

ARAŞTIRMA MAKALESİ / RESEARCH ARTICLE

DOI: 10.52122/nisantasisbd.1090246

THE EFFECT OF HOUSEWIVES' EDUCATION LEVELS ON HEALTH LITERACY: A STUDY ON HOUSEWIVES LIVING IN ISTANBUL**Dr. Öğr. Üyesi Bora GÜNDÜZYELİ****İstanbul Topkapı Üniversitesi, İİSBF, Yönetim
Bilişim Sistemleri Pr.

e-posta: boragunduzyeli@topkapi.edu.tr

ORCID 0000-0001-5098-8713

**Dr. Öğr. Üyesi Rana ÖZYURT
KAPTANOĞLU**** İstanbul Topkapı Üniversitesi, İİSBF, Yönetim
Bilişim Sistemleri Pr.

e-posta: ranaozyurt77@gmail.com

ORCID 0000-0002-0341-4722

ABSTRACT

Both today's technological development and easy access to information enable individuals to have knowledge about their diseases and research what is good for them. Health literacy has an essential issue in individuals' access to health services. In the broadest sense, health literacy is the ability of individuals to acquire, understand, and use the information to maintain and improve their health for their full well-being. This ability, closely related to all people, affects women even more because a woman's health affects both herself and her family. Many factors affect health literacy, and demographic characteristics are at the forefront of these factors. In the light of this information, the study aims to examine the effect of women's education level on health literacy. In the study, first of all, studies in the literature about the concept of health literacy and the concepts related to health literacy are included. In the methodology part of the study, a face-to-face survey was conducted with 250 housewives residing in five different districts of Istanbul by using the European Health Literacy scale with the convenience sampling method. Two invalid questionnaires were removed from the collected data, and the data were analyzed with the SPSS program over 248 questionnaires. In the study, participants' age range, educational status, how effectively they benefit from health services, their awareness of the services provided, their knowledge about smart drug use, and their knowledge and awareness of health literacy were measured. In the study, the participants were not asked questions such as their profession, whether they earn money by doing any work at home, and the reasons for not working. As a result of the analysis, there was no statistically significant relationship between the age of housewives and health literacy, but a statistically significant relationship was observed between education status and health literacy levels. The data were collected with the ethics committee report with meeting number 2021/7 held on 27.08.2021 at the Academic Research and Publication Ethics Committee of Istanbul Ayyansaray University. An informed consent form was presented to the participants.

Anahtar Kelimeler: Literacy, health literacy, health organization and group communication**Jel Kodları:** M10, M14, I0, I31**EV KADINLARININ EĞİTİM DÜZEYLERİNİN SAĞLIK OKURYAZARLIĞINA ETKİSİ:
İSTANBUL'DA YAŞAYAN EV KADINLARI ÜZERİNE BİR ARAŞTIRMA****ÖZ**

Gerek günümüzün teknolojik gelişimi gerekse bilgiye kolay erişim, bireylerin hastalıkları hakkında bilgi sahibi olmalarını ve kendilerine neyin iyi geldiğini araştırabilmelerini sağlamaktadır. Ancak bireylerin sağlık hizmetine erişimi için sağlık okuryazarlığı önemli bir yere sahiptir. Sağlık okur yazarlığı en geniş anlamda bireylerin tam iyilik hali için sağlığını koruma ve geliştirme amaçlı bilgi edinme, anlama ve kullanma yeteneğidir. Tüm insanları yakından ilgilendiren bu yetenek kadınları daha da çok etkilemektedir. Keza kadın sağlığı hem kendisini hem de ailesini etkilemektedir. Sağlık okuryazarlığı pek çok faktörden etkilemektedir ve demografik özellikler bu faktörlerin başında yer almaktadır.

Bu bilgiler ışığında çalışmanın amacı kadınların eğitim düzeyinin sağlık okuryazarlığına etkisinin incelenmesidir. Çalışmada öncelikle sağlık okuryazarlığı kavramı ve sağlık okuryazarlığı ile ilişkili kavramlar hakkında geniş literatür çalışmasına yer verilmiştir. Çalışmanın metodoloji kısmında Avrupa Sağlık Okuryazarlık Ölçeği ile kolayda örneklem yöntemi ile belirlenmiş İstanbul'da toplam beş ilçede ikamet eden 250 ev hanımı kadın ile yüz yüze anket yapılmıştır. Geçersiz sayılan iki anket sonrasında 248 anket üzerinden SPSS programı ile veriler analiz edilmiştir. Araştırmaya katılan ev hanımlarının cinsiyet, meslek, evde herhangi bir iş yaparak para kazanıp kazanmadığı, yaşadıkları il, çalışmama nedeni vb. demografik soruları sorulmamıştır. Böylelikle araştırmaya katılanların yaş aralığı ve eğitim durumları ile sağlık hizmetlerinden ne kadar etkin faydalandığı, sunulan hizmetlerin farkındalığı, akıllı ilaç kullanımı



hakkındaki bilgileri ve sağlık okur yazarlığı hakkındaki bilgi ve farkındalıkları ölçülmüştür. Yapılan ölçümlerin değerlendirilmesi sonucunda ev hanımlarının yaşları ile sağlık okuryazarlığı arasında istatistiki açıdan anlamlı bir ilişki bulunmazken eğitim durumları ve sağlık okuryazarlığı düzeyleri arasında istatistiki açıdan anlamlı bir ilişki olduğu gözlemlenmiştir. Veriler, İstanbul Ayvansaray Üniversitesi Akademik Araştırma ve Yayın Etiği Kurulunda, 27.08.2021 tarihinde yapılan 2021/7 toplantı numaralı etik kurul raporu ile toplanmıştır. Katılımcılara bilgilendirilmiş gönüllü onam formu sunulmuştur.

Keywords: Okuryazarlık, sağlık okuryazarlığı, sağlık örgütü ve grup iletişimi

Jel Codes: M10, M14, I0, I31

Geliş Tarihi/Received: 19.03.2022

Kabul Tarihi/Accepted: 15.06.2022

Yayın Tarihi/Printed Date: 30.06.2022

Kaynak Gösterme: Gündüzyeli, B. & Özyurt Kaptanoğlu, R., (2022). "The Effect of Housewives' Education Levels on Health Literacy: A Study on Housewives Living in Istanbul". *Nişantaşı Üniversitesi Sosyal Bilimler Dergisi*, 1(10) 01-22.

GİRİŞ

Today, the concept of literacy does not only include reading and writing skills but also defines the ability of interest and knowledge about some fields and subjects (Filiz & Bodur, 2022). The concept of health literacy, which has existed for a long time in the literature, has many similar definitions. The concept of health literacy was evaluated by Sorensen et al., not only in a clinical sense but also in terms of public health. The concept has been defined as the empowerment of the individuals in issues such as disease prevention, health care, and health promotion (Sorensen vd., 2012).

Literacy, which is the main determinant of health-related behaviors and benefiting from health services, generally refers to the ability to read, write and calculate. The definition of health literacy has been updated with the "Health Literacy in Healthy People 2030" initiative report published in the USA. With this update covering both individual and organizational health literacy, personal health literacy has been defined as the degree to which individuals have the ability to find, understand and use health-related decisions and actions, information, and services for themselves and others (www.health.gov.tr e.t. 15.05.2022). "Healthy People 2030", the fifth renewal of the Healthy People initiative founded in 1979, defines health literacy as not only individual talents but also the ability of organizations to make health-related information and services equally accessible and understandable (Santana vd., 2021).

According to TUIK data, the literacy rate is lower in women than in men. Women make up 64% of illiterate adults (TUIK, 2020). Turkey Demographic and Health Survey (TNSA) 2018 report states that women's health is affected by their literacy status and education (http://www.sck.gov.tr. E.t. 16.05.2022). The female figure in the family is closely related to the health of the whole family. Therefore, the high level of health literacy of women is important for the health of families and, therefore, society. Therefore, it is anticipated that the study will both contribute to the literature and provide social benefits

In the study, the relationship between health literacy and literacy level was examined. For the determination of health literacy, a questionnaire was applied to a total of 250 housewives between the ages of 25-50 in 5 provinces in Istanbul with the convenience sampling method. Two questionnaires were deemed invalid and the data were analyzed with the SPSS program on a total of 248 questionnaires. Participants' occupations, city of residence, etc. demographic characteristics were not included in the analyses. In addition, the relationships between participants' ages, health literacy levels and whether the participants lead a balanced life, general health status, relationships with family physicians, drug use habits, basic health information, behaviors in case of illness and methods of prevention from illness were examined.

As a result of the research, while there was no statistically significant relationship between the age of women and health literacy, it was observed that there was a statistically significant positive correlation between their educational status and health literacy levels. In addition, it was observed that the women participating in the research did not attach much importance to the necessary behaviors to protect their health, did not show the required care, but were more sensitive about their children's health.

1. Literacy and Health Literacy

1.1. Birinci Düzey Alt Başlık

Today, the concept of literacy is not only used to define literacy and understanding skill of an individual but also to define his/her knowledge about some areas or subjects. For example, concepts such as media literacy, financial literacy, computer literacy, nutrition literacy, and health literacy have been defined (Peerson & Saunders 2009).

The studies have revealed that the health literacy is more effective than socioeconomic factors in determining the health status of an individual (Ruth, Parker, Scott, Ratzan & Nicole, Lurie, 2003). According to Turkish Language Association, literacy is defined as the ability to read, write, and receive education for a person (TDK, <http://www.tdk.gov.tr> Date of access: 03/03/2018). Reading/writing and literacy are not the same things. Reading/writing is a static action and it is related with the ability to solve a certain letter system. Literacy requires interpretation in addition to this static behavior (Kurudayıoğlu & Tüzel, 2010).

1.2. Health Literacy

Even if the individuals have similar education level, their reading, writing, understanding and calculation skills may be different. Therefore, it is stated that the health literacy level should be considered not the education status while evaluating the individuals in health related subjects (Berkman et al., 2011). According to the results of the National Adult Literacy Survey (NALS) conducted in 1992 in the United States of America, it was determined that approximately half of the community were not sufficiently literate (Kindig et al., 2004).

Although high educational level does not warrant the adequacy of health literacy, it is obvious that there is a correlation between the health literacy and standard literacy. The weakness in the literacy status limits the development of individuals such as socio-cultural, personal and can constitute a barrier to health literacy (Nutbeam & Kickbusch, 1998). It refers to basic skills based on fundamental reading-writing and numerical function competencies necessary for meeting the people's needs in the places providing health services such as hospitals, health centers, and pharmacies (Terrence, Shaneyfelt, Michael, Mayo-Smith & Johann, Rothwangl, 1999).

It is stated that the concept of health literacy was first mentioned in 1974 but the related studies have increased since the 1990s (Speros 2005). It is seen that many definitions have been made about health literacy in the literature. The definition of health literacy in the Health Promotion Glossary prepared by WHO and translated into Turkish by the Ministry of Health is stated as "individuals' skills of accessing, understanding and using information in such a way to encourage and sustain the good health and their cognitive and social skills determining their motivation" (Nutbeam & Kickbusch, 1998).

In the report of the American Medical Institute, the health literacy is defined as "obtaining health information and service required to make individual decisions in accordance with the individual's health and the level of understanding and comprehending capacity (Kindig & Panzer, 2004). Here, the literacy emphasis in health includes active participation such as accessing and analyzing information, transferring the obtained knowledge to the others, having the capacity to criticize, not only having the meaning information but also establishing and

mentioning new messages (Aslantekin & Yumrutaş 2014). Health literacy is addressed at three levels. These levels are briefly as in Figure 1:

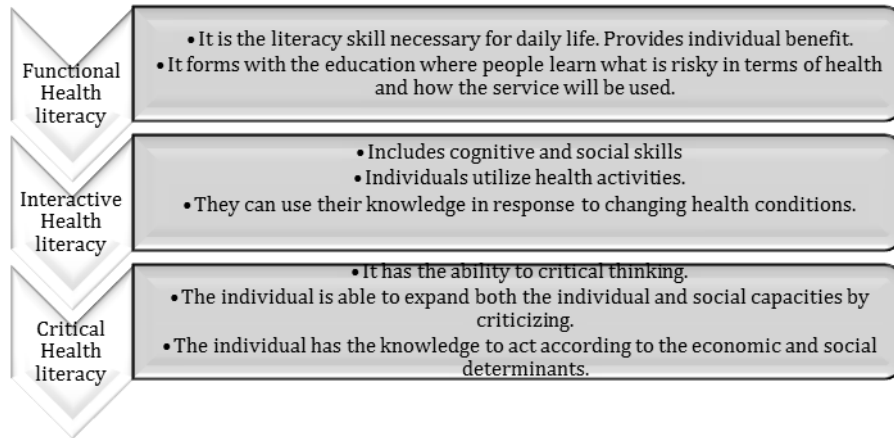


Figure 1. Health Literacy

Resource: Levels Nutbeam D, (2000). Health Literacy as a public health goal: A challenge for contemporary health education and communication strategies into the 21st century. *Health Promot Int*, 15, 260.

The concept of capacity is an important support for health literacy. The concept of “capacity” refers both to the innate potential and abilities of the individual. An individual's health literacy capacity is related to education and the sufficiency of his/her capacity is affected by properties of culture, language and health system environment (Kinding & Panzer, 2004).

According to Christina, Zarcadoolas, Andrew, Pleasant & David, Greer, (2005), an individual with the ability of health literacy can use the health-related information and concepts in new situations by comparing them. As in many complex behaviors of people, health literacy slowly evolves throughout life. Health literacy is affected by the health status of the individual as well as by the sociopolitical, psychosocial, demographic and cultural factors. The benefits of being a health literate are seen in all vital areas such as home, work, society and culture. The authors have defined the health literacy as a broad collection of skills covering the abilities of searching and finding, comprehending, evaluating and using health information that will help people to make conscious choices to reduce health risks and enhance the quality of life and recommended a multidimensional model for the society to understand and improve the health literacy. Four basic components of this model are;

- 1) Basic literacy: Includes strategies for reading, writing, speaking and calculation skills.
- 2) Science literacy: Refers to the level of sufficiency for the science and technology (knowing basic scientific concepts, and knowing that the scientific knowledge is changing rapidly and there is no certainty in science).
- 3) Civil literacy: Citizens are aware of public issues and participate in decision-making processes (being a media literate, being aware that individual health decisions affect public health).
- 4) Cultural literacy: It is the competence of recognizing and using the social beliefs, traditions, world view, and social identities for the purpose of interpreting and behaving about health information (Zarcadoolas et al., 2005).

Baker has noted that the common statement in the definitions of health literacy is “the whole of individual capacities allowing the individual’s skills to acquire and use new information” and stated that although the individual capacity can be increased with education programs or can be reduced with the pathological processes decreasing the aging and cognitive functions, it does not show significant changes over time. According to Baker, health literacy is determined by both the individual characteristics and the characteristics of the health care system (Baker, 2006).

The time spent of the physician with the patients during their treatment is limited and the patient needs to understand adequately the information received from the physician during this period. It is sometimes needed to not only to understand the mentioned information but also confirm the authenticity and reliability of the information from other sources. In addition, the patients play active consumer role not the passive one and they want to participate in treatment and care decisions. In addition to its many functions, health literacy facilitates the communication between the health service providers and the patients who receive health care service and serves as a mediator between the two for better understanding each other (Osborne 2013, Cited by Pınar, Balçık, Serap, Taşkaya & Bayram, Şahin, 2014). Definition of health literacy has been broadened in such a way to emphasize the groups along with the people. Public health literacy (PHL) is a complement of individual health literacy.

In the past 30 years, a person's literacy capacity as a mediating factor in health and making decisions about health has been conceptualized as "Health literacy" (Coulter & Ellins 2007). Although the concept of health literacy is defined by many organizations, with the form expressed jointly with the mentioned institutions, it is a series of individual skills allowing people to acquire and use new information, being stable over time but improving with the education programs and worsening with aging or pathological processes (Baker, 2006).

The ideal individual health literacy is also the ability to access the health information necessary to maintain well-being status and includes the items below;

- ❖ To understand and apply the practice of complex daily treatments with self-care behaviors,
- ❖ To plan and realize lifestyle changes which are necessary to maintain health,
- ❖ To be aware of positive developments related to health,
- ❖ To know how to access health care institutions when necessary,
- ❖ To distinguish health promotion activities from the others,
- ❖ To be able to talk about health issues in the community (Mitic & Rootman 2012).
- ❖ addition to this static behavior (Kurudayıoğlu & Tüzel, 2010).

1.3. Concepts Related to Health Literacy

Tones (2002) describes health literacy as "new wine in the old bottle". In the WHO's Health Promotion and Development Glossary, concepts related to health literacy are addressed and the concepts are as follows with brief descriptions:

Health Promotion/Development: It is the process of facilitating people to promote their health and to increase their controls about health. This process is not just about increasing the skills or capacity of the individual. The process aims to improve the economic, social or environmental conditions and thereby alleviate the effects of these factors on the individual or community health (Nutbeam & Kickbusch, 1998).

Health Education: Education is actually a form of communication designed to improve the knowledge and life skills. Therefore, the education not only contains information share but also encourages motivation, trust and skill to improve health (Nutbeam & Kickbusch, 1998).

Health Communication: It is a strategic way to inform the public about the concerns existing in the health area and to keep important health problems in the public's attention. It aims to increase the awareness of the individuals and thus the community about the important health issues through the use of all technological tools that will provide mass communication (Nutbeam & Kickbusch, 1998).

Social Marketing: With the social marketing theory, the approach that the successful and effective experiences in the market analysis, planning and control techniques in the trade marketing can be applied successfully in the social events is dealt. The goal in social marketing is

to provide services for the benefit of society and the real needs of the society by using traditional marketing methods.

1.4. Studies on Determining the Health Literacy Level

The “clinical risk” approach in the health literacy model of Nutbeam (2008) proposes to identify the individuals with low health literacy level and to do improvement interventions about this issue. Healthcare professionals can take an active role in improving their health by recognizing the health literacy level of the individuals. Some clues can help the healthcare professionals in determining the health literacy level of the individuals. For example, situations such as not being able to fill the forms given to the patients, not completing the medication treatment, using the medication in the wrong way, and not coming to the appointments may show low level of health literacy (Michael, Maniaci, Michael, Heckman & Nancy, Dawson, 2008).

In case of the lack of these clues, it is difficult to estimate the patients’ degree of understanding the issues about health. In order to determine the level of health literacy, some questionnaires and scales have been developed (Parker et al., 2003). In the scales related to health literacy, issues like applying to a health institution and understanding the directions given in the institution, reading, understanding and filling the medical forms, understanding the directions about medications and healthcare professionals and understanding the information about coming to the control are questioned in general (Chew et al., 2008). Each of these scales has different limitations and comprehensive and applicable valid measures that will define the health literacy level are required (Mancuso 2009).

2. Method

For determining health literacy, a questionnaire was applied to a total of 250 housewives in the age range of 25-50 years in Istanbul with convenience sampling method. Two of the questionnaires were invalidated and 248 questionnaire data were analyzed by using SPSS program. The questionnaire is composed of the questions of the European Health literacy scale which was adapted into Turkish in 2016 by Okyay and Abacıgil. In seven of the ten questions about evaluating the health literacy, the participants were asked to state how often they have problems about “applying health care institutions” and “guidance in the institution”, “medical forms”, “medication instructions” and “understanding what the health care professionals tell”. There are questions about personal information in the first part of the questionnaire with a total of 55 questions, health status and habits in the second part, about basic health in the third part, health care service usage in the fourth part, and protective and preventive health in the fifth part. There are 10 questions about determining the health literacy in the sixth part. In this context, the research hypothesis is as follows;

H1: There is a significant correlation between the literacy level and health literacy in the same direction.

Since the sample is composed only of housewives living in Istanbul, demographic questions such as gender, occupation, whether they earn money by working at home or not, the city they live, reason of not working etc., were not asked. In this way, how much the participants benefit from the health care services, their awareness of the services offered, their knowledge about the smart medication usage and their information and awareness about health literacy were measured. In the final phase of the study, hypothesis test was conducted and the H1 hypothesis was confirmed. In addition to the hypothesis analysis of the study, whether the participants live a balanced life or not, their general health statuses, their behaviors about family physician, drug using habits, basic health information, their actions in the case of illness, methods of prevention from diseases, and health literacy need status of the participants were analyzed.

2.1. Results

All of the participants were female. When their mean age was examined, it was observed that 23.39% were below 30 years old, 46.37% were in the age range of 31-40 years, 18.95% were in the age range of 41-50 years, 8.47% were in the age range of 51-60 years, and 2.82% were aged 61 years and over. 21.37% were in their own homes and 78.63% resided in the rental houses. In terms of their education status, 3.23% of them were not literate. 12.09% were literate. 16.53% were the primary school graduates, 30.65% were elementary school graduates, 35.89% were high school graduates, 1.21% had the associate's degree, and 0.40% had postgraduate education. 1.61% of the participants were living alone. In their house, 13.71% were living with more than two people, 18.15% more than three people, 21.36% more than four people, 23.39% more than five people, 12.50% more than six people, 4.84% more than seven people, 1.21% more than eight people, 2.42% more than nine people, and 0.81% more than ten people.

The monthly incomes of the participants were 1800 TL and lower for 8.47%, between 1801-2500 TL for 22.98%, 2501-3000 TL for 27.42%, 3001-3500 TL for 22.18%, 3501-4000 TL for 11.69%, 4001-4500 TL for 4.43%, 4501-5000 TL for 2.02%, and 5000 TL and above for 0.81%.

Table 1. Demographic Characteristics of the Participants

Variable	Number	Percentage
Distribution of the Participants According to the Age Range		
30 and younger	58	23.39
31-40	115	46.37
41-50	47	18.95
51-60	21	8.47
61 and over	7	2.82
Home Ownership of the Participants		
Home owner	53	21.37
Rental	195	78.63
Distribution of the Participants According to Their Education Status		
Illiterate	8	3.23
Literate	30	12.09
Primary School Graduate	41	16.53
Elementary Sch. Graduate	76	30.65
High School Graduate	89	35.89
Associate Degree	3	1.21
Postgraduate Degree	1	0.40
Number of People Living at Home		
1	4	1.61
2	34	13.71
3	45	18.15
4	53	21.36
5	58	23.39
6	31	12.50
7	12	4.84
8	3	1.21
9	6	2.42
10 and more	2	0.81
Monthly Income of the Household		
Below 1800 TL	21	8.47
Between 1801- 2500 TL	57	22.98
Between 2501-3000 TL	68	27.42
Between 3001-3500 TL	55	22.18
Between 3501-4000 TL	29	11.69
Between 4001-4500 TL	11	4.43
Between 4501-5000 TL	5	2.02
5000 TL and more	2	0.81

Table 2. General Health Status of the Participants

Variable	Number	Percentage
How Participants See Their Own Health Status		
Very good	39	15.72
Good	82	33.06
Middle	98	39.52
Bad	21	8.47
Very bad	8	3.23
Whether Participants Have any Disease or Not		
Yes	71	28.63
No	177	71.37
The presence of Diagnoses Given by the Doctor		
Yes	64	25.81
No	184	74.19

Table 2 is related to the general health status of the participants. For the question of how the participants find their health statuses, 15.72% responded as very good, 33.06% good, 39.52% moderate, 8.47% bad, and 3.23% very bad.

Table 3. Participants' Vital Habits

Variable	Number	Percentage
Daily Tea Consumption of the Participants		
0 (occasionally)	59	23.79
Between 1-5	78	31.45
Between 6-10	101	40.73
More than 10	10	4.03
Daily Turkish Coffee Consumption of the Participants		
0 (occasionally)	95	38.31
1 cup	130	52.42
2 cups and more	23	9.27
Daily Water Consumption of the Participants		
Less than 5 Glasses	131	52.82
Between 6-10 Glasses	83	33.47
More than 10 Glasses	34	13.71
Weekly Vegetable Consumption Status of the Participants		
At most 1 day	78	31.45
2-5 days	115	46.37
Everyday	55	22.18
Weekly Fruit Consumption Status of the Participants		
Maximum 1 day	63	25.40
2-5 days	99	39.92
Everyday	86	34.68
Daily Sleep Time of the Participants		
4-5 hours	10	4.03
6-7 hours	64	25.81
8-9 hours	81	32.66
10 hours and more	93	37.50

Table 3 shows the participants' answers to the question about their vital habits. Of the participants, 23.79% stated that they occasionally or never drink tea, 31.45% drank 1-5 cups of

tea in a day, 40.73% drank 6-10 cups of tea in a day and 4.03% stated that they drank more than 10 cups of tea in a day. Their daily consumption of Turkish coffee had close results. 38.31% of the participants stated that they never or rarely drank Turkish coffee, 52.42% drank 1 cup per day, and 9.27% stated that they drank more than 2 cups a day. When the daily water consumption of the participants was examined, it was seen that the participants did not consume daily minimum required amount in general. Only 13.71% of the participants consumed more than 10 glasses of water in a day. While 33.47% stated to drink water between 6-10 glasses, 52.82% stated to drink less than 5 glasses.

In the participants' fruit and vegetable consumption, their healthy nutrition levels were also observed to be low. 31.45% of the participants stated that they consumed vegetables mostly 1 day a week and 25.40% consumed fruit mostly 1 day per week. A great majority of the participants slept for minimum 7 hours a day. Only 4.03% of them slept between 4-5 hours a day. This result can be thought to be associated with the fact that the participants were housewives.

Table 4. Basic Health Information of the Participants

Are the Following Diseases Chronic?		
Disease	Correct	%
Obesity	80	32.26
Hypertension (High Blood Pressure)	167	67.34
Acne (Pimple)	35	14.11
Epilepsy	93	37.50
Tuberculosis	89	35.89
Callus	189	76.21
Allergic Diseases	29	11.69
Diabetes	207	83.46
Scabies	66	26.61
Hernia	49	19.76
Varicosity (Vascular Diseases)	27	10.89
Are the following diseases infectious?		
Tuberculosis	230	92.74
Obesity	199	80.24
Pneumonia	65	26.21
Rabies	242	97.58
Pediculus	247	99.60
Hepatitis	191	77.02
Colds	179	72.18
Kidney Disease	167	67.34
Dysentery	103	41.53
Cancer	215	86.69
AIDS	235	94.75
Sleep disorders	207	83.47
Gonorrhea	205	82.66

Table 4 shows the result table of the questions measuring participants' basic health information. In this section, the participants were asked whether the mentioned diseases were chronic or not. 32.26% of the participants responded correctly that obesity is chronic, 67.34% hypertension, 14.11% acne, 37.50% epilepsy, 35.89% tuberculosis, 76.21% callus, 83.46% diabetes, 26.21% scabies, and 19.76% hernia. It was observed that the knowledge of the participants about the infectious diseases was more. 230 people gave correct information that the tuberculosis is infectious, 242 people gave correct information that the rabies is infectious, 103 people gave

correct information that dysentery is infectious, 235 people gave correct information that AIDS is infectious, and 205 people gave correct information that the gonorrhoea is infectious.

Table 5 shows the results of the participants to the questions asked for the medication use. In this section, the participants were asked in which situations they used drugs. Of the participants, 46.9% stated that they did not use medication without doctor's advice, 75% stated that they did not follow the instructions of the circle, 59.68% did not use drug with their own knowledge, 42.24% used medication by consulting with the pharmacy, 82.66% recommended the drugs, which were good for them, to the others, 40.73% stated that they stopped using the medication when they thought that they got well, 57.66% said that sometimes they used natural treatment methods at home and did not use drug, and 77.42% preferred alternative treatment methods.

Table 5. Information About the Drug Use

Questions	Never	%	Some times	%	Always	%
I use drugs without doctor's advice	123	49.60	99	39.92	26	10.48
I use drugs with the advice of the circle	186	75.00	33	13.31	29	11.69
I use drugs based on my own drug knowledge	148	59.68	42	16.93	58	23.39
I use drugs by consulting with the pharmacy	104	41.94	38	15.32	106	42.74
I recommend the drugs, I thought that it was good for me, to my circle	205	82.66	34	13.71	9	3.63
I stop using my drugs when I believe that I get well	101	40.73	102	41.13	45	18.14
I take natural things at home and I do not use drugs	54	21.77	143	57.66	51	20.57
I use the methods such as leeches, blood cupping, cupping	192	77.42	50	20.16	6	2.42

When examining the table showing how often the participants go to the family centers, it was observed that 61.69% went to the family center 1-3 times a year, 19.76% 4-6 times a year, 8.47% more than 7 times a year, and 10.08% never.

Table 6. Frequency of going to Family Health Center

Frequency of Going to Family Health Center by the Participants		
	Number	%
Never	25	10.08
1 - 3 times a year	153	61.69
4 - 6 times a year	49	19.76
More than 7 times a year	21	8.47

Table 7. Questions About the Family Health Center and Family Physician
Participants' Thoughts about Family Health Center

	Yes	%	No	%
Do you take pregnant and postpartum women to family physician?	179	72.18	69	27.82
Will you take your baby and children to family physician for control and vaccination	246	99.19	2	0.81
Reasons for not going to Family Physician				
	Number	%		
I do not know what the Family Physician is	0	-		
I have no social security	7	2,82		
Since the family physician behaves negatively	33	13,31		
I go to a hospital if necessary	208	83,87		
I do not go to any health institution	0	-		
Since I pay medication	0	-		
Total	248	100		

Table 7 shows the responses of the participants to questions on what they think about family physicians. This part has entered in two separate evaluation processes. In the first part, the participants were asked whether or not they went to the family physician in pregnancy and whether or not they took their babies to the family physician. 72.18% of the participants stated

that they preferred family medication during their pregnancy and postpartum periods and a high rate such as 99.19% took their children to the family practice especially for vaccination. In the second part, the reasons for not going to the family physician were examined. The participants stated that they did not go to the family physician since 2.82% of them had no social security, 13.31% did not like the negative behaviors of the family physician and 83.87% preferred to go to hospital instead of going to the family doctor. It was determined that all participants had information about family practice.

Table 8 shows the results of the responses given to the questions about the participants' status of getting ill. In the responses given to the first actions of the participants when they got ill, 35.48% marked that they went to a doctor, 18.55% indicated that they used the drugs at home, 18.15% stated that they preferred to go to a hospital, 20.97% stated that they went to the emergency department, 5.24% stated that they did not do anything and 4 participants marked the option of other.

When the participants were asked which action they would take first in case of an inflammatory disease, they responded with similar rates as warm shower by 30.24%, applying water with vinegar by 27.82%, and going to the emergency department by 26.22%.

Table 9. Participants' Approaches About Ways of Protection from Disease

	<i>Number</i>	<i>%</i>
Which is the most important one Among the ways of Protection from Disease?		
Hand and foot cleaning	83	33.47
Vaccination	100	40.32
Regular Sports	13	5.24
Health Education	31	12.50
Using medication	5	2.02
No idea	16	6.45
What Provides Continuation of Good Well-Being?		
Individual cleaning	28	11.29
Using medication	3	1.21
Healthy nutrition	92	37.10
Not being in public places	8	3.23
Personal hygiene	66	26.60
Regular sports	7	2.82
Not using cigarette/alcohol	33	13.31
Education	2	0.81
Working	1	0.40
No idea	8	3.23
Total	248	100

Table 9 shows the results in the section questioning the thoughts of the participants about the ways of protection from disease. 40.32% of the participants thought that vaccination was the most important way for protection. The participants stated the hand and foot cleaning at the rate of 33.47% in the second rank. In order to sustain being health, 37.10% of the participants stated that the health nutrition is important, 26.60% stated that they hygiene is important, and 13.31% stated that not using cigarette and alcohol is important. Table 10 shows the results of the section about how much the participants needed the health literacy.

Table 10. Health Literacy Need of the Participants

Questions	<i>I don't need</i>	<i>%</i>	<i>Does n't matter</i>	<i>%</i>	<i>Better to have</i>	<i>%</i>	<i>I need it</i>	<i>%</i>	<i>I really need it</i>	<i>%</i>
ITEM-1	6	2.42	57	22.98	110	44.36	53	21.37	22	8.87
ITEM 2	2	0.81	20	8.06	81	32.66	95	38.31	50	20.16
ITEM 3	5	2.02	55	22.18	101	40.73	57	22.98	30	12.09

ITEM 4	11	4.44	28	11.29	93	37.50	71	28.63	45	18.14
ITEM 5	2	0.81	79	31.85	59	23.79	61	24.60	47	18.95
ITEM 6	12	4.84	31	12.50	128	51.61	42	16.94	35	14.11
ITEM 7	1	0.40	57	22.98	94	37.91	80	32.26	16	6.45
ITEM 8	-	-	3	1.21	60	24.19	141	56.86	44	17.74
ITEM 9	53	21.37	107	43.15	49	19.76	29	11.69	10	4.03
ITEM 1	About having knowledge about basic health information									
ITEM 2	Information about benefiting from healthcare services									
ITEM 3	Information about chronic disease and their treatment									
ITEM 4	Information about infectious diseases and treatment									
ITEM 5	Information about health- threatening behaviors.									
ITEM 6	Information about how to protect from diseases									
ITEM 7	Information about health lifestyle behaviors such as correct nutrition.									
ITEM 8	Getting information about diseases									
ITEM 9	Getting information about communication skills									

44.36% of the participants responded to the question about getting information about basic health information as "it would be good if". 95 participants stated that they needed to have knowledge about benefiting from the healthcare services.

While 37.50% of the participants thought positively about having knowledge about infectious diseases, 40.73% had positive thoughts about having knowledge about chronic diseases.

The participants' responses about asking information about the health threatening subjects were slightly different from the other responses. Number of the participants requesting such information was determined as 67.34% in total, which was lower than the other subjects.

31.85% of the participants considered that it does not make any difference whether or not they had knowledge about this issue. 51.61% of the participants thought that it would be better to have knowledge about how to protect from diseases, and 37.91% thought that it would be better to have knowledge about healthy lifestyle behaviors such as correct nutrition.

Almost all participants stated that they wanted to obtain information about diseases. 107 of the participants indicated that getting information about communication would not make any difference.

Table 11. Health Literacy Level of the Participants

	<i>Number</i>	<i>%</i>	<i>P</i>
Which one is the most important way to protect from the disease?			
Understanding the drug description of the pharmacist	190	76.61	.587
Understanding the vaccination card or diet forms	178	71.77	.589
Understanding the information given by the doctor and nurse	130	52.42	.899
Understanding the writings, posters and brochures in the hospital	171	68.95	.595
Knowing the commonly used terms about health	63	25.40	.903
Performing the processes in the hospital alone	111	44.76	.367
Calculating the drug use times	153	61.69	.577
Being able to find the places needed in the hospital	148	59.68	.899
Understanding drug prescriptions	74	29.84	.309
Drug Dosage Calculation	35	14.11	.388

Health literacy levels of those who gave correct answers to at least 6 out of 10 questions asked in health literacy section were accepted as correct.

Table 12. Participants' Demographic Characteristics and Health Literacy Status

Variable	Insufficient	Sufficient	P
Distribution of Participants in terms of Age Range			
30 and younger	58 (23.39)	50 (20.16)	.934
31-40	115 (46.37)	75 (30.24)	
41-50	47 (18.95)	30 (12.09)	
51-60	21(8.47)	14 (5.65)	

61 and over	7 (2.82)	2 (0.81)	
Home ownership of the participants			
Home owner	53 (21.37)	31 (21.50)	.876
Rental	195 (78.63)	178 (71.77)	
Distribution of the participants in terms of the education status			
Illiterate	8 (3.23)	2 (0.81)	<0.001
Literate	30 (12.09)	14 (5.65)	
First School Graduate	41 (16.53)	21(8.47)	
Primary School Graduate	76 (76.65)	50 (20.16)	
High School Graduate	89 (35.89)	58 (23.39)	
Associate Graduate	3 (1.21)	3 (1.21)	
Postgraduate	1 (0.40)	1 (0.40)	

When the women were evaluated according to their demographic characteristics, a significant correlation in the same direction was found between the literacy level and health literacy ($p < 0.001$).

CONCLUSION

In the study, the effect of the demographic characteristics of the women on the health literacy was not measured. In this context, different future studies in which these measurements are carried out will bring different results. In addition, the correlation between some behaviors of women about health and the health literacy may be different in different scales. In the literature, each different scale can evaluate health literacy differently. In some scales, smoking/alcohol usage or exercises are not the concepts related to health literacy. In the study conducted by ChristianVon, Wagner, Katherine, Knight, Andrew, Steptoe & Jane, Wardle, (2007) with almost 750 female participants they determined that health literacy was higher in those who did not smoke and did regular exercise. In the study conducted by Lee, Shoou-Yih, Tzu, Tsai, Yi-Wen, Tsai & Ken Kuo. (2012) with approximately 1800 women participants in order to investigate their awareness status in the changes such as skin color, weight increase etc., smoking, how much they pay attention to the expiration date of the foods, and if or not they had smear test or checkup within the last two years, it was concluded that health literacy was not related with the investigated concepts. It was found in the study by Arnold et al., (2001) that the literacy of the women was not related with their smoking status.

In this study aiming to measure to what extent the health literacy of housewives are, it was seen that some of the participants were concerned about not being able to give correct answers to some questions. It was suggested that the collection of data of this community-based study in women's own environment and the time they wanted increased the data reliability.

When examining the demographic characteristics of the participants, 37.50% of them were seen to have high school and higher education. Accordingly, the educational level of the community including the participants was close to the average in Turkey but it was low in general. As mentioned in the study, the general education situation can affect the health literacy in the same way. In this context, if the study is conducted on a sample with a higher average educational level, it is more likely to get different results.

In women, the rate of showing health protective behaviors was found to be low. Women do not show the necessary care for their health. The fact that women went to family practice or doctor during pregnancy and postpartum period and also took their infants and children for control and vaccination with a rate of almost 100% suggested that women cared the health of their children and other family members more than their own health status. There are quite distinct differences in the mentioned subject between women and men. Therefore, the presence of the opposite gender in the sample of the study will change the results.

Buraya yorum/tartışma kısmı eklenmeli ve yukarıda verilen önerilere dikkat edilmelidir. Bulgulardan anlaşılması gereken özet bilgilere burada yer verilmelidir.

REFERENCES

- Aslantekin, F. & Yumrutaş, M. (2014). Sağlık Okuryazarlığı ve Ölçümü. *TAF Preventive Medicine Bulletin*, 13(4), 327-334 Doi:10.5455/pmb1-1364566995
- Arnold, C. L., Davis, T. C., Berkel, H. J., Jackson, R. H., Nandy, I., & London, S. (2001). Smoking status, reading level, and knowledge of tobacco effects among low-income pregnant women. *Preventive medicine*, 32(4), 313-320. <https://doi.org/10.1006/pmed.2000.0815>
- Baker, D. W. (2006). The meaning and the measure of health literacy. *Journal of general internal medicine*, 21(8), 878-883. doi: 10.1111/j.1525-1497.2006.00540.x
- Balçık, P. Y., Taşkaya, S., & Şahin, B. (2014). Sağlık okur-yazarlığı. *TAF Preventive Medicine Bulletin*, 13(4), 321-326. Doi: 10.5455/pmb1-1402386162
- Berkman, N. D., Sheridan, S. L., Donahue, K. E., Halpern, D. J., Viera, A., Crotty, K., ... & Viswanathan, M. (2011). Health literacy interventions and outcomes: an updated systematic review. *Evidence report/technology assessment*, (199), 1-941. Retrieved from <https://europepmc.org/article/nbk/nbk82434> on 01.02.2022.
- Chew, L. D., Griffin, J. M., Partin, M. R., Noorbaloochi, S., Grill, J. P., Snyder, A., ... & VanRyn, M. (2008). Validation of screening questions for limited health literacy in a large VA outpatient population. *Journal of general internal medicine*, 23(5), 561-566. doi: 10.1007/s11606-008-0520-5
- Coulter, A. & Ellins, J. (2007). Effectiveness of strategies for informing, educating, and involving patients. *Bmj*, 335(7609), 24-27. Doi: <https://doi.org/10.1136/bmj.39246.581169.80>
- Filiz, E., & Bodur, S. (2022). Gebe kadınlarda sağlık okuryazarlığı ve sağlık algısı ilişkisinin değerlendirilmesi. *Selçuk Sağlık Dergisi*, 3(1), 17-33.
- Hacettepe Üniversitesi Nüfus Etütleri Enstitüsü. (2019). 2018 Türkiye Nüfus ve Sağlık Araştırması, Temel Bulgular. Hacettepe Üniversitesi Nüfus Etütleri Enstitüsü, T.C. Cumhurbaşkanlığı Strateji ve Bütçe Başkanlığı ve TÜBİTAK, Ankara, Türkiye http://www.sck.gov.tr/wp-content/uploads/2020/08/TNSA2018_ana_Rapor.pdf e.t. 16.05.2022
- <https://health.gov/healthypeople/priority-areas/health-literacy-healthy-people-2030> e.t. 15.05.2022
- Kindig, D. A., Panzer, A. M., and Nielsen-Bohlman, L. (Eds.). (2004). *Health literacy: a prescription to end confusion*. Washington DC: National Academies Press.
- Kurudayıoğlu, M. & Tüzel, A. G. M. S. (2010). 21. yüzyıl okuryazarlık türleri, değişen metin algısı ve Türkçe eğitimi. *Türklük Bilimi Araştırmaları*, 28(28), 283-298. Retrieved from <https://dergipark.org.tr/en/download/article-file/157039> on 01.02.2022.
- Lee, S. Y. D., Tsai, T. I., Tsai, Y. W., and Kuo, K. N. (2012). Health literacy and women's health-related behaviors in Taiwan. *Health Education & Behavior*, 39(2), 210-218. <https://doi.org/10.1177/1090198111413126>
- Mancuso, J. M. (2009). Assessment and measurement of health literacy: an integrative review of the literature. *Nursing & Health Sciences*, 11(1), 77-89. doi: 10.1111/j.1442-2018.2008.00408.x
- Maniaci, M. J., Heckman, M. G., & Dawson, N. L. (2008). Functional health literacy and understanding of medications at discharge. *Mayo Clinic Proceedings* 83(5), 554-558, <https://doi.org/10.4065/83.5.554>
- Mitic, W. and Rootman, I. (2012). *Inter-sectoral approach to improving health literacy for Canadians*, Vancouver, BC: Public Health Association of British Columbia.

- Nutbeam D.(2000). Health Literacy As A Public Health Goal: A Challenge For Contemporary Health Education And Communication Strategies Into The 21st Century. *Health Promot Int*, 15, 259-67. Retrieved from <https://academic.oup.com/heapro/article/15/3/259/551108?login=true> on 02.03.2022
- Nutbeam, D., & Kickbusch, I. (1998). Health promotion glossary. *Health promotion international*, 13(4), 349-364. Retrieved from https://www.jstor.org/stable/45152457?casa_token=p64Mid1a24QAAAAA%3AVrgt-g8XcJkDwa8QfRLrleoKpsdcwvz8kJ4OCtBRuFW2ZvJLO2Gv0xFFPNCdshgnnmIS8HNdD423adMtSXR5NFq9vO4n3cs5l2pwG3AjZrY1CewveNy&seq=1#metadata_info_tab_contents on 02.03.2022
- Okyay, P., & Abacıgil, F. (2016). Türkiye sağlık okuryazarlığı ölçekleri güvenilirlik ve geçerlilik çalışması. *TC Sağlık Bakanlığı*, 19-75. Retrieved from <https://sbu.saglik.gov.tr/Ekutuphane/Yayin/530> on 10.10.2020
- Parker, R. M., Ratzan, S. C., & Lurie, N. (2003). Health Literacy: A Policy Challenge For Advancing High-Quality Health Care. *Health Affairs*, 22(4), 147-153.doi: <https://doi.org/10.1377/hlthaff.22.4.147>
- Peerson, A., & Saunders, M. (2009). Health Literacy Revisited: What Do We Mean And Why Does It Matter?. *Health Promotion International*, 24(3), 285-296. <https://doi.org/10.1093/heapro/dap014>
- Richmond, M., Robinson, C., Sachs-Israel, M., & Sector, E. (2008). *The global literacy challenge*. Paris: UNESCO. Retrieved August, 23, 2011. Retrieved from https://www.right-to-education.org/sites/right-to-education.org/files/resource-attachments/UNESCO_The_Global_Literacy_Challenge_2008_En.pdf on 10.1.2022
- Santana, S., Brach, C., Harris, L., Ochiai, E., Blakey, C., Bevington, F., ... & Pronk, N. (2021). Updating health literacy for Healthy People 2030: defining its importance for a new decade in public health. *Journal of public health management and practice: JPHMP*, 27(Suppl 6), 258-64. <http://dx.doi.org/10.1097/PHH.0000000000001324> PubMed
- Sayed, Y., & Ahmed, R. (2015). Education quality, and teaching and learning in the post-2015 education agenda. *International Journal of Educational Development*, 40, 330-338. <https://doi.org/10.1016/j.ijedudev.2014.11.005>
- Shaneyfelt, T. M., Mayo-Smith, M. F., And Rothwangl, J. (1999). Are Guidelines Following Guidelines?: The Methodological Quality Of Clinical Practice Guidelines In The Peer-Reviewed Medical Literature. *Jama*, 281(20), 1900-1905. doi:10.1001/jama.281.20.1900
- Speros, C. (2005). Health Literacy: Concept Analysis. *Journal Of Advanced Nursing*, 50(6), 633-640. <https://doi.org/10.1111/j.1365-2648.2005.03448.x>
- Tones K. (2002). Health Literacy: New Wine In Old Bottles? *Health Educ Res*, 17, 287-90 <https://doi.org/10.1093/her/17.3.287>
- Von Wagner, C., Knight, K., Steptoe, A. And Wardle, J. (2007). Functional Health Literacy And Health-Promoting Behaviour In A National Sample Of British Adults. *Journal Of Epidemiology & Community Health*, 61(12), 1086-1090. doi: 10.1136/jech.2006.053967
- Zarcadoolas, C., Pleasant, A., And Greer, D. S. (2005). Understanding Health Literacy: An Expanded Model. *Health promotion international*, 20(2), 195-203. <https://doi.org/10.1093/heapro/dah609>

EXTENDED ABSTRACT**GENİŞLETİLMİŞ ÖZET****EV KADINLARININ EĞİTİM DÜZEYLERİNİN SAĞLIK OKURYAZARLIĞINA ETKİSİ:
İSTANBUL'DA YAŞAYAN EV KADINLARI ÜZERİNE BİR ARAŞTIRMA**

Giriş ve Çalışmanın Amacı: Gerek günümüzün teknolojik gelişimi gerekse bilgiye kolay erişim, bireylerin hastalıkları hakkında bilgi sahibi olmalarını ve kendilerine neyin iyi geldiğini araştırabilmelerini sağlamaktadır. Ancak bireylerin sağlık hizmetine erişimi için sağlık okuryazarlığı önemli bir yere sahiptir. Sağlık okur yazarlığı en geniş anlamda bireylerin tam iyilik hali için sağlığını koruma ve geliştirme amaçlı bilgi edinme, anlama ve kullanma yeteneğidir. Tüm insanları yakından ilgilendiren bu yetenek kadınları daha da çok etkilemektedir. Keza kadın sağlığı hem kendisini hem de ailesini etkilemektedir. Sağlık okuryazarlığı pek çok faktörden etkilenmektedir ve demografik özellikler bu faktörlerin başında yer almaktadır. Bu bilgiler ışığında çalışmanın amacı kadınların eğitim düzeyinin sağlık okuryazarlığına etkisinin incelenmesidir.

Kavramsal/kuramsal çerçeve: Günümüzde okuryazarlık kavramı bireyin sadece okuma yazma anlama becerisini değil, aynı zamanda bazı alanlarla veya konularla ilgili bilgisini tanımlamak için de kullanılmaktadır. Örneğin medya okuryazarlığı, finansal okuryazarlık, bilgisayar okuryazarlığı, beslenme okuryazarlığı, sağlık okuryazarlığı gibi kavramlar tanımlanmıştır (Peerson ve Saunders 2009). Sağlıkla ilgili davranışın ve sağlık hizmetinden yararlanmanın temel belirleyicilerinden olan okuryazarlık genel olarak okuma, yazma ve hesap yapma becerisi olarak bilinmektedir. Araştırmalar sağlık okuryazarlığının bireyin sağlık durumunu belirlemede sosyoekonomik faktörlerden daha etkili olduğunu göstermektedir (Parker vd., 2003). Her ne kadar öğrenim düzeyinin yüksekliği sağlık okur yazarlığının yeterli olduğuna kefil olmasa da sağlık okur yazarlığı ile standart okur yazarlık arasında bir bağlantı olduğu aşikardır.

Bireylerin sağlıklı ile ilgili aldıkları kararları ne denli iyi alabildiği önemli bir kavramdır. Bu anlamda bireyin doğru karar alabilmesi sağlıkla ilgili bilgi erişimine kolay ulaşabilmesi, ulaşılan bilgileri doğru şekilde anlayıp yorumlayabilmesi anlamına da gelebilecek olan sağlık okuryazarlığı ile ilintilidir. Sağlık okuryazarlığı kavramının, fonksiyonel, iletişimsel ve eleştirel olmak üzere üç alt boyutu mevcuttur. Okuryazarlığın düşük olması durumu hem hastalar hem de sağlık hizmetini sunanlar istenmeyen bu durum bireyler için sunulan hizmetin verimli şekilde alınmamasına sağlık hizmetlerini sunan hatta sağlık politikalarını oluşturanlar için ise maliyet faktörünün negatif anlamda etkilenmesine neden olmaktadır. Yazarlar sağlık okuryazarlığını, sağlık risklerini azaltmak ve yaşam kalitesini yükseltmek için kişilerin bilinçli tercihler yapmalarını sağlayacak olan sağlık bilgisini, arayıp bulma, kavrama, değerlendirme ve kullanma yeteneklerini kapsayan geniş beceriler topluluğu olarak tanımlamışlardır. Sağlık okur-yazarlığı, pek çok işlevinin yanı sıra, sağlık hizmeti sunucuları ile sağlık hizmeti alan hastalar arasındaki iletişimin sağlanmasını da kolaylaştırmakta ve her iki tarafın birbirini daha iyi anlamalarında arabulucu işlev görmektedir (Osborne 2013, Akt. Balçık vd., 2014). İdeal bireysel sağlık okuryazarlığı, aynı zamanda iyilik halinin sürdürülebilmesi için gerekli sağlık bilgisine erişebilme yeteneğidir.

1970'lerden sonra literatürde incelenmeye başlanan bu konu son günlerde yoğunlaşmış olsa dahi yeter derecede değildir. Bu yüzden çalışmanın literatüre özgün katkısı olacağı düşünülmektedir.

Yöntem ve Bulgular: Sağlık okuryazarlığı tespiti için İstanbul'da 25-50 yaş aralığında toplam 250 ev hanımına kolayda örneklem yöntemi ile anket uygulaması yapılmıştır. Anketlerin 2 adedi geçersiz kılınmış ve 248 anket verisi SPSS programı kullanılarak analiz edilmiştir. Anket soruları Avrupa Sağlık Okuryazarlığı ölçeğinin Okyay ve Abacıgil tarafından 2016 yılında Türkçeye uyarlandığı ölçek sorularından oluşmuştur. Toplam 55 sorudan oluşan ankette ilk bölümde kişisel bilgiler, ikinci bölümde sağlık durumu ve alışkanlıklar, üçüncü bölümde temel sağlık, dördüncü bölümde sağlık hizmet kullanımı, beşinci bölümde koruyucu ve önleyici sağlık hakkında sorular vardır. Altıncı bölümde sağlık okur yazarlığının belirlenmesine yönelik sorulan 10 soru yer almaktadır. Örnekleme sadece İstanbul'da yaşayan ev hanımları oluşturduğu için cinsiyet, meslek, evde herhangi bir iş yaparak para kazanıp kazanmadığı, yaşanılan il, çalışmama nedeni vb. demografik soruları sorulmamıştır. Böylelikle araştırmaya katılanların sağlık hizmetlerinden ne kadar etkin faydalandığı, sunulan hizmetlerin farkındalığı, akıllı ilaç kullanımı hakkındaki bilgileri ve sağlık okur yazarlığı hakkındaki bilgi ve farkındalıkları ölçülmüştür.

Araştırmanın hipotez analizi haricinde katılımcıların dengeli bir yaşam sürüp sürmedikleri, genel sağlık durumları, aile hekimi ile ilgili davranışları, ilaç kullanma alışkanlıkları, temel sağlık bilgileri, hastalanma durumundaki eylemleri, hastalıktan korunma yöntemleri ve sağlık okur yazarlığına ihtiyaç durumlarının analizi yapılmıştır. Kadınların demografik özelliklerine göre değerlendirildiğinde okuryazarlık düzeyi ile sağlık okur yazarlığı arasında anlamlı ve aynı yönde ilişki bulunmuştur.

Sonuç ve Öneriler: Çalışmada kadınların demografik özelliklerinin sağlık okur yazarlığına etkisi ölçülmemiştir. Bu bağlamda ileride bu ölçümlerin yapıldığı daha farklı çalışmalar farklı sonuçlar doğuracaktır. Ayrıca kadınların sağlığa yönelik bazı davranışları ile sağlık okur yazarlığı ilişkisi farklı ölçeklerde farklı sonuçlanabilmektedir. Literatürde farklı her bir ölçek sağlık okur yazarlığını farklı şekilde değerlendirebilmektedir. Bazı ölçeklerde sigara / alkol kullanımı veya egzersiz sağlık okur yazarlığı ile ilişkili kavramlar değildir. Ev hanımlarının sağlık okur yazarlığının ne ölçüde olduğunun ölçümünü hedefleyen bu çalışmada katılımcıların bir kısmının bazı sorulara doğru cevap vermeme kaygısı yaşadıkları görülmüştür. Toplum tabanlı bu çalışmanın verilerinin kadınların kendi ortamında ve istedikleri bir zamanda toplanması veri güvenilirliğini artırdığı düşüncesini getirmiştir. Katılımcıların demografik özelliklerini bakıldığında toplamda %37,50'sinin lise ve üzeri eğitiminin olduğu görülmektedir. Buna göre katılımcıların oluşturduğu topluluğun eğitim durumu Türkiye ortalamasına yakın olmakla birlikte genel itibari ile düşüktür. Çalışmada da bahsedildiği üzere genel eğitim durumu sağlık okur yazarlığını aynı yönde etkileyebilmektedir. Bu bağlamda çalışma ortalama eğitimi düzeyi daha yüksek olan bir örneklem üzerinde yapılırsa sonuçların farklı çıkma ihtimali yüksektir. Kadınlarda sağlığı koruyucu yönde davranışlarda bulunma oranı düşük çıkmıştır. Kadınlar sağlıklarına gerekli özeni göstermemektedir. Kadınların gebelik loğusalık döneminde aile hekimliğine veya doktora gitmesi ayrıca bebek ve çocuklarını da %100'e yakın oranda kontrol ve aşı için götürmesi kadınların çocuklarının ve ailenin diğer üyelerinin sağlık durumuna kendi sağlık durumlarından daha fazla değer verdiği sonucunu çıkarmaktadır. Kadınlar ve erkekler arasında bahsi geçen konuda oldukça belirgin farklar vardır. Bu yüzden çalışmanın örnekleminde karşı cinsin de olması sonuçları değiştirecektir.



KATKI ORANI BEYANI VE ÇIKAR ÇATIŞMASI BİLDİRİMİ

Sorumlu Yazar <i>Responsible/Corresponding Author</i>	Bora Gündüzyeli			
Makalenin Başlığı <i>Title of Manuscript</i>	The Effect of Housewives' Education Levels on Health Literacy: A Study on Housewives Living in Istanbul			
Tarih <i>Date</i>	26.06.2022			
Makalenin türü (Araştırma makalesi, Derleme vb.) <i>Manuscript Type (Research Article, Review etc.)</i>	Araştırma			
Yazarların Listesi / List of Authors				
Sıra No	Adı-Soyadı <i>Name - Surname</i>	Katkı Oranı <i>Author Contributions</i>	Çıkar Çatışması <i>Conflicts of Interest</i>	Destek ve Teşekkür (Varsa) <i>Support and Acknowledgment</i>
1	Bora Gündüzyeli	%50	-	-
2	Rana Özyurt Kaptanoğlu	%50	-	-