International Scholars Journals

African Journal of Nursing and Midwifery ISSN 2198-4638 Vol. 2 (7), pp. 368-377, September, 2015. Available online at www.internationalscholarsjournals.org © International Scholars Journals

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*Full Length Research Paper*

# A study on the attitude and practice of female health workers towards cervical cancer screening in the university of Port Harcourt teaching hospital, Rivers State, Nigeria

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Accepted 9 August, 2015

**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, Rivers state. The descriptive survey design was adopted for the study. A sample size of 352 was used for the study. A self structured questionnaire was the instrument used for data collection. 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 soft ware package, for Social Sciences 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) were used to analyze the data. Findings showed that the female health workers have negative attitude and poor practice of CCS. The p-value was greater than 0.05 in nine 9 out of 13 items, therefore the null hypothesis was accepted while the alternate hypothesis was rejected; we can conclude that there is no significant relationship between profession and attitude of female health workers towards the uptake of CCS.**

**Key words:** Cervical cancer screening, female health workers, attitude, practice.

## INTRODUCTION

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 29women 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.

### 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 the influence of profession on the attitude of female health workers towards cervical cancer screening in the studied hospital

### Hypothesis

1 There is a significant relationship between profession and the practice of cervical cancer screening among female health workers in the studied institution.

## MATERIALS AND METHODOLOGY

### 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, people engage in various social life

**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 |

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 12$^{th}$ October, 2006, it was commissioned at its permanent site with 600 bed capacity at Alakahia East West Road, where its colposcopy unit 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 outpatient 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. 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, Akwa Ibom, 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.

**Validity of Instrument**

Two (2) specialists in measurement and evaluation assessed the face and content validity of the instrument and their comments were used to make necessary corrections before administration.

**Reliability**

Test – 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

**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 | |
| Higher diploma | 31 | 8.8 | |
| Diploma | 206 | 58.5 | Dominant |
| Total | 352 | 100.0 | |

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.

### 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/oral 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 soft ware 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 analyze the data.

## RESULTS

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%).

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

| | | Responses | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **SN** | **Item** | **SA N(%)** | **A N(%)** | **D N(%)** | **SD N(%)** | **Mean** | **Std** | **Decision** |
| 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)

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

Table 3 showed that a good number of the respondents 323 (91.7%) did not support opinion that all women of child bearing age should participate in the uptake of CCS while a few 29 (8.3%) supported it. Majority of the health workers 326 (92.6%) did not support that CCS should be for only those in O & G unit while 26(7.3%) supports it. 325(92.3%) disagree with the opinion that CCS should form part of the routine examination for women of menopausal and child bearing age, only a few 27(7.6%) agreed. 48(13.7%) of the respondents agree that women who maintain good genital hygiene and one sex partner do not need CCS while 304(86.3%) disagreed. 195(45.3%) of the respondents agree that subjecting self for cervical cancer screening amounts to debasing one's womanhood but others 157(44.7%)did not. 128 (36.4%) Of the respondents supported that participating in CCS should be made compulsory for all female health workers while 224 (63.6%) did not. 151 (42.9%) Of the respondents

**Table 4:** Practice of CCS among Female health workers

| SN | Item | Responses | | |
|---|---|---|---|---|
| | | Yes N(%) | No N(%) | Decision |
| 14 | I have voluntarily presented myself for cervical cancer screening | 93 (26.4) | 259 (73.6) | * |
| 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 | 57 (16.2) | 295 (83.8) | * |
| 18 | I will willingly join a group that is engaged in educating the populace on cervical cancer screening in the community | 59 (16.8) | 293 (83.8) | * |
| 19 | I follow- up 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

favoured the view that lack of national cervical cytology screening, political will, funding and poor advocacy for CCS are responsible for high prevalence of cervical cancer while 201(57.1%) did not favour this opinion.

The table also shows the grand 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 favorable 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 showed that only 93 (26.4%) have voluntarily presented themselves for cervical cancer screening while 259(73.6%) have not.286 (81.3%) have not encouraged and /or referred some friends and relations /patients to present themselves for the screening exercise.

Also only few 23(6.5%) have conducted cervical cancer screening on patients requiring such services while majority 329(93.5%) have not. Only 57(16.2%) have interpreted the result of pap smear test to patients that have undergone the test, 295(83.8%) have not. Only 58(16.5%) of the respondents follow- up cases who have tested positive to cervical cancer smear test. 177(50.3%) will subject themselves for cervical cancer screening if tested positive.

Table 5 shows that only 168 out of 234 nurses, 63 out of 75 doctors, 14 out of 22 pharmacists 8 and 6 of medical laboratory scientists and radiographers respectively have voluntarily presented themselves for cervical cancer screening.53 of the nurses,8 of the doctors,4 of the pharmacists, none of the medical laboratory scientists and 1 of the radiographers have encouraged and /or referred some friends and relations /patients to present themselves for the screening exercise. 14 the nurses,5 of the doctors, none of the pharmacists,2 of the medical laboratory scientists and 2 of the radiographers have conducted cervical cancer screening on patients requiring such services. 195 the nurses,65 of the doctors,20 of the pharmacists,9 of the medical laboratory scientists and 6 of the radiographers have interpreted the result of pap smear test to patients that have undergone the test. 33 of the nurses,15 of the doctors,2 of the pharmacists,5 of the medical laboratory scientists and 3 of the radiographers follow- up cases who have tested positive to cervical cancer smear test.

The Table further showed that since p-value is greater than the .05 level of significance in each case (item), we conclude that profession does not significantly influence the practice of cervical cancer screening by female health workers.

Table 6 showed mean, SD and ANOVA on the attitude of female health workers towards the uptake of CCS based on profession. Table 5 further showed that since the p-value was greater than .05 in nine (9) out of 13 items, we can conclude that there is no significant relationship between profession and the attitude of female

**Table 5:** Influence of profession on the practice of cervical cancer screening among female health workers

| SN | Items | Nursing N=234 | Medicine N=75 | Pharmacy N=22 | Medical laboratory N=13 | Radiography N=8 | $\chi^2$ | p-value | Decision |
|---|---|---|---|---|---|---|---|---|---|
| | | Yes (No) | Yes (No) | Yes (No) | Yes (No) | Yes (No) | | | |
| 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 follow- up 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.*

female health workers towards the uptake of cervical cancer screening.

## DISCUSSION

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 heath 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 transcended to the womenfolk. Records and reviewed literature have revealed a poor uptake of CCS which has resulted to high incidence, mortality rate and poor treatment outcome of cervical cancer.

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

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 2$^{nd}$ most common cancer in women worldwide and most

**Table 6:** Relationship between profession and the attitude of female health workers towards the uptake of CCS in the studied institution.

Mean, SD and ANOVA on the attitude of female health workers towards the uptake of CCS based on profession.

| SN | Item | NursingN =234 | Medicine N=75 | PharmacyN= 22 | Medicallaboratory 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 (0.96) | 2.11 (1.09) | 2.41 (1.30) | 2.31 (1.25) | 2.50 (1.31) | .714 | .583 | ***ns*** |
| 9 | Non existence of national cervical cytology among others increase the prevalence of cervical cancer in Nigeria | 2.28 (0.72) | 2.35 (1.05) | 2.00 (0.82) | 2.23 (0.83) | 2.00 (0.76) | 1.026 | .394 | ***ns*** |
| 10 | Medical professionals have known everything harmful about cervical cancer screening | 1.80 (0.68) | 1.71 (1.09) | 1.55 (0.51) | 1.92 (0.76) | 2.50 (0.53) | 2.529 | .040 | S |
| 11 | Cervical can screening is a valuable and necessary for all women | 2.40 (0.50) | 2.87 (0.78) | 2.45 (0.51) | 2.62 (0.51) | 2.63 (0.52) | 9.635 | .000 | S |
| 12 | I look forward to being screened for cervical cancer screening | 2.18 (0.76) | 1.99 (0.97) | 1.55 (0.60) | 1.38 (0.51) | 1.25 (0.46) | 8.333 | .000 | S |
| 13 | I would like to study about cervical cancer screening to develop my knowledge about womanhood | 2.29 (0.99) | 2.45 (0.84) | 2.45 (0.80) | 1.77 (0.93) | 1.63 (0.74) | | | |

ns=not significant, p>.05, s=significant, p<.05, df1=4 df2=347

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 years survival rate., The women presenting themselves for screening will in many ways 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 poor attitude 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 qualified 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 (2006) 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 screening skills are meant to help prevent, cure, cervical cancer or reduce the disease 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 is poor practice of cervical cancer screening among 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. Other several reports on the practice of female health workers towards uptake of screening agree with this result. Some of these reports include; A study in port Harcourt on female health care providers which 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 Mutyaha Mmiro & weiderpass (2006) reported that 81% eligible female respondents in their study had never been screened for cervical cancer. Udigwe (2006), 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.

### Influence of profession on the practice of CCS among female health workers

Table 5 revealed that cutting across the profession; the female health workers have the same poor attitude towards CCS.

These female health workers should be responsible for the opportunist screening of women but sadly they are not keen in 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 cancer, its 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.

### Relationship between profession and female health workers attitude towards CCS

Table 6 also revealed that cutting across the proffession that the female health workers have negative attitude towards the uptake of CCS. 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 of health workers found in most health institutions in our contemporary time. This leads to either not been interested to conduct the test, learning the skill, been committed to creating the awareness as well as not been involved in the uptake.

## 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 unfavorable 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.

### 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.

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