



Clinical education

Web-based education about vulvodynia and its care among student healthcare staff: A quasi-experimental study

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ABSTRACT

Student healthcare providers are the type of primary healthcare professionals who usually have first contact with young women who have problems with intimacy, such as vulvar pain – known as vulvodynia. However, a need to increase healthcare professionals' level of knowledge of vulvodynia and its care has been identified. This study aimed to assess the awareness and knowledge of vulvodynia and its care among student healthcare providers, before and after Web-based education. The study design was national, descriptive and quasi-experimental, and was conducted across Finland. A total of 79 participants completed baseline measurements, 58 completed web-based education and 30 took part in a follow-up survey. A survey instrument called 'Awareness and knowledge of vulvodynia and its care' was developed for this study, and the data were collected using a web-based questionnaire. Descriptive statistical methods were used to evaluate the participants' awareness and knowledge of vulvodynia and its care before and after web-based education. The primary results indicated that the participants' awareness and knowledge of vulvodynia and its care was statistically significantly improved following web-based education.

1. Introduction

Vulvar pain with no clear aetiology is usually called vulvodynia, and it may result in numerous physical and psychosexual functional disorders in women (Goldstein and Burrows, 2008; Bohm-Starke, 2010; Sadownik, 2014). In Finland, student healthcare providers are the type of primary healthcare professionals who usually have first contact with young women who have problems with intimacy. However, women with vulvodynia have reported negative experiences with Finnish primary healthcare in terms of knowledge of the condition and its care (Törnävä et al., 2012). A recent study also found that the student healthcare providers who meet and care for females of fertile age have insufficient awareness and knowledge of vulvodynia and its care (Törnävä et al., 2017). To date, no study has evaluated the effectiveness of any type of education with regard to increasing the awareness and knowledge of vulvodynia and its care among healthcare providers.

2. Background

2.1. Web-based education

Web-based education (WBE) is a cost-effective way of educating

large numbers of healthcare providers, in terms of travel costs, as well as personnel time and trainer costs, enabling them to deliver the same consistent programme (Cook et al., 2010; Brown and Bullock, 2014; Lahti et al., 2014a). Well-designed WBE is also a dynamic, innovative and rich method of providing nursing staff with education on specific topics. It allows learners to access the particular website, follow lectures or complete assignments according to their own schedules, and the learners have sole control over the content, place and time of learning (Durkin, 2008; Cheng, 2012; Lahti et al., 2014a).

Evaluation of WBE interventions has shown that interactivity, practice exercises, repetition and feedback improve learning outcomes. A comparison of WBE intervention- and non-intervention-related knowledge has shown promising results in the medical field, although the findings have sometimes been contradictory (Cook et al., 2010; Lahti et al., 2014a). However, there remains a lack of evidence regarding the impact of WBE methods in nursing education (Lahti et al., 2014a).

2.2. Vulvodynia and its care

The International Society for the Study of Vulvar Diseases (ISSVD, 2016) defines vulvodynia as chronic pain or discomfort involving the

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vulva for more than 3 months, and for which no obvious aetiology can be found (Haefner, 2007). The exact causes of vulvodynia remain uncertain; however, previous studies have identified some possibilities, including inflammation, genetic factors, hormonal factors and contributory psychosocial factors (Goldstein and Burrows, 2008; Bohm-Starke, 2010; Danby and Margesson, 2010; Reed et al., 2014). Vulvodynia may be triggered during sexual intercourse and/or by nonsexual activities, such as wearing tight-fitting clothing or even sitting (Harlow and Stewart, 2003; Danby and Margesson, 2010; Sadownik, 2014). It can be classified according to the anatomical site of the pain; it may be localised to a specific area (localised vulvodynia) or to all over the vulva (generalised vulvodynia). It can also be categorised on the basis of whether the experienced pain is provoked or unprovoked (Haefner, 2007; Danby and Margesson, 2010; Sadownik, 2014). Localised, provoked vulvodynia is the most common form of the condition, and the patients are usually young nulliparous women. The lifetime prevalence of unexplained vulvar pain can be as high as 16%; generalised, unprovoked vulvodynia is less common, with a 6–7% prevalence. Generalised vulvodynia presents as a diffuse, constant, burning or raw pain anywhere on the genitals and/or the pelvic area. (Harlow et al., 2001; Danby and Margesson, 2010).

The lack of randomised trials means that the care of women with vulvodynia is primarily based on clinical experience, descriptive studies and reports made by expert committees. An individualised multidisciplinary approach is recommended to address both the physical and psychosexual aspects of the condition (Danby and Margesson, 2010; Nunns et al., 2010; ASCCP, 2016). It has been shown that such an approach increases women's knowledge of vulvodynia and helps them to gain the skills they need to address their pain, and also encourages them to take responsibility for their own care (Munday et al., 2007; Sadownik et al., 2012; Törnävä et al., 2012).

Counselling by healthcare personnel with regard to gentle self-care of the vulva area and other instructions to address pain is first-line treatment in minimising vulva irritation (Cox and Neville, 2012; Lindstrom and Kvist, 2015; ASCCP, 2016). It has also been shown that pelvic floor physiotherapy, such as biofeedback, electrical stimulation and pelvic floor manipulation, reduces pain in women with vulvodynia (Bergeron et al., 2001; Nunns et al., 2010; Melnik et al., 2012; Murina et al., 2013; Morin et al., 2016). Moreover, psychosexual interventions are effective in reducing vulvar pain and in improving associated psychosexual outcomes for these women and their partners (Bergeron et al., 2014; Davis et al., 2015). Medical interventions include topical, oral and injectable medical substances (Nunns et al., 2010; ASCCP, 2016); if conservative treatments have not been useful, and the pain is due to localised, provoked vulvodynia, a surgical procedure known as vestibulectomy may be effective (Andrews, 2011; Tommola et al., 2011).

2.3. Knowledge of vulvodynia and its care

Previous research into knowledge of vulvodynia and its treatment among healthcare professionals has primarily focused on the perspectives of either patients (Gordon et al., 2003; Buchan et al., 2007; Törnävä et al., 2012) or physicians (Updike and Wiesenfeld, 2005; Toeima and Nieto, 2011; Phillips et al., 2013); only one study also assessed the perspectives of nursing and therapy staff (Törnävä et al., 2017). The studies that investigated women's experiences of the care they received reported that the knowledge of healthcare staff was inadequate from the patients' perspective (Gordon et al., 2003; Buchan et al., 2007; Törnävä et al., 2012). In addition, an estimated 40% of women seeking treatment fail to receive help, and this estimate may even be conservative (Harlow and Stewart, 2003; Goldstein and Burrows, 2008).

It has been reported that junior gynaecologists have insufficient understanding of vulvodynia and its management (Toeima and Nieto, 2011), although Updike and Wiesenfeld (2005) and Phillips et al.

(2013) reported a good awareness among obstetricians and gynaecologists. A recent study found that student healthcare providers who meet and care for women of fertile age have insufficient awareness and knowledge of vulvodynia and its care and, creation of educational programs was recommended to provide evidence-based care for women with the condition (Törnävä et al., 2017).

3. AIMS

The present study aimed to assess awareness and knowledge of vulvodynia and its care among student healthcare providers before and after WBE.

4. Methods

4.1. Design and sample

The study design was national, descriptive and quasi-experimental, and it was conducted in student healthcare, which is part of primary healthcare in Finland. All student healthcare providers (N = 191) who serve students of universities and other institutions of higher education, were chosen as the target group, and were recruited nationwide from all 12 student healthcare units. These individuals were invited to participate in the survey, and to receive WBE on vulvodynia and its care. They were invited via an email, which included information on the study, sent by the nurses in charge of the student healthcare units.

A baseline survey was conducted between February and April 2015. A letter reminding the participants of the follow-up survey was sent by the nurses in charge of the units at 2, 4 and 6 weeks after the survey began. WBE on vulvodynia and its care was provided for a duration of 4 weeks, between October 2015 and November 2015. The follow-up survey was carried out 2 weeks after the completion of WBE, between December 2015 and February 2016.

4.2. Survey instrument

The web-based questionnaire consisted of individual background factors, demographic factors and three questions self-assessing each participant's own skills with regard to caring for women with vulvodynia (Table 1), as well as the 'Awareness and knowledge of vulvodynia and its care' (AKVDC) survey instrument developed by the authors (Table 2). The latter consisted of two parts: 'Awareness of vulvodynia and its care' (Part 1) and 'Knowledge of vulvodynia and its care' (Part 2). Part 1 was developed on the basis of patient-related qualitative research findings on the care experiences of women with vulvodynia (Törnävä et al., 2012, 2013), while Part 2 was based on previous studies of vulvodynia (e.g. Bohm-Starke, 2010; Reed et al., 2014; Sadownik, 2014) and its management (e.g. Danby and Margesson, 2010; Nunns et al., 2010; Melnik et al., 2012).

Part 1 covers four main dimensions of awareness: the identification of vulvodynia (14 items), the treatment of vulvodynia (13 items), the significance of encountering patients (15 items) and the significance of providing information and support to patients (24 items). A 6-point Likert scale, ranging from 1 (completely disagree) to 6 (completely agree) or ranging from 1 (I know it remarkably poorly) to 6 (I know it remarkably well), was used to measure the participants' awareness.

Part 2 of the AKVDC instrument includes 20 items relating to the participants' knowledge of vulvodynia and its care. This part of the instrument is a knowledge test in which three possible options for the answers are given: true, false and not sure.

The face validity and content of the AKVDC instrument was tested in a pilot study by an independent panel of multi-professional healthcare staff (N = 9), composed of uro/gynaecological nurses, pelvic floor physiotherapists, sex counsellors and gynaecologists, prior to the survey. They commented on the structure, phrasing, clarity, comprehensibility, relevance and assessment scale of the instrument. The

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