ADDIS ABABA UNIVERISTY

COLLEGE OF HEALTH SCIENCES

SCHOOL OF ALLIED HEALTH SCIENCES

DEPARTMENT OF NURSING AND MIDWIFERY

ASSESMENT OF KNOWLEDGE, UTILIZATION AND ACCESSIBILITY OF PALLIATIVE CARE AMONG CERVICAL CANCER PATIENTS IN TIKUR ANBESA HOSPITAL ADDIS ABABA ETHIOPIA

BY: HASNA MUSEMA (BSC)

A THESIS TO BE SUBMITTED TO THE PROGRAM OF POST GRADUATE STUDIES OF ADDIS ABABA UNIVERSITY, COLLEGE OF HEALTH SCIENCES, SCHOOL OF ALLIED HEALTH SCIENCES, DEPARTMENT OF NURSING AND MIDWIFERY FOR PARTIAL FULFILLMENT OF REQUIREMENTS FOR THE DEGREE OF MASTER OF SCIENCE IN MATERNAL AND REPRODUCTIVE HEALTH NURSING

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JUNE 2014

ADDIS ABABA, ETHIOPIA

Approve by Board of Examiners

This thesis by **Hasna Musema** is accepted in its present form by the board of examiners as satisfying thesis requirement for degree of masters of Science in **Maternity and Reproductive Health Nursing**.

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ABOVE ALL THANKS TO ALLAH

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List of Abbreviations

AAU = Addis Ababa university

AOR= Adjusted Odd Ratio

CC= Cervical cancer

ETB = Ethiopian Birr

FDRE = Federal Democratic Republic of Ethiopia

FPs= Family physicians

HMIS= Health Management Information System

LSGs=Local self governments

NGOs = Non government organizations

NHPCO = National Hospice and Palliative Care Organization's

NSAIDS= Non steroidal anti inflammatory drugs

PC = Palliative care

QOL= Quality of life

ROCs= Reproductive organ cancer

RT = Radiotherapy

SPSS = Statistical Package for Social Sciences

TAH = Tikur Anbesa Hospital

UICC = Union International against Cancer Care

USA = United States of America

WHO= World Health Organization

Abstract

Background-Palliative care is defined by World Health Organization as an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other physical, psychosocial and spiritual problems. This study attempted to assess the knowledge, accessibility and Utilization of palliative care Services to Cervical Cancer and its determinants at Tikur Anbesa Hospital, Ethiopia,

Method: This study was a cross-sectional Institution based study of women who had Cervical Cancer in TAH. The study was carried out in Tikur Anbesa Hospital with purposive selection, since it was the only center of palliative care and treatment services in Ethiopia. Data was collected by interviewing the client's using a pretested Amharic version questionnaire. During the survey, 384 women with cervical cancer were interviewed. Data entry was done using Epi Info version 3.5.1 and was exported to SPSS version 21 for analysis. Logistic regression was applied to control confounders.

Result: Out of the total clients interviewed, 239(62.2%) respondents who had treatment in Tikur Anbesa Specialized Hospital were knowledgeable about palliative care for cervical cancer. About 86% of client's were in the age 35 years old or older. About Nine out of ten (89.8%) respondents reported problems on accessibility of palliative care services for cervical cancer in Tikur Anbesa hospital. Women's knowledge of care (AOR=26.9), presence of little physical wellbeing to the respondents (AOR=3.1), social wellbeing of the respondents (AOR=1.7); monthly income of the respondents (AOR=0.25) and marital status of the women (AOR=55.4) were statistically significantly associated with respondent's utilization of palliative care services for cervical cancer at Tikur Anbesa Hospital.

Conclusion: Among patients with cervical cancer who were interviewed, nearly, more than three women out of five had reported palliative care services from its center at Tikur Anbesa Hospital in the last 12 months of data collection.

Recommendation: Community Mobilization through the media, posters and face to face on community health day focusing on palliative care services to cervical cancer must be addressed by Addis Ababa Town administrations and policy makers. Since the center was only TAH, the FDRE government must build another center in Addis or elsewhere in the country so that the problems of resources can be solved.TAH has to fulfill all the facilitations listed and needed for clients with cervical cancer for palliative services based on the standards.

Key words: palliative care, cervical cancer, Tikur Anbesa Hospital, Addis Ababa, Ethiopia.

Introduction

Palliative care is defined by World Health Organization (WHO) as an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other physical, psychosocial and spiritual problems(1). It has been recognized as essential health care which should be comprehensive, accessible, and appropriate to the community they serve.(2) Changing demographic health transitions which brought burden on health care services are increasingly those due to chronic and incurable diseases..(3)

Patients with advanced cancer have many significant physical and psychological symptoms including pain, fatigue, weight loss, lack of appetite, nausea, shortness of breath, depression, anxiety, and confusion (4) These symptoms often have a major impact on patients' quality of life. Therefore, good control of these symptoms is one of the most important aspects of the care of advanced cancer patients and requires comprehensive interdisciplinary care.(5)

Palliative care (PC) by a comprehensive interdisciplinary team has been shown to provide effective symptom management (6) In fact, PC has become an important part of the continuum of care for cancer patients, and many studies have demonstrated benefits such as improvements in quality of life, various physical and psychosocial symptoms, and survival outcomes.(7,8)

For the first time in India, a Pain and Palliative Care policy to guide and facilitate the development of community-based home care initiatives under the leadership of local self-governments (LSGs) was declared by the Government of Kerala state.(9)

Gynecological cancers are a frequent group of malignancies in women, accounting for approximately 18% of all cancers of women worldwide.(10). Cervical cancer (CC) is the first fatal cancer In developing countries, 500,000 new cases are diagnosed every year, some of which

are the actual cause of death among women of age 35 to 45 years. The CC risk is 1% during the life of a woman living in a developed country, whereas the corresponding value for a woman living in a country without preventive programs is 5%.(11)The development of screening programs and new advances in treatment have contributed greatly to increased survival rates and, in some cases, cure of gynecological cancers. These resulted in a subset of women, known as survivors, who return to their normal functioning and live years after the initial diagnosis without symptoms of the disease. Survivors may experience a wide range of side effects that do not dissolve with time and may persist for a long-term period, such as sexual problems, pain, premature menopause, fatigue, and decreased physical functioning. These side effects can reduce cancer survivors' quality of life (QOL) (12).

Study conducted in Tanzania shows that Palliative services are only available in a few towns and three hospitals with the use of morphine limited by national policies. Finally, there is no formal training program within Tanzania for any discipline of oncology, forcing candidates to travel abroad, often to South Africa or Europe for training (13).

Statement of the problem

In the developed countries, great strides have been made in the treatment of cancer and death has become medical zed and curative procedures are often prioritized ahead of palliative care.(13) Public awareness has increased, treatment modalities improved and consequently the number of survivors is rapidly increasing. Concomitantly, advances in palliative care have also taken place, even though at a slightly lower speed. Unfortunately, that is not the case in most of the developing countries where the majority of cancer patients are diagnosed with advanced stage disease in which, the only realistic treatment option for these patients is palliative care.(13). Further, in most developing countries there is still a general lack of government policies that recognize palliative care. (14)

Cancer has been the leading cause of death worldwide for more than two decades.(15) Gynecological cancers are accounting for approximately 18% of all cancers of women worldwide.(10) Cervical cancer (CC) is the second most deadly gynecological malignancy in the world(11).

Patients with gynecologic cancer experience significant symptom burden throughout their disease course and treatment, which negatively impacts their quality of life. In a comprehensive cancer care model, palliative care, including symptom management, is offered concurrently with anticancer therapies throughout the disease course, not just at the end of life and not only once curative attempts have been abandoned. Good symptom management begins with routine symptom assessment and use of a standardized screening tool can help identify patients with high symptom burden.(16)

Many patients with advanced cervical cancer will develop physical and psychological symptoms related to their disease. These symptoms are infrequently treated by conventional care. Palliative care programs have been developed to fill this gap in care. However, there are limited beds in

hospice units. To allow more terminal cancer patients to receive care from a hospice team, a combined hospice care system was recently developed in Taiwan.(17)

For many Ethiopians whose cervical cancer is detected too late for treatment, no or few palliative care program is available, either in the formal health care system or in Alternative schemes like home care and hospices. For those the high proportion of cervical cancer, if diagnosed at all, too late for meaning ful intervention. At the Community Level Individuals and communities are not aware of palliative care purposes or the potential for their treatment. At the Systems Level, Nationwide, there is no or few organized palliative care program (18)

Significance of the study

It is evident that research in palliative and end-of-life care at all levels and in particular outcomes-focused and cost effectiveness research is needed in order to improve service delivery and ultimately, optimize patients' quality of life. And the consequences of both in terms of medical expenditure, it is anticipated that the need for palliative and end-of-life care will intensify resulting in a greater need for research in this area. Within the context of considering research priorities in palliative care,

Palliative care is an urgent humanitarian need worldwide for people with cervical cancer Palliative care is particularly needed in places where a high proportion of patients present in advanced stages and there is little chance of cure. Ideally, palliative care services should be provided from the time of diagnosis of life-threatening illness, adapting to the increasing needs of cancer patients and their families as the disease progresses into the terminal phase. They should also provide support to families in their respect.

Effective palliative care services are integrated into the existing health system at all levels of care, especially community and home-based care. They involve the public and the private sector and are adapted to the specific cultural, social and economic setting. In order to respond to the cancer priority needs in a community and make the best use of scarce resources, palliative care services should be strategically linked to cancer prevention, early detection and treatment services for adult.

It is widely recognized that palliative care service in many developing countries like Ethiopia, are not mostly applicable. Due to many factors like lack of knowledge about the importance of palliative care in care giver , clients, family etc to provide quality care within acceptable time frames and lack of experiences of those who are working in palliative care units .Within the context of considering research priorities in palliative care, therefore, it is essential to assess knowledge ,utilization and accessibility of palliative care in cervical cancer patients in order to examine its relevance and overall contribution to the area of palliative and end of life care.

Literature review

The study conducted at Colorado shows that the goals of palliative and hospice care are to achieve the best quality of life for patients during the dying process, and to assist their families with direct care needs and with saying goodbye to their loved one. According to the National Hospice and Palliative Care Organization's (NHPCO*): Hospice* Care in America, in 2008 approximately 41.6% of all deaths in the United States were under the care of a hospice program with 83% of these hospice patients aged 65 years or Older, and 38% aged 85 years or older (19).

Study conducted in Washington DC shows that several studies have documented improvements in survival and multiple indicators of well-being following palliative care intervention. Many providers lack the resources, and in some case the skills, to provide adequate palliative care services to cervical cancer patients. Where these services are offered, they are either denied for reimbursement by insurers or reimbursed at very low rates, making these services an absorbed cost for hospitals. Some experts recommend incorporating palliative care into oncology provider education and certification programs to improve palliative care for cervical cancer patients (20).

The study conducted in Texas shows that Palliative care (PC) is a critical component of comprehensive cancer care. Previous studies on PC access have mostly examined the timing of PC referral. The proportion of patients who actually receive PC is unclear. They determined the proportion of cancer patients who received PC their comprehensive cancer center and the predictors of PC referral. In total, 366 of 816 (45%) decedents had a PC consultation. The median interval between PC consultation and death was 1.4 months and the median number of medical team encounters before PC was 20. On multivariate analysis, older age, being married, and cervical cancer patients were significantly associated with a PC referral. the longest interval between an advanced cancer diagnosis and PC consultation (median, 16 months), the shortest interval between PC consultation and death (median, 0.4 months), and one of the largest numbers of medical team encounters (median, 38) before PC (21).

The study conducted in Canada shows that Radiotherapy (RT) is an effective palliative treatment in many scenarios faced by patients with metastatic cancer; RT in these scenarios can improve quality of life, and in some circumstances improve survival outcomes. However, palliative RT is often underutilized, potentially because of a lack of knowledge of the indications for it. Family physicians (FPs) are the primary caregivers of patients with metastatic cancer in many jurisdictions, including most of Canada, and are therefore the physicians in the best position to

identify patients who may benefit from palliative RT and initiate a referral. A relationship between underutilization of palliative radiotherapy and limited exposure to radiation oncology has been suggested; however, the emphasis in the literature has been on medical school exposure, with relatively limited research assessing post-MD exposure to radiation oncology or palliative care (22).

The study conducted in china shows that the major symptoms presented to the hospice consultation team were pain (58%), dyspnea (52%), constipation (45%), and fatigue (23%). The psychosocial problems identified by the hospice consultation team are (56%) The most common problem was emotional disturbance.(23)

The study conducted in India shows that most women with cervical cancer were diagnosed at later stages of the disease Radical surgery for treatment of early stages of cancer and radiotherapy for later stages, were available for private and military sector patients, but was usually financially and geographically inaccessible for public sector patients in two of the three districts. Frequently, women using public services had to travel to other districts in Uttar Pradesh or to New Delhi to receive cancer treatment. Palliative care, including opioid treatment for pain relief, for terminally ill women was even less accessible. Only one non-governmental organization had recently started providing palliative care services in one of the assessment districts (24).

The study conducted in kerala india shows that the major complaint was weakness (43, 41.3%), i.e., motor dysfunction or inability to move any part of the body. The second was tiredness (33, 31.7%) and third was pain (28, 27%). Twenty-six (25%) persons complained of urinary incontinence, 13 (12.5%) complained of ulcer, 11 (10.6%) of edema, and 10 (9.6%) of mental/emotional agony. Eight (7.7%) persons each complained of insomnia or breathlessness, five (4.8%) complained of bleeding from anybody orifices. Six (5.8%) are having dysphasia or aphasia(25).

The study conducted in kerala ,India Home care given: Sixty-three (60.6%) had received medical care, which included drugs for their symptoms and specific diseases. Sixty-nine (66.3%) had received some forms of supportive services like cash or kinds. Four had received water beds, two received walkers, and one received wheel chair. Thirty-one (29.8) received catheter care which included putting, changing, or bladder wash during this period. Seven (6.7%) were receiving ulcer care and two (1.9%) were receiving infection care.(25)

Study conducted Islamic societies shows that, unlike several Western societies, are more death accepting, and live in coexistence with the realization of the inevitability of death. Such an attitude has an impact as to how a patient and his family may view death, also knowing what lies beyond it (26) Another cultural barrier to the delivery of palliative care is that people associate such care with 'giving up' on life, rather than providing quality of life when suffering terminal illness (27) Further, trying to translate findings from the West may be problematic in non-Western, and particularly non-Christian cultures; as many of the assumptions that underlie the approach to suffering and death in the West are culturally based on values and beliefs of western European society (28) and 60%–90% of patients with advanced cancer experience moderate to severe pain (29)

The study conducted in kuweit showes 181 patients consisted of 117(64.6%) women with breast cancer, 42(23.2%) with cervical cancer, 4(2.2%) with endometrial cancer and 18(9.9%) with ovarian cancer, mean age 44.6 years. Cervical cancer patients were significantly older than others ($P < 0.0001$). The patients were predominantly married (62.4%), formally not employed (i.e., housewives, 82.9%), and only 31.5% had up to high school education. They had been ill for 3.2 (SD2.7) years. Although the cervical cancer patients were significantly more likely to be divorced or widowed ($P < 0.001$), there were no significant differences in occupation and education between the groups of patients ($P > 0.05$). While those with cervical cancer were significantly older at onset of illness than the others ($P < 0.0001$), there were no significant differences in duration of illness ($P > 0.05$). In all the domains, the three groups of cancer patients had similar scores ($P > 0.05$). Similarly, there were no significant differences for the corresponding family caregiver groups ($P > 0.05$). The caregiver ratings of the patients were in the same direction, except for the independence domain, where patients with cancer of the ovary were rated as having significantly higher scores than those with cervical cancer. In addition, spouses (all men) rated the patients as having a higher QOL than the parents rated them in the social relations domain (30).

Study conducted In Low- and Middle-Income Countries shows, access to cancer care is often poor. The availability of trained human resources and physical resources are fundamental problems in cancer control among developing countries. However, other factors also limit access to services in developing countries. In addition to availability, accessibility, acceptability,

affordability and accommodation. Palliative services are only available in a few towns and three hospitals with the use of morphine limited by national policies. Finally, there is no formal training program within Tanzania for any discipline of oncology, forcing candidates to travel abroad, often to South Africa or Europe for training. (26)

The study conducted in developing Public awareness campaigns and government health programs for developing countries have often been largely geared towards communicable diseases The potential impact of building awareness of principles of cancer treatment, prevention and early detection on access to care in developing countries may be tremendous. Only one third of patients seeking medical attention for cancer at a large cancer clinic in Delhi, India believed that cancer could be cured. The situation may be complicated by modest or limited health care worker training in basic principles of oncology and sometimes even a lack of awareness of the curability of cancer (31). Beyond building awareness among the general public, creating an awareness of the need for cancer services in developing countries among government officials, medical educators, policy makers and key advocates in the public and press is crucial. The health services research community has an important role to play in improving awareness on these fronts, informing communications and targeting messages as effectively as possible. Organizations such as the International Union Against Cancer (UICC), and the World Health Organization (WHO) have taken leadership in this area, though a substantial effort is still needed to expand awareness among all parties. (31)

The study conducted in Tanzania shows that the caregivers responded that morphine was prescribed to patients with severe pain which is not responding to Non steroidal anti inflammatory drugs (NSAIDS) and weak opioids. All the caregivers indicated that the use of morphine was safe, acceptable and effective for relieving pain associated with chronic cancer. Most frequently mentioned side effects were constipation, drowsiness, headache, nausea and vomiting all of which are manageable. (32)

The study conducted in Nigeria shows that in the period under review, 178 patients with advanced uterine cervical cancers accessed the newly introduced palliative care services alongside other treatment. [The age range for the patients was 17 to 96 years; mean age was 55 years and 54 years for cervical cancer. the study showed details of age distribution among

the patients. 66% of cervical cancer patients were seen on outpatient basis while residing at the Alanu house, a charity home provided by a philanthropic group to accommodate patients referred from far distance. 25 of the patients domicile in Ibadan were on home based care. Almost all the patients had pain as one of their symptoms at presentation to the palliative care team] the study showed source of patients accessing palliative care service; 100 (56.2%) of them were patients referred to the hospital from different parts of the country. All the patients were glad to have been introduced to palliative care service of the hospital, 83 (46.6%) of the patients however regretted non availability of similar service at their home base for continuum of care. The palliative care was seen by all the patients as a "new" treatment approach which was acceptable without any reservation. At the time of this review, 65 (36.5%) had gone back to their respective home base from where they were referred with symptoms well controlled, 102 (57.3%) were reported dead while 11 (6.2%) were still in the care of the palliative care team. Median follow was 6 months. The study shows that majority of patients (48.88%) that accessed the palliative care services were in the 41-60 age bracket.(33)

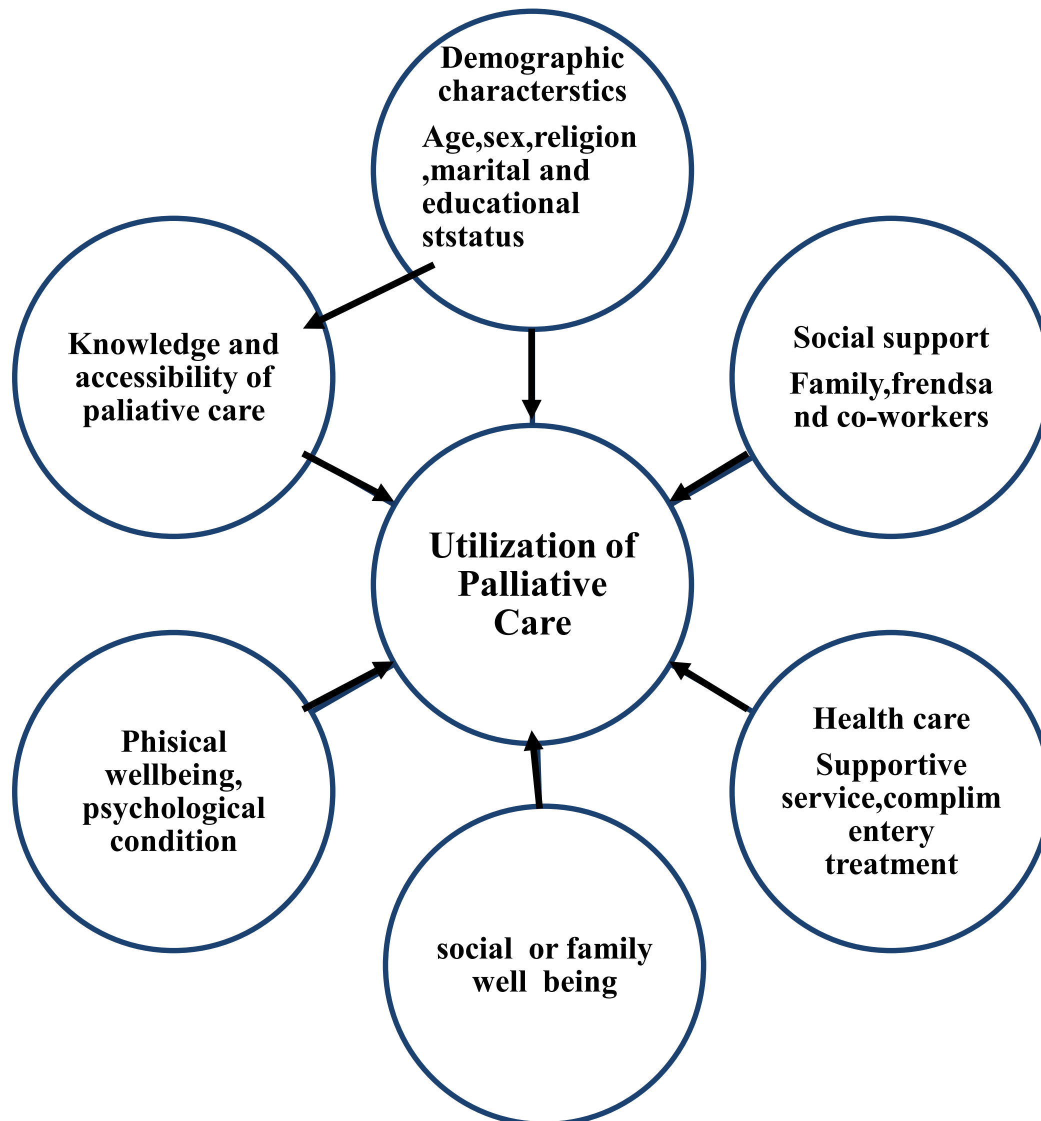
The study conducted in Uganda, Kenya, Malawi shows that details the number of patients, family careers, staff, volunteers, and community leaders interviewed Though the three programmers delivered palliative care through different models, and the contexts of delivery were different, patient and career needs and their experiences of receiving palliative care were strikingly similar, as were the challenges that the three programmes faced. Palliative care in each programme was characterized by being more than just pain relief, or social care. Patients, careers and the local communities spoke of how the personalized package of care that they received made a difference in how they experienced and viewed death and dying, although further financial and practical support would have been greatly appreciated by many. The findings from each country are now presented in turn. The team brought knowledge about illnesses and encouraged access to services, changing community attitudes towards the dying. Volunteers referred patients to the palliative care nurses and their paid assistants, the home based care assistants for more specialized care, and they in turn referred through to hospital care.(34)

Volunteers supported their patients and families throughout the duration of the illness, and this was enhanced by the innovative way mobile phones were used to deliver palliative care. As one volunteer explained, ″Nurses really help us volunteers when we

call them. We flash them from our cell phones, and they ring us back, and if we need them they come" Flashing - calling the number but not letting the call go through - did not cost anything, but alerted the nurse to the need for a conversation to give advice and assistance thus creating an ongoing communication line.(34)Lack of public awareness about early detection, treatment of invasive cancer and palliative care as a barrier in countries with limited cervical cancer treatment services, like Ethiopia(35).

Conceptual frame work for assessment of knowledge, utilization and accessibility of palliative care among cervical cancer patients which is adopted from a thesis which is conducted at queensland university of technology by Vanessa beesley(36)

Figure one



Objectives

General objectives

- To assess knowledge, utilization and accessibility of palliative care among cervical cancer patients in Tikur Anbesa Hospital, Addis Ababa Ethiopia.

Specific objective

- To asses knowledge of palliative care among cervical cancer patients attending Tikur Anbesa Hospital.
- To determine utilization of palliative care among cervical cancer patients attending Tikur Anbesa Hospital.
- To asses accessibility of palliative care among cervical cancer patients attending Tikur Anbesa Hospital.

Method and Procedures

Description Of study area and period

The study was conducted at Tikur Anbessa specialized hospital which is located in lideta sub city in Addis Ababa which is the only tertiary referral hospital of Ethiopia. Where it provide gynecologic and the only radiotherapy service in Tikur AnbessaHospital . The rationale I selected this hospital is that it is tertiary level hospital and cervical cancer patients lastly refer to here there is also pathology department for easily diagnosis and staging of cervical cancer patients. Tikur Anbessa hospital is specialized referral teaching hospital with 600 beds in the ward and 9684 new and old cervical cancer patients visit and managed at Addis Ababa University (AAU), Tikur Anbesa Hospital(TAH). The study was conducted from November to June 2014.

Study design

Hospital based descriptive cross sectional study was conducted.

Source population

All cervical cancer clients in gynecologic and radiotherapy departments of Tikur Anbessa Hospital.

Study population

All cervical cancer clients on follow up and admitted in tikur anbessa hospital.

Inclusion and exclusion criteria

Inclusion criteria

Cervical cancer client's currently on follow up and treating in gynecologic and radiotherapy departments of this hospital.

Exclusion criteria

All other gynecologic cancers

Cervical cancers treated in the past

Cervical cancer with unconscious

All other cancer clients

Variables

Independent Variables

Demographics characteristics

Social support

Health care supportive services

Physical well being

Social or family well being

Dependent Variables

Knowledge about palliative care

Utilization of palliative care

Accessibility of palliative care

Data collection technique

Quantitative assessment using a structured questionnaire was conducted. Three Msc students who have previous data collection experience were selected and two day training was provided. One data collection supervisor was assigned. The questions were administered using face to face interview by data collectors for each study participants.

Sample *Size Calculation*

Sample size was determined by using single population proportion based on the following assumptions: 95% confidence level, there is no previous prevalence finding found so I was taken (0.5) and a 5% margin of error.

$$n_i = \frac{(Za/2)^2\, p(1-p)}{d^2}$$

Where: - n= sample size

$Z_{a/2}$= critical value = 1.96 for 95% CI

p = prevalence of previous study= 0.5

d = precision (marginal error) = 0.05

ni= $(1.96)^2.0.5(1- 0.5)/ (0.05)^2$

With the above inputs the minimum sample required was 384. Taking 5% contingency the final sample size is 403.

Sampling procedure

Systematic sampling technique was used to select the study subjects. There were three wards and two outpatients of gynecology and radiotherapy departments with cervical cancer treatment services. Client's number of HMIS book was used for systematic sampling. Accordingly, 807 clients were visited TAH for a month, so every second patient were included in the study after randomly selection of one client in the first two.

Data quality assurance

Questionnaire was prepared in English version and translated in to Amharic and back to English.

Data collection was carried out by trained three MSC students who have previous data collection experience. The collected data was checked by the supervisor daily for completeness and finally the principal investigator had monitored the overall quality of data collection.

Data analysis

Completed questionnaires were checked for completeness and consistency. Code was prepared for each question by the principal investigator. The data entry was done using EPI- info Data clean up was performed to check for accuracy, consistencies and values. Any error identified was corrected. The cleared data was exported to SPSS Version 21 software for analysis. Data analysis was performed using scores, frequency and percentage. A variety of descriptive statistics such as mean, standard deviation, median and inter-quartile range was calculated to describe some parts of the results and logistic regression was used to determine association of dependant variable versus independent variable.

Operational Definitions

Palliative care is defined by World Health Organization (WHO) as an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other physical, psychosocial and spiritual problems.

Knowledgeable the ability of the cervical cancer patients to remember and answer according to cronbach's alpha was computed for the questionnaires of knowledge towards palliative care after pretest and a value superior or equal to 0.7 was considered as reliable or knowledgeable .i.e from ten awareness questions seven was answered to be knowledgeable.

Utilization is the extent to which cervical cancer patients uses according to cronbach's alpha was computed for the questionnaires of utilization towards palliative care after pretest and a

value superior or equal to 0.5 was considered as reliable or utilized .i.e from ten utilization questions five was answered to be utilized palliative care services in the past 12 months.

Accessibility is the extent to which cervical cancer patients that reaches appropriate palliative care services from nine of accessibility questions at least they was receive five of them.

Cronbach's alpha Is statistical measurement of knowledge greater than mean values.

Ethical consideration s

Ethical clearance was secured from Addis Ababa University College of Health Sciences, Research and Ethics Committee of the Department of Nursing and Midwifery .A formal letter of cooperation was written to Tikur Anbessa Hospital administrative bodies. Informed Consent was obtained from each respondent.

A consent form(Annex) and information sheet (Annex) Was attached to each questionnaire which explained about the purpose of the study, confidentiality, and the respondent's full right to take part or not to take part in the study. One day training was given to data collectors on the importance of informed consent and how to get informed consent from study participants. Finding of the study is kept confidential and all records are kept in a locked cabinet.

Dissemination and Utilization of results

Result of the study will be disseminated to Addis Ababa University School of Nursing as partial Fulfillment of Master's degree in Nursing. And will be communicated to Tikur Anbesa Hospital, Ministry of Health and all government health services in Addis Ababa. The findings Will be presented in different seminars, meetings and workshops and will be published in a Scientific journal. Hard and soft copy will be available in the library of Addis Ababa University For graduate students as well as for other concerned readers.

Results

Socio-Demographic Characteristics of the respondents

As summarized in the table below, Majority of the respondents 343(89.3%) were above the age 34 years with mean age of 45.8 years ± 11.3 years std.dev. Most respondents were married 238(62%) and belonged to Christian Orthodox 190(49.5%) religion followers. More than two-thirds of respondents 184(75.4%) had a maximum 1000ETB monthly income with a median income of 750ETB ± 1021.8ETB std.dev. Above half the respondents 226(58.9%) had not have formal education at all (Table One).

Table One: Socio-demographic characteristics of the respondents with cervical cancer, Tikur Anbesa Hospital, Addis Ababa, Ethiopia, 2014.

Characteristics		Number	Percent
Age(yrs)	<35	41	10.7
	≥35	343	89.3
	Mean±std.dev	45.8 ± 11.3	
Marital status	Single	8	2.1
	Married	238	62.0
	Widowed	85	22.1
	Separated	46	12.0
	Divorced	7	1.8
Religion	Christian Orthodox	190	49.5
	Christian Protestant	71	18.5
	Muslim	103	26.8
	Others	20	5.2
Ethnicity	Tigray	44	11.5
	Amhara	146	38.0
	Oromo	103	26.8
	Gurage	53	13.8
	Others	38	9.9
Family Size	1-2	55	14.3
	3-4	149	38.8
	≥5	175	45.6
	Mean ± std.dev	4.6 ± 2.2	
monthly Income(ETB)	<500	51	20.9
	500-1000	133	54.5
	>1000	60	24.6
	Median ± std.dev	750 ± 1021.8	
Education	No education	226	58.9
	Primary	67	17.4
	Secondary	52	13.5
	Above Secondary	39	10.2

Knowledge of the Clients on palliative care for Cervical Cancer

Figure1 Below summarized knowledge of respondents who had cervical cancer at Tikur Anbesa Hospital. Of 384 respondents who had cervical cancer, 239(62.2%) respondents were knowledgeable about cervical cancer. As also seen in table below, 207(86.6%) respondent were above ≥35 years of age and knowledgeable of palliative care services among other clients who had knowledge. About 113(47.3%) respondent had knowledge of palliative care and no any formal education. The majority 85(60.7%) respondents had no knowledge of cervical cancer palliative care among those who had the diseases. Most 73(86.9%) respondents among those who had no knowledge had less than or equal to 1000 monthly income per respondent. The major groups of respondents 175(73.2%) who had knowledge had the occupation of House wife and employed either in government organization, private organization or NGO. In the contrast, a few respondents 15(10.3) were found in no knowledge category were in the employment category of the patients (Figure One, Table Two).

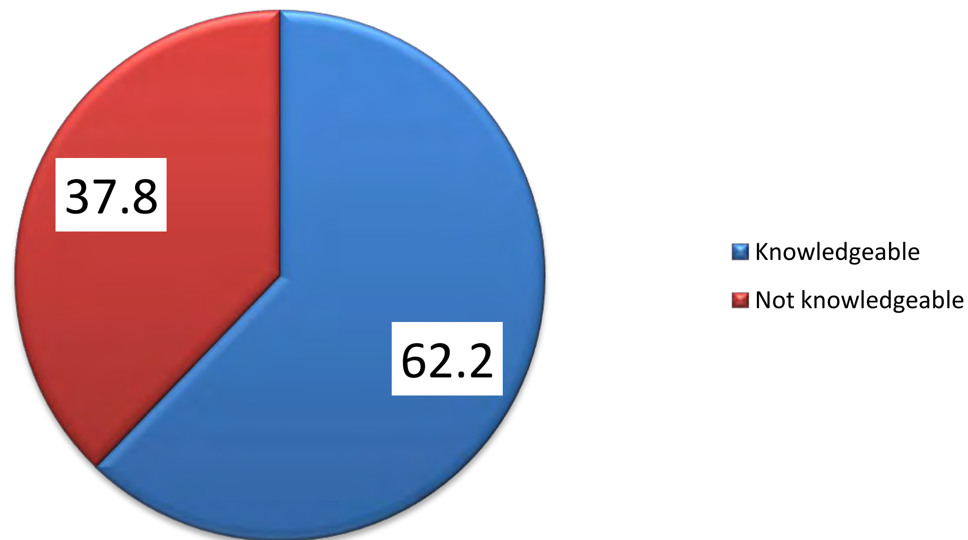


Figure Two: Percent distribution of respondents by knowledge of cervical cancer, Tikur Anbesa Hospital, Addis Ababa, Ethiopia, 2014.

Table Two: Percent distribution of cervical cancer client's by their knowledge of palliative care and selected socio-demographic characteristics, Tikur Anbesa Hospital, Addis Ababa, Ethiopia, 2014.

characteristics		Knowledge	
		Yes, N=239	No, N=145
Age(years)	<35	32(13.4)	9(6.2)
	≥35	207(86.6)	136(93.8)
Educational status	No education	113(47.3)	113(77.9)
	primary	50(20.9)	17(11.7)
	secondary	40(16.7)	12(8.3)
	University/college	36(15.1)	3(2.1)
Family size	1-2	33(13.8)	22(15.7)
	3-4	116(48.5)	33(23.6)
	≥5	90(37.7)	85(60.7)
	missing	0	5(3.4)
Income(ETB)	<500	43(18.0)	8(9.5)
	500-1000	68(28.5)	65(77.4)
	>1000	49(20.5)	11(13.1)
	missing	79(33.1)	61(42.1)
Occupation	Farmer	34(14.2)	52(35.9)
	House wife	82(34.3)	57(39.3)
	Employed[1]	93(38.9)	15(10.3)
	Merchant	7(2.9)	10(6.9)
	Others[2]	23(9.6)	11(7.6)

N.B: [1] government, private or NGO [2] others – daily laborer, unemployed, disabled, retired, and student

Accessibility of Palliative Care by Clients Perspective

Out of 384 clients with cervical cancer, 23(6.0%) respondents reported High accessibility of Counseling Services at the hospital. Even though majorities were satisfied (171(44.5%)) with the services given to them by the hospital, about 51(15.4%) of client's said this services as not applicable in the hospital. From the Total number of clients interviewed as above, 0% respondent reported High accessibility of receiving 24 hours telephone support and Cancer advisory services and about 228(59.4) respondents responded as if the service was not applicable at all in the Hospital. Another major level of responses that client said High were Performance of home activities 46(12.0%).But, at this level comparatively a minimum number of client 15(3.9%) had responded as home activities were not applicable in the hospital. Table below summarized level of clients responses by the services provided in the hospitals(Table Three).

Table Three: Percent distribution of respondents with cervical cancer by level of response and accessibility characteristics, Tikur Anbesa Hospital, Addis Ababa, 2014.

Accessibility Characteristics	Level of response and client satisfaction					
	Not applicable, n(%)	Fully satisfied, n(%)	Low, n(%)	Moderate, n(%)	High, n(%)	Total N(%)
Counseling Services	59(15.4)	171(44.5)	90(23.4)	41(10.7)	23(6.0)	384(100)
Service brochure and benefit	210(54.7)	21(5.5)	135(35.2)	17(4.4)	1(0.3)	384(100)
Books and Videos library	236(61.5)	15(3.9)	112(29.2)	16(4.2)	5(1.3)	384(100)
Relaxation class	179(46.6)	30(7.8)	151(39.3)	19(4.9)	5(1.3)	384(100)
Drop counseling and support service	49(12.8)	164(42.7)	110(28.6)	42(10.9)	19(4.9)	384(100)
24hrs telephone support and cancer advisory	228(59.4)	31(8.1)	117(30.5)	8(2.1)	0	384(100)
Home nursing service	162(42.2)	35(9.1)	54(14.1)	105(27.3)	28(7.3)	384(100)
Perform home activities	15(3.9)	30(7.8)	97(25.3)	196(51.0)	46(12.0)	384(100)
Monitory allowances	263(68.5)	17(4.4)	98(25.5)	6(1.6)	0	384(100)

Clients Use of Palliative Care for Cervical Cancer

Of the total clients included in the study, the major 265(69%) respondent had palliative service from its center at Tikur Anbesa Hospital or Other in the last 12 months of data collection. About 98(25.5%) respondents had Community Based Cancer Support group services of palliative care in the last 12 months of experiences of cancer. And a major 311(81.0%) respondents ever had palliative services from center of palliative care, and the least 107(27.9%) respondents ever had Community Based Cancer Support group services of palliative care in the experiences of cancer(Table Four).

Table Four: percent distribution of clients with cervical cancer by services they had ever or in the last 12 months, Tikur Anbesa Hospital, Addis Ababa, 2014.

Services used	Yes, n(%)	percent(%)
Ever had cancer information and support	152	39.6
Had cancer information and support in the last 12 months	120	31.3
Ever had Community Based Cancer Support group services	107	27.9
Had Community Based Cancer Support group services in the last 12 months	98	25.5
Ever had face to face counseling services	196	51.0
Had face to face counseling services in the last 12 months	172	44.8
Ever had palliative service from center of palliative care	311	81.0
Had palliative service from center of palliative care in the last 12 months	265	69.0

Factors Associated WITH Clients' Use of Palliative Care

The multivariable analysis carried out using binary logistic regression model indicated that six variables: client's knowledge, having little physical wellbeing, social wellbeing, monthly income and marital status were significantly associated with client's utilization of palliative care for cervical cancer.

Respondents who had Knowledge of palliative services to cervical cancer were 26.9 times (AOR=26.9, 95% CI; 12.3, 59) more likely to use the services as compared to those who had no knowledge. Clients who had little physical wellbeing were 3.1 times (AOR=3.1, 95% CI; 1.96, 4.9) more likely to use the palliative services than those who had no physical wellbeing, some physical wellbeing, and/or full physical wellbeing. Women who had social wellbeing were 1.7 times (AOR=1.7, 95% CI; 1.01, 2.8)more likely to use palliative services than those who were lacking social services, little social services, or some social services. Respondents who had 500-1000ETB monthly income were 0.25 times (AOR=0.25, 95% CI; 0.09, .7) less likely to use palliative care for cervical cancer than those who had below 500ETB monthly income per a respondent. And women who were single at data collection period were 55.4 times (AOR=55.4, 95% CI; 1.2, 2660.4) more likely to use palliative services for cervical cancer than those who were divorced. Respondents who had some physical wellbeing had association with utilization of

palliative care than those who had no, little, or full physical wellbeing in binary regression, but not significantly associated by adjusted odds ratio.

Table Five: Multivariable logistic regression model for client's use of palliative services by selected characteristics, Tikur Anbesa Hospital, Addis Ababa, Ethiopia, 2014.

characteristics		Utilized palliative care							
		Yes, n=210 (54.7%)	No, n=174 (45.3%)	COR	95% CI lower	95% CI upper	AOR	95% CI lower	95% CI upper
Knowledge	Knowledgeable	180(85.7)	59(33.9)	11.7*	7.1	19.2	26.9*	12.3	59.0
	Not knowledgeable	30(14.3)	115(66.1)	1.0+			1.0+		
Little Physical wellbeing	Yes	158(75.2)	83(47.7)	3.3*	2.2	5.1	3.1*	1.96	4.9
	No	52(24.8)	91(52.3)	1.0+			1.0+		
No physical wellbeing	Yes	123(58.6)	126(72.4)	1.9*	1.2	2.9	0.8	0.5	1.3
	No	87(41.4)	48(27.6)	1.0+			1.o+		
Social/family wellbeing	Yes	171(81.4)	120(69)	2*	1.2	3.2	1.7*	1.01	2.8
	No	39(18.6)	54(31)	1.0+			1.0+		
Monthly Income[1]	<500	41(27%)	10(10.9)	1.0+			1.0+		
	500-1000	70(46.1%)	63(68.5)	0.27*	0.13	0.59	0.25*	0.09	0.7
	>1000	41(27%)	19(20.7)	0.53	0.22	1.27	0.3	0.1	1.01
Marital Status	Single	7(3.3)	1(.6)	42.0*	2.1	825.7	55.4*	1.2	2660.4
	Married	157(74.8)	81(46.6)	11.6*	1.4	98.2	7.1	0.47	109.6
	Widowed	38(18.1)	47(27)	4.8	0.6	42.0	1.4	0.08	22.9
	Separated	7(3.3)	39(22.4)	1.1	0.1	10.4	0.39	0.02	7.0
	Divorced	1(0.5)	6(3.4)	1.0+			1.0+		

N.B: +reference category, * statistical significant, [1] missed case 58(27.6%

Discussion

This Institution based cross-sectional study attempted to assess knowledge, utilization and accessibility of palliative care among cervical cancer patients in Tikur Anbesa Hospital, Addis Ababa, Ethiopia. In addition, the study tried to investigate status of physical and social wellbeing of the respondents in this Hospital.

In this study, about 239(62.2%) respondents out of the total interviewed were knowledgeable about palliative care for cervical cancer. Of this, 207(86.6%) respondents were relatively older (≥35 years of age) and the rest 32 (13.4%) respondents were younger (<35years of age). This finding was not in line with African study (Nigeria) where majority of patients (48.88%) that accessed the palliative care services were in the 41-60 age bracket (33). And 83% of hospice patients aged 65 years or Older in other study of USA (19). These differences may be due to age classification of the respondents in this study and studies of America and Africa.

Out of the total sample size responded in this study, about 39(10.2%) respondents reported that there were full accessibility of palliative care services to cervical cancer women at Tikur Anbesa Hospital, as of client's perspectives. The rest reported moderate, low, or no palliative care services. Study in other country showed that about 83 (46.6%) of the patients regretted non accessibility of the services for continuum of care (33). This difference may be due to low cervical cancer palliative care centers in Ethiopia, since it was only at Tikur Anbesa Hospital in Addis Ababa.

Of the total clients included in this study, about 265(69%) had palliative services from its center at Tikur Anbesa Hospital, Ethiopia, in the last 12 months of data collection.

In this study, respondents who had used palliative care services to cervical cancer were statistically significantly associated (AOR=26.9, 95% CI; 12.3, 59) with those who had knowledge of the services. This relation is similar with the fact that lack of public awareness about early detection, treatment of invasive cancer and palliative care as a barrier in countries with limited cervical cancer treatment services, like Ethiopia(35).

Palliative care utilization were statistically significantly associated (AOR=3.1, 95% CI; 1.96, 4.9) with Clients who had little physical wellbeing. This was may be due to increased client need for full physical wellbeing and good quality of living.

Palliative care utilization were statistically significantly associated (AOR=1.7, 95% CI; 1.01, 2.8) with women who had full social wellbeing. This was may be due to social support and encouragement that helps the client for utilization of palliative care.

Palliative care utilization were statistically significantly associated (AOR=0.25, 95% CI; 0.09, .7) with respondents who had 500-1000ETB monthly income. This was may be due to insufficient monthly income the respondents had and the need not to interrupt this small amount of monthly income due to illnesses, made them to utilize palliative services.

Palliative care utilization were statistically significantly associated (AOR=55.4, 95% CI; 1.2, 2660.4) with single marital status of women. This was may be due to the need to give child by the never married respondents make them very careful to utilize palliative services.

Strength and Limitations of the Study

Strength of the Study

It was advantageous for future researchers for references since no evidence of previous study exists in Ethiopia.

It was an opportunity for TAH to plan based on this findings to have the requirements needed based on the standard.

Limitation of the study

Judging the level of response for ordinal questions were a challenge to respondents, since the level can be subjective for accessibility of services by client perspective, but it was a primary option to get response on client side accessibility. The fact that women who died from cervical cancer were excluded from the study, might underestimate the results.

Conclusion

Of the total sample size responded to the questions, more than half of respondents being treated on TAH had knowledge of palliative care for cervical cancer. About Nine out of ten respondents reported problems on accessibility of palliative care services for cervical cancer in Tikur Anbesa hospital. Women's knowledge of care, presence of little physical wellbeing to the respondents, social wellbeing of the respondents; monthly income of the respondents and marital status of the women were statistically significantly associated with respondent's utilization of palliative care services for cervical cancer at Tikur Anbesa Specialized Hospital.

Recommendation

1. **For Providers of Palliative care services**

   Since Knowledge of the women were an important determinant of the service Utilization, Health care providers at TAH has to have health education session focusing on palliative care services to the clients with cervical cancer.

2. **Facility where palliative care provided**

   As accessibility of the client were low for palliative care services at TAH as of client perspective, The Hospital is recommended to aware and provide services of palliative care to the client's with cervical cancer

   TAH has to fulfill all the facilitations listed and needed for clients with cervical cancer for palliative services based on the standards.

3. **Government and Policy Makers**

   Community Mobilization through the media, posters and face to face on community health day focusing on palliative care services to cervical cancer must be addressed by Addis Ababa Town administrations and policy makers

   Since the center was only TAH, the FDRE government must build another center in Addis or elsewhere in the country so that the problems of resources can be solved

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Annexes

Annex I: English Version Questionnaire, information and consent sheet

Good Morning/Good Afternoon. My name is _________________ I am working for a research to Addis Ababa University Department of nursing and midwifery . This team is conducting a study on Knowledge, Utilization and accessibility palliative care among cervical cancer patients in TikurAnbessa Hospital; Addis Ababa, Ethiopia." This study is very helpful to assess utilization and availability of palliative care for cervical cancer on patients and their family and to design appropriate strategies in local and national level by different stakeholders.

You are selected for this study randomly and participation in this study is based on Voluntariness. You have full right not to participate in this study however we encourage you to participate since your responses are very crucial to look at the burden of cervical cancer without palliative care service. It may also help to design appropriate strategies and improve the health of cervical cancer patients and their family. During our stay we will ask you some questions. These questions include socio - demographic variables, level of awareness Health status, use of palliative care services and accessibility of the cervices. In the study there are no procedures and questions that may harm or give you a feeling of discomfort. We would like to assure you that your personal identifications will not be written in the questionnaire. Your response will be kept confidential. All records of this study will be kept in a locked cabinet. If findings of this study are ever presented in a workshop or seminar your name or other personal identification will not be mentioned. If you agree to participate in this study, our questionnaire interview may take us 30-45 minutes. If you feel discomfort or want to withdraw in the middle of our interview, it is your right to discontinue without any penalty. It is also your right not to give a response to some of our question if you don't want to respond .Do you have any questions? If you want to ask questions for clarification about the study later on;you can contact Sr Hasna musema the principal investigator by cell phone numbers 0911-834152 during the working hours in the week days.

May I continue to consent sheet!

May I have your permission to the consent sheet?

Yes .... (Continue)

No .... (Stop)

Consent sheet

According to the above information given to you regarding the study objectives, I agree to be interviewed for all the questions that the interviewer asks me.

Interviewer Name______________________________

Sign_____________________________

Respondent Sign_____________________________

May I have your permission to the interview?

Yes .... (Continue)

No .... (Stop)

Section I. Socio - economic and demographic characteristics

S. No.	Questions	Possible answers and coding	Skip
101	How old are you?	1.__________years 98. I don't know 99. Refused to tell	
102	What is your current marital status?	1. Single (never been married) 2. Married 3. Widowed 4. Separated 5. Divorced	
103	What is your educational status?	1. Illiterate 2. Read andwriteonly 3. Grade 1- 8 (specify completed) _____ 4. Grade 9 -12 (specify completed) _____ 5. College, University graduated	
104	What is your main occupation (Past twelve months)?	1. Farmer 2. House wife 3.Government employed 4. NGO employed 5. Employed private for profit sector 6. Merchant (private business) 7. Pupil/ student 8. Daily laborer 9. Unemployed 10. Retired 11. Disabled/ sick 12. Other (specify) _____________	
105	What is your monthly income?	1 ________Birr or ___________in Kind 98. I don't know 99. Refused to tell	
106	What is your religion?	1. Christian orthodox 2.Christianprotestant 3. Muslim 4. Catholic 5. Others (specify) _____________	
107	What is your ethnicity?	1. Tigray 2. Amhara 3. Oromo 4. Gurage 4. Others (specify) _____________	
108	Where is your permanent residence area?	1.Region _________________ 2.woreda _________________ 3. kebele	

109	Number of people living in your family?	1. ______________ 98. Refused to tell	
110	What is your family monthly income?	1. ______________ 98. I don't know 99. Refused to tell	

Section II Awareness and Use of palliative services and support organization

S. No	Types of support(palliative) services	Questions	Possible answers	Skip
112	Cancer information and support or palliative care services for cervical cancer patients	**A.** Do you have an awareness of cancer information and support or palliative care for cervical cancer patients?	1.yes 2.no	→ 113
		B . Did You referred by health care provider for cancer information and support or palliative care services?	1.yes 2.no	
		C. Have You ever utilize cancer information and support or palliative care with your cancer experience?	1.yes 2.no	
		D. Have you utilized in the past 12 month for cancer information and support or palliative care with your cancer experience?	1.yes 2.no	
		E. Do you satisfied over all with the cancer information andsupport or palliative care services?	1.yes 2.no	
113	Community–based cancer support group services for cervical cancer patients	**A.** Do you have an awareness of community- based cancer support group for cervical cancer patients ?	1.yes 2.no	→ 114
		B.Did You referred by health care provider for community-based cancer support or palliative care services?	1.yes 2.no	
		C Have You ever utilized community-based cancer support group service with your cancer experience?	1.yes 2.no	
		D. Have you utilized in the past 12 month for community-based cancer support group services with your cancer experience?	1.yes 2.no	
		E. Do you satisfied over all with community-based cancer supportgroup services?	1.yes 2.no	

114	Face to face counseling services for cervical cancer patients	A. Do you have an awareness of face to face counseling services for cervices cancer patients?	1.yes 2.no →	115
		B. Did You referred by health care provider for face to face counseling services?	1.yes 2.no	
		C. Have you ever utilized face to face counseling services with your cancer experience?	1.yes 2.no	
		D. Have you utilized in the past 12 months of face to face counseling services with your cancer experience?	1.yes 2.no	
		E. Do you satisfied over all with face to face counseling services?	1.yes 2.no	
	Support services offered by organization			
115	Center for palliative care for cervical cancer patients at Tikur Anbesa Hospital	**A .**Do you have an awareness of center for palliative care for cervical cancer patients at Tikur Anbesa Hospital?	1.yes 2.no →	next
		B. Did You referred by health care provider for center of palliative care services at Tikur Anbesa Hospital?	1.yes 2.no	
		C. Have you ever utilizedpalliative care from center of palliative care at Tikur Anbesa Hospital?	1.yes 2.no	
		D. Haveyou utilized in the past 12 month palliative care from center for palliative care at Tikur Anbesa Hospital?	1.yes 2.no	
		E. Do you satisfied over all with palliative care received from center for palliative care atTikurAnbesaHospital?	1.yes 2.no	

Section III accessibility of palliative care services

Serial No	Questions	Possible answers	Skip
116	Counseling services (eg counselor, psychologist social worker, nurse, and specialist) at the hospital or clinic for you?	1.notapplicable 2.fully satisfied 3.low need 4.moderate need 5.high need	→117
117	Brochures about services and benefit for patients with cancer	1.notapplicable 2.fully satisfied	

	is accessible?	3.low need 4.moderate need 5.high need	
118	Library of books and videos about cancer and related issues is easily accessible?	1.notapplicable 2.fully satisfied 3.low need 4.moderate need 5.high need	
119	Relaxation class in palliative care unit is it accessible?	1.notapplicable 2.fully satisfied 3.low need 4.moderate need 5.high need	
120	Do you think drop counseling and support services?	1.notapplicable 2.fully satisfied 3.low need 4.moderate need 5.high need	
121	Do you receive 24-hours telephone support and cancer advisory?	1.notapplicable 2.fully satisfied 3.low need 4.moderate need 5.high need	
122	Do you receive Home nursing services?	1.notapplicable 2.fully satisfied 3.low need 4.moderate need 5.high need	
123	Do you perform Home activities?	1.notapplicable 2.fully satisfied 3.low need 4.moderate need 5.high need	
124	Monitory allowance for traveler ,treatment and equipment expenses services?	1.notapplicable 2.fully satisfied 3.low need 4.moderate need 5.high need	

Section IV Physical well being

S. No	Questions	Possible answers	Skip
125	Have you a lack of energy?	0. not at all 1.alittle bit 2.some what 3.very much	
126	Do you have nausea?	0. not at all 1.alittle bit 2.some what 3.very much	
127	Because of your physical condition do you have trouble meeting the needs of your family?	0. not at all 1.alittle bit 2.some what 3.very much	
128	Do you have pain in mobility/physical activity?	0. not at all 1.alittle bit 2.some what 3.very much	
129	Are you bothered by side effect of treatment?	0. not at all 1.alittle bit 2.some what 3.very much	
130	Do you feel ill?	0. not at all 1.alittle bit 2.some what 3.very much	
131	Do you forced to spend time in bed?	0. not at all 1.alittle bit 2.some what 3.very much	

Section V Social /family well-being

Serial No	Questions	Possible answers	Skip
132	Do you feel close to your friends?	0. not at all 1.alittle bit 2.some what 3.very much	
133	Do you get emotional support from your family?	0. not at all 1.alittle bit 2.some what 3.very much	

134	Do you get support from your friends?	0. not at all 1.alittle bit 2.some what 3.very much	
135	Do your family accepted your illness?	0. not at all 1.alittle bit 2.some what 3.very much	
136	Do you satisfied with family communication about your illness?	0. not at all 1.alittle bit 2.some what 3.very much	
137	Do you feel close to your partner?	0. not at all 1.alittle bit 2.some what 3.very much	

የአማርኛ መጠይቅ እና መረጃ ቅጽ

እንደምንዋሉ /አደሩ ስሜ --------ይባላል ይህንን ጥናት እያካሀድኩ ያለሁት በአዲስ አበባ ዩኒቭርሲቲ ነርሲግ እና አዋላጅ ነርስ ትምህርት ክፍልነው፡፡የጥናቱ አላማ በጥቁር አንበሳ ውስጥ የሚታከሙ የመሀፀን ጫፍ ካንሰር/ደዌህመምተኞች በድጋፍ እንክብካቤ ያላቸውን ግንዛቤ፡አገልግሎቱን መጠቀም እና ተገቢዉን አገልግሎት ማግኘት ይሰኛል፡፡

ይህ ጥናት የመሃፀን ጫፍ ታማሚ በሽተኞች የድጋፍ እንክብካቤ አቅርቦት እና አገልግሎት ላይ ለማወቅ እንዲሁም በሀገር አቀፍ ደረጃ በተለያዩ አካላት በጉዳዩ ላይ አቅድ ለማዉጣት ከፍተኛ ጠቀሜታ አለው፡፡

እርሶበዚሁጥናትየተካተቱት ያለምንም ቅድመ ሁኔታ ሲሆን በጥናቱ ያለመሳተፍ ሙሉ መብት አሎት ሆኖም ግን እርሶ የሚሰጡን ምላሽ የመሃፀን ጫፍ ካንሰር ታማሚዎች በድጋፍ እንክካቤ አገልግሎትና ግንዛቤ ለመጨመር ከፍተኛ ጥቅም አለው፡፡ከዚሂም ባሻገር የመሀፀን ጫፍ ካንሰር በሽተኞች እንዲሁም ቤተሰቦቻቸው አጠቃላይ ጤና ለማሻሻል ጠቀሜታ አለው፡፡

በበሽታው ምክንያት የሚከሰተው ጫና ያለድጋፍ እንክብካቤበ ተጨባጭ ለመገመት ስለሚረዳ እና ለችግሩ መፍትሄ ለመፈለግ ስለሚያግዝ እንዲሳተፍ እናበራታታዎታለን፡፡

በሚኖረን ለአፍታ ቆይታ የተወሰኑ ጥያቄዎችን እናቀርብሎታለን የሚቀርብሎ ጥያቄዎች አጠቃላይ መረጃዎችን ስለድጋፍ አገልግሎት ያሎትን ግንዛቤ አገልግሎቱን መጠቀም እና የድጋፍ አገልግሎት ተደራሽነት እና እንዲሁም ሌሎች ተያያዥ ጉዳዮች የሚዳስሱ ይሆናሉ፡፡ ጥያቄዎቹ ውስጥ ምንም በርሶ ላይ ጥሩ ስሜት እንዳይሰማዎታ የሚያደርግ ጥያቄ የለውም፡፡ በጥያቄው ላይ ስለእርሶ ማንነት የሚገልፅ ምንም ኣይነት ነገር እንገልጽም የሚነግሩን ነገሮች ሁሉ ሚስጥራዊነታቸው የተጠበቁ ናቸው፡፡በጥናቱ ለመሳተፍ ፍቃደኛ ከሆኑ ጥያቆዎች ከ30-45 ደቂቃ ሊፈጅ ይችላሉ፡፡በማነኛውም ስኣት የማቋረጥ መብቶ የተጠበቀ ነው፡፡መመለስ የማይፈልጉትን ጥያቄ ካለ እንዲመልሱ አይገደዱም፡፡መጠየቅ የሚፈልጉትን ነገር አለ?በጥናቱ ላይ ዘርዘር ያለ መረጃ ከፈለጉ የጥናቱን ዋና ተመራማሪ ሲ/ርሀሰና ሙሰማ በግል ስልክ ቁጥር 091183 41 52 ዘውትር በስራ ሠአት ሊያገኙዋት ይችላሉ፡፡

ቃለ መጠይቁን መጀመር እችላለሁ ?

አዎ ቀጥል   አይደለም አመሰግነው ወደሚቀጥለው ታማሚ ይሂዱ

ክፍል አንድ ማህበራዊና ኢኮኖሚያዊ ጥያቄዎችን በተመለከተ

101 እድሜዎ ስንት ነው ?

1------- አመት 98 አላውቀውም

99 ለመናር ፍቃደኛ አደለሁም

102 የጋብቻ ሁኔታ እንዴት ነው?

1 ያላገባ 3.በሞትየተለየ 5.የተፋታ

2. ያገባ 4.ተለያይቶየሚኖር

103 የትምህርት ደረጃ ?

1. ያልተማረ
2. ማንበብናመፃፍብቻየሚችል
3. ከ 1ኛ- 8ኛ (ስንተኛእንደጨረሱይጥቀሱ)
4. ከ 9-12ኛ(ስንተኛእንደጨረሱይጥቀሱ)
5. የኮሌጅወይምየዩንቨረሲቲምሩቅ

104. ስራዎ ምንድ ነው?

1.ገበሬ

2.የቤትአመቤት 7. ተማሪ

3.የመንግስት ሰራተኛ 8.የቀን ሰራተኛ

4.መግስታዊ ያልሆነ ድርጅት ሰራተኛ 9.ስራአጥ

5. በግል ድርጅት ተቀጣሪ 10.በጡረታ የተገለለ

6.ነጋዴ 11.ሌላ ካለ ግለፁ

105. የወር ገቢዎ ስንት ነው?

1-----ብር ወይም በአይነት 99 ለመናገር ፍቃደኛ አይደለሁም 99 አላውቅም

106.ሀይማኖቶምንድነው ?

1. ኦርቶዶክስ ክርስቲያን 4. ካቶሊክ

2.ፕሮቴስታንት 5. ሌላከሆነይጥቀሱ---------

3. ሙስሊም

107. ብሄሮዎ ምንድ ነው?

1. ትግሬ 4.ጉራጌ

2.አማራ 5.ሌላከሆነይጥቀሱ

3.ኦሮሞ

108. ቋሚ መኖርያ ቦታዎ የት ነው ?

1. -ክልል

2.----ወረዳ

3.----ቀበሌ

109. ከርሶ ጋር የሚኖር የቤተሰብ ብዛት ስንት ነው?

1--------

98. መናገርአልፈልግም

110 .ያቤተሰቦ ወራዊ ገቢ ስንትነው

1. ----- ብር

98 አላውቀውም

99 መናገርአልፈልግም

112. የካንሰር መረጃ ድጋፍ አገልግሎት ለመሀፀን ጫፍ ካንሰር ህመምተኞች .

ሀ. የካንሰር መረጃ እና ድጋፍ አገልግሎት ለመሃፀን ጫፍ ካንሰር ህመምተኞች አዳለ ግንዘቤው አሎት ?

1 አዎ

2.አይደለም

ለ. በጤና ገልግሎት ሠጪዎች ወደ ካንሰር መረጃ እና ድጋፍ አገልግሎት እንዲሄድ ተልከው ነበር?

1. አዎ

2.አይደለም

ሐ. በካንሰር በሽታዎ ጊዜ የካንሰር መረጃ እና ድጋፍ አገልግሎት ተጠቅመው ያውቃሉ ?

1. አዎ

2. አይደለም

መ. ባለፉት 12 ወራት ውስጥ በካንሰር በሽታዎ ጊዜ የካንሰር መረጃ እና ድጋፍ አገልግሎት ተጠቅመው ያውቃሉ?

1. አዎ

2. አይደለም

ሠ. ባገኙት አጠቃላይ የካንሰር መረጃ እና ድጋፍ አገልግሎት እርካታ አግኝተዋል ?

1. አዎ

2. አይ

113 ማህበረሰብ አቀፍ የካንሰር ድጋፍ ቡድን አገልግሎት ለመሃፀን ጫፍ ካንሰር ህመምተኞች

ሀ. የማህበረሰብ አቀፍ የካንሰር ድጋፍ ቡድን አገልግሎት ለመሀፀን ጫፍ ካንሰር ህመምተኞች እንዳለ ግንዛቤው አሎት ?

1 አዎ

2.አይደለም

ለ. በጤና አገልግሎት ሰጪዎች ወደ ማህበረሠብ አቀፍ የካንሠር ድጋፍ ቡድን አገልግሎት እንዲሄዱ ተልከው ነበር ?

1 አዎ

2.አይደለም

ሐ በካንሰር በሽታዎ ጊዜ የማህበረሠብ አቀፍ የካንሰር ድጋፍ ቡድን አገልግሎት ተጠቅመው ያውቃሉ ?

1 አዎ

2.አይደለም

መ. ባለፉት 12 ወራት ውስጥ በካንሰ በሽታዎ ጊዜ የማህበረሠብ አቀፍ የካንሰር ድጋፍ ቡድን አገልግሎት ተጠቅመው ያውቃሉ?

1 አዎ

2.አይደለም

ሠ. ባገኙት አጠቃለይ የመህበረሰብ አቀፍ የካንሠር ድጋፍ ቡድን አገልግሎት እርካታ አግኛተዋል ?

1 አዎ

2.አይደለም

114. አካል በኣካል የምክር አገልግሎት ለመሀፀን ጫፍ ካንሰር ህመምተኞች

ሀ. የአካል በአካል የምክር አገልግሎት ለመሀን ጫፍ ካንሰር ህመምተኞች እንደለ ግንዛቤው አሎት?

1 አዎ

2.አይደለም

ለ. በጤና አገልግሎት ሠጪዎች ወደ አካል በአካል የምክር አገልግሎት እንዲሄዱ ተልከው ነበር?

1. አዎ

2. አይደለም

ሐ. በካንሰር በሽታዎ ጊዜ አካል በአካል የምክር አገልግሎት ተጠቅመው ያውቃሉ ?

1 አዎ

2.አይደለም

መ. ባፉት 12 ወራት ውስጥ በካንሰር በሽታዎ ጊዜ አካል በአካል ምክር አገልግሎት ተጠቅመው ያውቃሉ?

1 አዎ

2.አይደለም

ሠ. ባገኙት አጠቃላይ የአካል በአካል የምክር አገልግሎት እርካ ታአግኝተዋል ?

1 አዎ

2.አይደለም

የድጋፍ አገልግሎት በድርጅት የቀረበ

115. የድጋፍ አገልግሎት ማዕከል ለመሀፀን ጫፍ ካንሠር ህመምተኞች በጥቁር አንበሳ ሆስፒታል

ሀ. የድጋፍ አገልግሎት ማዕከል ለመሀፀን ጫፍ ካንሰር ህመምተኞች በጥቁር አንበሳ ሆስፒታል እንዳለ ግንዛቤው አሎት ?

1 አዎ

2.አይደለም

ለ. በጤና አገልግሎት ሠጪዎች ወደ ድጋፍ አገልግሎት ማዕከል በጥቁር አንበሳ ሆስፒታል የሚገኘው እንዲሄዱ ተልከው ነበር?

1. አዎ
2. አይደለም

ሐ. የድጋፍ አገልግሎት ከድጋፍ አገልግሎት ማዕከል ጥቁር አንበሳ የሚገኘው ተጠቅመው ያውቃሉ ?

1. አዎ
2. አይደለም

መ. ባለፉት 12 ወራት ውስጥ የድጋፍ አገልግሎት ከድጋፍ አገልግሎት ማዕከል ጥቁር አንበሳ ሆስፒታል ከሚገኘው ተጠቅመውያ ውቃሉ?

1. አዎ
2. አይደለም

ሠ. ባገኙት አጠቃላይ የድጋፍ አገልግሎት ከድጋፍ አገልግሎት ማዕከል ጥቁር አንበሳ ሆስፒታል ከሚገኘው እርካታ አግኝተዋል ?

1. አዎ
2. አይደለም

ክፍል 3 የድጋፍ አገልግሎት አቅርቦት

115. የምክር አገልግሎት (ለምሳሌ አማካሪዎች ሣይኮሎጂስቶች ማህበራዊ ጉዳይ ባለሙያዎች ነርሶች እና እስፔሻሊስቶች) በሆስፒታል ወይም ከክሊክ አገልግሎት አግኝተው ያውቃሉ?

1.ተግባራዊ አይደለም
2. አጥጋቢነው
3.ዝቅተኛነው
4. መካከለኛነው
5. ከፍተኛነው

116. ስዕላዊ መግለጫ ስለ አገልግሎቱና ለካንሰር ሁመማን ጠቀሜታ ያላቸውን በቀላ ሉማግኘት ይችላል?

1. ተግባራዊ ይደለም
2. አጥጋቢነው
3. ዝቅተኛነው
4. መካከለኛነው
5. ከፍተኛነው

117 ከቤተ መፀሀፍት መፀሀፍቶችን እና የተቀረፁ ቪዲዮ ስለካንሰር እና ተያያዥ ጉዳዮችን በቀላሉ ማግኘት ይቻላል ?

1. ተግባራዊ አይደለም
2. አጥጋቢነው
3.ዝቅተኛነው
4.መካከለኛነው

5.ከፍተኛነው

118 የመዝናኛ ቦታ በድጋፍ ገልግሎት መስጫ አካባቢ አቅርቦቱ አለ

1. ተግባራዊ አይደለም

2. አጥጋቢነው

3.ዝቅተኛነው

4.መካከለኛነው

5. ከፍተኛነው

119 የምክር እና የድጋፍ አገልግሎት በቂ አለ ብለው ያስባሉ ?

1.ተግባራዊ አይደለም

2. አጥጋቢነው

3.ዝቅተኛነው

4. መካከለኛነው

5. ከፍተኛነው

120 የ24 ሠአት የስልክና የካንሰር አማካሪ አገልግሎት አግኝ ተውያውቃሉ ?

1.ተግባራዊ አይደለም

2. አጥጋቢነው

3.ዝቅተኛነው

4.መካከለኛነው

5. ከፍተኛነው

121. ቤት ለቤት የነርሶች አገልግሎት አግኝተው ያውቃሉ ?

1.ተግባራዊ አይደለም

2.አጥጋቢነው

3.ዝቅተኛነው

4.መካከለኛነው

5. ከፍተኛነው

122 ቤት ውስጥ እንቅስቃሴ ያደርጋሉ ?

1.ተግባራዊ አይደለም

2.አጥጋቢነው

3. ዝቅተኛነው

4.መካከለኛነው

5.ከፍተኛነው

123 የኪስ ገንዘብ (የነፃ አገልግሎት)ለማጓጓዝ ለመዳሀኒት እና ለአንዳንድ መገልገያዎች አግኝተ ውያውቃሉ ?

1. ተግባራዊ አይደለም

2. አጥጋቢነው

3.ዝቅተኛነው

4.መካከለኛነው

5.ከፍተኛነው

ክፍል 4 አካላዊ ደህንነት

124. የሀይል እጥረት አለቦት?
0. በፍፁም
1. ትንሽ ትንሽ
2.በተወሰነመጠን /መካከለኛ
3.በጣም
125. ማቅለሽለሽ አሎት ?
0. በፍፁም
1. ትንሽ ትንሽ
2.በተወሰነመጠን /መካከለኛ
3. በጣም
126 በአካላዊ ደህንነት ምክንያት የቤተሰቦዎን ፍላጎት የማሟላት ችግር ውስጥ ገብተዋል ወይም ወድቀዋል?
0. በፍፁም
1. ትንሽ ትንሽ
2.በተወሰነመጠን /መካከለኛ
3. በጣም
127 በሚቀሳቀሱበት ግዜ /አካላዊ እንቅስቃሴ ሲያደርጉ ህመም አሎ እንዴ ?
0. በፍፁም
1. ትንሽትንሽ
2. በተወሰነመጠን /መካከለኛ
3. በጣም
128. በመድሀኒት የጎንዮሽ ውጤት ተቸግረዋል እንዴ?
0. በፍፁም
1. ትንሽ ትንሽ
2.በተወሰነመጠን /መካከለኛ
3.በጣም
129. የህመምተኛነት ስሜት አሎት እንዴ ?
0. በፍፁም
1. ትንሽ ትንሽ
2.በተወሰነመጠን /መካከለኛ
3. በጣም
130. ህመም ብዙ ሰአት እንዲተኙ ያስገድዶታል እንዴ ?
0. በፍፁም
1. ትንሽ ትንሽ
2.በተወሰነመጠን /መካከለኛ
3.በጣም

ክፍል 5 ማህበራዊ /ቤተሰባዊደህንነት

131 ከጓደኞቾ የመገለል ስሜት አድሮቢኛል ብለው ያስባሉ?
0. በፍፁም
1. ትንሽትንሽ
2.በተወሰነመጠን /መካከለኛ
3.በጣም
132. ከቤተሰብዎ ኤይዞት የሚሎት /የቅርብ ድጋፍ የሚያደርግሎት አለ ?
0. በፍፁም
1. ትንሽ ትንሽ
2.በተወሰነመጠን /መካከለኛ
3.በጣም
133. ከጓደኞች አይዞት የሚሎት /የቅርብ ድጋፍ የሚያደርግሎት አለ ?
0. በፍፁም
1. ትንሽ ትንሽ
2.በተወሰነመጠን /መካከለኛ
3.በጣም
134. የርሦን ህመም ቤተሰቦቾ አምነው ተቀብሎዎታል?
0. በፍፁም
1. ትንሽ ትንሽ
2.በተወሰነመጠን /መካከለኛ
3.በጣም
135 ከቤተሠቦ ጋር ስለ ህመሞ ባሎት ውይይት ረክተዋል?
0. በፍፁም
1. ትንሽትንሽ
2.በተወሰነመጠን /መካከለኛ
3.በጣም
136. ባልደራቦቾ አግልለውኛል   ብለው   ያስባሉ?
0. በፍፁም
1.ትንሽ ትንሽ
2.በተወሰነመጠን/መካከለኛ
3.በጣም