Lived Experience and Coping Mechanisms of Cervical Cancer Patients:

A Phenomenological Study at Black Lion Hospital

By:

Adelahu Gebre

A Thesis Submitted to the School of Social Working to meet the Partial Fulfillment of the Requirements for the Degree of Master of Art in Social Work

Addis Ababa University

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College of Social Science

Graduate program

This is to certify that the thesis prepared by Adelahu Gebre, entitled: Lived Experience and coping mechanisms of Cervical Cancer Patient: A Phenomenological study the case of Black Lion hospital in oncology and radiology department submitted in partial fulfillment of the requirements for the Degree of Master of Arts in Social Work complies with the regulations of the University and meets the accepted standards with respect to originality and quality.

Signed by the Examining Committee:

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Advisor ____________________ Signature_______________ Date_____________

Advisor_____________________Signature____________________Date_____________

Chair of Department or Graduate Program Coordination

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Acronym

ACS: American Cancer Society

AIDS: Acquire Immune Deficiency Syndrome

CC: Cervical Cancer

CSA: Central Statistics Agency

EDHS: Ethiopia Demographic Health Survey

EHA: Emergency Health Training Program for Africa

FMOH: Federal Ministry of Health

FIGO: International Federation of Gynecology and Obstetrics

GLOBOCAN: Global Burden of Cancer Study

HPV: Human Papilloma Virus

HIV: Human Immune Virus

IARC: The International Agency for Research on Cancer

PAP : Papanicolaou

SNNPR: Southern Nation Nationalities People Region

STI: Sexually Transmitted Infection

VIA: Visual Inspection with Acetic Acid

WHO: World Health Organization

Acknowledgment

I would like to acknowledge Addis Ababa University, school of social works for giving me this opportunity to conduct the study on this topic and also I would like to extend my gratitude to my advisor Dr. Firehiwot Jebessa.

My appreciations goes to Black Lion Specialized Hospital, Oncology Unit staff and radiology departments for their cooperation especially Dr. Edom who facilitate the process to conducting my data collection on time. Finally, it is my pleasure to thanks all women who participated in the study for their invaluable input.

Last but not least my family especially my mother Aselefech who is my role model and always there for me and supported me no matter what. You are the greatest mom I ever know so at least this is the way to say you thank you for everything you have done in my life.

Abstract

Cervical cancer is the fourth most prevalent disease worldwide and the second highest prevalent disease in Ethiopia. As a result, a high number of morbidity and mortality with cervical cancer are reported especially in Sub Saharan Africa. There are associated factors for cervical cancer increment mainly woman behavioral characteristics, woman's poor knowledge and practices of cervical cancer screening, health professionals lack of knowledge on cervical cancer disease and inaccessibility of health services which results delaying of getting the services. To meet the general objectives qualitative research method was used to explore the lived experiences and coping mechanisms of cervical cancer patient after they have been diagnosed. Non probable purposively sampling technique used to fulfill the inclusion criteria so unstructured in-depth interview, key informant guideline and observation were used as method of tools for data collection. Women and health workers have low knowledge about CC that women experienced repeated visit in the facility, long referral chain between health facilities and waiting longer time to get the service at Black Lion Hospital were the contributing factors for the delay and high degree of CC. As a result, woman gets reach to get the service when the cancer is already at advanced stage which alters their usual life style. CC patient experienced new life definition after they have been diagnosed because the disease affects their psychology, social, spiritual, financial and their health condition. Sadness, anxiety, depression, fear of social stigmatization and recurrences of the disease plus the challenging experience to cover the costs for their medical bills and everyday transport cost was the major finding of the study. However, getting psychosocial supports from their family members and the spirituality enable these women to cope up with their circumstances. Therefore, working integrally with multidisciplinary professional is vital to enhance the quality life of CC patient, policy maker should design effective strategies on screening and treatment programs to alleviate the problems, still further research's need on the area including the experiences of CC patient family plus create awareness to the wider community on the issues is the social work implication.

Key words: *cervical cancer, experience, psychosocial, financial and coping mechanisms.*

CHAPTER ONE: INTRODUCTION

1.1 Background of the Study

Cervical cancer is a non-communicable disease and it is the fourth most common cancer among women worldwide, with both incidence 6.6% and mortality 7.5% (The International Agency[i] for Research on Cancer, 2018). Cervical cancer is the most common women cancer and the prevalence is high in low socioeconomic countries (GLOBOCAN, 2012). Eighty-three percent of new cases and eighty-five percent of related deaths occur in resource poor countries (Addis, 2010).

According to WHO (2006), over 90% of which were recorded in developing countries particularly in sub-Saharan Africa, 72,000 new cases were recorded in the same year and 56,000 women die. Next to Southern Africa, East Africa the prevalence of CC is the 2nd very high from the region which is 40.1 and 30.0 per 100,000 incidence and mortality respectively (GLOBOCAN, 2018).

Cervical cancer is the second most common female cancer in women aged 15 to 44 years in Ethiopia and it estimates 6294 new cases and 4884 death record in Ethiopia (Bruni et al., 2018). Thus there are nearly 26 million Ethiopian women who are over the age of 15 and believed to be at risk of getting Human Papilloma Virus (HPV) which is the causative agent of cervical cancer (Bruni et al., 2018).

Human papilloma virus (HPV) which is sexually transmitted disease is the leading factor for the causes of cervical cancer which encounters 90%. And other factors like multiple sexual partners, sexual intercourse at an early age, smoking, and use of birth control pills and history of sexually transmitted infection are co-factors (Kowalski & Brown, 1994; Chaves, McMullin, Mishra & Hubbell, 2001).

Despite the fact of screening decreases the incidences and death due to cervical cancer by detecting early either screening for cervical cytology (Pap smear) or human papillomavirus (HPV), there was yearly increment of cervical cancer patient new case registry with in study years among these cervical cancer patients, the most exposed age group were between 40-49 years old women (Abate, 2015; Memirie et al., 2018).

Cancer occurs when cervical cell become abnormal and over time, grow out of control (American Cancer Society (ACS), 2016). Cervical cancer is treatable and believed to be curable if it is detected early however the variety of factors which militate against women accessing screening. Associated factors that include usually in combination: socioeconomic disadvantage; physical, intellectual or psychiatric disability; history of sexual abuse; family dysfunction; or simply being born in a country where there is no routine screening (Hobbs, 2008).

The three option are used to treat CC: (1) radical hysterectomy with bilateral pelvic lymph node dissection (surgery) if less than stage IIA, (2) surgery with adjuvant radiation or chemotherapy if less than stage IIA with risk factors for recurrence, or (3) chemo radiation or radiation alone if medically inoperable and for patients greater than 65 years of age (Pfaendler et al., 2016).

Study conducts in Sydney shows that the distress at the diagnosis of cancer and the immediate questions concerning threat to survival may be compounded by worries about future reproductive ability, sexual function and body image, as well as a generalized distrust of health care providers. CC's ongoing problems with anxiety, depression and relationship difficulties are often reported, as are persistent difficulties with sexual function (Hobbs, 2008). In general, lack of access to quality of service, poor performance status at diagnosis and the morbidity associated with several weeks of chemo-radiation, psychological factors, socioeconomic impoverishment combined to make the treatment course a difficult process.

Study conducted on the impact of cervical cancer on quality of life of women in Hubei China, patients who had undergone radiotherapy and chemotherapy had experienced more symptoms like fatigue, nausea and vomiting, pain, appetite loss, constipation, diarrhea and financial difficulty than those who underwent surgery only. Psychological factors were highly correlated with subjectively reported physical complaints (CULL et al., 1993). Additionally, there is frequently generalized anxiety and worry associated with fear of recurrence, or development of a new cancer (Hobbs, 2008).

The fact that the high prevalence and incidences of CC globally and sub-Saharan Africa particularly debilitating women lives. It affects the psychosocial, economic and spirituality of a woman that forced her to experience new life style after affected by the disease.

Therefore, the paper explored the lived experiences and coping mechanisms of cervical cancer patients: A phenomenological study in the case of Black Lion Hospital in oncology and radiology department. Qualitative methodology was the enquiry of the study to have depth knowledge and to understand multifaceted experience of the study participant. The study participants selected purposively and non-probable sampling was the sampling techniques of data collection. In depth interview, key informant interview and observation and document review used as a methods of tool.

1.2 Statement of the Problem

The dramatic increment of the burden of non-communicable disease in developing countries is significantly increased. Cervical cancer ranks fourth and the incidence is 569,847 and mortality is 311,365 globally (GLOBOCAN, 2018). According to FMOH, based on the national cancer control data 2015, the most prevalent cancers and the causes of woman death in Ethiopia among the adult population next to breast cancer (30.2%) is cancer of the cervix (13.4%). The prevalence of CC in Ethiopia, the incidence is 18 per 100,000 individuals and 14 per 100,000 of mortality (Woldeamanuel et al., 2013). According to Addis (2010). records show that of the nearly 22 million Ethiopian women over the age of 15, approximately 7,600 are diagnosed with cervical cancer and roughly 6,000 women die of the disease each year.

The risk factors for cancer are also profoundly associated with the socio-economic status. The incidence and prevalence are higher for populations with low-socio-economic-status populations than in wealthier social settings because of limited access to health service, either no existence of cervical cancer screening or reaches only few women who need the service (WHO, 2012). Cervical Cancer (CC) increase in incidence started with 40- to 44 year olds and peaked for 60- to 64-year-olds (Memirie et al., 2018). The trends of CC in Ethiopia between 1997 up to 2012 proportion of women diagnosed at advanced stages of cervical cancer was higher than those diagnosed at an earlier stage (Abate, 2015).

Cervical cancer is preventable and curable if it detected early. One time screening prevent women by 25% of getting cervical cancer for five years because the disease growing slowly to change to cancerous lesion (Addis, 2010). However cervical cancer related deaths are among women that have never been screening in addition women seek consultation only when the disease is already at an advanced stage. More than 90% of women report that they have never had a pelvic exam and the proportion is largest in Malawi, Ethiopia and Bangladesh (Rozek, 2018). Only 2.9% of ever having undergone a screening test for cervical cancer screening rate in Ethiopia (Gelibo et al., 2017). Accurate data on cervical cancer morbidity and mortality are scarce and generally based on hospital data and estimates and also scarce or generate poor-quality data (WHO, 2012).

In fact, the diagnosis of cancer of any type has a potential to be catastrophic and is life altering event. Even for long-term survivors, significant numbers report considerable distress associated with the fear of recurrence and adjustment to a new self-concept (Hobbs, 2008). A study in Australia, women may experience a unique emotional and psychological burden for main reasons: CC is largely a preventable cancer with effective screening test and it is readily available; and it is associated with a sexually transmitted virus so raising guilt and blame, at least in the minds of many women. Moreover, more than one-third carried the additional burden of believing themselves responsible for the onset of their disease (Cull et al., 1993).

Cervical cancer affects the quality life of the individuals and has a high risk of developing psychological, social, physical, financial and cognitive dysfunction. The treatment side effects symptoms like fatigue, nausea/ vomiting and pain during treatment also their other experience. Loss of fertility, sexual dysfunction and lower limb lymphedema, these women may have to contend with the additional burdens of menopausal symptoms and vaginal stenosis, both of which may make more difficult their sexual rehabilitation and resumption of a normal lifestyle (Hobbs, 2008).

For many women, the psychosocial distress evident at the time of the cancer diagnosis, relates to more than just the cancer itself. Anxiety and fear of death as the first and most recurrent challenge they faced (Ngutu &, Nyamongo 2015). Interpersonal relations of patients with the family, coworkers, friends, and religious groups and significant others were affected after the diagnosis with cervical cancer. Some couldn’t visit their relatives or friends like before (Konjit, 2014).

The majority of participants reported having only one income earner to support an entire family of 4.89 individuals on average. These factors tie in to the enormity of the economical challenge placed on cancer patients and their families (Sara, 2015). A study which conducted in Kenya indicates being a referral hospital, some cervical cancer patients come from far and often are accompanied by their family members due to their health condition, the transport and accommodation costs become an added expense on their already constrained budgets.

Cervical cancer patient experiences use different coping mechanism to survive. Information seeking is a more common coping mechanism in the early stages of the disease, when the diagnosis is new and the patient is dealing with a variety of new healthcare professionals (Nail, 2001). According to Lindau et al (2015) denial is a protective mechanism from this tremendous threat and it is a common initial reaction to the overwhelming threat however it allows patients to remain more focused on the decision making.

Low knowledge and wrong attitude of women were challengeable issues in cervical cancer prevention programs (Konjit, 2014). Patients from a rural area or with lower economic status or illiterate people might be unaware of cervical cancer. So, these individuals may usually reach the hospital with the late stage of cancer, which leads to poor treatment outcome and consequently a reduced quality of life (Thapa et al., 2018).

Studies conducted on the area of The Psychosocial Experiences and the Needs of Women Patients Diagnosed with Cervical Cancer at Black Lion Hospital (Konjit, 2014). However, studies conducted to understand the lived experiences of women suffering from cervical cancer is dearth and very little. Though, the data indicated the problem confirms that is growing from time to time, calls the attention of researchers to carry out an in depth inquiry to further realize the magnitude of the problem. Thus the main purpose of the research is to explore lived experiences and coping mechanism of cervical cancer patients after receiving a series of treatments. It also provides additional knowledge on the extent to which the problem is overgrowing and set certain reliable information on the possible means of way forwards.

1.3 Research Objectives

1.3.1 General Research Objectives

- To explore cervical cancer patients lived experiences and coping mechanisms after they have been diagnosed in the case of Black Lion hospital.

1.3.2 Specific Objectives

- To investigate the psychosocial factors of cervical cancer at Black Lion.
- To explore the health factors of cervical cancer patient at Black Lion.
- To investigate the financial challenges of cervical cancer at Black Lion
- To explore the coping mechanisms of cervical cancer patient.

Specific Question

- What is the psychosocial factor of cervical cancer at Black Lion?
- What is the health factor of cervical cancer patient at Black Lion?
- What is the financial challenge of cervical cancer at Black Lion?
- What is the coping mechanism of cervical cancer patient?

1.4 Significance of the Study

Approximately 570 000 women developed cervical cancer and 311 000 women died from it, approximately 84% of all cervical cancers and 88% of all deaths caused by cervical cancer occurred in lower-resource countries (Ferlay & Bray, 2018). According to WHO, over 90% of which were recorded in developing countries particularly in sub-Saharan Africa, 72,000 new cases were recorded and 56,000 women die in the same year. Technically speaking the prevalence is high in low socioeconomic country than wealthier society

Therefore, the assessment insight and explore their holistic lived experiences and coping mechanism of cervical cancer patient after series treatments and to provide data for improvement of their quality of life. The study creates opportunities for social workers how to deal with the bio psychosocial and spiritual experience of cervical cancer patient and how to maintain the patient quality of life as before. Moreover, for social work academicians who peruse to study is used as secondary source of data on the area.

The study finding is significant to Black Lion Hospital to address the problem from the finding especially towards to health professional knowledge, service provision and care, working integrally with multidiscipline team to promote quality life of the service users.

Furthermore, helps policy makers to concentrate on the serious health problems of a community to identify solution for improving the health of the community. Thus, the data forward possible solution for policy makers due pay more attention to focus on the improvement of the quality life of cervical cancer patient by designing and implementing various approach towards in improving care and treatment service, accessibility and availability plus focusing on quality of service.

1.5 Definition of Terms

Cancer: Cancer occurs when cervical cell become abnormal and over time, grow out of control (American Cancer Society (ACS), 2016).

Cervical Cancer: is a disease in which malignant (cancer) cells form in the cervix (Physician Data Query (PDQ), 2016).

Experience: is the result, the sign and the reward of interaction between organism and environment which, when it is carried to the full, is a transformation of interaction into participation and communication are coupled with human phenomena like emotional, cognitive, sensual, cultural, physical, etc. (Dewey, 2005). Transactions in and across space and time within irreducible person-in-setting units; and it is perfused with affect that is not (only) the result of mental constructions (Roth & Jornet, 2014).

Psychosocial: Oxford concise dictionary (1997), define psychosocial as all those psychological and social factors as well as all human interactive behavior.

Coping Mechanism: A capacity to cope or responds to and to recover from something stressful (WHO/ EHA, 1998).

CHAPTER TWO

2. REVIEW OF THE LITERATURE

2.1. Overview

According to GLOBOCAN (2008), Africa has four and a half times the incidence of cervical cancer compared with the USA and just over ten times the mortality despite the fact that almost every case is preventable through a program of screening, treatment and vaccination.

Low- and middle-income countries the incidence rates are highest especially in sub-Saharan Africa. Nearly 90% of cervical cancer deaths occurred in developing parts of the world: 60,100 deaths in Africa, 28,600 in Latin America and the Caribbean, and 144,400 in Asia (GLOBOCAN, 2012). According to FMOH (2015), the national cancer control data indicated the most prevalent cancers in Ethiopia among the adult population are breast cancer (30.2%), cancer of the cervix (13.4%) and colorectal cancer (5.7%) accordingly. Cervical cancer is the 2th most common female cancer in women aged 15 to 44 years in Ethiopia that 7,600 are diagnosed with cervical cancer and roughly 6,000 women die of the disease each year (Memirie et al., 2018).

2.2. History of cervical cancer

Cancer starts when cell in the body begin to grow out of control. Cells nearly any part of the body can become cancer and can spread to other area of the body (ACS, 2016). Cervical cancer is a cancer which affects the cervix or the lower part of the womb (uterus). Studies show that most CC begins in the cell in the transformation zone so that it doesn’t change to cancer suddenly. Instead the normal cells of the cervix gradually changed to cancer.

> *According to ACS (2016), there are three types of cervical cancer: squamous cervical cancer which is the most common one and the cancers develop from cells in the exocervix, 9 people out of 10 will acquire squamous cervical cancer. The second cervical cancer is adenocarcinomas which is cancer that developed from gland more common the past 20 years. The third one is mixed or adenosquamous carcinoma and it is rare and has low prevalence.*

2.3. Ethological Factors of cervical cancer

Ethological factors mean a causative agent to cervical cancer disease which increases the risks of the cervical cancer. Multifactorial etiology of cervical cancer are the causative factors of cervical cancer like HPV, HIV/AIDS, smoking, using birth control pills for a long time (five or more years), having given birth to three or more children etc.

2.3.1. Behavioral Factors/ Multiple Sexual Partners

HPV is a major causative agent has a direct association to increase the risk of CC which is more than 90%. HPV is sexually transmitted virus related to having multiple partners, no use of condom and has direct association with a history of STI increase the risks of HPV and CC. A country where a high prevalence of HIV/AIDS, the problem will be double because of HPV and HIV has a co-infection. Women living with HIV are more readily infected with certain types of HPV, more likely to develop precancerous lesions, and more vulnerable to rapid development of these lesions than HIV-negative women (Addis, 2010).

According to ACS 2016, Women who were younger than 17 years when they had their first full-term pregnancy are almost 2 times more likely to get cervical cancer later in life than women who waited to get pregnant until they were 25 years or older.

2.3.2. High Parity

A woman with high parity or having more children is getting at risk of CC. In Ethiopian case girls at younger age become childbearing/ teenage mother due to early marriage (which is most common cultural practice in most rural settings). According to EDHS 2016, fertility is notably higher among rural women than urban women. 13% of women age 15-19 in Ethiopia have begun childbearing and teenage childbearing is more common in rural than in urban areas 5.2 versus 2.3 children per woman respectively.

> *ACS studies indicated "Women who have had 3 or more full-term pregnancies have an increased risk of developing cervical cancer. Also, studies have pointed to hormonal changes during pregnancy as possibly making women more susceptible to HPV infection or cancer growth. Another thought is that pregnant women might have weaker immune systems, allowing for HPV infection and cancer growth.*

2.3.3. Age

CC increase with age increase. Cervical cancer is rare in women under 30 years of age and most common in women over 40 years, with the greatest number of deaths usually occurring in women in their 50s and 60s (WHO, 2012).

In contrast to being high parity, women use hormonal contraceptives to avoid unwanted or unplanned pregnancy. However, this long term contraceptive is a risk for getting CC.

2.4. Associated factors

In general, factors like economic, environmental, behavioral and social factors have significant association towards to the burden of cervical cancer especially in developing countries with low resources country. Only 2.9% of ever having undergone a screening test for cervical cancer due to socio demographic and economic condition of the women are the contributing factors to low CC screening rate in Ethiopia (Gelibo et al., 2017). The access to tertiary cervices and shortage of oncologist are challenges in our health system.

2.4.1. Lack of Access to Cervical Cancer Screening Service

Economically low country like Ethiopia, the prevalence of CC would be very high compared with high economic country because of low investments of infrastructure, training and laboratory capacity etc. to address the issue of CC. WHO recommended that HPV vaccination is one of the most prevention methods of CC at the age of 9 to 13 years old girls however due to the expensiveness of the vaccine make it inaccessible. Vaccination. The vaccine is given to young girls between the ages of 9-13 and a secondary target group which are referred to as the "catch up population (Tadesse, 2015).

The limitation of service provision is significant issues. Even in the capital city of (Addis Ababa) CC screening provision centers are very limited and in only few public centers and private sectors where providing the service. Cervical Cancer Screening and treatment providing Health Centers and Hospitals in Addis Ababa city are around 23 Health facilities (Bedassa, 2017).

The health care system is unequally dense, with rural states being underserved compared to their urban counterparts. According to Gelibo et al (2017). women in urban areas (6.9%) were more likely to have undergone cervical cancer screening than the rural (0.9%) women population.

In general, women living outside province center must travel long and costly distances to receive advanced diagnostic and treatment care (Teame et al., 2018). Poor knowledge and coverage of CC screening and vaccine to prevent CC among care providers connected to lack of training, time constraints, lack of laboratory resources and equipment and supplies and low prioritization are the barrier factors for cervical cancer screening (Roza, 2017).

Moreover, Hepatitis B and HPV vaccination are eradicating 70% of the disease which saves the life of 200,000 women in a year so that most developed country reducing the disease by fourth compared to developing country. Unfortunately, the expense of the vaccine is 320 USD per girl which is beyond the health budget of all African country (Regional committee for Africa, 2010). Vaccination: Though HPV vaccine was approved in 49 countries in 2006, the high cost of the vaccine has made the availability in many developing countries impossible. The vaccine requires three doses to be fully effective and it costs up to 300-500 USD to get the full dose (Tadesse, 2015).

2.4.2. Health Seeking Behavior

More than 90% of women report that they have never had a pelvic exam and the proportion is largest in Malawi, Ethiopia and Bangladesh (Rozek, 2018). Though socio-cultural factors play an important and crucial role in influencing the health seeking behavior of women, that affects the health seeking tendency of women (Sara, 2015).

Culture influences: how health, illness and disability are perceived; attitudes toward health care providers, facilities, and how health information is communicated; help seeking behaviors; preferences for traditional versus non-traditional approaches to health care; and, perceptions regarding the role of family in health care (Denboba et al., 1998).

Participants commonly believed that a woman only got cervical cancer by the will of God as a punishment, which they mention it as “Yegziabher Kuta” (Gebru et al., 2016). Cultural beliefs have reduced Pap smear uptake and hampered health- seeking for cervical cancer (Daher, 2012). Some of the women also raised the potential for feelings of shame, if diagnosed with cervical cancer, as a barrier to screening for others in their community (Gebru et al., 2016).

2.4.3. Insufficiency or lack of information and skills:

The main factor for the high prevalence of cervical cancer in low socioeconomic countries is due to lack of information of women and care providers towards the cancer prevention and management. As a result, many women don’t know about the disease and the mode of transmission that many are at risk of getting cervical cancer in association with it.

A study which was conducted in St. Paul, Black Lion and Gandhi Memorial Hospitals on care providers (nurse and midwifery) shows that only 36% were able to correctly identify all major risk factors of cervical cancer (Kress et al., 2015).

Knowledge and skills of the health professionals are also seen as one of the barriers for the creation of public awareness. In the educational curriculum the cervical cancer screening is not included most of the health workers didn’t know how cervical cancer screening procedures were done (Roza et al., 2017, p. 99).

Cervical cancer awareness of etiology and risk factors was low among nurses and midwives. Providers had no experience performing cervical cancer screening on a routine basis with <40% having performed any type of cervical cancer screening. Barriers to performing screening were lack of training 52% and resources 53% (Kress et al. 2015). Only 22% of health care providers reported having performed a pap smear. Of those who reported having performed a pap smear, only 28% had done more than ten. Even fewer health care providers (11%) reported experience with VIA and of those, 29% had performed it more than ten times (Kress et al., 2015).

Furthermore, Hailemariam, (2017) which is done in Yirgalem hospital indicated that the health workers have lack of knowledge on cervical cancer and screening program so does the service users woman. However, women seeking consultation when the disease is at severe and late stage and at this point it is difficult to get the woman health back as before.

2.4.4. Lack of Effective Screening and Treatment Policy, Strategies and Programs

Largely explains the high cervical cancer prevalence and mortality in countries with no access to quality prevention and detection services. Furthermore, poor coordination b/n primary health facility and tertiary health facility worsen the situation because after she get and screening positive for HPV, a woman need further treatment and follow up at tertiary health facility for precancerous stage or before it become stage 4 cancer. However, due to the burden of service users and other factors at tertiary level, woman will wait long period of time which discouraging her and to have poor seeking health behaviors.

There are no policies that encourage the provision of cervical cancer screening. Our policies mainly focus on non-communicable diseases promotion, prevention and control. “Those politicians that assign budget have concern on acute disease not chronic disease that affect long time (Roza et al., 2017).

According to WHO (2012), no matter what resource constraints a country faces, a well-conceived, well- managed national cancer policy culminating in a NCCP is the best way to achieve reduction of morbidity and mortality from cancer and improve the quality of life of cancer patients and their families. Lew et al (2017), stated after implementation of the National Cervical Screening Program in 1991, incidence of cervical cancer declined by 36%, and mortality by 44%, by the mid-2000s since then, incidence and mortality in Australia seem to have stabilized.

2.5. Intervention Plan

The burden of disease increase dramatically unless the problem is intervened and controlled, many women on reproductive age group will lost their life. The solution will be enhancing the general awareness about cervical cancer towards the mode of disease and prevention, and the improvement and getting equal access of existing health care services, providing more training skills to the health workers to improve fill their knowledge gap, effective screening programs and promote the introduction of HPV vaccination introduction effectively can reduce the burden of cervical cancer for women and for the health care system. World health organization recommended using VIA screening for resources low country. VIA is easy procedures and only give training to the health workers thus it addresses large number of women because it can be applicable to urban and rural settings (WHO, 2012).

Cervical cancer prevention strategies in low-resource settings are most successful and cost-effective when they require few visits and offer a “screen and treat” (single-visit) approach (Addis, 2010). Single- visit prevention strategy can reduce woman life time risk by 25% and it requires only low-cost and widely available equipment, can be performed by non-physicians, and does not require complex laboratory infrastructure (Addis, 2010).

According to ACS, all women should begin cervical cancer testing (screening) at age 21. Women aged 21 to 29, should have a Pap test every 3 years. HPV testing should not be used for screening in this age group (it may be used as a part of follow-up for an abnormal Pap test). And beginning at age 30, the preferred way to screen is with a Pap test combined with an HPV test every 5 years. This is called co-testing and should continue until age 65.

2.6. Cervical Cancer Staging

Staging helps to decide and determine the treatment of cancer and the clinical stage is based on the doctor physical exam, biopsies, imaging test and other test like cystoscopy and proctoscopy. According to the FIGO (International Federation of Gynecology and Obstetrics) divide the staging into four.

Stage I: system cancer cells have grown from the surface of the cervix into deeper tissues of the cervix and it may also be growing into the body of the uterus, but it has not grown outside the uterus. It might or might not have spread to nearby lymph node and has not spread to distant sites. Stage I is divided into Stage IA and IB based on the amount of cancer that is found.

Sage II: The cancer has grown beyond the cervix and uterus, but hasn't spread to the walls of the pelvis or the lower part of the vagina. It might or might not have not spread to nearby lymph nodes and not spread to distant sites.

Stage III: The cancer has spread to the lower part of the vagina or the walls of the pelvis and may be blocking the ureters (tubes that carry urine from the kidneys to the bladder). It might or might not have spread to the nearby lymph node and distant site. It might or might not have not spread to nearby lymph nodes.

Stage IV

The cancer has spread to the bladder or rectum or it is growing out of the pelvis. The cancer has spread to distant organs beyond the pelvic area, such as distant lymph nodes, lungs, bones or liver. It might or might not have spread to nearby lymph node.

2.7. Treatment and Management of Cervical Cancer

The treatment of cervical cancer is depending on the stage of the disease. According to radiology cancer society, divided the treatment procedures accordingly.

Surgery: For Stage 0 or precancerous disease, patients typically undergo one of the following procedures either Cryosurgery (killing the abnormal cells), Laser Surgery (used to burn off the abnormal cervical cells) or LEEP (loop electrosurgical excision procedure)/ Conization (an electric current removes cells and a thin layer of tissue in the lower genital tract) which allow women to become pregnant in the future:

When the disease is in an advanced stage different procedures are used to eliminate the cancer distribution or abnormal growth of the cell such as:

Hysterectomy: is one method which is removing the cervix and uterus of the body. And if it is radical hysterectomy in addition to that it includes also the upper part of the vagina and some ligaments and tissue near the uterus. Pelvic lymph nodes are often removed as well.

Radiation Therapy: It is using high voltage of X-ray and the purpose is to kill abnormal growth number of cell the cancer. Often use together or in combination with surgery.

Chemotherapy: treatment involves the use of drugs given intravenously (by vein) or orally to kill cancer cells or to keep them from dividing and multiplying. Chemotherapy is typically used as a supplemental treatment in combination with radiation to decrease the chance of the disease returning elsewhere in the body.

2.8. Impacts of Cervical Cancer

Cancer affects the whole different dimension of individual life like the psychology, physical, social, and spiritual aspects. Research clearly indicates that cancer enters the emotional, social, physical, and spiritual well-being of patients and their family members (Northouse, 2005)

2.8.1. Psychological Factors

Whatever the type of cancer, people are faced with ongoing uncertainty about their future as they deal with the potential for an unpredictable course (Dankert et al., 2003). Studies which conducted in different countries shows psychosocial impacts are the common experience of the patient. 94% of women with depression and 78% of women with anxiety reported fatigue (Krista et al. 2015). Especially the first time of knowing their status which is life threaten situation.

Diagnosis the first time of cervical cancer makes woman emotionally unstable and vulnerable because many women beliefs that cancer is untreatable and no cure which associated with low knowledge about the disease. Study conducted in China reports that less education had been associated with limited knowledge about health issues and poor health.

Furthermore, most women blame themselves because it is commonly caused by sexually transmitted infection like HPV and not taking CC screening and preventing the disease on time. More than one-third carried the additional burden of believing themselves responsible for the onset of their disease (Cull et al, 1993).

2.8.2. Social Factors

Walking the illness journey with a loved one can contribute too many reactions, including feelings of loss of control, disrupted family organization, and altered relationships (Shell & Kirsch, 2001). Family members with similar values may inadvertently promote the same delaying behaviors that the patient is using including lack of knowledge about symptoms also may cause a delay (Linda et al., 2003).

According to Lindau et al (2015), Disruptions in schedules and taking on new roles of caregiving, meal preparation, and other family duties may put a strain on some family members. Role changes can contribute to communication problems if one is not sure of the usual routines or schedules. Social supports are necessary for the individual to maintain her development and wellbeing and a mechanism one can to rely on other. Social support is the number of social contacts maintained by a person or cohesiveness of a social network (Kaplan et al., 1993).

Often patient faces either isolation or undesired increases in social contact at their home because the support can be too much or too little as a result fail to meet the patient needs (Monesa, 2003). According to Monesa, too little support patients may experience incorrect support because the family tends to misconceive their needs and priority. On the other hand, crowding causes tension and prevents people from experiencing needed state of privacy.

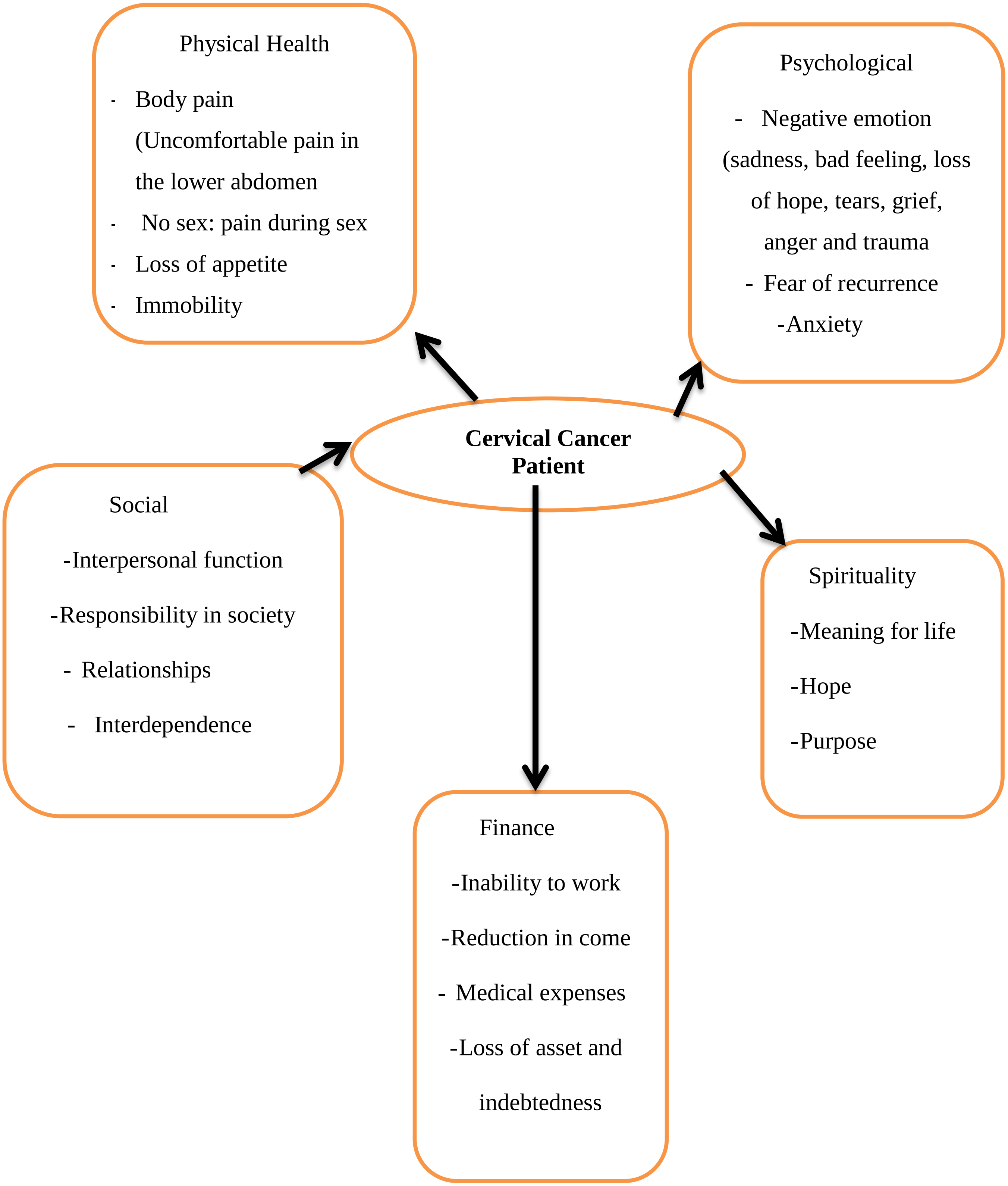
2.8.3. Physical Impacts

Bladder dysfunction and other urologic complications with both surgical treatment and radiation therapy, and particularly when both modalities are utilized, there are risks of long term squeal to the urinary system that can significantly impact quality of life. It is estimated that approximately 20% of cervical cancer survivors have long term bladder dysfunction (Pfaendler et al. 2015).

2.8.4. Financial Factors

Chronic disease like cervical cancer has a huge impact on the individual finances because first of all the expensiveness of the treatment and management procedure. Secondly, the physical dysfunction of the women due to the disease and side effects of the treatment, most of the women become unemployed. McGuire, Bikson & Blue-Howells (2005), measured patient's psychosocial needs such as financial assistance, housing, and counseling. Almost two-thirds of patients reported experiencing psychosocial barriers. Sixty-three percent reported financial problems, and 62% reported personal stress. More than one third (38%) of the patients had problems such as unemployment, poor transportation, and relationship issues. About quarter of the patients were homeless (28%) or needed home health care (21%). Only 15% of those surveyed reported experiencing no psychosocial barriers to following primary care recommendations, and most of the patients (74%) had more than one social problem.

2.9. Conceptual Framework



CHAPTER THREE: RESEARCH METHODOLOGY

This section describes the philosophical view, research design, the study area, sampling techniques and participant selection procedure, the data collection tools, data collection procedure, trust worthiness of the study, ethical considerations, data analysis and limitations of the study.

3.1 Philosophical View

Philosophical world view stands either positivists (post positivist), constructivist, transformative or pragmatist. The study used constructivist philosophical world view to understand the subjective and varied individual view of the situation. Creswell 2014, constructivist philosophical view individuals understanding the world develop subjective meaning, varied and leading the researcher to look for the complexity of views rather than narrating meaning into few categories. The researcher/reader tries to absorb or get inside the viewpoint it presents as a whole and then develop a deep understanding of how its parts relate to the whole (Kreuger & Neuman, 2006).

3.2 Research Design

Research design is the heart of research that it precisely and clearly defines the research objectives. Research design stated based on their dimension: the purpose of the research, the time dimension, and techniques.

The purpose of the study is to explore the experiences and coping mechanisms of cervical cancer patients. Exploratory research designed to explore in depth experiences and explain the phenomena of cervical cancer patients. Exploratory researchers are creative, open minded, and flexible; adopt an investigative stance; become familiar with the basic facts, setting, and concerns and explore all sources of information and create a general mental picture of conditions (kreuger and Neuman, 2006).

Time dimension of the study, according to Krueger and Neumann (2006), research gives a snapshot of a single fixed time or a moving picture of events over a period of time. Cross sectional time dimension was used for the research where cervical cancer woman is interviewed at single point in time.

Data collection tools: Qualitative data collection is used to address multifaceted factors of the issue. Qualitative research study holistically used to identify many factors which use multiple perspectives and many factors involved in a situation (Creswell, 2014, p.196). In addition, according to Creswell (2014), qualitative research is an approach for exploring and understanding the meaning individuals or groups ascribe to a social or human problem.

The phenomenological inquiry approach was used as a part to uncover the lived experience and coping mechanisms of cervical cancer patient at Black Lion hospital. Phenomenology design according to Somekh & Lewin (2005) can be directly researched by exploring human knowing, through accessing consciousness, and indirectly by investigating human being, through accessing the senses and shared background meanings and practices. The study used hermeneutic phenomenology (interpretive) that allow interpreted the meaning found in relation to the phenomena. The use of language and the interpretation of a person's 'meaning-making', their attribution of meaning to phenomena, is central to Heidegger Ian phenomenology (Smith et al., 2009). Hermeneutic phenomenology prefers not to formalize an analytical method so that the context of the phenomenon itself can dictate how the data are analyzed (Langdridge

2007). Thus phenomenology inquiry uses to explore the lived experiences and coping mechanisms of cervical cancer patient at Black Lion hospital. Hence the finding of this study will serve as primary resource for interested group.

3.3 Study Area

The study was conducted in Black Lion specialized hospital which is located in Addis Ababa, the capital city of Ethiopia. Black Lion Specialized Hospital serves as the main government hospital in Ethiopia and accepts referrals from all over the nation. It was selected as the study site because it is the only central referral hospital in Ethiopia that has an oncology ward and that provides radiation therapy and chemotherapy treatments for cancer patients. The study was specifically carried out in the gynecology and radiotherapy departments of the hospital. The oncology ward which has been serving as the main center for cancer patients was established in 1997.

The gynecology department deals with evaluation and surgical treatment, while the radiotherapy department exclusively deals with providing chemotherapy, radiotherapy and palliative care for cancer patients.

3.4 Sampling Technique and Participants Selection Procedure

The target population of the study was cervical cancer patients who enrolled at Black Lion Hospital and already start their treatment either chemotherapy with radiotherapy together or radiotherapy alone. Regarding with the stages of cancer all the women enrolled in the study were on stage 2 and above because other studies indicated that woman with higher stage of cancer experienced more challenges than woman at early stage of cancer. The sample size of the participant was totally 14 which consisted 11 from service user and 3 from service provider.

After the participants had shared the same experiences, the study reaches the saturated information so to save time and resources only 11 participants enrolled in the study. The key informants were from Oncology department coordinator and Stuff nurse, and from head of Radiology departments. These individuals selected purposively based on their position, educational levels and closer contacts to service users, they were keys to the study.

Participants of the study were selected. Non probable purposive sampling technique was employed sampling technique. Thus purposive data sampling was used as technique for the study. Purposive sampling aim is addressing the situation of cervical cancer patient who get the service in Gynecology and Radiology department so that the participants selected purposively for the study. Purposive sampling enables the full scope of issues to be explored (Cohen, Manion, & Morrison, 2005).

Purposive sampling is known that produce well matched groups and the idea is to pick out the sample in relation to some criterion which is considered important for the particular study (Singh, 2006). Purposive sampling occurs when a researcher wants to identify particular types of cases for in-depth investigation (Kreuger and Neuman, 2006). Therefore, the scope of the study was to answer the research questions and meet the objectives stated in the previous sections

Inclusive Criteria: to select the study participants:

- Women who were willing to participate in the study.
- Women who start the treatment therapy, onstage 2 and above.
- Able to communicate and well-coordinated (not chronically ill).
- And age greater than 18 years.

3.5 Data Collection Tools

Primary and secondary data sources were employed for the study. Three data collection tools: in-depth interview, key informant interview, observation and document review were the main sources of data pertinent to the study.

3.5.1 In-depth interview

In-depth interview was employed as a primary data collection which gives the participants the opportunity to express them and to discuss their opinion. In-depth interview aims to explore the contextual boundaries of that experience or perception, to uncover what is usually hidden from ordinary view or reflection or to penetrate to more reflective understandings about the nature of that experience (Johnson, 2002). In-depth interview encourages mutual self-disclosure in the context of an emotionally charged atmosphere where freely express their views about an issue (Douglas, 1985).

For the purpose of meeting such advantage, unstructured in depth interview questionnaire was employed with the participants of the study. Unstructured interview is an open situation, having greater flexibility and freedom to express the subjective feelings as fully and as spontaneously is able (Cohen et al. 2005). It is an approach especially to be recommended when complex attitudes are involved and when one's knowledge of them is still in a vague and unstructured form (Moser & Kalton, 1977).

11 cervical cancer patients from stage two and above were participated during the in-depth interview. Unstructured in-depth interview prescribed for the informants and were documented through tape recording with analytic memos was also used to record personal reflections or comments about the data. However, there was need arise for study participants

where tape recording is found to be convenient except for one participant so note taking was used to document the information from her. But to rest participants, tape recording was convenient

3.5.2 Key Informant Interview

Key informant interview was employed in the study to incorporate expertise on the area. Key informant interview is use to provide information from knowledgeable people and it is the opportunity to explore unanticipated ideas (Podrabsky, 2006). Using key informant checklist, three key informants participated during the study, radiology and two oncologist's professionals who are expert on the area

3.5.3 Observation

Observation was carried out to explore the participant experience of the situation plus in order to increase the trustworthiness of the data. Observation is on understanding the natural environment as lived by participants, without altering or manipulating it (Gay, 2012). Observation enables the researchers to have full meaning of interview responses through watching attentively the body language, gestures and facial expression of the respondents (Denzin, 2003).

Observing the respondent's facial expression, action and gesture during the discussions was cardinal. Thus, for the purpose of achieving the above-mentioned advantages, observation during interviews and take notes from the observation on the spot conducted.

3.5.4 Document Review

The study also incorporated secondary data from other sources of information from medical report, progress report, and guideline, documented stories of the clients, evaluation report, research studies and other available secondary data. In this case the study incorporated document review from oncology and Radiotherapy department registration, and follow up/ Tracking record registration and from the patient card of the participants such as age, marital status, stage of cancer, service payment status, number of gravida and past history etc. Document review supplemented and supported the primary data to know the depth of the situation and to fill the gaps that the study couldn't address during the primary data collection tools.

3.6 Data Collection Procedures

Base on the supporting letter obtained from Addis Ababa University to precede the study as an academic requirement purpose, the initial collaboration/ permission requested from Black Lion hospital research center coordinator for the intended study. Once the agreement was made, a research proposal was submitted to the head of oncology department for a reviewing and then assigning supportive staff from the ward prior to any further steps commences the research.

Selecting the potential respondents purposively until it was saturated possible was obtained eleven willing service user participants. Once the participants identified, they introduced and given explanations about the purpose and importance of the research and also their role in the research that enables them to make their own choice/ willingness to participate in the study. The information includes: the purpose of the study, procedure, discomforts as well as confidentiality and related ethical issues. Then written consent forms translated into Amharic and signed by each participant. After that the appointments settled with each participant in such a way that it was suitable for both the participants and the researcher’s intention of finishing data collection on time. The in depth interview guide took 30 minute for each of the participants from March 2- March 22, 2019. Usually the data collection took place in the morning because the study participants appointed for their treatment were in the morning. The avenue of the data collections where arranged at Black Lion Hospital in a very quiet place enabled the participants to share their feeling, belief, thought and experience freely. The study use tape recording to capture all the answers based on the willingness of the study participants except one participant who refused to be recorded so hand writing was convenient to gather the data. Observation also take placed while capturing gesture and other expression right away.

After the data collection, Amharic language data was transcribed and translated to English. Then, analysis was conducted every day because the study used thematic content analysis techniques. The qualitative data was analyzed manually using codes. The codes were merged into categories and the themes were determined based on the combination of similar categories.

3.7 Trust Worthiness of the Study

Validity

In qualitative research, validity is the degree to which qualitative data accurately measure. Triangulation is one strategy to measure the data validity of the study data. Triangulation is multiple observers or researchers add alternative perspectives, backgrounds, and social characteristics and will reduce the limitations in addition combining data from a variety of observers is more likely to yield a more definitive picture of the setting (kreuger and Neuman, 2006). Triangulation is to see it as a way of adding complexity and depth to the data and analysis in this way, social phenomena are approached as multi-sited narratives, each narrator's account is worthy of analysis in its own right (Amir, 2004).

According to Gay 2012, two common terms used to describe validity in qualitative research are trustworthiness and understanding. Qualitative researchers can establish the trustworthiness of their research by addressing the credibility, transferability, dependability, and conformability of their studies and findings

Reliability

Reliability is the other dimension for measuring the quality of data. According to Amir 2004, reliability allows us to replicate research results over time and across different investigators or investigations. Reliability is the degree to which study data consistently measure whatever they measure (Gay, 2012). The study tried to be specific and consistent across different participants so that it assessed a cohort and complete in exploring all aspects of the study under investigate.

3.8 Ethical Considerations

As social work research, ethical consideration is an issue in undertaking the research. Thus, for ensuring ethical procedures, prior to selecting participants, the purpose and objective of the study was clearly discussed with the management of the organization, through which participants were accessed. In the process of selection of participants, the purpose of the research and the extent of confidentiality were discussed for potential participants to make sure that participants are well aware of what they are giving their willingness for. In line with that, after the participants were selected, a proper rapport was established with them in order to avoid discomfort of sharing personal matters. Before the beginning of the data collection, participants were informed that they have a right to withdraw from the study at any time without any explanation and that it has nothing to do with their benefits to which they are entitled.

Moreover, written consent attained to protecting respondents from participating involuntarily and approving their willingness. On the other hand, the confidentiality of the information from the respondents was ensured through anonymity, as the real names of the participants do not appear in the research document and pseudonyms were used in the analysis.

In addition, agreement for use of tapes to record data during interviews was made prior to setting the data collection time frame. All these ethical issues were made clear in the written consent form prepared for both participants and staff members who participated in the study. The venue and time for interviews were arranged in the hospital which gave the participants comfort.

3.9 Data Analysis

Data analysis in qualitative research consists of preparing and organizing the data (that is text data as in transcript or image data as photographs) for analysis, then reducing the data into themes through a process of coding and condensing the codes and finally representing the data in figures, table or a discussion (Creswell, 2007). In qualitative research the process of data analysis proceeds simultaneously with data analysis of the study was an ongoing process. The analysis process began with organizing note and transcription of audio records collected from in depth interview of study participants in Amharic language. Transcriptions of audio record were followed by compiling note taken in the interview session with transcribed audio record. The compiled transcript was translated to English and transcribed into written form by summarizing into categories and then into themes. Then, I read the data repeatedly and organized to get the meaning as well as the general idea of what the participants want to express. After thoroughly examining the data the necessary coding followed then organized the data into sub-themes. Later the codified themes were described in narratives form to convey the results of the analysis. Finally, meaning derived from the critical analysis of the primary data, the literature and conceptual framework.

3.10 Limitation of the Study

The study participants were cervical cancer patients whose stage was two and above because studies indicated that women experience challenge more when the degree of the stages of cancer increase hence study inclusively focus on those women that it excluded woman who was below stage two cancer plus the study also exclude their family members.

Moreover, the study inclusively uses qualitative study data that the study sample of the participants are not representative to make generalization. As a result, the purpose of the study is to give an insightful depth of the experiences and coping mechanisms of cervical cancer women.

CHAPTER FOUR: FINDING OF THE STUDY

The study used phenomenological study to explore the experience of the participant psychosocial, health and financial experiences and their coping mechanisms through in depth interview, key informant interview and observation.

Note that the study used pseudonym names for the purpose of confidentiality.

4.1. Socio demography of the participants

Table1: Participants by their socio Demographic characteristics

No	**Name**	**Age**	**Marital Status**	**Permanent Resident**	**No of childr**	**Religion**	**Educational status**	**Occupation**	**CC Stage**	**Charges of service**
1	Abebech	36	M	Bahirdar	3	Orthodox	Diploma	Cashier and secretory	2B	paid
2	Melkam	30	M	Wolayita	5	Protestant	2	Housewives	3A	paid
3	Aynalem	70	W	Jigjiga	6	Orthodox	Able to read and write	Trader	2B	paid
4	Tigist	57	W	Gojam	6	Orthodox	Able to read and write	Farmer	2B	Free
5	Hirut	34	M	Debrezeit	4	Orthodox	10	Housewives	3A	paid
6	Tesfanesh	47	M	Arsi	5	Orthodox	10	Depot	4A	Free
7	Rahewa	50	W	Metu	5	Muslim	9	Trading	4 A	paid
8	Alefech	55	D	Welo	8	Orthodox	Not able to write and read	Housewives	4	paid
9	Tarika	45	M	Gonder	5	Orthodox	Able to write and read	Farmer	4A	Paid
10	Berhan	30	M	A.A	1	Protestant	Diploma	Investigator	3	Paid
11	Sihene	50	M	Jimma	4	Muslim	Not able to read and write	Farmer	3A	Free

The study participants were women who diagnosed with cervical cancer in oncology and radiotherapy ward at Black Lion Hospital. From the total of 14 participants 11 from cervical cancer patients and 3 from health professionals from oncology nurse, ontologies ward head and radiologist.

The age of the participants 4 of them were in age b/n 30 to 40 years old, 5 were in b/n 45-55 years old, Tigist and Aynalem were 57 & 70 years old respectively. Seven participants were orthodox religious followers, Rahewa and Sihene were Muslim and Melkam and Berhane were protestant followers. Out of the total 7 participants were married, Tigist Aynalem and Rahew were widowed and Alefech got divorced. Four of the participants have 5 children, Aynalem and Tigist have 6 children, Sihene and Hirut have 4 children, Abebech have 3 children, Berhan and Alefech have 1 and 8 children respectively. Except Berhane, all of the participant permanent resident places were in the country side of outside Addis Ababa city, 4 participants came from Amhara and Oromia region each, Melkam came from SNNPR and Aynalem from Somali region. Educational status of the participants: Abebech and Berhan were the highest candid of the participants have diploma, 4 participants were from grade 2 up to 10th, Aynalem, Tigist and Tarika were able to read and write. Sihine and Alefech were unable to read and write.

Most of these women were engaged in economic sector activities: Aynalem and Rahewa was trader, Tigist, Tarika and Sihene were farmer, Abebech, Tesfanesh and Berhane were cashier, depot and investigator respectively but 3 were housewives. It depending on cervical stage and the health condition of the woman that determined treatment regimen either radiotherapy and chemotherapy together or radiotherapy alone so that 3participants were on stage 2, four of them were on stage 3 and 4 participants were on stage 4.

4.2. Knowledge towards cervical cancer

Most of the study participants which encounter 9 women out of 11 didn't know about cervical cancer disease before however Hirut had some information about the issue through mass media and Rahewa who had experienced in her family history that she knew about caner tough. Tesfanesh said “I still question myself how I get caught of the disease. Although I am illiterate, I suspect it might be poor personal hygiene”.

Tarika said “after I knew I had cervical cancer I am thinking it might be the cloth which my friend gave it to me back in the day. Actually, it was new clothes though but I have my suspicion. Let me once get cured first, I am decided I will never wear clothes of someone gift.”

Alefech add “I had symptoms of sever pelvic pain somewhat like for longer time but in my resident area people related such problems with superstition that I was taking some herbal medication for it even though I wasn’t healed me”.

Differently, Hirut said “I had some information about cervical cancer screening through mass media but not exactly know about the disease”. Similarly, Rahewa who had some information about cancer said “my sister had breast cancer so that I had some information about cancer but not exactly cervical cancer”.

Experience of the participants before the diagnosis of cervical cancer: Although due to miss diagnosis of the problem together with the longer chain of the referral system took quite time for the delaying of getting the service. All participants visited at least more than two health facilities in their resident area before it was confirmed cervical cancer. And the participants shared miss diagnosis was the reason of visiting many health facilities.

Tarika said “I have been visited countless number I guess it was more than 10 health facilities because the health professionals didn’t know my case that I had been taken so many medications as they prescribed”.

> *Tigist said word by word the health workers told me that I had hypertension so I was taking anti hypertension drugs as a treatment for 4 years but my hypertension was never being stable until confirmed it was cervical cancer. As the health workers told me after my diagnosis with cervical cancer, it was miss diagnosis that I was taking the wrong medication.*

Aberash, Hirut and Tigist described their situation of their first visit of health clinic due to excessive and irregular bleeding accordingly:

> *I visited one health clinic but it was frequently for the reason of having clotted bleeding until cervical cancer was confirmed then they referred me to Jigjiga hospital. But Jigjiga hospital told me the stage of cervical cancer was higher and needs to start radiation therapy urgently so that they referred me to Black Lion Hospital immediately.*

> *I first visited Debrezeit private clinic for recurrent irregular menstruation so they gave me pills for it but still my menstruation wasn't regular tough. So I came to Addis Ababa to get better medical services and I went to Korea Hospital, after full medical examination, cervical cancer was confirmed then the hospital referred me to Black Lion Hospital to get the treatment service straightaway.*

> *I had bleeding for three consecutive days then I go to the clinic but the clinic refereed me to higher health facility. I took ultra sound in the*

> *hospital then cervical cancer was confirmed so they again referred me to Bahir Dar hospital. At Bahir Dar hospital again done other investigation and it was confirmed that the stage of cervical cancer was high so they referred me to Addis Ababa at Black Lion Hospital. I told them I couldn't afford the travel and the costs of treatment unless I sell my assets so I insisted them to treat me there by removing it surgically but they told me that radiation and chemotherapy treatment is necessary that I came here.*

All experienced the symptoms of vaginal discharges, abdominal pain, irregular menstruation and bleeding before confirmed cervical cancer. Hirut mentioned "I had irregular menstruation and leg cramping". Alefech complimented "I had bleeding and sever pelvic pain just like a labour pain".

Aynalem said" I had itching on my genital part then after started vaginal discharge and bleeding". Berhane add "first time I had seen bleeding after sexual intercourse which associated with severe abdominal cramp and discharge".

Most women waited longer time for an appointment of laboratory results and in getting the services of the treatments. Ten of the participants had gotten the treatment therapy service after two month of appointment. Except Hirut who got the services within seven days of time.

Aynalem said "to start the radiation therapy together with chemotherapy totally took me two months because of laboratory investigation result which include the result of the sample which was taking from my cervix area alone took one month plus due to the high flow of service users taking longer time”. Abebech said “the laboratory result let alone others took more than one-month time”.

4.3. The Experiences of Women health condition on the treatment

The side effects of the treatments: Most participants experienced: body weakness, loss of appetite, pelvic pain, diarrhea, weight loss and headache were the major side effects of radiation and the chemo therapy treatment. Berhan said “I have diarrhea, body weakness, weight loss and sleepy all the day after I start the treatment”.

Alefech reported that:

> *After I start the radiotherapy, side effects are currently the challenges of my health despite I have progress of the disease symptoms. Currently I have body weakness which make me to spent most of my days at home plus I can’t even control my feces (incontinent) that I always use diaper.*

All women who currently live with their husband’s stop their sexual relationship with their partners because of loss or lack of sexual drive plus they have pain during sexual intercourse. Hirut said “we talked about the issue of our sexual relationships and he said his priority is focusing on my health issue that he doesn’t want to do it rather waiting me until I am fine”.

Tesfanesh said the following:

> *Since I was sick, I and my husband never do sexual intercourse but recently he keeps insisting yet I have no desire to do it. Today I plan to talk to the medical person after I take my radiation therapy and ask them if there is no problem of doing that. I mean he is my husband and have the right to ask plus don't forget that he is a man.*

4.4. The Psycho social experiences of cervical cancer women

All participants were diagnosed with cervical cancer for the first time and most of them also never had a history of any cancer patient in the family except Rahewa hence most participants first time reaction was unpleasant and terrified experience.

Rahewa said "first time knowing I had cervical cancer didn't change my scary experiences despite my sister had breast cancer so that I had headache and my blood pressure rise very high". Abebech add "I was scared too much since I heard about cancer before and it was similar like HIV/AIDS that there is no cure so I thought I will dye overnight".

In contrary, Alefech and Aynalem experienced different than those women. Alefech said "I didn't feel anything because I never heard of cervical cancer before so I didn't know the degree of the problem". Aynalem add "I felt nothing because I live with my former husband ever since I was a girl even though he died before 15 years so there is nothing to fear".

Most of them disclose their cases to their nuclear family member 6 participants shared to their partners, Aynalem, Tigist, Rahewa and Alefech share to their children but Tesfanesh shared to her friends. However, not only those women had scared first experience knowing they had cervical cancer but also their family member shared this experience too.

Alefech said “my daughter was with me at the time when the doctor told me I had cervical cancer which it didn’t bother me at all because I didn’t know the degree of the problem but to my daughter it was unpleasant experience that she cried a lot”.

Hirut said as the following:

> *When I told my husband I had cervical cancer he was scared than I was and knowing it was cancer he thought I will die overnight so I tried to calm him down and said him with grace of God I will be fine plus I told him the doctors told me that as soon as I get the treatment I will be okay.*

Except Tesfanesh who shared her secret to her friend for the first time said;

> *First time knowing I had cervical cancer I first disclose my situation to my friend who is a health officer. She used to live together with me before she was a health officer so I told her about my case thinking that she might be helping me in reassuring and dealing with this experience because she is a health professional other than my friends.*

Furthermore, most of them not yet disclosed to their neighbor about their case because of fear of discrimination as a result when people asked them about their cases they told false diagnose.

Hirut said “I didn’t tell my situation to others but when people keep asking me about my case I told them I am here for my leg case. Since people in Debrezeit town have different meaning about cervical cancer disease”.

Tesfanesh add “I didn’t still tell to my neighbor because they might consider me as rude because cervical cancer is sexually transmitted disease like HIV/AIDS as a result they might be discriminate me”.

Rahewa put her idea by saying “never telling to anyone except my children because no need of announcement about my situation to others whom they couldn’t find any solution for my problem”. Differently Abersah stated “now I am here in Addis and yet didn’t get back to my home so I didn’t tell them even though I occasionally contacted them through my phone”.

The rest Alemiye and Berhan disclosed their situation to others. Melkam said “I told to my friends and my neighbors about my disease and they accepted me and supported me that they are taking care of my five children”.

Most study participants currently have developed the experience of emotional instability, worrying, anxiety and depression after the diagnosis towards with their health condition, social responsibility, spirituality and financial insecurity.

Rahewa said “I usually feel unhappy because I am worried of my children if I die soon”. Tigist compliments “I am worried because I raised my children all alone so if I die soon I couldn’t able to see while they grow, having started their own life includes having children of their own”.

Alefech said “I frequently upset and worried ever since knowing I have cervical cancer because of the disease I become dependent and burden to my daughter”. Hirut added “different from my previous experience now I feel anxious and irritable easily so mostly I cried all alone when I had those feelings. Because in my experience I don’t share my feelings of anxiety and worry to others including my husband and make them feel bad and have petty”.

In contrary to the rest participants, Tesfanesh said “now I am stable with my emotions after I buy the book name booklet with the advice of Sifu whom he works in radiology wards”. The booklet tells me in detail about cancer and what I should do. Aynalem add “I didn’t worry much I am old women and I lived long enough plus I am in the hands of God that he will cure me at the end”.

Most of the women still didn’t have any clue about the overall cervical cancer including the prevention of cervical cancer so that they shared the feeling of future uncertainty towards their occurrence of cervical cancer makes them worry since none of them ever get professional psychosocial supports in the hospital.

Social Interaction and role of women: The women role and responsibility were altered in the family role because of the disease and the side effect of the treatment that debilitated her making her former day to day activities. Melkam stated, “Since I came to Addis with my husband for my treatment, my neighbors are the one who taking care of my five children”.

Berhan said the following on the issues:

> *I am three months lactating mother but due to the disease and the treatment I couldn’t able to care for my three-month old son even to*

> *carrying him thus my husband and my mother did for me. I can say my role and responsibility is totally changed due to my illness.*

Tarikua said "I came here with my husband and my second child and I left my third child in the neighbors to take care of him. I couldn't bring him here with me even though I am his mother and I should be taking care of him. So I call every day how he was doing especially now a day I couldn't even sleep just thinking about him a lot".

Out of 11 participants six of them get supports from their own daughters who taking care of the family members. Hirut said "my role and responsibility are changed due to my current situation so talking care of the family fall on the shoulders of my elderly daughter and the only thing which makes me involved when money needed for food and other staffs".

Tesfanesh and Alefech said as accordingly:

> *I take the radiation therapy every month. After the treatment I get back home and rest for like one or two weeks until I regained strengthen. During that time my daughter do all the domestic activities although she is a student because boys are boys that they didn't do nothing so am worried they might be hungry if she is unable to do.*
>
> *I stayed here with my daughter house since two months. Although I have a son, my daughter is the only person who is taking care of me which includes changing my diapers, preparing foods and come with me during my appointment time.*

All women except Berhane came all along from the country side to get the service which is far away from their own resident area as a result the women role and participation in her family and in the social activities are limited by the distance. Furthermore, woman who are taking radiotherapy every day staying longer time in Addis Ababa city until they finished their treatment. Tarika mentioned that I called and checked every time to my neighbor because I left my second child with them so it enables me to know how he is doing in a way to say hello to them.

Except Berhane who live in Addis said as follows:

> *In terms of social relationships everybody visited me ever since I am sick. I guess I am the lucky one here towards my social involvement however sometimes I couldn't even find the space and time for myself.*

Therefore, from the finding most participants came from outside the city that loses their social ties from their residential environment. Thus, the distances affect their social capital that either they get limited or no support from their social interaction.

4.5. The Financial Expenditure of the participants

Even though most of them were members of informal association none of them were get supports because there is no trend of those institutions to support their members in such situation. As a result, their sources of financial assistance mostly leaned on their family members in covering the expense of laboratory investigation, medication and treatment expenses unless they were free charge, place to stay and for transport expense.

All of them cost a lot of money for laboratory investigation and treatments because woman repeat the laboratory investigation all over again before they start the therapy even though they had previous laboratory results from the other health facilities where they referred from Alefech, Hirut and Melkam who were housewives got their expense fully covered by either their partners or children.

Hirut said as follows:

> *My husband and my sister husband cover for my costs. Before I start the treatment, it was necessary to repeat every laboratory investigation include chest x-ray, CT scan, MRI, and others which is not available at Black Lion Hospital. But it was available in private clinic and it costs me a lot of money.*

The other issue was the cost of transport: most participants complain the challenging experiences regarding with their daily cost of transport service with their follow up appointment until they finished their therapy. Hirut explained her cost for the treatment therapy and for Lada contract Taxi every day to take her to the hospital and to return back to her home.

Alefech said as follows:

> *Aside from the treatment cost, I use contract Taxi whenever I have an appointment to take me to the hospital and take me back home which is covered by my daughter. Because I always use diapers which is difficult and uncomfortable to me to use public transport feeling that I might have smell.*

Women like Tigist, Aynalem and Rahewa who used to be the head of the family engaged in economic activity so that their all expense was covered by themselves by selling their assets like cattle, herd, meals or their properties. Tigist said “I used to be a farmer and the moment I know I had cervical cancer and needed me to follow up here in Black Lion Hospital I sold all my cattle to cover all my medical expenses”.

Rahewa illustrated as the following:

> *I used to be trader after knowing my cervical cancer disease I had to sell some of my properties to cover my medical and other expenses plus from*

> *my saving money. Till know I didn't ask any supports but no one knows about the future because currently I didn't work that if my hands are short, I will ask supports from my children.*

Abebech, Tesfanesh and Berhane were used to be an employee however for their different expenses including the medical expenses covered by their partners, staffs and extended family. Berhane illustrated "I got coved of all my expenses by my mother sisters who live abroad". Tesfanesh add "until now my husband and stuffs covered for me".

Abebech said as the following:

> *I am here for six months now and my husband cover all the expense. My husband is working in non-governmental organization that with his salary and the contribution of his staffs plus for some months his office also covered for me. If we face challenges, my husband asks credit from his office.*

Women with cervical cancer disease facing challenges of financial strains because of their health condition, most of them decrease their economic contribution on the family or cease from their former economic productivity. Tigist illustrated, "I am single mothers and I brought up all my six children all alone. But now because of the disease I couldn't able to sustain my former contribution in the farm land like before".

Except Tesfanesh who still works in her bureau said "I am still working because my work is depot so it doesn't take much efforts of me and sometimes when I face hard works my staffs covered for me".

4.6. Coping Experience of the Study Participants

However, most of them had improved experiences in relation to understanding the disease is curable if it gets early management. Because after they start the treatment in the hospital they make new friends and developed new social members in the hospital to whom with they share the same experiences. Sharing experience to each other ease their desperateness and increase the chance of hope being cured by seeing other experience plus it gave them the chance to share new information.

Tesfanesh address the situation as the following:

> *After knowing I had cervical cancer, no belief of being cure that I feel hopeless. But now I am changing a lot after starting the therapy because I make new friends in the hospital whom they have the same problem like mine so they share me their experience especially their health progress of their cancer after they started the therapy. Even some of them get cured after they finished their treatment.*

All the participants got psychosocial supports mainly from their family members such as from their partners, children and parents which they didn't still get from professionals so that the supports enabled them to get hope from their problems. Aynalem said "my daughter assured me if it is necessary she is going to sell her properties and send me abroad to get advanced medical treatment until she make sure I was fine".

Abebech said "ever since I told my husband I have cervical cancer, he assured me that I am going to be fine plus promised me that he will send me abroad if necessary until I get the cure. Even my cousin takes her annual leave to take care of me".

Melkam said “my husband is here with me from the beginning until now even he left our 5 children in the neighbors to support and near with me until I finished my treatment. So I feel good and secured knowing that my husband is a supportive one”.

Key informant Interview

Data prepared from Key informants interview revealed that participant were from Oncology department and Radiotherapy unit. Three health professionals participated in the study which consisted oncology department head, staff nurse and radiologist each. Year of service experiences: head of the department, 16 years, Staff nurse 5 years and radiology department 5 years of working experience.

The professionals explain cervical cancer is abnormal growth of cell in the cervix area. The etiological factor for cervical cancer is mainly HPV which is sexually transmitted disease. Cervical cancer patient commonly has symptoms of vaginal bleeding, discharge and pelvic pain before their diagnosed with cervical cancer.

Regarding with vulnerability of the society: the head of the departments said “from my experiences women with both low educational and economic status are highly vulnerable than women with high education and economic status because low education woman has low knowledge about the problem”.

According to the ward head and stuff nurse, the admission criteria is depending on something which is emergency, all functional test like organ function test, chest x-ray, CT scan and ultra sound should be done in the outpatient department first the result must be in normal range and with the referral paper from other health facility then after confirmed all this documents are available then we facilitate the admission. The head ward added “regarding with the initiation to chemotherapy we all make sure the results of the investigation is normal, otherwise we couldn’t administer chemotherapy due to the adverse effect of the treatment”.

In fact, chemotherapy treatment is administering for radical cervical cancer patient only for stage is 2 up to stage 3A. However, for grade 3B and 4 never administered rather take radiotherapy to alleviating their symptoms only according to key informant.

Towards the availability of the service: there is drug availability which expenses high cost to afford unless charge free patient. As the key informant illustrated the high expenses of the drug even some patient discontinues their treatment which is beyond the professional control and I feel unhappy about it. Not only the drug but also the laboratory investigation is done outside the hospital in private health facility.

However, all the participants took special training towards cervical cancer, none of them give psychosocial support service to those women unless for the adverse effect of chemotherapy and radiation treatment because there is no any social worker and psychologist in the ward to address the psychosocial problem. The key informant said “no social workers in oncology ward, I don’t even think in most other wards of the hospital. I belief the role of social works is helping people to get financial support in NGOs”.

Some of the women don’t know their stage of cancer. According to the key informants, “telling the truth to the patient is health ethics yet different factors avert them from disclosing it such as work burden and fear to tell to the patient who possibly let them hopeless and also women educational status is the factors”.

Therefore, the long chain of appointment of service users due to over flow of service users and only cancer center in the country many got their cancer degree changed to precancerous. According to radiology department “waiting appointment for longer period of time is the experience of not only cervical cancer patient but also the problem of overall cancer patient in the matter of fact the cancer stage become high and complicated”.

Moreover, shortage of stuffs and specialist on the area, affordability of drugs, shortage of admission bed, only cancer center in the country challenges the hospital service delivery, accessibility and quality of care.

Document review

The study incorporated document review to supplement the primary data. The document review was seeing the patient cards and registration/tracking records. Reviewing patients cards such the status of patient’s service charge, as age, number of gravida and stages of cancer and address of the patient. From the review many participants were multigravida mother and some of them even have more than five children during their reproductive age, age between 30-50 years old mothers, cervical cancer staging above stage two cancer, and residents were outside Addis Ababa city. In addition, in the tracking record, observing some patients missed their appointment date that it was blank.

CHAPTER FIVE:

DISCUSSION FROM THE MAJOR FINDINGS

Cervical cancer is tremendously affects women. Studies indicated that the prevalence and incidence of cervical cancers increase significantly unless it focused on prevention strategies. However, HPV which is the major causative agent of cervical cancer disease and others cofactors such as age, high parity, hormonal contraceptives use, smoking and have low immunity women are risk factors. Unless it focused on prevention strategies, according to world health organization, the problem will increase by 25% in 2025. Therefore, screening with visual inspection acetic acid (VIA) is the only way to detect cervical cancer especially for low resource countries which is efficient and effective methods and can be also applicable wherever.

From the findings result of 14 participants in whom 11 were service users and 3 of them were key informants of the study participants. A nine depth interview, key informant interview, observation and document review used as the tool of data collection and review of the literature used as a supplement. The finding presented in summarized and compiled form.

In the findings most of the women age was greater than 40 years old and when the women age increase, risk factor for cervical cancer increase. Similar study which conducted at Black Lion Hospital 2015 by Sintayehu shows that among cervical cancer patients, the most exposed age group was between 40-49 years old women.

Cervical Cancer increase in incidence started with 40- to 44 year olds and peaked for 60- to 64-year-olds (Memirie et al., 2018). Cervical cancer is rare in women under 30 years of age and most common in women over 40 years, with the greatest number of deaths usually occurring in women in their 50s and 60s (WHO, 2012).

High parity has long been suspected of being associated with an increased risk for cervical cancer. The data collection indicated the participants were high parity mother. Concomitant, study has found a direct association between the number of full-term pregnancies and squamous-cell cancer risk: the odds ratio for seven full-term pregnancies or more was 3.8 compared with nulliparous women and 2.3 compared with women who had one or two full-term pregnancy (Nesanet, 2017).

ACS studies indicated “Women who have had 3 or more full-term pregnancies have an increased risk of developing cervical cancer. Also, studies have pointed to hormonal changes during pregnancy as possibly making women more susceptible to HPV infection or cancer growth.

Except two of the participants who had some information about cervical cancer through media and the other one because her sister had breast cancer. The rest of the participants were with less education and low economic status that cervical cancer prevalence is high because less educated women have the chance to know about cervical cancer is less that the participants were associated the occurrence of the problem with superstitious, poor personal hygiene, transmission by clothes and others. Hence, women with lack of information and knowledge about cervical cancer increase her susceptibility, have poor trends of screening plus it is the factors for delay of the treatment According to Lindau et al (2015). lack of knowledge about symptoms also may cause a delay. Patients from a rural area or with lower economic status or illiterate people might be unaware of cervical cancer. So, these individuals may usually reach the hospital with the late stage of cancer, which leads to poor treatment outcome and consequently a reduced quality of life (Thapa et al., 2018).

Out of the total of 11, 9 of the participants came from different region of the country which in contrary to the study where conducted at Black Lion Hospital in 2015 Addis Ababa shows that Oromia, and Amhara took (32.98%, 30.11% & 19.72% respectively) the higher proportion of cervical cancer patients which shows currently. Thus in the current trends of Addis Ababa there might be increase accessibility of cervical cancer screening service and awareness towards cervical cancer in the city which might result decrease CC incidence and prevalence.

Furthermore, another factors which contributed for the delay to get medical service on time is due to poor knowledge of the health professionals that women experienced to visit many health institution, the longer chain of referral system between the health institution and Black lion hospital is the only radiotherapy cancer centers in the country that over flow the service users and shortage of man power contributing factors for the high stage of woman cancer.

A cohort study which conducted at Black Lion hospital indicate because of the huge patient load, the median waiting time was 1.8months between first registration at the Radiotherapy Center and the first appointment with the radiation oncologist. The median waiting time between the appointment with the radiation oncologist and the start of radiotherapy was 0.2 months for emergency radiotherapy, 1.7 months for curative radiotherapy, and 2.3 months for palliative radiotherapy.

When an abnormal result is detected in a smear of a woman, she needs a referral for assessment or other specialized procedure provided by specialists. Colposcopy, radiotherapy and chemotherapy cervices are located in tertiary, urban-based institutions and provided in subspecialty centers. This necessity established problems of access for women (especially poor women) living in remote areas (Bayrami, 2014).

Likewise, according to Teshager et al., (2014) lack of awareness, lack of professional, lack of support and lack of referral linkage were also statistically significant factors that decrease the rehabilitation service utilization.

Most of these women first time reaction of knowing they had cervical cancer was unpleasant emotional experience because many women beliefs cervical cancer is untreatable and no cure. Study which conducted by Konjit, 2014 women experienced feeling of confusion, anxiety, fear, stress, hopelessness and strain after recognition of their cancer diagnosis with cervical cancer. First time reaction was not only the experiences of cervical cancer women but also the unpleasant experiences of those care givers during which they had low knowledge about the problem and related with history of cancer patient in the family member.

Similarly, study conducted in Kenya reported that they had no prior knowledge of cervical cancer until diagnosed plus the caregivers also reported that they did not know much about cervical cancer until someone from their family was diagnosed with the condition.

According to the key informants sometimes they didn't disclose the stage of cancer to the CC patients due to fear of disclosing the results to patients and burden of the patient flow in the hospital. Thus woman might not know their stage of cancer which was comply data finding from the in depth interview. This circumstance disabled woman to be alert and to comply with the situation.

Openness about the diagnosis and prognosis enables patients to think more realistically about their condition and participate actively in treatment planning. Healthcare professionals need to address the family's fears about sharing the news and offer suggestions for assisting the patient. Creating a balance between providing some information without alienating the patient and family can be difficult (Linda et al., 2003)

From the data many women never disclosing their situation to other members of the family like neighbors and extended family because the disease its associated gynecological symptom which is humiliating, uncomfortable and socially stigmatized plus which is not something easily to spoke about it.

Study in Iran concur that the socio-cultural issue affects the health care seeking behaviors of women most women do not like to talk about their genital tract diseases even cancer and sexual transmitted disease. Study which conducted in Thailand agreed that common psychosocial problem identified were stigmatization from the family and community member problem with sexuality and varied belief in meaning and causation of disease.

In relation to their future uncertainty after their treatment, the result showed that the participants worried and fear of recurrence of the disease because not yet know the etiological factors of cervical cancer and how to prevent it. Similar study, even for long-term survivors, significant numbers report considers there is frequently generalized anxiety, worry and distress associated with the fear of recurrence or development of a new cancer (Hobbs, 2008).

The adverse effect of the radiation treatment, women physically experienced pains in numerous parts of the body including the abdomen, waist, genital area, fatigue, body weakness and sleepy. They express share emotional feeling by stressing even crying due to the chronic disease of cervical cancer.

Furthermore, the adverse effect of radiotherapy make woman to have libido or loss of sexual desire. All women shared this experience that they stop having sexual relation with their partners because they don’t have the desire or the feeling. However, the purpose of radiotherapy is killing cancer cells in a way it kills also normal cell of the body, has its own common side effects of no desire having sexual relationships. Radiotherapy patients were significantly more likely to report pain and loss of sexual pleasure after treatment (Cull et al., 1993).

Sexual dysfunction both radical surgery and radiation therapy can have medium term and long term impact on sexual functioning amongst cervical cancer survivors. Because cervical cancer survivors tend to be relatively young average age of diagnosis is 50 sexual functions can even more significantly impact quality of life than in an older cancer survivor population (Pfaendler et al., 2016).

Women role and responsibility are shifted due to the illness their role are filled by other members of the family that most of the time they spent their day time by staying home all the day because of their illness which let them disadvantaged from their social participation and also to attend the church services. Especially, women social involvements or participation decrease because they came all along to get the service from their permanent resident that the place they were staying was new environments though. As a result, this might create stress to the woman and strain in the family relation.

Women patients couldn’t play their maternal and wife hood roles in their house following to their diagnosis with cervical cancer. Moreover, some of the patient while coming to Addis Ababa to waiting long appointments for investigation and admission. Their roles are lost and discontinued due to the impact of the illness and the treatments in general (Konjit, 2014).

According to Linda (2003) disruptions in schedules and taking on new roles of caregiving, meal preparation, and other family duties may put a strain on some family members. Spouses, children, parents and siblings have to adjust to the shifting priorities, duties and responsibilities for the wellbeing of their ailing family member and sometimes these shifting priorities may bring in strained relationships, causing family stress (Sellors et al., 2004).

Women who were the breadwinner in the family got covered their own medical expenditure by selling their assets to cover all the expenses costs. Hence, the family encounters financial strain to sustain their life. Correspondingly, cost of treatment of the disease also rendered some patients indebted while others lost some assets due to attempts to pay for the treatment of the disease. The poverty of the women who are affected worsened because they are the breadwinners of the rural communities (Binka, 2017).

Moreover, women costs for the transport fee for frequent radiotherapy appointment were the challenging experiences of women in rendering their financial situation. Because these women didn’t use public transports like mid taxi, bus etc. at least every day they cost some amount of birr. Congruent study, transport costs for the frequent hospital visits and accommodation arrangements were adversely mentioned by the cervical cancer patients and their care givers as additional costs (Mariah, 2015).

In addition, women not any more involved in the economic activity of the family because cervical cancer make those women physically incapacitated and let her not to participate and contribute in the family income earner as before. Thus finical experience women were disrupted that they ask support from their families.

According to Binka (2017). the cervical cancer patients also experienced economic disruption in terms of their inability to work, reduction in income, medical bills, loss of asset and indebtedness as a result of their inability to work actively as they used to, their income stream was disrupted;

Cervical cancer is a chronic disease that individuals need to get support for prolonged time. From the findings family members either from the nuclear family, extended family or from their social capitals playing cardinal role in providing psychosocial supports in which helps them to cope up their circumstances.

Family provided a strong pillar and support as a means of coping with the illness experience. Despite the financial constraints, family members put the health of the patient first and desire to see her getting better (Mariah, 2015). Social supports are necessary for the individual to maintain her development and wellbeing and a mechanism one can to rely on other. Social support is the number of social contacts maintained by a person or cohesiveness of a social network (Kaplan et al., 1993).

Women start to make new friends whom they are along with their state of mind mostly in the hospitals because they can share their fear and doubt the one who have the same experience with them. Thus women ease their anxiety and raise hope of to be get cure. Information seeking is a more common coping mechanism in the early stages of the disease, when the diagnosis is new and the patient is dealing with a variety of new healthcare professionals (Nail, 2001).

Spirituality in the lives of these women play significant role in coping with their stressful circumstances and building positive images of their future life thus women have faith of hope to get back of their former self or experiences.

Giving up their life and health to a higher power gives the cervical cancer patients the strength to carry on with life without so much fear of death from their health condition. This hope helps the families live with and care for the cervical cancer patients taking each day at a time without many anxieties of what next (Mariah, 2015).

CHAPTER SIX:

CONCLUSION AND IMPLICATION OF THE STUDY

6.1. Conclusion

Cervical cancer is prominent risk factors for women that the prevalence is very high in low economic country especially East Africa from the region primarily related to low access to prevention and poor knowledge of women and the health professionals. Thus, women are delay to get the treatment on time that woman reach the health facility when the stage of cancer where precancerous. Therefore, woman diagnosed with cervical cancer has to now live with a chronic disease faced with structural, physiological and psychological, as well as socioeconomic challenges.

Even after starting the therapy women experienced physical dysfunction due to the side effects of the treatment and the burden of cancer in their body. The major symptoms are: fatigue, body weakness, poor appetite, heavy bleeding odorous discharge and losses of sexual desire made it difficult for them to associate freely with people.

The high costs of CC for treatment and management is the challenges of those women. In addition, the transport and accommodation which they travel from outside Addis Ababa including the costs that accompanied by their caregivers are the extra expense which they faced. Together with the net effect of the withdrawal from their former economic contribution that affects the overall family income.

As illustrated in the study, the high cost of cervical cancer management, anxiety of recurrence and fear of death, sexual health concerns, as well as fear of stigmatization and avoidance are psychosocial challenges of women living with cervical cancer.

Therefore, the management of cervical cancer poses psychosocial, financial and medical challenges that cause disruptions in the lives of the women. Women with cervical cancer require early biological intervention and provisions of psychosocial support by professionals to improve the quality of life and the quality of care of woman with cervical cancer.

6.2. Social Work Implication

Implication for Social Work Education

Social work education should prepare education manual or guideline to improve and address the gaps of knowledge of the professionals and wider community towards cervical cancers. In addition, appropriate training for professional to specialize on the area.

Implication for Social Work Practice

Social worker student engaged themselves to practice the approach of bio psychosocial and spiritual model to address the constraints and to maintain their previous health of cervical cancer patient. Furthermore, needs to work integrally with other professionals or multidisciplinary team like clinical psychologists, health professionals and financial institutions need to be well acquainted with the range of community support services which can be engaged in parallel with the cancer care team, to assist women and their families whole as they confront the problems associated with the diagnosis and treatment of cervical cancer. Social work practice should entertain palliative care intervention to those chronically ill cancer patients to promote peaceful life and their death.

Implication for Social Work policy maker

Policy maker better designs effective strategies and program on screening and treatment policy, to focus on promotion and prevention of the community health because of the high cancer prevalence and mortality in countries with no access to quality prevention and detection services. In addition, promote population immunization programs of cervical cancer which is likely to be dramatically reduces the number of new cases of cervical cancer.

Implication for Social Work Research

Further research on the area is necessary to improve the scientific based research, plus researchers should take on the burden of demonstrating the relevance studies and findings to the overall goal of reducing cancer health disparities and addressing caregiver experiences in tackling the difficult circumstances of their situation and to fill the existed problem. Moreover publishing recent findings on the area will show the current prevalence, indicate the depth problem of CC, and enhances the awareness towards cervical cancer.

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Appendix A

Informed Consent Form

My name is Adelahu Gebre. I am from School of Social Work at Addis Ababa University. I am currently collecting data for my Thesis project entitled "experiences and coping mechanisms of cervical cancer at Black Lion Hospitals. The purpose of the study is to have insight knowledge on the experiences of cervical cancer patients and their coping mechanisms so that to indicate appropriate intervention to design by primary stakeholders to address the issue.

This form is intended to further ensure confidentiality of data obtained during the course of the study entitled the experiences of cervical cancer patient. The study might not directly benefit or affects you but it has a positive contribution to address the issue as a result your full engagement and fact is necessary. The paper will ensure your confidentiality that anonymity (pseudo name) will be used. If you are not willing to answer or under any circumstances not willing to continue the interview you are free to do so.

I hereby affirm that I will not communicate or in any manner disclose publicly information discussed during the course of this interview. I agree not to talk about material relating to this study or interview with anyone outside the researcher [or moderator]. Thank you for your time.

By signing the paper, I confirm that I am willing to participate in the interview

Name of the Participant: _______________ Name of the Interviewer ___________

Signature: ___________________ Signature ___________________

Appendix B

ለመላሾች የተዘጋጀ መጠይቅ

መግቢያ

የጥናቱ ርዕስ፡ የማህፀን በር ካንሰር የተያዙ ሴቶች ህክምናውን ከጀመሩ በኋላ ያላቸውን የህይወት ተሞክሮ ለማወቅ የተዘጋጀ ነው፡፡

ስሜ--------------------- ይባላል፡፡ በአዲስ አበባ ዩኒቨርስቲ የሶሻል ወርክ (የማህበራዊ ሳይንስ) የ3ኛ ዓመት የድህረ ምረቃ ተማሪ ስሆን የመመረቂያ ፅሁፍ ለማዘጋጀት በሂደት ላይ ነው፡፡

እርስዎም በዚህ ጥናት ፅሁፍ እንዲሳተፉ የተጋበዙ ሲሆን ለውጤታማነቱ በጋራ እንድንሰራ እጠይቆታለሁ፡፡ በጥናቱ ላይ ለመሳተፍ ከመወሰኖ በፊት መረጃ ማሰባሰብ አስፈላጊነቱ ላይ ሊያምኑበት ይገባል፡፡ የጥናቱ አላማ የማህፀን በር ጫፍ ካንሰር የተያዙ ሴቶች ያላቸውን የህይወት ተሞክሮ ለማወቅ የሚዳስስ ጥናት ነው፡፡

እርስዎ የሚሰጡት ምላሽ በግበአትነት ተይዞ ለጥናቱ ውጤታማነት ይረዳል፡፡ ስለሆነም ይህ ጥናት የሚካሄደው በርስዎ ሙሉ ፍቃደኛነት ላይ ተመርኩዞ ነው፡፡ ለዚህ ጥናት በሚሰጡት ትክክለኛ መረጃ ሊከሰትብዎ የሚችል ችግርም ሆነ ጉዳት እንደሌለ ልገልፅልዎ እወዳለሁ፡፡ በጥናቱ ላይ የእርስዎም ስም ወይም እርስዎን የሚገልፅ ምንም አይነት መረጃ እንደማልጠቀም አረጋግጣለሁ፡፡ ስለሆነም የመረጃው ሚስጥራዊነት የተጠበቀ ነው፡፡ መጠየቁ ቢበዛ ከ20-30 ደቂቃ ሊወስድብዎ ይችላል፡፡

የጥናቱ ጠቀሜታ የማህፀን በር ጫፍ ካንሰር በሽታ የተያዙ ሴቶች የሚያጋጥማቸውን መሰናክል በማሳየት ሊደረጉ የሚገባን መፍትሄና አመላካች መንገዶች ለሚመለከተው አካል ለመጠቆም ነው፡፡

በመሆኑም መጠይቁን ለመመለስ ፍቃደኛ ከሆኑ በመረጃ መስጫ ወረቀት ላይ ፊርማዎትን እንዲያስቀምጡ እጠይቆታለሁ፡፡ መጠይቁን ለማቋረጥ ቢፈልጉ በማንኛውም ጊዜ ምንም ምክንያት ሳይሰጡ ሊያቋርጡ ይችላሉ፡፡ ከጥያቄዎቹ መካከል ለመመለስ የማይፈልጉትን ያለመመለስ መብት አሎት፡፡ አመሰግናለሁ

መጠይቁን የሞላው አጥኚ ስም---------------------------- ፊርማ-------------------

በጥናቱ ላይ ፈቃደኝነቱን የሰጠው ሰው ስም ---------------------------- ፊርማ----------

Appendix C

In depth Interview Guideline for Cervical Cancer Patient

Socio Demographic Information of Participants

Name____________________ Age ___________________Marital Status_____________

Permanent Resident_______________ No of Children_________

Religion ___________ Educational Status_______________ Occupation_________________

Charges of the service ____________

Health information

1. Would you please tell me for how long you have been start your treatment?
2. Is it your first time diagnosis with cc?
3. What was your initial symptom?
4. How many health facilities you had been visited before Black Lion Hospital and the time span of referral?
5. Would you please tell me the stage at diagnosis and the treatment you are taking currently?
6. Would you please tell me your experiences of pain/ side effects while on treatment?
7. Would you like to share me your pain and discomfort while in treatment? (probing)

Psychosocial Information

1. Is there any history cancer in your family?
2. What would be your first reaction knowing you have cervical cancer?
3. Would you please tell me your situation in which you are experiencing of stress after diagnosis with cervical cancer?
4. Would you like to share me your current situation in relation to your emotional stability after you start the treatment?

5. Whom do you think you are getting your companionships? How? (Probing).
6. Would you tell me what do you feel/think about your future life? (Probing)
7. Would you share me your experiences to whom you disclosing your situation for the first time after the diagnosis?
8. What was the first reaction of your care givers when you were disclosing the situation?
9. Do you think your family understands your situation? How (Probing)
10. What kinds of support are you getting from your family? (Probing).
11. Do you feel the support you get from your family met your needs? How?
12. Would you please describe me any changes in your role and responsibility in your family?
13. Would you disclose me any changes in your relationship status with your partners especially your current sexual experience? (Probing)
14. Tell me your current experiences of your social participation?
15. Would you please tell me what it looks like your interaction with your neighbor?
16. What is the role of religion in your life and purpose? Probing
17. Do you attend church frequently? Probing

Financial Information

1. Are you a member of in any informal association (Idir, Ikubetc?)
2. Would you please tell me in what ways are this informal association is helping you with?
3. Would you please tell me what is your sources of finance?
4. Would you please tell what your cost for treatment and medication is?
5. Would you please tell me the place where you are staying now?

Coping Mechanisms

1. Would you please tell me how you are securing your financial expenses?
2. Would you please tell me how you are dealing with your financially strain?
3. How you are coping up your role and responsibility in your family?
4. How you are dealing with your emotion and stress?
5. Would you please explain me how you are maintaining your social networks?

Appendix D

Key informant interview Guideline: prepared for Service Provider

Socio demographic information

Age_________________ Education __________________ profession _____________

Responsibility ________________ Experience _______________

1. What is cervical cancer?
2. What are the etiological factors and behavioral health risk factors of cervical cancer?
3. What are Sign and symptom of cervical cancer?
4. What are the rends of cervical cancer screening and practice of women from your experiences?
5. Which groups of the society is vulnerable to cervical cancer?
6. What are the criteria of admission for chemotherapy and radiotherapy?
7. What are the availability of services and resources? Probing
8. Have you take special training towards cervical cancer?
9. What kind of support you are providing?
10. What are the challenges in terms of infrastructures, over burden and priorities?
11. What kinds of psychosocial supports you are provided?
12. Anything you would like to add

Thank you

Declaration

I declare that LIVED EXPEIREINCE AND COPING MECHANISIMS OF CERVICAL CANCER PATIENT is my own original work and has not been presented for any degree in any other university, and that all sources of materials used for the thesis have been fully acknowledged.

Name: Adelahu Gebre

Signature:

Date:

Name of the Advisor: Firehiwot Jebessa (PhD)

Signature:

Date: