

Improving Health Education Skills for Nurses Working in MCH Centers in Egypt to Enhance Women Awareness Regarding Family Planning

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Abstract: Both availability and quality of family planning services are believed to have contributed to increasing contraceptive use and declining fertility rates in developing countries. Family planning is an integral component of family welfare. It saved the lives of women and children. Women education about family planning is essential to good health. Nurses play a key role in the promotion of women's reproductive health. **Aim:** The aim of this study was to improve Health Education Skills for Nurses working in MCH centers to enhance women awareness regarding family planning. **Subject and methods** A quasi experimental study was used, and conducted in 6 MCH centers in North of Cairo zone. Purposive sample of 29 nurses (total number of nurses 106) and 192 married women were taken. A self-administered questionnaire for nurses were used to assess socio-demographic data and nurse's knowledge related to health education and observational checklist to assess nurses' performance. For women; an interviewing questionnaire was used to assess socio-demographic data and knowledge about family planning. Data were collected at pre-post program. **Results:** The results showed that at post test, an improvement in nurses' knowledge and nurses' performance regarding health education. Also it illustrated that an improvement in women' knowledge about family planning post intervention with a highly significant difference post intervention program related to women and nurses. **Conclusions:** Health education program was successful improving health education skills for nurses and family planning knowledge for women.

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1. Introduction

Family planning and reproductive health programs have contributed greatly to fertility decline in developing countries **Hong et al. (2006)**. Both availability and quality of family planning services are believed to have contributed to increasing contraceptive use and declining fertility rates in developing countries. There is general agreement that the quality of family planning and reproductive health services positively affects contraceptive use and behavior of the clients; and that clients deserve to receive safe and high quality services with respect and dignity **RamaRao (2003)**.

Half of the world's population is in or entering their child bearing years. Consequently there is tremendous need for contraceptive use, especially in areas with high fertility **Nalwadda et al. (2010)**. High fertility and high maternal morbidity and mortality not only strain individuals, families, and public resources, but also hinder opportunities for economic development. Use of contraceptives have the potential to avert unplanned births, decrease maternal morbidity and mortality, increase welfare and protect future generations. **Marston and Cleland (2004); Cleland et al. (2006)**;

Egypt's rapid population growth in recent decades is considered a major obstacle to the developmental goals set by the Egyptian government (**Hong et al., 2011**). Egypt has been pursuing a population control program by stimulate demand for family planning and promote use of contraceptive services through better supply, training and supervision of providers (**Hong et al., 2006**). The program was designed to promote the supply of quality family planning services through better training and supervision of providers and to stimulate demand for family planning (FP) by promoting higher quality services to the public (**Hong et al., 2011**). Family planning saved the lives of women and children by helping to avoid unsafe abortion, limiting the risk of pregnancy and childbirth, reducing the number of births, and limiting pregnancy to the healthiest ages and desired points in time (**Mai, 2003**). Reproductive health knowledge is important for women as a woman's health and well-being (**Smith, 2002**). Women knowledge or education about what affects them, awareness about the role of family planning in family life as well as access to safe and effective methods of family are essential to good health (**Akande, 2000**).

Health education (HE) is any combination of planned learning experience based on sound theories

that provide individuals, groups, and communities the opportunity to acquire information and the skills needed to make quality health decisions (**Wurzbach, 2004**). The basic purpose of HE is to help clients and families develop the self-care abilities (knowledge, attitude, and skill) that enable them to maximize their functioning and quality of life (**Taylor et al., 2004**).

Health education is an important intervention for nurses in all-healthcare setting. (**Danial, 2004**). Nurses educate consumers about ways to manage their health process more effectively (**Robotham and Frost, 2005**). Any nurse who wishes to be an effective educator must first learn to communicate. Good communication skills enable nurses to get to know their clients and, ultimately, to meet their need for HE. (**Heyner et al., 2004**). A major factor affecting the success of family planning program is the provision of information, education and effective communication. Adequate communication enhances family planning acceptance, client satisfaction, as well as effective and continued use of contraception (**Abdel-Tawab and Roter, 2002 and Kim et al., 2008**) The provision of family planning services requires unique skills, knowledge and sensitivity to client needs (**Bednash et al., 2009**)

Aims of the study:

The aim of this study was to improve Health Education Skills for Nurses working in MCH centers to enhance women awareness regarding family planning

2. Subjects and Methods

A quasi experimental study was used in this study. The study was conducted in 6MCH centers affiliated to Ministry of Health in North of Cairo zone, this zone comprised three districts. First :El Hadaek, second : El zytone, Third: El Zawya

Sampling: purposive sample in the previously mentioned settings was divided into two groups:

1. A sample of 29 nurses (total number of nurses 106) were taken from the total sample for application of health education program. Inclusion criteria were; all nurses assigned for HE activities and family planning clinics at selected six MCH centers. El hadaek , El khalig Elmasry, El Ameria, Saray El Kobba and El Zyton, and El Zawya El kadima. Also nurses who didn't receive health education training program.
2. All women at reproductive age (15-49), had at least one children and attended family planning clinics were received health education program in selected six MCH centers El hadaek, El khalig Elmasry, El Ameria, Saray El Kobba and El Zyton, and El Zawya El kadima that were included in the study sample to measure pre- post program effect (number = 192 married women).

43 of them showed their unwillingness in participation in the study due to various reasons including illnesses and shortage of time.

Tools of data collection:

A self-administered questionnaire, It was developed by the researchers based on review of literature. It was consisted of ;

- 1- Socio-demographic data such as: age, educational level, marital status, qualification, and working conditions as regards: working hours, past experience, previous training.
- 2- **Nurse's knowledge assessment format (pre-post):** related to health education: definition, objective, principles, characteristic of health educator, HE process, method, materials, and effective communication.
- 3- **Nurse's health education performance skills observational checklist (pre-post):** Observational checklist was designed to assess nurses' performance as a health educator; it was constructed in English language. It covered the following skills; appropriate communication and health education session conduction.
- 4- **Women knowledge assessment format (pre-post):** An interviewing questionnaire was designed to assess women knowledge about family planning and it covers the following items; socio demographic data, family planning use, source of information about family planning, Source of contraceptive method. Women knowledge regarding contraceptive methods definition, importance, type, methods classification, uses, side effect, advantages and disadvantages

Program construction:

The current study was carried out on three phases, preparatory phase, implementation phase and evaluation phase.

Faze I: Preparatory phase:

Human rights and ethical permission were obtained to conduct the study. An official permission was obtained from the director of ministry of health in which the study was conducted and then the official permission was obtained from the director of 6 MCH centers. Nurses and women were fully informed of the study. The voluntary nature of participation was stressed as well as confidentiality. Consent was obtained from each nurse and woman.

The program (Nursing intervention) was designed by the researchers and based on the results obtained from the study tools; also, it was revised and modified according the related literature, cultural and socio-demographic aspects of the study sample. This program content was revised and validated by committee of Faculty of Education and experts in

Faculty of Nursing, community health nursing department.

Phase 2: Implementation phase:

Data collection was carried out during the period from May 2010 to October 2010. The pre test was done for nurses and women in order to have base line information. The implementation phase of the program lasted for 3 months. The time taken to develop educational skills program for nurses one month, and then the program was implemented by nurses to women who attended family planning clinics and in the presence of the researchers, to assess their performance while conducting health education sessions for women. The program was designed by the researchers and based on the result obtained from the study tools and findings of similar researches, also it was revised and modified according the related literature.

Evaluation phase

Evaluation was applied before and after the program, in order to identify differences, similarities and areas of improvement, as well as defects. This was done through pre and post administration of the self-administered questionnaires and observation checklist for health education performance skills for nurses. Also the program evaluated through measure improvement of women awareness regarding family planning.

Data analysis:

Data were revised, coded, analyzed and tabulated using the number and percentage distribution and carried out using SPSS version 16. the statistical tests used are chi-square test. A value of $p < 0.05$ was considered to be statistically significant.

3. Results:

Table (1): describes that the mean age of the studied nurses was 27.79 ± 6.65 years, 62.1% of them were married, and (44.8%) of nurses had nursing diploma. In relation to working conditions it was found that the mean of salary per month was 229.69 LE, and 55.2% of them had an experience between 5-15 years. As regards previous training 75.9% of nurses not attended training program. Regarding barriers to conducting effective health education it was found that, the most of barriers (48.3 %, 37.9 %, 27.6 %) were related to unsuitable place for health education, work stresses, lack of time respectively.

Table (2) showed that the mean age of studied women was (31.6 ± 6.57) years. As regard educational level of women (41.1%) were illiterate. As regard the women' job it was found that (68.7%) of them were housewives, (41.7%) had three to four children and (60.4%) their age at last pregnancy was ≤ 35 . Also the table illustrated that (68.8%) used contraception methods, (15.1%) of them their source of FP

information from nurses. As regard type of contraceptive (72.7%) used non-hormonal methods as contraceptive method. Also it was found that 68.1% their source of contraceptive methods were MCH.

Table (3) demonstrates that there was an improvement in nurses' knowledge about health education elements post intervention whereas mean of total knowledge score level was 46.03 ± 14.571 before the program, changed to 115.34 ± 9.926 after the program with a highly statistically significant difference. Also it shows that the highest level of mean score knowledge was health education methods followed by effective communication (35.34 ± 5.633 and 29.72 ± 3.881 respectively), whereas the lowest level was basics of health education (12.45 ± 2.197).

Table (4) illustrates that there was an improvement in women' knowledge about family planning post attended health education session with a highly statistically significant difference. Also it reflects that 90.6%, 78.1%, 73.4%, 82.3%, 79.7%, 80.7%, 73.4%, 91.7% of women had satisfactory knowledge after attendance of health education session regarding their knowledge about definition, Importance, Type, Methods Classification, Uses, Side effect, Advantages, Disadvantages.

Table (5) indicates that there was an improvement in nurses' performance regarding total communication skills post intervention whereas mean of performance score level was 5.72 ± 2.76 before the program, changed to 15.07 ± 3.33 after the program. Also it shows that there was improvement in nurses' performance related to total health education session conduction post intervention whereas mean of performance score level was 2.24 ± 2.38 before the program, changed to 19.69 ± 5.59 after the program.

4. Discussion:

The aim of this study was to improve health education skills for nurses to enhance women awareness regarding the family planning in MCH centers in North Cairo Zone. This study revealed some important findings about access to family planning services, which may be valid in today's context. The program aims to improve outcomes by improving the quality of care through a process of developing health education skills for nurses.

The study revealed that the nurses age of the studied sample ranged between 20 – 35 years, with the mean age of the studied nurses was 27.79 ± 6.65 years (Table1). These finding were in agreement with **Abd El-Latif (2004)**, who found that more than two fifth of nurses aged 25 years, also **Kim et al. (2008)**, found that most of nurses their age ranged between 35 up to 53 years.

Regarding nurses qualification and marital status, the current study found that 44.8% of nurses had nursing diploma and were married (Table 1).

This result was in agreement with **Todd et al. (2007)**. In relation to working condition, results revealed that more than half 55.2% of nurses had an experience ranged between 10 up to 15 years (Table 1). This results in agreement with **Abd El-Latif (2004)**, & **Kim et al. (2008)**. In this regards, **Clawson & Haskins (2006)**, commented that there is evidence that the more experienced expert nurse is able to grasp the intricacies of clinical situation rapidly and can sort out relevant from irrelevant information.

In relation to working conditions it was found that the mean of salary per month was 229.69 LE, This results in agreement with **Todd et al. (2007)**, who found that more significant, were key findings related to lack of job security, lack of benefits and low pay.

As for as the previous training in HE, it was apparent that approximately three quarters 75.9 % of nurses did not attend training program, (Table 1). **Tanner (2005)**, emphasized the important of educational training program which are designed to provide knowledge, skills and attitude for enhancement of nursing action. **Laschinger et al. (2003)** added that work environment that provide access to information, support, resources, and opportunity to learn and develop; are empowering and influence employee work attitudes and organizational effectiveness.

Focusing on barriers to conductive effective HE, results revealed that, unsuitable place for health education, work stress and lack of time were a highest percentage of barriers respectively 48.3%, 37.9%, and 27.6% (Table 1). In previous study has identified a number of HE barriers as the lack of educational aids and materials, the low priority held for HE in health services for conducting group HE in the health services. The lack of communication skills among HPs and the negative influence of factors such as family, commercial advertising, culture and traditional beliefs on HE. Resource constraints may also hinder HPs from achieving their potential in health promotion. There may be staff shortages and work overload, leading to less time available for long term health promotion work (**Elfituri and Sherif, 2009; World Health Organization, 2003**).

Regarding to age of studied women was (31.6 ± 6.57) years. This result disagreed by **Hong et al. (2006)** revealed that age distribution shows that 4% of women were aged 15-19, 16% were 20-24, 21% were 25-29, 16% were 30-34, 17% were 35-39, 14% were 40-44, and 12% were 45-49.

Regarding to educational level the majority of women were (41.1%) illiterate and more than half of the women were housewives and nearly 40% had three births Table 2. This result disagreement by **Hong et al.**

(2006) reported for slightly more than one-third had no education, 13% had some primary education, 14% had completed primary education, and the remaining 37% had completed secondary or higher education. **Ibnouf et al. (2007)** added that the participants with higher education, better knowledge, and those working. It was confirmed that education generally exerts a negative influence on fertility; Egyptian Demographic Health Survey (EDHS) documented the negative impact of maternal lack of education on the low use of contraceptive services, National demographic survey concluded that age at marriage and a woman's education are apparently the most important determinants of low fertility behavior. These appeared in a strong association between the use of services and education **Al sheeha (2010)**.

Regarding to contraception methods more than two third (68.8%) of women in this study were used it although they have lack of education level. **Hong et al. (2006)** reported that contraceptive use is associated with socio demographic characteristics of the user and with the supply source of the method. The use of modern contraceptives among women who obtained their method from public sources tends to be positively associated with number of living children. Educated and wealthier women are more likely to be able to pay for their contraception and they may get it from the private sector, while poor or uneducated women may rely more on the public sector for their methods.

The minority (15.1%) of the women their source of FP information from nurses this result agreement with **Rasheed and Al-Dabal (2007)** reported that the poor knowledge regarding the simple variety of contraceptive methods and the main source of knowledge, that is the family members, who share their limited individual experience. This is consistent with the popularity of oral pills and a limited role of the health workers in providing the information about contraception, which reflects the conservative culture of the community and the power of the family. **Dehlendorf et al. (2010)** added that one contributor to poor communication between providers and patients about contraceptive methods may be that providers have incomplete knowledge of evidence-based information about contraceptive methods. In contrast with **Todd et al. (2007)** demonstrated the majority of the nurses 73% indicated that that they would like to provide more patient education, and is a significant role for family planning / PHS nurses. **Potter and Perry (2006)** added Educating clients is a role for nurses in all health care settings In primary health care settings, the nurse is often the main source of information about health promotion and illness prevention.

As study results regard type of contraceptive (72.7%) used non-hormonal methods as contraceptive method. According this result **Ministry of Health and**

Population, 2004 reported that Since 1988, the IUD has remained the most popular contraceptive method in Egypt. Before that, oral contraceptive was the leading method used by Egyptian women. IUD use is a good proxy indicator to measure clinical contraceptive use in Egypt. **Moronkola et al. (2006)** added that 20% of the women used other contraceptive methods and 43% did not use contraception.

The study revealed that 68.1% of the women source of contraceptive methods were MCH this result congruent with **Hong et al (2006) and Moronkola et al. (2006)** revealed that 37% of currently married women presently used IUD, 24% got their IUD from a public source and 13% from a private source. The result of this study revealed that there is a significant difference between improvement in nurses' knowledge about health education elements post intervention. **Tanner (2005)**, mentioned that teaching effectively is a learned skill. Development of this skill requires knowledge of educational process, including HE methods and materials available and ways to use them with a variety of clients and settings. **Dehlendorf et al. (2010)** added that several studies have suggested that provider knowledge is in fact deficient in some aspects of contraception. **Abdel-Tawab and Roter (2002)** added that in Egypt, as in more developed countries, the patient-centered model of care delivery is associated with better client outcomes than provider-centered care. Clients were more likely to be satisfied and to continue using a family planning method if the doctor consultation was client-centered; she was less likely to continue using the provided method if the provider was directive or negative. The study illustrates that there was an improvement in women' knowledge about family planning post attended health education session. Also one study concluded that educational intervention on family planning increases the knowledge about modern methods of contraceptives among men (**Shahamfar et al., 2007**)

As for as nurses knowledge score level regarding HE process, methods and materials, it was apparent that an increase in nurses knowledge score level in the post test as compared to the pre test. This result was in agreement with **Lamiani and Furey (2008)**, their findings demonstrate that a 2-day workshop on patient education, based on a patient-centered approach, improved nurses' communication skills and knowledge, and their sense of preparedness. Also they added that patient education skills can be taught and learned like other nursing skills. Nurses should be provided with more educational opportunities based on a patient-centered approach to improve their patient education skills. **Moore et al. (2002)** also emphasized the importance of educational programs in enhancing caring behavior in nurses.

Table (1): Number & percent distribution of nurses according to socio demographic characteristics

Parameter	No = 29	%
Age(mean and SD)	27.79 ±6.651	
Marital status		
Single	18	17.2
Married	5	62.1
Divorced and widow	6	20.7
Qualification		
Diploma	13	44.8
Specialty	11	37.9
Technical	5	17.2
Working hours		
6-8h	5	17.2
more than 8h	24	82.8
Income (mean and SD)	229.69 ±50.298	
Previous training		
yes	7	24.1
No	22	75.9
Years of Experience		
less 5 v	8	27.6
5-15v	16	55.2
more 15 v	5	17.2
Barriers to conducting effective health education:		
Lack of time	8	27.6
Lack of resources	2	6.9
Work stresses	11	37.9
High attendance rate	3	10.3
Shortage in number of nurses	1	3.4
Unsuitable place for health education	14	48.3

Table 2: Number and percent distribution of women according to their socio demographic characteristics

Parameter	N=192	%
Mean of age:	31.6 ± 6.57	
Educational level:		
Illiterate	79	41.1
Basic education	56	29.2
Secondary and higher education	57	29.7
women job:		
House wife	132	68.7
Working	60	31.3
Number of children		
1-2	37	19.3
3-4	80	41.7
5-	75	39
Age at last pregnancy		
≤35	116	60.4
>35	76	39.6
Using of contraception:		
Yes	132	68.8
No	60	31.2
*Type of contraceptive (n= 132):		
Non hormonal	96	72.7
Hormonal	33	25
Natural	10	7.6
Source of information about FB(n=132):		
Physician	68	51.5
Nurses	20	15.1
Relative	22	16.7
Neighbor	22	16.7
Source of contraceptive method (n=132):		
M.C.H.	90	68.1
Pharmacy	10	7.6
Special clinic	32	24.3

The study result revealed that highest level of mean score knowledge was health education methods followed by effective communication after program. Also many studies have tested the impact of formal training programmes on nurses' ability to communicate with patients. Their results indicate how such training can be improved the quality of family planning counseling and other types of nurse-patient communication. such as active listening, to include friendliness, gestures, and praise (Shattell, (2004) and Kim *et al.*, 2008. Barnes (2002), mentioned that if nurse lacks in professional knowledge, she should be given appropriate instruction and training. Hence, it is implied that the health care institution must develop comprehensive continuing educational programs. Taylor *et al.* (2004) and Allender & Spradely (2005), added that a client remains interested when the nurse is

enthusiastic during conducting a health education session by using non verbal skills a good nurse carefully plans the order in which to present information.

This study revealed improvement in nurses' performance regarding total communication skills post intervention. This results in agreement with Kim *et al.* (2008), who illustrated that nurses' communication skills are a key factor in good communication. The conventional approach to strengthening nurses' communication skills is training. (Sully & Dallas, 2005). McKenzie *et al.* (2005) stressed that, effective HE depends on a good understanding of communication principles, process, and elements. Principles and guidelines for using effective communication techniques can strengthen all caring relationships established within the health professional.

Table (3): Mean Scores of knowledge regarding Health Education Elements among nurses at the pre and post intervention phase

Health Education Elements	pre		post		T test SIGN
	MEAN	SD	MEAN	SD	
Basics of health education	6.31	2.269	12.45	2.197	11.447 HS
Effective communication	12.90	5.192	29.72	3.881	23.229 HS
Health education process	8.28	3.422	24.38	2.770	17.385 HS
Health education methods	11.48	5.686	35.34	5.633	17.935 HS
Health education materials	7.07	3.751	13.45	1.785	10.344 HS
Mean score TOTAL KNOWLEDGE	46.03	14.571	115.34	9.926	25.180 HS

N.B. HS= highly significant

Table (4): Number and percent distribution of women according to their pre and post satisfactory knowledge regarding family planning.

Parameter	pre (% satisfactory)		post (% satisfactory)		Chi SIGN
	NO=192	%	NO=192	%	
definition	28	14.6	174	90.6	2.226 HS
Importance	38	19.8	150	78.1	1.307 HS
Type	29	15.1	141	73.4	1.324 HS
Methods Classification	33	17.2	158	82.3	1.628 HS
Uses	37	19.3	153	79.7	1.402 HS
Side effect	48	25	155	80.7	1.197 HS
Advantages	33	17.2	141	73.4	1.226 HS
Disadvantages	49	25.5	176	91.7	1.731 HS

N.B. HS= highly significant

Table (5): Scores of performance regarding health education skills among nurses at the pre and post intervention phase

Parameter	Pre		Post		T TEST
	Mean	SD	Mean	SD	
Communication skills					
Building relationship	0.52	0.57	3.45	0.73	14.79 HS
Communication process	2.48	1.47	4.41	0.73	8.12 HS
Communication technique	2.72	2.06	7.14	2.27	8.82 HS
Total Performance Of Communication Skills	5.72	2.76	15.07	3.33	15.36 HS
Health education session conduction					
Preparatory phase	0.34	0.48	6.59	1.82	21.06 HS
Conducting of session	1.41	1.35	4.38	1.14	9.89 HS
Ending phase	0	0	3.34	1.37	13.14 HS
Documentation	1.24	1.88	3.34	2	5.2 HS
Total Performance of Health education session conduction	2.24	2.38	19.69	5.59	17.13 HS

N.B. HS= highly significant

5. Conclusion

Our findings revealed that Health Education program was successful improving health education and communication skills for nurses and enhance family planning knowledge for women.

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