PREVALENCE OF CERVICAL CANCER SCREENING UTILIZATION AND ASSOCIATED FACTOR AMONG 30-49 YEARS WOMEN WHO ATTEND IN MARRYSTOPS AND FAMLLY GAIDANCE MODDEL CLINIC IN JIMMA TOWN, SOUTH WEST ETHIOPIA

BY; GENET WOLDEKIDAN (BSc N)

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JIMMA, ETHIOPIA

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ADVISOR:

1. **Mr LAKEW ABEBE (ASSOCIATE PROFESSOR)**
2. **SIJI SAM (MSC)**

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Abstract

Background: Cervical cancer is the malignant neoplasm of the cervix). Globally, there are nearly 1.5 million cases of clinically recognized cervical cancer. Eighty five percent (85%) of these are in developing countries like Ethiopia.

Objective: The objective of this study was to asses prevalence of cervical cancer screening utilization and associated factor among 30-49years women in Jimma town, south west Ethiopia .

Methods: An institutional based cross sectional study design was employed on 422 women of age 30-49years war include in the study from both family guidance association and Maries stops clinic through consecutive sampling technique Descriptive statistics and frequency Logistic regression analysis were done. Bivariate analysis with p-value <0.25 considered candidate for multivariate analysis and factors with p-value <0.05 at multivariate logistic regression were considered as significant.

Result: Among 403 respondents, 309 (76.7%) of them were never screened. Mothers who were educated up to grade 5-8 were seven times (AOR=6.798) more likely not to be screened for cervical cancer compared to those with higher level of education. As the Knowledge level of women about cervical cancer increased by one unit surprisingly the chance of getting screening is decreased by 0.25times (AOR:.232.). Women with negative attitude towards the screening practice were 24 times (AOR=24.524) less likely not to be screened cervical cancer compared to those women with positive attitude. For women who had negative spouse support the chance of getting screening was decreased by two (AOR=.2.1811, 95% CI.078, 4.413**)** times as compared to positive spouse support.

Conclusions and Recommendation This study showed that the proportion of screening for premalignant cervical lesions was 23.3%. Low educational level, poor attitude, negative spouse support, poor knowledge, poor provider suggestion and inconvenient time were significantly associated with the screening practice.

Government and non-government organization emphasis on female education. Clinics more focused permanent screening time for researchers- to conduct further researches regarding this issue by using strong study designs like longitudinal studies, healthcare providers need to do promoting cervical cancer screening.

Acknowledgement

First of all I want to thank God the almighty for his blessing and support throughout my life. I would like to express my heartfelt gratitude to Jimma University giving me this opportunity and

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Finally I would like to acknowledge the study participants and data collectors

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List of Acronyms and abervetion

AIDS: Acquired Immune Deficiency Syndrome

Ca: Cancer

Cc: Cervical cancer

DC: Data collector

DNA: Deoxyribo-Nucleic Acids

FGAE: Family Guidance Associations Ethiopia

FMOH: Federal Ministry of Health

HIV: Human Immune Virus

HPV: Human papillomavirus

OPD: Out Patient Department

PAP: Papanicolau

PI: Principal investigator

SSA: Sub-Saharan Africa

UK: United Kingdom

VIA: Visual inspection with acetic acid

VILI: Visual inspection with Lugol‟s iodine

WHO: World Health Organization

CHAPTER ONE- INTRODUCTION

1.1 Background

The cervix is the base part of the uterus, which connects the uterine body to the vagina or the birth canal. Cancers can be caused by DNA (Deoxyribo-Nucleic Acids) mutations (gene defects) that activate cells promoting cell division (oncogenes).Sometimes this could be caused by inactivation of tumour suppressor genes, resulting to abnormal proliferation of cervical cells(6 3).The most important risk factor is Human Papilloma virus (HPV) infection, whereas lack of accessible cervical screening services is a major barrier to screening uptake. Other risk factors are early age at sexual contact, early marriage (below age 20 years), and multiple partners, polygamy, multiparty and lack of awareness of the disease (7). Cervical cancer is attended by huge financial and social burden. It is a social disease especially of the poor and less educated in whom the risk factors are most prevalent. Tanzania is extrapolated to lose between 347.4 and 482.7 million US Dollars each year to cancers (8).Cancer of the cervix occurs when the cells of the cervix grow out of control where malignant cancer cells continue to divide until they form a growth or tumor that may appear as a cauliflower-like growth that bleeds easily on make contact with. If left unnoticed, the cancer cells become invasive, spreading to tissues and organs outside of the cervix such as the bladder, intestines, liver, uterus and ovaries(9, 10). Most cervical cancers develop gradually in the lining of the cervix as pre-cancerous changes known as pre cancer lesions (dysplasia) that can potentially develop into cancer if not treated early, but some lesions may not be malignant and can disappear without treatment (11,12).

1.2. Statements of the problem

Cancer is a major cause of death worldwide Cervical cancer is a leading public health concern globally (1, 2). Although a decline has been observed in cervical cancer incidence and deaths in the developed world over the past 20 years, there has not been a significant change in the same key indicators in poor resource settings (3, 4, 5).

Cervical cancer is the malignant neoplasm of the cervix... While industrialized countries have reduced its incidence by over 70% in the last 50 years, the burden seems to be on the rise in less developed countries. It is expected that the incidence of cervical cancer in developing countries

will rise from 444,546 to 588,922 between 2012 and 2025 (2)Cancer of the cervix is the second most common cancer among women worldwide with an estimated 529,409 new cases and 274,883 deaths in 2008. About 86% of the cases occur in developing countries, representing 13% of female cancers (1, 3). Each year approximately, 10,000 women develop cervical cancer, and about 8,000 women die from cervical cancer in Nigeria (6). In 2008, 12.7 million cases of the disease were diagnosed globally and 7.6 million individuals lost their lives as a result of the condition (1, 2). Spine reported in their study that over half the study population was less than 50 years of age suggesting this disease is responsible for a disproportionately greater loss of life-years and social cost." Records from cancer registry UCH indicate that the incidence is high; it was 353 out of 1942 total malignancies in 2007. Evidence of decline in incidence has been observed from countries like the United States where there are established screening protocols with an estimated 12,710 new cases diagnosed in the US(12) in 2011 and 4,290 reported deaths . Some 80% of cervical cancers occur in developing countries (13). In addition, mortality rate of cervical cancer among Asian women is similar to that of Caucasian women. In 2002–2006, the age-adjusted death rate of among Asian women in the U.S. was 2.2 per 100,000 (vs. 2.2 for stages Caucasians) for cervical cancer (12).Many countries in Asia and Africa face the biggest challenge with half a million new cases of cervical cancer reported yearly which result in 250,000 deaths occurring every year (9, 14).

Cervical cancer is however easily detectable and curable in its early. Unfortunately, Only 5% of women in developing countries undergo screening for cervical cancer compared to over 40% in developed countries and 70% or higher in countries that have shown marked reduction in incidence and prevalence of cervical cancer. It is therefore not surprising that in Africa, where screening rates are very low the majority of women present at late stages with invasive and advanced disease (15). The increasing incidence of cervical cancer is often associated with lack of regular cervical cancer screening and follow-up of abnormalities (12). Previous studies also showed that regular uptake of cancer screening and follow-up reduces the incidence of cervical cancer (5, 16).

The widespread use of the Papanicolau (Pap) screening test for over 50 years has progressively reduced the mortality of disease by 50–60% in high-resource countries(9, 14). However, in developing countries, due to inadequate personnel and deficiencies in health system infrastructure, cervical cancer prevention remains largely opportunistic, often relying on low-resource visual inspection methods using acetic acid (VIA), or Lugol"s iodine (VILI) with a 'see-and-treat' same-

day approach(12, 17).Reported uptake of even these screening services remains low, suggesting that there are barriers preventing women from being screened.

In sub-Saharan Africa (SSA) the magnitude of the problem has been under-recognized and under prioritized compared to competing health priorities such as HIV& AIDS, tuberculosis and malaria. In sub-Saharan Africa, 34.8 new cases of cervical cancer are diagnosed per100, 000 women annually and 22.5% per 100,000 women die from the disease (WHO, 2013). This is due to lack of epidemiological data and poor awareness, lack of human and financial resources, non-existent cancer service policies and lack of political will to address the complex problem (15, 18, and 19).

Cervical cancer is a treatable disease and tertiary interventions have contributed to reductions in mortality rates (7).

However, when downstream activities are combined with preventive efforts, there is greater impact in terms of lives saved. There is widespread acceptance that regular screening is the single most important public health strategy to reduce cervical cancer incidence and subsequent mortality. Screening tests such as conventional cytology (commonly referred to as the Pap smear) are used to identify pre-cancers, which can be treated to prevent the occurrence of invasive cancer or allow the disease to be identified at an earlier stage, permitting more effective treatment. The systematic review on which this paper is based provided evidence for the Canadian Task Force on Preventive Health Care to update their guideline regarding screening of average-risk women for cervical cancer. Much of the recent research has focused on reductions in precursor cervical lesions, which are more common and present earlier outcomes for measurement during trials. (9)

The proportion and uptake of cervical cancer screening remains a major challenge in Malaysia. A cross-sectional study conducted in 2009 showed that the uptake of cervical cancer screening has remained very low while the mortality and morbidity associated with cervical cancer has remained high (10, 11, and 20). On the uptake of Pap smears, there has been no significant increase in the number of Pap smears for the past ten years, as it has constantly ranged from 350,000 to 400,000. The coverage of the Pap smear screening program in 1996 was only 26% (10, 20, and 21).

Given the current situation in Malaysia, this study was conducted to determine the perceived susceptibility to cervical cancer.

Cervical cancer is the most frequent form and leading cause of cancer mortality among Ethiopian women, which account with an overall mortality of 70%. Cervical cancer is often at an advanced stage by the time they seek screening services. Records show that of the 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 (22, 23).As cross sectional study conducted in FGAE in 2013 among 334 screened clients, 43 (12.9 %) were found to have VIA positive result while 287 (85.9 %) had negative test result. The remaining four (1.2 %) were found to have lesions suspicious for cancer. (Jimma (19)

Even though cervical cancer screening is proven to reduce cervical cancer incidence, many factors influence the screening uptake among women. Factors such as poor awareness of the benefits of the Pap smear test, lack of knowledge about cervical cancer and its risk factors, fear of being embarrassed by health care workers, fear of pain and fear of getting a positive result, have become major hindering factors in cervical cancer screening (5,6,22).

Over the years awareness and uptake of cervical cancer screening services has remained poor despite all the studies on cervical cancer screening. Various studies indicate that cervical cancer screening services is poorly utilized and the awareness of the need for it is very low but can be treated if detected early (6, 23). Problems associated with cervical cancer incidence include late reporting, ignorance and cultural issues relating to cervical cancer screening.

The barriers identified by were “ignorance about cervical cancer, cultural constraint/beliefs about illness, economic factors, domestic gender power relations, alternative authoritative sources of reproductive health knowledge and unfriendly health care services”(24).

Women in developing countries like Ethiopia seem to utilize reproductive health services more during pregnancy. They also use reproductive health services for post natal checkup and family planning or when faced with various gynecological problems. It is important to ensure that these women are screened in order reduce incidence of cervical cancer. Their visit to the clinics provides opportunity to give them information on the importance of the screening and where to get the services. The researchers observed that many women attending various health facilities have not been screened. Thus the need to identify the factors influencing utilization of cervical screening services among women in selected Health facilities in Jimma town, Ethiopia.

1.3. Significances of the study

Little is known about the practice and factors associated with cervical cancer screening among women in Ethiopia. Therefore, understanding of the factors associated with underutilization of the cervical cancer screening among women is important in order to increase overall cancer screening rates. Therefore, this study is aimed to determine the practice and associated factors toward the cervical cancer screening among 30-49 years women in Jimma town.

Policymakers can use finding of this study proposal to expand their understanding of current practice and inform future policy development. Researchers can use finding of this study proposal to better understand practices that warrant evaluation and provide context for developing evaluation protocols. The finding of this study proposal also provides rich material for additional inquiry. FGAE, Marie's stops, zonal health bureau, regional health bureau and FMOH can use information from this study to understanding of the factors associated with underutilization of the cervical cancer screening among women. My finding provides a unique insight into the understanding of the factors associated with the utilization of the cervical cancer screening among women of age 30-49 years in Jimma town.

CHPTER TWO: LITERATURE REVIEW

Screening for cervical cancer is the most preventive measure and the purpose of the screening is to detect the early pre-cancerous lesions and treat them before they can develop into invasive cervical cancer (9). Among all the cancers, cervical cancer is the only type that can be totally prevented if there is regular screening and treatment of its pre-cancerous lesions (14, 16). Every woman should be screened at every opportunity of contact with a health professional, at postnatal clinics, STI clinics and gynecological clinics. For women who are sexually active, annual screening from age 18 to 35 years is advised; thereafter every 3 to 5 years, provided the test results remain negative (25). In developed countries where resources are allocated to prevention initiatives, the prevalence and mortality of cervical cancer has fallen between 30% and 75% (20). However, the success of cervical cancer screening initiatives depend on high participation of the targeted group, which is also determined by the women's knowledge, perceptions, attitudes and other socio-cultural issues.

Regular Pap smear testing has been utilized to identify cervical cancer at early stages, and have been shown to be effective in decreasing cervical cancer deaths (9). The success and effectiveness of an organized cancer screening program is largely dependent on obtaining high participation rates through effective recruitment and retention strategies. However, cervical cancer screening rates are consistently low among Asian women, both in Asian and Western countries. In the United States, Asian Americans and Pacific Islanders have the lowest cervical screening rates among all ethnic groups (2). A study published in 2000 reported that compared with21% Asian women (28% Chinese, 8% Japanese, 15% Filipino, 25% Korean, 36% Vietnamese, and 26% Asian Indians) never had a Pap test compared with only 5% of white women in the sample (26). Similar cervical cancer screening rates for Asian women have been reported in countries such as Canada, UK and Australia (2, 8).

Many authors agree that a screening program is important in improving uptake, they strongly argue that other factors like knowledge, attitude of both women and health workers, socioeconomic, cultural beliefs and other supporting institutional factors like sufficient and trained staff supersedes just the availability of an organized screening program (12, 27). Analysis of data from a study conducted in Netherlands showed that women's beliefs about cervical cancer screening and attendance are the best predictors of uptake of the service, even when organizational aspects are taken into account (28, 29). In countries like Chile, Colombia, Costa Rica, Cuba and Mexico which

have been having organized screening programs in place, mortality due to cervical cancer has remained the same or even increased. The reasons for this were reported to be other underlying factors such as inadequate infrastructure, insufficient human resource and lack of education among the masses. The countries have had to go back on the drawing board to address some of those challenges (23, 27).

In a cross-sectional study conducted among clinic attendees in Trelawney, Jamaica in 2007, 18% of women who had never had a Pap smear reported that it was not necessary as it would only increase a woman's anxiety if the results were found to be suggestive of cervical cancer. A survey in Thailand concluded that Asian women, in particular Thai women, believe that it is more beneficial to do Pap smears if one is married, compared to being unmarried (910,)

Several challenges face cervical cancer screening programs and help-seeking for cervical cancer in sub Saharan Africa. The majority of cervical screening programs are opportunistic and are faced with challenges including poor physical access to cervical screening facilities, low level or lack of knowledge about cervical cancer screening and its benefits (12), low level of self-perceived risk for cervical cancer, and understaffed and poorly equipped health facilities and long distances to screening facilities and high transport costs (1).Furthermore, inadequate training and few human resources that are poorly distributed affects effectiveness of cervical screening and management in developing nations(26) .

Persistent stress related to challenging working environments with cancer patients often leads to burnout and poor quality of car (15) as well as low morale and distress to the healthcare professionals. Likewise, lack of knowledge, misconceptions about disease and lack of skills in management of a disease among health professionals may lead to suboptimal care (16). There are limited data from operational healthcare providers on barriers and proposed remedies for cervical cancer care, yet the healthcare providers are well placed to contribute context specific strategies that can catalyze policies on cervical cancer early detection and control. Understanding of local factors influencing care is critical to design of targeted interventions (30) to promote help seeking. For Asian women, barriers to cancer screening utilization include cognitive barriers (knowledge about screening, understanding the purpose of the test, or benefits of testing for early detection), emotional barriers (fear/social stigma), economic barriers (time, taking time off work, insurance coverage), logistic barriers (lack of consistent physician, limited office hours, childcare,

transportation, waiting times, language barriers) and social barriers (support of family and friends, support within the physician's office (2,15).

Socioeconomic disparities influenced participation, and women with lower educational levels and lower household income were less likely to be screened. Despite public health efforts, the rate of cervical cancer screening may not be uniform across groups with different socioeconomic status and socioeconomic disparities existed in cancer screening rates [8,13], and, in particular, global evidence suggested that the cervical cancer screening rate was influenced by socioeconomic factors as well as demographic factors such as race [14-20]. Studies in the United States and Korea also showed that socioeconomic disparities constant in cervical cancer screening participation, though there has been an improvement in overall screening rate [8, 21].

Previous studies have shown that individuals who believed they had risk factors for cervical cancer and perceived vulnerability to an illness were more likely to take action to prevent an adverse outcome subsequent to getting the disease (10).

The perception that one is not at risk of cervical cancer has been verified in previous studies as a reason for not obtaining Pap smear tests (31). The importance of high perceived susceptibility will influence positive perception of the importance of preventive measures. In another cross-sectional survey of (2003), it was found that only 40.0% of participants had Pap smear tests and that the major barriers to obtaining Pap smear tests included inadequate knowledge about the benefits of Pap smear screening, insufficient information about the Pap smear screening procedure, provider's attitudes, and limited access to physicians (5,6).

As cross sectional study conducted in China in 2013 women who were willing to undergo screenings had higher knowledge levels. ''Anxious feeling once the disease was diagnosed'' (47.6%), ''No symptoms/discomfort'' (34.1%) and ''Do not know the benefits of cervical cancer screening'' (13.4%) were the top three reasons for refusing cervical cancer screening. Women who were younger than 45 years old or who had lower incomes, positive family histories of cancer, secondary or higher levels of education, higher levels of knowledge and fewer barriers to screening were more willing to participate in cervical cancer screenings than women without these characteristics (32).

A cross sectional study was conducted with a sample of 354 women aged 18 to 69 years of Tanzania in 2012 less than one quarter (22.6%) of the participants had obtained cervical cancer screening. The following characteristics, when examined separately in relation to the uptake of

cervical cancer screening service, were significant: husband approval of cervical cancer screening, women's level of education, women's knowledge of cervical cancer and its prevention, women's concerns about embarrassment and pain of screening, women's preference for the sex of health provider, and women's awareness of and distance to cervical cancer screening services. Knowledge of cervical cancer and its prevention and distance to the facility which provides cervical cancer screening were significantly associated with screening uptake (33).the study conducted in UK and South Asia show that cultural beliefs and perceptions influence uptake of cervical cancer screening (14,34),.

The studies revealed that black minority ethnic groups in United Kingdom and South Asian women consider cervical cancer as being caused by promiscuity; therefore it is considered a taboo, or a just punishment from God. As a result of these beliefs, a big proportion of women shy away from screening because they do not want to be associated with such a disease that is considered a curse from God. Many other studies have also reported embarrassment when seen seeking care for cervical cancer, stigma, and lowered self-esteem when one receives a negative result (30, 34). Also, a UK based study reported that women had fear of getting abnormal screening results because of worry associated with such results (4).

The women claimed that abnormal results would have severe effect on day to day functioning leading to depressed mood, decreased libido and feeling of less attractive, tarnished, defiled or contaminated and dirty feelings. Some cultural/religious belief such as Muslim women can only be seen naked by their husbands; who influenced their preference for female general practitioners especially for cervical smears. Also in this study, it was revealed that Pakistani Muslims were not comfortable attending to a doctor from the same cultural background they would only go along for a smear test if the doctor was not of the same cultural background for fear of being found out, 30). Additional studies that explored culture show that cultural gender roles and behaviors of women, may also affect the uptake of cervical cancer screening (15).

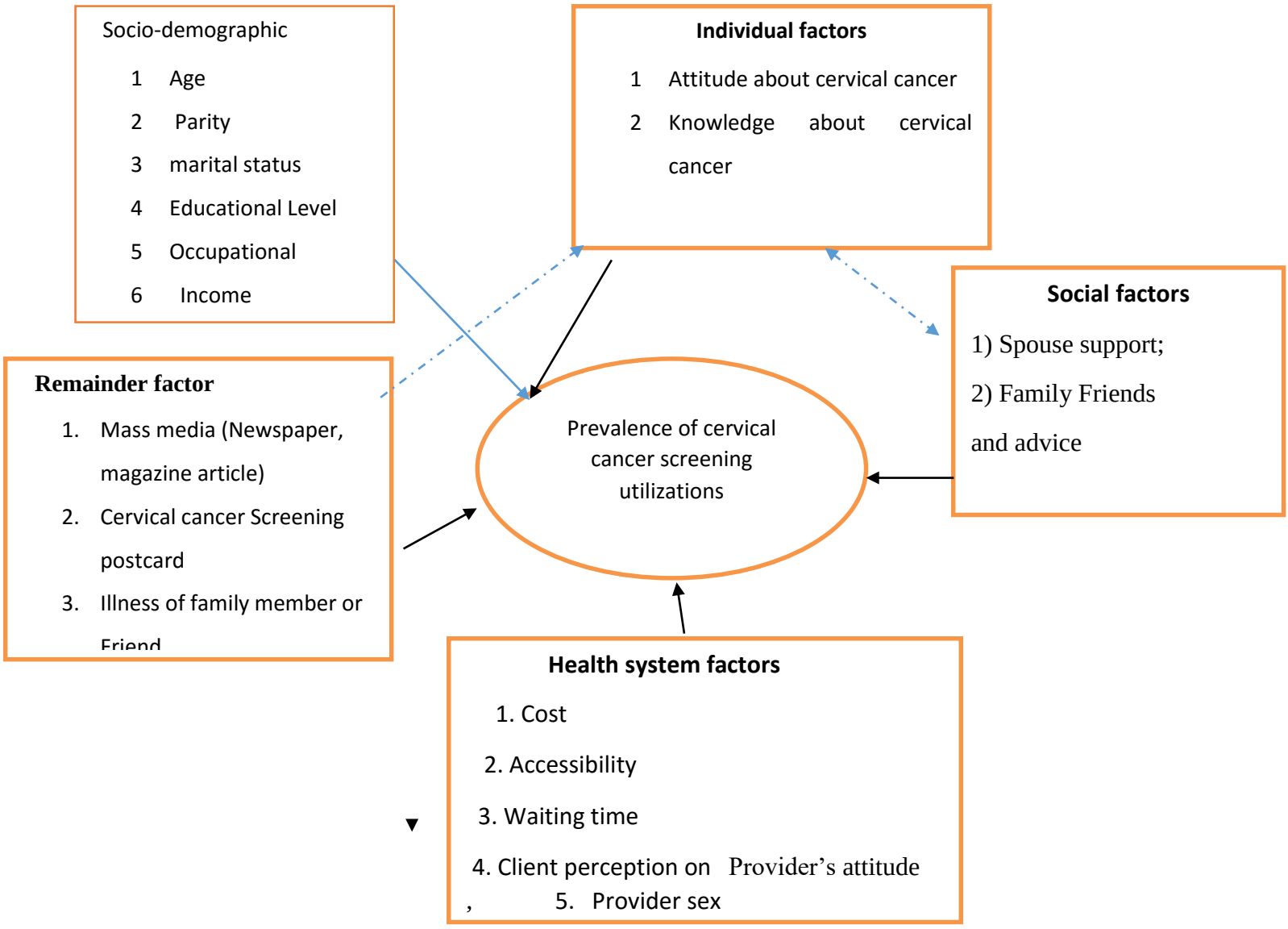
The exploratory study was conducted in Uganda revealed that cervical cancer is being a condition affecting women’s sexual and reproductive health was likely to be shrouded in silence since these are issues that are socially and culturally perceived to be private and cannot be openly discussed in public (16,20).

Therefore, women found difficulty in accessing information even when they experienced cervical cancer like symptoms .Other social gender roles and behaviors that hindered cervical cancer

screening include inability to leave house-hold chores, pre-occupation with family problems and lack of approval from husbands (20) argues that, if women and communities were educated and understood the importance of having a cervical cancer screening, and the importance of further follow up, culture would not be a bigger hindrance since the results of her study showed that, women's general attitude was positive towards cervical cancer screening (15,22).

Institutional factors have also been shown by different studies to be influencing uptake of cervical cancer screening. According to International Agency for Research on cancer Organization (2003), uptake of screening is increased when the governments ensure that there is an organized screening program in place. Mortality due to cervical cancer reduced drastically in developed countries which had sustained organized screening program that were equipped with infrastructure, trained human resource, organized follow up and surveillance systems (6, 7, 8).

A review of five qualitative studies that were conducted in Mexico, Peru and Ecuador showed that the main barriers to increasing uptake of cervical cancer included inaccessible and unavailability of high-quality health services, the lack of comfort and privacy in facilities, and unfriendly health worker (4, 7). The study conducted in Queensland Women described the bearers for screening participation is reminder factor and practitioner characteristics, particularly for women who did not attend screening**.** (36)



. Figure: 1 Schematic diagrams showing conceptual frame work of prevalence of cervical cancer screening utilization adopted from different literature (27, 36)

CHAPTER THEREE: OBJECTIVE OF THE STUDY

3.1. General Objective

- The general objectives of the study is to assess of prevalence of cervical cancer screening utilization and its associated factors among woman's 30-49 women who attend in marry stops and family guidance model clinic in Jimma town, south west Ethiopia in 2016.

3.2. Specific objectives

- To assess the proportion of prevalence of cervical cancer screening utilization among woman's 30-49 years.
- To identify factors that associated with prevalence of cervical cancer screening utilization among woman's 30-49 years.

CHAPTER FOUR: METHODS AND MATERIALS

4.1.Study Area/ setting

Jimma town is located at 354Km South west of Addis Ababa. The town has an altitude of 1750-2000m above sea level, temperature range of 20-30^{o}C and average annual rainfall of 800-2500mm^{3}. According to the national census of 2007, the projected total population of the town is 174,396 (86,326 males and 88,070 females) (27). There are 36,333 total households. There are 5 public health institutions (3 health centers & 2 hospitals) and 18 private clinics (6 higher and 12 medium clinics) clinic in addition to two non-governmental clinics mainly rendering reproductive health services. Family Guidance Association of Ethiopia (FGAE) and Marie stops are the leading non-governmental providers of sexual and reproductive health (SRH) care in Ethiopia. This study will conducted at FGAE and Marie stops Jimma model clinic (JMC). The catchment area of the clinic is Jimma town and surrounding districts. The clinic started opportunistic screening of cervical Ca since September 2012 and 2014 respectively.

4.2.Study Design

Institutional based cross sectional study design was conducted among women 30-49years in Jimma town, Ethiopia.

4.3 Study period

The study was conducted for 12 consecutive working days

4.4 Source population

All women's between age 30-49 years attending outpatient services at Marie's topes and FGAE clinic.

4.5.Study population

All selected women between age 30-49years attending outpatient services at Marie's topes and FGAE during data collection period.

4.6 Inclusion criteria

- ✓ All women between age 30-49 years attending outpatient services at Marie's topes and FGAE clinic during data collection who are willing to participate in the study.

4.7 Exclusion criteria

- ✓ All women's between age 30-49years attending outpatient services at Maries topes and FGAE those was unable to communicate due to critical illness.

4.8 Sampling method and sampling technique

4.8.1. Sample size

The appropriate sample size was calculated using single proportion formula based on 95% confidence interval and assuming the uptake of cervical cancer screening of 50% since no previous study on a similar population.

Formula:

$n = (Z_{1-\alpha/2})^2 ([P (1 - P)]/d^2$

n = the required sample size

Z = the critical value associated with the level of significance

P = the estimated prevalence cervical cancer screening (0.5)

d = degree of precision chosen for the study

Z = 1.96 for 95% level of confidence

P = 0.5

d = 0.05 degree of precision

N= infinite

$n = 1.96^2 [(0.5 (1 – 0.5)]/0.05^2$

Therefore the desired sample size was 384.

Add contingency 10% which is equal to 10/100*384=38

Total sample was 384+38= 422 women

4.9 Sampling procedure

Non Probability consecutive sampling technique were used on purposively selected 2 model clinic those provides the cervical cancer screening services in Jimma town. A total of 422 study participants take from women of age 30-49years those attending Marie's topes and FGAE through consecutive selection until sample size will achieved. Participants will select from both study area

based on proportion of the patients they served daily. FGAE is served 25 women of age between 30-49 years daily, whereas Maries stops serves only 15'wome n per day. Based on this information: the proportional allocation of samples indicated as follows: I allocated sample for both study area.

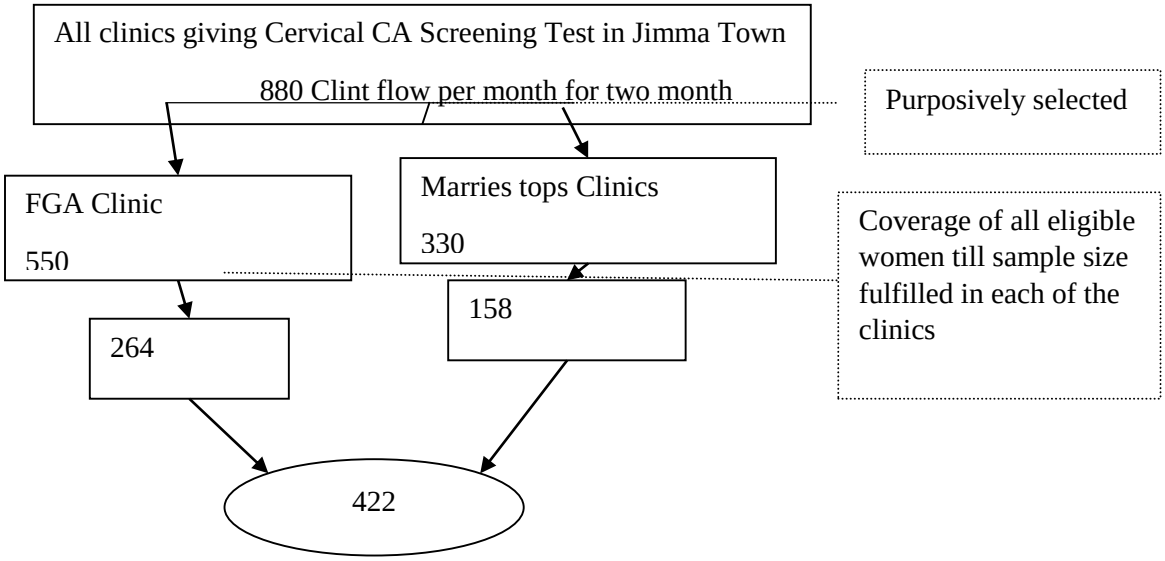


Figure 2: Sampling Framework prevalence of cervical cancer screening utilization and associated factor among 30-49years women who attend in marry stops and family guidance model clinic in Jimma town, south west Ethiopia

4.10 Instruments and Measurements

Pretested and structured questionnaire were used. Translation of instrument were made from English language to local Amharic language and Afan Oromo and back to English language by different individuals who were blind to the original version of the questionnaire (English version) in order to facilitate reliable responses to underline questions and keep the original meaning of the instrument.

Study questionnaire for each items are adopted from previously conducted similar study (32) and modified to the local context. The instrument contains three parts: starting from socio demographic status of the clients (10 items), (Cervical cancer knowledge (17 items) cervical cancer knowledge and screening uptake (nine items) a combination of response formats of multiple responses and 'Yes and No' 'assuming score of 'yes'=1, or 'No' =0 and for every correct item there was a

reversed incorrect item . all of which eliciting responses on a five-point Liker's scale format ranging from 'strongly disagree' to 'strongly agree' was included. Each of the responses was scored: strongly disagree'=1, 'disagree'=2,'undeciced/not sure'=3,'agree'=4 and 'strongly agree'=5.After reversed for negatively worded items to positively worded items, score was summed for each respective factors and construct validity was ensured. To ensure reliability of the scale, internal consistency of items was seen separately for each construct using Chrombanch's alpha score of >60% as cut off point. The specific values include; attitude (α=0.72) and Social factors (α=0.84).

4.11 Study variables

4.11.1 Dependents variables

Prevalence of cervical cancer screening utilization

4.11.2. Independents variables

1) **Socio demographics**

Age

Parity

Marital status

Educational level

Occupational

Income

Individual factors

1 Knowledge of cervical cancers

2 attitude toward cervical cancers screening

Social factors

1) spouse support
2) family and friend

Health system factors

1. Cost
2. Accessibility

3. Perception of client on Provider's attitude about screening,
4. Provider gender

Remainder factor

1. Mass media (Newspaper, magazine)
2. Cervical cancer Screening post card
3. Illness of family member.

4.12 Operational definition

Prevalence of cervical cancer screening utilization: those who ever had got a Visual inspection with acetic acid /VIA test on in a life time considered as having screening practice. And those who never screened were regarded as having no screening practice. In my research this variable measured by one items with 'Yes' scored '1' and 'no scored '0''answer question. Thus, the highest score is 1and the minimum score is 0. The scores from 0-1 is going to be considered a dichotomous variables; and those scored 1 is considered as having cervical Ca practicing or otherwise considered as not having cervical Ca practicing.

The knowledge status of mothers on cervix cancer screening practice.

Knowledge: The knowledge of cancer of the cervix and screening for premalignant cervical lesion was assessed using a 17 points scale. There were 17 yes or no questions that carried a total of 17 correct responses. Each correct response was given a score of 1 and a wrong response a score of 0. Total points to be scored will 17 and the minimum will 0. Study participants' cervical cancer/screening knowledge scores were converted into a dichotomous categorical variable of knowledge levels using above and below average (mean) knowledge scores (36).

Poor Knowledge refers to for those scored below the mean.

Knowledge refers to for those scored below the mean

Attitude about cervical Ca screening: the belief and feeling of the respondents about screening for premalignant cervical lesions It measured by likert's scale with the score of 1 for strongly disagree, 3 as neutral and score 5 for strongly agree. I have total 17 items having a total of a maximum 85 score with minimum 17 score.

Positive attitude Refers to for those scored the mean and the above and

Negative attitude refers to for those scored below the mean.

Social support: Support and advice from partner, family and friends will reported as important factors that encouraged compliance and participation in recommended cervical Ca screening health programs among the participants. Women often discussed their cervical Ca screening health problems with their family and close friends and received emotional support and advice that encouraged them to seek solutions for their health problems. This will measured by using likert's scale with a total of 3 items. It measured by likert's scale with the score of 1 for strongly disagree, 3 as neutral and score 5 for strongly agree. I have total 3 items having a total of a maximum score with minimum 1 score.

Health system factors- assessed by yes/no items. Cost, lack of accessibility of services, and waiting time for care captured the structural characteristics of the health care system that may affect screening intention. A single item-question with a yes/no response was used to assess women's perceptions about the influence of these health care system factors on screening.

Accessibility: refers presence or absence of screening service for cervical Ca and explained that women had to travel long distances to get the services and lack of service in the nearest health institution this item-question with a yes/no Each correct response was given a score of 1 and a wrong response a score of 0 if the respondent answer yes this problem affecting this crevice but no not this carves.

Cost of screening. The financial constraints imposed by user payments negatively affected participants' attitudes towards screening. Indirect costs such as outpatient cards and transportation fees will consider additional barriers. The low socioeconomic status of women caused many of them to focus their limited incomes on their most immediate basic needs rather than on preventive health care. This question help us how the issue of cost adversely affect attitudes towards cervical Ca screening, and perhaps her intention to screen: this item-question with a yes/no Each correct response was given a score of 1 and a wrong response a score of 0 if the respondent answer yes this problem affecting this crevice but no not this carves

Client perception on Attitudes of health professionals/Approach: is the attitude that health professionals have toward cervical Ca screening practice. this item-question with a yes/no Each

correct response was given a score of 1 and a wrong response a score of 0 if the respondent answer yes this problem affecting this crevice but no (0) answer not affecting this carves It help us to measure impact of health professionals' attitude on client to have to screen to cervical Ca or not.

Reminder factor; remainder factor for this study focused on the facilitator factors to cervical cancer screening test. This includes Mass media, Reminder post card, Illness of family member or Friend, Newspaper, magazine article. In this study remainder factors assessed by using **Mass media**– are strategies which consists radio, television as well as newspapers and magazines that use to disseminate health information on prevalence of cervical cancer screening utilization and its importance and used as reminder messages for cervical screening check-up.

Reminder postcards- such as postcards to remind client's memories to come to health institution for cervical screening check-up.

A newspaper - is a serial publication containing news, and other informative articles such as health and medicine (on cervical cancer screening and its importance) and used as reminder messages for cervical screening check-up.

Magazines-are publications, usually periodical publications, that are printed or electronically published (the online versions are called online magazines.) They are generally published on a regular schedule and contain a variety of content like health and medicine (on cervical cancer screening and its importance) and used as reminder messages for cervical screening check-up...

Illness of the family member or friend- by cancer cases like cervical cancer is used to remind client's memories to come to health institution for cervical screening check-up.

4.13. Data collection procedure

Four (4) data collector and two supervisor was recruited to assist in the data collection. These research assistants was a bachelor's degree in health related courses. They were trained by the principal investigator on the study tool, the aims and objectives of the study as well as the ethical considerations, how to conduct questionnaire interviews (interviewee questionnaire) to minimize information bias. Permission to conduct the study was seek from the JU and respective organizations. After an explanation of the purpose of the study and obtaining oral consent from the participants the data collection were started. The research assistants introduced themselves to

the participants and underscored that their participation were voluntary and that they would not be victimized in any way.

Confidentiality was assured by ensuring that their names did not appear anywhere in the questionnaire.

1. Interview questioner prepared in English.
2. The English questioner was translated to Afan Oromo and Amharic questioner. Afan Oromo and Amharic questioner was used to collect the necessary information from participants through interviewee.
3. The data collectors was trend before data collection period

   The internal consistency of scales of attitude and Social factors (spouse support, family advice & advice from friend) was measured using Cronbanch's alpha. In this study values above 0.7 are generally considered to indicate satisfactory internal consistency and below o.6 were considered unacceptable.

   Both items had acceptable to good and very good Cronbanch's alpha indicating that the scale is consistent and reproducible for use. The specific values include; attitude (α=0.72) and Social factors (α=0.84).

4.14. Data Analysis

Each questionnaire was checked for completeness, missed values and unlikely responses and then manually cleaned up on such indications before living the study area. Data was coded and entered in to Epi data version 3.1. Data was cross checked for consistency and accuracy, and after clearing exported to SPSS version 20 for statistical analysis.

Frequency distributions, percentages, proportions, measures of central tendency and dispersions, tables and charts were used to show results of Univariate analysis. All explanatory variables which was have association in bivariate analysis with p value less than 0.25 was entered in to Multivariable logistic regression model in order to assess the significant association between dependent and independent variables.

Multivariable analysis were done using the logistic regression models to control for potential confounders in the analysis. For the purpose of this study, statistical significance was defined at a probability level of 0.05 ($p<0.05$).

Finally, to test whether or not the final model provides a good fit to the data, a Goodness -of -Fit test was performed. Furthermore, results was presented in tables, bar charts, graphs and pie charts as appropriate.

4.15. Data Quality Assurance/control

The quality of data were ensured by using a standardized instruments and 5% pre-testing of the questionnaires in the same institute prior to two weak of data collection period on 5% of the participants, and by giving training for the data collectors and supervisors before the actual data collection performed. Appropriate modifications were made after reviewing the pre-test result and overall supervision was made by the principal investigator. Every day after data collection, questionnaires were reviewed and checked for completeness, accuracy and clarity by the supervisors and principal investigator and the necessary feedback was offered to data collectors prior to collect the next data. Data collectors was four nurses not working in study institutions and one supervisor. Training were given for two days.

4.16. Ethical consideration

Data collection was started after permission obtained from Jimma University Ethical research review committee. The letter was written to the respective organizations to obtain permission. All respondents were asked for their willingness of participation in the study and verbal consent was obtained after convincing respondents' issues of confidentiality. Questionnaire was labelled with ID number not by name in order to keep its confidentiality. Strict rules of confidentiality was followed during the data collection, analysis, and reporting of this study. Each interview subject was provided anonymity. All notes was kept on the person of the field worker at all times. Participants and non-participants will not be allowed to view the notes at any time and content of discussions and interviews will not be revealed to anyone else, to protect participants from possible harm at the revelation of such information. Names of interviewees will not be used at any stage of the data collection process. Pre-determined identification numbers was used on data collection form (topic guide and notes).

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4.17. Dissemination of the result

Final document of the study will given to Research and Publication office of Jimma University, post graduate coordinating office and Jimma University nursing & Midwives department. Attempt will made for publication of the research on reputable journal.

CHAPTER FIVE – RESULTS

5.1. Socio-demographic Characteristics

The total number of women included in this study were four hundred three making the response rate of 95.5%. 255 (63.27%) of women lay in the age category of 30-39 years and the rest 148(36.73) were from the age group 40-49 years. The mean age of the respondents was 37.96 ±SD 5.43).

351(87.09%) of the women were multipara and the rest 52 (12.91) were primi para and 225(55.8%) of the women were married (Living with partner), 111 (27.5 %), attended grades 5-8, whereas Muslim 198 (49.1 %) followed by Protestant 75(18.6 %) majority of them, 229 (56.8%) were Oromo 50 (12.4%).

103 (25.6 %)were merchant For 107(26.84%) respondents, the average monthly income lay up to 600., For 117(29.57%) respondents, the average monthly income lay between 1801-3000 Eth. Birr.

Table 1: Socio-demographic characteristics of the respondents in Jimma town, Ethiopia 2016 (n=403)

Characteristics		Frequency (N)	Percent (%)
Age	30-39	255	63.27
	40-49	148	36.72
Parity	delivered once	523	12.9
	delivered above two	51	87.09
marital status	Single (never married)	41	10.2
	Married (Living with partner)	225	55.8
	Married (separated)	61	15.1
	Divorced	44	10.9
	Widowed	32	7.9
Educational Level	1-4	53	13.2
	5-8	111	27.5
	9-10	77	19.1
	11-12(preparatory)	54	13.4
	TVT (colleges)	79	19.6
	University and above	29	7.2
Religion	Orthodox	73	18.1
	Muslim	198	49.1
	Catholic	50	12.4
	Protestant	75	18.6
Ethnicity	Amahra	45	11.2
	Oromo	229	56.8
	Tigriy	50	12.4
	Gurage	49	12.2
	Other	30	7.4
occupational	House wife	44	10.9
	Private employee	96	23.8
	Farmer	8	2.0
	Government employee	100	24.8
	Daily laborer	48	11.9
	Merchant	103	25.6
Income	1st percentile	107	26.84
	2nd percentile	95	23.03
	3rd percentile	117	29.57
	4th percentile	84	20.55

5.2PREVALENCE OF CERVICAL CANCER SCREENING UTILIZATIONS

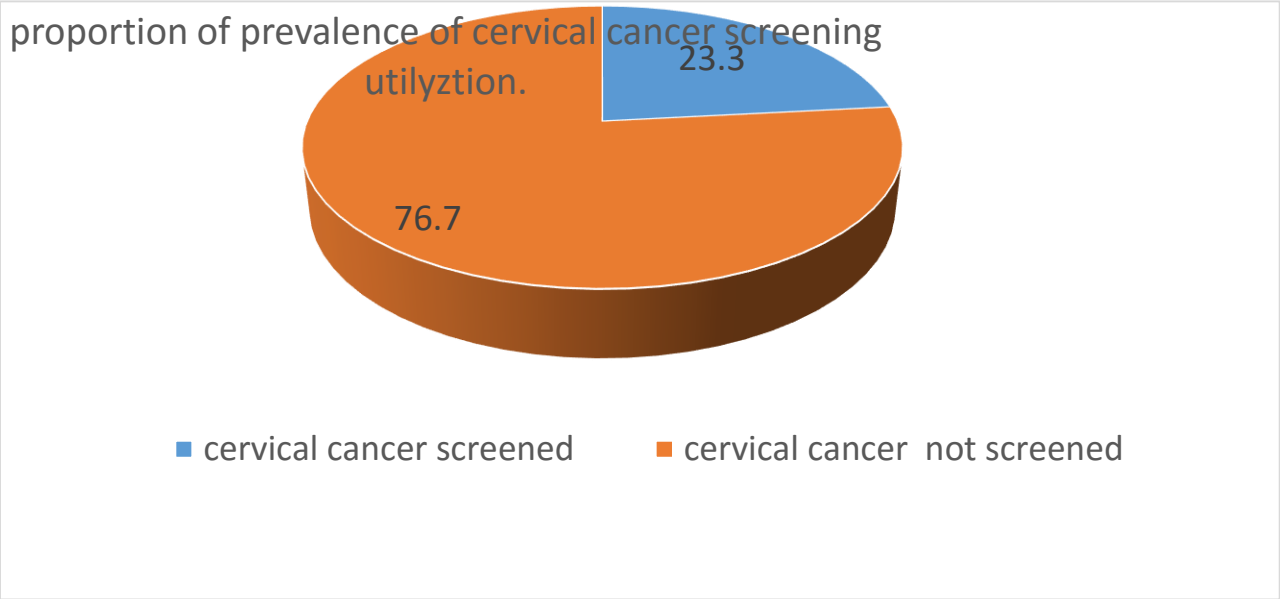

Figure 3 proportion of prevalence of cervical cancer screening utilization and associated factor among 30-49years women who attend in marry stops and family guidance model clinic in Jimma town, south west Ethiopia

5.3 Factors affecting cervical cancer screening

5.3.1 Reminder factors

Among the reasons for screening of cervical cancer in mothers were; 37(9.2%) information from Illness of family or Friend, 22(5.5%) Family members, 28(6.9%) Friends and 9(2.2%) nurse.

Table 2: Reminder factors toward cervical cancer screening in Jimma town, Ethiopia 2016

Variable		Frequency	Percent
Remainder factor	Family members	22	5.5
	Illness of family or Friend	37	9.2
	Friends	28	6.9
	Nurse	9	2.2

5.3.2 Knowledge of respondents on cervical cancer screening

The knowledge of cancer of the cervix and screening for premalignant cervical lesion was assessed using a 17 points scale. There were 17 yes or no questions that carried a total of 17 correct responses. Each correct response was given a score of 1 and a wrong response a score of 0. Total points to be scored will 17 and the minimum will 0 .Respondents were asked about their Knowledge towards screening for premalignant cervical lesion (222 ,55.1%) of the respondents had poor Knowledge towards screening for premalignant cervical lesion. The mean knowledge score was 7.36 ±SD 3.626.) The minimum knowledge score was 0 and maximum score was 16. The result showed in

Table 3 show the proportion of women who correctly responded to the knowledge question regarding the Cervical Cancer Screening in Jimma town, Ethiopia 2016

Variable knowledge		Frequency	Percent
Knowledge on cervical cancer	poor Knowledge	222	55.1
	Knowledgeable	181	44.9

5.3.3 Attitude of respondents on cervical cancer screening:

The attitude of the respondents about screening for premalignant cervical lesions It measured by likert's scale with the score of 1 for strongly disagree, 3 as neutral and score 5 for strongly agree. I have total 17 items having a total of a maximum 85 score with minimum 17 score. This score Positive attitude Refers to for those scored the mean and the above and Negative attitude refers to for those scored below the mean Majority of the respondents 210 (52, 1%) had negative attitude and the rest 193 (49.9%) had positive attitude on screening of cervical cancer lesion see (Table 4).

Table: 4 Distribution scores of attitude of the respondents toward cervical cancer screening in Jimma town, Ethiopia 2016

	variable	**Frequency**	**Percent**
Attitude of respondents on cervical cancer screening	negative Attitude	193	49.9
	positive Attitude	210	51.1

5.3.4 Health system factor of respondents on cervical cancer screening

When asked the respondent about health system problem their said that 44(61%) Not suggested by the health care workers, 144(35.7).The Health system factor was 1.6998 (SD1.32585), the minimum Health system factor score was 0 and maximum score was 6**.**

Table 5;health system factor of respondents among attendants in Marry stops And Family Guidance Model Clinic in Jimma Town, South West Ethiopia, 2016

Variable Health system factor of respondents		Frequency	Percent%
Not suggested by the health care workers	No	157	39.0
	yes	246	61.0
Lack of female screeners at the health facility	no	330	81.9
	yes	73	18.1

poor Approach of health care workers	no	359	89.1
	yes	44	10.9
Lack of convenient clinical time	No	345	85.6
	Yes	58	14.4
Lack of designated rooms for screening at health facility	no	364	90.3
	yes	39	9.7
Not offered at the nearest health facility	no	259	64.3
	yes	144	35.7
Long distances to a health facility	no	335	83.1
	yes	68	16.9
The screening is expensive	no	351	87.1
	yes	52	12.9

5.3.5 Social factor

Majority of the respondents Disagree on friends198 (48.9%) next to Disagree spouse support 196**(**48**.6**)

Table ;6 Social factor of respondents among attendants in Marry stops And Family Guidance Model Clinic in Jimma Town, South West Ethiopia, 2016

Variable Social factor		frequency	Percent
My partner have recommended to screening	Strongly Disagree	70	17.4
	Disagree	196	48.6
	Not Sure	19	4.7
	Agree	113	28.0
	Strongly Agree	5	1.2
My family have advised me to go doctors	Strongly Disagree	34	8.4
	Disagree	86	21.3
	Not Sure	36	8.9
	Agree	193	47.9
	Strongly Agree	54	13.4

My friends have talked to me about the importance of cc	Strongly Disagree	89	22.1
	Disagree	197	48.9
	Not Sure	22	5.5
	Agree	87	21.6
	Strongly Agree	8	2.0

5.2 Bivariate

5.2.1 Table 7: Bivariate analysis of socio-demographic characteristics and cervical cancer screening factor Association between socio-demographic characteristics toward cervical cancer screening

Table 7: Bivariate analysis of socio-demographic characteristics of respondents toward cervical cancer screening in Jimma town, Ethiopia 2016

Variables	Screening practice			Crude OR
		Yes	NO	[95% CI]
age	30-39	60(63.8%)	195(63.3%)	1.032(o,638-1.667)
	40-49	34(36.2%)	114(36.9%)	1
parity	prmipara	11(21.2%)	41(78.8%)	1.154(.568-2)
	Multipara	83(23.6%)	268(76.4%)	1
marital status of respondent	Single	15(36.6%)	26(63.4%)	.678 (.250,1.842)
	Married	50(22.2%)	175(77.8%)	1.370(.596.3.148)
	M Separated	13(21.3%)	48(78.7%)	1.445(.540,3.867)
	Divorced	7(15.9%)	37(84.1%0	2.068(.677,6.317)
	Widowed	9(28.1%)	23(71.9%)	**1**
Educational level of respondents	1-4 grade	13(24.5%)	40(75.5%)	**5.035(1.896 ,13.373)**
	5-8 grade	19(17.1%)	92(82.9%)	**7.923(3.228019.451)**
	9-10 grade	8(10.4%)	77(100.0%	**14.1144.948-40.255)**
	11-12 grade	9(16.7%)	45(83.3%)	8.182(2.901,23.073)
	TVTcollees	27(34.2%)	52(65.8%)	3.152(1.304,7.617)
	University	18(62.1%)	11(37.9%)	**1**
	House wife	3(6.8%)	41(93.2%)	41.000(3.205,524.435)

Occupation of respondents	Private	13(13.5%)	83(86.5%)	19.154(1.850-198.336)
	Farmer	1(12.5%)	7(87.5%)	21.000(.961,458.842)
	Government	35(35.0%)	65(65.0%)	5.571(.558-55.580)
	Daily laborer	7(14.6%)	41(85.4%)	17.571(1.593-193.871)
	Merchant	32(31.1%)	71(68.9%)	**1**
Respondent	**1st p**	19(17.8%)	88(82.2%)	3.474(1.800-6.705)
income cat	**2nd p**	14(14.7%)	81(85.3%0	4.339(2.127-8.854)
	3rd p	25(21.4)	92(78.6%)	2.760(1.487-5.121)
	4th p	36(42.9%	48(57.1%)	1
Respondent knowledge	Knowledgeable	17(73.9%)	6(26.1%)	1
Towered screening	Poor knowledge	23(8.9%)	234(91.1%)	11.768(6.359,21.779)
Respondent attitude toward screening	negative attitude	8(3.3%	75(62.0%)	32.390(15.012,.895)
	positive attitude	86(528%)	77(47.2%)	1
spouse support Towered screening	negative spouse support	38(14.3%)	228(85.7%)	4.148(2.557,6.729)
	Positive spouse support	56(40.9%)	81(59.1%)	1
family support toward screening	negative family support	57(36.5%)	99(63.5%)	32.390(15.012,.895)
	positive family support	57(36.5%)	99(63.5%)	1
suggested by the health care workers	No	66(42.0%)	91(58.0%)	**.1**
	yes	28(11.4%)	218(88.6%	177(.107.3)
	No	75(22.7%)	255(77.3%	**1**

Lack of female screeners	yes	19(26.0%)	255(77.3%	1.196(.643)
poor Approach of health care workers	No	85(23.7%)	274(76.3%)	1
	yes	9(20.5%)	35(79.5%)	.829(.383-1.794)
Lack of convenient time	No	86(24.9%)	259(75.1%	**1**
	yes	8(13.8%)	50(86.2%)	**.482(.220-1.057)**
Lack of designated rooms	No	87(23.9%)	277(76.1%	**1**
	yes	7(17.9%)	32(82.1%)	**.**696(.297-1.634)
facility Not offered at the nearest health	No	69(26.6%)	190(73.4%)	**1**
	yes	25(17.4%)	119(82.6%	1.729 (1.036,2.884)
Long distances to a facility	No	80(23.9%)	255(76.1%	**1**
	yes	14(20.6%)	54(79.4%)	.826(.436-1.566)
The screening is expensive	No	86(24.5%)	265(75.5%	**.1**
	yes	8(15.4%)	44(84.6%)	560(.254-1.236)

COR= crude odds ratio, AOR=adjusted odds ratio P= percentile *** significant multivariable**

Association between socio-demographic characteristics and cervical cancer screening, parity and Age were not associated with cervical cancer screening. In bivariate analysis, level of education, income, Occupation and marital were significantly associated with cervical cancer screening of the respondents.

Association between Cervical cancer screenings with health institution factor according to health institution factor like provider suggestion problem, Lack of convenient clinic time, facility not offered to screening is significantly associated But Lack of female screeners, poor Approach of

health care workers, Lack of designated rooms (privacy), Long distances to a health facilities was not significantly associated .Regarding of Bivariate social factor was significantly associated with prevalence of cervical cancer screening utilization .including spouse, family and friends sport significantly associated towered prevalence of cervical cancer screening utilization**.**

Multivariable analysis

		Screening practice		**Exp(B)**	AOR	**Sig.**
		yes	No		(95% C.I.for)	
Educational	1-4 grade	13(24.5%)	40(75.5%)	4.266(1.030,17.670)		.045
status	5-8 grade	19(17.1%)	92(82.9%)	8.043(2.256,28.682)		.001
	9-10 grade	8(10.4%)	77(100.0%)	6.837(1.578,29.623)		.010
	University	18(62.1%)	11(37.9%)	----------		
Attitude	negative attitude	38(14.3%)	75(62.0%)	24.524(10.199,58.971)		.000
	positive attitude	56(40.9%)	77(47.2%)	----------		
spouse support	negative s support	38(14.3%)	228(85.7%)	2.181(1.078,4.413)		.030
	positive s support	56(40.9%)	81(59.1%)	----------		
suggested by the	yes	66(42.0%)	228(85.7%)	.276(.134(.567)		.000
health care	no	28(11.4%)	81(59.1%)	----------		
Lack of	yes	86(24.9%)	91(58.0%)	.176(.061,.509)		.001
conconvenient	no	8(13.8%)	218(88.6%	----------		
time						
Knowledge	Knowledgeable		6(26.1%)	----------		.000
	Poor knowledge	17(73.9%)	234(91.1%	.232(.107,505)*		

Multivariable analysis

Multivariable Logistic regression analysis was also performed to examine the association between prevalence of cervical cancer screening utilization and certain variables. In bivariate logistic regression, analysis, marital status, level of education, income, Occupation were significantly associated with the study towards cervical cancer screening. However in multivariate analysis indicated that only level of education, were significantly associated with the respondent's prevalence of cervical cancer screening utilization. Mothers who were 5-8 seven times (AOR=6.798, 95%CI: 1.526-30.289), not to be screened cervical cancer compared to those university and above in both bivariate and multivariate analysis. Regarding knowledge towards screening practice, as knowledge level of cervical cancer increased by one unit surprisingly the chance of getting screening is decreased by.25times (OR:.232. 95% CI: 107,.505**)**.According to Respondent attitude toward screening practice negative attitude 24 times (AOR=24.524 95% CI: 10.199**,** 58.971**)** not to be screened cervical cancer compared to those positive attitude respondent

Regarding of health institution factor health provider suggestion increased by one unit surprisingly the chance of getting screening was decreased by 2, 8 times (AOR=2.76 95% CI: .134, .567) and convenient clinical time has increased by one unit chance of getting screening is decreased by 0.2 times (AOR=.176. 95% CI: .061.509) prevalence of cervical cancer screening utilization than those who says no lack of convenient clinical time. For women who had negative spouse support the chance of getting screening was decreased by two (AOR=.2.1811, 95% CI.078, 4.413**)** times as compared to positive spouse support.

CHAPTER SIX- DISCUSSION

Prevalence of cervical cancer screening utilization in the study area was 23.3% which was comparable with the study done in Tanzania in which 22.6% (33) of the respondents were screened for cervical cancer. In contrary, a study conducted in Asia showed that about 89% of the women were screened for cervical cancer (2, 8). This dispersions may be due to low educational status of and low access for health care for African women.

In addition the study conducted in Korean women's is very high (58.5%) compared to this study. This may be due to the difference in educational status and negative attitude of the woman's for the screening practice in this area (4). Similarly a cross-sectional study conducted among clinic attendees in Trelawney, Jamaica in 2007, revealed that majority (82%) of women were screened for cervical cancer. This might be due to the poor visibility and accessibility of the cervices in this resources limited country.

A review of five qualitative studies that were conducted in Mexico, Peru and Ecuador showed that the main barriers to increasing uptake of cervical cancer include inaccessible and unavailability of high-quality health services, the lack of comfort and privacy in facilities, and unfriendly health workers, but this factors are not significantly associated with prevalence of cervical cancer screening utilization in this study area(4, 7) This might be due to difference in study methods used and socio-cultural difference between the two country**.**

The findings from this research showed that only educational level had showed a statistically significant association with the outcome variable from the socio-demographic variables of this study. This finding is almost similar with the study conducted in China in which women having higher levels of education were more willing to participate in cervical cancer screenings (32).

Knowledge and attitude towards prevalence of cervical cancer screening utilization showed a statistical significance. This finding is consistent with a study conducted in Southern Ghana, which reported a lack of knowledge about cervical cancer among women (37). This finding is also similar

to a study conducted in China in 2013 in which women who were willing to undergo screenings had higher knowledge levels (32).

Also from the social factors, only spouse support was found to have a statistical significant association with the screening practice. This is similar with a study done in Uganda in which spousal support were considered to be very important to women's ability to access services (38).

Limitation of the study

- ✓ Social desirability bias since any reproductive health illness may associate with social discrimination and denial or other social issues
- ✓ the use of self-reported cervical screening history may also have led to over-reporting of screening status
- ✓ pre-testing of the questionnaires conducting in the same institute it may be led to information contamination

CHAPTER SEVEN- CONCLUSIONS AND RECOMMENDATIONS

7.1. Conclusion

This study showed that very low rate of screening for premalignant cervical lesions.

The analysis shows that low screening rate had low educational level, poor attitude, negative spouse support poor knowledge, poor provider suggestion and inconvenient time grossly affects screening practice.

. 7.2. Recommendations

Governmental and non-governmental organizations: Emphasis on female education. Efforts to promote cervical cancer screening among women should focus on informing that active and regular screening can detect the pre-cancerous stage, hence enabling early treatment and prevention of cancer development.

Clinics more focused on accessibility of permanent screening time and should create awareness regarding cervical cancer screening since screening services like VIA is being given at these facilities FGAE (Family Guidance Association of Ethiopia) and Mari stops. The government should play its part by increasing health care budgets and put priority on screening practice for researchers- to conduct further researches regarding this issue by using strong study designs like longitudinal studies. For health provider**:** healthcare providers such as general practitioners and nurses need to do their part in promoting cervical cancer screening. They should disseminate information that focus on educating the women about cervical cancer risks, prevention and early detection to enhance uptake of screening practices

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Annex A: Questionnaire (English version)

Informed Consent

Participant information sheet and consent form

My name is _____. I am here to study assessment of cervical cancer practices and associated factors among women attending on marry stop and FGEA model clinic. You are selected to participate in this study. The information you provide will help to plan on prevention of cervical cancer lesion. The interview takes an average of 30 minutes to complete. Whatever information you provide was kept strictly confidential and will not be shown to other persons. Your name will not be written on this form, and will never be used in connection with any of the information you tell me. Participation in this survey is voluntary and you can choose

not to answer any individual question or all of the questions. However, we hope that you will participate fully in this survey since your views are important

Are you willing to participate in the study? Yes ____ No ____ Ok thanks

Yes may I begin the interview now? YES –Continue

Place of data collection:

Clinic----------

Date of data collection _____

Name of the data collector_____ Signature_____

I certify that I have filled this questionnaire in accordance with the training I was given and instructions stated in it. I confirm that the information in it is correct.

Name of Supervisor _____ Signature _____Date Checked _____Questionnaire ID: _____ Date: ___/___/_____ Sub-Location:_____

INDIVIDUAL FACTORS

A.DEMOGRAPHIC INFORMATION

1. How old are you?
2. Your birth Date is?
3. Parity (Number of previous deliveries)_____

1, perm-para 2, multipara

4. What is your marital status?
   1) Single (never married) (2) Married (Living with partner
   3) Married (separated) 4) Divorced
   5) Widowed
   5) What is your current educational status?
   4) 1-4 4. 11-12(preparatory)

5) 5-8 5. TVT (colleges)
6) 9-10 6. University and above 6
7. Others (specify)…….
6) Religion?
1) Orthodox 2) .Muslim
3) Catholic 4) Protestant
5).Other (specify)
7) What is your Ethnicity?
1. Amahra 2. Oromo
3. Tigriy 4. Gurage
5. Other specify
8). Occupation
1. House wife 2. Private employee
3. Farmer 4. Government employee
5. Daily laborer 6. Merchant
7. Others (specify)
9).How much do you earn in a month? _____

PART TWO.CERVICAL CA SCREENING PRACTICES

10. Have you ever heard of cervical cancer screening?
a) Yes 1 b) No 0
11. Have you ever been screened for cervical cancer? If yes skip to part three, if no to 12
a) Yes 1 b) No 0

12. Below are some of the reasons women do not go for screening. Select all that apply?

Question	Choice	
a) Little understanding of cervical cancer	1	0
b) Cervical cancer screening is painful	1	0
c) Not thinking that one is at risk	1	0
d) Fear of a vaginal exam	1	0
e) Not knowing where to go for screening	1	0
f) Lack of husband/partner approval	1	0
g) Not allowed by religion/culture	1	0

Part TWO. Reminder factors

13. How did you know and performing to you screened for cervical cancer lesion? Tick all that apply

A) Family members 1

B) Illness of family member or Friend 2 ,

C) Friends 3

D) Nurse 4

E) Doctor 5

F) Radio/TV 6

G) Reminder post card 7

H) Magazine / Newspaper 8

I) Health extension worker 9

14. The best place to reach women with cervical cancer screening messages?

a) Local women's groups

b) Places of worship (church/mosque) 2

c) Health facilities 3

d) At home) Markets 4

Part three CERVICAL CANCER KNOWLEDGE

15. The following are the warning sign of cervical cancer. Please tick "yes", or "no" for all that apply.

Question	YES	NO
a. Can cervical cancer is prevented	1	0
b. Can Vaccination with HPV vaccine prevent cervical Ca	1	0
c. Can Routine Screening prevent cervical Ca	1	0
d. Can Limiting the number of sexual partners prevent cervical Ca	1	0
e. Can Not smoking and avoiding secondhand smoke prevent cervical Ca	1	0

f. Can Using a condom if one is sexually active prevent cervical Ca	1	0
g. Can Following up on abnormal screening results prevent cervical Ca	1	0
h. do you know vaginal bleeding between periods could be sign Of cervical cancer	1	0
i. do you know persistent lower back pain could be sign of cervical cancer	1	0
j. do you know persistent vaginal discharge that unpleasant could be sign of cervical cancer	1	0
k. do you know discomfort or pain during sex could be sign of cervical cancer	1	0
l. do you know menstrual period that is heavier and longer than usual could be sign of cervical cancer	1	0
m. do you know persistent diarrhea could be sign of cervical cancer	1	0
n. do you know vaginal bleeding during, before and after menopause could be sign of cervical cancer	1	0
o. do you know vaginal bleeding during or after sex could be sign of cervical cancer	1	0
p. do you know blood in the stool and urine could be sign of cervical cancer	1	0
q. do you know unexplained weight loss could be sign of cervical cancer	1	0

C Attitude Questions

16. How strongly agree or disagree the following may increase woman chance of developing cervical Cancer?

Thick that matches your choice of agreement from 1 to 5 or strongly disagree to strongly agree continuum.

	Strongly Disagree	**Disagree**	**Not Sure**	**Agree**	**Strongly Agree**
1) Smoking cigarettes	**1**	**2**	**3**	**4**	**5**
2) Having a weakened immune system	**1**	**2**	**3**	**4**	**5**

3) Long-term use of contraceptive pill	**1**	**2**	**3**	**4**	**5**
4) Infection with sexually transmitted infections	**1**	**2**	**3**	**4**	**5**
5) Having a sexual partner who is not circumcised	**1**	**2**	**3**	**4**	**5**
6) Starting to have sex at young age	**1**	**2**	**3**	**4**	**5**
7) Having many sexual partners	**1**	**2**	**3**	**4**	**5**
8) Having many children (>5)	**1**	**2**	**3**	**4**	**5**
9) Having a sexual partner with many previous sexual partners	**1**	**2**	**3**	**4**	**5**
10) Not going for regular cervical Ca screening)	**1**	**2**	**3**	**4**	**5**
11))Good health practices can help to prevent cervical cancer.	1	2	3	4	5
12)Screening can detect treatable precancerous lesion before progress cancer.	1	2	3	4	5
13Cervical cancer develop slowly and preventable.	1	2	3	4	5
14 women's age 30and older are more likely develop cervical cancer than younger women	1	2	3	4	5
`5Women in their 30s 40ss old be screened at list once.	1	2	3	4	5
12) the screened procedure relatively simple quick and not pan full	1	2	3	4	5
17) the screened test that is positive not death	1	2	3	4	5

<u>Part four. Health system factor</u>.

18. Below are some of the reasons women do not go for screening. Select all that apply?

Question	Choice	
a) Not suggested by the health care workers	1	0
b) Lack of female screeners at the health facility	1	0
c) poor Provider's attitude about screening, on client	1	0
d) Lack of convenient and long Waiting time of clinic time	1	0
e) Lack of designated rooms for screening at health facility (privacy)	1	0

f) Not offered at the nearest health facility	1	0
j) Long distances to a health facility	1	0
K) The screening is expensive	1	0

Part five social factor

19. Now, I am going to ask you some questions about your Social factors (Please circle one answer for each of the following questions)

	questions	*Strongly Disagree*	Disagree	not sure	Agree	Strongly Agree
1	My partner, have recommended for me to get checked for cancer.	1	2	3	4	5
2	My family have advised me to go to a doctor to check for cancer.	1	2	3	4	5
3	My friends have talked to me about the importance of getting checked for cancer.	1	2	3	4	5

Annex B. Questioner (Amharic version)

ጅማ ዩኒቨርስቲ የህክምና ፋኩልቲ የሀረተሰብ ጤና ሳይንስ ክፍልጤናይሰጥልኝስሜ ይባላል።በዚህ ሰዓት በዚህ የተገኘሁት በጅማዩኒቨርስቲ በነርሲንግ ትምህርት ቤት በኩል የማህፀን ካንሰር ቅድመ ምርመራ እና ተያያዥ ሁኔታዎችን በተመለከተ ጥናታዊ መረጃ ለመሰብሰብ ነው።ይህ መጠይቅ የተዘጋጀው በቤተሰብ መምሪያ እና በሜሪሰቶፕስ ሞዴል ክሊኒክ አገልግሎት ለማግኘት ከሚመጡት ሴቶች ስለማህፀን ጫፍ ቅድመ ካንሰር ምርመራ እና ተያያዥ ሁኔታዎ ለመጠየ ነው።የጥናቱ ዋና አላማ የማህፀን ጫፍ ቅድመ ካንሰር ምርመራ ያደረጉ እና ያላደረጉትን መለየት እና ቅድመምርመራውን ለማድረግ የሚያስችሉ እና የማያስችሉ ሁኔታዎችን መለየት የሚያስችሉ መረጃዎችን ለማግነት ነው። አንድ

ማረጋግጥላችሁ ነገር በዚህ መተይቅ ውስጥ ስሞትንና እርሰን ለመለየት የሚያስችሉ ነገሮች አይጻፉም። የሚሰጡት መረጃ ከጥናታዊ ጽሁፍ ውጪ ለሌላ ለምንም አገልግሎት አልጠቀምም። መመለስ ያልፈለጉ ጥያቄዎችን እዲመልሱ አይገደዱም በጥናቱ ላለመካፈል በማንኛውም ጊዜ መወሰን ይችላሉ ነገር ግን ትክክለኛውን መረጃ እንዲሰጡኝ አበረታታለሁ፡:መጠይቁ ከ30 ደቂቃ በላይ አይወስድበወትም።ግልጽ ያልሆነ ነገር ካለ በማንኛውም ጊዜ መጠየቅ ይቻላል ።

ጥናቱ በማንም ግለሰብ እና ህ.ሰብ ላይ የሚያስከትለዉ ምንም ችግር የለዉም

የጥናቱ ጥቅም ለፖሊሲ አዉጭ እንደ ግብአት በመሆን ለቅድመ ካንሰር ምርመራ እቅዶችን ለማዉጣትና ለህ.ሰቡ ቀድሞ በመመርመር ካንሰርን ለመከላከል ያገለግላል። በተጨማሪ ጥናቱ ካለቀ በኃላ ዉጤቱ ለርሰወ በተለያየ መንገድ ይገለጽለወታል። አጥኝው ስለጥናቱ አለማና ሌሎች የሚስፈልጉትን መረጃዎች በትክክል አብራረቶልኛል በተጨማሪም በጥናቱ ላይ ላለመከፈል መብት እንዳለኝ እና በሚያስፈልገኝ ጊዜ ማቋረጥ እንደምችል ተነግሮኛል በዚህም ላይ በመመስረት በጥናቱ ላይ ለመካፈልና የተጠየቀውን መረጃ ለመስጠት መስማማቴን አረጋግጣለሁ።በጥናቱ ላይ ለመካፈል ፈቃደኛነት ተጠያቂው ከተስማሙ ወደ ጥያቄዎቹ ይለፉ ተጠያቂው ካልተስማሙ አመሰግነው ወደ ሌላ ተጠያቂ ይለፉ

መረጃው የተሰበሰበበት ቦታ ክሊኒክ ---------- መረጃዉ የተሰበሰበበት ቀን ----------

መረጃውን የሰበሰበው ሰው ስም ---------- ፊርማ ---

ይህንን መጠየቂያ ቅጽ በሰለጠንኩት መሰረት እና በቅጽ ውስጥ በተቀመጠው ትዕዛዝ መሰረት በትክክል መሙላቴን ትክክል መሆናቸውን ማረጋገጥ እወዳለሁ።

የተቆጣጣሪው ስም ---------- ፊርማ ----------

ማንኛዉም ጥያቂ ካለወ በ0912062295 ብለዉ ይደዉ

u.ስለማህበራዊና ዲሞግራፊያዊ መረጃዎች

1 ዕድሜ ---------- -2 የተወለዱበት ቀን----------3 ስንት ልጆች ወልደዋል ----------

4. የጋብቻሁኔታ

1.ያላገባ -) 2 ያገባ 3. ተጋብተዉ አንድ ቦታ የማይኖሩ

4.መ.የፈታች 5. ባሏየሞተባት

5.የትምህርት ደረጃ

1. ከ1-4 ክፍል

2.ከ5-8

3.ከ9-10)

4.ከ11-12

5. ኮሌጅ

6 ዩንቨርሰቲ አና ከዚያ በላይ

6.ሀይማኖት

1. ኦርቶዶክስ 2. እስልምና 3 .ካቶሊክ 4. ፕሮቴስታንት 5.ሌተ(ይጠቀስ)----------

7.ብሔር

1. አማራ 2. ኦሮሞ 3. ትግሬ

4. ጉራጌ 5. ሌላ ·l ይጠቀስ ----------

8.ስራዎ ምንድን ነው

1. የቤት እመቤት 2.የግልሰራተኛ 3 .አርሶ አደር 4. የመንግስት ሰራተኛ 5.የቀን ሰራተኛ 6.ነጋዴ 7 ሌላ ካለ ይጠቀስ---

9.**ውርሃዊ ገቢዎ ስንት ነው በኢትዮጵያ ብር** ----------

ክፍል አንድ የመህፀን ጫፍ ምርመራ ተግባራት

10. ስለ የማህፀን ጫፍ ቅድመ ካንሰር ምርመራ ሰምትዉ ያዉቃሉ

ሀ.አዎ (1) ለ.አላዉቅም(0)

11. የማህፀን ጫፍ ቅድመ ካንሰር ምርመራ አድርገው ያውቃሉ?

ሀ. አድርጊያለሁ(1) ለ.አላደረኩም (0)

መልስዉ አላደረኩም ከሆነ ለምን ነደላድረጉ ጥያቄ ቁጥር 12ትን ይምልሱ; አድርጊያለሁ ከሆነ ወደ ክፍል ሶስት ይለፉ.

12. ከዚህ በታች የተዘረዘሩት የቅድመ ካንሰር ምርመራ ላለማድረጌ ምክንያቶች ናቸው ብለዉ እርስዉ የሚስማሙበትን አዎ የማይስማሙበትን አይደለም በማለት ይመልሱ

t.q>	ጥያቄ	አዎ	አይደለም
ሀ.	ስለ ቅድመ ·ካንሰር ምርመራ ብዙ እውቀት ስለሌለኝ	1	0
ለ.	በምርመራ ግዜ ውስጥ ህመም አለዉ ብየ ስለማስብ	1	0
ሐ.	በዚህ በሽታ እጠቃለው ብየ አስቤ ስለማላወቅ	1	0
መ.	የማህፀን ምርመራ በመፍራት	1	0
ሠ.	የምርመራ ቦታ ስለማላዉዉ	1	0
ረ.	የፍቅር ጓደኛ አለመፍቀድ(ስለማይፍክድልኝ	1	0
ሰ.	ሐይማኖትና ባህሌ ስለማይፈቅድልኝ	1	0

ክፍል ሁለት. ምርመራ ለማካሄድ አሰተዋጾ ሊያደረጉ የሚችሉ ሁኔታዎች

13 . ከሚከተሉት ዉስጥ ምርመራ ለማካሄድ አሰተዋጾ ያደረገለዎትን ይግለጹልን

1. ከቤተሰብ መረጃ ማግኘት 2.ከቤተሰብ የታመመ ስለነበረ 3.ከጓደኛ መረጃ በማግኘቴ

4. ከነርስ .ከጓደኛ መረጃና ምክር በማግኘቴ 5.ከዶክተር መረጃና ምክርና በማግኘቴ

6 ረዲዮ/ቲቪ 7. ከበራሪ ወረቀቶቺ

8 . ከጋዚቶች/ከመጽሂቶች 9.ከጤናኤክስቴንሽን መረጃና ምክርና በማግኘቴ

14 ስለማህፃን ጫፍ ምርመራ ትምህርት የት ቢሰጥ ይሻላል ይላሉ

1. በሴቶችማህበር 2. በሃይማኖትቦታ 3. በጤናድርጅት 4. በገበያ

ክፍል ሶስት የእዉቀት ጥያቄ

15. የሚከተሉትን ጥያቄዎች የማህጸን ጫፍ ካነሰር መከላከያና ቅድመ ምልክቶች ናቸዉ የምትሏቸዉን አዎ ወይም አይደለም በማለት መልሱ.

ተ.ቁ	ጥያቄ	አዉ	አይደለም
ሀ	የማህፀን ጫፍ ካንሰር መከላከል ይቻላል	1	0
ለ	የማህፀን ጫፍ ካንሰር በክትባት መከላከል ይቻላል	1	0
ሐ	የማህፀን ጫፍ ካንሰር በቅድመ ምርመራ ክትትል በማድረግ መከላከል ይቻላልን	1	0
መ	የማህፀን ጫፍ ካንሰር የፍቅር ጓደኛ በመቀነስ መከላከል ይቻላል	1	0
ሠ	የማህፀን ጫፍ ካንሰር ሲጋራ ባለማጨስ መከላከል ይቻላል	1	0
ረ	የማህፀን ጫፍ ካንሰር ኮንዶም በመጠቀም መከላከል ይቻላል	1	0
ሰ	ተመርምሮ የማህፀን ጫፍ ካንሰር መኖሩን በማወቅ መከላከል ይቻላል	1	0
ሸ	ከወር አበባ መምጫ ጊዜ ውጪ የሚከሰት የማህፀን ደም መፍሰስ የማህፀን ጫፍ ካንሰር ምልክት መሆኑን ያዉቃሉ	1	0
ቀ	ለረጅም ጊዜ የሚቆይ የጀርባ ህመም የማህፀን ደም መፍሰስ የማህፀን ጫፍ ካንሰር ምልክት መሆኑን ያዉቃሉ	1	0
በ	ለረጅም ጊዜ የሚቆይ መጥፎ ሽታ ያለው የማህፀን ፈሳሽ ካንሰር መሆኑን ያዉቃሉ	1	0

ተ	በግብረ ስጋ ግንኙነት ጊዜ የሚኖር ህመም ወይም ምቾት አለመኖር የማህፀን ጫፍ ካንሰር ምልጀክት መሆኑን ያዉቃሉ	1	0
ቸ	የወር አበባ መብዛት እና እየፈሰሰ ለብዙ ጊዜ መቆየት የካንሰር ምልክት መሆኑን ያዉቃሉ	1	0
ነ	የወርአበባማየትካቆመች(ከእርጣት)በሕዋላየሚከሰትደም መፍሰስ የማህፀን ጫፍ ካንሰር ም ልክት መሆኑን ያዉቃሉ	1	0
ኘ	ለረጅም ጊዜ የሚቆይ ተቅማጥ የማህፀን ጫፍ ካንሰር ምልክት ሊሆን ይችላል መሆኑን የዉቃሉ	1	0
አ	በግብረ ስጋ ግንኙነት ጊዜ ወይም በኋላ የሚፈሰስ ደም የካንሰር ምልክት መሆኑን ያዉቃሉ	1	0
ከ	በሽንት ወይም በሰገራ ላይ የሚታይ ደም የማህፀን ጫፍ ካንሰር ምልጀክት መሆኑን ያዉቃሉ	1	0
	ምክንያቱ ያልታዎቀ የክብደት መቀነስ የማህፀን ጫፍ ካንሰር ምልክት መሆኑን ያዉቃሉ	1	0

ሐ. የአመለካከት ጥያቄ

16. ከዚህ በታች የተዘረዘሩት ሁኔታወች የማህፀን ጫፍካንሰር የመከሰት እድሎች ሰፊ ሊያደርጉ ይችላሉ በሚለው ሃሳብ ምን ያህል ይስማማሉ

	ጥያቄዎች	በ.አል ስማ ማም	አልስ ማም	እርግጠኛ አይደለሁ ም	እስማ ማለሁ	በ.እስ ማማ ለው
ሀ	ሲጋራ ማጨስ	1	2	3	4	5

ለ	የሰውነት የበሽታ የመከላከያ አቅም መቀነስ	1	2	3	4	5
ሐ	ለረጅምግዜ የወሊድ መቆጣጠሪያ መውሰድ	1	2	3	4	5
መ	በግብረስጋ ግንኙነት የሚተላለፉ በሽታወች መኖር	1	2	3	4	5
ሠ	የወንድ የፍቅር ጓደኛ አለመገረዝ	1	2	3	4	5
ረ	በልጅነት እድሜ የግብረ ስጋ ግኙኝነት መጀመር(መፈጠ,ጸም)	1	2	3	4	5
ሰ	ከብዙሰዎችጋር ወሲብመፈፀም	1	2	3	4	5
ሸ	ብዙ ልጆችመውለድ (»5)	1	2	3	4	5
ቀ	ከዚህ በፊትብዙ ፍቅኛች ካሉት sˆጋር ግንኙነት ማድረግየፍ	1	2	3	4	5
በ	ጊዜውን የጠበቀ ቅደመ ካንሰርምርመራ አለማድረግ	1	2	3	4	5
ተ	ጥሩ የጤና አጠባበቅ መኖር ካንሰር ይከላከላል ብለው ያምናሉ	1	2	3	4	5
ቸ	ፈጥነው በመመርመር እና በመታከም ካንስርን መከላከል ይቻላል	1	2	3	4	5
ነ	ካንሰር የሚከሰተው ቀስ በቀስ ነው ብለው ያምናሉ	1	2	3	4	5
ኘ	ከ30ዓመት በላይ የሆኑ ሴቶች የመጠቃት እድላቸው ከፍ ያለ ነው	1	2	3	4	5
አ	ከ30-49 ዓመትያሉ ሴቶች ቢያንስ አንድ ግዜ መመርመር አለባቸው	1	2	3	4	5
ከ	ቅድመ ካንሰር ምርመራ ቀላል ፈጣንና ከህመም ነፃ ነው	1	2	3	4	5
	ተመርምረው የካንሰር በሽታን አለ ማለት ሞትን አይገልጽም	1	2	3	4	5

ክፍል አራት .በጤና ድርጅቶች ሊከሰቱ የሚችሉ ተጽኖወች

17.ከሚከተሉትሁኔታዎችመካከልወደምርመራለመሄድ የማያስችሉ ናችዉ የሚሉትን አዎ አይደለም ከሆነ አይደለም በማለት መልሱ

	ጥያቄ	አዎ	አይደለ ም
ሀ	የጤና ባለሞያዎች ስለ ካንሰር ምርመራ ምክር ስለማይሰጡ	1	0
ለ	የሴት መርማሪዎች እጥረት ስላለ	1	0
ሐ	የጤና ባለሞያዎች lቅድመ ምርመራ ያላቸዉ አመለካከት ጥሩ ስላልሆነ	1	0
መ	የጤና ድርጅቶች የምርመራ ሰዓት አመች ወይም ቆሚ ስላልሆነ	1	0
ሠ	የጤና ድርጅቱ የመመርመሪያ ክፍል ሚስጥርን ለመጠበቅ አመቺ ሆኖ ስላልተቀመጠ	1	0
ረ	በቅርብ ቦታ ባለ የጤና ድርጅት ውስጥ አገልግሎቱ ወይም ምርመራ ስለማይሰጥ	1	0
ሰ	ጤና ድርጅቶች በጣም ስለሚርቁ	1	0
ሸ	የምርመራ /የህክም እና የትራንስፖርት ክፍያ ስለሊለን (ዉድ ስለሆነ)	1	0

ክፍል አምስት ከህብረተሰቡ ሊከሰቱ የሚችሉ ተጽኖወች

19.የሚከተሉት ጥያቄዎች ከህብረተሰቡ yn&Åu*f*ኔª ሊከሰቱ የሚችሉና ምርመራ ልማካሄድ ከፍተኛ አስተዋጾ ያላቸዉ ናቸው እርስዉ ከሚከተሉት የስምምነት ምርጫ በማንኛው ይስማማሉ

	ጥያቄ	በ.አልማ ማም	አልስ ማም	እርግጠኛአ ይደለሁም	እስማ ማለሁ	በ.እስማ ማለው
1	የትዳር ጓደኛየ እንድመረመር ምክር ድጋፍ አድርገዉልኛል	1	2	3	4	5

2	ቤተሰቦቸ ዶ/ር ጋር ሄጀ መመርመር እንዳለብን ድጋፍና ምክር ሰጥተዉኛል	1	2	3	4	5
3	ጓደኞቸ የምርመራ አስፈላጊነት አስገንዝበዉኛል እንድመረመር ምክር ሰጥተዉኛል	1	2	3	4	5

ጊዜወን መስዋት አድርገዉ አስፈላጊወን መልስ ስለሰጡን እናመሰገናለን.

Annex C. QUESTIONNIARE (AFAN OROMO VERSION)

Yunivarsitii Jimmaa Fakalitii fayyaa dame saayinsii fayyaa hawaasaa

Akkam jirtu. Ani _____n jedhama. Yeroo ammaa kanin asitti argame karaa yunivarsitii Jimmaa Fakalitii fayyaa dame saayinsii fayyaa hawaasaatiin yaalii dursaa kaansarii gadameessaa fi haalota kanaan walitti hidhata qaban ilaalchisee ragaa qu'annoo sassaabuufi. Gaafannoon kun kan qophaa'e dubartoota tajaajila argachuuf gara qajeelcha karoora Maatiifi Kilinika Modelii Mariistoppii dhufan irraa waa'ee wal'aansa dursaa kaansarii fiixee gadameessaa fi haalota kanaan walitti hidhata qabanii gaafachuufi. kaayyoon qu'annichaa inni guddaan dubartoota yaalii dursaa fiixee gadameessaa taasisaniifi hin taasisne adda baasuufi yaalii kana taasisuuf dhimmoota

dandeessisaniifi rakkoo ta'an ragaa sassaabuufi. maqaan keessaniifi wantoonni maalummaa keessan ibsan kamuu qu'annoo kana keessatti hinbarreeffamu. Ragaa isin kennitanu kamuu dhimma qu'annoo kanaatiif male dhimma biraatiif itti hinfayyadamu. Gaaffii deebisuuf hinfeene deebisuuf hindirqamtanu. Qu'annoo kana keessatti hirmaachu diduuf yeroo kamuu murteessuu dandeessuu. Haata'u male, ragaa dhugaa akka naa kennitanu isinin gaafadha. Gaafannochi daqiiqaa 30 caalaa isinitti hinfudhatu. Wanti ifa isiniif hintaane yoo jiraate yeroo kamuu gaafachuu dandeessu. Kaayyoofi wantoota barbaachisan kan biroo qu'atichi naa ibseera. Akkasumas qu'annicha irratti hirmaachuufis hirmaachuu diduufis mirga akkan qabuufi yeroon barbaadetti addaan kutuu akkan danda'u naa ibseera. Qu'annicha irratti hirmaachuuf namni gaafatamu fedhii yoo hinqabaanne galateeffadhuu gara nama gaafatamu biraatti darbi.Iddoo ragaan irraa sassaabame

Kilinika _____

Guyyaa ragaan itti sassaabame _____

Maqaa nama ragicha sassaabee _____

Mallattoo _____

Gaffilee

Lakkofsa Eenyyummaa Gaaffii Guyyaa Iddoo

1. Gaaffiilee eyyummaa nama dhunfaa
    A. Oddeeffannoo eyyummaa
        1. Umrii _____
        2. Guyyaa dhalota
        3. Baay'ina da'umsaa

4. Haalii fudhaa fi heerumaa keessan maal fakkataa?

    a. Hin heerumnee

    b. Heerumeraa ykn abbaa mana koo wajjin jiraacha jira.

    c. Heerumeera /garuu ammaa iddoo gara gara jiranna

    d. Hikeen jira/ wal hikneere

    e. Abbaan mana koo nairraa du'eera

5. Sadarkaan barumsaa keessan meeqa?

    a. Kuta 1-4

    b. Kuta 5-8

    c. Kuta 9-10

    d. Kuta 11-12

    e. Kolleejji

    f. Yuunvarsitti fi Sana olii

6. Amantii keessa_____

    a. Kirstaanaa ortoodoksii

    b. Musilimaa

    c. Kirstaana kaatolikii

    d. Kirstaana piroostantii

    e. Kan biro _____

7.sabnii kee maalii

    A.amhara

    b.oromo

    c,tigre

d.gurage

e.kan bira jiratu ibsii

8.Hojiiin kee maalii _____

a.haadha mana

b. hojii dhunfaa

c. qottee bula

d. hojjetaa mootummaa

e.dafqan bulaa

f. daldaalaa

g. barataa

h. kan biro_____

9. galii maatii keessaanii ji'aan meeqaa?_____

10.. wa'ee kaanseerii afaan gadameessaa dhagettanii bektuu?

A.eyyen

b.miti

11.kaanseerii afaan gadameessaa lallamtanii bektuu

a.lallamera

b.hin lallamne

yoo hin lallamne tahee maliif akka lallamu diddanii gaafii 12 deebisa,yoo eyyee jettanii gara kuta

3 ffatti dabra

12. Gaaffiin Armaan Gadii Sababoota Dubartoonni Qorannoo Afaan Gadameessaa Hin Taasisneedha. Filaadha.

	Gaaffii	Yes	No
a	Waa'ee kaansrii afaan gadameessaa hubbannoo xiqqoo qabaachuu		
b	Qorranichii dhukkubi waan qabuuf		
c	Kaansarii afaan gadameessaan wantaan qabamuu waan natti hin fakkanneef		
	Soda qorannoo gadameessaattif		
e	Abbaa mana koo waan hin eeyyamnee iddoo qorannoo		
f	iddoo qorannoo itti geggeeffamuu waan hin beekneef		
g	Amantii fi adaan waan hin heyyemneef		

Kutaa 3 ffa qorannoo gochufi wantootaa gargaranii

13. haala qorannoo kaansarii afaan gadameessaa eessa dhageesse

a. maatii keessaa

b. hirriyya irraa

c. naarsii irraa

d. dooktora irraa

e. eksisteeshini fayyaa irraa

f. kan biro_____

14. iddoo ergaa/ yaadachisa waa'ee kaansarii afaan gadameessaa eessa garriin essaa jettanii yaadu?

a. waldaa dubartoota naannoo

b. iddoo waaqeffannaa /sagadatti

c. waajjira eegumsa fayyaatti

d. manatii

e. iddoo qabaati

f. kan biro_____

kuta tokkoffa :gaffii beekumsaa

15.gaffiwwanii armanii gadii kaansarii afaan gadameessaa ittisufi mallatto isa eyyen tkn lakkii jedha deebisa

Lakk	Gaaffii	Eyyee	Lakkii
a	Kaanseerii afaan gadameessaa ittisuun ni danda'ama		
b	Kaanseerii afaan gadameessaa kittibaata HPVni ittifma?		
c	Kaanseerii afaan gadameessaa qorannoo yeroo yeroon godhamuu ni ittifama?		
d	Kaanseerii afaan gadameessaa namoota wal qunnamtiisaala walii rawwatan murteessudhan ni ittifamaa?		
e	Kaanseerii afaan gadameessaa sigaraa /tamboo xuxuu dhisuudhaan ni ittifamaa?		
f	Kaanseerii afaan gadameessaa kondomii fayyadamuun ni ittifamaa?		
g	Kaanseerii afaan gadameessaa hordoffii firii qoranno garii hin ta'ee godhamuu ni ittifamaa?		
h	Dhanga'uun dhigaa osoo laguu hin ga'iin dhufuu mallattoo kaanseerii afaan gadameessaati		
i	Dhukkubni dugda gara gadii anaa walitti fufinsaa mallatto kaansari afaan gadamessaatti		

j	Dhangala'oon foolii qabeessa amma ammaa ba'uu mallattoo kaanseerii afaan gadameessatti		
k	Dhukkubni yeroo wal qunnamtii saala amma ammaa umaamuu mallattoo kaanserii afaan gadameessaatti		
l	Gara kaasan amma ammaa mallattoo kaanseerii afaan gadameessatti		
m	Laguun Dhigni baay'ee bahuu mallatto kaaserii afaan gadaameessatti		
n	Dhigni ergaa haati tokko laguu erguu dhisuun duraa fi boodaa jiruu mallattoo kaanseerii afaan gadaameessatti		
p	Dhigni boolii furdaa fi boolii bishaanii wajjin bahuu mallattoo kaanseerii afaan gadameessatti		
q	Ulfaatina qaama baay'ee hiraachuun mallattoo kaanseerii afaan gadameessaatti		

Gaffii ilalchaa

16..Gaaffiilee armaan gadiif hammaam tokko sirritti waliif galtuu ykn sirritti walif hin galee haatti tokko carraa kaasarii afaan gadaamessaa qabamuu dabala? Filadhaa?

Lakk	Gaaffilee	Baay'ee sirritti	sirritti	Hin murteesi ne	Walin hin galu	Baay'ee waliihin galuu
a	Taamboo xuxuu					
b	Hiraachuu madinummaa qaama (HIV,fi k.k					
c	Yeroo dheeraaf qoorichaa /kininii dahumsaa ittisuu fayyadamuu					

d	Dhukkubbota qaamoolee wal hormaata					
e	Abbaa mana hin kitaanamee qabaachuu					
F	Wal qunnamtii saala umrii xiqqaati eegaluu					
G	Namoota hedduu wajjin wal qunnamti saala owwachuu					
H	Ijjoolee baa'ee (5 ol qabaachuu)					
I	Abbaa mana namoota hedduu wajjin wal qunnamtii saala rawwate qabaachuu					
j	Qoranno /hordoffii kaansarii afaan gadameessa rawwachuu dhisuu					
k	Hojiilee fayyummaa egsisaan rawwaachuun kaasarii afaan gadameessaa ni ittisaa					
l	Kaansarii afaa gadaameessa sutaa kan dhufuu fi kan ittifamudha					
m	Qorannoon kaansarii afaan gadameesaa yaalamee fayuu addaa baasuuf ni fayyadaa					
n	Haati ykn dubaartiin umriin 30 fi 40 isaa ol caraa kaansarii afaan					

	gadameessaan qabamuu kan umrii <30 gadi calaa qabdi					
o	Haati /dubaartiin umrii 30 hanga 40 yoo xiqqaatee al tokko ilaalamuu qabdi					
p	Qorannoon kaansarii afaan gadameessaa salphaa fi arittin kandhukkubii hin qabneedha					
q	Bu'a qorannoo kaansarii afaan gadameessaa qabaachuu agarsiisuun ni duuta jechuu miti					

Gaaffilee rakoowanii wajjirallee fayyatiin waliiqabatanii

17.gaffillee armanii gadii kessa lallamu fi gufuu kan tahanii eyyee ykn lakkii jedha debisa

a	Oogeesaa fayyaattin wanta itti isinitti hin hirmaamneef	Eeyye	Lakkii
B	Hir'ina ogeessaa fayyaa dubbartota		
C	Simanaa oogessaa fayyaa gaarii hin taanee		
D	Yeroo qorannoo itti gaggeeffamuu waan hin mijaanneef		
E	Qorannichi galii waan ta'eef		
F	Iddoo qorannoo mana yaala waan hin mijaanneef		
G	Waajjira yaala dhihootti waan hin kennamneef		
H	Iddoo qorannoo itti gaggeefamuu irraa fagoo waan ta'eef		

Kuta 5ffa rakkowanii dhibba hawasatiin dhufanii

gaffillee armanii gadii kessa rakkowanii dhibba hawasatiin dhufanii lallamudhafi iddoo gudda qaba jettanii kan yadanii fillanno kaneeni kessa kamii

	Gaaffii	Sirritti Walif hin galu	Walif hin galu	Hin beeku u	Sirritti walif galuu	Baay'ee sirritti walif gala
1	,Abbaa mana , koo akkaan qorannoo gageessuu na jajjabessuu					
2	Maati fi dooktaara birraa akkaa deemu na jajjabeessuu					
3	hirriyyoonni faayida qorannoo kaansaricha natty himu					