



Understanding Health Information Seeking Behaviours Across Educational Status: A Cross-Sectional Survey



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Abstract

Background: Rapid advances in healthcare and information technology have transformed the way people access health information. Health information-seeking behaviour (HISB) plays a vital role in improving health literacy, supporting informed decision-making, and promoting appropriate healthcare utilization. Educational attainment is an important determinant of an individual's ability to obtain, understand, and use health information effectively. **Objective:** The purpose of the present study was to assess health information-seeking behaviours among adults with different educational levels in Dhaka South City and examine the influence of educational status on preferred sources of health information. **Methodology:** This cross-sectional descriptive study was conducted in Dhaka South City from January to December 2022 among 250 adults. Participants were selected using a non-probability convenience sampling technique. Data were collected through face-to-face interviews using a pretested, semi-structured questionnaire. Information on sociodemographic characteristics, educational status, and preferred sources of health information was obtained. Data were analyzed using descriptive statistics, and findings were presented as frequencies, percentages, means, and standard deviations where appropriate. **Results:** The mean age of the respondents was 34.78 years. Most participants were male (58.8%), while 41.2% were female. More than two-thirds (68.4%) were born in urban areas, and over half (56.0%) had been delivered at home. Regarding educational attainment, 13.2% were illiterate, whereas 23.2% had completed graduation or higher education. Distinct differences in health information-seeking behaviour were observed across educational groups. Illiterate respondents predominantly relied on pharmacies (39.4%) and government hospitals (33.3%) for obtaining health information, indicating greater dependence on easily accessible healthcare sources. In contrast, participants with higher educational attainment were more likely to seek health information from qualified general physicians, accounting for 27.1% of respondents with higher secondary education and 39.7% of those with graduation or higher. These findings demonstrate a positive relationship between educational level and preference for professional healthcare providers as trusted sources of health information. **Conclusion:** Educational status significantly influences health information-seeking behaviour among adults in Dhaka South City, highlighting the need for targeted health education, improved access to reliable health information. [*Journal of National Institute of Neurosciences Bangladesh, July 2025; 11(2):132-137*]

Keywords: Health Information; Behaviours; Educational Status

Introduction

In recent decades, remarkable advances in healthcare services, digital technologies, and communication systems have fundamentally transformed the way people access and use health information. The widespread

availability of the internet, social media platforms, mobile health (mHealth) applications, and online healthcare resources has created unprecedented opportunities for individuals to obtain health-related information. Health information seeking behaviour

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(HISB) refers to the process through which individuals actively search for information regarding health promotion, disease prevention, diagnosis, treatment, and rehabilitation to make informed decisions about their health. Effective health information seeking has become an essential component of modern healthcare, contributing to improved self-care, timely healthcare utilization, better treatment adherence, and enhanced quality of life. Furthermore, informed individuals are more likely to participate in preventive health practices, communicate effectively with healthcare providers, and adopt healthier lifestyles.

Health information seeking is influenced by numerous demographic, socioeconomic, cultural, and psychological factors. Among these, educational status is considered one of the strongest determinants of an individual's ability to access, understand, evaluate, and utilize health information. Education enhances literacy, critical thinking, and communication skills, enabling individuals to identify credible information sources and distinguish evidence-based information from misinformation. Previous research has consistently shown that individuals with higher educational attainment are more likely to engage in proactive health information-seeking behaviours, use multiple sources of information, and critically evaluate the reliability and accuracy of the information they obtain¹. In contrast, individuals with limited education often experience difficulties in understanding health-related information, navigating healthcare systems, and making informed healthcare decisions. Consequently, they are more likely to rely on informal or easily accessible sources such as pharmacies, relatives, neighbours, or traditional healers, which may not always provide accurate or evidence-based information.

Maintaining good health requires more than simply having access to healthcare services. It depends on an individual's ability to obtain timely, relevant, and reliable information regarding disease prevention, health promotion, diagnosis, treatment options, and healthy lifestyle practices. Appropriate health-related decisions can only be made when individuals possess sufficient knowledge and understanding of available health information. Therefore, health literacy has emerged as a fundamental public health concern worldwide. Health literacy extends beyond the ability to read and write; it encompasses the cognitive and social skills needed to access, comprehend, interpret, and apply health information effectively in everyday life². As healthcare systems become increasingly complex and technology-driven, individuals require advanced literacy

and digital competencies to navigate health information efficiently and participate actively in healthcare decision-making.

In low- and middle-income countries such as Bangladesh, disparities in educational attainment and health literacy remain substantial. Although internet access and smartphone use have increased considerably in recent years, significant inequalities persist in the availability and utilization of reliable health information. Many adults continue to depend on community pharmacies, informal healthcare providers, or interpersonal networks rather than qualified healthcare professionals for health-related advice. Such practices may contribute to delayed diagnosis, inappropriate self-medication, irrational use of antibiotics, poor treatment adherence, and adverse health outcomes. Understanding how educational status influences health information-seeking behaviour is therefore essential for designing effective health education programs, improving communication strategies, and reducing health disparities.

Despite the growing importance of health information seeking, limited evidence is available regarding its relationship with educational status among adults in urban Bangladesh. Dhaka South City, one of the country's most densely populated urban areas, represents a diverse population with varying educational backgrounds and healthcare access. Investigating health information-seeking patterns in this setting can provide valuable insights for policymakers and healthcare providers to develop targeted interventions that promote equitable access to reliable health information.

Therefore, this study aimed to assess the patterns of health information-seeking behaviour among adults with different educational levels in Dhaka South City and to examine the association between educational status and preferred sources of health information. The findings are expected to contribute to the development of evidence-based health communication strategies and interventions that improve health literacy and support informed healthcare decision-making among diverse population groups.

Methodology

Study Design, Setting, and Population: This was a community-based cross-sectional descriptive study conducted from January 2022 to December 2022 over a period of one year in Dhaka South City Corporation (DSCC), Bangladesh. The study aimed to assess the pattern of health information-seeking behaviour among adults with different educational levels residing in the

study area. Dhaka South City is one of the largest and most densely populated metropolitan regions in Bangladesh, comprising people from diverse socioeconomic, cultural, and educational backgrounds. This heterogeneous population provided an appropriate setting to explore variations in health information-seeking practices across different educational groups. The study population consisted of adults aged 18 years and above who were permanent residents of Dhaka South City and were available during the data collection period. Individuals who were willing to participate and provided informed consent were included in the study. Those who were seriously ill, mentally incapacitated, unable to communicate effectively, or unwilling to participate were excluded from the study. A total of 250 respondents were enrolled in the study. Considering the descriptive nature of the research, this sample size was considered adequate to describe the distribution of health information-seeking behaviour among adults with varying educational attainment.

Sampling Technique: A non-probability convenience sampling technique was employed to recruit the study participants. Respondents were selected based on their accessibility and willingness to participate during the study period. Data collectors approached eligible adults from different residential areas, community settings, and public places within Dhaka South City. Although convenience sampling limits the generalizability of findings to the entire population, it was considered appropriate because of time constraints, logistical feasibility, and resource limitations. Every effort was made to include participants from different age groups, sexes, occupations, and educational backgrounds to obtain a diverse representation of the adult population.

Study Instrument: Data were collected using a pretested, structured interviewer-administered questionnaire developed specifically for this study after an extensive review of relevant national and international literature on health information-seeking behaviour and health literacy. The questionnaire was designed according to the objectives of the study and consisted of both closed-ended and a limited number of multiple-response questions. The questionnaire included several sections covering Socio-demographic characteristics (age, sex, place of birth, occupation, marital status, educational level, and other relevant variables); Sources of health information; Patterns of health information-seeking behaviour; Preferred healthcare providers; educational status and its relationship with health information sources. The

questionnaire was prepared in English and translated into Bangla to facilitate communication with respondents. To ensure linguistic accuracy and consistency, the translated version was carefully reviewed and compared with the original questionnaire. **Pretesting of the Questionnaire:** Before the commencement of the main study, the questionnaire was pretested among a small group of adults from an area outside the selected study population who shared characteristics similar to those of the target participants. The purpose of pretesting was to evaluate the clarity, comprehensibility, sequence, appropriateness, and cultural relevance of the questions. Based on the feedback obtained during the pretest, ambiguous or difficult questions were modified, unnecessary items were removed, and the final questionnaire was refined to improve its validity and reliability.

Data Collection Procedure: Data were collected through face-to-face interviews conducted by the principal investigator using the pretested questionnaire. Before each interview, respondents were informed about the purpose, objectives, and significance of the study. Participation was entirely voluntary, and written or verbal informed consent was obtained from every participant prior to data collection. Each interview was conducted in a private and comfortable environment to encourage honest responses and maintain confidentiality. Respondents were given sufficient time to answer each question without interruption. Whenever necessary, additional explanations were provided to ensure that respondents clearly understood the questions without influencing their responses. The average duration of each interview was approximately 15–20 minutes. Throughout the data collection period, completed questionnaires were reviewed daily for completeness, consistency, and accuracy. Any missing or inconsistent information was clarified immediately whenever possible to minimize information bias and data entry errors.

Statistical Analysis: Statistical analysis was performed by Windows based software named as Statistical Package for Social Science (SPSS), versions 22.0 (IBM SPSS Statistics for Windows, Version 22.0. Armonk, NY: IBM Corp.). Continuous data were expressed as mean, standard deviation, minimum and maximum. Categorical data were summarized in terms of frequency counts and percentages. Chi-square test was used for comparison of categorical variables and Student t test was applied for continuous variables. Every effort was made to obtain missing data. A two-sided P value of less than 0.05 was considered to

indicate statistical significance. Differences between case and control were tested.

Ethical Consideration: All procedures of the present study were carried out in accordance with the principles for human investigations (i.e., Helsinki Declaration 2013) and also with the ethical guidelines of the Institutional research ethics. Formal ethics approval was granted by the local ethics committee. Participants in the study were informed about the procedure and purpose of the study and confidentiality of information provided. All participants consented willingly to be a part of the study during the data collection periods. All data were collected anonymously and were analyzed using the coding system.

Results

Figure presents the histogram of participants' age distribution with a superimposed normal distribution curve.

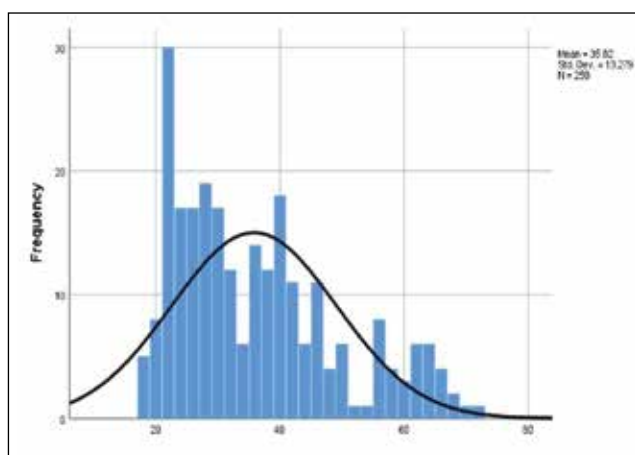


Figure I: Age of the Respondents

The ages ranged approximately from 18 to 75 years, with a mean age of 35.82 years (SD = 13.28; n = 250). The distribution was slightly positively skewed, with the highest frequency observed among participants aged between 20 and 30 years. The frequency gradually

declined with increasing age, although participants from all adult age groups were represented. Overall, the age distribution approximated a normal distribution with a mild right-skew (Figure I).

Figure illustrates the gender distribution of the study participants (n = 250). Of the total participants, 149 (59.6%) were male, while 101 (40.4%) were female, indicating that males constituted the majority of the study population (Figure II).

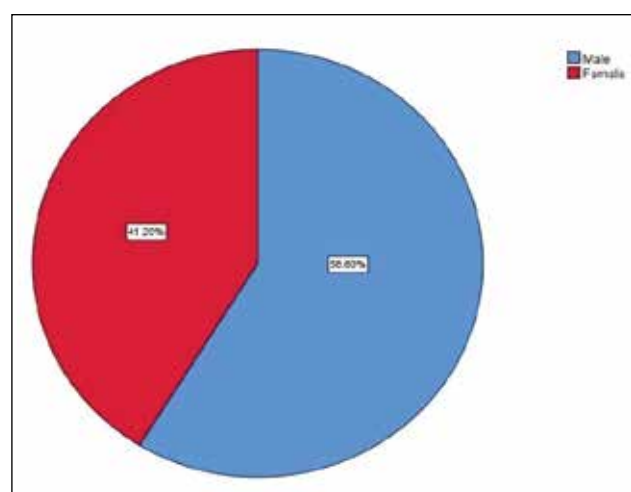


Figure II: Gender of the respondent

More than two thirds of the respondents were born in urban area and more than half of the respondent was delivery by home (Table 1).

Table 1: Place of Birth of Respondents

Variables	Frequency	Percent
Residence Wise		
• Urban	171	68.4
• Rural	79	31.6
Delivery Wise		
• Home	140	56.0
• Hospital	110	44.0

Table 2: Educational Status Versus Place to Seek Health Information

Educational Status	Pharmacy	General Physician	Private Hospital	Self-Awarded	Clinic	Govt. Hospital	Friends	Total
Illiterate	13(39.4%)	3(9.1%)	0(0.0%)	5(15.2%)	1(3.0%)	11(33.3%)	0(0.0%)	33(100.0%)
Upto class 5	25(47.1%)	7(13.2%)	0(0.0%)	6(11.3%)	2(3.8%)	12(22.6%)	1(1.9%)	53(100.0%)
Upto SSC	23(39.7%)	7(12.1%)	2(3.4%)	8(13.8%)	1(1.8%)	13(22.4%)	4(6.9%)	58(100.0%)
Upto HSC	9(18.8%)	13(27.1%)	2(4.2%)	6(12.5%)	3(6.3%)	9(18.8%)	6(12.5%)	48(100.0%)
Graduation & above	4(6.9%)	23(39.7%)	17(29.3%)	6(10.3%)	4(6.9%)	3(5.2%)	1(1.7%)	58(100.0%)

The majority of the illiterate respondents relied on pharmacies (39.4%), with a notable proportion seeking information from government hospitals (33.3%). A significant percentage of respondents of primary level (47.1%) sought health information from pharmacies. Higher percentage of respondents of HSC, and Graduation and above preferred general physicians (27.1% and 39.7%) respectively (Table 2).

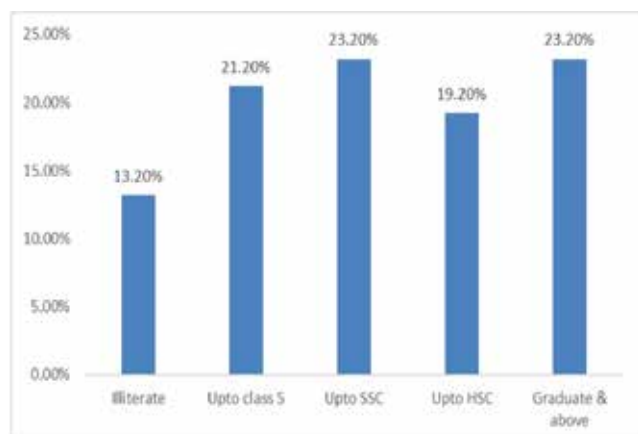


Figure III: Showing the Educational Status of the Respondents

More than one-fifth (23.2%) respondents were educated up to Graduation Level. Though, 13.2% of respondents were illiterate (Figure III).

Discussion

The study was done in Dhaka South City Corporation to study the pattern of health information Seeking behaviour among adults of Dhaka South City. The average age of the respondent was 34.78 years with minimum value of 18 years and maximum value of 72 years. In this study most of the respondents (58.8%) were male. The findings of this study revealed that respondents with low level of educational status preferred pharmacies. Educational attainment is closely linked to health literacy, which impacts individuals' ability to access, understand, and utilize health information effectively³.

This situation may contribute to poorer health outcomes and increased vulnerability to health disparities, particularly in marginalized communities⁴. Conversely, for individuals with higher educational attainment, public health campaigns can focus on promoting the importance of regular check-ups and preventive care through general physicians and private hospitals, thereby encouraging responsible health practices⁵.

Regarding the place of birth, 68.4% of respondents

were born in urban areas. Urban areas typically offer better healthcare facilities and resources compared to rural settings, which may experience shortages of healthcare providers and limited access to specialized services⁶. Additionally, the finding that 56.0% of respondents were delivered at home. Home deliveries can pose risks for both mothers and infants, particularly in the absence of skilled healthcare providers, which could contribute to higher maternal and infant mortality rates⁷.

The findings illustrate a clear link between educational status and health information-seeking behavior. Individuals with lower educational attainment tend to rely on pharmacies, potentially leading to poorer health outcomes and disparities in health literacy. Conversely, those with higher education are more likely to engage with formal healthcare providers. Additionally, the predominance of urban births suggests better access to healthcare resources, which is vital for reducing maternal and infant mortality risks. This study underscores the disparities in health information-seeking behaviors based on educational status. Addressing these disparities is essential for developing strategies that promote equitable access to health information and services, thereby enhancing health literacy and outcomes across diverse populations.

Conclusion

In conclusion, the relationship between educational status and health information-seeking behaviours highlights significant disparities in access to healthcare resources. By recognizing and addressing these disparities, healthcare providers and policymakers can implement strategies that promote equitable access to health information and services for all individuals, regardless of their educational background.

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Data Availability

Any inquiries regarding supporting data availability of this study should be directed to the corresponding author and are available from the corresponding author on reasonable request.

Ethics Approval and Consent to Participate

Ethical approval for the study was obtained from the Institutional Review Board. As this was a prospective study the written informed consent was obtained from all study participants. All methods were performed in accordance with the relevant guidelines and regulations.

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