Research Article

IT Medical Team
https://www.itmedicalteam.pl/

Health Science Journal
ISSN 1791-809X

2024
Vol. 18 No. 5: 1144

Cervical Cancer Status, Knowledge, Attitude and Associated Factors among Reproductive Age Women Residing in Hargeisa, Somaliland

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Citation: Nour HM, Kahsay AB (2024) Cervical Cancer Status, Knowledge, Attitude and Associated Factors among Reproductive Age Women Residing in Hargeisa, Somaliland. Health Sci J. Vol. 18 No. 5: 1144.

Abstract

Introduction: Cervical cancer results from a Human Papilloma Virus (HPV) infection. Seventy (70%) cervical cancers and pre-cancerous cervical lesions are attributed to HPV types 16 and 18. In low- and middle-income countries (LMICs), there is poor awareness and limited access to preventative measures, and cervical cancer is often diagnosed at a late stage when women develop metastatic symptoms. In addition, access to treatment for cancerous lesions is also limited, resulting in a higher rate of death from cervical cancer. In Somaliland, there is very limited information concerning cervical cancer awareness and associated factors in the community.

Objective: To determine the overall status of knowledge, attitude, and associated factors of cervical cancer among reproductive-aged women residing in Hargeisa, Somaliland.

Methods: We conducted a cross-sectional survey among reproductive-age women residing in Hargeisa, Somaliland. A structured questionnaire was developed, and we interviewed 270 women. Moreover, a record review of two hospitals in Hargeisa that were involved in cervical cancer screening was conducted. Data were entered into SPSS version 23, and descriptive and advanced statistical analysis were run. Proportions, mean scores, and standard deviations were calculated, and chi-square statistics were run to determine associations. A P-value of less than 0.05 was considered statistically significant. Results were presented in text and tables.

Results: The mean age of the study participants was 29 (SD 7.6). We found that less than half of the participants, 118 (43.7%), had good knowledge about the risk factors and symptoms of cervical cancer. Moreover, 125 (46.3%) of the study participants have a positive attitude towards the risk factors and symptoms of cervical cancer. All the study participants have heard about cervical cancer. Their age, monthly income, and educational status were found to have a statistically significant association with the knowledge of the respondents, with p-values of 0.004, 0.023, and 0.001, respectively. Moreover, the age of the respondents, educational status, marital status, and status of children were found to have a statistically significant association with the attitude of the participants, with a p-value of 0.002, 0.001, 0.003, and 0.001, respectively.

Conclusion: The overall knowledge and attitude toward cervical cancer screening are low. Age, monthly income, educational status, and marital status are the factors associated with knowledge and attitude towards cervical cancer. There is a need to promote, educate, and encourage women to undergo early cervical cancer screening by informing them of their susceptibility to cervical cancer. In addition to health education, availing of free screening services and free vaccines will improve cervical cancer prevention.

Keywords: Cervical cancer; Knowledge; Attitude; Hargeisa; Somaliland

Received: 1-May-2024, Manuscript No. iphsj-24-14895; **Editor assigned:** 4-May-2024, PreQc No. PQ-14895; **Review** 20-May-2024, QC No.Q-14895, **Revised:** 25-May-2024, Manuscript No. Iphsj-24-14895 (R); **Published:** 30-May-2024; DOI: 10.36648/1791-809X.18.5.1144

Introduction

Cervical cancer is a type of cancer in which the cells of the cervix develop abnormally and form a tumor. Adenocarcinoma and squamous cell carcinoma are the two most common histologic forms of cervical cancer [1]. Cervical cancer is the most common malignancy in women worldwide, with data indicating that 24.6 million people are suffering from cancer [2]. According

to a WHO survey from 2015, the global incidence, death rate, and prevalence of cervical cancer were 7.9%, 7.5%, and 9%, respectively. In Africa, 715,000 new cancer cases and 542,000 cancer deaths were recorded. 4 In Sub-Saharan Africa, the incidence rate was 25.2%, the death rate was 23.2%, and the prevalence was 27.6% [3].

Almost nine out of ten (87%) cervical cancer deaths occur in less developed regions. The mortality varies between the different regions of the world, with rates ranging from less than 2 per 100,000 in Western Asia, Western Europe, and Australia/New Zealand to more than 20 per 100,000 in Melanesia (20.6), Middle Africa (22.2), and Eastern Africa (27.6) [4,5]. Moreover, affecting relatively young women, cervical cancer is the single largest cause of years of life lost to cancer in the developing world [6]. Women in sub-Saharan Africa lose more years to cervical cancer than to any other type of cancer, and it affects women at a time in their lives when they are critical to the social and economic stability of their families [7].

In low- and middle-income countries (LMICs), there is poor awareness and limited access to preventative measures, and cervical cancer is often diagnosed at a late stage when women develop metastatic symptoms. In addition, access to treatment for cancerous lesions is also limited, resulting in a higher rate of death from cervical cancer [8,9].

Cervical cancer results from a Human Papilloma Virus (HPV) infection. Seventy (70%) cervical cancers and pre-cancerous cervical lesions are attributed to HPV types 16 and 18 [10].

Detecting cervical cancer by visual inspection with acetic acid (VIA) is a simple, inexpensive test with moderate sensitivity and specificity for screening that can be combined with simple treatment procedures for early cervical lesions [11]. Health workers or nurses can be trained as test providers, and the results are available immediately. VIA is feasible in many low-resource areas where it is difficult to sustain high-quality cytology programs. Several studies have been conducted in different parts of the developed world, but less is documented in Africa, and specifically, no studies about cervical cancer among women were conducted. The study will provide data on the magnitude of cervical cancer and associated factors among women attending the gynecology department in Hargeisa, Somaliland, and will serve as an input to fight against cervical cancer and to take public health measures and strategies for the treatment, prevention, and control of cervical cancer among women in the study area and also for the country at large. Moreover, the study will be used as baseline data for further research and implementing strategies and policies for routine cervical cancer screening programs prior to vaccination against the human papilloma virus. Therefore, the main aim of this study is to determine the overall status of cervical cancer, knowledge, attitude, and associated factors among reproductive-age women residing in Hargeisa, Somaliland.

Methods and Materials

Study setting

Somaliland is a self-declared state located in the north-west of Somalia. The autonomous region of Puntland lies to the east, Ethiopia to the west and south, and Djibouti to the northwest. Like most of Somali, Somaliland is an Islamic country governed by Sharia law The regions of Somaliland is divided into six administrative regions, Awdal, Sahil, Maroodi-Jeeh, Togdheer, Sanaag and Buro. Hargeisa is the capital of the self-proclaimed republic of Somaliland. In recent years, it has been one of the safest places in Somalia, though threats of violence were made against foreigners in May of 2011. Hargeisa, with 800,000 inhabitants (according to a DHS 2000 estimate), is the capital of the self-declared republic of Somaliland. Various public and private health institutions provide healthcare service to the community. However, services provided related to cervical cancer are very insignificant in the country.

Study design

We conducted a cross-sectional study (January and February 2024) among women of reproductive age residing in Hargeisa, and reviewed records in selected hospitals in Hargeisa, Somaliland.

Sampling and data collection

The sample size of 270 was determined using a single population proportion formula. We interviewed 270 reproductive-age women from seven districts in Hargeisa using a structured interviewer-administered questionnaire. The questionnaire comprises questions such as different items like socio-demographics, knowledge, and attitude questions towards cervical cancer screening. Questionnaires were adapted from different pieces of literature from previous studies. The hospitals were selected based on the services that they provide. We also used a data extraction checklist for the hospital record review. Five percent of the questionnaire was pretested, and modifications were made to contextualize it in the local community language. The data was collected by experienced healthcare providers who were trained for two days on the methods of data collection. The investigators routinely checked for the completeness and consistency of the data.

Data management and analysis

The collected data was entered into SPSS version 23 statistical software for analysis. Descriptive statistical analyses such as proportions, mean scores, and standard deviations were calculated. Moreover, chi-square statistics were run to determine the factors associated with cervical cancer. Finally, results were presented in text and tables. A p-value of less than 0.05 was considered statistically significant.

Study Variables

- **Independent Variables:** Demographic details include age, educational level, marital status, monthly income, etc.
- **Dependent Variables:** Knowledge and attitude

Operational definition

Questions regarding knowledge and attitude of risk factors and symptoms for cervical cancer were scored and pooled together and the mean score was computed to determine the overall knowledge and attitude of the respondents.

- **Good Knowledge:** Respondents who scored above the mean score of knowledge assessing questions.

- **Poor knowledge:** Respondents who scored below the mean score of knowledge assessing questions.
- **Positive attitude:** Those respondents who scored above the mean score of attitude assessing questions.
- **Negative attitude:** Those respondents who scored below the mean score of attitude assessing questions.

Ethical considerations

Ethical clearance was solicited from the office of research and ethical committee of the Edna Adan University Hospital, and confirmation of permission to access the data from the archives was secured from these hospital directors. The patient charts were handled appropriately, guaranteeing that the survey's confidentiality was respected both during data extraction and when the charts were returned to the hospital's repository for storage. Moreover, verbal consent was obtained from the reproductive age women for the interview after explaining the risks and benefits of the survey. The interview was conducted on a voluntary basis, and all data were kept confidential.

Results

Sociodemographic characteristics of the respondents

We interviewed a total of 270 women aged 15–49 residing in nine districts of Hargeisa, Somaliland. The mean age of the study participants was 29 (SD 7.6), and the mean monthly income was $185. About 114 (42.2%) of them had a university degree, and 112 (41.5%) of them were married. Moreover, 120 (44.5%) of the study participants have at least one child [**Table 1**].

Table 1: Sociodemographic characteristics of the study participants, Hargeisa, Somaliland (n=270).

Variable	Category	Number	Percent
Age of respondents	15-19	24	8.9
	20-24	65	24.1
	25-29	76	28.1
	30-34	39	14.4
	35-39	31	11.5
	40-44	25	9.3
	45-49	10	3.7
Monthly income in USD	50-250	207	76.7
	251-500	52	19.3
	501-750	6	2.2
	751-1250	5	1.9
Educational status	University degree	114	42.2
	High school	42	15.6
	Primary	22	8.1
	Qur'an	46	17.0
	No formal education	46	17.0
Marital status	Single	135	50.0
	Married	112	41.5
	Divorced	20	7.4
	Widowed	3	1.1
Status of children	Yes	120	44.4
	No	150	55.6

Knowledge of the risk factors and symptoms of cervical cancer

About 110 (40.8%) of the respondents believe that contraceptive use is one of the risk factors for cervical cancer. Moreover, 132 (48.9%) believe that aging is among the risk factors for cervical cancer. In addition, 105 (38.9%) believe that cervical cancer is caused by HPV. Concerning the main symptoms of cervical cancer, the majority of them think that menstrual irregularities (76.3%) and anemia (70.4%) are among the major symptoms. Knowledge of the study participants about the risk factors and the main symptoms of cervical cancer [**Table 2**].

After calculating the mean score, we found that less than half of the participants, 118 (43.7%), had good knowledge, whereas 152 (56.3%) had poor knowledge about the risk factors and symptoms of cervical cancer. Moreover, all the study participants have heard about cervical cancer. When asked about the pap smear, 125 (46.3%) of the 270 participants had heard about it. And the sources of information were 15 (5.6%), 14 (5.2%), 79 (29.3%), and 17 (6.3%) from relatives, friends, health workers, and the mass media, respectively. In addition, when asked about "How many times should a healthy woman undergo a Pap smear test?" 169 (62.6%) of the study participants did not know, while 17 (6.3%) answered only once, 24 (8.9%) two times, and 60 (22.2%) at least three times and above.

Factors associated with the knowledge of reproductive-age women towards cervical cancer screening

In further analysis to check whether the sociodemographic characteristics of the study participants are associated with the status of knowledge, we conducted a chi-square test and examined the age of the respondents. Their monthly income and educational status were found to have a statistically significant association with the p-values of 0.004, 0.023, and 0.001, respectively. Moreover, marital status and the status of children have no association with the knowledge status of the study participants [**Table 3**].

The attitude of the study participants towards the risk factors and symptoms of cervical cancer screening

Overall, 125 (46.3%) of the study participants have a positive attitude towards the risk factors and symptoms of cervical cancer screening, whereas 145 (53.3%) have an unfavorable or negative attitude towards cervical cancer screening. About 147 (54.5%) replied that they believe having multiple sexual partners is a risk factor for cervical cancer. More than half, 143 (53.0%), believed that HIV positivity could increase the chance of getting cervical cancer. On the other hand, only 85 (31.5%) believe that the use of oral contraceptive pills is a risk factor for cervical cancer. Regarding smoking and early marriage, of those who had heard about them, 151 (54.9%) and 90 (33.4%) believed these conditions were risk factors for cervical cancer, respectively [**Table 4**].

Table 2: Knowledge on risk factors and symptoms of cervical cancer, Hargeisa, Somaliland (n=270)

Variable	Response	Frequency	Percent
Contraceptive use	Yes	110	40.8
	No	95	35.2
	Do not know	65	24.1
Old-age (Aging)	Yes	132	48.9
	No	96	35.6
	Do not know	42	15.6
Poor hygiene	Yes	114	42.2
	No	114	42.2
	Do not know	42	15.6
Sexually transmitted disease	Yes	125	46.3
	No	102	37.8
	Do not know	43	15.9
	Yes	139	51.5
	No	89	33.0
	Do not know	42	15.6
Having multiple sexual partner	Yes	138	51.2
	No	91	33.7
	Do not know	41	15.2
Poor dietary habits	Yes	108	40.0
	No	116	43.0
	Do not know	46	17.0
	Total	270	100.0
Early marriage	Yes	77	28.5
	No	135	50.0
	Do not know	58	21.5
Family history of cervical cancer	Yes	101	37.4
	No	116	43.0
	Do not know	53	19.6
HPV is a causative agent for cervical cancer	Yes	105	38.9
	No	68	25.2
	Do not know	97	35.9
Unexplained weight loss	Yes	187	69.2
	No	83	30.8
Anemia	Yes	190	70.4
	No	80	29.7
Generalized body weakness	Yes	200	74.0
	No	70	26.0
Menstrual problems	Yes	201	76.3
	No	64	23.7
Fever	Yes	189	70
	No	81	30
Intra or post coital bleeding	Yes	170	63
	No	100	37
Bleeding after menopause	Yes	167	61.9
	No	103	38.1
Persistent blood stained and foul vaginal discharge	Yes	169	62.6
	No	101	37.4
Lower abdominal pain	Yes	170	63.0
	No	100	37.0
Cervical cancer is preventable	Yes	137	50.7
	No	133	49.3
Cervical cancer is curable	Yes	133	49.3
	No	137	50.7

Table 3: Sociodemographic characteristics versus knowledge status of the study participants, Hargeisa, Somaliland (n=270).

Variable	Category	Knowledge status		Total N (%)	P-value
		Good knowledge N(%)	Poor knowledge N(%)		
Age of respondents	15-19	18 (6.7%)	6 (2.2%)	24 (8.9%)	0.004*
	20-24	29 (10.7%)	36 (13.3%)	65 (24.1%)	
	25-29	21 (7.8%)	55 (20.4%)	76 (28.1%)	
	30-34	17 (6.3%)	22 (8.1%)	39 (14.4%)	
	35-39	17 (6.3%)	14 (5.2%)	31 (11.5%)	
	40-44	11 (4.1%)	14 (5.2%)	25 (9.3%)	
	45-49	5 (1.9%)	5 (1.9%)	10 (3.7%)	
Monthly income in USD	50-250	101 (37.4%)	106 (39.3%)	207 (76.7%)	0.023*
	251-500	14 (5.2%)	38 (14.1%)	52 (19.3%)	
	501-750	2 (0.7%)	4 (1.5%)	6 (2.2%)	
	751-1250	1 (0.4%)	4 (1.5%)	5 (1.9%)	
Educational status	University degree	37 (13.7%)	77 (28.5%)	114 (42.2%)	0.001*
	High school	20 (7.4%)	22 (8.1%)	42 (15.6%)	
	Primary	12 (4.4%)	10 (3.7%)	22 (8.1%)	
	Qur'an	17 (6.3%)	29 (10.7%)	46 (17.0%)	
	No formal education	32 (11.8%)	14 (5.2%)	46 (17%)	
Marital status	Single	56 (20.7%)	79 (29.3%)	135 (50.0%)	0.583
	Married	49 (18.1%)	63 (23.3%)	112 (41.5%)	
	Divorced	11 (4.1%)	9 (3.3%)	20 (7.4%)	
	Widowed	2 (0.7%)	1 (0.4%)	3 (1.1%)	
Status of children	Yes	52 (19.3%)	68 (25.2%)	120 (44.4%)	0.506
	No	66 (24.4%)	84 (31.1%)	150 (55.6%)	

Table 4: Attitude on risk factors and symptoms of cervical cancer, Hargeisa, Somaliland (n=270).

Variable	Response	Frequency	Percent
Believe having multiple sexual partners is risk factor for CC	Agree	147	54.5
	Disagree	80	29.5
	No opinion	43	16.0
Believe CC is transmittable through sexual intercourse	Agree	115	42.6
	Disagree	101	37.4
	No opinion	54	20.0
Believe HIV positivity increases the chance of getting CC	Agree	143	53.0
	Disagree	67	24.8
	No opinion	60	22.2
Believe use of oral contraceptive pill is a risk factor for CC	Agree	115	42.5
	Disagree	85	31.5
	No opinion	70	26.0
Think that smoking is a risk factor for CC	Agree	151	55.9
	Disagree	63	23.3
	No opinion	56	20.8
Think early marriage is risk factor for CC	Agree	90	33.4
	Disagree	112	41.5
	No opinion	68	25.1
Think CC is a major health problem for females of reproductive age group	Agree	143	52.0
	Disagree	65	24.0
	No opinion	62	24.0
Think it is possible to detect CC with early screening before symptoms appear	Agree	149	55.2
	Disagree	57	21.1
	No opinion	64	23.7
Think early detection of CC is good for treatment outcome.	Agree	156	57.8
	Disagree	56	20.7
	No opinion	58	21.5
Believe CC is preventable	Agree	137	50.8
	Disagree	75	27.8
	No opinion	58	21.5
Think it is possible to cure cervical cancer	Agree	137	50.7
	Disagree	62	23.0
	No opinion	71	26.3

CC: Cervical Cancer

Table 5: Sociodemographic characteristics versus attitude status of the study participants, Hargeisa, Somaliland (n=270).

Variable	Category	Attitude status		Total N (%)	P-value
		Negative attitude	Positive attitude		
Age of respondents		N(%)	N(%)		
	15-19	13 (4.8%)	11 (4.1%)	24 (8.9%)	0.002*
	20-24	42 (15.6%)	23 (8.5%)	65 (24.1%)	
	25-29	47 (17.4%)	29 (10.7%)	76 (28.1%)	
	30-34	22 (8.1%)	17 (6.3%)	39 (14.4%)	
	35-39	7 (2.6%)	24 (8.9%)	31 (11.5%)	
	40-44	10 (3.7%)	15 (5.6%)	25 (9.3%)	
	45-49	4 (1.5%)	6 (2.2%)	10 (3.7%)	
Monthly income in USD	50-250	103 (38.2%)	104 (38.5%)	207 (76.7%)	0.38
	251-500	34 (12.6%)	18 (6.7%)	52 (19.3%)	
	501-750	4 (1.5%)	2 (0.7%)	6 (2.2%)	
	751-1250	4 (1.5%)	1 (0.4%)	5 (1.9%)	
Educational status	University degree	83 (30.7%)	31 (11.5%)	114 (42.2%)	0.001*
	High school	22 (8.2%)	20 (7.4%)	42 (15.6%)	
	Primary	10 (3.7%)	12 (4.4%)	22 (8.1%)	
	Qur'an	17 (6.3%)	29 (10.7%)	46 (17.0%)	
	No formal education	13 (4.8%)	33 (12.2%)	46 (17.0%)	
Marital status	Single	90 (33.3%)	45 (16.7%)	135 (50.0%)	0.003*
	Married	44 (16.3%)	68 (25.2%)	112 (41.5%)	
	Divorced	10 (3.7%)	10 (3.7%)	20 (7.4%)	
	Widowed	1 (0.4%)	2 (0.7%)	3 (1.1%)	
Status of children	Yes	47 (17.4%)	73 (27.0%)	120 (44.4%)	0.001*
	No	98 (36.3%)	52 (19.3%)	150 (55.6%)	

Factors associated with the attitude of reproductive-age women towards cervical cancer screening

In further analysis to check whether the sociodemographic characteristics are associated with the status of attitude of the study participants, we conducted a chi-square test. The age of the respondents, educational status, marital status, and status of children were found to have a statistically significant association with a p-value of 0.002, 0.001, 0.003, and 0.001, respectively. Moreover, monthly income has no association with the attitude status of the study participants [Table 5].

Discussion

Despite the high growing burden of cervical cancer, it continues to receive low public health priority in Africa, largely because of limited resources and other pressing public health problems. It may also be in part due to a lack of awareness about the magnitude of the current and future cancer burden among policymakers, the general public, and international private or public health sectors. Knowledge and attitude of reproductive age women towards cervical cancer are essential for the prevention and control of the disease. In the current study, we found that less than half of the participants, 118 (43.7%), had good knowledge, whereas 152 (56.3%) had poor knowledge about the risk factors and symptoms of cervical cancer. These findings were concordant with the studies conducted in Wolaita, Southern Ethiopia (43.1%) [1] and Adigrat, northern Ethiopia (46.4%) [2]. Moreover, our current finding was higher than studies done in Addis Ababa (27.7%), [3], Gondar town (19.9%), [4] Finote Selam (30.3%) [5], Gurage Zone (26.2%) [6], Dire Dawa (9.3%) [7], Nepal (13%) [8], Cameroon (3.6%) [9], Perambalur (36.5%) [10], and India (11%) [11]. This variation might be due to differences in time, study setting, sample size, and Sociodemorgaphic characteristics of study participants. In contrast, our finding was lower than the report from Gondar (59.3%) [12], Dessie (51%) [13], Addis Ababa (60.8%) [14], Ambo (50.7%) [15], Rwanda (50.1%) [16], and China (51.9%) [17]. This difference might be because of the variation in study setting and population, as well as the socioeconomic and demographic variation. Overall, 125 (46.3%) of the study participants in the current study have a positive attitude towards the risk factors and symptoms of cervical cancer screening, whereas 145 (53.3%) have an unfavorable or negative attitude towards cervical cancer screening. This finding was lower than the report in the two Gondar studies (67.7%, 58.2%) [18,19], Finote Selam (58.1%) [5], Dire Dawa (60.1%) [20], Adigrat (53.3%) [2], China (96%) [17], Perambalur (83.8%) [10], and Nepal (85%) [8]. This discrepancy might be due to socioeconomic, Sociodemorgaphic, study setting, and study population differences. In the present study, age, educational status, and monthly income were found to be significantly associated with the knowledge of cervical cancer screening. This is in line with different studies conducted in else were in the world [1,5,13-15,17]. These might be due to the fact that, better educated people read more, listen the advice of medical professionals, and learn more about their health conditions which may give them better knowledge about cervical cancer screening. Similarly, Women with higher levels of education have greater abilities to communicate and an increased capacity for knowledge retention, which may

help them comprehend the nature of the disease and have a favorable attitude toward cervical cancer screening. Moreover, all the study participants have heard about cervical cancer screening. And the sources of information were (5.6%), (5.2%), (29.3%), and (6.3%) from relatives, friends, health workers, and the mass media, respectively. This finding is lower than that of the studies in Spain [12] and Nigeria [13]. Healthcare workers were the main source of information for the study participants which is in agreement with similar studies done in Kenya [21], but contrary to studies conducted in Ethiopia [22] and Hong Kong [23] where the main source of information was the mass media. In addition, 147 (54.5%) of the study participants replied that they believe having multiple sexual partners is a risk factor for cervical cancer, which is higher than other studies conducted in Uganda (38.3%) [23] and Nigeria (42.1%) [24]. Considering factors associated with the attitude of reproductive-age women towards cervical cancer in the present study, we found that the age of the respondents, educational status, marital status, and having children or no children have a statistically significant association. The association of marital status with the attitude towards cervical cancer screening is in line with a similar study conducted in Wolaita Zone, Southern Ethiopia [1]. Likewise, educational status was significantly associated with the attitude toward cervical cancer screening. This finding was consistent with earlier studies [5-17]. Furthermore, younger aged women were also having a statistically significant association with the attitude towards cervical cancer screening which is concordant with a similar study done in Debre Tabor town, Ethiopia [24]. Regarding the attitude of the study participants towards the risk factors and symptoms of cervical cancer screening,147 (54.5%) of the participants replied that they believe having multiple sexual partners is a risk factor for cervical cancer which is comparable with similar studies reported in Tanzania and India [25,26]. Concerning the main symptoms of cervical cancer, the majority of the study participants in the current study think that menstrual irregularities (76.3%) and anemia (70.4%) are among the major symptoms of cervical cancer which is in contrast with a similar study conducted in India (79%) [27], that indicates vaginal bleeding between menses as the main symptom of cervical cancer.

Conclusion

The overall good knowledge and positive attitude towards cervical cancer screening was low and the majority of the participants did not know how many times a healthy woman should undergo cervical cancer screening checkups. Educational status, monthly income, and age were found to be significantly associated with knowledge of the women toward cervical cancer, and marital status, educational status, and status of having children or not having children were also found to have statistically significant association with the attitude of the reproductive-aged women toward the cervical cancer screening. Therefore, health education and awareness creation regarding cervical cancer and cervical cancer screening should have to be provided at the primary health care level. Moreover, the health education can be also provided for students at secondary level. Finally, further comprehensive research at the community level is recommended.

Acknowledgment

We would like to express our gratitude to the two hospitals in Hargeisa, Somaliland, who volunteered to provide us with access to the records and the registration books. We would also like to acknowledge the reproductive-age women who provided us with their detailed information for the interview. Additionally, we would like to Acknowledge SOFHA for their funding support for the research

Data availability

The datasets used and/or evaluated in this study are available from the corresponding author upon reasonable request.

Conflicts of interest

We, the authors, declare that we have no conflicts of interest.

Authors' Contributions

ABK was responsible for the study concept, design, statistical analysis, and interpretation of the results. HMN acquired data from the records and interviews and participated in the data analysis. HMN wrote the concept and the first draft of the manuscript. ABK: I critically reviewed the manuscript for intellectual content. Both authors read and approved the final manuscript.

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