



Addis Ababa University
College of Educational and Behavioral Studies
School of Psychology:

Master of Counseling Psychology:

Assessment of Cervical Cancer Patients of Psycho-Social Support:

A case study of Black Lion Specialized Teaching Hospital

By

Yenewid Gebeyehu

(A Thesis Submitted to Addis Ababa University College of Educational and Behavioral Studies School of Psychology in Partial fulfillment for the Requirements for the MA Degree in Counseling Psychology)

June, 2019

Addis Ababa Ethiopia

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DECLARATION

I, Yenewid Gebeyehu declare that this research paper entitled “*assessments of Cervical Cancer Patients of Psycho-Social Support, the case study Black Lion Specialized Teaching Hospital*” is my original work, and has not been presented for a degree or diploma in any other university and it is in partial fulfillment to the requirement of the program Master of Counseling Psychology.

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Perception of cervical cancer patients of psycho-social support *a case study of Black Lion Specialized Teaching Hospital*

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Advisor: MOGES AYELE (Ph.D.)

I, the advisor, declare that, to the best of my knowledge, this thesis is the research product of my advisees Ms. Yenewid Gebeyehu, and complies with the regulations of Addis Ababa University College of Educational and Behavioral Studies School of Psychology and meets the accepted standards with respect to originality and quality.

Signature _____ Date _____

Addis Ababa, Ethiopia
June 2018

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Completing this research, which has proved to be more frustrating than I had anticipated, would have been very challenging if it were not for the help I received in many forms. I would like to use this prologue, which has provided a pleasant opportunity to thank everyone who has extended a valuable criticism, suggestion, or encouragement. For the ever ending assistance He rendered throughout this process, for my provider of wisdom, understanding and everything I have now, I thank my Lord God. First and foremost I would like to praise the almighty God for his unspeakable gifts, Saint Virgin Mary for her special motherly contribution, Saints and Angels who protecting me though all of my voyages without interruption.

For their valuable time, provision of material and guidance, I extend my heartfelt gratitude for my advisor MOGES A. (PhD). Supporters of Patients are indeed busy but I have never witnessed a busier people than those working in the Hospitals. Contrary to this, almost all respondents in the hospitals, where I have had the pleasure of conducting the research, have been very cooperative. Without their assistance, the objective of the research would have stayed a limbo. I proffer my appreciation and gratitude to all. Inspiration comes in many forms; my friends have been one great source of muse for my research. From a direct contribution to the research through material provision and being an object of pretest, they have never failed to support and motivate me with love and encouragement throughout the research. Thank you for believing in me. Special thanks go; I owe you much more than this.

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Acronyms and Abbreviations

ACCP	American College of Clinical Pharmacy
ACSA	Cute Coronary Syndrome
AMREF	African Medical and Research Foundation
BLTSH	Black Lion Teaching specialized Hospital
DES	Data Encryption Standard
DNA	Deoxyribonucleic Acid
HPV	Human Papilloma Virus
IUD	Intrauterine Device
MOH	Minster of Health
NCDs	Non-Communicable Diseases
PTSD	Posttraumatic Stress Disorder
WHO	World Health Organization

Abstract

This research is about the Assessment of Cervical Cancer Patients Psycho-Social Support in the cases of Black Lion Specialized Teaching Hospital. Specifically, this research is done in order to identify the psychological challenges of cervical cancer patients, to assess psy, and to identify how patients treat themselves for cervical cancer. In order to achieve the above objectives this study used primary data which was collected through questionnaires and interview. The data collected from the sample were analyzed and interpreted by descriptive data analysis technique. The results of this study indicated that psycho-social support given to that cervical cancer patient was poor and there is a lack of psycho-social support for cervical cancer patients .. In addition to that the result indicated that, the existence of poor utilization of services was due to poor practice and lack of knowledge and information. Finally, the researcher recommended that there should be broad promotion to cervical cancer screening among women by informing them on their susceptibility and encouraging regular screening in order to detect cervical cancer at the pre-cancerous stage.

Key words: Cervical Cancer, Counseling Psycho-Social support services, Palliative care:

CHAPTER ONE

INTRODUCTION

1.1. Background of the study

Cancer is one of the major non-communicable diseases (NCDs), which include cardiovascular diseases, diabetes and chronic respiratory diseases. Together they cause over 60% of total global mortality every year. It is estimated that cancer kills over 7.9million people globally every year constituting close to 13% of total deaths worldwide. While communicable diseases still remain the leading killers in many developing countries, the incidence and mortality from non-communicable diseases is rising rapidly. This has resulted in a ‘double burden’ of diseases, which is imposing strain on existing health system, National Cancer Control Plan of Ethiopia 2016-2020.

The cervical cancer is serious disease to women in many parts of the world specifically it was very serious in Africa. Nonetheless, the true incidence of cervical cancer in many African countries is unknown because of gross under-reporting. Very few countries have functioning cancer registries and recordkeeping is minimal or non-existent. Some of the figures quoted in the literature are hospital-based, which represent a small fraction of women dying from cervical cancer, screening programmer’s most frequent report cancer among women between 15 and 44 years of age specific incidence rate was 34 per 100,000 individuals. Projected number of new cervical cancer cases in Tanzania in 2,025 is 12,416. Projected number of cervical cancer deaths in 2,025 is 9,923per year if specific measures are not put in place. Something has to be done to reduce this number of new cases and deaths as the projections above show. HPV is the primary etiologic agent of cervical cancer, there are over 100 types of HPV, and the genital-type HPVs are divided into high intermediate and low-risk types, according to the association with genital tract cancer (Denny, 2010).

The survival rate for cervical cancer in sub-Saharan Africa in 2002 was 21 Percent compared with 70 Percent and 66 Percent in the United States and Western Europe, respectively. The reported mortality rates in developed countries were successfully deterring the growth and development of one’s country. Globally, it is the second most common cancer for women’s and it is the most common disease in developing countries.

Current estimates shows that 493,243 women are diagnosed with cervical cancer per year and 273,505 were died. In Africa, which has a population of 267.9 million women aged 15 years or greater, it is estimated that 78,897 women are diagnosed with cervical cancer annually and 61,671 (78 Percent) were died. The result indicated that the mortality rate of cervical cancer patients in developing countries were higher than those developed countries (Denny, 2010).

The Sub Sahara Africa is the region with the highest incidence of cervical cancer in the world. Many factors are responsible for the high prevalence of cervical cancer in this region. The major factors among many are socio cultural factors, socio economic factors, biological factors, lack of awareness of cervical cancer and poor cervical cancer screening (Ntekim, 2012).

Cervical cancer has a significant physiological impact on the individual and it is important to develop strategies to deal with this. There is evidence that providing psychological and practical support may have a positive effect on patients' well-being. The interventions included structured psychological support, relaxation techniques, orientation programs and general psychological support. The interventions reduced anxiety levels and improved quality of life (Management of cervical cancer ,*n.d.*).

According to Singer and Schwarz,2002, there is a high need for psycho-social counseling which is not considered enough in the daily clinical practice. Good prepare is just as important as good after care to reduce anxiety, pain and increase well-being.

In Ethiopia, cancer accounts for about 5.8% of total national mortality (Globocan, 2012).Although population-based data do not exist in the country except for Addis Ababa, its estimated that the annual incidence of cancer is around 60,960 cases and the annual mortality is over 44,000. The most prevalent cancers in Ethiopia among the entire adult population are breast cancer (30.2%), cancer of the cervix (13.4%) and colorectal cancer (5.7%). About two-thirds of annual cancer deaths occur among women (AACR, 2014).

In Ethiopia, patients often present with advanced stages of cancer. Over 80% of deaths from NCDs are caused by four main diseases cardiovascular disorders, cancer, diabetes mellitus and chronic obstructive pulmonary disease (National Cancer Control Plan of Ethiopia 2016-2020).

1.2. Background of the Organization

The federal Ministry of health estimates that there could be more than 150,000 cancer case in Ethiopia each year, but available data is limited. As the nation's sole cancer referral center, Black Lion Hospital is treating only about one percent of these patients. Health experts explain that many Ethiopians with cancer never seek medical treatment and, of those who do, they may not be referred to the cancer center in Addis Ababa. Affiliated with the Addis Ababa University's school of medicine, Black Lion Hospital is the training center for undergraduate and postgraduate medical students, dentists, nurses, pharmacists, laboratory technicians, and others (International Network for Cancer Treatment and Research at Black Lion Hospital 2018).

Currently, Black Lion Hospital is organized with 600 patient beds, 627 nurses, 26 dedicated oncology nurses, 10 pathologists and 2 hematologists. In 2010, in black lion hospital 266,975 patients were seen and from those Patients 15,415 patients were cancer patients.

1.3. Statement of the Problem

In the developing world, access to effective health care is a major problem in terms of availability, accessibility, affordability, and acceptability. Clients in developing countries are even less likely better off to receive effective health care in case of demand and supply problems . On the supply side, good quality, effective health care may not be offered.

On the demand side, individuals may not utilize services from which they could benefit (O'Donnell, 2007).

Ethiopia has not different health care access situation in general and for advanced case illnesses as cervical cancer. Income, prices, distance, education and knowledge are significantly determining factors for the health care demand in the country. Moreover, culture and gender issues are demand constraints for the health care access of the cervical cancer patients to the Hospital.

The challenges, psycho-social support in general and counseling in particular can be seen as important means of treatment. So, the Hospitals should be investigated for the psycho-social support services to the cervical cancer cases by views of the patients. So that best practices should be encouraged and expanded to other hospitals in the country and gaps revealed.

1.4. Basic Research Questions

- What are the psycho-social supports given in Black Lion Hospital for cervical cancer patient?
- What are the psychological challenges of cervical cancer patients in Black Lion Hospital?
- How cervical cancer patients perceive about the psycho-social support they got?

1.5. Research Objectives

1.5.1 General objectives

The major objective of this study is an Assessment of Cervical Cancer Patients Psycho-Social Support services in Black Lion specialized teaching hospital.

1.5.2. Specific Objectives

The specific objective of this study was;

- . To assess the extent to which the psycho-social support given for cervical cancer patients in BLSTH .
- .To identify the psychological challenges faced by cervical cancer patients in Black Lion Hospital.
- .To evaluate the relative challenge of the existing psycho-social support on overall patients feeling and perception.

1.6. Significance of the Study

This study can assist how the hospitals help cervical cancer patients' psychologically and emotionally. In addition to this, the results of the study are believed to be helpful to suggest opinions that help to improve the Black lion Hospital Managements and policy makers to take remedial action. Finally, it would be a reference for other researchers as stepping stone for those who want to make further study on the area of Cervical Cancer Patients about Psycho-Social Supports. Finally, it suggested directions for improvement of support of cervical cancer patients.

1.7. Scope of the study

The scope of this study is restricted to the assessment of Cervical Cancer Patients about Psycho-Social Supports at Black Lion Specialized Teaching Hospital. The study focused on the theoretical and literature concepts related to the cervical cancer only. In addition to this, the research applied also a methodological scope of purposive sampling technique to select the target hospital and random sampling technique to interview the samples.

1.8. Definition of terms

Cancer: A disease caused by an uncontrolled division of abnormal cells in a part of the body.

Cervix:The lower, narrow end of the uterus that forms canal between the uterus and vagina, which contain endo and exo Cervix

Psycho Social: The relation to the interrelation of social factors and individual thought and behavior.

1.9. Limitation of the Study

In due process of this study it is difficult to take interview from patients' about cervical cancer due to lack of interest to give responses and some patients were wrongly perceive the questions. the method used by the researcher has drawback to get the genuine health information of patients in front of other clients

1.10. Organization of the Study

This study organized into six chapters. Chapter one, presents background and, introductions of the study, statement of the problem, objective, scope, significant of the study, definition of terms and Limitation of the study. The literature review and theoretical concept of the study also presented in Chapter two. Chapter three presents the research design and methodology of the study as well as reliability and validity test. The results of this paper were presented in chapter four. The finding of discussion was including in chapter five. Finally, chapter six present the summary of findings, conclusions and recommendations.

CHAPTER TWO

LITERATURE REVIEW

2.1. Introduction

In this part of the study, the researcher applied literature concepts related with the objective of the research. Accordingly, it encompassed such titles like the risk factor for cervical cancer, including a psycho-social support services, and it constructed the incidence, the mortality and the prevalence theoretical information's and the challenge that come by means of cervical cancer with psychological, emotional and social issues. The treatment of cervical cancer, and psychological therapies included in this literature and supportive care also include in the review. The review has the importance of palliative care and challenges of cancer in the work place. Finally, conclusions on the Empirical Research and theoretical frame work are presented in the last section.

2.1.1. Theoretical Concept of Cancer

Cancer arises from a stepwise accumulation of genetic and epigenetic changes in oncology genes and tumor suppressors that liberate plastic cells from the homeostatic mechanisms that govern normal cell proliferation. The mutation theory of cancer was always challenged by alternative notions that cancer cannot be reduced to molecular interactions. Recently, it has been suggested that one alternative theory is on a road of acceptance, replacing the mutation theory to explain the complexity of cancer on tissue levels. As suggested, carcinogenesis represents a problem of tissue organization and "somatic mutation theory should be dropped and replaced". Under the pressure of the alternative theory, it has been acknowledged that somatic mutations do not explain the complex biology of human tumors, simply because tumors are complex tissues. If mutations cannot explain cancer, then what can? The alternative theory does not offer any molecular mechanism. Instead, it insists that the somatic mutation theory is contradicted by evidence. Here I discuss that "evidence" may contradict only to misinterpretations of somatic mutation theory not to the theory itself (Mikhail V,2005).

Cancer cells as 'species'. There are thousands of different cancer cell lines, such as Hela, which already live for years in vitro. Cancer cells live in a wild, like unicellular organisms? Astonishingly, canine sarcoma spread from one dog to another as venereal disease. Neither sarcoma virus nor cellular DNA but sarcoma cells themselves. Once sarcoma cells spread to a new dog, the tumor grows progressively for about months and then regresses; lethal metastasis occurs in puppies and immune suppressed dogs, And the mutation in my promoter reveals that this sarcoma cell 'species' has arisen in one dog decades ago and still live in a wild. This free living cancer cell line is evolving as another unicellular pathogen, by acquiring the ability to escape immune response(Mikhail V, 2005).

Cancer cells can also invade (grow into) other tissues, something that normal cells can't do. Growing out of control and invading other tissues are what makes a cell a cancer cell. Cells become cancer cells because of damage to DNA (which present in every cell and direct all its actions). In a normal cell, when DNA is damaged the cell either repairs the damage or the cell dies. In cancer cells, the damaged DNA is not repaired, but the cell doesn't die like it should. Instead, this cell goes on making new cells that the body does not need. These new cells will all have the same damaged DNA as the first abnormal cell does. People can inherit damaged DNA, but most often the DNA damage is caused by mistakes that happen while the normal cell is reproducing or by something in our environment. Sometimes the cause of the DNA damage is something obvious, like cigarette smoking. But often no clear cause is found (ACS, 2014).

Based on the site of growth, there are two types of cancer cell growth: primary and secondary. Primary cancer refers to the first mass of cancer cells (tumor) that have divided and multiplied uncontrolled in the organ or the tissue. The tumor is limited to its original site, such as the bowel. This is known as a cancer in-situ, carcinoma in-situ or localized cancer.

Secondary cancer is when malignant tumor cells from the primary cancer site grow and form another malignant tumor at a new site, by moving through the blood or lymphatic system. The abnormal cells divide and multiply and form other masses of abnormal cells (metastases). This is also called metastatic cancer. Secondary cancer can occur if primary cancer is not treated or cannot be treated (Cancer Council, 2014).

The cervix is located in the lower part of the uterus also called uterine cervix, it connects the body of the uterus called end of cervix, to the birth canal by the part named as exo-cervix. Cells covering the cervix are squamous cell and the glandular cells (American Cancer Society, 2010).

Cervical cancers are a cancer malignant of the cervix or within the cervical area. It may form in the interior lining of the cervix, junction of the vagina and the uterus (Saonere, 2010).

Cervical cancer begins to develop in the cells around the cervix. The pre-cancerous cells cancer can fully grow into cancer. There are two main forms of cervical cancer namely squamous cell carcinoma and adenoma carcinoma, of these types 80 Percent to 90 Percent of the cervical cancers are due to the squamous cell carcinoma which begin where the exo -cervix joins the end cervix. Cervical adenoma carcinoma develops from the mucus-producing gland cells of the end cervix(ACS, 2010). In some cases some of the cancers can be as a result of a combination of both squamous cells carcinoma and adenoma carcinoma, the carcinoma is known as adenoma squamous carcinoma or mixed carcinoma. In some women precancerous cells go away with no treatment whatsoever while others turn into true invasive cancers (ACS, 2010.)

There are other rare types of cervical cancer that may be occurred namely primary cervical lymphoma that involves the lymph nodes on the cervical area. However this does not commonly occur. In 2005, there were less than 60 cases of this kind of cervical cancer. Neuro endocrine cervical cancer is one of the aggressive tumors that are hard to discover or at times may be misdiagnosed. Melanoma of the cervix can be formed as a result of migrated metastasized lesion from any other part of the body. The adenoid cystic carcinoma of the cervix forms most of the time in elderly group of patients in the early stages of the diagnosis (Saonere, 2010,).

Diagnosis of cervical cancer that helps to define the different stages can be classified by the use of the history- pathological criteria which follows the royal college of pathologists. The reports of the cervical tumors indicate the type of tumor, size and extent of the tumor. Also the depth and pattern of invasion could be determined. This assessment should be thoroughly done and well standardized since the diagnosis done determines the start and path of treatment (Scottish Intercollegiate Guidelines Network, 2008).

There are a variety of stages of cervical cancer that identify the extent and site of infection. The first stage is stage 0 which is also in another name known as cervical carcinoma in situ, located at the top layer of cells along the cervix line. Carcinoma in situ is not considered as a cancer but in some cases it may develop into cancer if left untreated (Cancer Research UK,2011.)

Stage 1 cervical cancer is only found in the cervix. Stage 2 cervical cancer spreads from the cervix into the upper part of the vagina. Stage 3 cervical cancer spread into the lower part of the vagina and spread to the pelvic wall and the surrounding lymph nodes. The most crucial stage is Stage 4 which has cervical cancer spread to the bladder, rectum and even other parts of the body. In the stage 4B the cervical cancer may even spread to the liver, intestinal tract or lungs causing it to be a very deadly level (Saonere et al 2010).

According to an article by American Cancer Society(n.d), cervical cancer starts in the cells lining the cervix-the lower part of the uterus (womb). Most cervical cancers begin in the cells in the transformation zone (place where the two main types of cells covering the cervix, squamous cells (on the exocervix) and glandular cells (on the endocervix) join). These cells do not suddenly change into cancer. Instead, the normal cells of the cervix first gradually develop cancerous changes that turn into cancer.

2.2. The Risk Factors for Cervical Cancer

The HPV virus infection which is the infection mainly responsible for cervical cancer is transmitted through sexual intercourse. There are 100 different types of HPV virus but only about 40 of these affect the genital areas. Some of the other types infect the skin on other body areas like the hands or feet. Genital warts known as condylomata acuminata are usually small, flat cauliflower like bumps that carry HPV virus even though at times it is small Percentage, Therefore not necessarily at risk of causing cervical cancer. Type 6 and 11 are responsible for causing of the warts which develop in a period of six weeks to eight months.

HPV virus hardly has any symptoms therefore causing it to be very hard to identify hence the need to go for cervical checkup and HPV testing. There are a total of 13 high risk HPV types that can cause low-grade cervical cell abnormalities. The high risk types have been detected in 90 Percent of the cervical cancer tests with 70 Percent of these being from HPV types 16 and 18.

Infection by one type of HPV virus does not protect that a person is not susceptible to infection by a second or more types, among people infected with mucosal HPV about 5 Percent to 30 Percent get infected with more than one type of virus simultaneously.

A woman having multiple sexual partners puts her at risk of acquiring the HPV infection which is dominant in men. However, a woman's risk of cervical cancer depends less on her own sexual behavior of her husband or other male partners. By this hypothesis the author pointed out clearly on how men at that time and age are more promiscuous women were known to be, unlike women majority of men are just carriers of the HPV virus and can transfer from one partner to another with them not getting any infection. Unfortunately with the new generation of reckless sexual behaviors that has equally evident among both genders, increase the risk of infection of cervical cancer. In some other cases the HPV infection cells may be generated faster through direct carcinogenic action that are aided by long term use of contraceptives also contribute greatly to the HPV virus development, contraceptives act as a generative agent with an increase of folds increase in risk level although there has been no link clearly explaining the relation between the contraceptives and HPV virus.

Woman that have three or more full term pregnancies are also said to be high risk patients. This is seen to be due to the different hormonal changes that make the women more susceptible to HPV infection. It is also considered a high risk for young aged women at about 17 years of age or younger when they have had their first full time pregnancies. They are twice more at risk of cervical cancer on in life compared with women that get pregnant at 25 years and over.

Diethylstilbestrol (DES) which is a hormonal drug for women with high chances of miscarriage given between the year 1940 to 1971 has found to be of high risk not to the women taking drugs but the women's daughters. About 1 in 1000 of these women develops cervical cancer. Those whose mothers took the drug during the first 16 weeks of pregnancy were found to be of higher risk. The drug however is no longer in use. Family medical history can be a major risk factor for any female not just those that mother's used the DES hormone medication but also women whose family has history of cervical cancer (ACS, 2014).

According to the WHO (2002) there are a total of over thousand million smokers worldwide, though the population of developing countries smoking women is decreasing there is still a significant number still participating women in the habit while in developed countries the habit continuous to be more popular among the women closely getting equal to the number of men smoking. Smoking whether active or passive has been found to be risk factor. A strong correlation has been found between smoking habits and sexual behaviors in social setting in many populations. Chemicals substances in the cigarettes have also been detected in cervical mucus therefore aiding in development of cervical cancer by causing damage on DNA around the cervical cells (Health report of WHOM 2002).

Some cultural and religious beliefs keep the women away from the screening programmers. An example of such communities is the Chamorro women of the Micronesia who are raised with the momahloa region. Which calls for a sense of shame in women in exposing anything on their sexuality or gynecological health hence keeping them away from the health centers? Due to this cervical cancer has remained to be the second leading concern of death among the women of this community and the highest behind Asian and Caucasian women. Cervical cancer may run in some families. If them other or sister had cervical cancer, the chances of developing the disease are 2 to 3 times higher than if no one in the family had it.

Poverty is also a risk factor for cervical cancer. Many low-income women do not have ready access to adequate health care services, including Pap tests. This means they may not get screened or treated for cervical pre-cancers. However, a recent study found that women who had ever used an intrauterine device (IUD) had a lower risk of cervical cancer(Health report of WHOM 2002).

2.3. Incidence, Mortality and Prevalence of Cervical Cancer

Cervical cancer has continuously been striking hard on the poorest countries such as central and south America, the Caribbean, sub-Saharan Africa , some parts of Oceania and Asia with rates as high as 30 per 100,000 women, compared with North America and Europe that have reports of about 10 per 100,00 cases. Approximately 1.4million women worldwide living with cervical cancer and India may account for more than one-fourth of the total reporting nearly 132,000 new cases annually. A small population of women from the poor and developed countries that receive

cervical cancer treatments therefore having a window of 7 million women worldwide inclusive of possible precancerous conditions that have not been identified (ACCP, 2004).

Developing countries have continued to increase the stress of the importance of breast cancer while over the years yet cervical cancer has reigned as a major cause of morbidity and mortality greatly due to the level of awareness both among society and healthcare providers as opposed to developed countries such as Finland that has been records of increase in HPV virus without affecting the mortality (WHO, 2002).

Cervical cancer is the fourth most common cancer in women, and the seventh overall, with an estimated 528,000 new cases in 2012. The WHO (2000) reports cervical cancer as the most common form of cancer affecting women from developing countries. As with liver cancer, a large majority around 85 Percent, of the global burden occurs in the less developed regions, where it accounts for almost 12 Percent of all female cancers. High-risk regions, with estimated ASRs over 30 per 100,000, include Eastern Africa (42.7), Melanesia (33.3), Southern (31.5) and Middle (30.6) Africa. Rates are lowest in Australia/New Zealand (5.5) and Western Asia (4.4). Cervical cancer remains the most common cancer in women in Eastern and Middle Africa. There were an estimated 266,000 deaths from cervical cancer worldwide in 2012, accounting for 7.5 Percent of all female cancer deaths. Almost nine out of ten (87 Percent) cervical cancer deaths occur in the less developed regions. Mortality varies 18-fold between the different regions of the world, with rates ranging from less than 2 per 100,000 in Western Asia, Western Europe and Australia/New Zealand to more than 20 per 100,000 in Melanesia (20.6), Middle (22.2) and Eastern (27.6) (Africa ,International Agency for Research on Cancer,2012).

**Table 1: Cervical Cancer Estimated Incidence, Mortality and Prevalence
World wide in 2012.**

Estimated numbers (000)

Area of the cases	Cases	Deaths
World	528	266
More developed regions	83	36
Less developed regions	445	230
WHO Africa region (AFRO)	92	57
WHO Americas region (PAHO)	83	36
WHO East Mediterranean region (EMRO)	15	8
WHO Europe region (EURO)	67	28
WHO South-East Asia region (SEARO)	175	94
WHO Western Pacific region (WPRO)	94	43
IARC membership (24 countries)	206	103
United States of America	13	7
China	62	30
India	123	67
European Union (EU-28)	34	13

Source: Adopted from International Agency for Research on Cancer,2012

The American Cancer Society's estimate for cervical cancer in the United States for 2015 indicate that about 12,900 new cases of invasive cervical cancer will be diagnosed and about 4,100 women will die from cervical cancer. Cervical cancer was once one of the most common causes of cancer death for American women. But over the last 30 years, the cervical cancer death rate has gone down by more than 50 Percent. The main reason for this change was the increased use of the Pap test. Cytology smears are the gold standard for cervical cancer screening. This screening procedure can find changes in the cervix before cancer develops. It can also find cervical cancer early – in its most curable stage.

Cervical cancer tends to occur in midlife. Most cases are found in women younger than 50. It rarely develops in women younger than 20. Many older women do not realize that the risk of developing cervical cancer is still present as they age. More than 15 Percent of cases of cervical

cancer are found in women over 65. However, these cancers rarely occur in women who have been getting regular tests to screen for cervical cancer before they were 65(ACS, 2015).

2.4. Adverse Challenges of Cervical Cancer

If cervical cancer is in its advanced stages before the patient receives any treatment, it is often fatal. As a result, cervical cancer causes more deaths annually than any other cancer among women in Tanzania, with an annual mortality rate of 32.5 per 100,000 women of all ages. Breast cancer and Kaposi's sarcoma are a distant second and third at 8.8 and 6.3 deaths per 100,000 women (WHO/ICO HPV Information Centre, 2010).

The high prevalence of cervical cancer is an important issue that needs to be resolved because it has serious and long-lasting effects on its victims and on society. Of the 200 patients sampled at the Kilimanjaro Christian Medical Center (KCMC) out of 374 cervical cancer patients, 30 Percent were discharged for palliative care and 17 Percent died in the hospital (Mosha et al, 2009).

Women play an integral role in child rearing, cooking, and other household activities that are essential for a family to function efficiently. When the mother of a family is lost, a great burden is placed on the rest of the family. The children of the family now must take on the myriad responsibilities that the mother once completed. Furthermore, losing a mother takes a serious emotional toll on all members of the family.

The World Health Organization recognized that physical/ health status, psychological status and social functioning are essential components that must be considered when examining quality of life. Even if a woman survives about of cervical cancer, she may experience debilitating effects on her quality of life after cancer. Numerous studies have documented the physical, mental, and sexual effects of radiation and surgical treatments on the patient's quality of life years after the procedures (Ashing.G, 2010; Bartoces et al., 2009; Vistad, et al., 2006).

The physical well-being of patients immediately following radiation therapy is known to be poor, and long-term effects are significant but under-reported. Frequent urination and diarrhea following radiation therapy are observed as long as two years after treatment. A combination of surgery and radiation therapy resulted in an inability to control urination and defecation in

approximately 40 Percent of patients. The immediate effects of radiation therapy, such as nausea and vomiting, are also significant burdens on the physical quality of life (Vistad, et al. 2006).

The physical changes that occur after radiation and surgical treatment of cervical cancer often result in long-lasting psychological issues. The changes in physical appearance (such as weight gain), in relationships, and in self-perception can cause the patient to experience a drastic reduction in self-esteem (Bartoces et al. 2009).

Low self-esteem can result in depression, and a review by Vistad, Fossa, and Dahl (2006) noted that 33 Percent of those who received radiation therapy or surgery for cervical cancer were depressed 97 weeks after treatment argue that the psychological problems are more important than the physical problems because of their long-lasting impact and call for psychological follow-up assessments for several years after treatment (Bartoces et al. 2009).

A patient's sex life after cervical cancer treatment suffers because of a culmination of physical and psychological effects. Of the patients who required their ovaries to be removed during surgery, 38 Percent experienced vaginal dryness and 33 Percent experienced hot flashes, both of which tend to hinder a healthy sexual relationship. These physical side effects can translate into psychological sexual disorders. Dyspareunia, or painful sexual inter-course, is one such disorder. Fifty-five Percent of patients who received radiation therapy experienced dyspareunia as long as two years after treatment. Feelings of low self-esteem can also lead a woman to worry about the satisfaction of her partner and make her reluctant to participate in sexual relations. Nearly every subject who underwent radiation or surgery reported a decreased frequency of sexual activity (Vistad, et al. 2006).

In addition to its impacts on the quality of life, cervical cancer also frequently results in infertility. Infertility has serious consequence, particularly in a society such as Tanzania's in which childbearing is strongly valued and both mothers and fathers desire many children (National Bureau of Statistics and ORC Macro 2005).

Infertility may cause a woman to be subject to severe social stigma. In societies that place great importance in having children, infertility will be a major limitation to a married couple. It can have massive effects on an infertile person's life, relation-ships, and social well-being. Andrews,

Abbey, and Holman, (1991) found that the negative impacts of infertility on quality of life are stronger for the wife than for the husband in a relationship.

Women often feel highly responsible for matters of fertility, subjecting themselves to personal pressure, but pressure can also come from outside sources—particularly in-laws. Parents may place significant pressure on their children to have children, at times even forcing the son to have a child outside the marriage. The husband's family is a frequent source of social stigma regarding infertility.

Studies suggest that women are more vulnerable to social stigma than men. Vieira da Cunha et al, (2008) observed that the prevalence of common mental disorders was high among women with in-fertility. In addition, women who are infertile may be deprived of certain privileges and vulnerable economically. In some societies women who are infertile are denied any privileges when it comes to the husband's wealth since they have no children.

Fear or anxiety (a feeling of worry or unease) may occur from the shock of diagnosis it can be frightening to hear that the cancer has come back, has spread or is at an advanced stage to begin with, feeling concerned about having less control over aspects of life; or having thoughts about dying. It may be angry because victim had to deal with cancer already or because weren't diagnosed earlier. Sometimes it may even be difficult to pinpoint exactly what the anger is about. Women may blame them-self for the cancer, but the reason cancer spreads or doesn't respond to treatment is usually unknown. Patients may be worried about the impact cancer could have on their family or feel guilty that they may have to take care of them. Besides, the patient may feel they have less control over their life. It can be hard to adjust to an uncertain future. Though, some people may also feel a sense of hope in the uncertainty. People with advanced cervical cancer feel sad or depressed. But if the sadness lasts longer than two weeks, they will face insomnia (trouble sleeping) or not enjoying things usually they like doing. Clients may feel lonely at times even if they have many people around them. It's natural to wonder if anybody else understands what they're going through. Their family and friends may have trouble dealing with the diagnosis and some may even distance themselves from the clients. Even clients with an advanced cancer diagnosis can be hard to accept. Denial can give the patient time to adjust, but it becomes a problem if it stops them from getting treatment or help. A diagnosis of cancer often

leads people to question their values and priorities, as well as what life means for them(National Bureau of Statistics and ORC Macro 2005).

2.5. Psychological Issues

In addition to general detrimental effects on emotional well-being, living with cancer can pose specific problems that have a strong psychological impact, including body image and sexuality problems, interpersonal difficulties, and anxiety, fear or concerns related to survival and recurrence.

Most people with cancer will experience minor or transient symptoms of anxiety and depression. Some will develop more severe problems, such as clinical anxiety, depression or post-traumatic stress disorder (PTSD), and will require specialized treatment.

The extent to which a person with cervical cancer has support and feels supported has been identified as a major factor in their adjustment to the disease .It is essential to check the extent of support available to the patient, to recommend additional support as required and to provide information about where this is available. Health professionals involved in the care of people with cancer are encouraged to organize their practice and develop their professional skills to ensure they can provide optimal patient support. A patient's need for support will vary depending on individual strategies, and to what extent emotional concerns impair their daily living. Understanding and utilizing patients' existing coping mechanisms is a useful strategy and can help ensure the most appropriate information, reassurance, and support are provided. People with cancer (and their families and carers) may not voice their concerns or even recognize them; often these must be carefully and thoughtfully elicited.

2.6. Emotional and Social Issues

People with cervical cancer experience a range of emotional and social difficulties. They often report feelings like 'being in a state of shock', 'feeling out of control' or being angry, fearful or helpless. Grief and loss are often key issues and there may be powerful feelings of distress and fear that the cancer could be fatal. People treated for cancer may also find their life has changed in other ways such as curtailment of activities they enjoy emotional response.

People vary in their emotional responses to the circumstances surrounding the diagnosis and treatment. An individual's level of distress may also change over time. For example, among people with head and neck cancer, stress levels have been shown to be highest at the point of confirmed diagnosis, and recede during the treatment. Psychological functioning and global quality of life gradually improves over three years after the treatment. In women with cervical cancer, distress and disruption is reported to be high at diagnosis and treatment, yet the majority return to a level of functioning similar to pre-diagnosis. Episodes of intense, unpleasant and distressing emotions such as tearfulness, fear and anger are part of the normal range of responses to a stressful event. These reactions are very common, are usually occasional, rarely last more than a day or two, and are not indicative of disorder.

There are a number of potential barriers to patients discussing emotional concerns, including not having the words to describe how they feel, not wanting to be a burden, fearing breaking down, being ashamed of admitting problems with coping, or perceiving that the doctor is too busy or disinterested. Health professionals may avoid discussion because of fear of causing distress, harm or worry for patients, feeling out of their depth or that the existential domain is not an appropriate part of medicine.

2.7. Treatment of Cervical Cancer

Cervical cancer is preventable and often curable if the right interventions are made available to those who are at risk or develop cervical cancer. Studies indicate that preventive strategies to reduce cervical cancer incidence should focus on preventing risk factors. Cervical pre-cancers are diagnosed far more often than invasive cervical cancer.

According to the views of the health professionals serving on the American Cancer Society (2015), the options for treating each patient with cervical cancer depend on the stage of disease. The stage of a cervical cancer describes its size, depth of invasion (how far it has grown into the cervix), and how far it has spread. The treatment for cervical cancer depends on how far the cancer has spread. Common types of treatments for cervical cancer include surgery, radiation therapy, chemotherapy (chemo) and targeted-therapy. For early cervical cancer, surgery to remove some or all of the womb, radiotherapy, or a combination of the two are recommended

where as for advanced cervical cancer, radiotherapy and/or chemotherapy is advised, although surgery is also sometimes used.

Deciding which treatment is best for the disease can often be confusing, which is why hospitals use multidisciplinary teams (MDTs) to treat cervical cancer. If a cure is not possible, the goal may be to remove or destroy as much of the cancer as possible to help clients to live longer and feel better. Sometimes treatment is aimed at relieving symptoms, this is called palliative treatment. The goal of palliative care is to minimize and prevent suffering and maximize physical function and quality of life in patients with serious illness.

2.8. Psychological Therapies

Psychological interventions include cognitive behavioral therapy, psychotherapy, group therapy, family and/or couple therapy, telephone counseling, and complementary therapies. Features of therapy common to all psychological interventions include empathetic manner, listening, affirmation, reassurance and support. The most appropriate psychological therapy will depend on the patient, on the issues at hand and the training and skills of the therapist. Therapies maybe delivered individually, or via a group or family model and may be face-to-face or remote. While some people will be more comfortable with the privacy of individual counseling, others will benefit from group counseling where they can gain from sharing the commonality of their experience (Clinical practice guidelines forth psychological care of adults with cancer, April 2003.).

2.9. Counseling Vs Psycho-Social Support

Counseling is one form of psycho social support where as psychological support is a wider range of palliative treatment from assesment of patient's cases to providing psychological counseling and social support (Alliance for Cervical Cancer Prevention, 2004).

Much of the research with womensuffering from life threatening chronic illnesses(e.g., cervix cancer) shows that they passthrough a period of significant life changes thatrequire immense psychological and socialsupport. Lack of support during this phaseinterferes with their psychological and physicalfunctioning. The degree of socialsupport received from family and

friends was positively related to physiological and psychological wellbeing of the patients. High social support tended to reduce the severity of the negative consequences of illness.

Those with high level of social support also strongly believed that the illness was either in their own control or in the control of doctors. High social support reduced the experience of disease-related pain and promoted hope for better outcomes (Alliance for Cervical Cancer Prevention, 2004).

2.10. Supportive Care or Palliative Care: The Psycho-Social Support

The World Health Organization (WHO) defines Palliative care “improves the quality of life of patients and their families facing the problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification, assessment and treatment of pain and other problems, physical, psychosocial and spiritual.” . A study done on 156 countries were found to have some level of palliative care service available, 45 of which (primarily developed countries) had fully integrated it into their healthcare system. It can help to cope with the symptoms of cancer and treatment, as well as the practical problems of daily life (WHO, 2011).

Palliative care (or supportive care) is care that focuses on relieving symptoms caused by serious illnesses like cancer. It can be given at any point during a person’s illness to help them feel more comfortable. The information here will help you learn more about palliative care, sometimes also called supportive care (ACS, 2015).

In addition to treatment to slow, stop, or eliminate the cancer, an important part of cancer care is relieving a woman’s symptoms and side effects. This approach is called palliative or supportive care, and it includes supporting the patient with her physical, emotional, and social needs.

Palliative care is not just for end-of-life care, it can help a woman at any stage of illness. Women often receive treatment for the cancer and treatment to ease side effects at the same time. In fact, patients who receive both often have less severe symptoms, better quality of life, and report they are more satisfied with treatment.

Palliative treatments vary widely and often include medication, nutritional changes, relaxation techniques, and other therapies. You may also receive palliative treatments similar to those meant to eliminate the cancer, such as chemotherapy, surgery, and radiation therapy.

Before treatment begins, talk with the health care team about the possible side effects of the specific treatment plan and supportive care options. And during and after treatment, the patients have to be sure that to tell the doctor or another health care team member if they are experiencing a problem or not so it is addressed as quickly as possible (Cancer.Net, 2015).

Cancer that is unlikely to be cured and life threatening are to be specially supported and cared. Such cancer is advanced cancer. It is a term commonly used to describe primary cancer or secondary (metastatic) cancer that is unlikely to be cured (Cancer Council, 2013).

2.11. Who provides Palliative Care/Psycho-Social Support?

Partners, family members, friends and those close to the patient can be good sources of support. To know more about advanced cancer and how it might affect the patient, or get help with practical problems, it is better to start talking with general practitioner (GP) or other members of treatment team. This may include a nurse, palliative care specialist or physician, counselor or psychologist, pastoral career or spiritual adviser, social worker, occupational therapist or physiotherapist, pharmacist and dietitian. In most trials, the therapy was provided by a specially trained counselor, nurse, social worker or psychologist. However, greater effects have been demonstrated when psychological therapies were conducted by more highly trained therapists and continued for longer periods of time(Cancer Council, 2013).

2.12. Importance of Palliative Care

In general, if you have been told your cancer is unlikely to be cured, you can still feel hope. What you hope for may change with time. Sometimes, you may hope for good days with understanding company or the love of family and friends. You may find yourself hoping you will maintain your sense of independence or stay pain-free. Some people explore activities they've never tried before and find hope in this new aspect of their lives. Others find hope in small projects, such as completing a scrapbook of their life or planning an excursion with their family.

The same article by the cancer Council states that while the cancer and its treatment can limit your activities, some people discover new strengths in themselves, and this gives them hope. For some people, faith or spiritual beliefs can help them get through tough times. People who find hope in these beliefs describe feelings of optimism that are hard to explain to others.

For other people, cancer can test their beliefs. Either way, you may find it helpful to talk to your spiritual or religious adviser, if you have one.

The following two quotes are relevant and shows hope in the life of cancer patients:

*“If I think of myself as a person who is dying of cancer, then what lies ahead is a hopeless end. If I think of myself as a person who is living with cancer, then my daily life is an endless hope.”*Roberta

“There is still a life to be lived and pleasures to be found and disappointments to be had. Living with advanced cancer is a different life, not just a journey towards death” (Julie June 13 2011).

Palliative care allows people with advanced cancer to maintain their quality of life. It helps you cope with the symptoms of cancer or its treatment, as well as the practical problems of daily life.

Many people think that palliative care is just for people that are dying, but it is appropriate at any stage of advanced cancer. People can receive palliative care for many months or even years. Palliative care also involves spiritual care and the support of relatives and carriers. It incorporates a range of services offered by medical, nursing and allied health professionals, as well as volunteers and careers (Cancer Council, 2013).Cervical cancer is most common cancer affectingwomen.¹ Patients with cancer is psychologically vulnerable for many reasons, including the stress of the diagnosis, debilitating treatments and chronic pain. Distress can compromise compliance with treatment and negatively affect prognosis and survival rates, ^{1,2} so the significance of patients’ psychological status forms an essential element of logical treatment (varsoers 2002).

Newer treatments make this increasingly important because the disease is now often viewed as curable or chronic. Distress is often undertreated because of time constraints, the physical crisis taking precedence or patient’s not volunteering information about their distress (varsoers 2002). Psycho-oncology deals with the psychological reactions of patients and families to cancer and treatment, as well as the needs of oncology healthcare professionals. Considerable research documents the psychological problems that patients with breast cancer face. However, it is

difficult for busy family practitioners to review the extensive literature((varsoers 2002).The most prevalent co-morbid psychological conditions are depression and anxiety. Between 62.5 Percent and 85 Percent of patients with cancer meet the criteria for depression and anxiety disorders. A study of OshwamboNamibianand Sesotho South African patients with breast cancer found high levels of hopelessness following diagnosis that correlated positively with psychological morbidity. Research into Indian South African patients with breast cancer highlighted depressive symptomatology. A South African cross-cultural analysis of patients with breast cancer showed depression to be a significant variable. Standardized diagnostic systems classify anxiety disorders four types (varsoers 2002).

- *Anxious adjustment disorder*: Anxious adjustment disorder is a quantitatively excessive response that starts within one month of a stressful event.
- *Generalized anxiety disorder*: Generalized anxiety disorder requires more symptoms and persistence for over six months.
- *Panic disorder*: Panic disorder is when anxiety builds up rapidly to a crescendo.
- *Phobic anxiety*: Phobic anxiety arises from a provoking stimulus.

In addition, organic anxiety is abnormal anxiety that is linked to an organic cause, and implies a feature of anxiety that is specific to oncology: the difficulty of making a differential diagnosis while the symptomatology presented by cancer therapies is similar. This presents the clinician with symptoms such as fearfulness, restlessness and an inability to concentrate, and associated somatic symptoms such as tremors, palpitations and dyspnoea resulting from the disease or treatment, making definitive diagnosis difficult. Somatic processes can cause organic anxiety.

Anxiety is characterized by physiological and psychological symptoms. Autonomic over activity (palpitation and sweating) and anxious behavior (restlessness and reassurance seeking) feature. Apprehension and poor concentration, as well as muscle tension and fatigue maybe present.³³Anxiety after a cancer diagnosis is not necessarily abnormal, but may become maladaptive. The Diagnostic and Statistical manual of mental disorders diagnostic classification Communication with the patient remains the main diagnostic approach to assessing anxiety. A discussion on the reasons for the patient's anxiety can lead to an understanding of how the patient perceives the disease, how she is coping and to identify symptoms for diagnosis.

Cognitive behavior therapy (CBT) is a useful approach; although any intervention should account for socio-cultural differences within various African oncology settings. Coping style can mediate positive adaptation to breast cancer. Coping refers to cognitive and behavioral efforts which the patient makes to tolerate external and internal demands. Coping may be active or passive. Active coping refers to confronting problems and deciding on solutions, while passive coping refers to escaping the source of the distress positive behavioral pattern can assist with adaptive function, as opposed to hopelessness or helplessness style which contributes to poor treatment outcome (Michael M., 2006).

2.13. The challenges of Cancer on Employment Patterns

Cancer has negative challenges on employment patterns with studies estimating between 10 and 38 Percent of employees do not return to work following treatment for cancer. As more people are diagnosed at earlier stages and surviving cancer, they are increasingly likely to be of working age, therefore issues regarding productivity and continuing employment must be addressed by patients and employers alike. Overall, the ability of people with cancer, and cancer survivors, to continue employment is supported by the available research (Scibner 2005, New York).

There is evidence that a supportive work environment is positively associated with rates of cancer survivors returning to work, and physically demanding manual labor is negatively associated with returns. Cancer has a negative impact on employment patterns with studies estimating between 10% and 38% of employees do not return to work following treatment for cancer. As more people are diagnosed at earlier stages and surviving cancer, they are increasingly likely to be of working age, therefore issues regarding productivity and continuing employment must be addressed by patients and employers alike. Overall, the ability of people with cancer and cancer survivor's to continue employment is supported by the available research. There is evidence that a supportive work environment is positively associated with rates of cancer survivors returning to work and that physically demanding manual labor is negatively associated with return-to work rates. Research commissioned by The Cancer Council WA suggests that about two thirds(67%) of employees continue to work while undergoing treatment and that a large majority of careers (94%)also continue to work. This small Australian study suggested that about10% of employees did not go back to work after treatment for cancer (Scibner M., 2005).

The Spanish Association against Cancer, in coordination with the Employment Service in Andalusia, has been working since 2005 on a job placement program to promote social-labor integration of cancer patients.

The program emphasizes modifying factors in the job placement process, especially those related to cancer. For the early detection of those factors, an adapted Job Placement Psychological Factors Questionnaire is employed. Analysis of those elements, along with a customized employ ability diagnosis, provides the adoption of specific strategies for each cancer patient. The program's job placement rate is 62.5%. This is probably a relatively good outcome, because the program is focused on individuals who have problems returning to work and need help with their labor integration. In an average population of cancer patients, the return to work is 62% after 12 months. There is a considerable body of evidence about the adverse effects of cancer and cancer treatments on employment, work ability, work performance, and work satisfaction among cancer survivors (AnjaM.et al, 2013).

Factors negatively associated with return to work were: a non-supportive work environment; manual labor; and have had head and neck cancer. During consultation for Working with Cancer, comments made by HR managers suggest that a formal return to-work program contributes to a supportive workplace environment for all employees and not just those people returning to work after cancer diagnosis or treatment. Such initiatives appear to be more prominent in Queensland, NSW and Victoria but there is nothing to stop individual organizations adopting the better practices from these schemes as appropriate. Cancer-related fatigue is very common among people being treated for cancer. Cancer-related fatigue can present significant challenges for workers: affecting their physical functioning, causing emotional distress and making it difficult to concentrate. Cancer-related fatigue can have a substantial negative impact on the physical, psychosocial and economic wellbeing of both employees with cancer and caregivers. Employees who are not offered alternative working arrangements during and following cancer treatment may be up to 15 times more likely to experience significant financial difficulties. There is evidence that the adverse effects of cancer-related fatigue can be significantly reduced by:

- Work adjustment policies
- Adjustments to working hours and alternative working arrangements
- Return-to-work meetings

– Regular consultations about managing workload. Very few women in sub-Saharan Africa are ever screened for cervical cancer. Low levels of awareness and poor knowledge of cervical cancer coupled with unavailability and inaccessibility of cervical cancer screening services are responsible for the very small number of women being screened in sub-Saharan Africa and in other developing countries. In developed countries people seem to be aware of cancer and screening services are widely available and utilized. In a cross-sectional survey of 650 women 15-78 years of age randomly recruited at 2 hospitals in London, England, 76.2 Percent perceived cervical cancer to be a common disease and there was good awareness of the association between this cancer with smoking and the number of sexual partners. Furthermore, 91.7 Percent believed cervical cancer could be treated if detected early enough (James J., 2011)

A study done in Malaysia on women aged 21-56 years and who had never had a Pap smear test, with the aim to explore their knowledge and awareness of cervical cancer and its screening, showed that there is a lack of knowledge on cervical cancer as well as lack of knowledge on the Pap smear test. Many women did not have a clear understanding of the meaning of an abnormal cervical smear and the need for the early detection of cervical cancer. Many believed that the purpose of the Pap smear test was to detect existing cervical cancer, leading to the belief that Pap smear screening is not required because the respondents had no symptoms. Despite considerable awareness of a link between cervical cancer and sexual activity, as well as the role of a sexually-transmitted infection, none of the respondents had heard of the human papilloma virus.

In Kuwait in one study done regarding cervical cancer screening among Kuwaiti women found that the knowledge about the test was adequate in 147 (52.3 Percent) women only. In Africa A study done in Cameroon to assess the knowledge of cervical cancer by women living in Maria, the capital of the Far North Province of Cameroon showed that, of 171 women studied, only 48 (28 Percent) had prior knowledge of cervical cancer.

In a study done in Lagos, 81.7 Percent of 139 patients with advanced cervical cancer had never heard of cervical cancer before, and 20 Percent, 30 Percent and 10 Percent respectively thought the symptoms they had were due to resumption of menses, lower genital infection and irregular menses.

In Nigeria, a cross sectional study done in the General outpatient, department of a tertiary hospital in Ibadan, Nigeria, women aged 20 to 65 years attending or visiting the GOP department

in a University Teaching Hospital were studied. Of the respondents, only 15 Percent had heard of cervical cancer (James J., 2011).

A cross-sectional survey among college women in a university in Ghana showed that only 7.9 Percent were aware of the link between human papilloma virus and cervical cancer.

Knowledge is also poor among health professionals where in Niger a survey of 144 female health professionals at two referral hospitals with facilities for Pap smear showed that twenty two Percent could not list any risk factor for cervical carcinoma. Practice towards screening for cervical carcinoma is poor to even those with knowledge of the disease and knowledge on the importance of screening. In developed countries majority went for screening as compared to developing countries. In a cross-sectional survey of 650 women 15-78 years of age randomly recruited at 2 hospitals in London, England. 80.5 Percent of these women had had at least 1 Pap smear and 71.5 Percent reported regular smears (every 3-5 years).

Practice on screening among Africans was also shown to be poor as shown in a study done in South Africa, in spite of knowledge of cervical screening and the availability of such services, majority of women (87 Percent) from higher social and educational backgrounds did not undergo cervical screening. Most patients resided within a 12-kilometer radius of a facility that either provided or could potentially provide screening (James J., 2011).

2.14. The challenges of Cancer in the Workplace

This section of working with cancers based on research studies carried out in the United Kingdom, the USA and Australia. From the available evidence, the information presented in the international studies hold true for Australian workplaces but more Australian studies are needed. Evaluation research will be undertaken as part of the implementation of working with cancer.

Cancer treatment can impact physical and emotional health. In a UK study, 57% of cancer survivors who were in work when diagnosed had to give up work or change their roles as a result of their diagnosis. Of these, 43% were not physically able to work and a quarter were not emotionally strong enough to work(25%).⁴ But getting people back to work successfully can be an important part of their recovery - a job can restore routine, stability, social contact and income. Fatigue is one of the most common side effects of cancer and its treatment.⁵ Fatigue is different for every cancer patient – some people experience fatigue a few days a month around

the time of treatment while others experience it on a daily basis. Fatigue affects individuals' physical functioning, causing emotional distress and making it difficult to concentrate. Small adjustments at work, such as providing additional short breaks for rest and exercise, can make a difference. Some cancer patients experience treatment-related cognitive impairment.

The typically mild form of cognitive change that some patients experience after chemotherapy is sometimes called "chemo brain". Even this mild change can affect memory and concentration levels and may make it difficult for a person to multi-task.⁶ For some people, a change in tasks or responsibilities may be part of the return-to work process. Support needs may be long-term. For some people, support may be needed over many years after the initial diagnosis as they continue to live with the physical and emotional impacts of cancer. For people living with metastatic cancer, the most advanced stage of cancer, support needs are likely to be ongoing. It's important for employers to take a holistic approach to support and not focus solely on the first few days or weeks after a person returns to work. Cancer patients may be unprepared for the full emotional and physical effects of their treatment. We know that very few patients are advised by health professionals about the impact cancer treatment may have on their ability to work.⁴ Yet, many cancer survivors want to regain a sense of control over their own health and wellbeing. For employers, this means providing access to information and tools that empower patients to self-manage their health and help them to tailor support that meets their individual needs (Harris P.,2014).

Employers report a level of complexity in managing employees' cancer-related needs beyond that associated with any other type of disease or condition. This complexity relates to the costs and definition of quality cancer care, the extensive number and array of services needed to support employees and their families when faced with a cancer diagnosis, and the multi-faceted role a benefit professional must play in assisting employees;(Jeremy Nobel, MD, MPH; Emily Sesser, MPH; Jennifer Weiss, MA; & Laurel Pickering, MPH October 2015)

Cancer survivorship research seeks to improve the physical, psychosocial, and economic outcomes of individuals who have a history of cancer. For working-age adults with cancer, work impairment may be one of the most burdensome consequences of cancer. Inability to return to work after cancer treatment, frequent or prolonged work absenteeism, or problems with work performance may have substantial economic impact on the survivor and her or his family.

Changes in work also may have substantial impact on self-esteem, quality of life, and social or family roles. Finally, work performance after cancer treatment may be a measure of recovery units own right (John F. et al., 2004).

A detailed assessment of work intensity, role, and content is important, because paid work is a complex process. Individuals may work full-time or part-time, seasonally or year-round; they may be self-employed and they may have concurrent jobs that impose different physical and cognitive demands. The impact of cancer on work function also can be complex. After diagnosis or treatment, individuals may be unwilling or unable to return to the job they held previously, yet they may be eager or compelled to work in some other capacity. Thus, simply reporting the proportion of patients who return to some form of paid work after cancer provides an incomplete assessment of the impact of cancer on work. Information about the type, amount, content, physical demands, and cognitive demands of work is helpful in assessing the work impact of cancer in a comprehensive way.

A comparison of aspects of work, such as hours worked, job duties, productivity, and attitudes about work, at multiple time points after the diagnosis of cancer may help identify the impact of cancer on work in both the short-term and the long term.

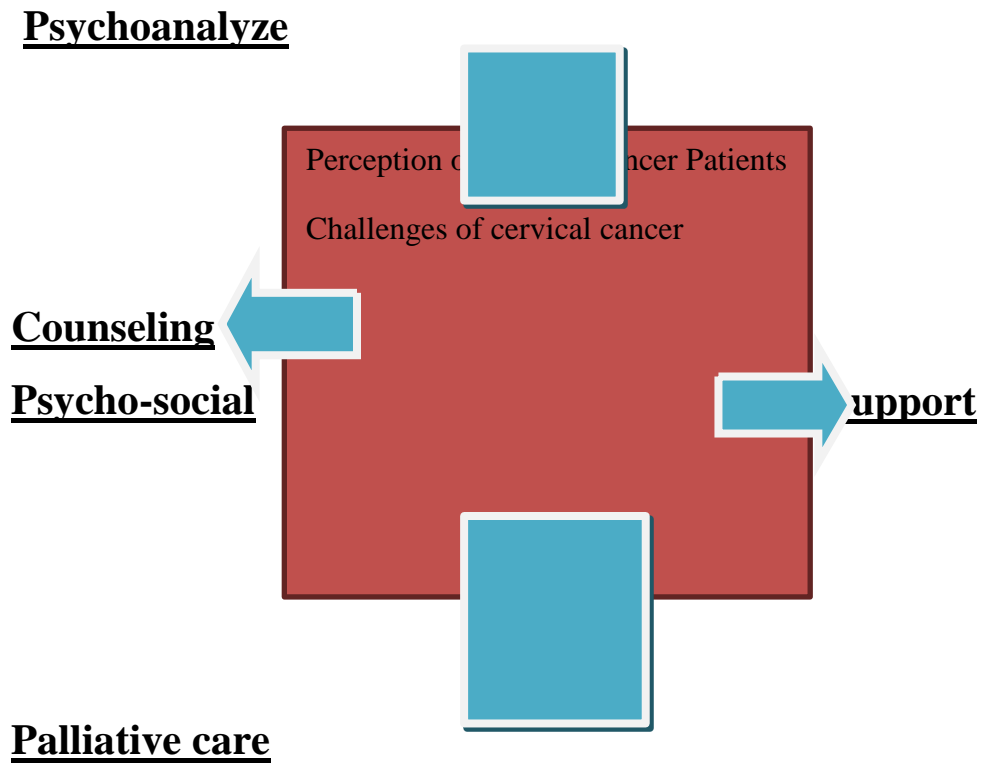
The impact of cancer on the economic status of the individual and the family should be assessed, because decisions about work after cancer are likely to be influenced profoundly by financial considerations. Individual income is an important part of this assessment. However, the income of spouses or of other family members who provide financial support for the patient and the potential economic impact on those family members or dependents also may be critical to the cancer survivor, the family, and society. Closely related issues, such as the amount of disability benefits to offset lost income, also should be assessed (John F. et al., 2004)

2.15. Theoretical Frame work of the study

On the basis of the literature and theoretical concepts of which described above in the study applied the following model for the research. In the context of the objective of the study, i.e., to asses views of cervical cancer patients on psycho-social support services of BLTH and its

challenges for palliative treatment in order to alleviating anxiety & distress and improving wellbeing of the patients , the research applied the following model.

Figure 2.1.1 Theoretical frame work of the study:



Source: Adopted from Literature

CHAPTER THREE

RESEARCH METHODOLOGY

3.1. Introduction

This chapter described about the procedures and strategies that were used in the study and it focuses on the research design, location of the study, the population and the sample size of the study, the source of data, the method used to collect and analyze the data and the method used to present the data.

3.2. Research Design

The study employed a descriptive survey design to assess the perception of cervical cancer patient's psycho-social support in Black Lion Hospital. This means the researcher took the number of interviewees' response out of percentage to quantify for each interview questions that related with the specific objectives. According to Lokesh(1984), descriptive research studies are designed to obtain pertinent and precise information concerning the status and phenomena whenever possible to draw valid general conclusions. This design was deemed appropriate that enabled the researcher to collect primary data from patients.

3.2. Research Methods

In order to achieve the research objective qualitative data analysis technique and descriptive approach had been adopted. The researcher used primary data collected through administrated interview survey tools to gather primary data from selected samples, and explained descriptively by taking similar responses summation of respondents.

3.2.1. Source of Data

In this study, the researcher used primary data collected through structured interview survey and quantified this in percentage based on the responses from samples. The structure of data collection systems have been concerned on the Black Lion Hospital cervical cancer patients.

3.2.2. Area of target Population

Black Lion specialize teaching Hospital is the largest hospital in Ethiopia in terms of patients it serve. Most of those cervical cancer patients come across the country visit the hospital for medication service. Because of the above reason the researcher of this stud select Black Lion Hospital cervical cancer patients as target population in order to address the objective of this study.

3.2.3. Sampling Techniques

In order to achieve this research objectives, the study were applied purposive and convenience sampling techniques; this was because the researcher focused on cervical cancer patients and psycho-social service supporters of Black Lion Hospital patients in convincing approach. The convenience approach purported the researcher to easily select samples from patients and support workers.

3.2.4. Sample Size

To determine the sample size, the study employed purposive sampling method and take the sample from Black Lion Specialized Teaching Hospital in Addis Ababa. The researcher takes a sample of 50 from all cervical cancer patients in black Lion specialized and teaching hospital. Due to homogeneity characteristics of the target population, it was not necessary to adopt large population. So that only 50 samples were taken as respondents.

3.2.5. Data Presentation and Analysis

Based on the interview responses and observation of the researcher the study thrived to quantify the data using frequency and percentage according to the given structured interview questions. Open ended interview questions like “how”, “Why”, demonstrated by the researcher on the basis of responses from selected samples.

3.2.6. Data Collection Instruments and procedures

The researcher used primary data collected through administrated interview survey tools to gather primary data from selected samples, and explained descriptively by taking similar responses summation of respondents.

Interview guide was prepared to collect data from purposively selected sample respondents at Black Lion Specialized Teaching Hospital in Addis Ababa. 50 cancer patients were interviewed about their perception regarding psycho-social support provided by the hospital to cancer patients. Each interview was conducted by the researcher taking about an hour for each respondent. The data was recorded and organized for analysis.

3.2.7. Validity and Reliability Test

3.2.7.1. Validity Test

To observe the validity test, the researcher applied content and constructive validity test which means, the content of interview questions were analyzed meticulously against with the objective of the study. This technique supports either the nature of the questions aligned with the specific objectives or not. In addition to this, constructive validity tests were conducted in order to examine carefully the nature of the literature relevance with the title and objectives of the study. This indicated that the study had a convergent validity with the concepts of literature.

3.2.7.2. Reliability Test

Reliability is consistency of measurement, Bollen, 1989, or stability of measurement over a variety of conditions in which basically the same results should be obtained, Nunn ally, 1978. For the sake of reliability test for qualitative descriptive study, the study applied test-retest approach using experimental type of approach, this means, the interview data taken by researcher and other interviewer for the same respondents and interview question, observed the similarity of their responses carefully.

3.3. Method of Analysis

Even if the study applied interview tools which were qualitative method of data gathering from respondents, the researcher attempted to quantify the described responses using frequency and percentage (descriptive statistics) based on the total sum of similar responses for the specific

questions. Regarding this, the researcher applied SPSS tools to measure a descriptive statistics analysis.

3.4. Ethical considerations

Participant were fully informed about the purpose of the study and consented verbally. Measures were taken to ensure respect, dignity and freedom of the respondent to assure confidentiality of the study. Participants were informed that the information they provided would be kept confidential and would not be disclosed to anyone else including the Hospital.

CHAPTER FOUR

DATA PRESENTATION AND INTERPRATION

The previous chapters of the study addressed the contextual, theoretical, and descriptive aspects of the paper. The study was intended to assess the perceptions of cervical cancer patients on psycho-social support in the case of Black Lion specialized teaching hospital. This chapter focused on the analysis of the field data and it examines the collected data in relation to the objectives of the study.

4.1. Response rate of respondents

The study used structured interview approach for 50 selected samples by applying convenience sampling techniques, so all respondents were interviewed and given their own responses.

4.1.1. Social-demographic characteristics of participants:

Table 4.1 Demographic Characteristics of Respondents

No	Variables	Characteristics	n=50	Percent
1		Female	50	100.00%
		Total	50	100%
2	Age	20-30	10	20.00%
		31-40	31	62.00%
		41 and Above	9	18.00%
		Total	50	100.00%
3	Educational Background	Illiterate	13	26.00%
		10 and 12 grade completed	14	28.00%
		Diploma graduates	7	14.00%
		Degree graduates	6	12.00%
		Masters graduates	10	20.00%
		Total	50	100%
4	Frequency of diagnosis	0-5 times	32	64.00%
		6 times and above	18	36.00%
		Total	50	100.00%

Above Table 4.1 indicated the demographic characteristics of respondents, according to the report from the total respondents, 50(100.00%) were “Female”. In addition to this, 10(20%), 31(62%), and 9(18%) were categorized under the age bracket of 20-30, 31-40, and 41 above respectively. Following this, the educational characteristics posited illiterate 13(26%), 10 and 12 completed 14(28%), Diploma holder 7(14%), Degree holder 6(12%), and master holder 10(20%).The frequency of diagnosis was 32(64%), from 0-5 times and 18(36%) diagnoses 6 times and above.

4.2. The Analysis of Interviewee Answer Related Questions

4.2.1. Questions related Psycho-social support of Black Lion Hospital for cervical cancer patients

Table: 4.2. Psycho-social support response

No	Variables	Characteristics	No respondent	%	
1	Psychological support	Yes	15	30.00%	
		No	35	70.00%	
		Total	50	100.00%	
2	Treatment is obtained mostly	Surgery /Medication	32	64.00%	
		Counseling	18	36.00%	
		Total	50	100.00%	
3	Counselors or social works				
	Counselors	Yes	3	6.00%	
		No	47	94.00%	
		Total	50	100.00%	
	or Social works	Yes	47	94.00%	
		No	3	6.00%	
Total		50	100.00%		
4	Stress level increase or decrease after you get psycho-social support	Yes	35	70.00%	Decrease of stress
		No	15	30.00%	
		Total	50	100.00%	
5	Counseling service provides a positive aspect	Yes	35	70.00%	
		No	15	30.00%	
		Total	50	100.00%	
6	Psycho-counseling for cervical cancer patients	Important	25	50.00%	
		Very important	10	20.00%	
		Not important	8	16.00%	
		Not very important	7	14.00%	
	Total		50	100.00%	

After the interview conducted for cervical cancer patients in Black Lion Hospital, their responses organized in tabular form . Since the research was qualitative the respondent attempted to quantify by taking similar responses. Accordingly, 35(70%) interviewees said that had no psychological support, and only 15(30%) said there was support. In the case of treatment obtained mostly in hospital, 32(64%) replied medication treatment whereas 18(36%) responded counseling treatment. For the case of workers either social or counselors, most respondents suggested they got service from social workers with figure of 47(94%), and the rest 3(6%) counselor. When the research analyzed, the stress level of patients after psycho support, 35(70%) replied decrease of stress, and 15(30%) increase stress level. For counseling service provides a positive aspect or not, most respondents 35(70%) suggested “yes”, and 15(30%) said “no”. For the sake of the importance of psycho counseling support for cervical cancer patient, 25(50%) posited important,10(20%) said very important, 8(16%) said not important and 7(14%) said psycho counseling for cervical cancer patient had no any high importance.

The result shows that the hospital provides medical terms like surgery and medication rather than giving proper counseling service to cervical cancer patients. The hospital does not have counselors or any social work that is responsible for those mental disorders. The diagnosis of cancer in any site has the potential to be a catastrophic, life- altering event. Immediate response usually focuses on existential issues of survival and impact on family and caregivers. There are number of patients in the hospital related to cervical cancer. This is pre-counseling for at list to 30 minutes which is not formal counseling. Some of the interviewee were come from other country like America and Europe and they attempt to share the experience of other country. They said that almost all the hospitals have social works or counselor who is provided psychosocial support for cervical cancer patients.

4.2.2. Questions Related How the Patients Perceive Cervical Cancer

Table 4.3; How patients perceive cervical cancer

No.	Variables	Characteristics	No. of respondents	%
1	How patients perceive cervical cancer	Through counseling	3	6.00%
		Through medication	27	54.00%
		Through surgery	20	40.00%
	Total		50	100.00%
2	Your life changes with these diseases	Yes	32	64.00%
		No	18	36.00%
	Total		50	100.00%
3	Your feelings emotions associated with having cervical cancer	Good	3	6.00%
		Not good	37	74.00%
		Neutral	10	20.00%
	Total		50	
4	There is a link between your life activities and cervical cancer	Yes	47	94.00%
		No	3	6.00%
	Total		50	100.00%
5	Being a cervical cancer patient changed your view for society	Yes	35	70.00%
		No	15	30.00%
	Total		50	100.00%
6	What are your main feeling and emotions associated with living with cervical cancer?	Good	26	52.00%
		Bad	17	34.00%
		No feeling	7	14.00%
	Total		50	100.00%

7	Do you think your life activity lead you to be a cervical cancer patient?	Yes	32	64.00%
		No	14	28.00%
		Not recognized	4	8.00%
	Total		50	100.00%

Table 4.3 above indicated how patients perceive cervical cancer. As seen in the report, most respondents perceive cervical cancers suggested that most of them, i.e., 27(54%) said that perceived cervical cancer through medication, 20(40%) through surgery time, and only 3(6%) perceived through counseling. For the sake of question that indicated either the diseases changes the life of patients, 32(64%) replied “yes” the diseases changed the life to the patients, whereas, 18(13%) suggested “no”, the disease had no changed life of the patients. Following this, the feeling of emotion patients toward the diseases (cervical cancer), most respondents 37(74%) suggested not good, 10(20%) said that neutral, and 3(6%) indicated well. For the sake of link between the disease (cervical cancer) and life of the patients, most respondents suggested “yes” with figure of 47(64%), and only 3(6%) said have no any link between the disease and life of them. In addition to this, for the question of “being cervical cancer” patients have changed view toward the society, 35(70%) said yes which means changed view toward the society, and 15(30%) replied “no”. The research also assessed the main feelings of patients that living with the cervical cancer”, 26(52%) replied the feelings were “good”, 17(34%) said “bad”, whereas, only 7(14%) suggested “neutral or no feelings”. For the final interview questionnaire, i.e., “your life activity lead you being cancer patient”, 32(64%) respondents said “yes”, 14(28%) replied “no”, and 4(8%) posited “not recognized”

Based on the report, the study implies that most of them responded that beyond the impact of the treatment and questions counseling prognosis, the legacy of being cancer patients is pervasive even for long- term survives, significant numbers report considerable distress associated with the fear of recurrence and adjustment to anew self-concept. Most of them have conceded that was kill them. They understood that it is a catastrophic and their life is totally changed with this pathology some of them were treat well by doing like minimizing stress balancing nutrition, visiting religious place.

4.2.3. Question Related To Psychological Challenges of Cervical Cancer on Patients

Table4.4 Psychological challenges of cervical cancer on patients

No	Variables	No. of respondents	%
1	What kind of diseases are patients exposed?	0	0.00%
	Physical sickness	12	24.00%
	Psychological sickness	15	30.00%
	Both physical and psychological sickness	23	46.00%
	Total	50	100.00%
2	What kind of diseases is it?	0	0.00%
	Permanent pain	20	40.00%
	Vaginal bleeding	3	6.00%
	Vomiting,	7	14.00%
	Sexual dysfunction	3	6.00%
	Bladder problem	2	4.00%
	Bowel problem	15	30.00%
	Total	50	100.00%
3	What kind of depressions has a cervical patient?	0	0.00%
	Sadness only	15	30.00%
	Helpless only	23	46.00%
	Both sadness and helpless	12	24.00%
	Total	50	
4	Does your health problem led to feelings of depression for you?	0	0.00%
	Yes	36	72.00%

No	14	28.00%
Total	50	100.00%

Table 4.4 above posited about the psychological challenges of cervical cancer on patients, according to the report, most respondents replied that the kind of disease that exposed due to cervical cancer was both physic and psychological with figure of 23(46%), 15(30%) replied exposed to psychologically, and finally only 12(24%) suggested that exposed to physically.

For the second question, i.e., what kind of disease is it due to cervical cancer? 20(40%) said permanent pain, 15(30%) replied bowel problem, 2(4%) replied bladder problem, 7(14%) suggested “vomiting”, 3(6%) indicated “vaginal bleeding” and “sexual dissatisfaction”. The next question which dealt about, what kind of depression has a cervical patient, 23(46%) said “helpless”, 15(30%) replied “sadness”, whereas 12(24%) posited both “sadness and helpless”. The final question, i.e., does your health problem lead to feelings of depression for you?” 36(72%) replied “yes”, whereas 14(28%) said “no”.

According to the response, the study has implication that is both physically and psychologically. Permanent pain, swelling, vomiting, sexual dysfunction, bladder problem, bowel problem and other problems are the challenges of cervical cancer physically. On the other hand stress, depression, intense anxiety is common psychological challenges of cervical cancer. Depression is common with cervical cancer victim. According to the response which is gain from interview most of the patients were sad and helpless and show low self esteem. They are not considering them serves equal with others and they are dreamless as a result they usually crying and hide their feeling from others and most of them are not good with their families. Some of them were married their spouse did not treat well them. More than half of them did not have children. The disease by itself didn’t give the chance to them to have a child. Some of the patients were blaming GOD, the society and their family. The others had traveled to holy water (tebel) in order to cure with worship. In contrary some of the patients were show strength, they have good relationship with their family. These group shows hope and they believe that they become cure with medical surgery or with the power of GOD. Although some of them not open enough to express what had happened on their life but could express verbally like showing sad face, not

responding any word crying, visiting toilet. The principal investigator also observed almost all of them need to cure immediately with any miracle.

4.2.4. Questions related how they can treat themselves cervical cancer

Table 4.5; Patients how treat themselves cervical cancer

No	Variables	Characteristics	No of respondents	%
1	Patients are treated themselves personally	Yes	17	34.00%
		No	33	66.00%
	Total		50	100.00%
2	In what ways and conditions patients are exposed to support themselves?	By reading psychological books	5	10.00%
		By requesting counseling workers	23	46.00%
		By injecting medicine or taking medicine tablets to themselves	12	24.00%
	Total		40	80.00%
3	What are other ways you use in order to cope with these health problems?	Continuous follow up with counselor	33	66.00%
		Self-spiritual treatment	6	12.00%
		With reading of psychological books	11	22.00%
	Total		50	100.00%
4	What were the effects of your health problem on your marital status?	Has negative effect	35	70.00%
		Has positive effect	3	6.00%
		Has no any effect	12	24.00%
	Total		50	100.00%

For the sake of question which focused on how patients treat themselves of cervical cancer, the report was disclosed in the Table 4.5. According to the report, for the question of patients are treated themselves personally, 33(66%) of respondents replied “yes”, which means most respondents were not treated themselves, however, only 17(34%) suggested “yes” which referred most respondents treat themselves. Next to this, about ways and condition for patients that are

exposed to support themselves, 23(46%) of them posited they treated themselves, by requesting counseling workers,12(24%) suggested by injecting medicine or tablets to themselves, and the rest 5(10%) said by reading psychological books. In addition to the above opinions, the respondents suggested their comments about ways to use in order to cope with these health problems, most respondent 33(66%) replied there were continuous follow up with counselor, 11(22%) said they treat themselves by reading of psychological books, and only 6(12%) respondents indicated self-spiritual helped to treat themselves. The final question which emphasized about, the effect of the cervical cancer on marital status of the patients, 35(70%) said the disease had negative effect on their marital status, 12(24%) said there was no any effect on their marital status, and only 3(6%) suggested there was positive effect on their marital status.

Based on the interview questions, the study implies that, where and when the patients are treated themselves personally. The comparison of cancer patients in different academic background, educational level, economic level and the family life style condition , despite of very little psychological support, such as group and individual therapy in Black Lion Hospital . These patients exposed to support themselves in different support need conditions. Psychological support has been found to reduce distress and show beneficial effects on anxiety and depression among patients with cervical cancer. Most of patients praying for their God to get cure and relief due to lack of available drug and methodology for pain management in poor countries particularly in Ethiopia, most of people with cervical cancer do not have access of pain relief.

CHAPTER FIVE

DISCUSSIONS

This study found that the hospital provided medical treatment like surgery and medication rather than giving proper counseling service to cervical cancer patients. The total number of respondents were 43 (86%) of patients were responded this question. Almost the entire respondent was got any kind of psychological support. The hospital does not have counselors or any social work that is responsible for those mental disorders. Cervical cancer is both physical and physiological disorder. The diagnosis of cancer in any site has the potential to be a catastrophic, life- altering event. Immediate response usually focuses on existential issues of survival and impact on family and caregivers. There are number of patients in the hospital related to cervical cancer. This is pre-counseling for at list to 30 minutes which is not formal counseling. Some of the interview were come from other country like America and Europe and they attempt to share the experience of other country. They said that almost all the hospitals have social works or counselor who is provided psychosocial support for cervical cancer patients.

On the other study Mosha et al, 2009 found that if cervical cancer is in its advanced stages before the patient receives any treatment, it is often fatal. As a result, cervical cancer causes more deaths annually than any other cancer among women in Tanzania, with an annual mortality rate of 32.5 per 100,000 women of all ages. Breast cancer and Kaposi's sarcoma are a distant second and third at 8.8 and 6.3 deaths per 100,000 women (WHO/ICO HPV Information Centre, 2010). The high prevalence of cervical cancer is an important issue that needs to be resolved because it has serious and long-lasting effects on its victims and on society. From 200 patients sampled at the Kilimanjaro Christian Medical Center (KCMC) out of 374 cervical cancer patients, 30% were discharged for palliative care and 17% died in the hospital (Mosha et al, 2009).

The result of this paper shows that cervical cancer has an impact on patients both physically and psychologically. Permanent pain, swallowing, vomiting, sexual dysfunction, bladder problem, bowel problem and other problems are the impacts of cervical cancer physically. On the other hand distress, depression, intense anxiety is common psychological impact of cervical cancer. Depression is common with cervical cancer victim. According to the response which is gain from interview most of the patients were sad, helpless and show low self-esteem.

They are not considering themselves equal with others. They are dreamless. They are usually crying and hide their feeling from others. Most of them are not good with their families. Some of them were married and their spouse did not treat them well. More than half of them did not have children.

The disease by itself did not give the chance to have a child. Some of the patients were blaming GOD, the society and their family. The others had traveled to holy water (tebel) in order to cure with worship. In contrary some of these patients show strength, they have good relationship with their family. These group shows hope and they believe that they become cure with medical surgery or with the power of GOD. Although some of them not open enough to express what had happened on their life but could express verbally like showing sad face, not responding any word crying, visiting toilet. The principal investigator also observed almost all of them need to cure immediately with any miracle. Finally this study found that Based on the interview provided patients were responded patients were responded the following idea. These research questions were questions which are acquainted together. Almost all questions were expressed about how where and when the patients were treated themselves personally.

According to the respondents, aside from their pain relief, the needs of cancer patients were vary accordingly with their life style. The comparison of cancer patients in different academic background, educational level, economic level and the family life style condition. These patients exposed to support themselves in different support need conditions. Psychological support has been found to reduce distress and show beneficial effects on anxiety and depression among patients with cervical cancer. Most of patients praying for their God to get cure and relief due to lack of available drug and methodology for pain management in poor countries particularly in Ethiopia, most of cervical cancer patients do not have access of pain relief.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1. Conclusions

Based on the major findings of the study the following conclusion has been made. This study implies that the hospital provides medical terms like surgery and medication rather than giving proper counseling service to cervical cancer patients. The hospital does not have counselors or any social work that is responsible for those mental disorders, and it has no had counseling service or any other alternative to help cervical cancer patients psychologically.

Cancer patients especially the majority of cervical cancer patients who came in this hospital for evaluation and treatment are in complicated last stages or in metastatic stage. Thus their physical and mental capacity to get and have behavioral change though process of counseling service is poor. In addition to this the hospital don't have suitable counseling service center and professionals to help those victims and to build their future hope about healthy life. Most of them have conceded that was kill them. They understood that it is a catastrophic and their life is totally changed with this pathology some of them were treat well by doing like minimizing stress balancing nutrition, visiting religious place.

The legacy of being cancer patients is pervasive even for long- term survives significant numbers report considerable distress associated with the fear of recurrence and adjustment to anew self concept and permanent pain, swallowing, vomiting, sexual dysfunction, bladder problem, bowel problem and other problems are the challenges of cervical cancer physically. The comparison of cancer patients in different academic background, educational level, economic level and the family life style condition , despite of very little psychological support, such as group and individual therapy in Black Lion Hospital.

The cervical cancer patients are not considering them serves equal with others and they are dreamless. As a result they usually crying and hide their feeling from others and most of them are not good with their families. Some of them were married their spouse did not treat well them and more than half of them did not have children, therefore they were blaming GOD, rather than the society and their family. In contrary some of the patients were show strength, because of good relationship with their family.

Although some of them not open enough to express what had happened on their life but could express verbally like showing sad face, not responding any word crying, visiting toilet. The principal investigator also observed almost all of them need to cure immediately with any miracle.

The comparison of cancer patients in different academic background, educational level, economic level and the family life style condition , despite of very little psychological support, such as group and individual therapy in Black Lion Hospital . These patients exposed to support themselves in different support need conditions. Psychological support has been found to reduce distress and show beneficial effects on anxiety and depression among patients with cervical cancer. Most of patients praying for their God to get cure and relief due to lack of available drug and methodology for pain management in poor countries particularly in Ethiopia, most of people with cervical cancer do not have access of pain relief.

6.2. Recommendations

In order to give efficient and effective service to those patients in Black Lion Hospital it is important to have basic counseling service department with skilled and professional counselors. Cancer patients seek great psychological supports besides medical treatment. Basic facilities to address those services should give priority and conduct side by side with treatments and medications. By considering the severity of the cervical cancer Black Lion Hospital should care and create awareness for its patient when they are newly diagnosed, and how they cope during and after treatment.

Further investment in symptom awareness campaigns requires in order to ensuring earlier diagnosis, to encouraging women to attend cervical screening when they invited, to create awareness on the society in general and women's in particular, to reduce time and cost of treatment and finally it is important to create productive work force in the society by taking care their health status.

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APPENDIX

Addis Ababa University
College of Educational and Behavioral Studies
School of Psychology
Department of Counseling

Dear Respondents;

I am currently pursuing my Masters of Counseling Psychology (MCPSY) at the Addis Ababa University. As partial fulfillment towards the completion of my postgraduate degree, I am undertaking research on the Perception of Cervical Cancer Patients about Psycho-Social Support at Black Lion Specialized Teaching: Implication of Counseling. Hence, I kindly request you to answer the interview while assuring that information you provide will be treated with confidentiality and shall only be used for the purpose of this academic research. I would like to remind you that your fair and impartial feedback will make the research a very successful one.

Thank you for your cooperation & Assistance in advance sincerely;

Yenewid Gebeyehu

1. Sex: A. Female
2. Educational Background
A. Illiterate B. 10 and 12 grade completed
C. Diploma graduates D. Degree graduates
E. Masters graduates
3. Age:
A. 20-30 B. 31-40 C. 41 and above
4. Time of diagnosis
A. 0-5 B. 6 and above

Part II: Interview Questions related to the main subject of the research.

Structured Interview Questions for Cervical cancer Patients

Question N^o 1 Related to psycho-social support of Black Lion Hospital for cervical cancer patients:

1. Is there a psychological support for cervical cancer patients especially after screening and diagnosis?

2. What kind of treatment is obtained mostly? Is it surgery and medication rather than giving proper counseling service to cervical cancer patients?

3. Have you any counselors or social works that are responsible for those mental disorders?

4. Does your stress level increase or decrease after you get psycho-social support?

5. Do think this counseling service provides a positive aspect in the construction and maintenance of self-esteem?

6. How is important psycho-counseling for cervical cancer patients?

Question N° 2. Questions related how the patients perceive cervical cancer.

1. How patients perceive cervical cancer?

2. Do you believe that your life changes with these diseases? If it is so, what are the changed factors?

3. What are your feelings candy emotions associated with having cervical cancer?

4. Do you think that there is a link between your life activities and cervical cancer?

5. Being a cervical cancer patient changed your view for society?

6. How has your attitude to life changed since you are a victim?

7. What are your main feeling and emotions associated with living with cervical cancer?

8. Do you think your life activity lead you to be a cervical cancer patient?

Question N° 3. Question related to psychological challenges cervical cancer on patients:

1. What kind of diseases are patients exposed? Is it harmful both physical and psychological?

2. What kind of diseases is it? Is it Permanent pain, vaginal bleeding, vomiting, sexual dysfunction, bladder problem, bowel problem and other problems are the impacts of cervical cancer physically?

3. What kind of depressions has a cervical patient?

4. Does your health problem led to feelings of depression for you?

5. Has cervical cancer your role in your family?

6. Do you think cervical cancer patients stigmatized?

7. How did it affect your relationship to your friends and your social life?

8. To what extent has your standard of living/ life style been affected?

9. Does being a cervical cancer patient has an challenges on your emotional psyecology health?

Question N^o 4. Questions related how they can treat themselves cervical cancer patients:

1. How, where and when the patients are treated themselves personally?

2. In what ways and conditions patients are exposed to support themselves?

3. What are the resources you use in order to cope with these health problems?

4. What were the effects of your health problem on your marital status?

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Thank you for your devotion to answers these interviews.