

**ATTITUDE AND PRACTICE OF CERVICAL CANCER SCREENING
AMONG FEMALE HEALTH WORKERS IN UNIVERSITY OF PORT
HARCOURT TEACHING HOSPITAL, PORT HARCOURT RIVERS STATE**

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TITLE PAGE

**ATTITUDE AND PRACTICE OF CERVICAL CANCER SCREENING
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HARCOURT TEACHING HOSPITAL (UPTH),RIVERS STATE.**

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AWARD OF MASTERS OF SCIENCES DEGREE IN (MEDICAL-
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SUPERVISOR: DR (MRS.) I. O. EHIEMERE

JUNE, 2014

APPROVAL

This dissertation titled "Attitude and practice of cervical cancer screening among female health workers in UPTH Rivers state" is the original work by Frank, Maureen Dike with registration number PG/MSc/08/47839 of the Department of Nursing, Faculty of Health Sciences and Technology, University of Nigeria Enugu Campus.

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CERTIFICATION

This is to certify that this project is the original work by Frank, Maureen Dike in the Department of Nursing Sciences, University of Nigeria Enugu campus.

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DEDICATION

This study is dedicated to almighty God who in His infinite mercy kept me and my family alive and also saw us through to the end of this programme. May all Praise, Thanks, Glory, and honour be ascribed unto Him alone, now and forever more, Amen.

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TABLE OF CONTENTS

Title page -	-	-	-	-	-	-	i
Approval page -	-	-	-	-	-	-	ii
Certification page -	-	-	-	-	-	-	iii
Dedication	-	-	-	--	-	-	iv
Acknowledgement	-	-	-	-	-	-	v
List of table	-	-	-	-	-	-	vi
List of appendix	-	-	-	-	-	-	vii
Abstract -	-	-	-	-	-	-	viii

CHAPTER ONE: INTRODUCTION

Background to the Study - --	-	--	-	-	-	-	1
Statement of Problem -	-	-	-	-	-	-	4
Purpose - - - - -	-	-	-	-	-	-	6
Objectives - - - - -	-	-	-	-	-	-	6
Research questions -	-	-	-	-	-	-	6
Significance of the Study ---	-	-	-	--	-	-	7
Scope of the Study -	-	-	-	-	-	-	9
Operational definition -	-	-	-	--	-	-	9

CHAPTER TWO: LITERATURE REVIEW

Conceptual Review -	-	--	-	-	-	-	11
Development of Cancer - -	-	-	-	-	-	-	12
Cervical Cancer Development -	-	-	-	-	-	-	13
Cervical Cancer Staging - -	-	-	-	-	-	-	15
Incidence of Cervical cancer	-	-	-	-	-	-	16
Types of Screening, strengths and Weakness - -	-	-	-	-	-	-	18
Theory Underlying the Study -	-	-	-	-	-	-	20
Application of the Model to the Study -	-	-	-	-	-	-	21
Empirical Review - -	-	-	-	-	-	-	25
Attitude and Practice of Health Care workers - -	-	-	-	-	-	-	26
Summary of Literature Review --	-	-	-	-	-	-	29

CHAPTER THREE: RESEARCH METHOD

Research Design - - - - -	30
Area of Study - - - - -	30
Population of Study - - - - -	31
Sample - - - - -	32
Sampling Techniques - - - - -	32
Inclusion Criteria - - - - -	33
Instrument for Data Collection - - - - -	33
Validity of Instrument - - - - -	34
Reliability of Instrument - - - - -	34
Ethical Consideration - - - - -	35
Procedure for Data Collection - - - - -	35
Method of Data Analysis - - - - -	35

CHAPTER FOUR: PRESENTATION OF RESULTS

Introduction	
Presentation Results - - - - -	34
Presentation of socio demographic data- - - - -	34
Summary Findings - - - - -	41

CHAPTER FIVE

Discussion, Conclusion and Recommendation	
Discussion of major findings - - - - -	42
Implications of findings - - - - -	49
Limitation of the Study - - - - -	50
Summary - - - - -	51
Conclusion - - - - -	52
Recommendations -- - - - -	53
Suggestions for further Research - - - - -	54
References - - - - -	55
Appendices - - - - -	58

LIST OF TABLES

1. Composition of sample for the study through proportionate Stratified random sampling technique
- 2 Distribution of respondents based on age
- 3 Distribution of respondents based on duration of service
- 4 Distribution of respondents based on qualification
- 5 Mean, standard deviation and percentage responses on the attitude of female health workers towards the uptake of cervical cancer screening
- 6 Frequency and percentage responses on female health workers practices of cervical cancer screening
- 7 Mean, standard deviation and ANOVA on the attitude of female health workers towards the uptake of cervical cancer screening based on profession
- 8 Frequency percentage and chi-square statistics on the relationship between profession and practices of cervical cancer screening among female health workers.

LIST OF APPENDICES

- 1 Sample questionnaire on the attitude and practice of cervical cancer screening among female health workers in the hospital studied and factors that influence uptake of screening.
- 2 Letter of introduction from head of department of nursing UNEC.
- 3 Letter of introduction from the director of clinical services and training of Braithwaite memorial specialist hospital (BMSH), rivers state.
- 4 Calculation of reliability co-efficient.
- 5 Calculation of sample size.
- 6 Calculation of sample size from each stratum using proportional stratified random sampling technique.
- 7 Staff description of female staff (January 2013).
- 8 Approval letter from hospital (UPTH) ethical committee

ABSTRACT

The purpose of the study was to examine the attitude and practice of female health workers towards cervical cancer screening (CCS) in the university of Port Harcourt teaching hospital (UPTH), Rivers state. The descriptive survey design was adopted for the study. A sample size of 352 was used for the study. This sample size was approximately 40% of the target population. This sample was considered representative of the population with an accurate level of more than 97%. A self-structured questionnaire was the instrument used for data collection. The validity of the instrument was ascertained by the project supervisor and two (2) other senior lecturers one being a specialist in measurement and evaluation. The reliability indices were established using Test-retest. The scores obtained were correlated using Pearson's product-moment coefficient of correlation to obtain the reliability co-efficient (r) of 0.94 which was considered adequate. Data analysis was done using statistical software package, for Social Sciences (SPSS) version 20.0. Descriptive statistics of percentages, mean, standard deviation and mean cut-off criterion of 2.5 as well as inferential statistics (chi-square and Analysis of variance (ANOVA)) were used to analyse the data. Findings showed that the female health workers have negative attitude and poor practice of CCS. Profession has no influence on their attitude and practice.

CHAPTER ONE

INTRODUCTION

Background to the study

Cervical cancer remains the commonest genital tract cancer yet it is largely preventable by effective screening programmes. Considerable reduction in cervical cancer incidence and deaths has been achieved in developed nations with systematic cytological smear screening programmes.(Babatunde&Ikimalo,2010; Mutyaha,Mmiro& Weiderpass,2006).

One woman dies of cervical cancer in every two minutes worldwide, 80% of these deaths occur in developing nations.(Okunnu 2010).

For every two women who die of breast cancer, one dies from cervical cancer worldwide. It is 2nd most common cancer in women worldwide and most common in African women thus the most leading cause of cancer deaths in women in sub-Saharan Africa including Nigeria with a very poor 6-year survival rate.(Okunnu,2010; Obi,Ozumba& Onyebuchi,2008; Oguntayo Samaila,2008;Papadopoulos,Devaja,Cason &Raji,2000).

Most cervical cancers are caused by HPV infection with two prominent types, (16 and 18) which are responsible for about 70% of all cases. [National cancer institute, 2007]. They can both be prevented and

detected early. Prevention can be achieved by immunizing young girls between the ages of 9-16 [before the age of sexual debut] while cervical screening is used for early detection. (Qiao, 2008, WHO, 2006).

Studies conducted in some parts of Africa, Nigeria inclusive reported that in Benin Nigeria, Carcinoma of the cervix constitute 74.6% of all malignant gynaecological tumors with stage IIb and above constituting 67.6% of all cases; in Zaria it accounted for 66.2% with advanced carcinoma of the cervix stage IIb and above making up 58.7% of the cases. In Kenya, 55% of patients presented with stage III diseases and beyond (stage iv-v).

Otolorin&sule (2008) also reported that in Nigeria, cervical cancer affects 29 women per 100,000 women. Some factors have been implicated in this tragic and unnecessary loss of lives. WHO (2006), observed that many women do not attend screening programmes because of ignorance of the risk for cervical cancer and/or the benefit of screening in its early detection and cure.

Qiao (2008) from his clinical study reported that well organized cervical cancer prevention programmes based on primary screening with cervical cytology lead to impressive reductions in cervical cancer rates in developed Countries. Screening in the UK saves up to 5000 lives per year (Olaitan, 2008).

Consequently in industrialized world, effective screening programme has helped identify precancerous lesions at a stage when they can be easily treated thereby leading to impressive reduction in cervical cancer death rates while lack of screening programmes in poorest countries means that the disease is not identified until it is too late resulting in high mortality (Ojiyi&Dike, 2010 ; Qiao, 2008).This is similar to what is prevalent in Nigeria where most cervical cancer cases seen in health facilities are in stages II and above.

Cervical screening is a health intervention used on population of woman at risk of developing cervical cancer [WHO, 2008]. It is not undertaken to diagnose the disease but to identify individuals with a high probability of having or developing the disease at the precancerous stage. The individual may actually feel perfectly healthy and may see no reason to visit a health facility. Preventing the incidence of cancer causing Human papilloma virus infection, significantly reduces the incidence of cervical cancer and the burden of the sickness on women, family and the nation at large.

There are different screening programmes that can be used to detect the precancerous changes so as to prevent the development of the diseases and curb its serious consequences. Some of these programmes include; visual method such as Pap smear or visual inspection with acetic acid

(VIA), visual inspection with Lugol's iodine (VLI), care Human papilloma virus [care-HPV], HPV-DNA based screening among others.

The screening programmes are performed by qualified health professionals and they serve as models to the public. They are generally believed to be well informed on health issues better than the public. Their attitude and practice transcends to society health behaviors. Female Health workers are expected to have a better understanding of the benefits of cervical screening than women in other spheres of life, thus be effective agents in creating and disseminating information about the importance of the screening programmes for the sexually active, post menopausal women as well as immunization for the girl child between the ages of 9- 16 years by example. Thus their attitude and practice towards screening for cervical cancer have a far reaching implications to its acceptance consequently contributing to the reduction in death of women from cervical cancer.

Statement of problem

Cervical cancer screening (CCS) has been identified as an effective instrument in early detection as well as cure for cervical cancer. Yet women are still dying of cervical cancer, which could have been prevented given the new technologies available. It has been observed that the commitment of health workers towards exclusive breastfeeding has served as a good motivator to the mothers, this has resulted in

a significant reduction of infant mortality. Ana, Mercedes, Jeremy, Jose, (2001) observed that exclusive breast feeding of infants aged 0-3 months and partial breast feeding for the remainder of the first year would prevent about 52 000 infant deaths a year in Latin America. They further observed that, promotion of breast feeding has an important role in increasing survival of infants. In the same vein if the female health workers are committed to cervical cancer screening, this will motivate the women to participate in the screening, thus helping in reduction of the incidence and mortality as has been observed with that of exclusive breastfeeding.

Women in other spheres of life without much knowledge about health issues look up to female health workers for positive health behaviours such as participating in the uptake of CCS, thus female health workers have strong influence on women and as such are role models in health issues. Reviewed literature revealed that there seem to be a problem of uptake of CCS among the womenfolk resulting in high incidence, mortality and poor treatment outcome of cervical cancer. It is in the light of these that the following pertinent questions are seeking for answers; What is the attitude of female health workers towards the uptake of cervical cancer screening; how do the female health workers in the studied institution practice CCS; how does profession influence the attitude of female health workers towards the uptake of cervical cancer

screening; and how does profession influence the practice of cervical cancer screening by female health workers?

Purpose

The purpose of the study is to examine the attitude and practice of female health workers towards cervical cancer screening at university of Port Harcourt Teaching Hospital (UPTH), Rivers state.

Objectives

The objectives of this study are to;

1. determine the attitude of female health workers towards cervical cancer screening in the hospital studied.
2. determine how the female health workers in the studied institution practice CCS.
3. determine how profession influences attitude of cervical cancer screening among female health workers in the studied hospital
4. determine how profession influences the practice of cervical cancer screening by female health workers in the studied hospital

Research Questions

- 1 What is the attitude of female health workers towards the uptake of cervical cancer screening?
- 2 How did the female health workers in the studied institution practice CCS.

- 3 How does profession influence the attitude of female health workers towards the uptake of cervical cancer screening?
- 4 How does profession influence the practice of cervical cancer screening by female health workers?

Significance of the study

Early detection is the key to better treatment outcome of cervical cancer. However in the developing countries, Nigeria inclusive, this effective tool of early detection still seems to be a mirage.

Health care professionals are important predictors of the use of cervical cancer screening (Nwobodo&Malami, 2005). Being knowledgeable about cervical screening for cancer serves as an advantage thus they serve as effective agents in creating awareness about screening, its usefulness in prevention and better treatment outcome of cervical cancer.

This study will help in identifying the level of health workers commitment to utilization of cytology services which in turn will motivate uptake of screening among women folk and as such reduce deaths from cervical cancer.

The findings of this study will also identify the attitude of female health workers towards screening and in turn inform the hospital administration on policies that will promote uptake among female health workers, thereby ensuring their commitment to the uptake.

A positive attitude involves personally participating in the uptake and being fully committed to it. By so doing, the health worker will be in a better position to encourage the women to participate; she calms their fear and disabuses the misconception and erroneous belief about screening, thus helping to reduce mortality and poor treatment prognosis.

A negative attitude indicates lack of interest in the uptake and in creating awareness among women. Thus lacks the required instrument to empower the women against the disease and save them from the preventable and curable disease.

The findings of the study will help determine the practice of female health workers towards the uptake of cervical screening. When the female health workers participate in the uptake, creating awareness through health education and health counseling about the disease and its prevention (immunization); refer patients for screening, conduct the screening test and interpret the result for the patients, they are actively working with the formidable health care team in the fight against cervical

cancer. These healthy practices improve their effectiveness in encouraging the women to utilize the service.

The findings will also inform the policy makers especially in the health sector to accord high priority to cervical screening, make policies, create programmes and allocate sufficient funds to encourage procurement of vaccines, screening equipment, promote follow-up of results of screening, early diagnosis and treatment of identified cases. These programmes of activities will also form part of the health care service of health institution and thus reduce mortality from cervical cancer. Also, training institutions for health workers should incorporate practical skills on cervical screening in their training centre.

Scope of study

The study is delimited to attitude and practice of female health workers in UPTH towards cervical cancer screening. Variables under studied include attitude, practice and influence of profession on attitude and practice of female health workers towards cervical cancer screening and also factors that influence the uptake of cervical cancer screening.

Operational Definitions.

Practice of CCS refers to being screened, participating in pre and post-test counseling, conducting the screening test and interpreting the result. Attitude of CCS refers to various reasons for not screening patients, not referring patients for screening and not getting screened.

Health professionalsThe female health workers in the study include Nurses, Doctors, Medical laboratory Scientist, Radiographers and Pharmacists.

CHAPTER TWO

LITERATURE REVIEW

This chapter presents relevant literature reviewed from abstracts, published studies, internet materials and textbooks under the following headings.

Conceptual Review; Theoretical Review; Empirical Review; Summary of literature review

Conceptual Review

The information gathered from these materials showed that many lives are being lost from cervical cancer disease and that most women who die from cervical cancer particularly in developing countries may be raising children, caring for the family and contributing to economic life of the city, town or village. Cervical cancer is largely preventable by effective screening programmes and considerable reduction in cervical cancer incidence and deaths has been achieved in developed nations with systematic cytological smear screening programmes

Cancer Development

Cancer is a disorder of cell growth and behaviour. Its ultimate causes originate at both cellular and sub cellular levels. The term 'cancer' refers to a large group of diseases characterized by uncontrolled growth and spread of abnormal cell. Watson (2004) defines it as a group of diseases in which the mechanism within the cell and its microenvironment responsible for restraint of growth is defective and therefore the cancer cell reproduces without regard for need. These cells fail to grow up to perform their proper functions because they remain immature. In this undeveloped form, the cells feed on the body,

stealing nutrition from the body in order to grow larger and larger. They grow up into Killer cells. (Don Colbert 1999).

Cervical cancer is malignant neoplasm of the cervix uteri or cervical area. It may present with vagina bleeding but symptoms may be absent until the cancer is in its advanced stage. (Kumar, Abul, Fausto and Mitchell 2007). It is one of the leading causes of cancer death in women in the developing world. The primary underlying cause is infection with human papillomavirus (HPV), a very common virus that is sexually transmitted.

Development of Cervical Cancer

The stratified squamous epithelium is a multilayered epithelium of increasingly flattened cells. It normally covers most of the ectocervix and vagina, its lowest (basal) layer, composed of rounded cells, is attached to the basement membrane, which separates the epithelium from the underlying fibromuscular stroma. The columnar epithelium lines the cervical canal and extends outwards to a variable portion of the basement membrane.

The original squamo columnar junction (SCJ) appears as a sharp line, with a step produced by the different thicknesses of the columnar and squamous epithelia. The location of the original SCJ varies with woman's age, hormonal status, history of birth trauma, pregnancy status, and use of oral contraceptives, (WHO, 2006).

The stratified squamous epithelium covering the cervix provides protection from toxic substances and infection. Under normal circumstances, the top layers are continually dying and sloughing off, and the integrity of the lining is maintained by the constant, orderly formation of new cells in the basal layer.

Histologically, invasive cervical cancer shows several subtypes which include squamous cell cancer, adenocarcinoma, neuroendocrine carcinoma; but the squamous cell carcinoma accounts for almost 80% of all cervical cancer.

The primary cause of squamous cervical cancer is persistent or chronic infection with one or more of the so-called high-risk or oncogenic types of human papillomavirus (HPV). The most common cancer-causing types are 16 and 18, which are found in 80-85% of all cervical cancer reported. In the presence of persistent HPV infection and other co-factors, the metaplastic squamous cells later multiply in a disorderly manner typical of cancerous change to produce squamous cell carcinoma which occurs when there is invasion of abnormal cells into the thick fibers connective tissue underlying the basement membrane. It starts with a microinvasive stage which is not visible with the naked eye on speculum examination. It then evolves into larger lesions, which may extend to the vagina, pelvic walls, bladder, rectum and distant organs and manifesting with cervical cancer progresses into a predictable manner and will almost always lead to death.

Cervical cancer staging

The classification of cervical carcinoma precursor lesions has changed many times over the 20th century. The WHO classification system was descriptive of the lesions, naming them mild, moderate or severe dysplasia or carcinoma in situ (CIS). The term, cervical intraepithelial neoplasia (CIN) was developed to place emphasis on the spectrum of abnormality in these lesions and help to standardize treatment. It classifies mild dysplasia as CIN1, moderate dysplasia as CIN2, and severe dysplasia and CIS as CIN3. The most recent classification

is the Bethesda system, which divides all cervical epithelia precursor lesions into 2 groups; low grade squamous intraepithelial lesion (LSIL) and High-grade squamous intraepithelial lesion (HSIL): LSIL corresponds to CIN1, and HSIL includes CIN2 and CIN3 (cancer research UK websites, and DeMay, M (2007).

However, the International Federation of Gynecology and Obstetrics (FIGO) system is often used to describe the extent of cancer invasion and to select treatment options (WHO, 2006).

There are four, usually sequential routes through which invasive cancer progresses. The disease is generally confined to the pelvis for a long period.

Stage 0: Carcinoma in situ, full thickness involvement of the epithelium without invasion into the stroma. This is not considered invasive cancer, since the lesion has not gone beyond the basement membrane.

Stage 1 : Within (limited to) the cervix micro invasive carcinoma strictly confined to the cervix not clinically visible.

1A- Diagnosed only by microscopy: no visible lesions.

- 1A1 ñ stromal invasion less than 3mm in depth and 7mm or less in horizontal spread, 5-7years survival with optimal treatment 95%.
- 1A2 ñ Stromal invasion between 3 and 5mm with horizontal spread of 7mm or less, 5- 7years survival with optimal treatment 95%.

1B ñ Carcinoma strictly confined to the cervix and clinically visible lesion on a microscope, with more than 5mm of depth or horizontal spread of more than 7mm.

- 1B1- Visible lesion 4cm or less in greatest dimension. 5-years survival with optimal treatment 85%

- 1B2- visible lesion more than 4cm. 5-years survival with optimal treatment 75%

Spread from a tiny focus of microneoplastic cancer, eventually involving the entire cervix which can enlarge to 8cm or more in diameter. The cancer can be ulcerating, exophytic (growing outwards) or infiltrating (growing inwards) in this stage, the individual experiences vaginal discharge, sometimes foul smelling, irregular bleeding (of any pattern) post coital spotting post menopausal spotting or bleeding.

Stage II: Invades beyond cervix to adjacent structures.

IIA- without parametral invasion but involve upper 2/3 of vagina. 5-years survival with optimal treatment 75%.

IIB ñ with parametral invasion 5-years survival with optimal treatment 65%.

Direct spread in all directions is possible: downwards to the vagina, upwards into the uterus, sideways into the parametrium (the tissues supporting the uterus in the pelvis) and the ureters, backwards to the rectum, and forwards to the bladder. The patient will be experiencing urinary frequency, urgency, backache, and lower abdominal pain.

Stage III: extends to pelvic wall or lower third of the vagina

IIIA ñ involves lower third of vagina. 5-years survival with optimal treatment 30%.

IIIB ñ extends to pelvic wall and/or causes hydronephrosis or non-functioning kidney. 5-years survival with optimal treatment 30%

Patient will be experiencing weight loss, decreased urine output (from the obstruction of the ureters or renal failure.)

IVA ñ invades mucosa of bladder or rectum and/or extends beyond true pelvis. 5-years survival with optimal treatment 10%

IVB ñ distant metastasis. 5-years survival with optimal treatment 10%. Through the blood stream and lymph channels. Cervical cancer cells may spread through the blood stream and lymphatic system to develop distant metastases in the liver, bone, lung and brain. With the patient manifesting leaking of urine or faeces through the vagina (due to fistulae), swelling of the lower limbs, breathlessness (due to anaemia, or rarely lung metastases or effusion).

Incidence of Cervical cancer

There have been a lot of studies done on cervical screening which ranges from awareness of cervical screening to knowledge and attitude towards the exercise.

Onyije, Eroje and Fawehinmi (2010) in their 3 years retrospective study on the incidence of cervical cancer in UPTH reported that there is a fluctuation in the trend in the incidence of cervical cancer in UPTH. The few number of cases reported may not be a reflection of low cervical cancer cases in the region but rather may indicate poor knowledge and a negative attitude to the utilization of cervical cytology services, non availability or at best poor information about cervical cytology screening and these could account for under reporting of cases.

One woman dies of cervical cancer in every two minutes worldwide, 80% of these deaths occur in developing nations.(Okunnu 2010) in her campaign on cervical cancer screening with her picto-pamphlets stating that No woman Need to die from cervical cancer, reported that,. For every two women who die of breast cancer, one dies from cervical cancer worldwide. It is 2nd most common cancer in women worldwide and most common in African women thus the most leading cause of cancer deaths in women in sub-Saharan Africa including Nigeria with a very poor 6-year survival rate.(Obi,Ozumba and Onyebuchi,2008; Oguntayo and Samaila,2008;Papadopoulos,Devaja,Cason and Raji,2000).

Otolarin and sule (2008), in their study on cervical cancer prevention in low resource settings: Jhpiego's experience also reported that in Nigeria, cervical cancer affects 29 women per 100,000 women. Some factors have been implicated in this tragic and unnecessary loss of lives

Qiao (2008) from his own cross sectional clinical study on a new HPV-DNA Test for cervical cancer screening in developing regions stated that cervical cancer is the second most common cancer in women worldwide with about 500,000 new cases and 274,000 deaths every year, over 86% of which occur in developing world. He went further to say that "it is broadly accepted that well organized cervical cancer prevention programmes based on primary screening with cervical cytology lead to impressive reductions in cervical cancer rate in developed countries" Screening in the UK save up to 5000 lives per year (Adeola, 2008).

Types of screening tests, strengths and weaknesses

Effective interventions against cervical cancer exist; these include screening for and treatment of precancerous and invasive cancer. The cure rate for invasive cancer is closely related to the stage of disease at diagnosis and the availability of treatment. If left untreated, cervical cancer is almost always fatal. A good screening test should be; accurate, reproducible inexpensive, easy to perform and easy to follow up, acceptable and safe. Various methods of screening for cervical cancer abound as explained below.

Visual Methods

- i. Visual inspection with acetic acid (VIA)
- ii. Visual inspection with Lugol's solution

In a visual test, the provider applies acetic acid (in VIA) or Lugol's iodine Solution (in VIL) to the cervix and then looks to see if there is any staining allowing the provider to make a diagnosis. A VIA test is positive if there are raised and thickened white plaques or acetowhite epithelium, a VLI test is positive if there are mustard or saffron-yellow coloured areas, usually near the SCJ. Either test is suspicious for cancer if a cauliflower-like fungating mass or ulcer is noted on the cervix. Visual screening results are negative if the cervical lining is smooth, pinkish with acetic acid and dark brown or black with Lugol's iodine.

Strengths:

Relatively simple and inexpensive ,results available immediately and low level of infrastructure required.

Weaknesses:

High provider variability, lack of standardization, lower specificity resulting in high referral rates and other treatments.

HPV-DNA Screening Methods

A molecular testing for HPV. Sample of cells are collected from the cervix or vagina using a swab or small brush and placed in a small container with a preservative solution. The specimen can be collected by a health care provider or by the woman herself inserting a swab deep into the vagina. The specimen containers are transferred to a laboratory.

Strengths: Detects high grade cervical dysplasia, automated processing, high specificity in women over age 35, can be combined with pap smear to increase sensitivity.

Weaknesses: Results not immediately available, high unit cost, complex laboratory requirement and specimen transport.

Care HPV

This test is specifically designed for screening of woman in low-resource regions of the world in order to identify individuals at high risk of developing cervical cancer. It works by detecting the presence of 14 high-risk, or potentially cancer-causing, HPV types (Qiao, 2008).

It requires samples of exfoliated cervical cells which can be collected allowing the provider to make an immediate assessment of a positive (abnormal) or negative (normal) results.

Strengths:

Relatively simple and inexpensive, results available immediately, low level of infrastructure required.

Weaknesses:

High provider variability, lack of standardization, lower specificity resulting in high referral rates.

Theory underlying the study

Rosen stock's Health Belief Model

Rosenstock was one of the first scholars interested in determining why some people change their health behaviours whereas others do not. For example when the surgeon general's report on smoking first came out in 1960, some people immediately quit smoking (Kay 2005). Over the years, evidence condemning smoking has accumulated and been widely communicated, yet many intelligent people still smoke. Rosenstock wondered why. He formulated a model of health belief that illustrates how people behave in relationship to health maintenance. The model was developed in response to the failure of tuberculosis health screening programme.

Health belief model (HBM) has been developed to help determine whether an individual is likely to participate in disease prevention and health promotion activities. It examines the meaning of predisposing characteristics and analysis how individuals specific health belief affects decisions to seek care and adopt health behaviours. It can be a useful tool in developing programmes for helping people change or develop a mote positive attitude towards preventive health measures.

Cervical cancer screening has been identified as an effective instrument in early detection as well as cure for cervical cancer. Women are still dying of cervical cancer this could have been avoided if they accept that they are at risk and believe that screening is an effective tool against cervical cancer they will utilize the available opportunities of cervical screening, stay free of cervical cancer, be healthy, alive, and continue with their positive contributions to the development of their families, cities and nations.

Application Model to the Study

The model has three components

- individual perception
- modifying factors
- variables likely to affect action

The components of the theory under this study are individual perception and variables likely to affect action.

Individual perception

This component is subdivided into perceived susceptibility, perceived seriousness and perceived threat.

Perceive Susceptibility

This means how the individual sees oneself as being at risk or susceptible to develop the disease.

Being conscious of one's sex-female (Demographic), having the knowledge about the disease target ñ sexually active (structural) having managed a client or being scared by the thoughts of a friend or family member who died of the same disease (internal cue) and being around the environment where different

degrees of awareness about the disease is being created (external cue) will make an individual realize that she is at risk and thus will be motivated to undergo cervical screening.

Perceived seriousness

Explains that if the individual realizes that the disease is deadly in nature and that if one develops, it poses a great danger to health both physically, emotionally and financially, the individual will be motivated to participate in the exercise and as such avoid the unfavorable burdens associated with the disease.

Perceived Threat

Perceived susceptibility and perceived seriousness (severity) of the disease will give rise to perceived threat. That is when the individual perceives that she is susceptible and realizes the severity of the disease. This will make her understand and believe that developing the disease will bring danger to her life. This will make her take actions towards prevention of its occurrence.

Modifying Factor

These are factors that will likely make the individual to adopt positive behaviors or life styles towards preventing the occurrence of the disease. Such factors include demographic (sex-sexually active female), structural (knowledge ñ educated and enlightened), cue to action ñ internal or external.

Internal cue: (treating or caring for a patient with cervical cancer or thought of a neighbor suffering from such disease).

External cue: (seminars and workshops on cervical screening by professional bodies).

Likelihood of Action

This is concerned with the actions/inactions the individual is determined/not determined to take in order to prevent disease and maintain health.

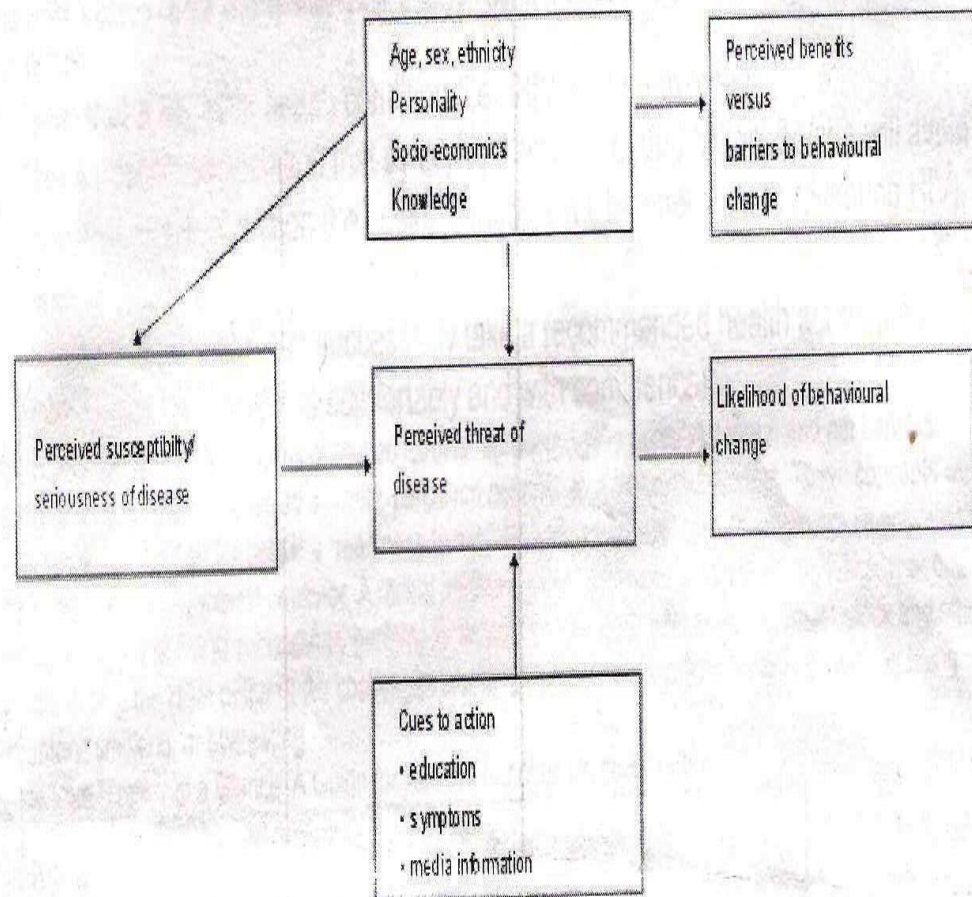
If an individual has the knowledge that early detection through cervical screening forms a strong base for preventing the development of cervical cancer and as such save the individuals life, she will not be daunted by the inconvenience associated with the screening exercise such as the cost, feeling of embarrassment among others, but rather she will readily accept and willingly participate in the screening.

Diagrammatic Representation of the Model

INDIVIDUAL PERCEPTIONS

MODIFYING FACTORS

LIKELIHOOD OF ACTION



Source: Glanz et al, 2002, p. 52

Empirical Review

Documented evidence shows that early detection through screening can reduce the incidence and mortality rates.

Adeola, (2008), from her study on knowledge, attitude and practice of cervical cancer screening (pap smear) using a self administered questionnaire on 144 female nurses in Nnewi south eastern Nigeria observed that there were multiple reasons why cervical cancer is so common in Nigeria, there is no effective screening programme and awareness of cervical cancer among health care workers is low.

Nwankwo, Aniebue, Aguwa, Anarado and Agunwa, (2011), in their study on knowledge, attitude and practice of cervical cancer screening among urban and rural Nigeria women in Enugu revealed that only 15.5% of the respondents were aware of availability of screening services while only 4.2% had ever done pap smear and all were referred for screening

Egwuatu, Eze, Johnson (2008) conducted a six-month study (1st July to 31st December, 2007) on awareness and practice of cervical cancer among 500 female hospital attendees (respondents) in Afikpo southeast nigeria and observed that out of 500 female hospital attendees (respondents) only 37.5% respondents were aware of cervical cancer, 13.9% knew that cervical cancer is preventable, 25% knew about pap smear, 20.8% knew centers that conducted pap smear and only 0.6% had done pap smear in the past. Non availability of centers locally, cost and time were the major reasons why the respondents did not do pap smear. Over all, 62.5% of all the respondents indicated willingness to do pap smear.

The colposcopy unit of university of Nigeria Teaching Hospital (UNTH) Enugu showed that in 2008. 432 women were screened and only 64 women out of this number did the screening on self-referral, 136 were referred cases from health care facilities and 232 came as a result of outreach programme on cervical screening.

Also, records from colposcopy unit UPTH Showed that in 2007, only 100 cases were screened and only 36 of them reported back with their results for a follow ñ up. There was a remarkable increase in the number of screened cases in the subsequent years (2008 - 20012) after several outreach programme.

In 2008; 176 were screened; in 2009, 169 were screened; In 2012, 203 were screened; in 2011, 312 were screened; in 2012 ;(January-August) 210 were screened. The low uptake of cervical cancer screening among women is a reflection of the attitude and practice of female health workers towards cervical cancer screening. The female health workers are pacesetters, role models and effective advocates of healthy behaviours.

Attitude and practice of health care workers

It has been observed that the commitment of health workers towards exclusive breastfeeding has served as a motivator to the mothers , and this has resulted in a significant reduction of infant mortality,

Exclusive breast feeding of infants aged 0-3 months and partial breast feeding for the remainder of the first year would prevent about 52 000 infant deaths a year in Latin America (Ana, Mercedes, Jeremy,Jose, 2001).They further

observed that, promotion of breast feeding has an important role in increasing survival of infants. In the same vein female health workers' commitment to cervical cancer screening will serve as a motivation to women and as such enable them participate in the screening, thus helping in reduction of the incidence and mortality as has been observed with that of exclusive breastfeeding.

Knowledge of cervical cancer screening among female nurses in Nnewi is high while uptake rate is abysmally poor, this was observed by Udigwe, (2006) in her study on the knowledge, attitude and practice of cervical cancer screening among female nurses in Nnewi. She therefore suggested that there is need to further educate the nurses who will play a major role in enlightening the public on the availability and need for cervical cancer screening services.

Mutyaha, Mmiro and weiderpass,(2006) in their study observed that despite knowledge of the gravity of cervical cancer and prevention by screening using a pap smear, attitudes and practices towards screening were negative. The medical workers who should be responsible for opportunist screening of women are not keen on getting screened themselves. They suggested that there is need to explain/ understand the cause of these attitudes and practices and identify possible interventions to change them. Medical students leave medical school without adequate skills to be able to effectively screen women for cervical cancer where they go to practice. Medical students and nurses training curricula needs review to incorporate practical skills on cervical cancer screening (Mutyaha, Mmiro and weiderpass, 2006).

Mutyaha, Mmiro, Weiderpass,(2006) in their study observed that the majority of respondents in their study were nurses, who form the bulk of medical workers in most health units in Africa. Most of these nurses and midwives thought that speculum examination and pap smear are doctors procedures; Doctors in disciplines other than gynaecology thought that speculum examination was an activity of the gynaecologists only; In departments other than gynaecology, the negative practice of not screening the patient who came under their care could be attributed to their routines, but this would not explain the reluctance to get screened themselves despite the availability of a free service almost any time they wished to .They further observed that 81% eligible female respondents had never been screened, mostly because they did not feel vulnerable to the disease . It is also unlikely that these medical workers would feel motivated to screen others or advise the women accordingly.

The result of the study done by Dim, Ekwe, Madubuko, Dim and Ezegwui (2008) showed that 79 female medical practitioners in Enugu State of Nigeria from February to May 2007 were studied, and all the respondents were aware of pap smear but only 14(17.7%) of them had used it, and repeat tests were only observed among respondents that screened as routine. They concluded with an observation that increase awareness of Pap smear does not translate to its use in Enugu and indeed Nigeria, and that there is more to the use of Pap smear among women in Nigeria than its awareness

Nwobodo and Malami (2005), in their cross sectional survey on 159 female health care providers in UsmanDanfodiyo University teaching hospital Sokoto

North Western Nigeria reported that knowledge of cervical cancer screening is high among the respondents. However 4.4% had availed themselves of the opportunity for the test.

Summary of Literature Review

Women in various parts of Nigeria know little about cervical cancer and pap smear (Ojiyi& Dike, 2008). Female health workers are in the better position to create a wider range of awareness about CCS. It is therefore pertinent to establish how well informed the population at risk is as well as their attitude and practice towards cervical screening.

There are but a few studies on CCS done in Rivers state but none in UPTH. Also the objectives, setting and population of this study differs from those of the other studies done in the state. Thus this study covers up the gap between the female health workers attitude and practice of CCS in the studied institution, as well as the recorded high incidence, high mortality rate and the poor prognosis.

CHAPTER THREE

RESEARCH METHOD

This chapter presents research design, area of study, population of study, sample and sampling technique, instrument for data collection, validity and reliability of the instrument, ethical consideration, procedure for data collection and method for data analysis.

Research Design

The research design used in this study was descriptive survey. The data was collected at one point in time. It is also designed to provide insights about the selected projects. The design was used because the study involved gathering, describing, tabulating and interpreting data to proffer answers to questions.

Area of Study

The study was carried out at university of Port Harcourt Teaching Hospital (UPTH), Rivers State South-South region of Nigeria. The state has a lot of both good indigenous and foreign oil servicing companies and this has enabled the state to enjoy a good number of social amenities and infrastructures like good road network, electricity supply through gas turbine among others. Consequently, the people engage in various social life activities of different kinds which promote promiscuity and thereby predispose the inhabitants to a high risk of developing cervical cancer.

UPTH was established in April 1980 at Emohua with a bed capacity of 60. In September 1983, it was relocated to 200 bed capacity at Port Harcourt General Hospital. In 12th October, 2006, it was commissioned at its permanent site with 600 bed capacity at Alakahia East West Road, where its

coloposcopyunit was established the same year (2006). Here, cervical cancer screening activities are conducted and these include: pre-screening counseling, screening (collection of specimen/conducting the screening) post screening counseling, result reading and interpreting, following-up of results.

It has over 600 doctors, with about 130 consultants, has over 600 nurses, 40 pharmacists, 80 laboratory scientists and 20 radiographers.[Brief history of university of port Harcourt Teaching Hospital Port Harcourt]. The hospital treats well over 400,000 out patient per annum, over 10,000 in-patients per annum and well over 5000 surgeries per annum.

The hospital is one the major training institution for medical workers in the state and therefore it should be the trendsetter for best practice regarding cervical cancer prevention and management. What is known and done in this tertiary institution transcends to what the rest of the medical health workers elsewhere in the state, region and more broadly in the country know and do.

There are other tertiary institutions in Rivers State such as Braithwaite Memorial Specialist Hospital (BMSH). University of Port Harcourt Teaching Hospital was selected because it is the apex medical institution in Rivers State and a catchment area for the whole of the Niger Delta, including Abia, Akwalbom, Bayelsa, Cross River, Delta and Imo States.

Population of study

The population of study comprised of all female health workers with clinical contacts with patients. There are 580 nurses and 195 doctors, 30 Medical

laboratory Scientist, 55 pharmacists and 20 female radiographers giving a total population of 880 respondents.

Sample and sampling technique

Sample Size:

A sample size of 352 was used for the study. This sample size was approximately 40% of the target population. This sample was considered representative of the population with an accurate level of more than 97% based on the suggestion by Constantine (2002) that a sample of 246 is accurate for population size of 800 at 97%, accuracy. Also, this sample size was considered based on the opinion of Nwana in Ofoegbu (2009) stating that where the population of study is a few hundreds, a 40% sample size will be adequate.

Sampling Procedure

The population being a heterogeneous population of female health workers was stratified according to profession: doctors, nurses, pharmacist, medical laboratory scientist and radiographers. A proportional stratified random sampling technique was used to select an appropriate sample size from each stratum. (Please see appendix c).

Table 1 Composition of sample for the study through proportionate Stratified random sampling technique

Strata	Medicine	Nursing	Pharmacy	Med-lab	Radiography	Total
Populations	195	580	55	30	20	880
Proportion	0.22	0.66	0.06	0.03	0.03	1
Selected size	78	233	22	11	8	352

Inclusion Criteria

All female health workers who have clinical contact with patients.

Instrument for Data Collection

The instrument for data collection used was questionnaire. It has three (3) sections A, B and. C

- Section A has five questions which elicited information on socio demographic profile of the respondents
 - Section B has thirteen questions which sought information on the attitude of female health workers towards cervical cancer screening.
 - Section C has seven questions and that elicited information on practice
- Section B used Likert's type of instrument while Section C used Yes / No response.

Likert's type of instrument measures the extent to which a person agrees or disagrees to a concept. A rating scale of 1-4 was used where.

1= Strongly disagree (strongly unfavorable to the concept or question)

2= Disagree (somewhat unfavorable to the concept or question)

3= Agree (some what favorable to the concept or question)

4= Strongly agree (Strongly favorable to the concept in. (see Appendix A.)

Ron Garland (1991) in his study on: The Mid-Point on a Rating Scale: Is it Desirable?, Observed the evidence that social desirability bias, arising from respondents' desires to please the interviewer or appear helpful or not be seen to give what they perceive to be a socially unacceptable answer, can be minimised by eliminating the mid-point ('neither... nor', uncertain etc.) category from Likert scales.

Validity of Instrument

Project supervisor and other two (2) senior lecturers, One (1) being a specialist in measurement and evaluation assessed the face and content validity of instrument and their comments were used to make necessary corrections before administration.

Reliability

Test ñ retest was used to ascertain the reliability of the instrument. 10 copies of the questionnaire were administered to and collected from female health workers in Braithwaite memorial specialist hospital (BMSH) with comparable characteristic of the population of study: two(2) doctors, two (2) nurses, two(2) medical laboratory scientists, two(2) pharmacists and two(2) radiographers. Two weeks later, the same numbers of questionnaire were administered to the same group of respondents. Their responses were subjected to product-moment coefficient of correlation statistical calculations to obtain the reliability co-efficient (r) of 0.94. (Please see appendix E)

Ethical Consideration

With an introduction letter from the Head of Department of nursing sciences, including researcher's application letter, twelve (12) copies of the proposal were forwarded to the ethical/legal unit of UPTH which is the body concerned with research/study protocols for approval of the study. They granted the researcher approval to collect the data. Also, written informed consent was obtained from each of the respondents.

Procedure for data collection

Researcher trained 8 research assistants on the purpose of the study and also how and when to administer and collect the questionnaire. The respondents were approached when they were less busy with their assigned duties, and that was between 3pm and 4pm daily. The approval letter from the legal unit, verbal discussions and phone contacts were used to gain access to and obtain permission from the heads of the units where the respondents reside. The nominal roll and the duty roster were used to randomly select the respondents until the required number was selected. The distributing and retrieving of the questionnaire lasted for 6 weeks. (First week of may to third week of June). A 95% return rate was achieved

Method for data analysis

The raw data collected were coded in a spreadsheet for easy analysis. Statistical software package, Statistical Package for Social Sciences (SPSS) version 20.0 was used for the analysis. Descriptive statistics of percentages, mean, standard deviation and mean cut-off of 2.5 as well as inferential statistics (chi-square and ANOVA) were used to analyse the data.

CHAPTER FOUR

PRESENTATION OF RESULTS

This chapter deals with the presentation of analyzed data as well as the results or answers to the research questions.

Table 2: Distribution of the respondents based on :

Profession	N	%	Remark
Nursing	234	66.5	Dominant
Medicine	75	21.3	
Pharmacy	22	6.3	
Medical laboratory	13	3.7	
Radiography	8	2.3	
Total	352	100.0	

Experience (years)	N	%	Remark
1-10 years	249	70.7	Dominant
11-20 years	75	21.3	
21-30 years	28	8.0	
Total	352	100.0	

Qualification	N	%	Remark
First degree	115	32.7	Dominant
Higher diploma	31	8.8	
Diploma	206	58.5	
Total	352	100.0	

Table 2 shows that the majority of the respondents were nurses (66.5%), this was followed by the doctors (21.3%) and the least were those in radiography (2.3%). Most of the respondents had 1-10 years of working experience (70.7%). This was followed by those who had 11-20 years of working experience (21.3%) and the least was those with 21-30 years of working experience.

Majority of the respondents hold Diploma certificates (57.8%). This was followed by holders of first degree (32.7%) and the least were holders of higher diploma certificates (8.8%).

Research question 1: What is the attitude of female health workers towards the uptake of cervical cancer screening?

Table 3: Attitude of female health workers towards the uptake of cervical cancer screening (CCS).

SN	Item	SA N(%)	A N(%)	Responses		Mean	Std	Decision
				D N(%)	SD N(%)			
1	I feel a sense of insecurity when attempting cervical cancer screening	144 (40.9)	181 (51.4)	16 (4.5)	11 (3.1)	3.30	0.70	*
2	I am always under terrible strain in a cervical cancer screening test	11(3.1)	20(5.7)	160 (45.5)	161 (45.7)	1.66	0.73	#
3	The proposal that all women of menopausal and childbearing age should present themselves for cervical cancer screening is a good one	21(6.0)	8(2.3)	104 (29.5)	219 (62.2)	1.52	0.81	#
4	Cervical cancer screening is for health workers in the obstetrics and gynecology(O&G) unit only	16(4.5)	10 (2.8)	131 (37.2)	195 (55.4)	1.57	0.76	#
5	Cervical cancer screening should form part of the routine examinations for women of menopausal and childbearing age	11 (3.1)	16 (4.5)	142 (40.3)	183 (52.0)	1.59	0.72	#
6	Women that maintain good genital hygiene and one sex partner do not need cervical cancer screening	28 (8.0)	20 (5.7)	99 (28.1)	205 (58.2)	1.63	0.91	#
7	Subjecting self for cervical cancer screening amounts to debasing one's womanhood	69 (19.6)	126 (35.8)	110 (31.3)	47 (13.4)	2.62	0.95	*
8	Participating in the cervical cancer screening should be made compulsory for all female health workers	58 (16.5)	70 (19.9)	132 (37.5)	92 (26.1)	2.27	1.03	*
9	Non existence of national cervical cytology among others increase the prevalence of cervical cancer in Nigeria	12 (3.4)	139 (39.5)	133 (37.8)	68 (19.3)	2.27	0.81	*
10	Medical professionals have known everything harmful about cervical cancer screening	12 (3.4)	42 (11.9)	156 (44.3)	142 (40.3)	1.78	0.78	*
11	Cervical can screening is a valuable and necessary for all women	18 (5.1)	147 (41.8)	186 (52.8)	1 (.3)	2.52	0.60	#
12	I look forward to being screened for cervical cancer screening	11 (3.1)	94 (26.7)	148 (42.0)	99 (28.1)	2.05	0.82	
13	I would like to study about cervical cancer screening to develop my knowledge about womanhood	37(10.5)	116 (33.0)	114 (32.4)	85 (24.1)	2.30	0.82	*
Grand mean						2.08	0.80	*

*Positive(favourable)

Negative (unfavourable)

Table 3 showed the mean, standard deviation and percentage responses on the attitude of female health workers towards the uptake of cervical cancer screening. The decision cut-off point is 2.5. Any item in which the respondents have a mean score of 2.5 and above are regarded as positive or favourable while those less than 2.5 is regarded as negative.

Research question 2:How do the female health workers practice cervical cancer screening?

Table 4: Female health worker's practice of cervical cancer screening.

SN	Item	Responses		Decision
		Yes N(%)	No N(%)	
14	I have voluntarily presented myself for cervical cancer screening	259 (73.6)	93 (26.4)	#
15	I have encouraged and /or referred some friends and relations /patients to present themselves for the screening exercise	66 (18.8)	286 (81.3)	#
16	I have conducted cervical cancer screening on patients requiring such services	23 (6.5)	329 (93.5)	#
17	I have interpreted the result of pap smear test to patients that have undergone the test	295 (83.8)	57 (16.2)	*
18	I will willingly join a group that is engaged in educating the populace on cervical cancer screening in the community	293 (83.2)	59 (16.8)	*
19	I advocate for follow- up of all cases who have tested positive to cervical cancer smear test	58(16.5)	294(83.5)	#
20	I will subject myself for cervical cancer screening if I test positive	177 (50.3)	175 (49.7)	*

*practice # not practiced

Table 4 showed the frequency and percentage responses on female health workers practices of cervical cancer screening.

Research question 3: How does profession influence the attitude of female health workers towards the uptake of cervical cancer screening?

Table 5: Attitude of female health workers towards the uptake of cervical cancer screening (CCS) based on profession.

SN	Item	Nursing N=234	Medicine N=75	Pharmacy N=22	Medical laboratory N=13	Radiography N=8	F	p-value	Decision
		Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)			
1	I feel a sense of insecurity when attempting cervical cancer screening	3..28(.73)	3..37(.632)	3.41(.73)	3.15(.69)	3.13(.35)	.641	.633	ns
2	I am always under terrible strain in a cervical cancer screening test	1.69(.753)	1.67(.644)	1.45(.510)	1.54(.967)	1.63(.744)	.622	.647	ns
3	The proposal that all women of menopausal and childbearing age should present themselves for cervical cancer screening is a good one	1.55(.844)	1.55(.776)	1.23(.429)	1.38(.870)	1.50(.756)	.896	.466	ns
4	Cervical cancer screening is for health workers in the obstetrics and gynecology(O&G) unit only	1.64(.764)	1.47(.777)	1.23(.429)	1.38(.870)	1.63(.744)	2.147	.075	ns
5	Cervical cancer screening should form part of the routine examinations for women of menopausal and childbearing age	1.64(.729)	1.51(.742)	1.36(.492)	1.38(.870)	1.75(.463)	1.448	.218	ns
6	Women that maintain good genital hygiene and one sex partner do not need cervical cancer screening	1.72(.966)	1.47(.759)	1.45(.800)	1.54(.877)	1.38(.518)	1.558	.185	ns
7	Subjecting self for cervical cancer screening amounts to debasing one's womanhood	2.66(.977)	2.49(.844)	3.00(.816)	2.31(.947)	1.88(.835)	2.990	.019	S
8	Participating in the cervical cancer screening should be made compulsory for all female health workers	2.29(.096)	2.11(.109)	2.41(.130)	2.31(.125)	2.50(.131)	.714	.583	ns
9	Non existence of national cervical cytology among others increase the prevalence of cervical cancer in Nigeria	2.28(.072)	2.35(.105)	2.00(.082)	2.23(.083)	2.00(.076)	1.026	.394	ns
10	Medical professionals have known everything harmful about cervical cancer screening	1.80(.068)	1.71(.109)	1.55(.051)	1.92(.076)	2.50(.053)	2.529	.040	S
11	Cervical can screening is a valuable and necessary for all women	2.40(.050)	2.87(.078)	2.45(.051)	2.62(.051)	2.63(.052)	9.635	.000	S
12	I look forward to being screened for cervical cancer screening	2.18(.076)	1.99(.097)	1.55(.060)	1.38(.051)	1.25(.046)	8.333	.000	S
13	I would like to study about cervical cancer screening to develop my knowledge about womanhood	2.29(.099)	2.45(.084)	2.45(.080)	1.77(.093)	1.63(.074)			

ns=not significant, $p>.05$, s=significant, $p<.05$, $df1=4$ $df2=471$

Table 5 showed mean, SD and ANOVA on the attitude of female health workers towards the uptake of cervical cancer screening (CCS) based on profession.

Research questions 4: How does profession influence the practice of cervical cancer screening by female health workers?

Table 6: Relationship between profession and female health workers practices of cervical cancer screening.

SN	Item	Nursing N=234	Medicine N=75	Pharmacy N=22	Medical laboratory N=13	Radiography N=8		p-value	Decision
	Items	Yes (No)	Yes (No)	Yes (No)	Yes (No)	Yes (No)	χ^2		
14	I have voluntarily presented myself for cervical cancer screening	168(66)	63(12)	14 (8)	8 (5)	6(2)	6.67	.154	ns
15	I have encouraged and /or referred some friends and relations /patients to present themselves for the screening exercise	53 (181)	8 (67)	4 (18)	0 (13)	1 (7)	8.76	.067	ns
16	I have conducted cervical cancer screening on patients requiring such services	14 (220)	5 (70)	0 (22)	2(11)	2(6)	7.79	.100	ns
17	I have interpreted the result of pap smear test to patients that have undergone the test	195 (39)	65 (10)	20 (2)	9 (4)	6(2)	3.801	.434	ns
18	I will willingly join a group that is engaged in educating the populace on cervical cancer screening in the community	189 (45)	67 (8)	20 (2)	11(2)	6(2)	4.35	.360	ns
19	I advocate for follow- up of all cases who have tested positive to cervical cancer smear test	33 (201)	15 (60)	2 (20)	5 (8)	3(5)	9.64	.050	ns
20	I will subject myself for cervical cancer screening if I test positive	111 (123)	46 (29)	10 (12)	7 (6)	3 (5)	5.21	.266	ns

ns=not significant, $p>.05$, $df=4$.

Table 6 shows frequency, percentage and Chi-square statistics on the relationship between profession and female health workers practices of cervical cancer screening.

Summary of findings

- The attitude of female health workers towards the uptake of cervical cancer screening was unfavourable or negative
- There was poor practice of cervical cancer screening by female health workers
- Profession does not significantly influence the attitude and practice of cervical cancer screening by female health workers.

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

This chapter deals with discussion of the results of the study. Conclusions of the study are also made. Recommendations based on the results, as well as limitations of the study are presented. It also highlights the implications of the results and Suggestion for further study.

Discussion of Findings

Table 2 shows that the majority of the respondents were nurses, this was followed by the doctors and the least were those in radiography.

Nurses form large proportion of health workers in the studied population. Their attitude and practice reflects what is obtainable among the female health workers. Their attitude and practice of CCS is quite significant since they form the core of the health personnel that health educate the public. Thus their attitude and practice towards CCS will affect the quality of their health education. The result of this finding shows that there is negative attitude and poor practice of cervical cancer screening among female health workers. This is in consonance with the observation of Mutyaha, Mmirro&Weiderpass (2006), in their study that the majority of the respondents in their study were nurses who form the bulk of medical workers in most health units in Africa. Also Udigwe (2006) observed that knowledge of cervical cancer screening among female nurses is high but the uptake is abysmally poor. Thus there is a poor uptake of CCS among the nurses which extended to other female health workers as observed in this study. This has inevitably affected the women negatively. Records and reviewed literature have revealed a poor uptake of

CCS which has resulted to high incidence, mortality rate and poor treatment outcome of CCS.

Attitude of female health workers towards the uptake of cervical cancer screening

Cervical cancer screening (CCS) has been identified as an effective instrument in early detection as well as cure for cervical cancer. Yet women are still dying of cervical cancer, which could have been prevented given the new technologies available.

Observations have shown that the commitment of health workers towards exclusive breastfeeding has served as a good motivator to mothers; this has resulted in a significant reduction of infant mortality. Ana, Mercedes, Jeremy, Jose,(2001) observed that exclusive breast feeding of infants aged 0-3 months and partial breast feeding for the remainder of the first year would prevent about 52 000 infant deaths a year in Latin America. They further observed that, promotion of breast feeding has an important role in increasing survival of infants. In the same vein if the female health workers are committed to cervical cancer screening, this will motivate the women to participate in the screening, thus helping in reduction of the incidence and mortality as has been observed with that of exclusive breastfeeding.

The result in table 3 showed that the attitude of female health workers towards the uptake of CCS was not favourable. This is not quite impressive considering the fact that cervical cancer has been identified as the 2nd most common cancer in women worldwide and most common in African women, thus the most leading cause of cancer deaths in women in sub ñ saharan Africa including Nigeria with a very poor 6 years survival rate., The women presenting themselves for screening will in manyways such as early detection and good treatment outcome reduce the high mortality from cervical cancer. It has also being observed that well organised cancer prevention programmes based on primary screening with cervical cytology lead to impressive reductions in cervical cancer rate in developed countries .Adeola (2008) stated that screening in the Uk saved up to 500 lives per year. .

Also this observation agrees with the findings of Mutyaha, Mmiro&Weiderpass (2006), they observed that in departments other than O & G; there is a negative practice of not screening patients which could be attributed to the routines of those departments. Routine procedures are usually done to collect data on the health status of the patients. Just like checking the temperature and blood pressure of the patient gives an idea of their health status and attracts prompt attention if there is any deviation from normal thus helping to avert complication; Cervical cancer screening as a routine procedure when not restricted to those in O & G will help in early detection of cervical cancer and prevent its attendant problems.This could be an issue with policy on what is routine and whose responsibility it is. Health institution policies should be for the adequate care of the patients either in form of preventive, curative or palliative care. Policies that do not promote/encourage quality health care

practitioners to practice skills learnt on the course of training do not promote holistic care of the patient. This is also supported by the observation of Mutyaha, Mmiro&weiderpass in their study which identified lack of clear policy on who should do the screening. They further observed that referral for screening in the gynecology department was very low reflecting an absence of policy on health promotion and diseases prevention in mulago hospital

Cervical cancer skills are meant to help prevent, cure, cervical cancer or reduce the diseases burden on people. Policies guiding this procedure should involve health care providers that have sufficient contact to conduct this procedure on the patients. The health care professionals are aware of predisposing or risk factors to cervical cancer, but unfortunately their attitude is quite discouraging as observed by Udigwe (2006) in her study on knowledge attitude and practice of cervical cancer (Pap smear) among female nurses Nnewi South East Nigeria using a self- administered questionnaire as instrument for Data collection from 144 female nurses in the studied area. She stated that the knowledge of cervical cancer screening among female nurses in Nnewi is high while uptake is abysmally poor. This shows that the female health workers are failing in playing their role as models and watch dogs. For if they know the health benefits and also do the test, they will also encourage others to do so and thus become effective advocates in the practice of good health behaviors.

The practice of cervical cancer screening by female health workers

The result in Table 4 revealed that there was poor practice of cervical cancer screening by female health workers. This indicates that their poor utilization

has inevitably impacted the public negatively with the consequent deadly implications it has on the women who are looking up to them (health workers) for positive influence. There are several reports on the practice of female health workers towards uptake of screening. Some of these reports include; A study in port Harcourt on female health care providers showed that only 17 out of 133 respondents had have pap smear (Adda, Ojule&Feibai ,2012), Nwobodo&Malami (2005) in their study on female health workers in Sokoto North Western Nigeria reported that knowledge of cervical cancer screening is high among the respondents. However only 4.4% had availed themselves of the opportunity for the test.

Another study by Dim, Ekwe, Madubuko, Dim &Ezegwui (2008) reported that only 14 out of 79 representing 17.75% female medical practitioners have undergone cervical cancer screening. Also MutyahaMmiro&weiderpass (2006) reported that 81% eligible female respondents in their study had never been screened for cervical cancer. Udigwe (2006), knowledge of cervical cancer screening among female nurses in Nnewi is high while uptake is abysmally poor. She reported that only 5.7% of her study population (166) had ever undergone a pap smear. The female health workers who should be responsible for opportunist screening of women are not keen on getting screened themselves. There is need to explain/ understand the cause of these attitude and practices and identify possible interventions to change them.

The practice of CCS was observed to be poor as less than 20% of the respondents said that they have conducted cervical screening on patients while less than 6% have interpreted results of paps smear to patients. This

clearly supports the findings of the discussion in the paragraph above. Since they are nonchalant to being screened, they will not also be committed to encouraging, screening or interpreting the result for the patient. This agrees with the observation of Mutyaha, Mmiro&Weiderpass (2006) on knowledge, attitude and practice on cervical cancer screening among the medical workers of Mulago hospital Uganda.

They conducted a cross-sectional survey in Mulago hospital in Kampala Uganda on 288 medical workers and observed that it is unlikely that the medical workers who have various reasons not to be screened will feel motivated to screen others or be involved in screening activities. Ogun&Bejide (2006) reported that poor advocacy is one of the reasons for high prevalence of cervical cancer in Nigeria. WHO (2007), in their study on Determinants of Women's participation in Cervical Cancer Screening trial, Maharashtra, India, reported that, their Staff included medical Female health workers who were mainly in-charge of inviting women and providing health counseling; also women from all of the study arms were invited to a meeting led by female health workers in each village, where the purpose and characteristic of the screening were explained and women could ask questions. This enabled them to witness a very good screening coverage of about 80% of the target population. This is a situation where female health workers were actively involved and it yielded a great result of turnout of participants. This agrees with observation from the colposcopy unit of UNTH (2008) that recorded a higher number of screened women after an outreach programme. Also, majority of the respondents accepted that they have encouraged and /or referred some friend and relations/patients to present themselves for the screening exercises.

This is contrary to the observations of Mutyaha, Mmiro&weiderpass (2006) that since the medical health workers refused to be screened, they will be less motivated to advise others to do so. Though this shows a typical case of telling others to do what you have refused to do (hypocrisy) like the biblical pharisees.

Influence of profession on the attitude of female health workers towards CCS.

Result on table 5 showed that the p-value is greater than .05, which is the significant level, thus indicating that profession does not significantly influence the attitude of female health workers towards the uptake of CCS. The female health workers being knowledgeable about CCS should be in the forefront of promoting the uptake of CCS, but the reverse is the case as observed from this study. . This is in agreement with the study of Mutyaha, Mmiro&Weiderpass (2006) on knowledge, attitude and practice of cervical cancer screening of medical workers in Mulago hospital, Uganda which revealed that most nurses and midwives thought that speculum examination and pap smear were doctors' procedure while doctors in disciplines other than O&G thought that speculum examination was an activity for gynecologists only. This is the most common attitude and practice of health workers found in most health institutions in our contemporary time. This leads to either not being interested to conduct the test, learning the skill, being committed to creating the awareness as well as not being involved in the uptake. Thus there is poor attitude and negative practice of not screening the patient that come under their care with its consequent effect of high mortality

Influence of profession on the practice of female health workers towards CCS.

Table 6 also showed that the level of uptake is very poor. These female health workers should be responsible for the opportunist screening of women but sadly they are not keen on getting screened themselves and therefore cannot be committed to screening the women who came under their care. This observation agrees with the findings of other studies. Mutyaha, mmiro&weiderpass (2006) observed that 81% eligible respondents had never being screened; Dim, Eze, Ekwe, Madubuko, Dim &Ezegwui (2008) observed that only 4.4% out of 159 respondents in their study had availed themselves of the opportunity for the test. It is unfortunate that the female health workers despite being knowledgeable of the gravity of cervical cancerits prevention by screening yet exhibits poor practice towards CCS .Thus, there is need to explain/ understand the cause of these attitudes and practices and identify possible interventions to change them. Also, this calls for more enlightenment and to further educate the health workers who will play a major role in enlightening the public on the availability and need for cervical cancer screening services.

Implications of findings:

The findings of this study have shown that from their responses, the female health workers have negative attitude towards cervical cancer screening. Majority of them responded that cervical cancer screening is for only the health workers in O& G and also that cervical cancer screening should not form part of routine examination for women of childbearing age. This could be due to policy of the health institution. The obvious implication is that the health institutions should state and ensure the implementation of a clear policy on who should do the screening in order to encourage commitment to screening

by the health workers. Furthermore, cervical cancer screening should form part of the curriculum in institutions where health workers are trained.

Also, the findings of this study have shown that the practice of cervical cancer screening among female health workers is poor. The implication of this is that cervical cancer screening should be made compulsory for all female health workers, as this will motivate them to screen others and / or advise them accordingly.

Limitation of the Study

This study is necessary to elicit the attitude, practice and influencing factors of cervical cancer screening among female health workers, which eventually transcends to the womenfolk. Their positive attitude and practice will transcend to high uptake and reduction in incidence, death and disease burden of cervical cancer while the reverse is the case if they exhibit negative attitude. This study was limited only to female health workers including nursing, medicine, pharmacy, radiography and med-lab who have clinical contact with the female patients. This is due to limited time, finance and level of clinical interactions they have with the patients. Other female health workers in some units such as administrative unit, nutrition/ dietician, medical records among others may not have a considerable clinical contact with the patients as to create such opportunity of interacting on clinical issues with the patients.

Summary

This research studied the attitude and practice of cervical cancer screening among female health workers in UPTH. Its objectives were to;

- determine the attitude of female health workers towards cervical cancer screening
- determine the practice of female health workers towards cervical cancer screening
- .
- determine how profession influences attitude and practice of cervical cancer screening among female health workers in the studied hospital

Literatures relevant to the study were reviewed to cover the objectives of the study. The research design was descriptive survey. A sample size of 352 was used for the study. This sample size was approximately 40% of the target population and was considered representative of the population with an accurate level of more than 97%. Being a heterogeneous population of female health workers, (doctors, nurses, pharmacy, medical-laboratory scientist and radiographers) a proportional stratified random sampling technique was used to select an appropriate sample size from each stratum.

Major findings of the study showed that;

- 1 The female health workers involved in the study have negative attitude towards cervical cancer screening.
- 2 The practice of cervical cancer screening among the female health workers is poor.
- 3 profession does not have any influence on attitude and practice of cervical cancer screening among female health workers in the studied hospital

Conclusion

Based on the findings, the following conclusions were made:

Female health workers involved in the study demonstrated negative attitude towards cervical cancer screening. The decision cut-off point is 2.5. Any item in which the respondents have a mean score of 2.5 and above is regarded as positive or favourable while those less than 2.5 is regarded as negative. The grand mean result of their attitude is 1.98 which shows a negative or unfavourable attitude.

The attitude and practice of female health workers towards cervical cancer screening is poor. Profession does not significantly influence the attitude and practice of female health workers towards the uptake of CCS.

Recommendations

Based on the findings of the study, the discussions and implications drawn from the study, the following recommendations were made;

- 1 there is need for an intensive and extensive sensitization of female health workers about the necessity of cervical cancer screening
- 2 there is need to change the attitude that screening is only for those in O&G unit. Health workers in other departments need to be sensitized on the gravity of cervical cancer and the importance of screening in preventing the disease and death and so should encourage and/or refer women of child bearing age for screening.
- 3 Training curricular of health workers need to be revised to include more practical cervical cancer skills.
- 4 Health institutions should establish clear guidelines on screening for cervical cancer, such as making it one of the routines for women of child bearing age and as such providing the necessary equipments for the procedure to all the different units and also training workers on the skills..
- 5 There should be a national cervical cytology screening centers; adequate funding and advocacy by the government and non-governmental agencies so as to reduce the high incidence of cervical cancer and its consequent negative effects on the people.
- 6 Strategies such as free or subsidized screening and / or treatment services should be utilized to encourage women and also increase screening uptake and reduce high incidence and death.

Suggestions for further Research:

Further research is needed to explain the reticence to get screened by female health workers despite their ready access to screening facilities in the hospital. Also the influence of age and duration of service on attitude and practice of cervical cancer screening among female health workers is suggested. Again, factors influencing the uptake of CCS should be looked into and suggestions to overcoming hindering factors made; there is need to identify the motivating factors and thus utilize them to encourage the women to undergo cervical cancer screening.

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APPENDIX A

Section A

Demographic Data

- Age: Specific age last birth day. []
- Profession: Nursing [] Medicine [] Pharmacy [] Medical lab []
Radiography []
- Duration of service: 1-10 years [] 11-20 years [] 21-30 years []
- Academic level: Diploma [] First Degree [] Higher Degree []
- Nationality: Nigerian [] others; specify _____

SECTION B

We are interested in your opinion about Cervical Cancer Screening (CCS). It will be appreciated if you respond to these questions accordingly and honestly. This instrument is not something to be graded and your answers are absolutely anonymous. Please tick [X] in the box corresponding to your answer. Strongly Agree (SA), Agree (A), Disagree (D), or Strongly Disagree (SD). Thank you for your help!

Attitude

SN	Item	Strongly agree	Agree	Disagree	Strongly disagree
1	A woman who maintains only one sex partner does not need cervical cancer screening.				
2	Cervical cancer screening is for prostitutes only				
3	The proposal that all women of menopausal and childbearing age should present themselves for cervical cancer screening is a good one				
4	Cervical cancer screening is for health workers in the obstetrics and gynecology(O&G) unit only				
5	Cervical cancer screening should form part of the routine examinations for women of menopausal and childbearing age				
6	Women that maintain good genital hygiene and one sex partner do not need cervical cancer screening				
7	Subjecting self for cervical cancer screening amounts to debasing one's womanhood				
8	Participating in the cervical cancer screening should be made compulsory for all female health workers				
9	Non existence of national cervical cytology among others increase the prevalence of cervical cancer in Nigeria				
10	Medical professionals have known everything harmful about cervical cancer screening				
11	I look forward to being screened for cervical cancer screening				
12	I look forward to being screened for cervical cancer screening				
13	I would like to study about cervical cancer screening to develop my knowledge about womanhood				

SECTION C

Practice

SN	Item	Yes	No
14	I have voluntarily presented myself for cervical cancer screening		
15	I have encouraged and /or referred some friends and relations /patients to present themselves for the screening exercise		
16	I have conducted cervical cancer screening on patients requiring such services		
17	I have interpreted the result of pap smear test to patients that have undergone the test		
18	I will willingly join a group that is engaged in educating the populace on cervical cancer screening in the community		
19	I advocate for follow- up of all cases who have tested positive to cervical cancer smear test		
20	I will subject myself for cervical cancer screening if I test positive I advocate for cervical cancer screening for women in churches and market places to intimate women on the activities.		

Appendix B
Calculation of sample size.

$$\frac{40}{100} \times \frac{880}{1} = 352$$

APPENDIX C

Calculation of sample size from each stratum using proportional stratified random sampling technique

$$\text{Medicine: } \frac{195}{880} = 0.22 \times 352 = 78$$

$$\text{Nursing: } \frac{580}{880} = 0.66 \times 352 = 233$$

$$\text{pharmacy: } \frac{55}{880} = 0.06 \times 352 = 22$$

$$\text{Medical-laboratory : } \frac{30}{880} = 0.03 \times 352 = 11$$

$$\text{radiography : } \frac{20}{880} = 0.02 \times 352 = 8$$

$$\text{TOTAL} = 352$$