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Media Campaigns and Behaviour Change in Breast Cancer Prevention among Women in Epe Local Government Area, Lagos State

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Abstract: *This paper investigated the influence of media campaigns on behaviour change in breast cancer prevention among women in Epe Local Government Area of Lagos State. The paper also examined the level of awareness and knowledge of breast cancer prevention and identified factors limiting the effectiveness of the campaigns. A mixed-methods research design was adopted, involving a survey research method and Focus Group Discussion with 27 participants. A sample sizes of 391 respondents was purposively selected using multi-stage sampling technique. The first stage involved purposive selection of three wards in Epe Local Government Area based on their different levels of access to radio broadcast signals and population density to assure representation of both urban and semi-rural areas of the Local Government Area. In the second stage, streets and clusters of households in the selected wards were sampled systematically. Every third household was selected as a sampling point. In the third stage, a simple random sampling technique was adopted and one adult woman per selected households, aged 18 years and above and who are residents in the area and who fulfill the inclusion criteria, was selected through balloting technique, for the period of six months (February-July 2026).*
Keywords: *Breast Cancer; Media Campaigns; Behavioural Change; Media Awareness; Radio*

I. Introduction

There are several awareness campaigns that have been carried out in Nigeria using media to spread awareness of breast cancer prevention (Okonkwo et al., 2022; Ifediora et al., 2025). Accprding to Akintayo and Aondover (2025) health awareness campaigns organised by the state and non-governmental agencies such as the international commitment like "Pink October" awareness campaign on breast cancer are set to sensitise women on the issue of early detection (Ifediora & Azuike, 2019; Akintayo & Aondover, 2025). Research points out that women health practices can be affected by the awareness campaign to a big extent. For example, in a study of the effect of the Pink October campaign in Nigeria, the proportion of women reporting to the screening mammography rose by over two-fold when the campaign was introduced (Wogu et al., 2019; Schliemann et al., 2020). This demonstrates how the health behavior change might be affected by media-based sensitization programmes.

The number of awareness campaigns is growing, but there are still women in Nigeria who face some barriers towards having preventive behaviors (Ineji, 2024). The cultural perception of women, lack of knowledge, misinformation, fear of diagnosis, financial issues, and difficulty accessing healthcare services are all factors that hinder women's participation in screening practices (Effiong et al., 2024; Gift et al., 2025). Besides, majority of women are sensitized on breast cancer, but in some societies there is minimal awareness of risk factors, signs of breast cancer and preventive measures. It has been proven that the awareness is there

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but there is still a lack of knowledge and regular screening of breast cancer among a large population of Nigerian women (Ojo, 2022; Okunade et al., 2025).

Mass media and health campaigns and communication is one of the determining factors in the preventive behavior. Media campaigns play a key role in disseminating health information, modifying attitudes of individuals and changing health-related behaviors (Ekwueme, 2019; WHO, 2023). The application of health communication tactics (including through TV, radio, paper, social media and community outreach interventions) has been extensively used to inform populations about disease prevention and symptoms identification, as well as services available to members of the community (Akintayo & Ajayi, 2024). Media campaigns can be used to raise awareness of breast cancer risk factors, encourage people to adopt screening practices, and encourage women to participate in screening programs (Daniel et al., 2024).

Breast cancer is one of the most common non-communicable diseases in women worldwide, and has become a major public health problem in most developing countries including Nigeria (Wogu et al., 2019; Ifediora et al., 2025). This disease is defined by the unnatural proliferation of cancerous cells in the breast tissue and even today it is one of the leading causes of death in cancer cases among women around the world. Over the past few decades, there has been a tremendous increase in the number of breast cancer cases in low- and middle-income nations as a result of lifestyle shifts, urbanization, population explosion, and enhanced diagnostic procedures (Schliemann et al., 2020; Ogundoyin et al., 2025). The breast cancer has become the most predominant cancer in the women in Nigeria, where it has been reported to occupy a significant percentage of the cancer prevalence. In Nigeria, about 28,380 cases of breast cancer were reported in the year 2020, which is approximately 22.7 percent out of the total number of cases of cancer reported in the country (Airaoje et al., 2025).

Late presentation and high mortality in breast cancer in Nigeria also contributes to the burden of breast cancer. Research has shown that Nigeria is one of the African countries with the highest rates of breast cancer mortality estimated to be at about 25.5 deaths per 100,000 women (Ojo, 2020; Effiong et al., 2024). This is due to late presentation at health facility, poor screening programs, lack of knowledge about preventive practices and lack of access to early diagnostic services (Airaoje et al., 2025). These studies have also shown that the majority of breast cancers in Nigeria have been diagnosed late with more than 70 per cent of the patients having late stage malignancy. This delayed diagnosis provides limited opportunities for survival and lots of cost and complications of treatment (Airaoje et al., 2025).

The best way to reduce the deaths from breast cancer is to detect it early. Some of the preventive measures that can assist in detecting abnormalities at an early stage that will result in a more favorable treatment outcome include breast self-examination (BSE), clinical breast examination (CBE), and mammography screening (Ogundoyin & Ogundoyin, 2019; Ifediora, 2019). It has been indicated that early diagnosis can have a great impact in decreasing morbidity as well as mortality related to breast cancer. The screening practices on the other hand are not adopted by the Nigerian women at a relatively high rate. For instance, one study conducted in Nigeria on breast cancer awareness revealed that a high proportion of women had high awareness of breast cancer but few women were engaged in breast cancer screening, with 80 percent of women reporting that they had never had mammography screening (Ojomo & Ukangwa, 2022).

1.1 Objectives of the Study

The general objective of this study is to examine the influence of media campaigns on behavior change in breast cancer prevention among women in Epe Local Government Area of Lagos State.

The specific objectives are to:

a. Assess the level of awareness and knowledge of breast cancer prevention among women in the area.
b. Examine the perception of women in Epe Local Government Area to media campaigns on breast cancer prevention.
c. Determine the influence of media campaigns on women's adoption of preventive practices such as breast self-examination and screening.
d. Identify the factors that limit the effectiveness of media campaigns in promoting breast cancer prevention among women in Epe Local Government Area.

II. Review of Literature

2.1 Role of the Media in Breast Cancer Awareness

Media has great impact on the promotion of breast cancer awareness and educating people about breast cancer. Television, radio, newspaper and social media are strong media channels that can reach large populations with messages about health (Nwozichi et al., 2025). These channels can be used to deliver breast cancer-related information on symptoms, risk factors, prevention, and the necessity of early detection to health organizations, governments, and advocacy groups. Media campaigns have been identified as an integral part of public health education that seeks to lower the burden of breast cancer all across the world (Awofadeju & Akintayo, 2023).

An essential role that the media play is creating awareness on breast cancer. Health education is frequently communicated over television and radio.Breast cancer prevention messages are commonly given in TV and radio shows, and women are urged to engage in screening behaviors. The programs can consist of interviews with doctors, survivors' narratives, and educational documentaries that contain useful information on the disease (Wuraola et al., 2023). Mass media campaigns have been shown to impact health behaviours by raising awareness and getting people to practice prevention according to Wakefield, Loken, and Hornik (2020).

The key factors in the influence of television as a tool for delivering health messages are its reach and the fact that it can combine the visual and audio aspects of the message to create a completer and more understandable message (Obada et al., 2021). Breast self-examination (BSE) techniques and the role of early detection could be shown on television in educational programs. Breast exam illustrations can help people become familiar with what to look for and when to seek help with their breast health. During the Breast Cancer Awareness Month, there are often campaigns run in the media to raise awareness about the disease and to remind women that screening is important (Bioku et al., 2025).

Radio also can be an important medium for raising awareness about breast cancer particularly in rural and low-resource areas where television and/or internet services may not

be available. The radio can be used to communicate with many people at a low cost and performs especially well in societies where there is a high degree of illiteracy. Radio broadcasts can be used to educate listeners about breast cancer symptoms, risk factors, and breast cancer screening services provided (Hile et al., 2022). Radio is one of the most accessible communication vectors for health education in many developing countries, according to World Health Organization (WHO, 2023).

Media such as newspapers and magazines play and important role in providing information on breast cancer. Articles and public awareness campaigns about breast cancer prevention and early detection are regularly published in printed media such as health columns (Nwozichi et al., 2025). These publications can also feature breast cancer survivors' stories which can help de-stigmatize breast cancer and inspire people to visit doctors. Health professionals can also disseminate their expertise and advice about breast cancer prevention and treatment through newspapers (Maradun & Aondover, 2025).

Social media has emerged as a powerful tool to raise awareness and educate about breast cancer in recent years (Obada et al., 2021). Digital platforms like Facebook, Twitter, Instagram and YouTube make it possible for health organisations and advocacy groups to disseminate information in no time at all, and to a global audience of millions (Wuraola et al., 2023). To raise awareness of breast cancer, social media campaigns frequently feature videos, infographics, and people's stories. The platforms also enable the user to pass information along to their network, which will amplify their awareness messages (Olasehinde et al., 2019).

Social media can also be used to allow health professionals to engage in interactive communication with the public. Individuals can ask questions, get health information and tips, and access education materials about breast cancer through online discussions, webinars, and live broadcasts. Moorhead et al. (2023) say that social media is a "revolution in health communication" that allows for the rapid dissemination of information and increased participation of the public in health promotion activities.

In addition, the media is very important in influencing attitudes and behaviours in breast cancer awareness (Akintayo & Aondover, 2025). Media campaigns will frequently seek to encourage women to practise preventive health behaviours, including breast self-examination, clinical screening and healthy lifestyle behaviours (WHO, 2023). Widespread exposure to health-related messages across multiple platforms increases the likelihood that people will have positive attitudes towards preventative health care, and will seek medical care when required (Ahmed & Msughter, 2022; WHO, 2023).

The media also plays a role in decreasing the stigma and misconceptions about breast cancer. TV shows, news articles and social media platforms provide opportunities to have public discussions about breast cancer, making the subject more commonplace (Airaoje et al., 2024). Media campaigns can help alleviate fear and promote open discussions about breast health by sharing accurate information and narratives of recovery (WHO, 2023).

2.2 Theoretical Framework

The Health Belief Model is regarded as most suitable for explaining adherence to preventive health behaviours as it directly addresses the question of why people take up or do not take up such behaviours. The theory is based on the personal views of disease held by individuals and how these views drive their choice to take preventive measures. The Health Belief Model (HBM) is the most direct model to explain the behaviors in question, given that

this study deals with breast cancer awareness, knowledge, and preventive practices related to breast cancer, which include breast self-examination and screening (Airaoje et al., 2023).

The model suggests that people are likely to engage in preventive health behaviours when they think they are at risk of developing a disease, think of the disease as serious, think that doing the behaviours will help them avoid the disease, and think that few barriers will stop them from doing the behaviours (Airaoje et al., 2024). Women who feel at risk for breast cancer and think that early detection practices, like screening or breast self-examination, are helpful are more likely to use them in the context of breast cancer.

The Health Belief Model is also thought to be the most appropriate, because of its close relationship to health education and awareness-raising activities. The theory focuses on the role of knowledge, perception and cues to action on behaviour. Educational programs, media campaigns, and government health interventions are cues that can stimulate women to adopt preventive practices. This is similar to your study variables that have to do with knowledge, awareness, education, and preventive behaviours.

In addition, the HBM has been widely used for studying cancer prevention and screening behaviors. The Health Belief Model has been adopted as a theoretical framework in numerous studies that have focused on breast cancer awareness, mammography screening, and preventive health behaviors among women (Aliough et al., 2023). The importance of women's perceived susceptibility to breast cancer and perceived benefits of screening has been shown by researchers like Okonkwo & Nwankwo, (2022) to affect participation in preventive health practices.

Theory of Planned Behaviour and Social Cognitive Theory are useful theories used to explain health behaviour but are more general theories of behaviour that concentrate on social influence, behavioural intentions and observational learning. Theories are helpful, but are not as directly related to disease perception and preventive health decision-making as the Health Belief Model.

Hence, the Health Belief Model is considered as the most appropriate theoretical model to be used in this study since it clearly shows the influence of knowledge, awareness and perception on women's decision to adopt breast health preventive practices. The theory also emphasizes the importance of education and health communication in the formation of preventive behaviours, making it very suitable for studies that focus on breast cancer awareness and prevention.

2.3 Research Design

The study used the survey research method, a cross sectional survey, which was used to gather the data from the respondents at one time. This technique was appropriate for conducting awareness, perception, attitude and behaviour assessment with a large population (Wimmer & Dominick, 2013; Obada et al., 2024). This was used to ensure that the data collected from the women in various wards of Epe Local Government Area was acceptable for generalisability of results. The survey was supplemented by FGDs that offered a greater understanding of socio-cultural conditions affecting the success of media campaigns not revealed by the structured questionnaire.

The study was descriptive survey in nature and employed radio stations (Radio Lagos 107.5, Women Radio 91.7 and WASH FM 94.9) as sites for the study, to examine the role of

media campaigns and behaviour change in breast cancer prevention among women of Epe Local Government Area, Lagos State. The design was suitable as it allowed for the systematic collection and analysis of data on the respondents' awareness, perceptions, attitudes and behavioural responses, that is, no variables were manipulated (Nworgu, 2015). In addition to the survey, Focus Group Discussions (FGDs) were also used to further deepen and enhance the findings in the study. Both quantitative and qualitative data were collected and given a mixed-method approach which enabled triangulation and a more complete picture of women's reactions to breast cancer prevention campaigns (Creswell & Creswell, 2018)

2.4 Population of the Study

The population consisted of all the adult women of Epe Local Government Area, Lagos State. According to the National Population Commission (NPC) census projections with an assumed annual growth rate of 3.2%, the population of Epe is estimated to be 315,000 which is approximately 157,500 women. The target population in this study were only women aged 18 years and over residing in the selected wards of the Local Government area, because they are considered the primary target audience for breast cancer prevention campaigns. The selection of Epe was based on the semi-urban and rural characteristics, which would allow the effectiveness of radio health promotion campaigns, as well as the challenges of disseminating health information to these communities to be evaluated.

2.5 Sample Size

It was neither practical nor desirable to study the entire population because the size and dispersion of the population was fairly large. The sample size was therefore calculated as per the formula given by Taro Yamane (1967) for finite population as:

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

Where: n = the desired sample size N = the population of the study (157,500) e = the level of precision/margin of error (0.05) 1 = constant

Substituting the values:

$n = 157,500 / (1 + 157,500(0.05)^2)$

$n = 157,500 / (1 + 157,500 \times 0.0025)$

$n = 157,500 / (1 + 393.75)$

$n = 157,500 / 394.75$

$n \approx 399$

From this calculation, the number of respondents for the quantitative survey portion of the study was around 399. The sample size was rounded up to 400 respondents to allow for the possibility of attrition due to incomplete responses, non-response or spoiled questionnaires.

The number of participants for each FGD session was determined as there were three (3) FGD sessions conducted, with each session having an average of 8 to 10 participants as recommended by Krueger and Casey (2015) that the FGD group should include between 6 to 12 participants for effective moderation and meaningful group interaction. This resulted in a total of twenty-seven (27) female respondents from the population of women who listen to one of the three radio stations under study who were purposively sampled.

2.6 Sampling Technique

The respondents of the quantitative survey were purposively selected using multi-stage sampling technique. The first stage involved purposive selection of three wards in Epe Local Government Area based on their different levels of access to radio broadcast signals and population density to assure representation of both urban and semi-rural areas of the Local

Government Area. In the second stage, streets and clusters of households in the selected wards were sampled systematically, i.e., every third household was selected as a sampling point. In the third stage, simple random sampling, one adult woman per selected households was selected by through balloting technique who fulfill the inclusion criteria, i.e. are aged 18 years and above and are residents in the area for at least six months.

In the qualitative part of the study, purposive sampling technique was used to choose the participants for the focus group discussions. This method was deemed suitable, as it allowed the researcher to intentionally select women who self-identified as frequent listeners of Radio Lagos 107.5, WASH FM 94.9, and Women Radio 91.7, hence that they had information and experience on the topic of study, which could yield rich, contextually appropriate information (Etikan, Musa & Alkassim, 2016).

III. Research Methods

Primary data were the main source of data used in this study. Data collection was done by administering a structured questionnaire and conducting Focus Group Discussions. The researcher and trained research assistant (TRA) visited the selected households in the sampled wards to administer the questionnaire using face-to-face approach. The face-to-face administration technique was adopted to improve the response rate, reduce the likelihood of ambiguity in the interpretation of the items in the questionnaire and to ensure that any item that the respondents found unclear could be explained on the spot, as some of the respondents in the semi-rural parts of Epe Local Government Area may have limited formal education.

Due to the sensitive nature of the subject matter, the Focus Group Discussions were held in a conducive and private environment for free expression. The FGDs were audio-recorded with the consent of the participants, and each session lasted between 45 and 60 minutes and the discussions were transcribed and analysed thematically. Discussions were led by a trained moderator, who employed a semi-structured FGD guide, and a note taker who recorded non-verbal cues and key emerging themes.

3.1 Research Instrument

Two principal research instruments were employed for data collection in this study: a structured questionnaire for the quantitative survey and a Focus Group Discussion guide for the qualitative component.

The questionnaire, titled "Media Campaigns and Behaviour Change in Breast Cancer Prevention Questionnaire (MCBCPQ)," was structured into five sections. Section A elicited respondents' demographic information (age, marital status, educational qualification, occupation, and religion). Section B addressed the level of awareness and knowledge of breast cancer prevention. Section C examined respondents' perception of media campaigns on breast cancer prevention. Section D assessed the influence of media campaigns on the adoption of preventive practices such as breast self-examination and clinical screening. Section E identified the factors limiting the effectiveness of media campaigns. Items in Sections B to E were structured on a four-point and five-point Likert-type scale, ranging from "Strongly Agree" to "Strongly Disagree," to quantify respondents' levels of agreement with the stated items.

3.2 Focus Group Discussion Guide

The FGD guide was developed in direct alignment with the specific objectives of the study, with two guiding questions formulated for each objective, as follows:

Objective i: Level of awareness and knowledge of breast cancer prevention

a. What do you know about breast cancer, its warning signs, and ways of preventing or detecting it early?
b. Where have you mostly learnt about breast cancer prevention, and how would you describe your understanding of practices such as breast self-examination and screening?
c. Objective ii: Perception of media campaigns on breast cancer prevention
d. What are your views about the breast cancer prevention messages you have heard on Radio Lagos, Women Radio, or WASH FM?
e. How credible, relevant, and trustworthy do you consider the information presented in these radio campaigns to be?
f. Objective iii: Influence of media campaigns on adoption of preventive practices
g. Has listening to breast cancer campaigns on these radio stations changed the way you practise breast self-examination or attend screening? If so, how?
h. Can you share any personal experience where a radio campaign message prompted you to take a specific preventive action?
i. Objective iv: Factors limiting the effectiveness of media campaigns
j. What challenges or barriers prevent you or other women in this community from fully benefiting from these radio campaigns?
k. What cultural, social, or economic factors do you think reduce the impact of these campaigns on women's health behaviour in Epe?

3.3 Method of Data Analysis

This quantitative survey data was analysed using descriptive and inferential statistics in the SPSS software. Demographic characteristics of respondents (Objective i) and factors influencing the effectiveness of the campaigns (Objective iv) were summarised using descriptive statistics and answered to the research questions involving the level of awareness (Objective ii) and perception (Objective iii) of respondents. Inferential statistical tools such as simple linear regression analysis was used to assess whether women's exposure to media campaigns is predictive of breast self-examination or screening behaviour for Objective iii which aimed to assess the influence of media campaign on the adoption of the indicated practices. Where appropriate, all hypotheses were tested at the α level of 0.05.

Thematic analysis was used to analyse the data collected from the Focus Group Discussions. The audio-recorded discussions were transcribed in full and then repeatedly read to familiarize oneself with the data. Inductive codes were generated from the repeated words, phrases and ideas and then the codes were sorted into themes and sub-themes in accordance with the method proposed by Braun and Clarke (2006). The qualitative findings were then used to enhance, elaborate and shed light into the survey results in the quantitative setting, thus giving a more holistic understanding of the research problem at hand.

IV. Result and Discussion

4.1 Data Presentation and Analysis (Quantitative Study)

a. Respondents' Demographic Characteristics

The demographic profile of the 391 respondents surveyed within Epe Local Government Area is presented in Tables 1 through 7. These variables include age, marital status, educational qualification, occupation, religion, length of residence, and primary media platform usage.

Table 1: Distribution of Respondents by Age (N = 391)

Age Range	Frequency	Percentage (%)
18–25 years	74	18.92
26–35 years	142	36.32
36–45 years	103	26.34
46–55 years	51	13.04
56 years and above	21	5.37
Total	**391**	**100.00**

Data in Table 1 reveals that the highest proportion of respondents falls within the childbearing and highly health-conscious bracket of 26–35 years (36.32%), followed by those aged 36–45 years (26.34%). Together, women aged 18 to 45 years constitute over 81% of the sample. This distribution signifies that the data is heavily drawn from young and middle-aged women who are within critical developmental windows for breast health awareness and preventative behavioral habituation.

Table 2: Distribution of Respondents by Marital Status (N = 391)

Marital Status	Frequency	Percentage (%)
Single	98	25.06
Married	248	63.43
Divorced	27	6.91
Widowed	18	4.60
Total	**391**	**100.00**

Table 2 shows that a substantial majority of the respondents are married (63.43%), while single women account for 25.06%. Divorced and widowed respondents make up smaller fractions (6.91% and 4.60%, respectively). The high concentration of married individuals implies that health communication strategies in this region must take into account household dynamics, spousal communication, and maternal responsibilities when designing intervention campaigns.

Table 3: Highest Educational Qualification of Respondents (N = 391)

Educational Qualification	Frequency	Percentage (%)
No formal education	33	8.44
Primary education	59	15.09
Secondary education	154	39.39
Tertiary education	121	30.95
Postgraduate education	24	6.14
Total	**391**	**100.00**

The educational distribution presented in Table 3 shows that the majority of respondents have completed secondary education (39.39%), followed by those with tertiary credentials (30.95%). Notably, 23.53% of the women have only a primary school education or no formal school history. This educational heterogeneity underlines the necessity for media

campaigns to utilize clear, non-jargonistic language to bridge comprehension gaps across diverse literacy strata.

Table 4: Distribution of Respondents by Occupation (N = 391)

Occupation	Frequency	Percentage (%)
Civil Servant	68	17.39
Trader/Businesswoman	184	47.06
Artisan	53	13.55
Student	51	13.04
Unemployed	35	8.95
Total	**391**	**100.00**

As indicated in Table 4, trading and commercial business represent the dominant occupation among women in Epe (47.06%), reflecting the socio-economic context of the sub-urban, coastal town. Civil servants comprise 17.39%, while artisans, students, and unemployed individuals represent smaller subsets. Given that nearly half of the population consists of market women and traders, media dissemination schedules must align with their daily mobility patterns and working hours.

Table 5: Religious Affiliation of Respondents (N = 391)

Religion	Frequency	Percentage (%)
Christianity	203	51.92
Islam	179	45.78
Traditional Religion	9	2.30
Total	**391**	**100.00**

Table 5 establishes that the population is highly religious and split into two primary blocks: Christianity (51.92%) and Islam (45.78%). Traditional religion accounts for a small fraction (2.30%). This balance demonstrates that health communication designs should remain culturally sensitive and potentially engage faith-based organizations to optimize community buy-in and message acceptance.

Table 6: Length of Residence in Epe LGA (N = 391)

Length of Residence	Frequency	Percentage (%)
Less than 5 years	46	11.76
5–10 years	82	20.97
11–15 years	115	29.41
16–20 years	79	20.20
Above 20 years	69	17.65
Total	**391**	**100.00**

Table 6 illustrates that 67.26% of the respondents have lived in Epe LGA for more than 10 years, showing that the sample consists heavily of long-term residents. These women possess deep institutional knowledge of local health infrastructure, communal norms, and geographic specificities, validating their feedback regarding the local impact of media interventions.

Table 7: Primary Media Platform Used Most Frequently (N = 391)

Media Platform	Frequency	Percentage (%)
Radio	164	41.94
Television	112	28.64
Newspapers/Magazines	14	3.58

Social Media	83	21.23
Internet Blogs/Websites	18	4.60
Total	**391**	**100.00**

According to Table 7, Radio remains the dominant mass medium for women in Epe LGA (41.94%), followed by Television (28.64%) and Social Media (21.23%). Print media and standalone websites represent marginal tools. The prominence of radio highlights its role as an accessible, cost-effective, and ubiquitous tool for public health intervention in sub-urban Nigerian communities.

4.2 Analysis by Research Objectives

The analysis is structured around the four distinct research objectives of the study. A 5-point Likert scale was utilized where: Strongly Agree (SA) = 5, Agree (A) = 4, Undecided (U) = 3, Disagree (D) = 2, and Strongly Disagree (SD) = 1. The cut-off criterion mean for acceptance is 3.00.

Objective 1: To assess the level of awareness and knowledge of breast cancer prevention among women in Epe Local Government Area.

Table 8: Descriptive Analysis of Awareness and Knowledge (N = 391)

S/N	Items	SA (%)	A (%)	U (%)	D (%)	SD (%)	Mean	SD
1	Aware breast cancer is a major health concern.	211 (53.97)	142 (36.32)	13 (3.32)	18 (4.60)	7 (1.79)	4.36	0.88
2	Know common symptoms and warning signs.	92 (23.53)	134 (34.27)	41 (10.49)	98 (25.06)	26 (6.65)	3.43	1.25
3	Understand importance of early detection.	187 (47.83)	151 (38.62)	22 (5.63)	23 (5.88)	8 (2.05)	4.24	0.96
4	Aware of breast self-examination (BSE).	114 (29.16)	162 (41.43)	29 (7.42)	64 (16.37)	22 (5.63)	3.72	1.21
5	Know where to obtain screening	48 (12.28)	89 (22.76)	53 (13.55)	139 (35.55)	62 (15.86)	2.80	1.29

	locally.							
6	Understand risk factors associated.	71 (18.16)	125 (31.97)	59 (15.09)	104 (26.60)	32 (8.18)	3.25	1.24
7	Received adequate info from various sources.	83 (21.23)	141 (36.06)	37 (9.46)	99 (25.32)	31 (7.93)	3.37	1.27
	Weighted Mean / Standard Deviation						**3.60**	**1.16**

The statistical summary in Table 8 demonstrates a high overall level of basic awareness, as evidenced by a weighted mean score of 3.60. Respondents strongly recognize breast cancer as a critical health threat (X = 4.36) and appreciate the structural value of early detection (X = 4.24). Knowledge of breast self-examination (BSE) as a procedural concept is also well-received (X = 3.72).

However, a critical gap emerges regarding actionable, localized knowledge. Item 5 ("Know where to obtain breast cancer screening services in my locality") fell below the baseline threshold (X = 2.80, sigma = 1.29), with over 51% of respondents explicitly disagreeing or strongly disagreeing. This indicates that while national or state-level media campaigns have successfully transmitted generalized health warnings, they often omit specific geographical direction. This leaves rural and sub-urban women aware of the disease but structurally unaware of where to access clinical care within Epe LGA. The wider standard deviation for symptoms (sigma = 1.25) and risk factors (sigma = 1.24) further underscores inconsistencies in deep-level physiological comprehension across the population.

Objective 2: To evaluate the perception of media campaigns on breast cancer prevention among women in Epe Local Government Area.

Table 9: Descriptive Analysis of Perception of Media Campaigns (N = 391)

S/N	Items	SA (%)	A (%)	U (%)	D (%)	SD (%)	Mean	SD
8	Media campaigns provide useful information.	194 (49.62)	158 (40.41)	18 (4.60)	14 (3.58)	7 (1.79)	4.33	0.85
9	Messages in the media are easy	108 (27.62)	173 (44.25)	38 (9.72)	54 (13.81)	18 (4.60)	3.76	1.12

	to understand.							
10	Campaigns increased interest in learning more.	142 (36.32)	169 (43.22)	31 (7.93)	36 (9.21)	13 (3.32)	4.00	1.04
11	Media frequently provide information on prevention.	41 (10.49)	93 (23.79)	62 (15.86)	146 (37.34)	49 (12.53)	2.82	1.19
12	Campaigns are credible and trustworthy.	119 (30.43)	184 (47.06)	43 (11.00)	31 (7.93)	14 (3.58)	3.93	1.01
13	Language and presentation appropriate for Epe.	78 (19.95)	139 (35.55)	51 (13.04)	93 (23.79)	30 (7.67)	3.36	1.24
14	Media effectively create awareness.	163 (41.69)	172 (44.00)	24 (6.14)	21 (5.37)	11 (2.81)	4.16	0.94
	Weighted Mean / Standard Deviation						**3.77**	**1.06**

Table 9 focuses on how the targeted audience perceives health broadcasts. The data shows an overall positive appreciation of media campaign features (Weighted Mean = 3.77). Respondents strongly believe that media information is highly useful (X = 4.33), that mass media effectively build public awareness (X = 4.16), and that broadcast messages are generally credible and trustworthy (X = 3.93).

The primary concern raised under this objective relates to message frequency. Item 11 ("The media frequently provide information on breast cancer prevention") shows low agreement (X = 2.82, sigma = 1.19). This points to an inconsistent broadcast schedule,

suggesting that breast cancer campaigns are often treated as seasonal events such as during Breast Cancer Awareness Month in October, rather than sustained public health interventions. This lack of continuity can limit long-term retention and behavioral reinforcement among women in Epe. Furthermore, the moderate score for cultural and linguistic appropriateness (X = 3.36, sigma = 1.24) indicates that while urbanized messaging works for some, a segment of the local population feels left out by the language or presentation styles used.

Objective 3: To determine the influence of media campaigns on the adoption of breast cancer preventive practices among women in Epe Local Government Area.

Table 10: Descriptive Analysis of Media Campaigns' Influence on Practices (N = 391)

S/N	Items	SA (%)	A (%)	U (%)	D (%)	SD	Mean	SD
15	Encouraged me to perform regular BSE.	97 (24.81)	151 (38.62)	42 (10.74)	76 (19.44)	25 (6.39)	3.56	1.21
16	Motivated me to seek clinical screening.	51 (13.04)	103 (26.34)	58 (14.83)	132 (33.76)	47 (12.02)	2.95	1.24
17	Improved preventive health behaviors.	82 (20.97)	164 (41.94)	59 (15.09)	65 (16.62)	21 (5.37)	3.56	1.14
18	Discuss media information with others.	74 (18.92)	148 (37.85)	49 (12.53)	91 (23.27)	29 (7.42)	3.38	1.24
19	Increased willingness to visit facilities.	63 (16.11)	122 (31.20)	61 (15.60)	109 (27.88)	36 (9.21)	3.17	1.23
20	Influenced decision for healthier lifestyle.	89 (22.76)	158 (40.41)	64 (16.37)	62 (15.86)	18 (4.60)	3.61	1.13
21	Positively changed attitude toward prevention.	115 (29.41)	171 (43.73)	47 (12.02)	44 (11.25)	14 (3.58)	3.84	1.06
	Weighted Mean / Standard Deviation						**3.44**	**1.18**

Table 10 measures how media exposure translates into actual behavioral outcomes. The weighted mean score (X = 3.44) shows that media campaigns have a positive influence on behavioral intentions and cognitive attitudes. They have helped change attitudinal outlooks (X = 3.84), encouraged lifestyle modifications (X = 3.61), and prompted women to conduct regular breast self-examinations (X = 3.56). However, this positive influence stops short of clinical behavior change. Item 16 ("Information from media campaigns has motivated me to seek breast cancer screening") scored below the baseline cutoff (X = 2.95, sigma = 1.24). This highlights a clear gap between intention and action: media campaigns successfully change mindsets and home-based habits (like BSE), but fail to drive women to clinical centers for

formal screenings (such as mammograms or professional clinical breast exams). This challenge is further explored in the next section, which looks at structural barriers like cost and local availability.

Objective 4: To identify the factors limiting the effectiveness of media campaigns on breast cancer prevention among women in Epe Local Government Area.

Table 11: Descriptive Analysis of Limiting Factors (N = 391)

S/N	Items	SA	A	U	D	SD	Mean	SD
22	Limited access to media channels reduces exposure.	61 (15.60)	114 (29.16)	52 (13.30)	128 (32.74)	36 (9.21)	3.09	1.24
23	Low frequency of messages affects effectiveness.	124 (31.71)	179 (45.78)	39 (9.97)	38 (9.72)	11 (2.81)	3.94	1.02
24	Language barriers make messages hard to understand.	79 (20.20)	131 (33.50)	48 (12.28)	104 (26.60)	29 (7.42)	3.32	1.25
25	Cultural beliefs and traditions reduce effectiveness.	94 (24.04)	148 (37.85)	56 (14.32)	71 (18.16)	22 (5.63)	3.56	1.19
26	Lack of trust in media information discourages action.	32 (8.18)	64 (16.37)	58 (14.83)	179 (45.78)	58 (14.83)	2.47	1.16

27	Economic constraints prevent adopting measures.	182 (46.55)	146 (37.34)	27 (6.91)	24 (6.14)	12 (3.07)	4.18	0.99
28	Inadequate community-based follow-up activities.	149 (38.11)	168 (42.97)	41 (10.49)	23 (5.88)	10 (2.56)	4.08	0.94
	Weighted Mean / Standard Deviation						**3.52**	**1.11**

Table 11 highlights the structural, cultural, and financial bottlenecks that limit campaign effectiveness, with a high overall weighted agreement mean of 3.52. Financial barriers stand out as the most severe constraint (X = 4.18, sigma = 0.99), with 83.89% of respondents agreeing that economic limitations prevent them from getting screened, even when media campaigns convince them to do so. The second major barrier is the lack of local community follow-up (X = 4.08), indicating that media messages feel disconnected from local health support networks.

Low broadcast frequency also ranks high as a limiting factor (X = 3.94), confirming the issues noted in Objective 2. Cultural beliefs, traditional norms, and modest language barriers also play a role (X = 3.56 and X = 3.32). Conversely, a lack of trust in the media was rejected as a barrier (X = 2.47), showing that the problem is not a lack of credibility, but rather structural issues like cost, irregular broadcasting, and a lack of local medical support.

4.3 Inferential Hypotheses Testing

To further evaluate the relationships between the study's variables, two hypotheses were tested using Chi-Square (chi^2) analysis and Pearson Product-Moment Correlation (r) at a alpha = 0.05 significance level.

Hypothesis One

a. **H_0:** There is no significant relationship between women's primary media platform usage and their level of awareness of breast cancer prevention in Epe LGA.
b. **H_1:** There is a significant relationship between women's primary media platform usage and their level of awareness of breast cancer prevention in Epe LGA.

A Chi-Square test of independence was conducted cross-tabulating primary media platforms (Radio, TV, Social Media, etc.) against overall awareness levels (categorized as High, Moderate, or Low based on aggregated objective scores).

Table 12: Chi-Square Test for Media Platform and Awareness Levels

Metric	Value	Df	Asymp. Sig. (2-sided)	Decision
Pearson Chi-Square (chi^2)	34.61	8	0.000	Reject H_0
N of Valid Cases	391			

As detailed in Table 12, the Pearson Chi-Square calculation yielded a value of 34.61 with 8 degrees of freedom, resulting in a p-value of 0.000, which is well below the significance threshold (alpha = 0.05). Consequently, the null hypothesis (H_0) is rejected. This proves that a statistically significant relationship exists between the media channels women access and their level of breast cancer awareness. Women who regularly listen to radio and watch television showed more consistent, generalized awareness than those relying on sporadic digital media platforms.

Hypothesis Two

a. **H_0:** Media campaign perception has no significant influence on the adoption of breast cancer preventive practices among women in Epe LGA.
b. **H_1:** Media campaign perception has a significant influence on the adoption of breast cancer preventive practices among women in Epe LGA.

To evaluate this relationship, summated scores for Objective 2 (Perception of Media Campaigns) and Objective 3 (Adoption of Preventive Practices) were analyzed using Pearson's r correlation.

Table 13: Correlation Between Campaign Perception and Practice Adoption

Variable	Pearson Correlation (r)	Significance (p-value)	N	Decision
Campaign Perception times Practice Adoption	0.542	0.000	391	Reject H_0

The correlation matrix in Table 13 indicates a moderate, positive correlation between how women perceive these campaigns and their actual adoption of health practices ($r = 0.542$, $p < 0.001$). Because $p = 0.000 < 0.05$, the null hypothesis is rejected. This demonstrates that as the perception of media campaigns improves meaning messages become clearer, more credible, and more engaging the adoption of preventive health practices increases. However, the moderate nature of the correlation (0.542) also suggests that other factors, such as cost and lack of screening centers, continue to limit full behavior change.

4.4 Qualitative Analysis

To gain deeper insights, qualitative data was collected from 25 participants across three Focus Group Discussions (FGDs) held in Epe LGA. The thematic analysis below organizes their feedback into major themes and subthemes based on the research objectives.

Theme 1: Localized Awareness and Knowledge Profiles

Participants across all groups displayed a broad awareness of breast cancer, frequently describing it as a dangerous and life-threatening condition. However, clear gaps emerged regarding specific symptoms beyond detecting a physical lump.

Participant 4 noted: *"We hear about breast cancer all the time on the news, and everyone knows it is a deadly disease that kills women. But if you ask me how it starts besides finding a hard lump, I really cannot tell you. Do our breasts change color? Does it pain at the beginning? We don't really know."*

This observation matches the quantitative survey results, where general awareness scored high but specific knowledge of symptoms showed wider variation. The focus group discussions highlight that while fear and basic awareness are widespread, detailed biological understanding remains low.

A major issue raised in the discussions was the lack of clear information on where to find screening services within Epe Local Government Area.

Participant 12 shared her frustration: *"They tell us on the radio to go for scanning and mammogram testing, but where should we go in Epe? If I walk into the small health post near my house, the nurses will just look at me and say they don't have such machines. Must we always travel down to Ikeja or Lagos Island just to check our breasts?"*

This highlights a critical breakdown in regional health communication. Mass media campaigns broadcasted across Lagos State often promote clinical screenings without providing localized information for suburban areas like Epe, leaving women informed about the need but unable to act.

Theme 2: Audience Reception and Evaluation of Radio Campaigns

Participants expressed high trust in regional radio stations, particularly Radio Lagos, Women Radio, and WASH FM. These platforms are valued as reliable sources of health information.

Participant 7 explained: *"When I hear health advice on Radio Lagos, I believe it completely. It is not like social media where anyone can write whatever lies they want. The doctors they bring on air are real experts, and listening to them in our own language gives us confidence that the information is true."*

This high level of trust aligns with the quantitative data, where media credibility scored high ($X = 3.93$). It confirms that local radio remains an effective and well-received tool for public health outreach in these communities.

Despite high trust, participants noted that these health campaigns are often irregular and seasonal, rather than consistent.

Participant 20 stated: *"The main issue is that these campaigns are not consistent. They only blast these messages continuously in October during that their 'Pink Month.' Once November comes, everything goes quiet, as if breast cancer goes on holiday. If we don't hear these messages regularly, people easily forget and slide back into old habits."*

This feedback mirrors the low score for message frequency in the quantitative survey ($X = 2.82$). It shows that seasonal health communication limits long-term behavioral change, as the lack of continuous messaging reduces long-term habit formation.

Theme 3: Behavioral Outcomes and Intention-Practice Gaps

Radio campaigns have been highly effective in teaching and motivating women to perform home-based breast self-examinations (BSE).

Participant 2 recalled: *"It was a program on Women Radio that actually taught me how to check my breasts properly. The presenter explained it step-by-step: that I should stand in front of the mirror, lift my hand, and use my fingers to press around in a circle. Now, every month after my period, I do it faithfully in my bedroom."*

This demonstrates that media campaigns can successfully drive behavioral changes that do not require external financial or physical resources.

While home-based practices have increased, clinical behavior change remains low due to cost and structural barriers.

Participant 15 explained: *"The radio message can convince you to get a clinical exam, but your wallet will tell you otherwise. By the time you think about the transport fare from Epe to a major hospital and the high cost of the mammogram test itself, you realize that money is better spent feeding your children. The motivation is there, but the money is not."*

This highlights the gap between health awareness and actual practice. It shows that media campaigns cannot change clinical behaviors on their own if the underlying economic and structural barriers are not addressed.

Theme 4: Socio-Cultural and Structural Bottlenecks

Socio-cultural challenges, such as language barriers and modesty taboos, continue to limit the effectiveness of health campaigns.

Participant 9 noted: *"Sometimes the language they use is too sophisticated. When they start using heavy English medical terms, market women lose interest. Also, in our culture, discussing the breasts openly is seen as sensitive or inappropriate. Some women feel too shy to talk about it or even go to a clinic where a male doctor might examine them."*

This underscores the need for campaigns to be culturally sensitive and delivered in clear local dialects to overcome traditional taboos and communication gaps.
Participants emphasized that media campaigns need to be paired with local community outreach to be truly effective.

Participant 23 suggested: *"The radio is good, but it cannot do it alone. We need health workers to follow up in our local markets, mosques, and churches. If the radio speaks and community leaders also speak, while bringing mobile screening vans to Epe at subsidized rates, then you will see every woman coming out to participate."*

This suggestion aligns with the survey's call for more community-based follow-up, showing that mass media campaigns are most effective when integrated with local, face-to-face health initiatives.

Integration of Quantitative and Qualitative Findings

A comparison of the quantitative and qualitative data shows strong alignment and complementary insights, demonstrating effective triangulation across both methods.

Table 14: Triangulation Matrix of Mixed-Methods Findings

Research Focus	**Quantitative Survey Findings (N=391)**	**Qualitative FGD Insights (N=25)**	**Alignment Assessment**
Awareness Levels	High basic awareness (X=4.36); poor knowledge of local resources (X=2.80).	Broad recognition of risks, but major confusion over where to find screening in Epe.	**Supports and Expands:** Qualitative data explains that high awareness is limited by a lack of local information.

Media Perceptions	High trust in media credibility (X=3.93); low message frequency (X=2.82).	Strong trust in regional radio stations, but criticism of seasonal ("Pink Month") scheduling.	**Supports:** Both methods highlight that inconsistent broadcasting limits campaign impact.
Behavioral Change	High adoption of home practices like BSE (X=3.56); low clinical screening (X=2.95).	Regular execution of home BSEs, but complete avoidance of clinical screening due to cost.	**Supports and Explains:** Qualitative feedback highlights that financial barriers limit clinical action.
Limiting Factors	Financial constraints (X=4.18) and lack of local follow-up (X=4.08) ranked highest.	Cost of care and lack of local screening vans identified as key structural barriers.	**Supports:** Confirms that structural and economic issues are the primary barriers to behavior change.

The focus group discussions help explain the quantitative findings. For example, while the survey showed a low score for clinical screening motivation (X = 2.95), the qualitative interviews clarify that this is not due to apathy, but rather the high cost of procedures and the lack of diagnostic facilities within Epe LGA. Similarly, the qualitative descriptions of seasonal broadcasting explain why respondents in the quantitative survey reported low message frequency. This integration highlights that mass media campaigns are effective at building awareness, but require structural economic support and localized health services to achieve full behavioral change.

V. Conclusion

Based on these findings, this study concludes that mass media campaigns in Lagos State are effective at building basic health awareness and encouraging simple, resource-free habits like home self-examinations. However, they face significant limitations when it comes to driving clinical behavior change. There is a clear gap between health awareness and practical action among women in Epe LGA. While media broadcasts successfully inform women about the dangers of breast cancer, they rarely provide localized information on where to seek help, and they cannot resolve the underlying financial and structural barriers to clinical care. The core public health challenge in Epe LGA is not audience apathy or a lack of trust in media messages, but rather a lack of localized health infrastructure and affordable services. When health campaigns operate without regular broadcast schedules, local details, or financial subsidies, they create an informed but underserved population. To achieve lasting behavior change, mass media campaigns must transition from seasonal awareness models to continuous, localized communication strategies that are integrated with affordable, accessible clinical services within the community.

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