

**CERVICAL CANCER SCREENING PRACTICE AND ASSOCIATED FACTORS, AMONG
WOMEN OF REPRODUCTIVE AGE IN BUTAJIRA TOWN, CENTRAL ETHIOPIA.**



BY- Mr. MELKAMU TADESSE ZEWDE (BSc)

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ABSTACT

Background

Cervical cancer is the second most common and the leading causes of morbidity and mortality among female cancers. Globally a marked increase has been predicted, especially in developing countries with a 58% cases and 63% deaths to 2025. Despite this fact, very few women have received screening services in Ethiopia. Ethiopia has a strategic goal to reduce cancer incidence and mortality by 15% by 2020 of which cervical cancer is the priority.

Objective

This study aimed to identify cervical cancer screening practice and its associated factor among women of reproductive age in Butajira, central Ethiopia, 2018.

Methods and materials

A community based cross-section study was conducted on 611(quantitative) and 20(qualitative) among eligible women of reproductive age in Butajira town, from March 20 – April 19, 2018GC. A multi stage sampling technique was used. Structured and semi structured Amharic questionnaire and indepth interview were used. Data cleaned and entered with epidata 3.1 and analysed by SPSS version 20. Descriptive statistics was used to describe the results and bivariate and multivariate logistic regression has done to identify associated factors for cervical cancer screening practice.

Result

Six hundred eleven women of reproductive age groups participated for quantitative study and 20 for in-depth interview, with the response rate of 98.7%. Thirty nine (6.4%) of participants were screened for cervical cancer in the study area before the study. Among participants, 345 (56.5%) and 295(48.3%) were heard of cervical cancer and screening respectively. Hundred sixty three (26.7%) of participants were found to be knowledgeable about cervical cancer and screening [AOR: 11.437, 95% CI (3.255, 40.187), $P < 0.000$]. Among those, who heard about cervical cancer, 163 (47.2%) had good perceived barriers [AOR: 4.057, 95% CI (1.606, 10.248), $P < 0.003$]. Hundred and ninty one (31.2%) participants heard about cervical cancer through media [AOR: 4.871, 95% CI (1.887, 12.574), $P < 0.001$]. Only 92(15.1%) have gotten health education about cervical cancer and screening [AOR: 4.440, 95% CI, (1.763, 11.586) $P < 0.002$].

Conclusion and Recommendations

Cervical cancer screening uptake among females of reproductive age in Butajira town was insufficient. Knowledge, perceived barriers, media heard and health education on cervical cancer and screening were an important predictors of cervical cancer screening uptake. Strong attention should be given on better awareness creation and attitudinal change by health education through different means of communications.

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TABLE OF CONTENT

ABSTRACT	I
ACKNOWLEDGEMENT	II
LIST OF TABLES	V
LIST OF FIGURES	VI
ABBREVIATION	VII
CHAPTER ONE; INTRODUCTION.....	1
1.1 Background	1
1.2 Statement of the problem.....	3
CHAPTER TWO; LITRETURE REVIEW	4
2.1 Socio-demographic and prevalence of cervical cancer.....	4
2.2 Overview of cervical cancer screening service utilization.....	5
2.3 Factors affecting utilization of cervical cancer screening service	6
2.3.1 Individual factors on cervical cancer & screening.....	6
2.3.2 Community factors for cervical cancer and screening.....	8
2.3.3 Organizational factors for cervical cancer and screening.....	9
CONCEPTUAL FRAMEWORK.....	10
SIGNIFICANCE OF THE STUDY	11
CHAPTER THREE: OBJECTIVE	12
3.1 General objective	12
3.2 Specific objective.....	12
CHAPTER FOUR: METHOD AND MATERIALS	13
4.1 Study area and period	13
4.2 Study design	13
4.3 Population	13
4.3.1 Source population	13
4.3.2 Study population.....	13
4.3.3 Inclusion and exclusion criteria.....	13
4.3.4 Sampling units.....	13
4.3.5 Study unit	13
4.4 Sample size determination	14
4.4.1 Sample size for quantitative part	14
4.4.2. Sample size for qualitative part.....	14

4.5 Sampling techniques	15
4.6 Study variables	16
4.6.1 Dependent variables	16
4.6.2 Independent variables	16
4.7 Operational definitions	17
4.8 Data collection procedure	18
4.8.1 Data collection instruments	18
4.8.2. Data collection methods	18
4.9 Data quality assurance	18
4.10 Data entry and analysis plan	19
4.11 Ethical considerations	19
4.12 Dissemination plan	19
CHAPTER FIVE: RESULT	20
5.1 Socio-demographic characteristics	20
5.2 Current status of cervical cancer screening	21
5.3 Individual factors	22
5.3.1 Knowledge on cervical cancer and screening	22
5.3.2 Attitude on cervical cancer and screening	23
5.3.3. Individual related factors	24
5.4 Community factors for cervical cancer and screening	25
5.5 Health organization factors for cervical cancer and screening	26
CHAPTER SIX DISCUSSION	30
CHAPTER SEVEN: CONCLUSION AND RECOMMENDATION	33
REFERENCES	34
ANNEX I Quantitative questionnaire (English version)	38
ANNEX II Quantitative questionnaire (Amharic version)	47
ANNEX-III Qualitative questionnaire (English version)	56
ANNEX-V Qualitative questionnaire (Amharic version)	58

LIST OF TABLES

Table 1. Sample size determination using single population proportion formula based on selecting of different relatively similar study areas proportion on specific variables and taking of the maximum sample size	13
Table 2. Socio-demographic characteristics of females of reproductive age, Butajira, Ethiopia, 2018.....	20
Table 3. Reason for not utilized cervical cancer screening among women of reproductive age in Butajira, 2018	21
Table 4. Health organization associated factors for cervical cancer and screening among females of reproductive age, Butajira, Ethiopia, 2018	26
Table 5. Bivariate and Multi-variable logistic regression analysis of factors associated with cervical cancer screening service uptake among females of reproductive age group, Butajira, Ethiopia, 2018.....	27

LIST OF FIGURES

Figure 1. Conceptual frame work adapted and developed based on relevant literatures to show how socio-demography, individual, community and organization variables affect cervical cancer screening practice among reproductive age groups in Butajira, 2018.....	10
Figure 2. Schematic presentation of sampling procedure for quantitative, systematic and simple random sampling techniques with proportional allocation to the select eligible reproductive age groups, Butajira Town, 2018.....	15
Figure 3. Reason for cervical cancer screening service uptake among women of reproductive age in Butajira town, 2018.....	21
Figure 4. Knowledge status on cervical cancer and screening among women of reproductive age in Butajira town, 2018.....	22
Figure 5. Poor attitude towards cervical cancer and screening for those who were heard about the disease, among females of reproductive age groups, Butajira, Ethiopia, 2018.....	23
Figure 6. Individual risk factors for cervical cancer and driving for screening among females of reproductive age, Butajira, Ethiopia, 2018.....	24
Figure 7. Community associated factors for cervical cancer and screening among females of reproductive age, Butajira, Ethiopia, 2018.....	25

ABBREVIARION

AIDS	Acquired Immuno- Deficiency Syndrome
DNA	Di-nucleic Acid
FMOH.....	Federal Ministry of Health
FP	Family planing
HBM	Health Belief Model
HH	House Hold
HIV	Human immune deficiency virus
HPV	Human Papilloma Virus
ICC	Invasive Cervical Cancer
IUCD	Intra uterine contraceptive device
LMICs	Low and Middle Income Countrie
Pap	Paparicolaou
PSI	Population Service International
SNNPR	Southern Nation and Nationality people regional state
SSA	Sub- Saharan Africa
STI	Sexual transmitted infection
VIA	Visual inspection with acetic acid
VILI	Visual inspection with Lugol's Iodine
WHO	World Health Organization

CHAPTER ONE; INTRODUCTION

1.1 Background

Cervical cancer is one of the reproductive organ cancer, mostly caused by human papillomavirus/HPV (subtypes 16 and 18) through sexual contact(1).Which occur on the cervix, where squamous and glandular cells meet (called the transformation zone) (1). A minority of HPV infections persist and may lead to cervical cancer 10 to 20 years later, if not detected and treated early(2).

The disease affect all adult females but commonly affects women with ages of 30 to 55 and the only gynecologic cancer that can be prevented by regular screening and preventive vaccination (3). Cervical cancer has four stages .**Stage I:** found only in the cervix. **Stage II:** spread from the cervix to the upper part of the vagina or the tissue around the uterus.but not spread to the pelvic wall, **Stage III:** spread to the lower part of the vagina or to the pelvic wall and lymph nodes in the pelvis and **Stage IV:** spread to other body parts within or outside of the pelvis.(3)

Cervical cancer is the second most common female cancer worldwide (4–7) In 2012 over 528,000 cases and 266,000 deaths of women by cervical cancer (more than 85% in developing countries) (8–10). Which accounted 7.5% of all female cancer death worldwide(8). Nearly 85% (445,000 cases and 230,000 deaths) of cervical cancer were in less developed nations(10). Alarminglly increasing in cervical cancer morbidity and mortality lead to heavy economic and social burden.(11,12). A marked increase has been predicted especially in developing countries with a 58% cases and 63% deaths projected to 2025(13).

The majority (above 80%) of cervical cancers cases and deaths were in Africa(mainly sub-Saharan Africa) predominantly due to lack of information and accessible service(14). In 2010, in sub-Saharan Africa, over 70,722 new cases of invasive cervical cancer (ICC) by HPV and it was responsible for a quarter of all female cancers(15). HPV (type16 &18) were the main causes of cervical cancer, which accounted 69.2% (ranges from 43.7% in Senegal to 90.2% in Ethiopia).(15) In Ethiopia, nearly 22 million Ethiopian women over the age of 15, approximately 7,600 are diagnosed with cervical cancer and roughly 6,000 women die of the disease each year(16). The incidence and mortality from cervical cancer in Ethiopia is 26.4 and 18.4/100,000 respectively (16). Which was constituted 25.8% to 32% of all female malignancies (17).

Cervical cancer is preventable disease through different safe screening modalities; Cytology: conventional (Pap smear), HPV DNA, Visual inspection: with acetic acid (VIA) and Lugol's

iodine (VILI) (14,18–21). **In cytology: Conventional Pap smear** and Liquid-based cytology (LBC) tests-cells are scraped from the squamo-columnar junction of the cervix and fixed on a glass slide for reading by a trained cytologist, **HPV DNA test**, taking of sample from the cervix/vagina using a swab or small brush, and placed in a small container with a preservative solution (sophisticated and expensive) and **Visual inspection: with acetic acid (VIA) or Lugol's iodine (VILI)** screening tests are much easier and fast which is performing of high concentration of intracellular proteins leads to a dense aceto-whitening effect (14,18–23)

Doing regular screening can prevent the disease by around half (45 %) in age of 30s and three quarter (75 %) cases in 50s and 60s(24). Screening service was insufficient and inequalities all over the world; in 2014 globally cervical cancer screening practice had been 1% in Bangladesh to 73% in Brazil(22) and 30% to 79% in Europe (25). Where as in developing countries less than 19% (2.0% - 20.2% in urban areas and 0.4% - 11.7% in rural areas) (18,22).

In Ethiopia over all screening uptake was 1.6% of urban and 0.4% of rural areas(14). Ethiopia has put a strategic goal to reduce cancer incidence and mortality by 15% by 2020, since cervical cancer was considered priority cancer for intervention(14). Cervical screening with VIA combined with access to cryotherapy was piloted in Ethiopia by the FMOH in collaboration with Pathfinder started from 2009 as a single-visit approach to cervical cancer prevention(14). Cervical cancer screening and control programme comprises an organized set of activities as part of the Global action plan for the prevention and control of NCDs 2013–2020 W (2,26).

The main problems for effective cervical cancer screening services uptake in low and middle income countries are due to; individual, community and health systems(organization) related factors; Low level of knowledge, attitude, community concern, lack of screening access, competing health priorities and absence of a well-organized national screening program(27). Some of the disparity in screening practice between the developing and developed world is due to low level of awareness, technology, lack or poorly organized national cytological screening services program strategies in most developing countries (14,28,29). Cultural based problems, competing health priorities and absence of a well-organized national screening and surveillance (26,30,31). The aim of this study is to determine the status of screening practice and associated factors for cervical cancer screening on female of reproductive age groups in Butajira town.

1.2 Statement of the problem

Cervical cancer is becoming a common disease among women in 45 countries of the world, and it kills more women than any other form of cancer in 55 countries, especially in sub-Saharan Africa (2).

Cervical cancer prevalence is becoming increase all over the world; In China(2015) 98,900 new cases and 30,500 deaths(4), in Brazil(2012), incidence rate was 17.49 per 100,000.(32). Prevalence of HPV infection of cervical cancer in North America 5%, Latin America and Caribbean's 16%, Europe14%, Africa 21% and Asia 19% (33).

In Africa, over 70,722 new cases of invasive cervical cancer (ICC) which caused by HPV (type16 &18) in 2010(15). The survival rate for invasive cervical cancer was 21% in sub-Saharan Africa(30). In Ethiopia, nearly 22 million women over the age of 15 are at risk of cervical cancer, among those, nearly 7,600 cases 6,000 deaths of cervical cancer in each year(16). Which constituted 25.8% to 32% of all female malignancies (17). In “Tikur Anbesa specialized Hospital”, Addis Ababa there were 16,622 new cases of cancer diagnosed between 1997 and 2012 and out of those 5293 (31.8%) were cervical cancer patients with prevalence of; Addis Ababa, Oromia, and Amhara 32.98%, 30.11% & 19.72% respectively(29).

Screening is the best means of reducing the burden of cervical cancer worldwide, especially in developing countries, but its uptake still abysmal(28). In 2015, among eligible women in developing countries less than 19% were undergone screening (22). In most low and middle income countries (LMIC), less than 5% of eligible women undergo screening (14). Nearly 60% of the women diagnosed with ICC have never had cervical cytology test screened (30).

In Sub- Saharan Africa cervical cancer screening was at best 20.2% of urban and 14.0% of rural areas of Congo and at lowest, 1.6% of urban and 0.4% of rural areas in Ethiopia(14). Ethiopia has put a strategic goal to reduce cancer incidence and mortality by 15% by 2020, since cervical cancer was considered priority for intervention (14).

The reasons for low cervical cancer screening services uptake in developing countries are due to; individual, community and health systems (organization) related factors; Low level of awareness, poor attitude and insufficient screening services(27), sporadic and poorly coordinated as well as urban-based services(28), competing health priorities, the absence of a well-organized screening and surveillance systems(2,26,30,31), fear of procedure cost (34), lack of commitment (35), cultural and religious beliefs (36). Even if the above stated factors were common in Africa, have variable features and difference among the nations.

CHAPTER TWO; LITRETURE REVIEW

Cervical cancer is a major public health problem worldwide, especially in the developing countries(2). The disease can affects all adult female but more on women of reproductive age due to sexual contact leading to HPV infection(3). WHO recommends that all women(especially between the ages of 30 and 50 years) should be screened for cervical cancer at least once in every three years(12). Doing regular screening (no more than once every three to five years) can prevent the disease by around 45% of the cases in age of 30s and 75 % cases in 50s and 60s (24). Barriers for effective cervical cancer screening services uptake in low and middle income countries are due to; individual, community and health systems (organization) related factors. (27).

In most developing countries cervical cancer screening practice were relatively much better than developing nations fore example;73% in Brazil)(22) and 30% to 79% in Europe (25). Where as in developing countries less than 19% (2.0% - 20.2% in urban areas and 0.4% - 11.7% in rural areas) (18,22). This study aimed at to identify indivial factors (knowledge, attitude, risk and other related factors), community associated factors (information about cervical cancer and screening through Medias, literatures, families, friends and social institutions) and health organization associated factors (health education on cervical cancer and screening, availability and accessibility of screening service and advocacy on screening services)

2.1 Socio-demographic and prevalence of cervical cancer

Cervical cancer is highly associated with active age, low economic, education, early marriage and early age sexual contact and multy parity, so such group need more attenstion for screening(23). Cervical cancer is the second most common cause of female cancer globally with an approximated 528,000 new cases and 266,000 female deaths in 2012 (9). Nearly 85%(445,000 cases and 230,000 deaths were in less developed nations)(10). In 2010, in sub-Saharan Africa, over 70,722 new cases of invasive cervical cancer (ICC) by HPV(15). Approximately 7,600 are diagnosed with cervical cancer and roughly 6,000 women die of the disease each year(16).

Cervical cancer becoming public health concern globaly with variability among continents, in some of developed nations in China, cervical cancer was the seventh most common cancer among female, accounting for 3.3% of all new cancer cases in 2015 (8), age standardized incidence of cervical cancer in South Asia 22, Bangladesh 19.2, in Sri Lanka13, in Iran 2.8 and the highest number of cases were from India, 122,844 cases and 67,477 death(18).

Cervical cancer is becoming one of public health concern in Ethiopia. In “Tikur Anbesa specialized Hospital”, Addis Ababa, Ethiopia there were 16,622 new cases of cancer diagnosed between 1997 and 2012 and out of those 5293 (31.8%) were cervical cancer patients with prevalence of; Addis Ababa, Oromia, and Amhara 32.98%, 30.11% & 19.72% respectively(29). The variation in the incidence and prevalence of cervical cancer were; Low level of awareness, attitude, community concern and insufficient screening services(27).

2.2 Overview of cervical cancer screening service utilization

Cervical cancer is potentially preventable disease through effective and safe screening modalities; Cytology: conventional (Pap smear), HPV DNA test and Visual inspection: with acetic acid (VIA) or Lugol’s iodine (VILI) (14,18–20). Doing regular screening (no more than once every three to five years) can prevent the disease by around 45% of the cases in age of 30s and 75 % cases in 50s and 60s(24,37). Globally cervical cancer screened coverage had been ranges from 1% in Bangladesh to 73% in Brazil(22), in Europe from 30% to 79% (25). In developing world estimated that 60% of the women who were diagnosed with ICC have never had cervical cytology testing or screened within the (30).

Screening utilization in developed countries were relatively better for example; in Iran 27.1 (38), in chain, 63.7% (12), in Johannesburg/South Africa 34.0%(39). In most developing countries screening utilization were insufficient; less than 19% had screening test(18,22) where as in less developed countries (2.0% - 20.2% in urban and 0.4% - 11.7% in rural areas) undergone screening test(2,14,15,18). In most sub-Saharan countries, screening programmes have been as research or pilot projects(15) and screening coverage had been at best 20.2% of urban and 14.0% of rural areas in the Congo, and lowest, 1.6% of urban and 0.4% of rural areas in Ethiopia(14). Studies on screening uptake in different parts of Ethiopia ; in Mekele 19.8% of (16). In Addis Ababa(Black lion), 3.0%.(6), In Arba Minch, 5.9%(40), In Hossana, 9.9%(13) and mizan Tepi,14.8% (5).

Cervical cancer screening with VIA combined with access to cryotherapy was piloted in Ethiopia by the FMOH in collaboration with Pathfinder started from 2009 as a single-visit approach but still less than 5% of eligible women undergo cytology-based screening (14). Ethiopia has put a strategic goal to reduce cancer incidence and mortality by 15% by 2020 and cervical cancer was considered priority for intervention(14). The possible variation in screening up take among the nations were due to; Economical, technological, facilities, accessibility of the service and lack of standard policy and low level of community awareness, attitude and motives(15,22).

2.3 Factors affecting utilization of cervical cancer screening service

The main barriers to scale-up of cervical cytology-based screening programs falling in to four inter-related factors: **the insidious nature of the disease, individual level factors, community level factors, and institutional factors**(14,17,27). Low supplies, nonexistence of a national screening system, low access of impoverished population to health care contribute to inefficient testing, late diagnosis in most Africa countries(41). Absence of a well-organized surveillance and recall system is a major obstacle to effective implementation(2,14,24).

2.3.1 Individual factors on cervical cancer & screening

2.3.1.1 Knowledge on risk factors on cervical cancer and screening

Most peoples even health care workers may not have a clear understanding of HPV infection and its relationship to cervical cancer development and prevention,so!,This situation is exacerbated by the “nature” of cervical cancer delay in symptoms until reach to at an advanced stage.(14). Awareness level of the community highly related with the over all screening service uptake and better motivation to wards to cervical cancer cytologic based tests (42). Such condition highly hinder the screening services utilization as early as possible.(14)

A study conducted, in the city of Floriano, Brazil showed that, 94.5% of women had heard of the cervical cancer and screening test.(32). A study in China showed that, 51.9% found to be knowledgeable; 57.8%, 41.5% heard about cervical cancer and screening respectively(12). Studies conducted in South Africa and Uganda indicated that 61%(39) and 62.2% heard of cervical cancer respectively.(43). A study in Democratic Republic of Congo(DRC) showed that 19.3 % and 17.6% know risk factor and preventive measures for cervical cancer respectively(11).

A study conducted in Addis Ababa showed that 34.2% know about cervical cancer and 31.4% know about screening, but only 25.1% found to be knowledgeable(24). A Study in Mekele evidenced that 38.1%,35.6% and 26.6% know cervical cancer risk factors; early age sexual contact, Human papuloma virus(HPV) and multiple sexual contact respectively(44). A study in Dessie 57.7% heard of cervical cancer, 55.0% heard of cervical cancer screening and 51.0% had sufficient knowledge about cervical cancer(41). A study in Arba Minch,southern Ethiopia, 36.4% and 34.8% heard of cervical cancer and screening respectively and 34.2% had good knowledge about the disease and screening too(45). The reasons for insufficient awareness about cervical cancer and screening belongs to personal, community and institutional factors.(46)

2.3.1.2 Attitude & behavior towards Cervical Cancer and Screening

Low understanding on severity and being as risky group for cervical cancer, fears and imagine that of complicate procedure to seeking services, misperceptions, community and interpersonal barriers are the possible attitudinal problems that end up low access of cervical cancer screening services (22). Studies in rural China 96.0% (12), in Nepal,27.3% have good attitude towards cervical cancer and screening.(21), in Kinshasa,/DRC 80% (11) and in Uganda 80% of the females have positive attitude about cervical cancer and screening test (35).

Studies conducted in different parts of Ethiopia; in Arba minch, 53.8%; 41.4% and 30.3% have good attitude, positive perceived suceptability and severity towards cervical cancer screening respectively(40), in Mizan Tepi, 61.24% had positive attitude and 49.28% had good perceived susceptibility towards screening (5) and in Hossana, 43.6% believed that all women are at risk of getting cervical cancer(13).

The possible reasons for poor attitude toward cervical cacer and screening were low level of awareness, less attension and absence of early manifestation of the disease.(14,42), Unknowing of the procedure and fear of procedure cost (34), lack of commitment (35), cultural and religious beliefs (36). Few communities belived that screening cannot cure cervical cancer, since the disease is due to the devil, as a punishment for violating normal sexual behaviors.(17)

2.3.1.3 Risk and related factors to cervical cancer and screening

Some of the risk factors that highly associated with cervical cancer; Human papilloma Virus/HPV and chlamydial infection of SIT, weaked immunity by HIV/AIDS, multiple sexual partner, smoking, alcoholism and family history of cervical cancer have a higher chances of developing the disease but IUCD - had a lower risk of cervical cancer (23). Taking oral contraceptives for a long time increases the risk of cervical cancer and women who smoke are about twice as likely as non-smokers to get cervical cancer(47).HIV positive females ten times more risk for cervical cancer than their counterparts(1,30). Risky groups need more attention for cervical screening.(2)

STI of HPV (sub type 16,18) is the main cause of cervical cancer and mainly affected young age groups with early age sex(19,48). A Study in India concluded that HPV(subtype 16 and 18) related cervical cancer prevalence has varied from 87.8% to 96.67%(18). A study in Zimbabwean on developing countries, almost 85% global burden of cervical cancer were mainly by HPV with the low acesses of effective screening measure(49). HPV (type16 &18) were the main causes of

cervical cancer, which accounted 69.2% (ranges from 43.7% in Senegal to 90.2% in Ethiopia)(50). Highly risky groups deserve better screening accesses than others(1,2,14).

Religious beliefs including gender norms that vagina area which is a “sacred” area and should not be seen or touched by any other person (36), in Johannisburg, South Africa showed that 29.0% eligible women have tested for HIV/AIDS.(39) and in Addis Ababa, Ethiopia, 29.3% did not know that it is one of STI caused by HPV(51).

2.3.2 Community factors for cervical cancer and screening

Community mobilization and health education are essential components of an effective cervical cancer prevention and control programme to ensure high screening coverage (2). Whenever possible, cervical cancer education (including information on HPV vaccination and screening) should be given through radio, television, print media, colleagues, families and other means to convey messages to a larger and more dispersed when women arrive at a health-care facility for any service, in schools and social organizationse(2,14).

Studies conducted in Brasil, 36.3% heard about cervical cancer from media and literatures while 19.5% from friends/ relatives t(32),in India,39.7% and 19.9% heard about cervical cancer and screening respectively(52) and in Nepal, 18.1%, 7.6% and 1.9% heard/read about cervical cancer and screening from friends/relatives, media and books and news papers respectively(53).

Studies in Malawi and FMOH guideline low uptake cervical cancer screening services in low and middle income countries are due to; lack of familiarity with screenig among communities, geographic and economic inaccessibility to the service(14,27). Studies in Kinshasa (DRC), 30.3% heard about cervical cancer from media (11), in Johannesburg, SA. 68% of women had heard cervical cancer messages through medias, only 28% had heard or seen similar messages about HPV(39).

Studies in Addis Ababa 53.6 % heard of cervical cancer, 58.2% ,11.8% and 10.0 % from media, literatures and from friends and family respectively(24), in Hossana, 22.4%,13.2%,10.5% and 9.2% heard about cervical cancer and screening from neighbours, colleagues,spouse and family/relatives respectively.(13) The possible communities based factors for low leve of awareness and delay in seeking of screening service utilization were influenced reluctance to undergo cervical smear tests fear of procedure cost (34), lack of communities commitment (35), cultural and religious beliefs (36) and less concer because of absence of disease symptom (10).

2.3.3 Organizational factors for cervical cancer and screening

Health facilities are responsible for the implementation and design of appropriate communication and advocacy strategies to increase the utilization of cervical cancer screening services(2,14).

Facility-based: community-based statical and an outreach based individual as well as group health education should be given to aware all womens of reproductive age who, are attending health facilities for any kinds of health care (14).

Studies in Brasil, 44.2% were heard about cervical cancer and screening from health professional(32), in India, 40.5% have gotten cervical cancer and screening education from health personels in health facilities. and in Democratic of Congo(DRC), only 3.7% were heard about cervical cancer and screening from health workers/physician/ within the health facilities(11).

Studies done in Malawi, Addis Ababa and Arba minch indicated that the possible organizational factors for women not utilize cervical cancer screening are, lack of effective screening programs, computing health priority and insufficient health care delivery (29,45,54), lack of infrastructures, trained personnel's, being technician-dependent (14,35).

Shortage of laboratories and poorly organized standard national screening programs also the major facility related problems on the diminished cervical cancer screening uptake(31). Insufficient advice and health education from health professionals to access cervical cancer screening, misconception among community on cervical cancer and screening, lack of health insurance, walk long distances to health facilities for screening are among the main challenge to of deserving cervical cancer screening service(49).

CONCEPTUAL FRAMEWORK

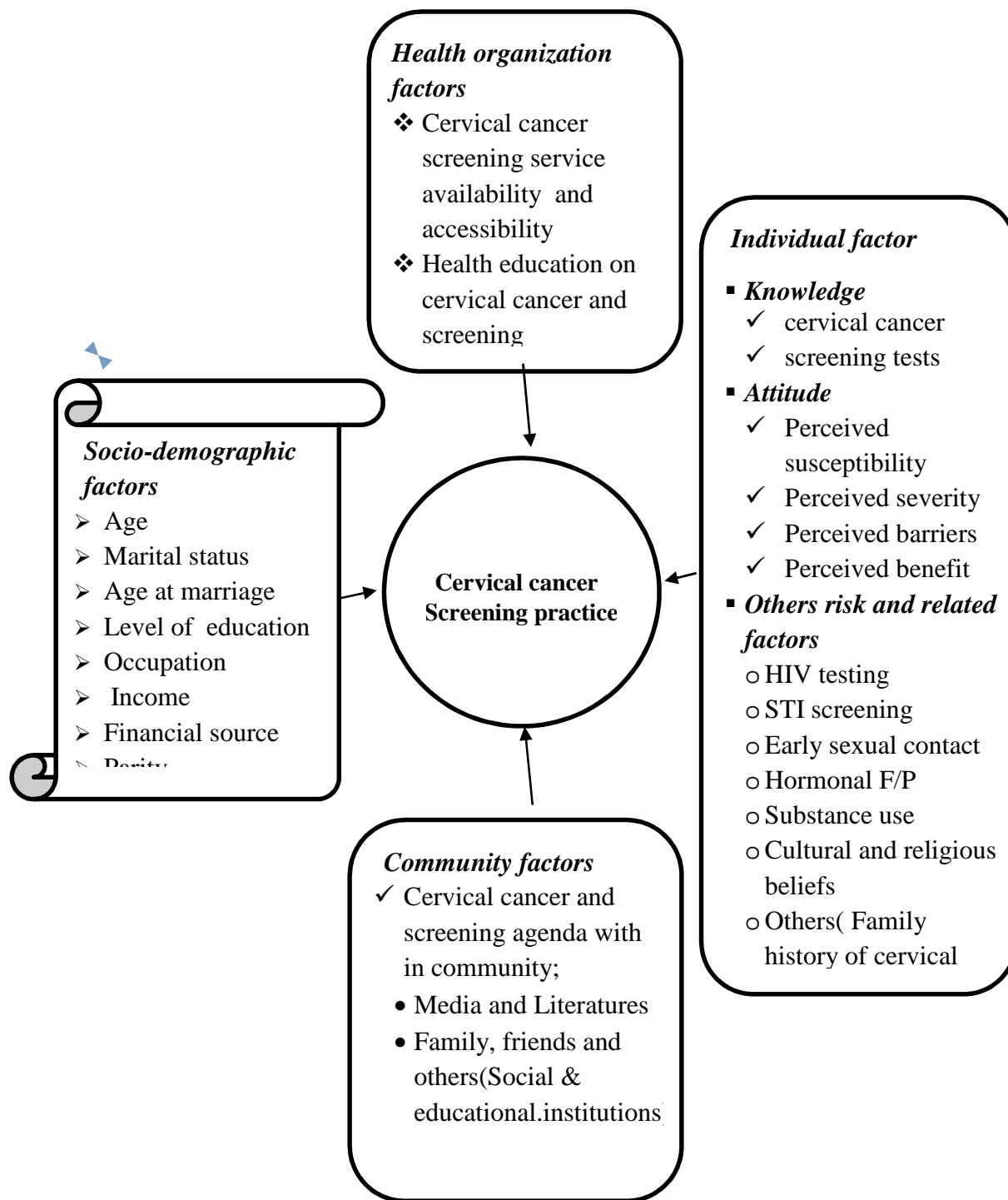


Figure 1. Conceptual frame work adapted and developed based on relevant literatures to show how socio-demography, individual, community and organization variables affect cervical cancer screening practice among reproductive age groups in Butajira, 2018(9,55,56).

SIGNIFICANCE OF THE STUDY

Nowadays cervical cancer becoming one of public health problem worldwide, especially in developing nations, including Ethiopia. Even if cervical cancer is easily preventable through simple cost effective screening test before it become malignancy and fatal stage, but screening uptake in less developing countries was insufficient.

Therefore knowing of cervical cancer screening practice and possible associated factors in local as well as national wide is the key step for better interventions on improving screening service uptake. This study can indicate the current cervical cancer screening practice and associated factor among females of reproductive age in Butajira town.

The study may creat a source of agenda to the local community and the responsible bodies to alert and to think about the issue. Meanwhile the local and regional states concerned bodies may initiate for the possible intervention on the disease and better accesssing of screening programme.

Lastly, this study might be used as an initiation for wide range and detail ininstitutional and community based study which encompasses urban as well as rural dwellers regionaly and nationaly.

CHAPTER THREE: OBJECTIVE

3.1 General objective

To identify the status of cervical cancer screening practice and associated factors among women of reproductive age group (15-49) in Butajira town, central Ethiopia.

3.2 Specific objective

- To identify the status of cervical cancer screening practice among females reproductive age in Butajira town.
- To identify individual a factors (knowledge, attitude and others) for cervical cancer screening among females reproductive age group in Butajira town.
- To identify community factors(public advocacy and agenda) for cervical cancer screening among females reproductive age group in Butajira town
- To identify organizational factors(accessibility of service and H/professionals) for cervical cancer screening among females reproductive age group in Butajira town

CHAPTER FOUR: METHOD AND MATERIALS

4.1 Study area and period

The study was conducted from March 20 – April 19, 2018 in Butajira town, southern Ethiopia, which located 162km far from SNNPR, main city Hawassa to northwest and 135 km far from Addis Ababa to the south direction. The total population of the town is 53, 397, female 26,165 (49%). An estimated of 12,281 reproductive age group (15-49). The town has five kebeles (01-05), 51 ‘gotts’, one governmental and two non-governmental hospitals, one health center; one industrial college, two high schools and two junior schools. Female reproductive age literacy rate (read and write) is 81% and financial dependency rate is 89%.

Cervical cancer screening service accessible (daily) in Butajira hospital, Mersy hospitals” 9 Km far to south west of the town and “Worabe comprehensive and specialized” 52 km far to south of the town (57).

4.2 Study design

Community-based cross-sectional (quantitative and qualitative) study was conducted to assess the cervical cancer screening practice and associated factors among females of reproductive age in Butajira town.

4.3 Population

4.3.1 Source population

- All women of reproductive age who, lived in the town at least for 6 months.

4.3.2 Study population

- All selected women of reproductive age who lived in town at least for 6 months.

4.3.3 Inclusion and exclusion criteria

4.3.3.1 Inclusion Criteria;

- Healthy and self-expressive females of reproductive age (15-49yrs).

4.3.3.2 Exclusion criteria

- Women with seriously sick, mentally incapable and social crisis.(at time of study)

4.3.4 Sampling units

- Household

4.3.5 Study unit

- Women of reproductive age (15-49 yrs).

4.4 Sample size determination

4.4.1 Sample size for quantitative part

The sample size determination for quantitative measure, by a single population proportion formula using 95 % confidence level ($\alpha = 0.05$), $Z (1 - \alpha/2) = 1.96$, 3 % margin of error ($d = 0.03$) and 15 % non-responses.

Sample size calculation was done based on similar studies on *Utilization of cervical cancer screening and associated factors in; Hossana(13), Arba minch(40) and Mizan Tepi(5).*(table 1)

Table 1. Sample size determination using single population proportion formula based on selecting of different relatively similar study areas proportion on specific variables and taking of the maximum sample size. (NB 15% non-response rate and $d = 0, 03$)

Area & year of study	Utilization of cervical cancer screening		Associated factors			
	<i>cervical cancer screening</i>	<i>Calculated sample (d=0.03)</i>	<i>Knowledge on cervical cancer and screening Proportion</i>	<i>Sample</i>	<i>Positive attitude toward cervical screening Proportion</i>	<i>Sample</i>
Hosanna	9.9	381	53.7	420	65.2	384
Arba minch	5.9	237	34.2	381	53.8	420
Mizan Tepi	14.8	538	53.1	421	55.7	417

$$n = (Z \alpha/2)^2 * \frac{P(1-p)}{d^2}$$

$$n = (1.96)^2 * \frac{0.148(1-0.148)}{(0.03)^2} \quad n = 3.842 * \frac{0.148(0.852)}{0.0009} = \mathbf{538}$$

$n = \mathbf{538} + 15\%$ (81 non-response) = **619**. Total sample size for quantitative = 619

Key: n = sample size, P = proportion $Z (1 - \alpha/2) = 1.96$,
 α = confidence level (95% = 0.05) d = marginal error ($d = 0.03$)

4.4.2. Sample size for qualitative part

Twenty (20) key informants for in-depth interview.

4.5 Sampling techniques

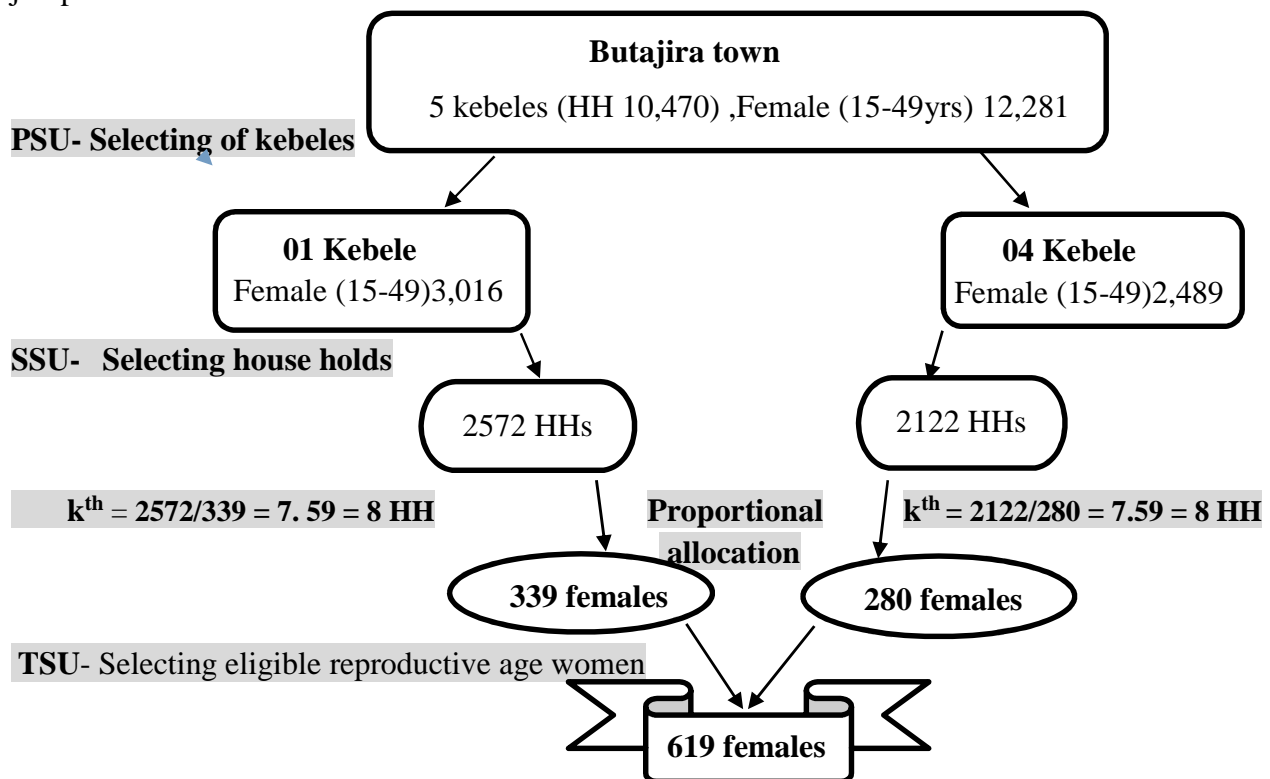
4.5.1 Sampling technique for quantitative

Multi stage sampling technique was used to select households and eligible reproductive age women.

First sampling unit; from five kebeles, two kebeles was selected using simple random sampling.

Second sampling unit; selecting house holds. Initially find the center of each kebele and random direction was chosen by spinning a pencil then after getting the direction walk along a straight line until reaching the boundary (numbering left and right) and then walk along the other direction until to the boundary. To found k^{th} dividing households to the study sample size ($4694/619 = 7.58$ which means ever 8 household/ vicinity). The first house/vicinity was selected by lottery method.

Third sampling unit; eligible reproductive age women were from each kebele. One female was selected from each household/family (**believed that within the family, there may be information sharing**). Those selected householde which were no eligible females of reproductive age were jumped to next k^{th} interval.



NB; One sample from each selected (HH) by using simple random method (Lottery method)

Figure 2. Schematic presentation of sampling procedure for quantitative, systematic and simple random sampling techniques with proportional allocation to the select eligible reproductive age groups, Butajira Town, 2018.

4.5.2. Sampling technique for qualitative

Purposive sampling technique was used to identify key informants for in- depth interview. For each key informant, the interview was taken 15 – 25 minutes. (Averagely 20minutes)

Total of twenty female key informants were selected

- Two from women & child affairs officer/heads/staffsof the kebeles (one from each kebele),
- Two from developmental arm leaders/1 to 5 (one from each kebele),
- Two influential females within the community (one from each kebele),
- Two females from social institutions leaders (example “Edir”.) (one from each kebele),
- Four model female students (grade 9, 10, 11 and 12) from two schools.
- Two female school teachers (from two schools)
- Two urban health extension workers(nurses) (one from each kebele),
- Two female health professionals (midwife and nurse) from government health organization.
- Two health professionals (midwife/nurse) from non-government H/ organization.

4.6 Study variables

4.6.1 Dependent variables

Cervical cancer screening practice

4.6.2 Independent variables

Socio-Demographic factors.

- Age, marital status, level of education, occupation, financial sources, income, age at marriage and parity.

Individual associated factors

- Knowledge, attitude towards cervical cancer screening(HBM)(9,16,17,40),Others associated factors on cervical cancer and screening(Hormonal contraceptive usage, family/relatives history of cervical cancer, HIV and STItesting history and substance use.

Community associated factors on cervical cancer and screening

- Community cervical cancer and screening agenda and advocacy; media, literatures, educational centers, family, relatives & friends and social institutions.

Health organization associated factors on cervical cancer and screening

- Cervical cancer education, screening service accessible, availability of nearby health organization/s.

4.7 Operational definitions

- ***Cervical cancer screening practice***- a female who had been screened for cervical cancer once or more in her life time.
- ***Knowledge on cervical cancer and screening*** – assess the response on proposed awareness questions(risk, prevention measures and possible means of screening of cervical cancer)
 - ✓ **Knowledgeable** – If correctly answer at least one risk factor and one preventive measures and response scored 70% and above the mean.
- ❖ ***Attitude*** – Asses reproductive age females perception of susceptibility, severity, benefits and barriers on cervical cancer and screening based on HBM(Health Belief Model) “Likert scale”; strongly agree, agree, undecided, disagree and strongly disagree
 - ***Perceived susceptibility, severity and benefits***- a female responding on proposed attitude questions(considering as risky, severity of the disease and benefit of screening)
 - ✓ **Good perceived susceptibility, severity and benefits** – Sum of “Likert scale” result above the mean.
 - ***Perceived barrier***- a female responding on proposed barriers attitude questions.
 - ✓ **Good perceived barrier**- Sum of “Likert scale” result below the mean.
- ***Accessibility of screening service*** – If the service available regularly (at least once per week) within the town or with reasonable time (30 mintes) and.distance radius (within 60 km radius)
- ***HIV and STI testing history***- HIV and STI testing history with in the past 5 years.
- ***Recently substance use*** – regularly taking of (Khat daily or weekly, cigarette at least 1/week, alcohol drinking – in average 1 bottle or glass /day & heavy drug- narcotics, psychotropic without doctor prescribed) within past 5 years.
- ***Discussion among/with family, relative and friends and community***: Any formal or informal discussion on cervical cancer and screening among, family, relatives, friends and community.
- ***Advocacy on cervical cancer screening service***; any information, poster, announcement about cervical cancer and screening service from health organization/s.
- ***Health education about cervical cancer screening***; any education on cervical cancer screening from any health professional/s at any time and place.
- ***Health professionals unethical behavior*** – any for of malbehavior that can violate on individual phycologically, physical and social aspects of life.

4.8 Data collection procedure

4.8.1 Data collection instruments

Structured and semi structured questionnaire adapted from NCD(55), and developed based on the objective of the study.

4.8.1.1. Quantitative data collection instrument

The quantitative questionnaire has 73 questions in five parts; **Socio-demographic characteristics, Individual associated factors on cervical cancer and screening, Utilization of cervical cancer screening test, community and Health organization associated factors** on cervical cancer and screening.

4.8.1.2. Qualitative data collection instrument

In-depth interview (qualitative questionnaire has 11 questions in four parts).

4.8.2. Data collection methods

Face to face interviewer administered questionnaire.

Quantitative data was collected from two selected kebeles (01 and 04) in Butajira town, after two days training. Quantitative data was collected by six urban health extension workers (clinical nurses). A male supervisor and principal investigator were followed the overall process daily. Data was collected from Monday to Saturday at home/vicinity early in the morning and late afternoon. Each data collectors were averagely collected three to four questionnaires per day/individual.

Qualitative data (in-depth interview) was made on selected females key informants in Butajira town by principal investigator (myself). Before conducting in-depth interview, explanation on the purpose to do the in-depth interview was explained. Each in-depth interview averagely 15 to 20 minutes used. In-depth interview was done from Monday to Friday at their working place and time. Each day two interview was done. During in-depth interview, audio recorder and notes was taken after asked their willingness.

4.9 Data quality assurance

4.9.1 Data quality assurance for qualitative data

Structured and semi structured questionnaire was adapted from WHO and NCD and developed in English, then translated to Amharic and back to English by language experts. Two days training was given to data collectors and supervisor. Data was collected by six females' data collectors. The questionnaire was pre-tested (5% of sample size) in nearby "Ensen" town and analysed for Cronbach' alpha / reliability test (HSOPSSC- user guideline), which was 0.727(~0.73), but the result was not included in the analysis.

The collected data was checked by supervisor and principal investigator for completeness, legibility and correctly recorded. The collected data was cleaned & coded before analysis. The data which was not clear, completeness and missed (greater than 10%) not included in analysis.

4.9.2 Data quality assurance for qualitative data

Open ended questions was used for in- depth interviews. Key informants for in-depth interview were include all segments of reproductive age females. Detail explanation on the purpose of interview was explained and audio recorded Interviewed data was coded, written, transcribed and thematized according to respondents their own words carefully before analysis.

4.10 Data entry and analysis plan

Data was coded and entered in to Epi-data 3.1 version and export to SPSS version 20 software. Bivariate analysis was done for all independent variables. Finally a multivariate analysis was done to identify associated variables. Sufficient candidate variables (fourteen) with p value of <0.05) was candidate for analysis. Chi square and normality assumption was assessed. Strength of association was described using odds ratio (OR) and 95 % CI. Analysis was written in tables, graphs and sentence.

4.11 Ethical considerations

Before the commencement of the data collection ethical clearance was obtained from ethical review committee of Jimma University, formal letter from Butajira Town administration health office and informed verbal and written consent also obtained from each study participants. In addition for those who were less than 18 years old informed consent was obtained from their parents too. Confidentiality was kept and explained to the participants that was only for research purpose. For those participants who were not interested on the study lefted out and based on systematic sampling rule replaced by others.

4.12 Dissemination plan

The results of this study will be presented to Jimma University scientific community after approval from the Department. Soft and hard copy will be given to the department of epidemiology. Soft copy will be given to Butajira town health office. Strong efforts will be made to publish the research article in scientific journals.

CHAPTER FIVE: RESULT

5.1 Socio-demographic characteristics

In this study, 631 females of reproductive age participated (611 quantitative and 20 in-depth interview for qualitative) with a response rate of 98.7 %. The mean age of study participants was 30 (± 7.631 SD). Two hundred and forty eight (40.6%) and 86(14.1% participants were reached to secondary and tertiary education respectively. The average monthly income of the study participants were 2837(± 2418.7 SD) and 188(30.8%) of them have their own income.

Table 2 Socio-demographic characteristics of females of reproductive age, Butajira, Ethiopia, 2018

Variables	Category	Freq	%
Age	15 - 18 years	41	6.7
	19 – 29 years	263	43.1
	30 – 39 years	230	37.6
	40 – 49 years	77	12.6
Marital status	Single	144	23.6
	Married	401	65.6
	Divorced	19	3.1
	Widowed	47	7.7
Age at marriage	Not married	144	23.6
	< 18 years	40	6.5
	18 years	427	69.9
Educational status	Not formally educated	62	10.1
	Primary education (First phase grade 1 – 8)	215	35.2
	Secondary education (grade 9 – 12)	248	40.6
	Tertiary education (grade > 12)	86	14.1
Occupation	House wife	216	35.4
	Student	135	22.1
	Employee**	105	17.2
	Others*	155	25.4
Monthly income	2000 EB	300	49.1
	2001 - 4000EB	175	28.6
	> 4001EB	136	22.3
Financial source	Independent/self	188	30.8
	Husband	294	48.1
	Family, relative/s and other***	129	21.1
Parity	Has no child	161	26.4
	Has child/children	450	73.6

NB * Merchant, Self & daily labourer), **Governmental & non-governmental, ***Close intimate friends, lover

5.2 Current status of cervical cancer screening

Cervical cancer screening services accessible in the study area (Butajira). Among all participants, Only 39 (6.4%) of the respondents were screened before the survey. Twenty (51.3%), 9(23.1%) and 10(25.6%) of them screened within the past two years, three and five year respectively.

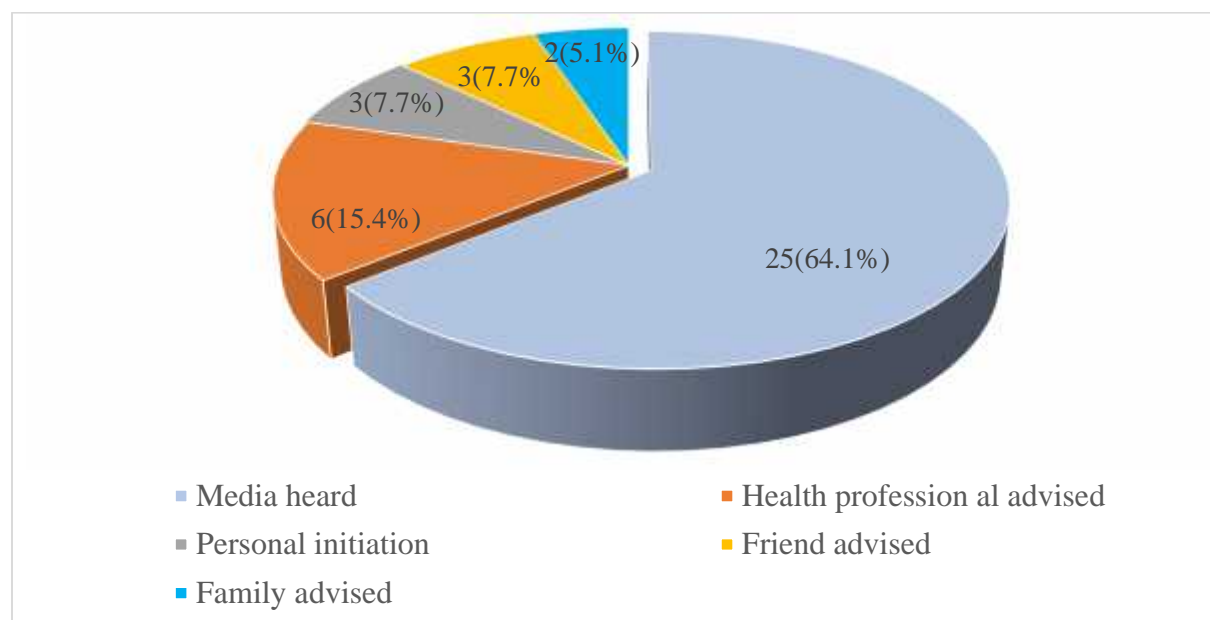


Figure 3 Reason for cervical cancer screening service uptake among women of reproductive age in Butajira town, 2018.

Majority of study participants were not screened. The reason is illustrated on the table.

Table 3 Reason for not utilized cervical cancer screening among women of reproductive age in Butajira, 2018

Reason for not screened	frequency	% from not screened	% from all
Never heard of screening	316	55.2	51.7
Heard of screening but not screened	256	44.8	41.9
Not well aware	97	17.0	15.9
As if being health	149	26.0	24.4
Fear and not decided	10	1.7	1.6

5.3 Individual factors

5.3.1 Knowledge on cervical cancer and screening

Three hundred forty five (56.5%) and 295(48.3%) heard of cervical cancer and screening respectively. Hundred sixty three (26.7%) found as knowledgeable. Handred seventy eight (29.1%) and 295(48.3%) heard at least one risk factor and preventive measure respectively.

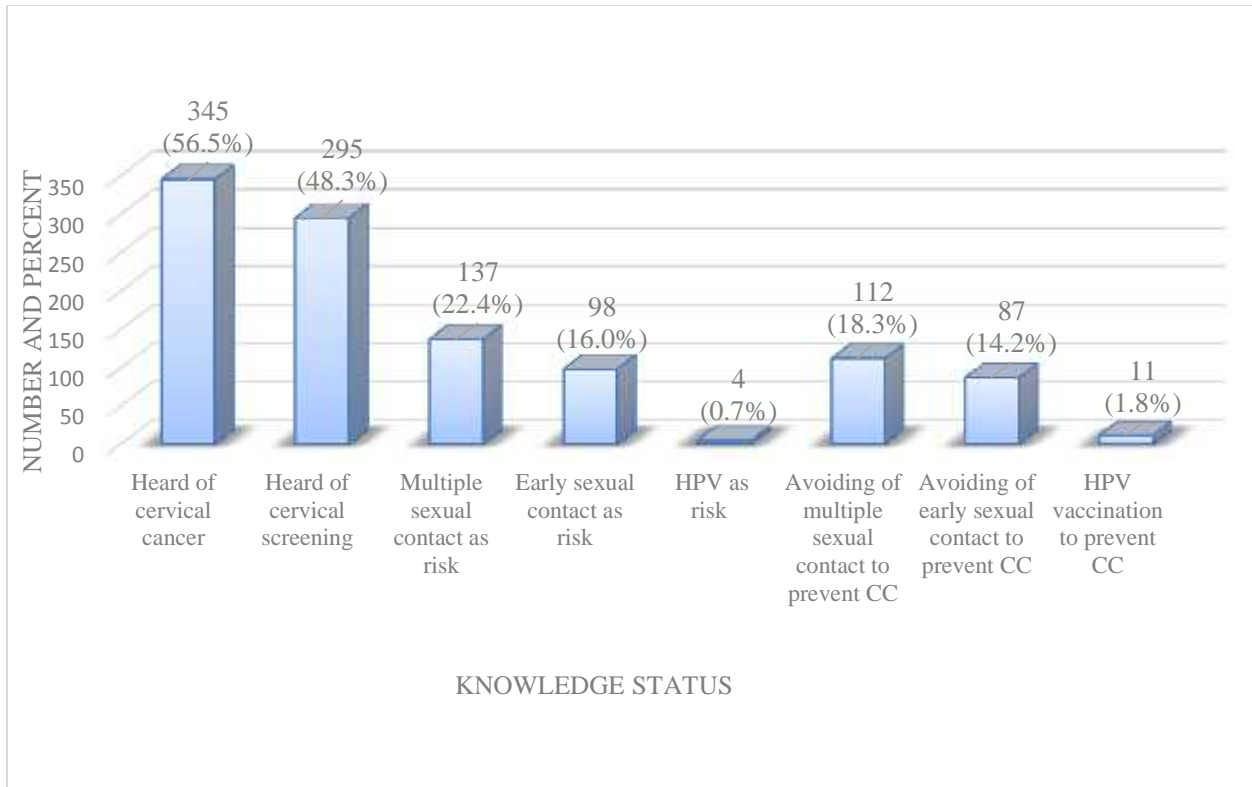


Figure 4 Knowledge status on cervical cancer and screening among women of reproductive age in Butajira town, 2018

This finding were consistent with in-depth interview. All of interviewed participants believed awearness problem could be the main reason for not screened for cervical cancer.

A 35 years old women and child affair officer of the kebele replied that,

”I didn’t know about cervical cance and screening except some rumors. I believe that most females didn’tt aware it. Concerned bodies need to awareness and motivate womens to screen”

Almost half, 9 (45%) of interviewed participants were not aware of any risk factors and preventive measures of cervical cancer.

A 33 year’s old nurse, who working in non-governmental hospital explained that,

”I didn’t have detail awearness about cervical cancer risk factors, sign and sypptoms and all preventive measure!,I can’t explain and teach about the disease and screening to other!”

5.3.2 Attitude on cervical cancer and screening

Based on Health Belief Model (HBM) conceptual frame works in health behaviours. The following figure showed that, among those 345 who, heard about cervical cancer and their poor attitude.

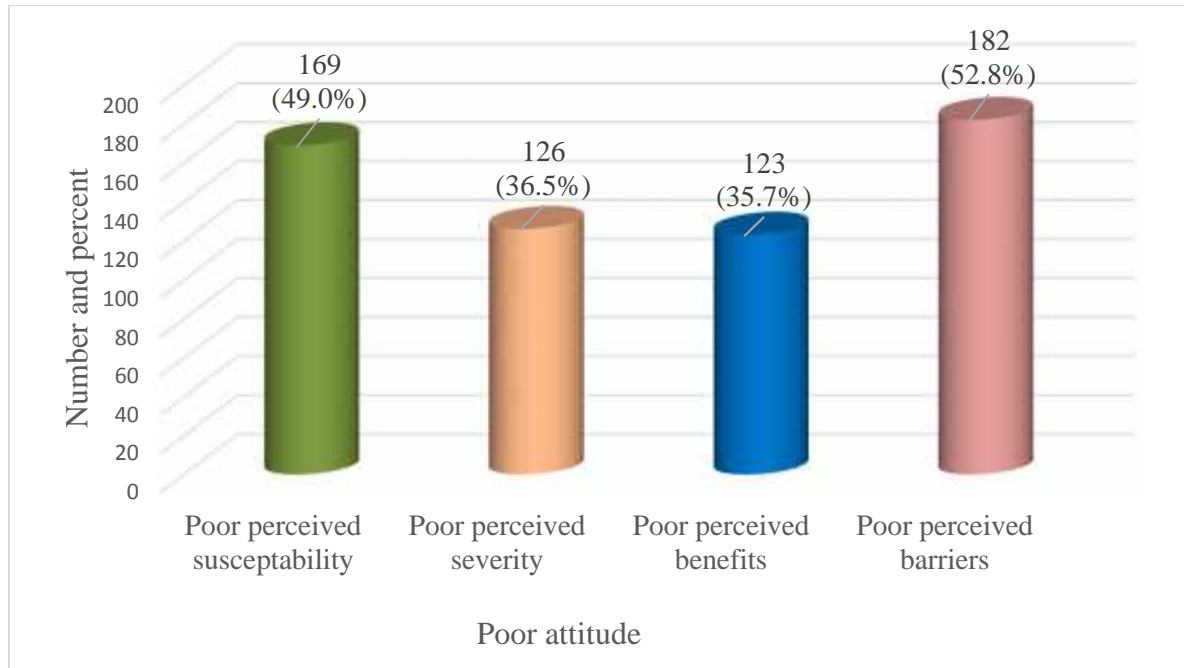


Figure 5 Poor attitude towards cervical cancer and screening for those who were heard about the disease, among females of reproductive age groups, Butajira, Ethiopia, 2018.

This finding were consistent with in-depth interview result. Eleven (55%) and 3(15%) of them have good perceived susceptibility and barriers respectively.

A 38 years old teacher in Butajira secondary school replied that,

"I didn't have detail aweranness about cervical cancer, but I think the disease is dangerous, since it is a cancer. I don't think that I am risky for the disease. I imagine that screening is complex procedure, costly and time taking. I believed that many females will belive like that"

Eleven (55%) of interviewed participants belive that, they are not risky for the disease.

An 18 years old girl, grade 11 student replaid that,

"I think cervical cancer be a dangerous diseasas since it is cancer. I don't think that I'm risky for the disease! I heard rumor about screening, but I didn't know where the service is giving. I imagine the procedure could be complicated, costly and time consuming!"

5.3.3. Individual related factors

Some risk and related factors are highly associated with cervical cancer screening service uptake. As stated from WHO(2), and FMOH cervical cancer guide (14) some of the related factors illustrated as below.

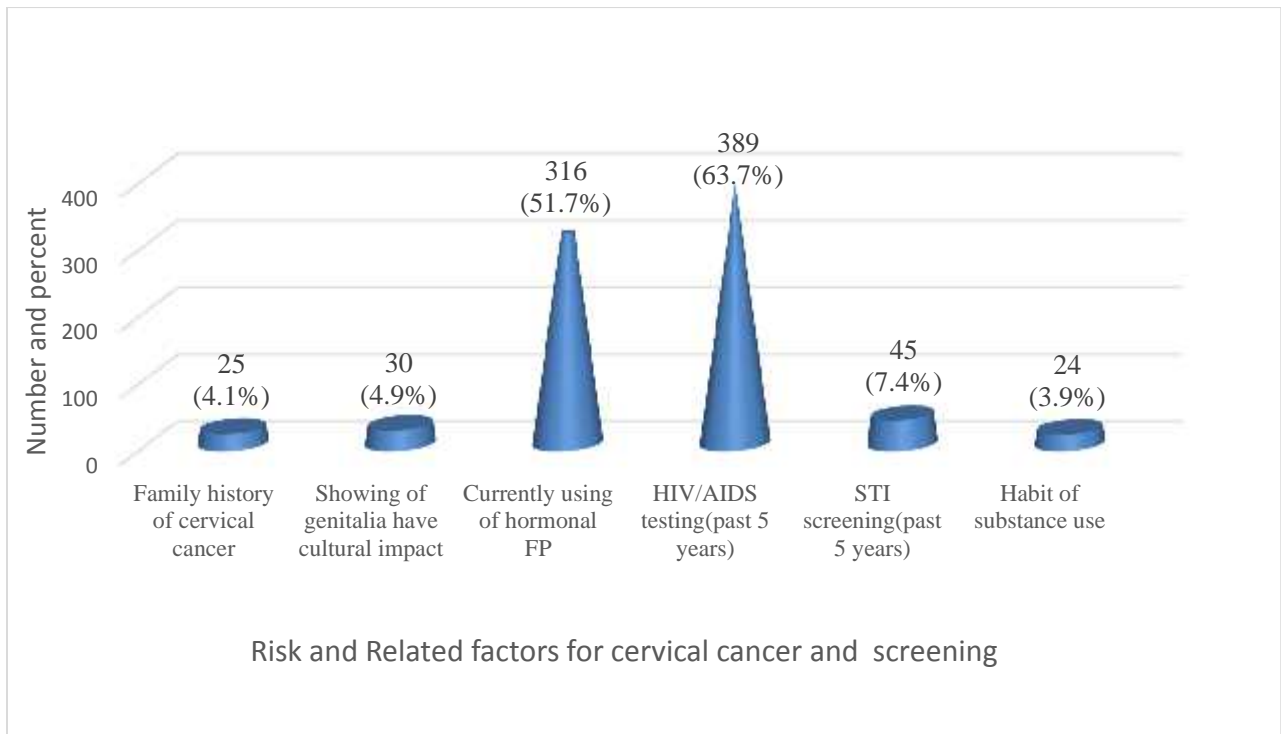


Figure 6 Individual risk factors for cervical cancer and driving for screening among females of reproductive age, Butajira, Ethiopia, 2018.

This finding were consistent with in-depth interview. Few 3(15%) of interviewed participants believed that showing of genitalia for screening can have religion and cultural impact.

A 17 years old grade 10 student stated that,

”I think showing of genitalia for screening with out any symptoms of disease can have religious as well as cultural impact!”

A 29 years old urban health extension worker stated that,

“Most females will not be volunteer to have cervical cancer screening like HIV testing. Few females belied that showing of genitalia for screening may have religious and cultural influence, especially the rural females. Oftenly few females believed that uterus related disease including cervical cancer as “cursed effect” that can transmited within the family.”

5.4 Community factors for cervical cancer and screening

Community factors like; media information, literatures reading, families discussion and advise , friends discusion, educational centers teaching and social inistitutions discussion on cervical cancer and screening have great role on cervical cancer screening service utilization among community members.(Table).

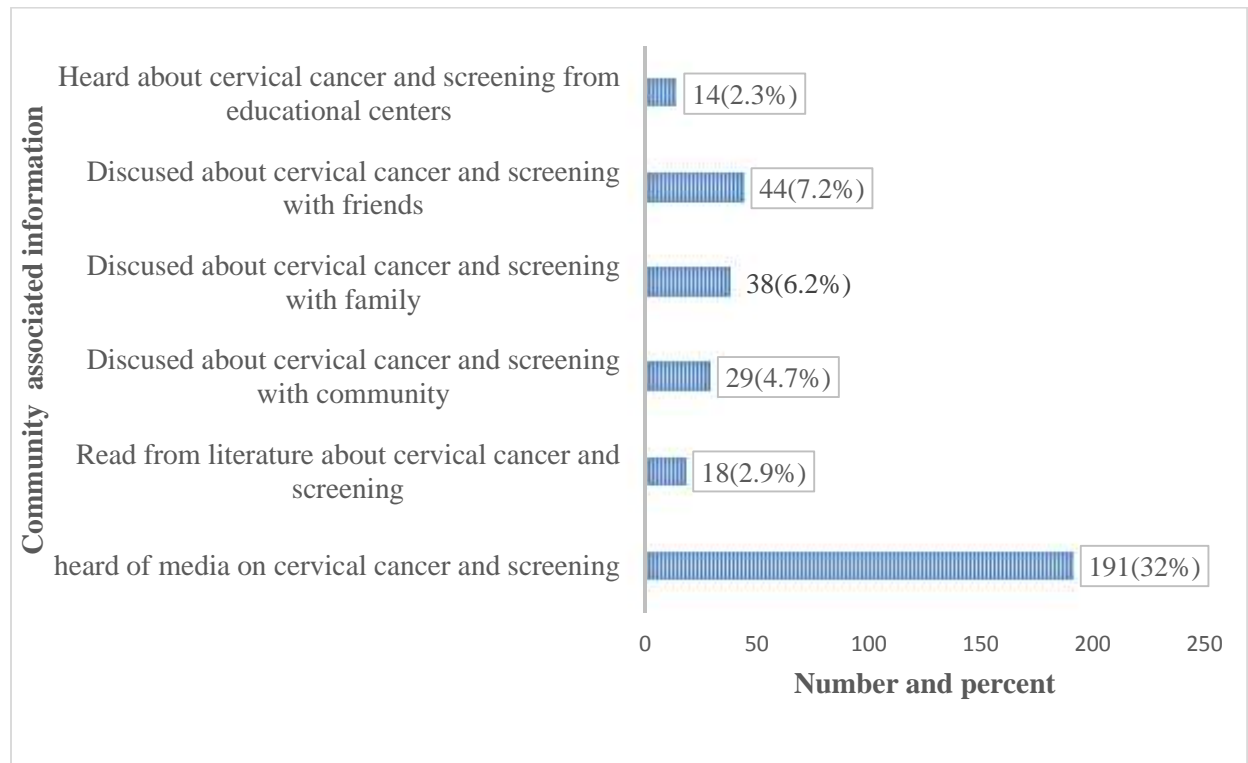


Figure 7 Community associated factors for cervical cancer and screening among females of reproductive age, Butajira, Ethiopia, 2018.

This findings were consistent with In-depth interview. Less than half, 9 (45%) of in-depth interviewed participants were heard about cervical cancer from media.

A 43 years old, leader of female’s social institution (“Edir”) stated that,

“I didn’t heard about cervical cancer and screening from any media and individuals. I believe that such information should be announced through media to aware the community.”

None of interviewed participants were read from litreture or ever discussed with their families or friends.

A 37 years old community 1 to 5 female’s leader explained that,

“Before fewe years ago I did not have any information about cervical, until I heard fron media and urban health extension worker but after Iheard about cervical cancer,I never discussed with family or friends.”

5.5 Health organization factors for cervical cancer and screening

Health education on cervical cancer and screening, availability and accessibility of screening service in nearby health facilities and service advocacy to the community are major decisive factors for routine screening service utilization among women. The following table shows organizational factors for screening service.

Table 4 Health organization associated factors for cervical cancer and screening among females of reproductive age, Butajira, Ethiopia, 2018.

Variables description	Category	Freq.	%
Aware of screening service availability in health organization/s	Yes	241	39.4
	No	370	60.6
Aware of availability of nearby health organization which giving screening service	Yes	106	17.3
	No	505	82.7
Advocacy on screening service from nearby health organization	Yes	10	1.6
	No	601	98.7
Advice/education on cervical screening from health professional/s	Yes	92	15.1
	No	519	84.9
Believed that health professionals unethical behavior can affect screening service utilization?	Yes	224	36.7
	No	387	63.3

The above findings were consistent with In-depth interview. Three- fourth, 15(75%) of interviewed participants had never got any education about cervical cancer and screening from any health professional.

A 35 year old teacher in preparatory high school responded that,

“I have heard about HIV/AIDS, TB and Hypertension from health professionals in health organization and in school, but I have never heard about cervical cancer and screening. I believe that routine health education is important to aware the community like other diseases”.

Less than half, 8(40%) of interviewed females have information about availability of screening service. Only 2(10%) knows screening service availability in nearby health organization.

An 18 years old grade 12 student explained that

“I didn’t heard about cervical cancer screening from any one. I didn’t know where and when the service is giving. I think most girls may not aware about screening. So that!, health education about screening should be given to the communities (especially for females)!”

Bivariate and multivariate analysis

Bivariate logistic regression analysis was done for all independent variables to identify candidate for multivariate logistic regression. Multivariable logistic regression analysis was done only for those 14(fourteen) variables with (p- value <0.05) to identify association between independent variables with dependent one. The model was good fitted with Hosmer and Lemeshow test of 0.536.

Table 5. Bivariate and Multivariate analysis of factors associated with cervical cancer screening service uptake among females of reproductive age group, Butajira, Ethiopia, 2018.

Variables and variable category	Ever screened condition		COR	AOR
	Screened	Not screened	P- value & 95% CI	P- value & 95% CI
Socio-demograph				
Educational status			P = 0.000	P = 0.526
No formal educated	1(2.6%)	61(10.7%)	1	1
Primary education (grade 1 – 8)	11(28.2%)	204(35.7%)	3.289(0.416, 25.988)	0.174(0.008, 3.845)
Secondary education (grade 9 – 12)	12(30.8%)	236(41.3%)	3.102(0.396, 24.319)	0.151(0.007, 3.311)
Tertiary education (grade > 12)	15(38.4%)	71(12.4%)	12.887(1.654, 100.404)	0.097(0.004, 2.494)
Occupation			P = 0.002	P = 0.915
House wife	10(25.6%)	206(36.0%)	1	1
Student	5(12.8%)	130(22.7%)	0.792(0.265, 2.370)	1.889(0.322, 11.077)
Employee**	16(41.0%)	89(15.6%)	3.703(1.618, 8.478)	1.069(0.227, 5.044)
Others*	8(20.5%)	147(25.7%)	1.121(0.432, 2.909)	1.058(0.273, 4.104)
Monthly income			P = 0.001	P = 0.146
2000EB	9(23.1%)	291(50.9%)	1	1
2001 - 4000 EB	12(30.8%)	163(28.5%)	2.380(0.982, 5.769)	0.639(0.205, 1.990)
> 4000EB	18(46.1%)	118(20.6%)	4.932(2.154, 11.291)	1.747(0.644, 4.738)
Individual factors				
Knowledge on cervical ca. & screening			P = 0.000	P = 0.000
Knowledgeable	36(92.3%)	127(41.5%)	16.913(5.097, 56.129)	11.437(3.255, 40.187)
Not knowledgeable	3(7.7%)	179(58.5%)	1	1

<i>Perceived susceptibility</i>			P = 0.003	P = 0.916
Good perception	29(74.4%)	147(48.0%)	3.137(1.477, 6.660)	0.941(0.303, 2.924)
Poor perception	10(25.6%)	159(52.0%)	1	1
<i>Perceived severity</i>			P = 0.032	P = 0.825
Good perception	31(79.5%)	188(61.4%)	2.432(1.081, 5.471)	0.875((0.267, 2.868)
Poor perception	8(20.5%)	118(38.6%)	1	1
<i>Perceived benefit</i>			P = 0.018	P = 0.181
Good perception	32(82.1%)	190(62.1%)	2.791(1.193, 6.529)	1.983(0.728, 5.400)
Poor perception	7(17.9%)	116(37.9%)	1	1
<i>Perceived barrier</i>			P = 0.000	P = 0.003
Good perception	32(82.1%)	131(42.8%)	6.107(2.614, 14.268)	4.057(1.606, 10.248)
Poor perception	7(17.9%)	175(57.2%)	1	1
<i>Past(5 yrs) HIV testing</i>			P = 0.001	P = 0.331
Yes	36(92.3%)	353(61.7%)	7.445(2.265,24.467)	2.053(0.481, 8.768)
No	3(7.7%)	219(38.2%)	1	1
<i>Past(5 yrs) STI screening</i>			P = 0.002	P = 0.138
Yes	8(20.5%)	37(6.5%)	3.731(1.602,8.692)	2.443(0.750, 7.963)
No	31(79.5%)	535(93.5%)	1	1
<i>Media Heard about cervical ca. and screening</i>			P = 0.000	P = 0.001
Yes	25(64.1%)	166(29.0%)	4.367(2.215, 8.610)	4.871(1.887, 12.574)
No	14(35.9%)	406(71.0%)	1	1
<i>Discussed about cervical cancer with with families</i>			P = 0.003	P = 0.069
Yes	7(17.9%)	31(5.4%)	3.818(1.561, 9.337)	3.249(0.911, 11.586)
No	32(82.1%)	541(94.6%)	1	1
<i>Discussed about cervical cancer with friends</i>			P = 0.002	P = 0.398
Yes	8(20.5%)	36(6.3%)	3.842(1.647, 8.966)	1.840 (0.447, 7.582)
No	31(79.5%)	536(93.7%)	1	1
<i>Health education about cervical cancer</i>			P = 0.000	P = 0.002
Yes	23(59.0%)	69(12.0%)	10.479(5.278, 20.806)	4.440(1.763, 11.181)
No	16(41.0%)	503(88.0%)	1	1

NB * Merchant, Self & daily labourer, **Governmental & non-governmental, EB- Ethiopian B

Factors associated with cervical cancer screening practice

Bivariate logistic regression analysis was done to assess association between individual independent variables and women's of reproductive age cervical cancer screening practice. After controlling the effect multicollinearity among variables, multi variable logistic regression analysis was done to assess significant associated factors.

Knowledge, good perceived barriers on cervical cancer and screening (from individual factor), Media heard about cervical cancer and screening(from community factor) and Health education on cervical cancer and screening (from health organization factor) continued to be significantly associated with cervical cancer screening service uptake (P-values<0.05).

Knowledgeable females (who, aware at least one risk factor and one preventive measures) were 11 times more likely to undergo screened when compared with those who were not [AOR: 11.437, 95% CI (3.255, 40.187), P< 0.000]. On the other hand women of reproductive age, who, have good perceived barriers towards cervical cancer and screening were 4 times more likely to screened when compared with those counter part [AOR: 4.057, 95% CI (1.606, 10.248), P< 0.003].

Women of reproductive age who media heard about cervical cancer and screening were 5 times more likely to undergo screened when compared with those who were not heard [AOR: 4.871, 95% CI (1.887, 12.574), P< 0.001] and women of reproductive age. Who, got education about cervical cancer and screening were 4 times more likely to undergo screened when compared with those counter part [AOR: 4.440, 95% CI (1.763, 11.181), P< 0.002].

CHAPTER SIX DISCUSSION

Individual, community and health organization factors about any disease including cervical cancer offer crucial opportunity for comprehensive prevention/screening and control strategies of the disease. Therefore, this study addressed the status of screening practice and how those factors influence screening practice among women of child bearing age in Butajira town.

The current cervical cancer screening uptake in the study area was (6.4%). This finding indicates that the behavioral intervention for screening were low as women were not screened and they tried to mention their reasons for not having an intention to be screened so that the level of awareness about benefit of screening and screening practice among women of reproductive age were is low.

The finding was higher than Ethiopia national cervical cancer guide reports, which was 1.6% in urban and 0.4% in rural part of Ethiopia(14) and a study done in, Thulamela, South Africa (3.2%)(58) Addis Ababa/black lion 3% (6). This could most probably be due to the study set up in South Africa which was conducted on rural females and the study in Addis Ababa only on those who visited black lion and variation on urban and rural screening service accessibility.

The difference from Ethiopia cervical guide might be due the guide incorporate the over all average rural and urban communities screening status. Currently, the government of Ethiopia is expanding the screening centers which might have increased screening service uptake. Screening itself has become a routine procedure for gynecologic patients and is part of the standard care for women who are diagnosed as HIV positive. Recently, there is also a campaign of to screen all HIV positive women who are on ART who were not screened before. The current result is consistent with a study done in Arba minch, 5.9%(45). This finding is smaller than studies done, Iran, 27.1%(38), Mekele, 19.8% (16). This may partly be due to difference in the socio-economic characteristics of the community, better access of information, screening services accessibility and relatively good advocacy of the service on those bigger towns.

The findings of this study showed that less than half (26.7%) of participating women had good level of comprehensive knowledge score from the composite score regarding risk factors and methods of prevention of cervical cancer. As one of individual factor, knowledge about cervical cancer and screening was a significant factor for screening practice. Majority of the participants in this study were not able to cite at least one risk factor and preventive measure for cervical cancer. So that there were huge gap on the level of awareness about screening among women of reproductive age

is low. The current study result is higher than a study in South Africa, 21.0%(39), Zimbabwe, 19.0%(49). This might be due to study setup that were study done in rural areas which have much difference from urban area. The study finding was consistent with a study done in, Addis Ababa, 25.1%(24) and Mizan Tepi, 25.36%(5). The above finding is smaller than studies done; in Haiti, 40.8%(7), Mekele (82.5%)(16), Arba minch, (34.2%)(40). The variations could be explained by, due to, the first three studies conducted on bigger towns, so!, there may be better facilities for health care delivering and health education that in favor of better awareness.

As observed from the study, 33.2% of the participants had good perceived barriers. As one of individual factor, good perceived barriers about cervical cancer and screening was a significant factor for screening practice. This finding indicates that most women of reproductive age have poor attitude as women tried to mention and describe their reasons and perception for not having an intention to be screened.

This finding is smaller than with studies conducted in Mekele, (38.1%)(16), Addis Ababa, (36.5%)(59) This difference might be due to the practice of routine community health education that takes an advantage of bringing attitudinal change on women of reproductive age. The current result is higher than a study in Nigeria, (6.0%)(60). The variation could be study set up since, the study was mainly focused on those less educated market women's of the communities in one of small town of the nation.

The current study showed that, 31.3% of participants have heard media about cervical cancer. As one of community factor, media heard about cervical cancer and screening was a significant factor for screening practice. This study showed that there could be low attention given to media promotion, low habit of hearing information among women of reproductive age about cervical cancer and screening. Since as if the women tried to confirm that not beside not have wide coverage of media on the issue and they did not had habit of hearing media.

This finding lower than a study done in Botswana, 95.5%(34), Desei, 55.3%(41). The variation could be explained by, variation on socio-economical, better media access and coverage about cervical cancer and screening. Nearly similar with a studies done in India, 31.2%(61) and southern Ethiopia (sidama zone), 29.2%(31). The difference might be due the presence of better media coverage on the issue, access of local Medias which can advocate screening benefits and accessibility. The current study is higher than a study conducted in South Africa, 13%(58). This

could most probably be due to the rural community as study participants'. Well understood rural communities have less access on Medias than urban.

In this study only 15.1% of participants have got health education about cervical cancer and screening. As one of health organization factor, health education about cervical cancer and screening was a significant factor for screening practice This finding indicates that the behavioral intervention on health education about cervical cancer and screening was low attention as women tried to mention their health education experience and reasons for not having an intention to be screened so that the level of awareness about screening behavior through health education among women of reproductive age was low.

This result is smaller than a study conducted in Botswana, 26.6%(34), Addis Ababa, 53.6%(24), Dessei (55.3%)(41). The variation may be explained by socio-economical variation, better health care delivering organizations and personnel's to give better health care services and routine education. The result is little higher than a study conducted in India,11.8%(61). The difference could be set up, which encompasses on both rural and urban, so there may be variation in access of health education between urban and rural.

Strength of the study

This study encompasses both quantitative as well as qualitative datas and relatively sufficient sample size for better result and applicability. The study focussed on the most vulnerable reproductive age groups of the community to show extent of screening uptake and associated factors. In addition the study used only female's urban health extension nurses as data collectors to keep respondent's privacy and reliable information on the issue.

Limitation of the study

This study was conducted on medium town (Butajira) of the country and focused on only urban females of reproductive age groups. There was some selection bias encounterd, since the data collectors' selected one female among those who were present at time of data collection by lottery method. Some problems of uniformity and detailed expression of the concepts of the questions clearly by each data collectors. This study focused on only urban reproductive age group (15-49years) females, so could rise issue of external validityfor all females, since rural and other age groups not included.

CHAPTER SEVEN: CONCLUSION AND RECOMMENDATION

7.1 Conclusion

In this study, below a quarter of study participants were screened for cervical cancer, which mean screening practice was insufficient but relatively little better than the over all the national screening coverage. Majority of study participants were not-screened because of not well awared about screening and as ifthey were being healthy. Different associated factors contributed for low up take of screening; low level of awareness, attitude, low local and national Media's coverage on the issue, insufficient health education and limited advocacy of screening services among females of reproductive age in Butajira town.

7.2 Recommendation

Even if cervical cancer screening service relatively accessible with in the study area, but its up take is not satisfactory. The local responsible bodies should give attension to tackle the individual, communities and organizational related problems on cervical cancer and screening by means of different means of communications.

Based on the findings of the study, we recommend the following specific groups

To Butajira Town health office and health organizations

- ❖ Community mobilization at all level, link communities with screening services availability with well facilities and professionals. Further more, needs to work with Butajira Town women's & child affairs, urban health extension workers, kebele and religious leaders and influential community members, schools and social institutions.

To Local media

- ❖ Should give strong attention and emphasis on information dissemination about cervical cancer and screening.

To Health care providers

- ❖ Provide coordinated routine health education to the community and school based intensifying awareness creation

To Researchers

- ❖ Cervical cancer becoming alarming public health problem. It needs larger scale clinical and public studies at regional and national level.

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General instructions

1. Attempt all question properly & encircle appropriate response of each question by pencil only.
2. Clarify questions to the respondents accordingly but if the questions need to jump follow skip based accordingly.
3. Only one female from one household (believed that there may be information sharing), but if respondent are not volunteer, continue to the next respondent.
4. Keep respondents privacy depending on their age, culture and religion, in addition care should be taken on asking of some sensitive questions
5. Data should be collected responsibly, avoid unreadable and illegible information if need arise correct on time

Part 1 -Socio demographic data

Instructions

1. Use full years for those deserved questions
2. Clarify questions on income, education and age of intercourse to the respondents accordingly

CODE	QUESTIONS	CATEGORIES	SKIP
101	How old are you? Years	
102	How is you marital status?	1. Single 2. Married 3. Divorced 4. Widowed 88. Refuse to respond	
103	At what age did you married	1. Before 18 years 2. After 18 years 3. Not yet married 88. Refuse to respond	
104	To what level are you educated?	1. No formal education 2. Primary education (1- 8) 4. Secondary education(9-12) 5 Tertiary education (>12 grade) 88. Refuse to respond	
105	What is your occupation?	1. House wife 2 Student. 3. Government employee 4. Private employee 5. Merchant 6. Daily laborer 7. Non-government employee. 8. Other 88. Refuse to respond	
106	How much money do you get per month? birr	
107	Who is your individual financial source?	1. Self 2. Husband 3. Family, relative/s and others	
108	At what age did you had first intercourse?	1. Before 18 years 2. After 18 years 3. Yet to start intercourse 88. Refuse to	
109	How money children do you have	1. One 2.Two 3. Three 4. >=4 5. I didn't have 88. Refuse to respond	

Part 2. Utilization of cervical cancer screening

Instructions

1. Try to ask individual current and past experience on cervical cancer screening carefully.
2. Explanation needed based on respondent age and level of education.

CODE	QUESTIONS	CODING CATEGORIES	SKIP
110	Have you ever screened for cervical cancer?	1. Yes 2. No 88. Refuse to respond	If No, go to 114
111	How many times do you had cervical screened?	1. Once 2. Two times 3. More than two 88. Refuse to respond	
112	When was the last time you had CC screened?	1. past two years 2. past three years 3. past five years 4. past ten years 5. I don't remember 88. Refuse to respond	
113	What was the reason for undergone cervical cancer screening?	1. Media 2.H/ professional advise 3. Personal initiation 4. Literature reading 5. Friend advice 6. Family advice 7. Other88. Refuse to respond	
114	If not screened!, What was the reason/s?	1. Not have information 2. Being of healthy 3. Not decided 4. Other 88. Refuse to respond	If 110 Yes, skip 114
115	Have you ever have interest on cervical cancer screening test?	1. Yes 2. No 88. Refuse to respond	
116	Have you ever have plan on cervical cancer screening test?	1. Yes 2. No 88. Refuse to respond	
117	Have you ever made effort to get cervical cancer screening test?	1. Yes 2. No 88. Refuse to respond	
118	Have you ever got any advice on cervical cancer screening?	1. Yes 2. No 88. Refuse to respond	

Part 3. Individual associated factors on cervical cancer and screening

Instructions

1. Carefully ask knowledge based question of cervical cancer and screening separately
2. If the respondent/s have no information on cervical cancer and screening jump to the next question accordingly

3.1 Knowledge on cervical cancer

CODE	QUESTIONS	CATEGORIES			SKIP
119	Have you ever heard of cervical cancer?	1. Yes	2. No	88. Refuse to respond	If No go to 122
120	If yes!, Do you know about the risk factors of cervical cancer?	1. Yes	2. No	88. Refuse to respond	If No to 121
120A	Do you think multiple sexual partners contact can be the risk factor?	1. Yes	2. No	88. Refuse to respond	
120B	Do you think early age sexual intercourse can be the risk factor for cervical cancer?	1. Yes	2. No	88. Refuse to respond	
120C	Do you think HPV can be the risk factor for cervical cancer?	1. Yes	2. No	88. Refuse to respond	
121	Do you know prevention measures for cervical cancer?	1. Yes	2. No	88. Refuse to respond	If No to 122
121A	Do you think that early cervical cancer screening preventive measure?	1. Yes	2. No	88. Refuse to respond	
121B	Do you think that avoid multiple sexual partner (> one partner) is one of preventive measure?	1. Yes	2. No	88. Refuse to respond	
121C	Do you think that avoid early age sexual contact is preventive measure?	1. Yes	2. No	88. Refuse to respond	
121D	Do you think that vaccination preventive measure?	1. Yes	2. No	88. Refuse to respond	

122	Do you ever heard of cervical cancer screening?	1. Yes	2. No	88. Refuse to respond	If No to 124
123	If yes!, do you know the importance of cervical cancer screening?	1. Yes	2. No	88. Refuse to respond	
123A	Is screening important for married women only?	1. Yes	2. No	88. Refuse to respond	
123B	Is screening important for unmarried women only?	1. Yes	2. No	88. Refuse to respond	
123C	Is screening important for all women?	1. Yes	2. No	88. Refuse to respond	

3.2 Attitude on cervical cancer and screening

Instructions

1. Ask their attitude on cervical cancer and screening in positive aspect
2. Explanation needed based on the attitude questions

3.2.1 Perceived susceptibility					
CODE	QUESTIONS	CODING CATEGORIES		SKIP	
124	Do you think that you may be at risk of cervical cancer?	1. Strongly disagree	2. Disagree	3. Undecided, 4. Agree 5. Strongly agree 88. Refuse to respond	
125	Do you think, there may be possible risk for cervical cancer?	1. Strongly disagree	2. Disagree	3. Undecided, 4. Agree 5. Strongly agree 88. Refuse to respond	
126	Do you think that unprotected sexual contact may be the risk for cervical cancer?	1. Strongly disagree	2. Disagree	3. Undecided, 4. Agree 5. Strongly agree 88. Refuse to respond	
127	Do you think that your fiancé may become possible risk factor to you for cervical cancer?	1. Strongly disagree	2. Disagree	3. Undecided, 4. Agree 5. Strongly agree 88. Refuse to respond.	
128	Do you think that STI may be the risk factors for cervical cancer?	1. Strongly disagree	2. Disagree	3. Undecided, 4. Agree 5. Strongly agree 88. Refuse to respond	

3.2.2 Perceived severity			
CODE	QUESTIONS	CODING CATEGORIES	SKIP
129	Do you think that cervical cancer is severe disease?	1. Strongly disagree 2. Disagree 3.Undecided, 4. Agree 5. Strongly agree 88. Refuse to respond	
130	Do you think that cervical cancer is fatal?	1. Strongly disagree 2. Disagree 3.Undecided, 4. Agree 5. Strongly agree 88. Refuse to respond	
131	Do you think that cervical cancer have no good chance of cure?	1. Strongly disagree 2. Disagree 3.Undecided, 4. Agree 5. Strongly agree 88. Refuse to respond	
132	Do you think that cervical cancer can lead to advanced stage if not detected early?	1. Strongly disagree 2. Disagree 3.Undecided, 4. Agree 5. Strongly agree 88. Refuse to respond	
133	Do you think that cervical cancer can have severe pain at late stage, if not detected early?	1. Strongly disagree 2. Disagree 3.Undecided, 4. Agree 5. Strongly agree 88. Refuse to respond	
3.2.3 Perceived benefits			
CODE	QUESTIONS	CODING CATEGORIES	SKIP
134	Do you believe cervical cancer screening test beneficiary for once health?	1. Strongly disagree 2. Disagree 3.Undecided, 4. Agree 5. Strongly agree 88. Refuse to respond	
135	Do you feel sense of safe if once having cervical cancer screening test?	1. Strongly disagree 2. Disagree 3.Undecided, 4. Agree 5. Strongly agree 88. Refuse to respond	
136	Do you believe cervical cancer screening help to detect pre-cancerous?	1. Strongly disagree 2. Disagree 3.Undecided, 4. Agree 5. Strongly agree 88. Refuse to respond	
137	Do you believe that early cervical cancer screening can reduce late complication of the disease?	1. Strongly disagree 2. Disagree 3.Undecided, 4. Agree 5. Strongly agree 88. Refuse to respond	
138	Do you believe early cervical cancer screening is beneficiary for all female?	1. Strongly disagree 2. Disagree 3.Undecided, 4. Agree 5. Strongly agree 88. Refuse to respond	

3.2.4 Perceived barriers			
CODE	QUESTIONS	CODING CATEGORIES	SKIP
139	Do you think that cervical cancer screening expensive?	1. Strongly disagree 2. Disagree 3. Undecided, 4. Agree 5. Strongly agree 88. Refuse to respond	
140	Do you think that cervical cancer screening time consuming?	1. Strongly disagree 2. Disagree 3. Undecided, 4. Agree 5. Strongly agree 88. Refuse to respond	
141	Do you think that cervical cancer screening service accessible?	1. Strongly disagree 2. Disagree 3. Undecided, 4. Agree 5. Strongly agree 88. Refuse to respond	
142	Do you think that cervical cancer screening complex procedure?	1. Strongly disagree 2. Disagree 3. Undecided, 4. Agree 5. Strongly agree 88. Refuse to respond	
143	Do you think that cervical cancer screening test is embarrassing?	1. Strongly disagree 2. Disagree 3. Undecided, 4. Agree 5. Strongly agree 88. Refuse to respond	
3.3 Risk and related factors for cervical cancer and screening			
CODE	QUESTIONS	CODING CATEGORIES	SKIP
144	Is there history of family or relative with cervical cancer?	1. Yes 2. No 88. Refuse to respond	
145	Do you believe that showing your cervix for screen is culturally not acceptable?	1. Yes 2. No 88. Refuse to respond	
146	Do you use any form of Hormonal contraceptives?	1. Yes 2. No 88. Refuse to respond	
147	Do you have a history of HIV testing?	1. Yes 2. No 88. Refuse to respond	
148	Do you have history of STI testing?	1. Yes 2. No 88. Refuse to respond	
149	Do you any habit of substances use?	1. Yes 2. No 88. Refuse to respond	If no to 142
150	If, Yes which type do you use	1. Smoking 2. Drinkig(>1/each day 3. khat chewing 4. Protected elite drugs 5. Other 88. Refuse to respond	

Part 4. Community associated factors on cervical cancer screening

Instructions

1. Social institution means: “Edir”, “Baltina”, “Ekub” and the like...
2. Local media means: Area based information dissemination through audio or audio-video.
3. Explain and elaborate the questions based on age, educational status and etc...

CODE	QUESTIONS	CODING CATEGORIES			SKIP
151	Did you heard on cervical cancer and screening from the any media?	1. Yes	2. No	88. Refuse to respond	
152	Did you ever got information on cervical cancer and screening from any literatures?	1. Yes	2. No	88. Refuse to respond	
153	Did you heard or made any discussion on cervical cancer and screening among your community?	1. Yes	2. No	88. Refuse to respond	
154	Did you heard any information on cervical cancer and screening from social institution/s?	1. Yes	2. No	88. Refuse to respond	
155	Did you discussed on cervical cancer and screening among your family and/or relatives?	1. Yes	2. No	88. Refuse to respond	
156	Did you discussed on cervical cancer and screening among your friends?	1. Yes	2. No	88. Refuse to respond	
157	Did you get information on cervical cancer and screening from educational centers?	1. Yes	2. No	88. Refuse to respond	
158	Did you get advice to screen for cervical cancer from your friends, family and relatives?	1. Yes	2. No	88. Refuse to respond	

Part 5. Health organization associated factors on cervical cancer and screening

Instructions

1. Advocacy mean: any cervical cancer and screening information, motivation, initiation.
2. Explanation will be needed based on their age, educational status and other situation.
3. Health professional/s advice or education should be considered within the organization and outside of the organization
4. Health professional/s unethical behavior should be considered as any unacceptable and violence of human rights.

CODE.	QUESTIONS	CODING CATEGORIES			SKIP
159	Do you know the availability of cervical cancer screening test service in health organization/s?	1. Yes	2. No	88. Refuse to respond	If no g to 161
160	Is there nearby health organization which giving cervical cancer screening service?	1. Yes	2. No	88. Refuse to respond	
161	Did you heard of any advocacy on cervical cancer screening service from your nearby health organization/s?	1. Yes	2. No	88. Refuse to respond	
162	Did you get any advice or education on screening from any health professional/s?	1. Yes	2. No	88. Refuse to respond	
163	Do you believe that health professionals may have unethical behavior that can affect on screening service utilization?	1. Yes	2. No	88. Refuse to respond	

ANNEX II Quantitative questionnaire (Amharic version)

ስለ ማህጸን በር ካንሰር በሽታ እና ምርመራ መጠይቅ

በጅም ዩኒቨርሲቲ፣ የጤና ት/ርት ክፍል፣ የኢፒ ዲሞሎጂ ዲፓርትመንት

በደቡብ ኢትዮጵያ በቡታጅራ ከተማ ውስጥ በመራባት የዕድሜ ክልል ውስጥ በሚገኙ ሴቶች ላይ የማህጸን በር ካንሰር ምርመራ እና ተዛማጅ ነባራዊ ሁኔታዎችን መጠይቅ.

በመረጃ ሰብሳቢዎች የሚሞላ

ለደንበኛ ሰላምታ መስጠት!

እኔ ስሜይባላል, ሙያዬ ሲሆን እኔ የመጣሁት ጤና ድርጅት ነው። በጎ ፈቃድ ከሆነ በመራባት የዕድሜ ክልል ውስጥ ለሚገኙ ሴቶች የማህጸን በር ካንሰር ምርመራ እና ተዛማጅ ነባራዊ ሁኔታዎችን ለጥቂት ደቂቃዎች ልንጠይቅዎት/ሽ እፈልጋለሁ ፍቃደኛ ከሆኑ ከልብ እያመሰገንኩኝ የሚሰጡት ማንኛውም መረጃ በምስጢር ተጠብቆ የሚቆይ ሲሆን ስምዎትም/ሽም አይመዘገብም። የመጠይቁ ዋና አላማ በጅም ዩኒቨርሲቲ ለሁለተኛ ዲግሪ /ማስተር/ መርሃግብር ለሚከናወን ጥናት አላማ ነው።

የዚህ ጥናት አላማ በደቡብ ኢትዮጵያ በቡታጅራ ከተማ ውስጥ በመራባት የዕድሜ ክልል ውስጥ በሚገኙ ሴቶች ላይ የማህጸን በር ካንሰር ምርመራ እና ተዛማጅ ነባራዊ ሁኔታዎችን ለመጠየቅ ብሎም እንደአስፈላጊነቱ ለሚመለከተው ክፍል ተገቢውን መረጃ በማሳወቅ የማህጸን በር ካንሰር ምርመራ አገልግሎትን ለማጠናከር እና ለማሻሻል እንዲረዳ ነው። ስለሆነም የእርስዎ መረጃ እጅግ በጣም ጠቃሚ ነው።

ለመቀጠል ፈቃደኛ ነዎት? አዎ አይ

የደንበኛው የመለያ ቁጥር

የጠያቂው ስም ፊርማ

የተቆጣጣሪ ስም ፊርማ

አጠቃላይ መመሪያ

1. ሁሉንም ጥያቄ ሙሉ በሙሉ በአግባቡ ይጠይቁ እና የተሰጡ ምላሾችን በአግባቡ በእርሳስ ብቻ ይክበቡ/ክበቧ
2. እንደ ሁኔታዎች ጥያቄዎችን ለተጠያቂዎች ማብራራት ያስፈልጋል ነገር ግን ጥያቄው የማይመለከታቸው ከሆነ እንደ አስፈላጊነቱ ይዘለል
3. ከአንድ ቤተሰብ አንድ ሴት ብቻ ይጠይቁ (መረጃ መለዋወጥ ይኖራል ተብሎ ይገመታል) ነገር ግን ምላሽ ሰጪ ፈቃደኛ ካልሆኑ ወደ ቀጣዩ ተጠያቂ ይቀጥሉ.
4. የተጠያቂዎችን መብት እና ነጻነት እንደ እድሜያቸው፣ ባህላቸው እና ሀይማኖታቸው ይጠበቅ፡ በተጨማሪም አንዳንድ ለተጠያቂዎችን ግልጽ ለመናገር የሚያዳግቱ ጥያቄዎችን በጥንቃቄ ይጠይቁ
5. መጠይቁን በአግባቡ ይሙሉ፤ ስርዝ ድልዝ መረጃ እንዳይኖር ጥንቃቄ ይደረግ ፣ ምናልባት ማስተካከል ካስፈለገ በወቅቱ ወዲያውኑ ይከናወን

ክፍል አንድ - ስነ ማህበራዊ ሁኔታ መረጃ

መመሪያ

1. አመትን ላካተቱ ጥያቄዎች ሙሉ አመትን ተጠቀሙ/ሚ
2. ገቢን፣ የትምህርት ደረጃን፣ ለመጀመሪያ ጊዜ ግብረ ስጋ ግንኙነት የተፈጸመነት እድሜ የሚጠየቁ ጥያቄዎች ላይ እንደ አስፈላጊነቱ ዝርዝር ማብራሪያ ይሰጥ

ኮድ	ጥያቄ	የመጠይቅ ዝርዝር ምርጫ	ዝላ
101	እድሜዎ/ሽ ስንት ነው? ዓመት	
102	የጋብቻ ሁኔታ እንዴት ነው?	1. ያላገባች 2. ያገባች 3. የተፋታች 4. ባል የሞተባት 88. ምላሽ ያለመስጠት	
103	በስንት ዓመት/ሽ/ዎ አገባሽ/ቡ?	1. 18 ዓመቱ በፊት 2. 18 ዓመቱ በኋላ 3. ገና አላገባሁም 88. ምላሽ ያለመስጠት	
104	እስከ ምን ደረጃ ተምረሻል/ዋል?	1. መደበኛ ትምህርት የለም 2. የመጀመሪያ ደረጃ ትምህርት (1-4) 3. ጁኒየር ትምህርት (5- 8) 4. የሁለተኛ ደረጃ ትምህርት (9-12) 5 ከፍተኛ ትምህርት (> 12 ኛ ክፍል) 88. ምላሽ ያለመስጠት	
105	ሥራሽ/ዎ ምንድነው?	1. የቤት . እመቤት 2. ተማሪ 3. የመንግስት ሰራተኛ 4. የግል ሰራተኛ 5. ነጋዴ 6. የቀን ሰራተኛ 7. መንግስታዊ ያልሆነ ድርጅት ሰራተኛ 8. ሌላ 88. ምላሽ ያለመስጠት	
106	በ ወር ምን ያህል ገቢ ታገለግሻለሽ/ ያገኛሉ? ብር	
107	የእርስዎ/ ያንቺ የገቢ ምንጭ ማነው?	1. እራሴ. 2. ባለቤቱ 3. ቤተሰብ ዘመድ እና ሌላ 88. ምላሽ ያለመስጠት	
108	የመጀመሪያው ያታ ግንኙነት የፈጸመሽ.ወ./ሙት በስንት አመት/ሽ/ዎ ነበር?	1. 18 ዓመቱ በፊት 2. 18 ዓመቱ በኋላ 3. ገና አልፈጸምኩም 88. ምላሽ ያለመስጠት	
109	ስንት ልጅ አለዎት/ሽ?	1. አንድ 2. ሁለት 3. ሶስት 4. አራት እና ከዚያ በላይ 5. ልጆች የሉኝም 88. ምላሽ ያለመስጠት	

ክፍል ሁለት: የማህጸን በር ካንሰር ምርመራ የማድረግ ልምድ መመሪያ

1. በዚህ ክፍል የወክቱን እና ያለፈውን ማህጸን በር ካንሰር ምርመራ ልምድ በጥንቃቄ ይጠይቁ/ጠይቁ
2. እንደ ተጠያቂ/ዋ የእድሜ እና ትምህርት ደረጃ ዝርዝር ገለጻ ይሰጥ

ኮድ	ጥያቄ	የመጠይቅ ዝርዝር ምርጫ	ዝለል
110	የማህጸን በር ካንሰር ምርመራ አድርገው ያውቃሉ/ታውቁያለሽ?	1. አዎ 2. አይ 88. ምላሽ ያለመስጠት	አይከሆን ወደ 114
111	ምን ያክል ጊዜያት የማህጸን በር ካንሰር ምርመራ አድርገው ያውቃሉ/ታውቁያለሽ?	1. አንድ ጊዜ 2. ሁለት ጊዜ 3. ከሁለት በላይ 88. ምላሽ ያለመስጠት	
112	የማህጸን በር ካንሰር ምርመራ ለመጨረሻ ጊዜ ያደረጉት/ግሽው መቼ ነበር?	1. ባለፉት ሁለት ዓመታት 2. ባለፉት ሦስት ዓመታት 3. ባለፉት አምስት ዓመታት 4. በአለፉት አስር ዓመታት ውስጥ 88. ምላሽ ያለመስጠት	
113	አዎ ከሆነ! ምርመራውን ያከናውኑት/ንሸበት ምክንያት ምን ነበር?	1. መገናኛ ብዙዓን 2. የጤና ባለሙያ ምክር 3. የግል ፍላጎት 4. ስነፅሁፍ መረጃ 5. የጓደኞች ምክር 6. የቤተሰብ ምክር 7. ሌላ 88. ምላሽ ያለመስጠት	
114	የማህጸን በር ካንሰር ምርመራ እስካሁን ካላደረጉ ያላደረጉት/ሸበት ምክንያት ምን ነበር?	1. መረጃ ባለማግኘት 2. ጤነኛ ስለሆኑኩኝ 3. ስላልወሰንኩኝ 4. ሌላ 88. ምላሽ ያለመስጠት	110 አዎ ከሆነ 114 ይዘለል
115	የማህጸን በር ካንሰር ምርመራ ለመመርመር ፍላጎት ነበረዎት/ሽ ?	1. አዎ 2. አይ 88. ምላሽ ያለመስጠት	
116	የማህጸን በር ካንሰር ምርመራ ለማድረግ ዕቅድ ኖሮዎት/ሽ ያውቃል?	1. አዎ 2. አይ 88. ምላሽ ያለመስጠት	
117	የማህጸን በር ካንሰር ምርመራ ለማድረግ ጥረት አድርገው/ሽ ያውቃሉ/ታውቁያለሽ?	1. አዎ 2. አይ 88. ምላሽ ያለመስጠት	
118	ስለ ማህጸን በር ካንሰር ምርመራ ምክርም አግኝተው/ሽ ያውቃሉ/ታውቁያለሽ?	1. አዎ 2. አይ 88. ምላሽ ያለመስጠት	አይ ከሆነ ወደ 119

ክፍል. ሦስት ስለ ማህጸን በር ካንሰር እና ምርመራ ግለሰብ ተኮር እና ተዛማጅ ሁኔታዎች መመሪያ

1. ስለ ማህጸን በር ካንሰር እና ምርመራ ግንዛቤ በጥንቃቄ ለየብቻ ይጠይቁ/ጠይቁ
2. ተጠቂዎች ስለ ማህጸን በር ካንሰር እና ምርመራ ምንም አይነት ግንዛቤ ከሌላቸው እንደ ሁኔታው ወደሚቀጥለው ጥያቄ ይሸጋገሩ/ተሸጋገሪ

3.1.1 ስለ ማህጸን በር ካንሰር እና ምርመራ ግንዛቤ

ኮድ	ጥያቄ	የመጠይቅ ዝርዝር ምርጫ			ዝላል
119	ስለ ማህጸን በር ካንሰር ሰምተው/ሸታዉቁያለሽ/ ያውቃሉ?	1. አዎ	2. አይ	88. ምላሽ ያለመስጠት	አይ ከሆነ ወደ 122
120	አዎ ከሆነ!፣ ስለ መንስኤዎች ታዉቁያለሽ/ ያውቃሉ?	1. አዎ	2. አይ	88. ምላሽ ያለመስጠት	አይ ከሆነ ወደ 121
120ሀ	ከብዙ ሰዎች ጋር የግብረ ሥጋ ግንኙነት መፈጸም ለማህጸን ካንሰር ያጋልጣል ብለው ታስቢያለሽ/ ያስባሉ?	1. አዎ	2. አይ	88. ምላሽ ያለመስጠት	
120ለ	በሌጋ እድሜ የጾታ ግንኙነት መፈጸም ለማህጸን ካንሰር ያጋልጣል ብለው ታስቢያለሽ/ ያስባሉ?	1. አዎ	2. አይ	88. ምላሽ ያለመስጠት	
120ሐ	HPV ለማህጸን ካንሰር ያጋልጣል ብለው ታስቢያለሽ/ ያስባሉ?	1. አዎ	2. አይ	88. ምላሽ ያለመስጠት	
121	ስለ ማህጸን በር ካንሰር መከላከያ ዘዴዎች ታዉቁያለሽ/ ያውቃሉ?	1. አዎ	2. አይ	88. ምላሽ ያለመስጠት	አይ ከሆነ ወደ 122
121ሀ	አስቀድሞ መመርመር የመከላከያ ዘዴ ነው ብለው ታስቢያለሽ/ ያስባሉ?	1. አዎ	2. አይ	88. ምላሽ ያለመስጠት	
121ለ	ከብዙ ሰዎች ጋር የግብረ ሥጋ ግንኙነት አለመፈጸም የመከላከያ ዘዴ ነው ብለው ታስቢያለሽ/ ያስባሉ?	1. አዎ	2. አይ	88. ምላሽ ያለመስጠት	
121ሐ	በሌጋ እድሜ ከየግብረ ሥጋ ግንኙነት መታቀብ የመከላከያ ዘዴ ነው ብለው ታስቢያለሽ/ ያስባሉ?	1. አዎ	2. አይ	88. ምላሽ ያለመስጠት	
121መ	ክትባት የመከላከያ ዘዴ ነው ብለው ታስቢያለሽ/ ያስባሉ?	1. አዎ	2. አይ	88. ምላሽ ያለመስጠት	

122	ስለ ማህጸን በር ካንሰር ምርመራ ሰምተው ያውቃሉ/ ታወቁያለሽ?	1. አዎ	2. አይ	88. ምላሽ ያለመስጠት	አይ ከሆነ ወደ 124
123	አዎ ከሆነ ማህጸን በር ካንሰር ምርመራ ማድረግ ይጠቅማል?	1. አዎ	2. አይ	88. ምላሽ ያለመስጠት	
123A	የማህጸን በር ካንሰር ምርመራ ማድረግ ለባለትዳር ሴቶች ብቻ ይጠቅማል?	1. አዎ	2. አይ	88. ምላሽ ያለመስጠት	
123B	የማህጸን በር ካንሰር ምርመራ ማድረግ ላላገቡ ሴቶች ብቻ ጠቅማል?	1. አዎ	2. አይ	88. ምላሽ ያለመስጠት	
123C	የማህጸን በር ካንሰር ምርመራ ማድረግ ለሁሉም ሴቶች ይጠቅማል?	1. አዎ	2. አይ	88. ምላሽ ያለመስጠት	

3.2 ስለ ማህጸን በር ካንሰር እና ምርመራ አመለካከት

መመሪያ

1. ስለ ማህጸን በር ካንሰር እና ምርመራ ያላቸውን አመለካከት በአወንታዊ መልኩ ይጠይቁ/ጠይቁ
2. እንደ አመለካከት ጥያቄ ማብራሪያ መስጠት ያስፈልጋል
3. ተጠያቂ/ዎች የአመለካከት ምድባቸውን እንዲመርጡ እና እንዲወስኑ አቅጣጫ መጠቀም

3.2.1 ተጋላጭነትን ከማሰብ አንጻር

ኮድ	ጥያቄ	የመጠይቅ ዝርዝር ምርጫ	ዝላል
124	ለማህጸን በር ካንሰር ተጋላጭ ነኝ ብለው ያስባሉ/ታስቢያለሽ?	1. በጣም አልስማማም 2. አልስማማ 3. መወሰን የሚከብድ 4. እስማማለሁ 5. በጣም እስማማለሁ 88. ምላሽ ያለመስጠት	
125	ለማህጸን በር ካንሰር አጋላጭ የሆኑ ሁኔታዎች አለው ብለው ያምናሉ/ታምናሉ?	1. በጣም አልስማማም 2. አልስማማ 3. መወሰን የሚከብድ 4. እስማማለሁ 5. በጣም እስማማለሁ 88. ምላሽ ያለመስጠት	
126	ጥንቃቄ የሰጠው የግብረ ሥጋ ግንኙነት ለማህጸን በር ካንሰር እንዲከሰት አጋላጭ ምክንያት ነው ብለው ያምናሉ/ታምናሉ?	1. በጣም አልስማማም 2. አልስማማ 3. መወሰን የሚከብድ 4. እስማማለሁ 5. በጣም እስማማለሁ 88. ምላሽ ያለመስጠት	
127	የፍቅር አጋሬ ምናልባት ለማህጸን በር ካንሰር አጋላጭ ምክንያት ሊሆን ይችላል ብለው/ሽ ያስባሉ/ታስቢያለሽ?	1. በጣም አልስማማም 2. አልስማማ 3. መወሰን የሚከብድ 4. እስማማለሁ 5. በጣም እስማማለሁ 88. ምላሽ ያለመስጠት	
128	የመራቢያ አካል በሽታዎች ምናልባት ለማህጸን በር ካንሰር ሊያጋልጡ ይችላሉ ብለው/ሽ ያስባሉ/ታስቢያለሽ?	1. በጣም አልስማማም 2. አልስማማ 3. መወሰን የሚከብድ 4. እስማማለሁ 5. በጣም እስማማለሁ 88. ምላሽ ያለመስጠት	

3.2.2 አደገኛነትን ከማሰብ አንጻር

ኮድ	ጥያቄ	የመጠይቅ ዝርዝር ምርጫ	ዝላል
129	የማህጸን በር ካንሰር አደገኛ በሽታ ነው ብለው/ሽ ያስባሉ/ ታስቢያለሽ?	1. በጣም አልስማማም 2. አልስማማ 3. መወሰን የሚከብድ 4. እስማማለሁ 5. በጣም እስማማለሁ 88. ምላሽ ያለመስጠት	
130	የማህጸን በር ካንሰር ሞትን የሚያስከትል ነው ብለው/ሽ ያስባሉ/ ታስቢያለሽ?	1. በጣም አልስማማም 2. አልስማማ 3. መወሰን የሚከብድ 4. እስማማለሁ 5. በጣም እስማማለሁ 88. ምላሽ ያለመስጠት	
131	የማህጸን በር ካንሰር በጊዜ በምርመራ ካልታወቀ የሙዳን ዕድል የለውም ብለው ያስባሉ/ታስቢያለሽ	1. በጣም አልስማማም 2. አልስማማ 3. መወሰን የሚከብድ 4. እስማማለሁ 5. በጣም እስማማለሁ 88. ምላሽ ያለመስጠት	
132	የማህጸን በር ካንሰር በጊዜ በምርመራ ካልታወቀ ወደ ከፍተኛ ደረጃ ሊሸጋገር ይችላል	1. በጣም አልስማማም 2. አልስማማ 3. መወሰን የሚከብድ 4. እስማማለሁ 5. በጣም እስማማለሁ 88. ምላሽ ያለመስጠት	
133	የማህጸን በር ካንሰር በጊዜ በምርመራ ካልታወቀ ወደ ከፍተኛ ስሜት ሊያስከትል ይችላል ብለው/ሽ ያስባሉ/ታስቢያለሽ?	1. በጣም አልስማማም 2. አልስማማ 3. መወሰን የሚከብድ 4. እስማማለሁ 5. በጣም እስማማለሁ 88. ምላሽ ያለመስጠት	

3.2.3 ጥቅምን ከማሰብ አንጻር

ኮድ	ጥያቄ	የመጠይቅ ዝርዝር ምርጫ	ዝላል
134	የማህጸን በር ካንሰር ምርመራ ማድረግ ለ ራስ ጤና ጠቃሚ ነው ብለው ያስባሉ/ ታስቢያለሽ?	1. በጣም አልስማማም 2. አልስማማ 3. መወሰን የሚከብድ 4. እስማማለሁ 5. በጣም እስማማለሁ 88. ምላሽ ያለመስጠት	
135	የማህጸን በር ካንሰር ምርመራ ቢያደረጉ/ ብታደርጉ ደህንነት ይሰማልዎታል/ሻል?	1. በጣም አልስማማም 2. አልስማማ 3. መወሰን የሚከብድ 4. እስማማለሁ 5. በጣም እስማማለሁ 88. ምላሽ ያለመስጠት	
136	የማህጸን በር ካንሰር ምርመራ ማድረግ ቅድመ-ካንሰርን ለመለየት ያግዛል ብለው/ ያምናሉ/ታምናላሽ	1. በጣም አልስማማም 2. አልስማማ 3. መወሰን የሚከብድ 4. እስማማለሁ 5. በጣም እስማማለሁ 88. ምላሽ ያለመስጠት	
137	የማህጸን በር ካንሰር ምርመራ ማድረግ ወደፊት ሊከሰት ከሚችል ውስብስብ የበሽታው ጠንቅ መቀነስ ያስችላል ብለው/ሽ ያምናሉ/ታምናላሽ	1. በጣም አልስማማም 2. አልስማማ 3. መወሰን የሚከብድ 4. እስማማለሁ 5. በጣም እስማማለሁ 88. ምላሽ ያለመስጠት	
138	የማህጸን በር ካንሰር ምርመራ ማድረግ ለሁሉም ሴቶች ይጠቅማል ብለው/ሽ ያምናሉ/ ታምናላሽ	1. በጣም አልስማማም 2. አልስማማ 3. መወሰን የሚከብድ 4. እስማማለሁ 5. በጣም እስማማለሁ 88. ምላሽ ያለመስጠት	

3.2.4 ማንቆዎችን ሊሆኑ የሚችሉ ሁኔታዎችን ከማሰብ አንጻር

ኮድ	ጥያቄ	የመጠይቅ ዝርዝር ምርጫ	ዝላል
139	የማህጸን በር ካንሰር ምርመራ ውድ ነው ብለው/ሽ ያምናሉ/ታምኛሉ?	1. በጣም አልስማማም 2. አልስማማ 3. መወሰን የሚከብድ 4. እስማማለሁ 5. በጣም እስማማለሁ 88. ምላሽ ያለመስጠት	
140	የማህጸን በር ካንሰር ምርመራ ጊዜ ይወስዳል ብለው/ሽ ያምናሉ/	1. በጣም አልስማማም 2. አልስማማ 3. መወሰን የሚከብድ 4. እስማማለሁ 5. በጣም እስማማለሁ 88. ምላሽ ያለመስጠት	
141	የማህጸን በር ካንሰር ምርመራ አገልግሎት ተደራሽ ነው ብለው/ሽ ያምናሉ/ታምኛሉ?	1. በጣም አልስማማም 2. አልስማማ 3. መወሰን የሚከብድ 4. እስማማለሁ 5. በጣም እስማማለሁ 88. ምላሽ ያለመስጠት	
142	የማህጸን በር ካንሰር ምርመራ ሂደት ውስብስብ ነው ብለው/ሽ ያምናሉ/ታምኛሉ?	1. በጣም አልስማማም 2. አልስማማ 3. መወሰን የሚከብድ 4. እስማማለሁ 5. በጣም እስማማለሁ 88. ምላሽ ያለመስጠት	
143	የማህጸን በር ካንሰር ምርመራ ማድረግ የሚያሳፍር ነው ብለው/ሽ ያምናሉ/ ታምኛሉ?	1. በጣም አልስማማም 2. አልስማማ 3. መወሰን የሚከብድ 4. እስማማለሁ 5. በጣም እስማማለሁ 88. ምላሽ ያለመስጠት	

3.3 ለማህጸን በር ካንሰር አጋላጭ እና ከምርመራ ጋር ተዛማጅነት ያላቸው ሁኔታዎች

ኮድ	ጥያቄ	የመጠይቅ ዝርዝር ምርጫ	ዝላል
144	ከቤተሰብ ወይም ከዘመድ በማህጸን በር ካንሰር ታሞ የሚያውቅ ነበረ?	1. አዎ 2. አይ 88. ምላሽ ያለመስጠት	
136	ለማህጸን በር ካንሰር ምርመራ ሂደት ሀፍረተ ስጋዎን/ሽ ማሳየት የባህል ተጸእኖ ይኖረዋል ብለው/ሽ ያስባሉ/ታስቢያሉ?	1. አዎ 2. አይ 88. ምላሽ ያለመስጠት	
137	ዘመናዊ የቤተሰብ ምጣኔ አገልግሎት ይጠቀማሉ/ ትጠቀሟል?	1. አዎ 2. አይ 88. ምላሽ ያለመስጠት	
138	ባለፉት 5 ዓመታት ውስጥ ለኤች አይ ቪ/ኤድስ ምርመራ	1. አዎ 2. አይ 88. ምላሽ ያለመስጠት	
139	ባለፉት 5 ዓመታት ውስጥ ለአባላዘር በሽታ ምርመራ አድርገው/ሽ ያውቃሉ/ ታውቁያሉ?	1. አዎ 2. አይ 88. ምላሽ ያለመስጠት	
140	የተለያዩ ደባል ሱስ የመጠቀም ልምዶች አለዎት/ሽ?	1. አዎ 2. አይ 88. ምላሽ ያለመስጠት	አይ ከሆነ ወደ 142
141	አዎ ከሆነ የትኛውን ዓይነት ይጠቀማሉ/ትጠቀሟል?	1. ሲጃራ ማጨስ 2. አልኮል መጠጣት 3. ጫት መቃም 4. የተከለከሉ አደንዘዥ መድሃኒቶች 5. ሌላ 88. ምላሽ ያለመስጠት	

ክፍል አራት: ስለ ማህጸን በር ካንሰር እና ምርመራ ማህበረሰብ ተኮር እና ተዛማጅ ሁኔታዎች መመሪያ

1. የማህበረሰብ ተቋም ማለት፤ እድር፤ ባልትና፤ እቁብ እና የመሳሰሉትን ማለት ነው
2. የአካባቢ መገናኛ ብዙሀን ማለት፤ በአካባቢው በድምጽ ወይም በድምጽ እና በምስል መረጃ የሚሰጡ እንደ እድሜ፤ የትምህርት ደረጃ እና ...

ኮድ	ጥያቄ	የመጠይቅ ዝርዝር ምርጫ	ዝላል
151	ስለ ማህጸን በር ካንሰር እና ምርመራ መረጃ ከማንኛውም የአካባቢ ወይም ሀገር አቀፍ መገናኛ ብዙሀን ተላልፎ ሰምተው/ሽ ያውቃሉ/ ታውቁያለሽ?	1. አዎ 2. አይ 88. ምላሽ ያለመስጠት	
152	ስለ ማህጸን በር ካንሰር እና ምርመራ መረጃ ከማንኛውም ስነ ጽሁፍ አንብበው ወይም ሰምተው/ሽ ያውቃሉ/ ታውቁያለሽ?	1. አዎ 2. አይ 88. ምላሽ ያለመስጠት	
153	ስለ ማህጸን በር ካንሰር እና ምርመራ በማህበረሰቡ ውስጥ ሲወራ ሰምተው/ሽ ወይም ተወያይተው ያውቃሉ/ ታውቁያለሽ?	1. አዎ 2. አይ 88. ምላሽ ያለመስጠት	
154	ስለ ማህጸን በር ካንሰር እና ምርመራ መረጃ ከማንኛውም የማህበረሰብ አቀፍ ተቋማት ተላልፎ ሰምተው/ሽ ያውቃሉ/ ታውቁያለሽ?	1. አዎ 2. አይ 88. ምላሽ ያለመስጠት	
155	ስለ ማህጸን በር ካንሰር እና ምርመራ ከቤተሰብ እና/ወይም ከዘመድ ጋር ተወያይተው/ሽ ያውቃሉ/ ታውቁያለሽ?	1. አዎ 2. አይ 88. ምላሽ ያለመስጠት	
156	ስለ ማህጸን በር ካንሰር እና ምርመራ ከጓደኛ ጋር ተወያይተው/ሽ ያውቃሉ/ ታውቁያለሽ?	1. አዎ 2. አይ 88. ምላሽ ያለመስጠት	
157	ስለ ማህጸን በር ካንሰር እና ምርመራ መረጃ ከማንኛውም የትምህርት ተቋም ተላልፎ ሰምተው/ሽ ያውቃሉ/ ታውቁያለሽ?	1. አዎ 2. አይ 88. ምላሽ ያለመስጠት	
158	የማህጸን በር ካንሰር ምርመራ እንዲያድረጉ ከማህበረሰብ ከቤተሰብ ወይም ከዘመድ ወይም ከጓደኛ ምክር አግኝተው/ሽ ያውቃሉ/ ታውቁያለሽ?	1. አዎ 2. አይ 88. ምላሽ ያለመስጠት	

ክፍል አምስት: ስለ ማህጸን በር ካንሰር እና ምርመራ የጤና ድርጅት ተኮር እና ተዛማጅ ሁኔታዎች መመሪያ

1. ቅስቀሳ ማለት፤ ስለ ማህጸን በር ካንሰር እና ምርመራ ማንኛውም መረጃ፤ ማበረታታት፤ ማነሳሳት ማለት ነው
2. እንደ እድሜ፤ የትምህርት ደረጃ እና እነደሁኔታው ጥያቄዎችን ማብራራት እና መግለጽ ያስፈልጋል
3. ከጤና ባለሙያ ምክር ወይም ትምህርት መውሰድ ሲባል፤ በጤና ድርጅት ውስጥ አና ውጪ ያለውን ያካትታል
4. የጤና ባለሙያ ስነ-ምግባር ተብሎ የሚቆጠረው፤ ማንኛውም አይነት የሰብአዊ መብት ጥሰትን ያካትታል

ኮድ	ጥያቄ	የመጠይቅ ዝርዝር ምርጫ			ዝላል
159	የማህጸን በር ካንሰር ምርመራ አገልግሎት በጤና ድርጅቶች መኖሩን ያውቃሉ?	1. አዎ	2. አይ	88. ምላሽ ያለመስጠት	አይ ከሆነ ወደ 161
160	በአቅራቢያዎ/ሽ የማህጸን በር ካንሰር ምርመራ አገልግሎት የሚሰጥ የጤና ድርጅት/ቶች አለ/አሉ?	1. አዎ	2. አይ	88. ምላሽ ያለመስጠት	
161	በአቅራቢያዎ/ሽ ካለ የጤና ድርጅት/ቶች የማህጸን በር ካንሰር ምርመራ አገልግሎት የሚሰጥ መሆኑን ማስታወቂያ ወይም መረጃ ሰምተው ያውቃሉ/ታውቁያለሽ?	1. አዎ	2. አይ	88. ምላሽ ያለመስጠት	
162	ስለ ማህጸን በር ካንሰር ምርመራ ከማንኛውም የጤና ባለሙያ ምክር ወይም ትምህርት አግኝተው/ሽ ያውቃሉ/ታውቁልሰሽ?	1. አዎ	2. አይ	88. ምላሽ ያለመስጠት	
163	የጤና ባለሙያዎች ስነ ምግባር ጉድለት ለማህጸን በር ካንሰር ምርመራ ለመጠቀም እንቅፋት ይሆናል ብለው/ሽ ያስባሉ/ታስቡያለሽ?	1. አዎ	2. አይ	88. ምላሽ ያለመስጠት	

ANNEX-III Qualitative questionnaire (English version)
QUALITATIVE QUESTIONNAIRE FOR CERVICAL CANCER AND SCREENING PRACTICE

In-depth interview

Jimma University institute of Health and faculty of Public health, department of epidemiology
Questionnaires on cervical cancer screening practice and associated factors among
reproductive age groups in Butajira town, southern Ethiopia.

To be filled by data collectors

Greeting to client!

My name is, My
profession is I came from
..... Health organization/university. Here by, if you are volunteer,
I would like to ask you a few questions on cervical cancer screening practice and associated
factors among reproductive age groups. I would be very grateful if you could spend a few
minutes with me to answer questions. The information you give will be kept confidential and
your name will not register. This is only for Jimma University master degree study program.
The purpose of this study is to assess cervical cancer screening practice and associated factors
among reproductive age groups in Butajira town, southern Ethiopia and finally to give
important information to concerned bodies that will help to strengthen and improve screening
service, for this, your information is very important.

Are you volunteer to continue? Yes No

Code number of the client

Interviewer nameDate Signature

Supervisor/investigator name

Cervical cancer and screening questions for in-depth interview to key informants

In-depth interview

- 1 What do you think about utilization of cervical cancer screening test? Have ever screened?
- 2 What do you think about individual associated factors on cervical cancer and screening?
 - 2.1 What information do you have about cervical cancer and screening?
 - 2.2 What is your attitude on cervical cancer and screening?
 - 2.2.1. Perception of susceptibility
 - 2.2.2. Perception of severity
 - 2.2.3. Perception of benefits
 - 2.2.4. Perception of barriers
 - 2.3 What will be others individual associated factors for cervical cancer and screening?
- 3 What do you think about community associated factors on cervical cancer and screening?
4. What do you think about health organization associated factors on cervical cancer & screening?

ANNEX-V Qualitative questionnaire (Amharic version)

ስለ ማህጸን በር ካንሰር በሽታ እና ምርመራ ቃለ- መጠየቅ

በጅም ዩኒቨርሲቲ፤ የጤና ት/ርት ክፍል፤ የኢፒ ዲሞሎጂ ዲፓርትመንት

በደቡብ ኢትዮጵያ በቡታጅራ ከተማ ውስጥ በመራባት የዕድሜ ክልል ውስጥ በሚገኙ ሴቶች ላይ የማህጸን በር ካንሰር ምርመራ እና ተዛማጅ ነባራዊ ሁኔታዎችን መጠይቅ.

በመረጃ ሰብሳቢዎች የሚሞላ

ለደንበኛ ሰላምታ መስጠት!

እኔ ስሜይባላል, ሙያዬ ሲሆን እኔ የመጣሁት ጤና ድርጅት. ነዉ በጎ ፈቃድ ከሆነ በመራባት የዕድሜ ክልል ውስጥ ለሚገኙ ሴቶች የማህጸን በር ካንሰር ምርመራ እና ተዛማጅ ነባራዊ ሁኔታዎችን ለጥቂት ደቂቃዎች ልንጠይቅዎት/ሽ እፈልጋለሁ ፍቃደኛ ከሆኑ ከልብ እያመሰገንኩኝ የሚሰጡት ማንኛውም መረጃ በምስጢር ተጠብቆ የሚቆይ ሲሆን ስምዎትም/ሽም አይመዘገብም። የመጠይቁ ዋና አላማ በጅም ዩኒቨርሲቲ ለሁለተኛ ዲግሪ /ማስተር/ መርሃግብር ለሚከናወን ጥናት አላማ ነው.

የዚህ ጥናት አላማ በደቡብ ኢትዮጵያ በቡታጅራ ከተማ ውስጥ በመራባት የዕድሜ ክልል ውስጥ በሚገኙ ሴቶች ላይ የማህጸን በር ካንሰር ምርመራ እና ተዛማጅ ነባራዊ ሁኔታዎችን ለመጠየቅ ብሎም እንደአስፈላጊነቱ ለሚመለከተው ክፍል ተገቢውን መረጃ በማሳወቅ የማህጸን በር ካንሰር ምርመራ አገልግሎትን ለማጠናከር እና ለማሻሻል እንዲረዳ ነው። ስለሆነም የእርስዎ መረጃ እጅግ በጣም ጠቃሚ ነው.

ለመቀጠል ፈቃደኛ ነዎት? አዎ አይ

የደንበኛው የመለያ ቁጥር

የጠያቂው ስም ፊርማ

የተቆጣጣሪ ስም ፊርማ

ከማህበረሰብ ለተመረጡ ወሳኝ ሴቶች ስለ ማህጸን በር ካንሰር እና ምርመራ ጥልቅ ቃለ-መጠይቅ ለማካሄድ የተዘጋጀ

1. ስለ ማህጸን በር ካንሰር ምርመራ ማድረግ ምን አመለካከት አለዎት/ሽ? ተመርምረሽ ታወቁያለሽ?
2. ስለ ማህጸን በር ካንሰር እና ምርመራ ግለሰብ ተኮር ምክንያቶች ምን ምን ናቸው ብለው ያስባሉ/ታስቢያለሽ?
 - 2.1 ስለ ማህጸን በር ካንሰር እና ምርመራ ምን አይነት መረጃ አለዎት/ሽ?
 - 2.2 ስለ ማህጸን በር ካንሰር እና ምርመራ ምን አይነት አመለካከት አለዎት/ሽ?
 - 2.2.1 ተጋላጭነትን ከማሰብ አንጻር
 - 2.2.2 አደገኛነትን ከማሰብ አንጻር
 - 2.2.3 ጥቅምን ከማሰብ አንጻር
 - 2.2.4 ማነቆዎችን ሊሆኑ የሚችሉ ሁኔታዎችን ከማሰብ አንጻር
 - 2.3 ሌሎች ግለሰብ ተኮር ምክንያቶች ምን ምን ናቸው ብለው ያስባሉ/ታስቢያለሽ?
3. ስለ ማህጸን በር ካንሰር እና ምርመራ ማህበረሰብ ተኮር ምክንያቶች ምን ምን ናቸው ብለው ያስባሉ/ታስቢያለሽ?
4. ስለ ማህጸን በር ካንሰር እና ምርመራ የጤና ድርጅት ተኮር ምክንያቶች ምን ምን ናቸው ብለው ያስባሉ/ታስቢያለሽ?