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CERVICAL CANCER SCREENING PRACTICES AMONG WOMEN ATTENDING MARIE STOPES CLINICS AT KOKOMLEMLE AND DANSOMAN, GREATER ACCRA REGION

BY

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DECLARATION

I, Barbara Dede Sasraku, proclaim that, with the exemption of previously published publications that have been properly cited, this thesis is the result of my own original independent study conducted with the supervision of Prof. Phyllis Dako-Gyeke. I further confirm that this work has never been submitted to a journal for publication or to any organization for an award in any way.

Signature..... **Date: 17/10/2023**

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Prof. Phyllis Dako-Gyeke

(Supervisor)

DEDICATION

I dedicate this work to the Almighty God for the knowledge and strength he gave me to do this work. I also want to express my gratitude to my loving mother, Madam Joyce Obeng-Somuah, my husband, Mr. Padmond Cudjoe, and our lovely kids, Kwesi Nhyira Bossman, and Zuriel Nkunim Cudjoe, for all the numerous sacrifices they made to make this program a success.

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ABSTRACT

Introduction- Cervical cancer is the second most common malignancy in women overall. (Sung et al, 2021). About 90% of the anticipated 487,000 cervical cancer fatalities in 2021 took place in low- and middle-income nations. Cervical cancer screening rates are still quite low in impoverished nations like Ghana, even though early detection and screening improve outcomes and prognoses. The goal of the study was to evaluate how often women of reproductive age who attend Marie Stopes Clinic, Dansoman and Kokomlemle branches screen for cervical cancer.

Methods: It was done using descriptive quantitative approach. 335 women of reproductive age who live in Dansoman and Kokomlemle and attended the Kokomlemle and Dansoman locations of the Marie Stopes International Clinic for sexual and reproductive health services participated in a cross-sectional survey. The information was gathered using a suitably formatted questionnaire with questions that are both closed-ended and open-ended. STATA version 17 was used to clean, export the data to an excel sheet, and do the analysis.

Findings: Only a small percentage of women who were aware of cervical cancer had appropriate knowledge, and among those who knew about the disease's screening procedures (30.1%)., there were insufficient cervical cancer screening practices (33.7%) Women mostly learned about cervical cancer through the media (i.e., radio, television, and internet). Even though most women (50.6%) did not want to get examined, the poll also showed that only a small percentage of women (30.1%) had their cervical cancer screened. The main cause of this was a lack of awareness and information about cervical cancer screening. The results show that, with P values of 0.001, 0.000, and 0.011 at a 95% Confidence Interval, respectively, educational level, kind of employment and the availability of information and services, are statistically significant in positively influencing awareness and knowledge level.

Conclusion: Cervical cancer screening programs are not widely used among women of reproductive age who attend the Marie Stopes International Clinic facilities in Dansoman and Kokomlemle. Consequently, it is essential to implement strategic steps to motivate women to get screened for cervical cancer.

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1.0 INTRODUCTION

1.1 Introduction

Cervical cancer is the second most frequent female cancer in the world, with 604 000 new cases predicted in 2020. (Sung et al, 2020). In 2020, 342,000 cervical cancer fatalities were projected, with low- and middle-income countries accounting for almost 90% of those deaths.

Cervical cancer is mostly brought on by chronic, high-risk Human Papillomavirus (HPV) infection. (Okunade, 2020).

Early screening can help prevent cervical cancer, and there is evidence that screening for the disease in developed nations has decreased the number of deaths among women who receive it (Huh et al, 2015). According to Finocchario-Kessler et al (2016), majority of women with cervical cancer are African American women. The disease burden must be reduced, thus more funding and research are urgently required to enhance efforts at vaccine, screening, and treatment. (Ngwa et al, 2020). Ntekim (2012) states that because of the high disease burden, concern over the cervical cancer incidence rate is widespread in emerging and least developed countries. This could be the case as screening facilities are more prevalent in industrialized countries than in less developed countries, enabling many women in those developed countries to screen for cancer and receive frequent checkups. The rates of mortality assessed in developed and developing countries differ significantly as a result.

Despite the existence of both preventative and curative treatment options, Ghana nevertheless has a high incidence rate. In Ghana, cervical cancer screening is mostly done in main teaching hospitals, regional hospitals, and certain private health facilities.

About 90% of cervical cancer-related deaths, according to the World Health Organization (2018a), takes place in low- and middle-income countries. In addition, the World Health Organization (WHO) estimated that Ghana had a mortality rate of 21.4/100,000 and an age-standardized incidence of cervical cancer of 27.4/100,000. The World Health Organization (WHO, 2018a) states that effective screening, early diagnosis, prevention, and treatment programs may help to lower the high global death rate from cervical cancer. To detect precancerous cervical lesions and cervical cancer early, for example, screening with cervical cytology or HPV testing should be done. (Moyer, 2012).

According to Agbokey (2014), most patients arrive with the disease at a late stage, even though it is avoidable, according to evidence from gynecological clinics in Ghana. The absence of or extremely limited coverage for cervical cancer screening in several African countries, including Ghana is the main cause of the late presentation. (Jedy-Agba et al, 2020). There are a variety of reasons why cervical cancer screening programs are not widely available in less developed countries. Unawareness of the illness and associated screening procedures, as well as preconceptions and attitudes based on cultural and religious beliefs, are a few of them (Modibbo et al, 2016) There may be additional causes for this low coverage, including a weak health infrastructure and other conflicting health interests. (Marques et al, 2020)

Unawareness of cervical cancer and associated screening methods is a serious obstacle to early identification, treatment, or prevention of the disease and the issues it relates to. (Kessler, 2017). According to a study done in Elmina by Ebu et al. (2015), most respondents at the time (68.4%) were not aware of cervical cancer, 93.6 percent were not aware of its risk factors, and 92 percent were not aware of its prevention and treatment.

According to studies conducted by Chinaka et al, (2013) and Ebu et al, (2015) there is a larger correlation between women's screening habits and several characteristics, such as partner rejection and expense, among others, than there is with factors like marital status, occupation, and education level.

1.2 Problem Statement.

Cervical cancer is an important public health problem globally and in Ghana. Cure rates are high if the condition is diagnosed early. Screening has a role to play in early diagnosis, but uptake of screening is low in Ghana and that is why it *is* of serious public health concern. Most cervical cancers diagnosed in Africa are in the advanced clinical stage and do not respond to the minimal treatment options that are available. A meagre 5% of women in Africa have received a Pap smear. This is in sharp contrast to 75% of women in developed countries who have participated in some type of screening (Tsu & Levin, 2008). Most women in developing countries don't screen regularly for cervical cancer. The result of this poor uptake is the high incidence of the disease in these countries (Sankaranarayanan, 2006). There is a significance drop in the incidence of cervical cancer in developed countries because of intensive cervical screening programs (Mutyaba, Faxelid et al. 2007).

Women's responsibilities in society, which include supporting strong families, creating more resilient communities, and acting as powerful forces for economic growth, are all impacted by cervical cancer (Aranda et al, 2018). According to the World Population Review study in 2020, Ghana's female population has consistently outnumbered its male population since 1995.

A Papsmear test is suggested every three years for women aged 21 to 29 and every five years for those aged 30 to 65, respectively. (American Cancer Society, 2019).

Cervical cancer has the highest prevalence of all age-standardized mortality rate for female malignancies in Ghana of 30–35 / 100,000 according to WHO (2018). Despite studies demonstrating the effectiveness of Pap smear cervical cancer screening, the test is not widely available in Ghana's healthcare institutions and. (Manning, 2016), (Abotchie, & Shokar, 2009).

Instead of being part of a standard gynecologic examination, pap smears are only carried out in cases of abnormal vaginal bleeding in Ghana (Adanu, 2002). Only 16.2 percent of women said they had regular gynecologic checkups, according to research, while Adanu (2002) discovered that 2.1 percent of women had undergone a single cervical cancer screening (Handlogten et al, 2014). Cervical cancer screening techniques are not available in most Ghana's primary healthcare facilities according to World Health Organization research (WHO 2014). Research on education have discovered that women with greater levels of education have higher screening rates, regardless of the person's sociodemographic situation. (Dim & Ezegwui, 2009). These women might choose not to undergo screening, nevertheless. As a result, further causes need to be found. Younger women (20–29 years old) and older women (60+ years old) have much lower screening uptake (Dim et al, 2009). Research on education have discovered that women with greater levels of education have higher levels of screening. (Dim & Ezegwui, 2009). However, these women may decide not to get screened. Therefore, more reasons must be identified. Women who are younger (20-29 years old) and older (60+ years old) participate in screenings at considerably lower rates (Dim et al. 2009). Furthermore, divorced, and widowed women were less likely to be screened than married women. (Lyimo. et al, 2012).

According to the information above, there are other criteria that should be considered in addition to cervical cancer awareness when determining who will use screening services for the disease. The healthcare provider variables (Waller, et al. 2009), sociocultural factors (Singh, 2012), and knowledge factors, which are explored below, should be some of these factors. According to a study by Waller. et al, (2009), health care provider characteristics may prevent women from getting screened for cervical cancer.

The researchers also pointed out that a woman's desire to get cervical cancer screening can be affected by how far she lives from facilities that provide the service. According to Akinyemiju, (2012), more effort is needed to increase the adoption of cervical cancer screening in developing countries. Also, socio-cultural issues must be considered as being of utmost importance when analyzing the cervical cancer screening practices of women. Women brought up in certain groups and tribes may find it uncomfortable to undergo screening since talking about reproductive health is a taboo. (Singh & Badaya, 2012). Considering the data, it is crucial to investigate cervical cancer screening practices among women in the Ayawaso Central Municipality of Accra, Ghana.

1.3. Health belief model (HBM)

Researchers state that the health belief model (HBM) is based on the idea that people would participate in an activity connected to their health (and for this study, screening practices for cervical cancer) if they believe that a bad health condition can be avoided, have faith in their capacity to engage in a suggested health action efficiently, and have a positive expectation that doing so would stop a harmful health condition. (Glanz, & Rimer. 2017). Perceived importance, perceived benefits, perceived restrictions, and perceived susceptibility are the health belief Model's main building blocks (Rosenstock, et. al, 1988; Quist, & Adomah-Afari, 2017)

1.4. Conceptual Framework

In the development of public health programs, theories and models are employed to comprehend and clarify a range of health behaviors as well as to direct the selection, creation, and application of remedies (Glanz& Bishop 2010). The utilization of cervical cancer screening is affected by several factors including fear to know the outcome, Knowledge about cervical cancer screening, cultural and religious beliefs, accessibility, affordability, and socio-demographics characteristics of the study population. A conceptual framework explains how several elements interact to influence a circumstance or a course of action. The author created this conceptual framework based on the health

belief model to meet the demands of the study. The framework's variables have been divided into dependent and independent variables to make measuring them easier. The graphic shows the many variables influencing women's cervical cancer screening habits as the dependent variable and the habits as independent variables. Several preventive measures, such as routine screening, should be undertaken to help women reduce the high incidence of cervical cancer morbidity and mortality. The acceptance of these cervical cancer preventive techniques depends significantly on the general public's understanding, awareness of the disease and willingness to screen for the disease.

Social conventions, availability of information and healthcare resources, attitudes, and beliefs about cervical cancer, as well as women's intents to test for the disease, may all have an impact on how often they choose to get screened.

Depending on their age, marital status, and level of education, women may be exposed to health information, such as directions on how to utilize cervical cancer preventative therapies and instructions on how to learn about the disease. Higher educated individuals could have easier access acquiring information from sources including television (TV), the internet, radio, and other mediums of information than individuals with lesser educational backgrounds. Due to conditions like pregnancy, delivery, childcare, or other problems linked to age and marital status, a woman is more likely to visit a medical institution more frequently, which can also increase her exposure to information about cervical cancer. Women who now have the signs or symptoms similar to cervical cancer may be more knowledgeable about it than women who don't. The closeness of healthcare practitioners and organizations that offer pertinent services may also have an impact on a woman's knowledge, awareness of and screening practices for cervical cancer.

Additionally, a variety of societal factors, including religious restrictions, cultural practices, and beliefs, terrify women and give rise to several myths and misconceptions regarding cervical cancer.

These may be addressed if women have access to information and medical care. The way a community views and responds to medical treatments may influence how interested they are in learning more about cervical cancer. Women who want to prevent the disease will also look for information about cervical cancer.

Each of these unique attributes has an impact on how women in the Ayawaso Central and Ablekuma West municipality are screened for cancer of the cervix.

The chart below depicts the link between the many factors that have an impact on women's cervical cancer information and awareness, as well as cervical cancer screening.

Conceptual Framework on Cervical Cancer Screening Practices.

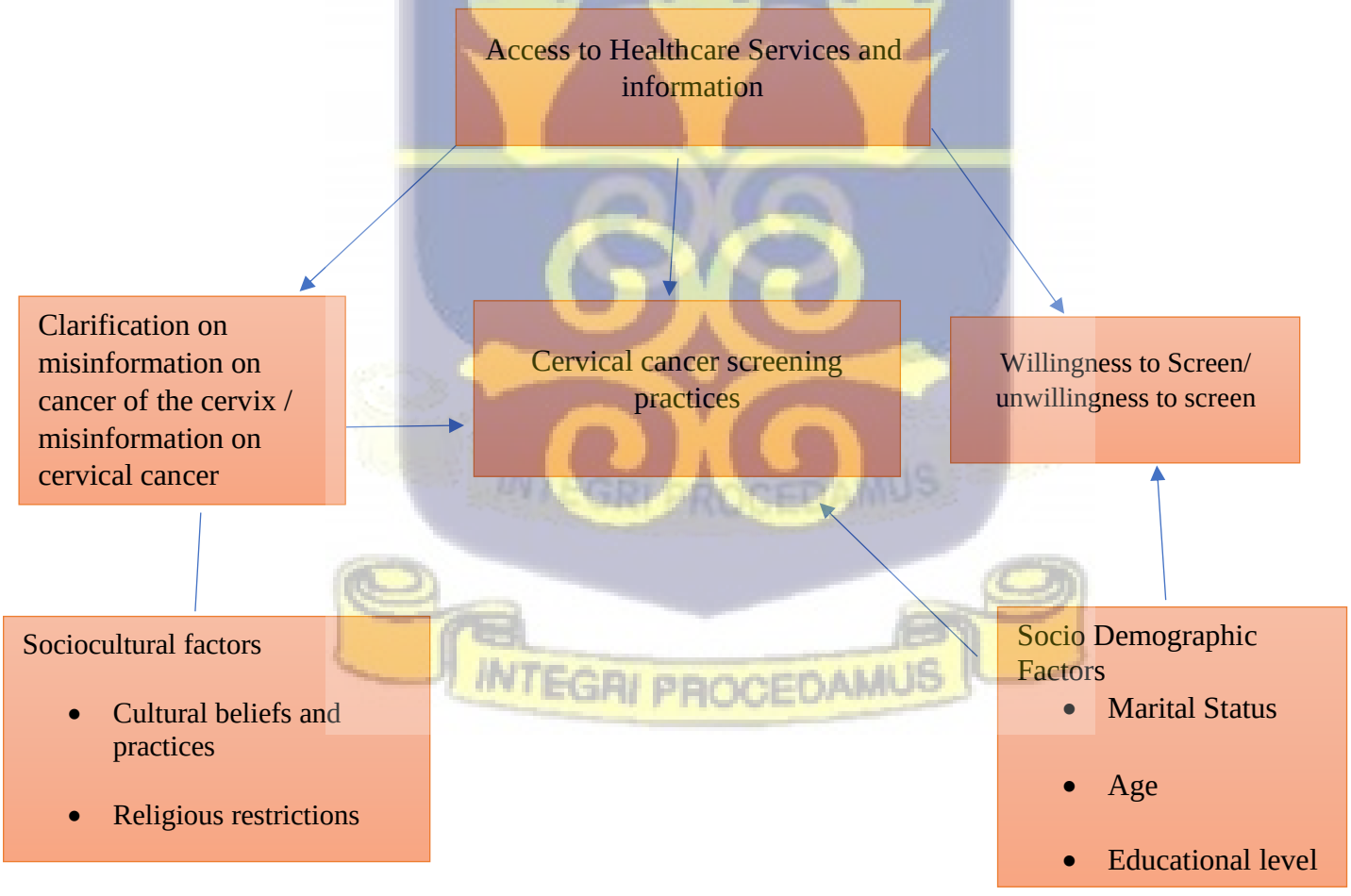

Figure 1: Conceptual Framework on Cervical Cancer Screening Practices.

(Source: Principal Investigator)

1.5. Justification

Ghana experiences considerable negative consequences due to the death and morbidity of women from cervical cancer (William, et al. 2013). Women between the ages of 15 and 49 who are fertile are more susceptible to cervical cancer. Given this burden, an approach to preventing and reducing Preventing cervical cancer prior to malignant stage, where the outcome is often extremely bad and treatment is highly costly owing to late presentation, must be a top priority given the frequency of cervical cancer and its related mortality.

Even though studies show Ghanaian women lack understanding about cervical cancer (Binka. et al. 2019), there is currently a paucity of information on the causes, risk factors, screening practices, symptoms, and management for cervical cancer among women, and there is a relatively high prevalence of cervical cancer among Ghanaian women. (Ayanore, et al. 2019)

The study's conclusions may be utilized to develop focused, evidence-based campaigns to promote and broaden cervical cancer screening practices among women in the municipality, with the goal of lowering the prevalence and death rates of the illness among women in Accra and throughout Ghana. This information may be useful to the Ayawaso Central Municipal Health Directorate, other significant stakeholders, and Ghana overall. Our understanding of women in Ghana will considerably progress because of these findings.

1.6 Research Objectives

1.6.1. General Objectives

Analyze cervical cancer screening practices among women of reproductive age attending Marie Stopes clinic Kokomlemle and Dansoman branches.

1.6.2 Specific Objectives

i. Estimate the prevalence of cervical cancer awareness and knowledge among women of reproductive age attending Marie Stopes clinic Kokomlemle and Dansoman branches.

ii. Determine cervical cancer screening practices among women of reproductive age attending Marie Stopes clinic Kokomlemle and Dansoman branches.

iii. Identify the willingness of women of reproductive age attending Marie Stopes Kokomlemle and Dansoman branches in taking up cervical cancer screening.

iv. Identify the expected challenges of cervical cancer screening among women of reproductive age attending Marie Stopes clinic Kokomlemle and Dansoman branches.

1.7 Research Questions

I. What is the prevalence of cervical cancer awareness and knowledge among women of reproductive age attending Marie Stopes clinic Kokomlemle and Dansoman branches.

II. What are the cervical cancer screening practices among women of reproductive age attending Marie Stopes clinic Kokomlemle and Dansoman branches.

III. How willing are women of reproductive age attending Marie Stopes clinic Kokomlemle and Dansoman branches in taking up cervical cancer screening.

IV. What are the expected challenges of cervical cancer screening among women of reproductive age attending Marie Stopes clinic Kokomlemle and Dansoman branches

1.8 Organization of the Study

There were five (5) chapters in the study. The study's background, problem description, theoretical and conceptual framework, study objectives, justification for the investigation, and study organization were all presented in the first chapter. The second chapter provided a pertinent survey of the literature to aid in evaluating the understudied study and its conceptual and theoretical stances.

In chapter three (3), the methodology was explained. It included the research design, study area, target population, study population, sampling procedures, sample size, method of data collecting, data processing, data analysis, ethical consideration, and study limitations.

Chapter four (4) of the study focused on data presentation analysis and discussion of findings. The fifth chapter present the summary of findings, conclusions, recommendation, and implication for enhanced screening practices of cervical cancer among women in Ghana.

CHAPTER 2

2.0 REVIEW OF LITERATURE

2.1 Introduction

This chapter contains a review of the literature related to this study. It discusses the varied literature on women's knowledge and awareness of cervical cancer and screening practices, their intents and readiness to undergo cervical cancer screening, the anticipated impediments to such screening, and their degree of knowledge of the advantages of such screening.

The material has been organized into a variety of sections in accordance with the study's research goals. The review was undertaken with the following topics in mind: the burden of cervical cancer, general understanding of the illness, determinants influencing disease awareness and knowledge levels, and variables influencing screening practices. Google Scholar, PubMed, Medline, and Science Direct were the databases that were utilized to locate the literature. Cervical cancer and screening for cervical cancer were the search terms for articles.

2.2 Understanding Cervical Cancer Disease

The unrestrained growth and spread of aberrant cells within the human body, according to the American Cancer Society, is what defines a group of illnesses collectively known as cancer. If the spread is unchecked, the condition can be fatal (ACS, 2019).

Cervical cancer is cancer of the uterine cervix (mouth of the uterus). A genetic change known as mutation must first begin to occur for healthy cells to turn into abnormal ones. Malignant cells proliferate and reproduce uncontrolled and do not die, whereas healthy normal cells proliferate and

at a predictable pace before dying at a specified time. Cancer cells can infect nearby tissues and then spread (metastasize) to other regions of the body. Cancer cells can infect nearby tissues and then spread (metastasize) to other regions of the body.

There are several forms of cervical cancer that can manifest, including adenocarcinomas, adenosquamous carcinomas and squamous cell carcinomas The kind of cancer and the stage at the time of diagnosis have a significant impact on the course of therapy and prognosis for cervical cancer. Squamous cell carcinomas, a type of cervical cancer commonly starts in the external region of the cervical canal and spread into the vagina.

Adenocarcinomas are a kind of cancer of the cervix that has increased in frequency during the past 20 to 30 years. They often begin in the column-shaped glandular cells that border the cervical canal. There is also a less frequent variety of cervical cancer that has features of both squamous cell carcinomas and adenocarcinomas, thus the name Adenosquamous or Mixed carcinomas. Other cancers, like lymphomas, sarcomas and melanomas, Lymphoma, and Sarcoma, can occur in the cervix in addition to these primary kinds of cervical cancer.

2,784 women globally who are 15 years of age or older have been identified by the ICO HPV as being at risk of getting cervical cancer. According to this research, of the total, 3,244.4 are in lower and middle income developed nations, while 634.5 are in more developed countries (ICO HPV, 2019).

Human papillomavirus (HPV) is the most common infection in the reproductive system, according to research. (WHO, 2018). According to the WHO (2018), many sexually active women and men have a chance of contracting HPV at some point in their life, with some contracting it more than once. Typically, the illness is contracted after being sexually active. Skin-to-skin genital contact is

the most prevalent way for HPV to spread during sexual activity. According to the WHO publication, there are other kinds of HPV that are not problematic (WHO, 2018). HPV infections are thought to clear up on their own after a few months, and 90 percent clear up within two years. However, some HPV infections with specific strains can progress to cancer. (WHO, 2018). It is shown that the most prevalent HPV infection typically contributes to cervical cancer (WHO, 2018).

Cervical cancer is extremely common and sometimes fatal in impoverished and marginalized women, as well as in young, frequently heavily pregnant women. Even women who have never given birth might acquire cervical cancer. Additionally, prolonged oral contraceptive usage puts women at risk for cancer of the cervix (Huchko et al. 2015, ACS, 2016).

Smoking is one lifestyle choice that has been linked to cervical cancer, especially squamous cell carcinoma. Radiation exposure and some chemical pollutants can both lead to cervical cancer. Women with weakened immune systems brought on by illnesses like HIV may be more prone to cervical cancer.

According to studies on cervical cancer survival, people with the disease had a 68 percent and 64 percent relative survival rate between five and ten years. The five-year survival rate for this group was 92%, and nearly half of the patients (46%), had cancer that was localized when it was discovered (ACS, 2016).

Findings from Marques. et al (2020) showed Many women in Europe lacked basic understanding about cervical cancer since only 29% of respondents knew about the method of HPV transmission. Inspite of this, most of participants (87%) felt that gynecological checkups (90%) and Pap smear screening may aid in the prevention of cervical cancer (83 percent). In a similar vein, Jassem et

al. (2018) observed many of their research participants (67%) were aware of Pap smear screening as a form of screening for cancer of the cervix. According to a study by Belachew et al (2018), only 21.2 percent % HIV-positive women in Ethiopia knew about the relevance of screening for cervical cancer as a method to prevent cervical cancer. Comparable to this, it was found that over half of the respondents who took part in a study were unaware of Pap smear screening, despite their willingness to take part (Tokuc et al, 2017).

Some students in China have found that women living in rural regions had a high prevalence of cervical cancer (Song, 2017). However, studies show that only a small portion of these women are aware of cervical cancer screening (Di et al. 2015; Liu, 2017). Pap smear screening checks are less common among Chinese women in rural areas than they are in urban areas (Wang, 2015). According to the study, just 7.4 percent of respondents had taken Pap tests for screening for cancer of the cervix, and many of these ladies thought it was unnecessary. (Abulizi et al, 2018). According to research, women who are more aware about cervical cancer are more likely to consent to a screening test. (Jia et al. 2013).

Abotchie and Shokar (2009) found just 9.2 percent of 140 students polled were aware that HPV can cause cervical cancer. Most Ghanaian women were also unaware of the numerous cervical cancer screening procedures that were available in Ghana. Despite their lack of information about cervical cancer and its screening, women in most African countries have good attitudes regarding the treatment. (Mulatu et al 2016).

Contrary to the assumption made above, research done in countries in Africa demonstrate that women in these countries are well-informed on screening practices of cervical cancer. (Tapera. 2017; Mutambara et al. 2017)

2.2.1 Cervical Cancer Symptoms and Signs

Many HPV infections recover on their own without symptoms or illness (Handisurya et al., 2009). However, chronic infection with HPV strains (types 16 and 18) may cause precancerous lesions to appear. These lesions might potentially turn into cervical cancer if ignored for a long time. Pre-invasive cervical lesions are frequently asymptomatic. As the malignant cells proliferate and spread, they infect other tissues and produce symptoms. Vaginal bleeding during or after sex, during pelvic examination, during douching, in between periods, or after menopause is one of the most prevalent signs of cervical cancer. Some vaginal bleeding linked with cancer of the cervix is likely to be puzzling as well. Vaginal bleeding may be accompanied with a watery, bloody discharge that is thick and odorous. Furthermore, cervical cancer may be associated to unexplained pelvic discomfort as well as pain during and after sex. Back and leg pain are two potential signs. Anemia, bloody urine (hematuria), urination difficulty (dysuria), rectal bleeding, weight loss, and rare fevers are further clinical indications of cervical cancer. (Laura & Martin, 2018).

2.2.2 Management of Cervical Cancer

Cervical cancer can be effectively controlled if detected early in the stage before cancer. A loop electrosurgical excision treatment can be used to treat precancerous cervical lesions. (LEEP). With the use of an electric current-heated wire loop, the aberrant tissues are destroyed. Other treatments include cryotherapy, which involves freezing cells to death, laser ablation, which causes tissue to be destroyed, and conization, which involves destroying cone-shaped tissue around the aberrant tissue. In contrast, the combination of targeted treatment and conventional chemotherapy was claimed to enhance the general survival in women with recurrent, persistent, or metastatic cancer of the cervix. (ACS, 2016).

2.2.3 Prevention of Cervical Cancer

Combining targeted treatment with standard chemotherapy, on the other hand, was claimed to enhance overall survival in women with metastatic, chronic, or recurrent cervical cancer. (ACS, 2019).

The most prevalent HPV types that cause cervical cancer have been targeted by vaccinations, but other HPV types and infections that already present are not completely protected, according to the American Cancer Society. Women who have gotten the HPV vaccination are recommended to continue getting cervical cancer screenings.

There are now 62 countries with age limits of up to 26 years that target young and teenage girls and try to immunize women older than 26 by including the HPV vaccine in their national immunization programs (Sankaranarayanan, 2015).

Cervical cancer screening is the major way of prevention since it allows the illness to be discovered early and managed before it advances to the carcinoma stage. Two cervical cancer screening treatments are PAP smear and Visual Inspection with Acetic Acid (VIA).

Reducing childbearing, avoiding extended oral contraceptive usage, stopping smoking, and eating a diet high in fruits and vegetables are some ways to address the predisposing factors for the condition. As a result, there will be fewer numerous partners and early sexual encounters, fewer pregnancies, and no cervical cancer.

Cultural and religious norms that govern sexual behavior and HPV transmission have a substantial influence on avoiding cervical cancer, according to study by Netfa. et al. (2020). This is because they assert that while cervical cancer incidence rates are over 50 per 100,000 women in countries

like Cameroon, Zimbabwe, and South Africa, where sexual practices are generally more liberal, the incidence rates are under 10 per 100,000 women in countries like Niger, Gambia, Zambia, and Ethiopia, where sexual behaviors are more restrictive in general (Gelband et al., 2015).

Appropriate awareness about cancer of the cervix, its risk factors, etiology, indicators, as well as symptoms are essential for women to take up preventative methods as it is believed that increasing awareness of the disease will significantly improve women's healthcare seeking behaviors for services aimed at preventing cervical cancer (Shiferaw et al., 2016).

2.2.4 HPV Persistence and Cervical Cancer Development Risk Factors.

Early sexual experience, many sexual partners, cigarette use, and immune suppression are all potential HPV risk factors that might lead to the development of cervical cancer. (WHO, 2018). With an estimated 672,000 new cases reported in 2015, cervical cancer is one of the most common cancers in women worldwide. In 2016 (Garland et al.). More than Women who have certain sexually transmitted diseases (STDs), such as HIV/AIDS, syphilis, gonorrhea, and chlamydia, are more likely to get the HPV virus, which can cause cervical cancer. Other forms of cervical infections can put a woman at risk of contracting cervical cancer. (ACS, 2016; ICO HPV, 2017a).

85 percent of the 270,000 cervical cancer deaths each year occur in less developed regions (Garland et al., 2016). "A few STIs, such as syphilis, chlamydia, gonorrhea, and HIV/AIDS, predispose women to HPV infection, which may result in cervical cancer. Cervical chronic infections from other sources can potentially increase a person's risk of developing cervical cancer (ACS, 2016; ICO HPV, 2017a).

There is a high level of awareness about cervical cancer screening among women, according to several American research (Johnson, et al, 2020). For instance, a study of 433 women in Texas

indicated that just 3.2 percent of the participants were unaware of the risk factors for developing cervical cancer. This suggests that the majority, or 96.8 percent, were aware of these risk factors. (Riza et al., 2020) More than 70% of the respondents were aware that women who have sex without using condoms and those with STDs had a higher chance of developing cervical cancer. Additionally, more than half (60.5%) were aware that a woman's chance of acquiring cervical cancer increases if she has numerous males in her life. While more than half of their respondents (71 percent) had heard of cervical cancer, very few of them were aware of its causes and ways of treatment, according to Shiferaw et al results among Ethiopian women with HIV diagnoses in 2016. One type of cervical cancer therapy was mentioned by 33% of participants.

There are screening programs for women in developed nations, which helps to find most pre-cancerous lesions at stages when they are easily treatable (see Belinson, & Belinson, 2010). In these nations, early treatment lowers cervical cancer incidence by 80%. The disease is frequently discovered at an advanced stage when symptoms have already shown in underdeveloped nations due to the restricted availability to efficient screening. Additionally, there may be limited options for therapy at an advanced stage, which would raise the death rate in these nations. The worldwide mortality rate of cervical cancer might be decreased by implementing efficient screening and treatment programs (see Belinson, & Belinson, 2010).

2.3. Knowledge and Level of Awareness of Cervical Cancer and its Screening

Cervical cancer has become the most fatal disease in developing countries, according to Perkins (2007), since there are no screening programs in place. Women who are informed about cervical cancer respond well to the urgent need for screening, according to research that has been done time and time again. In Honduras, a poor country, the incidence of cervical cancer is 40/100,000, which

is four times the rate in the US. This demonstrates how important education is in lowering the risk of cervical cancer. A comparable study was carried out in India to ascertain the degree of knowledge and awareness regarding cervical cancer awareness among female students at famous institutions in Kolkata. 43 percent of the students understood the age at which cervical cancer initially manifests in Indian women, according to the results. The students had insufficient understanding of risk factors. The awareness of "many sex partners" as a risk factor was lowest (3%) and was followed by "other 12 cervical infections" (4%) in that order. 29 percent of the students agreed that smoking was a danger factor. The etiology of cervical cancer may be connected to sexual behavior, according to 41% of the interviewees. Only 15% and 11% of students, respectively, had ever heard of the phrases "Pap smear test" and "HPV." Four hundred and seventy-two out of the 630 students said they would want to get vaccinated against cervical cancer.

In a separate survey, which looked at the knowledge of Ethiopian women regarding cervical cancer, it was found that 495 (78.7%) of the respondents had heard of the condition. When asked where they obtained their information, 301 respondents (60.8%) cited radio or television, followed by 173 (34.9%) health professionals and 107 from friends and relatives (21.6 percent). A total of 529 respondents (84.1%) have gone to a hospital for any reason, and 138 (23.5%) of them also knew someone who had cervical cancer. As part of the survey, the respondents were asked several questions on cervical cancer's risk factors, key symptoms, accessible therapies, and strategies for early detection and prevention. A little over half of respondents being 47.5 percent did not know if there are risk factors for cervical cancer or not, and 17 (2.7 percent) said there are none. Despite claiming that cervical cancer had a risk factor, 118 of the survey participants (18.8%) were unable to provide one.

In general, 195 (31.0%) of them were able to list at least one risk factor for cervical cancer. 132 (21.0%) and 103 (16.4%) of the respondents, respectively, reported specific risk factors for STI and early commencement of sexual activity. When asked about the signs of cervical cancer, a total of 222 (35.3%) and 187 (29.7%) of the respondents mentioned copious and foul vaginal discharge, respectively. Of the 13 responses, 249 (39.5%) were unable to list any symptoms. Sixty-two out of the 400 respondents, or 63.9 percent, knew that cervical cancer could be prevented. Routine medical exams (screenings) were cited by 345 respondents (54.8%) as an effective preventative approach. Additionally, 416 respondents (66.1%) were aware that cervical cancer is treatable, and 332 respondents (52.8%) agreed that cervical cancer is curable if caught early. To ascertain the respondents' general level of knowledge, questions about risk factors, symptoms, available treatments, and preventative and early detection strategies for cervical cancer were scored, compiled, and the mean score was computed. Knowledgeable respondents were those who received average or higher scores on the survey.

2.4 Cervical Cancer Screening

This section presents commentary on the idea of screening. Cervical screening is expected to involve testing all women who are at risk for the disease, regardless of whether they are displaying any symptoms or not. The goal of screening is to find precancerous lesions that, if ignored, might develop into cancer. Early therapy is necessary for women who exhibit anomalies during screening in order to stop the growth of cancer. Early treatment is required for those with cancer (WHO, 2006). Cervical cancer screening might involve a variety of procedures (American College of Obstetricians and Gynecologists (ACOG), 2019). Large communities have embraced the Pap smear (cytology) because research suggests it lowers cervical cancer incidence and death. Despite being in use, other tests (Via, VILI, and HPV) have not been proven to be useful. (WHO, 2018)."

2.4.1 Information Sources on Cervical Cancer and Screening

Specialized data about cervical cancer, its prevention and detection are lacking in Africa (Ogbonna. 2017). According to the study, respondents knew 38.2 percent more about cervical cancer screening than about cervical cancer itself, which was comprehended by 10.8 percent of respondents. This is corroborated by study by Mofolo et al. (2018), which revealed that just a tiny portion of their respondents comprehended that a virus is the primary cause of cervical cancer, even if most of their respondents (15.4 percent) were aware that it affects the cervix. Based on their study, Williams, and Amoateng (2012) concluded that the majority of Ghanaian women are uninformed of the significance of cervical cancer screening in preventing the disease. Maree, et al (2012) reported that just 3% of South African women felt that Pap smear screening for cervical cancer may prevent a woman from contracting the disease. Many South African women were found to be ignorant of the procedure.

Women have access to resources that give cervical cancer information. Cervical cancer information may be obtained from a variety of sources, including health experts, social media and the internet, radio and television, schools, family, and friends.

In a study conducted in Serbia in by Rani, et al (2020)., 1011 of the students under investigation named the media as their primary source of knowledge on cervical cancer and its screening. For the other two categories, 866 and 538 students, respectively, cited organized health education (OHE) and personal contact as their sources. Twenty-five of the 250 respondents claimed they had no knowledge about cervical cancer or screening. The awareness about cervical cancer was much greater among respondents who obtained their information from the media, healthcare providers, and friends and family.

According to Jassem et al, (2012), the three primary sources of information for women about cervical cancer and cervical cancer screening are gynecologists (52.4 percent), family and friends (19 percent), and the media thirteen percent. Both Babatunde, et al (2018) and Oluwole, et al (2018) discovered that many of their respondents had learned about cervical cancer and screening from medical professionals and the media. Furthermore, many survey respondents claimed they learned about cervical cancer screening via media, followed by their neighbors, while a tiny percentage named health staff. Another research by Modibbo et al. (2016) in Nigeria indicated that women were not well-informed on the signs and symptoms of cervical cancer. Some respondents provided the inaccurate responses of back discomfort and stomach pain, even though certain participants were aware that uncomfortable intercourse and profuse bleeding might be symptoms of cervical cancer in some women.

2.5 Willingness to take up Cervical Cancer Screening

Precancerous lesions should be treated as soon as they are found, which typically prevents the development of cancer. An early Pap smear screening test is required for the prevention and early diagnosis of cervical cancer, according to Burd, (2003). Cervical cancer incidence has fallen dramatically in developed countries because of well-designed screening and treatment systems. Contrarily, due to ineffective screening programs and a lack of screening desire, the number of cervical cancer diagnoses and fatalities has increased in developing nations like Ghana (Assoumou et al., 2016).

Women in underdeveloped countries often have little information of cervical cancer and the need of screening as a preventative step. Screening programs are almost never available, and when they are, they are in capital cities, which are far from rural areas. (Eze- Oko et al., 2016). There is

presently no national cervical cancer screening program in Ghana (Opoku et al. 2016). Only 29.2 percent (136/442 participants) of individuals in the Gabonese research had heard of cervical cancer screening, according to the statistics. According to Assoumou et al (.2016), many women (68.1%) (84/128) had previously undergone a Pap smear test, and according to the various ladies, "the demand of their doctor" (69.1 percent, 56/82) was the main reason for doing so. According to Opoku et al. (2016), in Ghana, many women (n = 298, 98 percent) said they would seek cervical cancer screening if the facility provided screening services, whereas 12 (3 percent) said they would not screen under identical conditions. Most of the women (n=290, 97%) expressed excitement about getting a free cervical cancer screening. Many respondents (n=239, 82%) were willing to pay something for screening, although just 14 (4.7%) of the participants were female. 57 people (17%) were characterized as being price-sensitive and unwilling to pay.

57 individuals forming 19% were found to have a variable willingness to pay attitude. Furthermore, Eze et al. (2012) reported on women's knowledge about cervical cancer, its preventative nature, cervical screening, and screening facilities and found that all of them were below 50% and that the uptake of cervical screening was 0.9 percent with a variety of justifications given in Nigeria. These included lack of knowledge (62.5%), lack of nearby screening facilities (20.8%), cost (19.4%), and period (16.4 percent). 7.5% of women believed the test was just for married people, 5.8% were afraid of the possible outcome, 5.3 percent believed they were faithful and did not need the test, and 1.4 percent were certain they used herbal remedies for the illness. Absolute preparedness to be tested was shown by 62.5 percent.

2.6 Barriers to Cervical Cancer Screening

Ethnic groups, marital status, religion, age, educational level, and occupation are several elements that might affect women's awareness and understanding about cervical cancer. A study found that African women are much less knowledgeable about cervical cancer, especially in terms of prevention, early identification, and treatment. (Azam, 2016). The study found that a variety of sociodemographic factors, including level of education, location of residence, employment, religion and marital status, had an impact on certain Ethiopian women's attitude, awareness, behavior and knowledge. (Azam, 2016) Age, marital status, employment position, and educational attainment of women were shown to be significantly associated with their understanding of and sensitivity to cervical cancer in Nigeria. (Chinaka & Nwazue, 2013).

Higher educated women may have more information about cervical cancer than lower educated women, especially among tertiary students and health professionals. According to Shiferaw et al. (2016), women and students at universities were far more likely to recognize some cervical cancer risk factors. Additionally, it was proven that those HIV-positive women who were sampled for the study had considerably higher awareness of cervical cancer, with 72% of the study participants knowing about the disease. Because of their illness, individuals were more likely to be exposed to and engage with healthcare providers often (Shiferaw et al., 2016).

Cost, a lack of a value-guaranteed framework, the inaccessibility of or lack of training for pathologists as well as competing general healthcare demands, such as transferrable illnesses, are just a few of the challenges that low-income nations must overcome in order to adopt and put into place an effective screening program. In reaction to cervical cancer results in several studies conducted by various international health organizations, the Alliance for Cervical Cancer Prevention (ACCP) was founded. Alternative cytology approaches that were more suitable for

low-asset circumstances were supported by ACCP. (ACCP, 2011). The initiatives that came after were suitable for developing countries, turned out to be helpful, and significantly impacted the lives of many women. (Sherris et al., 2009). The fundamental misunderstanding among women in the US and the UK was that the Pap smear is a diagnostic test used to find cervical cancer and other reproductive health disorders that have already happened. According to the National Cancer Institute, (2005), most women failed to recognize that the Pap smear is a cervical screening treatment. Women believed that finding they had malignant cells indicated they would die soon and, according to research by Makin et al. (2011) Many women found learning more about cervical cancer to be uncomfortable and were reluctant to do so, despite the fact that it is fatal. (Austin et al. 2002). According to Byrd, et al, (2004), young Hispanic women reject screening because they do not want to disclose that they have engaged in sexual activity. Also, Sairafi and Mohamed (2009) said several women refused to participate in screening because they were concerned about becoming sick from the Pap smear test process. The main obstacles to cervical cancer screening, according to numerous studies, include worries about the potential consequences of the disease, shame, pain, and financial constraints, as well as the attitudes of medical professionals, a lack of convenient clinic hours, and a lack of female screeners. (Bessler et al. 2007).

Marlow, et al (2015) also cited worry, shame, feelings of uneasiness, a lack of time, the absence of clear indicators of illness, and a failure to perceive oneself as susceptible as barriers to screening for cervical cancer. The belief that screening for cervical cancer is done intentionally to detect cancer rather than prevent it, according to Abotchie and Shokar (2009), is the main obstacle to cervical cancer screening. Other concerns were fear that their spouses might restrict them from taking the exam (40.6 percent) and concern that the screening would be costly (23.2 percent), difficulties to locate a cervical cancer screening facility in the nation (24.3 percent), fear of being

perceived as unfaithful or spoiled (24.6 percent), and the incorrect assumption that it causes pain (24.6 percent) (9.4 percent). It has been decided that additional information about cervical cancer and screening protocols is essential to aid women in overcoming these disease-related hurdles. (Marlow, et al, 2015). Most females who have not had cervical cancer screening in Columbia are between the ages of 60 and 65. (Crawford, et al, 2016).

Furthermore, according to Bukirwa et al. (2015), barriers to cervical cancer screening include misconceptions that women who undergo screening will have their ovaries and wombs removed, fears of pain, exposure to the elements, and not being vulnerable to the disease, lack of periodic reminders, the possibility that they would need to stay at the medical institution for a long period while having the screening, and a lack of support and encouragement from the staff.

2.7. Summary of key gaps in Literature

This chapter provided support for the fundamental concepts forming the study's backdrop with evidence from recent literature. The essential concepts of cervical cancer, screening, Pap smear uptake, and variables involved with Pap smear uptake have all been well investigated. Some of the constraints found in the literature review are, not enough study has been made into the other obstacles to cervical cancer screening among women that are peculiar to Ghana although very few research have looked at these gaps. Also, most of the methods used for the literature above were qualitative study, which meant that many study participants were not recruited for the study. Other gaps identified in the literature review above includes lack of understanding about the cervical cancer disease, its early detection techniques, fear of the disease's stigma, spousal disagreement to screening, violating social and religious rules, and concerns about the intrusiveness of screening methods. In view of these, the study's rationale (see to 1.6) was given. The study methodology is described in the next chapter.

CHAPTER 3

3.0. METHODOLOGY

3.1. Introduction

The study's techniques and instruments are described in this chapter. It comprises, among other things, the research design, the study region, the study population, sampling strategies, data collecting instruments and methodologies, data processing and analysis, and ethical concerns.

3.2. Study Design

To evaluate the cervical cancer screening practices among women of reproductive age at the Marie Stopes Dansoman and Kokomlemle Clinics, the study used a descriptive cross-sectional design and a quantitative methodology. Given that a big population was the target of the study, the quantitative research approach was a good choice.

3.3. Study Location

Ayawaso Central and Ablekuma West Municipal.

The study was done at Marie Stopes Kokomlemle Clinic, which is in the Ayawaso Central Municipality. The Municipal is one of 261 Metropolitan, Municipal, and District Assemblies (MMDAs) in Ghana, and one of 29 MMDAs in the Greater Accra Region. The Kokomlemle district serves as the capital of the Ayawaso Central Municipal Assembly, which was created from the Accra Metropolitan Assembly. The study was conducted at Kokomlemle. Joy FM, as well as the Accra Technical Training Center (ATTC), are in Kokomlemle, a town in the Accra Metropolitan District, a district in Ghana's Greater Accra Region.

Kokomlemle is regarded as the Ayawaso Central Municipal District's capital city. Other communities including Newtown, Nima, and Asylum Down are also around it. The Ghanaian government inaugurated it together with five other legislatures on Tuesday, February 9, 2019.

According to the 2021 population and housing census, there are 94,831 people living in the Municipality, including 46,488 men and 48,343 women. White collar occupations are the major source of income in Kokomlemle, and they are traded for by a small group of individuals.

Christians make up most of the population, while Islam and traditional African faiths make up the minority.

Clinic Marie Stopes The study's site, the Dansoman Branch, is in the Ablekuma West Municipality. The Municipality is one of the Greater Accra Region's twenty-six (26) Metropolitan, Municipal and District Assemblies (MMDAs) and one of Ghana's two hundred and fifty-four (254) MMDAs. It was withdrawn from the Accra Metropolitan Assembly in 2017. Dansoman serves as the seat of government, and the Assembly was established by legislative document (2017) L.I.2309. The Municipal Assembly includes two Zonal Councils that operate outside of the Assembly structure.

The General Assembly has seventeen (17) members, comprising one (1) member of parliament, two (6) government appointees, and ten (10) elected members (Ablekuma West Constituency).

The Municipal Chief Executive, who is chosen by the President and confirmed by the General Assembly, serves as the political and administrative chief of the whole Municipality, while the Municipal Coordinating Director serves as the assembly secretary.

The Municipality is bordered to the north by the Ablekuma North Municipality, to the east by the Accra Metropolitan Area, and to the west by the Weija Gbawe Municipality. Moreover, to the south is the Gulf of Guinea. It has roughly 25 settlements with a population of 200,000 or more, covering a geographical area of about 15.01 sq. km.

According to the 2021 population and housing census, there are 153,490 people living in the Municipality, including 73,879 men and 79,611 women. Christians make up most of the population, while Muslims and traditional beliefs make up the minority.

The Municipality's economy is primarily driven by three sectors: industry, business, and agriculture, each of which have experienced substantial expansion. The presence of some firms, factories, financial institutions, estate developers, and other small businesses in the municipality is lucky.

At the Marie Stopes Clinics in Kokomlemle and Dansoman, the study was conducted. One of the biggest global providers of safe abortion services, sexual and reproductive health care, and contraception is Marie Stopes International (MSI). To support women and girl's empowerment by empowering them to prevent unexpected pregnancies and make decisions about their futures, they support a woman's right to make her own reproductive decisions and offer access to contraception and safe abortion services. Because of this, there are less unsafe abortions and preventable

incidences of maternal death and morbidity. MSI has a consistent commitment to assist communities with the greatest unmet need, offer equal access to services, and guarantee that our work is in line with a rights-based approach. Marie Stopes International (MSI), which has been active in Ghana since 2006, aims to make high-standard, affordable sexual and reproductive healthcare available to all.

Marie Stopes International operates 46 clinics in Ghana. The Greater Accra Region is home to 13 clinics in total, including 4 in the Ashanti Region, 5 in the Western Region, 6 in the Eastern Region, 7 in the Volta Region, 3 in the Northern Region, 1 in the Bono and Bono East Regions, and 3 in the Central and Upper East Regions.

Since then, MSI Ghana has grown to be among the leading providers of sexual and reproductive healthcare in the country, making sure that no one is left behind by expanding access for impoverished and disadvantaged populations.

They provide counseling services, including post-abortion care, in collaboration with the Ghanaian government and other partners to lessen the likelihood that any woman may have issues because of a miscarriage or unsafe abortion procedure. They offer a variety of temporary, long-term, and permanent types of contraception at their service locations. They also offer counseling to make sure that clients are aware of their lifestyle demands and preferences, as well as their eligibility for future pregnancies and medical requirements. Additionally, they offer services for sexual and reproductive health such fertility testing and counseling, STI testing, and cervical cancer screening.

3.4. Study Population

A systematic sampling method was used to select the respondents. Women who attended Marie Stopes International's Kokomlemle and Dansoman locations within the study's time frame and gave their agreement to be enrolled in the study made up the population that was used for the study. Participants in the research were women between the ages of 15 and 49 who were in the reproductive age range, with many of them falling between 18 and 35. These individuals were chosen because the prevalence of sexual activity among women in this age range puts them at higher risk of acquiring cervical cancer. This is because HPV infection is frequently associated with early onset of sexual behavior and having several partners, both of which are prevalent in this age range. (Faridi. et al, 2011)

3.5. Variables

The screening habits of women for cervical cancer were the dependent variable in this study. Women who had just undergone a pap smear examination served as a proxy for the trustworthy variable that was measured.

The following were the independent variables for this study:

Age, marital status, level of education, employment, and location are just a few examples of the women's sociodemographic traits.

women's level of awareness and education on cervical cancer and screening procedures.

the readiness of women to undergo cervical cancer screening, and Obstacles to using services for cervical cancer screening.

3.6. Sample Size Calculation

The study's sample size was calculated using Fisher's method. Only 28% of respondents in a comparable survey conducted in Agogo (kyeraa, 2019) reported having heard of cervical cancer, which was used by the Fisher's technique to establish the sample size for the research.

$$N = \frac{(Z\alpha/2)2 \times p(1-p)}{e^2}$$

N is the sample size, Z (z-score) is the reliability coefficient at 95% confidence interval (CI), P which is 28% or 0.28, is the estimated knowledge level on cervical cancer from the previous study, and e is the margin of error of 5%, which equals 0.05.

$$N = \frac{(1.96)2 \times 0.28(1-0.28)}{(0.05)2}$$

N= 310

310 x 0.1 = 31 after accounting for a 10% non-response rate.

Thus 310 + 31 = 341

Therefore, 341 women between the ages of 15 and 49 who visited the Kokomlemle and Dansoman branch of the Marie Stopes clinic throughout the study's period comprised the determined sample size that was employed for the study.

3.7 Data Collection Tools and Techniques

Using data collection techniques, we may carefully compile information about the people, objects, and occurrences that make up our study subjects as well as the settings in which they occur. When acquiring data, we must be systematic. If data are acquired randomly, it will be difficult to offer a conclusive solution to our study's questions. (Lobe et al, 2020). There are several methods for

gathering data, such as using secondary data, observation, face-to-face interviews, distributing written surveys, focus group talks, etc.

A structured questionnaire was the method and instrument for data collection employed in this investigation. This is because data collected through this method is easy to compile for immediate analysis. The study goals served as the foundation for the questionnaire's design. Both open-ended and closed-ended questions were included. In contrast to open-ended questions, which had no answer possibilities, close-ended questions contained response options from which respondents may select appropriate responses. This was done to provide respondents the freedom to express themselves freely. Age, marital status, educational background, religion, place of residence, and parity were among the sociodemographic details covered in the questionnaire. Thirty

four items were used to measure awareness and knowledge level, as well as screening practices in all. six items looked at the source of the information of cervical cancer to the women. Seven questions on perception. The questions on women perception about cervical cancer screening included, if women have been screened before if not what the reasons for are not being screened, the reasons were, if the procedure is painful, cost of treatment, outcome of results, fear of stigmatization, spousal disapprovement and the results leading to marital separation.

The criteria for assessing proportion of women screened looked at who recommended the screening to them, the duration, cost, review dates, confidentiality, and provision of privacy of cervical screening services. The frequency of screening they have done, staff attitude and how they felt about the screening procedure.

To evaluate the accessibility of the screening services to women, the following questions were probed; How far was the screening center from residence? How will they rate the distance from their residence to the screening center? What was the means of transport from their home to the screening center? If by public transport, how much do they spend for transport from their home to the screening center. How do they consider the cost of transport to the facility? The questionnaire was read, interpreted, and explained by four research assistants in a language that the respondents could understand. For individuals who could not read or comprehend English, they were also taught how to check or write the correct response on behalf of the participants. To ensure accurate responses, the questionnaires were only given to those who could read and write in English.

3.8. Pretesting

The New Cross Clinic in Nima pretested a sample of the questionnaire. Nima, a residential neighborhood in the Ayawaso Central Municipality, was chosen because its residents had sociodemographic traits in common with those of Dansoman and Kokomlemle.

3.9. Data Analysis

Data for the study that was gathered in the field was carefully handled. After checking the completed questionnaires for mistakes and consistency, each one was coded before being entered into Excel. Data cleaning and analysis were performed once the data was loaded into STATA version 17 software. Descriptive statistics were used to characterize continuous data, such as age, and they were reported as means and standard deviations, while categorical variables were

expressed as percentages and frequencies. Chi square (x2) analyses were performed to determine the association between dependent and independent variables under the study. Logistic regression was used to determine the simple relationship between the outcome variable and each of independent variable. The strengths of the associations were determined with multiple logistic regressions. Socio demographic characteristics were included into regression model to control confounding. Inferences were made with 95% confidence interval with 5% error margin and p value <0.05. The results were presented in frequency and cross tabulation tables.

3.10. Quality Control

Four research assistants underwent training on the ethics of administering questionnaires, how to properly introduce themselves to participants to build rapport, and how to walk them through the purpose of the study to ensure the validity and reliability of the data that was collected. Additionally, the research assistants were directed to accurately translate the questions from English into the local dialect to ensure that the questions' intended meaning was maintained and that participants gave proper answers.

3.11. Ethical Consideration

Ethical issues in research ensure that no harm is done to participants because of a research study. Ethical approval with ID No. GHS-ERC 046/09/22 was obtained from the Ghana Health Service Ethical Review Committee (GHSERC).

The approval letter received from GHSERC was sent to Marie Stopes International to seek permission before the commencement of data collection.

Furthermore, the participants were informed of the study's goal, the promise of confidentiality and privacy, and the ability to withdraw at any moment.

Informed consent forms were obtained from the participants before data collection was done. The names and other identifying data of the participants were not collected to ensure anonymity of the data collected.

CHAPTER 4

4.0. RESULTS

4.1. Introduction

This chapter contains a presentation of the study's findings. The results of a structured questionnaire given to 335 women between the ages of 15 and 49 are described in this chapter. The response rate for this study was 100%. Tables are used to display the findings. This chapter is divided into subsections, which cover topics such as the sociodemographic characteristics of research participants, knowledge of cervical cancer and cervical cancer screening, sources of cervical cancer information, and risk factors for cervical cancer. Obstacles and plans for cervical cancer screening. This chapter also discusses the relationships among the major independent factors and knowledge and awareness of cervical cancer.

4.2. Participants Socio-Demographic information in the Study

The respondents' sociodemographic information is shown in Table 1. The ages of the respondents ranged from 15 to 49 years old, with a mean of 27.6 years and a standard deviation of 6.069 years. Most of the respondents 189 (55.9%) were aged between 20 to 29 with 95 being participants from Kokomlemle and 94 being participants from Dansoman. Cohabiting respondents made up the same number of respondents as those who were married (35.0%) from both clinics. 100 participants from Dansoman had between 1 to 4 kids while 149 participants from Kokomlemle also had 1 to 4 kids, making them the majority (74.6%). Regarding respondents' educational backgrounds and occupation, Dansoman had the highest number of educated participants, (156) as against

Kokomlemle that had 148 educated participants, a total of 9.3 percent had no formal education. Twenty-Eight-point one percent (28.1%) of the participants from Dansoman were employed and 23.3% of the participants from Kokomlemle were also employed. This shows that, the number of participants who were employed in Dansoman was greater than those employed in Kokomlemle. Eighty-six-point two percent (86.2%) of respondents from both clinics identified as Christians, while 80.2 percent of respondents forming the majority were Akan.

Table 1: Socio-demographic Information about Participants (N=335)

Information	**Frequency (%)**		**Total**
Category of Age.	**Dansoman**	**Kokomlemle**	
15 – 19	28 (56.0)	22 (44.0)	50 (100)
20 – 29	94 (49.7)	95 (50.3)	189 (100)
30 – 39	30 (49.2)	31 (50.8)	61 (100)
40 – 49	15 (42.9)	20 (57.1)	35 (100)
Marital Status			
Single	41 (49.4)	42 (50.6)	83 (100)
Married	60 (50.8)	58 (49.2)	118 (100)
Co-habitation	58 (49.6)	59 (50.4)	117 (100)
Divorced	3 (33.3)	6 (66.7)	9 (100)
Widowed	3 (37.5)	5 (62.5)	8 (100)
Educational Level			
Illiterate	20 (64.5)	11 (35.5)	31 (100)
Primary	30 (50.8)	29 (49.2)	59 (100)
JHS	70 (50.3)	69 (49.7)	139 (100)
SHS	36 (50.0)	36 (50.0)	72 (100)

Tertiary	20 (58.8)	14 (41.2)	34 (100)
Occupation			
Unemployed	60 (42.8)	80 (57.2)	140 (100)
Self-employed	70 (47.6)	77 (52.4)	147 (100)
state employed.	18 (51.4)	17 (48.6)	35 (100)
Student	7 (53.8)	6 (46.2)	13 (100)
Number of Children			
None	30 (54.5)	25 (45.5)	55 (100)
1 – 4	100 (40.2)	149 (59.8)	249 (100)
5 or more	15 (48.3)	16 (51.6)	31 (100)
Religion			
Christian	108 (37.5)	180 (62.5)	288 (100)
Muslim	20 (47.6)	22 (52.4)	42 (100)
Traditionalist	5 (100)	0 (0.0)	5 (100)
Ethnicity			
Akan	170 (63.4)	98 (36.6)	268 (100)
Ga	10 (62.5)	6 (37.5)	16 (100)
Ewe	8 (61.5)	5 (38.4)	13 (100)
Others	18 (47.3)	20 (52.7)	38 (100)

4.3. Cervical cancer Awareness and Screening.

Only 20.4% (133) of 335 participants, as shown in Table 2 below, reported having heard about cervical cancer, with the vast majority of 202 respondents (79.6%) stating they had never heard of the disease. When asked about their understanding of cervical cancer screening, 79 of the

participants who knew of the condition knew that it could be checked for. The Pap smear test was mentioned as a screening method known by 18.7% of 133 participants who had heard of screening for cervical cancer, and 2.1 percent mentioned that screening might be carried out using herbal remedies, even though 79.2 percent of the of participants did not know any of screening techniques.

Many respondents (85.4%) who were asked where screening might be done provided the names of hospitals and clinics instead of their actual locations. Greater Accra Regional Hospital and Korle Bu Teaching Hospital were cited as locations for cervical cancer screening by 4.1% and 2.1% of respondents, respectively.

Table 2: Cervical Cancer Awareness and Screening (N=335)

Responses	**Frequency (%)**		**Total**
knows of cervical cancer	**Dansoman**	**Kokomlemle**	
Yes	69 (61.1)	44 (38.9)	113 (100)
No	116 (52.2)	106 (47.8)	222 (100)
Heard of cervical cancer screening			
Yes	62 (54.8)	51(45.2)	113 (100)
No	105 (47.3)	117 (52.7)	222 (100)
Known Cervical cancer screening methods.			
Pap smear	35 (58.3)	25 (41.7)	60 (100)

VIA	18 (54.5)	15(45.5)	33 (100)
No Idea	10 (50.0)	10 (50.0)	20 (100)
Cervical Cancer Screening point			
Hospital/clinic	24 (57.1)	18 (42.9)	42 (100)
Herbal clinic	3 (60.0)	2 (40.0)	5 (100)
GARH	20 (57.1)	15(42.9)	35 (100)
KBTH	14 (53.8)	12(46.2)	26 (100)
No idea	2 (40.0)	3 (60.0)	5 (100)

4.4 Knowledge about Cervical Cancer

Table 3 provides comments about the level of knowledge about cervical cancer. The level of knowledge was assessed based on the responses given about cervical cancer prevention, risk factors, causes, indicators, and symptoms, as well as preventive and treatment options. Responses to these questions were graded, with one representing excellent knowledge and 0 representing inadequate knowledge. One point was given for good understanding for the risk factors questions, three points for the signs and symptoms questions, and one point for the preventative measure's questions. These cutoffs were established based on fundamental knowledge about cervical cancer.

Among the 113 responders, only 25.0% had a thorough understanding of cervical cancer. HPV was cited as the primary cause of the illness by 30.1% of those studied, even though majority of participants (34.5%) had no idea what the true cause of cervical cancer was.

Cervical cancer impacts the reproductive system, according to 30.9 percent of respondents, while the cervix was mentioned by 13.2 percent. Some responses mentioned the breast and the neck. This information is shown in table 3 below.

At least three symptoms could be accurately described by 35.3% of respondents, while at least four cervical cancer risk factors could be correctly mentioned by 23.5% of respondents. Only 19.1% of respondents correctly named three or more preventative measures, even though 56.6 % of respondents believed cervical cancer could be avoided and 46.9 % of respondents believed cervical cancer could be cured.

Table 3: Knowledge about cervical cancer. (N=113)

Responses	**Frequency (%)**		**Total**
Cervical cancer causes.	**Dansoman**	**Kokomlemle**	
Infection	15 (60.0)	10 (40.0)	25 (100)
Herpes simplex virus	10 (66.6)	5 (33.4)	15 (100)
HPV	24 (70.6)	10 (29.4)	34 (100)
No idea	20 (51.2)	19 (48.8)	39 (100)
Known cervical cancer risk factors.			
Early sexual behavior	6 (37.5)	10 (62.5)	16 (100)
Smoking	5 (50.0)	5 (50.0)	10 (100)
Several sexual partners	10 (52.6)	9 (47.4)	19 (100)
Other STDs	16 (57.1)	12 (42.9)	28 (100)

Multiparity	8 (53.3)	7 (46.7)	15 (100)
Douching	5 (50.0)	5 (50.0)	10 (100)
Witchcraft	2 (40.0)	3 (60.0)	5 (100)
unfaithfulness	5 (50.0)	5 (50.0)	10 (100)

cervical cancer signs and symptoms	**Dansoman**	**Kokomlemle**	
bleeding intermittently	13 (61.9)	8 (38.1)	21 (100)
bleeding post menopause	7 (41.2)	10 (58.8)	17 (100)
unexpected vaginal discharge	7 (41.2)	10 (58.8)	17 (100)
Painful intercourse	12 (54.5)	10 (45.5)	22 (100)
Bleeding after intercourse	10 (38.4)	16 (61.6)	26 (100)
Other	5 (50.0)	5 (50.0)	10 (100)
Woman of reproductive age can acquire it.			
Agree	40 (57.1)	30 (42.9)	70 (100)
Disagree	10 (55.6)	8 (44.4)	18 (100)
No idea	15 (60.0)	10 (40.0)	25 (100)
Cervical cancer preventable			
Yes	40 (62.5)	24 (37.5)	64 (100)
No	10 (50.0)	10 (50.0)	20 (100)
No idea	19 (65.5)	10 (34.5)	29 (100)

Cervical cancer Preventive measures			
Vaccination	8 (61.5)	5 (38.5)	13 (100)
Early screening	10 (55.6)	8 (44.4)	18 (100)
Refraining from early sex	13 (56.5)	10 (43.5)	23 (100)
Safe sex practice	14 (53.8)	12 (46.2)	26 (100)
Avoiding smoking	10 (76.9)	3 (23.1)	13 (100)
Sacrifices / Prayers	10 (50.0)	10 (50.0)	20 (100)
Cervical cancer is treatable.	**Dansoman**	**Kokomlemle (%)**	**Total**
Yes	33 (62.2)	20 (37.8)	53 (100)
No	20 (57.1)	15 (42.9)	35 (100)
No idea	15 (60.0)	10 (40.0)	25 (100)
Options for treatment			
Oral medication	12 (44.4)	15 (55.6)	27 (100)
Surgery	13 (56.5)	11 (43.5)	23 (100)
Radiotherapy	7 (50.0)	7 (50.0)	14 (100)
Herbal treatment	6 (46.2)	7 (53.8)	13 (100)
Prayers	17 (62.9)	10 (37.1)	27 (100)
No idea	5 (55.6)	4 (44.4)	9 (100)
Body Part Affected			
Cervix	18 (48.6)	19 (51.4)	37 (100)
Womb	12 (50.0)	12 (50.0)	24 (100)
Breast	4 (66.7)	2 (33.3)	6 (100)
Vagina	3 (37.5)	5 (62.5)	8 (100)
Neck	2 (100)	0 (00.0)	2 (100)

Abdomen	1 (33.3)	2 (66.7)	3 (100)
Rep. system	8 (42.1)	11 (57.9)	19 (100)
No Idea	8 (57.1)	6 (42.9)	14 (100)

4.5 Information sources used to get data about cervical cancer.

Table 4 lists the respondents' different sources and how they learnt about cervical cancer. When respondents with knowledge of cervical cancer were asked to name more than one informational source, the majority (48.7%) chose the media (radio, TV, and internet), followed by friends and peers (21.2%), healthcare professionals (19.5%) and teachers (6.2%). The informational sources obtained from family members was less than 5% of respondents selected.

Table 4. Information sources used to get data about cervical cancer. (N=113)

Responses	Frequency (%)		Total
	Dansoman	Kokomlemle	
Media	30 (54.5)	25 (45.5)	55 (100)
Relatives	3 (60.0)	2 (40.0)	5 (100)
Healthcare providers	12 (54.5)	10 (45.5)	22 (100)
Friends	10 (41.7)	14 (58.3)	24 (100)
Teacher	3 (42.8)	4 (57.2)	7 (100)

4.6. Utilization of and Intent to Use Cervical Cancer Screening.

The findings were acquired and reported in table 5, with GARH and KBTH acting as the venues for the screenings, respectively. Only 30.1% of the 113 participants who said they were aware of cervical cancer had ever undergone a screening for the disease. They made the decision to be checked because they had received advice to do so from media experts and health professionals, and they wanted to know how they were doing. The respondents' replies when asked if they

intended to go through the screening varied: 49.4% indicated they did, contrasted to 50.6 percent who said they either did not plan to or hadn't made up their minds. Table 5 lists the numerous justifications given by respondents who did not intend to or had not taken the decision to seek treatment for cervical cancer.

Table 5: Utilization of and Intent to Use Cervical Cancer Screening (N=113)

Responses	**Frequency (%)**		**Total**
cervical cancer screening within a year	**Dansoman**	**Kokomlemle**	
Yes	20 (58.8)	14 (41.2)	34 (100)
No	40 (50.6)	39 (49.4)	79 (100)
Screening center			
GARH	18 (47.3)	20 (52.7)	38 (100)
KBTH	16 (50.0)	16 (50.0)	32 (100)
No Idea	22 (51.1)	21 (48.9)	43 (100)
intention to do a cervical cancer screening.			
Yes	20 (51.2)	19 (48.9)	39 (100)
No	20 (50.0)	20 (50.0)	40 (100)

4.7. Cervical Cancer Screening Uptake Obstacles

Responses of participants who were asked to state some of their reasons or what they saw to be the obstacles to doing so are also included in Table 6. Fifty-four-point one percent (54.1) % of the participants from the Kokomlemle clinic and 45.9% of the participants from Dansoman clinic said

lack of knowledge was the main obstacle to cervical cancer uptake. 51.7% of the participants from Dansoman and 49.3% of the participants from Kokomlemle said access was the main obstacle to their uptake of cervical cancer screening. 50% of the participants from Kokomlemle and 50% from the Dansoman clinic all said they had not screened for cervical cancer because a medical professional had not requested it.

Table 6: Cervical cancer Screening uptake Obstacles. (N=335)

Responses	Frequency (%)	Total

Obstacles to Screening	*Dansoman*	*Kokomlemle*	
lack of knowledge	28 (45.9)	33 (54.1)	61 (100)
not having access	15 (51.7)	14 (48.3)	29 (100)
Screening cost	16 (51.6)	15 (48.4)	31 (100)
Health workers behavior	11 (57.8)	8 (42.2)	19 (100)
Feeling timid	20 (64.5)	11(35.5)	31 (100)
Partner objection	6 (46.2)	7 (53.8)	13 (100)
Unavailability	10 (40.0)	15 (60.0)	25 (100)
Gender of provider	7 (53.8)	6 (46.2)	13 (100)
Societal disapproval	10 (50.0)	10 (50.0)	20 (100)
Feeling healthy	12 (50.0)	12 (50.0)	24 (100)
Fear of test results	15 (51.7)	14 (48.3)	29 (100)
Not requested by clinician	20 (50.0)	20 (50.0)	40 (100)

4.8. The Relationship Between Cervical Cancer Screening Knowledge and the Various Independent Variables.

Multivariate analysis was used as the suitable measure of significance at 95% Confidence Interval (CI) to further investigate the relationship between respondents' awareness of cervical cancer screening and the various independent variables of the research. After accounting for confounders, age, marital status, parity, religion, and ethnicity were statistically insignificant in determining the level of awareness of cervical cancer and its screening practices but the respondents' level of education and occupation were statistically significant in determining their awareness of cervical

cancer screening, with a P-value of 0.001 and 0.000 respectively at a 95% CI and a 5% margin of error.

Table 7: The Relationship Between Cervical Cancer Screening awareness and Participants Sociodemographic Characteristics.

Variable	Total (N=335) %	Knowledge of CCS (N)%	No knowledge of CCS (N)%	P-Value
SOCIO-DEMOGRAPHICS				
Age (years)				**0.112**
15-19	50 (14.9)	14 (12.4)	36(16.2)	
20-29	189(56.4)	55(17.7)	134(60.4)	
30-39	61 (18.2)	20(46.7)	41(18.5)	
40-49	35(10.5)	24(21.2)	11 (4.9)	
Marital status				**0.262**
Single	69 (27.9)	15(16.7)	54 (24.3)	
Married	72(50.7)	50 (66.7)	22 (9.9)	
Co-habitation	96 (8.7)	24(0.0)	72 (32.4)	
Separated	55(7.1)	14 (5.6)	41 (18.5)	
Widowed	43 (5.6)	10 (11.0)	33 (14.9)	
Educational level				**0.001**
No formal education	69 (20.6)	20 (17.7)	49 (22.1)	
Primary	45 (13.4)	13 (11.5)	32(14.4)	
JHS	56 (16.7)	23 (20.4)	33 (14.9)	
SHS	80 (23.9)	26 (23.0)	54(24.3)	
Tertiary	85 (25.4)	31 (27.4)	54 (24.3)	
Occupation				**0.000**
Unemployed	75(22.4)	30(26.5)	45(20.3)	
Self-employed	100(29.8)	28(24.8)	72(32.4)	
Government employed.	95 (28.4)	35(30.9)	60(27.0)	
Student	6519.4)	20(17.7)	45(20.3)	

Number of kids				**0.427**
None	100(29.8)	37(32.7)	65(28.4)	
1 – 4	150(44.8)	40(35.4)	110(49.5)	
5 and over	85(25.4)	34(30.9)	51(22.1)	
Religion				**0.588**
Christian	185(55.2)	60(53.1)	125(56.3)	
Muslim	120(35.8)	30 (26.5)	90(40.6)	
Traditionalist/other	30(9)	23(20.4)	7(3.1)	
				0.311
Ethnic Group				
Akan	115(34.3)	41(36.2)	74(80.0)	
Ga	102 (30.5)	22(19.5)	80(33.3)	
Ewe	50 (14.9)	27(23.9)	23(10.4)	
Others	68(20.3)	23(20.4)	45(20.3)	

After a multivariate analysis using Chi- Square and accounting for confounders, Table 8 below on the relationship between knowledge of cervical cancer and cervical cancer screening and access to information and services revealed that with a P-value of 0.011, the respondents' access to information and services were statistically significant in determining their level of awareness of cervical cancer and cervical cancer screening.

Table 8: Relationship between Knowledge of Cervical Cancer Screening and Access to Information and Services.

Variable	**Total N= 335(%)**	**Knowledge N=113 (%)**	**No knowledge N=222 (%)**	**P-value**
HAVING ACCESS TO SERVICES AND INFORMATION				**0.011**
Yes	111(33.1)	37(32.7)	74(33.3)	
No	224(66.9)	76 (67.3)	148(66.7)	

Table 9 presents the multivariate analysis of the relationship between knowledge of cervical cancer screening and Screening Intentions, after accounting for confounders, with a P-value of 0.904 at 95% Cl, the findings from Table 9 below showed that there was no correlation between respondents' intentions to test for cervical cancer and their knowledge and awareness of the disease's screening techniques.

Table 9: Relationship between Knowledge of Cervical Cancer Screening and Screening Intentions.

Variable	**Total N=335 (%)**	**Knowledge of CC N=113 (%)**	**No knowledge of CC N=222 (%)**	**P-value**
AIM TO CONDUCT CERVICAL CANCER SCREENING				**0.904**
Yes	90(26.9)	30(26.5)	60(27.0)	
No	245(73.1)	83(73.5)	162(73.0)	

CHAPTER 5

5.0 Discussion on Findings

5.1 Introduction

The study's results are discussed in this chapter considering the study's goals and major factors. The Ghana Demographic Health Survey 2021 reported that more than half of Ghana's population is under the age of 30, which is consistent with the study's findings that most respondents were between the ages of 20 and 29. Majority of the respondents had only completed junior high school, while a sizeable percentage had no formal education. This may have helped to explain the respondents' poor grasp of the condition, since women with higher educational levels are more likely to comprehend cervical cancer and associated screening protocols.

5.2 Women's Level of Awareness and Knowledge Around Cervical Cancer and Screening

Better healthcare seeking habits for services linked to cervical cancer prevention and treatment results from more public awareness of the disease. The study's conclusions indicated that little is known about cervical cancer and cervical cancer screening. The percent of the respondents who knew something about cervical cancer was 20.4%. As a result, just 133 out of the 335 respondents knew about cervical cancer and its screening procedures. In a similar vein, little was known about cervical cancer screening. Thus, even though 48 out of the 133 respondents who claimed to be knowledgeable about cervical cancer said they were aware of the services available for cervical cancer screening, most of them had no idea of the various screening methods or the precise places where cervical cancer screening might be done. This outcome is consistent with prior research

conducted in Ethiopia that showed that women's awareness of cervical cancer screening was insufficient. (Mulatu et al. 2017),

Media outlets, including television stations, radio stations, and internet sources, were cited as the primary source of knowledge about cervical cancer by 73.5 percent of the respondents, while 25 percent named health providers. Most of the women evaluated in earlier research by Getahun et al. (2013) and Modibbo et al. (2016) learnt about cervical cancer via the media. This contrasts with research conducted in Ethiopia by Shiferaw et al., (2016), wherein health professionals served as the primary information source for women recruited from healthcare facilities. This may imply that medical staff at Marie Stopes International aren't doing much to educate their patients about cervical cancer and its preventative services. Providing their clients with correct information on a range of health conditions is one of the main responsibilities of health service providers. Inadequate health education programs, poorly designed healthcare facilities, limited access to health care services for rural inhabitants, a lack of experience, and a general lack of public awareness may affect how successfully these crucial tasks are carried out. (Azam, 2016). Additionally, this study found that health care workers' knowledge, abilities, and key involvement in health education have a significant influence in affecting women's understanding about cervical cancer. When contemplating ways and tactics to alert women about cervical cancer, these findings are extremely important. Since most material in the media cannot always be verified, it is also important to guarantee that the information being provided is accurate.

Numerous studies have consistently shown that women's attempts to prevent the illness are substantially influenced by their level of information about cervical cancer (Azam, 2016). However, there is a lack of knowledge among women in the country on the risk factors, causes, indications, prevention, as well as treatment for cervical cancer (Binka et al., 2017). Few women

who attend the Dansoman and Kokomlemle branches of Marie Stopes International had a high degree of understanding of the illness, according to the study's findings, which demonstrate that just 17 participants who had awareness about cervical cancer had strong knowledge of the problem. The study's findings are in line with observations in the literature indicating Sub-Saharan African women have poor levels of knowledge and awareness about cervical cancer (Ebu et al, 2015; Shiferaw et al, 2016).

Knowing the causes and risk factors for cervical cancer is essential for women to seek preventive measures. Only 10.3 percent of those surveyed agreed that HPV was the real cause of the illness, which is comparable to a study conducted in Lagos in Nigeria where 8% cited the human papilloma virus as the cause. Most responders were unsure of what the disease's real etiology was (Idowu et. al., 2016). The reproductive system was mentioned, but most of the respondents did not even know the specific body area that had been affected. shockingly, several respondents identified the neck and breast as the body parts that were affected by cervical cancer. This demonstrates that breast cancer has received more attention than cervical cancer (Adanu, 2013). Study respondents who identified having early sex, having numerous sexual partners, having other STIs, douching and smoking as the various risk factors were 39.8%. Only 23.5% of the study respondents correctly recognized at least four risk factors, even though some respondents also named witchcraft, curses, and adultery as cervical cancer risk factors. At least three of cervical cancer symptoms, including unpleasant vaginal discharges, bleeding after sexual activity, painful sexual activity, and bleeding after menopause, were accurately identified by 35.3 percent of respondents. Additionally, several responders accurately recognized back discomfort, stomach pain, and urine issues as signs of cervical cancer. According to Adanu. (2015) and Binka et al. (2017), the lack of thorough education or enlightenment on the disease among women in Ghana is the cause of the lack of

insight about cervical cancer and its screening protocols. This contrasts with research on other diseases including breast cancer, HIV, and malaria. etc.

Although they lacked knowledge, most of respondents thought that any woman of reproductive age may be affected by cervical cancer. Most of the women also agreed that the condition could be prevented and treated, but only 19.1 percent of the respondents could correctly list at least three preventive measures. Vaccination of young females who are not sexually active yet, early screening, avoiding early sexual engagement, participating in safe sex, and stopping smoking are all examples of preventive measures. Majority of the participants also thought that prayer could help treat or prevent cervical cancer. Women's lack of knowledge about cancer of the cervix may lead to a low acceptance of screening programs, resulting in a delay in disease detection and treatment. This is consistent with other studies that show women will be more willing to receive cervical cancer screening if they are informed and aware of the condition. (Interis, et al, 2015). Therefore, a comprehensive plan is required to inform and sensitize women of reproductive age within the districts of Ayawaso Central and Ablekuma West on cancer of the cervix and its screening measures. Primary health professionals may do this by delivering thorough information on cervical cancer and related screening procedures at the many clinics and hospitals in both districts, including the general OPD, Antenatal, Postnatal and Child Welfare Clinics. Additionally, public outreach initiatives might be launched to provide information on cancer of the cervix to residents' doorsteps by using messaging that the general population could readily grasp, enhancing a more accurate and thorough awareness of the disease (Momberg et al., 2017). Like this, effective media interventions might be made through radio, television, the internet, flyers, posters, and newspapers, among other channels. In Ghana, women do not get the same level of education or

sensitization about cervical cancer as they do about other disorders like breast cancer, malaria, and HIV. This results in women having a better understanding of the disease.

5.2 Uptake and Intention to screen for Cervical Cancer

According to the study's findings, relatively few women who visit Marie Stopes International branches in Dansoman and Kokomlemle have ever had their cervical cancer checked at GARH or KBTH. Only 11.4% of those polled said they had. This is much less than studies conducted in Ethiopia, and Agogo, where 14.8%, and 15.3 percent of people had taken up screenings (Mulatu et al., 2017; Ziba et al., 2015). Furthermore, Ndejjo et al. (2016) observed that just 4.8 percent of respondents in rural Uganda had ever received cervical cancer screening, indicating a limited adoption of the procedure there. Their reason was, they followed the advice of a medical specialist to examine their situation. Rural Ugandan studies found the same thing. (Ndejjo,et al, 2016).

According to the findings of the study, the key reason affecting most of the respondents' decision to forego cervical cancer screening was a lack of information of the illness and its screening. As a result, the level of women's understanding of the condition has a considerable impact on the acceptance and efficacy of cervical cancer screening. (Azam, 2016).

5.4 Obstacles to the Screening for Cervical Cancer

Absence of screening services, excellent health, unwillingness to display their external female reproductive genitalia to strangers, and fear of test results are just a few of the perception-related problems that respondents described as having an impact on the usage of screening services. Similar challenges have been noted in other regions (Ndejjo et al., 2016). This lack of understanding of screening programs was evident in all these difficulties, which has been supported by prior studies (Hasahya et al., 2016). Two key barriers to adoption include a lack of official policies or programs for cervical cancer screening, as well as a scarcity of screening facilities in Ghana and other impoverished

countries. They are not easily placed in the districts since most screening facilities are found in regional hospitals in regional capital cities. (Ziba; Adanu 2013)

According to the study's findings, using bivariate analysis to measure significance, respondents' educational background, employment status, and resource availability all have a statistically significant role in predicting their knowledge of cervical cancer and screening practices, for a P-value of 0.01, 0.00, and 0.00 respectively. Higher educated women are more likely to be aware of and choose to get screened for cervical cancer. This may be because these women have access to both print and electronic media for information. This is similar with previous research carried out in Ethiopia among HIV-positive women and educated women, which discovered that women with greater levels of education or access to the health system had lower rates of infection. were more likely to be conscious of cervical cancer and screen for it (Shiferaw et al., 2016; Adanu, 2013)

Women's screening behaviors in our nation's districts have not only been the focus of prior research, but also been studied broadly. By promoting the screening practices of cancer of the cervix among women in the districts through deliberate interventions, the comparatively high cervical cancer prevalence rate in the Greater Accra Region may be decreased.

CHAPTER SIX

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS.

6.1. Summary of Findings

The research examined screening practices of cancer of the cervix among women of reproductive age in the districts of Ayawaso Central and Ablekuma West. A standardized questionnaire was used to interview 335 women in total and gather their responses, which were then evaluated.

The following is a list of the study's main conclusions.

1. According to the study, the participants had little understanding about cancer of the cervix and its screening practices. The majority of those studied had not heard of cervical cancer. In addition, individuals who were aware of cervical cancer did not have a thorough awareness of the etiology, risk factors, clinical manifestations, preventative measures, and available treatments.

2. According to the study, respondents, said, television, radio, and the internet were their primary sources of knowledge on cervical cancer, including information about screening.

3. The study also found that very few responders had screened for cervical cancer.

4. The study also revealed that the study participants faced obstacles to cervical cancer screening.

6.2. Conclusion

Cervical cancer has a greater impact on women and their families in Ghana and Sub-Saharan Africa as a whole. The study identified large information gaps that exist among women about both

cervical cancer and cervical cancer screening, which has a detrimental influence on the uptake of screening, prompt diagnosis, and early treatment measures. The respondents' lack of knowledge regarding screening services' availability in the area was the major impediment to screening for cervical cancer within the municipality, but the study also identified additional obstacles. These elements might all have had a role in the poor uptake rate of cervical cancer screening. It's critical that these women receive enough knowledge regarding the risk factors, causes, symptoms, prevention, consequences, and treatments of the illness to boost their motivation to take up cervical cancer screening.

6.3. Recommendation

Based on this study's findings, stakeholders should work more closely together to help women in the districts and the entire country learns more about cervical cancer and its screening practices. To contribute to lowering the disease's high incidence and death rates. These subsequent suggestions must be considered in this regard.

1. Health professionals working in both districts' healthcare facilities should be required by their District Health Directorates to include thorough and intensive cervical cancer education at their various public health units as well as at clinics like the general OPD, at Antenatal, Postnatal and Child Welfare Clinics.
2. The District Health Team should regularly launch community outreach programs to educate district residents, particularly women, about cervical cancer and its screening practices. These programs must use locally understood languages and messages to help people understand cervical cancer more accurately.

3. The District Health Team in both districts should also launch strategic media interventions to increase public awareness, including through posters, internet, radio, television, and newspapers, among other mediums.
4. To urge women to have regular cancer of the cervix screening, the District Health Directorate should establish adequate cervical screening facilities within their districts and frequently schedule outreach and screening events at locations like hospitals and clinics, schools and markets, and schools throughout the municipality and the region.

5. Lastly, Ghana should develop a National Cervical Cancer Prevention and Education Policy or Program and urge the Ministry of Health and the Ghana Health Service to collaborate of Women's Health NGOs and International Organizations to set up more centers for screening Cancer of the cervix nationwide around. To encourage regular health education on the importance of screening for cancer of the cervix and the disease itself for women within health facilities nationwide.

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APPENDIX A

QUESTIONNAIRE

SCHOOL OF PUBLIC HEALTH
UNIVERSITY OF GHANA

Dear Respondent,

I am Barbara Dede Sasraku, a Master of Public Health student from the School of Public Health, University of Ghana. I am conducting research on **"Cervical Cancer Screening Practices Among Women attending Marie Stopes Clinics at Kokomlemle and Dansoman, Greater Accra Region."** in partial fulfillment for the award of a Master of Public Health degree.

I therefore solicit your cooperation to complete the questionnaire. This is purely an academic work and the information provided will be treated with maximum confidentiality. No part of the information will be disclosed without prior consent from you.

Respondent No……...

INSTRUCTION (INTERVIEWER): Please tick (√) the chosen answer(s).

QUESTIONNAIRE NUMBER……

SECTION A. BACKGROUND CHARACTERISTICS OF RESPONDENTS

1. Age …… years

2. Level of Education

- No formal education [ ] Primary [ ] J.H.S [ ] Secondary level [ ] Tertiary [ ] Other (specify)……..

3. Occupation

- Unemployed [ ] Self-employed [ ] Government employed [ ]

House wife [ ] Others (specify)…….

4. Marital status

- Single [ ] Married [ ] Co-habitation [ ] Separated/divorced [ ] Widowed [ ]

5. Number of children

- None [ ] 1 –4 [ ] 5 and more [ ]

6. Religion

- Christian [ ] Muslim [ ] Traditionalist [ ] Others (specify)…….

7. Ethnicity

- Akan [ ] Ga [ ] Ewe [ ] Frafra [ ] Others (specify) ……

8. Place of residence (specify) ……

SECTION B. KNOWLEDGE AND AWARENESS ON CERVICAL CANCER AND CERVICAL CANCER SCREENING.

9. Have you ever heard about cervical cancer?

- Yes [ ]
- No [ ]

10. If yes, from where? Select all that apply

- Health worker [ ]
- Radio/ TV/ Internet [ ]

- Family members [ ]
- Friends/peers [ ]
- Others (specify)…….

11. What is cervical cancer / which part of the body does cervical cancer affects?

……

12. What is the actual cause of cervical cancer?

- Human papilloma virus [ ]
- Herpes simplex virus [ ]
- No idea [ ]
- Others (specify) [ ]

13. What are some of the risk factors of cervical cancer? Please select all that apply

- Early sexual activity [ ]
- Multiple sexual partners [ ]
- Smoking [ ]
- Other STIs [ ]
- Nulliparity or Multiparity [ ]
- Inserting herbs into the vagina /Douching [ ]
- Witchcraft and curses [ ]

- Disobedience to partner or elders [ ]
- No Idea [ ]
- Others (explain)…….

14. What are some of the symptoms of cervical cancer? Please select all that apply

- Bleeding in between periods [ ]
- Vaginal bleeding after menopause [ ]
- Foul smelling vaginal discharges [ ]
- Pelvic pain or pain during intercourse [ ]
- Bleeding after intercourse [ ]
- No idea [ ]
- Other (explain)…….

15. Cervical cancer rate is high and it's among the leading causes of women death in Ghana

- Agree [ ]
- Disagree [ ]
- No idea [ ]

16. Any woman in the reproductive age can acquire cervical cancer

- Agree [ ]
- Disagree [ ]
- No idea [ ]

17. Is cervical cancer preventable?

- Yes [ ]
- No [ ]
- No idea [ ]

18. If yes, How can cervical cancer be prevented? Please select all that apply

- Vaccination of young girl before initiation of sexual activities [ ]
- Early screening and vaccination [ ]
- Avoid early sexual activity [ ]
- Keeping one sexual partner [ ]
- Avoid smoking [ ]
- Prayers / sacrifices [ ]
- No idea [ ]
- Others (explain)……

19. Have you ever heard of cervical cancer screening?

- Yes [ ]
- No [ ]

20. What screening methods do you know of?

- Pap Smear [ ]
- VIA [ ]
- No Idea [ ]

- Other (specify) ……..

21. Where can cervical cancer screening be done?

- Specify …….
- No idea [ ]

22. What is the cost of cervical cancer screening?

- Free [ ]
- GHc……
- No idea [ ]

23. Have you ever been screened for cervical cancer?

- Yes [ ]
- No [ ]

If 'No'' go to question 27

24. When was the screening done?

- Within the last 1 – 12 months [ ]
- 1 year and over [ ]

25. Where was the screening done? ……

26. Reasons for doing the screening

- Wanted to know status [ ]
- Health workers recommendation [ ]

- Previous test result [ ]
- Others (specify) ……...

27. Reasons for **not** doing the screening?

- Do not know where to go [ ]
- Feeling of being healthy [ ]
- Cost of screening [ ]
- Fear of test results [ ]
- Other reasons (specify)……

28. What do you think are the barriers to the uptake of cervical cancer screening? Select all that apply

- Lack of information [ ]
- Access to health services [ ]
- Cost of screening [ ]
- Attitude of health service providers [ ]
- Feeling shy [ ]
- Partner refusal [ ]
- Busy schedule [ ]
- Sex of provider [ ]
- Societal/ Religious disapproval [ ]
- Other (specify) …….

29. What do you think can be done to increase the uptake of screening?

- Education [ ]
- More female service providers [ ]
- Availability of services [ ]
- Others (specify) …….

30. Is cervical cancer treatable/curable?

- Yes [ ]
- No [ ]
- No idea [ ]

31. How can cervical cancer be treated? Please select all that apply

- Drugs given at hospital [ ]
- Surgery [ ]
- Radiotherapy [ ]
- Herbal treatment [ ]
- Prayers / Sacrifices [ ]
- No idea [ ]
- Other (explain)

SECTION E: WILLINGNESS TO SCREEN FOR CERVICAL CANCER

32. Are you willing to go for cervical cancer screening?

- Yes [ ]

- No [ ]

33. If Yes, when and where do you intend going for the screening

……
34. If No, why?

……
……
Thank you for participating in the study.