

Promoting Reproductive Health Preventive Behaviours in Married Women Workers

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ABSTRACT

This study was conducted in order to determine the knowledge levels, behaviours and attitudes of married women workers about reproductive health preventive behaviours. This study was carried out semi-experimental research. Population of the research was consisted of 160 women who work in factory A. 25 volunteer women who were chosen by convenience sampling method were included to "Reproductive Health Education Programme". The research data were collected by using a "Women Information Form", "Women's health knowledge test" and "The Scale for Determining the Reproductive Health Preventive Attitudes of Married Women" was used. It was determined that, women workers' knowledge levels, behaviours and attitudes about reproductive health preventive behaviours were inadequate and there weren't any comprehensive education programmes in A factory. When the efficacy of the health education programme for women was evaluated, it was found that the programme was successful in general; the difference before and three months after education for Women Health Knowledge Test, Total Scale Point and subscale points of "Preventing Genital Infections", "Visiting Doctor In Reproductive Health Related Issues", "Preventing Reproductive System and Breast Cancers", "General Health Behaviours for Preventing Reproductive Health" were statistically significant. It has been determined that there is a significant difference between the reproductive health of women who Pre-training and Post-training and that training positively affects the reproductive health practices of women. It has been determined that the training provided to women is an effective initiative in increasing the reproductive health practices of women.

Keywords: Reproductive health, education, working women

INTRODUCTION

Reproductive health has been defined as "Within the framework of WHO's definition of health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so." by The World Health Organisation (1, 2, 3, 4). Reproductive health has also been recognized as the situation where individuals experience

a satisfying and safe sexual life and have the freedom to decide whether or not to use their reproductive abilities as well as when and how often to use them (5, 6).

Accordingly, reproductive health includes a state of complete mental and social well-being along with the freedom to make decisions. However, many women from all over the world do not have access to reproductive health and cannot exercise their rights with regard to reproductive health due to various reasons associated with gender such as having insufficient knowledge about human sexuality and reproductive health, lack of education, inappropriate or inadequate reproductive health services, discriminatory social practices, discrimination against girls and women and violence against women. However, reproductive health is an important phenomenon that is not only special for women but also directly affects their lives (7, 8, 9). Accordingly, women's reproductive health is a specific and essential issue. Fertility is a phenomenon that takes place in the female body, therefore what women experience while performing this function may adversely affect their overall health status. Protecting women's reproductive health brings with healthy and happy families and therefore helps building a healthy society and future. It should further be considered that an occupational risk likely to affect the female reproductive system will not be limited to women's life, its effects may be transferred to future generations (2, 9, 10, 11, 12, 13, 13).

As it has been increasingly emphasized globally in recent years and as many studies conducted in the field of health have revealed, the status of women is the most significant factor affecting their knowledge, attitudes and behaviors about general health and their use of services. Factors such as a woman's educational background, working in an income-generating job and taking part in decision-making processes are determinative in benefiting from reproductive health services (2, 8, 10, 11, 12, 13, 14). Women's health problems most frequently develop in the reproductive age and based on their reproductive health characteristics (8, 9). Negativities that may be attributed to the fact that women's reproductive health problems are considered as confidential in our country, the feeling of shame, abstaining from receiving services from a health care professional of the opposite sex may affect the procurement of services in matters concerning women's health and cause reproductive health problems that can otherwise be easily treated with early diagnosis (15, 16).

The concept of health promotion is referred to as the process of enabling people to increase control over and to improve their health status. Knowing and adopting the right behavioral patterns related to health and their consequences make it possible to protect and improve health (17).

Health education is a method used to protect and improve health and constitute the most important power of preventive health services (18, 19). Health-related problems may be eliminated and may even be prevented before it occurs, by providing education services. Health education includes interactions that encourage people to lead a healthy lifestyle; however, the main responsibility lies with the woman herself (20, 21). Health trainings to be provided may help women gain this responsibility. Women may assume an active role in protecting and improving their own health by taking simple precautions and making arrangements to protect their reproductive health.

This study was planned in order to determine the knowledge levels, behaviours and attitudes of married women workers about reproductive health preventive behaviours; and also to develop an advanced education model according to established problems of women by taking the adult education principles into consideration, and to evaluate the efficacy of this model.

METHODS

Sample

This study was carried out semi-experimental research. Data of the research were collected from September 2001 - May 2002. Population of the research was consisted of 160 women in factory A. This factory serves in textile business. The reason why this industry is preferred is that the number of female employees is higher compared to others. After giving the required information, 25 volunteer women who were chosen by convenience sampling method. The sample selection criteria were as follows: (1) Being a primary school graduate, (2) Married, (3) agreed to participate in the study. The evaluation was made on 22 women, since two women left the job during the application and one of them did not want to fill out the forms.

Instruments

For the collection of research data, we used a Women Information Form, Women's Health Knowledge Test and The Scale for Determining the Reproductive Health Preventive Attitudes of Married Women.

Women Information Form:

This form prepared by the researchers in line with the literature consists of questions which aim at determining the socio-demographic and marital features, income status, residence, family type (nuclear, extended etc.) and educational background.

Women's Health Knowledge Test:

This form prepared by the researchers in line with the literature consists of questions which aim at determining their knowledge and behaviors regarding reproductive and sexual health.

The Scale for Determining the Reproductive Health Preventive Attitudes of Married Women:

This scale was developed by Demirci et al. (2004) to determine the attitudes of married women towards reproductive health. It consists of 39 items. It has five subdimensions: Behavior of Going to the Doctor on Issues Concerning Reproductive Health (8 items), Protection from Reproductive Organ and Breast Cancer (4 items), General Health Behaviors to Protect Reproductive Health (10 items), Protection from Genital Infections (14 items) and Protection from Unwanted Pregnancy (3 items). The scale has a 5-item Likert type assessment. The lowest score to be obtained from the scale is 39 while the highest score is 195. In score calculation of the scale, the first 16 items are assessed reversely. A high score implies that the individual has a positive attitude towards reproductive health. Cronbach alpha coefficients of the scale are 0.82 for the whole scale (22).

Procedure

In the study, the research was applied that Women Information Form", "Women's health knowledge test" and "The Scale for Determining the Reproductive Health Preventive Attitudes of Married Women" by using the face-to-face interview technique after the necessary

explanations were made by the researcher. The data were collected within 30-40 minutes in total.

“Women Information Form”, “Women's health knowledge test” and “The Scale for Determining the Reproductive Health Preventive Attitudes of Married Women” was applied to the women in the education group the first interview. The education was prepared in ten sessions with the subjects such as women's health, female reproductive organs, occurrence of pregnancy, reproductive organs infections, contraceptive methods, reproductive organs cancers and breast cancer was given by the researcher. The education was done using question-answer, lecture, slide show, showing on the figure, showing and making methods. In the education group “Women's health knowledge test” and “The Scale for Determining the Reproductive Health Preventive Attitudes of Married Women” was re-applied in by meeting the women face to face in the three months later.

Data analysis

Descriptive data are presented as number, percentage, mean, Kolmogrow-Smirnov. The data gathered from the groups were compared with the one-sample T test and independent samples t-test. All analyses were carried out using the SPSS for Windows, release 20.0 (SPSS, Inc., Chicago, IL, USA). A p value of <0.05 was thought to be crucial for all analyses.

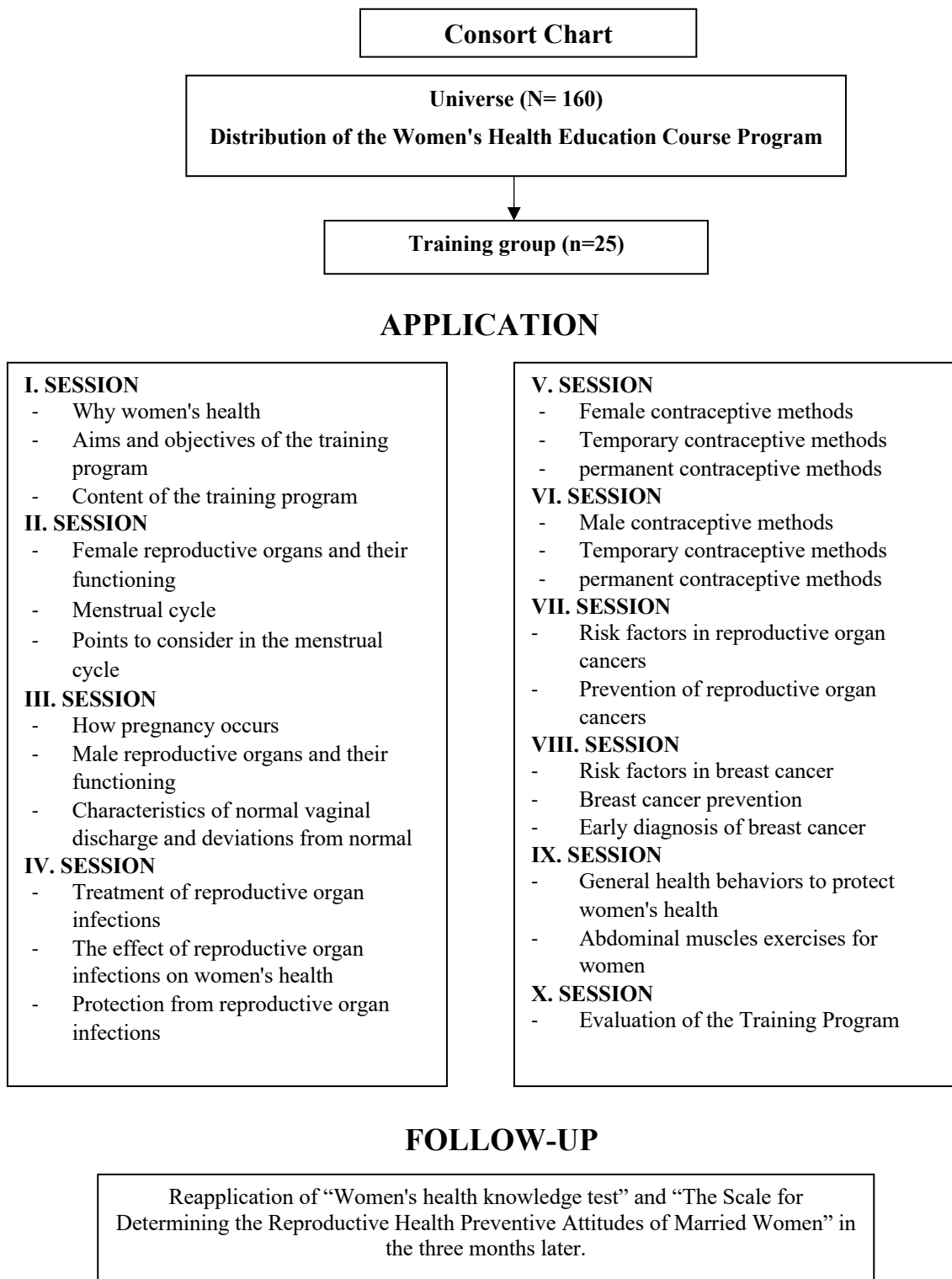


Figure 1: Consort Chart of the Study

Consort 2010 Flow diagram, Moher D, Schulz KF, Altman D. The Consort Statement: Revised Recommendations for Improving the Quality of Reports of

RESULTS

Considering the descriptive features of individuals comprising the study group, the training group had a mean age of 31.32 ± 5.69 . Women in training group 40.9% of them graduated from elementary school, 68.2% of them have nuclear family, 36.4% of them 7-14 years working, 51.8% she has been married for 1-10 years, first pregnancy mean age of them is 21.31 ± 3.63 and all of them had social security.

Comparing of the training group before and after training; it was determined that the total score average of Scale for Determining Reproductive Health Preventive Attitudes of Married Women was 138 ± 13.48 in before training, 151 ± 15.07 in after training and a significant difference was obtained in the statistical analysis which was performed to compare the group ($t= 5.085$, $p<0.05$) (Table 1).

It was determined that the total score average of sub-scale Behavior of Going to the Doctor on Issues Concerning Reproductive Health was 29.32 ± 6.18 in before training, 31.86 ± 5.19 in after training and a significant difference was obtained in the statistical analysis which was performed to compare the group ($t=2.273$, $p<0.05$). It was determined that the total score average of sub-scale Protection from Reproductive Organ and Breast Cancer was 6.68 ± 2.48 in before training, 8.14 ± 3.08 in after training and a significant difference was obtained in the statistical analysis which was performed to compare the group ($t=2.727$, $p<0.05$). It was determined that the total score average of sub-scale General Health Behaviors to Protect Reproductive Health was 30.23 ± 4.78 in before training, 35.32 ± 5.83 in after training and a significant difference was obtained in the statistical analysis which was performed to compare the group ($t= 5.171$, $p<0.05$). It was determined that the total score average of sub-scale Protection from Genital Infections was 60.86 ± 5.89 in before training, 64.18 ± 3.36 in after training and a significant difference was obtained in the statistical analysis which was performed to compare the group ($t= 4.007$, $p<0.05$). It was determined that the total score average of sub-scale Protection from Unwanted Pregnancy was 11.27 ± 2.93 in before training, 11.77 ± 2.62 in after training and a significant difference was not obtained in the statistical analysis which was performed to compare the group ($t= 4.007$, $p<0.05$) (Table 1).

Comparing of the training group before and after training; it was determined that the total score average of Women's Health Knowledge Test was 16.41 ± 7.24 in before training, 28.14 ± 8.49 in after training and a significant difference was obtained in the statistical analysis which was performed to compare the group ($t= 9.327$, $p<0.05$) (Table 2).

DISCUSSION

Some reproductive system diseases may be prevented with sufficient knowledge. Therefore, it is necessary to determine the level of knowledge of women on this subject, to replenish their deficient information and to correct their wrong beliefs and practices in order to protect and improve women's health. Women should be educated on this issue and should be brought to a level where they can assume the responsibility for their own reproductive health. This is possible with health education (22).

Workplaces are important environments to evaluate risky behaviors of employees and to execute health promotion programs that will support positive health behaviors (24). For these reasons a Women's Reproductive Health Education Program, addressing women employees

was prepared and implemented. Three months after the training, Reproductive Health Scale (RHS) and a Women's Health Quiz were administered to 22 women who agreed to participate and collected data were evaluated with the purpose to determine the effect of the applied training program on the knowledge, attitudes and behaviors towards protecting and improving women's reproductive health.

In our study, it was determined that there was significant difference between the scores of the before training (138 ± 13.48) and the after training (151 ± 15.07) on the Scale for Determining Reproductive Health Preventive Attitudes of Married Women.

In Er and et al. research it was revealed that women's Scale for Determining Reproductive Health Preventive Attitudes of Married Women total average score was 156.0 ± 17.3 , In Koştu ve Taşçı' research, it was 122.14 ± 19.61 , and In the study of Erbil ve Göktaşlar, it was 142.80 ± 20.73 (2, 6, 10). Results derived in this study with regard to reproductive health were at a lower level than the results of the research conducted by Er et al. on married women who attend a post graduate program and at a higher level than the results obtained by Koştu and Taşçı. These results suggest that educational background and working status have a significant effect on the reproductive health protective attitudes.

There is a correlation between the status of women both in the family and society and their reproductive health (25). Educational background of the woman, her working status in an income-generating job, the educational background of her husband and the economic status of the family are important factors in determining the status of the woman (26, 27, 28). Studies have revealed that the educational background and working status of women affect reproductive health; accordingly genital hygiene behaviors of women with higher educational background and working status were found to be more positive (2, 27, 29). These results imply that awareness of women with regard to protecting their health improves, health-seeking behavior gets better, and women attach more importance to protecting reproductive health and pay attention to medical practices in parallel with the increase in age, education level and participation in work-life.

When women' total Scale for Determining Reproductive Health Preventive Attitudes of Married Women and subdimension scores are considered to after training, it is seen that women received high scores in all the dimensions. This finding may imply that women display a positive attitude towards reproductive health. It is argued that knowledge, beliefs and emotions are in a systemic and continuous organizational relationship in the formation of attitudes. This shows us the presence and importance of learning process in the formation of attitudes. Accordingly, it can be suggested that women have more positive attitudes towards reproductive health owing to the information they obtained in the training.

Studies conducted in our country have revealed that women do not have sufficient knowledge about protective attitudes and behaviors with regard to reproductive health and that their health behaviors are not at the desired level (2, 30, 31, 32, 33).

Education is defined as the process of gaining desired behaviors in accordance with the education given about a subject in individuals, rather than loading information. It is aimed that the information given through education, which is not a static but a dynamic process, is

converted into behavior and that these behaviors are maintained and made into a way of life. As shown in the literature, it has been determined that the women who receive education turn their education into the correct practices by bringing them into the way they behave (14, 34, 35, 36, 37).

The difference between pre-training and post-training scores of the women in the Women's Health Quiz were statistically highly significant ($p=0.000$). Literature review with regard to studies carried out in workplaces revealed that health education programs implemented in workplaces have yielded successful returns and women's post-training quiz scores increased significantly compared to pre-training levels (33, 38, 39, 40, 41, 42, 43). Since the general purpose of education is to change behavior in the individual, it is expected that the behavior of the individual going through the education process will change in the direction of education and in the desired direction. When the research is evaluated, it can be said that it parallels our research that reproductive health education creates behavior change and positively affects her life permanently.

When the data were evaluated, it was determined that there was a positive change in the reproductive health of women who received education on subjects such as female reproductive organs and their functioning, menstrual cycle, treatment of reproductive organ infections, hygiene, and that the education program was successful.

Results of our study confirm that reproductive health protection and development programs to be implemented in workplaces will increase the knowledge of female workers in these areas and will help them develop behaviors to protect their reproductive health.

In conclusion, it has been determined that there is a significant difference between the reproductive health of women who Pre-training and Post-training and that training positively affects the reproductive health practices of women. It has been determined that the training provided to women is an effective initiative in increasing the reproductive health practices of women.

Conflict of Interest

No financial support was received in the study. The authors declare no conflict of interest.

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References

1. http://www.who.int/topics/reproductive_health Available at: 15.01.2013.
2. Koştu N, Taşçı KD. Determination of 15–49-year-old married women's protecting attitude their reproductive health. Journal of Atatürk University Nursing School. 2009; 12 (1): 91- 7.
3. Koluçak S, Güneş G, Pehlivan E. The Knowledge of the students of Inonu University about the reproductive health and their expectations from the services. Journal of Turgut Ozal Medical Center. 2010; 174(1): 7-14.

4. Bozdemir N, Özcan S. Overview of sexuality and sexual health. *Turkish Journal of Family Medicine and Primary Care*. 2011; 5(4): 37-46.
5. Reis N. Reproductive health women in the sexual maturity period. *Journal of Atatürk University Nursing School*. 2001; 4(1): 48-53
6. Erbil N, Göktaşlar Z. Determination of affecting factors and the reproductive health protective attitudes of married women. *Journal of Clinical Obstetrics & Gynecology*. 2010; 20(5): 295-303.
7. Şahiner G, Akyüz A. Gender and women's reproductive health. *TAF Prev Med Bull*. 2010; 9(4): 333-342.
8. Kızılkaya Beji N, Meram H E. Kadın sağlığına genel bakış. In: Kızılkaya Beji N, editör. *Hemşirelere ve Ebelere Yönelik Kadın Sağlığı ve Hastalıkları*. 3. Baskı. İstanbul: Nobel Tıp Kitabevi; 2019; pp 5-48.
9. Kızılkaya Beji N, Kaya G, Savaşer S. The priority problems of women's health in Turkey. *Ordu University J Nurs Stud*. 2021; 4(1): 105-112.
10. Er Güneri S, Şen S, Taşpınar A, Şirin A. Reproductive health problems of married women continuing post-graduate education and the effecting factors. *TAF Prev Med Bull*. 2008; 7(3): 231-236.
11. Clayton AH. The pathophysiology of hypoactive sexual desire disorder in women. *Int J Gynaecol Obstet*. 2010; 110(1): 7- 11.
12. Yaşar H, Özkan L, Tepeler A. Current approach to sexual dysfunctions in women. *Journal of Clinical and Experimental Investigations*. 2010; 1(3): 235- 240.
13. Karakoyunlu F, Öncel S. Prevalence of sexual dysfunction among married women ages 15-49 (Antalya/Turkey). *Türkiye Klinikleri Journal of Nursing Sciences*. 2014; 6(2): 63- 74.
14. Esen E, Siyez DM. Effect of sexual health education programme on 9 th grade students' sexual health knowledge and attitude. *H. U. Journal of Education*. 2017; 32(3): 560-580.
15. Daşkan Z, Sevil Ü. Psychosocial factors restraining gynecological examinations in women. *STED*. 2017; 26: 75-83.
16. Tanrıverdi, G., Bedir, E, & Seviğ, Ü. (2007). The effect of gender on health-related attitudes and behaviors. *TAF Prev Med Bull*, 6, 435-438.
17. Özvarış ŞB. Sağlığı geliştirme ve sağlık eğitimi. Ankara: Hacettepe Üniversitesi Basımevi; 2011.
18. Hacıaloğlu N. Hemşirelikte Öğretim Öğrenme ve Eğitim. 2. Baskı. Erzurum: Nobel Tıp Kitabevleri; 2013; pp. 91-102.
19. Uzpak R. Toplumun sağlık eğitimi. In: Pektekin Ç, Akın S, editors. *Sağlık Bilimlerinde Eğitim*. İstanbul: İstanbul Tıp Kitabevleri; 2020; pp.199-233.
20. Akyüz A, Kök G. Kadın sağlığının geliştirilmesi. In: Bahar Z, editör. *Yaşam Döngüsünde Sağlığı Geliştirme: Hemşirelik Uygulamaları*. 1. Baskı. Ankara: Türkiye Klinikleri; 2019; pp. 40-43.
21. Ayyıldız N, Ulupınar S. Health education activities of the nurses working in the primary care health services towards disabled persons. *Journal of Health Science and Profession*. 2019; 6(1): 51-61.
22. Demirci, H. Çalışan Evli Kadınlarda Üreme Sağlığını Koruyucu Davranışların Geliştirilmesi. İstanbul Üniversitesi Sağlık Bilimleri Enstitüsü Doktora Tezi; 2004.

23. Consort 2010. Flow diagram, Moher D, Schulz KF, Altman D. The Consort Statement: Revised Recommendations for Improving the Quality of Reports of.
24. Yildiz AN, Çaman ÖG, Nihal ES. İşyerinde sağlığı geliştirme programları. Ankara: TÜRK-İŞ; 2012.
25. Akın A, Sevensan F. Women's health level and status of family planning practices in Turkey. *Turkiye Klinikleri J Surg Med Sci*. 2006; 2 (13): 1-14.
26. Altıntaş HK, Temel F, Özer Ç, Yılmaz B, Tural G, Tutar N, Peker O. The health status and expectations of women participating in BELMEK courses in the Keçiören Municipality in Ankara. *Turkiye Klinikleri J Med Sci*. 2005; 25(5): 669-77.
27. Erbil N, Pasinlioğlu T. The effect of the woman in decision making within the family. *Journal of Atatürk University Nursing School*. 2004; 7(2): 1-11.
28. Erci B. Women's efficiency in decision making and their perception of their status in the family. *Public Health Nurs*. 2003; 20(1): 65-70.
29. Ege E, Eryılmaz G. The effect of planned education given to the women on genital hygiene behaviours. *Journal of Atatürk University Nursing School*. 2006; 9(3): 8-16.
30. Turan S, Özvarış ŞB. Mamak halk eğitim merkezi kadın kursiyerlerinin kadın sağlığı ile ilgili eğitim ihtiyaçlarının belirlenmesi. *Sağlık ve Toplum Dergisi*. 2004; 14(4): 34-42.
31. Altay B. Healthy lifestyle behaviours of 15-49 aged married women in the district of 6 Numbered Primary Health Care Center in Samsun. *OMU Tıp Dergisi*. 2006; 23(1): 1-8.
32. Dişçigil G, Şensoy N, Tekin N, Söyleme A. Breast health: Knowledge, behaviour and performance in a group of women living in the Aegean region. *Marmara Medical Journal*. 2007; 20(1): 29-36.
33. Güngör N, Çeçen D, Özbaşaran F. Manisa organize sanayi bölgesindeki bir tekstil fabrikasında çalışan 15-49 yaş kadınlara aile planlaması ve kontraseptif yöntemler konusunda verilen eğitimin değerlendirilmesi. *Hemşirelik Forumu Dergisi*. 2004; 7(2): 17-26.
34. Demirbağ BC, Çan G, Köksal İ, Kaya S. A different approach in protection and development of reproduction health: Evaluation of transferring of the training done by mothers to daughters. *Ejovoc (Electronic Journal of Vocational Colleges)*. 2013; 3(1): 136-148.
35. Brieger WR, Delano GE, Lane CG, Oladepo O, Oyediran KA. West African Youth initiative: Outcome of a reproductive health education program. *Journal of Adolescent Health*. 2001; 29(6): 436-446.
36. Park MN, Choi SY. Development of reproductive health program and identification of effect for married women immigrants. *Journal of Korean Academy of Nursing*. 2014; 44(3): 248-258.
37. Van der Geugten J, De Vries NK, Van Meijel B, Den Uyl M H. Evaluation of a sexual and reproductive health education programme: Students' knowledge, attitude and behaviour in Bolgatanga municipality, Northern Ghana. *African Journal of Reproductive Health*. 2015; 19(3): 126-136.
38. Brill PA, Kohl HW, Rogers T, Collingwood TR, Sterling CL, Blair SN. The relationship between sociodemographic characteristics and recruitment, retention, and health improvements in a worksite health promotion program. *Am J Health Promot*. 1991; 5(3): 215-221.
39. Kurtz M E, Kurtz JC, Given B, Given CC. Promotion of breast cancer screening in a work site population. *Health Care Women Int*. 1994; 15 (1): 31-42.

40. Thomas B, Stamler LL, Lafreniere KD, Delahunt TD. Breast health educational interventions. Changes in beliefs and practices of working women. *AAOHN J*. 2002; 50(10): 460-467.
41. Turan S, Özvarış SB, Üner S. Bir fabrika çalışanlarına yönelik su ve besinlerle bulaşan hastalıklar eğitim programı geliştirme çalışması. *Hacettepe Toplum Hekimliği Bülteni*. 2002; 23(2): 23-24.
42. Esin N, Bulduk S. Worksite health promotion programs: Practices of occupational health nursing. *Florence Nightingale Journal of Nursing*. 2004; 13(53): 39-50.
43. Güngör İ. Toplum merkezleri kadın sağlığı eğitim programı değerlendirme raporu. SHÇEK Türkiye Aile sağlığı ve Planlaması Vakfı. Ankara: 2010.

Table 1: The distribution of women's total mean scores on Scale for Determining Reproductive Health Preventive Attitudes of Married Women before and after the training (three months later) (n= 22)

Scale mean score	Pre-training			Post-training (Three months later)			t	p
	Min.	Mak.	Mean ± SD	Min.	Mak	Mean ± SD		
Scale for Determining Reproductive Health Preventive Attitudes of Married Women	101	158	138 ± 128	181	151	151 ± 5.08	5	0.00
			13.48			15.07		0
Behavior of Going to the Doctor on Issues Concerning Reproductive Health *	13	37	29.32 ± 6.18	22	40	31.86 ± 5.19	2.27	0.03
							3	4
Protection from Reproductive Organ and Breast Cancer *	4	12	6.68 ± 2.48	4	18	8.14 ± 3.08	2.72	0.01
							7	3
General Health Behaviors to Protect Reproductive Health *	19	36	30.23 ± 4.78	22	44	35.32 ± 5.83	5.17	0.00
							1	0
Protection from Genital Infections *	46	68	60.86 ± 5.89	56	70	64.18 ± 3.36	4.00	0.00
							7	1
Protection from Unwanted Pregnancy *	6	15	11.27 ± 2.93	7	15	11.77 ± 2.62	1.14	0.26
							9	4

* Maximum expected scores in row order: 195, 40, 20, 50, 70, 15

Table 2: The distribution of women's total mean scores on Women's Health Knowledge Test before and after the training (Three months later) (n= 22)

Mean score	Pre-training			Post-training (Three months later)			t	p
	Min.	Mak.	Mean ± SD	Min.	Mak.	Mean ± SD		
Women's Health Knowledge Test **	2	28	16.41 ± 7.24	9	48	28.14 ± 8.49	9.327	0.000

** Maximum score:100