

# Knowledge, attitude and practice of cervical cancer screening among market women in Zaria, Nigeria

Saad Aliyu Ahmed, Kabiru Sabitu<sup>1</sup>, Suleiman Hadejia Idris<sup>1</sup>, Rukaiya Ahmed<sup>2</sup>

Departments of Pathology, <sup>1</sup>Community Medicine, <sup>2</sup>Education, Ahmadu Bello University, Zaria, Nigeria

## ABSTRACT

**Background:** Cervical cancer is the most common genital cancer and one of the leading causes of death among female population. Fortunately, this cancer is preventable by screening for premalignant lesions but this is rarely provided and hardly utilised. We assessed the knowledge, attitude and utilisation of cervical cancer screening among market women in Sabon Gari, Zaria. **Materials and Methods:** This was a cross-sectional study to evaluate the knowledge, attitude and practice of cervical cancer screening among market women. A total of 260 women were administered with questionnaires which were both self and interviewer administered. These were analysed using SPSS version 11. **Results:** Respondents exhibited a fair knowledge of cervical cancer and cervical cancer screening (43.5%); however, their knowledge of risk factors was poor. There was generally good attitude to cervical cancer screening (80.4%), but their level of practice was low (15.4%). **Conclusions:** There was a fair knowledge of cervical cancer and cervical cancer screening among Nigerian market women in this study, their practice of cervical cancer screening was poor.

**Key words:** Cervical, cancer, screening, Zaria

### Address for correspondence:

Dr. Saad Aliyu Ahmed,  
Department of Pathology, Ahmadu  
Bello University, Zaria, Nigeria.  
E-mail: sahedni@yahoo.com

## INTRODUCTION

Invasive cervical cancer is the second-most common cancer in women worldwide, but 80% of cases occur in developing countries.<sup>1</sup> Although readily detectable in its premalignant stage, cervical cancer remains the second most common cancer in Nigeria<sup>2</sup> and fifth in the United Kingdom.<sup>2</sup> Among the female population in Nigeria, it is the most common cancer.<sup>3-5</sup> In 2007, it was reported that 36.59 million women aged ≥15 years in Nigeria are at risk of developing cervical cancer. There are 9922 cases diagnosed annually with 8030 deaths. Human papilloma virus (HPV) prevalence is 24.8%. Incidence of cervical cancer in Nigeria is 250/100,000 women.<sup>6</sup>

Market women constitute an important group/economic driving force in the country and therefore it is important to know whether knowledge, attitude and practice of cervical cancer screening among female market population

is associated with or determined by certain socio-demographic factors.

## MATERIALS AND METHODS

This was a descriptive cross-sectional, questionnaire-based study carried out to assess the knowledge, attitude and utilisation of cervical cancer screening among market women, aged 15 years and above, in Sabon Gari Local Government Area of Kaduna State. Only female shop owners/attendants aged 15 years and above in Sabon Gari Main Market who gave their consent were included in this study.

### Sample size

Sampling size for the study was calculated based on the formula below.<sup>7</sup>

$$\text{Sample Size } n = Z^2 \frac{pq}{d^2}$$

$$n = 244$$

Deliberate over-sampling was done to the tune of 10% to make up for incomplete responses. Therefore, a sample size of 269 was used.

Epitable of EPI INFO 2002 statistical package was used to generate 270 random numbers, assuming that there would be an average of one female of 15 years and above per shop. Questionnaires were administered for data collection.

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Questions were both closed ended and open ended, providing information about basic demographic data and items sold, pregnancy history and gynaecological history like menstrual history, vaginal discharge, and pain during intercourse, post-coital bleeding, etc. Knowledge about the risk factors of cervical cancer and screening methods, attitude and utilisation of cervical cancer screening were assessed.

### Data analysis

Data were analysed using SPSS version 11. The results were summarised into tables, charts and graphs and were subjected to test of statistical significance, where necessary. The knowledge, attitude and practice of cervical cancer screening were scored using the responses from the questions asked, with each correct answer having one point and wrong responses scoring zero. Knowledge score ranged from 0-20, attitude 0-7 and practice 0-4. Knowledge score was categorised thus: Poor (0-9) and Good (10-20). Attitude score categorisation was: Poor (0-3) and Good (4-7); while practice score categorised as Poor (0-2), and Good ( $\geq 3$ ).

## RESULTS

There were 269 questionnaires given, out of which 260 were analysable. Most of the respondents were aged 15-44 years with a mean of 33.2 +/- 11.7 years; there were 135 (51.9%) Christians and 121 (46.5%) Muslims [Table 1]. Most of the respondents were married (60.2%), only 15.7% were single. Major tribe of the respondents is Hausa. This is depicted in Table 2. Most of the respondents have some form of education; only 21.2% have no formal education.

Most respondents (77.7) had conceived previously. Of this, only 8.8% primiparous and majority of the respondents (66.9%) have heard of cervical cancer. The knowledge score of cervical cancer screening showed that there was a fair knowledge (43.5%) of cervical cancer screening among respondents.

Their knowledge of risk factors for cervical cancer was generally is poor; although 62.5% of them were aware

that sexually transmitted infection were a risk factor. Although their knowledge of symptoms of cervical cancer was fair [Tables 3-5], their attitude towards cervical cancer screening was poor (19.6%). Some patients would go to seek care after noticing symptoms in hospitals (72.1%), traditional healers (10.5%), religious healers (7.4%), while 10.1% would not go anywhere. Better facilities, provision of more female staff at screening centres and offering service at cheaper cost would enhance utilisation of cervical cancer screening [Table 6].

**Table 1: Frequency distribution of age and religion of respondents**

		Religion			Total
		Islam	Christianity	Others	
Age	15-24	41	26	0	67
	25-34	37	47	0	84
	35-44	22	40	1	63
	45-54	10	17	3	30
	55-64	9	4	0	13
	65-74	2	1	0	3
Total		121	135	4	260

**Table 2: Distribution of respondents marital status and ethnic groups**

		Marital status					Total
		Married	Divorced	Single	Separated	Widowed	
Ethnic group	Hausa	52	10	15	8	4	89
	Igbo	22	1	12	3	2	40
	Yoruba	34	3	1	2	8	48
	others	45	0	12	8	12	77
Total		153	14	40	21	26	254

**Table 3: Distribution of respondents by educational status**

Level of education	Frequency (%)
No formal education	55 (21.2)
Primary	69 (26.5)
Secondary	81 (31.2)
Tertiary	55 (21.2)
Total	260 (100.0)

**Table 4: Knowledge of risk factors by the respondents**

Risk factors	Yes (%)	No (%)	Don't know (%)	Total (%)
Age of onset of sexual intercourse	146 (58.6)	39 (15.7)	64 (25.7)	249 (100.0)
Advanced Age	91 (36.3)	78 (31.1)	82 (32.7)	251 (100.0)
Family History	81 (32.9)	90 (36.6)	75 (30.5)	246 (100.0)
Number of sexual partners	121 (50.6)	58 (24.3)	60 (25.1)	239 (100.0)
Type of diet	65 (25.5)	102 (40.0)	88 (34.5)	255 (100.0)
Low socioeconomic status	59 (23.3)	124 (49.0)	70 (27.7)	253 (100.0)
Number of children	67 (26.5)	105 (41.5)	81 (32.0)	253 (100.0)
Cigarette smoking	108 (44.3)	78 (32.0)	58 (23.8)	244 (100.0)
Sexually transmitted infections	150 (62.5)	37 (15.4)	53 (22.1)	240 (100.0)
Uncircumcised male partner	87 (36.7)	78 (32.9)	72 (30.4)	237 (100.0)

**Table 5: Knowledge of symptoms by the respondents**

Symptoms	Yes (%)	No (%)	Don't know (%)	Total (%)
Vaginal bleeding	152 (61.5)	43 (17.4)	52 (21.1)	247 (100.0)
Post-coital bleeding	137 (56.1)	57 (23.4)	50 (20.5)	244 (100.0)
Weight loss	116 (47.2)	74 (30.1)	56 (22.8)	246 (100.0)
Foul smelling vaginal discharge	169 (69.5)	30 (12.3)	44 (18.1)	243 (100.0)
Abdominal pain	163 (66.5)	36 (14.7)	46 (18.8)	245 (100.0)

**Table 6: Factors that will enhance utilisation of screening services**

Factors	Yes (%)	No (%)	Total (%)
Better facilities	152 (77.2)	45 (22.8)	197 (100.0)
More female staff	140 (76.1)	44 (23.9)	184 (100.0)
Cheaper cost	155 (82.4)	33 (17.6)	188 (100.0)
Do not know	36 (97.3)	1 (2.7)	37 (100.0)

Many (32.7%) of the women had never heard of cervical cancer screening before, but 32.7% others had been screened for cervical cancer. Of those who had been screened, 80.6% did so voluntarily 68.2% had advised a friend/relation in the past to take up cervical cancer screening. Respondents identified fear of outcome of screening, lack of information and public awareness, lack of health worker request, high cost of screening and lack of personnel at the screening centres as the reasons why people do not patronise cervical screening.

## DISCUSSION

Cervical cancer is a preventable non-communicable disease of public health importance. Invasive cervical cancer is the second most common cancer in women worldwide, but 80% of cases occur in developing countries.<sup>1</sup> Women often become aware of cervical cancer and screening in the course of their interaction with other each other.<sup>8</sup>

It is important to note that that only 21.2% lack formal education. This is similar to study done in Ezem in Eastern Nigeria and Ogunbode *et al* in Ibadan.<sup>8,9</sup> Most of the respondents (77.7%) had a history of previous conception. About 8.8% of the respondents that had a history of conception are primiparous. Multiparity is one of the risk factors for developing cervical cancer. Ogunbode *et al.*,<sup>8</sup> recorded most women in their series to be in their third and fourth decades and 48% were either multiparous or grand multiparous. Parity is higher in this study probably because most respondents are of Hausa ethnic group where the practice of early marriage is high and practice of modern contraception is low.

Only 66.9% of respondents ever heard of cervical cancer, and of these 68.6% have heard of cervical cancer screening. This contrasts most reports from Nigerian communities who found that majority of respondents never heard of

cervical cancer or cervical cancer screening. Ogunbode *et al.*,<sup>9</sup> carried out a study among market women in Ibadan and only 19.7% were aware of cervical cancer screening. Similarly, in a study in Aba<sup>10</sup> only 16% of respondents had knowledge of screening services. However, studies done among hospital workers had similar reports to this study.<sup>11-14</sup> A study among female health workers in Ilorin<sup>11</sup> showed the level of awareness to be 69.8%, another study in Nnewi recorded 87%. The high level of awareness in this study may be due to the fact that community health outreach programs usually target market women and of recent a group of American cancer experts visited the market. They discussed issues of cancer prevention, particularly screening. They also offered cervical cancer screening service at the nearby Sabon Gari Comprehensive Health Centre.

Most of the respondents in the present report heard about this from healthcare personnel and few heard from friends, family and media. This is also in contrast to previous reports by Ayinde *et al.*,<sup>15</sup> who found that most respondents get information from radio, family and friends. Most of the respondents (43.5%) had some good knowledge of cervical cancer screening as in a report by Mutyaba *et al.*,<sup>16</sup> in Uganda.

Many respondents opined that better facilities, provision of more female staff and offering service at cheaper cost at the screening centres will enhance utilisation. Adefuye<sup>14</sup> reported that lack of physicians' referrals and ignorance about location of service centers were the two most frequent reasons for failure of utilisation. According to Aboyeji *et al.*,<sup>11</sup> and others,<sup>9,13,17,18</sup> the reasons for why women avoided screening included outright rejection, fear of detection of cancer and religious beliefs.

Our finding agrees with earlier studies that reported low level of practice even when the good knowledge is good.<sup>9,15,19,20</sup> Studies by Aboyeji *et al.*,<sup>11</sup> Gharoro *et al.*,<sup>20</sup> and Adefuye<sup>14</sup> reported other reasons to include ignorance, misconceptions and religious beliefs. These were similar to the reasons adduced in our study.

## CONCLUSIONS

The general knowledge of cervical cancer screening was good and the attitude was fair; however, this did not translate to good practice. High cost of screening, lack of

female health workers and fear of outcome were some of the reasons responsible for low screening patronage.

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