



Research paper

The effects of fertility-supporting health training on healthy lifestyle behaviors and infertility self-efficacy in infertile women: A quasi-experimental study[☆]

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ABSTRACT

Introduction: It is important to change behaviours and situations that affect fertility in a negative way (e.g. obesity, smoking and stress). Healthy lifestyle behaviours supporting fertility involve changing these habits. The development of healthy lifestyle behaviours which can support fertility can be achieved through taking personal responsibility to change unhealthy behaviours. This study was aimed at determining the effects of fertility supporting health training on healthy lifestyle behaviours and self-efficacy in infertile women. This study aimed to determine the effects of fertility supporting health training on changing healthy lifestyle behaviours and self-efficacy in infertile women.

Methods: The study used a pre-test/post-test quasi-experimental model with a control group and was carried out between March and October 2017. The power analysis calculated the number of infertile women in each group as 62 (N = 124). The women in the experimental group were provided with two sessions of fertility-supporting health training. Eight weeks after the first session, the post-test data were collected. Data collection included a “Personal Information Form”, the “Healthy Lifestyle Behavior Scale II (HLBS-II)” and the “Infertility Self-Efficacy Scale – Short Form (ISE-SF)”.

Results: The HLBS-II post-test mean values were 136.52 ± 19.25 in the experimental group and 126.90 ± 17.02 in the control group, and the difference was significant ($p < 0.05$). The ISE-SF post-test mean values were significantly different for the experimental group (23.16 ± 4.13) compared to the control group (20.43 ± 4.19) ($p = 0.000$).

Conclusions: Women being treated for infertility may wish to participate in initiatives that promote fertility. Training, adopting healthy lifestyle behaviours and perceptions of self-efficacy can be improved.

1. Introduction

Infertility has been defined as a condition where pregnancy is not achieved in a year despite having regular sexual intercourse at least two times a week [1,2]. Infertility is a significant health problem which affects 10–15% of individuals of reproductive age [3,4]. Studies have reported a prevalence of infertility of 7.5–21.5% in the United States, 16.7% in Russia, 18.4% in Australia, 12.2% in France and 6.6% in Norway [4,5]. According to the World Health Organization, Turkey is among the countries with the highest infertility rates [6]. According to the 2013 Turkey Demographic and Health Surveys (TDHS), the percentage of women aged 15–49 who were not able to become pregnant was 11.2% [7,8].

Infertility treatment options have become more abundant in parallel to the technological developments in recent years. This increase in treatment options has led to a greater consideration of issues such as the approach of infertile women towards the treatment process, their state of being influenced by this process and their self-efficacy perceptions [9,10,11]. Infertility self-efficacy perception is closely related to the way woman cope during infertility treatment [5,12–14]. The application of assisted reproductive techniques and the resulting failures may especially lead the self-efficacy perceptions of women to drop [9–11]. Studies in recent years on this issue have especially emphasised the importance of adopting fertility-supporting lifestyle behaviours aimed at eliminating infertility risk factors, and have indicated that this may affect infertility self-efficacy perceptions positively [5,15,16]. The

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lifestyle factors that have been studied in relation to changes that support fertility include nutritional issues around obesity and being underweight, lack of sufficient physical activity, smoking, alcohol and caffeine consumption, exposure to harmful substances in the environment, stress and sexually transmitted infections [17–20].

The healthy lifestyle behaviours supporting fertility are the positive changes in habits, behaviours and situations that have previously affected fertility in a negative way [21]. Since supporting and sustaining fertility is largely based on one's lifestyle, individuals must check their behaviours that might affect their health and regulate them by choosing alternative suitable behaviour [17–20]. Infertile individuals typically aim to succeed in their treatment and adopt behavioural changes that may contribute to fertility [15,17]. Individuals engaged in the fertility treatment process tend to have confidence in themselves regarding the recommended practices and tasks that should be carried out. However, when the treatment results in loss and failure most of the time or when the treatment process is prolonged, they may lose confidence in their ability to perform the recommended practices during treatment [15,17,22]. At this stage, individuals receiving infertility treatments should be supported to protect and improve their health, and to increase their self-efficacy perceptions [5,13]. In this process, healthcare professionals should guide infertile women to focus on the successful aspects of their treatment, despite its results, encourage maintenance and improvement of interpersonal relationships and ensure that strategies that will increase self-efficacy perceptions are followed [5,22,23]. In this endeavour, it is believed that fertility-supporting health training given to infertile women will contribute to their self-efficacy perceptions. Additionally, with the new evidence in recent years regarding infertility risk factors, the importance of supporting and maintaining fertility by adopting healthy lifestyle behaviours has increasingly been recognized [17,18]. For these reasons, the aim of this study was to determine whether fertility-supporting health training provided to infertile women on changing lifestyle behaviours improved infertility self efficacy perceptions.

2. Methods

This study was carried out between March 2017 and January 2018 at a private in vitro fertilization centre located in Eastern Turkey using a pre-test/post-test quasi experimental model with a control group. Regular follow-ups and monitoring processes are held for infertile couples at the mentioned institution, and no educational material was used in the scope of the provided standard healthcare service. The study population consisted of women who visited the centre for infertility treatment. The sample size was calculated as 62 infertile women in each group ($N = 124$), as a result of the power analysis for a 5% two-sided level of significance, 95% confidence interval and 80% representation of the population. In order to prevent a within-group effect, the control group was first included in the study. The women who satisfied the inclusion criteria were selected from within the population by the method of non-probability random sampling. The study included all women who:

- were literate,
- did not have any psychiatric diagnosis, and
- chose at least one invasive (IVF, insemination, etc.) infertility treatment. The flow chart of study is given in Fig. 1.

2.1. Data collection tools

The data were collected using a Personal Information Form, the Healthy Lifestyle Behavior Scale II and the Infertility Self-Efficacy Scale – Short Form.

2.2. Personal information form

This form was developed based on the information in the literature [5,12,13] to collect data on the personal and obstetric characteristics of the women (age, education, employment, education of the spouse, employment of the spouse, length of marriage, medical history, length of treatment, type of treatment, history of any failed treatments, spousal support, family support, exercise, caffeine consumption and dietary habits).

2.3. The healthy lifestyle behavior scale II (HLBS-II)

This scale measures behaviours that increase health and was developed by Walker et al. based on the health promotion model and in relation to healthy living. The scale was reorganised in 1996 and renamed HLBS-II [24]. It was reported that HLBS-II may be used to investigate health-promoting behaviours and the contribution of training towards adopting these behaviours. The scale was checked for reliability and validity in Turkey by Bahar et al. (2008). HLBS-II consists of 52 positive items in the form of a 4-point Likert-type scale [1 (never), 2 (sometimes), 3 (often) and 4 (always)]. The scale consists of six sub-dimensions: self-fulfillment, nutrition, exercise, health responsibility, interpersonal support and stress management. High scores indicate that the individual practices at a high level the health behaviours presented as items in the scale. The maximum possible score in the scale is 208, while the minimum is 52. The Cronbach's Alpha internal consistency reliability coefficient of the scale was reported as 0.92 [25]. In this study, the Cronbach's Alpha value was 0.88.

2.4. Infertility self-Efficacy scale – short form (ISE-SF)

The Infertility Self-Efficacy Scale was developed by Cousineau et al. in 2006 to analyse the infertility-related self-efficacy perceptions of infertile individuals regarding their cognitive, emotional and behavioural skills [12]. The 9-point Likert-type scale (1-not at all important and 9-extremely important) consists of 16 items. Cousineau et al. developed the short form of the scale with 10 items. Arslan Özkan et al. adapted the scale for Turkish use as the short form. This 4-point Likert-type (1-not applicable to me at all and 4-completely applicable to me) short form consists of eight items. ISE-SF is scored between 8 and 32. High scores indicate high self-efficacy perceptions, and all statements in the scale are positive. There is no cutoff point. The scale's Cronbach's Alpha value is 0.78'dir [5], while, in this study, the Cronbach's Alpha value was 0.80'dir.

2.5. Data collection

The data were collected by the researcher in the institution mentioned above via face-to-face interviews. The pre-test data were collected in the first interview using the Personal Information Form, HLBS-II and ISE-SF. After collecting the pre-test data, fertility-supporting health training was provided for the women in the experimental group. Four weeks after the first session, the participants were given a reminder session which investigated whether there were any problems or issues they did not understand regarding the fertility-supporting health training. Four weeks after the reminder session, the post-test data were collected using HLBS-II and ISE-SF. The pre-test data for the control group were collected in the same manner. The post-test data for the control group were collected eight weeks after the first interview using HLBS-II and ISE-SF.

2.6. Intervention

The fertility-supporting health training provided for the infertile women in the experimental group was carried out in two stages: in the first session and in a reminder session four weeks after this training. The

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