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Assessment of Knowledge, Attitude and Practice of Cervical Cancer Screening among Women at Igando Ultra Modern Market, Lagos State.

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CHAPTER ONE
INTRODUCTION

1.1 Background To The Study

Cervical cancer is the fourth most common cancer among women globally, with nearly all cases attributed to human papillomavirus (HPV). According to the World Health Organization (WHO, 2016), over 500,000 new cases of cervical cancer and more than 250,000 deaths occur annually worldwide. More recent data indicates 570,000 new cases nand 311,000 deaths across various regions globally. Amoo et al. (2018) highlighted that 80% of cervical cancer cases occur in low-income countries, where access to screening and preventive services is severely limited. Additionally, studies have shown that out of 78,897 women diagnosed with cervical cancer annually in Africa, 61,671 succumb to the disease. This indicates that African women face a cancer mortality rate twice as high as their counterparts in developed countries.The availability of early cancer screening programs has significantly reduced cervical cancer mortality rates in countries where such programs are accessible. However, the high prevalence of cervical cancer in developing nations, such as Nigeria, is largely attributed to the widespread occurrence of HPV infections and the absence of effective cervical cancer screening initiatives. Even in areas where screening programs are available, limited awareness and negative health-seeking behaviors among the population have resulted in low utilization of these services. In Nigeria, cervical cancer screening is conducted sporadically and typically on an opportunistic basis for individuals visiting specific clinics.

Nigeria lacks a standardized policy or protocol for cervical cancer screening. Available screening methods include the Pap smear, visual inspection of the cervix with acetic acid (VIA), HPV DNA testing, and colposcopy. According to Moorley et al. (2018), the incidence of cervical cancer has remained relatively stable over time, likely due to poor screening coverage. Many women present with advanced stages of the disease when curative treatment is no longer possible, creating significant challenges for gynecologists and contributing to higher incidence rates and lower survival outcomes. While cervical cancer is preventable through regular screening and treatment, these services are rarely accessible in most developing countries.Low participation in screening programs is influenced by several factors, including limited awareness of the benefits of early detection. Increased knowledge could improve screening uptake. Additional barriers include low socioeconomic status and ineffective strategies to reach women in the informal

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sector. These challenges are compounded by the absence of established cervical cancer screening programs and a lack of culturally sensitive, tailored health promotion campaigns (Amos et al., 2018).

Enhancing women's knowledge about cervical cancer screening and prevention is an essential component of a comprehensive strategy for cervical cancer prevention and control. This approach could play a critical role in addressing the issue. However, studies indicate that health workers, who are expected to take the lead, often have limited knowledge about cervical cancer as a disease, with only a moderate understanding of Pap smear testing.Among market women, the majority exhibit a positive attitude toward cervical cancer prevention, yet only about one-third possess good knowledge, and very few (2.7%) demonstrate good screening practices. Additionally, over half of cervical cancer patients are aware of the malignancy of the disease.

This underscores the importance of knowledge about cervical cancer and its screening in improving uptake rates. Women with limited awareness of cervical cancer and its preventive measures are significantly less likely to utilize screening services (Ezeonu& Ejikeme, 2019).

The incidence of cervical cancer remains disproportionately high in developing countries. In Nigeria, an estimated 53.3 million women are at risk of developing cervical cancer, with a national age-standardized prevalence rate of 33.0 per 100,000. Several factors contribute to the development of cervical cancer, including sexually transmitted infections, reproductive and hormonal influences, genetic predispositions, and host factors.Complications from cervical cancer are often linked to late diagnosis, a lack of awareness, cultural barriers to screening, and the absence of accessible cervical cancer screening programs in most developing nations. Despite being a preventable disease, the incidence of cervical cancer is projected to nearly double by 2025, with mortality rates remaining alarmingly high.

Sexually active women of reproductive age should undergo cervical cancer screening every 10 years. However, evidence regarding knowledge, attitudes, and practices related to cervical cancer screening is limited, particularly in Nigeria. Healthcare professionals with sufficient knowledge play a vital role in shaping positive beliefs and preventive behaviors among the general public. They significantly contribute to improving cervical cancer screening practices among women.

When healthcare providers regularly deliver health education and recommend Pap smear testing, it enhances knowledge about cervical cancer and its screening, fosters positive attitudes, and encourages screening practices, ultimately reducing the disease burden.

Market women, as an economic driving force in Nigeria, represent a critical demographic for understanding the relationship between knowledge, attitudes, and practices of cervical cancer screening. Examining how sociocultural and socioeconomic factors influence these variables among market women in Igando is essential.

1.2 STATEMENT OF PROBLEM

Cervical cancer continues to pose a significant public health challenge in many low- and middle-income countries, where it ranks as either the leading or second leading cause of cancer-related deaths among women. In Africa, where approximately 267.9 million women aged 15 and older are at risk, around 80,000 new cervical cancer cases are reported annually, with over 60,000 deaths. The continent bears the

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highest global incidence and mortality rates for cervical cancer, approximately ten times higher than those observed in Western countries (Okunowo, 2020).

In Nigeria, cervical cancer is the second most prevalent cancer among women, with 14,943 new cases and 10,407 deaths reported in 2019. It has been documented that cervical cancer constitutes a significant portion of malignancies treated at Ahmadu Bello University Teaching Hospital, Zaria (Yahya, 2019).Nigeria currently lacks a national population-based cervical cancer screening program. Given the high concentration of women in market areas, these locations could serve as strategic hubs for implementing population-based cervical cancer screening initiatives.A significant barrier to effective cervical cancer prevention in Nigeria is the low level of awarenessand poor knowledge about cervical cancer screening methods. Additionally, HPV infections present a considerable reproductive health challenge for both adolescent and older women, increasing their vulnerability to cervical cancer. Although HPV vaccines have been approved, they are not yet incorporated into Nigeria's Expanded National Immunization Program. Instead, they are only accessible to individuals through personal arrangements (Okunade et al., 2017).Hence there is a need to assess the knowledge, attitude and practice of cervical cancer screening among women at Igando market, Lagos state.

1.3 OBJECTIVE OF THE STUDY

The broad objective of the study was to assess the knowledge, attitude and practice of cervical cancer screening among women at Igando Market, Lagos State.

The specific objectives of the study were as follows, To;

- assess the level of knowledge of women at Igando market on cervical cancer screening
- assess the attitude of women at Igando market toward cervical cancer screening
- determine the practice of cervical cancer screening among women at Igando Market.
- identify factors that hinder cervical cancer screening among women at Igando market.

1.4 RESEARCH QUESTIONS

The following research questions were answered through the study:

- What is the level of knowledge of women at Igando market on cervical cancer screening?
- What is the attitude of women at Igando Market towards cervical cancer screening?
- Will the women at Igando market practice cervical cancer screening?
- What are the factors hindering cervical cancer screening among women at Igando market?

1.5 RESEARCH HYPOTHESIS

The following null hypothesis were formulated and tested to guide the study

H_1: There is no significant relationship between the age and knowledge of cervical cancer among women at Igando market on cervical cancer screening.

H_2: There is no significant relationship between the attitude and utilization towards cervical cancer screening among market women at Igando market.

H_3:There is no significant relationship between socio-demographical factors and practice of cervical cancer screening among market women at Igando market.

1.6 SIGNIFICANCE OF THE STUDY.

The research work will be significant for the following reason:

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The findings from this study will help to increase the knowledge of the market women at Igando and the populace on cervical cancer screening.

The findings from the study will be used by health care professionals to increase strategies on increasing their knowledge and creating awareness on cervical cancer screening to the market women.

The findings from the study will be used in planning and designing training manuals and guidelines and formulating deliberate policies in training nurses, doctors and other health personnel involved in the fight against cervical cancer.

The outcome of the study will help the policies maker and stake holders to identity the important of creating social awareness on cervical cancer screening.

The study will add to the existing knowledge in nursing on cervical cancer screening services and will serve as a reference for future research.

1.7 SCOPE OF THE STUDY

The study was limited to the market women at Igando ultra-modern market using 168 study participants.

1.8 DEFINITION OF OPERATIONAL TERMS

Attitude: refers to the acceptance ofcervical cancer screening among market women at Igando.

Cervical cancer: a malignant tumor of the lower part of the uterus that can be prevented by Pap smear screening and an HPV vaccine**.**

Knowledge: refers to the awareness and understanding of cervical cancer screening among women

Papanicolaou smear: is a procedure to test for cervical cancer in women.

Practice: Utilization of cervical cancer screening services among market women at Igando.

CHAPTER TWO
LITERATURE REVIEW

2.0 INTRODUCTION

This chapter review the theoretical and empirical concept, upon which the study is hinged.

2.1 CONCEPTUAL REVIEW

Cervical cancer develops in the cells of the cervix, the lower part of the uterus that connects to the vagina. It occurs when cervical cells grow abnormally and invade nearby tissues and organs (William & Shiel, 2018).The majority of cervical cancer cases are linked to specific strains of human papillomavirus (HPV), a sexually transmitted infection. Factors contributing to cervical cancer associated with this viral infection include early initiation of sexual activity, frequent use of oral contraceptives or birth control pills, and having multiple sexual partners.

Anatomy/Physiology of cervix

The cervix is a cylinder-shaped neck tissue of the vagina and uterus. It is approximately 1 inch long and 1 inch wide and opens into vagina. Located at the lowermost part of the uterus, the cervix is composed primarily fibro muscular tissue. Functions as the entrance of sperm to the uterus, during menstruation, it opens slightly to allow menstrual blood flow out of the uterus.

Types of Cervical cancer

Cervical cancer is categorized into two primary types based on how the cells of the cervix appear under a microscope:

1. **Squamous Cell Carcinoma**
   This type originates in the thin, flat cells lining the lower part of the cervix. It accounts for approximately 80% of all cervical cancer cases.

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2. **Adenocarcinoma**
   This type begins in the glandular cells lining the upper portion of the cervix and makes up about 20% of cervical cancer cases.

In some cases, both cell types may be involved in cervical cancer. While other types of cancer can occur in the cervix, they are uncommon. For instance, metastatic or invasive cervical cancer originates in the cervix but spreads to other parts of the body.

Invasive Cervical Cancer
This form spreads from the surface of the cervix into deeper cervical tissues or to distant organs, such as the lungs, liver, bladder, vagina, and rectum (Traci, 2020).

Causes of Cervical Cancer
The majority of cervical cancer cases are caused by the sexually transmitted human papillomavirus (HPV). There are over 100 different strains of HPV, but only specific types are linked to cervical cancer. The two most common types associated with cervical cancer are HPV-16 and HPV-18 (Melissa, 2018).

Risk Factors for Cervical Cancer
The primary risk factor for cervical cancer is HPV infection. Other factors that may increase the risk include:
Early Sexual Activity: Studies suggest that the higher rates of cervical cancer among women with lower socioeconomic status are not solely due to higher rates of HPV infection, but rather early sexual experiences that may increase the cancer-causing potential of HPV. It is believed that women who begin sexual activity earlier and contract HPV tend to have the infection for a longer period, compared to those who acquire it later in life.

Multiple Sexual Partners (or a partner with multiple sexual partners): Engaging in sexual activity with multiple partners, or having a partner who has had many sexual partners, increases the likelihood of exposure to HPV, which is transmitted through sexual contact. As a result, having numerous sexual partners or a partner with multiple partners is associated with a higher risk of cervical cancer.

Multiparity: Having multiple pregnancies has been associated with an increased risk of cervical cancer in women infected with HPV. The hormonal changes that occur during pregnancy may make the cervix more susceptible to the harmful effects of HPV.

Immunosuppression: Women with weakened immune systems, such as those with HIV, those who have undergone organ transplantation, or those suffering from malnutrition, are at a significantly higher risk of developing cervical cancer.

Chlamydia: Some studies have indicated that women with evidence of past or current chlamydia infection, as shown through blood tests and cervical mucus, may have a higher risk of cervical cancer. Researchers have speculated that immune system cells at the site of a chlamydia infection could damage normal cells, potentially causing them to become cancerous. Recent research has suggested that certain serotypes of *Chlamydia trachomatis* are linked to the development of cervical squamous cell cancer.

Smoking: Tobacco by-products have been detected in the cervical mucus of women who smoke. These substances are believed to damage the DNA of cervical cells, which may contribute to the development of cervical cancer. Additionally, smoking weakens the immune system's ability to fight off HPV infections.

Obesity: Excess body fat has been linked to higher estrogen levels, which may contribute to the development of both endometrial and cervical cancer, particularly adenocarcinoma.

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Family History of Cervical Cancer: Some researchers believe that certain rare cases of cervical cancer may be due to an inherited condition that makes some women more susceptible to HPV infections, making it harder for them to fight off the virus.

Birth Control Pills: The use of oral contraceptives has been associated with an increased risk of cervical cancer, possibly by altering the vulnerability of cervical cells to persistent infections with high-risk HPV strains.

Teenage or Adolescent Pregnancy: It is thought that teenage pregnancy may increase the risk of HPV due to the biological vulnerability of the immature cervix, which could be more susceptible to persistent HPV infections, thereby raising the risk of cancer development.

Exposure to Diethylstilbestrol (DES): Women whose mothers took diethylstilbestrol during pregnancy to prevent miscarriage are at a higher risk of developing cervical cancer(Stephanie, 2019).

Clinical Symptoms of Cervical Cancer

Cervical cancer often does not show symptoms until it has reached an advanced stage. Common symptoms of cervical cancer include:

- Light bleeding or spotting between periods.
- Menstrual bleeding that is heavier or lasts longer than usual.
- Bleeding after sexual intercourse, douching, or a pelvic exam.
- Bleeding after menopause.
- An increase in vaginal discharge that may have an unusual color or odor.
- Painful intercourse (dyspareunia).
- Persistent, unexplained pelvic and/or back pain.
- Frequent urination.
- Painful urination (dysuria)(Traci, 2020).

Diagnosis of Cervical Cancer

Cervical cancer can be diagnosed through the following methods:

- Pap smear
- HPV typing test
- Colposcopy
- Cervical conization

Pap Smear

A Pap smear, also known as a Pap test or conventional cytology, is a screening method for cervical cancer. It detects the presence of precancerous or cancerous cells on the cervix. During the procedure, cells from the cervix are collected and examined for abnormal growth. Current guidelines suggest that women should have regular Pap smears every three years, beginning at age 21. Women who are at higher risk for cervical cancer, such as those who are HIV-positive, may need more frequent screenings.During the procedure, the woman lies in a dorsal lithotomy position on the examination table, and the healthcare provider inserts a speculum into the vagina to keep the vaginal walls open, allowing access to the cervix. A sample of cervical cells is collected using a spatula, brush, or cytobrush. This sample is then sent to a laboratory for testing to check for abnormal cells. A Pap smear should be rescheduled if the woman is menstruating, has douches, or used spermicidal products the day before. A normal or negative result indicates no cell changes were found on the cervix. An unclear result means the cervical cells appear abnormal, but it's not clear if the changes are related to HPV or other factors like pregnancy, menopause, or an infection. An abnormal result indicates that cell changes were detected, which are often linked to HPV. These changes can be low-grade (minor) or high-grade (serious), but this does not necessarily indicate the presence of cervical cancer at the time.

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The HPV typing test

This a screening procedure used to detect the DNA or RNA of specific HPV types (particularly types 16 and 18) known to cause cervical cancer. High-risk HPV types, such as 16, 18, 31, and 45, can lead to changes in the cervical cells, which may appear as abnormal on a Pap test. This test may be conducted alongside a Pap test for women aged 30 to 65 years, or following abnormal Pap test results. A positive HPV test does not indicate that a woman has cervical cancer, but it suggests the presence of an HPV type that could be associated with an increased risk of developing cervical cancer.

Table 1: Recommended management of combined HPV test and Pap test

HPV test	Pap test	Management
Negative	Negative	Repeat testing in 5 years
Unclear	Negative	Repeat testing in 3 years
Negative	Atypical squamous cells of undetermined significance (ASC-US)	Repeat testing in 3 days
Negative	Low-grade squamous intraepithelial lesion (LSIL)	Repeat testing in 6-12 months
Not performed	Atypical squamous cells of undetermined significance (ASC-US)	Repeat testing in 6-12 months
Positive	Negative	Repeat testing in 6-12 months
Not performed	Low-grade squamous intraepithelial lesion (LSIL)	Immediately colposcopy
Positive	Low-grade squamous intraepithelial lesion (LSIL)	Immediately colposcopy
Unclear	Atypical squamous cell cannot rule out high-grade lesion (ASH-H)	Immediately colposcopy
Positive	Atypical squamous cells of undetermined significance (ASC-US)	Immediately colposcopy
Unclear	High-grade squamous intraepithelial lesion (HSIL)	Immediately colposcopy
Unclear	Squamous cell carcinoma (SCC)	Immediately colposcopy
Unclear	Atypical glandular cells (AGC)	Immediately colposcopy

Colposcopy

Colposcopy is a diagnostic procedure that involves examining the cervix, vagina, and vulva through an illuminated magnified view. This examination helps identify pre-

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cancerous and cancerous lesions, as these areas may exhibit detectable characteristics. Using magnification, the healthcare professional can visually differentiate between normal and abnormal tissue and collect tissue samples for biopsy to further investigate any potential pathology.Before the procedure, the healthcare provider takes a medical history, which includes details such as pregnancy history, contraception use, past abnormal Pap smear results, allergies, previous medical conditions, medications, prior cervical treatments, and lifestyle factors like smoking. A pregnancy test may also be done in certain cases. The procedure is thoroughly explained to the patient, who is then given the opportunity to ask questions before signing a consent form.During a colposcopy, the woman lies in a dorsal lithotomy position, and a speculum is inserted into the vagina after the vulva is examined for any suspicious lesions. A diluted acetic acid solution (1% or 3%) is applied to the cervix using cotton swabs. Any areas of the cervix that turn white or show abnormal blood vessel patterns after the acid is applied are typically considered for biopsy. If no abnormalities are visible, iodine solution may be used to highlight potential areas of concern. After the examination, the healthcare provider identifies the areas with the most noticeable abnormalities and may take biopsies from these regions using tools like punch forceps, SpiraBrush CX, or Soft Biopsy. Although anesthesia is generally not necessary, some healthcare providers may use a topical anesthetic, such as lidocaine, or a cervical block to minimize discomfort, particularly if multiple biopsies are performed. The main goal of colposcopy is to prevent cervical cancer by detecting and treating precancerous lesions early. Colposcopy is not generally performed for persons treated for cervical cancer if their pap tests show low-grade squamous intraepithelial lesion or less. Unless a person has a visible lesion, colposcopy does not do a recurrence of cervical cancer.

Cervical conization

Cervical conization is a procedure in which a cone-shaped portion of tissue is removed from the cervix's mucous membrane. This can be done for diagnostic purposes, as part of a biopsy, or for therapeutic purposes to eliminate precancerous cells. The two main types of cervical conization are cold knife conization (CKC) and loop electrical excision procedure (LEEP).If a biopsy reveals invasive cancer, additional tests may be performed to determine the extent of its spread, including:

- Chest X-ray: To examine the lungs.
- Blood tests: To analyze the blood.
- Cystoscopy: To evaluate the bladder and urethra.
- Proctosigmoidoscopy and barium enema: To inspect the rectum.
- CT, MRI, or PET scan: To assess the lymph nodes.
- Intravenous pyelogram (IVP): To examine the urinary tract.

Pathophysiology of Cervical cancer

There are over 100 types of human papillomavirus (HPV), but eight of the most common types associated with cervical cancer are HPV 16, 18, 31, 33, 35, 45, 52, and 58. HPV-16 is the leading cause of cervical cancer worldwide. The progression of cervical cancer is categorized into stages based on the epithelial tissue, starting from normal epithelium to cervical intraepithelial neoplasia (CIN) stages 1-3, and eventually leading to invasive cervical cancer. CIN 3 is unlikely to regress on its own and, if left untreated, may eventually penetrate the basement membrane and progress to invasive carcinoma over time.

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CIN is graded as follows:

- Mild cervical dysplasia
- Moderate dysplasia
- Severe dysplasia and carcinoma in situ.

The transformation from an HPV-infected cell to a cancerous one is a complex process. In simple terms, it starts with the infection of basal cells located between the squamous epithelium of the ectocervix and the columnar epithelium of the endocervix. The virus replicates within the epithelial cells during their differentiation cycle, which involves the activation of genes responsible for viral replication. This cycle is necessary for the production of viral particles on the surface of the squamous epithelium. HPV DNA replication starts when the DNA of the basal cell is duplicated (Melissa, 2016).

Stages of Cervical cancer

Cervical cancer is categorized into four stages based on its progression and spread within the body:

- **Stage 1:** The cancer is confined to the cervix and may have spread to nearby lymph nodes, but not to other distant parts of the body.
- **Stage 2:** The cancer has grown larger and may have extended beyond the cervix and uterus or into the lymph nodes, but has not spread to other distant organs.
- **Stage 3:** The cancer has spread to the lower part of the vagina or pelvis and may be obstructing the ureters.
- **Stage 4:** The cancer has spread beyond the pelvis to distant organs such as the lungs, bones, or liver (Stephanie, 2019).

Treatment of Cervical cancer

Cervical cancer can be effectively treated if detected early. The main treatment options include:

- **Surgery**
- **Radiation therapy**
- **Chemotherapy**
- **Targeted therapy**

These treatments are sometimes combined for greater effectiveness.

Surgery:

The goal of surgery is to remove as much cancerous tissue as possible. In cases of extensive cancer, this may involve removing the cervix along with other pelvic organs. Various types of surgery are used to treat cervical cancer, such as:

- **Cryosurgery**: Uses a probe to freeze and destroy cancer cells in the cervix.
- **Laser surgery**: Employs a laser beam to burn away abnormal cells.
- **Conization**: Removes a cone-shaped portion of the cervix using a surgical knife, laser, or electrically heated wire.
- **Hysterectomy**: Involves removing the entire uterus and cervix. A radical hysterectomy also removes the upper part of the vagina.
- **Trachelectomy**: Removes the cervix and part of the upper vagina but leaves the uterus intact, allowing for future childbirth.
- **Pelvic exenteration**: May involve removal of the uterus, vagina, bladder, rectum, lymph nodes, and parts of the colon, depending on how far the cancer has spread.

Radiation Therapy

Radiation therapy uses high-energy X-ray beams to target and destroy cancer cells. Similar to surgery, radiation only affects the cancer cells in the treated area. The treatment can be external, internal, or a combination of both:

- **External Radiation**: A large machine is used to direct radiation beams at the pelvis. The procedure typically lasts only a few minutes and is done five days a week for 5-6 weeks. An additional dose, known as a "boost," is given at the end of the treatment.

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- **Internal Radiation (Brachytherapy)**: A radioactive capsule is placed inside the cervix, delivering cancer-killing rays directly to the tumor while minimizing damage to surrounding healthy tissue.

Chemotherapy

Chemotherapy involves the use of powerful anticancer drugs to kill cancer cells in the body. The treatment is typically administered in cycles, with periods of intense treatment followed by recovery phases, allowing the body time to heal before the next cycle.

Biological Therapy (Immunotherapy)

When chemotherapy is ineffective, biological therapy, or immunotherapy, may be used. This involves the drug pembrolizumab (Keytruda), which is given intravenously every three weeks to block certain proteins on cancer cells, thereby shrinking tumors or inhibiting their growth.

Targeted Therapy

Bevacizumab (Avastin) is a new type of drug that works differently from chemotherapy and radiation. It blocks the development of new blood vessels that support cancer cell growth and survival. Bevacizumab is often combined with chemotherapy to enhance its effectiveness (Traci, 2020).

Prevention of Cervical cancer

One of the most effective ways to prevent cervical cancer is through regular screenings with a Pap smear or high-risk HPV test. These screenings can detect precancerous cells that can be treated before they develop into cancer.Most cases of cervical cancer are caused by HPV infection, which can be prevented with the vaccines Gardasil and Cervarix. The vaccine is most effective when given before someone becomes sexually active.

Other measures to reduce the risk of HPV and cervical cancer include:

- Limiting the number of sexual partners.
- Consistently using condoms or other barrier methods during vaginal, oral, or anal sex.
- Quitting smoking(Stephanie, 2019).

Complications of cervical cancer can include:

- Early onset of menopause.
- Presence of blood in urine (hematuria).
- Intense pain.
- Swelling caused by lymphatic obstruction (lymphedema).
- Pulmonary embolism.
- Blockage of the urinary tract (obstructive uropathy).
- Kidney failure.

Prognosis of Cervical cancer

Cervical cancer detected at an early stage, when it is still confined to the cervix, has a five-year survival rate of 92%. However, once the cancer spreads within the pelvic region, the five-year survival rate decreases to 56%. If the cancer spreads to distant parts of the body, the survival rate drops to just 17%.

The five-year survival rates based on the stage of cancer are as follows:

- Stage I: 80-90%
- Stage II: 60-75%
- Stage III: 30-40%
- Stage IV: 0-15%

Nearly 80% of recurrences occur within two years.

Factors that negatively affect prognosis include:

- Involvement of lymph nodes.
- Large tumor size and volume.
- Deep invasion into cervical stromal tissue.
- Invasion of surrounding tissues (parametrial invasion).
- Lymphovascular space invasion.
- Non-squamous histology.

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2.1.2 THE LEVEL OF KNOWLEDGE ON CERVICAL CANCER SCREENING

Olumide (2017) conducted a study on women's awareness of cervical cancer, its symptoms, prevention, and screening among 2,000 women in Ogun State. The results revealed that only 6.5% of the respondents were aware of cervical cancer and screening, which was very low. Knowledge about cervical cancer screening was also poor, with only 2.3% of women identifying a virus as the cause of the disease, and just 4.1% recognizing screening as a preventive measure. Additionally, 97.7% had little to no knowledge of cervical cancer symptoms. A significant 90.5% cited lack of awareness as a major barrier to the uptake of cervical cancer screening in Nigeria. The study highlights the need for greater focus on raising awareness and improving women's knowledge about cervical cancer and screening. Although awareness of cervical cancer is generally low globally, it is particularly poor in developing countries. In a related study by Audu (2018), 33.1% of women in Lagos State had adequate knowledge about cervical cancer and screening, compared to 23% in Ogun State and 19% in Kano State.In Ghana, many women, especially those in rural areas, have limited access to opportunities for learning about reproductive health (Adanu, 2016). This is largely due to the fact that the Pap smear test, which is commonly used in developed countries, is available only at a few healthcare facilities in the country. Additionally, the lack of a nationwide health screening program restricts the number of women who undergo screening. Abotchie and Shokar (2019) conducted a study on the lack of awareness among college women at a university in Ghana regarding the purpose of Pap screening in diagnosing cancer.In a study by Tebeu et al. (2017) assessing the knowledge, attitudes, and perceptions of cervical cancer among women in Maroua, Cameroon, it was found that the women's understanding of cervical cancer was insufficient. The study emphasized the need for an intensive campaign to raise awareness about cervical cancer and its prevention to reduce deaths from this curable and preventable disease.Similarly, a study by Harries et al. (2019) in South Africa examined the key challenges and attitudes toward HPV vaccination. The findings showed a lack of understanding about the purpose and preventive role of the Pap smear. While many women were aware of cervical cancer screening, they did not fully grasp the purpose of the Pap smear. Some women mistakenly believed that the Pap smear was a procedure for cleansing or scraping the womb after potential exposure to a sexually transmitted infection, which may have contributed to their reluctance to accept the cervical cancer screening service.A study by Arulogun and Maxwell (2019) found that 81.7% of respondents believed women should begin screening after becoming sexually active. Additionally, 38.2% thought screening should be done annually, while 30.2% supported screening every two years. The study highlighted that a negative attitude toward screening puts women at a higher risk of developing cervical cancer.In a separate study by Igbinomwanhia (2016) on the knowledge, attitudes, and practices related to cervical cancer prevention among women in Okada Community, Edo State, it was found that 91.1% of respondents had never heard of cervical cancer. Only 8.9% had heard of it, and 3.2% were familiar with the Pap smear. These findings underscore the low awareness of cervical cancer screening among women in developing countries.

2.1.3 THE ATTITUDE TOWARDS CERVICAL CANCER SCREENING

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A study conducted by Adedokun &Ayodapo (2016) at the Polytechnic Ibadan explored perceptions of cervical cancer screening. The findings revealed that 89.1% of participants were aware that cervical cancer is a life-threatening condition, and 67.4% recognized its association with HPV. A majority (75.7%) believed that cervical cancer is more common among women with multiple sexual partners, and 73.2% identified early sexual activity as a risk factor. Most respondents (85.7%) agreed that early detection of cervical cancer allows for treatment, and 78.8% acknowledged the importance of cervical cancer screening.

A study conducted by Kalayu& Tesfay (2018) among students at Debre Berhan University in Ethiopia found that only 33.2% of participants believed they were at high risk of acquiring cervical cancer. However, 85% considered cervical cancer to be a serious illness, and 65.2% believed it could be treated. Despite this, 74.5% of the participants acknowledged that cervical screening could prevent the disease. Similarly, a study by Awodele (2017) at Lagos University Teaching Hospital in Nigeria revealed that 99% of respondents were aware of cervical cancer, and 92% knew it was caused by HPV. Despite this awareness, 91% were familiar with screening, yet most had never undergone it. Another study conducted by Nigerian medical practitioners between June 3rd and August 7th, 2019, showed that 37.9% of Nigerian women knew about cervical cancer and its prevention, but only 11.5% had ever had a Pap smear, indicating a lack of positive attitude towards prevention and screening, despite its availability in many Nigerian hospitals.

2.1.4 THE PRATICE OF CERVICAL CANCER SCREENING

Several factors can influence a woman's willingness and ability to engage in cervical cancer prevention programs, and the decision-making process plays a crucial role in this. Therefore, it is important for cervical cancer prevention initiatives to address the key barriers that hinder women's participation, while also creating conditions that encourage their use of available services (American Cervical Cancer Association-ACCA, 2016). A study by Akujobi et al. (2018) conducted at a tertiary institution in southeastern Nigeria found that 66.4% of participants were unaware of the Pap smear test, and none had ever undergone a Pap screening.

In a study by Bakari et al. (2021) conducted among health workers in Maiduguri, Nigeria, 88.5% of participants expressed a willingness to undergo screening only if it was free, similar to 70.6% of participants who would do so if offered at no cost. A similar level of willingness was reported in Udigwe (2019), where participants who had not yet participated in screening expressed interest in doing so in the future, and in Eze et al. (2018), where 62.5% of respondents indicated a willingness to be screened.In another Nigerian study by Udigwe (2019), only 5.7% had ever undergone a Pap smear, and 37.1% provided no reasons for not attending cervical screening despite 9.3% having lost relatives to cervical cancer. In a study by Mugalo (2021) at Pumwani Maternity Hospital in Nairobi, participants cited fear (51.9%), shame (22%), and lack of information about cervical screening (18.9%) as the main reasons for not seeking screening.

2.1.5 THE FACTORS HINDERING THE UTILIZATION OF CERVICAL CANCER SCREENING

Inadequate knowledge about cervical cancer and its prevention, along with the long distance to screening locations, are among the factors hindering the uptake of cervical screening services (Lyimo, 2017; Weller &

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Bartoskek, 2019). Other contributing factors include the need for partner approval, negative attitudes towards the service, socioeconomic challenges, and constraints within the healthcare system (Singh & Badaya, 2018).

A study by Ezem (2018) in Owerri, southeastern Nigeria, revealed that low awareness (46.1%), lack of perceived need for screening (12.5%), and fear of a positive result (11.6%) were key factors influencing the uptake of cervical screening. In contrast, a study by Oche et al. (2018) among females of reproductive age in Sokoto found that only 17.6% were aware of cervical cancer screening. Additionally, 27.8% believed that only women with symptoms should undergo screening, while 77.8% planned to seek screening in the future when they were older and at higher risk. The most common reason for not undergoing a Pap smear among the respondents was the perception that they were not at risk for the disease (34.4%).

In a study by Eze et al. (2018) in Nigeria, 39.7% of participants provided various reasons for not undergoing screening. These reasons included not being sexually active (5%), the high cost of screening (15%), discomfort or pain (9.7%), and delayed results (10%). Additionally, 28.1% of the women cited the lack of physical symptoms as a reason, while 11.6% believed they were not at risk for cancer. Furthermore, 10.3% of participants mentioned the lack of adequate information about screening facilities and fear of a positive result as factors influencing their decision.

2.2 THEORETICAL /CONCEPTUAL, FRAME WORK

Health Belief Model

The Health Belief Mode (HBM) is a psychological model that attempts to explain and predict health behaviors by focusing on the attitudes and beliefs of individuals (Glanz et al, 2002). This model is the theoretical framework which seeks to explain behavioral factors that influence an individual's willingness to engage in health enhancing behaviors. It postulates that person's willingness to engage in health seeking behavior is influenced by perceived benefits, perceived barriers, perceived susceptibility and perceived seriousness of the disease and cues from the social environment to act and enhance one's health.

The key variables of the HBM are as follows;

Perceived Threat: Consist of two parts which are perceived susceptibility and perceived severity of a health condition**.** The model foresees that individuals who identify themselves as prone to a health problem will engage in behaviors to minimize their risk of developing the health problem.

Perceived Susceptibility: Ones perception of the risk of contracting a health condition. This is a wide variation in a person's feeling of personal vulnerability to an illness or a disease. The model foresees that individuals who identify themselves as prone to a health problem will engage in behaviors to minimize their risk of developing the health problem.

Perceived Severity: Feelings concerning the seriousness of contracting an illness or of leaving it untreated (including evaluations of both medical and clinical consequences and possible social consequences).There is a wide variation in a person's feeling of severity, often a person considers the medical consequences (e.g. family life, social relationships) when evaluating the severity. According to the model, those individuals who think a problem is a major one will enroll in activities which reduce the occurrence or severity.

Perceived Benefits: The believed effectiveness of strategies designed to

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reduce the threat of illness.This refers to the person's perception of the effectiveness of various actions available to reduce the threat of illness or disease, or to cure illness or disease. It is an individual's assessment of the value or efficacy of engaging in a health-promoting behavior to reduce risk of contracting a disease. The course of action a person takes in preventing or curing illness or disease relies on consideration and evaluation of both perceived susceptibility and perceived benefits, such that the person would accept the recommended health action if it was perceived as beneficial.

Perceived Barriers: The potential negative consequences that may result from taking particular health actions including physical, psychological, and financial demands.There is a wide variation in the person's feelings of barriers or impediments which lead to a cost benefit analysis. The person weighs the effectiveness of the actions against the perception that it may be expensive, dangerous (e.g. side effect), unpleasant (e.g. painful), time-consuming or inconvenient.

Cue to Action: These are events, either physical (e.g., media exposure) or external (e.g., advice from others, a family member's illness, or a newspaper article), that motivate individuals to take action. Cues to action, a component of the Health Belief Model (HBM), have not been extensively studied. They can be internal, such as physical symptoms like chest pain or wheezing, or external, such as external prompts like recommendations from others or information from the media.

Other Variables: These include various demographic, socio-psychological, and structural factors that influence an individual's perceptions, which in turn indirectly affect health-related behaviors.

Self-Efficacy: This refers to the belief in one's ability to successfully perform the behavior necessary to achieve a desired outcome. Introduced to the model in 1980, self-efficacy is a key element in many behavioral theories as it plays a direct role in determining whether an individual will carry out the intended behavior.

2.2.1 APPLICATION OF THEORY TO THE STUDY

Perceived Susceptibility: The market women believe they are at risk of developing cervical cancer and feel they may have been exposed to HPV.

Perceived Severity: The market women recognize that the consequences of HPV infections are serious enough to warrant prevention.

Perceived Benefit: The market women believe that taking preventive actions, such as avoiding early sexual contact and limiting sexual partners, can help reduce their risk of HPV infections.

Perceived Barriers: The market women assess potential obstacles to taking preventive actions, including physical, psychological, financial, and social challenges.

Cue to Action: The market women are motivated to take action when exposed to triggers such as TV advertisements or reminders from a physician or healthcare provider.

Self-Efficacy: The market women are willing to take action if they feel confident in their ability to successfully carry out the necessary steps or if they perceive a significant risk of disease.

2.3 EMPIRICAL REVIEW

Olumide (2017) conducted a study in Ogun State, assessing 2,000 women's understanding of cervical cancer, its symptoms, prevention, and screening. The findings revealed that only 6.5% of the respondents were aware of cervical cancer and its screening, which was quite low. Knowledge about cervical cancer screening

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was also limited, with just 2.3% of women identifying a virus as the cause of cervical cancer, and only 4.1% recognizing cervical cancer screening as a preventive measure. A significant 97.7% of the women had little or no knowledge of the symptoms of cervical cancer.A study found that 90.5% of respondents identified lack of awareness as a major barrier to the uptake of cervical cancer screening in Nigeria. This highlights the importance of focusing efforts on raising awareness and improving women's knowledge about cervical cancer and its screening. While cervical cancer awareness is generally low globally, it is particularly lower in developing countries. Additionally, research by Audu (2018) revealed that 33.1% of women in Lagos State had sufficient knowledge about cervical cancer and screening, compared to 23% in Ogun State and 19% in Kano.In Ghana, many women, especially those in rural areas, have limited access to reproductive health education (Adanu, 2016). The Pap smear test, which is commonly used in developed countries, is only available at a few healthcare facilities in the country, and the lack of a nationwide health screening program further limits the number of women who undergo screening. Similarly, a study by Harries et al. (2019) in South Africa explored the challenges and perceptions surrounding HPV vaccination. It found that many women had poor knowledge of the purpose and preventive benefits of the Pap smear. While they were aware of cervical cancer screening, many did not understand its purpose, and some even associated the Pap smear with procedures like cleansing or scraping the womb after potential exposure to a sexually transmitted infection. This misconception may have contributed to their reluctance to participate in cervical cancer screening.A study by Arulogun and Maxwell (2019) revealed that 81.7% of respondents believed women should begin cervical cancer screening after becoming sexually active. Additionally, 38.2% felt that screening should be conducted annually, while 30.2% supported screening every two years. These findings highlight that a negative attitude towards screening increases the risk of women developing cervical cancer. Similarly, Adedokun and Ayodapo (2016) conducted research on cervical cancer screening perceptions at the Polytechnic Ibadan. Their findings showed that 89.1% of participants recognized cervical cancer as a life-threatening condition, and 67.4% were aware of its link to HPV. Furthermore, 75.7% believed the disease primarily affects women with multiple sexual partners, while 73.2% identified early onset of sexual activity as a significant risk factor for cervical cancer. The majority (85.7%) agreed that cervical cancer is treatable if detected early, and 78.8% acknowledged the importance of cervical cancer screening. A study conducted by Kalayu and Tesfay (2018) among students at Debre Berhan University in Ethiopia found that only 33.2% believed they had a high risk of developing cervical cancer. However, 85% perceived it as a severe disease, and 65.2% believed it to be curable. Additionally, 74.5% of participants recognized that cervical screening could help prevent cervical cancer. Similarly, a study by Awodele (2017) at Lagos University Teaching Hospital, Nigeria, revealed that 99% of respondents were aware of cervical cancer, 92% knew that HPV is the causative organism, and 91% were aware of screening, although most had never undergone the procedure. Regarding cervical cancer screening practices, Bakari et al. (2021) conducted research among health workers in Maiduguri, Nigeria. A significant proportion (88.5%) of participants expressed willingness to undergo screening only if it was offered free of charge, similar to 70.6% of participants

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who were inclined to take the test if it was cost-free. Comparable levels of willingness were observed in a study by Udigwe (2019), where participants who had not yet undergone screening showed interest in doing so in the future. Similarly, Eze et al. (2018) reported that 62.5% of respondents were willing to be screened.In another Nigerian study by Udigwe (2019), only 5.7% of participants had ever undergone a Pap smear. Among those who had not, 37.1% did not provide any specific reason for their decision, despite 9.3% of them having lost relatives to cervical cancer.In a study conducted by Mugalo (2021) at Pumwani Maternity Hospital in Nairobi, key reasons for not undergoing cervical cancer screening included fear (51.9%), shame (22%), and lack of information (18.9%). Several factors hinder the utilization of cervical cancer screening services. These include insufficient knowledge about the disease and its prevention, as well as the long distance to screening facilities (Lyimo, 2017; Weller & Bartoskek, 2019). Additional barriers include the need for partner approval, negative attitudes toward the service, socioeconomic challenges, and constraints within the healthcare system (Singh & Badaya, 2018).

A study by Ezem (2018) in Owerri, southeastern Nigeria, highlighted low awareness levels (46.1%), perceived lack of need for screening (12.5%), and fear of a positive result (11.6%) as key factors affecting screening uptake. Similarly, a study by Eze et al. (2018) in Nigeria revealed various reasons for not undergoing screening: not being sexually active (5%), high screening costs (15%), discomfort or pain (9.7%), and delayed results (10%). Additionally, 28.1% of women cited the absence of physical symptoms, while 11.6% believed they were not at risk of developing cancer. Furthermore, 10.3% identified inadequate information about screening facilities and fear of a positive result as barriers.

SUMMARY

Cervical cancer remains a significant public health burden in many low- and middle-income countries, ranking as the most common or second most common cause of cancer-related deaths among women. Globally, nearly 270,000 women die from cervical cancer annually. The high prevalence of HPV infection and the absence of effective cervical cancer screening programs contribute to this burden in developing countries. Even in areas where screening programs exist, poor awareness and negative health-seeking behaviors have resulted in underutilization of these services. Screening is often sporadic and conducted opportunistically for women visiting specific clinics. Additionally, some developing countries lack standardized policies or protocols for cervical cancer screening. Common screening methods include Pap smear, visual inspection of the cervix with acetic acid (VIA), HPV DNA testing, and colposcopy.

Colposcopy is not utilized as a primary screening test but is instead combined with other diagnostic methods. For primary prevention, HPV vaccination for girls aged 9 to 15 years is crucial. Increasing the screening rate among women who have never been screened or who screen infrequently is an essential strategy for reducing the incidence and mortality associated with cervical cancer. Awareness and knowledge about cervical cancer and it's screening significantly influence the likelihood of women utilizing screening services. Women with limited knowledge about cervical cancer and its prevention are less likely to access these services.

Research indicates that cervical cancer is a leading cause of morbidity and mortality among women globally. Studies have

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demonstrated that cervical cancer screening effectively reduces both incidence and mortality rates. However, the impact of screening programs is maximized when the quality, coverage, and follow-up rates are high.

In many developing countries, there are no organized cervical cancer screening services, leaving many women without access to these life-saving programs. Barriers such as lack of awareness about cervical cancer, limited knowledge of available screening services, accessibility challenges, misconceptions about the disease, and inadequate information about risks are common. Additionally, attitudes toward cervical cancer screening and the limitations of health facilities in regions like Igando have been identified as significant obstacles to the acceptability and uptake of cervical cancer screening services.

Although various studies have explored the knowledge and acceptability of cervical cancer screening on global and regional scales, limited research has focused specifically on the knowledge, attitudes, and practices related to cervical cancer screening in Nigeria. It is anticipated that the findings from such a study will contribute to enhancing awareness, fostering positive attitudes, and encouraging better practices regarding cervical cancer screening among women.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1: RESEARCHDESIGN

Adescriptive research study designwasusedinthisstudy.

3.2: RESEARCHSETTING

Igando is a community located in Alimosho local government area of Lagos State, South-Western Nigeria. The research study area is Igando Market. The market was established in 1976 and is one of the largest markets in Lagos State. Food items and clothing are the major wares for sale at the market. The market has more than 5000 traders.

3.3: TARGETPOPULATION

The target population consists of all women trading in this Market.

3.4: SAMPLESIZEDETERMINATION

The respondent for the study were drawn from women trading at Igando market, using a convenience sampling technique; the total number of women was about 300. The sample size was determined using the formula below:

The sample size in the study was determined by a single proportion.

Formula for sample size is; $n=z^2pq/d^2$

Where;

n=sample size

z=standard normal deviate set at 1.96

d=desired degree of accuracy (taken at 0.05)

p=estimate of proportion of the target population

Therefore, the sample size for the study was;

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

$$n=\frac{z^2pq}{d^2}$$

$$n=\frac{(1.96)^2\,(0.5)\,(0.5)}{(0.05)^2}$$

$$n=\frac{3.8416\times0.25}{0.00255}$$

$n=384.16$

$n=384$

However, since the target population for the questionnaire was less than 384 and the average number of women at Igando market were 300, the sample estimate was calculated using;

$$Nf=\frac{n}{1+(n/N)}$$

Where;

Nf= the desired sample from finite population

n= sample estimated using the formula

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$n= z^2pq=384$
n= target population
$Nf= \frac{384}{1+(384/300)}$
$Nf= \frac{384}{1+1.28}$
$Nf = \frac{384}{2.28}$
Nf = 168
Hence, the sample size for the study was 168.

3.5: SAMPLINGTECHNIQUE
A non- probability convenient sampling technique was used to select the study participants and a total number of 168 women trading in this market were used for the study.

3.6: INSTRUMENTFORDATA COLLECTION
A self-developed adopted questionnaire was used for the collection of data. The questionnaire was divided into five sections; A, B, C, D, E. SectionA-Demographiccharacteristics of the respondents. Section B- knowledge of cervical cancer screening among the respondents. Section C-attitude of cervical cancer screening among the respondents. SectionD-practice of cervical cancer screening among of the respondents and Section E – factors hindering cervical cancer screening among the respondents.

3.7: VALIDITYOFINSTRUMENT
Face and content validity were used to validate the instrument for the study.

3.8: ELIABILITYOFINSTRUMENT
To ensure reliability of the questionnaire, a few copies of questionnaire were administered to few women trading atIgando market within a day. The test – retest method was used for the reliability test, which yielded 0.78 coefficients.

3.9: METHODOFDATACOLLECTION
A self-developed adapted questionnaire methodwas used for the collection of data. The researcher personally administered 168 questionnaires with the help of a research assistant. Detail of the study was explained and interpreted to the study participants, the researcher sought for theconsent of the study participants before they participated in answering the questionnaire and the entire 168 questionnaire was retrieved back immediately.

3.10: METHODOF DATAANALYSIS
The data was analyzed through descriptive statistical techniques in which frequency, distribution tables, pie charts, bar charts were employed. The results were represented in percentages and opinions of the respondents were properly organize and analyzed using frequency and distribution tables.

3.11: ETHICALCONSIDERATION
A letter of permission was collected from the research committee of Lagos State College of nursing Igando, the letter was given to the ethical board of the local government authorities and was presented to the market leader (Iyaloja) of the market who gave her consent for the collection of data. Also, verbal consent was taken from the market women having explained the aim and goals of the research to them. The selected respondents were fully informed about the questionnaire and assured of confidentiality and non-maleficence.

CHAPTER FOUR
ANALYSIS AND PRESENTATION OF DATA

4.0: INTRODUCTION
This chapter deals with the presentation of data collected from the respondents.The research findings are related to the research

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questions that guided the study. The data used for the analysis were generated from questionnaires administered to the study respondents. This chapter is discussed under these headings: Data Presentation, Data Analysis, and Discussion of Results, it entails the description of demographic and socio-economic characteristics of the respondents.

4.1 : SOCIO-DEMOGRAPHIC CHARACTERISTICS

A total of 168 respondents participated in the study, with a valid return rate of 168(100.0%).Analysis of data was done using SPSS 23.0 and primary data was used as a source of data with use of questionnaireAnalysis of data was done using SPSS 23.0 and primary data was used as a source of data with use of questionnaire. In the rating of the respondents' knowledge, attitude and practice on cervical cancer screening, a five (5) points Likert's Scale was used. The relative means for each of the items were calculated with 5 as the highest and 1 the lowest score. Bivariate analysis was done by using Chi-square Correlation to test the hypothesis at 0.05 level of significance and result presented according to the hypothesis stated in chapter one.

Table 4.1: Respondents' socio-demographic characteristics

Socio-demographic Characteristics	Frequency	Percentage (%)
Age (in Years)		
20-25	45	26.8
26-30	45	26.8
31-35	33	19.6
36-40	28	16.6
41 years and above	17	10.2
Total	**168**	**100.0**
Religion		
Christians	110	65.5
Muslims	39	23.2
Others (Traditional)	19	11.3
Total	**168**	**100.0**
Ethnicity		
Yoruba	101	60.1
Igbo	31	18.5
Hausa	6	3.5
Other ethnic minorities	30	17.9
Total	**168**	**100.0**
Marital Status		
Single	35	20.8
Married	107	63.7
Divorced/Widowed	26	15.5
Total	**168**	**100.0**
Educational Background		
Primary	62	36.9
Secondary	75	44.6
Tertiary	31	18.5
Total	**168**	**100.0**

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Number of Births		
None	54	32.1
1-2	24	14.4
3-4	62	36.9
5 and above	28	16.6
Total	**168**	**100.0**
Age of sex debut		
10 years	3	1.8
11-15 years	9	5.4
16-20 years	103	61.3
21 years and above	37	22.0
Others	16	9.5
Total	**168**	**100.0**

Table 4.1 above shows that the majority of respondents were young adults in their active reproductive years. Specifically, 33 (19.6%) were aged 31–35 years, and 45 (26.8%) were aged 26–30 years. Additionally, 45 respondents (26.8%) were between 20–25 years, 28 (16.6%) were aged 36–40 years, and 17 (10.2%) were 40 years and above.The majority of respondents, 110 (65.5%), identified as Christians, while 39 (23.2%) were Muslims and 19 (11.3%) adhered to traditional beliefs.In terms of education, 75 (44.6%) of the respondents had completed secondary education, 62 (36.9%) had attained primary education, and only a few, 31 (18.5%), had tertiary education.Regarding marital status, 107 (63.7%) of the respondents were married, 35 (20.8%) were single, and 26 (15.5%) were either divorced or widowed.More than half of the respondents, 103 (61.3%), reported having their first sexual intercourse between the ages of 16–20 years. A total of 22 (13.1%) were 21 years and above at the time of their first sexual experience, while only a few, 3 (1.8%) and 9 (5.4%), reported their first sexual intercourse at 10 years and between 11–15 years, respectively.

The majority of the respondents, 101 (60.15%), identified as Yoruba, followed by 31 (18.5%) who were Igbo, 6 (3.5%) who were Hausa, and 30 (17.9%) who belonged to other ethnic minority groups.In terms of childbirth, 62 (36.9%) of the respondents had 3–4 children, 54 (32.1%) reported having no children, 24 (14.4%) had 1–2 children, and 28 (16.6%) had 5 or more children.

4.2 ANSWERING OF RESEARCH QUESTIONS

Research Question 1: What is the level of knowledge of women at Igando market on cervical cancer screening?

Table 4.2: Respondents' knowledge about cervical screening

Variables	Frequency	Percentage (%)
Cervical cancer is a disease that can affect women who are sexually active		
Yes	40	23.8
No	128	76.2
Total	168	100.0

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Cervical cancer can be treated if detected early		
Yes	34	20.2
No	134	79.8
Total	168	100.0
Awareness status regarding cervical cancer		
Aware	56	33.4
Not aware	112	66.6
Total	168	100.0
Knowledge of human papillomavirus as etiological agent of cervical cancer		
Knowledgeable	12	7.1
Not knowledgeable	156	92.9
Total	168	100.0
Awareness of cervical cancer vaccination for someone		
Aware	20	11.9
Not aware	148	88.1
Total	168	100.0
Cervical cancer can be preventable		
Yes	15	8.9
No	153	91.1
Total	168	100.0

Table 4.2 above highlights a low level of knowledge regarding cervical cancer screening among respondents. Only 54 (33.4%) reported being aware of cervical cancer, while the majority, 112 (66.6%), were unaware. Furthermore, just 40 (23.8%) knew that cervical cancer affects sexually active women, whereas 128 (76.2%) had no knowledge of this.Additionally, only 34 (20.2%) of respondents were aware that cervical cancer can be treated if detected early, while 134 (79.8%) were unaware. A small proportion, 12 (7.1%), knew that cervical cancer is caused by the human papillomavirus (HPV), with 156 (92.9%) being unaware. Similarly, only 20 (11.9%) were aware that vaccination is available for cervical cancer, while 148 (88.1%) lacked

this knowledge. Lastly, just 15 (8.9%) understood that cervical cancer is preventable, whereas 153 (91.1%) were not aware.

Figure 4.1: Respondents' primary source of information regarding cervical cancer (n = 40)

The figure 4.1above revealed that out of the respondents who have heard about cervical cancer is a disease that can affect sexually active women, majority 25(62.5%) obtained their information from the hospitals through health workers, 9(22.5%) heard about cervical cancer through television and radio, 4(10%) through friends and only a few 2(5%) from the market

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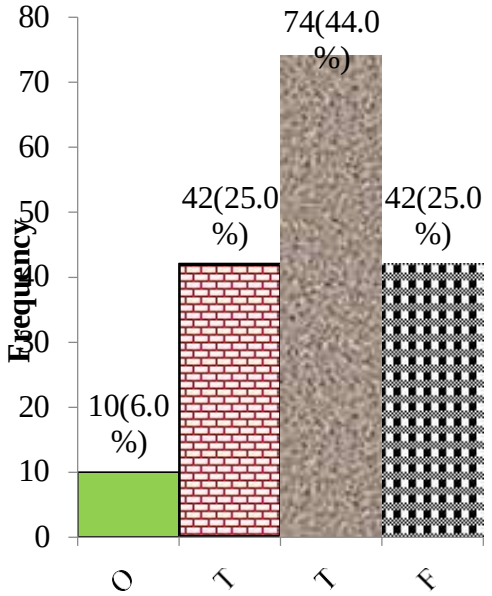

Figure 4.2: Respondents' knowledge of number of vaccination doses needed for prevention of HPV (n = 168)

As shown in figure 4.2 above, nearly half 74(44%) of the study population knew that three doses of vaccination are required for the prevention of HPV, a quarter 42(25%) reported two doses and 4-5 doses respectively while only 10(6%) believed that the number of doses required to prevent HPV is only a dose.

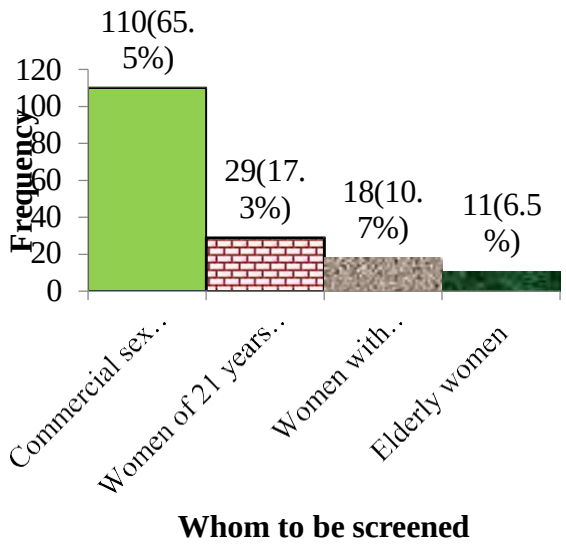

Figure 4.3: Respondents' knowledge of whom to be screened for cervical cancer (n = 168)

The figure 4.3 above revealed that as high as 110(65.5%) of the respondents believed that only commercial sex workers are required to be screened for cervical cancer. 29(17.3%) knew that screening is meant for women of 21 years and above, while 18(10.7%) and 11(6.5%) felt that it is for women with multiple sexual partners and elderly women respectively.

Table 4.3: Respondents' knowledge of age for cervical cancer prevention (n = 168)

Variables	Frequency	Percentage (%)
Age of commencement for cervical cancer screening		
21 years	71	42.3
19 years	30	17.9
25 years	41	24.4
50 years	26	15.4
Total	**168**	**100.0**
Recommended age for girls to undergo vaccination against cervical cancer		
11-15 years	35	20.8
16-20 years	119	70.8
21 years and above	14	8.4
Total	**168**	**100.0**

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Table 4.3 above shows that nearly half of the respondents, 71 (42.3%), believed that 21 years is the ideal age to start cervical cancer screening. Meanwhile, 30 (17.9%) thought 19 years was the best age, and only 26 (15.4%) considered 50 years to be the appropriate age for screening. A significant majority, 119 (70.8%), agreed that girls should receive the cervical cancer vaccine between the ages of 16-20 years. Additionally, 35 (20.8%) thought the recommended age for vaccination was between 11-15 years, while only 14 (8.4%) correctly identified the appropriate age as 21 years and above.

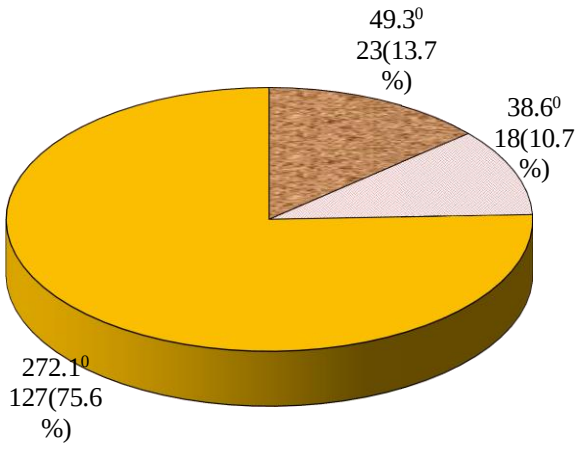

Figure 4.4: Respondents' knowledge of debut period for cervical cancer screening for women (n = 168)

Figure 4.4 above illustrates the respondents' understanding of when a woman should begin cervical cancer screening. Approximately three-quarters, 127 (75.6%), of the respondents believed that screening should start when a woman has a sexually transmitted infection. In contrast, only 23 (13.7%) thought screening should begin when a woman becomes sexually active, and 18 (10.7%) believed it should start after menopause.

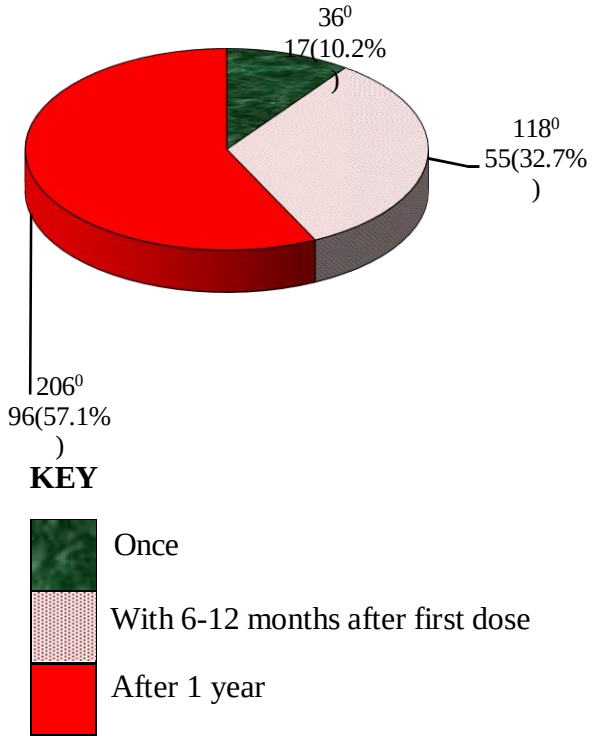

Figure 4.5: Respondents' knowledge of the right interval for administration of vaccination (n = 168)

Figure 4.5 above displayed the respondents' understanding of the appro riate interval for vaccination. More than half, 96 (57.1%), confirmed that the vaccination is given after one year, while 55 (32.7%) believed it should be administered within 6-12 months after the first dose. Only a mall number, 17 (10.2%), thought it was given only once. These findings indicate that the knowledge

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of women at Igando market regarding cervical screening was inadequate.

Research Question 2:

What is the attitude of women at Igandomarket towards cervical cancer screening?

Table 4.4: Respondents' attitude towards cervical cancer screening

Attitude	Strongly Agree	Agree	Disagree	Strongly Disagree	Total	*X*	Remark
Cervical cancer screening is valuable and important for all women	17 (10.1%)	22 (13.1%)	78 (46.5%)	51 (30.3%)	168 (100.0%)	1.9	Poor
Only women with multiple sexual partners need cervical screening	85 (50.6%)	36 (21.5%)	28 (16.6%)	19 (11.3%)	168 (100.0%)	1.8	Poor
Cervical cancer screening should form part of routine examination for every woman of childbearing and menopausal age	25 (14.9%)	16 (9.5%)	58 (34.5%)	69 (41.1%)	168 (100.0%)	2.3	Poor
Women that maintain good hygiene and one sexual partner do not need cervical cancer screening	78 (46.5%)	62 (36.9%)	18 (10.7%)	10 (5.9%)	168 (100.0%)	1.8	Poor
Cervical cancer is not a death sentence for most people	60 (35.7%)	75 (44.6%)	7 (4.2%)62	26 (15.5%) (12.0%)	168 (100.0%)	3.1	Good
Pap smear screening every 3 years with appropriate follow-up can reduce cervical cancer incidence among women in Nigeria	47 (28.0%)	79 (47.0%)	29 (17.3%)	13 (7.7%)	168 (100.0%)	2.9	Good
Average						**2.3**	**Poor**

Note: Criteria for scoring:
Mean score between 1.0-2.5 is rated poor while 2.6-4.0 is rated good.

Table 4.4 above shows that only 17 (10.1%) of the study participants strongly agreed that cervical cancer screening is essential for all women, and 22 (13.1%) agreed. In contrast, 51 (30%) strongly disagreed, and 78 (46.5%) disagreed.Around half, 85 (50.6%), strongly believed that only women with multiple sexual partners need cervical screening, with 36 (21.5%) agreeing, 19 (11.3%) strongly disagreeing, and 28 (16.6%) disagreeing.Only 25 (14.9%) strongly agreed that cervical cancer screening should be a routine part of every woman's examination during childbearing and menopausal years, while 16 (9.5%) agreed. However, 69 (41.1%) strongly disagreed, and 58 (34.5%) disagreed.

Nearly half, 78 (46.5%), strongly believed that women who maintain good hygiene and have one sexual partner do not need screening, while 62 (36.9%) agreed, 10

(5.9%) strongly disagreed, and 18 (10.7%) disagreed.

Further, the table shows that 60 (35.7%) of the respondents strongly believed that cervical cancer is not a death sentence for

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most people, and 75 (44.6%) agreed with this. However, 26 (15.5%) strongly disagreed, and 7 (4.2%) disagreed.

Lastly, more than three-quarters, 47 (28.0%), strongly believed that having a Pap smear screening every 3 years with proper follow-up could reduce the incidence of cervical cancer among women, while nearly half, 79 (47%), agreed. On the other hand, 13 (7.7%) strongly disagreed, and 29 (17.3%) disagreed.

The overall attitude towards cervical cancer screening was poor, with a mean score of 2.3. These findings indicate that the women in Igando market have a poor attitude towards cervical screening.

Research Question 3:Will the women at Igando market practice cervical cancer screening?

Table 4.5: Respondents' practice of cervical cancer screening

Practices	**Freq.**	**Percentage (%)**
Screening status		
Screened	25	14.9
Never been screened	143	85.1
Total	**168**	**100.0**
Place of uptake of cervical screening		
Hospital/Clinic	25	100.0
Number of screenings ever done		
Once	8	32.0
2-3 times	14	56.0
More than 3 times	3	2.0
Total	**25**	**100.0**
Last screening done		
I can't remember	9	36.0
1-2 years ago	8	32.0
2-3 years ago	3	2.0
More than 3 years	5	30.0
Total	**25**	**100.0**
Reason for the cervical screening		
Routine to prevent cancer	6	24.0
Mass screening for all	3	2.0
It was done for free	12	48.0
On health grounds	4	16.0
Total	**25**	**100.0**
Informed on the outcome of cervical screening status		
Aware about screening result	23	92.0
Unaware about screening result	2	8.0
Total	**25**	**100.0**
Scheduled for appointment for next screening		
Given appointment	21	84.0
Not given next appointment	4	16.0
Total	**25**	**100.0**

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Willingness to go for screening if is free		
Willing	127	88.8
Unwilling	16	11.2
Total	**143**	**100.0**

Table 4.5 above shows that only a small number, 25 (14.9%), of the respondents have ever been screened for cervical cancer, with all screenings conducted at health facilities. The majority, 143 (85.1%), have never undergone screening. Among those who have been screened, 14 (56%) had been screened 2-3 times, while 8 (32%) had been screened once, and 3 (2%) had been screened more than 3 times. However, 9 (36%) of them could not remember the exact number of screenings, and 8 (32%) and 3 (2%) had their most recent screening 1-2 years and 2-3 years ago, respectively. Additionally, 5 (30%) had their last screening over 3 years ago.

The reasons cited for undergoing cervical screening included free and mass screening, mentioned by 12 (48%) and 3 (2%) of respondents, respectively. Additionally, 6 (24%) participated as part of routine health screening for cancer prevention, and 4 (16%) did so based on health recommendations.

Almost all (92%) of those who were screened reported that they were informed about their results, while 2 (8%) were not. Furthermore, 21 (84%) were scheduled for their next screening appointment, while 4 (16%) were not given any follow-up appointment. Among those who have not yet been screened, 127 (88.8%) expressed willingness to undergo screening only if it is free of charge, while 16 (11.2%) were unwilling to participate even if the screening is free.

Research Question 4: What are the factors hindering cervical cancer screening among women at Igando market?

Table 4.6: Respondents' perceived factors influencing the practice of cervical cancer screening

Factors	Scale	Frequency	Percentage (%)
Lack of awareness/information about cervical cancer screening	Strongly Agreed Agreed Disagreed Strongly Disagreed	94 55 7 12	56.0 32.7 4.2 7.1
		168	100.0
It is too embarrassing to do cervical cancer screening.	Strongly Agreed Agreed Disagreed Strongly Disagreed	63 48 25 32	37.5 28.6 14.9 19.0
		168	100.0
My husband would not want me to do cervical cancer screening.	Strongly Agreed Agreed Disagreed Strongly Disagreed	44 38 40 46	26.2 22.6 23.8 27.4
		168	100.0
Attitude of health personnel's and doctors can discourage one from going	Strongly Agreed Agreed	52 57	30.9 33.9

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to hospital for Cervical cancer screening.	Disagreed Strongly Disagreed	34 25	20.3 14.9
		168	100.0
Not knowing where to go for Cervical cancer screening is a major reason why people don't go for Cervical cancer screening.	Strongly Agreed Agreed Disagreed Strongly Disagreed	91 26 21 30	54.2 15.5 12.5 17.8
		168	100.0
The cervical screening is expensive.	Strongly Agreed Agreed Disagreed Strongly Disagreed	61 32 14 61	36.3 19.0 8.4 36.3
		168	100.0

As shown in Table 4.6 above, more than half, 94 (56%), of the study participants cited lack of awareness or information about cervical cancer screening as a factor influencing their practice, with 55 (32.7%) agreeing with this statement. In contrast, 12 (7.1%) strongly disagreed, and 7 (4.2%) disagreed.

Additionally, 91 (54.2%) strongly believed that their practice of cervical screening is influenced by not knowing where to access the screening, with 26 (15.5%) agreeing. On the other hand, 30 (17.8%) strongly disagreed, and 21 (12.5%) disagreed with this statement.

Other factors that had less influence on their decision to undergo cervical screening included feeling embarrassed about the procedure. Of the respondents, 63 (37.5%) strongly agreed with this, and 48 (28.6%) agreed. However, 32 (19%) strongly disagreed, and 25 (14.9%) disagreed with the idea that embarrassment influenced their decision.

About 61 (36.3%) of the respondents strongly agreed that cervical screening is expensive, while only 32 (19%) agreed, 61 (36.3%) strongly disagreed, and 14 (8.4%) disagreed.

In addition, 52 (30.9%) of the respondents strongly agreed that the attitude of healthcare personnel and doctors discourages them from seeking the screening, with 57 (33.9%) agreeing. However, 25 (14.9%) strongly disagreed, and 34 (20.3%) disagreed.

Finally, 44 (26.2%) of the respondents felt that their husbands would not approve of them undergoing the screening, and 38 (22.6%) agreed with this. In contrast, 46 (27.4%) strongly disagreed, and 40 (23.8%) disagreed.

The findings indicate that the main factors influencing the practice of cervical cancer screening are a lack of knowledge about where screening centers are located and insufficient knowledge about cervical cancer and its screening.

TESTING OF RESEARCH HYPOTHESES

$H_0$1: There is no significant relationship between the age and knowledge of cervical cancer among women at Igando market on cervical cancer screening.

Table 4.7: Age in relation to knowledge of cervical cancer

Age	Knowledge of Cervical Cancer			

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	Knowledgeable	Not knowledgeable	Total	Chi-square test (x^2)	p-value
20-25 years	11(13) 24.4%	34(32) 75.6%	**45**	**8.898**	**0.202**
26-30 years	11(10) 24.4%	34(35) 75.6%	**45**		
31-35 years	8(10) 24.2%	25(23) 75.8%	**33**		
36-40 years	7(5) 25%	21(23) 75%	**28**		
41 years and above	4(2) 23.5%	13(15) 76.5%	**17**		
Total	**40 23.8%**	**128 76.2%**	**168 100.0%**		
Degree of freedom = 5	**Level of significance = 0.05**				
Calculated value =8.898	**Critical value = 11.070**				

The null hypothesis (H_0) is accepted since the p-value is > 0.05.

Conclusion: As seen in Table 4.7 above, age and knowledge among market women at Igando market, the result shows that there is statistical significance. The alternate hypothesis H_0 is thereby accepted, this means there is significant relationship between the age and knowledge of Cervical cancer screening among women atIgando market.

$H_0$2: There is no significant relationship between women's attitude and their practice of cervical screening services.

Table 4.8: Attitude towards cervical screening being valuable, important for all women in relation to practice.

Attitude	Utilization of cervical screening			Chi-Square (x^2)	p-value
Regarding how valuable and important the screening is for all women	**Screened**	**Not screened**	**Total**		
Necessary	6 (15.4%)	33 (84.6%)	**39**	**9.768**	**0.000**
Not necessary	19 (14.7%)	110 (85.3%)	**129**		
Total	**25 14.9%**	**143 85.1%**	**168 100.0%**		
Degree of freedom = 1	**Level of significance = 0.05**				

The null hypothesis (H_0) is rejected since the p-value is < 0.05.

Conclusion: There is significant relationship between women's attitude and

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their practice of cervical screening among women at Igando market.

Ho3: There is no significant relationship between socio-demographic factors and practice of cervical cancer screening among market women at Igando market.

Table 4.9: Attitude towards cervical screening being valuable, important for all women in relation to utilization

	Cervical Cancer Screening		
Socio-demographic Characteristics	**Screened (%)**	**Not Screened (%)**	**x^2(p-value)**
Age (in years):			
20-25	7(53.6%)	38(46.4%)	
26-30	7(85.5%)	38(14.5%)	
31-35	5(98.4%)	28(1.6%)	
36-40	4(14.3%)	24(85.7%)	
41 years and above	3(17.7%)	14(82.3%)	69.74(0.125)
Religion:			
Christians	16(14.9%)	94(85.5%)	
Muslims	6(15.4%)	33(84.6%)	14.02(7.420)
Others	3(15.8%)	16(84.2%)	
Ethnicity:			
Yoruba	15(14.9%)	86(85.1%)	
Igbo	5(16.1%)	26(83.9%)	24.82(3.491)
Hausa	1(16.7%)	5(83.3%)	
Other ethnic minorities	5(16.7%)	25(83.3%)	
Marital Status:			
Single	5(14.3%)	30(85.7%)	
Married	16(14.9%)	91(85.0%)	19.27(1.467)
Divorced/Widowed	4(15.4%)	22(85.6%)	
Educational Background:			
Primary	9(14.5%)	53(85.5%)	
Secondary	16(14.7%)	64(85.3%)	27.29(3.178)
Tertiary	5(16.1%)	26(83.9%)	
Number of Births:			
None	8(14.2%)	46(85.2%)	19.27(9.564)
1-2	10(41.7%)	14(58.3%)	
3-4	9(14.5%)	53(85.5%)	
5 and above			

The null hypothesis (H_0) is accepted since the p-value is > 0.05.

Conclusion: There is no significant relationship between socio-demographical factors and practice of cervical cancer screening among market women at Igando market.

CHAPTER FIVE

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DISCUSSION OF FINDINGS

5.0: INTRODUCTION

This chapter provides details on the findings of the research project as derived from the analysis of the acquired data. The findings were discussed in relations with previous research studies and literature review. Answers were provided to research questions in form of discussion and corresponding implications to Nurses were appropriately discussed. Recommendation and suggestions for further studies were also highlighted in this chapter.

Cervical cancer is said to be the second cancer after breast cancer that kills more women globally. One of the reasons for this may be the attitude towards the diseases which makes the disease detected late. The study was carried out to assess the knowledge, attitude and practice of cervical cancer screening among women at Igandoultra-modern market, Lagos State.

5.1: DISCUSSION OF FINDINGS

The findings of this study indicated that the majority of respondents, 90 (53.6%),wereagedbetween20 and 30 years, which aligns with a study by Ogbonna (2017), where 70.2% of participants were also within the 20–35 age range. In both studies, only a small percentage of participants were 40 years and above—10.2% in the current study compared to 8.6% in Ogbonna's research.This study also showed that most participants, 107 (63.7%), were married, while only a few, 35 (20.8%), were single. This contrasts with Ogbonna's findings, where 93% of the study population were single.Additionally, over half of the respondents, 110 (65.5%), identified as Christians, and 103 (61.3%) reported having their first sexual intercourse between the ages of 16 and 20. Similarly, Ogbonna's study found that 89.9% of participants were Christians and that most had their first sexual intercourse between the ages of 16 and 18.

Objective 1: To access the level of knowledge of women at Igando market on cervical cancer screening.

The study revealed a poor level of knowledge about cervical cancer screening among women at Igando market. Nearly half, 74 (44%), were aware that three doses are required for HPV vaccination, while only 29 (17.3%) knew that women aged 21 years and above, regardless of profession, are the appropriate group to be screened for cervical cancer. Additionally, 71 (42.3%) acknowledged 21 years as the ideal age to commence cervical cancer screening. A significant number, 127 (75.6%), mistakenly believed that screening should begin when a woman contracts a sexually transmitted infection.These findings align with Igbinomwanhia (2016), who reported that 85 (90%) of respondents had never heard of cervical cancer, with only 10 (6.5%) aware of cervical screening eligibility and 5 (3.5%) familiar with Pap smear tests. Similarly, Olumide (2017) found that only 35 (6.5%) of respondents were aware of cervical cancer and its screening. Knowledge levels were remarkably low, with just 12 (2.3%) identifying a virus as the cause of cervical cancer and 15 (4.1%) recognizing screening as a preventive measure. Furthermore, 72 (97.7%) demonstrated poor knowledge of cervical cancer symptoms, and 66 (90.5%) cited lack of awareness as a primary barrier to cervical cancer screening uptake in Nigeria.

Objective 2: To access the attitude of women at Igando market towards cervical cancer screening.

The study revealed a low level of knowledge about cervical cancer screening among the respondents, which likely influenced their attitudes toward the practice. Only 17 (10.1%) of the women demonstrated a positive attitude, considering cervical cancer

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screening valuable and important for all women. Half of the respondents, 85 (50.6%), strongly believed that screening is necessary only for women with multiple sexual partners, while 78 (46.5%) strongly felt that women who maintain good hygiene and have only one sexual partner do not require screening. However, more than three-quarters, 47 (28%), strongly believed that undergoing a Pap smear every three years with appropriate follow-up could significantly reduce cervical cancer incidence among women in Nigeria.The findings align with those of Adedokun and Ayodapo (2016), who reported that the majority, 95 (76.5%), of their study population held a negative attitude toward cervical screening, with more than half, 30 (23.5%), not recognizing the need for cervical cancer prevention. Similarly, Wright et al. (2017) found that one-third, 67 (48.3%), of respondents exhibited a negative attitude, believing that cervical cancer is fatal and cannot be prevented at any stage, thus dismissing the need for screening. Additionally, 35 (30.5%) of respondents felt that screening was unnecessary without symptoms of cervical abnormalities, while 20 (16.7%) believed they were not at risk and therefore saw no need for screening.In contrast to Kalayu and Tesfay (2018), who reported that only 49 (33.2%) of participants believed the risk of acquiring cervical cancer was high, the majority, 112 (85%), perceived cervical cancer as a severe disease, and 94 (65.2%) believed it to be curable. Awodele et al. (2019) noted a positive attitude in their study, with 115 (89%) participants believing it was advisable to undergo a Pap smear and 42 (34%) recommending it to others. However, this study revealed that over half, 110 (65.5%), of the women in Igando market believed that cervical screening was intended only for commercial sex workers, while 85 (50.6%) associated it with women having multiple sexual partners. The findings highlight a statistically significant negative relationship between the women's attitude and their practice of cervical screening, likely stemming from a lack of awareness about cervical cancer screening among the respondents.

Objective 3: To determine the practice of cervical cancer screening among women at Igando market.

The findings revealed that only a few participants, 25 (14.9%), had ever been screened for cervical cancer at a hospital or clinic. Among them, 14 (56%) had been screened 2-3 times in their lifetime, while 8 (32%) and 3 (2%) had been screened only once and more than three times, respectively. Furthermore, 8 (32%) of the respondents reported their last screening occurred 1-2 years ago, 9 (36%) could not recall when they were last screened, and nearly half, 12 (48%), underwent screening solely because it was free. Similarly, low participation rates were reported by Akujobi et al. (2018) in a study involving female students in southeastern Nigeria, where 66.4% of the participants were unaware of Pap smears, and none had undergone the test. This low participation was attributed to a lack of awareness about Pap smears, ignorance of screening center locations, and a poor understanding of the importance of screening and risk factors for cervical cancer. Similarly, this study found that a majority of women in Igando market lacked adequate knowledge about cervical cancer risk factors, with 107 (65.5%) believing that only commercial sex workers and 85 (50.6%) believing that only women with multiple sexual partners needed cervical cancer screening.The findings of this study showed that the majority, 102 (88.5%), of participants expressed willingness to undergo cervical cancer screening only if it was provided free of charge. This is

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comparable to the findings of Bakari et al. (2021), where 96 (70.6%) of participants were willing to take the test if offered at no cost. Similarly, Udigwe (2019) reported that participants who had not yet undergone screening expressed a willingness to do so in the future, aligning with the findings of Eze et al. (2018), where 98 (62.5%) of respondents indicated readiness to be screened.This study also revealed that the primary reason for cervical cancer screening among women in Igando market was its free availability, as reported by 12 (48%) of respondents, while 6 (24%) mentioned undergoing screening as part of routine cancer prevention. In contrast, Udigwe (2019) found that only 2 (5.7%) of participants had ever undergone a Pap smear, while 12 (37.1%) had no specific reason for notseeking cervical screening, despite 3 (9.3%) having lost relatives to cervical cancer.Mugalo (2021) reported similar findings, where participants identified fear (27, 51.9%), shame (9, 22%), and lack of information about cervical screening (6, 18.9%) as key reasons for not undergoing the screening. These factors highlight the underutilization of screening services, contributing to the rising rates of cervical cancer-related mortality and morbidity.

This study further emphasizes the numerous barriers preventing women from accessing cervical cancer screening. Like many African countries, Nigeria faces challenges such as limited screening programs, which are often restricted to specific districts. This makes it particularly difficult for women in remote or hard-to-reach areas to access screening services, even when they are aware of them. To address this, there is a need to establish additional screening centers and venues in underserved regions to enhance the utilization of cervical cancer screening services.

Objective 4: To identify factors that hinders cervical cancer screening among women at Igando market.

In exploring the factors influencing the utilization of cervical cancer screening services among women in Igando market, the primary reasons highlighted were a lack of awareness or information about cervical cancer screening (94, 56%) and limited knowledge of screening locations or venues (91, 54.2%). Additionally, some respondents cited embarrassment during the screening procedure, while 52 (30.9%) attributed their lack of participation to the attitude of healthcare personnel and doctors.Similar findings were reported by Uzem (2018), where 46.1% of participants demonstrated a low level of awareness, 12.5% felt that cervical screening was unnecessary, and 11.6% expressed fear of receiving a positive result as barriers to screening uptake. However, contrasting factors were noted in the study by Oche et al. (2018), where 77.8% of respondents indicated they intended to undergo screening in the future when they perceived themselves to be older and at greater risk.The predominant reason cited by respondents for not accessing Pap smear screening was the belief that they were not at risk of developing the disease. This aligns with findings by Eze et al. (2018), where 39.7% of participants indicated that not being sexually active was their reason for avoiding screening. Additionally, 5% mentioned the high cost of screening, 9.7% cited discomfort or pain during the procedure, and 10% attributed their reluctance to delays in receiving results.

5.2: IMPLICATIONS TONURSING PRACTICE

The rising incidence of morbidity and mortality from cervical cancer among women remains a significant reproductive health challenge, particularly in developing

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countries. If no effective measures are implemented to address this issue, the number of cases may continue to rise. The findings of this study indicate that cervical cancer screening practices among women are inadequate. With such poor knowledge and negative attitudes towards screening, the incidence of cervical cancer is likely to increase, as women will only seek treatment after the disease has developed. This will result in overcrowded hospital wards, with health resources being diverted to treat cervical cancer patients, often at the expense of other health conditions. Furthermore, this situation could hinder the achievement of Sustainable Development Goals 4, 5, and 6. To address these challenges, it is essential to review the barriers hindering cervical cancer screening and develop strategies to overcome them. This presents a critical issue for the nursing profession, as nurses and midwives play a key role in educating the public about cervical cancer and its prevention. It is crucial for nurses and midwives to focus on increasing awareness, especially among non-literate groups, by providing sufficient knowledge that will enable individuals to adopt safe health behaviors and promote better reproductive health outcomes.

5.3: LIMITATIONS OF STUDY

Language barrier was experienced particularly among respondents with low educational status. To limit this, the researcher got the assistant of colleagues who can understand various local languages for clearer interpretation of the questionnaires.Respondent's reluctance in filling the questionnaire and time constraints. The busy life of the market made it difficult to access some of the traders.

5.4: SUMMARY OF THE FINDINGS

The study findings revealed that women at Igando market had limited knowledge about cervical cancer screening. Only 29 (17.3%) were aware that women aged 21 and older should be screened, while 127 (75.6%) believed that cervical cancer screening should begin when a woman has a sexually transmitted infection. Their attitudes toward screening were also found to be poor, with an average mean score of 2.3. Only 17 (10.1%) of the participants had a positive attitude, viewing cervical cancer screening as valuable and important for all women. Additionally, about 85 (50.6%) of the women strongly believed that screening is only necessary for women with multiple sexual partners, and 78 (46.5%) felt that women with good hygiene and a single sexual partner do not need to undergo screening.In terms of cervical cancer screening practices, only a small number, 25 (14.9%), of the women had been screened. Among them, 14 (56%) had been screened 2-3 times in their lifetime, while 8 (32%) had been screened once, and 9 (2%) had been screened more than three times. The main barriers identified by the women in Igando market were a lack of awareness/information about cervical cancer screening (94, 56%) and a lack of knowledge about where or how to access screening services (91, 54.2%). The study found no significant relationship between age and knowledge of cervical cancer among the women at Igando market. However, a significant relationship was observed between the women's attitudes and their utilization of cervical screening services. Based on these findings, conclusions and recommendations were drawn.

5.5: CONCLUSION

In conclusion, the findings of this study indicated that the women at Igando market had limited knowledge, poor attitudes, and

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low participation in cervical cancer screening. The primary factors contributing to this low level of practice included a lack of awareness and information about cervical cancer screening, as well as insufficient knowledge about where to access screening services. The study also highlighted a significant relationship between negative attitudes and the poor utilization of cervical screening services. Therefore, it is crucial to increase awareness and improve the knowledge of market women regarding cervical cancer screening, while also addressing misconceptions to encourage more women to participate in screenings. Additionally, the government should invest in establishing more accessible and well-equipped centers for cervical cancer screening.

5.6: RECOMMENDATIONS

Based on the findings of the study, the discussions, and the implications drawn, the following recommendations are made:

- Health workers, particularly nurses, should be educated about the severity of cervical cancer and the crucial role of screening in preventing the disease and related deaths. They should actively encourage or refer market women and all women of childbearing age for screening.
- Health institutions should establish clear guidelines for cervical cancer screening, making it a routine procedure for women of childbearing age. This includes ensuring that necessary equipment is available across different healthcare units and training staff in the required skills.
- The government and non-governmental organizations should invest in expanding national cervical cytology screening centers, ensuring they are well-funded and actively advocating for their services to reduce the high incidence of cervical cancer and its adverse effects.
- Initiatives such as offering free or subsidized cervical cancer screening and treatment services should be implemented to encourage market women to participate in screening, which would help decrease the incidence and mortality from cervical cancer.
- The National Health Insurance Scheme should be strengthened to improve access to cervical cancer screening for market women and women in general, helping to reduce the national burden of cervical cancer.
- State governments should increase public awareness of cervical cancer and its prevention, while also setting up well-organized screening programs closer to market areas to facilitate access.
- The Ministry of Health should commit to increasing budget allocations to sustain the supply of screening resources at healthcare centers offering these services and provide subsidized rates for market women.

5.7: SUGGESTIONS FOR FURTHER RESEARCH

Further research is necessary to explore the factors that influence the uptake of cervical cancer screening and to propose solutions to overcome the barriers. It is important to identify the motivating factors and use them to encourage women to participate in screening.

REFERENCES

Adam, F., & Christina, C. (2019). Cervical Cancer: Symptoms, Causes, Stages and Treatment « *Medical News Today*, https://www.medicalnewstoday.com/articles/159821

Akpo, D., Deji, P., Idiake, V., et al (2016). Knowledge, screening practices and vaccines among female medical students. *Archives of Medicine*, *8*(5): 178-185.

DOI: https://doi.org/10.5281/zenodo.14585032

Amal, A., Mohammed, S., Hisham, E.,et al (2016). Knowledge, attitudes and practices regarding cervical cancer screening among female healthcare workers in primary healthcare. *World Family Medicine Journal: Incorporating the Middle East Journal of Family Medicine*, *99*(3660): 1-12.

Anushree, D., Neha, R., Begum, S. et al (2019). Perspectives of primary healthcare providers on implementing cancer screening services. *South Asian Journal of cancer*, *8*(3): 145.

Arbyn, M., Elisabete, W., Laia, B. et al (2018). Estimates of incidence and mortality of cervical cancer in 2018: a worldwide analysis. *The Lancet Global Health*, *8*(2): 191-203.

Attah, D. I., Ochejele, S., Attah, M. C., et al (2019). Comparism of knowledge, attitude and acceptance of cervical cancer screening between female health and non-health personnel in a teaching hospital. *Journal of Biomedical Research and Clinical Practice*, *2*(2): 113-120.

Bhabani, P., Niharika, D., Jaya, C., et al (2017). Nurses' knowledge and attitude regarding cervical cancer screening at a tertiary care hospital. *International Journal of Reproduction, Contraception, Obstetrics and Gynaecology*, *6*(10): 907.

Bray, F., Ferlay, J., Soerjomataram, I., et al (2018). Global cancer statistics 2018: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. *Cancer Journal for Clinicians*, *68*(6): 394-424.

Chidi, O., Uzoma, E., Robinson, C. et al (2018). Knowledge, attitude and practice of Nigerian specialist doctors in training of cervical cancer and its screening. *Tropical Journal of Obstetrics and Gynaecology*, *35*(3): 327-332.

Chigozie, G., Deborah, A., & Uzoamaka, O. (2019). Knowledge, attitude and practice of cervical cancer prevention among student health professionals. *Asian Pacific Journal of Cancer Care*, *4*(4): 125-130.

Divya, K., & Naveen, A. (2019). Knowledge, attitude and practice of cervical cancer and its screening among community health workers. *Journal of Family Medicine and Primary Care*, *8*(5): 1715.

Dubale, D., & Deresse, N. (2017). Knowledge about cervical cancer screening and its practice among female healthcare workers. *Internal Journal of Women's Health*, *9*(7): 365.

Fawcett, N. (2020). The Global Incidence of Cervical Cancer is a "Tragedy" « *Michigan Health Lab*, accessed, 8 October 2020, https://labblog.uofmhealth.org/rounds/global-incidence-of-cervical-cancer-a-tragedy, doi: 10.001/amajethics,2020.126

Firdawek, G., Adamu, A., Shiferaw, N. et al (2019). Assessment of cervical cancer services and cervical cancer related knowledge of health service providers in public health facilities. *BMC research notes*, *12*(1): 1-5.

Godson, U., Irikefe, P., Ibiyemi, O. et al (2018). Perspectives of cervical cancer and screening practices among staff of a teaching hospital. *Journal of Cancer Research and Practice*, *5*(2): 67-73.

Ifemelumma,C., Anikwe, C., Okorochukwu, B.et al (2019). Cervical Cancer Screening: Assessment of Perception and Utilization of Services among Health Workers in Low Resource Setting. *International Journal of Reproductive Medicine, 2019,* 6505482. https://doi.org/10.1155/2019/6505482

James, O., Charles, O., Shobhana, N. (2019). Role of community health workers in cervical cancer screening in low-income and middle-income countries. *BMJ global health*, *4*(3): 1452.

Jiang-Li, D., Song, B., Shannon, R. et al (2016). Knowledge of cervical cancer screening among healthcare workers providing services. *Asian Pacific Journal of Cancer Prevention*, *17*(6): 2965-2972.

Leila, G., & Fariba, H. (2020). Knowledge, attitude and practice of health workers toward cervical cancer screening. *Depiction of Health*, *11*(3): 272-280.

Melissa, C. S. (2016). Cervical Cancer: Symptoms, Stages and Treatment « *Medicine Net*, accessed, 8 October 2020, https://www.medicinenet.com/cervical_cancer/defintion.htm

Rohan, J., Alpesh, G., Zeel, N., et al (2018). Knowledge, attitude and practices about cervical cancer and screening among nurses of a tertiary care centre. *National Journal of Community Medicine,9*(6): 391-395.

Shazia, S. (2018). A survey of cervical cancer and Pap smear awareness and utilization of pap smear test among female healthcare providers in a Secondary Care Hospital. *Journal of the society of Obstetrics and Gynaecologists of Pakistan*, *8*(3): 143-147.

Stephanie, W., & Deborah, W. (2019). Cervical Cancer: Causes, Symptoms, Prevention and Treatment « Healthline, https://www.healthline.com/health/cervical-cancer, accessed, 13 October 2020.

Suchitra, A., & Anupama, V. (2020). Awareness on factors contributing to cervical cancer and its screening techniques among health workers. *International Journal of Health Sciences and Research*, *10*(3): 109-113.

Traci, C. J. (2020). Cervical Cancer: Causes, Symptoms, Diagnosis, Treatment and Outlook « *WebMD Medical Reference*, https://www.webmd.com/cancer/cervical-cancer/cervical-canceraccessed, 13 October 2020.

Vikas, F., Shailee, F., Purnima, T., et al (2017). Awareness of cervical cancer among health workers. *International Journal of Reproduction, Contraception, Obstetrics and Gynaecology*, *6*(23): 4419.

William, C. S. (2018). Medical Definition of Cervical Cancer « *Medicine Net*,https://www.medicinenet.com/cervical_cancer/defintion.htm, accessed, 8 October 2020.

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