CULTURE AND RELIGION AS PERCEIVED CHALLENGES TO EARLY CERVICAL CANCER SCREENING

By

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DECLARATION

I declare that **CULTURE AND RELIGION AS PERCEIVED CHALLENGES TO EARLY CERVICAL CANCER SCREENING** is my own effort and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

Fungai Gutusa	January 2021
FULL NAME	DATE

DEDICATION

To the millions of people the world has lost to cervical cancer-related deaths.

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- Thank you so much, Prof Lizeth Roets, my supervisor, for your guidance, patience and unwavering encouragement throughout this study.
- I want to thank the Department of Health Higher Degrees Ethics Committee of the University of South Africa (Unisa), for permitting me to conduct this study.
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- Thanks to my sons, Linval Isheanesu Muzvidziwa and Munyaradzi Josiah Muzvidziwa, for the motivation to work harder.
- I would like to thank God almighty for the grace that has brought me this far.

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ABSTRACT

Early cervical cancer screening is crucial in the protection against cervical cancer because it allows healthcare providers to detect cancer and precursor lesions to facilitate appropriate treatment if detected at an early stage. This intervention thus prevents cancer from progressing to an advanced stage before it is diagnosed.

The purpose of this study was to describe women's perception regarding the effect that culture and religion have on their decision to utilise early cancer screening services in an attempt to recommend possible interventions to promote early screening. An exploratory and contextual qualitative design was utilised to explore this phenomenon within Mutasa district in Manicaland Province of Zimbabwe. Non-probability convenience sampling was used to select women aged 18-49 years who attended the rural hospital from 1 May to 30 June 2018, and they received information letters and could volunteer to participate. Semi-structured interviews were conducted between 27 September 2018 and 30 September 2018 until saturation was reached after 17 interviews. Data were analysed using Tesch's qualitative open-coding data analysis method. Five themes were identified, namely a lack of knowledge, stigmatisation, cultural beliefs and values, religion, and a lack of resources. Different categories underpinned the themes, and the categories were formed by grouping similar direct quotations from participants.

Based on the study's findings, recommendations for possible interventions focused on (1) how to improve knowledge, (2) address attitudes, (3) and take beliefs and cultural diversity into consideration, ultimately motivating or supporting women in utilising early cervical cancer screening services. The researcher will electronically share the research findings with the Ministry of Health and Child Care, Zimbabwe National Family Planning Council, and other technical and interested stakeholders. The research report will also be shared with the Ministry of Health at the district level. Platforms such as existing and planned Ministry of Health workshops, where different stakeholders involved in cervical cancer who have an interest in women's health meet, will be targeted to share the findings. An ad hoc committee at the district level that include community leaders, ordinary members from the community, church (religious) leaders, educators, as well as representative from the Cancer Association of Zimbabwe should be formed to ensure that a holistic approach to health education can be shared in all health education material and awareness programmes. This measure will ensure that culture and religion are effectively addressed in health education.

Key concepts

Attitudes, Cervical Cancer, Early Cancer Screening, Culture, Religion.

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CHAPTER 1
ORIENTATION TO THE STUDY

1.1 INTRODUCTION AND BACKGROUND TO THE RESEARCH PROBLEM

The World Health Organization (WHO) (2020:7) reports that cancer of the cervix is the second most common cancer among women worldwide. The number of annual cases is projected to increase from 570 000 to 700 000, and it is anticipated that the annual number of deaths will increase from 311 000 to 400 000 between 2018 and 2030 (WHO 2020:7). The majority of cervical cancers (over 60%) in sub-Saharan Africa are detected in late stages, predominantly due to a lack of information about cervical cancer and prevention services (Dunyo, Effah & Udofia 2018:2). When advanced, cancer of the cervix is said to be a major cause of morbidity and mortality among women in resource-poor settings, as found in most African countries (WHO 2020:7). However, cervical cancer screening presents an opportunity for detection and treatment before the disease progresses to invasive cancer (WHO 2020:8).

According to the United Nations Population Fund (UNFPA), cervical cancer is the most common cancer among Zimbabwean women, accounting for 33.4% of all cancer cases (UNFPA, 2016:1). These statistics correlate with the Zimbabwe papillomavirus and related-cancers factsheet of 2016, where cervical cancer accounted for 34.5% of all cancers affecting women in Zimbabwe in 2015, with an incidence of 2 270 new cases annually, and 1 451 annual deaths. Cervical cancer thus remains a significant problem of public health concern in both developed and developing countries (WHO 2020:7). The primary underlying cause of cervical cancer is an infection caused by the human papillomavirus (HPV), which is primarily sexually transmitted. HPV is recognised as being responsible for 62.8% of invasive cervical cancers, yet a high proportion of women infected by HPV have this infection resolve without further consequences. When HPV is persistent and left untreated, pre-cancerous cells might develop, causing cervical cancer (WHO 2020:28).

Cervical cancer screening is considered a good precaution because it gives healthcare professionals the ability to detect cancer and precursor lesions to facilitate appropriate treatment if detected at an early stage; a process called ‘see and treat’. This process is useful in preventing cancer from progressing to an advanced stage before it is diagnosed. Cervical cancer screening has been proven to significantly reduce (by 80%) women of childbearing age’s risk of developing cancer (Manuel 2017:90) and challenges regarding early screening should thus be investigated.

1.2 STATEMENT OF THE RESEARCH PROBLEM

Cervical cancer is a problem of public health significance among women of childbearing age (Manuel 2017:86), yet it is the most easily preventable cancer if it is diagnosed early. Cervical cancer is the second most common cancer globally, but is often not identified until it has advanced (Kuguyo, Matimba, Tsikai, Magwali, Madziyire, Gidiri, et al. 2017:2). According to Dunyo, et al. (2018:2), late screening of cervical cancer is a primary reason why most women receive cancer treatment at an advanced stage when it is difficult to manage. A low-cost screening approach, namely Visual Inspection with Acetic Acid and Cervicography (VIAC) has thus been implemented in 105 sites in Zimbabwe to promote early screening. These sites include three central hospitals, seven provincial hospitals, eight district hospitals, seven mission hospitals, as well as 77 polyclinics funded by Population Service International (PSI) and the United Nations Population Fund (UNFPA) (UNFPA Zimbabwe, 2019:22).

In developing countries, such as Zimbabwe, there are no clear-cut cervical cancer screening guidelines and policies in place, while developed countries, such as the United States of America, have clear policies (Ministry of Health and Child Care [MOHCC] 2015:26). Cancer screening services in Zimbabwe are mainly provided by the Ministry of Health and Child Welfare with assistance from partners such as the UNFPA and PSI. There is currently no mechanism in place for the coordination of cervical cancer screening, and fragmented service provision occurs as a result (Mapanga, Brown & Singh 2019:12). Among others, these challenges are faced by women and service providers in most developing countries, as early detection of cervical cancer can be delayed. This leaves the obligation with the health workers who consult eligible women to motivate screening or refer them to a unit where screening can be done. Therefore, the current expected practice is to opportunistically screen eligible women when they attend health units for other reproductive services (Chi'nombe, Sebata, Ruhanya & Matarira 2014:1).

Some documented factors associated with the utilisation of cancer screening include educational background, socioeconomic status, cultural influence, as well as knowledge of cervical cancer and cervical cancer screening (Mugass & Frumence 2019:347). It is therefore important to understand to what extent some of these factors can influence early screening for cervical cancer among Zimbabwean women. Although all other factors are acknowledged by the researcher, culture and religion are the focus of this study.

Cultural and religious diversity has been found to influence communication patterns with patients, which contribute to challenges in effective patient education due to miscommunication between the patient and the healthcare provider (Ebu 2018:4). It is therefore vital for healthcare providers to understand women's cultural and religious beliefs and priorities that might prevent them from accessing cancer screening services at an early stage. Understanding these challenges will allow healthcare providers to implement recommended interventions to motivate early cancer screening.

1.3 RESEARCH PURPOSE

The purpose of this study was to describe women's perception regarding the effect that culture and religion have on their decision to utilise early cancer screening services in an attempt to recommend possible interventions to promote early screening.

1.4 RESEARCH OBJECTIVES

The following objectives relates to the aim of this study:

- Describe the cultural beliefs that motivate early cervical cancer screening
- Describe the cultural beliefs that hinder early cervical cancer screening

- Describe the religious beliefs that motivate early cervical cancer screening
- Describe the religious beliefs that hinder early cervical cancer screening
- Propose recommendations for interventions to promote early cervical cancer screening

1.5 SIGNIFICANCE OF THE STUDY

The study's findings provided information on women's perceptions regarding the effect that culture and religion have on their decision to undergo early cervical cancer screening. These findings contributed to recommendations for possible interventions, such as health education to motivate women to undergo early cervical cancer screening.

1.6 DEFINITION OF KEY TERMS

1.6.1 Cervical cancer

Cervical cancer is cancer that starts in the cervix, in the lower part of the uterus or womb (Pan American Health Organization (PAHO) 2019:2).

1.6.2 Early cancer screening

Early screening for cervical cancer entails the detection of pre-cancerous changes or abnormal tissue cells of the cervix before symptoms of cancer appear (PAHO 2019:2).

1.6.3 Culture

According to Nanda and Warms (2015:35), 'culture' is defined as the characteristics and knowledge of a particular group of people with shared patterns of behaviours, interactions, and cognitive constructs. These behaviours entail an effective understanding that is learned through a process of socialisation, and the shared patterns identify the members of a cultural group while also distinguishing those of another group.

1.6.4 Religion

Nanda and Warms (2015:274) define ‘religion’ as a set of beliefs, feelings, and practices that define the relationship between human beings and a spiritual entity.

Early cancer screening in this study refers to the testing of all Zimbabwean women between the ages 18 and 49 willing to participate to detect pre-cancerous cervical changes, which, if not treated, may lead to cancer.

1.6.5 Perception

Perception is the process whereby people select and organise data from their surroundings and make sense of the information (Qiong, 2017:18).

1.6.6 Challenges

Challenges refer to situations that are difficult and require individuals to use a lot of effort and determination in order to succeed (Frye, 2021).

1.7 OPERATIONAL DEFINITIONS

An operational definition is a way in which a researcher decides to measure variables in a particular study. The following operational definitions were adopted in this study.

1.7.1 Early cervical cancer screening

Early cancer screening in this study refers to the testing of all women between the ages of 18 and 49 years to detect pre-cancerous cervical changes, which, if not treated, may lead to cancer.

1.7.2 Culture

Culture refers to social norms and beliefs that motivated or hindered women between the ages of 18 to 49 from accessing health services to undergo early cervical cancer screening.

1.7.3 Religion

Religion is the spiritual beliefs that motivated or hindered women between the ages of 18 and 49 in a community from utilising health services for early cervical cancer screening.

1.7.4 Perceptions

Perception is the way a community thinks and believes, which may be a hindrance to early cervical cancer screening.

1.7.5 Challenges

Challenges in this study refers to the difficult situations that women face that hinder them from attending early cervical cancer screening.

1.8 RESEARCH PARADIGM

Paradigms are a basic set of common beliefs that guide actions or perceptions and help researchers understand phenomena under investigation (Rehman & Alharthi 2016:51). Paradigms differ according to four dimensions: (1) ontology – the nature of reality to be studied, (2) epistemology – the nature of knowledge, (3) axiology – the values associated with areas of research and theorising, and (4) methodology – ways for gathering, collecting and analysing data (Patel 2015:2).

The researcher adopted an interpretivist methodology that allowed her to collect data and describe participants' subjective experiences or perspectives to provide meanings to their actions, as described by Leavy (2017:12) (see Section 2.2).

1.9 RESEARCH DESIGN AND METHODOLOGY

Polit and Beck (2017:742) define a research methodology as the process followed to collect information and data, the processes followed to investigate a problem, and also the steps taken to analyse collected data. A qualitative approach with semi-structured interviews was used to collect data from study participants.

Qualitative research was used for this study, as the researcher was interested in understanding the meaning participants constructed, and how they made sense of their own thoughts and experiences (Merriam & Tisdell 2016:6). The qualitative research process probes for participants' underlying beliefs and assumptions (Polit & Beck 2017:462).

1.9.1 Setting

The setting of the study refers to the specific location from which participants of a study are recruited (Polit & Beck 2017:744). Due to the qualitative nature of this study and the very nature of the dissertation, one rural district hospital out of the seven district hospitals was purposively selected in Mutasa district in Manicaland Province of Zimbabwe (see Section 2.4). This specific district was chosen because it is one of the districts dominated by the African Apostolic Faith believers who do not visit the clinic or hospital for any health service, representing 38% of the population in the district (UNICEF Zimbabwe 2016:7). The rural district hospital is one of the 88 facilities offering VIAC screening services in Zimbabwe, and is also a referral hospital for this specific district.

1.9.2 Population of the study

Polit and Beck (2017:249) define a population as the total number of all research elements in which the researcher has an interest. The study population comprised the total population of women of childbearing age (18-49 years) in the selected district in Zimbabwe, which stands at 41 974 women based on the statistics provided by the Ministry of Health and Child Care (Zimbabwe Demographic Profile 2019). The accessible population was all women who attended the selected rural district hospital for reproductive health services (see Section 2.5).

1.9.3 Unit of analysis

A unit of analysis refers to who or what the researcher will be analysing to enable the researcher in focusing the study (Sedgwick 2014:2). A researcher might examine different potential units of analysis, but the most common units to include are individuals, groups, and organisations. In this study, the unit of analysis was 17 women of childbearing age (18-49 years) who volunteered to participate in the study and were interviewed (see Section 2.8).

1.10 DATA COLLECTION METHODS AND PROCEDURES

Data collection is the process whereby the researcher collects data from participants in a systematic way to reach study objectives (Polit & Beck 2017:725). After ethical approval was received from the Health Studies Research Ethics Committee, Department of Health Studies, Unisa (see Annexure 1), the participating hospital (see Annexure 3), Medical Research Council of Zimbabwe (MRCZ), as well as from every individual participant who volunteered to participate (see Annexures 5, 6 and 7), data gathering commenced. Semi-structured interviews were conducted (see Annexure 4) with open-ended questions, followed by probing questions to ensure that all possible and relevant data could be obtained. The process allowed participants to discuss and share their perceptions and experiences freely.

Semi-structured interviews involve a few open-ended questions that the interviewer poses to study participants to ensure detailed information is obtained about a certain topic or subject (Datco 2015:142). Probing questions followed the answers to the open-ended questions to ensure rich data. The interviews were audio-recorded, and the verbatim transcripts were analysed and coded (see Section 3.3.2).

1.10.1 Data management and analysis

Qualitative data analysis is the range of processes that researchers follow to collect qualitative data to provide an explanation and understanding of the people being investigated (Polit & Beck 2017:725). Tesch's (in Creswell 2014:196) descriptive framework of open coding was used to conduct the analysis and identify the themes and categories (see Section 2.11).

1.10.2 Trustworthiness

Trustworthiness refers to the degree to which qualitative study findings are true to the data and the research context (Gunawan 2015:10). This qualitative study was conducted rigorously so that the researcher had confidence in the data that were obtained. The four aspects of trustworthiness that were adhered to included credibility, transferability, dependability, and confirmability (Gunawan 2015:10). Each of these four aspects is discussed in detail in Chapter 2 (see Section 2.11).

1.11 ETHICAL CONSIDERATIONS

The researcher obtained ethical approval from the Research Ethics Committee of the Department of Health Studies, Unisa (see Annexure 1) and from the MRCZ (see Annexure 5). Permission was also sought from the Permanent Secretary of the Ministry of Health and Child Care of Zimbabwe (see Annexure 3), and from the district medical officer (see Annexure 4) to collect data and use it for the research purpose. The district medical officer (head of the health department at a hospital) received the research information letters (see Annexure 7) and distributed these to possible participants. Those participants who volunteered provided their contact details to the district medical officer who informed the researcher. The researcher then contacted the volunteers and a date, time, and venue for the interviews were arranged.

All the participants were over the age of 18 years, and written informed consent was obtained. The participants were assured of their confidentiality and privacy, that their identity would not be traceable in the transcripts or study findings, and that the information they provide would be kept confidential (see Section 2.9). An information letter containing details about the study and the implications for participation was provided to all participants to allow them to make an informed choice regarding participation (see Annexure 2). The complete ethical principles adhered to in this study are discussed in Section 2.10.

1.12 STRUCTURE OF THE DISSERTATION

The dissertation is arranged into four chapters, as illustrated in Table 1.1.

Table 1.1: Chapter layout

Chapter 1	Orientation to the study
Chapter 2	Research design and method
Chapter 3	Data analysis, interpretation and literature control
Chapter 4	Conclusions, recommendations and limitations

1.13 CONCLUSION

Cancer screening is essential to detect cervical cancer cells (pre-cancerous lesions) at an early stage. Prompt treatment can prevent the majority of cervical cancer cases resulting in negative outcomes. The cultural and religious factors that possibly hinder women from undergoing early cervical cancer screening need to be identified and described to present recommendations for interventions that may contribute to changes in these women's health-seeking behaviour. Chapter 1 provided an overview of the study, and Chapter 2 will describe the methodology that was followed to answer the purpose of the study and allow for a clear data trail to be followed by other researchers, if needed.

CHAPTER 2
RESEARCH DESIGN AND METHOD

2.1 INTRODUCTION

The study aimed to describe women's perception regarding the effect that culture and religion have on their decision to utilise early cancer screening services in an attempt to recommend possible interventions to promote early screening. This chapter describes the research design and methodology that was used to fulfil the objectives of the study.

The study setting and the context in which the study was conducted, the population, sample, and data gathering technique and analysis, together with the data's trustworthiness are described. The ethical principles that were adhered to are also covered.

2.2 RESEARCH PARADIGM

The research paradigm is described by Rehman and Alharthi (2016:51) as a set of common beliefs that are shared by researchers regarding how problems should be understood. In this study, the researcher looked at the phenomenon under study from an interpretive paradigm perspective. Collected data could then be described to provide explanations for study participants' actions (Rehman & Alharthi 2016:51).

According to Leavy (2017:12), the purpose of interpretative research is to understand people's experiences. Interpretative research takes place in a natural setting where the participants make their living (Leavy 2017:12). Interpretive research is based on the assumption that reality is multiple and shaped by many people according to their experiences and social settings (ontology) (Rehman & Alharthi 2016:51). Interpretivists believe that knowledge is socially constructed and is best examined within its socio-historic context by accommodating the individual interpretations of various participants (epistemology) (Leavy 2017:12).

The participants in this study were studied in their social context, and the researcher employed a semi-structured interview guide as part of the data collection instrument. The researcher used her observational skills, interviewing skills, and her ability to extract the correct information from participants. The researcher was fully aware of her personal preconceptions, avoided distorting the results of the study (bracketing), and ultimately interpreted observations provided by the participants.

2.2.1 Strengths of interpretive research

An interpretive research design was used for this study as it is well-suited for exploring hidden reasons behind complex and interrelated social processes, where quantitative evidence may be biased, inaccurate, or otherwise difficult to obtain (Leavy 2017:12). The interpretive research approach assisted the researcher to uncover interesting and relevant research questions as participants shared their experiences.

2.2.2 Weakness of Interpretive research

According to Pham (2018:4), a major weakness of interpretive research designs is that it tends to be more time and resource-intensive compared to the positivist research design in terms of data collection and analysis. Conversely, Rahman (2017:106) claims that interpretive research designs require well-trained researchers, capable of seeing and interpreting complex social phenomena from participants' perspectives without adding personal biases into their interpretations. The researcher overcame this weakness by conducting four exploratory interviews before being declared competent to collect rich data and interpret the data to describe this complex social phenomenon.

Inadequate trust between participants and the researcher may also hinder full and honest self-representation by participants, and such trust-building takes time (Rahman 2017:107). The researcher conducted this study in a rigorous way to ensure trustworthiness, as discussed in detail in Section 2.11. Rapport was established with the research participants during introductions before the interviews commenced in order to get to know them, and was maintained for the duration of the semi-structured interviews. Participants were assured that they could ask questions without any influence from the researcher.

The interpretive research design can be influenced by the researcher's personal feelings and opinions, and can therefore be subjected to bias (Pham 2018:5). To minimise bias and influences, the researcher was fully aware of her own preconceptions, and did not allow this to interfere with her interpretation and presentation of the findings. The co-coder assisted the researcher in capturing all the words and responses from the interview audio tapes and written notes as the researcher read through the notes and played the audio tapes. The co-coder also assisted the researcher in grouping words with similar meaning into categories and themes.

2.3 RESEARCH DESIGN

A research design is the general procedure of inquiry and the plan for obtaining answers to the research questions of a study (Polit & Beck 2017:743). A qualitative, contextual, exploratory design was utilised in the study as it allowed the researcher to explore complex research problems through the participants' viewpoints (Polit & Beck 2017:743).

2.3.1 Qualitative research

Polit and Beck (2017:741) define qualitative research as the means by which researchers explore and understand the feelings and meanings of individuals in groups. This approach focuses on a description of the meaning individuals attach to their experience. Qualitative research raises more issues through broad and open-ended inquiries in order to understand the behaviours, values, beliefs and assumptions of an individual or community (Polit & Beck 2017:741).

The qualitative research approach was appropriate in this study for the researcher to capture women's perceptions of culture and religion as possible barriers to cervical cancer screening. The advantages of the qualitative approach (Grove, Gray & Burns 2015:66) that motivated the utilisation thereof in this study were:

- The strength of qualitative research is that it investigates human emotions and perceptions which cannot be quantified by numerical values. Words are primarily used to describe the views and priorities shared by the participants (see Section 3.4, Table 3.1). This approach allowed the researcher to handle complex narrative data that could not be explained with statistical figures but was rather coded and analysed into themes and categories.

- Another strength of qualitative research is that it is holistic and could be used to gain insight into people's feelings, contributing to an understanding of how and why people behave in a certain manner (Grove, et al. 2015:66). In this study's context, the qualitative inquiry was beneficial in assisting and describing women's opinions regarding early cervical cancer screening.

- The qualitative research design allows researchers to explore complex research problems and identify knowledge deficits as seen through the eyes of participants (Grove, et al. 2015:66). The qualitative nature of this study enabled the researcher to explore and describe women's perceptions regarding early cervical cancer screening.

- Qualitative designs are flexible, unique, and actively involve the researcher throughout the research process, allowing the researcher to change and/or adapt the research in accordance to emerging findings (Queirós, Faria & Almeida 2017:371). This approach therefore allowed the researcher to probe and adapt when new findings emerged.

- Qualitative data provide an understanding of cultural activities that might otherwise be missed in quantitative surveys or experiments (Polit & Beck 2017:741). The approach was appropriate within this study's context, as the researcher sought to describe how culture and religion might influence women's decision to undergo cervical cancer screening. Thus, women's health-seeking behaviour were explored.

2.3.2 Contextual research

Contextual research is when research is being conducted in natural and uncontrolled settings that are free from manipulation (Duda, Warburton & Black 2020:1). Qualitative research is contextual, and the study's findings cannot be generalised because the context of one setting is different from another setting (GOV.UK, 2020). Findings can only be transferable to settings similar to the specific research context explored in the current study (Holtzblatt & Beyer 2015:11). In this study, the contextual design assisted the researcher in understanding women's perceptions regarding the effect that culture and religion had on their decision to utilise early cervical cancer screening services, within their own environment and context, and focused on the local rural hospital that they would attend for screening, if they decided to do so.

2.3.3 Explorative

According to Hazzi and Maldaon (2015:3), an exploratory study design is used to discover, refine, improve and thoroughly probe the nature of an issue by exploring the views of participants. An explorative interview allows the researcher to gain new insights and knowledge about an issue, and was therefore an appropriate design to explore women's views regarding the effect that culture and religion had on their decision to utilise early cervical cancer screening services.

2.4 THE RESEARCH SETTING

According to Polit and Beck (2017:744), the setting of a study refers to the physical, social and cultural place where research information is gathered. This study was conducted at a rural hospital situated in a selected district in Zimbabwe, as explained below.

Zimbabwe is located in southern Africa, and it is surrounded by Zambia to the north, Mozambique to the east, South Africa to the south, and Botswana to the west. Zimbabwe covers an area of 390 575 km^2, with a population estimated at 14 916 330 and an annual average growth rate of 1.1% (Worldometers 2020). The country has six central hospitals in the three major cities of Zimbabwe (Harare, Bulawayo and

Chitungwiza), eight provincial hospitals, 44 district hospitals, 62 mission hospitals, 32 private hospitals, 1274 clinics, and 307 rural health centres (Zach.org.zw 2020). The health delivery system in Zimbabwe falls under the Ministry of Health and Child Care, with 14% of all the health facilities being situated in urban areas, while 86% are in rural areas. Eighty-six per cent of healthcare delivery in rural areas are from mission hospitals and clinics (Zach.org.zw 2020).

The primary healthcare system in Zimbabwe is designed in such a way that a patient has to attend the clinic before they can visit a hospital. The clinic refers all cases beyond their level of management to a rural hospital, which is usually found at the district level. The specific hospital where the sample of participants was recruited was purposively selected because it serves as a referral hospital for all rural communities of the district, as well as the peri-urban population in the district. It is the only referral hospital in the district that offers cervical cancer screening on a daily basis, thus all women who require cervical cancer screening are referred to this hospital.

2.5 POPULATION

A population consists of all elements or everyone being studied that meet the sample criteria for inclusion in a study (Burns & Grove 2015:508). The target population is the entire population in which a researcher is interested (Burns & Grove 2015:342). The target population for this study was women of childbearing age (those between the ages of 18-49 years) in a selected district in Zimbabwe; approximately 41 974 women (Zimbabwe Demographic Profile 2019).

2.6 SAMPLING

Sampling is a process employed to select individuals to be studied or a portion of the population to represent the entire population. A sample is therefore a subset of the population selected by means of a sampling technique (Polit & Beck 2017:743). The sample size for this study was not predetermined; the researcher conducted interviews until no new information was collected; thus, until data saturation was attained. Data saturation was achieved after 15 participants were interviewed, but two additional interviews were conducted to ensure that no new information emerged.

A convenience non-probability sampling technique was used for this study, where participants were selected based on their ease of access to the researcher and their geographical proximity to the hospital. Convenience sampling does not give all the individuals in the population an equal chance of being selected (Etikan, Musa & Alkassim 2016:2). However, the researcher chose this sampling method because it was possible to make use of gatekeepers to share the recruitment letter with all women attending the clinic within the period of data gathering; between 27 September and 30 September 2018.

2.7 RECRUITMENT OF PARTICIPANTS

Grove, et al. (2015:374) define ‘recruitment’ as a process of identifying, accessing and communicating with prospective study participants. After ethical approval to conduct the study was obtained from the Health Studies Research Ethics Committee, Unisa (see Annexure 1), and written permission was received from the Permanent Secretary of the Ministry of Health and Child Care (see Annexure 3) as well as the specific hospital under study (see Annexure 4), the gatekeeper (district medical officer) started to recruit participants on behalf of the researcher. All women aged 18-49 years who attended the rural hospital from 27 September and 30 September 2018 received information letters (see Annexure 7) from the district medical officer who acted as the gatekeeper. Those who volunteered provided their contact details (phone numbers) to the gatekeeper, who then shared the contact details with the researcher. The researcher then contacted the volunteers and a date, time and venue for the interviews were arranged. The researcher contacted the first participant telephonically, who agreed and arranged for a suitable date, time and venue to conduct the interview. This process was repeated until data saturation was reached (see Section 1.9).

2.8 UNIT OF ANALYSIS

According to Roller and Lavrakas (2015:262), units of analysis are the objects of study within a research project. A total of 17 participants were interviewed and formed the unit of analysis. This decision was made in accordance with the principle of saturation that stipulates a researcher stops collecting data because fresh data no longer sparks new insights or reveals new properties (Fusch & Ness 2015:1408).

2.9 DATA COLLECTION

According to Polit and Beck (2014:191), data collection is the process whereby the researcher collects data from participants in a systematic way to reach the study objectives. Data were collected by means of a semi-structured interview (see Annexure 8) that allowed the participants to respond freely, while the researcher was able to probe to obtain additional information. The researcher conducted individual, face-to-face, semi-structured interviews with participants. The interviews were audio-recorded to enable a verbatim transcription for accurate and comprehensive data analysis.

2.9.1 Semi-structured interviews

Semi-structured interviews are the most common method of data collection in qualitative research as it allows for flexibility as well as the introduction of new issues (Datco 2015:142). These interviews are based on an interview guide, which is a written list of open-ended questions or topics that need to be covered during the interview (Grove, et al. 2015:107). The semi-structured interview allowed the researcher to obtain a detailed picture from each individual (Grove, et al. 2015:107) regarding their perceptions of cervical cancer screening.

The first part of the interview guide (Section A) consisted of demographic information while the second part consisted of nine open-ended questions pertaining to women's perceptions of culture and religion as possible barriers to cervical cancer screening (see Annexure 8).

All 17 interviews were conducted in either Shona and/or English according to the language literacy level of the participant and their language preference. The interviews varied in length, but lasted no longer than 45 minutes.

2.9.2 Advantages of semi-structured interviews

According to Grove, et al. (2015:107), the advantage of semi-structured interviews is that they offer an opportunity for clarification so that all relevant data can be captured in the participants' own words rather than in the researcher's words. The semi-structured interviews allowed the researcher to explore the reasons why women do or do not utilise early cervical cancer screening services, and it facilitated free interaction between the researcher and participants, as suggested by DeJonckheere and Vaughn (2019:2).

Semi-structured interviews promoted open-ended responses from participants and in-depth information. The meanings behind an act may be revealed as the participants are able to speak for themselves with little direction from the interviewer (Grove, et al. 2015:107), as was the case in this study. Moreover, with semi-structured interviews, the researcher can probe areas suggested by the participant's answers, and pick up on information of which the researcher had no prior knowledge (Grove, et al. 2015:107).

2.9.3 Disadvantages of semi-structured interviews

Despite the many advantages, semi-structured interviews also have some disadvantages or weaknesses that have to be addressed. One such weakness is the need for an experienced researcher to sufficiently probe without being judgemental during the interview process (DeJonckheere & Vaughn 2019:2). The researcher was guided and supported by a supervisor who is experienced in qualitative research methods. Four exploratory interviews were conducted to assess the researcher's interviewing skills and test if the questions elicited the anticipated data. This processes ensured that quality data were collected (see Section 2.3.3).

According to Adams (2015:494), the analysis of semi-structured interviews can be time consuming, difficult and biased if the data analysis is not done by the person who conducted the semi-structured interviews. The researcher conducted all interviews herself after being found competent, did the data analysis personally, and used a co-coder to assist for trustworthiness purposes.

2.9.4 The interviewer

Grove, et al. (2015:1371) state that the main role of the interviewer is to obtain the information needed to address and answer the study objectives. An interviewer or researcher conducting qualitative interviews should be experienced in conducting semi-structured interviews as the quality of data depends on the interviewer's communication and interpersonal skills, as the main instrument in data collection (Polit & Beck 2014:53).

The qualities and competencies of a competent interviewer, as described by Grove, et al. (2015:1371), include:

- good interpersonal skills, such as the ability to establish rapport;
- the ability to ask probing questions to encourage participants to give more information;
- the ability to observe the participant and listen actively to what is being said; and
- as the primary and key instrument in data collection, the interviewer should act and dress in a professional manner at all times.

Four exploratory interviews were conducted to ensure that the researcher was a competent interviewer with the mentioned skills (see Section 2.8.4) before the actual data gathering commenced.

2.9.5 Exploratory interview

According to Hazzi and Maldaon (2015:3), an exploratory interview, sometimes referred to as a pilot interview, consists of a trial run that is utilised to test the data collection methods. Exploratory interviews were conducted by the researcher prior to the actual data gathering, in order to assess whether the interview questions were clear, whether the relevant responses would be received, and to assess her interviewing competency and skills, as explained in Section 2.8.4.

Each of the four exploratory interviews was assessed by the research supervisor, who is an expert in qualitative research and data gathering techniques. The supervisor has supervised many masters and doctoral students who conducted interviews and is in possession of a PhD in nursing. Some questions were changed to allow the researcher to gather relevant information pertaining to culture and religion as perceived barriers to cervical cancer screening. After the fourth exploratory interview, the supervisor approved the semi-structured interview guide and informed the researcher to start with data gathering.

2.9.6 Data collection process

Data collection is the process of gathering and measuring information on variables of interest in an established systematic manner that allows the researcher to evaluate outcomes (Polit & Beck 2017:725). Following approval from the Health Studies Research Ethics Committee, Department of Health Studies at Unisa (Annexure 1), and written permission from the Permanent Secretary of the Ministry of Health and Child Care (see Annexure 3), the local hospital (see Annexure 4), MRCZ, as well as from every individual participant who volunteered to participate (see Annexures 5, 6 and 7), the researcher proceeded to data collection using the semi-structured questionnaire as an interview guide (see Section 1.12 and Annexure 8).

The researcher arranged with the district medical officer to provide information letters (see Annexure 7) to women accessing reproductive health services such as family planning clinics, opportunistic infection clinics, and antenatal clinics at the hospital under study. The information letter presented these women an invitation to volunteer to participate. Those who volunteered were asked to provide their contact details to the gatekeeper who shared the information with the researcher. The researcher then contacted the individual volunteers to arrange for a time, date and venue for the semi-structured interviews to be conducted (one by one and until data were saturated).

All the volunteering participants indicated that the most convenient time for them was every day between 11:00 and 16:00. All the participants who volunteered to take part in the interviews were from nearby communities and did not incur any cost to come to the hospital for the interviews.

The semi-structured interviews were conducted on the agreed dates and times (from 27 September and 30 September 2018; 09:00 till 16:00 each day). Every participant was received by the researcher in a private room that was well ventilated, as arranged by the district medical officer at the hospital. The researcher greeted the participant in a culturally appropriate way, and introduced herself. The researcher then asked the participant to take a seat on a chair in front of her, with the chairs positioned in a manner that conveyed a relaxed atmosphere in which a personal conversation could take place. The participant was briefed again on the purpose of the interview and her right to withdraw from the study at any time should she feel the need to do so, without any negative consequence.

The researcher explained the process of writing field notes to the participant and that the interview would be audio-recorded. A signed participant voluntary consent form (see Annexure 6) was also obtained, which mentioned the need for the interview to be audio-recorded. A table with a digital recorder was set in the corner of the room so that it would not be in the participant's direct view, but close enough to be able to record. A bottle of water was also set on the table. Each participant was reminded that the interview would be audio-recorded as the researcher would not be able to remember all the details that were discussed and all the participants agreed to the process (see Annexure 7).

The researcher explained that the participant could withdraw at any time if they felt they could not continue with the interview. The participants were allowed to use their language of choice; that is, either Shona or English. Written consent was then obtained from those who agreed to take part in the study, and the interview commenced. The interviewer started by asking demographic questions as a way of creating rapport. When the participant was relaxed, the researcher started asking questions on cervical cancer screening (see Annexure 8).

The researcher probed to follow up on the participant's responses. According to Polit and Beck (2014:310), probing is one of the facilitation skills utilised by researchers during the interview to get more useful information from participants. Paraphrasing was also done to ensure that the researcher understood the response from the participant correctly. This skill entailed the researcher clearly expressing an idea by repeating the participant’s response in another manner to ensure the response was understood the same way (Grove, et al. 2015:184).

In addition to audio recording, the researcher also wrote field notes that enabled her to recall what she heard, saw, experienced and thought while conducting the interviews (Schwandt 2015:95). Field notes refer to a written account of the things the researcher hears, sees, experiences and thinks about during the process of collecting data. These notes assist the researcher in remembering participants’ behaviours and other observations that were made during the interview (Schwandt 2015:95).

At the end of each interview, the researcher thanked the participants for their participation. The participants were not remunerated for transport as they were recruited locally from within walking distance from the venue in which they chose to be interviewed.

The recordings were downloaded directly to the researcher’s personal computer and were saved in a password-protected file. The field notes were also stored in a lockable drawer in the researcher’s office to ensure the confidentiality of the data. Field notes were also coded and did not include the identity of the participants.

Data gathering continued until saturation was reached – when no new information emerged from interviewing more participants (Polit & Beck 2017:743). A total of 17 interviews were ultimately conducted.

2.10 ETHICAL CONSIDERATIONS

Ethical considerations are ways of ensuring that the rights and welfare of human participants are protected (WHO 2017:120). In this study, the researcher sought permission to conduct the research from all relevant authorities, as described in Section 2.9.6. The principles of autonomy or respect for persons, the right to protection from discomfort and harm, the principle of justice or a right to fair treatment, and the right to confidentiality and privacy were considered in this study. The participants were assured that the information obtained during the course of the study would not be divulged to any other person without permission from the study participants. The right to confidentiality was also assured by allocating participants with numbers so that their identity would be protected at all costs, both during and after the interviews. In the event that a report or article is written or presented on this study, the researcher will continue to protect participants' identities as the data will be presented without any identifiable data of any individual participant.

2.10.1 Autonomy and respect for persons

Autonomy or respect for persons is a fundamental ethical principle which entails the right to self-determination and the right of each person to have enough information to allow for knowledgeable, informed consent (WHO 2017). Participants were given information by means of a detailed information sheet (see Annexure 7) that addressed the research aims and the entire research process, and was provided in a language that was comprehended by the participants. Participants who volunteered to participate were requested to sign the informed consent form.

2.10.2 Right to protection from discomfort and harm

The right to protection from discomfort and harm falls under the principle of beneficence, which is the principle of doing good to research participants and preventing their exposure to harm (Barrow, Brannan & Khandhar 2020:4). This means that the researcher must be prepared to terminate the interview at any time if continuation would result in distress. The researcher assured participants that their participation and the information they provided would not be used against them in any way, they could withdraw at any time, and discontinuation from the interviews would not affect their access to health care (see Annexure 7). The researcher also advised participants that there were no direct benefits from participating in the study, but it was anticipated that the study might provide information and a greater understanding of the cultural and religious factors that hinder women from utilising early cervical cancer screening services, ultimately benefitting women's health in future.

2.10.3 Right to fair treatment

The researcher adhered to the principle of justice and fair treatment by ensuring that there would not be any exploitation of the participants on the grounds of religion, age, tribe and economic class (Sykes, Brandt & Evans 2020:424). Participants were selected in a convenient and free manner that was free from coercion. Only participants who were able and willing to participate were included in the study.

2.10.4 Privacy and confidentiality

Privacy refers to the freedom that the research participant has to decide on the time, amount and general circumstances under which personal information will be shared with or withheld from others (Grove, et al. 2015:105). In this study, the right to privacy was assured by interviewing participants in a private room, with a “do not disturb” sign on the door. The room was also located far from where people could hear what was being discussed. Confidentiality means that no information that the participant divulges is made public or available to others (Grove, et al. 2015:106). Confidentiality was ensured in this study by the researcher allocating participants a code instead of using their names during the recordings so that the responses could not be linked to any individual. The participants were informed that the information gathered during the interview would not be distributed or shared with anyone except the researcher, supervisor and co-coder who were directly involved in the study. Consent forms were also kept separate from the verbatim transcripts. All completed consent forms (see Annexure 6), audio-recordings, and transcribed materials were kept in a locked cabinet and will be destroyed five years after completing the study. The data will only be accessible to the researcher and the supervisor.

2.11 DATA ANALYSIS

According to Polit and Beck (2017:725), data analysis is a rigorous process that involves organising and structuring data, such as interview transcripts and field notes, to address research questions and derive meaning from the narrative material obtained from participants. Data analysis was carried out concurrently with data collection to allow findings to inform later data collection and determine the point of data saturation. The researcher transcribed the audio-recorded semi-structured interviews as soon as possible after the interviews, as suggested by Polit and Beck (2017:728). In this study's context, transcription was done at the end of each day after the last interview of the day was conducted. The audio-recordings were listened to and the verbatim transcripts were read to assess when data saturation was reached. After saturation was attained, the researcher analysed the data following Tesch's framework (in Creswell 2014:196-200):

1. The researcher read all the transcripts and field notes to get a general sense of the information (Polit & Beck 2017:725).
2. The researcher read the transcripts a second time to gain greater meaning of the underlying concepts and identify general ideas. Thoughts and topics that were mentioned were written down in the margins of the transcript.
3. After completing the above steps (steps 1 and 2) for several interviews, similar topics that related to each other were then grouped together into categories.
4. The categories were alphabetised, and data belonging to each category were assembled. The researcher grouped categories together to form the themes.
5. Direct quotations from the transcripts that best illustrated and underpinned the categories, reflected as the sub-categories, were used to present, interpret and discuss the findings.
6. The researcher made a summary of the themes, categories, and sub-categories (participants' quotes) (see Section 3.4).
7. The researcher then interpreted and reported the results and findings using tables, narrative descriptions, and a literature control to support or contradict findings.

2.12 TRUSTWORTHINESS

The study was conducted in the most rigorous way to ensure trustworthiness. The principles of credibility, transferability, dependability and confirmability were applied (Gunawan 2015:10), as discussed next.

2.12.1 Credibility

Credibility is defined as evaluating whether the research findings are reliable from the perspective of the participants within the context of the study (Polit & Beck 2014:585). To ensure credibility, the researcher did an exploratory interview to ensure that participants understood the semi-structured interview questions and that the questions would provide answers in line with the research purpose. At the same time, the researcher's competency to conduct the interview was assessed, and after four exploratory interviews, she was declared competent and the questions clear, ensuring that rich data would be gathered.

The researcher established rapport with the research participants during introductions before interviews commenced.

2.12.2 Transferability

Polit and Beck (2014:585) define 'transferability' as the degree to which the results of qualitative research are applicable in other settings (Polit & Beck 2014:585). The researcher provided a dense description of the context, the methodology, the process utilised to obtain data, as well as how the data were analysed, allowing other researchers to assess possible transferability to similar contexts.

2.12.3 Confirmability

Confirmability refers to the degree to which the results of a study can be confirmed or verified by others (Polit & Beck 2014:585). To ensure the objectivity of the study's findings, the audio-recordings of the semi-structured interviews were transcribed verbatim. A registered general nurse with a diploma in nursing who was trained in qualitative data collection and analysis assisted with the co-coding to enhance the confirmability of the analysed data in terms of themes, categories, and sub-categories (direct quotations).

2.12.4 Dependability

Dependability refers to the stability and consistency of the data over time, and it ensures that the research process is logical and well documented (Polit & Beck 2014:585). Dependability was achieved by conducting an exploratory interview to test the relevance and clarity of the semi-structured interview questions, as well as the competency of the interviewer (see Section 2.8.3).

2.13 CONCLUSION

This chapter described the research design and methodology, including the population, sampling and sample size, data collection and analysis, ethical considerations and trustworthiness that were applied in conducting this research. Chapter 3 provides information regarding the data analysis, interpretation and presentation of the findings, as well as the literature control that was used to support or contradict the findings.

CHAPTER 3

DATA ANALYSIS, INTERPRETATION AND LITERATURE CONTROL

3.1 INTRODUCTION

Chapter 3 presents the data analysis, interpretation, as well as the literature control to support or contradict the findings. The analysis of data was done according to the process described by Tesch (1990 in Creswell 2014:236), outlined in Section 2.11. The literature control is integrated with the data interpretation and presentation to assist with the discussion and put the findings into context. This also allows for easy reading and understanding as the literature control indicated resemblances or disagreements.

Five themes emerged after grouping similar ideas in the form of categories (see Table 3.1).

3.2 UNIT OF ANALYSIS

Seventeen participants volunteered to participate in the research and were interviewed. Data saturation was reached after 15 participants, and adding many more participants to the study would not have resulted in additional information, as explained by Creswell (2014:296). However, two more interviews were conducted to secure saturation.

3.3 BIOGRAPHICAL DATA

3.3.1 Age

According to the WHO (2020:53), the age range for cervical cancer screening clients is between 21-65 years. As indicated in Table 3.1, two study participants were between the ages of 20-25 (11.7%), five were between the ages of 26-30 (23.5%), five were between the ages of 31-35 (29.4%), four were between the ages of 36-40 (23.5%), one participant was between the ages of 41-45 (5.8%), and one was between 46-50 years of age (5.8%). Cervical cancer mostly occurs between the ages of 35-44

(WHO, 2014:53), where early screening can be seen as part of routine care. In this study, five (29%) of the participants were aged 35-44, an age where routine screening is advisable (WHO 2014:53).

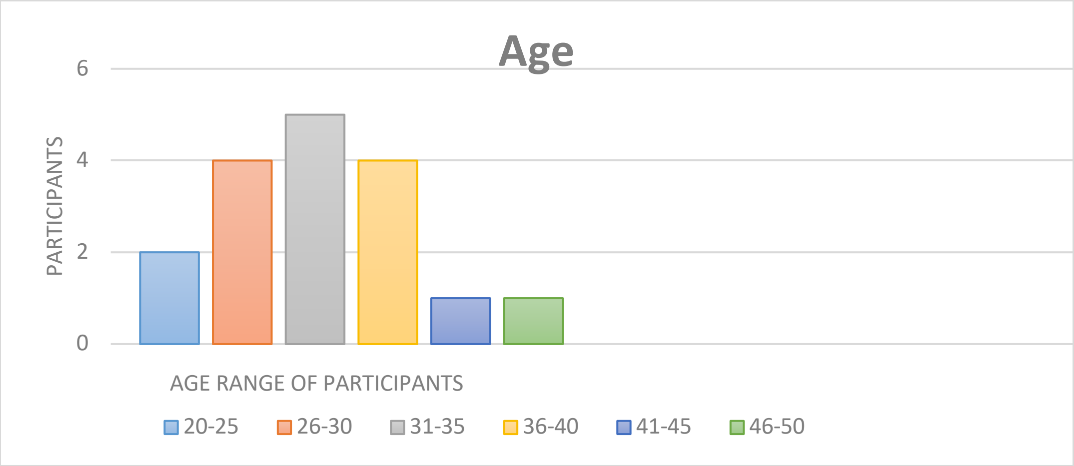


Figure 3.1: Age of respondents

3.3.2 Marital status

Marital status is a factor recognised to influence women’s motivation to undergo cervical cancer screening (Ncube, Bey, Knight, Bessler & Jolly 2015:107) because a husband’s support can influence women’s decision either positively or negatively (WHO 2014:62). Figure 3.2 indicates that 10 of the participants were married (f=58.8%), three were single (f=16.4%), one (f=5.9%) was divorced, and three (f=16.4%) were widows. Cultural beliefs, such as the role of a male partner in health-seeking behaviour, possibly influenced the 10 married women’s decision to go for cervical cancer screening, as explained by Rosser, Zakaras, Hamisi and Huchko (2014:17). Alarmingly, the study’s findings revealed that only two (2%) of the married women had ever gone for cervical cancer screening, supporting the view regarding husbands’ possible influence on their health-seeking behaviour.

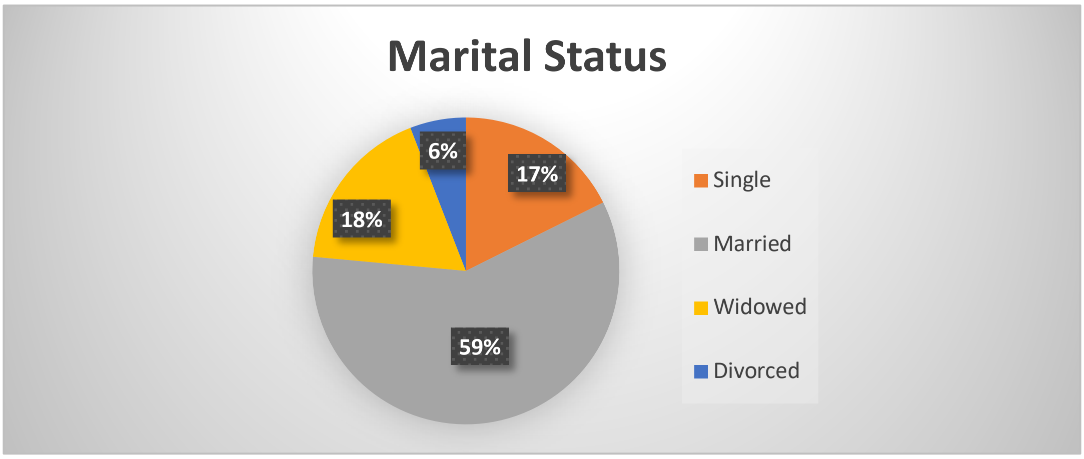


Figure 3.2: Marital Status of respondents

3.4 DISCUSSION OF FINDINGS

The five identified themes were (1) Lack of knowledge, (2) Stigmatisation, (3) Cultural beliefs and values, (4) Religion, and (5) Lack of resources. Twelve categories emerged that underpinned the themes, namely (1) Absence of symptoms, (2) Incurable disease, (3) Side effects, (4) Husband's opinion, (5) Friends attitude, (6) Trust, (7) Traditional medicine, (8) Health-seeking behaviour, (9) Role of spiritual leaders, (10) Religious beliefs, (11) Policies, and (12) Resources (see Table 3.1) Direct quotes were presented as sub-categories (see Table 3.1) to illustrate how they fit into the various identified categories and themes. As explained in Section 2.11, the researcher used the seven steps proposed by Tesch (in Creswell 2014:263) to analyse the data.

Table 3.1: Themes, categories, and direct quotes

Themes	Categories	Sub-categories: Direct quotes
Lack of knowledge (3.4.1)	*Symptoms (3.4.1.1)*	*"You cannot just find yourself at the hospital whilst you are not sick. As long as one is not feeling well there is no need to go to the clinic"* *"If someone is not feeling well and they suspect they have cervical cancer, then they should be screened but if they are fine there is no need"* *"I will not burden myself with going to the clinic when I have no signs or pain in any part of my body."* *"I am not sure if it is really important to get screened but I think as long as one is having vaginal bleeding and foul-smelling vaginal discharges, they should be screened"* *"I will not go to the clinic when I am not sick, it is a waste of time. It's only those who are sick who needs a nurse or a doctor."*
	Incurable disease (3.4.1.2)	*"I don't see any reason of going at the clinic because I was told that cancer is a killer disease that cannot be cured."* *"What is the use of getting to know that I have a disease when the nurses cannot cure the cancer disease?"*

Themes	**Categories**	**Sub-categories: Direct quotes**
		"We grew up being told that cervical cancer cannot be treated and people with cancer eventually die from the disease."
	Side effects (3.4.1.3)	*"My friend told me that they insert a metal object in the cervix which they scrap with an object during screening".* *"I fear contacting other diseases such as HIV/AIDS as I have heard that most doctors that have been treating patience end up catching the disease".*
Stigmatisation (3.4.2)	*Attitudes (3.4.2.1)*	*"Cervical cancer is disease which many people including myself do not discuss about with friends and neighbours because people may gossip and laugh thereafter"* *"Every woman should get screened in time to ensure that they get treated early if any signs of cancer is detected"* *"I am not ready now, I have other important things that I need to be attending to"* *"People in this community believe that if a person is said to have such a disease is a curse because bad luck falls upon them due to doing some bad things such as sinning"*

Themes	**Categories**	**Sub-categories: Direct quotes**
Cultural beliefs and values (3.4.3)	*Trust (3.4.3.1)*	*"When I went to the gynaecology for the screening. I went inside and the doctor told me to take off my pants, and I suddenly did not want to do the screening"* *"Cervical cancer is considered to be a sexually transmitted disease and having such a disease will lead to loss of trust for the wife by her husband who may think that the wife was sleeping around with other men"* *"I didn't find many problems. The only problem I got was when I was told to remove my clothes but later I realised they were fellow women. I looked at them, I became strong and removed the clothes"*
	Traditional medicine (3.4.3.2)	*"My grandmother when she got cancer visited a herbalist who resides in our village"* *"I don't see any reason for screening at a health centre because cancer is only treated by herbs and not the modern medicine."*
	Husbands' involvement (3.4.3.3)	*"My husband decide whether I should go for screening"* *"If I want to go to the clinic I seek permission from my husband and if he doesn't want me to go for cancer screening I have to be obedient."*

Themes	Categories	Sub-categories: Direct quotes
		"Men are not comfortable with their women being checked their private parts" *"Our culture does not allow women to go for medical examination alone without any male members of the family, this means that I can go to the clinic for screening only when my husband is around and willing to accompany me"* *"Our men do not want anyone who goes to check especially the private parts of the body, they will become suspicious if you start talking of private parts examination and this can destabilise a marriage if you do without their permission."* *"My husband may divorce me if he knows that I have cervical cancer"* *"This disease is associated with cheating in marriages, therefore getting screened will cause male partners to marry another healthier woman"*
Religion (3.4.4)	*Spiritual leaders (3.4.4.1)*	*"Some spiritual leaders opt for prayers and in case a person is infected they will be prayed for and they get healed"* *"My pastor always gives me holy water every when I go to church and I am sure that will help me not to suffer from cervical cancer"*

Themes	Categories	Sub-categories: Direct quotes
		“There are discussion held mostly in Pentecostal churches where people interact and teach about the importance of cervical cancer screening” *“There is nothing as such hidden from our church as everything is revealed to them through the prophets. The prophets will pray for us so that we do not contract diseases including cancer”*
	Religious beliefs (3.4.4.2)	*“I believed cervical cancer is a disease that is unavoidable and it is in only in God`s nature in control.”* *“People in this community believe it’s a curse to have such a disease as cancer and therefore cleansing by holy water and prayers is needed”*
Lack of resources (3.4.5)	*Policies (3.4.5.1)*	*“There is lack of cervical cancer testing services that motivate us in the rural areas to seek cervical cancer screening”* *“Cervical cancer screening should be done for free in all clinics whether government of private”* *“We need this educational forum so that we can understand. It is the same as when HIV started, there was little information given, but when they started laying it out then people started to understand.”*

Themes	Categories	Sub-categories: Direct quotes
	Lack of equipment (3.4.5.2)	*"Sometimes when you go to the clinic they say some things are not there (speculums) so we have to go and check with bigger hospital."* *"The clinic is far, and also long queues and also sometimes they say they don't have tools."*
	Lack of human resources (3.4.5.3)	*"Nurses are few compared to the patients in the rural areas, they fail to meet the demand."* *"I once went to the clinic and I came back before screening after waiting the whole day without being attended to."*

3.4.1 Lack of knowledge

A lack of knowledge affects health-seeking behaviour negatively (Twinomujuni, Nuwaha & Babirye 2015:8), including early cervical cancer screening (Oche, Kaoje, Gana & Ango 2013:57). Women have little knowledge pertaining to early cervical cancer screening, and sometimes present for treatment too late and only after the appearance of cervical cancer symptoms (Matenge & Mash 2018:8).

Participants in this study identified a lack of knowledge about cervical cancer screening as a reason for not being screened. The fact that a lack of knowledge negatively affected early screening, as portrayed by the study participants, is of concern; late screening or not undergoing screening will delay the diagnosis of cervical cancer, negatively affecting the treatment and outcome of the disease (Oche, et al. 2013:57).

3.4.1.1 Symptoms

The symptoms of cervical cancer primarily become evident at an advanced stage (WHO 2013:14) of the illness. Therefore, women who wait until they experience symptoms before they go for cervical cancer screening might already be in an advanced stage of cervical cancer. Diagnosis at an advanced stage can be life threatening as the cancer could have metastasised, resulting in poor outcomes (Al-Azri 2016:325). Unfortunately, the participants confirmed that they do not go for screening in the absence of symptoms:

> *"You cannot just find yourself at the hospital whilst you are not sick. As long as one is not feeling well there is no need to go to the clinic"*

a) Pain

Pain is a symptom that is a major driver for people to seek medical attention (Nyeko, Tumwesigye & Halage 2016:17), and in the absence of pain, women do not seek healthcare (Habtu, Yohannes & Laelago 2018:14). This view was supported by participants stating:

> *"Women should not waste their time going to the clinic if they are healthy and no signs of pain in any part of your body they is no need to go for screening"*

Yet the absence of pain is not indicative of the absence of cervical cancer. Typically, cervical cancer develops slowly, and symptoms appear when the cancer is at an advanced stage (Straughn & Yashar 2018:76); thus illustrating the importance of early screening to enhance patient outcomes (Matenge & Mash 2018:13). Alarmingly, a participant claimed:

> *"I will not burden myself with going to the clinic when I have no signs or pain in any part of my body."*

Other than pain, the following symptoms of cervical cancer are recognised, although not all of them were mentioned by the participants:

b) Vaginal bleeding

Vaginal bleeding is one of the symptoms of cervical cancer (Matenge & Mash 2018:7) that can occur after vaginal sex, after menopause, as well as bleeding or spotting between periods (Cancer.org 2020:16). Once vaginal bleeding occurs, women have typically already reached stage 2 of the disease, and the cancer becomes challenging to successfully treat (Eleje, Eke, Igberase, Igwegbe & Eleje 2019:3). A participant indicated that:

> *"I am not sure if it is really important to get screened but I think as long as one is having vaginal bleeding and foul-smelling vaginal discharges, they should be screened"*

A lack of knowledge about when symptoms appear, such as when vaginal bleeding occurs, can result in poor patient outcomes, as explained by Sawadogo, Sheba, Rutebemberwa, Sawadogo and Meda (2014:4), who also suggest that awareness on cervical cancer symptoms need to be increased.

c) Vaginal discharge

Offensive vaginal discharge is a symptom of cervical cancer that can already appear in stage 1 (Mwaka, Orach, Were, Lyratzopoulos, Wabinga & Roland 2020:855; Ibrahim, Bukar & Audu 2016:48). One of the participants was aware of this symptom, and reported:

> *"Women should get screened when they have a foul-smelling vaginal discharge."*

Vaginal discharge can be normal and present as a white or clear non-offensive smelling discharge, while abnormal vaginal discharge normally changes colour and odour, and is coupled with itching and soreness of the vagina (Rao & Mahmood 2020:11). The cause of abnormal discharge can only be ascertained by means of a thorough history and examination of the patient once they present with symptoms of abnormal vaginal discharge.

Thus, there is a need for improved health education at different levels, including capacity building of nurses and women to increase their awareness and motivation to attend cervical cancer screening services (Maar, Wakewich, Wood, Severini, Little, Burchell, et al. 2016:6).

3.4.1.2 Incurable disease

Women have the misconception that cervical cancer is not preventable or curable, mostly due to a lack of knowledge (Matenge & Mash 2018:8). The benefits of being screened are often ignored, as was the case with HIV in the past (Ndikom, Ofi & Omokhodion 2014:5). The myth that cancer is incurable and a death sentence can be a barrier for women to go for early cervical cancer screening (Matenge & Mash 2018:8). There is thus a need for women's improved education and awareness on this phenomenon in order to address misconceptions regarding cervical cancer screening, and emphasise the importance of regular cervical cancer screening (Tapera, Manyala, Erick, Maswabi, Tumoyagae, Letsholo, et al. 2017:2449). Misconceptions regarding early screening and the outcomes were emphasised by participants:

> *"We grew up being told that cervical cancer cannot be treated at the hospital and that people with cancer eventually die from the disease."*
>
> *"So I don't see any reason of going at the clinic because I was told that cancer is a killer disease that cannot be cured."*
>
> *"What is the use of getting to know that I have a disease when the nurses cannot cure the cancer disease?"*

This study's findings are supported by those of another study conducted by Ali-Risasi, Mulumba, Verdonck, Van den Broeck and Praet (2014:11) in Kinshasa, Democratic Republic of Congo (DRC). The authors found that women perceived cervical cancer to be a serious condition that could not be treated. However, when healthcare users are knowledgeable about cervical cancer and the importance of early screening, their health-seeking behaviour is positively influenced (Hami 2013:180). In this study, participants who were knowledgeable showed an understanding of the importance of cervical cancer screening and said:

> *"I should go for screening so that when I have cervical cancer it is detected at an early stage and I am referred for treatment before I develop complications. Cancer can be treated if detected early"*

It remains a concern that some participants were of the opinion that cervical cancer is incurable, and they also believed screening results in specific side effects. These views prevented them from going for screening.

3.4.1.3 Side effects

An important aspect that negatively influences health-seeking behaviour in general is the side effects associated with diagnostic procedures (Bukirwa, Mutyoba, Mukasa, Karamagi, Odiit, Kawuma, et al. 2015:5). When misconceptions about the side effects pertaining to any diagnostic procedure exist (Kumakech, Andersson, Wabinga & Berggren 2015:23), patients may not want to undergo the procedure, including cervical cancer screening. These misconceptions might be based on stories that women hear from their peers within the community (Williams 2014:6), something that a participant confirmed:

> *"My friend told me that they insert a metal object (speculum) in the cervix and they scrape you with this object during screening"*

The fear of contracting other diseases such as HIV was also cited by participants as a factor that prevented them from undergoing screening.

> *"I fear contacting other diseases such as HIV/AIDS as I have heard that most doctors that have been treating patience end up catching the disease."*

The effective integration of cervical cancer screening in health education at all services that involve women has been associated with improved knowledge and understanding of the advantages of early cancer screening. This results in fewer women presenting to the health centre with an advanced stage of cervical cancer (Bukirwa, et al. 2015:7).

3.4.2 Stigmatisation

Stigmatisation is a common occurrence where so-called ‘incurable diseases’ are concerned, and women fear rejection by those close to them if they are known to have an incurable disease (Marlow, Wardle & Waller 2015:835). Stigma pertaining to cervical cancer arises due to the fact that most cervical cancers are caused by HPV, which is spread between sexual partners. HPV and cervical cancer are therefore associated with sexual promiscuity (Gerend, Shepherd & Shepherd 2013:94), and this may prevent women from undergoing screening for fear of being rejected by family and friends if they are suspected or known to have cervical cancer (Nyblade, Stockton, Travasso & Krishnan 2017:58). The stigma related to cervical cancer therefore causes those with symptoms to be rejected by their communities and families (Nyblade, et al. 2017:58). This fear of stigma was emphasised in the participants’ narratives, as quoted below:

> *“when my aunt had cervical cancer, no one wanted to be friends with her maybe they thought that it can spread by being together and eating food from the same plate”*
>
> *“My husband may divorce me if he knows that I have cervical cancer”*

Stigma thus has a significant influence on women’s attitudes towards cervical cancer screening. Those women who are able to discuss issues of cervical cancer freely with friends and relatives normally show a positive attitude towards cervical cancer screening (Sankaranarayana 2014:80).

3.4.2.1 Attitudes

Aydeniz and Kotowski (2014:3) define ‘attitudes’ as beliefs or emotions that are expressed by an individual after considering a particular issue with some degree of favour or disfavour that influence behaviour, including health-seeking behaviour.

Women’s attitudes towards cervical cancer and screening have been shown to influence their decision to be screened for the disease (Oshima & Maezawa 2013:4314; Mannava, Durrant, Fiher, Chersich & Luchters 2015:6). A participant who portrayed a positive attitude towards screening said:

> *“Every woman should get screened in time to ensure that they get treated early if any signs of cancer are detected”*

However, another participant was of the opinion that:

> *“I am not ready now, I have other important things that I need to be attending to”*

Despite cervical cancer screening services being offered for free at all government healthcare centres, there is still a low screening uptake among Zimbabwean women (Gabaza, Chonzi, Chadambuka, Shambira, Juru, Gombe, et al. 2019:7). Statistics to scientifically link the low uptake of cervical cancer screening to either a lack of knowledge, stigmatisation or attitude towards screening is not available as yet, although some evidence is provided from the narrative data obtained from participants, as described above.

3.4.3 Cultural beliefs and values

Cultural beliefs refer to socially shared expectations, norms and practices that reflect the standard in a community as being immoral or wayward (Birhanu, Abdissa, Belachew, Deribew, Segni, Tsu, et al. 2012:15); values form a vital part of cultural beliefs (Reyna, Nelson, Han & Pignone 2015:17). In every culture, a set of beliefs and values influences the health-seeking behaviour of the people in the community (Habtu, et al. 2018:18; Ncube, et al. 2015:110), including their behaviour in terms of the motivation and acceptability to go for early cervical cancer screening. The most prominent cultural barriers cited by participants as hindering them from going for early cervical cancer screening were (1) trust, (2) the use of traditional medicine, and (3) their husbands’ involvement.

3.4.3.1 Trust

Undressing in front of strangers and being exposed during a vaginal examination to allow for screening is an invasion of privacy and a factor that prevents some women from getting screened (Ncube, et al. 2015:105). Trust between the patient and the healthcare worker is therefore essential in the healthcare worker and patient relationship (Padingani, Marape, Hwalima, Gombe & Juru 2018:156). A lack of trust between the healthcare worker and patient can hinder a patient from going for early cervical cancer screening. When there is a trusting relationship, the patient feels protected and respected, and is willing to undress in front of the healthcare worker (Maar, et al. 2016:7). Participants explained:

> *"When I went to the gynaecology for the screening. I went inside and the doctor told me to take of my pants, and I suddenly felt I did not want to do the screening"*

Upon recognising that the healthcare worker responsible for the screening was female, another participant said:

> *"The only problem I got was when I was told to remove my clothes but later I realised they were fellow women. I looked at them, I became strong and removed the clothes"*

It is not only the trusting relationship between the healthcare worker and patient that is important, but also the trusting relationship between partners and spouses (National Center for Biotechnology Information 2020). Some men are prejudiced against women with cervical cancer, likely associated with the possibility of multiple sexual partners and early intercourse (Kim, Kim & Kim 2018:155). The mentioned behaviours are recognised as risk factors associated with the development of cervical cancer (Kim, et al. 2018:155). This lack of trust between partners can destabilise marriages if the woman is found to have cervical cancer (Birhanu, et al. 2012:16). Participants also reiterated this view by saying:

> *"Cervical cancer is considered to be a sexually transmitted disease and having such a disease will lead to loss of trust between husband and wife as the husband may think that the wife was sleeping around with other men"*

> *"Our culture does not allow women to go for medical examination alone without any male members of the family, this means that I can go to the clinic for screening only when my husband is around and willing to accompany me"*

Another important cultural aspect that was influential in participants' health-seeking behaviour in terms of early cervical cancer screening was the use of traditional medicine, as discussed next.

3.4.3.2 Traditional medicine

Traditional medicine in many African countries is used as complementary and alternative medicine to treat and cure different types of cancers, including cervical cancer (Okoronkwo, Onyia-pat, Okpala, Agbo & Ndu 2014:3). Traditional and herbal medicine for the treatment of cancer is a common practice that has been widely used in most parts of Zimbabwe (Padingani, et al. 2018:157). Conversely, early cancer screening is a modern healthcare service to assist with early diagnosis, even before any signs of illness are experienced, and therefore might not be attractive to women.

According to Shoko (2018:2), people in Zimbabwe choose to use traditional medicine over modern medicine as a source of healthcare when feeling ill. This notion was supported by a participant stating:

> *"My grandmother when she got cancer visited an herbalist who resides in our village"*

The myth that diseases such as cancer are a traditional condition that can only be treated by traditional medicine and herbs can negatively impact women's decision to utilise early cervical cancer screening services (Modibbo, Dareng, Bamisaye, Jedy-Agba, Adewole, Oyeneyin, et al. 2016:22). There is thus a need to educate women that while traditional medicine could be effective in treating cervical cancer, traditional healers might not always be trained to identify the early signs of cancer in order to treat the disease before it gets serious.

3.4.3.3 Husbands' involvement

Women's decision to utilise early cervical cancer screening services points towards their husband's understanding of the importance of cancer screening, thus the male partner's role in positively supporting women's decision to utilise a service for early cervical cancer screening is essential (Rosser, et al. 2014:20). Some women needed approval from their spouses to go for cervical cancer screening, while others indicated that they might not be able to seek screening services due to being prohibited from leaving their homes by their spouses. Participants confirmed this notion by explaining:

> *"My husband decides whether I should go for screening"*
>
> *"If I want to go to the clinic I seek permission from my husband and if he doesn't want me to go for cancer screening I have to be obedient."*
>
> *"Men are not comfortable with their women being checked their private parts"*

This delay or disapproval by husbands for their wives to undergo early cervical cancer screening is mainly due to limited or a lack of husbands' involvement in cervical cancer screening issues, which poses a barrier to women's uptake of cervical cancer screening (Osei 2018:2).

However, some men, according to Rosser, et al. (2014:5), encourage their spouses to go for screening and support their wives even in the event of a positive diagnosis. A participant mentioned that:

> *"My husband accompanies me to the clinic every time I go for screening"*

The findings of this study illustrate the need for cervical cancer education among men so that they will be in a position to support and motivate their wives to undergo cervical cancer screening and treatment.

3.4.4 Religion

Religion is a set of beliefs, feelings and practices that define the relationship between human beings and the spiritual (Nanda & Warms 2015:274). Religious beliefs can be a barrier to cervical cancer screening among Christian and Muslim women across the world (Kuguyo, et al. 2017:17) as some churches believe in the healing powers of God. Some religious denominations, such as Jehovah’s Witnesses and some apostolic sects do not go to clinics or hospitals for any medical check-ups or treatment, but instead believe in prayer, holy water or oil (Onyenwenyi & Mchunu 2018:22). The belief that cervical cancer is a curse for past sins can also negatively affect women’s cervical cancer screening practices. This was emphasised by a participant stating:

> *“People in this community believe it’s a curse to have such a disease as cancer and therefore cleansing by holy water and prayers is needed”*

Some women believe that their religion would protect them from such curses and they also believe in fate; they perceive cervical cancer to be a disease that cannot be avoided and is in God’s control (Balogun & Omotade 2018:22). A participant shared:

> *“Cervical cancer is a disease that is unavoidable and it is in only in God’s nature in control.”*

3.4.4.1 Spiritual leaders

Spiritual leaders are the most respected individuals in churches and communities and, as such, have the power to influence the attitudes, behaviours and practices of their congregants (Ncube, et al. 2015:113). Spiritual leaders provide spiritual coping to their followers, and the congregants look up to them for guidance and direction. Spiritual leaders can therefore play a pivotal role in influencing women’s decision to utilise early cervical cancer screening services (Twinomujuni, et al. 2015:11). Participants mentioned:

> *“Some spiritual leaders opt for prayers and in case a person is infected they will be prayed for and they get healed”*

> *"My pastor always gives me holy water every when I go to church and I am sure that will help me not to suffer from diseases"*

Religious leaders can also be in a position to empower women with knowledge regarding cervical cancer and early screening as they are people who are listened to by their followers (Padela, Peek, Johnson-Agbakwu, Hosseinian & Curlin 2014:321). Programmes to educate women on cervical cancer should therefore also include religious leaders being trained to disseminate knowledge and awareness on early cervical cancer screening.

3.4.4.2 Religious beliefs

Religious beliefs entail the belief in a supernatural power or spiritual aspect of religion (Padela, et al. 2014:329). Religious beliefs related to health and sickness (such as some doctrines prohibiting members from seeking medical services at clinics and hospitals) affect early cervical cancer screening (Zimbabwe National Statistics Agency and ICF International 2016:45). Pentecostal churches, through women's fellowship programmes, encourage congregants to take good care of their health, including going for cervical cancer screening (WHO 2013:9). However, some participants indicated that their prophets pray for them, and they believe that their religion would protect them from diseases such as cervical cancer (Padingani, et al. 2018:157). A participant explained:

> *"There is nothing as such hidden from our church as everything is revealed to them through the prophets. The prophets will pray for us so that we do not contract diseases including cancer"*

The belief that God influences all health and that some diseases are unavoidable was also identified in the literature as a barrier towards women's healthcare behaviour and accessing early cervical cancer screening (Twinomujuni, et al. 2015:11).

3.4.5 Lack of resources

A lack of physical resources, such as a lack of equipment used for cervical cancer examinations and a lack of adequate human resources, including competent nurses, can hinder cervical cancer screening uptake (Thulaseedharan, Malila, Hakama, Esmy, Cheriyan, Swaminathan, et al. 2012:2996). Long walking distances and prolonged waiting times were noted by participants as a key barrier to cervical cancer screening because there were too few nurses to attend to those who came to the clinic for cervical cancer screening:

> *"There is lack of cervical cancer testing services that motivate us in the rural areas to seek cervical cancer screening"*

3.4.5.1 Policies

According to the WHO (2014:15), Zimbabwe has no clear policy on cervical cancer screening and treatment, and this has a significant impact on women's uptake of cervical cancer screening in the country. Policies increase women's awareness and motivation to attend early cervical cancer screening (Okoronkwo, et al. 2014:4) and can therefore contribute to the utilisation of early cancer screening services. Zimbabwe's government can develop a policy to promote early cervical cancer screening by engaging local volunteers and the community at large (WHO 2014:9), as was the case in other countries (Kuguyo, et al. 2017:6). Similarly, some participants identified the need for government intervention:

> *"There is need for the government to have laws to consider cancer as HIV in terms of screening. It should be made mandatory for women who visit the clinics and hospitals to be screened."*

> *"Cervical cancer screening should be done for free in all clinics whether government of private"*

> *“We need this educational forum so that we can understand. It is the same as when HIV started, there was little information given, but when they started laying it out then people started to understand.”*

It is the government’s responsibility to facilitate people’s education on cervical cancer screening (Padingani, et al. 2018:161), with support from non-governmental organisations (NGOs), rather than relying on them.

3.4.5.2 Lack of equipment

The lack of equipment, such as vaginal speculums, gloves, fluorescent lights and acetic acid is a major limitation experienced in state-owned facilities, such as government clinics and hospitals, resulting in inconsistent service delivery (Kadzatsa & Chokunonga 2017:4). Women get frustrated when they go for screening at clinics and hospitals, only to be told there is no available equipment (Matenge & Mash 2018:14). This lack of equipment creates missed opportunities for cervical cancer screening among women because of a loss of confidence in the healthcare system (Bukirwa, et al. 2015:8). A participant echoed that:

> *“Sometimes when you go to the clinic they say some things are not there (speculums) so we have to go and check with bigger hospital.”*

The National Statistics Agency and ICF International (2016:167) confirmed the lack of modern equipment, and donors such as United Nations Population Fund (UNFPA) and PSI are assisting with resources. However, the resources remain limited and cannot meet the strong demand for rural woman’s access (WHO 2014:16).

3.4.5.3 Lack of human resources

According to the Ministry of Health and Child Care Annual Report 2014, the nurse-to-patient ratio in Zimbabwe is low in most local clinics and district hospitals (Ministry of Health and Child Care Guidelines 2014:8); the ideal nurse-to-patient ratio is one nurse for every four patients. The Zimbabwean nurse-to-patient ratio, however, stood at one nurse for every 25 patients in 2019. With such a scenario, access to quality health care and screening services could be compromised (Ministry of Health and Child Care Annual Report 2019:36). The participants also reported long and slow-moving queues at the clinics when they go for cervical cancer screening:

> *"I went to the clinic and I came back before screening after waiting the whole day in a long queue without being attended to."*

> *"Nurses are few compared to the patients in the rural areas, they fail to meet the demand"*

The identified themes, categories and direct quotations identified from the narratives indicate that a lack of knowledge, stigmatisation, cultural beliefs and values, religion, and a lack of resources have a negative impact on women's decision to go for early cervical cancer screening (Matenge & Mash 2018:11). The government should invest in providing adequately trained and experienced nurses and other healthcare personnel, such as health promotion officers, to provide basic health education and awareness to patients at local clinics and hospitals (WHO 2014:86; The National Statistics Agency and ICF International 2016:167).

3.5 CONCLUSION

In this chapter, the researcher presented and discussed the research findings that emerged from data analysis. A literature control provided information to support or contradict the findings. Chapter 4 offers the conclusions, recommendations and limitations of this study.

CHAPTER 4

CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

4.1 INTRODUCTION

Chapter 4 presents the conclusions, recommendations and limitations of the study. The purpose of this study was to describe women's perception regarding the effect that culture and religion have on their decision to utilise early cancer screening services in an attempt to recommend possible interventions to promote early screening.

4.2 RESEARCH DESIGN AND METHODS

An exploratory, qualitative design was followed (see Section 2.3.3) to explore women's perceptions regarding the effect that culture and religion have on their decision to utilise early cancer screening services. From an interpretative paradigm, the researcher studied the participants in their own context using semi-structured interviews to gather data in English and Shona. The semi-structured interviews were audio-recorded, transcribed verbatim and analysed. Tesch's seven-step (in Creswell 2014:196) data analysis method was used to analyse the data (see Section 2.11). Five themes emerged from the analysis, namely (1) Lack of knowledge, (2) Stigmatisation, (3) Cultural beliefs and values, (4) Religion, and (5) Lack of resources.

4.3 CONCLUSIONS

4.3.1 Lack of knowledge

Participants reported their lack of knowledge regarding cervical cancer screening as a barrier that hindered their utilisation of early cervical cancer screening services (see Section 3.4.1).

Participants were of the opinion that a lack of symptoms, inadequate information regarding the advantages of early screening, misconceptions and a lack of understanding of the expected outcomes, prevented them from going for early screening.

4.3.2 Stigmatisation

Stigma, associated with the screening of other health conditions such as HIV, was also reported by the participants to be a deterring factor. Cervical cancer is associated with the causative organism HPV (McCance & Huether 2013:934), which is spread between sexual partners, and people associate having HPV with sexual promiscuity. As a result, participants felt hesitant to undergo screening for fear of being rejected by their spouses, family and friends if they were suspected of having cervical cancer (see Section 3.4.3.3).

4.3.3 Cultural beliefs and values

Participants reported cultural beliefs and values as one of the barriers to cervical cancer screening (see Section 3.4.3). Aspects such as undressing in front of others, which is against their culture, was mentioned as preventing them from undergoing screening, specifically when the examiner was male.

Cultural concerns such as requiring their husband's permission before being screened for cervical cancer (see Section 3.4.3.3) and fear of being abandoned once diagnosed with cervical cancer were also concerning.

A belief and reliance in traditional medicine were mentioned by participants to be causing delays in going for early cervical cancer screening (see Section 3.4.3.2). Participants perceived that traditional medicine was effective in the treatment of cervical cancer, and they doubted the effectiveness of modern medicine to treat the disease (see Section 3.4.3.2). The use of traditional medicine, however, may lead to late diagnosis of the disease and ultimately affect treatment outcomes.

4.3.4 Religion

The use of holy water as complementary treatment for people living with HIV (Ketema & Weret 2015:128) was also practiced in participants' communities. Members of the apostolic faith anoint themselves with holy water, as advised by their religious leaders instead of going to the clinic for medical attention (see Section 3.4.4.2). However, it was also determined that leaders in mainstream churches encourage women to take good care of their health through women's fellowship programmes (WHO 2013:9).

Spiritual leaders were viewed as being influential and respected by their congregants, and participants felt that they have great influence where health-seeking behaviour is concerned (see Section 3.4.4.1).

4.3.5 Lack of resources

In Zimbabwe, women in rural areas often walk 10km to 50km to access the nearest health facility (Mangundu, Roets & Janse van Rensburg 2020:1). Participants also indicated a lack of physical resources such as clinics in their proximity, the equipment needed to perform the screening, as well as the lack of competent nurses as a hindrance to early cervical cancer screening (see Section 3.4.5.2). Women became frustrated when they walked long distances to clinics and found screening equipment unavailable, resulting in missed screening opportunities. Moreover, long waiting times due to a shortage of nurses in clinics demotivated them from going for screening (see Section 3.4.5.3), despite receiving a free service.

4.4 RECOMMENDATIONS

It is important to note that the study's findings are contextual, thus transferability to similar contexts is possible, but the intention is not to generalise the findings. For this reason, the recommendations are specifically focused on the setting where the study was conducted.

Based on the study's findings, recommendations for possible interventions include:

- improving knowledge,
- addressing attitudes,
- taking beliefs and cultural diversity into consideration, ultimately motivating or supporting women to utilise early cervical cancer screening services.

The researcher will electronically share the research findings with the Ministry of Health and Child Care, Zimbabwe National Family Planning Council, and other technical and interested stakeholders. The research report will also be shared with the Ministry of Health at the district level. The researcher will focus on existing and planned Ministry of Health workshops where different stakeholders involved in cervical cancer screening who have an interest in women’s health, meet. An opportunity for a presentation at one of these workshops will be requested to ensure the research findings are shared and discussed with all the stakeholders to raise awareness on the identified issues affecting early cervical cancer screening.

The following aspects, with evidence from the research findings, will be emphasised: (1) Women’s lack of knowledge on cervical cancer screening, (2) Stigmatisation associated with positive results, (3) Cultural beliefs and values, (4) Religion, and (5) Lack of resources for cervical cancer screening.

The Ministry of Health, after the presentation of the findings, will be asked to support the appointment of a voluntary ad hoc committee at district level to develop context-specific and vernacular health education materials that can be available in written format (pamphlets). It is proposed that pictures and graphs be used, shared via social media, in all healthcare centres, shops and other public places.

The stigmatisation associated with positive results must also be addressed. The ad hoc committee mentioned above must, in all the health education material, focus on family-centred care, thus emphasising male involvement in the health of a community. It is recommended that the ad hoc committee must include community leaders, ordinary members from the community, church and religious leaders, educators, as well as representatives from the Cancer Association of Zimbabwe to ensure that a holistic approach to health education can be shared in all health education material and awareness programmes.

The compilation of the committee is essential to ensure that culture and religion can be effectively addressed and taken into consideration in health education.

4.5 RECOMMENDATIONS FOR FURTHER RESEARCH

- A cross-sectional study to measure the accessibility of cancer screening services at all levels of healthcare, and the primary deterrents to access and the utilisation of the same services, can be valuable.
- A study focusing on the role of traditional medicine in the development and treatment of cervical cancer can provide possible solutions and interventions to address cervical cancer treatment.
- There is also a need to study religious leaders' role in influencing women's decision to utilise early cervical cancer screening services.
- A study to assess the best way to motivate the community and change behaviour pertaining to early cancer screening can be beneficial.

4.6 LIMITATIONS OF THE STUDY

Although the qualitative research design of this study was vital to address the research questions, an interviewer who is experienced in conducting semi-structured interviews was needed. It was a very time consuming process for the researcher to become a competent interviewer. Several exploratory interviews were conducted for the researcher to gain experience and become competent before the data gathering could commence. Although the time spent on exploratory interviews was limiting and time consuming for the researcher, it was essential to ensure the trustworthiness of the data presented in the dissertation.

4.7 CONCLUSION

The findings of this study revealed that a lack of knowledge, stigmatisation, cultural beliefs and values, religion, and a lack of resources at health centres affected women’s decision to utilise early cervical cancer screening services. Health education material focusing on women’s health must include preventative interventions, such as early cancer screening. Moreover, if behaviour change within a very diverse community is to be achieved, their cultural and religious beliefs need to be taken into consideration in the preparation and development of health promotion material.

REFERENCES

Adams, W. 2015. *Handbook of Practical Program Evaluation*. 4th Edition. Wiley. Washington, D.C.

Al-Azri, M.H. 2016. Delay in Cancer Diagnosis: Causes and Possible Solutions. Oman Medical Journal, 31(5):325-326.

Ali-Risasi, C., Mulumba, P., Verdonck, K., Vanden Broeck, D. & Praet, M. 2014. Knowledge, attitude and practice about cancer of the uterine cervix among women living in Kinshasa, the Democratic Republic of Congo. *BMC Women's Health,* 14(1).

Audu, B.M., Bukar, M., Ibrahim, A.I. & Swende, T.Z. 2014. Awareness and perception of human papilloma virus vaccine among healthcare professionals in Nigeria. *J Obstet Gynaecol*, Vol. 12.

Aydeniz, M. & Kotowski, M.R. 2014. Conceptual and Methodological Issues in the Measurement of Attitudes Towards Science. *The Electronic Journal of Science Education,* 18:1-24.

Balogun, F. & Omotade, O. 2018. "She must have been sleeping around"...: Contextual interpretations of cervical cancer and views regarding HPV vaccination for adolescents in selected communities in Ibadan, Nigeria. *PloS one,* 13(9), e0203950. https://doi.org/10.1371/journal.pone.0203950.

Barrow, J.M., Brannan, G.D. & Khandhar, P.B. 2020. *Research Ethics.* Treasure Island (FL): StatPearls Publishing. [online] Available from: https://www.ncbi.nlm.nih.gov/books/NBK459281/ [Accessed 26 November 2020].

Birhanu, Z., Abdissa, A., Belachew, T., Deribew, A., Segni, H., Tsu, V., Mulholland, K. & Russell, F.M. 2012. Health seeking behavior for cervical cancer in Ethiopia: a qualitative study. *International Journal for Equity in Health*, 11:83. http://www.equityhealthj.com/content/11/1/83.

Bukirwa, A., Mukasa, B., Mutyoba, J.N., Karamagi, Y., Odiit, M., Kawuma, E. & Wanyenze, R.K. 2015. Motivations and barriers to cervical cancer screening among HIV infected women in HIV care: A qualitative study. *BMC Women's Health,* pp 2-11.

Burns, N. & Grove, S.K. 2015. *Understanding nursing research*. 6th Edition. Pretoria: Saunders/Elsevier.

Cancer.org. 2020. *Cancer Facts & Figures 2020 | American Cancer Society*. [online] Available at: <https://www.cancer.org/research/cancer-facts-statistics/all-cancer-facts-figures/cancer-facts-figures-2020.html> [Accessed 19 December 2020].

Chin'ombe, N., Sebata, N.L., Ruhanya, V. & Matarira, H.T. 2014. Human papillomavirus genotypes in cervical cancer and vaccination challenges in Zimbabwe. *Infectious Agents and Cancer,* 9:11.

Creswell, J.W. 2014*. Research design: Qualitative, quantitative, and mixed methods approach*. Thousand Oaks. CA: Sage publications.

Datko, J. 2015. Semi-structured Interview in Language Pedagogy Research. *Journal of Language and Cultural Education*, 3:142-156.

DeJonckheere, M. & Vaughn, L. 2019. Semi-structured interviewing in primary care research: a balance of relationship and rigour. *Family medicine and community health,* 7(2).

Duda, S., Warburton, C. & Black, N. 2020. Contextual Research. In: Kurosu M. (eds) Human-Computer Interaction. Design and User Experience. HCII 2020. *Lecture Notes in Computer Science,* Vol 12181. Springer, Cham. https://doi.org/10.1007/978-3-030-49059-1_3

Dunyo, P., Effah, K. & Udofia, E. 2018. Factors associated with late presentation of cervical cancer cases at a district hospital: a retrospective study. *BMC Public Health*, 18:1156.

Ebu, N.I. 2018. Socio-demographic characteristics influencing cervical cancer screening intention of HIV-positive women in the central region of Ghana. *Gynecologic oncology research and practice,* 5:3.

Eleje, G., Eke, A., Igberase, G., Igwegbe, A. & Eleje, L. 2019. Palliative interventions for controlling vaginal bleeding in advanced cervical cancer. *Cochrane Database of Systematic Reviews,* 19(3).

Etikan, I., Musa, S.A. & Alkassim, R.S. 2016. Comparison of Convenience Sampling and Purposive Sampling. *American Journal of Theoretical and Applied Statistics,* 5(1):1-4. doi: 10.11648/j.ajtas.20160501.11.

Fowler, J.R. & Jack, B.W. (2020). *Cervical Cancer*. Treasure Island (FL): StatPearls Publishing. Available at: https://www.ncbi.nlm.nih.gov/books/NBK431093/ [Accessed 20 October 2020].

Frye, D. 2021. How to See Challenges as Opportunities. [online] Psychology Today. Available at: <https://www.psychologytoday.com/us/blog/what-doesnt-kill-us/201611/how-see-challenges-opportunities> [Accessed 22 April 2021].

Fusch, P.I. & Ness, L.R. 2015. Are we there yet? Data saturation in qualitative research. *Qual. Rep*. 20(9).

Gabaza, C., Chonzi, P., Chadambuka, A., Shambira, G., Juru, T. P., Gombe, N. T., Nsubuga, P. & Tshimanga, M. 2019. Utilization and outcomes of cervical cancer screening services in Harare City, 2012-2016: a secondary data analysis. *BMC health services research,* 19(1):454.

Gerend, M.A., Shepherd, M.A. & Shepherd, J.E. 2013. The multidimensional nature of perceived barriers: Global versus practical barriers to HPV vaccination. *Health Psychology*, 32(4):361-369.

GOV.UK. 2020. Contextual Research and Observation. [online] Available at: https://www.gov.uk/service-manual/user-research/contextual-research-and-observation [Accessed 26 November 2020].

Grove, S.K., Gray, J.R. & Burns, N. 2015. *Understanding nursing research, building evidence-based practice.* 6th Edition. Philadelphia: Elsevier.

Gunawan, J. 2015. Ensuring Trustworthiness in Qualitative Research. *Belitung Nursing Journal,* 1:10-11.

Habtu, Y., Yohannes, S. & Laelago, T. 2018. Health seeking behavior and its determinants for cervical cancer among women of childbearing age in Hossana Town, Hadiya zone, Southern Ethiopia: community based cross-sectional study. *BMC Cancer*, 18(1).

Hami, M.Y. 2013. *Intentions to use cervical cancer screening services among women aged 42 and older in Malawi.* University of South Africa, Pretoria. Available at: http://hdl.handle.net/10500/9026 [Accessed 7 Januayr 2019].

Hazzi, O. & Maldaon, I. 2015. A Pilot Study: Vital Methodological Issues. *Verslas: Teorija ir Praktika,* 16(1):53-62.

Holtzblatt, K. & Beyer, H. 2015. *Contextual Design*. San Francisco: Elsevier Science.

Ibrahim, S., Bukar, M. & Audu, B. 2016. *Management Of Abnormal Vaginal Discharge In Pregnancy*. 3rd ed. London: IntechOpen Limited.

Kadzatsa, W. & Chokunonga, E. 2017. *The Status and Challenges of Cancer Care in Zimbabwe.* Available at: https://meetings.asco.org/am/daily-news/status-and-challenges-cancer-care-zimbabwe [Accessed 6 February 2017].

Ketema, A.K. & Weret, Z.S. 2015. Assessment towards use of holy water as complementary treatment among PLWHA, Northeast, Ethiopia. *American Journal of Internal Medicine,* 3:127.

Kim, H.W., Kim, D.H. & Kim, Y. 2018. Men's awareness of cervical cancer: a qualitative study. *BMC Women's Health*, 18:155.

Kuguyo, O., Matimba, A., Tsikai, N., Magwali, T., Madziyire, M., Gidiri, M., Dandara, C. & Nhachi, C. 2017. Cervical cancer in Zimbabwe: a situation analysis. *Pan African Medical Journal*, Vol 27.

Kumakech, E., Andersson, S., Wabinga, H. & Berggren, V. 2015. Integration of HIV and cervical cancer screening perceptions and preferences of communities in Uganda. *BMC Women's Health*, 15:23.

Leavy, P. 2017. *Research design: Quantitative, qualitative, mixed methods, arts-based, and community-based participatory research approaches*. New York & London: The Guilford Press.

Maar, M., Wakewich, P., Wood, B., Severini, A., Little, J., Burchell, A.N., Ogilvie, G. & Zehbe, I. 2016. Strategies for increasing cervical cancer screening amongst First Nations communities in Northwest Ontario, Canada. *Health Care for Women International,* 37(4):478-495.

Mangundu, M., Roets, L., Janse van Rensberg, E. 2020. Accessibility of healthcare in rural Zimbabwe: The perspective of nurses and healthcare users. *Afr J Prm Health Care Fam Med,* 12(1):a2245. https://doi.org/10.4102/phcfm.v12i1.2245.

Mannava, P., Durrant, K., Fisher, J., Chersich, M. & Luchters, S. 2015. Attitudes and behaviours of maternal health care providers in interactions with clients: a systematic review. *Globalization and Health*, 11(1).

Manuel, V.H. 2017. Screening and Prevention of Cervical Cancer in the World. *J Gynecol Res Obstet*, 3(3):086-092.

Mapanga, W., Brown, B. & Singh, E. 2019. Knowledge, attitudes and practices of young people in Zimbabwe on cervical cancer and HPV, current screening methods and vaccination. *BMC Cancer*, 19(1).

Marlow, L.A.V., Wardle, J. & Waller, J. 2015. Understanding cervical screening non-attendance among ethnic minority women in England. *Br J Cancer,* 113(5):833-839.

Matenge, T.G. & Mash, B. 2018. Barriers to accessing cervical cancer screening among HIV positive women in Kgatleng district, Botswana: A qualitative study. *PLOS ONE*, 13(10):e0205425. Available at: <https://pubmed.ncbi.nlm.nih.gov/30356248/> [Accessed 7 November 2020].

McCance, K.L. & Huether, S.E. 2013*. Pathophysiology: The Biologic Basis for Disease in Adults and Children*. 6th Edition. Mosby. Washington. D.C.

Merriam, S.B. & Tisdell, E.J. 2016. *Qualitative Research: A Guide to Design and Implementation.* 4th Edition. San Francisco, CA: Jossey Bass.

Ministry of Health and Child Care, 2014. Sexual reproductive health. Available at: http://www.mohcc.gov.zw/index.php?option=com_content&view=article&id=171&Itemid=717. [Accessed 2 January 2019].

Ministry of Health and Child Care, 2015. Acts & Policies. Available at: http://www.mohcc.gov.zw/index.php?option=com_phocadownload&view=category&id=6:acts-policies [Accessed 4 June 2019]

Ministry of health and Child Care, 2019. Annual Report. Available at: http://www.mohcc.gov.zw/. [Accessed 5 May 2018].

Modibbo, F.I., Dareng, E., Bamisaye, P., Jedy-Agba, E., Adewole, A., Oyeneyin, L., Olaniyan, O. & Adebamowo, C. 2016. Qualitative study of barriers to cervical cancer screening among Nigerian women. *BMJ open*, 6(1):e008533.

Mugass, A. & Frumence, G. 2019. Factors influencing the uptake of cervical cancer screening services in Tanzania: A health system perspective from national and district levels. *Nursing Open*, p. 247.

Mwaka, A., Orach, C., Were, E., Lyratzopoulos, G., Wabinga, H. & Roland, M. 2020. Awareness of Cervical Cancer Risk Factors and Symptoms: Cross-Sectional Community Survey in Post-Conflict Northern Uganda. *Health Expect*, 19(4):854-867.

Nanda, S. & Warms, R.L. 2015. *Culture counts. A Concise Introduction to Cultural Anthropology.* 3rd Edition. Cengage Learning.

Ncube, B., Bey, A., Knight, J., Bessler, P. & Jolly, P.E. 2015. Factors associated with the uptake of cervical cancer screening among women in Portland, Jamaica. *North American Journal of Medical Sciences*, 7(3):104-113.

Ndikom, C.M., Ofi, B. & Omokhodion, F. 2014. Willingness to Utilize Cervical Cancer Screening Services Among, Antenatal Clinic Attendees in Selected Hospitals in Ibadan, Nigeria. *Journal of Women's Health, Issues and Care*, 3(3).

Nyeko, R., Tumwesigye, N. & Halage, A. 2016. Prevalence and factors associated with use of herbal medicines during pregnancy among women attending postnatal clinics in Gulu district, Northern Uganda. *BMC Pregnancy and Childbirth,* 16(1).

Nyblade, L., Stockton, M., Travasso, S. & Krishnan, S. 2017. A qualitative exploration of cervical and breast cancer stigma in Karnataka, India. *BMC women's health*, 17(1):58.

Oche, M.O., Kaoje, A.U., Gana, G. & Ango, J.T. 2013. Cancer of the cervix and cervical screening: Current knowledge, attitude and practices of female health workers in Sokoto, Nigeria. *Int J Med Med Sci,* 5(4):184-190.

Okoronkwo, I., Onyia-pat, J., Okpala, P., Agbo, M. & Ndu, A. 2014. Patterns of Complementary and Alternative Medicine Use, Perceived Benefits, and Adverse Effects among Adult Users in Enugu Urban, Southeast Nigeria. *Evidence-Based Complementary and Alternative Medicine,* 2014, pp. 1-6.

Onyenwenyi, A.O.C. & Mchunu, G.G. 2018. Barriers to cervical cancer screening uptake among rural women in South West Nigeria: A qualitative study. *South African Journal of Obstetrics and Gynaecology,* 24(1). ISSN 2305-8862.

Osei, E. 2018. Fear of the Unknown in Relation to Cervical Cancer Screening. *Advances in Cancer Prevention*, 3(1).

Oshima, S. & Maezawa, M. 2013. Perception of cervical cancer screening among Japanese university students who have never had a pap smear: a qualitative study. *Asian Pacific journal of cancer prevention (APJCP),* 14(7):4313-4318.

Padela, A.I., Peek, M., Johnson-Agbakwu, C.E., Hosseinian, Z. & Curlin, F. 2014. Associations between religion-related factors and cervical cancer screening among Muslims in greater Chicago. *Journal of Lower Genital Tract Disease,* 18:326-332. doi: 10.1097/LGT.0000000000000026.

Padingani, M., Marape, G., Hwalima, Z., Gombe, N. & Juru, M. 2018. Uptake of Cervical Cancer Screening among Women Attending Health Facilities in the City of Bulawayo, 2012. *Open Journal of Epidemiology*, 08(03):153-163.

Pan American Health Organization. (PAHO). 2020. *Cancer.* Available at: https://www.paho.org/en/topics/cancer. [Accessed 3 September 2019].

Patel, S. 2015. *The research paradigm – methodology, epistemology and ontology – explained in simple language.* Available at: http://salmapatel.co.uk/academia/the-research-paradigm-methodology-epistemology-and-ontology-explained-in-simple-language/ [Accessed 15 October 2019].

Pham, L. 2018. *A Review of Advantages and Disadvantages of Three Paradigms: Positivism, Interpretivism And Critical Inquiry*. Masters. University of Adelaide.

Polit, D.F. & Beck, C.T. 2014. *Essentials of nursing research appraising evidence for nursing practice*. 8th Edition. Philadelphia: Lippincott Williams & Wilkins.

Polit, D.F. & Beck, C.T. 2017*. Nursing Research: Generating and Assessing Evidence for Nursing Practice.* 10th Edition, Wolters Kluwer Health, Philadelphia.

Qiong, Q. 2017. A Brief Introduction to Perception. *Studies in Literature and Language,* 15(4):18.

Queirós, A., Faria, D. & Almeida, F. 2017. Strengths and Limitations of Qualitative and Quantitative Research Methods. *European Journal of Education Studies*, 3(9).

Rahman, S. 2017. The advantages and disadvantages of using qualitative and quantitative approaches and methods in language "testing and assessment" research: a literature review. *Journal of Education and Learning,* 6(1).

Rao, V. & Mahmood, T. 2020. Vaginal discharge. *Obstetrics, Gynaecology & Reproductive Medicine*, 30(1):11-18.

Rehman, A.A. & Alharthi, K. 2016. An introduction to research paradigms. *International Journal of Educational Investigations,* 3(8):51-59.

Reyna, V.F., Nelson, W.L., Han, P.K. & Pignone, M.P. 2015. Decision making and cancer. *The American Psychologist,* 70(2):105-118.

Roller, M.R. & Lavrakas, P.J. 2015. *Applied qualitative research design: A total quality framework approach*. New York, NY: Guilford Press.

Rosser, J., Zakaras, J., Hamisi, S. & Huchko, M. 2014. Men's knowledge and attitudes about cervical cancer screening in Kenya. *BMC Women's Health*, 14(1).

Sankaranarayanan, R. 2014. Screening for cancer in low- and middle-income countries. *Ann Glob Health,* 80(5):412-417.

Sawadogo, B., Sheba, G., Rutebemberwa, E., Sawadogo, M. & Meda, N. 2014. Knowledge and beliefs on cervical cancer and practices on cervical cancer screening among women aged 20 to 50 years in Ouagadougou, Burkina Faso, 2012: a cross-sectional study. *Pan African Medical Journal,* 18.

Schwandt, T. 2015. *The SAGE dictionary of qualitative inquiry.* Choice Reviews Online, [online] 52(11). Available at: <https://www.researchgate.net/publication/278667863_The_Sage_Dictionary_of_Qualitative_Inquiry> [Accessed 8 October 2020].

Sedgwick, P. 2014. Unit of observation versus unit of analysis. *BMJ,* 348:g3840-g3840.

Shoko, T. 2018. Traditional Herbal Medicine and Healing in Zimbabwe. *J Tradit Med Clin Natur,* 7:254. doi: 10.4172/2573-4555.1000254

Sykes, L., Brandt, P. & Evans, W. 2020. *The Ethics of Research: Part 4: Safeguarding The Scientist, Protecting The Participants.* [online] Scielo.org.za. Available at: <http://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S0011-85162016000900012> [Accessed 19 December 2020].

Straughn, M. & Yashar, C. 201). *UpToDate*. [Online] Uptodate.com. Available at: https://www.uptodate.com/contents/cervical-cancer-treatment-early-stage-cancer-beyond-the-basics [Accessed 15 October 2019].

Tapera, R., Manyala, E., Erick, P., Maswabi, T.M., Tumoyagae, T., Mbongwe, B. & Letsholo, B. 2017. Knowledge and Attitudes towards Cervical cancer screening amongst University of Botswana female students. *Asian Pac. J. Cancer Prev*, 18:2445-2450. doi: 10.22034/APJCP.2017.18.9.2445.

Tapera, O., Kadzatsa, W., Nyakabau, Mavhu, W., Dreyer, G., Stray-Pedersen, B. & Hendricks, S.J.H. 2019. Sociodemographic inequities in cervical cancer screening, treatment and care amongst women aged at least 25 years: evidence from surveys in Harare, Zimbabwe. *BMC Public Health,* 19:428.

Thulaseedharan, J.V., Malila, N., Hakama, M., Esmy, P.O., Cheriyan, M., Swaminathan, R., Muwonge, R. & Sankaranarayanan, R. 2012. Socio demographic and reproductive risk factors for cervical cancer – a large prospective cohort study from rural India. *Asian Pacific Journal of Cancer Prevention*, 13(6):2991-2995.

Twinomujuni, C., Nuwaha, F. & Babirye, J.N. 2015. Understanding the Low Level of Cervical Cancer Screening in Masaka Uganda Using the ASE Model: A Community-Based Survey. *PLoS ONE,* 10(6):e0128498. doi: 10.1371/journal.pone.0128498

United Nations Children's Fund (UNICEF). 2016. *Cervical Cancer Vaccine Introduced in Zimbabwe.* Available at: https://www.unicef.org/zimbabwe/pressreleases/cervical-cancer-vaccine-introduced-zimbabwe. [Accessed 4 March 2018]

United Nations Population Fund (UNFPA), 2016. Why Get Checked for Cervical Cancer. Harare: UNFPA Zimbabwe.

UNFPA Zimbabwe, 2019. *Annual Report*. [online] Harare: UNFPA Zimbabwe, p.22. Available at: https://zimbabwe.unfpa.org/en/publications/unfpa-zimbabwe-2019-annual-report [Accessed 24 November 2020].

Vargas-Hernández, V.M. 2017. Screening and Prevention of Cervical Cancer in the World. *J Gynecol Res Obstet,* 3(3):086-092.

Williams, M.S. 2014. A qualitative assessment of the social cultural factors that influence cervical cancer screening behaviors and the health communication preferences of women in Kumasi, Ghana. *Journal of Cancer Education*, 29(3):555-562. 10.1007/s13187-014-0611-4.

World Health Organization (WHO). 2013. *Comprehensive cancer prevention and control: a healthier future for girls and women*. Available at: http://www.who.int. [Accessed 20 June 2016].

World Health Organization (WHO). 2017. *HIV/AIDS.* [Online] Available at: http://www.who.int/gho/hiv/en/ [Accessed 25 November 2018].

World Health Organization (WHO). 2020. WHO framework for strengthening and scaling-up of services for the management of invasive cervical cancer. Geneva: World Health Organization; 2020. Licence: CC BY-NC-SA 3.0 IGO.

Worldometers.info. 2020. *Zimbabwe Population (2020) Worldometer*. [online] Available at: <https://www.worldometers.info/world-population/zimbabwe-population/> [Accessed 1 October 2020].

Zach.org.zw. 2020. *ZACH in The Fight Against Cervical Cancer – ZACH*. [online] Available at: <https://www.zach.org.zw/fight-against-cervical-cancer/> [Accessed 19 December 2020].

Zimbabwe Demographic Profile 2019. [online] Available at: <https://www.indexmundi.com/zimbabwe/demographics_profile.html> [Accessed 1 October 2020].

Zimbabwe National Statistics Agency and ICF International. 2016. Zimbabwe Demographic and Health Survey 2015: Key Indicators. Rockville, Maryland, USA: Zimbabwe National Statistics Agency (ZIMSTAT) and ICF International.

ANNEXURE A: ETHICAL CLEARANCE UNIVERSITY OF SOUTH AFRICA HIGHER DEGREES RESEARCH AND ETHICS COMMITTEE

UNISA
university
of south africa

RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES
REC-012714-039 (NHERC)

1 March 2017

HSHDC/655/2017
MS F Gutusa
Student: 4490-657-9

Supervisor: Prof L Roets
Qualification: PhD
Joint Supervisor: -

Dear MS F Gutusa

Decision: Ethics Approval

Name: MS F Gutusa

Proposal: Culture and religion as perceived challenges to early cervical cancer screening.

Qualification: MPCHS94

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted for the duration of the research period as indicated in your application.

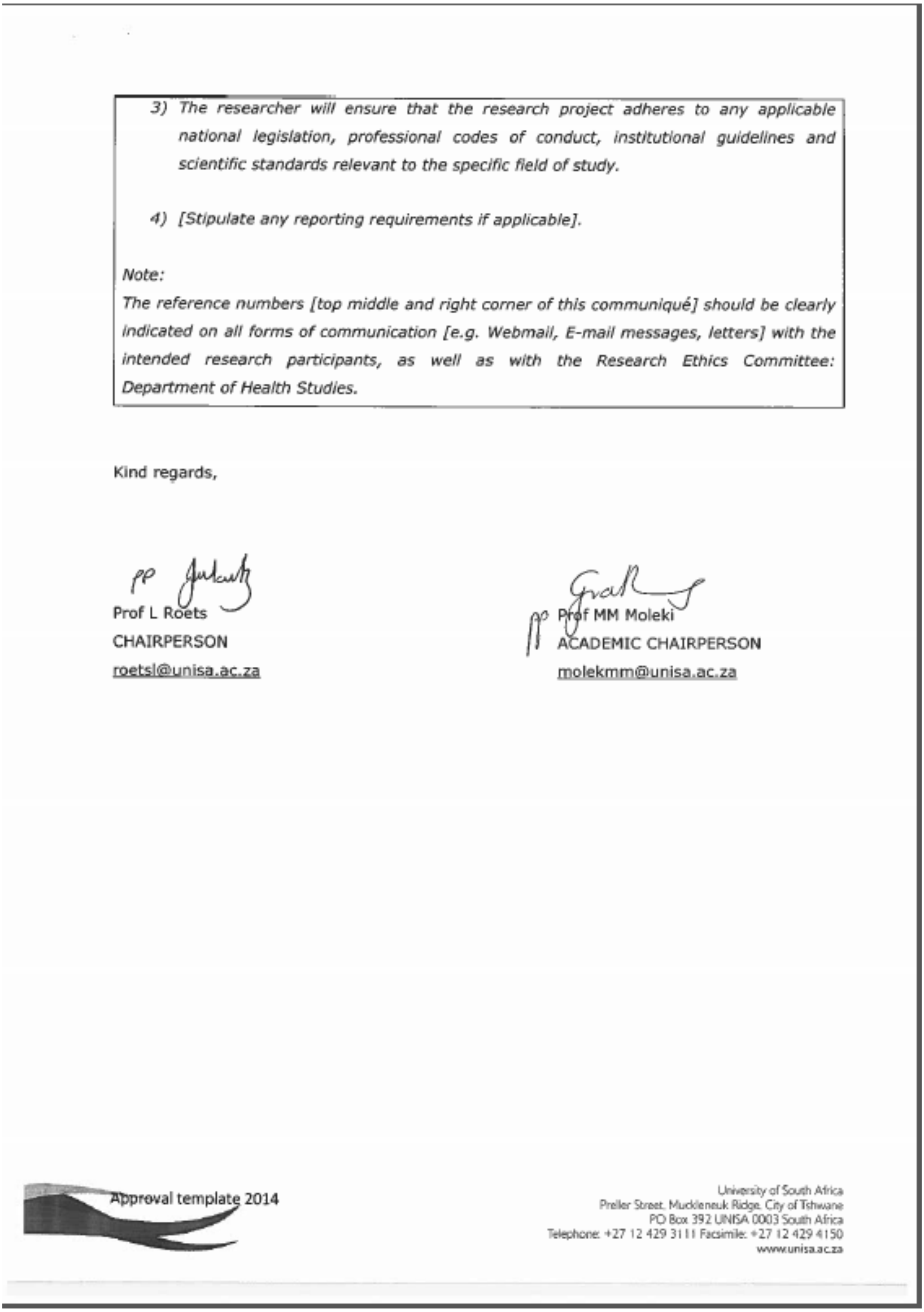
The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on 1 March 2017.

The proposed research may now commence with the proviso that:

1) *The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*

2) *Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*

Open Rubric



3) *The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*

4) *[Stipulate any reporting requirements if applicable].*

Note:

The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.

Kind regards,

pp

Prof L Roets
CHAIRPERSON
roetsl@unisa.ac.za

pp

Prof MM Moleki
ACADEMIC CHAIRPERSON
molekmm@unisa.ac.za

Approval template 2014

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

ANNEXURE B: REQUEST FOR PERMISSION TO CONDUCT STUDY – HAUNA RURAL HEALTH CENTRE

Hauna Rural Hospital
Ministry of Health and Child Care
Mutasa, Zimbabwe

The District Medical Officer,

My name is Fungai Gutusa currently studying for a Master student of Public Health at the University of South Africa (UNISA). I hereby ask your permission to conduct the research at your health centre. The title of my research is Culture and religion as perceived challenges to early cervical cancer screening. The aim of the study is to describe the perception of women regarding the effect of culture and religion on the decision to utilize early cancer screening services. The results may assist in the development of interventions to promote early screening of cervical cancer. The research will be conducted under the supervision of Prof Lizeth Roets from the UNISA Department of Health Studies. I would like to apply for permission to conduct this research at your health facility.

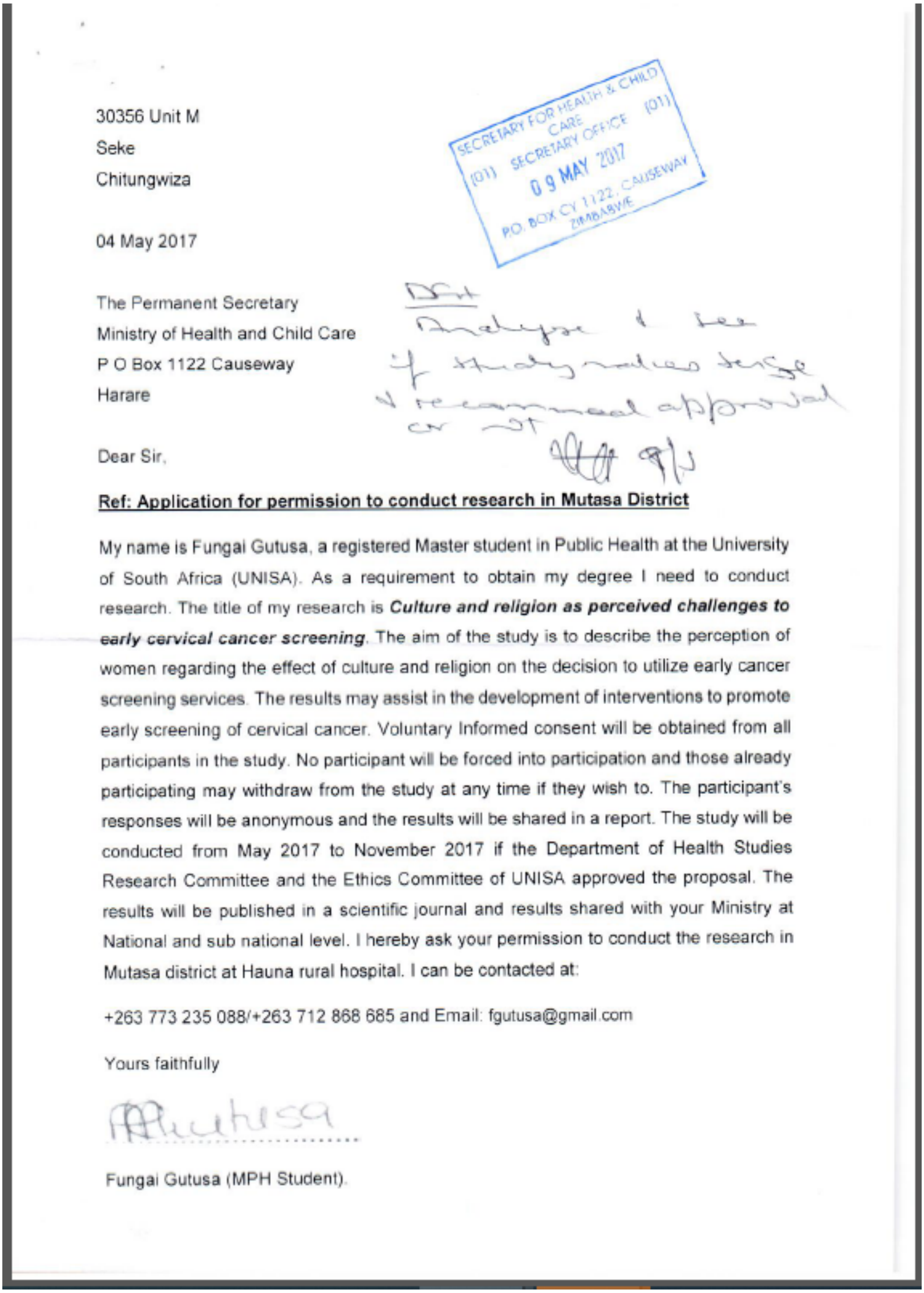
A bound copy of the full research copy will be provided to the health centre upon completion of the study. Should any further information be required, I can be contacted on mobile phone number: +263 773 235 088 and email: fgutusa@gmail.com. My supervisor Prof Lizeth Roets can be contacted on phone number: +2712 429 2226 and email: roetsl@unisa.ac.za

Yours faithfully

…………………………

Fungai Gutusa

ANNEXURE C: PERMISSION/ APPROVAL TO CONDUCT STUDY – PERM SEC



SECRETARY FOR HEALTH & CHILD CARE
(01) SECRETARY OFFICE (01)
0 9 MAY 2017
P.O. BOX CY 1122, CAUSEWAY
ZIMBABWE

30356 Unit M
Seke
Chitungwiza

04 May 2017

The Permanent Secretary
Ministry of Health and Child Care
P O Box 1122 Causeway
Harare

DSt
Analyse & see if study makes sense & recommend approval or not
9/5

Dear Sir,

Ref: Application for permission to conduct research in Mutasa District

My name is Fungai Gutusa, a registered Master student in Public Health at the University of South Africa (UNISA). As a requirement to obtain my degree I need to conduct research. The title of my research is ***Culture and religion as perceived challenges to early cervical cancer screening***. The aim of the study is to describe the perception of women regarding the effect of culture and religion on the decision to utilize early cancer screening services. The results may assist in the development of interventions to promote early screening of cervical cancer. Voluntary Informed consent will be obtained from all participants in the study. No participant will be forced into participation and those already participating may withdraw from the study at any time if they wish to. The participant's responses will be anonymous and the results will be shared in a report. The study will be conducted from May 2017 to November 2017 if the Department of Health Studies Research Committee and the Ethics Committee of UNISA approved the proposal. The results will be published in a scientific journal and results shared with your Ministry at National and sub national level. I hereby ask your permission to conduct the research in Mutasa district at Hauna rural hospital. I can be contacted at:

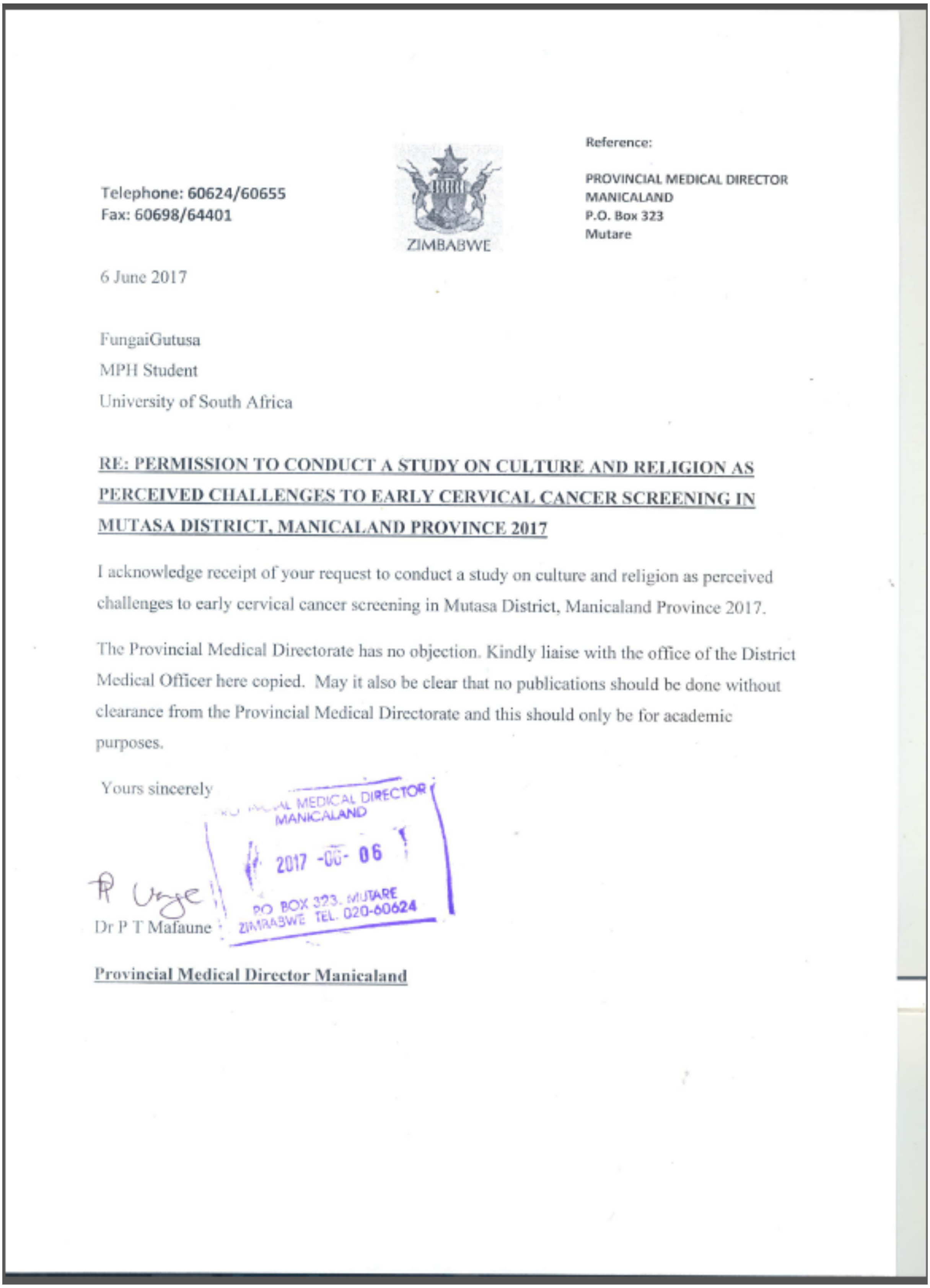
+263 773 235 088/+263 712 868 685 and Email: fgutusa@gmail.com

Yours faithfully

FGutusa
....

Fungai Gutusa (MPH Student).

ANNEXURE D: PERMISSION TO CONDUCT STUDY – PMD AND DISTRICT



Telephone: 60624/60655
Fax: 60698/64401

ZIMBABWE

Reference:

PROVINCIAL MEDICAL DIRECTOR
MANICALAND
P.O. Box 323
Mutare

6 June 2017

FungaiGutusa
MPH Student
University of South Africa

RE: PERMISSION TO CONDUCT A STUDY ON CULTURE AND RELIGION AS PERCEIVED CHALLENGES TO EARLY CERVICAL CANCER SCREENING IN MUTASA DISTRICT, MANICALAND PROVINCE 2017

I acknowledge receipt of your request to conduct a study on culture and religion as perceived challenges to early cervical cancer screening in Mutasa District, Manicaland Province 2017.

The Provincial Medical Directorate has no objection. Kindly liaise with the office of the District Medical Officer here copied. May it also be clear that no publications should be done without clearance from the Provincial Medical Directorate and this should only be for academic purposes.

Yours sincerely

MEDICAL DIRECTOR
MANICALAND
2017 -06- 06
PO BOX 323, MUTARE
ZIMBABWE TEL. 020-60624

Dr P T Mafaune

Provincial Medical Director Manicaland

Telephone: +263-4-798537-60
Telegraphic Address:
"MEDICUS", Harare
Fax: +263-4-729154/793634
(702293 FHP)
Telex: MEDICUS 22211ZW

ZIMBABWE

Reference:
Ministry of Health and Child
Care
P O Box CY1122
Causeway
HARARE

May 16, 2017

Fungai Gutusa
MPH Student
University of South Africa

RE: PERMISSION TO CONDUCT A STUDY IN MUTASA DISTRICT

Your application requesting to conduct a study in MutasaDistrict has been noted.

The research titled "Culture and religion as perceived challenges in early surgical screening makes interesting research topic.

Hopefully, your results will help MOHCC scale up cervical cancer screening in the country as we try to reduce the burden of the disease in the country.

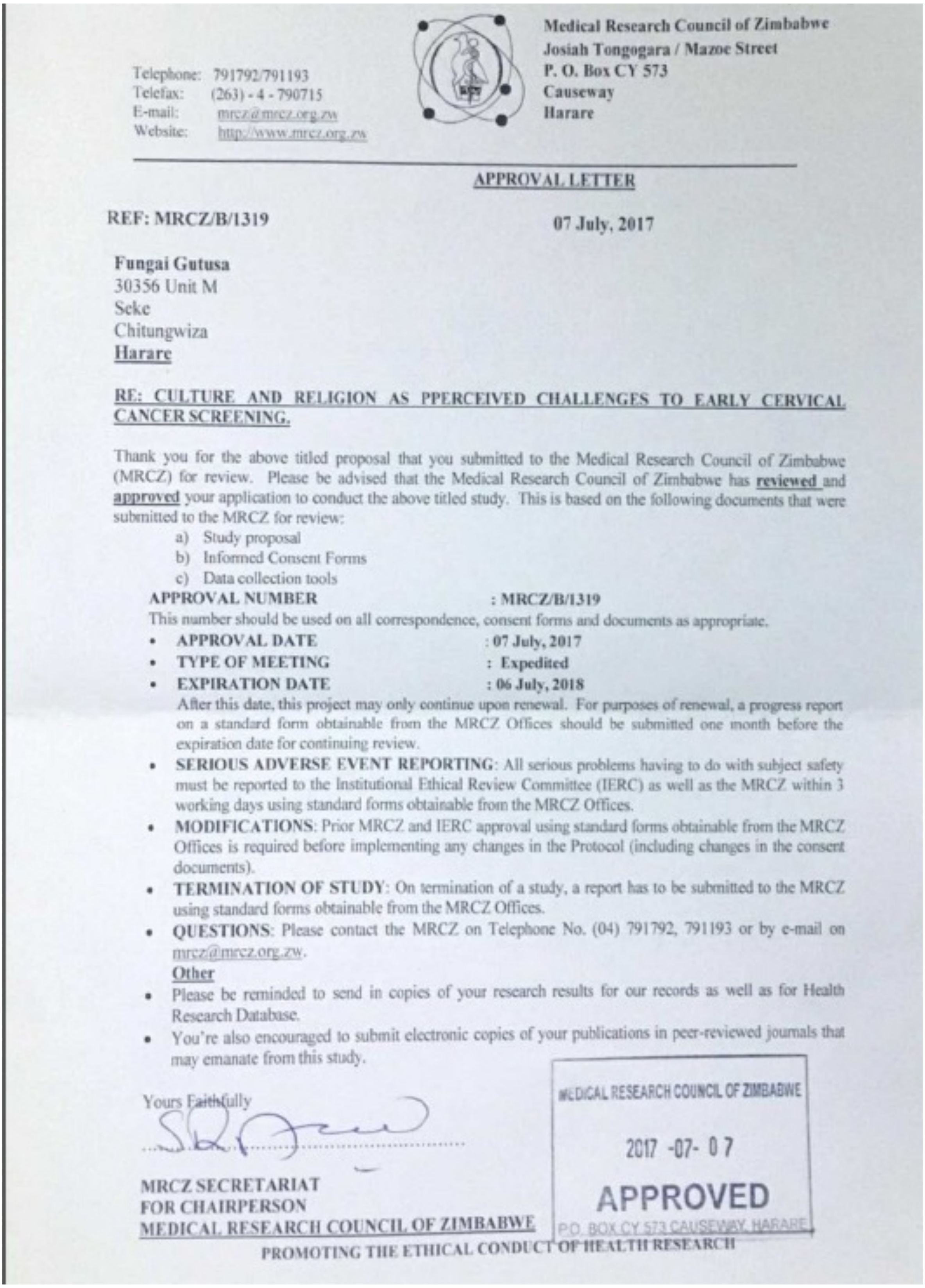
You have support of the Ministry. Kindly liaise through the office of the provincial Provincial Medical Director, Manicaland Province here copied.

Yours sincerely

SECRETARY FOR HEALTH & C/C
(PRINCIPAL DIRECTOR) POLICY
PLANN. MONITORING & EVALUA.
17 MAY 2017
P.O. BOX CY 1122, CAUSEWAY
ZIMBABWE

DR R MUDYIRADIMA
ACTINGSECRETARY FOR HEALTH AND CHILD CARE
cc: PMD Manicaland, Dr P T Mafaune

ANNEXURE E: APPROVAL MEDICAL RESEARCH COUNCIL OF ZIMBABWE (MRCZ)



Telephone: 791792/791193
Telefax: (263) - 4 - 790715
E-mail: mrcz@mrcz.org.zw
Website: http://www.mrcz.org.zw

Medical Research Council of Zimbabwe
Josiah Tongogara / Mazoe Street
P. O. Box CY 573
Causeway
Harare

APPROVAL LETTER

REF: MRCZ/B/1319 **07 July, 2017**

Fungai Gutusa
30356 Unit M
Seke
Chitungwiza
Harare

RE: CULTURE AND RELIGION AS PPERCEIVED CHALLENGES TO EARLY CERVICAL CANCER SCREENING.

Thank you for the above titled proposal that you submitted to the Medical Research Council of Zimbabwe (MRCZ) for review. Please be advised that the Medical Research Council of Zimbabwe has **reviewed** and **approved** your application to conduct the above titled study. This is based on the following documents that were submitted to the MRCZ for review:

a) Study proposal
b) Informed Consent Forms
c) Data collection tools

APPROVAL NUMBER : **MRCZ/B/1319**

This number should be used on all correspondence, consent forms and documents as appropriate.

- **APPROVAL DATE** : **07 July, 2017**
- **TYPE OF MEETING** : **Expedited**
- **EXPIRATION DATE** : **06 July, 2018**

  After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the MRCZ Offices should be submitted one month before the expiration date for continuing review.
- **SERIOUS ADVERSE EVENT REPORTING**: All serious problems having to do with subject safety must be reported to the Institutional Ethical Review Committee (IERC) as well as the MRCZ within 3 working days using standard forms obtainable from the MRCZ Offices.
- **MODIFICATIONS**: Prior MRCZ and IERC approval using standard forms obtainable from the MRCZ Offices is required before implementing any changes in the Protocol (including changes in the consent documents).
- **TERMINATION OF STUDY**: On termination of a study, a report has to be submitted to the MRCZ using standard forms obtainable from the MRCZ Offices.
- **QUESTIONS**: Please contact the MRCZ on Telephone No. (04) 791792, 791193 or by e-mail on mrcz@mrcz.org.zw.

Other

- Please be reminded to send in copies of your research results for our records as well as for Health Research Database.
- You're also encouraged to submit electronic copies of your publications in peer-reviewed journals that may emanate from this study.

Yours Faithfully

MRCZ SECRETARIAT
FOR CHAIRPERSON
MEDICAL RESEARCH COUNCIL OF ZIMBABWE

MEDICAL RESEARCH COUNCIL OF ZIMBABWE
2017 -07- 07
APPROVED
P.O. BOX CY 573 CAUSEWAY, HARARE

PROMOTING THE ETHICAL CONDUCT OF HEALTH RESEARCH

ANNEXURE F: PARTICIPANT INFORMED CONSENT FORM

I ___________________________(first and last name) understand that I am being asked to participate in a research study at Hauna Rural Hospital. This research study will describe the perception of women regarding the effect of culture and religion on the decision to utilize early cancer screening services.

I understand that I will be personally interviewed by the researcher for approximately 30 to 60 minutes. The interview will be tape-recorded and take place in a private office at the Hauna Rural Hospital on a time and date mutually agreed upon. No identifying information will be included when the interview is transcribed. All the information given by me will be kept confidential by the researcher. I understand that I will receive no remuneration for participating in the study. There are no known risks associated with this study.

I realize that the knowledge gained from this study may help either me or other peers in the future. I realize that my participation in this study is entirely voluntary, and that I may withdraw from the study at any time if I wish to. If I decide to discontinue my participation in this study, I will continue to be treated in the usual and customary fashion and will not be disadvantaged in any way.

I am aware that the, information obtained may be used in public health publications or presentations.

If I need any information regarding this study and my participation I can contact the Higher Degree Committee Office at Unisa +27 (0) 12 429 2226.or the researcher at +263 773 235 088

The study has been explained to me. I have read and understand this consent form, all of my questions have been answered, and I agree to participate. I understand that I will be given a copy of this signed consent form.

I have read this consent form and voluntarily consent to participate in this study.

Subject's signature_____________________ Date______________________

I have explained this study to the above subject and have sought his/her understanding for informed consent.

Researcher signature____AMuthesa......................Date______________________

ANNEXURE G: RESEARCH INFORMATION SHEET FOR POTENTIAL RESPONDENTS

STUDY TITLE: Culture and religion as perceived challenges to early cervical cancer screening

You are being asked to participate in a research study "Culture and religion as perceived challenges to early cervical cancer screening." This study is being conducted by Fungai Gutusa, a student pursuing a Master in Public Health degree with the University of South Africa. The information obtained will be used to improve women's utilization of cervical cancer screening services. You will be asked questions about you perceptions in relation to different areas concerning cervical cancer. The interview will take approximately 30 minutes of your time. You will be recruited into the study along with fourteen other women accessing health care services at Hauna Hospital.

The interview is entirely voluntary and you are free to withdraw at any time. Participation, no participation, or withdrawal will not affect you in any way whatsoever. Therefore prospective participants have the right to decide voluntarily to participate in a study; ask questions for clarification; refuse to give information or to withdraw from the study at any stage without incurring any negative consequences. All the information collected is confidential. Numbers instead of names will appear on the completed interview guides. To further enhance privacy and confidentiality, all completed interview schedules will be kept under lock and key. Only the researcher will have access to this locker. The research report will not contain any information that would identify any particular individual.

There are no anticipated risks attached to participating in this study. You may not receive a direct benefit if you agree to participate. However, it is anticipated that the information obtained from this research would improve health providers' understanding of issues affecting women's utilization of cervical cancer screening services and therefore improve interventions. Implementation of recommendations based on the results could improve women's perceptions of cervical screening and cervical cancer.

In the event of having further questions, comments or complaints relating to the research contact; Fungai Gutusa at 30356 Unit M Seke Chitungwiza, Telephone number +263 773235088.

Thank you for considering to participate in this study.

Yours sincerely

Fungai Gutusa

ANNEXURE H: INTERVIEW GUIDE

Culture and religion as perceived challenges to early cervical cancer screening.

My name is Fungai Gutusa studying with the University of South Africa. I am carrying out research as one of the requirements for the partial fulfilment of my Master's Degree in Public Health. Thank you for reading all the information in the information letter and for agreeing to participate in this study. As you know the interview is entirely voluntary and you are free to withdraw at any time without any negative effects.

The purpose of this study is to analyse the influence of culture and religion in early cancer cervical screening. The findings will be shared with the Ministry of Health and the Manicaland Community on how cancer screening can be successfully implemented for the benefit of women. All responses shall be treated with anonymity to protect the respondents and confidentiality is therefore guaranteed. There are no incentives or monetary value attached to your participation in the study. Your assistance will be greatly appreciated.

Section A: Demographic Questions (Mibvunzo maererano nechimiro chemhuri)

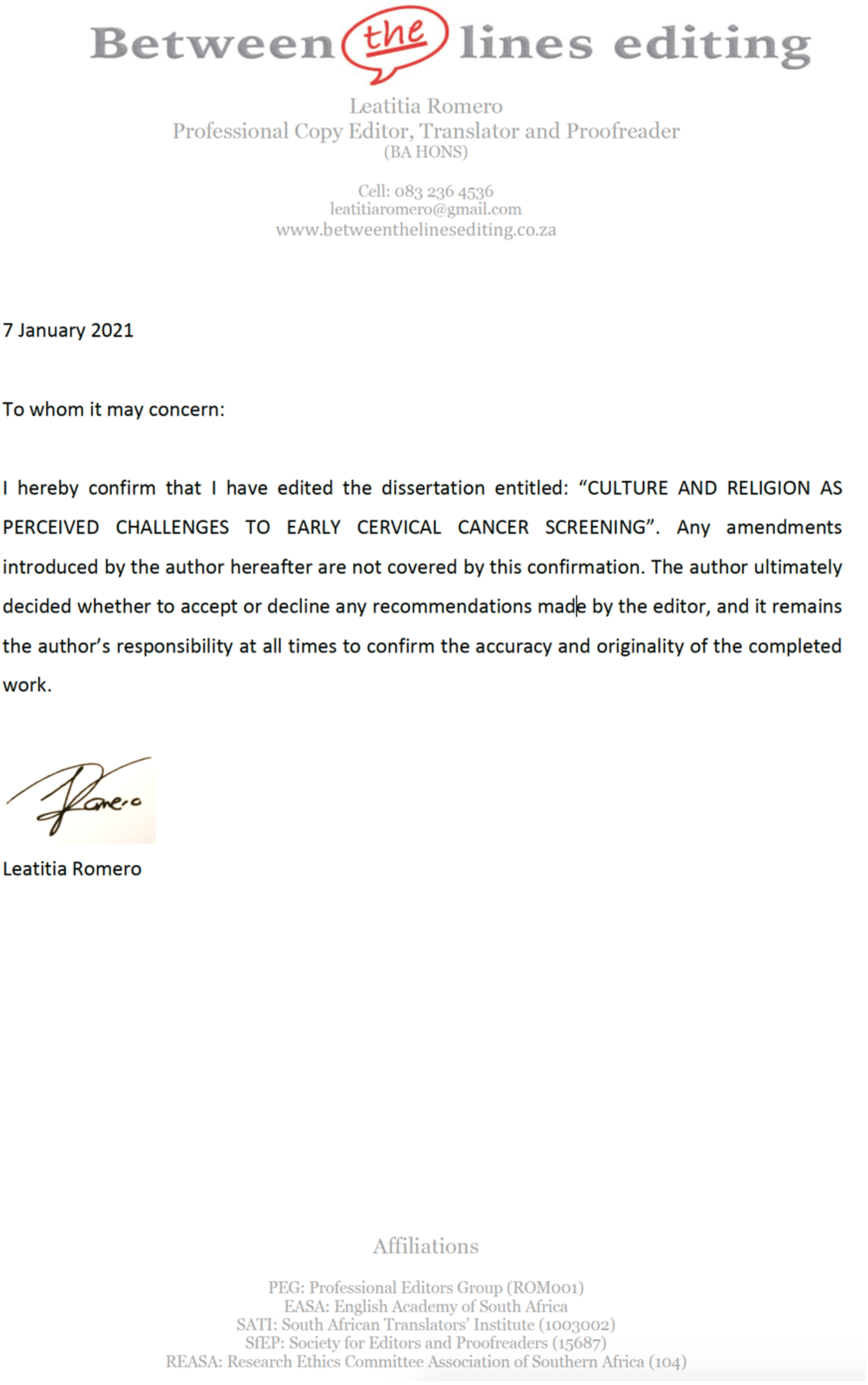
1. What is your age?...
2. What is you marital status? ……. ……………………
3. What is your highest level of education? ……………..
4. What do you currently do for a living?.........
5. How many other females are in your household?..........
6. How old is she/are they………………….

The aim of this study is to describe the perception of women regarding the effect of culture and religion on their decision to utilize early cancer screening services in an attempt to recommend possible interventions to promote early screening.

1. Have you ever gone for cancer screening?
2. *Please explain to me what motivated you to go for screening?*
3. Please explain to me why you think that women should either go, or not go for cancer screening?
4. Please explain to me whether you think that culture can influence a woman's decision to go for cancer screening?

5. Can you please explain to me exactly how culture do influence a woman’s decision to go for cancer screening?
6. Please explain to me whether you think that religion can influence a women’s decision to go for cancer screening?
7. Can you please explain to me exactly how religion influence a woman’s decision to go for cancer screening?
8. How do men participation influence a woman or their wife to make a decision to go for early cancer screening?
9. What do you think can be done to ensure that women can get early screening for cervical cancer …………………

ANNEXURE I: EDITING CERTIFICATE



Between the lines editing

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7 January 2021

To whom it may concern:

I hereby confirm that I have edited the dissertation entitled: "CULTURE AND RELIGION AS PERCEIVED CHALLENGES TO EARLY CERVICAL CANCER SCREENING". Any amendments introduced by the author hereafter are not covered by this confirmation. The author ultimately decided whether to accept or decline any recommendations made by the editor, and it remains the author's responsibility at all times to confirm the accuracy and originality of the completed work.

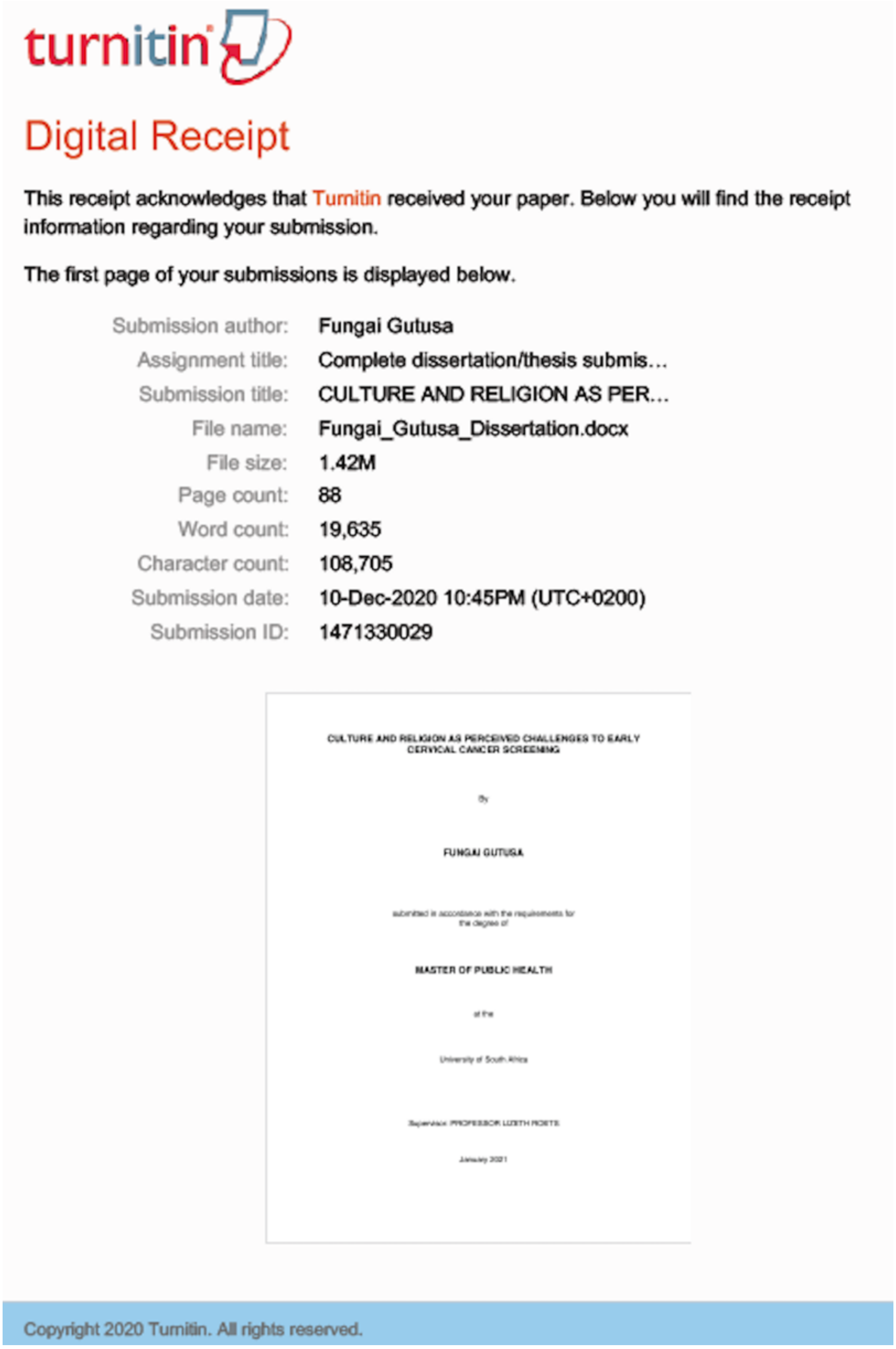
Romero

Leatitia Romero

Affiliations

PEG: Professional Editors Group (ROM001)
EASA: English Academy of South Africa
SATI: South African Translators' Institute (1003002)
SfEP: Society for Editors and Proofreaders (15687)
REASA: Research Ethics Committee Association of Southern Africa (104)

ANNEXURE J: TURNITIN RECEIPT



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CULTURE AND RELIGION AS PERCEIVED CHALLENGES TO EARLY
CERVICAL CANCER SCREENING

By

FUNGAI GUTUSA

submitted in accordance with the requirements for
the degree of

MASTER OF PUBLIC HEALTH

at the

University of South Africa

Supervisor: PROFESSOR LIZETH ROETS

January 2021