

KNOWLEDGE, ATTITUDE AND PRACTICE OF CERVICAL CANCER SCREENING AMONG WOMEN IN DALHATU ARAF SPECIALIST HOSPITAL LAFIA, NASARAWA STATE, NIGERIA

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Abstract

Cervical Cancer is enduringly a topical issue and causing significant number of mortalities among women globally, especially in areas with limited resources and access to health care services. Cervical Cancer's early detection is considered a cost-effective way to decrease its prevalence, yet the uptake of screening in the research area is extremely low. This study assesses the knowledge, attitude and practice of Cervical Cancer screening among women receiving antenatal and postnatal care at Dalhatu Araf Specialist Hospital, Lafia. Several literature was reviewed, out of which Health Belief Model and the Rational Choice Theory were adopted as theoretical framework for the study. A survey research design was used in gathering primary data through quantitative and qualitative methods. Surveys were conducted with women who are attending antenatal and post-natal clinics in the hospital through the use of questionnaires. Additionally, 4

Introduction

In recent times, the global prevalence of Cervical Cancer has become a significant health issue among women and the commonest form of genital malignancy among women. Globally, it is the 4th most common form of cancers among women (WHO, 2018) and Bray, Ferlay, Soerjomatarm, Siegel, Torre, and Jemal (2018). In 2018, an estimated 570,000 new cases and 311,000 deaths from cervical cancer were reported worldwide. Similarly, in 2020, over 604,127 new cases of 341,831 deaths was recorded, resulting to about cervical cancer was record (Bruni,

key informant interviews were conducted with healthcare workers in the hospital. Findings reveal a high level of awareness of cervical cancer, yet discrepancies exist in understanding risk factors, particularly regarding sexual behavior, childbirth, and human Papilloma virus infection. While smoking is widely recognized as a risk factor, uncertainty persists for other factors. Awareness of screening methods, notably Pap smear, is limited, with a significant portion unaware of its existence. Attitudes towards screening vary, with mixed perceptions of prevalence and safety of screening methods. Screening uptake is low, with reasons including low perceived risk, cost, fear of diagnosis, and lack of knowledge about facilities. Factors influencing uptake encompass personal, socio-economic, cultural, and healthcare system-related barriers. These findings highlight the need for targeted education and intervention programs to improve cervical cancer screening rates in the community. It is therefore recommended that healthcare providers should prioritize comprehensive education on risk factors and screening methods, particularly targeting misconceptions and uncertainties. Efforts to increase accessibility and affordability of screening services, including the provision of free or subsidized screening, should be pursued. Culturally sensitive approaches, such as community outreach programs and involvement of religious leaders may help address barriers related to socio-cultural factors. Additionally, healthcare policies should aim to strengthen healthcare infrastructure and ensure availability of screening facilities. Collaborative efforts between healthcare providers, policymakers, community leaders, and advocacy groups are essential to overcome the multifaceted barriers to cervical cancer screening uptake.

Keywords: Cervical Cancer, Cancer, Health Belief, Rational Choice, Cervical Cancer Screening

Albero, Serrano, Mena et al, 2021). Most cases of these deaths occur in low and middle-income countries, with Sub-Saharan Africa countries having the highest rate of cervical cancer mortality (Fitzmaurice, Dicker, Pain, Hamavid et al, 2015; Desta, Getaneh, Yeserahm Worku, Eshete et al, 2021).

Cervical Cancer is the second most frequent cancer among Nigerian women aged 15 to 44 with over 14,000 new diagnoses and more than 20 deaths daily (Ferlay, Ervik, Lam, Colombet, Mery, Piñeros et al, 2020). Also, Nigeria has one of the highest rates of Human Papillomavirus (HPV)-related diseases in Sub-Saharan Africa (Bruni et al, 2021). According to Aminu, Gwafan, Inabo, Immunoglobulin G (IgG) antibodies against HPV had prevalence above 40% among Nigerian women in the northern region. HPV infection rates in female outpatients in Southwest Nigeria have also been reported to range from

30.4 to 36.5% (Adegbesan, Okunade and Omilabu, 2014; Okunade, Nwogu, Oluwole, Anorlu, et al., 2017).

Nearly all cases of cervical cancer and over 70% of malignancies affecting the vagina, vulva, and oropharynx are caused by the human papillomavirus (HPV). HPV is the most prevalent viral infection of the reproductive tract, with most women experiencing it shortly after becoming sexually active (Derbie, Mekonnen, Nibret, Maier, Woldeamanuel and Abebe. 2022). There are more than 100 distinct HPV types, and around 30 of them affect the genitalia (Pichainarongk and Bidaisee, 2018). High-risk or oncogenic types of HPV, mainly HPV types 16 and 18, cause 70% of all cases of cervical cancer (Pichainarongk et al, 2018; Ratanasiripong, 2012; Portnoy, Abbas, Sweet, Kim and Jit, 2021).

Comprehensive prevention and control strategies for cervical cancer have been proposed by the World Health Organization in 2020. The strategies encompassed primary, secondary and tertiary prevention such as community education, social mobilization, vaccination, screening, treatment and palliative care (WHO, 2020). Vaccination against Human Papilloma Virus, pre-cancerous lesion screening and therapy, early identification and rapid treatment of invasive malignancies, and palliative care are established cost effective options for addressing cervical cancer across the care continuum (Abraham, D'Souza, Jing, Gange, Sterling, Silverberg, et al. 2013). Expanded HPV vaccination coverage is expected to eradicate roughly 70% of cervical cancers globally, and cervical cancer screening performed by women in their 30 or 40s could reduce the risk of cervical cancer by 25–30% (WHO, 2014). Vaccination against HPV infection among adolescents before their first sexual experience is one of the most important cervical cancer preventive measures (WHO, 2014). The provision of HPV vaccines in low- and middle-income country is a key component of the global action plan to reduce cervical cancer prevalence (Perlman, Wamai, Bain, Welty, Welty and Ogembo. 2014).

The World Health Organization (2009) recommends giving HPV vaccine to girls between the ages of 9 and 13 before sexual exposure because the vaccine is most effective if the girls have not already been infected with HPV. Girls between 9 and 13 years of age should receive a two-dose HPV vaccine regimen with a 6-month interval between doses (0, 6 months), while women aged 16 to 26 years old can receive a three-dose regimen (0, 1, and 6 months or 0, 2, and 6 months), with cervical cancer screening still required after HPV vaccination (Akinola, Aimakhu, Ezechi and Fasubaa 2018). Cervical screening can be done with one of three types of tests that are now accessible and commonly utilised namely HPV DNA testing, cytology-based Papanicolaou tests (Pap tests), and unaided Visual Inspection with Acetic Acid (VIA). However, there is a lack of public awareness of these tests, particularly in underdeveloped nations (Jassim, Obeid and Al Nashee. 2018).

Statement of Problem

The prevalence of human papillomavirus (HPV), an important cause of cervical cancer, is higher in less-developed countries than in developed regions (Schiffman, Doorbar, Wentzensen, de Sanjosé, Fakhry, Monk, et al, 2016; Bruni, Diaz, Castellsagué, Ferrer, Bosch and de Sanjosé, 2010). Majority of deaths associated with cervical cancer occur in women who were never screened or treated as well as those who had an early sexual exposure, a history of multiple sexual partners, and a high number of live births (Chelimo, Wouldes, Cameron and Elwood, 2013). Strong evidence shows that the progression of cervical cancer into its later stages can be prevented through screening and treatment of premalignant lesions. Thus, in developed countries, the incidence of cervical cancer has been controlled due to effective screening programs, especially the systematic use of the Papanicolaou (Pap) smear test for identifying premalignant changes in the cervix (Elfström, Herweijer, Sundström and Arnheim-Dahlström, 2014); however, in many developing countries, screening services are lacking or are poorly accessible for the majority of the population (Bradford and Goodman, 2013).

Although the HPV vaccine was first introduced in Nigeria in 2009, the knowledge and vaccination against HPV as a preventive intervention against cervical cancer as well as vaccination uptake by the target demographic of young people, remains low (Isara and Osayi, 2021). According to recent research, less than 15% of adolescent girls have received HPV vaccine (Ogochukwu, Akabueze, Ezeome, Aniebue and Oranu, 2017; Ndkam and Oboh, 2017) and about 10% of women had cervical cancer screenings (Wright, Aiyedehin, Akinyinka, Ilozumba, 2014; Idowu, Olowookere, Fagbemi, and Ogunlaja, 2016). Similarly, Awodele, Adeyomoye, Awodele, Kwashi, Awodele and Dolapo (2011) reported low cervical screening uptake among more than 150 Nigerian nurses, with 60% reporting having never been checked for cervical cancer. Parents and caregivers of young people in Nigeria have exhibited a lack of understanding about cervical cancer prevention and screening for their children (Ifedioha and Azuike, 2018; Azuogu, Umeokonkwo, Azuogu, Onwe, Okedo-Alex, and Egbuji, 2019). Lack of such knowledge may have a negative impact on HPV vaccine acceptability and uptake. Furthermore, the low acceptance of cervical screening in Nigeria has been linked to barriers such as lack of awareness, insufficient knowledge of diseases and preventive treatments, insufficient spousal support, misperceptions, stigma, and cultural views resulting in poor outcomes and high mortality rates (Lim and Ojo, 2017). This paper will investigate whether lack of accessibility and other factors may hinder the utilization of cervical cancer screening

Objectives of the Study

The following objectives are stated as thus:

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- i. Determine how knowledgeable women are about uptake of cervical cancer screening in Dalhatu Araf Specialist Hospital Lafia.
- ii. Examine the attitudes of women of reproductive age towards uptake of cervical cancer screening in Dalhatu Araf Specialist Hospital Lafia.
- iii. Examine the socio-cultural factors that influencing the practice of cervical cancer screening among women of reproductive health in Dalhatu Araf Specialist Hospital Lafia.
- iv. Ascertain the level of practice of cervical cancer screening among women of reproductive health in Dalhatu Araf Specialist Hospital Lafia.

Conceptual and Theoretical Framework

Cervical Cancer

Cervical Cancer is a type of cancer that affects the cervix. Cervical cancer is the most common gynecologic cancer in women (Lea and Lin, 2012). High-risk human papillomavirus (HPV) is implicated as the major etiologic agent. Most invasive cervical cancers are preceded by a severe cervical dysplasia or carcinoma-in-situ (Lea et al., 2012). The World Health Organization (2018) opined that cervical cancer is a largely preventable disease, but worldwide it is one of the leading causes of cancer death in women. The primary cause of cervical pre-cancer and cancer is persistent or chronic infection with one or more of the “high-risk” (or oncogenic) types of human papillomavirus (HPV). HPV is the most common infection acquired during sexual relations, usually early in sexual life.

Cervical Cancer Screening

Cervical cancer screening involves identifying precancerous cervical lesions in women in otherwise good health before the lesions progress to malignancy (Parham, MulindMwanahamunta & Hicks, 2014). The goal of cancer screening is to systematically administer a quick, painless test to all women falling within a specific target age group to identify preclinical disease in a population that seems to be healthy (Banerjee, Mithal, Mandal & Basu, 2022). The World Health Organisation (WHO) advised screening of women between the ages of 30 and 49 (WHO, 2017). Zhang, Zhong, Zhao et al. (2020) outlined four screening procedures for cervical cancer among which are the conventional Pap smear, liquid-based cytology (LBC) or HPV testing, Visual inspection with acetic acid (VIA), and Lugol's iodine (VILI). This screening procedure allows for samples to be collected directly in a preservative solution and slides meticulously prepared to avoid any uneven manual smearing and thus reduce human error during interpretation (Safaeian, Solomon & Castle, 2007).

Knowledge of Cervical Cancer Screening among Women

In many developing countries, women's knowledge of Cervical Cancer and preventive measures are limited. The screening rate of cervical cancer is low in low-income countries. For example, studies such as have reported that only 13–29% of women in North Korea (Tran, Choe, Taylor, Ko, Pyo, So 2011) and 28% in Gabon (Assoumou, Mabika, Mbiguino, Mouallif, Khattabi, Ennaji, 2015) are aware of cervical cancer screening, and 15% of women in India (Hussain, Nasare, Kumari, Sharma, Khan, Das, et al., 2014), 26% in Malaysia (Johnson, Bhatta, Gurung, Aryal, Lhaki and Shrestha, 2014) and 36% in Thailand (Charakorn, Rattanasiri, Lertkhachonsuk, Thanappapasr, Chittithaworn and Wilailak, 2011) are aware of the HPV vaccine. In a Cambodian study, Touch and Oh (2018) reported that only 34% of women had heard about cervical cancer and the Papanicolaou (Pap) Smear test.

Ncane, Faleni, Pulido-Estrada, Apalata, Mabunda, Chitha and Nomatshila (2023) conducted a cross-sectional study among 108 purposively selected health workers in rural health facilities in the Eastern Cape Province to assess knowledge on cervical cancer and associated risk factors through the use of validated structured questionnaires. The Statistical Package for Social Sciences was used for analysis, with a 95% confidence interval and a p-value of 0.05 considered significant. A total of 91.7% of the 108 participants were female, and 25% were over the age of 50. A total of 88% and 85.2% indicated sexually transmitted disease and human immunodeficiency virus as major risk factors, respectively. This study identified inadequacies in essential knowledge for successful implementation of cervical cancer services and found that extensive training was needed.

Women Attitudes towards Cervical Cancer Screening

Omoyeni and Tsoka-Gwegweni (2022) conducted an observational cross-sectional study in three rural clinics in South Africa on the uptake of cervical cancer screening among women between the ages of 18-65 Years. The analyses revealed that 89.9% of the participants agreed with the statement that cervical cancer is highly prevalent in South Africa. Similarly, 90.0% of the participants agreed that any adult woman is at risk of cervical cancer. Half (54.1%) of the participants agreed that cervical cancer cannot be transmitted from one person to another. Thus, the majority of women (81.1%) showed a good or positive attitude towards cervical cancer screening in the study area.

In another study, an assessment of the attitudes of female staff in a Nigerian University was reported. The report showed the attitude of the participants towards cervical cancer screening and vaccination; it was reported that 48.5% (97) of the workers strongly agreed that they feel uncomfortable with a male doctor performing the colposcopy/pap test and 7.5% (15) strongly agreed that they do not see the need for cervical screening

since there are no early clear signs or symptoms. Sixty-eight staff (34%) strongly disagreed that they do not think that cervical cancer screening and HPV vaccine are necessary while 43.5% (87) of the participants agreed that Pap test is very expensive. Less than 25% (41) strongly agreed that they feel uneasy talking about cancer while 16.5% (33) and 30% (60) workers stated that they don't think there is any screening site in the primary health care facility close by and that they are scared of a cancer diagnosis and treatment respectively. Overall, less than half of the participants (46%) had a positive attitude towards cervical cancer screening and vaccination. In a similar vein, Tavafian (2012) in his study found that 45.2% of the respondents agreed that lack of female screeners in health facilities contribute to not screening. This may be as a result of religious reasons. Also, majority disagreed that they do not see the need for cervical screening since there is no sign or symptom and that they don't think the cervical cancer screening and HPV vaccine are necessary.

Factors Affecting the Uptake of Cervical cancer Screening

The poor uptake of the cervical cancer screening may be attributed to the lack of communication between healthcare workers and patients regarding availability and benefits of the screening. Specifically, factors such as a feeling of embarrassment, perceived pain during examination, fatalism associated with a diagnosis, unsupportive husbands and lack of awareness about cervical cancer and available services can play a key role (Twinomujuni et al, 2015). In a study on the barriers to the uptake of cervical cancer screening, it was reported that Barriers to screening highlighted by the discussants in our study include; the sex of the person performing the test, financial constraints, requiring consent from husbands, and superstitious beliefs. Due to cultural and religious beliefs, it is not uncommon for women to shy away from vaginal examinations by male health workers especially when it is not a medical emergency or not during the process of childbirth. A similar finding was reported by Modibbo, Dareng, Banisaye, Jedy-Agba et al in a study conducted in two hospitals, in the southwest and northcentral regions of Nigeria. The study showed that religious and cultural obligations of modesty, gender of healthcare providers, fear of disclosure of results, fear of nosocomial infections, lack of awareness, discrimination at hospitals, and need for spousal approval as barriers to uptake of screening (2016). In a study by Pinzon-perez, Perez, Torres and Krenz (2005) among Latino women living in California, most women showed a preference for female health workers. The study further showed that some of the factors that hinder the uptake of Pap smear are long waiting periods, a lack of continuity of care, a perceived lack of quality of care, language differences, and a lack of knowledge regarding how to access the health system.

Theoretical Framework

Two Theoretical Framework were adopted for this study.

Health Belief Model

Health Belief Model (HBM) is one of the first models that adapted theory from the behavioral sciences to health problems, and it remains one of the most widely recognized conceptual frameworks of health behavior. The HBM attempts to predict health-related behavior in terms of certain belief patterns. A person's motivation to undertake a health behavior can be divided into three categories: *individual perceptions*, *modifying factors*, and *likelihood of action*. *Individual perceptions* are factors that affect the perception of illness and with the importance of health to the individual, perceived susceptibility, and perceived severity. *Modifying factors* include demographic variables, perceived threat, and cues to action. *The likelihood of action* is the perceived benefits minus the perceived barriers of taking the recommended health action. The combination of these factors causes a response that often manifests into the likelihood of that behavior occurring (Janz and Becker, 1984; Rosenstock and Strecher, 1988).

The HBM proposes that the perception of a person's health behavior is influenced by at least three factors, general health values, which include interest and concern about health; specific health beliefs about vulnerability to a particular health threat; and beliefs about the consequences of the health problem (Hochbaum and Rosenstock, 1952). If a person perceives a threat to their health, is consecutively cued to action, and their perceived benefits outweigh the perceived barriers, then they are likely to undertake the recommended preventive health action.

Adopting the HBM to explain the attitude and practice of uptake of cervical cancer screening, the model proposes that people are most likely to take preventative action if they perceive the threat of a health risk to be serious, if they feel they are personally susceptible and if there are fewer costs than benefits to engaging in it. Therefore, a central aspect of the Health Belief Model is that behavior change interventions are more effective if they address an individual's specific perceptions about susceptibility, benefits, barriers, and self-efficacy.

The HBM proposes that the uptake of cervical cancer screening is more likely to occur if the patient feels that:

- i. If an individual feels *susceptible* to this disease.
- ii. The individual believe that the disease is *serious*.
- iii. The individual believe that the *benefits* of the uptake of the screening will outweigh the *costs* or *barriers* involved in following it.
- iv. When an individual feels *confident* that she can carry out the recommended screening successfully.

In addition, HBM suggests that patients are more likely to undertake the screening if they are exposed to cues to action, such as available services, written or telephone reminders, or public announcements such as posters and public service advertisements on radio.

Rational choice theory

The Rational Choice Theory has its roots in the classic school of criminology developed by the Italian social thinker Cesare Beccaria (Devine, 1982). The theory is also popular and widely used in Sociology, Economics, Marketing and other academic disciplines. In Sociology however, the theory was pioneered by George Homas, who in 1961 laid the basic framework for exchange theory, which he grounded in assumptions drawn from behavioral psychology. During the 1960s and 1970s, other theorists (Blau, 1964; Coleman, 1973 and Cook, 1977) extended and enlarged Homas's framework and helped to develop a more formal model of rational choice theory (Scott, 2000). The theorists assumed that individuals are motivated by their personal wants and goals driven by personal desires. Since it is not possible for individuals to attain all of the various things that they want, they must make choices related to both their goals and the means for attaining those goals. Individuals must anticipate the outcomes of alternative courses of action and calculate which action will be best for them. In the end, rational individuals choose the course of action that is likely to give them the greatest satisfaction. The Rational Choice Theory has three key elements. The first is the belief that all action is fundamentally "rational" in character. This distinguishes it from other forms of theory because it denies the existence of any kinds of action other than the purely rational and calculative. It argues that all social action can be seen as rationally motivated, however much it may appear to be irrational. Secondly, humans act with rationality when making choices and lastly choices made are aimed at optimization of the pleasure or benefits (Scott, 2000).

The theory is useful in explaining some of the motivations which encourage uptake of cervical cancer screening among women. The explanation of uptake of screening will be more meaningfully understood if we approach it from the view that human behaviour is a carefully calculated action meant to achieve defined goals and are designed to prevent the occurrence of the disease which is considered more difficult and costly to treat.

Methodology

As a survey kind of study, the researchers which entails collecting information from a fraction of a population, utilizes both quantitative and qualitative research technique. Thus, the population is 1672 consisting all the pregnant women and women attending postnatal care between the ages of 15-49 who have registered for antenatal care services

at Dalhatu Araf Specialist Hospital Local Government Area of Nasarawa State between the periods of October 2023 to January 2024.

Since the population is finite, the researchers take a sample of 310 respondents using Krejcie and Morgan's (1970) sample size determination table of 95% confidence level and 5% margin error (see appendix I). Simple Random Sampling technique was employed to select the respondents who attend anti-natal and post-natal screening, four days a week from Monday, Tuesday, Thursday and Fridays using lottery method. In each antenatal visit/day, numbers from 1-60 were assigned to all the participants. Hence, forty (40) questionnaires was distributed randomly on each clinic day for two weeks until the entire sample size is covered.

However, for the purpose of In-depth Interview, four Key Informants were interviewed comprising Mentor mother Nurses, Midwives and Gynecologist who provide anti-natal services to the participants, to ascertain the professional perspectives on the knowledge, attitude and practice of women attending maternal care services towards their uptake of Cervical Cancer screening in Dalhatu Araf Specialist Hospital Lafia.

Results

Table 1: Awareness of Cervical Cancer

Response	Frequency	Percentage
I am aware	260	84.4
Not aware	48	15.5
Total	308	100%

Source: Field Survey, 2025

Table 1 provides insights into the level of awareness of cervical cancer among women of reproductive age. The results indicate that the vast majority of respondents, comprising 84.4%, affirmed that they have heard of cervical cancer. This high level of awareness suggests a foundational knowledge base within the surveyed population regarding the existence of cervical cancer as a health issue. However, it is noteworthy that a small proportion, 15.5%, reported no awareness of cervical cancer, highlighting the importance of targeted educational initiatives to reach individuals who may be uninformed about this critical health concern.

Table 2: Attitudes of Women towards Cervical Cancer Screening

Responses	Strongly Agree (%)	Agree (%)	Neutral (%)	Disagree (%)	Strongly Disagree (%)	Total
Cervical Cancer is a common disease among women in Lafia	37 12.0%	102 33.1%	86 27.9%	52 16.8%	31 10.6%	308 100%

Responses	Strongly Agree (%)	Agree (%)	Neutral (%)	Disagree (%)	Strongly Disagree (%)	Total
Any adult woman can acquire cervical cancer	82 26.6%	88 28.5%	48 15.5%	56 18.1%	29 9.4%	308 100%
cervical cancer causes no harm to a client	40 12.9%	65 21.1%	80 25.5%	83 26.9%	41 13.3%	308 100%
I am willing to get screened for cervical cancer	70 22.7%	99 32.1%	62 20.1%	44 14.2%	32 10.3%	308 100%
I am willing to be screened if it is free and cause no harm	87 28.2%	138 44.8%	31 (10.6)	32 10.3%	20 10.3%	308 100%
I intend to advice other women to undergo cervical cancer screening	85 27.5%	91 29.5%	48 15.5%	56 18.1%	26 8.4%	308 100%

Source: Field Survey, 2025

Table 2 offers a comprehensive view of women's attitudes towards cervical cancer screening. Firstly, regarding the perception of cervical cancer prevalence in Lafia, the data reveal a mix of awareness levels, with a significant proportion agreeing (33.1%) or remaining neutral (27.9%), suggesting recognition of the disease's prevalence, while others disagreed (31.5%) indicating potential skepticism or lack of awareness about the issue's magnitude. The table showed a varied understanding of cervical cancer risk factors among respondents. While a substantial percentage strongly agreed (28.5%) that any adult woman can acquire cervical cancer, suggesting widespread recognition of the disease's potential impact, a notable minority strongly disagreed (18.1%), indicating a degree of denial or lack of awareness regarding the associated risks. Also, the data indicate varying degrees of willingness to get screened for cervical cancer, with a substantial proportion expressing agreement (32.1%) or strong agreement (22.7%) towards undergoing screening, but a notable minority disagreeing (14.2%) suggesting potential barriers or concerns regarding screening uptake.

Equally, attitudes towards the perceived safety of pap smears revealed mixed sentiments, with a notable percentage disagreeing (26.9%) that pap smears cause no harm to clients, underscoring the need for education about the safety and efficacy of screening methods. Furthermore, attitudes towards cervical cancer screening methods exhibit a spectrum of responses. A considerable majority (32.1%) expressed willingness to undergo screening if it were free and deemed harmless, showcasing a positive inclination towards preventive healthcare measures.

Also, regarding intentions to advocate for cervical cancer screening, the data reflect a moderate level of willingness among respondents. While a substantial portion agreed (27.5%) to advise other women to undergo screening, a notable minority disagreed (18.1%) indicating potential barriers or hesitancy towards engaging in health advocacy efforts.

Findings from the interview revealed a negative attitude towards cervical cancer screening. The participants opined that most women are unwilling to undertake the screening. In the words of a participant

I would say that most women are unwilling to undertake cervical cancer screening especially when they are not experiencing any symptoms of the disease. I can bold say that it is not just women who come for maternal care that but even some female health care workers within this facility (43 years, Healthcare Worker)

Table 3: Response on the uptake of Cervical Cancer Screening

Practice of cervical cancer screening		
Ever undergone screening	Frequency	Percentage
Ever had	94	30.5
Never have	214	69.4
Total	308	100%
Number of times you had yourself screened for cervical cancer		
Once	80	26.3
Twice	14	4.3
Thrice	0	0.0
Never	214	69.4
Total	308	100%
When last did you have yourself screened?		
Within last three years	54	17.5
More than three years ago	40	14.2
Never	214	69.4
Total	308	100%
Reason for getting screened		
Request from a health worker	54	17.5
Had signs and symptoms	23	7.4
I voluntarily want to know my status	17	5.5
Never	214	69.4
Total	308	100%

Source Field Survey, 2025

A significant proportion of respondents, consisting 69.4% have never undergone screening. 30.5% of the total respondents indicated having been screened at least once. Among those who had undergone screening, 26.3% had it once, 4.5% of the total respondents had the screening twice respectively. While examining the recency of screening, the data reveal that the majority of respondents who had undergone screening within the last three years constitute 17.5%. while 14.2% had their last screening for more than three years from the time of the study. This highlight potential gaps in adherence to recommended screening intervals.

Further response from table 3 shows that 17.5% of the total respondents undergone cervical cancer screening due to request from a health worker. 7.4% undergone through the screening due to signs and symptoms, while 5.5% of the total respondents expressed a voluntary desire to know their status.

This was reiterated from the responses from the interview that shows that the practice of cervical cancer screening is abysmally low among women in the study area. In the words of one of the participants:

Having worked closely with women in our communities, I have gained firsthand insight into the challenges contributing to the low uptake of cervical cancer screening. Despite ongoing efforts to promote awareness and emphasize the importance of early detection, a significant number of women continue to exhibit hesitancy or reluctance towards screening. (Health Worker).

From the forgoing, it can be deduced that the uptake of cervical cancer screening is low among women in Lafia and for those who were screened, mostly only underwent the screening as a result of medical recommendations and most of them were screened for about three years ago.

Table 4: Response on Factors Influencing the Uptake of Cervical Cancer Screening

Cervical cancer screening is risky	Frequency	Percentage
Yes	238	77.7
No	70	22.7
Total	308	100%
Lack of Spousal Approval	Frequency	Percentage
Yes	246	79.8
No	62	20.1
Total	308	100%
High Cost of Screening	Frequency	Percentage

Cervical cancer screening is risky	Frequency	Percentage
Yes	221	77.1
No	87	28.24
Total	308	100%
Fear of being diagnosed with cancer	Frequency	Percentage
Yes	211	68.5
No	97	31.4
Total	308	100%
Awareness of screening centers	Frequency	Percentage
Aware	188	61.0
Not Aware	120	38.9
Total	308	100%
My religious belief does not encourage it.	Frequency	Percentage
Yes	80	25.9
No	228	74.0
Total	308	100%
Being ashamed to be screened by a male doctor	Frequency	Percentage
Yes	184	59.7
No	124	40.2
Total	308	100%
Ignorance	Frequency	Percentage
Yes	193	62.6
No	115	37.3
Total	308	100%

Source: Field Survey, 2025

From table 4, the factors impacting the uptake of cervical cancer screening identifies various significant obstacles within the surveyed community. These obstacles consist of a low perceived risk of cervical cancer (77.7%), absence of spousal approval (79.8%), high costs associated with screening (77.1%), fear of receiving a cancer diagnosis (68.4%), lack of knowledge regarding screening facilities (61.0%), religious convictions (25.9%), discomfort with male healthcare providers (59.7%), and a general lack of awareness (62.6%). These findings agree with responses from the interview. In the words of some of the participants:

There are numerous factors I can mention that has hindered some women and even health workers here in the hospital from undertaking the screening among which are the perception that they are not

vulnerable and in some cases the fear of getting a positive diagnosis. But most importantly is the fact that some women are not comfortable opening their cervix for screening especially if the health practitioner is male personnel. I can categorical tell you that apart from child delivery or in cases of having symptoms, most women are unwilling to be examined on the grounds of been shy (43 years, healthcare worker) One of the main challenges is ensuring that all women have access to screening services, especially those in rural or underserved areas. Financial constraints can also be a barrier for some women, as screening tests and follow-up procedures may not always be affordable. Additionally, cultural beliefs and stigma surrounding reproductive health can sometimes deter women from seeking screening, which is why education and awareness campaigns are so important (Health Worker).

These results highlight the intricate interaction of personal, socio-economic, cultural, and healthcare system-related elements that influence screening behavior. Overcoming these barriers requires comprehensive strategies that involve awareness initiatives, enhanced accessibility, cost-effective measures, and culturally sensitive healthcare approaches to promote the uptake of cervical cancer screening.

Discussion of Findings

Findings on the knowledge of cervical cancer screening reveal that there is a high level of awareness of cervical cancer among respondents, with the majority recognizing it as a health issue. This agrees with studies like Idowu et al (2016) who reported that about three quarter of their study participants are aware of cervical cancer. However, there are discrepancies on respondents' understanding regarding the risk factors, with varying levels of agreement observed for factors such as sexual behavior, childbirth, smoking, age, HPV infection, and alcohol consumption. While there is generally high level of agreement regarding smoking as a risk factor, uncertainty exists for other factors. Additionally, the awareness of cervical cancer screening methods is limited with a significant proportion of respondents indicating they have never heard of it. This agrees with the findings of John-Akinola et al (2021) who reported that the level of knowledge of cervical screening is low. Despite some respondents expressing preferences for screening intervals and methods, a notable proportion remains uncertain or uninformed.

Findings on women's attitudes towards cervical cancer screening in Lafia showed that there is a mixed perception of cervical cancer prevalence. A significant proportion

recognizing its existence but skeptic and lack awareness about its magnitude. Further findings show variation among respondents' understanding of cervical cancer risk factors, with some acknowledging the disease's potential impact while others exhibit denial or lack of awareness regarding associated risks. More so, the findings show that the attitudes towards screening are diverse, with a substantial proportion expressing willingness to undergo screening but also a notable minority indicating potential barriers or concerns. Moreover, while there is a positive inclination towards screening if it were free and deemed harmless, intentions to advocate for cervical cancer screening vary among respondents, suggesting differing levels of willingness to engage in health advocacy efforts. This agrees with the findings reported by Oluwole et al. (2019) which showed that 86.7% of the research participants expressed willingness to undergo screening if given the opportunity. This finding is similar to the report of Okunowo et al. (2018) who reported that the reason for not being screened is the lack of awareness and recommendation from health practitioners.

On the practice of screening uptake, the finding reveals that a significant portion of participants, accounting for 70.7%, have never undergone any form of screening. Conversely, only 24.6% of respondents reported having been screened at least once. This finding aligns with what literatures had reported in different parts of the world. The findings from various studies have consistently shown a lack of participation in cervical cancer screening among women in Nigeria (Ahmed et al., 2013, Oluwole et al., 2019; Ifemelumma et al., 2019; Dozie et al., 2021). When considering the regency of screening, it is noteworthy that the majority, amounting to 60.7%, have been screened within the past three years, indicating recent engagement with screening services. On the other hand, a minority, constituting 38.5%, had their last screening more than three years ago, suggesting potential gaps in adherence to the recommended screening intervals. The reasons for undergoing screening varied among participants, with the most common being a recommendation from a healthcare professional, accounting for 45.1% of respondents. Screening due to signs and symptoms was reported by 26.1% of participants, while 7.7% expressed a voluntary desire to know their status as the motivation for screening.

The examination of factors impacting the uptake of cervical cancer screening identifies various significant obstacles within the surveyed community. These obstacles consist of a low perceived risk of cervical cancer 77.7%, absence of spousal approval 79.8%, high costs associated with screening 77.1%, fear of receiving a cancer diagnosis 68.5%, lack of knowledge regarding screening facilities 61.0%, religious convictions 25.9%, discomfort with male healthcare providers 59.7%, and a general lack of awareness 62.6%. Furthering this point, McCaul et al. (1996) found a positive association between risk perception and uptake of screening for certain cancers. Hence, low risk perception

could have resulted in the belief that there is no need for screening uptake among them. Also, spousal refusal is also a reason that could also explain the low screening uptake among our respondents. In countries with strong cultural values and family ties as Nigeria, husbands are the key decision takers in most homes. Thus, women are often careful of services requested from healthcare providers in order not to be tagged as women of low virtues by their spouses and their significant others. Moreover, almost 68.5% of the women could not go for screening for fear of positive result after screening. This corroborates with Vrinten et al. (2014) who argues that thought of positive results after screening predicted low uptake of colorectal cancer screening among respondents in the United Kingdom. This could have also been responsible for the low cervical cancer screening observed among participants in the study area. These results highlight the intricate interaction of personal, socio-economic, cultural, and healthcare system-related elements that influence screening behaviour.

Theoretically, aligning to the Health Belief Model (HBM) on the attitude of women towards the uptake of cervical cancer screening, it underscores the multifaceted nature of factors influencing cervical cancer screening uptake in the community of Lafia. While there is a high level of awareness of cervical cancer, discrepancies exist in understanding risk factors, indicating variations in perceived susceptibility and severity of the disease. Despite limited awareness of screening methods, a willingness to undergo screening is evident among some respondents, aligning with perceived benefits. However, numerous barriers, including low perceived risk, cost concerns, and cultural factors, present significant challenges to screening uptake, reflecting perceived barriers. Healthcare provider recommendations serve as critical cues to action, motivating screening participation. Additionally, differences in intentions to advocate for screening highlight varying levels of self-efficacy among respondents. Addressing these factors through comprehensive strategies, such as awareness initiatives, enhanced accessibility, and culturally sensitive approaches, is crucial to promoting cervical cancer screening uptake and reducing disparities in screening participation in the community of Lafia.

Conclusion and Recommendation

The study emphasizes various important discoveries related to cervical cancer screening among women in the examined community. Despite a good level of knowledge about cervical cancer itself, there are noticeable deficiencies in understanding risk factors and screening methods, especially Pap smear. The participation in screening remains limited, with a considerable number of participants never having undergone screening. Based on the findings regarding awareness and understanding of cervical cancer and its screening methods, it is recommended to implement targeted education and awareness

campaigns. These campaigns should focus on addressing knowledge gaps regarding risk factors and screening methods, particularly Pap smear.

- i. Healthcare providers should also be trained to provide accurate information and guidance to women regarding cervical cancer and screening options.
- ii. To address the low uptake of cervical cancer screening, efforts should be made to improve accessibility and affordability of screening services. This could involve establishing mobile screening clinics in underserved areas, reducing or eliminating screening costs for low-income individuals, and providing transportation assistance to those in need.
- iii. Community-based outreach programs should be implemented to raise awareness about the importance of screening and to encourage women to seek screening services.
- iv. To encourage regular screening and adherence to recommended intervals, healthcare providers should emphasize the importance of regular screening during routine health visits. Reminders and follow-up appointments should be scheduled to ensure that women receive screening at appropriate intervals. Furthermore, educational materials should be provided to women to help them understand the benefits of regular screening and the potential consequences of delaying or skipping screenings.
- v. To address barriers such as lack of spousal approval, fear of diagnosis, and cultural beliefs, it is important to engage with community leaders and stakeholders to promote acceptance and support for cervical cancer screening. Culturally sensitive educational materials and interventions should be developed to address misconceptions and alleviate fears surrounding screening. Additionally, efforts should be made to involve male partners in the screening process and to educate them about the importance of cervical cancer screening for women's health.

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