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ARAŞTIRMA / RESEARCH

Effect of the premarital sexual health/reproductive health training on knowledge level and marital adjustment of the newly married women

Evlilik öncesi cinsel sağlik/üreme sağlığı eğitiminin yeni evli kadınların bilgi düzeyi ve evlilik uyumuna etkisi

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Abstract

Purpose: This study was conducted in order to determine the effect of the premarital Sexual Health/Reproductive Health Training on the knowledge level, marital adjustment and sexual satisfaction of the newly married woman.

Materials and Methods: This study was an experimental study based on the design of pretest-posttest with control group. The study was performed with 149 women.

Results: In the pretest measurements of the study, total score of The Assessment Form on Sexual Knowledge Level of the experimental group was 65.19 ± 9.88 and total score of The Assessment Form on Sexual Knowledge Level of the control group was 63.33 ± 11.51, and it is observed that total scores were similar between the groups. It was determined that the posttest total score was significantly higher in the experimental group (74.08 ± 11.98) compared to the control group (62.33 ± 12.57). It was determined that Marital Adjustment Scale, Golombok Rust Inventory of Sexual Satisfaction and The Marital Beliefs and Attitudes Scale; Health Belief Model total scores of the women in the experimental and the control groups did not show a statistically significant difference.

Conclusion: The training was effective in increasing the knowledge levels of the women on sexual matters but it did not affect their marital adjustment and sexual satisfaction in a four-month period.

Keywords:. Marital adjustment; premarital training; sexual satisfaction; sexual health; reproductive health

Öz

Amaç: Bu çalışma, evlilik öncesi Cinsel Sağlık/Üreme Sağlığı Eğitiminin yeni evli kadının bilgi düzeyi, evlilik uyumu ve cinsel memnuniyeti üzerindeki etkisini belirlemek amacıyla yapılmıştır.

Gereç ve Yöntem: Bu araştırma öntest-sontest kontrol gruplu desene dayanan deneysel bir araştırmadır. Çalışma 149 kadınla yapılmıştır.

Bulgular: Çalışmanın ön testinde, deney grubunun Cinsel Konular ile İlgili Bilgi Düzeyine İlişkin Değerlendirme Formu toplam puanı 65.19 ± 9.88, kontrol grubunun toplam puanı 63.33 ± 11.51 olup toplam puanların gruplar arasında benzer olduğu görülmüştür. Son test toplam puanının deney grubunda (74.08 ± 11.98) kontrol grubuna (62.33 ± 12.57) göre anlamlı derecede yüksek olduğu tespit edilmiştir. Deney ve kontrol gruplarındaki kadınların Evlilik Uyum Ölçeği, Golombok-Rust Cinsel Doyum Ölçeği - Kadın Formu ve Evliliğe Yönelik İnanç ve Tutumlar Ölçeği; Sağlık İnanç Modeli toplam puanları arasında ise istatistiksel olarak anlamlı bir fark bulunmamıştır.

Sonuç: Evlilik öncesi eğitimin kadınların cinsel konulardaki bilgi düzeylerinin artırılmasında etkili olduğu ancak dört aylık dönemde evlilik uyumlarını ve cinsel doyumlarını etkilemediği sonucuna varılmıştır.

Anahtar kelimeler: Evlilik uyumu; evlilik öncesi eğitim; cinsel doyum; cinsel sağlık; üreme sağlığı

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INTRODUCTION

The marriage is a relationship among two people accepted legally or approved by the society, providing the parties with some rights and obligations and generally including sexuality[1]. The aim of the marriages is the happiness of the individuals. The mutual adjustment and expectations should come true and the satisfaction should be met in order to provide happiness[2]. When the marriage is successful, it affects the satisfaction with life, physical health and the psychological well-being of the couples positively[3].

Although marriage is a widespread individual choice all over the world, it may bring some negative results with it. For many married couples, the marriage starts with satisfaction and pleasure it may end with sorrow and disappointment. In cases where family integrity cannot be maintained, the couples prefer to divorce. It has been determined that the reasons of divorce involve sexual problems like impotence, sexual anorexia, vaginismus as well as socio-demographic variables, early marriage, low education and income level, the carrier of the woman, communication conflict, domestic violence and the economic problems[4-6].

It is seen that among the reasons for divorce, the sexuality has an important part in the spousal relation[7]. It has been determined in the studies that there is a relationship between the marital adjustment and the sexual harmony and satisfaction. When the adjustment levels of the couples with and without sexual problems are compared, the dyadic adjustment of the couples without sexual problems has been found to be significantly high[8-11].

The sexual problems are common in the marriages and cause them to end[7,8]. The inadequate knowledge of the young people on sexual matters reflect on their relationships in the marriage. There are many studies on inadequacy of the knowledge of the young population on the Sexual Health/Reproductive Health (SH/RH) in Turkey and in the World[4,5,7-12]. When the age at first marriage in Turkey is examined, informing the newly married couples about SH/RH has a great importance as they are also a part of this young population[13].

It has been determined in the studies assessing the premarital knowledge levels of the individuals on the Sexually Transmitted Diseases (STD), Family Planning (FP) and infant care that the women have lack of knowledge on FP and pregnancy[12,14-16]. This can cause unintended pregnancies and important problems threatening the reproductive health. For this reason, it is very important that the FP services are provided effectively for the young people[17].

STD is one of the most important results of the unconscious and irresponsible sexual behavior[18]. STD are one of the major etiological factors that cause loss of life in youth in the developing countries. It is stated in the studies that 73.4-82.0% of the women have no knowledge or lack of information on STDs[12,19].

Wrong beliefs and attitudes on SH/RH may be observed among the young people together with FP and STDs. In a study, it was determined that women started to show a tendency to have a vaginal douching together with the marriage and generally they had vaginal douching after the sexual intercourse[20]. In a study determining the SH/RH levels of the university students, the students stated that they had lack of knowledge on the subjects like the formation of the pregnancy (35.6%), organs and functioning of the male and female reproductive system (27%), and healthy sexuality (61.4%)[21].

In the light of these data, it has been stated that the training performed on the SH/RH increases the knowledge levels of the women on sexual matters and this increase in knowledge may contribute to the sexual satisfaction and marital adjustment of the couples[2,10,22].

As the family is the smallest but the basic unit of the society, the families with a firm basis have great importance in terms of the healthy development and improvement of the society and providing social peace. Providing pre-marital consultancy services on the subjects like the healthy family pattern, reproductive health, contraceptive methods, and infectious diseases may raise awareness of the people on the possible risks, results and protection ways[14]. Obstetric and Gynecology Nurses play a number of roles in health protection, development, education, research, counseling and advocacy. These services are not limited to the reproductive function of women, but also cover all life periods of women. For this reason, it is of great importance to extend the trainings on SH/RH issues before marriage[23]. This study was conducted in order to determine the effect of the premarital SH/RH Training on knowledge level, marital adjustment, and sexual satisfaction of the newly married woman.

MATERIALS AND METHODS

This study was an experimental study based on design of pretest- posttest with control group. The study was conducted in the Mustafa Kızıklı Family Health Center (MKFHC) located in the city center of Kayseri between August 2016-August 2017. In Turkey, every couple is obliged to receive a health certificate before marriage. MKFHC is the only center that gives a health certificate for marriage in Kayseri. MKFHC of Kayseri Governorship has been providing services since November 2004. One nurse is on duty and provides individuals, who come to the center for medical counseling, with blood-grouping tests and examinations such as Venereal Diseases Research Laboratory (VDRL), Acquired Immune Deficiency Syndrome (HIV), Hepatitis C (HCV) and Hepatitis B (HBS) on request.

In all the phases of the study, the ethical principles were paid attention to be followed. The academic committee resolution from Erciyes University Health Sciences Faculty, the Ethics Committee approval from Erciyes University Social and Human Sciences Ethics Committee (Application 2016/21) the written institutional permission from the center, where the study was conducted, were received in order to conduct the study. The individuals included in the study were informed about the purpose of the study and their verbal consent was received and they signed the informed consent forms.

Sample

The population of the study consisted of the women who came to give blood in MKFHC to receive a health certificate before marriage. The sample groups were determined as totally (d= 0,5, α = 0,05, 1-β = 0,80, n2 / n1 = 1) 184 people (92 for experimental group and 92 for control group), with simple random sampling method. The women who meet the inclusion criteria were recorded in the interview list in the order of their arrival. The ones with the odd number in the list are included in the experiment and those with the even number in the control group. The women who were aged 17 years and over, were at least primary school graduate, had no visual and hearing impairment, had no communication barrier, did not get a professional assistance for any kind of psychiatric disorder and sexual dysfunction and would get married for the first time were included in the study. The study was completed with 149 women (77 in the experimental group and 72 in the control group), as some women broke up without getting married, divorced, stated that they had time problems, did not want to fill in the questionnaire or some of them could not be reached (Figure1).

Measures

The Personal Information Form, the Marital Beliefs and Attitudes Scale; the Health Belief Model (HBM), The Assessment Form on Sexual Knowledge Level (AFSKL), the Golombok Rust Inventory of Sexual Satisfaction- Woman Form (GRISS), and the Marital Adjustment Scale (MAS) were used as the data collection tools in this study (Figure1).

Personal Information Form

The Personal Information Form prepared by the researcher upon the literature review[2,10,12] is composed of a total of 21 questions including the socio-demographic characteristics of the women, the characteristics about the husband-to-be, and their attitudes on the sexuality and FP.

The Marital Beliefs and Attitudes Scale; Health Belief Model (HBM)

The Turkish reliability and validity study of the scale developed by Sullivan et al.[24], was conducted by Vural and Temel (2007). HBM has 23 items under the subscales of the perceived susceptibility, seriousness, barriers, and benefits. It is a five-point Likert type scale and items are scored between 1 and 5 points. Higher scores signify that the individuals' marital attitudes and beliefs, and perceived susceptibility, benefits, seriousness increase positively and their barriers increase negatively. The lowest score is 23 and the highest score is 115 in this scale[2].

The Assessment Form on Sexual Knowledge Level (AFSKL)

The scale was developed by Vural in 2007 and its reliability and validity study was conducted. This form has 25 items related to the anatomy and physiology of male and female reproductive organs, reproductive health, FP methods, sexual life, sexual dysfunctions, and STD. The participants are asked to answer each item as true or false. Every false item is 0 point and every true item is 4 points. Total knowledge score to be obtained from the questionnaire varies between 0 and 100 and as the total knowledge score increases, their knowledge level also increases[2].

Golombok Rust Inventory of Sexual Satisfaction (GRISS)

The reliability and the validity study of the scale, developed by Rust and Golombok (1983), was conducted by Tuğrul et al., (1993) in Turkey. GRISS is a scale used to assess the quality of the sexual intercourse and the sexual dysfunctions. The scale has 28 items in the seven subscales: "avoidance", "dissatisfaction", "non-communication", "non-sensuality", "the infrequency", "vaginismus", and "anorgasmia"., It is a five-point Likert type scale and both the scale total score and the subscale scores can be used in the assessment of the scale. The raw scores can be converted into standard scores ranging from 1 to 9. As 5 points and over are identified with the dysfunction of sexual intercourse or its functions, the participants with 5 points and over were named as the "problematic group" and the ones with less than 5 points were named as the "unproblematic group[25].

Marital Adjustment Scale (MAS)

Being developed by Locke and Wallace, MAS is a scale with 15 questions. Its reliability and validity study was conducted by Kışlak (1999) and adapted into Turkish. The scale is composed of two structures including the agreement or disagreement situations and the relationship style. While the highest score is 58, the lowest score is 0. Those who get 43.5 points and over are evaluated as well-adjusted in their marriage and those getting the scores under 43.5 are evaluated as maladaptive[26].

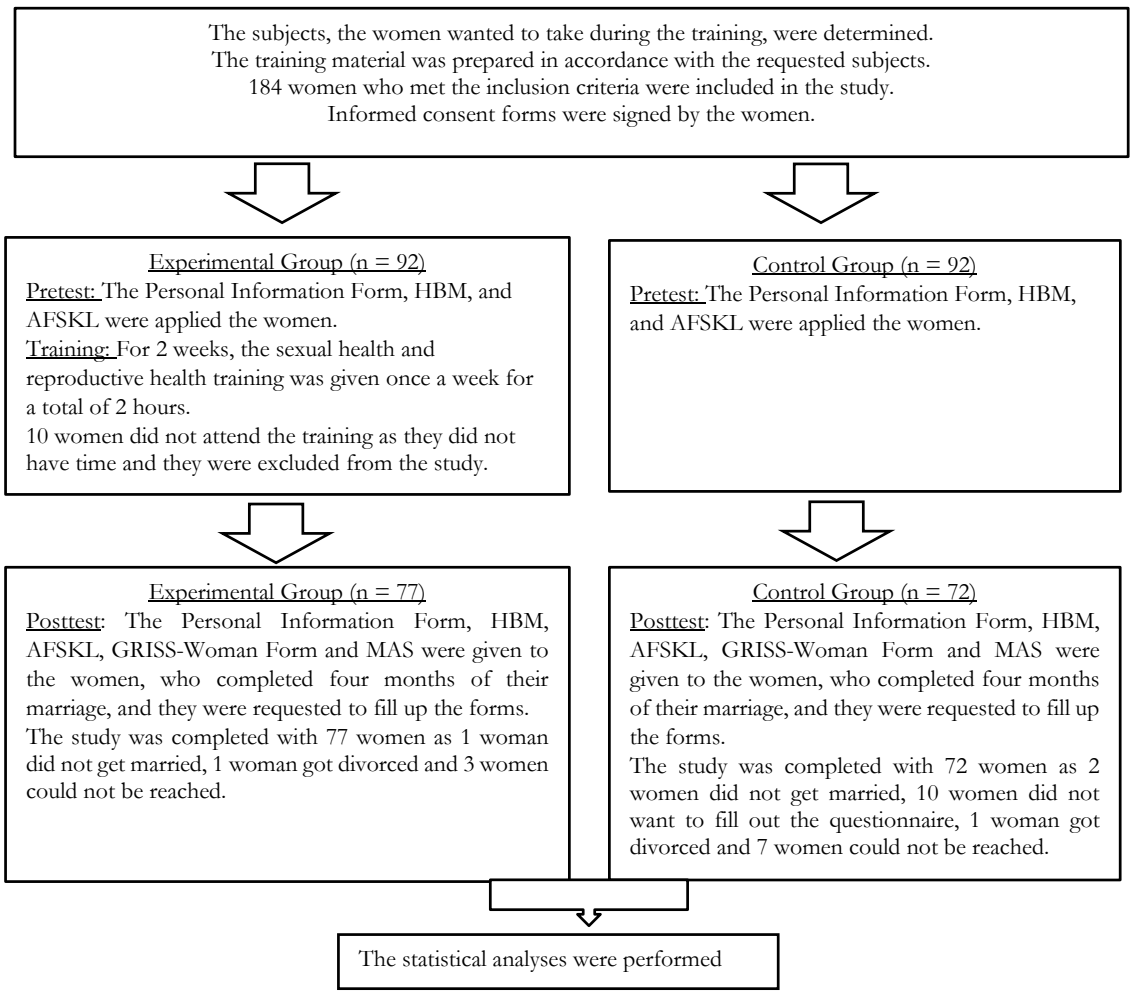

Figure 1. Study flow chart

Procedure

The questionnaire forms including the training subjects related to SH/RH were applied for 30 women who came to MKFHC to receive a health certificate before marriage. As a result of these questionnaires, the SH/RH subjects, in which the women wanted to have a training, were determined as the anatomy and physiology of the male and female reproductive organs, the physiology of sexuality and healthy sexual life, the formation of pregnancy, FP methods, STD and safe motherhood. The training material was prepared in accordance with the requested subjects and the approval of the experts was received (Figure 2). These 30 women were not included in the sample group.

Figure 2. Preparation and implementation process of educational material

Aim of Education	**Increasing the knowledge level and awareness of women on SH/RH issues**
1. Subjects of Education of the Session	The structure and functioning of the male and female reproductive system Hymen Menstrual cycle Pregnancy FP methods Factors affecting fertility Infertility
2. Subjects of Education of the Session	Sex action physiology in women and men The first night in marriage Virginity Perineum hygiene STD and protection methods
Preparation Period	3 month
Training Method	Visual material-Slide presentation
Duration of Training for Each Woman	120 minutes * 2 sessions = 240 minutes in total
Number of Persons in Sessions	Minimum 1 maximum 4 people
Total Sessions	78

In the study, the women included in the experimental group and the control group were informed about the purpose and importance of the study and they signed the informed consent forms. The Personal Information Form, HBM, and AFSKL, to assess their knowledge on the topics included in the SH/RH training, were applied for the women in the experimental and control groups and the pretests lasting approximately 15 minutes were performed. In order to prevent the women to be affected by their partners, their partners waited out of the room while the women were filling up the forms. The women in the experimental group were given appointment before the wedding/marriage, the training was provided by the research in the specified days. The training was performed with small groups of 1 to 4 persons as the women in the experimental group had problems in determining the time to participate in the training. Each group was provided training once a week for approximately 120 minutes in totally two sessions (240 minutes). Totally 78 sessions of training were provided for 77 women and the training process was completed averagely in one year. No training was provided for the women in the control group. After completing four months of their marriage, the Personal Information Form, HBM, AFSKL, GRISS-Woman Form, and MAS were given to the women in the experimental and the control groups with the face-to-face interview method and they were requested to fill out the forms.

Statistical analysis

The data obtained in the study were analyzed using SPSS (Statistical Package for Social Sciences) (IBM Corp., Armonk, New York, USA) for Windows 24.0 program. The mean of the variables, with 95% confidence interval, count of the participants and the percentage of the data were used. The Kolmogorov-Smirnov test was used to determine whether the distributions of continuous variables were normal; the Levene's test evaluated the homogeneity of variances. Continuous variables were shown as

mean±standard deviation or median (min-max), where applicable. Distribution analysis of women's descriptive qualifications was done with Chi-square and anova test. In the analysis of the AFSKL and HBM scale mean scores of women, the dependent sample-t test was used to compare the mean scores of the dependent group, while the independent sample-t test was used to compare the average scores of the two independent groups. The analysis of the total score averages of the Marriage Adjustment Scale and GRISS scale of the women in the experimental and control groups were done with the Mann-Whitney U test. The data were reviewed at the 95% confidence level, and a p-value of <0.05 was considered significant.

RESULTS

Table 1 shows the distribution of the women in the experimental and control groups according to their descriptive characteristics. The age average of the women in the experimental group was 23.74± 3.18, the average age of the women in the control group was 24.09± 3.65 and 61.0% of the women in the experimental group and 57% of the women in the control group were college graduates. 57.1% of the women in the experimental group and 62.5% of the women in the control group were employed. 94.8% of the women in the experimental group and 97.2% of the women in the control group had no kinship with their husbands.

72.7% of the women in the experimental group and 80.6% of the women in the control group stated that they met with their husbands compromisingly. The women included in the study were similar in terms of the descriptive characteristics and the marital characteristics and the groups had a homogeneous distribution (p>0.05). All the women included in the study were Muslim.

Table 1. The distribution of the women in terms of their descriptive characteristics

Variables	Groups				
	Experimental (n=77)		Control (*n*=72)		*p*
Average Age (X ± Sd, year)	23.74 ± 3.18		24.09 ± 3.65		0.525
Educational level	*n*	%	*n*	%	
Primary School	8	10.4	6	8.3	0.707
High School	22	28.6	25	34.7	
College	47	61.0	41	57	
Working status					
Employed	44	57.1	45	62.5	0.505
Unemployed	33	42.9	27	37.5	
Income level					
Middle	40	51.9	30	41.7	0.251
High	37	48.1	42	58.3	
Husband's Educational level					
Primary School	13	16.9	9	12.5	0.229
High School	19	24.7	27	37.5	
College	45	58.4	36	50.0	
Husband's Occupation					
Worker	15	19.5	16	22.2	0.582
Civil servant	43	55.8	34	47.2	
Self-employed	19	24.7	22	30.6	
Kinship					
Yes	4	5.2	2	2.8	0.682
No	73	94.8	70	97.2	
Way of deciding on marriage with their husband					
Arranged marriage	21	27.3	14	19.4	0.334
With dating	56	72.7	58	80.6	
Duration of acquainting with their husband (mean±SD, month)	28.29 ± 32.95		36.08 ± 39.30		0.191
Duration of making marriage decision (mean±SD, month)	15.87 ± 23.51		21.44 ± 30.08		0.208

* Chi-square and anova test

Table 2 shows the distribution of the women in the experimental and control groups according to the AFSKL mean scores. In the pretest measurements of the study, total score of AFSKL of the experimental group was 65.19 ± 9.88 and total score of AFSKL of the control group was 63.33 ± 11.51, and it is observed that total scores were similar between the groups (p>0.05). It was determined that the posttest total score was significantly higher in the experimental group (74.08 ± 11.98) compared to the control group (62.33 ± 12.57) (p<0.05). It was determined that the posttest total score (74.08±11.98) of the experimental group was higher compared to the pretest total score (65.19±9.88) (p<0.05) and no statistically significant difference was found between the pretest and posttest total scores of the control group (63.33±11.51, 62.33±12.57, p>0.05, respectively). Tables 3 and 4 show the distribution according to the mean scores of the women for Marital Adjustment Scale, GRISS and HBM. As a result of the analyses, it was determined that MAS, GRISS and HBM total scores of the women in the experimental and the control groups did not show a statistically significant difference (p>0.05).

Table 2. Distribution of the women in terms of AFSKL mean scores

AFSKL	**Experimental Group**	**Control Group**	***t***	***p***
	n=77 *(Hatal Yer işareti tanımlanmamış.mean± SS)*	*n=72* *(Hatal Yer işareti tanımlanmamış.mean± SS)*		
Pretest scale total score	65.19±9.88	63.33±11.51	1.056	0.293
Posttest scale total score	74.08±11.98	62.33±12.57	5.840	<0.001
Knowledge acquisition	+8.89	-1		
p	<0.001	0.485		

* Dependent sample t test, independent samples t-test

Table 3. Distribution of the women in terms of Marital Adjustment Scale and GRISS mean scores

Scale	**Groups**			
	Experimental Group n=77	**Control Group n=72**	***p***	
Marital Adjustment Scale Total median score *(min-max)*	49.00 (30.00-58.00)	47.00 (19.00-58.00)	U: 2403.500	0.161
GRISS Total score *mean± SD*	7.09±0.89	7.08±0.96	t: 0.050	0.960

*Mann-Whitney U test

Table 4. Distribution of the women in terms of HBM scale mean scores

Mean ± SD	**Experimental Group n=77**			**Control Group n=72**			**Comparison of the groups**			
	Pretest	Posttest	*p*	Pretest	Posttest	*p*	Pretest		Posttest	
							t	*p*	*t*	*p*
Susceptibility	11.40±2.85	12.26±3.80	0.085	11.43±2.14	12.53±3.42	0.013	0.067	0.946	0.451	0.652
Seriousness	16.27±8.37	19.91±6.44	0.001	15.43±8.34	20.54±5.68	<0.001	0.615	0.540	0.634	0.527
Barriers	9.49±2.37	8.88±2.51	0.039	9.38±2.41	9.57±2.44	0.584	0.303	0.763	1.690	0.093
Benefits	33.44±4.12	33.34±3.38	0.817	32.28±4.60	31.42±4.50	0.189	1.630	0.105	2.932	0.004
Scale Total score	70.61±10.10	74.39±9.08	0.010	68.51±10.46	74.06±8.37	<0.001	0.600	0.147	0.233	0.816

* Dependent sample t test , independent samples t-test

DISCUSSION

It is very important for the young people, who will get married, to be aware of SH/RH in order to increase the health level of the society.

It is stated that the individuals, who prepare to get married, want to have knowledge of SH/RH. Also the knowledge level of the couples is low and even they have misinformation and misbelief on these subjects[2,10,12,13,28,31].

It was determined that while the knowledge levels of the experimental and control groups on the sexual subjects were similar before the training ($p>0.05$), the knowledge scores of the experimental group increased after the training ($p<0.001$). In a study in which a premarital sexual consultancy program was applied, it was determined that the pretest total mean score of the experimental group was 72±9.88, the posttest total mean score was 83.94±7.78, the pretest total mean score of the control group was 70.85±9.29 and the posttest total mean score was 72.97±8.94[2]. In this study, the total knowledge score of the women was found to be high due to their educational level and as they lived in the big cities. In another study, total knowledge scores of a group which was provided with a sexual health training were similar to the present study[27]. As a result of this study, according to pretest total knowledge mean scores, it was observed that both groups did not have enough knowledge about sexual health, as in the similar studies. The knowledge score increase in the experimental group was in accordance with the anticipated values and it demonstrated the effectiveness of the SH/RH training provided for the women. In the study by Vural, a positive significant correlation was found between the knowledge levels of the women on the sexual matters and their sexual satisfaction.[2] In the study by Doğan and Yoo, it was also similarly reported that the individuals with low knowledge level on sexual health matters experienced sexual problems[22,27]. In this study, no significant correlation was found between the knowledge levels of the women on sexual matters and their sexual satisfaction.

A successful marriage is a factor that affects the physical health and the psychological well-being of the couples positively[3,29]. In a study, using the agreement and communication skills training and the problem-solving techniques, it was determined that the marital adjustment of the couples increased[32]. In the previous studies, it was determined that the marital adjustment of the couples, who received training before marriage, increased[3,29]. According to the results of this study, it was found that the women in both groups had the adjusted marriages as their marital adjustment scale total score was over 43.5. Although the median score of the marital adjustment scale of the women in the experimental group was mathematically higher compared to the control group, this was not statistically significant ($p>0.05$). It is stated that the martial adjustment of the couples may be provided averagely in 4 months and the adjustment may increase or decrease in time.[5] In this study, it was found that the marital adjustment of the women in the experimental and control groups was similar. It is thought that the effect of the training on the marital adjustment may increase in time.

It should be remembered that the sexual satisfaction has an important effect in establishing healthy relationships between the spouses. The sexual satisfaction is one of the most crucial and binding points of the sexuality within the marital relationship[32]. In a previous study, it was stated that the sexual satisfaction of the women increased after the training provided for the couples,[2,30] and it was also stated in a similar study that the premarital training had positive effects on the sexual lives of the couples and their sexual satisfaction increased[33]. In this study, no statistically significant difference was found between the groups in terms of the GRISS total mean scores of the women ($p>0.05$). It was determined the women had problems in terms of the sexual satisfaction as the sexual satisfaction scores of both groups were over 5. It is thought that as the content of the SH/RH training applied before marriage includes mostly protecting and promoting health, it does not have enough effect on the sexual satisfaction of the women. There are studies indicating that the sexual satisfaction increases with the advancing age and the sexual satisfaction of the young people is low[34]. It is expected that the sexual satisfaction of these women will be low as they are also young. Although it has been stated that the sexual satisfaction increases in the advancing ages compared to young ages, some previous studies revealed that the sexual satisfaction level was also low in the advancing ages[35]. In addition, the sexual satisfaction mean scores may have been low as the sexuality is considered a taboo and the sexual matters cannot be talked easily and due to the cultural characteristics in Turkey[28].

It is known that there is a positive correlation between the marital adjustment and sexual satisfaction[9]. The marriage may be affected negatively in the situations where the sexual satisfaction between couples cannot be met[5]. In the study conducted by Erbek and Soydaş to examine the relationship between the sexuality and the dyadic adjustment, it was determined that the marital adjustment of the couples having sexual problems was low; on the other hand, in this study, no significant correlation was found between the marital

adjustment and the sexual satisfaction of the couples[9].

The health behaviors of the individuals are affected by their belief, values, and attitudes. The fact that the awareness of the couples on the problems that may be experienced in the marriages increases affects their tendency to receive premarital consultancy services for the resolution of the problems positively. For this reason, the perceived susceptibility, seriousness, benefits, and barriers of the individuals on the matter are important in acquiring health behaviors for them[24].

In this study, it was determined that HBM scale posttest total mean scores of both groups increased compared to the pretest mean scores and no statistically significant difference was found between the groups. As a result of this study, the HBM scale total mean scores of the groups had similarity with the literatüre[2]. As no statistical difference was found between the groups in terms of HBM scale posttest total mean scores, it was determined that the training provided did not affect the belief and attitudes of the women about the marriage.

In the study, post-test total mean score of only the benefits subscale among the subscales of the HBM scale, was found to be significantly higher in the experimental group, compared to the control group. The fact that the score of the experimental group was high in this subscale might be associated with the fact that the women in the experimental group believed that the premarital consultancy might deliver healthy solutions for the problems that they perceived as a threat in their marriages and these were beneficial. Among the women included in the control group, no significant difference was found between HBM scale barriers subscale pretest and posttest mean scores and a significant difference was found between HBM scale barriers subscale pretest and posttest mean scores among the women provided with the training. This difference was thought to indicate that the training decreased the negative beliefs and attitudes of the women towards the premarital consultancy. In a similar previous study, it was determined that there was no difference between the HBM scale benefits subscale total mean scores of the experimental and control groups[2].

Vural stated that there was a positive correlation between the beliefs and attitudes of the women about the marriage and their sexual satisfaction and knowledge levels on the sexual matters, however, in this study, no significant correlation was found between the beliefs and attitudes of the women about marriage and their sexual satisfaction and marital adjustments[2].

Consequently, it was observed that the SH/RH training provided for the women increased their AFSKL mean scores significantly. However, it was determined that this training had no effect on the marital adjustment and sexual satisfaction in a four-month period.

Among the limitations of this research; In the center where women receive medical reports for their marriage procedures, the appropriate environment (room) where the researcher can inform women about the working content and communicate effectively is not provided, women are not reached due to changing the phone numbers of the women sought for the application of posttests, The final tests, which cannot be applied by face to face method, have to be filled by phone and mail.

Limitations of the studywere that some women, who were called for the application of the posttests, could not be reached as they changed their phone numbers. Some women did not come for their appointments determined for the training. These limits us to reach all of proposed sample.

In conclusion, the SH/RH training is effective in increasing the level of knowledge on sexual matters. But is not affect women marital adjustment and sexual satisfaction in a four-month period. For this reason, lifelong learning is targeted and such trainings can be extended over a long period of time and repeated in certain periods, as well as increasing the level of knowledge of women, as well as providing effectiveness in other life areas such as sexual satisfaction and marital adjustment.

Yazar Katkıları: Çalışma konsepti/Tasarımı: ÖK, TB; Veri toplama: ÖK; Veri analizi ve yorumlama: ÖK; Yazı taslağı: ÖK; İçeriğin eleştirel incelenmesi: TB; Son onay ve sorumluluk: ÖK. TB; Teknik ve malzeme desteği:ÖK; Süpervizyon: TB; Fon sağlama (mevcut ise): yok.
Etik Onay: Erciyes Üniversitesi Sosyal ve Beşeri Bilimler etik Kurulu'ndan etik kurul onayı (uygulama 2016/21) merkezden yazılı kurumsal izin. Çalışmadaki tüm prosedürler, kurumsal komitenin etik standartlarına ve 1964 Helsinki Deklarasyonu ve daha sonraki değişiklikleri veya karşılaştırılabilir etik standartlara uygun olarak gerçekleştirildi.
Hakem Değerlendirmesi: Dış bağımsız.
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Author Contributions: Concept/Design : ÖK, TB; Data acquisition: ÖK Data analysis and interpretation: ÖK; Drafting manuscript: ÖK; Critical revision of manuscript: TBM; Final approval and accountability:

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Ethical Approval: The Ethics Committee approval from Erciyes University Social and Human Sciences Ethics Committee (Application 2016/21) the written institutional permission from the center. All procedures in the study were performed in accordance with the ethical standards of the institutional committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards.
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