

RESEARCH ARTICLE

Knowledge and Attitude of Women Attending Aba South Health Center, Abia State towards Cervical Cancer

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Abstract

Cervical cancer, also known as carcinoma of the cervix, is a malignant tumor that originates from the cervix's squamous or glandular cells. It presents a major health problem for women in developing nations such as Nigeria. This descriptive survey aimed to evaluate the knowledge and attitudes of women attending Aba South Health Center towards cervical cancer. Using systematic sampling, 218 women of reproductive age were selected. Data was gathered through a validated, structured, closed-ended questionnaire. SPSS was used for the statistical analysis, and chi-square tests were used with a level of significance of $P \leq 0.05$. Most participants (17.9%) were aged 20–24 years, with 61% having tertiary education. While 62.4% knew about cervical cancer risk factors, 66.5% lacked awareness of symptoms, 66.1% were unfamiliar with screening methods, and 49.5% did not know about preventive strategies. Attitudinally, most women (average score = 3.08) believed they were not at risk, indicating a negative perception. There was no significant correlation between age and knowledge level ($P=0.777$), but a significant association between education and knowledge was observed ($P=0.007$). Age and education did not significantly influence attitudes ($P=0.416$ and $P=0.242$). These results reveal poor awareness and negative attitudes toward cervical cancer among women of reproductive age. There is a need for enhanced education on cervical cancer's nature, risks, screening, and prevention. Governments and NGOs should focus on health education policies aimed at cervical cancer prevention screening.

Keywords: Knowledge, Attitude, Women, Health Center, Cervical Cancer.

1. Introduction

Cervical cancer is the most preventable cancer of the female reproductive system and the second leading cause of cancer deaths among women worldwide¹. It is the second most common cancer in women globally², accounting for 17% of all cancer-related deaths among women aged 30 to 69³. In 2018, all but

one of the top 20 countries with the highest rates of cervical cancer were in Africa⁴. The World Health Organization (2013) estimates that approximately 000 new cases and 270,000 deaths occur annually due to this preventable disease⁵. The most common cancers include breast (36.5%), colorectal (11.7%), prostate (8.1%), cervical (7.2%), soft tissue (6%),

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non-melanoma skin (5.2%), ovarian (4%), metastatic (4%), gastric (2.6%), thyroid (1.8%), and salivary gland (1.4%)⁶. About 83% of new cases and 85% of deaths from cervical cancer happen in developing countries⁷, with Nigeria accounting for over 10%⁵. In 2007, it was reported that 36.59 million women aged 15 and above in Nigeria were at risk of developing cervical cancer, with 9,922 cases diagnosed annually and 8,030 deaths⁸. The incidence rate in Nigeria is 250 per 100,000 people⁹.

The Human Papilloma Virus (HPV), a sexually transmitted infection that may be prevented in part by vaccination and safe sexual behavior, is the recognized main cause of cervical cancer^{7,10}. Cervical cancer has a more favourable prognosis when detected early; nevertheless, research undertaken in Nigeria indicates a significant prevalence of late-stage tumour presentations. It is estimated that 90 percent of cervical cancer develop as a result of HPV.¹¹ Late presentation results in complex diagnosis and therapy, unfavourable prognosis, heightened risks of adverse effects from second- or third-line medicines, substantial treatment expenditures, diminished productivity, and elevated mortality rates.^{7,12} There are more than 100 strains of HPV virus but high risk subtypes 16 and 18 are highly carcinogenic and are involved in cervical cancer.^{13,14} However, anogenital warts are linked to the low-risk subtypes 6, 11, 40, 42, 43, 44, 54, 61, 70, 72, and 81.¹⁴ Potentially changeable sexual and non-sexual behavioral risk factors account for around 70% of cervical cancer cases.¹⁵ Sexual behavior factors include having several sexual partners, being under the age of eighteen while having sex for the first time, and having a sexually transmitted infection (e.g., HIV and HPV). Using oral contraceptives for more than five years and smoking tobacco are examples of non-sexual behavioral variables.¹⁶ It is thought that certain aspects of sexual behavior increase the risk of contracting HPV.¹⁷ Cancer of the cervix is asymptomatic in the early stages. In advance stages women may experience post coital bleeding, post-menopausal bleeding, watery vaginal discharge, lower abdominal pain, offensive blood stain vagina bleeding etc.¹⁰

Knowledge and attitude of cervical cancer is important in determining appropriate health seeking behaviours, with the aim of taking appropriate preventive and control actions against cervical cancer. According to research, many women in underdeveloped nations lack the necessary knowledge and have a negative attitude about cervical cancer, which results in them not taking the necessary preventative and control measures. However, misunderstandings about the context of cervical cancer and a lack of awareness

about its associated risks and preventative strategies have contributed to the rise in the disease's incidence and prevalence. Additionally, increasing community awareness, knowledge, attitudes, and behaviors are strategic interventions that are thought to be a tool for diagnosis, treatment, early detection, and primary prevention.¹⁸ Prenatal health discussions on cervical cancer can help close the communication gap that results in a lack of awareness about the disease and how to prevent it.

Nigeria is one of the emerging nations where cervical cancer is becoming a more serious issue¹¹. It ranks second among women in terms of cancer-related morbidity and death¹⁹. Cervical cancer-related mortality and morbidity have remained a danger to women's lives. In addition to affecting the health and lives of these women in their prime working years, this potentially fatal illness has turned into a social issue because of the impact on the children of these women, who experience a decline in school attendance and nutritional status, as well as on the families and the community at large. To take preventive action against cervical cancer, women of childbearing age must have knowledge and a positive attitude about the disease. However, studies have revealed that many women in developing nations lack knowledge or are misinformed about the nature of cervical cancer^{9,19}, its risk factors, and preventive behaviors. As a result, preventive measures are not carried out as needed. Additionally, only a tiny percentage of women getting prenatal care and family planning services have access to health education, HPV vaccination, and cervical cancer screening in underdeveloped nations. All of these issues, however, have inevitably resulted in a rise in the disease's incidence, prevalence, and death and morbidity rates.²⁰ This context informs the design of the survey on women's attitudes and knowledge regarding cervical cancer. It is intended that the results of this investigation will serve as a basis for tackling the issues that have been found.

Aba South Health Center is the biggest health center in Aba South Local Government Area, Abia State. It has more than eight units, but Antenatal and Family Planning units are the units most utilized by women of childbearing age. These women's visit to the health center provides a good chance to gauge their attitude and degree of awareness on cervical cancer. As far as we are aware, this cohort has not been used in any cervical cancer research. It is possible to get a representative sample of sexually active women by interviewing expectant mothers in prenatal clinics.²¹ Thus, the purpose of this study is to evaluate the sociodemographic factors of interest, such as age and educational attainment, as well as the knowledge

and attitudes of women who visit Aba South Health Center regarding cervical cancer.

2. Materials and Methods

A descriptive survey was conducted amongst women who were enrolled at the Aba South Health Center in the Aba South Local Government Area of Abia State, Nigeria. Aba South is one of Abia State's seventeen (17) local governments, which serves as the state's main commercial hub and beating heart. It is located at the junction of the highways that connect to Port Harcourt and Ikot Ekpene, and it runs along the west bank of the Aba River.²² Aba South L.G.A lies on latitude 5° 06 -5.100° N and longitude 7 21-7.350 E (Wikipedia, 2015). Aba South L.G.A has a population of 423 852 with an area of 49km² and a postal code of 450 and it is surrounded by about 13 communities and has about 32 health centers, major markets, several churches, 70 primary schools and 56 secondary schools. The major religion practiced here is Christianity, also the major socio-economic activity found here is trading and the major language spoken here is igbo. It also has markets such as; Ahia Ohuru, Ehi Road Market, Cemetery Markert, Shopping Center Aba, Waterside Market (Nkwo Ngwa) etc. and churches such as; St, Joseph Catholic Church Aba, Christ the King Church (CKC), Methodist Church Aba, ST. Michael's Cathedral etc. All women of childbearing age who visited the prenatal and family planning unit at the Aba South Health Center in Abia State were included in the research population.

The sample size was gotten using the formula below;

$$n = N / 1 + N (e)^2$$

Where;

n= Sample Size

N= Target Population = (201 and 108)

e= degree of error = 0.05 (5%)

For the antenatal unit;

$$n = 201 / 1 + 201 (0.05)^2 = 134$$

For family planning unit;

$$n = 108 / 1 + 130 (0.05)^2 = 84$$

To choose the sample sizes of 134 and 84, a systematic random sampling approach was employed. These women were randomly selected during their routine visit to the antenatal and family planning unit of Aba South Health Center, Abia State. The sampling frame/ interval was calculated using;

$$K = N / n$$

Where;

K= sampling frame/ interval

N= target population (201 and 108)

n= sample size (134 and 84)

i.e. For antenatal unit, $K = 201 / 134 = 1.5 = 2$

For family planning unit, $K = 108 / 84 = 1.29 = 1$

A well-structured, closed-ended questionnaire that was created in English and based on reviewed literature was used to collect data. The questionnaire, which has 20 items and three parts, was created to collect data on the sociodemographic variable of interest as well as respondents' attitudes and knowledge regarding cervical cancer. The questionnaire, which included 20 items and was divided into three sections, was intended to collect data on the sociodemographic variable of interest as well as respondents' attitudes and knowledge regarding cervical cancer. The sociodemographic information on women, including age, marital status, and educational attainment, is included in Section A. While Section C focused on women's attitudes regarding cervical cancer, Section B addressed women's understanding of the disease by going over its definition, risk factors, symptoms, screening test, and preventative measures and behaviors. With the assistance of the clinic's qualified health personnel, the questionnaire was given to willing women who were enlisted at their regular visit after they had been briefed about the study's specifics.

All researchers received training from the lead investigator and engaged in data collecting. The training emphasised the elements of the questionnaire, comprehension of the study objectives and methodology, as well as any issues that may occur during data collecting and their corresponding remedies. The test-retest approach was used to assess the instrument's reliability. The questionnaire's reliability was assessed using the Crombach test, and an 85% reliability coefficient was found. Questionnaires that were fully completed were categorized and sorted. The statistical software for social sciences was then used to enter and analyze this (SPSS 21.0). Frequency tables and charts were used to display the findings. Means, standard deviations, proportions, and percentages were used to calculate and provide descriptive statistics of the participants' sociodemographic data, knowledge, and attitudes.

We informed the authorities of center about the objective of our study and obtained permission to collect data. The ethical task team of the Federal University of Technology, Owerri's Department of Public Health granted ethical authorization. Institutional approval was obtained from the H.O.D Aba South Primary Health Care Department and also from the unit head of antenatal and family planning unit. Participants

gave their verbal agreement after being fully informed about the study's specifics and procedures. The names and addresses of the respondents were omitted from the questionnaire to maintain confidentiality and anonymity. All records and relevant materials were assessed only by authorized personnel.

3. Results

The purpose of the 218 questionnaires was to evaluate women's attitudes and knowledge regarding cervical cancer. There was a 100% response rate

from the 218 ladies who filled out the survey form. The majority (17.9%) of respondents were between the ages of 20 and 24 according to the results of the sociodemographic characteristics of the respondents by age (16.5%). 35–39, 16.1% 25–29, 14.7% 30–34, 14.7% 9.8%, 40–44, ≤19, 6.8% 45–49, (4.1%) ≥50 (table 1).

Respondents' educational backgrounds included basic education (6.9%), secondary education (22.5%), university education (61.0%), and no formal knowledge (9.6%) (table 1).

Table 1. Distribution of women participating in the study by age and educational level

Variables	Frequency (N= 218)	Percentage (%)
Age		
≤19	21	9.6
20-24	39	17.9
25-29	35	16.1
30-34	32	14.7
35-39	36	16.5
40-44	32	14.7
45-49	14	6.4
≥50	9	4.1
Educational level		
No formal Education	21	9.6
Primary Education	15	6.9
Secondary Education	49	22.5
Tertiary Education	133	61.0

The results of the respondent's cervical cancer knowledge score are displayed in Table 2. Table 2 shows that 71 (32.6%) individuals had strong knowledge about cervical cancer, compared to 147 (67.4%) who had low or no information. A good

number of the respondents (32.6%) indicated that cervical cancer develops or starts in the vagina, (31.2%) chose the neck of the womb (cervix), (24.3%), breast and (11.9%) choose the ovary (table 3).

Table 2. knowledge score of respondent on cervical cancer

Variable	Frequency (N=218)	Percentage (%)
Poor knowledge (0 - 4)	147	67.4
Good knowledge (5 – 9)	71	32.6

Table 3. distribution of respondent's knowledge on definition of cervical cancer

Variables	Frequency (N= 218)	Percentage (%)
Starts in the cells of the breast	53	24.3
Develops in the ovary	26	11.9
Starts in the cells of the neck of the womb	68	31.2
Affects the vagina	71	32.6

Concerning the risk factors majority (62.4%) indicated multiple sexual partners, (20.2%) chose being infertile, (9.6%) indicated that having a female is a risk factor while (7.8%) chose being a baby (table 4) Table 5 lists the symptoms and indicators of cervical cancer. Of these, 35.5 percent of respondents said that vaginal itching is not a sign or symptom of the

disease, while 26.6% said that bleeding after sexual activity, offensive blood-stained vaginal bleeding, and watery vaginal discharge are. The pap smear test (28.9%), colposcopy (20.2%), and visual aided vaginal discharge (17.0%) were selected by the respondents as non-screening tests in the results of the screening test for identifying abnormal changes in the cervix that

can predispose to cervical cancer, while the widal test was selected as a non-screening method by 13.9% of the respondents (figure 1) . Concerning the preventive measures, figure 2 indicated that vaccination against HPV (19.7%), screening using pap smear test (15.1%),

having protected sexual intercourse (14.7%) are not preventive measures for cervical cancer of which they are and (50.5%) correctly chose regular exercise as a non- preventive measure.

Table 4. *distribution of respondent's knowledge on Risk factors of cervical cancer*

Variables	Frequency (N= 218)	Percentage (%)
Having multiple sexual partners	136	62.4
Having a female child	21	9.6
Being a baby	17	7.8
Being infertile	44	20.2

Table 5. *distribution of respondent's knowledge on Signs and Symptoms of cervical cancer*

Variables	Frequency (N= 218)	Percentage (%)
Bleeding after intercourse	58	26.6
Itching in the vagina	73	33.5
Offensive blood stain vagina bleeding	51	23.4
Watery vagina discharge	36	16.5

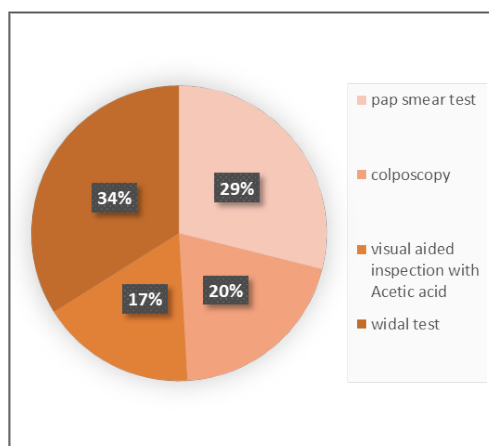


Figure 1. *pie chart showing the knowledge of respondents on screening test for cervical cancer*

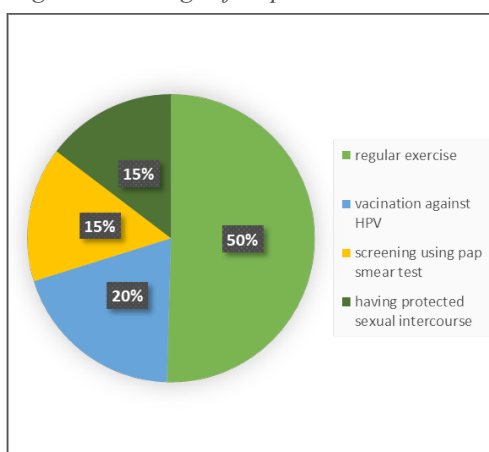


Figure 2. *pie chart showing the knowledge of respondents on Preventive measures for cervical cancer*

The attitude scores of the respondents as presented in table 6 showed that respondent's attitudes towards cervical cancer are (83.0%) negative and (17.0%) positive. According to table 7, (42.2%) strongly disagreed that the can never have cervical cancer, (3.7%) disagreed, (0.5%) were indifferent, (39.0%) agreed and (15.1%) strongly agreed. In can cervical

cancer occur in very holy people (32.1%) strongly disagreed, (16.5%) disagreed, (4.6%) were indifferent, (31.7%) agreed and (15.1%) strongly agreed. Pap smear screening test for detecting abnormal changes in the cervix should be a must for young girls, (32.6%) chose strongly disagreed, (6.4%) disagreed, (3,2%) were indifferent, (49.1%) agreed and (8.7%) strongly

agreed.(11.0%) strongly disagreed to the fact that immunization against cervical cancer should be encouraged for young girls while (14.7%) disagreed, (0.5%) were indifferent, (66.5%) agreed and (66.5%) strongly agreed.(15.6%) strongly disagreed that those that keep their vagina clean can also develop cervical cancer, (17.0%) disagreed, (18.3%) were indifferent, (35.5%) agreed and (15.6%) strongly agreed. Responses to women with one sexual partner can also develop cervical cancer were (17.0%) strongly

disagreed, (20.6%) disagreed, (5.0%) were indifferent, (35.8%) agreed and (21.6%) strongly agreed. In surgical intervention as a preventive measure, (29.5%) strongly disagreed, (14.7%) disagreed, (8.7%) were indifferent, (34.9%) agreed and (12.4%) strongly agreed. Engaging in protected sexual intercourse as a preventive measure were indicated by respondents as, (28.6%) strongly disagreed, (11.9%) disagreed, (7.8%) were indifferent, (38.5%) agreed and (13.8%) strongly agreed.

Table 6. Attitude score of respondents on cervical cancer

Variables	Frequency (N=218)	Percentage (%)
negative attitude (0-3)	181	83.0
positive attitude (4-8)	37	17.0

Table 7. Summary of scores and mean of respondent's attitude towards cervical cancer

Variables	SD		D		IN		A		SA		Mean
	F	%	F	%	F	%	F	%	F	%	
Do you think you can have cervical cancer	92	42.2	8	3.7	0	0.5	85	39.0	33	15.1	3.08
Cervical cancer can occur in very holy people	70	32.1	36	16.5	10	4.6	69	31.7	33	15.1	2.72
Pap smear screening test for detecting abnormal changes in the cervix should be must for every woman after age 21	71	32.6	14	6.4	7	3.2	107	49.1	19	8.7	2.99
Immunization against cervical cancer should be encouraged for young girls	24	11.0	32	14.7	1	0.5	14.5	66.5	145	66.5	1.62
Those that keep their vagina clean can also develop cervical cancer	34	15.6	37	17.0	40	18.3	73	33.5	34	15.6	2.12
Women with one sexual partner can also develop cervical cancer	37	17.0	45	20.6	11	5.0	78	35.8	47	21.6	2.38
Surgical intervention can be used as a preventive measure for cervical cancer	84	29.5	32	14.7	19	8.7	76	34.9	27	12.4	2.64
Engaging in protected sexual intercourse can also prevent one from developing cervical cancer	61	28.0	26	11.9	17	7.8	84	38.5	30	13.8	2.65

In table 8, the relationship between women of different age group and knowledge score of cervical cancer showed that, ≤ 19 had a poor (71.4%) and a good (28.6%) knowledge of cervical cancer, between 20-24 showed (74.4%) poor and (25.6%) good knowledge, 25-29,(68.6%) poor and (31.4%) good knowledge, 30-34(59.4%) poor and (40.6%) good knowledge, 35- 39 (61.1%) poor and (38.9%) good knowledge, 40-44 (68.8%) poor and (31.3%) good knowledge, 45-49 (78.4%) poor and (21.4%) good knowledge, ≥ 50 (55.6%) poor and (44.4%) good knowledge.

Respondents' educational attainment: 80% and 20% of those with primary education had poor and good knowledge of cervical cancer, respectively, while 71.4 percent of those with secondary education had poor and 28.6% had good knowledge, while those without formal education had 60.2% and 39.8% of those with education levels that were both poor and good, respectively.

Also in table 9, the relationship between women of different age groups and the knowledge scores of

cervical cancer showed that, ≤ 19 had a poor (81%) and a good (19%) knowledge of cervical cancer, between 20-24 showed (71.8%) poor and (28.2%) good knowledge, 25-29, (82.9%) poor and (17.1%) good knowledge, 30-34 (81.3%) poor and (18.8%) good knowledge, 35-39 (86.1%) poor and (13.9%) good knowledge, 40-44 (87.5%) poor and (12.5%) good knowledge, 45-49 (92.9%) poor and (7.1%) good knowledge, ≥ 50 (100%) poor and (0%) good knowledge.

Respondents' educational attainment: tertiary-educated respondents (86.5%) and (13.5%) had poor and good knowledge of cervical cancer, respectively; primary-educated respondents (73.3%) and (26.7%) had poor and good knowledge, respectively; secondary-educated respondents (511.6%) had poor and 18.4%) had good knowledge, and those without formal education (7.4%) and (28.6%) had poor and good knowledge, respectively.

Table 8. Relationship between respondent's socio-demographic characteristics and knowledge score of cervical cancer

	Knowledge Score				X ²	P value
	Poor knowledge (0-4)	%	Good knowledge (5-9)	%		
Age						
<19	15	71.4	6	28.6	4.021	0.777
20-24	29	74.4	10	25.6		
25-29	24	68.6	11	31.4		
30-34	19	59.4	13	40.6		
35-39	22	61.1	14	38.9		
40-44	22	68.8	10	31.3		
45-49	11	78.6	3	21.4		
>50	5	55.6	4	44.4		
Educational level						
No formal knowledge	20	92.2	1	4.8	12.040	0.007
Primary education	12	80.0	3	20.0		
Secondary education	35	71.4	14	28.6		
Tertiary education	80	60.2	53	39.8		

Table 9. Relationship between respondent's socio-demographic characteristics and attitude score of cervical cancer

	Attitude score				X ²	P value
	Negative attitude(0-3)	%	positive attitude (5-9)	%		
Age						
≤ 19	17	81%	4	19%	7.125	0.416
20-24	28	71.8%	11	28.2%		
25-29	29	82.9%	6	17.1%		
30-34	26	81.3%	6	18.8%		
35-39	31	86.1%	5	13.9%		
40-44	28	87.5%	4	12.5%		
45-49	13	92.9%	1	7.1%		
≥ 50	9	100%	0	0%		
Educational level						
No formal knowledge	15	71.4%	6	28.6%	4.189	0.242
Primary education	11	73.3%	4	26.7%		
Secondary education	40	81.6%	9	18.4%		
Tertiary education	115	86.5%	18	13.5%		

4. Discussion

This survey evaluates women's attitudes and knowledge regarding cervical cancer. According to the respondents' sociodemographic details, the majority

of women (17.9%) were in the 20–24 age range, and 61% of them had completed higher education. This is comparable to a research on women's knowledge, attitudes, and screening practices for cervical cancer in

a primary health facility in Qatar, where the majority of respondents (57.8%) had completed postsecondary education.²³ The similarities in their finding can be due to the fact the Aba as a city has a high number of tertiary universities (private and Government).

Of the responders, just 32.6% were aware that the cervix is where cervical cancer begins. This is less than the results of a study conducted in Ibadan on the causes of cervical cancer, screening use, and awareness among Nigerian women, which showed that 41.8% of them were unaware of the disease.²⁴ The inconsistency in the observations can be attributed to the fact the women attending abasouth health center do not even know where cervical cancer develops.

As regards the preventive and screening measures for cervical cancer, only (50.5%) and (33.9%) respectively knew the preventive measures and screening test for cervical cancer. These results are consistent with a research that found that 23.6% of women who visited gynecology clinics at a tertiary level medical facility in South Eastern Nigeria were aware of cervical cancer screening tests.²⁵ The findings' similarity may be the result of respondents' limited understanding of the availability and advantages of screening tests and cervical cancer prevention.

Respondents' understanding of cervical cancer is really inadequate. This is comparable to a research that found that Ugandan women had very little awareness of cervical cancer and the factors influencing the use of reproductive health services in the Nsangi community in Uganda and its implications on the uptake of cervical cancer screening.²⁶ One reason for this could be that women obtaining reproductive services, such family planning and prenatal care, at Aba South Health Center are not given information about cervical cancer.

The findings showed that respondents had very high and unfavorable opinions toward cervical cancer. Few respondents (8.7%) agreed that pap smears, a cervical cancer screening test, should be required for all women over the age of 21, while a sizable portion (32.6%) disagreed. This finding is comparable to a research on the attitudes and practices around cervical cancer screening among female healthcare professionals at Port Harcourt Teaching Hospital in Rivers State, where a sizable portion of respondents (91.7%) disagreed with the idea while 8.3% agreed.²⁷

While 15.6% of respondents disagreed with this, 15.6% of respondents agreed that women who maintain a clean vagina can also acquire cervical cancer. Also (21.6%) of respondents were of the opinion that

women who maintain one sexual partner can also develop cervical cancer while (17%) disagreed. However, according to research by Ehiemere et al., 13.7% of female health workers agreed and 6.3% disagreed that women who have one sexual partner and practice good genital hygiene do not require cervical cancer screening.²⁷ This finding's consistency can be explained by the fact that female health workers are unable to inform women who attend the clinic about the advantages of cervical cancer screening because they lack enough understanding of the disease and its screening methods. The responses supported the idea that, contrary to popular belief, holy persons can have cervical cancer and that, God forbid, they cannot.

Age and women's awareness of cervical cancer did not significantly correlate, with a chi square (X^2) of 4.021 and a P value of 0.777 at the 5% level of significance. However, with a chi square (X^2) of 12.040 and a P value of 0.007, it was discovered that women's educational attainment was substantially correlated with their degree of cervical cancer knowledge. This did not support the findings of Al-Meer et al. (2009), which showed that respondents' level of awareness of cervical cancer was substantially correlated with their age and educational attainment (P values of less than 0.01 and 0.01 respectively).²³ The significant correlation between respondents' education and their degree of awareness of cervical cancer may have happened by accident, despite the fact that the majority of respondents (61%) had university education.

Women's attitudes toward cervical cancer did not significantly correlate with their age or educational attainment, as indicated by chi square (X^2) values of 4.189 and 7.125 and P values of 0.242 and 0.416, respectively, at the 5% level of significance. This implies that a decrease in the educational level of respondents will invariably cause a decrease in their attitudes.

5. Conclusion

Cervical cancer will continue to be the second most common cause of death for women and the most preventable malignancy of the female genital tract. According to this study, women who attended Aba South Health had limited awareness of cervical cancer, its risk factors, screening, and preventative strategies. Additionally, respondents' attitudes concerning cervical cancer were unfavorable since most women thought they couldn't get the disease.

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