Mehmet Akif Ersoy Üniversitesi
Sosyal Bilimler Enstitüsü Dergisi
ISSN: 1309-1387
Cilt: 9 Sayı: 22 2017 Aralık (s. 194-206)

THE RELATIONSHIP BETWEEN THE HEALTH AND MEDIA LITERACY: A FIELD STUDY

SAĞLIK VE MEDYA OKURYAZARLIK ARASINDAKİ İLİŞKİ: BİR ALAN ÇALIŞMASI [1]

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Abstract

Health literacy and media literacy are important indicators for development a region. Aim of the study was to determine the health and media literacy levels of people and the relationship between two types of literacy in Mut County, Mersin/Turkey. This is a descriptive study. The survey was conducted among 275 people using a standard questionnaire. The data were collected via survey technique. The questionnaire includes respondent's socio-demographic background, media literacy scale and HLS-EU (Health Literacy Survey-Europe) scale. It was found that general index score for health literacy was 35.99 in Mut province. It was determined that 10% of the participants were "inadequate", 27 % of them were problematical and % 23 of the respondents was excellent in term of general health literacy. Total media literacy level of the participants was 3.89. A positive and medium level relationship was found between health literacy and media literacy levels. According to study results, the participants had an average knowledge on the health and media literacy level in Mut province.

Keywords: Health literacy, media literacy, health, media, literacy

Öz

Bir bölgenin gelişmişlik düzeyini gösteren sağlık okuryazarlığı ve medya okuryazarlığı önemli kavramlardır. Bu çalışmanın amacı, Mersin'in Mut ilçesinde ikamet eden bireylerin sağlık ve medya okuryazarlık düzeyi ve bu iki okuryazarlık arasındaki ilişkiyi tespit etmektir. Tanımlayıcı tipte olan bu çalışmada 275 kişiye ulaşılmıştır. Veriler anket yoluyla toplanmıştır. Verilerin toplanmasında katılımcıların sosyo-demografik özelliklerine ait sorular, medya okuryazarlık ve SOYA-AB (Sağlık Okuryazarlığı Anketi-Avrupa Birliği) ölçeği kullanılmıştır. Mut ilçesinin sağlık okuryazarlık genel indeks puanı 35.99 bulunmuştur. Genel

[1]This study was presented as an oral presentation in International Congress on Political, Economic and Social Studies Sarajevo- Bosnıa Herzegovına (19-22 May 2017)

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Başvuru Tarihi: 19.04.2017
Yayına Kabul Tarihi: 19.12.2017
DOI: 10.20875/makusobed.307031

sağlık okuryazarlığının kategorik değerlendirmesinde ilçenin %10'u "yetersiz", %27'si sorunlu, %40'ı yeterli ve %23'ünün ise mükemmel olduğu saptanmıştır. Toplam medya okuryazarlık düzeyi ortalaması ise 3.89 bulunmuştur. Sağlık okuryazarlığı ve medya okuryazarlık düzeyi arasında ise pozitif ve orta düzeyde bir ilişki ortaya çıkmıştır. Çalışma sonuçlarına göre; Mut ilçesinde sağlık ve medya okuryazarlık düzeyi, katılımcıların özellikleri dikkate alındığında, yeterli bir düzeyde olduğu saptanmıştır.

Anahtar Kelimeler: Sağlık okuryazarlığı, medya okuryazarlığı, sağlık, medya, okuryazarlık

1. INTRODUCTION

Literacy is the primary skill which will allow individuals to actively participate in the social life and increase their life quality (Aslantekin and Yumrutaş, 2014: 327). The idea of literacy conjures up different images for different people (Veronica, 2011). In the traditional sense, the concept of literacy is defined as the reading and writing skills of the individual (Sezgin, 2013: 76). The establishment of the Experimental World Literacy Program in 1966 used what they termed a functional definition, "A person is functionally literate who can engage in all those activities in which literacy is required for effective functioning of his (her) group and community and also for enabling him (her) to continue to use reading, writing and calculation for his (her) own and the community's development" (UNESCO, 1978). That United Nations declared the year 1990 as "international literacy year" increased the interest in the concept of literacy and defined many literacy areas. Health literacy and media literacy are also included in these defined literacy concepts (Kurt and Kürüm, 2010: 21).

The complex structure of the health system produces problems of correct perception and understanding in terms of those who are served. The diagnosis and treatment processes of people who cannot understand the health service he/she is receiving or will receive are far from desired. The capacity of individuals to obtain information about the service they receive, to interpret and understand it is important. Therefore, the satisfaction of individuals who are health literate for the health service they receive will be higher.

The importance of media literacy is obvious for individuals to be able to understand the world and the time they live in with a holistic approach and define what they experience. When it is considered that the interaction areas of health literacy are health system, cultural social factors and education system, the contribution of media literacy in this regard should be taken into consideration. The fact that the direct target of health literacy and media literacy is the whole society requires these two issues to be studied together.

1.1. Health Literacy

Health system and services have a quite complicated structure. Health system users need to be informed about the provided services in order to benefit from these services. Within this scope, they have different responsibilities for making decisions in their own health needs. So, individuals should have necessary level of health literacy in order to make correct health decisions (Ilgaz and Gözüm, 2016: 67).

Health literacy was first used by Scott Simmons as a term in 1974 in an article titled "Health Education and Social Policy" (Akbolat et al, 2016: 355). However, its common use in the literature started after a study called National Assessment of Adult Literacy (NAAL). The concept still exists as an important matter attracting the attention of health researchers, law makers and clinicians in the area of health services and public health (Balçık et al, 2014: 321). Researchers and policy makers frequently define the expression of health literacy as "a set of skills required for functioning in health environment" (De Walt et al., 2004: 1228). Health literacy is a process allowing development of public health and increase of control (Nutbeam, 1998: 357). There are

important differences between the online learning processes of people with limited health literacy and those with adequate health literacy, which may cause the former to benefit less from the Internet as an informational source for learning about one's condition and management (Yom-Tov et. al, 2016: 1111).

Health literacy represents the social and cognitive skills determining the motivations and skills of individuals in using information, comprehension and reaching information for sustaining and developing the well-being in health (Nutbeam, 1998: 357). According to Nutbeam (1998), health literacy has three levels. These are basic/functional health literacy, interactive health literacy and critical health literacy.

1) Basic/functional health literacy: It (health literacy) is based on basic reading and writing skills and individuals in this level can read educational material in the subjects of health risks and use of health services (Aslantekin and Yumrutaş, 2014: 330). Also, this level of health literacy focuses on the relation between literacy skills and health outputs (De Walt et al., 2004: 1228).

2) Interactive health literacy: It is cooperation with others in developing and encouraging the self-management of the individual (Uğurlu, 2011: 8). It is related to the skills of an individual to participate in daily life with cognitive and social skills, ability to obtain information, interpreting different types of communication. Thus, health literacy includes the motivation of an individual to access health information as well as cognitive and social skills (Tanrıöver et al., 2014: 18). Health literacy comprises the expectations of individuals, their choices, skills of individuals seeking information about the issue and services meeting their expectations (Bohlman et al., 2004: 2).

3) Critical health literacy: It includes a higher level of developed cognitive and social skills (Ilgaz and Gözüm, 2016: 73). The individual is expected to correctly interpret and evaluate the health information obtained from health service providers and included in the media. If the individual evaluates and questions the given information, an apparent social gain will be acquired in addition to the individual gain (Sezgin, 2013: 78).

In order to better understand the concept of health literacy, factors that affecting the health literacy level and results of health literacy should be known (Balçık et al., 2014: 324) because health literacy is beyond individual information acquisition. The intersection of health services provided here and socio-cultural factors and educational levels of individuals is important (Bohlman et al., 2004: 2). Also, the health literacy is affected by demographical, cultural and psycho-social factors, general level of literacy, individual characteristics, experiences about illness and factors about health service system (Balçık et al., 2014: 324).

1.2. Media Literacy

One of the biggest differences in our age compared to the past terms is the development of mass communication technologies and availability of these in a large part of daily life. The media has many properties and functions which comprises an important part of daily life. Media naturally has undesired effects as well as its benefits. Recent years, important studies have been carrying out on the effects of media use on individuals. Particularly, there are suggestions on measures against negative effects of media. The concept of media literacy is actually these concerns in flesh and bone.

Multiple literacy types which computer and communication technologies seen as new types of literacy are intensely used. They are evaluated within social and cultural change process. These multiple literacy areas will lead to the integration of individuals comprising the society with information, welfare and social development (Önal, 2010: 117).

Media literacy is a concept known and included in educational programs for nearly 50 years with the introduction of mass communication tools to social life in countries like England, Canada and primarily America (Kıncal and Korkmaz, 2015: 76). Media literacy has two basic points. First of them is the skill to use technology to access the content in media and the second is the skill not only to understand the presented content but also to evaluate this content (Solmaz and Yılmaz, 2012: 56). Individuals with media literacy need to have some thinking skills in order to become more critical consumers in the media consumption. A media literate individual chooses and uses media on a purpose and tries to access valid and reliable information. The media literate individual, who is aware that messages in the media are constructed as a result of planned work and by which tools the media messages are constructed, indicates questioning behavior with these characteristics (Kurt and Kürüm, 2010: 23).

While the period we live in is called "the age of things", the most distinct characteristics of this period is that it transforms people into a fictionalized world and individuals functionalized as obedient actors of this world. In this period, the behaviors of individuals are affected and the understanding of constantly consuming and living for consuming is made to prevail. In such an environment, individuals are obliged to keep up with the age of things even reluctantly in the misleading reality presented by mass communication tools (Yurttaş and Şişman, 2012: 454).

Media literacy is defined as the skill to access to written and unwritten messages in different forms (television, video, cinema, advertisements, internet etc.), analyze them, assess and transmit those. Elizabeth Thoman, who is the founder and head of Center for Media Literacy emphasized that the media literacy is an act which requires the students not only to read the media product they see, but also to participate actively in the creation process of it (Cited by: İnceoğlu, 2006: 4).

First of all, efforts are needed to provide more information and skills about media analysis and production by reaching more educators, children and young people through well-organized programs, activities and educational experiences. Secondly, it is important to develop theories and researches to document, measure and evaluate the complicated learning and teaching processes about media with this important audience. Only through the information and evidences to be obtained from these two types of actions the hope may be increased to solve great discussions about the media (Hobbs, 2004: 136).

It was seen that the studies in the area of media literacy in a media literacy course program weren't examined with a comprehensive and up-to date point of view. When the program is examined within itself, it may be suggested to have an internal consistency. However, there are inconsistencies when issue is examined in terms of media literacy. Especially when the content of the program (units) are examined, it is seen that the selective media literacy class remains at the level of media introduction rather than media education. This situation may have resulted from disregarding the academic background in the area of media literacy in program preparation (Altun, 2009: 107-108).

Again in local media knows the region and the people who are living in the region very well, local people may see the problems and development of their own region, their own voice and face. It may help people to better understand the issues and embrace the issues related to them. Thus, the opportunities provided by the local for effective media literacy are much more than those provided by the national one. However, the facts that the local media institutions are not or cannot be completely independent in terms of economy and policy

transforms the opportunities seen at the hands of local people for effective media literacy into impossibilities (Nacaroğlu, 2006: 87).

Therefore, purpose of the study was to determine the health and media literacy levels of people who are living in Mut province of Mersin, Turkey and the relationship between two types of literacy. We started this study with research questions like what is media and health literacy level of Mut populations and is there any relationship between media and health literacy? We tried to find out the media and health literacy level of the populations and the relationship between the literacy.

2. MATERIALS AND METHODS

A descriptive study was carried among the people who live in Mut County of Mersin province, Turkey. We included people who live in Mut county and aged between 18- 65. We excluded the people who came to Mut for visit their relatives, friends and tourist. Whose age under 18 or above 65 years old was excluded because they could not understand the questions on the survey. Data was collect by researchers from February to October 2015 at study center

A standard questionnaire was used to data collection. The questionnaire contains three parts such as socio–demographic, media literacy and health literacy. The first part about socio-demographic factors, this part was developed by the researchers. The second part is about media literacy which was developed by Karaman and Karataş (2009). There are 17 questions in this part. The questions have five options such as 1=never, 2=seldom, 3= some times, 4= most of the time and 5= always. As the score increases, the media literacy level of people also increases.

The third part of the study is health literacy scala, the scala was developed by The European Health Literacy Consortium (HLS-EU-2012). The scala was translated into Turkish and reliability and validity tests were done by Tanrıöver et al. (2014). There are 47 questions in the scala. There are four options such as 1= so difficult, 2= difficult, 3= easy, 4= very easy. The scala consists of three parts; health care (HL-16 items), disease prevention (DP-16 items) and health promotion (HP-15 items). Each of these parts have four dimensions which are accessing health information (FHI), understanding health information (UHI), judging health information (JHI) and applying health information (AHI). Alongside a general health index (GHL) comprising all 47 items was calculated.

Sample size was calculated based on the formula (Sümbüloğlu and Sümbüloğlu, 2007).

$$n= \frac{t^2pq}{d^2} = \frac{(1,96)^2(0,24*0,76)}{0,0025^2} = 276$$

Based on the calculation our sample size should be 276 for our study. In order to data collection we have visited house to house and government workplace. Total 298 data was collected and then 23 data was excluded because so many questions were not answered. Also index scores were only computed for respondents who had rated (validly answered) at least 80% of the items associated to the specific indices. Total 275 data were collected.

Based on the previous study, health literacy parameters median was used in order to get index. Respondents were calculated according to index. These indices were standardized according to unified metric with a minimum 0 and a maximum 50, where 0 represents the least possible health literacy and 50 represents the best possible one. Formula; Index= (mean-1) x (50/3), the specific index was calculated; Mean is the mean of all participating items for each individual; 1 is the minimal possible value of the mean (leads to a minimum value of the index of 0); 3 is the range of the mean; 50 is the chosen maximum value of the new metric.

For the four indices (general, healthcare, disease prevention, health promotion) the values were set, dividing the scores into 4 categories: 'inadequate' (0-25 score), 'problematic' (>25-33 score), 'sufficient' (>33-42 score) and 'excellent' (>42-50 score) health literacy.

In this study independent variables are the participant's socio-demographic information such as occupation, age, gender, education background etc and the dependent variables are media and health literature scores. The collected data were analyzed using SPSS version software. Descriptive statistics were used to describe the study population. The skewness and kurtosis test were used to check whether the data normally distribution or not. The t-test and Anova test were used to identify a relationship between the literacy and other factors. Correlation analysis was carried out for the association of health and media literacy variables. The reliability of the scales was measured using Cronbach alpha. The results show that Cronbach alpha was 0.94 for the media literacy and 0.98 for the health literacy.

3.RESULTS

Table 1. Socio-demographic characteristics of respondents

Variable	Groups	N	%
Gender	Female	135	49
	Male	140	51
Occupation	Public servant	112	41
	Housewife	33	12
	Unemployed	6	2
	Self-employment	55	20
	Other	69	25
Age	18-28	82	30
	29-38	79	29
	39-48	47	17
	49-65	67	24
Marital Status	Married	187	68
	Single	88	32
Education	Literacy/ Elementary School Graduate	37	14
	High School Graduate	91	33
	Diploma	47	17
	University/Master	100	36
Income Status	Bad	23	8
	Average	146	53
	Well	96	35
	Very well	10	4
House	Rent	101	37
	Own house	165	60
	Other	9	3
Social Security	Yes	218	79
	No	22	8
	Other	35	13
Do you enjoy watching TV?	Yes	152	55
	No	24	9
	Partially	99	36
How many hours do you watch television?	Less than 1 hour	21	8
	1-5 hours	104	38
	6-10 hours	96	35
	10-20 hours	37	14
	More than 20 hours	17	6
Do you read the newspaper daily?	Yes	88	32
	No	80	29
	Partially	107	39
Is there computer?	Yes	200	73
	No	75	27
Do you use the Internet?	Yes	206	75
	No	69	25
Total		275	100

Table 1 shows socio-demographical characteristic of the participants of the study. Of the participants, 51% were males, 41% were public officers, 30% was in 18-28 age group, 68% were married, 36% had graduate/master level degree, 53% had a medium level of income, 60 % owned their own houses, 79% had social insurance. Also, of the participants, 55% reported that they like watching television and 38% of this rate watching television for 1-5 hours per day. 39% of participants reported, they partly read daily newspapers. 73% of participants own computers and 75% of respondents reported that they are using internet. The participants had read an average 6 books in a year in the province (Min 0-Max 150).

Table 2: Descriptive statistics of variables (N=275)

	Min	Max	Median	Std. Error of Mean	SS	Skew.	Std. Error of Skew.	Kurtosis	Std. Error of Kurtosi
GEN-HL	1.53	4	3.16	0.03	0.49	-0.09	0.15	-0.36	0.29
ML	1.06	5	3.89	0.05	0.77	-0.75	0.15	0.64	0.29

Parametric tests were carried out considering skewness and kurtosis test results (Table 2). Skewness between -1 and +1, and kurtosis between -2 and +2 can be used as indications regarding normality. Standard errors of kurtosis and skewness values can be determined and accepted as normality in conditions with result value/SH<2 (Şenocak, 2014: 144). Also, Tabachnick and Fidell (2013), stated that kurtosis and skewness values indicated normal distribution when they are between the values of +1.5 -1.5.

Table 3: Average Values of General Health Literacy Index and Sub Literacy Index and Related %95 Reliability Intervals

	Median Index Score	95% Confidence Interval for Mean	
		Lower Bound	Upper Bound
General health literacy (HL)	35.99	35.02	36.95
Health care (HC-HL),	36.29	35.29	37.29
Disease prevention (DP-HL)	35.83	34.79	36.87
Health promotion (HP-HL)	35.83	34.74	36.91
Finding health information (FHI)	36.33	35.31	37.35
Understanding health information (UHI)	36.84	35.83	37.86
Judging health information (JHI)	35.77	34.73	36.80
Applying health information (AHI)	34.99	33.92	36.07
HL: Health Literacy			

Table 4: Prevalence of General Health Literacy Index and Sub Literacy Index

	Inadequate HL (%)	Problematic HL (%)	Sufficient HL (%)	Excellent HL(%)
GHL	10	27	40	23
HC-HL	11	20	45	25
DP-HL	8	28	36	28
HP-HL	15	18	41	27
FHI	10	20	42	28
UHI	9	21	40	31
JHI	13	21	42	25
AHI	14	27	34	26

The distribution average health literacy and percentage of three main and four sub-index are presented in Table 4. General health literacy index was found to be 35.99 (Table 3). Health literacy, as measured by the HLS-EU-Q items, an average score of health care was higher (mean= 36.29) than disease prevention (mean= 35.83) and health promotion (mean= 35.83) in the total sample.

The following score intervals were chosen for the four levels of general health literacy (Table 4): 10% for 'inadequate', 27% for 'problematic', 40% for 'sufficient' and 23% for 'excellent'.

Table 5: General health literacy index and averages media literacy score by Socio-demographic characteristics of participants

		GHL index	SS	t	p	ML Med.	SS	t	p
Gender	**Female (n=135)**	36.33	0.51	0.68	0.49	3.81	0.74	-1.74	0.08
	Male (n=140)	35.66	0.46			3.97	0.80		
Marital Status	**Married (n=187)**	35.02	0.49	-2.91	0.00	3.84	0.79	-1.45	0.15
	Single (n=88)	38.04	0.45			3.99	0.73		
Use the internet	**Yes (n=206)**	36.86	0.50	3.14	0.00	4.04	0.72	5.58	0.00
	No (n=69)	33.37	0.42			3.46	0.79		
Income Status	**Bad/ Average (n=169)**	34.90	0.48	-2.85	0.00	3.75	0.82	-3.82	0.00
	Well/Very well (n= 106)	37.73	0.48			4.11	0.64		
		GHL index	**SS**	**F**	**p**	**ML Med.**	**SS**	**F**	**p**
Education	**Literacy/ Elementary School Graduate (n=37)**	32.73	0.48	3.71	0.01	3.22	0.87	13.85	0.00
	High school (n=91)	35.90	0.46			3.90	0.78		
	Ön Lisans (n=47)	35.12	0.52			3.91	0.71		
	Lisans/Master (n=100)	37.68	0.48			4.12	0.62		
	Total	35.99	0.49			3.89	0.77		
Age group	**18-28 (n=82)**	37.47	0.45	3.21	0.02	3.91	0.66	0.99	0.40
	29-38 (n=79)	36.95	0.52			3.99	0.77		
	39-48 (n=47)	34.82	0.49			3.85	0.79		
	49-65 (n=67)	33.86	0.46			3.78	0.89		
Occupation	**Public servant (n=112)**	36.32	0.53	1.19	0.32	4.01	0.75	4.35	0.00
	House wife (n=33)	33.97	0.47			3.47	0.90		
	Self-employment (n=55)	35.29	0.50			3.94	0.70		
	Other (n=75)	36.29	0.42			3.87	0.75		
Reading newspaper	**Yes (n=88)**	37.39	0.43	1.95	0.15	4.05	0.72	5.46	0.00
	No (n=80)	35.33	0.55			3.67	0.88		
	Partially (n=107)	35.32	0.48			3.92	0.70		

Table 5 shows general health literacy index and averages media literacy score by socio-demographic characteristics of participants based on t-test. The statistical analysis results demonstrated there was no

significantly difference between the two literacy (general literacy index and media literacy score) of the participants and gender (p>0.05). The general literacy index and media literacy score was significantly difference by internet use and income level (p< 0.05). There was no significantly difference between media literacy and marital status (p>0.05), but there was significantly difference between general health literacy index and marital status (p< 0.05). There was significantly a difference between the both literacy and educational level (p< 0.05). When general health literacy index and media literacy average scores were evaluated according to the educational level, the results demonstrated that master's degree holders had highest score while primary education degree holders had lowest score. When we look at health literacy levels of the participants and age groups,-there was significantly difference (p< 0.05), while there wasn't statistical difference between age groups and media literacy levels (p> 0.05). There was no significantly difference between general health literacy index and occupation groups and newspaper reading of participants (p> 0.05), while there was difference between occupational groups and media literacy scores of the participants (p< 0.05).

Table 6: Correlation test on health literacy and media literacy

		GHL	ML
GHL	Pearson Correlation	1	0.438**
	p		0.000
ML	Pearson Correlation	0.438**	1
	p	0.000	

**. Correlation is significant at the 0.01 level (2-tailed).
Listwise N=275
r<0.30 low-level relationship, 0.30<r<0.69 mid-level relationship, r≥0.70 high-level relationship (Geçgil and Tikici, 2016).

As seen in Table 6, there was a positive and mid-level relationship was between health literacy and media literacy (r= 0.438, p< 0.01).

4. DISCUSSION

Individuals are required to access, comprehend, assess and implement information about health service provision, protection from disease and development of health. In the light of this information, the individuals' making correct decisions for developing the quality of life for now and future, their motivations for implementation and capacities are related to their status of health literacy.

Today, when the expression of global village is widely used, mass media brings the world closer. An age has come in which mass media use has increased considerably and individuals are being effected consciously or unconsciously. While mass media continues its existence on the axis of managing and directing the perception of individuals, affection too many individual can ignite fuse of social events in a chain reaction. Therefore, correct comprehension of media by the individuals would decrease the possibility of negative influences. Increase in the number of individuals with media literacy in society will form a resistance against its negative effects.

Aim of this study was to determine the health and media literacy levels of people who are living in Mut province of Mersin, Turkey and the relationship between two types of literacy. General health literacy index of Mut county was found to be 35.99. In categorical evaluation of general health literacy, 40% of the county was found to be adequate and 23% was found to be excellent. Total media literacy level of the participants was 3.89. A positive and medium level relationship was found between health literacy and media literacy levels. According to study results, the participants had an average knowledge on the health and media literacy level in Mut province.

A health literacy study from Turkey (Tanrıöver et al, 2014: 93) reported only 35.4% of the society has adequate or excellent health literacy. In the study, literacy levels of participants differed according to their educational status. It is thought that literacy level increases as educational level increases. Health literacy is related to the general level of reading. Weak reading skills limit the personal, social and cultural development of individuals and directly influence human health by preventing the development of health literacy (Nutbeam, 1998: 357). When the ages and literacy levels of the individuals were evaluated, there was no difference found between media literacy level while a difference was found for health literacy level. In the study of Tanrıöver et al. (2014: 93), it was found that as age increases and educational level decreases, health literacy decreases linearly. However, even patients with a high literacy or educational level sometimes have difficulties in comprehending complicated health information. In this regard, it is possible to say that health literacy is effective in realizing many tasks such as getting appointment, approval and completing insurance forms, explaining their medical history to the doctor, comprehending information about pre- and post-operational care and applications (Keser and Çıracıoğlu, 2015: 53). When marital status and health literacy index was evaluated, there was a difference between married and single people in terms of literacy. Health literacy index of single individuals is higher than the married people. When evaluated in terms of media literacy, there is no meaningful difference bur similar findings were obtained with health literacy.

In gender evaluation, no difference was found about literacy (health and media) levels. However, health literacy index of females is higher than that of males. In the study of Tanrıöver et al. (2014: 93), the literacy level of females was found to be lower than the males. In terms of media literacy, average literacy values of males are higher than that of females. In the study of Karaman (2016: 326), males' media literacy levels and critical thinking dispositions are higher than those of female. According to the results of another study, there was no meaningful difference between female and male students in terms of media literacy scientifically although the media literacy levels of female students were (Aktı and Gürol, 2012: 243).

A difference was found between the income levels of participants. General health literacy index and media literacy scores of individuals with higher income levels were also higher. Thus, it is considered that higher income level may affect the literacy level because high income levels may provide an advantage in accessing and assessing information. Literacy levels of individuals using internet are high. It can be considered that these individuals are more capable of accessing and analyzing information. Health information and effective use of this information are important for supporting health literacy (Nutbeam, 1998: 357).

In the study, 55% of the participants indicated they liked watching television. On media literacy found very important finding such as small size families may be passive and active in front of television from time to time and families have the potential to assess and criticize media with their active position. Primary reasons for being passive are tiredness and busyness and the content of television defined as low in quality. All families want to protect their children from negative effects of television. These findings also indicate their desire for a planned and programmed education (Özsoy, 2010: 57-58).

According to data obtained from a study carried out by RTÜK (2012: 7), when the frequency of use of communication tools is examined, the communication tools used most frequently are television and computer. Least frequently used communication tools by the students are telephones, radios and magazines/newspaper. It was found in the study that 73% of participants have own computer and 75% of them were used internet. Also, there was a difference between newspaper reading rates of participants and media literacy scores. In the study,

32% of the participants stated that they read newspaper daily, and 36% of them stated they read sometimes. As the newspaper reading rate was considered to be inadequate, it is considered that programs should be developed for reading.

One of the most important findings of the study was the detection of a positive and medium level relation between health literacy and media literacy. The detection of a positive and medium level relation between health literacy and media literacy in the participants in Mut county was important. In the light of obtained data, the result to obtain was that the steps to be taken in both issues would contribute to the other positively. This result is important although it was obtained from a limited area because it provides a scientific justification to the fact that developing the literacy will also develop the others.

Use of mass communication tools is also one of the strategies for developing health literacy level (Gönenç, 2015: 69). The advantages provided by the media to reach large masses in a fast way may also provide important functions in providing health information. The first issue to note in health information sharing through media is the media literacy status of the audience. In a society with low media literacy, provided information will not contribute to the health literacy. It will even cause more harmful results in addition to not making positive contributions even if it isn't desired. Both media literacy and health literacy of the individuals in the society should be increased with conscious steps in a way to complete each other.

5. CONCLUSION

This study was examined media and health literacy of people who live in Mut county of Mersin, Turkey. Generally, the participants had an average knowledge on the health and media literacy. There is no significantly difference between both literacy and gender. Respondents who had higher education and high income had good knowledge on media and health literacy. It is also found that public servants had good knowledge on the both literacy.

The level of knowledge on the both literacy was higher among good educated, high income and public servant respondents so the Mut County should promote the media and health literacy through seminars, radio and TV programs, newspaper, posters etc to increase the population's literacy and more focuses on housewives and self employees. Furthers research should conduct in different location and bigger sample size.

6. ETHICS

An official permission was obtained from the Health and Social Services Workers Association, Mut county local government and Mut Health Department to carry on the study. Verbal consent was obtained from each individual study participants.

7. LIMITATIONS

There are some limitations in this study. First, the data was collected using selfadministered questionnaires so information bias may occur since the questionnaires may generate biased and preconceived answers. Second. The results obtained in this study should not be generalized to all Mut or Mersin population since this study was carried out among small number of Mut population.

8. ACKNOWLEDGEMENT

The authors would like to thank Mut county government for giving permission for the study. The authors also like to thank all the people who participated in the study, F. Nihan Ready for helping with data analysis.

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