Chapter-VII

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7.1 Introduction

Cervical cancer is the second most common cancer in the world. Every year cervical cancer is diagnosed in about 500,000 women globally and was responsible for more than 280,000 deaths annually. About 14.0 percent cervical cancers occur in the developed countries and about 86 percent cervical cancers occur in developing countries. In India, cervical cancer is the largest killer of middle aged women, followed by breast cancer. In India, each year cervical cancer accounts for 26.7 percent of worldwide incidence and 72,825 Indian women die due to cervical cancer. It is a major cause of morbidity and mortality in India and more than 1, 32,000 women are diagnosed with cervical cancer every year, In fact 200 women are dying for every 24 hours in India due to cervical cancer. Incidence and mortality of cervical cancer vary according to age, reaching a peak in women aged around 40 years. The age distribution of cervical cancer is pyramidal with a higher percentage of younger women being diagnosed with pre-cancer symptoms and invasive disease.

Cancer is a generic term for a large group of diseases that can affect any part of the body. Other terms used are malignant tumours and neoplasm. One defining feature of cancer is the rapid creation of abnormal cells that grow beyond their usual boundaries, and which can then invade in to adjoining parts of the body and spread to other organs. Cancer of the cervix is also called cervical cancer, begins in the cells lining the cervix. The cervix is a part of a woman’s reproductive system connecting the uterus to the vagina. These cells do not suddenly change into cancer. Instead, the normal cells of the cervix first slowly change into pre-cancer cells that can turn into
cancer (five years to as long as 20 years). These changes may be called dysplasia. The change can take many years, but sometimes it happens faster and it can be found by the Pap test.

Cervical cancer can affect women of all socio-economic strata, both in rural and urban areas. All sexually active women are at risk of having cervical cancer. There are number of risk factors attributed to cervical cancer. These are early age at marriage or early onset of sexual activity, multiple pregnancies, pregnancies in quick succession, and more than one sexual partner, long-term use of oral contraceptives, malnutrition, unhygienic genital health, individual's immune status, and smoking or even genetic predisposition.

In early stages, it's often show no symptoms. That’s why it’s important to consult a doctor for regular screening with a pap test. (a procedure in which cells are scraped from the cervix and looked at under a microscope). When symptoms do occur, they may include Pain or bleeding during or after intercourse, unusual discharge from the vagina, Blood spots or light bleeding other than a normal period.

These symptoms can be caused by cervical cancer or by a number of serious conditions, and should be evaluated promptly by a medical professional. Cervical cancer can be prevented by regular screening and vaccination. A majority of cervical cancer cases can be detected by screening. Regular screening with pap smears/HPV DNA, etc. can help to detect it in the early stages. Vaccination is given for all girls and women aged 10 – 45 years in three doses over a period of six months. For the best form of protection, it is very important to get all the three doses of the vaccination as per schedule. Regular screening should be continued after vaccination to offer the best possible protection against cervical cancer IAP (Indian Academy of
Paediatrics) and FOGSI (Federation of Obstetrics and Gynaecology Society of India) recommends that regular screening and vaccination can help women fight this disease which is the biggest cause of cancer-related deaths amongst Indian women.

In India large number of female population is vulnerable to cervical cancer. The recognized risk factors for cancer cervix are, illiteracy, low socio-economic status, early marriage, multiparty, first child birth at early age, poor genital hygiene and genital infections and it is widely prevalent. However, the risk of development of cervical cancer is due to the life style of the individual, social customs and personnel hygiene. The present study tries to analyse the socio-economic and Health practices relating to knowledge on cancer cervix among married women. However, there were few studies which focussed on the preventive practices towards the cervical cancer among women. The present study focused on knowledge on cervical cancer, female reproductive system; symptoms and the barriers to access the health services, preventive health practices of women, through structured teaching programme.

In India Cervical cancer is a major health problem among women. One of the reasons may be lack of early detection as means that women often access the health services when disease is in advanced stage. There is a limited resource of the health care services and a stunted health care system which does not have the capacity to offer treatment for more advanced cases of cervical cancer such as radiation combined with chemotherapy. In addition to that, referral to higher recognized institutions for specialized care is difficult due to huge travel and treatment costs. Hence, knowing about the barriers to health services and interventions to improve the survival due to cervical cancer is needed.
There are certain studies relating to knowledge levels, barriers and preventive modes on cervical cancer in Indian context. However to fill the gap, this study tries to focus on effective structured teaching program on cervical cancer among women as many women were not aware of the severity of the disease. Hence knowledge on cervical cancer through structured teaching program can make them understand and improve their decision making in health checkups.

The health problems of women were varied and they are related to the customs and beliefs, which they follow according to norms of particular society. In order to reach the women on cervical cancer perspectives, there was a need to implement inclusive specialized policies and programs by the policy makers. An awareness programs on primary prevention can bring change in their life style, social customs and hygiene practices. So the studies, to promote preventive behavior and to prevent cancer cervix by detecting it at early stage through screening will be helpful in bringing the policies & programs on reproductive health and also to get the support of the family in screening.

As there is a dearth of literature on the cervical cancer especially in Indian context, it is significant that this study bridge the gap by providing effective teaching program on cervical cancer to increase the knowledge levels among women. It will in turn help to develop appropriate policies and new innovative approaches to address and prevent the cervical cancer among women.

There is a need to educate women on importance of cervical cancer screening and of responsibilities for their own reproductive health matters is a critical element in fighting against cervical cancer. So, community based studies focused on the
importance of educating the women especially in rural areas are significantly important.

Hence, an attempt has been made to study the effectiveness of structured teaching program on knowledge about cervical cancer among married women in rural areas.

7.2 Methodology

The major objective is to

- To assess the effectiveness of structured teaching programme on the knowledge of cervical cancer among married women.

And the specific objectives are

- To determine the women’s knowledge on preventive health practices of cervical cancer before and after teaching programme.
- To determine the women’s perceived severity of cervical cancer by collecting pre-test and post-test knowledge.
- To find association between socio demographic variables and knowledge on preventive practices of women through pre-test & post test.
- To describe the association between socio demographic variables & perceived susceptibility and severity of cervical cancer.
- To study socio demographic variables and perceived benefits from and barriers to seeking cervical cancer screening before & after the STP.
A quasi experimental research design has been selected for the study. The present research investigation is undertaken from YSR district in the state of Andhra Pradesh by using multistage random sampling. **In the first stage** of study from the YSR district four mandals are selected they are Oulavaripalli, Chitvel, Rly kodur and Pullam peta. **In the second stage**, from each mandal 5 villages were selected constituting 20 villages were randomly selected from all the four mandals the villages are selected Y.kota, Balireddypalli, C.H Podu, Mangampet and Kakarlavaripalli villages from Obulavaripalli mandal, Nagirapadu, Polo palli, Margo palli, Thimmayapalem and Pedduru villages from Chitvel mandal, Obunapalli, Raghavararaja puram, Setti guntta, Upparavaripalli and Madavaram from Railway kodur mandal and Reddipalli, Chinnam palli, Vathaluru, Apparajupet and Dondlopalli villages from Pullam peta mandal. **In the third stage** from each village, 25 married rural women were selected by simple random sampling technique to collect the data. Like that, from 20 villages 500 married women were selected. The information was collected from all the 500 women using the interview schedule without any STP. **For the structured teaching program**, 250 married rural women from above mandals and from same villages were selected. From each village, 10-13 were selected through the lottery method by preparing the slips with names of married rural women (who are the respondents of the pre-test study). The data has been collected during August 2011 to September 2012 by using interview schedule. Same schedule was used for pre-test and post test to collect data by the researcher.

The data collection comprised of three phases

**Pre-intervention phase** - involved the collection of cross sectional base line information using questionnaire consisting of multiple choice, open and closed ended questions. The study instrument was divided in to sections comprising of socio-
economic and demographic data, knowledge on cervical cancer, anatomy & physiology of female reproductive system, severity of cervical cancer, symptoms, diagnosis and treatment, benefits of cervical cancer screening, barriers, and preventive health practices.

The intervention phase - includes health education and communication through the audio visual aids like teaching aids and lecturer consists of various issues on cervical cancer, charts on female reproductive system and short-films on cervical cancer. Intervention phase also includes exhibiting the cards on risk factors, symptoms, importance of screening and preventive practices with regards to cervical cancer prepared in Telugu language. Each session took around two hours. The women were also informed that the post test will be conducted after two weeks.

Post-Intervention phase - was carried out with 250 members after two weeks of the intervention phase and researcher provide sufficient time for collecting the interventional effect information on cervical cancer by using the same instrument in both the preliminary survey and the post assessment.

7.3 Results and Discussion

7.3.1 Socio-demographic factors of the respondents

More than two fifth of the respondents were in the age group of 30-39 years followed by only a minor proportion in the age group of 40-49 years. More than two thirds of the respondent puberty age was in between 13-14 years followed by only a minor proportion of the respondents’ age at puberty in between 15-16 years. More than half of the respondents were married between 15-18 years by followed a very minor proportion were married between the age of 27-30 years, One third of the
respondents had two children followed by more than five children and only 6.6 percent of the respondents were not having children. One third respondents were having IIInd gravida and a minor proportion with more than 5th gravida. Two thirds of the respondents were in nuclear families as against a very minor proportion in extended families.

More than half of the respondents were illiterates as against only 11.0 percent of the respondents with secondary education. Nearly three fifths of the women (59.2 percent) were coolie / daily labourers as against only 10.2 percent of the respondents in petty trade like selling fruits, vegetables and milk. More than two third of the respondents monthly family income was in between is Rs.1000-5000 followed by a very minor proportion (2.80 percent) of the respondents monthly family income is in between Rs.16000-20000. Among those who had abortions less than two thirds of respondents had spontaneous abortions followed by only 10.6 percent of the respondents had induced abortions by doctor. Nearly two third of the respondents were Hindus followed by only 7.2 percent of Christians. Three fifths of the respondents were not having any habits as against the remaining two fifths were having habits like chewing betel leaves and tobacco.

7.3.2 Effectiveness of Structured Teaching Programme on knowledge of cervical cancer

Awareness of Cervical Cancer

In pre-test only one third of the respondents were aware of cervical cancer where as an overwhelming proportion were aware of cervical cancer after the structured teaching programme. Axillary Nurse midwife was the major source of
awareness in pre-test however in post test for more than two third of the respondents teaching module was the major source of awareness.

**Knowledge of Anatomy & Physiology**

In pre-test more than half of the respondents correctly stated uterus as an organ of female reproductive system. Where as in post test an overwhelming proportion of the respondents correctly stated uterus as an organ of female reproductive system. One fourth (24.4 per cent) of the respondents stated fundus, body and cervix were the parts of uterus in pre test where as in post test more than three fourths of the respondents correctly stated fundus, body and cervix were the parts of uterus. Only a minor proportion of the respondents correctly stated cervix was located between the uterus and vagina in pre test where as in post test a major proportion of the respondents correctly stated cervix was located between the uterus and vagina.

**Knowledge of Perceived Severity of Cervical Cancer**

In pre-test nearly two thirds do not know about the severity of cervical cancer whereas after the structure teaching programme three fourths of the respondents were aware of severity of cervical cancer.

**Knowledge of Causative Organism**

In pre-test only a minor proportion of the respondents had idea about the organism involved in the causation of cervical cancer where as in post test a major proportion of the respondents knew about the organism involved in the causation of cervical cancer. Only a minor proportion of the respondents know that the Human Papilloma Virus will spread through contacts in pre test on other hand in post test
majority of the respondents knew that Human Papilloma virus will spread through sexual contacts.

**Knowledge of Susceptibility to Cervical Cancer**

In pre-test more than one third of the respondents were aware about the susceptibility to cervical cancer Where as in post an test an over whelming proportion of the respondents were aware about susceptibility to cervical cancer.

**Knowledge of Symptoms of Cervical Cancer**

In pre-test on third of the respondents were aware of symptoms of cervical cancer where as in post test an over whelming proportion was aware about symptoms of cervical cancer.

**Knowledge of Screening, Diagnoses & Treatment**

In pre test only 0.4 percent of the respondents correctly stated pap smear was the screening test for cervical cancer. On the other hand in post test more than two thirds of the respondents correctly stated Pap smear was the screening test for cervical cancer. Only 0.4% of the respondents have undergone for cervical cancer screening by the motivation of Health worker/ ANM in pre test where as in post test more than one fourth of the respondents have under gone for screening after the structured teaching programme. In pre-test only more than a quarter of the respondents know about the benefits of cervical cancer screening. However after the STP in post test an over whelming proportion were aware about the benefits of cervical cancer screening. Only a minor proportion of the respondents stated that they had barriers for cervical cancer screening in pre test on the other hand in post test more than two thirds of the respondents had barriers for cervical cancer screening. In pre test one third (34.8
percent) of the respondents know about the treatments available, for cervical cancer. However after the STP an overwhelming proportion of the respondents had (89.2 percent) known about the availability of treatment for cervical cancer.

Knowledge of Preventive Practices

Only 0.4 percent of the respondents in pre test correctly stated Gardasil vaccine will prevent cervical cancer, whereas in post test two thirds of the respondents correctly stated Gardasil vaccine will prevent the cervical cancer. Only 4.0 percent of the respondents correctly stated that the ideal age to give vaccine for cervical cancer is between 9-26 years before the STP. Whereas in post test a major proportion of the respondents correctly stated the ideal age for the vaccination is between 9-26 years.

Menstrual & Sexual Hygiene

More than one third of the respondents have been using old cloth during menstruations in pre test, whereas in post test more than one fourth of the respondents were using old cloth to absorb menstrual blood. In pre test more than one third of the respondents had the habit of cleaning private parts before / after the changing pads / napkins on the other hand in post test more than two thirds of the respondents had the habit of cleaning private parts before / after the changing pads / napkin. Only a minor proportion of the respondents were cleaning private parts before sexual intercourse before the STP whereas after the STP less than half of the respondents were cleaning private parts before sexual intercourse.
7.3.4 Socio-demographic characteristics and knowledge of anatomy and physiology of female reproductive system

The knowledge of the respondents on Anatomy and Physiology of female reproductive system increased with all the variables after the STP. In all the ages the respondents’ knowledge has been increased to high. However higher knowledge has been observed among those in between 23-26 years with lesser proportion in 50-59 years of age, primary education, with three children, coolie/daily lab ours and with income levels between Rs 11000-15000. However, only education & occupation of the women has been observed to be statistically significant at 1% level and all the other variables were found to be statistically significant at 5% level.

7.3.5 Socio-demographic characteristics and knowledge of susceptibility to cervical cancer screening

The socio demographic variables were found to have an effect on the level of knowledge of susceptibility of cervical cancer screening. The knowledge of the respondents on the susceptibility of cervical cancer screening has been increased in the post test after the STP programme for all the variables. However age at marriage and number of children were found to be statistically significant at 1% level on the knowledge of the respondents on susceptibility of cervical cancer screening. Education, Occupation and income have been observed to be significant at 5% level.

7.3.5 Socio-demographic characteristics and knowledge of symptoms of cervical cancer

Effective structured teaching programme has been observed to have an impact on the knowledge of symptoms of cervical cancer. In all the age group in post test
knowledge of the respondents has increased to high from low levels in the pre test. Age & Occupation of the respondents has been statistically significant at 1% level with the knowledge on symptoms of cervical cancer. The increase in the knowledge levels can also be observed with the differences in age at marriage and education of the respondents. Ages at marriage, education, income and Number of Children of the respondents have been statistically significant at 5% level with the knowledge on symptoms of cervical cancer. Women with three & four children had high knowledge than the children with no children and single child. More number of respondents in petty business acquired high knowledge after the STP. Respondents of all income levels had high knowledge in post test.

7.3.6 Socio-demographic characteristics and knowledge of diagnosis and treatment

Knowledge of respondents on diagnosis and treatment of the respondents increased after the post test with the socio demographic variables. The respondents’ level of knowledge has showed an inverse relationship with Age, women in younger ages had higher level of knowledge on diagnosis and treatment after the STP. More number of illiterates with low level of knowledge had high knowledge on diagnosis and treatment after the STP. The same pattern can also be observed with number of children occupation, income of the respondents. However education and occupation were observed to be statistically significant at 1% level. Age, age at marriage, number of children and income were observed to be significant at 5% level with the knowledge on diagnosis & treatment of cervical cancer.
7.3.7 Socio-demographic characteristic and perceived benefits of cervical cancer screening

The respondents in all the age groups perceived high benefits of cervical cancer screening after STP. However women in younger age perceived moderate and high benefits than the other ages. Same pattern can be observed with age at marriage. Those married in younger ages perceived moderate and high benefits than those married at late ages. The age, age at marriage, numbers of children, occupation were found to have a statistical significance of 1% level with the perceived benefits of cervical cancer screening. However education & income have been observed to be a statistically significant at 5% level with the perceived benefits of cervical cancer screening.

7.3.8 Socio-demographic characteristics and perceived barriers of cervical cancer screening

With all the socio demographic variables the respondents perceived high barriers to cervical cancer screening after the post test. However women in younger ages, married between 27-30 years of age, perceived high barriers when compared with other groups. Age at marriage has been observed to statistically significant at 1% level with the perceived barriers of cervical cancer screening of the respondents. Ages, education, occupation, Income and Number of children have been observed to be significant at 5% level.

7.3.9 Socio-demographic characteristics and level of knowledge of preventive practices of cervical cancer

The knowledge of the respondents on preventive practices of cervical cancer increased with all the variables after the STP. In all the age groups the respondents’ knowledge increased in both moderate and high levels. However higher knowledge have been observed among the younger respondents, those with lesser age at
marriage, secondary education, with five and above number of children, house wives
and with income levels between Rs.6,000-10,000. Age at marriage and occupation
observed to be statistically significant at 1% level, whereas age, education, number of
children and income of the respondents were statistically significant at 5% level.

The overall knowledge on cervical cancer with ‘t’ value of 30.673 is found to
be highly significant (0.0001) with the STP programme. The mean score of the
respondents before the STP is 23.1000 which have been increased to 80.4520 after the
STP.

### 7.4 Logistic Regression Analysis

To analyse the knowledge of the respondents on cervical cancer, symptoms of
screening, logistic regression model has been used. The summary results, three sets
of odds ratio for the knowledge about cervical cancer, knowledge about symptoms of
cervical cancer and knowledge about screening of cervical cancer. The respondents
had substantial knowledge about cervical cancer. Number of background variables
influenced the knowledge levels of the respondents. Among the socio demographic &
economic variables, number of pregnancies emerged as strong and significant factor
which had an effect on the knowledge levels of the respondents. Women with more
pregnancies predicted it as a risk factor and they were more inclined to know about
the cervical cancer its symptoms & screening. Though the other variables like Age,
education & income have been found to be insignificant, they may emerge as
significant factors if they were grouped with other factors, or if the sample size was
more. An in depth analysis with a larger sample size may be helpful in knowing
about the effects of these background variables on the knowledge of the respondents.
The odds of knowledge about cervical cancer, symptoms & screening have been high
among the women with more number of pregnancies than women with less number of pregnancies. The differences were observed to be statistically significant.

7.5 Policy recommendations

Carcinoma of the cervix is the only human cancer that is almost entirely preventable. It is also 100 per cent curable if picked at very early stage. Treatment is cheap and simple in early stages requiring minimal manpower to achieve the high cure rate.

Cancer of the cervix has an established screening method that works. Today, vaccines are available for primary prevention of cervical cancer. The vaccine for cervical cancer should be part of the country’s immunization plan and like in other countries. Control of cervical cancer depends on increase in public awareness of the disease. Government should subsidize the treatment and incorporate screening programme into the primary health care as well as improve infrastructure and development of health facilities. To reduce the burden, there should be constant training and re-training of personnel.

As the present study shows the effectiveness of the STP, as a strategy to reduce the burden of disease in the community providing education on this particular issue should be considered.

In order to stimulate regular screening among women, there should be an aggressive health promotion intervention designed to increase knowledge levels and to correct impressions about cervical cancer in the community. Importantly, the outcome of such screening would guide management of conditions throughout life, including the decision-making process, in which the individual would be an important
part. The need of the hour is that we should begin to talk about cervical cancer especially in our rural communities so that the health of the women at the gross root level can be improved.

Women in rural areas rely mostly on health care professionals to educate and recommend health care practices that were beneficial in terms of health promotion. Lack of information was the main barrier. Information on pamphlets or posters should be user friendly i.e. translated to the local language and also distributed to the female population as widely as possible. The health managers should review packaging of information so as to simplify complex terminology when necessary to enhance understanding by all women. Hence cervical cancer and screening messages should form part of the basic health education package offered to all women, irrespective of their health status. Mini surveys should also be periodically conducted to elicit the level of understanding on cervical cancer and the importance of screening. Information obtained would then assist health professionals to further improve the screening services. This should be coupled with staff training and periodic in-service education, but also revision of basic health programs would also be necessary. Health educational initiatives should also target men since studies suggest that male partners could play a vital role in increasing the awareness of this service.

More emphasis on awareness on symptoms, screening and benefits can be given to the women with higher number of pregnancies can have positive effects on the knowledge levels of women on cervical cancer. Hence the programmes on cervical cancer should focus more on the women with more number of pregnancies. The findings of the present analysis may be useful in policy making on cancer awareness for all sections of women. It can be recommended that initiatives of national cancer programmes should focus on women with higher pregnancies, lesser
literacy and with higher age. Hence information, education & communication strategies focus on these women need to be strengthened. For these women provision of information regarding early detection of cancer symptoms, would reduce the burden of delayed care seeking & treatment and the concomitant increase in mortality & morbidity burden.

Comprehensive cervical cancer control encompasses prevention, early detection, diagnosis, cure and monitoring and requires collaboration among relevant programmes, departments and organizations. To this end, the following additional recommendations were made.

7.5.1. Strengthen action to consolidate cervical cancer control

The steps to be taken would vary from country to country depending on the control measures existing in the countries.

7.5.2. Appoint a leading body responsible for cervical cancer prevention

This body could be an institution or department responsible not only for preventive activities, such as screening, but also for health education, vaccination (if it is to take place), and the collection, monitoring and evaluation of data.

7.5.3. Ensure the availability and accessibility of treatment services before initiating a screening programme

The treatment of precancerous lesions should be administered on an outpatient basis whenever possible, using LEEP and/or cryotherapy. Centralization of the treatment of cancerous lesions and a referral system should be recommended. The needs of women with incurable disease should be addressed by palliative care services. Any cervical cancer programme needs to ensure that morphine is available.
7.5.4. Organize screening programmes

If an opportunistic screening programme were in place, concrete measures would be needed to organize it according to evidence-based guidance. Evidence is defined at international level but countries also need national data. In defining the screening methodology, the following WHO guidelines should be taken into account:

1. Cytology is recommended for large-scale cervical cancer screening programmes, if sufficient resources exist.
2. Visual screening methods are recommended for use in pilot projects or other closely monitored settings.
3. HPV tests can be used in conjunction with cytology or other screening tests, where sufficient resources exist.
4. Colposcopy is recommended only as a diagnostic tool (not as a screening tool) and should be performed only by trained and skilled providers.

The manpower required for the different tasks needs to be defined, taking into account the resources (human and financial) available and the international guidelines. Nurses and midwives have the competency to be involved in screening.

Capacity building should be organized according to needs. In defining the target population and screening interval, it is necessary to take into account that it is more important to achieve high coverage than to repeat tests on the same women. According to the WHO guidelines: (1) screening should not take place before the age of 25 and should not be done on an annual basis; (2) screening should start at age 25 and continue with three-year intervals until the age of 49; (3) from age 50 to age 64, screening should be with five-year intervals; and (4) screening should stop at age 65 if the last two smears were negative.
7.5.5 Improve screening implementation

Implementation is a continuous process and should be continuously monitored. The evaluation of existing infrastructures and gaps is part of this process. To achieve a high level of participation, the target population should be invited through call recall systems. Starting information and awareness-raising campaigns. Seeking the active collaboration of service providers and develop communication strategies. If cytology is used as a screening test, this should include quality control of the whole process of smear taking, fixation, transportation and reading.

7.5.6. Make use opportunities for primary prevention

Health education should be an integral part of comprehensive cervical cancer control. Health and sexual health education, including the promotion of condom use, are valuable strategies for the primary prevention of cervical cancer.

7.5.7. Assess the introduction of HPV vaccines

Preparing for evidence-based decision-making on the introduction of HPV vaccines as part of comprehensive cervical cancer prevention package by making use of WHO guidance and other relevant technical documentation and information.

7.6 Country wide activities for cervical cancer prevention

- Political will and commitment, including assured resources, are needed to start and sustain a cervical cancer prevention programme.
- Health authorities should be instructed to promote organized screening, discourage opportunistic (over-) screening and implement guidelines.
• Current screening practices have to be improved by optimizing participation and assuring quality. A high coverage rate can only be attained if general practitioners are involved and if the communities are better informed and educated. Training of health staff is an important element in quality assurance.

• A framework is required for evidence-based decision-making with regard to:

  (1) screening policy (start and stop ages, intervals, population groups); (2) screening method; (3) diagnostic, follow-up and treatment methods; (4) vaccination; and (5) delivery services.

• There is a need for comprehensive sexual education as well as information and education on the use of innovative methods, such as the ABC approach, HPV vaccination, screening, etc., in cancer prevention.

• A comprehensive information system, including registries of the target population, participation details, screen-test results, follow-up, links to the cancer registry and HPV surveillance systems, would allow monitoring of the quality of the screening and vaccination programmes and evaluation of the impact.

• In introducing the HPV vaccine, it is important to clarify how to avoid misperceptions and stigmatization in providing sensitive information and how to organize the registration and monitoring of data so that they can be linked with those of the screening registries.

• It is important to have an international assessment of the effectiveness of new technologies.
• Involving civil societies, such as anticancer leagues and NGOs, can be helpful in setting up cervical cancer programmes and keeping them high on the agenda.

7.7 Recommendations for Further Research

➢ A comparative research can be done on knowledge and compliance of the high risk women and their husbands in terms of their preventive practices and health seeking behaviour.

➢ Similar research can be undertaken with a true experimental design on women with more number of pregnancies.

➢ Similar studies with descriptive approach can be undertaken with large sample to generalize the findings.

➢ Similar research can be conducted among female health worker / ANMs who have more contact with the women and thus cervical cancer can be prevented by imparting knowledge to them at their door step.

➢ Large scale studies should conducted focusing on exploring health care resources that influence access across the district so as to better understand reasons for the low uptake of the screening service in this rural community.