ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCES

SCHOOL OF NURSING AND MIDWIFERY

QUALITY OF GYNECOLOGICAL CANCER CARE FROM THE PATIENT'S PERSPECTIVE AT SELECTED PUBLIC HOSPITALS IN ADDIS ABABA, ETHIOPIA, 2025.

BY:

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A RESEARCH THESIS SUBMITTED TO THE SCHOOL OF NURSING AND MIDWIFERY, COLLEGE OF HEALTH SCIENCES, ADDIS ABABA UNIVERSITY AS PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SCIENCE IN MATERNITY AND REPRODUCTIVE HEALTH NURSING.

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APPROVAL BY THE BOARD OF EXAMINATION

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STATEMENT OF DECLARATION

By my signature below, I declare and affirm that this thesis is my own work. I have followed all ethical principles of scholarship in the preparation, data collection, data analysis and completion of this thesis. All scholarly matter that is included in the thesis has been given recognition through citation. I affirm that I have cited and referenced all sources used in this document. Every effort has been made to avoid plagiarism in the preparation of this thesis.

This thesis is submitted in partial fulfillment of the requirement for a graduate degree from the Addis Ababa University at College of Health Sciences, School of Allied Health Sciences department of Nursing and Midwifery. The thesis is deposited in the Addis Ababa University Digital Library and is made available to local, national and international scientific community. I solemnly declare that this thesis has not been submitted to any other institution anywhere for the award of any academic degree, diploma or certificate.

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LIST OF ABBREVIATIONS

CVD…… ..Cardiovascular Disease

DM……. Diabetes Mellitus

HIV/AIDS……Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome

HTN……. Hypertension

ID……Identity-oriented approach dimension

LMICs ……Low- and middle-income countries

MOH…… Ministry of Health

MT……. Medical–Technical competence dimension

PR……Perceived Reality

PT……Physical–Technical conditions dimension

QPP…… Quality from the Patient's Perspective

QPPGYN CA ……. Quality of patient perspective on gynecological cancer care

SPHMMC…… St. Paul's Hospital Millennium Medical College

SC……Socio-Cultural atmosphere dimension

SI…… Subjective Importance

TASH……. Tikur Anbessa Specialized Hospital

TB……Tuberculosis

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Abstract

Background: Gynecologic cancers contribute significantly to global morbidity and mortality, with a pronounced impact in developing countries. Patients' perception of care quality refers to patients' view of services received and the results of the treatment and are monitored to assess the delivery and quality of healthcare, while patient experiences is a reflection of what actually happened during the care process. Evaluating healthcare from the patient's perspective including both perceived quality and actual experiences is essential for improving care delivery.

Objective: To assess the quality of gynecological cancer care from the patient's perspective and determine the influencing factors in public hospitals in Addis Ababa, Ethiopia, in 2025.

Methods: A Cross-sectional study was conducted at public hospitals in Addis Ababa from February 18 to March 18, 2025. A simple random sampling method was used to select 410 study participants and proportionally allocated to each hospital. Data was collected through face-to-face interviews. QPP-GynCa tool was used to measure patient perspective on the quality of gynecological cancer care. The data was collected through a Kobo data collector and then transferred to SPSS version 27 for analysis. Descriptive statistics, paired t-test and binary logistic regression analysis was used to see the association of different variables.

Result. Overall, 204 (49.8%) and 253 (61.7%) of the participants had high perceived reality and high subjective importance, to gynecological cancer care. All QPP dimensions show a statistically significant difference between what patients experienced and what they considered important with P-values < 0.001**.** With p-value < 0.05, higher education, income greater than 7000 ETB, ovarian cancer type were statistically associated with perceived realty of care. Similarly, marital status, service charge, vaginal cancer type and 3rd and 6th chemotherapy cycle were significantly associated with subjective importance.

Conclusion: Women rated care importance was higher than their actual experience, indicating a gap in care quality. The study found that factors such as education, income, ovarian cancer diagnosis, marital status, service charge, vaginal cancer diagnosis, and chemotherapy cycles significantly impact patients' perception of gynecological cancer care quality.

Keywords: Gynecologic cancer care, patient's perspective, Perceived reality of care, subjective importance of care.

1 INTRODUCTION

1.1 Background

Cancer remains a significant public health challenge worldwide, with gynecologic cancers among the leading causes of morbidity and mortality in women (1), which include cervical, ovarian, and uterine cancers with rising incidence rates particularly evident in low- and middle-income countries (LMICs)(2). Around 5.8% of all deaths are caused by cancer. It is estimated that the annual incidence of cancer is approximately 60,960 cases, the annual mortality rate is over 44,000 and breast cancer (30.2%), and cervix cancer (13.4%) are the most common cancers among Ethiopia's adult population (3). In every year, 5.7–8.4 million people die as a result of poor healthcare in low- and middle-income nations, mostly from a lack of patient-centered treatment, disease transmission, and poor drug adherence(4). In low- and middle-income countries (LMICs). Healthcare facilities lack essential medicines, equipment, and diagnostic tools due to inadequate infrastructure, insufficient funding, shortage of trained professionals (5).

Patients' perception of care quality refers to patients' view of services received and the results of the treatment and are monitored to assess the delivery and quality of healthcare, while patient experiences is a reflection of what actually happened during the care process(6). Patients' perceptions of quality of care are influenced by their norms, expectations, experiences, and interactions with the existing care structure(7). Quality of healthcare is essential for effective cancer management and patient outcomes (8). The quality of oncology services is multidimensional, encompassing technical competence, accessibility, infrastructure, and patient-centered care. Patient satisfaction, a critical measure of healthcare quality, reflects patients' perceptions of the care they receive and their interactions with healthcare providers (9). Patients' assessments of the quality of care are now a crucial part of health care quality improvement evaluations (10).

2 Statement of the Problem

Globally, an estimated 1.4 million women were newly diagnosed with gynecologic cancers, leading to over 680,000 deaths (11), the incidence of gynecological cancers has risen to 30.3 cases per 100,000 women, with a mortality rate of 13.2 per 100,000. In sub-Saharan Africa, gynecological cancers account for approximately one-third of all female cancers (32.67%); Of this, cervical cancer has the highest prevalence of all female cancers (81.6%)(12) and the incidence rate exceeds 50 per 100,000, significantly higher compared to Northern Africa, where it stands at 17.1 per 100,000 (13). In Ethiopia, out of all 3002 cancer case 522 (17.4%) case of gynecological cancer was identified (14).

Gynecologic cancer which include cervical cancer, ovarian cancer, uterine cancer, vaginal cancer, vulvar cancer, and fallopian tube cancer, impose substantial physical, emotional, and financial burdens on patients and their families (15, 16). Women with gynecological cancers often require extensive medical care, including surgery, chemotherapy, and follow-up treatments, leading to increased healthcare utilization(17). The diagnosis and treatment of gynecological cancer can strain family dynamics, as caregivers often face emotional and financial burdens(18).

According to several studies in Ethiopia Gynecological cancers significantly impact survivors' quality of life, with low scores in social and physical functioning among patients (17). The economic burden of gynecological cancers is substantial, affecting both healthcare costs and lost productivity due to illness. Furthermore gynecological cancer patients experienced sexual dysfunction post-diagnosis and treatment(2). The burden of gynecologic cancers in Ethiopia is exacerbated by many challenges, including limited access to early detection, inadequate treatment facilities, and a shortage of trained healthcare professionals. These systemic issues contribute to a healthcare environment that may not adequately address the needs and expectations of women undergoing treatment for these cancers (19, 20).

Interventions to improve gynecological cancer care Ethiopian National Cancer Control Plan (NCCP) is being implemented to address the rise in cervical cancer incidence and mortality, including through public awareness, HPV vaccination, risk identification, screening, and early detection and treatment. (21). Training of healthcare providers to provide cervical screenings and is procuring resources like cryotherapy machines for treatment and integrating patient-centered care models (22, 23).

Several factors influence the quality of gynecological cancer care. Socioeconomic status, education level, geographical barriers, healthcare infrastructure, provider-patient communication, and cultural beliefs all play crucial roles in shaping patients' experiences. Poor communication, long waiting times, inadequate pain management, and financial constraints significantly impact patient satisfaction and treatment adherence (2, 24).

Despite the importance of assessing patient perspective in oncology care, there is a notable lack of research focusing specifically on women with gynecologic cancers in Ethiopia. Existing literature highlights various barriers to quality care. So, this study aims to assess the quality of gynecological cancer care from the patient's perspective (perceived reality and subjective importance) and determine the influencing factors in selected public hospitals in Addis Ababa, Ethiopia.

2.1 Significance of the Study

Understanding the perspectives of women receiving gynecological cancer care and influencing factors is essential for developing targeted interventions that address their unique needs and improve the overall quality of gynecological cancer care for this vulnerable population.

The findings of this study could also inform resource allocation strategies aimed at strengthening gynecological cancer care across Ethiopia. Furthermore, this study seeks to contribute to a better understanding of how to improve the quality of gynecological cancer care, supporting the overall goal of enhancing patient-centered care and optimizing health outcomes for women with gynecological cancer in Ethiopia. Additionally, this study will contribute to healthcare professionals, community, and health program managers and as baseline data for further research.

3 LITERATURE REVIEW

3.1 Overview of the literature review

This literature review aims to distinguish and explain the previous findings of this study to understand better the existing research and concerns linked to women's perspective in gynecological cancer care and the burden of the problem.

Quality of care is a multidimensional concept central to achieving positive health outcomes and patient satisfaction. According to the World Health Organization (WHO), quality care is care that is effective, safe, patient-centered, timely, equitable, integrated, and efficient(25). In oncology, and particularly in gynecological cancer care, assessing the quality of care from the patients' perspective is essential, as it reflects not only clinical effectiveness but also responsiveness to individual needs (26).

The Quality from the Patient's Perspective (QPP) model is widely used to evaluate patients' views on care. The tool measures two core components for each aspect of care: Perceived Reality (PR) what patients actually experienced and subjective Importance (SI) how important patients consider that aspect of care. This dual structure enables identification of care areas where expectations exceed experiences(7).The QPP-Gyn Ca version has been adapted for gynecological cancer patients, capturing medical-technical, identity-oriented, physical-technical, and sociocultural dimensions (27).

3.1.1 Medical-technical dimension

Medical-technical competence refers to the perceived skill, knowledge, and accuracy of the healthcare professionals in diagnosing and treating the disease. A cross-sectional study was done in Sweden the highest levels of perceived reality and subjective importance were seen in the dimension physical-technical conditions of the care organization and the factor respect and empathy(28). Other study in Sweden also shows the highest mean scores on perceived reality for the total group were found for the factors medical care, information before procedures, respect, and secluded environment(10). In Northern Ethiopia, 70% of patients reported satisfaction with cancer pain treatment, and effective pain management techniques and communication(29).

3.1.2 Physical-technical Dimension

This domain relates to the environment, equipment, and logistical arrangements of care delivery including the cleanliness, privacy, and comfort of the facilities. Study findings in Turkey revealed that 50.7% of patients wanted more thorough information, 49.3% were unhappy with the doctor's approach, 46.4% were not told about their illnesses, and 33.4% experienced a delayed diagnosis (30). Many studies identifies issues that have an impact on patient satisfaction, such as a lack of cancer-specific facilities, inadequate equipment, and unclear appointment schedules, Lack of communication and limited patient time is perceived by patients and healthcare providers as compromising patients (31),(32),(33),(34). The study found that 33.4% of patients and 52.1% of participants experienced a long diagnosis wait time, with 1-2 months being the most common duration(30), (35), (36). A Nigerian study reveals limited access to facilities, lack of comprehensive diagnostic tools, and high costs significantly impacting patient satisfaction levels (37). In a mixed study in England, 14% of respondents praised the speed or efficiency of the treatment provided, including timely diagnosis, and then the short period between diagnosis and the start of treatment (38)

3.1.3 Identity-orientated Dimensions

The identity-orientated domain focuses on whether the care supports the patients' dignity, autonomy, and personal integrity. A cross-sectional study was done in Sweden the lowest levels of perceived reality and subjective importance were seen in the dimension identity-orientation approach together with the factors information related to self-care and information related to aspects of sexuality regardless of treatment modalities(28).Other study in Sweden the least favorable rankings for perceived reality in the total group were found for the factors participation, commitment, empathy and information after procedures(10).A systematic review done in Portugal shows that 55% of gynecologic cancer survivors reported feeling that there were insufficient choices for preserving fertility (39), (40). A cross-sectional study in south Nigeria revealed that most respondents did not experience disrespectful acts from health personnel with 95.1% and 88.8% are not being abused or having their requests ignored (41).

The study done in Finland show that friendly and respectful care from nursing professionals significantly enhances the experience of older cancer patients in hospital settings (42). A study done in Saudi Arabia revealed that satisfaction with information provided by medical staff about their illness, information about medical tests, and information about treatment was given(43) . A study done in Canada shows that Patients' perceptions of problematic parts of care, such as knowing the next steps in care and being informed about follow-up care, are common predictors of overall quality perception (44). A cohort study in united state show that clear treatment plan explanations and empathetic interactions with healthcare providers improve patient understanding, and effective communication between patients and healthcare providers is essential for patient satisfaction in oncology(45).

3.1.4 Sociocultural Atmosphere Dimension

The sociocultural atmosphere refers to the care context's responsiveness to patients' social, cultural, and emotional needs. A qualitative study was done in Canada reviled that patient positively experienced in treated as a person with respect and dignity, clear communication and access to relevant equipment (46). A comparative cross-sectional Norway study done in physical-technical conditions and sociocultural atmosphere received significantly higher scores in the new hospital than in the old hospital(47). A study done in USA reveled that respectful communication and emotional support significantly enhance cancer patients' perceptions of care, with family involvement and patient satisfaction being key factors(48).

3.2 Influencing Factors of Gynecological Cancer Care

3.2.1 Sociodemographic characteristics

A cohort study done in the USA shows that patient satisfaction in gynecologic oncology services is significantly influenced by factors such as age ($p < 0.001$), income ($p = 0.03$)., and education ($p = 0.03$). Higher education and income levels are positively associated with satisfaction, as they may improve understanding of care processes and access to resources (49).Similarly, A cross sectional study done in Nigeria, implies that, gynecological cancer patients with a higher educational level had a positive perception of care services when compared with patients with lower level of education (36).

According to a recent descriptive study by Samah Mohamed Ibrahim in Egypt found that married individuals have higher perspective of cancer care than the divorced individuals (50). In a study in Tikur Anbessa Specialized Hospital (TASH), issues such as financial difficulties, delays in diagnosis, and limited psychosocial support contributed to lower satisfaction scores among patients, particularly those from rural areas (51). Patients often experience financial distress when paying out-of-pocket, which directly affects their treatment behavior and satisfaction with care(52).Patients in rural areas with endometrial cancer have several obstacles to treatment, financial hardship, and geographical barriers. Thus, extensive outreach, assistance, and resources are required to guarantee fair results (53).

3.2.2 Clinical variables

A study done in Netherland showed that after diagnosis of recurrent disease, endometrial(12%) and ovarian cancer (43%) patients were less satisfied with care compared with patients without a recurrence (54). Another study done in Cameroon shows that Lack of access to advanced diagnostic tools like imaging techniques or limited treatment options like surgery, chemotherapy, and radiation therapy can significantly decrease patient satisfaction (55). Patients diagnosed with early-stage gynecological cancers (like cervical cancer Stage IA1) typically have better treatment outcomes and higher satisfaction due to the potential for curative surgery with minimal side effects (56) Patients with advanced-stage cancers often face more aggressive treatment regimens like chemotherapy and radiation, leading to increased side effects and potentially lower satisfaction levels (57).The other study in Iran shows that patients with their 3rd and 5th cycle of chemotherapy cycle experienced a significance pain and fatigue that worsen quality of life compared to the first 2 cycles of chemotherapy (58).

Conceptual framework

Illustrate the inter-relationship between independent and the dependent variables. Each factor contributes uniquely, but they are also interdependent. These variables influence the quality of care from patient perspective.

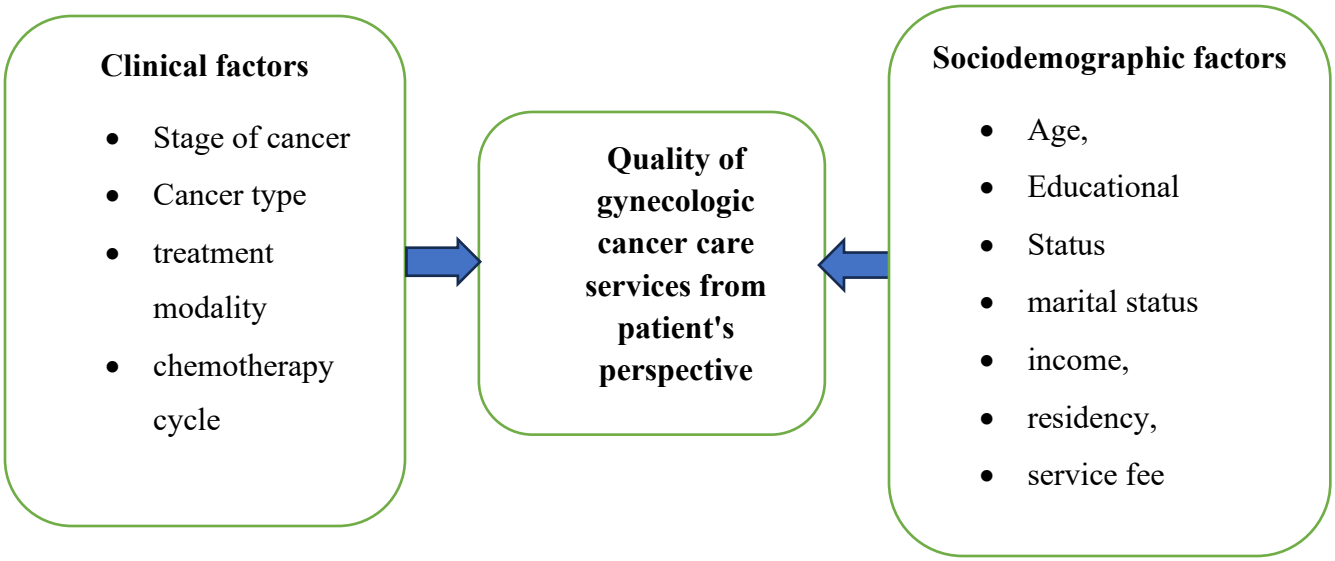


Figure 1:conceptual framework of the study quality of gynecologic cancer care from patient perspective in the selected public hospitals of Addis Ababa, Ethiopia, 2025 (36, 50, 51, 53, 59, 60, 61).

4 OBJECTIVE

4.1 General Objective

- To assess the quality of gynecological cancer care from the patient's perspective and determine the influencing factors in selected public hospitals in Addis Ababa, Ethiopia, 2025.

4.2 Specific Objectives

- ❖ To assess the quality of gynecological cancer care from the patient's perspective (perceived reality & subjective importance) among gynecological cancer patient on treatment
- ❖ To determine the influencing factor of the quality of gynecological cancer care in public hospitals, Addis Ababa, Ethiopia, 2025.

5 METHODS

5.1 Study setting

The study is conducted in Addis Ababa, the capital city of Ethiopia, covering 527 square kilometers(62). It is divided into 11 sub-cities. There are 6 hospitals and 98 health centers under the Addis Ababa Health Bureau and 8 hospitals under the federal government, which are 5 hospitals under the Federal Ministry of Health and 3 hospitals under the defense force and police. The study was conducted at Tikur Anbessa Specialized Hospital (TASH) and Saint Paul's Hospital Millennium Medical College (SPHMMC) purposively selected. TASH is the largest tertiary hospital located in the Lideta sub-city of Addis Ababa, Ethiopia. The hospital, which is run by Addis Ababa University, has over 800 beds, among which 25 were devoted to cancer care.

TASH's oncology unit is the country's largest referral center, serving over 9,000 cancer patients each year. It is the country's only oncology referral center for radiation. There are three in-patients and two out-patient rooms in the oncology department at TASH. There are 825 nurses, 204 non-specialist medical doctors, 209 medical specialists, and 50 medical subspecialists, including 15 oncology nurses and 8 clinical oncologists in the hospital (63).

Saint Paul's Hospital and Millennium Medical College (SPHMMC) is the second-largest teaching and referral hospital in Ethiopia, located in the Gulelle sub-city of Addis Ababa. The oncology center at SPHMMC was opened on August 1, 2018, and it is the country's second hospital to provide cancer treatment (64). The hospital has a total of 700 beds, among which 13 are devoted to cancer patients. The hospital serves around 4,152 patients each year. There are 2 inpatient and 3 outpatient rooms in the oncology department at SPHMMC.

5.2 Study design and period

An institution-based cross-sectional study design was conducted at public hospitals of oncology units in Addis Ababa, Ethiopia, from February 18 to march18, 2025.

5.3 Source population and study population

Source population

All women diagnosed with gynecological cancer who receive oncology services at TASH and SPHMMC,

Study population

All Women diagnosed with gynecological cancer at TASH and SPHMMC receiving care during the study period.

5.4 Eligibility Criteria

Inclusion Criteria

(i) All women willing to participate in the study

(ii) who had already history of primary biopsy-confirmed gynecologic malignancy and started treatment during the study period (i.e., at least greater than or equal to one cycle of chemotherapy, day surgery in the past two weeks, or follow-up care in the past 3 to 24) Gynecological oncology outpatient clinic)(65)

(iii) Patients admitted for gynecologic oncology care who are being discharged following the completion of their inpatient treatment.

Exclusion Criteria

(i) Women with gynecologic cancer (aged < 18 years)

(ii) Patient who are critically ill.

(iii) patient who have comorbidity (non-communicable disease (mental health disorder, DM, CVD and HTN) and communicable disease (HIV/AIDS and TB)

5.5 Sample Size Determination

The sample size of study participants was calculated using the single population proportion formula. The calculation considered the Prevalence of patient satisfaction taking 41% of the studies in Jimma (66). By using the following formula, the sample size was calculated:

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

Where:

- n = Required sample size
- Z = Standard normal value at a given confidence level (1.96 for 95% confidence)
- p = Estimated proportion of (41%= 0.41)
- d = Margin of error (d=0.5, 5% margin of error)

Sample size n=**372**, Then after adding a 10% for possible nonresponse rate, the optimal sample size was **= 410**

5.6 Sampling Procedures

There are 14 public hospitals in Addis Ababa; however, not all offer gynecologic cancer care. Therefore, this study was conducted purposively at two public hospitals that provide oncology services: St. Paul's Hospital Millennium Medical College and Black Lion Specialized Hospital. The total sample size was proportionally allocated based on the previous year's annual gynecologic cancer admission reports from each hospital, with a combined total of 3,772 admissions. Study participants were then selected using a systematic random sampling method.

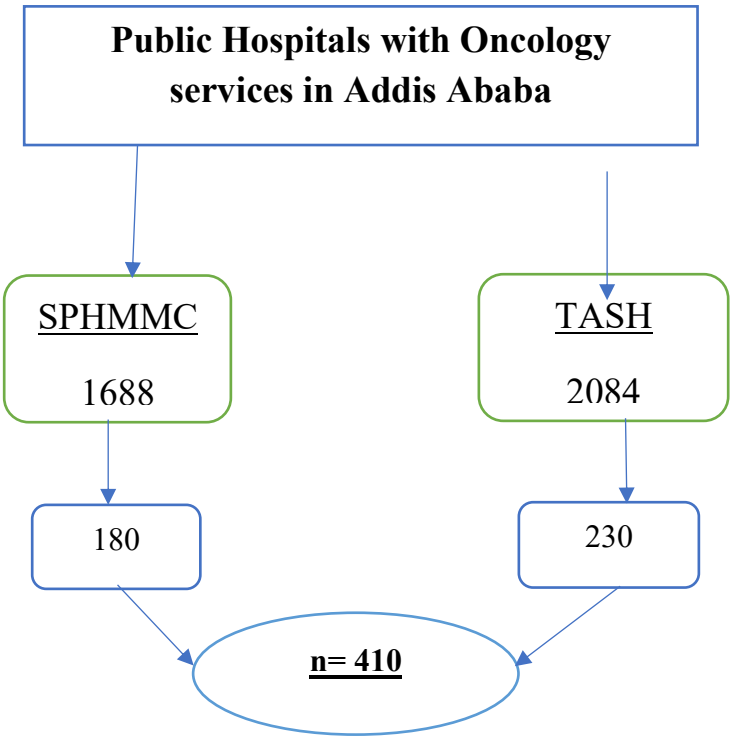


Figure 2:Diagrammatic presentation of the sampling procedure for patient perspectives with the quality of gynecological cancer care in selected public hospitals, Addis Ababa, Ethiopia, 2025.

5.7 Data collection tool and procedures

A structured interview questionnaire was used for data collection. Part I: sociodemographic information of the study participants. Part II: The participant's clinical characteristics and treatment history was taken from the chart. Part III: The QPP-Gyn CA (Quality of patient perspective on gynecological cancer care) tool consists of a 27-item assessment of the quality of care derived from patients' perceptions of care, which has four dimension (Medical-technical competence, Physical technical condition, Identity oriented approach, and Socio cultural). Each item of the QPP was answered in 2 ways: how the patients perceived the quality of care during treatment (perceived reality [PR] scale), that is, "this is how I experienced the care…" and how they perceived the importance of each aspect of care (subjective importance [SI] scale), that is, "this is how important it was to me…". A 4-point Likert-type scale was used. The PR scale ranged from 1 "do not agree at all" to 4 "fully agree", and the SI scale from 1 "no importance" to 4 "of very importance"). A "not applicable" option was available for both scales (67). Based on the calculated mean, Level scores of PR classified as high if the score greater than or equal to the mean score (2.95) and low if the score less than the mean score (2.95), and SI classified as high if the score greater than or equal to the mean score (3.6) and low if the score less than the mean score (3.6).

Outpatient were recruited by referring from the hospitals log book which encompasses patient clinical history and appointment date. Inpatient participants were recruited by examining their medical records which also indicate the clinical history and length of stay in the ward. After identifying the number of valid participants, the questionnaire was customized for this study in English language and then translated into Amharic language by language expert. Informed consent was obtained from each study participant before the data collection. Data was collected in a separate room to avoid the introduction of bias during the interview. The data was collected through a Kobo collector and then transferred to SPSS version 27 for analysis. Descriptive statistics and binary logistic regression analysis was done to see the association of different variables with outcome variables.

5.8 Study Variables

Dependent Variables:

- Quality of gynecological cancer care in terms of received reality
- Quality of gynecological cancer care in terms of Subjective importance

Independent Variable

- **Sociodemographic characteristics**: Includes age, marital status, educational level, Occupation, Household income, service fee and residential area.
- **Clinical factors:** types of cancer, stage of cancer, treatment modality, chemotherapy cycle.

5.9 Operational Definition

Quality of care from patient perspective

Patients' views on what is important in connection with the care they receive seen as one aspect of quality of care and patient satisfaction has increasingly come to be seen as an indicator of quality of care (68).

Perceived reality [PR]: how the patients perceived the quality of care during treatment, that is, "this is how I experienced the care…" and

Subjective importance [SI] scale: how the patients perceived the importance of each aspect of care, that is, "this is how important it was to me…".

- ❖ Score for PR: Patients perceived realty scoring above or equal to the mean (2.95) is high perceived reality (PR) score and below the mean is low score of PR (67).
- ❖ Score for SI: Patients subjective importance more than or equal to mean (3.6) is high subjective Importance and below the mean score is low SI (67)

Quality of care in patient perspective, QPP, classified based on previous studies on bases PR and SI score as bellow (47)

- Care QPP is considered to be high when PR scores are higher than scores on SI and also when both scores on PR and SI are high and in balance (high scores on QPP items range from about 3.30 to 4.0).
- Care quality is considered deficient from the patient's perspective when scores on SI are higher than scores on PR.
- Care quality is considered low when the balance is low on both SI and PR (scores ranging from 3.00 and lower are considered a low-quality rating).
- Scores ranging between 3.30 and 3.00 are considered a modest rating.

The 27 QPP-Gyn Ca 4 dimension:

- Medical–technical competence was assessed by 5 items,
  - e.g. The best possible medical treatment is carried out with accuracy and care.
- Physical–technical conditions were assessed by 2 items,
  - e.g. Access to the technical aids I need medical equipment
- Identity–orientated approach was assessed by 16 items
  - e.g. The feeling that I was treated with respect by the health personal and received helpful information.
- Socio–cultural atmosphere was assessed by 4 items,
  - e.g. The feeling that my desires and needs were not restricted by the organization and getting opportunity to speak to health personal

For mean deference

- **positive value**-expectation not meet (care was important to the patient but their experience was worse)
- **zero**-expectation meet
- **negative value**-care exceeded expectations

Waiting Time: According to the WHO's general guidelines, an acceptable waiting time for oncology services at a hospital should be no longer than two months (62 days) from the date of an urgent referral for suspected cancer to the start of definitive treatment; this includes the time needed for diagnosis and treatment planning (69).

5.10 Data Quality Control

The questionnaire was prepared in English, translated to Amharic (the national language), and retranslated to English to check for inconsistency. Two weeks before the data collection, the tool was tested on 20 patients (5%) of the total sample size and tested the samples at Yekatit12MC. Four BSc experienced nurses, and two experienced MSc nurse supervisors were trained for a day, and each were assigned to hospitals and collected the data. During the data collection time, close supervision and monitoring was carried out by supervisors and investigators to ensure the quality of the data. Finally, the supervisor and investigator checked all the collected data for completeness and consistency during the data management, storage, and analysis.

5.11 Data processing and analysis

Data was checked for completeness and consistency, and then it was exported to SPSS software version 27 for analysis. Cross-tabulation was done among the dependent variable and independent variables. The model fitness to the data was checked using the Hosmer and Lemeshow test. Mean was used for normally distributed continuous variables and paired T-test was used to compared mean score difference between subjective importance (SI) and perceived reality (PR) to identify care quality gaps in the four dimensions (medical technical competence, physical technical competence, identity-oriented approach and socio-cultural atmosphere) of quality of care from patient perspective. In the bi-variable analysis, variables with p-values<0.25 was analyzed and fitted to multivariate analysis. In the final logistic regression model, the statistical significance was declared at $p<0.05$, and the presence and strength of associations was summarized using an adjusted odds ratio with 95% confidence intervals. Finally, study findings are presented in texts, graphs, and tables.

5.12 Ethical Clearance

First, Ethical clearance was obtained from AAU, College of Health Science, School of Nursing and Midwifery, as well as the SPHMMC ethical clearance committee. Verbal consent was received from the study participant after explaining the study objectives and procedures and their right to refuse to participate in the study any time they want. Information is gathered in

separate rooms to maintain their privacy and information acquired from the patient was kept confidential. Names were anonymous by using study record numbers only. It is believed that there is no anticipated harm for the patients except for their time scarification at the time of data collection.

5.13 Dissemination Plan

The result of the study will be submitted and presented to Addis Ababa University, School of Nursing and Midwifery. The study result will also be submitted to TASH, SPHMMC, the Ministry of Health (MOH), and other interested parties to update information and use it for intervention. In addition, the result will submit for publication in peer-reviewed and indexed journals.

6 RESULT

The findings of this study are presented in three sections. The first section focuses on the socio-demographic characteristics of gynecological cancer patients. The second section examines the clinical and medical factors related to these participants. The third section explores the perceived reality and the subjective importance of gynecological cancer care and treatment among women currently undergoing treatment for gynecological cancer.

6.1 Socio demographic factors

A total of 410 gynecological cancer patients were included in this study with 100% response rate. The mean age of the study participants was 52.2 (12.82±) ranging from 20-82 years. Among the participants, 227 (55.4%) were urban by residence, while 209 (51%) and 153 (37.3%) of them were married and not attained formal education. About 216 (52.7%) of them were housewife, whereas 244 (59.5%) were community-based health insurance user for their medical care and treatment. The results of socio demographic characteristics of study participants were shown in (Table 1)

Table 1. Socio-demographic characteristics of study participants (n=410)

Variables		Frequency	Percent
Age	20-29	16	3.9
	30-39	50	12.2
	40-49	113	27.6
	50-59	108	26.3
	≥60	123	30
Marital status	Married	209	51
	Single	71	17.3
	Divorced	101	24.6
	Widowed	29	7.1
Educational status	No formal education	153	37.3
	Can write and read	74	18
	Primary school	66	16.1
	Secondary school	53	12.9
	College or university	64	15.6
Occupation	Governmental	65	15.9
	Self	100	24.4
	Daily laborer	21	5.1
	Student	8	2.0
	Housewife	216	52.7
Household monthly income	<7000 ETB	244	59.5
	>=7000ETB	166	40.5
Service charge	Community health insurance	244	59.5
	Out of pocket	166	40.5
Residence	Urban	227	55.4
	Rural	183	44.6

6.2 Clinical or medical factors

Among the study participant majority of them, 187 (45.6%) were patients with cervical cancer followed by ovarian cancer 71 (17.3%), while only 31 (7.6%) and 35 (8.5%) of the participant on treatment and care for their vulvar cancer and vaginal cancer respectively. The result also shows that a significant number of women who currently on treatment had advanced stage of cancer. Of them 129 (31.5%) accounts for cancer stage 2 and 136 (33.2%) for cancer stage 3. Among the participants who were on cancer treatment 182 (44.4%) of them treated with both chemotherapy and radiotherapy while 36 (8.8%) were managed with all the three-treatment modality (Chemotherapy, radiotherapy and surgery). About 105 (25.6%) of the patient took 1 up to 6 chemotherapy cycle on the other hand, about 65 (15.9) of them not yet started. The result of participant clinical factors shown below in table 2

Table 2. Clinical factors of patients with gynecological cancer care and treatment(n=410)

Variables		Frequency	Percent
Type of gynecological cancer	Cervical	187	45.6
	Ovarian cancer	71	17.3
	Vulvar cancer	31	7.6
	Vaginal cancer	35	8.5
	Endometrial cancer	37	9
	Other gynecological cancer	49	12
Stage of cancer	Stage 1	66	16.1
	Stage 2	129	31.5
	Stage 3	136	33.2
	Stage 4	79	19.3
Treatment modality	Chemotherapy only	71	17.3
	Surgery and chemotherapy	67	16.3
	Chemotherapy and radiotherapy	182	44.4
	Surgery and radiotherapy	15	3.7
	Surgery only	23	5.6
	Chemotherapy, radiotherapy and surgery	36	8.8
	Radiotherapy only	16	3.9
Chemotherapy cycle	Not started	65	15.9
	Cycle 1	23	5.6
	Cycle 2	39	9.5
	Cycle 3	11	27.1
	Cycle 4	37	9
	Cycle 5	30	7.3
	Cycle 6	105	25.6

6.3 Perceived reality and subjective Importance of gynecological cancer patients on treatment

In this study, 27 Likert scale items; (sub-classified as Medical-technical competence, physical technical condition, Identity Oriented approach, information related to self-care, respect and socio-cultural atmosphere) were used to assess gynecological cancer care quality from patient's perspective, i.e. perceived reality and the corresponding subjective Importance of that care among gynecological cancer patient's cancer treatment journey.

6.3.1 Perceived reality of gynecological cancer patients for gynecological cancer treatment

The lowest perceived reality score was 27 and the highest was 105. The mean score was 2.95 with standard deviation (SD ± 0.46). Overall, 204 (49.8%) of the participants had high perceived realty and 206 (50.2%) had low perceived reality regarding to gynecological cancer care and treatment. Less than half of the participants125 (30.5%) in the medical-technical competence item, strongly agreed that they had received the best possible help for their troublesome symptoms. Majority of the participants, 255 (62.2%), somewhat disagreed that they received information about urinary problem related to their cancer treatment. See Table 2

Table 3. Gynecological cancer patients and their Perceived realty for their treatment and care in Black Lion and St. Paul's specialized hospitals,2025(n =410)

Perceived reality statements about gynecological care and treatment among gynecology cancer patient under treatment		Not agree at all	Somewhat disagree.	Somewhat agree	Fully agree
		N (%)	N (%)	N (%)	N (%)
Medical-Technical Competence	I received the best possible help for Troublesome symptoms	28(6.8)	47(11.5)	210(51.2)	125(30.5)
	I received the best possible help for pain.	27(6.6)	60(14.6)	187(45.6)	136(33.2)
	I received the best possible help for Lack of sleep.	46(11.2)	109(26.6)	176(42.9)	71(17.3)
	I received the best possible help for anxiety.	45(11)	115(28)	168(41)	79(19.3)
	I received the best possible medical treatment and care.	8(2)	68(16.6)	192(46.8)	141(34.4)
	I received examinations and treatment within acceptable wait times.	95(23.2)	66(16.1)	170(41.5)	79(19.3)
	I had access to the necessary equipment	32(7.8)	51(12.4)	208(5.7)	119(29)
	I received helpful information about Planning continued treatment and care.	14(3.4)	109(26.6)	197(48)	90(22)
	I received helpful information about how examinations and treatments would take place.	21(5.1)	73(17.8)	212(51.7)	104(25.4)
	I received helpful information about the results of examinations and treatments.	10(2.4)	82(20)	191(46.6)	127(31)
	I had good opportunities to participate in decisions that applied to my individual care plan	32(7.8)	52(12.7)	194(47.3)	128(31.2)
Information related to self-care and sexuality	I received helpful information about Self-care	49(12)	76(18.5)	174(42.4)	97(23.7)
	I received helpful information about Urinary problems.	152(37.1)	252(61.5)	3 (0.5)	3 (0.5)
	I received helpful information about difficulty in controlling the bowels.	34(8.3)	66(16.1)	188(45.9)	122(29.8)
	I received helpful information about Genital discomfort	3(0.7)	53(12.9)	188(45.9)	162(39.5)
	I understood my medications effects and how to take them.	87(21.2)	89(21.7)	143(34.9)	90(22)
	I received helpful information on cancer and its treatment could affect my sexual function.	82(20)	126(30.7)	124(30.2)	73(17.8)
	I received helpful information about How my sexual function could be preserved.	82(20)	71(17.3)	172(42)	82(20)
	How cancer and its treatment affect fertility	3(0.3)	14(3.4)	240(58.5)	153(37.3)

Respect & empathy	The HCP Seemed to understand how I experienced my situation.	4(1)	31(7.6)	182(44.1)	186(45.4)
	The HCP Treated me with respect	4(1)	241(58.8)	165(40.2)	00
	The HCP Showed commitment: "cared about me"	8(2)	30(7.3)	216(52.7)	156(38)
Socio-Cultural Atmosphere	My care was guided by my needs rather than by routines.	6(1.5)	62(15.1)	172(42)	161(39.3)
	I was allowed to speak to HCP undisturbed when I wanted	4(1)	60(14.6)	217(52.9)	123(30)
	My relatives were treated with respect.	6(1.5)	40(9.8)	172(42)	192(46.8)
	the HCP I met had the competence and skills necessary for my care (as far as I could tell)	27(6,6)	60(14.6)	187(45.6)	136(33.2)
	I received helpful information about who to contact at the hospital if I had any questions.	32(7.8)	52(12.7)	194(47.3)	128(31.2)

HCP: health care professionals

6.3.2 Subjective Importance of gynecological cancer patients for gynecological cancer treatment

The descriptive analysis result of the study indicts that the lowest subjective Importance score was 27 and the highest score was 108. The mean score was 3.6 with standard deviation (SD ± 0.48). Participants who score less than mean score (3.6) were considered as having low subjective importance whereas those who scores greater than or equal to 3.6 were considered as having high subjective importance. Overall, 253 (61.7%) of the participants had high subjective importance and 157 (38.3%) had low subjective importance regarding to gynecological cancer medical care and treatment. More than two-third (84.9%) of gynecological cancer patient, receiving the best possible help for their treatment related pain was very important. Similarly, about 355(86.6%) of them claimed that during the gynecological cancer treatment, getting the best possible medical treatment and care was very important. See table,3.

Table 4: Gynecological cancer patients Subjective Importance for their treatment and care Black Lion and St. Paul's specialized hospitals; Ethiopia, 2025

Subjective Importance Statements about gynecological care and treatment among gynecology cancer patient under treatment		no importa	Slightly important	Moderately important	Very important
		N (%)	N (%)	N (%)	N (%)
Medical-Technical Competence	**How important** receiving the best possible help for Troublesome symptoms	4(1)	1(0.2)	53(12.9)	350(85.4)
	I received the best possible help for pain.	2(0.5)	4(1)	56(13.7)	348(84.9)
	I received the best possible help for Lack of sleep.	11(2.7)	103(25.1)	296(72.2)	5(0.20)
	I received the best possible help for anxiety.	2(0.5)	78(19)	107(26.1)	222(54.1)
	I received the best possible medical treatment	2 (0.5)	10(2.4)	43(10.5)	355(86.6)
Physical-Technical Conditions	I received exam. and treatment within acceptable wait times.	2(0.5)	14(3.4)	36(8.8)	358(87.3)
	I had access to the necessary equipment.	2(0.5)	23(5.6)	142(34.6)	243(59.3)
	I received helpful information about Planning continued treatment and care.	6(1.5)	19(4.6)	116(28.3)	269(65.6)
	I received helpful information about how examinations and treatments would take place.	4(1)	5(1.2)	80(19.5)	320(78)
	I received helpful information about the results of examinations and treatments.	2(0.5)	28(6.8)	117(28.5)	262(63.9)
	I had good opportunities to participate in decisions that applied to my individual care plan.	4(1)	25(6.1)	126(30.7)	255(60.2)
Information related to self-care and sexuality	I received helpful information about Self-care	4(1)	30(7.3)	104(25.4)	272(66.3)
	I received helpful information about Urinary problems.	2(0.5)	20(4.9)	61(14.9)	327(79.8)
	I received helpful information about difficulty in controlling the bowels.	13(3.2)	52(12.7)	136(33.3)	209(51)
	I received helpful information about Genital discomfort	12(2.9)	55(13.4)	132(32.2)	208(50.7)
	I understood my medications effects and how to take them.	4(1)	38(9.3)	119(29)	249(60.7)
	I received helpful information about How cancer and its treatment could affect my sexual function.	3(0.7)	8(2)	93(22.7)	306(74.8)
	I received helpful information about How my sexual function could be preserved.	3(0.7)	9(22)	63(15.4)	335(81.7)
	How cancer and its treatment affect fertility	2(0.5)	28(6.8)	105(25.6)	275(67.1)

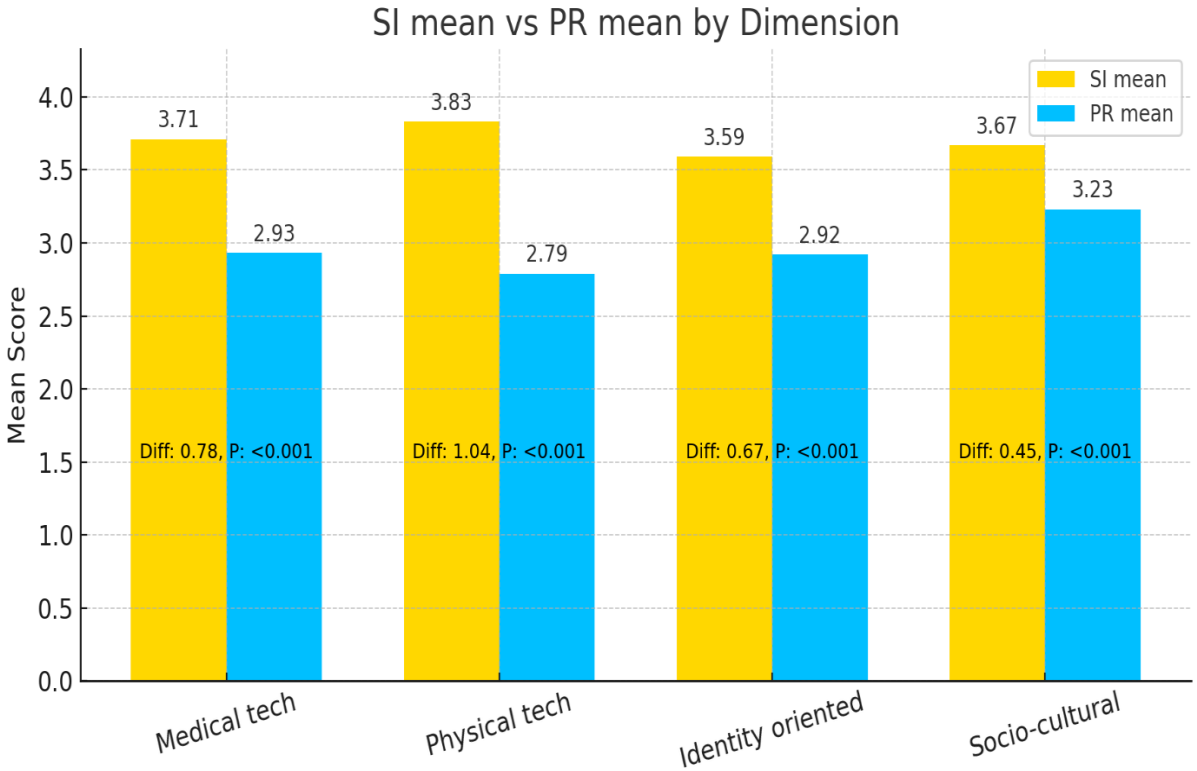
Respect and empathy	The HCP understand me how I experienced my situation.	3(0.7)	5(1.2)	82(20)	318(77.6)
	The HCP Treated me with respect	4(1)	19(4.6)	111(27.1)	276(67.3)
	The HCP Showed commitment: “cared about me”	3(0.7)	5(.2)	44(10.7)	358(87.3)
Socio-cultural Atmosphere	my care was guided by my needs rather than by routines	4(1)	19(4.6)	111(27.1)	276(67.3)
	I was allowed to speak to HCP undisturbed when I wanted	2(05)	4(1)	167(40.7)	234(57.1)
	My relatives were treated with respect	3(0.7)	5(1.2)	44(10.7)	358(87.3)
	The HCP I met had the competence and skills necessary for my care.	2(0.5)	4(1)	56(13,7)	348(84.9)
	I received helpful information about who to contact at the hospital if I had any questions.	2(0.5)	8(2)	142(34.6)	258(62.9)

6.3.3 Differences in gynecological Cancer Patients' Perspective of Quality of Care in Terms of Perceived Reality and Subjective Importance

All four dimensions (medical technical competence, physical technical competence, identity-oriented approach and socio-cultural atmosphere) show a statistically significant difference between what patients experienced (PR) and what they considered important (SI), with P-values < 0.001. Patients consistently rated the importance of care (SI) higher than their actual experiences (PR). This indicates a gap in quality-of-care patients are not receiving care at the level they feel is important. See the following graph.

The lowest gap was reported in socio-cultural atmosphere (Mean Difference: 0.45), which significant ($p<0.001$) this area showed a closer alignment between expectations and experiences. The highest gap was reported in Physical-Technical Conditions (Mean Difference: 1.04) Patients felt this was highly important but rated their actual experience significantly lower ($p< 0.001$).

Figure 3: Mean of subjective importance and perceived reality according to item group or dimension.



6.3.4 Factors associated with perceived reality of gynecological cancer treatment

In bivariate logistic regression analysis, a total of 11 (7 socio-demographic variables and 4 clinical factors) were tested to check for association with dependent variable (perceived reality of gynecological cancer treatment). Among these variables, nine of them (marital status, level of education, occupation, monthly income, service fee, residence of the participant, cancer type, stage of cancer and chemotherapy cycle) were found to have significant association with perceived reality of gynecological cancer treatment. Eight variables that were found to have significant association perceived reality of gynecological cancer care and treatment in binary logistic regression were put in to multiple logistic analysis model.

In multivariate analysis level of education, monthly household income, cancer type and chemotherapy cycle were significantly associated with perceived reality of gynecological cancer treatment and care. Patients who were educated at the college or university level were, 5.63 times more likely to have high perceived realty about the gynecological cancer care and treatment than those who don't have formal education (AOR =5.631; 95% CI= 1.82-17.50; P= .003). Similarly, women whose household monthly income greater than 7000 ETB have higher perceived realty about the gynecological cancer medical treatment with the odds of 2.05 than those earned less than 7000 ETB (AOR=2.05; 95% CI= 1.11-3.78; P=0.022). Cancer type and chemotherapy cycle also significantly associated with the outcome variable. Patients with ovarian cancer 3.04 times more likely to have high gynecological cancer treatment perceived realty than who were with cervical cancer (AOR=3.04; 95% CI=1.24-7.50; P=0.015). However, Other cancer type (Gestational trophoblastic disease and fallopian tube cancer) 0.24 times less likely to have high gynecological cancer treatment perceived realty than who were with cervical cancer. Finally, compared to those patients who didn't start chemotherapy, those who have taken 2 cycles were 8.4 more likely to have higher perceived realty of gynecological cancer treatment (AOR=8.4; 95% CI=1.25=57.17).

Table 5. Bivariate and multivariate regression analysis of factors associated with patient perceived reality for gynecological cancer treatment, 2025.

Variables		Perceived reality of care		COR (95% CI)	AOR (95% CI)	P-Value
		Low	High			
Level of education	No education	93	60	1	1	1
	write & read	46	28	0.943 (0.53,1.67)	0.95(0.43, 2.10)	0.891
	Primary	30	36	1.860(1.04,3.33)	1.640(.700, 3.84)	0.255
	Secondary	25	28	1.736 (0.94, 3.26)	1.232(.462, 3.287)	0.676
	Higher education	12	52	6.72(3.31,13.62)	5.631(1.82,17.50)	**0.003**
Occupation	Gov. Employ	28	37	1	1	1
	Self-employ	41	59	1.089 (0.58, 2.05)	1.29(0.55, 3.04)	.561
	Daily laborer	15	6	0.303 (0.10, 0.89)	1.30(0.30, 5.64)	.726
	Student	4	4	0.757(0.17,3.29)	2.75(0.30, 25.39)	.374
	House wife	118	98	0.628 (0.36, 1.10)	2.11(0.86, 5.2)	.105
Monthly HH.income	<7000 ETB	145	99	1	1	1
	≥7000 ETB	61	105	2.521(1.68, 3.78)	2.05(1.11, 3.78)	**.022**
Service fee	Insurance	134	110	1	1	
	Paid	72	94	1.590 (1.07, 2.37)	1.12(.658, 1.916)	.671
Residency	Urban	102	125	1	1	
	Rural	104	79	0.62(0.47, 0.92)	1.19(0.66, 2.16)	.566
Cancer type	Cervical	85	102	1	1	
	Ovarian	31	40	1.60(0.85, 3.02)	3.04(1.24, 7.50)	**.015**
	Vulvar	18	13	1.72(0.84,3.60)	0.80(0.32, 2.00)	.635
	Vaginal	22	13	0.963 (0.39,2.39)	0.61(0.21, 1.81)	.377
	Endometrial	22	15	.788(0.324, 1.92)	0.388(0.14,1.08)	.069
	Other ca	28	21	0.909 (0.38, 2.16)	0.243(0.073, 0.80)	**.021**
Stage of cancer	Stage 1	37	29	1	1	
	Stage 2	72	57	1.01(0.56, 1.84)	0.529(0.19, 1.45)	.217
	Stage 3	60	76	1.616(0.89, 2.92)	0.73(0.25, 2.11)	.556
	Stage 4	37	42	1.448(0.75, 2.79)	0.54(0.17, 1.69)	.291
Chemotherapy cycle	Not started	41	24	1	1	
	Cycle 1	15	8	0.91(0.34, 2.46)	1.45(0.18, 12.02)	.729
	Cycle 2	16	23	2.464 (1.10, 5.54)	8.436(1.25, 57.17)	.029
	Cycle 3	72	39	0.93(0.50,1.75)	1.778(0.29, 10.84)	.533
	Cycle 4	8	29	6.19(2.44,15.71)	11.93(1.68, 84.64)	.013
	Cycle 5	15	15	1.71(0.712, 4.10)	2.13(0.29, 15.89)	.458
	Cycle 6	39	66	2.89(1.52,5.49)	3.979(0.626, 25.29)	.143
Subjective Important	Low	102	104	1	1	
	High	55	149	2.66(1.76, 4.01)	2.72(1.58, 4.69)	**.000**

1 – reference category, HH. Income= Household income

In bivariate logistic regression analysis, a total of 11(7 socio-demographic variables and 4 clinical factors) were tested to check for association with dependent variable (perceived reality of gynecological cancer treatment). Among these variables, seven of them (marital status, monthly income, service charge, residence of the participant, cancer type, stage of cancer and chemotherapy cycle) were found to have an association with subjective importance of gynecological cancer patients to the treatment and care. The seven variables that were found to have an association perceived reality of gynecological cancer care and treatment in binary logistic regression were put in to multiple logistic analysis model.

In multivariate analysis, marital status, service charge, cancer type and chemotherapy cycle were significantly associated with subjective importance of gynecological cancer treatment and care. Those gynecological cancer patients who were single by marital status had 0.17 times low subjective importance to cancer treatment and care compared to married women (AOR=0.17; 95%CI=0.07-0.43; P=0.000). While women who were community-based health insurance user for their medical care and treatment have 1.899 times higher subjective importance about the gynecological cancer medical treatment (AOR=1.899; 95% CI=1.065, 3.389; P=.030). similarly, women who have vaginal cancer were 8 times more likely to have higher subjective importance to gynecological cancer treatment compared to cervical cancer (AOR=8.04;95% CI=2.45-26.42; P=0.001). finally, those women who took 3rd and 6th cycle of chemotherapy have 7.84 and 10.77 times more likely to have higher subjective importance to gynecological cancer medical treatment compared those who didn't start chemotherapy respectively ((AOR=7.84; 95% CI= 1.48-41.59; P=.016 and AOR=10.77; 95% CI; 1.93, 60.17P= 000).

Table 6 : Factors associated with patient subjective importance of medical care and treatment among women with gynecological cancer on treatment in Tikur Anbessa and St.Paul's Specialized Hospitals, Ethiopia

Variables		**Subjective Importance**		COR (95% CI)	AOR (95% CI)	P-Value
		Low	**High**			
Marital status	Married	74	135	1	1	
	Single	36	35	0.53(0.31,0.92)	0.17(0.07, 0.43)	**.000**
	Divorced	33	68	1.13(0.68, 1.87)	1.00(0.50, 1.99)	.999
	Widowed	14	15	.587(.269, 1.283)	0.36(0.12, 1.06)	.064
Monthly income	<7000ETB	111	133	1	1	1
	≥7000 ETB	46	120	2.18(1.43, 3.32)	1.80(0.94, 3.47)	.079
Service fee	Insurance	108	136	1	1	1
	Paid	49	117	1.896(1.25, 2.88)	1.899 (1.065, 3.389)	**.030**
Residency	Urban	73	154	1	1	
	Rural	84	99	0.56(0.37, 0.84)	0.71(0.39,1.29)	.264
Cancer type	Cervical	68	119	1	1	
	Ovarian	32	39	0.696(.40, 1.21)	1.11 (0.43, 2.85)	.836
	Vulvar	16	16	0.54(0.25, 1.15)	0.87(0.32,2.36)	.784
	Vaginal	10	25	1.43(0.65, 3.15)	8.04(2.45, 26.42)	**.001**
	Endometrial	11	26	1.35(0.63, 2.90)	2.12(0.75,5.98)	.154
	Other ca	20	29	0.83(0.44, 1.58)	0.72 (0.23,2.24)	.569
Stage of cancer	Stage 1	26	40	1	1	
	Stage 2	52	77	0.96(0.53, 1.77)	0.678(.216,2.127)	.505
	Stage 3	60	76	.823(1.498, .452)	.454 (.141,1.461)	.185
	Stage 4	19	60	2.05(1.00,4.19)	1.12(0.31, 4.08)	.867
Chemotherapy cycle	Not started	29	36	1	1	
	Cycle 1	14	9	0.52(0.196, 1.366)	2.13 (0.29,15.75)	.461
	Cycle 2	24	15	.503(.224,1.131)	3.16(0.51,19.79)	.218
	Cycle 3	42	69	1.32(0.71, 2.46)	7.84 (1.48, 41.59)	**.016**
	Cycle 4	9	28	2.51(1.02, 6.14)	6.24(0.94,41.41)	.058
	Cycle 5	12	18	1.21(.502, 2.910)	6.688 (0.94, 47.38)	.057
	Cycle 6	27	78	2.33(1.02, 4.49)	10.77(1.93, 60.17)	**.007**
Perceived reality	Low	102	104	1	1	
	High	55	149	2.66(1.76, 4.01)	2.95(1.72,5.08)	**000**

Key: 1 – reference category

7 Discussion

This study assessed gynecological cancer care quality from patient's perspective, i.e. perceived reality and the corresponding subjective Importance of that care among gynecological cancer patient's treatment course in St. Paul millennium medical college and Tikur Anbessa specialized hospital, Ethiopia. It aimed to provide an insight about quality of care to gynecological cancer among patients on any types of gynecological cancer care and treatment.

According to the findings in the present study, about half, 204 (49.8%) of the participants had high perceived realty concerning to the quality of gynecological care they received. Similarly, majority of gynecological cancer patients, 253 (61.7%) had high subjective importance in terms of care quality to any gynecological cancer care and treatment. This is almost consistent with the study done in Swedish on endometrial cancer care quality which reported the highest levels of perceived reality and subjective importance were reported in the dimension physical-technical conditions and for the factor respect and empathy(28). This high percentage of perceived realty and subjective importance of gynecological cancer care might be due to the good health care provision in all Medical-technical competence, physical technical condition, Identity Oriented approach, information related to self-care, respect and socio-cultural atmosphere to gynecological cancer.

The results of the paired t-test analysis reveal significant discrepancies between patients perceived reality of care and the importance they assign to different aspects of care across all measured dimensions. In all four domains (medical-technical competence, physical-technical conditions, identity-oriented approach, and socio-cultural atmosphere) patients rated the subjective importance of care significantly higher than their actual experiences. The largest gap was observed in physical-technical conditions. According to Quality from patient perspective model, when scores on SI are higher than scores on PR, health care quality is considered deficient from the patient's perspective(47).

The study identified key factors significantly associated with patients perceived reality regarding gynecological cancer care and treatment as a care quality measure. Patients with college or university-level education were over five times more likely to have a high perceived reality about their treatment compared to those with no formal education This finding is

consistent with previous study. A cross sectional study done in Nigeria, implies that, gynecological cancer patients with a higher educational level had a positive perception of care services when compared with patients with lower level of education(36). This suggests that higher education enhances health literacy, enabling patients to better understand their diagnosis, treatment options, and the importance of adherence to medical advice. Furthermore, educated patients are more likely to seek information, ask relevant questions, and engage actively in their care process, all of which might be contribute to a heightened perception of the treatment reality. Similarly, household income emerged as a significant predictor. Women from households earning more than 7000 ETB per month had twice the odds of having a high perceived reality compared to those with lower income. This is in line a study done in USA which suggests higher income levels were positively associated with patient satisfaction (positive output of care quality) (49). Higher income may reflect better access to healthcare resources, the ability to afford transportation and supportive care, and reduced financial stress, all of which can positively influence patients' perceptions and engagement in their treatment. The type of gynecological cancer also influenced patients' perceptions. Those diagnosed with ovarian cancer were three times more likely to report high perceived reality than those with cervical cancer. In contrast to our study, a study done in Netherland many patients diagnosis with ovarian cancer less satisfied with care compared with patients other type of cancer treatment (54). This may be due to differences in the public awareness, or treatment pathways between cancer types. Ovarian cancer often requires more intensive diagnostic and treatment regimens, possibly leading to more frequent patient-provider interactions and greater awareness of the disease process. The number of chemotherapy cycles completed showed a strong association with perceived reality. Patients who had completed two cycles of chemotherapy were eight times more likely to report high perceived reality of care compared to those who had not started treatment. Controvert to this study a research in Iran shows that patients with their 3rd and 5th cycle of chemotherapy cycle experienced a significance pain and fatigue that worsen quality of life compared to the first 2 cycles of chemotherapy (58). (This suggests that direct experience with treatment may reinforce patients' understanding and acceptance of their condition and care plan. It may also indicate increased communication and education during the treatment process.

There were also factors which have significantly association with the other gynecological cancer quality indicator in patient perspective; i.e. Subjective importance. Women who were

single had significantly lower perceived importance of cancer treatment and care compared to their married counterparts. A study in Egypt found that married individuals have high subjective importance than divorced individuals (50)**.** This may be attributed to the emotional, psychological, and logistical support often provided by spouses in times of illness. Married women may benefit from greater encouragement to seek care, better treatment adherence, and increased engagement in decision-making processes, all of which could enhance their perception of the importance of treatment. In contrast, access to community-based health insurance was associated with a higher perception of treatment importance. Women who used such insurance services were nearly twice as likely to report higher subjective importance of gynecological cancer care compared to those paid. In contrast to this, the study done in USA, about sixty-five percent of the patients reported being in debt due to their gynecological cancer care. This finding suggests that financial protection plays a critical role in improving patients' attitudes toward medical care. By reducing out-of-pocket expenses and financial stress, community-based health insurance may increase patients' willingness and ability to seek and value treatment(70).

In this study type of cancer also significantly influenced subjective importance of the care. Women diagnosed with vaginal cancer were eight times more likely to perceive cancer treatment as important compared to those with cervical cancer. This could be related to vaginal cancer may present more severe symptoms in early stage or require more intensive treatment, prompting a stronger perception of treatment urgency and value among those affected.

Moreover, chemotherapy experience was strongly associated with increased perceived importance of treatment. Women who had received the third and sixth cycles of chemotherapy were significantly more likely to report higher subjective importance of gynecological cancer treatment than those who had not begun chemotherapy. A study in Iran shows, patients with their 3rd and 5th cycle of chemotherapy experience a significance pain and fatigue that worsen quality of life compared to the first 2 cycles of chemotherapy (58). This suggests that as the number of chemotherapy cycles increases, the intensity of treatment-related side effects such as pain and fatigue also rises. Consequently, patients undergoing later cycles of chemotherapy are more likely to seek intensive care and support to manage these complications. The increased

burden of side effects may heighten patients' perception of the importance of treatment, as they associate intensive care with relief from their worsening symptoms.(71)

8 LIMITATIONS AND STRENGTH OF THE STUDY

8.1 Limitations

- Healthcare quality is a broad concept that is affected by several factors and cannot be adequately explained through quantitative studies alone; there need to be triangulated with other researcher type.
- The study may be subject to recall bias, particularly among gynecologic cancer outpatients who attended follow-up appointments more than six months after treatment(72)

8.2 Strength of this study

- This may be the first research in Ethiopia assessment on quality of gynecological cancer care from patients' perspectives, (QPP-Gyn Ca).

9 CONCLUSION AND RECOMMENDATION

9.1 Conclusion

The overall subjective importance (SI) of care to the present study is higher than perceived reality (PR) of women treated for gynecological cancer, which may indicate that deficient care was given. This means the healthcare system did not meet the patient's expectations in crucial areas**.** The study showed that college or university level education, living income greater than 7000 ETB, diagnosis with ovarian cancer type, as well as marital status, service charge, diagnosis with vaginal cancer type and 3rd and 6th chemotherapy cycle were significantly associated with patient perspective of the quality of gynecological care.

9.2 RECOMMENDATION

The study showed that the overall subjective importance score of gynecological cancer patients was high compared to the corresponding perceived realty (actual care received) of patient for their cancer treatment and care. This may indicate that insufficient attention was given to important care aspects. Therefore:

- In the city administration level: Addis Ababa health bureau needs to be facilitated a broad and Integrative research to further aware about the care quality compromising in gynecological cancer.
- In hospital level: the two research site hospitals (St. Paul Millennium medical college and Tikur Anbessa Specialized hospitals) should revise their protocols and guidelines.
- Implication to Nursing Practice: ongoing training and quality improvement initiatives are essential to bridge the gap between perceived importance and actual care, ultimately enhancing patient satisfaction and health outcomes in gynecological cancer care
- Furthermore, the hospitals should give training on gynecological cancer care for their staffs.

10 REFERENCE

1. Sankaranarayanan R, Ferlay J. Worldwide burden of gynaecological cancer: the size of the problem. Best practice & research Clinical obstetrics & gynaecology. 2006;20(2):207-25.
2. Zhu B, Gu H, Mao Z, Beeraka NM, Zhao X, Anand MP, et al. Global burden of gynaecological cancers in 2022 and projections to 2050. Journal of global health. 2024;14:04155.
3. Non-Communicable O. National strategic action plan (nsap) for prevention & control of non-communicable diseases in Ethiopia. Google Scholar. 2016.
4. Sciences NAo, Medicine, Division M, Health BoG, Globally CoItQoHC. Crossing the global quality chasm: improving health care worldwide. 2018.
5. Muntlin Å, Gunningberg L, Carlsson M. Patients' perceptions of quality of care at an emergency department and identification of areas for quality improvement. Journal of clinical nursing. 2006;15(8):1045-56.
6. Organization WH. The world health report 2000: health systems: improving performance: World Health Organization; 2000.
7. Wilde B, Starrin B, Larsson G, Larsson M. Quality of care from a patient perspective: a grounded theory study. Scandinavian journal of caring sciences. 1993;7(2):113-20.
8. Spinks TE, Ganz PA, Sledge Jr GW, Levit L, Hayman JA, Eberlein TJ, et al., editors. Delivering high-quality cancer care: the critical role of quality measurement. Healthcare; 2014: Elsevier.
9. Shan L, Li Y, Ding D, Wu Q, Liu C, Jiao M, et al. Patient satisfaction with hospital inpatient care: effects of trust, medical insurance and perceived quality of care. PloS one. 2016;11(10):e0164366.
10. Tishelman C, Lundgren E-L, Skald A, Törnberg S, Larsson BW. Quality of care from a patient perspective in population-based cervical cancer screening. Acta Oncologica. 2002;41(3):253-61.
11. Kataki AC, Tiwari P, Thilagavthi R, Krishnatreya M. Epidemiology of gynaecological cancers. Fundamentals in Gynaecologic Malignancy: Springer; 2023. p. 1-8.
12. Parkin DM, Ferlay J, Jemal A, Borok M, Manraj S, N'Da G, et al. Cancer in Sub-Saharan Africa: International Agency for Research on Cancer; 2018.
13. Zhu B, Gu H, Mao Z, Beeraka NM, Zhao X, Anand MP, et al. Global burden of gynaecological cancers in 2022 and projections to 2050. Journal of Global Health. 2024;14.
14. Gebretsadik A, Bogale N, Dulla D. Descriptive epidemiology of gynaecological cancers in southern Ethiopia: retrospective cross-sectional review. BMJ open. 2022;12(12):e062633.
15. Isiaka-Lawal SA. An exploration of symptom burden among breast and gynaecological cancer patients accessing care at University of Ilorin teaching hospital, Ilorin, Kwara State, Nigeria. 2017.

16. Heerdegen ACS, Petersen GS, Jervelund SS. Determinants of patient satisfaction with cancer care delivered by the Danish healthcare system. Cancer. 2017;123(15):2918-26.
17. Ayalew M, Mamo F, Derseh L. Health-related Quality of Life and Its Associated Factors among Gynecologic Cancer Patients in Oncology Centers in Northwest Ethiopia 2023: Structural Equation Modeling. 2023.
18. Spagnoletti BRM, Bennett LR, Keenan C, Shetty SS, Manderson L, McPake B, et al. What factors shape quality of life for women affected by gynaecological cancer in South, South East and East Asian countries? A critical. 2022.
19. Derbie A, Mekonnen D, Nibret E, Misgan E, Maier M, Woldeamanuel Y, et al. Cervical cancer in Ethiopia: a review of the literature. Cancer Causes & Control. 2023;34(1):1-11.
20. Ayenew AA, Zewdu BF, Nigussie AA. Uptake of cervical cancer screening service and associated factors among age-eligible women in Ethiopia: systematic review and meta-analysis. Infectious Agents and Cancer. 2020;15:1-17.
21. Hussein K, Wafula F, Kassie GM, Kokwaro G. Barriers and facilitators to implementation of the Ethiopian national cancer control plan strategies: Implications for cervical cancer services in Ethiopia. PLOS Global Public Health. 2024;4(7):e0003500.
22. Lott BE, Halkiyo A, Kassa DW, Kebede T, Dedefo A, Ehiri J, et al. Health workers' perspectives on barriers and facilitators to implementing a new national cervical cancer screening program in Ethiopia. BMC women's health. 2021;21(1):185.
23. Özcan H, Demir Doğan M. Gynecological cancer awareness among women. Indian Journal of Gynecologic Oncology. 2021;19:1-9.
24. Spagnoletti BRM, Bennett LR, Keenan C, Shetty SS, Manderson L, McPake B, et al. What factors shape quality of life for women affected by gynaecological cancer in South, South East and East Asian countries? A critical review. Reproductive Health. 2022;19(1):70.
25. Organization WH, Group WB. Delivering Quality Health Services: A Global Imperative: OECD Publishing; 2018.
26. Larsson BW, Larsson G. Patients' views on quality of care: do they merely reflect their sense of coherence? Journal of Advanced Nursing. 1999;30(1):33-9.
27. Wilde-Larsson B, Larsson G, Kvist LJ, Sandin-Bojö AK. Womens' opinions on intrapartal care: development of a theory-based questionnaire. Journal of clinical nursing. 2010;19(11-12):1748-60.
28. Olsson C, Larsson M, Holmberg E, Stålberg K, Sköld C, Rådestad AF, et al. Quality of Endometrial Cancer Care from the Patients' Perspective: A Cross-Sectional Study. Cancer Care Research Online. 2024;4(4):e061.

29. Amsalu M, Ashagrie HE, Getahun AB, Berhe YW. Patients' satisfaction with cancer pain treatment at adult oncologic centers in Northern Ethiopia; a multi-center cross-sectional study. BMC cancer. 2024;24(1):647.

30. Alan M, Kurt M, Alan Y, Oruç MA, Sancı M. The satisfaction level in cases with gynecologic cancer. Journal of Experimental and Clinical Medicine. 2019;36(1):13-22.

31. Yadav S, Jayaseelan V, Pandjatcharam J, Roy G, Susindran B, Ravel V. Facilitators and Challenges in Patient's Satisfaction with Quality of Cervical Cancer Care in a Tertiary Care Hospital, Puducherry, India: A Qualitative Study. South Asian J Cancer. 2023;12(3):250-5.

32. Singer S, Danker H, Meixensberger J, Briest S, Dietz A, Kortmann R-D, et al. Structured multidisciplinary psychosocial care for cancer patients and the perceived quality of care from the patient perspective: a cluster-randomized trial. Journal of Cancer Research and Clinical Oncology. 2019;145:2845-54.

33. Costa DGD, Moura G, Moraes MG, Santos J, Magalhaes AMM. Satisfaction attributes related to safety and quality perceived in the experience of hospitalized patients. Rev Gaucha Enferm. 2020;41(spe):e20190152.

34. Vu TT, Weiss M, Nguyen LT-H, Tran HT, Ho HT, Ngo VK. Adult cancer patients' barriers to and satisfaction with care at a National Cancer Hospital in Vietnam. Plos one. 2024;19(5):e0303157.

35. Schein YL, Winje BA, Myhre SL, Nordstoga I, Straiton ML. A qualitative study of health experiences of Ethiopian asylum seekers in Norway. BMC Health Services Research. 2019;19:1-12.

36. Akinlusi FM, Olayiwola AA, Adeniran A, Rabiu KA, Oshodi YA, Ottun TA. Patients' perception of the quality of gynecological services in a tertiary public health facility in Lagos, Nigeria. Journal of Patient Experience. 2022;9:23743735221077550.

37. Shimels T, Gashawbeza B, Gedif Fenta T. Access to advanced healthcare services and its associated factors among patients with cervical cancer in Addis Ababa, Ethiopia. Frontiers in Oncology. 2024;14:1342236.

38. <cancer-services-patient-EXPRCINCE IN ENGLAND.pdf>.

39. Gonçalves V, Ferreira PL, Saleh M, Tamargo C, Quinn GP. Perspectives of young women with gynecologic cancers on fertility and fertility preservation: a systematic review. The oncologist. 2022;27(3):e251-e64.

40. Vitale SG, La Rosa VL, Rapisarda AMC, Laganà AS. Fertility preservation in women with gynaecologic cancer: the impact on quality of life and psychological well-being. Human Fertility. 2018;21(1):35-8.

41. Kuyinu Y, Onyemenam J, Goodman O, Odugbemi B. Satisfaction among patients attending oncology clinic in a tertiary hospital in South West, Nigeria. Research Journal of Health Sciences. 2019;7(3):204-10.

42. Launonen M, Vehviläinen-Julkunen K, Mikkonen S, Kvist T. Care quality and satisfaction at the cancer hospital–a questionnaire study of older patients with cancer and their family members. BMC Health Services Research. 2024;24(1):190.

43. Mahran SM, Al Nagshabandi E. Oncology patients' satisfaction towards quality health care services at Accredited University Hospital. American Journal of Nursing. 2016;5(4):162-8.

44. Sandoval GA, Brown AD, Sullivan T, Green E. Factors that influence cancer patients' overall perceptions of the quality of care. International Journal for Quality in Health Care. 2006;18(4):266-74.

45. Mojdehbakhsh RP, Hurtado ACM, Uppal S, Milakovich H, Spencer RJ. The long game: Telemedicine patient satisfaction metrics and methods of recurrence detection for gynecologic cancer patients throughout the initial year of the COVID-19 pandemic. Gynecologic Oncology Reports. 2022;42:101037.

46. Fitch MI, Coronado AC, Schippke JC, Chadder J, Green E. Exploring the perspectives of patients about their care experience: identifying what patients perceive are important qualities in cancer care. Supportive Care in Cancer. 2020;28:2299-309.

47. Grøndahl VA, Kirchhoff JW, Andersen KL, Sørby LA, Andreassen HM, Skaug E-A, et al. Health care quality from the patients' perspective: a comparative study between an old and a new, high-tech hospital. Journal of multidisciplinary healthcare. 2018:591-600.

48. Mundy LR, Homa K, Klassen AF, Pusic AL, Kerrigan CL. Breast cancer and reconstruction: normative data for interpreting the BREAST-Q. Plastic and reconstructive surgery. 2017;139(5):1046e-55e.

49. Esselen KM, Gompers A, Hacker MR, Bouberhan S, Shea M, Summerlin SS, et al. Evaluating meaningful levels of financial toxicity in gynecologic cancers. International Journal of Gynecologic Cancer. 2021;31(6).

50. Ibrahim SM, Shenouda MS, Elsawy MM. Cancer patients' satisfaction toward health services provided by non-governmental organizations. Egyptian Nursing Journal. 2021;18(3):152-9.

51. Wasihun GA, Addise M, Nega A, Kifle A, Taye G, Gebrekidan AY. Gap analysis of service quality and associated factors at the oncology center of Tikur Anbessa Specialized Hospital, Addis Ababa, Ethiopia, 2022: a cross-sectional study. BMJ open. 2024;14(1):e078239.

52. Zafar SY, Peppercorn JM, Schrag D, Taylor DH, Goetzinger AM, Zhong X, et al. The financial toxicity of cancer treatment: a pilot study assessing out-of-pocket expenses and the insured cancer patient's experience. The oncologist. 2013;18(4):381-90.

53. Spees LP, Biru BM, Brewster WR, Leeman J, Taffe B, Wheeler SB. Abstract A130: Stakeholder perspectives of the multi-level barriers to treatment among rural endometrial cancer patients: A qualitative study. Cancer Epidemiology, Biomarkers & Prevention. 2023;32(12_Supplement):A130-A.
54. de Rooij BH, Ikiz H, Boll D, Pijnenborg JM, Pijlman BM, Kruitwagen RF, et al. Recurrent cancer is associated with dissatisfaction with care—A longitudinal analysis among ovarian and endometrial cancer patients. International Journal of Gynecologic Cancer. 2018;28(3).
55. Ngalla C, Didymus J, Manjuh F, Nwufor M, Nkfusai J, Elit L, et al. Challenges faced in managing cervical cancer patients who present post-operatively with more advanced disease in LMICs: Case studies from Cameroon. Gynecologic Oncology Reports. 2024;55:101485.
56. Guimarães YM, Godoy LR, Longatto-Filho A, Reis Rd. Management of early-stage cervical cancer: a literature review. Cancers. 2022;14(3):575.
57. Sarfati D, Koczwara B, Jackson C. The impact of comorbidity on cancer and its treatment. CA: a cancer journal for clinicians. 2016;66(4):337-50.
58. Heydarnejad MS, Hassanpour DA, Solati DK. Factors affecting quality of life in cancer patients undergoing chemotherapy. African health sciences. 2011;11(2).
59. Esselen KM, Gompers A, Hacker MR, Bouberhan S, Shea M, Summerlin SS, et al. Evaluating meaningful levels of financial toxicity in gynecologic cancers. International Journal of Gynecological Cancer. 2021;31(6):801-6.
60. Adams EJ, Tallman D, Haynam ML, Nekhlyudov L, Lustberg MB. Psychosocial needs of gynecological cancer survivors: mixed methods study. Journal of Medical Internet Research. 2022;24(9):e37757.
61. Ferreira DC, Vieira I, Pedro MI, Caldas P, Varela M, editors. Patient satisfaction with healthcare services and the techniques used for its assessment: a systematic literature review and a bibliometric analysis. Healthcare; 2023: MDPI.
62. Eshetu T. Evaluation of introducing light rail transit into urban median street at grade crossing (A case of Addey Ababa intersection): Thesis, Addis Ababa, Ethiopia; 2019.
63. NIGUS A. FACTORS AFFECTING PALLIATIVE CARE SERVICE UTILIZATION AMONG CANCER PATIENTS AT PUBLIC HOSPITALS ONCOLOGY UNIT ADDIS ABABA, ETHIOPIA, 2022 2022.
64. Hailu HE, Mondul AM, Rozek LS, Geleta T. Descriptive Epidemiology of breast and gynecological cancers among patients attending Saint Paul's Hospital Millennium Medical College, Ethiopia. PloS one. 2020;15(3):e0230625.
65. Brédart A, Anota A, Young T, Tomaszewski K, Arraras JI, Moura De Albuquerque Melo H, et al. Phase III study of the European Organisation for Research and Treatment of Cancer satisfaction with

cancer care core questionnaire (EORTC PATSAT-C33) and specific complementary outpatient module (EORTC OUT-PATSAT7). European journal of cancer care. 2018;27(1):e12786.

66. Atnafu T, Daka DW, Debela TF, Ergiba MS. Women's satisfaction with cervical cancer screening services and associated factors in maternal health clinics of jimma town public health facilities, Southwest Ethiopia. Cancer Management and Research. 2021:7685-96.

67. Olsson C, Larsson BW, Larsson M, Holmberg E, Marcickiewicz J, Tholander B, et al. Adaption of the Quality From the Patient's Perspective Instrument for Use in Assessing Gynecological Cancer Care and Patients' Perceptions of Quality Care Received. Cancer Care Research Online. 2022;2(1):e019.

68. Davies AR, Ware Jr JE. Involving consumers in quality of care assessment. Health affairs. 1988;7(1):33-48.

69. Quinn L, Bird P, Lilford R. Effect of cancer waiting time standards in the English National Health Service: a threshold analysis. BMC Health Services Research. 2024;24(1):929.

70. Zeybek B, Webster E, Pogosian N, Tymon-Rosario J, Balch A, Altwerger G, et al. Financial toxicity in patients with gynecologic malignancies: a cross sectional study. Journal of Gynecologic Oncology. 2021;32(6):e87.

71. Culakova E, Thota R, Poniewierski M, Kuderer N, Wogu A, Dale D, et al. Patterns of chemotherapy-associated toxicity and supportive care in US oncology practice: a nationwide prospective cohort study. Cancer Med. 2014; 3 (2): 434–44.

72. Chung EH, Mebane S, Harris BS, White E, Acharya KS. ONCOFERTILITY RESEARCH PITFALL? RECALL BIAS AMONG YOUNG ADULT CANCER SURVIVORS. Fertility and Sterility. 2021;116(3):e45.

11 ANNEXES

11.1 ANNEX I: Information Sheet

Good morning/ afternoon.. I am conducting a study on the assessing patient perspectives on the quality of gynecological cancer care in Addis Ababa public hospitals, Ethiopia, 2025.

Title of the research: Quality of patient perspectives on the quality of gynecological cancer care selected in Addis Ababa public hospitals, Ethiopia, 2025.

Objective: To assess patient perspective on the quality of care provided for women with gynecologic cancer in Addis Ababa public hospitals, Ethiopia, 2025.

Participants: All women diagnosed with any type of gynecologic cancers

Potential Risks: There is no foreseen risk by being involved in this study.

Benefits: No financial benefits are related to this study. Hence, you are indirectly benefiting other patients and society in this respect. I want to ask you a few questions. Your honest response to the questions can help the study achieve its objective. All the information that you give will be kept confidential and private. Only the principal investigator and interviewer will have access to the information. You are kindly requested to respond voluntarily. You can also choose not to participate in this study totally or if you become uncomfortable during the study, you will be allowed to leave the interview at any time. At any time that you have questions, you can contact me by using the following Addresses.

Principal investigator, Betelhem Degfe

Email, betelihemdegfe@gmail.com

11.2 ANNEX II: Consent Form

In signing this document, I have been informed that the purpose of this study is to assess the level of patient satisfaction with the quality of gynecologic cancer care service in selected public hospitals, Addis Ababa, Ethiopia, 2025. I understand that participation in this study is entirely voluntary. I have been told that my answers to the questions will not be given to anyone else and no reports of this study ever identify me in any way. I have also been informed that my participation or non-participation or my refusal to answer questions will not affect me. I understood that participation in this study does not involve risks.

Respondent's signature_____

Date of interview: _____ Time started: _____ Time finished: _____

Interviewer Name_____Signature_____Date_____

Supervisor's name _____ signature _____

Results of the interview questionnaire

1. Completed

2. Refused

3. Partially complete

11.3 Annex III Questioner

Socio-demographic characteristics of the study participant on the study of patient satisfaction with the quality of oncology services provided for women with gynecologic cancer in selected public hospitals, Addis Ababa, Ethiopia, 2025.

S. N	QUESTIONS	RESPONSE
101	What is your age?	1….
102	What is your educational level?	1. No formal education
		2. Primary school
		3. Secondary school
		4. Certificate and above
103	What is your marital status?	1. Single
		2. Married
		3. Divorced
		4. Widowed
104	What is your monthly income	1. <7000ETB
		2. ≥7000 ETB
105	Where is your permanent residency?	1. Urban
		2. Rural
106	Types of service fee	1.community health insurance
		2.out pocket

The distribution of the characteristics of the participants related to their disease is presented

201	Types of cancer	1. Cervical cancer
		2. Ovarian cancer
		3. Vulvar cancer
		4. Vaginal cancer
		5. Endometrial cancer
		6. Other gynecological cancer
202	Stage of cancer	1. Stage 1
		2. Stage 2
		3. Stage 3
		4. Stage 4
203	Cycle of chemotherapy and radiotherapy	1. ……
204	Cycle of chemotherapy	1……..
205	Cycle of radiotherapy	1……..
206	Types of treatment modality	1. Chemotherapy only
		2. Surgery and chemotherapy
		3. Chemotherapy and radiotherapy
		4. Surgery and radiotherapy
		5. Surgery only
		6. Chemotherapy, radiotherapy and surgery

		7. Radiotherapy only

QPP-Gyn Ca quality of care from patient perspective 27 items question answered in two way

		PR (perceived reality)				SI (subjective importance			
NO.		1. Do not agree at all	2.some what disagree	3. Some what agree	4. fully agree	1. no important at all	2. slightly Important	3. moderately important	4. very important
	Medical-Technical Competence								
301pr	During my cancer treatment, I received the best possible help for(when needed) Troublesome symptoms.								
301(si)	How important was to receive the best possible help for troublesome symptoms								
302(pr)	During my cancer treatment, I received the best possible help for pain.								
302 (si)	How important was it to receive the best possible help for pain								

303(pr)	During my cancer treatment, I received the best possible help for Lack of sleep.								
303(si)	How important was it to receive the best possible help for Lack of sleep.								
304(pr)	During my cancer treatment, I received the best possible help for anxiety.								
304(si)	How important was it to receive the best possible help for anxiety.								
305(pr)	During my cancer treatment, I received the best possible medical treatment and care.								
305(si)	How important was it to receive the best possible medical treatment and care.								
	Physical-Technical Conditions								
306(pr)	During my cancer treatment, I received examinations and								

	treatment within acceptable wait times.								
306(si)	How important was it to received examinations and treatment within acceptable wait times.								
307(pr)	During my visit to the hospital, I had access to the necessary equipment.								
307(si)	How important was it to had access to the necessary equipment.								
	Identity-Oriented Approach								
	General information and participation during cancer treatment								
308(pr)	During my cancer treatment, I received helpful information about Planning continued treatment and care.								
308(si)	How important was it to receive helpful information about Planning continued treatment and care.								

309(pr)	During my cancer treatment, I received helpful information about how examinations and treatments would take place								
309(si)	How important was it to receive helpful information about how examinations and treatments would take place								
310(pr)	I received helpful information about the results of examinations and treatments.								
310(si)	How important was it to receive helpful information about the results of examinations and treatments.								
311(pr)	I received helpful information about who to contact at the hospital if I had any questions.								
311(si)	How important was it to received helpful information about who to contact at the hospital if I had any questions								
312(pr)	During my cancer treatment, I had good opportunities to								

	participate in decisions that applied to my individual care plan.								
312(si)	How important was it to had good opportunities to participate in decisions that applied to my individual care plan.								
	Information related to self-care								
313	During my cancer treatment, I received helpful information about Self-care: “how I should best manage my health” (e.g., diet and exercise)								
313(si)	How important was it to received helpful information about Self-care: “how I should best manage my health” (e.g., diet and exercise)								
314(pr)	During my cancer treatment, I received helpful information about Urinary problems.								

314(si)	How important was it to received helpful information about Urinary problems.								
315(pr)	During my cancer treatment, I received helpful information about a Bloated abdomen and difficulty in controlling the bowels.								
315(si)	How important was it to received helpful information about a Bloated abdomen and difficulty in controlling the bowels.								
316	During my cancer treatment, I received helpful information about Genital discomfort (e.g., irritation or soreness and bleeding)								
316(si)	How important was it to received helpful information about Genital discomfort (e.g., irritation or soreness and bleeding)								

317(pr)	My medications, so I understood their effects and how to take them.								
317(si)	How important was it to understood their effects and how to take them.								
	Information related to aspects of sexuality								
318(pr)	During my cancer treatment, I received helpful information about How cancer and its treatment could affect my sexual function.								
318(si)	How important was it to received helpful information about How cancer and its treatment could affect my sexual function.								
319(pr)	During my cancer treatment, I received helpful information about How my sexual function could be preserved.								
319(si)	How important was it to received helpful information								

	about How my sexual function could be preserved.								
320(pr)	How cancer and its treatment affect fertility								
320(si)	How important was it to received helpful information How cancer and its treatment affect fertility								
	Respect and empathy								
321(pr)	The healthcare personnel I met at the time of my cancer diagnosis Seemed to understand how I experienced my situation.								
321(si)	How important was it to you that the healthcare personnel you met at the time of your cancer diagnosis understood how you were experiencing your situation.								
322(pr)	The healthcare personnel I met at the time of my cancer treatment, treated me with respect								

322(si)	How important was it to you that the healthcare personnel treated you with respect								
323(pr)	The healthcare personnel I met at the time of my cancer tereatment, Showed commitment: “cared about me” How important was it to you that the healthcare personnel you met at the time of your cancer treatment Showes commitment: “cared about you”								
	Socio-Cultural Atmosphere								
324(pr)	During my cancer treatment, my care was guided by my needs rather than by routines.								
324(si)	How important was it to you During your cancer treatment, your care was guided your needs rather than by routines.								

325(pr)	I was allowed to speak to HCP undisturbed when I wanted								
325(si)	how important was it to you allowed to speak to HCP undisturbed when you wanted								
326(pr)	during my cancer treatment, my relatives were treated with respect.								
326si	How important was it to treat your relatives with respect during your cancer treatment								
	Global single item related to HCP person-related qualities								
327(pr)	During my time at the hospital, the HCP I met had the competence and skills necessary for my care (as far as I could tell)								
327(si)	How important was it to you the HCP you met had the competence and skills necessary for your care (as far								

	as you could tell) During your time at the hospital,								

አባሪ 1፡

የመረጃ ሉህ እንደምን አደሩ/ ከሰአት። ስሜ ቤተልሄም ደግፌ እባላለሁ በአሁኑ ጊዜ በአዲስ አበባ ዩኒቨርሲቲ፣ በጤና ሳይንስ ኮሌጅ፣ በነርሲንግ እና አዋላጅ ትምህርት ቤት ተመራቂ ተማሪ ነኝ። በአዲስ አበባ የሕዝብ ሆስፒታሎች፣ ኢትዮጵያ፣ 2017፣ በአዲስ አበባ የሚሰጠው የማህፀን ካንሰር ህክምና ጥራት በታካሚ እይታ ግምገማ እያካሄድኩ ነው።

የጥናቱ ርዕስ፡- በአዲስ አበባ የሚሰጠው የማህፀን ካንሰር ህክምና ጥራት በታካሚ እይታ ግምገማ፣ ኢትዮጵያ፣ 2017

ዓላማ፡- በአዲስ አበባ በተመረጡ የህዝብ ሆስፒታሎች ውስጥ የማህፀን ካንሰር ህክምና አሰጣጥ ጥራት በታካሚዎች እይታ መገምገም.

ተሳታፊዎች፡- ሁሉም ሴቶች በማንኛውም አይነት የማህፀን ካንሰር ተይዘዋል

ሊሆኑ የሚችሉ አደጋዎች፡ በዚህ ጥናት ውስጥ በመሳተፍ አስቀድሞ የተገመተ አደጋ የለም።

ጥቅሞች፡- ከዚህ ጥናት ጋር ምንም አይነት የገንዘብ ጥቅማጥቅሞች የሉም። ስለሆነም በዚህ ረገድ በተዘዋዋሪ ሌሎች ታካሚዎችን እና ማህበረሰቡን እየጠቀማችሁ ነው። ጥቂት ጥያቄዎችን ልጠይቅህ እፈልጋለሁ። ለጥያቄዎቹ የሰጡት ታማኝነት ጥናቱ ዓላማውን እንዲያሳካ ሊረዳው ይችላል። ሁሉም የሚሰጡት መረጃ ሚስጥራዊ እና ሚስጥራዊ ይሆናል። ዋናው መርማሪ እና ቃለ መጠይቅ አድራጊ ብቻ ነው መረጃውን ማግኘት የሚችሉት። በፈቃደኝነት ምላሽ እንዲሰጡ በአክብሮት እጠይቃለው። እንዲሁም በዚህ ጥናት ውስጥ ሙሉ በሙሉ አለመሳተፍ ይችላሉ ወይም በጥናቱ ወቅት ምቾት የማይሰማዎት ከሆነ በማንኛውም ጊዜ ቃለ መጠይቁን ለቀው እንዲወጡ ይፈቀድልዎታል። በማንኛውም ጊዜ ጥያቄዎች ሲኖሩዎት የሚከተሉትን አድራሻዎች በመጠቀም ሊያገኙኝ ይችላሉ።

ዋና መርማሪ ቤተልሄም ደግፌ

ኢሜል፣ betelihemdegfe@gmail.com

አባሪ II፡ የስምምነት ቅጽ

ይህንን ሰነድ በመፈረም የዚህ ጥናት ዓላማ የህዝብ ሆስፒታሎች አዲስ አበባ ፣ ኢትዮጵያ ፣ 2017 በታካሚው የማህፀን ካንሰር እንክብካቤ አገልግሎት ጥራት ያለውን እርካታ ደረጃ ለመገምገም እንደሆነ ተነግሮኛል። በዚህ ጥናት ውስጥ መሳተፍ ሙሉ በሙሉ በፈቃደኝነት እንደሆነ ተረድቻለሁ። ለጥያቄዎቹ የእኔ መልሶች ለሌላ ሰው እንደማይሰጡ ተነግሮኛል እና ምንም የዚህ ጥናት ዘገባ በምንም መልኩ እኔን ለይቶ አይገልጽም። የእኔ ተሳትፎ ወይም አለመሳተፍ ወይም ለጥያቄዎች መልስ አለመስጠት በእኔ ላይ ተጽዕኖ እንደማይኖረው ተነግሮኛል. በዚህ ጥናት ውስጥ መሳተፍ አደጋዎችን እንደማያጠቃልል ተረድቻለሁ።

የተጠሪ ፊርማ _____

የቃለ መጠይቁ ቀን፡- _____ **የተጀመረበት ጊዜ፡-** _____ **የተጠናቀቀው ጊዜ፡-** _____
የጠያቂው ስም _____ **ፊርማ**_____**ቀን**_____
የሱፐርቫይዘሩ ስም _____ **ፊርማ** _____

የቃለ መጠይቁ መጠይቁ ውጤቶች

1. **ተጠናቅቋል**

2. **እምቢ አለ።**

3. **በከፊል የተጠናቀቀ**

የጥናቱ ተሳታፊ ስነ-ሕዝብ ባህሪያት በታካሚዎች እርካታ ላይ የህዝብ ሆስፒታሎች ውስጥ የማህፀን ካንሰር ላለባቸው ሴቶች የሚሰጠውን የካንኮሎጂ አገልግሎት ጥራት በተመለከተ አዲስ አበባ, ኢትዮጵያ, 2017

ኤስ.ኤን	ጥያቄዎች	ምላሽ
101	ዕድሜሽ ስንት ነው?	1.....
102	የትምህርት ደረጃሽ ስንት ነው?	1. መደበኛ ትምህርት የለም
		2. የመጀመሪያ ደረጃ ትምህርት ቤት
		3. ሁለተኛ ደረጃ ትምህርት ቤት
		4. የመጀመሪያ ዲግሪ
		5. የድህረ ምረቃ እና ከዚያ በላይ
103	የጋብቻ ሁኔታሽ	1. ባያገባ
		2. ያገላ
		3. አግብታ የተፋታች
		4. የሞተባት
105	ሥራሽ ምንድን ነው?	1. የመንግስት ቀጣሪ
		2. የግል ተቀጣሪ
		3. የግል ስራ
		4. የቀን ሰራተኛ
		5. ተማሪ
		6. የቤት እመቤት
106	ወርሃዊ ገቢ ምንያህል ነዉ?	1. ከ 7000 ብር ያነሰ
		2.ከ 7000 ብር በላይ
107	የአገልግሎት ክፍያ አይነት?	1. የጤና መድን ተጠቃሚ
		2. ከፋይ
108	የመኖሪያ ቦታ	3. ከተማ

		4. ገጠር

ከበሽታቸው ጋር የተያያዙ የተላታፊዎች የበሽታስርጭት

101	የካንሰር ዓይነቶች	1. የማኅጸን ካንሰር
		2. የማህፀን ካንሰር
		3. የቫልቫር ካንሰር
		4. የሴት ብልት ካንሰር
		5. ኢንዶሜትሪክ ካንሰር
102	የካንሰር ደረጃ	1. ደረጃ 1
		2. ደረጃ 2
		3. ደረጃ 3
		4. ደረጃ 4
103	የሕክምና አማራጮች	1. በኬሞቴራፒ
		2. ቀዶ ጥገና እና ኬሞቴራፒ
		3. ኬሞቴራፒ እና የጨረር ሕክምና
		4. ቀዶ ሕክምና እና የጨረር ሕክምና
		5. በኬሞቴራፒ፡ የጨረር ሕክምና እና ቀዶሕክምና
		6. ቀዶ ሕክምና ብቻ
		7. የጨረር ሕክምና ብቻ
104	ለመጨረሻ ጊዜ የወሰዱትስንተኛ ዙር ነዉ	1.1ኛ ዙር
		2.2ኛ ዙር
		3.3ኛ ዙር
		4.4ኛ ዙር
		5.5ኛ ዙር
		6.6 ኛ ዙር

		የታወቀ እውነታ				ርዕሰ-ጉዳይ አስፈላጊነት			
		1.በፍፁም አለመስማማት	2. አልተስማማም።	3. በከፊል እስማማለሁ	4. ሙሉ በሙሉ እስማማለሁ	1. በፍፁም አስፈላጊ አይደለም	2. በትንሹ አስፈላጊ ነዉ	3 በመጠኑ አስፈላጊ ነዉ	4. በጣም አስፈላጊ
	የሕክምና-ቴክኒካዊ ብቃት								
101	በካንሰር ህክምናዬ ወቅት፣ (በሚያስፈልግበት ጊዜ) ለሚያስቸግሩ ምልክቶች የሚቻለውን እርዳታ አግኝቻለሁ።								
	ለአስጨናቂ ምልክቶች በጣም ጥሩውን እርዳታ መቀበል ምን ያህል አስፈላጊ ነበር።								
102	በካንሰር ህክምናዬ ወቅት, ለህመም በጣም ጥሩውን እርዳታ አግኝቻለሁ.								
	ለህመም በጣም ጥሩውን እርዳታ መቀበል ምን ያህል አስፈላጊ ነበር								
103	በካንሰር ህክምናዬ ወቅት ለእንቅልፍ እጦት ምርጡን እርዳታ አግኝቻለሁ።								
	ለእንቅልፍ እጦት በጣም ጥሩውን እርዳታ መቀበል ምን ያህል አስፈላጊ ነበር.								
	አካላዊ-ቴክኒካዊ ሁኔታዎች								
104	በካንሰር ህክምናዬ ወቅት, ለጭንቀት በጣም ጥሩውን እርዳታ አግኝቻለሁ.								
	ለጭንቀት በጣም ጥሩውን እርዳታ ማግኘቱ ምን ያህል አስፈላጊ ነበር.								

105	በካንሰር ህክምናዬ ወቅት በጣም ጥሩውን የህክምና እና እንክብካቤ አግኝቻለሁ።								
	የሚቻለውን የህክምና አገልግሎት እና እንክብካቤ ማግኘት ምን ያህል አስፈላጊ ነበር።								
106	በካንሰር ህክምናዬ ወቅት፣ ተቀባይነት ባለው የጥበቃ ጊዜ ውስጥ ምርመራዎች እና ህክምና አግኝቻለሁ።								
	ተቀባይነት ባለው የጥበቃ ጊዜ ውስጥ ምርመራዎችን እና ህክምናዎችን መቀበል ምን ያህል አስፈላጊ ነበር.								
107	ወደ ሆስፒታል በሄድኩበት ወቅት አስፈላጊውን መሳሪያ አግኝቻለሁ.								
	25. አስፈላጊውን መሳሪያ ማግኘት ምን ያህል አስፈላጊ ነበር.								
	ማንነትን ያማከለ አቀራረብ								
	በካንሰር ህክምና ወቅት አጠቃላይ መረጃ እና ተሳትፎ								
108	በካንሰር ህክምናዬ ወቅት ቀጣይ ህክምና እና እንክብካቤን ስለማቀድ ጠቃሚ መረጃ አግኝቻለሁ።								
	ስለቀጣይ ህክምና እና እንክብካቤን ስለማቀድ ጠቃሚ መረጃ መቀበል ምን ያህል አስፈላጊ ነበር።								

109	በካንሰር ህክምናዬ ወቅት ምርመራዎች እና ህክምናዎች እንዴት እንደሚከናወኑ ጠቃሚ መረጃ ደርሶኛል								
	ምርመራዎች እና ህክምናዎች እንዴት እንደሚከናወኑ ጠቃሚ መረጃ መቀበል ምን ያህል አስፈላጊ ነበር።								
110	በካንሰር ህክምናዬ ወቅት ስለ የምርመራ እና የሕክምና ውጤቶች ጠቃሚ መረጃ ደርሶኛል.								
	ስለ የምርመራ እና የሕክምና ውጤቶች ጠቃሚ መረጃ መቀበል ምን ያህል አስፈላጊ ነበር.								
111	ማንኛውም ጥያቄ ካለኝ በሆስፒታሉ ማንን ማግኘት እንዳለብኝ ጠቃሚ መረጃ ደርሶኛል።								
	ማንኛውም ጥያቄ ካሎት በሆስፒታሉ ማንን መጠየቅ እንዳለቦት መረጃ ማግኘት ምን ያህል አስፈላጊ ነበር								
112	በካንሰር ህክምናዬ ወቅት፣ በግለሰብ እንክብካቤ እቅዴ ላይ በሚተገበሩ ውሳኔዎች ላይ ለመሳተፍ ጥሩ አጋጣሚዎች ነበሩኝ።								
	ከራስ እንክብካቤ ጋር የተያያዘ መረጃ								
113	በካንሰር ህክምናዬ ወቅት፣ ስለራስ እንክብካቤ ጠቃሚ መረጃ ደርሶኛል፡- “ጤንነቴን እንዴት በተሻለ ሁኔታ መቆጣጠር እንዳለብኝ”								

	(ለምሳሌ አመጋገብ እና የአካል ብቃት እንቅስቃሴ)								
	ስለራስ እንክብካቤ ጠቃሚ መረጃ መቀበል ምን ያህል አስፈላጊ ነበር፡ “ጤንነቴን እንዴት በተሻለ ሁኔታ መቆጣጠር እንዳለብኝ” (ለምሳሌ አመጋገብ እና የአካል ብቃት እንቅስቃሴ)								
114	በካንሰር ህክምናዬ ወቅት ከሽንት ጋር ተያያዥ ችግሮንች በተመለከተ ጠቃሚ መረጃ ደርሶኛል.								
	በካንሰር ህክምናዬ ወቅት ከሽንት ጋር ተያያዥ ችግሮንች በተመለከተ ጠቃሚ መረጃ ማግኘት ምን ያህል አስፈላጊ ነበር.								
115	በካንሰር ህክምናዬ ወቅት የሆድ ድርቀት እና ሰገራ የመቆጣጠር ችግርን በተመለከተ ጠቃሚ መረጃ ደርሶኛል።								
	የሆድ እብጠት እና ሰገራ የመቆጣጠር ችግርን በተመለከተ ጠቃሚ መረጃ ማግኘት ምን ያህል አስፈላጊ ነበር።								
116	በካንሰር ህክምናዬ ወቅት ስለ ብልት አለመመቸት (ለምሳሌ ህመም እና ደም መፍሰስ) ጠቃሚ መረጃ ደርሶኛል								
	ስለ ብልት አለመመቸት (ለምሳሌ ህመም እና ደም መፍሰስ) ጠቃሚ መረጃ መቀበል ምን ያህል አስፈላጊ ነበር								

117	የእኔ መድሃኒቶች, ስለዚህ ውጤቶቻቸውን እና እንዴት እንደሚወስዱ ተረድቻለሁ.								
	የመድሃኒቶችውጤቶቻቸውን እና እንዴት እንደሚወስዱ መረዳት ምን ያህል አስፈላጊ ነበር.								
	ከጸታዊነት ገጽታዎች ጋር የተያያዘ መረጃ								
118	በካንሰር ህክምናዬ ወቅት ካንሰር እና ህክምናው እንዴት በጸታዊ ተግባሬ ላይ ተጽዕኖ እንደሚያሳድሩ ጠቃሚ መረጃ ደርሶኛል።								
119	በካንሰር ህክምናዬ ወቅት ስለ ፆታዊ ግኑኝነት በተመለከተ እንዴት መጠበቅ እንደሚቻል ጠቃሚ መረጃ ደርሶኛል።								
	ስለ ፆታዊ ግኑኝነት በተመለከተ እንዴት መጠበቅ እንደሚቻል ጠቃሚ መረጃ መቀበል ምን ያህል አስፈላጊ ነበር።								
120	ካንሰር እና ህክምናው በስነ ተዋልዶ ጤናዬ ተዕኖ ሊኖረው እንደሚችልጠቃሚ መረጃ ደርሶኛል።								
	ህክምናው በስነ ተዋልዶ ጤናዬ ተዕኖ ሊኖረው እንደሚችልጠቃሚ መረጃ ማግኘት ምን ያህል አስፈላጊ ነበር.								
	መከባበር እና መተሳሰብ								
121	በካንሰር ምርመራ ወቅት ያገኘኋቸው የጤና ባለሙያ ሁኔታዬን እንዴት								

	እንዳጋጠመኝ የተረዱ ይመስሉ ነበር።								
	በካንሰር ምርመራ ወቅት ያገኟቸው የጤና ባለሙያ ሁኔታዎን እንዴት እያጋጠሙዎት እንደሆነ መረዳታቸው ለእርስዎ ምን ያህል አስፈላጊ ነበር								
122	በካንሰር ህመም ጊዜ ያገኘኋቸው የጤና ባለሙያ በአክብሮት ያዙኝ።								
	የጤና ባለሙያ እርስዎን በአክብሮት ማስተናገዳቸው ለእርስዎ ምን ያህል አስፈላጊ ነበር።								
123	በካንሰር ህክምና ጊዜ ያገኘኋቸው የጤና ባለሙያ ቁርጠኝነትን አሳይተዋል፡ “ስለእኔ ያስባሉ”								
	በካንሰር ህክምናዎ ወቅት ያገኟቸው የጤና እንክብካቤ ሰራተኞች "ስለእርስዎ እንደሚያስቡ" ቁርጠኝነትን ማሳየታቸው ለእርስዎ ምን ያህል አስፈላጊ ነበር.								
	ማህበራዊ-ባህላዊ ድባብ								
124	በካንሰር ህክምናዬ ወቅት እንክብካቤዬ በዕለት ተዕለት እንቅስቃሴዬ ሳይሆን በፍላጎቴ ተመርቷል።								
	በካንሰር ህክምናዎ ወቅት ለእርስዎ ምን ያህል አስፈላጊ ነበር, እንክብካቤዎ ከመደበኛ ስራዎች ይልቅ ፍላጎቶችዎን ይመራ ነበር.								
125									

	በፈለጉት ጊዜ ሳልጨነቅ የጤና ባለሙያለ እንዳናግር ተፈቅዶልኛል።								
	በፈለጉት ጊዜ ሳይጨነቁ የጤና ባለሙያለ እንዲያናግሩ መፍቀዱ ለእርስዎ ምን ያህል አስፈላጊ ነበር።								
126	በካንሰር ህክምናዬ ወቅት ዘመዶቼ በአክብሮት አገልግሎቱን አግኝተዋል								
	በካንሰር ህክምናዎ ወቅት ዘመዶችዎ በአክብሮት አገልግሎቱን አግኝታቸው ምን ያህል ጠቃሚ ነዉ								
	የጤና ባለሙያለ ጋር የተዛመዱ ጥራቶች ጋር የሚዛመድ ዓለም አቀፍ ነጠላ								
127	በሆስፒታል ቆይታዬ፣ ያገኘሁት የጤና ባለሙያለ ለእኔ እንክብካቤ አስፈላጊ የሆነ ብቃት እና ችሎታ ነበረው								
	በሆስፒታል ቆይታዎ ያገኙት የጤና ባለሙያለ ለእርስዎ እንክብካቤ አስፈላጊ የሆነ ብቃት እና ችሎታ ያለው መሆኑ ምን ያህል አስፈላጊ ነበር፣								