Influence of Health Information in Promoting Good Nutritional Practices and Behavioural Change Among Pregnant Women in South- West, Nigeria

Dr. J.K. Ajayi & N. A. Ajayi

ABSTRACT

The study assessed health information and good nutritional practices among pregnant women in Nigeria. One hundred questionnaires were distributed to pregnant women on pre-natal clinicdays at Teaching and Government hospitals in Ekiti and Osun States, Nigeria. 90 questionnaire were found useful. Summation Weighted Average (SWA), frequencies and percentages applied for variable distribution, while data was analysed using SPSS Software and Chi-square test, t-text and spear correlation-test used for the hypotheses. Results showed that ages 26-35 ranked highest (51.1%), 83.3% were married, and mostly in second parity. 55.6% were civil servants and many (62.2%) had tertiary education. Respondent's highest income falls between N31, 000 and N40, 000 monthly, while many fall below N10, 000. A significant relationship exists between respondents' level of information competence and health status (rcal 0.390 is greater than rtab 0.174); between health information accessibility level and respondents nutritional choices (rcal 0.338 greater than rtab (0.174) all at 0.05 level of significance. It was revealed that health information awareness and accessibility were inadequate. The study therefore recommended organised talks for pregnant women at community level, while media-campaign, seminar/workshops with library playing prominent role should be intensified.

Keywords: health information, pregnant women, nutritional choice, behavioural change, pre-natal clinics, information competence, health status.

Classification: FOR Code: 920507

Language: English

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The study assessed health information and good nutritional practices among pregnant women in Nigeria. One hundred questionnaires were distributed to pregnant women on pre-natal clinicdays at Teaching and Government hospitals in Ekiti and Osun States, Nigeria. 90 questionnaire were found useful. Summation Weighted Average (SWA), frequencies and percentages applied for variable distribution, while data were analysed using SPSS Software and Chi-square test, t-text, and spear correlation-test was used to test the hypotheses. Results showed that ages 26-35 ranked highest (51.1%), 83.3% were married, and mostly in second parity. 55.6% were civil servants and many (62.2%) had tertiary education. Respondent's highest income falls between N31, 000 and N40, 000 monthly, while many fall below N10, 000. A significant relationship exists between respondents' level of information competence and their health status (rcal 0.390 is greater than rtab 0.174); between health information accessibility level and respondents nutritional choices (rcal 0.338 greater than rtab (0.174) all at 0.05 level of significance. It was revealed that health information awareness and accessibility were inadequate. The study therefore recommended organised talks for pregnant women at community level, while media-campaign, seminar/workshops with library playing prominent role should be intensified.

I. INTRODUCTION

Woman body goes through a great deal of hormonal, physiological, and physical changes during pregnancy. The way she nourishes her body during this process will affect her own health, as well as the health of her baby (Healthline, 2015). This is because during pregnancy, woman's body has increased nutritional needs. Her body requires macro-nutrients (for example, calories, protein, and fluids), and micro-nutrients (for example, calcium, foliate, and iron). In general, most women can meet these increased nutritional needs by choosing a diet that includes a variety of nutritious foods. Nutritional information aims at improving knowledge, attitudes and information rather than activities that aimed at increasing food availability. Health information then is a set of abilities needed to recognise a health information need, identify likely information sources and use them to retrieve relevant information, assess the quality of the information and its applicability to a specific situation, and then analyse, understand, and use the information to make a good decision (MLA, 2007). The World Health Organization Constitution over the years recognised and emphasized the need for careful

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use of scarce resources of information, education and communication as the most cost-effective intervention of health (Popoola, 2009). Appropriate nutritional information could also aid in avoiding stressful events or avoiding exposure to infections or complications in pregnancy (Cohen, 2003).

II. HEALTH CARE NUTRITIONAL STATUS OF WOMEN IN NIGERIA

In Nigeria, the number of rural poor women is roughly twice that of the urban poor and the depth of poverty was more than double in rural areas. Income inequality is worse in rural areas, with a Gini-coefficient of 45.6 compared with the urban areas of 39.9 (Fos, 2000). Most home lack basic amenities, mothers are underprivileged and poorly educated. They cannot recognise a health information need, cannot identify likely information sources and cannot use information to make good decision. Many women belief in taboos that a pregnant woman should not eat certain types of food or engage in certain work/duties.uch include; a pregnant woman must not eat egg, beans and even meat, not work in the sun and so on.

However, eating the right foods can help persons avoid certain diseases and recover faster when illness occurs. Poor maternal nutrition during these periods may adversely affect infant growth and development and may increase life-time risk of developing chronic disease (Osmond & Barker, 2001). Dietary change is generally needed for women to meet the increased nutrient requirements of pregnancy: and while some women make significant dietary changes, others find it difficult to do. Notably, even when women do make changes to their diet, they do not always adopt evidence based dietary recommendations (Crozier et al, 2009; Forster et al, 2009).

Ajayi and Adewale (2010) postulated that the concept of health information literacy pre-supposes that an individual recognises the need for information and how to find, evaluate, use and subsequently communicate information effectively to solve particular problems or make decisions. Absence of health information is a significant barrier to effective health care for many people. A wide range of health-enhancing behaviour significantly, depends on health information literacy and consequently, drives health-information seeking needs of individuals (Atulomah & Atulomah, 2012). In view of Obuh-Raph and Adamo (2012), the level of ignorance in terms of nutrition especially by pregnant mothers was still on the high side. The ignorance cut across all classes of people from the last to the greatest. Many pregnant mothers are not aware of what to eat for proper development of the growing foetus. In Nigeria, Akowe (2009) quoted in Ogunjimi et al (2012) found that the country constitutes just 1% of the World population, and accounts for 10% of the worlds' maternal and under-five mortality rates and that annually, an estimated 52,900 Nigerian women die from pregnancy related complications out of a total of 529,000 global maternal death. The study revealed further that woman's chance of dying from pregnancy and childbirth in Nigeria is 1 in 35. It is imperative then to investigate the influence of health information in promoting nutritional information practices and behavioural changes among pregnant women in Nigeria, which this study intended to carryout.

III. LITERATURE REVIEW

Several qualitative studies found risk avoidance was a strong motivator of dietary change during pregnancy (Begley, 2002; Szwajcer et al. 2007; Tessema et al. 2009; Ferrari et al; 2013; Reyes, Klotz & Herring, 2013; Wennberg et al .2013). Specifically not wanting to jeopardise their own life or their unborn baby's life (Reyes, et al., 2013) led women to make dietary changes to avoid preventable adverse pregnancy outcomes. Healthier eating-patterns are common among socio-demographically diverse women who believed their personal behaviour had a stronger influence on their nutrition and health than external factors (Springer et al. 1994). As a result, women of high social position see adequate nutrition as how much one can afford in terms of

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junk foods. Women occupying the base of the social ladder believe that adequate nutrition is the quantity of food one can consume during pregnancy, but studies have shown that women's nutrition knowledge significantly influenced dietary choice (Begley, 2002; Tessema et al, 2009; Massad & Chapman, 2010; Barbour et al. 2012; Ferrari et al. 2013; Groth & Morrison – Beedy, 2013; Reyes, et al 2013; Wennberg et al, 2013). Barriers to health diet choices include; lack of knowledge regarding the quantity of certain foods required to ensure nutritional adequacy (Begley, 2002); exposure to confusing and frequently changing dietary information (Ferrari et al. 2013; Wennberg et al 2013); and misconceptions about health choice alternatives (Groth & Morrison – Beedy, 2013; Reyes, et al 2013). Furthermore, Kelli & Shieh (2010) found that first time mothers were more engaged than non-first time mothers in using various information sources.

Aaronson and Pfoutz (2015) in a study that investigated "seeking information: where do pregnant women go" found that healthcare providers and books were first or second most important by the largest number of respondents. It added that women of higher Socio-economic status (SES) relied more on books and less on family than did women of lower SES. Also, having had a previous pregnancy was associated with greater use of one's self as information source. Women who perceived more support from their providers viewed them as more important source of information. Schiwartz, Woloshin & Baazek (2002) opined that consumers get most of their nutrition information from television news of how diet influences the development of disease. They benefit from news coverage of nutrition when they learn to make lifestyle changes that will improve their health. Studies by Thorndike et al 2012 and Hersy et al. 2013 revealed that nutrient–specific labels which incorporated both text and colour were most effective at aiding selection of healthier foods by pregnant women, while mass media campaigns have also been shown to be effective in achieving change in health related behaviours and could be used for dissemination of up –to-date evidence (Wakefield, Loken & Hornik, 2010). Piper (2009) submittted that community health nurse play a vital role in promoting health during pregnancy. The most important role is figured in teaching and providing pregnant women with information needed based on social and psychological behavioural changes to maintain health during pregnancy on mainly those related to nutritional aspects.

3.1 Theoretical Framework

This study was anchored on Information Utilization Capacity Theory (IUCT). This theory propounded by Curras in 1986 states that the utilization of information is dependent on the ability of the users to access information. According to Currás-Bosch (1986), the user's educational background, personality, belief, etc, will to a great extent affect the ability of the user to access information. Supporting this theory, Wilson (1999) stated that personal characteristics such as beliefs held by a person, interests, needs or existing attitudes, personal cognitive need (knowledge base) and level of information literacy may constitute barriers to access and use of information. The implication of this theory is that pregnant woman's personal characteristics as stated earlier may influence the level of health information access and use for nutritional choices and behavioural changes at gestation period. IUCT seen as a concept associated with personal beliefs in determining information adoption and usage anchored the base of this research work.

3.2 Statement of the Problem

Absence of health information is a significant barrier to effective health care while health information literacy is believed to be an effective strategy to enhance a successful pregnancy. Mothers are under privileged and poorly educated in Nigeria and that many cannot recognize a health information need, identify likely information sources and majority cannot even use information to make good decision (Ajayi & Adewale, 2010). Therefore it becomes imperative to examine how health information could

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influence pregnant women's decision making in relation to their good nutritional choices and behavioural change particularly in Nigeria.

3.3 Objectives of the Study

i. The prime objective of the study is to assess the level of influence of health information in promoting good nutritional practices and behavioural change among pregnant women in South-west, Nigeria. Specific objectives were to;

ii. Find out the sources of health information and their relative importance for healthy nutritional practices and promotion among the respondents;

iii. Examine respondents perceptions, practices and health status to determine their health information needs;

iv. Determine the respondents health information accessibility level for healthy nutritional choices;

v. Determine the health information competence level of the respondents;

vi. Identify the participant's health information access barriers in promoting healthy nutritional practices.

3.4 Research Questions

1. Does the respondent's information competence level have any influence on health information accessibility level of the respondents?

2. Do barriers to health information accessibility have significant influence on the respondents' health information competence level?

3.5 Hypothesis

➢ There will be no significant relationship between health information competence level of the respondents and their health status

➢ There will be no significant relationship between the respondents health information accessibility level and improvement of their nutritional choices for healthy living.

IV. METHODOLOGY

The study population comprised 100 pregnant women of gestational age attending pre-natal clinics in six (6) health centers located in two major cities of Ile-Ife and Ado Ekiti, Southwest Nigeria. A stratified random sample technique was used. A random sampling of 90 pregnant women was used and a method of proportional allocation to sample was adopted to obtain the sample size of each stratum. The method assumed that the sampling fraction is equal to the sampling fraction for each stratum i.e (f=fh) and fh-nh/N (see table 1). This technique was adopted because of peculiarity of the clinics.

Table 1: Sampling fraction for stratum

Clinics	Nh	Nh
1	18	=16
2	19	=17
3	18	=15
4	16	=14
5	15	=12
6	17	=16
	103	90

The study ran for three months (August-October, 2019). The purpose of the study was explained and informed consent also obtained from the participants. A total of 100 questionnaires were distributed among the women on clinic days. 94 questionnaires were returned out of which 90 were found useful, representing 90.0 percent. The instruments include; A five-item Health Information Competency Scale developed in previous CHESS (Comprehensive Health Enhancement Support System) studies, to assess the respondent's perception the respondents get and use health information, while barriers to Information Access Scale (Arora et al. 2002) was modified to assess if participants had difficulty finding health information.

V. DATA ANALYSIS

Sample characteristics and variable distribution were described using tables, frequency counts, means and percentages. Some results were

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analysed using Statistical method of Summation of Weighted Values (SWV). Likert scale 5 ratings namely: Strongly Agree (SA), Agree (A), Disagree (D) and Strongly Disagree (SD), Undecided (1) corresponding to scales of preference of 5, 4, 3, 2, 1 respectively was used in the instrument. Data were analysed using the statistical package for the social sciences (SPSS version 7.0) software, and applying chi-squire test, t-test and spear correlation test to determine the level of significance.

range of 26-35 years, while few (11.1%) per cent were within 36 and 50 years. The mean age was 30 years. Fifty-six per cent (55.6%) of the respondents were civil servants, 13.3 per cent were full housewives while 31.1 per cent were self-employed/petty traders. Educational background of the respondents revealed that primary school certificate holders were 1.1%, secondary school certificate (28.9%), and higher education (62.2%) while 7.8% had non-formal education.

VI. RESULTS AND DISCUSSION

6.1 Results

Socio-Demographic variable of the respondents (Table 2) showed that many (51.1%) were in the

Table 2: Socio-Demographic Variable of Respondents

		Frequency	Percentage
Age	Under 18 years	19	21.1%
	18-25 years	15	16.7%
	26-35 years	46	51.1%
	36-50 years	10	11.1%
	Total	90	100.0%
Occupation	Civil Servant	50	55.6%
	Full housewife	12	13.3%
	Self-employed/Petty trader	28	31.1%
	Total	90	100.0%
Education Attained	Primary School	1	1.1%
	Secondary	26	28.9%
	Higher education	56	62.2%
	Non-formal	7	7.8%
	Total	90	100.0%

Figure 1 showed the importance of socio-economic status of pregnant women in meeting and caring for their pregnancies cannot be detached from education and economic status. Many (44.5%) of the pregnant women earned between #31, 000 -#40, 000 per month, 13.3% earned between #21, 000 - #30, 000 per month, 22.2% received between #11, 000 - #20, 000, and 15.6% earned less than #10, 000 per month (see

fig, 1). (#450.00 = US $ 1.00). Most of the pregnant women sampled earned less than $89.00 per month, the amount which is not enough to maintain a family. This result agrees with Shelly (2002) that about 1.2 million people in the developing world are absolutely poor with only a dollar a day to meet food, shelter and other basic
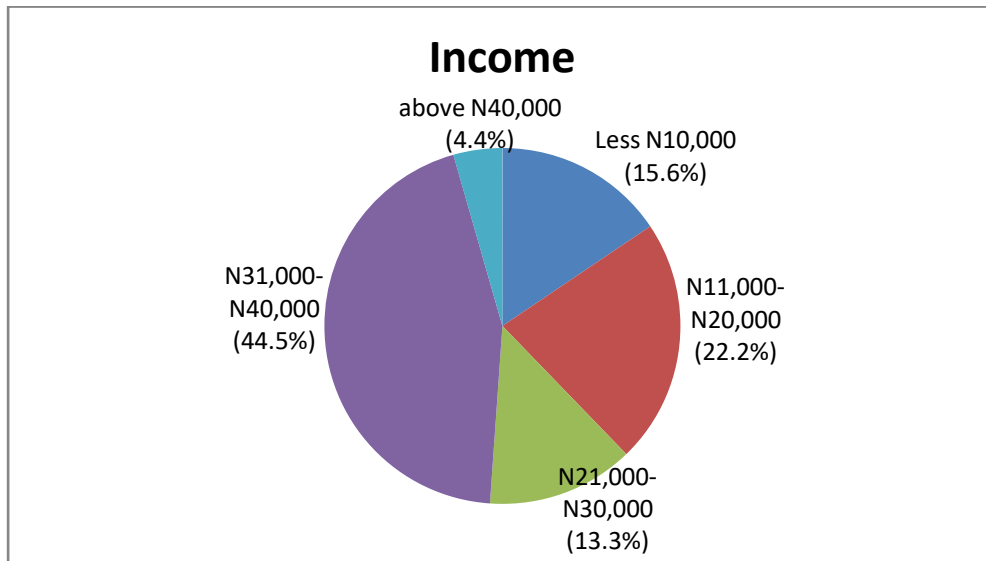
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Figure 1: Pie-Chart showing the income level of respondents per month

Parity: Table 3 revealed that 24.4% of the respondents were 1st time pregnant, 31.1% were 2nd timer, 24.4% 3rd timer, while 20.0% were at 4th and above pregnancy.

Table 3: Frequency table showing number of Parity

Items	Frequency	Percentage
1st time Pregnant	22	24.4
2nd Pregnant	28	31.1
3rd Pregnant	22	24.4
4th above	18	20.0
Total	90	100.0

Sources of information: Figure 2 showed that majority of the respondents frequently use radio as their source of health information. Television, friends and healthcare providers also serve as good sources of health information. The findings revealed that the newspaper, library, family/relatives, posters were less frequently used as sources of health information. Food labels also serve as a good source of health information as they are easily scanned through before purchase for consumption. The result also revealed a good frequency on the use of public health campaign as a source of health information among the respondents.
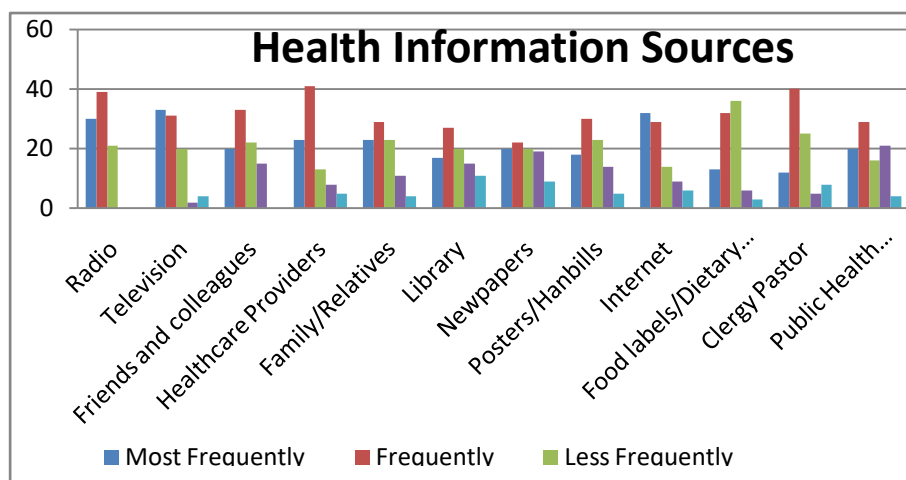
Figure 2: Sources of Health Information by the Respondents

Table 4 respondents' Health Information Accessibility level index reveals that 2.99 of the respondents strongly agreed that they could easily locate diverse sources of health information when making nutritional choices while 2.95 cannot confidently and easily locate such diverse sources.

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2.91 of the respondents agreed to have got the skill to access various sources of health information when they needed to make diet choices, however, 2.79 showed non-confidence in accessing information when needed to make diet choices and few (2.71index) of the women could access health information resources without any form of assistance. This is followed by those who can only access health information on ante-natal visiting day with index of 2.68. Those who could not access health information because of health information were not readily available had index of 2.32, moreover, facilities like library, information centers, and internet not being available to provide health information, coupled with information centers not found in the respondent's locality recorded indexes of 2.24 and 2.14 respectively.

Table 4: Respondents' Health Information Accessibility level

S/N	Health Information Accessibility Level	SA 4	A 3	D 2	SD 1	Total	Index
1	I feel fit to do every task because I always access health information needed for my pregnancy growth	120	126	14	9	269	2.99
2	I can easily locate various sources of health information when making nutritional choices	76	159	26	5	266	2.95
3	I know how to access health information when I need to make diet choices	92	126	38	6	262	2.91
4	I find it easy to locate, access and use health information for health living	68	138	36	9	251	2.79
5	I don't have frequent contact with healthcare providers for health information	68	57	70	19	214	2.78
6	I can access health information without any form of assistance	88	84	64	8	244	2.71
7	I can only access health information on ante-natal visiting day	84	87	60	10	241	2.68
8	I cannot access health information because it is not readily available	60	57	72	20	209	2.32
9	Facilities like library, information centers, and internet are not available to provide health information	48	75	52	27	202	2.24
10	Information centers are not found in my locality	36	63	68	26	193	2.14

Health Information competence level of the respondents: Table 5 showed, 87.8% of the respondents agreed that they know exactly what they want to learn about their healthcare, 5.6% could not decide while 6.6% showed they did not. Majority (85.6%) indicated that they could check/access health information from different sources with ease, but 7.8% would not be able, and 6.7% were undecided. Also, 53.3% of the respondents found health information more difficult to obtain than other types of information, but 35.5% disagreed, whereas 11.1% could not decide. The results showed that majority (88.9%) of the respondents were satisfied with the way they currently learn about health issues however, 8.9% of the respondents disagreed. Also, 68.9% felt they are in control of how and what they have as health information as against 18.9% who disagreed while 12.2% could not decide on the item.

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Table 5: Health Information Competence level of the Respondents

Items	Agree		Undecided		Disagree	
	Freq	%	Freq	%	Freq	%
I know exactly what it is that I want to learn about my healthcare	79	87.8	5	5.6	6	6.6
I can check for health information from different sources with ease	76	85.6	6	6.7	7	7.8
Health information is more difficult for me to obtain than other types of information	48	53.3	10	11.1	32	35.5
I am satisfied with the way I currently learn about health issues	80	88.9	2	2.2	8	8.9
I feel that I am in control over how and what I have as health information	62	68.9	11	12.2	17	18.9

Health Information Access Barriers: Table 6 revealed identified barriers to adequate health information which includes: lack of seminar/workshop to sensitize the respondents on relevant health information and the perception that health information can only be given by health workers, and never mind to access other sources ranked highest in what constitute barriers to information accessibility among the pregnant women under study with index of 3.50 each, followed by facilities needed to access health information being sited far away from respondents locality with index of 3.46. The non-recognition of library to provide adequate health information as other sources recorded index of 3.32, followed by lack of knowledge of the need for health information during pregnancy and, Library not made available within respondent's locality to provide health information ranked equal with indexes of 3.29 respectively. Other barriers like culture/tradition e.g. certain taboo forbidding one from eating certain food despite adequate health information, one's religion not supporting compliance with certain healthcare even with access to health information (e.g. blood transmission/use of drugs) and respondents not knowing where to find health information recorded indexes of 2.9, 2.76,and 2.54 respectively, while those who perceived they do not need health information to guide their nutritional choice ranked lowest with index of 2.43. All these constitute barriers to easy accessibility of health information among the respondents in different dimensions and levels as revealed from table 5 above.

Table 6: Health Information Access Barriers

S/N	Items	SA 5	A 4	U 3	D 2	SD 1	Total	Index
1	There is Lack of seminar/workshop on health information for pregnant women in my community	200	20	30	60	5	315	3.5
2	Health information can only be given by hospital and doctors, and never mind to access other sources	200	36	27	40	12	315	3.5
3	Facilities needed to access health information are sited far away from my locality	175	40	51	36	10	312	3.46
4	Library cannot provide adequate health information as other sources	200	4	24	60	11	299	3.32
5	I have no knowledge of the need for health information during pregnancy	175	40	9	60	12	269	3.29
6	Library is not available in my locality to	200	36	24	6	30	296	3.29

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	provide health information							
7	My culture/tradition e.g. certain taboo forbid me from eating certain food despite adequate health information	85	52	27	92	5	261	2.9
8	My religion does not support compliance with certain healthcare even with access to health information (e.g. blood transmission/use of drugs)	50	76	30	82	10	248	2.76
9	I do not know where to find health Information	-	96	48	80	5	229	2.54
10	I do not believe I need health information to guide my nutritional choice	-	132	39	8	40	219	2.43

Hypotheses Testing

H_O1: There will be no significant relationship between Health Information competence level of the respondents and health status. Table 7 showed that r_{cal} (0.390) is greater than r_{tab} (0.174) at 0. 05 level of significance. The null hypothesis (H_o) is therefore not accepted which implies that there is a significant relationship between Health Information competence level of the respondents and health status.

Table 7: PPMCC showing the relationship between Health Information competence level of the respondents and health status

Variable	N	$\bar{x}$	S.D	Df	r_{cal}	r_{tab}
Health Information competence level	90	2.01	1.011	89	0.390	0.174
	90	1.84	0.860			

p < 0.05

H_O2: There will be no significant relationship between Health Information accessibility level and improvement of their nutritional choices for healthy living. Table 7 showed that r_{cal} (0.338) is greater than r_{tab} (0.174) at 0. 05 level of significance. The null hypothesis (H_o) is therefore rejected which implies that there is a significant relationship between Health Information accessibility level and improvement of their nutritional choices for healthy living.

Table 7: PPMCC showing the relationship between Health Information competence level of the respondents and health status

Variable	N	$\bar{x}$	S.D	Df	r_{cal}	r_{tab}
Health Information competence level	90	2.01	1.011	89	0.390	0.174
Health Status	90	1.84	0.860			

p < 0.05

VII. DISCUSSION

Human being requires food to grow, reproduce and maintain good health. Behavioural changes are necessary to assist mother to change their eating habits and practices that contribute to nutritional deficits. Knowledge of health

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information serves as a basis for managing uncertainty, coping with change and maintaining some control regarding health decisions.

The study revealed that majority of the respondents who attended pre-natal clinic were within ages 26 and 35, and married. Most of them were civil servants (55.6%) who had post-secondary qualifications. This could have been responsible for their information consciousness and clinic attendance as just a few pregnant women (7.8%) with non-formal education/illiterates did not attend pre-natal clinic regularly throughout the period (3-months) of this study. This corroborates the findings of Ajayi & Adewale (2010) that mother are under privileged and poorly educated in Nigeria and that they cannot recognise a health information need, identify likely information sources, and cannot even use information to make good decision. The study also revealed that monthly income for individual in Nigeria is still very low. The highest paid among the respondents receive between N31, 000-N40, 000 ($83.68-$119.5) monthly while some still receive as low as N10, 000 ($39.8) per month. The poor income must have also been responsible for the bulk of illiterates who ignore clinics for lack of money to pay hospital bills (Finlayson & Downe, 2015). This agrees with Titaley et al. (2010) posits that financial difficulty emerged as the major issue among women who did not fulfil the minimum requirement for antenatal care services. This was related to the cost of health services and transportation costs.

The findings also showed that healthcare providers followed by clergy/pastor, and radio in order of preference were the most sought sources of health information. This conformed to Aaronson and Pfoutz (2015) that healthcare provider was the most important by the largest number of pregnant women studied. Reason attributed to this was that women who perceived more support from their provider viewed them as more important source of information. This therefore contradicted the finding of Schiwartz, Woloshin and Baazek (2000) that consumers get

most of their nutrition information from television.

The result indicated that accessibility to health information is high among the respondents. Those who claimed to feel fit to do every task due to healthy nutritional choices as a result of adequate health information at their disposal ranked highest followed by those who could easily locate various available sources of health information. The findings also revealed that there is a correlation between respondent's information accessibility level on the promotion of nutritional choice and behavioural change. Cohen (2003) was of the opinion that nutritional information could also aid in avoiding stressful life events or avoiding exposure to infections or carcinogenic agents. The competence level is also found to be high among the respondents .Those who know exact information to seek has the highest.

VIII.   CONCLUSION

Understanding of health information as a factor influencing women's dietary choices is central to motivating positive dietary behaviour before, during and after pregnancy. It enables interested health professionals and policymakers to identify efficient strategies for improving healthy food choices among pregnant women. Accessibility to health information was high among those civil servants with post-secondary qualifications (educated) while very few with non-formal education (illiterates) attended pre-natal clinic indicating low information literacy. Poverty and cultural/traditional beliefs affected the respondents' nutritional practices within the community. Healthcare providers and pastors were the major sources of health information with little concern about the libraries.

IX.   RECOMMENDATIONS

Library should stand out through its mobile services in providing educational packages to be based on a careful community survey of cultural beliefs and general knowledge about health

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practices during pregnancy. This will allow programs to respond to taboos/beliefs and/or at least recognize when information disseminated is contradicting local beliefs held by the women themselves, friends, and family.

Various government agencies should adopt persuasive communication methods, directed at target audiences to aid in educating and influencing women in their child-bearing years and providing pregnant women with automated daily feedback regarding their adherence with dietary recommendations. This would promote positive diet practices through presenting series related to nutrition with emphasis on preparing healthy meals, considering socio-economic status of all population and common health problems in the community.

Nigeria's investment in nutrition education should further improve in diets promotion for healthy living among low-income women.

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