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# Knowledge and Attitude towards Cervical Cancer Screening among Females Attending out Patient Department in Health Centre IIIs in Oyam District

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## Abstract

Cervical cancer is a serious health concern in Uganda. Early screening and detection certainly improves chances of survival and treatment outcome. Sound knowledge and positive attitudes highly influence acceptability and uptake of screening methods. This descriptive cross-sectional study determines knowledge and attitudes towards Cervical Cancer screening amongst female out-patients aged 15 - 49 years, attending Health Centre IIIs in Oyam District, Northern Uganda. A systematically obtained sample of 445 respondents was interviewed using semi-structured questionnaires and focused group discussions. Quantitative data was analyzed using SPSS 16.0. Directed content analysis of themes of transcribed qualitative data was conducted manually. Of the 445 respondents, only 62.7% (n = 279) had heard of cervical cancer amongst which only 35.1% (n = 85) had been screened; 13.7% (n = 34) did not know what screening was; 3.7% (n = 9) were not sure and 5.8% (n = 14) knew it as removal of the cervix. Only 39.1% (n = 174) believed that cervical cancer can be prevented. There is still limited knowledge and lots of misconceptions about cervical cancer screening in the communities, which requires massive sensitization of the population at risk to change negative attitudes and maximize acceptability to screening methods.

## Keywords

Knowledge, Attitudes, Cervical Cancer, Female Out-Patients, Screening

## 1. Introduction

Every year, 7.6 million lives are lost to cancer worldwide more than AIDS, tuberculosis, and malaria combined [1]. A new report by the World Health Organization's International Agency for Cancer Research (IARC) suggests that the incidence of cancer worldwide will grow by 75% by the year 2030, nearly doubling in some of the developing countries. Those increases will put a much larger burden on the poorly developed healthcare systems in such countries because care of cancer is much more expensive than care for infectious diseases [2].

The regions hardest hit by Cervical Cancer are among the world's poorest. Central and South America, the Caribbean, Sub-Saharan Africa, parts of Oceania, and parts of Asia have the highest incidence rates of over 30 per 100,000 women [3].

Cervical Cancer is the second most common type of cancer among women, with virtually all cases linked to genital infection with the human papillomavirus (HPV). Among women in the urban setting, the development of Cervical Cancer is just bad luck and they do not want to know if they have it. Women who do not get screened often mention that they do not get tested because others will think they are having sex and if they are not sexually active, they do not need to be screened particularly among the Hispanic and Asian [4].

Cervical Cancer ranks as the 1$^{st}$ most frequent cancer among women in Uganda, and the 2$^{nd}$ most frequent cancer among women between 15 and 44 years of age [5]. It is estimated that every year approximately 40 women in every 100,000 develop Cervical Cancer in Uganda. Statistics also confirm that about half of the women with Cervical Cancer die within three years of diagnosis [6]. Cervical Cancer is the most common malignancy among women in Mbarara, the second most common in West Nile District [7] and accounts for over 80% of female cancers among women in Kyadondo County, Kampala District, where a well-established population-based cancer registry exists. Statistics also confirm that cancer is deadly for women in Uganda. According to Kyadondo data, about half of the women with Cervical Cancer die within three years of diagnosis [8].

The Uganda Ministry of Health during the launch of the cervical screening HPV Programme was to vaccinate all girls in Primary Four irrespective of their age. In addition to primary four girls all 10 year old girls who are not in school were to be vaccinated as well. From 2014 onwards, all girls aged 9 to 13 years would be vaccinated as recommended by World Health Organization. The launch that took place on the 6$^{th}$ of September 2012 therefore marked the first step towards the introduction of HPV vaccine in Uganda, twelve Districts selected of which Oyam District was among them and more to that Cervical Cancer screening camps in these Districts were set up [9].

The pathway to preventing deaths from Cervical Cancer is simple and effective. Precancerous changes in cervical tissue can linger for years, but if they are identified and successfully treated early, the lesions will not develop into Cervical Cancer. Screening women for precancerous changes and treating the abnormal tissue seems to protect women from developing Cervical Cancer [10].

The knowledge and attitude towards Cervical Cancer screening among women in Oyam District had not been largely assessed. The study therefore will help to correct misperception about Cervical Cancer screening and identify information that women require for early detection of Cervical Cancer, treatment seeking, future implementation of Cervical Cancer screening programmes and making Cervical Cancer screening facilities available in the Health Centres.

## 2. Methodology

This was a cross-sectional descriptive study conducted in Oyam District Health Centre IIIs. Oyam District is located in northern Uganda boarded by Gulu District to the North, Pader District to the North East, Kole District to the East, Apac District to the South, Kiryandongo to the South West and Nwoya to the West. Oyam has one hospital which is private nonprofit owned (Aber Hospital), one Health Centre IV (Anyake), Three Health Centre IIIs (Otwal, Ngai, Agulurudde) and seventeen Health Centre IIs (Adyegi, Aber, Atura, Ariba, Atipe, Alao, Abela, Alira'B', Iceme, Akwang, Zambia, Adigo, Loro, Minakulu, Amwa, Acimi, Acokara) government owned and two Health Centre IIIs private nonprofit (Iceme and Minakulu). A sample of 445 Female out patients obtained by Kish and Leslie formula (1965) in five Health Centre IIIs (Otwal, Ngai, Minakulu, Iceme, Agulurudde) in Oyam were sampled. The inclusion criteria included 89 female outpatients aged 15 - 49 from each Health Centre. This was got by dividing the sample size among the five Health centers and systematic sampling method used with the first female eligible participant interviewed then the second and third skipped instead the fourth would be sampled. The sequence continued until the required number of study participants was obtained with an identification number on their books that they came along with to avoid being recruited twice. Female health workers in the selected Health Centre IIIs, Females aged 15 - 49 who were mentally ill and the critically ill were excluded from the study. Ethical clearance was sought from Institutional Review committee (IRC) of Gulu University and Informed consent sought from all respondents before executing the study. The collected Data was coded, entered and analyzed using SPSS version 16, descriptive statistics were used with confidence set at 95%. This study was however also limited by its results, as it only represented the views of women attending Out-patient department in only five selected health centre IIIs in Oyam District. Therefore, knowledge, attitude and barriers to cervical cancer screening uptake in other health centers and departments could not be generalised.

## 3. Results

Of the 445 respondents, mean age was 27.84 years, their age ranged from 15 - 49 majority had ever heard of cervical cancer 62.7% (n = 279). Of those who had ever heard about cervical cancer, majority defined it as cancer of the cervix 51.7% (n = 230), 0.7% (n = 3) defined it as a skin disease, 4.9% (n = 22) didn't know whereas the rest were not sure. Majority 41.6% (n = 185) had accessed in-

formation about cervical cancer from health workers. Others had heard it from radios, television, their husbands, relatives and village health teams. When asked what cervical cancer screening was (n = 279); 13.7% (n = 34) did not know, 3.7% (n = 9) were not sure, 5.8% (n = 14) knew it as removal of the cervix whereas 76.5% (n = 186) knew it as inspection of the cervix under a machine. Majority 80.5% (n = 194) had heard information about cervical cancer screening from health workers, 7.1% (n = 17) from posters, others had heard it from radios and friends. Much as most respondents know the cervical cancer screening process was not harmful as show in **Figure 1**, only about 35.1% (n = 85) had been screened When asked why they had not been screened (N = 155), 32.9% (n = 51) reported having no screening facilities at their nearby health facilities, 9.1% (n = 14) thought screening requires money, 9.7% (n = 15) just feared whereas others just thought it was not important. Majority of the respondents were not sure of the interval from when they were to have the next cervical cancer screening done as illustrated in **Figure 2**.

There percentage of respondents who had ever had about cervical cancer increased with age as shown in **Figure 3**. This was further supported by a statistically significant relationship between the two variables. ($X^2$ = 1.101E2, P = 0.004). Even though there was no statistically significant relationship between level of education and cervical cancer ($X^2$ = 11.80, P = 0.083) the percentage of people with this was found to increase with higher levels of education.

When asked whether they would go for cervical cancer screening even without

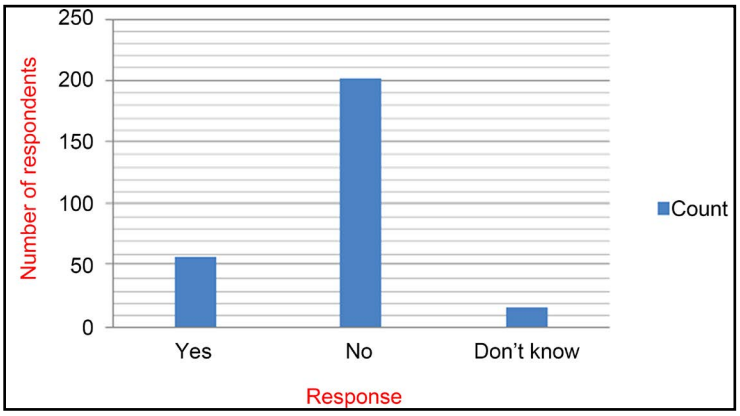


**Figure 1.** Responses to whether cervical cancer screening harmful.

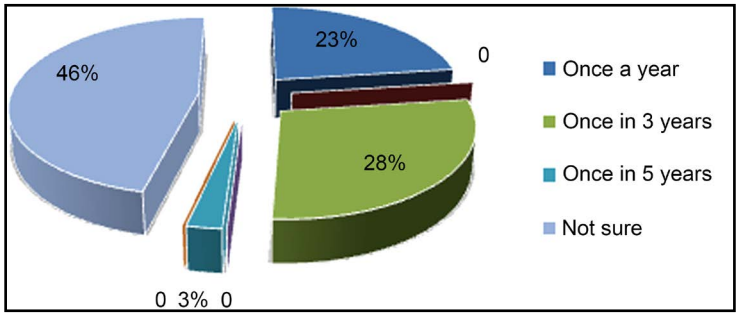


**Figure 2.** Showing Respondents' Perceived Frequency of Cervical Cancer Screening.

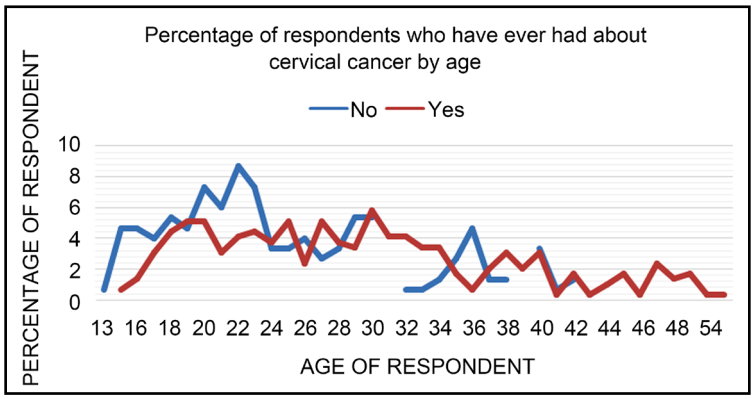


**Figure 3.** Percentage of respondents who have ever had about cervical cancer by age.

symptoms, a large percentage of respondents with where willing to comply irrespective of their level of education or age. There was no statistically significant relationship between these variables. ($X^2$ = 1.055, p = 0.788, CI = 0.788) ($X^2$ = 33.61, P = 0.535, CI = 95)

## 4. Discussion

Although cervical cancer screening was acceptable amongst female out patients attending health Centre IIIs in Oyam district, there are still mixed reactions and wrong perceptions about the intervention. 62.7% had heard of cervical cancer in the present study. This proportion is higher than that reported in a Nigerian study [11], though comparable to a study in Cameroon [12] and slightly lower than that reported in an Ethiopian study [13]. Only 39.1% (n = 174) believed that cervical cancer can be prevented and indeed only a few had been screened. Lack of the opinion that early detection of cervical cancer could certainly improve chances of survival as had been elicited by earlier studies [14] [15].

The statistically significant relationship between age and knowledge ($X^2$ = 1.101E2, P = 0.004) with knowledge increasing with age could be explained in part by the social stigma that is associated with discussing reproductive health with unmarried and young girls, however this is the age when girls contract the implicated pathogens thus incorporating cervical cancer education during reproductive lesson in the primary school curriculum could have a huge positive ripple effect in the fight against cervical cancer.

Even though there was no statistically significant relationship between level of education and cervical cancer ($X^2$ = 11.80, P = 0.083) the percentage of people with this was found to increase with higher levels of education which also further reinforces the importance of the girl child education in the fight against cervical cancer.

A large percentage of respondents were willing to comply irrespective of their level of education or age, and there was no statistically significant relationship between these variables ($X^2$ = 1.055, P = 0.788, CI = 0.788) ($X^2$ = 33.61, P = 0.535, CI = 95). This is not congruent with the low turn up for screening 35.1% (n = 85). This could be explained by the wide spread lack of knowledge about

cervical cancer as seen even in focused group discussion that demonstrated that women still lacked basic understanding of the cervical cancer screening process, purpose, limitation and results of the screening.

To increase the uptake and acceptability of screening the misconceptions related to infertility associated with cervical cancer screening needs to be urgently addressed through massive sensitization using community based approaches otherwise lack of symptoms and low perception of risk has been shown to be major barriers to Cervical Cancer screening tests [16]. During focused group discussion, this study demonstrated that women still lack basic understanding of the cervical cancer screening process, purpose, limitation and results of the screening, a finding similar to previous studies [17] [18] [19]. Some women in the present study believed cervical cancer screening should be only performed on those who present with a reproductive health problem such as vaginal discharge, heavy bleeding, or painful intercourse, those asymptomatic felt should not be screened. Other studies have reported similar [20] [21]. Up to 46% in the present study did not know that cervical cancer screening should be repeated in the interval of 1 - 3 years. This proportion was much higher than that reported in southern Illinois [22]. Although previous vaginal examination is positively associated with willingness to undergo a screening test for Cervical Cancer [23], such pelvic assessments need to be performed in a manner that warrantees privacy and or presence of female chaperons especially for older women who often feel uncomfortable or embarrassed being assessed by the male gender which hinders their screening test acceptability as demonstrated by the present and earlier studies [24].

## 5. Conclusion and Recommendations

Although acceptability to Cervical Cancer screening was high in the present study, very few respondents had been screened. There is still limited knowledge and lots of misconceptions about cervical cancer screening in the communities. Since women's knowledge and beliefs are the strongest predictors of repeated cervical cancer screening [25] [26], there is an immense need for massive sensitization of the population at risk changing negative attitudes and maximizing acceptability to screening methods.

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