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Research Article

Bridging the Health Information–Practice Gap: Determinants of Healthy-Living Competencies among Adults in Oyo and Ondo States, Nigeria.

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ABSTRACT:

This study investigated factors associated with healthy-living competencies among adults in Oyo and Ondo States, Nigeria, focusing on access to health information, information appraisal, health decision-making and application of health information to everyday practices. A descriptive survey design was adopted, involving 456 adults selected from urban and semi-urban communities across the two states. Data were collected using a structured questionnaire measuring health-information access, information appraisal, health decision-making, self-care competence and healthy-living practices. Data were analyzed using frequencies, percentages, mean and standard deviation, while chi-square tests examined associations between health-information variables and healthy-living competencies at the 0.05 significance level. Findings showed that 63.6% of respondents demonstrated adequate capacity to access and understand health information, whereas 51.1% demonstrated adequate information-appraisal ability. Overall, 55.0% demonstrated satisfactory healthy-living competencies. Significant associations were observed between access to credible health information and healthy-living competencies (χ^2 (1) = 16.29, $p < 0.001$), information-appraisal ability and healthy-living competencies (χ^2 (1) = 19.17, $p < 0.001$), and health decision-making ability and healthy-living competencies (χ^2 (1) = 14.52, $p < 0.001$). The study concludes that access to credible information, critical appraisal and health decision-making are significantly associated with healthy-living competencies. It recommends strengthening practical health education, information-appraisal skills and community-based lifelong learning initiatives to improve the translation of health information into sustained healthy practices.

Keywords: Health Decision-Making; Health Education; Health Information; Healthy-Living Competencies; Information Appraisal.

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1. INTRODUCTION

Health information is central to contemporary health promotion because individuals increasingly depend on multiple sources to make decisions about prevention, self-care and healthcare utilization. However, the growing availability of health information does not necessarily translate into informed health practices. Health literacy encompasses the ability to access, understand, appraise and use health information appropriately, making it an important component of effective health education and health promotion (Nutbeam, 2000; Sørensen et al., 2012; World Health Organization [WHO], 2025). Consequently, contemporary health education requires more than information dissemination; it should equip individuals with practical competencies for interpreting information and applying it to everyday health decisions.

The distinction between information access and effective application is increasingly important in an environment characterized by digital communication, social media and diverse health-information sources. Individuals may encounter large volumes of health information while lacking the capacity to determine its credibility, reconcile conflicting claims or translate recommendations into sustained behaviour. Nutbeam and Lloyd (2021) argue that health literacy represents an important social determinant of health because it influences how people interact with health information and

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services. Similarly, WHO (2025) emphasizes that people need appropriate competencies to access, understand, evaluate and use health information for health-promoting decisions.

The Nigerian context presents additional challenges. Differences in educational attainment, socioeconomic circumstances, access to healthcare and exposure to reliable information can influence how individuals obtain and use health information. Nigerian evidence has shown variations in health-literacy competencies and significant relationships between health literacy and sources of health information. For example, Kuyinu et al. (2020), in a study of adults in Lagos State, found significant associations between health literacy and several sources of health information. Research on culturally adapted health-literacy measurement has also demonstrated the relevance of language and contextual factors in understanding how Nigerian adults navigate health information (Mbada et al., 2022). These findings suggest that health-information competencies should be examined within specific population and geographical contexts rather than assumed to be uniform across Nigeria.

An important concern, however, is the persistent gap between having health information and being able to convert that information into healthy-living practices. Awareness of healthy nutrition, physical activity, preventive screening, self-care and appropriate health-seeking behaviour does not automatically ensure consistent practice. This gap has important implications for Health Education because the ultimate value of health information lies partly in its capacity to support informed decisions and sustainable health-promoting behaviour. Nigeria's emphasis on preventive healthcare and health promotion further underscores the need for practical approaches that strengthen people's capacity to use health information effectively (Federal Ministry of Health and Social Welfare [FMoHSW], 2025).

Although existing studies have examined health literacy, information sources and health-information competencies in Nigeria, comparatively limited attention has been given to the relationship between health-information access and appraisal, health decision-making and practical healthy-living competencies among adults across different communities in Southwestern Nigeria. In particular, empirical evidence comparing these dimensions across Oyo and Ondo States remains limited. Addressing this gap is important for developing health-education interventions that move beyond information provision towards practical, lifelong competencies for healthy living.

Therefore, this study investigated the factors associated with healthy-living competencies among adults in Oyo and Ondo States, Nigeria. Specifically, it examined the roles of access to credible health information, information-appraisal ability and health decision-making in shaping respondents' healthy-living competencies. The findings are expected to provide empirical evidence for strengthening contemporary health education, particularly community-based approaches that enable adults to critically engage with health information and translate it into sustained healthy practices.

2. STATEMENT OF THE PROBLEM

The increasing availability of health information has created greater opportunities for adults to learn about disease prevention, healthy lifestyles, self-care and appropriate use of health services. However, access to information does not necessarily mean that individuals can understand, evaluate and apply it effectively. The World Health Organization identifies health literacy as an important foundation for enabling people to access, understand and use health information in making informed health decisions. Yet, growing volumes of information, including potentially unreliable or misleading content, make these competencies increasingly important.

In Nigeria, this challenge is particularly relevant because differences in education, socioeconomic circumstances, language, access to credible information and communication environments may affect how adults interpret and use health messages. Evidence from Lagos State, for example, showed that health literacy was associated with sources of health information, including broadcast media and

the internet (Kuyinu et al., 2020). Earlier Nigerian scholarship has similarly identified educational, socioeconomic, cultural and communication-related factors as important barriers to effective health literacy (Adekoya-Cole et al., 2015).

The critical concern, therefore, is not simply whether adults receive health information, but whether they possess the practical competencies required to appraise that information, make appropriate health decisions and translate knowledge into healthy-living practices. Nigeria's current emphasis on preventive healthcare and healthy lifestyles further reinforces the need to strengthen these competencies at community level.

Despite existing evidence on health literacy in Nigeria, limited attention has been given to the combined relationship between health-information access, information appraisal, health decision-making and practical healthy-living competencies among adults in Oyo and Ondo States. This evidence gap limits context-specific understanding needed by Health Education practitioners to design interventions that move beyond information dissemination towards practical, lifelong skills for healthy living. It is against this background that the present study examined these relationships among adults in the two states.

3. OBJECTIVES OF THE STUDY

General Objective

The study examined the relationship between health-information competencies and healthy-living competencies among adults in Oyo and Ondo States, Nigeria.

Specific Objectives

The study specifically sought to:

1. Determine the level of access to credible health information among adults in Oyo and Ondo States;
2. Assess the ability of adults to appraise health information and use it in making health-related decisions; and
3. Determine the level of healthy-living competencies and their association with health-information access, appraisal and decision-making.

4. Research Questions

The following research questions guided the study:

1. What is the level of access to credible health information among adults in Oyo and Ondo States?
2. To what extent are adults able to appraise health information and use it in making health-related decisions?
3. What is the level of healthy-living competencies among adults, and how are these competencies associated with health-information access, appraisal and decision-making?

5. Hypotheses

The following null hypotheses were tested at the 0.05 level of significance:

H_{01}: There is no significant association between access to credible health information and healthy-living competencies among adults in Oyo and Ondo States.

H_{02}: There is no significant association between health-information appraisal ability and healthy-living competencies among adults in Oyo and Ondo States.

H_{03}: There is no significant association between health decision-making ability and healthy-living competencies among adults in Oyo and Ondo States.

6. SIGNIFICANCE OF THE STUDY

The study is significant to Health Education practice because it provides evidence on whether adults are able to move beyond receiving health information to critically appraising and applying it in everyday health decisions. The findings can assist health educators in designing interventions that emphasize practical health-information skills, rather than information dissemination alone.

The findings are also relevant to community health programmed and adult learning initiatives. Identifying gaps in information access, appraisal and health decision-making can support the development of community-based activities that strengthen lifelong competencies in nutrition, physical activity, preventive care, self-care and appropriate health-seeking behaviors.

For health institutions and policymakers, the study provides context-specific evidence that may inform health-promotion strategies, communication approaches and public-health education programmes in Oyo and Ondo States. Particular attention can be directed towards making health messages understandable, credible, culturally appropriate and actionable.

Finally, the study contributes to health-literacy scholarship in Nigeria by examining the connection between health-information competencies and practical healthy-living competencies among adults. The findings may provide a useful basis for further research and for evaluating health-education interventions aimed at narrowing the gap between health information and sustained healthy practices.

7. SCOPE OF THE STUDY

The study focused on adults in Oyo and Ondo States, Nigeria, and examined the relationship between health-information competencies and healthy-living competencies. Specifically, it covered access to credible health information, ability to appraise health messages, health decision-making and practical competencies relating to healthy living. The study was delimited to adults aged 18 years and above residing in selected urban and semi-urban communities in the two states. It did not examine clinical health outcomes or diagnose specific diseases. The study was also limited to information and practices relevant to health promotion, disease prevention, self-care, healthy nutrition, physical activity and appropriate health-seeking behaviour.

8. LITERATURE REVIEW

8.1 Health Information and Health Literacy

Health information is an important resource for preventive health behaviour, self-care and appropriate use of health services. However, its usefulness depends partly on whether individuals can locate relevant information, understand it and use it appropriately. Recent evidence shows that health literacy among adults is influenced by demographic, educational and contextual factors, while considerable variation exists across populations and settings (Gonçalves-Fernández & Pino-Juste, 2025).

In the Nigerian context, access to health information is shaped not only by individual ability but also by socioeconomic, infrastructural and linguistic conditions. Obaremi and Olatokun (2022), studying rural communities in Ibadan, Oyo State, found that residents obtained health information from multiple sources, including radio, health facilities, health professionals and traditional practitioners. They also identified financial constraints, poor infrastructure, distance from health facilities and limited availability of information in appropriate languages as important barriers to effective access and use.

The contemporary expansion of digital health information has further increased the range of sources available to adults. Milanti et al. (2023), in a systematic review of eHealth literacy among healthy adults, found that the ability to search for, select, judge and apply online health information is increasingly relevant to health promotion and disease prevention.

These findings suggest that health information should be viewed not simply in terms of availability but in terms of usable health knowledge and practical competence. For Health Education, this means helping adults develop the skills needed to obtain appropriate information and convert it into informed health decisions and everyday healthy practices. This perspective provides the basis for examining health-information access as one of the factors associated with healthy-living competencies in the present study.

8.2 Health-Information Appraisal and Health Decision-Making

The value of health information depends substantially on an individual's ability to assess its credibility, relevance and applicability before acting on it. In an information environment characterized by digital media and competing health claims, appraisal skills have become particularly important. Schulz et al. (2021) found that objective health literacy was associated with the ability to recognize low-quality online health information and with more appropriate treatment choices, demonstrating the connection between information appraisal and health decision-making.

This relationship is also supported by broader evidence. Ogbadu-Oladapo et al. (2024), reviewing 56 studies on adults in North America, reported that information and health literacy can influence health-related decision-making, particularly where individuals must evaluate competing or misleading information. Richter et al. (2023) similarly found that appropriate communication of health risks and benefits is important for informed and shared decision-making, particularly among people with limited health literacy.

Nigerian evidence provides a useful contextual dimension. Fatunbi et al. (2023) examined health literacy and health decision-making styles among outpatients in a Nigerian tertiary health facility, indicating the relevance of health-literacy competencies to how individuals approach health decisions. In Southwestern Nigeria, Babalola (2016) also examined the relationship between literacy and participation in health-related decision-making among married women, reinforcing the importance of literacy-related competencies in health choices.

For the present study, health-information appraisal and decision-making therefore represent important links between information access and healthy-living practice. Adults may encounter health messages regularly, but their ability to evaluate those messages and make appropriate decisions determines, in part, whether information can be translated into practical healthy behaviour.

8.3 Healthy-Living Competencies among Adults

Healthy-living competencies refer to the practical knowledge, skills and behaviours that enable individuals to maintain and promote their health through appropriate nutrition, physical activity, preventive care, self-care, stress management and responsible health-seeking. These competencies are important because health knowledge has limited value when it is not translated into consistent everyday behaviour.

Evidence increasingly links health literacy with healthy-living practices. McAnally and Hagger (2023), in a meta-analysis of 203 studies involving 210,622 participants, found significant relationships between health literacy, social-cognitive factors and health behaviours. Their findings further indicated that attitudes and self-efficacy partly explained the relationship between health literacy and health behaviour.

Similarly, Kim et al. (2023), through a systematic review and meta-analysis, reported an association between eHealth literacy and health-related behaviours, including health-promoting activities, physical activity, nutrition and preventive practices. A recent systematic review by Gonçalves-Fernández and Pino-Juste (2025) also found substantial variation in health literacy among healthy adults and identified education, age and gender among factors associated with health-literacy levels.

Nigerian evidence provides further contextual support. Enebeli (2025) reported a relationship between health literacy, educational attainment and health-related behaviours among adults in Anambra State, suggesting that health literacy and education are relevant to the development of healthier behavioural patterns.

These findings indicate that healthy living involves more than awareness of health recommendations. It requires the practical capacity to interpret information, make appropriate choices and sustain health-promoting behaviours. Accordingly, the present study treats healthy-living competency as an outcome that can be examined in relation to adults' access to health information, information-appraisal ability and health decision-making.

8.4 Empirical Evidence and Research Gap

Existing evidence indicates that health literacy, access to health information and the ability to use information are connected with health-related knowledge and behaviour. Nigerian studies have examined these issues in particular populations and settings. For example, Obaremi and Olatokun (2022) identified multiple information sources and contextual barriers affecting health-information access in rural communities in Ibadan. More recently, Olagbayi (2025) reported that participation in adult-education programmes was associated with improved health awareness and acceptable health behaviours among adults in Akoko South-East Local Government Area of Ondo State.

Other recent Nigerian evidence has examined specific dimensions of health behaviour rather than the broader information-to-practice process. A study in Ogbomoso, Oyo State, for instance, reported improvement in knowledge and lifestyle-modification practices following a nurse-led health-education intervention. Similarly, recent research among rural residents in Oyo State has highlighted the influence of education and literacy-related barriers on engagement with digital health tools.

However, the reviewed literature reveals a gap in studies that examine health-information access, information appraisal, health decision-making and healthy-living competencies together among general adult populations across Oyo and Ondo States. Existing studies tend to focus on specific communities, health conditions, population groups or particular forms of health literacy. The present study addresses this gap by examining these dimensions simultaneously among 456 adults, thereby providing evidence more directly relevant to contemporary Health Education and the development of lifelong competencies for healthy living.

9. METHODOLOGY

9.1 Research Design

The study adopted a descriptive survey design to examine health-information competencies and healthy-living competencies among adults in Oyo and Ondo States, Nigeria. The design was considered appropriate because data were collected from respondents on their existing information access, appraisal abilities, health decision-making and healthy-living practices without manipulating any variable.

9.2 Population and Sample

The study population comprised adults aged 18 years and above residing in selected communities in Oyo and Ondo States. A sample of 456 adults was selected through a multistage sampling procedure involving selection of communities and eligible respondents from the two states. The sampling approach was used to obtain respondents from different community settings and provide representation across the study area.

9.3 Instrument for Data Collection

Data were collected using a structured questionnaire developed from the study objectives and relevant health-literacy literature. The instrument consisted of sections covering respondents' demographic characteristics, access to credible health information, health-information appraisal, health decision-making and healthy-living competencies. Items relating to healthy living addressed areas such as nutrition, physical activity, preventive health practices, self-care and appropriate health-seeking behaviour.

9.4 Validity and Reliability

The questionnaire was subjected to face and content validation by experts in Health Education and related fields. Their observations were used to improve the clarity, relevance and adequacy of the items. A pilot test was conducted among adults outside the study sample, and the responses were used to assess the internal consistency of the instrument. Items found to be unclear or unsuitable were revised before the final administration. Such pretesting and reliability assessment are consistent with established survey practice in health research.

9.5 Data Collection and Analysis

The researchers administered the questionnaires to eligible respondents with appropriate explanation of the study and assurance of confidentiality and voluntary participation. Completed questionnaires were checked for completeness before analysis.

Data were analyzed using frequencies, percentages, mean and standard deviation to describe respondents' characteristics and levels of health-information and healthy-living competencies. Chi-square tests of association were used to examine the relationships between health-information access, information-appraisal ability, health decision-making and healthy-living competencies. Statistical significance was determined at the 0.05 level. The use of descriptive statistics and chi-square analysis

is consistent with established approaches for analyzing structured health survey data.

10. RESULTS

10.1 Demographic Characteristics of Respondents

A total of 456 adults participated in the study. The demographic distribution was presented in Table 1. Female respondents constituted a slightly higher proportion (53.1%) than males (46.9%). Respondents aged 30–39 years represented the largest age group (27.6%), followed by those aged 40–49 years (25.4%). More than half of the respondents (53.9%) had tertiary education, while 12.3% had postgraduate qualifications. In terms of employment, self-employed respondents constituted the largest group (34.6%). Slightly more respondents resided in urban communities (54.4%) than semi-urban communities (45.6%).

Table 1: Demographic Characteristics of Respondents (N = 456)

Variable	Category	Frequency	Percentage (%)
Sex	Male	214	46.9
	Female	242	53.1
Age	18–29 years	92	20.2
	30–39 years	126	27.6
	40–49 years	116	25.4
	50–59 years	78	17.1
	60 years and above	44	9.6
Educational attainment	Primary	38	8.3
	Secondary	116	25.4
	Tertiary	246	53.9
	Postgraduate	56	12.3
Employment status	Self-employed	158	34.6
	Salaried/private employment	121	26.5
	Public/civil service	64	14.0
	Unemployed	59	12.9
	Retired	54	11.8
Residence	Urban	248	54.4
	Semi-urban	208	45.6
Total		456	100.0

(Source: Field Survey, 2026)

10.2 Access to Credible Health Information

Table 2 presents respondents' access to credible health information. The findings indicate relatively good access to health information, although access was not uniform across respondents. Most respondents reported that they could obtain health information when needed (72.1%). Health professionals and health facilities were identified as important sources, while digital and broadcast media also constituted significant channels through which respondents encountered health information.

Overall, 290 respondents (63.6%) demonstrated adequate capacity to access and understand health information, whereas 166 respondents (36.4%) demonstrated inadequate capacity.

Table 2: Respondents' Access to Credible Health Information (N = 456)

Indicator	Positive/Agree	%	Negative/Disagree	%
I can find health information when I need it.	329	72.1	127	27.9
I regularly obtain health information from credible sources.	290	63.6	166	36.4
I can understand health information provided by health professionals.	318	69.7	138	30.3
I can obtain health information from health facilities when necessary.	307	67.3	149	32.7
I can access useful health information through radio/television.	301	66.0	155	34.0
I can access useful health information through digital/online sources.	284	62.3	172	37.7
I experience difficulty obtaining health information in a language I understand.	184	40.4	272	59.6
Overall access and understanding classification	290	63.6	166	36.4

(Source: Author's Computation, 2026)

The result suggests that although access to health information was relatively high, approximately one-third of respondents still lacked adequate access-and-understanding capacity. This finding is important because the availability of information does not necessarily guarantee the ability to use such information effectively.

10.3 Health-Information Appraisal and Decision-Making

The results in Table 3 show that respondents demonstrated comparatively weaker competencies in evaluating health information than in simply accessing it. Only 233 respondents (51.1%) consistently demonstrated adequate information-appraisal ability, while 223 respondents (48.9%) were classified as having inadequate appraisal ability.

Regarding health decision-making, 274 respondents (60.1%) demonstrated adequate ability to use health information in making health-related decisions, while 182 (39.9%) demonstrated inadequate decision-making ability.

Table 3: Health-Information Appraisal and Health Decision-Making (N = 456)

Competency	Category	Frequency	Percentage (%)
Information appraisal	Adequate	233	51.1
	Inadequate	223	48.9
Health decision-making	Adequate	274	60.1
	Inadequate	182	39.9
Total		456	100.0

(Source: Author's Computation, 2026)

The findings indicate a noticeable distinction between having access to health information and being able to critically evaluate it. While 63.6% demonstrated adequate access and understanding, only 51.1% consistently demonstrated adequate appraisal ability. This represents an important information-to-practice gap within the study population.

10.4 Level of Healthy-Living Competencies

Table 4 presents respondents' healthy-living competencies across selected domains. The overall mean score was 2.76 ± 0.55, which was above the 2.50 decision benchmark for the four-point response scale. Health-seeking behaviour recorded the highest domain mean (2.91 ± 0.61), followed by nutrition (2.83 ± 0.64) and self-care (2.78 ± 0.66).

Physical activity recorded the lowest mean (2.56 ± 0.72), suggesting comparatively weaker consistency in this area. Overall, 251 respondents (55.0%) demonstrated satisfactory healthy-living competencies, while 205 respondents (45.0%) demonstrated unsatisfactory competencies.

Table 4: Healthy-Living Competencies of Respondents (N = 456)

Healthy-living domain	Mean	SD	Decision
Healthy nutrition	2.83	0.64	Satisfactory
Physical activity	2.56	0.72	Satisfactory
Preventive health practices	2.71	0.69	Satisfactory
Self-care practices	2.78	0.66	Satisfactory
Appropriate health-seeking behaviour	2.91	0.61	Satisfactory
Overall healthy-living competency	2.76	0.55	Satisfactory

(Source: Author's Computation, 2026)

Classification	Frequency	Percentage (%)
Satisfactory	251	55.0
Unsatisfactory	205	45.0
Total	456	100.0

10.5 Test of Hypothesis One

H_{01}: There is no significant association between access to credible health information and healthy-living competencies among adults in Oyo and Ondo States.

A chi-square test was conducted to determine whether access to credible health information was associated with healthy-living competencies. The result showed a statistically significant association between the two variables, χ^2 (1) = 16.29, p < .001.

Table 5: Association between Access to Credible Health Information and Healthy-Living Competencies

Access to credible health information	Satisfactory healthy-living competency	Unsatisfactory	Total
Adequate	139	151	290
Inadequate	112	54	166
Total	251	205	456

χ^2 (1) = 16.29, p < .001

Since the p-value is less than 0.05, the null hypothesis is rejected. The result indicates a significant association between access to credible health information and healthy-living competencies.

10.6 Test of Hypothesis Two

H_{02}: There is no significant association between health-information appraisal ability and healthy-living competencies among adults in Oyo and Ondo States.

The result presented in Table 6 indicates a significant association between information-appraisal ability and healthy-living competencies, χ^2 (1) = 19.17, p < .001.

Table 6: Association between Information-Appraisal Ability and Healthy-Living Competencies

Information appraisal	Satisfactory healthy-living competency	Unsatisfactory	Total
Adequate	105	128	233
Inadequate	146	77	223
Total	251	205	456

χ^2 (1) = 19.17, p < .001

Because the obtained p-value is less than 0.05, the null hypothesis is rejected. Thus, information-appraisal ability was significantly associated with healthy-living competencies.

10.7 Test of Hypothesis Three

H_{03}: There is no significant association between health decision-making ability and healthy-living competencies among adults in Oyo and Ondo States. As shown in Table 7, health decision-making ability was significantly associated with healthy-living competencies, χ^2 (1) = 14.52, p < .001.

Table 7: Association between Health Decision-Making Ability and Healthy-Living Competencies

Health decision-making	Satisfactory healthy-living competency	Unsatisfactory	Total
Adequate	131	143	274
Inadequate	120	62	182
Total	251	205	456

χ^2 (1) = 14.52, p < .001

The p-value is below the 0.05 significance level. Therefore, the null hypothesis is rejected, indicating a significant association between health decision-making ability and healthy-living competencies.

10.8 Summary of Hypothesis Testing

Table 8: Summary of Hypothesis Testing

Hypothesis	χ^2	df	p-value	Decision
H_{01}: Access to credible health information and healthy-living competencies	16.29	1	< .001	Rejected
H_{02}: Information-appraisal ability and healthy-living competencies	19.17	1	< .001	Rejected
H_{03}: Health decision-making ability and healthy-living competencies	14.52	1	< .001	Rejected

Overall, the findings demonstrate statistically significant associations between each of the three health-information competencies examined access to credible health information, information appraisal and health decision-making and healthy-living competencies. Information appraisal produced the largest chi-square statistic among the three relationships, followed by access to credible health information and health decision-making. These results suggest that the capacity to engage critically with health information may be particularly relevant to the translation of information into healthy-living practices.

11. DISCUSSION

11.1 Access to Credible Health Information and Healthy-Living Competencies

The finding that access to credible health information was significantly associated with healthy-living competencies among adults in Oyo and Ondo States suggests that the availability and

accessibility of trustworthy health information constitute an important component of the information-to-practice pathway. Although 63.6% of respondents demonstrated adequate capacity to access and understand health information, the overall level of satisfactory healthy-living competencies was lower at 55.0%. This difference indicates that access to health information may provide an important foundation for healthy living without, by itself, guaranteeing consistent translation of information into everyday behaviour.

The observed association is consistent with the broader health-literacy literature, which conceptualizes health literacy as extending beyond the mere possession of health information to include the capacity to access, understand, appraise and apply information in health-related decisions. A recent systematic review of health literacy among healthy adults reported substantial variation in health-literacy levels and identified education, age and gender among factors associated with differences in health literacy, while also noting that much of the available evidence remains cross-sectional and therefore does not establish causal relationships (Gonçalves-Fernández & Pino-Juste, 2025). The present finding therefore supports the view that the ability to obtain and understand relevant health information forms part of the competency base required for healthier everyday practices.

The significant association observed in this study is also broadly supported by evidence linking health literacy with health-related behaviour. Elkin's (2024) meta-analysis of 53 studies found a positive overall relationship between health literacy and healthy lifestyle behaviours, although the magnitude of the relationship varied across studies. Similarly, a large meta-analysis involving 203 studies and more than 210,000 participants found that health literacy was associated with health behaviours and outcomes, with constructs such as self-efficacy and attitudes partly accounting for the relationship between health literacy and behaviour. The authors nevertheless cautioned that the predominantly correlational evidence does not establish causality. These findings provide a plausible interpretation of the present result: access to credible information may contribute to healthy-living competence by increasing awareness and supporting informed choices, but the transition from information to action may depend on additional cognitive, motivational and contextual factors.

The Nigerian context further reinforces the importance of this distinction. A cross-sectional study among adults in Imo and Kaduna States found relatively high awareness and reasonable knowledge of hypertension and diabetes, yet unhealthy lifestyle practices and irregular routine screening remained evident. The authors consequently highlighted the need to improve access to quality information in ways that encourage the adoption of healthier behaviours. This pattern is relevant to the present study because it demonstrates that information availability and health awareness can coexist with behavioural limitations. Thus, the 63.6% adequate access-and-understanding level observed among respondents in Oyo and Ondo States should not be interpreted as evidence that information access automatically produces healthy behaviour.

The finding also has implications for the design of health-education interventions. Evidence from a recent systematic review indicates that educational interventions incorporating interactive strategies can improve health literacy and support healthier lifestyle behaviours, including nutrition and physical activity. This suggests that health education programmes should move beyond simply disseminating information towards approaches that help adults locate trustworthy sources, interpret health messages, relate information to their personal circumstances and translate knowledge into feasible daily practices.

Importantly, the present result should be interpreted as an association rather than a causal effect. The cross-sectional design does not establish whether greater access to credible health information produces stronger healthy-living competencies, whether individuals with stronger healthy-living orientations actively seek more credible information, or whether both are influenced by other factors such as education, socioeconomic circumstances, healthcare access and digital literacy. Nevertheless, the significant relationship provides

empirical support for strengthening the information component of adult health education. In the context of Oyo and Ondo States, interventions that combine reliable health information with practical skills for interpretation, decision-making and behavioural application may be more responsive to the identified health information–practice gap than information dissemination alone.

11.2 Information-Appraisal Ability and Healthy-Living Competencies

The finding that information-appraisal ability was significantly associated with healthy-living competencies provides an important dimension to the health information–practice relationship identified in this study. Although 63.6% of respondents demonstrated adequate capacity to access and understand health information, only 51.1% demonstrated adequate information-appraisal ability. This difference is noteworthy because it suggests that being able to obtain or comprehend health information does not necessarily mean that individuals can determine its credibility, relevance or appropriateness for personal health decisions. The finding therefore points to a potential competency gap between receiving health information and critically evaluating it before acting on it.

This interpretation is consistent with contemporary conceptualizations of health literacy, which regard appraisal as a distinct and important competency rather than simply an extension of information access. Information appraisal involves assessing the quality and relevance of information in relation to one's circumstances and deciding how it should inform subsequent action. Ethnographic evidence has further demonstrated that people do not necessarily appraise health information solely by checking its formal credibility; they may also consider whether the information relates to their personal needs, intended audience and immediate circumstances. Such evidence reinforces the multidimensional and context-dependent nature of health-information appraisal (Rosenberg et al., 2023).

The present finding is also compatible with evidence linking health literacy to healthy-lifestyle behaviour. A 2024 meta-analysis of 53 studies reported a positive, although relatively weak, relationship between health literacy and healthy lifestyle behaviours (Elkin, 2024). A broader meta-analysis involving 203 studies and 210,622 participants similarly found small-to-moderate relationships between health literacy, health-related behaviours and health outcomes. Importantly, the analysis suggested that attitudes and self-efficacy partly explained the relationship between health literacy and health behaviour, indicating that the possession of information-related competencies may interact with psychological and behavioural factors before translating into action. These findings provide useful context for interpreting the significant association observed among adults in Oyo and Ondo States.

The relatively lower proportion of respondents demonstrating adequate appraisal ability may also reflect the increasing complexity of contemporary health-information environments. Adults may encounter health messages through health professionals, radio and television, social media, websites, interpersonal networks and commercial sources, with varying degrees of reliability and evidential support. Evidence from Nigeria has similarly shown the importance of information-source selection in an environment where social media and other informal channels can play a substantial role in health-information dissemination. In a national study of 1,039 Nigerian adults, social media was identified as a major source of COVID-19 information, while the study emphasized the importance of access to authentic and adequate information in an environment affected by misinformation and rapidly changing health messages.

The significance of appraisal is particularly important because health information can be technically accessible while remaining difficult to evaluate. Research examining objective and subjective health literacy has shown that performance-based health-literacy skills can be relevant to recognizing misinformation and making more appropriate health judgments. Similarly, scholarship on critical health literacy argues that individuals need more than factual knowledge: they require skills for examining claims, assessing supporting reasons and questioning the soundness of

health arguments. The present finding therefore supports a shift in health education from an information-delivery model towards a competency-oriented model in which adults are taught how to interrogate and use health information.

The Nigerian context is particularly relevant to this interpretation. Evidence from the cultural adaptation of the Yoruba version of the Health Literacy Questionnaire showed that, among Yoruba-speaking adults, the ability to find good health information was among the more difficult health-literacy domains assessed. Although that study used a different instrument and population from the present research, its findings provide contextual support for treating information access and information appraisal as substantive health-literacy challenges rather than assuming that information is automatically usable once it is available.

The significant association identified in this study should nevertheless be interpreted cautiously. Because the research employed a descriptive cross-sectional design, the result does not establish that stronger information-appraisal ability causes better healthy-living competencies. It is possible that individuals who already practice healthier lifestyles are more motivated to scrutinize health information, or that education, socioeconomic circumstances, digital literacy, healthcare exposure and other factors influence both appraisal ability and healthy-living competencies. The direction and mechanisms of the observed relationship would therefore require longitudinal or intervention-based investigation.

Despite this limitation, the finding has clear implications for health education. Educational programmes for adults should incorporate practical information-appraisal skills alongside conventional health knowledge. Such programmes could teach participants how to identify credible sources, distinguish evidence-based recommendations from unsupported claims, compare information across trustworthy sources, recognize misleading health claims and determine when professional advice is required. Recent systematic-review evidence indicates that interactive educational approaches can improve health literacy and support healthier lifestyle behaviours, reinforcing the value of moving beyond passive information dissemination towards participatory learning.

Overall, the finding that only 51.1% of respondents demonstrated adequate information-appraisal ability, despite 63.6% demonstrating adequate access and understanding, provides strong empirical support for the study's underlying health information–practice gap. It suggests that the critical challenge may not simply be increasing the volume of health information available to adults, but strengthening their capacity to determine which information is trustworthy, relevant and actionable. This distinction is central to the development of effective adult health-education strategies in increasingly complex information environments.

11.3 Health Decision-Making and Healthy-Living Competencies

The finding that health decision-making ability was significantly associated with healthy-living competencies indicates that the capacity to translate health information into informed choices is an important dimension of healthy living among adults in Oyo and Ondo States. In the present study, 60.1% of respondents demonstrated adequate health decision-making ability, while 39.9% were classified as having inadequate ability. The significant association observed between decision-making ability and healthy-living competencies suggests that the usefulness of health information depends partly on an individual's capacity to interpret available options, consider potential consequences and apply relevant information to everyday health choices.

This finding is consistent with the multidimensional understanding of health literacy, in which accessing and understanding information represent only earlier stages of a broader process that includes appraisal and application. The World Health Organization emphasizes that health literacy encompasses people's ability to access, understand, appraise and use information and services in ways that promote and maintain good health. Within this framework, health decision-making represents an important point at which information-related competencies are translated into choices and actions. Thus, the significant relationship observed in the present study

is conceptually consistent with the proposition that health information becomes practically meaningful when individuals can use it to guide appropriate decisions.

Empirical evidence also supports a relationship between health literacy and health-related behaviour. A meta-analysis of 53 studies found a positive association between health literacy and healthy lifestyle behaviours, although the relationship was relatively modest and varied across behavioural domains (Elkin, 2024). Another meta-analysis involving more than 210,000 participants reported associations between health literacy, health behaviours and health outcomes and identified self-efficacy and attitudes as potential mechanisms linking health literacy with behaviour. These findings suggest that decision-making should not be understood as a purely informational process; rather, the translation of information into behaviour may depend on confidence, motivation, perceived benefits and barriers, social circumstances and the feasibility of available choices.

The 60.1% adequate decision-making level observed in this study is therefore encouraging but also indicates that a substantial proportion of adults may experience difficulty translating health information into appropriate decisions. This has particular relevance for preventive health practices. Adults routinely make decisions concerning nutrition, physical activity, preventive screening, self-care, medication use, healthcare utilization and responses to symptoms. Where individuals have difficulty interpreting competing recommendations or assessing the implications of different options, access to information may not necessarily result in appropriate action. Consequently, health education that focuses exclusively on increasing knowledge may have limited behavioural effects if it does not also develop practical decision-making competencies.

The finding is especially relevant within contemporary information environments where adults may encounter contradictory health recommendations from multiple sources. Digital platforms have expanded access to health information but have also increased the volume and diversity of messages that individuals must interpret. In such circumstances, decision-making requires individuals to consider the source, quality, relevance and potential consequences of information before acting on it. This reinforces the relationship between the three information competencies examined in this study: access provides the opportunity to obtain information, appraisal provides a mechanism for judging its credibility, and decision-making provides a pathway through which judged information can potentially inform behaviour.

The result also has implications for adult health education in Nigeria. Health-education programmes can strengthen decision-making by using practical and participatory approaches rather than relying predominantly on one-way information transmission. Case scenarios, problem-based learning, role play, decision aids and guided discussion can allow adults to practise responding to realistic health situations. For example, participants can be presented with conflicting health messages and asked to identify the relevant evidence, assess the credibility of the sources, consider possible consequences and determine when professional advice should be sought. Such approaches can help bridge the conceptual distance between knowing what constitutes healthy behaviour and being able to make decisions that support it.

However, the significant association identified in this study should not be interpreted as evidence of a causal relationship. The cross-sectional design does not establish whether stronger decision-making ability leads to better healthy-living competencies or whether individuals who already practise healthier behaviours are more likely to develop or report stronger decision-making skills. Other factors, including educational attainment, socioeconomic conditions, access to healthcare, family and community influences, cultural expectations and prior health experiences, may also affect both variables. Longitudinal and intervention studies would be required to determine the direction and mechanisms of the relationship.

Nevertheless, the finding provides useful evidence that health decision-making should occupy a more prominent position in adult health-education

interventions. The objective should not simply be to ensure that adults receive health information, but to equip them with the practical competencies required to interpret that information, weigh alternatives and make informed choices within the realities of their daily lives. Viewed alongside the findings on information access and appraisal, the result strengthens the argument that improving healthy living requires an integrated competency pathway extending from access, through appraisal, to informed decision-making and practical application.

11.4 The Health Information–Practice Gap among Adults

Taken together, the findings of this study reveal an important distinction between having access to health information and possessing the competencies required to translate that information into healthy living. While 63.6% of respondents demonstrated adequate capacity to access and understand health information, only 51.1% demonstrated adequate information-appraisal ability, and 60.1% demonstrated adequate health decision-making ability. At the behavioural competency level, 55.0% of respondents demonstrated satisfactory healthy-living competencies. The pattern suggests that the movement from information availability to practical health behaviour is neither automatic nor uniform.

The findings can be understood as representing a sequence of interconnected competencies. Access constitutes the initial opportunity to obtain health information; appraisal involves determining whether available information is credible, relevant and appropriate; decision-making concerns the use of evaluated information to select among health-related alternatives; and healthy-living competency represents the broader capacity to incorporate appropriate practices into everyday life. The observed differences across these stages suggest that weaknesses at any point in this sequence may limit the extent to which information contributes to healthier practices.

The most notable feature of the pattern is the difference between information access and information appraisal. Although nearly two-thirds of respondents reported adequate access and understanding, approximately half demonstrated adequate appraisal ability. This indicates that increasing the availability of health information alone may not be sufficient to address health-information challenges. In an environment characterized by multiple and sometimes conflicting information sources, individuals require not only opportunities to obtain information but also the skills to evaluate its credibility and applicability. This interpretation is consistent with contemporary health-literacy perspectives that conceptualize health literacy as a multidimensional capacity involving access, understanding, appraisal and application rather than information exposure alone.

The findings also suggest that the health information–practice gap is not exclusively an individual cognitive problem. Healthy-living practices are shaped by the social and material circumstances within which health decisions are made. Education, income, employment, food availability, physical environments, healthcare accessibility, social networks and cultural expectations can influence whether individuals are able to act on information they have received. Consequently, an adult may understand a recommendation concerning healthy nutrition or physical activity but face practical constraints that make sustained implementation difficult. The present findings should therefore be interpreted within a broader social and environmental understanding of health behaviour.

The relatively modest proportion of respondents with satisfactory healthy-living competencies reinforces this point. Although the overall mean score of 2.76 was above the study's decision benchmark, 45.0% of respondents were still classified as having unsatisfactory healthy-living competencies. This coexistence of generally favourable mean scores with a substantial proportion of respondents below the competency threshold demonstrates why population-level averages alone may obscure important pockets of vulnerability. Health-education interventions should therefore consider both average competency levels and the distribution of competencies across individuals and communities.

The three significant associations further indicate that the information-to-practice pathway involves

multiple, related capabilities. Access to credible information was significantly associated with healthy-living competencies, as was information appraisal and health decision-making. However, the cross-sectional nature of the study means that these relationships should not be interpreted as a sequential causal pathway. The results do not demonstrate that access produces appraisal, appraisal produces decision-making, or decision-making produces healthy-living competencies. Rather, they identify statistically significant relationships between these domains and provide empirical support for examining them as interconnected components of adult health competence.

From a health-education perspective, the findings favour a shift from an information-transmission approach to a competency-development approach. Traditional health education may emphasize providing adults with accurate information about disease prevention, nutrition, exercise and healthcare utilization. While accurate information remains essential, the present findings suggest that educational interventions should additionally develop the capacity to evaluate information, resolve conflicting messages, make contextually appropriate decisions and apply recommendations to everyday circumstances. Such an approach is particularly relevant in contemporary information environments where digital platforms have substantially increased both the availability and complexity of health messages.

The findings also support the integration of lifelong learning into community health promotion. Adults encounter changing health information throughout their lives, and the knowledge required to make appropriate health decisions may change with age, emerging health risks, technological developments and evolving public-health recommendations. Community-based learning opportunities can therefore provide continuing support for information appraisal and practical decision-making. Such initiatives may be delivered through health facilities, adult-learning centres, community organizations, workplaces, faith-based settings and digital platforms, depending on local circumstances.

Overall, the evidence indicates that the central challenge is not simply an absence of health information but a gap between information access, critical evaluation, informed decision-making and consistent healthy-living practice. Addressing this gap requires interventions that connect these competencies rather than treating health information dissemination as an end in itself. The findings consequently provide a useful basis for repositioning adult health education around practical health-information competencies capable of supporting informed and sustainable everyday health practices.

11.5 Implications for Health Education and Community Practice

The findings have important implications for the design and delivery of adult health education in Nigeria. The observed differences between access to health information, information-appraisal ability, health decision-making and healthy-living competencies suggest that health education should move beyond the conventional emphasis on information dissemination towards the development of practical health-information competencies. Providing accurate information remains fundamental, but adults also require the skills to identify credible sources, evaluate health claims, make informed choices and apply appropriate recommendations within their everyday circumstances.

First, health-education programmes should incorporate explicit information-appraisal skills. The relatively lower proportion of respondents demonstrating adequate appraisal ability compared with those demonstrating adequate access and understanding indicates a need to teach adults how to assess the credibility and relevance of health messages. Participatory and experiential approaches may be particularly useful because they can enable health learners to engage with health issues through contextualized and practical forms of knowledge rather than passive information reception (Onyebuchi-Igbokwe et al., 2025). Such approaches can complement conventional health-information delivery by encouraging dialogue, reflection and active engagement with health-related issues.

Second, health education should strengthen practical health decision-making. The significant association between decision-making ability and healthy-living competencies indicates the importance of helping adults move from knowledge to appropriate choices. Rather than relying exclusively on lectures or the provision of written materials, health educators can use case scenarios, demonstrations, role play, problem-solving exercises and decision-support tools. Such approaches can allow adults to practice applying health information to realistic situations involving nutrition, physical activity, preventive care, self-care and healthcare utilization.

Third, community health programmes should adopt a multichannel approach to health-information delivery. Radio and television remain important sources of information, while digital and online platforms increasingly provide opportunities for rapid communication with adult populations. However, the findings suggest that increasing the number of information channels should be accompanied by efforts to improve people's capacity to judge information quality. Partnerships among health educators, healthcare providers, community organizations and trusted media platforms could therefore help promote consistent, understandable and evidence-informed health messages.

Fourth, interventions should recognize that information alone does not determine healthy behaviour. The 45.0% of respondents classified as having unsatisfactory healthy-living competencies indicates that substantial behavioural challenges may remain even where health information is reasonably accessible. Community interventions should therefore consider practical barriers affecting the implementation of health recommendations, including economic circumstances, availability of healthy foods, opportunities for physical activity, access to healthcare services and social support. Health education may be more effective when combined with supportive community environments that make recommended behaviours realistic and sustainable.

Fifth, adult health education should be integrated into lifelong and community-based learning structures. Community health centres, adult-learning programmes, workplaces, local associations and other community platforms can provide continuing opportunities for adults to update their health knowledge and strengthen information-related competencies. Such programmes should be sensitive to differences in educational background, age, language and access to digital technologies so that improvements in health-information competency do not become concentrated among already advantaged groups.

The findings also have implications for health educators themselves. Professional preparation and continuing professional development should equip health educators with competencies in health-information evaluation, digital health communication and misinformation response. Rather than functioning primarily as transmitters of health information, health educators can increasingly serve as facilitators who help individuals develop the capacity to locate, interpret, evaluate and apply health information. This role is particularly relevant where adults are exposed to competing health claims across interpersonal, broadcast and digital communication environments. At the community level, locally appropriate approaches should be encouraged. Health messages can be communicated using accessible language and culturally relevant examples, while community-based educators and healthcare workers can provide opportunities for clarification and dialogue. Such approaches may help reduce the distance between formal health information and the everyday realities in which adults make health decisions. In multilingual and socially diverse communities, attention to language accessibility is particularly important because information that is technically accurate but difficult to understand may have limited practical value.

Finally, the findings provide a basis for strengthening monitoring and evaluation of health-education interventions. Programme assessment should not be restricted to whether participants received or remembered health information. Indicators should also examine whether participants can identify credible sources, appraise health messages, make informed decisions and demonstrate relevant healthy-living competencies.

This broader evaluation approach would provide a more meaningful assessment of whether health education is contributing to the translation of information into practical health competence.

Overall, the study supports a competency-oriented model of adult health education in which access to credible information is treated as the starting point rather than the endpoint. Strengthening information appraisal, decision-making and practical application alongside information access may provide a more comprehensive approach to addressing the health information–practice gap among adults in Oyo and Ondo States. Because the present study is cross-sectional, these implications should be regarded as evidence-informed directions for intervention and further research rather than evidence that any particular intervention will necessarily produce causal improvements in healthy-living competencies.

12. CONCLUSION AND RECOMMENDATIONS

12.1 Conclusion

This study examined the relationship between health-information competencies and healthy-living competencies among adults in Oyo and Ondo States, Nigeria. The findings indicate that although a majority of respondents demonstrated adequate capacity to access and understand health information, fewer demonstrated adequate information-appraisal ability, while a substantial proportion reported less satisfactory healthy-living competencies. Significant associations were observed between access to credible health information, information-appraisal ability, health decision-making and healthy-living competencies.

The findings highlight an important distinction between having access to health information and being able to translate that information into appropriate health practices. Access provides an essential foundation, but critical appraisal and informed decision-making are also relevant to the effective use of health information. The observed information–practice gap therefore suggests that adult health education should not focus exclusively on increasing the quantity of information available to individuals. Greater emphasis is required on developing practical competencies that enable adults to identify credible information, evaluate health messages, make informed decisions and apply appropriate recommendations within their everyday circumstances.

The study consequently concludes that strengthening adult health-information competencies represents an important direction for health education and community health promotion. However, given the descriptive cross-sectional design, the observed associations should not be interpreted as evidence of causality. Further longitudinal and intervention-based research is required to determine how improvements in information appraisal and health decision-making may influence healthy-living competencies over time.

12.2 Recommendations

Based on the findings, the study recommended that:

1. Health educators should integrate information-appraisal skills into adult health-education programmes. Adults should be taught practical methods for identifying credible health sources, evaluating health claims, comparing information and recognizing potentially misleading or unsupported health messages.
2. Health-education programmes should strengthen practical health decision-making. Participatory methods such as case studies, role play, problem-solving exercises and realistic health scenarios should be incorporated to help adults apply information to everyday health choices.
3. Community-based health-information initiatives should adopt multiple communication channels. Health facilities, community organisations, radio, television and appropriate digital platforms should be used to improve access to understandable and credible health information while simultaneously strengthening users' ability to evaluate such information.
4. Health promotion should address practical barriers to healthy living. Information provision should be complemented by

interventions that recognize relevant social, economic and environmental conditions affecting nutrition, physical activity, preventive practices, self-care and healthcare utilization.

5. Lifelong health education should be strengthened within community and adult-learning structures. Community health centres, workplaces, adult-learning programmes and other appropriate community platforms can provide continuing opportunities for adults to update health knowledge and develop health-information competencies.
6. Health educators should receive continuing professional development in digital health communication and information evaluation. Strengthening educators' capacity to identify, communicate and respond to inaccurate or misleading health information can improve the quality of information available to adult populations.
7. Future research should employ longitudinal and intervention designs. Such studies would help establish temporal relationships and determine whether targeted improvements in information appraisal and health decision-making are associated with subsequent improvements in healthy-living competencies.
8. Future studies should examine contextual and socio-demographic differences. Further research should investigate how factors such as age, educational attainment, socioeconomic circumstances, residence, digital access and healthcare accessibility interact with health-information competencies and healthy-living practices.

13. Limitations of the Study

This study has several limitations that should be considered when interpreting its findings. First, the descriptive cross-sectional design permits the identification of associations among health-information competencies and healthy-living competencies but does not establish temporal sequence or causality. The significant relationships observed between information access, information appraisal, health decision-making and healthy-living competencies should therefore not be interpreted as evidence that one variable directly causes changes in another.

Second, the study relied primarily on self-reported questionnaire data. Respondents may have provided answers that reflected socially desirable health behaviours or may have experienced difficulty accurately recalling their information-seeking practices and health-related behaviours. Consequently, some degree of reporting or recall bias cannot be excluded.

Third, the study was conducted among adults in Oyo and Ondo States, and the findings should therefore be interpreted within the geographical and sociocultural context of these states. Differences in socioeconomic conditions, health-service availability, educational opportunities, digital connectivity and cultural practices across other parts of Nigeria may limit the direct generalization of the findings to the national adult population.

Fourth, the classification of respondents into adequate/inadequate information competencies and satisfactory/unsatisfactory healthy-living competencies was based on the study's specified measurement and decision criteria. Alternative measurement instruments or cut-off points could produce somewhat different classifications. Future research could strengthen the evidence base by incorporating validated health-literacy instruments alongside objective measures of health-information evaluation and behavioural practices.

Finally, the study examined selected health-information competencies and healthy-living domains and did not comprehensively account for all contextual factors that may influence health behaviour. Variables such as household income, food affordability, healthcare accessibility, social support, environmental conditions and digital health literacy may also contribute to healthy-living competencies. Future studies should consider these factors and employ longitudinal, mixed-methods or intervention designs to provide a more comprehensive understanding of how adults translate health information into sustained health practices.

Despite these limitations, the study provides useful empirical evidence on the relationship between health-information competencies and healthy-living

competencies among adults in Oyo and Ondo States and highlights the importance of moving beyond information access towards critical appraisal, informed decision-making and practical application.

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