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THE EFFECT OF SOCIAL GENDER BASED EDUCATION AND CONSULTANCY SERVICES ON WOMEN'S HEALTH BEHAVIOUR: A SAMPLE OF SOUTHEAST IN TURKEY FAMILY

KADINLARDA TOPLUMSAL CİNSİYETE DAYALI EĞİTİM VE DANIŞMANLIK HİZMETLERİNİN SAĞLIK DAVRANIŞLARINA ETKİSİ: YAVUZ SELİM MAHALLESİ ÖRNEĞİ

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Abstract

This research was made to determine the effect of education and consulting services on married women's health behaviors living in Yavuz Selim District through qualitative and experimental study. The sample of research was composed of 40 women living in Yavuz Selim District of Şanlıurfa. Data of this research were collected using semi-structured interview form with standardized open- ended interview technique and Healthy Lifestyle Behaviors Development II scale. Data were evaluated using SPSS and NWIVO program. It was determined that most of the women were younger than their husbands and had lower level of education than them. Most of the women (67.5%) stated that their families were male dominant type and domestic decisions were taken by their husbands. According to HLB-IIS, women's average score increased after the trainings and statistical difference was significant (P <0.01). It was determined that planned training based on social gender and monitoring at home can cause significant chance in women's health behaviors.
Keywords; Gender, woman, healthy behaviors, family, education.

Özet

Araştırma Yavuz Selim Mahallesi'nde yaşayan kadınlarda toplumsal cinsiyete dayalı eğitim ve danışmanlık hizmetlerinin sağlık davranışlarına etkisini belirlemek amacıyla, deneysel ve kalitatif olarak yapılmıştır. Araştırmanın örneklemini 2010-2011 yılları arasında Şanlıurfa Yavuz Selim Mahallesi'nde yaşayan 40 kadın oluşturmuştur. Araştırmanın verileri Standartlaştırılmış açık-uçlu görüşme (yarı yapılandırılmış) tekniği ile anket formu, yarı yapılandırılmış görüşme formu ve Sağlıklı Yaşam Biçimi Davranışları Geliştirme II Ölçeği ile toplanmıştır. Veriler toplandıktan sonra geliştirilmiş toplumsa cinsiyete dayalı eğitim tamamlanmıştır. Eğitimden sonra değişimler takip etmek amacıyla ev ziyaretleri başlamıştır. 3 ay sonra SYBD-IIÖ tekrar uygulanmış, ev ziyaretleri bitirilmiştir. Veriler SPSS ve NWIVO programında değerlendirilmiştir. Bulgulara göre; kadınların çoğunun eşlerine göre daha genç ve düşük eğitime sahip olduğu saptanmıştır. Kadınların % 80,0'ı kızlara yönelik baskılardan dolayı okula devam edemediklerini ve % 87,5'i tekrar okumak istediklerini ifade etmişlerdir. Kadınların çoğu (% 67,5) ataerkil aileden geldiklerini, aile içi kararları kocalarının verdiğini ifade etmişledir. Kadınların hepsi sağlığı tanımlayamamış, yarısı sağlıklı olmak için ne yapması gerektiğini bilmediğini ifade etmiştir. Kadınların eğitimden sonra SYBD-II ölçeğine göre puan ortalamalarının arttığını ve aradaki istatiksel fark ileri derecede anlamlı bulunmuştur (p<0.01). Bu çalışmada kadının yaşı, eğitim durumu, yaşadığı yer ve aile özellikleri değişmese bile, geliştirilmiş toplumsal cinsiyete dayalı eğitim ve evde izlem ile kadınların sağlık davranışlarında önemli bir değişim yaratılabileceği saptanmıştır. Kadınların ifadelerinde de toplumsal cinsiyete dayalı eğitimden sonra önemli değişimler belirlenmiştir.
Anahtar Kelimeler: Toplumsal Cinsiyet, Kadın, Sağlık Davranışları.

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INTRODUCTION

The most important determinant in the level of development in a nation is the existence of healthy populations. This can be achieved by protecting and improving the health of women who constitute more than half of the world's population. Gender mainstreaming is one of the most important factors influencing women's health and their ability to make sensible decisions for the community (Kukulu, 2008; Sancar, 2006; Aktaş, 2007; Aksu, 2008; Polat, 2005; TNSA, 2008). Due to problems arising from gender roles, particularly in developing countries, women live under more unhealthy circumstances, underutilize health services, are subjected to violence more, suffer more ill-health and receive less education (Aksu, 2008; Polat, 2005; TNSA, 2008; TUİK, 2010; Ökten, 2009).

The difference in literacy levels between men and women is one of the most prominent indicators of sexual inequality. According to the 2008 Turkish Demographic and Health Survey (TDHS-2008) 33% of women as opposed to 20% of men had no education or never completed elementary school (TNSA, 2008). Underutilization of educational opportunities by women leads to a decline in their participation in the labor market, brings forward gender roles and the spousal and/or maternal identity. Early marriage can lead to many reproductive health problems[7]. Dominant attitudes such as those entailing the encouragement of pregnancy and having children soon after marriage deter women from having control over their own bodies, their own fertility and sexuality. Motherhood in Turkish society, particularly upon bearing male children, is one of the most empowering experiences women can have because it provides advantages such as self actualization, higher status and economic benefits. On the other hand, having children at a young age can have negative impact on the health and quality of life of both mother and child, and limit women's ability to take advantage of educational opportunities and economic activities (Sancar, 2006; Ökten, 2009; Yücel, 2006).

Having their individual identities fall astern their spousal and maternal identities can lead women to put second their own concerns, particularly their own health problems. They virtually become able to accept and internalize being made invisible and insignificant. Therefore they either ignore even serious health problems of their own, or if they do heed these problems, fail to verbalize their concerns. According to the research, it is noteworthy that many women, when asked about their biggest current concern, mention the problems of their families rather than their own personal problems (Hablemitoğlu, 2005; Akın and Demirel, 2003; Yeşilorman, 2001; Subaşı and Akın, 2003; Başbakanlık Kadının Statüsü Genel Müdürlüğü, [13-17]. Furthermore, due to serious gender discrimination stemming from gender roles, women also face issues of starvation, nutritional disorders, overwork and violence at the hands of friends and spouses. Married women who are not gainfully employed experience higher levels of psychological problems than do men [16-18]. Inequalities and discriminatory practices subjected to females in the context of gender roles set the stage for environments that prevent them from even exercising their right to life. Complete eradication of this problem is possible through education and consciousness-raising.

What is ultimately desired is for women to abandon their traditional roles, to elucidate, dispose of, question and rethink preconceptions, transitioning from submissiveness to assertiveness, from obedience to independence. While gender-specific division of labor is undergoing reconfiguration due to the current socio-economic trends, views on social roles of women are shifting at a slower pace and this delay creates a problem area (Polat, 2005; Yeşilorman, 2001; Esin and Öztürk, 2005). In this context, public health nurses whose primary task is to protect and improve

health have a very important role. The fact that women constitute a larger portion of the population served by public health nurses is significant in terms of easier access to women. Nurses shoulder the responsibility of being positive role models to women, conducting individual and group educational activities based on gender mainstreaming, liaising with various organizations to organize out-of-home activities for women, and providing counseling and guidance (Zeyneloğlu, 2008; Sayılan ve Özkazanç, 2009; Dökmen, 2004; Glick, Sakallı and Ferreira, 2002; Güldü and Ersoy, 2008; Yıldırak, Gülçubuk and Gün, 2002; Oktay, 2007).

Women are traditionally taught to help everyone, be contented with the condition they are in, hide their anger, say “no” under none circumstances and make people happy and relaxed any time. In addition, women are also taught to avoid taking risks. As a result, all these make women stay on lower status and prevent their decision making powers from developing. It is known that in the continents like Asia and Africa which are underdeveloped or developing, less money on health is spent for women in the family. The money is generally under the control of the men. This situation prevents women to reach health care and spend money for it. Besides these financial difficulties, there are other traditional and cultural obstacles for women to reach health care. For example, it may be perceived as a dishonor both for the woman and her family if she goes out alone or without the permission from her husband and gets examined by a male doctor in case there are not any female medical staff. The woman may abstain from getting health care in this situation. In many cultures, women believe that suffering is their destiny. For example; they think that problems like headache and leucorrhea are normal. Lower self-confidence limits women’s ability to demand. If the case demanded is a problem which the society does not approve, lower self-confidence may be reinforced with embarrassment. Lack of education may affect self-confidence in a negative way, too and it can also prevent women from determining their health care needs in a proper way by lowering their self-respects (Aktaş, 2007; Aksu, 2008; Battal, 2008).

In accordance with the literature taken into account above, the effect of education and consulting services on married women’s health behaviors was given priority. This study aims to evaluate the manner and extent of the effects of gender mainstreaming based education on the health of women.

METHODS

This study was conducted experimentally using qualitative research methods in order to evaluate the effects of gender-sensitive education and counseling services on the health behaviors of women. The research was done in the city of Sanliurfa which is located in the southern east part of Anatolia. According to TUIK’s (Turkish Statistical Institute) 2010 data; average marriage age in the city Sanliurfa is 23.1; schooling rate for woman in primary education is %94.89; crude marriage rate is %0 9.24 and total fertility rate is 4.9. In the light of these data, it can be said that Sanliurfa area is a place where male dominant mind and attitude are prevalent and where woman gender and body is under pressure and people generally behave in accordance with the tribes or local communities. The role of the women is substantially defined by the traditional roles and status in places where traditional community structure is common. Background studies show that social gender inequality is seen more in the areas where there is traditional society structure; people’s socioeconomic levels are lower and the density of illiterate and non-working women is high. Under the light of these data, the research is done in Yavuz Selim Neighborhood which is located in the center of the city Sanliurfa and linked to 4. Primary Health Care Center located in Harran University Education and Application Field. The socioeconomic level of this neighborhood is the lowest in the city according to 2009 data. The total population of

Yavuz Selim Neighborhood is 8242; total woman population is 3984 and married woman number among this population is 1541. It is defined that 1015 (%65.9) women are illiterate in the neighborhood. Apart from these, according to another study conducted (Sayılan and Özkazanç, 2009) in the same area, it was defined that most of the women are under 40 years old, more than half of the women speak Kurdish and %88.6 of them are graduates of a primary school and literate. %66.4 of the illiterate women stated that they were not sent to a school just because they were female. The monthly income of the %78.5 of the women is 600 Turkish Liras or below. It was also defined that %75.6 of the women do not have a job that yields money; %85.0 of them marry at or under the age of 20 and %57.3 of them marry in a prearranged way . From the house index cards of the families linked to fourth Primary Health Care Center; the non-working women who are between 20 and 40 years old and married were defined.

INTERVENTION

The application of this study was completed in 4 stages.

First Stage: (Sample, Interviews, Questionnaire Form)

As stated before, the total population of Yavuz Selim Neighborhood is 8242; total woman population is 3984 and married woman number among this population is 1541. The universe and sampling is based these numbers. The House Index Cards (HIC – ETF) which were selected in accordance with the research criterion were listed by the researcher. 80 HICs, 40 principal and 40 backup were selected in accordance with simple random sampling system from this list. The researcher went to the women's houses to meet them, inform them about the research, receive their approval and understand that they know Turkish. In the first interview, the aim of the research, the identity of the researcher and the process of the study were explained to the women and their oral and written approvals were received. During this process, because 19 women were not found in the already stated address and 1 did not know Turkish, 20 women were selected from the backup list. 17 of the women approved to take part in the study in the first interview but in the next interview they refused to continue the study either by saying; "My husband does not let me do it" or saying, "I have got a lot of work to do and I have to take care of my children" and 2 women came on the first day of the education and quit the study from the second day by saying, "I have got things to do and they are retarding." These women also were exchanged with those in the backup list and the sample number of the study, 40, was completed. The power analysis for the study sample was calculated as 1 for $\alpha = 0.05$, as based on Sayılan's study (2009). The calculated sample size of 40 participants was deemed adequate for the study. The women were visited at their homes for the preliminary meeting and to provide information on as well as to receive their consent for participation in the study. During the preliminary meeting, the study aims and the identity of the researchers were explained to the women prior to obtaining oral and written consent.

Second Stage (In-depth interviews)

The participants were called one day in advance by phone and interviewed at home on 15 October - 5 November through "semi-structured interview forms". Upon interviews, participants were informed that they would be phoned again before the date of training about the timing and days of program. The participant women were prepared a suitable physical environment so that they could feel themselves comfortable and not be disturbed during the interview. (The interviews were done between 13.00- 15.00 hrs when men were at work and it was children's sleep time or school time). Conversations were recorded on tape and notes were taken down upon their approval. The interviews ranged between 1 hour and 1.5 hours.

Before starting the interviews, participants' trust was built up by stating:

- No implication of harm is intended for participants
- The conversation can be recorded only upon their permission
- If not content with the conversation, the participants can request deletion of the interviews and a statement to revoke use of the data for research.

Third Stage (Training)

In preparation of training program for this research, awareness raising training activities under the scope of Southeastern Anatolia Project regarding "Gender Equality" on January-June 2006 within the framework of "Strengthening the Women's Socio-Economic Perspective" run in cooperation of United Nations Development Programme (UNDP) with GAP and financial support of Swiss Government were utilized. The scope of training was finalized upon literature examination and 2 expert opinions.

Trainings were given 2 days a week and 3 hours per day for groups of three women whose houses were close to each other. The training hours were determined according to the participants. Laptops and books were taken to houses in order to improve effectiveness of the training. The sessions were provided by questioning their experiences and reflections apart from lecture, question-answer and discussion methods in order to ensure women's participation and retention of information.

Fourth Stage (Home Visits)

Researchers started to make home visits to each woman every two weeks after these trainings finished. Home visits were made 5 days a week between the hours of 9-10, 11-12, 13-14 and 15-16 and 4 home visits were made each day. These visits lasted 20-40 minutes. The first two visits included the repetition of unapprehended points in the trainings and nursing care was given in accordance with their needs (generally about child care, nutrition and family planning issues). In the last two visits, "semi-structured interview form" (Annex-2) was applied to reveal the changes in thinking and behavior of participants upon their acquired information and applications related to training.

3 months after home visits, Healthy Life-Style Behavior Scale – II were employed and the participants were thanked at the end of the study.

Study data were collected using a survey questionnaire regarding socio-demographic characteristics of the participants; the 'Semi-Structured Interview Form' comprised of health information and practices, information on cultural and social traits; and the 'Healthy Life-Style Behavior Scale – II' (HLSBS-II) which identifies health-related behaviors of women.

Qualitative data were assessed via the NWivo-7 program, while the SPSS program was used to evaluate quantitative data. In this study, the subjects' socio-demographic characteristics were the independent variables while their HLSBS-II scores constituted the dependent variables. Statistical significance was determined as $p<0.05$. Data were summarized using means, standard deviations, medians, minimum and maximum values and percentages. Shapiro and Kolmogorov-Smirnov tests were applied to determine normal distribution of the HLSBS-II scores. For normally distributed scores, the paired t-test or Wilcoxan was used for significance testing between differences in means of paired groups, and independent t-test or Mann Whitney U test was used for differences between means.

MATERIALS and SUBDIMENSIONS

Healthy Life Style Behaviors-II Scale (HLBS-II) was revised by Walker and his friends in 1996 and named Healthy Life Style Behaviors-II Scale, also the number of bullets was taken to 52. The Cronbach Alpha value of the scale was determined as 0.94 at first and in the test retest which was applied 3 weeks later it was found as 0.89. The values of six sub-factors showed difference between 0.79 and 0.87 (64, 65). The validity and reliability tests of the scale were applied by Esin in 1997; by Akca in 1998 and by Bahar in 2008. The Cronbach Alpha value of the scale was found 0.92. And in this research, the Cronbach Alpha value of the scale is 0.92 and the general score of the scale gives the score of "healthy life style behaviors." All the bullets of the scale are positive. The rating is in accordance with the quart Likert Type system. "Never" is (1); "Sometimes" is (2); "Often" is (3) and "Regularly" is (4). The lowest score for the whole scale is 52 and the highest score for it is 208. The fact that the score is going up in the scale shows healthy behavior development. The scale was applied in September – December 2012 and includes sub-dimensions of General Health Score, Health Behaviors, Physical Activity, Nutrition, Spiritual/Moral Development, Interpersonal Relations and Stress Management. Data were collected through audio recordings and subsequently transcribed.

Semi-Structured Interview Form

Semi-structured interview form was prepared depending on Cultural Properties Diagnostics Guide. The question of "women's previous family structure", "their new family structure", "wedding type", "relationship between the spouses", "dressing style", "communication style", "traditional practices", "religious practices" and "practices related to health" were taken from Cultural Characteristics Diagnostic Guide. These questions were revised again in the presence of expert consultants. The form includes two parts with open-ended questions that reveal their perceptions of cultural, social, and health status characteristics. The participants talked about their family structure, greetings in the family and addressing style among the family members

RESULTS

In this study on the effects of gender-sensitive education and counseling services on the health behaviors of women, 50% of the participants were under the age of 30 while 75% had spouses over the age of 30. The women were younger than their husbands. In analyzing educational levels, it was found that 90% of the women had completed elementary school or were literate while 55% of their spouses had at least middle school education. Women had lower levels of education then their husbands. 80% of the women stated that their education was interrupted due to oppression of females and 87.5% expressed that they would continue with their education if they had the means to do so. Almost all of the women who articulated the wish to go back to school used phrases similar to those below:

Subject #38: (turning her gaze downward) "I had to leave school when I was at elementary grade 2 because my father forced me to….In our circles, girls don't study. Otherwise, I would have liked to become a lawyer, to be a spokesperson for women, but….I have been silenced…suppressed..."

Subject #35: "They took me out of school because I was a girl…Yet now, especially since I can see the powerlessness of women, I would really like to study had I the chance. Everything would be within my reach, I would be free to go out…I would not depend on men…(sighs)"

Following the gender mainstreaming based training, the women conveyed the view that education is an important factor in decreasing gender bias and expressed the intentions to do all they can to educate their own daughters.

Subject #38: "I dropped out of school under my father's orders, yet I had even chosen a career. I was silenced…I cried a bit then gave up, accepted the situation as if it were normal. That's because at first it seemed like it was normal for girls not to get an education. I began to think that once girls grow up, it would be disgraceful for them to go to school…(after training) Now I realize it is even more important for my daughter to be educated than my son…."

Subject #35: "They took me out of to my school because I was a girl, but I won't do the same thing to my daughter…I will even keep telling my son to encourage his girlfriends to study…"

A majority of the women and their husbands had spent most of their lives in the city (90%, 82.5%). 52.5% of the women said they had been living in the same neighborhood for 6 or more years. Almost all of them (95%) expressed the wish to continue living in the city. When asked to explain, almost all replied that in villages, the workload in the paddocks and at home, looking after children and livestock is too much of a burden and despite working very hard, that is where women are subjected to more scorn, oppression and social pressures. This is reflected below:

Subject #2: "It's easier to live in the city; you can go out more. If you go out in the village, rumors start flying. There, women have to stay at home all the time."

Subject #14: "City women are better groomed, healthier, more organized and more aware. They are better off. Village women, what with the dust, working with animals, laboring in the fields, and tending to the kids and neighbors, sleep less, are belittled and oppressed more. They can't say anything."

Following training: *Subject #14: "I now realize that the health of village women is worse. Because of all the work they have to shoulder….they have more health problems…no one pays attention when they get sick…I think it's harder to change such things in villages than it would be in cities…"*

72.5% of the women stated that their husbands are either unemployed or are seasonal workers. The fact that 72.5% of the women earn less than US$300 per month and that 42.5% have no social security indicates that most of the families within the scope of this study were from low socio-economic backgrounds. In examining the family structures and methods of getting married, it was found that 67.5% of the women came from extended or nuclear families where males are dominant and that 40% had their marriages arranged to men chosen by their fathers without consulting them. 70% of the women said that they had to get married because girls are under more pressure to do so.

Subject #9: "My family went by my father's rules. My mother kept silent. (with a sad, tearful expression) My dear mother suffered so much at the hands of my father…What could she do? I guess my fate is no different to hers…Women have no right to speak and marriages are arranged…They never asked me…I got married even though I did not want to."

Subject #21: "Mine is my cousin….(in a quiet voice) They never asked me because he is my uncle's son…When I kept quiet, they said it was because I wanted him…Because once a girl is over a certain age, they say it's too late, she's left on the shelf…So they marry her off…"

95% of the women said that their husbands were the head of the household and 52.5% reported that family decisions are made by their husbands (Table 3.1).

Following training: *Subject #21: "I don't differentiate between my daughter/s and son/s. I have started to treat them equally…I'll marry off my daughter late. She won't suffer the hardships I have experienced…And if she wants to marry someone she loves, I'll even oppose my husband if necessary…"*

Subject #9: "…after training, I told my husband that women have a right to be heard and that from now on, we'll make joint decisions…first he told me not to worry my head…he said he'd make (the decisions)…and I should just take care of the home…but bit by bit he began to listen to me…"

57.5% of the women indicated that they were ill-treated by their husbands. 82.6% of those who were ill-treated explained that their husbands constantly yelled at them, belittled them, did not allow them to leave the house alone, and that they could not do anything for fear of their husbands. They have explained the situation as follows:

When asked about division of labor between the sexes, all the women stated that women are responsible for domestic chores such as looking after the home and the children, cleaning and cooking, while men are responsible for going out to work, bringing home money and providing for the household. When asked what 'sexuality' means, 30% answered "satisfying a man's needs" while another 30% replied "I don't know".

All the women replied to the question "What would your husband do if you died?" with "He would immediately remarry or be married off." The answer of almost all women to the question "What would you do if you lost your husband?" was "I would stay home and look after the children."

Table 1(insert table 1 about here) depicts the health awareness and health behaviors of women. 35% declared that they do not know what 'health' means, 65% said health was a good thing yet could not explain the expression 'good' in this context. When asked to define 'illness' 22.5% replied "I don't know", 47.5% said "a bad thing" yet could not expound on it. 42.5% of the subjects specified sorrow and stress as the cause of illnesses.

Half of the study subjects conveyed the view that in order to be healthier, it is necessary to be careful about what one eats and drinks, and to keep one's home clean. Those who provided this answer reported that in order to be healthier, they try to eat fruit and vegetables, drink plenty of water and clean and air their homes every day. 27.5% of the women said they do not do anything in particular to be healthy, while 12.5% explained that they watch health-related programs on television, but do not put what they learn into practice. 52.5% said they do not use traditional medicine while 27.5% reported making purchases from herbalists and using the herbs generally to treat coughs and influenza or to lose weight, and that they pray for health or against evil eyes. 20% stated that they pray at mausoleums and wear amulets to ward off evil eyes.

82.5% of the women explained that receiving the services of male health professionals is canonically legitimate and that they have received permission to do so either from their husbands or from clerics who teach Quran courses.

Subject #37 vocalized her situation as follows: "Health (long pause)…I wouldn't know. Women get sick, then get better…I don't do anything about it…I personally wouldn't mind if I need to go to a health professional who is male, but sometimes my husband doesn't let me. I try to avoid such things as much as I can…I try not to get examined."

The statement below reflects positive developments in women's attitudes following training:

Subject #37: "There is no man or woman when it comes to health... I keep telling my husband... Last evening, I told my husband everything you told me…first he got angry, then…he must have thought about it because…he is not as stern as he used to be and I am not as inflexible as I used to be…I do whatever I can for health.

Table 2 (insert table 2 about here)depicts the mean HLSB S-II scores and the results of the paired samples t-test related to women's healthy life style behaviors before and after gender awareness training. Accordingly, an increase in mean scores was observed after training in comparison to those before training. The differences in the mean HLSBS-II scores on general health and of each sub-dimension before and after training was determined to be highly statistically significant ($p<0.003$, $t=5,554$and $p<0.001$, $t=5,250$)

Table 3 shows the results pertaining to monthly income of women, healthy life style behavior scores before and after the trainings and sub-dimensions of the scale. According to this table, women with a monthly income of less than 600 TL were seen to have higher level of mean scores in all HLSB S-II general health and sub-dimensions after the training compared to pre-training results. The difference was statistically significant ($p<0.001$).

Women with a monthly income of more than 601 TL were seen to have increasing mean scores in all HLSB S-II general health and sub-dimensions after the training. The sub-dimensions of the scale had significant differences between pre and post-training results except for health behaviors dimension ($p<0.05$).

Women with a monthly income of less than 600 TL and those with more than 601 TL had the biggest mean score difference in health behavior dimension in terms of pre and post training results. This relationship was not found to be significantly different ($p>0.05$).

At the same time, the HLSB mean general health score and sub-dimensional scores of women by income before and after training show that women who have an average monthly income less than USD 300 show a considerable difference in the Healthy Life-Style Behavior scores before and after training when compared to those that are at income levels of USD 301 and above ($p>0.05$).

The pre-post difference in sub-dimensions of nutrition, interpersonal relations and stress management was larger in the gender-equal family group than in the male-dominated family group ($p>0.05$). The largest difference in average pre and post training scores of women from gender-equal family units and those of women from male-dominated family units was in the physical activity sub-dimension ($p>0.05$).

It was determined that except for physical activity, the difference in average pre and post training HLSB scores of women with regards to general health and its sub-dimensions was higher in women who state that their husbands make the family decisions compared to those who stated that they make joint decisions ($p>0.05$).

It was also determined that in the sub-dimensions of general health, health behaviors, spiritual development and stress, women subjected to violence by their husbands had higher post-training scores than those who were not subjected to such violence ($p>0.05$). This was also the case with regard to interpersonal relations and the difference was statistically significant ($p<0.05$).

DISCUSSION

Gender mainstreaming education is considered necessary in order to change women's traditional viewpoints on gender roles and to familiarize them with gender equality (Yeşilorman, 2001; Glick, Sakallı and Ferreira, 2002). This study has determined that even if no changes occur with regards to women's ages, literacy levels, places of residence and family structures, gender awareness training and monitoring at home can lead to important changes in their health behaviors. Significant differences were found between women's pre and post training HLBS-II scores for general health and its sub-dimensions ($p<0.01$). In comparing to statements made during the preliminary meeting with those made during the post-training home visits, significant changes were observed concerning their perception of the status and health of women.

Health is defined by the World Health Organization as "…a state of complete physical, mental and social well-being…". For women to attain this state of wellness, they need raised awareness, independence and the ability to make decisions about their own lives (Kukulu, 2008; Sancar, 2006; Aktaş, 2007; Aksu, 2008). However, this study found that women's education, marriage and decision to make children are governed by the directives of men. It is thought that as a result of suppression, the inability to self-affirm prevents women from gaining the knowledge and competence necessary for maintaining healthy life-styles. The results of this study support this hypothesis. It was determined that before training, almost all the subjects lacked sufficient understanding of the value of health as well as the knowledge required to attain it.

In a Turkey-wide study on health-related attitudes where 40 working women were directed the question "What do you do when you become ill?" almost half gave similar answers indicating that they would accept their lot, do nothing and just wait for it to pass. Also, 17.5% of the women indicated that they would not use the services of male health-care professionals. It can therefore be said that due to traditional gender roles and responsibilities, women do not feel they have a right to get sick, and if they do become ill, avoid seeking medical help as they hope it will pass. This situation not only indicates that women put their health second, but also prevents early diagnosis and leads to the possibility of minor illnesses turning into major ones. The rise in post-training scores indicates that the gender-mainstreaming training raised women's health awareness.

Almost all of the women attributed their lack of education to 'being a girl'. According to TDHS-2008 (9) 13.5% of female students leave school during the mandatory education period. The school drop-out rates established in this study were higher than the Turkish national average and those reported by similar studies conducted in other regions (Sayılan and Özkazanç, 2009). This study also shows that women left school not for financial reasons, but because of the gender roles imposed upon them. This finding indicates the gravity of gender bias and its function in depriving female children of the basic human right to education. It is safe to say that the behavior of participants is generally preponderated by not their own wishes but by what is considered acceptable within the male-dominant attitudes of their clans or communities. It cannot be denied that this situation which unfavorably affects women's social status, hinders their mobility and limits their range of activities, consequently increasing dependence on men and negatively impacting their health (Battal, 2008; Çayboylu, 2002; Bozkurt, 2007; Yücel, 2006; Kitiş and Bilgici, 2007; Prus and Gee, 2003; Şenesen, 2008; Demren, 2008; Demirkıran et al, 2009).

Decreased awareness in women due to not being able to attend school renders them more ready to accept the traditional structures learned since birth and evokes in them the belief that this makes them stronger so as to overcome the roles and responsibilities they are burdened with. In addition, childbirth at a young age will

extend women's fertility period which may result in more births wearing them out faster, thus increasing their dependence on their husbands. The findings of this study showed that women under the age of 30 before the training were lower in HLSBS-II general health and the sub-dimension scores of health behaviors and nutrition, but that following training they showed more improvement compared to females over the age of 31. We observed the same situation with regards to educational levels. The difference between pre and post training scores of women who were literate primary school graduates in general health and its sub-dimensions, in particular spiritual/moral development; was greater than that in women who had completed junior high school or high school.

TDHS-2008 indicates that 81.2% of Turkish women live in a nuclear family and that the number of extended families is on the decline. However, the results of the current study are not consistent with this finding. More than half of the participants came from nuclear families. The characteristic of the family unit generally influences distribution of wealth within the family and affects the health and wellbeing of its members. Large family units can generate health problems(Çayboylu, 2002; Kitiş and Bilgici, 2007). Males, especially fathers, are important elements of extended families which are usually patriarchal. They not only control all aspects of the lives of the women within the family unit, including their domestic and public procurements, sexuality and fertility; but are also the owners of all the family assets. Women internalize an acceptance of this situation and replicate it in their own offspring, thus transferring it to the following generations (Ökten, 2009; Bozkurt, 2007). Furthermore, the current study findings show that the patriarchal model is maintained even in the families of participants from nuclear families. This prompts the thought that gender bias against women does prevail, that it is imposed upon them from birth, imposing upon them the requirement to maintain it throughout their own lives. It was found in the current study that women from gender-equal family structures had higher scores in general health, nutrition, interpersonal relations and stress management than those from male-dominant families. Based on these results, women from male dominant families attain increased knowledge and awareness after gender mainstreaming training, but possibly due to obstacles such as male authority and having to obtain consent from their husbands, it comes at a slower rate than to those from gender-equal families.

It has been observed that in societies where traditional relationship models prevail, individuals do not possess the autonomy to make their own decisions(Kahraman, 2010). Other studies also support this finding (Ökten, 2009; Sayılan and Özkazanç, 2009). As such, it is thought that this situation affects women's decision-making and behavioral processes. According to a study conducted in Eastern and South Eastern Anatolia, women are unable to visit a hospital, be examined by male doctors, make family-planning decisions or utilize many such health services without the consent of their husbands (Akın and Demirel, 2003). In a study by Atalay et al designed to assess the fundamental characteristics of the Turkish family structure, it was reported that a majority of urban families practiced joint decision-making whereas in the rural areas the families where decisions were made by the man were more prevalent(Atalay, 2011). It would be safe to say that women who see themselves and their decisions as secondary to others, would also put second their own health and their own use of health services. Almost all women who participated in our study indicated that their husbands were the head of the family and made the decisions. As such, women accept their husbands as the head of the family and disregard their own selves. Women have been rendered unable to even make decisions regarding themselves. This leads to the premise that women, constantly dependent on the decisions of a man, end up taking less responsibility for their own health.

This is an indication of reinforced identity on the part of the women, since in contrast to those who make joint-decisions, the women who replied “My husband” had increased scores in all HLSBS-II subdivisions except for physical activity.

Most of the study subjects stated that they cannot do much of anything for fear of their husbands who yell at them, belittle them and will not allow them out alone. They all indicated that even if they were mistreated, they would not get a divorce. It is beyond the scope of the current study to reach a definite conclusion with regards to whether the small number of divorces observed are due to the existence of happy families or by the fact that women cannot overcome the situation they are in or the hurdles they face. One reason for this may be the fact that family conflicts are generally not externalized by Turkish families whose fundamental rule is to ‘not to air out dirty laundry in public’. Fear of stigmatization and alienation frequently leads to the under-reporting of conflicts (Polat, 2005; Oktay, 2007; Şahiner, 2007; Prus and Gee, 2003; Şenesen,2008; Demren, 2008; Demirkıran et al, 2009; Ataklı et al, 2004). The majority of the subjects of the current study are faced with alienation and belittlement, leading to reduced mental health. Our findings show that women subjected to violence, in contrast to those who are not, scored less in their HLSBS-II both before and after training and that their health was negatively impacted. However, it was determined that the training did raise their scores and positively affected their health. The fact that the biggest improvement after the intervention was observed in the sub-dimensions of health behaviors, spiritual/moral development, interpersonal relations and stress management suggests a larger effect on psychological state and mental health.

CONCLUSION

1- Women- gender inequality has been identified as one of the factors that affect women's social status and health adversely.

2- Women's, changing the traditional view on gender roles, gaining perspective in providing equitable, gender-based education has been shown to be significant.

3- it was determined that planned training based on social gender and monitoring at home can cause significant chance in women’s health behaviors even if women’s age, education level, residence and family characteristics remain same.

In light of these findings, we suggest:

1. The provision of continued education for health-care professionals directed at enhancing awareness of sex-discrimination and its impacts on health;

2. The provision of gender-awareness based training for couples planning on getting married and having children;

3. The replication of the current study and others similar to it by various organizations in different regions of Turkey in order to disseminate and reinforce these findings.

For nurses to familiarize themselves with the communities they serve and the inherent gender-role related characteristics thereof in order to facilitate relevant training programs to improve public health.

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Table 1- Distribution of Women According to Health Awareness and Health Behavior

Variables	Number (n)	Percentage (%)
What is Health?		
I do not know	14	35.0
It is a good thing; it is being well	26	65.0
What is Illness?		
I do not know	9	22.5
It is a bad thing	19	47.5
It is experiencing pain and having to go to bed	12	30.0
Causes of Illness		
I do not know	5	12.5
Germs, dirt, everything around us	5	12.5
What you eat and drink, air and water	17	42.5
Sorrow and stress	6	15.0
The evil eye	7	17.5
Steps Taken to Become Healthier		
I do not do anything	11	27.5
I pay attention to what I eat and drink, and the cleanliness of the home	5	12.5
I watch health-related television programs	4	10.0
I go straight to the doctor	20	50.0
Traditional Methods of Becoming Healthier		
I do not use traditional methods	21	52.5
Going to the mausoleums, wearing amulets, praying to ward off the evil eye	8	20.0
Making purchases from a herbalist	11	27.5
Utilizing the Services of a Male Health-Care Professional when ill		
Utilizes	33	82.5
Does not utilize	7	17.5
Fasting		
Continues to fast even if it affects the health	10	25.0
Discontinues fasting if health is affected	30	75.0

Table 2 - The Distribution of Mean Scores for General Health and its Sub-dimensions for Women's Healthy Life-Style Behaviors-II Scale Prior to and Following Training

HLSB-II Score	**Prior to Training**		**Following Training**		**Significance Test**
Sub-dimensions	**Min-Max**	$\bar{X}$ **± SS**	**Min-Max**	$\bar{X}$ **± SS**	**P and t**
General Health Score	74-170	116.9±23.4	74-182	134.4±24.4	0.002, 6,638
Health Behaviors	10-34	20.2±5.7	11-35	23.9±5.3	0.003 ,5,554
Physical Activity*	8-27	13.2±4.4	8-28	15.3±4.9	0.001, 5,250
Nutrition	10-33	20.7 ±4.8	12-34	23.4±4.4	0.002, 5,484
Spiritual/Moral Development	13-34	22.5±5.1	13-36	26.1±5.2	0.002, 4,745
Interpersonal Relations	16-30	22.9±4.2	16-35	26.3±4.7	0.002, 4,435
Stress Management	9-30	17.0±4.3	9-30	19.3±4.3	0.001 6,167

* paired samples t- test

Table 3. The Distribution of Mean Scores for General Health and its Sub-Dimensions for Women's Healthy Life-Style Behaviors-II Scale Prior To And Following Training In Terms of Monthly Income of Women

HLSB-II Score	**Less than 600 TL (29)**			**More than 601 TL (11)**			**Sign. Test**
	Prior to Training	**Following Training**		**Prior to Training**	**Following Training**		
Sub-dimensions	$\overline{X}$ **± SS**	$\overline{X}$ **± SS**	**p***	$\overline{X}$ **± SS**	$\overline{X}$ **± SS**	**p***	**p****
General Health Score	116.1±21.0	133.8 ±21.5	0.001,	119.0 ±30.0	135.6±31.8	0.002	0.82
Health Behaviors	20.0±5.63	24.3±4.84	0.001	20.8±6.33	22.7±6.64	0.089	0.06
Physical Activity	13.1±4.03	15.1±4.76	0.001	13.5±5.55	15.8±5.61	0.011	0.77
Nutrition	20.5±4.91	23.3±4.17	0.001	21.2±4.83	23.5±5.37	0.009	0.60
Spiritual/Moral Development	22.7±4.92	25.8±4.97	0.001	22.6±5.98	26.6±6.05	0.003	0.48
Interpersonal Relations	22.7±3.91	26.0±4.28	0.002	23.2±5.29	27.0±5.94	0.038	0.79
Stress Management	16.8±3.38	19.1±3.46	0.001	17.4±6.45	19.9±6.17	0.013	0.90

*Wilcoxan t test
**Mann Whitney U testi