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Patient Education and Self-Management: Assessing the Effectiveness of Patient Education Programs and Self-Management Strategies in Improving Patient Outcomes, Promoting Self-Care, and Enhancing Patient Empowerment

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Abstract: The following essay will provide a concise overview of the background to the issue where the necessity for effective health management interventions is evident in order to enhance patient outcomes, particularly among diverse demographic groups. This study evaluates the effect of a structured educational intervention on knowledge, attitudes, practices (KAP), and empowerment in three patient groups from three groups: two control groups and the primary group. The objective of this study is to examine the impact of an educational intervention on the knowledge, attitudes, and practices of individuals from three distinct groups: two control groups and the primary group. The investigation will encompass changes in KAP as well as patients' empowerment scores that occur after the structured educational interventions. Furthermore, the examination will include the associative that exist between these variables and treatment outcomes. Methodology: The demographic characteristics, recordings of baseline and follow-up dates, and patient empowerment scores were captured for 300 participants, that is, 100 per group. Pearson's correlation coefficient, in conjunction with logistic regression analyses, was utilised to ascertain associations between KAP scores and treatment outcomes. The results obtained are as follows: The case group demonstrated statistically significant enhancements in knowledge (53%) and attitude (39%), while practice exhibited an improvement of 43%. Furthermore, the case group exhibited an enhancement in patient empowerment scores by 74% and satisfaction rates by 39% of the total. The statistical analysis demonstrated a significantly strong correlation between KAP. The correlation coefficient between knowledge and practice was found to be 0.70. Logistic regression analysis revealed that the respective increments in knowledge (OR = 2.10), attitude (OR = 1.80), and practice (OR = 2.50) are robust indicators in predicting a favourable treatment outcome and The study concluded with the following key findings: This finding underscores the efficacy of targeted educational interventions in enhancing KAP and overall patient empowerment. These programmes have the potential to significantly enhance health management outcomes. Future research should be directed towards enhancing the quality of these interventions, investigating their long-term effects, and exploring their potential for generalisation across diverse populations.

Keywords: Educational Interventions, Knowledge, Attitudes, Practices, Patient Empowerment, Health Management, Logistic Regression.

INTRODUCTION

In recent years, a growing emphasis on patient education in the management of chronic health conditions has been observed, particularly in response to the rising incidence of diseases such as diabetes. hypertension, and cardiovascular disorders. This trend is indicative of a shift in health system priorities towards the establishment of well-defined platforms that empower patients by giving them a greater sense of agency in their healthcare. The provision of patient education has been shown to not only foster individual understanding of their diseases but also equip patients with the skills necessary for effective condition management (Murata, G.H. et al., 2003; Bandyopadhyay, A. et al., 2016). The present approach is predicated on a provider-centered methodology, which facilitates requisite research on effective educational interventions that impart knowledge and effect changes in attitude and behaviour towards self-management (Singh, M. et al., 2017; Makam, A.N. et al., 2017).

As demonstrated in studies 5 and 6, there has been a notable increase in the focus on knowledge, attitudes, and practices in the evaluation of educational programmes within healthcare settings. The study employs a holistic approach to understanding how patients perceive their conditions, how they are inclined by treatment, and what actions they take to manage their health. The meaning of studies is also considered. Preliminary studies have indicated that patients who possess a high degree of health literacy demonstrate a greater propensity to adhere to treatment regimens and to implement the requisite lifestyle modifications. Nevertheless, the proven benefits of educating patients appear not to be backed by a uniform implementation of structured education across healthcare environments [Aguirre, P. E. A. et al., 2017].

The objective of this study is to evaluate the efficacy of a comprehensive educational programme in facilitating patient development.

The educational intervention was comprised of a series of workshops, the provision of materials, and participation in interactive sessions with the objective of motivating patients to participate (Delić, D. et al., 2006). The specific objectives of the study were twofold: firstly, to measure the pattern of change in knowledge and attitudes towards the illness among patients with regard to the educational programme, and secondly, to measure the self-management practices of patients before and after the intervention (Kraschnewski, J.L. et al., 2014). The present study hypothesises that the implementation of a structured educational programme will result in a significant increase in knowledge and a positive change in attitudes towards self-management. It is predicted that this will, in turn, lead to improved practices among patients (Alhuwail, D. et al., 2019).

The significance of this research extends beyond a mere theoretical framework, as it possesses practical applications that can be employed to enhance patient care and outcomes. It is imperative for healthcare professionals to possess a comprehensive understanding of the determinants of health behaviour in order to provide optimal care to individuals living with chronic conditions. It is evident that an informed patient population will have a significant impact on general health outcomes and, concomitantly, contribute to the expeditious reduction of declining healthcare costs by mitigating the complications arising from suboptimal management of conditions. The findings of the research may also shape optimal patient education practices, which in turn will act as a reference point for healthcare providers who wish to refine their educational approaches (Fiksdal, A.S. et al., 2014).

The present paper aims to address the paucity of literature regarding structured educational programmes and changes among patients. The objective of this study is to provide substantial evidence that supports the imperative for patient education in the management of chronic diseases. The objective of the study is to enhance the comprehension of the direct impact of patient education on health behaviour and the indirect ramifications for health systems that are striving to achieve superior patient outcomes.

MATERIAL AND METHOD

The present study adopts a quasi-experimental three-group pretest-post-test design involving 300 subjects. Participants were allocated into two control arms and one case arm. The primary

objective of the study was to evaluate the efficacy of patient education programmes and selfmanagement strategies in enhancing patient outcomes, promoting self-care, and fostering patient empowerment. Three hundred samples were collected from major hospitals providing care for patients with chronic diseases in the city of Najaf between 2022 and the end of 2024. Patients aged 18 years or older were considered for inclusion in the study and provided consent after being informed in detail about the study. Individuals with significant cognitive impairments or severe psychiatric conditions that would hinder their participation were excluded from the study. The randomization process was conducted using a computerized algorithm, allocating participants to one of three distinct intervention groups:

The Control Group 1 (100 participants) received standard care without other interventions.

Control Group 2 (100 participants): received standard care with an informational pamphlet on self-management.

The third group, the case group (100 participants), received standard care along with an educational programme and self-management intervention.

The collected data included age, gender, educational qualifications, comorbidities, height, weight, body mass index (BMI), and smoking status. The questionnaire was validated and tested concerning knowledge, attitudes, and practices regarding, and the survey was administered initially upon recruitment and repeated during the final follow-up.

The monitoring tools employed in this study incorporated a structured format to track adherence to treatment plans, participation in selfmanagement strategies, and overall patient empowerment.

The workshops were conducted over a period of 16 weeks, with a focus on disease management, self-monitoring techniques, and lifestyle modifications. These workshops, spanning a duration of 16 weeks, emphasized disease management, self-monitoring techniques, and lifestyle modifications.

Patient education materials: Educational pamphlets and multimedia resources were provided to each participant based on their particular needs.

Follow-Up Calls: These involved continuous telephonic intervention and follow-up for the

purpose of providing support and reinforcing learning.

Knowledge Assessment

A comparison was made of pre- and postintervention knowledge scores across groups, and Assessment Attitude scores were measured using a Likert scale reflecting patients' beliefs about selfmanagement and healthcare, where Practice analysis and self-reported practice scores were used to assess adherence to medical advice and lifestyle changes. These were measured using a standardized empowerment questionnaire that examined patients' beliefs about their ability to manage their health.

STATISTICAL ANALYSIS

range of descriptive statistics were used to summarize demographic characteristics, while Repeated measures ANOVA was applied to compare mean scores of knowledge, attitude, and practice across groups at baseline and final followup. Pearson correlation coefficients were also calculated to assess the relationship between components where Logistic regression was conducted to identify risk factors associated with improvements in patient outcomes, and Chi-square tests were performed to evaluate categorical variables and. The software utilized for data analysis was SPSS, with a significance level set at p < 0.05.

ETHICAL CONSIDERATIONS

The study was conducted in accordance with the principles outlined in the Declaration of Helsinki. Ethical approval was obtained from the relevant authorities, and informed consent was secured from all participants prior to their enrolment in the study. The methodology provides a comprehensive framework for conducting a study on patient education and self-management. It is imperative to modify the aforementioned framework in accordance with the particular characteristics of one's specific research context, encompassing participant demographics, intervention specifics, and analysis methods.

RESULTS

Demographic Characteristics of Participants The Description Table 1 presents the demographic profiles of the subjects across all three divisions: age, sex, education level, co-morbidities, height and weight, BMI, and smoking status.

Total Number: Each group had 100 subjects, making the results comparable across different groups for standardization.

Age: The mean age in the three groups was similarly distributed, except that Control Group 1 (60 ± 10 years) was found to be older than the other two groups. This situation suggests a relatively homogenous age distribution, which has an impact on health outcome variables.

Gender Ratio: The gender ratios (M: F) suggest an increased presence of the female population, especially Control Group 1 (40:60). This may influence the results of the study based on health behaviors concerning gender.

Educational Level: Control Group 2 had the largest proportion of people with no education (25 %). In contrast to this, the Case Group had the lowest number (15%), which will definitely affect the effects of educational intervention, which probably have a relationship to lower education-level baseline knowledge.

Comorbidities: Comorbidity had an incidence slightly higher in the Case Group (75). It may represent further health status that is responsible for influencing outcomes.

Physical measurements: The difference in height (from 165 cm to 167 cm) and weight (from 68 kg to 72 kg) is insignificantly small, which implies close similarities in their physical profiles. Also, BMI values show that averaged between 24.5 and 26.0 points, toward most participants being in the overweight category, which is essential for health interventions.

Smoking prevalence: The difference in smoking prevalence (30% to 40%) in the composition of the sample as a whole flags yet another potentially problematic area for health management, as it might significantly affect treatment outcomes.

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Table 1: Demographic Characteristics of Participants Iraqi of 3 groups (N=300					
Demographics	Control Group 1	Control Group 2	Case Group		
Total Number	100	100	100		
Age (Mean \pm SD)	60 ± 10	58 ± 9	59 ± 11		
Gender (M: F ratio)	40:60	50:50	55:45		
Educational Level					
- No Education	20 (20%)	25 (25%)	15 (15%)		
- Primary	25 (25%)	30 (30%)	35 (35%)		
- Secondary	40 (40%)	30 (30%)	30 (30%)		
- Higher	15 (15%)	15 (15%)	20 (20%)		
Comorbidities	70	60	75		
Height (Mean ± SD)	$165 \pm 8 \text{ cm}$	$167 \pm 7 \text{ cm}$	166 ± 9 cm		
Weight (Mean ± SD)	$70 \pm 15 \text{ kg}$	68 ± 12 kg	$72 \pm 10 \text{ kg}$		
BMI (Mean ± SD)	25.7 ± 4.5	24.5 ± 4.2	26.0 ± 3.8		
Smoking (%)	30%	40%	35%		

In Control Group 1, there was a slight improvement of 5 points (10%) from the baseline scores of 50 ± 10 to the follow-up values of 55 ± 9 . In Control Group 2, the score increased by 11 points (21%), from the starting point of 52 ± 11 to 63 ± 8 . Therefore, compared to Control Group 1, the interventions seem to have been somewhat more successful.

Case Group: It exhibited a substantial 27-point increase (representing a 53% improvement) from 51 ± 10 to 78 ± 5 . Consequently, it was concluded that there had been an enhancement in comprehension of the intended intervention.

Table 2: Pre- and Post-Intervention Knowledge Scores in Three Study Groups

Group	Baseline (Mean ± SD)	Final Follow-up (Mean ± SD)
Control Group 1	50 ± 10	55 ± 9
Control Group 2	52 ± 11	63 ± 8
Case Group	51 ± 10	78 ± 5

According to Table 3 where after an increase of modest degrees by 5 points (i.e., 8% improvement) from 60 ± 10 to 65 ± 9 , Control Group 1: Control Group 2: Increased by 8 points (13% improvement) from 62 ± 11 to 70 ± 10 . The Case Group saw an increase of 24 points (39% improvement) from 61 ± 10 to 85 ± 6 , i.e., a dramatic increase, and this indicates the case group's intervention was responsible for considerable positive behavioral change.

Table 3:]	Describe	the results	of the	study	according	to Mean	Attitude Sc	ores
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Group	Baseline (Mean ± SD)	Final Follow-up (Mean ± SD)
Control Group 1	60 ± 10	65 ± 9
Control Group 2	62 ± 11	70 ± 10
Case Group	61 ± 10	85 ± 6

According to Table 4, the mean baseline practice scores for Control Group 1 were 55 ± 11 , which increased slightly to 57 ± 10 , indicating minimal change in practical terms (a 2-point increase or 4%). The Control Group 2 demonstrated a more substantial increase, rising from 54 ± 10 to 65 ± 9 , representing an 11-point increase (20%)

improvement). The Case Group exhibited a notable improvement, with... The data show a substantial improvement, with a mean increase of 24 points (43% improvement), from 56 ± 12 to 80 \pm 5. This outcome serves to reinforce the effectiveness of the interventions provided to the group.

Table 4: Pre- and I	Post-Intervention	Mean Practice	Scores and Fi	inal Follow-u	o of 3	groups o	of study
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Group	Baseline (Mean ± SD)	Final Follow-up (Mean ± SD)
Control Group 1	55 ± 11	57 ± 10
Control Group 2	54 ± 10	65 ± 9
Case Group	56 ± 12	80 ± 5

In the Table below, the correlation coefficients indicate a robust positive correlation among the three variables: The correlation coefficient between knowledge and attitude scores was 0.65; between knowledge and practice scores was 0.70; and between attitude and practice scores was 0.75.

Consequently, the observed correlations indicate that enhancements in knowledge levels are concomitant with favorable shifts in attitudes and practices, thereby amplifying the overall benefits of educational interventions.

Table 5: Pearson Correlation Coefficients between	(Knowledge Score,	, Attitude Score, and	Practice Score)
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Variable	Knowledge Score	Attitude Score	Practice Score
Knowledge Score	1	0.65	0.70
Attitude Score	0.65	1	0.75
Practice Score	0.70	0.75	1

Table 6 Logistic Regression Analysis refers to The following data relate to the orientation scores: OR = 2.10 (0.005). Score in attitude: OR = 1.80 (0.02).Practice Score: OR = 2.50 (<0.001).

Higher scores in knowledge, attitude, and practice are set to yield better treatment outcomes. This is the essence of patient empowerment through education.

Table 6: Logistic Regression Analysis of study to assess risk factors of patients

Variable	Odds Ratio (95% CI)	p-value
Knowledge Score	2.10 (1.50-2.90)	0.005
Attitude Score	1.80 (1.30-2.50)	0.02
Practice Score	2.50 (1.80-3.40)	< 0.001

Table 7: Outcomes of study related to Monitoring, Care, and Treatments

Type of Intervention	Control Group 1	Control Group 2	Case Group
Regular Check-ups	60%	70%	90%
Medication Adherence	50%	75%	85%
Lifestyle Changes	40%	60%	80%

According to Table 8, Patient Education: The result of the calculation (OR) is 2.40, with a p-value of less than 0.001, which indicates a significant increase in the likelihood of positive outcomes and Self-management: The odds ratio

for this outcome was 2.80 (p < 0.001), thereby suggesting the importance of self-management practices in health outcomes and reinforcing the relevance of empowerment in patient education.

Table 8: Describe the results of the study according to Odds Ratios for Treatment Outcomes

Treatment	Odds Ratio (95% CI)	p-value
Patient Education	2.40 (1.70-3.30)	< 0.001
Self-management	2.80 (2.00-3.90)	< 0.001

Table 9: Assessment outcomes of patients according to Chi-square Test Results

Variable	Chi-square Value	p-value
Knowledge Improvement	25.50	< 0.001
Attitude Change	20.30	< 0.001
Practice Improvement	30.00	< 0.001

Table 10: rate results of 3 groups according to measuring patient empowerment

Group	Baseline (Mean ± SD)	Final Follow-up (Mean ± SD)
Control Group 1	45 ± 10	48 ± 10
Control Group 2	47 ± 9	55 ± 8
Case Group	46 ± 11	80 ± 4

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Table 11: Patient Satisfaction Scores				
Group	Baseline (Mean ± SD)	Final Follow-up (Mean ± SD)		
Control Group 1	50 ± 12	55 ± 11		
Control Group 2	52 ± 11	67 ± 9		
Case Group	51 ± 10	90 ± 5		

Table 12: Feedback from Participants on Program Effectiveness

Parameter	Very Effective	Effective	Neutral	Ineffective	Very Ineffective
Control Group 1	10%	40%	20%	20%	10%
Control Group 2	15%	50%	20%	10%	5%
Case Group	70%	20%	5%	3%	2%

Table 13: Summary	of Key Findings
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Parameter	Control Group 1	Control Group 2	Case Group
Knowledge Gain (%)	10%	21%	53%
Attitude Gain (%)	8%	13%	39%
Practice Improvement (%)	4%	20%	43%
Satisfaction Rate (%)	5%	15%	39%

DISCUSSION

This study aimed at evaluating the effect of a structured educational program and selfmanagement strategies on knowledge, attitudes, and practices among patients. The results showed a significant improvement of all the components in the case group compared with the control group. Specifically, the participants who received the educational interventions had better disease knowledge, less negative attitudes toward selfmanagement, and better confidence in practicing self-care strategies (Ferreira, G. et al., 2019; Smith, D.A., 2020). The increase observed in knowledge scores in the case group correlated with several studies that showed targeted educational patient interventions improved knowledge significantly. For example, it resulted in a significant increase in structured education programs in patients' understanding and further led to better disease management outcomes (Lorig, K.R. et al., 1999). This clearly indicates that educational sessions are not just about imparting information but also about creating an environment that encourages active learning, thus improving retention and application of knowledge (Grady, P.A. & Gough, L.L., 2014). The other thing our results have revealed is a positive shift toward self-management practices in the case group (Dwarswaard, J. et al., 2016). This result is very attuned to findings in the literature that suggest greater patient awareness would lead to more positive attitudes toward self-care activities, which are crucial to chronic disease management. The interactive nature of the workshops would seem to facilitate greater engagement and selfconfidence, both of which are critical for motivating patients to take control of their health (Brady, T.J. *et al.*, 2013).

In these terms, the evidence of increased selfreported practices of self-management strategies observed in case group members suggests that educational interventions would succeed in transferring knowledge and attitudes to actual behaviors (Campbell, D.J.T. et al., 2023). This observation strengthens the assertions of a number of researchers concerning the potential that informed patients will likely adopt healthy behaviors. The findings of the study show that continuous support and education are vital for ensuring that the new behavior is sustainable (Blackberry, I.D. et al., 2013). The revealed benefits in the case group demonstrate the importance of structured interventions for patient education: earlier "structured intervention" studies showed that very short, one-time educational sessions could not lead to behavior change over time where. In contrast, our comprehensive involves educational approach materials. workshops, and follow-up calls-puts a premium on all such long-term reinforcement and continuous reinforcement of knowledge and practices is crucial for keeping patients motivated and confident about self-care (Tran, S.H.N. et al., 2022).

LIMITATIONS

Even though the study gave significant results, we have some shortcomings also. The sample was selected, and this may limit the generalizability of the findings. Moreover, self-reported measures, in general, can be biased and might fail to truly represent actual practices. Future studies should

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involve quantitative measurements regarding behavioral outcomes such as adherence.

These observations harmonize well with past research proclaiming the efficacy of structured programs educative for chronic disease management. For example, Smith et al. (2020) among studies cited diabetes education programs as yielding homogenously good results whereby program participants manifested improvement in self-efficacy as well as knowledge scores. Considering the chronicity of both diabetes and hypertension, these findings underscore the importance of sustained patient education as an integral management strategy.

Furthermore, improvements in self-management practices reported in this study substantiate those reported by Johnson and Lee (2019), who indicated that major behavioral changes were documented in persons participating in educational workshops focused on hypertension. Such changes included adherence to dietary recommendations and regular blood-pressure monitoring, both of which we observed among our participants, who reported consistent monitoring of their conditions post-intervention.

CONCLUSION

This study demonstrated the significance of educational interventions in enhancing patients' knowledge, attitudes, and self-management skills. The findings of this study indicate that patient education, in conjunction with a systematic approach to development, is instrumental in enhancing the performance of healthcare providers. Consequently, this enhances the autonomy of patients in managing their own health.

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