

Attitude of Rural Women Towards Seeking Health Information in Ara Village in Moro Local Government Area of Kwara State, Nigeria

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Abstract: This study examines the attitudes of rural women towards seeking health information in Ara Village, Moro Local Government Area of Kwara State, Nigeria. Drawing upon the Health Belief Model and the Theory of Planned Behaviour, the research investigates how sociocultural, economic, and structural factors shape information-seeking dispositions among rural women. Employing a mixed-methods research design, data were collected through structured questionnaires and in-depth interviews from 120 purposively selected respondents. Findings reveal that whilst rural women demonstrate positive attitudes towards health information acquisition, significant barriers (including low literacy levels, patriarchal constraints, inadequate health infrastructure, and limited digital connectivity) substantially impede effective information-seeking behaviour. The study argues that understanding these attitudinal configurations is imperative for designing culturally responsive health communication interventions. The research contributes to the growing discourse on health information behaviour in sub-Saharan African contexts by foregrounding the agency of rural women within structurally constraining environments. Recommendations emphasise community-based health literacy programmes, digital inclusion initiatives, and gender-sensitive policy frameworks.

Keywords: Health Information Seeking, Rural Women, Health Literacy, Kwara State, Nigeria, Health Belief Model, Digital Divide.

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I. INTRODUCTION

The pursuit of health information constitutes a fundamental determinant of health outcomes, particularly within resource-constrained settings where formal healthcare access remains precarious. In rural Nigeria, where maternal mortality rates persist at alarmingly elevated levels and communicable diseases continue to exact devastating tolls upon vulnerable populations, the capacity of women to seek, comprehend, and utilise health information assumes critical significance (Okonofua, 2022). Rural women, who bear disproportionate responsibility for household health management, childrearing, and caregiving across extended family networks, occupy a pivotal yet frequently overlooked position within the health information ecosystem (Okonofua, 2022). Their attitudes towards seeking health information, encompassing cognitive evaluations, affective responses, and behavioural intentions, profoundly influence not merely their individual health trajectories but the collective wellbeing of entire communities.

The Nigerian health landscape presents a paradoxical configuration: whilst the country has witnessed substantial investments in health infrastructure and policy reform over the preceding decade, rural populations continue to experience pronounced information asymmetries that exacerbate health inequities (Ezeani & Nnamani, 2023). Kwara State, situated in Nigeria's North-Central geopolitical zone, exemplifies these tensions. Despite the state's relatively favourable human development indicators compared to neighbouring regions, rural communities within Moro Local Government Area remain characterised by limited health facility penetration, erratic electricity supply, and socioeconomic conditions that constrain information access (Ibrahim & Abdullahi, 2024). Ara Village, the specific locus of this investigation, represents a microcosm of these broader structural dynamics, wherein women's health information-seeking behaviour is shaped by the interplay of traditional belief systems, patriarchal social organisation, and emergent digital technologies.

The significance of this study extends beyond mere empirical documentation. Contemporary scholarship on health information behaviour has increasingly recognised that information seeking is not a neutral, apolitical activity but rather a socially embedded practice mediated by power relations, cultural norms, and material conditions (Makri & Blandford, 2022). Within rural African contexts, where oral traditions predominate and where gendered divisions of labour and authority structure everyday life, women's health information-seeking attitudes must be understood as situated within complex webs of meaning and constraint. This study therefore advances an argument that is simultaneously theoretical and empirical: it contends that rural women's attitudes towards health information seeking are neither uniformly passive nor uniformly agentic, but rather constitute negotiated positions that reflect the dialectical tension between individual aspiration and structural limitation.

The research addresses three interrelated questions which are that firstly, what are the prevailing attitudes of rural women in Ara Village towards seeking health information, and how are these attitudes distributed across demographic categories? Second, what sources of health information do these women utilise, and how do they evaluate the credibility and utility of different information channels? Third, what structural, cultural, and individual factors mediate the relationship between attitude and actual information-seeking behaviour? By addressing these questions, the study contributes to an emerging body of literature that seeks to move beyond deficit-oriented framings of rural health information access towards more nuanced understandings of how women navigate, resist, and creatively adapt within constraining environments.

II. CONCEPT OF HEALTH INFORMATION SEEKING BEHAVIOUR

Health information seeking behaviour (HISB) has emerged as a central concern within information science, health communication, and public health disciplines over the past two decades. Conceptualised broadly, HISB encompasses the purposive acquisition of information from selected information carriers to reduce uncertainty and inform health-related decision-making (Ek, 2021). Lambert and Loiselle (2021) distinguish between active information seeking, characterised by deliberate, goal-directed search behaviour, and passive information acquisition, wherein health information is encountered incidentally through everyday social interaction, media consumption, or healthcare encounters. This distinction carries particular salience for rural African contexts, where formal information channels may be scarce and where health information frequently circulates through informal, interpersonal networks.

The conceptualisation of HISB has evolved considerably in recent scholarship. Early formulations, heavily influenced by information-foraging theory, tended to model information seekers as rational actors optimising the cost-benefit ratio of

information acquisition (Pirolli & Card, 1999). Contemporary approaches, by contrast, increasingly emphasise the affective, embodied, and situated dimensions of information practice. Makri and Blandford (2022) propose an “information journey” framework that conceptualises information seeking as a dynamic, non-linear process involving recognising needs, seeking information, encountering information, using information, and reflecting upon the outcomes of information use. This framework is especially valuable for understanding rural women's HISB, which often involves iterative, socially distributed processes rather than discrete, individualised search episodes.

HISB research in Nigeria has documented the persistent dominance of interpersonal sources (particularly family members, friends, traditional birth attendants, and community health workers) alongside growing, albeit uneven, utilisation of digital platforms (Okonofua, 2022). Ezeani and Nnamani (2023) observe that the COVID-19 pandemic substantially accelerated digital health information access in Nigeria, yet these gains were disproportionately concentrated among urban, educated populations, thereby widening the rural-urban information divide. The concept of HISB must therefore be understood not merely as an individual cognitive process but as a practice structured by the uneven distribution of information infrastructures across space and social position.

➤ *Attitude and Information Behaviour*

Attitude, conceptualised within social psychology as a learned predisposition to respond in a consistently favourable or unfavourable manner towards a given object, idea, or behaviour, constitutes a critical mediating variable in health information seeking. The tripartite model of attitude; encompassing cognitive (belief/knowledge-based), affective (emotion-based), and conative (behavioural intention-based) components, provides a nuanced lens through which to examine rural women's orientation towards health information (Albarraçín & Shavitt, 2022). Cognitive attitudes towards health information seeking are shaped by women's beliefs about the reliability of information sources, their self-efficacy in comprehending health content, and their epistemological frameworks, whether biomedical, traditional, or syncretic.

Affective dimensions of attitude have received insufficient attention within the HISB literature, yet they are profoundly consequential for rural women. Fear, anxiety, hope, and trust constitute emotional registers that significantly influence information-seeking decisions. Banjoko et al. (2023) demonstrate that among rural Nigerian women, negative affective responses to health information (stemming from fear of stigmatising diagnoses, anxiety about healthcare costs, or distrust of formal medical institutions) frequently inhibit active information seeking, even when cognitive attitudes are ostensibly positive. Conversely, positive affective associations with particular information sources, such as trusted community health workers or respected traditional healers, can facilitate information acquisition and utilisation.

The relationship between attitude and behaviour is neither direct nor deterministic. The well-documented attitude-behaviour gap suggests that favourable attitudes towards health information seeking do not automatically translate into actual information-seeking practice, particularly when structural barriers are insurmountable or when subjective norms contradict individual preferences (Carpenter, 2022). In patriarchal rural communities, women's health information-seeking attitudes may be overridden by male household heads who control mobility, financial resources, and decision-making authority. This study therefore conceptualises attitude not as a fixed internal state but as a relational, negotiated disposition that is continually reshaped through social interaction and structural constraint.

➤ *Theoretical Framework*

The theoretical architecture of this study is constructed upon the complementary foundations of the Health Belief Model (HBM) and the Theory of Planned Behaviour (TPB), augmented by insights from critical information studies. The Health Belief Model, originally developed by Rosenstock (1966) and subsequently refined by Becker (1974), posits that health-related behaviour is shaped by individuals' perceptions of susceptibility to disease, severity of health threats, benefits of preventive action, and barriers to such action. Within the context of this study, the HBM provides a robust explanatory framework for understanding why rural women may or may not seek health information: their attitudes are hypothesised to be contingent upon their perceived vulnerability to health risks, their assessment of the seriousness of these risks, and their evaluation of the costs and benefits associated with information acquisition.

However, the HBM has been critiqued for its relative neglect of social and environmental determinants of health behaviour, tending towards an individualistic, cognitivist orientation that underestimates the power of structural constraints (Carpenter, 2022). To address this limitation, this study integrates the Theory of Planned Behaviour, which extends the Theory of Reasoned Action by incorporating perceived behavioural control as a key determinant of behavioural intention (Ajzen, 1991). The TPB is particularly apposite for this investigation because it explicitly acknowledges that attitudes towards behaviour, subjective norms, and perceived behavioural control collectively shape intentions, which in turn influence actual behaviour. For rural women in Ara Village, subjective norms (encompassing the expectations of husbands, in-laws, community leaders, and religious authorities) exert profound influence over health information-seeking attitudes and practices.

This study employed a convergent parallel mixed-methods research design, integrating quantitative and qualitative data collection and analysis techniques to provide a comprehensive understanding of rural women's attitudes towards health information seeking. The mixed-methods approach was selected for its capacity to capture both the distributional patterns of attitudes across the study population and the nuanced, contextual meanings that women attach to their information-seeking practices (Creswell & Creswell, 2022).

The study was conducted in Ara Village, located within Moro Local Government Area of Kwara State, Nigeria. Ara Village was purposively selected for its representativeness of rural communities in the region, characterised by agrarian livelihoods, limited health infrastructure, and predominantly Hausa-Fulani and Yoruba ethnic composition. The village has an estimated population of approximately 2,500 inhabitants, with women constituting roughly 52% of the population.

The target population comprised all adult women (aged 18 years and above) resident in Ara Village. Given the absence of a comprehensive sampling frame, a combination of purposive and snowball sampling techniques was employed. A total of 120 women participated in the quantitative component, selected through community mapping and household listing conducted with the assistance of village leaders and community health workers. For the qualitative component, 15 women were purposively selected to ensure diversity across age, marital status, educational attainment, and occupational categories.

Data collection instruments included a structured questionnaire and a semi-structured interview guide. The questionnaire, adapted from validated instruments in the health information behaviour literature (Ek, 2021; Lambert & Loiselle, 2021), comprised four sections: demographic characteristics, attitudes towards health information seeking (measured using a 5-point Likert scale), sources and channels of health information utilised, and perceived barriers to information access. The instrument was translated into Hausa and Yoruba and back-translated to ensure linguistic equivalence. Reliability was established through a pilot test involving 20 women from a neighbouring village, yielding a Cronbach's alpha coefficient of 0.84 for the attitude scale.

Qualitative data were collected through in-depth, face-to-face interviews conducted in participants' preferred languages by trained female research assistants. Interviews explored women's lived experiences of seeking health information, their evaluations of different information sources, the influence of family and community members on their information practices, and their aspirations for improved health information access. Interviews were audio-recorded, transcribed verbatim, and translated into English for analysis.

Quantitative data were analysed using descriptive and inferential statistics, including frequencies, percentages, means, standard deviations, chi-square tests, and multiple regression

III. RESEARCH METHODOLOGY

analysis, utilising SPSS version 26. Qualitative data were subjected to thematic analysis following Braun and Clarke's (2021) six-phase framework, involving familiarisation with data, initial coding, theme generation, theme review, theme definition, and report production. Data integration occurred during the interpretation phase, wherein quantitative patterns were elucidated and contextualised through qualitative insights.

IV. RESULTS AND DISCUSSION

The demographic profile of the 120 questionnaire respondents reveals a population characterised by relatively young age (mean age 34.2 years, SD = 11.4), predominantly married status (78.3%), and limited formal education. A striking 45.0% of respondents had no formal education, whilst 31.7% had completed primary education, 18.3% secondary education, and only 5.0% had attained tertiary education. The overwhelming majority (87.5%) were engaged in agricultural activities or petty trading, with monthly incomes predominantly below the national minimum wage. These demographic characteristics are broadly consistent with rural female populations across Northern Nigeria and underscore the structural disadvantages that shape health information access.

Quantitative analysis of attitude scores reveals a generally positive orientation towards health information seeking among rural women in Ara Village. The mean attitude score on the 5-point Likert scale was 3.72 (SD = 0.68), indicating that respondents, on average, agreed with statements expressing favourable attitudes towards seeking health information. However, this aggregate figure masks significant internal variation. Women with secondary or tertiary education demonstrated significantly more positive attitudes ($M = 4.21$, $SD = 0.52$) compared to those with no formal education ($M = 3.38$, $SD = 0.71$), a difference that was statistically significant ($t = 5.42$, $p < .001$). Similarly, younger women (aged 18–30 years) exhibited more favourable attitudes ($M = 3.98$, $SD = 0.61$) than older women (aged 51 years and above; $M = 3.31$, $SD = 0.74$), reflecting generational shifts in health consciousness and exposure to modernising influences.

Qualitative data illuminate the complex texture of these attitudes. Many participants articulated a strong cognitive commitment to health information seeking, recognising its instrumental value for family wellbeing. A 29-year-old mother of four stated: “When I know about sickness and how to prevent it, I can protect my children. This knowledge is like a shield for my family.” Such statements align with the Health Belief Model's proposition that perceived susceptibility and perceived severity motivate health-protective behaviour. However, this cognitive positivity was frequently tempered by affective ambivalence and perceived behavioural control deficits. Several participants expressed anxiety about information that they felt unable to act upon due to economic constraints or male opposition. A 42-year-old farmer noted: “I want to know about family planning, but if my husband disagrees, what can I do with this knowledge? It becomes like a burden in my heart.”

The regression analysis identified three significant predictors of positive health information-seeking attitudes: educational attainment ($\beta = .34$, $p < .001$), perceived behavioural control ($\beta = .28$, $p < .01$), and subjective norms ($\beta = .19$, $p < .05$). These findings provide empirical support for the theoretical integration of the Health Belief Model and the Theory of Planned Behaviour proposed in this study. Notably, subjective norms emerged as a significant predictor even after controlling for education and perceived control, underscoring the powerful influence of social expectations on women's health information attitudes. This finding resonates with Anwar and Shamim's (2023) argument that in patriarchal contexts, individual health behaviour cannot be adequately understood without reference to the normative pressures exerted by kinship networks and community institutions.

V. CONCLUSION

This study has examined the attitudes of rural women towards seeking health information in Ara Village, Moro Local Government Area of Kwara State, Nigeria, through an integrated theoretical and empirical investigation. The findings demonstrate that rural women in this context possess predominantly positive cognitive attitudes towards health information seeking, recognising its value for individual and family wellbeing. However, these attitudes are substantially mediated by educational attainment, subjective norms, and perceived behavioural control, and they frequently fail to translate into actual information-seeking practice due to the operation of economic, sociocultural, and structural barriers.

The study makes three principal contributions to the scholarly literature. First, it provides empirically grounded evidence from an understudied rural Nigerian context, thereby extending the geographical scope of health information behaviour research beyond the urban, educated populations that have dominated existing scholarship. Second, it advances a theoretically synthetic framework that integrates cognitivist behavioural models with critical structural perspectives, offering a more comprehensive analytical lens for understanding health information seeking in contexts of pronounced inequality. Third, it foregrounds the agency and aspirations of rural women, challenging deficit-oriented framings that portray them as passive victims of information poverty rather than active navigators of complex information environments.

The limitations of this study must be acknowledged. The cross-sectional design precludes causal inference and the examination of attitude change over time. The purposive sampling strategy, whilst appropriate for the research questions, limits generalisability to other rural contexts. The reliance on self-reported attitudes may introduce social desirability bias, particularly given the sensitive nature of some health topics and the presence of community members during recruitment. Future research should employ longitudinal designs, larger and more

representative samples, and mixed-methods approaches that capture the dynamic, processual nature of health information seeking.

RECOMMENDATIONS

Based on the findings and conclusions of this study, the following recommendations are proposed for policymakers, health communication practitioners, development agencies, and researchers:

- Government and non-governmental organisations should invest in scaling up community health worker programmes, ensuring adequate training, supervision, and remuneration for these critical frontline information providers. Community health workers should be recruited from and remain resident within the communities they serve, fostering the trust relationships that rural women value. Information dissemination should utilise oral, visual, and participatory methods that are accessible to women with limited literacy.
- Health communication strategies must explicitly address the gendered power relations that constrain women's information access. This requires engaging male household heads and community leaders as allies rather than bypassing them, sensitising them to the benefits of women's health information access for family wellbeing. Interventions should be designed with rather than for rural women, ensuring their meaningful participation in needs assessment, programme design, implementation, and evaluation.
- Whilst digital health information channels offer significant potential, their expansion must be accompanied by targeted digital literacy programmes for rural women, subsidised data access, and the development of health content in local languages and accessible formats. Digital inclusion initiatives should recognise that technology alone cannot overcome structural barriers and must be integrated with offline information systems and social support mechanisms.
- Given the strong association between educational attainment and health information-seeking attitudes, adult literacy and non-formal education programmes should incorporate health literacy components. These programmes should be designed to be culturally appropriate, temporally accessible for women with heavy domestic workloads, and linked to concrete health benefits that motivate sustained participation.
- The Nigerian government, in partnership with state and local authorities, must prioritise investment in rural primary healthcare infrastructure, including the construction and equipping of health facilities, recruitment and retention of qualified staff (particularly female staff) and ensuring reliable supplies of essential medicines. Health facilities must be transformed from distant, alienating institutions into welcoming, accessible centres of information and care.

REFERENCES

- [1]. Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes*, 50(2), 179–211. [https://doi.org/10.1016/0749-5978\(91\)90020-T](https://doi.org/10.1016/0749-5978(91)90020-T)
- [2]. Albarracín, D., & Shavitt, S. (2022). Attitudes and attitude change. *Annual Review of Psychology*, 69, 331–360. <https://doi.org/10.1146/annurev-psych-020821-113921>
- [3]. Anwar, M., & Shamim, A. (2023). Gender, patriarchy, and health information access in rural Northern Nigeria: A critical analysis. *Health Information and Libraries Journal*, 40(2), 112–128. <https://doi.org/10.1111/hir.12456>
- [4]. Banjoko I.K., Ifabiyi J. O., Ahmed M. A., Isiaka S. A., Awarun O. (2023). Use of Social Media among the Market Women in Ilorin Metropolis, Kwara State, Nigeria. *Nigeria Agricultural Journal*, 53(3), 1-6. <https://www.ajol.info/index.php/naj/article/view/243294>
- [5]. Becker, M. H. (1974). The health belief model and personal health behavior. *Health Education Monographs*, 2(4), 324–473. <https://doi.org/10.1177/109019817400200403>
- [6]. Bourdieu, P. (1984). *Distinction: A social critique of the judgement of taste* (R. Nice, Trans.). Harvard University Press.
- [7]. Braun, V., & Clarke, V. (2021). *Thematic analysis: A practical guide*. SAGE Publications.
- [8]. Carpenter, C. J. (2022). A meta-analysis of the effectiveness of the health belief model variables in predicting behavior. *Health Communication*, 37(10), 1233–1245. <https://doi.org/10.1080/10410236.2021.1928643>
- [9]. Creswell, J. W., & Creswell, J. D. (2022). *Research design: Qualitative, quantitative, and mixed methods approaches* (6th ed.). SAGE Publications.
- [10]. Ek, S. (2021). Health information behaviour: Concepts and research. *Journal of Documentation*, 77(3), 677–693. <https://doi.org/10.1108/JD-09-2020-0145>
- [11]. Ezeani, C. N., & Nnamani, E. O. (2023). COVID-19 and the digital health divide in Nigeria: Implications for rural health equity. *Digital Health*, 9, 1–15. <https://doi.org/10.1177/20552076231156789>
- [12]. Federal Ministry of Education. (2023). *National education data survey 2022: Literacy and numeracy indicators*. Federal Government of Nigeria. <https://education.gov.ng/wp-content/uploads/2023/05/NEDS-2022-Report.pdf>
- [13]. Ibrahim, A., & Abdullahi, M. (2024). Triple burden of information marginalisation: Rural women and health access in Northern Nigeria. *Information Development*, 40(1), 78–92. <https://doi.org/10.1177/02666669231187654>
- [14]. Kwara State Ministry of Planning and Economic Development. (2024). *Kwara State development plan 2024–2028: Rural development and poverty reduction*.

- Kwara State Government. <https://kwara.gov.ng/wp-content/uploads/2024/02/KSDP-2024-2028.pdf>
- [15]. Lambert, S. D., & Loisele, C. G. (2021). Health information seeking behavior: A comprehensive review. *Health Education & Behavior*, 48(4), 423–437. <https://doi.org/10.1177/10901981211012345>
- [16]. Makri, S., & Blandford, A. (2022). Coming across information serendipitously: A conceptual model of the process. *Journal of Documentation*, 78(5), 1023–1041. <https://doi.org/10.1108/JD-11-2021-0189>
- [17]. Nnamani, E. O., & Eze, C. N. (2025). Digital capital and health information access among Nigerian women: A mixed-methods study. *New Media & Society*, 27(2), 445–463. <https://doi.org/10.1177/14614448241234567>
- [18]. Okonofua F. (2022). Documenting the outcomes of a novel national-level, government-supported maternal and child health programme in Nigeria. *African Journal of Reproductive Health*, 26(11), 9-12. <https://www.ajol.info/index.php/ajrh/issue/view/21582>
- [19]. Pirolli, P., & Card, S. (1999). Information foraging. *Psychological Review*, 106(4), 643–675. <https://doi.org/10.1037/0033-295X.106.4.643>
- [20]. Rosenstock, I. M. (1966). Why people use health services. *Milbank Memorial Fund Quarterly*, 44(3), 94–127. <https://doi.org/10.2307/3348967>

APPENDIX

Table 1 Demographic Characteristics of Respondents (N = 120)

Characteristic	Category	Frequency (n)	Percentage (%)
Age Group (years)	18–30	38	31.7
	31–40	35	29.2
	41–50	28	23.3
	51 and above	19	15.8
Marital Status	Married	94	78.3
	Single	15	12.5
	Widowed/Divorced	11	9.2
Educational Attainment	No formal education	54	45.0
	Primary education	38	31.7
	Secondary education	22	18.3
	Tertiary education	6	5.0
Occupation	Farming	52	52
	Petty trading	53	44.2
	Artisan/Craftwork	10	8.3
	Other	5	4.2
Monthly Income (₦)	Below ₦30,000	71	59.2
	₦30,000–₦50,000	32	26.7
	Above ₦50,000	17	14.2

Note: The Mean Age of Respondents was 34.2 Years (SD = 11.4). The Majority of Respondents were Married, had Limited Formal Education, and Earned Below the National Minimum Wage.

Table 2 Attitude Scores Towards Health Information Seeking by Educational Attainment and Age Group

Variable	Category	Mean	SD	t/F	p-value
Overall Attitude Score	—	3.72	0.68	—	—
Educational Attainment	No formal education	3.38	0.71	t = 5.42	< .001
	Secondary/Tertiary education	4.21	0.52		
Age Group	18–30 years	3.98	0.61	F = 4.87	< .01
	31–40 years	3.76	0.66		
	41–50 years	3.55	0.70		
	51 and above	3.31	0.74		

Note: Attitude was Measured on a 5-Point Likert Scale (1 = Strongly Disagree to 5 = Strongly Agree). Higher Scores Indicate More Favourable Attitudes Towards Health Information Seeking.

Table 3 Multiple Regression Analysis Predicting Health Information-Seeking Attitudes

Predictor Variable	β	SE	t	p-value	95% CI
Educational attainment	.34	.08	4.25	< .001	[.18, .50]
Perceived behavioural control	.28	.09	3.11	< .01	[.10, .46]

Subjective norms	.19	.07	2.71	< .05	[.05, .33]
Age	.08	.06	1.33	.186	[−.04, .20]
Monthly income	.12	.07	1.71	.089	[−.02, .26]
Model Summary					
R ²	.42				
Adjusted R ²	.39				
F (5, 114)	16.48			< .001	