Women's Perception About Cervical Cancer Screening Services in Bomachoge Chache Sub County

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ABSTRACT

Objective: To describe women's perceptions about cervical cancer screening services in Bomachoge Chache Sub County.

Methods: This was a mixed methods study. A total of 394 participants from seven health facilities were selected for the study through stratified random sampling. Quantitative data was gathered using questionnaires while qualitative data was obtained via focused group discussions. Chi-square test was used to determine association of women's perception of cervical cancer screening. Logistic regression analysis was used to assess the determinants of cervical cancer screening practices. A p-value of 0.05 was considered statistically significant. Qualitative data was analyzed thematically

Results: Two hundred and six (57.5%) of the participants were aged between 16 to 19 years, 190 (53%) were married with over 67% of them having at least secondary school education. Notably, although 248(69.2%) of the participants were aware of cervical cancer only 104 (41.9%) were screened. Cervical cancer screening was positively associated with feeling of being at risk of cervical cancer (p <.0001), not being afraid of screening procedures (p <.0001), preference of being attended by a female (p <.0001), a distance of <1km from the nearest screening center (p < .0007). Participants perceived cervical cancer to be caused by witchcraft, curses and sexual immorality. They also had misconceptions such as prayers being a cure to cervical cancer. Further, delay in service delivery was attributed to shortage of health care professionals and inadequate hospital infrastructure.

Conclusions: Participants were aware of cervical cancer, risk factors, and warning signs. Screening practices were positively associated with knowledge on cervical cancer, source and monthly income and level of education. Participants perceived that they were not at risk of cervical cancer and believed that witchcraft and sexual immorality were causes of cervical cancer and prayers perceived as the cure.

Keywords: cervical cancer, screening, Bomachoge Sub County

BACKGROUND

Globally, cervical cancer is the fourth most common cancer among women of reproductive age with an estimated incidence of 604,000 and mortality of 342,000 in the year 2020 with approximately 90% of these occurred in low- and middle-income countries [1].

In Low- and Middle-income Countries (LMICs) the proven effectiveness of intervention measures, such as vaccination against the most oncogenic Human Papilloma Virus (HPV) types 16 &18 and screening, makes cervical cancer a largely preventable disease. In developed countries remarkable progress in terms of reduction in cervical cancer incidence and mortality has been achieved, where high quality screening, timely treatment, and follow-up care services are routinely available. However, in LMICs, where the vast majority of cases and deaths occur, progress in reducing incidence and mortality has been slow, with a number of countries reporting increases in incidence or mortality rates in the past decade.

In 2020, WHO launched the global Cervical Cancer Elimination Initiative to accelerate the elimination of cervical cancer, aiming to reduce incidence below a threshold of 4 cases per 100000 women per year in every country and thus narrow international disparities associated with this disease. The 90–70–90 target set by the initiative to be achieved by 2030 requires 90% of girls to be vaccinated by age 15 years, 70% of women to be screened with a high-performance test at least two times by age 45 years, and 90% of women identified with cervical pre cancer or cancer to be treated. The WHO elimination strategy has emphasized the need for continuous and improved surveillance and monitoring for cervical cancer as a fundamental step forward for action that will enable program managers to identify gaps and take specific actions (WHO 2020).

In Africa, the highest regional incidence and mortality is in countries located in East, South, and West Africa. When compared with North America and west Asia, incidence and mortality is 7-10 times higher in Africa.

In East Africa, cervical cancer is the most common female cancer with the age standardized incidence and mortality rate of 42.7 and 27.6 per 100,000 women respectively [2].

In Kenya, cervical cancer, the second most prevalent cancer after breast cancer, has had an increasing incidence. Between 2020 and 2021 the prevalence stood at 28.7% with a mortality rate of 49.8% of the cases diagnosed in 2020 [1].

A study done in Kisii County by Kei et al., (2016) had shown low cervical cancer screening with common screening methods being, Visual Inspection with Acetic acid (VIA) and Visual Inspection with Lugol's Iodine (VILI).

It is of no doubt that early detection with low-cost screening techniques such as VIA and VILI, that can be carried out by health care providers with five days training is a key intervention to decrease the incidence of cervical cancer [3]. However, such interventions remain underutilized. The study therefore aimed at assessing determinants of cervical cancer screening among women of reproductive age in Bomachoge Chache Sub County, Kisii County, Kenya.

Problem Statement

Cervical cancer remains the most commonly diagnosed cancer in 28 countries and the leading cause of cancer death in 42 countries, the vast majority of which are in Sub-Saharan Africa and South-Eastern Asia. The highest regional incidence and mortality rates are seen in Africa/

It is estimated that Kenya has a population of 16.8 million women aged 15 years and above who are at risk of developing cervical cancer. Every year approximately 5,236 women are diagnosed with cervical cancer and 3,211 die from the disease [4].

Despite the acknowledgement that screening is the best approach towards cervical cancer treatment, it is apparent that the level of screening, particularly in Kenya, remains low. The ministry of health [3], provides policy guidelines on 90–70–90, which requires 90% of girls to be vaccinated by age 15 years, 70% of women to be screened with a high-performance test at least two times by age 45 years, and 90% of women identified with cervical pre-cancer or cancer to be treated. In the year 2017, Bomachoge Chache Sub County attained cervical cancer screening coverage of 4% against a national target of 75% [5]. Therefore, this study sought to examine the determinants of cervical cancer screening among women of reproductive age living in the sub county to inform policy.

Study objective

To describe women's perceptions about cervical cancer screening services in Bomachoge Chache Sub County.

METHODS

Study design

The study utilized a mixed methods approach - convergent parallel design where data for both quantitative and qualitative strands were collected at the same phase of the research process, the methods were equally

prioritized and kept the strands independent during analysis and results presentations with mixing during the overall interpretation at the discussion level.

Study area

The study was carried out at Bomachoge Chache Sub County among seven health facilities comprising both public and private/faith-based.

Study population

The target population was women of reproductive age. The study population comprised of women of reproductive age seeking health care services at the sub county Health facilities.

Study Procedure

Mothers seeking services in maternal and child health welfare (M.C.H) clinics participated; those mothers who brought their children for immunization/vaccination, or for family planning services. In all the sampled hospitals, mothers were recruited after being attended to by the healthcare providers.

362 study participants were explained to the purpose of the study and that led to obtaining informed consent and assent. The above is provided for in Reproductive Health Policy in Kenya (M.O.H, 2015). For emancipated or mature minors, they signed both assent and consent forms. Emancipated/mature minors are adolescents who are under the legal age, but who are in circumstances where they are clearly outside of parental influence or control. The clients willing to participate were requested to sign the consent form/ assent form. The questionnaires were administered by the researcher with the help of trained research assistants on those who gave consent. Research assistants were qualified volunteer nurses working in the sub county.

Participants for the focus group discussion were selected using purposive sampling. Four focus groups were selected, one from each level of care. Each group comprised eight women, those who consented. Focused group discussions were conducted at the tail end of the data collection process; after the quantitative data had been collected.

Data management and analysis

Data was coded before being entered into the computer for analysis using Statistical Package for the Social Sciences (SPSS) version 27. The association between the predictors of cervical cancer screening and the independent variables (awareness levels, perceptions, access to cervical cancer screening services were determined using Chi-square test. In addition, the association between potential predictors of cervical cancer screening was determined by bivariate regression analyses.

Qualitative data was processed through four main steps; familiarization, the researcher first read the transcribed documents severally to acquaint and understand the data. The data was then condensed by identifying and sorting the meaning of the content into similar units, this was done carefully so as not to lose the meaning of the respondents. Coding and categorization were then done by labeling and organizing the condensed data to identify different themes and sub themes.

Ethical Considerations

The Moi University/MTRH IREC reviewed and approved the conduct of this study and no data collection took place prior to approval.

RESULTS

Socio-Demographic Data of the Participants

The study analyzed age, marital status, level of education, source of income, average monthly income and number of children of the participants. A total of 358 out of 362 questionnaires were completed and returned which represents a response rate of 98.9%. The 4 participants voluntarily dropped out before end of the study.

It was established that 206(57.5%) of the participants at the sub county health facilities were aged between 16 and 29 years while a few 3(0.81%) were above 50 years of age. An analysis on the marital status established that more than half of the participants 190(53%) were married in a monogamous set up while 22(5.6%) were widowed. The study found that the level of education among the participants was distributed as follows; 152(42.5%) secondary, 103(28.8%) primary and 89(24.9%) tertiary with only 14(3.9%) lacking formal education.

The study further assessed employment status among the study participants. It was established that 139(38.8%) were self-employed while 110(30.6%) were unemployed. Few participants 64(18%) had a formal employment while 45(12.6%) were casual workers. In addition, assessment was done on the average monthly income among the study participants. The study found that more than half 190(53.2%) of the study participants had an average monthly income of less than 4000KShs, 83(23.2%) had an income of between 4001 and 10999KShs, 34(9.5%) had an income bracket of between 11000 and 20999 KShs while 50(14%) had a monthly income of more than 21000KShs. On the number of children that the study participants had at the time of the study, it was established that 151(42.2%) had between 2 to 3 children, 121(33.8%) had only one child or none while 86(24.1%) had more than 4 children. Table 4.1 illustrates the findings.

Women's Perception about Cervical Cancer Screening

The second objective of the study was to establish the perception around cervical cancer and screening practices among the participants. The study focused on the level to which the participants agreed or disagreed on whether they were at risk of developing cervical cancer, had fears about screening procedures, were afraid of vaginal examination, their preference for male or female health workers, whether they would refer women for cervical cancer screening, if they ever discussed cervical cancer with their spouses, peers or relatives.

The study analyzed data on the perceptions ranging from risks, fears, preferences, free discussions, sharing information and confidentiality levels. It was found that over half 194(54.5%) of the study participants disagreed that they were at risk of cervical cancer indicating fears. It was also found that 223(62.3%) of the study participants indicated they had no fears about screening procedures for cervical cancer. It was further found that 181 (50.8%) of the participants were not afraid of vaginal examinations while 175 (49.2%) were afraid. The study participants were further assessed on their preference for female, male or either gender of health workers. A total of 195(54.6%) preferred female health workers, 35(9.8%) preferred male while 127(35.6%) preferred either gender.

The study participants were asked whether they were free to discuss cervical cancer with their spouses, peers or close relatives. A total of 245(68.8%) of them indicated that they had never discussed with their spouses, 207(58.1%) had never discussed with peers while 231(65.4%) had never discussed with close relatives on cervical cancer. On the fear of cervical cancer diagnosis, 174 (50.6%) of the participants disagreed that they had fears with 170 (49.0%) agreeing that they had the fears; 15 (4.2%) agreed that cultural beliefs hindered them from screening with 340 (95.8%) disagreeing); 349 (98.0%) disagreed that religious beliefs affected their screening behaviour with 7 (2.0%) agreeing. Further 311 (87.9%) agreed that they were satisfied with how they were handled at the health facilities while 43 (12.1%) indicated that they were not satisfied.

On association between admitting risk and screening, participants who reported to have been screened for cervical cancer were more likely to admit that they were at risk (OR 4.99; 95% CI 2.90-8.55), have fears about screening procedures (OR 0.21; 95% CI 0.21-0.40), would refer women for cervical cancer screening (OR 0.80; 95% CI 0.31-2.07), had fears of vaginal examinations (OR 0.17; 95% CI 0.09-0.30) had discussed with their spouses (OR 10.53; 95% CI 5.72-19.49), peers (OR 9.95; 95% CI 5.34-18.54) and close relatives (OR 4.51; 95% CI 2.46-6.98).

Participants who reported not to have been screened for cervical cancer were those who did not have fear of cervical cancer diagnosis (OR 1.31; 95% CI 0.71-1.80), cultural beliefs did not hinder them from screening (OR 1.11; 95% CI 0.35-3.59), religious beliefs did not affect their screening behavior (OR 02.41; 95% CI 0.28-20.37), and those who were satisfied with how they were handled at the facility during screening (OR 0.84; 95% CI 0.41-1.75).

Table 1: Perceptions about Cervical Cancer and its Screening

Are you at risk of cervical cancer?	**n=102 Yes**	**n=254 No**	**n=356 Total**	**COR**	**P Value**
No	28(27.5%)	166(65.4%)	194(54.5%)	1	
Yes	74(72.5%)	88(34.6%)	162(45.5%)	4.99(2.90-8.55)	<0.001
Any fears about screening procedures?					
No	86(84.3%)	137(53.5%)	223(62.3%)	1	
Yes	16(15.7%)	119(46.5%)	135(37.7%)	0.21(0.12-0.40)	<0.001
Are you afraid of vaginal examinations?					
No	81(79.4%)	100(39.4%)	181(50.8%)	1	
Yes	21(20.6%)	154(60.6%)	175(49.2%)	0.17(0.09-0.30)	<0.001
Preference for male or female health workers					
Female	40(39.2%)	155(60.8%)	195(54.6%)	1	
Male	6(5.9%)	29(11.4%)	35(9.8%)	0.80(0.31-2.07)	<0.001
Either	56(54.9%)	71(27.8%)	127(35.6%)	3.06(1.83-5.09)	
Would you refer women for cervical cancer screening?					
No	14(13.7%)	183(71.8%)	197(55.2%)	1	
Yes	88(86.3%)	72(28.2%)	160(44.8%)	15.98(7.64-33.43)	<0.001
Ever discussed cervical cancer with your spouse?					
No	33(32.4%)	212(83.5%)	245(68.8%)	1	
Yes	69(67.6%)	42(16.5%)	111(31.2%)	10.55(5.72-19.49)	<0.001
Ever discussed cervical cancer with your peers?					
No	22(21.6%)	185(72.8%)	207(58.1%)	1	
Yes	80(78.4%)	68(26.8%)	148(41.6%)	9.95(5.34-18.54)	<0.001
Ever discussed cervical cancer with your close relatives?					
No	44(43.6%)	187(74.2%)	231(65.4%)	1	
Yes	53(52.5%)	53(21.0%)	106(30.0%)	4.15(2.46-6.98)	<0.001
I have fear of a cervical Cancer diagnosis					
No	48(48.5%)	126(51.4%)	174(50.6%)	1	
Yes	51(51.5%)	119(48.6%)	170(49.4%)	1.13(0.71-1.80)	0.622
Cultural beliefs hinder me from screening					
Yes	4(3.9%)	11(4.3%)	15(4.2%)	1	

No	98(96.1%)	242(95.7%)	340(95.8%)	1.11(0.35-3.59)	0.857
Religious beliefs affect screening behaviour					
Yes	1(1.0%)	6(2.4%)	7(2.0%)	1	
No	100(99.0%)	249(97.6%)	349(98.0%)	2.41(0.28-20.37)	0.404
Satisfied with how you were handled today					
Yes	90(89.1%)	221(87.4%)	311(87.9%)	1	
No	11(10.9%)	32(12.6%)	43(12.1%)	0.84(0.41-1.75)	0.648

Source: Field data, 2021

Perceptions about Cervical Cancer and screening

This theme focused on the cultural orientation and religious beliefs on how they influence cervical cancer screening among women of reproductive age at health facilities in Bomachoge Chache Sub-County.

On religion, the FGD focused on whether there are religious beliefs, which influence decision in seeking care for cervical cancer screening among the participants. Most of the participants indicated there were no religious beliefs that influenced their uptake of cervical cancer screening. One of the participants narrated that;

".... there are no religious beliefs which tell me not to go for screening for cervical cancer..." (45-year-old mother of 4) while another indicated that;

".... No religious beliefs which discourage cervical cancer screening. 'My church encourages people to visit hospitals...."(36 year old mother of 3)

On the other hand, a participant indicated that;

"...God created heaven and earth and therefore has power to heal anybody with strong faith. No need to screen and even treat in the hospital....." (48-year-old mother of 5).

On perception about cervical cancer, the participants were asked whether they thought they were at risk of suffering from cervical cancer and why. They expressed being at risk since cervical cancer is like any other disease. For example, 45-year-old mother of 3 narrated that;

".....Yes, I think I am at risk because cancer is like any other disease...."

While another 31-year-old mother of 6 indicated that: "*.... Yes, because it can be transferred from one infected person to another when taking care of the affected person in the hospital*....." This further shows limited awareness on how cervical cancer is transmitted.

A number of participants also thought they were not at risk since the disease is not transmitted from one person to another, have not been screened, they observe hygiene and nutrition and the disease is not hereditary. Some of the narrations were;

"...I am not at risk because I don't feel ill in my body...." (44-year-old mother of 2)

"I am not at risk because cervical cancer is a curse and I have never been cursed...." (42-year mother of 3).

On cultural orientation, the participants expressed that there were no cultural beliefs that barred them from screening for cervical cancer. Some of the narrations from the participants include;

"...No cultural barrier, in case of any infection there is unity in our culture to take one to hospital....." (25-

year-old mother of 3 children)

Some of the participants however agreed that there were cultural beliefs which barred some of their members from being screened on cervical cancer. Some of them believed that cervical cancer can be transmitted from the patient to a caregiver, it is out of being bewitched and that it is a curse. Some of the narrations were;

"…. It is shameful for a woman to expose her nakedness to somebody else who is not the husband. It is considered to be promiscuous…." (35-year-old mother of 5).

"*…. Cervical cancer is caused by witchcraft because cure cannot be found in hospitals but in the witchdoctors……" (45-year-old mother of 4)*

Multivariate analysis

The study conducted analysis of the findings through regression and correlation as illustrated in Table 4.13. This was meant to establish the association levels among the independent and dependent variables of the study. The study focused on predictors of cervical cancer screening among the participants which included age, average monthly income, awareness level, smoking cigarettes, early sexual debut, knowledge about cervical cancer screening, smelly discharge, vaginal bleeding after menopause, vaginal bleeding during or after sex, fears about screening procedures and distance to the nearest cancer screening center.

Most variables with a p value of less than 0.05 were subjected to the logistic regression process where most variables were dropped retaining only those that produced the best fit for the model. In the logistic regression, age was a weak predictor for cervical cancer screening. Those aged between 40-49 years were more likely to undergo cervical cancer screening than those aged between 16-29 years. (aOR 17.04; 95% CI 3.20-90.79)

On the awareness of cervical cancer, the strongest predictors for cervical cancer screening were, having ever heard of cervical cancer (aOR27.84; 95% CI: 3.92-197.90) and cervical cancer screening (aOR 75.59; 95% CI: 15.05-379.74), awareness of risk factors such as smoking and early sexual debut. This also includes warning signs such as vaginal bleeding after menopause and vaginal bleeding during or after sex.

On the perception about cervical cancer screening, the strongest predictors of cervical cancer screening, include fears about screening procedures (aOR0.22; 95% CI: 0.07-0.66), and being able to refer other women for cervical cancer screening (aOR56.10; 95% CI: 15.53-202.65).

Access factors associated with of cervical cancer screening only had one predictor which was distance to the nearest cervical cancer screening center. Those staying between 6-10 km from the nearest screening center were less likely to undergo cervical cancer screening than those who stay less than 1 kilometer away from the nearest screening facility (aOR0.12; 95% CI: 0.03-0.44).

Table 2: Logistic regression of predictors of cervical cancer screening

	Ever been screened for cervical cancer before					
Variables	**Yes**	**No**	**Total**	**OR (95%CI)**	**AOR (95%CI)**	**P Value***
Age in years	**n=102**	**n=256**	**n=358**			
16-29	50(49.0%)	156(60.9%)	206(57.5%)	1	1	
30-39	38(37.3%)	73(28.5%)	111(31.0%)	1.62(0.98-2.70)	1.32(0.53-3.30)	0.553
40-49	13(12.7%)	25(9.8%)	38(10.6%)	1.62(0.77-3.42)	17.04(3.20-90.79)	0.001
≥50	1(1.0%)	2(0.8%)	3(0.8%)	1.56(0.14-7.69)	133.99 (NE)	0.578
Average monthly income in KES						

<4000	42(41.2%)	148(58.0%)	190(53.2%)	1	1	
4001-10999	25(24.5%)	58(22.7%)	83(23.2%)	1.52(0.85-2.72)	1.18(0.39-3.54)	0.768
11000-20999	11(10.8%)	23(9.0%)	34(9.5%)	1.69(0.76-3.75)	8.27(1.76-38.96)	0.008
>21000	24(23.5%)	26(10.2%)	50(14.0%)	3.25(1.66-6.37)	1.55(0.48-5.02)	0.464
Ever heard of cervical cancer?						
No	3(2.9%)	108(42.4%)	111(31.1%)	1	1	
Yes	99(97.1%)	147(57.6%)	246(68.9%)	24.24(6.78-86.76)	27.84(3.92-197.90)	0.001
Smoking cigarettes						
Agree	84(82.4%)	160(62.7%)	244(68.3%)	1	1	
Disagree	15(14.7%)	70(27.5%)	85(23.8%)	0.41(0.22-0.76)	0.26(0.09-0.81)	0.021
I don't know	3(2.9%)	25(9.8%)	28(7.8%)	0.23(0.07-0.79)	0.08(0.01-0.61)	0.015
Early sexual debut						
Agree	56(54.9%)	89(34.9%)	145(40.6%)	1	1	
Disagree	36(35.3%)	119(46.7%)	155(43.4%)	0.48(0.29-0.80)	0.54(0.21-1.39)	0.203
I don't know	10(9.8%)	47(18.4%)	57(16.0%)	0.34(0.16-0.74)	8.46(1.47-48.56)	0.017

Ever heard of cervical cancer screening						
No	4(3.9%)	152(59.4%)	156(43.6%)	1	1	
Yes	98(96.1%)	104(40.6%)	202(56.4%)	35.81(10.84-118.33)	75.59(15.05-379.74)	<0.001
Smelly discharge						
Agree	91(89.2%)	193(75.7%)	284(79.6%)	1	1	
Disagree	8(7.8%)	38(14.9%)	46(12.9%)	0.45(0.20-1.00)	0.23(0.04-1.38)	0.108
I don't know	3(2.9%)	24(9.4%)	27(7.6%)	0.27(0.08-0.91)	9.05(1.16-70.51)	0.036
Vaginal bleeding after menopause						
Agree	87(85.3%)	187(73.3%)	274(76.8%)	1	1	
Disagree	13(12.7%)	32(12.5%)	45(12.6%)	0.87(0.44-1.75)	28.67(4.68-175.69)	<0.001
I don't know	2(2.0%)	36(14.1%)	38(10.6%)	0.12(0.03-0.52)	0.02(0.00-0.26)	0.003
Vagina bleeding during/after sex						

Agree	88(86.3%)	187(73.3%)	275(77.0%)	1	1	
Disagree	9(8.8%)	42(16.5%)	51(14.3%)	0.46(0.21-0.98)	13.61(2.50-74.24)	0.003
I don't know	5(4.9%)	26(10.2%)	31(8.7%)	0.41(0.15-1.11)	1.95(0.24-15.71)	0.529
Any fears about screening procedures?						
No	86(84.3%)	137(53.5%)	223(62.3%)	1	1	
Yes	16(15.7%)	119(46.5%)	135(37.7%)	0.21(0.12-0.40)	0.22(0.07-0.66)	0.007
Would you refer women for cervical cancer screening						
No	14(13.7%)	183(71.8%)	197(55.2%)	1	1	
Yes	88(86.3%)	72(28.2%)	160(44.8%)	15.98(7.64-33.43)	56.10(15.53-202.65)	<0.001
Distance to the nearest cancer screening center						
<1km	**n=102**	**n=254**	**n=356**	1	1	
1-5km	61(59.8%)	119(46.9%)	180(50.6%)	1	1.31(0.48-3.56)	0.595
6-10km	28(27.5%)	68(26.8%)	96(27.0%)	0.80(0.47-1.38)	0.12(0.03-0.44)	0.002
>10km	10(9.8%)	54(21.3%)	64(18.0%)	0.36(0.17-0.77)	5.12(0.52-49.69)	0.16

Source: Field data, 2021

DISCUSSION

Women's Perception, about Cervical Cancer Screening

On the perception about cervical cancer screening, the strongest predictors of cervical cancer screening were fears about screening procedures, and being able to refer other women for cervical cancer screening with over half (54.5%) of the participants disagreeing that they were at risk of cervical cancer indicating fears. There was also a close association with between admitting risk and screening.

These findings concur with those by Dönmez, Öztürk, Kısa, & Weller in Turkey among first year female nursing students to establish knowledge and perceptions about human papilloma virus (HPV), cervical cancer and HPV vaccine where it was established that 59.4% did not believe to be at risk of developing cervical cancer.54.6% preferred female health workers to handle their cases while those who indicate either were more likely to be screened [6]. Majority of the study participants never discussed cervical cancer with spouse, friends or relatives. 75% of them indicated that there was no religious belief which barred them from screening.

A qualitative study conducted at Ecuador to assess knowledge and Perceptions about Cervical Cancer and Human papilloma virus (HPV) Screening in Women in Rural Areas. Results showed that the perception of cervical cancer was focused on its severity, secondary to its infectious process and screening periodicity. However, despite the diverse knowledge, indigenous people do not relate it to the human papilloma virus; in addition, there is also certain resistance to undergo the Pap smear test, for reasons such as inaccessibility and sample collection process which make women feel uncomfortable [7]. Williams, Kenu, Dzubey, & Dennis-antwi, in their study in Ghana also showed that social cultural issues, such as stigmatization leads to low uptake of cervical cancer screening by women regardless of their educational levels [8].

In Kenya, a qualitative exploration study done at Busia and Trans Nzoia indicated that , patients, community health volunteers (CHVs), and health care providers (HCPs) perceived cervical cancer to be a chronic disease

that could be treated but inevitably led to death. All 174 participants alluded to sexual behavior etiologies, including multiple sexual partners, contracting sexually transmitted infections, and early engagement in sexual activities. Patients and CHVs cited unhealthy diet and use of selected family planning methods, while HCPs and CHVs added complications during delivery as causative. Only patients cited commercial sex, lack of vitamin B17, bacterial infections, smoking as factors. Additionally, CHVs added female circumcision, genetics, abortion, intercourse with men with long penises as causes [9].

CONCLUSION

It was concluded that the level of awareness about cervical cancer and screening practices among the study participants was above average. Qualitative findings showed that participants had knowledge about cervical cancer although there were misconceptions such as prayers being a cure to cervical cancer. Witchcraft, curses and sexual immorality were cited as causes of cervical cancer. Further, delay in service delivery was attributed to shortage of health care professionals and inadequate hospital infrastructure.

RECOMMENDATIONS

Health care workers to enhance awareness on risk factors for cervical cancer through forums such as women groups, church meetings, health facility, media, community mobilization and sensitization and outreach meetings, b) Demystify negative perceptions about the cause of cervical cancer such as witch craft and a curse and to Advocate for more screening centers/outreach services in the county in order to reduce distance the women take to get to the screening facilities.

Consent for Publication

Not Applicable

Availability of data and materials:

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

Competing interests:

The authors declares that they have no competing interests

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Authors' contributions:

BS designed, collected data, analyzed and interpreted the data and wrote the manuscript. BS analyzed and interpreted the data. PM and EN interpreted the data. All authors read and approved the final manuscript

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