Addis Ababa University
College Of Health Science
School Of Public Health

Cervical cancer screening uptake and associated factors at primary care facilities in peripheral settings of Oromia and SNNP Regions in Ethiopia

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As thesis research advisors, we here by certify that we have read and evaluated the thesis prepared by Zewednesh Debebe under our guidance, which is entitled "Cervical cancer screening uptake and associated factors at primary care facilities in peripheral settings of Oromia and SNNP Regions in Ethiopia"in its final format and is consistent and acceptable. Hence, we recommend that the thesis research be accepted as it fulfils the University and Department style requirements for the degree of Master of Science in Epidemiology and Biostatistics.

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Abbreviations and Acronyms

AAU	Addis Ababa University
ACS	American Cancer Society
CC	Cervical Cancer
CCS	Cervical Cancer Screening
EMOH	Ethiopian Ministry of Health
HIV	Human Immune Deficiency Virus
HPV	Human Papilloma Virus
MCH	Mother to Child Health
MSP	Multiple Sexual Partner
OPD	Outpatient Department
PI	Principal Investigator
SBCC	Social and Behavioural Change Communication
SPH	School of Public Health
SRS	Simple Random Sampling
STD	Sexual Transmitted Disease
VIA	Visual Inspection with Acetic Acid
WHO	World Health Organization

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Abstract

Background: Cervical cancer is the main cancer-related cause of illness and death globally including Ethiopia. While the incidence and mortality of cervical cancer are decreasing, it remains a major problem for women in developing countries. Cervical cancer screening can help prevent these cancers; nevertheless, its utilization remains far below as not being used as much as it could be, despite numerous initiatives aimed at increasing its uptake, particularly in developing nations. The low rate of cervical cancer screening uptake in primary care settings in rural areas is a significant public health concern. It is important to assess and explore the factors that contribute to this problem so that effective interventions can be developed.

Objective: This study aimed to assess Cervical Cancer Screening uptake and associated factors among age-eligible women at selected health centres in Oromia and SNNP Regions, 2023.

Methods: Facility-based cross-sectional study with concurrent qualitative study was carried out from March 3 to May 5, 2023. A total of 941 women was included to the study using a systematic sampling method. Data were collected by using interview-administered questionnaire by trained nurse. For the qualitative data, in-depth and key-informant interview were done. Descriptive statistics was computed using frequency, percentage, and summary measures. A binary logistic regression was used to identify independent factors for the low uptake of cervical screening. Adjusted odds ratio (AOR) with a 95% confidence interval (CI) was estimated in the final model. Statistical significance was declared with p-value of less than 0.05. Thematic content analysis was employed to analyse qualitative data.

Results: A total of 941 women were interviewed with a 100% response rate. The results showed that 235 women 24.97 % (95%CI: 22-28) were screened for cervical cancer. In multi variable logistic regression analysis higher educational level [AOR=3.2, (95%CI: 1.46-7.07)], early age at first sex [AOR=0.49, (95%CI: 0.32-0.75)], knowledgeable about cervical cancer screening [AOR=2.66, 95%CI: 1.82-3.89)], had favourable attitude [AOR=3.91, 95%CI: 2.61-5.84)] and had social support [AOR=2.01, 95%CI: 1.32-3.05)] were associated factors for the low uptake of cervical cancer screening. Insufficient availability of equipments, limited accessibility of services to a specific area, lack of awareness, inadequate competence of providers, and lack of trust and attention from trained providers were additional barriers identified with in depth interview.

Conclusion: Cervical cancer screening uptake were far less common among eligible women in study area. Age at first sex, educational level, knowledge of women, attitude, and social support were factors associated with cervical cancer screening uptake. Therefore, intervention programs that aim to improve cervical cancer screening services for women should prioritize the factors for low uptake; culturally appropriate and accesiable screening methods to meet the national and global elimination targets.

Key words: *cervical cancer, screening, Screening uptake, determinant*

1. Introduction

1.1. Background

Among all cancers that affect women worldwide, cervical cancer is the most prevalent (1). This cancer is regarded as avoidable since it has a long pre-invasive stage, with an average age at diagnosis of 53 years and a cure rate of >95% when treated early (2). Twelve different forms of HPV can cause human cancer, according to research from the International Agency for Research on Cancer. However, HPV 16 and 18 were responsible for 70% of invasive cervical cancer cases (3, 4).

The second most frequent cancer to be diagnosed and the main reason for cancer-related death in African women is cervical cancer (5). According to estimates, 604,127 new cases of cervical cancer was registered among all age in 2020. Eighty five percent of this burden is shared by low- and middle-income nations, where there are no formal screening or HPV vaccination programs. Additionally, it ranks third among all cancers in terms of prevalence worldwide and is the main reason why people die from cancer in many African nations (6–9). In addition, it has been predicted that the prevalence of cervical cancer could rise by 60% during the following 20 years (10). Worldwide, there are large differences in cervical cancer incidence, mortality, and morbidities; these differences are greater in developing countries than in industrialized ones (11).

If early and efficient intervention strategies for cervical cancer control were available to all women, nearly all of the maternal fatalities linked to the disease might be avoided. For the prevention of cervical cancer, a comprehensive strategy that includes prevention, early diagnosis, efficient screening, and treatment programs for pre-cervical lesions is crucial (12). In low-resource settings, visual examination with acetic acid (VIA) and visual inspection with Lugol's iodine (VILI) are frequently employed (5). The next most effective technique, with a 26% decrease in CC incidence and a further reduction in mortality from CC, was the combination of VIA and the prompt treatment of women who tested positive at the first visit (5). According to an incidence-based case-control study conducted in England, the regular attendance of all women for screening would lead to a decrease of 83% in the incidence (13).

All eligible women should have cervical cancer screening at least once every three years, according to recommendations made by the American Cancer Society (ACS), the World Health Organization (WHO), and the United States Preventive Services Task Force (USPSTF) (14). Ethiopia approved the World Health Organization's guideline that women aged 30 and older start cervical cancer screening at least one to three years of age using a see-and-treat strategy (15). However, regardless of age, it is advised that sexually active and HIV-positive women undergo screening every year (starting with HIV diagnosis) (15). However, despite the expectation of a systematic procedure, the reality is that screening often lacks consistency and is mainly influenced by the limited availability of necessary resources (16).

The Ethiopian government established a service for cervical cancer screening and has placed increased emphasis on initiatives aimed at cervical cancer early detection through advocacy work, by many stakeholders including academics, professionals, the media, and partners. Cervical cancer prevalence, however, continues to be a significant issue and is one of the main causes of morbidity and mortality among women in the nation (17). The success of cervical screening programs is shown to depend on the target population's high involvement, which is in turn influenced by the women's knowledge, perceptions, health orientations, and other sociocultural factors. Early marriage, early sexual activity, having a child before the age of 20, having numerous partners in sexual activity, and poor socio-economic position are other characteristics that have an impact (18). Therefore, addressing the different barriers to poor utilization of cervical cancer screening is essential component of intervention.The usual obstacles to cervical cancer screening were also a focus of the initiative. The study's findings can be utilized to create and implement methods to enhance screening adoption and, in turn, lower the high morbidity and death rates in the nation.

1.2. Statement of the problem

Cervical cancer is the fourth most common cancer in women and it is the most deadly disease-affecting women.The age-standardized incidence of cervical cancer is 131 per 100,000 women worldwide, with incidence rates ranging from 2 to 75 per 100,000 women (2). In eastern, western, middle, and southern Africa, cervical cancer is the most common cause of cancer-related mortality among women(2). It is the second most common type of cancer in Ethiopia,and responsible for the highest number of cancer-related deaths among women (19). Annually, around 7,445 new cases of cervical cancer are estimated in our country, resulting in approximately 5,338 deaths. Tragically, over 80% of these cases are diagnosed at an advanced stage, mainly due to insufficient awareness and knowledge about the disease (19).

According to WHO, human papilloma virus infections trigger about 68,000 cases of cervical cancer in Africa every year.However, this figure is likely lower than reality due to gaps in health information and cancer registries in the area (2).Cervical cancer is a preventable disease, but it is the most common female cancer in Africa, taking up 22% of all cases.Moreover,in Africa 34 in 100,000 women are diagnosed and 23 in 100,000 died from cervical cancer every year (2). Thus, Women must maintain screening by the most recent ACS early detection recommendations whether or not they have received a vaccination (20). Nonetheless, the percentage is typically less than half in Africa(20–23).Ethiopian ministry of health is implementing a strategy to improve existing services and ensure accessibility for cervical cancer screening and treatment in line with the WHO global strategy (90-70-90) to reach vaccination, screening, and treatment targets by 2030(19).Since 2015, the cervical cancer screening service has been recorded, and up until 2023, a total of 1,259,253 (12%) women have undergone screening for cervical cancer (19).

Cervical cancer screening is much more prevalent in Western nations when compared to SSA (24, 25). Cervical cancer screening rates are significantly lower in low and middle income countries (LMICs),which can be attributed to several interconnected factors.The complexity of the screening process itself, coupled with pervasive barriers in such settings, including but not limited to poverty, limited access to information,inadequate knowledge of cervical cancer, lack of sufficient healthcare infrastructure, scarcity of trained medical professionals, and the absence of sustained prevention programs, collectively contribute to this discrepancy. Previous acceptability tests conducted in Africa have demonstrated the widespread acceptance of VIA-based cervical cancer

screening(20,26). Even still, a few people are still getting screened(21–23). According to an Asian study, socio-demographic factors, awareness, attitudes, and beliefs about risk, perceived risk, psychological factors, self-efficacy, prior experiences, time, household, culture, fatalism, social support, access, cost, safety, insurance, and factors related to the health system are the reasons why people refuse screening (27).

These challenges act as deterrents, preventing many women in LMICs from benefiting from regular cervical cancer screenings(28).The proportion of cervical cancer screening uptake in Ethiopia ranges 5% to 38.7% (29–34). Thus far, research on cervical cancer screening in Ethiopia has only examined two groups: commercial sex workers and women living with HIV(31, 32, 34, 35). Research on the uptake of cervical cancer screenings was limited to HIV-positive women in hospital settings and focused on age categories different than the ones that the WHO and EMOH recommend for VIA (31, 36, 37). There has been comparatively little study on screening uptake and obstacles for the broader population eligible for VIA screening, including women from public health facilities. The researcher is aware of no study that asses screening uptake in Ethiopia based from the primary care setting perspective including the health posts for the service and providing some significant justifications for the obstacles highlighted in mixed studies to date.This gap necessitates research on the uptake, barriers, and related factors among women who are eligible for general population screening. Therefore, Investigating cervical cancer screening uptake, related factors, and barriers among eligible women in the Oromia and SNNP regions at certain health facilities was the aim of this study.

1.3. Significance of the study

The government of Ethiopia is working on a cancer control strategy and attempting to increase service accessibility by disseminating it to health centres, but uptake of cervical cancer screening is still low. This study will attempt to shed some light on why this is the case particularly in primary settings in peripheral settings of two regions in Ethiopia. It is anticipated that the results of this study will assist the programme in creating interventions aimed at removing barriers that prevent women who meet the screening criteria for cervical cancer from getting screening tests. It will use also the opportunity to provide information on factors that affect the uptake of screening services among women in the study area who are eligible for screening for cervical cancer. Moreover, it will share the findings with clear recommendations for improving the Ethiopia's cervical cancer screening programs with due emphasis on increasing the uptake of cervical cancer screening among eligible women so that reduce morbidity and mortality due to cervical cancer.

2. Literature review

2.1. Overview of Cervical Cancer

Cervical cancer is the fourth most common cancer in women worldwide, and there were likely to be 604 000 new cases of it in 2020. 90% of the estimated 342,000 cervical cancer deaths in 2020 took place in low- and middle-income nations (38).Cervical cancer continues to be a significant global health issue, ranking as the second most prevalent cancer in women worldwide. Africa now bears the highest burden of this disease (39). Over 85% of newly diagnosed cases are diagnosed at an advanced stage, rendering curative therapy impractical in developing nations, mostly in Africa, where 530,000 new cases are detected annually. The disease is responsible for an estimated 274,000 deaths annually (38). In 2019,the number of cases and deaths followed a normal distribution and peaked at age 15-49 years in eastern sub-sahara Africa (40).

In Eastern Africa, the rate of cervical cancer is 34.5 per 100,000, which is the highest in Africa at 25.2 and among the highest globally, surpassing rates in Europe and North America by more than three times(2).According to current estimates, approximately 7445 women receive a cervical cancer diagnosis annually, with 5338 losing their lives to the disease.Among women in Ethiopia, cervical cancer is ranked as the second most common type of cancer and is also the second most prevalent cancer among females aged 15 to 44. Unfortunately, there is no available data on the prevalence of HPV in the general population of Ethiopia. However, within Eastern Africa, the region to which Ethiopia belongs, it is estimated that about 4.7% of women carry cervical cancer (41).

2.2. Uptake of cervical cancer

According to research done in Côte d'Ivoire, 7.5% [95% CI: 6.0-9.0] of CC screenings were taken up overall. Forty-five (51.7%) of the 87 people who had undergone CC screenings used VIA. For 38 (43.6%) and 36 (41.4%) women, a reported CC screening was carried out following public awareness campaigns and at a healthcare processionals recommendation during a 6 to 8 postpartum visit. (14.9%) women said they took self-initiative. Lack of information about CC (75.5%), carelessness or negligence (20.5%), fear of cancer (3.9%), concern about additional expenditures (3.3%), and concern about a negative experience at the CC screening facility (0.3%) were the major hindrances to CC screening uptake (42).

Research conducted in Ghana revealed that 163 people, or more than half of them (81.5%), had heard about CC screening. However, (97%) said they had never been screened previously. Out of the (3%), people who had previously undergone screening, four (2%) had done so within the previous year, and (1%) claimed it had not been longer than five years. 99% were unsure of how frequently they ought to be screened. Interestingly, 87% of the examined women claimehgd they were interested in taking part in CC screening (43).

Most of the participants in an Arbaminch study thought that they were not at risk for developing cervical cancer, which may have an impact on whether women felt that screening was necessary. When questioned, two women claimed that they had never engaged in sexual activity and so did not believe they were required to go for screening. Other excuses included ignorance of the requirement, hearing others complain about the test, and embarrassment (44). Even though they understood the need for screening, some women claimed that their fear of the test, which they viewed as a painful tool, was a barrier. Few women observed that cancer conjured up feelings of secrecy, sometimes linked to other stigmatized conditions. Women avoid the service out of fear that they may die from cancer. Among other reasons, a few women said that they would be embarrassed if they were found to have cervical cancer. This would prevent them from attending screenings(44).

A different study conducted in Addis Ababa on HIV-positive women revealed that the majority of participants refused to have the screening done because they thought it would take too long(35.8%). The test's high cost and time commitment, fear of the test's outcome.During an in-depth interview, it was mentioned that receiving a diagnosis of cervical cancer, along with having

HIV, could cause irritability and a sense of hopelessness. A woman who had been diagnosed with HIV expressed this sentiment. Out of the study subjects, only 37 individuals (11.5%) had ever undergone a cervical cancer screening (45).

The study conducted in different part of Ethiopia, the prevalence of screening was reported to be 38.7% in a community-based study in Jimma, southwestern Ethiopia (30). A second study carried out in Addis Ababa found that although 86.2% of people surveyed would have welcomed free tests, the screening uptake rate was low (10.8%)(31). The lifetime screening uptake was just 10%, according to a study on HIV-positive women conducted in Gondar (32). In Bishoftu, the prevalence of HIV among women receiving adult anti retro viral therapy is 25% lower than the national guideline's suggested coverage rate (80%) (33). In another study carried out in Southern Ethiopia, 85% of study participants had no intention of having their cervix evaluated, and just 14.2% of women reported engaging in health-seeking behaviour for cervical cancer screening(34).

All of the above research suggested that screening uptake would rise if cost were not a factor. However, increased screening behaviour was associated with high knowledge levels, but not with screening awareness or feeling at risk, according to a Kenyan study(46).

2.3. Risks Factors of Cervical Cancer

2. 3.1. Socio demographic factors

Educational status Education level was linked to the uptake of cervical cancer screenings, according to a Rwandan study. The study found that cervical cancer screening was performed by 35.6% of participants with high education (secondary and above) compared to 16.8% of participants with low education (basic schooling or no formal education), and this difference was statistically significant (47). Similar studies in Ethiopia revealed that women with higher levels of education were more likely to use the cervical cancer screening service (43,47). In another study, it was observed that women with higher levels of education had lower screening uptake(48), thus other considerations must be taken into account.

Age Group: According to a study conducted in Debre Markos, Ethiopia, women aged 35 to 49 showed greater screening uptake (30). According to this study, women between the ages of 35 and

49 were 3.21 times more likely than women between the ages of 15 and 24 to undergo pre-cervical cancer screening. According to a study done in Addis Ababa, Ethiopia, screening uptake was greater in the age groups of 45 to 54 and over 55 (28). However, a study conducted in Dar es Salaam, Tanzania, discovered that screening participation was highest among women between the ages of 20 and 29, and declined as women get older (49). Age was linked with self-reported use of cervical cancer screening programs. Women between the ages of 40 and 49 had a lower likelihood of using the screening services than those aged 20–29 years (OR = 0.51, 95 % CI 0.26–0.99, p-value 0.047.

Marital status: Consistent analysis of marital status as a factor in cancer screening participation (50). Most studies found that single women were less likely to undergo cancer screening (48, 49). Married women were more likely than single women to undergo a cervical cancer screening, according to a Cameroonian study (51). According to another study carried out in Ethiopia, one of the important determinants for the use of cervical cancer screening was marital status. According to this study, married women were 3.4 times more likely to use cervical cancer screening than single, divorced, or widowed women (29).

Occupational status: A study carried out in Jimma, Ethiopia, revealed that women working for government agencies had greater screening uptake rates than women not working for them(52). According to a study done in Addis ababa, women who were working knew more about cervical cancer than those who were not(31).There are many study reveled that occupational status and cervical cancer screening uptake have a strong relationship.

Several children: A comprehensive research study was conducted in Malawi, focusing on women to investigate their participation in screening procedures. The results of this study displayed a fascinating trend, revealing a greater likelihood of women who had given birth to two or more children to engage in screening (53).This finding implies that the act of having multiple children might significantly increase the chances of women prioritizing and actively participating in screening procedures.

Furthermore, a separate study conducted in Korea further supports this notion, as it also observed that women with two or more children demonstrated a higher level of adherence to screening compared to those with only one child (54). This consistent observation across different cultures and regions underscores the potential impact of having multiple children on encouraging women to undergo necessary screening procedures.

Another study in Ghana also yielded similar results, reinforcing the notion that having multiple children plays a crucial role in motivating women to prioritize their health and attend screening appointments (55). These collective findings highlight the significance of family size in promoting women's engagement with crucial healthcare practices, indicating that the responsibility and experience of motherhood might enhance the likelihood of women availing themselves for necessary screening procedures.

2.3.2. Knowledge and attitude of cervical cancer and cervical cancer screening

According to a Kenyan study, participants who were unaware of the symptoms and indicators were 18 times more likely to report not having been checked. As people were more aware of the symptoms and indicators, it became less likely that they would skip the screening (46). The results of a different study conducted in Nigeria reached the same conclusions as the one conducted. Although those with high knowledge levels were willing to undergo the procedure, the actual uptake of cervical cancer screening in Kenya was only 14.1% (56).

According to a survey done in Cameroon, 86.96% of those interviewed agreed that there were screening procedures for cervical cancer, whereas 13.04% disagreed. The respondents' uptake for cervical cancer screening was found to be 43.48% (57). Among the 2,140 women who took part in the Addis Ababa trial, 10% were screened for cervical cancer, while 71% came from the intervention health centres. This finding indicates that community awareness could result in the change (58). Despite increased awareness of cervical cancer and cervical cancer screening, a Gondar research indicated that uptake is still low (32).

Different studies conducted in various countries have revealed that attitude plays a significant role in the uptake of cervical cancer screening. A study conducted in Kenya indicated that the prevalence of negative attitudes and fear towards cervical cancer is not surprising, given the

alarming rates of late-stage diagnosis and increased mortality rates associated with the disease (59). Similarly, a study conducted in central Nigeria supported this notion (60). In Ethiopia, it was found that women who possessed a positive attitude towards cervical cancer screening were 6.1 times more likely to undergo testing compared to those with a negative attitude (61). Furthermore, women who exhibited a favourable attitude towards screening also showed a higher likelihood of actually attending the screening (62).

2.3.3. Social support networks

Several studies carried out in different countries have consistently indicated a significant correlation between social support and the utilization of cancer screening. For instance, research conducted in the United States discovered that women who have the support of their family, friends, and spouse are more inclined to undergo screening in comparison to those lacking such support (63). The main objective of this study was to examine the impact of affectionate support and positive social interaction on cervical cancer screening among women from sub-Saharan African immigrant communities. The findings revealed a significant association between these factors and an increased likelihood of undergoing cervical cancer screening (63). The research conducted in both Malaysia and Malawi supported this finding (62, 63). These studies suggest that individuals such as friends, family members, and healthcare providers have an essential role in offering the needed information, emotional support, and financial aid to help individuals make decisions about screening. Additionally, addressing the societal stigma associated with cervical cancer is crucial(64). Research carried out in Ethiopia and sub-Saharan Africa has demonstrated that social stigma and a lack of social support significantly obstruct prompt screening and treatment initiatives(42, 63, 65, 66).

2.3.4. Cultural barriers

The intimate nature of cervical cancer screening may cause discomfort or a lack of confidence in certain individuals. This unease can be influenced by cultural, religious, or personal beliefs, as well as concerns about one's sexual modesty. People from conservative backgrounds or those who follow specific cultural or religious norms may be particularly affected by modesty concerns (64, 67).

Several studies indicate that an increase in modesty concerning sexual matters leads to an increase in the rate of cervical cancer screening. A study conducted in the Arab Emirates discovered that Arab Muslim women in the USA often encountered obstacles in cervical cancer screening programs due to feelings of modesty and embarrassment (67).

2.3.5. Health facility factors

The uptake of CC screening has been shown to increase when individuals receive pertinent information about cervical cancer and screening recommendations from their healthcare providers (18,64,68). This conclusion is further backed by a study conducted in Central Uganda, where it was discovered that women who received pertinent information from their healthcare providers had a greater likelihood of having undergone screening at some point in their lives (69). Healthcare professionals play a crucial role in health communication due to their expertise and credibility. In other instances, females who engaged in conversations with medical practitioners about cervical cancer demonstrated a greater willingness to undergo screening procedures (67,69).

In the Ilu Abba Bor zone of Ethiopia, a recent study uncovered that a mere 7.3% of individuals had utilized cervical cancer screening services within the past three years. The primary obstacles preventing individuals from undergoing such screenings were the lack of accessibility to the service and financial concerns. Additional reasons cited included a lack of awareness regarding where to obtain the service and apprehensions related to potential discrimination (45).

2.4. Conceptual framework

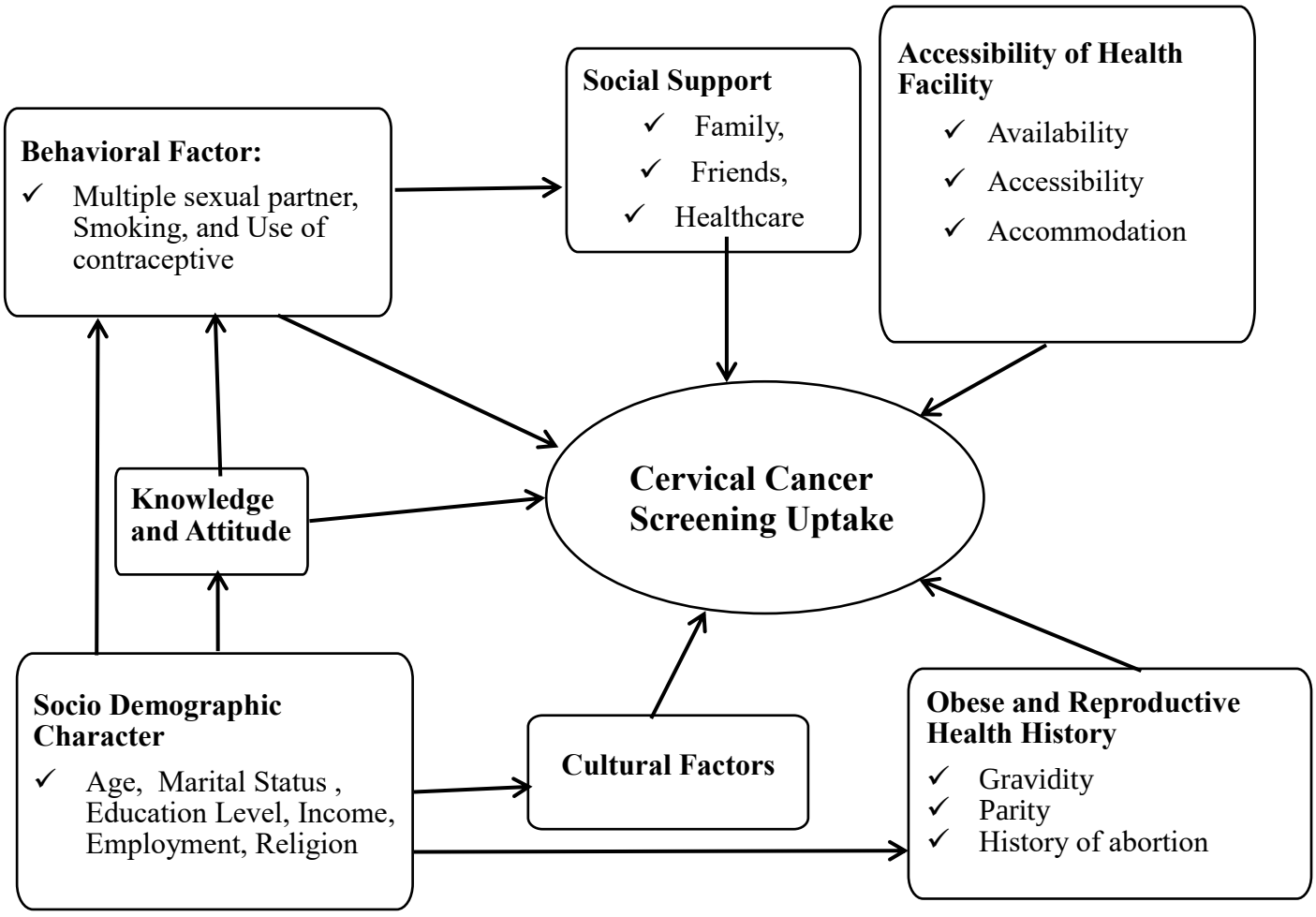

Figure 1: Conceptual framework for factors associated with uptake of cervical cancer screening. It is developed based on review of literature (21,46,65).

3. Objectives

3.1. General objective

⇒ To assess cervical cancer screening uptake and associated factors among women in selected health facilities in Oromia and SNNP from March to May 2023.

3.2. Specific objectives

⇒ To measure the magnitude of cervical cancer screening uptake by women in selected health facilities in Oromia and SNNP regions, Ethiopia, 2023.

⇒ To identify factors associated with cervical cancer screening uptake in selected health facilities in Oromia and SNNP regions, Ethiopia, 2023.

⇒ To explore barriers for low uptake of cervical cancer screening in selected health facilities in Oromia and SNNP regions, Ethiopia, 2023.

4. Methods

4.1. Study Area and Period

The study was carried out in primary health care facilities at Oromia and SNNP regions in Ethiopia. The family planning, immunization, ANC, PNC, and Under-five OPD units were included to select study participants. Oromia is one of the regional state in Ethiopia. Given that the population grows by about 1.1 million people per year,the Oromia regional state is home to a significant female population of 13,398,927 individuals (70). There are 20 zones in the area; of them, the research focused on East Shwa, South West Shewa, Arsi zone, and West Wollega zone. The SNNPR is the other large region, which has an estimated 14 million people, live in the region, 7,408,993 of whom are men and 7,492,997 of them are women (70). A 2012 data from the federal statistical agency states that there are 731 health centres in the area. The research was covered the following six zones: Gurage, Hadiya, Wolaita, Kembata Tembaro, Silte, and one special woreda called Alaba (Halaba). There are 11 zones in the region, and six of them are special woreda.

Peripheral cancer care project is under implementation in two regions since 2022 in 60 health facilities comprising 15 Hospitals, 15 health centres and 30 health posts. Of 24 health facilities, i.e. six of the hospitals and adjacent one health centres with two-health posts were from Oromia regions and the same proportion in the SNNPR. The aim of the project is improving cervical and breast cancer care in the selected areas starting from the screening to care follow up. Capacity development, supporting service improvement and conducting implementation research are among the main activities in peripheral cancer care project. Hence, this study was conducted in these primary care level health centres in both regions. Data were collected from March 3 to May 5 2023.

4.2. Study Design

A facility-based cross-sectional study with a concurrent qualitative study was conducted among eligible women attending health centres in Oromia and SNNP regions.

4.3. The source population

The source population was all women who are attending maternal and child health services units (family planning, vaccination, ANC, PNC, and Under-five OPD).

4.4. Study population

The study population was selected eligible women who are attending maternal and child health services units (family planning, immunization ANC, PNC, and Under-five OPD) during the study period at selected peripheral cancer care facilities of Oromia and SNNPR.

4.5. Inclusion and exclusion criteria

4.5.1. Inclusion criteria

All women who were age eligible came to the health facilities to get service from the maternal and child health service unit (family planning, immunization, ANC, PNC, and under five OPD) during the study period at selected peripheral cancer care facilities of Oromia and SNNPR.

4.5.2. Exclusion criteria

- ⇒ Women in critical condition, incapable of answering questions.
- ⇒ Women with known mental illness.

4.6. Sample size determination

The sample size for Objective 1: The actual screening uptake was assessed using a single population proportion formula while taking the following presumptions into account. The percentage (p) of women of reproductive age who take up cervical cancer screening and its predictors, which was obtained from a Jimma study at 38.7% (30), With a 95% confidence interval with a 4% margin of error and a 5% level of significance.Moreover, considering 10% non-response rate and 1.5-design effect, the final sample size was found to be 941.

$$n = \frac{\left(Z\alpha/_2\right)^2 p(1-p)}{d^2}$$

$$n = \frac{(1.96)^2\ 0.387(1-0.387)}{(0.04)^2}$$

$$n = 570$$

We arrived at a final sample size of 941, taking into account a design effect of 1.5 and a non-response rate of 10%.

The estimated sample size based on objective two: The sample size was also calculated based on second objective using Epi-Info version 7 for chosen variables under the assumptions of 95% confidence intervals (CI), 80% power, and a ratio of exposed to unexposed of 1.

Table 1: The estimated sample size for objective two.

Variables	% in unexposed	Ratio of E^+ to E^-	Power	Confidence level	OR	Sample size	Citation	NRR (10%)	Design effect (1.5)
Knowledge of CC screening	3.86	1:1	80%	95%	4.02	290	(29)	319	479
Attitude toward CC screening	3.14	1:1	80%	95%	3.23	524	(29)	576	865
Marital status	8.25	1:1	80%	95%	10.74	46	(30)	51	77

E^+: Exposed to E^-: Non- exposed NRR: Non-response rate

The study's sample size was 941 since the first objective's computed sample size was the greatest of all.

For the qualitative part: 15 in-depth interviews with research participants and 8 key informant interviews with healthcare professionals and accountable individuals were used in the study.

4.7. Sampling procedure

Quantitative: A multi-stage sampling approach was used to select participants from women attending a peripheral health centre. The research was conducted in selected facilities in the Oromia and SNNPR regions, specifically chosen as project sites for the Else Kröner Cancer Centre (EKCC). These facilities included six Zones from SNNPR (Gurage, Silte, Kembata Tembaro, Halaba Special zone, Wolaita, and Hadiya) and four Zones from Oromia (East Shewa, Southwest Shewa, Arsi, and West Wollega). In total, 15 health centres were included in the project, all of which provided cervical cancer screening services as part of EKCC. Therefore, the study was conducted in all fifteen-health centres of EKCC, with participants being women attending mother and child health (MCH), vaccination, and family planning clinics. Systematic sampling method was used to select each participant. As a result, all Kth (4^{th}) women from each health centre were selected for the study.

Qualitative: Purposive sampling method was done to select fifteen in-depth interview and eight key informants from all selected health centres and woreda offices.

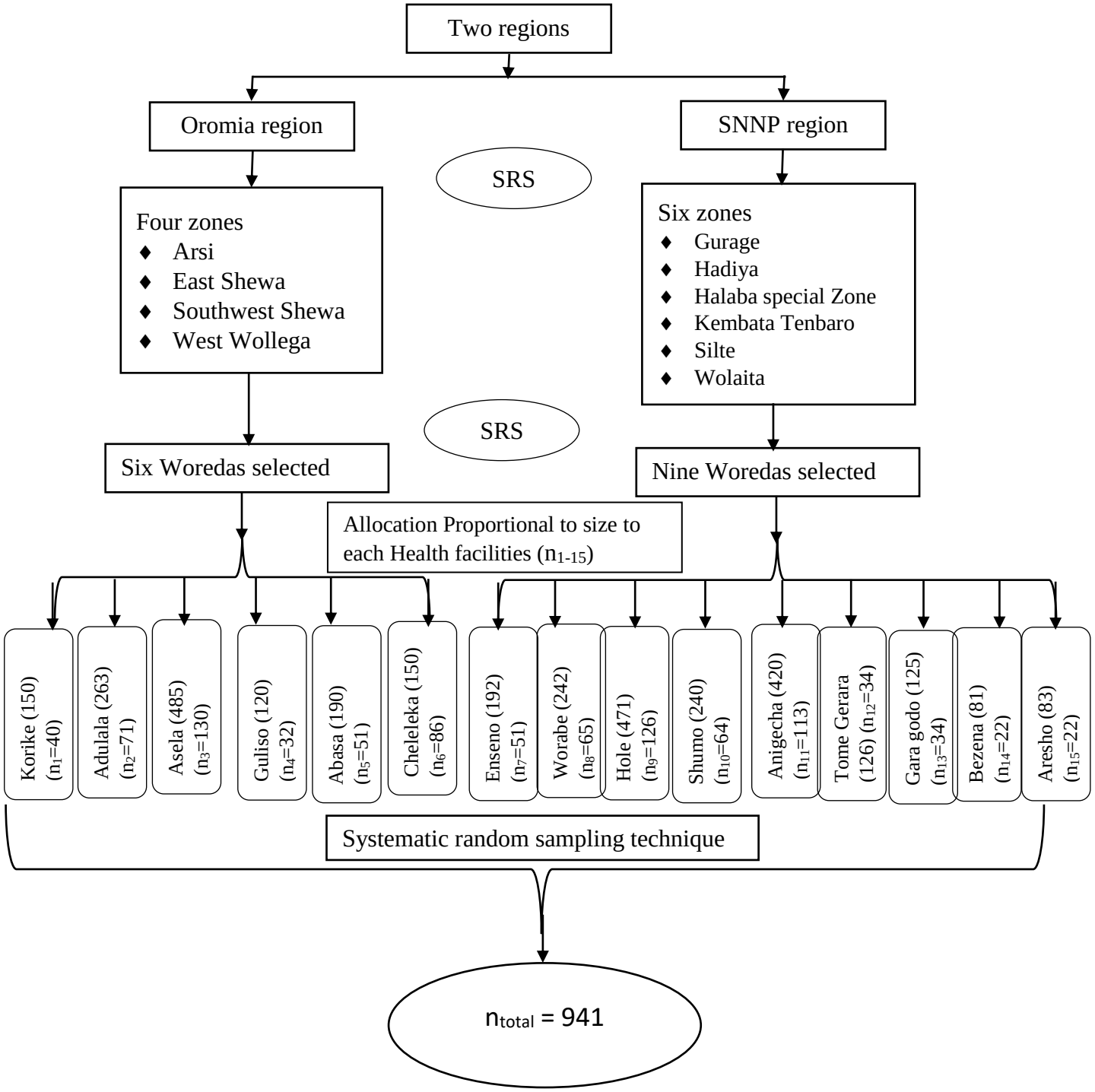

Figure 2: Schematic presentation of sampling procedure for the selection of study unit in the two regions, Ethiopia, 2023

4.8. Variables

4.8.1. Dependent Variable

⇒ Cervical cancer screening uptake

4.8.2. Independent Variables:

⇒ Socio-demographic factors: age, educational status, occupation, place of residence, marital status.
⇒ Obstetrics and reproductive history: Gr-avidity, parity, history of abortion
⇒ Women's Knowledge and attitude on cervical cancer and cervical cancer screening
⇒ Social support networks: family, friends and health care providers
⇒ Women's Access to Cervical Cancer Screening. Availability, accessibility affordability.
⇒ Behavioural factors: multiple sexual partners, smoking and use of oral contraceptive.
⇒ Cultural barriers: beliefs, preference of traditional medication and sexual modesty

4.9. Operational definition

Cervical cancer screening uptake: Women who have had a VIA test for cervical cancer screening once in their lives, regardless of whether they use the service regularly or not, self-reported the outcome variable. Individuals who failed to screen were considered to be non-users of the service(34, 65, 69).

Knowledge: knowledge of cervical cancer and screening was evaluated, If the response is accurate, it was received a score of one, else it was not. The results was then be added up, and women who received a summary score greater than or equal to the mean score and women who received a score below the mean score was used to classify, respectively, good and bad knowledge (31).

Attitude: Because of adding up the affirmative responses, a general attitude score for CC and screening was determined. Scores below the mean score was understood as indicating that the

women have a negative attitude toward CC screening, while scores above the mean score was regarded as indicating that the women have a positive attitude toward CC screening (66).

Social support networks: are an essential source of influence and assistance for women, provided by their family members, friends, and healthcare providers. To calculate the total score, individual scores will be added together. If the score is above the mean, it signifies a greater perception of social support from their networks (66).

Access to health care services: for women can be influenced by, various factors that make it either easier or more difficult for them to receive screening services. These factors include the availability, accessibility, affordability, accommodation, and acceptability of such services. A higher score above the average indicates that it is easier for women to access health care services, while scores below the average signify difficulties in accessing these services (66).

A cultural barrier: refers to various factors that may impede cervical cancer screening, such as cultural beliefs, a preference for traditional medicine, and sexual modesty. Women who score higher than the mean are likely to face fewer cultural barriers, while those who score below the mean are more likely to encounter cultural barriers when it comes to cervical cancer screening.

4.10. Data collection tools and procedures

For the quantitative part: Using a structured questionnaire, data was collected after reviewing relevant literature. Initially prepared in English, the questionnaire underwent translation to the local language and then back translated to English for consistency purposes. The questionnaire comprises nine sections, encompassing socio-demographic factors, reproductive history, knowledge of cervical cancer and screening, attitudes towards cervical cancer and screening, questions about screening practices, health-seeking behaviors, access to healthcare, social support and networks, and cultural barriers to screening.

For the qualitative part: The Principal Investigator effectively utilized a semi-structured open-ended and non-directive approach, employing a flexible probing technique. To ensure clear understanding, the initial translation of this approach was conducted in the local language. Subsequently, another individual proficient in both languages translated it back to English,

allowing for a comprehensive comparison with the original version to verify consistency. Throughout the process, participants were actively encouraged to openly articulate and freely express their ideas, elaborating on their experiences concerning cases pertaining to the discussed topic.

4.11. Data quality management

For quantitative part: The questionnaire for data collection was tested beforehand by 48 participants from health centers in Dukem and Churchill health center in Addis Ababa, which were not part of the actual study. Before starting data collection, supervisors and data collectors participated in a three-day training following the necessary modifications to the data collection tool. In addition, the questionnaire was checked every day for accuracy and consistency. The internal consistency of the Likert scale items and knowledge assessment was measured using Cronbach's alpha coefficient, which was 0.78 for knowledge questions and 0.82 for attitude in order to ensure the study instrument's reliability.

For qualitative part: The principal investigator, recorded on tape, did all interviews, verbatim transcription was done, and then translation was conducted. Participants were continued to be interviewed up until saturation is achieved, at which point the researcher was agreed that the replies were became redundant and no fresh insights was emerged.

4.12. Data processing and analysis

For the quantitative part: Data were carefully collected using ODK and exported to Excel and SPSS for data clearance and exported to STATA Version 17 for further statistical analysis. The data were examined for consistency and any missing values. The variables under the study were expressed using frequencies, percentages and summary measures. Binary logistic regression was utilized to identify predictors of cervical cancer screening uptake. First, bivariate logistic regression was done between each independent variables with the dependent variable. To transfer variables into a multi variable logistic regression analysis with a P-value of less or equal to 0.2 at bivariate logistic regression analysis. Finally, multi variable logistic regression was done and variables having p-value less than 0.05 and adjusted odds ratio (AOR) of non-inclusive null value was considered as significantly associated variables with the outcome variable.

The goodness of fit for the model was assessed using the Hosmer-Lemeshow test, which resulted in a chi-square value of 9.84 with 8 degrees of freedom and a significance level of 0.277. According to the Hosmer-Lemeshow test, a p-value of 0.05 or lower would indicate that the variable included in the model fits well. Therefore, with a p-value of 0.277, the variable is considered to fit the model. To check for collinearity, Kendall's tau-b and Spearman rho tests were conducted. The correlation coefficient for each variable was found to be below 0.75, indicating that the specific independent variable in question is not influenced by other independent variables in the model.

For the qualitative part: The qualitative data was analysed using open code and thematic analysis was used. Each interview was carefully read, and codes were assigned to the text. Subsequently, themes were constructed by categorizing the codes into various categories.

4.13. Ethical consideration

The proposal was approved by the Addis Ababa University School of Public Health, Research, and Ethics Committee. A formal letter of support was requested and sent to the relevant public health authorities. Verbal informed consent was acquired from research subjects. Study participants were made aware of the goals of the investigation and the interviewing procedure. Respondents were free to withdraw from the interview at any time and refusing to participate was not compromised the health care services they receive from the health centre or respective MCH unit. The privacy of the client and confidentiality of the information they give was secured at all levels. The data collector provided the participants with health education and assistance when their comprehension was low.

4.14. Dissemination of results

As a prerequisite for a master's degree in public health at Addis Ababa University School of Public Health, the study's findings will be presented. Furthermore, notification of the final report will be sent to the Oromia and SNNP regional health bureaus as well as any relevant organizations that are active in the region. Additionally, an attempt will be made to publish the work in publications locally as well as internationally**.**

5. Results

5.1. Socio-demographic characteristics of the respondents

A total 941 study participants were included with a response rate of 100%.The mean age of the study participant was 36.05 years (36.05 ±4.93 SD). The majority (44.85%) of respondents were aged 30-34 years old. Four hundred seventy-five (50.48%) of respondents were from rural area. Regarding religion, 362 (38.5%) were Muslims followed by orthodox 316 (33.58%) believers. Two hundred thirteen (22.6%) of respondents had not attended formal education and 838(89.1%) were married. The majority 544 (57.8 %) of respondents were government employees and 668 (71%) of women had >1000 Ethiopian birr monthly income. Of those who are married, their husband did not attend formal education 285 (34.01%) (Table 2).

Table 2: Socio demographic characteristics of women (n=941) age 30-49 in Oromia and SNNPR region, Ethiopia, 2023

Variable	Frequency	Percent
Age of respondent		
30-34	422	44.8
35-39	323	34.3
40-44	101	10.7
45-49	95	10.1
Marital status		
Married	838	89.1
Single	21	2.23
*Other	82	8.71
Religion		
Orthodox	316	33.6
Muslim	362	38.5
Catholic	204	21.7
**Other	59	6.3
Educational status		
No formal education	213	22.6

Primary education	415	44.1
Secondary education	228	24.2
College and above	85	9
Residence of women		
Urban	466	49.5
Rural	475	50.5
Occupation		
Housewife	59	6.3
Government employee	544	57.8
Private employee	121	12.9
***Other	217	23.1
Monthly income		
<499	70	7.4
500-1000	203	21.6
>1000	668	71
Husband education		
No formal education	285	34.01
Primary education	151	18.02
Secondary education	222	26.49
College and above	180	21.48

*Note: * (divorced, widowed and separated); ** (protestant and wakefeta); *** (merchant, farmer, unemployed, daily labourer and businessperson).*

5.2. Reproductive and behaviour characteristics

A total of 276 study participants, accounting for 29.3%, engaged in their first sexual intercourse at the age of 18 years old or below. Among the women, 201 (21.4%) had a history of multiple sexual partners (MSPs), while 70 (7.4%) had a history of sexually transmitted diseases (STD). Approximately 598 individuals (63.5%) had utilized modern family planning methods for a minimum of one year. In terms of births, 355 participants (37.73%) had given birth at least once, while the majority, 461 individuals (48.99%), had given birth to three or more live infants. Furthermore, 111 respondents (11.8%) had a family history of cervical cancer, and 11 (1.2%)

reported a history of smoking. Moreover, a small portion, approximately 0.3% of the participants, were current smokers (Table 3).

Table 3 Reproductive characteristic of women (n=941) age 30-49 in Oromia and SNNPR region, Ethiopia, 2023.

Variable	Frequency	Percent
Age started sexual intercourse (in years)		
≤18	276	29.3
>18	665	70.7
Multiple sexual partners		
No	740	78.6
Yes	201	21.4
Parity		
<3	461	48.99
3-4	150	15.94
≥5	330	35.07
Gr-avidity		
<3	355	37.73
3-4	193	20.51
≥5	393	41.76
Ever use a modern FP method		
Yes	598	63.5
No	343	36.5
Current use of OCP		
Yes	108	11.5
No	833	88.5
Family history of cervical cancer		
Yes	111	11.8
No	830	88.2
Lifetime history of STD		
Yes	70	7.4
No	871	92.6
History of smoking		
Yes	11	1.2
No	930	98.8
Currently smoker		
Yes	3	0.3
No	938	99.7

5.3. Knowledge Related to Cervical Cancer Screening Services

Only 55 (7.79%) of the women who had no screening knew that having too many children could raise the risk of cervical cancer. 126 (63.62%) of the tested women were aware that vaginal bleeding is a sign of cervical cancer. Furthermore, 138 women (19.55%) who were not screened were already aware that vaginal bleeding is a sign of developing cervical cancer. Furthermore, only 28 (3.81%) of the women who were not screened were aware that avoiding the use of oral contraceptives for an extended period is a prevention method for developing cervical cancer. Similarly, among the screened women, 53 (7.5%) knew that screening for cervical cancer is another prevention mechanism. Out of the screened women, 153 (65.11%) were aware that cervical cancer can be cured if diagnosed in the earliest stage. Similarly, 29 (31.87%) of the women who were not screened were aware of the cervical cancer screening methods.

Table 4: Knowledge about cervical cancer and screening of women (n=941) age 30-49 in Oromia and SNNPR region, Ethiopia, 2023.

A. Risk factors of developing cervical cancer = N (%)			
Do you think the following factors may increase the woman"s chance of developing cervical cancer?	**Overall 941(%)**	**Screened 235(%)**	**Not screened 706 (%)**
Heard about cervical cancer	534(56.75)	153(65.11)	381(53.97)
Acquiring HPV virus	86(9.14)	37(15.74)	49(6.94)
Having multiple sexual partners	200(21.25)	72(30.64)	128(18.13)
Early sexual intercourse	181(19.23)	79(33.62)	102(14.45)
Having too many children	92(9.78)	37(15.74)	55(7.79)
Smoking	94(9.98)	46(19.57)	48(6.8)
B. Signs and Symptoms of Cervical Cancer = N (%)			
Do you think the following are signs and symptoms of cervical Cancer?	**Overall 941(%)**	**Screened 235(%)**	**Not screened 706(%)**
Vaginal bleeding	264(28)	126(63.62)	138(19.55)
Foul smelling of vaginal bleeding	256(27.2)	113(48.09)	143(20.25)
Post-coital bleeding	567(60.25)	75(31.94)	492(69.69)
C: Prevention of Cervical Cancer = N (%)			
Can the following actions prevent cervical cancer?	**Overall 941(%)**	**Screened 235(%)**	**Not screened 706(5)**
Cervical cancer is preventable	415(44.1)	173(73.62)	242(34.28)

By administering the HPV vaccine	193(20.5)	72(30.64)	121(17.14)
Don't have many sexual partners.	180(19.12)	78(33.19)	102(14.45)
Stay away of early sexual activity	154(16.37)	67(28.51)	87(12.32)
Refrain from having too many kids.	79(8.39)	31(13.19)	48(6.8)
Refrain from long-term use of oral contraceptives.	44(4.67)	16(6.81)	28(3.81)
Give up smoking.	71(7.54)	34(14.47)	37(5.24)
Cervical cancer screening	101(10.73)	48(20.43)	53(7.51)
D: Awareness about Cervical Cancer screening	**Overall 941(%)**	**Screened 235(%)**	**Not screened 706(%)**
Can cervical cancer be cured if caught in its early stages?	354(37.62)	153(65.11)	201(28.47)
How is treatment for cervical cancer administered?			
Herbal treatments	66(7.01)	26(11.06)	40(5.67)
surgical	172(18.28)	57(24.26)	115(16.29)
Hospitals administer certain medications.	310(32.94)	129(54.89)	181(25.64)
Radiation therapy	53(5.63)	29(12.34)	24(3.40)
Chemotheraphy	489(51.97)	70(29.79)	419(59.35)
How much does therapy for cervical cancer cost in this country, in your opinion?	246(26.14)		
Have you heard anything regarding screening for cervical cancer?	337(36)	166(70.64)	171(24.22)
Are you familiar with the methods used to check for cervical lesions?	200(21.25)	60(55.05)	29(31.87)
Overall Knowledge Sub-scale			
Good	321(34.11)	142(60.43)	179(25.35)
Poor	620(65.89)	93(39.57)	527(74.65)
How frequently is screening for pre malignant cervical lesions done?(N=200)	93(46.50)	51(46.79)	42(46.15)
Who are eligible for the screening(N=200)	169(18)	100(91.74)	69(75.82)
Mentioned procedures (N= 200)			
VIA	37(18.5)	29(26.61)	8(8.79)
VILI	14(7)	10(9.17)	4(4.40)
Pap Smear	23(11.5)	16(14.68)	7(7.69)

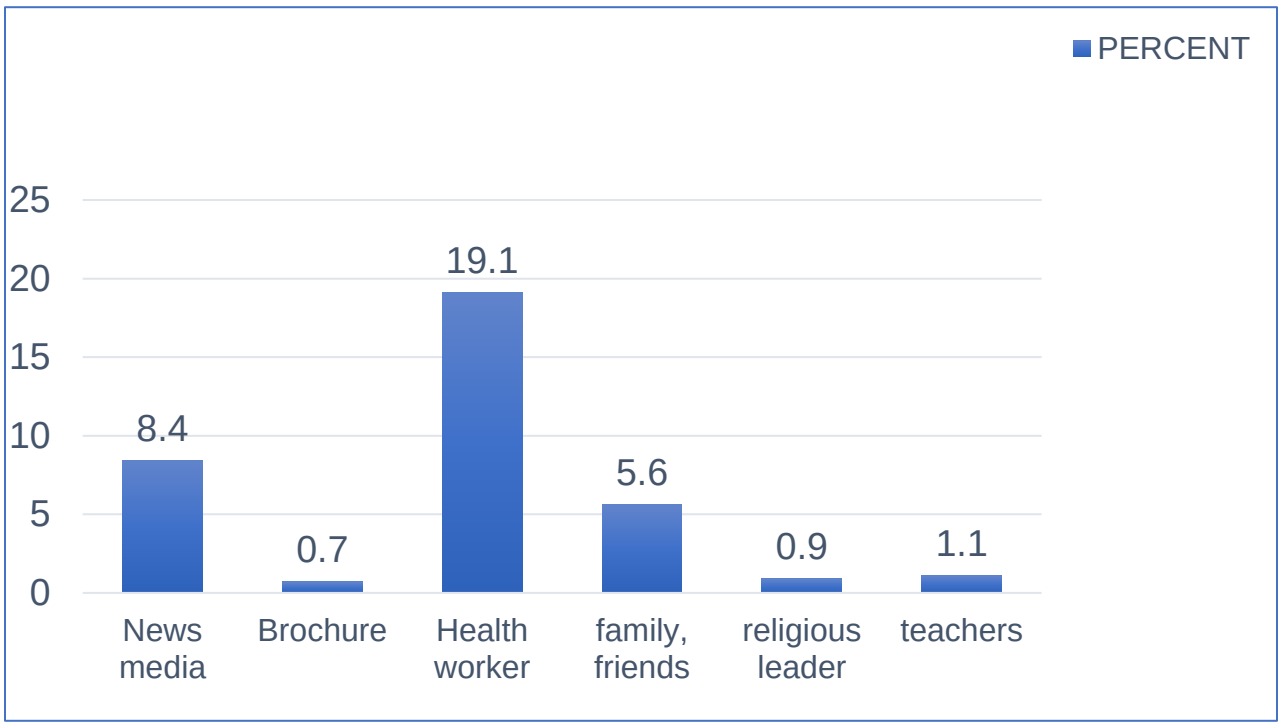

Figure 3: Source of information about cervical cancer screening uptake women aged from 30-49 in Oromia and SNNPR region, Ethiopia, 2023.

5.4. Attitude about cervical cancer and screening

Out of the women who underwent screening, 189 (80%) had a positive attitude towards cervical cancer screening if it was available free of cost and safe. Similarly, a nearly equal percentage of women who were screened and those who were not screened felt uncomfortable exposing their private parts to male service providers during the procedure (48.9% and 45.61% respectively).

Table 5 Attitude about cervical cancer and screening of women (n=941) age 30-49 in Oromia and SNNPR region, Ethiopia, 2023.

Items	Overall 941(%)	Screened 235(%)	Not screened 706 (%)
Cervical carcinoma is a disease that can strike any adult woman, even you.	480(51.01)	171(72.77)	309(43.77)
Cervical cancer cannot be spread from one person to another.	318(33.79)	116(49.36)	202(28.61)

Cervical cancer can be prevented by screening.	513(54.52)	204(86.81)	309(43.77)
There is no risk to the client from screening.	415(44.10)	170(72.34)	245(34.70)
Cervical lesion screening for precancerous lesions is inexpensive.	421(44.74)	168(71.49)	253(35.84)
Will you screen if it's free and doesn't hurt anyone?	530(56.32)	189(80.43)	341(48.30)
Do cervical cancer screenings make you nervous?	288(30.61)	93(39.57)	195(27.62)
Do you find it awkward to show your intimate areas to younger or male healthcare professionals during the procedure?	435(46.23)	113(48.09)	322(45.61)
Do you fear discomfort or agony when getting screened for cervical cancer?	494(52.50)	125(53.19)	369(52.27)
Do you worry that you will keep bleeding during or after the cervical cancer screening?	465(49.42)	135(57.45)	330(46.74)
Do you fear that following the screening, you may receive a cervical cancer diagnosis?	505(53.67)	155(65.69)	350(49.58
Attitude regarding cervical cancer screening			
Positive	430(45.70)	178(75.74)	252(35.69)
Negative	511(54.30)	57(24.26)	454(64.31)

5.5. Uptake of cervical cancer screening

Among all the respondents of the study only 235(24.97%) had cervical cancer screening. Of those who screened for cervical cancer 102(43.40%) screened in health centers and 90(38.30%) screened at hospital and the rest 43(18.30) were screened at private health facilities. Health professionals initiated screening for over two-thirds of them (62.98%), while the remaining 87 (37.02%) were self-initiated. Of these, 134 (57.02%) had only one screening exposure. When respondents without screening practice were asked why they did not screen, 363 (38.58%) said they felt healthy, 262 (27.84%) said they were not informed (knowledgeable), 74 (7.86%) said they felt insecure, and others gave similar answers (Table 6 and figure 3).

Table 6 Screening practice of women (n-941) aged 30-49 in Oromia and SNNPR region, Ethiopia, 2023.

Variables	Frequency	Percent
Cervical cancer screening		
Yes	235	24.97
No	706	75.03
Place of screening		
Public Hospital	90	38.30
Private health facility	43	18.30
Health centre	102	43.40
Indication for screening		
Self-initiated	87	37.02
Offered by the health professionals	148	62.98
Last screening		
Within the past year	134	57.02
Within the past 3 years	43	20.43
More than 3 years back	53	22.55

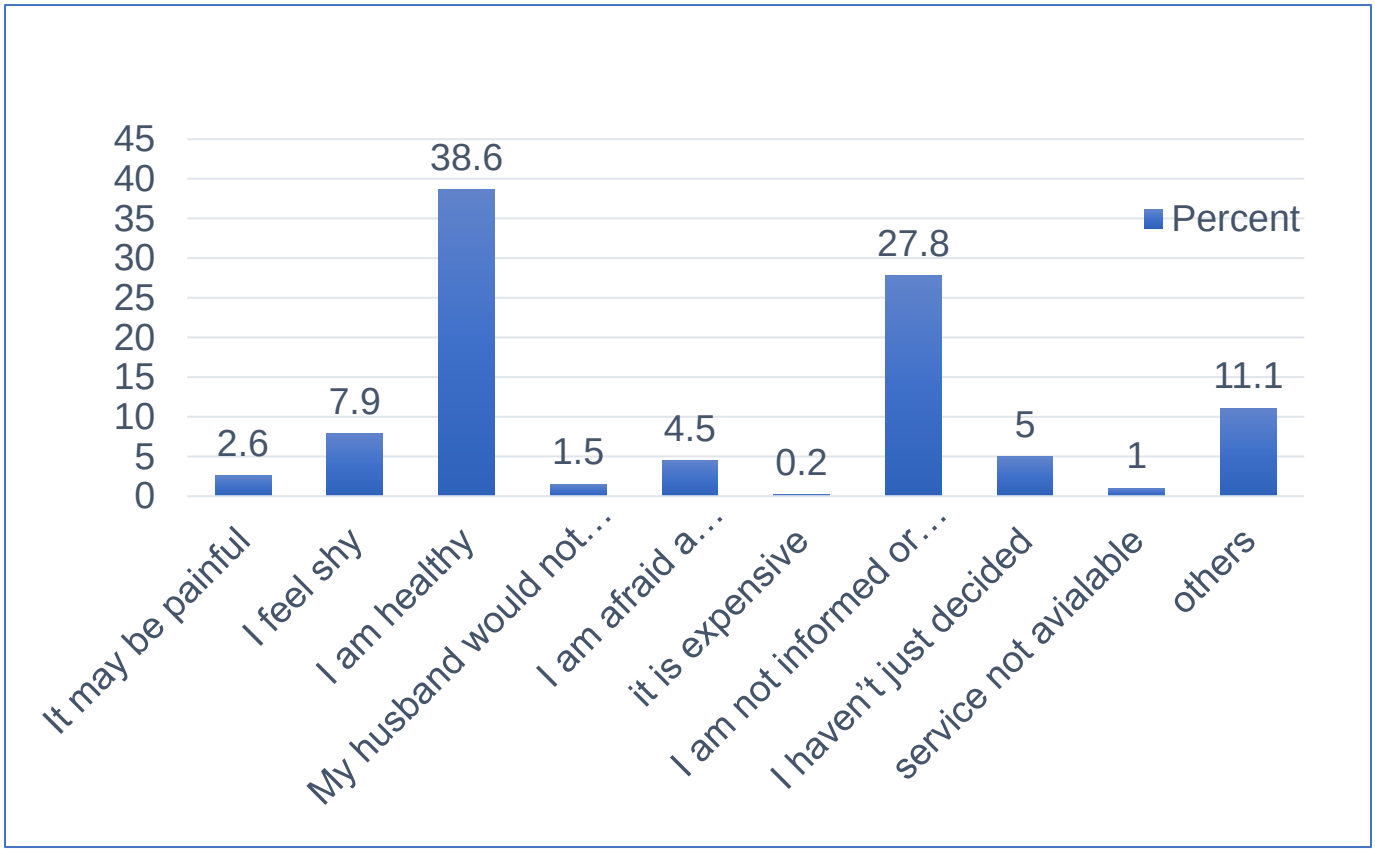

Figure 4: Reasons for not being cervical cancer screening uptake women aged from 30-49 in Oromia and SNNPR region, Ethiopia, 2023.

5.6. Health-seeking behavior

Three hundred eleven women (33.05%) went to a medical facility at least once a year. More than two-third 645(68.54%) preferred to visit government hospitals. Of them, 318(33.8%) are dissatisfied with the service they received. Health extension workers advice 294 (31.24%) and health education at the health facility 349 (37.09%) was considered the best methods of disseminating knowledge about cervical cancer and its screening. From the majority of the women who participated in the survey, 159 (17.08%) said that cultural concerns prevent them from getting a cervical cancer screening. The largest percentage of these issues, the taboo against exposing one's private parts, was accounted for 124 (77.19%). Only 230 women (24.68%) were aware of where to find of the test. Twenty-seven of them or 11.74% had a negative view toward the service provided. Regarding health care providers 137 (59.57%) and 66 (28.70%) of the women received well to excellent grades. Of the women who were aware that the facility offered screening services, 47 of them alleged that the service was not reasonably priced. One hundred three people (44.78%) reported waiting longer than thirty minutes, while 135 people (58.70%) reported arriving at the health center in less than an hour.

Table 7 Health- seeking behaviour of women (n=941) age 30-49 in Oromia and SNNPR region, Ethiopia, 2023

Variables	Frequency	Percent
Frequency of health care visit		
Twice a year	271	28.8
Once a year	311	33.05
Less than a year but twice in the past	214	22.74
*Other	145	15.41
Usual health care facility chosen when got sick		
Government hospital	645	68.54
Health centre	177	18.81
**Other	119	12.65
Satisfaction status of participants		
Satisfied	623	66.21
Not satisfied	318	33.8
best way used to make you more aware of CC		
Health education at health facility	349	37.09

Health extension advice	294	31.24
***Other	298	31.67
cultural issues hindering CCS		
Yes	159	17.08
No	772	82.92
which culture contribute		
religious Factors (Islamic culture)	35	22.01
the taboo of showing private part	124	77.99
Screening offered in the facility		
Yes	230	24.68
No	702	75.32
Service satisfaction		
Excellent	66	28.70
Good	137	59.57
Poor	27	11.74
Behavour of health care provider		
Excellent	67	29.13
Good	142	61.74
Poor	21	9.13
Affordability of screening		
Yes	183	79.57
No	47	20.43
Waiting time		
0-15 munutes	25	10.87
15-30 munutes	102	44.35
> 30 munutes	103	44.78
To reach to the facility		
<1 hour	135	58.70
1 hour	72	31.30
don't know	23	10.00

*Note * Means once in the past 5 years and not in the past year** mean private clinic, traditional healers and pharmacy ***mean printing media I.e magazine and news paper, social media I.e face book, telegram you tube, TV and radio and health care provider advice.*

5.7. Access to Cervical Cancer Screening Services

Among the respondents who did not receive screening, 38.95% indicated that the health care providers were inadequate. Others indicated long distance to the screening facility (31.02%); thought that they were not sick (38.39%) and some did not know where to go for screening (42.63%), and long waiting time (30.59%).

Table 8: Access to health care of women (n-941) aged 30-49 in Oromia and SNNPR region, Ethiopia, 2023.

Items	Overall 941(%)	Screened 235(%)	Not screened 706 (%)
Did you know where to go for the screening	495(52.6)	194(82.55)	301(42.63)
Screening sites are far (distant)	302(32.09)	83(35.32)	219(31.02)
Previously, I was badly treated	168(17.85)	39(16.60)	129(18.27)
Long waiting time	310(32.94)	94(40)	216(30.59)
The healthcare providers are inadequate	388(41.23)	113(48.09)	275(38.95)
There were no equipment and supplies	265(28.16)	76(32.34)	189(26.77)
I thought I was not sick	360(38.26)	89(37.87)	271(38.39)
Could not take time off my work/had other commitments/laziness Acceptability	329(34.96)	92(39.15)	237(33.57)
There is no privacy at the clinic	211(22.42)	70(29.79)	141(19.97)
Providers are males	202(21.47)	66(28.09)	136(19.26)
I do not see the reason to go for screening as I am too old/too young	217(23.06)	60(25.53)	157(22.24)
Access to screening			
Easily access health care	423(44.95)	130(55.32)	293(41.50)
Difficult to access health care	518(55.05)	105(44.68)	413(58.50)

5.8. Social Support Networks

The majority, 177 (75%), of the women who were screened and 401(57%) of the women who were not screened, indicated that they could share concerns with a health care provider. Very few, 197(20.94%), of the participants indicated that their family encouraged for cervical screening, and just above half of the respondents 492 (52%) got friends support for cervical screening. Family and friends were not encouraged and recommend for women cervical screening. The majority of the respondents received their social support from healthcare providers.

Table 9 Social Support of women (n=941) aged 30-49 in Oromia and SNNPR region, Ethiopia, 2023

Items	Overall 941(%)	Screened 235(%)	Not screened 706 (%)
Can share concerns with a health care provider?	578(61.42)	177(75.32)	401(56.80)
Get counselling from health care providers	285(30.29)	146(62.13)	139(19.69)
Financial support from family member	298(31.67)	116(49.36)	182(25.78)
Emotional support	251(26.67)	112(47.66)	139(19.69)
Can discuss with family	296(31.46)	132(56.17)	164(23.23)
Family encouragement	197(20.94)	100(42.55)	97(13.74)
Friends recommendation	231(24.55)	94(40)	137(19.41)
Friends support	492(52.28)	154(65.53)	338(47.88)
Friends can share the result	479(50.9)	175(74.47)	304(43.06)
Advice friends to have screening	471(50.05)	160(68.09)	311(44.05)
Social support networks			
Perceived social support	465(49.42)	168(71.49)	297(42.07)
Not Perceived social support	476(50.58)	67(28.51)	409(57.93)

5.9. Cultural barriers to cervical cancer screening

Majority of the participants 529(56.22%) would feel comfortable to talk about any gynaecological issues like sex, birth control and gynaecological health with their partners. Moreover, more than half of them 507(53.88%) could talk about anything with their spouse. Three hundred fifteen (33.48%) of the participants had claimed that the topic of sex is taboo between them and their partner. Very few 167(17.75%) of them could have discussed about the importance of being screened for cervical cancer.Almost all 621(65.99%) of the participants would prefer female health care providers for the screening purpose. However, 395(41.98%) would rather prefer male health

care professionals. Three hundred thirty one (35.18%) of the women would feel comfortable discussing and acknowledging their own sexuality. Most of the women 530(56.32%) claim that they could discuss easily about the topic of sex with her female friends.

The thought of gynaecological examination embarrasses 258(27.42%) of the participants. Moreover, 248(26.35%) of them embarrasses the health care providers examining their private part, but the same percentage 248(26.35%) of women belief that they were modest about their body examination. Around 229(24.34%) of the participants claimed that discussing with female friends about sex made them uncomfortable. More than half of the women506 (53.77%) usually take western medication when they are sick. Around 238(25.29%) of women usually take traditional medicine when they feel sick. Two hundred thirty five (24.97%) of them belief that traditional medicine is more effective than the western one.

Table 10 Cultural barriers to screening (communication culture of women with their partner) (n=941) aged 30-49 in Oromia and SNNPR region, Ethiopia, 2023.

Items	Overall 941(%)	Screened 235(%)	Not screened 706 (%)
Would feel comfortable to talk about any gynaecological issues	529(56.22)	145(61.70)	384(54.39)
Can talk about anything	507(53.88)	152(64.68)	355(50.28)
The topic of sex is taboo between me and my husband	315(33.48)	129(54.89)	186(26.35)
Discussed about Importance of getting screened Cc	167(17.75)	98(41.70)	69(9.77)
Comfortable with Male health care provider	395(41.98)	111(47.23)	284(40.23)
Comfortable with female health care provider	621(65.99)	187(79.57)	434(61.47)
Comfortable with discussing about sexuality	331(35.18)	140(59.57)	191(27.05)
Could discuss it easily with close female friends	530(56.32)	157(66.81)	373(52.83)
Embarrass gynaecological examination	258(27.42)	68(28.94)	190(26.91)
Embarrass health care provider examining my body	248(26.35)	57(24.26)	191(27.05)
I am modest	248(26.35)	64(27.23)	184(26.06)
Uncomfortable discussing with female friends about	229(24.34)	77(32.77)	152(21.53)
Usually take western medicine	506(53.77)	104(44.26)	402(56.94)
Usually take traditional medicine	238(25.29)	59(25.11)	179(25.35)
Traditional medicine is more effective	235(24.97)	62(26.38)	173(24.5)
Cultural barriers to screening			
Have cultural barriers	560(59.51)	173(73.62)	387(54.82)
Have no cultural barriers			

	381(40.49)	62(26.38)	319(45.18)

5.10. Factors associated with cervical cancer screening uptake

The multivariable logistic regression analysis was completed after each variable's bivariate logistic analysis. To evaluate the relative impact of the covariates on the outcome variable (screening for cervical cancer), the Enter method was applied. In the multivariable logistic regression analysis, only variables with P-value < 0.2 in the bivariate analysis were included to prevent an excessive number of variables and unstable estimates in the final model.

Women who attended college or higher education were 3.2 times more likely to be screened for cervical cancer than women who did not receive any formal education (AOR=3.2; 95%CI: 1.46, 7.07). Compared to women who had their first sexual experience before the age of 18; women who had their first sexual experience at age 18 or older were 49% less likely to be screened for cervical cancer (AOR=0.49; 95%CI:0.32, 0.75). The odds of screening for cervical cancer among women's having good knowledge of cervical cancer is 2.66 times higher as compared to those women's having poor knowledge (AOR=2.66; 95%CI: 1.82, 3.89). Women having positive attitude towards cervical cancer screening approximately four times more likely to be screened as compared to women having negative attitude (AOR=3.91; 95% CI: 2.61, 5.84). Women who had social support networks were two times as much of a chance of getting screened for cervical cancer compared to those who had not (AOR=2.01; 95% CI: 1.32, 3.05).

Table 11: Binary logistic regression analysis for factors Associated with cervical cancer screening uptake in Oromia and SNNPR region, Ethiopia, 2023.

Categories of Variables	Cervical Cancer Screening		COR(95%CI)	AOR(95%CI)	P-value
	screened	Not screened			
Religion					
Orthodox	91(38.72)	225(31.87)	**1**	**1**	
Muslim	80(34.04)	282(39.34)	0.70(0.49, 0.99)	1.03(0.68, 1.55)	0.907
Catholic	48(20.43)	156(22.10)	0.76(0.51, 1.14)	0.67(0.41, 1.10)	0.109
Others	16(6.81)	43(6.09)	0.92(0.49, 1.72)	1.03(0.48, 2.17)	0.948
Residence					
Cv/;lRural	91(38.72)	384(54.39)	**1**	**1**	
Urban	144(61.28)	322(45.61)	1.89(1.39 ,2.55)	1.02(0.67, 1.54)	0.941
Educational level					
No formal education	38(16.17)	175(24.79)	**1**	**1**	
Primary	102(43.40)	313(44.33)	1.5(0.99, 2.27)	1.24(0.75, 2.06)	0.401
Secondary	47(20)	181(25.64)	1.2(0.74, 1.92)	1.03(0.54, 1.96)	0.936
Collage and above	48(20.43)	37(5.24)	5.97(3.43, 10.39)	**3.2(1.46, 7.07)**	**0.004****
Occupation					
Housewife	11(4.68)	48(6.80)	0.65(0.31, 1.34)	0.88(0.38, 2.07)	0.772
Govn't employee	102(43.40)	442(62.61)	0.66(0.44, 0.99)	0.69(0.43, 1.11)	0.133
Private employee	80(34.04)	96(13.60)	2.4(1.5, 3.77)	1.32(0.75 , 2.35)	0.335
Others	42(17.87)	120(17)	1	1	
Age at first sex					
<18	76(32.34)	200(28.33)	**1**	**1**	
>=18	159(67.66)	506(71.67)	0.83(0.60, 1.14)	**0.49(0.32, 0.75)**	**0.001****
Parity					
Children <3	134(57.02)	327(46.32)	**1**	**1**	
Children 3-4	40(17.02)	110(15.58)	0.89(0.59, 1.34)	0.92(0.49, 1.69)	0.787
Children >=5	61(25.96)	269(38.10)	0.55(0.39, 0.78)	0.52(0.22, 1.21)	0.127
Gravidity					
gravida <3	106(45.11)	249(35.27)	**1**	**1**	
gravida 3-4	55(23.40)	138(19.55)	0.94(0.64, 1.38)	1.42(0.82, 2.48)	0.215
gravida >5	74(31.49)	319(45.18)	0.54(0.39, 0.77)	1.11(0.49, 2.48)	0.798
Current use of OCP					
No	200(85.11)	633(89.66)	**1**	**1**	
Yes	35(14.89)	73(10.34)	1.52(0.98, 2.34)	0.83(0.48, 1.41)	0.489
Life time history of STD					
No	208(88.51)	663(93.91)	**1**	**1**	
Yes	27(11.49)	43(6.09)	2.0(1.2, 3.32)	1.46(0.79 , 2.67)	0.222
Knowledge					
Good	142(60.43)	179(25.35)	4.50(3.29, 6.14)	**2.66(1.82 , 3.89)**	**0.0001****

Poor	93(39.57)	527(74.65)	1	**1**	
Attitude					
Positive	178(75.74)	252(35.69)	5.63(4.02, 7.87)	**3.91(2.61 , 5.84)**	**0.0001****
Negative	57(24.26)	454(64.31)	1	**1**	
Social support network					
Had social support	168(71.49)	297(42.07)	3.45(2.51, 4.76)	**2.01(1.32 , 3.05)**	**0.001****
No social support	67(28.51)	409(57.93)	1	**1**	
Health Access					
Easy to access	130(55.32)	293(41.50)	1.75(1.30, 2.35)	0.94(0.65 , 1.37)	0.751
Difficult to access	105(44.68)	413(58.50)	1	1	
Cultural barriers					
Had cultural barriers	173(73.62)	387(54.82)	2.3(1.66, 3.19)	1.20(0.77 , 1.87)	0.418
No cultural barriers	62(26.38)	319(45.18)	1	1	

** *Statistically signigicant at both 0.05 and 0.01.*

Qualitative results

Socio-demographic Characteristics of participants

A total of 15 women participated in the comprehensive interview. The age range of the majority of women (53.3%) was between 30 and 34. Out of the women interviewed, a significant proportion (80%) were married. The majority of them resided in rural and semi-urban areas, while 46.7% had received secondary or higher education.

The key informants include all cervical cancer focal personnel from the facility and were chosen purposefully from each health center. In addition, health extensions were chosen from each facility. The focus staff has three to seven years of work experience and has been a cervical cancer-trained professional for about a year and above. The majority of health extension workers have a high school diploma or a level four-degree.

Table 12: Characteristics of women for qualitative study for those women who came to take the service (N=15)

Characteristics	Frequency	Percent (%)
Age of women		
30-34	8	53.3
35-39	3	20
40-44	3	20
45-49	1	6.7
Marital status		
Married	12	80
Single	1	6.7
Divorce	2	13.3
Educational status		
No schooling	4	26.7
Primary	4	26.7
Secondary and above	7	46.7
Residence of women		
Urban	3	20
Rural	14	80

1. Health system barriers to cervical cancer screening

Despite the availability of cervical cancer screening services in healthcare facilities, women encounter obstacles within the health system that hinder their access to these crucial services when needed. These barriers prevent women from undergoing the necessary screening for cervical cancer. The staff at Adulala health center describe the situation as follows:

"*Firstly, there is a significant lack of communication between departments, which hinders the ability to gather information about women's screening histories and identify signs of cervical cancer. To put it simply, important departments such as adult OPD and EPI are essential to collaborate with, but due to inadequate linkage, we are unable to take those opportunities. Furthermore, healthcare professionals are too busy with their responsibilities, often neglecting to pay attention to these matters beyond their regular tasks."*

(Key informant #1, cervical cancer focal personnel at Adulala)

In various healthcare facilities, healthcare professionals are frequently assigned supplementary responsibilities, such as conducting cervical cancer screenings, in addition to their regular duties. Trained professionals, however, often view these screenings, as ancillary tasks rather than the focus. This perception is further reinforced by medical directors who assign these tasks to individuals who have received the necessary training, without allocating dedicated time for it. As a result, healthcare professionals may develop a distaste for working in this specific area due to the increased workload and added responsibilities. Moreover, the scarcity of essential equipment and materials required for these screenings, coupled with a lack of awareness among healthcare providers, poses an additional significant obstacle that needs to be addressed.

"*Regarding cervical cancer, there is lack of awareness among healthcare providers within our health facility. Trained professionals who possess the necessary knowledge are rare, resulting in inadequate support for women seeking consultation. Additionally, there is a shortage of essential supplies, including surgical gloves. Although the situation has improved to some extent, we previously experienced a major scarcity of surgical gloves."*

(Key informant #2, focal personnel for cervical cancer, trained staff at Shurmo hc)

Although cervical cancer screening services have been available for a period of two to three years, it is unfortunate that numerous facilities are unable to operate at full capacity due to a scarcity of essential materials required for screenings. Consequently, this has resulted in the existence of long waiting lists and extended wait times for women seeking these services, potentially deterring them from returning for future screenings and dissuading others from utilizing this life-saving service. Furthermore, the lack of widespread awareness regarding cervical cancer screening poses an additional hurdle, impeding early detection and timely treatment of this potentially lethal disease.

"*One of the main issues we face is the lack of sufficient gloves. However, we have recently received some support in this area, including speculum. The problem is that mothers now have to wait longer for their turn, as we need to boil and prepare the speculums for the next client. This is disturbing because clients should ideally only have to wait 30 minutes for any service, which is important if you want to keep them satisfied. If we make them wait longer, there is a risk that the patient may not return. Hence, it is crucial that we acquire gloves and equipments but also additional beds.* "

(Key informant 2, from shurmo Hc)

"Lack of trained professionals is a major barrier to cervical cancer screening and awareness creation in our facility. As the only trained professional, I am unable to do both effectively. Having more trained professionals would allow us to divide the responsibility, which would improve the overall screening and awareness creation activities."

(Key informant 1, from enseno Hc)

2. Health extension perspective of cervical cancer screening barriers

2.1. Knowledge gap among health extension workers

The presence of health extension staff is essential in disseminating information to rural communities. It is highly prudent to invest in strengthening the workforce that provides to rural

areas, particularly due to the limited availability of alternative information sources. The study indicated, as there was lack of awareness among health educators regarding their own susceptibility to cervical cancer. Moreover, this makes difficult to bring the required behavioural change among women in reproductive age. Therefore, the first step in the process of encouraging women to attend screenings and treating cancer as a preventable communicable disease, it is imperative that medical personnel receive appropriate training and stay up-to-date with new recommendations. Subsequently, the next step would involve actively working towards achieving the desired objective.

Lack of awareness about cervical cancer in the community is a major barrier to screening and prevention. Health extension workers are aware of this, but they feel that they cannot do much about it unless the government takes action. The government should develop a campaign to raise awareness about cervical cancer and encourage women to be screened. Additionally, the government should provide more resources to health extension workers so that they can more effectively disseminate information about cervical cancer. Here are some of the barriers the health extension workers mentioned;

"Since cervical cancer not being included in the 16 health extension program packages, we did not give much attention to it. Besides, we do not have detailed knowledge about the disease due to a lack of training and updates. Despite our limited understanding and inadequate training, we still strive to have a significant impact by motivating women to undergo screenings. We emphasize the seriousness of the disease and explain that early detection can lead to a possible cure through medication. However, we acknowledge that our knowledge is insufficient to offer detailed advice or address specific inquiries. As a result, we lack familiarity with the disease's risk factors, prevention methods, and recommended screening intervals."

(Health extension worker# 1, from chelelka Hc)

2.2. Absence of Health Education in the Health centers

Lack of health education about cervical cancer is a major barrier to early detection and prevention. The study indicated discontinuation of health education about cervical cancer in most health centers due to security issues and political instability. This is because women who came to the

health centers for other services did not receive information about cervical cancer. Additionally, the cervical cancer screening service is still relatively new and not well known. This, coupled with the fear of positive results, may be a factor in the low uptake of cervical cancer screening. One of the health extension worker's points of view.

"Many people are afraid of cervical cancer screening because people get afraid of being tested positive for the disease as they don't know much about the disease and they don't know that the disease is treatable. For example, on the first day, I get afraid and refused to be tested but on the next visit, I convinced myself that if the test came back positive, there would be a medical therapy because the disease has a stage at which we may be cured of it. After I have seen that the screening is very easy to undergo, I am now teaching and encouraging people to be tested without any fear."

(Health extension worker#2, Enseno Hc)

As the study reported one possible reason for the low participation in cervical cancer, screening is the lack of qualified professionals. Many women have cultural preferences, specific screening requirements, and other factors that lead them to seek female healthcare providers. However, there is a possibility that a female healthcare professional may not be available to fulfil this role. The finding also indicated one of the main factor for ensuring a high screening flow is the satisfaction of women. Women should be satisfied with the existing services provided by the health facility before they consider requesting extra offerings such as screening. Unfortunately, some facilities neglected to address the challenges faced by women due to their practice of disrespecting clients and failed to respect the existing culture. As a result, women chose to seek these services in other nearby towns.

"The health center has a shortage of trained professionals to provide cervical cancer screening. Currently, there are only two staff members who have been trained, and one of them is on maternal leave. This means that the male professional is the only one who can provide screening services. However, many women prefer to be examined by a female professional. Therefore, it is important to train more women professionals in cervical cancer screening. "

(Health extension worker #3, From Adulala)

One key informant also indicated that cervical cancer-screening uptake in relation to quality of service as follow;

"Quality of service in the health center can be one factor because if they didn't get the proper service they will be discouraged to get tested."

(Health extension worker # 1, from Chelelka Hc)

While some women prefer female healthcare providers, others feel more comfortable with male healthcare providers, particularly for certain types of examinations. This is because some women feel uncomfortable the way female healthcare providers treat them, or that they may not be able to provide the same level of privacy and confidentiality. One woman made the following comments regarding this matter.

"I prefer male health professionals since I had a negative experience with a female healthcare provider during childbirth. The female provider shouted and got angry with me, which made me feel very uncomfortable. In contrast, I have always found male doctors to be more understanding and deliver better treatment. I believe that many women share my preference for male doctors."

(45 years old participant from Enseno Hc)

2.4. Other related problems they face

Other important challenges that health extension workers have to deal with are people's reluctance to the training because they incorrectly feel that they are educated, and the inability to find women at home for house-to-home training because it is urban and most women work.The majority of health extension workers in urban areas, such as the Chelelka Health Centre in Debrezeyet, shared this opinion.

Health extension workers are facing a challenge with limited transportation options and their physical distance from the village. While it is expected that health extension workers should serve rural communities, certain areas are extremely isolated and hard to reach, causing residents to be reluctant in visiting and trying anything new.

Most recommendations from HEWs

The HEWs indicated the importance of "Women developmental army" as it is a training program that aims to empower female individuals who live within a community and who are influential to address sensitive issues affecting the community. These individuals have the ability to listen to the

community's worries and play an important role in addressing these problems. It is crucial to inform religious leaders about these matters, as they have a significant influence over their followers. This can be done through preaching and raising awareness, as we have seen the positive impact of religious leaders' involvement in spreading awareness about Covid-19 and the importance of taking antiretroviral therapy. Additionally, health extension workers have suggested including cervical cancer as one of the 16 packages for proper addressing, similar to other diseases.

As the study indicated to protect women from cervical cancer, we need to work together from the bottom up. Health extension workers should focus on raising awareness, and then health centers should improve their services and approach to women who come for testing. This will require teamwork and cooperation from everyone involved, from the local level to the national level.

"Increasing the number of trained health workers at the health center and providing training to both health center workers and health extension workers will allow us to broaden the scope of health education and improve our screening activities. We are currently disseminating what we heard from the staff who participated in the training"

(Key informant #4, health extension worker, from chelelka Hc)

"All the stakeholders should participate to improve the condition on the issue frequent meeting and discussions must be held. The reporting of screened and unscreened women must be recorded and submitted based on that intervention works must be done."

(Health extension worker #5, from Enseno Hc)

3. Barriers hindering them from screening

3.1. Awareness of cervical cancer and cervical cancer screening

Awareness regarding cervical cancer is low even the screened women could not describe it well because they screened accidentally or refereed by health professionals. Forty-three (43) years old, divorced women mentioned the following when she asked about cervical cancer

"To be honest I don't know too much about it. Health extension worker told us cervical cancer is severe disease. She also mentioned as if detected early it is curable. I know those things about it."

The study indicated that women have limited knowledge about cervical cancer. Although some women were aware of the symptoms such as unpleasant smell and discharge from uterus, they did not know the risk factors or much detail about the disease. When asked about cervical cancer, women often spoke generally about cancer. Even women who had been screened for cervical cancer were not able to say what type of screening they had or why they were screened. This suggests that there is a need to improve the way that information about cervical cancer is disseminated so that women can better understand the disease and its prevention.

3.2. Inaccessibility and Unavailability of Facilities

Forty-nine years old, HIV positive and screened for cervical cancer states the following regarding to availability of the service. *"Screening is very useful for early detection of diseases. For example, if people had been taught about the importance of screening for HIV, the epidemic may not have reached its current severe stage. Screening can help you know your status and get treatment early, before the disease damages your body. In the case of cervical cancer, we have heard about it recently and screening has been available in health centers for two years. If women continue to get screened, there will be no more deaths or serious illness from this disease."*

Women who had cervical cancer screening are even cannot explicitly mention the symptoms and risk factors of the disease. Healthcare professionals, in particular those who have received training in screening and awareness raising, have a duty to distribute information, however after undergoing screening and visiting other referral hospitals for the disease, the women were uninformed of the situation. They cannot tell the interval of screening and lifelong features of the disease.

When asked about other malignancies except for cervical cancer, the majority of women could often only name breast cancer and blood cancer. Nearly all wives received encouragement from their husbands to have their cervix checked, and regardless of the expense, they would be pleased

with their wife's good health. Most women did not use traditional herbal remedies but still some prefer to have those herbal remedies for all illnesses including cervical cancer.

3.3. Perceived Barriers to cervical cancer screening

The low number of women who get screened for cancer was due to a number of barriers, including lack of awareness and ineffective awareness-raising campaigns about cancer screening and its benefits, fear of the procedures involved in cancer screening, fear of the word "cancer" itself, lack of focus from government and health professionals. Here is the answered.

"The low focus the woreda health bureau and the health center professionals give for the cause. For example, if we do the work as a campaign like we did for the corona virus testing. We can solve the problem of low number of screenings."

(36 years old pharmacist participant from Chellelka Hc)

3.4. Culture and belifs related factors

Culture and some beliefs are factors that also affect cervical cancer and screening practices. Thirty-two years old, married woman answers the following when she was asked about cervical cancer

"Oh, that one. One of my friends; she is my neighbor. She told me that she is sick. I asked what she was feeling. She said her cervix is very itchy and that she has a cervical problem. I told her to go and be checked at the hospital. She said she did but she did not get better. So, I told her to wash up with warm water and salt."

From this could understand that the women prefer to use some home remedies when they faced such illnesses. Some of the participants thought that cervical cancer could acquire by having bad behaviours and it is a sign of having an inappropriate lifestyle. The same woman respond this,

"Because based on my lifestyle I don't think I have the disease. If my husband or I had bad behaviour, I would have been tested. We also do not have a bad disease in our neighbourhood. When someone gets sick, they tell us so we protect ourselves. For example, when I know a person is sick, I try to protect myself. Since, neither my husband nor I has bad behaviour; I do not believe I have the disease. If my husband was away, I would worry he might make a mistake and get the disease. I don't suspect anything since he is always with me."

To make it more clear there are a women who thought cervical cancer screening is needed for those who are marred and active at sexual activity."for example " i didn't got tested because one; i got divorced from my marriage long time ago so I have no problem, and another thing is am godly women so I know I don't have to involve in adultery activities"

(45 years old divorced women, from Enseno Hc)

Some Recommendations from Women

Included are some of the followings:

- ✓ Visiting kebele dwellers in person and treating as well as giving them education with love and respect since obviously people need love. If they do that the fear may go away and the dwellers get tested,
- ✓ In the community, there may be women with symptoms of cervical cancer but not tested: One of the women said, "You have oath after finishing your education right? For the sake of God and oath you made, you should treat and give health education by using your knowledge practically without negligence."
- ✓ Training must be given for the health extension workers because they are in direct contact with the community women. Moreover, the woreda health bureau should give a great concern for the issue and prepare campaigns and awareness creation programs, which advocate the benefit of the screening and the negative consequence of the disease for the community. Working on such measures will help women to raise the awareness of the community and the number of the women who come for screening.

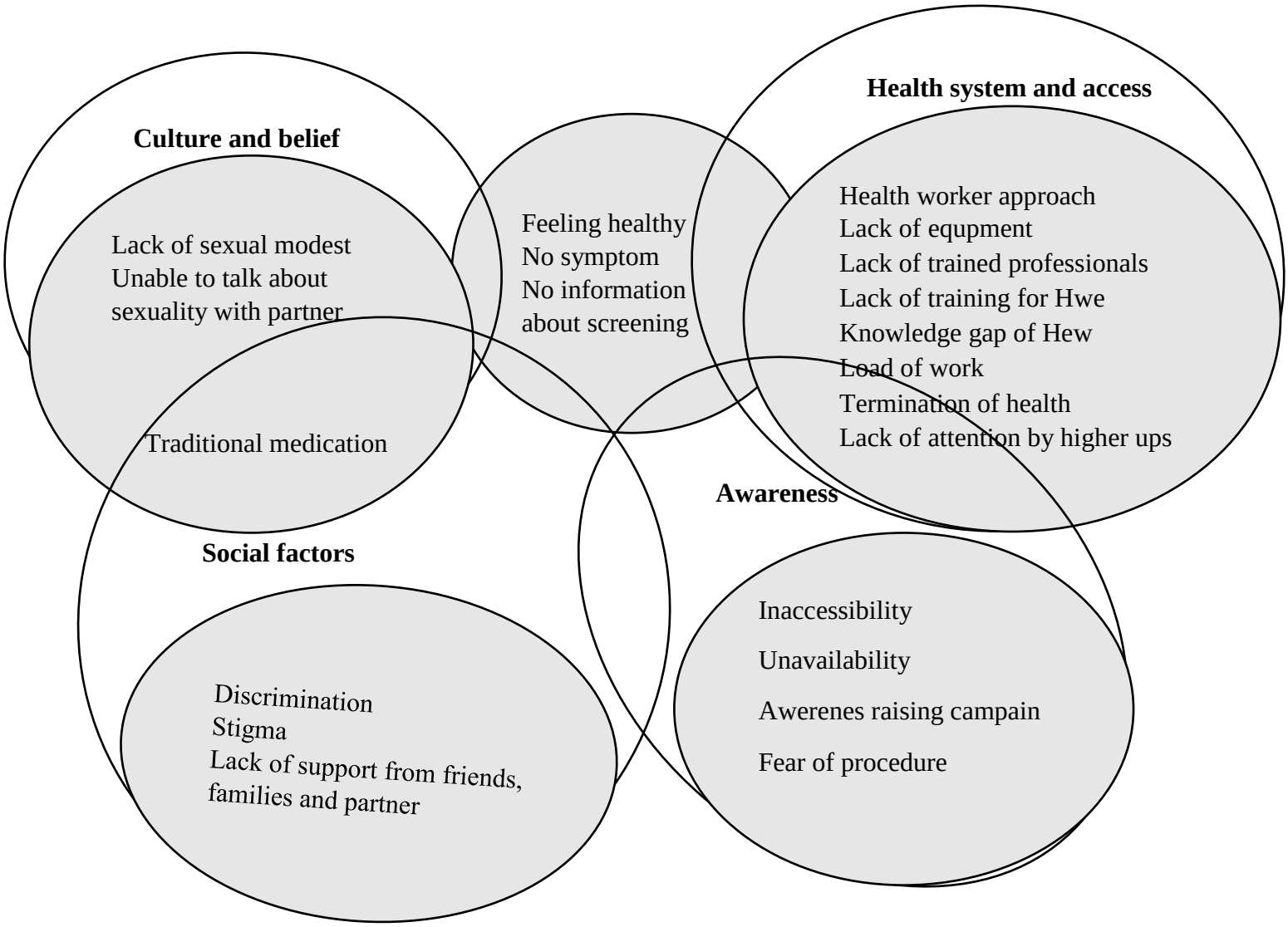

Figure 5: Perceived barriers of cervical cancer screening uptake in Oromia and SNNP region, Ethiopia, 2023

6. Discussion

This study assessed cervical cancer screening uptake among women and identify the factors influencing screening uptake. It is crutial to identify determinats of screening uptake in order to detect as early as possible to reduce morbidity and mortality linked with cervical cancer.

The survey reported that 24.97% of women took cervical cancer screening service. This figure is significantly lower than the rates reported in America (67.5%)(71), China (33.2%)(72), South Africa (35.4%)(73), and in South West Ethiopia (38.7%)(30). The discrepancy might be attributed to variations in the socio-demographic and economic backgrounds of the research participants, as well as differences in health policies and the effectiveness of screening programs implemented by each country. The high prevalence of CC screening in south west Ethiopia may be attributed to the implementation of SBCC activities and cervical cancer screening campaigns(30). This highlights the importance of conducting SBCC interventions and providing CC screening campaigns in order to improve the rate of participation(30). In Ethiopia,a small proportion of women are in contact with obstetric or gynaecological health services and that the health system may not have the capacity to provide effective screening to a larger number of women (74). Hence, it is imperative to implement intervention programs that aim to enhance the caliber of cervical cancer screening clinics. Another possible reason could be the availability and accessibility of cervical cancer screening services and techniques, such as Pap smears and HPV tests. Additionally,the presence of well-trained and skilled medical professionals who can perform screenings and accurately interpret results, socio demographic factors, differences in study design, data collection methods, sample sizes, and statistical analyses and age of study participants can all lead to variations in study outcomes and could be a reason for this discrepancy.

The findings of this study on the prevalence of cervical cancer screening are higher than those of previous studies conducted in Africa (75–77) and elsewhere in Ethiopia (22, 61, 78, 79). There are several possible reasons for this disparity. One possibility is that the study area and population in this study were different from those in the previous studies. Another possibility is that the age category of the study participants was different. Additionally, ignorance about cervical cancer and its screening practices, as well as perceptions and attitudes based on cultural and religious beliefs,

may have played a role. Finally, the time gap between the studies and the divergent locations of the study areas may have also contributed to the disparity.

Educational status was found to be significantly associated with uptake of cervical cancer screening. As women who completed college or higher were 3.2 times more likely to use cervical cancer screening services than those who did not complete any formal education. This finding was consistent with research conducted in different parts of Ethiopia (30, 78–81) and other country (46, 49, 73). This could be explained by the fact that as women's education level increase, their inclination to seek health care services rises and their access to health related knowledge from various sources expand. Education plays a crucial role in improving women's access to knowledge and empowering them in various aspects of their lives, including healthcare decisions like cervical cancer screening (74). Education equips women with the tools to comprehend, evaluate, and act upon health-related information, leading to better healthcare decision-making, higher health-seeking behavior, and improved access to knowledge about issues like cervical cancer screening (18). As a result, educated women are better positioned to take charge of their health and contribute positively to their own well-being and the well-being of their communities (82). The majority of the socio demographic factors were not significant in this study, implying that the socio demographic aspects no longer influence the screening and there would be other hindrance difficulties that may confront the service.

In this study, knowledge of women were significantly associated with cervical cancer screening uptake.Women who had good knowledge were 2.66 times more likely to have cervical cancer screening uptake when compared to women who had poor knowledge. This finding was in-line with a study done in different places (23, 27, 48, 80–82). Similarly this finding also consistent with a study done in Thailand (86). These findings can be explained by the fact that increased knowledge of the benefits of cervical cancer screening can directly lead women to utilize this screening service. This is because when women are more aware of their health, they are more likely to visit hospitals when they feel ill. Early detection and treatment can lead to better health outcomes. Increased awareness might also lead to women having more financial resources to spend on their health. This could result in better access to medical services and treatments. According to the qualitative part of this study, despite being aware of cervical cancer, some women might refuse to undergo screenings. This could be due to various reasons, such as a lack of noticeable symptoms,

fear of discomfort during the examination, or other concerns. The discomfort experienced during the cervical cancer screening process can be a significant deterrent for some women. This can lead them to avoid undergoing the screening despite being aware of its importance. Women who have already undergone screening might share their experiences with others. If they found the process painful or felt that healthcare providers were unfriendly, their negative feedback could discourage other women from seeking the screening.

To tackle those barriers the participants mentioned the following. Clear and accurate information about the importance of cervical cancer screening, its benefits, and the process itself can help dispel misconceptions and fears. Improving the experience of the screening process, such as minimizing discomfort and ensuring a friendly and supportive environment, can encourage more women to undergo screenings. Highlighting positive experiences from women who have undergone screenings and received support from healthcare providers can counteract negative perceptions. Emphasizing that cervical cancer often does not show symptoms in its early stages can help women understand the necessity of regular screenings for early detection. Healthcare providers should be culturally sensitive and provide information in a way that resonates with different groups of women. Healthcare systems should actively seek feedback from women who have undergone screenings to identify areas for improvement in the process and overall experience.

Social support was significant predictor of cervical cancer screening uptake. Odds of women having social support network were two times higher for cervical cancer screening than that of not having social support network women. This finding was in line with a study done in Malawi(66), a study done in sub shara Africa,(59) and an Amrica study on immigrants (87). It is clear that social support plays a significant role in increasing the uptake of cervical cancer services among women. Social support can come in various forms, including emotional, financial, and material

assistance(87). When women receive this support, it can lead to an improvement in their self-esteem and a greater willingness to face challenges, including potential health issues like cervical cancer(63). Having a supportive network can indeed contribute to a person's ability to cope with difficulties and maintain a positive outlook. This idea is supported with a study done on international students (87). The qualitative aspect of this study finds that, where women expressed their confidence in receiving support from their husbands, families, and friends, further emphasizes

the importance of these relationships in their decision-making process. Knowing that they have reliable sources of support can reduce barriers to seeking preventive healthcare services like cervical cancer screening.

Women's confidence in their ability to count on their social circle during challenging times also highlights the potential for interventions that encourage and strengthen these support systems(63). Public health campaigns and education initiatives could aim to enhance the understanding of the role of social support in women's health and encourage open communication within families and communities about health issues. Overall, these findings underscore the importance of recognizing the impact of social support on women's health behaviors and the potential for interventions that leverage this support to increase the uptake of cervical cancer services.

Age at fist sex is the other predictor, which was significantly associated with cervical cancer screening uptake. Women's odds of being screened for cervical cancer were 51% lower for age at first sex older than 18 years when compared to their counter part. this finding was in line with a study done in Debremarkos (29). This is because first sexual intercourse at early age is a factor to increase the chance of acquiring HPV infection. One plausible reason for this could be that women who partake in early sexual activity may be prone to contracting other sexually transmitted infections. As a result, when seeking medical care, they might inadvertently undergo cervical cancer screening as well.

Attitude of participants was significant predictor of cervical cancer screening uptake. The odds of women's having positive attitude about cervical cancer screening were approximately four times more likely to be screened for cervical cancer than women's having negative attitude. This study was supported by a study done in Debremarkos, Mekele , Southern Ghana and Thailand (29, 44, 83). The above reports might be explained with women who have a favourable attitude towards the importance of early detection and prevention can lead to higher screening uptake. Positive attitudes often stem from accurate knowledge about cervical cancer, its causes, and the purpose of screening. Lack of awareness can lead to negative or indifferent attitudes and, consequently, lower uptake.in general, attitudes towards cervical cancer screening significantly impact the decision to undergo screening. Positive attitudes driven by awareness, knowledge, perceived benefits, and support from healthcare providers and peers tend to lead to higher uptake. Conversely, negative

attitudes resulting from misconceptions, fears, and cultural factors can hinder participation. Public health efforts should focus on addressing these attitudes through education, communication, and support to increase cervical cancer screening uptake and, consequently, early detection and improved outcomes.

7. Strength and limitation of the study

Strength: ODK tool was utilized for collecting questionnaires, minimizing concerns about data quality. To ensure high-quality data, face-to-face interviews were conducted, enabling researchers to clarify any unclear questions for participants. Additionally, the principal investigator collected and analysed the qualitative portion of the questionnaire, contributing to the prevention of misunderstandings and maintaining a consistent flow of information.

Limitation: Despite the valuable insights it offers, the study is subjected to certain limitations. Firstly, the information about the use of CC screening services was collected through self-reports, which may have resulted in desirability bias. Additionally, our study specifically focused on a particular population consisting of individuals seeking health services at a public facility, which may have influenced their likelihood to seek screening services.

8. Conclusion

The utilization of cervical cancer screening among eligible women is relatively inadequate. Factors such as educational background, age at first sexual intercourse, knowledge, social support network, and women's attitude were found to influence the uptake of cervical cancer screening. Further barriers to low screening rates were discovered during detailed interviews. These barriers encompassed inadequate availability of necessary equipment, restricted accessibility to specific areas, lack of awareness, insufficient expertise of healthcare providers, the absence of health education at healthcare centres, and cultural beliefs. Consequently, it is crucial to enhance community knowledge and awareness regarding the disease and screening services through the current health extension program.

9. Recommendation

The following recommendations are provided based on the findings of this particular study. The study revealed a low level of uptake for cervical cancer screening. Additionally, low levels of knowledge and attitude regarding cervical cancer were observed, and these factors were found to be significantly associated with the uptake of screening in the study. Consequently, the study suggests that

The Ethiopian Ministry of Health (EMOH) should enhance public health education and awareness, as well as provide national training for health extension workers, specifically focusing on cervical cancer screening in both a general and study area context.

Furthermore, the Oromia and SNNP regional health offices should collaborate with the MOH to improve public health education and awareness creation, aiming to enhance the knowledge and attitude of eligible women towards cervical cancer screening in the study area.

Public health facility workers are also recommended to advise and motivate eligible women to undergo screening tests, as this will help increase the uptake of cervical cancer screening among the targeted population.

To gain a better understanding, further research is advised, specifically exploring the factors that affect cervical cancer screening uptake, such as culture and beliefs, using advanced epidemiological study designs in large-scale community-based settings.

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Appendixes

Appendix I- Information sheet

Introduction

My name is … I am working as data collector for master of public health student project in Addis Ababa University. We are conducting a research entitled "cervical cancer screening uptake and associated factors at primary care facilities in peripheral settings of Oromia and SNNP Regions in Ethiopia'.

Purpose of the study: - This study aims to assess Cervical Cancer Screening uptake and associated Factors among age-eligible women at health centres in Oromia and SNNP Regions.

Benefit: -You will profit both in the long and near term from participating in this study, even if there is no immediate incentive to do so. The long-term advantage of the study's findings will be that they can be used to extend and implement screening programs, which might be highly advantageous for you and the society as well as me. The immediate benefit is that following data collection, research participants will get knowledge on cervical cancer and screening.

Risk: - I may ask you about your disease which may be personal information and may not be comfortable. However, the information you provide will have paramount importance to conduct this research.

Procedures: - If you agree to participate in the study, you will be asked to answer some questions about research related questions and yourself. The interview will take 30 minutes.

Your participation will be voluntary: - Your participation is purely based on your willingness and you have the right to choose not to take part in this study. If you choose to take part, you have the right to stop the interview at any time. If you are willing to participate, refuse, or decide to withdraw later, you will not be subjected to any problems.

Confidentiality: - The information that you provide will be kept confidential by using codes and locking the data. No one will have access to the non-coded data except the investigators. The data will not be used for purposes other than the study.

Whom to Contact- If you have any questions, you may contact to the person stated below

Zewednesh Debebe - cell number: 0932507291/0911487310

Appendix II- Informed Consent

I understand the purpose of the study. The study has been explained to me in the language that I understand. I have had the opportunity to ask questions and the questions I asked have been answered to my satisfaction. I consent voluntarily to be part of the study and understand that I have the right to withdraw from the study at any time.

Participant

Signature_____ Date_____

Interviewer

Name_____ Signature_____

Questionnaires number_____

Date of interview_____ Starting time_____ Completed_____

Appendix iii English version questionnaire both for quantitative and qualitative part

Part I: Questions to assess the socio-demographic characteristics of the participant

No	Questions	Responses	Skipping
101	Tell me how old are you? Please	_____ years	
102	To which religion do you belong?	Orthodox Muslim Protestant Catholic Others specify	
103	Which type of area do you come from?	Urban Rural	
104	What is your current marital status?	Single Married Divorced Widowed Separated	
105	What is the highest level of education that you have attained?	Unable to read and write Read and write only Primary school Secondary School College and above	
106	If married in Q. 104 What is your husband's educational status.	Unable to read and write Able to read and/or write Primary education Secondary (9-12) College degree and above	Skip if Q104 is 1 or 3 or 4 or 5

107	What is your occupation? What kind of work do you mainly do?	Housewife Governmental Employed Merchant Private employed Farmer Unemployed Daily labourer Business lady Any other (please specify)	
108	Would you tell me your monthly household income in Birr?	_____ Birr	

Part-II: Reproductive history

201	How many children do you have?	_____ in number	
202	How old were you when you had sexual intercourse for the first time?	_____ in number	
203	Could you please tell me how many sexual partners you have had in your life?	_____	
204	How many times you have been pregnant.	_____	
205	Have you ever used any hormonal contraceptive methods?	Yes No	If the answer is no skip to QNO 208
206	If yes what type? Indicate all that apply	Oral contraceptive pills (COC). Injectables (Depo Provera,) Norplant (implants) Barrier methods IUCD Other specify	
207	If the response to the above question is 205, is yes, For how long have you used contraceptives?	_____ years	
208	Are you currently using oral contraception?	Yes No	
209	Family history of cervical cancer	Yes, present No	
210	Have you ever had STDs? (Lifetime history of STDs)	Yes No	
211	Ever history of smoking	Yes No	
212	Are you currently smoker?	Yes No	

Part-III: Knowledge about cervical cancer and screening

No	Question	Response	Skip
301	Have you ever heard about cervical cancer?	Yes No	
302	Where did you first hear about carcinoma of the cervix? *Multiple answers possible*	News Media (Radio, TV) Brochures, posters, and other printed materials Health workers Family, friends, neighbors, and colleagues Religious leadrs Social media (face book, Instagram, TikTok, Telegram)	

.			
303	What are the symptoms of carcinoma of the cervix? *Multiple answers possible*	Vaginal bleeding Foul-smelling of Vaginal discharges Post coital bleeding Do not know	
304	What are the risk factors for cancer of the cervix? *Multiple answers possible*	Acquiring HPV virus Having multiple sexual partners Early sexual intercourse having too many children Cigarette smoking Do not know Other (please explain)	
305	Cervical cancer is preventable	Yes No	
306	How can a person prevent getting cancer of the cervix? *Multiple answers possible*	Through vaccination of HPV vaccine Avoid multiple sexual partners Avoid early sexual intercourse Avoid having too many children Avoid using oral contraceptives for a long time Quit smoking Screening for cervical cancer Do not know Other (please explain)	
307	Can cancer of the cervix be cured if diagnosed in its earliest stages?	Yes No	
308	How can someone with cancer of the cervix be treated? *Multiple answers possible*	Herbal remedies surgery Specific drugs are given by hospital Radiotherapy Do not know Other	
309	How expensive do you think cancer of the cervix screening is in this country?	It is free of charge It is reasonably priced It is somewhat/moderately expensive It is very expensive Don't know	
310	Have you heard any information about cervical Cancer screening?	Yes No	
311	If yes for Q 311, from where you get the information?	News Media (Radio, TV) Brochures, posters, and other printed materials Health workers Family, friends, neighbors, and colleagues Religious leaders Social media (face book, Instagram, TikTok, Telegram) Other (please explain	
312	Are there screening procedures to detect cervical lesions?	Yes No	if no go to the next subsection

313	How frequently is screening for premalignant cervical lesions done?	Once every year Once every three years Once every 5 years Any other(mention) Don't know	
314	Who should be screened?	Women of 25 years and above Commercial sex worker Elderly women All women Don't know	
315	Do you know the procedures used in screening for cervical lesions?	Yes No	
316	Can you mention any of the procedures used in screening for premalignant Cervical lesions? Multiple answers possible	VIA VILI Pap Smear Other Don't know	

Part IV: Attitude Questions

No	Questions	Responses	Skip
401	Any adult woman including you can acquire cervical carcinoma	Strongly agree Agree Neither agree nor disagree Disagree Strongly disagree	
402	Carcinoma of the cervix cannot be transmitted from one person to another	Strongly agree Agree Neither agree nor disagree Disagree Strongly disagree	
403	Screening helps in the prevention of carcinoma of the cervix	Strongly agree Agree Neither agree nor disagree Disagree Strongly disagree	
404	Screening causes no harm to the client	Strongly agree Agree Neither agree nor disagree Disagree Strongly disagree	
405	Screening for premalignant cervical lesions is not expensive	Strongly agree Agree Neither agree nor disagree Disagree Strongly disagree	
406	If screening is free and causes no harm, will you screen	Strongly agree Agree Neither agree nor disagree Disagree Strongly disagree	
407	Do you fear cervical Cancer screening?	Strongly agree Agree Neither agree nor disagree Disagree Strongly disagree	

408	Do you feel shy to expose your private parts during the procedure to young or male service providers?	Strongly agree Agree Neither agree nor disagree Disagree Strongly disagree	
409	Are you afraid of pain/discomfort during cervical cancer screening procedures?	Strongly agree Agree Neither agree nor disagree Disagree Strongly disagree	
410	Are you afraid of bleeding during and after the cervical cancer screening procedure?	Strongly agree Agree Neither agree nor disagree Disagree Strongly disagree	
411	Are you afraid of being diagnosed with cervical cancer after undergoing the screening?	Strongly agree Agree Neither agree nor disagree Disagree Strongly disagree	

Part 5: Screening Practice Questions

No	Question	Response	Skip
501	Have you ever screened for any reproductive health screenings like HIV, STIs	Yes No	
502	Have you ever screened for cancer of the cervix?	Yes No	If no skip to QNO 507
503	Where did you screen?	Public Hospital Private health facility Health centers	
504	What was the indication?	Self-initiated Offered by the health professionals Other(specify)	
505	If yes how many times have you screened since you become sexually active	_____ number	
506	When was the last time you screened	_____ Months back	
507	If not, why? **Do not read the options**	It may be painful. I feel shy I am healthy My husband would not agree I am afraid a screening test would reveal cervical cancer it is expensive I am not informed or knowledgeable I haven't just decided Service not available Other	

Part 6: health-seeking behavior

No	Question	Response	Skipping
601	How often do you generally seek health care at a clinic or hospital? (Check one)	Twice a year Once a year Less than a year but twice in the past Once in the past 5 years Not in the past year	
602	Where do you usually first seek care when sick?	Government Hospital Health center Private clinic Traditional healers Pharmacy	
603	Are you satisfied with the services you are receiving currently?	Satisfied Not satisfied	
604	What is the best way that could be used to make you more aware of cervical cancer?	1, health education at health facility 2, health extension advice 3, printing media I.e magazin news paper 4, social media I.e Fb, telgram , you tube ,TV and radio 5, health care providers advice	
605	Do you know of any cultural issues associated with cervical cancer or the screening methods for cervical cancer?	Yes No	
606	If **Yes,** which one?	1, religious Factors (islamic culture) 2,taboo of showing private part 3, I don't know 4, other specify	
607	Do you know that screening services are offered in this health center?	Yes No →	701
608	What do you think about the service offered?	Excellent Good Poor Don't know	
609	What do you think about the behavior of health workers offering these services?	Excellent Good Poor Don't know	
610	Is cervical cancer screening at the health center affordable?	Yes No	
611	In your experience what is the waiting time for this clinic before receiving the required services?	0-15 minutes 15-30 munites >30 munutes >1 hour don't know	
612	How long does it take to reach these health centers?	<1 hour 1 hour	

		don't know	

Part 7: Access to healthcare

No	Question	Response	skipping
701	**Availability** Did you know where to go for the screening?	Yes No	
702	**Accessibility** Screening sites are far (distant)	Yes No	
703	Previously, I was badly treated	Yes No	
704	Long waiting time	Yes No	
705	**Accommodation** The healthcare providers are inadequate	Yes No	
706	There were no equipment and supplies	Yes No	
707	I thought I was not sick	Yes No	
708	Could not take time off my work/had other commitments/laziness Acceptability	Yes No	
709	There is no privacy at the clinic	Yes No	
710	Providers are males	Yes No	
711	I do not see the reason to go for screening as I am too old/too young	Yes No	

Part 8: Social support

No	Question	Response	Skipping
801	**Health care providers** Can you share your concerns about cervical cancer screening with a healthcare provider?	Yes No	
802	Have healthcare providers ever counselled (talked to) you about cervical cancer screening?	Yes No	
803	**Family members** Does your family try to help you with financial support to go for cervical cancer screening?	Yes No	
804	Do you get the emotional help and support you need from your family regarding cervical cancer screening?	Yes No	
805	Can you discuss cervical cancer screening with your family?	Yes No	
806	Have your family members ever encouraged you to be screened for cervical cancer?	Yes No	
807	**Friends** Have your friends ever recommended cervical cancer screening to you?	Yes No	
808	Can your friends provide social support when found (diagnosed) with cervical cancer?	Yes No	
809	Do you have friends with whom you can share your results of screening (examination)?	Yes No	
810	Can you encourage your friend to go for cervical Screening?	Yes No	

Part 9: Cultural Barriers to Screening

No	Question	Response	
901	**Communication with partner** If I needed to ask my husband/ partner about sex, birth control, or gynaecological health, I would feel comfortable doing so.	Yes No	
902	I can talk to my husband /partner about anything.	Yes No	
903	My husband/partner has brought up the topic of sex, birth control, or gynaecological health in the past. The topic of sex or anything related to sex is taboo between my husband/ parents, partners, and me	Yes No	
904	My husband/partner has talked to me about the importance of being screened for cervical cancer.	Yes No	
905	**Openness around sexuality** I would feel comfortable with a male physician examining my cervix as part of a medical exam	Yes No	
906	I would feel comfortable with a female physician examining my cervix as part of a medical exam.	Yes No	
907	Generally, I feel comfortable discussing and acknowledging my own sexuality.	Yes No	
908	If the topic of sex came up in conversation with a close female friend, I could discuss it easily.	Yes No	
909	The thought of getting a gynecological exam embarrasses me.	Yes No	
910	The thought of a doctor examining any part of my body embarrasses me.	Yes No	
911	I am modest about my body even if it involves a health examination.	Yes No	
912	I feel uncomfortable discussing matters of sexuality with my close female friends.	Yes No	
913	**Utilization of Western medicine** When I get sick, I usually take Western medicine (i.e., Tylenol, aspirin)	Yes No	
914	When I am sick, I usually take traditional medication (i.e., herbs,	Yes No	
915	I believe traditional medicine is very effective in treating health problems	Yes No	

Questions draft for qualitative study

1. Have you ever heard of cancer of the uterus?
2. Where did you heard?
3. What do you know about the disease? Symptoms treatment, screening, severity...
4. Have you heard of cervical cancer screening, from where you heard about?
5. Do you think screening is important, how?
6. Have you ever screened for any reproductive health screenings, HIV, STIs..., if no why
7. Have you ever think to screen
8. What do you think is the reason not to screen for cervical cancer and any other RH screenings in your community?
9. Are you willing to undergo cervical cancer screening, if not why?
10. How do you see the service provided by health professionals during follow up?
11. What do you recommend for the health facilities regarding cervical cancer screening service?
12. What do you recommend again to the community to do regarding cervical cancer screening?

Af-Gaaffii Afaan Oromoo Unka hayyamaa

Nagaan bultanii /ooltanii!

Maqaan koo _____ jedhama, waa'ee kaansarii gadameessaa fi dhimmoota kanaan walqabatan Qorannoo mata duree "fudhatama Qorannoo kaansarii gadameessaa fi wantoota kanaan walqabatan dubartoota umuriin isaanii ga'umsa qaban (30-49) naannoo Oromiyaa fi Ummattoota Kibbaa" jedhuuf odeeffannoo isin irraa walitti qabuuf dhiyaadheen jira. Odeeffannoo fuulduratti kenname ilaalchisee Qorannoo kana irratti hirmaachuun karaa kamiinuu balaa fi miidhaa hin qabu. Unka kana irratti maqaan kee hin barreeffamu odeeffannoon ati kennitu gonkumaa namoota biroof hin qoodamu. Gaaffii deebii itti kennuu hin barbaanne kamiyyuu deebisuu dhiisuu dandeessa akkasumas yeroo barbaaddetti gaaffii fi deebii kana addaan kutuu dandeessa. Amma qorannicha irratti hirmaataa akka taatuuf filatamuu kee sitti himuun barbaada. Deebiin dhugaa af-gaaffiidhaaf kennitan qorannichaaf baay'ee barbaachisaa waan ta'uuf, Qorannoo kana irratti fedhii keessaniin hirmaannaa keessaniif isin dinqisiifanna.

Tumsa fi dhaggeeffachuu keessaniif galatoomaa! Hirmaachuuf fedhii qabduu?

Eeyyee: ____ (Gaaffii fi deebii itti fufaa)

Lakki; _____ (Gaaffii fi deebii dhaabaa)

1. Maqaa dhaabbataa/hospitaalaa/Giddugala Fayyaa: _____
2. Guyyaa: _____ / _____ / _____

   Lakkoofsa Eenyummaa Af-Gaaffii: _____

   Maqaa Gaafataa: _____ Mallattoo _____

   Maqaa Suppervaayizaraa: _____ Mallattoo _____

Kutaa 1: Gaaffilee amala hawaas-dimoogiraafii hirmaataa madaaluuf

Lakk.	Gaaffiilee	Deebiilee	Yaada
1	Umuriin kee meeqa natti himi?	Waggaa _____	
2	Amantii kam keessa jirta?	Ortodoksii Muslima Pirootestaantii Kaatolikii Kanneen biroo	
3	Naannoo gosa kam irraa dhufta?	Magaalaa Baadiyyaa Hin beeku	
4	Haalli gaa'ela keessan amma maali?	kan hin fuune/heerumne Kan fuudhe/heerumte Kan hiike/te Dubartii abbaan manaa irraa du'e Kan Addaan bahe/te	
5	Sadarkaan barnootaa olaanaan ati argatte maali? FILANNOO HIN DUBBISinaa.	Mana Barumsaa Hin seenne Mana barumsaa sadarkaa tokkoffaa Mana Barumsaa Sadarkaa Lammaffaa Kolleejjii/Yuunivarsiitii Kan biroo, ibsaa	
6	Yoo heerumte gaaffii lakk. 4-irratti Abbaan manaa kee sadarkaa barnootaa maali irra jira?	dubbisuu fi barreessuu hin danda'u Dubbisuu fi/ykn barreessuu kan danda'u Barnoota sadarkaa tokkoffaa Sadarkaa Lammaffaa (9-12) Ragaa fi dippiloomaa Digirii kolleejjii fi isaa ol	

7	Hojiin kee maali/ hojii akkamii irra caalaa hojjetta/?	Qaxaramaa Hojii dhabeettii Haadha manaa Qonnaan bulaa Ogeessa Hojjetaa ogummaa hin qabne Hojjetaa guyyaa Giiftii daldalaa Kan biraa kamiyyuu (maaloo ibsaa)	
8	Galii ji'a ji'aan argattu qarshiin natti himtaa?	qarshii _____	
9	Ijoollee meeqa qabda?	Lakkoofsaan _____	
10	Yeroo jalqabaaf wal qunnamtii saalaa raawwattu umriin kee meeqa ture?	Lakkoofsaan _____	
11	Mee jireenya kee keessatti hiriyoota saalqunnamtii meeqa akka qabaatte natti himuu dandeessaa?	tokko qofa 2-3 4-5 6-10 10 ol	
12	Yeroo meeqa ulfoofte?		
13	Mala ittisa ulfa hormoonii kamiyyuu fayyadamtee beektaa?	Eeyyee Lakki	
14	Yoo eeyyee ta'e gosa akkamii? Kan ilaallatu hunda agarsiisi	Kiniinii ulfa ittisuu afaaniin fudhatamu (COC). Qoricha qoricha lilmoo (Depo Provera,) Norplant (implant) Malawwan danqaa Kan biroo, ibsaa	
15	Deebiin gaaffii armaan olii 1 yoo ta'e, Mala kana yeroo hammamiif fayyadamtee?	Waggoota _____	
16	Yeroo ammaa kana ittisa ulfaa afaaniin fudhatamu fayyadamaa jirtaa?	Eeyyee Lakki	
17			

Kutaa 2: Beekumsa waa’ee kaansarii gadameessaa fi Qorannoo

Lakk.	Gaaffiilee	Deebiilee	Yaada
1	Waa'ee kaansarii dhageessanii beektuu?	Eeyyee Lakki	
2	Waa'ee kaansarii gadameessaa dhageessanii beektuu?	Eeyyee Lakki	
3	Waa’ee kaansarii qaama gadameessaa jalqaba eessaa barte? Deebii dachaa ta'uu danda'a	Miidiyaa Waraqaa balaliituu, poostarootaa fi meeshaalee maxxanfaman kan biroo Hojjetoota fayyaa Maatii, hiriyoota, ollaa fi namoota wajjin hojjetan Abbootii amantii Barsiisota Kan biroo (maaloo ibsaa)	
4	Mallattoowwan kaansarii qaama gadameessaa maali? Deebii dachaa ta'uu danda'a	Dhiiguu qaama saalaa Dhangala’aa qaama saalaa dubartii foolii kennuu Hin beeku. Kan biroo	
5	Wantoonni kaansarii qaama gadameessaaf saaxilaman maali? Deebii dachaa ta'uu danda'a	Vaayirasii HPV qabaachuu Hiriyoota wal qunnamtii saalaa dachaa qabaachuu Walqunnamtii saalaa dafanii raawwachuu Ijoollee baay'ee godhachuu irraa of qusachuu Yeroo dheeraaf qoricha ulfa ittisuu afaaniin fudhatamu fayyadamuu irraa fagaachuu Tamboo xuuxuu Hin beeku Kan biroo (maaloo ibsaa)	
6	Namni tokko kaansarii qaama gadameessaa akkamiin ittisuu danda’a? Deebii dachaa ta'uu danda'a	Karaa talaallii HPV Hiriyoota wal qunnamtii saalaa dachaa ta'an irraa fagaachuu Walqunnamtii saalaa dafanii raawwachuu irraa fagaachuu Ijoollee baay'ee godhachuu irraa of qusachuu Yeroo dheeraaf qoricha ulfa ittisuu afaaniin fudhatamu fayyadamuu irraa fagaachuu Tamboo xuuxuu dhiisuu Qorannoo kaansarii gadameessaa	

		Kan biroo (maaloo ibsaa) Hin beeku	
7	Kaansariin qaama gadameessaa sadarkaa jalqabaa irratti yoo adda baafame fayyuu danda'aa?	Eeyyee Lakki Hin Beeku	
8	Namni kaansarii qaama gadameessaa qabu akkamitti yaalamuu danda'a? Deebii dachaa ta'uu danda'a	Qoricha baala mukaa baqaqsanii hodhuu Qorichoota adda ta'an hospitaalaan kennamaniin Raadiyooteraapii Hin beeku Kan biroo	
9	Biyya kana keessatti wal'aansi kaansarii qaama gadameessaa hangam qaala'a jettanii yaaddu?	Kaffaltii tokko malee Gatii madaalawaa qaba Hamma tokko/giddu galeessa qaala'aa dha Baayyee qaaliidha Hin beeku kan biraa (ibsaa)	
10	Hojimaatni Qorannoo madaa gadameessaa hamaa duraa adda baasuuf ni jiraa?	Eeyyee Lakki;	yoo lakki ta'e gara kutaa xiqqaa itti aanutti deemaa
11	Sakatta'iinsi madaa gadameessaa hamaa duraa yeroo meeqa raawwatama?	Waggaatti al tokko Waggaa sadiitti al tokko Waggaa 5tti al tokko Kan biraa(kaasuun) kamiyyuu Hin beeku	
12	Eenyuutu qoratamuu qaba?	Dubartoota waggaa 25 fi isaa ol Hojjetaa saalqunnamtii daldalaa Dubartoota gurguddoo Kan biroo Hin beeku	
13	Hojimaata madaa gadameessaa hamaa duraa qorachuu keessatti itti fayyadaman beektaa?	Eeyyee Lakki	
14	Hojimaata Qorannoo madaa gadameessaa premalignant keessatti	VIA VILI	

	fayyadaman kamiyyuu kaasuu ni dandeessaa? Deebii dachaa ta'uu danda'a	Paap Smear kan jedhamu Kan biroo Hin beeku	

Kutaa 3: Gaaffilee Ilaalcha

Lakk.	Gaaffiilee	Deebiilee	Bira darbuu
1	Rakkinni dhikkuba kanaa biyya keenya keessatti baay'inaan kan mul'atu yoo ta'u, Itoophiyaa keessatti dhukkuboota hamaa hunda keessaa sababa du'aa adda dureedha.	Cimseen waliigala Waliigala Hin fudhadhus hin mormus Hin fudhadhu Cimsee walii hin galle	
2	Dubartiin ga'eessi kamiyyuu si dabalatee kaarsinoomaa gadameessaa qabaachuu ni dandeessi.	Cimseen waliigala Waliigala Hin fudhadhus hin mormus Hin fudhadhu Cimsee walii hin galle	
3	Kaarsinoomaa gadameessaa nama tokko irraa gara nama biraatti daddarbuu hin danda'u.	Cimseen waliigala Waliigala Hin fudhadhus hin mormus Hin fudhadhu Cimsee walii hin galle	
4	Sakatta'iinsi kaarsinoomaa qaama gadameessaa ittisuuf gargaara.	Cimseen waliigala Waliigala Hin fudhadhus hin mormus Hin fudhadhu Cimsee walii hin galle	
5	Sakatta'iinsi maamila irratti miidhaa tokkollee hin geessisu	Cimseen waliigala Waliigala Hin fudhadhus hin mormus Hin fudhadhu Cimsee walii hin galle	
6	Sakatta'iinsi madaa gadameessaa hamaa duraa qaala'aa miti	Cimseen waliigala Waliigala Hin fudhadhus hin mormus Hin fudhadhu Cimsee walii hin galle	

7	Yoo sakatta'iinsi bilisa ta'ee fi miidhaa tokkollee kan hin geessisne ta'e, ni sakatta'amtaa	Cimseen waliigala Waliigala Hin fudhadhus hin mormus Hin fudhadhu Cimsee walii hin galle	
8	Qorannoo Kaansarii gadameessaa ni sodaattuu?	Cimseen waliigala Waliigala Hin fudhadhus hin mormus Hin fudhadhu Cimsee walii hin galle	
9	Yeroo adeemsa hojiitti qaama dhuunfaa kee namoota tajaajila kennitoota dargaggoota ykn dhiirotaaf ibsuuf qaaniin sitti dhaga'amaa?	Cimseen waliigala Waliigala Hin fudhadhus hin mormus Hin fudhadhu Cimsee walii hin galle	
10	Yeroo adeemsa Qorannoo kaansarii gadameessaa dhukkubbii/mijachuu dhabuu ni sodaattuu?	Cimseen waliigala Waliigala Hin fudhadhus hin mormus Hin fudhadhu Cimsee walii hin galle	
11	Yeroo Qorannoo kaansarii gadameessaa fi booda dhiiguu ni sodaattuu?	Cimseen waliigala Waliigala Hin fudhadhus hin mormus Hin fudhadhu Cimsee walii hin galle	
12	Qorannoo erga gootee booda kaansarii gadameessaatiin qabamuu ni sodaattaa?	Cimseen waliigala Waliigala Hin fudhadhus hin mormus Hin fudhadhu Cimsee walii hin galle	

Kutaa 4: Gaaffiiwwan Shaakala Qorannoo

Lakk.	Gaaffiilee	Deebiilee	Bira darbuu
1	Waa'ee agarsiisa kanaa dhageessanii beektuu?	Eeyyee Lakki	
2	Qorannoo fayyaa walhormaataa kamiyyuu kan akka HIV, STIs fudhattee beektaa?	Eeyyee Lakki	Deebiin kee Lakki yoo ta'e gara gaaffii lakkoofsa 7tti deemi
3	Kaansarii qaama gadameessaa qoratamtee beektaa?	Eeyyee Lakki	Deebiin kee Lakki yoo ta'e gara gaaffii lakkoofsa 7tti deemi
4	Eessatti qorannoo goote?	Hospitaala (Eeruun) Dhuunfaa (Eeruun) Buufataalee fayyaa (Eeruun)	
5	Wanti argisiisu maal ture?	Ofiin jalqabe Ogeessota fayyaatiin kan qajeelfame Kan biroo (ibsi)	
6	Yoo eeyyee ta’e erga saalqunnamtii raawwattee yeroo meeqa qoratamtee?	Lakkoofsaan _____	
7	Yeroo dhumaaf yoom qoratamte	Waggaa darbe keessa Waggaa sadan darban keessatti Waggaa sadii oliin dura	
8	Yoo hin taane maaliif?	Dhukkubbii ta'uu danda'a. Saalfinni natti dhagahama Fayyaa qaba Abbaan manaa koo walii hin galu ture Qorannoon kaansarii gadameessaa akka mul'isu sodaadha qaala'aa dha Ani odeeffannoo/beekumsa hin qabu Ani qofa hin murteessu Tajaajilli hin argamu Kan biroo	

Kutaa 5: Amala fayyaa barbaaduu

Lakk.	Gaaffiilee	Deebiilee	
1	Akka waliigalaatti yeroo meeqa kilinika ykn hospitaala keessatti kunuunsa fayyaa barbaadda? (Tokko filadhu)	Waggaatti al lama Waggaatti al tokko Waggaa tokko hin guunne garuu yeroo darbe yeroo lama Waggoota 5 darban keessatti al tokko Waggaa darbe keessa miti	
2	Yeroo baay'ee yeroo dhukkubsattu jalqaba eessatti kunuunsa barbaadda?	Hospitaala Mootummaa Kilinika dhuunfaa dawaa aadaa Mana qorichaa Hin beeku	
3	Tajaajila yeroo ammaa argachaa jirtanitti quufiinsa qabduu?	Quufe Hin quufne Hin beeku	
4	Karaan hundarra gaariin kaansarii gadameessaa caalaatti akka hubattu si gochuu dandeenyu maali?		
5	Dhimmoota aadaa kaansarii gadameessaa wajjin walqabatan ykn malawwan Qorannoo kaansarii gadameessaa wajjin walqabatan beektu?	Eeyyee Lakki	
6	Yoo EEYYEE, isa kam?		
7	Buufata fayyaa kana keessatti tajaajilli Qorannoo akka kennamu beektu?	Eeyyee Lakki (gaaffii 8tti darbi)	
8	Tajaajila kennamu ilaalchisee maal jettu?	Baay'ee gaarii dha Gaarii Gaarii miti Hin beeku	
9	Amala hojjettootta fayyaa tajaajila kana kennan irratti maal jettu?	Baay'ee gaarii dha Gaarii Gaarii miti Hin beeku	
10	Hojimaata Qorannoo kaansarii gadameessaa irratti maal jettu?		

11	Buufata fayyaa keessatti Qorannoon kaansarii gadameessaa gatii madaalawaa qabaa?	Eeyyee Lakki	
12	Muuxannoo keessan keessatti kilinika kanaaf tajaajila barbaachisu osoo hin argatin dura yeroon eegaa meeqa?	Daqiiqaa 0-15 Daqiiqaa 15-30 Daqiiqaa 30 ol Sa'aatii 1 ol Hin beeku	
13	Buufataalee fayyaa kanneen bira ga'uuf yeroo hangamii fudhata?	sa'aatii 1 gadi Sa'aatii 1 Hin beeku	

Kutaa 6: Tajaajila fayyaa argachuu

Lakk.	Gaaffiilee	Deebiilee	
1	Argamuu, Qorannoo kanaaf eessa akka deemtan beektu?	Eeyyee Lakki	
2	Dhaqqabummaa, Bakkeewwan Qorannoo fagoo (fagoo) dha.	Eeyyee Lakki	
3	Kanaan dura haala hamaadhaan narra ture	Eeyyee Lakki	
4	Yeroo dheeraa eeguu	Eeyyee Lakki	
5	Bakka jireenyaa, Dhaabbileen eegumsa fayyaa gahaa ta'uu dhabuu	Eeyyee Lakki	
6	Meeshaa fi dhiheessiin hin turre	Eeyyee Lakki	
7	Ani waanan hin dhukkubsanne natti fakkaate	Eeyyee Lakki	
8	Hojii koo irraa boqonnaa fudhachuu hin dandeenye/waada biraa dadhabummaa Fudhatama qaba ture.	Eeyyee Lakki	
9	Mana yaalaa keessatti iccitii eeguun hin jiru	Eeyyee Lakki	
10	Tajaajila kan kennan dhiirota	Eeyyee Lakki	
11	Ani baay'ee dulloome/baay'ee xiqqaa waanan ta'eef sababni Qorannoof deemu natti hin mul'atu	Eeyyee Lakki	
12			

Kutaa 7: Deeggarsa hawaasummaa

Lakk.	Gaaffiilee	Deebiilee	
1	Dhaabbilee eegumsa fayyaa, Waa'ee Qorannoo kaansarii gadameessaa ilaalchisee yaaddoo qabdan ogeessa fayyaa waliin qooduu dandeessu?	Eeyyee Lakki	
2	Ogeeyyiin fayyaa waa'ee Qorannoo kaansarii gadameessaa si gorsanii (haasa'anii) beekaa?	Eeyyee Lakki	
3	Miseensota maatii, Maatiin keessan Qorannoo kaansarii gadameessaa akka deemtan deeggarsa maallaqaatiin isin gargaaruuf yaalu?	Eeyyee Lakki	
4	Qorannoo kaansarii gadameessaa ilaalchisee gargaarsa miiraa fi deeggarsa maatii keessan irraa isin barbaachisu ni argattu?	Eeyyee Lakki	
5	Qorannoo kaansarii gadameessaa maatii keessan waliin mari'achuu dandeessu?	Eeyyee Lakki	
6	Miseensonni maatii keetii kaansarii gadameessaa akka qoratamtu si jajjabeessanii beekuu?	Eeyyee Lakki	
7	Hiriyyoota, Hiriyoonni kee Qorannoo kaansarii gadameessaa akka taasistu sii gorsanii beekuu?	Eeyyee Lakki	
8	Hiriyoonni keessan yeroo kaansarii gadameessaatiin qabaman (kan adda baafaman) deeggarsa hawaasummaa kennuu danda'uu?	Eeyyee Lakki	
9	Hiriyyoota bu'aa Qorannoo (qormaata) kee itti himuu dandeessu qabdaa?	Eeyyee Lakki	
10	Hiriyaan kee akka gara qorannoo gadaamessaa akka deemtu jajjabeessitaa?	Eeyyee Lakki	

Kutaa 8: Gufuulee Aadaa Qorannoo

Lakk.	Gaaffiilee	Deebiilee	
1	Hiriyaa waliin walitti dhufeenya, Waa'ee saalqunnamtii, to'annoo da'umsaa, ykn fayyaa dubartootaa abbaa warraa/ hiriyaa gaa'elaa koo gaafachuun yoo na barbaachise, kana gochuun natti tola.	Eeyyee Lakki	
2	Waa'ee waan fedhe abbaa manaa koo /hiriyaa koo wajjin haasa'uu nan danda'a.	Eeyyee Lakki	
3	Abbaan manaa/hiriyaan koo yeroo darbe mata duree walqunnamtii saalaa, to'annoo da'umsaa, ykn fayyaa dubartootaa kaase. Mata dureen walqunnamtii saalaa ykn waan saalqunnamtii wajjin walqabatu kamiyyuu abbaa warraa koo, hiriyoota koo, fi ana gidduutti dhorkaadha.	Eeyyee Lakki	

4	Abbaan manaa/hiriyaan koo barbaachisummaa Qorannoo kaansarii gadameessaa natti dubbateera.	Eeyyee Lakki	
5	Waa'ee saalqunnamtii irratti iftoomina qabaachuu, Ogeessi fayyaa dhiiraa akka qaama Qorannoo fayyaa tokkootti qaama gadameessaa koo yoo qoratu mijataa natti dhagahama ture	Eeyyee Lakki	
6	Ogeessi fayyaa dubartii akka qaama Qorannoo fayyaa tokkootti qaama gadameessaa koo yoo qorattu mijataa natti dhagahama ture.	Eeyyee Lakki	
7	Walumaagalatti, waa'ee saalqunnamtii mataa kootii irratti mari'achuu fi beekamtii kennuuf mijataa natti dhaga'ama.	Eeyyee Lakki	
8	Mata dureen saalqunnamtii hiriyyaa koo dubaraa dhihoo ta'e tokkoo wajjin haasa'uudhaan yoo ka'e, salphaatti mari'achuu nan danda'a ture.	Eeyyee Lakki	
9	Yaadni Qorannoo fayyaa dubartootaa na qaanessa.	Eeyyee Lakki	
10	Yaadni doktorri kutaa qaama koo kamiyyuu akka qoratu na qaanessa.	Eeyyee Lakki	
11	Qaamni koo Qorannoo fayyaa kan of keessaa qabu ta'us gad of qaba.	Eeyyee Lakki	
12	Hiriyyoota koo dubaraa dhihoo wajjin dhimma saalqunnamtii irratti mari'achuun natti hin tolu.	Eeyyee Lakki	
13	Orenteeshinii ittisaa, Paap smear mala gaarii kaansarii dafanii adda baasuuf gargaarudha.	Eeyyee Lakki	
14	Seenaa maatii kaansarii gadameessaa qabaachuu baattus, yeroo hunda qoratamuun barbaachisaadha.	Eeyyee Lakki	
15	Yeroo mallattoon dhukkubaa natti mul'atu qofa doktora ykn ogeessa kunuunsa fayyaa nan ilaala.	Eeyyee Lakki	
16	Dubartiin tokko ogeessa fayyaa dubartii ilaaluu kan qabdu yoo walqunnamtii saalaa raawwachaa jirtu qofa.	Eeyyee Lakki	
17	Yoon nyaata fayya qabeessa hordofe, nyaata sirrii nyaadhe, fi sochii qaamaa godhe, tarii maloota ittisaa biroo kan akka Qorannoo kaansarii irratti hirmaachuun na hin barbaachisu.	Eeyyee Lakki	
18	Dubartiin umriin ishee 18 fi isaa ol ta'e kamiyyuu saalquunnamtii raawwattus raawwachuu baattus qorannoo qaama gadaamessaa taasisuun ishee barbaachisa.	Eeyyee Lakki	
19	Yeroo booda waan tokko argachuu fi yaaluun dirqama ta'uu mannaa, carraaqqii Qorannootiin dafanii adda baasuun gaariidha.	Eeyyee Lakki	

20	Yeroo hunda doktora ykn ogeessa fayyaa ilaaluun barbaachisaa natti fakkaata	Eeyyee Lakki	
21	Dubartoota gaa'ela godhatanii fi ijoollee godhachuuf karoorfatan qofatu ogeessa fayyaa dubartootaa ilaaluu qaba.	Eeyyee Lakki	
22	Dhuguma yoon dhukkubsadhe malee ogeessa fayyaa koo jeequu waanan qabu natti hin fakkaatu.	Eeyyee Lakki	
23	Fayyadama qoricha warra dhihaa, Yeroon dhukkubsadhu, yeroo baay'ee qoricha warra dhihaa (fkn:- Tylenol, aspirin) nan fudhadha	Eeyyee Lakki	
24	Yeroon dhukkubsadhu, yeroo baay'ee qoricha aadaa (fkn: - baala mukaa) fudhachuun gaarii akka ta'e nan amana.	Eeyyee Lakki	

Wixinee gaaffii Qorannoo qulqullinaa

1. Waa'ee kaansarii gadameessaa dhageessanii beektuu?
2. Eessa dhageesse?
3. Waa'ee dhibee kanaa maal beektu? Mallattoolee wal'aansa, Qorannoo, cimina...
4. Waa'ee Qorannoo kaansarii gadameessaa dhageessaniittu, bakka dhageessanii?
5. Sakatta'iinsi barbaachisaa dha jettanii yaaddu, akkamitti?
6. Qorannoo fayyaa walhormaataa, HIV, STIs..., yoo hin taane maaliif akka ta'e qoratamtee beektaa?
7. Qorannoo gochuuf yaaddee beektaa?
8. Sababni kaansarii gadameessaa fi Qorannoo RH biroo hawaasa keessan keessatti hin sakatta'amne maali jettanii yaaddu?
9. Qorannoo kaansarii gadameessaa gochuuf fedhii qabdaa, yoo hin taane maaliif?
10. Tajaajila ogeessonni fayyaa yeroo hordoffii Kennan akkamiin ilaaltu?
11. Tajaajila Qorannoo kaansarii gadameessaa ilaalchisee dhaabbilee fayyaatiif maal gorsitu?
12. Qorannoo kaansarii gadameessaa ilaalchisee hawaasni maal akka godhu ammas gorsitu?

የተሳታፊዎችን ፍቃደኝነት መጠየቂያ ቅፅ

ስሜ _____ ሲሆን ፣ እዚህ የተገኙሁት በኦሮሚያና በደቡብ ብሄሐር ብሔረሰቦችና ህዝቦች ክልል ውስጥ እደሜያቸው ዘ30-49የሚገኙ ሴቶች ለማህፀን ካንሰር ምርመራ የሚመጡትን ማጢንያ እና ተጓዳኝ ጉዳዩች" በሚል ርዕስ ለሚካሄደው ጥናት ከእናንተ መረጃ ለማሰባሰብ ነው። በዚህ ጥናት ወስጥ ተሳታፊ በመሆናችሁም ይህን መረጃ በመስጣያችሁ ምክንያት ሊደርስ የሚችል ጉዳት ፍፁም አይኖርም። ስማችሁንም በቅፅ ላይ መፃፍ አስፈላጊ የማይሆን ሲሆን፡ የምተሰጡት መረጃም ለሌች ተላልፎ አይሰጥም። በተጨማሪም ምላሽ መስጠት የምትፈልጉት ጥያቄ ቢኖር (ካለ)ማህተም የትችሉ ሲሆን መረጃ መስጠቱን መቆም በምትፈልጉበት በማንኛውም ጊዜ ማቆም ትችላላችሁ። አሁንም ደግሞ የጥናትቱ ተሳታፊ እንድትሆኑ የተመረጣችሁ መኀህነን በመናገር እወዳለሁ። እናንተም ለጥያቄዎቹ ከልብ የምትሰጪቸው ምላሾች ለጥናቱ መሳካት በጣም አስፈላጊ ስለሚሆን፣ በዳሳሳ ጥናቱ ውስጥ ለማሳተፍ ስላሳያችሁት ፍቃደኝነት ማድነቅ እወዳለሁ።

በቅንነት ስለተባበራችሁኝና ስላዳመጣችሁን ሥጋና አቀርባለሁ።

ለማሳተፍ ፍቃደኛ ናችሁ? ☐ (ቃለምልልሱን ይቀጥሉ) አይደለሁም ቃ☐ምልሱን ይቀጥሉ

1. የአገልግሎት ሰሊው /ሆስፒታል/ በጢና ጣቢያ ሥም _____
2. ቀን፡- _____

   የቃለመጠይቁ መለያ ቁጥር _____

   የጠያቂው ሥም _____ ፊርማ _____

   የተቆጣጣሪው ሥም _____ ፊርማ _____

የአማርኛ ቅጂ መጠይቁ

ክፍል 1. የተሳታፊ ማህበራዊ ውቅር መለያ ባህሪያት ያዳሰሳ ጥያቄዎች

ቁ	ጥያቄዎች	ምላሽ	አስተያየት
1	እድሜሽን ንገሪግ	__ዓመት	
2	የየትኛው ሃይማኖት ተከታይ ነሽ?	ኦርቶዶክስ እስልምና ኘሮቴስታንት ካቶሊክ ሌሎች	
3	የመሸበት አካባቢ የትኛው ነው ?	ከተማ ገጠር አላውቀውም	
4	ያለሽበት የጋብቻ ሁኔታ ምንድነው?	ያገባ ያላገባ የተፋታ ባል የኦተባት የተለያየ	
5	በጠራተሃው ጥያቄ መሰረት ያገባሽ ከሆነ፣ የባለቤትሽ የትምህርት ደረጃ ምንድነው?	ማንበብና መፃፍ የማይችል አንደኛ ደረጃ ትምህርት ሁለተኛ ደረጃ ኮሌጅ/ዩቨርስቲ ሌላ ካለ?	
6	ከፍተኛ ትምህርት ደረጃሽ ምንድነው ? አማራጮችን ማንበብ አይገባም	ትምህርት ቤት ያገባ የመጀመያ ደረጃ ሁለተኛ ደረጃ ዘለሌጅ/ዩንቨርስቲ	

		ሌላ ካለ?	
7	ስራሽ ምንድነው/በመደኛነት የምሰሪው ሥራ ምንድነው?	ተቀጣሪ ሥራ-አጥ የቤት- እመቤት ግብርና በለሙያ ሙያነክ የግል ሥራ የቀን ሰራተኛ የንግድ ሥራ/ሙያተኛ ሌላ ካለ ቢጠቀስ ?	
ቁ	**ጥያቄዎች**	**ምላሽ**	**አስተያየት**
8	ወራዊ ገቢሽ ስንት ብር እንደነ ብትነገሪን?	____ብር	
9	ስንት ልጆች አሉሽ?	____(በቁጥር)	
10	ለመጀመሪያ ጊዜ የግብር ሥጋ ግንነነት ስትፈፅሚ እድሜሽ ስንት ነበር ?	____(በቁጥር)	
11	በህይወትሽ ውስጥ ከስንት ወንዶች ጋር የርብተ-ሥጋ ግንኙነት እንዳደረግሽ ብትነግሪን/ልትነግሪን ብትችይ ?	አንድ ብቻ ከ2 -3 ከ4 -5 ከ6 -10 ከ10 በላይ	
12	ስንት ጊዜ አርግዘሻል	____ጊዜያት	

13	የወሊድ መቆጣጠሪያ /መከላከያ ዘዴ ተጠቅመሽ ታተውቂያለሽ	አዎን እንዲያውም	
14	የላይኛው ጥያቄ መልስ አዎን (አወንታዊ ከሆነ)፣ የተጠቀምሻቸውን ዘዴዎች በሙሉ አመልክቺ	1. 2. 3. 4. 5. ሌላ ካለ ቢገለፅ?	
15	ለላያኛው ጥያቄ የተሰጠው መልስ አንድ ቁጥር ላይ የተጠቀሰው ይህን ዘዴ ለስንት ጊዜያት ተቅመሻል?	_____አመታት	
16		1.አዎን 2. አይደለለም	

ክፍል 2. ስለ ማህፀን ካንሰርና ምርመራ ያለው እውቀት

ቁ	ጥያቄዎች	ምላሽ	አስተያየት
1	ስለ “ካንሰር” ስምተሽ ታቂያለሽን?	አዎን እንዲያውም	
2	ስለማህፀን ካንስር ሰምተሽ ታውቂያለሽን?	አዎን እንዲያውም	
3	የማህፀን ካንስርን ስለሚያመጣው ነገር ለመጀመያ ጊዜ ያወቅሽው /ያወቁት የተረዳሽው የት ነው?	ከመገናኛ ብዙሀን ከሚበተኑ አነስተኛ ፅሁፎች፣ ማስታወቂያዎች እና ሌሎሽ የፅሁፍ ውጤቶች ከጤና ማለሙያ ከቤተሰብ/ከጓደኛ፣ ከጐረቤት እና ከስራ ባልደረቦቼ ከሀይማኖት መሪዎች ከመምህራን ሌላ ካለ ቢገለፅ	
4	የማህፀን ካንስር ምልክቶቹ ምንድናቸው? . በርካታ መልሶችን መስጠት ይችላል	የማህፀን መድማት ከማህፀን የሚፈሱ መጥፎ ሽታዎች/ጠረን አላውቅም ሌላ	
5	የማህፀን ክንሰ መንስኤዎች ምንድናቸው? በርካታ መልሶች መስጠት ይችላል	በዚህ ህዋሳት(view) መብቃት ወንዶች ጋር የግብረ ሥጋ ግንኙነት መአፀም ለአቅመ ሄዋን ሳይደርስ የሚፈፀም የግብረ ሥጋ ግንኙነት	(

		ከፍተኛ ቁጥር ያላቸው ህፃናት እንዲኖሩ ስለማድረግ በአፍ የሚወሰድ የወሊድ መቆጣጠሪያ መድሀኒት ለረጅም ጊዜ ባለመጠቀም ትምባሆ ማጨስ አላወቀውም ሌላ ካለ ይገለፅ	
6.	አንዲት ሴት በማህፀን ካንሰር ከመጠቃት እንዴት መከላከል ትችላለች? በርካታ መልሶችን መስጠት ይቻላል	HIV ክትባት በመውሰድ በብዙ ወንዶች ጋር የግብረሥጋ ግንኙነት ባለመፈፀም ለአቅመሄዋን ሳይደርስ የግብረ ስጋ ግንኙነት ከመፈፀም መቆጠብ/መታቀብ ከፍተኛ ቁጥር ያላቸው ልጆች ከመውለድ፣ መቆጠብ በአፍ የሚወሰድ የወሊድ መቆጣጠሪያ መድኃኒቶት ረዘም ላለ ጊዜ ከመውሰድ በመቆጠብ ትምባሆ ማጨሰ ደቆም/ማቋረጥ	
7	የመህፀን ካንሰር በቅደም ደረጃ ላይ እያለ ምርመራ በሚደረግ መፈውስ ይችላል ወይ?	አዎን እንዲያውም አላውቅም	
8	አንዲት የማህፀን ካንሰር ያለባት ሴት እንዴት ነው መረዳት ያለባት? በርካታ መልሶች መስጠት ይቻላል	እፅዋት መፍትሄዎች (በመጠቀም) በቀዶ-ጥገና ሆስፒታል በሚሰጥ ለየት ያሉ መድሃኔታች (drag)	

		Predict therapy አላውቅም ሌላ?	
9	እዚህ አገር የሚሰጠው የማህፀን ካንሰር ህክምና ምን ያህል ውይ ይመስላችኋል?	ከክፍያ ነፃነው /አያስከፍልም ክፍያው ተመጣጣኝ ነው ብዙ ውድ የሚባል አይደለም በጣም ውድ ነው አላውቅም ሌላስ?	
10		አዎን እንዲያውም	ካልሆነ ወይ በሚቀጥለው ንኡስ ክፍል? ይመልከቱ

ቁ	ጥያቄዎች	ምላሽ	አስተያየት
11	በምን ያህል ጊዜ ውስጥ ነው የማህፀን ጫፍ ምርመራ የሚደረገው?	በዐመት አንድ ጊዜ በሦስት አመት አንድ ጊዜ በአምስት ዓመት አንድ ጊዜ ከዚህ ሌለ ካለ (ቢጠቀስ) አላውቅም	
12	ምርመራ ማድረግ ያለበት ማነው ነው?	ዕድሜያቸው 25 እና ከዚያ በላይ የሆኑ ሴቶች በዝሙት የምትተዳደር ሴት እድሜያቸው ገፋ ያሉ ሌቶች ሌላ ካለ? አላውቅም	
13	የማህፀን ጫፍ ካንሰር ምርመራ የሚደረገው በምን ቅደም ተከተል እንደሆነ ታውቋያለሽ?	አዎ እንዲያውም	
14	ለመህፀን ካንሰር ምርመራ መአፀም ካለባቸው ቅደም ተከተሎች ውስጥ መጥቀስ የትምችይው ይኖራል ወይ? በርካታ መልሶችን መስጠት ይቻላል	VIA VICI Pag smear ሌላ ካለ? አላውቅም	

ክፍል 3 ጥያቄዎች

ቁ	ጥያቄዎች	ምላሽ	አስተያየት
1	የማህፀን ካንሰር በአገራችን ወስጥ በከፍተኛ ደረጃ የተስፋፋ በኢትዩጵያም ------ ሴቶች መካከል ሞትን የሚያስከትል ዋነኛው መንስኤ ነው	በጣም እስማማለሁ እስማማለሁ መስማማትም ይሁን አልስማማም እችላለሁ አልሰማም በጣም አልስማማም	
2	ማንኛውም ጐልማሳ ሴት እኛን ጭምር የማህፀን ካንሰር ተጠቂ ልትሆን ትችላለች	በጣም እስማማለሁ እስማማለሁ ይሁን መስማማት ይሁን አልስማም በጣም አልስማማም	
3	የማህፀን ካንሰር ከአንድ ሰው ወደ ሌላኛው መተላለፍ አይችልም	በጣም እስማማለሁ እስማማለሁ እስማማለሁም ይሁን አልስማማም አልልም አልስማማም በጣም አልስማማም	
4	ምርመራ ማድረግ ከማህፀን ካንሰር በመከላከል ረገድ		

5	መርምራ ማድረግ በተጠርጣሪሙ (በታካማው) ላይ የሚያደርሰው ምንም ጉዳት የለም		
6	ለመሀፀን ጫፍ ምርመራ የሚጠየቀው ክፍያ ውድ አይደለም		

ቁ	ጥያቄዎች	ምላሽ	አስተያየት
7	ምርመራው በነፃ ቢሆንና ምንም ጉዳት የማይኖረው ቢሆን፣ አንድ ምርመራ ታደርጊ ይሆን?		
8	የማህፀን ካንሰር ምርመራ ለማድረግ ትፈሪያሽን ?		
9	ምርመራ ቢሚካሄድበት ወቅር ሚስጥሪዋ የሰውነት ክፍሎችሽን ለመንካት ወይም ለወንድ ባለሙያ ለማሳየት ታፍሪያለሽ?		
10	የህፀን ካንሰር ምርመራ በሚካሄድበት ወቅት ህመም ወይም ያለምቾት መኖር ፍርሃት የሳድርብሻል?		
11	የማህፀን ካንሰር ምርመራ ሊደረግም ሆነ ከተካሄደ በኋላ መድማት ያስፈሪሻል?		

12	ምርመራ ካካሄድሽ በኋላ የማህፀን ካንሰር ያለብሽ መሆኑ ቢታወቅ ፍርሀት ያሳድርብሻል?		

ክፍል 4 የምርመራ ልምድ የተመለከቱ ጥያቄዎች

ቁ	ጥያቄዎች	ምላሽ	አስተያየት
1	ምርመራ /የማህፀን ካንሰር/ ስለመኖሩ ሰምተሽ ታውቂያለሽ?	አዎ እንዲያውም	
2	ለHIV /STTs ለመሳሰሉ	አዎን እነዲያውም	
3	የማህፀን ካንሰር መኖር/አለመኖሩን ለመረዳት ተመርምርሽ ታውቂያለሽን?	አዎ እንዲያው	
4	ምርመራውን ያደረግሽው የቱ ነው?	ሆስፒታል (ሰው ያውቃል) የግል (ይጠቀስ) ፀጠና ሐቢያዎች (ያውቃል)	
5	ማነው ያመለከተሽ? (what was the indication	በራስ አነሳሽነት በጤና ባለሙያዎች ስጦታ ሌላ ካለ ቢገለፅ?	
6	የላይኛው ጥያቄ ምላሽ አዎንታዊ፣ ከሆነ፣ የግብረ-ሥጋ ግንኙነት ለሚደረግ ከደረስበት ጊዜ አንስቶ እስካሁን ለስንት ጊዜያት ተመርምረሻል?	___(በቀጥር)	
7	ለመጨረሻ ጊዜ የተመረመሽው መቼ ነበር?	ባለፈው አመት ውስጥ ባለፉት ሦስት አመታት ባለው ጊዜ ውስጥ ከሦስት አመታት በፊት	
8	ያልተመረመርሽ ከነበረ ለምን	ሊያም ስለሚችል ሀፍረት ስለሚሰማኝ ጤናማ በመሆኔ	

		ባለቤቴ የማይስማማ ባለመሆኑማ ከመረመሩ የማህፀን ካንሰር መኖሩን ቢያሳውቅስ ብዬ ስለምፈራ ምርመራው ውድ ስለሆነ ምርመራ ስለመኖሩ መረጃ/እውቀት የፀለለኝ በመሆኑ እስካሁን ውሳኔ ላይ አልደረስኩም አገልግሎተ ባለመኖሩ . ሌላ ካለ?	

ክፍል 5: ጤና ለመጠበቅ የሚፈለግ አዝማሚያ

ቁ	ጥያቄዎች	ምላሽ	አስተያየት
1	ጤና ለመጠበቅ በመፈለግ ባጠቃላይ በምን ያህል ጊዜ ውስጥ ወደ ክሊኒክ ወይም ሆስፒታል፣ ትሄጂያለሽ? (አንዱን ምርመራ)	በአመት ሁለት ጊዜ በአመት አንድ ጊዜ ከአመት ባነሰ ጊዜ ሆኖም ባለፈው ኣመት ሁለት ጊዜ ባለፈፉት አምስት አመታት አንድ ጊዜ ባለፈው አመት አንድ ጊዜም	
2	ህመም ሲሰማሽ አብዛኛውን ጊዜ የጤና እረዳት ለማግኘት መጀመሪያ የምትሄጅው የት ነው?	የመንግስት ሆስፒታል የግል ክሚኒክ የባህል መድሃኒተኞናች መድሀኒት ቤት አላውቅም	
3	በወቅቱ በምታገኚያቸው (በሚሰጡሽ) ግልጋሎቶች እርካታ አለሽ?	ረክቻለሁ አልረካሁም አላውቅም	
4	ስለማህፀን ካንሰር የበለጠ ግንዛቤ እንዲያኖርሽ ፍርፊ የሚችለው ምርጥ መንገድ የትኛው ነው		
5	ስለማህፀን ካንሰር ወይም ስለ ማህፀን ካንሰር የምርመራ ዘዴዎችን አስመልክቶ ስለሚነሱ ባህላዊ ጉዳዩች የምታውቂው ነገር አለ ወይ?	አዎን እንዲያውም	

6	ምላሹ አቻን ከሆነ የትኛው		
7	በዚህ ጤና ጣቢያ የምርመራ ግልጋሎቶች እንደሚሰጡ ታውቂያለሽ	አዎን እንዲያውም (8ኛው ጥያቄ ይዘለለል)	
8	ስለሚሰጡት አገልግሎቶች ምን ታስቢያለሽ	እጅግ በጣም ይሩ ጥሩ ደካማ አላውቅም	
9	አገልግሎቱን ስለሚሰጡ የጤና ባለሙያዎች ፀሃይ? ያለሽ አስተያየት ምንድነው?	1. እጅግ በጣም ይሩ ጥሩ ደካማ አላውቅም	
10	ለማህፀን ካንሰር ስለሚደረገው የምርመራ ሂደት ያለሽ ሀሳብ ምንድነው?		
11	በጤና ጣቢያው ለሚሰጠው የማህፀን ምርመራ የሚጠየቀው ክፍያ አቅምን ያገናዘበ ነው?	አዎን እንዲያውም	
12	በአንዊ ተሞክሮ አስፈላጊውን ግልጋሎቶች ለማግኘት ምን ያህል ጊዜ ይወስዳል/ይጠበቃል	ከ0-15 ደቂያዎች ከ15-30 ደቂቃዎች ከ30 ደሚያዎች በላይ ከ1 ሰዓት ያነሰ	

		አላውቅም	
13	እነዚህ ጤና የቢያዎች ያለበት ቦታ ለማድረስ ምን ያህል ጊዜ ይወስዳል?	ከ1 ሰዓት ያነሰ አንድ ሰዓት አላውቅም	

ክፍል 6: ለጤና ጥበቃ ያለው አቅራቦት

ቁ	ጥያቄዎች	ምላሽ	አስተያየት
1	ምርማራ ለማድረግ የት መሄድ እንዳለብሽ ታውቂያለሽ	አዎ እንዲያውም	
2	ምርመራ ጣቢያዎች የማገኙባቸው ቦታዎች ሩቅ ናቸው?	አዎ እንዲያውም	
3	ከዚህ በፊት በመጥፎ ሁኔታ ተሰተናግጃለሁ	አዎ እንዲያውም	
4	ረጅም ጊዜ ያስጠብቃሉ	አዎ እንዲያውም	
5	የጤና ግልጋሎት ሰጪዎች በቂ አይደሉም	አዎ እንዲያውም	
6	መገልገያ መሳሪያዋኛ እቃዎች መድጋኒቶች አልነበሩም	አዎ እንዲያውም	
7	አልታመምኩም የሚል እሳቤ ነበረሽ	አዎ እንዲያውም	
8	ከሥራ መጥረት አልችልም ነበር ሌሎች አጣዳፊ ሥራዎች ነበሩብኝ /ስንፍና/ የተቀበይነት እጦት	አዎ እንዲያውም	
9	በክሊኒክ ውስጥ በግል (በሚስጥር) መያዝ ያለበት ነገር	አዎ እንዲያውም	
10	አገልግሎት ሰጪዎቹ ወንዶች ናቸው	አዎ እንዲያውም	

11	በጣም የርጀ በጣም ወጣት ስለሆንኩ ምርመራ የማድረግ አስፈላጊነት አይታየኝም	አዎ እንዲያውም	

ክፍል 7: ማህበራዊ ድጋፍ

ቁ	ጥያቄዎች	ምላሽ	አስተያየት
1	የጤና አጠባበቅ አገልግሎት ሰራተኞች የፀጠና ጥበቃ አገልግሎት ሰራተኞች የማህፀን ካንሰር ምርመሪ ግልጋሎት የጤና ሰራተኞችን በተመለከተ ያለብሽን ሥጋቶች ልታካፍይን ትችያለሽ ወይ?	አዎ እንዲያውም	
2	የጤና ጥበቀ አገልግሎት ሰራተኞች ስለ ማህፀን ካንሰር ምርመራ ምክር ሰጥተውሽ (ነግረውሽ) ያውቃሉ?	አዎ እንዲያውም	
3	የፀበተሰብ አባላት የማህፀን ካንሰር ምርመራ እንድታደርጊ ቤተሰቦችሽ የገንዘብ ድጋፍ በማድረግ ሊረዱሽ ይሞክራሉን?	አዎ እንዲያውም	
4	የማህፀን ካንሰር ምርመራ ማድረግን በተመለከተ የሚያስፈልግሽን እገዛና ድጋፍ ከቤተሰቦችሽ ታገኛለሽን?	አዎ እንዲያውም	
5	ከቤተሰቦችሽ ጋር ስለማህፀን ካንሰር ምርመራ መወያየት ትቺያለሽ ወይ?	አዎ እንዲያውም	
6	የቤተሰብ አባላችሽ የማህፀን ካንሰር ምርመራ እንድታደርጊ አበረታተውሽ ያውቃሉን?	አዎ እንዲያውም	
7	ጓደኞችሽ የማህፀን ካንሰር ምርመራ እንድታደርጊ አበረታተውሽ ያውቃሉን?	አዎ እንዲያውም	

8	የማህፀን ካንሰር እንዳለብሽ ብታውቂ ጓደኞችሽ ማህበራዊ ድጋፍ ሊያደርጉልሽ ይችላሉን?	አዎ እንዲያውም	
9	ሌላ የምርመራ ውጤትሽ ልትጋሪው የምትችይው ጓደኛ አለሽ ወይ ?	አዎ እንዲያውም	
10	ጓደኞችሽ የማህፀን ምርመራ ማድረግ እንድትችል ልታበረታቸት ትሺያለሽ ወይ	አዎ እንዲያውም	

ክፍል 8: ምርመራ ለማድረግ የሚቱ ማህበራዊ እንቅፋቶች

ቁ	ጥያቄዎች	ምላሽ	አስተያየት
1	ከትዳር ጓደኛ ጋር የሚደረግ ባለቤቲን ፣ጓደኛዬን ስለግበረ-ሥጋ፣ ስለወሊድ ቁጥጥር ወይም ስለማህፀን ጤና መጠየቅ ቤያስፈልገኝ ይህንን ለማድረግ ምቾት ስሜት ይሰማኛል?	አዎ እንዲያውም	
2	ከባለቤቴ/ከጓደኛዬ ጋር ስለምንም ጉዳይ መነጋገር እችላለሁ	አዎ እንዲያውም	
3	ባለቤቴ/ጓደኛዬ ስለ ፆታ ነክ፣ ስለግበረ-ሥጋ፣ ስለወሊድ ቁጥጥር ወይም ስለማህፀን ጤና ነክ ርዕሰች ለመወናየየት አነስቶ ያውቃል?	አዎ እንዲያውም	
4	ባለቤቴ/ጓደኛዬ የማህፀን ካንሰር ምርመራ ስለማድረግ በቋሚነት ነግሮኝ ያውቃል	አዎ እንዲያውም	
5	ፆታዊ ነ ጉዳይን በተመለከተ ያለው ግልፅነት ወንድ የማህፀን ሀኪም የጤና ምርመራ አካል አድርጐ የማህፀን ምርመራ ቢያደርግልኝ ምቾት ሊሰማኝ ይችላል	አዎ እንዲያውም	
6	ሴት የማህፀን ህክምና የፀጠና ምርመራ አካል አድርጋ የማህፀን ምርመራ ብታደርግልኝ ምቾት ሊሰማኝ ይችላል	አዎ እንዲያውም	
7-8	በአጠቃላይ ከቅር ጓደኛዬ ገር የፆታ ነክ ጉዳይ በክርክር መልክ ቢነሳ በጉዳዩ ያለምንም ጭንቀት መወያየት እችላለሁ	አዎ እንዲያውም	
9	የማህፀን ምርመራ ማድረግ ሀሳብ በራሱ ያሳፍረኛል	1. አዎ 2. እንዲያውም	

10	የትኛውንም የሰውነት ክፍሊን ዶክተር ምርመራ የሚደርግልኝ መሆኑን ማሰብ ራሱ ያሳፍረኛል	አዎ እንዲያውም	
11		አዎ እንዲያውም	
12	ፆታዊ ግንኙነት በሆኑ ጉዳዩች ላይ ከቅርብ የሴት ጓደኞቼ ጋር መወያየት ምቾት አይሰጠኝም	አዎ እንዲያውም	
13	ጥንቃቄ ማድረግን በተመለከተ ያው አረዳደድ ካንሰርን በቅደማያ የመወያየ ጥሩ ዘዴ ነው	አዎ እንዲያውም	
14	የቤተሰብ ውስጥ የህፀን ካንሰር ያለመኖናር ታሪክ ያለ ቢሆንም በመደበኛነት ምርመራ ማድረግ ጠቃሚ ነው	አዎ እንዲያውም	
15	ወደዶክተር ወየም ጤና አገልግሎት ሰጪ ዘንድ የምሄደው ምልክቶችን በማይበት ጊዜ ብቻ ነው	አዎ እንዲያውም	
16	አንዲት ሴት ወደ ማህዝን ምርመራ ባለሙያ ዘንድ መሄድ ያለባት (ግብረ-ሥጋ) ግንኙነቶች ካደረገች ብቻ ነው?	አዎ እንዲያውም	
17	ጤናማ አመጋገብ ሥርዓት ከተከተልከ፣ ትክክለኛ የምግብ አይነኀተችን ከተመገብሁ (ከበላሁ) እና ስፖርት ከሰራሁ እንደ ካንሰር ምርመራ የመሳሰሉ ሌሎች የመከላከያ መንገዶች (ዘዴዎች) ላይ መሳተፍ ካለበት ላያስፈልገኝ ይችል ይሆን	አዎ እንዲያውም	
18	ግብረ-ሥጋ ግንኙነት ደድርጋ የማታውቅ ብትሆን እንኳን 18 ዓመት ወይም ከዚያ በላይ ለሆኑት ሴት የማህፀን ምርመራ ማድረግ ጠቃሚ ነው	አዎ እንዲያውም	

19	የጤና ችግሮችን በምርመራ ጥረቶች አስጠደሞ መለየት ችግርን ዘግይቶ ከማወቅና ከመታከም የተሻለ ነው	አዎ እንዲያውም	
20	ወደ ዶክተር ወይም የጤና አገልግሎት ሰጪ ዘንድ በመሄድ በመደኛነትና መመርመር ጠቃሚ ይመስልሻል	አዎ እንዲያውም	
21	የማህፀን ምርመራ ባለሙያ ዘንድ መሄድ የማያስፈልጋቸው ያገቡና ልጆች መውለድ ዕቅድ ያላቸው ሴቶች ብቻ ናቸው	አዎ እንዲያውም	
22	በእርርግጠኝነት ህመምተኛ ካልሆንኩ/ካልታመምኩ በስተቀር ወደ ጤና አገልግሎት ሰጪ ዘንድ በመጌድ መረበሽ የለብኝም አይስልኝም	አዎ እንዲያውም	
23	ስለ ምዕራባውያራ መድኃኒቶች አጠቃቀም ስታመም አብዛኛውን ጊዜ ከምዕራብ ሀገኀረች የማመጠ መደጋኒኀተችን (እወስዳለሁ/ እጠቀማለሁ	አዎ እንዲያውም	
24	በደያመኝ ጊዜ በባህላዊ መድሃኒቶች (በቤት ያሉትን) አብዛኞቹን ጊዜ እጠቀማለሁ /እወስዳለሁ	አዎ እንዲያውም	
25	ለጤና ችግሮች ፈውስ ለማግኘት ባህላዊ ህክምና መጠቀም በጣም ውጤታማ ነው የሚል እምነት አለኝ	አዎ እንዲያውም	

1. ስለማህፀን ካንሰር ሰምተሽ ታውቂያለሽ ?

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2. ከየት ነው የሰማሽው ? _____
3. ስለበሽታው ማለትም ስለምክቶቹ፣ ህክምናው፣ ምርመራው፣ አስከፊነቱ ወ.ዘ.ተ ምርመራ ታውቂየለሽ ?

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4. ስለማህፀን ካንሰር ምርመራ ሰምተሽ ታውቂያለሽ ወይ? የት ነው መስማት የቻልሽው? _____

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5. ምርመራ ማድረግ ጠቃሚ ነው ብለሽ ታስቢያለሽ ? እንዴት?_____

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6. ስለበሽታው ማለትም ስለምክቶቹ፣ ህክምናው፣ ምርመራው፣ አስከፊነቱ ወ.ዘ.ተ አድርገሽ ታውቂያለሽ? ካላደረግሽ ለምን?_____

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7. ምርመራ ስለማድረግ አስበሽ ታውቂያለሽ? _____
8. በአንቺ ማህበረሰብ ውስጥ የማህፀን ካንሰር እና ሌሎች RH ምርመራዎች ላለማድረግ ምክንያቱ ምንድነው ብለሽ ታስቢያለሽ?_____
9. አንቺ የህፀን ካንሰር ምርመራ ለማድረግ ፍቃደኛ ነሽ ወይ? ካልሆንሽ ለምን?_____

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10. ክትትል በሚደረግበት ወቅት በጤና አገልግሎት ባለሙያዎች የሚሰጠውን ግልጋሎት እንዴት ታይዋለሽ___

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11. የማህፀን ካንሰር ምርመራን አገልግሎትን በተመለከተ ለጤና ተቋም የምትሰጫቸው ምክረ-ሀሣብ ምንድነው?_____
12. _የማህፀን ካንሰር ምርመራን አስመልክቶ ለማህበረሰቡ ያለሽ ምክረ-ሀሳብ ምድነው?_____

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