Possible Factors Inhibiting Cervical Cancer Awareness and Screening Among Women in Suleja Local Government Area

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Abstract
This study investigates factors inhibiting cervical cancer awareness and screening among women in Suleja Local Government Area. The study was guided by one objective and one hypothesis. The theory of planned behaviour and the Health Belief Model were used which has theoretical underpinnings because both explain individual perceptions and attitudes towards health knowledge and health seeking behaviour. The study made use of both qualitative and quantitative data. The cross-sectional survey design was employed. Taro Yamane was used to determine the sample size of the respondents. The Cochran formula was used to determine the sample distribution. Quantitative data gotten from the field was imputed into Statistical Package for Social Sciences (SPSS) software and analyzed using frequency, mean, standard deviation. Simple regression was used to test the study hypotheses at a .05 level of significance. The qualitative data was transcribed, and analysed thematically for responses and based on observation recorded during the Focus group discussion (FGD). The study revealed low screening rates among women who had knowledge of cervical cancer due to socio-cultural, psychological and socio-economic constraint. The study recommended that health professionals and social workers develop and implement evidence-based education programs to improve knowledge and awareness about cervical cancer risk factors.

Key Words: *cervical cancer, awareness, screening uptake, women's health, socio-demographic factors.*

INTRODUCTION

Cervical cancer is a significant public health concern, with many cases being diagnosed in advanced stages due to a lack of awareness and screening. Despite the importance of cervical cancer screening, many women face barriers that prevent them from accessing these life-saving services. According to Global Cancer Observatory (GLOBOCAN) (2020), cervical cancer is a significant public health concern globally, with high morbidity and mortality rates, particularly in low and middle-income countries. It is the world most common cancer in women worldwide, with an estimated 570,000 new cases and 311,000 deaths annually according to GLOBOCAN (2020). Nigeria is the most populous country in Africa with an estimated population of about 170 million in 2014 and with an estimated total population of women between 15-49 years about 40.43 million who are at risk of developing cervical cancer (Ingwu, 2020). No fewer than 14,089 new cervical cancer cases are diagnosed annually in Nigeria while WHO estimates ranked it as the second leading affliction in Nigeria especially among women aged 15 to 44. Corroborating this finding,

Akanbi (2019), stated that it has recently been estimated that every year, 17,760 new cases of cervical cancer are diagnosed and 11,659 die from the disease. GLOBOCAN estimates that cervical cancer is the second commonest cancer in Nigeria among women with an Age Standardized Incidence Rate (ASR) of 31.0 per 100,000 (GLOBOCAN, 2020). This is similar to rates quoted from Abuja and Ibadan cancer registries of 30.3 per 100,000 and 36.0 per 100,000 respectively (Ingwu, 2020). Despite the prevalence and burden of cervical cancer worldwide with almost 80% occurring in developing countries such as Nigeria, only about 52% of Nigerian women are aware of this deadly disease (Akanbi, 2019).

Cervical cancer awareness faces significant barriers, hindering efforts to prevent and treat this devastating disease. Despite being one of the most preventable and treatable forms of cancer, cervical cancer remains a leading cause of cancer deaths in women worldwide. One major challenge is lack of awareness and screening among women 15years and above. Many women, especially in low-income and marginalized communities, are unaware of the importance of cervical cancer screening, vaccination, and early detection. This knowledge gap leads to delayed diagnosis and treatment, resulting in poor health outcomes. Stigma and cultural barriers also pose significant challenges.

Cervical cancer is a health challenge that affect women (Ingwu, 2020). I observed over time that many women from the rural area in Suleja Niger state are being admitted as a result of cervical cancer, these rural areas do not have health care facilities that screen women for cervical cancer. Due to general prevalence of cervical cancer, women suffer and die in silent due to cervical cancer. There is low awareness of the cervical cancer symptoms, signs and early detection among women most especially those in the rural areas of Niger state. According to Idowu, Olowookere, Fagbemi and Ogunlaja, (2019) adopted screening for early disease detection of cervical cancer and Human Papilloma Virus (HPV) vaccination for primary prevention in girls of 9-15 years, though the level of implementation of this plan is still debatable in Nigeria (FMoH, 2022).

Although screening is a known cost-effective strategy used in reducing the burden of cervical cancer worldwide, its uptake particularly in developing countries is still low. One of the barriers to access is that most cervical cancer screening services in Nigeria had been sporadic and poorly coordinated as stated by Idowu, Olowookere, Fagbemi, & Ogunlaja, (2019). Most services are urban-based; the rural and semi urban dwellers are often neglected. Another problem is low awareness of women about cancer of the cervix and cervical cancer screening. Such cases are seen at their advanced stages when physicians cannot do anything to help them. In spite of efforts from governmental and non-governmental organizations to improve access to cervical cancer screening services in Nigeria, uptake has been appalling (Idowu et al., 2019).

This study answered the following question:

i. What are the possible factors inhibiting cervical cancer awareness and screening among women in Suleja L.G.A?

The aim of the study was to identify possible factors inhibiting cervical cancer awareness and screening among women in Suleja LGA of Niger state.

i. To ascertain possible factors inhibiting cervical cancer awareness and screening among women in Suleja L.G.A.

This study identified the following hypothesis which is stated in null form with a view to test the outcome of the findings:

H01: there is no significant influence between possible factors inhibiting cervical cancer awareness and screening among women in Suleja L.G.A.

This study provides valuable contributions to theory, practice and methodology. Theoretically, the findings at the end of this study are expected to support or validate or even challenge previous theories and premises in the area of factors that influence the attitudes of women towards cervical cancer awareness and screening, thereby upholding or calling for the formulation of new theories that can explain current realities in the field of cervical cancer awareness and screening among women.

Practically, it is expected that from the facts that were gathered in this study and the recommendation thereof, that cervical cancer awareness and screening policy makers will see it as an expose' of how they can affect the lives of women positively. Methodologically, the study is expected to provide methods, material for scholarship in the cervical cancer awareness and screening studies. The scope of the study purposively covers all the 10 wards in Suleja Local Government Area of Niger State.

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

A risk factor is anything that increases your chance of getting a disease such as cancer. Several risk factors increase a woman's chances of developing cervical cancer. Women without any of these risk factors rarely develop cervical cancer. According to American Cancer Society (2021) cervical cancer risk factors include:

Factors inhibiting effective cervical cancer awareness and screening.

The International Agency for Research on Cancer (IARC) (2023) event to mark Cervical Cancer Awareness Month, highlighted the work that remain to be done for the world to eliminate cervical cancer by the end of this century, and that is by promoting cervical cancer awareness and sensitization of persistent infection with high-risk types of human papillomavirus (HPV), an extremely common family of viruses that are transmitted through sexual contact among women.

The age standardized incidence rate for cervical cancer in Nigeria is more than double of the world's average (WHO/ICO, 2020). The age standardized mortality rate in Nigeria is 1,047.00 per 100,000 women per year, while that of Western Africa is 45.0 (WHO/ICO, 2020). According to Obokoh (2018), the high mortality rate of cervical cancer in Nigeria could be attributed to late diagnosis, lack of awareness, low utilization of screening services, poverty, affordability of HPV vaccines, and lack of knowledge of suggestive symptoms.

In Nigeria, according to Hadiza (2021) the use of condom between husband and wife is regarded as abnormal, notwithstanding whether the husband has other wives or mistresses. The low awareness of cervical cancer risk factors and symptoms among young girls may contribute to their vulnerability and exposures to cervical cancer risks including early age at sexual debut and multiple pregnancies. Apart from the above, the prevalence of sexual misdemeanour including exchange of sex for money (Wechsberg et al., 2021) is also a factor that aid women's vulnerability to cervical cancer. In addition, early marriage and high parity that are usual norms in Northern Nigeria equally contributes to the vulnerability of women to cervical. Some of these barriers that militates against cervical cancer awareness and screening are:

Ranjit, Gupta, Shrestha, Kushner, Nwomeh and Groen's study (2019) on the awareness and prevalence of cervical cancer screening among women in Nepal, found out of that out of the 816 women who answered the relevant survey question, 710 (87.0%) had no knowledge of cervical pap smear tests. Only 39 (4.7%) of the women had ever undergone a cervical pap smear test. In multivariate analysis, having undergone a cervical smear was associated with literacy and having not undergone the test associated with those living in rural areas.

In Kenya, Nishimura, Yatich and Huchko (2018) carried out a research on the facilitators and barriers to cervical cancer screening in Migori. The study revealed that the participants in both groups assessed their education around HPV, cervical cancer, and screening was very low in the community, and identified this lack of education as the main barrier to screening. Community members reported fear of pain and embarrassment as significant barriers to screening pelvic exam. They also reported that lack of knowledge and discomfort among providers was significant barriers. Providers reported workload and lack of supplies and trained staff as significant barriers. Most participants in the FGDs felt that self-collection would help address barriers.

In a study carried out by Idris and Ahmed (2023) on the knowledge, attitude and practice of cervical cancer screening among market women in Zamfara Nigeria, the researchers adopted a cross sectional study which involved a total number of 321 women. The study revealed that the respondents exhibited a fair knowledge of cervical cancer and cervical cancer screening (51.5%); however, their knowledge of risk factors was poor. There was generally increased attitude to cervical cancer (86.7%) but their level of practice was low (20.2%).

Economic status: Many low-income women do not have easy access to adequate health care services, including pap tests. This means they may not get screened or treated for cervical pre-cancers. Al-Amro, Gharaibeh, Oweis (2020) stated that lower economic status limited access to education, healthcare, and information, leading to lower cervical cancer screening services due to cost. Lower cervical cancer screening rates was rated at 20-30% in low-income countries. Higher economic status provides greater access to information, healthcare, education, increased access to screening services, including private healthcare and insurance coverage there by resulting in higher cervical cancer screening rates of about 70-80% in high-income countries. Economic status of women affects their perception to cervical cancer screening uptake.

In Leinonen, Campbell, Ursin, Trope and Nygard's (2019) study on the barriers to cervical cancer screening faced by immigrants: a registry-based study of 1.4 million women in Norway reported that out of the 208, 626 immigrants and 1,57,223 native Norwegians sampled for the study 52% of immigrants were not screened. All immigrants showed 1.72 times higher non- adherence rates compared with native Norwegian women when adjusted for age and parity. Being unemployed or not in the workforce, being unmarried, having low income and having a male general practitioner was associated with non-adherence regardless of region of origin.

Cultural and Religious beliefs.

Cultural and religious beliefs deter some women from participating in cervical cancer screening which they see it as inappropriate and against their culture and belief most especially in the northern/North central (Niger state is one) part of Nigeria which are mostly dominated by Muslims. African women are generally conservative in nature, they suffer embarrassment at lying on their backs with their legs open and exposing their private parts for examination, especially if it is a male providing the service, for example in Suleja LGA, which are dominated by Hausa culture, women are forbidden to allow another man to touch them or reveal their private parts.

Genital exposure is viewed as a violation of women's privacy. The cultural and religious norms which some Nigeria women value discourages them from exposing their intimate body parts to other people other than their husbands, unless if there are life threatening and compelling reasons. Sense of modesty, cultural and religious beliefs are significant barriers to the utilisation of cervical cancer screening services.

Education level on cervical cancer awareness and screening.

According to Fahmida, Zubaida, Fahmida and Monjurul (2020) study on the knowledge and awareness about risk factors of cervical cancer, its screening and vaccination among the women attending Chittagong medical college hospital found out that of the 508 respondents only 211(41.54%) had an idea about cervical cancer, while only 114 (22.44%) knew that VIA is the screening test for cervical cancer. A total of 390 (76.77%) respondents did not know any cause of cervical cancer. Most of the respondents (80%) came for VIA due to doctor's advice. After doing VIA among 229 respondents, 149 (65.07%) reported that they had been counselled for a follow-up by the health professionals and 118 (51.52%) were ready for routine periodic screening. Majority (85.88%) of the respondents were ignorant about the vaccine of cervical cancer. Age and marital status did not influence their knowledge, but the level of education and occupation was found to positively influence their knowledge of cervical cancer and their acceptance of the screening test.

Another study carried out by Zeitoun and Shemesh (2019) on the level of breast and cervical cancer awareness among women in a rural area of South Africa revealed that overall level of knowledge about breast and cervical cancer in rural Bushbuckridge were found to be reduced with 66.89% and 74.49% of women who rated themselves with a poor understanding of breast and cervical cancer knowledge respectively. Among the participating women, those over the age of 40, with higher level of education were found to be more cognizant in terms of breast and cervical cancer awareness with a 30% ($p = 0.0923$) and 52% ($p < 0.001$) respectively. Their younger and less educated counterparts had a 21% ($p = 0.078$) and 32% ($p = 0.034$) awareness of breast and cervical cancer, respectively. The leading source of information for both breast and cervical cancer was healthcare facilities with a 67.1% and 63.5% respectively.

In a cross-sectional study carried out by Liu, Li, Ratcliffe and Chen (2019) on assessing knowledge and attitudes towards Cervical Cancer Screening among Rural Women in Eastern China reported that out of the 405 rural women (with the mean age of 49 years) involved in the study, 210 (51.9%) participants had a high level of knowledge. An overwhelming majority, 389 (96.0%) expressed positive attitudes, whilst only 258 (63.7%) had undergone screening for cervical cancer. Related knowledge was higher amongst the screened group relative to the unscreened group. Age, education and income were significantly associated with a higher knowledge level. Education was the only significant factor associated with a positive attitude. In addition, women who were older, or who had received a formal education were more likely to participate in cervical cancer screening.

Theoretical framework

Health belief model (HBM)

The Health Belief Model (HBM) is a psychological model that attempts to explain and predict health behaviours. This is done by focusing on the attitudes and beliefs of individuals. The HBM was first developed in 1950s by four social psychologists, Hochbaum, Kegeles, Levental, and Rosenstock (Rosenstock 1974). The model was developed in response to the failure of a free tuberculosis health screening program. According to Rosenstock (1974), HBM four core assumptions are: Perceived Susceptibility: It refers to beliefs about the likelihood of getting a disease or condition. Perceived severity: An individual's assessment of the seriousness of the condition and its potential consequences. Perceived benefits: An individual's assessment of the positive consequences of adopting the behaviour. Perceived barriers: An individual's assessment of the influences that facilitate or discourage adoption of the potential behaviour.

When applied to this study, women must believe there is a possibility of getting cervical cancer before they would be interested in cervical cancer screening. Based on perceived susceptibility, most women are not aware of cervical cancer except when a friend or blood relation is diagnosed with the disease; until that happens most of them are not aware of cervical cancer talk more of cervical cancer screening. Based on perceived severity, when a woman is critically ill or loses her life to cervical cancer, a consciousness arises among women around her on the need to go for cervical cancer screening. When women realize the benefits of cervical cancer screening or treatment, they would take their health seriously (perceived benefits). Based on perceived barriers, when women are surrounded by people who encourage a healthy life style they are bound to take their health seriously.

HBM has been applied in studies on college students' health behaviour for osteoporosis preventive nutritional behaviours among Iranian women to explain patient involvement in patient safety Boyle and Mackinnon (2023) and explaining the several stages of exercise change in older adults. According to Grabara (2019). HBM has a long research history and broad applicability and it is the most widely used framework for understanding and predicting health behaviours Past experience and self-efficacy particularly are not well captured in HBM. According to Jeihooni, Hidarnia, Kaveh, Hajizadeh, & Askari (2024), stated that past behaviour is an important source of information, it shapes one's behaviour and value to thing around her because people generally think about their future behaviour according to how they behaved in the past behaviour and its effect on individual could be part of psychological and social factors disposition.

METHODOLOGY

The study utilised cross-sectional survey research design which aimed at collecting information on certain variables in a study population at one point in time. The study population covered the entire Suleja Local Government Area and its 10 wards. According to the National Population Commission (NPC, 2006) Suleja L.G.A. population was 215, 075 which comprise of 103,045 females. However, the projected female population of Suleja as 2023 was 174,542.

The projected population for Suleja is 364,303. The study is female focused because cervical cancer is a sexually transmitted disease suffered by women only. The target population for the study are women aged 15years and above are the target for the study. The age category is selected because cervical cancer is only obtainable in females who have attained the age of sexual maturity and sexually active. The projected female population to 2023 is **174,542** in Suleja L.G.A. Niger State.

Table 3.1: Suleja Wards' Female Population Distribution

S/n	Political ward	Population
1	Bagama 'A'	10,964
2	Bagama 'B'	9,873
3	Hashimi 'A'	10,050
4	Hashimi 'B'	10,939
5	Iku South I	10,618
6	Iku South II	10,342
7	Kurmin Sarki	9,101
8	Magajiya	10,045
9	Maje North	11,235
10	Wambai	9,878
	Total	**103,045**

National Population Commission (2006).

Sample size determination

The sample size for the study was gotten using Taro (1967) formulae for deriving sample size.
Taro formula:

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

n = sample size; N = Population of the study; e = Error estimate at 5% (0.05); 1 = Constant

$$n = \frac{174{,}542}{1+174{,}542(0.05)^2} \quad n = 399$$

Approximately n = 400

Therefore, sample size for the study was approximately 400, which would make up the quantitative aspect of this study according to Taro (1967). The projected female population was 174,542. Therefore, the sample size for the study was 400.

3.4 Sample distribution

The sampling plan is presented in Table 3.2.4 Wards, from 10 wards in Suleja LGA. Four wards were purposively selected for Focus Group Discussion [FGD] having 8-13 respondents each, because of they are urban and rural wards without primary health care facility. The sample size for the study was 400 respondents. The questionnaire for the quantitative study was administered to 350 respondents while a total of 50 participants participated in the Focus Group Discussion (FGD) which constituted the qualitative aspect of the study.

A proportional sampling technique was used to determine the sample size for the 10 wards participants. This was calculated using the Cochran (1977) formula. Thus, the following formula was used and the result shown in table below.

$$\text{CSS} = \frac{PCxSS}{TP}$$

Where:
CSS =proportional sample size
PC =Population of proportional
TP =Total population
SS =Sample size
Using the above formula above, the sample size for each of the selected ward was computed thus:

Table 3.2: Sample Selection Plan

S/n	Political ward	Projected Population	Proportional sampling
1	Bagama 'A'	17,964	$\frac{17,964x350}{174,542} = 36$
2	Bagama 'B'	16,873	$\frac{16,873x350}{174,542} = 34$
3	Hashimi 'A'	21, 050	$\frac{21,050x350}{174,542} = 42$
4	Hashimi 'B'	16,939	$\frac{16,939x350}{174,542} = 34$
5	Iku South I	15, 618	$\frac{15,618x350}{174,542} = 31$
6	Iku South II	17,342	$\frac{17,342x350}{174,542} = 35$
7	Kurmin Sarki	20,189	$\frac{20,189x350}{174,542} = 40$
8	Magajiya	15, 133	$\frac{15,133x350}{174,542} = 31$
9	Maje North	18,235	$\frac{18,235x350}{174,542} = 37$
10	Wambai	15, 199	$\frac{15,199x350}{174,542} = 30$
	Total	**174,542**	**350**

Source: Field work, 2024

This study used 10 wards that makes up Suleja local government area. These wards are: Bagama 'A', Bagama 'B', Hashimi 'A', Hashimi 'B', Iku South I, Iuka South II, Kurmin Sarki, Magajiya, Maje North and Wambai. These 10 wards are made up of villages and town in Suleja LGA. The study used the 10 wards for equal representation in the survey to be able to make a holistic generalization of the findings. The researcher drew her respondents from 10 political wards in Suleja LGA. The rationale behind using the entire 10 wards was to be able to access both urban and rural villages in the 10 wards.
In getting directly to respondents, the researcher utilized the Cochran formula of sample determination for its respondent from rural (Villages) and Urban (towns). Cochran (1977) was used to determine the questionnaire sample distribution across the ten wards. The outcome was, Bagama 'A' (36), Bagama 'B' (34), Hashimi 'A' (42), Hashimi 'B' (34), Iku South I (31), Iku South II (35), Kurmin Sarki (40), Magajiya (31), Maje North (37) and Wambai (30). The

researcher adopted a blend of availability and purposive sampling techniques to get respondents from the rural bloc. Females within the target population of the study were met at their convenience and administered the questionnaire using the kobo toolbox via an android phone. This procedure was also applied to the urban bloc.

Four focus group discussion (FGD) session were conducted in this research. The FGD cohort consisted of 10-13 respondents with a total of 50 respondent purposively selected from 4 wards namely; Iku south II, Maje, Kurmi Sarki and Wambai ward respectively in Suleja LGA namely. The women ranged from young, old, single and married, divorced, and widow.

The researcher employed both quantitative and qualitative techniques in the collection of data. A well-structured questionnaire was the major instrument for data collection in this study. The questionnaire was administered on 350 respondents while FGD respondent comprised 50 respondents making it a total of 400 respondents in this study. The questionnaire contained both open and close ended questions in line with the objectives of the study. The questionnaire information was labelled A-F. Section "A" contained information on socio-demographic characteristics such as gender, age, education level, marital status and occupation while section "B, C, D, E, and F" sought for the specific issues of the study bordering on the research objectives and other substantive issues relevant to the topic.

The data was administered to the respondents by the researcher and three research assistants who were fluent in Hausa, Koro and Gwari. The questionnaire was deployed on an android mobile phone software data collection app known as Kobo toolbox. The research assistants were trained for a day by the researcher on the method and objectives of the study. These research assistants were undergraduates from school of health, Suleja who have android phone/ tablet user friendly who visited the women at their community and administered the questions. The responses of the respondent were submitted online, which was sync at the back-end of kobo toolbox data base and hardcopy collection for the analysis. As the survey is not funded survey, the researcher administered few hardcopies of questionnaire and using soft copy questionnaire via kobo toolbox link was for easy data collection and cost effective. Qualitative data was generated using FGD, as the researcher moderated the FGD sessions while one of the research assistants served as the note taker.

The quantitative data from the questionnaire was collated from the backend of the kobo toolbox and coded. Data analysis was done using the Statistical Package for Social Sciences (SPSS). The data that was collected from the questionnaire was sorted out and coded for thematic systematic analysis. Descriptive statistics like frequencies and percentage was deployed to interpret the data. Regression analysis was used to test the hypothesis to determine the effects of some selected independent variables on the dependent variable. Data from the qualitative source was content analysis by relating outstanding points to the response to the objective of the study.

To ensure contentment and face validity, the researcher designed the instrument and the research instrument was scrutinized and modified by my supervisor and other experts in the Department of Social Work, Faculty of Social Sciences, Federal University of Lafia and other researcher from data and research department in my place of work. This was to ensure that it is capable of satisfying the objective of the study.

The reliability of the instrument was determined using a pilot study of 65 respondents aged 15 and above from non-participating LGA (Tafa LGA) that is closer to Suleja LGA. The result obtained was used to validate the instrument and the kobo toolbox link and its back-end before administering it on the target population.

This study considered individual's/respondents beliefs and preference in responding to the instrument of data collection. A letter of introduction was obtained from the department of social work and presented to ward development chairman (WDC) on the purpose of the study and why their participation is utmost important. Respondents were not compelled to respond to any questions considered contrary to their cultural or religious belief. Also, the researcher obtained oral informed consent from the respondent. Confidentiality and individualism ethics was considered in this research work, only for the purpose of academic work, learning and knowledge addition**.**

RESULTS

This section consists of presentation, interpretation and analysis of data gathered from the field. The section comprises of descriptive analysis of research questions, and test of hypothesis and discussion of findings. The hypothesis was tested using simple regression analysis. The qualitative data (FGD) is presented alongside the quantitative data to support the findings from the participants.

Questionnaire Distribution and Return Rate

Out of three hundred and fifty (350) copies of questionnaire were distributed to the respondents. Three hundred and forty-three (343) were correctly filled and returned. Given the figures obtained in percentage model, it appeared as follows

Total of questionnaire distributed = 350

Total of questionnaire returned = 343

$$\frac{total\ questionnaire\ returned\ and\ usable}{total\ questionnaires\ distributed} \times 100$$

$$= \frac{343}{350} \times 100 = 98\%$$

Percentage of returned questionnaires out of the total questionnaires distributed was 98%. This is further presented in Table 4.1.0 below:

Table 1: Response of questionnaire and Focus Group Discussion (FGD)

Instrument Distribution	Responses
Response number of distributed questionnaire	350
Returned questionnaires	347
Returned and usable questionnaire	343
Returned but excluded questionnaire	7
Questionnaire not returned	0
Response rate	98%
Usable response rate	98%
Focus Group discussion	50

Source: Fieldwork, 2024

The table above showed the return rate of the copies of questionnaire administered to the respondents. Ninety-eight per cent (98%) of the questionnaire properly filled and sent to the backend. While two per cent (2%) of the questionnaire were not returned. This implies that 98% of the respondents took time and attended to the questions in the questionnaire.

Table 2: Shows the Factors affecting cervical cancer screening

Statements	Yes	No	Not Sure	Total
Husband disapproval	318(92.7%)	-	25(7.3%)	343 (100%)
Lack of skilled health care professionals	272(79.3%)	-	71(20.7%)	343(100%)
Fear of being screen by a male Nurses	228(66.5%)	78(22.7%)	37(10.8%)	343 (100%)
Lack of health facility	209(60.9%)	86(25.1%)	48(14%)	343(100%)
Cultural influence	198(57.7%)	75(21.9%)	70(20.4%)	343(100%)
Rural-Urban Awareness differences	186(54.2%)	88(25.7%)	69(20.1%)	343(100%)
Distance/ accessibility to the hospital	150(43.7%)	156(45.5%)	37(10.8%)	343(100%)
Poverty as a hindrance	208(60.6%)	6(1.7%)	129(37.6%)	343(100%)
Fear of complication/discovering other diseases	153(44.6%)	100(29.2%)	90(26.2%)	343(100%)

Source: Fieldwork, 2024

The results indicate significant perceived barriers to cervical cancer screening. 92.7% of respondents identified husband disapproval as a barrier, highlighting the importance of involving partners in cervical cancer screening decisions. 79.3% of respondents cited lack of skilled healthcare professionals in cervical cancer screening. 66.5% of respondents expressed fear of being screened by a male nurse indicating a need for same sex screening options. 60.9% identified lack of well-equipped health facility as a barrier, highlighting the need for affordable and accessible screening facilities. 57.7% of respondents cited cultural influence as a barrier, suggesting that cultural sensitivities and awareness are crucial in promoting cervical cancer screening. Distance/accessibility to hospitability to hospital (43.7%) and poverty (60.6%) present notable practical barriers to screening. Fear of male nurse (66.5%) and fear of complications/discovering other diseases (44.6%) indicate the need to address psychological concerns in screening initiatives. The findings suggest that husband disapproval and lack of skilled healthcare professionals are significant barriers to screening. Also, fear of male nurses and lack of health facilities also present notable barriers. Cultural influence plays a crucial role in shaping attitudes towards cervical cancer screening.

> During the FGD in Iku South 11 (married female, 45 years) noted that: *Even with awareness, cultural influence and husband disapproval are hindrances that cannot be overlooked. I believe that more need to be done in raising awareness and emphasizing the benefits of cervical cancer screening to help women appreciate seeking cervical cancer screening.*

Another participant mentioned that:

> *Most doctors are males, and the fear of exposing one's private parts to male nurses or doctors is not a welcome idea by most husbands. This I think is the reason behind husband disapproval. Also, conservative attitude of women towards screening either for fear of discovering other disease are also factors to hinder screening even among the enlightened women. However, the North are now promoting female participation in medical courses so as to handle this gap.*

Another participant in Kurmi Sarki (Single, 25years) noted: *That women in the rural areas are more disadvantage compared to those in the urban centres. Women in the rural areas are not expose to the information as they should. For instance, I have never heard of cervical cancer. Again, most rural women are poor, rural hospitals are not well-equipped and have no professional health care provider, which makes going for screening tiring and discouraging.*

Test of hypothesis

In this section, the hypothesis earlier formulated in the study was tested and the result presented:

Hypothesis 1: There is no significant influence between possible factors inhibiting cervical cancer awareness and screening among women in Suleja L.G.A.

Table 4.2.1: Shows significant influence between possible factors inhibiting cervical cancer awareness and screening among women in Suleja L.G.A.

Hypothesis	Regression Weighs	Beta Coefficient	R^2	F	P-Value	Hypothesis Supported
H4	CBA⟶CCASB	.759	.575	462.039	.000	Yes

Note: P> .0001, CCBA- possible factors; CCASB-Cervical Cancer Awareness and Screening Behaviour.

A simple linear regression was used to test hypothesis. The dependent variable, Cervical Cancer Awareness and Screening Behaviour (CCASB) was regressed on the predicting variable possible factors such as Cultural Belief/Values. The predictor variable was found to be statistically significant; (F (1, 342) =462.039, P< .0001) indicating a significant influence between possible factors (cultural beliefs/values) and cervical cancer screening behaviour. Moreover, B=.759, implies that for everyone unit increase in cultural beliefs and values, cervical cancer awareness and screening behaviour will increase by .759 units. Also, R^2 =.575 depict that 57.5% of the variance in cervical cancer awareness and screening behaviour is explained by cultural beliefs and values.

Discussion of findings

Cultural belief & value affects cervical cancer awareness/screening among women in Suleja LGA

Inferentially the study found the predictor variable (cultural belief and value) to be statistically significant; (F (1, 342) =462.039, P< .0001) indicating a significant relationship between cultural beliefs/values and cervical cancer awareness and screening behaviour. More so, the descriptive findings also revealed 57.7% of respondents cited cultural influence as a barrier to cervical cancer screening, suggesting that cultural sensitivities and influence play a crucial role in shaping attitudes towards cervical cancer screening. This finding corroborates that of Jibrin (2022) who carried out a study in North Central Nigeria, on the prevalence and factors of cervical cancer among women in an urban community in Niger State. This was a cross-sectional study involving the screening of women aged 21-66 years for cervical cancer using Papanicolaou smear. The study revealed that only 12 (8.0%) respondents had positive cytology result, while the test was normal. According to the author, cultural and religious beliefs a major hindrance to some women participating in cervical

cancer screening. Women in the North Central especially indigenous women see such screening as inappropriate and against their cultural and religious belief.

Summary

This study aimed at investigating possible factors inhibiting cervical cancer awareness and screening among women in Suleja L.G.A. One research question and one specific objective guided the study. The summary of the finding is itemized below:

The study found that cervical cancer awareness and screening was significantly inhibited by possible factors among women in Suleja L.G.A. these factors include Husband disapproval, Fear of being screen by a male Nurses, Lack of health facility, Cultural influence, Rural-Urban Awareness differences, Distance/ accessibility to the hospital, Poverty as a hindrance, Fear of complication/discovering other diseases.

Conclusion

The major emphasis of the study was to investigate possible factors inhibiting cervical cancer awareness and screening among women in Suleja L.G.A.

The study focused on the extent to which cervical cancer awareness and screening among women in Suleja L.G.A is inhibited by possible factors. On the basis of this finding, the researcher concludes that there is need for targeted education and awareness campaigns to improve knowledge and perception of cervical cancer risk factors, improve screening rates and reduce cervical cancer incidence.

Recommendation

Based on the findings of this study, the following recommendation is made:

i. Targeted interventions on cervical cancer screening should focus on poverty reduction, addressing cultural and rural-urban disparities, and improving access to healthcare facilities and skilled professionals.

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