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REVIEW OF LITERATURE

NEED/IMPORTANCE OF THE STUDY

STATEMENT OF THE PROBLEM

OBJECTIVES

HYPOTHESES

RESEARCH METHODOLOGY

RESULTS & DISCUSSION

FINDINGS

RECOMMENDATIONS/SUGGESTIONS

CONCLUSIONS

SCOPE FOR FURTHER RESEARCH

ACKNOWLEDGMENTS

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APPENDIX/ANNEXURE

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CONTRIBUTIONS TO BOOKS

- Sharma T., Kwatra, G. (2008) Effectiveness of Social Advertising: A Study of Selected Campaigns, Corporate Social Responsibility, Edited by David Crowther & Nicholas Capaldi, Ashgate Research Companion to Corporate Social Responsibility, Chapter 15, pp 287-303.

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- Schemenner, R.W., Huber, J.C. and Cook, R.L. (1987), "Geographic Differences and the Location of New Manufacturing Facilities," Journal of Urban Economics, Vol. 21, No. 1, pp. 83-104.

CONFERENCE PAPERS

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- Kumar S. (2011): "Customer Value: A Comparative Study of Rural and Urban Customers," Thesis, Kurukshetra University, Kurukshetra.

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EFFECT OF HEALTH INFORMATION LITERACY ON THE ATTITUDE OF WOMEN TOWARDS FAMILY PLANNING

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ABSTRACT

Low literacy may impair functioning in the health care environment, affect patient-physician communication dynamics, and inadvertently lead to substandard medical care. It is associated with poor understanding of written or spoken medical advice, adverse health outcomes and negative effects on the health of the population. High level of literacy would increase the likelihood of saving lives and improving the overall health of women in developing countries by increasing socio-economic status, improvement and reproduction health.

KEYWORDS
Health information literacy, Attitude, practices, family planning.

INTRODUCTION

It is well recognized that mother's education has a positive impact on health care utilization. It is argued that better educated women are more aware of health problems, know more about availability of health care service, and use this information more effectively to maintain or achieve good health status. Educated women may have more understanding of the physiology of reproduction and be less disposed to accept the complication and risk of not attending antenatal clinics, than illiterate or an educated woman. Education has been described as "medications against fatalism". In addition to that, educated women may also be less likely to accept dangerous practices aimed at alleviating complications in pregnancy.

Nowadays people are no longer willing to simply take recommendations from physicians at face value. Rather, they want to participate in all aspects of their health care including the decision making process. Patients are insisting that they need to team up with health care professionals to determine their treatment plans and goals. This assumption come with a large responsibility; to become literate in an area that is complex, rapidly evolving and usually far removed from most people's daily experience. People need to obtain and analyse often complex data and information to partner in their healthcare decisions. This requires that they be able to read analyse data understand risk/benefit analysis and evaluate the quality of the recommendations they receive.

The ability to obtain, understands and use this type of information is called healthcare information literacy.

OBJECTIVE OF THE STUDY

To examine the relationship between literacy levels and the attitude of women towards family planning.

LITERACY AND HEALTH LITERACY

An important step in examining the relationship between literacy and health outcomes is to clarify what literacy means and how it has been measured. In the English language, literacy has taken on several different meanings. In its most common usage, literacy refers to an individual's ability to read and write (OED, 2003). It is also sometimes used to describe a person's facility with or knowledge about a particular topic. For example, we often see phrases such as "science literacy", "computer literacy," and "sports literacy". These terms generally refer to a person's ability to function in a particular context that requires some background knowledge.

In this same way, "health literacy" has been defined as a constellation of skills that constitute the ability to perform basic reading and numerical tasks that are required to function in the health care environment (AMA, 1999). Patients with adequate health literacy can read, understand, and act on health care information (AMA, 1999). Some authors have used an expanded definition of health literacy that includes a working knowledge of disease processes, self-efficacy, and motivation for political action regarding health issues(Nutbeam, D. 2000).

The issues of "health literacy" – is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions (IMR, 2004)– begins to cast a long patient safety shadow.

There is more to health literacy than reading and understanding health information (JCR, 2006). Health literacy also encompasses the educational, social and cultural factors that influence the expectations and preferences of the individual, and the extent to which those providing health care services can meet those expectations and preferences. Health care practitioners literally have to understand where their patients "are coming from" – the beliefs, values, and cultural mores and traditions that influence how health care information is shared and received.

HEALTH INFORMATION LITERACY

According to a 2004 report by the Institute of Medicine (IOM), nearly half of all American adults, about 90 million people, have difficulty reading and using health care information. A 2003 National Assessment of Adult Literacy found that 45% of the US population have basic or below basic skills. Below basic skills consists of being able to sign a form, add amounts on a bank slip, and search simple text for pre test instructions (Health Literacy: a prescription to end confusion, 2004). Health literacy is broader than general literacy in that it includes not only the ability to read, but the complex health information must be understood and acted upon. Some specific tasks that are influenced by the level of health care literacy are: the ability to analyze risks and benefits of proposed treatments, ability to interpret test results, ability to calculate and measure dosages of medication, and the ability to locate the needed health information to assist in these tasks

(Glassman, 2008). Glassman (2008) also states that there are multiple types of literacy needed within the healthcare decision arena: visual literacy or being able to understand graphs and over visually presented information, computer literacy, numerical literacy, and information literacy or being able to obtain relevant information.

According to the most accepted definition, health information literacy requires a skill set that allows one to: recognize a need for health information, identify sources for the information and be able to retrieve the relevant information, assess the quality and applicability to the specific situation, and analyze, understand and use the information to make good health decisions (Health information literacy task force final report, 2005).

Multiple studies show that limited health care literacy results in poor health and outcomes. The AMA (Glassman, 2008) states that poor health literacy is a stronger predictor of a person's health than their age, income, education level and employment. People with limited health literacy are more likely to skip preventive health care and wait until they are quite ill before seeking care. This same source also reports that limited health care literacy is associated with increased complications resulting from chronic illnesses such as diabetes, heart disease/heart failure, asthma hypertension, and HIV(Quick Guide to Health Literacy). Studies show there is a higher rate of hospitalization and use of emergency rooms by people with limited literacy skills (Quick Guide to Health Literacy). This adds a huge economic burden to our society and health care system resources. Low health care literacy results in shame for the people involved and as a result people often try to hide their literacy deficits. This lack of understanding regarding instructions for care and medications contributes to a lack of compliance. This leads to continued poor health and morbidity and even untimely death due to failure to treat and manage potentially treatable conditions. This is a critical issue that significantly impacts our whole country and economic system.

FAMILY PLANNING

Family planning is the planning of when to have children and the use of birth control and other techniques to implement such plans. Other techniques commonly used include sexuality education, prevention and management of sexually transmitted infections, pre-conception counseling and management, and infertility management (WHO, 2007).

Family planning is sometimes used as synonym for the use of birth control, however, it often includes a wide variety of methods, and practices that are not birth control. It is most usually applied to a female-male couple who wish to limit the number of children they have and/or to control the timing of pregnancy (also known as spacing children). Family planning may encompass sterilization, as well as abortion (Mischel, D R 2007).

Family planning services are defined as "educational, comprehensive medical or social activities which enable individuals, including minors, to determine freely the number and spacing of their children and to select the means by which this may be achieved.

Family planning enhances the quality of life by reducing infant mortality, improving maternal health, and alleviating pressures on governments to meet social and economic needs.

An expert Committee (1971) of WHO defined family planning as "a way of living that is adopted voluntarily upon the basis of knowledge, attitude and responsible decisions by individuals, and couples, in order to promote the health, and welfare of the family, group, and this contributes effectively to the social development of the country".

"The conscious efforts of couples to regulate the number and spacing births through artificial and natural methods of contraception. Family planning connotes conception control to avoid pregnancy and abortion, but it also include efforts of couple to induce pregnancy".

"Controlling reproduction, planning the timing of birth, and having as many babies as are wanted and can be supported".

"A system of limiting family size and the frequency of child bearing by the appropriate use of contraceptive techniques."

Family planning is a way of thinking and living that is adopted voluntarily upon the basis of knowledge, attitude and responsible decisions by individuals and couples in order to promote the health and welfare of the family group, and this contributes effectively to the social development of a country. (Isaiah, 2007).

EDUCATION

Royston (1998) argued that educated women may have more understanding of the physiology of reproduction and be less disposed to accept the complications and risk of not attending antenatal clinics, than illiterate or uneducated woman. Education has been described as a "medication against fatalism". In addition to that, educated women may also be less likely to accept dangerous practices aimed at alleviating complications in pregnancy. Amongst the Hausa people of Northern Nigeria, for example *girishi* cuts are a traditional surgical operation to treat obstructed labour by cutting the virgina with an un-sterilized blade. Whilst it is commonly performed on uneducated women, educated women rarely accept the practice (Royson, 1989). Uneducated women are less likely to seek the help of professional health services because they are probably less aware of what is available, and probably find the culture of modern health care facility more alienating and frightening.

Knowledge and practice of family planning is strongly related to higher level of education (Ramesh et al., 1996). In most of the studies it was found that education is the prime influencing factor and education affects the attitudinal and behavioural patterns of the individuals (Sajid and Malik, 2010; Mao, 1999). A number of Knowledge, Attitude and Practice survey has been carried out covering different population groups (Dabral S, Malik, 2004; Gautam and Seth, 2001; Takkar et al, 2005; Rao, 2005). Based on a majority of researches, in most countries of the world, female adolescents do not receive formal reproductive health education on time, since their puberty happens earlier than boys. Llyod (2009:85) contends that all 13-15 year olds should be acquiring "**reading and writing fluency for lifelong learning, critical thinking skills, health and reproductive health knowledge and skills for social and civic participation.** Nevertheless, it offers a standard to make informed and voluntary decisions in their lives, including their sexual, marital and reproductive lives. Studies have shown that 63.4% of puberty disorders and complications among females were because of their ignorance (Mohammadi et al., 2006).

Health education is an effective way of increasing the Knowledge and Attitude regarding family planning among the women.

INADEQUATE HEALTH LITERACY

Communication is essential for the effective delivery of health care, and is one of the most powerful tools in a clinician's arsenal. Unfortunately, there is often a mismatch between clinician's level of communication and a patient's level of comprehension. In fact, evidence shows that patients often misinterpret or do not understand much of the information given to them by clinicians. This lack of understanding can lead to medication errors, missed appointments, adverse medical outcomes, and even malpractice lawsuits.

Health literacy, as defined in a report by the Institute of Medicine, is the ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions and follow instructions for treatment. Many factors can contribute to an individual's health literacy, the most obvious being the person's general literacy – the ability to read, write, and understand written text and numbers. Other factors include the individual's amount of experience in the health care system, the complexity of the information being presented, cultural factors that may influence decision-making, and how the material is communicated.

IMPLICATIONS OF LIMITED HEALTH LITERACY

The limited ability to read and understand health related information often translates into poor health outcomes. Most clinicians are surprised to learn that literacy is one of the strongest predictors of health status. In fact, all of the studies that investigated the issue report that literacy is a stronger predictor of an individual's health status than income, employment status, education level, and racial or ethnic group. Though, we need to take cognizance of the fact that education level is a poor surrogate for general literacy skills and for health literacy. Education level only measures the number of years an individual attended school-not how much the individual learned in school. Thus, asking patients how many years of school they completed does not adequately predict their literacy skills.

LITERACY AND HEALTH KNOWLEDGE

Patients with limited health literacy have less awareness of preventive health measures and less knowledge of their medical conditions and self-care instructions than their more literate counterparts. This knowledge deficit has been documented for a variety of health conditions, ranging from childhood fever to asthma to hypertension. Persons with limited health literacy skills also exhibit less healthy behaviors (Arnold, CL, David, TC, Berkel, HJ, Jackson, RH, Nandi, I, London, S. 2001).

LITERACY AND HEALTH OUTCOMES

Persons with limited health literacy skills have poorer health status than the rest of the population (Sidore, RL, Yaffe, K., Sattenfield, S Harris, TB, et al, 2006). Indeed, several studies in diverse settings have shown that, even after controlling for a variety of sociodemographic variables, limited understanding of health concepts (i.e., poor health literacy) is associated with worse health outcomes. This may be due to the aforementioned deficits in health knowledge, as well as medication errors, poor understanding of medical instructions, and lack of self-empowerment. The combination of medication errors, excess hospitalizations, longer hospitals stays, more use of emergency departments, and a generally higher level of illness-all attributable to limited health literacy.

LITERACY AND HEALTH CARE COSTS

The adverse health outcomes of low health literacy translate into increases costs for the health care system.

FEMALE LITERACY AND EDUCATION

The value of female literacy and education is well recognized for its effects on fertility. It has been observed that, there is slower response to the population policies in societies with higher rates of illiteracy. Because, it is basically education which changes the attitude and behaviour of the people towards modernization and quality of life in general, education helps to overcome poverty, increase income, improves health and nutrition, and reduce family size. Therefore, it is relationship with population growth cannot be denied.

Studies have also shown that lower literacy is associated with lower cognitive ability. (Baker, D.W., Crazmararian, J.A., Sudano, J. et al., 2000).

In fact, a strong and positive relationship between family planning and education, especially of women, emerges as one of the most consistent findings from empirical analyses of reproductive knowledge, attitudes and behaviour in developing countries (see, for example, Ainsworth 1994, Ezeh et al 1996. Mboup and Saha 1998, Robey et al. 1992, Rutenberg et al. 1991). Education may be seen as a catalyst in diffusion-innovation theories. It is also typically employed as an indicator of socio-economic development or, among women, as a proxy for gender status.

It is well recognized that mother's education has a positive impact on health care utilization. In a study in Peru using DHS data, Elo (Elo, 1992) found quantitatively important and statistically significant effect of mother's education on the use of prenatal care and delivery assistance. In another study, Becker and colleagues (Becker et al., 1993) found mother's education to be the most consistent and important determinant of the use of child and maternal health services. Several other studies also found a strong positive impact of mother's education on the utilization of health care services (Fosu, 1994; Costello et al., 1996). It is argued that better educated women are more aware of health problems, know more about the availability of health care services, and use this information more effectively to maintain or achieve good health status. Mother's education may also act as a proxy variable of a number of background variables representing women's higher socioeconomic status, thus enabling her to seek proper medical care whenever she perceives it necessary.

BARRIERS TO FAMILY PLANNING SERVICE USE

The influence of physical access on the utilization of family planning services is well-founded, with many studies demonstrating the greater use of services among women who live in relative proximity to a service (Tsui and Ochoa, 1992). Research into the barriers faced in accessing reproductive health services, however, now recognizes that problem of access extend behind physical access to services, and include issues of economic, administrative, cognitive and psychosocial access (Bertrand *et al* 1995; Foreit *et al* 1978). Furthermore, the barriers to family planning service use are seen as extending beyond factors operating at the individual and household levels, to include characteristics of the social and cultural environment and the health service infrastructure. This view of access recognizes the importance of attributes of the health system in shaping an individual's ability to seek health care, highlighting the importance of the supply environment on health care utilization. This conceptualization of access incorporates factors operating at the individual, household and community level to influence an individual's ability to utilize a health service, thus framing an individual's access to services in terms of the socioeconomic, cultural and service supply context in which they live.

Previous studies of the use of reproductive health services have largely focused on factors operating at the individual and household levels, broadly categorized as demographic, socioeconomic, cultural and health experience factors. Demographic factors that have been shown to increase the likelihood of using reproductive health services are; low parity (Magadi, Madise, and Rodrigues 2000; Kavitha and Audinarayana 1997) and younger maternal age (Bhatia and Cleland 1995a). In terms of socioeconomic factors, the most consistently found determinant of reproductive health service utilization is a woman's level of educational attainment (Addai 1998; Bhatia and Cleland 1995a; Magadi, Madise, and Rodrigues 2000; Nuwaha and Amooti-Kaguna 1999; Obermeyer 1993). It is thought that increased educational attainment operates through a multitude of mechanisms in order to influence service use, including increasing female decision-making power, increasing awareness of health services, changing marriage patterns and creating shifts in household dynamics (Obermeyer 1993). Cost has often been shown to be a barrier to service utilization (Griffiths and Stephenson 2001: Bloom, Lippeveld and Wypij 1999) and also influences the choice of service provider. Socioeconomic indicators such as urban residence (Addai 1998), household living conditions (Magadi, Madise, and Rodrigues 2000; Bloom, Lippeveld and Wypij 1999), household income (Kavitha and Audinarayana 1997) women's employment in skilled work outside the home (Addai 1998), high levels of husband's education (Nuwaha and Amooti-Kaguna 1999) and occupational status (Nuwaha and Amooti-Kaguna 1999) have also proven to be strong predictors of a woman's likelihood of utilizing reproductive health services.

BENEFITS OF FAMILY PLANNING

Family planning saves lives and can improve the health of women, children and society as a whole. According to Berstein et al. (2006) gaining control of one's reproductive choices and fertility has health benefits for both mother and child. In 2000, about 90% of global abortion related and 20% of obstetric related mortality and morbidity could have been averted by the use of effective contraception by women wanting to either postpone or stop having children. In some cases, a mother's death is considered to be the death of the household (Daulaire et al., 2002). Daulaire et al. (2002), reports that children of deceased mothers are likely to be farmed out to relatives, forced on the street, and have a greater risk of dying themselves. In addition, using family planning to increase the interval at which women bear children not only has benefits to the mother, but also to the child (Daulaire et al., 2002). Children born within eighteen months of each other (live births) are at a greater risk of fetal death, low birth weight, prematurity, malnutrition and being small size for gestational age in both rich and poor communities (Bernstein et al., 2006).

Maternal mortality is not the only problem that stems from unintended pregnancies. According to the World Health Organization, (WHO) "for every maternal death an estimated 30 additional women suffer pregnancy-related health problems that are frequently permanently debilitating" (WHO 1997, pg. 3 as cited in Daulaire et al. 2002). Overall, an estimated 17 million women suffer from pregnancy-related health problems which include uterine rupture, prolaspe, hemorrhage, vaginal tearing, urinary incontinence, pelvic inflammatory disease and obstetric fistula (a muscle tear that allows urine or faces to seep into the vagina). These conditions are more likely to occur among women who are on the cusp of childbearing age, very young or very old, suffering poor health, malnutrition or have had multiple live births (Daulaire et al. 2002). The cost associated with such debilitation problems can lead to social and economic isolation as well as increasing the risk of maternal mortality during future pregnancies.

NIGERIA SITUATION

Nigeria which has a population of 140 million and an annual growth rate 3.2% (NPC, 2007) is the most populous country in Africa. Nigeria, according to khurfeld (2006), is already facing a population explosion with the resultant effect that food production cannot match the growing population. In Nigeria today, the birth rates are higher than the world average. (Nwachukwu & Obasi, 2008) Contraceptive Prevalence Rate (CPR) is still embarrassingly low in Nigeria, according to the report released by the international women's health coalition; the CPR among married women aged 15-49 years was 8% for modern methods and 12% for all methods. Also, other studies have reported a similarly low adoption rate of Modern Birth Control Methods (MBCM). (Haub & Yangishila, 1992; Makinwa Adebusuyi, 2001; Population Reference Bureau, 202; UNFPA, 2007).

Like many other developing nations, majority of Nigeria's population (about 70%) live in the rural communities. (Ekong, 2003). These rural communities have very high fertility rate and the CPR is also considerably lower in rural areas with CPR of 8% as compared with 18% in the urban areas in Nigeria (Ekong, 2003). Many rural women are reportedly reluctant to accept any artificial method of contraception. (Gaur, Goel M.K., Goel M., 2008) Several studies also revealed that rural women who were unwilling to accept family planning methods were concerned about child survival and viewed children as a source of support in old age.(Kartikeyan & Chaturvedi, 1995).

Studies carried out in Nigeria have shown that lack of adequate information and ignorance are key factors militating against family planning practice in Nigeria. (Adinma & Nwosu, 1995; Moronkola, Ojediran & Amosun, 2006) The socio-economic characteristics of women, notably educational levels have been argued to explain differences in reproductive behaviour and contraceptive choices (Anju, Vanneman & Kishor, 1995; Caldwell, 1982; Dyson & Moore, 1983; Kazi & Sathar, 2001). The perceptions and the behaviour related to reproduction have also been said to be strongly determined by prevailing cultural and religious values. (Srikanthan & Reid, 2008).

The 2008 Nigeria Demographic survey results show fertility in Nigeria has remained at a high level over the last 17 years from 5.9 births per woman 1991 to 5.7 births in 2008. On average, rural women are having two children more than urban women (6.3 and 4.7 children, respectively). Fertility differentials by education and wealth are noticeable. Women who have no formal education and women in the lowest wealth quintile on average are having 7 children, while women with higher than a secondary education are having 3 children and women in the highest wealth quintile are having 4 children.

Unplanned pregnancies are common in Nigeria. Overall, 4 percent of births are unwanted, while 7 percent are mistimed (wanted later). If all unwanted birth were prevented, women would have an average of 5.3 children, compared with the actual average of 5.7 children.

CONCLUSION AND RECOMMENDATION

Vulnerable population is an essential challenge. This population includes the elderly, minorities, immigrant populations, low income and people with chronic mental or medical health conditions. These people are more likely to have health literacy deficits due to lack of educational opportunity, learning disability, cognitive decline, and cultural differences (Glassman, 2008). Glassman (2008) reports that groups with the highest prevalence of illness and chronic debilitating disease often have the least ability to read and comprehend information needed to manage these conditions. The indirect effects of poor health literacy extend to insurance issues, accessibility to care, and poor health behaviour choices/lack of preventive care (Glassman, 2008).

Some specific ways to enact these recommendations are for consumer health provider's tod develops partnerships with public and private schools, health care associations, community based organizations, senior citizen facilities, and literacy groups to promote and expand health care literacy opportunities. These partnerships are based on shared values and goals to promote skills in information location, analysis of quality, and computer literacy. The health care provider may consider providing space for meetings, providing health care literacy materials, sponsoring seminars and classes to teach the necessary skills of visual, numerical, computer, and information literacy (Glassman, 2008).

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