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# The Interplay of Health Communication and Motivation in Women Living with HIV undergoing Precancerous Treatment: in the Case of Menelik II Comprehensive Specialized Hospital

Yemisirach, Hailu

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**BAHIR DAR UNIVERSITY**

**Faculty of Humanities**

**Department of Journalism and Communication**

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**By:**

**Yemisirach Hailu**

**August, 2024**

**Bahir Dar**

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# The Interplay of Health Communication and Motivation in Women Living with HIV undergoing Precancerous Treatment:in the Case of Menelik II Comprehensive Specialized Hospital

By:
Yemisirach Hailu

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of Masters of Arts in Media and Communication

**Advisor:**
**Negesse Belay (PhD)**

August, 2024

BAHIR DAR

# Declaration

This is to certify that the thesis entitled "The Interplay of Health Communication and Motivation in Women Living with HIV undergoing Precancerous Treatment:in the Case of Menelik II Comprehensive Specialized Hospital ", submitted in partial fulfillment of the requirements for the degree of Master of Art in Media and Communication of Department of Journalism and Communication, Bahir Dar University, is a record of original work carried out by me and has never been submitted to this or any other institution to get any other degree or certificates. The assistance and help I received during the course of this investigation have been duly acknowledged.

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## Approval of Thesis for Defense

I hereby certify that I have supervised, read, and evaluated this thesis titled “The Interplay of Health Communication and Motivation in Women Living with HIV undergoing Precancerous Treatment:in the Case of Menelik II Comprehensive Specialized Hospital” by Yemisirach Hailu Menigistu prepared under my guidance. I recommend the thesis be submitted for oral defense.

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| Advisor’s name | Signature | Date |
| Department Head | Signature | Date |

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## Faculty of Humanities

## Department of Journalism and Communication

## Approval of Thesis for Defense Result

As members of the board of examiners, we examined this thesis entitled “The Interplay of Health Communication and Motivation in Women Living with HIV undergoing Precancerous Treatment:in the Case of Menelik II Comprehensive Specialized Hospital” by Yemisirach Hailu Menigistu. We hereby certify that the thesis is accepted for fulfilling the requirements for the award of the degree of “Masters of Arts in Media and communication”.

**Board of Examiners**

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# Dedication

To the muse of my life, Hailu Menigistu, and the ineffable mom, Fasika T/Mariam.

# Acknowledgment

My most humble and sincere thanks to:

First and foremost, the omnipotent for bearing with me from dusk till dawn and for baptizing me with abundant blessings.

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All fellows from Bahir Dar and Addis Ababa.

# Abstract

*The study aimed to examine the interplay of health communication practices and motivation for cervical cancer early detection and treatment in Women Living with HIV: in the focus of Menelik II Comprehensive Specialized Hospital. This study assessed the impacts of communication at different levels for sustainable behavioral change: uncovered the health communication practices that were implemented to prevent and control cervical cancer for Women Living with HIV in the hospital setting and pinpointed how the socio-ecological factors interact with the motivational aspects that shape the women's experiences and behavioral change in relation to precancerous treatment. A qualitative study approach and explanatory research design were deployed to address the above objectives of the study. Data were collected through individual in-depth interviews and focus group discussions. A purposive sampling technique was deployed to select client participants((Women Living with HIV) and discussants(Women Living with HIV) and the health facility. Similarly, a convenience or availability sampling technique was utilized to select healthcare providers for the individual in-depth interview. Therefore, 9 participants (7 clients and 2 healthcare providers) for the individual in-depth interview and 12 clients' for the focus group discussions were included as participants of this study. The data gathered utilizing the above instruments were organized and analyzed thematically with the guiding spirit of Self-determination theory and the Socio-Ecological model. Unlike other studies by some researchers, this study's findings revealed that Women Living with HIV in Menelik II Comprehensive Specialized Hospital are not exposed to awareness campaigns or health education even though they are close to the healthcare system. It has rigorously increased misconceptions about the disease. As a result, it highly dictates the women's autonomy to undertake screening and their sustainable behavioral change; clients' relatedness in patient-provider communication, and their competence. In line with this, the study reveals the underutilization of participatory activities at the health facility. In addition, cultural norms related to culture, religious beliefs, and traditional medicine are impacting women's intrinsic motivation a concept that revolves around better learning, performance, and well-being. In line with this, the study reveals that cultural norms, autonomy support, and emotional support impact patients' preference for the gender of the health professional and their relatedness with female healthcare providers and competence for sustainable behavior change. Organizational factors related to insufficient human resources, training opportunities, functionality, and lack of equipment impact health outcomes, clients' autonomy, and the communication environment are the other findings of this study. However, room comfort and medical navigation service from ART(Antiretroviral Therapy)clinic show good implications for the clients'(Women living with HIV)intrinsic motivation. Therefore, the health communication practices at the multilevel influences possess a significant gap. Besides, patients' intrinsic motivation and identified regulation, which are the linchpin for effective health outcomes and sustainable behavior change are overlooked. In the same vein, due to the missed opportunities to utilize effective and well-designed communication approaches and strategies, patients are highly dependent on external regulation level of motivation. In conclusion, the results lead us to conclude that the health bureau and the health facility's communication office should frequently implement SWOT(Strength Weakness Opportunity Threat) analysis to design social and behavioral change communication for health promotion.*

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# Acronyms and Abbreviations

AIDS: Acquired Immunodeficiency Syndrome

ART: Antiretroviral Therapy

BCC: Behavior Change Communication

CBPR: Community-Based Participatory Research

Cx Ca: Cervical Cancer

C4D: Communication for Development

C4U: Competitive Creative Design

CDC: Center for Disease control and Prevention

COVID-19: Coronavirus Disease 2019

FGD: Focus Group Discussion

HIV: Human Immunodeficiency Virus

HPV: Human papillomavirus

ICAP: International Center for Aids Care and Treatment Program

IEC: Information, Education, and Communication

IDI: In-depth Interview

IRB: Institutional Review Board

LEEP: Loop Electro Surgical Excision Procedure

NCD: Non-communicable Disease

NGO: Non-governmental organizations

PAP: Papanicolaou Smear Test

PR: Public Relations

SBCC: Social and Behavior Change Communication

SWOT: Strength Weakness Opportunity Threats

WHO: World Health Organization

WLHIV: Women living with HIV

# Chapter One: Introduction

The first section of this chapter quotes earlier research findings of different scholars about the burden of cervical cancer in various contexts. The part on the problem statement that follows is based on the literature and other earlier research. Thereafter, the study's aim, its scope, limitations of the study, and the operational definitions of terms are positioned.

## 1.1.Background of the study

Research on health communication is rich, fascinating, and pertinent since it explores and clarifies the various ways that human and mediated communication impact health care and health promotion outcomes (Kreps, 2001). Health communication is becoming increasingly recognized as a crucial and pertinent field of study for addressing pressing healthcare and health promotion issues in academia, the healthcare delivery system, and major public health policy centers like the National Institutes of Health and the U.S. Centers for Disease Control and Prevention (Rogers, 1994).

Ibrahima and Logarajb (2021) explored that after diabetes, in recent years cancer has been the prominent cause of morbidity and mortality among non-communicable diseases. Getahun et al., (2013) define "women's reproductive cancers" as malignancies occurring in the female reproductive system, including the development of cervical cancer from malignant neoplasms. The high prevalence of cervical cancer is related to n factors such as early sexual activity, multiple partners, HIV infection, history of STIs, HPV infection, smoking, inadequate resources for early detection, and low HPV vaccination rates as attributed by( Arbyn et al., 2020). Unlike other cancer types and reproductive organ cancers cervical cancer is highly preventable and treatable(FMOH,2021). Likewise, WHO(2020) emphasizes the preventability and treatability of cervical cancer through early detection and efficient screening, with the importance of service accessibility and community awareness in facilitating increased screening. Having said that, Stelzle et al., (2021) highlight the role of HPV. This virus causes the development of cervical cancer, in most cervical cancer cases and the amplified risk faced by women living with HIV, particularly in Sub-Saharan Africa.

The global burden of cervical cancer is considerable, with an escalating incidence of new cases reported annually. Disparities in prevention and control efforts between low- and middle-income countries and developed nations are significant, as acknowledged by Oketch et al., (2019). Furthermore, Akanda et al., (2022) underscore the presence of policies addressing various aspects of cervical cancer prevention, with primary and secondary prevention being more frequently addressed. Howlader et al., (2014) note the declining incidence of cervical cancer in developed nations due to HPV vaccination and systematic screening. However, challenges related to health facilities and individual perceptions regarding screening persist, as identified by Ndejjo (2016). Zhang et al., (2021) observe decreasing trends in global cervical cancer incidence and mortality with a substantial regional imbalance. This emphasizes the urgent need for more effective prevention and management strategies to address cervical cancer as a significant public health issue. Yang et al., (2022) highlight differences in lifetime screening rates between women living with and without HIV, underscoring the need for improved screening strategies.

In Ethiopia, cervical cancer is the second most commonly diagnosed cancer among women, leading to an estimated 4700 deaths annually. The incidence of cervical cancer is rising, with over 6000 new cases and 4700 fatalities reported each year. Additionally, access to screening services and awareness of the disease is limited among women in Ethiopia. Only one in every seven eligible women undergo cervical cancer screening, which is significantly lower than the WHO recommendations.

## Communication Landscape

Dickson et al., (2023) identified physical barriers as the main factor contributing to the low prevalence of cervical cancer screening in several Sub-Saharan African nations. They also noted the influence of education, age, contraceptive use, media exposure, and STI status on screening rates. In addition, Giulia et al.,(No date) emphasized the importance of improving health communication in Africa through community-based and culturally appropriate strategies. Fayoyin (2016) highlighted the potential of creative communication techniques and digital media in addressing public health challenges in Africa. CBPR strategies were recognized as beneficial in underprivileged communities, fostering community participation and mitigating mistrust of researchers, as noted by Seay et al.,(2015) and Habila et al.,(2021) However, questions remain about the effectiveness of CBPR in addressing the lack of knowledge about cervical cancer in African populations.

With respect to cervical cancer and the communication landscape, the literature highlighted various communication barriers contributing to the underutilization of cervical cancer screening and precancerous treatment. These barriers include limited resources, lack of knowledge, restricted access to healthcare, individual and cultural contexts, fear, stigma, and cultural pressures, as outlined by Kutto (2014) and McDonald and Sherlock (2016). Desta et al., (2021) noted Ethiopia's efforts in cervical cancer screening and advocacy, emphasizing the critical need for early detection programs. Kebede et al., (2024) underscored cultural, socio-economic, and perception-related barriers, stressing the importance of creative, culturally conscious, and community-based interventions. Furthermore, Ford et al., (2005)emphasized the need for promoting accountability and behavioral change in addition to enhancing comprehension. They advocated the principles of "inclusion, participation, and self-determination" as essential for empowering individuals to take charge of their health.

## 1.2. Statement of the problem

Several quantitative and some qualitative research were conducted considering the issue of cervical cancer early detection and diagnosis of WLHIV as well as HIV-negative women. Concerning communication, a wide range of communication problems in the management of cervical cancer was highlighted by Kutto (2014). Lack of sufficient information, cancer-related myths that discourage discussion, fear of screening or certain treatment procedures, stigma, cultural pressures against talking about reproductive health, taboo, media use for campaigns to raise awareness, language barriers that cause miscommunication between rural women and medical professionals, and a lack of participatory communication are some of the reasons for this. In a similar vein, McDonald and Sherlock's (2016) assumptions seem to be well-grounded about the growing number of patients who want to be involved in decision-making rather than merely having more educated conversations with doctors, which is evidence that patient expectations are rising.

In the case of Ethiopia, unfortunately, few studies have emphasized communication in Ethiopian cancer care. Therefore, the recommended researches that look at the communication challenges encountered by physicians, patients, and family caregivers must be conducted to compromise the needs of several patients and the scarcity of available resources. More recent evidence Desta et al.,(2021) highlight that the government of Ethiopia launched a cervical cancer screening service and has given more emphasis on programs focusing on the early detection of cervical cancer using advocacy efforts by different stakeholders such as academia, professionals, media, and partners. However, the prevalence of cervical cancer remains a major problem, and it is one of the leading causes of morbidity and mortality among women in the country.

In the same vein, Mengistu et al.,(2022) outline that in Ethiopia, pre-cervical cancer lesions in women were linked to several characteristics. Birhanu et al., (2012) proposed the insidious nature of the disease, as well as individual-level, community-level, and institutional-level characteristics, have all been recognized as interrelated hurdles and challenges for early health-seeking behavior for cervical cancer in Ethiopia. In the same vein, a qualitative study about the experience of patients with cervical cancer treatment by Burrowes et al., (2022) showed that providers confront considerable training and health system barriers that hinder them from providing care and that patients experience bottlenecks and delays at every stage of care primarily because of health system weaknesses and poor patient-provider communication.

The extant literature within the public health domain predominantly comprises quantitative research studies focusing on Women Living with HIV (WLHIV) and their engagement with cervical cancer screening and treatment. These studies often center on constructs such as perceived severity, susceptibility, benefit, and health-seeking behavior, frequently utilizing the Health Belief Model as a theoretical framework. Research by Kebede et al., (2024) has delved into these aspects using the Health Belief Model, exploring perceived barriers, predictors, and facilitators to cervical cancer screening in separate studies by various researchers (Kebede et al., 2024; Gebrekirstos et al., 2022; Mpata and Nkosi, 2021; Moucherad et al., 2020; Erku et al., 2017;). While research by Musuka et al., (2022) and Moucherad et al., (2020) has emphasized knowledge, attitude, and belief related to screening; Wigfall et al., (2017) have focused on patient-provider communication. Notably, these studies have been conducted in isolation, lacking a comprehensive and integrated approach, meaning they lack assessing factors at a different level, how they impact each other, and how they impact clients' behavior and motivation.

In the same vein, existing local studies predominantly conducted by public health professionals have primarily focused on patients' knowledge, attitude, awareness, and satisfaction, neglecting sustainable health outcomes such as medication adherence and consistent follow-up that mainly stem from motivation and autonomy. In line with this, while individuals exhibit a notable hesitancy towards undergoing cervical cancer screenings, citing a myriad of reasons and factors, the existing research or longitudinal research only emphasizes identifying the factors that hinder the individual’s health-seeking behavior and neglects the concept of motivation that can be fostered or undermined by the communication landscape that exists at a different level. Blackwell (2020) studied the perceived barriers to early detection and treatment of Ghanaian women using the social-ecological framework and the study's findings revealed that different problems exist at individual, interpersonal, community, organizational, and policy levels. However, this study required introspecting the communication and motivation aspects.

In line with this, et al., (2021) insisted that research can be conducted on a variety of subjects, including the social and cultural contexts that influence how health campaigns are implemented as well as people's cognitive and emotional responses to communications about health. Interpersonal communication (IPC) may also be used to facilitate direct communication between a patient and a medical provider. Despite the presence of foreign and local research on patient-provider communication and behavior change in the context of cervical cancer, gaps persist. Getnet and Getachew (2019) stated the role of communication is to create a receptive and favorable environment in which information can be shared, understood, absorbed, and discussed by the intended audiences. Likewise, Freimuth and Quinn (2004) posited that health communication is an essential tool for achieving public health objectives, including facilitating and supporting behavioral change and eliminating health discrepancies.

With respect to motivation and participatory communication, Ford et al., (2005) highlighted the limitations of solely enhancing comprehension, emphasizing the need for accountability and behavioral change through self-determination. The guiding principles of "inclusion, participation, and self-determination" help overcome the main issues by simply increasing comprehension of why a particular health behavior is improper. These issues with simply increasing comprehension include the fact that awareness alone does not hold people accountable for their health. By addressing the many communication channels to be used and jointly identifying goals for desired change, it is possible to give individuals a voice in how health information can help them change.

With bearing in mind what has been studied, the researcher posits that introducing the concept of self-determination within the healthcare system can expedite cervical cancer elimination goals. Participatory communication, as advocated by McDonald and Sherlock (2016), plays a pivotal role in fostering patient self-management and driving consistent behavioral change through effective communication. Furthermore, community participation and engagement are considered crucial for sustaining disease prevention efforts and enhancing health outcomes

All in all, despite the existing body of research, there remains a dearth of studies examining WLHIV's experiences with precancerous treatment from a health communication perspective that dictates individual behavior change in Ethiopia. Therefore, this study aims to address this gap by examining current communication practices across different levels of interaction and their impact on individual behavior. By identifying and addressing critical issues, this research endeavors to bridge existing literature gaps and insights into the multilevel influences related to women's motivation in cervical cancer early detection and treatment. Therefore, this study examined the interplay of health communication and motivation in women living with HIV undergoing precancerous treatment in the case of Menelik II Comprehensive Specialized Hospital.

## 1.3. Objective

This study will be conducted based on the following general and specific objectives.

### 1.3.1. General objective

The general objective of this study was to explore the nexus between health communication and motivation in Women Living with HIV undergoing precancerous treatment in particular reference to Menelik II Comprehensive Specialized Hospital.

### 1.3.2. Specific objectives

The study specifically aimed to:

- to assess the influences of communication on health outcomes at multiple levels of interaction (individual, interpersonal, community, and organizational) for sustainable behavioral change of WLHIV at Menelik II Comprehensive Specialized Hospital

- uncover the health communication practices at different levels that were implemented to prevent and control cervical cancer for WLHIV in the hospital setting
- pinpoint how the socio-ecological factors interact with the motivational aspects that shape the women's experiences and behavioral change in relation to precancerous treatment

## 1.4. Research questions

1. How do the communication practices at different levels promote or undermine sustainable behavioral change of WLHIV at Menelik II Comprehensive Specialized Hospital?
2. What health communication practices were being enacted for cancer screening and treatment for WLHIV at Menelik II Comprehensive Specialized Hospital?
3. What are the factors that are related to motivation for screening, sustainable behavioral change, and effective health outcomes?

## 1.5. Significance of the study

Investigating the interplay of health communication and motivation in women living with HIV undergoing precancerous treatment at Menelik II Comprehensive Specialized Hospital could have conceptual and practical inputs for practitioners and to the existing literature. Formerly, this study will add a spark of insight from the communication aspect, to the medically dominated existing literature of cervical cancer. Even though, public health researchers suggest the necessity of integrating health communication in general and participatory communication and research in particular, scant resources are still available. Therefore, this study is hoped to provide deeper insights into the issue of the interplay of patient-provider communication, participatory communication, health promotion, and cervical cancer prevention and control that in turn extends the existing literature.

In light of this, this study is expected to benefit health professionals as well as communication professionals. Health professionals will garner information about their patients' preferences, desires, and challenges to be effective communicators with their patients at a practical level, particularly in diseases that are detrimental but overlooked. In line with this, the target audiences will be the ones who will benefit the most, for they are the primary source of information in this investigation and consumers of the services.  Moreover, the researcher hopes to add some value for PR officers at the health facility by giving insight into the design of social and behavioral communication strategies and placing more emphasis on participatory communication at the facility level by either utilizing CBPR strategies or by utilizing community mobilization.

Taking this into account, investigating the inclusion of ecological factors through participatory communication will benefit public health bureaus while conducting a situational analysis for social and behavioral change communication research. Since Menelik II Comprehensive Specialized Hospital is administered by the Addis Ababa City Administration health bureau, the health bureau will get a spark of information to design target-tailored SBCC strategies for cancer prevention and control using this research's findings as input for situation analysis. The health bureau could consider the findings of the current study while preparing strategies, annual plans, and training materials and modify the delivery of the training.

Last of all, this study can also be utilized by other professionals and NGOs that work on women's health care issues, to consider target group-oriented communication strategies or SBCC in their plans or to adopt some of the ideas that relate to their context. Moreover, future researchers who are interested in conducting action research or intervention programs can use this research as a point of reference and as a springboard material. Finally, yet importantly, it will be expected to provoke more research works in health communication initiatives in Ethiopia and provide information for other scholars conducting studies on women's health communication.

### 1.6. Scope of the study

This study aims to examine the interplay of health communication and motivation in women living with HIV undergoing precancerous treatment at Menelik II Comprehensive Specialized Hospital. Its aim is delimited to the investigation. Enactments of interventions are not part of this study. Apart from this, in this study an urban setting, i,e. Addis Ababa City is taken as a research site. Essentially, this study was conducted at Menelik II Comprehensive Specialized Hospital.

The basis for selecting the facility was based on an assessment made by the researcher prior to commencing the data collection task. During the assessment, the researcher discovered that Menelik II Comprehensive Specialized Hospital, among other federal health facilities administered by the Addis Abeba City Administration Health Bureau. It provides Cx Ca screening and pretreatment services. Furthermore, the researcher chose this facility since it was convenient for accessing information.

Methodologically, the researcher deployed a qualitative approach due to the nature of the research questions as the research questions can be addressed through deeper investigation. Theoretically, self-determination theory and socio-ecological model were used as a backdrop of this study in order to align the health concept with the communication aspect. Conceptually, this study assesses the communication landscape at intrapersonal, interpersonal, community, and organizational levels. Besides, it addresses factors and communication interventions at interpersonal, community, and organizational level and their impact on individual behavior change.

## 1.7. Limitation of the study

This research focused on assessing the interplay of health communication and motivation in women living with HIV undergoing precancerous treatment at Menelik II Comprehensive Specialized Hospital. Since the research is a qualitative study that takes WLHIV as participants in the study, some of the findings may not be representative of the wider and diverse experience of other women (HIV-negative women). Furthermore, due to the nature of the study, time frame and financial constraints prevented the researcher from including other health facilities administered under the health bureau.

## 1.8. Operational definitions of terms

Various academics may have different definitions for the vocabulary and concepts listed below. Nevertheless, I believe that in this particular case, the operational definitions offered below are consistent with the theoretical and methodological underpinnings on which this study is built.

**Health:** Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (World Health Organisation [WHO], 1948: 100).

**Health Communication**:: in a more general sense, it refers to all aspects and modes of communication that take place within medical contexts or broadly relate to the subject of health and illness (Harvey & Adolphs, 2012, p. 470). In the case of this study, it refers to a mode of communication that involves community engagement for sustainable behavior change and to improve health outcomes in the process of mitigating non-communicable diseases, such as cervical cancer.

**Participatory health communication:**: the process of involving and engaging community members actively in cleaning and protecting their environment from discriminatory human and household waste disposal activities (Meisner, 2009). In the case of this study, it refers to empowering patients taking precancerous treatment to actively engage in social mobilization activities and decision-making, for consistent adherence to treatment and sustainable follow-up.

**Sustainable behavior change:** a long-term behavioral change that is sustained over time and results in favorable environmental, social, and economic effects, accomplished through a mix of individual motivation, societal influence, and structural support (Linden et al., 2021). This definition emphasizes not only individual dedication but also the significance of social and structural forces in promoting long-term change. In the case of this study, **it represents** positive healthcare-seeking behavior and attending follow-ups.

**Disease prevention:** refers to performing knowledge-based activities ahead of time so as 'to make the subsequent progress of the disease improbable' (Figueira et al., 2009, p. 2). In the case of this study, refers to the early detection of non-communicable diseases (cervical cancer) by developing and improving self-determined behavioral change and by considering ecological factors.

**Patients or clients:** McCoy et al., (2021) define patients as individuals seeking or receiving medical care, who engage in a therapeutic relationship with healthcare providers, and who actively participate in decision-making regarding their health and treatment options. In this study it infers, WLHIV taking precancerous treatment at the health facility

**Healthcare Providers or Health Professionals:** The World Health Organization (WHO)(2020) defined a healthcare provider as "any individual or institution that delivers health services, including but not limited to physicians, nurses, pharmacists, and allied health professionals, who play a critical role in the prevention, diagnosis, treatment, and management of health conditions. In this study, only refers to nurses who provide service for WLHIV at the health facility in some contexts and any healthcare provider in scholars' notions.

# Chapter Two: Review of Related Literature

In this section of the study, the pertinent literature of different scholars is included to provide a brief insight into the backdrops of the study. Literature is reviewed, starting from the holistic term health communication to the interpersonal level of communication (patient-provider communication). Moreover, the two backdrops of this study which are the self-determination theory (SDT) and the socio-ecological model are briefly explained in this chapter.

## 2.1. Health Communication

Getnet and Getachew (2019) claim that communication is essential in the health sector in general as it is a means by which information is imparted and shared with others. Like other sectors in health, information is fundamental to choosing and making informed decisions. Without information, there is no choice. Therefore, information helps with knowledge and understanding. The other important concept that can be derived from the definitions is the objective of communication to influence individuals and communities. The role of communication is to create a receptive and favorable environment in which information can be shared, understood, absorbed, and discussed by the intended audiences.

Health communication emanates from two terms: health and communication. Its definition has been given by different scholars. (Verwey & Crystal, 1998; Schiavo ,2013) describe health communication as the art and science of educating, influencing, and inspiring institutional and general audiences about significant health issues using solid scientific and ethical reasoning. Similarly, Parvanta et al., (2011) define health communication as the study and use of communication to inform and influence individual and community decisions that enhance health. Moreover, Smith and Hornik (1999) define health communication as a process for the development and diffusion of messages to specific audiences to influence their knowledge, attitudes, and beliefs in favor of healthy behavioral choices. Likewise, Freimuth and Quinn (2004) posited that health communication is an essential tool for achieving public health objectives, including facilitating and supporting behavioral change and eliminating health discrepancies.

Schiavo (2013) defines health communication:

> as a multifaceted and multidisciplinary field of research, theory, and practice concerned with reaching different populations and groups to exchange health-related information, ideas, and methods to influence, engage, empower, and support individuals, communities, healthcare professionals, patients, policymakers, organizations, special groups, and the public so that they will champion, introduce, adopt, or sustain a health or social behavior, practice, or policy that will ultimately improve individual, community, and public health outcomes(p,7).

Gupta et al., (2021) define health communication as a "combination of the domains of communication and health to improve individual and public health" (p,2). This can be delivered through verbal and written approaches blending with theories and models to influence and empower individuals, populations, and communities to make healthier choices and promote positive attitudes and behavior change. In all communication contexts, including interpersonal, group, and media dialogues, research on health communication provides us with models and approaches for promoting talks on health-related topics (Giulia et al., No Date).

Health communication occurs in a variety of contexts, according to Giulia et al., (No Date), including interpersonal interactions between patients and doctors, organizational health communication that describes a patient's experience in a hospital (or other healthcare facilities), and TV campaigns. It is crucial as a component of development communication. It is generally acknowledged to be a crucial element of any public health program. Communication is a key element in HIV prevention efforts like the ABC (Abstinence, Be faithful, use Condoms) credo. Given that the HIV/AIDS epidemic in Southern Africa frequently has a more detrimental effect on women than on men, sex relations are an essential contextual component of health communication. Women's empowerment, which gives them the power to change their precarious position in sexual encounters and negotiations, must be used to support preventative messaging. Since prevention and treatment are interrelated, health communication should address both. (Giulia et al., No Date.).

Understanding and appreciating the underlying issues that plague health communication is essential. The following are listed The development of a message intended to be received by the broader public must incorporate crucial elements such as coordinated messaging for a specifically specified subset of the audience, community involvement, and the socio-cultural makeup of the audience (Demissie, 2022).

In summary, health communication strategies must consider the socio-cultural makeup of the audience to ensure messages resonate effectively and promote relevant health behaviors, especially in vulnerable populations. The communication process is essential for the diffusion of health messages, influencing knowledge, attitudes, and beliefs that encourage healthy decisions and practices. Besides, effective health communication serves to inspire and educate individuals and communities, promoting an understanding that can lead to proactive health behaviors. For health communication to be effective, it must involve coordinated messaging, community participation, and an understanding of the unique challenges faced by specific audiences, thereby addressing broader public health objectives. In the experience of HIV prevention, communication plays a vital role, stressing the importance of women's empowerment in sexual health communication. This underlines the need for gender-sensitive approaches that support women's roles in negotiating safer sexual practices.

### 2.1.1. Evolution of Health Communication

According to Gupta et al., (2021), health communication arose from agricultural extension work, which was largely a field-based top-down publicity model of training cultivators on growing methods and weather. Over the last six decades, the field of health communication has progressed. The extension communication strategies used in agriculture provided a ready platform for people to learn about family welfare and planning. This information-based method did not encourage long-term community engagement or dialogue. The focus of health communication has shifted over time, from health promotion and education to behavior and social change. The fundamental facts are confirmed by research that shows how good communication encourages people to establish healthy routines, increasing demand for preventative therapies. According to studies, the AIDS response, which began in the 1980s when antiviral medications were unavailable and prevention could only be achieved via concerted social and behavioral change, played a crucial impact in the development of the discipline of health communication. It is worth noting that these early HIV prevention strategies for communication were reinforced by past communication experiences that increased child survival and supported family planning (Naugle & Hornik, 2014).

According to Gupta et al. (2021), over the last nearly 40 years, health communication has evolved from information, education, and communication (IEC) to behavior change communication (BCC), social and behavioral change communication (SBCC), and, most recently, risk communication and community engagement. IEC was designed to educate a target, with the underlying notion that by doing so, recipients would be less likely to engage in risky or harmful behavior and more likely to engage in the desired positive behavior. Given this, BCC supporters, information is often required but insufficient. BCC conducts contextually relevant formative research to identify the mechanisms that encourage, impede, and support behavioral change. BCC responds by employing a range of strategies aimed at encouraging people to change their behavior. The study of health communication focuses primarily on the use of communication theory, concepts, and techniques to improve public health services and create a better knowledge of how such systems work. Several methodologies have been utilized, and each represents an important study at various levels of analysis, including bio-psychosocial (Gupta, 2021).

Malikhao (2020) investigates communication techniques in the context of the multiplicity paradigm at the individual, interpersonal, and group/community levels. With this in mind, Ryan and Deci's (2002) Self Determination Theory is decided on an individual basis. This idea focuses on an individual's environment or the external factors that push them to change their conduct. The internalization process begins when someone is given the option to pick what is important to them via the socialization process and receives validation for their decision. This means that changing behavior requires more than just hearing messages; a supportive environment must exist to encourage healthy living choices. To increase a person's natural capacity to defend against health hazards and risky behaviors, interpersonal education and training in life skills are required. Training in intercultural competency is required for healthcare staff to relate to patients and community members. At the group and community level, social capital such as peer networks and support groups, combined with positive reinforcement, can aid in the transformation of negative behaviors. The PRECEDE/PROCEED Model, Ecological Models of Health Behaviour, theories of social networks, and theories of social support all share enabling environment characteristics, such as advocacy communication, participatory communication, and communication for structural and lasting social change.

## 2.2. Participatory communication

Scholars in health communication highlighted the process of engagement and empowerment as the essential first step in bringing about beneficial change (Gupta & Bansal, 2014), in line with the emphasis placed on people's engagement by communication practitioners (Schiavo et al., 2014), that is, bottom-up design models and empowering communities in fostering the desired "change". Prilutski (2010) recommends community integration as the most effective communication approach for emerging countries. The guiding concepts of "inclusion, participation, and self-determination" help to solve the main obstacles by simply improving understanding of why a specific health practice is inappropriate. These concerns with simply increasing comprehension include the fact that raising awareness does not hold people responsible for their health. Individuals can have a say in how health information can help them change by addressing the different communication channels that will be used and collectively setting goals for desired change (Ford et al., 2005).

Similarly, Suggs et al., (2015) regarded the levels of interpersonal, intrapersonal, group, organizational, and societal health communication as possible. The development of a message aimed at reaching the broad public is expected to incorporate valuable components such as coordinated communications for certain segmentation audiences, community involvement, and audience sociocultural makeup. To be effective, preventative, control, and mitigation interventions should focus on "community engagement, participation, and ownership, as well as inter-sectoral coordination and collaboration."

According to Gupta et al., (2021), national governments invest a significant amount of money on information-based, linear health promotion and awareness initiatives. As a result, it was observed that most countries continued to use mass media and mid-media tools in a top-down manner while failing to understand the potential of participatory and community-based media. However, as communication science has advanced, it has become obvious that the general public is more than a passive consumer of information, and that mass media alone cannot change people's beliefs, attitudes, or behaviors. This is especially true when the desired goals involve fundamental health and development practices, such as the risk factors linked with certain disease control or pandemic tactics.

## 2.3. Patient-provider communication

According to research, surveys, and interviews, 40% of Americans do not feel emotional well-being, and a patient-physician relationship can greatly enhance emotional well-being. Most patients report having a positive relationship with healthcare practitioners who use a patient-centered communication paradigm (Jiang, 2017). In this communication approach, it is emphasized how important it is to listen intently to the patient, pose open-ended questions, and try to grasp the patient's point of view (Hashim, 2017).

As McCurdy (2018) concludes women have historically received unequal treatment when it comes to their health. This scholar insists that everyone should be concerned about the physical and mental well-being of the women in their lives, but women in particular should be concerned about this. It might be important to alter medical school curricula and office practices to make them more patient-centered and receptive to the perspectives of female patients in order to give the female population a voice and help start a larger conversation about the issue (Hashim, 2017). Additionally, it expands our knowledge base in the field of health communication by exploring a topic that academia has been shamelessly ignoring for years (Carpenter, 2010).

With this regard, McCurdy(2018) alleged it is time to lift the veil on women's health and investigate the communication gaps between doctors and patients, which frequently affect female patients more than male patients. The scholar asserted that everyone must take into account the unique perspectives of women who have had trouble communicating effectively with their doctors and endeavor to complete useful studies on how to achieve this. Except for pregnant women and women with breast and cervical cancer, McCurdy (2018) found that very little research has been done specifically on the subject of communication between female patients and their doctors. Because of this, only a small number of studies in the field of health communication have focused exclusively on the self-concept and well-being of female patients.

However, from the WHO constitution, we can infer three key ideas: it is crucial to consider "rights to health care," "health inequality reduction," and "health for all" while coming up with effective communication techniques to attain the health goal. This being said, Tsimtsiou et al.,

(2012) pointed out that there are many reports of doctors who appear unresponsive to questions, do not appear receptive to their patient's ideas, and do not appear to have enough health literacy for a certain subject.

In line with this, Rossman et al., (2021) stated that LMICs are primarily responsible for the bulk of cervical cancer-related mortality, which totals close to 90%. As their study shows to address patient-provider communication, and health system-level issues with cervical cancer control, numerous digital health strategies have recently been implemented in LMICs. Moreover, few attempts have been made, therefore, to fully assess the effectiveness and state of digital health interventions for preventing cervical cancer in LMICs. To lower the high death burden, Rossman et al., (2021) assert that it is essential to scale up sustainable cervical cancer control programs in LMICs, but to deliver, access, and use health services, cervical cancer control programs in LMICs must get through bottlenecks at the level of individuals, providers, and health systems. In the same vein, Burrowes et al., (2022) insist that information on patient and provider experiences with cervical cancer screening, diagnosis, and treatment is essential as the government implements the nation's first national cancer control strategy.

Concerning the issue of patient-provider communication and adherence to medication Haynes et al., (2008) and Andersson et al., (2014) as cited in McDonald and Sherlock(2016) have mentioned improved doctor-patient communication as being crucial to better drug adherence and, as a result, better health outcomes. The opposite is also true: a patient's health may suffer as a result of poor communication because it can cause worry and sadness to increase. One of the most easily quantifiable costs of poor communication is non-adherence to pharmacological treatments. Undoubtedly, non-adherence is a costly issue (McDonald & Sherlock,2016). In addition, Ha and Longnecker (2010) assist patient involvement and shared decision-making may have a favorable impact on health outcomes. Improved communication is crucial for a good doctor-patient relationship. McDonald and Sherlock (2016) underline the attempts to raise the level of communication in healthcare during the last 25 years have been examined in the study conducted. It has acknowledged the substantial progress made but has also maintained that there is still much to be done, not least since the requirements of shared decision-making demand more of the healthcare professional.

## 2.4. Empirical studies literature review

Research has been conducted globally across various dimensions related to cervical cancer prevention and control. Giulia et al., (No date) assert that in Africa, health communication is still in its early stages of development. To enhance communication between healthcare organizations conducting public awareness campaigns and the general public, as well as between medical professionals and patients, small but deliberate actions are being taken. The effectiveness of public health programs heavily reliant on interpersonal contact remains inadequately examined (Lagerwerf et al., 2010). Fayoyin (2016) proposed that applying creative communication techniques is vital to advancing the public health agenda in Africa, aiming to reduce the continent's high health burden. Advances in digital media and communication technologies hold significant promise for addressing pressing public health and development concerns. Social media platforms are increasingly crucial for promoting health literacy and improving health outcomes. Furthermore, Habila et al., (2021) advocate for community-based initiatives in countries where social factors and socio-demographics play a significant role. They emphasize the underutilization of community participation as a method for addressing health disparities, which contributes to the persistent disparity in cervical cancer mortality experienced by women in sub-Saharan Africa.

Given this, several barriers to screening and precancerous treatment have been identified in earlier research, including insufficient resources, lack of knowledge, inability to access healthcare delivery systems, individual psycho-social and cultural contexts, fear, limited family support, and community participation. Similarly, Musuka et al., (2022) noted that although a significant number of women are aware of cervical cancer and screening, women continue to use this service. Age, marital status, financial level, and the cultural and religious views of the women were identified as some of the individual-related barriers in a literature analysis conducted by Chidyaonga-Maseko et al., (2015).

Additionally, communication problems related to the management of cervical cancer, as highlighted by Kutto (2014), include a lack of sufficient information, perpetuation of cancer-related myths, fear of screening or treatment procedures, stigma, cultural pressures, and language barriers. McDonald and Sherlock's (2016) assumptions seem to be well-grounded about the growing number of patients who want to be involved in decision-making rather than merely having more educated conversations with doctors, which is evidence that patient expectations are rising. According to Tsimtsiou et al., (2012), there are many reports of doctors who appear unresponsive to questions, do not appear receptive to their patient's ideas, and do not appear to have enough health literacy for a certain subject. Moreover, it has been noted by Kuguyo et al., (2017) that a decrease in the use of screening and precancerous treatment is partly due to resource, infrastructural, specialized expertise, and patient knowledge constraints. Similarly, Mungo et al., (2024) found that the low availability of healthcare providers for precancer therapy has resulted in a limited reach for these treatments.

In the same vein, a qualitative study about the experience of patients with cervical cancer treatment by Burrowes et al.,(2022) showed that providers confront considerable training and health system barriers that hinder them from providing care and that patients experience bottlenecks and delays at every stage of care primarily because of health system weaknesses and poor patient-provider communication. Women were persuaded to engage in the screening process by the information provided by counselors, as stated by Mpata and Nkosi (2021). It has been discovered that healthcare providers' attitudes toward screening and women's health issues have a substantial impact on women's screening attendance. Rossman et al., (2021) assert that it is essential to scale up sustainable cervical cancer control programs in LMICs, but to deliver, access, and use health services, cervical cancer control programs in LMICs must get through bottlenecks at the level of individuals, providers, and health systems.

Concerning HIV and cervical cancer the included studies' by Kasraeiana et al., (2020) showed in their integrated review indicate that cervical cancer screening uptake rates among HIV-positive patients from low and middle incoming countries (LMICs) were lower than recommended at the national and international levels. The HIV-positive women who participated in the study of Kasraeiana et al., (2020) most frequently mentioned three main factors that influenced their decision to be screened: structural (costs, accessibility, time issues, resources, and infrastructure), social (patient-provider relationship, stigma, information sources, support from family/friends, and religious factors), and personal (knowledge and attitude, perceived susceptibility, embarrassment and fear of the procedure and test results). In line with this, in contrast to HIV-negative women, a greater percentage of HIV-positive women were screened for cervical cancer. When they visit health facilities frequently to get supplies of their HIV medications, women who are HIV positive may be exposed to increased awareness campaigns and calls for screening in addition to information from support groups (Musuka et al., 2022).

In the context of Ethiopia, a qualitative study by Kebede(2024) conducted at Yekatit 12 identified barriers encountered by HIV-positive women in accessing cervical cancer screening. A qualitative study conducted at Yekatit 12 showed the barriers encountered by HIV-positive women to take cervical cancer screening. Abi Kebede and his colleague's (2024) findings revealed that with knowledge about cervical cancer, most participants reported that they were told to get checked for the condition when they went to an ART clinic. Of the women, a small percentage said they had heard about it on TV and radio. In addition, their research finding shows that most participants of the study were unable to clearly state the cause of cervical cancer. The findings emphasize the need for improved education and awareness campaigns targeted at this demographic.

In conclusion, the participants in Mpata and Nkosi’s study proposed that health workers should educate women about cervical cancer by going door-to-door, visiting churches, and setting up tents to raise awareness of the disease. In addition, they discovered that peer health education is an effective strategy to raise women's awareness and their perceived benefit of cervical cancer screening for early detection (Mpata and Nkosi,2021). All in all, communication, community engagement, and targeted education are critical components for improving cervical cancer prevention and control, particularly in low- and middle-income countries. These efforts can help overcome individual, provider, and health system-level barriers, ultimately leading to better health outcomes and reduced mortality rates.

## 2.5. Theoretical Frameworks

Silverman (2021) has said of social theory more generally, 'Without theory, research is impossibly narrow. Without research, a theory is mere armchair contemplation' (p, 86). Several health communication theories and models can support disease prevention and health promotion efforts. They guide public health professionals in the selection of the most appropriate interventions, their development, and their implementation.

### 2.5.1. Self-Determination Theory (SDT)

Deci and Ryan proposed the theory of self-determination in 1985. Self-determination theory is a broad theory of human motivation that emphasizes how much behavior is relatively autonomous that is, how much behavior originates with the self as opposed to relatively controlled that is, how much behavior is influenced or coerced by intrapsychic or interpersonal forces. It is a general theory of human motivation that has been applied to domains such as health, education, work, and sport. It is the only theory of motivation that explicitly identifies autonomy as a human need that, when met, facilitates more autonomous forms of behavioral regulation (Ryan & Deci, 2000).

Ng et al., (2012 )state three basic psychological needs—autonomy (feeling of being the origin of one’s behaviors), competence (feeling effective), and relatedness (feeling understood and cared for by others)—are central to the model. A method of understanding human motivation known as SDT emphasizes the significance of the psychological desire for motivation and autonomy. Furthermore, autonomy denotes that a person has control over how their behavior is initiated, maintained, and regulated. As a result, motivational processes have been used to operationalize perceived autonomy (Ryan & Connell, 1989).

One of the distinguishing characteristics of SDT, according to Patrick and Williams (2012), is how it treats motivated behavior in terms of both the situation and the person (i.e., personality and social environment). Personality, however, does not fully convey the story. Indeed, in any given sector, the process of internalization and autonomous self-regulation may be aided or hindered by the social setting. Patrick and Williams (2012) mentioned promoting the internalization process, as well as the growth of the best motivation and personal wellness. SDT has identified three psychological demands as being essential. To feel free and in control of one's activities as the creator of them, one needs autonomy. Self-efficacy in social cognition theory is conceptually similar to competence in that both include the need to feel capable of obtaining desired results. The urge to be connected to and understood by significant persons is reflected in relatedness, which is the final concept.

Deci and Ryan (2013) developed a self-determination continuum, which includes diverse motivational strategies. There are two sorts of motivation: intrinsic and extrinsic. Intrinsic motivation refers to participating in an activity for the sake of happiness and fulfillment. The concept of autonomous self-regulation, which incorporates both intrinsic motivation and well-internalized extrinsic motivation, is central to SDT. According to SDT, autonomy implies behaving with free will and being conscious of one's willingness.

Extrinsic motivation, on the other hand, refers to doing something to achieve a goal rather than for intrinsic reasons. Internalization of extrinsic incentives and the maintenance of intrinsic motivation are two ways that social contexts, or specific features within social environments, that are deemed autonomy-supportive, have been found to promote autonomous self-regulation (Deci and Ryan, 2012). According to Deci and Ryan (2013), SDT claims that extrinsic motivation can have varying levels of self-determination than other theoretical perspectives, some of which may represent a relatively high level of self-determination ranging from low to high autonomy. As a result, while utilizing SDT, extrinsic incentives are classified into two types: external regulation and identified regulation.

The term "external regulation" refers to the use of incentives and constraints to influence behavior. Identified regulation refers to behaviors that people choose to engage in because they value them. According to SDT, persons who act based on intrinsic motivation and definable regulation have a high level of perceived autonomy or motivation. Individuals who carry out activities for external regulation, on the other hand, demonstrate little autonomy or motivation. As a result, this hypothesis will be used to investigate self-initiated screening and treatment adherence among the target populations.

#### 2.5.1.1 SDT in Public Health

According to Martin et al., (2017), a large portion of SDT research conducted in the context of a healthcare setting has centered on patients and their health-related behaviors. Social surroundings have the power to help or hinder people from meeting their basic needs. Ng et al., (2012) state support and subsequent satisfaction of these needs provide a higher quality of psychological energy that is predicted to and has been empirically confirmed to motivate health behavior consistently or sustainably.

In addition to the notion that people's basic needs can be met globally by various people in a variety of non-specific settings, Martin et al.,(2017) insist that there are also domain-specific settings (such as school and work) and specific people (such as nurses, doctors, and teachers) that are crucial in aiding people in meeting their basic needs. The emphasis on patient involvement recognizes that patients have a significant impact on their health care. Together with professionals, patients can debate and decide on the best course of therapy or management (Ng et al., 2012).

According to Patrick and Williams (2012), patients feel supported in their quest for autonomy, competence, and relatedness during a talk with their primary care physician. Fostering competence also requires promoting patient autonomy, which is ensuring that patients are fully volitional or adaptable. The first empirical evidence for the SDT model of health behavior change, which proposes that the social context (i.e., need support) predicts motivation (i.e., autonomous self-regulation), which, in turn, predicts health behavior and/or health outcomes, was presented when autonomous self-regulation for treatment was found to mediate the association between perceived need support and treatment outcomes halfway through the intervention.

A behavioral outcome may not be directly affected by an intervention, according to Patrick and Williams (2012), but the outcome may be indirectly improved by the intervention's impact on a psychological variable like self-efficacy or motivation. Environments that support individual autonomy help people feel in control of their lives and can lead to self-determined behavior. Environments, however, can prevent people from meeting their basic requirements as well as having a lack of support for autonomy (Martin et al., 2017). The level to which one senses the need for assistance from diverse contexts (such as exchanges between doctors and patients) is a major indicator of how autonomously regulated one is likely to be for prescribed behaviors ( Patrick and Williams, 2012).

Patrick and Williams (2012) note that a growing corpus of research has examined the relevance of SDT to health contexts, such as the hospital environment, health behavior change, and interventions, over the last 10 to 15 years. Together, these studies results show the importance of autonomous self-regulation and the need for support in a range of mental and physical health outcomes, including depression, anxiety, somatization, quality of life, quitting smoking, physical activity, weight loss, diabetes management, dental health, and medication adherence (Ryan, Huta, & Deci,2008).

### 2.5.2. Socio-Ecological Model

The social-ecological model (SEM) framework developed by McLeroy et al., (1988) as cited in Blackwell (2020) was applied to conceptualize how knowledge of the reciprocal relationships between individual and population-level determinants of behavior could lead to improvements in the timely detection, treatment, and management of cervical cancer.

Ruderman (2013) states the ecological model of health has its roots in psychology and human development, specifically in the work of Lewin, Barker, and Bronfenbrenner, among others, who started to examine behavior in the context of the interaction between the individual and the environment in the middle of the 20th century. Glanz et al., (2008) note that the core idea of an ecological model is that behavior is influenced at various levels, frequently at the intrapersonal (biological, psychological), interpersonal (social, cultural), organizational, community, physical environment, and policy levels.

Over the past ten years, the ecological model has established itself as a crucial and fundamental framework for patient-provider communication research and practice (Head & Bute, 2018). The medical encounter between a patient and a provider is positioned in the middle of Street's paradigm, in what he terms the interpersonal context. Building on the idea of the ecological frame, Street continues by identifying four non-interpersonal settings that are "broad, complex, and multifaceted" (p. 64). These include the organizational setting, cultural context, political-legal background, and media context. Street explains how each of these contexts, influences, and impacts can have a significant impact on a patient's emotive, cognitive, and behavioral processes during medical contact. It is a sophisticated and intricate model.

According to Moran et al., (2016), ecological models of health behavior incorporate a variety of realms of impact, from small-scale elements like health beliefs to more significant contextual elements like neighborhood features and local, state, and federal policies. In 2016, Moran et al., integrated ecological concepts as crucial for the field of health communication for several reasons. First and foremost, a broader field of study should yield theories, research, and methods that are more likely to lead to favorable health outcomes. Numerous micro to macro-level elements have been shown to have an impact on health outcomes. Furthermore, because they work through a variety of routes, health communication initiatives that reach beyond the individual level should have longer-lasting impacts.

The model identifies five levels of influence on health behavior and discusses the reciprocal relationship between them (Stokols, 1996; McLeroy et al., 1988).

1. Intrapersonal factors — these include individual characteristics such as knowledge, beliefs, and self-concept. Most health promotion programming is aimed at this level. Ruderman (2013) also mentioned individual factors, sometimes called intrapersonal factors, like genetics and individual behaviors.
2. Interpersonal processes and primary groups — these include the individual's social environment such as family, friends, peers, and co-workers that surround the individual and influence behavior. In turn, an individual's behavior also influences family, friends, and peers
3. Institutional or organizational factors — these refer to workplaces, churches, and other organized social institutions. These institutions have formal or informal policies and structures.
4. Community factors — these describe the relationships among organizations and institutions. This includes community norms.
5. Public policies — these refer to policies or regulations concerning health practices.

In the socioecological model, an individual's behavior influences and is influenced by factors at the other levels. Using this model allows a program planner to consider factors from multiple levels that can impact health.

Four core principles of ecological models of health behavior are proposed by Glanz, Rimer, and Viswanath (2008):

1. There are multiple influences on specific health behaviors, including factors at the intrapersonal, interpersonal, organizational, community, and public policy levels.

2. Influences on behaviors interact across these different levels. The interaction of influences means that variables work together.

3. Ecological models should be behavior-specific, identifying the most relevant potential influences at each level. Ecological models appear most useful to guide research and intervention when they are tailored to specific health behaviors.

4. Multi-level interventions should be most effective in changing behavior. A direct implication of ecological models is that single-level interventions are unlikely to have powerful or sustained population-wide effects.

#### 2.5.2.1. Socio-ecological model of communication

Kincaid et al., (No date) stated that rather than analyzing a single component in isolation from its embedded system, the socio-ecological model of communication describes the complexity, interrelatedness, and wholeness of the components of a complex adaptive system. This is because it adopts a systems approach to analysis as opposed to a reductionist one. The assumption of embeddedness, a state in which one system is nested in a hierarchy of other systems at different levels of analysis, and emergence, in which the system at each level is "greater than the sum of its parts," are the two fundamental system features of the socio-ecological model of communication and behavior change. Gupta et al., (2019) claimed that the foundation of all effective social and behavior change communication interventions is an awareness of the many social, cultural, and economic elements that contribute to the various levels of health and behavior determinants.

Kincaid et al., (No date) mentioned the ecology model's primary contribution is to highlight how higher levels either support or impede change at lower levels of analysis. Depending on the type of difficulties a program tackles, it is suggested that interventions for planned change should address all four levels to be effective. Most programs function at more than one level; some, to effect significant change at the population level, must function at all four levels. The model also suggests that the likelihood of self-sustaining individual change increases when it is encouraged and supported by societal changes occurring at higher levels.

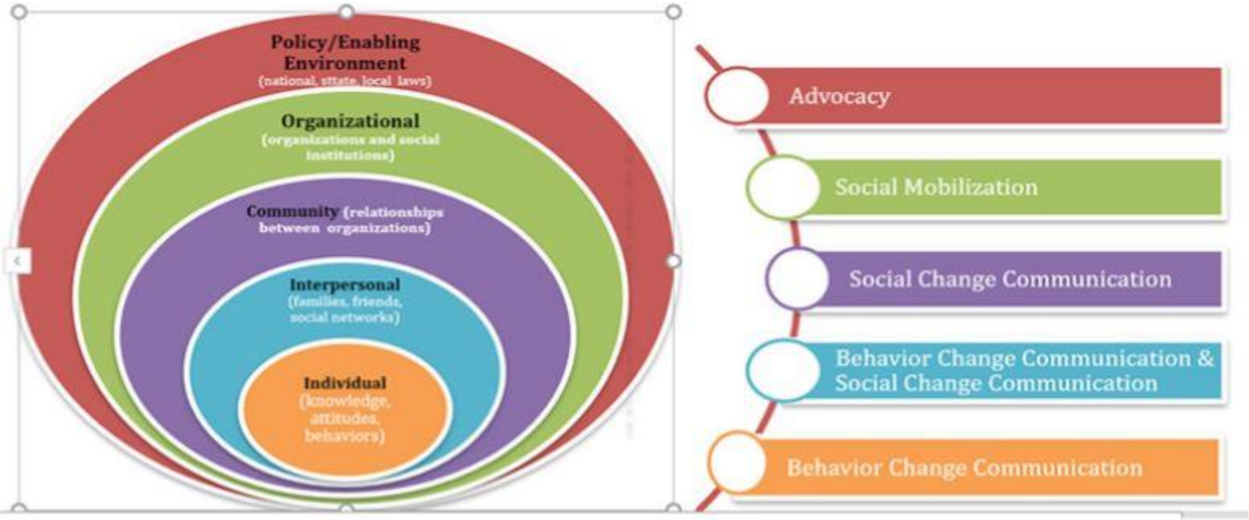

Figure 1:SBCC using Socio-Ecological Model

# Chapter Three: Research Methodology

In this chapter, the researcher explains the methods that were deployed to answer the research questions. By using a qualitative approach the researcher explored the interplay of health communication and motivation in women living with HIV undergoing precancerous treatment: a case study at Menelik II Comprehensive Specialized Hospital. Since communication is affected by ecological factors; it needs deeper investigation for the appropriate interpretation of data. Thus, the researcher deployed a qualitative appro≥≥≥ach to study the communication situation in depth. Moreover, the research design, sample subjects of the study, the sampling technique and instruments for data collection, and the methods of data analysis are discussed in this section of the study, as well.

## 3.1. Research Approach

A qualitative method was deployed since the researcher proposed to collect data over in-depth interviews and focus group discussions. The qualitative research approach is a method that attempts to gain an understanding of underlying reasons and enthusiasm for activities and establish a better answer. Ritchie et al., (2003) posited qualitative research covers a broad range of approaches that are linked to different beliefs about what there is to know about the social world and how to find out about it. Although definitions vary, the aims of qualitative research are generally directed at providing an in-depth and interpreted understanding of the social world, by learning about people's social and material circumstances, their experiences, perspectives, and histories. Yin (2015) also states qualitative research strives to collect, integrate, and present data from a variety of sources of evidence as part of any given study. Hence to understand and get more information from the study participants the researcher chose the qualitative method.

## 3.2. Research design

Since studies that integrate health and communication require deeper investigation from a different perspective, the qualitative research method happens to be the best that fits this study. Similarly, in order to answer the research questions of this study explanatory research type was deployed. Ritchie et al., (2003) posited because of its facility to examine subjects in-depth, qualitative research provides a unique tool for studying what lies behind or underpins, a decision, attitude, behavior, or other phenomena. Explanatory research is concerned with why certain phenomena occur and the forces and influences that drive their occurrence. It can be used to identify the factors or influences that underlie a particular attitude, belief, or perception, the motivations that lead to decisions, actions, or non-actions, the origins or formation of events, experiences, or occurrences, and the contexts in which phenomena occur.

The development of qualitative research was strongly influenced by ideas about the importance of understanding human behaviors in their social and material contexts; and by the need to understand the meanings that people attach to their own experiences. 'Interpretivism', which is integral to the qualitative research tradition, is seen to overcome some of the perceived limitations associated with 'positivism', the tradition most commonly associated with statistical social inquiry (Ritchie et al.,2003).

## 3.3. Sample Size

A sample size is a significant feature of any empirical study in which the goal is to make implications about a population from a sample. In practice, the sample size used in a study is usually determined based on the cost, time, or convenience of collecting the data, and the need for it to offer sufficient statistical power. According to Baker et al., (2012), there is no clear answer to the question of how many, and sample size relies on a number of factors, including epistemological, methodological, and practical issues. Therefore, seven (7) clients(WLHIV) and two (2) healthcare providers (nurses) who have direct relationships with the patients and healthcare providers who provide the screening and precancerous treatment to participate in the individual in-depth interviews. In addition, two (2) FGDs having 6 discussants(WLHIV) in each group were conducted considering the objectives of this study.

With this in mind, the final number of participants was determined by the point at which saturation was reached, meaning the same ideas and themes were being repeated, and no new information was being identified (Charmaz, 2005). The specific criteria the researcher utilized to determine the final number of participants were by assessing the richness and depth of data for theoretical saturation, meaning when the information shared by the participants was detailed and when it reached a point where the data was sufficient to address the researcher questions align with the guiding theory and model of the researcher. Besides, the researcher determined the final number when data was no longer bringing new theoretical insights. Besides, the researcher's judgment was another way of ensuring data saturation. The researcher used to review the data collected frequently(after finishing every IDI and FGD) considering the research objectives and depth of data.

### 3.4. Sampling Techniques

Probability and non-probability sampling techniques are the two main types of sampling strategies used in research. The researcher used non-probability sampling approaches due to the nature of this study. Non-probability sampling is a sampling strategy that takes into account factors other than chance, such as accessibility, proximity to a certain area, or the level of knowledge of the interviewees (Nikolopoulou, 2022).

In the case of this study, a purposive sampling technique was deployed to select the study site and the client participants of the study. The study was carried out in Addis Ababa city at Menelik II Comprehensive Specialized Hospital from January 2024 to February 2024 G.C. Addis Ababa city was selected as a research site of this study. The accessibility of data could be a possible reason for the selection of the study site. With respect to the selection of the hospital, a federal hospital, namely Menelik II Comprehensive Specialized Hospital was the hospital where the researcher gathered adequate sources for this study. The reason behind the selection of the hospital is due to its convenience and accessibility of data to garner input for the study. Besides, it's among the general hospitals that deliver cervical cancer screening and pretreatment services (secondary prevention) aside from LEEP service.

In addition, the healthcare providers who are working at the health facility at the cervical cancer screening and pretreatment clinic, concerning the case are two. Therefore, the researcher used the availability or convenience sampling technique to include these nurses in the study.

#### Inclusion Criteria

- WLHIV who attend the ART and cervical cancer screening and pretreatment clinic
- WLHIV who visit their healthcare providers ≥ two times
- WLHIV aged 15-49

### Exclusion Criteria

- HIV-negative women who attend the cervical cancer screening and pretreatment clinic
- Women(WLHIV or HIV-negative women) who attend the clinic for the first time

## 3.5. Data Collection Instruments

As the study employed a qualitative research approach, the following methods of data collection were used to collect the necessary data for the study: individual in-depth interviews and focus group discussions.

### 3.5.1. Focus group discussion

Group discussions are best suited for more abstract, ethereal, or conceptual themes because everyone may contribute to tackling the problem (Ritchie et al.,2003). Participants in focus group discussions discuss and respond, compare their experiences and impressions, and react to what others say in the group. Furthermore, a group conversation helps respondents remember some concerns from other participants' comments, which would be unlikely in individual interviews. Focus groups provide a social setting in which the phenomenon is perceived. They show how context influences people's opinions and how information is created via interactions with others. Furthermore, because of the environment, they vividly depict participant differences and allow such differences to be discussed openly and honestly.

Dominick and Wimmer (2011) suggested that between two and four FGDs could be enough for a small research project. Regarding the number of discussants, they recommend 6 to 12 participants. On the contrary, Brewer and Miller (2003) recommend 6 to 10 people per group, although greater or fewer numbers could work. Therefore, in this study the researcher employed two groups to implement the FGD having 6 discussants in each group These participants were selected based on their cancer diagnosis stage. Besides, the participants' educational status and age were considered to form the groups and maintain homogeneity.

Before beginning the FGDs, the discussants were given verbal and written consent, and full information about the study aim, with elaborated clarification concerning the confidentiality of the information to be acquired and the time permitted for the conversations. To provide an ideal and conducive environment for the discussants, the researcher requested the cooperation of healthcare providers in providing a favorable setting to conduct the FGDs and IDIs. The researcher proposed this idea based on the following reasons. Formerly, to avoid and diminish inconvenience that would happen due to moving from one place to another. Secondly, due to the participants' familiarity with the health facilities (considering their stay at the hospital), we could use it as a central place for meetings. Thirdly, to maintain the comfort of the participants where they feel they belong.

In conclusion, the FGDs were meant to create an interactive environment for participants, to assess the shared experiences of participants, and to garner various perceptions of the participants in this study. In addition, it helped the researcher to examine what they think how they think, and why they think through their lived and shared experiences.

### 3.5.2. Individual In-depth Interviews

Both semi-structured and unstructured interviewing methods were involved in this research, with detailed information from individuals who understand the phenomenon and could express their perspectives. Guba and Lincoln(1994) said that qualitative research involves the production of knowledge, not its discovery. Thus, the interviews with participants helped the researcher to obtain information in combination with interviewees to produce knowledge about their communication situations.

In addition, individual in-depth interviews allowed the researcher to have a deeper investigation that can’t be addressed thoroughly through naturally occurring data collection tools. To be specific, the researcher interviewed seven clients’(WLHIV). Moreover, two (2) healthcare providers from the health facility participated in the in-depth interview session.IDIs would be more specifically designed to provide insight into women’s individual experiences at the hospital. Likewise, the in-depth interview helped the researcher to understand every individual’s (clients’) detailed lived experience of the participants at their home and neighborhood and their beliefs and perceptions. For that, the information gathered through this instrument enabled the researcher to address and examine the factors that relate to sustainable behavioral change and the communication aspect.

### 3.6. Data collection method

In order to answer the study's research questions, IDIs and focus group discussions were conducted with clients and healthcare providers. Before beginning the IDIs and FGDs, the participants were given/read informed permission after outlining the study's goal, risk, benefit, confidentiality, and right to anonymity. Participants were informed that if they felt uncomfortable during the interview or FGD, they could withdraw at any time. Respondents who consented to participate provided written or verbal agreement for IDI and verbal or written consent for FGD. The data was obtained and treated discreetly, with no name tag attached. In order to keep any information that was provided by study subjects confidential, the data collection procedure was maintained by interviewing them alone and by conducting the FGD in a safe environment for free discussion. The IDIs took 45-50 minutes and the FGDs took 60-90 minutes.

### 3.7. Data analysis technique

The data was mainly gathered through qualitative data collection techniques. First, all the data was transcribed since the majority of data was gathered from oral discussions. Text analysis was employed for the IDI. After that, the relevant data was categorized to arrange them for analysis. The categorization is normally made based on their application to the essential ideas of the research questions raised in this study.

The qualitative data and the findings gathered from the in-depth interview and FGD was presented and analyzed using the thematic analysis method. Emerging themes serve as the categories for analysis in a type of pattern recognition within the data called thematic analysis (Fereday & Muir-Cochrane, 2006). According to Bowen (2009), the procedure necessitates rereading and reviewing the data with greater care. Thematic analysis is essential for reducing the intricacies of qualitative data into coherent and informative themes that are consistent with the study aims. After assigning preliminary codes to the data, the researcher used an iterative process of sifting and sorting these codes to uncover patterns that spoke to the heart of the research. The researcher combines and compares codes, working diligently toward larger themes that capture the substance of the individuals' experiences and opinions. These emerging themes not only serve as interpretive anchors but also provide a narrative structure that reflects the lived circumstances of WLHIV receiving precancerous treatment. The interpretation of these themes then entailed diving into their deeper significance, comprehending their ramifications in the larger societal and media context, and contrasting them with established theoretical frameworks. Finally, all the data was arranged logically and according to the theoretical frameworks of the study and with respect to the central research questions.

### 3.8. Reliability and Validity of Data

The researcher deployed in-depth interviews and focus group discussions by adopting a triangulation approach in order to assure data reliability and validity. In this research, on one hand, individual in-depth interviews were more specifically designed to provide insight into women's individual experiences at the hospital. Likewise, the in-depth interview helped the researcher to understand every individual's (clients') lived experience, perspective, and belief and to make them part of the solution by contributing their input for better and feasible strategies. Focus group discussions, on the other hand, foster group dynamics and allow for interactive exchanges among participants, enabling the exploration of shared experiences and the emergence of diverse viewpoints (Krueger & Casey, 2015). Therefore, FGDs were meant in part to capture what women had to say as general members of their community and their lived experiences.

In order to ensure the data reliability and consistent integration of terminologies, such as health communication practices, motivation (autonomy, connectedness, and relatedness), patient-provider communication, and participatory communication were taken into account throughout the study. Besides, data validity was reassured methodologically. Therefore, the interconnectedness of research questions, data gathering instruments, and data analysis techniques helped the researcher to ensure the data validity.

### 3.9. Ethical Consideration

Concerning ethical issues, the researcher obtained ethical clearance from the Bahir Dar University Institutional Review Board(Reference number 01/IRB/23 issued on October 10/2023) to carry out the review that was conducted by the Addis Ababa Public Health and Emergency Management Directorate. Besides, the researcher has obtained an official letter of cooperation from the Department of Journalism and Communication, Bahir Dar University in order to carry out the study at Menelik II Comprehensive Hospital. Likewise, the Addis Ababa Public Health and Emergency Management Directorate wrote an official letter to Menelik II Comprehensive Specialized Hospital. In turn, Menelik II Comprehensive Specialized Hospital, research committee wrote an official letter to the Obstetrics and Gynecology department.

Related to the ethical issues of participants, informed consent was given to the participants after explaining the purpose of the study, risk, benefit, confidentiality, and their right to anonymity. The respondents who agreed to participate were given written/verbal consent for IDIs as well as written/verbal consent for FGDs. The data that was obtained was treated privately with no name tag on it.  The participants were informed that they could withdraw from the interview and the FGD at any point in time if they felt any discomfort.

In order to keep any information that was provided by the study participants, the data collection procedure was maintained by interviewing them alone and by conducting the FGD in a safe environment for free discussion. The participants were assured that the information that they would give, be used only for the study, and confidentiality would be kept.

# Chapter Four: Data Presentation, Results and Discussion

This chapter presents the analysis of data collected through in-depth interviews and focus group discussions. The primary objective of the study was to critically evaluate the interconnectedness of health communication and motivation in women living with HIV undergoing precancerous treatment: in Particular Reference to Menelik II Comprehensive Specialized Hospital. The experiences of the respondents were examined based on the guiding spirit of the theories outlined in chapter two (Self-determination theory and Social-ecological Model). Therefore, the analysis was conducted by categorizing the responses of the respondents into theme and theory. The themes are categorized based on the levels of the socio-ecological model, major concepts of self-determination theory, and patient-provider communication. Interview participants were assigned to the code “R” and focus group discussion participants were assigned to "FGD".

## 4.1. Results

### 4.1.1. Socio-demographics of the respondents

In this study, there were 7 client interviewees, 2 healthcare provider interviewees, and 2 FGDs with 6 discussants in each group. The socio-demographic data of the IDI respondents showed that the age range of individuals in the sample group was between 30 and 50 years. In terms of marital status, 4(57.1%) were widows, 2(28.6%) were divorced, and 1(14.3%) were married. The most prevalent occupation was in the private sector at 3(42.9%), with unemployment at 3(42.9%) as well and 1(14.3%) of the group being housewives. Regarding educational levels, 4(57.2%) had completed secondary school, 2(28.6%) had diploma degrees, and 14.3% had primary school education. The age range of the healthcare providers was between 25 and 35 years, both with a background in nursing. N1 had 4 years of experience, and N2 had 10 years of experience, indicating a mix of early-career and more experienced nurses in the sample.

As the FGD1’s socio-demographic data indicate the age range of individuals in the sample group varies between 35 and 50 years. The youngest individual is in the 35-40 age group, while the oldest is in the 45-50 age group. The majority of individuals in the sample group are married, with 4(66.7%) individuals falling into this category. 2(33.3%) individuals are widows, making up of the sample group. Private sector employment is the most common occupation among the sample group, with 3(50%) individuals working in the private sector. 1(16.7%) individual is engaged in government employment. 2(33.3%) individuals are housewives, and 1(16.7%) is involved in private business.Individuals in the sample group have varying levels of educational attainment, with a mix of secondary school education, diplomas, and degree. Secondary school education is the most prevalent, with 3(50%) individuals having completed secondary school. 2(33.3%) individuals hold degree. One individual has a diploma 1(16.7%).

In the same vein, FGD2's socio-demographic data imply the age range of individuals in the dataset spans from 35 to 50 years. Individual A is the oldest in the 45-50 age group, with the majority of individuals falling within the 40-45 age range. The majority of individuals are married, 3(50%). falling into this category. 2(33.3%) individuals are widowed and 1 is single (16.7%). Government employment is represented by 2(33.3%) individuals, while the private sector and unemployed categories each have 2 individuals (33.3%). One individual is a housewife (16.7%). Secondary school education is held by 2 individuals (33.3%), while diplomas are held by three individuals (50%). One individual holds a degree (16.7%).

### 4.1.2. Communication infrastructure, health education and stakeholders involvement

#### 4.1.2.1. Media, possessed belief, knowledge, and behavior change

In order to answer the third objective IDI and FGD were conducted with clients and healthcare providers. The data gathered show that the clients have encountered challenges due to different reasons. Participants express a lack of awareness about cervical cancer, its severity, and the importance of screening attributing it to misconceptions and fear of the diagnosis process and results. Fear of the procedure and the disease itself hinders individuals from seeking screening and understanding the potential consequences of untreated precancerous conditions. Despite the fact that media and campaign programs are the main source of information for the community, the depth of information that is addressed through these approaches is distorting the community's attitude towards the disease.

R5 clearly described the information she remembers from the campaigns and media sources and the consequences as follows:

> I have heard about the disease from media and campaign programs at health centers, but I didn't give it that much attention, for the only information I heard repeatedly, was about taking the screening nothing more nothing less. Thus, I thought the disease wasn't that

> much scary. Besides, I couldn’t understand how vulnerable I was even though I am a woman as well as HIV positive (R5-personal interview on January 26,2024).

N1 more specifically mentioned reluctance to undergo screenings despite knowing the benefits. The fear and discomfort associated with screening procedures act as significant barriers to early detection and treatment initiation, reflecting individuals' perceived autonomy in choosing to avoid medical procedures they find distressing. In the same vein, the limited and seasonal nature of information disseminated through media channels contributes to the apprehension and reluctance of individuals to seek screening. Besides, focus group discussions and healthcare professionals emphasized the need for more consistent and detailed messaging. Participants highlighted the impact of media coverage on their awareness of the disease and the need for accurate information dissemination to dispel misconceptions and promote informed decision-making.In line with this, discussants mentioned the experiences of awareness creation during the outbreak of COVID-19 and HIV transmission. As the discussion with FGD2 revealed that:

> People fear to take the screening. The information disseminated through the media is seasonal and not detailed. The messages only focus on the highlights of the screening and taking the vaccination, unlike HIV and COVID-19. Disease-related information and education were widely available. In the case of cervical cancer, we may get the information someday and we might completely forget it without internalizing it. In addition, since it is a disease that affects our private organs, the messages should be detailed and easy to remember and internalize (FGD 2-group discussion on January 30,2024).

Another respondent commented:

> I don’t think that the media awareness creation programs are well designed and have the power to impact women’s behavior and attitude. For such a fatal disease, a time-framed awareness creation program is insufficient. We should learn from the experience of COVID-19. Even on those rainy days the media coverage as well as the campaigns were effective. We need that sort of mobilization activity (N2-personal interview on February 5,2024).

The other challenge raised by the healthcare providers was the issue of misconception about the cause of the disease and sexual intercourse which is the major cause for negligence for clients not to take the screening and reluctance to proceed with the treatment . The clients perceive themselves that they are not vulnerable for they stopped having sex right now. The perception of vulnerability among women due to their sexual experiences and a lack of comprehensive knowledge on disease transmission highlighted the importance of addressing misconceptions and promoting health literacy among patient populations. As the healthcare provider explained:

> The reason behind the high prevalence of cervical cancer is that people think I have stopped having sex right now. How could I be vulnerable to the disease since I stopped having sex? They even argue with us bringing this argument. They don't understand that the HPV virus can be detected due to sexual intercourse in the previous life. There is a huge lack of awareness and negligence. The women don't know that the disease doesn't reveal itself through symptoms before it is too late. On the contrary, they seek the symptoms as a confirmation to reach at conclusion that they are at risk or sick (N1-personal interview on February 2,2024).

The nurses also mentioned misconceptions about the disease, including beliefs that being healthy or not experiencing symptoms means that the clients are not at risk, leading to delayed diagnoses and treatment. As one interviewee explained:

> Our clients ask why are you diagnosing us frequently? Isn't it enough if I am diagnosed and treated once? The community thinks that the disease does not exist. Because the disease has no symptoms, they only become aware of it when it is advanced. They might hear about the disease, but they don't perceive themselves as vulnerable women. I have encountered many women with positive results while they were saying I am healthy why are you diagnosing me. We refer them to Tikur Anbessa Specialized Hospital. It is a double burden for them and they are suffering emotionally and physically (N1-personal interview on February 2,2024).

Being HIV positive is another factor for cervical cancer, most of the participants are not well informed about it. The nurses highlight knowledge gaps in their clients' regarding the causes and symptoms of cervical cancer. The discussion about the relation between HIV and cervical cancer underlined the need for enhanced patient education and disease understanding among participants.

In line with this, the interview with R1, R3, and R4 and the discussion with FGD discussants(FGD1 and FGD2) revealed their confusion about genital hygiene and cervical cancer. They perceived genital hygiene and restroom sanitation as causes for cervical cancer. Similarly, participants admitted that though they now have some understanding of the disease after taking the diagnosis, they emphasized they still lack a full and good understanding of the disease. This in turn is affecting the clients' behavior negatively.As one respondent mentioned:

> Although I do have a better understanding of the disease now after taking the diagnosis, I still do feel that I should get additional information unless it may affect my behavior negatively. I think people start to feel good and willing to do something when they have a full understanding of the disease. For instance, I come here on my appointment day to take medicines for HIV, for I completely understand and accept the causes, consequences and the benefits I get (R5-personal interview on January 26,2024).

Furthermore, the FGDs highlighted that due to knowledge gap the discussants, who have daughters are not willing to allow their daughters to take the screening, for they can't even explain to other individuals about the disease. FGD1, R4 and R6 reported they are taking the screening and the treatment for they are told to do so. This data shows that clients are in desperate need of information about the disease to have sustainable adherence to their follow-up. The knowledge gap is also revealed through that they are doing what they are doing without understanding it well. From the perspective of self-determination, these behaviors of clients imply that their motivation is reckon on external regulation. Besides, lack of knowledge about the causes of the disease is affecting the clients' competence.

Whereas, the data gathered from the IDIs(R1, R2, R3, R4, R5, R6, R7, FGD1, FGD2) indicated that personal experiences with screening results, whether negative or positive, serve as catalysts for developing little awareness and understanding. The respondents confirmed that this process helped them to get awareness about the disease eventhough there is significant misunderstanding and over looking of the importance of regular screening and follow up.

> I was sent to this department from where I have another appointment (ART clinic) and took the screening 2 years ago and the result was negative. Now, my test turned out to be positive. Then I started to ask questions, so through this process, I could get more awareness about the disease (R6-personal interview on January 30,2024).

More specifically, FGD1 disscussants show hesitation to attend for regular follow-ups mentioning factors like forgetting about their appointment day unless they are reminded by the healthcare professionals via phone call. They admitted they don't forget their follow up day for medicine supply for their HIV case,for they have already aware and accepted the case.Whereas, the misconceptions about their status and the HPV development stage affects ther attitude and motivation. Most of them don't know what exactly their results stands for.

In conclusion,clients autonomy to attend to their follow up is negatively impacted by scarce information through the media and campaign programs.In addition,their possessed or previous belif about the disease shows slim to none improvement after getting some understanding about the disease.This is revealed through their reluctance to undergo the screeing and misconception about the stage of the disease,symptoms,causes, regular follow up and the relation between HIV and cervical cancer.Thus,the aforementioned problems are highly dicating the clients to have low level of relatedness and competence in their precancerous treatment journey.

#### 4.1.2.2. Status of awareness initiatives at the health facility

The communication challenges raised by respondents regarding the hospital's communication infrastructure emphasized the importance of effective communication strategies in healthcare settings. The lack of awareness about the communication office and its role reflects a gap in information dissemination, potentially hindering individuals' access to vital resources and support (R3, R5, and R6). Moreover, the participants'(R1 and R2) observations regarding the public relations officers' activities point to a disconnect between perceived responsibilities and actual engagement in awareness creation and community engagement. Respondent 2's underscores the discrepancy between knowledge of public relations officers' roles and the absence of visible awareness initiatives at the hospital, indicating a need for improved communication strategies to bridge this gap and enhance community engagement.

> I used to work at this hospital as a HIV case manager in a case team at the ART clinic,so I have some information about the responsibility of public relations officers. For example, they prepare banners, brochures, and flyers, but I have never seen such activity at this hospital (R2-personal interview on January 15,2024).

As healthcare providers perspective show that public relations officers are identified as having a crucial role in disseminating information about precancerous treatment and cervical cancer, with a recognition that many individuals are dying due to lack of awareness and access to essential information. N1 and N2 believe that it ultimately impacts individuals' autonomy, relatedness, and competence in navigating healthcare decisions and outcomes. The critical role of public relations officers in disseminating information, and recognizing the negative consequences of inadequate awareness on individuals' health outcomes were the ideas that were emphasized by these participants.

Respondents(R1,R2,R4,R6,R7,FGD1,FGD2) reflect on a sense of autonomy in advocating for improved communication practices to combat the prevailing issue of misinformation in the community and its detrimental impact on individuals' well-being. The lack of collaboration with public relations officers(participatory environment) at the hospital signifies a missed opportunity to leverage their expertise in amplifying health education efforts and empowering individuals to make informed choices regarding precancerous treatment.

In a similar vein, N2's observation further emphasizes the potential for collaborative work with public relations officers to enhance the effectiveness of awareness initiatives, particularly in high-traffic areas such as emergency rooms and stations. The call for a collaborative approach highlights the interconnected nature of relatedness, as individuals seek to engage with healthcare professionals and communication experts to optimize the reach and impact of awareness campaigns. N1 mentioned, “I think public relations officers have the responsibility to disseminate information, for many people are dying because of lack of information. Unfortunately, we have not worked with the public relations officers at this hospital ever since I know.” Likewise, N2 affirms, “When we have time we try to give awareness at emergency rooms and stations but they are not effective. I hope they will be effective if we work with the public relations officers. It needs collaborative work.

Overall, as indicated by participants, the hospital's communication office fails to accomplish the intended tasks. As a result, clients' autonomy and competence are at their lowest levels due to a lack of knowledge, while client relatedness is at its lowest levels due to a lack of engagement.

#### 4.1.2.3. Healthcare providers role in awareness creation and impact of individual behavior on patient-provider communication

As it is mentioned previously, the respondents bring up that the information they got from the media outlets was unsatisfactory. They insisted that it leads them to be reluctant and negligent. However, the interpersonal communication they have with their healthcare providers helped them to establish intrapersonal communication by seeking more information about their health status through the diagnosis and treatment process. FGD discussants express concerns about confusion and uncertainty when seeking screening and diagnosis. Most of the discussants contended that they get perplexed when they come for screening and diagnosis. They added they get detailed information after they visit their nurses, most of them didn’t have any idea about the disease beforehand (FGD1). Likewise, participants expressed a desire for a deeper understanding of their condition and treatment, often seeking clarification and additional information from healthcare providers. As one respondent commented:

> I took the screening two years ago. At that time I didn’t enquire further and deeper information because of the communication barrier I had with the doctor. Whereas, in the second screening, I started to seek more information, explanation, and clarification from the nurses (R5-personal interview on January 26,2024).

In addition, some of the respondents mentioned that they didn’t have any clue that they were vulnerable because they were HIV positive. Both clients (R3, R4, R7, FGD1, and FGD2) and healthcare providers raised the issue of lack of information about the disease is also affecting patient-provider communication.

> I used to think cancer was a non-curable disease even at an early stage. This happens due to a lack of awareness. I used to ask and confront my healthcare provider why I should take the screening. However, I understand now that thinking I am healthy and why would I take the screening is unnecessary talk (R4-personal interview on January 26,2024).

Thus, the analyzed data under this theme show that participants' autonomy and competence in making informed decisions about their health were hindered by the lack of comprehensive awareness programs and misconceptions about the disease. The belief the clients possess, lack of awareness, and fear of the diagnosis procedure are the major themes identified. Their doubt about the disease and their existing beliefs meltdown after the healthcare providers give them counseling guidance. According to the data, patient-provider communication is the suitable way to create awareness, for the clients couldn't get enough awareness or information from campaign and media sources. The perceived gap in community knowledge about cervical cancer highlights the need for more detailed and accessible information to promote awareness and prevention efforts.

### 4.1.3. Interpersonal communication and social environment in nurturing motivation and emotional support

#### 4.1.3.1. Interpersonal communication with healthcare providers

Participants mentioned the power of open and transparent communication in shaping clients' behavior and adherence to appointments. Clients felt supported and valued, which motivated them, to attend their appointment promptly. Effective interaction not only facilitated timely access to care but also showed the significance of personal rapport and communication style in influencing patients' healthcare decisions.

R6, FGD1, and FGD2 emphasized the importance of warm greetings, open discussions, and the ability to ask questions freely, particularly with nurses, as key factors in enhancing their engagement with healthcare services. The data gathered from (R1, R2, R3, R4, R5, R6, FGD1, and FGD2) show that the interactions with healthcare providers are perceived as opportunities for emotional support, knowledge acquisition, and autonomy enhancement among clients. Furthermore, the data reveals that improved patient-provider communication not only facilitates information-seeking behavior but also empowers clients to actively participate in discussions about their health.

Besides, open discussions with nurses and the availability of comprehensive information empower clients to make informed decisions about their treatment and follow-up care. R2 and R4 expressed that they are motivated to have open discussions to get information that can lead to informed decisions due to the nurses' commitment and approach. R1, R2, R3, R4, R5, R6, R7, FGD1, FGD2 expressed their willingness to keep taking the diagnosis due to the healthcare providers commitment. In the same vein, patient-provider communication impacts on clients' autonomy experiencing, identified motivation. R1, R2, and R3 mentioned that they the following initiate a conversation for Q&A in order to get fulfillment and relief.As one respondent said:

> I have an open discussion with nurses. They treat their clients well. They give full information about the disease. They always remind us the disease is curable and manageable if they get the virus at the precancerous level. I always ask them freely if I have any questions. When the nurse called me to notify me that the result was already in hand, I asked her what was new with my result.Generally, open communication helps me to be curious about my health status and to know more (R2-personal interview on January 15,2024).

Another repondent said:

> After taking the screening, I asked the nurse what the result was. She told me that my result shows it is HPV 16 and HPV 18. My result shows that I am positive. My result sparked a negative thought in my mind with quite a few questions. I started to ask myself why this could happen to me and I started to stress about the reason behind it. My appointment was for the next six months, but I came back here within a week after undergoing the screening to get clear understanding about my status(R1-personal interview on January 15,2024).

This shows that clients are having open discussions with their healthcare providers to gain a deeper understanding of their condition and treatment and that they perceive the healthcare providers as their trusted figures sources of knowledge and emotional supporters. As one respondet said:

> I frequently ask questions, for I perceive the nurses as a father and mother. We wouldn't have any secret that we hide from our mother and father. The reason behind this is that the communication I have with them leads me to be conscious of my health and the way the nurses approach me (R3-personal interview on January 23,2024).

Some of the participants (R1,R2,R4,R5, R6,R7) participants expressed their decision to prioritize the appointment following the positive communication experience and highlighted the profound impact of respectful and empathetic communication on patient engagement. The motivation to attend appointments stems from a desire to maintain good health, diagnose complicated health issues at an early stage, and engage in discussions with healthcare providers about their health status.

> I think I will visit my nurses on the exact day of my appointment unless something beyond my power happens. Hence, there is no precious thing more than my health. What motivates me to have such motivation is that I am happy that the disease was identified and diagnosed at an early stage. In addition, I am taking the treatment. You can guess what will happen if I don't stick to my follow-up schedules. When the nurses stress and care for me, I should care for myself as well (R6-personal interview on January 30,2024).

Furthermore, clients prioritize being well-informed about their health condition and treatment options to make autonomous decisions that align with their well-being. The emphasis on self-care and internal well-being reflects a proactive approach to health management and a belief in the importance of personal responsibility for health outcomes. FGD and IDI participants expressed that they are in strong agreement with the nurses' advice about not having sexual intercourse after taking the screening. The participants said the humble explanation and the well-detailed explanation of the nurses convinced them to do as they told them to do so. As one repondents response shows:

> The nurse told me that I should not get involved in sexual intercourse 45 days after undergoing the screening. She also briefed me that in case I get involved, I should use a condom. What would the worst could happen if I completely avoided sexual intercourse for 45 days? There is nothing more than my well-being (R1-personal interview on January 15,2024).

Similarly, clients(IDIs and FGDs) acknowledge the discomfort and pain associated with the diagnosis and screening procedures but prioritize their health and well-being because of the commitment and efforts of healthcare providers, particularly nurses who demonstrate dedication through frequent communication and support. In addition, patients expressed that they seek a balance between receiving medical treatment and experiencing a supportive and caring environment that addresses their emotional and psychological needs.

The respondents and discussants also pinpointed some ideas that have impacted their attitude and behavior in their previous experience at this department. Based on the data gathered from them clients' satisfaction with the communication they have with their previous healthcare provider happened to be problematic to most of the respondents and discussants. R1, FGD1, and FGD2 mentioned how they were negligent and unsatisfactory with the service they received from their previous male doctor and how they feel right now. The lack of clear information caused the clients to miss their follow-up day. The narratives shared by participants in the focus group discussions shed light on the transformative impact of improved communication and open discussions with healthcare providers on clients' attitudes and behaviors toward their treatment. R2 and R5 highlighted the pivotal role of effective communication in fostering trust, promoting engagement, and influencing healthcare decisions among individuals living with HIV.

Furthermore, the participants expressed a sense of missed opportunity for positive reinforcement, suggesting that a more supportive and encouraging approach from the healthcare provider could have potentially mitigated feelings of confusion and disconnection. This emphasizes the need for healthcare professionals to not only provide accurate information but also to offer emotional support and reassurance to patients facing the challenges of living with HIV. Moreover, the participants'(FGD1,FGD2,R1 and R3) statements highlighted the unique emotional struggles that individuals living with HIV may face, pointing to the need for special attention and empathy from healthcare providers.

#### 4.1.3.2. Interpersonal communication with family and neighbors

The data gathered shows fear of discrimination and stigma within the community reflect the impact of social support and acceptance on individuals' willingness to seek help and support. R6 and R3's experiences of hesitancy to disclose their health concerns due to fear of discrimination underscore the importance of a supportive social environment in promoting healthcare-seeking behaviors. R3 mentioned, "Even though I visit my nurses on time, I couldn't make it once, for I twisted my leg. At that moment, I couldn't ask for help from my neighbors to bring me to the hospital. I was scared to tell them frightening the discrimination." Emotional support from spouses, as mentioned by participants, can provide individuals with the reassurance and encouragement needed to navigate health challenges and foster a sense of relatedness and connection during difficult times.As one respondet expressed:

> I was losing weight too much and I was asking myself why am I losing weight like a person who has cancer, but I couldn't share my feelings with my husband and family, for I was afraid of discrimination. After I knew my result I didn't have any choice except telling to my spouse. I called him and told him what happened. He told me that I should calm myself down and everything would be fine as the nurses told me (R6-personal interview on January 30,2024).

The other major issue raised by participants was that of family members and community members exhibiting reluctance to discuss the disease openly, viewing it as incurable and expressing discomfort with conversations about health issues.As the FGDs revealed:

> There is a lack of awareness in the community and we have exaggerated attitudes towards the disease. In a general sense, we don't have sufficient knowledge about reproductive health. For example, everybody knows the causes of HIV, for it has the desired coverage with great strategies. Unlike HIV, there might be quite a few people out there without any information about this disease. We can get the information from media sources, healthcare providers, and other people (FGD 1-group discussion on January 26,2024).

> The community thinks the disease is non-treatable. The community doesn't know the causes and the treatments of the disease. When people think of cancer the first thing that comes to their mind is chemotherapy and the suffering of cancer patients who take palliative care (FGD 2-group discussion on January 30,2024).

Furthermore, the emotional and financial challenges faced by widowed women, as highlighted by R1 and R3, underscore the interconnectedness of autonomy, relatedness, and competence in healthcare decision-making. The lack of social support and concerns about burdening family members emotionally and financially can hinder individuals' ability to seek timely and appropriate healthcare, emphasizing the need for holistic support systems and communication strategies that address both emotional and practical needs.

#### 4.1.3.3. Clients’ preferences and communication for treatment outcomes

The narratives shared by participants in the focus group discussions revealed the profound impact of healthcare providers’ gender on client satisfaction, willingness to engage in screening and treatment procedures, and overall healthcare experiences. The themes that emerged from the accounts of IDIs and FGDs stressed the significance of client preferences for female healthcare providers, citing reasons such as perceived comfort, better counseling, and positive interactions, particularly in the context of diseases related to private parts of the body.

As the discussion with FGD1 shows influence of healthcare provider gender on client willingness to engage in screening and treatment procedures, particularly in the context of cultural norms and privacy concerns. Both IDI and FGD participants expressed a preference for female providers, citing feelings of shame and discomfort in showing private parts to male providers, which impacted their willingness to seek necessary healthcare services. Similarly, reflection on the preference for nurses to conduct the diagnosis using a speculum based on their approach and treatment highlighted the significance of compassionate care and patient-centered communication in shaping patients' experiences. The participants’ positive perception of the nurses' approach and manner underlined the impact of respectful and empathetic interactions on patients' comfort, trust, and satisfaction with the healthcare experience.

The above response of participants show that the intersection of cultural considerations and gender dynamics in shaping patient preferences and healthcare-seeking behaviors. N2's observation regarding the clients' preference for female healthcare providers during diagnosis sessions reveals the impact of cultural norms and gender dynamics on healthcare experiences. N1 reported decrease in client numbers when a male doctor is present highlights the influence of gender on client comfort and willingness to engage in the screening and diagnosis process. This shows the importance of a supportive and relatable healthcare environment in facilitating patient engagement and satisfaction.

R7 provided a contrasting experience, illustrating the impactful communication and understanding demonstrated by a female nurse in addressing a client's discomfort during a screening procedure. The participant's justification underlined the importance of empathy and patient-centered care in healthcare interactions, particularly in acknowledging and addressing patient discomfort. This contrasted with the participant's experience with a male doctor, where a lack of understanding and an unwelcoming approach led to a disengagement from the screening process.

> I had the experience of taking the screening by male and female healthcare providers. However, I liked the service I received from the nurse, for I could openly tell her that I was not comfortable lying down on the bed to take the screening. She didn’t get angry against me rather she told me that she can think how it could be uncomfortable to open one leg for someone you don’t know. She waited for me until I was ready and I underwent the screening. Whereas, what I did with the male doctor was different. I told him I would get back when I was ready and I didn’t come back, for his approach wasn’t welcoming (R7 personal interview on Januuary 31,2024).

Furthermore, the healthcare providers’ reflection on clients' emotional sharing and their perception of female healthcare providers as more empathetic and understanding indicates the role of relatedness in healthcare communication. The clients' belief that female providers can better comprehend their feelings and experiences with the disease points to the significance of establishing a sense of connection and understanding in patient-provider interactions. This aspect of relatedness is integral in promoting patient autonomy, trust, and open communication, as individuals feel supported and validated in expressing their concerns and seeking information.

As mentioned by the healthcare providers the approach of assessing clients' emotions through facial expressions encourages open dialogue. By recognizing and responding to clients' emotional cues, healthcare providers can empower individuals to voice their concerns, ask questions, and actively participate in their care. This approach fosters a sense of autonomy and support in decision-making, enhancing clients' engagement and investment in their health outcomes.

> Our clients share with us their feelings about the disease and their emotions. They share with us their experience and their worries about living with a double burden. They usually say you are female so you can understand what I feel. Therefore, they start to ask for additional information about the disease. They usually ask about the causes of the disease. They are curious to know about the causes. Besides, I try to understand what she

> feels from her facial expression. If I suspect something is bothering her or unclear I insist her to ask me openly (N1-personal interview on February 2,2024).

When some clients express a preference for female healthcare providers, others prioritize the proficiency and treatment quality of the provider over their gender. Some participants such as, R6 and FGD1 proved that they don't have any problem with the gender of the healthcare provider. What really matters is the proficiency and treatment of the healthcare provider. They mentioned the issue of giving birth as an instance when people don't show their preference towards the sex of the healthcare professional.

The data shows how the communication between the patient and the healthcare provider brought patient satisfaction that can lead to autonomy. Patient-provider communication influences treatment decisions, as patients feel empowered to participate in their care and make informed choices based on the information and support they receive. The positive interactions with healthcare providers contribute to patients' confidence in the treatment process and their willingness either self-regulated extrinsic motivation or intrinsic motivation to engage in follow-ups and screenings. Furthermore, the importance of effective communication and support from healthcare providers in fostering patients identified regulation over their health and well-being.

This can also indicate that effective communication can lead to proactive health management among individuals. In essence, the thematic analysis of participant feedback illuminated the profound influence of healthcare provider gender on client preferences, comfort, and engagement in healthcare interactions. The narratives underscored the importance of understanding, empathy, and cultural sensitivity in patient-provider relationships, particularly in the context of sensitive medical encounters. These insights emphasized the significance of considering patient preferences for healthcare provider gender and the potential impact on patient satisfaction, comfort, and willingness to engage in essential healthcare services. In conclusion, the clients' are autonomously dependent on female healthcare providers because of the nurses' emotional and professional support

#### 4.1.3.4 The impact of patient-provider communication on clients' current motivation status and satisfaction

Although patient-provider communication is helping the patients to actively engage in discussion and fulfill their information-seeking behavior to a greater extent, there are communication barriers identified that lead them to depression and stress. The accounts shared by participants, including R1, R6, R7, FGD1, and FGD2, shed light on the critical importance of clear communication, comprehensive information dissemination, and patient understanding in the context of healthcare services. The narratives highlighted various aspects of patient experiences, ranging from ambiguity in result communication to the need for detailed information on treatment procedures, potential side effects, and disease understanding.

The participant's subsequent active method of seeking clarification demonstrated a sense of caution and personal agency in managing their healthcare. Some clients (R3,R6 and R7) feel hesitant to seek clarification due to shyness or confusion justifies the need for healthcare providers to prioritize clear communication and patient education. This indicates the importance of autonomy-supportive communication in fostering patient empowerment.

With this regard, FGD1 reflected on the significance of balancing emotional support with informational needs in healthcare interactions and over providing detailed status information rather than giving counseling. The participants' desire for detailed insights into their health condition reflected a sense of competence-relatedness, stressing the impact of understanding on promoting motivation and engagement in healthcare management. The acknowledgment that individuals are more likely to remain engaged when they feel well-informed highlighted the impact of health education on healthcare outcomes and patient satisfaction.One respondent explained:

> The nurses are good but they mostly give emphasis for counselling. I don't get satisfactory information about my status as much as the information I get from the counseling prior to the treatment and screening. I still want to know details about my case. People are willing to keep in touch with someone or stick to something when they feel they understand the case well. I should understand my health condition thoroughly. This makes me eager to know what will happen next. Otherwise, at some point, I might be negligent (R7-personal interview on January 31,2024).

FGD1 participants expressed ongoing uncertainty and confusion regarding their health condition, treatment rationale, and diagnosis, indicating a need for enhanced communication and education on disease management. The experiences of uncertainty regarding their health condition, treatment rationale, and outcome highlighted the importance of competence, support and information provision in facilitating patient understanding and self-efficacy. Besides, FGD2 reflection on the frustration experienced due to inadequate information on treatment side effects and duration shows the importance of setting realistic expectations and providing comprehensive patient support throughout the healthcare journey.

The narratives from FGD2 participants and R6 explained the experiences of feeling misled about procedural pain and the impact on willingness to engage highlighting the pivotal role of trust and truthful communication in promoting patient-provider relationships and promoting psychological preparedness. R4, N1, and N2 highlighted fear of medical procedures and screening may stem from a lack of understanding or misinformation, highlighting the importance of clear and empathetic communication between healthcare providers and clients in addressing fears and misconceptions.

The above experiences revealed that there are communication barriers between clients and healthcare providers on issues such as lack of sufficient information about their case, the effectiveness of their treatment, the pain they encounter while undergoing the screening, unsatisfactory information about the side effects of the treatment and lack of awareness about their vulnerability though taking the treatment. This shows that the clients are more inclined to have external motivation (external regulation and introjection) with respect to the aforementioned issues due to communication barriers. By promoting autonomy-supportive communication practices, healthcare providers can empower patients, strengthen patient-provider relationships, and promote positive health outcomes. In addition, trust is a crucial factor in patient-provider relationships, with patients expressing confidence in the information and care provided by healthcare professionals.

### 4.1.4. Cultural norms, communication, and health-seeking behavior

The data gathered from R1, R3, R4, R6, FGD1, and FGD2 highlight the influence of cultural beliefs, perceptions, and social support on individuals' healthcare-seeking behaviors and emotional experiences. The community's lack of culture to prioritize health check-ups accentuates the impact of cultural norms on preventive healthcare practices. The participants' adherence to cultural beliefs that prioritize traditional remedies over professional medical intervention reflects a perceived sense of autonomy in deciding their health-seeking behaviors based on familiar and culturally embedded practices.In addition, community's reliance on traditional or religious remedies over professional medical care indicates a sense of relatedness to communal beliefs and shared values, influencing individuals' preferences for healthcare practices rooted in spiritual or cultural traditions. This preference for alternative healing methods may hinder the timely diagnosis and treatment of conditions. Therefore, effective communication strategies that bridge the gap between traditional beliefs and evidence-based healthcare practices is needed.

> The reason behind the high prevalence of cervical cancer is that we Ethiopians lack the habit of adapting screening into our lives. Even though screening is the best option to detect the disease at an early stage, people have frightening of the procedure of the screening. When we have the chance to do our best at an early stage by taking the screening, many women are dying every year while being on the waiting list to take radiotherapy or chemotherapy. Besides, people take different local medicines. The biggest problem that we are encountering right now is that our clients relate their cases to religious aspects. When we refer them to another hospital, they prefer to go to religious places to be cured (N1-personal interview on February 2,2024).

The discussion with FGD1 and FGD2 on cultural beliefs associating diseases with 'devil spirits' and questioning medical understanding emphasize the role of cultural perceptions and beliefs in shaping individuals' attitudes towards illness. These beliefs may impact individuals' autonomy to seek appropriate medical care and challenge the effectiveness of traditional healthcare practices. Understanding and addressing these cultural beliefs through open communication and education can help bridge the gap between traditional beliefs and evidence-based healthcare practices, empowering individuals to make informed decisions about their health.

Moreover, women discouraging each other from undergoing cancer screenings due to perceived pain further highlights the role of communication in shaping individuals' perceptions of healthcare procedures. This peer influence within the community can reinforce fears and misconceptions about screenings, illustrating the impact of social influences on healthcare decision-making.As one respondent mentioned:

> In my neighborhood, the people say it is not cancer, it is another disease that can be cured by local medicine and they take the medicine. When they collapse they visit a doctor at a late stage. In Ethiopia, we don't visit doctors unless we collapse. For example, my mother died because of cervical cancer. I was the one who brought her to St. Paul Hospital. She said I couldn't go, due to fear of the screening and the diagnosis procedure (R4-personal interview on January 26,2024).

The thematic analysis shows the impact of possessed culture norms in cervical cancer early detection and treatment programs. Preference for local medicines religious beliefs and fear of the screening procedure are affecting women's autonomy for engaging themselves to undertake the screening and to stick to their follow-up.

#### 4.1.5. Community mobilization activities in addressing clients' motivation

The participants' voices echo a resounding call for more active community mobilization efforts to raise awareness about precancerous treatment, emphasizing the power of peer education and shared experiences in educating and supporting others within the community. FGD1 highlights the importance of self-initiated discussions and the desire for group mobilization activities within the community. The participants express a sense of autonomy in sharing information about the disease with close contacts, stressing the role of personal initiation in disseminating health knowledge. In addition, the absence of structured group mobilization activities was mentioned and it suggests a gap in relatedness, as community members seek collective efforts to raise awareness and educate others. This shows the potential for community-led initiatives to foster a sense of connectedness and shared purpose in promoting early detection and treatment of precancerous conditions.As FGD1 discussion revealed that the discussants don't have any participation or any role in creating awareness for the rest of the community in programs prepared by the hospital. In fact, there haven't been any community-oriented campaigns prepared by the hospital. Whereas, they mentioned that the hospital and the health bureau can utilize them and other cervical cancer clients as a way to teach others by preparing training and open discussion platforms. They insist when they teach each other through their lived experience the effect would be much better.

Similarly, the seconf group highlighted the need for active involvement of individuals living with HIV and cervical cancer in awareness campaigns and community programs is mandatory. Utilizing clients as resources for education, training, and open discussions, highlighting the importance of competence in leveraging lived experiences to enhance awareness and support within the community. By empowering individuals to share their stories and knowledge, the community can benefit from first-hand insights and peer support, ultimately contributing to a more informed and engaged population in combating cervical cancer(FGD2).

In addition, healthcare providers' comments on the lack of participatory activities involving clients stressed the need for inclusive and engaging communication strategies that prioritize individuals' competence in sharing their experiences and knowledge with the broader community. N1 and N2 showed their concer on the absence of client involvement in awareness activities points to a missed opportunity to harness their insights and lived experiences in educating others and fostering a sense of empowerment and support within the community.

The thematic analysis shows that even though the clients are willing to participate in community mobilization activities, the lack of involvement of women living with HIV and cervical cancer clients in hospital-led awareness campaigns points to a missed opportunity for utilizing these individuals as valuable resources in community education. By creating open discussion platforms and training opportunities, hospitals can empower clients to play an active role in raising awareness and promoting early detection of precancerous conditions. Through collaborative efforts that prioritize autonomy, foster connectedness, and enhance competence, communities can build a foundation of support and empowerment in promoting holistic health and well-being.

### 4.1.6. Healthcare facility environment impact on the medical interventions and communication

The organizational factor is the other issue that indicated positive and negative implications according to the data gathered. In examining the issues with respect to cervical cancer screening and diagnosis the following key themes have emerged. The analysis reveals challenges related to equipment accessibility, training opportunities, and privacy within the healthcare system.

Equipment accessibility surfaces as a critical concern, with individuals expressing apprehension towards undergoing diagnosis at external laboratory centers due to perceived inconveniences and distrust in the process. Anecdotes of (R6,R7,FGD1 and FGD2) about hesitance to pursue diagnosis at an external facility, insights into the importance of fostering a sense of security and familiarity within the healthcare environment to promote individuals' autonomy and confidence in seeking preventive care. Furthermore, participants' emphasis on the significance of equipment fulfillment in enhancing patient satisfaction and engagement justifies the interconnected nature of autonomy, relatedness, and competence within the healthcare setting.As one respondent commented:

> Giving broad coverage to the disease would not make any difference. Equipment should be fulfilled. Otherwise, patients will not be happy to visit the hospital. It could be a good reason for clients to avoid the screening. After giving prolonged counseling and convincing someone, equipment problems should not be an issue (R6-personal interview on January 30,2024).

By emphasizing the affordability barriers associated with PAP smear tests and the need for on-site testing options to accommodate clients with limited economic resources, N2 draws attention to the importance of equity, accessibility, and patient-centered care in addressing individuals' diverse needs and preferences.

> After giving counseling for the screening and after our clients take the screening their results might need further tests, we refer them to other health facilities or laboratories. They are not comfortable to go there and proceed the diagnosis, for firstly they take the screening without their full willingness then they hate to have another discussion with another healthcare provider. I can understand this by observing their facial expression after they take the screening and when I tell them I refer them to another facility. However, for example, recently we have been undertaking the test using the HPV DNA test tool. It is self-testing equipment. We get it from donations and it is 99% effective. Our clients are happy when they have this test. Most of our clients don't like the screening held by the healthcare provider due to privacy issues and the screening

> instrument(speculum). They are not happy with opening their legs for someone else. They don’t like the speculum at all (N2-personal interview on February 5,2024).

Through a detailed thematic analysis, the challenges faced by healthcare providers in ensuring comprehensive coverage and functionality of essential equipment are explored. Participants'(N1 and N2) reflections on the availability and functionality of equipment for screenings and tests reveal the intricate ways in which organizational factors can complicate communication and hinder effective interventions in healthcare settings. Concerns about the non-functionality of thermal ablation equipment and the absence of Leep services at the hospital show the importance of equipping healthcare facilities with alternative tools and resources to support accurate diagnosis and treatment.

Besides, the discussion with healthcare providers reveals critical insights into the challenges faced in delivering effective awareness and education initiatives due to limited human resources. They underline the importance of communication approaches, continuous professional development, and collaborative efforts to support individuals' autonomy and well-being in healthcare settings.

> In this hospital, there are some initiatives to create awareness at wards and stations, but they are not effective, for there are scarce human resources. For example, if we teach the people who visit the hospital through audio material, they might feel they understand the severity of the disease for the moment and they may forget to come and take the screening. Whereas, if the communication is in person the result would be much better and more effective. We can involve counseling as well (N2-personal interview on February 5,2024)..

The inadequate staffing levels and limited training opportunities at the hospital level indicate the systemic challenges faced by healthcare institutions in maintaining competency, expertise, and service quality in the face of resource constraints.The recognition of the budgetary and human resource constraints by N1 further emphasizes the need for collaborative initiatives, strategic resource allocation, and capacity-building measures to foster a supportive environment that empowers healthcare providers to deliver optimal care and support individuals in their health management journey.

> Even though we take training every two years, I can say there are no training opportunities at the hospital level aside from the two years training. As a hospital, we are not working in the desired effort expected from the hospital, for we are few who took training regarding the issue. We might be 4-6 healthcare providers. It is an unsatisfactory number for one referral hospital (N2-personal interview on February 5,2024).

On the conterary, client respondents and discussants expressed their acclamation of the conducive environment for privacy and the collaborative efforts between the ART clinic and the cervical cancer screening clinic underscore the role of connectedness and relatedness in fostering individuals' attendance and engagement with preventive care initiatives. By aligning organizational practices with individuals' needs and preferences, healthcare providers can create a safe and inclusive space that not only facilitates access to essential services but also nurtures a sense of belonging and support for vulnerable populations, ultimately enriching the fabric of healthcare delivery and community well-being.

> The room where the screening and the diagnosis take place is comfortable enough for patients to have privacy. Besides, the allied work of the ART clinic and the cervical cancer screening clinic is appreciable. Because of this many vulnerable women are attending the screening. Regarding this, the hospital is saving many women’s lives (R2-personal interview on January 15,2024).

By streamlining the diagnostic process and enhancing the convenience and ease of access for clients, healthcare organizations can empower individuals to actively participate in their care journey, fostering a sense of competence and self-determination in healthcare decision-making. R6's endorsement of the integrated screening and diagnosis room reflects the power of environmental design in fostering positive healthcare experiences, promoting individual autonomy, and enhancing communication dynamics between providers and clients.

> The room where the diagnosis and the screening take place is comfortable for clients and their privacy. Rather than sending us to another room, having the diagnosis and the screening here at the same spot makes the diagnosis procedure easy for patients. I like it (R6-personal interview on January 30,2024).

In conclusion, the thematic analysis illuminates that by addressing challenges related to equipment accessibility, training opportunities, specialized expertise the healthcare system can sustain individual's autonomy and empower them in healthcare interactions,

### 4.1.7. Multi-level intervention for multiple influences of cervical cancer early detection and treatment behavior across different levels of interaction

#### 4.1.7.1. Peer support and support group

The focus group discussions (FGDs) and IDIs shed light on the potential of communication strategies, and peer interactions facilitating early diagnosis, and enhancing individuals' autonomy and engagement in their healthcare journey**.** FGDs' reflections on their role in initiating others by sharing diagnostic procedures and healthcare provider information show the significance of peer support, knowledge sharing, and interpersonal communication in fostering individuals' understanding, engagement, and empowerment in healthcare settings. By emphasizing the importance of information exchange, FGD1 advocates for a collaborative approach that leverages peer interactions to enhance individuals' knowledge, confidence, and self-efficacy in navigating the complexities of cancer diagnosis and treatment.

Similarly, FGD2 emphasizes the importance of fostering relatedness, connection, and social support as key determinants of individuals' well-being and treatment outcomes.

> Discussions have a pivotal role among family members, friends, clients, and healthcare providers in increasing screening uptake and supporting individuals undergoing precancerous treatment.It potentially transforms the social connections, community engagement, and collaborative care approaches.In addition, it promotes health literacy, shared decision-making, and emotional support in cancer care settings. The influence of peer interactions and interpersonal relationships in sustaining individuals' motivation, adherence, and resilience throughout healthcare journey is priceless (FGD2-group discussion on January 30,2024).

That being said, R2, R5, R6, and R7 reported that peer influence plays a significant role in encouraging individuals to overcome fears and misconceptions about screening. Positive experiences with screening and treatment motivate some individuals to influence others to undergo screening, emphasizing the importance of sharing personal stories and providing evidence of undergoing screening themselves. R2 mentioned that “There are people who are not willing to take the screening at the health centers in their neighborhood. I bring them to the hospital and they take HIV tests and cervical cancer screening. I also show them my appointment card as and evidence that I took the screening and they get convinced.”(R2-personal interview on January 15,2024)

Other participants (R1, R4, and FGD1) agreed that personal experiences with screening, coupled with clear explanations from healthcare providers, empower individuals to advocate for themselves and encourage their friends and family to prioritize screening and early detection. In addition, the importance of regular screening prompts to take on the role of raising awareness and educating others about the disease.

#### 4.1.7.2. Stakeholders’ mobilization

Respondents and discussants recognized the media's impact in raising awareness, disseminating information, and reaching a wider audience in cancer education initiatives. This indicates the power of mass communication, public messaging, and media advocacy in shaping societal perceptions, behaviors, and attitudes toward cancer prevention and treatment. Acknowledging the role of media in creating awareness, engaging diverse audiences, and empowering individuals to take proactive steps toward their health and well-being is required. Furthermore, to dispel myths, and foster dialogue around cancer-related issues a multi-faceted approach that integrates traditional and digital media platforms are suitable so as to amplify health promotion efforts (FGD2-group discussion on January 30,2024).

In addition, FGD1's observations on the increasing media coverage of cancer-related topics on television and radio reflect the evolving landscape of health communication, public discourse, and information dissemination in shaping individuals' awareness, perceptions, and responses to health challenges. By questioning the novelty of the disease and the reasons behind its media visibility, FGD1 highlights the importance of information literacy and media literacy. They also navigate the complex landscape of health information, fostering individuals' autonomy, curiosity, and empowerment in seeking accurate, reliable, and relevant health-related content. Besides, N2's emphasis on the pivotal role of the media in spreading awareness about cervical cancer underscores the significance of providing individuals with accessible and engaging information to make informed decisions about their health. The nurses mentioned utilizing radio and television platforms to educate the public about screening, treatment, and palliative care could be a possibele way to address about the issue.

Moreover, R6's call for media organizations to incorporate images in their awareness creation programs implies the visual impact, emotional resonance, and storytelling potential of visual media in conveying complex health messages fosters connections with diverse audiences. Likewise, N1's suggests the power of storytelling and visual narratives in engaging audiences and dispelling misconceptions. Drawing parallels with the successful dissemination of information during the COVID-19 pandemic, N1 advocates for using compelling narratives to address concerns(dispel misconceptions) and educate individuals about the importance of early detection and preventive measures. This recommendation indicates the value of providing individuals with the knowledge and resources they need to feel confident and competent in making informed decisions about their health.

> Since we love visual information, dramas have the power to create successful awareness. For example, when COVID-19 pandemic happened everybody was aware of the disease and acted according to the commercials and dramas disseminated through television. In the same vein, there should be dramas that create awareness that the speculum is not painful. The media is the source we have on hand to create awareness the content shouldn’t be only about taking the screening. The content should include that the screening is not that painful, for quite a few women do not attend the screening due to fear of the pain of the screening. Health professionals should be invited and should give detailed explanation about the screening procedure (N1-personal interview on February 2,2024).

Participants' recommendations also highlight the importance of utilizing hospital resources, particularly public relations officers, to facilitate awareness creation programs that effectively engage clients. The perspectives shared by the participants from FGD1, R2, R3, R5, and R7 underline the significance of communication strategies grounded to empower individuals, enhance their autonomy, and nurture a sense of relatedness in healthcare settings.

> It is necessary that hospitals to proactively prepare banners, provide training, and organize awareness creation programs to educate visitors about diseases such as cancer.

> By creating a visual presence through banners and posters individuals who may have never heard of the disease will become curious and seek information from their family members or healthcare providers. Furthermore, by integrating awareness creation programs into educational settings and community-based activities the healthcare system can create a holistic approach that values individuals' autonomy, competence, and relatedness in their healthcare journey. Through initiatives that focus on prevention, education, and community involvement. The healthcare system can make clients make informed decisions about their health and well-being. (FGD1-group discussion on January 26,2024).

The discussion among the nurses highlighted the importance of ongoing awareness creation programs.N1's proposal for the health bureau to extend awareness creation programs beyond cervical cancer awareness Month in January reflects a proactive approach to promote health education throughout the year. By advocating for continuous efforts to raise awareness about cervical cancer, healthcare providers mentioned the importance of providing individuals with the information they need to make informed decisions about their health and well-being. This recommendation aligns with the principle of autonomy, as it emphasizes the importance of empowering individuals to take ownership of their health by providing ongoing opportunities for education and awareness.

Furthermore, N2 mentioned the support provided by the health bureau and ICAP Ethiopia in facilitating communication with clients through covering phone charges. By recognizing the importance of personalized communication and timely reminders for follow-up appointments, N2 highlights the significance of empowering individuals to take proactive steps in managing their health. Additionally, N1's emphasis on creating well-organized and detailed content for awareness campaigns, which address women's fears about screening procedures, reinforces the principle of autonomy by advocating for informed decision-making and personalized messaging that respects individuals' concerns and preferences.

> The health bureau alongside ICAP Ethiopia is supporting us by covering phone charge fees so that we can call our clients to remind them of their follow-up day and to bring their results on time. Thus, the health bureau should work with other organizations. The

> result and the change would be great.” For example, in the case of COVID-19, everybody was working together whether the concerned bodies or not. In the case of cervical cancer, the awareness creation should be the first issue that should be addressed (N2-personal interview on February 5,2024).

A call for training programs to enhance professional and communication skills among the nurses from the healthcare providers was raised and highlights the importance of competence. By recognizing the need to update their knowledge and adapt new communication approaches, N1 emphasizes the importance of continuous learning and skill development in healthcare settings. This recommendation underscores the value of providing nurses with the resources and support they need to excel in their roles, furthering their sense of competence and self-efficacy in providing quality care for patients.

In line with this, the nurses’ suggestion to increase the frequency of training programs and facilitate knowledge-sharing opportunities with international partners like ICAP and CDC reflects the principle of relatedness. By advocating for collaborative learning experiences and cross-cultural exchanges, N2 highlights the importance of building connections, fostering dialogue, and drawing inspiration from successful countries in combating cervical cancer. This recommendation emphasizes the value of creating a supportive environment where healthcare professionals can learn from each other, share best practices, and strengthen their sense of relatedness and connectedness in their professional development.N2 proposed:

> The training we take in two years is not sufficient enough. It should be prepared frequently. Since the health bureau is working with ICAP and CDC, the experience we get is only bounded at a country level. It will be a great opportunity for us to share experiences to take lessons from successful countries(N2-personal interview on February 5,2024).

#### 4.1.7.3. Community mobilization

The recommendation to create participatory stages for community engagement within the hospital settings indicates the potential of collaborative communication initiatives in empowering individuals and nurturing a sense of autonomy and relatedness. By integrating awareness creation stages into everyday hospital interactions, R3 advocates an approach that promotes information dissemination, dialogue, and active participation among individuals from diverse backgrounds. This participatory model not only enhances individuals' sense of autonomy and competence in healthcare decision-making but also strengthens their connection to the healthcare and promote a culture of shared responsibility and engagement.In line with this, FGD2 underscores the importance of creating a supportive environment where individuals feel empowered to seek information, share experiences, and take proactive steps toward their health and well-being.

R5 and R7's recommendations highlight the essential role of community-oriented communication strategies in promoting awareness and empowering individuals. House-to-house awareness creation teaching resonates with the importance of personalized communication and community engagement in empowering individuals with scarce knowledge about the disease. The role of health extension workers in identifying major health issues within the community draws parallels with their successful involvement in addressing HIV cases. This approach aligns with the principle of highlighting the importance of empowering healthcare professionals to take initiative, recognize community needs, and tailor interventions to address specific health challenges. By exploiting the expertise and local knowledge of health extension workers, healthcare communication initiatives can be tailored to meet the unique needs and preferences of the community, fostering a sense of ownership, autonomy, and empowerment among individuals.

Besides, the engagement of public relations officers and nurses in conducting small group talks, or "coffee talks," highlights the importance of interpersonal communication and interactive engagement in promoting awareness and facilitating information sharing as the respondents proposed. It helps to create a supportive environment where individuals can ask questions and receive personalized attention. Additionally, the initiative to expedite the screening process reflects a proactive approach to support individuals' health decisions and enhancing their engagement in preventive care."The public relations officers should focus on creating awareness creation stages. For example, if I don't come here to follow up, I won't have the chance to know if the screening is given at this hospital (R7-personal interview on January 31,2024).

Through a social support network that values openness, trust, and dialogue, R2 advocates for a community-driven approach that empowers individuals to seek screening services, share knowledge, and engage in health-promoting behaviors. As it is explained by R2:

> We create awareness in the community when we teach them about HIV preparing coffee ceremonies to gather the people. Some people accepted our offer and took the screening. Small women's group discussions and friend-to-friend discussions would be very effective from my experience. For example, when the youngsters in my neighborhood come and ask me for condoms, I will tell them to have HIV test and cervical cancer screening. The best solution can be to teach the community by attending different social life events and coffee discussions (R2-personal interview on January 15,2024).

Likewise, R5 advocates for a collaborative approach that values individuals' autonomy, competence, and connection to their community. Through initiatives that promote openness, dialogue, and mutual support, R5 highlights the importance of creating a supportive ecosystem that empowers individuals to take ownership of their health and well-being, thereby contributing to the reduction of new cases and mortality rates.

> The health bureau should give awareness at the Woreda, Kebele, and neighborhood levels. Especially at a neighborhood level, the bureau should create an environment that the victim people participate in the awareness creation programs. Nobody turns down such initiatives. For example, if they ask me to be part of the awareness creation program, I will be very happy. I will share my story of what happened to me and how I diagnosed it with other people. I think this could be a great solution to decrease the number of new cases and mortality rate (R5-personal interview bon January 26,2024).

N2 emphasizes the importance of leveraging the lived experiences and community-based approaches to create impactful messaging. This approach aligns with the principle of relatedness, as it prioritizes building connections, fostering dialogue, and promoting shared experiences within the community to empower individuals to take control of their health outcomes.

> The awareness creation can be implemented using Radio and Television,but teaching others from the lived experience of the women who have undertaken screening, precancerous treatment, and palliative care would be more effective. We should tell them

> that being proactive is better than being reactive. Using the 1 to 30 grouping at a neighborhood level and teaching the community can be the best option. I think learning in a group at a neighborhood level can be successful. As a healthcare professional, I believe that health extension workers can create awareness in the community (N2-personal interview on February 5,2024).

## 4.2. Discussion

The study was conducted under the title of “The Interplay of Health Communication and Motivation in Women Living with HIV Undergoing Precancerous Treatment:in the Case of Menelik II Comprehensive Specialized Hospital”. The main objective of the study was to show the interconnectedness between health communication practices in multi-influence at different levels and their influence on the motivation of WLHIV taking precancerous treatment at Menelik II Comprehensive Specialized Hospital. Suggs et al., (2015)highlighted the levels of intrapersonal, interpersonal, group, organizational, and societal health communication are all feasible. It is envisaged that a message aimed at the broad public will incorporate important elements such as community involvement, audience sociocultural makeup, and coordinated communications for specific segmented groups.

Stakeholders’ involvement was the major issue raised and concerned by the participants. Although media organizations are working on the case concerning awareness creation to the mass audience, there is still a huge gap in the information disseminated through the media. Besides, the seasonal nature of the information is one major cause of lack of knowledge and awareness. Due to this women are not getting the desired and sufficient information. Participants in a study by Mpata and Nkosi (2021) said that radio and television were useful media that could be used to boost uptake in cervical cancer screening programs. In a similar vein, they emphasized that they had only been told to go for screening and had not been given any information regarding the disease. Similarly, in the case of this study, participants expressed their concern about screening more specifically about the insufficient content of the information disseminated through the media. This in turn is impacting the client participants’ autonomy and competence.

In addition, it creates a communication barrier in the patient-provider communication. More specifically the nurses expressed that fear of the screening procedure and the assumption of not having the disease due to not observing the symptoms of the disease is complicating the patient-provider communication. As the participants explained this happens due to insufficient information. The major issue that is hindering women from taking the screening is fear of the screening procedure. Emru et al. (2021) findings show that among the major reasons that affect women's involvement in screening lack of awareness about the screening is a significant barrier followed by considering no symptoms as being healthy, fear of positive results, fear of painful procedures, and perception of not having a disease. It is affecting their autonomy and health-seeking behavior.

In relation to this, cultural norms and interpersonal communication (friends, neighbors, and family members) are affecting women's motivation to undertake the screening as well as to take the treatment negatively. Whereas, some of the respondents mentioned that they get involved in peer teaching by raising their experience of screening and diagnosis as an instance. In line with this, Mpata and Nkosi's (2021) study on the experience of WLHIV in Zimbabwe revealed that the women's perceived benefit of early detection of cervical cancer increased through peer health education. Participants highlighted that they benefitted from discussions with their peers. This indicates that the interpersonal communication that is dictated by the cultural norm in the community negatively affects clients' autonomy. On the contrary, peer teaching through sharing one's experience with others works as a way to initiate others to undertake the screening.

That being said, the experiences of clients related to their results and the interpersonal communication they have with their healthcare providers are helping them to gain awareness about the disease. Mesfin et al., (2023) revealed that most of the participants heard about cervical cancer from their healthcare providers. Some of them heard from the media and their close relatives, families, and friends. Since clients' have frequent communication with their healthcare providers the findings of this study show that the clients have good relationships with their healthcare providers. Burrowes et al., (2022) insist that information on patient and provider experiences with cervical cancer screening, diagnosis, and treatment is essential.

According to Patrick and Williams' (2012) research, SDT healthcare interventions can include clinicians providing patients advice or ideas, as long as it is done in a way that respects their autonomy. Patients often regard healthcare personnel as authorities and interpret their comments as restrictive, making this a tricky business. As a result, medical personnel who provide counsel or suggestions must be careful not to seem domineering and instead present knowledge that assists patients in making decisions rather than discreetly exercising control over them. Clinicians should create a need-supportive atmosphere by implementing a variety of behaviors and communication approaches (Ryan and Deci, 2017).

Literature, however, emphasizes that no single strategy can predict successful need support on its own, supporting the idea that a need supportive environment necessitates combining several techniques (Gillison et al., 2019). In relation to this, the good rapport (relatedness) between clients and the health care providers is affecting the health-seeking behavior of clients and helping them to develop autonomy in their health status. Besides, it created a feeling of competence in their diagnosis and treatment journey. In-depth analyses by Haynes et al., (2008) and Andersson et al., (2014) as cited in McDonald and Sherlock(2016) have mentioned improved doctor-patient communication as being crucial to better drug adherence and, as a result, better health outcomes. In addition, Ha and Longnecker (2010) assist patient involvement and shared decision-making may have a favorable impact on health outcomes. Improved communication is crucial for a good doctor-patient relationship. Furthermore, the preference of gender of the health care provider by the clients happens to be a deal maker in sustainable behavior change, medication adherence, and health outcomes. This focus on patient engagement acknowledges that patients play an important role in their health care.

Clients prefer to be diagnosed by female healthcare providers due to communication style and cultural norms (relatedness) that in turn create autonomy and competence. In addition,they expressed the necessity of the reminder phone calls they receive from the nurses. While it has been discovered that knowledge is the first step toward initial engagement in cervical cancer screening, Mpata and Nkosi (2021) asserted that ongoing reminders are necessary to ensure continuing participation. With this regard, the researcher argues that although the reminders are necessary and it shows clients relatedness,it influences their autonomy and competence in a great deal. Therefore, rather than using directive startegies that emphasize persuading and making the clients passive, non-directive approaches that promote engagement can possibly help in this case. In this counter,the clients motivation is at the lowest stage of the internalization process of external motivation which is external regulation. The worthmentioning issue here is that there is a shift in service every two years in the department. All healthcare professionals might not be the same. Some go beyond their way to support and some are negligent as mentioned by the participants. Therefore, being fully dependent on healthcare providers reminder will not help to attain the ultimate goal of sustainable behavior change.

Furthermore, patients are encouraged to adhere to their follow-up appointments and ask their female healthcare professionals for additional information about their health status due to the emotional support, open communication, and empathy that they receive. According to studies, polls, and interviews, 40% of Americans do not feel emotionally well, and a patient's relationship with their doctor can greatly enhance their emotional well-being (Jiang, 2017). According to research by Mpata and Nkosi (2021), women's attitudes and motivations to undergo screening are altered when they receive information and guidance from healthcare professionals. On the contrary, in this study participants mentioned that they had poor and unsatisfactory communication with their male healthcare provider and added that it affected their communication style,which in turn led them to depression, confusion and unwillingness to adherence to treatment.

According to Deci and Ryan, the concept of autonomy-support entails creating interpersonal situations that promote an individual's initiative, will, and integrity. In other words, it makes it easier to meet the basic psychological need for independence. It turns out that the other two basic psychological needs are also related to autonomy-support. This is most likely due to the fact that those who affirm others' autonomy tend to affirm their own criteria for competence and relatedness. However, it most likely goes deeper than that. When someone respects another's autonomy, that person is more likely to feel free to act in a way that meets their needs for relatedness and competence. Supporting autonomy often helps others meet all of their basic psychological requirements.

Having said that, unclear and insufficient sources of information from healthcare providers about clients’ current health status and causes of the disease are affecting patient-provider communication by creating misunderstanding and imposing stress on the clients. Similarly, McDonald and Sherlock(2016) noted that poor communication can have a negative impact on a patient's health since it can exacerbate feelings of anxietyNoncompliance with pharmaceutical treatments is one of the most easily quantifiable consequences of poor communication. Noncompliance is undoubtedly a costly issue.

Participants of this study brought up the misconception that having HIV puts one at a higher risk of developing cervical cancer. Similarly, Munoru et al., (2019) study’s shows that despite being at a higher risk than their HIV-negative peers, 98.9% of the study participants of women with HIV did not believe that they needed to be checked for cervical cancer. The barriers identified were extended wait periods for medical staff in Kenya, as well as people's ignorance, apathy, or fear of seeking cervical cancer care. However, Mpata and Nkosi (2021) noted in their study that some women believed they were more susceptible to cervical cancer because they were HIV-positive, which encouraged screening behavior. Information about what makes cervical cancer screening easier in Zimbabwe is scarce. They also suggest that, understanding the driving forces behind women's decision to undergo cervical cancer screening is essential, as the data may be applied to the creation of interventions aimed at increasing screening uptake.

Similarly, this misconception is impacting the attitude of clients about the disease and affecting their decision over their daughters’ whether the daughters to tahe the screening or not. It also affects their competence to share their knowledge about the disease with other vulnerable ones in their surroundings. According to Erku et al., (2017), study's findings showed that HIV-positive women have extremely low awareness of and adoption of cervical cancer screening. Increasing awareness of cervical cancer is crucial because research indicates that women who believe they are at risk of the disease can be encouraged to undergo routine screenings, while those who lack knowledge are less likely to be aware of the preventative measures (Massad et al., 2015,p.37).

At the hospital level, participants express an observable gap between the communication office and public relations officers. They expressed they are currently getting the service, for the ART and the Cx Ca screening and pretreatment clinics are working together. Other women who visit the hospital may miss the chance to take a screening, for the communication office is not creating the desired awareness creation programs in the hospital. In counter, According to Musuka et al., (2022), women who test positive for HIV may encounter more awareness campaigns and requests for screening when they frequently visit medical institutions to obtain supplies of their HIV medications and information from support groups. However,in the case of this study HIV women are not aware about the disease as much as the exposure they have to visit the hospital frequently. The one and only opportunity that is helping them to have some undersanding about the disease is the ART navigation service and the nurses. Aside from this, they didn’t encounter awareness campaign in the health facility.

In relation to this, the client participants mentioned that the public relations officers can utilize the clients’ experience to create support group discussions and community mobilization activities to motivate others’ to take the screening and treatment. Likewise, Malikhao (2020) insisted at the group and community level, social capital such as peer networks and support groups, along with positive reinforcement, can help to change bad habits. This indicates that the clients’ sense of relatedness is unfulfilled among one of the stakeholders is not incorporating them in awareness creation programs and it is impacting their competence.

Moreover, an initiative of awareness creation by healthcare providers is challenged due to dearth of communication approaches and continuous professional development, and limited human resources. This needs collaborative work among stakeholders. On one hand, this needs the collaborative effort of public relations officers to design and utilize effective communication approaches and strategies. In the same vein, the awareness creation programs are not well designed and they are seasonal as the same as the media campaign programs. On the other hand, the health bureau’s support in preparing training related to professional and communication training and increasing the number of human resources is required.Therefore, the autonomy and competence of the healthcare providers are not supported by other stakeholders.

In line with the emphasis placed on people's engagement by communication practitioners (Schiavo et al., 2014), health communication scholars highlighted the process of engagement and empowerment as the crucial first step in bringing about beneficial change (Gupta & Bansal, 2014). This means that bottom-up design models and empowering communities in fostering the desired "change" are important components of effective health communication. Participants’ emphasis on gathering communities at local levels and the role of public relations officers in disseminating information highlights the need for a collaborative approach to address the gaps in awareness and access to essential information. Furthermore, participants in Mpata and Nkosi (2021) suggested that health workers teach women about cervical cancer by going door-to-door, visiting churches, and setting up tents to promote awareness of the disease.

With respect to motivation, the participants' calls for enhanced collaboration with public relations officers and greater client involvement in awareness initiatives stress the intrinsic human needs for autonomy, relatedness, and competence in shaping individuals' healthcare engagement and decision-making processes. Healthcare communication can empower individuals to make informed decisions, build supportive networks, and take proactive steps towards better health outcomes by promoting autonomy through improved information dissemination, promoting relatedness through collaborative partnerships, and enhancing competence through inclusive participation.

In addition, participants expressed concerns about the availability and functionality of the equipment for screenings and tests, impacting individuals' autonomy in choosing where to undergo diagnosis. The lack of essential equipment,such as HPV DNA test tool and LEEP hinders individuals' ability to make informed decisions about their health, highlighting a gap in providing necessary resources for autonomous decision-making. The preference for self-testing equipment, such as the HPV DNA test tool, reflects individuals' desire for autonomy and control over the screening process. This preference underscores the importance of offering diverse testing options that align with individuals' autonomy and comfort levels.

Moreover, while positive feedback is provided regarding the comfort and privacy of screening rooms, these aspects contribute to creating a supportive environment for clients. Enhancing room facilities to ensure comfort and privacy aligns with the social ecological model emphasis on creating environments that support individuals' health behavior. Health communication occurs in a variety of contexts, according to Giulia et al., (No Date), including interpersonal interactions between patients and doctors, organizational health communication that describes a patient's experience in a hospital (or other healthcare facilities). On the contrary, some of the women in Mpata and Nkosi (2021) suggested that it would be more convenient for them to access all services under one roof.

The other issue raised by participants’ was budget constraints, human resource shortages, and delays in test results as significant organizational challenges, impacting the timely and effective management of precancerous lesions. Equipment problems are affecting both the medical intervention and the patient-provider communication. Besides, the human resource problem is hindering the potential of educating the hospital’s visitors. According to Mungo et al., (2024), women living in remote locations without access to referral centers face particular challenges in receiving existing precancerous treatments, which are dependent on skilled healthcare practitioners and a shortage of specialists.

Another concern mentioned by participants was the impact of cultural ideas about the disease and their relationship to local remedies. It shapes people's attitudes regarding disease. These beliefs may impact individuals' autonomy to seek appropriate medical care and challenge the effectiveness of traditional healthcare practices. The data underlines the critical influence of cultural norms, beliefs, and perceptions on healthcare-seeking behaviors within the community. Participants expressed a prevailing cultural norm of not prioritizing regular health check-ups, leading to delayed disease diagnosis and treatment. This reflects the interconnectedness between individuals and their cultural environment, shaping attitudes and behaviors related to health-seeking practices. Additionally, reliance on traditional or local medicines as a perceived alternative to professional medical intervention contributes to delayed health-seeking behavior. This emphasizes the role of autonomy and competence in shaping individuals' attitudes and behaviors toward healthcare decisions within their cultural context.

As an instance, participants' anecdotes underscored the influence of cultural perceptions on attitudes towards preventive healthcare, reflecting the impact of relatedness and cultural context on individual health behaviors. Expanding advocacy initiatives to enhance sociocultural and behavioral change communication, as well as raising women living with HIV's knowledge of cervical cancer screening is mandatory and a deal breaker (Wycliff et al., 2022).

In conclusion, clients highlight their valuable suggestions for strategic communication and awareness creation initiatives, emphasizing the role of social support, peer support, media, communication infrastructure at the hospital level, and community mobilization. Drawing upon social ecological model and self-determination theory, these recommendations stress the importance of leveraging interpersonal relationships, community networks, and participatory approaches to enhance awareness and promote proactive health behaviors. Similarly, healthcare providers highlighted key suggestions for strategic communication and awareness creation regarding cervical cancer. The themes that emerged from the data include the importance of the health system, media organizations and other stakeholders' involvement, and community mobilization in enhancing awareness and communication strategies.

# Chapter Five: Summary of the Major Findings, Conclusion, and Recommendations

This section of the study entails the major findings revealed from the study results and the researchers' conclusion based on the major findings. Besides, recommendations for different intervention initiatives and research implications are situated afterward.

## 5.1. Summary of major findings

Based on the data gathered through deploying a qualitative approach that involves IDIs (seven clients and two healthcare providers and FGDs (two FGDs with clients) to answer research questions that majorly revolve around the interplay of health communication and motivation, the following major findings are identified.

- There is a significant gap between awareness and action that need to be bridged, despite the fact that various stakeholders, including media, City administration of Addis Ababa health bureau, the health facility, and healthcare practitioners, have taken steps to lessen the burden of cervical cancer. More precisely, the clients' knowledge, beliefs, and attitudes are influenced by the awareness gap that now exists on an intrapersonal level. Due to the enormous awareness gap, women in the community are less likely to choose to get screened, which affects their autonomy. This in turn has an impact on clients' competency, their ability to change their behavior in a sustainable way, and health outcomes. Additionally, it hinders the relatedness of the clients and mandates improper patient-provider communication. In order to the extent that it influences client health-seeking behavior, clients' intrinsic motivation, and patient-provider communication.

As a result, the findings demonstrate the poor participation of stakeholders, including the health facility, media, and the health bureau. Furthermore, social mobilization at the hospital level, community-level social change communication, and individual-level behavioral change communication were opportunities that were underutilized and poorly integrated with cervical cancer prevention and control initiatives.

- Low level of health literacy due to lack of any communication practice by the public relations officers at the hospital due to lack of communication strategies and approaches. Besides, null community mobilization activities by the health facility make the communication approach top to down so that the clients are not actively engaged in activities. The findings indicate that the hospital's communication office is not focused on health education or health promotion.

This implies that social change communication practices at the community level and social mobilization activities at the hospital level were the opportunities that were taken for granted. Besides, behavior change communication that integrates IEC is not implementing and at its lowest stage in the hospital. The repercussions of these problems significantly affect the women’s intrinsic motivation revealed through participants' misconceptions and shortage of information about the disease.

- Communication gap or barrier in patient-provider communication due to utilizing one-way communication that emphasizes counseling and lack of communication strategies and approaches at this level. As the data revealed, this is the repercussion of insufficient training opportunities and not incorporating communication-oriented training in the once in while training opportunities.As an evidence the healthcare providers mentioned that they utilize the communication approaches they get through their experience. Besides, the lack of patient-centered communication results in high reliance of clients on female healthcare providers (autonomy-support). This created a motivation that relies on external regulation rather than internal regulation. In the long run, it affects the sustainable behavioral change of clients and health outcomes.
- Cultural norms lead to fear, discrimination, and misconception about the disease and treatment. The negative impacts of cultural norms on patient-provider communication, preference, motivation of clients, and health outcomes was the identified finding of the research. The findings reveal that insignificant social change and social mobilization communication practices which in turn influence sustainable behavior change of women in the community as well as clients’.
- Organizational factors that are related to insufficient human resources, training opportunities functionality, and lack of equipment influence health outcomes and clients’ autonomy. Besides, these problems influences the communication environment. Whereas, room comfort and the linked service with the ART clinic happen to be the factors that enhanced clients’ to attend screenings and treatment sessions.

- The utilization of instructional and directive communication approaches that focus on dissemination, persuasion, and compliance is revealed by this study. Non-directive communication approaches such as counseling are utilized in patient-provider communication. Other aspects of non-directive communication, such as dialogue and entertainment education have not been utilized. Similarly, advocacy is in its lowest stage. This finding significantly related with the negative result on intrinc motivation of clients.
- A suggestion of utilizing peer support and support groups for health education and emotional well-being, different stakeholders' involvement, and community mobilization for awareness creation were proposed by the healthcare providers as well as clients'. As the suggestions by the partcipants indicate the intervention approaches at different level of the socio-ecological model are not attained. Therefore, the intrinsic motivation at the individual level is repressed and a motivation dominated by external regulation is entertained without the conscious acknowledgment of the women's.

## 5.2. Conclusion

The study was conducted under the title of "The Interplay of Health Communication and Motivation in Women Living with HIV Undergoing Precancerous Treatment:in the case of Menelik II Comprehensive Specialized Hospital". The main objective of the study was to understand the interconnectedness between health communication practices in multi-influence at different levels and their influence on the motivation of WLHIV taking precancerous treatment at the Menelik II comprehensive hospital.

Suggs et al. ( 2015) considered the levels of interpersonal, intrapersonal, group, organizational, and societal health communication are all possible. Scholars in health communication highlighted the process of engagement and empowerment as the essential first step in bringing about beneficial change (Gupta & Bansal, 2014). Malikhao (2020) examines communication strategies in the context of the multiplicity paradigm at the individual, interpersonal, and group or community levels: The self determination Theory of Ryan and Deci proposed in 1985 is choosen to assess the experience of clients' chosen at the individual level. This theory focuses on a person's surroundings or the outside causes that motivate them to alter their behavior.

The data obtained from the IDIs and FGDs conducted imply that factors at different levels are influencing the behavior of WLHIV-taking precancerous treatment clients positively and negatively. As the suggestions by the partcipants indicate the intervention approaches at different level of the socio-ecological model are not attained. Therefore, the intrinsic motivation at the individual level is repressed and a motivation dominated by external regulation is entertained without the conscious acknowledgment of the women's.

The participants' experiences collectively underscore the interconnectedness of autonomy, relatedness, and competence and health communication practices at different levels in healthcare decision-making processes within the community. Healthcare providers can improve people's sense of agency, promote health literacy, and facilitate informed choices that lead to better health outcomes and quality of life by using effective communication, proactive equipment management, and a patient-centered approach to service delivery.Moreover, by prioritizing environmental factors and creating a supportive ecosystem that enhance participatory environment and individuals' sense of agency the healthcare system can promote health literacy, and engage individuals in shared decision-making processes. By prioritizing information sharing, social connections, and media advocacy, healthcare providers, media organizations, and community stakeholders can foster a supportive ecosystem that enables individuals to make informed decisions, participate in collaborative care processes, and advocate for their health needs and preferences.In addition, continuos professional development, and interdisciplinary collaboration,the healthcare syestem can create a nurturing environment that promotes individuals' active engagement, informed decision-making, and empowerment in their healthcare interactions.

In conclusion, the participants recommend the power of community-oriented communication strategies in promoting health awareness, empowering individuals, and fostering a sense of autonomy, competence, and relatedness in healthcare settings.

## 5.3. Recommendations

The research findings show that the communication approaches and strategies utilized for cervical cancer prevention and control for WLHIV taking precancerous treatment at Menelik II Comprehensive Specialized Hospital are not completely effective in fulfilling clients' intrinsic and partially fulfilling to their extrinsic motivation through autonomy support from their healthcare providers. Therefore, stakeholders and community mobilization activities should be reinforced to increase the number of screening and sustainable behavior changes.

- As the findings indicate, the current communication approaches are more top-down at the interpersonal level and in the awareness creation campaigns. Since this is affecting the behaviors of the clients to be fully dependent on external regulations, the communication approach, thereof, should be patient-centered at the interpersonal communication level to motivate clients and fulfill their intrinsic needs. Besides, at the awareness creation campaigns clients' intrinsic motivation (identified regulation) can be part of the campaign by utilizing a bottom-top communication approach by creating opportunities for support group discussions and community mobilization activities.
- The study's findings show that scarce of human power, equipment, and training opportunities. The health bureau should emphasize preparing trainings that include communication approaches and strategies that amplify two-way communication by working with communication officers. Moreover, specialized expertise on the case should get more attention.
- The research findings reveal that the public relations officers at the health facility are not actively involved in incorporating effective communication approaches and strategies to prevent and mitigate cervical cancer at the hospital level. Therefore, the PR officers should take responsibility for conducting a SWOT analysis along with the health bureau and designing feasible Social and Behavior Change Communication (SBCC) strategies. Besides, to conduct the SWOT analysis and SBCC strategies additional stakeholders such as research institutions and academicians would make a difference.
- To address the significant gap between awareness and action in cervical cancer prevention, it is essential to implement a multifaceted policy approach that enhances health communication and stakeholder engagement. This includes developing comprehensive health education programs that focus on two-way communication, empowering women through community mobilization initiatives, and fostering collaboration among healthcare providers, media, and local organizations. Additionally, establishing peer support groups and integrating behavior change communication strategies can enhance health literacy and intrinsic motivation among women.

### 5.3.1 Implications

- Longitudinal and phenomenological studies can help more to understand the integration of different health communication practices and engagement of WLHIV from their lived experience. Furthermore, studying the experience of women succumbing to cervical cancer at different treatment stages would bring additional insights.
- Conducting comparative studies across other health facilities under the City administration of Addis Ababa health bureau in line with the experience of WLHIV taking precancerous treatment from the perspective of health communication, motivation, and socio-demographics insight addition findings
- Since this study is not exhaustive, future researchers can include a large number of client participants, other healthcare providers, and stakeholders as participants of the study for a qualitative study.
- Either quantitative or mixed research approaches can be utilized to assess the cause-and-effect relationship of the concepts under the self-determination theory and socio-ecological model.

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# Appendices

## Appendix A: Socio-demographics of the respondents

### Table 1:In-depth Individual Interview Client participants

| No | Age | Marital status | Occupation | Educational Background |
|---|---|---|---|---|
| R1 | 40-45 | Widow | Unemployed | Secondary school |
| R2 | 35-40 | Widow | Private | Diploma |
| R3 | 40-45 | Widow | Unemployed | Diploma |
| R4 | 30-35 | Divorced | Private | Primary school |
| R5 | 45-50 | Divorced | Private | Secondary school |
| R6 | 45-50 | Married | Housewife | Secondary school |
| R7 | 45-50 | Widowed | Unemployed | Secondary school |

### Table 2: In-depth Individual Interview health care provider participants

| No | Sex | Age | Job title | Educational Background | Year of experience |
|---|---|---|---|---|---|
| N1 | F | 25-30 | Nurse | Nursing | 4 |
| N2 | F | 30-35 | Nurse | Nursing | 10 |

### Focus group discussion participants

### Table 3: Focus group discussion participants: FGD1

| No | Age | Marital status | Occupation | Educational Background |
|---|---|---|---|---|
| A | 35-40 | Married | Housemaid | Secondary school |
| B | 35-40 | Married | Private | Degree |

| | | | | |
|---|---|---|---|---|
| C | 35-40 | Widow | Private Business | Diploma |
| D | 45-50 | Married | Government | Degree |
| E | 40-45 | Widow | Housewife | Secondary school |
| F | 40-45 | Widow | Housewife | Secondary school |

**Table 4: Focus group discussion participants: FGD2**

| No | Age | Marital status | Occupation | Educational Background |
|---|---|---|---|---|
| A | 45-50 | Married | Unemployed | Secondary school |
| B | 40-45 | Widowed | Unemployed | Diploma |
| C | 35-40 | Married | Private | Diploma |
| D | 40-45 | Married | Government | Degree |
| E | 40-45 | Widow | Housewife | Secondary school |
| F | 35-40 | Single | Government | Diploma |

## Appendix B: English version Participant Information Sheet and Consent Form

### I. Participant Information Sheet

Good morning/Good afternoon, my name is Yemisirach Hailu. I am an MA student in Media and Communication, in the Department of Journalism and Communication, at Bahir Dar University. I am here today to discuss the interplay between health communication practices and motivation to prevent and control the burden of cervical cancer. I am interested in all your ideas, comments, and suggestions. Please feel free to tell me what you know and think about the issue. The information I collect will help to promote communication practices at different levels concerning cervical cancer prevention and control. The questions usually take about 30 to 50 minutes. I will be using my tape recorder in addition to notes I take on what you say. Thank you in advance for your cooperation!

**Objective of the study:** assessing the interplay between health communication practices and motivation for Women Living with HIV taking pre-cancerous treatment in particular reference to Menelik II Comprehensive Specialized Hospital

**Risk of the study:** Participating in this study will not have any risk or harm.

**The benefit of the study:** The participants will have long and short-term benefits. The short-term benefit would be the study participants will get an insight into cervical cancer prevention and control through the discussion and experience exchanged in FGDs. The long-term benefit would be, that the results of this study will be an input in designing cervical cancer prevention and control strategies. More specifically, it will be useful to expand and implement self-initiated screening programs and to have sustainable behavioral change which could be very beneficiary for the participants and also for the overall community.

**Rights of Participants:** You have a full right either to Participate or decline participation in this study as a participant. You may respond to all the questions or you may not answer questions you don’t want to and you may end the interview at any time you want. You can ask any question which is not clear to you.

**Confidentiality:** Any information forwarded will be kept confidential and names will not be written or specified. Your name will not be recorded to protect your confidentiality. All you say are confidential and used for research purposes, only.

### II. Informed consent

Good morning/Good afternoon, my name is Yemisirach Hailu. I am an MA student in Media and Communication, in the Department of Journalism and Communication, at Bahir Dar University. I am here today to discuss the interplay between health communication practices and motivation to prevent and control the burden of cervical cancer. Participating in this study has no risk. Your name will not be written. You may not answer any questions that you don't want to answer and you may end this interview/discussion at any time you want. I use my tape recorder only to capture the full idea of the discussion and after analyzing it recorded voice will be deleted. Your genuine discussion will be very important for the study. At the same time, I would like to appreciate your voluntary participation in the study after a thorough understanding of the information given to you.

I have read this form or it has been read to me in the language I comprehend and understand all conditions stated above. Are you willing to participate in this study?

Yes ☐ No ☐

**Name of principal investigator**: Yemisirach Hailu

**Cell phone**: 0977324359 Yemisisrach Hailu

058 320 6001 Bahir Dar University Institutional Review Board

0588304386 Department of Journalism and Communication, Bahir Dar University

## Appendix C: English Version Questions for IDIs

### I. Individual in-depth Interview Guide for Clients’

Good morning/Good afternoon, my name is Yemisirach Hailu. I am an MA student in Media and Communication, in the Department of Journalism and Communication, at Bahir Dar University.

I am here today to discuss the interplay between health communication practices and motivation to prevent and control the burden of cervical cancer. I am interested in all your ideas, comments, and suggestions. Please feel free to tell me what you know and think about the issue. I will be using a tape recorder in addition to notes I take on what you say. All you say are confidential and used for research purposes, only. Your name will not be recorded to protect your confidentiality. If you don't want to participate in the interview or decline to answer any questions you can do so. Thank you in advance for your cooperation!

1. Tell me what you know about CC. Its prevention and control methods? How do you know about it?
    - Have you ever participated in cervical cancer prevention and control campaign programs?
    - Who are the stakeholders of cervical cancer prevention and control?
2. Were you able to identify the symptoms of the precancerous lesion before taking the screening? How did you become aware of the symptoms?
    - To whom did you share your feelings?
    - How did you decide to visit a doctor?
3. How did you feel when you first heard that the precancerous lesion developed at the tip of your cervical cancer?
    - Do the healthcare providers understand your feelings? How did you describe the emotional support and treatment you received from the healthcare providers after you heard your result? Can you tell me any special story about such a case?
    - Do you feel comfortable to talk about the disease with the healthcare providers?
4. Do you remember the first time you took a Cx Ca screening? What motivated you to take the screening?
5. What specific activities do you do to treat your case? What was your role in discussing the activities that should be done? Why did you decide to do those activities?
    - What do you do to have a sustainable behavioral change to mitigate the risk of developing cervical cancer?
6. What are the challenges you encountered in doing these activities?
7. How do you describe the service delivered at this hospital in relation to cervical cancer prevention and control?
    - From the perspective of including you in different discussions and awareness-creation programs?
8. How frequently do you show up for medical check-up days?
    - What does your feeling seem like on your medical check-up day?
    - What issues do you discuss with your doctor on your medical check-up day?
9. What should clients, healthcare providers, public relations officers, the hospital, and the health bureau do to promote sustainable behavioral change?

## II. Individual In-depth Interview Guide for Healthcare Providers

Good morning/Good afternoon, my name is Yemisirach Hailu. I am an MA student in Media and Communication, in the Department of Journalism and Communication, at Bahir Dar University. I am here today to discuss the interplay between health communication practices and motivation to prevent and control the burden of cervical cancer. I will be using a tape recorder in addition to notes I take on what you say. All you say are confidential and used for research purposes, only.

Your name will not be recorded to protect your confidentiality. Thank you in advance for your cooperation!

1. Can you tell me about the burden of cervical cancer in this area? What services does this hospital deliver for cancer prevention and control initiatives?
2. What are the risk factors for cervical cancer in this area?
3. What do people think about cervical cancer?
    - What type of beliefs do the clients possess regarding cervical cancer?
    - How do you communicate with clients to make them aware of the disease?
4. How do you explain Cx Ca screening and treatment to the people who visit you?
    - How do you approach your clients' during screening and diagnosis?
5. Have you taken any communication courses? Do you take any training in how to communicate with your clients?
    - How do you make your way of communication understandable to your patients? Can you tell me any special story about such a case?
6. Do people come to the hospital for the sake of screening with self-initiation?
    - What could be the possible reasons for their visit? Can you tell me any special story about such a case?
7. Do people ever come to visit you for medical check-ups?
    - Have they ever told you the motive behind their visit? Can you tell me any special story about such a case?
    - Do your clients' are comfortable enough to talk about the disease?
8. How do you see this hospital's environment for cervical Cancer patients?
    - What are the initiatives you took in collaboration with public relations officers?
9. How do you see the relationship between communication and SBC?
10. What are the challenges you encountered in promoting SBC in the general context of cervical cancer and with your patients?
    - As a health care provider, what do you do to promote SBC?
    - What methods have you utilized? What activities do you get involved in? Why?
11. What should patients, communication experts, and health bureaus do to promote SBC?

## Appendix D: English Version FGD Guide for Client Discussants

Good morning/afternoon! Welcome to our discussion. First of all, I would like to introduce myself. My name is Yemisirach Hailu. I am an MA student in Media and Communication, in the Department of Journalism and Communication, at Bahir Dar University. The major purpose of this discussion is to discuss the interplay between health communication practices and motivation to prevent and control the burden of cervical cancer. I am very interested in all your ideas. Since the comments and suggestions you provide are highly valuable, you can raise everything that you feel with regard to the topics. Feel free to provide either positive or negative comments or suggestions. But please speak in turn to record your comments and suggestions at ease. All the information you provide in this discussion will be kept strictly confidential and will be used for only academic research purposes.

1. What image does it come to your mind when you hear/think about Cx Ca? Why?
2. Tell me what you know about CC. Its prevention and control methods? How do you know about it?

  - Have you ever participated in cervical cancer prevention and control campaign programs?
  - Who are the stakeholders of cervical cancer prevention and control?
3. What do the people around you say about Cx Ca?
4. Do you remember the first time you took Cx Ca screening? What motivated you to take the screening?

   - Were you able to identify the symptoms of the precancerous lesion before taking the screening? How did you become aware of the symptoms?
   - To whom do you share your feelings?
   - How did you decide to visit a doctor?
5. In terms of “what to do” and “what not to do” what sorts of advice do the health providers tell you? Do you put them into practice?
   - What specific activities do you do to treat your case? What was your role in discussing the activities that should be done? Why did you decide to do those activities?
   - What do you do to have a sustainable behavioral change to mitigate the risk of developing cervical cancer?
6. How is such sorts of advice implemented to promote SBC and effective health outcomes in the community?
7. In what ways do you participate in changing the conditions of Cx Ca in your Village? What about in the case of the hospital?
   - Can you describe any mobilization activity that your community has undertaken to promote SBCC?
8. What is the importance of communication to prevent and control the burden of cervical cancer?
   - How utilizing communication could increase effective health outcomes and SBCC?
   - How does this hospital implement communications that actively engage you?
9. What are the challenges related to self-initiated screening, effective health outcomes, and SBC?
10. What should clients, healthcare providers, public relations officers, the hospital, and the health bureau do to promote sustainable behavioral change?

## Appendix E: Amharic version Participant Informed sheet and Consent Form

### የምርምር/ ጥናት ማብራሪያ የስምምነት መግለጫ ቅፅ

ጥናት አድራጊ፡- የምስራች ኃይሉ

**ርዕስ ፡ ከኤችአይቪ ጋር የሚኖሩ እና የቅድመ ካንሰር ሕክምና ለሚደረግላቸው ሴቶች በራስ ተነሳሽነት ለሚደረግ ምርመራ የስነ-ተግባቦት ዘዴ ያለውን ፋይዳ በዳግማዊ ምኒልክ ኮምፕርሄንሲቭ ስፔሻላይዝድ ሆስፒታል መገምገም።**

**ጤና ይስጥልኝ።**

እኔ -----------------------------------በባህርዳር ዩኒቨርስቲ የጋዜጠኝነት እና ስነ-ተግባቦት ትምህርት ክፍል የሁለተኛ ድግሪ ተማሪ ነኝ ። ይህ ጥናት እና ምርምር ከኤችአይቪ ጋር የሚኖሩ እና የቅድመ ካንሰር ሕክምና ለሚደረግላቸው ሴቶች በራስ ተነሳሽነት ለሚደረግ ምርመራ የስነ-ተግባቦት ዘዴ ያለውን ፋይዳ በዳግማዊ ምኒልክ ኮምፕርሄንሲቭ ስፔሻላይዝድ ሆስፒታል ለመገምገም የተዘጋጀ ነው።

በጥናቱ ላይ ለመሳተፍ ከመወሰንዎ በፊት የጥናቱን አላማ ፤ጥናቱ ላይ በመሳተፊዎ የሚያገኙትን ጥቅምና ጉዳት እንደሚከተለው አብራራልዎታለሁ ።

አላማ፡ የዚህ ጥናት ዋና አላማ ከኤችአይቪ ጋር የሚኖሩ እና የቅድመ ካንሰር ሕክምና ለሚደረግላቸው ሴቶች በራስ ተነሳሽነት ለሚደረግ ምርመራ የስነ-ተግባቦት ዘዴ ያለውን ፋይዳ በዳግማዊ ምኒልክ ኮምፕርሄንሲቭ ስፔሻላይዝድ ሆስፒታል መገምገም ነው። የዚህ ጥናት ግኝት በራስ ተነሳሽነት የሚደረግ የቅድመ ካንሰር ምርመራ ባህልን እንዲሁም የማህጸን ካንሰር ህክምናን ፤የማህበረሰብ ተኮር ውይይቶችን በመተግበር የችግሩን አስከፊነት ለመቀነስ ይረዳል።

የአሰራር ሂደት፡ የስምምነት ቅጹን ከፈረሙ በኋላ ከ30-50ደቂቃ የተዋቀረ ቃለ-መጠየቅ በመጠቀም ጥያቄን አቀርባለሁ ።በተጨማሪም የቡድን ተኮር ውይይቶች በመጠቀም ተጨማሪ ጥያቄዎችን አቀርባለሁ።

ጥናቱ ሊያስከትለው የሚችለው ጉዳት ፡ በጥናቱ በመሳተፊዎ የሚደርስብዎት ምንም አይነት የጎንዮሽ ጉዳት የለም ።

የጥናቱ ጥቅሞች ፡ በጥናቱ በመሳተፊዎ የአጭርና የረጅም ጊዜ ጥቅሞችን ያገኛሉ ።

የአጭር ጊዜ ጥቅሙ የቡድን ተኮር ውይይቶች እና የተዋቀረ ቃለ-መጠየቅ በሚካሄድበት ወቅት ተሳታፊዎች ስለማህጸንጫፍ ካንሰር ሰፋያለ መረጃ፣ ከግል የህይወት ልምዳቸው መረጃን እርስበርስ የመለዋወጥ እድልን እንዲሁም የዚህ ጥናት ዋና አላማ የሆነውን የ ማህበረሰብ ተኮር ውይይት ለመተግበር ይጠቅማቸዋል።

የረጅም ጊዜ ጥቅሙ የፖሊሲ ቀራጮች ማህበረሰብ አሳታፊ ስልቶችን በእቅዶቻቸው ውስጥ እንዲያካትቱ አቅጣጫን ያመላክታል። በተጨማሪም የጤና ቢሮዎችና የህዝብ ግንኙነት ቢሮዎች በስልጠናዎቻቸው ላይ ታዳሚ ተኮር መልእክቶችን እንዲያዘጋጁ ይረዳል።

የጥናቱ ሚስጥራዊነት ፡ የሚመልሷቸው ጥያቄዎች ሁሉ ሚስጥራዊነታቸው የተጠበቀ ነው ። በጥናቱ ውስጥ ስመዎ አይጠቀስም ።

የጥናቱ ተሳታፊዎች መብት ፡ በጥናቱ ላይ ፍቃደኛ ካልሆኑ ያለመሳተፍ መብት አለዎት ፤ መመለስ የማይፈልጉት ጥያቄ ካለ እንዲመልሱ አይገደዱም፤ በፈለጉት ሰዓት ጥናቱን ማቋረጥ ይችላሉ ፤ ያልገባዎትን ጥያቄ የመጠየቅ መብት አለዎት ።

## የፍቃደኝነት መጠየቂያ ቅጽ

ጤና ይስጥልኝ።

በመጀመርያ የዚህ ጥናት አካል ለመሆን ፍቃደኝነታችሁን ለማሳየት ስለተገኛችሁ ከልብ አመሰግናለሁ።

ስሜ-------------------- ይባላል ። በባህር ዳር የኒቨርሲቲ የጋዜጠኝነት እና ስነ-ተግባቦት ትምህርት ክፍል የሁለተኛ ድግሪ የመመረቂያ ጽሁፌን ከኤችአይቪ ጋር የሚኖሩ እና የቅድመ ካንሰር ሕክምና ለሚደረግላቸው ሴቶች በራስ ተነሳሽነት ለሚደረግ ምርመራ የስነ-ተግባቦት ዘዴ ያለውን ፋይዳ በዳግማዊ ምኒልክ ኮምፕርሄንሲቭ ስፔሻላይዝድ ሆስፒታል መገምገም በሚል ርዕስ ላይ እየሰራሁ እገኛለሁ ።

የዚህ ጥናት ዋና አላማ ከኤችአይቪ ጋር የሚኖሩ እና የቅድመ ካንሰር ሕክምና ለሚደረግላቸው ሴቶች በራስ ተነሳሽነት ለሚደረግ ምርመራ የስነ-ተግባቦት ዘዴ ያለውን ፋይዳ በዳግማዊ ምኒልክ ኮምፕርሄንሲቭ ስፔሻላይዝድ ሆስፒታል መገምገም ነው። በጥናቱ የሚሳትፉ ፍቃደኛ የሆኑ ብቻ ናቸው።ለመሳተፍ ከፈቀዱ እድሜዎን፣ ስለትዳር ሁኔታዎ ፣ ስለትምህርት ደርጃዎ እንዲሁም ከጥናቱ ጋር በተያያዘ የጤና አገልግሎት ከሚሰጡ ሀኪሞችና ነርሶች ጋር ያለዎትን መስተጋብር/ግንኙነት እጠይቅዎታለሁ።

በዚህ ጥናት ላይ በመሳተፈዎ ምንም ጉዳት አይደርስብዎትም ። በጥናቱ ላይ ፍቃደኛ ካልሆኑ ያለመሳተፍ መብት አለዎት ፤ መመለስ የማይፈልጉት ጥያቄ ካለ እንዲመልሱ አይገደዱም፤ በፈለጉት ሰዓት ጥናቱን ማቋረጥ ይችላሉ ፤ ያልገባዎትን ጥያቄ የመጠየቅ መብት አለዎት፤ እንዲሁም የሚመልሷቸው ጥያቄዎች ሁሉ ሚስጥራዊነታቸው የተጠበቀ ይሆናል ፤ በጥናቱ ውስጥ ስምዎ አይጠቀስም ።
የጥናቱን አላማ ለማሳካት ከእርሰዎ ጋር በምናደርገው ቆይታ ወቅት የድምጽ መቅጃ መሰሪያ የምጠቀም መሆኑን በአክብሮት እገልጻለሁ።
ከላይ የተጠቀሱትን መረጃዎች በሚገባ ተረድቻለሁ።
ጥናቱ ላይ ለመሳተፍ ፍቃደኛ ነዎት ?
**ፍቃደኛ ነኝ** ☐ **ፍቃደኛ አይደለሁም** ☐
ፊርማ------------
የጥናት አድራጊው ስም ------------------ ፊርማ----------------
ስልክ ቁጥር 0977324359 የምስራች ኃይሉ
058 320 6001 የባህርዳር የኒቨርስቲ የጥናት ምርምር ገምጋሚ ቦርድ ጽህፈት ቤት
058 830 4386 የባህርዳር ዩኒቨርስቲ የጋዜጠኝነት እና ስነ-ተግባቦት ትምህርት ክፍል

## Appendix F: Amharic Version questions for IDIs

### በዳግማዊ ምኒሊክ ኮምፕርሄንሲቭ ስፔሻላይዝድ ሆስፒታል የማህፀን በር ካንሰር ቅድመ-ካንሰር ምርመራ እና ክትትል እንዲሁም የኤችይቪ ኤድስ ክትትል ለሚያድርጉ ሴቶች የተዘጋጀ ቃለ መጠይቅ

1.ስለማህፀን በር ካንሰር የሚያውቁትን ቢነግሩኝ? ስለማህፀን በር ካንሰር እንዴት ሊያውቁ ቻሉ ወይም መርጃውን ከየት ነበር ያገኙት?

- ስለማህፀን በር ካንሰር መቆጣጥሪያና መከላከያ መንገዶች የተዘጋጁ ግንዛቤ መፍጠሪያ መድረኮች ላይ ተሳትፈው ያውቃሉ?
- በማህፀን በር ካንሰር ዙሪያ ለሚደርጉ እንቅስቃሴዎች የሚመለከታችው ባለድርሻ አካላት እነማን ናቸው ብለው ያስባሉ?

2. ማህበረሰቡ ስለማህፀን በር ካንሰር ምን ያስባል?ያለው አመለካከት ምን ይመስላል?

3. ወደጤና ተቋም ከመምጣትዎ በፊት ስለቅድመ-ማህፀን በር ካንሰር ምልክቶች መረዳት ችለው ነበር? ስለምልክቱ እንዴት ሊረዱ ቻሉ?

- የሚሰማዎትን ስሜት ለማን ነበር ያጋሩት?
- ወደሆስፒታል ለመሄድ እንዴት ሊወስኑ ቻሉ?

4. የማህፀን በር ካንሰርን የሚያመጣው ህዋስ እንደታየ ለመጀመሪያ ጊዜ ሲሰሙ ምን ተሰማዎት?

- የሚሰማዎትን ስሜት የጤና ባለሙያዎቹ የአረዳድ ሁኔታቸውን እንዴት ይገልፁታል?
- ከጤና ባለሙያዎች ጋር በግልፅ ለመወያያት ያለውን ሁኔታ እንዴት ያዩታል?

5.የቅድመ ካንሰር ምርመራን ለመጀመሪያ ጊዜ የወሰዱበት ጊዜ መቼ ነበር? ለመውሰድስ ምን አነሳሳዎት?

6. ከማህፀን በር ካንሰር ጋር በተያያዘ የገጥምዎትን ችግር መደረግ ስላለባቸው ነገሮች በመወሰን ሂደት ውስጥ የእርስዎን ተሳትፎ እንዴት ይገልፁታል? ማድረግ እንዳለብዎት እንዴት ወሰኑ?

- ቋሚነት ያለው የባህሪ ለውጥ ለማምጣት የእርስዎ ጥረት ምን ይመስላል?

7. መደረግ ያለባቸውን ነገሮችን በተገቢው መንገድ ለመተግበር የገትጠምዎት ተግዳሮቶች ካሉ ቢገልፁልኝ?

8. ከማህፀን በር ካንሰር ጋር በተያያዘ የሆስፒታሉን አገልግሎት አሰጣጥ እንዴት ያዩታል?

- በሆስፒታሉ ስለማህፀን በር ካንሰር መቆጣጥሪያና መከላከያ መንገዶች የተዘጋጁ ግንዛቤ መፍጠሪያ መድረኮች ላይ ተሳትፈው ያውቃሉ?

9.በቀጠርዎት ቀን ሁሌም ይገኛሉ? ካልሆነም ለምን?

- የቀጠርዎት ቀን እንደደረሰ ሲያውቁ ምን ይሰማዎታል?
- ከጤና ባለሙያዎች ጋር በቀጠርዎት ቀን ስለምን ጉዳዮች ይወያያሉ?
  11. የማህፀን በር ካንሰር ቅድመ ካንሰር ምርመራ ተገልጋዮች፣የጤና ባለሙያዎች፣የህዝብ ግንኙነት ባለሙያዎች፣ሆስፒታሉ እንዲሁም የጤና ቢሮ ቋሚነት ያለው የባህሪ ለውጥን ለማምጣት ምን ማድረግ አለባቸው?

## በዳግማዊ ምኒሊክ ኮምፕርሄንሲብ ስፔሻላይዝድ ሆስፒታል የማህፀን በር ካንሰር ቅድመ-ካንሰር ምርመራ እና ክትትል አገልግሎት ለሚሰጡ የጤና ባለሙያዎች የተዘጋጀ ቃለ መጠይቅ

1. የማህፀን በር ካንሰር በአዲስ አበባ ምን ያለው ስርጭት ምን ይመስላል? ይህስ ሆስፒታል ከችግሩ ጋር በተያያዘ ምን አይነት አገልግሎቶችን እየሰጠ ይገኛል?
**2.** የማህፀን በር ካንሰር በአዲስ አበባ እንዲስፋፋ የሚያደርጉና ተጋላጭነትን የሚጨምሩ ምክንያቶች ምን ምን ናቸው?
3. ማህበረሰቡ ስለማህፀን በር ካንሰር ምን ያስባል? ያለው አመለካከት ምን ይመስላል?
    - የቅድመ ካንሰር ምርመራ እና ህክምና ክትትል ያላቸው ደንበኞች ስለማህፀን በር ካንሰር ያላቸው እምነትና እሳቤ ምን ይመስላል?
    - የደንበኞችን እምነትና እሳቤ ሳይንሳዊ ከሆኑ እውነታዎች ጋር ለማስታረቅ ምን ምን መንገዶችን ይጠቀማሉ?
4. የቅድመ ካንሰር ምርመራን ለማከናወን የሚመጡ ተገልጋዮችን ስለቅድመ ካንሰር ምርመራ ሂደት ገለፃ በሚያደርጉበት ወቅት ምን ምን ነገሮችን ታሳቢ ያደርጋሉ?ህክምናው ለሚከታተሉ ደንበኞችስ?
    - ቅድመ ካንሰር ምርመራው በሚካሄድበት ጊዜ ደንበኞቻችሁን በምን መልኩ ነው የሚቀርቡት?ህክምናው በሚካሄድበት ጊዜስ? ተመሳሳይ የስነ-ተግባቦት ዘዴ ነው የሚጠቀሙት?
5. ከህክምና ትምህርት ውጪ ከስነ-ተግባቦት ጋር የተያያዘ ትምህርት ወይም ስልጠናዎችን ወስደዋል?
    - እናንተ ጋር የሚመጡ እናቶች ከማህፀን በር ካንሰር በተያያዘ የምትሰጡዋቸውን መረጃ በተገቢው መንገድ እንዲረዱ ምን አይነት ዘዴዎችን ይጠቀማሉ?
6. በሆስፒታሉ ለሚሰጠው የቅድመ ካንሰር ምርመራ እና ህክምና፣ ተገልጋዮች በራስ ተነሳሽነት የመምጣት እና የአገልግሎቱ ተጠቃሚ የመሆን ባህላቸዉን እንዴት ይግልፁታል?
    - ተያያዥ ምክንያቶችስ ምን ሊሆኑ ይችላሉ? ከዚሁ ጋር በተያያዘ የሚያስታውሱት ለየት ያለ ገጠመኝ ካለ ቢንግሩኝ?
    - ደንበኞች ስለማህፀን በር ካንሰር ለመወያየት ፍቃደኛ ናቸው?

7. የቅድመ ካንሰር ምርመራ እና ህክምና ክትትል ያላቸው ደንብኞች በቀጠሮ ቀናቸው የመገኘት ልምዳቸው ምን ይመስላል?
    - ለመምጣትም ሆነ ላለመምጣት ምክንያታቸው ምን ይሆን?ከዚሁ ጋር በተያያዘ የሚያስታውሱት ለየት ያለ ገጠመኝ ካለ ቢንግሩኝ?
8. የማህፀን በር ካንሰር ቅድመ ምርመራና ክትትል ላላቸው ደንበኞች ሆስፒታሉ የሚሰጠውን አገልግሎት እንዴት ይገልፁታል?
    - ከህዝብ ግንኙነት ባለሙያዎች ጋር በመቅናጀት የሰራችኋቸው ስራዎች ምን ምን ይሆኑ?
9. ከማህፀን በር ጋር በተያያዘ ቋሚነት ያለው የባህሪ ለውጥ ለማምጣት በደንበኞች እና በጤና ባለሙያዎች መካከል ያለውን ግንኙነት እንዴት ያዩታል?
10. ከማህፀን በር ጋር በተያያዘ ቋሚነት ያለው የባህሪ ለውጥ በደንበኞች ላይ ለማምጣት እንደአንድ የህክምና ባለሙያ የገጠሞት ተግዳሮቶች ምን ይሆኑ?
    - እንደአንድ የህክምና ባለሙያ የገጠሞት እና የተመለከቷቸውን ተግዳሮቶች ለመለውጥ የወሰዳችኋቸው እርምጃዎች ምን ምን ናቸው?
    - ምን አይነት መንገዶችን ተጠቀሙ? ምን አይነት እንቅስቃሴዎች ውስጥ ተሳተፉ?
11. የማህፀን በር ካንሰር ቅድመ ካንሰር ምርመራ ተገልጋዮች፣የጤና ባለሙያዎች፣የህዝብ ግንኙንት ባለሙያዎች፣ሆስፒታሉ እንዲሁም የጤና ቢሮ ቋሚነት ያለው የባህሪ ለውጥን ለማምጣት ምን ማድረግ አለባቸው?

## Appendix G. Amharic version FGD Guide for Client Discussants

### በዳግማዊ ምኒሊክ ኮምፕርሄንሲቭ ስፔሻላይዝድ ሆስፒታል የማህፀን በር ካንሰር ቅድመ-ካንሰር ምርመራ እና ክትትል እንዲሁም የኤችይቪ ኤድስ ክትትል ለሚያድርጉ ሴቶች የተዘጋጀ የቡድን ተኮር ውይይት መነሻ ሀሳቦች

1. ስለ ከማህፀን በር ካንሰር ስታስቡ ወደጭንቅላታችሁ የሚመታው ሀሳብ ወይም ምስል ምንድን ነው?ምክንያቱስ ምን ይሆን?
2. ስለማህፀን በር ካንሰር የሚያውቁትን ቢነግሩኝ? ስለማህፀን በር ካንሰር እንዴት ሊያውቁ ቻሉ ወይም መርጃውን ከየት ነበር ያገኙት?
    - ስለማህፀን በር ካንሰር መቆጣጥሪያና መከላከያ መንገዶች የተዘጋጁ ግንዛቤ መፍጠሪያ መድረኮች ላይ ተሳትፈው ያውቃሉ?
    - በለማህፀን በር ካንሰር ዙሪያ ለሚደርጉ እንቅስቃሴዎች የሚመለከታችው ባለድርሻ አካላት እነማን ናቸው ብለው ያስባሉ?
3. ማህበረሰቡ ስለማህፀን በር ካንሰር ምን ያስባል?ያለው አመለካከት ምን ይመስላል?
4. የቅድመ ካንሰር ምርመራን ለመጀመሪያ ጊዜ የወሰዱበት ጊዜ መቼ ነበር? ለመውሰድስ ምን አ ነሳሳዎት?
    - ወደጤና ተቋም ከመምጣትዎ በፊት ስለማህፀን በር ካንሰር ምልክቶች መረዳት ችለው ነበር?
    - የሚሰማዎትን ስሜት ለማን ነበር ያጋሩት?
    - ወደሆስፒታል ለመሄድ እንዴት ሊወስኑ ቻሉ?

5. ከማህፀን በር ካንሰር ጋር በተያያዘ የጤና ባለሙያዎች መደረግ ስላለባቸው እና መደረግ ስለሌለባቸው ነገሮች ምን ምን ይሏችኋል? እናንተስ በተገቢው መንግድ ትተገብራላችሁ?
6. ከማህፀን በር ካንሰር ጋር በተያያዘ ለገጥምማችሁን ችግር መደረግ ስላለባቸው ነገሮች በመወሰን ሂደት ውስጥ የእናንተን ተሳትፎ እንዴት ትገልፁታላችሁ? ማድረግ እንዳለባችሁስ እንዴት ልትወስኑ ቻላችሁ?

  - መደረግ ያለባቸውን ነገሮችን ነገሮች በተገቢው መንገድ ለመተግበር የገትጠምዎት ተግዳሮቶች ካሉ ቢገልፁልኝ?

7. ከጤና ባለሙያዎች የሚሰጧችሁ ምክሮች የተሻለ ጤናማ ህብረተሰብን ከመፍጠር እና ቋሚነት ያለው ባህሪ ለውጥ በህብረተሰቡ ላይ ለማምጣት በምን በምን መንገዶች እየተተገበሩ ይገኛሉ?
8. በምትኖሩበት አካባቢ የማህፀን በር ካንሰርን ለመከላከልና ለመቆጣጠር በምን መልኩ እየተሳተፋችሁ ትገኛላችሁ? በዚህ ሆስፒታልስ?
9. የተለያዩ የስነ ተግባቦት ስትራቴጂዎችና ዘዴዎችን መጠቀም የማህፀን በር ካንሰርን ለመከላከልና ለመቆጣጠር ያለውን ፋይዳ እንዴት ትገልፁታላችሁ?
    - የተለያዩ የስነ ተግባቦት ስትራቴጂዎችና ዘዴዎችን መጠቀምስ የተሻለ ጤናማ ህብረተሰብን ከመፍጠር እና ቋሚነት ያለው ባህሪ ለውጥ በህብረተሰቡ ላይ ለማምጣት እንዴት ይጠቅማል?
    - ሆስፒታሉ የተለያዩ የስነ ተግባቦት ዘዴዎችን በመጠቀም እናንተን አሳታፊ መድርኮች ላይ ለማሳተፍ ያደልገው ሙከራ አለ?

10. በራስ ተነሳሽነት የሚደረግ የቅድመ ካንሰር ምርመራን እና ዘላቂነት ያለዉ የባህሪ ለዉጥን ለማምጣት አዳጋች የሚያደርጉ እክሎች ምን ምን ናቸዉ ብላችሁ ታስባላችሁ?
11. የማህፀን በር ካንሰር ቅድመ ካንሰር ምርመራ ተገልጋዮች፣የጤና ባለሙያዎች፣የህዝብ ግንኙነት ባለሙያዎች፣ሆስፒታሉ እንዲሁም የጤና ቢሮ ቋሚነት ያለው የባህሪ ለውጥን ለማምጣት ምን ማድረግ አለባቸው?