CHALLENGES OF COMMUNICATING CERVICAL CANCER SCREENING AWARENESS AND UPTAKE IN BUNGOMA COUNTY- KENYA

by

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13-1855

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CHALLENGES OF COMMUNICATING CERVICAL CANCER SCREENING AWARENESS AND UPTAKE IN BUNGOMA COUNTY- KENYA

I declare that this thesis is my original work and has not been submitted to any other college or university for academic credit.

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	- Acquired Immunodeficiency Diseases
BK	- Bikap-Koret Radio FM
CCS	- Cervical Cancer Screening
CCSS	- Cervical Cancer Screening Services
CHW	- Community Health Worker
DPHN	- District Public Health Nurse
FGD	- Focus Group Discussions
HBM	- Health Belief Model
HIV	- Human Immunodeficiency Virus
HPV	- Human Papilomavirus
ICO	- Information Centre on HPV and Cancer
NTV	- Nation Television
STDs	- Sexually Transmitted Diseases
TRA	- Theory of Reasoned Action
UN	- United Nations
WHO	- World Health Organization

ABSTRACT

There are ongoing communications campaigns of cervical cancer in Kenya for cervical cancer screening and uptake among women (National Cervical Cancer Prevention Program, 2012). However, data depicts that there is low level of screening and uptake in the rural population (ICO Information Centre on HPV and Cancer, 2014). This study adopted qualitative research design with a purpose of finding out the communication challenges of cervical cancer screening awareness and uptake among rural women in Bungoma County- Kenya. The objectives of the study were to: find out the communication channels of cervical cancer that rural women in Bungoma are exposed to; identify the communication challenges that rural women in Bungoma face regarding cervical cancer screening health campaigns, and to find out the level of awareness of cervical cancer among rural women in Bungoma County. The sample size consisted of 40 women from Mt. Elgon Constituency in the County. Focus group discussion and in-depth interviews were the sampling technique adopted. The data was analyzed by using QSR-Nvivo. The findings of the research showed that the main communication channels of cervical cancer were the media, health education and roadshows. The main communication challenges of cervical cancer screening and uptake were; lack of cervical cancer terminology, inadequate information on the communication channels and fear. There was low level of cervical cancer awareness and uptake among the participants. One of the recommendations was the need of educating media personalities and other major key health informants on cervical cancer for increase in uptake of screening services.

CHAPTER ONE

INTRODUCTION AND BACKGROUND OF THE STUDY

Introduction

Non-communicable diseases cause more deaths in sub-Saharan Africa compared to other infectious diseases (World Health Organization, [WHO] 2013). Cervical cancer is a non-communicable disease that is highly linked with Human papillomavirus (HPV) infection, irregular pap-test screening, multiple male sexual partners, engagement to sexual intercourse at an early age and immunosuppressive disorders example HIV/AIDS (Centres for Disease Control and Prevention, 2015).

WHO (2014) highlighted that cervical cancer accounts for 275,000 deaths globally every year, out of which at least 87% occurs in developing countries. Sibiya (2012) observed that most deaths caused by cervical cancer in developing countries, especially in the Sub-Saharan Africa, are as a result of lack of screening that permits precancerous detection and prevention at an early stage. The lack of early cervical cancer screening is usually as a result of low levels of awareness and knowledge on the disease (Nyambane, Mberia, & Ndati, 2015)

Communication about cancer and cancer control is a restricted subject of health communication because it deals with a topic that is negative and scary (Parhizkar, Nazari, & Hassan, 2012). During the communication process of cervical cancer, various challenges may arise such as; low levels of awareness, myths and misconceptions, fear, stigma, and language barriers (Kutto, 2014). Although the media is considered as the most reliable source of communicating cervical cancer, research shows that there are still some communication challenges during the process of disseminating information in the media (Parhizkar et al., 2012).

Kenya is ranked among the top 20 high cervical cancer disease burden countries worldwide, with almost 2, 451 out of 4,802 women diagnosed with cancer dying annually (WHO, 2014). The percentage of women who attend cervical cancer screening from the rural areas in the country is lower compared to those in the urban areas (ICO Information Centre on HPV and Cancer, 2014). There are therefore various communication platforms in the country that are adopted for cervical cancer screening awareness (Nyambane et al., 2015) However, research depicts that cervical cancer awareness level is still low among the general population in the country despite the on-going cervical cancer awareness and campaigns programs (Gichangi et al., 2003; Nyambane et al., 2015).

Background of the Study

Cervical cancer is easily preventable especially when it is detected early and treated (Eggert, 2010). However, there is still low rate of women who go for cervical cancer screening among the rural population in Kenya (ICO Information Centre on HPV and Cancer, 2014). Data depicts that 2.6% of women from the rural areas are screened for cervical cancer compared to 4.0% of urban women after every 3 years. Gichangi et al. (2003) states that adequate communication and knowledge on cervical cancer will aid in lowering the mortality rate of the disease in the country.

WHO (2006) recommended that cervical cancer screening programs should start screening women aged 30 years or more and should occur at three-year intervals. In Kenya, women who are between the ages of 15 years to 44 years are advised to go for cervical cancer screening because they are at higher risk of getting cervical cancer (ICO Information Centre on HPV and Cancer, 2014). Therefore, messages during the process of communicating cervical cancer should target the general population for it to be effective (Parhizkar et al., 2012).

The messages for cervical cancer screening awareness in Kenya are mostly aired during the cancer awareness month (Nyambane et al., 2015). The cancer awareness month is October. The mass media awareness and communication on cervical cancer in Kenya is therefore not proportionate to the gravity of the situation (Nyambane et al., 2015). To make matters worse, information and services offered by the government for cervical cancer screening awareness rarely reaches women who live in the rural areas (Kutto, 2014). This is despite the fact that rural women are at a higher risk of being infected with cervical cancer because of: poverty, cultural beliefs and gender-based issues (Arnolu, 2007).

Bungoma County has three main urban centres namely: Bungoma, Kimilli and Webuye and most of the areas in the county are in the rural setting (County Government of Bungoma, 2014). The women who live in Bungoma County are at a higher risk of getting cervical cancer because of the high levels of: cultural beliefs and attitudes, and unsafe sexual practice among residents (County Government of Bungoma, 2014). In addition, there is limited knowledge and general awareness of cervical cancer in some parts of Bungoma County (Friedman, et al., 2014). There are also low screening rates in the County as compared to its neighbouring places (Department of International Development, 2015). This study therefore sought to find out the challenges of communicating cervical cancer screening and awareness and uptake among women who live in Bungoma County.

Statement of the Problem

In Kenya, awareness and communication campaigns that are meant to promote the uptake of screening services towards prevention of cervical cancer are taking place (National Cervical Cancer Prevention Program, 2012). These communication campaigns mostly target the general public through: the media, Information Communication Technology, community health talks, work place programs, religious programs, and community models/champions (National Cervical Cancer Prevention Program, 2012). However, research still depict that

there is low level of cervical cancer knowledge and awareness among the general population (Nyambane et al., 2015). The low level of cervical cancer awareness among the population is reflected on the low level of cervical cancer screening uptake in the country as depicted by the ICO Information Centre on HPV and Cancer (2014). In addition, there is still low percentage of cervical cancer screening uptake among the rural women compared to the urban women in Kenya- 2.6 % versus 4.0% (ICO Information Centre on HPV and Cancer, 2014). This study therefore sought to establish the communication challenges during cervical cancer screening awareness and uptake among rural women.

Purpose of the Study

The study was aimed at determining the challenges of communicating cervical cancer screening among women who live in rural areas of Bungoma County.

Objectives of the Study

1. To find out the communication channels of cervical cancer that rural women (18-50) in Bungoma County were exposed to
2. To identify the communication challenges that women in rural areas (18 - 50) face regarding cervical cancer screening health campaigns
3. To find out the levels of awareness of cervical cancer among rural women (18-50) in Bungoma County

Research Questions

1. What communication channels of cervical cancer were rural women (18-50) in Bungoma County exposed to?
2. What communication challenges did women in rural areas (18-50) face regarding cervical cancer screening health campaigns?

3. What were the awareness levels of cervical cancer among rural women (18-50) in Bungoma County?

Justification of the Study

Communication for cervical cancer screening awareness and uptake among the general population in Kenya is on-going (National Cervical Cancer Prevention Program, 2012). However, rural women in the country rarely go for cervical cancer screening. Kutto and Mulwo (2015), identified various communication challenges during cervical cancer campaigns for cervical cancer screening and uptake among women. This study therefore sought to identify those challenges in one of the rural areas in the country so as to enlighten relevant stakeholders on the best messages and communication programs to develop and adapt to during communication processes of the disease.

Significance of the Study

The research would contribute towards health communication researches.

The research would inform communication programs on effective communication strategies for cervical cancer uptake and increase in screening among rural women in Western Kenya

The research findings would help various health organizations when carrying out cervical cancer communication campaigns

The research would also contribute to the discussions around communication and cervical cancer screening specifically among rural women. It will assist the ministry of health in the country and cervical cancer screening programs to promote cervical screening and Human Papillomavirus vaccination in rural areas.

Assumptions of the Study

Sampled women from the community who were willing to participate in the study provided truthful information.

Scope of the Study

This study dealt on the challenges of communicating cervical cancer awareness and uptake in Bungoma County-Mt. Elgon Constituency.

Limitations and Delimitations of the Study

The researcher faced a hard time during the process of collecting data because there was lack of cervical cancer term that the community members could relate to.

The researcher engaged the participants in the language that they are familiarized to, and adopted the word for cervical cancer that is used by Mt. Elgon District hospital during cancer campaigns in October month.

Definition of Terms

Cervical Cancer: A type of cancer which develops in the cervix of a woman (Eggert, 2012). In this study, cervical cancer is a cancer that develops in the cervix of a woman.

Cervical cancer screening: A process of identifying abnormal changes inside the cervix before it becomes cancerous (Eggert, 2012). In this study, cervical cancer screening is a process that a woman undergoes in order to identify Human Papillomavirus infection.

Human papillomavirus (HPV): A virus with subtypes which causes various diseases in people ranging from common warts to cervical cancer (Eggert, 2012). In this study, Human papillomavirus is a virus that causes cervical cancer.

Communication: A two-way process of reaching mutual understanding through exchanging information, creating and sharing meanings and ideas (Schiavo, 2007). In this study, communication is any channel used for cervical cancer information

Communication channel: A communication channel is defined as a particular type of medium that is used to transmit a message to its intended audience. In this study, communication channels refer to the systems of communicating cervical cancer to rural women.

Awareness: The Cambridge dictionary defines awareness as the knowledge, or an understanding of a subject or a situation that is in existence based on an experience or information. In this study, awareness refers to the knowledge and the perception of cervical cancer screening among rural women.

Uptake: An act of absorbing and incorporating especially into a cell, living organism, or tissue. In this study, uptake is the process of incorporating cervical cancer screening into one‟s daily life.

Summary

Chapter one has highlighted the introduction and background of cervical cancer disease and its burden internationally, in Kenya and in Bungoma County. The chapter has also discussed the communication channels used in cervical cancer screening in Kenya and the reason why the researcher wanted to carry out this research. The chapter has also highlighted the objective, scope, justification, significance, assumptions, limitation and delimitations of the study.

The following chapter will present the theoretical framework that will be used in the study and also discuss various literatures from different authors and scholars related to the research study.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter reviews literatures which are related to the research key concepts, findings and the existing gaps the study proposes to bridge. It begins with a theoretical review followed by an empirical review which is an analysis of other studies that are related to this particular study. It is then followed with a summary of all literature the researcher reviewed that are also related to this research. It finally concludes by highlighting the knowledge gap that exists and the researcher seeks to fill by carrying out this study.

Theoretical Framework

The two combined theories that were used in this research are the health belief model (HBM) and the theory of reasoned action (TRA).

Health Belief Model

Health belief model (HBM) was adopted to predict why individuals do or do not take up programs that detect or prevent diseases (Berker, Maiman, Kirscht, Haefner, & Drachman, 1997). The theory suggests that the likelihood of a person to engage in a specific health behaviour is a function of several beliefs: the extent to which one believes that they are susceptible to a particular illness; ones perception of the severity of the illness consequences; perceived barriers/costs of adopting a health behaviour; perceived benefits of adopting the targeted health behaviour. According to (Schiavo, 2007), the major contribution of the HBM to the health communication field is its emphasis on the importance of knowledge as a necessary step to change.

Application of the Theory to the Study

This theory was applicable in this study because knowledge about cervical cancer screening is a strong determinant of screening behaviour (Eggleston, Coker, Das, Cordray, & Luchok, 2007). Perceived susceptibility, perceived severity, perceived benefits, perceived barriers and cues to action all rely on the level of awareness and knowledge about cervical cancer. For example, if a woman has adequate knowledge on cervical cancer, she will be able to know the severity of the disease, the barriers, the benefits of carrying out cervical cancer screening and the susceptibility of the disease. Knowledge is brought to target audiences through an educational approach that primarily focuses on messages, communication channels and spokespeople (Schiavo, 2007).

Theory of Reasoned Action

The Theory of Reasoned Action (TRA) suggests that the strength of a person's intention to perform certain behaviour determines his/her behavioural performance (Ajzen & Fishbein, 1980). This intention is contributed by the attitude of that individual towards the behaviour and or the subjective norms of the individual on that behaviour. In this theory, the attitude has been described as the feelings and emotions that an individual has towards a certain behaviour or idea. On the other hand, subjective norms are defined as any positive or negative personal opinion that key influencers have on potential behaviours.

There are two kinds of beliefs under this theory; the normative beliefs, and the behavioural beliefs. The normative beliefs influences subjective norms and occurs when an individual places other people's approval on the behaviour he wishes to perform (Schiavo, 2007) and his motivation to comply with the approvals and ideas from them. The behavioural belief, on the other hand, is the attitude of an individual towards certain behaviour on the consequences of performing such behaviour.

Application of the Theory to this Study

Communication is crucial in the theory of reasoned action because it aids in the process of supporting behavioural intentions and changing subjective norms and, therefore, increasing its likelihood to become the actual behaviours on the targeted individuals (Schiavo, 2007). Women who have obtained relevant and adequate communication on the importance on cervical cancer screening may change their attitude and practice to curb their susceptibility to the disease.

Schiavo (2007) also argued that this theory is useful during the process of analysing and identifying the messages and actions which need to be adopted to change the targeted group attitudes because it is a good tool in profiling primary and secondary audiences. When communicating cervical cancer screening, there is a need for messages to be tailored to the baseline knowledge, perceptions, culture, and attitudes unique to the target population so that it can change their behavioural perception towards the disease.

Interaction of the Theories in this Study

The two theories (HBM and TRA) both assume that health decision making is largely deliberative and rational process. In both HBM and TRA, intention is a factor that will determine how one will behave (Bish, Sutton, & Golombok, 2012). Unlike the HBM, TRA introduces communication as the best aspect of shaping an individual‟s attitude and subjective norms example through the media campaigns, interpersonal communications, key health informers and friends (Gerend & Shephard, 2012). TRA is also a tool used in profiling primary and secondary audiences during the process of analyzing and identifying messages and actions which need to be adopted to change the targeted group attitude (Schiavo, 2007).

Bungoma County

Bungoma County lies between the latitude 00 28‟ and 10 30‟ North of the Equator, and longitude 340 20‟ East and 350 15‟ East of the Greenwich Meridian. It covers an area of 3032.4 Km2. The general projection for 2015 for the County in the year 2015 was1,655,281 with 808,449 males and 846,832 females (County government of Bungoma, 2014). The County also has 9 constituency namely: Kandunyi, Kabuchai, Sirisia, Kimilili, Tongaren, Webuye East, Webuye West, Mt Elgon and Bumula.

The County has three main urban centers namely Bungoma Kimilli and Webuye, but a total of 8 urban centres (County government of Bungoma, 2014). The total population of all the 9 urban centres in the County is 180,529. Most of the population therefore stays in the rural centers of Bungoma County with a total of 1,474,752 populations. The county also has 136 health facilities, out of which 4 are nursing homes, 78 are dispensaries, 16 are health centers, 134 are community units, 11 are hospitals and 27 are clinics. Unsafe sexual practice is the top listed condition of high mortality rate in the County, and it is due to inadequate knowledge in preventive measure, cultural beliefs and attitude (County government of Bungoma, 2014). HIV/AIDS is the major cause of deaths in the County (County government of Bungoma, 2014)

According to the report of cervical cancer activity in Kenya (America Cancer Society, 2015), there are 3 organization program activities for cervical cancer in the County: AMPATH, APHIA Plus and Western PS Kenya. These programs have their sites in of Bungoma County namely: Bungoma East and West, Webuye, Siboti, Nalando, Tonganren, Mechimeru and Kopsiro.

Mt Elgon Constituency is located in Bungoma County. It lies between latitude 0° 48′, and 1° 30′ North and Longitudes 34° 22′ and 35° 10′ east. The constituency has 11 wards two amongst them being Elgon and Kaptama Ward. Mt. Elgon District Hospital is one of the

clinical sites selected by Ampath University of Toronto with Moi University and its teaching hospital in Eldoret meant to improve reproductive health in Kenya. Cervical cancer screening services is therefore available in the district hospital.

General Literature Review

Cervical cancer can affect a woman of any age, but there are some factors which increase the risk of the cervical cancer Human papillomavirus. These factors include:

Social Behaviour- Cervical cancer is caused by a sexually transmitted virus called Human Papillomavirus (HPV). The virus is present on approximately 99% of cervical cancers (Eggert, 2010) and it is transmitted through genital contact with an infected person. Women who have multiple sexual partners have a higher risk of being infected with HPV and it is not 100% preventable with the use of condom Eggert (2010). Gatuno and Nyamongo (2005) also place women who are infected with HIV to be at risk of contracting cervical cancer.

Contraception- a woman who has been using oral contraceptives over a long period of time is a higher risk of getting cervical cancer by 2.5% (Eggert, 2012).

Smoking- Women who have either smoked tobacco actively or inactively are twice likely to get cervical cancer compared to none- smokers. This is because the tobacco by-products have been found on the cervical mucus of women who smoke (Eggert, 2012)

Social-economic factors- research has shown that the women who are from low economic status are at a higher risk of getting cervical cancer especially in the developing countries (Palacio-Mejia, Rangel-Gomez, Hernandez-Avila, & Lazcano-Ponce, 2003). Poverty contributes to the high rate of cervical cancer in developing world because the women may find it hard to access health services and treatment of cervical cancer (Nyambane et al., 2015).

Cervical Cancer in the Rural and Urban Populations

Women who live in rural areas are mostly affected by cervical cancer (Jemal et al., 2005) with a percentage of 60 to 70 in sub-Saharan countries. According to Palacio-Mejía et al. (2003), a place of residency is a social variable in cervical cancer mortality risk as it reflects health inequalities. This is because there is a big difference in terms of coverage of cervical cancer early detection programs and inadequate health services between the urban and the rural areas (Palacio-Mejia et al., 2003).

A research carried out by Pillay (2002) also found out that there were lower awareness levels of cervical cancer among women who live in rural areas compared to women who live in the urban areas. He found out that the main reason for the high number of mortality and infection rate of cervical cancer among women who live in rural areas of South Africa was medical attitude on the disease and low level of knowledge about the disease. Unlike urban women who consult a real doctor, rural women would consult traditional healers if they experience abnormal cervical bleeding (Pillay, 2002).

According to a report made by the American Hospital Association (2011), rural populations experience challenges when accessing health care facilities and they travel long distance for health services despite experiencing unreliable transportation which in return contributes to their high tendencies to rarely seek health care services. Other studies (Sankaranarayanan, Budukh, & Rajkumar, 2001) have also revealed that culture, financial status and education level contributes to the high rate of infection and mortality rate of cervical cancer in rural areas.

In Kenya, data shows that cervical cancer screening is still low among rural women compared to urban women (WHO, 2015). Low level of awareness and poor access to health facilities was identified as the major contributors of high cervical cancer infection in rural areas in Kenya (Gatune & Nyamongo, 2005). Inadequate screening facilities (Othman &

Rebolj, 2009) and limited knowledge of the disease because of culture attitude and stigma were also listed as contributors of the high rate of cervical cancer disease in rural Kenya. Gichongo (2012) in her research on utilization level of cancer screening in Central Kenya found that education level had an impact on cervical cancer screening uptake. Rosser, Njoroge and Huchko (2015) on the other hand identified shortage in staffing and insufficient staff training to be the main contributors of the low rate of cervical cancer screening in Western Kenya.

Kutto (2014) in her research on the communication issues regarding control of cervical cancer among rural women in Elgeyo-Marakwet County in Kenya, listed a number of factors which influences cervical cancer screening among the rural population. These factors include: fear to carry out cervical cancer screening, cultural beliefs among the community which prevented the women from discussing about the disease, stigma, lack of support at medical facilities, lack of understanding cervical cancer communication between the medical personnel and the rural women, and lack of indigenous knowledge blending with medical modern knowledge.

Communication and Cervical Cancer Screening Uptake

Raymond et al. (2014) have shown that knowledge is a factor that influences the uptake of cervical cancer screening services. In their study of finding how culture informs views on cervical cancer screening services among the Somali migrants, they noted that many women under the study did not go for cancer screening because of lack of information and knowledge on the disease.

Strategies such as education intervention, face to face communication, mass media communication, community outreach, have been developed to encourage women to go for cervical cancer screening (Nyambane et al., 2015). Most of these strategies have also been

adopted in the developing countries (IARC Handbook of cancer prevention, 2004) and their success depends mainly on the population area and the setting of the implementation.

Cervical cancer communication should involve all the goals in other forms of health communication like; awareness (current treatment and findings), cancer risks, persuasion, knowledge, behaviour change and massive population (Parhizkar et al., 2012). There is a need for the right media, target audience and message to be identified for effective cervical cancer communication (Pickle, Ahshular, & Scott, 2006). Study findings from a research suggested addressing messages of HPV during public discussions as one of the communication channel in order to lower the rate of alarm and worry in women (Barrera-Clavijo, Wiesner-Ceballosa, & Rincon-Martineza, 2015). The finding also debated that public discussions will assist the women in understanding the risk that comes with the virus (Barrera-Clavijo et al., 2015).

Mass media is one of the communication channels used in relying cervical cancer messages to the public because of its reliability (Parhizkar et al,. 2014; Steele, Mebane, Viswanath, & Solomon, 2008). According to (Oranje, Undie, Zulu, & Crichton, 2011), the media can be used to contribute towards addressing sexuality and reproductive health issues because of its agenda-setting role, comprehensive and correct information. For example, mass media campaigns on cervical cancer screening uptake carried out in Victoria (Mullins, Wakefield, & Broun, 2007) resulted in an increase of Pap test rate among women who were late for their cervical screening test. Similarly, consistent reporting of cervical cancer in the media resulted to an increase of cervical cancer screening among women in some parts of United Kingdom (Mac Arthur, Wright, Beer, & Paranjothy, 2011).

A research carried out in urban and rural areas of Tanzania on cervical cancer screening and HPV vaccine acceptability (Cunningham et al., 2015) likewise found out that cervical cancer awareness and uptake through mass media (radio, television & newspaper)

among women who participated was high. The above findings are however contrary to what Risi et al. (2004) found out. The research carried out to evaluate the effectiveness of media intervention in the increase of cervical cancer screening uptake in South Africa showed that the media (radio programmes) impact on women who went to carry out cervical cancer screening was low. Only 43 women of the 658 women under study (6.6%) reported to have had cervical cancer screening after 6 months of radio-drama with cervical cancer messages interventions (Risi et al., 2004).

On the other hand, mass media was seen as a source of communication which may be unreliable during health issues communication. This is because the media coverage on issues relating to cervical cancer was still low and some of its information was riddled with misconception, fear, stigma and culture (Calloway, Jorgensen, Seraiya, & Tsui, 2006). The media in sub-Saharan African was also identified to be shallow in depth when investigating health information and it lacked motivation, expertise and the right capacity to understand, interpret, and report research findings on Sexual and Reproductive health issues (Oronje et al., 2011).

Publications in the media also tended to miss out important information which might have had a positive effect among the vulnerable and minority population on health matters (Kriege et al., 2011). In their study in Appalachia and non-Appalachia Ohio newspaper publication on cervical cancer, they found out that some articles published in Appalachia newspaper rarely included vital information related to cervical cancer risk, and the necessary steps women can take to prevent being infected by the virus. Nyambane et al. (2015) therefore stated that the media need to engage with other sources of communication in order to increase the uptake of cervical cancer screening among women. The media is also advised to air consistently messages on the symptoms, risk factors and treatment options of cervical cancer for screening uptake (Nyambane et al., 2015).

The media channels which have been adopted in cervical cancer campaigns are the radio, newspaper, and television (Nyambane et al., 2015). Television has been a media with the highest impact on the uptake of cervical cancer screening in some of the developed countries because of its audio- visual characteristics, usage of motion, sound and sight, wider reach, and its impact of a lasting impact on the consumers mind (Anderson, Mullins, Siahpush, Spitted, & Wakefield, 2008). According to Anderson et al. (2008), cervical cancer campaigns on television in Victoria which ran between the years 2004 to 2005 increased the number of women who visited hospitals and clinics for cervical screening by 27%.

News reporting on cervical cancer in television also increased the number of cervical cancer screening uptake in wales UK (MacArthur et al., 2011). In addition, a research carried out in some part of Columbia, India, Mexico, Haiti and Puerto Rico (Vardeman, 2005) identified television programs such as soap operas as the main sources of cervical cancer information among women. Television as a form of media was found to be the main source of HPV and cervical cancer information among the rural folks of Penang Malaysia (Khoo et al., 2011)

Radio and television are the most preferred source of communication of cervical cancer in Kenya (Nyambane et al., 2015) - and also in influencing health policies. The radio in Kenya targets selective audiences by station format, is cheap, has a wider reach of audience and provides the listeners with an opportunity to participate during programs discussion (Nyambane et al., 2015) making it a preferred media for the vulnerable population. Kutto (2014) however dismissed the radio as the most convenient communication channel of health reproductive issues to the rural woman. In her research on the „use of participatory communication model to achieve reproductive health among rural women in Kenya“, Kutto (2014) advocated for interpersonal and participatory communication during reproductive programs among rural women in Kenya.

Communicating Cervical Cancer in Rural Women

The uptake of cervical cancer screening among women is influenced by factors like age, culture, attitude and occupation class (Sutton & Rutherford, 2005). Culture plays an important role during the process of communicating reproductive health issues to rural populations (Kutto & Mwulo, 2015). For instance Dunleavey (2009) found out that culture played an important role during cervical cancer communication because some women who had cervical cancer still felt that they had a role to play as wives in spite of the physically traumatizing experience.

The challenges of culture on communication which may be experienced by rural women include taboo and witchcraft (Dunleavey, 2009). Also, Kutto and Mwulo (2015) speculated that lack of disclosure about terminal illness may be another aspect of culture which will affect the process of communicating cervical cancer among rural women. In order to avoid negative treatment from the community and immediate family, a woman infected with cervical cancer will find it hard to disclose her condition (Moore & Spiegel, 2004) and, therefore, suffer silently without any healthcare services. Other aspects of culture which may impact negatively during the process of cervical cancer communication to rural population (Kutto & Mwulo, 2015) include; myths, beliefs and gender politics.

Stigma is also an issue which may act as a barrier during cervical cancer communication among the rural population (Kutto & Mwulo, 2015). Cervical cancer is a sexually transmitted disease and this may increase the rate of stigmatization among rural areas residence (Gregg, 2003). A woman who is infected with the disease will, therefore, be seen as being promiscuous. In order to avoid stigma, a woman in the rural area fails to seek treatment or health care services, and suffers silently (Dunleavey, 2009).

The finding of a research done by Kutto (2014) on communication issues regarding control of cervical cancer among rural women in Elgeyo-Marakwet County, Kenya stated

that the media had not been fully utilized in campaigning cervical cancer in rural Kenya. In her research, the participants claimed to have heard very little if any information on media despite the presence of local FM stations and television channels. The study also observed that during cervical cancer campaigns among the rural population, the women did not feel as part of the process because they were unable to understand the language being used. The study also found out that the participants who were rural women experienced confusion during the process of study because they had conflicting information on cervical cancer (Kutto, 2014).

Age and Cervical Cancer Screening Uptake

Cervical cancer affects women of all ages making age a special variable during the process of communicating cervical cancer screening uptake. Women who are younger are more at risk of contracting cervical cancer because they are sexually active, have different sexual partners and are poorly informed about cervical cancer disease (Smith et al., 2008).

According to Head and Cohen (2012), women of all ages need to have accurate information on cervical cancer. Young women with female adults need heath communication messages so that they can be supportive of their daughters‟ reproductive health issues in future (Head & Cohen, 2012). Various researches have been carried out to find out cervical cancer screening on adolescence (Brown, Little, & Leydon, 2009); the youths (Head & Cohen, 2012); and older women (Van-Til, Mac-Quarrie, & Herbert, 2003). Women who were between the ages of 30 to 50 years rarely went for cancer screening because they didn‟t visit health facilities for health issues like family planning services, child services and maternal services often (Arguto, 2005).

A report published in The Eve Appeal (2010) on the awareness levels of cervical cancer in England stated that women who were between 16 to 24 years had poor knowledge on the signs and symptoms of cervical cancer in comparison to women who were between 25

to 59 years. Similarly, a study carried out by Ansink et al. (2008) found out adolescence girls under the study listed shyness, embarrassment and negative cultural attitudes towards cervical cancer screening and vaccination programs to be the reason for their inability to perform such services. The girls noted that it was not socially acceptable to be examined for cervical cancer, especially by a male doctor.

Women who were between the 40 years to 49 years were stated to be familiarized with the signs and symptoms of cervical cancer, and the risk factor of the disease (The Eve Appeal, 2010). The findings also supported the result from (Fernandez-Esquer, Espinoza, Raminez, & McAlister, 2003) which stated that women who are below 40 years were more informed about cervical cancer because of their high rate of involvement in reproductive health care like family planning. Vandeman (2005) in his study on women meaning making of cervical cancer argued that women who are above 30 years are more knowledgeable on cervical cancer because they have experienced more communication on the disease compared to younger women.

The right channel of communicating cervical cancer to women of all ages needs to be identified in order to improve cervical cancer screening uptake. This is because many factors such as information and media preferences differ between women who are older and younger. In his research, Vandeman (2005) found out those women who are younger than 30 years wanted more information on cervical cancer that targets their age group to be communicated. For example, how they should behave to prevent cervical cancer when they wanted to have babies in the future. On the other hand, a study done by (Van- Till et al., 2003) revealed that women aged between 45 to 70 years noted traumatic, unpleasant, uncomfortable, embarrassment; and fear of the cervical cancer results during the screening processes. They felt that accurate information addressing those issues will increase their likelihood of having regular cancer screening tests (Van Til et al., 2003).

Head and Cohen (2012) recommended the need of highlighting HPV as an STI when communicating cervical cancer messages to young people. He noted that there was a need for younger women to realize that oral sex and skin to skin contact exposes a person to HPV. Although HPV is a sexually transmitted disease falling under reproductive health, it has not received a lot of attention like HIV and other STDs in the Kenya media. Cervical cancer being a type of cancer only receives attention on the media during Cancer months (Nyambane et al., 2015). Other health reproductive diseases like HIV have been receiving loads of attention in the Kenyan media through campaigns like „Nimechill' meaning (I am abstaining) and through television programs like „Shuga'. „Nimechill' campaign targeted teenagers (10 to 14 years) and encouraged the youths to abstain from early sex (Division of Reproductive Health, Ministry of Health, 2013).

The youths who took a step not to engage in early sex before marriage by stating „*nimechill*" were portrayed to be cooler than their counterparts who engage severally in early sex during the media campaigns. On the other hand, *Shuga* television series targeted 15 to 24 years old with HIV and STDs messages. Both of the programs aired in televisions nationwide had positive impacts on the young people because during *nimechill* campaign, the number of youths abstaining from sex increased to 92% from 88% while *Shuga* also reached a wider range countrywide mostly in urban areas on HIV messages (Division of Reproductive Health, Ministry of Health, 2013).

Empirical Literature Review

Demographic characteristic like education level plays an important role in the uptake of cervical cancer screening among women in Kenya. Gichongo (2012) in her research on utilization level of cancer screening in Central Kenya showed that 20% of educated women in Central Kenya went for cervical cancer screening because they knew its importance. However, the level of knowledge on cervical cancer in Kenya is very low as research depicts.

Nyambane et al. (2015) found out that 98.2% of women in her research carried out in Kenyatta hospital have no knowledge on cervical cancer and HPV.

Communication can impact on the uptake of cervical cancer screening. A research carried out by (Mullins, Wakefield, & Broun, 2007) depicts how television advertisement on cervical cancer encouraged 62% of the participants to go for cervical cancer screening. MacArther et al. (2011) also observed how communication through the media increased the number of women who attended cervical cancer screening increased by 19%. However, according to Nyambane et al. (2015), radio and television communication have a lower impact on the uptake of cervical cancer screening. In their studies carried out in Kenyatta Hospital in Kenya, Nyambane et al. (2015) observed that only 17% of women went for cervical cancer screening based on the information from the electronic media whereas 60% performed cervical cancer screening based from information from other sources.

Awareness also plays an important role during the process of cervical cancer screening uptake. A study carried out in Thika among 498 women on factors affecting uptake of cervical cancer, lack of awareness of cervical cancer and the benefits of early detection measure (Ngugi, Boga, Muigai, Wanzala, & Mbithi, 2012); found out that 17.3% of women who had gone for cervical cancer screening were aware of the disease and that HPV infection is a risk factor.

Conceptual Framework

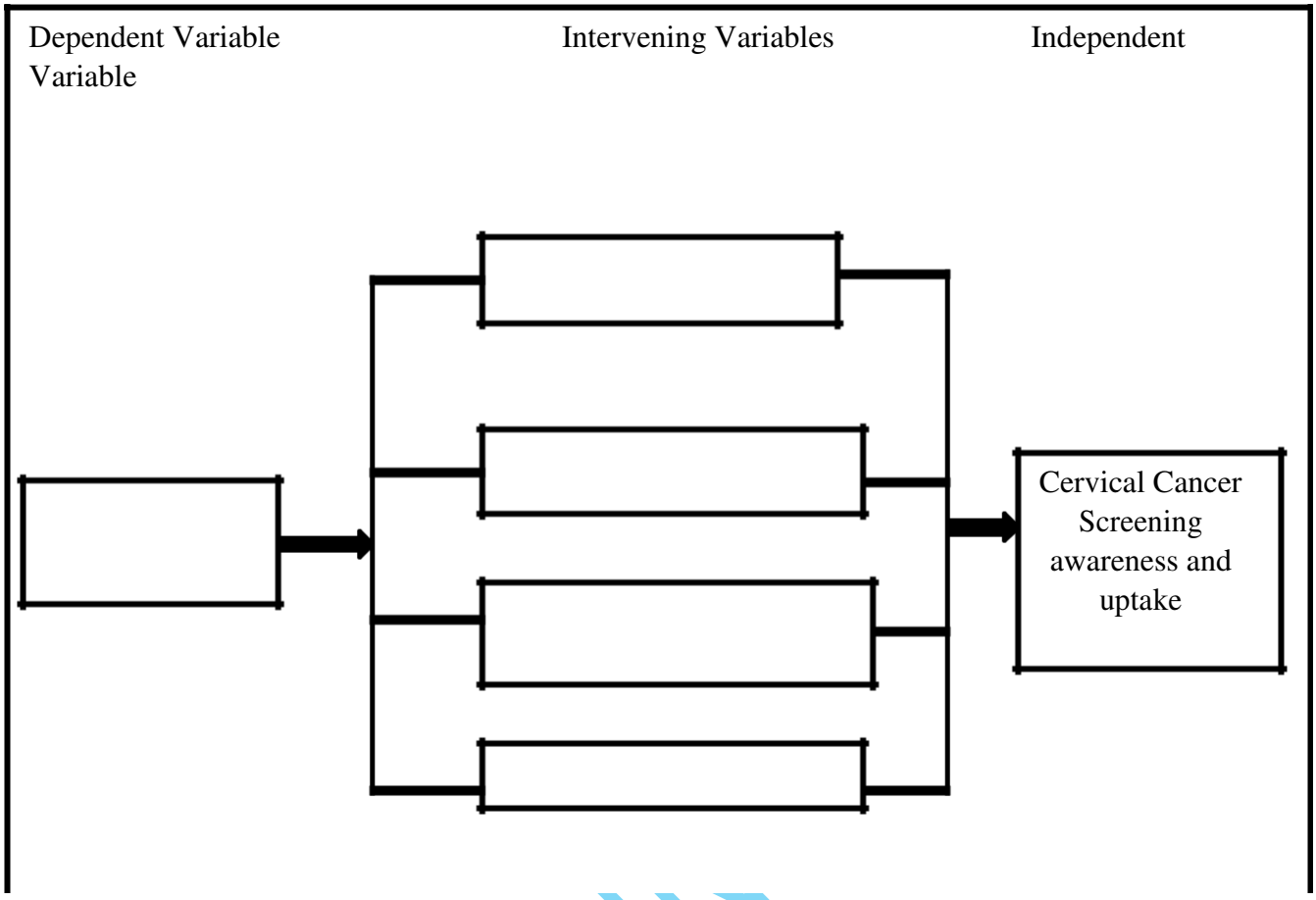

Figure 2.1: Conceptual Framework

Source: Author (2015)

Discussion

Cervical cancer communication for increase in screening awareness and uptake among women is influenced by the intervening variables: culture, age, and environment and communication channel. Culture can act as a perceived barrier of the uptake of cervical cancer screening from the HBM theory. For example, there might be a barrier during the process of communicating cervical cancer disease to a community which is full of misconceptions and myths of the disease, and still stigmatizes women who have cervical cancer disease (Kutto, 2014). This in turn affects the uptake of women who go for screening services. Adequate information on cervical cancer through different communication channels will increase the uptake of cervical cancer screening among women (Nyambane et al., 2015)

Age influences the level of awareness and the uptake of cervical cancer screening among women. This is because information and media preferences differ between women who are older and younger Vandeman (2005). More so, women who are younger are more susceptible of contracting cervical cancer because they are sexually active, have a lot of sexual partners and they are poorly informed about cervical cancer disease (Smith et al., 2008). If younger women know that they are at high risk of getting cervical cancer, they may decide to regularly perform cervical cancer screening.

Environment: Rural women are more susceptible of getting cervical cancer compared to urban women because of the low levels of awareness amongst them (Kutto, 2014). Also various factors like culture, poverty, stigma, inadequate medical facilities, and language barrier; acts as a perceived barrier for rural women to conduct cervical cancer screening. Women who are in the rural areas might also face barriers like distance to the hospital because of their environment, thus failing to be screened.

Communication channels: Communication can change an individual normative belief and behavioural belief towards cervical cancer screening uptake. Communication channels from the media or other key informants in the society may influence the woman to be informed on cervical cancer and therefore change her behaviour by going for cervical cancer screening as a preventive measure.

Summary

The above chapter has reviewed various literatures that are related to the research key concepts, findings and the existing gaps the study proposes to bridge. The chapter has also introduced and discussed the theoretical framework that will be adopted in the study. The next chapter is a discussion of the research methods that will be used in the study.

CHAPTER THREE

RESEARCH METHODOLOGY

Introduction

This chapter discusses the research methods that were used in the study. It describes the study design, the population to be studied, the sample selected, the sampling methods, the type of data, data collection methods, data collection procedures, data analysis plan and ethical considerations.

Research Designs

A research design is the arrangement of conditions for collection and analysis of data in a manner that aims to incorporate the relevance of the research purpose with economy in the procedure (Kothari, 2004). Qualitative research designs are concerned with qualitative phenomena example investigating human behavior (Kothari, 2004). The study research that was adopted therefore is qualitative and descriptive in nature with an aim of finding out the challenges of communicating cervical cancer awareness among women aged 18 to 50 years.

Population

An ideal study setting, according to Kothari (2004), is one which the researcher has an interest in, can easily access and allows him/her to have an immediate rapport with the respondents. The study was carried out in the rural areas of Bungoma County. The site was selected because a report as highlighted in the County Government of Bungoma integration plan (2014) depicted unsafe sexual practices among the residents resulted from a high rate of cultural beliefs and attitudes, and inadequate knowledge of preventive measures. Unsafe sex practices in the area were also listed as the highest risk factor of mortality rate in the County (County Government of Bungoma). HPV which causes cervical cancer is a sexually transmitted virus (Eggert, 2012) and there is a low rate of cervical cancer screening in the County (Department of International Development, 2015).

Target Population

According to Kothari (2004), a target population represents the information that is desired. The target population of this study included women in Bungoma County who were between 18 to 50 years because they are at risk of contracting cervical cancer according to (Eggert, 2012). The health nurse and other community key health informant were also targeted because they are the main source of health information to the community members (National Cervical Cancer Prevention Program, 2012).

The researcher settled to carry out the research in Mt Elgon Constituency of Bungoma County by using purposive sampling selection because there were various health reproductive programs being carried out in the place including cervical cancer screening programs (AMPATH Research Program Office, 2013; Fleischman, 2011; Kenya National Commission on Human Rights, 2012; & UNFPA Kenya Annual Report, 2013). Mount Elgon Constituency population was projected to be 207,029 by the year 2015 with a total of 87,834 women. The researcher carried out the research in 2 wards of Mt Elgon Constituency by using purposive sampling methods through identifying the wards that have stationed facilities for cervical cancer screening programs in the constituency.

Sampling Size

A sample size is an optimum size that fulfils the: efficiency, reliability, representation and flexibility requirements (Kothari, 2004). The sub location that the researcher selected was to determine the sample size the researcher was going to study. The two wards selected were Elgon and Kaptama. Elgon had a population of 16,076 women while Kaptama had a population of 16,693 women. The participant who participated in the FGD was 40.

Sampling Techniques

According to Richie and Lewis (2003), probability sampling is generally viewed as the most rigorous approach of sampling for statistical research, but largely inappropriate for

qualitative research. The sampling technique that was adopted in the study was non-probability sampling. In non-probability sampling design, the sampling method involves purposive or a deliberate selection of a particular unit of a population to constitute the whole of the population. (Kothari, 2004).

Kothari (2004) further states that when selecting a population element to represent the whole of the population based on the ease of access, one can use convenience sampling. The researcher used convenience sampling during the selection of women who participated in the focus group discussion. The inclusive criteria were the women who had visited Mt Elgon hospital- mother child clinic department. Participants from a women group in the community also participated in the FGD. The researcher also used purposive sampling during the selection of the health key informants in the community to be interviewed. The selected health key informants to be interviewed were to be engaged in passing information on cervical cancer as a health issue to the community members.

Types of Data

There are two types of data: primary data and secondary data (Kothari, 2004). Primary data is fresh data that is collected when conducting a research. Secondary data is the data that has been collected by someone who is not conducting the research. The type of data that was adopted for the study was both primary data and secondary data. Secondary data was adapted in the literature review part while primary data was adopted during the data collection process, analysis and interpretation.

Data Collection Methods

The data collection method that the researcher used was qualitative data collection method. The researcher used in-depth interview and focus group discussion during the process of collecting data. In depth interview was carried out to key health informants who included the public health nurse, community radio presenter and one community health

worker. Six focus group discussions were carried out with a total of 40 participants who were women from the community. The women were between 18 to 50 years.

Data Collection Procedures

Focus Group Discussion

Focus group discussions are a free form of discussion by a group of people led by a moderator designed to obtain information about some topics. It is a vital method for qualitative data collection because it is good for exploring a wide range of issues. A focus group discussion method has both participant observation and individual interviews (Gliner, Morgan, & Leech, 2011) and it is a good method used for exploring a wide range of issues.

The participants of focus group discussion were only women between the ages of 18 to 50 years and were residents of the selected study population because they were at risk of being infected by cervical cancer. The focus group discussion was also conducted according to the ages of the women under the research example between 18 to 35 and 36 to 50. The overall number of groups conducted was six.

Richie and Lewis (2003) stated that a focus group discussion needs to have around 6 to 8 participants so that all the participants will have a chance to participate in the discussion. Richie and Lewis further noted that the optimum size of the group depends on a number of things example the complexity and sensitivity of an issue. An issue that is complex and sensitive is better tackled in smaller groups. The researcher therefore carried out focus group discussion involving 6 to 7 participants in each group. The groups were facilitated by the researcher.

Qualitative Interviews

According to Bryman and Bell (2011), in-depth interviews in qualitative interviews enables the researcher to have rich detailed information, it is flexible and allows a direct response from the respondent. Qualitative in-depth interviews were used during the study.

Face to face interview was conducted to key health informants working in the county public hospitals and the community. The researcher conducted the interviews with the key health informants after booking an appointment, and obtaining an informed consent from them. The researcher briefed the interviewees about the research and that it was being carried out in partial fulfillment in requirement for the degree in Communication. The researcher also assured the participants that the information they give out will be handled confidentially by the researcher. The interviews and focus group questions were constructed in English then translated in Kiswahili to break language barrier during the interview session.

Pretesting

The researcher pretested the data collection instrument before the final data collection. Three participants who were relations of the researcher were purposively sampled and interviewed. The participants selected were between 18-50 years. The participants were selected due to time limitation. The researcher then debriefed participants by soliciting their assessment of the clarity and the appropriateness of the instrument section by section. The questions for the focus group discussion and the interview session was reconstructed for clarity, reliability and validity of the data collection instrument.

Data Analysis Plan

The researcher used QSR Nvivo for the data analysis. QSR Nvivo is mainly used in qualitative analysis. The researcher used audio to record what the participants were discussing for easy analysis of data because according to (Bryman & Bell, 2011), focus group discussions need to be recorded and transcribed. Bryman and Bell also pointed out that focus group recording are prone to inaudible elements that may affect transcriptions, therefore, the researcher was recording down notes during the discussion for analysis for accuracy. The ethical consideration of qualitative research in line with the focus group recordings arises from the difficulty of knowing who accesses the information (Bryman & Bell, 2011). The

researcher was the only one who had access to the recorded information during the period that was being transcribed. The themes were derived from the codes and nodes from the QSR-Nvivo program.

Ethical Considerations

The researcher ensured that there was informant consent from her participants during the research and upheld privacy and confidentiality in the whole process of conducting the research. Before the discussions, there was an oral consenting process whereby respondents were reminded of the purpose of the research; assured of confidentiality and privacy, and obtained permission to audio record them.

Permission to carry out the study was obtained from Daystar University, School of communication, National Commission for Science Technology and Innovation, ministry of Education, Science and Technology- Bungoma County and Mt. Elgon District Hospital. The data collected was not manipulated to suit any desired outcome.

The researcher practiced integrity during the process of collecting and analyzing data. Information acquired from participants was handled with confidentiality and only used for intended purpose; which was for partial fulfillment of Masters of Arts degree at Daystar University. Also, the information from the research will shade more light on the Kenyan's rural women knowledge and source of information and communication impact on the health-seeking behavior of cervical cancer among rural women. The findings will therefore be used for academic and other related work. There were no direct benefits from participating in this study.

Summary

The above chapter has described in details the design of the study and the methodology that was adopted. Some of the subdivision described under the chapter include;

research design, population, sample, data analysis plan and the ethical consideration during the process of the research.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

Introduction

The findings of the research from the focus group discussion and interviews are reported and discussed systematically in this chapter. The key findings obtained from the focus group discussion and interviews are summarized and presented by use of narrative and quotations, and tables and figures. The researcher saw it was necessary to interview key health informants because they assist in communicating health issues to the community.

The findings in this report are therefore divided in to two parts. The first part analyses and presents the information from the women in the focus group discussions while the second part analyses and presents the in-depth interview of the key health informants in the community.

Presentation, Analysis and Discussion

Social Demographic Data of FGD Participants

Women between ages 18-50 participated in the 6 focus group discussions. Three groups‟ participants were mothers from Mt. Elgon District Hospital who had visited the mother child health clinic. The clinic that is situated in the district hospital attends to mothers and news born babies from the two wards (Kaptama and Elgon). Because most of the participants in the mother child health clinic were between 18 to 35 years, the researcher with the help of a nurse from the hospital visited a women group in the community that had 30 members majority being above 36 years (*Mwanganza* women group).

The women selected from the women group were from Kaptama ward. The other FGD had participants who were general patients of the hospital and above 36 years, selected by the researcher with the help of the research assistant and the gateman. Four FGD therefore took place in one of the rooms in the hospital assigned to the researcher and two FGD took

place in the community, inside a house that belonged to one of the women of the group. The total number of women in the FGD was 40. The table 4.1 below describes the demographic characteristics of each participant who was involved in the focus group discussion.

Table 4.1: Focus Group Discussion of Participants

No of participants in FGD	Ward	Age Range	Marital Status	Education Level	Occupation
6 participants	Elgon	18-35	4 married 2 single	1 no education, 1 primary school, 1 college, 3 secondary school	1 teacher, 2 business, 3 Farmers
6 participants	Elgon	18-35	2 singles 4 married	3 secondary school, 3 primary school	5 Farmers 1 Clerical
7 participants	Elgon	36-50	4 married, 2 single & 1 widowed	1 no education, 5 primary school, 1 secondary school and 1 college	4 farmers and 2 business women and 1 nurse
7 Participants	Kaptama	36-50	6 married 1 divorced	1 no education, 2 Primary schools, 4 secondary schools.	5 farmer, 1 no occupation, 1 business woman
7 Participants	Kaptama	36-50	6 married 1 single	5 primary schools, 2 colleges	3 farmers, 3 business women, 1 teacher
7 Participants	Kaptama	18-35	7 married	4 primary school level, 2 secondary school, 1 university	6 farmers and 1 teacher

Awareness Level of Cervical Cancer

The FGD participants were asked if they had heard of cervical cancer screening in the demographic part of the FGD questions. Less than half of the participants 17/40 admitted to have heard about cervical cancer screening. When asked to name sexually transmitted diseases, only one participant from the 40 participants was able to identify cervical cancer. She had done a degree course from one of the public universities, where she had heard of the disease. Cervical cancer communication campaign in colleges was therefore identified by the researcher as an effective communication channel of raising awareness of the disease.

The researcher had a hard time of engaging all the participants during the focus group discussion because there was low level of knowledge and awareness of the disease and or

screening uptake among them. For example in the first group of 6 participants, only 3 people were aware of the disease and in FGD 6 only one participant admitted to have heard of cervical cancer screening services and knew about the disease among the 7 participants.

The low level of awareness of the disease was also depicted when some participants had misconceptions of how the disease is transmitted. They said that cervical cancer is transmitted through dirt, usage of protection (condom), combination of STDs, and through the usage of strong detergents like sprays and soaps.

Q IV: How is cervical cancer transmitted?

G1 R1: *When having sex na mtu mwenye ako na gonorrhea, wanasemanga pia ati saa zingine ukitumia kinga kama condom utapata* (When having sex with someone who has gornorhea, they also say that sometimes if you use protection like condom you can get it).

G2 R2: *Mtu anapata hizi virusi zikiwa combined. Yaani syphilis, gonorrhea na uchafu pia* (It is a disease that comes as a result of combination of viruses. That is syphilis, gonorrhea and also dirt)

G6 R1: *Inapatikana ukihave sexual intercourse with a lot of different men. Chenye inacourse tena ni kutumia hizi vitu kama sprays, sabuni mbaya mbaya na pia ukishare for example panties* (The disease is transmitted when you have sexual intercourse with different men. It is also caused from things like sprays, soaps that are bad and also sharing panties).

Other participants showed the low level of awareness when they mentioned that they had heard about cervical cancer but they did not understand how it is transmitted. There was also a participant who stated that cervical cancer is a disease that affects an individual stomach.

Q IV: What does cervical cancer mean to you?

G3 R1: *Ni ugonjwa inaeza kuwa kwa tumbo, sanasana kwa uzazi* (It is a disease that can be in the stomach but mostly in the uterus)

G4 R1: *Tulikuwa tunajua vile inaitwa, hatujui ni nini exactly* (we only knew what it is called; we don‟t know what it is exactly).

G4 R2: *Hatujapimwa, hata hatujui ni nini. Hatujui ni nini lakini tunajua venye inaitwa, na hiyo sasa inakujaje?* (We were never tested; even we don‟t know what it is. We do not know what it is but we know what it is called. How does that comes about -cervical cancer)?

G4 R3: *Mi nishawai pimwa alafu nikaambiwa tuu sina. Niliambiwa tuu ni cancer, wakasema tuu ni cancer, cervical cancer. Lakini hatujaelezwa kabisa ni kitu gani inacause.* (I have been screened and I was just told that I am not infected. I was only told it is cancer, they only say it is cancer, cervical cancer. But we have not been told clearly how it is caused).

G5 R1: *Nilisikia tuu ni ile ugonjwa inashika kina mama kwa nini ya uzazi* (I have only heard that it is a disease that affects mothers in that place of the uterus)

G5 R2: *Wengine wanasema ni kwa matiti* (others says it is on the breast)

However, a few participants had adequate knowledge of the disease because they were able to mention that cervical cancer is a sexually transmitted disease, it affects a woman reproductive organ and that some of the signs and symptoms include blood, puss discharge, and pains when walking or having sexual intercourse, wounds and itchiness.

QI: What does cervical cancer mean to you?

G1 R1: *Huwa inadhuru cervix* (it affects the cervix)

G1R2: *Ile ugonjwa inadhuru cervix alafu inafanya mtu anatoa uzaa* (it is a disease that affects the cervix and leads to secretion of puss)

G3 R3 (a nurse by proffession): *Cervical cancer inashika nyumba ya uzazi. Wakati unajamiana na mwanamme wako baada ya kumaliza unaona damu ama hiyo damu inaendelea kukuja ama usikie uchungu. Inapimwa na kitu inaiywa pap-smear, kuna uchafu inatolewa ndani alafu wanaangalia kama uko na hiyo cancer*. (Cervical cancer affects „the

house‟ of the uterus. During sexual intercourse with you man and when you are finished, you see blood or blood will continue to flow and there is pain. Pap-smear is dome when one goes for cervical cancer screening…)

QV: What are the signs and symptoms of cervical cancer?

G2 R1: *Mtu akiover bleed, uchungu katikati ya sex* (when a person bleeds too much and feels pain during sex)

G1 R1: *Saa zingine damu inatoka* (sometimes it causes bleeding)

G1 R2: *Ingine ni kua saa zingine ka unakojoa unasikia uchungu, kutembea ni shida* (another one is sometimes you feel pain when urinating, even walking is a problem).

G6 R1: *Nilikuwa naskia ati saa zingine ukitouch around that area unaskia kitu kako lump na nipainfull* (I heard that if you touch around the area you feel something like a lump which is painful).

A number of the participants had never performed cervical cancer screening. From the 40 participants, only 6 had been screened. Others stated that cervical cancer is a deadly disease; it can be prevented through screening and early treatment, and by being faithful to one sexual partner.

Q VIII: Can cervical cancer be prevented?

G1 R1*: unaeza zuia kwa kupata matibabu na kuwa faithful kwa mtu mmoja* (you can prevent it by getting treatment and being faithful to one partner)

Q XII: What are the advantages of cervical cancer screening exercise?

G2 R1: *Ukishaenda kwa matibabu ili upimwe si utapona kuliko kubaki kwa giza na hujui, si utakufa? Kwa hivyo ni vizuri kwenda kwa matibabu* (If you go to the hospital to get tested, will you not be healed instead of staying in darkness without knowing, will you not die? It is therefore important to go for treatment.

Cervical Cancer Communication Channels

Only 6 participants out of the 40 had performed cervical cancer screening. The six screened participants were between 36 to 50 years. Two of them were single mothers and 4 were married. One participant was screened because she had health challenges (not married), the nurse was screened because she had heard about the risk factors and she knew she was at risk because of her age and she has children (not married), the other 4 had received communication about the disease in the hospital- when there was free screening services and they were screened.

The table below displays the demographic characteristics of the women who were screened.

Table 4.2: Demographic Characteristics of Women who have been Screened

Participant	Age	Level of education	Occupation	Ward	Marital status	Reasoned for being screened
Participant 1	36 to 50	Secondary school	Farmer	Elgon	Divorced	Health reasons
Participant 2	36 to 50	College	Nurse	Elgon	Divorced	Educated about it
Participant 3	36 to 50	Secondary school	Farmer	Kaptama	Married	Free CCS in district hospital
Participant 4	36 to 50	Secondary school	Farmer	Kaptama	Married	Free CCS in district hospital
Participant 5	36 to 50	Secondary school	Business woman	Kaptama	Divorced	Free CCS in district hospital
Participant 6	36 to 50	College	Primary School Teacher	Kaptama	Married	Free CCS- district hospital

The participants were screened due to medical complications and communication from the hospital.

Question X: Have you ever been involved in cervical cancer screening? How often? What triggered you to perform it?

G3 R1: I attended the screening services because I had wounds in my private area, itchiness and pain and I was told by the doctors that there is a large swelling in my womb that is even making me not to have children. I have never had a child in my life…..that"s why I was screened.

G4 R1: *Walitangaza Kapsokwony wakasema wamama wakuje kupima. Madaktari. Alafu wakapea nurse mmoja ndo alikuwa anafanya hiyo kazi, na tukapimwa*…(They advertised in Kapsokwon and they said women should get screened by the doctors. They gave one nurse the responsibility of doing that job, and we were screened).

G5 R1: *Nilipimwa last year kwa hii hospitali vile kupima ilikuwa free. Nilipimwa pia breast cancer*. (I was screened in the district hospital last year when they were offering free services. I was also screened for breast cancer).

G5 R2: *ata mimi nilipimwa last year wakiannounce twende tupimwe*. (I was also screened during that time that they were making announcements in the community about free cervical cancer screening services).

Some participants who had been screened and those who had heard of cervical cancer screening admitted that the district hospital advertised about screening services of the disease last year during the month of October during the cancer week. There was a vehicle going around the community announcing about the screening services offered by the district hospital. The district public health nurse stated that there was an increase in the number of women performing cervical cancer screening during the cancer month as compared to other times.

Some of the other participants who had never been screened but had knowledge of cervical cancer also mentioned the media as the other source of cervical cancer

communication channel. The most stated television station and radio were citizen television and radio, *radio jambo*, *bikapkoret fm, mulembe fm* and west fm. When asked if they had ever come across an article on a newspaper on cervical cancer, they said they had never.

Question 2(i): Is there any communication channel (media, Community Health Workers, Health informants like doctors and nurses, health organizations e.t.c) which addresses cancer related issues or sexually transmitted disease in the region

G1 R1: Kuna wakati kulikuwa na matangazo lakini sikujua ni nini. Ilikuwa kwa radio, radio jambo.

G1 R2: *niliwatch kwa citizen tv alafu nikaskia kwa mulembe fm* (I watched it from citizen tv and also heard about it from *mulembe fm*)

G2 R1: *Niliskia kwa redio, tv na pia kwa mahospitali huwa wanatangaza. Pia waliweka notice*(I heard it from the radio, TV and also hospital. They placed notices)

G2 R3: Citizen tv and citizen radio (Citizen television and radio)s

G3 R1: Bikapkoret, Radio Jambo

G3 R2: *Niliskia hata kwa maredio wanatangaza cancer ya watu wa 45 years imekuja, ata hapa kwa community wametangaza.* (I heard on the radio, they were announcing that cancer of people who are above 45 years have come, even here in the community they have announced.

G3 R3: wanatuambianga magonjwa kama haya hospitalini. Hata juzi walituambia sisis watu wa 45 years. Madaktari walikuja hapa walituambia watu wa 45 years, hiyo cancer ni mbaya sana (We are always told of such diseases in the hospital. Even the day before yesterday we- who were 45 years old were told. Doctors came here and women above 45 years were told that cancer is very bad). The participants mentioned that doctors were students from Moi University School of health and from referral hospital. They had camps in

the market place motivating women to be screened so one of the women in the group had come for screening because of that campaign.

G6 R1: *College, kwa TV, internet, citizen TV, walikuwa wanaongelea causes, risk factors na vile wanataste cervical cancer* (College, citizen television, internet. They were discussing the risk factors, causes and how they taste for cervical cancer).

The table below summarizes the media channels that were mentioned by the participants.

Table 4.3: Summery of Media Channels of Cervical Cancer Screenings

Mostly listened to media channels	Media channels that communicate sexual reproductive issues	Media channels that have communicated on cervical cancer screening services
Citizen TV Nation media TV Citizen radio station Bikapkoret FM West FM Radio Jambo Radio Mambo Mulembe FM	Citizen TV Citizen radio station Bikapkoret FM West FM Radio Jambo Radio Mambo	Citizen TV and radio West FM Mulembe FM Radio Jambo Bikapkoret FM Internet

The Communication Challenges of Cervical Cancer Screening and Uptake

The participants who had heard of cervical cancer but had never been screened were 11 in numbers. They were asked why they were never screened and they mentioned various factors like inadequate information from the media or the hospital, fear of being stigmatized, fear of cervical cancer procedure during screening, financial constraints, lack of interest and lack of enough medical personnel.

Inadequate Information from the Communication Channels

The majority of the participants who had heard about cervical cancer but had never attended screening services stated that it was because of the inadequate information during the communication process. They either said it was because they never really understood what cervical cancer is and or the places that the cervical cancer screening was taking place.

Question 2 (viii): Has there been any discussion on the media encouraging women to go for cervical cancer screening? If yes, did the message convince them to go for cervical cancer screening?

G1 R1: *Hawakukuwa wanaexplain in details cervical cancer ni nini…* (they were not explaining in details what cervical cancer is).

G4 R1: *Tunaskianga tuu kwa redio lakini hatuambiwi pahali pa kuenda. Lakini hospitali ukiskia wanatangaza wanapita hata kwa njia wakisema wamama mkuje kwa screening ya cancer. Mtu ataamua aende au asiende*. (We only hear from the radio but we are not told where to go. But when you hear it advertised from the hospital, they pass on the road saying women you should come for screening. A person will decide to go or not to go).

Question 2(x). If you could request some kind of communication services for cervical cancer, what will you want?

G4 R3: They should take time with people, and they should not be in a hurry in the road. But they must come the way you have come right now, they inform us so that it will be better, compared to announcing on the roads or in the radio.

Lack of Interest

There are some participants who stated that they did not go for cervical cancer screening because they had no interest or they were busy when the screening was taking place.

G6 R1: *Nilikuwa na interest ya kuenda kujipima after niskie kutoka kwa citizen. Sikuwahi pata nafasi* (I had the interest to go and be screened after I heard from Citizen tv but I never got the time).

G2 R1: *Nilikuwa committed* (I was committed)

G2 R2: *Sikuwa na haja kwa sababu sijawai kuona anayeugua* (I wasn‟t interested because I have never seen anyone suffering from it)

Fear

The participants also highlighted fear of having the disease as a reason of not performing cervical cancer screening, even after hearing about it. Fear of being judged by the community members and of getting the disease.

Question 2 (viii). Has there been any discussion on the media encouraging women to go for cervical cancer screening? If yes, did the message convince them to go for cervical cancer screening? If yes, why? If no, why?

G3 R6 (Nurse): *Watu wengi wanaogopa maybe wakienda kufanyiwa screening ya cancer maybe watadhani ni ya HIV. Atakufa. Atashtuka alafu akufe. Hiyo huwa inafanya mtu akuwe na fear* (So many people fear maybe if they are screened for cervical cancer they will think it is for HIV. She may die. She will be shocked and then die

G5 R1: *Tuliogopa kwa sababu walikuwa wanatutisha kuwa ukieza patikana nayo utakuwa na stress. Kwa hivo niliogopa naeza kuwa nayo*. (We feared because they used to make us to be afraid that if you are found with it you will be stressed. I thus feared that I may have it.

G4 R2: *Lakini pia kila wakati wakikuja, wanatishanga watu. Hata sisi tuliwai fanyiwa ya matiti. Unaenda hapo unapata wamekaa, unafanyiwa ya matiti. Hata mimi niliskia kitu hapa (*pointing at one of her breast*) nikaanza kuita, daktari kuna kitu, ona iko hapa. Alafu wakaita daktari wengine. Wakaangalia wakapata hakuna kitu..mama hakuna. Unajua kuna wasisiwasi tuu, ata ukiskia kitu iko na hakuna. Ndo maana sijaenda*. (But also every time they come, they make people fear. We once had breast screening. You go there and find that they have sat, they do breast screening. I even felt something here (on her breast) and started to call, doctor there is something, look, it is here. They then called other doctors and didn‟t find anything. You know there is anxiety, even when you feel there is something yet there is nothing. That‟s why I have not been screened).

A participant in group 5 also stated that she feared performing cervical cancer screening because of the procedures that are involved in the process.

G5 R3: *Sikuenda kwa sababu kuna mwenye alienda akanieleza kuwa kuna vitu unaingizwa, vitu kama chuma kwa hivyo sikuenda*. (I never went because there was a person who was screened and she told me that there are things that are inserted, things like metal. That‟s why I never went).

Another participant in group 4 when discussing on better communication services of cervical cancer stated that, "*Wamama wengi wanaogopa. Wengine wanaambiana ukienda huko, ukienda huko daktari mwanamme anaingisha mkono wake sehemu za siri. Saa wamama wakiskia hivo ati 'hee!' wanaogopa*" (so many women are afraid. Some tell each other, when you go there, mal doctors insert their fingers in your private area. So when women hear that they are like, „hee!‟ and the fear. She was seconded by a participant who said that "*hata wakati tulipimwa, tulikuwa tunaambiwa tulale alafu wanaingisha mashine, saa utalala tuu vizuri upimwe. Sasa mwenye ako nnje ataambiwa, wacha nikuulize, alafu aogope. Saa inatakana kama umeingia ndani na hiyo ni style ya kupimwa, usiambie mwenye ako nnje, we enda tuu*. (When we were being tested, we were told to lie down and they inserted a machine, so you will sleep comfortably and get tested…..so if you are inside and that is the method of being tested, don‟t tell the one who is outside. Just go your way).

Medical Costs

During the focus group discussion, some of the participants pointed out that the reason she did not perform cervical cancer screening services was because of the cost of screening.

G3 R1: *Unaona unaeza kuwa unaumia na hauna kitu sasa kichwa inakukula na hauna kitu hasa ukikuja ni pesa. Walituambia ni free lakini sasa tumekuja wakatuitisha pesa na tumelipa*(You see, you might be in pains and you don‟t have something so your head is

eating you up and when you come it is money. They ask for money. They say it is free and when you come it is not free)

G3 R2 (Nurse): *Kufanya screening ni free lakini matibabu hiyo ni pesa.* (Screening is free but treatment requires money)

G3 R3: *Vile niliskia kwa media nilidhani nikikuja wataniitisha pesa ikanizuia. Lakini ningekuwa nishapimwa kitambo.* (When I heard in the media I thought that if I come they will ask me for money so I never came. I would have been screened a long time ago).

Lack of Enough Medical Personnel

There was a participant who mentioned that she did not go for screening because there were no enough doctors in the district hospital.

R1: *Unajua sasa hapa Kapsokwony inatakikana daktari. Lakini sasa, unaeza enda upate hakuna daktari* (Here in Kapsokwony doctors are needed. So you may go to the hospital and find that there are no doctors.

In Depth- Interviews

The researcher had planned to conduct in depth interview with health key informants from the hospital mainly the district public health nurse and the community health workers. During the focus group discussion, the researcher noted that there were some participants who mentioned a community radio FM that was less than one kilometer from the hospital as one their information source of cervical cancer. There was need for the health key informant interviews in order to identify challenges faced by the people who communicate to the participants on cervical cancer related issues. Below is the demographic data of the in-depth interview.

Table 4.4: Demographic Data of Participants Interviewed

	Age	Gender	Constituency	Profession	Education Level
Participant 1	42	Female	Mt. Elgon	District Public Health Nurse (DPHN)	Undertaking Master"s Degree
Participant 2	40	Female	Mt. Elgon	Community Health Worker (CHW)	High School Level
Participant 3	22	Male	Mt. Elgon	Journalist	Undergraduate Degree

Communication Challenges of Cervical Cancer Screening and Uptake

One of the communication challenge identified by the researcher from the interview session was from the CHW who had inadequate information of the disease. When asked about the transmission, signs and symptoms of cervical cancer, she said that she did not know any. She mentioned that she has been screened because of health related issues. She also admitted of never engaging the community on cervical cancer related issues.

On the other hand, the radio presenter confirmed that the radio station aired cervical cancer discussions, although not regularly. The last period it was aired was in April 2016. According to the presenter, the radio station targets old people in the community who are living deep in the interior areas but not women, youths and children- that is the reason they rarely hold such discussions. The participant mentioned that the program was aired by chance that day in April because the main topic was on the effects of chemicals on health, and they were encouraging community members to adapt to their ancestral lifestyle. The participant also stated that the program was held at night because it was a discussion targeting old women but not small children.(*..unajua huku Sabaot kuna maswala tunaosema ni ya watu wazima na maswala ya watoto saa watoto hawastahili kuskia maswala ya watu wazima*).

He went on to say that the person who was brought to discuss about the disease was a traditional medicine man who had inadequate knowledge on cervical cancer because of his

educational level. (*Lakini hatukuenda deep into cjui kuna vitu ambayo inacause those ahh sijui kama ni bacteria or virus. Hatukuenda ndani zaidi because tulikuwa tunajadili na mtu ambaye pia ni, siwezi sema daktari sana but anahudumia watu kwa matibabu ya kienyeji…hawajasoma sasa they cannot tell you yakwamba ni vitu kama AIDs au sijui nini inacause*…). He said that cervical cancer had not received much attention in the general media like other sexually transmitted diseases because it is not affecting many people especially in Mt. Elgon Region. (*Cervical cancer ni disease yenye haija pick sana despite the fact that it is a sexually transmitted disease. Lakini sio kama gornorhea na hiyo ingine, na ukimwi pia. But cervical cancer, especially in this region, in Mt.Elgon, or Western in abroad haijakuwa tatizo kubwa sana*). Lastly, he mentioned that west FM would invite real expertise to discuss about the disease.

The last participant who was interviewed was the district public health nurse. The nurse affirmed that the district hospital had screening facilities for cervical cancer. She stated that cervical cancer screening services was carried once in a year especially during cancer month because it was free. Apart from October, the nurse said that the health facility offers cervical cancer screening services rottenly to women who want to adapt to family planning. However, according to the nurse, women in the community can‟t access those services because they fear their husbands and the community at large. "*They fear their husbands and traditional medicine men who discourage them to adopt family planning method, because of a death of a woman who was believed to have been affected by family planning methods- which took place in the community some time back. It is therefore hard for them to be educated about cervical cancer or even to be screened for the disease".*

The nurse also mentioned lack of cervical cancer term that women in the community can understand. She stated that "*the community is only aware that cervical cancer is a disease that affects the reproduction part of a woman (Ugonjwa unaoadhiri wanawake katika*

sehemu ya uzazi). During October, Reproductive Health Camps (RH) are set up inside the hospital compound and women are motivated to visit the camps through road show advertisement in the community therefore more women get screened. "*The number of women who are screened for cervical cancer rises, so RH camps makes a big difference*".

Summary

The above chapter has discussed and reported systematically the findings of the research from the focus group discussion and in depth interviews done by the researcher. The next chapter is aimed at discussing this findings and implications in light of the theoretical framework as provided in chapter two by the researcher.

CHAPTER FIVE

DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

Introduction

This chapter will discuss the overall findings and implications in light of the theoretical framework as provided in chapter two. The chapter will also discuss the conclusion and make the recommendations from the findings, and propose the possibilities of other studies. The study sought to find out the communication challenges of cervical cancer screening awareness and uptake among women in rural areas- Bungoma County. This was achieved through qualitative research on selected members of Mt. Elgon Constituency in Bungoma County. This chapter will answer the three research questions which were:

i. To find out the communication channels of cervical cancer that rural women (18-50) in Bungoma County are exposed to

ii. To identify the communication challenges that women in rural areas (18 - 50 years) face regarding cervical cancer screening health campaigns

iii. To find out the levels of awareness of cervical cancer among rural women (18-50) in Bungoma County

Discussion of Key Findings

Level of Awareness

The findings showed that there was low level of awareness and uptake of cervical cancer screening among the participants. 17 of 40 participants in the focus group discussion had heard of cervical cancer, with only 6 out of the 40 participants were screened for the disease. This finding supports the data depicted by WHO information centre on HPV in Kenya that shows that there is low level of uptake of cervical cancer screening among the rural population (WHO, 2015).

Majority of the participants had low level of education. Two participants never attended school while 20 participants reached the primary level in school. During the focus group discussion, one participant said that women in the rural areas have difficulties of accessing written information on cervical cancer on newspapers. "*People like us from the rural area are not educated so we cannot read the posters or newspapers, when we wake up; it is all about our farms*". According to Sankaranarayanan et al. (2002), low level of education is one of the factors that contribute to the high mortality rate and illness of cervical cancer among the rural population.

In the HBM theory, knowledge about cervical cancer screening is a strong determinant of screening behaviour (Eggleston et al., 2007). Through knowledge of the disease, one will know the perceived susceptibility, perceived severity, perceived benefits, perceived barriers and cues to action. Majority of participants had inadequate knowledge of cervical cancer that is why they never went to be screened. They did not understand their vulnerability of being exposed to the disease, the severity of the disease, the benefits of being screened and the importance of overcoming the barriers of being screened like the cost.

The 40 participants in the focus group discussion were women who were between 18 to 50 years. The researcher carried out the focus group discussion according to ages of the participants for example, between 18 to 35 then 36 to 50 years. The research depicted that older women (36 to 50) had more knowledge of cervical cancer compared to younger women (18-35). 11 out of 17 participants who were aware of cervical cancer disease were between 36 to 50 years. More so, the only 6 participants who had once been screened for cervical cancer were above 36 years. Vandeman (2005) research on „women's meaning making of cervical cancer campaigns", states that women who are above 30 years have more knowledge on cervical cancer because they have experienced more communication on the disease compared to younger women.

However, other researches contradict this findings example according to Arguto (2005), women who were between the ages of 30 to 50 years rarely went for cervical cancer screening because they didn‟t visit health facilities for health issues like family planning services, child services and maternal services rottenly. The findings of Arguto (2005) supports the findings from the research because the district public health nurse stated that majority of the women in the constituency are not screened because they don‟t visit the health facility for family planning issues. The women had been screened because of health related issues and also after hearing cervical cancer being communicated from the hospital. In TRA, behavioural intention is an individual ability and capability of performing behaviour. It is as a result of the attitude or a behavioural norm.

Communication Channels and Challenges of Cervical Cancer

In TRA, communication process is critical because it impacts behavioural intentions and subjective norms to be actual behaviour (Schiavo, 2007). TRA also states that a person attitude and subjective norms determines his/her behaviour. The attitude of some of the participants towards cervical cancer procedures deterred them from uptake of cervical cancer screening. This finding supports Atuhaire (2013) and (Kitchener, Castle, & Cox, 2006) who observed that woman complained that CCS procedure was uncomfortable and it hindered some of them from adapting to CCS. There is therefore the need for women to be educated for them to be less embarrassed during the procedure.

There was a participant who admitted that she was not interested to be screened because she had never seen a person suffering from the disease. In TRA according to Fishbein and Ajzen (1975), subjective norms are influenced by the society, or close relations. The participants mentioned the media as one of the main channels of communicating CCS, apart from the health information from the district hospital. This finding supports the data

from the (National Cervical Cancer Prevention Program, 2012) that pointed out the media as one of the communication channel of CC.

However, around 4 participants stated that information from the media about cervical cancer was insufficient. They said that they were not told where the screening activity is taking place in the media. Also, one of the participant from the community FM radio station affirmed that discussion surrounding cervical cancer on the FM station was inadequate because they did not mention the cause, signs and symptoms. This finding supports Calloway et al. (2006) research that found out the media coverage on issues relating to cervical cancer is still low. It also supports the findings of Davidson and Wallack (2014) that argued that the media coverage on sexually transmitted diseases is inadequate because it omits relevant information.

Most women who were between 18-35 stated that they preferred communication on cervical cancer to be aired on the media mostly the radio and television, while the women who were 36-50 mentioned that they prefer Barazas in the community, chiefs/role models, women groups and churches, with support from the hospital and the media channels. This finding disagrees with Vanderman (2005) who found out media preferences differs between younger and older women.

When the participants were asked why they heard of cervical cancer but did not get screened, some of them said that it was because the media station did not say where the screening is taking place, or because it did not explain what cervical cancer exactly is. More than half of the participants had no knowledge of cervical cancer and they were never screened. According to Raymond et al. (2014), inadequate information and lack of knowledge contributed to the low uptake of cervical cancer screening among the Somali migrants in their study.

The participant interviewed from the community FM station also stated that the health program that had cervical cancer discussion was aired during a discussion on chemicals effect. "*And since we had seen how chemicals affected many people, we wanted to ask how they managed previously*". Calloway et al. (2006) did not only find out that there was low media coverage on issues related to cervical cancer but also that some of its information was riddled with misconception. Misconceptions about cervical cancer may have a negative impact on cervical cancer screening and uptake, especially if it is coming from the media or key health informants. There is therefore the need for accurate information of cervical cancer.

The community FM radio had invited a host who had inadequate knowledge on cervical cancer and other health issues that was being aired on the FM station. This finding supports Oranje et al. (2011) who also found out that the media in sub-Saharan African has shallow in depth information when investigating health issues and it lacks expertise and the right capacity to understand, interpret, and report research findings on Sexual and Reproductive health issues.

However, during the interview session, the participant said that other community radio FM like west FM would invite real expertise to talk about health issues, a finding that contradicts Oranje et al. (2011) research. Misconception about the disease from some of the participants, who were unable to relate HPV with cervical cancer because of insufficient communication, resulted to low level of cervical cancer screening.

One of the participant on the focus group discussion stated that she prefers information on cervical cancer to be communicated face to face because not everyone owns the radio or television, or even have the time to listen to them. She was supported by a participant who mentioned that instead of using the radio station or road shows, it is good to use people who will take time to help women understand about cervical cancer. "*They should take time with people; they should not be in a hurry in the road. But they must come the way*

you have come right now, they inform us so that it will be better, compared to announcing on the roads or in the radio". This finding supports what Nyambane (2015) suggested that the media should engage with other sources of communication in order to increase the uptake of cervical cancer screening among women.

The participants mentioned lack of cervical cancer terminology as a factor that contributed to low level of cervical cancer screening and uptake, and also as a communication challenge. This finding supports Kutto and Mulwo (2015) from their research on communication issues of cervical cancer in Elgeyo Marakwet, Kenya. Kutto and Mulwo (2015) found out that one of the emerging themes of communication challenges among women in Elgeyo marakwet was lack of cervical cancer term that could be understood by the researcher participants.

The participants also mentioned fear of getting the disease as one of the reason of not being screened. According to Gatune and Nyamogo (2005), women fear of getting positive result prevented them from carrying out cervical cancer screening. The fear of being stigmatized by others that they are HIV positive also acted as a preventive reason for the participants not to be screened. Kutto and Mulwo (2015) also found out that fear of being stigmatized prevented women in Elgeyo Marakwet from being screened.

The community health worker lacked enough knowledge of cervical cancer disease. This finding is in line with Friedman et al. (2014) research in western Kenya that showed there was low level of awareness of cervical cancer among health care givers. Rosser et al. (2015) also identified shortage in staffing and insufficient staff training to be the main contributors of the low rate of cervical cancer screening in Western Kenya. This finding supports the research because one participant mentioned that there were fewer doctors in the hospital that is why she did not go for cervical cancer screening. However, the community

health worker testified that she had never been trained about cervical cancer despite the fact that there used to be sporadic training session of the disease happening in the district hospital.

Conclusion

In conclusion, fewer women are aware of cervical cancer screening among the rural population, and also fewer women from the rural areas have been screened. The major communication channels of cervical cancer by the rural areas that were identified from the research are: the hospital and the media (both television and radio), especially the community channel radios.

The communication challenges of cervical cancer screening and uptake facing the rural populations are stigma, lack of cervical cancer terminology, fear of the disease, fear of the screening procedure, lack of adequate information from the media and other communication channels, stigma, lack of enough medical professionals, financial constraints and misconception about the disease.

Recommendation

The study proposes the following recommendations based on the findings of the research;

- Communication of cervical cancer should involve all channels for it to be effective
- Key informants in health issues for example the community health workers, media professionals, elders, traditional medicine men should be educated about cervical cancer and other health issues so that they can communicate adequately to the community.
- Women need to be educated and be informed about the process of screening and the procedure so that they will be less uncomfortable or ashamed during that process.
- A term for cervical cancer should be identified that can be used among some of the rural population who do not understand English or Kiswahili. Communication campaigns of cervical cancer should adopt those terms during the campaigning process

- Before a woman is screened, she should be told what she is being screened for, how the disease is transmitted, how it can be prevented and the signs and symptoms of the disease.

Areas of further Studies

The study was carried out in the rural population and there is need for a similar research to be carried out in the urban population. Research that will aid in understanding the overall communication challenges of reproductive diseases and related issues for example family planning among the rural population is also necessary.

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APPENDICES

APPENDIX A

CONSENT FORM

A research on the challenges of communicating cervical cancer screening awareness and uptake in Bungoma County

The investigator Faith NafulaKisiangani has explained to me the purpose of the study and that it"s meant in partial fulfilment of requirements for her Master of Arts degree in Communication at Daystar University. I am voluntarily consenting to participate in this study by answering questions as directed by the focus group discussion. I do not expect any monetary benefits from the investigator. However, the investigator will be using the information she collects to make recommendations for research purposes in cervical cancer screening and communication related studies. My responses will be confidential and will not be revealed to any other third party. My identity will not be used at any point during data collection and presentation of this work.

I …….on my own freewill accept to participate in the above study.

Signature…….Date……..

APPENDIX B

DEMOGRAPHIC INFORMATION-FGDs

Instructions: Kindly fill the following form before we begin the Focus Group Discussion. Tick appropriately.

Confidentiality: The responses you provide will be strictly confidential. No reference will be made to any individual(s) or organization in the report of the study.

1) What is your age?

18-25 ☐

26-35 ☐

35-40 ☐

40-50 ☐

2) What is your present marital status?

☐

☐

☐

3) What is your religious affiliation

☐

☐

Muslim ☐

Non-Affiliated ☐

Other:_____ (Please specify)

4) What is the highest level of education that you have

None ☐

Primary School ☐

Secondary School ☐

College/Technical School ☐

University Degree ☐

Other:_____

(Please specify)

5) How long have you been a resident in the community

< 1 year ☐

1-2 years ☐

3-4 years ☐

4-5 years ☐

5 years ☐

6) What is your primary source of income?

Agriculture ☐

Clerical ☐

Skilled manual labor ☐

Unskilled manual labor ☐

Business ☐

Teacher ☐

Other ☐

7) Have you ever heard of cervical cancer screening

Yes ☐

No ☐

APPENDIX C

SURVEY QUESTIONS FOR FOCUS GROUP

N/B. Record all the conversations to ensure that there is little or no loss of originality in the data collected.

Introduction

Good morning/afternoon. My name is ……., a communication student from Daystar University and currently conducting a study on the influence of communication on cervical cancer screening uptake. What are your names?

Please allow me to kindly ask you a few questions about cervical cancer and cervical cancer screening to make this study successful. This discussion will take approximately 1-1.5 hours. This discussion is completely voluntary. You can skip any uncomfortable questions and you can end your participation in the discussion at any time. The information you provide will be kept strictly anonymous and confidential; and will be used to make recommendations to relevant stakeholders in order to improve any communication challenges of cervical cancer screening uptake among Kenyan women.

Understanding Cervical Cancer and Cervical Cancer Screening

i. Which County/ Constituency/ ward/ area is this?
ii. Are there any diseases that affect women sexual organs and reproductive systems?
iii. If yes, what are they (probe)
iv. What does cervical cancer mean to you?
v. What are the signs and symptoms of cervical cancer?
vi. How is cervical cancer transmitted?
vii. What are the risk factors of cervical cancer?
viii. Can cervical cancer be prevented?

ix. How does one prevent it? What are the treatment options? Where can you receive the care?

x. Have you ever been involved in cervical cancer screening? How often? What triggered you to perform it?

xi. What are the advantages of cervical cancer screening exercise?

xii. What are the disadvantages of cervical cancer screening exercise?

Discuss the Communication Channel and Sources of Information of Cervical Cancer

i. Is there any communication channel (media, Community Health Workers, Health informants like doctors and nurses, health organizations e.t.c) which addresses cancer related issues or sexually transmitted disease in the region

ii. If yes, what are they (the channels)? What were their challenges and barriers when accessing information on the sexually transmitted diseases being addressed? Was there any cervical cancer message on the channel? If yes, what was the main message being discussed? What was their challenge of accessing the message of cervical cancer screening (if any)

iii. Which media station do they mostly listen to?

iv. Which among the ones listed has ever had a sexuality and reproductive health disease communicated

v. Have they ever come across an article or a discussion on the media on a sexually transmitted disease? If yes, which media and what disease was being discussed?

vi. Have they ever heard a discussion or news in the media on cervical cancer?

If yes, which media? What were the issues being addressed about the disease on the media? How often is the discussion being addressed (weekly, monthly, and annually?)

vii. Has there been any discussion on the media encouraging women to go for cervical cancer screening?

If yes, did the message convince them to go for cervical cancer screening?

If yes, why? If no, why?

viii. Do they know of any cancer organization aimed to increase information and raise awareness on cervical cancer screening?

ix. If you could request some kind of communication services for cervical cancer, what will you want?

Thank you for your time and assistance.

APPENDIX D

INTERVIEW GUIDE: IN-DEPTH INTERVIEWS (HEALTH KEY INFORMANTS)

N/B. Record all the conversations to ensure that there is little or no loss of originality in the data collected.

Introductions

Good morning/afternoon. My name is ……., a communication student from Daystar University and currently conducting a study on challenges of communication on cervical cancer screening uptake among women in rural areas of Kenya.

Please allow me to kindly ask you a few questions to make this study successful. The information you provide will be kept strictly anonymous and confidential; and its findings will be used to make recommendations to relevant stakeholders in order to deal with any communication challenges of cervical cancer screening uptake among Kenyan women.

Background Information

Name of Respondent…….....Age……...…Constituency …….

Marital status …….. Profession …….. Education level ……

Understanding of Cervical Cancer and Cervical Cancer Screening

Knowledge

i. Which County/Constituency/Ward is this?
ii. Does the hospital they work in have an operational cervical cancer department/clinic within it? If so, state the facilities and services offered. (if No, where do they refer patients who come for cervical cancer screening)

iii. Does the health facility offer cervical cancer screening services

iv. What does cervical cancer screening mean to them

v. What does cervical cancer mean to the people in the community? How is it treated and acquired

vi. What are the disadvantages?

vii. Have they been involved in communicating cervical cancer screening awareness to the community? How often? Did it make a difference (increase the number of uptake)

viii. What are the advantages and disadvantages that arises during the communication of cervical cancer screening to the community

Sources of Information and the Communication of Cervical Cancer Screening

i. What are the kinds of communication channels that are currently being used in the community for cervical cancer?

ii. Does the health facility provide cervical cancer brochures, magazines, books, videos/CDs to encourage women to adopt cervical cancer screening? If yes, how often, when, where (explain in details). Do they have an impact on the number of women going for screening?

iii. What are the cervical cancer screening messages (what does the message entail)?

iv. In your view, what is the best channel of communicating cervical cancer in women on this area?

v. Are you aware of any media channel that has discussed the issue? Which media? What was its impact in the screening uptake, how long did the information ran?

vi. What are some of suggestions that you think will encourage women in this community to undertake cervical cancer screening and which communication cannel do you prefer should be used (explain in details).

APPENDIX E

INTERVIEW GUIDE: IN-DEPTH INTERVIEWS (RADIO PRESENTER)

i. Which County/Constituency/Ward is this?

ii. Have you ever discussed about cervical cancer in the radio?

iii. What was the message?

iv. How often is the discussion?

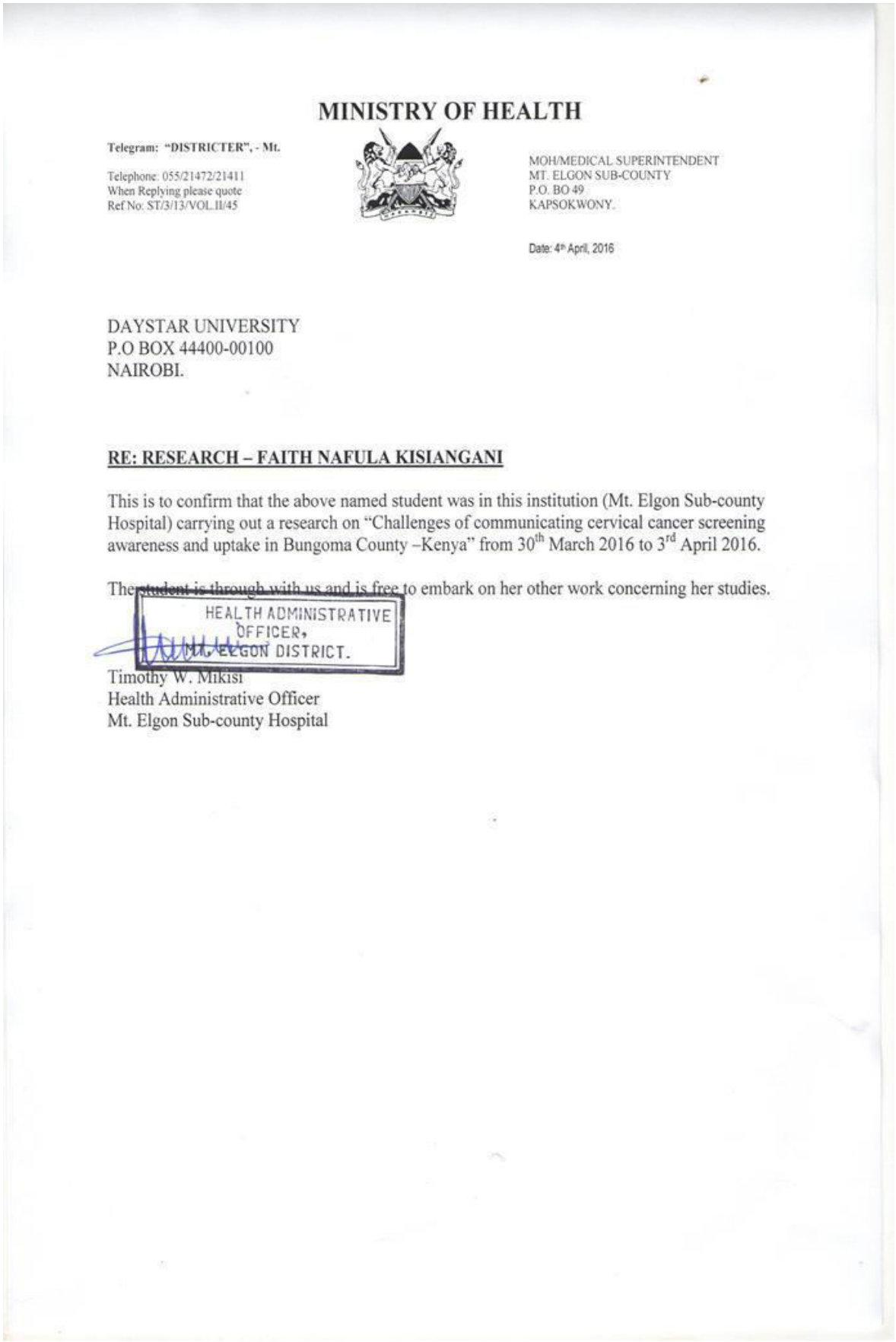
v. Is there any other media that you have heard of about cervical cancer? If yes, which station?

vi. Does cervical cancer get the same attention in the media like other sexually transmitted disease?

vii. What are some of the suggestions that you think will encourage women in this community to undertake cervical cancer screening and which communication cannel do you prefer should be used (explain in details).

Thank you for your time and assistance.

APPENDIX F
LETTER FROM THE ORGANIZATION



MINISTRY OF HEALTH

Telegram: "DISTRICTER", - Mt.

Telephone: 055/21472/21411
When Replying please quote
Ref No: ST/3/13/VOL.II/45

MOH/MEDICAL SUPERINTENDENT
MT. ELGON SUB-COUNTY
P.O. BO 49
KAPSOKWONY.

Date: 4th April, 2016

DAYSTAR UNIVERSITY
P.O BOX 44400-00100
NAIROBI.

RE: RESEARCH – FAITH NAFULA KISIANGANI

This is to confirm that the above named student was in this institution (Mt. Elgon Sub-county Hospital) carrying out a research on "Challenges of communicating cervical cancer screening awareness and uptake in Bungoma County –Kenya" from 30th March 2016 to 3rd April 2016.

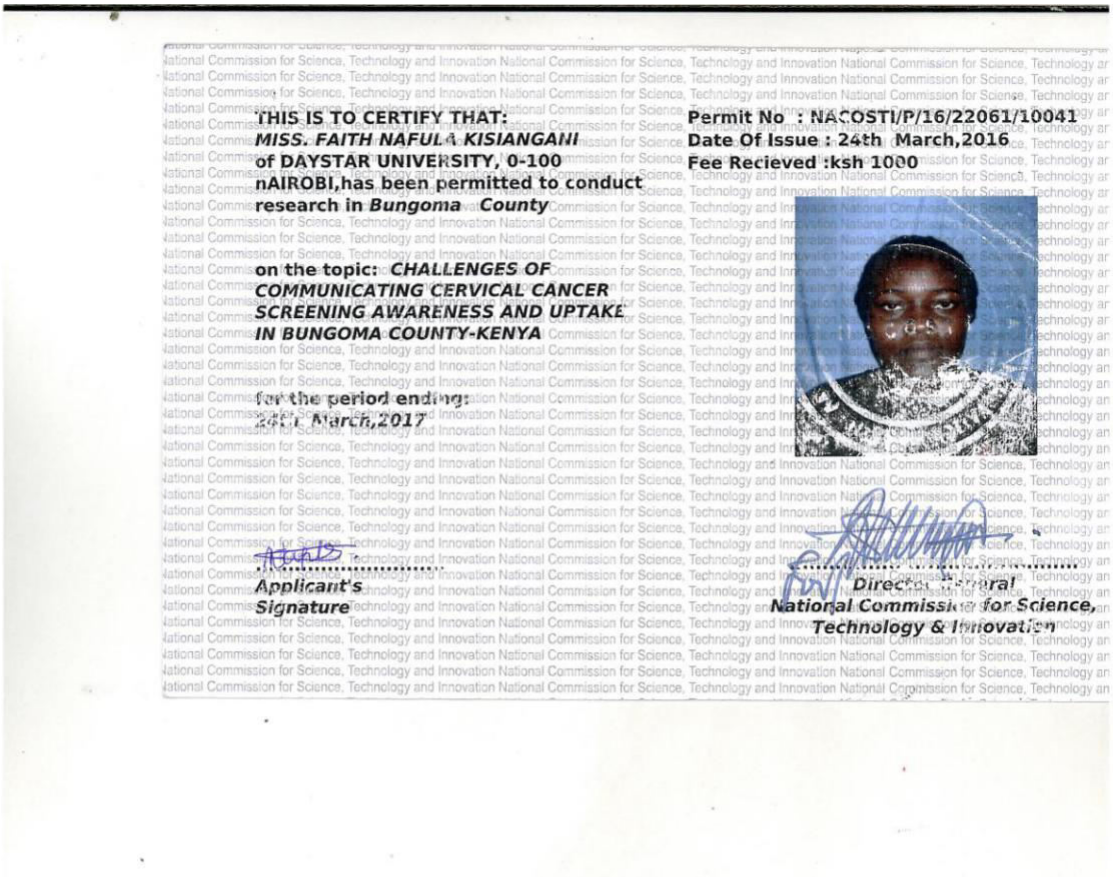
The student is through with us and is free to embark on her other work concerning her studies.

HEALTH ADMINISTRATIVE OFFICER, MT. ELGON DISTRICT.

Timothy W. Mikisi
Health Administrative Officer
Mt. Elgon Sub-county Hospital

APPENDIX G

REASERCH PERMITS



THIS IS TO CERTIFY THAT:
MISS. FAITH NAFULA KISIANGANI
of DAYSTAR UNIVERSITY, 0-100
nAIROBI,has been permitted to conduct
research in *Bungoma County*
on the topic: *CHALLENGES OF COMMUNICATING CERVICAL CANCER SCREENING AWARENESS AND UPTAKE IN BUNGOMA COUNTY-KENYA*
for the period ending:
24th March,2017

Permit No : NACOSTI/P/16/22061/10041
Date Of Issue : 24th March,2016
Fee Recieved :ksh 1000

Applicant's Signature

Director General
National Commission for Science, Technology & Innovation

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

Telephone: +254-20-2213471,
2241349, 310571, 2219420
Fax: +254-20-318245, 318249
Email: secretary@nacosti.go.ke
Website: www.nacosti.go.ke
When replying please quote

9th Floor, Utalii House
Uhuru Highway
P.O. Box 30623-00100
NAIROBI-KENYA

Ref: No. NACOSTI/P/16/22061/10041

Date: 24th March, 2016

Faith Nafula Kisiangani
Daystar University
P.O Box 44400-00100
NAIROBI.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"Challenges of communicating cervical cancer screening awareness and uptake in Bungoma County-Kenya,"*** I am pleased to inform you that you have been authorized to undertake research in **Bungoma County** for a period ending **24th March, 2017.**

You are advised to report to **the County Commissioner and the County Director of Education, Bungoma County** before embarking on the research project.

On completion of the research, you are expected to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.

DR. STEPHEN K. KIBIRU, PhD.
FOR: DIRECTOR-GENERAL/CEO

Copy to:

The County Commissioner
Bungoma County.

The County Director of Education
Bungoma County.

REPUBLIC OF KENYA

MINISTRY OF EDUCATION, SCIENCE AND TECHNOLOGY
State Department of Education – Bungoma County

When Replying please quote
e-mail: bungomacde@gmail.com

County Director of Education
P.O. Box 1620-50200
BUNGOMA

Ref No: BCE/DE/19 VOL I/197

Dates: 30th March, 2016

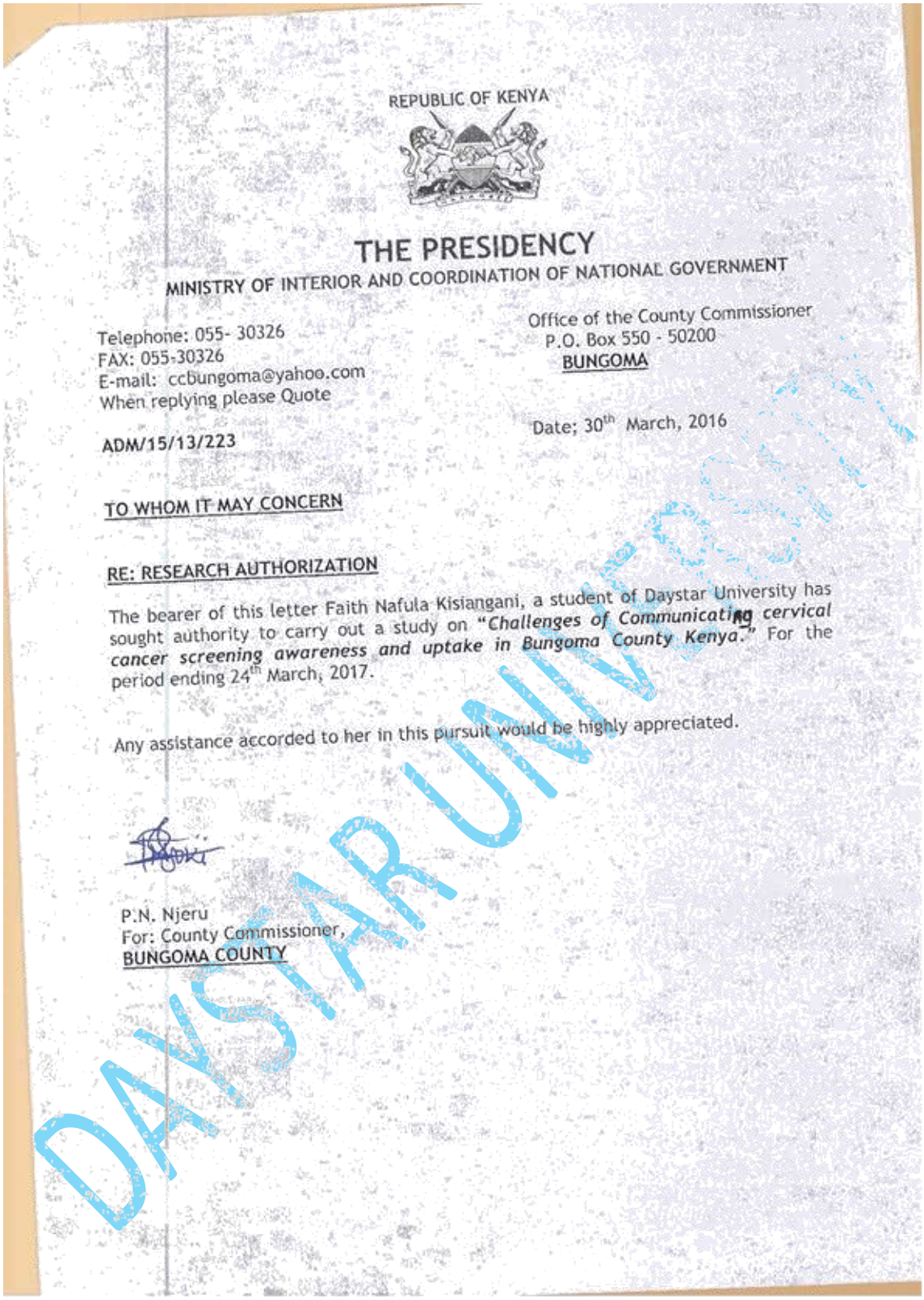
The Sub - County Directors of Education
BUNGOMA COUNTY

RE: AUTHORITY TO CARRY OUT RESEARCH – FAITH NAFULA KISIANGANI
ADMISSION NO- P/16/22061/10041

The bearer of this letter Faith Nafula Kisiangani is a student of Daystar University – She has been authorized to carry out research on ***"Challenges of Communication on cervical screening awareness and uptake in Bungoma County"*** the research period ending 24th **March, 2017**

Kindly accord her the necessary assistance.

CHARLES .A ANYIKA
COUNTY DIRECTOR OF BUNGOMA
BUNGOMA COUNTY.



REPUBLIC OF KENYA

THE PRESIDENCY

MINISTRY OF INTERIOR AND COORDINATION OF NATIONAL GOVERNMENT

Telephone: 055- 30326
FAX: 055-30326
E-mail: ccbungoma@yahoo.com
When replying please Quote

Office of the County Commissioner
P.O. Box 550 - 50200
BUNGOMA

ADM/15/13/223

Date; 30th March, 2016

TO WHOM IT MAY CONCERN

RE: RESEARCH AUTHORIZATION

The bearer of this letter Faith Nafula Kisiangani, a student of Daystar University has sought authority to carry out a study on "*Challenges of Communicating cervical cancer screening awareness and uptake in Bungoma County Kenya.*" For the period ending 24th March, 2017.

Any assistance accorded to her in this pursuit would be highly appreciated.

P.N. Njeru
For: County Commissioner,
BUNGOMA COUNTY