Journal of Biology, Agriculture and Healthcare
ISSN 2224-3208 (Paper) ISSN 2225-093X (Online)
Vol.6, No.6, 2016

Factors Associated with Uptake of Cervical Cancer Screening among Women Aged 18-49 Years in Njiru Sub-County, Nairobi Kenya

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Abstract
Cervical cancer remains a major public health concern in developing countries including Kenya, where it is currently ranked the highest cause of cancer deaths. Early detection of cervical cancer using Pap smear provides an appropriate way of prevention which, would in turn lead to a decrease in incidence and mortality. This study aimed at assessing the awareness, perceptions, reproductive and sexual practices influencing uptake of cervical cancer screening among women aged 18-49 years in Njiru Sub County, Nairobi County. Two hundred and forty seven women participated in this cross-sectional study. Data were collected using semi-structured questionnaires and focused group discussion (FGD). Data was analyzed using SPSS version 19.0. Descriptive statistics were used to give proportions and frequencies. Pearson's chi square ($\chi 2$) was used to test for associations among variables and differences were considered statistically significant at $p \leq 0.05$. The mean age of the respondents was 30.7±1.18 years. Most (32%), of the respondents were aged 25-29 years. Majority (96.4%) of the respondents in this study were Christians and most (68%) of them were married. Approximately fifty percent of the study respondents had primary level education followed by secondary (38.9%), tertiary (8.9%) and no formal education 2.4%. About 46% of the respondents were self-employed. Approximately eighty five percent (211/247) of the study respondents were aware of cervical cancer and had commonly (36.4%) obtained their information from media followed by health talks (34.8 %). Of those who were aware 25.6% (54/211) reported cervical cancer to be caused by Human Papilloma Virus (HPV). Most 43.6% (41/94) of the respondents who had ever been screened perceived the cervical screening procedures as uncomfortable followed by 24.5% (23/94) who perceived it as embarrassing. Majority 52.1% (49/94) of those who had been screened reported to have not received any support from their partners. More than ninety percent 94.7% reported that cervical cancer screening was very useful in the prevention of cervical cancer. The factors associated with uptake of cervical cancer screening were awareness ($p \leq 0.035$), opinion about cervical screening ($p \leq 0.000$), cervical screening usefulness ($p \leq 0.006$), frequency of having cervical screening done ($p \leq 0.000$) and partner support ($p \leq 0.000$). There is need to improve public awareness by educating women on the risk factors associated with cervical cancer and benefits of cervical screening through health talks and promotions, mass media awareness. Health professionals and healthcare workers should take the opportunity to educate and encourage women attending health facilities for other health problems to undergo cervical cancer screening. There is need to include men in education on cervical cancer especially sexual partners/ spouses so that they can encourage their spouses/partners in terms of moral and material support to increase the uptake of cervical cancer screening.
Keywords: cervical cancer, screening, uptake, awareness

1. Introduction

Cervical cancer is a disease characterized by uncontrolled growth and proliferation of abnormal cells (WHO, 2004). It may present with vaginal bleeding, but symptoms may be absent until the cancer is at an advanced stage. Treatment consists of surgery namely; local excision in early stages and hysterectomy in advanced stages. However, chemotherapy and radiotherapy are the treatments of choice (Kumar *et al*., 2007). When advanced, cervical cancer is often associated with high morbidity and mortality as the prognosis is very poor. Although cervical cancer is the second most frequent cancer after breast cancer in the world, (Schiff man *et al*., 2007) it is the most prevalent and leading cause of death related to cancers among females in developing countries. Globally about 530,000 new cases and more than 300,000 deaths occur due to cervical cancer annually (Ferlay *et al*., 2010). East Africa suffers the highest burden of cervical cancer accounting for 39% of all reported cases and 41% of all mortalities in Africa (WHO/ICO, 2010). Therefore, early detection and treatment of the precancerous stage is the key to success in achieving a reduction in cervical morbidity and mortality. However, it has received low priority among health care services in sub-Saharan Africa due to the overwhelming burden of communicable diseases (WHO, 2004). In Kenya, cervical cancer screening uptake is low with only 3.2% of all women reported to have undergone cervical cancer screening (WHO/ICO, 2010). This is due to poor perceptions regarding susceptibility to cervical cancer, the severity of cervical cancers and benefits of having a cervical cancer

screening. Other major contributing factors include low or lack of awareness on these cancers and screening and inadequate treatment facilities (Division of Reproductive Health, 2012). Early detection of cervical cancer screening using Papanicolaou (Pap) smear has shown success in increasing early diagnosis and therefore reducing mortality and morbidity in developed countries where this cytological cervical cancer screening has been introduced (Gakidou *et al.*, 2008).The most important risk factor for cervical cancer is irregular screening or lack of accessible cervical screening services. Other risk factors are early age of first sexual intercourse, HIV, exposure to HPV infection, early marriage (below age 20 years), multiple sex partners, polygamy, multiparty, circumcision, history of other cancers and those with family history of cervical cancer and lack of awareness of the disease itself (Saslow *et al*., 2002; Kumar *et al.,* 2007).This study aimed at assessing the factors that influence cervical cancer screening uptake among women aged 18-49 years in Njiru Sub County, Nairobi Kenya.

2. METHODS

This study was a descriptive cross-sectional study carried out in Njiru sub-County in Nairobi County. Approval to conduct the study was granted by Kenya Medical Research Institute (KEMRI) Scientific and Ethics Review Unit (SERU) (SSC NO. 2613) and the Nairobi County Department of Health Services. Permission to conduct the study was also sought from local community leaders.

The study population comprised of all women aged 18-49 years who lived in Njiru sub-County in Nairobi County and consented to participate. The sub-County has a vast surface area of 108 square kilometres and it is situated in the Eastern part of Nairobi County. It has a population of 343,382 with 107,822 women of reproductive age comprising 31.4% of the total population according to 2009 census. A sample size of 247 was calculated as a representative of the population. Njiru sub-county was purposively selected and multistage sampling was done in which three (3) out of five divisions in Njiru sub-county was randomly selected by lottery method. Stratified sampling was then used whereby each of the 3 randomly selected divisions were divided into strata (villages) followed by simple random sampling of 3 villages. A total of 82 households from each stratum (village) were selected using systematic random sampling where every 3rd household was selected and the participant interviewed if she met the eligibility criteria. This was done in the three divisions until the sample size was attained.

Data was collected using a semi-structured questionnaire that was available in both English and Swahili languages by trained enumerators. Each questionnaire was cross-checked before the respondent left so as to ensure completeness of data. A focused group discussion (FGD) of 12 participants, 4 from each division was conducted by the researcher in a health facility central to all the randomly selected divisions to gather qualitative data. The FGD was attended by the researcher who was the moderator of the discussion, and two research assistants, one recorded the audio while the other collected demographic data. The FGD was recorded using a camcorder

All the analyses were done using SPSS version 19.0. Descriptive statistics were used in analysis for proportions and frequencies. Bivariate analysis, Pearson's chi square (χ^2) tests were used to determine the association between uptake of cervical screening and socio-demographic factors, knowledge, attitude and practices influencing cervical cancer screening. Multivariate analysis was done on variables that were significant at bivariate level in order to determine the variables that independently influence cervical screening uptake. Differences were considered significant at $p \leq 0.05$.Qualitative data was analyzed using thematic analysis.

3. RESULTS

Socio-demographic and socio-economic characteristics of the respondents

The socio-demographic characteristics of the respondents are shown in Table 1. Two hundred and forty seven women from Dandora I (33.2%), Dandora II (33.2%) and Njiru (33.6%) Divisions were enrolled. The mean age of the respondents was 30.7±1.18 years. Most (32%), of the respondents were aged 25-29 years. Majority (96.4%) of the respondents were Christians and most (68%) of them were married. Approximately fifty percent of the study respondents had primary level education followed by secondary (38.9%), tertiary (8.9%) and no formal education 2.4%. About 46% of the respondents were self-employed.

Awareness of cervical cancer and availability of cervical cancer screening services

Eighty five percent (211/247) of the study respondents were aware of cervical cancer and had commonly (36.4%) obtained their information from media followed by health talks (34.8 %). Of those who were aware 25.6% (54/211) reported cervical cancer to be caused by Human Papilloma Virus (HPV) (Table 2).

Uptake of cervical cancer screening among women aged 18-49 year in Njiru Nairobi County

The overall uptake of cervical cancer screening (Table 3) was 38.1% (94/247). Most (38.3%) of the respondents who had ever been screened for cervical cancer resided in Njiru Division. The highest (31.9%) proportion of those who had ever been screened before were aged 25-29 years. Fifty percent of those who reported to have

ever been screened had secondary education. Majority (55.3%) of those who reported to have been screened before were self-employed.

Perception towards cervical cancer and cervical cancer screening
Most 43.6% (41/94) of the respondents who had ever been screened perceived the cervical screening procedures as uncomfortable followed at 24.5% (23/94) perceived it be embarrassing. Majority 52.1% (49/94) of those had been screened reported to have not received any support from their partners. More than ninety percent 94.7% reported that cervical cancer screening was very useful in the prevention of cervical cancer.

Socio demographic and socio economic factors associated with uptake of cervical cancer screening
Respondents with secondary level of education was the factor associated with cervical cancer screening uptake 47(50%) of the screened (n=94) as shown in table 4. No formal education had very low no of respondents screened 2(2.1). Majority of those not screened had primary level of education 86(56.2).

Association between awareness of cervical cancer and availability of cervical cancer screening services and uptake of cervical cancer screening among women 18-49 year in Njiru Nairobi County
Although the respondents were aware of availability of cervical cancer screening cervices, majority 105(68.6%) had not been screened. Over half of the respondents (51(54.3)) were not aware of HPV vaccine and majority 122 (79.7) of them had not been screened. Majority of the respondents who had no idea on prevention of cervical cancer were not screened 67(43.8). The summary is shown in table 5.

Association between reproductive and sexual practices and cervical cancer screening uptake among women 18-49 year in Njiru Nairobi County
Table 6 shows the association between reproductive and sexual practices influencing cervical cancer screening uptake. The proportion of respondents (62.8%) who had sexual encounters before the age of 18 years was higher among those who had ever been screened for cervical cancer than 52.9% among those who had not been screened. Age at first delivery (18-24 years (46.4%) n=153 were not screened was significantly associated with uptake of cervical cancer screening (p=0.022). Majority of the respondents who had not been screened had their first delivery at the age of 18-24 years and had 1-2 children. The percentage of respondents with no sexual partners at the time of the study was higher (57%) among those who had not been screened than (45.7%) in those who had ever been screened. Use of contraceptives among the screened and the not screened was 81.9% and 71.2% respectively.

Predictors of uptake of cervical screening services among women 18-49 year in Njiru Nairobi County
The predictors of uptake of cervical cancers screening shown in Table 7 awareness of cervical cancer screening; opinion about cervical cancer screening; usefulness of cervical cancer screening; how often is cervical cancer screening done; and partner support.

4. Discussion
Cervical cancer is a preventable non-communicable disease of public health importance. The risk of developing cervical cancer is high amongst women in developing countries due to the peculiar socio-economic characteristics such as poverty and illiteracy; low prevalence of condom use, high parity and poor utilization of screening services (Ombech *et al.,* 2012). Invasive cervical cancer is the second most common cancer in women worldwide, with 80% of cases occurring in developing countries (Holland *et al*., Nuffield provincial Trust; *Screening in health care;* 1990).

In the current study the mean age of the respondents was 30.7±1.18 years. Most (32%), of the respondents were aged between 25-29 years. Majority (96.4%) of the respondents in this study were Christians and most (68%) of them were married. Approximately fifty percent of the study respondents had primary level education followed by secondary (38.9%), tertiary (8.9%) and no formal education2.4%. About 46% of the respondents were self-employed. About half (48.9%) of the study respondents had primary level education followed by secondary education (38.9%). Slightly less than half (45.7%) were self-employed. These findings are different from findings on a study on "Awareness, perception and factors affecting utilization of cervical cancer screening services among women in Ibadan, Nigeria: a qualitative study" (Ndicom *et al.,* 2012). Participants were mainly married women (92.7%), 27.5±4.5 years mainly traders (39%) and from Yoruba ethnic backgrounds (87.8%) and had secondary education (39%). In a Malaysian study that sampled 959 women, a large proportion of the respondents had at least secondary or higher education at 51.5%, (62.7%) not employed and (80.7%) were married.

This study showed that level of cervical cancer screening uptake was 38.1% (94/247). Of the respondents 44.5% had heard of cervical screening services before but 61.9% (n=153) reported not to have never

been screened and 44.5% had heard of cervical cancer screening services in the present study. Findings of low uptake of cervical cancer screening was also demonstrated in a descriptive cross-sectional study conducted at Bindura provincial hospital, Zimbabwe Seventy (70) eligible participants were selected revealed that (97.1%) of the participants did not know about cervical cancer screening uptake. All did not seek Visual Inspection with Acetic Acid (VIA) and did not also get education on the National Cervical Cancer Screening Program Policy. Nearly eighty nine percent (89%) of the participants did not have an annual Pap smear. The study demonstrated a poor uptake of Cervical Cancer Screening because they did not know about the tests, tests were not available, and tests were expensive and also fear of procedures. This differs from study conducted among female staff and students of Niger Delta University, Nigeria, in which most of the respondents reported to have been aware of cervical cancer (70% of students, 80% of staff) (Owoeye and Ibrahim, 2013). This discrepancy might be attributed to the fact that different study populations were studied and there was a difference in the level of education and also most of the respondents from Nigeria might have had access to information through mass media, print media and internet due to the fact that they are within university. This discrepancy may be due to different population sizes studied (Gan and Dahlui, 2013).

Findings from the present study on the level of awareness showed that 47.2% (94/199) of the respondents were aware of cervical cancer screening, while 44.5% (94/211) had heard of cervical screening and 38.1% (94/247) reported to have had cervical screening done before. This study showed higher awareness as compared to a study that was conducted by Abiodun *et al.,* 2014, on knowledge, perception and predictors of uptake of cervical screening among rural Nigerian women that reported 159 out of 700 (15.6%) respondents were aware of cervical cancer while 58 (8.3%) had heard of cervical screening before, only 27 (3.9%) of the respondents had ever had cervical screening done.

The level of awareness in this study was however lower than the 87% level of awareness reported by Ombech *et al.,* 2012, on awareness of cervical cancer risk factors and practice of Pap smear testing among female primary school teachers in Kasarani division, Nairobi Kenya. This high awareness level may be due to access to many forms of information by the teachers as a result of their education status as compared to respondents of the present study.

A respondent in the FGD said “cervical cancer screening services should be expanded to reach more women in rural areas. Moreover, uptake of cervical screening was significantly associated with knowledge and perception scores. The mean total knowledge score was higher for screening than non-screening (t=7.54, P=0.000). The mean total perception score was higher among those who had done a cervical screening than those who had not (t=8.77, P=0.000) while in the present study, the level of education is the only social demographic characteristic that was found to influence uptake of cervical cancer screening services (P=0.041).

In a study that was conducted to assess cervical cancer screening uptake among HIV positive women of child bearing age at Bindura provincial hospital, Zimbabwe, found out that majority of the women (88.6%) did not get an annual Pap smear and only (11.4%) had an annual Pap smear. This does not concur with the present study as 43% (n=40) of women respondents reported to have had pap smear test while 56% (n=52) reported to have had cervical screening through VIA-VILLI method. This could be attributable to different populations studied in different geographical locations (Gundani and Chipfuwa, 2013). In terms of the opinion about cervical cancer screening, 43.6% (41/94) this being the majority of those screened reported screening as being uncomfortable followed at 24.5% (23/94) by those who reported that it was embarrassing.

For the twelve respondents in FGD on their opinion on cervical cancer screening; three respondents responded that it’s scary, painful, dreadful, fearful and uncomfortable respectfully. Other reasons for not doing the screening included: lack of awareness of Pap smear indications and benefits, perceived low susceptibility to cervical cancer, embarrassment and fear of pain. Furthermore, in a Ghanaian study by Ebu *et al.,* 2015, on knowledge, practice, and barriers toward cervical cancer screening in Elmina, showed that most 68.4% of the women had never heard about cervical cancer. Moreover, majority (93.6%) of the respondents had no knowledge of cervical cancer risk factors.

One of the respondents in FGD had this to say on risk factors associated with cervical cancer “be faithful to your sexual partner and also avoid having multiple sexual partners as this is one of the risk factors for cervical cancer. She also said that one should practice safe sex whenever she is having sexual intercourse. Another respondent said that “having sexual intercourse at an early age and also having many sexual partners increase the risk of cervical cancer”. The study showed that above half (53%) who responded that multiple sex partners was a risk factor had not been screened. Majority of the respondents in the study who had been screened (46%, n=153) did not know that HPV is a risk factor to cervical cancer and only 36.2% had undergone screening. In a Ghanaian study by Ebu *et al.,* 2015, on knowledge, practice, and barriers toward cervical cancer screening in Elmina, showed that most 68.4% of the women had never heard about cervical cancer. Moreover, majority (93.6%) of the respondents had no knowledge of cervical cancer risk factors.

5. Conclusions

The level of education, awareness of cervical screening services, opinion about cervical screening; whether cervical screening is useful; frequency of cervical cancer screening and having partner support was found to influence cervical cancer screening. There is need to improve public awareness by educating women on the risk factors associated with cervical cancer and benefits of cervical cancer screening through health talks and promotions through mass media. Health professionals and healthcare workers should take the opportunity to educate and encourage women attending health facilities for other health problems to undergo cervical cancer screening.

There is need to include men in education on cervical cancer especially sexual partners/ spouses so that they can encourage their spouses/partners in terms of moral and material support to increase the uptake of cervical cancer screening. Women need to be educated about the benefits of cervical cancer screening.

6. Acknowledgments

Our sincere appreciation goes to all participants who agreed to participate in this study for its success.

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Table 1.Socio-demographic and socio-economic characteristics of the respondents (n=247)

Characteristic	No. (%)
Residence	
Dandora I Division	82(33.2)
Dandora II Division	82(33.2)
Njiru Division	83(33.6)
Age in years	
18-24	53(21.5)
25-29	79(32)
30-34	40(16.2)
35-39	39(15.8)
40-49	36(14.6)
Religion	
Christians	238(96.4)
Muslims	6(2.4)
Atheists	3(1.2)
Marital status	
Married	168(68)
Single	71(28.7)
Widowed	8(3.2)
Highest level of education	
No formal education	6(2.4)
Primary	123(49.8)
Secondary	96(38.9)
Tertiary	22(8.9)
Occupation	
Self employed	113(45.7)
Formal employment	16(6.5)
Unemployed	66(26.7)
Others	52(21.1)

Table 2: Awareness of cervical cancer and availability of cervical cancer screening services among women 18-49 year in Njiru sub-County

Variable	No. (%)
Ever heard of cervical cancer	
Yes	211(85.4)
No	36(14.6)
Source of information	
Media	90(36.4)
Family	11(4.5)
Health talks	86(34.8)
Other sources	24(9.7)
Cause of cervical cancer	
HPV virus	54(21.9)
Bacteria	30(12.1)
Many sex partners	61(24.7)
Smoking	10(4)
No idea	92(37.2)
Awareness of availability of cervical cancer screening services	
Yes	199(80.6)
No	48(19.4)
Methods of cervical cancer prevention	
Avoid many sex partners	102(41.3)
Stop smoking	12(4.9)
HPV vaccination	42(17)
All the above	10(4)
No idea	78(31.6)
Others	3(1.2)

Table 3: Uptake of cervical cancer screening among women 18-49 year in Njiru Nairobi County

	Screened (n=94)	Not screened (n=153)	
Variable	**No. (%)**	**No. (%)**	**Total**
Division			
Dandora I	35(37.2)	47(30.7%)	82
Dandora II	25 (26.6)	57(37.3)	82
Njiru	34 (36.2)	49(32)	83
Age in years			
18-24	14(14.9)	39(25.5)	53
25-29	30(31.9)	49(32)	79
30-34	17(18.1)	23(15)	40
35-39	17(18.1)	22(14.4)	39
40-49	16(17)	20(13.1)	36
25-29 years	1(1.1)	3(2)	4
Above 30 years	1(1.1)	2(1.3)	3
Marital status			
Married	63(67)	105(68.6)	168
Single	27(28.7)	44(28.8)	71
Widowed	4(4.3)	4(2.6)	8
Education			
No formal education	2(2.1)	4(2.6)	6
Primary	37(39.4)	86(56.2)	123
Secondary	47(50)	49(32)	96
Tertiary	8(8.5)	14(9.2)	22
Occupation			
Self employed	52(55.3)	61(39.9)	113
Formal employment	6(6.4)	10(6.5)	16
Unemployed	18(19.1)	48(31.4)	66
Others	18(19.1)	34(22.2)	52

Table 4: Socio demographic and socio economic factors associated with uptake cervical cancer screening among women 18-49 year in Njiru Nairobi County

	Screened (n=94)	Not screened (n=153)		
Variable	**No. (%)**	**No. (%)**	**Total**	**P-value**
Age in years				0.341
18-24	14(14.9)	39(25.5)	53	
25-29	30(31.9)	49(32)	79	
30-34	17(18.1)	23(15)	40	
35-39	17(18.1)	22(14.4)	39	
40-49	16(17)	20(13.1)	36	
25-29 years	1(1.1)	3(2)	4	
Above 30 years	1(1.1)	2(1.3)	3	
Marital status				0.776
Married	63(67)	105(68.6)	168	
Single	27(28.7)	44(28.8)	71	
Widowed	4(4.3)	4(2.6)	8	
Education				0.041*
No formal education	2(2.1)	4(2.6)	6	
Primary	37(39.4)	86(56.2)	123	
Secondary	47(50)	49(32)	96	
Tertiary	8(8.5)	14(9.2)	22	
Occupation				0.087
Self employed	52(55.3)	61(39.9)	113	
Formal employment	6(6.4)	10(6.5)	16	
Unemployed	18(19.1)	48(31.4)	66	
Others	18(19.1)	34(22.2)	52	

* *Significant p≤0.05*

Table 5: Association between awareness of cervical cancer and availability of cervical cancer screening services and uptake of cervical cancer screening among women 18-49 year in Njiru Nairobi County

	Screened(n=94)	Not screened (n=153)		
Variable	**No. (%)**	**No. (%)**	**Total**	**p-value**
Ever heard of cervical cancer				0.000*
Yes	94(100)	117(76.5)	211	
No	0(0)	36(23.5)	36	
Source of information				0.000*
Media	25(26.6)	65(55.6)	90	
Family	7(7.4)	4(3.4)	11	
Health talks	53(56.4)	33(28.2)	86	
Other sources	9(9.6)	15(12.8)	24	
Cause of cervical cancer				0.000*
HPV virus	34(36.2)	20(13.1)	54	
Bacteria	13(13.8)	17(11.1)	30	
Many sex partners	23(24.5)	38(24.8)	61	
Smoking	2(2.1)	8(5.2)	10	
No idea	22(23.4)	70(45.8)	92	
Awareness of availability of cervical cancer screening services				0.000*
Yes	94(100)	105(68.6)	199	
No	0(0)	48(31.4)	48	
Knew where Cervical Cancer services are offered				0.000*
Yes	92(97.9)?	78(51)	170	
No	2(2.1)	75(49)	77	
Methods of cervical cancer prevention				0.000*
Avoid many sex partners	49(52.1)	53(34.6)	102	
Stop smoking	6(6.4)	6(3.9)	12	
HPV vaccination	23(24.5)	19(12.4)	42	
All the above	3(3.2)	7(4.6)	10	
No idea	11(11.7)	67(43.8)	78	
Others	2(2.1)	1(0.7)	3	
Awareness of HPV vaccination				0.000*
Yes	43(45.7)	31(20.3)	74	
No	51(54.3)	122(79.7)	173	
Vaccination against cervical cancer				0.017*
Yes	10(23.3)	1(3.2)	11	
No	33(76.7)	30(96.8)	63	
History of cervical cancer				0.173
Yes	10(10.6)	9(5.9)	19	
No	84(89.4)	144(94.1)	228	

* *Significant p≤0.05*

Table 6: Reproductive and sexual practices influencing cervical cancer screening uptake among women 18-49 year in Njiru Nairobi County

	Screened (n=94)	Not screened (n=153)		
Variable	**No. (%)**	**No. (%)**	**Total**	**P-value**
Age at 1st delivery				0.022*
Not yet	3(3.2)	12(7.8)	15	
Below 18 years	12(12.8)	25(16.3)	37	
18-24 years	64(68.1)	71(46.4)	135	
25-29 years	11(11.7)	39(25.5)	50	
30-34 years	3(3.2)	4(2.6)	7	
>35 years	1(1.1)	2(1.3)	3	
Parity				0.243
None	4(4.3)	18(11.8)	22	
1-2 children	38(40.4)	67(43.8)	105	
3-4 children	36(38.3)	45(29.4)	81	
>four	15(16)	22(14.4)	37	
Missing	1(1.1)	1(0.7)	2	
No. of sexual partners				0.208
None	43(45.7)	86(57)	129	
One	34(36.2)	50(33.1)	84	
Two	12(12.8)	10(6.6)	22	
Three	5(5.3)	5(3.3)	10	
Contraceptives usage				0.059
Yes	77(81.9)	109(71.2)	186	
No	17(18.1)	44(28.8)	61	

* *Significant p≤0.05*

Table 7: Predictors of uptake of cervical screening services among women aged 18-49

Predictor	P -value	95% Confidence Intervals
Awareness of availability of cervical screening services	0.035	1.7-45.8
Opinion about cervical screening	0.000	5.1-14.2
Is cervical screening useful	0.006	3.2-18.1
How often is cervical screening done	0.000	3.7-12.6
Partner support	0.000	17.7-44.6