ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCEINCES

SCHOOL OF PUBLIC HEALTH

SHARED DECISION-MAKING IN CERVICAL CANCER CARE AT TIKUR ANBESSA SPECIALIZED HOSPITAL, ADDIS ABABA, ETHIOPIA

BY: Sosina Workineh Tilahun (Bsc)

A Thesis Submitted to the Graduate Program of Addis Ababa University, College of Health Sciences, School of Public Health in Partial Fulfillment for the degree of Masters of Public Health in Epidemiology and Biostatics (specialty in Health Research Ethics)

DATE: JUNE, 2025

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MASTER OF PUBLIC HEALTH

RESEARCH PROJECT SUBMISSION FORM

Name of Investigator	Sosina Workineh Tilahun (Bsc)
Name of Advisor (s)	Dr. Adamu Addissie (PhD, Associate Professor) Lealem Wagaw (Bsc, Msc) Adiam Nega (Bsc, MPH)
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LIST OF ACRONYMS

CC…….Cervical Cancer

ECOG……East Oncology performance Status Scale

HLS-Q……..Health Literacy Survey Questionnaire

IOM……....Institute of Medicine

LMIS…….....Low and Middle Income Countries

REC……Research Ethics Committee

SDM…….Shared Decision Making

SDs……Standard Deviations

TASH……Tikur Anbessa Specialized Hospital

TiOS……..Trust in Oncologist Scale

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ABSTRACT

Background: Shared decision-making is crucial for alignment of treatment options with patient values and preferences in clinical cancer care due to the complexity of treatment options and the significant impact of decisions on patients' lives. However, currently in Ethiopia, shared decision-making in clinical care of cancer, in which cervical cancer is not exceptional, is not well understood.

Objectives: To determine the level of shared decision-making in the clinical care of women with cervical cancer and its associated factors.

Methods: The study employed a convergent mixed study design from February to June 2025 at Tikur Anbessa Specialized Hospital. Quantitative data were collected through interviewer-administered questionnaires from 203 women undergoing treatment for cervical cancer. Additionally, qualitative data were gathered through in-depth interviews with 15 women with cervical cancer on follow-up, as well as 10 clinical oncologists who have provided care for these patients for the past three years. Statistical analysis was executed using software SPSS (version 26). Descriptive statistics were employed to summarize the variables of the study. Multiple linear regression analysis was then carried out to determine significant predictors of level of shared decision-making. Thematic analysis was conducted for the qualitative findings. Quantitative and qualitative findings were integrated to explain factors predicted the level of shared decision-making in the clinical care of women with cervical cancer.

Result: With a ranging scale of 16–53 and a standardized mean score of 3.78 (± 0.54), the overall mean score for the current study's level of shared decision-making was 33.94 (± 9.11). According to this study, there are significant positive linear associations between higher levels of shared decision-making practice and younger age, separated marital status, active employment, increased trust in oncologists, short duration since diagnosis, and lower health literacy. The thematic analysis depicted socio-demographic, psychological, communication and institutional factors affecting practice of shared decision making in clinical care of women with cervical cancer.

Conclusions: The study emphasizes the complex interplay of socio-demographic, psychological, communication, and institutional factors affecting practice of shared decision-making in the

clinical care of women with cervical cancer. Thus, understanding these dynamics may help to enhance the practice of shared decision-making in the clinical care of women with cervical cancer.

Keywords: Shared Decision Making, Cervical Cancer, Tikur Anbessa Specialized Hospital

1. INTRODUCTION

1.1. Background

In 2022 cancer affected over 20 million people worldwide, with approximately 9.7 million cancer-related deaths. Globally, lung and breast cancers are the most prevalent types, leading in mortality rates (1). In Africa, 1,109,209 new cancer cases were recorded in 2022, resulting in 711,429 deaths. The leading forms of cancer in the continent are breast cancer and cervical cancer, representing 16.8% and 10.6% of cases, respectively (2). According to GLOBOCAN 2022, Ethiopia reported 80,334 new cancer cases and 54,698 cancer-related deaths. Notably, approximately 73% of the country's cancer patients are women, with breast and cervical cancers being the leading causes of mortality, accounting for 9,626 (17.6%) and 5,975 (10.9%) deaths, respectively (3).

Cervical cancer (CC), which is mostly known among women with low socioeconomic status, is reported to globally affect around one million women. In 2022, the Agency for Research on Cancer estimated that 570,000 women were diagnosed with cervical cancer and 311,000 women died of it. Cervical cancer contributed more than 85% to cancer cases and related deaths in low- and middle-income countries (LMICs), where sub-Saharan Africa (SSA) is not an exception. Next to breast cancer, cervical cancer is the second most common cancer in Ethiopia, with an estimated 6,294 (13.6%) new cases and 4,884 (10.2%) deaths each year(4,5). According to a study, women with cervical cancer have experienced multiple types of moderate or severe physical, psychological, social, and spiritual suffering (6).

For decades, physicians were solely responsible for determining patients' treatment plans, with little to no input from the patients themselves, leaving patients fully responsible for their treatment process (7). However, patient involvement in the clinical decision-making process has become a cornerstone of contemporary medicine. Involving patients in decision-making of clinical care includes disclosure of alternative treatment options for specific conditions. Furthermore, this practice upholds their autonomy and is strengthened by the principles of informed consent (8). Throughout the health care procedure, medical professionals have the freedom to suggest treatments drawing from their knowledge and experience. Simultaneously, patients maintain the ability to decline these proposals, encouraging a shared decision-making (SDM) approach**.**

Shared Decision-Making (SDM) is a preferred model of decision-making in healthcare. In the SDM model, treatment decisions are made only after the patient fully understands the entire treatment plan, including its potential risks and benefits, through the informed consent process (9,10). Moreover, SDM is recognized as a key component of patient-centered care within the healthcare system (11). SDM is crucial in clinical decisions for serious illnesses, i.e., cancer care, where choices about interventions can directly impact treatment outcomes, making the model an essential tool in cancer care (10). According to the Institute of Medicine (IOM), delivering high-quality cancer care requires a patient-centered approach and emphasizes the importance of shared decision-making due to several factors: 1) Cancer care can be highly complex, and patients' treatment choices can significantly affect their health outcomes and quality of life; 2) the evidence supporting many cancer care decisions is often limited or incomplete; and 3) patients differ in how they prioritize the trade-offs between different treatment options (12). Thus, the need for SDM in cervical cancer care is inevitable.

Cervical cancer, recognized as the most frequent cancer among women, is also known for the consequences of the treatment modalities later in life, as well as being life-threatening (13). Thus, SDM was witnessed to play a lion's role in determining the outcome of treatment modalities in the care of cervical cancer with increasing levels of adherence to treatment intervention among those populations (14). However, in Ethiopia, where cervical cancer is a common type of cancer, the application of SDM in caring for cervical cancer is not documented. Thus, this current study will determine the level of SDM in the clinical care of cervical cancer with its associated factors among women with cervical cancer having treatment follow-up at Tikur Anbessa Specialized Hospital.

1.2. Statement of Problem

Studies indicated that shared decision-making (SDM) has the potential to enhance health outcomes in healthcare (15), as it allows patients to make decisions based on their values, preferences, and experiences (16). According to a 2018 study from the United states of America, about half of adult patients report being involved in their clinical care decisions (15). The rates of SDM did not increase from 2003 to 2013; in fact, SDM among adult patients decreased from 61.1% in 2003 to 51.4% in 2013. Several factors have been identified as contributing to this decline, including a lack of clear communication between physicians and patients (10). This communication gap has also been linked to patient dissatisfaction (17). Furthermore, this established communication failure is strongly associated with the risk of medicolegal malpractice litigations, as studies show that ignoring or failing to recognize patient preferences places clinicians at greater risk of being sued (10).

Previous research highlights the financial and emotional advantages of positive patient-provider communication (18,19). A study found that supporting patients in decision-making enhances both the quality of decisions and the decision-making process, ultimately leading to better health outcomes (20). Conversely, it has been reported that ineffective shared decision-making (SDM) correlates with poor health outcomes, diminished quality of care, and increased healthcare utilization (21). Furthermore, additional studies have indicated that implementing SDM can yield significant positive affective and cognitive outcomes that enhance shared decision-making (22,23). These positive outcomes boost patient autonomy and reduce decisional regret, further validating the use of the SDM model (24). However, there are potential challenges when external factors, such as governmental, political, or institutional influences, dictate the patient-provider relationship, affecting this patient-provider communication and leading to affecting clinical decision-making (8).

SDM is often promoted as an ethical approach for decision-making in cancer care. The growing attention to high-quality cancer care has turned its focus on SDM in cancer care. However, many cancer patients find it challenging to make decisions about their own treatment (10,16), and there are frequent reports of the limited applicability of SDM in cancer care contexts. Cancer treatments can lead to toxicity and significant lifestyle changes, making it hard for patients to navigate their

care decisions (10). Furthermore, a cancer diagnosis and its treatments can have profound psychological and practical impacts on both patients and caregivers, creating various difficult situations (25). In cervical cancer care, different treatment modalities have come into existence in the past two decades, including endocrine-based to surgical-based, requiring careful selection of treatment approach (26). And patients' varying attitudes regarding various treatment modalities make SDM the most crucial step in the treatment strategy for cervical cancer.

Despite the availability of decision-making tools, there is an inherent complexity in SDM due to the behavioral traits and attitudes of physicians and patients (27). In developed countries, SDM is a legal obligation (28), and it has been shown to increase the satisfaction of the patient, improve cost-effectiveness, and reduce malpractice lawsuits (29,30). It is claimed to be a keystone to guarantee good quality cancer care (30), and it is highly recommended by medical associations (31). The implementation of SDM has persistent barriers (32–36), and it is still poor (37,38). Measuring SDM as a quality indicator and reimbursing professionals that actually use SDM have been floated as another idea involving incentivization (28). On the other hand, while SDM can improve patient outcomes, it may also increase the time demands on physicians (12).

Although patients were found to value information about treatment plans, it is difficult to integrate the attitude and practice of SDM into daily clinical routine (39). Despite the leading stress of cervical cancer in Ethiopia, the practice of SDM is not widely adopted in Ethiopia, and the existing practice of involvement of patients in treatment decision-making is not well understood in the country. Therefore, our current study aims to measure the level of SDM in cervical cancer care and explain the factors that can enhance and obstruct shared decision-making in this context.

1.3. Significance of Study

In Ethiopia, the incidence of cancer, especially cervical cancer, is increasing with grave outcomes. The complex nature of these diseases often leaves patients finding it difficult to understand and identify suitable treatment options. As a result, integrating shared decision-making (SDM) into clinical oncology care could improve treatment outcomes and optimize the use of resources for cancer management. This study aims to provide evidence for future researchers on the implementation of SDM in cervical cancer care, ultimately leading to improved treatment processes for these women.

2. LITERATURE REVIEW

SDM, which is widely known in Europe, is defined as an approach where clinicians and patients make decisions together using the best available evidence (39). This definition of SDM has been introduced with several central components, including creating awareness of choice, describing treatment options, learning about the person receiving care, tailoring information, discussing the preferences of people receiving care, deliberation, and making or deferring the decision (38,40,41). Moreover, the principle of SDM in health care is considered a key element in patient-centered care. Additionally, this principle is a favored model in preference-sensitive settings (42). Additionally, it is known as an important tool in decision-making in the clinical setting of cancer care (10). And can be implemented during patient encounters with healthcare teams or providers, with at least the presence of two participants (e.g., a healthcare provider and a patient or family caregiver) (24).

2.1. Level of Shared decision making in cancer care

Studies have reported different levels of shared decision-making in the clinical care of women with cancer, particularly breast and cervical cancer. In the study from Holland, among women with breast cancer, the level of SDM was reported to be 16 on average (43). Another study of SDM implementation among women with breast cancer found that the level of perceived SDM was 72% before implementation of SDM, which was found to decrease after direct implementation to 33% (44). Furthermore, a study from Germany reads, Level of SDM among women with breast cancer was 73.8 (SD: 20.8) (13).

2.2. Factors Associated with SDM in cancer care

In recent years, women with gynecological cancer have been involved in the shared decision-making process or have let the physicians decide independently. Patients' perceived level of participation in clinical decision-making has been found to be affected by several factors. A study among women with breast cancer depicted that patients' trust in the oncologist was found not to be associated with the perceived level of shared decision-making (43). A study from the same

country revealed that SDM is associated with consultation time (β=0.2, P<0.001) (44). Furthermore, a study from Germany further depicted that age was found to be associated with level of SDM, in which older patients stated a higher level of participation than younger patients (13). This finding was found to be similar to another study where older patients perceive a high level of participation in decision-making ($p < 0.0001$) (45). Furthermore, patients who had had a mastectomy were found to depict an increased level of SDM.

In Taiwan, a study examines the relationship between shared decision-making and health literacy, reporting that high health literacy was found to be associated with a high level of shared decision-making (46). Despite the potential benefits of SDM, patients with lower health literacy may be less engaged in their healthcare overall. Other vulnerability characteristics (e.g., older age, racial/ethnic minority, lower socioeconomic status (SES), health-care access barriers, and poor health status) may further exacerbate efforts to improve patient-centered health-care outcomes (15).

A wide range of barriers at different levels, including individual, organizational, and systemic, has been identified as obstacles to the implementation of shared decision-making. For clinicians, these barriers include limited skills, knowledge, or formal training and limited resources, including time (47,48). Patients may have limited health literacy, awareness of choice, or belief in their capacity to be involved in decision-making (38,41,47,48). Although many healthcare providers may prefer to implement SDM into routine patient encounters, many variables, such as high levels of uncertainty, the complexity of medical decisions, multiple treatment options, and time constraints, can limit or prevent the use of SDM during communication encounters (12) .

Numerous studies supporting the use of SDM in patients with cancer, lack of time, and misunderstanding in communication were also cited as barriers to shared decision-making in clinical care of women with cancer (12). In a qualitative study by (49) on the promoters and barriers to nursing practice, patient, institutional policy, professional scope of practice, insurance coverage, and administrative barriers were identified as reasons for limited participation in SDM (50). A study from India reported that cultural beliefs and prejudices impact the extent of participation and engagement of a patient in a treatment plan (10).

2.3. Summary

Studies indicate that SDM is a skill that requires extensive training and effective communication (10). This holds true in cancer care, where emotional distress can significantly impair a patient's ability to make decisions. Additionally, not all physicians are adequately prepared to support patients in this process. This study will first examine the decision-making process in cancer care, identifying the facilitators and barriers alongside the current practices. This foundational understanding will pave the way for future research focused on implementation strategies following the findings of this paper. In Ethiopia, where the number of women cancer patients is increasing every year,, specifically cervical cancer, these decision-making aids require information from the concerning body. However, first, the level of practice of shared decision-making and barriers and facilitators of shared decision-making in the setting should be uncovered.

3. CONCEPTUAL FRAMEWORK

According to several studies, shared decision-making in clinical care has been found to be associated with a number of factors, including the socio-demographic status of the patient ((13) (45), the clinical status of the patient (45) (15), the health literacy of the patient (46), trust in the clinical oncologist (48), and consultation time between the patient and the health care provider (44). **Fig1.**

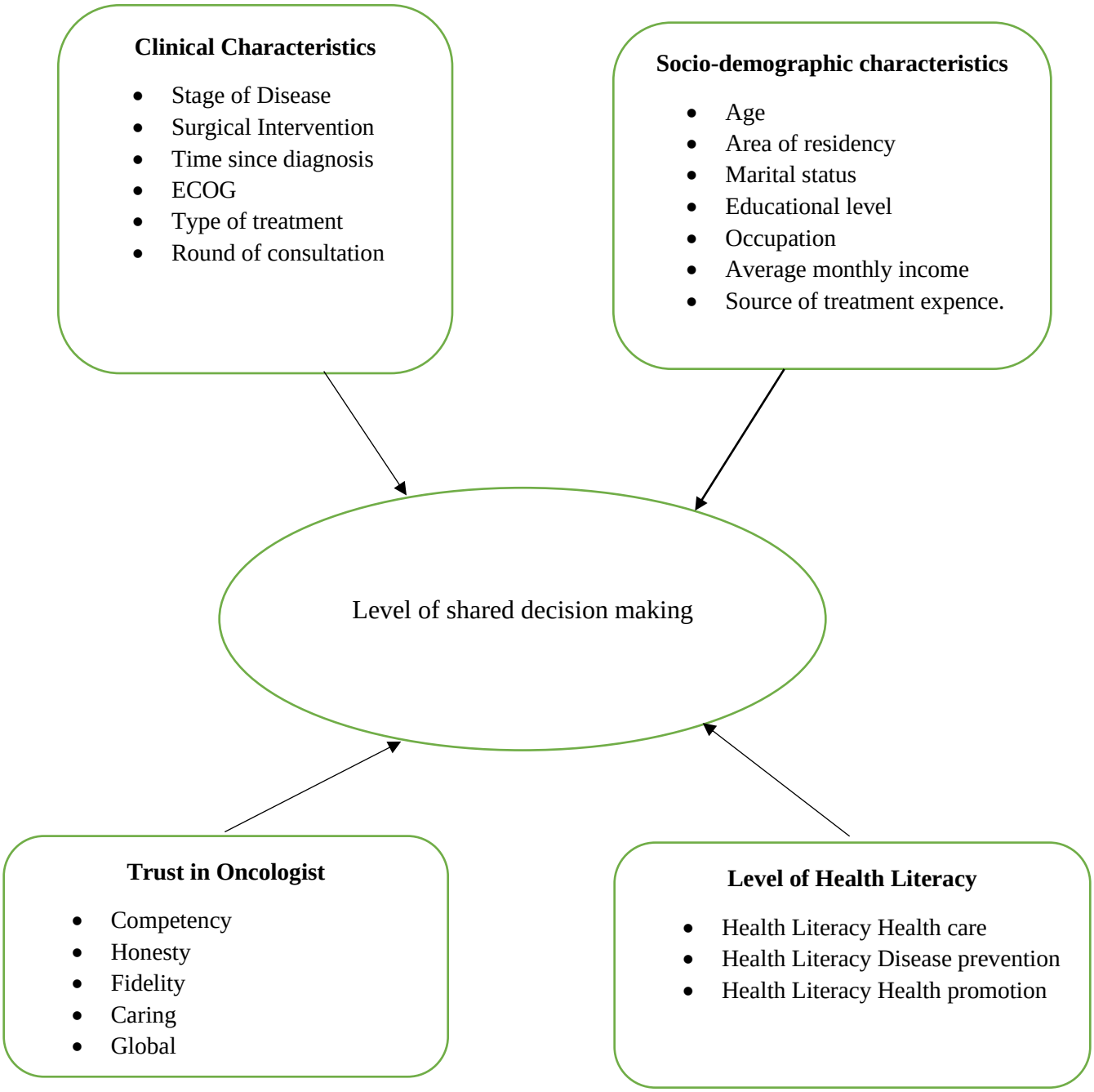

Figure 1. Conceptual Framework depicting factors predicting level shared Decision Making

4. OBJECTIVE OF THE STUDY

4.1. General Objective

To assess levels of shared decision making and associated factors in Cervical Cancer care at Tikur Anbessa Specialized Hospital (TASH), Addis Ababa, Ethiopia

4.2. Specific Objectives

- To determine level of Shared Decision Making in clinical care of women with cervical cancer
- To identify predictors of level of Shared Decision Making in clinical care of women with cervical cancer

5. METHODS

5.1. Study Design

The study employed a convergent parallel mixed study design to explain predictors of perceived level of shared decision-making in clinical care of cervical cancer. Unlike sequential mixed research designs, convergent designs collect and analyze quantitative and qualitative data separately, with the integration of findings occurring later (51,52). Thus, this approach enabled the authors to give equal weight to both quantitative and qualitative data. **Fig 2.**

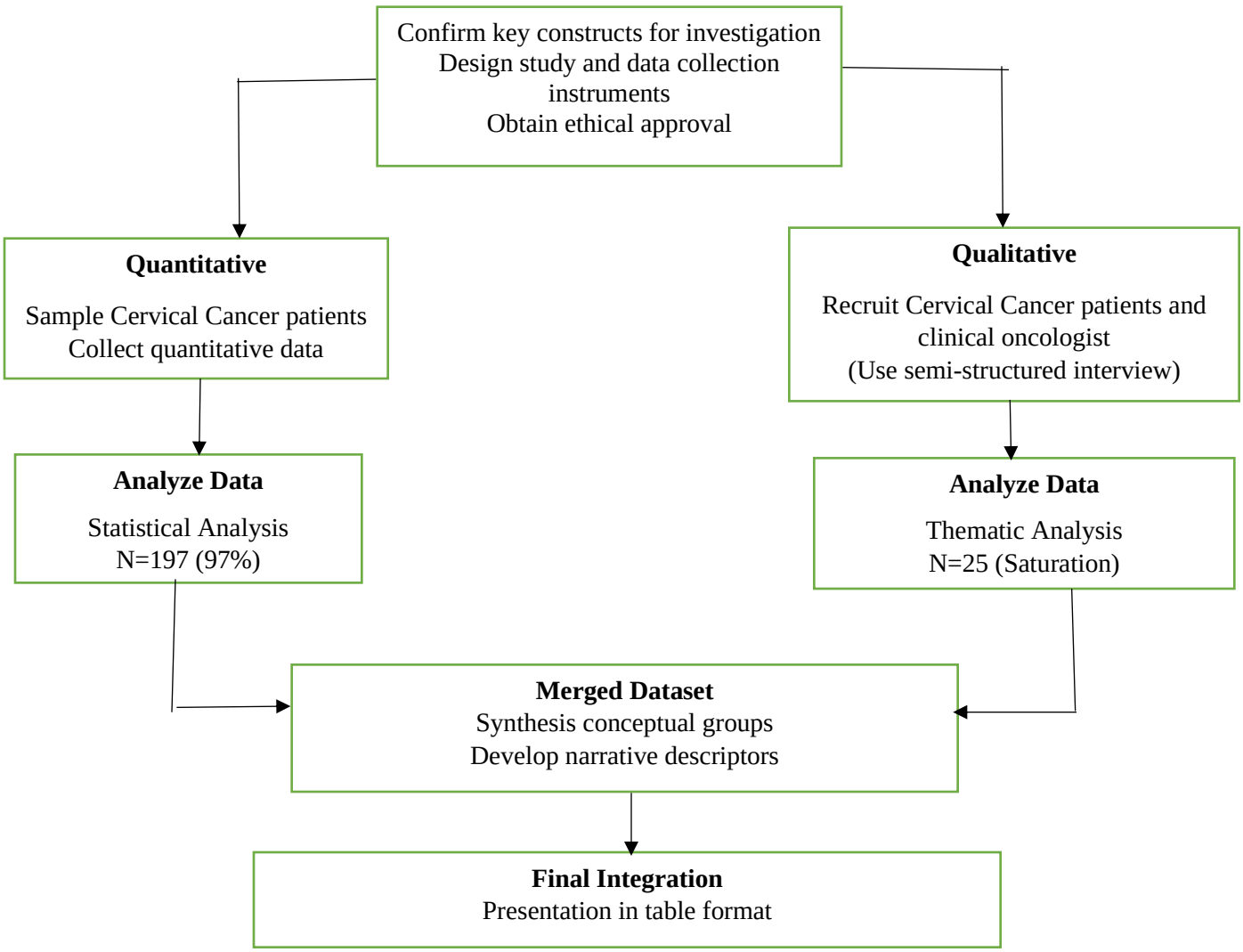

Figure 2: Study Design- Convergent Parallel Mixed Design

5.2. Study Setting

The study was conducted from February to June 2025 at the Adult Oncology Unit of Tikur Anbessa Specialized Hospital (TASH), Addis Ababa, Ethiopia. TASH, the only hospital in Ethiopia with a 700-beds independent cancer center, also serves as a training center for undergraduate and postgraduate students, dentists, nurses, midwives, pharmacists, medical laboratory technologists, radiology technologists, and other professionals who address the nation's health issues and those of the community (53). Since its establishment in 1997 by the Ethiopian government in collaboration with the International Atomic Energy Agency, the oncology center at TASH has been the sole national cancer referral center. It has an inpatient unit for patients who need to stay in the hospital for treatment, as well as an outpatient unit that serves new and follow-up patients (54).

TASH was selected as it is the largest center in the country for cancer care, including radiation therapy. Thus, the researchers can secure participants with different sociodemographic backgrounds at the same spot.

5.3. Study Participant for the Quantitative Design

Source Population: All cervical cancer patients attending follow-up care at TASH during the Study period

Study Population: Cervical cancer patients at TASH who meet the inclusion criteria and are Available during the data collection period.

Study Participants: The 203 cervical cancer patients who completed the survey and whose data Were analyzed.

5.4. Study Participants for the Qualitative Design

Women with cervical cancer who were mentally capable of taking part in the study and who had finished at least one cycle of adjuvant or neoadjuvant chemotherapy/radiotherapy at the time of data collection were recruited for the qualitative interview. Likewise, medical oncologists who had been closely involved in cancer patient care at TASH over the previous three years were recruited.

5.5. Sample size determination for the Quantitative Design

The sample size for the survey was calculated by using a single population proportion formula. Since we didn't have a study on the perceived level of shared decision-making under the same socio-demographic background, we took 50% of the P-value with a 95% confidence level and a 0.05% margin of error. Consequently,

$$n = \frac{\left(z\alpha_{/2}\right)^2 p(1-p)}{d^2}$$

$$\frac{(1.96)^2 \times 0.5 \times 0.5}{(0.05)^2} = 410.1975$$

n = 384

For possible non-response during the survey, the final sample size was increased by 10% to n = 384 + 10%, which is 39 = 423. But, since the population under study was less than 10,000, the correction formula was used. The calculated sample size was 423, and the population size of cervical cancer patients in follow-up at TASH was 390, according to cancer registration of the hospital.

Thus, the final, corrected sample size was,

N_c= N/1+N/PT

N_c= 203

5.6. Sampling Techniques for Quantitative Study Design

The study units were sampled consecutively until the final sample size was achieved for the survey study. This approach was selected in order to secure enough participants within the set period of data collection.

5.7. Participant Recruitment for the Qualitative Design

The study recruited 15 women with cervical cancer and 10 medical oncologists for the qualitative study design. Cervical cancer patients were recruited purposively for in-depth interviews (IDIs)

based on their mental health status and number of treatment rounds completed, which was at least one round of chemotherapy/radiotherapy. Health care providers, medical oncologists who had been working with cancer patients for at least three years, were selected for key-informant interviews purposively.

5.8. Data collection Methods for the Quantitative Study Design

5.8.1. Data Collection Procedures

Participants were provided with an interview-based questionnaire by trained data collectors. Following a review of numerous pertinent works of literature, questionnaires were adapted and developed. Language experts translated the questionnaires into Amharic language, and then translated them back into English. The tools were translated into Amharic for data collection once the researcher and the language experts had agreed on the discrepancies.

Data were collected by two female data collectors who have Master of Science degrees in nursing with two years of experience and have had one day of training by the principal investigator. Data were collected starting from February to June 2025 at the Oncology Center of TASH by using the Kobo Toolbox mobile application that was downloaded on the data collectors' mobile phones. The questionnaires were first pre-tested at Saint Paul Millennium Medical College in order to check consistency and time how much it takes for data collection. Then after revisions were made to the questionnaires afterwards.

5.8.2. Measurements

Following revision of numerous literary works, sociodemographic questionnaires were created. A patient's age, place of residence, education, marital status, employment status, monthly income, health expenditure coverage scheme, and religion were among the sociodemographic details that were documented. The patient's clinical details were also recorded, including the Eastern Oncology Performance Status Scale (ECOG), the type and stage of the cancer, the type of chemotherapy, the type of treatment, the history of surgery, the round of consultation, and the time since diagnosis.

The Health Literacy Survey Questionnaire (HLS-EU-Q) was used to measure the patients' level of health literacy (46). The European Health Literacy Consortium created the 47-item HLS-Q questionnaire. It assesses three domains of health: health promotion (16 things), disease prevention (15 items), and healthcare (16 items). From very easy (4) to extremely difficult (1), the tool's four scales measure health literacy; a higher score implies a higher level of literacy. HLS-Q was found to have good internal consistency (46), test-retest reliability (55), construct validity (56), and concurrent validity (Toçi et al. 2015).

Trust of patients in their oncologist was measured by the Trust in Oncologist Scale (TiOS), an 18-item tool. TiOS measures four dimensions of trust, namely competence, fidelity, honesty, caring, and general, on a 5-point Likert scale (1 = strongly disagree to 5 = strongly agree) (Hillen et al. 2012). Competency (Items 1, 6, 9, and 11), Honesty (Items 2, 3, and 12), Fidelity (Items 4, 5, 8, 10, and 15), Caring (Items 7, 13, 14, and 16), and Global (Items 17 and 18). Reverse scoring was applied to negatively keyed items 9, 11, and 13: '***Sometimes you worry that your doctor's medical decisions are wrong,*** *'* *'****Sometimes your doctor does not pay full attention to what you are trying to tell him/her,*** *' and '****You have doubts whether your doctor really cares about you as a person***.' Scores sum up higher scores, indicating stronger trust. The tool was documented to have Cronbach's $\alpha = 0.9$ in the Netherlands (57) and $\alpha = 0.92$ at the University of Amsterdam (58).

Level of perceived involvement in clinical decisions among women who have been diagnosed with cervical cancer and are on treatment follow-up was measured by SDM-9. SDM-9 was developed to measure intervention aiming to improve shared decision-making (59). SDM-9, developed in 2010, was coined to measure patients' perceived level of involvement in shared decision-making (60). The tool rates its items measuring perceived patient participation in the process of shared decision-making on a 6-point Likert scale from "completely disagree" (0) to "completely agree" (5), in which the range is from 0 to 45 points (46).

5.9. Data collection methods for Qualitative Study Design

5.9.1. Data Collection Procedure

In-depth interviews were conducted with patients who were diagnosed with cervical cancer and who had completed at least one round of chemotherapy/radiotherapy. A research assistant guided

the interview by using pre-prepared semi-structured interview guides (see Annex II). The interview guides were translated from English to Amharic, then piloted, and necessary modifications were made thereafter.

Key Informant Interviews were conducted with health care providers (medical oncologists) who have at least three years of experience working with women who have been diagnosed with cervical cancer. A research assistant guided the interview by using pre-prepared semi-structured interview guides (see Annex II). The interview guides were translated from English to Amharic, then piloted, and necessary modifications were made then after.

5.10. Study Variables

5.10.1. Dependent Variables

Level of Shared Decision Making

5.10.2. Independent Variables

Socio-demographic Status

Clinical Characteristics

Health Literacy questionnaires

Trust in Oncologist Scale

5.11. Data Quality Management for Quantitative Study Design

In order to keep the data safe, the collectors were asked to send the data by the time it was collected after checking for its completeness. The data were stored in the Kobo Toolbox database, which was locked with a password and controlled by the principal investigator. The data were exported to SPSS version 26 (SPSS, Inc., an IBM Company, and Chicago, IL) after being checked for second-round completeness by the principal investigator, after which cleaning and analyses were undertaken.

5.12. Trustworthiness (Rigor)

Trustworthiness of the qualitative data was determined by the data's credibility, dependability, confirmability, and transferability. Credibility was assured by the researcher being present for a prolonged time at the study area during the data collection to link the result to the data. Dependability was assured by the principal investigator and additional data collector in that they interpreted and reported the data separately**.** And the result was compared, in which any inconsistency was addressed. Conformability was assured by using explanatory writing in which the researcher explains the scene during the data collection, including the sign languages of the participants. The study setting was described, and an audit trail, that is, well-documented details of the research process, was provided.

5.13. Data Analysis procedures for Quantitative Study Design

Statistical analyses were performed using SPSS version 26. For descriptive analyses, means with standard deviations (SDs) were calculated for continuous variables and absolute numbers with percentages for categorical variables. The total and standardized mean were calculated for the perceived level of shared decision. And a simple linear regression followed by multiple linear regression was conducted in order to determine predictors of perceived level of shared decision-making. Simple linear regression helped to identify candidate variables for multiple linear regression, selecting those with a p-value ≤ 0.25. For all analyses, a P value < 0.05 was considered significant.

5.14. Data Analysis procedures for Qualitative Study Design

For the qualitative data, thematic analysis (61)was conducted. First, audio-taped voices were transcribed by verbatim transcription and translated to English. Then data was coded and categorized with respect to sub-themes and then themes by using the inductive analysis method. Then, the data was analyzed by sorting information and looking for similarities, differences, or contradictions.

5.15. Ethical Consideration

Ethical clearance was obtained from the Department of Epidemiology and Biostatistics Research Ethics Committee (REC) of the School of Public Health, the College of Health Sciences, and Addis Ababa University. A written information sheet (**Annex I**) was distributed to study participants in order for them to read and understand the study, both its benefits and risks. Then written individual informed consents were gained from each study participant by making them sign on the consent sheets (**Annex II**). Individual information was kept confidential by avoiding possible identifiers such as the names of the study participants.

6. RESULT

6.1. Socio-Demographic Characteristics of Participants

A total of 197 completed responses were collected, resulting in a 97% response rate. The participating women were aged between 28 and 80 years (with a mean age of 54.34 ± 10.57). Among these participants, 124 (62.9%) lived in urban areas. The majority of participants, 143 (72.6%), identified as Orthodox Christians and had not pursued formal education, totaling 109 (55.3%). Additionally, over half of the participants, 148 (75.15%), were unemployed. The majority, 126 (63.9%), were married, and 176 (89.3%) did not have any sponsor to cover their healthcare costs. **Table 1**

6.2. Clinical Characteristics of Participant

The majority of the participants were diagnosed with stage III, 92 (46.7%), followed by stage II, 53 (26.9%). Notably, 75 participants (38.1%) received their diagnosis within one year. Among the women, 128 (65%) underwent surgical intervention. Additionally, the majority, 113 (57.9%) participants, received both chemotherapy and radiation therapy. On average, the participants had a score of 68.3 (±10.81) consultation rounds. **Table 2**

Table 1: Table showing socio-demographic characteristics of women with Cervical cancer at TASH, Addis Ababa, Ethiopia, February to June 2025 (n = 197)

Socio-demographic Characteristics	**Frequency**	**Prevalence (%)**
Age in years SD(Mean)		
<50	71	36.1
≥50	126	63.9
	54.34(±10.57)	
Area of Residence		
Urban	124	62.9
Rural	73	37.1
Religion Affiliation		
Orthodox	143	72.6
Protestant	21	12.7
Muslim	32	16.2
Other	1	0.5
Educational status		
Did not join formal education	109	55.3
<High school	56	28.4
≥High school	32	16.3
Occupation		
Unemployed	148	75.1
Employed	49	24.9
Average Monthly Income	3014.96(±2489.1)	
Marital status		
Never been married	14	7.2
Married	126	63.9
Separated	57	28.9
Source of treatment expense		
Sponsored	176	89.3
Not Sponsored	21	10.7

Table 2: Clinical characteristics of women with Cervical cancer on adjuvant therapy at TASH, Addis Ababa, Ethiopia, February to June 2025 (n = 197)

Clinical Characteristics	Frequency	Prevalence (%)
Stage of the disease		
Stage I	6	3
Stage II	53	26.9
Stage III	92	46.7
Stage IV	46	23.4
Surgical Intervention		
Yes	128	65
No	69	35
Time Since Diagnosis (SD(Mean)	34.25(±38.11)	
<1year	75	38.1
1-2years	35	17.8
2-3years	32	16.2
3-5years	21	10.7
>5years	34	17.3
ECOG		
0	0	0
I	43	21.8
II	122	61.9
III	28	14.2
IV	4	2
Type of treatment		
Chemotherapy	36	18.3
Radiotherapy	44	22.3
Chemotherapy and Radiotherapy	113	57.9
Other*	3	1.5
Round of Consultations	68.3(±10.81)	

Footnote: ECOG: Eastern Cooperation Oncology Group; * Radiation and Surgery

6.3. Level of Shared decision making

The overall mean perceived level of shared decision-making (SDM) in this study was 33.94 (SD = 9.11), with a scale range of 16 to 53 and a standardized mean score of 3.78. One item scored above 4.00: "***My doctor made it clear that a decision needs to be made***," with a mean of 4.01 on a scale of 2 to 6, while the least score was for "***My doctor and I selected a treatment option together,***" with a mean score of 3.60 on scale of 1 to 6. **Table 3**

Table 3: Descriptive statistics of perceived level of shared decision making among women with cervical cancer at TASH, Addis Ababa Ethiopia, February to June 2025. (n=197

Descriptive Statistics				
Variables	**Minimum**	**Maximum**	**Mean**	**Std, Deviation**
My doctor made it clear that a decision needs to be made	2	6	4.01	1.123
My doctor wanted to know exactly how I wanted to be involved in making the decision	2	6	3.84	1.171
My doctor told me that there are different options for treating my medical condition	2	6	3.94	1.146
My doctor precisely explained the advantages and disadvantages of the treatment options	1	6	3.60	1.189
My doctor helped me understand all the information	1	6	3.83	1.128
My doctor asked me which treatment option I prefer	1	6	3.68	1.095
My doctor and I thoroughly weighed the different treatment options	1	5	3.68	1.071
My doctor and I selected a treatment option together	1	6	3.60	1.100
My doctor and I reached an agreement on how to proceed	1	6	3.77	1.047

6.4. Trust in oncologist

The overall mean level of trust in oncologists (TiOS) in this study was 69.94 (±9.43), with a scale range of 34 to 90 and a standardized mean score of 3.89 (±0.52). Among the subscales of TiOS, the Global, Honesty, and Fidelity subscales demonstrated high mean levels of 3.98, 3.92, and 3.90, respectively. **Table 4.**

Table 4: **The mean and maximum and minimum scores in each subscales of TiOS (N=197).**

TiOSq – Subscales	Mean (SD)	Min-Max
Competency	3.89 (0.52)	2.50-5.00
Honesty	3.92 (0.70)	1.67-5.00
Fidelity	3.90 (0.58)	1.40-5.00
Caring	3.80 (0.57)	1.75-5.00
Global	3.98 (0.67)	1.50-5.00

Footnote: TiOSq (Trust in Oncologist Questionnaires)

6.5. Health literacy among Cervical Cancer patients

The overall mean health literacy score for the women included in our study was 114.36 (±25.1), with a minimum score of 75 and a maximum score of 188. The standardized mean of the health literacy score was 2.43 (±0.54). Among the factors in the health questionnaires, Disease Prevention Literacy had the highest mean score of 2.48 (±0.60).**Table 5**

Table 5: **The mean and maximum and minimum scores in each factor on the Health Literacy (N=197).**

Health literacy Factors	Mean (SD)	Min-Max
Factor I: HL-HC	2.40 (0.55)	1.00-0.00
Factor II: HL-DP	2.48 (0.60)	1.20-0.00
Factor III: HL- HP	2.42 (0.56)	1.25-0.00

Footnote: HL_HC (Health Literacy of health care); HL-DP (Health Literacy of Disease prevention); HL-HP (Health literacy of Health Promotion)

6.6. Predictors of Perceived Level of Shared Decision Making

We conducted a simple linear regression analysis to explore the relationship between each independent variable and the level of shared decision-making, aiming to identify variables for inclusion in multiple linear regression. The following variables had a p-value ≤ 0.05 and were considered for further analysis: age distribution, area of residence, marital status, educational level, occupation, average monthly income, and stage of disease, ECOG, average time of diagnosis, health literacy, and trust in oncologists (TiOS).

In total, ten variables were included in the multiple linear regression analysis. Significant predictors of level of shared decision-making among women with cervical cancer included age, area of residence, marital status, occupation, time of diagnosis, mean health literacy, and mean trust in oncologists. The model accounted for 66.1% of the variation, while the remaining factors explained 33.9% (R-squared = 0.661, unadjusted R-squared = 0.604).

Women aged younger than 50 years, separated marital status, and have increased trust in oncologists exhibited a significant positive linear association with level of shared decision-making. When controlling for all variables in the model, women less than 50 were 1.38 times more likely to participate in shared decision-making compared to those above 50 (1.38, 95% CI = (0.013, 1.45); P = 0.03). Additionally, separated women were 2.41 times more likely to participate in shared decision-making compared to married women (2.41, 95% CI = (-0.38, 4.45); P = 0.021). Furthermore, when women whose trust in their oncologist get increased in one unit, are more likely to participate in shared decsision making by 0.57 (0.57, 95% CI = (0.34, 0.82); P = 0.00).

Area of residence, time of diagnosis, and health literacy demonstrated a significant negative linear association with the level of participation in shared decision-making. Women from rural areas were 2.06 times less likely to participate in shared decision-making compared to those living in urban areas (-2.06, 95% CI = (-4.24, 0.12); P = 0.04). Similarly, unemployed women were 2.13 times less likely to participate in shared decision-making compared to actively employed women (-2.13, 95% CI = (-4.37, 0.12); P = 0.01). Furthermore, for each unit increase in the average time of diagnosis, the level of patients participating in shared decision-making decreases by 0.52 (-0.52, 95% CI = (-0.11, 0.001); P = 0.012). Finally, for each unit increase in health literacy, the level of participating in shared desion making decreased by 0.92(-0.92, (-1.18, -0.67); P = 0.000). **Table 6**

Table 6: Multiple linear regression analysis predicting perceived level of shared decision in cervical cancer care at TASH, Addis Ababa, Ethiopia, February to June , 2025 (n = 197)

Variables	Unadjusted Unstandardized ß 95% CI of β	Adjusted unstandardized ß 95% CI of β
Age Distribution		.
≥50	**Ref**	**Ref**
<50	0.005(-0.18,0.009)	1.38 (0.013,1.45)**
Area of Residence		
Urban	**Ref**	**Ref**
Rural	-5.65(-8.14,-3.15)	-2.06 (-4.24, 0.12) **
Marital		
Married	**Ref**	**Ref**
Single	3.39 (-1.59, 8.36)	3.06(-0.270, 6.39)
Separated	-1.18 (-4.00, 1.64)	2.41(-0.38, 4.45) **
Education level		
Didn't join formal Education	**Ref**	**Ref**
<High school	5.00 (2.23, 7.74)	1.67(-0.64,3.98)
≥High School	7.52 (4.16, 10.89)	0.053 (-3.01,3.12)
Occupation		
Employed	**Ref**	**Ref**
Unemployed	-4.44 (-7.30,-1.58)	-2.13 (-4.37, 0.12) **
Average Monthly Income	0.01 (0.000, 0.001)	0.00 (-0.001, 0.000)
Stage of Disease		
Stage I	4.70 (-2.80, 12.15)	-0.69 (-6.14, 4.76)
Stage II	2.12 (-0.93, 5.17)	-0.48 (-3.03, 2.07)
Stage III	1.50 (-1.70, 4.70)	-1.85 (-4.12, 0.41)
Stage IV	**Ref**	**Ref**
ECOG		
I	2.42 (-0.70, 5.54)	0.71 (-1.60, 3.01)
II	-2.80 (-6.44, 0.93)	-1.46 (-4.04, 1.12)
III	**Ref**	**Ref**
IV	0.53 (-8.40, 9.46)	0.11 (-6.12, 5.90)
Time of Diagnosis	0.023 (-0.010, 0.056)	-0.52(-0.11, 0.001) **
Health literacy	-1.23 (-1.47,-1.06)	-0.92 (-1.18, -0.67)
Trust in Oncologist (TiOS)	0.98 (0.74,1.21)	0.57 (0.34, 0.82)

Key: Ref= Reference, R=.813, R Square=.661, unadjusted R Square=0.604, Std. Error of the Estimate=5.65, **Significance value <0.05, Dependent variable: Shared Decision making, Max VIF 1.62 (no Multi-collinearity: VIF <1)

6.7. Integrations of Quantitative and Qualitative Data

Socio-demographic characteristics of Participants

For the qualitative data, fifteen women with cervical cancer who had received at least one round of chemotherapy but did not take part in the quantitative interview were invited for an in-depth interview. The age range of the participants was 39-56, with an average of 47.6. (**Table 7**)

Table 7: Socio-demographic characteristics of participants for In-depth interview (n=15)

Participants	Age	Area of residency	Religion	Level of education	Occupation
P1	42	Urban	Orthodox	4th Grade	Unemployed
P2	50	Urban	Orthodox	No formal education	Unemployed
P3	45	Rural	Orthodox	11th Grade	Unemployed
P4	47	Rural	Protestant	10th Grade	Unemployed
P5	52	Urban	Orthodox	8th Grade	Unemployed
P6	42	Rural	Orthodox	10th Grade	Unemployed
P7	49	Rural	Protestant	Diploma	Unemployed
P8	54	Urban	Orthodox	6th Grade	Unemployed
P9	48	Rural	Muslim	6th Grade	Unemployed
P10	45	Urban	Protestant	Degree	Stopped working
P11	56	Rural	Orthodox	No formal education	Unemployed
P12	54	Rural	Orthodox	No formal education	Unemployed
P13	49	Rural	Protestant	Diploma	Stopped Working
P14	42	Urban	Muslim	Degree	Stopped working
P15	39	Urban	Protestant	Degree	Stopped working

A key informant interview was conducted with ten medical oncologists who had at least three years of experience. Participants ranged in age from 32 to 44, with an average age of 32.8. None of the participants had received training regarding clinical decision-making or communication. Six of the ten medical oncologists, or 60% of the participants, were men. (**Table 8**)

Table 8: Socio-demographic characteristics of participant for key informant interview(n=10)

Participants	Age	Gender	General Experience	Experience in Oncology	Training on communication/shared decision making
P1	40	Male	15years	8years	No
P2	42	Male	18years	12years	No
P3	32	Female	7years	3years	No
P4	34	Male	9years	4years	No
P5	36	Female	11 years	6 years	No
P6	38	Male	13 years	7 years	No
P7	37	Female	13 years	7 years	No
P8	32	Male	7years	3 years	No
P9	32	Male	6years	3 years	No
P10	35	Female	8 years	3 years	No

The final data integration into concepts comprises a synthesis of the qualitative interview findings and quantitative survey results. The qualitative data was thematized as demographic and psychological characteristics, communication characteristics and contextual factors affecting the level of shared decision-making in the clinical care of women with cervical cancer.(**Table 9**) The study employed the joint-display (62) method in order to present the qualitative and the quantitative data as summarized in **Table 10**. For clarity of presentation, a narrative summary of integrated concepts is presented below with extracts of quotes.

Table 9: Themathization of the qualitative Data

Themes	Sub-themes	Codes
Barriers to shared decision Making	Socio-demographic barriers	Age
		Finance
		Language
	Psychological barriers	Culture
		Attitude
	Communication related barriers	Passive
		Directive
	Institutional barriers	Care system
		Patient Overload
		Time constraint
Facilitators of shared decision making	Socio-demographic facilitators	Residence
		Understanding
	Psychological facilitators	Resilience
		Supportive care
	Communication related facilitators	Gradual

Theme I: Barriers of Shared decision Making

Sub-theme I: Socio-demographic Barriers

Finance

Socio-economic status of the patient, like financial status, was reported to contribute to the level of perceived shared decision-making. Women who are actively employed often experience this sense of '*financial security*.' Since cancer treatments are monetary incentive interventions, the providers might also get challenged to reveal available treatment options.

> "*Sometimes, decision of the patients is determined by their financial ability rather than the information they have. And here, a lot of women have already stopped their regular job due to the disease. So, they listen to your suggestions just because they can afford, it is not because they understand it*. "(**Health Care provider, 10 years of experience**).

Unaffordable and unavailable services have also reported to impede the perceived level of shared decision making. In order not to stress the patients, physicians may not fully discuss expensive and unavailable services with the patients. Withholding information about unavailable treatments can erode trust between patients and providers.

> "*Shared decision making is much difficult for radiotherapy more than the chemotherapy. In this hospital, radiotherapy is available on the private wing but it is expensive. So, we mostly don't tell them about the option of private wing, if we believe they cannot afford it. Because telling them would just create frustration! But, for your surprise most of the time they already knew and that is another frustration.*" (**Health Care provider, 4 years of experience**)

Age

Age of the patients was also explained to impede the understanding of patients and affect the status of the patients, further affecting their participation in shared decision-making. The increased age of the patients may also leave them in a weak state, which further exacerbates their understanding ability of the situation.

> "*Sometimes the patients may be old ages so that they don't understand us that much and may also be very weak where they don't understand the process.*" (**Health Care provider, three years of experience**)

Language

When physicians use clinical terms or languages, patients can be reluctant to participate in open discussion with the provider, as it causes them to feel less adequate. And this can make the patients have unanswered questions in their treatment process.

> "*I asked why I got swollen. I have already had surgery. Why did I have the swelling? Then he started explaining, but I didn't listen to him attentively since it was mostly clinical language.***"** (Patient, 50 years)

Sub-theme II: Psychological Barriers

Cultural Background

Patients believed that their upbringing instilled a belief of inherent superiority of which physicians are more knowledgeable than they are. This assumption has made the society not ask to participate in communication with their physicians about their care process. And this may create a dynamic where patients feel less empowered. And this may indicate that the physicians have full authority over the care process, further preventing the patients from participating in the discussion fully.

> "*I think our society and the way we grow up prevents us from fully communicating with our physicians. Because we grew up thinking physicians knows for us better than we do for our self.*"(**Patient, 42 years old**).

Health care providers have noticed that the level of shared decision-making is impacted by attendant intervention. Culturally, the attendants are protecting the emotional well-being of the patients by keeping information from them, which hinders the practice of patients and healthcare professionals working together to make decisions. This strategy could make it harder for the clinicians to interact with the patient when the caregivers are not around, which makes it more challenging to foster an atmosphere of transparency and collaboration.

> "*Sometimes, the attendants think that telling the patient everything about the disease may hurt the emotion of patient. So, they tell you not to tell the patients. They will even tell you that they will discuss with other caregivers back home. And most of the time this make it difficult for us communicate with patients freely*." (Health Care Providers, 6 years of experience)

Attitude

Patients have witnessed that when their doctor is not involved and attentive, it can lead to irritation and a withdrawal from shared decision-making. Furthermore, patients may be less likely to disclose critical information with their healthcare providers if direct contact is not prioritized by physicians. This could further complicate the care process since critical medical history may be overlooked.

"*There was a young physician in the room when I entered. And he began speaking to me while writing on a piece of paper in front of him. Finally, he looked up and gave me the paper and sent me to the pharmacy. Then I became offended and told him that he does not fit into the profession.*" (**Patient, 42 years**).

It was also revealed that the patients' negative attitudes regarding health care communication had an impact on the shared decision-making process used in patient clinical care. Patients might anticipate expert guidance from their doctors when presented with several treatment options. Patients may feel insecure and mistrust the decision-making process if the practitioner does not offer a recommendation based on their earned knowledge.

"Now I encounter a patient who was given options to select from chemotherapy and radiation therapy, and she was very offended. She thought the doctor was incompetent to tell her the best management. So, in these kinds of situation it will be difficult to make patients participate in the process of shared decision making."(**Health Care Providers, 5 years of experience**)

In a similar way, the provider's attitude on the patient's socioeconomic status may shape the type of communication about the proposed course of therapy. Providers tend to limit their conversations with patients regarding available treatment modalities if they believe the patient may be experiencing financial difficulties.

"*Now when I believe the family can afford the treatment process, I tell them that there are available therapies with risks and benefits so that they can buy and take.*" (Health care provider, 12 years)

Disrespectful attitudes from the health care providers can make the women feel less likely to ask any questions, which leaves them feeling uncertain. In the presence of a lack of respect, the women may feel less likely to voice their concerns. This may make the women feel unwelcomed in the consultation room and make them withdraw from any communication and asking questions altogether. This may further limit their understanding of their conditions.

"*Some physicians don't talk to you respectfully. They also don't treat you properly. When they don't talk to you properly, you even let go of what you think of asking them in the consultation room." (Patient, 48 years old)*

Sub-theme III: Institutional barriers

Care system

Tertiary hospitals in Ethiopia which are serving as cancer centers are also teaching hospital at the same time. Thus, for the sake of active teaching purpose, patients' privacy and confidentiality may become under questions. And this process may make the women lose control over their care process, suppressing level shared decision making in the way.

"*Let me tell you, I have reservation on the examination process. They made me open my cervix and there were a lot of students, and they teach the students by cervix like that. So, they let me sleep over the couch without cloth on, on opening my cervix for over 30 minutes. So, do you think I will want further communication with the physician? No. I will never.*" (Patient, 56 years old)

Similarly, patients may be compelled to meet different kinds of physicians in every flow up. This practice makes them to encounter inconsistent information which increase burden to the patients, because the patients have to share their history in every follow up, which is boredom for them.

"*Always you meet a new doctor when you come for follow up. So, you need to talk all over again with the new doctor. Communicating with each of them all over again the boring part of the follow up.*" (Patient, 49 Years Old)

Patient Overload

In Ethiopia, most cervical cancers are treated at government hospitals due to the lack of radiation therapy at private hospitals. Thus, this will create patient overload at the government hospital like our study site (Tikur Anbessa teaching hospital). When there is a high number of patients, the health care provider will face time constraint to consult all patients adequately, resulting in practicing low level shared decision making.

> *"We don't tell them everything as we are treating a number of patients and can't do it for everyone. Upon admission, we may give them a brief introduction to the disease."* (**Health Care provider, 5 years of experience**).

Time Constraints

Furthermore, because of patient overflow and time constraints, patients may fail to ask questions and express their concerns and preferences which are bases for provision of subjective care and building shared decision making.

> *"Additionally, given the high patient load, they may not have adequate time for extended discussions with each patient."* (**Patient, 54 Years old**).

Sub-theme IV: Communication related Barriers

Passive Communication

Limited communication can lead patients to have a poor understanding of their disease and its specific outcomes. As a result, they may become less engaged in their clinical care. This lack of understanding can force patients to seek other alternatives, such as visiting traditional healers, other patients and avoid further communication with healthcare providers. Additionally, patients may turn to multiple sources for information, which can exacerbate their condition due to the overwhelming nature of information overload.

> "*I wanted to ask the physician about my disease, but the physician didn't give me much of an answer. He just told me that I need to have radiation. Then when everything became*

complicated for me, I started to visit women who were already diagnosed and were receiving radiation to ask for information about radiation. And visiting and talking to them made me fear the radiation." **(**Patient, 45 years old)

Also, passive involvement of patients was reported to affect perceived level of shared decision making, as it makes patients depend on the caregiver or provider which further shift away the decision from preferences of the patients.

"*The patients may don't want to know about the disease. Sometimes, the patients may don't want to know the status and the stage of the disease. Some people may be 'Decide by yourself' type of people.*" (Health care provider, three years of experiences).

Directive communication

When there is one-way information flow, like in passive care practice, the patient may fail to feel the need to participate in communication with the physicians. Further, in this directive way of communicating, where physicians focus solely on instructing or directing the patient, they will miss the opportunity to collaborate with the patient and build trust. It may also lead patients to feel like their preferences, thoughts, and concerns are disregarded, making them more frustrated and uncertain.

"Because no one asks you what you feel? They just say, 'Take this.' 'Do this.' Now I fear, what if the disease comes back tomorrow? I always fear that. But I don't ask the doctor. I have never asked the doctor, as they don't tell me clear and true things about my disease." (Patient, 52 years old)

Theme II: Facilitators of Shared decision Making

Sub-theme I: Socio-demographic facilitators

Residence area

Health care providers noted a clear distinction in the engagement level of patients in shared decision-making, depending on their residential area. People from urban areas have differences in communication style and increased engagement in shared decision-making. Further, those populations come prepared with questions and a willingness to communicate, as they may have increased sources of information.

> "*Now when our patients come from urban area, they ask you a lot and it also easy for us to communicate with them.*" (**Health care provider, seven years of experience**).

Level of Understanding

Patients noticed that a solid understanding of their cases can empower them to participate in the shared decision-making process. Further patients may consider interventions that align with their values and preferences. Further, this increased understanding and knowledge can enhance their confidence in their interaction with their healthcare providers.

> **"***Now there was a person who told me not to go to treatment, rather to go to holy water. Then I told them I would go to both holy water and treatment. So, knowing about the disease helps you a lot in knowing what to do next and understanding your doctor.*" (**Patient, 39 years old**).
>
> *"Lack of awareness about the disease and medications also prevents us from asking for more information.*" (**Patient, 45 years old**).

Similarly, providers may tend to support the preferences of the more knowledgeable patient because, as the knowledge makes them empowered, they will be more involved in expressing their preferences and concerns, which can simplify the patient and health provider communication. This emphasizes the importance of encouraging patient education as a means to empower patients in their care process.

"*There are some patients who ask intensively. Those who come after searching for some information and have educated asks you in detail.*" (Health care provider, 3 years of experience).

Sub-theme II: Psychological facilitators

Resilience

Emotional resilience of the patient has also been witnessed to contribute to the increased level of shared decision-making. Because the patient's ability to manage anxiety can help in facilitating constructive conversation about the potential path forward. Further, emotional resilience can enable patients to involve themselves in meaningful discussions with their physicians.

"*Since I am emotionally good, I was not much anxious with my physician about the futurity of the disease. Because the years you live are given by God. If he wants to, he will cure me.*" (**Patient, 47 years old**)

Supportive care

Empathetic care makes the patients feel valued and respected, and it will create an environment in which the patient can discuss freely with their physician, further making the patient more supported and cared for. Further, reassurance can decrease fear of the patients and encourage them to further communicate with their physician. Because it gives patients to get space and time to reflect on their values and concern.

"*He assured me that if we detect it early, there is no need to fear, as timely treatment allows people to live with it. He told me, 'Mother, this is not something you need to be afraid of.' After that, I began asking him unnecessary questions, even bringing up things I had heard from other patients."* (Patient, 56 years old).

Further, the compassionate care approach of the providers helps them build trust with their patients. Because patients who trust their providers tend to share information with their providers creating a more conducive environment for the treatment process and make patients more likely to follow treatment recommendations and adhere to care plans.

"*Building trust with your patients will solve a lot of problem related to communication. Because building trust will increase the patient's adherence to the medications and make the patient feel at ease around you.*" (Health care provider, seven years of experience).

Sub-theme III: Communication Related Facilitators

Gradual Communication

In addition to clear communication, gradual communication also contributes to enhancement of understanding of the patients. Further, gradual communication style can help with emotional resilience of the patient.

"*He told me slowly. He did not tell me at once. I don't know for others. But truly speaking they were very clear for me. I was understanding what he was telling me.*" (Patient, 28 years).

Table 10: Integration of survey and interview findings

Themes	Integrated Concepts	Quantitative data	Illustrative Interview Response	Integration
Barriers	Age Distribution and Socio-demographic barriers (**Age**)	**<50 years old** (1.38; P = 0.03)	*Sometimes the patients may be old ages so that they don't understand us that much and may also be very weak where they don't understand the process.*	**Divergent** Patients who are young can understand the situation and easy to communicate with
	Psychological barriers (**Cultural**) and Marital Status	**Separated Marital** (2.41;P=0.021)	*Sometimes, the attendants think that telling the patient everything about the disease may hurt the emotion of patient. So, they tell you not to tell the patients. They will even tell you that they will discuss with other caregivers back home. And most of the time this make it difficult for us communicate with patients freely*. (**Health Care Providers, 6 years of experience**)	**Divergent** Culturally, caregivers can control the treatment process of the patient.
	Socio-demographic barriers (**Finance**) and **Occupation**	**Unemployed** (-2.13; P=0.01).	*Sometimes, decision of the patients is determined by their financial ability rather than the information they have. They listen to your suggestions just because they can afford, it is not because they understand it*. (Health Care provider, 10 years of experience).	**Divergent** Women who are actively employed tends to be financially stable and will be comfortable to decide of effective intervention

Facilitators	Socio-demographic facilitators (**Residency**) and Area Residence	**Urban Dwellers** (2.06; P = 0.04)	*Now when our patients come from urban area, they ask you a lot and it also easy for us to communicate with them.*" (Health care provider, seven years of experience).	**Convergent** Patients from urban setting creates conducive clinical environment for communication between and providers and patients
	Psychological facilitators (**Supportive care**) and Trust in Oncologist	**Trust in Oncologist Scale** (0.57; P = 0.00).	*Building trust with your patients will solve a lot of problem related to communication. Because building trust will increase the patient's adherence to the medications and make the patient feel at ease around you.*" (**Health care provider, seven years of experience**). *He assured me that if we detect it early, there is no need to fear, as timely treatment allows people to live with it. He told me, 'Mother, this is not something you need to be afraid of.' After that, I began asking him unnecessary questions, even bringing up things I had heard from other patients."* (**Patient, 56 years old**).	**Convergent** Women who trusts their oncologist tends to participate in shared decision making more likely. The trust of the women in the oncologist can be built through compassionate care and reassurance from the oncologists.

	Socio-demographic facilitators (**Level of understanding**) and Area Residence	**Mean Score Health Literacy** (-0.92;P = 0.000)	"*There are some patients who ask intensively. Those who come after searching for some information and have educated asks you in detail.*" (**Health care provider, 3 years of experience**).	**Parallel**

7. DISCUSSION

The study investigated the perceived level of shared decision-making in the clinical care of patients with cervical cancer using a convergent mixed study design that was theoretically informed. The results showed a perceived level of shared decision-making of 33.94 (SD = 9.11), significantly higher than the 16 (63) reported for breast cancer patients in Holland. In contrast, women with breast cancer in Germany reported a level of 73.8 (SD: 20.8) (64), and those with head and neck cancer in the UK reported a level of 78.6 (SD: 26.3), with this level of perceived shared decision-making being much lower. These differences may contribute to differences in the health care system, the cultural background of the study participants, the types of cancer being treated, and the care of cancer being applied in different countries. Further, the observed difference may be explained by changes in demographic characteristics of the patients and methods of study that are being employed.

Duration of time since the diagnosis was also reported to have a negative linear association with shared decision-making (β = -0.52, P = 0.012). In other words, the longer the time since the diagnosis, the less they feel like involving themselves in the treatment process and communication with the physicians. A study read that this contributes to a decline in cognitive ability and emotional stability, which complicates patients' ability to participate in shared decision-making (65). Similarly, how qualitative data from the qualitative study emphasizes that the physicians prefer to communicate with patients who are cognitively intact and have a good understanding. Similarly, a study evidenced that people who stay on treatment for a long time tend to be more anxious and depressed (66). This may contribute to loss of trust in the oncologist and increased health care-related anxiety.

With a β value of 2.06 (P = 0.04), the quantitative analysis found a significant positive linear association between living in an urban environment and the level of shared decision-making. According to these findings, patients who live in urban areas are more inclined to communicate about health care decisions in a shared manner. The thematic analysis supported this finding by pointing out that healthcare professionals prefer to interact with urban inhabitants. This might be

as a result of urban people's greater access to resources, education, and information, which enables them to actively participate in their treatment and ask more informed questions. Although level education was not associated significantly in the multiple linear regression in our study, a study has enabled us to understand that women with better relevant information and better education tends to participate in clinical decision making and get satisfied with treatment outcomes (67). This discrepancy might be happen contributing to sample size or method of analyzing.

Unlike other studies (45,64), in the current study, younger patients were depicted to have a significant positive linear association with the perceived level of shared decision-making ($\beta = 1.38$; $P = 0.03$). These findings were strengthened by the qualitative interview findings, which demonstrate the difficulty of communicating with old-aged patients. This may be the reason, as older patients have different priorities when compared to younger generations, and they rather depend on life experience and emotion in order to decide rather than the knowledge of the physician (68). Moreover, multi-morbidity of older patients was also identified to complicate the practice of shared decision-making, as the management is not the sum of the parts (69). This may be the case for cervical cancer patients who tend to be older and have comorbid diseases, usually HIV/AIDS or immunosuppressant diseases. However, for older patients, participating in shared decision-making is perceived as a struggle to maintain their autonomy, which can be overridden by family members or caretakers (68).

In light of this, the current study revealed that having a separate marital status was found to have a significant positive linear association with the perceived level of shared decision-making ($\beta = 2.41$; $P = 0.021$). This was confirmed by the qualitative data, as the interference of family attendants or caregivers was reported to affect the perceived level of shared decision-making. This finding tends to implicate that when patients do not have family support or are not in a marriage bond, they tend to be in control of their health and care. However, this finding needs to be examined in light of other existing literatures, which highlight the positive influence of caregivers on communication of patients with healthcare providers by providing informational and emotional support, which ultimately helps in treatment adherence (70–72). However, cultural deference may also contribute to family involvement in the clinical decision-making of a patient. Moreover, sometimes individual decisions can be shaped by their social and familial relationships, '*relational*

autonomy' (73,74). Thus, excluding family members in clinical decision-making may not be in the best interest of every patient.

The current study revealed an increased level of shared decision-making among women who have increased trust in their oncologist (β=0.57, P=0.00), which was supported by our thematic analysis and a study from Germany (63). This aligns with the body of literature emphasizing the crucial role of trust in the patient-doctor relationship. Trust is a fundamental component in clinical care, enabling collaboration and mutual understanding (75). Furthermore, in clinical care of cancer, where treatment decisions can be complex and emotionally challenging, trusting the oncologist may be so crucial for the patient.

Unemployed patients tend to have decreased participation in shared decision making (β=-2.13, P=0.01), which was demonstrated in thematic analysis as financial constraint of the patients affects their practice of involving themselves in shared decision making. This may consolidate the socio-economic disparities in health care access and quality (15). A health care provider stated, "***Sometimes, the decision of the patients is determined by their financial ability rather than the information they have. They listen to your suggestions just because they can afford it; it is not because they understand it***." Because financially constrained patients rather worry about the cost of the treatment than its effectiveness. Thus, the socioeconomic status of the patients determines their participation in shared decision-making. Further, unemployed patients may have low education levels, which may affect their health literacy and understanding.

Unlike other study (15) and findings from our thematic analysis, the health literacy of our study participants had a strong negative linear association with the level of participation in shared decision-making (β=-0.92; P=000). Since quantitative studies use standardized tools, if the tool do not align with the population under study, it may not capture the actual experiences of the patients. Moreover, qualitative interviews allow exploration of deep thoughts, which cannot be done with quantitative scales, leading to contrasting results. Saying this, patients with low levels of literacy also may have low skills in participating in shared decision-making unless the provider has good communication skills and the ability to simplify information using visual aids or using local language (76). On the contrary, information overload and avoidant behavior of literate individuals may prevent them from participating in shared decision-making. Further, individuals with a high

level of literacy may deem to have enough information, which may make them avoid participating in shared decision-making (77).

8. STRENGTH AND LIMITATIONS

As the strength, the current study employed a convergent parallel mixed study, which enables us to understand predictors of shared decision-making more. Further, this study design can solve limitations of statistical analysis as it tends to explore reasons for the predictors. That can help to generate new hypotheses. Further, the findings from the study can be validated as convergent design used multiple methods, enhancing the credibility of the data.

The study followed a cross-sectional timeline, which could not help to capture the practice of shared decision-making over time and depending on the status of the disease. Further, conflicting findings from both the qualitative and the quantitative findings were also another limitation of the study.

9. CONCLUSIONS

The current study informed that being young in age, having a short duration since diagnosis, living in an urban area, having increased trust in the oncologist, being financially stable (actively employed), and being free of partner influence can make patients participate more in shared decision-making practices in their clinical care. On the other hand, an increased level of health literacy of patients had a negative association with the level of shared decision-making in the clinical care of women with cervical cancer. In conclusion, the study emphasizes the complex interplay of socio-demographic, psychological, and communication characteristics along with institutional factors affecting the practice of shared decision-making in the clinical care of women with cervical cancer. Thus, understanding these dynamics may help physicians and responsible body to enhance the practice of shared decision-making in the clinical care of cervical cancer.

10. RECOMMENDATIONS

Policy Level

Community outreach in rural settings might focus on primary health care-level interactions between patients and doctors. In order to prevent cervical patients from having to quit their jobs in order to receive full-time treatment, workplace support initiatives may also be implemented. To boost patient trust in healthcare, health care personnel can be equipped with communication skills through in-service training and the introduction of various teams, including psychologists.

Operational Level

This study recommends age-specific communication tactics; digital communication, such as audio materials or mobile applications, may be more beneficial for younger patients. Deep conversation, however, might be beneficial for elderly patients. Additionally, if the hospital has a method for patient input, it could help the oncologist better understand their patient. The women's health literacy may be raised by creating educational materials with interactive features, clear language, and images.

11. REFERENCES

1. Bray F, Laversanne M, Sung H, Ferlay J, Siegel RL, Soerjomataram I, et al. Global cancer statistics 2022: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. CA Cancer J Clin. 2024;74(3):229–63.
2. International Agency for Research on Cancer WHO. Africa Cancer Fact sheets. Globocan [Internet]. 2020;598:1–2. Available from: https://gco.iarc.fr/today/data/factsheets/populations/903-africa-fact-sheets.pdf
3. Ferlay J, Colombet M, Soerjomataram I, Parkin DM, Piñeros M, Znaor A, et al. Cancer statistics for the year 2020: An overview. Int J Cancer. 2021;149(4):778–89.
4. Martei YM, Pace LE, Brock JE, Shulman LN. Breast Cancer in Low- and Middle-Income Countries: Why We Need Pathology Capability to Solve This Challenge. Clin Lab Med. 2018;38(1):161–73.
5. Sharma R, Aashima, Nanda M, Fronterre C, Sewagudde P, Ssentongo AE, et al. Mapping Cancer in Africa: A Comprehensive and Comparable Characterization of 34 Cancer Types Using Estimates From GLOBOCAN 2020. Front Public Heal. 2022;10(April):1–14.
6. Kantelhardt EJ, Moelle U, Begoihn M, Addissie A, Trocchi P, Yonas B, et al. Cervical Cancer in Ethiopia: Survival of 1,059 Patients Who Received Oncologic Therapy. Oncologist. 2014;19(7):727–34.
7. Dunn M, Strnadová I, Scully JL, Hansen J, Loblinzk J, Sarfaraz S, et al. Equitable and accessible informed healthcare consent process for people with intellectual disability: a systematic literature review. BMJ Qual Saf. 2024;33(5):328–39.
8. Hilger DJ, Raviele KM, Hilgers TA. Hormonal Contraception and the Informed Consent *. 2018;85(4):375–84.
9. Howard L, Ibrahim E, Rowbottom C. The role of shared decision-making in enhancing patient experience: Insights from a cohort of curative head and neck cancer patients. Radiography [Internet]. 2024;30(5):1349–54. Available from: https://doi.org/10.1016/j.radi.2024.07.020
10. Doval D, Kumar P, Talwar V, Vaid A, Desai C, Ostwal V, et al. Shared decision-making and medicolegal aspects: Delivering high-quality cancer care in India. Indian J Palliat Care. 2020;26(4):405–10.
11. Rabben J, Vivat B, Fossum M, Rohde GE. Shared decision-making in palliative cancer care: A systematic review and metasynthesis. Palliat Med. 2024;38(4):406–22.
12. Kane HL, Halpern MT, Squiers LB, Treiman KA, McCormack LA. Implementing and evaluating shared decision making in oncology practice. CA Cancer J Clin. 2014;64(6):377–88.
13. Psycho-Oncology - 2022 - Feiten - Shared decision-making in routine breast cancer care in Germany A cross-sectional study.pdf.
14. Han J, Jungsuwadee P, Abraham O, Ko D. Shared decision-making and women's adherence to breast and cervical cancer screenings. Int J Environ Res Public Health. 2018;15(7).
15. Wigfall LT, Tanner AH. Health Literacy and Health-Care Engagement as Predictors of Shared

Decision-Making Among Adult Information Seekers in the USA: a Secondary Data Analysis of the Health Information National Trends Survey. J Cancer Educ. 2018;33(1):67–73.

16. Haltaufderheide J, Wäscher S, Bertlich B, Vollmann J, Reinacher-Schick A, Schildmann J. "I need to know what makes somebody tick …": Challenges and Strategies of Implementing Shared Decision-Making in Individualized Oncology. Oncologist. 2019;24(4):555–62.

17. Durand MA, Moulton B, Cockle E, Mann M, Elwyn G. Can shared decision-making reduce medical malpractice litigation? A systematic review Health policy, reform, governance and law. BMC Health Serv Res [Internet]. 2015;15(1):1–11. Available from: ???

18. Stacey D, Légaré F, Lewis KB. Patient decision aids to engage adults in treatment or screening decisions. JAMA - J Am Med Assoc. 2017;318(7):657–8.

19. Rist PM, Tzourio C, Elbaz A, Soumaré A, Dufouil C, Mazoyer B, et al. Structural brain lesions and restless legs syndrome: A cross-sectional population-based study. BMJ Open. 2014;4(11):1–6.

20. Steffensen KD, Vinter M, Crüger D, Dankl K, Coulter A, Stuart B, et al. Lessons in integrating shared decision-making into cancer care. J Oncol Pract. 2018;14(4):229–35.

21. Hughes TM, Merath K, Chen Q, Sun S, Palmer E, Idrees JJ, et al. Association of shared decision-making on patient-reported health outcomes and healthcare utilization. Am J Surg [Internet]. 2018;216(1):7–12. Available from: https://doi.org/10.1016/j.amjsurg.2018.01.011

22. Street RL, Mazor KM, Arora NK. Assessing patient-centered communication in cancer care: Measures for surveillance of communication outcomes. J Oncol Pract. 2016;12(12):1198–202.

23. Sambasivarao S V. Where is the evidence? A systematic review of shared decision making and patient outcomes. J Soc Med Decis Mak [Internet]. 2013;18(9):1199–216. Available from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4270851/

24. Graskemper JP. Shared decision making. J Am Dent Assoc. 2016;147(1):5.

25. Cincidda C, Pizzoli SFM, Ongaro G, Oliveri S, Pravettoni G. Caregiving and Shared Decision Making in Breast and Prostate Cancer Patients: A Systematic Review. Curr Oncol. 2023;30(1):803–23.

26. Oprea N, Ardito V, Ciani O. Implementing shared decision-making interventions in breast cancer clinical practice: a scoping review. BMC Med Inform Decis Mak [Internet]. 2023;23(1). Available from: https://doi.org/10.1186/s12911-023-02263-8

27. Politi MC, Studts JL, Hayslip JW. Shared Decision Making in Oncology Practice: What Do Oncologists Need to Know? Oncologist. 2012;17(1):91–100.

28. Maes-Carballo M, Muñoz-Núñez I, Martín-Díaz M, Mignini L, Bueno-Cavanillas A, Khan KS. Shared decision making in breast cancer treatment guidelines: Development of a quality assessment tool and a systematic review. Heal Expect. 2020;23(5):1045–64.

29. Schoenfeld EM, Mader S, Houghton C, Wenger R, Probst MA, Schoenfeld DA, et al. The Effect of Shared Decisionmaking on Patients' Likelihood of Filing a Complaint or Lawsuit: A Simulation Study. Ann Emerg Med [Internet]. 2019;74(1):126–36. Available from: https://doi.org/10.1016/j.annemergmed.2018.11.017

30. Maes-Carballo M, Gomez-Fandino Y, Garcia-Garcia M, Martin-Diaz M, De-Dios-de-Santiago D, Khan KS, et al. Colorectal cancer treatment guidelines and shared decision making quality and

reporting assessment: Systematic review. Patient Educ Couns. 2023;115:107856.

31. Elwyn G. Shared decision making: What is the work? Patient Educ Couns [Internet]. 2021;104(7):1591–5. Available from: https://doi.org/10.1016/j.pec.2020.11.032

32. Volk RJ, Llewellyn-Thomas H, Stacey D, Elwyn G. Ten years of the International Patient Decision Aid Standards Collaboration: Evolution of the core dimensions for assessing the quality of patient decision aids. BMC Med Inform Decis Mak. 2013;13(SUPPL. 2):1–7.

33. Stacey D, Hill S, McCaffery K, Boland L, Lewis KB, Horvat L. Shared decision making interventions: theoretical and empirical evidence with implications for health literacy. In: Health Literacy. IOS Press; 2017. p. 263–83.

34. Savelberg W, Boersma LJ, Smidt M, Goossens MFJ, Hermanns R, van der Weijden T. Does lack of deeper understanding of shared decision making explains the suboptimal performance on crucial parts of it? An example from breast cancer care. Eur J Oncol Nurs [Internet]. 2019;38(July 2018):92–7. Available from: https://doi.org/10.1016/j.ejon.2018.12.004

35. Légaré F, Thompson-Leduc P. Twelve myths about shared decision making. Patient Educ Couns. 2014;96(3):281–6.

36. Gillick MR. Re-engineering shared decision-making. J Med Ethics. 2015;41(9):785–8.

37. Staveley I, Sullivan P. We need more guidance on shared decision making. Br J Gen Pract. 2015;65(641):663–4.

38. Légaré F, Adekpedjou R, Stacey D, Turcotte S, Kryworuchko J, Graham ID, et al. Interventions for increasing the use of shared decision making by healthcare professionals. Cochrane database Syst Rev. 2018;7:CD006732.

39. NHS. Implementing shared decision making in the NHS and patients should be the first step in giving patients choice. 2021;(2010).

40. Bomhof-Roordink H, Gärtner FR, Stiggelbout AM, Pieterse AH. Key components of shared decision making models: A systematic review. BMJ Open. 2019;9(12).

41. Bravo P, Härter M, McCaffery K, Giguère A, Hahlweg P, Elwyn G. 20 years after the start of international Shared Decision-Making activities: Is it time to celebrate? Probably…. Vol. 171, Zeitschrift für Evidenz, Fortbildung und Qualität im Gesundheitswesen. Elsevier; 2022. p. 1–4.

42. Stiggelbout AM, Pieterse AH, De Haes JCJM. Shared decision making: Concepts, evidence, and practice. Patient Educ Couns [Internet]. 2015;98(10):1172–9. Available from: http://dx.doi.org/10.1016/j.pec.2015.06.022

43. Jost TS. Religious Freedom and Women's Health — The Litigation on Contraception. N Engl J Med. 2013;368(1):4–6.

44. Van Veenendaal H, Voogdt-Pruis HR, Ubbink DT, Hilders CGJM. Effect of a multilevel implementation programme on shared decision-making in breast cancer care. BJS Open. 2021;5(2):0–5.

45. Gaster C, Hofheinz RD, Burkhardt H. Shared Decision-Making in Oncology: Preferences in Older versus Younger Patients of an Oncology Clinic - A Conjoint Analysis. Oncol Res Treat. 2021;44(1–2):4–10.

46. Shen HN, Lin CC, Hoffmann T, Tsai CY, Hou WH, Kuo KN. The relationship between health literacy and perceived shared decision making in patients with breast cancer. Patient Educ Couns [Internet]. 2019;102(2):360–6. Available from: https://doi.org/10.1016/j.pec.2018.09.017

47. Waddell A, Lennox A, Spassova G, Bragge P. Barriers and facilitators to shared decision-making in hospitals from policy to practice: a systematic review. Implement Sci. 2021;16(1).

48. Alsulamy N, Lee A, Thokala P, Alessa T. What Influences the Implementation of Shared Decision Making: An Umbrella Review. Patient Educ Couns. 2020;103(12):2400–7.

49. McCarter SP, Tariman JD, Spawn N, Mehmeti E, Bishop-Royse J, Garcia I, et al. Barriers and Promoters to Participation in the Era of Shared Treatment Decision-Making. West J Nurs Res. 2016;38(10):1282–97.

50. Fallowfield LJ. Treatment decision-making in breast cancer: The patient-doctor relationship. Breast Cancer Res Treat. 2008;112(SUPPL. 1):5–13.

51. Schifferdecker KE, Reed VA. Using mixed methods research in medical education: Basic guidelines for researchers. Med Educ. 2009;43(7):637–44.

52. Creswell JW, Clark VLP. Designing and conducting mixed methods research. Sage publications; 2017.

53. Location S, Ababa A. Tikur Anbessa Specialized Hospital (Addis Ababa University). 2016;2015–7.

54. Araya LT, Fenta TG, Sander B, Gebremariam GT, Gebretekle GB. Health-related quality of life and associated factors among cervical cancer patients at Tikur Anbessa specialized hospital, Addis Ababa, Ethiopia. Health Qual Life Outcomes. 2020;18:1–9.

55. Toçi E, Burazeri G, Sørensen K, Kamberi H, Brand H. Concurrent validation of two key health literacy instruments in a South Eastern European population. Eur J Public Health. 2015;25(3):482–6.

56. Duong T V., Aringazina A, Baisunova G, Nurjanah, Pham T V., Pham KM, et al. Measuring health literacy in Asia: Validation of the HLS-EU-Q47 survey tool in six Asian countries. J Epidemiol. 2017;27(2):80–6.

57. Engelhardt EG, Smets EMA, Sorial I, Stiggelbout AM, Pieterse AH, Hillen MA. Is There a Relationship between Shared Decision Making and Breast Cancer Patients' Trust in Their Medical Oncologists? Med Decis Mak. 2020;40(1):52–61.

58. Hillen MA, Koning CCE, Wilmink JW, Klinkenbijl JHG, Eddes EH, Kallimanis-King BL, et al. Assessing cancer patients' trust in their oncologist: Development and validation of the Trust in Oncologist Scale (TiOS). Support Care Cancer. 2012;20(8):1787–95.

59. Doherr H, Christalle E, Kriston L, Haèrter M, Scholl I. Use of the 9-item Shared Decision Making Questionnaire (SDM-Q-9 and SDM-Q-Doc) in intervention studiesA systematic review. PLoS One. 2017;12(3):1–16.

60. Scholl I, Loon MK Van, Sepucha K, Elwyn G, Légaré F, Härter M, et al. Measurement of shared decision making - A review of instruments. Z Evid Fortbild Qual Gesundhwes [Internet]. 2011;105(4):313–24. Available from: http://dx.doi.org/10.1016/j.zefq.2011.04.012

61. Braun V, Clarke V. Thematic analysis revised. J Chem Inf Model. 2019;53(9):1689–99.

62. Guetterman TC. Joint Displays to Facilitate Integration of Qualitative and Quantitative Research. Mix Methods Int Res Assoc [Internet]. 2019;(MMIR and IIQA Webinar):1–47. Available from: http://mmira.wildapricot.org/admin/website/?pageId=1514647

63. Jost TS. on Contraception. 2013;4:3–6.

64. Feiten S, Scholl I, Dünnebacke J, Schmidt M, Franzen A, Ernst W, et al. Shared decision-making in routine breast cancer care in Germany—A cross-sectional study. Psychooncology. 2022;31(7):1120–6.

65. Elwyn G, Frosch D, Thomson R, Joseph-Williams N, Lloyd A, Kinnersley P, et al. Shared decision making: A model for clinical practice. J Gen Intern Med. 2012;27(10):1361–7.

66. Guo XR, Xiao L, Liu X, Chen J, Tong Z, Liu Z. Enhancing Doctor-Patient Shared Decision-Making: Design of a Novel Collaborative Decision Description Language. J Med Internet Res. 2025;27.

67. Sabo B, St-Jacques N, Rayson D. The decision-making experience among women diagnosed with stage I and II breast cancer. Breast Cancer Res Treat. 2007;102(1):51–9.

68. Holm AL, Berland AK, Severinsson E. Older Patients' Involvement in Shared Decision-Making—A Systematic Review. Open J Nurs. 2016;06(03):170–85.

69. Hoffmann T, Jansen J, Glasziou P. The importance and challenges of shared decision making in older people with multimorbidity 3 Centre for Medical Psychology and Evidence-based Decision-making. PLoS Med [Internet]. 2018;15(3):e1002530. Available from: http://journals.plos.org/plosmedicine/article/file?id=10.1371/journal.pmed.1002530&type=printable

70. Schulman-Green D, Feder SL, Dionne-Odom JN, Batten J, En Long VJ, Harris Y, et al. Family Caregiver Support of Patient Self-Management During Chronic, Life-Limiting Illness: A Qualitative Metasynthesis. J Fam Nurs. 2021;27(1):55–72.

71. Gurmu Y. Patient Preferences in Shared Decision Making During Healthcare and Associated Factors Among Adult Admitted Patients at Public Hospitals of West Shoa Oromia, Ethiopia. Patient Prefer Adherence. 2022;16(July):1781–6.

72. Almazrou SH, Alaujan SS, AlSaad NF. Assessing the Roles and Responsibilities of Informal Caregivers from the Perspective of Adult Patients in Saudi Arabia: A Cross-Sectional Study. Healthc. 2025;13(9):1–10.

73. Buedo P, Daly T. Strengthening autonomy in mental health care through a relational approach. Nat Ment Heal. 2024;2(11):1271–2.

74. Lewis J. Does shared decision making respect a patient's relational autonomy? J Eval Clin Pract. 2019;25(6):1063–9.

75. Hall MA, Dugan E, Zheng B, Mishra AK. Trust in Physicians and Medical Institutions: What Is It, Can It Be Measured, and Does It Matter? Milbank Q. 2001;79(4):613–39.

76. Toapanta N, Salas-Gama K, Pantoja PE, Soler MJ. The role of low health literacy in shared treatment decision-making in patients with kidney failure. Clin Kidney J. 2023;16(1 S):I4–11.

77. Ghorbanian Zolbin M, Huvila I, Nikou S. Health literacy, health literacy interventions and decision-making: a systematic literature review. J Doc. 2022;78(7):405–28.

ASSURANCE OF PRINCIPAL INVESTIGATOR

I, the undersigned, agree to accept all responsibilities for the scientific and ethical conduct of this research project.

Name of the student: Sosina Workineh Tilahun (Bsc)

Date: 7/7/2025

Signature: 

APPROVAL OF THE PRIMARY ADVISOR

Name of the primary advisor: Dr. Adamu Addissie (MD, MPH, MA, PhD, Associate Professor)

Date: 7/7/2025

Signature: 

ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCES

SCHOOL OF PUBLIC HEALTH

DEPARTMENT OF EPIDEMIOLOGY AND BIOSTATISTICS

Title: Shared decision-making in cervical cancer care patients at Tikur Anbessa specialized Hospital, Addis Ababa, Ethiopia

BY: Sosina Workineh Tilahun

APPROVED BY THE EXAMINING BOARD

Dr. Sofonias Getachew _____

Chairman, Departement Signature

Dr. Beza Ketema _____

Internal Examiner Signature

Dr. Erdaw Tachbele

External Examiner Signature

ANNEX I: INFORMATION SHEET

Participant Information Sheet

Principal Investigator: Sosina W. Tilahun

Dear Respondent:

My name is Sosina W. Tilahun, a student at Addis Ababa University, school of Public health. I kindly request you to participate in a study that is aimed examine shared decision making in clinical care of women with cervical cancer. The participation in this study is voluntary; you can also withdraw at any time from the study if you feel uncomfortable. Refusal to participate will not affect any of your social status and benefit you gain from the hospital in any way.

Confidentiality will be ensured by not using your name or address on the questionnaire and final thesis report. Additionally, the data from this study will only be handled by principal investigator and will kept in password locked laptop which is owned by the principal investigator. Furthermore, the data from this study will not be shared with anyone without your permission and does not be used for other purpose rather than the purpose of the current study you are eligible to.

There are no risks involved in participating in this study. The study has no immediate benefits to the respondents, and there will be no immediate financial compensation to the participants. Although, there is no immediate benefit from the study, the study will provide data for future researchers to use the evidence in order to commence application of Shared decision making in cervical cancer care.

I welcome any question if you have any about the study and your participation. Should you have any questions about the research or any related matters, please contact the researcher at +251917652639 and email: sosiworkineh143@gmail.com

ANNEX II: CONSENT SHEET

I, the under signed, understand the nature of the study, benefits, right to voluntary participation, confidentiality and withdrawal from the study without any victimization. I have had the opportunity to ask questions and answered to my satisfaction. I hereby freely consent to take myself to be part in this study.

Signature of the participant _____ Date_____

Supervisor Name _____

Date_____/_____/____E.C. signature_____

Name of interviewer _____

Date _____/_____/_____E.C. signature_____

Your participation will be appreciated.

ANNEX III: QUANTITATIVE DATA QUESTIONNAIRES

Part I: Socio-demographic characteristics of the respondent

No.	Variable	Responses
101.	Age in years	_____years old
102.	Area of Residence	1. Urban 2. Rural
103.	Religion Affiliation	1. Orhtodox 2. Protestant 3. Muslim 4. Catholic 5. Other
104.	If other, please specify	_____
105.	Educational status	1. Cannot Reda and Write 2. Didn't join formal education 3. Primary school (1-8) 4. Secondary School (9-12) 5. Tertiary School (>/= diploma)
106.	Occupation	1. Unemployed /Houswife 2. Government employed 3. Private Emploed (Work for individual) 4. Self-employed
107.	Average monthly income of the HH (Birr)	_____ETB
108.	Marital status	1. Married 2. Single 3. Divorced 4. Widow 5. Separated
109.	Source of treatment expense	1. Employer Sponsored 2. Health Insurance 3. Not Sponsored

Part II: Clinical Characteristics of the respondents

No.	Variable	Responses
201.	Stage of the disease	1. Stage I 2. Stage II 3. Stage III 4. Stage IV
202.	Surgical Intervention	1. Yes 2. No
203.	Time Since Diagnosis	_____
204.	ECOG	1. I 2. II 3. III 4. IV
205.	Type of treatment	1. Chemotherapy 2. Radiotherapy 3. Chemotherapy and Radiotherapy 4. Other
206.	Please specify other	_____
207.	Type of chemotherapy	1. Single therapy 2. Combined therapy
208.	Name of Chemotherapy	_____
209.	Round of consultation with clinicians	_____

Part III: Shared Decision Making Scale

No.	Variable	Responses
501.	My doctor made it clear that a decision needs to be made	1. Completely disagree 2. Strongly disagree 3. Somewhat disagree 4. Somewhat agree 5. Strongly agree 6. Completely agree
502.	My doctor wanted to know exactly how I wanted to be involved in making the decision	1. Completely disagree 2. Strongly disagree 3. Somewhat disagree 4. Somewhat agree 5. Strongly agree 6. Completely agree
503.	My doctor told me that there are different options for treating my medical condition	1. Completely disagree 2. Strongly disagree 3. Somewhat disagree 4. Somewhat agree 5. Strongly agree 6. Completely agree

504.	My doctor precisely explained the advantages and disadvantages of the treatment options	1. Completely disagree 2. Strongly disagree 3. Somewhat disagree 4. Somewhat agree 5. Strongly agree 6. Completely agree
505.	My doctor helped me understand all the information	1. Completely disagree 2. Strongly disagree 3. Somewhat disagree 4. Somewhat agree 5. Strongly agree 6. Completely agree
506.	My doctor asked me which treatment option I prefer	1. Completely disagree 2. Strongly disagree 3. Somewhat disagree 4. Somewhat agree 5. Strongly agree 6. Completely agree
507.	My doctor and I thoroughly weighed the different treatment options	1. Completely disagree 2. Strongly disagree 3. Somewhat disagree 4. Somewhat agree 5. Strongly agree 6. Completely agree
508.	My doctor and I selected a treatment option together	1. Completely disagree 2. Strongly disagree 3. Somewhat disagree 4. Somewhat agree 5. Strongly agree 6. Completely agree
509.	My doctor and I reached an agreement on how to proceed	1. Completely disagree 2. Strongly disagree 3. Somewhat disagree 4. Somewhat agree 5. Strongly agree 6. Completely agree

Part IV: health literacy items for the respondents

No.	**Variable**	**Responses**
301.	Finding information on symptoms of illnesses that concern you	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
302.	Finding information on treatments of illnesses that concern you	1. Very Easy 2. Fairly Easy 3. Fairly Difficult

		4. Very Difficult
303.	Finding out what to do in case of a medical emergency	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
304.	Finding out where to get professional help when you are ill	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
305.	Understanding what your doctor says to you	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
306.	Understanding the leaflets that come with your medicine	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
307.	Understanding what to do in a medical emergency	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
308.	Understanding your doctor's or pharmacist's instructions on how to take a prescribed medicine	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
309.	Judging how information from your doctor applies to you	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
310.	Judging the advantages and disadvantages of different treatment options	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
311.	Judging when you may need to get a second opinion from another doctor	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
312.	Judging if the information about illness in the media is reliable	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
313.	Using information the doctor gives you to make decisions about your illness	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
314.	Following the instructions on medication	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
315.	Calling an ambulance in an emergency	1. Very Easy

		2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
316.	Following instructions from your doctor or pharmacist	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
317.	Finding information about how to manage unhealthy behavior such as smoking, low physical activity and excessive drinking	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
318.	Finding information on how to manage mental health problems such as stress or depression	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
319.	Finding information about vaccinations and health screenings that you should have	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
320.	Finding information on how to prevent or manage conditions such as being overweight, high blood pressure or high cholesterol	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
321.	Understanding health warnings about behavior such as smoking, low physical activity and excessive drinking	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
322.	Understanding why you need vaccinations	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
323.	Understanding why you need health screenings	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
324.	Judging how reliable health warnings are, such as smoking, low physical activity and excessive drinking	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
325.	Judging when you need to go to a doctor fora check-up	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
326.	Judging which vaccinations you may need	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
327.	Judging which health screenings you should have	1. Very Easy 2. Fairly Easy 3. Fairly Difficult

		4. Very Difficult
328.	Judging if the information on health risks in the media is reliable	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
329.	Deciding if you should have a flu vaccination	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
330.	Deciding how you can protect yourself from illness based on advice from family and friends	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
331.	Deciding how you can protect yourself from illness based on information in the media	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
332.	Finding information on healthy activities such as exercise, healthy food and nutrition	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
333.	Finding out about activities that are good for your mental well-being	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
334.	Finding information on how your neighborhood could be more health-friendly	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
335.	Finding out about political changes that may affect health	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
336.	Finding out about efforts to promote your health at work	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
337.	Understanding advice on health from family members or friends	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
338.	Understanding information on food packaging	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
339.	Understanding information in the media on how to get healthier	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult

340.	Understanding information on how to keep your mind healthy	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
341.	Judging how where you live affects your health and well-being	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
342.	Judging how your housing conditions help you to stay healthy	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
343.	Judging which every day behavior is related to your health	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
344.	Making decisions to improve your health	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
345.	Joining as ports club or exercise class if you want to	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
346.	Influencing your living conditions that affect your health and well-being	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult
347.	Taking part in activities that improve health and wellbeing in your community	1. Very Easy 2. Fairly Easy 3. Fairly Difficult 4. Very Difficult

Part IV. Trust in Oncologist Questionnaire

No.	**Variable**	**Responses**
401.	Your doctor is very careful and precise	1. totally disagree 2. disagree 3. as much agree as disagree 4. agree 5. Strongly Agree
402.	Your doctor is totally honest in telling you about all the different treatment options available for your condition	1. totally disagree 2. disagree 3. as much agree as disagree 4. agree 5. Strongly Agree

403.	Your doctor always gives you honest information about your prospects	1. totally disagree 2. disagree 3. as much agree as disagree 4. agree 5. Strongly Agree
404.	Your doctor strongly cares about your health	1. totally disagree 2. disagree 3. as much agree as disagree 4. agree 5. Strongly Agree
405.	Your doctor always tells you everything you want to know about your illness	1. totally disagree 2. disagree 3. as much agree as disagree 4. agree 5. Strongly Agree
406	You think your doctor can handle any medical situation, even a very serious one	1. totally disagree 2. disagree 3. as much agree as disagree 4. agree 5. Strongly Agree
497.	Your doctor always takes his/her time with you	1. totally disagree 2. disagree 3. as much agree as disagree 4. agree 5. Strongly Agree
408.	Your doctor explains everything so that you can consent to medical decisions	1. totally disagree 2. disagree 3. as much agree as disagree 4. agree 5. Strongly Agree
409.	Sometimes you worry that your doctor's medical decisions are wrong [a]	1. totally disagree 2. disagree 3. as much agree as disagree 4. agree 5. Strongly Agree
410.	Your doctor only thinks about what is best for you	1. totally disagree 2. disagree 3. as much agree as disagree 4. agree 5. Strongly Agree
411.	Sometimes your doctor does not pay full attention to what you are trying to tell him/her [a]	1. totally disagree 2. disagree 3. as much agree as disagree 4. agree 5. Strongly Agree
412.	Your doctor would always tell you the truth about your health, even if there was bad news	1. totally disagree 2. disagree 3. as much agree as disagree 4. agree 5. Strongly Agree

413.	You have doubts whether your doctor really cares about you as a person[a]	1. totally disagree 2. disagree 3. as much agree as disagree 4. agree 5. Strongly Agree
414.	Your doctor listens with care and concern to all the problems you have	1. totally disagree 2. disagree 3. as much agree as disagree 4. agree 5. Strongly Agree
415.	Your doctor will do whatever it takes to get you all the care you need	1. totally disagree 2. disagree 3. as much agree as disagree 4. agree 5. Strongly Agree
416.	Your doctor is available for you whenever you need him/her	1. totally disagree 2. disagree 3. as much agree as disagree 4. agree 5. Strongly Agree
417.	You have no worries about putting your life in your doctor's hands	1. totally disagree 2. disagree 3. as much agree as disagree 4. agree 5. Strongly Agree
418.	All in all, you have complete trust in your doctor	1. totally disagree 2. disagree 3. as much agree as disagree 4. agree 5. Strongly Agree

ANNEX IV: QUALITATIVE INTERVIEW GUIDES

Part II: In-depth interview with women with Cervical Cancer

1. First I would like you to introduce yourself (Age, level of education, Occupation, residence, marital status, monthly income)
2. Can you tell me your diagnosis? What is its name? What is its stage? What is your treatment modalities?
3. How was first time experience when you get diagnosed with cancer? Let us remember that time?

   Probe: How did you get the news? Who was with you? How was communication with the doctor? Who did communicate with the doctor on your behalf?
4. What is shared decision making for you? Did you participate in treatment decision making? Why or why not?
5. Do you think you participated in decision making process for your treatment? If not why? If yes How?
6. What would make patients more likely to be involved in the decision-making process? How?
7. What would make patients less likely to be involved in the decision making process? How?

Part II: Key Informant interview with Health care Provider (Clinical Oncologist)

1. Firs I would like you to introduce yourself (Age, level of expertise, years of experiences, training related to shared decision making)
2. What is your responsibility in the care of women diagnosed with cancer?

3. How do you communicate treatment options and risks to patients? What strategies do you use to ensure understanding and engagement?
4. Tell me what you know about shared decision making?
5. Do you think you have involved your patients in their treatment process? If not why? If yes, how?
6. What facilitators can you discuss in shared decision making?

   Probe: practice related facilitators, patient related facilitators, institutional policy related facilitators, professional related facilitators, scope of practice related facilitators, insurance coverage related facilitators, and related facilitators
7. What barriers can you discuss in shared decision making?

   Probe: practice barrier, patient barrier, institutional policy barrier, professional barrier, scope of practice barrier, insurance coverage barrier, and administrative barrier

አባሪ I. ለጥናቱ የተሣታፊ መረጃ ወረቀት

ዋና መርማሪ፡- ሶሲና ወርቅነህ ጥላሁን

ውድ ተጠሪ፡-

ሶሲና ወርቅነህ እባላለሁ በአዲስ አበባ ዩኒቨርሲቲ የፐብሊክ ጤና ትምህርት ቤት ተማሪ ነኝ። በማህፀን በር ካንሰር ያለባቸውን ሴቶች የሕክምና እንክብካቤ ላይ የጋራ ውሳኔ አሰጣጥን ለመመርመር የታለመ ጥናት ላይ እንድትሳተፉ በትህትና እጠይቃለሁ። በዚህ ጥናት ውስጥ ያለው ተሳትፎ በፈቃደኝነት ነው; ምኞት የማይሰማዎት ከሆነ በማንኛውም ጊዜ ከጥናቱ መውጣት ይችላሉ። ለመሳተፍ ፈቃደኛ አለመሆን ማንኛውንም ማህበራዊ ደረጃዎን አይጎዳውም እና በማንኛውም መንገድ ከሆስፒታሉ የሚያገኙት ጥቅም አያስቀርም።

ሚስጥራዊነት: የሚረጋገጠው ስሞትን ወይም አድራያሾትን በመጠይቁ እና በመጨረሻው ዘገባ ላይ ባለመጠቀም ነው። በተጨማሪም፣ ከዚህ ጥናት የተገኘው መረጃ የሚካሄደው በዋና መርማሪ ብቻ ነው እና በይለፍ ቃል በተቆለፈው ላፕቶፕ ውስጥ በዋና መርማሪው ባለቤትነት ይቀመጣል። በተጨማሪም፣ ከዚህ ጥናት የተገኘው መረጃ ያለእርስዎ ፈቃድ ለማንም አይጋራም እና እርስዎ ብቁ ከሆኑበት የአሁኑ የጥናት ዓላማ ይልቅ ለሌላ ዓላማ አይውልም።

በዚህ ጥናት ውስጥ ለመሳተፍ ምንም አይነት አደጋዎች የሉም. ጥናቱ ለምላሾች ፈጣን ጥቅም የለውም, እና ለተሳታፊዎች ፈጣን የገንዘብ ማካካሻ አይኖርም. ምንም እንኳን በጥናቱ ምንም አይነት ፈጣን ጥቅም ባይኖርም ጥናቱ ወደፊት ተመራማሪዎች በማህፀን በር ካንሰር እንክብካቤ ላይ የጋራ ውሳኔዎችን መተግበር ለመጀመር መረጃውን ለመጠቀም መረጃ ይሰጣል.

ስለ ጥናቱ እና ስለ እርስዎ ተሳትፎ ማንኛውም ጥያቄ ካለዎት እቀበላለሁ. ስለ ጥናቱ ወይም ተያያዥ ጉዳዮች ማንኛውም አይነት ጥያቄ ካሎት +251917652639 ላይ ተመራማሪውን ያነጋግሩ እና በኢሜል፡ sosiworkineh143@gmail.com

ባሪ 2. ለጥናቱ የተሣታፊ ስምምነት ቅጽ

የተፈራረምኩትን፣ የጥናቱ አይነት፣ ጥቅማጥቅሞች፣ በፍቃደኝነት የመሳተፍ መብት፣ ሚስጥራዊነት እና ምንም አይነት ተጎጂ ሳይሆኑ ከጥናቱ የመውጣት መብት ተረድቻለሁ። ጥያቄዎችን ለመጠየቅ እድሉን አግኝቻለሁ ። በዚህ ጥናት ውስጥ ለመሳተፍ በነጻነት ተስማምቻለሁ።

የተሳታፊው ፊርማ _____ ቀን_____

የተቆጣጣሪ ስም _____

ቀን____/_____/____ፊርማ _____

የጠያቂው ስም _____

ቀን _____/____/_____ ፊርማ _____

አመሰግናለሁ

አባሪ III፡ የቁጥር መረጃ መጠይቆች

ክፍል አንድ፡ የተሳታፊው ማህበራዊ-ስነ-ሕዝብ ባህሪያት

No.	Variable	Responses
101.	የተሳታፊው ዕድሜ	_____ ዓመት
102.	የተሳታፊው የመኖሪያ አካባቢ	3. ከተማ 4. ገጠር
103.	የተሳታፊው ሃይማኖት	6. ኦርቶዶክስ 7. ፕሮቴስታንት 8. ሙስሊም 9. ካቶሊክ 10. ሌላ_____
104.	ሌላ ከሆነ እባክዎን ይጥቀሱ	_____
105.	የተሳታፊው የጋብቻ ሁኔታ	1. ያላገባች 2. ያገባች 3. ባል/ምስት የሞባት/ችበት 4. የተፋታ/ች 5. ተለያይተዋል
106.	የተሳታፊው የትምህርት ደረጃ	6. መፃፍ እና ማንበብ የማይችል 7. መደበኛ ትምህርትን አልተቀላቀለም። 8. የመጀመሪያ ደረጃ ትምህርት ቤት (1-8) 9. ሁለተኛ ደረጃ ትምህርት ቤት (9-12) 10. ከፍተኛ ትምህርት ቤት (>/= ዲፕሎማ)
107.	የተሳታፊው ሥራ	5. ሥራ አጥ 6. መንግስት ተቀጠረ 7. የግል ተቀጣሪ 8. ጡረተኛ
108.	የተሳታፊውአማካይ ወርሃዊ ገቢ በገንዘብ	_____ETB
109.	የተሳታፊው የሕክምና ወጪ ምንጭ	4. ስፖንሰር የተደረገ 5. ጤና መድህን

ክፍል II፡ የተሳታፊው ክሊኒካዊ ባህሪያት

No.	Variable	Responses
201.	የበሽታው ደረጃ	1. ደረጃ I 2.ደረጃ II 3. ደረጃ III 4. ደረጃ IV
203.	የቀዶ ጥገና ህክምና ተሰጥቷታል	3. አዎ 4. አይደለም
204.	በሽታው ከታወቀ ምን ያህል ጊዜ ሆነዉ	_____
205.	ECOG (የታካሚው አፈፃፀም ሁኔታ)	5. I 6. II 7. III 8. IV
206.	የሕክምና ዓይነት	1. ኪሞቴራፒ 2. ራዲዮቴራፒ 3. የሆርሞን ቴራፒ 4. ሌላ
207.	ሌላ ከሆነ እባክዎን ይጥቀሱ	_____
208.	የኬሞቴራፒ ዓይነት	1. ነጠላ ህክምና 2. የተቀናጀ ሕክምና
209.	የኬሞቴራፒው ስም	_____
210.	ከክሊኒኮች ጋር የሚደረግ ምክክር _____	_____

ክፍል III፡ የጋራ ውሳኔ አሰጣጥ ልኬት

No.	Variable	Responses
301.	ዶክተሬ ውሳኔ መስጠት እንደሚያስፈልግ በግልፅ ተናግሯል	1.ሙሉ በሙሉ አልስማማም 2. በጣም አልስማማም 3. በመጠኑ አልስማማም 4. በመጠኑ ይስማማሉ 5. በጠንካራ ሁኔታ ይስማማሉ 6. ሙሉ በሙሉ ይስማማሉ
302.	ዶክተሬ በውሳኔው ውስጥ እንዴት እኔ መሳተፍ እንደምፈልግ በትክክል ማወቅ ፈልጎ ነበር	1.ሙሉ በሙሉ አልስማማም 2. በጣም አልስማማም 3. በመጠኑ አልስማማም 4. በመጠኑ ይስማማሉ 5. በጠንካራ ሁኔታ ይስማሙሉ 6. ሙሉ በሙሉ ይስማሙሉ
303.	ዶክተሬ የጤና ሁኔታዬን ለማከም የተለያዩ የህክምና አማራጮች እንዳሉ ነግሮኛል	1.ሙሉ በሙሉ አልስማማም 2. በጣም አልስማማም 3. በመጠኑ አልስማማም 4. በመጠኑ ይስማማሉ 5. በጠንካራ ሁኔታ ይስማሙሉ

		6. ሙሉ በሙሉ ይስማሙሉ
304.	ዶክተሬ የተለያዩ የህክምና አማራጮችን ጥቅምና ጉዳት በትክክል አብራርቶ ገልፆልኛል	1.ሙሉ በሙሉ አልስማማም 2. በጣም አልስማማም 3. በመጠኑ አልስማማም 4. በመጠኑ ይስማማሉ 5. በጠንካራ ሁኔታ ይስማሙሉ 6. ሙሉ በሙሉ ይስማሙሉ
305.	ዶክተሬ ሁሉንም መረጃ እንድረዳ/እንዲገባኝ ረድቶኛል	1.ሙሉ በሙሉ አልስማማም 2. በጣም አልስማማም 3. በመጠኑ አልስማማም 4. በመጠኑ ይስማማሉ 5. በጠንካራ ሁኔታ ይስማሙሉ 6. ሙሉ በሙሉ ይስማሙሉ
306.	ዶክተሬ የትኛውን የህክምና አማራጭ እንደምመርጥ ጠይቆኛል	1.ሙሉ በሙሉ አልስማማም 2. በጣም አልስማማም 3. በመጠኑ አልስማማም 4. በመጠኑ ይስማማሉ 5. በጠንካራ ሁኔታ ይስማሙሉ 6. ሙሉ በሙሉ ይስማሙሉ
307.	እኔ ና ዶክተሬ የተለያዩ የሕክምና አማራጮችን በሚገባ ተወያይተናል	1.ሙሉ በሙሉ አልስማማም 2. በጣም አልስማማም 3. በመጠኑ አልስማማም 4. በመጠኑ ይስማማሉ 5. በጠንካራ ሁኔታ ይስማሙሉ 6. ሙሉ በሙሉ ይስማሙሉ
308.	ዶክተሬ እና እኔ አንድ ላይ ህክምናዬን አብረን መረጥን	1.ሙሉ በሙሉ አልስማማም 2. በጣም አልስማማም 3. በመጠኑ አልስማማም 4. በመጠኑ ይስማማሉ 5. በጠንካራ ሁኔታ ይስማሙሉ 6. ሙሉ በሙሉ ይስማሙሉ
309.	ዶክተሬ እና እኔ እንዴት መቀጠል እንዳለብን ስምምነት ላይ ደርሰናል	1.ሙሉ በሙሉ አልስማማም 2. በጣም አልስማማም 3. በመጠኑ አልስማማም 4. በመጠኑ ይስማማሉ 5. በጠንካራ ሁኔታ ይስማሙሉ 6. ሙሉ በሙሉ ይስማሙሉ

ክፍል IV: የተሳታፊው የጤና እውቀት

No.	**Variable**	**Responses**
401.	እርስዎን በሚያሳስቡ በሽታዎች ምልክቶች ላይ መረጃ ማግኘት ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል

		3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
402.	እርስዎን በሚያሳስቡ በሽታዎች ላይ የህክምና አማራጮች በተመለከተ መረጃ ማግኘት ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
403.	የሕክምና ድንገተኛ ሁኔታ ሲያጋጥም ምን ማድረግ እንዳለበት ማወቅ ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
404.	በሚታመሙበት ጊዜ የባለሙያ እርዳታ የት እንደሚያገኙ ማወቅ ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
405.	ዶክተርዎ የሚነግርዎትን መረዳት ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
406.	ከመድኃኒትዎ ጋር የሚመጡትን በራሪ ወረቀቶች መረዳት ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
407.	በህክምና ድንገተኛ ሁኔታ ውስጥ ምን ማድረግ እንዳለቦት መረዳት ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
408.	የታዘዘ መድሃኒት እንዴት እንደሚወስዱ የዶክተርዎን ወይም የፋርማሲስት መመሪያዎችን መረዳት ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
409.	የዶክተርዎ መረጃ ለእርስዎ እንዴት እንደሚተገበር ማስተዋል ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
410.	የተለያዩ የሕክምና አማራጮችን ጥቅምና ጉዳት ማስተዋል ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
411.	ከሌላ ዶክተር ሁለተኛ አስተያየት ማግኘት በሚያስፈልግበት ጊዜ ማስተዋል ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ

412.	በመገናኛ ብዙኃን ስለበሽታው ያለው መረጃ አስተማማኝ ስለመሆኑ ማስተዋል ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
413.	ስለ ህመምዎ ውሳኔ እንዲወስኑ ዶክተሩ የሰጡትን መረጃ መጠቀም ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
414.	በመድሃኒት ላይ ያሉትን መመሪያዎች መከተል ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
415.	በአደጋ ጊዜ አምቡላንስ መጥራት ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
416.	ከዶክተርዎ ወይም ከፋርማሲስትዎ መመሪያዎችን መከተል ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
417.	እንደ ማጨስ፣ ዝቅተኛ የአካል ብቃት እንቅስቃሴ እና ከመጠን በላይ መጠጣትን የመሳሰሉ ጤናማ ያልሆኑ ባህሪያትን እንዴት መቆጣጠር እንደሚቻል መረጃ ማግኘት ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
418.	እንደ ጭንቀት ወይም ድብርት ያሉ የአእምሮ ጤና ችግሮችን እንዴት መቆጣጠር እንደሚቻል መረጃ ማግኘት ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
419.	ሊያረጉ የሚገባውን ክትባቶች እና የጤና ምርመራዎች መረጃ ማግኘት ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
420.	እንደ ከመጠን ያለፈ ውፍረት፣ የደም ግፊት ወይም ከፍተኛ ኮሌስትሮል ያሉ ሁኔታዎችን እንዴት መከላከል ወይም መቆጣጠር እንደሚቻል መረጃ ማግኘት ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
421.	እንደ ማጨስ, ዝቅተኛ የአካል ብቃት እንቅስቃሴ እና ከመጠን በላይ መጠጣትን የመሳሰሉ የጤና ማስጠንቀቂያዎችን መረዳት ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
422.	ለምን ክትባቶች እንደሚያስፈልጉመረዳት ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል

		3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
423.	የጤና ምርመራ ለምን እንደሚያስፈልግ መረዳት ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
424.	እንደ ማጨስ፣ አነስተኛ የአካል ብቃት እንቅስቃሴ እና ከመጠን በላይ መጠጣት ያሉ የጤና ማስጠንቀቂያዎች ምን ያህል አስተማማኝ እንደሆኑ መረዳት ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
425.	ወደ ሐኪም መሄድ ሲያስፈልግዎ ማስተዋል ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
426.	የትኞቹ ክትባቶች ሚሲያስፈልግዎ ማስተዋል ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
427.	የትኛውን የጤና ምርመራ ማድረግ እንዳለቦት ማስተዋል ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
428.	በመገናኛ ብዙሃን ላይ ስለ ጤና አደጋዎች መረጃው አስተማማኝ ከሆነ ማስተዋል ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
429.	የጉንፋን ክትባት መውሰድ እንዳለቦት መወሰን ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪlt
430.	ከቤተሰብ እና ከጓደኞች ምክር በመነሳት እራስዎን ከበሽታ እንዴት እንደሚከላከሉ መወሰን ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
431.	በመገናኛ ብዙኃን ላይ ባሉ መረጃዎች ላይ በመመርኮዝ እራስዎን ከበሽታ እንዴት እንደሚከላከሉ መወሰን ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
432.	እንደ የአካል ብቃት እንቅስቃሴ፣ ጤናማ ምግብ እና አመጋገብ ባሉ ጤናማ እንቅስቃሴዎች ላይ መረጃ ማግኘት ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ

433.	ለአእምሮ ጤንነትዎ ጠቃሚ የሆኑ ተግባራትን ማወቅ ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
434.	ሰፈራችሁ እንዴት ለጤና ተስማሚ ሊሆን እንደሚችል መረጃ ማግኘት ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
435.	ጤናን ሊጎዱ ስለሚችሉ የፖለቲካ ለውጦች ማወቅ ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
436.	ጤናዎን በሥራ ቦታ ላይ ለማሳደግ ስለሚደረጉ ጥረቶች ማወቅ ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
437.	በጤና ላይ ከቤተሰብ አባላት ወይም ከጓደኞች ምክር መረዳት ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
438.	በምግብ ማሸጊያ ላይ መረጃን መረዳት ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
439.	ጤናን እንዴት ማግኘት እንደሚቻል የሚዲያ መረጃን መረዳት ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
440.	የአዕምሮዎን ጤና እንዴት እንደሚጠብቅ መረጃን መረዳት ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
441.	የሚኖሩበት ቦታ ጤናዎን እና ደህንነትዎን እንዴት እንደሚነካ ማስተዋል ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
442.	የመኖሪያ ቤት ሁኔታዎ ጤናማ ሆነው እንዲቆዩ እንዴት እንደሚረዳዎት ማስተዋል ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
443.	የየቀኑ ባህሪ ከጤናዎ ጋር የተያያዘው የትኛው እንደሆነ ማስተዋል ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል

		3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
444.	ጤናዎን ለማሻሻል ውሳኔዎችን መወሰን ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
445.	ከፈለጉ የአካል ብቃት እንቅስቃሴ ክፍል መቀላቀል ማስተዋል ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
446.	በጤናዎ እና በጤንነትዎ ላይ ተጽእኖ በሚፈጥሩ የኑሮ ሁኔታዎችዎ ላይ ተጽእኖ ማድረግ ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ
447.	በማህበረሰብዎ ውስጥ ጤናን እና ደህንነትን በሚያሻሽሉ ተግባራት ውስጥ መሳተፍ ምን ያህል ቀላል ነው?	1. በጣም ቀላል 2. ቀላል 3. ትንሽ አስቸጋሪ 4. በጣም አስቸጋሪ

ክፍል V. በኦንኮሎጂስት ላይ ያሎት እምነት

No.	Variable	Responses
501.	ዶክተርዎ በጣም ጠንቃቃ እና ትክክለኛ ነው	1. ሙሉ በሙሉ አልስማማም 2. አልስማማም 3. ያልተስማማውን ያህል ይስማማሉ 4. እስማማለሁ 5. በጣም እስማማለሁ
502.	ዶክተርዎ ለህመምዎ ስላሉት የተለያዩ የሕክምና አማራጮች ሲነግርዎ ሙሉ በሙሉ ታማኝ ነው	1.ሙሉ በሙሉ አልስማማም 2. አልስማማም 3. ያልተስማማውን ያህል ይስማማሉ 4. እስማማለሁ 5. በጣም እስማማለሁ
503.	ዶክተርዎ ሁል ጊዜ ስለ ተስፋዎ ትክክለኛ መረጃ ይሰጥዎታል	1. ሙሉ በሙሉ አልስማማም 2. አልስማማም 3. ያልተስማማውን ያህል ይስማማሉ 4. እስማማለሁ 5. በጣም እስማማለሁ
504.	ዶክተርዎ ስለ ጤንነትዎ በጣም ያስባል	1. ሙሉ በሙሉ አልስማማም 2. አልስማማም 3. ያልተስማማውን ያህል ይስማማሉ 4. እስማማለሁ

		5. በጣም እስማማለሁ
505.	ዶክተርዎ ስለ ህመምዎ ማወቅ የሚፈልጉትን ሁሉ ሁልጊዜ ይነግርዎታል	1. ሙሉ በሙሉ አልስማማም 2. አልስማማም 3. ያልተስማማውን ያህል ይስማማሉ 4. እስማማለሁ 5. በጣም እስማማለሁ
506	ዶክተርዎ ማንኛውንም የጤና ችግር ሊቋቋም ይችላል ብለው ያስባሉ፣ በጣም ከባድ የሆነውን እንኳን	1. ሙሉ በሙሉ አልስማማም 2. አልስማማም 3. ያልተስማማውን ያህል ይስማማሉ 4. እስማማለሁ 5. በጣም እስማማለሁ
507.	ዶክተርዎ ሁል ጊዜ ከእርስዎ ጋር ጊዜ ይወስዳል	1.ሙሉ በሙሉ አልስማማም 2. አልስማማም 3. ያልተስማማውን ያህል ይስማማሉ 4. እስማማለሁ 5. በጣም እስማማለሁ
508.	ዶክተርዎ ስለህክምና ውሳኔዎች ስምምነት ሁሉንም ነገር ያብራራል	1.ሙሉ በሙሉ አልስማማም 2. አልስማማም 3. ያልተስማማውን ያህል ይስማማሉ 4. እስማማለሁ 5. በጣም እስማማለሁ
509.	አንዳንድ ጊዜ የዶክተርዎ የሕክምና ውሳኔዎች የተሳሳተ ነው ብለው ይጨነቃሉ	1. ሙሉ በሙሉ አልስማማም 2. አልስማማም 3. ያልተስማማውን ያህል ይስማማሉ 4. እስማማለሁ 5. በጣም እስማማለሁ
510.	ዶክተርዎ ስለሚጠቅም ነገር ብቻ ነው የሚያስብ	1. ሙሉ በሙሉ አልስማማም 2. አልስማማም 3. ያልተስማማውን ያህል ይስማማሉ 4. እስማማለሁ 5. በጣም እስማማለሁ
511.	አንዳንድ ጊዜ ዶክተርዎ ሊነግሩት የሚፈልጉትን ነገር ሙሉ ትኩረት አይሰጡም	1. ሙሉ በሙሉ አልስማማም 2. አልስማማም 3. ያልተስማማውን ያህል ይስማማሉ 4. እስማማለሁ 5. በጣም እስማማለሁ
512.	ምንም እንኳን መጥፎ ዜና ቢኖርም ዶክተርዎ ስለ ጤናዎ ሁልጊዜ እውነቱን ይነግርዎታል	1.ሙሉ በሙሉ አልስማማም 2. አልስማማም 3. ያልተስማማውን ያህል ይስማማሉ 4. እስማማለሁ 5. በጣም እስማማለሁ

513.	ዶክተርዎ እንደ ሰው ያስባልዎት እንደሆነ ጥርጣሬዎች አሉዎት	1.ሙሉ በሙሉ አልስማማም 2. አልስማማም 3. ያልተስማማውን ያህል ይስማማሉ 4. እስማማለሁ 5. በጣም እስማማለሁ
514.	ዶክተርዎ ያለዎትን ችግር ሁሉ በጥንቃቄ ያዳምጣል	1.ሙሉ በሙሉ አልስማማም 2. አልስማማም 3. ያልተስማማውን ያህል ይስማማሉ 4. እስማማለሁ 5. በጣም እስማማለሁ
515.	ዶክተርዎ የሚፈልጉትን ሁሉ ለእርስዎ ለማግኘት አስፈላጊውን ሁሉ ያደርጋል	1.ሙሉ በሙሉ አልስማማም 2. አልስማማም 3. ያልተስማማውን ያህል ይስማማሉ 4. እስማማለሁ 5. በጣም እስማማለሁ
516.	ዶክተርዎ በሚፈልጉበት ጊዜ ሁሉ ለእርስዎ ዝግጁ ነው	1. ሙሉ በሙሉ አልስማማም 2. አልስማማም 3. ያልተስማማውን ያህል ይስማማሉ 4. እስማማለሁ 5. በጣም እስማማለሁ
517.	ህይወትዎን ለሀኪምዎ እጅ ለመስጠት ምንም ስጋት የለዎትም	1.ሙሉ በሙሉ አልስማማም 2. አልስማማም 3. ያልተስማማውን ያህል ይስማማሉ 4. እስማማለሁ 5. በጣም እስማማለሁ
518.	በአጠቃላይ በሀኪምዎ ላይ ሙሉ እምነት አለዎት	1. ሙሉ በሙሉ አልስማማም 2. አልስማማም 3. ያልተስማማውን ያህል ይስማማሉ 4. እስማማለሁ 5. በጣም እስማማለሁ

ክፍል II፡ የማህፀን በር ካንሰር ካለባቸው ሴቶች ጋር የተደረገ ጥልቅ ቃለ ምልልስ

1. በመጀመሪያ እራሶትን እንድታስተዋውቅ እፈልጋለሁ (ዕድሜ፣ የትምህርት ደረጃ፣ ሥራ፣ መኖሪያ፣ የትዳር ሁኔታ፣ ወርሃዊ ገቢ)

2. ምርመራዎን ሊነግሩኝ ይችላሉ? ስሙ ማን ይባላል? ደረጃው ምንድን ነው? የእርስዎ የሕክምና ዘዴዎች ምንድን ናቸው?

3. በካንሰር ሲመረመሩ ለመጀመሪያ ጊዜ ያጋጠመዎት እንዴት ነበር? ያንን ጊዜ እናስታውስ?

መርማሪ፡- ዜናውን እንዴት አገኘኸው? ካንተ ጋር ማን ነበር? ከሐኪሙ ጋር መግባባት እንዴት ነበር? እርስዎን ወክሎ ከሐኪሙ ጋር የተነጋገረው ማነው?

4. ለእርስዎ የጋራ ውሳኔ ምንድ ነው? በሕክምና ውሳኔ ላይ ተሳትፈዋል? ለምን ወይም ለምን አይሆንም?

5. ለህክምናዎ በውሳኔ አሰጣጥ ሂደት ውስጥ የተሳተፉ ይመስልዎታል? ካልሆነ ለምን? አዎ ከሆነ እንዴት?

6. ሕመምተኞች በውሳኔ አሰጣጥ ሂደት ውስጥ የመሳተፍ እድላቸው ከፍተኛ እንዲሆን የሚያደርገው ምንድን ነው? እንዴት፡

7. ታካሚዎች በውሳኔ አሰጣጥ ሂደት ውስጥ የመሳተፍ እድላቸው አነስተኛ እንዲሆን የሚያደርገው ምንድን ነው? እንዴት፡

ክፍል III፡ ቁልፍ መረጃ ሰጪ ከጤና እንክብካቤ አቅራቢ ክሊኒካል አንኮሎጂስት ጋር ቃለ ምልልስ

1. መጀመሪያ እራስህን እንድታስተዋውቅ እፈልጋለው (ዕድሜ፣ የእውቀት ደረጃ፣ የዓመታት ተሞክሮዎች፣ ከጋራ ውሳኔ አሰጣጥ ጋር የተያያዘ ስልጠና)

2. በካንሰር የተያዙ ሴቶችን በመንከባከብ ረገድ የእርስዎ ኃላፊነት ምንድን ነው?

3. የሕክምና አማራጮችን እና አደጋዎችን ለታካሚዎች እንዴት ያስተላልፋሉ? ግንዛቤን እና ተሳትፎን ለማረጋገጥ ምን አይነት ስልቶችን ይጠቀማሉ?

4. ስለ የጋራ ውሳኔ አሰጣጥ የምታውቀውን ንገረኝ?

5. ታካሚዎቻችሁን በሕክምና ሂደታቸው ውስጥ ያሳተፏቸው ይመስልዎታል? ካልሆነ ለምን? አዎ ከሆነ እንዴት?

6. በጋራ ውሳኔ አሰጣጥ ላይ የትኞቹን አመቻቾች መወያየት ይችላሉ?

ምርመራ፡ ከተግባር ጋር የተያያዙ አስተባባሪዎች፣ ታካሚ ተዛማጅ አስተባባሪዎች፣ ተቋማዊ ፖሊሲ ነክ አስተባባሪዎች፣ ሙያዊ ተዛማጅ አስተባባሪዎች፣ የተግባር ጉዳዮች ወሰን፣ የመድን ሽፋን ነክ አስተባባሪዎች እና ተዛማጅ አስተባባሪዎች

7. በጋራ ውሳኔ አሰጣጥ ላይ ምን መሰናክሎች መወያየት ይችላሉ?

ምርመራ፡ የተግባር ማገጃ፣ የታካሚ እንቅፋት፣ ተቋማዊ የፖሊሲ እንቅፋት፣ ሙያዊ እንቅፋት፣ የተግባር እንቅፋት፣ የኢንሹራንስ ሽፋን እንቅፋት እና አስተዳደራዊ እንቅፋት

Shared decision-making in clinical care of cervical cancer patients at Tikur Anbessa specialized Hospital, Addis Ababa, Ethiopia

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Approved

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