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Original Research Article

Awareness and acceptance of cervical cancer screening among women attending a tertiary care hospital: a cross-sectional study

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ABSTRACT

Background: Cervical cancer remains a major public health challenge in India despite the availability of effective screening methods and HPV vaccination. Limited awareness and poor utilization of screening services contribute significantly to delayed diagnosis.

Methods: A hospital-based cross-sectional study was conducted among 334 married women aged 20–65 years attending the gynaecology outpatient department of a tertiary care hospital in Telangana from February–November 2025. Data were collected using a pretested structured questionnaire. Statistical analysis was performed using SPSS version 26. Chi-square test and multivariate logistic regression were applied. A p value <0.05 was considered statistically significant.

Results: Only one third (31.4%) of participants were aware of cervical cancer. Awareness regarding symptoms (13.5%), risk factors (8.9%), preventive measures (6.9%), and HPV vaccination (14.0%) was low. Awareness of screening tests was reported by 12.8%, and only 7.0% had ever undergone screening. Despite poor knowledge and minimal screening practice, willingness to undergo screening was high (82.0%). On multivariate analysis, employment status (Adjusted OR 2.31; 95% CI: 1.18–4.52), knowledge of screening tests (Adjusted OR 3.11; 95% CI: 1.49–6.48), and willingness to undergo screening (Adjusted OR 5.62; 95% CI: 2.71–11.64) were independent predictors of awareness.

Conclusions: Awareness and utilization of cervical cancer screening services were inadequate despite high willingness. Strengthening targeted health education and provider-initiated counselling is essential to improve screening uptake.

Keywords: Awareness, Cervical cancer, HPV vaccination, Screening

INTRODUCTION

Globally, cervical cancer remains the fourth most common cancer in women, with 660,000 new cases estimated in 2022. In the same year, about 94% of the 350,000 deaths caused by cervical cancer occurred in low- and middle-income countries.¹

It is the second leading cause of female cancer among women aged 15–44 years in India. Approximately 123,907 new cervical cancer cases are diagnosed annually in India (estimates 2023).²

While cervical cancer cases have declined in developed countries, they continue to pose a heavy burden in developing nations, where the risk of developing cervical cancer is estimated to be 35% higher compared to developed countries. About 25% of global mortality due to cervical cancer occurs in India.³

Countries worldwide are accelerating efforts to eliminate cervical cancer by 2030, guided by the global 90-70-90 targets: 90% of girls fully vaccinated with the HPV vaccine by age 15, 70% of women screened by ages 35 and 45, and 90% of women with precancerous lesions or invasive cancer receiving appropriate treatment.¹

The primary cause of cervical cancer is infection with oncogenic types of human papilloma virus (HPV). It has been demonstrated that more than 99.7% of cervical cancers test positive for HPV DNA worldwide.⁴

Most HPV infections are asymptomatic and are cleared by the immune system within a year. However, in up to 10% of women, the infection may persist, and in a small proportion, persistent infection can eventually lead to cervical cancer.⁵

Primary prevention of cervical cancer is achieved through HPV vaccination.⁶ While secondary prevention relies on cervical cancer screening to detect the precancerous lesions before possible progression to invasive disease.⁷

Cytology is the most commonly used method, either in the form of conventional (pap smear) or liquid-based cytology, in order to identify cervical pathology, while HPV DNA testing has been used in high resource settings, either alone or in combination with cytology.^{8,9} WHO recommends visual inspection with acetic acid for basic settings i.e., developing and underdeveloped countries which lack the necessary resources of an organized cytology or HPV-based screening programme.¹⁰

The strength of cervical screening comes from repeating the screening test at agreed rescreening intervals, which allows more accurate detection of precancerous abnormalities over the long preinvasive stage of squamous cervical cancers.¹¹

Recognition of cervical screening as a program of rescreening at regular intervals rather than as a single opportunistic test is important.¹² Early diagnosis and treatment of cervical cancer in women are crucial for reducing mortality rates.¹³

According to various reports, in developed countries 68%-84% of women are being screened by pap smear, but in India this proportion is 2.6%-5% only. This is one of the main reasons that in India, patients are being diagnosed at advanced stages.¹⁴

Despite the availability of screening tests and effective HPV vaccination, most women continue to present at advanced stages of disease. Poor awareness, sociocultural factors, and lack of organized screening programs contribute significantly to delayed diagnosis. Understanding the level of knowledge and awareness among women is essential for implementing effective preventive strategies.

Therefore, the present study was undertaken to assess the awareness, attitude, and preventive practices related to cervical cancer among women attending a tertiary care hospital.

Aim of the study was to assess awareness and acceptance of cervical cancer screening tests among women attending a tertiary care hospital. Objectives of the study were (a) to assess awareness regarding cervical cancer, its symptoms, risk factors and preventive measures; (b) to evaluate awareness of cervical cancer screening programs; (c) to assess acceptability of available screening tests; and (d) to identify factors affecting acceptability of cervical cancer screening tests.

METHODS

This hospital-based cross-sectional study was conducted in the Department of Obstetrics and Gynecology at Bhaskar Medical College, Yenkapally, Moinabad, Rangareddy District, Telangana, India, over a period of ten months from February 2025 to November 2025. Ethical approval was obtained from the Institutional Ethics Committee prior to the commencement of the study. Women attending the Gynecology outpatient department during the study period constituted the study population.

The sample size was calculated using the standard formula for prevalence studies:

$$n = Z^2pq/d^2$$

where; n is the required sample size, Z is the standard normal variate at a 95% confidence level (1.96), p is the anticipated prevalence (30%), q = 1-p, and d is the allowable error (5%). Based on this calculation, the minimum required sample size was 323 and after accounting for non-response, 334 women were included.

Women aged 20 years and above who were married or sexually active and who provided informed consent were included. Pregnant women, women previously diagnosed with cervical cancer, women with active vaginal infection, active vaginal bleeding, and those unwilling to participate were excluded from the study.

Participants were recruited using a consecutive non-probability sampling technique, wherein all eligible women attending the gynecology outpatient department during the study period were invited to participate until the required sample size was achieved

Data were collected using a predesigned, structured questionnaire developed after review of relevant literature. Information collected included sociodemographic characteristics, parity, age at first childbirth, awareness of cervical cancer and sources of information, knowledge of symptoms, risk factors and preventive measures, awareness of HPV vaccination, knowledge and acceptability of cervical cancer screening tests, and factors affecting the acceptability of screening. The questionnaire was pretested, and necessary modifications were made before final data collection. Data were collected through face-to-face interviews in the local language. The collected data were used to address the study objectives and to

identify areas requiring intervention to improve cervical cancer screening uptake among women.

Data were entered into Microsoft Excel and analyzed using SPSS version 26.0. Descriptive statistics were used to summarize the data. Categorical variables were expressed as frequencies and percentages. The Chi-square test (χ^2) was used to assess the association between awareness of cervical cancer (dependent variable) and selected sociodemographic, reproductive, and screening-related variables. Variables showing statistical significance on bivariate analysis were included in a multivariate logistic regression model to identify independent predictors of awareness. Adjusted odds ratios (ORs) with 95% confidence intervals (CIs) were calculated. A p-value of <0.05 was considered statistically significant.

RESULTS

Sociodemographic characteristics

A total of 334 women participated in the study. The majority of participants were aged 21-30 years (50.6%), followed by 31-40 years (32.9%). Most respondents were Hindu (91.0%) and belonged to the middle socioeconomic class (85.0%). Regarding education, 69.8% had attained middle school education or above, while 30.2% were illiterate. Most women were homemakers (78.4%), and 21.6% were employed, predominantly in farming-related occupations. The detailed sociodemographic profile of the participants is presented in Table 1.

Table 1: Demographic profile of study participants (n=334).

Variable	Category	Frequency (N)	Percentage (%)
Age (years)	21-30	169	50.6
	31-40	110	32.9
	Others	55	16.5
Religion	Hindu	304	91.0
	Others	30	8.9
Socioeconomic status	Middle class	284	85.01
	Others	50	14.9
Education	Illiterate	101	30.2
	Middle school	233	69.7
Occupation	Homemaker	262	78.4
	Employed	72	21.5

Association between awareness and sociodemographic variables

The association between awareness of cervical cancer and selected sociodemographic variables was assessed using the Chi-square test. Awareness was significantly higher among employed women compared to homemakers ($\chi^2 = 6.12, p = 0.013$). No statistically significant association

was observed between awareness and age group, education, religion, socioeconomic status, duration of marital life, or parity ($p > 0.05$). These associations are summarized in Table 2.

Table 2: Association between awareness of cervical cancer and sociodemographic variables (n=334).

Variable	χ^2	df	P value
Age group	1.94	2	0.38
Education	2.79	2	0.25
Occupation	6.12	1	0.013*
Socioeconomic status	0.84	1	0.36
Religion	0.21	1	0.64
Marital life duration	1.67	1	0.19
Parity	0.92	2	0.63

Chi-square test applied; *p<0.05 statistically significant

Reproductive and marital profile

Nearly half of the participants (48.5%) had a marital life duration of less than 10 years. Most women had two children (45.2%), followed by one child (23.1%). Early childbearing was common, with 35.1% of women having their first childbirth before the age of 20 years, while 59.3% had their first child between 21 and 25 years. The reproductive and marital characteristics are detailed in Table 3.

Table 3: Reproductive and marital profile (n=334).

Variable	Category	Number	Percentage (%)
Marital life	<10	162	48.5
	>10	172	51.5
Parity	P1	77	23.0
	P2	151	45.2
	>P3	106	31.7
Age at first child birth	<20	107	35.0
	21-25	181	59.3
	>26	17	5.5

Table 4: Awareness of cervical cancer; source of information (n=334).

Variable	Category	Number	Percentage (%)
Awareness	Yes	105	31.4
	No	229	68.6
Source of information	Doctors	44	13.1
	Media	42	12.5
	Others	19	5.6
	No information	229	68.6

Awareness of cervical cancer and sources of information

Out of 334 participants, 105 women (31.4%) were aware of cervical cancer, whereas 229 (68.6%) were not aware.

Among those who were aware, the most common source of information was doctors (13.1%), followed by media (12.5%). Awareness status and sources of information are shown in Table 4.

Knowledge regarding symptoms, risk factors, and prevention

Only 13.5% of participants were aware of one or more symptoms of cervical cancer, while 8.9% knew at least one

risk factor. Knowledge regarding preventive measures was reported by only 6.9% of women. Additionally, 30.5% of participants believed that cervical cancer is preventable.

Chi-square analysis showed a significant association between awareness of cervical cancer and knowledge of symptoms, risk factors, preventive measures, and belief regarding preventability (p<0.001 for all). These associations are presented in Table 5.

Table 5: Association between awareness and knowledge variables (n=334).

Variable	Yes, N (%)	No, N (%)	χ ²	df	P value
Knowledge of symptoms	45 (13.5)	289 (86.5)	18.41	1	<0.001
Knowledge of risk factors	30 (8.98)	304 (91.1)	21.76	1	<0.001
Knowledge of preventive measures	23 (6.88)	311 (93.11)	16.88	1	<0.001
Belief cervical cancer is preventable	102 (30.5)	232 (69.5)	12.32	1	<0.001

Chi-square test applied; p<0.05 statistically significant

Awareness and practices related to screening and HPV vaccination

Awareness regarding HPV vaccination was reported by 14.0% of participants. Only 29.0% knew that screening helps in early detection of cervical cancer, and 33.8% believed that early-stage cervical cancer is curable. Knowledge of specific screening tests was reported by 12.8% of women.

Screening practice was very low, with only 7.0% having ever undergone cervical cancer screening. Despite low awareness and screening practice, 82.0% of participants expressed willingness to undergo screening in the future.

Table 6: Knowledge and practice related to screening and HPV vaccination (n=334).

Variable	Yes, N (%)	No, N (%)
Awareness of HPV vaccination	47 (14)	287 (86)
Knowledge that screening detects cancer early	97 (29.0)	237 (70.9)
Belief that early cancer is curable	113 (33.8)	224 (66.2)
Knowledge of screening tests	43 (12.8)	291 (87.1)
Ever undergone screening	22 (7.0)	312 (93.0)
Willingness to undergo screening	274 (82)	60 (18)
Knowledge of screening eligibility	16 (4.8)	318 (95.2)
Knowledge of screening frequency	9 (2.7)	325 (97.3)
Will recommend screening to others	334 (100)	0 (0)

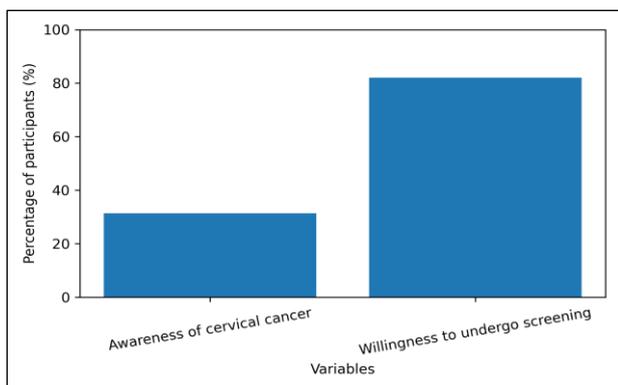


Figure 1: Awareness and willingness to undergo cervical cancer screening among study participants (n=334).

The figure 1 demonstrates a substantial gap between low awareness and high willingness to undergo screening.

Knowledge regarding eligibility for screening (4.8%) and recommended screening frequency (2.7%) was extremely limited. All participants reported willingness to recommend screening to others. Details of screening-related knowledge and practices are shown in Table 6.

Association between awareness and screening-related variables

Awareness of cervical cancer showed a statistically significant association with awareness of HPV vaccination, knowledge of screening tests, previous screening practice, and willingness to undergo screening (p=0.002). These associations are summarized in Table 7.

Factors affecting unwillingness to undergo screening

Among women unwilling to undergo screening, the most commonly reported reasons were fear of pain (7.2%), refusal for pelvic examination (5.4%), and perception of no risk (1.8%). Social and logistic barriers such as stigma,

distance, financial constraints, and lack of time were reported by fewer participants.

Factors affecting unwillingness are presented in Table 8.

Table 7: Association between awareness and screening-related variables (n=334).

Variable	χ^2	Df	P value
Awareness of HPV vaccination	14.96	1	<0.001*
Knowledge of screening tests	19.22	1	0.002
Ever undergone screening	9.87	1	<0.001*
Willingness to undergo screening	27.54	1	<0.001*

Chi-square test applied; *p<0.05 statistically significant

Table 8: Factors affecting unwillingness to undergo screening (n=60).

Reason for unwillingness	Variable	Frequency	Percentage (%)
Personal	Fear of pain	24	40
	Refusal for pelvic examination	18	30
	Perception of no risk	6	10
Social factors	Social stigma	5	8.3
	Long distance	4	6.6
	Financial constraints	2	3.3
	Lack of time	1	1.66

Multivariate logistic regression analysis

On multivariate logistic regression analysis, employment status, knowledge of symptoms, knowledge of risk factors, knowledge of screening tests, and willingness to undergo screening were identified as independent predictors of awareness of cervical cancer. Employed women were 2.31

times more likely to be aware compared to homemakers (Adjusted OR = 2.31; 95% CI: 1.18-4.52). Women with knowledge of symptoms and risk factors had significantly higher odds of awareness (Adjusted OR = 3.84 and 4.27, respectively). Knowledge of screening tests and willingness to undergo screening were also strongly associated with awareness. The detailed regression analysis is shown in Table 9.

Table 9: Multivariate logistic regression analysis for predictors of awareness (n=334).

Variable	Adjusted OR	95% CI	P value
Employed (vs homemaker)	2.31	1.18-4.52	0.015*
Knowledge of symptoms	3.84	1.92-7.68	<0.001*
Knowledge of risk factors	4.27	2.01-9.06	<0.001*
Knowledge of screening tests	3.11	1.49-6.48	0.003*
Willingness to undergo screening	5.62	2.71-11.64	<0.001*

*p<0.05 statistically significant

DISCUSSION

The findings demonstrate poor knowledge and low utilization of cervical cancer screening services despite a high willingness to undergo screening. These observations highlight significant gaps in awareness and preventive practices, which are consistent with those reported in several studies conducted in similar sociodemographic settings.

Only about one-third of participants were aware that cervical cancer is preventable. This low level of awareness is comparable to findings reported by Gupta et al and Bansal et al, who observed that awareness regarding preventability ranged between 20% and 40% among

Indian women.^{15,16} Lack of structured health education programs and limited dissemination of information at the community level have been cited as major contributing factors.

Awareness of cervical cancer was significantly higher among employed women, while education level did not show a statistically significant association. This suggests that workplace exposure and social interaction may play a more important role than formal education alone in improving awareness.

Awareness regarding HPV vaccination was very low among participants. Similar findings have been reported by Sreedevi et al. and Rashid et al., where awareness about

HPV vaccination ranged from 10% to 20%.^{17,18} In contrast, studies conducted among urban and educated populations have reported higher awareness levels, highlighting the influence of education and access to health information.¹⁹

Less than one-third of participants knew that screening aids in early detection and that early-stage cervical cancer is curable. Comparable observations were reported by Aswathy et al and Nene et al, where poor understanding of the benefits of screening and misconceptions regarding cancer prognosis were common.^{20,21} Such beliefs may contribute to delayed health-seeking behaviour and late-stage presentation.

Knowledge of specific screening tests and actual screening uptake were alarmingly low, with screening uptake being below 10%. This finding aligns with national estimates and other Indian studies reporting screening rates between 5% and 12%.^{22,23} Identified barriers in earlier studies include absence of symptoms, fear of cancer diagnosis, embarrassment, lack of recommendation by healthcare providers, and poor accessibility of screening services.²⁴

Despite these gaps, a large proportion of participants expressed willingness to undergo screening. Similar levels of willingness have been reported by Vedantham et al and others, suggesting that women may accept screening when adequate awareness, counselling, and accessible services are provided.²⁵ The discrepancy between willingness and actual practice indicates missed opportunities within the healthcare system.

Knowledge regarding eligibility criteria and recommended screening frequency was extremely limited. Comparable findings have been reported in studies conducted in rural and semi-urban populations, emphasizing that awareness initiatives often fail to provide practical, guideline-based information.²⁶ In contrast, populations covered by organized screening programs demonstrate better compliance and knowledge.²⁷

Overall, these findings are consistent with existing literature and underscore the urgent need for comprehensive awareness programs focusing on cervical cancer prevention, HPV vaccination, and screening guidelines. Integrating education into routine healthcare services and strengthening healthcare provider-initiated counselling may help translate willingness into actual screening practice, thereby reducing cervical cancer burden.

This study has few limitations. This hospital-based cross-sectional study may have limited generalizability to the wider community, and causal relationships cannot be inferred. Data were collected through interviewer-administered questionnaires and may be subject to recall and social desirability bias. Nevertheless, the study highlights critical gaps between awareness and willingness for cervical cancer screening.

CONCLUSION

The present study demonstrates poor knowledge and very low uptake of cervical cancer screening among the study participants, despite a high willingness to undergo screening. Awareness regarding cervical cancer preventability, HPV vaccination, screening methods, eligibility criteria, and recommended screening intervals was markedly inadequate. Actual screening practice was extremely low, reflecting a substantial gap between willingness and utilization of services.

The findings underscore the need to strengthen provider-initiated cervical cancer screening counselling within routine outpatient services, particularly targeting homemakers and women with limited health awareness. Integration of cervical cancer screening and HPV vaccination education into existing national reproductive health and primary care programs could help translate high willingness into actual screening uptake.

Recommendations

The study highlights the need to strengthen health education programs at the community level with a focus on cervical cancer prevention, available screening methods, and HPV vaccination. Healthcare provider-initiated counselling during routine outpatient and antenatal visits should be emphasized to improve the uptake of screening services. Integrating cervical cancer screening into existing primary healthcare programs may further enhance accessibility and utilization. In addition, mass media campaigns and community outreach activities should be used to disseminate accurate and practical information regarding screening eligibility and recommended screening frequency. Promotion of awareness regarding HPV vaccination should also be prioritized as an important primary preventive strategy against cervical cancer.

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