

**EFFECTIVENESS OF STRUCTURED TEACHING PROGRAMME IN
TERMS OF KNOWLEDGE AND ATTITUDE REGARDING
CERVICAL CANCER AMONG ADULT FEMALES IN
NANCHIYAMPALAYAM AT DHARAPURAM,
TIRUPUR DIST.**

**A DISSERTATION SUBMITTED TO
THE TAMILNADU DR. MGR MEDICAL UNIVERSITY, CHENNAI
IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE
DEGREE OF MASTER OF SCIENCE IN NURSING**

2008 - 2010

**EFFECTIVENESS OF STRUCTURED TEACHING PROGRAMME IN
TERMS OF KNOWLEDGE AND ATTITUDE REGARDING
CERVICAL CANCER AMONG ADULT FEMALES IN
NANCHIYAMPALAYAM
AT DHARAPURAM, TIRUPUR DIST.**

2008 - 2010

Certified Bonafide Project Work

Done By

Mrs. MUTHUMARI.M

M.Sc., Nursing II Year
Bishop's College of Nursing,
Dharapuram

Internal Examiner

External Examiner

COLLEGE SEAL

**A DISSERTATION SUBMITTED TO
THE TAMILNADU DR. MGR MEDICAL UNIVERSITY, CHENNAI IN
PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE
DEGREE OF MASTER OF SCIENCE IN NURSING**

2008 - 2010.

CHAPTER – I

INTRODUCTION

**“While there are many diseases, there is, in a sense,
only one health”**

Park,K.,(2007)

BACKGROUND OF THE STUDY :-

Health For All by 2010 AD is the goal of WHO and the key to the attainment of this through primary health care, which gives importance to health care, by the people and for the people. The International Conference on primary health care (WHO 1978) report states, that individual and families need to accept greater responsibility for health to ensure the success of primary health care. It focuses on promotion of health, prevention of disease, early detection and prompt treatment.

WHO (1978)

The uterus, or womb, is a small, pear-shaped organ located in the pelvic, consisting of the cervix, or neck of the uterus, and the corpus or main body of the uterus. The uterus is the organ in which the fertilized egg attaches it self and develops during pregnancy.

Cancer of the female reproductive tract has a high incidence amongst Indian women. Human papilloma (Hpv) is the most prevalent risk factor for cervical cancer and has been associated with cancer of the ovaries and endometrium. Environmental and dietary risk factors for cervical, ovarian, and endometrial cancers have been investigated in case-control and cohort studies.

Narayan,K.,(2002)

The two common forms of uterine cancer are cervical (from the neck of the uterus) and endometrial (from the lining of the corpus or body of the uterus). The cells covering called dysplasia before becoming cancer. Similarly tissue lining the corpus goes through mild to severe changes called hyperplasia before becoming cancer.

The pre-cancerous conditions do not necessarily lead to cancer. It is important however, that any woman with such a condition be treated and then examined by a physician at regular intervals.

The earliest stage of uterine cancer is called carcinoma in situ (cancer confined to its original site). If not detected and treated properly, cancer cells penetrate into deeper layers of the uterus, then spread to

neighbouring organs such as the vagina, bladder or rectum and eventually metastasize to other parts of the body.

Schaefer,J.,(2002)

Cervical cancer is the most common cancer of the female genital tract in India, with approximately 1,00,000 new cases occurring each year. This accounts for almost 20% of all new cases diagnosed in the world annually. The incidence is higher in rural areas, where prevention and screening programs are not as easily available as in urban areas.

Data from six metropolitan and one rural cancer registry in India show that the five most common cancers in India, in women are cancer cervix (23.5%), breast (19.3%), ovary (5.5%), oesophagus (4.4%) and mouth (3.9%) are the five most common sites.

Gupta , M.C et.al.,(2005)

Cancer of the cervix is the second most common cancer among women world wide, with an estimated 524,000 new cases in 1995. Developing countries, where it is of ten most common cancer among women, account for 80% of cases. Wide variations in incidence and mortality from the disease exist between countries.

Park,K., (2007)

"Cervical cancer caused by HPV comprises over 34% of cancers among women in India, making it the most common. Of this, 70% of the cancers are said to be caused by two strains of the virus – HPV 16 and HPV 18 – against which a vaccine has been developed," explained Dr Neerja Bhatla, additional professor of the Department of Obstetrics and Gynecology at the AIIMS.

Neerja Bhatla.,(2003)

In most of the developing countries including India. Carcinoma of the cervix is the most common malignancy in female and a major public health problem. It ranks first, the second being breast carcinoma. The ratio between breast carcinoma and cervical carcinoma being 1:3

Dutta, D.C., (1994)

Cervical cancer is easily detected in the pre - invasive or cervical intraepithelial neoplasia (cin) phase by cervical cytology. Cervical cancer is thus perhaps the only cancer that is preventable, yet in many parts of the developing and underdeveloped world cervical cancer is diagnosed in a late stage and as a consequence results in a high mortality. About 50% of all women in the industrialized countries would have had at least one pap smear test during a 5 year period compared to only 5% in developing countries. In contrast cervical

cancer continues to be a leading cause of Mortality and morbidity in developing countries.

Arul kumaran ,et.al., (2005)

Cervical Cancer is the commonest malignancy in female in India. Tata memorial hospitals, Bombay shows incidence of cancer in female as cervical 39% ,corpus and ovarian 1%, each vulva and vagina 1% each and that of breast 18%.

Dawn ,C.S., (1997)

Women are the sustaining force of the Individual, Community and Nation. Women burdened with ill health will not be able to provide primary care to their children, parents and elderly, unless women are educated about their basic human right to health and development. The most frequent sites of cancer in women are the cancer of the uterine cervix, Breast and oral cancer, which are preventable by adopting to several healthy life styles, behavioral modifications which are essential in order to prevent the risk of developing cancer.

Prabhakar , A.K., et.al ., (2002)

NEED FOR THE STUDY :-

World health organization had estimated the world wide prevalence rate of cervical cancer to be 2, 274, 000 cases. The incidence rate is 510,000 new cases per year. Cervical cancer is the second leading cause for death, about 288,000 annually.

WHO (2003)

Cervical cancer has a major impact on women's lives, particularly in developing countries where it is the leading cause of cancer deaths among women. According to the latest global estimates 493.000 new cases of cervical cancer occur each year among women, and 274.000 women die of the disease annually. Four out of five new cases, and a similar proportion of deaths, occur in developing countries ,where screening programs are not well established or effective.

Shantha,V.,(2003)

There is wide range of geographical variation in the incidence of major genital malignancies. The reason is far from clear. In USA(1985) cancer of the ovary and uterus accounts for 51% of all cancers among females. These sites accounted for 28% of all deaths caused by cancer. In most of the developed countries, cancer of cervix tops the list in female malignancies. There is also not only wide variation in the incidence but

also in the distribution and life time risk of a major genital malignancies.

Dutta,D.C., (1994)

South Australia recorded a lower incidence of cervical cancer than comparison countries in 2002. The highest incidence was in Southern Africa, which was about six time the South Australian rate.

Globocan,(2002)

Cervical cancer is much more common in Asia than the quarter of a million new cases recorded each year, according to an expert, who says government should consider vaccinating all women because screenings are too costly. Asia recorded around half of the world's 500,000 new cases each year, but women in swathes of the continent lacked access to proper medical services.

Venugopal, T .C.,(2007)

According to official statistics over 1,00,0000 new cervical cases are recorded in china every year, a counting for one fifth of the world's total.

Lang Jinghe ,(2008)

To an estimated annual global incidence of 5,00,000 cervical cancers, India contributes 1,00,000 ie 1/5 of the world burden. The magnitude of the problem is thus more than evident. The world pattern of cervical cancer, together with the age adjusted rate and ranking clearly indicate that cervical cancer is predominating a problem of poorer socio-economic societies.

Globally, cervical cancer is increasing, IARC shows that 15 million cases in the year 2020. Cervical cancer is highly preventable and suitable for primary prevention. There are estimated 500, 000 cases of cervical cancer every year worldwide, of which 80 percent occur in developing countries. In India, 20-70 percent of female reproductive tract cancers are cervical cancers. There are approximately 130,000 new cases of cervical cancer in India.

Pal, S.K, et.al .,(2004)

Cervical cancer is the commonest cancer among middle aged women in India, says Dr. Ranajit senior gynecologist and menopausal consultant in the northwestern Indian city of Chandigarh that the incidence of this cancer begins to rise among Indian women in their early 30 and around 40 - 50.

Ranajit, (2004)

Cancer of the cervix is less common than it was once because of early detection by pap smear. Over the last 40 years, invasive cervical cancer has decreased from 45 cases per 100,000 women to 15 cases per 100,000 women. However, it is still the most common female reproductive cancer among Indian women. It occurs most commonly between the ages of 30 and 45, but it can occur as early as age of 18.

Nalini, S.J.,(2009)

A feasibility project was conducted in south Arcot also concluded that a rural cervical screening program was very worthwhile with a cervical cancer pick up rate of 115.92/1,00,000 women and that a cervical smear is desirable but not mandatory.

The data published in cancer Incidence in five continent for various Indian registries for different periods and publication by the Individual registry serviced as the source material. During the years 1990 - 1997, the age - adjusted incidence rates for cervical cancer varied from 10.9 - 65.4 amongst various registries. The highest incidence was noted is the Ambillikai registry. The age - specific incidence rates (ASIR) for cervical cancer revealed that the disease increases from 35 yrs and reaches a peak between the ages 55 - 64 years. In India, an organized mass screening programme with pap smear for early detection of

cervical cancer is not in practice.

Murthy, et.al.,(2005)

British Columbia screening campaign (2003) has estimated that 85% of the population now at risk are screened annually, with a sharp drop in the incidence of invasive cervical cancer by about 78% and a similar reduction in mortality. Organized screening programs in Nordic countries have demonstrated a 50% reduction in mortality in Iceland and Finland which have instituted nationwide screening. In Denmark, 40% coverage resulted in a 25% reduction in mortality, while in Norway, with only 5% coverage, the mortality fell by only 10%. In the Uk cervical cancer screening program, it is estimated that 800 lives are saved annually at a cost of 124 million /5 year.

Tricia, S. Tang et.al., (2008) had conducted a study on Beliefs and predictors of cervical cancer screening Among women attending a women's Health clinic in kolkata, India. II year Medical students recruited 299 women from a gynecology clinic in Kolkata, India who completed a questionnaire aggressing demographic information health care history, pap test utilization, and knowledge, beliefs and attitudes about cervical cancer and screening. It reveals that total of 10% had revived a pap test at least once.

Uterine cervical cancer is a favourable site for an effective control program. It is easily accessible and there is usually a long latent period of intraepithelial neoplasia which is easily recognizable by the Pap smear. Furthermore, treatment at this stage is very effective. The burden of cervical cancer in India, taken in the context of the additional problems of examination could detect 45% of early disease. It is realized that pre cancers were missed but the introduction of aided visual inspection may overcome this.

If an awareness is created among married women and motivate them to undergo screening, then they are in a better position to take care of their own health and reduce the incidence of cervical cancer and there by decrease the morbidity and mortality. The women are the suitable group to assess the knowledge, and attitude regarding prevention and early detection of cervical cancer.

The cervical cancer which is a preventable cancer, if the women are educated to undergo regular screening, to identify the early symptoms of cervical cancer, seek medical attention early and treated accordingly will reduce the incidence, decrease the morbidity and mortality. Since cervical cancer is more common in women and those who are sexually active, so it is a dire need to assess the knowledge,

and attitudes of women regarding cervical cancer which will contribute towards developing right awareness in women.

The investigator has observed that the adult females has less awareness about cervical cancer particularly in the community. so the researcher felt the need for educating the adult females regarding cervical cancer there by creating awareness which helps in prevention, identification and early treatment of cervical cancer.

STATEMENT OF THE PROBLEM :-

A study to evaluate the effectiveness of Structured teaching Programme in terms of knowledge and attitude regarding cervical cancer among the adult females in Nanchiyampalayam at Dharapuram.

OBJECTIVES :-

1. To assess the pretest knowledge and attitude scores regarding cervical cancer among the adult females.
2. To assess the post test knowledge and attitude scores regarding cervical cancer among the females.
3. To compare the pretest and post test knowledge and attitude scores regarding cervical cancer among the adult females.

4. To find out the association between the post test knowledge scores with their selected demographic variables.
5. To find out the association between the post test attitude scores with their selected demographic variables.

OPERATIONAL DEFINITIONS :-

Effectiveness :-

It means producing an intended result.

In this study it refers to determine the extent to which the teaching program has brought the result intended that is measured in terms of significant difference in pre and post test knowledge and attitude scores by using statistical measurement.

Structured teaching Programme :-

It is a planned, orderly framed content to educate an individual or group purposefully.

In this study it is a planned teaching activity for group of females regarding definition, causes, signs and symptoms, investigations, treatment and preventive measures of cervical cancer which will be done by using compact disc and laptop for 45 minutes.

Knowledge :-

It means information gained through education. In this study it refers to the verbal response regarding their level of understanding among adult females about cervical cancer which is measured by structured interview schedule and its scores.

Attitude :-

It is a way of thinking or feeling about someone or something. In this study it refers to the expressed feeling of respondents regarding cervical cancer which is measured by five point likert scale and its scores.

Cancer

Cancer is a collective term describing a large group of disease characterized by uncontrolled growth and spread of abnormal cells.

Cervical cancer :-

It refers to the malignant tumor and visible lesions in the cervix.

Adult females :-

Those who are in the age group of 18-60yrs (18-40 Early adult, 40-50 middle adult, 50-60yrs older adult.

In this study the adult females are females who are in the age group of 30-50 yrs, residing in Nanchiyampalayam.

HYPOTHESES :-

- H₁ - The mean post test knowledge scores is significantly higher than the mean pretest knowledge scores.
- H₂ - The mean post test attitude scores is significantly higher than the mean pre test attitude scores.
- H₃ - There will be significant correlation between post test knowledge scores and attitude scores.
- H₄ - There will be a significant association between the post test knowledge scores with their selected demographic variables.
- H₅ - There will be a significant association between the post test attitude scores with their selected demographic variables.

ASSUMPTION :-

- The adult females may have some knowledge regarding cervical cancer
- Knowledge influences attitude regarding cervical cancer among the adult females.
- Structured teaching programme enhances the adult females to improve their knowledge regarding cervical cancer.

- Nurses have an important role in educating the adult females regarding cervical cancer.

DELIMITATION :-

The study is delimited to

- 100 samples
- five weeks for data collection

PROJECTED OUTCOME :-

The adult females will gain adequate knowledge and develop favourable attitude regarding cervical cancer, through the structured teaching programme. This in turn will help the adult females to identify the cervical cancer at an early stage and this will improve the quality of life of the adult females.

CONCEPTUAL FRAMEWORK

HEALTH BELIEF MODEL

Roennstoch's(1974) and Becker and Maiman's (1975) – addresses the relationship between a person's beliefs and behaviors. It provides a way of understanding and predicting how clients will behave in relation to their health and how they will comply with health care therapies.

INDIVIDUAL PERCEPTIONS

PERCEIVED SUSCEPTIBILITY

According to theorist, perceived susceptibility to a disease is the belief that one either will or will not contract a disease. Perceived susceptibility ranges from being afraid of contracting a disease to completely denying that certain behaviors will result in illness.

In this study adult female's frequent sex ,multiple sexual partner, Marriages at an early age, Low socio-economic status, Illiteracy, Active or passive smoking, Low dietary intake of vitamin C, Long term use of oral contraceptive, Poor genital hygiene, Multiparity are perceived susceptibility to get cervical cancer.

PERCEIVED SERIOUSNESS

In this theory perceived seriousness of a disease concerns the perception of the seriousness of the disease and its effect on the person's life style. This component is related to how much the person knows about the disease and can result in a change in health behavior.

In this study the perceived seriousness refer to the adult females perception of the seriousness of cervical cancer and its effect on their health. This perception is influenced and modified by demographic and socio psychological variables, perceived threats of the illness and cues to action.

The adult females perception is influenced by the demographic and socio psychological variables like age, educational status, , type of family, marital status, number of children and source of health information, occupation, income, religion, structural variables, knowledge about cervical cancer prior contact with cervical cancer.

The perceived threat of illness refers to how for the adults females perceive the cervical cancer as serious which may affect the way she takes care of her self.

The cues to action which modifies and influences the adult females perception is the structured teaching programme regarding cervical cancer which explains the meaning, incidence, risk factors signs and symptoms, cervical screening, prevention and treatment.

LIKELIHOOD OF ACTION

The theory says, the third component is the likelihood of action that a person will take as preventive action – results from the person's perception of the benefits of and barriers to taking action.

Perceived benefits of action is concerned with how effective the individual believes preventive measures will be in preventing illness.

Preventive action may include life style changes increased adherence to medical therapies or a search for medical advice or treatment. This factor is influenced by the person's conviction that carrying out a recommended action will prevent or modify the disease and by the person's perception of the cost and effects of performing the health behavior

In this study perceived benefits of action is concerned with the adult females adequate knowledge and positive attitude regarding cervical cancer. Perceived barriers of adult females are poor knowledge,

negative attitude regarding cervical cancer, illiteracy, low socio-economic status ,lack of facilities.

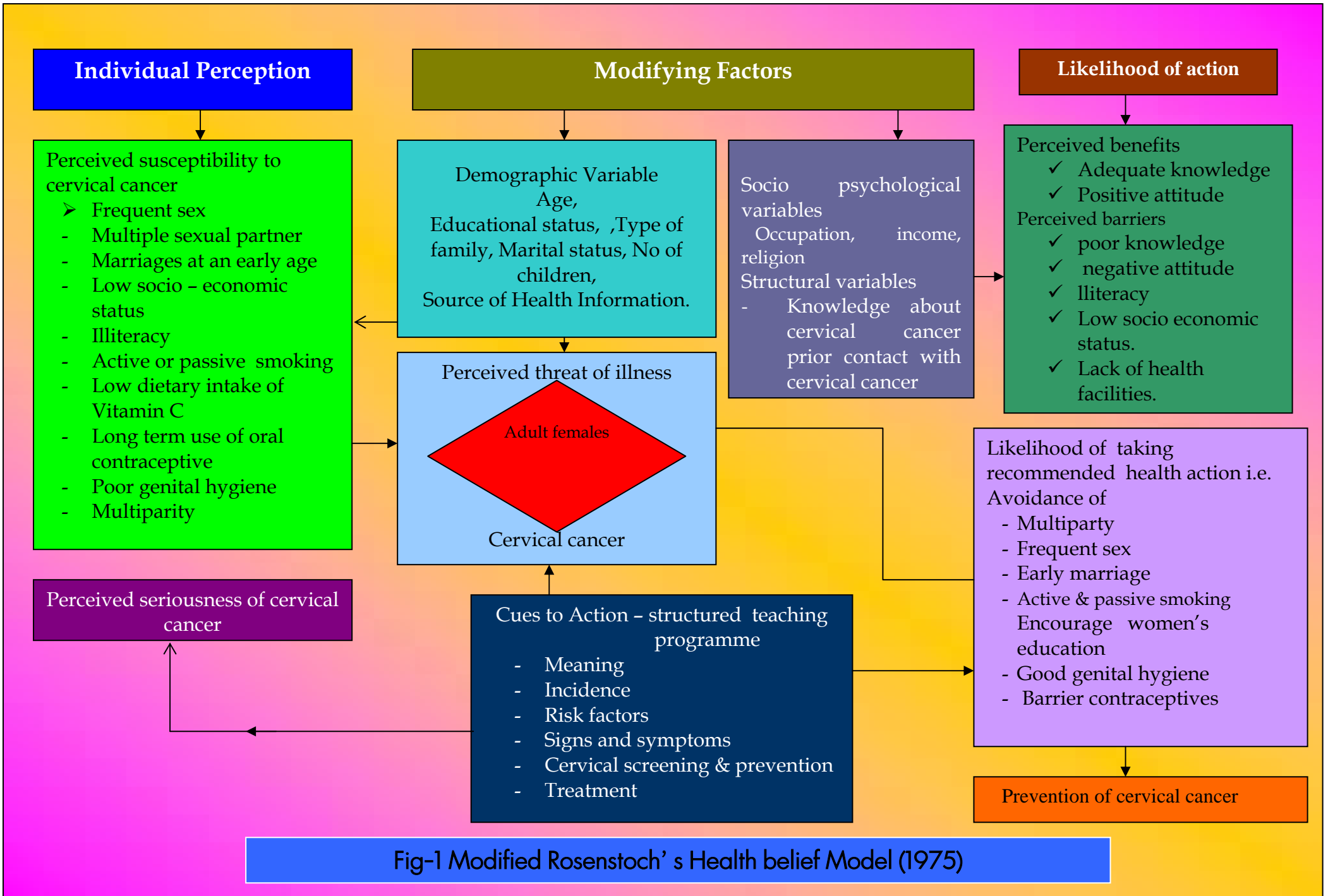
In this study preventive action may include doing a pap smear once in three years (increased adherence to medical therapies) or a search for medical advice or treatment

In this study likelihood of taking recommended health action of adult females are avoidance of multiple parity ,Frequent sex, Early marriage, active and passive smoking, women's education, Good genital hygiene, Barrier contraceptives will prevent the cervical cancer.

MODIFYING FACTORS

According to theorist these factors interact to influence the perceived benefits of preventive action minus the perceived barriers to preventive action.

In this study the factors interact to influence the perceived benefits of preventive action minus the perceived barriers to preventive action or the demographic variables like, age, educational status, occupation, income, religion, type of family, marital status, number of children and source of health information and socio psychological variables like, occupation, income, religion, structural variables knowledge about cervical cancer prior contact with cervical cancer.



CHAPTER – II

REVIEW OF LITERATURE

The review of literature is presented under the following headings.

- Part – I - Over view of cervical cancer
- Part – II -
 - a) Studies related to cervical Cancer.
 - b) Studies related to structured teaching program of cervical cancer
 - c) significance of media in educational programme.
 - d) Role of nurse in prevention of cervical cancer.

PART – I : OVER VIEW OF CERVICAL CANCER

NATURAL HISTORY :-

Cancer cervix seems to follow a progressive course from epithelial dysplasia to carcinoma in situ to invasive carcinoma. There is good evidence that carcinoma in situ persists for a long time, more than 8 years on an average. The proportion of cases progressing to invasive carcinoma from pre invasive stage is not known it may average 15 – 20 years or longer. The duration of the pre invasive stage is also not known.

Park,k.,(2007)

DEFINITION :-

If refers to the malignant tumor and visible lesions in the cervix.

Normal epithelium \longleftrightarrow dysplasia \longleftrightarrow cancer in situ \longrightarrow Invasive cancer.

CAUSATIVE AGENT :-

There is evidence pointing to human Papilloma virus. Sexually transmitted as the cause of cervical cancer. This virus was once supposed to produce only vegetate warts, but now acknowledged as responsible for a much wider clinical and sub clinical cessions. The virus is found innovate then 95% of the cancers. Current evidence suggests that the virus is a necessary but not sufficient cause of the disease and researchers are now trying to define other co factors.

RISK FACTORS :-

Age:-

Cancer cervix affects relatively young women with incidence increasing rapidly from the age of 25 - 45, then leveling off and finally falling again.

Genital warts :-

Past and for present occurrence of clinical genital warts has been found to be an important risk factor.

Marital status :-

Cases are less likely to be single more likely to be widowed, divorced or separated and having multiple sexual partners. The fact that cancer of the cervix is very common in prostitutes and practically unknown among virgins suggests that the disease could be linked with sexual intercourse.

Early Marriage :-

Early marriage, early coitus early child bearing and repeated child birth, have been associated with increasing risk.

Oral contraceptive pills :-

There is renewed cancer about the possible relationship between pill use and the development of invasive cervical cancer. A recent WHO study finds an increased risk with increased duration of pill use and with the use of oral contraceptives high in estrogen.

Socio Economic Class :-

Cancer cervix is more common in the lower socio economic groups reflecting probably poor genital hygiene.

Moorthy,et.al.,(2000)

Oqunbowale and Tosin et,al (2008) conducted a study to identify the risk factors for cervical cancer. This study identified predictors of cervical dysplasia and assessed the prevalence of risk factors for cervical cancer among women of different socioeconomic classes in Ogun State, Nigeria. In a two-phase study, self-reported information on cervical cancer awareness, risk factors and cervical cancer screening practices was obtained from 278 randomly selected working women. A random subset was screened for dysplasia using visual inspection with acetic acid (VIA). : Of the 278 women, 126 (45.3%) were semi-skilled while 152 (54.7%) were skilled and professional workers. Median age at first sexual intercourse was 19 years (range 13-29) and lower than the median age at first marriage (25 years). Gonorrhoea and genital warts were the commonest reported sexually transmitted infections. Only 12.2% of the women used male condoms as their primary method of birth control and 4.7% of the women had ever had a Papanicolaou smear, a practice that was significantly higher among the professional/skilled compared with semi-skilled workers ($P = 0.031$). Of

the 125 screened, 20 (16%) had positive VIA. Young age at first sex (≤ 17 years) (OR = 3.7 (95% CI, 1.07-12.8)) and early first marriage (< 25 years) (3.3 (1.00-10.9)) were associated with a positive VIA. Women with lower parity (0-3) had borderline significantly increased risk of having a positive VIA (3.1 (0.9-10.6)). Women currently over 34 years and those without a history of sexually transmitted infections had lower risk of positive VIA ($P > 0.05$)

Siriha, K. Anderson et.al., (2003) had conducted a study on cancer risk and diet in India which reported that change of diet is among the factors that may be responsible for the changing disease rates. Diet in India encompasses diversity unknown to most other countries with many dietary patterns emanating from cultural and religious teaching that have existed for thousands of year. Very little is known however, about the role of the Indian diet in causation of cancer, although more attention is being focussed on certain aspects of the Indian diet, such as vegetarianism, spices, and food additives, of particular interest of cancer prevention is the role of turmeric an ingredient in common Indian curry spice

Shanta, et.al., (2000) conducted a study in which the result revealed, that the estimated new cancer cervix cases per year in 500,000 of which 79% occur in the developing countries. Cancer cervix occupies either the top rank or cancer among cancer in women in the developing countries, where as in the affluent countries cancer cervix, does not even find a place in the top 5 leading cancer in women. The truncated rate (TR) in triage group 65 - 64 yrs in Chennai, India is even higher (99.1/1,00,000) 1982 - 95, than rate reported from cali, Colombia (77.4/1,00,000, 1987 - 91) The cervical cancer burden in India alone is estimated as 1,00,000 in 2001 AD.

SIGNS AND SYMPTOMS :-

Some of the symptoms are

- White discharge per vagina
- White discharge with blood stained
- Inter menstrual bleeding
- Post menopausal bleeding
- Bleeding after intercourse

Van Schalkwyk et.al., (2008) conducted a study in south Africa to identify the signs and symptoms of women seeking treatment for cervical cancer. In South Africa, in 2005-06, 100% of primary health care clinics in South Africa had health professionals trained to conduct Pap smears, yet the screening rate was only 1.3% and one in 26 women develop cervical cancer during their lifetime. Many women admitted to oncology wards are at such an advanced stage of disease that palliation is the only treatment option left. The purpose of this qualitative study in 2007, using semi-structured interviews with 15 women with advanced cervical cancer, was to understand the routes they followed from first signs and symptoms of disease to receive treatment. The willingness of the women to be diagnosed was a positive finding

PREVENTION AND CONTROL :-

Primary prevention :-

Until the causative factors are more clearly understood there is no prospect of primary prevention of the disease. It may be that with improved personal hygiene and birth control, cancer of the cervix will slow the same decline in developing countries as already experienced in most of Europe and North America.

Dutta,D.L.,(1994)

Secondary prevention :-

This rests on early detection of cases through screening and treatment of radial surgery and radio therapy. The 5 year survival rate is virtually 100% for carcinoma in situ, 79% for local invasive disease and 45% for regional invasive disease. Cancer cervix is difficult to cure once symptoms develop and is fatal if left untreated.

Kohli, M. et.al., (2006) conducted a study to predict the public health impact on cervical disease by introducing human papillomavirus (HPV) vaccination in the United Kingdom, they developed a mathematical model that can be used to reflect the impact of vaccination in different countries with existing screening programmes. Its use is discussed in the context of the United Kingdom. The model was calibrated with published data. The impact of vaccination on cervical cancer and deaths, precancerous lesions and screening outcomes were estimated for a vaccinated cohort of 12-year-old girls, among which it is estimated that there would be a reduction of 66% in the prevalence of high-grade precancerous lesions and a 76% reduction in cervical cancer deaths. Estimates for various other measures of the population effects of vaccination are also presented. they concluded that it is feasible to forecast the potential effects of HPV vaccination in the

context of an existing national screening programme. Results suggest a sizable reduction in the incidence of cervical cancer and related deaths.

D.Saranath et.al., (2003) conducted a study on district level cervical cancer, Early detection program in south arcot was initiated in 1992 and funded by the government of India. The objectives were to train all women doctors in the district and taluk hospitals and primary health centers in the early detection of cervical cancer, to train VHNs in visual inspection and digital examination for detection of an abnormal cervix and to take a pap smear. The project trained 258 doctors, 672 village health nurses and 30 block health educators. 59,314 women were screened 854 pap smears were done for those with an abnormal cervix, visual inspection and 20 pre-cancers were detected, with a pick-up rate of 230/1,00,000 screened. In addition 310 clinical cervical cancers were detected (12.3% early and 87.7% late disease)

COMPLICATION :-

It has been estimated that average span of life after development of symptoms for carcinoma cervix is about 18 months, if the patient is left untreated. The cause of death due to complications may be the following Renal failure, uraemia following urethric obstruction. This was an important cause of deaths for more than 50% cases

hydronephrosis & pyelonephritis are the preceding lesions for this complication. However currently on treatment this complication is getting less haemorrhages due to erosion of the pelvic vessels, Pain cachexia & exhaustion, Septic peritonitis and Visceral metastasis. other complications may vesicovaginal and rectovaginal fistulae pyometra pelvic inflammation severe anaemia and fever.

Arul Kumaran, et.al.,(2005)

PART - II

A.STUDIES RELATED TO CERVICAL CANCER.

Ashing Giwa T.K. et.al (2008) conducted a study on cervical cancer survivorship in a population based sample. The purpose of the study is to utilize a multidimensional framework to assess health related quality of life and its salient predictors among a population based sample of cervical cancer survivors. A cross sectional design was used with a population based sample ascertained from the California cancer surveillance program. The results reveals that participants were 560 cervical cancer survivors English speaking Latina (n=88), Spanish. Speaking Latina (n=199) and European (n=273) Americans. They concluded that these cervical cancer survivors reported poor to moderate with persistent psychosocial challenges.

Wright et.al., [2007] stated the American society for coloscopy and cervical pathology guidelines for the management of women with abnormal cervical cancer screening tests noted that HPV testing is incorporated into the management of their initial evaluation with colposcopy and endometrial sampling. It reveals that colposcopy is recommended for women who subsequently test positive for HPV DNA or who are found to have greater on their repeate cytologic tests both tests are negative, women can return to routine cytologic testing.

Nancy,J.Burke,et.al., [2006] states Cervical epithelium provides a protective to the virus to subvert the immune responses. The absence of an inflammatory milieu in the cervix makes the resident dendrite and langerhan cells tolerogenic to HPV antigens. CD4+ cells predominated in regressing cervical intraepithelial neoplasia lesions, whereas CD8+ cells were dominant in invasive carcinoma. A reduced expression of T cell signaling molecule T-cell receptor zeta chain was observed in CD8+ lymphocytes. Decreased numbers of NKG2D expressing natural killer and T cells were present in patients with cervical cancer and cervical intraepithelial neoplasia. Increased frequencies of CD4+ CD25+ FoxP3+ T regulatory cells were observed in patients with cervical cancer. The Nrp-1+Treg showed greater suppressive activity. A network of Trig and

indoleamine 2, 3-dioxygenase expressed in tumor cells facilitates immune escape of tumor cells.

Moreira, E.D, et.al., (2006) Conducted a study to assess the knowledge and attitude about human papilloma virus (HPV) cervical cancer, and papanicolaou (pap) smears among young women. A questionnaire was administered to 204 women aged 16 - 23 years, attending a public clinic. Data were gathered on socio demographic characteristics, knowledge, and attitudes related to HPV, overall, 92% of women reported current/previous sexual activity, 42% perceived themselves at high risk of acquiring a sexually transmitted disease, 67% did not know that HPV can cause cervical cancer (warts, and only 10% acknowledge that HPV might lead to cervical cancer. In general, women had a poor knowledge on HPV diagnosis / Treatment, condyloma signs, and pap smear test. The main reasons for not having a pap smear test done before were embarrassment (63%) and fear of pain (6%) knowledge of HPV infection and cervical cancer was low in this urban young population.

Nancy J. and Burke et.al (2004) conducted a study on Development of a cervical cancer control outreach program for Vietnamese immigrants. Cervical cancer incidence rates are higher among Vietnamese American women than among any other

race/ethnic group in the United States. High rates of cervical cancer are associated with low rates of Papanicolaou (Pap) testing adherence methods. Twenty five qualitative interviews and 5 focus groups were conducted with Vietnamese women. Interviews and focus groups revealed unanticipated information about socio cultural influences on women's beliefs about risk factors for cervical cancer. These data were utilized to develop culturally appropriate outreach materials.

Indian cancer registry (2002) A study undertaken by the Nargis dutt memorial cancer hospital at Barshi, demonstrated a significantly higher percentage of women with early stage cancers reporting for treatment in the intervention arm, 66% with stage I and II disease compared with 25% in the control arm. The intervention group was provided with an effective education and awareness program; no such programs existed in the control group. This highlights the vital role of education in any prevention program.

B. STUDIES RELATED TO TEACHING PROGRAM OF CERVICAL CANCER.

Navarro et.al., [2007]. conducted a study of breast and cervical cancer screening information through a community health advisor program targeting Latino women of low socioeconomic level and low level of acculturation in San Diego, California. Seventeen community

health advisors ("consejeras") were recruited and trained to conduct educational group sessions. Each consejera recruited peers from the community to participate in the 12 sequential weekly sessions (i.e., primary participants). In addition, each of the primary participants identified up to two friends and/or family members (i.e., "learning partners") with whom they intended to share the cancer education information received. Pretest and posttest telephone surveys were conducted between 1996 and 1997. A total of 311 primary participants completed the pretest and 285 the posttest. Among the learning partners, 269 completed the pretest and 222 the posttest. It reveals that knowledge about breast and cervical cancer and self-reported use of screening tests increased among primary participants and learning partners. However, the increase was not statistically significant in mammography screening among participants 40 years old or older. Overall, increases in knowledge were more pronounced among primary participants when compared to learning partners

Kulukulualani and Braun M., et.al., [2006] conducted a study to develop and test brochures. The Study followed a participatory four-step protocol, involving more than 200 health providers and clients, to develop and test culturally targeted brochures on skin, oral, cervical, prostate, and testicular cancers. The final products featured Hawaiian

faces, scenes, words, and activities. They proved more attractive than existing materials, in particular to younger Hawaiians, and posttests suggested good comprehension of intended messages.

Perkins, et.al., [2006] conducted a study to evaluate a community based education program. This study examined changes in knowledge and behavior after a community-based cervical cancer education program in Honduras. The program consisted of radio broadcasts targeting rural women and presentations to community nurses. The effectiveness of the radio broadcasts was assessed using a cross-sectional design (control groups n = 124, n = 243; intervention group n = 233). A pre-/post-test design was used to evaluate the nurses' training program (n = 32). A subset of nurses (n = 16) was retested two years later. Evaluation included t tests, chi-square and Fisher exact analyses. It reveals that the radio broadcast increased the proportion of women who were familiar with the term "cervical cancer," who could identify means of preventing cervical cancer, and who understood the purpose of the Pap smear. In addition, older and under-screened women were successfully recruited for screening via radio. The nurses' program improved understanding of the correct use of the Pap smear, the age-related risk of dysplasia, and the proper triage of abnormal results. The

nurses retained a significant amount of knowledge two years after this training.

Duggan P.M., et.al., [2006] conducted a comparative study to evaluate the EVS and Traditional teaching method regarding cervical cancer. Electronic Voting Systems have been used for education in a variety of disciplines. Outcomes from these studies have been mixed. Because results from these studies have been mixed, we examined whether an EVS system could enhance a lecture's effect on educational outcomes. A cohort of 127 Year 5 medical students at the University of Adelaide was stratified by gender, residency status and academic record then randomized into 2 groups of 64 and 63 students. Each group received consecutive 40-minute lectures on two clinical topics. One group received the EVS for both topics. The other group received traditional teaching only. Evaluation was undertaken with two, 15-question multiple-choice questionnaires (MCQ) assessing knowledge and problem solving and undertaken as a written paper immediately before and after the lectures and repeated online 8-12 weeks later. Standardized institutional student questionnaires were completed for each lecture and independent observers assessed student behavior during the lectures. Lecturer's opinions were assessed by a questionnaire developed for this study. It reveals that two-thirds of

students randomized to EVS and 59% of students randomized to traditional lectures attended. One-half of the students in the EVS group and 41% in the traditional group completed all questionnaires. There was no difference in MCQ scores between EVS and traditional lectures ($p = 0.785$). The cervical cancer lectures showed higher student ranking in favour of EVS in all parameters. The breast cancer lectures showed higher ranking in favour of traditional lectures in 5 of 7 parameters ($p < 0.001$). The observed higher-order lecturer-students interactions were increased in the EVS lecture for one lecturer and reduced for the other.

Jayanthi .V. (2008) conducted a study to assess the knowledge, attitude and practices of married women (18 - 45 years) in the prevention and early detection of cervical cancer in Begur village, of Bangalore. The total number of 100 sample was selected by Purposive sampling technique. The findings of the study revealed that overall mean knowledge of mother (48.4 percent) was found inadequate about the prevention and early detection of cervical cancer and overall attitude of women (74.8 percent) was found, (17 percent) were negative attitude about cervical cancer. Overall mean practices scores was (55.9 percent) showed that women had moderate practices and further the practice of respondents assured at 68.3 percent practices in relation to the prevention of cervical cancer.

C.SIGNIFICANCE OF MEDIA IN EDUCATIONAL PROGRAMME:

Medias are sensitive tools used in teaching and as avenues for learning. These are planned educational materials that appeal to the senses of the people and quickens learning, facilitates for clear understanding.

Neeraja, KP.,(2003)

Audio visual aids or devices or technological media or learning devices are added devices that help the teacher to clarify, establish, correlate and coordinate accurate concepts, interpretations and appreciations and enable him to make learning more effective, interesting, inspirational, meaningful and vivid. These are the stimuli for learning 'why', 'how', 'when' and 'where'.

Basavanthappa, B.T.,(2003)

Mass media are a "one-way" communication. They are useful in transmitting messages to people even in the remotest places. The number of people who are reached usually count in millions. Their effectiveness can give high returns for the time and money involved.

Park, K., (2007)

Dewey defines Media as a process of sharing experience till it becomes a common possession. It modifies the disposition of both the parties who partake it.

Stanford University states that media is concerned with all the ways in which information and ideas are exchanged and shared.

The media can be the spoken word, signal, gesture, picture, visual display, print, broadcast, film, all the signs and symbols by which human try to convey meaning and value to one another.

Wilber schramn, (2007)

The media is based on application of electromechanical equipments for instructional purposes. These includes computers, radio, motion pictures, over head projector, slides, tap recorder, television, compact disc and laptop.

Mock, J., et.al., [2007] conducted a study to promote cervical cancer screening among Vietnamese American women in Santa Clara County, Calif. In 2001-2004, they recruited and randomized 1005 Vietnamese American women into 2 groups: lay health worker outreach plus media-based education (combined intervention) or media-based education only. Lay health workers met with the combined intervention group twice over 3 to 4 months to promote Papanicolaou (Pap) testing.

they used questionnaires to measure changes in awareness, knowledge, and Pap testing .It reveals that testing increased among women in both the combined intervention (65.8% to 81.8%; $P<.001$) and media-only (70.1% to 75.5%; $P<.001$) groups, but significantly more in the combined intervention group ($P=.001$). Among women never previously screened, significantly more women in the combined intervention group (46.0%) than in the media-only group (27.1%) obtained tests ($P<.001$). Significantly more women in the combined intervention group obtained their first Pap test or obtained one after an interval of more than 1 year (became up-to-date; 45.7% to 67.3%, respectively; $P<.001$) than did those in the media-only group (50.9% to 55.7%, respectively; $P=.035$). Combined intervention motivated more Vietnamese American women to obtain their first Pap tests and to become up-to-date than did media education alone.

Perkins, et.al., [2006] conducted a study to evaluate a community based education program. This study examined changes in knowledge and behavior after a community-based cervical cancer education program in Honduras. The program consisted of radio broadcasts targeting rural women and presentations to community nurses. The effectiveness of the radio broadcasts was assessed using a cross-sectional design (control groups $n = 124$, $n = 243$; intervention

group n = 233). A pre-/post-test design was used to evaluate the nurses' training program (n = 32). A subset of nurses (n = 16) was retested two years later. Evaluation included t tests, chi-square and Fisher exact analyses. It reveals that the radio broadcast increased the proportion of women who were familiar with the term "cervical cancer," who could identify means of preventing cervical cancer, and who understood the purpose of the Pap smear. In addition, older and under-screened women were successfully recruited for screening via radio. The nurses' program improved understanding of the correct use of the Pap smear, the age-related risk of dysplasia, and the proper triage of abnormal results. The nurses retained a significant amount of knowledge two years after this training.

Media plays a vital role in educating the people in the community. Based on the literature and previous research studies, the investigator has selected the compact disc and laptop as Audio-Visual Aid in the present study.

D. ROLE OF NURSE IN PREVENTION OF CERVICAL CANCER

Community health nurse to observe, react and take action with respect to determinants of health of individual, family and community at large. Community health nurse has a better chance to make

observations of all these factors since she has more opportunities to contact people in their living places and clinic setting than any other member of the health team.

Teaching and training is the basic task of nursing. It is one of the important and key functions of community health nurses. They educate individuals, families and community not only when they are sick or have any health problem but also when they are well, but require help to promote health and prevent illness. The ultimate aim of community health nursing is to help to promote health knowledge, modify health attitude, health behavior and develop competence to become self dependant, self reliant in dealing their health matters etc. This is achieved through health education. So any intervention which is taken for individual, family and community is done by educating them. Education may be planned and structured.

A key aspect of nursing care includes education about reducing the risk factors for cervical cancer. Young women need to be informed that early sexual activity and multiple sexual partners place them at increased risk for cervical cancer. Avoiding sexually transmitted disease exposure can reduce risk. The importance of regular, frequent pap smears should be emphasized,

CHAPTER - III

METHODOLOGY

This chapter deals with methodology adopted for the study. It includes research approach, research design, population, criteria for sample selection, sample and sampling technique, instrument, collection and data analysis.

RESEARCH APPROACH :-

Evaluative research approach was used to conduct this study.

RESEARCH DESIGN :-

The design for this study was pre experimental design.(ie) one group pre test and post test design.

SCHEMATIC REPRESENTATION :-

Group	Pretest	Intervention	Post test
Group I	O ₁	X	O ₂

The symbols used are explained as :

O₁ - Collection of demographic data, assessment of the level of knowledge and attitude regarding cervical cancer before structured teaching programme.

- X - structured teaching programme was done in the form of health teaching to the adult females, using compact disc and laptop.
- O₂ - Post test to assess the level of knowledge and attitude regarding cervical cancer, after giving the structured teaching programme.

SETTING :-

The study was conducted in urban area in Nanchiyampalayam which comes under Dharapuram block. The total population is 6770. In this the adult females are 1200. The area consists of 7 streets. The main occupation of the people of Nanchiyampalayam is coolie.

POPULATION :-

Population of this study is adult females.

SAMPLE

Sample of this study are adult females who are residing in Nanchiyampalayam.

CRITERIA FOR SAMPLE SELECTION :-

Inclusion Criteria :-

- The adult females who are in the age group of 30-50 yrs.
- The adult females who are available at the time of data collection.

- The adult females who knows Tamil.

Exclusion Criteria :-

- The adult females who are blind and deaf.
- The adult females who are sick at the time of data collection.

SAMPLE SIZE ;-

The study consists of 100 adult females who are available during the data collection period and fulfills the inclusion criteria.

SAMPLING TECHNIQUE :-

Non-probability, purposive sampling technique was used to select the samples.

A) THE DISCRPTION OF THE TOOL

The instrument consists of 3 parts.

Part - I :-

It consists of demographic variables, viz age, education, occupation, income, religion, type of family, marital status, no of children, and source of health information.

Part - II :-

It consist of structured interview schedule to assess the knowledge regarding cervical cancer. It has 25 multiple choice

questions. Each questions has four options out of which one is correct answer.

Part-III

Consists of five point likert scale to assess the attitude regarding, cervical cancer among adults females. It has 10 items out of which 6 are positive statements and 4 are negative statements.

Scores were interpreted as follows :

Level of knowledge	Scores	Percentage
Adequate	17-25	67 - 100%
Moderately adequate	9-16	31 - 66%
Inadequate	0-8	<33%

PART - III

Five point likert scale consists of 10 statements to assess the attitude regarding cervical cancer among adult females.. Total score is 50.

For the positive attitude questions the score is measured as follows :

Strongly Agree	:	5
Agree	:	4
Uncertain	:	3
Disagree	:	2
Strongly disagree	:	1

For the negative attitude questions the score is measured as follows :

Strongly Disagree	:	5
Disagree	:	4
Uncertain	:	3
Agree	:	2
Strongly Agree	:	1

SCORES WERE INTERPRETED AS FOLLOWS :

Level of attitude	Scores	Percentage
Favourable	34 - 50	> 66%
Moderately Favourable	18 - 33	34 - 66%
Unfavourable	<17	< 33%

VALIDITY AND RELIABILITY OF THE TOOL :-

Validity :-

The validity of the tool was established in consultation with four nursing experts in the field of community health nursing and one community medicine. The tool was modified according to the suggestions and recommendations of the experts.

Reliability :-

The reliability of the structured interview schedule on knowledge questionnaire was assessed by testing the stability and internal consistency. Stability was assessed by test retest method using Karl Pearson Co-efficient formula. The value was found to be reliable ($r=0.89$). Internal consistency was assessed by using split half technique where Spearman's Brown prophecy was used. The value was found to be reliable ($R=0.88$). Hence the structured interview schedule was found to be reliable.

The reliability of the five point Likert scale was computed by test retest method. Karl Pearson's formula was used and the value was found to be reliable ($r=0.88$). The split half method, where the Spearman's prophecy formula was used to find out the internal consistency of the tool and found to be reliable ($R=0.88$).

Pilot Study :-

The Pilot study was conducted on 10 samples, for a period of one week in Kamarajapuram, At Dharapuram. Oral consent was obtained from the participant after explaining the purpose of the study. The Samples who met the inclusion criteria were selected by convenience sampling method and the study was conducted. On the first day demographic variables, knowledge and attitude regarding cervical cancer were assessed for 30-40 mts through a structured interview schedule and followed by that a structured teaching programme was given for 40-45 minutes, as group teaching for 5-6 adult females by using a compact disc and laptop. The effectiveness of the structured teaching was assessed through a post test on the seventh day with the same instrument. The data were analyzed and the findings showed that the mean post test knowledge score (20) was higher than the mean pretest knowledge score (9.5)and the mean post test attitude score (27) was higher than the mean pretest attitude scores (18.1) and found it was feasible and practicable to conduct the main study.

DATA COLLECTION PROCEDURE :

The study was conducted in Nanchiyampalayam, Dharapuram which is urban area. The written permission was obtained from the municipal health officer, Dharapuram. The data was collected in the

month of August, for the period of five weeks. Oral consent was obtained from the participant. Per day 5-6 adult females were interviewed by the investigator. The investigator maintained good rapport, collected demographic data and conducted pre test by using structured interview schedule for 45 minutes to assess the knowledge of the adult females regarding cervical cancer and five point Likert scale used to assess the attitude of the adult females. On the same day structured teaching was given to 5-6 adult females for 45 minutes regarding cervical cancer by using compact disc and laptop. On the seventh day post test was done using the same structured interview schedule and likert scale to assess the knowledge and attitude of adult females after structured teaching programme.

Data analysis :-

The data related to assessment of knowledge and attitude regarding cervical cancer of adult females was analyzed in terms of descriptive statistics and inferential statistics.

Statistical methods :

The statistical methods used for analysis are both descriptive and inferential statistics analysis methods.

Sl. No	Data analysis	Methods	Remarks
1.	Descriptive statistics	Frequency percentage	To assess the demographic variables of adult females.
		Mean, Standard deviation	To assess the pre and post test knowledge and attitude regarding cervical cancer.
2.	Inferential statistics	'z' test	To evaluate the effectiveness of structured teaching programme regarding cervical cancer among adult females.
		Karl pearson coefficient formula	To determine relationship between knowledge and attitude regarding cervical cancer
		Chi-square test	To find out association between adult females knowledge scores regarding cervical cancer with their demographic variables. To find out association between adult females attitude scores regarding cervical cancer with their demographic variables.

Protecting human subjects :-

The proposed study was conducted after the approval of dissertation committee of the college. The written permission was obtained from municipal health officer, Dharapuram. Oral consent of each subject was obtained before starting the data collection. Confidentiality was maintained throughout the study.

CHAPTER – IV

DATA ANALYSIS AND INTERPRETATION

This chapter deals with the analysis and interpretation of the data collected to assess the effectiveness of the structured teaching Programme on knowledge and attitude of adult females regarding cervical cancer.

Data were collected from 100 adult females in Nanchiyampalayam using structured interview schedule and attitude five point likert scale. The data were obtained, analyzed and presented under the following headings.

The data has been tabulated and organized as follows.

Section A: Distribution of demographic variables.

Section B: Comparison between pre and post test knowledge and attitude scores regarding cervical cancer among adult females.

Section C: Correlation between post test knowledge scores with attitude scores regarding cervical cancer among adult females.

Section D: Association between post test knowledge scores with the selected demographic variables of adult females.

Section E: Association between post test Attitude scores with the selected demographic variables of adult female.

Section - A: DISTRIBUTION OF DEMOGRAPHIC VARIABLES.

Table: 1 Frequency and percentage distribution of demographic variables of adult females.

N= 100

SL No	Demographic variables	Frequency	%
1	AGE		
1.1	30- 35 years	36	36
1.2	36 -40 years	35	35
1.3	41 - 45 years	17	17
1.4	46 -50 years	12	12
2	Education		
2.1	No formal education	29	29
2.2	Primary education	35	35
2.3	Secondary education	20	20
2.4	Higher Secondary education	8	8
2.5	Graduates	8	8
3	Occupation		
3.1	Coolie	31	31
3.2	House wife	39	39
3.3	Farmer	18	18
3.4	Others	12	12
4	Income		
4.1	Rs. 1000 - 1500/-	35	35
4.2	Rs. 1501 - 2000/-	29	29
4.3	Rs. 2001 -2500/-	22	22
4.4	Rs. 2500 above	14	14

SL No	Demographic variables	Frequency	%
5	Religion		
5.1	Hindu	48	48
5.2	Christian	30	30
5.3	Muslim	22	22
6	Type of family		
6.1	Joint family	43	43
6.2	Nuclear family	57	57
7	Marital status		
7.1	Married	82	82
7.2	Unmarried	6	6
7.3	Widow	8	8
7.4	Divorce	4	4
8	Number of children		
8.1	No child	7	7
8.2	One	35	35
8.3	Two	45	45
8.4	3 above	13	13
9	Source of information		
9.1	Radio programme	17	17
9.2	Television programme	21	21
9.3	Relatives, friends,	33	33
9.4	family members	17	17
9.5	Health Personnel	12	12

The table 1 showed that distribution of adult females by demographic variables.

The majority the adult females 36(36%) were belonged group of below 30 - 35 years, 36 -40 years females were 35 (35%), 41 -45years adult females were few 17 (17%) ,46 -50years adult females were very few 12 (12%).

There were 29(29%) adult females who had no formal education, 35(35%) of the adult females studied primary education, 20 (20%) of the adults studied secondary education 8(8%) of the adult females studied higher education ,very few 8(8%) adult females were graduates.

The data showed that the most 31(31%) of the adult females were coolie, Majority 39(38%) of the adult females were house wives 18 (18%) of the adult females were farmer, very few 12(12%) of the adult females were self employees.

The data showed that the majority 35 (35%) of the adult females had income between Rs. 1000 - 1500/-, 29(29%) of the adult females had income between Rs. 1501-2000/-,22(22%)-of the adult females income between Rs.2000 - 2500/-, very few 14(14%) of the adult females had income of above 2500Rs.

The highest number 48(48%) of the adult females were Hindus, Few 30(30%) of the adult females were Christian very few 22 (22%) of the adult females were Muslims.

Majority of the adult females 57 (57%) belonged to nuclear family. Most number 43 (43%) of the adult females belonged to Joint family.

The Majority 82(82%) of the adult females were married, very few 6(6%) of the adult females were unmarried, 8(8%) of the adult females were widow, 4(4%) of adult females were Divorced.

The data showed that the majority 7(7%) of the adult females had no child, 35(35%) of the adult females had one child 45(45%) of the adult females had 2 children and very few 13(13%) of the adult females had above 3 children.

The majority of the adult females 17(17%) had health information from Radio programs 21(21%) of the adult females had health information from television programs 33(33%) of the adult females had health information from newspaper and magazines. 17(17%) of the adult females had health information from family members relatives and friends very few 12(12%) of adult females had health sources information from health care Personal.

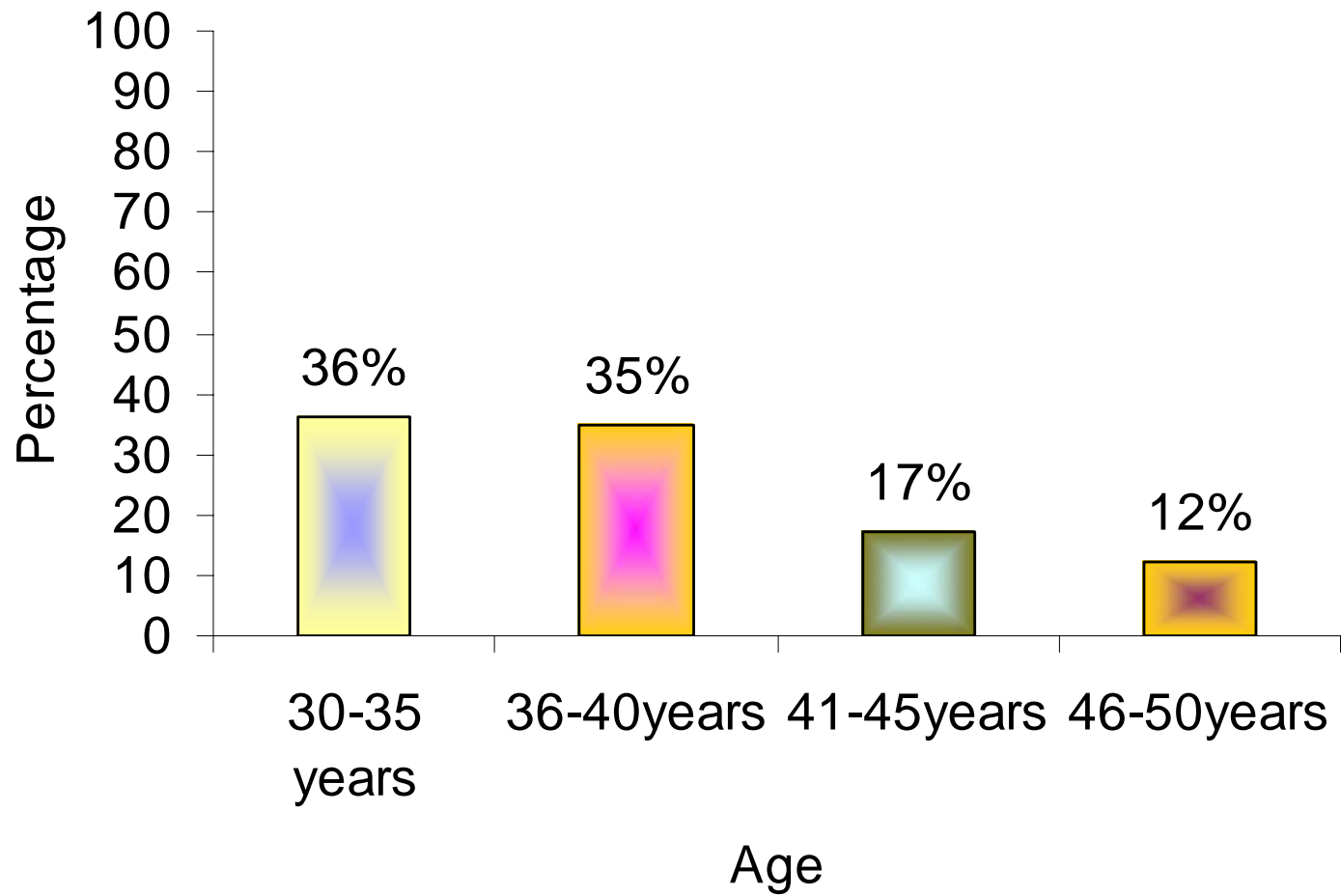


Fig: 2 Percentage distribution of adult females according to their age.

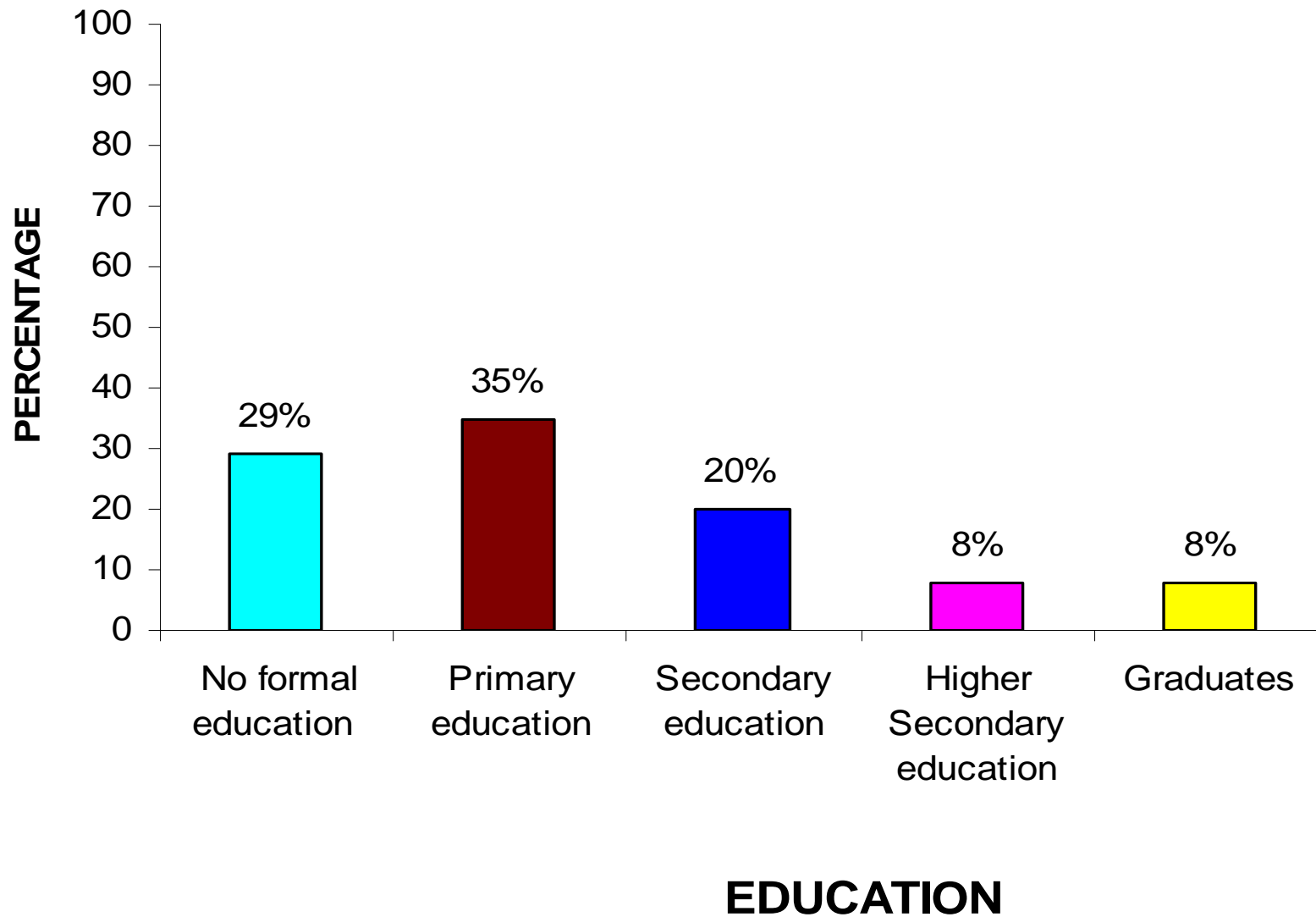


Fig : 3 Percentage distribution of adult females according to their education

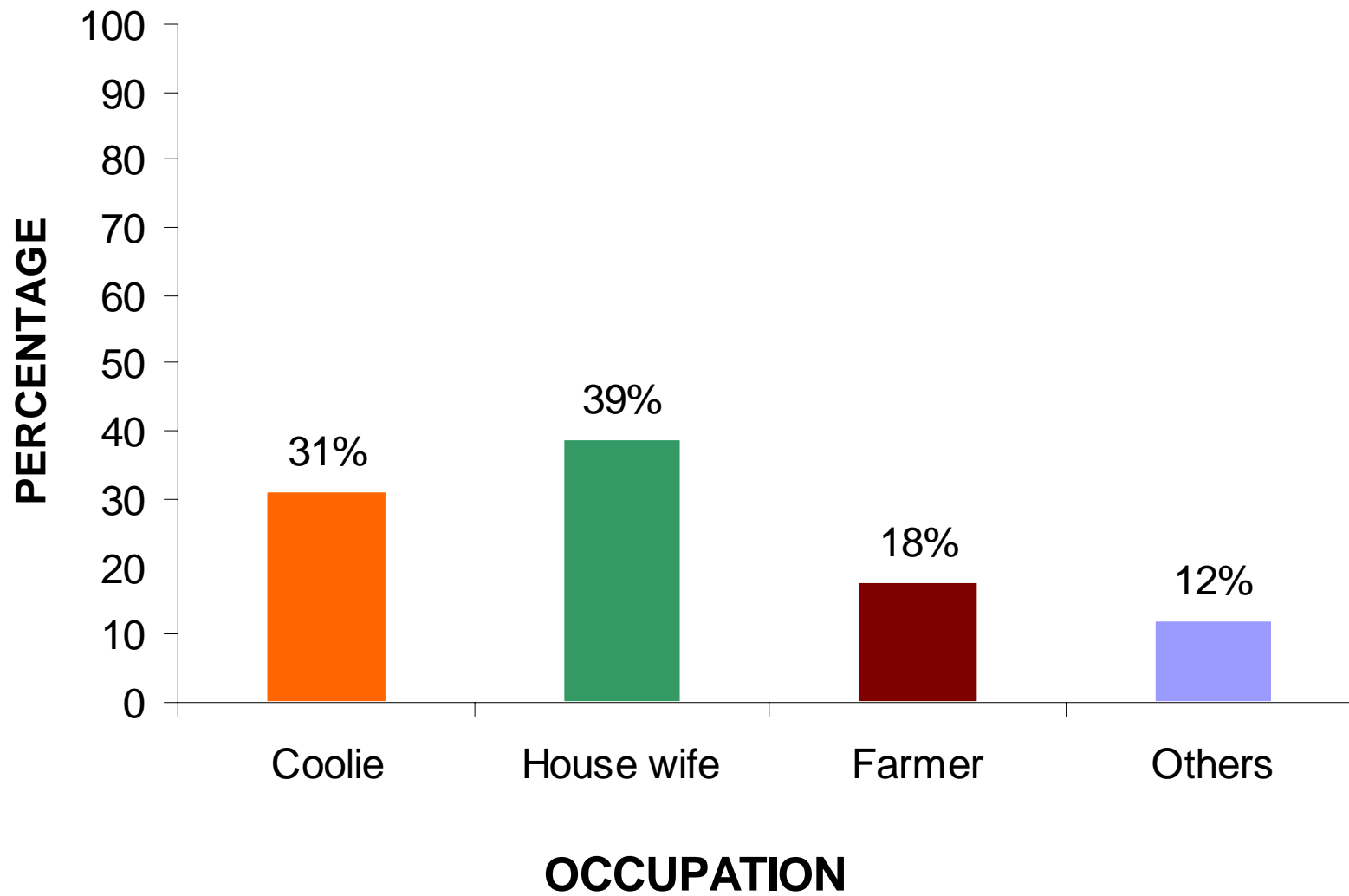


Fig: 4 Percentage distribution of adult females according to their occupation.

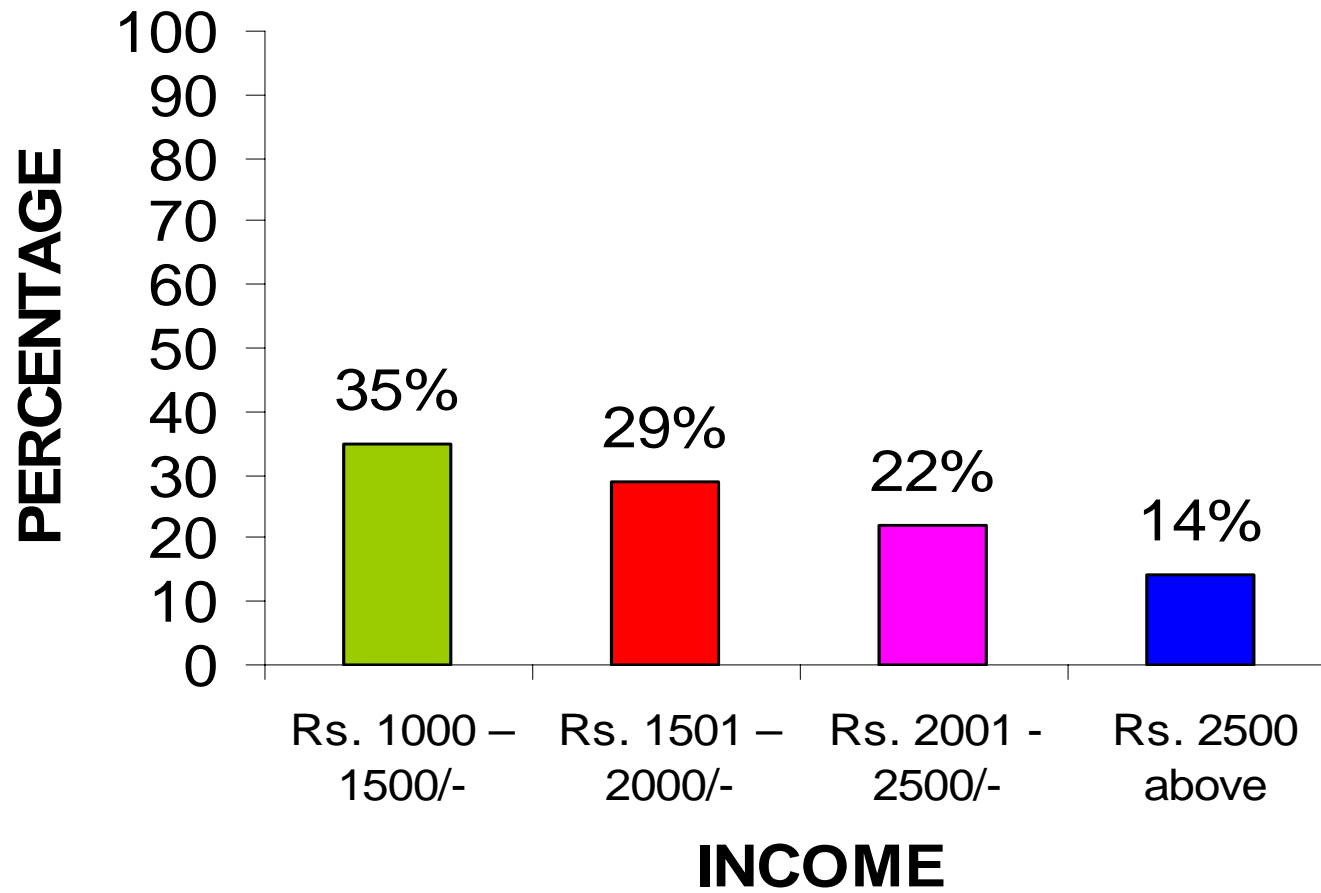


Fig:5 Percentage distribution of adult females according to their income.

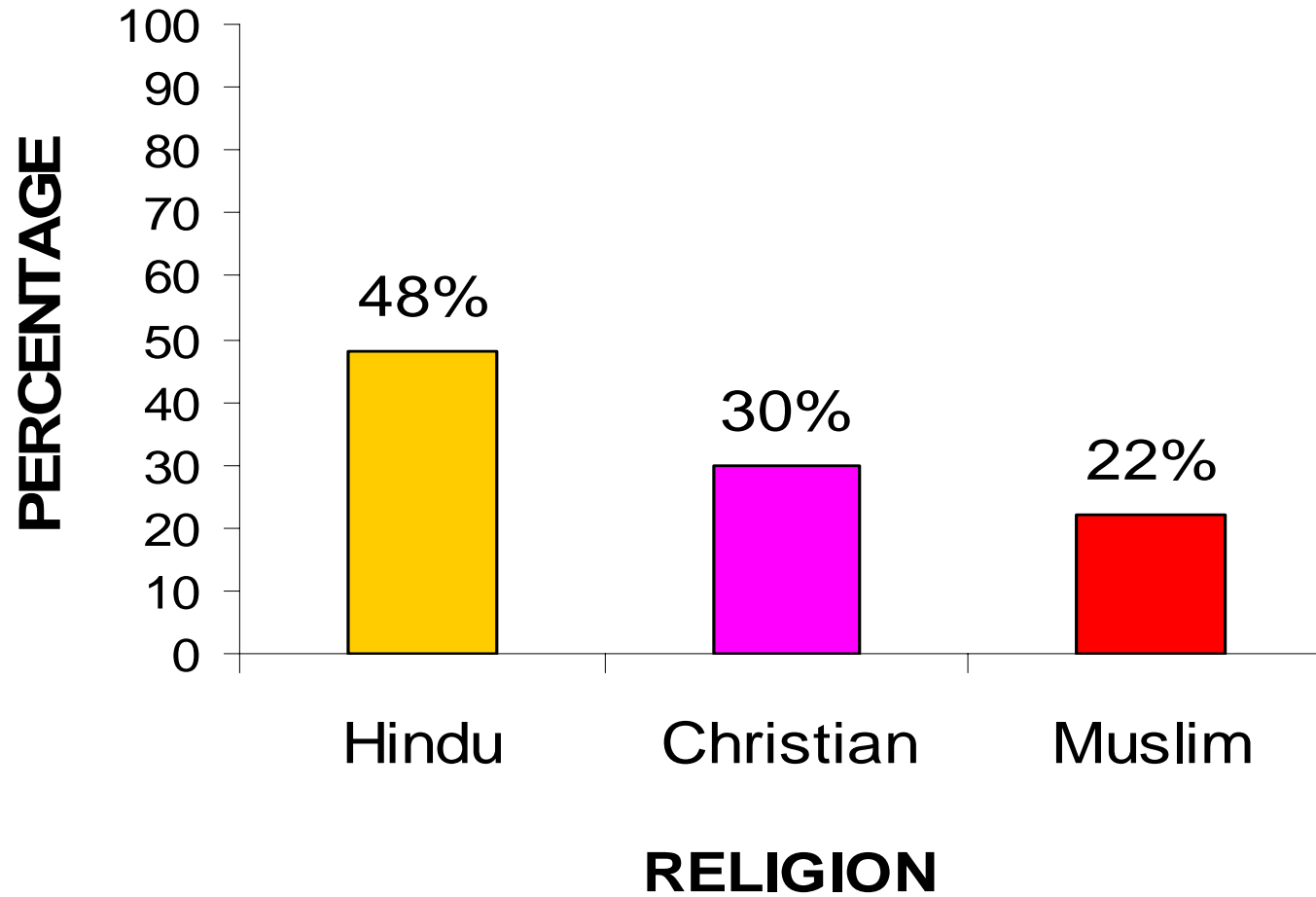
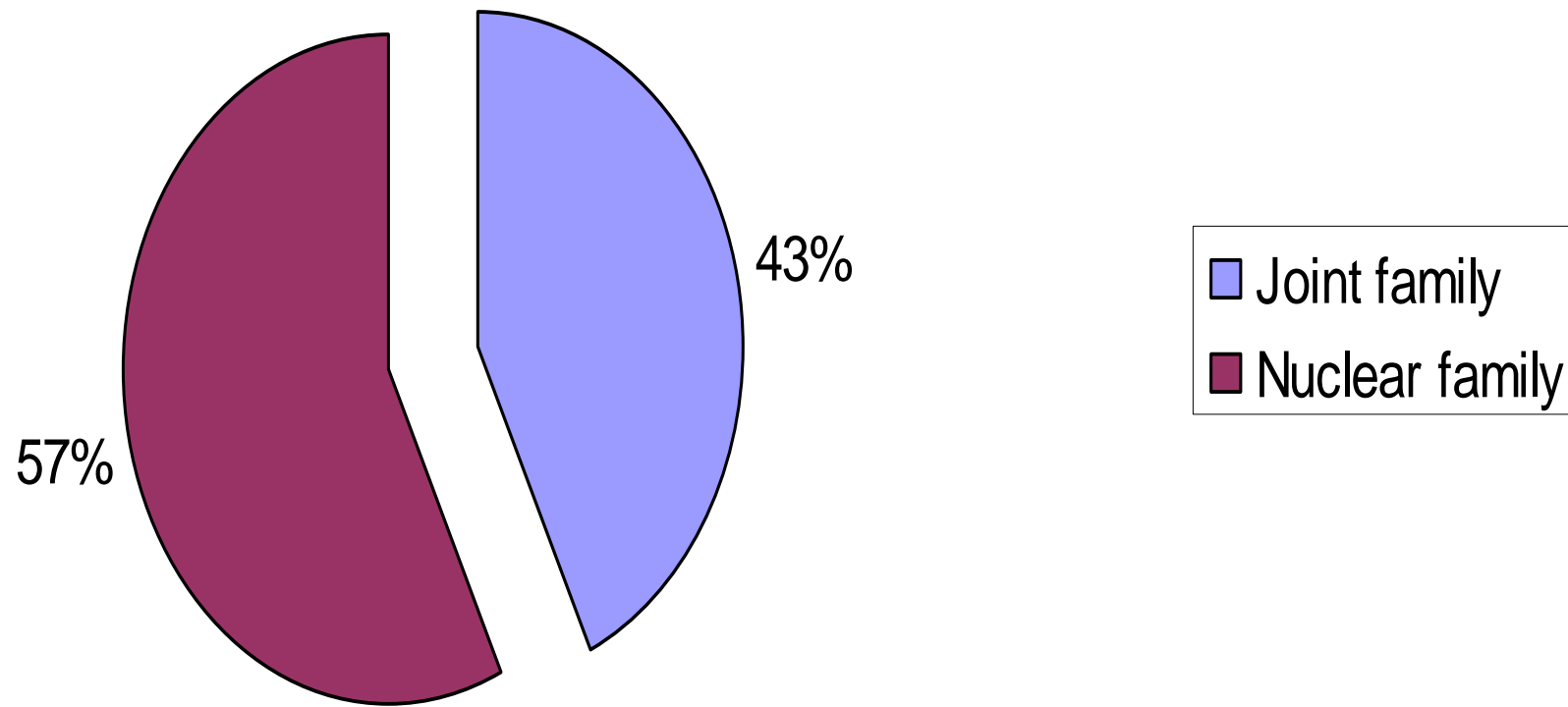


Fig:6 Percentage distribution of adult females according to their religion



TYPE OF FAMILY

Fig:7 Percentage distribution of adult females according to their type of family

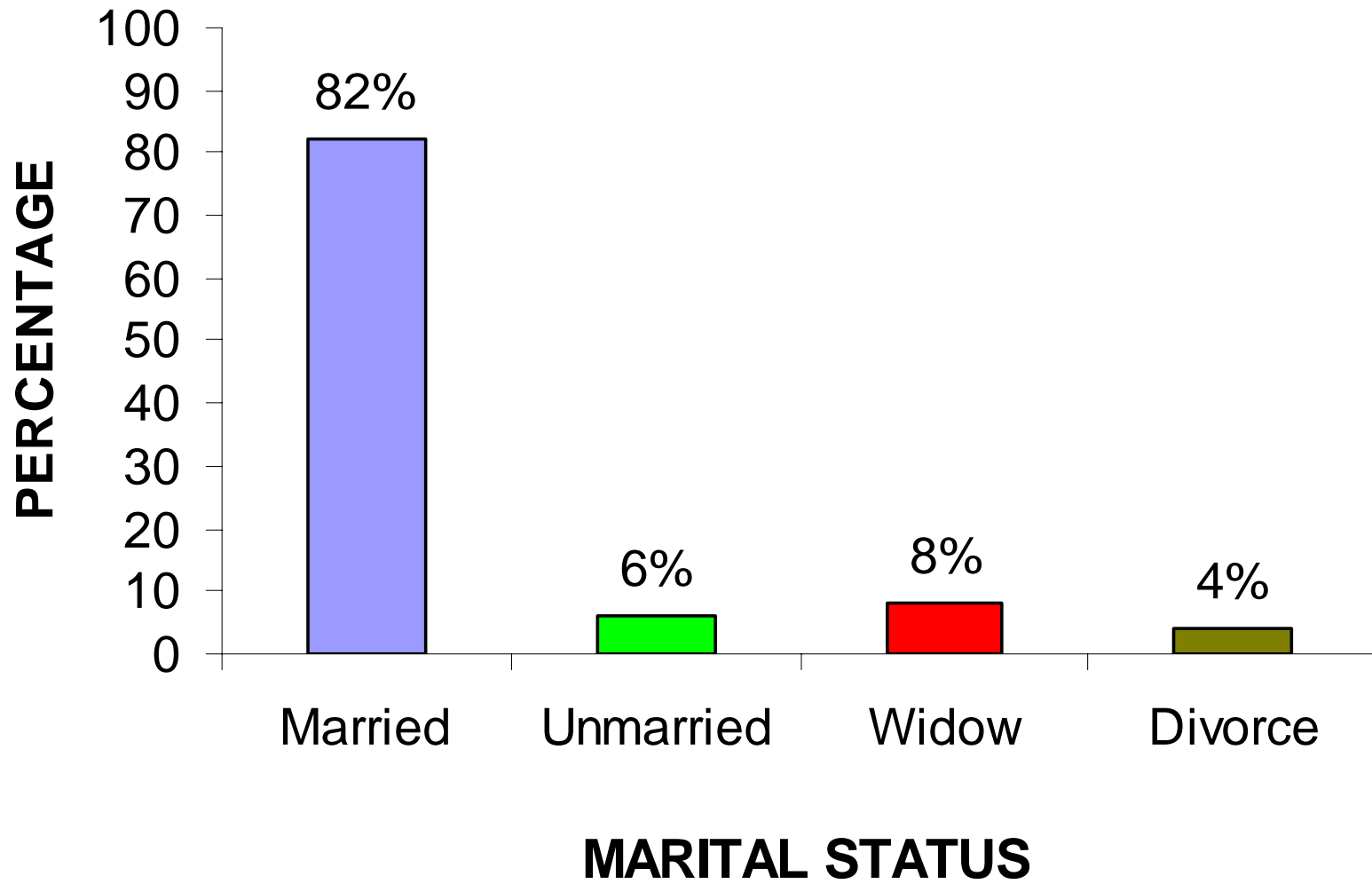


Fig:8 Percentage distribution of adult females according to their marital status

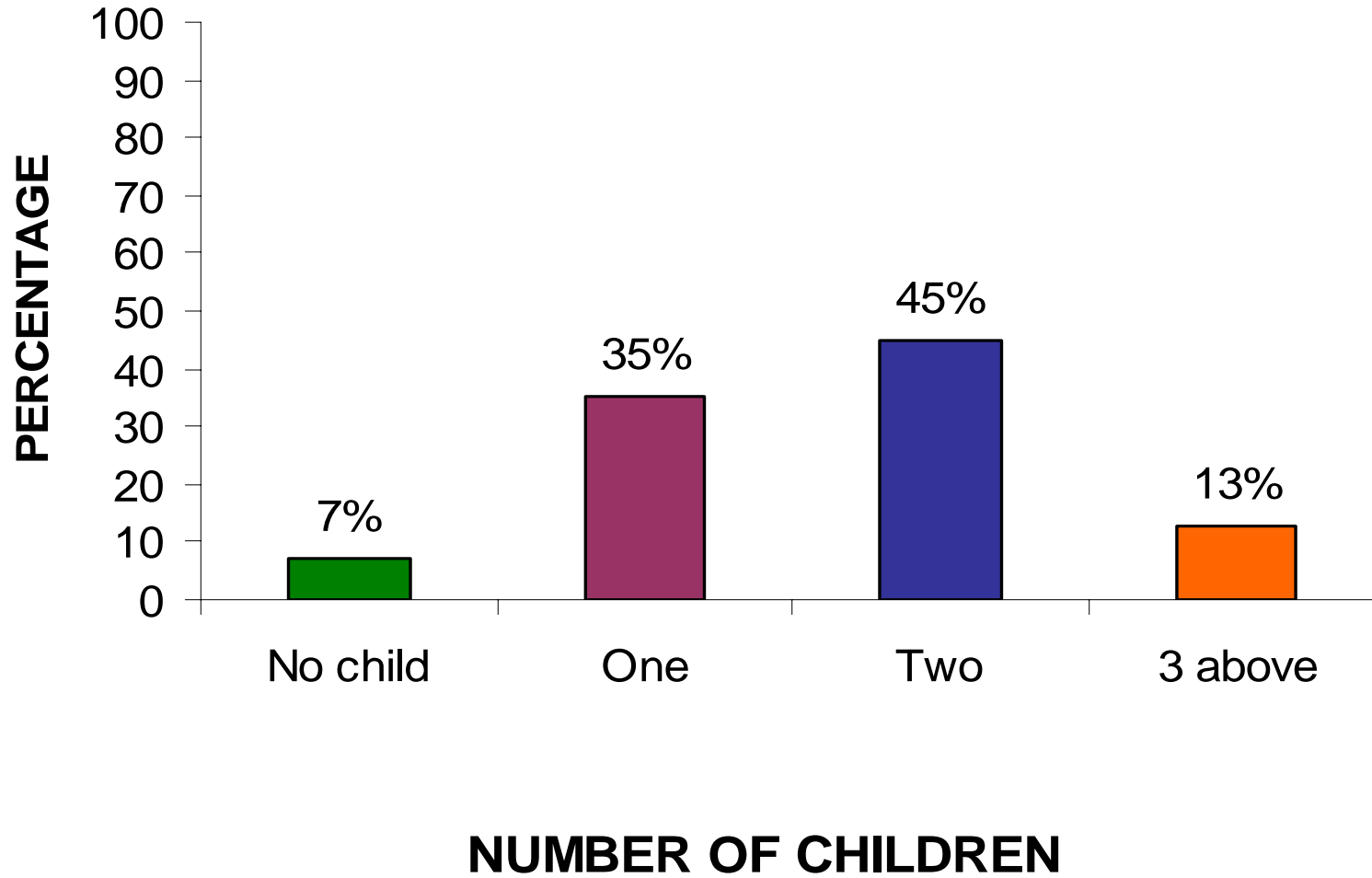


Fig: 9 Percentage distribution of adult females according to their number of children

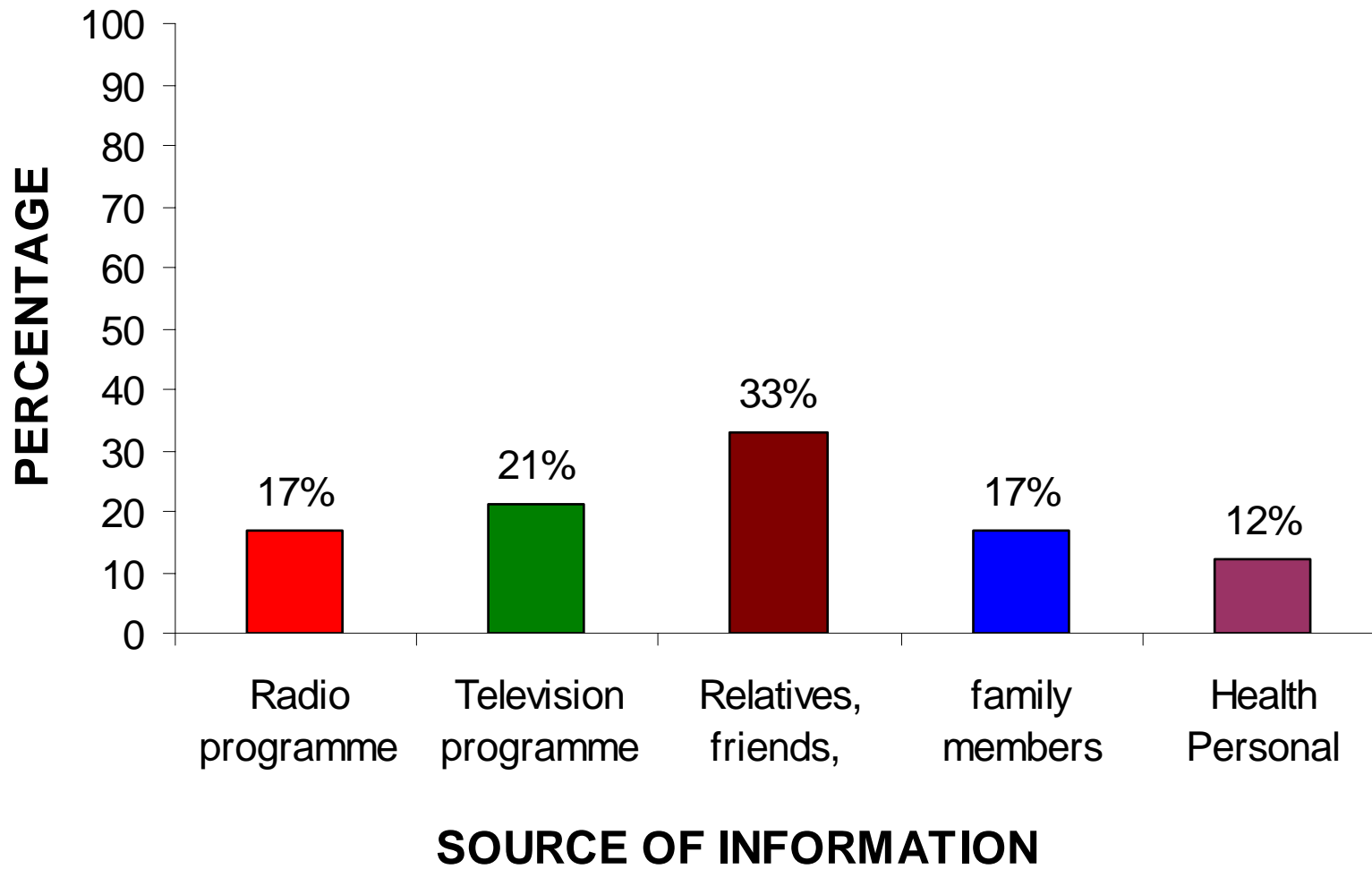


Fig:10 Percentage distribution of adult females according to their source of information.

SECTION B: COMPARISON BETWEEN PRE AND POST TEST KNOWLEDGE SCORES REGARDING CERVICAL CANCER AMONG ADULT FEMALES.

Table 2:

Compare the pretest and post test knowledge scores regarding cervical cancer among adult females.

Level of knowledge	Pretest		Posttest	
	f	%	f	%
Adequate knowledge	4	4	55	55
Moderately Adequate knowledge	26	26	36	36
Inadequate knowledge	70	70	9	9
Total	100	100	100	100

Table 2 showed that, in pretest 70 (70%) had Inadequate knowledge, 26 (26%) had moderately adequate knowledge and 4 (4%) of the adult females had adequate knowledge regarding cervical cancer.

In posttest 55(55%) had adequate knowledge, 36(36%) had moderately adequate knowledge and 9(9%) had inadequate knowledge regarding cervical cancer.

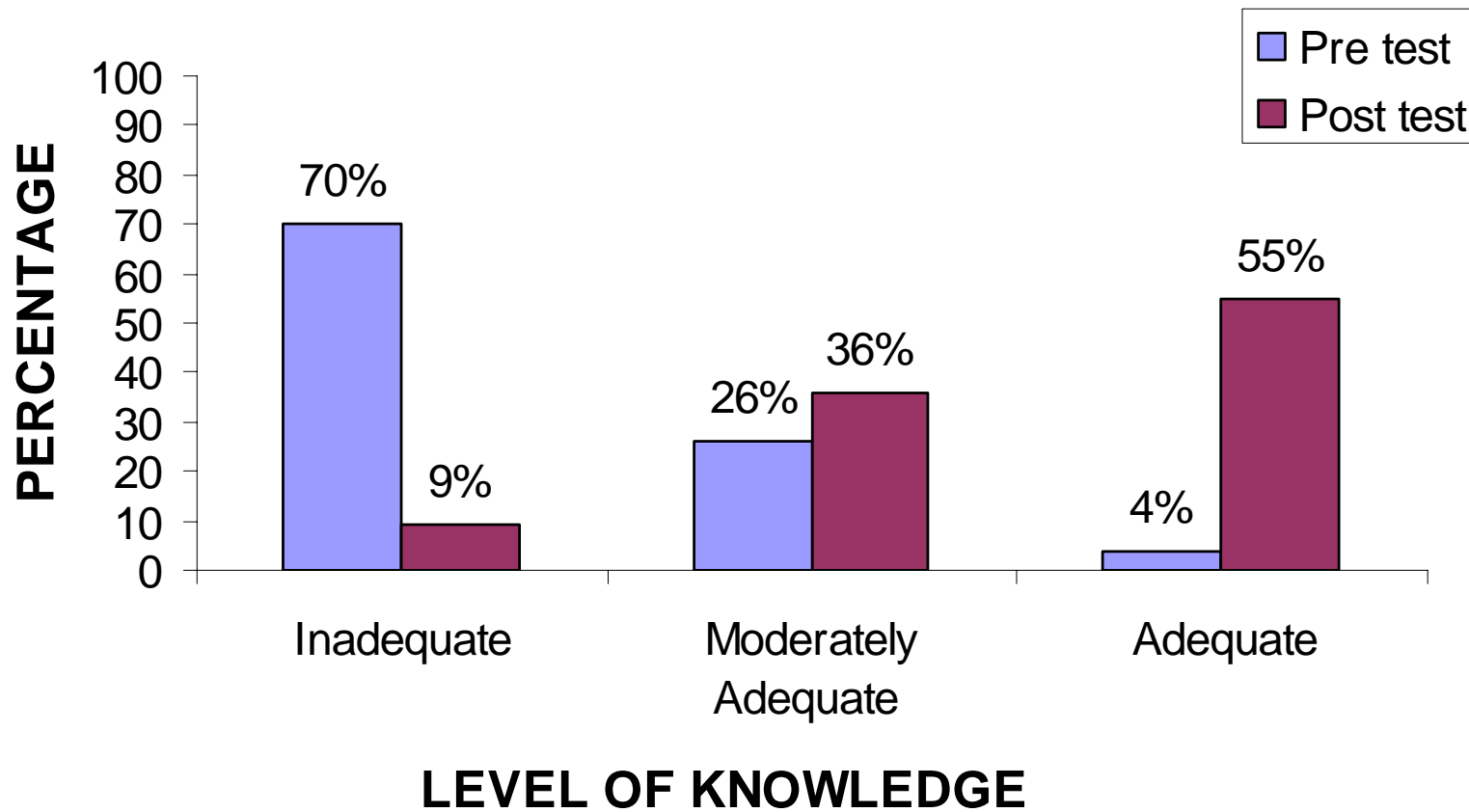


Fig-11 Percentage distribution of pre test and post test knowledge scores regarding cervical cancer among adult females

Table 3:

Compare the pretest and post test attitude scores regarding cervical cancer among adult females.

N=100

Level of attitude	Pretest		Posttest	
	f	%	f	%
Favourable attitude	15	15%	53	53%
Moderately Favourable attitude	37	37%	43	43%
Unfavoruable attitude	58	58%	4	4%
Total	100	100	100	100

Table 3 showed that, in pretest 15(15%) had favourable attitude, 37(37%) had moderately favourable attitude, and 58(58%) had unfavouruable regarding cervical cancer.

In post test, 53(53%) had favourable attitude and 43(43%) had moderately favorable attitude and 4 (4%) had unfavoruable regarding cervical canner.

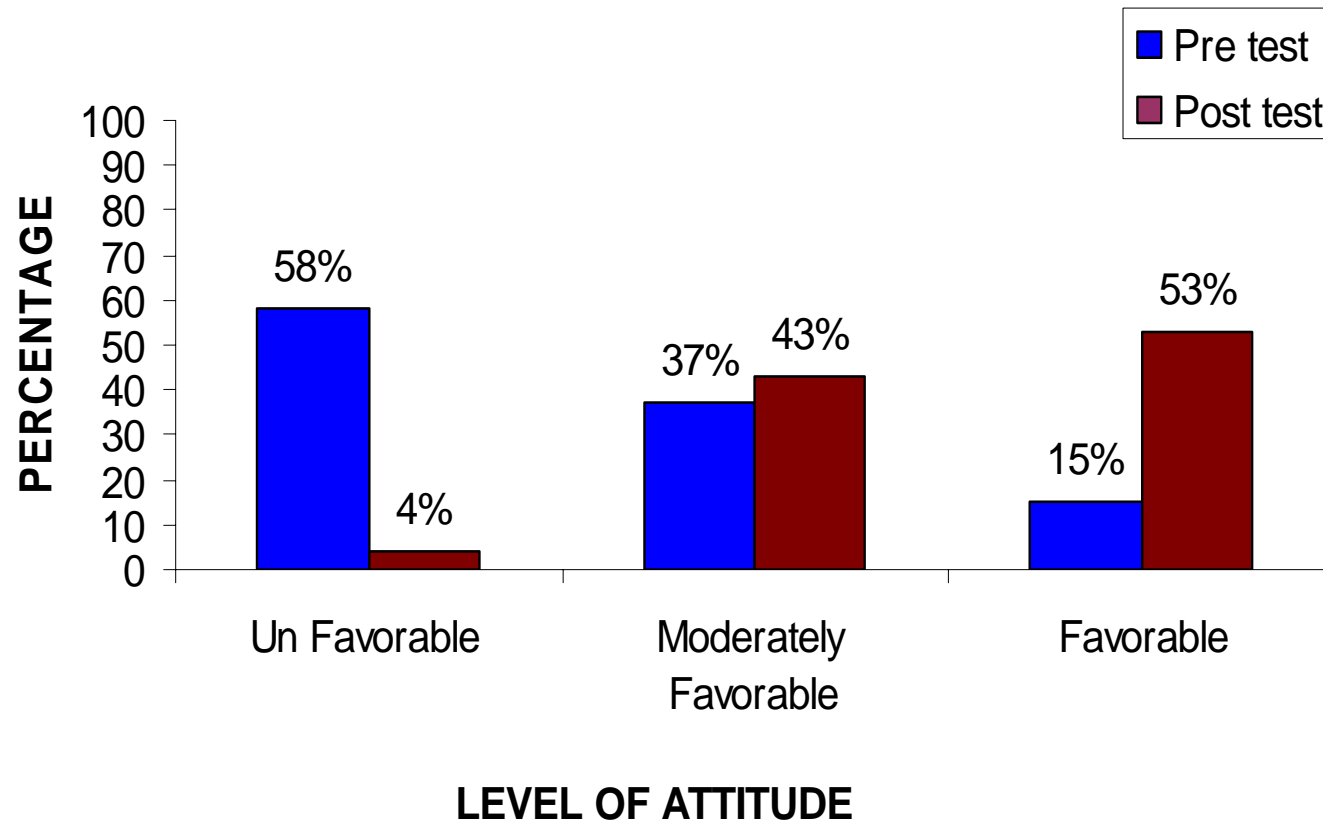


Fig-12 Percentage distribution of pre test and post test Attitude scores regarding cervical cancer among adult females.

Table: 4

Comparison of mean SD and “Z” test value of pre and post test Knowledge scores among adult females.

N= 100

SL No	Variable	Mean	SD	'z'	Table Value
1.	Pretest	8.59	3.13	14.42	1.96
2.	Post test	15.58	3.70		

df-99 p<0.05

The table 4 showed that mean pretest and post test scores of the adult females regarding cervical cancer were 8.59 (SD \pm 3.13) and 15.58 (SD \pm 3.70) respectively. The post test mean scores was higher than the pretest mean score. The 'z' value is 14.42 which was significant at 0.05 level.

Table-5

Comparison of mean SD and “z” test value of pre and post test attitude scores among adult females.

N= 100

SL No	Variable	Mean	SD	'z'	Table Value
1.	Pretest	18.83	5	23.35	1.96
2.	Post test	31.79	2.43		

df =99

p<0.05

The table 5 showed that mean pre test and post test attitude scores regarding cervical cancer among adult females were 18.83 (SD(\pm 5) and 31.79 (SD(\pm 2.43) respectively. The mean post test attitude score was higher than the mean pretest attitude scores. The ‘z’ value is 23.35 which is significant at 0.05 level.

Section - C: CORRELATION OF POST TEST KNOWLEDGE SCORES WITH ATTITUDE SCORES AMONG ADULT FEMALES.

Table - 6

Correlation between the mean Post test knowledge and attitude scores among adult females.

N=100

SL NO	Variable	Mean Scores	Co- Efficient of co - relation	Table Value
1	Knowledge	15.58		
2	Attitude	31.79	0.92	0.1946

Df = 98

P < 0.05

Table 6 showed that there was positive correlation (r=0.92) between mean post test knowledge and attitude scores regarding cervical cancer among adult females.

Section -D: ASSOCIATION BETWEEN POST TEST KNOWLEDGE SCORES REGARDING CERVICAL CANCER AMONG ADULT FEMALES WITH THEIR SELECTED DEMOGRAPHIC VARIABLES.

Table -7

Association between Post test knowledge scores regarding cervical cancer among adult females with their selected demographic Variables.

N=100

Sl. No	Demographic Variables	Level of Knowledge						χ^2	Table Value	Inference
		Adequate		Moderately Adequate		Inadequate				
		F	%	F	%	F	%			
1)	AGE									
1.1	30 -35 years	19	19	15	15	2	2	0.01	3.38	[NS]
1.2	36 -40years	20	20	12	12	3	3			
1.3	41 -45 years	11	11	5	5	1	1			
1.4	46 -50 years	5	5	4	4	3	3			

2)	Education									
2.1	No formal education	12	12	11	11	6	6			
2.2	Primary Education	24	24	11	11	-	-			
2.3	Secondary Education	9	9	8	8	3	3			
2.4	Higher Secondary Education	4	4	4	4	-	-	2.55	3.38	[NS]
2.5	Graduate	6	6	2	2	-	-			
3)	Occupation									
3.1	Coolie	18	18	10	10	3	3			
3.2	House wife	24	24	13	13	2	2			
3.3	Farmer	8	8	9	9	1	1	2.35	3.38	
3.4	Others	5	5	4	4	3	3			[NS]
4	Income									
4.1	Rs.1000- 1500	17	17	15	15	3	3			
4.2	Rs.1501- 2000	16	16	8	8	5	5			
4.3	Rs.2001-2500	14	14	7	7	1	1	0.82	3.38	[NS]
4.4	Rs.2500above	8	8	6	6	-	-			
5)	Religion									
5.1	Hindu	24	24	18	18	6	6			
5.2	Christian	17	17	12	12	1	1	0.86	3.38	[NS]
5.3	Muslim	14	14	6	6	2	2			

6	Type of family									
6.1	Joint Family	21	21	18	18	4	4			
6.2	Nuclear family	34	34	18	18	5	5	3.51	3.38	[S]
7	Marital Status									
7.1	Married	44	44	31	31	7	7			
7.2	Unmarried	5	5	1	1	-	-	0.11	3.38	[NS]
7.3	Widow	5	5	1	1	2	2			
7.4	Divorce	1	1	3	3	-	-			
8)	No of children									
8.1	No child	4	4	38	38	44	44			
8.2	One child	15	15	1	1	5	5	2.76	3.38	[NS]
8.3	Two child	28	28	3	3	5	5			
8.4	Above 3	8	8	3	3	1	1			
9)	Source of information									
9.1	Radio Program	7	7	10	10	-	-			
9.2	Television program	13	13	6	6	2	2			
9.3	Newspaper, Books, magazine	18	18	12	12	3	3	0.11	3.38	[NS]
9.4	Relatives friends	10	10	4	4	3	3			
9.5	Health Personal	7	7	4	4	1	1			

df-1 S = significant

NS - Not Significant

P<0.05

Chi-square values were calculated to find out the association (table 7) between post test knowledge scores regarding cervical cancer among adult females with their demographic variables such as age, education, occupation,

family income, religion, type of family, marital status, number of children and source of information.

Only one demographic variable (type of family) was associated with knowledge scores regarding cervical cancer among adult females. Other demographic variables like age ,education, occupation, income, religion, marital status, number of children and source of information had no association with knowledge scores regarding cervical cancer. Therefore, there was no significant association between knowledge scores and demographic variables except for type of family.

Section -E: ASSOCIATION BETWEEN POST TEST ATTITUDE SCORES REGARDING CERVICAL CANCER AMONG ADULT FEMALES WITH THEIR SELECTED DEMOGRAPHIC VARIABLES.

Table -8

Association between Post test Attitude scores regarding cervical cancer among adult females with their selected demographic variables.

N=100

Sl. No	Demographic Variables	Attitude						x^2	Table Value	Inference
		Favorable		Moderate		Unfavorable				
		No	%	No	%	No	%			
1)	AGE									
1.1	30 -35 years	18	18	17	17	1	1	4.17	3.38	[S]
1.2	36 -40years	15	15	19	19	1	1			
1.3	41 -45 years	11	11	4	4	2	2			
1.4	46 -50 years	9	9	3	3	-	-			
2)	Education									
2.1	No formal education	13	13	14	14	2	2	1.09	3.38	[NS]
2.2	Primary Education	19	19	15	15	1	1			
2.3	Secondary Education	12	12	8	8	-	-			
2.4	Higher Secondary Education	5	5	3	3	-	-			
2.5	Graduate	4	4	3	3	1	1			

3)	Occupation									
3.1	Coolie	14	14	15	15	2	2			
3.2	House wife	21	21	17	17	1	1	0.04	3.38	[NS]
3.3	Farmer	10	10	7	7	1	1	(N.S)		
3.4	Others	8	8	4	4	-	-			
4	Income									
4.1	Rs.1000- 1500	19	19	15	15	1	1	2.31	3.38	[NS]
4.2	Rs.1501- 2000	12	12	14	14	3	3			
4.3	Rs.2001-2500	14	14	8	8	-	-			
4.4	Rs.2500above	8	8	6	6	-	-			
5)	Religion									
5.1	Hindu	24	24	21	21	3	3	0.331	3.38	[NS]
5.2	Christian	17	17	13	13	-	-			
5.3	Muslim	12	12	9	9	1	1			
6	Type of family								3.38	
6.1	Joint Family	22	22	19	19	2	2	0.05		[NS]
6.2	Nuclear family	31	31	24	24	4	4			
7	Marital Status									
7.1	Married	41	41	40	40	1	1			
7.2	Unmarried	5	5	1	1	-	-	0.13	3.38	[NS]
7.3	Widow	5	5	1	1	2	2			
7.4	Divorce	2	2	1	1	1	1			

8)	No of children									
8.1	No child	4	4	2	2	1	1	0.04	3.38	[NS]
8.2	One child	31	31	4	4	-	-			
8.3	Two child	12	12	31	31	2	2			
8.4	Above 3	6	6	6	6	1	1			
9)	Source of information									
9.1	Radio Program	10	10	7	7	-	-	0.33	3.38	[NS]
9.2	Television program	10	10	10	10	1	1			
9.3	Newspaper, Books, magazine	17	17	14	14	2	2			
9.4	Relatives friends	9	9	8	8	-	-			
9.5	Health Personal	7	7	4	4	1	1			

df-1 N- Significance

NS-Not significance

p<0.05

Chi - square values were calculated to find out the association (table 8) between the Attitude scores regarding cervical cancer among adult females with their demographic variables such as age, education, occupation, income, religion, type of family, marital status, number of children and source of information.

There was no association between education, occupation, income, religion, type of family, marital status, number of children, source of information. There fore no significant association was found between attitude and demographic variables except for age.

CHAPTER - V

DISCUSSION

The discussion chapter deals with sample characteristics and objectives of the study.

The aim of this present study was to evaluate the effectiveness of structured teaching programme in terms of knowledge and attitude regarding cervical cancer among adult females in Nanchiyampalayam at Dharapuram, Thirupur District.

Description of Sample characteristics

The majority the adult females 36(36%) were belonged group of below 30 - 35 years, 36 -40 years females were 35 (35%), 41 -45years adult females were few 17 (17%) ,46 -50years adult females were very few 12 (12%).

There were 29(29%) adult females who had no formal education, 35(35%) of the adult females studied primary education, 20 (20%) of the adults studied secondary education 8(8%) of the adult females studied higher education ,very few 8(8%) adult females were graduates.

The data showed that the most 31(31%) of the adult females were coolie, Majority 39(38%) of the adult females were house wives 18 (18%) of the adult females were farmer, very few 12(12%) of the adult females were self employees.

The data showed that the majority 35 (35%) of the adult females had income between Rs. 1000 - 1500/-, 29(29%) of the adult females had income between Rs. 1501-2000/-,22(22%)-of the adult females income between Rs.2000 - 2500/-, very few 14(14%) of the adult females had income of above 2500Rs.

The highest number 48(48%) of the adult females were Hindus, Few 30(30%) of the adult females were Christian very few 22 (22%) of the adult females were Muslims.

Majority of the adult females 57 (57%) belonged to nuclear family. Most number 43 (43%) of the adult females belonged to Joint family.

The Majority 82(82%) of the adult females were married, very few 6(6%) of the adult females were unmarried, 8(8%) of the adult females were widow, 4(4%) of adult females were Divorced.

The data showed that the majority 7(7%) of the adult females had no child, 35(35%) of the adult females had one child 45(45%) of the adult females had 2 children and very few 13(13%) of the adult females had above 3 children.

The majority of the adult females 17(17%) had health information from Radio programs 21(21%) of the adult females had health information from television programs 33(33%) of the adult females had health information from newspaper and magazines. 17(17%) of the adult females had health information from family members relatives and friends very few 12(12%) of adult females had health sources information from health care Personal.

The findings of the study are discussed according to the objectives as follows .

1. Assess the pretest knowledge attitude scores regarding cervical cancer among the adult females.
2. Assess the posttest knowledge and attitude scores regarding cervical cancer among the females
3. Compare the pretest and post test knowledge and attitude scores regarding cervical cancer among the adult females.

4. Correlate the post test knowledge scores with attitude scores of adult females.
5. Find out the association between the post test knowledge scores with their selected demographic variables.
6. Find out the association between the posttest attitude scores with their selected demographic variables

The first objective- - Assess the pretest knowledge and attitude scores regarding cervical cancer among adult females

The assessment of knowledge regarding cervical cancer among 100 adult females revealed, 70% had inadequate knowledge in pre test. Assessing the Attitude regarding cervical cancer among 100 adult females 58% had unfavorable attitude in pretest. It revealed that there was a need for structured teaching program for adult females on cervical cancer.

This is consistent with the study findings of Shyla Isaac (2009) where 76.7% had inadequate knowledge in pre test.

The second objective- Assess the posttest knowledge and attitude scores regarding cervical cancer among adult females.

The assessment of knowledge regarding cervical cancer among 100 adult females shows 55% had adequate knowledge in post test.

Assessing the Attitude regarding cervical cancer among 100 adult females 4% had unfavorable attitude in post test. It revealed that the knowledge and attitude had increased after structured teaching programme.

The present study revealed that the adult females had adequate knowledge and attitude about cervical cancer in post test. This is consistent with the study findings of Shyla Isaac (2009) where 80% had adequate knowledge in post test.

The third objective- compare the pre test and post test knowledge and attitude scores regarding cervical cancer among the adult females.

The assessment of knowledge score of adult females after being exposed to structured teaching program showed that knowledge score had been markedly increased as evidenced by the posttest analysis. Table 6 revealed that knowledge level of adult females in post test had mean score of 15.58 (SD± 3.7) which was increased compared to the mean score of 8.59 (SD± 3.13) in the pretest. It is significant at $P < 0.05$ level. Hence the hypothesis H_1 was accepted (The mean post test knowledge scores is significantly higher than the mean pre test knowledge).

Table 3 showed that the attitude level of adult females in post test had mean score of 31.79(SD± 2.43) which was increased compared to the mean score of 18.83(SD± 5) in pre test. It is significant at $p < 0.05$ level. Hence the hypothesis H₂ was accepted (The mean post test attitude scores is significantly higher than the mean pre test attitude scores) .

The fourth objective to correlate the post test knowledge scores with attitude scores of adult females.

There was positive correlation ($r = 0.92$) between mean post test knowledge and attitude scores among adult females regarding cervical cancer (table 6) Further it could be inferred that knowledge and attitude depends on each other. The reason might be when the knowledge is improving, attitude also will develop positively. Hence the hypothesis H₃ was accepted (There will be a significant correlation between post test knowledge and attitude scores).

The fifth objective to find the association between posttest knowledge scores and demographic variables of adult females.

Chi - square values were calculated to find out the association (table 7) between of the post test knowledge score of among adult females with their age ($\chi^2 = 0.01$) education ($\chi^2 = 2.55$) occupation ($\chi^2 = 2.35$) income ($\chi^2 = 0.82$) religion ($\chi^2 = 0.86$) type of family ($\chi^2 = 3.51$) marital

status ($\chi^2=0.11$) number of children ($\chi^2= 2.76$) and health source information ($\chi^2= 0.11$)

Among demographic variables, type of family was associated with knowledge among adult females (table 7). Other demographic variables (age, education, occupation, income, religion, marital status, number of children, health source information) had no association with knowledge regarding cervical cancer. Therefore there was no significant association between knowledge and demographic variables except for type of family.

The sixth objective to find the association between posttest attitude scores and demographic variables of adult females.

Chi - square values were calculated to find out the association (table 8) of between the attitude of adult females with their age ($\chi^2= 4.11$) education ($\chi^2= 1.09$) occupation ($\chi^2= 0.82$) income ($\chi^2= 1.47$) religion ($\chi^2= 0.33$) type of family ($\chi^2= 0.05$) marital status ($\chi^2= 0.13$) number of children ($\chi^2= 0.04$) and health source information ($\chi^2= 0.33$).

The demographic variables age, education, occupation, income, religion, type of family, marital status, number of children and health source information had no association with attitude regarding cervical

cancer. There fore, there was no significant association between attitude and demographic variables except for age.

This study findings are contradictory with the study findings of Mrs.Jayanthi (2008) where results of the study revealed significant association between the Knowledge ,attitude, practice and demographic variables such as age, occupation, family income, marital life and number of children of respondents on prevention and early detection of cervical cancer ($P >0.05$)

CHAPTER-VI

SUMMARY, CONCLUSION, IMPLICATION, RECOMMENDATIONS AND LIMITATION

This chapter is divided in to five aspects.

- ❖ Summary of the study
- ❖ Conclusion
- ❖ Implications for nursing
- ❖ Recommendation
- ❖ Limitation

SUMMARY OF THE STUDY :-

The study was done to assess the effectiveness of structured teaching programme on knowledge and attitude regarding of cervical cancer conducted in Nanchiyampalayam, dharapuram.

The conceptual framework of the study was based on the modified health belief Model 1975. The design used for the study was one group pretest and post test, pre-experimental design. Non-probability, purposive sampling technique was used to select 100 samples of the study. The instrument used for the study was structured interview schedule and an attitude five point Likert's scale, which was

used before and after structured teaching programme. The data, were analyzed employing descriptive and inferential statistics

The investigator gave brief introduction and pretest was conducted for 45 minutes. Based on this, structured teaching programme on cervical cancer was given immediately after the pretest, using compact disc and laptop. Post test was done on the 7th day using same instrument. The data were analyzed and interpreted using descriptive and inferential statistics.

The finding are followed as,

- Most of the (36%) adult females were in the age group of 30-35yrs.
- Most of the (35%) adult females studied primary education.
- Almost(39%)of the adult females was house wives.
- Most of the (35%) adult females were in the income group between Rs. 1000 - 1500 /-
- Highest percentage (48%) of the adult females were Hindus.
- Majority (57%) of the adult females were nuclear family.
- Majority (82%) of the adult females were married.
- Majority (45%) of the adult females were having two child.
- The highest percentage (33%) of adult females got health sources information from relative and friends.

- During pre test, majority of adult females 70 (70%), had inadequate. The highest percentage of adult females 55 (55%) had adequate knowledge after the structured teaching programme.
- During pre test, majority of adult females 58 (58%), had Unfavorable attitude. The highest percentage of adult females 53 (55%) had favorable after the structured teaching programme
- High degree of positive correlation was found between post test knowledge and attitude scores (0.92).
- No significant association was found between the post test knowledge scores with their demographic variables except for type of family.
- No Significant association was found between post test attitude scores with their demographic variables except for age.

The study revealed that the knowledge and attitude scores regarding cervical cancer was significantly higher after administration of structured teaching programme.

Findings showed that the structured teaching programme was effective in increasing the knowledge, and attitude among adult females

regarding cervical cancer. Thus structured teaching programme played an important role in improving the knowledge, and attitude among adult females.

CONCLUSION

The study findings revealed that there was a significant improvement in the knowledge and attitude of adult females followed by structured teaching programme. Based on the statistical findings it is evident that provision of such kind of structure teaching programme will motivate the adult females and help them to acquire knowledge (z value=14.42) and develop positive attitude (z value=23.35) regarding cervical cancer.

NURSING IMPLICATIONS

Nursing service

- ❖ The structured teaching can be used to improve the knowledge and attitude on cervical cancer among adult females
- ❖ Health promotion is a vital function of the nurse and nurse can use this structured teaching programme on three levels of prevention (ie. Primary, Secondary and Tertiary)
- ❖ Nursing personnel working in maternal child health clinic, primary health centre, sub centre should be given in service

education to update and improve their knowledge regarding cervical cancer.

- ❖ The result of the study will help the nurses to enlighten their knowledge on importance of health education.

Nursing education

- ❖ Students can utilize the structured teaching programme to give health education to adult females.
- ❖ Teaching can motivate the students to do mini project among adult females in various aspects.
- ❖ Students can conduct mass education programme in community by using A.V.aids like Hand out,poster,television,laptop and compact disc.

Nursing administration

- ❖ Nursing administrator can formulate policies that will includes all nursing staff to be actively involved in health education programme in their respective community areas.
- ❖ Nursing administrators can utilize the structured teaching programme while conducting inservice education programme for directing and motivating staff towards of cervical cancer
- ❖ Nurse administrators have more responsibility as supervisor on creating awareness among adult females regarding prevention of

complication by facilitating free distribution of booklets, handouts, charts regularly to adult females health clinics in urban and rural.

Nursing research

- ❖ This study can be effectively utilized by the emerging researchers for their reference purpose.
- ❖ A similar study could be replicated by taking larger samples.

RECOMMENDATIONS

- ❖ An information booklet can be prepared as a teaching aid in the community.
- ❖ A similar study can be done with control group.
- ❖ A longitudinal study can be done using post test after one month, six months and one year to see retention of knowledge.
- ❖ A similar study can be done in urban and rural areas so findings can be compared.
- ❖ Similar study can be replicated on a large sample.

LIMITATION

- ❖ It was time consuming for the investigator for interview and structured teaching programme, since the level of understanding among adults females varied.

BIBLIOGRAPHY

BOOK REFERENCE

1. Basavanthappa, B.T.(1998). "**Text Book of community Health Nursing**", (6th ed.). Delhi: Japee Brothers, 118 - 119.
2. Dawn,C.S., (1997), "**Text Book of Gynecology and Contraception**", (12th ed.). India: Published by Dawn Books, 401 - 422.
3. Dutta. D.L. (1994). "**Text Book of Gynecology**", (2nd ed.). Calcutta: published by new central book agency, 312-322.
4. Hacker, et.al., (2004). "**Essentials of Obstetrics and Gynecology** ", (4th ed.). India: Elsevier, 447-458.
5. Joyce. M. Black et. al., (2004). "**Medical Surgical Nursing, Clinical Management for Positive outcomes**", (7th ed.). New Delhi: Elsevier Pvt Ltd,1014.
6. Judith Ann Allender,M.C et.al., (2001). "**Community Health Nursing Concepts and practice**", (5th ed.). New Delhi: Lippincott Publications,105.
7. Kothari, C. R., (2000). "**Research Methodology Methods and Technique**", (2nd ed.). New Delhi: Willey Eastern Ltd,53.
8. Lewis, et.al., (2004). "**Medical Surgical Assessment and Management of Clinical problems**", (7th ed.). London: Mosby Company,89.
9. Mahajan Gupta, M. C., (2000). "**Text Book of Preventive and Social Medicine**", (2nd ed.).New Delhi: Jaypee Publishers,560.
10. Park,K., (2009). "**Text Book of Preventive and Social Medicine**", (20th ed)., Jabalpur: Bansaridas Bhanot Publishers, 243 - 247.

11. Sabarathan Arulkumaran, et.al., (2005). "**Essentials of Gynecology**", (1st ed.). New Delhi: published by Jaypee brothers, 248 - 252.
12. Stanhop Marcia, et. al., (2000). "**Community Health Nursing**", (4th ed.). London: Mosby yearbook,535.
13. Sundar Rao, P. S. S., (1999). "**An Introduction to Bio statics**", (3rd ed.). New Delhi: Vora Medical publication,89.
14. Wilma, J. Phipps, et. al., (1996). "**Shatter's Medical Surgical Nursing**", (7th ed.). New Delhi: B. I Publications Pvt Ltd,87.
15. White Lois, (2005). "**Foundations of Nursing** ", (2nd ed.). Missouri: Elgevier,45.

JOURNAL REFERENCE

16. Arevian, M., Nouredin, S., et.al., (1997 Jul). "A survey of Knowledge, attitude and practice of Cervical screening among Lebanese", **Armesian women, Nursing Outlook**, 45 (16), 18 - 22.
17. Biswas, L. N., et. al., (1997)." Sexual risk factors for cervical cancer among rural Indian women; a case control study" **International Journal of Epidemiology**, 26(6), 491 - 495.
18. Chantal Sauvageau., (2007), "Human papilloma Virus Vaccine and Cervical Cancer, Screening acceptibility among adults in quebec, Canada", **BMC public health** , 56 (6), 304.
19. Daly, S. F et .al., (1998), "Can the number of cigarettes smoked predict high grade cervical intra epitrelial neoplasia among women with middly abnormal cervical smears? "**American Journal of Obstetrics and Gynecology** ", 17 (67), 399 - 402.

20. Davis Mostyn, J., (1991). "Pap tests needed for woman of all ages" **Post Graduate Medicine**, 89 (27), 30.
21. Denny, L., et. al, (2005), "Screen and Treat approaches for cervical cancer prevention in low source settings", a randomized controlled trail", **Journal of the American Medical Association**, 294 (17) 2173-2181.
22. Elcee., (1998), "Cancer Cenix is Curable", **Health action**, 18 (18), 27 - 28.
23. Gang, S et. al., "Reproductive Morbidity", **BMJ, Journal**", 67(78) 69.
24. Higgins Chris, (1997), "Screening for Cervical Cancer", **Nursing times** 93, (6), 50 - 51.
25. Jadall & Sharaya, et. al., (1998), "view about knowledge cancer knowledge and attitudes" **Cancer Nursing** 21(13), 269 - 273.
26. Lunette Denny, et. al., (2005), "Queen and Treat approaches for Cervical cancer prevention in Con - Resources setting". **The Journal of the American Medical Association**. 18 (294) , 2173 - 2181.
27. Murthy, et. at., (2005), "Trends in Cervical incidence Indian scenario", **European Journal of Cancer prevention**", 14(6) , 513, 518.
28. Nancy, J. Burke, et. al., (2004), "Good Health for New years Development of a Cervical cancer control reach program for Vietnamese Immigrants **Journal of Cancer education**", 19 (4), 244, 250.
29. Nanda Kumar, et. al., (1995), "Incidence, Mortality and Survival in Cancer of the Cervic in Bangalore", **Indian Journal cancer**, 71, (6)1348 - 52.

30. Phillips L et. al., (2005), "**Knowledge of Cervical cancer and screening among women in east - central England**", 15 (4), 639 - 645.
31. Sankaranarayanan, et. at., (2009), "HPV screening for Cervical cancer in rural India, **National Institute of Health**",7 (18),97.
32. Shyla Issac, (1996), "Cancer of Cervix", **Nightingale Nursing Times** 5,(1).
33. Sankaranarayanan, R. et.a., (2005) " A critical assessment of screening methods For cervical heoplasia", **International Jouran: Crynerol Obset** 89 (12),78.

UNPUBLISHED THESIS :-

34. Mrs. Jayanthi.V., (2008). "A Study to assess the knowledge , Attitude and practices of Married women (18-45 years)on the prevention and early detection of Cervical cancer with a view to develop an educational pamphlet in Begur P.H.C. Area, Bangalore".The Rajiv Gandhi Universiy of Karnataka.

NET REFERENCE

35. http://www.cdc.gov/vaccine_safety/
36. <http://cancerres.aacrjournals.org/cgi/>
37. <http://www.womeningovernment.org/prevention>
38. <http://medicalcentre.osu.edu/patientcare/healthcare>
39. <http://www.china.org.in/health>
40. <http://www.cancer.gov/pdq/prevention/cervical>
41. <http://in.reuters.com/article/health>

APPENDIX-G

Structured teaching programme regarding cervical cancer among adult females.

Topic	:	Cervical cancer
group		Adult females
Place		Nanchiyampalayam
Duration		40 Mts
Method of teaching		Lecture cum discussion
Teaching aid	:	compact disc with laptop
Medium of Instruction		Tamil

Central Objective :-

The adult females will acquire knowledge regarding cervical cancer and develop positive attitude and skill in managing cervical cancer specific objectives.

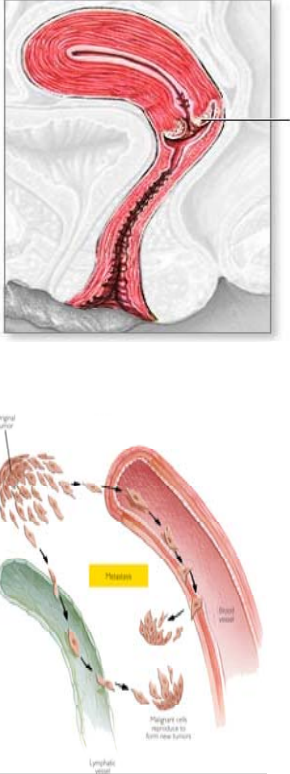
Specific Objectives

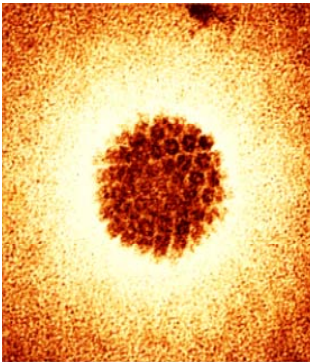
At the end of structured teaching program adult females will be able to



- ❖ explain the anatomy and physiology
- ❖ discuss the cancer
- ❖ define cervical cancer
- ❖ describe the causative agent of cervical cancer
- ❖ enumerate the risk factors
- ❖ list down the sign and symptoms
- ❖ explain the stages of cervical cancer
- ❖ diagnostic procedures of cervical cancer
- ❖ surgical procedures of cervical cancer
- ❖ explain the prevention of cervical cancer
- ❖ enumerate the prognosis


Specific Objective	Content	A.V. Aids	Teaching Activities
	<p>INTRODUCTION :-</p> <p>Cervical cancer trends to occur in midlife. Most cases are found in women younger than 50 yrs. It rarely develops in women younger than 20 yrs. Cervical cancer is the most common form of cancer among women in India, with an estimated 1,00,000 new cases developing annually in the country. A woman's cervix is lined with cells, change which can affect deeper cell layers or spread to other organs and cause damage. Health cells that make up the body's tissues grow, and are replaced as needed. This keeps the body in good repair. Below this orifice is a larger opening. The vaginal orifice or introitus. On each side of the vestibular gland a bean sized structure that empties its mucous secretion through a small duct. The opening of the duct lies within the labia minora, external to the hymen. The area between the vagina and rectum is called the perineum</p> <p>ANATOMY AND PHYSIOLOGY OF FEMALE REPRODUCTIVE SYSTEM :-</p> <p>The female reproductive system consists of external and internal structures</p>		

Specific Objective	Content	A.V. Aids	Teacher and learner's Activities
explain the anatomy and physiology	<p>EXTERNAL GENITALIA :-</p> <p>The external genitalia (the vulva) include two thick folds of tissue called the labia majora and two smaller lips of delicate tissue called the labia minors, which lip within the labia majora, Upper portions of the labia minors units, forming a partial covering for the clitoris, a highly sensitive organ composed of erectile tissue. The external opening of the female urethra is about 3cm long. Below this orifice is a larger opening the vaginal orifice.</p> <p>INTERNAL REPRODUCTIVE STRUCTURES :-</p> <p>The internal structures consist of the vagina, uterus, Ovaries and fallopian or uterine tube</p> <p>UTERUS :-</p> <p>The uterus a pear shaped muscular organ is about 7.5cm long and 5 cm wide at its upper part. Its wall are about 1.25cm 1.5 inch thick the size of the uterus varies depending on party.</p>		Lecture cum discussion



Specific Objective	Content	A.V. Aids	Teacher and learner's Activities
<p>discuss the cancer</p>	<p>The uterus has two parts, the cervix, which projects into the vagina, and a larger upper part, the fundus or body which covered posteriorly and partly anteriorly by peritoneum..</p> <p>CANCER :-</p> <p>Cancer is a collective term describing a large group of disease characterized by un controlled growth and spread of abnormal cells</p> <p>NATURAL HISTORY :-</p> <p>Cancer cervix seems to follow a progressive course from epithelial dysplasia to carcinoma in situ to invasive carcinoma. There is good evidence that carcinoma in situ persist for a long time more than 8 years on an average. The proportion of cases progressing to invasive carcinoma from pre invasive stage is not known it may average 15 - 20 years or longer. The duration of the pre invasive stage is also not known. There is evidence that some in situ cases will spontaneously regress, the disease spreads by direct extension into the lymph nodes and pelvic organs.</p>		<p>Lecture cum discussion</p>

Specific Objective	Content	A.V. Aids	Teacher and learner's Activities
<p>define cervical cancer</p> <p>enumerate the risk factors</p>	<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <p>Normal epithelium ↔ Dysplasia ↔ cancer in situ ↔ Invasive cancer</p> </div> <p>Definition It refers to the malignant tumor and visible lesions in the cervix</p> <p>CAUSATIVE AGENT There is evidence pointing to human papilloma virus (HPV)</p> <p>RISK FACTORES Age Cancer cervix affect relatively young women with incidence increasing rapidly from the age 25 to 45, then leveling of, and finally falling again</p> <p>GENITAL WARTS :- Past and or present occurrence of clinical genital warts has been found to be an important risk factor</p>		<p>lecture cum discussion</p> <p>lecture cum discussion</p>


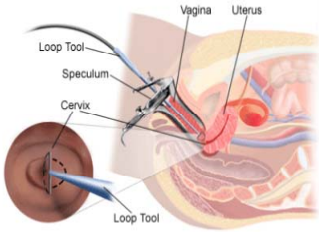
Specific Objective	Content	A.V. Aids	Teacher and learner's Activities
	<p>MARITAL STATUS :-</p> <p>Cases are less likely to be single more likely to be widowed, divorced or separated and having multiple sexual partners. The fact that cancer of the cervix is very common is prostitutes and practically unknown among virgins suggests that the disease could be linked with sexual inter course.</p> <p>EARLY MARRIAGE :-</p> <p>Early marriage early coitus, early childbearing, and repeated child birth have been associated with increasing risk.</p> <p>ORAL CONTRACEPTIVE PILLS :-</p> <p>There is renewed cancer about the possible relationship between pill use and the development of invasive cervical cancer. A recent WHO study finds an increased risk with increased duration of pill use and with re use of oral contraceptives high in estrogen.</p>	 	

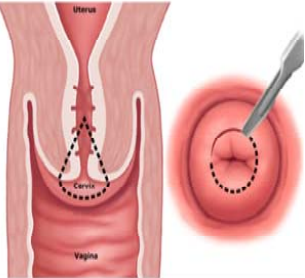
Specific Objective	Content	A.V. Aids	Teacher and learner's Activities
List down the signs and symptom	<p>SOCIO ECONOMIC CLASS :-</p> <p>Cancer cervix is more common in the lower socio economic groups reflecting probably poor genital hygiene.</p> <ul style="list-style-type: none"> ❖ Sexual Activity <ul style="list-style-type: none"> ➤ Multiple sex partners ❖ HIV infection ❖ Smoking ❖ Exposure to human papillomaviru ❖ Exposure to diethylstilbestrol (DES) in uteri ❖ Nutritional deficiencies <ul style="list-style-type: none"> ➤ (folate, beta- carotene and vitamin C levels are lower in women with cervical cancer than in women without it) ➤ Chronic cervical infection. 		Lecture cum discussion

Specific Objective	Content	A.V. Aids	Teacher and learner's Activities
	<p>SIGNS AND SYMPTOMS:</p> <p>The early stages of cervical cancer may be completely asymptomatic.</p> <p>(i) Vaginal bleeding:</p> <p>Vaginal bleeding contact bleeding or (rarely) a vaginal mass may indicate the presence of malignancy. Also moderate pain during sexual intercourse are vaginal discharge are symptoms or cervical cancer. In advanced disease, metastases may be present in the abdomen, lungs or elsewhere.</p> <p>symptoms of advanced cervical cancer</p> <ul style="list-style-type: none"> ➤ Loss of appetite ➤ Weight loss Fatigue 		

Specific Objective	Content	A.V. Aids	Teacher and learner's Activities
<p>explain the prevention</p>	<ul style="list-style-type: none"> ➤ Pelvic pain ➤ Back pain ➤ Leg pain ➤ Heavy bleeding from the vagina ➤ White discharge with blood stained ➤ Inter menstrual bleeding ➤ Bleeding after intercourse <p>. STAGES OF CERVICAL CANCER</p> <p>1) Stage 0 :- The abnormal cells are found only in the first layer of cells lining the uterus.</p> <p>2) Stage 1 :- Cancer involves the cervix but is still confined to the uterus. This stage has six levels depending upon the size of the cancer.</p>	 	<p>Lecture cum discussion</p>

Specific Objective	Content	A.V. Aids	Teacher and learner's Activities
	<p>3) Stage 2 :-</p> <p>Cancer has spread to nearby areas but is still inside the pelvic area. This stage has two levels depending upon whether the cancer has spread to the upper two thirds of the vagina (or) into the pelvis.</p> <p>4) Stage 3 :-</p> <p>Cancer has spread throughout the pelvic area. This stage has two levels depending on the whether there is the cancer has spread to the lower third of the vagina. More broadly into the pelvis.</p> <p>5) Stage 4 :-</p> <p>Cancer has spread to other parts of the body. This stage has two levels depending on the which organs the cancer has spread to bladder, rectum (or) more distant organs.</p> <p>DIAGNOSTIC PROCEDURE</p> <p>Early diagnosis :-</p> <p>The diagnosis of cervical cancer usually begins in your doctor's office during a routine pelvic exam and pap test.</p>		



Specific Objective	Content	A.V. Aids	Teacher and learner's Activities
	<p>) Schiller's iodine test :-</p> <p>The colposcopist may use another test using an iodine solution. Normal tissue cervix stains dark brown when iodine is applied on the hand pre-cancer not stain with iodine.</p> <p>ii) Acetic acid colposcopy :-</p> <p>Doctor applies a vinegar solution to the cervix and vagina with a cotton ball or swab.</p> <p>The vinegar makes abnormal tissue turn white so your doctor can identify areas that may need further evaluation</p> <p>Later diagnosis :-</p> <ol style="list-style-type: none"> 1. Loop Electro Surgical Excision Procedure (LEEP) A procedure which uses an electric wire loop to obtain a piece of tissue. 2. Colposcopy : A procedure, to exam the cervix for abnormalities. If abnormal tissue is found, a biopsy is usually performed. 	 	


Specific Objective	Content	A.V. Aids	Teacher and learner's Activities
	<p>3. Endocervical Curettage (ECC) L A procedure which uses a narrow instrument called a currette to scrape the lining of the endocervical canal. This type of biopsy is usually completed along with the colposcopic biopsy.</p> <p>4. Cone biopsy : A biopsy in which a large cone shaped piece of tissue is removed from the cervix by using the loop electro surgical exersion procedure (or) the</p> <p>Treating Cervical Cancer :-</p> <p>If the cancer is only on the surface Early Treatment of the cervix the doctor will attempt to destroy the cancerous cells.</p> <ul style="list-style-type: none"> • Cryotherapy • Electro coagulation • Carbon dioxide laser procedure 		

Specific Objective	Content	A.V. Aids	Teacher and learner's Activities
	<p>Later Treatment :-</p> <p>If the tumor has spread into deeper layers of the cervix. But has not spread beyond the cervix the doctor may perform surgery to remove the tumor but leave the uterus and ovaries. In other cases you may need to have a hysterectomy.</p> <p>Hysterectomy :-</p> <p>A hysterectomy is surgical removal of the uterus including the cervix some times the fallopian tubes and ovaries are removed as well. The doctor may choose to remove lymphnodes near the uterus to determine whether the cancer has spread.</p> <p>ABDOMINAL HYSTERECTOMY :</p> <p>A cut is made in the layer abdomen to expose the tissue and blood vessels that surround the uterus and cervix. These tissues are cut and the blood vessels are tied off to remove the uterus stitches are placed in these deep structures, which will eventually dissolve and do not need to be removed. The uterus is loosened to prevent infection and to keep the intestine from dropping downward.</p>		

Specific Objective	Content	A.V. Aids	Teacher and learner's Activities
	<p>LAVH(laparoscopically assisted vaginal hysterectomy) :-</p> <p>A laparoscope is inserted through a small cut near the navel. This small, telescope like device, about the width of a pencil, with a light on one end and a magnifying lens on the other, helps the doctor see the pelvic organs. The abdomen is inflated with a harmless gas to improve your doctors visibility and provide room to work. Images from the laparoscope are viewed on a special monifor.</p> <p>Other small (¼ - ½ inch wide) unit are made in the abdomen, through which the doctor inserts instruments to help move organs and remove the uterus. A cut is also made where the uterus joins the vagina. The bladder and rectum are gently pushed off the uterus. Which is removed through the cut made in the vagina. The vagina is closed to prevent infection and to keep the intestines from dropping downward The cuts are all closed with stitches which will likely leave small scars.</p>		

Specific Objective	Content	A.V. Aids	Teacher and learner's Activities
	<p>With each procedure a vaginal packing dressing is placed in the vagina. This will be removed after a day or 2</p> <p>VAGINAL HYSTERECTOMY :-</p> <p>The vagina is stretched and kept open by special instruments, no external incision is made. The doctor does, however, make an internal incision at the top of the vagina around the cervix. The uterus and cervix are cut free from their supporting ligaments and surrounding tissue, and connecting blood vessels are tied off. The uterus and cervix are removed through the vagina, which is then closed to prevent infection and to keep the intestines from dropping downward.</p>		

Specific Objective	Content	A.V. Aids	Teacher and learner's Activities
	<p>PREVENTION :-</p> <p>Awareness :-</p> <p>According to the US national cancer institute's 2005. Information national trends survey only 40% of American women surveyed had heard of human papillomavirus (HPV) infection and only 20% had heard of its link to cervical cancer. In 2008 an estimated 3,870 women in the US will die of cervical cancer, and around 11,000 new cases are expected to be diagnosed.</p> <p>Screening :-</p> <p>The widespread information of the papanicolano test or pap smear for cervical cancer screening has been credited with schematically reducing and mortality rate.</p>	 	

Specific Objective	Content	A.V. Aids	Teacher and learner's Activities
	<p>CONDOMS :-</p> <p>Condoms may also be useful in treating potentially precancerous changes in the cervix. Exposure to semen appears to increase the risk of precancerous changes, and use of condoms helps to cause these changes to regress and helps clear HPV o.</p> <p>NUTRITION :- Higher levels of vegetable consumption were associated with or 54% decreases risk of HPV persistence. Consumption of papaya at least once a week was inversely associated with persistent HPV infection.</p> <p>VITAMINS A :- There is weakly evidence to suggest a significant deficiency of retinol can increases changes of cervical dysplasia independently of HPV infection. A small care control.</p> <p>FOLIC ACID :- Improving folate status in subjects at risk of getting infected or already infect with high risk. HPV may have a beneficial import in the prevention of cervical cancer</p>		

Specific Objective	Content	A.V. Aids	Teacher and learner's Activities
explain the prognosis	<p>Primary prevention until the causative are more clearly understood there is no prospect of primary prevention of the disease. If may be that with improved personal hygiene and birth control, cancer uteri will show the same decline in developing countries as already. Experienced in most of Europe and north America secondary prevention. This rests on early detections of cases through screening and treatment by radical scenery and radio therapy. The 5 year survival rate is virtually 100% for carcinoma is situ, 79% for local invasive driears cancer cervix is difficult to care once symptoms develop and is total if left untreated prognosis is strongly dependent upon the stage of disease at detections and treatment. Vaginal as to logy may suggest malignancy but a biopsy will settle the diagnosis where it has been implemented. Even then the invasive carcinoma is defected. It is so early that a 85 - 100% 5 year survival role could be achieved.</p>		Lecture cum discussion

Specific Objectives	Contents	AV Aids	Teachers and Learners Activity
	<p>PROGNOSIS :-</p> <p>Prognosis depends on the stage of the cancer with treatment the 5 years relative survival rate for the earliest stage of invasive cancer is 92% and the overall 5 years survival rate is about 72 % these statistics may be improved rate is applied to women newly diagnosed bearing in mind that these outcomes may be partly based on the state of treatment five years ago when the women studied were first diagnosed With treatment 80 - 90% of women stage cancer and 50 - 65% those with stage II cancer are alive 5 years after diagnosis only 25 - 35% of women with stage III cancer and 15% or fewer of those with stage IV cancer are alive after 5 years.</p>		

Specific Objectives	Contents	AV Aids	Teachers and Learners Activity
	<p>The type of therapy given.</p> <p>Stage 0 - 100% Stage III - 30%</p> <p>stage I - 85% Stage IV 5 - 10%</p> <p>Stage II - 50%</p> <p>CONCLUSION :-</p> <p>Although significant advances in primary and secondary cervical cancer prevention have been achieved, their true realization and ultimate impact on global disease outcomes will be affected by a number of complex and interrelated factors. Cervical cancer screening programs must continue, and the relative roles of HPV vaccination in young women and HPV testing in older women (alone or in conjunction with cytology) will be determined over the next decades.</p>		

வரையறுக்கப்பட்ட விளக்கப்படம்

தலைப்பு	-	கர்ப்பப்பை வாய் புற்று நோய்
குழு	-	நடுத்தர வயதினர்
இடம்	-	நஞ்சியம்பாளையம்
நேரம்	-	45 நிமிடங்கள்
கற்பிக்கும் முறை	-	விரிவுரை மற்றும் கலந்தாய்தல்
செயல்விளக்கப் பொருட்கள்	:-	குறுந்தகடு
கற்பிக்கும் மொழி	-	தமிழ்

முக்கியக் குறிக்கோள் :-

வரையறுக்கப்பட்ட இக்கல்விப்பயிற்சி நிறைவடையும் போது நடுத்தர வயதினர்கள் கர்ப்பப்பை வாய் புற்றுநோய் பற்றிய அறிவு மற்றும் நேர்மறையான மனப்பான்மையை வளர்த்துக்கொண்டு அந்த அறிவை அவர்களுடைய தினசரி வாழ்க்கையில் பயன்படுத்துவார்கள்.

குறிப்பிடத்தக்க குறிக்கோள்கள் :-

வரையறுக்கப்பட்ட இக்கல்விப்பயிற்சி நிறைவடையும் போது நடுத்தர வயதினை உடையவாடகளால்.

- ❖ கர்ப்பப்பை வாய் புற்றுநோயைப் பற்றி வரையறுக்க முடியும்.
- ❖ கர்ப்பப்பை வாய் புற்றுநோய் வருவதற்கான காரணிகளை அறியமுடியும்.
- ❖ கர்ப்பப்பை வாய் புற்றுநோய் உண்டாக்கக் கூடிய விளைவுகளை அறிய முடியும்.

- ❖ கர்ப்பப்பை வாய் புற்றுநோயின் அறிகுறிகளை கண்டறிய முடியும்.
- ❖ கர்ப்பப்பை வாய் புற்றுநோயின் நிலைகளை கண்டறிய முடியும்.
- ❖ கர்ப்பப்பை வாய் புற்றுநோயின் பரிசோதனைகளை விவரிக்க முடியும்.
- ❖ கர்ப்பப்பை வாய் புற்றுநோயின் அறுவை சிகிச்சை முறைகளை விளக்க முடியும்.
- ❖ கர்ப்பப்பை வாய் புற்றுநோயிக்கான தடுப்பு முறைகளை விவரிக்க முடியும்.

கர்ப்பப்பை வாய் புற்றுநோய்

முன்னுரை :-

கர்ப்பப்பை வாய் புற்றுநோய் நடுத்தரவயது உடையவர்களுக்கு வருகிறது. அதிகமாக 50 வயதிற்கு உட்பட்டவர்களுக்கு வருகிறது. குறைவாக 20 வயதிற்கு உட்பட்டவர்களுக்கு வருகிறது. தற்போது 1,00,000 பேர்களுக்கு கர்ப்பப்பை வாய் புற்று நோய் வருவதாக கணக்கு எடுக்கப்பட்டிருக்கிறது.

பெண்ணின் இனப்பெருக்க உறுப்பு வடிவமைப்பு :-

பெண்ணின் இனப்பெருக்க உறுப்பு உட்தோற்றம் என்றும் வெளிப்புற தோற்றம் என்று இரண்டு பிரிவுகளாக பிரிக்கப்பட்டுள்ளது.

வெளிப்புற தோற்றம் :-

வெளிப்புறத் தோற்றம் வல்வா லேபியா மெஜோரா லேபியா மைனோரா என்ற பகுதி களை கொண்டது. லேபியா மைனோரா வின் மேல் பகுதியில் கிளிண்டோரிஸ் என்ற உணர்ச்சி உறுப்பு உள்ளது. திசு தாரையும் சிறுநீர் பாதையும் கீழ்ப்பகுதியில் உள்ளது

உட்புற தோற்றம் :-

உட்புற தோற்றம் கர்ப்பப்பை, கருமுட்டைப்பை, கருப்பப்பை குழாயை கொண்டது.

கர்ப்பப்பை :-

முத்து போன்ற வடிவம் கொண்ட கர்ப்பப்பை 7.5 cm நீளம் 5 cm அகலம் கொண்டது. அதை சுற்றியுள்ள சுவர் போன்ற பகுதி 1.25 cm முதல் 1.5 அங்குலம் ஆளைப் பொருத்து கர்ப்பப்பை அளவு வேறுபடும். கர்ப்பப்பை இரண்டு பகுதிகளை உள்ளடக்கியது. கீழ்ப்பகுதியான கருப்பப்பை வாய் கர்ப்பப்பையின் கழுத்துப்பகுதியில் அமைந்துள்ளது. குறுகலாக இருக்கும் கீழ்ப்பகுதி இது கீழே சிசுத்தாரைக்குள் நீட்டிக் கொண்டிருக்கும். உடற்பகுதி பெரிடோனியம் எனும் வெளிப்பக்கச் சுவரால் ஆனது. அண்டபை அல்லது கருமுட்டை பையில் மாதவிலக்கு நடைபெறுவதற்கு தேவையான சுரப்பிகள் உள்ளது. 28 நாட்கள் சரியான மாதவிலக்கு இடைவெளி ஆகும்.

புற்றுநோய் :-

அசாதாரண செல்களின் வளர்ச்சி அதிகமாவதால் திசுக்களின் எண்ணிக்கையும் அதிகமாகிறது. இதனால் இறுதி நிலையில் புற்றுநோய் செல்கள் மற்ற இடங்களுக்கும் பரவுகிறது.

வரலாறு :-

புற்றுநோய் யாருக்கு வேண்டுமானாலும் எந்த வயதிலும் வர வாய்ப்பு உள்ளது. அதில் கர்ப்பப்பைவாய் புற்றுநோய் பெண்களை அதிகமாக தாக்குகிறது. கர்ப்பப்பை வாய் புற்றுநோய் ஒரு நிலையில் இருந்து உடலின் மற்ற பகுதிகளுக்கும் பரவக்கூடிய தன்மை உடையது. பரவும் நிலைக்கு முன்பு

8 வருடத்திற்கு அதே நிலையில் இருக்கக்கூடிய தன்மையைக் கொண்டது. நிணநீர் முடிச்சுகளாலும், இடுப்பு கூடி பகுதிகளாலும் பரவக் கூடிய தன்மையைக் கொண்டது.

சாதாரண எபித்திலியம் \longleftrightarrow புற்றுநோய்செல்களின் வளர்ச்சி இடம் மாறுதல் \longleftrightarrow புற்றுநோய் செல்கள் இருந்த இடத்தில் இருத்தல் \longleftrightarrow ஊடுருவி செல்தல்

குறிப்புரை :-

கர்ப்பப்பையின் வாயில் திரவ நிலையில் காணப்படும் பரவக்கூடிய ஒரு கட்டி போன்ற அமைப்பு.

பரவக்கூடிய காரணி :-

வைரஸ் என்ற கிருமி இதற்கு அடிப்படை காரணமாக உள்ளது.

காரணிகள் :-

1) வயது:-

அதிகமாக 50 வயதிற்கும் குறைவான பெண்களுக்கு வர வாய்ப்புள்ளது.

2) பிறப்புறுப்பில் புண் :-

இது ஒரு முக்கியமான காரணியாகும்.

3) திருமணநிலை :-

விவாகரத்து ஆன பெண்களுக்கும், கணவனை இழந்த பெண்களுக்கும், அதிகமாக உடலுறவு கொள்ளும் பெண்களுக்கும் வரவாய்ப்புள்ளது.

4) இள வயது திருமணம் :-

இளவயது திருமணம், இள வளது உடலுறவு, இளவயது பிள்ளைப் பேறு, அடிக்கடி மகப்பேறு, கர்ப்பப்பை வாய் புற்றுநோய் வருவதற்கு வாய்ப்புள்ளது.

5) கருத்தடை மாத்திரை :-

கருத்தடை மாத்திரைக்கும், கர்ப்பப்பை வாய் புற்றுநோய்க்கும் தொடர்பு உள்ளது. உலக நல அமைப்பு அடிக்கடி கருத்தடை மாத்திரை பயன்படுத்தினால் கர்ப்பப்பை வாய் புற்றுநோய் வரும் என்பதை கண்டுபிடித்துள்ளது.

6) குறைந்த பொருளாதாரம் நிலை:-

கர்ப்பப்பை வாய் புற்றுநோய் அதிகமாக குறைந்த பொருளாதார நிலையில் உள்ள பெண்களுக்கு ஏற்படுகிறது.

- ❖ உடலுறவு பலருடன் உடலுறவு வைத்துக்கொள்ளுதல்
- ❖ ஹச்.ஐ.வி
- ❖ புகைபிடித்தல்
- ❖ வைரஸ்
- ❖ உணவு பற்றாக்குறை

7) அறிகுறிகள் :-

ஆரம்ப நிலையில் எந்த அறிகுறியும் காணப்படுவதில்லை.

- ❖ திசுத்தாரையில் இரத்த போக்கு
- ❖ திசுத்தாரையில் கட்டி காணப்படுதல்
- ❖ உடலுறவிற்கு பின்பு இரத்த போக்கு ஏற்படுதல்

இறுதிநிலையில் வயிற்றுப் பகுதிக்கும், நுரையீரலுக்கும் பரவுகிறது.

- ❖ பசியின்மை
- ❖ எடைகுறைவு
- ❖ மயக்கம் வருதல்
- ❖ இடுப்புக்கூடு வலி
- ❖ முதுகு வலி
- ❖ கால் வலி
- ❖ அதிக இரத்தப் போக்கு
- ❖ வெள்ளைப்படுதல்
- ❖ மாதவிலக்கு இடையில் இரத்த போக்கு
- ❖ உடலுறவிற்கு பின்பு இரத்த போக்கு

நிலைகள் :-

1) நிலை 0 :-

அசாதாரண நிலை செல்கள் கருப்பையின் எபிதீலிய செல்களில் காணப்படுகிறது.

2) நிலை I :-

அசாதாரண நிலை செல்கள் கருப்பையின் பகுதியில் காணப்படுகிறது. அது ஆறு நிலையில் அதன் அளவினைப் பொறுத்து காணப்படுகிறது.

3) நிலை II :-

அசாதாரண நிலை செல்கள் இடுப்பு பகுதியில் காணப்படுகிறது. 3ல் 2 பங்கு பிறப்பு உறுப்பில் காணப்படுகிறது. நிலை I, II ன் பரிசோதனை கதிரியக்கம், கர்ப்பப்பையை சுற்றியுள்ள பகுதிகளை எடுத்தல்.

3) நிலை III :-

அசாதாரண நிலை செல்கள் இடுப்பு பகுதியில் முழுவதுமாக காணப்படுகிறது. கீழ்ப்பகுதியில் 3ல் 1 பங்கு பகுதியின் பிறப்பு உறுப்பில் காணப்படுகிறது.

3) நிலை IV :-

அசாதாரண நிலை செல்கள் மற்ற உடல் பகுதிக்கும் சிறுநீர்ப்பை, மலப்புழை வழியாக பரவுகிறது.

பரிசோதனை :-

முதல் நிலை பரிசோதனை :-

முதல் நிலை கர்ப்பப்பை வாய் புற்று நோயில் இடுப்பு கூடு பரிசோதனை மற்றும் பாப் பரிசோதனை தொடர்ச்சியாக காணப்படுகிறது.

பாப் பரிசோதனை ஒரு சில நிமிடங்களில் செய்யப்படுகிறது. இது ஒருவலி இல்லாத செய்முறை. இந்த பரிசோதனை மருத்துவரின் மூலமாக செய்யப்படுகிறது. இந்த பரிசோதனையை நுண்ணோக்கியின் மூலமாக கண்டறிந்து பஞ்ச குச்சியின் மூலமாக கருப்பப்பையிலிருந்து கருப்பப்பை வாய் வரை செல்களை வழித்து எடுக்கப்படுகிறது.

எல்லா நடுத்தர வயது பெண்களும் ஒவ்வொரு ஐந்து வருடத்திற்கும் ஒரு முறை பரிசோதனை செய்து கொள்ள வேண்டும். இரத்த போக்கு அதிகமாக இருந்தால் மகப்பேறு மருத்துவரை அணுகவும்.

1) அயோடின் பரிசோதனை :-

சாதாரண செல்கள் அயோடின் கரைசலை ஊற்றினால் அது காப்பி கலராக படையும். அசாதாரண செல்கள் அயோடின் கரைசலை படயாது.

2) அசிட்டிக் அமில பரிசோதனை :-

வினிகர் கரைசலை பஞ்சுகளில் நனைத்து கர்ப்பப்பை வாயிலும், திசு தாரையிலும் ஊற்ற வேண்டும். அசாதாரண செல்கள் இருந்தால் வெள்ளை கலராக தெரியும்.

இறுதி பரிசோதனை :-

- மின்சாரம் மூலமாக பரிசோதனை செய்யப்படுகிறது.
- கர்ப்பப்பையின் வாயில் உள்ள திசுக்களை சுரண்டி எடுத்து பரிசோதித்தல்.
- எண்டோ கர்ப்பப்பை சுரண்டி எடுத்து பரிசோதனை செய்தல்
- கோன் பயாப்சி மூலம் முக்கோண வடிவத்தில் ஒரு திசுக்களை எடுத்து பரிசோத்தல்
- சர்விக்கல் பயாப்சி இது ஒரு உறுதி பரிசோதனை ஆகும்.

முதல் நிலை பரிசோதனை :-

- ஐஸ் கட்டிகளை அசாதாரண செல்களின் மேல் பயன்படுத்துதல்.
- மின்சாரம் மூலமாக செலுத்தி அசாதாரண செல்களை அழித்தல்.
- கார்பன் - டை - மோனாக்சைடை லேசர் மூலமாக செலுத்தி பரிசோதித்தல்.

இறுதி நிலை அறுவை சிகிச்சை :-

அ) கர்ப்பப்பையை எடுத்தல் :-

அறுவை சிகிச்சை மூலமாக கர்ப்பப்பை, கர்ப்பப்பை வாய் சில நேரங்களில் கர்ப்பப்பை குழாய்யை நீக்குதல்.

ஆ) வயிற்றின் வழியாக கர்ப்பப்பையை எடுத்தல் :-

- வயிற்றின் கீழ்பகுதியை கிழித்து இரத்த குழாயை முடித்து போட்டு கர்ப்பப்பையை எடுத்தல்.
- லோபராஸ்கோப் மூலம் சிசுதாரை வழியாக கர்ப்பப்பை எடுத்தல்.
- லோபராஸ்கோப் மூலமாக தொப்புளுக்கு பக்கமாக கிழித்து டெலிஸ்கோப்பை உள்ளே செலுத்தி பகுதிகளை நன்கு ஆய்ந்த பிறகு வயிற்று பகுதியில் காற்றை செலுத்தி கர்ப்பப்பையை எடுத்தல் எளிமையான முறையில் கர்ப்பப்பையை எடுப்பதற்கு இது வழி முறையாகும்.

சிசுதாரை வழியாக கர்ப்பப்பையை எடுத்தல் :-

கர்ப்பப்பை மற்றும் கர்ப்பப்பை வாய் சிசுதாரை வழியாக கர்ப்பப்பையை எடுத்தல்.

முடிவுரை :-

முதல் நிலை மற்றும் இரண்டாம் நிலை தடுப்பு முறை மூலம் கர்ப்பப்பை வாய் புற்றுநோய் தடுக்கலாம். இள வயதில் தடுப்பு மருந்து மூலம் கர்ப்பப்பை வாய் புற்று நோயை வராமல் தடுக்கலாம்.

APPENDIX - H

DEMOGRAPHIC DATA:

PART - I

SECTION - A

Code No .	<input type="checkbox"/>
1. Age	
a) 30 - 35 yrs	<input type="checkbox"/>
b) 36 -40 yrs	<input type="checkbox"/>
c) 41 - 45 yrs	<input type="checkbox"/>
d) 46 - 50 yrs	<input type="checkbox"/>
2. Education	
a) No formal education	<input type="checkbox"/>
b) Primary Education	<input type="checkbox"/>
c) Secondary Education	<input type="checkbox"/>
d) Higher Education	<input type="checkbox"/>
e) graduate	<input type="checkbox"/>
3. Occupation of the women	
a) Coolie	<input type="checkbox"/>
b) House wife	<input type="checkbox"/>
c) Farmer	<input type="checkbox"/>
d) Other	<input type="checkbox"/>
4. Family income	
a) Rs 1000 -1500/-	<input type="checkbox"/>
b) Rs 1501-2000/-	<input type="checkbox"/>
c) Rs 2001-2500 /-	<input type="checkbox"/>
d) Above 2500 Rs	<input type="checkbox"/>

5. Religion
- a) Hindu
 - b) Christian
 - c) Muslim
6. Type of Family
- a) Joint family
 - b) Nuclear family
7. Marital status
- a) Married
 - b) Un married
 - c) Widow
 - d) Divorce
8. Number of children
- a) No child
 - b) 01
 - c) 02
 - d) 03 and above
9. Source of health information
- a) Radio programs
 - b) Television programs
 - c) News paper/ magazines/ books
 - d) Family members/ relatives/ friends
 - e) Health personnel

PART - II
STRUCTURED INTERVIEW SCEDULE

1. What are the internal parts of the female reproductive system?
 - a) Uterus, ovaries and fallopian tubes
 - b) Kidney, Uterus and bladder
 - c) Abdomen, liver, and pancreas
 - d) Colon, rectum and Stomach

2. Where is cervix situated?
 - a) part of the ovary
 - b) Part of the colon
 - c) Lower most part of the uterus
 - d) Part of the vagina

3. What is the normal duration of menstrual cycle?
 - a) Once in 28 days
 - b) Once in 45 days
 - c) Once in 60 days
 - d) Once in 15 days

4. What do you mean by cancer?
 - a) A communicable disease
 - b) A hereditary disease
 - c) An incurable disease
 - d) Abnormal growth of cells which will destroy cells

5. Who can get cancer?
 - a) Anybody at any age group
 - b) Only men
 - c) Only women
 - d) Only Children

6. What is the common cancer that affect females?

- a) ovarian cancer
- b) Cervical cancer
- c) bone cancer
- d) lung cancer

7. What is the causative agent that is associated with cervical cancer?

- a) Bacteria
- b) Virus
- c) Fungus
- d) Parasite

8. Which age group of cervical cancer is more common?

- a) 16-24 year
- b) 25-29year
- c) 30-50year
- d) above 50year

9. Which one of the following will increase the risk for cervical cancer?

- a) Obesity
- b) After tubectomy
- c)Using copper 'T'
- d) Repeated child bearing

10. Which one of the following is not a causative factor associated with cervical cancer?

- a) Early Sexual activity
- b)Consanguineous marriage
- c) Early marriage
- d) Multiple sexual partner

11. How will you identify the diseased cervix ?
- a) Vomiting blood
 - b) Blood in the stool
 - c) Abnormal vaginal bleeding
 - d) Blood in the urine
12. Which one of the following is not a common symptom of cervical cancer?
- a) Lump in the breast
 - b) Abnormal vaginal bleeding
 - c) Back ache
 - d) Weight loss
13. Which one of the following drugs can cause cervical cancer ?
- a) Oral contraceptive pills
 - b) Steroids
 - c) Thyroid hormones
 - d) Calcium tablets
14. How cervical cancer can be detected at an the early stage?
- a) Scanning
 - b) Acetic acid colposcopy
 - c) Blood test
 - d) Urine test
15. How cervical cancer can be detected at later stage ?
- a) History collection
 - b) Physical examination
 - c) Loop electric surgical excision procedure
 - d) X - ray

16. Who require pap smear test?
- a) Only married women
 - b) Only women at risk
 - c) Only menopausal women
 - d) All women after 35 years of age
17. What is the time taken to do a pap smear test?
- a) Less than 5 min
 - b) Less than 10 min
 - c) Less than 15 min
 - d) Less than 20 min
18. From where do you seek the pap test?
- a) Private clinics
 - b) Maternity hospitals
 - c) Sub centers
 - d) Primary health center
19. How often pap smear test to be done?
- a) Only once in a life time
 - b) Once in ten years
 - c) Once in five years
 - d) Once in four years
20. What measures will you take when you notice abnormal vaginal bleeding ?
- a) Take home remedies
 - b) Go for prayers
 - c) Go to hospital
 - d) Visit traditional healers

21. How the diagnosis of cervical cancer will be confirmed?
- a) Endoscopy
 - b) Laparoscopy
 - c) Cervical Biopsy
 - d) Abdominal scan
22. What is the treatment for early stage cervical cancer?
- a) Hysterectomy
 - b) Cryotherapy
 - c) Tubectomy
 - d) Radiation therapy
23. What is the treatment for Stage I and II Stage of cervical cancer?
- a) Removal of uterus, ovaries.
 - b) Partial removal of uterus
 - c) Dilation and curettage
 - d) Only radiation therapy
24. Which one of the following is not useful in prevention of cervical cancer?
- a) Avoid multiple sexual partners
 - b) Regular exercise
 - c) Avoid early coitus
 - d) Regular pap test
25. Which one of the following is a measure to control cervical cancer?
- a) Sterilization
 - b) Oral contraceptive pills
 - c) Timely treatment
 - d) Dietary restrictions

PART - III

Attitude scale (5 point likert scale)

Sl. No	Item	Strongly agree	Agree	Uncertain	Strongly Disagree	Disagree
1.	Cervical cancer is the curse of god					
2.	Cervical cancer can be cured by performing religious rites.					
3.	Multiple sexual partners is risk for cervical cancer					
4.	Early sexual coitus is unsafe					
5.	Treatment of cervical cancer is very expensive					
6.	Cervical cancer can spread to bladder and rectum					
7.	Cervical cancer is a hereditary disease					
8.	Cervical cancer women are need to be isolated					
9.	Cervical cancer is not a shameful disease					
10	Every sexually active women should undergo pap test regularly					

சுய மதிப்பீடு
வரையறுக்கப்பட்ட நேர்காணல் அட்டவணை

பகுதி - அ

சமுதாய குடும்ப காரணிகள்

கீழ்க்காணும் கேள்விகளை வாசித்து சரியானவற்றிற்கு நேரே கொடுக்க
பட்டுள்ள கட்டத்தில் (டிக்) செய்யவும்

எண்:

1. வயது

அ) 30-35 வயது

ஆ) 36-40 வயது

இ) 41-45 வயது

ஈ) 46-50 வயது

2. கல்வி

அ) கல்வியறிவற்றவர்கள்

ஆ) ஆரம்ப நிலை கல்வி பயின்றவர்கள்.

இ) உயர்நிலைக்கல்வி பயின்றவர்கள்

ஈ) மேல்நிலை கல்வி பயின்றவர்கள்

உ) பட்டப்படிப்பு பயின்றவர்கள்

3. பெண்களின் உத்யோகம்

அ) கூலி

ஆ) இல்லத்தரசி

இ) விவசாயி

ஈ) மற்றவை

4. குடும்ப வருமானம்

அ) ரூ.1,000 - 1,500/-

ஆ) ரூ.1,501 - 2,000/-

இ) ரூ. 2,001- 2,500/-

ஈ) ரூ. 2,500/-க்கு மேல்

5. மதம்

- அ) இந்து
- ஆ) கிறிஸ்துவம்
- இ) முஸ்லீம்

6. குடும்ப விதம்

- அ) கூட்டுக்குடும்பம்
- ஆ) தனிக்குடும்பம்

7. திருமணத்தகுதி

- அ) திருமணமானவர்கள்
- ஆ) திருமணமாகாதவர்கள்
- இ) விதவை
- ஈ) விவாகரத்து பெற்றவர்கள்

8. குழந்தைகள் எண்ணிக்கை

- அ) குழந்தை இல்லை
- ஆ) 1
- இ) 2
- ஈ) 3 அல்லது அதற்கு மேல்

9. சுகாதாரம் பற்றிய தகவல்கள் அறிய

- அ) வானொலி நிகழ்ச்சிகள்
- ஆ) தொலைக்காட்சி நிகழ்ச்சிகள்
- இ) செய்தித்தாள், புத்தகங்கள், பத்திரிகைகள்
- ஈ) குடும்ப உறுப்பினர்கள் , உறவினர்கள் , நண்பர்கள்
- உ) சுகாதார அலுவலர்கள்

வரையறுக்கப்பட்ட நோக்காணல்

பகுதி-ஆ

அறிவுத்திறன் அட்டவணை

1. பெண்களின் இனப்பெருக்க உள்நூறுப்புகள் யாவை?

- அ) கர்ப்பப்பை , கருமுட்டைப் பை , கருப்பை குழாய்
- ஆ) சிறுநீரகம், கர்ப்பப்பை , சீறுநீர்ப்பை,
- இ) வயிறு, கல்லீரல், கணையம்
- ஈ) மலக்குடல், மலப்புழை, இரைப்பை.

2. கருப்பப்பை வாய் எங்கு அமைந்துள்ளது

- அ) கருமுட்டைப் பகுதி
- ஆ) மலக்குடல் பகுதி
- இ) கர்ப்பப்பையின் அடியில்
- ஈ) பிறப்புறுப்பு பகுதி

3. மாதவிடாய் இடைவெளி என்ன?

- அ) 28 நாட்களுக்கு ஒரு முறை
- ஆ) 45 நாட்களுக்கு ஒரு முறை
- இ) 60 நாட்களுக்கு ஒரு முறை
- ஈ) 15 நாட்களுக்கு ஒரு முறை

4. புற்றுநோய் என்றால் என்ன?

- அ) ஒரு தொற்று வியாதி
- ஆ) ஒரு பரம்பரை வியாதி
- இ) ஒரு குணப்படுத்த முடியாத நோய்
- ஈ) செல்களை அழிக்க செல்களே அதிக வளர்ச்சி பெறுதல்

5. புற்றுநோய் யாருக்கு வரும்?

- அ) எந்த வயதிலும் யாருக்கு வேண்டுமானாலும்
- ஆ) ஆண்களுக்கு மட்டும்
- இ) பெண்களுக்கு மட்டும்
- ஈ) குழந்தைகளுக்கு மட்டும்

6. பெண்களை அதிகமாகத் தாக்கும் புற்றுநோய் எது?

- அ) கருமுட்டை எருவாகும் இடத்தில் வரும் புற்றுநோய்
- ஆ) கருப்ப்பை வாய் புற்றுநோய்
- இ) எலும்பு புற்றுநோய்
- ஈ) நுரையீரல் புற்றுநோய்

7. கர்ப்பப்பை வாய்புற்றுநோய் பரப்பும் கிருமி எது?

- அ) பாக்டீரியா
- ஆ) வைரஸ்
- இ) பூஞ்சைக்காளான்
- ஈ) நுண்ணுயிரிகள்

8. கர்ப்பப்பை வாய்புற்றுநோய் அதிகம் தாக்கப்படும் வயது எது?

- அ) 16-24 வயது
- ஆ) 25-29 வயது
- இ) 30-50 வயது
- ஈ) 50 வயதுக்கு மேல்

9. கீழ்க்கண்டவற்றுள் எவை கர்ப்பப்பை வாய்புற்றுநோய்க்கான வாய்ப்புக்கு காரணமாகிறது?

- அ) உடல்பருமன்
- ஆ) கருத்தடை அறுவை சிகிச்சைக்குப் பிறகு
- இ) காப்பர் டி
- ஈ) தொடர்ச்சியான குழந்தைப் பேறு

10. கீழ்க்கண்டவற்றுள் கர்ப்பப்பை வாய்புற்றுநோய் ஏற்படக் காரணி அல்லாதது எது?

- அ) முன்கூட்டியே உடலுறவு கொள்ளுதல்
- ஆ) உறவு முறையில் திருமணம்
- இ) இளம் வயதில் திருமணம்
- ஈ) பலருடன் உடலுறவு கொள்ளுதல்

11) கர்ப்பப்பை வாய்புற்றுநோயை எப்படி கண்டறிய முடியும்?

அ) இரத்த வாந்தி,

ஆ) இரத்தம் கலந்த மலம்

இ) பிறப்பிறப்பில் அதிக இரத்த போக்கு

ஈ) சிறுநீரில் இரத்த கசிவு

12) பின்வருவனவற்றுள் கர்ப்பப்பை வாய்புற்றுநோயின் அறிகுறிகள்

அல்லாதது எது?

அ) மார்பகத்தில் கட்டி

ஆ) அதிக இரத்தப் போக்கு

இ) முதுகுவலி

ஈ) எடை குறைதல்

13) கீழ்க்கண்டவற்றுள் எந்த மருந்து வகை கர்ப்பப்பை வாய்புற்றுநோய்

வாய்ப்பை அதிகரிக்கிறது?

அ) கருத்தடை மாத்திரை

ஆ) ஸ்டிராய்ட்ஸ்

இ) தைராய்டு ஹார்மோன்

ஈ) கால்சியம் மாத்திரைகள்

14) தொடக்க நிலையில் கர்ப்பப்பைவாய் புற்றுநோயை எவ்வாறு

கண்டுபிடிக்கலாம்?

அ) ஸ்கேன் செய்து பார்த்தல்

ஆ) அசிடிக் அமில சோதனை

இ) இரத்தப் பரிசோதனை

ஈ) சீறுநீரக பரிசோதனை

15) இறுதி நிலையில் கர்ப்ப்பை வாய்புற்றுநோய் கண்டறியும் பரிசோதனை எது?

அ) குடும்ப விவர பட்டியலை சேகரித்தல்

ஆ) உடல் பரிசோதனை

இ) லீப் முறையில் கர்ப்ப்பை வாயிலிருந்து திசுக்களை எடுத்து பரிசோதித்தல்

ஈ) எக்ஸ்ரே

16) யாருக்கு பாப் ஸ்மியர் பரிசோதனை அவசியம்?

அ) திருமணமான பெண்களுக்கு மட்டும்

ஆ) கர்ப்ப்பை வாய் புற்றுநோய் வாய்ப்புகள் அதிகம் உள்ள பெண்களுக்கு மட்டும்

இ) மாதவிடாய் சுழற்சி நின்ற பெண்களுக்கு மட்டும்

ஈ) 35 வயதுக்கு மேற்பட்ட பெண்களுக்கு மட்டும்

17) பாப் ஸ்மியர் பரிசோதனையை ஒரு முறை பரிசோதிக்க ஆகும் நேரம் எவ்வளவு?

அ) 5 நிமிடங்களுக்கும் குறைவு

ஆ) 10 நிமிடங்களுக்கும் குறைவு

இ) 15 நிமிடங்களுக்கும் குறைவு

ஈ) 20 நிமிடங்களுக்கும் குறைவு

18) கர்ப்ப்பை வாய்புற்றுநோய் பரிசோதனை எங்கு செய்யலாம்?

அ) தாலுகா மருத்துவமனையில்

ஆ) மகப்பேரு மருத்துவமனையில்

இ) துணை சுகாதார மையங்களில்

ஈ) ஆரம்ப சுகாதார நிலையம்

19) எவ்வளவு கால இடைவெளியில் கர்ப்பப்பை வாய்புற்றுநோய் பரிசோதனை செய்யலாம்?

அ) வாழ்நாளில் ஒருமுறை

ஆ) பத்து ஆண்டுகளுக்கு ஒரு முறை

இ) ஐந்து ஆண்டுகளுக்கு ஒரு முறை

ஈ) நான்கு ஆண்டுகளுக்கு ஒரு முறை

20) கர்ப்பப்பை வாய்புற்றுநோய் அறிகுறி கண்டறிதால் நீங்கள் என்ன செய்வீர்கள்?

அ) வீட்டிலேயே மருத்துவ சிகிச்சை பெறுதல்

ஆ) இறைவழிபாடுகள் செய்தல்

இ) மருத்துவமனைக்கு செல்லுதல்

ஈ) பழையமையான மருத்துவ முறைகளை அணுகுதல்

21) எந்த பரிசோதனை மூலம் கர்ப்பப்பை வாய்புற்றுநோய் உறுதி செய்யப்படுகிறது?

அ) எண்டோஸ்கோப்

ஆ) லேப்ராஸ்கோப்

இ) கர்ப்பப்பை வாயில் திசுக்களை எடுத்தல்

ஈ) ஸ்கேன்

22) கர்ப்பப்பை வாய்புற்றுநோயின் தொடக்க நிலை சிகிச்சை என்ன?

அ) கர்ப்பப்பையில் எடுத்தல்

ஆ) கர்ப்பப்பை வாயில் அதிக குளிர்ச்சியை ஏற்படுத்துதல்

இ) கருத்தடை சிகிச்சை முறை

ஈ) கதிரியக்க சிகிச்சை முறை

23) இறுதிநிலை கர்ப்பப்பை வாய்புற்றுநோயக்கான சிகிச்சை முறை என்ன?

அ) கர்ப்பப்பை வாய், கருமுட்டை பையை நீக்குதல்

ஆ) கர்ப்பபையின் பாதியை மட்டும் நீக்குதல்

இ) கருக்கலைப்பு

ஈ) கதிரியக்க சிகிச்சை மட்டும்

24) பின்வருவனவற்றுள் கர்ப்பப்பை வாய்புற்றுநோயைத் தடுக்க எடுக்க

வேண்டிய நடவடிக்கைகள் அல்லாதது எது?

அ) பலருடன் உடலுறவு கொள்ளாததை தடுத்தல்

ஆ) ஒழுங்கான உடற்பயிற்சி

இ) திருமணத்திற்கு முன் உடலுறவை தவிர்த்தல்

ஈ) முறையான பாப் ஸ்மியர் பரிசோதனை மேற்கொள்ளாதல்

25) பின்வருவனவற்றுள் எது கர்ப்பப்பை வாய்புற்றுநோயை கட்டுப்படுத்தும்?

அ) குடும்ப கட்டுப்பாடு முறை

ஆ) கருத்தடை மாத்திரை உபயோகப்படுத்துதல்

இ) சரியான நேரத்தில் மருத்துவம்

ஈ) உணவு கட்டுப்பாடு முறை

பகுதி - இ

மனப்பான்மை திறனாய்வு கேள்விகள்

வ. எண்	பொருள்	முற்றிலும் ஒப்புக் கொள்கிறேன்	ஒப்புக் கொள்கிறேன்	கருத்துகள் இல்லாமல்	கொள்ளவில்லை	கடுமையாக எதிர்க்கிறேன்.
1.	கர்ப்பப்பை வாய்புற்றுநோய் கடவுளின் தண்டனை					
2.	மதப்பூஜைகளால் கர்ப்பப்பை வாய்புற்றுநோயைக் குணப்படுத்தலாம்					
3.	பலருடன் உடலுறவு கொள்ளுதல், கர்ப்பப்பை வாய்புற்றுநோய் வருவதற்கு வழிவகுக்கும்					
4.	இளம் வயதிலேயே உடலுறவு கொள்ளுதல் பாதுகாப்பானது அல்ல					
5.	புற்றுநோய்க்கு மருத்துவச் செலவு அதிகமாகும்					
6.	கர்ப்பப்பை வாய்புற்று நோய் சிறுநீர் பைக்கும், மலப்புழைக்கும், பரவுகிறது.					
7.	கர்ப்பப்பை வாய்புற்று நோய் ஒரு பரம்பரையாக வியாதி					
8.	கர்ப்பப்பை வாய்புற்று நோய் ஒரு தொற்று வியாதி					
9.	கர்ப்பப்பை வாய்புற்று நோய் ஒரு அவமானப்படும் நோய் அல்ல.					
10.	உடலுறவில் விருப்பம் கொள்ளும் பெண்கள் கர்ப்பப்பை வாய்புற்று நோய் பரிசோதனை செய்து கொள்ள வேண்டும்					

APPENDIX - I

PART - II

KNOWLEDGE SCORING REGARDING CERVICAL CANCER

Questions	OPTIONS			
S. No	a	b	c	d
1.	1	0	0	0
2.	0	0	1	0
3.	1	0	0	0
4.	0	0	0	1
5.	1	0	0	0
6.	0	1	0	0
7.	0	1	0	0
8.	0	0	1	0
9.	0	0	0	1
10.	0	1	0	0
11.	0	0	1	0
12.	1	0	0	0
13.	1	0	0	0
14.	0	1	0	0
15.	0	0	1	0
16.	0	1	0	0
17.	1	0	0	0
18.	0	1	0	0
19.	0	0	1	0
20.	0	0	1	0
21.	0	0	1	0
22.	0	1	0	0
23.	1	0	0	0
24.	0	1	0	0
25.	0	0	1	0

PART - III

**5-POINT LIKERT' S SCALE SCORING REGARDING CERVICAL
CANCER**

Q. No	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
1.	1	2	3	4	5
2.	1	2	3	4	5
3.	5	4	3	2	1
4.	5	4	3	2	1
5.	5	4	3	2	1
6.	5	4	3	2	1
7.	1	2	3	4	5
8.	1	2	3	4	5
9.	5	4	3	2	1
10.	5	4	3	2	1