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Factors Influencing Uptake of Cervical Screening among Reproductive Aged Women in Iworoko-Ekiti, Ekiti State

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Abstract: *This study assessed the factors influencing the uptake of cervical screening among women of reproductive age in Iworoko, Ekiti State, Nigeria. Using a cross-sectional design, data were collected from women attending family planning, antenatal, and child welfare clinics at the Comprehensive Health Centre, Iworoko. A systematic random sampling technique was employed to select 225 participants, of whom 206 completed a structured, self-administered questionnaire. The instrument assessed socio-demographic characteristics, knowledge of cervical screening, cultural beliefs, healthcare accessibility, and perceived facilitators of screening uptake. Data were analysed using SPSS version 27 with descriptive statistics. Findings revealed that awareness of cervical screening was generally low despite moderate understanding of screening methods and the importance of early detection. Cultural factors, including perceptions of pain and embarrassment, and the influence of family, community, and religion, significantly shaped screening behaviour. Structural barriers such as cost, limited availability of female screeners, inconvenient clinic schedules, and long waiting times further hindered utilisation. Hypothesis testing showed no significant association between knowledge of cervical screening and uptake, indicating that awareness alone does not translate into action. However, a significant association existed between perceived facilitators and screening uptake. Health education, free or subsidised services, community-based outreach, and encouragement from family members and religious leaders emerged as strong motivators. The study concludes that improving cervical screening uptake requires culturally sensitive, socially grounded, and structurally enabling interventions that address both community norms and health system constraints.*

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INTRODUCTION

Cervical cancer screening is an important public health practice that seeks to detect precancer cave and cancer lesions on the cervix at an early stage. According to the definition expressed by World Health Organization, cervical screening is the regular examination of Human Papillomavirus (HPV) infection and related cellular alterations to detect precancerous changes and invasive disease in early, non-metastatic state (W.H.O., 2024). Despite cervical cancer being a high preventability and highly treatable condition when observed at an early age, the disease is a major health challenge in many regions globally, especially the low- and middle-income countries where preventive services in screening are not readily available and the health systems are inadequate (Uchendu et al., 2021). The world has recorded inconsistent improvements in its attempts to intensify screening. An international survey of 202 countries and territories found that 139 (69%), cervical screening national recommendations, conditioned cytology was the most frequently recommended (n=109 countries, 78%), HPV-based screening national recommendations (n=48 countries, 35%), and visual inspection with acetic acid (VIA) was more common in resource-limited settings (Bruni et al., 2022). In spite of these policy frameworks, coverage is still poor especially in the developing regions.

The incidence of screening is still low among women at the highest risks in the world. Only 15 percent of women aged 30 to 49 years in 2019 had been screened within the past one year, 28 percent within the past three years, 32 percent within the past five years, and 36 percent had been screened at any time in their lives. This is about 662 million women in the age category of 3049 and 1.6 billion women 2070 who have not been screened against cervical cancer (Bruni et al., 2022). Radical disparities in terms of income are present. However, in high-income countries, 84 percent of women age 30–49 had been screened at least once in their lives, equivalent to 48 percent in upper-middle-income countries, 9 percent in lower-middle-income countries, and 11 percent in low-income countries (Bruni et al., 2022). These differences do highlight the nexus of economic development, health system capacity, and access to preventive care.

Cervical cancer is the most prevalent malignancy of the female genital tract in Nigeria where 10,000 new cases and 8,000 deaths are documented annually. Nigeria is estimated to have 36.6 million women aged 15 years and above who are at risk of getting the disease (Uchendu et al., 2021). The protracted precancerous planning attributes it to the disease and gives a great opportunity to detect and intervene early. Premalignant lesions may be effectively screened and treated to prevent genetic mutation into invasive cancer, thus having a significant impact on reducing the morbidity and mortality. Nevertheless, the promise of this preventive measure has not been actualised in Nigeria since few people take screening and the system is also a barrier to access.

The transformative nature of organised screening programmes is shown through experience in other areas. In China screening of cancer has had an implementation spanning more than 60 years and the government has financed four official national screening programs since the year 2005. By 2016 some 2 million high risk patients had been screened leading to 55,000 cancer diagnosis and an early rate of detection of 80% (Maomao et al., 2021). However, screening in these conditions should be introduced cautiously because it can cause physical pain, mental and indirect harm, especially when it targets asymptomatic groups. In that way, the screening programmes should neither exceed the benefits in some cases nor endanger the false positives orientation; moreover, they should be within the national priorities and the capacities of health systems (Maomao et al., 2021).

Cervical cancer screening in the United States has one major aim of detecting precancerous lesions that can be treated, such as adenocarcinoma in situ and high-grade cervical intraepithelial neoplasia, which will develop into invasive cancer without treatment. Another minor yet essential objective is early diagnosis of invasive disease so as to minimize morbidity and mortality associated with the treatment (Fontham et al., 2020). To be optimal as much as possible, screening strategies are aimed at identifying only clinically significant abnormalities and minimising detection of transient HPV infections as well as benign lesions which may result in overtreatment and psychological distress and trauma. These principles emphasize the necessity of context-sensitive screening strategies that are based on epidemiological realities and health system capabilities.

The use of cervical cancer screening among the sub-Saharan Africa population is very low. It has been shown that there is a high relationship between screening behaviour and knowledge about cervical cancer with uptake dependent on various sociodemographic and health related factors such as level of education, age, awareness of screening sites, HIV status, attitudes towards screening, gender of health care providers, prior knowledge of HPV, contraceptive use, insurance status and condom use. Others are fear of favourable outcomes, weakness of awareness about the severity of the disease, sexual activity, previous infection by sexually transmitted diseases, exposure to guidance, and the availability of the public health facilities (Yimer et al., 2021). These findings indicate that successful interventions have to be culturally competent and modified to be in line with the existing levels of literacy, social constructs, and attitudes in the community.

In Nigeria, the same trends have been witnessed. Although screening services are available, females in urban Lagos exhibit low productivity to screening of cervical cancer. The obstacles are lack of knowledge about the disease and screening procedures, lack of information, and unwillingness of the healthcare specialists to prescribe screening. On the other hand, the significant participants of facilitation encompass the support of friends and relatives, suggestions of doctors and nurses, and exposure to health-related material in the media (Okunowo et al., 2020). These relations underline the central role of interpersonal networks and health professionals to influence preventive health behaviours.

A case of Ekiti state also portrays the incongruity between awareness and utilisation. One study found that 71.8 percent of the women had heard about cervical cancer and screening through the nurses, but there was still no good uptake of screening, even in healthcare professionals themselves. Today, the poor utilisation rates among nurses and other female health workers were contrary to expectations that informed nurses can be modelling positive health behaviour, whereas all were aware of the positive health implications of screening (Owolabi et al., 2021). This lack of relevance undermines the credibility of health promotion initiatives and highlights the issues system-wide in terms of health care delivery in Nigeria.

There are several screening modalities, such as the HPV DNA-tests, Pap smear cytology, and visual inspection with acetic acid (VIA) or Lugol Iodine (VILI). In spite of the fact that Pap smear is the gold standard in most high-income initiatives, its technical and structural requirements place constraints on its practical use in high resource-constrained locations like Nigeria. VIA and VILI on the other hand are applicable in mass screening as they can be conducted by lowly trained health workers and final treatment of the precancer lesion with thermal ablation or cryotherapy can be carried out immediately and thus does not need repeated attendance (Adepoju et al., 2024). These features render them especially suitable to the rural and underserved society.

In spite of these developments, cervical screening uptake is critically low, which is a significant barrier to disease prevention (Durowade et al., 2020). Participation is still weakened by limited awareness, sociocultural barriers, fear and misconceptions and structural constraints. Ideally, in most societies, there is stigmatization and cultural taboos of reproductive health problems and these factors discourage open discussion and active health seeking behaviours. It also is complicated by geographic and infrastructural factors since in many cases, screening services are not provided in their immediate primary health centres, and a woman has to travel to adjacent towns to receive care (Adeleye, 2021). These structural injustices limit access especially to rural and poor populations.

The role of healthcare providers in the development of screening behaviour is vital, but there are still communication weaknesses and the inability to get counselling. Many women are afraid of being uncomfortable, they are afraid of test results, and they do not believe that the test results are accurate. The relationship between patients and healthcare workers has become an important piece of information, thus required to create effective interventions. It is against this backdrop that the current paper aims at evaluating determinants of cervical cancer screening adoption among women in the Ekiti State of Iworoko. The research is expected to produce context-specific evidence by analyzing the individual, sociocultural, and structural determinants and use the results to make specific efforts to enhance screening attendance and lower the incidence of cervical cancer in Nigeria. The study assessed the factors influencing uptake of cervical screening among reproductive aged women in Iworoko, Ekiti, Ado- Ekiti. The specific objectives were:

1. To determine the knowledge of cervical screening among reproductive aged women living in Iworoko-Ekiti

2. To identify the cultural beliefs that influences the uptake of cervical screening among reproductive aged women in Iworoko, Ekiti State
3. To assess the role of healthcare accessibility in the uptake of cervical screening among women of reproductive age in Iworoko-Ekiti.
4. To identity the perceived facilitators that will promote the uptake of cervical screening among reproductive aged women living in Iworoko-Ekiti, Ekiti State

LITERATURE REVIEW

Cervical cancer is a global issue of high public health significance also when it is considered to be one of the most preventable and treatable types of cancer when it is detected at an early stage of diagnosis by the means of an efficient screening program and timely intervention. The patterns of differentiation in cervical cancer incidence, mortality and screening uptake are highly patterned globally with women in low- and middle-income countries having a disproportionate burden of diseases. Although high-income nations have made high gains in cervical cancer mortality rates through organised cervical cancer screening campaigns and HPV vaccination, regionally low screening rates, late diagnosis rates, and low treatment rates are still noted in many developing countries. The inequalities have led to the egregious study of drivers, barriers and enabling factors that are related to uptake of cervical cancer screening in various populations.

Global experience always shows that knowledge, perceived vulnerability, the availability of health care services, social cultural values, price and providers factor has pivotal roles in shaping the screening behaviour. Research among the immigrant and minority groups in the developed world also goes a further step to demonstrate that challenges in cultural background and health system navigation among the population play a significant role in influencing preventive health practices. As an illustration, Nwabichie et al. (2020) studied the factors influencing cervical cancer screening in African women in Klang Valley, Malaysia and found out that around 68.4% of the study sample, indicating that it had never heard the Pap smear test before, and only 27.2% reported going through the screening in the past three years. The same low screening was observed among the Iraqi immigrant women in Malaysia (24%), and the African American women in the United States (28%). These observations are consistent with the previous data that indicated that less screening is used by the immigrant and minority groups in the country because of language obstacles, lack of information, perceived stigma and poor integration in the host-country health systems.

Similar information available in other regions further shows that there is uneven access to screening in the world. Abdul (2019) mentioned that the prevalence of cervical cancer screening was among Hispanic women in the United States at 64.3% which is quite high as compared to the rates of immigrant populations in southeast Asia and Africa. Screening among the immigrants in the Myanmar's north-district of Yangon among the immigrants was observed to be only 19.1 percent confirming the patterns of low attendance by socially marginalised groups. Surprisingly, Nwabichie et al. (2020) found that the poor screening practices among African women living in their motherland, especially those living in West Africa were also not low, but relayed at a slightly higher rate in comparison to those living in other countries. An example is the prevalence of

screening among women in Cameroon was 75.6 percent and market women recorded 32.7 percent prevalence in Zaria, Nigeria (Ahmed as cited in Nwabichie et al., 2020). The differences between these cases indicate that despite the differences in contextual factors, structural and informational barriers are still widespread across environments.

In addition to prevalence rates, other international research findings find marital status, frequent access to child professionals, perceived barriers, and level of knowledge to be the robust predictors of screening uptake. The authors of the study by Nwabichie et al. (2020) found that the marital status, a regular healthcare provider, perceived barriers, and knowledge were critical to determination of Pap smear utilisation among African women in Malaysia, which is why it is important to engage with health services and health education in the long run. These results are analogous to the general international literature which puts screening behaviour in the context of multifaceted interactions between personal cognition, the social environment and the health system properties.

In sub-Saharan Africa, cervical cancer is one of the top leading causes of cancer-related deaths in women, which is mainly attributed to late diagnosis and access to screening and treatments practices. Atnafu, Khatri, and Assefa (2024) organized a narrative review of 60 articles published during the past 2013-22 to investigate the factors that drive cervical cancer prevention and management in the area. Through their analysis, which is directed by a socio-ecological framework, they were able to find that multilevel factors including individual, interpersonal, organisational, community, and policy levels of influence screening uptake. At the individual level, poor awareness of cervical cancer and screening, perception of less risk, fear concerns the outcome of the test, negative attitudes, and socio-economic factors including age and educational level were significant discouraging factors. Interpersonal factors involved embarrassment, approval by spouse/partner, social support groups and having of peers or relatives who demonstrate preventive behaviour.

At the organisational level, factors that relate to the providers including poor training, insufficient skills on screening, gender of healthcare practitioners, poor counselling practices, and competing work obligations were found as the areas of utmost importance in determining service utilisation. Stigma, deeply rooted sociocultural norms and traditional beliefs, which consider it a taboo to discuss reproductive health at the community level, were among the challenges encountered. The geographic remoteness, absence of facilities nearby, ineffective resource distribution, expensive screening costs, fractured policies on promotion, bad logistics oversight, and the inexistence of decentralised cancer control strategies were pointed out as the constant restraint at the system and policy levels (Atnafu et al., 2024). The authors concluded that the most effective way of managing cervical cancer in sub-Saharan Africa is to conduct combined interventions to cover multilevel bottlenecks such as behavioural, structural, and institutional levels.

These observations are supported by other developing areas. The multilevel analysis of cervical cancer screening in women of reproductive age in India revealed in Jeetendra et al. (2024) the screening prevalence of 1.2 in general, which was poor, as was data in the National Family Health

Survey. The relationship to screening rates was considerably linked to the age, contraceptive use, and wealth index on which the use was more prevalent among women aged 30–49 years and those in the upper socioeconomic status. The prevalence was highest in southern states, with the lowest coverage being recorded in the north, which led to requests to have more awareness campaign and information dissemination that should be inclusive. These results are similar to what is found in sub-Saharan Africa, where access to the health system and socioeconomic status are key determinants of preventive health behaviour.

Nigeria is a reflection of most of the above mentioned regional issues and is still facing low levels of cervical cancer screening despite increased awareness programs and policies. A variety of empirical research works performed in various geopolitical areas gives an understanding of what determines screening behaviour. In their survey of women in Ibadan, which utilises the multistage systematic random sampling method, Ilevbare et al. (2020) indicated that despite the high awareness of cervical cancer and good attitudes toward screening, utilisation of the screening was low. The awareness about cervical cancer was quite high, but the cultural and religious factors, discomfort regarding screening tests, and the unwillingness to be checked by men health workers were important limitations to the continued participation. Other women felt that they were not under risk whereas others went to get screening and were afraid that they would be thought of as promiscuous. The authors have highlighted the necessity of greater educational interventions that can eliminate the misconceptions and minimize the disease burden.

Equally, Okunowo et al. (2018) studied a cohort of women visiting a tertiary hospital in Lagos and found out that the general awareness rate of cervical cancer was about 80 per cent, significantly higher than previous research conducted in Nigeria which established the awareness level between 37 to 38 per cent. This level of awareness was explained by the fact that the population under study was highly educated as 75.6% had post-secondary education. Nevertheless, this did not mean that knowledge about Pap smear testing was high since only 31.7% of the population knew what was its use. The level of awareness about symptoms and risk factors was even less 40% and 15.6 respectively. Notably, the level of education was not associated with greater uptake of screening which highlights the gap between the knowledge on awareness and behavioral response. Only education level was significant determinant of good stronger knowledge of the disease with further boost in recognition by healthcare providers and personal familiarity with cases of cervical cancer. However, the screening attendance was unfortunate, which is why persistent provider-led education and active recommendations are necessary (Okunowo et al., 2018).

Iheanyi, Hewitt-Taylor, Turner-Wilson, and Nwakasi conducted an integrative review which expanded the knowledge on screening determinants in Nigeria by synthesising knowledge, attitudes, perceptions and service utilisation evidence. The review has established education, occupation, cultural beliefs, and religious beliefs as some of the factors that impact on screening behaviour. Notably, these authors pointed at the lack of research on the contribution of male partners to influencing the health-seeking behavior of women, since male figures in households have considerable sociocultural power. They supported the participation of males in reproductive health campaigns, as well as long-term planning of gender empowerment measures through the

primary healthcare agencies and the Ministry of Health. As the necessary parts of sustainable screening programmes, patient-centred and culturally sensitive educational interventions offered in partnership with religious and traditional leaders were suggested (Uchendu et al., 2021).

Nigerian studies done by other researchers also depict the complexity of the issue. Ohaeri et al. studied the psychosocial determinants of screening among female civil servants of Delta State and discovered that despite the awareness about cervical cancer (38.4 out of 55.4% as indicated by the study), only 93.6 out of 55.4% reported ever having a screening done. The biggest discouraging factors were cost and inaccessibility as indicated by 54.5% and 58.2% participants respectively but 73.6% indicated that he would have been willing to be screened with the removal of barriers. These results underscore the value of financial protection system and decentralisation in the provision of the services to enhance utilisation (Stelzle et al., 2021).

A much more recent evidence of Oyo State shows somewhat different picture. According to Roy'lagbaja et al. (2024), 63.5percent of female civil servants polled had already been subjected to cervical screening, which is far higher than the figures in the country. This could either denote better institutional access, health programmes in the workplace or sampling dissimilarity. However, the authors restated that cervical cancer is one of the most common causes of female deaths concerning the developing countries because awareness and preventive measures still have loopholes.

The screening and vaccination coverage in young population groups is dismally low. Nwokorie et al. (2024) evaluated female undergraduates in the University of Nigeria, Enugu Campus, and discovered that only a small percentage (6.8) had once experienced Pap smear tests, and a small percentage (2.4) had once received Canada HPV vaccination. The most prevalent barriers to the screening process were lack of awareness (47.3%), whereas the attitude of health workers and cost were the negative criteria associated with vaccination. Knowledge of individual risk status and the need to regularly screen themselves were the best predictors of utilisation. Academic faculty and ethnicity were also major predictors of vaccination, which has implicated the existence of invisible sociocultural and informational gradients even in educational population segments.

Low screening practices are not an exemption of healthcare workers themselves. Research in female primary healthcare professionals shows that knowledge and risk perception are moderately high but screening behaviour is poor. Absence of symptoms, fear of discomfort and time limitations are proposed as commonly used barriers. The public campaigns, schools and mass media are also the common source of acquiring information, but they do not offer effective behaviour-change communication strategies that would help to translate knowledge to practice. The levels of knowledge in health workers have varied considerably across settings with greater levels recorded in Ethiopia, Ibadan and Sokoto, and lesser levels recorded in Addis Ababa, Saudi Arabia, rural India and Cote d Ivoire. This variation can probably be explained by the differences in professional composition, the design of the studies, and the measurement tools.

James et al. (2021) found that although the majority of primary healthcare workers in rural

Northern Uganda identified HPV as the primary cause of cervical cancer, a small proportion identified cigarette smoking as a risk factor, and the majority did not know the intervals and timing of screening. This was a problem though relatively high awareness of symptoms was conducted because cervical cancer is most often asymptomatic in its early phases. The authors claimed that training of the providers needs to focus on the importance of screening by the means of the screening without symptoms and reinforcement of counselling skills, which foster early detection. HPV education was perceived to be beneficial to achieve vaccine advocacy and eliminate patient-related misunderstandings, unlike the results of Seyoum et al. (2019), who found awareness about HPV contribution to be much less.

Together the literature illustrates that knowledge, attitudes, sociocultural beliefs, economic limitations, health system capacity and provider involvement are part of a complex interaction that influences the level of uptake of cervical cancer screening. Strengths and inequities of the structure and systems across the world and countries, as well as ephemeral and suboptimal health services within the nation, and wrong information and cultural sensitivities, cost barriers, and non-uniform provider suggestions impede access to and participation in screening services. These trends warrant the context-specific studies of local determinants of screening behaviour. These dynamics in communities like Iworoko, Ekiti State are thus important in designing specific interventions that can help improve uptake and decrease late stage presentation, and eventually reduce morbidity and mortality associated with cervical cancer.

METHODOLOGY

This study adopted a cross-sectional research design, enabling the collection of data at a single point in time to generate in-depth information on the factors influencing the uptake of cervical screening among women in Iworoko, Ekiti State. It focused on women of reproductive age attending the Comprehensive Health Centre in Iworoko particularly those present during family planning, antenatal, and child welfare clinic days. The target population comprised 420 women, from which a representative sample was drawn. Using Taro Yamane's formula with a 5% level of precision, a sample size of 203 was obtained and adjusted for a 10% attrition rate to yield a final sample of 225 participants. A systematic random sampling technique was employed to ensure that each eligible woman had an equal chance of selection, thereby minimising selection bias and enhancing representativeness within the large clinic-based population.

Data were collected using a structured, self-administered questionnaire developed to capture relevant dimensions of cervical screening behaviour. The instrument comprised five sections: socio-demographic characteristics, knowledge of cervical screening, cultural beliefs influencing uptake, healthcare accessibility, and perceived facilitators of screening, yielding a total of 27 items. Prior to deployment, the questionnaire was subjected to expert review to establish face and content validity, with constructive input provided by a specialist in the field to ensure clarity, relevance, and alignment with study objectives. Reliability was assessed through a pilot study involving 10% of the sample size at Adebayo Comprehensive Health Centre in Ado-Ekiti under conditions similar to those of the main study. Cronbach's alpha analysis yielded a coefficient of 0.8, indicating high

internal consistency and suitability of the instrument for data collection. During fieldwork, 225 questionnaires were administered and explained to respondents by the researcher, resulting in 206 completed instruments. Immediate retrieval after completion minimised loss and ensured data completeness.

Collected data were electronically sorted and analysed using the Statistical Package for Social Sciences (SPSS) version 27. Descriptive statistics, including frequencies, tabulations, and graphical representations, were employed to summarise respondent characteristics and patterns of screening uptake. Ethical approval for the study was obtained from the Ekiti State Ministry of Health, and institutional permission was granted by the Officer-in-Charge of the Iworoko Health Centre. Participation was voluntary, and verbal informed consent was obtained after clear and respectful explanation of the study's purpose. Confidentiality was strictly maintained, with data securely stored and accessible only to authorised personnel.

RESULTS

Table 1: Demographic Information of Respondents

Variables	Responses	Frequency	Percentage
Age	15-25 years	69	33.5%
	26-35 years	79	38.3%
	36-45 years	58	28.2%
	Total	**206**	**100%**
Marital Status	Single	64	31.1%
	Married	138	67.0%
	Divorced	4	1.9%
	Total	**206**	**100%**
Educational Level	Primary	37	18.0%
	SSCE	97	47.1%
	Undergraduate	62	30.1%
	Postgraduate	10	4.9
	Total	**206**	**100%**
Employment Status	Students	13	6.3%
	Employed	184	89.3%
	Unemployed	9	4.4%
	Total	**206**	**100%**

The data presented in Table 1 further shows the demographic profile of respondents whereby in the age distribution, 69 respondents (33.5%) were in the 15-25 years category, 79 respondents (38.3%) fell within the 26-35 years category, and 58 respondents (28.2%) were between 36-45 years. The majority of respondents were married, with 138 individuals (67.0%) with single respondents constituting 64 individuals (31.1%), while only a small fraction, 4 individuals (1.9%),

reported being divorced. 97 individuals (47.1%), had Secondary School Certificate Examination (SSCE), followed by 62 individuals (30.1%) who held undergraduate degrees, 37 individuals (18.0%) with primary education, and 10 individuals (4.9%) who had attained postgraduate degrees. Majority of respondents were employed, with 184 individuals (89.3%). Students accounted for 13 individuals (6.3%), and the unemployed were represented by 9 individuals (4.4%).

Table 2: Responses on Knowledge of cervical screening among women

Variables	Responses	Frequency	Percentage
Have you heard about cervical screening before?	Yes	34	16.5%
	No	172	83.5%
Do you know any methods used for cervical screening?	Yes	115	55.8%
	No	91	44.2%
Should women undergo cervical screening regularly?	Yes	111	53.9%
	No	95	46.1%
Is cervical screening important for early detection of cervical cancer?	Yes	133	64.6%
	No	73	35.4%
Do you believe cervical screening is essential for women's health?	Yes	121	58.7%
	No	85	41.3%
Have you ever done cervical screening?	Yes	144	69.9%
	No	62	30.1%

The data in Table 2 provides insights into the knowledge and perceptions of cervical screening among women respondents. When asked if they had heard about cervical screening before, only 34 respondents (16.5%) answered "Yes," while the vast majority, 172 respondents (83.5%), answered "No." 115 respondents (55.8%) indicated that they were aware of methods used for cervical screening, whereas 91 respondents (44.2%) were not. A slight majority, 111 respondents (53.9%), believed that regular screening is necessary, while 95 respondents (46.1%) did not share

this belief. The importance of cervical screening for the early detection of cervical cancer was acknowledged by 133 respondents (64.6%), while 73 respondents (35.4%) did not view it as important. When asked if they believed cervical screening is essential for women's health, 121 respondents (58.7%) agreed, whereas 85 respondents (41.3%) did not. A notable majority of 144 respondents (69.9%) reported having participated in cervical screening, while 62 respondents (30.1%) had never done so.

Table 3: Responses on cultural beliefs that influences the uptake of cervical screening among respondents.

Variables	Responses	Frequency	Percentage
Does your culture influence your decision to undergo cervical screening?	Strongly Disagree	57	27.7%
	Disagree	65	31.6%
	Agree	73	35.4%
	Strongly Agree	11	5.3%
Cervical screening is painful and embarrassing?	Strongly Disagree	18	8.7%
	Disagree	33	16.0%
	Agree	148	71.8%
	Strongly Agree	7	3.4%
Do you think that your community decision influences your decision on cervical screening uptake?	Strongly Disagree	20	9.7%
	Disagree	32	15.5%
	Agree	137	66.5%
	Strongly Agree	17	8.3%
Does your family influence your decision to undergo cervical screening?	Strongly Disagree	21	10.2%
	Disagree	44	21.4%
	Agree	117	56.8%
	Strongly Agree	24	11.7%
My religion does not agree to me taking cervical cancer screening?	Strongly Disagree	26	12.6%
	Disagree	35	17.0%
	Agree	127	61.7%
	Strongly Agree	18	8.7%

The data in Table 3 shows how cultural beliefs influence the uptake of cervical screening among respondents. When asked if their culture influences their decision to undergo cervical screening, 57 respondents (27.7%) strongly disagreed, 65 respondents (31.6%) disagreed, 73 respondents (35.4%) agreed, and 11 respondents (5.3%) strongly agreed. 18 respondents (8.7%) strongly disagreed that cervical screening is painful and embarrassing while 33 respondents (16.0%)

disagreed, 148 respondents (71.8%) agreed, and 7 respondents (3.4%) strongly agreed. On the influence of community decisions on the uptake of cervical screening, 20 respondents (9.7%) strongly disagreed, 32 respondents (15.5%) disagreed, 137 respondents (66.5%) agreed, and 17 respondents (8.3%) strongly agreed. Concerning family influence on the decision to undergo cervical screening, 21 respondents (10.2%) strongly disagreed, 44 respondents (21.4%) disagreed, 117 respondents (56.8%) agreed, and 24 respondents (11.7%) strongly agreed. When asked if their religion disagrees with taking cervical cancer screening, 26 respondents (12.6%) strongly disagreed, 35 respondents (17.0%) disagreed, 127 respondents (61.7%) agreed, and 18 respondents (8.7%) strongly agreed.

Table 4: Responses on the role of healthcare accessibility in the uptake of cervical screening among respondents

Variables	Responses	Frequency	Percentage
Cervical screening is expensive	Strongly Disagree	23	11.2%
	Disagree	48	23.3%
	Agree	122	59.2%
	Strongly Agree	13	6.3%
No known cervical screening center	Strongly Disagree	29	14.1%
	Disagree	26	12.6%
	Agree	131	63.6%
	Strongly Agree	20	9.7%
Lack of female screeners in health facilities contributes for not doing cervical cancer screening	Strongly Disagree	20	9.7%
	Disagree	31	15.0%
	Agree	137	66.5%
	Strongly Agree	18	8.7%
Lack of convenient clinic time is a barrier to routine cervical screening	Strongly Disagree	66	32.0%
	Disagree	56	27.2%
	Agree	61	29.6%
	Strongly Agree	23	11.2%
Long waiting time for cervical screening results is a barrier to routine cervical screening	Strongly Disagree	17	8.3%
	Disagree	21	10.2%
	Agree	127	61.7%
	Strongly Agree	41	19.9%

The data in Table 4 explains the role of healthcare accessibility in the uptake of cervical screening among respondents. 23 respondents (11.2%) strongly disagreed that cervical screening is

expensive while 48 respondents (23.3%) disagreed, 122 respondents (59.2%) agreed, and 13 respondents (6.3%) strongly agreed that cervical screening is expensive. 29 respondents (14.1%) strongly disagreed on the availability of cervical screening centers, 26 respondents (12.6%) disagreed, 131 respondents (63.6%) agreed on the availability of cervical screening centers, and 20 respondents (9.7%) strongly agreed. 20 respondents (9.7%) strongly disagreed with the lack of female screeners in health facilities, 31 respondents (15.0%) disagreed, 137 respondents (66.5%) agreed with the lack of female screeners in health facilities, and 18 respondents (8.7%) strongly agreed. 66 respondents (32.0%) strongly disagreed on the lack of convenient clinic times, 56 respondents (27.2%) disagreed, 61 respondents (29.6%) agreed on the lack of convenient clinic times, and 23 respondents (11.2%) strongly agreed. 17 respondents (8.3%) strongly disagreed that long waiting times for cervical screening results are a barrier, 21 respondents (10.2%) disagreed, 127 respondents (61.7%) agreed, and 41 respondents (19.9%) strongly agreed that long waiting times for cervical screening results are a barrier.

Table 5: Responses on perceived facilitators of cervical screening.

Variables	Responses	Frequency	Percentage
Detailed Health Education	Strongly Disagree	6	2.9%
	Disagree	27	13.1%
	Agree	122	59.2%
	Strongly Agree	51	24.8%
Free Screening	Disagree	4	1.9%
	Agree	110	53.4%
	Strongly Agree	92	44.7%
House-to-House provision of screening	Strongly Disagree	4	1.9%
	Disagree	9	4.4%
	Agree	114	55.3%
	Strongly Agree	79	38.3%
Awareness campaigns	Strongly Disagree	6	2.9%
	Disagree	11	5.3%
	Agree	113	54.9%
	Strongly Agree	76	36.9%
Advice from a family member or friend	Strongly Disagree	6	2.9%
	Disagree	6	2.9%
	Agree	19	9.2%
	Strongly Agree	175	85.0%

Encouragement from Religion leaders	Strongly Disagree	8	3.9%
	Disagree	7	3.4%
	Agree	16	7.8%
	Strongly Agree	175	85.0%

The data in Table 5 shows perceived facilitators of cervical screening among respondents. 6 respondents (2.9%) strongly disagreed that health education is a facilitator of cervical screening while 27 respondents (13.1%) disagreed, 122 respondents (59.2%) agreed, and 51 respondents (24.8%) strongly agreed that health education is a facilitator of cervical screening. Only 4 respondents (1.9%) disagreed on the provision of free screening, while 110 respondents (53.4%) agreed, and 92 respondents (44.7%) strongly agreed on the provision of free screening. 4 respondents (1.9%) strongly disagreed on the topic of house-to-house provision of screening, 9 respondents (4.4%) disagreed, 114 respondents (55.3%) agreed, and 79 respondents (38.3%) strongly agreed on the topic of house-to-house provision of screening. 2.9%(6 respondents) strongly disagreed with awareness campaigns as a facilitator on cervical screening while 11 respondents (5.3%) disagreed, 113 respondents (54.9%) agreed, and 76 respondents (36.9%) strongly agreed. Concerning advice from a family member or friend, 6 respondents (2.9%) strongly disagreed, 6 respondents (2.9%) disagreed, 19 respondents (9.2%) agreed, and 175 respondents (85.0%) strongly agreed. Regarding encouragement from religious leaders, 8 respondents (3.9%) strongly disagreed, 7 respondents (3.4%) disagreed, 16 respondents (7.8%) agreed, and 175 respondents (85.0%) strongly agreed. This demonstrates that encouragement from religious leaders is viewed as a significant facilitator by most respondents.

Testing of Hypotheses

Hypothesis 1: There is a significant association between knowledge of cervical screening and the uptake of cervical screening among reproductive aged women in Iworoko, Ekiti State.

Table 6: Chi-Square analysis to determine significant association between knowledge of cervical screening and the uptake of cervical screening among reproductive aged women.

Knowledge of Cervical screening	**Uptake of cervical screening among reproductive-aged women**			**Chi-Square (X^2) value**	**df**	**p-value**
	Yes	No	Total			
Adequate Knowledge	83(40.3%)	31(15.0%)	114(55.3%)	1.023	1	0.312
Inadequate Knowledge	61(29.6%)	31(15.0%)	92(44.7%)			
Total	144(69.9%)	62(30.1%)	206(100%)			

Data presented in table 6 shows that there is no significant association ($p<0.05$) between knowledge of cervical screening and the uptake of cervical screening among reproductive aged women as p-value equals 0.312 which is greater than statistically significant value 0.05.

Hypothesis 2: There is a significant association between the perceived facilitators of cervical screening and uptake of cervical screening among reproductive-aged women in Iworoko, Ekiti State.

Table 7: Chi-Square analysis to determine significant association between the perceived facilitators of cervical screening and uptake of cervical screening among reproductive aged women.

Knowledge of Cervical screening	**Uptake of cervical screening among reproductive aged women**			**Chi-Square (X^2) value**	**df**	**p-value**
	Yes	No	Total			
Strongly Disagree	1(0.5%)	5(2.4%)	6(2.9%)	12.535	3	0.06
Disagree	9(4.4%)	2(1.0%)	11(5.3%)			
Agree	86(59.7%)	27(13.1%)	113(54.9%)			
Strongly Agree	48(23.3%)	28(13.6%)	76(36.9%)			
Total	144(69.9%)	62(30.1%)	206(100%)			

Data presented in table 7 shows that there is a significant association ($p<0.05$) between the perceived facilitators of cervical screening and uptake of cervical screening among reproductive aged women as p-value equals 0.006 which is lesser than statistically significant value 0.05.

DISCUSSION OF FINDINGS

The demographic profile of respondents in this study reflects a relatively young and economically active population, with the majority falling within the 26–35-year age group, followed by those aged 15–25 years and 36–45 years. This age distribution is consistent with the reproductive age range and represents a group that stands to benefit most from preventive reproductive health services such as cervical cancer screening. Most respondents were married, while a substantial proportion were single, and only a small fraction reported being divorced. Educational attainment varied, with nearly half possessing secondary school certificates, about one-third holding undergraduate degrees, and a smaller proportion having only primary or postgraduate education. This pattern aligns with findings by Okunowo et al. (2018), who reported that education level was the only sociodemographic variable significantly associated with greater understanding of cervical

cancer. The predominance of employed women in the sample suggests a population with potential financial autonomy, yet this did not necessarily translate into improved screening behaviour, underscoring the complexity of factors influencing health-seeking practices beyond economic engagement alone.

Findings on knowledge of cervical screening reveal a striking gap between awareness and understanding. A large proportion of respondents were unaware of cervical cancer screening, mirroring earlier Nigerian studies that reported similarly low awareness levels (Okunowo et al., 2018). Although more than half indicated familiarity with screening methods and acknowledged the importance of regular screening and early detection, nearly half did not believe regular screening was necessary. This divergence highlights the distinction between surface awareness and meaningful knowledge, a phenomenon previously observed by Okunowo et al. (2018), who emphasised that awareness does not equate to comprehension or behavioural readiness. Notably, a substantial proportion of respondents reported having undergone screening in the past, suggesting that exposure may occur through episodic encounters with healthcare services rather than sustained understanding. The absence of a significant association between knowledge and screening uptake in this study ($p = 0.312$) reinforces this interpretation and suggests that knowledge alone may be insufficient to drive behaviour change without addressing broader sociocultural and structural determinants.

Cultural beliefs emerged as powerful influences on screening behaviour. While a portion of respondents denied that culture affected their decisions, a considerable majority agreed that cervical screening is painful and embarrassing, that community norms influence uptake, and that family and religious beliefs shape health choices. These findings are consistent with Okunowo et al. (2018), who reported that discomfort, fear of stigma, and concerns about being perceived as promiscuous deter women from screening. The influence of family, particularly male partners, aligns with Uchendu et al. (2021), who emphasised the sociocultural authority men hold over women's health-seeking behaviour in African contexts. The substantial proportion of respondents who perceived religious disapproval of screening further supports the need for culturally grounded interventions in Nigeria's multireligious and heterogeneous society (Uchendu et al., 2021). These dynamics illustrate that cervical screening is not merely a medical act but a socially mediated practice embedded within communal norms, gender relations, and moral frameworks.

Healthcare accessibility also significantly shaped respondents' perceptions and experiences. Most participants viewed cervical screening as expensive, corroborating findings by Stelzle et al. (2021), who identified cost as a psychosocial barrier among female civil servants in Delta State. Although many respondents acknowledged the availability of screening centres, barriers persisted in the form of limited female screeners, inconvenient clinic times, and prolonged waiting periods for results. The preference for female providers is particularly salient in culturally conservative settings, where intimate examinations by male staff may be unacceptable. Long waiting times and rigid clinic schedules further compound opportunity costs for women balancing domestic and economic responsibilities. These structural constraints echo the observations of Uchendu et al. (2021), who argued that system-level deficiencies undermine women's ability to translate intention into action. The persistence of such barriers suggests that improving physical availability alone is

insufficient; service organisation must be responsive to gendered realities and everyday constraints.

In contrast to the weak association between knowledge and uptake, perceived facilitators demonstrated a strong and statistically significant relationship with screening behaviour ($p = 0.006$). Health education was widely endorsed as a facilitator, reflecting the view that informed engagement can motivate preventive practices. This aligns with Nwabichie et al. (2020), who linked low screening prevalence in Nigeria and Ghana to poor awareness and weak educational outreach. The strong endorsement of free or subsidised screening reinforces evidence by Stelzle et al. (2021) that financial relief can enhance utilisation by reducing economic barriers. Respondents also strongly supported house-to-house screening services and awareness campaigns, indicating receptiveness to community-based and proactive outreach models. These findings are consistent with earlier recommendations advocating decentralised and mobile screening strategies in resource-limited settings.

Perhaps most striking is the overwhelming agreement that encouragement from family members, friends, and religious leaders would facilitate screening uptake. The near-universal endorsement of religious leaders' influence underscores the centrality of faith institutions in shaping health behaviour. Uchendu et al. (2021) similarly argued that engagement with religious and traditional leaders is imperative in contexts where health-seeking practices are deeply embedded in cultural and spiritual norms. The prominence of interpersonal encouragement suggests that trust and social validation are critical motivators, potentially outweighing formal health messaging. These results imply that cervical screening interventions must move beyond clinic walls and engage the social ecosystems in which women live.

Taken together, the findings reveal a multifactorial pattern in which demographic characteristics, limited knowledge, cultural beliefs, and healthcare accessibility intersect to shape screening behaviour. The absence of a direct association between knowledge and uptake highlights the limitations of information-based interventions when unaccompanied by structural reform and cultural engagement. Conversely, the strong predictive value of perceived facilitators demonstrates that women are responsive to enabling environments that reduce cost, increase convenience, and mobilise trusted social actors. These insights affirm the conclusions of prior Nigerian and regional studies that cervical cancer prevention requires integrated strategies addressing individual cognition, social norms, and health system design (Okunowo et al., 2018; Uchendu et al., 2021; Stelzle et al., 2021). For communities such as Iworoko, effective programmes must therefore combine sustained health education with community mobilisation, religious and family involvement, gender-sensitive service delivery, and financial protection mechanisms. Only through such holistic approaches can cervical screening become a routine and socially acceptable practice, thereby reducing preventable morbidity and mortality among women.

CONCLUSION

This study concludes that awareness of cervical screening among women remains low, despite a general understanding of screening methods and the importance of early detection. Uptake is strongly shaped by cultural beliefs, including perceptions of pain and embarrassment, as well as the influence of family, community, and religion. Structural barriers within the health system, such as cost, limited access to female screeners, inconvenient clinic schedules, and long waiting times, further hinder utilisation. While knowledge alone does not significantly determine screening behaviour, perceived facilitators particularly health education, free or subsidised services, community-based outreach, and encouragement from family members and religious leaders play a decisive role in promoting uptake. These findings underscore the need for culturally sensitive, socially grounded, and structurally enabling interventions to improve cervical screening participation.

Recommendations

1. Sustained and culturally sensitive education programmes should be implemented to improve awareness of cervical screening, dispel myths about pain and embarrassment, and emphasize the benefits of early detection. These programmes should be delivered in local languages and adapted to community values.
2. Given the strong influence of family and faith institutions, religious leaders, community heads, and spouses should be actively involved in advocacy efforts to normalize cervical screening and encourage women's participation.
3. Screening services should be made more accessible by subsidizing or eliminating costs, ensuring the availability of female screeners, extending clinic hours, and streamlining procedures to minimize waiting times.
4. House-to-house and community-based screening initiatives should be introduced to reach women who face mobility, time, or cultural constraints, thereby bringing services closer to households and increasing uptake in underserved areas.

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