# SOCIAL FACTORS INFLUENCING CERVICAL CANCER SCREENING UPTAKE AMONG REPRODUCTIVE AGE WOMEN IN KWARA SOUTH SENATORIAL DISTRICT

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## Abstract

*Cervical cancer remains a major public health issue, particularly in low and middle-income countries where access to preventive health services is limited. This study investigated whether stigmatisation, fear of embarrassment, and poor attitude of health workers would be social factors influencing cervical cancer screening uptake among reproductive age women in Kwara South Senatorial District. The study employed a descriptive research design of survey type. The population of this study comprised 400,291 reproductive-age women residing in Kwara South Senatorial District, with a target population of 30,587 reproductive-age women. A multi-stage sampling procedure was used to select 305 participants. A researcher-designed, validated questionnaire, which was tested for reliability through the split-half method with a coefficient of 0.82, was used. The data obtained was analysed with percentages and the Chi-Square Goodness of Fit test. The findings of the study were that stigmatisation ($\chi 2 = 117.43$, $p=0.00<0.05$), fear of embarrassment ($\chi 2 = 133.92$, $p=0.00<0.05$), and poor attitude of health workers ($\chi 2 = 142.31$, $p=0.00<0.05$) are significant social factors influencing cervical cancer screening uptake among reproductive age women in Kwara South Senatorial District. The findings suggest that interventions aimed at improving screening uptake must address both community-level perceptions and healthcare system practices. Public health campaigns should focus on destigmatising cervical screening through education and awareness, while healthcare institutions must prioritise training providers to adopt respectful, supportive, and empathetic attitudes.*

**Keywords:** Social factors, Cervical Cancer, Screening Uptake

## Introduction

Cervical cancer remains a major public health issue, particularly in low and middle-income countries where access to preventive health services is limited. Regular cervical screening is recognised as an effective strategy for early detection and prevention, yet utilisation among reproductive age women has continued to be low in many settings. Understanding the determinants of screening uptake is therefore essential for addressing

the growing burden of cervical cancer and guiding context-specific interventions. Cervical cancer is almost always caused by Human Papilloma Virus (HPV) infection. Cervical cancer is a malignant neoplasm of the cervix uteri or cervical area. It may present with vaginal bleeding, but symptoms may be absent until the cancer is in its advanced stages (Cohen et al., 2019). Cervical cancer is a typically slow-growing cancer that may not have symptoms, but can be early diagnosed by doing a Pap smear. The burden of disease due to transmissible diseases such as HIV and HPV is increasing, especially in developing countries. Research has shown that HPV is the cause of about 70% of all cervical cancers (WHO, 2010).

Cervical cancer is a killer disease that is incurable but preventable. Early screening is a proven, cost-effective cervical cancer control strategy (Viveros-Carreño et al, 2023); thus, early screening of cervical cancer is an important preventative strategy. To date, cervical screening faces serious challenges in developing countries, as a lack of resources and a lack of awareness limit its coverage (Bansil et al., 2014). Studies have revealed that low awareness levels of cervical cancer and its prevention are likely to limit uptake of screening. Uptake of cervical screening services for cervical cancer is done by only a few who know about cervical cancer screening and its importance (WHO, 2010; Moshi et al., 2019). Ugwu et al. (2013) conducted a study among health professionals in Nigeria, which revealed low uptake of cervical cancer screening. It is noteworthy that, despite adequate knowledge of this group of professionals on the importance of cervical cancer screening tests, uptake was still low. Vhuromu et al. (2018) found that out of 79.2% of women who agreed to undergo cervical cancer screening, only 41.4% had ever done so.

Globally, over half a million women are diagnosed with cervical cancer each year, resulting in more than 300,000 deaths (Cohen et al., 2019). In Nigeria alone, approximately 12,075 new cases are reported annually, with 7,968 associated deaths (Olubodun et al., 2022). The problem posed by cervical cancer in Nigeria cannot be ignored, as many of the affected women report to the hospital late, when cancer prognosis is poor, as a result of the cancer cells leaving their primary tumour site to infiltrate surrounding tissues and also distant organs in the body. This has reduced the survival rate of cancer-related deaths in Nigeria. In Nigeria, the prevalence was notably high (10.8%) in 2021 (Ehwarieme et al., 2025). Moreover, there is a high risk of developing cancer of the cervix among

reproductive-age women, specifically sexually active teenagers, yet awareness of the disease is low. It has been reported that women in Nigeria are not adequately informed about the disease, the predisposing factors, and are uncertain about the importance of the screening tests. Women also hold negative beliefs and perceptions about screening tests (Mabotja et al., 2023).

The determinants of cervical screening services among women of reproductive age are multifaceted. Kirubarajan et al. (2021) reported that young women are poorly informed about cervical cancer with its associated risk factors, and are unclear about the intent of cervical screening, as well as holding on to negative or inaccurate beliefs or attitude to pap testing. Cultural norms surrounding female sexuality frequently contribute to the stigmatisation of cervical cancer screening. In many contexts, undergoing screening may be erroneously interpreted as an indicator of sexual immorality, prompting avoidance due to fear of social judgment.

A qualitative study in Addis Ababa found that women and healthcare providers identified stigma around promiscuity and fear of discrimination, including spousal disapproval and social labelling as key reasons for low screening uptake (Mohammed et al., 2025). In patriarchal societies, interpersonal dynamics, especially spousal and familial influences, shape women's decisions regarding screening. In Nigeria, Olubodun et al. (2022) reveal that the lack of spousal support and misconceptions about the purpose of screening hinder women's attendance. Similarly, research in Uganda identified that peer, familial, and partner attitudes significantly affect screening behaviour (Namutundu et al., 2024). Encouragement from family and peers, however, was noted to counteract stigmatisation by fostering trust and agency.

In rural South Africa's Vhembe District, Vhuromu et al. (2018) found that embarrassment accounted for 15.2% of reasons why women avoided Pap smears, alongside fear of pain (24.4%) and lack of facilities (30.0%). This underscores embarrassment as a central barrier, particularly when compounded with limited access and infrastructural constraints. Qualitative investigations further illuminate the nature of embarrassment. Chorley et al. (2017) reported that women often experienced strong emotional responses to screening procedures, describing them as degrading, shameful, or violating. The physical tools used, such as the speculum, were associated with feelings of vulnerability and loss of

bodily control; nudity in a clinical context broke deeply held social norms and magnified the emotional discomfort.

Utilisation of cervical cancer screening services among reproductive age women remains suboptimal, particularly in low- and middle-income countries. Though numerous structural, cultural, and knowledge-related barriers have been thoroughly documented, time constraints, including busy schedules, clinic wait times, and competing responsibilities, have emerged as significant impediments to screening uptake (Peterson et al., 2021). Vhuromu et al. (2018) found that the barriers to undergoing cervical cancer screening as cited by women of reproductive age were fear of pain, embarrassment, lack of awareness and, importantly, time constraints inhibiting attendance.

Vhuromu et al. (2018) highlighted that dismissive, rude, or judgmental behaviours from providers discouraged women from attending screening sessions. The finding resonates with the study by Marques et al. (2023), which showed that negative experiences with healthcare providers, reported by about 12.4 per cent of women, substantially reduced their likelihood of returning for subsequent screening appointments. The emotional consequences of such interactions underscore how even isolated instances of disrespect may deter long-term engagement with cervical cancer prevention services.

Women in developing countries like Nigeria seem to utilise reproductive health services more during pregnancy. They also use reproductive health services for post-natal, antenatal checkup and family planning or when faced with various gynaecological problems. It is important to ensure that these women are screened to reduce the incidence of cervical cancer. Their visit to the clinics provides an opportunity to give them information on the importance of the screening and where to get the services. Most women who die from cervical cancer, particularly in developing countries, are in the prime of their lives. They may be raising children, caring for their families and contributing to the social and economic lives of their towns and villages. A woman's death is both a personal tragedy and a sad and unnecessary loss to her family and her community, with enormous repercussions for the welfare of both. These deaths are unnecessary because there is compelling evidence that cervical cancer is one of the most preventable and treatable forms of cancer if it is detected early and managed effectively.

Ncube et al. (2015) documented that an average of 19% of women in developing countries have been screened for cervical cancer, as against 63% of women in developed countries. The question is, why are reproductive-age women not going for screening in developing countries? Could this be attributed to misconceptions, misuse of ideas and negative beliefs about cervical cancer or rather as a result of ignorance about existing/available screening services? A typical scenario in the Kwara South Senatorial District illustrates this challenge. For instance, a 36-year-old woman, married with three children, presents with recurrent post-coital bleeding but does not seek screening. Her inaction may be due lack of awareness, sociocultural constraints such as the need for spousal approval, limited financial resources, poor health-seeking behaviour, and inadequate health worker recommendations. This situation mirrors the experiences of many reproductive age women in peri-urban and rural communities within Kwara South, where multiple individual, cultural, and structural barriers reduce screening uptake and contribute to the progression of preventable precancerous lesions into invasive cancer.

Studies in Nigeria support these observations. Durowade et al. (2012) found that precancerous cervical lesions were prevalent among women in an urban community in Kwara State, underscoring the need for improved screening. Similarly, Agboola and Bello (2021) reported that while antenatal attendees in Ibadan demonstrated awareness and willingness to screen, actual utilisation remained low and was strongly associated with educational attainment and knowledge of cervical cancer. Furthermore, a qualitative study in Lagos by Olubodun et al. (2022) identified barriers such as cost, spousal influence, preference for female providers, and lack of awareness as major obstacles to screening utilisation. Most studies in Nigeria have been facility-based and concentrated in large urban areas such as Lagos and Ibadan, leaving rural and semi-urban populations, like those in Kwara South Senatorial District, underexplored (Agboola & Bello, 2021; Olubodun et al., 2022).

Studies such as Durowade et al. (2012) provided data on prevalence and risk factors of cervical cancer in Kwara State, but did not explore how social factors influence screening utilisation among women of reproductive age. Addressing these gaps is critical given that cervical cancer disproportionately affects women in their most productive and reproductive years, with dire socio-economic consequences for families and communities.

Thus, the need to explore the social factors influencing cervical cancer screening uptake among reproductive-age women in the Kwara South Senatorial District.

**Research Questions**

The following research questions were answered in the study:

1. Will stigmatisation influence cervical cancer screening uptake among reproductive-age women in Kwara South Senatorial District?
2. Will fear of embarrassment influence cervical cancer screening uptake among reproductive-age women in Kwara South Senatorial District?
3. Will the poor attitude of health workers influence cervical cancer screening uptake among reproductive-age women in the Kwara South Senatorial District?

**Research Hypotheses**

The following hypotheses were tested in the study:

$Ho_1$: Stigmatisation will not have a significant influence on cervical cancer screening uptake among reproductive age women in Kwara South Senatorial District.

$Ho_2$: Fear of embarrassment will not have a significant influence on cervical cancer screening uptake among reproductive-age women in Kwara South Senatorial District.

$Ho_3$: Poor attitude of health workers will not have a significant influence on cervical cancer screening uptake among reproductive age women in Kwara South Senatorial District.

**Methodology**

In this study, a descriptive research design of survey type was employed. This can be traced to the fact that the study was carried out among selected reproductive-age women out of a large population of women. The population of this study comprised reproductive-age women (15-45 years) residing in the seven Local Government Areas (Ifelodun, Irepodun, Ekiti, Isin, Oke-Ero, Offa, and Oyun) within Kwara South Senatorial District, Kwara State, Nigeria. The total population of reproductive age women in the seven Local

Government Areas of Kwara South Senatorial District is 400,291 (Estimates of National Population Commission and National Bureau of Statistics, 2020).

The target population were 30,587 reproductive age women from eight wards in randomly selected four local government areas. The sample size was determined based on Leslie Kish's formula: $n = \frac{Z^2pq}{d^2}$ where n = the required sample size, Z= total population, p = 1% of women of childbearing age, q= 1-p, $d^2$ = margin of error set at 0.5 (precision set at 10% of the calculated sample size will be added for non-responses). Therefore, the total sample size of respondents was 305. A multistage sampling procedure was employed to select the sample for the study. Stage one: A simple random sampling technique was used to select four Local Government Areas out of the seven LGAs that make up the Kwara South Senatorial District. This was done by using the fishbowl method of choosing four wrapped papers out of seven wrapped papers containing the names of the LGAs. The LGAs selected are Offa, Ifelodun, Oke-Ero and Ekiti.

Stage two: The purposive sampling technique was used to select two wards from each of the selected LGAs. Hence, the purposive sampling technique was used to select the two (2) most populous wards from each of the selected LGAs. The selected wards are Offa: Shawo Central and Ojomu Central, Ifelodun: Share 1 and Oke-Ode 1, Ekiti: Osi 1 and Etan ward, Oke-Ero: Aiyedun and Idofin Igbana 1. Stage three: A proportionate sampling technique was used to select 1% of the total population of women of childbearing age in each of the eight (8) selected wards. This took the total population of sample respondents to 305. Stage four: An accidental sampling technique was used to select the actual 305 samples from the selected wards. Women of childbearing age who met accidentally in the selected wards and consented to the study were sampled.

**Table 1**

*Sample Summary*

| S/N | LGAs | WARDS | POPULATION OF WOMEN OF CHILD-BEARING AGE | 1% SAMPLE |
|---|---|---|---|---|
| 1. | Offa | Shawo Central | 6,118 | 61 |
| 2. | | Ojomu Central | 5,774 | 58 |

| S/N | LGAs | WARDS | POPULATION OF WOMEN OF CHILD-BEARING AGE | 1% SAMPLE |
|---|---|---|---|---|
| 3. | Ifelodun | Share 1 | 4,109 | 41 |
| 4. | | Oke-Ode 1 | 2,002 | 20 |
| 5. | Ekiti | Osi 1 | 3,341 | 33 |
| 6. | | Etan ward | 3,211 | 32 |
| 7. | Oke-Ero | Aiyedun | 3,099 | 31 |
| 8. | | Idofin Igbana 1 | 2,933 | 29 |
| **Total.** | | | **30,587** | **305** |

A self-designed questionnaire was used to elicit information from the respondents. The instrument consists of two sections. Section A contained items on the demographic data of the respondents, while Section B contained statements for measuring the social factors influencing cervical cancer screening uptake with a response mode of a modified four-point Likert format rating scale of Strongly Agree (SA), Agree (A), Disagree (D), and Strongly Disagree (SD). The validity of the instrument was ensured by three experts. The split-half method was used, involving the administration of 20 copies of the instrument to reproductive-age women from Ganmo, which was not part of the sampled area for the study.

Spearman Brown was used to correlate the data, yielding a coefficient of 0.82. Permission to administer the instrument to the targeted respondents was obtained from the heads of the sampled PHCs. After permission was granted, the instrument was administered with the help of trained research assistants who were nurses from the sampled PHCs. Participation in the study was voluntary, and consent of each participant was obtained. The researcher kept all confidential information supplied by the respondents, as well as ensured the privacy of the participants. The researcher ensured that completed copies of the questionnaire were collected immediately to avoid loss of the instrument. The data obtained from this study were sorted, coded and subjected to appropriate statistical analysis. Descriptive statistics of frequency and percentage were used to answer the research questions, while Chi-Square was used to test the formulated hypotheses at a 0.05 level of significance.

**Results**

**Answer to Research Questions**

**Research Question 1:** Will stigmatisation influence cervical cancer screening uptake among reproductive-age women in Kwara South Senatorial District?

**Table 2:** *Stigmatisation as a Social Factor Influencing Cervical Cancer Screening Uptake*

| S/N | ITEMS | SA | A | Positive Response | D | SD | Negative Response |
|---|---|---|---|---|---|---|---|
| 1. | I feel embarrassed to talk about cervical screening with others. | 95 (31.1%) | 82 (26.9%) | 177 (58.0%) | 74 (24.3%) | 54 (17.7%) | 128 (42.0%) |
| 2. | I worry about being judged if I undergo cervical screening. | 104 (34.1%) | 88 (28.9%) | 192 (63.0%) | 66 (21.6%) | 47 (15.4%) | 113 (37.0%) |
| 3. | The stigma associated with cervical screening affects my decision to get screened. | 112 (36.7%) | 83 (27.2%) | 195 (63.9%) | 59 (19.3%) | 51 (16.7%) | 110 (36.1%) |
| 4. | I fear being labelled if I am seen going for cervical screening. | 126 (41.35) | 78 (25.6%) | 204 (66.9%) | 60 (19.7%) | 41 (13.4%) | 101 (33.1%) |
| 5. | I believe there is a social stigma attached to cervical screening. | 139 (45.6%) | 72 (23.6%) | 211 (69.2%) | 54 (17.7%) | 40 (13.1%) | 94 (30.8%) |
| 6. | Concerns about what others will think of me influence my choice to utilise cervical screening services. | 118 (38.7%) | 91 (29.8%) | 209 (68.5%) | 58 (19.0%) | 38 (12.5%) | 96 (31.5%) |
| | **Mean** | | | **198 (65%)** | | | **107 (35%)** |

The findings in Table 2 reveal that stigmatisation significantly influences cervical cancer screening uptake among reproductive-age women in the Kwara South Senatorial District. A majority of respondents expressed concerns about embarrassment, judgment, and social labelling, with 65% providing positive responses compared to 35% negative responses. This indicates that stigma, manifested through fear of being judged, labelled, or socially ostracised, acts as a substantial barrier to screening.

**Research Question 2:** Will fear of embarrassment influence cervical cancer screening uptake among reproductive-age women in Kwara South Senatorial District?

**Table 3:** *Fear of Embarrassment as a Social Factor Influencing Cervical Cancer Screening Uptake*

| S/N | ITEMS | SA | A | Positive Response | D | SD | Negative Response |
|---|---|---|---|---|---|---|---|
| 7 | I feel embarrassed discussing cervical screening with healthcare providers. | 122 (40.0%) | 84 (27.5%) | 206 (67.5%) | 59 (19.3%) | 40 (13.2%) | 99 (32.5%) |
| 8 | Fear of embarrassment prevents me from scheduling cervical screening appointments. | 130 (42.6%) | 83 (27.2%) | 213 (69.8%) | 54 (17.7%) | 38 (12.5%) | 92 (30.2%) |
| 9 | I worry about feeling embarrassed during cervical screening procedures. | 143 (46.9%) | 90 (29.5%) | 233 (76.4%) | 42 (13.8%) | 30 (9.8%) | 72 (23.6%) |
| 10 | Embarrassment is a significant factor in my decision to avoid cervical screening. | 137 (44.9%) | 88 (28.9%) | 225 (73.8%) | 47 (15.4%) | 33 (10.8%) | 80 (26.2%) |
| 11 | I would rather not have cervical screening than risk feeling embarrassed. | 118 (38.7%) | 86 (28.2%) | 204 (66.9%) | 65 (21.3%) | 36 (11.8%) | 101 (33.1%) |
| 12 | Concerns about feeling embarrassed deter me from utilizing cervical screening services. | 127 (41.6%) | 91 (29.8%) | 218 (71.5%) | 52 (17.0%) | 35 (11.5%) | 87 (28.5%) |
| | **Mean** | | | **217 (71%)** | | | **88 (29%)** |

Table 3 demonstrates that fear of embarrassment exerts an even stronger influence than general stigmatisation. Here, 71% of respondents gave positive responses compared to only 29% negative responses. Concerns about embarrassment, whether in discussing screening with healthcare providers, undergoing procedures, or being perceived by others, were consistently reported as deterrents.

**Research Question 3:** Will the poor attitude of health workers influence cervical cancer screening uptake among reproductive-age women in Kwara South Senatorial District?

**Table 4:** *Poor Attitude of Health Workers as a Social Factor Influencing Cervical Cancer Screening Uptake*

| S/N | ITEMS | SA | A | Positive Response | D | SD | Negative Response |
|---|---|---|---|---|---|---|---|
| 13 | I have experienced disrespectful behaviour from healthcare providers during cervical screening. | 124 (40.7%) | 85 (27.9%) | 209 (68.5%) | 56 (18.4%) | 40 (13.1%) | 96 (31.5%) |
| 14 | Negative attitudes of healthcare providers have deterred me from seeking cervical screening. | 131 (43.0%) | 81 (26.6%) | 212 (69.6%) | 53 (17.4%) | 40 (13.1%) | 93 (30.4%) |
| 15 | I feel uncomfortable discussing cervical health with healthcare providers due to past rudeness. | 116 (38.0%) | 88 (28.9%) | 204 (66.9%) | 59 (19.3%) | 42 (13.8%) | 101 (33.1%) |
| 16 | Health workers' insolence has influenced my decision to avoid cervical screening. | 128 (42.0%) | 86 (28.2%) | 214 (70.2%) | 55 (18.0%) | 36 (11.8%) | 91 (29.8%) |
| 17 | I have been discouraged from seeking cervical screening due to disrespectful treatment. | 119 (39.0%) | 91 (29.8%) | 210 (68.9%) | 58 (19.0%) | 37 (12.1%) | 95 (31.1%) |
| 18 | The behaviour of healthcare providers affects my willingness to utilise cervical screening services. | 145 (47.5%) | 84 (27.5%) | 229 (75.1%) | 44 (14.4%) | 32 (10.5%) | 76 (24.9%) |
| | **Mean** | | | **213 (70%)** | | | **92 (30%)** |

The results in Table 4 further emphasise the role of healthcare provider behaviour in influencing screening uptake. Seventy per cent of respondents reported negative experiences with health workers, including disrespect, rudeness, and discouraging attitudes, compared to 30% who did not.

**Hypotheses Testing**

**$H_{01}$**: Stigmatisation will not have a significant influence on cervical cancer screening uptake among reproductive age women in Kwara South Senatorial District.

**Table 5:** *Chi-Square ($\chi^2$) Analysis on Stigmatisation as a Social Factor Influencing Cervical Cancer Screening Uptake*

| Variable | N | df | Cal. $\chi^2$ | Sig. Value | Decision |
|---|---|---|---|---|---|
| Stigmatisation as a social factor influencing cervical cancer screening uptake | 305 | 15 | 117.43 | 0.001 | **$H_{01}$ Rejected** |

Table 5 indicates that the calculated Chi-Square ($\chi^2$) value is 117.43 at 15 degrees of freedom and a significance level. value of 0.001. Since the sig. The value of 0.001 is less

than the 0.05 alpha level. Therefore, the null hypothesis is rejected. This implies that stigmatisation is a significant social factor influencing cervical cancer screening uptake among reproductive-age women in the Kwara South Senatorial District.

**$H_{02}$**: Fear of embarrassment will not have a significant influence on cervical cancer screening uptake among reproductive-age women in the Kwara South Senatorial District.

**Table 6 :** *Chi-Square ($\chi^2$) Analysis on Fear of Embarrassment as a Social Factor Influencing Cervical Cancer Screening Uptake*

| Variable | N | df | Cal. $\chi^2$ | Sig. Value | Decision |
|---|---|---|---|---|---|
| Fear of Embarrassment as a Social Factor Influencing Cervical Cancer Screening Uptake | 305 | 15 | 133.92 | 0.001 | **$H_{o2}$ Rejected** |

Table 6 indicates that among 305 respondents, the calculated Chi-Square ($\chi^2$) value of 133.92 at 15 degrees of freedom and a significance level. value of 0.001. Since the sig. The value of 0.00 is less than the 0.05 alpha level. Therefore, the null hypothesis is rejected. This implies that fear of embarrassment is a significant social factor influencing cervical cancer screening uptake among reproductive-age women in the Kwara South Senatorial District.

**$H_{03}$**: Poor attitude of health workers will not have a significant influence on cervical cancer screening uptake among reproductive age women in Kwara South Senatorial District.

**Table 7:** *Chi-Square ($\chi^2$) Analysis on Poor Attitude of Health Workers as a Social Factor Influencing Cervical Cancer Screening Uptake*

| Variable | N | df | Cal. $\chi^2$ | Sig. Value | Decision |
|---|---|---|---|---|---|
| **Poor Attitude of Health Workers as a Social Factor Influencing Cervical Cancer Screening Uptake** | 305 | 15 | 142.31 | 0.001 | **$H_{o3}$ Rejected** |

Table 7 shows that the calculated $\chi^2$ value of 142.31 at 15 degrees of freedom and a significance level. value of 0.001. Since the sig. The value of 0.00 is less than the 0.05 alpha level. Therefore, the null hypothesis is rejected. This indicates that the poor attitude of health workers has a significant influence on cervical cancer screening uptake among reproductive-age women in Kwara South Senatorial District.

**Discussion**

The findings from this study reveal that social factors significantly influence cervical cancer screening uptake among reproductive-age women in the Kwara South Senatorial District. The study explored the social factors such as stigmatisation, fear of embarrassment and poor attitude of health workers as determinants of cervical cancer screening uptake among reproductive age women. A significant finding was that stigmatisation has a significant influence on cervical cancer screening uptake among reproductive age women in Kwara South Senatorial District. The result aligns with the study of Petersen et al. (2022), who identified stigma as one of the most consistent barriers to cervical cancer screening in low- and middle-income countries, particularly where discussions around reproductive and sexual health are considered taboo. Similarly, Nwabichie et al. (2018) noted that women often associate cervical cancer screening with sexual promiscuity or sexually transmitted infections, leading to fear of moral judgment. This fear of public scrutiny or being mischaracterised by community members discourages women from utilising screening even when available and affordable (Isa Modibbo et al., 2016). Also, Binka et al. (2019) found that many women in sub-Saharan Africa perceive cervical cancer screening as something shameful or stigmatised, leading to delayed or avoided screening.

Another notable finding is that fear of embarrassment has a significant influence on cervical cancer screening uptake among reproductive-age women in the Kwara South Senatorial District. The result aligns with the study of Adzigbli et al. (2025), who noted that in conservative communities, discussing sexual or reproductive health is often considered inappropriate, which can fuel women's reluctance to participate in preventive services such as screening. Mafiana et al. (2022) also emphasised that feelings of vulnerability and embarrassment often discourage women from seeking cervical screening

services, particularly in conservative settings. Yeh et al. (2019) observed that in many African societies, the pelvic examination process involved in cervical screening is often seen as intrusive and shameful, especially when conducted by male health professionals or in facilities lacking privacy. This perception contributes to poor uptake even among women with adequate knowledge.

Finally, the study identified poor attitude of health workers has a significant influence on cervical cancer screening uptake among reproductive age women in Kwara South Senatorial District. This finding is consistent with the findings of Mafiana et al. (2022), who reported that poor communication, dismissive attitudes, and a lack of empathy among healthcare providers discourage women from seeking cervical health services. This finding resonates with the study by Marques et al. (2023), which showed that negative experiences with healthcare providers, reported by about 12.4 per cent of women, substantially reduced their likelihood of returning for subsequent screening appointments. The emotional consequences of such interactions underscore how even isolated instances of disrespect may deter long-term engagement with cervical cancer prevention services. Also, Vhuromu et al. (2018) highlighted that the attitudes of health workers were among the most critical barriers to the uptake of cervical cancer screening services. Women often reported that dismissive, rude, or judgmental behaviours from providers discouraged them from attending screening sessions.

## Conclusion

The study concluded that stigmatisation, fear of embarrassment, and poor attitude of health workers affect cervical cancer screening uptake among reproductive age women in Kwara South Senatorial District. Stigmatisation discouraged women from seeking screening, due to fear of judgment and societal labelling. Fear of embarrassment was a notable deterrent, especially regarding discussions and procedures related to cervical screening. The poor attitude of health workers played a critical role, as disrespectful or rude behaviour from healthcare providers discouraged many from returning for screening.

## Recommendations

Based on the conclusions drawn from this study, the following recommendations were made:

1. Public health education campaigns should aim to normalize cervical screening by correcting misconceptions, promoting positive narratives, and involving trusted community leaders in awareness efforts through culturally sensitive outreach and testimonials from screened women.
2. Health interventions should include strategies that normalise the screening experience, ensure privacy and offer options for female providers. Community-based education should also tackle the myths surrounding cervical screening and provide reassurance that the procedure is respectful and confidential.
3. Continuous professional development and patient-centred care training should be implemented to improve the attitudes and communication skills of healthcare workers involved in cervical screening.
4. Collaboration between government agencies, NGOs, and community leaders to improve HPV vaccine accessibility and acceptance should be intensified to ensure public sensitisation on the importance of HPV vaccination as a primary prevention strategy against cervical cancer. The government should help in mandating the incorporation of HPV immunisation awareness into school health programmes, maternal health services, and community outreach initiatives.

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