Original Article

Relationship Between Rate of Access to Resources and Guidelines of Health Information and Quality of Life in Women Referring to Hospitals in Qom in 2016

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Abstract

Background & Objectives: In Iran, few studies have been conducted on health information sources. The aim of this study was to determine the relationship between rate of access to resources and guidelines of health information and quality of life in women referring to hospitals in Qom city in 2016.

Materials & Methods: This cross-sectional descriptive-analytical study was performed on 254 women referring to hospitals in the city of Qom in 2016. The subjects were selected via multi-stage sampling method. Data were collected by a researcher-made questionnaire on sources and guidelines of health information and the valid Quality of Life Questionnaire. The collected data were entered into SPSS V.20 software and were analyzed using Chi-square, ANOVA, and Pearson correlation coefficient tests.

Results: There was a significant negative correlation between the quality of life score and the use of the resources and guidelines of health information (r=-0.14, p=0.02), as with increasing the use of the resources and guidelines of health information, the score of quality of life of the subjects reduced. In addition, there was a significant relationship between educational level and type of the resources and guidelines of health information (p<0.02) so that, the people with university education were more likely to use more self-resources and mass media to obtain health information.

Conclusion: Given the significant relationship between quality of life and the use of the resources and guidelines of health information, people should be properly informed about and familiarized with the reliable sources and guidelines of health information that are suitable for their conditions and levels of literacy.

Keywords: Quality of Life, Rate of Access, Health Information, Guidelines

Introduction

Medical societies' growing attention to self-care (1,2) and leading clients to autonomy and knowing their own health rights (3), has increased the importance and necessity of their empowerment in the field of getting health information (4). To make sure of accessing reliable information in health area, it is required that we make sure of the importance of this information and the way of achieving it (5). Searching for health information through helping people to understand health threats and its challenges not only promotes the adaptation with

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diseases and the ability to make medical decisions (6,7), but also leads to more effective interactions with health-care attendants, lower stress level, access to lifestyle-related habits (8), lower anxiety, and negative feelings (9). Several studies have introduced media including TV educational programs, books, and magazines as health information achieving media (10-12).

There are so different information sources used by different groups that people with low and average socio-economic status mostly used the TV, and the educated group mostly use the internet as the information resource to receive information about health and prevention (13). Recommended sources to search for health information are affected by cultural and social-individual factors such as age, gender, ethnicity, education, income, informational literacy and health literacy, health status, and different stages of a disease (14-17). Not many studies are reported according to searching health information but radio and television, internet, and health-care attendants are stated the most usual sources for searching health information through general population of the city of Tehran, respectively (18). Regarding Iranians' lack of familiarity with English, low information and health literacy, lack of internet access, and reliable Persian sources that are able to present information to people in simple words and practically, and regarding the high work load of health-care attendants, lack of the ability to get along with clients, insufficient clinical observation, low motivation among health-care attendants, lack of information individuality, and special religio-cultural theme, it seems that Iranian clients follow different models to look for health information (19).

According to studies results, women are active health information seekers (20-22), and pay more attention and sensitivity to their health and take more preventive actions than men (23). Therefore, doing health-care for family members, plays a key role in determining the family life-style (22). People's quality of life is affected by their social right, mental status, and health life, thus presenting proper information and promoting information level in the field of health can be helpful for improving people's lives (24). Quality of life literally means how to live. Quality of life is unique for every single person and different from others, however (25). Quality of life involves different aspects of health and physical, mental, and social comfort (26). In fact, health-related quality of life mentally evaluates individual's current health status, health care, and health-promoting activities that declare their lives' precious goals (27). Based on this, this study is designed aiming at determining health information sources and guideline and its relationship with quality of life in women referring to Qom hospitals to help health-care attendants present information based on Iranian women's needs regarding health information sources with a clearer understanding of their health information sources, and, as a result, achieving favorable health consequences is facilitated and quality of life gets better.

Materials & Methods

This is a descriptive-analytical, cross-sectional study on women referring to Ayatollah Golpayegani and Imam Reza hospitals in Qom, during a year, in 2016. The sampling was carried out in a multi-stage sampling method, in which educational hospitals were initially listed on paper. Then, Ayatollah Golpayegani and Imam Reza hospitals were selected from 10 hospitals in a simple accidental way and then the samples were randomly selected from these two hospitals. Afterwards, 254 women were selected using sample volume formula based on Meybodi (28) study with a variance of 14.14 and error of 0.05 and accuracy of 2 and accounting 25% of sample drop out of the women referring to these two hospitals. This study inclusion criteria included clients who needed outpatient services, as well as full and informed consent to participate in the study, and exclusion criteria included having any chronic disease and having history of psychiatric diseases, pregnancy, and immunosuppressive medication use.

After coordinating with Qom Azad University and hospitals, the questionnaire was distributed. During the data collection process, the objective of the research was explained to the participants, consent was obtained, and the collected data were kept confidential.

Data were collected in this study through two questionnaires (a researcher-made questionnaire regarding health information sources and guideline, and WHO standard questionnaire of quality of life). The researcher-made questionnaire included two parts; the first part was about demographic information involving 6 questions (age, job, educational status, number of children, history of disease and insurance). The second part was about health information sources

and guideline (using health-care staff consisting of health experts, physicians, nurses, midwives…) including 5 questions, using social media including 5 questions, using culture and religion including 6 questions, using mass media including 5 questions, using self-information including 2 questions. The validity of the questionnaire was assessed through Cronbach's alpha coefficient test (α=0.86) and its reliability was confirmed through experts' opinions panel. The second questionnaire was the WHO Quality of Life Questionnaire (WHOQOL-BREF) was used to measure health related quality of life. This questionnaire has been valid and reliable in Iran (29) and has 26 questions that assess the quality of life in four domains: physical health (7 questions), mental health (6 questions), social relations (3 questions) and environmental health (8 questions) on a 5-point Likert scale. Questions 1 and 2 are also general questions from a person regarding their personal assessment of their quality of life and satisfaction with their health. Questions 3, 4 and 26 are scored reversely. Scores were calculated according to the World Health Organization (WHO) standard score (30), from 0 to 100 for each domain. A higher score on this questionnaire indicates a better quality of life.

It should be noted that the questionnaires were distributed among the samples before providing health services. Data were analyzed through SPSS V.20 software using Chi-square, ANOVA and Pearson correlation coefficient tests with the significance level of 0.05.

Results

Results showed that mean and standard deviation of the subjects' age was 34.28±11.04. Subjects were mostly housewives (45.6%), having 3 or fewer children (89.2%), and having university degrees (39.8%). Regarding the rate of using health information sources and guideline, health-care staff, and self-resourcing with 99.6% and 80.3% were the first and the last priorities, respectively. 92.4% of the subjects had insurance and 7.6% did not, also 60.5% of them had no disease history in contrary to 33.1%. Generally, mean and SD of quality of life score in the study group was 45.98± 12.68, and mean of the scores of physical and psychological micro scales were 20.95± 8.3, and 53.7 ±15.03, and social and environmental relationships were 52.22±15.53, 56.20±97.87 respectively.

In checking the relationship between the rate of using health information sources and guideline, Pearson correlation test showed that there was a significant relationship between age, and using health centers staff , self-resourcing (self-exploring, the sixth sense, previous experience), and using social media ($p<0.05$), so that with increasing of age, the rate of using social media and self-resourcing as health information sources and guideline increases, but the rate of using health centers staff as health information sources and guideline decreases, while there was no significant relationship between the rate of using health information sources and guideline and variables such as job and the number of children ($p>0.05$).

Pearson correlation test showed that there was a significant negative correlation between quality of life and health information sources and guideline plus the number of children ($p<0.05$), so that with increasing the use of health information sources and guideline and the number of children, the score of quality of life decreases [Table 1].

ANOVA test showed that there was a significant relationship between educational status and quality of life ($p<0.05$), so educated

Table 1. Correlation between quality of life score with use of health information resources and guideline, age and number of children

Variables		Mean	SD	P
Quality of life	Resources and Health Information guideline	14.02	3.09	p=0.02 r=-0.14
	Age	34.28	11.04	p=0.07 r=-0.11
	Number of children	1.69	1.55	p=0.04 r=-0.13

people had better quality of life, but no significant relation was found between job and quality of life (p>0.05). [Table 2].

Chi-square test showed that a significant relation between educational status and health information sources and guideline except culture and religion (p<0.05), so that in people with elementary-intermediate education the use of two sources of health-care staff and social media was more. Also, it showed that people with university degrees mostly used self-resourcing and mass media to achieve health information [Table 3].

Chi-square test showed that among health information sources and guideline there was only a significant relation between mass media and

Table 2. Relationship between Quality of life with job and educational status

Variables			Mean	SD	P
Quality of life	Job	Housewife	44.98	13.22	>0.05
		Employee	47.53	12.83	
		Other	45.97	11.73	
	Educational status	Illiterate	43.86	12.56	<0.05
		Elementary-Intermediate	42.52	13.31	
		Diploma	45.75	12.27	
		Academic	48.45	12.37	

Table 3. Relationship between the use of health information resources and guideline with educational status

Variables		Prevalence (%)	P
Health centers staff	Illiterate	27 (10.88)	<0.001
	Elementary-Intermediate	98 (39.51)	
	Diploma	68 (27.41)	
	Academic	55 (22.17)	
Social networks (peers, daily social interactions)	Illiterate	100 (40)	0.03
	Elementary-Intermediate	68 (27.2)	
	Diploma	55 (22)	
	Academic	27 (10.8)	
Culture and Religion (Experiences of elders, Traditional Medicine, Religious Teachings)	Illiterate	98 (40.32)	0.52
	Elementary-Intermediate	52 (21.39)	
	Diploma	66 (27.16)	
	Academic	27 (11.11)	
Mass media (electronic media, printed media and digital media)	Illiterate	54 (21.95)	<0.001
	Elementary-Intermediate	26 (10.97)	
	Diploma	68 (27.64)	
	Academic	97 (39.43)	
Self-resourcing (self-exploring, the sixth sense, and previous history)	Illiterate	55 (22)	<0.001
	Elementary-Intermediate	68 (27.2)	
	Diploma	27 (10.8)	
	Academic	100 (40)	

history of disease (p<0.05), so that people with no history of disease are more likely to choose mass media to achieve health information [Table 4].

for people and unfavorably affects their quality of life. Nevertheless, it is highly related to people's life conditions and the sort of their available resources. In line with this, a study by

Table 4. Relationship between the use of resources and guideline to health information with history of disease

Variables		Mean	SD	Prevalence (%)	P
Health centers staff	With history of disease	3.69	1.27	84 (33.6)	P=0.19 t=1.29
	Without history of disease	3.46	1.27	166 (66.4)	
Social networks	With history of disease	2.95	1.49	84 (33.3)	P=0.22 t=1.23
	Without history of disease	2.71	1.42	168 (66.6)	
Culture and Religion	With history of disease	3.36	1.46	83 (33.87)	P=0.57 t=0.55
	Without history of disease	3.24	1.54	162 (66.12)	
Mass media	With history of disease	2.75	1.51	84 (33.87)	P=0.008 t=2.69
	Without history of disease	3.24	1.29	162 (65.85)	
Self-resourcing	With history of disease	1.32	0.77	84 (33.3)	P=0.69 t=0.40
	Without history of disease	1.27	0.78	168 (66.6)	

Discussion

This study results showed that the score of quality of life among all the participants was lower than average and the highest achieved score in this field belonged to physical health. A study by Ghasemi et.al. showed that the average of quality of life among Kermanshah rural women in physical, mental, social, and environmental aspects were (61.55, 53.22, 60.58, 47.94), respectively (31). A study by Kaldi et.al. showed a favorable quality of life (113.05) and the highest score was for the physical area, this contrast might be due to the target population (32).

Furthermore, this study results showed a negative significant correlation between health information sources and guideline and quality of life and this relationship states that the increase in using health information sources and guideline leads to the decrease in people's quality of life. This is likely due to the increase in information resources without effective education and interaction that leads to more stress and anxiety Heidari et.al. showed that not considering quality of life, leads to frustration, lack of motivation for any effort, and the reduction of social, economic, cultural and health activities; in other words, the promotion of quality of life is in line with the health promotion (33).

Health information results in self-care, so increasing awareness, knowledge, motivation, self-esteem, self-effectiveness, self-control, and preventive behaviors and in other words empowering people leads to health and promoting quality of life (4), this relationship between quality of life and people empowerment has been tested and confirmed in different studies (5,33).

In this study, there was a significant relationship between quality of life and the following variables: educational status, age, and the number of children. Studies by Rimaz et.al. (34) and Ghasemi et.al. also showed a significant relationship between age, educational status, having the history of disease or having it

currently and the quality of life (31). A study by Saeid Pour (26) and Ghamari (27), showed results similar to the current study. But the results of a study by Namdar et.al. showed no significant relationship between the average of quality of life and educational status, economic situation, employment status, history of diseases, the number of children, and the disease duration (35). These differences are probably due to different places of conducting the study and different survey methods. Further, in this study there was a significant relationship between social media and the number of children, age and health-care plus self-resourcing (self-exploring, the sixth sense, and previous history), education and all health information sources and guideline except culture and religion. The same significant relationship between demographic information and the sort of selected resources by participants is also seen in studies by Kahouie (36) and Okhovati (37), but in the results of some studies including a study by Meybodi in Kerman (28), this relationship was not observed, while the results of a study by Hesse et.al. with the title of "Health Information Resources and Reliability: the effect of internet and its effect on health-care presenters" showed a significant difference between the subjects' age and using internet, TV, and magazine (38).

Also a study by Shakouri Monfared showed that people with bachelor and master degrees prefer using printed media (12), while a study by Lam (39), educated people tend to use on-line resources. Also in a study by Esmaeilzadeh et.al. the most important sources to obtain health information were Internet and virtual social media (40). However, in this study, people with university degrees, preferred mass media (including printed sources, electronic and digital media), and self-resourcing, and illiterate people referred to resources including health centers staff, social media, and culture and religion.

In this study, health-care staff were the mostly used health information guidelines and afterwards were culture and religion, mass media, and self-resourcing, respectively. It is a tradition in some places to refer to health-care staff. The results of a study by Yoo-Lee (41) and Warner (22), introduced on-line resources and friends plus family as the most practical health resources and guideline. A study by Riahi et.al. showed that family and friends were the most important source of access to information to them (42). Generally, resources for achieving health information are different in various studies and related to the group's socio-economic level. For example, in the field of health-care, the staff are selected as the prior guideline for achieving health information (10,43). The reverse is observed in some studies like Sharami's, though, in such a manner that midwives and physicians usually considered as the most reliable information sources for contraception were the third priority (%11.7) (44). Studies by Dart and Okhovati also showed the effects of education, the subjects' social and economic level on the information resource in such a manner that unlike people with university degrees, people with average and low education level, referred less to the internet (13,37). Therefore, regarding the ruling conditions, and the rate of people's access to the sort of health information sources and guideline in different environments, it would most likely be effective in selecting the type of information source. This study strengths included recognizing health information sources and guideline and the rate of using each among women, the relationship between each source with quality of life rate and determining some health information sources and guideline that received less attention from the area of health so far. The limitations of this study included inability to check all educational and non-educational hospitals, women out of the hospitals, cause and effect and self-reporting of the study tools.

Conclusions

Today, people's participation in care activities is not only a legal right, but also a gold international standard for health-care systems and care and service presenters must try to achieve this goal. Creating desire in people to use available information sources considering different groups of people in terms of quantity and quality is an important thing in this line. With regard to the significant relationship between life quality and health information sources and guideline, people must become familiar with reliable scientific sources related to health and use them correctly.

Regarding the development of technology and health information sources and guideline availability, this can be potentially used to promote health-care level and also help patients cure and increase their life quality. Furthermore, recognizing health information sources and guideline can control the creation of sources for

wrong beliefs and information in the area of health.

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Conflict of Interests

The authors announce no conflict of interest.

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مقاله پژوهشی

ارتباط بین میزان دسترسی به منابع و راهنماهای کسب اطلاعات سلامت با کیفیت زندگی در زنان مراجعه کننده به بیمارستان های شهر قم

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چکیده

زمینه و هدف: در ایران در زمینه منابع جستجوی اطلاعات سلامت پژوهش های کمی گزارش شده است. این مطالعه با هدف تعیین ارتباط بین میزان دسترسی به منابع و راهنماهای کسب اطلاعات سلامت با کیفیت زندگی در زنان مراجعه کننده به بیمارستان های شهر قم انجام شده است.

مواد و روش ها: این مطالعه از نوع توصیفی-تحلیلی مقطعی بود که روی ۲۵۴ نفر از زنان مراجعه کننده به بیمارستان های شهر قم به صورت نمونه‌گیری چند مرحله ای انجام شد. داده ها از طریق پرسشنامه محقق ساخته منابع و راهنمای کسب اطلاعات سلامت و پرسشنامه استاندارد کیفیت زندگی جمع آوری و با استفاده از نرم افزار آماری SPSS V.20 از طریق آزمون های آماری تی مستقل، ANOVA، ضریب همبستگی پیرسون مورد تجزیه و تحلیل قرار گرفت.

نتایج: بین نمره کیفیت زندگی و استفاده از منابع و راهنمای کسب اطلاعات سلامت همبستگی منفی و معنی داری مشاهده گردید (p=۰/۰۲،r=-۰/۱۴)، به طوری که با افزایش استفاده از منابع و راهنمای کسب اطلاعات سلامت، نمره کیفیت زندگی افراد کاهش می‌یابد. همچنین بین سطح تحصیلات و نوع منابع و راهنمای کسب اطلاعات سلامت ارتباط معنی‌دار مشاهده شد(p<۰/۰۲)، به طوری که افراد دارای تحصیلات دانشگاهی برای کسب اطلاعات سلامت، بیشتر خودمنبعی و رسانه‌های جمعی را استفاده می کنند.

نتیجه گیری: با توجه به وجود رابطه معنی دار بین کیفیت زندگی و استفاده از منابع و راهنمای کسب اطلاعات سلامت، بایستی مردم با منابع علمی موثق مرتبط با سلامت و متناسب با شرایط و سطح سواد خود آشنا شوند و به درستی از آنها استفاده کنند.

کلمات کلیدی: کیفیت زندگی، میزان دسترسی، اطلاعات سلامت، راهنماها

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