

PERCEPTIONS AND PRACTICES OF STROKE PREVENTION AMONG HEALTHCARE WORKERS IN A NIGERIAN HOSPITAL

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Abstract

Introduction:

Stroke is increasingly a problem of public health significance globally. It is a major cause of disability and mortality. Healthcare professionals must have a good attitude, sufficient knowledge, and practice of stroke prevention to reduce the burden of the disease.

Methods:

This study utilized a cross-sectional design among 200 Healthcare workers in the Federal Medical Centre, Asaba, Nigeria, selected by systematic sampling technique. A semi-structured questionnaire was used to collect data on the research variables. Data were analyzed using the IBM SPSS version 25 statistical package.

Results:

A total of 200 Healthcare workers participated in the study. About 77% and 84% of respondents have good aggregate attitudes and knowledge towards stroke prevention respectively. This did not influence their poor practice (54%) of stroke prevention. There was a significant association ($p < 0.0001$) of good knowledge of stroke by Clinical Healthcare workers [Chi-squares = 27.1, 95%CI = (0.029-0.256)] when compared with non-clinical healthcare workers. This is in contrast with their poor practice of stroke prevention (Chi-squares = 3.570, $p = 0.02$, 95%CI (0.321-1.023)). However, there was no significant association ($p = 0.423$) between the good attitude toward stroke prevention by the Clinical Health care workers [Chi-square = 0.130, 95%CI = (0.458-1.713)], when compared with Non-Clinical Health care workers.

Conclusion: It is possible to improve the practice of stroke prevention by encouraging health educational programs on Knowledge and behavior-changing strategies towards stroke prevention. Amidst vaccine safety hesitancy risks, this analysis applies CREAC method to interpret Ghana's Food and Drugs Law 1992 (PNDCL 305B) establishing regulation alongside Public Health Act 2012 (Act 851) enabling compulsion, evaluating policy levers balancing access assurance and outbreak response efficacy with dissent and rights protections. Key amendments and guidance recommended affirm nuanced applications upholding exemption and exclusion fairness amidst necessity, minimizing restrictions through transparent and accountable procedures. Significantly, codifying posterity considerations builds trust in oversight systems with Phase IV post-market surveillance while proactive rights jurisprudence presses judicious state action – fostering adoption not resistance.

Keywords: Attitude, knowledge, practice, stroke, prevention

Introduction

Cardiovascular diseases are a group of disorders believed as the main cause of mortality and the major contributor to disability globally¹. Heart and blood vessel conditions are the main parts of cardiovascular disease, including

stroke, coronary heart disease, and other disorders that adversely influence global and public health². Stroke remains the second leading cause of death worldwide, with a documented 26% increase in stroke mortality in the last two decades, consisting of about 10% of all deaths and killing 5.5 million people each year, with 44 million disability-adjusted lifeyears (DALYs) lost^{3,4}. Stroke was the sixth most common cause of death in Africa in 2019, presenting a growing trend, according to WHO approximations⁵. Globally, the maximum age-standardized incidence of stroke is in sub-Saharan Africa⁶. According to the Centers for Disease Control and Prevention (CDC), stroke is the principal source of preventable disability globally⁷. It is the main reason for long-term disability and has likely a huge emotional and socioeconomic drain on patients, their families, and health services. These disabilities that result from the disease are recognized to have far-reaching implications on the health and quality of life of stroke survivors and their caregivers⁸. In Nigeria, stroke has been stated to be responsible for the bulk of medical admissions, with 30-day case fatality rates of 28 to 37% and functional disability rates of 60.9%^{7,8}. The Sustainable Development Goals (SDGs)⁹ 3 by 2030 aims to reduce by one-third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being, Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol. It also substantially increases health financing, the recruitment, expansion, re-training, and retaining of the health workforce in developing countries, least developed countries, and Small Island developing States. Universal health coverage included financial risk protection, access to quality essential healthcare services, and access to safe, effective, quality, affordable essential medicines and vaccines for all⁹.

Preventive approaches in sub-Saharan Africa are extremely necessary to lessen the burden of stroke and reduce disability and healthcare costs. Literature proposes that preventive care services in African countries, and data from developed countries suggest that a strong importance on prevention would be needed to reduce the burden of stroke¹⁰. From a public health point of view, preventive strategies to reduce the risk of stroke would provide more cross-cutting. It is likely that improvement in general knowledge (K) about stroke will help people recognize the signs or symptoms of stroke correctly and will add to other practical information about stroke and how to manage it. Also advising those at high risk to seek out knowledge (k) on stroke will consequently influence people on good attitudes (A) towards stroke prevention practices (p). Then, accepting a healthy lifestyle will contribute to changing the practice (P) of conventional management of stroke especially in sub-Saharan Africa^{11, 12}. Therefore, understanding what a stroke is would help young patients and their parents evaluate the causative factors and how to prevent it. It will also contribute to the execution of suitable health education policies.

In the study conducted among the rural population in Saudi Arabia, subjects with college degrees or above demonstrated a statistically significantly higher average score of attitudes towards stroke prevention than those with high school or below¹³. And those who were employed showed a significantly higher practice towards stroke prevention than the other occupations. They concluded that those results were expected as knowledge about stroke prevention increases with higher education and being employed⁸. Thus, attitudes and practices would be enhanced

with good knowledge. A possible explanation for these results might be that employed and educated people are either exposed to more educational programs or can easily access required resources.

There is a paucity of evidence on primary preventive strategies of stroke studies among Health Professionals. The present study will explore the Attitude regarding the Knowledge and practice of healthcare workers on preventive strategies of stroke and this will complement the body of knowledge and promote further research on Stroke prevention.

Methodology

This was a descriptive cross-sectional study conducted at Federal Medical Centre, Asaba¹⁴. The study participants were Health Care Workers; doctors, nurses, pharmacists, physiotherapists, radiographers, laboratory scientists, health attendants, Administrative staff, workers, and other Hospital workers. They were grouped into two for the study. Those who worked directly with the patients in the wards. They had responsibilities related to diagnosis and treatment. They were considered "Clinical Health Care workers" This represented the Doctors and the Nurses¹⁵. Those who did not work directly with the patients in the ward and had no responsibilities relating to diagnosis and treatment were considered "Non-clinical Health Care Workers". This represented others¹⁵.

The Health Care workers were sampled by using simple random sampling of systematic technique¹⁶. Purposive sampling of the non-probability method will be used in sharing the sample size. Doctors 290, Nurses 480, Pharmacists 52, physiotherapists 20, Radiographers 20, Lab science 44, Health attendants 50, and other non-clinical health workers 485, giving a total of 1441 Health care workers. The Inclusion criteria were:

- 1) Those who have been in the employment of Federal Medical Centre for not less than six months.
- 2) Those who were not in any way incapacitated.
- 3) Those who were willing to dispense information.
- 4) Those who gave consent and their confidentiality maintained. Those who did not give consent were excluded from the study.

3.5.1 SAMPLE SIZE CALCULATION

The sample was derived using Taro Yamane's formula¹⁷ for sample size determination.

$$N = \frac{1 + N(e^2)}{1 + N(e^2)}$$

Where e = level of precision = 0.05 N = population size = 335

n= sample size

$$\frac{N}{1+N(e^2)} =$$

$$= \frac{335}{1+335(0.0025)}$$

$$= \frac{335}{1+0.8375}$$

$$= \frac{335}{1.8375} = 182.31 \sim 182 + 10\% = 200.$$

Total= 200 which was the sample size

Systematic random sampling¹⁶ was used for each of the workgroups. The sampling interval was derived using the formula below: Sample interval = a Total number of health workers/Sample size. From the total list of healthcare workers in the different categories, a sampling ratio was calculated for each category giving an Nth number of 3, n=200 sample size

N=1441 Total number of healthcare workers

Sampling fraction

$$200/1441$$

$$N= 0.1388$$

Doctors 290x 0.1388 = 40.25 approximate 40

Nurses=480x 0.1388=66.62 Ω 67

Pharmacist 52x 0.1388=7.21 Ω 7

Physiotherapist 20x 0.1388=2.78 Ω 3

Radiographers 20x 0.1388=2.78 Ω 3

Lab science 44x 0.1388= 6.11 Ω 6

Health attendant=50x 0.1388=6.94 Ω 7

Contract staffs = 485x 0.1388= 67.32 Ω 67

1. Doctors – 290/40=7
2. Nurses-480/67=7
3. Pharmacist-52/7=7
4. Physiotherapist-20/3=7
5. Radiographers 20/3=7

6. Lab scientist 44/6=7
7. Health attendant 50/7=7
8. Other non-clinical staffs 485/67=7

Therefore every 7th Staff of the hospital in each category was recruited for the study until the total number was obtained.

DATA COLLECTION.

The study was conducted by using a semi-structured interviewer administered questionnaire^{13, 18, 19}. The questionnaire was developed with the help of reviewed literature in the empirical review of the study. It will consist of three parts :(1) Socio-demographic characteristics (age, gender, job designation, etc.), (2) Attitude of Health Care workers on Preventive Strategies of Stroke, symptoms or signs and its risk factors, (3) Knowledge of Health care workers on Preventive Strategies of stroke, symptoms or signs and its risk factors (4) Practice of Health care workers on Preventive Strategies of stroke, symptoms or signs and its risk factors. The nature and purpose of the study were explained to each respondent and informed and written consent was obtained. The duration of the study was one month

For the convenience of analyses, the total number of questions to assess Attitude and knowledge were (9) and (10) respectively. The total number of questions to assess Practice was (11), each correct response was scored one (1), and for each wrong response zero (0). The total scores for each respondent were converted to percentage scores and a score of > 50% was termed Good Attitude, knowledge, or Practice, and a score of < 50% was categorized as poor Attitude, knowledge, or Practice.

METHOD OF DATA ANALYSIS

Data was screened for completeness, entered, and analyzed using Statistical Package for Social Sciences (SPSS V. 25.0). Univariate analysis was carried out as quantitative variables were presented using percentages and frequencies. Aggregate scores were calculated on Attitude, knowledge, and practice to know if Attitude, knowledge, and practice were high or low. Bivariate analysis was carried out between the socio-demographic variables of attitude, knowledge, and practice, using chi-square and p-value to determine the level of significance (set at $P < 0.05$). **DURATION OF THE STUDY:** This study was carried out within a month.

ETHICAL ISSUES/CONSIDERATION

Ethical permission to conduct this research was obtained from the Research and Ethics Committee and the due processes in carrying out research in the hospital were maintained and no harm or discomfort to participants during the questionnaire distribution

Privacy: The privacy of the respondents was of utmost importance during the conduct of the research. The code of ethics was aimed at protecting the rights of the individuals who were used as subjects of the research. Respondents were not forced into participating in the research project.

Maintenance of confidentiality: the research subject names were withheld and information given was not divulged to other people but rather was treated with utmost secrecy and strictly for the research.

RESULTS

Socio-demographic characteristics of Respondents

We had a total number of 200 participants that met the inclusion criteria in our study. Their Ages ranged from 18 to 58 years (mean = 36.20 ± 10.60). The majority of respondents 144 (72%) were aged above 30 years, 113 (56.5%) the participants were female, 126 (63%) were married, had completed tertiary education 193 (97.5%), and practiced Christianity as a religion 193(96.5%) (Table 1). About 109(54.5%) of them were Clinical Healthcare workers (Figure 1).

Table1. Socio-demographic characteristics of the respondents

VARIABLE	FREQUENCY (N = 200)		PERCENTAGE 100%
Gender			
Male	87		43.5
Female	113		56.5
Age1 (years)			
<= 30	56	28	
>30	144		72
Age (in Years)			
<20	5		2.5
21-30	55		27.5
31-40	68		34
41-50	47		23.5
51-60	25		12.5
Marital Status			
Single	68		34

Married	126	63
Divorced	2	1
Widowed	4	2
Profession1		
Clinical Healthcare workers	109	54.5
Non-clinical Healthcare workers	91	45.5
Profession		
Medical doctor	40	20
Nurse	67	33.5
Pharmacist	7	3.5
Lab scientist	6	3
Radiographers	3	1.5
Physiotherapist	3	1.5
Health attendants	7	3.5
Other Non-clinical Health care workers	67	33.5
Education Level1		
Poorly Educated	7	3.5
Tertiary Educated	193	97.5
Educational Level		

No formal education	0	0
Primary education	3	1.5
Secondary education	4	2
Tertiary education	193	96.5

Religion		
Christianity	193	96.5
Muslim	3	1.5
Traditional	4	2

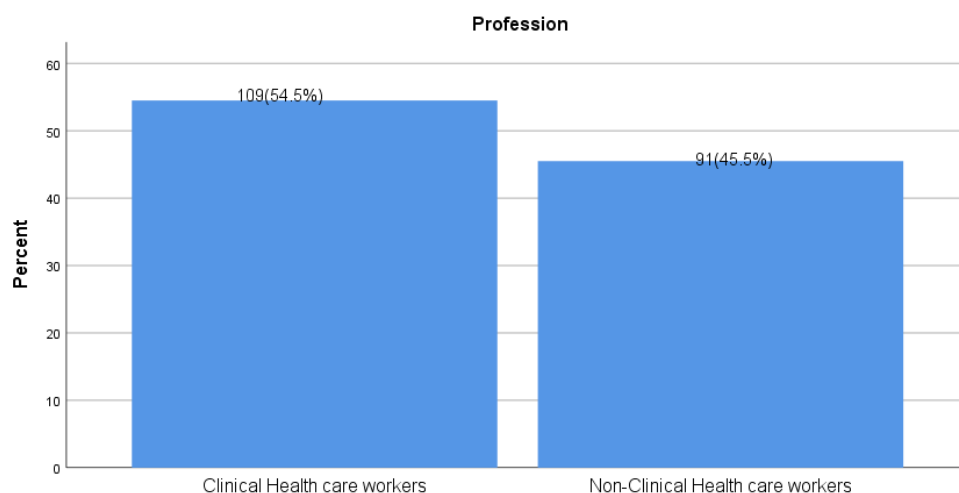


Fig1, Distribution of Healthcare workers

Respondents' attitude on stroke Prevention

Although, the majority, 154(77.0%) of the 200 respondents have good aggregate attitudes towards stroke prevention. About 92.5% agreed that stroke is preventable. Of the specific attitudes towards stroke prevention, the findings showed that most respondents (91.5%) strongly agreed that stroke is treated in the hospital by a neurologist (83%), however will still explore the spiritual churches (71%) for healing, followed by traditional medicine healers 69%, and disagreed that food supplements (32.5%) and chemist shops 41% are not the best

practice. However, more than ninety-six percent of the respondents believe that good family support enhances early recovery (Table 2).

Table2. Attitude of Respondents on Stroke and its Prevention

ATTITUDE	QUESTIONS	YES (%)	NO
(%)			
	Do you think people who have a stroke can live a happy life	70	30
	Do you think family care is helpful for early recovery of		
	Stroke patients after discharge	96	4
	Do you think people with stroke can be reemployed in their job	75	25
	Stroke is a preventable disease	92.5	7.5
	Stroke patients should be treated by a Neurologist	83	17
	Stroke can be treated in a chemist shop	41	59
	Stroke patients can be treated with food supplements	32.5	67.5
	Stroke can be treated in spiritual churches	71	29
	Stroke can be treated by traditional Medicine Healers	69	31
Aggregate score on Attitude of Healthcare workers	Frequency	percent (%)	
Good	154	77	
Poor	46	23	

Respondents' knowledge of stroke: Although, the majority, 168 (84.0%) of the 200 respondents have good aggregate knowledge about stroke, about 87.5 % knew stroke as a disease of the blood vessels in the brain and also preventable (93.5%), however about less than half (48%) of them believe that stroke is a curable disease (Table 3).

Table3. Knowledge of Stroke and its Prevention among respondents

KNOWLEDGE	QUESTIONS	YES (%)	NO (%)
Is stroke a disease of the blood vessels of the Brain?	87.5	12.5	
Is Stroke a Preventable disease?		93.5	6.5

Can one have a stroke more than once?	83	17	Does stroke affect daily activities like driving a car, dressing, having a job, etc	95.5	4.5
Is Stroke a disease requiring urgent care?	94.5	5.5			
Stroke is a disabling disease	63	37			
Stroke is a curable disease	48	52			
Stroke is an old man's disease	93.5	6.5			
Stroke is a contagious disease	2	98			
Stroke a hereditary disease	78.5	21.5			
Aggregate score on Knowledge of Healthcare workers	Frequency	percent (%)			
Good	168	84			
Poor	32	16			

Respondent's knowledge of the signs or symptoms of stroke: The majority, 144 (72.0%) of the 200 respondents had good knowledge of the signs or symptoms of a stroke. The signs or symptoms of stroke most commonly known to the respondents include sudden weakness or paralysis on one side of the body (88.5%), sudden loss or reduced sensation all over the body (76%), sudden loss or reduced sensation on one side of the body (73.5%). More than half of respondents (73.0%) had sudden severe Headaches, sudden dizziness or loss of balance or coordination (66.0%), and sudden loss of vision (60.0). (Table 4)

Table4. Respondent's knowledge of stroke symptoms or warning signs

Stroke Symptoms or signs	Yes (%)	No (%)
Sudden loss of vision	60	40
Sudden loss or reduced sensation on one side of the body	73.5	26.5
Sudden dizziness or loss of balance or coordination	66	34
Sudden and severe headache	73	27
Sudden weakness or paralysis on one side of the body	88.5	11.5
Sudden loss or reduced sensation all over the body	76	24
Aggregate Knowledge of stroke warning signs or symptoms		
Good	144	72
Poor	56	28

Respondent's knowledge of stroke risk factors: The majority, 156 (78.0%) of the 200 respondents had good knowledge of stroke risk factors. The stroke risk factors most commonly known to the respondents include

hypertension (93.0%), being overweight or obese (76.0%), excessive alcohol intake (75.5%), cigarette smoking (74.5%), and diabetes mellitus (73.5%). More than half of respondents knew aging (62.0%) as a stroke risk factor (Table 5).

Table5. Respondent's knowledge of stroke risk factors

Stroke Risk factors	yes (%)	No (%)
Excessive alcohol intake	75.5	24.5
Diabetes Mellitus	73.5	26.5
Cigarette smoking	74.5	25.5
High Blood Pressure (Hypertension)	93.0	7
Advancement in Age	62	38
Being overweight or obese	76	24
Aggregate Knowledge of stroke risk factors		
Good	156	78
Poor	44	22

Respondents' stroke prevention practices:

The aggregate practice of stroke prevention among healthcare workers was poor (54%). Most of the respondents observed that stroke prevention practices such as taking the patient to the hospital on the slightest suspicion of stroke or its warning sign (91.5%) and reduction in alcohol intake (75.7%) were important, while less than half of them will check their Blood pressure (30.0%) regularly or check their blood sugar (46%) regularly for those who are diabetics or counsel others to do so. The same with healthcare workers (43.5%) who control their cholesterol or advise others to do so and also for those who try to lose weight (46.5%) or advise others regularly to do so. About one-third (39%) of the respondents do regular exercise (Table 6).

Table6. The practice of Stroke Prevention among respondents

PRACTICE QUESTIONS	YES (%)	NO (%)
What will you do if you happen to witness a person with a stroke? (Sprinkle water over the face)	11	89
What will you do if you happen to witness a person with a stroke? (Take him/her to the Hospital)	91.5	8.5
What will you do if you happen to witness a person with a stroke? (Wait for spontaneous recovery)	14.5	85.5
What will you do to prevent stroke, please specify	43.5	56.5

the options for stroke management

eg Acute Management	30	70
Are you aware of the options for stroke management eg Surveillance	39	61
Are you aware of the options for stroke management eg Rehabilitation	46.5	53.5
Are you aware of the options for stroke management eg Prevention	46	54
Are you aware of one of the methods of recovery like Physiotherapy	84.5	15.5
Are you aware of one of the methods of recovery like Speech therapy	69	31
Are you aware of this method of recovery like Physiotherapy? & speech therapy together	64.5	35.5
Aggregate score on practice of Healthcare workers,	Frequency	percent (%)
Good	92	46
Poor	108	54

HealthCare Workers relationship with Attitude, knowledge, and practice of stroke prevention.

There was a significant association ($p < 0.0001$) of good knowledge of stroke by Clinical Healthcare workers [Chi-squares =27.1, 95%CI= (0.029-0.256)] when compared with non-clinical healthcare workers. This is in contrast with their poor practice of stroke prevention (Chisquares=3.570, $p = 0.02$, 95%CI (0.321-1.023). However, there was no significant association ($p=0.423$) between the good attitude toward stroke prevention by the Clinical Health care workers [Chi-square=0.130, 95%CI= (0.458-1.713)], when compared with Non-Clinical Health care workers (Table 7).

Table7. Healthcare worker's relationship with Attitude, knowledge, and practice of Stroke Prevention

Variables	Good attitude (%)	Poor attitude (%)	Chi-square	P-value	95%CI
Clinical Healthcare workers	85(78)	24(22)	0.130	0.423	(0.458-1.713)
Non-clinical Healthcare workers	69(75.8)	22(24.2)			
Healthcare worker's relationship with knowledge of stroke prevention					
Variables	Good knowledge (%)	Poor knowledge (%)	Chi-square	P-value	95%CI
Clinical Healthcare workers	105(96.3)	4(3.7)	27.1	0.0001	(0.029-0.256)
Non-clinical Healthcare workers	63(69.2)	28(30.8)			

Healthcare worker's relationship with the practice of stroke prevention

Variables	Good Practice (%)	Poor Practice (%)	Chi-square	P-value	95%CI
Clinical Healthcare workers	49(45.0)	60(55.0)	3.570	0.02	(0.321-1.023)
Non-clinical Healthcare workers	29(31.9)	62(68.1)			

Discussion

Stroke is a distressing issue in low-income countries than the middle and high-income countries of the world²⁰, and it is thought as the primary cause of morbidity and death among noncommunicable diseases. Stroke can be averted and managed if its risk factors are altered and if warning signs are discovered earlier²⁰. A good understanding of knowledge and attitude towards stroke risk factors are essential for early stroke prevention⁸.

In our study the majority of respondents (72%) were aged above 30 years, (56.5%) of the participants were female, (63%) were married, and (96.5%) had completed tertiary education. However, in another study conducted among hypertensives in a rural population in Saudi Arabia¹³, most respondents were males, younger adults, not married, had a college degree or above, and almost half of them controlled their blood pressure. However, our study was conducted in an urban area among Healthcare workers of whom (93%) knew hypertension was a risk factor for stroke and was above 30 years (72%) of age. In the Kingdom of Saudi Arabia Hypertension was also at high risk in males and this may not be unconnected with the difference in health-seeking behaviors among genders in the two environments. They found that hypertension sharply increases with age and other combinations of cardio-metabolic risk factors²¹. In this study majority, (84.0%) of the 200 respondents have good aggregate knowledge about stroke, 87.5 % knew stroke was a disease of the blood vessels in the brain and also preventable (93.5%), it revealed that Healthcare workers had good aggregate Knowledge of risk factors (78%) or symptoms (72%). This is consistent with other studies done in Sokoto Nigeria, where about (86.6%) of the respondents had good knowledge of stroke risk factors and symptoms (87%)⁸. The majority (87.4%) of them knew stroke as a disease of the blood vessels in the brain. This is uniform with other studies in Africa, like in Benin, Nigeria²² and Cameroon²³ where they described the general public's level of knowledge on stroke in Benin City and Yaoundé as good. However, in the studies done in the Kingdom of Saudi Arabia^{13,24}, most respondents had a poor level of knowledge about stroke prevention, risk factors, symptoms, and stroke complications. Other studies in support of their findings were done in Iran²⁵ and Brazil²⁶. These disparities in their knowledge of stroke risk factors and warning signs may be due to differences in the studied populations; - in terms of community or hospital-based studies, their different levels of perceptions based on their levels of education, traditional beliefs, and religious inclinations. About 97.5% of Healthcare workers in our study had a tertiary education as opposed to 73.5 % of respondents in a community-based study in Saudi¹³ who had a college education or above. In the Iran study about

62.9% were poorly educated and may not recognized these signs and symptoms and in Brazil about 25% had tertiary education, only 29.03% of them could mention 2 or 3 stroke risk factors. Another possible explanation for these results is that most respondents here may lack information due to insufficient awareness campaigns about stroke prevention and its risk factors and warning signs. The significant education gap may have created major difficulties for them to access enough knowledge.

Although, the majority, 154(77.0%) of the 200 respondents in the current study have good aggregate attitudes towards stroke prevention. However, there was no significant association ($p=0.423$) between the good attitude toward stroke prevention by the Clinical Health care workers [Chi-square=0.130, 95%CI= (0.458-1.713)], when compared with Non-Clinical Health care workers. Most of them (91.5%) strongly agreed that stroke is treated in the hospital by a neurologist (83%), however will still explore the spiritual churches (71%) for healing, followed by traditional medicine healers 69%. Of course, they (54%) had a poor aggregate practice of stroke prevention. However, the study in Saudi established that most respondents had poor attitudes towards monitoring their blood pressure, early diagnosis¹³, treating heart disease, and smoking cessation to prevent stroke. Some other studies showed most hypertensive participants had a neutral attitude toward stroke prevention approaches²⁷. Another study conducted in India showed a relatively higher attitude score of hypertensive people than non-hypertensive people towards stroke prevention²⁸. They concluded that the poor knowledge and attitude of respondents may influence their behaviors toward stroke prevention.

In Brazil³⁰, Workers with tertiary education levels had significantly more knowledge about stroke than those with poor education. Workers' attitudes towards stroke prevention are overall good at 81.4%. Their belief in a supernatural or mystical origin witnessed there and in studies performed in Ivory Coast (50.9%)³¹ and in Burkina Faso (15%)³², could be explained by traditional notions of disease in African societies, which often point to a mystical origin to the disease. The study in

Enugu North Nigeria¹⁸ is also in tandem with our findings that most of the respondents had an incorrect attitude and poor practice toward stroke prevention. They still believed that spiritual healers (yes=61.1%, don't know=14.9%) and traditional medicine healers (yes=48.2%, don't know=16.6%) could treat stroke. These conflicting attitudes will prevent the early presentation of stroke patients to the hospital even if they recognize the risk factors or warning signs. This is a mismatch between practice and knowledge of stroke management due to contradictory attitudes. This result is consistent with another study conducted in a tertiary care hospital in Pakistan which indicated that stroke prevention practices were sub-optimal²⁹

Limitations.

This was a hospital-based study conducted in an urban location and therefore is not representative of a multi-centre or community-based study. The structured questions with "yes" or "no" answers in our questionnaire did not ascertain the reasons why patients hold a convinced outlook about stroke.

Conclusion

Findings from this study show that conflicting attitudes toward a good knowledge of stroke prevention influence the practice of stroke prevention negatively with adverse consequences. Therefore, improvement in health educational systems and behavior-changing strategies for healthcare professionals, and urban and rural dwellers is essential to increase general public awareness about stroke prevention and other health-related affairs.

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