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ORIGINAL RESEARCH

Factors Associated with Cervical Cancer Screening Uptake Among Women Attending Outpatient Department in a Rural District Hospital in Uganda. A Cross-Sectional Study

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Background: Sub-Saharan Africa (SSA) faces persistently low cervical cancer screening uptake, averaging only 13% over the past five years, with Uganda reporting less than 5%. This study aimed to assess the factors influencing cervical cancer screening uptake in a rural district hospital to inform targeted interventions that enhance screening coverage for the rural community.

Methods: This was a cross-sectional study conducted at Kaberamaido General Hospital (KGH) outpatient department. A total of 422 participants aged between 25 and 49 years were interviewed and data analyzed using STATA version 16.0. Bivariate and multivariate analyses were performed using modified Poisson regression with robust error estimates to identify key factors associated with cervical cancer screening uptake. Variables with P-value <0.05 were considered statistically significant.

Results: The average age of participants was 32 (SD ±7) years. 77.5% (n=327) of participants were married, had primary level of education, 69.2% (n=292), and were unemployed, 89.3% (n=377). Awareness about screening was high as 85.5% (n=360) of respondents had heard about cervical cancer screening. Cervical cancer screening uptake was low, as only 20.4% (n=86) had been screened in the past five years. Factors significantly associated with increased screening uptake, including age older than 35 years, adjusted Prevalence Ratio [aPR]= 1.7 (95% CI: 1.08–2.69), availability of free government screening services, aPR = 1.6 (95% CI: 1.09–2.38), provision of screening service at the nearest health facility, aPR = 2.1 (95% CI: 1.09–3.97), and a positive family history of cervical cancer, aPR = 1.7 (95% CI: 1.14–2.65).

Conclusion: Our study confirms that cervical cancer screening uptake in Kaberamaido District remains low, highlighting the need for enhanced awareness campaigns and improved access to screening services. Our findings emphasize the need for policies that strengthen community outreach programs and expand cervical cancer screening services at primary healthcare facilities.

Keywords: uterine cervical neoplasms, cervical cancer screening, women, cervical cancer awareness

Introduction

Cervical cancer remains one of the most significant yet preventable public health challenges among women of reproductive age globally.[1,2] It is estimated that over 570,000 new cases are reported annually, accounting for approximately 7.9% of all cancer cases in women worldwide.[3,4] The burden of cervical cancer is disproportionately higher in low- and middle-income countries (LMICs), with sub-Saharan Africa (SSA) bearing 84% of the global incidence.[5]

Persistent infection with high-risk human papillomavirus (HPV) is the primary cause of cervical cancer, making it a preventable disease if effective screening and vaccination programs are implemented.[3,6] However, in SSA, where

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health systems are fragile, access to screening and early detection services remains limited, with an average screening rate of only 13% for the eligible women,[7] exacerbating disease progression to advanced, often untreatable stages.[8]

Cervical cancer remains among the leading cause of cancer-related deaths among women in over 36 LMICs countries.[7] In 2022 alone, there were 661,021 new cases and 348,198 deaths resulting from cervical cancer, making it the 4th leading cause of morbidity and mortality among female cancers globally.[9] Currently, cervical cancer is the second leading cause of morbidity and mortality in SSA, with an incidence of 35 new cases per 100,000 women, and a mortality rate of 23 per 100,000 women.[9,10] East Africa experiences the highest burden, with Uganda reporting an incidence of 54.8 per 100,000 women and a mortality rate of 40.5 per 100,000 women—far exceeding the global average of 6.8 per 100,00, translating to approximately 6959 women diagnosed with cervical cancer each year and 4607 deaths.[11] These statistics highlight a critical gap in preventive healthcare services, particularly in rural and underserved populations.

Despite advancements in cervical cancer screening technologies—such as visual inspection with acetic acid (VIA), cytology (Pap smears), and HPV DNA testing—uptake remains suboptimal in SSA.[12–14] Most of cases of cervical cancer disease in the region are diagnosed at an advanced stage when treatment options such as radiotherapy, chemotherapy, and surgery are either ineffective, unavailable, or prohibitively expensive.[10,15,16] The uptake of cervical cancer screening in low-income countries (LICs) is alarmingly low at less than 20%, a stark contrast to the 63% screening coverage in high-income countries (HICs), translating to a 44% disparity.[17,18] Specifically, Uganda has one of the lowest cervical cancer screening rates in rural communities at 4.8%.[19] These figures underscore the urgent need for targeted strategies to improve screening uptake, particularly in remote areas where existing interventions are limited.

Recognizing the global disparities in cervical cancer prevention and control, the World Health Organization (WHO) launched the Cervical Cancer Elimination Strategy in 2020, aiming to reduce cervical cancer incidence to fewer than four cases per 100,000 women. This ambitious goal is anchored on a "90–70–90" target: vaccinating 90% of girls against HPV by age 15, screening 70% of women between ages 25 and 49, and ensuring that at least 90% of those diagnosed with precancerous lesions or invasive cancer receive treatment.[20] Among these interventions, cervical cancer screening has been identified as a crucial component for early detection and improved treatment outcomes. Evidence suggests that widespread HPV vaccination and routine screening can prevent up to 80% of cervical cancer cases, significantly reducing mortality.[12,21,22]

Women in SSA face significant barriers to accessing cervical cancer screening services. Multiple socio-ecological factors—including limited healthcare infrastructure, cultural beliefs, financial constraints, lack of awareness, and fear of diagnosis—contribute to low screening uptake.[2,23,24] The success of cervical cancer screening programs in resource-limited settings therefore hinges on identifying and addressing these barriers through context-specific interventions and policy implementation.

We aimed to investigate the factors influencing the uptake of cervical cancer screening in Kaberamaido District, Uganda, to inform evidence-based strategies to enhance screening coverage and ultimately contribute to the broader goal of cervical cancer elimination in low-resource settings.

Materials and Methods

Study Design

This study employed a cross-sectional design to assess factors influencing the uptake of cervical cancer screening among women aged 25–49 years attending outpatient services at Kaberamaido General Hospital (KGH), Kaberamaido District, Uganda. A quantitative approach was used to measure cervical cancer screening uptake and identify associated factors.

Study Site

The study was conducted at Kaberamaido General Hospital (KGH), a district-level healthcare facility serving Kaberamaido District, Uganda. The district has an estimated population of 215,026 people.[25] KGH serves as a primary healthcare provider for the district and is a referral center for lower health facilities. The outpatient department (OPD) was chosen as the study site because it receives a diverse patient population, including women within the recommended age bracket for cervical cancer screening (25–49 years).

Sampling Strategy

A consecutive sampling technique was used to recruit women aged 25–49 years attending the OPD clinic at KGH between March and May 2024 until the sample size of 422 was reached. This approach was chosen due to the varied patient flow at the OPD, which experiences peak attendance on Mondays and lower attendance on other days. The sampling approach, therefore, was able to give a mix of participant population since it was stretched over a 3-month period.

Sample Size Determination

The Kish Leslie formula for sample size estimation in cross-sectional studies was used to calculate the required sample size of 384 participants, based on an assumed prevalence of cervical cancer screening uptake of 50% to give the maximum sample size possible. To account for non-responses and incomplete responses, the sample size was adjusted by 10%, giving a final sample size of 422 respondents.

Data Collection

Data was collected using a structured questionnaire entered into the kobo toolkit and administered through face-to-face interviews. The questionnaire was designed to capture socio-demographic characteristics (age, education level, marital status, occupation, and income level), Knowledge and awareness of cervical cancer screening (awareness of risk factors, availability of screening services, and perceived benefits), Health system-related factors (accessibility of screening services, availability of healthcare providers, affordability, and previous interactions with the health system). The primary outcome was prevalence of cervical cancer screening defined as having ever been screened within a 5-year period prior to the interview with a Yes/No response and the secondary outcome was the factors associated with cervical cancer screening. The questionnaire was pre-tested among a small sample of women attending a different health facility in the region to ensure clarity, reliability, and validity before the actual data collection.

Data Management and Analysis

Collected data were exported to STATA version 16.0 for analysis. Descriptive statistics (frequencies and percentages) were used to summarize categorical variables, while means and standard deviations were computed for continuous variables. Bivariate analysis was conducted using modified Poisson regression with robust error estimates to determine the levels of association between independent variables and outcome of interest. The final multivariable modified Poisson regression model was built based on variables whose p-value were less than 0.1 at bivariate level, those with confounding effects and those with known biological plausibility. Variables whose confidence interval did not contain a null (1.0) were considered statistically significant.

Results

Social Demographic Characteristic of Study Respondents

Out of 422 women in this study. Most were aged 25 to 35 years (303, 71.8%), with an average age of 32 (SD ±7) years, majority (327, 77.5%) were married, with almost half (178, 42.2%) were catholic. Regarding education, about (292, 69.2%) had primary education, majority (377, 89.3%) were unemployed, and about (261, 61.8%) had a parity of fewer than 5 (Table 1).

Awareness and Uptake of Cervical Cancer Screening

The majority (360, 85.3%) of respondents had heard about cervical cancer screening, but only 86 (20.4%) had been screened in the past five years, while 336 (79.6%) had never undergone screening (Table 2).

Factors Associated with Cervical Cancer Screen

Multivariate analysis revealed that a mother's age, source of funds for hospital visits, availability of cervical cancer screening services at the nearest health facility, and a family history of cervical cancer were statistically significant

Table 1 Social Demographic Characteristics of Study Participants

Variable	Frequency, N=422	Proportion
Age group		
25-35 years	303	71.8
>35 years	119	28.2
Average age (SD)	32 (±7)	
Marital status		
Single	63	14.9
Divorced or widowed	32	7.6
Married	327	77.5
Religion		
Catholic	178	42.2
Anglican	134	31.8
Muslims, Pentecostals or others	110	26.1
Highest level of Education		
None/Primary	292	69.2
Post primary	130	30.8
Employment status		
Employed	45	10.7
Unemployed	377	89.3
Mothers Parity		
< 5	261	61.8
≥ 5	161	38.2
Median Parity (IQR)	3 (4)	

Table 2 Awareness and Uptake of Cervical Cancer Screening

Variable	Frequency (n=422)	Proportion
Ever heard about cervical cancer screening		
Yes	360	85.3
No	62	14.7
Screened for cervical cancer in the past five years		
Ever	86	20.4
Never	336	79.6

factors associated with cervical cancer screening. Women aged over 35 years were 1.7 times more likely to undergo cervical cancer screening (aPR = 1.7, 95% CI: 1.08–2.69) compared to those aged 25 to 35 years. Women who relied on other sources of hospital income (salary, business, and borrowing) were 1.6 times more likely to be screened (aPR = 1.6, 95% CI: 1.09–2.38) compared to those who depended on free government service. Women whose nearest health facility offered cervical cancer screening services were 2.1 times more likely to be screened (aPR = 2.1, 95% CI: 1.09–3.97) than those without access to such services. Additionally, women with a family history of cervical cancer were 1.7 times more likely to be screened (aPR = 1.7, 95% CI: 1.14–2.65) compared to those with no family history (Table 3).

Table 3 Multivariate Analysis of Factors Associated with Cervical Cancer Screening

Variable	Screened for Cervical Cancer in Last Five Years		Prevalence Ratio (PR) (95% CI)	Adjusted Prevalence Ratio (aPR) (95% CI)	P-value for aPR
	Yes (n=86) n (%)	No (n=336) n (%)			
Age group					
25-35 years	42(13.9)	261(86.1)	1.0	1.0	
>35 years	44(37.0)	75(63.0)	2.7(1.85–3.87)	1.7(1.08–2.69)	0.022
Parity					
<5 children	34(13.0)	227(87.0)	1.0	1.0	
≥5 children	52(32.2)	109(67.7)	2.5(1.69–3.64)	1.4(0.85–2.16)	0.203
Marital status					
Single	4(6.3)	59(93.7)	1.0	1.0	
Married	75(22.9)	252(77.1)	3.6(1.37–9.52)	2.1(0.74–5.93)	0.158
Divorced or widowed	7(21.9)	25(78.1)	3.4(1.09–10.91)	1.7(0.52–5.81)	0.366
Highest education level					
None/Primary	68(23.3)	224(76.7)	1.0	1.0	
Post primary	18(13.8)	112(86.2)	0.6(0.37–0.96)	0.9(0.59–1.52)	0.824
Source of funds for Hospital visits					
Free government service	37(14.9)	211(85.1)	1.0	1.0	
Salary, Business or borrowing	49(28.2)	125(71.8)	1.9(1.29–2.76)	1.6(1.09–2.38)	0.016
Ever heard about cervical cancer screening					
No	5(8.1)	57(91.9)	1.0	1.0	
Yes	81(22.5)	279(77.5)	2.8(1.18–6.61)	1.9(0.79–4.36)	0.158
Provision of Cervical Cancer screening in Nearest Health Facility					
No	8(11.8)	60(88.2)	1.0	1.0	
Yes	78(22.0)	276(78.0)	1.9(0.95–3.69)	2.1(1.09–3.97)	0.027
History of Cervical Cancer in the family					
No	70(18.4)	311(81.6)	1.0	1.0	
Yes	16(39.0)	25(61.0)	2.1(1.37–3.29)	1.7(1.14–2.65)	0.010

(*Continued*)

Table 3 (Continued).

Variable	Screened for Cervical Cancer in Last Five Years		Prevalence Ratio (PR) (95% CI)	Adjusted Prevalence Ratio (aPR) (95% CI)	P-value for aPR
	Yes (n=86) n (%)	No (n=336) n (%)			
Religious encouragement of cervical cancer screening					
No	30(13.3)	195(86.7)	1.0	1.0	
Yes	56(28.4)	141(71.6)	2.1(1.43–3.18)	1.5(0.99–2.36)	0.052

Discussion

Our study aimed at assessing the level of uptake of cervical cancer screening and associated factors among women in the reproductive age (25–49years) and eligible for screening as per the national and WHO guidelines.[26,27] The average age of participants was 32 years, with three in four (3/4) of participants married, about 7 in 10 having attained only the primary level of education and 9 in 10 being unemployed.

Awareness about cervical cancer screening services among the study participants was high as 85.5% of respondents had heard about cervical cancer screening. Cervical cancer screening awareness has significantly improved in the recent years across multiple settings, with studies in Eastern Uganda and Dodoma-Tanzania reporting 7 in 10 women to have heard about cervical cancer screening from the various sources.[28,29] Earlier studies have shown that cervical cancer screening awareness or the lack of it is directly linked to uptake of cervical cancer screening services.[2,10,17,30,31] However, the high awareness of cervical cancer screening services in our study did not translate to receiving the service and there was no significant difference in screening between participants who were aware and those not aware of cervical cancer screening. The uptake of screening services in KGH could therefore be linked to other factors such as the availability of the free screening services in the nearest health facilities.

Uptake of cervical cancer screening in KGH was low as only 20% of participants had been screened in the past five years. This screening level is still suboptimal and below the WHO 2030 target of 70% screening.[26] Cervical cancer screening uptake in Uganda and SSA has been generally low, with reported prevalence of <5% in rural Uganda[19] and 20% in urban areas.[32] Even among high risk populations of women in Uganda, such as female sex workers, cervical cancer screening is still suboptimal at only 32%.[33] The average uptake of cervical cancer screening in SSA has been at about 13%,[7] with significant variations across countries, that is, 8% in Tanzania,[29] 18.7% Kenya,[8] 3–5% in Cameroon,[18] and 39% in Ethiopia.[6] The observed uptake of 20% in our study therefore indicates some progress, though not very satisfactory.

We observed that women older than 35 were about twice more likely to have received cervical cancer screening compared to women below 35 years. Older women have been generally noted to have received cervical cancer screening services in different settings.[34,35] As women get older, they perceive themselves to be at a higher risk of cervical cancer disease, and therefore their tendencies to seek cervical cancer screening services increase.[1] Chances are that eventually the odds of obtaining information about cervical cancer screening and eventually being screened increases.[34]

Similarly, our study found that women with a positive family history of cervical cancer were more likely to have been screened for cervical cancer. Our previous study on cervical cancer screening uptake among female sex workers in Northeastern Uganda demonstrated high acceptability of the service by the women who had family history of cervical cancer.[33] Other studies in Ethiopia have equally shown a positive correlation between cervical cancer screening and family history of the disease.[13,21] The higher uptake of cervical cancer screening among women with a family history of cervical cancer is positively linked to increased knowledge, risk perception and awareness of cervical cancer and higher exposer to chances of screening.[21]

The source of funding to finance hospital visits was a significant determinant of the uptake of cervical cancer screening in our study. Women who solely depended on free government services and had no other source of income

were less likely to have been screened for cervical cancer than those who depended on other sources for their medical bills. Financial capability has been identified in other studies as a significant predictor and access to healthcare-seeking practices.[1,36] Kaberamaido being a rural setting in a low-income country, and the unemployed population is disproportionately higher, partly explaining the low uptake we observed.[24]

In KGH, participants whose nearest health centre provided cervical cancer screening were twice more likely to have screened for cervical cancer than those whose health facilities do not provide the service. More often because of financial limitations as earlier noted, women in this rural communities are more likely to attend the nearest health centre, which, if it provides cervical cancer screening, were more likely to be screened. In Uganda, one of the major contributors to low uptake of cervical cancer screening in rural areas is the associated cost, mostly in terms of transport, because women in rural areas are faced with a greater geographical accessibility burden to health care facilities.[37] Because of the absence of Cervical cancer screening services in majority of rural health centres, research has also reported that doctors in these areas are less likely to recommend women from cervical cancer screening further escalating the reduced uptake.[37]

Limitations of the Study

Our study was not free of limitations. First, the study adopted a quantitative survey design that does not study reasons and motivations behind the observed hinderances of cervical cancer screening. Such reasons inform targeted interventions. Secondly, this study was prone to social desirability bias since the outcomes of this study were entirely dependent on participant reports. Third, the sampling method used was a consecutive sampling approach which introduces selection and temporal bias.

Conclusion

Although cervical cancer screening awareness was high in Kaberamaido district, its uptake is far below the WHO target by 2030, with only 1 out of 5 participants having been screened. It is paramount to strengthen access to cervical cancer screening services through primary health care facilities and community outreaches targeting young women who are unable to visits the health facility due to financial constraints or other unknown fears, thus, enabling early detection and treatment of precancerous lesions.

Ethical Considerations

Our study complied with the Declaration of Helsinki guidelines by ensuring the health and well-being of participants as our first consideration and ensuring respect for all participants and protection of their health and rights. Ethical approval for the study was obtained from the Mbale Regional Referral Hospital Research and Ethics Committee (REC), approval number- MRRH-2024-402. Administrative clearance was granted by the Kaberamaido District Health Officer (DHO) and the KGH Medical Superintendent before the study commenced. Written informed consent was obtained from all study participants before their inclusion in the study. Participants were assured of their voluntary participation and the right to withdraw at any point without consequences. All interviews were conducted in a private setting to ensure participant confidentiality. No identifiable personal information (such as names, phone numbers, or national identification details) was collected. Data were stored securely in a locked cabinet, and digital data were password-protected, accessible only to the research team.

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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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Disclosure

The authors declare no conflicts of interest in this work.

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