

## Knowledge of Risk Factors for Cervical Cancer among Women in Togo

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### Abstract

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*Background.* Despite the high morbidity and mortality rates associated with cervical cancer in Togo, there is a lack of studies documenting the knowledge of risk factors for this disease. *Purposes.* The aims of this study are 1- to assess the knowledge of risk factors for cervical cancer among women in Togo; and 2- to develop policies which can potentially contribute to the prevention of cervical cancer in Togo. *Method.* Data were collected from 147 women via a cross-sectional survey conducted in Lomé, Togo in January 2011. *Results.* Data analysis indicates poor knowledge of risk factors for cervical cancer among the participants. The study also shows that knowing someone with cancer is negatively associated with knowledge of risk factors for cervical cancer. *Conclusion.* Using a feminist sociological theory, the study points towards the difference in status among genders as the main explicative factor of the poor knowledge of risk factors for cervical cancer among the respondents. The findings lead to policy implications.

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**Keywords:** cancer; cervical cancer; HPV; feminist sociological theory; Togo

### 1. Introduction

According to a report by WHO/ICO (2011), there were an estimated 52,940 new cases of cervical cancer worldwide in 2008, with the majority of the cases (86%) located in developing countries. The above percentage illustrates the unequal distribution of the disease among nations and underlines how vulnerable people in poor nations are compared to people living in wealthier countries. Not only did poor nations harbor most cases of cervical cancer, but also they suffer higher death tolls due to this disease (Ayinde & Omigbodun, 2003). For example, in 2007 it was estimated that from the 78,897 women suffering from cervical cancer in Africa, 78% (61,671) died (HPV Information Centre, 2011). This number shows how pervasive and devastating cervical cancer is in Africa, including Togo, which is the country of focus in this study (Gichangi et al., 2003; Kidanto, Kilewo, & Moshiri, 2002; Rogo, 2001; Rostad, Schei, & da Costa, 2003; Schalkwyk, Maree, & Wright, 2008).

Regarding Togo, the most accurate estimate indicates there were 595 new cases of cervical cancer in 2008, from which 417 women (70%) died the same year as diagnosis (WHO/ICO, 2011). Among these new cases, 458 (77%) were women whose ages ranged from 0 to 64 years. The remaining 23% (137) were 65 years or older. Using the same data of 2008, researchers projected that by 2025 the percentage of new cases will have increased by 73% in the category of 0 to 64 year-olds and by 85% for the 65 and older category if no drastic measures are taken to counter the spread of the disease (WHO/ICO, 2011). However, to take effective countermeasures against the advance of this disease, it is crucial to understand the risk factors associated with it.

### 2. Needs and Purposes

Two major needs underline the importance of this paper. First, there is a lack of studies on cervical cancer in Africa, in general, and Togo, in particular. The literature search yields only two studies on cervical cancer in Togo (WHO/ICO, 2011; HPV Information Centre, 2011). Even though these reports reveal interesting findings on cervical cancer in Togo, they lack some details regarding the disease because of their scope of study.

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The reported study of the World Health Organization, for instance, covers several types of cancer in Togo, Africa, and the world. It also discusses some other infectious diseases in Togo. The results of the 2007 report of the HPV Information Centre present interesting statistics on cervical cancer in Togo but cover many other countries in the world. As a result, the findings of this report cover only a limited aspect of the disease in the geographical context of Togo. Second, the alarming statistics related to cervical cancer, especially the annual number of deaths per new cases, which was 70% in 2008, warrant additional investigations on the topic.

The purpose of this study is linked to these needs and is twofold. First, this paper will investigate the knowledge of risk factors for cervical cancer among Togolese women. This will help in addressing the first need regarding the insufficiency of research on the topic, and, in so doing, contribute to the literature. Second, knowledge gained from this investigation will be helpful in crafting potential strategies for prevention of cervical cancer. This combination will ultimately contribute to the effort of alleviating the burden of the disease among Togolese women.

### 3. Background

Given the dearth of studies on cervical cancer in Togo, this section on the literature review is mainly based on research in other developing countries, especially African nations. Past studies on risk factors for cervical cancer consistently pointed to human papillomavirus or HPV as the principle cause of the disease (Louie, de Sanjose, & Mayaud, 2009). There are several types of HPV, however, with five most associated with invasive cervical cancer among women. In decreasing order of importance--from more to less important--these types are 16, 18, 45, 33, and 35 (HPV Information Centre, 2011). Of these five types of HPV, 16 and 18 are found to be the most prevalent among women living in sub-Saharan Africa, where nearly 70% of cases of cervical cancer worldwide exist (Anorlu, 2008; Louie et al., 2009).

The fact that about 70% of women who are suffering from cervical cancer live in sub-Saharan Africa is indicative of an unequal distribution of the disease. This unequal distribution of cervical cancer at the global level suggests that even though HPV is a main cause of the disease, it is not the exclusive cause (Schottenfeld & Beebe-Dimmer, 2005). Other factors also come into play in the spread of HPV and ultimately into the etiology of cervical cancer in this part of the African continent. One factor that affects the infection of HPV and the development of the virus to its oncogenic stage in women in sub-Saharan Africa is the age at which women first marry (Anorlu, 2008; Kidanto et al., 2002; Ogunbowale & Lawoyin, 2008). However, it seems for some researchers that the age at first marriage is not by itself the problem as much as the sexual activity and the child bearing associated with it (Louie et al., 2009; Rostad et al., 2003). For example, Rostad et al., in their study among Mozambican women with cervical cancer, found sexual intercourse and pregnancy at a younger age to be positively associated with the disease. Their results indicated that up to 90% of the women suffering from the disease had their first sexual intercourse when they were 19 years old or younger. Regarding pregnancy, 62% of the respondents also had their first pregnancy at 19 years old or younger.

The correlation between younger age at first pregnancy and cervical cancer among Mozambican women is also found in other African countries, such as Kenya (Gichangi et al., 2003) and Tanzania (Kapiga et al., 1999). In addition to early age at first pregnancy, the number of lifetime births is associated with the disease. More explicitly, high parity--high number of children--is also found to be positively associated with invasive cervical cancer (Anorlu, 2008; Gichangi et al., 2003; Rostad et al., 2003). It is worthwhile noting that not all of the studies pointed to the positive association between high parity and cervical cancer. In fact, Ogunbowale and Lawoyin (2008), in their study among Nigerian women in rural areas, found that low parity (0-3) is also correlated with the disease.

Polygamous marriage and multiple sexual partners constitute another set of risk factors linked to cervical cancer among African women (Walker, Michelow, & Walker, 2002). Given that most of the HPV infection occurs through sexual contact, it appears that polygamy, which is a common practice in many cultures within the African continent, can contribute to the spread of the disease (Bosch, Qiao, & Castellsagué, 2006). As with the case of polygamy, having multiple partners also increases the chance of contracting HPV as well as the likelihood of developing cervical cancer (Bosch et al., 2006). Both practices are also responsible for the spread of sexually transmitted diseases (STDs), which are found to be contributing to the high incidence of cervical cancer in Africa (Drain, Halperin, Hughes, Klausner, & Bailey, 2006; Rostad et al., 2003). The proliferation of STDs on the continent, such as chlamydia, gonorrhea, syphilis, and genital herpes, has such taxing effects on the immune system that the body seems to be almost defenseless in the attack and progression of HPV among women living in sub-Saharan Africa (Schottenfeld & Beebe-Dimmer, 2005).

Among STDs associated with cervical cancer, HIV has been the most studied. It is argued that the immunosuppressive character of the HIV virus makes women more vulnerable to the infection of HPV (Kapiga et al., 1999). The vulnerability caused by HIV explains why HIV-infected women are at higher risk of being infected by HPV and developing cervical cancer than women uninfected by HIV (Leitao, White, & Cracchiolo, 2008; Logan, Khambaty, D'Souza, & Menezes, 2010). Other risk factors include nutritional status (Rogo, 2001), use of oral contraceptives (Rostad et al., 2003), tobacco smoking (Abotchie & Shokar, 2009), residing within the 30 to 69 year-old age range (Rogo, 2001; Schalkwyk et al., 2008), and the absence of screening (Francis et al., 2010). Living in rural areas is found to be a contributing factor of the high incidence of the disease as well (Ogunbowale & Lawoyin, 2008).

The low socioeconomic status (SES) of the majority of African women also contributes to the high rate of cervical cancer on the continent (Anorlu, 2008; Ayinde & Omigbodun, 2003). The association between cervical cancer and low SES explains the reason for the disease's being more common among women living in developing countries than developed ones. Regarding SES, several studies pointed to the role of poverty in the etiology of the disease (Anorlu, 2008; Kidanto et al., 2002; Louie et al., 2009). In the literature, SES has been ascertained in various ways. However, the majority of studies have used employment status and/or level of education as indicators of SES. Using these two indicators, Rostad et al. (2003) reported that the majority of Kenyan women (66%) with cervical cancer had a lower level of education (1 to 9 years) and were unemployed (67%). That is, cervical cancer is prevalent among women with low levels of education or illiteracy and who are unemployed or are housewives (Rostad et al., 2003). Similar remarks regarding the inverse relationship between SES and cervical cancer are also reported in other research studies in Africa (Anorlu, 2008; Kidanto et al., 2002). While most studies corroborated the existence of a negative relationship between SES and invasive cervical cancer, some reached a significantly different conclusion (Abotchie & Shokar, 2009; Ogunbowale & Lawoyin, 2008). Ogunbowale and Lawoyin, for example, found no relationship between low SES and cervical cancer.

Despite previous studies having identified several factors associated with the risk factors for cervical cancer, there is evidence suggesting that African women are the most at risk and have little or no knowledge about the causes of this disease (Abotchie & Shokar, 2009; Kidanto et al., 2002). In the absence of adequate knowledge regarding the causes of cervical cancer, it appears that the disease will continue spreading at an alarming rate (Abotchie & Shokar, 2009). A study among educated Ghanaian women indicated that with the exception of sexual activity, they had very little (sometimes less than 1%) knowledge about other risk factors for cervical cancer, such as past sexual experiences of their partners, HPV, and smoking (Abotchie & Shokar, 2009). Additionally, the study showed that the Ghanaian women interviewed were not aware of the existence of the Pap smear, a test to diagnose cervical cancer. They had misconceptions about the screening, such as the belief that the screening test is painful and can take away their virginity.

The inadequate knowledge about cervical cancer is not exclusive to Ghanaian women but seems to be commonplace in Africa. In fact, a study among women of Dar Es Salaam reported the same lack of knowledge of the causes and the symptoms of cervical cancer (Kidanto et al., 2002). According Kidanto et al., the poor knowledge of the common symptoms and causes associated with the disease account for the delay of women in seeking biomedical attention. Cain et al., (2007) and Schalkwyk et al., (2008) argued that poor knowledge about cervical cancer among women is only part of the problem because sometimes health care professionals also do not have adequate information regarding the disease. As solutions, they recommended the education of the public, politicians, traditional/alternative providers, community leaders, and a re-education of the health care providers on the causes, symptoms, diagnostic tests of and vaccine for cervical cancer.

A study documenting the knowledge about cervical cancer among South African women indicated that culture influences knowledge and beliefs about cervical cancer. For example, some South African black women believed that cancer, including cervical cancer, is a disease of "white people" (Schalkwyk et al., 2008). Such a belief would have a tendency to nullify campaigns aimed at raising cervical cancer awareness among black women in South Africa. As in South Africa, women in Botswana are also reported to be misinformed about the causes of cervical cancer (McFarland, 2009). A qualitative study conducted by McFarland among women in Botswana revealed that they had very poor to no knowledge about the known scientific causes of cervical cancer.

The respondents associated cervical cancer with cervical irritants such as vaginally inserted chemical agents, traditional medicine, intrauterine devices, intravaginal washing, excessive/rough sexual activity, traditional sitz baths, vaginal suppositories, and toilet paper (McFarland, 2009). Additionally, the interviewed women believed that breaking sexual taboos, such as having sex after the death of a spouse or after miscarriage, could lead to cervical cancer (McFarland, 2009).

From the literature review, it appears that the population which is at the highest risk of harboring this devastating type of cancer, i.e., women living in sub-Saharan Africa, has, ironically, very poor knowledge of the disease. Not having appropriate knowledge on the causes of cervical cancer will contribute tremendously to many African women suffering from the disease. Also, being ignorant to the fact that cervical cancer can be prevented and cured if diagnosed at an early stage can contribute to an increased death rate due to the disease. The lack of awareness of the existence of the Pap smear as a means to detect the presence of HPV, and other risk factors of the disease makes cervical cancer the deadliest cancer in sub-Saharan Africa. Given the poor prognosis of women suffering from the disease in Africa, it is important that more studies be conducted on the continent. The fact that culture affects the definition and the perception of the disease and influences people's behaviors and attitudes (Weiss & Lonquist, 2009; Cockerham, 2010) makes clear that more investigations documenting the disease and people's knowledge of it within different geographic and cultural contexts are needed.

#### 4. Theoretical Foundation

The paper is founded on the theoretical perspective of feminist sociological theory formulated by Dorothy Smith (1987, 2005). Feminist sociological theory is a woman-centered theory interested in describing and analyzing the experiences of women from the female vantage point in order to improve their situations. In addition to ameliorating women's conditions in society, feminist sociological theory has brought new dimensions to women's issues through the introduction of new concepts, two of which are standpoint and relations of ruling.

The concept of standpoint is central to feminist sociological theory and refers to the individual position or standing in society (Appelrouth & Edles, 2012). According to Smith (1987) each gender has a different standpoint. For example, women have a devaluated standpoint while men have a privileged one. As a result of distinct and unequal standpoints, women and men do not experience reality in the same way. Having different experiences translates into different levels of knowledge. Hence, there is a relationship between standpoint and knowledge (Wood, 2005). That is, the knowledge that an individual possesses reflects his or her position/standing in society (Smith, 1987). In a male-dominated world, women, as a group, are more likely to be associated with a less privileged position, which in turn can influence their experiences and their knowledge.

A closer analysis of the concept of standpoint, as it relates to the theoretical work of Smith, indicates some neo-marxist and phenomenological roots. The neo-marxism influence on the concept can be felt when Smith established a link between standpoint, an individual's position in society, and inequality. The phenomenological root of the concept can be detected from the way Smith explained the effects an individual's position has on his or her knowledge.

An examination of Smith's second concept, the ruling relations, suggests some post-structural influence. Smith used the concept of the ruling relations to emphasize how the underlying structure of texts or discourses in society perpetuates the subjugation of women. Because of their subjugation in society, women are rarely associated with the decision-making process. Consequently, issues related to and important to women are not frequently brought forth nor discussed, at least not enough, in the public arena. Such negative treatment of women can have negative repercussions on society, especially on women and their knowledge.

It appears that standpoint and ruling relations, two pivotal concepts in Smith's feminist sociological theory are linked to knowledge and will be helpful in understanding the knowledge of risk factors for cervical cancer among women in the geographic context of Togo. In Togo and just about every African country where the stratification system is highly hierarchical and based on patriarchy, women occupy a lower position/standpoint compared to men (Gatwiri & Mumbi, 2016). Since the individuals' standpoints are linked to their knowledge, it is conceivable that the standpoint of Togolese women can have an influence on their level of knowledge of risk factors for cervical cancer. Alternatively, not only can the standpoint affect knowledge, but it can also have implications for the ruling relations.

In other words, as a result of women being associated with a less privileged standpoint, their issues, including health related issues, are less likely to receive enough attention in societal discourses. Not receiving adequate coverage in public discourses or texts can conceivably have negative effects on the levels of knowledge people have about women and their challenges, including their health-related issues, such as cervical cancer. From this theoretical background, we hypothesized that respondents will report poor knowledge of risk factors for cervical cancer.

## 5. Methods

### 5.1 Data collection and measurement

Cross sectional, nonrandom data were collected in Lomé, Togo in January 2011. The questionnaire was comprised of questions on beliefs about and knowledge of cervical cancer risk factors derived from the guidelines of the American Cancer Society (2011). This study reports data on knowledge of cervical cancer risk factors only. Participants were asked about their beliefs about cervical cancer risk factors and were presented with a well-established list of risk factors for cancer found in cancer literature (Oduşanya, 2001, Waller, McCaffery, & Wardle, 2004). For instance, they were asked if cervical cancer risk increases with the following: age, oral contraceptive pills, smoking, multiple partners, and being HIV positive. The response categories for each of the questions were: yes, no, and don't know. However, in this paper, the response categories 'no' and 'don't know' were grouped together as a 'lack of knowledge' category. One hundred forty-seven people participated in the study.

#### 5.1.1 Dependent variable

Knowledge of risk factors for cervical cancer was measured by the five following statements: 1) cervical cancer risk increases by increasing age; 2) cervical cancer risk increases by the usage of oral contraceptive pills; 3) cervical cancer risk increases by smoking; 4) having multiple sexual partners increases cervical cancer risk; 5) being HIV positive increases the risk of cervical cancer. Response categories are coded in the following manner: 1 = yes; 2 = no; and 3 = don't know. A higher number of correct answers on these statements indicates good knowledge of risk factors for cervical cancer, whereas a lower number of correct answers suggests poor knowledge among the participants.

#### 5.1.2 Predictors

*Age.* This variable was measured using an interview question asking respondents how old they were. *Gender.* Gender was measured by asking the respondents to indicate their sex between the two following options: 1 if male and 2 if female. *Marital status.* Marital status in this study was measured by a question in which respondents should indicate their marital status. *Years of education.* This variable was measured with the question asking the respondents their highest year of education. *Knowing someone with cancer.* This predictor was measured with the question asking the respondents whether or not they knew somebody who had cancer. *Have cancer.* This last predictor was assessed with the question asking respondents whether their physician told them they had cervical cancer.

### 5.2 Statistical procedure

The paper uses two major levels of analysis: univariate and multivariate. The univariate analysis was used to assess the percentage distribution of the sociodemographic factors of the respondents and their knowledge of risk factors for cervical cancer. The multivariate analysis, the regression analysis, was helpful in determining the effect of the sociodemographic factors on the knowledge of risk factors for cervical cancer.

## 6. Results

The examination of Table 1 shows that approximately 60% of the respondents were 40 years old or younger. There were more females than males (55% vs. 45%). Most of the respondents were married (53%) and had a college level degree (65%). When asked whether or not they had cancer, the majority of them reported that they did not (98%). However, close to half of them said that they knew someone who was suffering from cancer (48%).

**Table 1: Descriptive statistics**

Variables	N	%
Age		
≤ 40	82	55.8
≥ 41	65	44.2
Marital status		
Married	73	49.7
Unmarried	74	50.3
Level of education		
Primary	10	6.8
Secondary	58	39.5
College	79	53.7
Have cancer		
Yes	3	2.0
No	144	98.0
Know somebody with cancer		
Yes	69	46.9
No	78	53.1

Table 2 shows that most of the respondents in the sample were not knowledgeable about the risk factors for cervical cancer, as evidenced by the means above (1.00). For example, most of the respondents were not aware that the risk of cervical cancer increases with oral contraceptive usage ( $M = 1.74$ ,  $SD = .44$ ). Given that this mean of 1.74 is the highest in Table 2, it suggests that the majority of the respondents knew less about the association between cervical cancer and oral contraceptive usage than the other risk factors. The lowest mean in Table 2, which is 1.10 ( $SD = .30$ ), indicates that even though most respondents were not knowledgeable about the correlation between tobacco smoking and cervical cancer, they are more likely to recognize this risk factor than the one related to contraceptive usage.

From the results of Table 2, it appears that the respondents knew little about the risk factors for cervical cancer. However, Table 2 also shows that respondents were less ignorant about some risk factors than others, as indicated by the difference in means. To investigate these differential levels of knowledge of risk factors, the paper assesses the potential influence of the sociodemographic variables. For this purpose, a regression analysis was performed to estimate the relationship between knowledge of risk factors and each sociodemographic variable.

**Table 2: Percentage distribution of knowledge of risk factors of cervical cancer among respondents**

Factors	Yes (%)	No (%)	Mean	SD
Risk of cervical cancer increases with age	52(35.4)	95(64.6)	1.65	.48
Risk of cervical cancer increases with oral contraceptive usage	38(25.9)	109(74.1)	1.74	.44
Risk of cervical cancer increases with tobacco smoking	132(89.8)	15(10.2)	1.10	.30
Risk of cervical cancer increases with multiple partners	66(44.9)	81(55.1)	1.55	.50
Risk of cervical cancer increases for people with HIV/AIDS	76(51.7)	71(48.3)	1.48	.50

Table 3: Impacts of sociodemographic factors on knowledge of risk factors of cervical cancer

	B <sup>a</sup>	SE <sup>b</sup>	p <sup>c</sup>
Age	.772	.525	.144
Marital status	.656	.487	.180
Level of education	.543	.383	.159
Diagnosed with cancer	1.340	1.599	.403
Knowing someone with cancer	-1.237	.480	.011
Constant	2.699	3.845	.484
R <sup>2</sup>	.091		
R <sup>2</sup> adj	.057		
F	2.727		
N	142		

Note.

a: Unstandardized coefficient

b: Standard error

c: p-value

Table 3 presents the results of the regression analysis assessing the influence of the five predictors on the knowledge of risk factors for cervical cancer. The five predictors entered in the model are age, marital status, level of education, having been diagnosed with cancer, and knowing someone with cancer. The examination of Table 3 indicates that the regression model is statistically significant  $R^2 = .091$ ,  $R^2 \text{ adj} = .057$ ,  $F(5, 137) = 2.727$ ,  $p = .022$ . The  $R^2$  of .091 suggests that about 9% of the variation in the knowledge of risk factors for cervical cancer is explained by its relationship with the predictors.

A further examination of Table 3 shows that, among the five predictors, only knowing someone with cancer is significantly associated with knowledge of the risk factors for cervical cancer ( $b = -1.237$ ,  $p = .011$ ). The unstandardized coefficient of -1.237 associated with knowing someone with cancer represents the correlation coefficient between knowledge of the risk factors for cervical cancer and knowing someone with cancer. The  $b$  of -1.237 signifies that, on average, the knowledge of risk factors for cervical cancer is reduced with each additional person with cancer known to the respondent by about 1.237 points, all else being equal.

## 7. Discussion

The purpose of this study is to assess the knowledge of risk factors of cervical cancer among women in Togo. To reach this goal, we hypothesized that respondents will report poor knowledge of risk factors for cervical cancer. The examination of Table 2 indicates that our hypothesis is supported. That is, the majority of respondents were not knowledgeable about most of the risk factors for cervical cancer (five in total) that were presented to them. In fact, more than half of them did not know that variables such as age (64.6%), oral contraception (74.1%), and multiple partners (55.1%) were associated with cervical cancer. This poor knowledge of the risk factors for cervical cancer among women in Togo is not unusual. Indeed, previous studies have reached similar findings (Louie et al., 2009; McFarland, 2009).

According to past studies, the poor knowledge of women regarding the causes of cervical cancer is attributable to the low level of literacy among women in Africa (Anorlu, 2008; Kidanto et al., 2002). However, this literacy argument would not be effective in explaining our findings regarding the low knowledge of risk factors for cervical cancer among women in Togo because the descriptive analysis of our sample indicates that about 54% of the respondents had a college level education (Table 1). This result shows that the women in our sample were fairly educated; therefore, education could not be a logical explicative factor for their poor knowledge of risk factors for cervical cancer. An alternative explanation can be found by using a feminist sociological theory. Using this theoretical perspective, it is possible to link the poor knowledge about the risk factors for cervical cancer to the fact that the disease affects only women, who in Togo society have a less privileged standpoint. From this perspective, it is conceivable that cervical cancer is less likely to receive the necessary attention in the societal discourses and texts in Togo, including the education system and media.

Without proper coverage of cervical cancer in societal discourses, it appears then that the majority of Togolese, including women, will have a poor knowledge of this disease as well as its risk factors. A further analysis of the regression model reveals that knowing someone with cancer is negatively and significantly associated with the knowledge of risk factors for cervical cancer ( $b = -1.237, p = .011$ ). This negative  $b$  for this predictor shows that knowing someone with cancer is associated with lesser knowledge of risk factors for cervical cancer. This result can be indicative of the lack of knowledge in cancer patients about their disease.

Not well informed about their disease, cancer patients were more likely to share erroneous information about the risk factors related to their disease with people within their networks. This explanation is highly probable as there is evidence suggesting that sometimes health providers themselves, such as nurses, are not knowledgeable about the risk factors for cervical cancer in some African countries (Ayinde & Omigbodun, 2003; Cain et al., 2007; Schalkwyk et al., 2008). The erroneous belief that cancer patients hold about the risk factors related to their disease which can be linked to the poor knowledge about cervical cancer of some health professionals in African countries underscores a potential lack of emphasis on cervical cancer in the societal discourses and texts in Togo.

## 8. Conclusion and Policy Implications

This study on the knowledge of risk factors for cervical cancer among women in Togo has two limitations. The first one is related to the technique of data collection. The data used in the study is based on a convenient sampling technique. The second limitation is related to the small sample size ( $N = 147$ ). The combination of these two limitations can potentially be a source of bias for the study; therefore, readers should use caution when generalizing our findings. These limitations warrant future studies which should address the weaknesses of the present study.

Despite these limitations, the study is significant because not only does it indicate that women in Togo have poor knowledge of risk factors for cervical cancer, but also it explains why by applying a feminist sociological theory. Previous studies on the topic in the geographic context of the African continent rarely used a theoretical perspective in explaining their results. The findings of the current study have policy implications. For example, using a feminist sociological theory, this study indicates that the problem of poor knowledge of risk factors for cervical cancer is not necessarily caused by low literacy levels among women, as most past studies have shown. Instead, the poor knowledge among women in Togo can be due to differential statuses between men and women with its corollaries, such as different standpoints and the ensuing power relations among both genders. This finding calls for structural changes which will reduce the inequality in status between men and women. The finding related to the negative influence of knowing someone with cancer suggests some potential problems with the health care system in Togo. To solve the problem related to the erroneous information that cancer patients hold about their disease, it is important that health care professionals, especially physicians, spend more time educating cancer patients about their disease. Additionally, educational campaigns focusing on cancer, especially cervical cancer, should be an integral part of societal discourses in Togo, including media, the educational system, and governmental agencies as well as non-governmental organizations.

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