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Facilitators and Barriers to Cervical Cancer Screening Among Women in a Rural District of Northeastern Uganda, a Qualitative Study

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Introduction: Cervical cancer screening in Uganda has remained relatively low, with fewer than one in 10 of eligible women screened, despite the availability of cervical cancer screening services in most health facilities. The barriers and facilitators of cervical cancer screening in remote rural settings of Northeastern Uganda like Ngora are not yet well understood. This study therefore aimed to assess the barriers and facilitators to cervical cancer screening among women of reproductive age in a remote rural district Ngora, Northeastern Uganda.

Methods: This study employed a qualitative approach to gather in-depth insight into the barriers and facilitators of cervical cancer screening. We conducted six focused group discussions (FGDs) (4 females and 2 males) with the community members and nine key informant interviews (KIIs) with the health workers in Ngora district. The participants for FGDs were chosen through convenient sampling while those for KIIs were chosen through purposive sampling methods. The interviews were audio-recorded and subsequently transcribed for analysis. Data was analyzed using thematic analysis techniques to identify significant patterns and themes related to cervical cancer screening behaviors, while inductive coding was conducted to identify codes and create meaning around the texts.

Results: The facilitators of cervical cancer screening were active community sensitization, availability of screening services at designated facilities, supportive national policies, and integration with other health services, while the barriers included myths and misconceptions about cervical cancer screening, stock-outs of essential commodities for screening, long distances to the health facilities, limited human resources, and informal costs charged by the health facilities.

Conclusion: Improving cervical cancer screening uptake requires a multi-pronged approach that strengthens health systems, addresses myths and misinformation, reduces financial and logistical burdens, and mobilizes community support.

Keywords: cervical cancer, facilitators, barriers, community sensitization

Introduction

Cervical cancer has a significant contribution to the disease morbidity and mortality globally, with low- and middle-income countries bearing the largest burden at 84% of the new cases and 90% of deaths.[1,2] In Uganda, cervical cancer was the commonest cancer among women with an age standardized rate (ASR) incidence of 56.2 per 100,000 and cancer related death rate of 41.4 per 100,000 in 2020.[2,3]

Cervical cancer is most commonly (at least 95%) caused by persistent infection with certain strains of the human papillomavirus (HPV) transmitted through sexual intercourse.[4,5] There are more than 100 types of HPV of which at least 13 are cancer causing and 2 types cause 70% of cervical cancer, that is 16 and 18.[6]

Cervical cancer prevention can be primary (vaccination) or secondary (screening) and early treatment of the precancerous lesions.[4] The Uganda Ministry of Health (MoH) recommends screening with Visual Inspection with Acetic acid (VIA) for all women aged 25–49 years at an interval of every three years for women living with HIV and every five years for HIV- negative women.[7,8] However, screening uptake in Uganda has been generally low, less than 5% in general population in 2016,[9] increasing only to 20% in the recent years.[10,11] Even among high risk women such as

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women living with HIV (WLHIV) and female sex workers who are routinely provided with cervical cancer screening services as a comprehensive package for HIV prevention and treatment services, cervical cancer screening is still suboptimal, at about 30%.[12,13]

Various studies have identified barriers to cervical cancer screening as knowledge gaps, lack of awareness, limited accessibility, sociocultural characteristics, fear of embarrassment, lack of social support, limited resources and limited capacity of health centers to carry out screening.[2,9,14–16] Other societal and cultural issues such as fear to undress, fear of receiving a positive test have greatly hindered cervical cancer screening in the African context.[17] Barriers to cervical cancer screening among women in Mayuge district, Uganda included lack of knowledge about cervical cancer and screening, health system challenges, fear of the test, outcomes and consequences and financial constraints.[15]

On the other hand, facilitators to cervical cancer screening have been identified as knowledge about cervical cancer and screening, positive attitude and a female health worker examining females facilitate cervical cancer screening in addition to good policy framework.[18,19]

Cervical cancer screening coverage in Teso sub-region (Northeastern Uganda) where our study district, Ngora is located is only 20% among women in the general population[11] and 32% among high-risk women such as female sex workers.[13] Screening for cervical cancer in this sub-region is mainly supported by donors, especially through funding from United States Presidential Plan for AIDS Relief (PEPFAR) which targets women living with HIV, thereby leaving the bulk of the population with limited access to the service.

There is lack of evidence on the local barriers and facilitators of cervical cancer screening in remote areas of northeastern Uganda such as Ngora. Therefore, our study aimed to understand content specific barriers and facilitators of cervical cancer screening in a rural and remote district of Northeastern Uganda. By identifying these factors and designing targeted interventions to enhance facilitators and mitigate barriers, we can promote early diagnosis and treatment.

Methods and Materials

Study Design

This was a qualitative study design conducted among health workers who were key informants and community members (men and women aged 20–49years) who participated in focused group discussions. This study was nested in a large prospective study titled "profiling the disease burden in Teso subregion during community based medical education and research services at Soroti University" which seeks to understand the burden of the common diseases in Northeastern Uganda (Teso subregion), the community understanding of the prevention strategies and the health systems response to these diseases. The data collection processes were led by medical students who were placed for their community-based medical education and research services (COBMERS) in Ngora HCIV, whom during their problem analysis using facility-based records and interviewing of opinion leaders found that cervical cancer is a common challenge and the screening services are limited.

Study Site

The study was conducted in Ngora district, Northeastern Uganda, which is 273 km from Kampala, the capital city of Uganda. The district has two counties, 7 sub counties, 4 town councils, 73 parishes and 146 villages. The total population in Ngora district is 181,482[20] carrying out mainly subsistence farming as an economic activity. The district has Ngora Health Centre IV, which is the largest government supported health facility which conducts regular cervical cancer screening. Besides the Health Centre IV, there are several health Centre IIIs and IIs, in addition to a private-not-for-profit hospital spread throughout the district which provides cervical cancer screening services. The cervical cancer screening service is supported by PEPFAR through United States Centre for Disease Control and Prevention (CDC), with a focus on screening women living with HIV. The women in the general population therefore have limited access to the service and being in the rural community, several of them are unable to access paid services elsewhere.

Study Population

Women and men aged 20 to 49 years in Ngora district who have been residents in the district for at least 6 months were included in the FGDs while members of the district health teams, including the district health officer and health workers at different levels who are directly or indirectly involved in cervical cancer screening were included in the KIIs.

Men and women with mental illnesses, those who were too sick and those who did not consent to participate in the study were excluded.

Sample Size and Sampling Techniques

Six focused group discussions (4 for females and 2 for males) and nine key informant interviews were conducted in July 2024. Using convenient sampling method, men and women aged between 20 and 49 years were selected to participate in the FGD interviews. They were organized into six groups each with 10–13 members for the FGD interviews (n = 72, Male = 22, female = 50). Participants of the KIIs, who are members of the district health teams (health workers) were purposively selected based on their technical involvement in decision making relating to cervical cancer screening services provision. Nine key informant interviews were done. These numbers of FGDs and KIIs enabled theoretical saturation, when no new ideas were emerging.

Data Collection Technique, Tools and Procedure

Thematic guides for FGDs and KIIs guides (supplementary file 1) were developed based on previous studies. The FGD guide explored personal, healthcare system, economic and financial, sociocultural barriers and facilitating factors of cervical cancer screening. The KII administered to the health workers explored barriers and facilitators around community knowledge and perceptions about cervical cancer, access to screening services, health system capacity to carry out cervical cancer screening and opinion on measures to increase utilization of screening services. Both guides had several probes and prompts to guide us during data collection.

The FGDs, with about 10–13 participants, were conducted by a team of five students from Soroti university who were in Ngora HCIV as part of their COBMERS placement. The students had studied qualitative research methodologies prior to their COBMERS placement and two of them were experts in the local language (Ateso) who, together with the Village Health teams (VHTs), supported in the translation and back-translation of the consent and FGD sessions. For quality control, all the FGDs and KIIs were audio recorded with consent from participants. One of the students moderated and facilitated the discussions while the others took notes. FGDs were conducted at both the health facility (Ngora HCIV) and in nearby communities. Sites for interviews were carefully selected to reduce interference from non-participants, and all study participants were encouraged to openly discuss their opinions.

Local leaders, VHTs and maternity in charge aided in arranging the venues, mobilizing the participants and agreed with them a convenient time for the discussion. FGDs lasted on average 1 hour, excluding 10–15 minutes we spent administering consent and participant information sheets and building rapport. For KIIs, after key informants were identified, appointments were made by phone, and interviews were scheduled at convenient times. The interviews were conducted by researchers in places convenient for the informants mostly at their workplaces, lasting an average of 45 minutes.

Data Management and Analysis

From field notes and audio recordings, our data analysis unfolded through a systematic process of inductive coding, subtheme development, and theme generation, guided by both content and thematic analysis methodologies. Initially, we meticulously examined the data to identify recurring patterns and assign descriptive codes. Subsequently, related codes were synthesized to form more interpretive subthemes, revealing underlying connections within the data. Finally, these subthemes were aggregated to construct overarching themes, representing the higher-level conceptual insights derived from the dataset. This dual approach, employing content analysis to identify and quantify key elements and thematic analysis to interpret deeper meanings and experiences, allowed for a comprehensive and nuanced understanding of the phenomena under investigation.

Results

Sociodemographic Characteristics of Study Participants

Out of the 72 participants for the FGDs, the average age was 34.7 years, and most were females (50, 69.4%). The majority were married (51; 81.9%). Close to half (35; 48.6%) had completed primary education as their highest level of education. Most participants were peasant farmers (42; 58.3%) (Table 1).

The Emerging Themes and Categories

The emerging themes and categories from the key informant interviews are summarized in Table 2 while the emerging themes and categories for the focused group discussions are summarized in Table 3.

Facilitators of Cervical Cancer Screening

Theme 1: Individual Facilitators

Awareness of Cervical Cancer Screening Services

The participants in the FGD had moderate awareness of the availability of cervical cancer screening services. Those who were aware were the ones who reported that they had screened, while the participants who were not aware had not screened.

Table 1 Social Demographic Characteristics of Participants for FGD

Characteristics	Frequency (n=72)	Percent (%)
Age Category/years		
20–29	24	33.3
30–39	30	41.7
40–49	18	25
Sex		
Female	50	69.4
Male	22	30.5
Marital status		
Married	59	81.9
Not married	13	18
Education level		
None	5	6.9
Primary	35	48.6
Secondary	30	41.7
Tertiary/university	2	2.8
Occupation		
Peasant farmer	42	58.3
Business	15	20.8
Housewife	10	13.9
Others	5	6.9

Table 2 Emerging Themes on Facilitators and Barriers to Cervical Cancer Screening from Key Informants (KII)

Themes	Categories	Codes
Individual facilitators	Awareness of cervical cancer	• Low to moderate awareness
	Perceived importance	• Generally positive attitude
Health system facilitators	Screening services availability	• Daily cervical cancer screening offered in key facilities, • Availability of supplies • Integrated with other health services • Have various screening methods
	Health worker trainings	• Midwives trained
	Health education and Community outreach programs	• School outreach, • Community campaigns
	Support policy environment and HPV Vaccination	• Integration of Reproductive health services with cervical cancer screening • Emphasis on screening women living with HIV • Partner support for screening
Community facilitators	Community sensitization	• Through VHTs, • Integrated outreaches conducted • NGO support offered
Individual barriers	Clients' misconceptions	• Painful process • Removes uterus, • FP causes cervical cancer screening
Health system related barriers	Inadequate supplies	• Stock-out supplies eg gloves, speculums, sterile water
	Human resource constraints	• Poor staff attitude to screening • Few trained staff • High workload
	Screening service inaccessibility	• Only 8 facilities provide cervical cancer screening in the district • Limited space for clinics • Costly in private • Inconsistent service
Community related barriers	Negative social and cultural beliefs	• Male partners discourage or restrict screening • Associated with witchcraft
	Religious beliefs	• Religious beliefs that discourage screening
	High transport costs	• Long distances to the facilities with screening services

> I went to the health center last year and they told me about cervical cancer screening, the following day, I went back just to get myself screened. (PA43)

Perceived Importance of Cervical Cancer Screening

The participants generally displayed positive attitudes towards cervical cancer screening during the discussion. Besides, there is always high acceptance when the staff go out for the integrated outreaches in the community.

> There are always many people wanting to screen during the integrated community outreaches, but we are always constrained by logistics and just screen a few we can manage. (KII07)

Table 3 Emerging Themes on Facilitators and Barriers to Cervical Cancer Screening from Focus Group Discussions

Themes	Categories	Codes
Individual facilitators to Cervical cancer screening	Male Perceptions to cervical cancer diagnosis that facilitate cervical cancer screening	• Encourage her to stay strong, • Support treatment access • Consent to removal of uterus
Health system related facilitators	Service availability	• Free treatment at government facilities • Offered every Thursday at Ngora HCIV
Community related facilitators	Male partner involvement	• Husband escorts wife to facility for screening • Polygamous men allow their women to screen
	Available peer support	• Friends encourage me to screen. • Friends escort me to facility
Individual related barriers	Personal fears	• Fear of positive results • Feel embarrassed to undress
	Personal misconceptions	• Screening services can cause wounds and infections. • It is painful procedure • Uterus will be blocked
	Financial barriers	• Lack of transport to screening sites. • Private screening facilities are costly • Some government facilities charge money
	Male Perceptions to cervical cancer diagnosis that deter screening	• Chase her away • Isolate her from others to stop spread
Health system related barriers	Service availability	• They are free in government facilities, but they still charge money (tea) • Health workers are too busy to offer service • High cost in private facilities
Community related barriers	Religious beliefs	• Pray against witchcraft that leads to cervical cancer, • Religions do not allow cervical cancer screening
	Negative social and cultural beliefs	• Women who produce few children do not get cervical cancer screening. • Whites are trying to reduce the African population by screening and vaccines.

Theme 2: Health System Facilitators

Health Education and Community Sensitization

Awareness creation through community-based health education emerged as a key facilitator. Health workers, particularly midwives and community health volunteers (VHTs), played a central role in disseminating information on cervical cancer and the importance of screening. Community outreaches, radio talk shows, health education during antenatal care (ANC), and school sensitization programs were reported as effective channels for creating awareness. In Ngora, participants clearly recognized these efforts:

> We educate women during ANC and also use radio and community meetings. (KII6)

> The VHTs told us that cancer of the cervix can be treated early if we go for screening. (PA08)

Moreover, women who were informed showed a higher likelihood of attending screening services, highlighting the role of knowledge in behavior change.

Availability of Screening Services

Ngora district has established cervical cancer screening clinics in various facilities including Ngora HCIV, FREDCA, and several Health Centre IIIs. Health workers mentioned that services are provided daily in some centers and are integrated with other services such as HIV care and family planning.

> We screen during immunization and family planning visits to capture more women. (KII09)

The availability of free treatment at the government facilities, integrated with other primary care services such as family planning and immunization encouraged women to come for cervical cancer screening, reduced missed opportunities and addressed the issue of time and transport barriers by providing multiple services during a single health facility visit.

> Me and my wife had gone for family planning at Ngora HCIV, the nurse advised us about cervical cancer screening and my wife was screened. (PA25)

Training of Health Workers

Midwives are trained to conduct cervical cancer screening, and they cascade the training to their colleagues. In facilities like Ngora HCIV and Ngora FREDICA Hospital where there is more than one trained health worker, the services are offered every day, with minimal interruptions.

> In facilities where there are more than one health worker trained, cervical cancer screening is done every day, while in the lower health facilities with only one person trained, sometimes the services are interrupted due to unavailability of the trained person. (KII02)

Supportive Policy Environment and HPV Vaccination

The presence of Ministry of Health (MOH) guidelines requiring screening of all women living with HIV (WLHIV) every 3 years and HIV-negative women every 5 years were a strong facilitator. The roll-out of HPV vaccination for girls aged 10 years was also noted as a proactive preventive strategy. This policy aligns with global cervical cancer prevention frameworks and creates a structured expectation for screening.

> All WLHIV from 25 to 49 years must be screened… and we also vaccinate girls in schools. (KII8)

Theme 3: Community Facilitators

Community Sensitization

Community sensitization and mobilization through the village health teams (VHTs) and the integrated outreaches, combined with immunization and antenatal services have significantly boosted the cervical cancer screening service access. These outreach activities are donor supported as they support the VHTs to mobilize and the health workers to take services closer to the people.

> We have been able to reach and screen many women for cervical cancer during our integrated community outreach activities. (KII01)

Male Partner Involvement

There are male partners who provide very strong social support to their wives to go for cervical cancer screening, and the women have always taken this advice very seriously and gotten screened. Some male partners provide cash to transport their wives or carry them on bicycles for cervical cancer screening and other health services.

I came with my husband to the hospital for family planning services, but while here, he heard the nurse talking about cervical cancer screening and also advised me to go for the screening. (PA65)

Availability of Peer Support System

Most participants expressed positive perceptions toward screening. Many women who had undergone cervical cancer screening reported that the procedure was neither painful nor embarrassing. In fact, their testimonies helped demystify the process for others.

I screened and it wasn't painful… now I encourage others to go too. (PA01)

My friends told me it is good to screen, so I went. (PA05)

Additionally, husbands and family members were often cited as supporters who motivated women to attend screening. Such social support plays a critical role in reducing stigma and building confidence.

Barriers to Cervical Cancer Screening

Theme 4: Individual Barriers

Clients' Misconceptions

Despite the sensitization efforts, significant myths and misconceptions still exist. Many women in FGDs shared inaccurate information, suggesting that cervical cancer is caused by family planning, poor hygiene, or even witchcraft. Some thought that screening involves "removing the uterus" or that it could "spread the disease." And this discouraged them from screening. Such misconceptions not only deter participation but also create fear, shame, and anxiety thus reduced screening cervical cancer screening rates.

For me I can't screen…. I heard the uterus is pulled out during screening… others say it causes wounds. (PA2)

Personal Fears

Some women fear to undress Infront of the health workers for screening, whereas others fear getting positive results which would disorganize their lives.

I have been postponing screening because I worry of getting positive results, how will I explain it to my husband? (PA15)

Financial Barriers

Although cervical cancer screening is officially free at government facilities, many women reported being charged small unofficial fees ("tea"), paying for missing supplies, or being referred to expensive private facilities.

Even if it's free, you still pay for medicine or give chai" ……. without money, I don't go. (PA36)

At some of the private facilities, it costs 80,000 to 130,000 shillings. (PA58)

In addition, transport costs and long distances were frequently cited as barriers, especially for women in remote rural areas without spousal support.

I live far and can't afford transport to the health center. (PA49)

Male Perceptions That Deter Screening

Some men threaten to chase their women away should they get screened and diagnosed with cervical cancer. Others isolate the women from the community claiming to avoid the spread of the disease to other family members.

I can't stay with a woman who has cervical cancer (PC08)

My husband told me not to go back to his home if I screen positive for cancer, that he doesn't want it spread to other members of the family. (PA12)

Theme 5: Health System Barriers

Inadequate Supplies

The research identified systemic limitations that undermine service delivery. Stock-outs of essential materials such as gloves, speculums, and sterilizing equipment were common. This increases workload and reduces service efficiency.

Some participants also reported long waiting times, poor facility infrastructure, and unprofessional conduct by some health workers, further discouraging service use.

Sometimes the doctors are not around… you wait long and get tired….and go without the service. (PA06)

Human Resource Constraints

There are a few trained staff for cervical cancer screening, mainly midwives who are assigned other heavy duties besides cervical cancer screening. The few staff are therefore overworked and develop poor attitudes due to the work overload.

There are few of us trained… we're overwhelmed, and the supplies are not always available. (KII9)

Screening Services Inaccessibility

Only 8 facilities provide cervical cancer screening in the district, with limited space for cervical cancer screening in these facilities and inconsistent services, where some days the services are completely not available more so when the trained person is away on leave or other duties.

Not all our facilities are able to provide cervical cancer screening. Only health centre IIIs upwards have the capacity to do so, whereas we have many health centre IIs closer to the community but no services. (KII03)

Theme 6: Community Barriers

Negative Social and Cultural Beliefs

Some beliefs hindered access to screening. Some men feared screening would affect their wives' fertility or expose them to strangers. Some people believe that whites are trying to reduce the African population by screening and vaccination.

I can't allow my wife to go for screening because other people will see my things. (PA33)

High Transport Costs

Some of the clients travel very long distances to reach a facility which offers free screening services. This is a major barrier to cervical cancer screening. Since cervical cancer is a silent killer, the clients far away from the screening sites tend not to have the motivation for early screening and only report to the facility when the disease has spread in advanced state.

Some of our patients stay far away from facilities which conduct cervical cancer screening and end up not going for the service because of the long distance. (KII06).

Religious Beliefs

Certain religions discouraged cervical cancer screening, they prefer to pray against the spirits that bring cervical cancer and thus promoting divine healing. This hinders the members of such a religion from accepting to go for the service even if it's made available at no cost in the nearby health facilities.

My church doesn't allow screening… they say pray and God will heal you. (PA1)

Discussion

The Rationale for the Study

This study explored the facilitators and barriers to cervical cancer screening among women in a rural district of Northeastern Uganda. Understanding these factors is essential, as early detection through screening plays a critical role in reducing the morbidity and mortality associated with cervical cancer.

Main Findings

From this study, the main barriers identified included existence of a large knowledge gap and deeply rooted misconceptions, health system challenges, financial and logistical barriers, cultural and religious beliefs. On the other hand, awareness through community-based health education, integration of services, supportive policy environment and HPV vaccination, positive perceptions and supportive social environments were the identified facilitators. This study is unique from the previous studies since it explored in-depth understanding of the barriers and facilitators of cervical cancer screening through a qualitative approach, interviewing both men and women. Most studies previously done in Northeastern Uganda and other parts of the country focused on the quantitative analysis of the levels and factors associated with cervical cancer screening[9–11,13,21] which could not elicit detailed understanding of the observed factors.

Facilitators of Cervical Cancer Screening

In our study, community outreaches, radio talk shows, health education during antenatal care (ANC), and school sensitization programs were reported as effective channels for creating awareness which motivated women to go for screening as said by one of the participants. Women who were informed showed a higher likelihood of attending screening services, highlighting the role of knowledge in influencing their decision to go for screening. Other studies previously highlighted the contribution of health education to cervical cancer screening uptake,[22–24] which is consistent to findings in our study.

Service Availability and Integration with existing programs was another key facilitator of cervical cancer screening in the region. Some women who had screened reported that they were utilizing some of the services provided by the health facility. Screening services were reported to be accessible at several health facilities in the district. Earlier studies done in the region suggest that the availability of free government services promotes cervical cancer screening.[11,13] The approach of service integration reduced missed opportunities and addressed the issue of time and transport barriers by providing multiple services during a single health facility visit. This facilitated screening because women who had gone to the facility for other purposes, say family planning, also got the opportunity to screen.

The presence of Ministry of Health (MOH) guidelines requiring screening of all WLHIV every three years and HIV-negative women every five years[7,8] was a strong systemic facilitator. The roll-out of HPV vaccination for girls aged 10 years was also noted as a proactive preventive strategy. This policy aligns with global cervical cancer prevention frameworks and creates a structured expectation for screening. Through the HAART clinic, many women have been screened to follow the policy thus increased screening rates.

Most participants expressed positive perceptions toward screening. Many women who had undergone cervical cancer screening reported that the procedure was neither painful nor embarrassing. In fact, their testimonies helped demystify the process for others. Additionally, husbands and family members were often cited as supporters who motivated women to attend screening. Such social support plays a critical role in reducing stigma and building confidence. These findings are consistent with earlier studies.[18]

Barriers to Cervical Cancer Screening

Despite ongoing community sensitization initiatives, widespread misconceptions and limited knowledge about cervical cancer and its screening procedures persist among women in rural communities. Such misconceptions not only reflect poor health literacy but also create fear, shame, and anxiety, leading to avoidance of screening services. These findings are consistent with global literature, which emphasizes that misinformation and low levels of health literacy are significant barriers to screening uptake in low-resource settings. Fear of results, stigma, and misinformation act as

major deterrents in many low- and middle-income countries (LMICs).[17] Cervical cancer patients tend to think cervical cancer is a sexually transmitted infection and many tend to seek treatment for STIs at first.[25] Addressing these knowledge gaps is essential and requires comprehensive, culturally tailored health education that can dispel myths and foster a supportive environment for preventive health behaviors.

The study also highlighted numerous structural and systemic challenges within the healthcare delivery system that impede effective cervical cancer screening. Similar challenges such as stockouts of supplies, shortages of trained personals and long waiting time have been reported in other parts of the world.[14,19,26,27]

While cervical cancer screening is officially offered free of charge at government health facilities, many women reported having to pay informal fees—commonly referred to as "tea"—to access services. Beyond direct costs, logistical barriers such as transport expenses and the long distances to health centers were frequently cited as obstacles, particularly for women in remote rural areas. The lack of spousal or family support further compounded these challenges. Financial burden, particularly in rural and underserved populations, significantly affects screening uptake and timely follow-up.[28] In addition, partner support was earlier identified in Uganda as a key facilitator of cervical cancer screening.[29]

Cultural norms and religious beliefs were also found to significantly influence attitudes toward cervical cancer screening. In patriarchal settings, male partners or religious leaders often wield significant influence over women's healthcare choices. This trend is well documented in global literature.[14,18] Ugandan women equally feel stigmatized and fear to expose their private parts for examination by healthcare workers.[30]

To address these challenges, it is essential to involve community gatekeepers, including religious leaders, traditional healers, and male partners, in health education campaigns. Culturally sensitive and community-driven approaches are more likely to build trust and reshape perceptions toward screening.

Study Strengths and Limitations

The qualitative approach used in this study provided in-depth understanding of personal, cultural, and systemic factors influencing cervical cancer screening behavior. The study was well-suited for exploring complex, multifaceted barriers and facilitators that cannot be fully captured through quantitative methods. Use of KIIs and FGDs allowed participants to express their views freely, contributing to the richness and authenticity of the data. The inclusion of men in the FGDs provided the partners views, which are rarely captured, on barriers and facilitators of cervical cancer screening. These findings are locally relevant and provide actionable insights for improving screening uptake in the specific setting or population studied.

On the other hand, the qualitative nature of our analysis introduces the potential for subjectivity and researcher bias in the interpretation of participants' narratives. The relatively small sample size, while allowing for in-depth exploration of experiences, may limit the generalizability of our findings to the wider population of women beyond Ngora district. The self-report of the barriers and facilitators of cervical cancer in the district is subject to social desirability bias.

Conclusion and Recommendation

Improving cervical cancer screening uptake requires a multi-pronged approach that strengthens health systems, addresses myths and misinformation, reduces financial and logistical burdens, and mobilizes community support. Without tackling these issues holistically, cervical cancer screening programs risk excluding the very populations they are designed to serve. There is need to strengthen health education and community sensitization to address the myths, misconceptions and fears in the community regarding cervical cancer screening, while improving the capacity of the health workers to provide culturally appropriate and socially affordable screening services.

Abbreviations

FGD, Focused Group discussion; KII, Key informant interview; CaCx, Cervical cancer; CaCxS, Cervical cancer screening; HPV, Human papilloma virus; Pap, Papanicolaou; HIV, Human immune-deficiency virus; VIA, Visual inspection with acetic acid; MoH, Ministry of Health; HC IV, Health Centre IV; TPB, Theory of planned behavior; DNA, Deoxyribonucleic acid; VILI, Visual inspection with Lugol's iodine; WHO, World Health Organization; PEPFAR,

President's Emergency Plan for AIDS Relief; COBMERS, Community Based Medical Education, Research and Services.

Data Sharing Statement

All the data used in this study are included in this manuscript.

Ethical Approval and Consent to Participate

This research project was reviewed and approved by the ethics committee of Mbale Regional Referral Hospital, Mbale Regional Referral Hospital (MRRH-REC), No. MRRH-2024-437 as part of a bigger study to profile the burden of disease in Teso sub-region through community based medical education and research services at Soroti University. Administrative clearance was obtained from the district health officer and health facility in-charges prior to data collection. Written informed consent was obtained from all participants after the moderator explained the study aims, benefits and potential risks. In addition, the participants consented to their anonymized answers and direct quotes to be used in the final report to demonstrate key codes and themes, while ensuring that no identifiable details were published. Our study complied with the declaration of Helsinki.[31]

Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

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The authors declare that no competing interests exist in this work.

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