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Uptake of cervical cancer screening services among women of reproductive age attending Hoima regional referral hospital. A cross-sectional study.

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Abstract

Background:

Cervical cancer is the fourth most common cancer in women globally, but for those in their prime reproductive years, it is the second most frequent threat. It is almost entirely preventable with regular screening and early detection. The study aimed to assess the individual, health care system-related, and social and cultural factors affecting uptake of cervical cancer screening among women of reproductive age attending Hoima Regional Referral Hospital.

Methodology:

The study adopted a descriptive cross-sectional design, with the use of semi-structured questionnaires. Simple random sampling was used to obtain 60 respondents, and data were collected with the help of semi-structured questionnaires. Collected data was analysed using Microsoft Excel and presented in the form of tables and figures.

Results:

More than half of the respondents, 44(73.3%), felt uncomfortable with cervical cancer screening because it involves genital examination. While 31(51.7%) avoided being screened for cervical cancer due to long waiting time, 51.7% avoided it because they had been discouraged by their partners. Even though 84.6% reported that they would go for screening if given adequate information about cervical cancer screening, fear of results, 61.7%, and preference for a specific gender of health workers seemed to be influencing factors.

Conclusions:

Key barriers to seeking care include long wait times, partner discouragement, and a fear of results. Additionally, the gender of health workers plays a role in their decision-making. However, there is a strong willingness to undergo screening if adequate information and education are provided. Socio-cultural factors included feeling ashamed of the procedure and being refused by partners.

Recommendations:

The hospital administration should work towards improving the quality and accessibility of cervical cancer screening services by reducing long waiting times, improving staffing levels, and introducing organized appointment systems.

Keywords: *`, Women of reproductive age, Hoima regional referral hospital.*
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Background

Cervical cancer is cancer of the cervix, the lower part of the uterus that connects to the vagina. Cervical cancer develops from the cells of the cervix, the narrow passage connecting the uterus to the vagina. It typically progresses over many years, often starting with precancerous changes that can be detected through screening. Cervical cancer is primarily caused by persistent infection with high-risk strains of the human papillomavirus (HPV). Additional risk factors of cervical cancer include smoking, which weakens the immune system, multigravida, early onset of sexual activity, having multiple sexual partners, and a family history of cervical cancer, among others (Bulamba et al., 2025).

Globally, cervical cancer (CC) is the fourth most common cancer in women, and ranks second among common cancers among women aged 15–44 years old. In 2019, there were 95 %(187609.22) incidence cases of cervical cancer. It is the only cancer for which the cause is well known, making it a disease that can be managed and prevented. The primary cause of CC is persistent high-risk human papillomavirus (HPV) infection. Alarmingly, studies have shown an increasing prevalence of CC among younger age groups(Zhang et al., 2024).

In the United States, approximately 10,370 new cases of cervical cancer are diagnosed annually, and an estimated 3,710 deaths occur from the disease, making it the sixth most

common cause of malignancy among American women (Daniyal et al.,2015).

Africa has the highest age-standardized incidence and mortality from cervical 7 per cancer. For example, the age-standardized incidence of cervical cancer is 36 per 100,000 women in Southern Africa, compared with a rate of 6 per 100,000 women in North America and 100,000 in Western Europe (Mulongo & Chibwesha, 2022).

In Sub-Saharan Africa, the vast majority of cancer diagnoses—roughly 80%—occur only after the disease has reached an advanced stage. Furthermore, the regional incidence rate stands at approximately 35 new cases for every 100,000 women annually. The estimated effective screening coverage in sub-Saharan Africa is 10%, while it is less than 1% in four West African countries and Ethiopia (Atnafu et al., 2024).

In East Africa, the incidence rate of cervical cancer is 42.7 per 100,000 women. Specifically, Tanzania has 54 per 100,000 women. Extant evidence from Tanzania indicates that 9772 new cases and 6695 deaths are recorded each year, making it an important health concern (Okyere et al., 2024).

Uganda faces a significant public health challenge as one of the world's ten most affected nations by cervical cancer. With an annual incidence rate of 28.8 per 100,000**,** the country holds the second-highest burden in Eastern Africa, seeing over 6,400 new diagnoses and approximately 4,300 deaths each year. In 2020, about 35.7% of new cancer cases among Ugandan women were due to cervical cancer, and approximately 11 million Ugandan women are at risk of cervical cancer, caused by a sexually transmitted persistent infection with oncogenic subtypes of HPV, mainly HPV 16 and HPV 18 (Sarah Maria et al., 2022).

In Uganda, an Oyam study in the north revealed that of the 62.7% of women attending health services at various health centers who had undergone cervical cancer screening, only 37.2 had been screened. Similarly, in two districts in Eastern Uganda, out of the 4.8% of women who knew about cervical cancer screening,07.2% had voluntarily gone for cervical cancer screening. In Isingiro, Western Uganda, among rural women,4.62% had knowledge about cervical cancer screening, but with only a 0.33% utilization rate of cervical cancer screening services. At Mbarara Regional Referral, the proportion of cervical cancer was found to be 25.2%, contributing to 1o% of all gynaecological diseases and 73.9% of all gynaecological cancers (Musubika,2024).

In Hoima City, the incidence of cervical cancer reported among women is very high. Out of the 137,000 target population for the Hoima Regional Referral Hospital catchment area, 2% are diagnosed with cervical cancer (Kusiima, 2018). This study determined the individual, health care system-related, and social and cultural factors affecting uptake of cervical cancer screening among women of reproductive age attending Hoima Regional Referral Hospital.

Methodology

Study design

A descriptive cross-sectional study design was used for the study topic, Factors Affecting Uptake of Cervical Cancer Screening Services among women of reproductive age, because it enabled the collection of data at a single point in time.

Study area

The study was carried out at Hoima Regional Referral Hospital, which offers dental, obstetrics, gynaecology, general medicine, pediatrics, and special clinic services. It is a public-funded hospital that offers free services like delivery(maternity), minor and major operations (surgery), internal medicine, orthopedics, laboratory, radiology, family planning, counselling, antenatal care services, pediatric care, and immunization services, etc., to people of Hoima and neighboring districts such as Kikuube, Bulisa, Kibaale, Kiryandongo, Kagadi, and Masindi.

Study population

This information was obtained from 60 women of reproductive age attending Hoima Regional Referral Hospital.

Sample size determination

The sample size was calculated using Fisher's formula (1998.

n = KPQ/L*L

Where;

n=the desired sample size

L=permissible error in the estimate 10% (0.1) k=constant 4

P=81.6%, which equals 0.816 (estimated percentage of all among women of reproductive age at HRRH; since the prevalence rate is not known, the prevalence of 81.6 % was used)

Q= 1-P

$$n=\frac{4(0.816)(0.184)}{0.1x0.1}$$

n~ 60

Therefore, 60 participants were enrolled in the study.

Sampling method

The study employed a simple random sampling method where every member had an equal chance of being selected. The method involved selecting participants based on their age. I employed this method because each participant had an equal chance of being selected, hence no bias.

Sampling procedure

Enrolment of participants was done by employing a simple random sampling method using a random number method

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in which females attending the outpatient department who met the inclusion criteria were given numbers from 1-20 written on small pieces of paper placed in a box. Five pieces of paper were picked at random by participants corresponding to numbers given until a required sample size of 60 was reached.

Data collection method

This research was conducted using a semi-structured questionnaire method. In this method, questionnaires were printed and disseminated to the participants and picked up immediately when the participants were done filling. The questionnaire ensured a high response rate, and it requires less time and energy to administer.

Data collection tool

Data was collected using semi-structured questionnaires with closed-ended questions that were specifically designed to meet the objectives of the study. These questionnaires were written in simple and straightforward language to ensure that they were easily understood by both literate and illiterate patients who participated in the study. Those individuals who were unable to read and write were assisted.

Data collection procedure

The questionnaires were distributed personally to the respondents who had agreed and consented to be part of the research study. Clear guidelines, instructions, and consent forms were given to participants on how to fill out these questionnaires. After filling out the questionnaires, the data were collected to monitor the responses of all the participants. After collecting, the questionnaires were reviewed to ensure that the participants had answered appropriately. Information was kept confidential and under lock and key in order to ensure confidentiality.

Independent variable

Individual, socio-cultural, and healthcare system-related factors influencing uptake of cervical cancer screening among women of reproductive age attending Hoima Regional Referral Hospital.

Dependent variable

Uptake of cervical cancer screening among women of reproductive age at Hoima Regional Referral Hospital.

Quality control

Piloting the study

A pilot study was conducted at Hoima Regional Referral Hospital. The study area was visited a week before the actual research to seek and obtain permission from the hospital administration. This visit aimed to ensure that the conditions within the hospital had not changed in the facility and to rule out the presence of highly infectious diseases that could hinder the research from being carried out.

Pre-testing of the study tool

Questionnaires were pre-tested using a small number (12) as compared to the estimated study population before actual data collection to allow modifications and ensure reliability and validity of the questions.

Ample time for data collection

During the study, illiterate participants were given 30 minutes, and the literate were given 15 minutes to fill out the questionnaires.

Observation of SOPS.

This involved social distancing, hand hygiene, and hand rub so as to avoid cross-infection, and making sure not to break the hospital operating procedures and avoid hindering the normal running of the health center activities because of research.

Data analysis and presentation

The data was manually analyzed using statistical tally sheets and then entered into the computer using Microsoft Excel software. The findings were presented quantitatively through bar graphs, pie charts, and frequency distribution tables accompanied by narratives to facilitate easy interpretation.

Ethical consideration

On approval by the Mildmay Institute of Health Sciences Research Committee, written permission to conduct the research study was obtained from the Principal of the School of Clinical Medicine, introducing me to the medical superintendent of Hoima Regional Referral Hospital, who in turn connected me to the in-charge of out patient department. The in-charge guided me on data collection at the outpatient department.

I sought consent from the participants with informed written consent before the study was conducted. I gave a full explanation of the research procedures to the participants, who understood it. Consent forms were used to seek written consent before interviewing.

The information given was kept confidential. The names of the participants were not included in the report. The participation was voluntary, and one was free to withdraw from the research at any time without any punishment or loss of benefit.

RESULTS

Individual factors affecting uptake of cervical cancer screening services among

women of reproductive age attending Hoima Regional Referral Hospital, Hoima City

Table 1: Shows respondents' responses to individual factors affecting uptake of cervical cancer screening services among women of reproductive age (n=60).

Question	Response	Frequency (n)	Percentage (%)
Do you avoid cervical cancer screening because you are afraid of finding out that you may have cervical cancer?	Yes	23	38
	No	37	61.7
	Total	**60**	**100**
Do you avoid cervical cancer screening because you can not afford the cost?	Yes	17	28
	No	43	72
	Total	**60**	**100**
Have you ever avoided cervical cancer screening because you don't know enough about the disease or the screening process?	Yes	39	65
	No	21	35
	Total	**60**	**100**
If yes, would you be more likely to go for screening if you were given more information about cervical cancer and its early detection?	Yes	33	84.6
	No	6	15.4
	Total	**39**	**100**
Do you avoid cervical cancer screening because you have a negative or doubtful attitude towards the screening services?	Yes	33	55
	No	27	45
	Total	**60**	**100**

Regarding respondents' responses on whether they avoided cervical cancer screening due to fear of results, most of the respondents, 37(61.7%), avoided cervical cancer screening due to fear of results, while the least, 23(38%), avoided cervical cancer screening not due to fear of results.

In view of the respondent's response on whether they avoided cervical cancer due to lack of affordability, the majority of the respondents, 43(72%), had not screened for cervical cancer, not due to lack of affordability, while the minority, 17 (28%), had not screened for cervical cancer due to lack of affordability.

In response, if respondents avoided cervical cancer screening due to lack of knowledge, most of the respondents, 39(65%), avoided screening due to lack of knowledge on cervical cancer screening, while the least, 21(35%), avoided cervical cancer screening not due to lack of knowledge.

Regarding respondents' responses on whether they would go for cervical cancer screening if given information regarding cervical cancer, the majority of the respondents, 33(84.6%), were willing, while to go for screening minority of 6(15.4%) were not willing.

For respondents' responses on whether they avoided cervical cancer due to having a negative attitude, more than half of the respondents, 33 (55%), avoided screening due to a negative attitude towards the screening services, while less than half, 27(45%), avoided cervical cancer screening, not due to having a negative attitude.

Health system-related factors affecting uptake of cervical cancer screening services

Figure 1: Shows respondents' responses on whether they avoided being screened for cervical cancer due to long waiting time, n=60.

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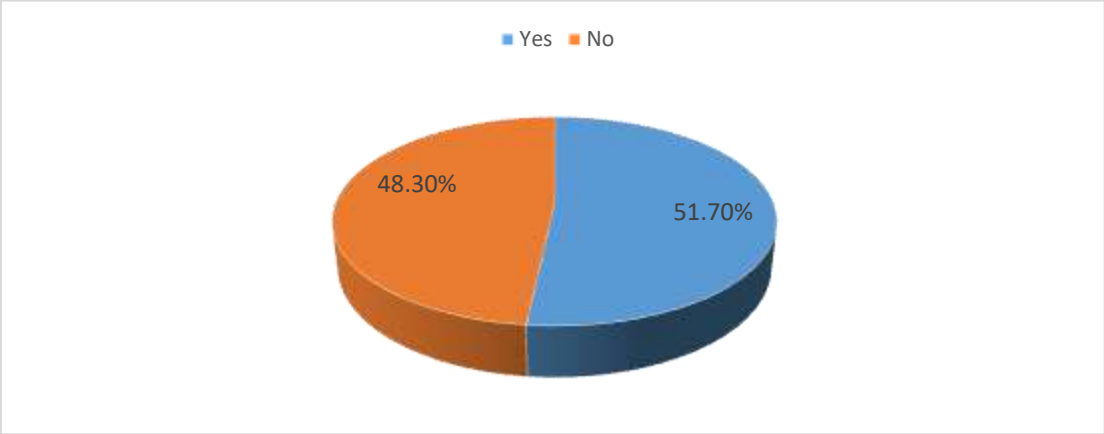
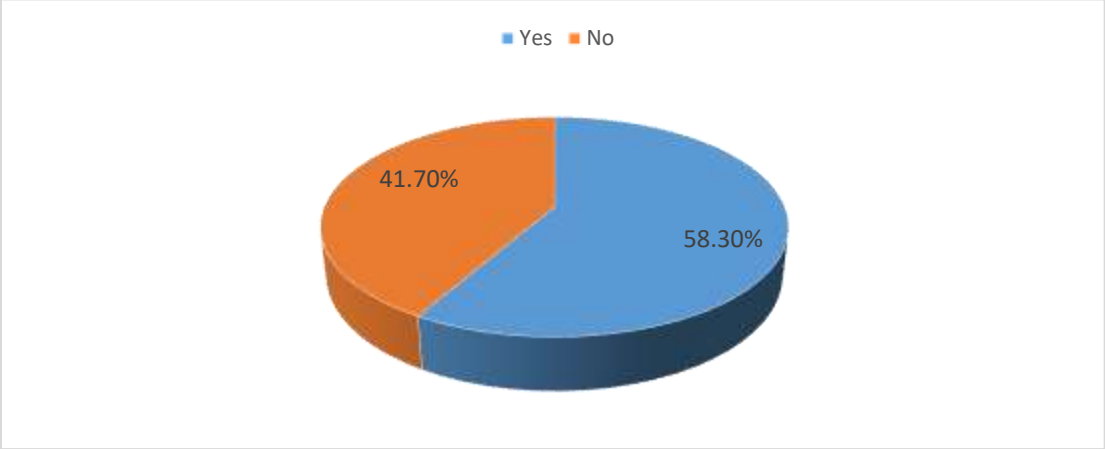


From the figure, more than half of the respondents, 31(51.7%), avoided being screened for cervical cancer due to long waiting time, while less than half, 29(48.3%), avoided being screened for cervical cancer not due to long waiting time.

Figure 2: Shows respondents' responses on whether they had avoided cervical cancer screening due to preference for a certain gender, n=60.



From Figure 2, more than half of the respondents, 35(58.3%), had avoided cervical cancer screening due to a preference for a certain gender of health care provider, while less than half, 25(41.7%), had avoided cervical cancer screening not due to a preference for a certain gender.

Table 2: Shows respondents' responses on whether they had ever avoided cervical cancer screening because of the long distance to the facility.

Question	Response	Frequency (n)	Percentage (%)
Have you ever avoided cervical cancer screening because the health facility was far from where you live?	Yes	47	78.3
	No	13	21.7
	Total	60	100

From table 2, most of the respondents, 47(78.3%), had avoided cervical cancer screening, not due to long distance to the facility, while a minority, 13(21.7%), had avoided cervical cancer screening due to long distance to the facility.

Social and cultural factors affecting uptake of cervical cancer screening services among women of reproductive age attending Hoima Regional Referral Hospital.

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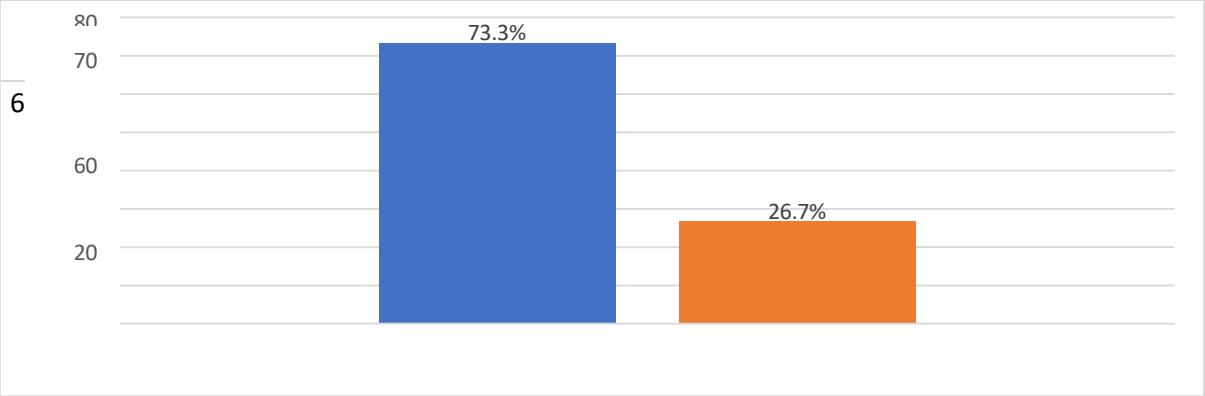
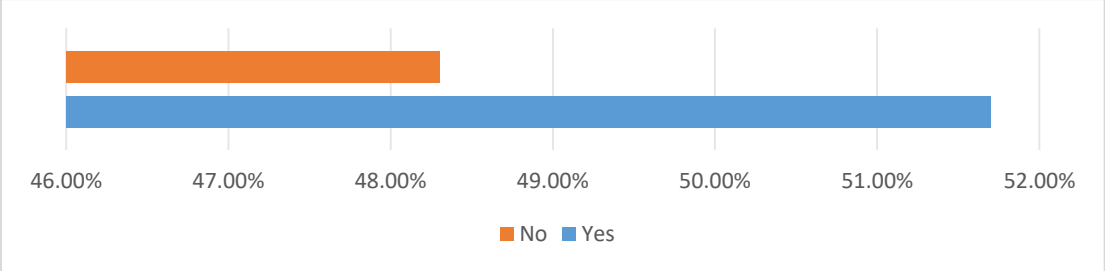
Figure 3: Shows respondents' responses on whether they feel uncomfortable with cervical cancer screening because it involves genital examination, n=60.



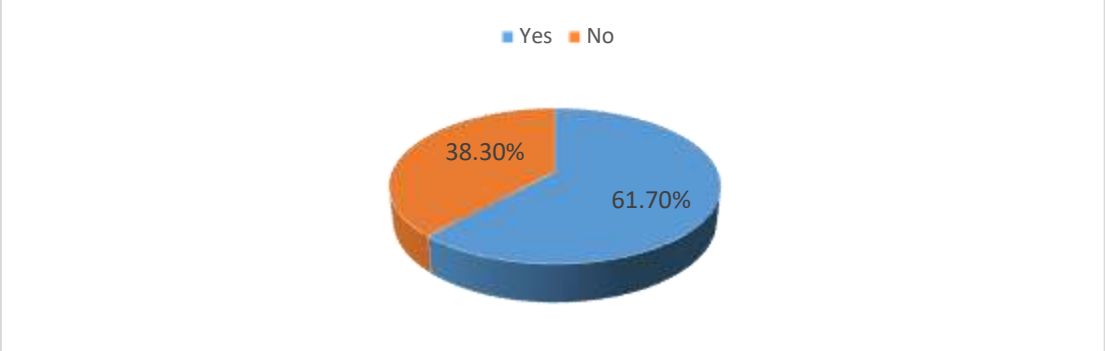
From figure 3, the majority of the respondents, 44(73.3%), felt uncomfortable with cervical screening because it involves genital examination, while a minority did not feel uncomfortable with cervical cancer screening because it involves genital examination.

Figure 4: Shows respondents' responses on whether they had been discouraged by their partners from getting screened for cervical cancer, n=60.



From Figure 4, more than half of the respondents, 31(51.7%), had been discouraged from getting screened by their partners, while less than half, 29(48.3%), had not been discouraged from getting screened by their partners.

Figure 5: Shows respondents' responses whether they have ever avoided cervical screening or a taboo topic in their culture, n=60.



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From Figure 5, most of the respondents, 37(61.7%), avoided cervical cancer screening not because they felt it was embarrassing or a taboo topic in their culture, while the least 23 (38.7%) avoided cervical cancer screening because they felt that it was embarrassing or a taboo topic in their culture.

Table 3: Shows respondents' responses on whether being immigrants or coming from another culture had affected their access to or understanding of cervical cancer screening services, (n=60).

Question	Response	Frequency (n)	Percentage (%)
Do you think being an immigrant or coming from another culture affected your access to or understanding of cervical cancer screening services?	Yes	6	10
	No	54	90
	Total	60	100

From Table 3, a minority of the respondents, 6(10%), reported that being an immigrant or coming from another culture had affected their access to understanding of cervical cancer screening services, while the minority of the respondents, 54(90%), had not been affected.

Discussion

Individual factors affecting uptake of cervical cancer screening services

Results on whether respondents avoided cervical cancer screening due to fear of results, most of the respondents 61.7% avoided cervical cancer screening due to fear of results. This indicates that most of the respondents feared results from the screening, which became a barrier to the uptake of cervical cancer screening. This is because the possibility of being diagnosed with a serious illness can cause anxiety, denial, and hesitation, leading individuals to avoid screening altogether. These results are not in line with those of Ubah et al (2022) about perceived barriers to cervical cancer screening uptake among women of an urban community in south-eastern Nigeria, which stated that 44.3% of the women expressed fear of discovering they had cervical cancer, and this influenced their decision to avoid screening. This suggests a significant psychological barrier that substantially hinders screening uptake; this fear may delay early detection and treatment, thereby increasing cervical cancer morbidity and mortality. Therefore, targeted educational interventions focusing on explaining the screening process and providing counseling are imperative to alleviate fears, empower women with knowledge, and encourage timely participation in cervical cancer screening programs.

Regarding the response on whether respondents avoided cervical cancer screening due to lack of affordability, most of them 72% reported having avoided cervical cancer because they could not afford the services. This implies that most of the respondents avoided cervical cancer screening because of the inability to afford it. This is due to the high expenses for healthcare services, limited financial resources, and competing economic priorities These results are in line with the findings according to (Onduko et al., 2025) about Utilization of Cervical Cancer Screening and it's Associated Factors among Women aged 25-49 years in Kaloleni Sub -County, Kilifi county which found out that 75.6% of the respondents could not afford the screening services. This indicates that financial constraints are a critical barrier to accessing cervical cancer screening services. Therefore, implementing free screening programs targeted at economically disadvantaged women is essential to improve their screening uptake and early detection rates.

Regarding whether respondents would go for cervical cancer screening if given information regarding cervical cancer, 84.6% reported that they would go for screening if given adequate information about cervical cancer screening. This indicates majority of the respondents lacked knowledge of cervical cancer screening. This is because limited awareness, poor health education, and inadequate dissemination of information hinder women's understanding of the benefits, procedures, and availability of cervical cancer screening services. These results are not in line with the study findings by Ago et al. (2022) in a study about socio-demographic and gynaecological factors that influence uptake of cervical cancer screening, a cross-sectional study in Calabar, Nigeria, which found that 69.44% of the respondents lacked adequate knowledge about cervical cancer. This implies that the lack of essential information about cervical cancer screening contributed to low screening uptake and increased risk of late detection, hence the need for comprehensive community-based health education programs led by trained healthcare workers.

Results on whether respondents avoided cervical cancer screening due to having a negative attitude, more than half, 55% of them, reported having a negative attitude. This indicates that more than half of them did not go for these services because they had a negative attitude towards the screening services. This is because of the misconceptions, fear, cultural beliefs, and lack of trust in the healthcare system, which can shape negative attitudes, leading women

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to perceive screening as unnecessary and uncomfortable, thereby discouraging them from seeking these services. These findings are in line with the results of the study done by Lahole (2024) about determinants of cervical cancer screening intention among reproductive-age women in Ethiopia, which found that 67% had a negative attitude towards cervical cancer screening. This indicates a barrier to screening uptake, which could be addressed through comprehensive health education programs that focus on improving awareness, correcting misconceptions, and fostering positive perceptions about cervical cancer prevention and early detection. Health care system-related factors affecting uptake of cervical cancer screening services.

Regarding whether respondents had avoided cervical cancer screening due to long waiting time, more than half, 51.7% of the respondents, avoided cervical cancer screening due to long waiting time. This indicates that long waiting time at the hospital discourages women from going for screening services. This is because long waiting times can lead to inconvenience, frustration, and disruption of daily schedules, making it less likely for women to prioritize or attend cervical cancer screening This is in agreement with a study done by Reichheld etc al (2020) about prevalence of cervical cancer screening and awareness among women in an urban community in South India which showed that only 7.1% of women underwent cervical cancer screening and it was attributed long waiting time to be seen by healthcare professionals. This indicates that long waiting times discourage attendance at these services, and this could be addressed by reducing clinic wait times through better staffing, appointment systems, or mobile screening services.

Results on whether respondents had avoided cervical cancer screening due to preference for a certain gender, more than half, 58.3% of the respondents, reported that they liked a certain gender. This implies that more than half of the respondents would not go for screening if that gender is not available. This is because many women feel more comfortable and less embarrassed being examined by a healthcare provider of their preferred gender, making the absence of such a provider a barrier to cervical cancer screening. This is not in line with a study done by Kassa (2024) about integrated cervical cancer screening uptake and associated factors among women attending primary care services at public health centers in Addis Ababa, Ethiopia, which found that women who preferred male HCPs for CCS had a 95.5% lower likelihood of using the service. These results imply that gender preference can strongly deter women from cervical cancer screening, so healthcare facilities should ensure the availability of female providers to accommodate patient preferences.

Regarding whether respondents had avoided cervical cancer screening due to the long distance to the facility, the majority 78.3% had avoided cervical cancer screening due to the long distance to the facility. This indicates that the long distance to the facility hindered women from going for screening. This is because long distances increase travel time, transportation costs, and physical effort, making it difficult for women to access cervical cancer screening services. The findings are not in line with the study results by Kwamena et al. (2023) in a study about screening for cervical cancer among women in five countries in sub-Saharan Africa, which revealed that the percentage of women who faced long distances to the hospital was 31.8%. This indicates a geographical barrier to access. Long distances can lead to delayed or missed screenings, which in turn increases the risk of late diagnosis and higher cervical cancer mortality. To reduce this barrier, mobile health clinics or community-based screening programs could be implemented. These services can travel to remote areas, bringing cervical cancer screening closer to women.

Socio-cultural factors affecting uptake of cervical cancer screening services

Results on whether respondents felt uncomfortable with cervical cancer screening because it involves genital examination, most 73.3% of them reported that they felt uncomfortable. This implies that most of the respondents felt uncomfortable when their genitals were being examined. This is because of cultural or social norms regarding modesty, fear of pain, lack of privacy, or anxiety about the procedure. These results are not in agreement with the study findings according to (Yang et al, 2018) about Barriers to cervical cancer screening among rural women in eastern China, which found that nearly all of the participants reported feeling embarrassed by the cervical cancer screening procedure, attributing their discomfort to cultural norms of their rural communities. This shows that cultural norms and beliefs about modesty are major barriers to accessing preventive care in rural communities. Such embarrassment can lead to hesitation or avoidance of screening, increasing the risk of late detection of cervical cancer. Therefore, providing female healthcare providers and ensuring privacy, respectful screening environments so women feel comfortable undergoing cervical cancer screening without embarrassment.

Results on whether respondents had been discouraged by their partners from getting screened more than half 51.7% avoided cervical cancer screening because they had been discouraged by their partners. This indicates that more than half of the respondents reported that their decision to avoid screening was affected by their partners, showing that partners can play a critical role in health behaviors. This is because social and relational influences, such as a partner's attitudes and beliefs, can significantly shape an individual's health decisions. This is in line with results by (Petersen et al., 2022) about Barriers to uptake of cervical cancer screening services in low- and middle-income countries, which found that 21% of men disapproved of cervical cancer

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screening, and some prevented their wives from being screened. This implies that partner disapproval is a significant social barrier to cervical cancer screening, indicating a need for targeted interventions that engage men to support and encourage their partners' preventive health behaviors through educational programs to raise awareness about the importance of screening for their partners' health. Regarding their response on whether being immigrants or coming from another culture had affected their access to or understanding of cervical cancer screening services, a minority of the respondents, 54(10%), reported that they were affected. This implies that a few of them were affected by being immigrants from other cultures. This is because individuals from diverse cultural settings may face barriers such as language difficulties, limited awareness of available health services, cultural beliefs surrounding women's health, or unfamiliarity with the healthcare system in the host country. These results are not in line with the study findings according to (Suk et al, 2022) about assessment of US Preventive Services Task Force Guideline Concordant Cervical Cancer Screening Rates and
Reasons for under-screening, 2005 to 2019 which revealed that 84.3% of the respondents found that race and ethnicity affected their screening participation. This shows the enduring role of sociocultural determinants in shaping preventive health behaviour, suggesting that interventions must prioritize culturally responsive education and equitable access strategies to effectively reduce disparities in screening uptake.

Conclusion

Individual factors were fear of results, lack of knowledge, lack of affordability, and a negative attitude toward screening for cervical cancer. Health care system factors were long waiting hours, preference for a certain gender, long distance to the facility, and socio-cultural factors were feeling ashamed of the procedure, refusal by partners, race, and ethnicity.

Recommendation

The Ministry of Health should strengthen national strategies aimed at increasing cervical cancer screening uptake by developing and implementing comprehensive, culturally appropriate health education programs.
Stakeholders should engage in community sensitization campaigns to address negative attitudes, fear, partner influence, and cultural beliefs that hinder women from seeking screening.
Hoima Regional Referral Hospital should work toward improving the quality and accessibility of cervical cancer screening services by reducing long waiting times, improving staffing levels, and introducing organized appointment systems.

Implications for clinical medicine

Low uptake of cervical cancer screening services leads to diagnosis of cervical cancer in late stages, whereby it's incurable by this time, hence increasing the cervical cancer mortality rate.

Acknowledgement

I would like to extend my deepest gratitude to almighty God for his guidance and blessings throughout this research journey.
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I also wish to acknowledge my mother, Kyazike Jalia, for her unwavering support and encouragement throughout this entire process. May the almighty God reward you abundantly.

List of abbreviations

AIDS: Acquired Immune Deficiency Syndrome
CC: Cervical cancer
CCS: Cervical cancer screening
HPV: Human Papillomavirus
HRRH: Hoima Regional Referral Hospital
MOH: Ministry Of Health
STIs: Sexually Transmitted Infections
WHO: World Health Organisation
PAP: Papanicolaou

Source of funding

The study was not funded.

Conflict of interest

The author declares that there was no conflict of interest.

Author contributions

MN- Inveinitiated the study
MO- Supervised the Study.
HN- Supervised the Study.
FS-Supervised the Study.
JFN-Supervised the Study.

Data availability

Data is available upon request.

Informed consent

There was full disclosure; full comprehension, and respondents voluntarily consented to participate in the study.

Author biography

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