main foci in early research were to define health
literacy, gauge the health literacy status of Americans, and identify any relationships to health
literacy (Parker & Ratzan, 2010).

Some important components of health literacy, such as retention of medical information by
patients, patients’ ability to successfully follow medical direction, and communication between
health care providers and patients, have been studied by researchers for many years. However, it
was not until 2003 that the health literacy of the American public was measured via a large-scale
national assessment (Berkman et al., 2010). The Department of Health and Human Services,
through the Healthy People 2010 initiative and health services researchers, requested that health-
related items be included in the 2003 Department of Education’s National Assessment of Adult
Literacy (NAAL), which evaluated the need for adult education due to below basic skill levels
(Berkman et al., 2010). The results of the 2003 NAAL study revealed that 90% of survey
respondents had trouble using widely available health information from sources such as medical
offices, media, community, and retailers (Eadie, 2104; Kutner, Greenberg, Jin, & Paulsen, 2006).
These results catapulted the need for individual health literacy skills into the national spotlight as
a serious public health concern.

2.2.1 Literacy
Research on health literacy carried out by medical researchers and health educators were
summarised. Now the focus is on Literacy Studies, a field of research populated by linguists,
education researchers, psychologists, social anthropologists and others. Literacy Studies is a field of research that is concerned with the role of reading and writing in different social contexts and situations and by different groups of people. The focus of Literacy Studies goes beyond reading and writing in schools and formal education. It is interested in looking at the importance of literacy in people’s everyday lives and in institutions and workplaces. This is also what makes Literacy Studies relevant to the topic of this literature review. A small number of studies have looked at the role of written texts in health-care contexts.

For most of its history in English, the word ‘literate’ meant to be ‘familiar with literature’ or, more generally, ‘well educated, learned’. Only since the late nineteenth century has it also come to refer to the abilities to read and write text, while maintaining its broader meaning of being ‘knowledgeable or educated in a particular field or fields. Thus, the original meaning of the English word ‘literacy’ is different from its translations in several other languages. Since the mid-twentieth century, scholars have devoted considerable attention to defining literacy, and their work has had direct implications for approaches to practice and policy (Fransman, 2005). Academics from such wide-ranging disciplines as psychology, economics, linguistics, sociology, anthropology, philosophy and history have engaged in an ongoing and, at times, highly contested debate over the meaning and definition of the term ‘literacy’ and how it is related to the broader notions of education and knowledge. Taking into account these evolving debates, including the major traditions, critiques and approaches to literacy, this section presents four discrete understandings of literacy:

1. Literacy as an autonomous set of skills;
2. Literacy as applied, practised and situated;
3. Literacy as a learning process;
4. Literacy as text.

These broad areas of enquiry accommodate almost all theoretical understandings of literacy.

2.2.1.1 Literacy as skills (Reading, writing and oral skills)

The most common understanding of literacy is that it is a set of tangible skills particularly the cognitive skills of reading and writing that are independent of the context in which they are acquired and the background of the person who acquires them. Scholars continue to disagree on the best way to acquire literacy, with some advocating the ‘phonetic’ approach and others ‘reading for meaning’, resulting in what has sometimes been called the ‘reading wars’ (Goodman, 1996 & Street, 2004). The emphasis on meaning has recently given way to ‘scientific’ attention to phonetics, word recognition, spelling and vocabulary. This approach has lately turned to research in the cognitive sciences on important features of human memory (e.g. how the brain processes reading patterns) and to techniques such as phonological awareness training and giving increasingly faster-reading tasks (Abadzi, 2003, 2004).

A tendency to favour the ‘scientific’ principles of phonetics has given rise to claims that writing is the transcription of a speech and hence ‘superior’ to it. Similarly, some claim the alphabetic system is technologically superior to other script forms, since it is phonetic, rather than reliant on pictures to denote meaning (Olson, 1994 & Street, 2004) notes that many such views are founded on deeper assumptions about the cognitive consequences of learning to read and write. The cognitive argument has been linked to broader societal development so that literacy becomes a condition or instrument for economic growth, ‘progress’ and the transition from ‘oral’ to ‘literate’ cultures (Olson, 1994). The transition from oral to literate modes has a fundamental impact on
human consciousness. Not only does it allow for the representation of words by signs, but it gives a linear shape to thought, providing a critical framework within which to think analytically. While rational consciousness is often taken to be a given good, it derives from a classical epistemology, which may be less appropriate for societies founded on different patterns of thought and interaction. Consequently, an understanding of literacy that maintains some focus on oral skills is desirable.

In the 1970s, some social psychologists argued that many of the assumptions about literacy, in general, were linked to school-based writing, resulting in serious limitations in accounts of literacy particularly in the claim that it improves faculties of reasoning (Scribner & Cole, 1978).

Numeracy and the competencies it comprises usually understood either as a supplement to the set of skills encompassed by literacy or as a component of literacy itself. A recent research review notes that the English term ‘numeracy’ was first coined in 1959 (in the Crowther report submitted to the United Kingdom’s Ministry of Education), as the ‘mirror image of literacy’, to refer to a relatively sophisticated level of what we now call ‘scientific literacy’ (Coben, et al., 2003).

Numeracy is most often assumed to depend upon a solid mathematical education and innumeracy to be the result of poor schooling. This ‘limited proficiency’ conception of numeracy, which emphasizes equipping the workforce with minimum skills, continues to dominate and has been adopted by many national and international assessment agencies (Coben et al., 2003). More recently, ‘numeracy’ has been used to refer to the ability to process, interpret and communicate numerical, quantitative, spatial, statistical and even mathematical information in ways that are appropriate for a variety of contexts. The term increasingly refers to a competence allowing more effective participation in relevant social activities (Evans, 2000).
2.2.1.1.2 Skills enabling access to knowledge and information

The word ‘literacy’ has begun to be used in a much broader, metaphorical sense, to refer to other skills and competencies, for example ‘information literacy’, ‘visual literacy’, ‘media literacy’ and ‘scientific literacy’. International organizations – notably the OECD through publications such as *Literacy in the Information Age* (2000) and *Literacy Skills for the Knowledge Society* (1997) – have given impetus to the use of such terms, eventually giving rise to a new French term, *littératie* (Fernandez, 2005). The meaning of these concepts tends to be diverse and shifting, ranging from the view of literacy as a set of largely technical skills (the OECD perspective) to the idea that these skills should be applied in critical ways to examine one’s surroundings (e.g. the workplace and the media) and push for social change (Hull, 2003).

Acknowledging the limitations of a skills-based approach to literacy, some scholars have tried to focus on the application of these skills in ‘relevant’ ways. One of the first coordinated efforts to do so was through the development of the notion of ‘functional literacy’. In the 1960s and 1970s, this concept initially emphasized the impact of literacy on socio-economic development. Views of functional literacy often assumed literacy could be taught as a universal set of skills (applicable everywhere) and that there was only one literacy, which everyone should learn in the same way.

Literacy was seen as neutral and independent of social context. This understanding evolved as scholars argued that the ways in which literacy is practised vary by social and cultural context (Barton, 1994).
Among key concepts in this view of literacy are literacy events (any occasion in which a piece of writing is integral to the nature of the participants’ interactions and their interpretative processes) and literacy practices ‘the social practices and conceptions of reading and writing’ (Street, 2004). The literacy as applied, practised and situated approach questions the validity of designations of individuals as ‘literate’ or ‘illiterate’, as many who are labelled illiterate are found to make significant use of literacy practices for specific purposes in their everyday lives (Doronilla, 1996). Yet, this approach has been criticized by some scholars, who claim it overemphasizes local exigencies and insufficiently recognizes how external forces (e.g. colonial administrations, missionaries, international communication and economic globalization) have impinged upon the ‘local’ experiences of specific communities (Brandt and Clinton, 2002; Collins and Blot, 2003). Maddox (2001) and Stromquist, et al. (2004) question the reluctance of advocates of this approach to examine the potential of literacy to help people move out of ‘local’ positions into fuller economic, social and political participation.

As individuals learn, they become literate. This idea is at the core of a third approach, which views literacy as an active and broad-based learning process, rather than as a product of a more limited and focused educational intervention. Building on the scholarship of Dewey and Piaget, constructivist educators focus on ways in which individual learners, especially children, make sense of their learning experiences. In the field of adult education, some scholars see the personal experience as a central resource for learning.

More recently, social psychologists and anthropologists have used terms such as ‘collaborative learning’, ‘distributed learning’ and ‘communities of practice’ to shift the focus away from the individual mind and towards more social practices building on newer understandings of literacy (Rogoff, 2003). Rogers (2003) distinguishes between ‘task-conscious’ learning, typically
evaluated by test-based task completion, and ‘learning conscious learning’, which is assessed from the perspective of the learner.

The more traditional learning methods of children (‘task-conscious test learning) are often used for adults, as is evident in many adult literacy programmes. Paulo Freire is perhaps the most famous adult literacy educator whose work integrated notions of active learning within socio-cultural settings. Freire emphasized the importance of bringing the learner’s socio-cultural realities into the learning process itself and then using the learning process to challenge these social processes. Central to his pedagogy is the notion of ‘critical literacy’, a goal to be attained in part through engaging with books and other written texts, but, more profoundly, through ‘reading’ and ‘writing’ the social world. Freire’s ideas have been used as pedagogical tools to support learners who have been oppressed, excluded or disadvantaged, due to gender, ethnicity or socio-economic status.

In francophone Africa, scholars such as Joseph Ki-Zerbo from Burkina Faso have documented mobilization for an ‘Africanized’ literacy that would directly respond to the pressing communication needs of the continent (Fernandez, 2005).

The fourth way of understanding literacy is to look at it in terms of the ‘subject matter’ (Bhola, 1994) and the nature of the texts that are produced and consumed by literate individuals. Texts vary by subject and genre (e.g. textbooks, technical/professional publications and fiction), by the complexity of the language used and by ideological content. This approach pays particular attention to the analysis of discrete passages of text, referred to by socio-linguists as ‘discourse’. Influenced by broader social theories, it locates literacy within wider communicative and socio-
political practices that construct, legitimate and reproduce existing power structures (Fairclough, 1991).

In summary, these four approaches broadly reflect the evolution of the meaning of ‘literacy’ in different disciplinary traditions.

### 2.2.2 Information Literacy

The term information literacy is credited to Paul Zurkowski. Zurkowski (1974) used the phrase to describe the “technique and skills” known by the information literate for utilizing the wide range of information tools as well as primary sources in moulding information solutions to their problem. Information literacy also is increasingly important in the contemporary environment of rapid technological change and the proliferation of information resources. Goad (2002) defined IL as “the ability to search for, find, evaluate and use information from a variety of sources”. IL is the foundation for effective lifelong learning practice, personal and professional empowerment. According to Pennell (1999), information literate students are competent and independent learners because they are able to display confidence in their ability to know what relevant information will be able to solve an information need.

Information literacy as a field of study has been more actively pursued well in North America and Australia and the UK. In the US, there have been a lot of initiatives. The first initiative is the Institute for Information Literacy and the second one is the National Forum on Information Literacy. These two initiatives encourage the teaching of information literacy both in the second cycle and tertiary institutions. The forum support initiates and monitors the projects of IL both in the US and abroad (Johnson & Webber, 2017). Some scholars have suggested that the digital
divide between the developed and developing world has widened because of the lack of information literacy skills in developing countries Dewan, Ganley and Kraemer (2005). The low level of information literacy among Africans has led to inefficient use and utilization of ICT in developing nations.

Dorman and Gorman (2006) in trying to defined information literacy for the developing country, defined information literacy as the set of abilities of an individual or group of people in their unique context: to understand when information can help, to know how to find and evaluate it, to understand to integrate the relevant, information to create new knowledge or add to existing knowledge, to use this knowledge as needed to resolve their problems and to evaluate and learn from experience. Developing nations, as well as less developed countries, must strive in their effort to find pragmatic strategies to address the issue of IL across all sectors. To this effect, Dadzie (2007) emulated that a joint project should be put together to help individual countries to broaden and intensify their existing activities on IL implementation as well as promotion.

Aiyepeku, Atinmo and Aderinoye (2002) advocating for the development of Information Literacy in developing countries stated that program should be developed to suit the specific needs and local environment proposed that the goal of information literacy programs in Africa should be to help “inculcate a lifelong habit of identifying an information need and efficiency searching for and using, indigenous oral, print, electronic and other sources of information to satisfy that need and thereby enhance personal, community and socio-economic interest”. Aggrey (2009) took a bigger view of Information Literacy skills across Ghana and advocated for the development of National Information Literacy Standards to support students’ academic work in the long term, he further recommended the teaching of information retrieval at all levels of both new and continuing students at the University.
To be information literate, a person must be able to recognize when information is needed and have the ability to locate, evaluate and use effectively the needed information. Ultimately information literate people are those who have learned how to learn. They know how to learn because they know how information is organized, how to find and how to use information in such a way that others can learn from them. Osborne (2004) asserts, “Information literacy is about people to operate effectively in an information society. This involves critical thinking, awareness of personal and professional ethics, information evaluation, conceptualizing information needs, organizing information, interacting with information professionals and making effective use of information in problem-solving”. UNESCO defines information literacy broadly as ‘refer to the ability to access and use a variety of information sources to solve an information need’.

2.2.3 Health Information

The significance of health information to community development has been variously highlighted and justified by various authors. Ties (2013) stressed that health information is a critical component of a community system and is essential for generating and reporting data for the national level which in the long run enhances development. WHO (2014) health information gives a clear picture of health and sickness across the entire population and this knowledge can help prevent the spread of disease and improve individual health. The advent of the information age and related increase in the amount of information potentially available and enhance focus on self-monitoring and self-care, as well as interest in predictors of health promotion and illness prevention activities has given rise to health information seeking among the public (Johnson, 2003).

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2.3 Health Information Needs

The idea of information in information science is described in various means. Information is defined as data that is organised to produce meaning and that actively informs some phenomenon of interest. This means that its value is largely dependent on the context and the user and it is the user who determines what information is. All information is transmitted by means of communication and only useful if it is relevant, reliable and accurate.

The information needs of the individual change at different stages of his/her career and with changes in his/her projects. “It is, perhaps, self-evident that information needs will vary not only according to the subject interest of the users but likewise in relation to the type of activity in which they are engaged.” Rees’ observation (1963) can be extended even further, Information is gained throughout life. It is often perceived by one individual differently than it is by another. This is what makes information so elusive and the determination of information needs so uncertain. The information needs of the individual change as the various aspects of a task or problem are completed. New needs appear as former needs fade.

According to Maslow, these needs can create internal pressures that can influence a person’s behaviour. The needs theories attempt to identify internal factors that motivate an individual’s behaviour and are based on the premise that people are motivated by unfulfilled needs. If one looks at the needs we do have esteemed needs that refer to the need for self-esteem and respect, with respect and respect and admiration from others. Employees who might be prompted to seek for information due to some other compelling factors. Some of these factors might need to learn as articulated by Maslow in his theory of humanistic learning to (1908-1970). Because of diversified nature of needs Wilson’s definition of information seeking Wilson (1999) stated that, "those activities a person may engage in when identifying their own needs for information, searching for
such information in any way, and using or transferring that information” Wilson is in agreement that people will always seek for information because of a number of reasons.

2.3.1 Factors that influence health information needs.

A fundamental aspect of health-seeking, in general, is the information needs of the individual. Health information needs to influence what patients do in the treatment and management of their health conditions (Parker et al., 2018). Health information need has been defined as the subjective evaluation of patients in relation the health information they consider as important in helping them manage their conditions (Akuoko et al., 2017; Clegg-Lamptey et al., 2009). Health information needs require critical health needs assessment where patients examine issues relating to their health such as their immediate health concerns, opportunities and barriers for meeting those concerns (Couture, Chouinard, Fortin & Hudon, 2017). Health information needs, therefore influence the sources from where patients access their health information.

The health issues of individuals in a community are fundamentally determined, in part, by functional health need, cognitive consciousness and accessible health information at their disposal (Nutbeam, 2008). These are affected by the cultural settings, educational opportunities, behavioural skills gained and socio-economic factors that support social life in the community. It is now an accepted fact that health behaviour has connections to health outcomes and these connections, in turn, are dependent on issues related to health-seeking (Sokey, 2016).

Tsehay (2014) studied the sources of maternal health information in rural Ethiopia. Using focus group discussions and in-depth interviews, Tsehay sampled women from the Mecha woreda district in the Amhara State in Addis Ababa. The health information-seeking behaviour of the
women was driven by the diseases they had been affected with or what a family member had suffered, and their quest to live a healthy life. Some of the diseases the rural women seeking information on include: Malaria, Maternal Mortality and morbidity, HIV/AIDS and Communicable Diseases. He further found that interpersonal sources were the main channels of maternal information. Health extension officers and health professionals were the most frequently accessed and most preferable source of information. These health workers were primarily nurses and midwives who were available for consultation whenever the rural women needed assistance or information on particular health issues. Tsehay (2014) also found that families and friends were the next most accessed source of health information. The rural women also used social gatherings like coffee ceremonies as avenues to seek information from friends. They inquired maternal information from friends who had participated in formal information provision services offered by professionals. Modern sources (electronic or print media) were found to be the least consulted source of maternal information among the women whilst a few women used the booklets and brochures provided by the health officers, the broadcast media, especially radio.

I. Recognise health information need: this means knowing what is known, knowing what is not known and identifying the gap.

II. Distinguish ways of addressing a gap: this refers to knowing which information sources are likely to satisfy the information need.

III. Construct strategies for locating information: this indicates knowing how to develop and refine an effective search strategy.
IV. Locate and access: this refers to knowing how to access information sources and search tools to access and retrieve information.

V. Compare and evaluate: this involves knowing how to assess the relevance and quality of information retrieved.

VI. Organise, apply and communicate: implies knowing how to associate new information with the old, to take actions or make decisions and ultimately how to share the outcomes of these actions or decisions with others.

VII. Synthesise and create: this refers to knowing how to assimilate information from a variety of sources for the purpose of creating new knowledge.

The Seven Pillars Model can be likened to a ladder of progression that is from the path of a novice to that of the expert.

2.4. Health Information Source

An integral aspect of the current public health landscape is the emergence of an unprecedented high number of sources from which individuals obtain information including health information (WHO, 2017). There is a countless number of places and avenues where individuals can obtain information regarding their health. Information sources are therefore defined as the various avenues, outlets or places from which patients obtain health information that they use to manage their conditions (Scantlebury, Both & Hanley, 2017).

According to Corrarino (2013), adults obtain health-related information in a number of ways including traditional (eg, newspapers, books, magazines) as well as non-traditional (eg, the
Internet) print media sources. In addition, adults obtain health-related information through nonprint media (eg, television and radio). A US Department of Education survey measured how people with varying levels of health literacy obtained information about health matters. Fewer adults with below basic health literacy reported that they obtained health information from written sources compared with those with higher levels of health literacy. For example, 41% of those with below basic skills obtained no information from books or brochures compared with 11% of those at intermediate or proficient health literacy levels. Similarly, 80% of those with below basic health literacy never obtained information from the Internet, compared with only 15% of those with proficient health literacy. This is an area that is evolving and deserves further study with regard to the utilization and impact of these modalities for persons with lower health seeking skills. When it came to nonprint media, there were differences as well. The authors reported that persons with below basic health literacy were almost twice as likely to obtain a lot of information from television and radio (33%) as those with proficient levels (17%). Higher percentages of those with intermediate or proficient levels obtained health information from health professionals (eg, physicians, nurses and midwives, etc.). Those with below basic levels were more than twice as likely to never obtain health information about health matters from health professionals as those with proficient levels (18% vs 8%).

2.5 Health Information Seeking

Education has been an essential component of action to promote health and prevent disease throughout this century. The campaign to promote immunization, maternal and child health and to prevent communicable diseases have a long history Nutbeam (2010). According to Baker (2006), expert panel divided the domain of "health seeking" into cultural and conceptual knowledge, oral
literacy, including speaking and listening skills, print literacy, including writing and reading skills, and numeracy. Poor literacy skills among adults are surprisingly common in developed countries. Estimates of the proportion of the population in individual Organisation for Economic Co-operation and Development (OECD) countries lacking functional literacy skills range from 7% to 47% (UN Development Program, 2007). In developing countries, these figures are far higher. Though there is a range of definitions of functional literacy, most focus on the ability to read the basic text and write a simple statement on everyday life. Functional literacy is important. It is through these skills of reading and writing that those who are literate are able to participate more fully in society, both economically and socially, and are able to understand and exert a higher degree of control over everyday events (Nutbeam, 2008). According to Parker (2000), it is not surprising that low literacy in a population is associated both directly and indirectly with a range of poor health outcomes. Research shows a relationship between low literacy levels and declining use of available health information and services. This is observed in relation to responsiveness to health education, the use of disease prevention services and poor self-management of disease (DeWalt, Berkman, Sheridan, Lohr & Pignone, 2004; Nutbeam, 2008). Research has exposed the relationship between low literacy, patient decision making, compliance with prescribed medication use, and capacity to self-manage disease has emanated from the United States, Canada and other European countries. The Institute of Medicine (2004), report health literacy as the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions. This approach infers that ‘adequate functional health literacy means being able to apply literacy skills to health-related materials such as prescriptions, appointment cards, medicine labels and directions for home care’ (Parker et al., 1995).
Many medical librarians offer services to help patients and consumers find the best available and current information (Parker et al. 2017; WHO, 2017). Health information seeking is a simple yet complex and integrate concept which requires two essential elements that are recognizing health information needs and identifying appropriate health information sources (Sbardutt, 2001).

2.6. Health seeking behaviour and life expectancy among women.

Poor health-seeking behaviour (HSB) is associated with many negative health outcomes and is a major challenge in public health and health outcome. An individual with an adequate level of health-seeking behaviour has the ability to take responsibility for one’s own health as well as one’s family health and community health. According to Tokuda, et al. (2009), there is a growing body of evidence supporting the impact of poor health-seeking on the health of individuals. Inadequate or health-seeking behaviour has been linked to lower use of preventive services, delayed care-seeking when symptomatic, poor understanding of one’s medical condition, low adherence to medical instructions, poor self-care, higher healthcare costs and increased mortality. Despite accumulating evidence on health issues related to health-seeking behaviour or health literacy in the U.S. and European countries, a recent study indicated no association between health literacy and health status in ethnic minorities in the U.S. To determine the association between functional health-seeking behaviour and physical and mental health status in Latinos and African Americans, Guerra and Shea (2007) et al. conducted a cross-sectional study that used the STOFHLA and SF-12 in a sample of about 1300 Medicaid and/or Medicare Latino and African American adult patients at community clinics in Philadelphia and found that health literacy was not significantly associated with physical or mental health status thus questioning the generalizability to a sample.
of ethnic minorities of the perceived link between inadequate health literacy and poor health status.

Thus, research on the potential link between health literacy and health status is needed for people living outside the U.S. or Europe. Adequate levels of health literacy are reported to assist in reducing health care cost, preventing illness and chronic diseases and reducing mortality rates (Canada Council on Learning, 2008). Health seeking behaviour, on the other hand, is a strong determinant of health outcomes. There is a growing body of evidence which demonstrates that limited health literacy is associated with higher utilization of health services and poorer health status (Keleher & Hagger, 2007).

Gottfredson and Deary (2004) found out in their research that, “intelligence has been linked with various health behaviours and outcomes. On the positive side, physical fitness, a preference for low-sugar and low-fat diets and longevity increase with higher intelligence; on the negative side, alcoholism, infant mortality, smoking and obesity increase with lower intelligence”. Gottfredson and Deary (2004) explained in their results that, intelligence enhances individuals’ care of their own health because it represents learning, reasoning, and problem-solving skills useful in preventing chronic disease and accidental injury and in adhering to complex treatment regimens. Psychometric intelligence has manifested in generic thinking skills such as efficient learning, reasoning, problem-solving, and abstract thinking. High intelligence is a useful tool in any life domain, but especially when tasks are novel, untutored, or complex and situations are ambiguous, changing, or unpredictable (Gottfredson, 2002).

Dealing with the novel, ever-changing, and complex is what health self-care demands. Preventive information proliferates, and new treatments often require regular self-monitoring and complicated
self-medication. Good health depends as much on preventing as on ameliorating illness, injury, and disability. Preventing some aspects of the chronic disease is arguably no less cognitive a process than preventing accidents, the fourth leading cause of death in the United States, behind cancer, heart disease, and stroke (Gottfredson, 2002). Preventing both illness and accidents requires anticipating the unexpected and “driving defensively in a well-informed way, through life. The cognitive demands of preventing illness and accidents are comparable, remain vigilant for hazards and recognize them when present, remove or evade them in a timely manner, contain incidents to prevent or limit the damage, and modify behaviour and environments to prevent reoccurrence. Health workers can diagnose and treat incubating problems, such as high blood pressure or diabetes, but only when people seek preventive screening and follow treatment regimens.

Many do not. In fact, perhaps a third of all prescription medications are taken in a manner that jeopardizes the patient’s health. Non-adherence to prescribed treatment regimens doubles the risk of death among heart patients (Gallagher, Viscoli, & Horwitz, 1993). For better or worse, people are substantially their own primary health care providers.

In Ghana, (Avogo, 2013 and Amoah, 2017) found that direct participation in voluntary groups such as health and other medical group is associated with the likelihood of reporting positive health status in Ghana. Health seeking behaviour has become an essential component of health systems because of its potential to reduce inequalities in health outcomes (Haun et al., 2015). From a public health perspective, health-seeking behaviour is now a requisite for individuals and groups as health systems continue to make complex demands on consumers and expect greater understanding from them (Nielsen-Bohlman, Panzer & Kindig, 2004). A significant body of literature has reported outcomes among different population groups across several contexts on the relationship between
health education and longevity of lives (Berkman et al., 2011; Protheroe, Wolf & Lee, 2012).

Friedman, Kern, & Reynolds (2010) information on health outcomes that involve important matters such as longevity, serious disease, or productivity can be difficult to gather and because the optimal research designs often involve long-term, longitudinal study, psychological research commonly relies solely on subjective health and well-being. Epidemiological studies researchers have discussed suggest that health care policy and practice will be more effective if they take into account how cognitive competence influences health and survival.

2.6.1 Health Seeking behaviour and Prevalence

Health seeking behaviour involves skills that allow patients to evaluate complex medical information and make treatment decisions for themselves or their relatives or loves ones. The National Network of Libraries of Medicine (NNLM) (2013) and the U.S. Department of Health and Human Services (HHS) (2014) lists the following as important health-seeking skills:

1. The ability to critically analyse the integrity and quality of health information in spoken word, print and internet.
2. Evaluate the risks and benefits involved in health care situations and decisions, determine the proper dosage of medication based on provider directions or medication labels.
3. Have the ability to access health information
4. Have a general knowledge of the body and diseases or medical conditions.

For persons to complete such tasks, they likely need to be able to interpret visual information such as graphs or pictorial representations, be able to operate a computer effectively, have a basic understanding of the human body, be able to find and apply pertinent information.
Also, of significant importance is the ability of both layperson and professionals to communicate verbally. It is critical for patients to correctly state their medical concerns, health history, symptoms and questions to providers. Just as important is the ability of the professional medical doctor to use verbal and non-verbal communication in a way that enhances the layman’s ability to understand what a provider says during a medical encounter (HHS, 2014). In recent years people-centred care, also known as patient-centred care, has become considerably integrated into health care. This approach of medicine places the patient in a shared decision-making role with the physician, with the intention to improve health care. This is a step in the right direction, but it also makes the role of health literacy all the most important (NNLM, 2013).

2.7 Social demography (age, education, religion and income level) and health Seeking

In a recent report, 48% of U.S. adults lack the reading and numeracy skills to fully understand and act on health information. Similarly, substantial portions of European populations have also been shown to have inadequate health literacy. Limited functional health-seeking abilities among adults is a major public health problem. Functional health literacy is defined as an individual’s capacity to obtain, process, and understand basic health information and services sufficiently to make appropriate health decisions and will be used interchangeably with the term “health literacy” in this review (Institute of Medicine, 2004). Limited health-seeking behaviour is of particular concern among older adults, who often have increased needs for health information and services to maintain their health and well-being. National literacy surveys indicate that more than 70% of adults aged older than 65 years in the world lack the basic health literacy skills required for successful interactions with health systems (Canadian Council on Learning, 2008; Kutner, Greenberg, Jin, & Paulsen, 2006). Outcomes of limited health literacy among older adults include
the incorrect taking of prescription medication, poor chronic disease management, low use of preventive health services, and increased risk of overall mortality (Berkman, Sheridan, Donahue, Halpern, & Crotty, 2011; Sudore et al., 2006).

Tokuda, et al. (2009) Educational attainment, along with race and age, has been shown to be the leading demographic predictors of health-seeking in the U.S. their research show participants with low health-seeking abilities represented a higher proportion of those with a lower educational attainment, while participants with adequate health literacy represented a higher proportion of those with a higher education attainment.

Figure 2.1 shows the physical and psychological wellbeing by health literacy level. A bar indicates the mean value of scores by health literacy level. It explains the relationship between literacy and the wellbeing of an individual. The findings from Tokuda, et al (2009) shows that people of high literate are more likely to physically and psychological health advantageous because they are more health literate as compare to their counterparts who are less or low or not literate. The fewer literates have a deficiency in health literacy, which transcends to affecting their physical and psychological wellbeing.

Figure 2.1 Physical and Psychological Wellbeing of Health Literacy
Studies conducted by Paasche-Orlow et al. (2005) shows that the most common demographic features reported to be associated with health literacy were education level, age, ethnicity, geographic location, and income. The studies reveal that education, age and income have a great influence on the individual’s health status. Cutilli, (2007) identified that the demographic data from her research show that multiple factors influence an individual's health-seeking behaviour. Besides age, individuals with less education, lower income, “blue-collar” jobs, and poor health status (mental and physical) can be at risk of marginal or inadequate health-seeking ability. Providing care to low health literacy patients is complicated by commercially prepared healthcare materials.

Moreover, recent studies show that community-dwelling elderly persons found that the negative association between reading skills and age persisted even beyond age fifty-five. Poor reading skills
among older populations have tremendous importance because of this group’s high prevalence of chronic disease and their need to know sources health-related information. Studies suggest that reading ability may deteriorate with age. Reading is a complex cognitive process that requires adequate vision, concentration, word recognition, working memory, and information processing. Deficits in any of these areas may affect reading comprehension, and the prevalence of these problems may increase with age. Which in effect leads to poor sources of health information or health-seeking behaviour among people.

Ageing has often been conceptualized as a progressive pathological breakdown of normal health functioning until death (Siegler, Bosworth, & Elias, 2003) and the individual’s accepting and adapting to this natural decline as constituting successful old age (Aguerre & Bouffard, 2003).

2.8 Factors or challenges that mitigate health-seeking among market women

Health seeking behaviour is a significant problem in Africa, affecting major of people. Low health literacy has been linked to poor seeking behaviour and poorer health outcomes. Health seeking behaviour is an essential element of a woman’s ability to identify a need, find the appropriate source, process, and act on health-related information and spans health promotion and disease prevention activities. The impact of inadequate health-seeking skills touches women, their children, and their families. Without an appropriate level of understanding regarding health care information through seeking, it is difficult to make informed decisions that can, in turn, translate into improved health outcomes (Corrarino, 2013).

Access to information is becoming increasingly important for individuals’ health decisions. Recovery after illness, sickness absence and rehabilitation also involve decisions that are likely to
be better if based on relevant information. There seems to be a growing and implicit obligation on the part of individuals to search for information themselves, to understand rights and responsibilities and to make decisions in health issues. The purpose is to enable individuals to promote health or solve health problems by themselves or to be an active partaker and negotiator in health care interventions. Decisions in health issues are complicated, however considering the increasing amount of information about health, illness and healthcare. A crucial feature of an individual’s access to and benefit of health information is her (market woman) level of health literacy.

Health Information literacy skills broadcast programmes cannot be without proper integration into the educational system across the basic and secondary level, churches and other community areas. World Bank in 2013 revealed, developing countries are faced with a number of problems in their quest to health information literacy programmes. These major challenges or problems are; Traditional cultural beliefs, Low literacy rate, Low-level publishing and Communication skills.

Findings from a study conducted in Ghana by Aryee (2014) shows a considerable use of mobile phones for disseminating and seeking health information in communities in Ghana. Haddon & Vincent (2007) noted the cost of phone service as the biggest challenge for individuals, especially among youth, to use the device for any form of activities.

Limited English proficiency (LEP) is another key barrier to health care, also associated with poorer health status in Latinos, Asian Americans, and other racial/ethnic groups (Gee & Ponce, 2010; Jacobs, Karavolos, Rathouz, Ferris, & Powell, 2005). Individuals who are isolated from both oral and written materials are uniquely unable to obtain, process and fully understand basic health information and/or access preventive services (Andrulius & Branch, 2007).
2.9. **Summary of Chapter**

This chapter has been able to cover the following areas: introduction and review of related literature covering specifically on all the objectives of the study.
CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter discusses the philosophical assumptions and also the design strategies underpinning this research study. This chapter presents the methodology for gathering the data for the study. The sections captured here are research design and approach, research setting, selection of participants (population of the study, sample and sampling techniques), data collection instrument, ethical consideration, data collection procedures and data analysis while explaining the stages and processes involved in the study.

The research design for this study was a survey method that was analysed through qualitative and quantitative methods. A survey method was used to analysed the market women. Face-to-face interviews and questionnaire were used as data collection methods. Furthermore, the justification for each of the data collection methods to be used in the study would be discussed.

3.2 Research Design and Approach

The research method is a strategy of enquiry, which moves from the underlying assumptions to research design, and data collection (Myers, 2019). Although there are other distinctions in the research modes, the most common classification of research methods is into qualitative and quantitative. Mitchell and Jolly (2012) describe a research design as the plan according to which we obtain research participants (subjects) and collect information from them, with a view to
reaching conclusions about the research problem. A research design thus describes the ways, the processes or techniques for gathering and analysing data (Creswell, 2013).

A research approach is defined as the overall strategy that is chosen to integrate different parts of a study in a coherent manner to address a research question (Ary, Jacobs, Irvine & Walker, 2018). Research approaches fall into two broad categories which are qualitative and quantitative research (Creswell & Creswell, 2017).

The mixed-method approach was adopted because it is appropriate for a descriptive survey and studies that require in-depth investigations and are mostly used in studies that have a very large population size (Creswell, 2013). Mixed-method strategies offset both the weakness of qualitative and quantitative by allowing for both exploration and analysis in the same study. The researcher is able to use all the tools available to them and collect more comprehensive data. This provides results that have a broader perspective of the overall issue or research problem (Bernard & Bernard, 2012).

The qualitative research methodology helped the researcher to access the respondents’ perception, knowledge, ideas, thoughts and beliefs on health whilst the quantitative allowed the researcher to access the opinion of the participants.

On the basis of a review of the reasons for combining qualitative and quantitative research mentioned by the authors of mixed methods studies, Bryman (2006) formulated a list of more concrete rationales for performing mixed methods research. These are;

(a) **Credibility** – refers to suggestions that employing both approaches enhances the integrity of findings.
(b) *Context* – refers to cases in which the combination is justified in terms of qualitative research providing contextual understanding coupled with either generalizable, externally valid findings or broad relationships among variables uncovered through a survey.

(c) *Illustration* – refers to the use of qualitative data to illustrate quantitative findings, often referred to as putting “meat on the bones” of “dry” quantitative findings.

(d) *Utility* or improving the usefulness of findings – refers to a suggestion, which is more likely to be prominent among articles with an applied focus, that combining the two approaches will be more useful to practitioners and others.

(e) *Confirm and discover* – this entails using qualitative data to generate hypotheses and using quantitative research to test them within a single project.

(f) *The diversity of views* – this includes two slightly different rationales namely, combining researchers’ and participants’ perspectives through quantitative and qualitative research respectively, and uncovering relationships between variables through quantitative research while also revealing meanings among research participants through qualitative research. (Bryman, p. 106).

In this case, the mixing of methods, methodologies, and/or paradigms will help answer the research questions and make improvements over more basic study design. Fuller and richer information will be obtained in the mixed methods study where the researcher would use both questionnaire and interview. The questionnaire was for shop owners in the market and the interview for market leaders.
3.3 Research Setting

A research setting is defined as the location or the place where the data for a study are gathered (Creswell & Creswell, 2017). Research settings can be organisations or institutions, community, district, region or a country based on what the focus of the study. The current study was a Municipal-based research where the study was taken from a market place specifically Madina market.

Madina is a fast-developing suburban settlement situated on the Accra plains some 16.0934 kilometres northeast of Accra on the Accra - Aburi Road and some 3.21869 kilometres north of the University of Ghana, Legon. The historical background to the founding of Madina in 1959 by Muslims from Northern Ghana and elsewhere, and its subsequent development as a 'mixed' suburb with residents of many different ethnic and widely different occupational and educational backgrounds (Beery, 1967). The Madina market is suitable for the study because it has a large number of market women and most of these women stay in the farming areas (peri-urban communities) within the municipal who come to the market to trade and go back after close of the day. Furthermore, the Madina market has heterogeneous market women who meet the researcher’s needs and the market is accessible to the researcher.

The La Nkwantanang-Madina Municipal District is one of the sixteen (16) districts in the Greater Accra Region of Ghana. Its capital is Madina. La Nkwantanang-Madina Municipal district was established in 2012 by Legislative Instrument (L.I.) 2131. The total area of the district is 70.887 square kilometres. According to the 2010 census, the population of the district is 111,926, with 54,271 males and 57,655 females. The study will investigate market women between the ages of 20 and 60 above years of age who trade at the market.
3.4 Selection of Participants

This section describes how participants were selected for the study. This sub-section discussed here the description of the population for the study, sample size and sampling techniques for selecting participants.

3.4.1 Population of the Study

A research population is a well-defined collection of individuals who share similar characteristics based on what a researcher is interested in and therefore qualify to be included in the study (Creswell, 2013). Within the context of research, a population is defined as a group of individuals taken from the general population who share a common characteristic, such as age, sex, or work conditions who are researched on because of their relevance to a research question (Uprichard et al., 2018).

The Population and Housing Census (2010), results indicate that more than one-third (35.5 %) of the population (of both sexes) is engaged in service and sales work, especially females (51.8 %). This is expected because traditionally, such occupations are associated with females. Higher proportions of males than females are engaged in craft and related trades (28.3% and 15.7% respectively) and plant and machine operators and assemblers (14.3% and 0.4% respectively). This indicates the most women in the Municipality are into trading. According to the Population and Housing Census (2010), an estimated population of 29,865 women engage in trading in the Municipality. The researcher will conduct the study on market women in Madina who own shops recognized by the Municipal Assembly or sell in shops.
The study investigated market women who were in shops and trade legally at Madina Market since such individuals have their records with the Madina Municipal Assembly and in a better position to give well-informed opinions about health-seeking behaviour and the researcher can easily locate them in case of follow up questions or follow up on them for later information. According to the Madina Municipal office (2018), the number or list of women who own or in shops in the market is 1,020. Therefore, the population for the study was 1,020.

The researcher intended to consider the various market queens in his study. In this instance, he cannot give the exact population of the market queen since every commodity sold in the market have their queen.

### 3.4.2 Selection of Sample (size and techniques)

A sample is defined as the proportion of a population that is selected for research (Patten & Newhart, 2017). Two reasons account for why a sample is selected from the population. The reason is that, especially in social science research, it is impossible or impractical to study the entire population and secondly, it is allowed to select a portion of the population to study and inferences made about the entire population (Creswell & Creswell, 2017). A sample size ensures that a true picture is gained about the entire population of interest.

For the purpose of research, the sample size is always selected from the population and used for the research. However, the sample size should be large enough so that the findings from the study can be generalized to the entire population (Paquot & Plonsky, 2017). A sample size explains the specific number of elements that will be selected from the population or universe for the study (Kothari, 2004). Kothari stated that a sample should not be too large or too small but fairly
representative of the population. According to Neuman (2006), a researcher will be motivated by three issues for his or her sample size. That is;

1. The degree of accuracy required.
2. The diversity of population and
3. The number of different variables to be examined at the same time.

In reference to this study, 10% of the population will be considered as the sample size as stated by Neuman (2006). Thus, the sample size is calculated by dividing ten by one hundred and multiplying by the population.

Sample size (SP) = \( \frac{10}{100} \times 1020 = 102 \).

There are two broad categories of sampling techniques, these are probability sampling and non-probability sampling techniques. Probability sampling is the type of sampling procedure where each member of the population has an equal chance of being selected for the study.

On the other hand, non-probability sampling, on the other hand, is a sampling technique, where the elements of a population do not have equal chances of selection (Creswell, 2013). In this study, mixed research methodology was adopted. Qualitative analyses typically require a smaller sample size than quantitative analyses but qualitative sample sizes should be large enough to obtain enough data to sufficiently describe the phenomenon of interest and address the research objectives. The goal of qualitative researchers is the attainment of saturation. Saturation occurs when adding more respondents or participants in the study does not result in additional perspectives or information. Glaser and Strauss (2017) recommend the concept of saturation for achieving an appropriate sample size in qualitative studies. Other guidelines have also been recommended, for an ethnography, Creswell (2013) suggested approximately 30 – 50
participants. For grounded theory, suggested 30 – 50 interviews, while Glaser and Strauss (2017) suggested only 20 – 30. For phenomenological studies, Creswell (2013) recommends 5 – 25 and suggests at least six. These recommendations will help the researcher estimate how many participants he will consider, but ultimately, the required number of participants will depend on when saturation is reached.

The sample of participants was selected using convenience sampling technique for market women who sell in shops, inclusion criteria were women from the age of 20 years and above who own or sell in a shop, while market women less than 20 years of age, hawkers and women who came to the market to buy products were excluded (Obaji et al., 2013) and snowball technique for the market leaders. Creswell (2013) a convenience sampling technique has an element of flexibility in the selection of research participants such that participants who are available at the time of data collection and are ready to take in the study are used.

3.5 Data Collection Instrument

According to Hsu (2007), data collection instruments is the tools or means through which a researcher measures the variables of interest in a study through the process of data collection. The research instrument is important as it serves as a means through which a researcher can gain insight into a phenomenon under research or study. Data collection instruments used in this study included observation, questionnaire, interview and review of papers. The instrument for the study was a mixed-method, which consist of questionnaire and personal interview. According to Frankfort-Nachmias et al (2015), Personal interview is a face-to-face situation in which an interviewer asks respondents questions designed to elicit answers pertinent to the research hypothesis. A
questionnaire on the other side, is a set of questions administered to respondents to obtain their concern about a study.

3.5.1 Interview

According to Kumekpor (2002), the interview in social investigation implies more than merely asking questions and expecting answers. It is a conversation between two categories of people. But it is a conversation with a difference. This conversation involves two parties (the interviewer and the interviewee), who are relative strangers to each other and/or who hardly know each other and most probably, will never see each other again after the conversation.

Advantages of Interview

The major advantage of the interview is its adaptability. A skilful interview can follow up ideas, probe responses and investigate motives and feelings, which the questionnaire can never do (Bell, 2010).

According to Frankel and Warren (2006) advantages and disadvantages can be derived from using interviews. Some of the advantages are as follows;

I. Interviews outline increases the comprehensiveness of the data and makes data collection somewhat systematic for each respondent.
II. Respondent’s answers the same questions, thus increasing comparability of responses, data are complete for each person on the topic addressed in the interview and it reduces interviewer effect and biases when several interviewers are used.

III. Data analysis is simple, responses can be directly compared and easily aggregated and many questions can be asked in a short time.

Disadvantages of Interviews

Some disadvantages as given by Frankel and Wallen (2000), are as follows,

I. Important and salient topics may be inadvertently omitted. Interviewer flexibility in sequencing and wording of questions can result in substantially different responses from different perspectives, thus reducing the comparability of responses

II. Little flexibility in relating the interview to particular individuals and circumstances, standardized wording of questions may constrain and limit naturalness and relevance of questions and answers.

There are three fundamental types of research interviews: structured, semi-structured and unstructured. Structured interviews are, essentially, verbally administered questionnaires, in which a list of predetermined questions are asked, with little or no variation and with no scope for follow-up questions to responses that warrant further elaboration. Consequently, they are relatively quick and easy to administer and may be of particular use if clarification of certain questions is required or if there are likely to be literacy or numeracy problems with the respondents. However, by their very nature, they only allow for limited participant responses and are, therefore, of little use if ‘depth’ is required
Conversely, unstructured interviews do not reflect any preconceived theories or ideas and are performed with little or no organisation. Such an interview may simply start with an opening question such as ‘Can you tell me about your experience of last visiting the hospital?’ and will then progress based, primarily, upon the initial response. Unstructured interviews are usually very time-consuming (often lasting several hours) and can be difficult to manage, and to participate in, as the lack of predetermined interview questions provides little guidance on what to talk about (which many participants find confusing and unhelpful). Their use is, therefore, generally only considered where significant ‘depth’ is required, or where virtually nothing is known about the subject area (or a different perspective of a known subject area is required).

Semi-structured interviews consist of several key questions that help to define the areas to be explored, but also allows the interviewer or interviewee to diverge in order to pursue an idea or response in more detail. This interview format is used most frequently in healthcare, as it provides participants with some guidance on what to talk about, which many find helpful. The flexibility of this approach, particularly compared to structured interviews, also allows for the discovery or elaboration of information that is important to participants but may not have previously been thought of as pertinent by the researcher.

### 3.5.2 Questionnaire

These are formal questions framed and written down for a respondent to provide answers. A questionnaire is a research instrument consisting of a series of questions and other prompts for the gathering of data from respondents. According to Oppenheim (2000), a questionnaire can be open-ended or closed-ended and can be administered personally, by post or e-mail or through telephone depending on the nature of the research.
For the purpose of the study, a self-administered questionnaire was used to collect data from the market women except for the market leaders. This implies that the questionnaire was the primary data collection instrument used for the study. The decision to use the questionnaire was influenced by the fact that it is practical, makes data compilation easy, can be carried out by a single researcher or any number of people and can be analysed more scientifically (Gillham, 2008).

Nevertheless, the use of a questionnaire for data collection has certain disadvantages (Oppenheim, 2000; Polit & Beck, 2006). Among these are lack of personal contact, low returns rate and varying levels of subjectivity. Kothari (2004) also indicated that the researcher’s control over the questionnaire is lost once it’s sent out to respondents. This makes the usefulness of the data collected skewed towards the understanding of the respondents.

However, considering the calibre of the respondents the researcher presumed they were not highly educated therefore, questions asked were simple, short and brief whilst still conveying the meaning intended.

3.5.3 Mode of Data Collection

Data collection was done by a combination of primary and secondary sources. The primary source was self-administered questionnaire and personal interviews conducted from the field while the secondary sources consist of data gathered from previous works such as; reports, books, journals, articles, electronic databases and other related resources that were deemed necessary for the study.
The structured personal interview format was used to collect data from the market leaders and the researcher used this approach because it is used most frequently in healthcare research, as it provides participants with some guidance on what to talk about, which many find helpful.

An introductory letter was taken from the Department of Information Studies, University of Ghana. The letter of introduction was sent to La-Nkwantanang Municipal office to collect data on the shops within the market. The introduction letter was also taken to the information centre in the market to collect data on the market leadership but unfortunately the manager at the information centre could not have any record on the market leaders, so he directed the researcher to one of the leaders and after talking with the leader, she also directed the researcher to the subsequent one and it followed. The letter was carried along as the researcher meet each leader to introduce himself and also sort permission from the market women.

The questionnaire and interviews were conducted in two months, December 2018 and January 2019. The researcher contracted two research assistants who are familiar with the Madina market and also speaks “Ga” and “Twi”. These two languages together with English were the mode of communication used to gather the data. “Ga” and “Twi” because “Twi” is the most dominant Ghanaian language spoken widely across the country and also “Ga” because it is the local language among the “Gas” of Accra.

During the interview, clarifications were made on areas that the respondents did not understand clearly. An audio recorder was used to record responses and transcribed for evolving themes and was analysed accordingly. The researcher faced some challenges during the data collection, some respondents refused to participate in the research, some the research has to purchase their produce
to convenience them to participate, others did not see the need to participate and others too the researcher had to come another to collect their response.

3.6 Pre-testing

Zikmund (2003) states that a pilot test or pre-test is done to collect data from a small group of respondents that serves as guidance for greater research. “A pilot study is often used to pre-test or try out a research instrument” (Baker, n. d., p. 182)

The researcher and his research assistants were involved in the pre-test of the questions to enable them to know the expectation of the fieldwork and also get insight into the research two weeks before the actual research.

The actual administration of instruments was done with the two research assistants at the Madina market to ascertain market women knowledge and attitude towards health information seeking. All interviews conducted in vernacular will be translated into English by the researcher. The data was transcribed. Verbatim transcription of interviews was carried out in “Twi” and “Ga” and was done in consultation with the experts in “Twi” and “Ga”.

3.6.1 Transcription

The audio-recorded interviews were transcribed, the researcher listened and typed out responses of the respondents verbatim. Unique identification numbers and initials were assigned to each respondent to maintain their confidentiality. The numbers were preceded by the initial ML representing Market Leader. For example, the first respondent was tagged ML1 and ML2 etc
3.7 Data analysis

This section describes how data retrieved from the study were analysed for discussion and interpretation.

Data collected through the interviews was analysed using thematic content analysis approach by Miles & Huberman (1994). The thematic content analysis is a type of qualitative analysis approach to analyse classifications and presents themes or patterns that relate to the data and using interpretations in dealing with diverse subjects in the data (Boyatzis, 1998).

The thematic content analysis approach was more appropriate for this study because it will provide flexibility in the use of both inductive and deductive approaches and the opportunity to code and categorise data into themes (Miles & Huberman, 1994).

After the questionnaires were collected, the researcher generated a coding manual that was used for the data entry. The statistical Package for Social Sciences (SPSS Version 21) was used to analyse the data. The responses from the questionnaire were inputted in the data view to create the needed report. Frequencies and percentages, as well as graphs, were also used to illustrate the findings of the study.

The actual data collection was undertaken in December 2018 and it involved the researcher and two other research assistants who were expert in” Twi” and “Ga”. This was to enable the researcher to move freely in the market and interact. The training was given to them on the proper administration of the instrument as well as the objectives and another critical aspect of the study.
The training of the research assistants offered the opportunity for the correct translation of questions into the local language.

### 3.8 Ethical Consideration

Israel and Hay (2006), posit that researchers are advised to adhere to some professional ethical codes and regulations while undertaking research. Researchers need to protect their research participants, develop a trust with them, promote the integrity of research, guard against misconduct and impropriety that might reflect on their organisations or institutions and cope with new and challenging problems.

Frankel and Wallen (2006) have indicated that “all subjects should be assured that any data collected from or about them will be held confidential. Frankel and Wallen (2006) further indicated that whenever possible, the names of the participants in a study should be removed from all data collection forms. This according to them can be done by assigning a number or letter to each form.

Respondents were adequately informed in order to seek their consent before being engaged in the study. The objectives and nature of the research, outcomes of the research and how results were circulated were made known to the respondents. This convinced the respondents that the purely for academic work thereby encouraging them to give their responses.

According to Neuman (2007) “a fundamental ethical principle of social research is never compelling anyone into participation; participation must be voluntary at all times”. Thus, respondents were allowed to participate or answer questions out of their own free will.
Additionally, the researcher adhered to the codes of conduct within the University of Ghana for graduate research. Also, to avoid plagiarism the researcher acknowledged all sources that were used in the study by providing appropriate, complete and adequate references of such sources. Finally, data was not manipulated to fit research objectives.

3.9. Chapter summary

The chapter has exhaustively covered the following areas; introduction, research design, population for the study, sampling techniques the researcher employed in the study, data collection instruments, pre-testing or pilot study, data processing techniques that were employed and ethical considerations were all covered.
CHAPTER 4

DATA ANALYSIS AND FINDINGS

4.1 Introduction

In this chapter, the research presents a detailed analysis of the data gathered from the various respondents through the survey questionnaire and structured interviews. This chapter presents and interprets results obtained from the analysis of the data during the fieldwork. This focuses on the analysis of data and has been analysed and presented under six thematic areas in line with the objectives of the study. These are:

- Level of Health Information Literacy (HIL) competency.
- The health information needs.
- The sources of health information.
- How the market women evaluate the content and sources of health information.
- Challenges market women face in Health Information Seeking.

The chapter also considers the rate of responses and demographic characteristic of the market women as well as the findings of each objective in the research study. In total, 102 copies of the questionnaire were distributed to the market women who are in shops or owe shop at Madina market. All 102 questionnaires were retrieved which gives a response rate of 100% hence constituting the total sample size used.
The questionnaire was structured to find out Sources of Health Information (HI), the Relationship between health-seeking behaviour and Long Life, the Relationship between demographic factors and HIS, health needs, Factors that influence the health information needs and challenges market women face in HIS. There was also structured interviews using an interview guide with a list of suggested questions conducted with 10 market leaders. This was to find out the competence level of health information literacy they had as leaders of the market women, their knowledge about health education the market women have, what they are doing in terms of health information to help the health information literacy level of the market woman, identify any challenges they have come across in the market and what measures they have put in place to help the market women seek health information appropriately for healthy lifestyle.

The chapter is presented in two main parts: part one deals with the analysis of results from the questionnaire distributed to respondents of the study while part two, deals with the analysis of results from the interviews conducted.

4.1.2 Rate of Responses.

The response rate (completion rate or return rate) is defined as the rate at which individuals respond to a specific request or question that is posed to them (Baruch & Holtom, 2008). Therefore, in an attempt to find answers to the questions concerning health information seeking among the women in a Peri-urban community, copies of questionnaire were distributed to market women in Madina Municipality and face-to-face interviews were conducted with some of the market leaders in the same market.
4.1.3 Demographic Characteristics of the respondents

Background information or demographic characteristic data of the market women in Madina market was collected with the purpose of describing how these characteristics influence their information behaviour or trend. The demographic information collected includes age, marital status, educational background and religious affiliation. These have been presented below in the following.

4.1.4 Age of respondents

Age is one of the few and most important determinants of an individual’s maturity to own a shop in the market. The inclusion of ages of respondents in research helps to determine the average age with which the researcher worked with. With this in mind, the researcher grouped the respondents into age groups for easy analysis.

In Ghana, when a child attains the age of eighteen (18) and above, he or she is considered to be an adult (CIA World Factbook, 2018). Hence, eighteen-year-old individuals trading in the market cannot be categories as child labour. Figure 4.1 represents the age distribution of the respondents.
Figure 4.1. Age distribution of market women in Madina Municipality.

Source: Field data (2019).

The results that are presented in Figure 4.1 shows the age distribution of respondents from market women in Madina. From Figure 4.1, 22 (21.6%) of the respondents were in the age group 20 – 30, 28 (27.5%) are in the age group ranging from 31 – 40, 25 (24.5%) are in the age group ranging from 41 – 50, 15 (14.7) are in the age group ranging from 51 - 60. The remaining 12 (11.8%) were in the age group from sixty and above. It is evident from Figure 4.1 that majority of the respondents
were found within the age group 31 – 40 categories, followed by the age group between 41 – 50. The age group with the lowest number of respondents was sixty and above.

4.1.5 Marital Status of Respondents

Marriage is a union between two people (male and female). This union goes a long way to unite both families of the two parties involved. As part of the demographic data, respondents were asked to indicate their marital status and the findings, however, revealed that some of the women were single, some were married and others were divorced. Figure 4.2 presents the distribution of the marital status of the market women in Madina sampled for the study.
Figure 4.2. Marital status of respondents

<table>
<thead>
<tr>
<th></th>
<th>Single</th>
<th>Married</th>
<th>Divorced</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>38.2</td>
<td>56.9</td>
<td>4.9</td>
<td>100</td>
</tr>
<tr>
<td>No. of Respondents</td>
<td>39</td>
<td>58</td>
<td>5</td>
<td>102</td>
</tr>
</tbody>
</table>

Source: Field data (2019).

From Figure 4.2 above, it can be seen that majority of the respondents, 58 (56.8%) were married, 39 (38.2%) were single and 5 (4.9%) of the respondents were divorced.
4.1.6 Educational background of respondents

This sub-section presents the educational profile of the respondents. Formal education contributes largely to the individual’s ability to read and write and as well, react to health issues or acquire health information. Informal education also has some impact on the level of health information literacy or information-seeking behaviour of an individual. It is therefore important to consider the educational background of the respondents. Figure 4.3 shows the distribution of the educational background of the respondents.

**Figure 4.3. Education background of respondents**

<table>
<thead>
<tr>
<th>Education Level</th>
<th>Percentage</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>JHS</td>
<td>36.3%</td>
<td>37</td>
</tr>
<tr>
<td>SHS</td>
<td>24.5%</td>
<td>25</td>
</tr>
<tr>
<td>Degree</td>
<td>15.7%</td>
<td>16</td>
</tr>
<tr>
<td>Other</td>
<td>15.7%</td>
<td>16</td>
</tr>
<tr>
<td>None</td>
<td>7.8%</td>
<td>8</td>
</tr>
</tbody>
</table>

**Source:** Field data (2019).
In Figure 4.3, the educational backgrounds of the respondents have been presented. It can be seen from Figures 4.3, that 37 (36.3%) respondents had Junior High School as their highest level of education. This is followed by 25 (24.5%) respondents with Senior High School as their highest level of education. There were 16 (15.7%) respondents with degrees (tertiary) as their highest level of education, another 16 (15.7%) respondents with other levels (which could be indicated as either informal education or some professional certificate) and 8 (7.8%) respondents did not have any formal education.

4.1.7 Religious affiliation of the respondents

Religiously the Madina Municipality is an environment that is engulfed with a lot of churches and mosques. This prompted the curiosity of the researcher to include religious background into the demographic characteristics. This was to find out if religion influences the market women’s knowledge of health or their health information seeking behaviour.
Figure 4.4. Religious affiliation of respondents

<table>
<thead>
<tr>
<th></th>
<th>CHRISTIAN</th>
<th>ISLAM</th>
<th>OTHERS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO. of Respondents</td>
<td>57</td>
<td>38</td>
<td>7</td>
<td>102</td>
</tr>
<tr>
<td>%</td>
<td>55.9</td>
<td>37.3</td>
<td>6.86</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Field data, 2019.

According to figure 4.4, 57 (55.9%) respondents indicated that they were Christians, 38 (37.3%) respondents indicated that they were Muslims and 7 (6.86%) respondents indicated themselves as others (which could be interpreted as neither Christian nor Muslim). They could be traditionalists or atheists.

4.2. Respondents’ competence level of Health Information Literacy (HIL)

The first objective was to find out the competence level of HIS among respondents, their views sought on knowing about your health, asking questions about your health, desire information on
health, personal control over health information, adhering to health literacy recommendations, information on health, and seeking health information. The views of the respondents were categorised into ‘highly important’, ‘important’, ‘not important’ and ‘don’t know.’

Table 4.1: Respondents’ competence level of Health Information Literacy (HIL)

<table>
<thead>
<tr>
<th>STATEMENT</th>
<th>Highly Important</th>
<th>Important</th>
<th>Not Important</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STATEMENT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowing about your health</td>
<td>60</td>
<td>58.8%</td>
<td>38</td>
<td>2.1%</td>
</tr>
<tr>
<td>Asking questions about your health</td>
<td>75</td>
<td>73.5%</td>
<td>19</td>
<td>4.7%</td>
</tr>
<tr>
<td>Desire information on health</td>
<td>59</td>
<td>57.8%</td>
<td>30</td>
<td>8.8%</td>
</tr>
<tr>
<td>Personal control over health information</td>
<td>45</td>
<td>44.1%</td>
<td>36</td>
<td>14.7%</td>
</tr>
<tr>
<td>Adherence to health literacy recommendations</td>
<td>85</td>
<td>83.3%</td>
<td>10</td>
<td>4.7%</td>
</tr>
<tr>
<td>Information on health</td>
<td>80</td>
<td>78.4%</td>
<td>15</td>
<td>3.9%</td>
</tr>
<tr>
<td>Seeking health information</td>
<td>91</td>
<td>89.2%</td>
<td>7</td>
<td>2.1%</td>
</tr>
</tbody>
</table>

*Source: Field data (2019)*

In table 4.1 above, out of the one hundred and two (102) respondents, 60 (58.8%) respondents indicated that knowing about your health is highly important, 38 (37.2%) indicated that knowing about your health is important, 2 (1.9%) indicated that knowing about your health not important and finally, no respondent indicated don’t know for knowing about your health.
75 (73.5%) indicated that asking for questions about your health is highly important, 19 (18.6%) indicated that asking for questions about your health is important, 5 (4.7) of the respondents indicated that asking for questions about your health is not important and 1 (0.9) indicated don’t know.

59 (57.8%) respondents indicated that desiring information on health highly important, 30 (29.4%) indicated is important, 9 (8.8%) respondents indicated that desiring information on health is not important and 2 (1.9%) respondents indicated don’t know.

45 (44.1%) respondents indicated that personal control over health information is highly important, 36 (35.2%) indicated that personal control over health information is important, 15 (14.7%) of participants indicated personal control over health information is not important and 4 (3.9%) of participants indicated don’t know.

85 (83.3%) respondents indicated that adhering to health literacy recommendations is highly important, 10 (9.8%) of the participants indicated that adhering to health literacy recommendations is important, 5 (4.7%) participants indicated that adhering to health literacy recommendations is not important and no participant indicated that don’t know for adhering to health literacy recommendations.

80 (78.5%) respondents indicated that information on health is highly important, 15 (14.7%) participant indicated that information on health is important, 4 (3.9%) respondents indicated that information on health is not important and 1 (0.9%) respondents indicated don’t know for information on health.

Finally, 91 (89.2%) respondents indicated that seeking health information is highly important, 7 (6.8%) respondents indicated that seeking health information is important, 2 (1.9%) participants
indicated that seeking health information is not important and there were 0 (0.0%) participants indicated that don’t know for seeking health information.

Based on the data provided in table 4.1, the first five (5) competences levels measured by the total percentage of respondents are first: health-seeking information with 91 (89.2%), second is adhering to health literacy recommendation with 85 (83.3%), third is information on health with 80 (78.4), forth is asking questions about your health 75 (73.5%) and the fifth is knowing about your health with 60 (58.8) respondents. In all the statements by the respondents, the one that received the lowest was personal control over health information with 45 (44.1%). This indicates that no individual can have all or know or dependently knowledgeable about HIL without seeking it from somewhere. As indicated in table 4.1, it can be seen that in all the statements very few people indicated that they do not know which is between 0 (0.0%) to 4 (3.9).

4.3. Health information needs of Madina market women

The second objective of this study was to determine the health information needs of market women. Respondents’ views were sought and represented in figure 4.5 below.
Figure 4.5. Health information needs

Source: field data (2019)

From figure 4.5, regarding the information needs by respondents, the results that were gathered shows that 70 (68.6%) respondents from Madina market required information on prevention, 92 (90.2%) required information cure, 29 (42.6%) required information on treatment, 89 (87.3%) required information on causes of sickness and 63(61.8%) required information on specialist or specialized facilities, 74 (72.5%) required information on family planning and 20 (19.6%) required information on all the mentioned type of health information. The findings, therefore, indicate that
cure, treatment, causes of sickness and family planning were the health information needs, needed by respondents. This goes on to show that market women’s health needs are varied, it is clear from the data that cure, treatment, causes of sickness and family planning needs form a fundamental part of market women’s health needs at Madina market.

4.4. Source of Health Information (HI) among Madina market women

The third objective, Source of information refers to the home of certain knowledge or the bases on which a particular knowledge is gathered. It is therefore important to scrutinize, monitor and evaluate the sources market women within a peri-urban community such as the Madina market receive their health information.
Table 4.2: Source of Health Information.

<table>
<thead>
<tr>
<th>Sources of Health Information</th>
<th>Total</th>
<th>Percentages (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radio/Television</td>
<td>102</td>
<td>100</td>
</tr>
<tr>
<td>Relatives /friends/neighbours</td>
<td>92</td>
<td>90.2</td>
</tr>
<tr>
<td>Midwives/Nurse</td>
<td>70</td>
<td>68.6</td>
</tr>
<tr>
<td>Doctor</td>
<td>55</td>
<td>53.9</td>
</tr>
<tr>
<td>Community Health Workers</td>
<td>40</td>
<td>39.2</td>
</tr>
<tr>
<td>Health Outreach Program</td>
<td>30</td>
<td>29.4</td>
</tr>
<tr>
<td>Internet</td>
<td>20</td>
<td>19.6</td>
</tr>
<tr>
<td>Newspaper/Magazine</td>
<td>15</td>
<td>14.7</td>
</tr>
</tbody>
</table>

Source: Field data, (2019)

Based on the multiple choices of the sources of HI by respondents, it is seen that 102 (100%) respondents received HI from radio and television. The next source of HI received by the respondents is from relatives, friends and neighbours and 92 (90.2%) respondents indicated that the third major source of HI by respondents is the midwife and nurse, and 70 (68.6%) respondents indicated that the fourth most important source of HI by respondents is doctor, which is indicated by 55 (53.9) respondents. The final major source of health information by the respondents is the community health workers and 40 (39.2%) respondents indicated that. Below is the ranking by order of importance of the source of HI among the market women in Madina Municipality. Few
respondents of 30 (29.4%) indicated health outreach program, 20 (19.6%) indicated the internet and the least of 15 (14.7%) indicated the newspaper and magazines. To rank the first five sources of HIL by order of importance, radio/television will be first, relatives, friends and neighbours will be second, midwives and nurses will be third, doctors will fourth and the community health workers will be fifth. Below is the tabulated ranking of sources of health information found in Table 4.3.

Table 4.3: Ranking Sources of HI.

<table>
<thead>
<tr>
<th>Rank</th>
<th>Sources of HI</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>Radio/Television</td>
</tr>
<tr>
<td>2nd</td>
<td>Relatives/friends/ neighbours</td>
</tr>
<tr>
<td>3rd</td>
<td>Midwife/Nurse</td>
</tr>
<tr>
<td>4th</td>
<td>Doctor</td>
</tr>
<tr>
<td>5th</td>
<td>Community Health Workers</td>
</tr>
</tbody>
</table>

Source: Field data (2019).
4.5. Relationship between the socio-demographic factors and health information seeking behaviour (HISB) among market women.

It is assumed that some socio-demographic factors can influence the HISB on the market women. Some of these include income, educational background, ethnic group, religious affiliation, dialect (language), age, and marital status. In the survey respondents were asked to indicate with a ‘yes’ and ‘no’ answer to the factors outlined that influence their knowledge of HISB.

Table 4.4: Relationship between socio-demographic factors and HIS.

<table>
<thead>
<tr>
<th>S-D FACTORS</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq</td>
<td>%</td>
</tr>
<tr>
<td>INCOME</td>
<td>90</td>
<td>88.2</td>
</tr>
<tr>
<td>EDUCATION</td>
<td>70</td>
<td>68.6</td>
</tr>
<tr>
<td>ETHNIC GROUP</td>
<td>60</td>
<td>55.8</td>
</tr>
<tr>
<td>RELIGIOUS AFFILIATION</td>
<td>30</td>
<td>29.4</td>
</tr>
<tr>
<td>DIALECT</td>
<td>20</td>
<td>19.6</td>
</tr>
<tr>
<td>AGE</td>
<td>15</td>
<td>14.7</td>
</tr>
<tr>
<td>MARITAL STATUS</td>
<td>5</td>
<td>4.9</td>
</tr>
</tbody>
</table>

Source: Field Survey (2019)
As indicated in table 4.4, 90 (88.2%) respondents indicated that the level of income greatly influences a person’s HIS. The next influential social-demographic factor was education and 70 (68.6%) respondents indicated that. The next factor was ethnic group and 60 (55.8%) respondents indicated that. When it comes to religious affiliation, 30 (29.6%) respondents indicated that it is an influential factor with respect to HISB. In ranking the top five (5) socio-demographic factors where respondents indicated that they affect the acquisition of HI, income with 90 (88.2%) respondents was first. The second in rank was education with 70 (68.6%) of the respondents. The ethnic group was third in rank with 30 (58.7%) respondents. The fourth factor in rank was their religious affiliation with 30 (29.4%) respondents and the fifth was dialect or language where 20 (19.6) of the respondents indicated.

4.6. Evaluation of content and sources of health information

Table 4.5. How the market women evaluate their health information

<table>
<thead>
<tr>
<th>Statements to evaluate the authenticity of health information</th>
<th>Number of respondents</th>
<th>Percentages (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discuss with health Professionals</td>
<td>90</td>
<td>88.2%</td>
</tr>
<tr>
<td>Discuss with a partner for advice or second opinion</td>
<td>80</td>
<td>78.4%</td>
</tr>
<tr>
<td>Discuss with family for opinion</td>
<td>92</td>
<td>90.2%</td>
</tr>
<tr>
<td>Discuss with fellow market women</td>
<td>98</td>
<td>96.1%</td>
</tr>
<tr>
<td>Compare content with what I ready to know</td>
<td>69</td>
<td>67%</td>
</tr>
<tr>
<td>Read more on it/ ask someone to read on it to me</td>
<td>66</td>
<td>64.7%</td>
</tr>
<tr>
<td>Verify it from people who are more educated</td>
<td>59</td>
<td>57.8%</td>
</tr>
<tr>
<td>Others</td>
<td>Nil</td>
<td>Nil</td>
</tr>
</tbody>
</table>
Source: Field data (2019).

Table 5.4 shows that respondents used diverse ways and means to evaluate health information. These ways and means range from formal medical ways to informal or traditional ways. The formal medical ways mainly considered discussions with health professionals 90 (88.2%). The informal ways that is interpersonal or traditional ways included; discussion with partners for advice or second opinion 80 (78.4%), discussion with family for opinion 92 (90.2%), discussing with fellow market woman 98 (96.1%), compare with what I already know 69 (67.6%), read more on it or ask someone to read on it to me 66 (64.7%) and verify from people who are more educated 59 (57.8%).

4.7. Challenges or barriers market women face in seeking health information

The study also sought to point out possible barriers or challenges that may impede successful or appropriate health information seeking. The researcher decided to assess the views of the respondents on the challenges the market women face in relation to HIS in the Madina market. Respondents were asked to indicate as many as applicable.
Table 4.6. Challenges or barriers market women face in accessing health information.

<table>
<thead>
<tr>
<th>Barriers in health information seeking</th>
<th>Number of respondents</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>No library</td>
<td>40</td>
<td>39%</td>
</tr>
<tr>
<td>Illiteracy</td>
<td>98</td>
<td>96.1%</td>
</tr>
<tr>
<td>Language barriers</td>
<td>56</td>
<td>54.9%</td>
</tr>
<tr>
<td>Lack of time</td>
<td>102</td>
<td>100</td>
</tr>
<tr>
<td>Financial barrier</td>
<td>100</td>
<td>98%</td>
</tr>
<tr>
<td>No health facility in the market</td>
<td>87</td>
<td>85.3%</td>
</tr>
</tbody>
</table>

Source: Field data (2019)

Table 4.6 above evaluates the challenges or barriers faced by the Madina market women in accessing health information. It is clear from the table, that library resources is not the major barrier to the access of health information by respondents with 39%, illiteracy with 96.1% of respondents, language barriers with 54.9% respondents, lack of time with 100% of respondents, financial with 98% of respondents and no health facility within the market recording 85.3% of respondents.
4.8. Responses from Market Leaders

4.9. Introduction

This section presents a report on the interviews with some of the market leaders in the Madina Market. The actual number of market leaders interviewed were ten (10). For verification purposes, some data was collected through observation. The data from the interviews were analysed using content analyses. The researcher decided on this method of analysis so that the collation of the findings will be easy. The researcher, after listening through the interview responses, observed that most of the responses to the questions addressed particular themes of the research. Therefore, the data was analysed together to avoid repeating the same response to particular questions. This chapter is hence organised into four specific sections, which comprise of

1. Level of HIS awareness among market leaders
2. Sources of HIS among market leaders
3. Training on HIS among market leaders
4. Challenges associated with lack of HIS

4.9.1. Level of awareness HIS among market leaders

The leadership of the market women at the Madina market have a reasonable awareness level of HIS. The respondents on their view of HIS expressed their knowledge of its importance to the market women. Some of the reasons they indicated the importance of HIS are:
a. *It is very essential for every market woman to be privy to HIS because the nature of their work attracts various forms of infections hence the market women need to be very particular about their health issues.*

b. *About seventy per cent (70%) of the market woman could be described as literate with various levels of academic backgrounds so they acknowledge the relevance of health information.*

When the market leaders were to evaluate the knowledge base of the market women about HIS, the following are the comments they gave:

a. *Due to some advancement in the health system, now the use of radio and television has helped the market women to keep themselves healthy. This is because of constant listening to the radio and watching television have updated their knowledge.*

To verify if the market leaders had put any measures in place to support the market women on HIS, the respondents said the market leaders do not necessarily have measure put in for the market women concerning HIS. The outcome of that is

b. *The market leaders believe that market women have not acquired enough health education.*

c. *There is an information centre in the market where medical practitioners come to sell medicine and other health-related stuff. Therefore, the market women listen to them and through that, the market women get some information and gain education on health especially on certain common illnesses.*

The assessment was made to find out if there was any awareness program that the market leadership organizes for the market women to aide them in HIS. The respondents indicated that
market leaders do not specifically organize any awareness program for the market pertaining to HIS. Information gathered as

a. Health workers come to the market area occasionally to check the health conditions of the market women and educate them on some health tips.

b. Even in the case of an organised health program, not everyone is able to participate because at a point the market women would need to concentrate on selling their foodstuffs and products.

c. Some of the market women would always want to close and go home early due to other household chores in wait.

d. A marginal section of the market women is actually concerned about HIS and their personal health system.

4.9.2. Sources of health information (HI) among market leaders

To find out whether the market leaders had knowledge about the sources of HI, the respondents were asked to mention the sources. The respondents indicated that the main source of HI for the market women comes from the media. The finding from the data obtained revealed that Adom TV and Oman FM occasionally come to the market to organize health screening and testing programs for the market women. The respondents attested to the reliability of the media as a major source of HI for the market women. The reasons indicated by the respondents were:

1. When the media house comes to the market to organise the health screening and testing, the team gives the participants medical results of the screening process to the market women who participate in the activity. If there were, any emergency
health issues discovered in the process, the team would advise the person to go to the hospital for further diagnosis and treatment.

2. Occasional health screening and testing programs are available to the market women.

The market leadership were asked to indicate which source of HI the market women preferred.

The respondents indicated as follows:

“We prefer a permanent place to organize such health screening and testing programs.”

“We need more health workers to come and work in market places.”

“The health workers should extend the duration of their visits beyond a day to a period of time so that more market women can participate conveniently.”

The respondents gave reasons that are:

1. The one-day programs are not enough to help the market women gain relevant health knowledge.

The respondents also placed emphasis on the fact that some of the market women may be present whiles others may not.

4.9.3. Training on HIS among market leaders

To find out if the market women were receiving any kind of HIS training and its importance, the market leaders who were interviewed agreed strongly that it is very important for the market women to gain some form of training in HIS. The respondents indicated that unfortunately, the
market women do not really receive any kind of training on HIS to their personal knowledge. The respondents affirmed that lack of training was and would affect the market women’s level of knowledge on HIL. Some of the respondents said,

“it is not advisable for an individual to lack HIL.”

Some of the respondents also expressed that every individual needs some level of health education to be able to identify what is happening in a person’s body, its level of severity and where to find a solution. They did indicate that lack of training facility hence the market women individually find their own way to seek education and training on HIS.

4.9.4 Barriers to or challenges associated with HIS

The study of HIS among market women in the Madina cannot be addressed without assessing the challenges. In view of this, to find out if the market women face any form of challenges in accessing HI, the respondents were asked to indicate the challenges they identify in association with HIS. The respondents stated as follows:

“Lack of a permanent health consultation facility for the market women.”

“Lack of a First Aid centre in the market.”

“Lack of a constant awareness program from the health directorate of the municipality.”

The respondents recommended that if the above-mentioned resources were available to the market women in Madina, there would be an urgency in people to seek medical attention, medical knowledge, go to the hospitals, health facilities and medical centres to ask questions related to their health matters and in general seek HI from professionals.
4.10. Chapter Summary

This chapter has been able to cover comprehensively, brief introduction, data presentation and analysis. Data presentation, analysis and presentation were based on the research instruments that covered all the objectives of the study. The analysis and interpretations were based on data from the field.
CHAPTER FIVE

DISCUSSION OF FINDINGS

5.0. Introduction

This chapter dealt with discussions on the results of the findings. According to Bellamy (2012) discussion of the results of a study allows for the determination of “whether the data analysis supports the general conclusions drawn from the research to answer research questions”. Hence, this chapter provides meanings to the data obtained from the study in line with previous studies in the field.

The purpose of this research study was to investigate health information seeking behaviour among market women in Madina. Specifically, this research study set out to find the competence level of health information literacy among the market women. This was undertaken by examining the health information needs of market women; sources of health information for the market women; the relationship between socio-demographic factors such as; age, marital status, educational background and religious background, and health information seeking behaviour among the market women; determine the factors that influence the health information needs of the market women; find out the challenges these market women face in access or seeking health information, and make some recommendations based on the research findings. The chapter gives an account of the discussion of the findings.

Health information seeking is one of the key relevant components that enhance the development of any community, as the people within that geographical environment is
concerned (Tie, 2013). This is because it helps in acquiring knowledge about sickness, causes of diseases, prevention of diseases, and provision of valuable information for the monitoring, evaluation, self-care, intervention and prevention of diseases to enhance the total living conditions of people for the purpose of development (WHO, 2014). In order for this to be achieved, there is a need for the availability of acquisition sources and education or knowledge about health by individuals (Scantlebury, Both, & Hanley, 2017). These sources to obtain health information come in both traditional and non-traditional ways (Corrarino, 2013). Unfortunately, many do not have enough or the required information on health and this is where seeking health information is important and needed (Parker, Baker, Williams, & Nurss, 1995). The daily life cycle or information behaviour of people contribute to our health and it is in this direction that this research focuses the study on market women. The results of the study are supported by some other finding (Berkman, Sheridan, Donahue, Halpern, & Crotty, 2011; Sudore et al., 2006). The issue of health information seeking among market women especially within the Madina municipality cover knowledge of the health information, health information needs, sources of acquiring health information, evaluation of information content and source, socio-demographic factors; educational background, religion and age among others and challenges or barriers.

5.1. The competence level of health information literacy among the market women

To have knowledge about one’s health is very relevant. The degree to which a person obtains, process and understands certain basic health information to be able to make good health decisions through various means is highly commendable (McKinney, 2000). In the study’s
assessment, a sample size of 102 out of a population of 1020, 60% of the market women indicated that knowing about your health was highly important, 38% said it’s important and the rest of 2% don’t really saw its importance. This showed that there was a reasonable population interested in health information. With about 94 (92.1%) asking questions about their health, 89 (87.2%) having the desire to get information on health matters, 98 (96%) seeking health information, 95 (93%) already knowledgeable on health and 95 (93.1%) who adhere to health literacy recommendations, indicates that the culture of health information literacy does exist and it is important.

5.2. Health information needs among market women

It has been estimated that at least 75 per cent of all health care takes place at the family or individual level. Within households it is women, particularly in their role as mothers, who have the greatest responsibility for promoting the family’s health and nutrition, therefore need health information.

The results indicated that people are generally motivated by different circumstances to seek health information. However, in all these activities, the overriding motivation was to satisfy one's need. This confirms Wilson’s (1996) observation that “there must be a resultant aim when a person experiences an information need”.

The study revealed that market women like any other category of the social group needed health information for their daily activities. The market women had different health information needs which required different sources to fulfil these needs. The findings of the study showed that the respondents had high information needs on all the health information needs provided. The
respondents ranked cure health information need as the highest need, followed by treatment, followed by causes of sickness, family planning, prevention and specialist in that order.

5.3. The source of health information among the market women

The availability of information for any purpose contribute greatly to the knowledge impartation and acquisition. In this direction, the source of health information becomes key. From the study, it was realised that the highest source of health information received by these market women was the radio and television, 100% of the respondents’ indication. This was attributed to the fact that most of these market women, depending on their nature of businesses had a portable radio or television around them during working hours on a daily bases to also get well informed. Information comes to them mostly through advertisement from hospitals, health programs and awareness on a certain disease by some health organizations both local and international.

Other major sources recognised as an immediate source by 92% of the respondents were relatives, friends and neighbours. They also indicated that midwives or nurses (70%) and doctors (55%) play a good role in helping them with information on their health. A marginal number of 40% also pointed out that the next source of their health information was from the community health workers who visit occasionally from the health directorate. Just a few of 20% affirmed that they would resort to the internet whiles the lowest number of 15% considered newspapers and magazines.

These findings contradict Saleh and Lasisi (as cited in Patrick and Ferdinand, 2016) carried out a study on the information seeking behaviour of rural women in Borno State, Nigeria. The findings of their research showed that the most preferred source of information for the rural women in
Borno State is the informal source as they rely on information gotten from friends, relatives, husband, children and fellow market women.

Health information seeking is an essential element of a woman’s ability to identify a need, identify a source, and act on health-related information and spans health promotion and disease prevention activities (Corrarino, 2013). Her findings further showed that the impact of inappropriate health sources touches women, their children, and their families. Without an appropriate level of understanding regarding health care information through appropriate sources, it is difficult to make informed decisions that can, in turn, translate into short life span.

5.4. The relationship between socio-demographic factors and health information seeking.

In the survey, the socio-demographical factors that were considered to probability have a certain relationship with health information seeking include age, ethnic group one belongs to, the dialect or language one speaks or is able to speak, an individual’s income level, the educational background, marital status and religious affiliation.

5.4.1. Age of respondents

The age range for the respondents in the survey was between 20 – 60 years and above. This indicates that all the respondents are mature enough to own a shop or trade in shops and might have embarked on seeking health information at one point in time or the other. The age
dimension revealed a multiple analysis because most of the respondents remained associated with the other factors significantly. Respondents from the survey revealed that about 62.7% within the ages of 30-40 years were concerned about health information-seeking behaviour while 37.5% within the ages of 41-50 did not give much attention to health information seeking. Comparisons between the two age groups indicated that the more people grow the less they dealt with their health matters independently.

5.4.2. Ethnic group

The influence of ethnic group proved that health information seeking was one way or the other subjected to cultural scrutiny. Culture is defined as “the integrated pattern of human behaviour that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group” (CASSP Technical Assistance Center, 1989). By ethnic difference, people’s way of life defines everything about them. The way they communicate, understand each other or attend to a situation or circumstance will differ from other people of different ethnic or respond to health information. This influence was based on their belief system, values, and attitudes and how they apply knowledge to be able to produce a positive health outcome. (U.S Department of Health and Human Services., 2001).

Andrews and Boyle (2008) and Singleton and Krause (2009) identified health belief models or systems that different cultural groups use to explain health and illness thereby affecting health seeking. Beliefs relevant to the health literacy discussion include, but are not limited to, magico-religious, biomedical, and deterministic beliefs.
1. *Magico-religious* refers to belief in supernatural forces which inflict illness on humans, sometimes as punishment for sins, in the form of evil spirits or disease-bearing foreign objects. This view may be found among African, Latin American, African American, and Middle Eastern cultures.

2. *Biomedical* refers to the belief system generally held in the US in which life “is controlled by a series of physical and biochemical processes that can be studied and manipulated by humans” (Andrews & Boyle, 2008, p.68). The disease is seen as the result of the breakdown of physical parts from stress, trauma, pathogens, or structural changes.

3. *Determinism* is the belief that outcomes are externally preordained and cannot be changed. Those holding to this belief system ask questions, such as “If the illness is bestowed by God, why try to prevent it or seek treatment”?

The respondents attested to this from the survey where about 58.8% confirmed that their ethnic group influence the kind of health information they acquire or seek and keep for their general well-being. It is through the lenses of culture wherein in this survey ethnic group, that people define health, perceived and responded to health messages. This was because it affects how people seek health information, or whether they would choose the medical treatment or adhere to spirituality.

4. **Dialect**

Low health literacy, cultural barriers, and limited English proficiency had been coined the “triple threat” to effective health communication by The Joint Commission (Schyve, 2007). Nurses, who work with patients from increasingly diverse cultural groups, experience daily...
how these three threats offer a challenge to the effective provision of care at the system, provider, and patient levels. Over the past 15 years, healthcare providers in the United States (US) have begun to address two of these threats to effective care, namely culture and language, and to demonstrate a growing awareness of the need for culturally and linguistically competent healthcare.

Linguistically, the way individuals communicate influences every literacy-focused agenda they set out to achieve (McKinney, 2000), but based on the respondents from the survey, the dialect one speak had no major or particular influence in their health behaviour. It was reported that language barriers were often overcome through translations especially where the medical practitioner is not a native from the community in which he or she works, or totally a foreigner, such medical volunteers who have travelled to help with medical support in a marginalised community some or where there is a medical epidemic. In the survey, only 19.6% of the respondents agreed that their dialect may influence their health information seeking. This was due to the fact that not all literacy resources are read or translated materials that are simplified to the common or layperson to be able to read.

5.4.4. Income level

According to Porr, Drummond and Richteer (2006) statistics reveal that limited health literacy is prevalent among those of lower socioeconomic status.

When income level was taking into consideration, the majority of the respondents of 88.2% said it was a very influential factor in relation to their health information seeking. Their assertion was a divided perception where some were negative influences and others were
position. For example, some respondents maintain that if the income level is low it means they will not have the financial support to go to the hospital or seek medical assistance and consultation. Others also indicated that if the income level is high it means they stand at an advantaged level to be able to afford any kind of health information or service they would wish to acquire.

The 11.8% of respondents who said they feel income does not influence them also had diverse perspectives. This, they indicated that as long as one has access to many sources through an individual seek health information literacy, their income was not really a major factor to them. This unveiled that the significance of income in relation to health information literacy is on the borderline even though the probability of acquiring HIL is high when the income level exposes an individual to either accessing HIL and on the contract being deprived when the income level is low.

5.4.5. Educational background

Health literacy is an important determinant of good health and well being. However, a significant proportion of the adult population lacks basic health literacy skills. The National Assessment of Adult Literacy (NAAL) indicates that 36% of adults have basic or below basic health literacy skills, which means they are unable to interpret or perform a range of everyday tasks (Speirs, Messina, Munger & Grutzmacher, 2012).

Health literacy encompasses several different skills. Reading skills include prose literacy “the ability to read and understand text” and document literacy “the ability to locate and use
information in documents”. Numeracy skills encompass “the ability to apply arithmetic operations and use numerical information in printed materials” (Nutbeam, 2009).

In Ghana, basic education is attaining a certain level of educations of one personal life goals in life or the educational opportunities available to people. It can only be a chose for some people to get a formal education or not. Some can be contributed to their geographical local and demands of the community in which they spend their livelihood. Education attainment also has a greater influence on the decision we make in our daily lives, which include health information literacy. Currently, the Vision 2020 Ghana Education Service policy document has one of its objectives that is to “ensure all citizens regardless of gender or social status, are functionally literate and productive at the minimum.” This is one of the few indications that basic education for every Ghanaian is a force to reckon with by the leadership of the country.

Based on the responses from the survey, it can be concluded that the highest percentage of 36.3 of the sample size have acquired basic education, and 24.5% have gained a senior high education. Those who have acquired degrees by 15.7% of the respondents followed. Others have acquired other diplomas and certificate courses making 15.7% and 7.8% declared that they have not received any form of formal education. The result indicators confirmed that majority of the market women had a certain level of academic background and could possibly influence the decisions they make about their lives and more importantly with the nature of their work and its health-related issues. Education, therefore, became a social determinate of health.

There was an improved understanding of the relationship between education and health which would help individuals to identify where intervention is most appropriate and effective in
improving both the individual and population health-wise. The Organisation for Economic Cooperation and Development (OECD), Social Outcomes of Learning project, concluded that there is reasonably strong evidence of large effects of education on health and for that matter health information literacy. (Feinstein, Sabates, Anderson, Sorhaindo, & Hammond, 2006)

5.4.6. **Marital status**

Sociologically, marital strain undermines people’s well-being whether the person is single, married or divorced. This is because the quality of marital satisfaction is important to the health of every individual (Williams, 1988). It is believed that healthier people with positive well-being attribute it to the fact that they are married and about to get married, whereas those who are assumed less healthy are unmarried, separated from their spouses or divorced (Keyes, 1998). According to the results from the respondents, 56.9% were married women, 38.2% were single women and 4.9% were divorced. Marriage brings companionship, emotional support, sustained sexual intimacy, and economic stability and health behaviours to the couple (Frey & Stutzer, 2002) and all these qualities contribute to a healthy lifestyle of the individual as compared to the unmarried or divorced. This in many cases prompts one’s desire to seek health information literacy.

5.4.7. **Religious affiliation**

Religious faith and spiritual beliefs may affect healthcare-seeking behaviour and people's willingness to accept specific treatments or behaviour changes. Religion is critiqued by Karl Max as the opium of the masses (Turner, 1999). People’s motives are described as “the impetus
towards belonging; toward associating with those sharing a common heritage, belief, and way of life; and toward the human need to share” (Harris, 1989). Interestingly, full appreciation has not been given to the multidimensional character of religious involvement or what religious effects have on diverse health outcomes. Religious groups have practices that make or not make ‘religious-friendly’ with issues like health information literacy.

Religious influence on health information literacy even affects a health or social care worker liable to misunderstand ways of responding to suffering, healing and dying of their patients. Religion influences health information literacy in the sense that it makes people concentrate on adapting compassionate service to the values and beliefs of individuals and communities to ensure that their experience of life’s sorrows and joys is as appropriate as possible as established in literature by both local and foreign scholars such as Kingsley Larbi, Max Assimeng, Kofi A. Opoku and Paul Gifford (Sackey, 2000). In health information literacy, religion becomes needful for the care of particular patients of faith but also in order to draw on the wisdom and energy of faith for the sake of wider society.

5.5. Evaluation of health information content and source among market women.

The study also investigated how respondents evaluated the content of the health information they get. This is commanding because, in order to understand people’s information seeking behaviours, it is imperative to understand how they evaluate and judge information quality. World Health Organisation “WHO’s” (2017) health literacy report indicates that all patients, whether literate or illiterate engage in the process of evaluating the health information they receive.
However, it is worth noting that different patients evaluate their health information differently. The fundamental interest was to assess how market women in Madina evaluate the content of the health information they receive from the various sources. Findings showed that market women evaluate health information from both formal and informal ways. The formal ways included mainly discussion with health professionals to seek their professional advice. The informal ways were mainly interpersonal means where they sought a second opinion from people close to them comprising; discuss with partners for advice or second opinion, discuss with family members for a second opinion, verifying from people who are more educated, and discuss with a fellow market woman for a second opinion.

Integrating, how they evaluate their health information with their sources of health information, two patterns emerge. They relied on health professionals for the primary source of information and that constitutes quality for them. However, when it comes to informal sources, they depend on them as a secondary source of information when evaluating information.

These findings contradict with Boadi (2018) in her findings that “breast cancer patients relied on health professionals for their source of information and constitute quality for them. However, when it comes to informal sources, they do not depend on them as a source of information but only seek their second opinion when evaluating the information they have received from the health professional”.
5.6. Challenges market women face in health information seeking.

There is a global acceptance that health and social wellbeing are determined by many factors outside the health system which include socioeconomic conditions, patterns of consumption associated with food and communication, demographic patterns, learning environments, family patterns, cultural and social fabric of societies. In such a situation, health issues can be effectively addressed by adopting a holistic approach by empowering individuals and communities to take action for their health, fostering leadership for public health, promoting intersectoral action to build healthy public policies (Sanjiv and Preetha, 2012).

The issue of health information seeking comes with its own challenges, especially among market women in Madina. These include the following:

1. Lack of health information centres within the market area.
2. Lack of time
3. Communication barriers
4. Language barriers
5. Religious restrictions
6. Financial barriers
7. Lack of Community awareness programs
8. Low literacy
9. Low health information literacy interventions
5.7. Level of HIS among market leaders

The leadership of the market women in Madina were interviewed to generally access their knowledge of health information seeking. In general, market leaders had a high level of awareness of health information literacy. They indicated a strong interest in addressing health information literacy among the market women. One of the leaders expressed that due to the nature of the work of the market women, it is very important that the market women show a keen interest in their health because of the environmental factor within the market. She said, “the market area is not high class, there are areas that need developing, storage facilities are not up to standard, even transporting the fresh foodstuff from one location to the other within the market is a bit of a challenge. This takes a toll on the women and surely have health implications hence it is of much concern that we make sure the women access a lot of health information to help them take care of themselves and stay healthy.” One of the market leaders revealed that due to the schedule of the women, most of them do not like visiting the hospital even for a check-up until they are actually sick or experiencing some ill health.

Another leader was of the view that they pay tax or “A.M.A Toll” but authorities are not concerning about their health.

5.8. Source of HI among market leaders

According to the respondents (ML1), most of the market women are educated to a certain level, but most of them receive their health information through the radio and televisions. The reason indicated was that, since they spend the majority of their time working in the market they are not about to go out of the market environment to seek health information.
One of the leaders indicated (ML2), “it seems like there is a bit of advancement in the health system. This is because occasionally we receive health personnel who come from various health institutions such as Korle-bu Teaching Hospital, Ridge Hospital now Accra Regional Hospital and Madina Polyclinic to do a check-up of some conditions such as high blood pressure, cancer, breast cancer, ulcer, hepatitis B and stroke and many other diseases the health personnel thinks can affect the market women due to the nature of their work.”

Another said that (ML3) “apart from the radio and television some get health information from midwives and nurses when they get pregnant and have to schedule antenatal”. Other independent health officials come to the market to do check-ups and health talk for the women at some fees.

5.9. Challenges associated with lack of HIS

The most obvious way to address health seeking behaviour is to make sure there is access to the required information. No individual, organization or community can seek health information to improve health or lives if there is no source and access to information.

1. One of the major challenges associated with health information behaviour when communicating with people was illiteracy. People who have low literacy, especially when they cannot read or write. It is very difficult to win the trust of such people. In most cases, the patient does not feel comfortable to open up about their health issues, ask relevant questions to get the most appropriate answers or even disclose their personal health information when they have to. (Schillinger, Bindman, Wang, Stewart, & Piette, 2004). Report from the field indicated that some market women do not check the expiring date of medicines they consume.
2. Even though there is a lot of information on health matter available on the internet, people who are not much educated or those who do not have enough money to access these sources will definitely lack proper HIS (Paasche-Orlow & Wolf, 2007).

3. There are also instances where health information delivery personnel were not professionally equipped to deliver or provide specific health information or health care. Some market women said they even buy such drugs from drugs sellers who come to the market to sell and some drugs had no expiring dates (ML4).

4. Some people are not able to maintain the same health service provider hence it becomes challenging to develop and maintain a good relationship between them and the health information or service providers.

5. (ML5) in most cases, it is realised that the health information seeker is totally different from the health information service provider in terms of some socio-demographic factors such as age, ethnic background, education, socio-economic status, religious background among other factors. These factors pose a great challenge for people and hence prevent them from seeking health information.

6. Some people are able to access health information but are not able to process the information in terms of understanding the height of a particular medicine status (ML6). This is a result of the lack of fundamental skills to compute to solve problems which do not influence health information seeking behaviour to achieve a personal goal or even to make the health decisions.
CHAPTER SIX

SUMMARY, CONCLUSION & RECOMMENDATIONS

6.1. Introduction

In this chapter, there is a presentation of a summary of the findings, the conclusion of the study and a set of recommendations, which is based on the data that was gathered and analysed in the previous chapters. In addition, the chapter presents an outline of some of the limitations of the research, and recommendations of further studies. The objectives of the study were:

1. Find out the competence level of health information literacy among market women.
2. Determine the health information needs of the market women
3. Examine the sources of health information.
4. Examine the how market women evaluate health information.
5. Find out challenges market women face in health information seeking.
6. Make recommendations based on the research findings.

Existing studies show that social participation presents opportunities for even the socioeconomically disadvantaged to obtain health-related information from others (Lee et al., 2012). Research in Ghana indicates that when people have an opportunity to interact with others through avenues such as market centres and religious affiliation, their health-related knowledge improves (Takyi, 2003). This is attributed to access to potentially knowledgeable persons who can positively influence health knowledge. Although aspects of social participation and other sources of social capital, can also have adverse effects on health through misinformation and promotion of health defeating behaviours, the foregoing research largely indicates that the phenomena can help
to diffuse proper health information as well (Amoah, 2018). This position has also been highlighted by a study among women in urban Ghana, which suggests that group-based interventions enhance health information sharing (Lori et al., 2014).

6.2. Summary of findings

The study was undertaken at the Madina market, which assessed the health information seeking behaviour among the market women. In the process of executing the research, the data that was analysed from the survey questionnaires, the structured interviews and the observations revealed some findings, which were based on the objectives of the study.

6.2.1. The level of health information literacy among market women

The study found that there is a marginal level of health information literacy among market women in the Madina Municipality. Both the market women and the market leaders have a reasonable level of health information literacy, which they gained through different sources such as the radio and television, relatives, friends and neighbours, midwives and nurses, doctors and community health workers. Through the various sources, the market women received health information, the majority of them received health information from the radio and television, which provides them with current information and events on various health products and services. This information ranges from local health or medical practitioners who have their own health centres, those who sell traditional medicine and herbs or some new drug manufactured by some pharmaceutical companies.
6.2.2. Health information needs of the market women.

The second objective was to assess the health information needs of Madina market women and the findings showed that majority of market women need information on cure, treatment, causes of sickness, family planning, prevention and specialists in that systematic order.

6.2.3. The sources of health information.

The third objective assessed sources of health information among market women in Madina. Findings showed that the dominant sources were radio and television, followed by relatives/friends/neighbours before health professionals consisting of doctors/ midwives and community health workers. The other sources were health outreach programmes, internet and newspapers or magazines.

6.2.4. How the market women evaluate health information.

The fourth objective of the study assessed how market women evaluated health information. Findings showed that the market women used both formal and informal ways of evaluating health information. The formal ways included mainly discussing health issues with health professionals to seek their professional advice. The informal ways were mainly interpersonal ways, including; discussion with family members for a second opinion, discussing it with a partner (husband or boyfriend), discussing it with family, discussing it with a fellow market woman.
6.2.5. The relationship between socio-demographic factors and health information seeking among market women

The study discovered that no matter the competence level that the market women had, their knowledge of the information were influenced by some socio-demographic factors which include income, education, ethnic groups the individual belongs to, the religious affiliation, the dialect or language spoken by the individual, their age and marital status.

1. Income to some extent gives an individual a kind of social status. Therefore, higher income is related to social status, hence these two (2) factors are linked to an individual attaining better health and health service hence has the highest potential to seeking health information from accredited sources. This indicates that the greater the gap between the rich and the poor depicts a great difference in their health as well. Income level does affect the availability of funds to seek health information. The research reviewed that even with the existence of National Health Insurance Policy, some medical centres are not working with the scheme hence those who do not have enough funds cannot cater for their full medical responsibilities. Some women indicated that some medical centres even though accept the National Health Insurance card, sometimes the medication prescribed by the doctors are not available in the hospital pharmacies hence patients are to go to private pharmacies to purchase them at a very high cost. As a result, many of these market women resort to self-medication with the reason that their cycle of work does not give them sufficient time to

2. When it comes to education, it was found that when an individual has high education it is proportionally linked to proper health information-seeking behaviour. It, therefore, means that as long as one has low education level it directly projects into the poor health information-seeking behaviour, which will finally end in poor health conditions. There is also greater
support that individuals respect depending on the particular ethnic group he or she belongs. This shows that support from family, friends and the community an individual life or is identified with influences health through the health information sources the person is able to access from these areas.

3. Religious affiliation to some extent influences people’s health information behaviour. This is because every religious body has its faith-based rules and regulations when it comes to their understanding of some health conditions and how to seek information to deal with the health issue. In religion, some ill-health is assumed to need spiritual healing which may interfere with proper health-seeking.

4. Language in different cases influences health information seeking among women. Through the study, it was found that limited English proficiency is a great barrier to health information seeking and health care in general. This is because the language barrier is directly associated with poor health service. When an individual has low health information literacy as a result of information-seeking behaviour, they are not able to recognize or are willing to admit their limitations in understanding health information (Sheridan, et al., 2011).

5. In various ethnic groups, people whose health information seeking is influenced by the ethnic group they belong to usually focus on specific approaches to the well-being of the individual’s health. Such information includes the person’s physical health, emotional and sometimes spiritual health.

6. Age is one dynamic socio-demographic factor that influences health in general. From the study, it was found that almost all the respondents agreed that at every stage there is the need for an individual to seek health information. This is because the few of the older participants between the ages of fifty-one (51) to sixty (60) and above scored lower as compared to the middle-aged
adults between twenty (20) – thirty (30). Those who portrayed low verbal abilities, some execute functioning, and reasoning skills performed less in their level of health information literacy. This showed that older adults may encounter more health difficulties. Age, therefore, becomes one of the highest correlates of low health information seeking (Cutilli, 2007).

7. The influence of marital status, in general, does not necessarily have a direct impact on health information seeking unless it is linked with other factors such as geographical location, religious affiliation and income status. The findings from the study indicated that when an individual is single, married or divorced has its own implications to the individual’s health because they are connected to the other factors determine a person’s desire to seek health information.

8. In the case of a solution, the community planners need to be tailored to meet the needs of the local people and in this research the market women in Madina Municipality. This helps in developing long-term health education and promotion campaigns for local communities such as the Madina market.

6.2.6. Challenges market women face in seeking health information

The study found these major challenges market women face in seeking health information; no library, low literacy rate, language barrier, lack of time, financial barrier, communication barrier and no health facility in the market.

Lack of education or low literacy remains the primary obstacle to meeting the information needs of working poor in developing countries. For example, because most market women are illiterate, they often get information that is outdated, unreliable and inaccurate through informal networks thereby have an effect on their health.
Due to the nature of their work, market women do not have time to identify appropriate information sources to be able to retrieve the information that is relevant to their health needs. They spend little time to assess the quality of the health information they seek.

Health care and health information providers fail to communicate health information that is clear, personal and deliverable in a way that speaks to the individual accessing the health information.

Seeking health information at the appropriate centre comes with a financial cost which deters people from coming forward as compare to informal networks.

Information gathered also showed that language can be a barrier to information seeking. The choice of language on printed material or the service provider can affect the seeking and acquisition of information.

6.3. Conclusion

The research sought to determine the health information seeking among market women in Madina. Health information seeking is very important to the well-being of the individual. This is because it affects the general lifestyle of an individual. Many socio-demographic factors influence one’s access to it, the level of competency, challenges that individual’s face in their quest to seek it and the various sources that need to be readily available to seek health information. The findings of the research show that there is some awareness of health information literacy in the market, but needs an upgrade. The different sources are accessed
according to their availability due to the nature of work of the Madina market women. However, these market women face some challenges in seeking health information.

6.4. Recommendations

Researchers, authorities and health information providers can benefit from the current proliferation of health information-seeking behaviour research. The literature that exists seems to be limited with respect to the questions addressed in this research study. However, this study supports health information behaviour, the sources of health information, challenges faced by market women in seeking health information, socio-demographical factors that influence (health information seeking) HIS among market women and factors that influence the lack of HIS. In addition to that, the data collected from the study suggests that focus should be made in the education of the market women on health. Medical knowledge should be improved among women in the Madina market.

1. Health information facilities could develop an economic test of knowledge which systematically plans and conducts everyday health information searches in the various known sources such as the print media (newspapers and magazines), social media, (radio and television), internet, medical professionals (doctors, nurses, community health workers).

2. The market women need knowledge, skills and motivation to understand health information so that they will be able to seek the help they need to reach optimum health. Therefore, market women need proficient health knowledge. This means, there should be an introduction of new strategies and approaches to increase health information seeking skills among the market women in Madina.
3. Madina as a municipal, it would be important for health information providers and some community-based organizations to work together in developing health information materials that the market women can easily seek, access and understand so that they can gain the ability to understand or question health information provider’s diagnosis or judgements. (Thorburn, Kue, Keon, & Lo, 2012)

4. Health care and health information providers can introduce a practice called “teach-back” technique, which gives the individual the opportunity to describe what they learn from their health information providers to the health information providers, family and friends.

5. There should be community-based organizations that could provide health education programs which focus on solely giving health information to the market women to help increase their health information seeking proficiency level.

6. There should be consultation points within the market. The finding revealed that some of the market women suggested that the issues of health information provision and access to certain health information were a problem, hence it is recommended that health authorities in the various health centres within the Madina Municipality should set up an office within the market where a health professional is available solely in charge of providing health assistance to the market women, answering questions when the market women walk in to make enquiries about certain health-related issues, in general, to acquire HI as well as boost their competence level. This is deemed to encourage the market women to interact without barriers and boost the confidence level of some of the market women who feel intimidated when they go to the main medical centres.
7. Authorities should include health literacy in national studies and surveys such as the National Commission for Civic Education programme.

In summary, the fundamental contribution of this research is to recognise the essentiality of health information seeking skills, which seemed to have been considered less important issues among the market women. The study identified age, educational background, ethnic group, religious affiliation, dialect and marital status as some of the socio-demographic factors that influence HIS.

6.5. Areas for further studies

Based on the findings and conclusion of this study, it is recommended that future research focus on the following areas:

1. The study was limited to market women at the Madina market, further studies can be replicated at other market centres.

2. Financial capabilities of market women to access health information.

3. The attitude of market women toward health information programmes.

4. Challenges confronting health-related issues among market women.
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University of Ghana http://ugspace.ug.edu.gh


APPENDIX A: QUESTIONNAIRE FOR MADINA MARKET WOMEN

TOPIC: HEALTH INFORMATION SEEKING AMONG WOMEN IN A PERI-URBAN COMMUNITY: A STUDY OF MARKET WOMEN IN MADINA.

A. DEMOGRAPHIC DATA

1. Age: 20-30 [ ] 31-40 [ ] 41 -50 [ ] 51-60 [ ] 61 and above [ ]
2. Marital Status: Single [ ] Married [ ] Divorced [ ]
3. Educational Background: JHS [ ] SSCE [ ] Tertiary [ ] Others [ ]
   None [ ]

B. COMPETENCE LEVEL ON HEALTH INFORMATION LITERACY

<table>
<thead>
<tr>
<th>Statements</th>
<th>Highly Important</th>
<th>Important</th>
<th>Not Important</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Knowing about your health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Asking questions about your health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Desire information on health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Personal control over health information</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Adherence to health literacy recommendations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Information on health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Seeking health information</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

11. How do you rate your level of health information literacy between 1 – 10?

C. HEALTH INFORMATION NEEDS

12. Please indicate your health information need (check as many as applicable)
   a) Prevention [ ]
   b) Cure [ ]
   c) Treatment [ ]
d) Causes of sickness [   ]

e) Specialist or specialise facilities [   ]

f) Family planning [   ]

13. When do you need health information? Or At what points in your life do you normally seek health information? (check as many as applicable)

a) Support health care at home and community [   ]

b) Build health skills and knowledge [   ]

c) When there is an outbreak of diseases [   ]

d) Fear and anxiety [   ]

D. SOURCE OF HEALTH INFORMATION

This section examines where you obtain Health Information on cause, treatment and management of diseases. Respond by ticking against

14. Where do you get information on health?

a. Internet [   ]

b. Community Health Worker [   ]

c. Radio / Television [   ]

d. Doctor [   ]

e. Relatives/friends/neighbours [   ]

f. Newspaper/Magazine [   ]

g. Midwife/Nurse [   ]

h. Health Outreach Program [   ]
E. SOCIO-DEMOGRAPHIC FACTORS AND HEALTH INFORMATION SEEKING

15. Does your age influence your Health Information Seeking Behaviour?
   Yes [ ]    No [ ]
   a. If yes, explain

16. Does your ethnic background influence your Health Information Seeking Behaviour?
   Yes [ ]    No [ ]
   a. If yes, explain

17. Does your language or dialect influence your Health Information Seeking Behaviour?
   Yes [ ]    No [ ]
   a. If yes, explain

18. Does your income influence your Health Information Seeking Behaviour?
   Yes [ ]    No [ ]
   a. If yes, explain

19. Does your education influence your Health Information Seeking abilities?
   Yes [ ]    No [ ]
   a. If yes, explain

20. Does your marital status influence your Health Information Seeking abilities?
   Yes [ ]    No [ ]
   b. If yes, explain

21. Does your religious affiliation influence your Health Information Seeking Behaviour?
   Yes [ ]    No [ ]
   c. If yes, explain
F. EVALUATION OF INFORMATION CONTENT

This sub-section examines how you evaluate information on your health. Respond by ticking the options against the statements.

a. Very often,  b. Often,  c. Sometimes and d. Not at all

<table>
<thead>
<tr>
<th>How often do you engage in any of these to evaluate the authenticity of information</th>
<th>Very Often</th>
<th>Often</th>
<th>Some times</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discuss with health professionals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discuss with my partner for advice or second opinion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discuss with family for opinion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discuss with a fellow market woman</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compare content with what I already know</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Read more on it/ Ask someone to read on it to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Verify it from people who are more educated.

Others:

<table>
<thead>
<tr>
<th>G. BARRIERS OR CHALLENGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>22. What are the challenges or barriers you encounter during health information seeking?</td>
</tr>
<tr>
<td>Indicate as many as applicable.</td>
</tr>
<tr>
<td>No library [ ]</td>
</tr>
<tr>
<td>Illiteracy [ ]</td>
</tr>
<tr>
<td>Language barriers [ ]</td>
</tr>
<tr>
<td>Lack of time [ ]</td>
</tr>
<tr>
<td>Financial barriers [ ]</td>
</tr>
<tr>
<td>No health facility within the market [ ].</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>23. What do you think can be done to solve the challenges of Health Information seeking?</th>
</tr>
</thead>
<tbody>
<tr>
<td>- THANK YOU -</td>
</tr>
</tbody>
</table>

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APPENDIX B: INTERVIEW GUIDE FOR MARKET LEADERS

<table>
<thead>
<tr>
<th>1. Serial number for Interviewee:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Date:</td>
<td></td>
</tr>
<tr>
<td>3. Time:</td>
<td></td>
</tr>
</tbody>
</table>

SECTION A: BIOGRAPHIC INFORMATION

| 4. Age |       |
| 5. Level of education |       |

6. How long have you been trading in this market?

SECTION B: HEALTH INFORMATION LITERACY LEVEL

7. What do you know about Health Information?

8. Do the market women know about Health Information Literacy?

9. How important is Health Information?
   a. To you
   b. To the market women

10. How is Health Information Literacy going to help the market women?

11. As a market leader, are there any measures put in place to support the market women know about Health Information seeking?
12. Do you think the market women have ample knowledge of Health Information seeking?

13. As a market leader, what has the leadership body as a whole done to help the market women Health Information or knowledge?

14. Are there any awareness programs the leadership organizes for the market women to aide them in Health Information Literacy?

SECTION C: SOURCES OF HEALTH INFORMATION

15. What are the sources of acquiring Health Information?

16. Which of those sources would you say are reliable?

17. Are those sources available to the market women?

18. Which of the sources will be most preferred by the market women?

SECTION D: TRAINING ON HEALTH INFORMATION SEEKING

19. Do the market women receive any training in Health Education?
   a. If yes, who organized the training?
   b. What kind of training do they receive?
   c. How has the training affected their knowledge on Health?

SECTION E: CHALLENGES ASSOCIATED WITH HEALTH INFORMATION SEEKING

20. What do you think are some of barriers or challenges of Health Information seeking among market women?

21. Is the market leadership taking any measures to help the market women access Health Information?