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Assessing Knowledge, Attitude, and Practices of Women of Reproductive Age (15-49) Towards Cervical Cancer Screening in Adyel Division, Adyel Ward, Lira City West Division, Lira City

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Abstract: Background: The WHO estimates that only about five per cent of women in the developing world have been screened for cervical cancer in the last five years compared to 75 per cent in the developed world. In Uganda, cervical cancer is the number one cause of cancer related death in women. The WHO estimated that in 2014, approximately 3915 Ugandan women were diagnosed with cervical cancer and that 2160 died from the disease (HPV information center, 2016). A 33% prevalence of HPV among women in Uganda combined with low screening uptake has resulted into the country having one of the highest cervical cancer incidence rates in the world of 47.5 per 100.000 per year (HPV information center 2016). Aim: The aim of this study is to assess the knowledge, attitudes and practices of women of reproductive age towards cervical cancer screening so that the magnitude of the problem is reduced and if possible, eliminated from the prevailing health problems in Uganda. Methods: This study is a descriptive cross-sectional design employing quantitative data collection method conducted in Adyel division, Lira district among women of reproductive age (15-49) on cervical cancer screening. Results: Nearly all the respondents (97.9%) heard of cervical cancer, almost every respondent had heard about cervical cancer screening reflected by (93.8%) respondents, sixty-two-point two percent (69.2%) of the respondents were aware that cervical cancer is transmitted from men to women, the majority of the respondents (82.2%) knew that cervical cancer affects women only and nearly all respondents (82.2%) knew that cervical cancer can be prevented. More than half of the respondent (51.7%) had ever screened for cervical cancer, the greatest proportion of the respondent (43.4%) screened from private clinics. Whereas none of the demographic factors of the respondents was significantly associated with hearing about cervical cancer as revealed by chi-square analysis results($p>0.05$), there exists a weak negative association between the overall attitudes of respondents and screen status for cervical cancer as confirmed by chi-square test result of p-value = 0.040, X2 = 10.04, CI = (0.001-0.54). Conclusion: The general awareness and attitude regarding cervical cancer screening were both positive. However, this did not convert into appropriate screening practises for cervical cancer, as less than half of the population had ever been screened. The high expense of screening, the absence of cervical cancer screening services, and the absence of the disease contributed to the low screening rate.

Keywords: Cervical cancer, Screening, Knowledge, Awareness and Attitudes

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1. Introduction

Cancer of the cervix is the fourth most common disease in women worldwide, accounting for 6.6% of all female cancers, with 570,000 new cases expected in 2018. It is the second most prevalent cancer among women in Southeast Asia, with around 175,000 new cases diagnosed annually (Tapera et al, 2017, Hassan et al 2021, Ali et al 2021). The human papillomavirus (HPV) causes nearly all occurrences of cervical cancer and over 90 percent of all anal malignancy (HPV information center, 2016). Approximately 5% of women in the developing world have undergone cervical cancer screening in the past five years, compared to 75% of women in the developing world. 22.5 percent of all cancer diagnoses in women in Sub-Saharan Africa are cervical cancer, with the great majority of patients live in rural areas. Eastern Africa is one of the worst-affected regions, with more than 30 cases per 100,000 women each year. Almost 90% of cancer-related deaths occurred in low - and middle-income nations (Chuang et al., 2016). There were around 527,624 new cases of cervical cancer and 265,672 deaths from it in 2012. Approximately 85% of these deaths occurred in Sub-Saharan Africa (Ferlay et al., 2013). In many underdeveloped nations, however, women lack knowledge about cervical cancer and prevention measures (Ferlay, 2013).

According to studies conducted in various nations, women's knowledge and attitudes on cervical Cancer prevention and treatment differ. In contrast to women in industrialized countries, women in poor countries lacked knowledge about cervical cancer and its prevention (Shrestha, Saha, &Tripathi, 2013). In several studies, a significant direct relationship was shown between women's awareness and attitude towards cervical cancer and its prevention and their subsequent utilization of the Pap smear test (Mirzaei-Alavijeh, 2014). Literature indicates an exceedingly low rate of cervical cancer screening in low- and middle-income countries (Al Rifai & Nakamura, 2015). A study on the health-seeking behavior of patients with cervical cancer in Ethiopia revealed that women in the early stages of the disease were unaware of cervical cancer and opted for conventional remedies. According to this study, the barriers to receiving any sort of treatment are a lack of knowledge and access to suitable health care. It also revealed that women with cervical cancer were stigmatised by society and received insufficient emotional support (Birhanu et al., 2012).

Uganda has one of the highest cervical cancer incidence rates in the world (HPV information center, 2016). The leading cause of cancer-related deaths among Ugandan women is cervical cancer. According to the World Health Organization, around 3,915 Ugandan women were diagnosed with cervical cancer in 2014, with 2,160 succumbing to the disease (HPV information center, 2016). With 47.5 per 100,000 women infected with HPV, Uganda has one of the highest incidences of cervical cancer in the world. Due to this and low screening participation, the United States has one of the highest HPV prevalence rates in the world (HPV information centre 2016). According to the Uganda Cancer Institute (UCI), eighty percent of women diagnosed with cervical cancer had advanced disease. The study done in Northern Uganda's Lira District revealed a poor rate of cervical cancer screening and vaccination (Kisaakye et al., 2018). This could be linked to a lack of awareness of the harmful effects of cervical cancer. This study aims to evaluate the knowledge, attitudes, and practices of women of reproductive age in Adyel Division-Lira district on cervical cancer screening.

2. Methodology

2.1. Study Design

This study used a descriptive cross-sectional design employing quantitative data.

2.2. Study Site and Setting

The study was conducted in Adyel division, Lira municipal Council, Lira district. The Division had a total population of 31,934 of which 16,869 were female, 15,057 were male with total household of 7,630 (National Census Report 2014 UBOS). This was because there was no study conducted in Adyel Division on cervical cancer screening and yet there were very many women of reproductive age who might have not been aware of cervical cancer screening.

Study Population

The study population was the women of reproductive age (15-49) in Adyel division, Lira municipal Council, Lira district the target group were those who had ever had sexual intercourse in their life time. These are people who were high risk of getting infected with HPV which later manifest in menopause.

Sample Size Determination

Sample size used was obtained using the Kish Leslie formula (1965).

$n=Z^2pq/d^2$

Where n is sample size

Z was test statistic, the value corresponding to 95% level of significance = 1.96

P =was prevalence of cervical cancer is 33%

p= 0.33

q= (1-0.33), =0.67

d is precision = 0.08

Since the prevalence of the cervical cancer in the study area was not known but for Uganda was 33%, It was used to calculate the sample size.

$n= (1.96^2x0.33x0.67)/0.08^2$=133 participants

The sample size participants for the study were 133. Ten percent (10%) of 133 is added to cater for the non-responses during the study hence a total of 146 participants.

Sampling technique

Simple random sampling technique was employed where lottery was used to select the parishes/wards and villages in which study was conducted.

Out of the 9 parishes/wards in the Division, 2 were chosen to take part in the study. All parishes were written on individual strips of paper, folded and shaken then two parishes were picked at random. Still basing on simple random sampling technique, also 2 villages were chosen using the same method from each parish/ward, making a total of 4 villages in the whole study.

2.3. Eligibility Criteria

All women of reproductive age (15-49) found at home and was physically and psychologically healthy was chosen to participate in the study.

Inclusion Criteria

Women of reproductive age (15–49) who had ever engaged in sexual activity were included in the study. These individuals were highly susceptible to contracting HPV, which manifests itself in menopause.

Exclusion Criteria

Women of reproductive age who had not yet had sexual intercourse, physiologically sick and had mental problem would not participate in the study. Those who refused to engage in the research were also excluded.

Data Collection Method and Instruments

For quantitative approaches, interviewer administered questionnaires with close ended questions were used for collecting data. Prospective respondents were asked questions concerning the study which was to be answered by the researcher from their various homesteads.

Data Entry and Cleaning

The closed ended questionnaires were checked for accuracy and completeness. The data was cleaned, stored in the flash disc.

Data Analysis

The accurate data from the structured questionnaires were coded and entered in to the computer designed sheet and then processed using SPSS software program and then merged with the demographic and socio-economic data for analysis. The baseline knowledge, attitudes, and screening habits of women of reproductive age on cervical cancer screening were characterized and given in frequency distribution tables.

Quality Control

Quality was ensured by use of the following measures;

Pre-testing the data collection tools for accuracy.

Checking for completeness and accuracy of the already collected data was done at the end of the day. This was to assist in addressing errors like missing data. Incomplete and inaccurate tools were not considered in the study.

Ethical considerations

Uganda was consulted with the Faculty of Health Science Research and Ethics Committee at Lira University. Permission to conduct the research was to be obtained from the LCV. Chairperson and District health officer of Lira district.

Consent

Participants in the study gave their informed consent and were able to opt out at any time. The goal of the study, the study's contents, and the study's benefits were all explained to the participants.

Privacy Protection

From the beginning to the end of the study, privacy of the respondents' information was maintained by having the session in a private place.

Confidentiality

All information obtained from the respondent was kept confidential in that the questionnaire did not bear ask for name and contact address of the study participant neither by the researcher. The questionnaires were given numbers for identification.

Study Limitations and Mitigation

Some individuals were not around during the time of conducting the research which interfered with the data collection process. This was addressed by following up these individuals one more time.

Low response from some study participants will be addressed by ensuring a good rapport building with the study participants.

3. Results

Socio-Demographic characteristics

As shown in Table1, the study reveals that the majority (35.5%) of respondents were in the age group 26-34 and the least proportion (5.5%) was in the age group of 43-49 years. Almost half (43.2%) of respondents were engaging in business as their occupation and the least number (5.5%) of the respondents were civil servants. Whereas the dominating denomination was Christianism (95.2%) of the respondents, 4.8% of respondents were Muslim. More than half of the respondents (56.2%) were married and only 2.7% of the respondents were widowed. The biggest proportion of the respondents (39.0%) had attained secondary level of education followed by (38.4%) who attained primary level and the least proportion had attained tertiary institution education (11%).

Table 1. Demographic information about the respondents

Variable	Frequency (146)	Percent
Age group		
15-21	48	32.9%
22-28	52	35.6%
29-35	26	17.8%
36-42	12	8.2%
43-49	8	5.5%
Total	146	100.0%
Occupation of respondents		
Civil Servant	8	5.5%
unskilled labour	12	8.2%
Business	63	43.2%
student	25	17.1%
Farmer	38	26.0%

Total	146	100.0%
Variable	**Frequency**	**Percent**
Denomination of respondents		
Christians	139	95.2%
Muslim	7	4.8%
Total	146	100.0%
Marital status of respondents		
Single	46	31.5%
Married	82	56.2%
Divorced	14	9.6%
Widowed	4	2.7%
Total	146	100.0%
Educational level of respondents		
None	17	11.6%
Primary	56	38.4%
Secondary	57	39.0%
Tertiary	16	11.0%
Total	146	100.0%

Source: Primary data, January, 2021

Knowledge on cervical cancer screening

Respondent's general knowledge of cervical cancer screening was assessed. The respondents were required to indicate their level of knowledge by choosing the options presented under each question.

Table 2 Indicates that nearly all the respondents (97.9%)) had heard of cervical cancer although (2.1%) had never interfaced with any form of information about cervical cancer.

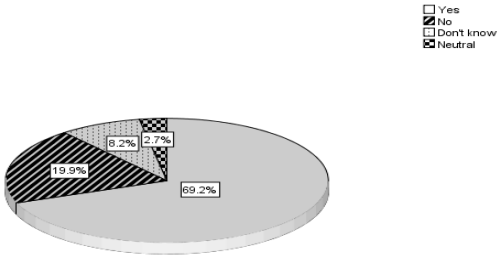
Table 2. Awareness of women of reproductive age in Adyel Division about cervical cancer

Response	Frequency (146)	Percentage
Yes	143	97.9%
No	3	2.1%
Total	146	100.0%

Source: Primary data, January, 2021

Figure 2 below, reveals that whereas only 2.7% of respondents were neutral in their responses and 8.2% did not know whether cervical cancer is transmitted from.

Figure 1. whether cervical cancer is transmitted from men to women



The table 3 below shows that the majority of the respondents (82.2%) knew that cervical cancer affects women only and only a handful (8.2%) did not know whether cervical cancer affects women only or not.

Table 3. Whether cervical cancer affects women only

Response	Frequency	Percentage
Yes	120	82.2%
No	14	9.6%
Don't know	12	8.2%
Total	146	100.0%

Source: Primary data, January, 2021

From the bar graph below, nearly all respondents (82.2%) knew that cervical cancer can be prevented, although some few (8.2%) did not know at all.

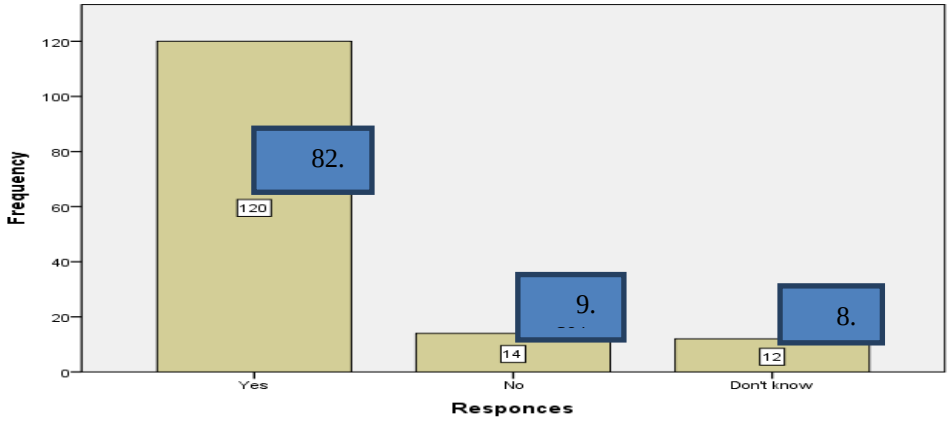


Figure 2. Whether cervical cancer can be prevented

Table 4 shows that almost every respondent had heard about cervical cancer screening reflected by (93.8%) respondents and (6.2%) had never heard about cervical cancer screening at all.

Table 4. Whether the respondent heard of cervical cancer screening

Response	Frequency	Percentage
Yes	137	93.8%
No	9	6.2%
Total	146	100.0%

Source: Primary data, January, 2021

Figure 4 below indicates that the majority of the respondents (76.71%) knew that cervical cancer screening should be done after every three years. Moreover, 15.07% and 8.22% of the population

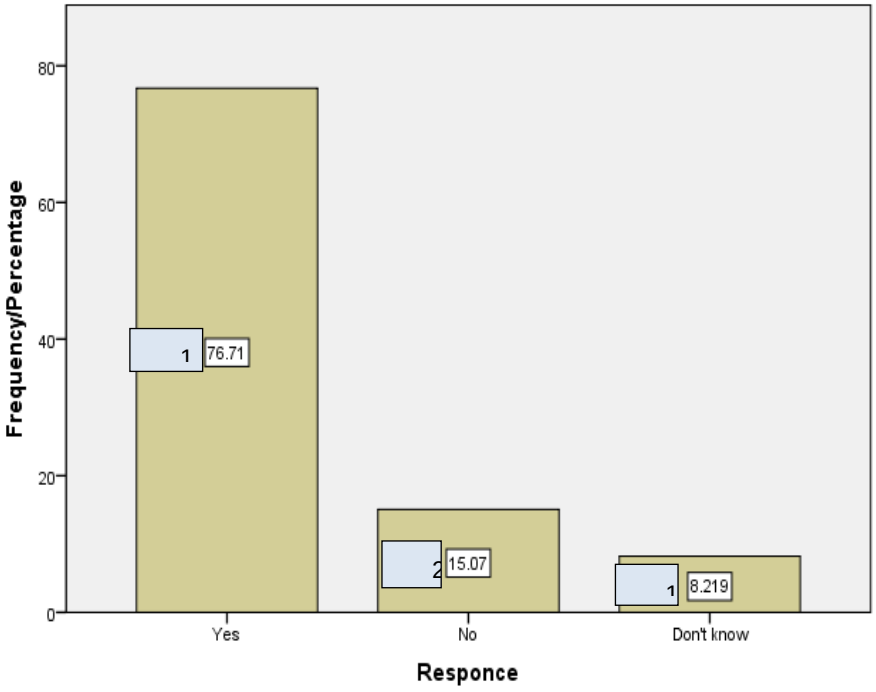


Figure 3. whether cervical cancer screening should be done after every three years

said it should not be done after every three years and did not know about how often the screening for cervical cancer should be done respectively. Table 5 shows that, among the respondents who had ever heard about cervical cancer, the majority (36.4%) were within the age group of 22-28 years old, followed by (31.5%) who were within the age group of 15-21 and least (5.6%)were from the age

group of 43-49 years. However, all respondents who had never interfaced with any form of information on cervicalcancer were within 15-21 years. The respondents most likely to have heard about cervical cancer were businesswomen (44,1 percent), followed by farmers (26,6 percent), and unskilled labourers (7,7 percent). In addition, 66.7% of the respondents who had never heard of cercal cancer were students, whereas 33.3% were unskilled labourers. Almost all respondents (95.1%) who heard about cervical cancer were Christians and the rest (4.9%) were Muslims. More than half of the respondents (57.3%) who heard about cervical cancer were married. This is followed by (30.1%) of respondents who were single ladies. However, all respondents (100%) who had not heard about cervical cancer were single ladies. Among the respondents who heard about heard about cervical cancer, equal proportion (41.3%) attained primary education and secondary education. The smallest proportion (8.0%) attained tertiary level of education. On the other hand, the highest proportion (37.1%) of those who did not meet any information on cervical cancer attained secondary education followed by (34.3%) that stopped at primary level.

However, none of the demographic factors of the respondents was significantly associated with hearing about cervical cancer as revealed by chi-square analysis results ($p>0.05$)

Table 5. Association between socio-demographic factors and knowledge of respondents towards cervical cancer screening

Cross-tabulation					
	Whether respondent have ever heard about cervical cancer.				
	Yes N(%)	**No (%)**	**X^2**	**Df**	**p-value**
Age group					
15-21	45(31.5%)	3(100%)			
22-28	52(36.4%)	0(0%)			
29-35	26(18.2%)	0(0%)	6.253	4	0.181
36-42	12(8.4%)	0(0%)			
43-49	8(5.6%)	0(0%)			
Occupation					
Civil Servant	8(5.6%)	0(0.0%)			
Unskilled labor	11(7.7%)	1(33.3%)			
Business	63(44.1%)	0(0.0%)	9.028	4	0.06
Student	23(16.1%)	2(66.7%)			
Farmer	38(26.6%)	0()0.0%			
Denomination					

Muslim	7(4.9)	0(0%)			
Christian	136(95.1)	3(100%)	0.154	1	0.695
Marrital status					
Single	43(30.1%)	3(100%)			
Married	82(57.3%)	0(0%)			
Divorced	14(9.8)%	0(0%)	6.659	3	0.084
Widowed	4(2.8%)	0(0%)			
Education level					
None	16(11.2%)	1(33.3%)			
Primary	56(39.2%)	0(0%)			
Secondary	55(38.5%)	2(66.7%)	3.347	3	0.341
Tertiary	16(11.2%)	0(0%)			

Source: Primary data, January, 2021

* Statistically significant values, X^2 =Chi-square value, df= degrees of freedom

Practices of women of reproductive age on cervical cancer screening

Table 6 reveals that more than half of the respondent (51.7%) had ever screened for cervical cancer and nearly half of the respondents (48.3%) had never screened themselves for cervical cancer.

Table 6. Have ever screened of cervical cancer

Response	Frequency	Percentage
Yes	75	51.7
No	70	48.3
Total	145	100.0

Source: Primary data, January, 2021

Table 7 indicates that the greatest proportion of the respondent (33(43.4%) were screened from private clinic, followed by 27(35.5%) who were screened from government hospital. The least proportion of respondent (1(1.3%)) did screening for cervical cancer from NGO.

Table 7. Places of cervical cancer screening

Variable	Frequency	Percent
Government hospital	27	35.5%
Private clinic	33	43.4%
NGO	1	1.3%
Reproductive health clinic	15	19.7%

Total	76	100.0%

Source: Primary data, January, 2021

In the figure 5, majority of the respondents (34.18%) who did not screen or have not yet screened for cervical cancer gave not having the disease as a reason behind not screening for cervical cancer. Aquater of the respondents (25.32%) felt that screening is very painful and equal proportion of respondents did not know any reason hindering them from screening for cervical cancer.

Figure 4. Reasons for having not done cervical cancer screening

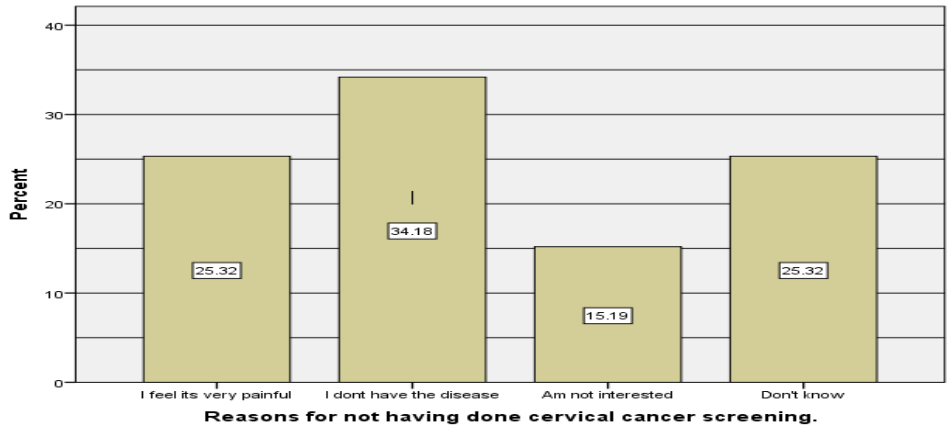


Figure 6: show that more than half of the respondents (54.79%) had never screened themselves for cervical cancer. This is followed by 26.03% of the respondents who at least did cervical cancer screening once. The least proportion (4.79%) had done cervical cancer screening thrice.

Figure 5. Number of times the respondents screened for cervical cancer.

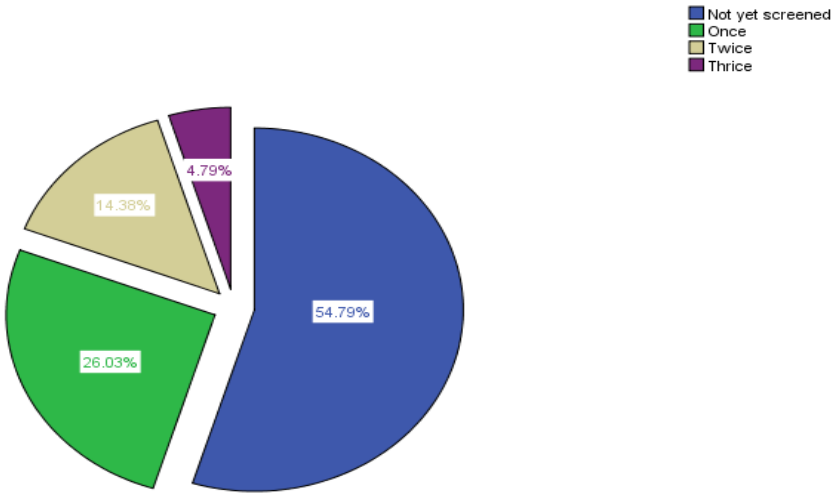


Table 4.8 reveals that the majority of respondents (34.7%) who screened for cervical cancer were within the age group of 22-28 years. This was followed by age group of 15-21 years with 30.7%. The smallest proportion was from the age group of 43-49 years where only (5.3%) screened for cervical cancer. The biggest proportion of respondents (35.7%) who did not screen for cervical cancer where in the age group 15-21 years and 22-28 years.

Business women made the greatest proportion of respondents (49.3%) who screened for cervical cancer, followed by farmers 26.7%. In the same order, business women were the majority (35.7%) of those who did not screen for cervical cancer, followed by farmers (25.7%). Nearly all of the respondents (94.7%) who screened for cervical cancer were Christians, the rest were Muslims. On the other hand, Christians still made the larger proportion of respondents (95.7%) who did not screen for cervical cancer and the rest were Muslims (4.3%). More than half of the respondents (69.3%) who screened for cervical cancer were married, followed by single respondents (25.3%) and none of the widows (0.0%) screened for cervical cancer. Married respondents still maintain to be the largest population (41.4%) among the respondents who did not screen for cervical cancer. Marital status of respondents was found to be significantly associates with screening for cervical cancer. This is proved by chi-square test result of p-value =0.035. Respondents with both a primary and secondary education made up the biggest proportion (41.3 percent) of those who had cervical cancer screening. The least proportion (9.3%) was those who did not attained any form of education. However, sociodemographic factors like age group, education, denomination and occupation are not significantly affecting the practice of screening for cervical cancer.

Table 8. : Association between socio-demographic factors and practice of respondents towards cervical cancer screening.

Cross-tabulation					
Variable	**Have ever screened for cervical cancer.**				
	Yes N(%)	**No (%)**	**X^2**	**df**	**P-Value**
Age group					
15-21	23(30.7%)	25(35.7%)			
22-28	26(34.7%)	25(35.7%)			
29-35	16(21.3%)	10(14.3%)	1.317	4	0.859
36-42	6(8.0%)	6(8.6%)			
43-49	4(5.3%)	4(5.7%)			
Occupation					
Civil Servant	4(5.3%)	4(5.7%)			
unskilled labour	4(5.3%)	8(11.4%)			
Business	37(49.3%)	25(35.7%)	4.595	4	0.332
student	10(13.3%)	15(21.4%)			
Farmer	20(26.7%)	18(25.7%)			
Denomination					

Muslim	4(5.3%)	3(4.3%)			
Christian	71(94.7%)	67(95.7%)	0.086	1	0.769
Marrital status					
Single	19(25.3%)	27(38.6%)			
Married	52(69.3%)	29(41.4%)			
Divorced	4(5.3%)	10(14.3%)	14.338	1	0.035*
Widowed	0(0.0%)	4(5.7%)			
Education level					
None	7(9.3%)	10(14.3%)			
Primary	31(41.3%)	24(34.3%)			
Secondary	31(41.3%)	26(37.1%)	2.690	3	0.442
Tertiary	6(8.0%)	10(14.3%)			

Source: Primary data, January, 2021

* Statistically significant values, X^2 =Chi-square value, df= degrees of freedom

Attitudes towards cervical cancer screening

Respondents' attitudes regarding cervical cancer screening were determined using attitudinal phrases that requested respondents to indicate their attitudes toward cervical cancer screening by selecting "Strongly agree,"

"Agree," "Neutral," "Disagree," and "Strongly disagree."

Table 4.8 below reveals that almost all respondents (84.9%) strongly agreed that cervical cancer screening helps in early detection and treatment and as well, the rest of the respondents (15.1%) agreed in the same line that cervical cancer screening helps in early detection and treatment. Greatest proportion of respondents (38.4%) disagreed with the statement that it's necessary for all women of reproductive age to screen for cervical cancer every after three years, followed (30.8%) 17.8% of respondent who on the other hand strongly agreed that it's necessary for all women of reproductive age to screen for cervical cancer every after three years and the least is 6.2% of respondents who did not take a side. Majority of the respondent (89.0%) strongly agreed that cervical cancer screening helps reduce cancer cases among women. 8.2% agreed with the idea that cervical cancer screening will help reduce cancer cases among women and the least proportion of respondents (2.7%) on the other hand, strongly disagreed with the statement that cervical cancer screening will help reduce cancer cases among women. Nearly all respondents (90.4%) strongly agreed that it's very painful and expensive to screen for cervical cancer and 9.6% agreed as well. Moreover, none of the respondents was neutral nor disagreed nor strongly disagreed with the idea that it's very painful and expensive to screen for cervical cancer. More than half of respondents (57.5%) strongly agreed that their family members might not accept to go for cervical cancer screening and 13.0% agreed as well. However, a handful of only 1.4% of the respondents disagreed that their family members might not accept to go for cervical cancer screening. More than half of the respondents (76.0%) strongly agreed that they feel to have high risk for cervical cancer if not screened. Fifteen-point one percent (15.1%) agreed that they feel to have high risk for cervical cancer if not screened, while only 8.9% of

respondents disagreed that they feel to have high risk for cervical cancer if not screened. Greatest proportion of respondents (30.1%) agreed that the decision to screen for cervical cancer is beyond their control followed by 26.7% who disagreed with the idea that the decisions to screen for cervical cancer is beyond their control and the least proportion of respondents 6.8% were neutral. The greatest proportion of the respondents (32.9%) strongly disagreed that they were confident to screen for cervical cancer, followed by 22.6% of the respondents who were neither agreeing nor disagreeing with being confident to screen for cervical cancer. The least proportion is 11.6% of respondents who agreed that they have confident to screen for cervical cancer. The highest proportion of respondents (37.0%) strongly agreed and agreed that they feel their husbands might not accept them to go to screen for cervical cancer, followed by 12.3% of respondents who disagreed that they feel that their husbands may not accept them to go to screen for cervical cancer and the least proportion is 4.1% who were neutral. Majority of the respondents (35.6%) disagreed with the feeling that screening for cervical cancer would expose their privacy.

Table 9. Percent distribution of respondents' attitude towards cervical cancer screening

Variable	Cervical cancer screening helps in early detection and treatment.				
	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Cervical cancer screening helps in early detection and treatment.	124(84.9%)	22(15.1%)	0(0.0%)	0(0.0%)	0(0.0%)
It's necessary for all women of reproductive age to screen for cervical cancer every after three years.	125(85.6%)	19(13.0%)	0(0.0%)	2(1.4%)	0(0.0%)
Cervical cancer screening will help reduce cancer cases among women.	111(76.0%)	22(15.1%)	0(0.0%)	13(8.9%)	0(0.0%)
It's very painful and expensive to screen for cervical cancer.	23(15.8%)	44(30.1%)	10(6.8%)	39(26.7%)	30(20.5%)
My family members might not accept to go for cervical cancer screening.	29(19.9%)	17(11.6%)	19(13.0%)	33(22.6%)	48(32.9%)
Whether feel to have high risk for cervical cancer if not screened.	54(37.2%)	54(37.2%)	6(4.1%)	18(12.4%)	13(9.0%)
The decision to screen for cervical cancer is beyond my control.	37(25.3%)	8(5.5%)	11(7.5%)	52(35.6%)	38(26.0%)
Confident to screen for cervical cancer	87(59.6%)	23(15.8%)	16(11.0%)	8(5.5%)	12(8.2%)
Feel that their husband may not accept her going to screen for cervical cancer.	23(15.8%)	6(4.1%)	27(18.5%)	50(34.2%)	40(27.4%)
Screening for cervical cancer would expose my privacy.	45(30.8%)	10(6.8%)	9(6.2%)	56(38.4%)	26(17.8%)
Cervical cancer screening helps in early detection and treatment.	130(89.0%)	12(8.2%)	0(0.0%)	0(0.0%)	4(2.7%)
It's necessary for all women of reproductive age to screen for cervical cancer every after three years.	132(90.4%)	14(9.6%)	0(0.0%)	0(0.0%)	0(0.0%)
Total	920(52.5%)	251(14.3%)	98(5.6%)	271(15.5%)	211(12.1%)

Source: Primary data, January, 2021

More than a quarter of the respondents (26.0%) strongly disagreed as well although 25.3% strongly agreed that

Screening for cervical cancer would expose my privacy. More than half of the respondents (59.6%) strongly agreed that it is very important to encourage fellow women to screen for cervical cancer, 15.8% of the respondents agreed as well. However, 8.2% and 5.5% of the respondents still strongly disagreed and disagreed respectively that it is very important to encourage fellow women to screen for cervical cancer. Greatest proportion of respondents (34.2%) disagreed with the thinking that the government should extent these services to other smaller health centers. This is followed by 27.4% of respondents who strongly disagreed with the thinking that the

government should extent these services to other smaller health centers. The least proportion (4.1%) agreed with the thinking that the government should extent these services to other smaller health centers.

Table below 10 reveals that majority of the respondents 66.9% had positive attitudes on cervical cancer screening. Moreover, 27.5% had negative attitudes towards cervical cancer.

Table 10. Overall attitudes of respondents

Attitudes	Frequency	Percentage
Positive attitude	49	66.9%
Neutral	4	5.6%
Negative attitude	20	27.5%
Total	73	100.0%

Source: Primary data, January, 2021

According to the situation in table 11 below, there exists a weak negative association between the overall attitudes of respondents and screen status for cervical cancer as confirmed by chi-square test result of p-value=0.040, X^2=10.04, CI=(0.001-0.54), Spearman correlation= -0.010).

Table 11. Correlation between attitudes of respondents and respondents' utilization of cervical cancer screening service

		Have you ever screened for cervical cancer?	Attitudes
Have you ever screened for cervical cancer?	Pearson Correlation Sig. (2-tailed) N	1 146	-.010 .684 146
Attitudes	Pearson Correlation Sig. (2-tailed) N	-0.010 0.0684 146	1 146

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Source: Primary data, January, 2021

4. Discussion

Knowledge on cervical cancer screening

Cervical cancer is a preventable, non communicable disease with significant public health implications. Invasive cervical carcinoma is the second most common cancer in women worldwide, with eighty percent of cases occurring in developing countries (Ahmed et al., 2013). Women frequently learn about cervical cancer and screening through their interactions with one another. It is paramount to note that only 11.6% lacked formal education. This is similar to (Ogunbode & Ayinde, 2005,Ezem, 2007 andAhmed et al., 2013). Less than half of respondents lacked formal education. More than half of the respondents knew that cervical cancer could be transmitted from men to women this considered men as risk factors. This agrees with Ali et al., 2010, The most common risk factor reported was sexual practice, which included unprotected intercourse, several partners, and other promiscuous conduct (45 percent).

This study further shows that nearly all the respondents (97.9%) had heard of cervical cancer although (2.1%) had never interfaced with any form of information about cervical cancer and 93.8% heard of cervical cancer screening. This shows good level of awareness and knowledge by the respondents on cervical cancer. However, this contrasts with a study done among market women in Ibadan, showed that only 19.7% were aware of cervical cancer screening (Ahmed et al., 2013). Still, it disagrees (Ogunbode & Ayinde, 2005) where only 40.8% of respondents were aware of cervical cancer as well as Kwan et al., 2008 who found that knowledge on cervical cancer was limited. This difference could be due to the disparity in the study areas and design which have influenced access to information concerning cervical cancer screening but this is not supported by result of this current study since the greatest proportion of respondents (44.1%) who heard about cervical cancer were business women in which they share almost the same occupation. Majority of respondents (78.77%) knew that cervical cancer can be treated when diagnosed early and besides, 76.71% of the respondents knew that cervical cancer screening should be done after every three years which is the right interval. Sherris, 2005 put it clear that cervical cancer is readily preventable when effective programs are implemented to detect and treat its precursor lesions meaning early diagnosis. Good information on cervical cancer screening changes attitudes and further translates in to practice of screening for cervical cancer which in turn leads to early detection and management hence reducing adverse health outcome (Chuang et al., 2016). This can be achieved by oftenly informing Women about screening and its importance and increasing consumer demand or political imperative to initiate or enhance screening programs (Sherris, 2005).Nearly all respondents (82.2%) knew that cervical cancer can be prevented. This is not in line with Ali et al., 2010study done among health professionals where only 37 out of 393 were aware of the vaccine against HPV which is one of the preventive measures of cervical cancer. This difference could be as a result of effective and efficient use of health education strategies currently established and time of these two studies. Current cervical cancer prevention strategies include primary prevention using prophylactic vaccinations against human papilloma virus as well as alternate screening techniques and methods (Denny, 2015). Whereas the demographic factors of the respondents was not significantly associated with awareness or knowledge about cervical cancer as revealed by chi-square analysis results ($p>0.05$), There was a considerable positive relationship between age (P 0.0001), degree of education (P 0.0001), and income levels ($P = 0.005$) and service uptake (Morema & Atieli, 2014).

Attitudes towards Cervical Cancer Screening

The majority of respondents, 66.9 percent, had favorable opinions toward cervical cancer screening, as shown by their overall sentiments. This was consistent with Ahmed et al., (2013) was finding that there was a generally positive attitude toward cervical cancer screening (80.4 percent). These positive attitudes were proven further by eighty-four-point nine percent (84.9%) of respondents who strongly agreed that cervical cancer screening helps in early detection and treatment and as well as reduction in cancer cases among women, fifth nine-point six percent (59.6%) of respondents strongly agreed that it is very important to encourage fellow women to screen for cervical cancer. The motivation for screening and other psychosocial factors determine health seeking behavior (Aswathy et al., 2012). Most of the respondents (46%) agreed that cervical cancer services should be extended to smaller health facilities for easy access of cervical cancer services.

However, when it comes to decision making to screen, greatest proportion of respondents (30.1%) lacks control. Husbands tend to dominate the decision concerning screening for cervical cancer. Whereas more than half of the respondents (76.0%) strongly agreed that they feel to have high risk for cervical cancer if not screened, a study done among nurse in Mulago hospital 2006 on cervical cancer stated that, 81% eligible female respondents had never been screened, mostly because they did not feel vulnerable to the disease. This could be due to pre-exposure to HPV vaccine they had before or misconception by women in Mulago hospital that they are exceptional which make them think they are not vulnerable to cervical cancer. This mindset needs to be addressed through effective communication for behavior change if the utilization of the screening services is to be much improved. However, this is a great barrier to utilization of cervical cancer screening services which in turn can lead to late diagnosis and adverse health outcome resulting from cervical cancer. The majority of respondents advocated for the expansion of cervical cancer services to smaller health facilities to facilitate access to cervical cancer screening services.

Screening for Cervical Cancer

Nearly half of the respondents (48.3%) had never screened themselves for cervical cancer. The major reason (34.18%) given not for having screened was not having the disease. This was in line with Aswathy et al., 2012 whose study showed that only 6.9% of the 809 women evaluated had received screening. According to Adefuye (2006), the two most common reasons for failure were a lack of physician referrals and ignorance about the location of service locations. Utilization Ahmed et al., 2013 revealed better facilities, more female employees, and offering services at a lower cost will improve screening centers. utilization (Ahmed et al., 2013). However, in India, the onus of preventing cervical cancer is on the women themselves (Aswathy et al., 2012). Primary high risk Human Papilloma Virus (hrHPV) screening can be considered as an alternative to current US cytology-based cervical cancer screening methods for the Low income countries (LIC)(Huh et al., 2015). This would could cut costs involved in screening for the community members and provide prior evidence to either further test or not.

On the other hand, those who screened (51.7%) did from different places; 43.4% were screened from private clinic, followed by 35.5% who were screened from government hospital and the least proportion of respondent (1.3%) did screening for cervical cancer from NGOs. Moreover, the least proportion (4.79%) completed up to three times of screening which is the recommended number of screenings times.

While a woman's ability and motivation to participate in cervical cancer prevention programmers can be influenced by a variety of circumstances (Aswathy et al., 2012), this current study found that marital status of respondents was found to be significantly associates with screening for cervical

cancer. This is proved by chi-square test result of p-value =0.035. However, socio demographic factors like age group, education, denomination and occupation are not significantly affecting the practice of screening for cervical cancer.

5. Conclusion

Knowledge and attitudes regarding cervical cancer screening were generally favorable. However, this did not convert into appropriate screening practices for cervical cancer, as less than half of the population had ever been screened. The high expense of screening, the absence of cervical cancer screening services, and the absence of the disease contributed to the low screening rate.

Recommendation

Adyel Division Health Authority should ensure that community sensitization on cervical cancer screening is implemented through effective health education strategies in order to increase screening coverage and raise awareness about the signs and symptoms, services, and complications of cervical cancer. This could be accomplished through health education at school, such as the introduction of cancer health education materials into primary and secondary school curricula, meeting places, and workplaces.

The ministry of health should ensure that cervical cancer screening services are extended closure to both rural and urban setting for easy access.

Future researchers intending to Assessing cervical cancer knowledge, attitudes, and practices should include questions about symptoms to investigate methods for prompt presentation at health care. More study is needed to better understand and analyse the efficiency of various initiatives for increasing cervical cancer information, improving attitudes, and increasing adoption of cervical cancer screening programmers.

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