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CANCER ASSOCIATION OF ZIMBABWE

“Committed to cancer prevention and improving the quality of life of cancer patients, their families and communities through timeous, sustainable and evidence based interventions”

BASELINE SURVEY FOR THE MUDZI DISTRICT WARD BASED CERVICAL AND BREAST CANCER EDUCATION AND SCREENING PROJECT

DRAFT REPORT (0 Draft)

Bristol-Myers Squibb Foundation

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LIST OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ATR	African Traditional Religion
BMSF	Bristol-Myers Squibb Foundation
BSE	Breast Self-Examination
CAZ	Cancer Association of Zimbabwe
DMO	District Medical Officer
FGDs	Focus Group Discussions
GMOs	Genetically Modified Organisms
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
KAP	Knowledge, Attitudes and Practices
KII	Key Informant Interviews
KS	Kaposi Sarcoma
MoHCC	Ministry of Health and Child Care
MRCZ	Medical Research Council of Zimbabwe
MRDC	Mudzi Rural District Council
NAC	National Aids Council
NCPCS	National Cancer and Prevention Control Strategy
NEDICO	New Dimension Consulting
NHIS	National Health Information System
NHL	Non Hodgkin's Lymphoma
PCN	Primary Care Nurse
PMTCT	Prevention of Mother to Child Transmission
SPSS	Statistical Package for Social Sciences
SQ	Survey Questionnaire
STF	Secure the Future
VIAC	Visual Inspection with Acetic Acid
VMMC	Voluntary Medical Male Circumcision
WCR	World Cancer Report
WHO	World Health Organization
ZDHS	Zimbabwe Demographic and Health Survey
ZNCR	Zimbabwe National Cancer Registry

DEFINITION OF KEY TERMS

Cancer	Cancer is a disease of the cells. It is not a single disease but a group of diseases which are caused by abnormal growth of body cells. Cells do not die when they should and they continue to multiply without control forming a mass or tumor. These growths are considered either benign (not cancer) or malignant (cancer). Cancer is always named after the part of the body where it starts, even if it spreads to other body parts later.
Human Papilloma Virus (HPV)	Human papillomavirus (HPV) is a DNA virus from the papillomavirus family that is capable of infecting humans. Most HPV infections are subclinical and will cause no physical symptoms; however, in some people subclinical infections will become clinical and may cause benign papillomas (such as warts [verrucae] or squamous cell papilloma), or cancers of the cervix, vulva, vagina, penis, oropharynx and anus. Persistent infection with "high-risk" HPV types—different from the ones that cause skin warts—may progress to precancerous lesions and invasive cancer. HPV infection is a cause of nearly all cases of cervical cancer; however, most infections do not cause disease. http://en.wikipedia.org/wiki/Human_papillomavirus (22/06/2014)
Hypothesis Testing	It is a method used for proving or disproving a research question concerning a population on the basis of experimental or Survey data.
Primary Care Nurse	Zimbabwean nurses that were trained in basic nursing only for only six months rather than the three (3) years required for one to be a Registered General Nurse.
P-value	The level of marginal significance within a statistical hypothesis test. The p-value is used as an alternative to rejection points to provide the smallest level of significance at which the null hypothesis would be rejected. The smaller the p-value, the stronger the evidence is in favor of the alternative hypothesis.
Reproductive age group	The age group that is sexually active. For the purpose of this survey, the lower age limit was set at 15 completed years while the upper age limit was set at 49 completed years.
Sampling	Is the process of selecting units (e.g., people, organizations) from a population of interest so that by Surveying the sample we may fairly generalize our results back to the population from which they were chosen. (http://www.socialresearchmethods.net/kb/sampling.php ; 02 July 2012)
Stratified Random Sampling	A method of sampling that involves the division of a population into smaller groups known as strata. In stratified random sampling, the strata are formed based on members' shared attributes or characteristics. A random sample from each stratum is taken in a number proportional to the stratum's size when compared to the population. These subsets of the strata are then pooled to form a random sample. http://www.investopedia.com/terms/stratified_random_sampling.asp 22/06/2014

EXECUTIVE SUMMARY

Introduction

This report provides findings, conclusions and recommendations from a baseline survey conducted by the Cancer Association of Zimbabwe in partnership with the Ministry of Health and Child Care. The Cancer Association of Zimbabwe in partnership with the Ministry of Health and Child Care is implementing a 12 month project on Mobile Cervical and Breast Cancer Screening and Education in Mudzi District, Zimbabwe. The project is funded by the Bristol-Myers Squibb Foundation (BMSF)-Secure The Future (STF). The project has three (3) components as follows:

- i. Community capacity building in advocating for cancer services;
- ii. Provision of cancer screening services; and
- iii. Cancer and HIV education/information dissemination.

Purpose of the Survey

The overall goal of this survey was to assess the knowledge levels, attitudes and practices on breast and cervical cancers of women of child bearing age (15-49 years). The survey also intended to determine challenges being faced by communities in accessing cancer services and how best they thought the challenges could be addressed. The baseline survey was part of project monitoring and evaluation and will provide pre-implementation benchmarks. An endline survey will be conducted in 2015 to objectively measure project outcomes and impact.

Objectives of the KAP Baseline Survey

The baseline survey seeks to:

- i. Assess the knowledge levels on breast and cervical cancers by women and men aged 15-49 years in Mudzi district;
- ii. Explore the attitudes on breast and cervical cancers by women and men aged 15-49 years in Mudzi district; and
- iii. Establish the practices on breast and cervical cancers by women and men aged 15-49 years in Mudzi district.

Survey Methodology

A total of 409 survey household questionnaires were administered to women of reproductive age (aged between 15-49 years) in five wards in Mudzi District. Additionally, 13 Key Informant Interviews (KII) were conducted (*7 community stakeholders KII and 6 Health Providers Facility KII*). The Survey further conducted 10 Focus Group Discussions (FGDs) in five randomly selected wards.

KEY FINDINGS AND CONCLUSIONS

Knowledge on cancers among community members

The majority (84.4% [345]) of respondents reported ever having heard about cancer while 15.6% [64] reported never having heard about cancer. This was corroborated by Focus Group Discussions where participants in all 10 FGDs conducted reported having heard of cancer. Less than 2 out of 10 (18.3%) respondents reported not knowing the symptoms of Cancer. There are low levels of knowledge on the specific symptoms of breast cancer with less than 20% of respondents identifying the five (5) key breast cancer symptoms. Similarly, more than half (51%) of respondents reported having no knowledge of cervical cancer symptoms.

The majority of respondents reported that they do not know any breast cancer risk factor (45.7%). Although tobacco consumption is a well-documented risk factor responsible for almost a third of the cancers worldwide (WCR, 2008), only one 1% of the respondents could identify tobacco as a risk factor of both cervical and breast cancer. None of the respondents identified “reducing alcohol intake” as a way of preventing breast and cervical cancer. Ninety two (92) of the total respondents (162) who had heard about breast cancer reported that they don’t know how breast cancer can be detected early.

Nearly 40% (38.6% [158]) of respondents reported having no knowledge of the link between cervical cancer and HIV and AIDS. Over 2 out of 10 (22.2%) [91] respondents rightfully identified “insertion of herbs into the vagina” as one of the common possible risk factors of cervical cancer while 34.2%, [140] of respondents reported not knowing any cervical cancer risk factors. Almost a third (29.9% [122]) reported not being aware of how cancer could be prevented.

Attitudes on Breast and Cervical Cancer

The baseline survey documented positive and negative attitudes on breast and cervical cancer. The main detrimental attitude that emerged relates to low self-risk perception of developing cervical cancer. In total 14.3% of respondents strongly disagreed while 1.6% disagreed and 4.8% neither agreed nor disagreed with the statement that “*any adult women including me can develop breast and cervical cancer*”. In total 17.5% of respondents agreed while 3.2% strongly agreed and 28% neither agreed nor disagreed with the statement that “*cervical cancer is a disease for the prostitutes*”. Respondents demonstrated the perception that post-menopausal women were safe from cervical cancer since they are no longer sexually active.

Cancer Related Practices

The baseline survey concluded that communities have poor health seeking behaviours related to cancer. The majority (92%) of the respondents reported never having visited a health facility to get any cancer related service for the past 12 months. Only a small proportion (8%) had visited a health facility to access cancer related service. The baseline survey also documented that the majority of the women do not discuss cancer related issues with their partners/spouses. Over five (5) in every ten (10) respondents (54.8%) reported that they had never discussed cancer issues with their partners in the past 12 months. Seven (7) in every ten (10) respondents (70.2%) reported that they had never discussed cervical cancer issues with other community members and 70.8% of the respondents had never discussed breast cancer related issues with other community members. There is low uptake of cancer screening services as most of the respondents (96.2%, [302]), reported never receiving cervical cancer screening in their lifetime. The majority of respondents reported performing breast self-examination (50.3%) while 49.7% had never done breast self-examination.

Availability and Accessibility of Cancer Related Services

The baseline survey found out that cancer related services are not readily available in the district and the available health institutions including the main district hospital (Kotwa Hospital) are not fully capacitated to offer comprehensive cancer services. Nearly half of respondents (48%, [160]) reported that in their communities there are no places they can visit to talk and find out more about cancer. Just over 1 in 10 people (11.1%) indicated that they do not know if such a place does exist in their communities. Respondents (23.7%, [97]) reported that unavailability of cancer services was the main challenge while 9.3%, [38] highlighted that high cost of services is a barrier in accessing cancer related services.

HIV and AIDS Practices and Access to Services

The baseline survey concluded that HIV and AIDS practices are more positive than cancer practices and that HIV and AIDS services are readily available as compared to cancer services. A remarkably significant proportion (69.9%) of the respondents had visited a health facility or any other place to discuss HIV and AIDS issues as compared to only 8% who reported ever visited a health facility or any other place to discuss cancer issues. More respondents (61.9%) indicated that they had ever discussed HIV and AIDS issues with a partner/spouse as compared to only 27% who reported ever discussed cancer issues with a partner/spouse. Most of the respondents (63.2%) reported having been tested for HIV in the previous twelve months. Nine in every ten (89.8%) of those who were tested of HIV were aware of their HIV status. Although, this baseline concluded that HIV and AIDS practices are more positive than cancer practices and that HIV and AIDS services are readily available as compared to cancer services, there are still challenges such as stigma and discrimination as well as gender imbalances which continue to militate against the community's access to HIV related services.

BASELINE SURVEY RECOMMENDATIONS

Category	Recommendations
Overall	<p><i>i.</i> Investments should be made towards mainstreaming integrated cancer and HIV and AIDS services in all health structures and existing programmes such PMTCT, Male Circumcision, and Demand Generation;</p> <p><i>ii.</i> Develop clear, context informed strategies to encourage male participation in the female cancer programmes since men also play a part in perpetuating some of the commonly reported risk factors of female;</p> <p><i>iii.</i> Design specific strategies to target and reach women and men belonging to the Apostolic sect which constitutes the majority of the population within the district. Strategies should be sensitive to their value systems while also ensuring women prioritize early detection and treatment of cancer.</p>
Cancer Knowledge Levels, Attitudes and practices on cancers	<p><i>iv.</i> Conduct community awareness and education on cancers. Sustainable approaches of cancer information dissemination should be contextually devised for the correct cancer information to be disseminated. Lessons learned can be drawn from other programmes like VMMC and PMTCT;</p> <p><i>v.</i> Prioritize messages that reinforce the need to avoid common risk practices such as multiple and concurrent sexual partnerships and insertion of herbs in the vagina for sexual pleasure and for enlarging the birth canal, for pregnant women.</p>
Availability and cost of cancer services	<p><i>vi.</i> Invest in programmes that ensure women receive free cancer screening services within their communities;</p> <p><i>vii.</i> There is need to prioritize support towards capacitating District Health staff to offer cancer services as well as to provide adequate information;</p> <p><i>viii.</i> Prioritize lobbying Government for provision of equipment that allows Health facilities to provide Cancer services locally.</p>
Long referral chain (resulting in lost to follow-up)	<p><i>ix.</i> Explore possibilities of providing treatment services after screening since the referral chain is longer and cancer treatment is currently being provided in the main cities (Harare and Bulawayo only);</p> <p><i>x.</i> Facilitate transportation of biopsies and their examination in the capital (Harare- Parirenyatwa) and bring back the results to the district hospital to reduce transport cost. This will ultimately reduce lost to follow-up clients.</p>

1. INTRODUCTION

1.1 OVERVIEW OF CANCERS IN ZIMBABWE

1.1.1 *General Cancer Overview*

In Zimbabwe, cancer is acknowledged as a major cause of morbidity and mortality with over 5000 new diagnoses being made and over 1000 deaths per year (National Cancer and Prevention Control Strategy NCPCS, 2014). The total number of new cancer cases recorded among Zimbabweans in 2010 was 4 520 comprising of 1 837 (40.6%) males and 2 683 (59.4%) females. These numbers increased to 5 553 comprising of 2299 (41.4%) males and 3254 (58.6%) females in 2011 (NCR, 2011). These statistics are also widely acknowledged as underestimated, as many cancers cases are not captured by the routine National Health Information System because many patients do not present for treatment or register the deaths.

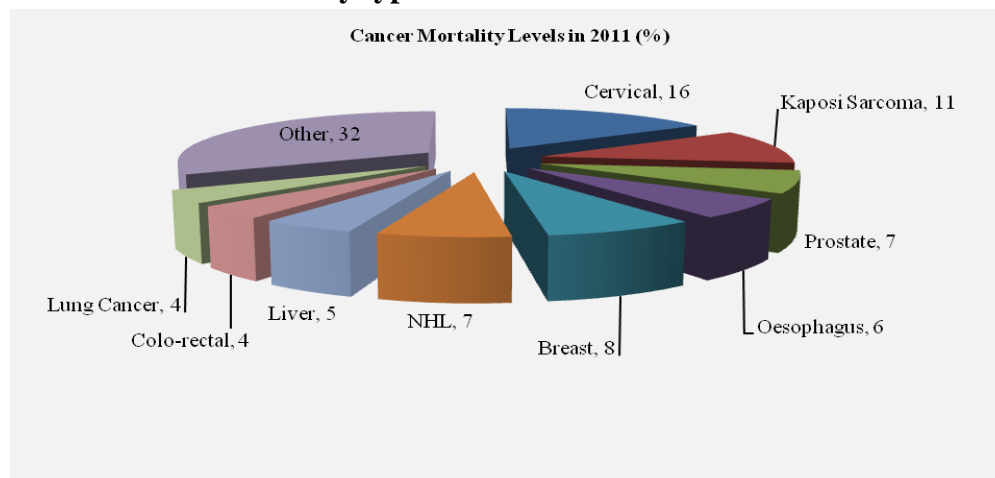
The HIV and AIDS pandemic is augmenting the rate of HIV-related cancers, with 60% of new cancers being associated with HIV and AIDS. Zimbabwe is severely affected by the AIDS epidemic, with a prevalence rate of 15% (ZDHS 2010-11). Prevalence is higher among women (18%) compared to men (12%). The Ministry of Health and Child Care (MoHCC) and its stakeholders launched the National Cancer Prevention and Control Strategy (2014-2018) (NCPCS) on the 27th of February 2014. The strategy spelt out the commitment of Government and other cancer stakeholders in the response to cancer. The strategy emphasizes on the following five key strategic areas:

NCPCS Key priority areas

Cancer Primary Prevention, Cancer Early Detection, Cancer Diagnosis and Treatment, Cancer Palliative Care and Rehabilitation and Cancer Surveillance and Research

Cancer and other related complications are also immensely contributing to Zimbabwe's mortality levels. A total of 1,758 cancer deaths comprising 772 (44%) males and 986 (56%) females were recorded in Harare (Capital City) alone in 2011. Of the reported cases, the leading causes of deaths were cervical cancer (16%), Kaposi Sarcoma (KS) (11%), breast cancer (8%), prostate cancer (7%), NHL (7%), oesophagus (6%), primary liver cancer (5%), lung cancer (4%) and colorectal cancer (4%). The other cancers constituted 32% of the recorded deaths. Cancer mortality in Zimbabwe is high mainly due to late presentation, inter-current conditions including HIV and AIDS and limited access to early detection and treatment services. An estimated 80% of patients present late (stage 3 and 4) for treatment. Figure 1 below shows distribution of cancer related deaths by type of cancer.

Figure 1: Cancer related deaths by type of cancer



Source: Zimbabwe National Cancer Registry (2011)

The National Cancer Prevention and Control Strategy for Zimbabwe (2013-2017) outlines that current statistics may not be reflective of the magnitude of the burden as many cancer cases escape the National Health Information System (NHIS) because patients do not seek modern treatment due to myths and misconceptions about cancer. In addition, not all deaths are captured as many patients die before being diagnosed due to highly centralized¹ cancer screening and unaffordable diagnosis services. The few patients who present themselves for treatment usually do so very late when cancer is at advanced stages resulting in little chances of treatment success.

Despite the current increase in cancer incidences and mortality levels, access to resources (financial, equipment, human resources) for cancer programmes remains limited, whilst the cost of accessing treatment remains high. Many cancer patients and their families as a result remain, without access to treatment, care and support services. Access to information on cancer prevention, early detection and management remains a challenge and Global guidance outlines the importance of prioritizing information as one of the building blocks for cervical cancer control and prevention (WHO, 2009). In Zimbabwe the Cancer Association of Zimbabwe is one of the few cancer resource centres.

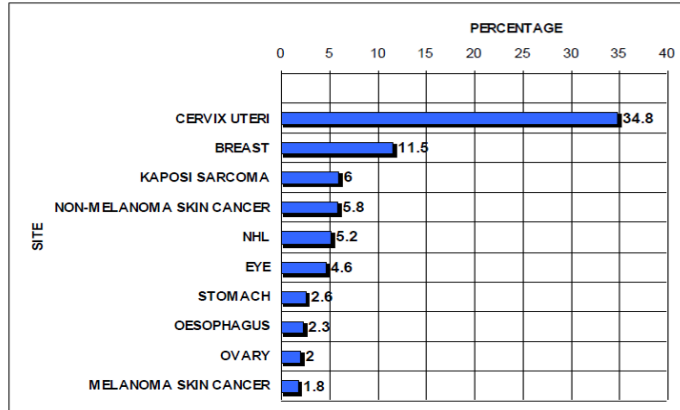
The government of Zimbabwe and its partners have already demonstrated commitment to reducing the national cancer burden as evidenced by the completion of the National Cancer and Prevention Control Strategy (2014-2018) (NCPCS). Development of this strategy was a critical step towards strengthening the overall national framework for cancer prevention and control in Zimbabwe. The Cancer Association of Zimbabwe through its organizational Strategic Plan (2014 – 2018) has also spelt out its commitment to complement government efforts in reducing the national cancer burden despite the currently experienced financial constraints.

¹Referral services are only provided in Harare and Bulawayo

1.1.2 Cervical and Breast Cancer Overview

Cervical and Breast cancer remain the top two cancers contributing a larger percentage to the national female cancer burden in Zimbabwe. The two cancers account for almost 50% of the national female cancer burden in Zimbabwe. Cervical and breast cancers contributed 34.8% and 11.5% respectively, to the total female (All races) new cancer cases in 2011 as illustrated in Figure 2 below:

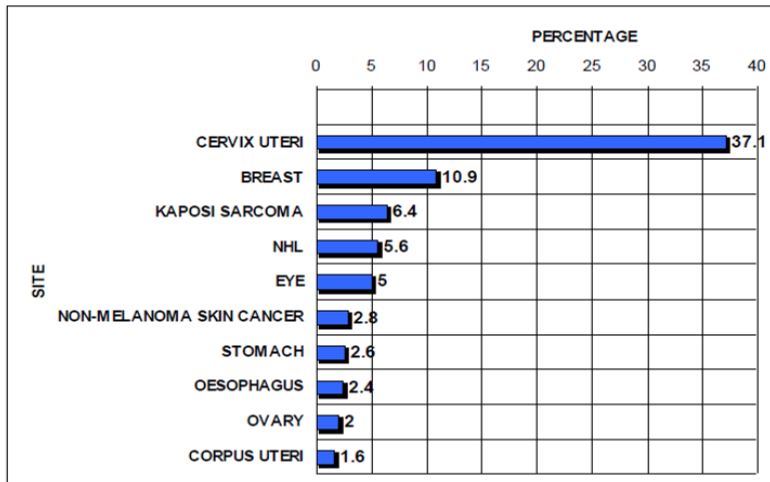
Figure 2: Most Common Cancers among all females in Zimbabwe



Source: NCR 2011

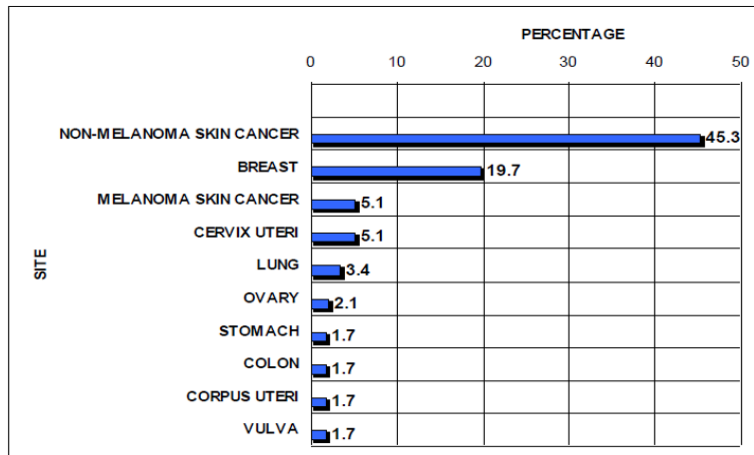
Cervical and breast cancers contributed 37.1% and 10.9% respectively, to the total black female new cancer cases in 2011 as illustrated in Figure 3 below:

Figure 3: Most Common Cancers among black females in Zimbabwe



The most common cancers among non –black females are Non –Melanoma Skin cancer and breast cancer. Non-Melanoma Skin cancer and breast cancers contributed 45.3% and 19.7% respectively, to the total Non-black female new cancer cases in 2011 as illustrated in Figure 4 below:

Figure 4: Most Common Cancers among Non - black females in Zimbabwe



1.1.3 HIV and AIDS and Cancers

Although, cancer is a group of diseases which is caused by abnormal growth of body cells and is not infectious; many cancers in the African and other developing regions are related to infectious agents (WCR, 2008). In Zimbabwe, the HIV and AIDS pandemic is augmenting the rate of HIV-related cancers, with 60% of new cancers being associated with HIV and AIDS (NCR, 2005). Zimbabwe is severely affected by the AIDS epidemic, with an adult prevalence rate of 15% (ZDHS, 2010-11). Regional statistics also show that, seventy percent of cervical cancer cases in Sub-Saharan Africa are caused by the Human Papilloma Virus (HPV), which is also sexually transmissible. Other infections of interest are hepatitis B and C and schistosomiasis (bilharzia). The relationship between Cancer and HIV and AIDS can be understood in the context of both conditions being immunosuppressant. The relationship between Cancer and HIV and AIDS has highlighted the need for stronger integration between Cancer and HIV/AIDS at policy and program levels.

Considering that the majority of HIV and AIDS infections in Zimbabwe (about 92%) are heterosexually acquired (NAC/UNAIDS; 2010), observing the Abstinence/delay of sexual debut, Being faithful/avoiding multiple and concurrent sexual partnerships, and Correct and Consistent Condom use (ABC) strategy of HIV and AIDS prevention becomes pertinent to the prevention of cancer in the country. The ABC strategy-is not only key to understanding and combating sexual transmission of HIV and other sexually transmitted infection but also cancer.

About 60% of the PLHIV in Zimbabwe are females, while about 59% of the new cancer cases reported in 2011 are females (www.nac.org.zw, NCR, 2011).The statistics demonstrate that current gender disparities in HIV and AIDS also exist in cancer. It is in the light of this overwhelming evidence that the Cancer Association of Zimbabwe, Ministry of Health and Child Welfare with Bristol-Myers Squib Foundation (BMSF) have embarked on the Mobile Cervical and Breast Cancer education and Screening Pilot Project in rural Mudzi district.

1.2 BACKGROUND TO THE BASELINE SURVEY

The Cancer Association of Zimbabwe in partnership with the Ministry of Health and Child Care is implementing a 12 month project on Mobile Cervical and Breast Cancer Screening and Education in Mudzi District, Zimbabwe. The project is funded by the Bristol-Myers Squibb Foundation (BMSF) Secure The Future (STF). The project has three (3) components as follows:

- i. **Capacity building:** Building the capacity of communities to advocate for cancer management, the link between HIV and cancer, HIV and AIDS care and sustaining these programs.
- ii. **Provision of cancer screening services:** Screening services are being delivered at ward level by the mobile Visual Inspection with Acetic Acid (VIAC) and cervicography and cryotherapy mobile unit.
- iii. **Cancer and HIV education:** Provision of cancer and HIV and AIDS information to educate people so as to dispel myths and misconceptions about cancer and HIV and AIDS as well as increase uptake of cancer screening services offered through the mobile clinic.

The baseline survey is part of project monitoring and evaluation to determine breast and cervical cancer knowledge levels, attitudes and practices before project implementation. The survey will provide benchmarks for measuring project progress. An endline survey will be conducted in 2015 to objectively determine project outcomes and impact.

1.3 OBJECTIVES OF THE BASELINE SURVEY

The objectives of the baseline survey are to:

- i. Assess knowledge levels on breast and cervical cancers by women and men aged 15-49 years in Mudzi district;
- ii. Explore attitudes on breast and cervical cancers by women and men aged 15-49 years in Mudzi district; and
- iii. Establish practices on breast and cervical cancers by women and men aged 15-49 years in Mudzi district.

1.4 BASELINE SURVEY METHODOLOGY

1.4.1 Sampling

The survey was conducted in five (5) out of 18 wards in Mudzi district. Multi-stage stratified sampling was used in this survey. The first level was dividing the district into five strata namely northern, southern, western, eastern and central areas of the district. One (1) ward was then selected from each stratum. Selection of wards was done in consultation with Mudzi Rural District Council. Within a ward, data collection was conducted using the same geographical criteria and random selection of one village (second level) in each geographical location. At village level, households (third level) were randomly selected inline with the sample size. One woman aged 15-

49 years was selected at each selected household. In households with more than one woman within the survey age range the enumerator would randomly select one woman from the household.

Figure 5: Study Sampling

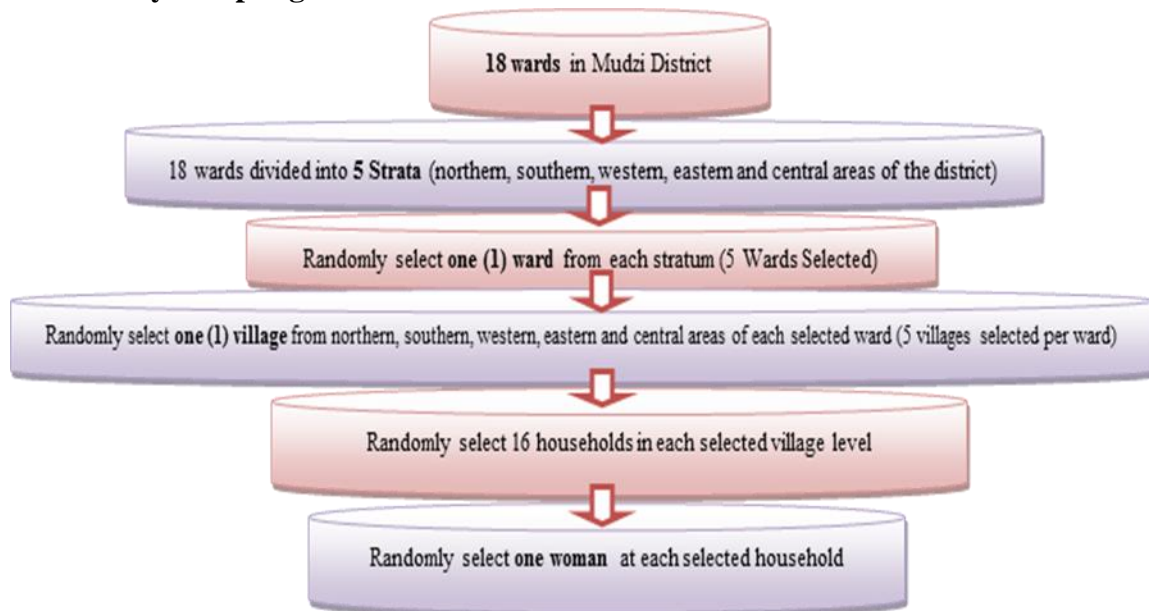
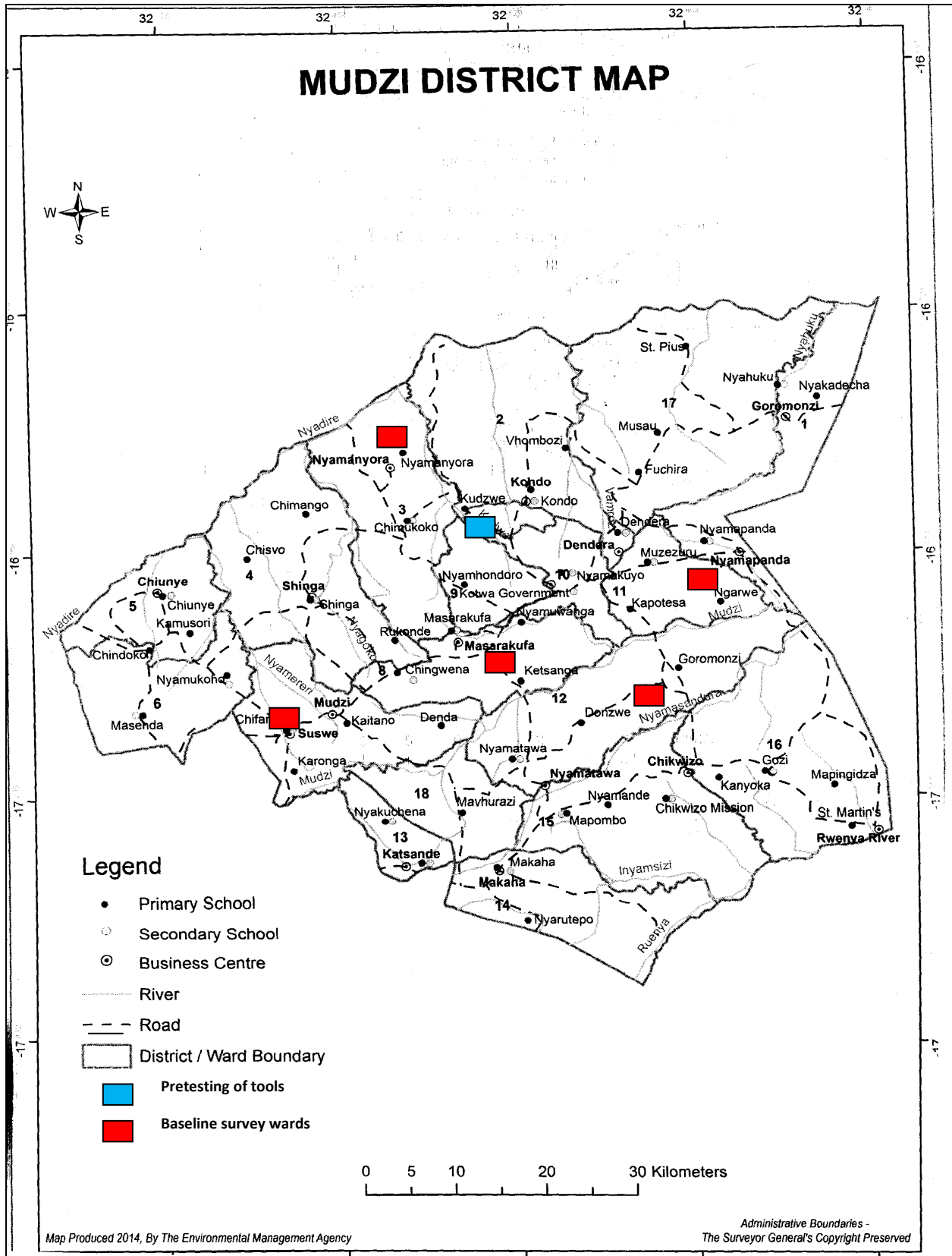


Figure 6: Map of Mudzi District



Sample Size

The household sample size was calculated using a confidence level of 95%, an acceptable margin of error of 5%, a response distribution of 50% as well as a population size of 29,111 women aged 15-49 years (Zimbabwe Census 2012, Mashonaland East Provincial Report). These preconditions yielded a statistically representative minimum sample size of 380 women aged 15-49 years. The sample size was further increased by 5% to account for contingencies such as non-response or recording error which increases the sample size to 399. This was rounded off to 400 to allow divisibility of sample size by five. The sample size was allocated equally to each of the selected five selected wards, with each ward allocated 80 women aged 15-49 years.

1.4.2 Data Collection Process

The Cancer association of Zimbabwe with assistance from NEDICO developed a Survey Protocol and Consent Forms which were submitted and approved by the Medical Research Council of Zimbabwe (MRCZ) for Ethical Clearance/Approval. As part of the Ethical Approval requirements, CAZ obtained clearances from Provincial and District authorities and key district stakeholders such as MRDC and the MoHCC.

A stakeholders' baseline survey meeting was held on the 24th of April 2014 at Kotwa Growth point in Mudzi district. Training of six (6) enumerators was done on the 24th of April 2014 at Kotwa District Hospital. Pre testing of data collection tools was done in five (5) villages of one ward (Mukota B ward) on the 25th of April 2014. Pre-testing included 25 household questionnaires, one (1) focus group discussion and two key informant interviews with community leaders. Feedback from the pre-test was incorporated into final data collection tools used for the baseline survey. Actual data collection started on the 28th of April and ended on the 2nd of May 2014. A total of 409 survey household questionnaires were administered to women of reproductive age (aged between 15-49 years) in five wards in Mudzi District. Additionally, 13 Key Informant Interviews (KI) were conducted (*7 community stakeholders KII and 6 Health Providers Facility KII*). The Survey further conducted 10 Focus Group Discussions (FGDs) in five randomly selected wards. The household questionnaires were administered by female enumerators in conformity with socio-cultural norms within the district.

1.4.3 Data Entry and Data Analysis

A data entry template was developed for the Survey Questionnaire using the Statistical Package for Social Sciences (SPSS 18). The software was chosen because of its ability to perform both simple and advanced quantitative analysis. Data cleaning was done before analysis through checking data completeness, verifying random samples of the electronic data against the original data and running frequencies, means or ranges to detect errors and anomalous values. Qualitative data was analyzed using thematic content analysis complemented with quasi statistics. Quantitative data was analyzed using descriptive statistics (i.e. % frequencies and counts) and advanced statistical techniques (i.e. tests of independence/association).

1.4.4 Report Writing

The Cancer Association of Zimbabwe developed the Baseline report which was reviewed by NEDICO. Preliminary Baseline survey results were shared with all community stakeholders² during a community debriefing meeting conducted on the 29th of May 2014. Emerging comments and feedback were incorporated and validated study findings.

1.5 BASELINE SURVEY LIMITATIONS

The baseline was conducted in five (5) wards in Mudzi district due to resource constraints. Ideally, more wards could have been included. However, to mitigate potential challenges, the survey was conducted in one ward per constituency/stratum to ensure representativeness of the survey findings to the whole district.

²Stakeholders included the ward leadership, traditional chiefs, MoHCC (district and Head Office (Reproductive Unit)

2. BASELINE SURVEY FINDINGS

A total of 409 questionnaires were successfully administered and completed against an expected total of 400 questionnaires. All 409 questionnaires were filled out yielding a response rate of 100%. This section presents baseline survey findings under five key sections as follows:

- Demographic information;
- Cancer knowledge;
- Attitudes on breast and cervical cancer;
- Cervical and breast cancer and HIV and AIDS practices; and
- Availability of cancer and HIV and AIDS related services.

2.1 DEMOGRAPHIC INFORMATION

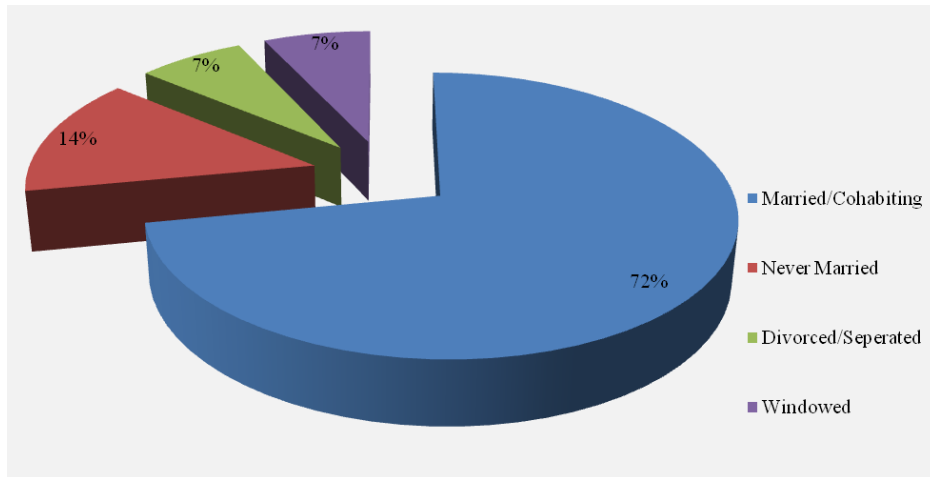
The majority of the respondents (37.2%) are aged between 15 and 24 years. The least proportion (8%) of respondents were in the 40-44 years age group. Table 1 below shows the age distribution of respondents.

Table 1: Age of Respondent

Age Group of Respondents	Frequency	Percent
15-19 years	76	18.6
20-24 years	76	18.6
25-29 years	63	15.4
30-34 years	47	11.5
35-39 years	66	16.1
40-44 years	36	8.8
45-49 years	45	11.0
Total	409	100.0

The average number of children ever born is 2.4 (n=409). This is lower than the national fertility rate of 3.7 children per woman (Multiple Indicator Monitoring Survey, Zimbabwe, 2009) and the total fertility rate for Zimbabwe of 4.1 children per woman (ZDHS, 2010-11). The majority (72%) of the respondents were either married or cohabiting followed by those who were never married (14%) and 7% who reported either being separated or divorced. Another 7% of respondents were widowed as shown in Figure 5 Below:

Figure 7: Marital Status of the Respondents



Nearly 6 out of 10 respondents (58.9% [241]) had some primary education. Only one (0.2%) respondent had attained diploma level education while 37.4% [153] of the respondents had attained ordinary level education. Only 2.7% [11] reported that they did not receive any formal education and 0.7 [3] reported having completed adult literacy education. The table 2 below shows the highest level of education attained by the respondents.

Figure 8: Highest level of education attained

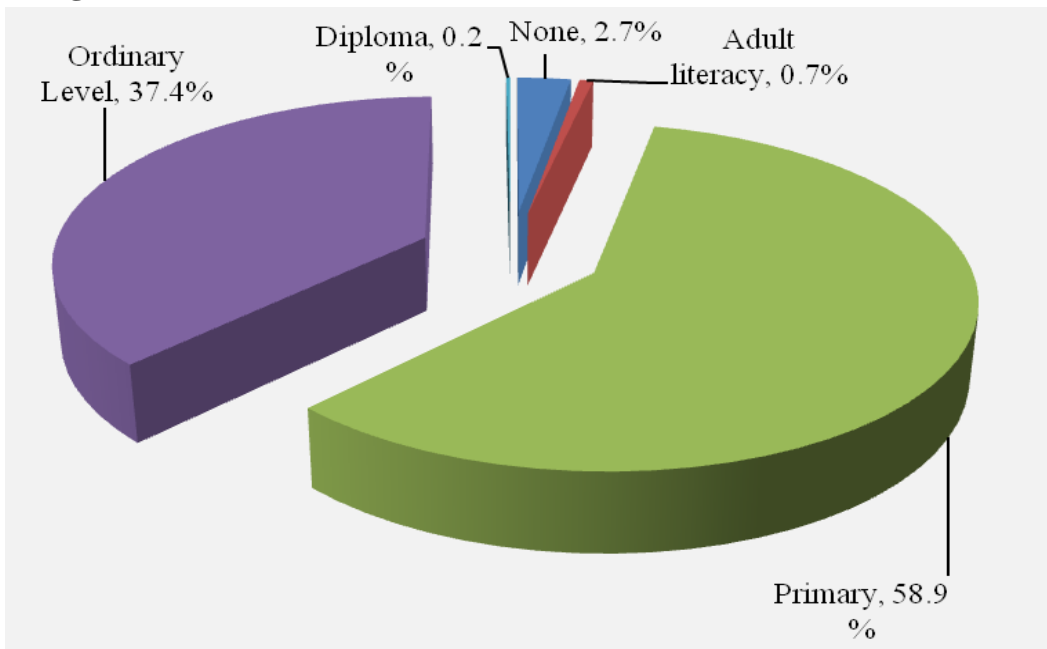
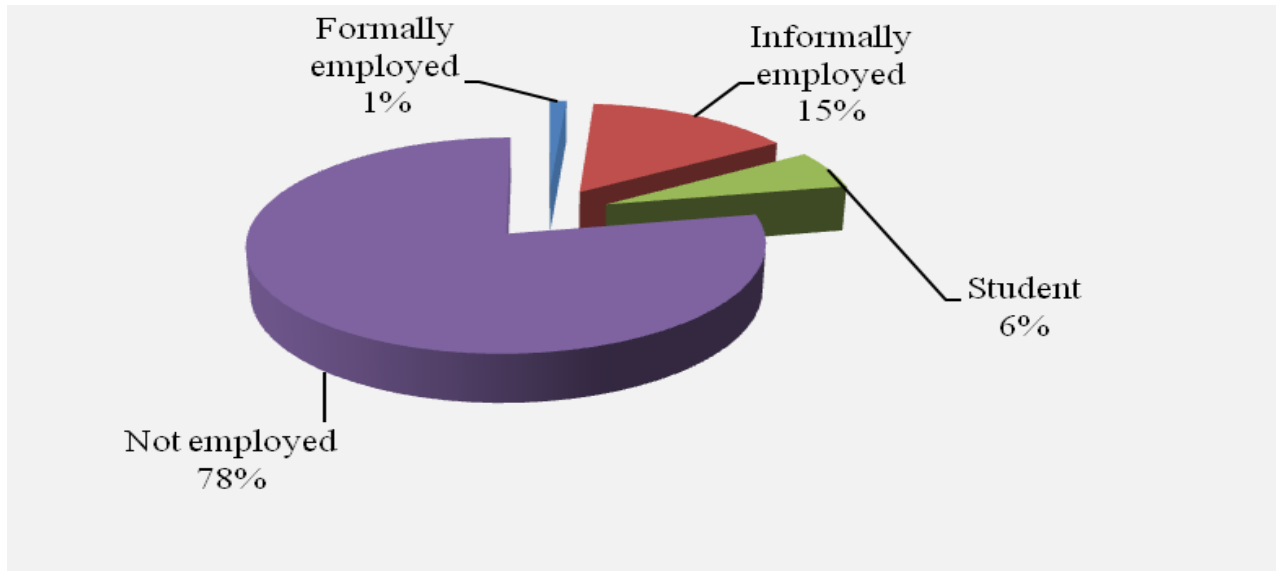
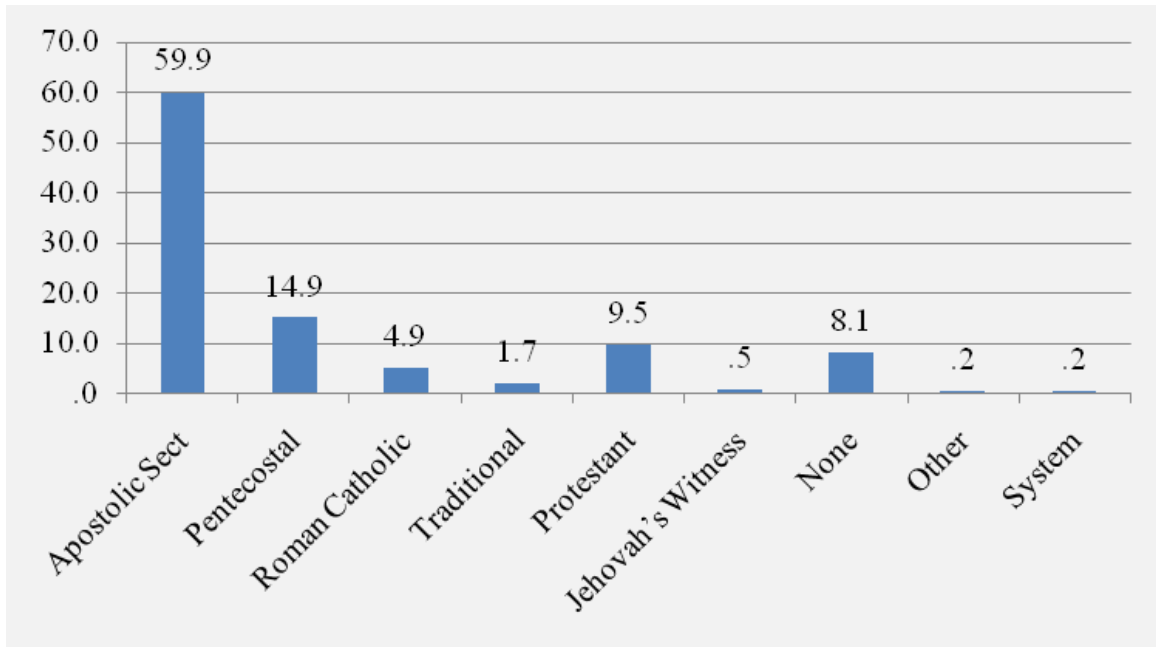


Figure 9: Employment Status



The majority [59.9%] of respondents belong to the apostolic sects, while 14.9% reported being part of Pentecostals. An additional 9.5% of respondents reported belonging to Protestant churches. A relatively small proportion [8.1%] of the respondents reported they don't belong to any particular religion while 1.7% of respondents reported belonging to the African Traditional Religion (ATR) and 0.5% of the respondents are adherence of Jehovah's Witness. The table below shows proportions of the respondents' different religious sects.

Figure 10: Religion of the respondents



2.2 CANCER KNOWLEDGE

2.2.1 GENERAL CANCER KNOWLEDGE

Overall, 84.4% [345] of respondents reported ever having heard about cancer while 15.6% [64] had never heard about cancer. There is a significant association (p -value =0) between the age of respondents and the likelihood of them having ever heard about cancer. The older the respondents the more likely they were to report having heard about cancer. The table below shows different age groups by respondents' responses on ever heard about cancer.

Table 2: Ever heard about cancer by age group (p -value =0, statistically significant)

			Heard about cancer		Total	
			Yes	No		
Age of Respondent	15-19 years	Count	49	27	76	
		% within Age of Respondent	64.5%	35.5%	100.0%	
	20-24 years	Count	65	11	76	
		% within Age of Respondent	85.5%	14.5%	100.0%	
	25-29 years	Count	54	9	63	
		% within Age of Respondent	85.7%	14.3%	100.0%	
	30-34 years	Count	41	6	47	
		% within Age of Respondent	87.2%	12.8%	100.0%	
	35-39 years	Count	61	5	66	
		% within Age of Respondent	92.4%	7.6%	100.0%	
	40-44 years	Count	34	2	36	
		% within Age of Respondent	94.4%	5.6%	100.0%	
	45-49 years	Count	41	4	45	
		% within Age of Respondent	91.1%	8.9%	100.0%	
	Total		Count	345	64	409
			% within Age of Respondent	84.4%	15.6%	100.0%

Focus Group Discussion participants also reported ever having heard about cancer. Masarakufa ward health committee members indicated that cancer is called either “Njinda or Nhuta” in their native terms. However, they outlined that the English word “Cancer” is well understood by the community members. FGD participants also indicated that they have seen someone suffering or heard about someone who had died of cancer. A 43 year old female member of Masarakufa ward health committee said “*My mother died of cervical cancer. She was admitted at Parirenyatwa where she was getting treatment*”. Responses from FGDs demonstrated that cancer is not a new disease in Mudzi communities as evidenced by the following quotations.

“My sister and husband died of cancer of the stomach. They discovered very late that they had cancer after having gone to traditional healers and faith healers”- 40 Year Old Female Health Committee Member Goronga B Ward

“I have seen someone who was suffering from leg cancer. It started as a small wound which later developed into something big” - 48 Year Old Male Health Committee Member Masahwa

“I suspect that what I have is cancer. I am yet to be tested since I cannot afford the amount of money needed at Parirenyatwa where I was referred last year” - 32 Year Old Female Community Member in Suswe ward who had a bandaged lump

Although FDG participants concurred with household questionnaire respondents that they have heard about cancers, some of their responses highlighted myths and misconceptions around cancer. A 43 year old male health committee member of Goronga B ward maintained that *“All people whom I have seen with cancer have died, I do not know of any cancer survivors”*. The misconceptions outlined the fact that although communities have heard about cancer, they are possibilities that information they have is inaccurate. The misconceptions also extend towards treatment options where communities reported trying to use methods that can cause more harm to people with cancer as the quotation below shows.

“We have heard that cancer is not curable, once chemotherapy is administered to a cancer patient, the cancer starts to spread with the whole body resulting in the death of the patients” -44 Year Old Female Community Member Suswe.

“My son came back from South Africa with cancer of the leg. He has tried seeking assistance from many places including the hospitals but it has come to nothing. I bought battery acid and poured it on the leg as a way of trying to cure the cancer, this is getting worse”- This came from a Community member who was met by one of the enumerators during the Data Collection Process.

The common cancers that known among respondents include breast (60.4%) and cervical (65.3) while 8.1% and 4.4 % of respondents reported that they knew about Kaposi sarcoma and Colon/Rectal Cancer respectively. The table below shows respondents’ knowledge of different cancer types.

Table 3: Knowledge of types of cancers

Types of cancers known	Respondents reporting knowledge of the cancer types	
	n	%
Breast Cancer	247	60.4
Cervical Cancer	267	65.3
Bladder Cancer	1	0.2
Kaposi sarcoma	33	8.1
Colon and Rectal Cancer	18	4.4
Endometrial Cancer (Uterus lining)	7	1.7
Kidney (Renal Cell) Cancer	2	0.5
Leukaemia (White Blood Cells)	5	1.2
Lung Cancer	6	1.5
Melanoma/Skin Cancer	7	1.7
Non-Hodgkin Lymphoma (Brain)	5	1.2
Pancreatic Cancer	0	0
Prostate Cancer	7	1.5
Thyroid Cancer	1	0.2

There is no statistically significant relationship (p-value=0.249) between age and knowledge of types of cancers.

2.2.2 BREAST CANCER KNOWLEDGE

The majority of respondents reported that they had heard about breast cancer through the media (40.8%) while IEC materials and religious leaders constitute the least sources of breast cancer information at 1.5% each. Figure 3 above shows that 59.9% of respondents belong to the apostolic sect therefore; it is clear in this baseline survey that the leaders of the apostolicsects are less likely to disseminate health information to members of their congregations. Evidence above further point to a shortage of informational materials on cancer. Health workers, Friends and community members are significant sources of breast cancer information in Mudzi district as they were cited by 15.6%, 7.8% and 9% of respondents respectively.

Teachers/schools and community gatherings are less significant sources of cancer information though they have traditionally been used as sustainable ways of disseminating health information. Focus Group Discussion participants indicated that they have heard of the cancers through the media but they outlined that they do not have detailed information on cancers. A 72-year-old male member of the Health Committee of Masahwa ward pointed out that they only hear of cancer through the radio as the following quote shows, “*We just hear of the disease on the radio especially, Radio Zimbabwe*”.

Table 4: Source of information

Source of information	n	%
Media (TV, Radio, Newspapers)	167	40.8
Brochures, posters and other printed materials (IEC Material)	6	1.5
Health workers	64	15.6
Family member	16	3.9
Friends	32	7.8
Religious leaders	6	1.5
Teachers/School	12	2.9
Community Gatherings/Campaigns	13	3.2
Community Member	37	9

There is no statistically significant relationship (p-value=0.699) between age and source of information about breast cancer.

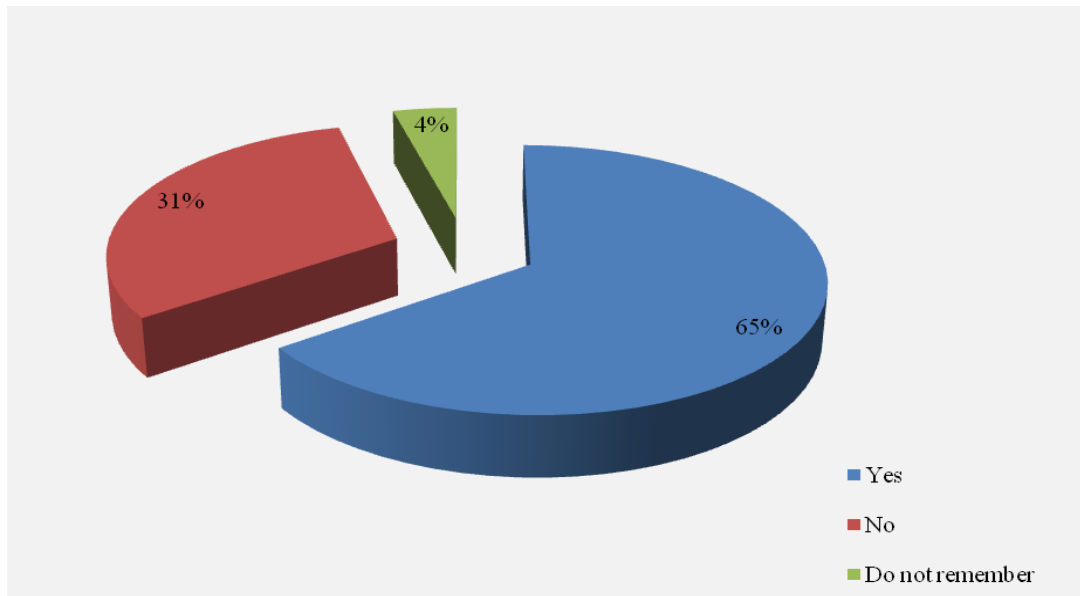


Figure 11: Heard about breast cancer in the past 6months

There is no statistically significant relationship (p-value=0.923) between age and hearing about breast cancer in the last 6months.

The majority of the respondents reported that they don't know the symptoms of breast cancer (18.3%) while the most common symptom of breast cancer known among the respondents is "a mass or lump" (27.8%). Eighteen of the thirty respondents who said "other symptoms" referred to an "ulcer on the breast" as symptom of breast cancer. The table below shows breast cancer symptoms knowledge levels among the respondents.

Table 5: Knowledge of breast cancer symptoms

Knowledge of breast cancer symptoms	n	%
A lump or thickening in or near the breast or in the underarm that persists through the menstrual cycle	46	11.2
A mass or lump, which may feel as small as a pea	68	16.6
A change in the size, shape, or contour of the breast	45	11
A blood-stained or clear fluid discharge from the nipple	20	4.9
Redness of the skin on the breast or nipple	20	4.5
Other (specify)_____	30	7.3
Do not know	75	18.3

There is no statistically significant relationship (p-value=0.482) between age and knowledge of symptoms of breast cancer.

Generally, knowledge levels of risk factors of breast cancer are very low. The majority of respondents reported that they don't know any breast cancer risk factor (45.7%). A small proportion of respondents know about environmental (3.2%) and Diet related risk factors (3.1%). Although tobacco consumption is a well-documented risk factor responsible for almost a third of the cancer worldwide (WCR, 2008), only one 1% of the respondents could identify tobacco as a risk factor. Twenty-two out of the twenty-seven respondents who said they know of "other" breast cancer risk factors cited "money getting in contact with the breast" (putting money in the bra) as a risk factor. The table below shows breast cancer risk factors knowledge levels among the respondents.

Table 6: Risk factors for breast cancer

Risk factors for breast cancer	n	%
Family history	3	0.7
Multiporus (5 or more births)	2	0.5
Age progression	2	0.5
Alcohol abuse	0	0
Lack of physical activity (exercise)	1	0.2
Overweight/Obesity	2	0.5
Diet	13	3.2
Tobacco	4	1
Environmental factors	13	3.2
Other (Specify)	27	6.6
Do not know	187	45.7

Respondents age does not affect their knowledge (p-value=0.266) on the risk factors for breast cancer.

FDGs participants in Goronga B, Masahwa, Suswe and Masarakufa wards unanimously indicated that they don't know the risk factors of breast cancer. Participants indicated limited knowledge on causes of breast cancer. They however, agreed that putting money in the bra is a risk factor of breast cancer. Two participants in Goronga, Masarakufa and Suswe wards noted that breast cancer runs in families (genetic factor) and that failure to do enough breast feeding may increase one's risk of developing breast cancer. Eating food cooked in pot with rust was also identified as one of the risk factors of breast cancer. One FGD participant in Chimukoko ward said insect bites such as tsetse fly and mosquito bites and eating meat from animals that have died on their own are some of the risk factors of breast cancer. Genetically modified foods and some imported foods were also identified by the FGD participants as causes of breast cancer.

“Kadrink_kanobva_nepaMoza_apa_kanonziDavita” translated to mean “A drink called Davida imported from neighboring country, Mozambique”- 40 year Old Female Health Committee Member Goronga B Ward. “The GMOs that we are eating on a daily basis may be putting us at risk of getting cancers”-35 Year Old Female Community Member Masarakufa

Results on levels of knowledge on breast cancer prevention show that respondents do have some knowledge on breast cancer prevention. The majority of respondents pointed out that exercising regularly can prevent breast cancer (60.9%). Nearly 16% (15.9%) of respondents identified Breast Self-Examination (BSE) and Mammogram as prevention methods for breast cancer (15.9%). None of the respondents identified “reducing alcohol intake” as a way of preventing breast cancer. Thirteen of those who responded “other” breast cancer prevention methods mentioned that avoiding placing money in the bra prevents breast cancer. The Table below shows breast cancer prevention knowledge levels among the respondents.

Table 7: Prevention Method

Prevention Method	n	%
Breast cancer screening(Self breast examination or mammogram)	65	15.9
Avoid exposure to environmental carcinogens	16	3.9
Reduce alcohol intake	0	0
Quit smoking	3	0.7
Exercising regularly	249	60.9
Balanced diet	6	1.5
Other (Specify)_____	15	3.7
Do not know	148	36.2

There is no statistically significant relationship (p-value=0.535) between age and knowledge of methods of preventing breast cancer.

Ninety two (92) of the total respondents who had heard about breast cancer reported that they don't know how breast cancer can be detected early. The majority rightfully, identified Breast

Self-Examination (93) and Clinical Breast Examination (86) as the methods of detecting breast cancer. Only two (2) and three (3) respondents identified Ultrasound scans and mammography respectively, as methods of detecting breast cancer early. The table below shows breast cancer early detection methods knowledge levels among respondents.

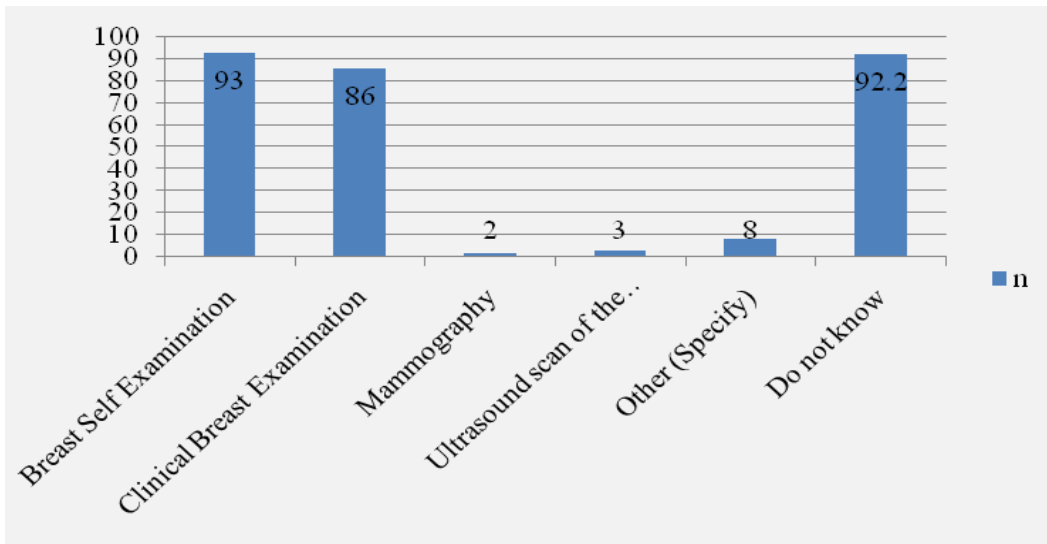
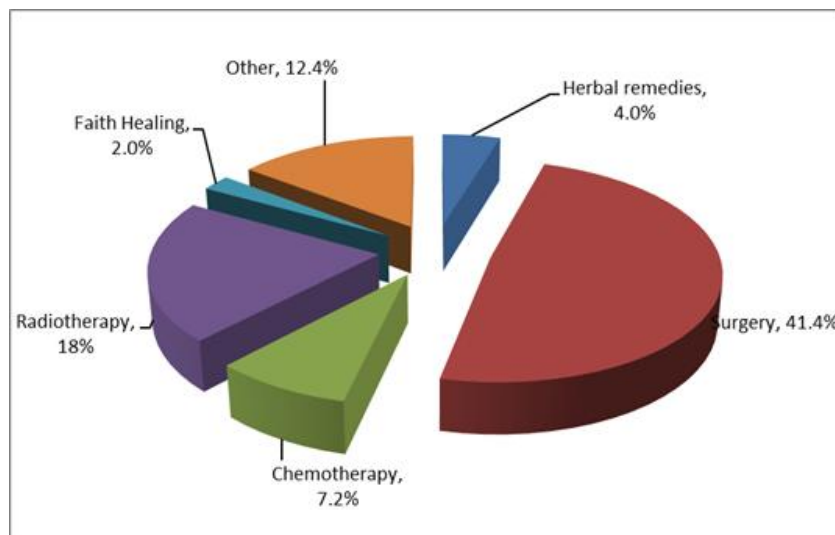


Figure 12: Breast cancer detection method

Respondents age does not affect their knowledge of breast cancer detection methods (p-value=.278). The majority of the respondents (41.4%) reported that chemotherapy is one of the treatment options for breast cancer while a significant proportion (18%) identified surgery as one of the treatment options for breast cancer. Respondents' responses on treatment options for breast cancer are shown in Figure 4 below:

Figure 13: Breast cancer treatment



Respondents age does not affect their knowledge of breast cancer treatment (p-value=0.746).

2.2.3 CERVICAL CANCER KNOWLEDGE

Media continues to be the major source of cancer information just like on breast cancer. Media accounted for 48% of all sources of cervical cancer information. Health workers, friends and community members constituted 14.9%, 5.6% and 4.9% of sources of cancer information respectively. Community gatherings (1.2%), religious leaders (6%), IEC material (1.5%) and schools/ teachers (2.7%) are the least sources of cervical cancer information. The table below shows cervical cancer sources of information among respondents.

Table 8: Source of information about cervical cancer

Heard about cervical cancer	n	%
Media (TV, Radio, Newspapers)	198	48.4
Brochures, posters and other printed materials (IEC Material)	6	1.5
Health workers	61	14.9
Family member	13	3.2
Friends	23	5.6
Religious leaders	6	1.5
Teachers/School	11	2.7
Community Gatherings/Campaigns	5	1.2
Community Member	20	4.9
Other (please specify)	1	0.2

There is no statistically significant relationship (p-value=0.602) between age and source of information above.

The percentage of respondents who could remember seeing or hearing anything about cervical cancer in the past six months is relatively high (47.4%) while 15.6% could not remember seeing or hearing anything about cervical cancer in the past six months as shown in the table below:

Table 9: In the last 6 months do you remember seeing or hearing anything about cervical cancer

	Frequency	Percent
Yes	194	47.4
No	64	15.6
Don't remember	12	2.9
Missing	139	34.0
Total	409	100.0

There is no statistically significant relationship (p-value=0.951) between age and remembering seeing or hearing anything about cervical cancer in the last 6months.

A relatively significant proportion of respondents shows no knowledge of the link between cervical cancer and HIV and AIDS (38.6% [158]) while only 20.8% [85] are aware of the link between cervical cancer and HIV and AIDS. Fifty respondents (12.2%) knew that HIV infected women are at risk of acquiring HPV which causes cervical cancer and only 1.5% are aware of the fact that HIV and AIDS prevention efforts also reduces incidence of cancers. This is shown in the tables below:

Table 10: Ever heard of the link between cervical cancer and HIV

	Frequency	Percent
Yes	85	20.8
No	158	38.6
Not sure	27	6.6
Missing	139	34.0
Total	409	100.0

There is no statistically significant relationship (p-value=0.831) between age and hearing the link between cervical cancer and HIV.

Table 11: Knowledge regarding the link of cervical cancer and HIV and AIDS

	n	%
HIV infected women are at risk of HPV infection (which causes cervical cancer)	50	12.2
HIV prevention efforts reduce incidences of cancers	6	1.5
Other (Specify)	14	3.4
Don't remember	18	4.4

There is no statistically significant relationship (p-value=0.101) between age and Knowledge regarding the link of cervical cancer and HIV and AIDS.

The level of knowledge on symptoms of cervical cancer is very low. More than half of the respondents (51%) reported that they don't know the common signs and symptoms of cervical cancer. Vaginal bleeding and foul smelling vaginal discharges were noted as some of the common symptoms of cervical cancer by 11% and 13% of the respondents respectively. A very low proportion of the respondents identified pain during sexual intercourse and back ache as symptoms of cervical cancer (6% and 3% respectively). The figure below shows distribution of the responses according to the common cervical cancer symptoms.

FGD participants show high knowledge of some of the symptoms of cervical cancer. They managed to identify pain during sexual intercourse, continuous vaginal bleeding, lower abdominal pains, swollen cervix and foul smelly vaginal discharge as some of the common symptoms of cervical cancer.

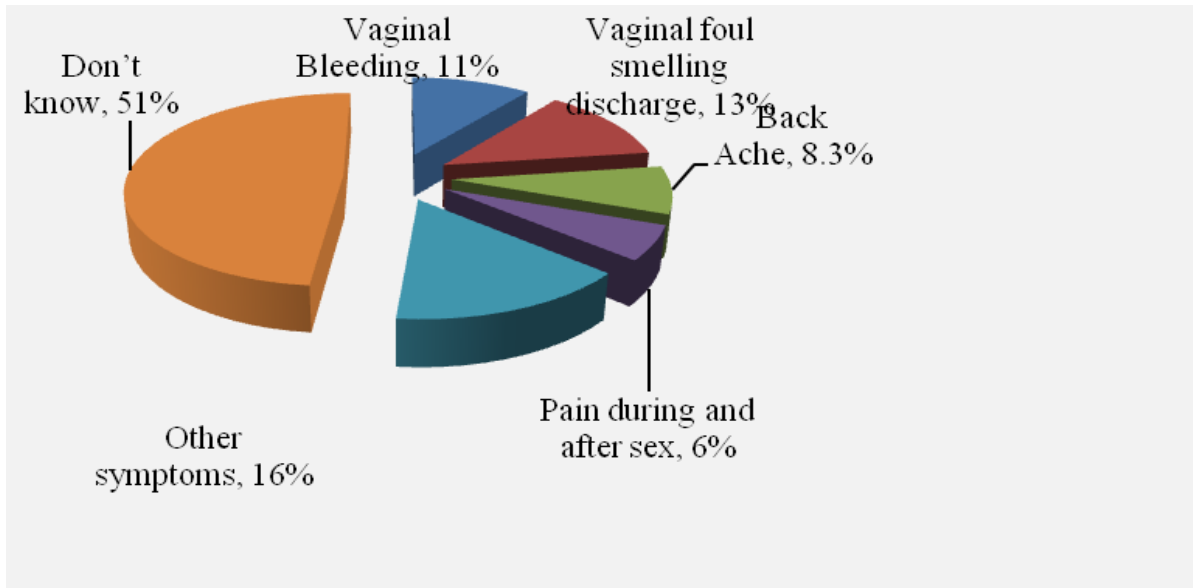


Figure 14: Symptoms of cervical cancer

There is statistically significant relationship (p -value=0.008, 0.026) between age and knowledge of symptoms of cervical cancer.

Generally, cervical cancer risk factors knowledge level among the respondents is very low. The majority of respondents reported that they don't know any cervical cancer risk factor (34.2%, [140]). A relatively significant proportion of respondents identified "insertion of herbs into the vagina" as one of the common risk factors of cervical cancer (22.2%, [91]). Although tobacco consumption is a well-documented risk factor responsible for almost a third of the cancer worldwide (WCR, 2008), only one 1% [4] of the respondents could identify tobacco as a risk factor. This is the same scenario with breast cancer above. According to the ZDHS, 2010-11, 22% of men use tobacco in Zimbabwe. Having multiple and concurrent sexual partners (13.2%), sexually transmitted infections (5.1%) and dry sex (4.2%) were also rightfully identified as common signs and symptoms of cervical cancer. The table below shows knowledge levels of cervical cancer risk factors among respondents.

Table 12: Risk factors of cervical cancer

Risk factors of cervical cancer	n	%
Having multiple sexual partners	54	13.2
Early onset of sexual activity	12	2.9
STIs (e.g.HPV virus)	21	5.1
Tobacco use	4	1
Insertion of herbs	91	22.2
Dry sex	17	4.2
Other (Specify)	26	6.4
Do not know	140	34.2

There is no statistically significant relationship (p-value>0.05) between age and knowledge of risk factors of cervical cancer.

Use of traditional herbs to enhance sex and child birth was cited as a common practice constituting a major risk of cervical cancer. FGD participants in all five wards agreed that the use of herbs for sexual enhancement is very common. Probed further to find out whether the use of herbs really works (perceived efficacy), Chimukoko ward male respondents agreed that the insertion of herbs do work and male partners can even notice the difference during sex. To further assert this, a 44 year old female community member in Suswe ward said ***“If you say traditional herbs should be avoided, give us a substitute for sexual enhancement”***.

“Women use powder made from local herbs for sexual enhancement. This is said to enhance sexual pleasure for men”- 41 Year Old Male Health Committee Member Goronga B

Failure by males to be circumcised was cited as one of the risk factors of cervical cancer. Multiple and concurrent sexual partnerships was also identified as a major common risk factor for cervical cancer in the community.

A female community member in Masarakufa ward noted that the Zimbabwe National Army Base (uniformed forces) in their ward

“This ward is close to the growth point and border to Mozambique which results in high levels of prostitution”- Councilor Goronga B Ward

result in casual sex which also put the female partners at risk of developing cervical cancer.

The majority of the respondents reported that they were not aware of how cervical cancer could be prevented (29.9%, [122]). This is the same scenario with breast cancer prevention as discussed above. Evidence from the baseline as presented above validates the conclusion that knowledge on both breast and cervical cancer prevention is very limited among women in the communities. Just over 10% (11.5%, [47]) of respondents highlighted that avoiding multiple and concurrent sexual partners and avoiding insertion of herbs in the vaginal canal/dry sex (20%, [82]) are ways of

preventing cervical cancer. A relatively small proportion of respondents identified avoiding early sexual intercourse (2.9% [12]), early treatment of sexually transmitted infections (3.4%, [14]), safer sex (5.6%, [23]), avoiding tobacco use (1%, [4]), regular screening (3.9%, [16] and vaccination (0.7%, [3]) as ways of preventing cervical cancer. Screening of cervical cancer is one known way of promoting early detection of cervical cancer. In Zimbabwe, VIAC have been rolled out and all sexually active females are encouraged to be screened but this baseline study showed that rural community women still do not recognize regular screening as a key way of preventing cervical cancer.

“Due to lack of knowledge on cancers, community members wait for advanced pain for them to come for the services”-DMO Mudzi District

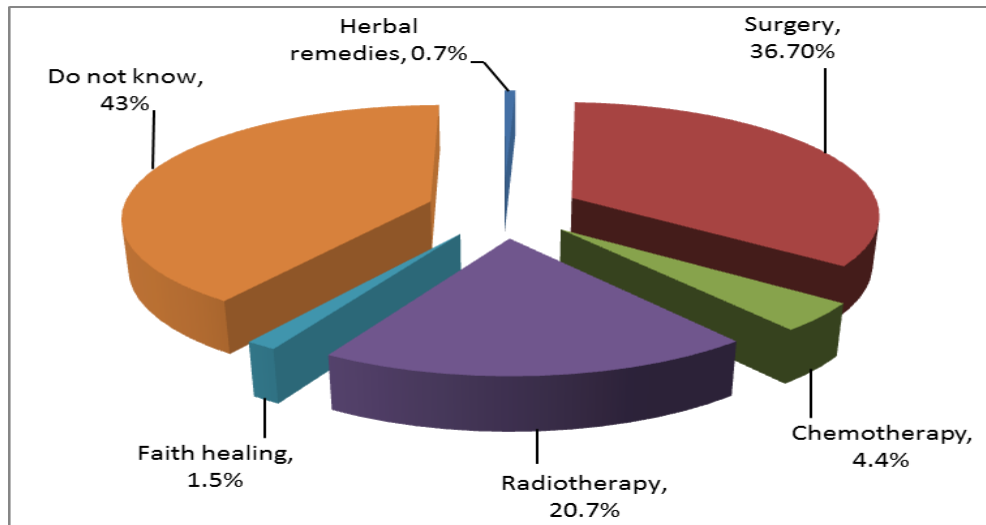
Table 13: Preventing of cervical cancer

Ways of preventing cervical cancer	N	%
Early treatment of STIs	14	3.4
Avoid multiple sexual partners	47	11.5
Avoid early sexual intercourse	12	2.9
Quit Tobacco use	4	1
Through vaccination of HPV vaccine	3	0.7
Practice safe sex	23	5.6
Avoid insertion of herbs/dry sex	82	20
Encourage Partner to go for Male Circumcision	26	6.4
Regular Screening	16	3.9
Other (Specify)	9	2.2
Do not know	122	29.8

There is no statistically significant relationship ($p\text{-value} > 0.05$) between age and knowledge of preventing the development of cervical cancer.

The majority of the respondents (43%) reported that they don't know how cervical cancer can be treated while a significant proportion (36.7%) identified surgery as one of the treatment options for cervical cancer. Respondents' responses on treatment options for cervical cancer are shown in the figure below:

Figure 15: Cervical cancer treatment (N=270)



There is no statistically significant relationship (p -value=0.303) between age and treatment methods of cervical cancer.

2.3 ATTITUDES ON BREAST AND CERVICAL CANCER

Over one out of 10 (14.3%) respondents strongly disagreed while 1.6% disagreed and 4.8% neither agreed nor disagreed with the statement that “any adult woman including me can develop breast and cervical cancer”. In addition, 17.5% agreed while 3.2% strongly agreed and 28% neither agreed nor disagreed with the statement that “cervical cancer is a disease for prostitutes. A small proportion (2.2%) strongly agreed while 10.9% agreed and 5.4% neither agreed nor disagreed with the statement that “Getting breast and cervical cancer is a death sentence. There is not much that can be done when someone has breast and cervical cancer”. Thus, some women’s self-risk perception is detrimental as this can reduce uptake of cancer prevention services. Some post-menopausal female FGD participants consider themselves having no risk of developing cervical cancer since they are no longer sexually active. This low self-risk perception is detrimental to the early detection and treatment of cancers. The following quotation illustrates the low self-risk perception:

“Our ages are safe because we are no longer sexually active. In the past we did not hear much about these cancers but they are now common”- 62 Year Old Female Community Member Masarakufa

The majority of respondents’ attitudes are positive, with 59.2% of them strongly disagreeing while 35% disagreed with the statement that “Talking to family/friends about symptoms of breast or cervical cancers is embarrassing” and 53.2% of the respondents strongly disagreeing while 28.2% disagreeing with the statement that “Getting breast and cervical cancer is a death sentence.

There is not much that can be done when someone has breast or cervical cancer”. The table below shows the attitudes on breast and cervical cancers.

Figure 16: Attitudes on Breast and Cervical Cancer

Attitudes	Strongly agree (%)	Agree (%)	Neither agrees nor disagree (%)	Disagree (%)	Strongly disagree (%)
Any adult woman including me can develop breast or cervical cancer	23.2	56.1	4.8	1.6	14.3
Cervical cancer is a disease for prostitutes	3.2	17.5	13.4	28.0	37.9
Breast and cervical cancer are diseases for the elderly women	3.2	7.0	8.0	36.9	44.9
I would rather not know if I had breast or cervical cancer	18.5	2.5	1.9	34.1	43.0
Getting breast and cervical cancer is a death sentence. There is not much that can be done when someone has breast or cervical cancer	2.2	10.9	5.4	28.2	53.2
Talking to family/friends about symptoms of breast or cervical cancers is embarrassing	1.9	2.9	1.0	35.0	59.2

2.4 GENERAL CERVICAL AND BREAST CANCER RELATED PRACTICES

The baseline survey sought to document cancer related practices of respondents and the majority (92%) of respondents had never visited a health facility to get any cancer related service for the past 12 months. Only a small proportion (8%) had visited a health facility to access cancer related service as shown in the figure below:

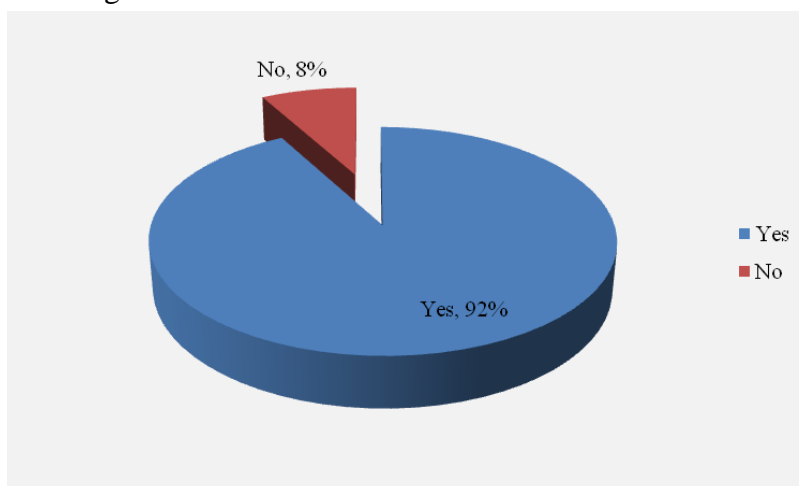


Figure 17: Ever visited a health facility to get cancer related service during the past 12 months

Discussing cancer issues with the partner/spouse reduce stigma and discrimination, myths and misconceptions on cancer and helps to enhance early detection of cancers. The baseline results show that the majority of women do not discuss cancer related issues with their partners/spouses. Five in every ten(10) respondents (54.8%) reported that they had never discussed cancer issues with their partners in the past 12 months while only 27.4% reported that they had a conversation about cancer with their partners/spouses as shown in the table below:

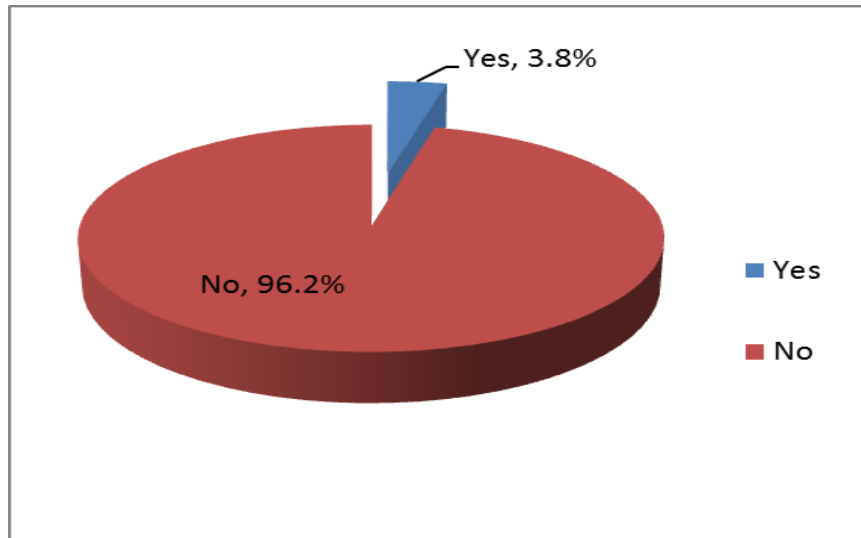
Table 14: Ever discussed cancer issues with your partner or spouse in the last three months

	Frequency	Percent
Yes	92	27.4
No	184	54.8
Do not remember	1	.3
Not Applicable	59	17.6
Total	336	100.0

2.4.1 CERVICAL CANCER RELATED PRACTICES

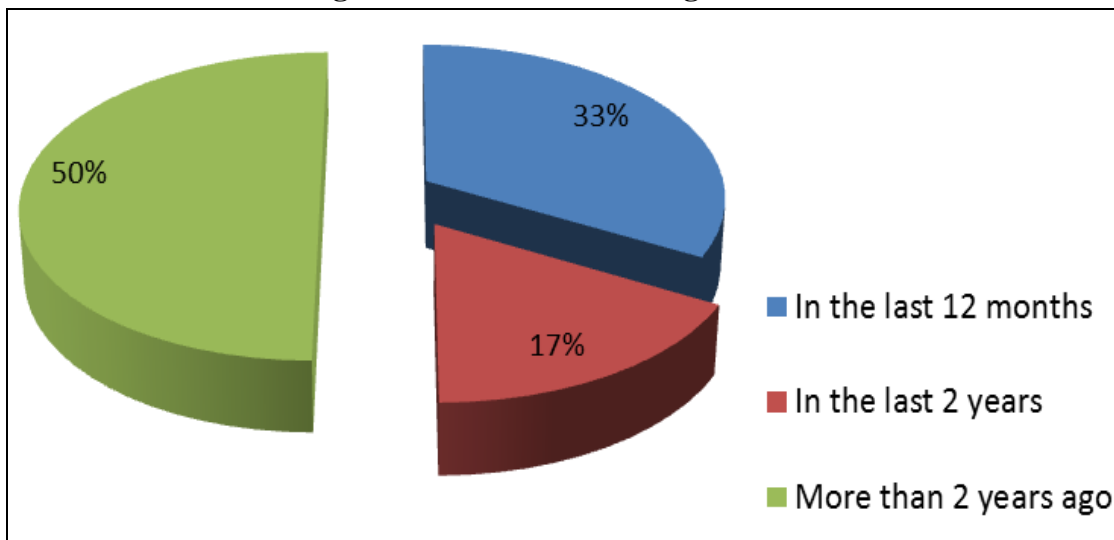
The development of cervical cancer involves undetected and untreated precursor lesions progressing and traversing the basement membrane invading cervical stroma over a period of 5–20 years. The invasion may then involve blood and lymphatic vessels and the disease may ultimately spread to the lymph nodes and distant organs. Early detection of asymptomatic precancerous lesions by screening and their effective treatment lead to prevention of invasive cervical cancer (WCR, 2008). Cervical cancer screening is therefore, crucial in not only enhancing early detection of cancer but also stopping the progression of precursor lesions to advanced cervical cancer. In this baseline survey it is worrying that most of the respondents (96.2%, [302]), had never received cervical cancer screening in their lifetime while only 3.8% of the respondents had received cervical cancer screening. These results are in line with the results presented above which show that a very small proportion (3.9%) of the respondents knew that regular cervical cancer screening is one the most effective ways of preventing cervical cancer. Thus, there is low uptake of cervical cancer screening services in the rural community. Figure 16 below shows the responses on whether one had received cervical cancer screening in their lifetime.

Figure 18: Cervical screening



Among the twelve respondents (3.8%) who received cervical cancer screening the majority (50%, [6]) had received the cervical cancer screening more than two year ago while 17%, [2] received it in the last two years and 33%, [4] received the screening within the last 12 months as shown in Figure 11 below:

Figure 19: Last time of having cervical cancer screening

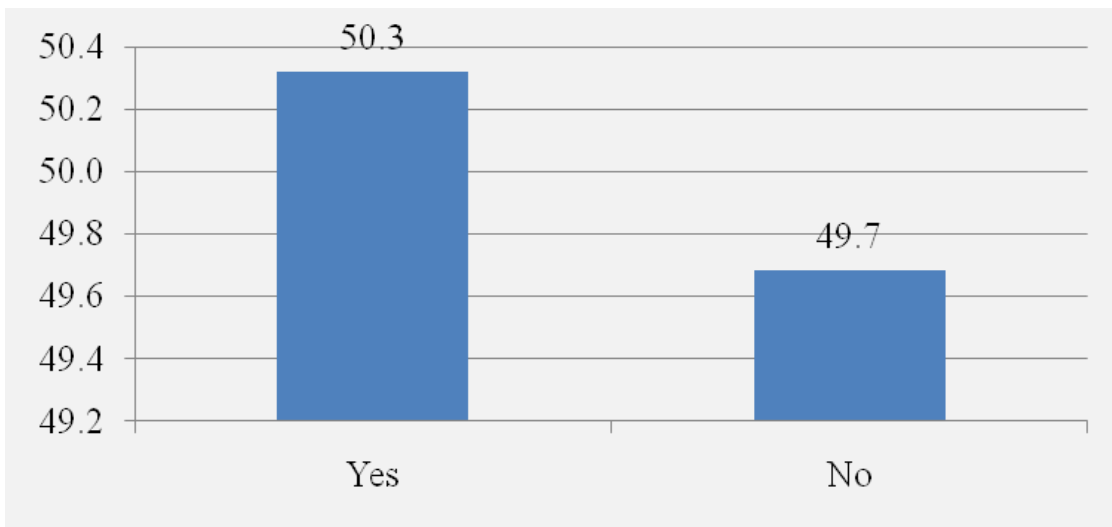


There is no statistically significant relationship (p -value=0.151) between age and having cervical cancer screening.

2.4.2 BREAST CANCER RELATED PRACTICES

The majority of respondents had performed breast self-examination (50.3%) while 49.7% had never done breast self-examination. The percentage of respondents who never done breast self-examination is high considering the fact that breast self-examination is the easiest and the initial screening that determine need for further breast cancer services such as clinical breast examination, mammography and other related breast cancer investigative procedures. Figure 12 below, shows percentages of respondents who reported ever performing Breast Self-Examination and those who never had breast self-examination.

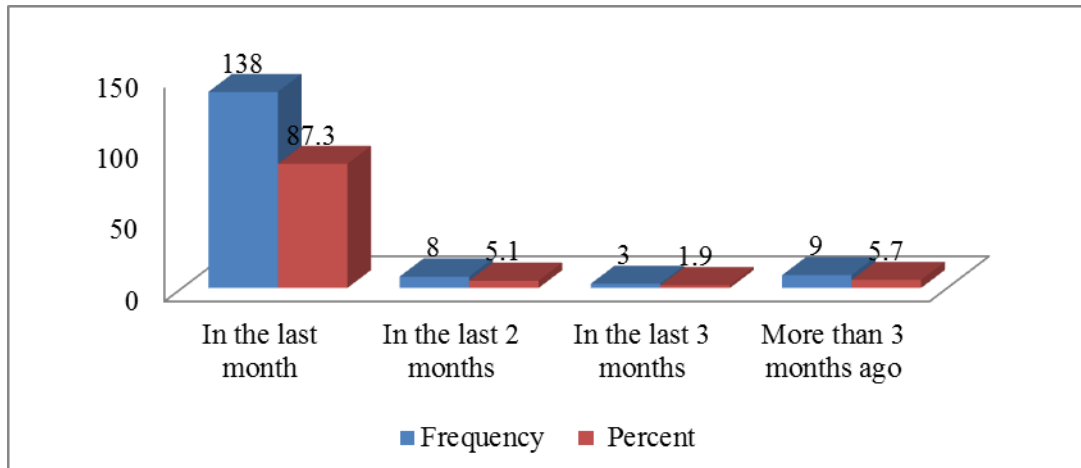
Figure 20: Ever had breast self-examination



There is no statistically significant relationship ($p\text{-value}=0.186$) between age and ever having a breast self-examination.

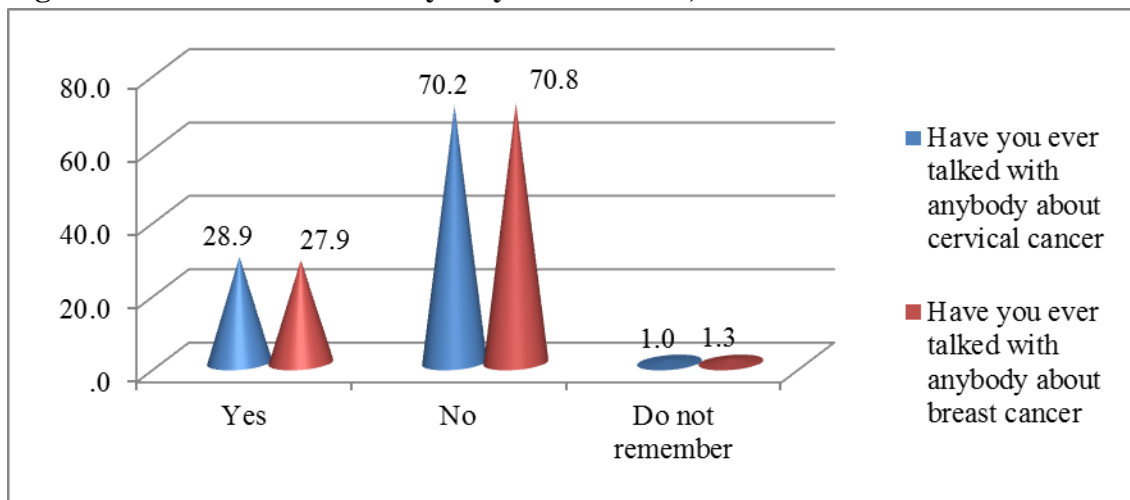
It is generally recommended that breast self-examination should be done once every month. In this baseline study, the frequency of doing breast self-examination by the majority of respondents is good as 87.3%, [138] of those who had breast self-examination had done it in the last 30 days (month). A very small proportion of respondents had had their last breast examination procedure in the last two months (5.1%, [8]), in the last three months (1.9%, [3]) and more than three months period (5.7%, [9]) as shown in Figure 13 below:

Figure 21: When last time you performed breast self-examination



Community dialogue on cancer issues is important in reducing stigma and discrimination associated with most of the reproductive related cancers, myths and misconceptions on cancer and helps to enhance early detection and treatment of cervical cancer. The baseline results show that the majority of the women do not discuss cervical cancer related issues other community members. Seven (7) in every ten(10) respondents (70.2%) reported that they had never discussed cervical cancer issues with other community members while only 28.9% reported that they had discussed about cervical cancer with other community members. Generally, the community dialogue on cancer issues in Mudzi district is very low. The majority of the respondents (70.8%) had never discussed breast cancer related issues with other community members while only 27.9% reported that they had discussed about breast cancer with other community members as shown in Figure 14 below:

Figure 22: Ever talked with anybody about breast, cervical cancer

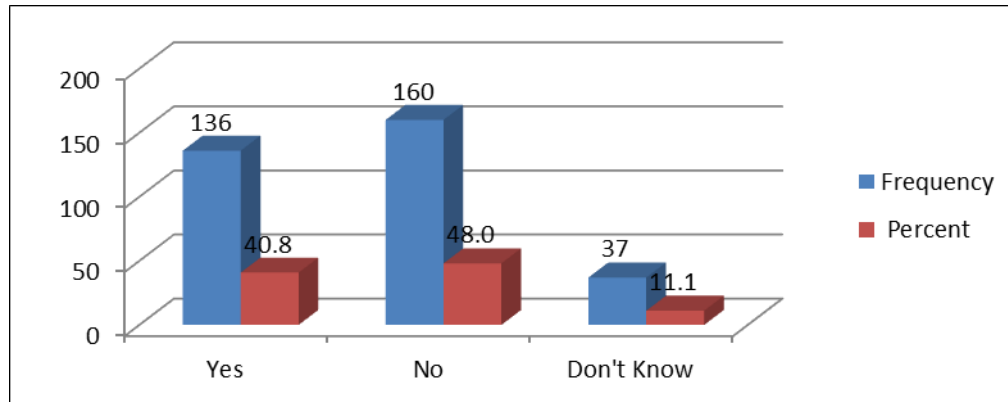


There is no statistically significant relationship ($p\text{-value} > 0.05$) between age and ever talking to anybody about breast, cervical cancer.

2.5 AVAILABILITY OF CANCER RELATED SERVICES

Most of the respondents (48%, [160]) reported that in their communities there are no places they can visit to talk and find out more about cancer while 40.8% reported that they do have such a place in their communities. An additional 11.1% indicated that they don't know if such a place does exist in their communities. Figure 16 below shows responses on whether there is a place in the communities where people can go to talk and find out more about cancers.

Figure 23: Is there a place in your community where people like you are able to visit to talk and find out more about cancer issues



Among the 136 (40.4%) respondents who reported that there are places in their communities where they can visit to find out more on cancers the majority identified clinic as the place (28.1%, [115]) while a small proportion (8.6, [35]) identified “Hospital” as the place. No single respondent identified household, support groups and workplace as places to find out more on cancer. Very few respondents identified community gatherings/campaigns (1.2%, [5]), church (1%, [4]), School (0.7%, [30]) and other places (1%, [4]) as shown in table 18 below: This a clear indication of the fact that cancer information is yet to be mainstreamed into rural district health structures, schools, community events and activities yet this is one of the proven ways of making any health intervention programmes more sustainable.

Table 15: Place to find out more about cancer issues

Place to find out more about cancer issues	n	%
Clinic	115	28.1
Hospital	35	8.6
Community gatherings/campaigns	5	1.2
Church	4	1
Other (Specify)	4	1
School	3	0.7
Household/Family	0	0
Support Group	0	0
Workplace	0	0

There is no statistically significant relationship ($p\text{-value}>0.05$) between age and knowledge of a place to find out about cancer issues.

FGD participants stressed the importance of mainstreaming cancer programmes into community calendars as evidenced by the following quotations:

“It will be best if as a community we would have people who are trained to talk about cancer issues just like in HIV. These can take advantage of community meetings to disseminate cancer knowledge”- 37 Year Old male Community Member Goronga B

“My daughter came to me and asked if the wound she had was a result of cancer. I told her it was not the case. The discussion came about because she had heard about cancer at school. It will be beneficial if school children are educated on this. In turn they will inform their parents”- 40 Year Old female Health Committee member Goronga B ward

Table 16: Cancer services provided in community/district/ward

Cancer services provided in community/district/ward	n	%
Education and counselling regarding Cancers	114	27.9
Do not know	20	4.9
Cancer Screening	6	1.5
Cancer Referrals	4	1
Cancer treatment	3	0.7
No response	2	0.5

There is no statistically significant relationship ($p\text{-value}>0.05$) between age and knowledge of cancer services provided in community/district/ward. The baseline survey found that the main barrier/challenge in accessing cancer related services is unavailability of cancer services. Most of the respondents (23.7%, [97] reported that unavailability of cancer services was the main challenge while 9.3%, [38] cited the high cost of services as a barrier to accessing cancer related services as shown in table 20 below:

Table 17: Challenges/barriers for accessing cancer related services

Challenges/barriers for accessing cancer related services	N	%
Unavailability of services	97	23.7
Do not know	83	20.3
Other (specify)	34	8.3
Cost of services (very high)	38	9.3
Stigma and discrimination at community level	9	2.2
Myths and misconceptions behind	3	0.7
Gender imbalances	0	0

There is no statistically significant relationship ($p\text{-value} > 0.05$) between age and knowledge of challenges of accessing cancer related services in community.

Unavailability and unaffordability of cancer related health services stressed by the household questionnaire respondents were also noted by KII participants as key barriers in accessing cancer services. The following quotations help to support the unavailability and unaffordability of cancer related services.

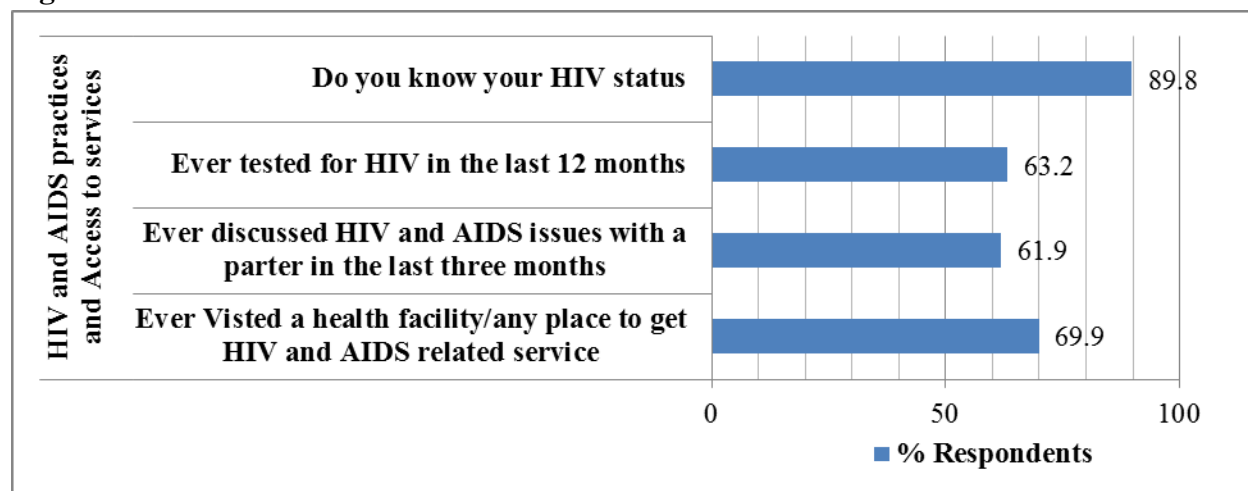
“No services are available locally, people have to travel long distances to hospitals far away”- Councilor Suswe Ward

“Vanhuvenharaundainovanongowanamarikamwechetepagore nekurimanzungusakahavazokwanisikuwanamariyekuendakun orapwa. Zvipfuwo zvekuti vatengese vamwe havana”- (people in this community obtains money once per year through selling groundnuts therefore, they don't afford treatment cost. Some don't have the domestic animals to sell and generate income. Councilor Chimukoko Ward.

2.6 HIV AND AIDS PRACTICES AND ACCESS TO SERVICES

The baseline survey found out that HIV and AIDS practices are more positive than cancer practices. Again access to HIV and AIDS services is higher compared to cancer services. Most of the respondents (69.9%) indicated that they had visited a health facility to access HIV and AIDS related services while 61% had discussed HIV related issues with a partner/spouse in the last three months, 63.2% were tested for HIV in the previous twelve months. Nine in every ten (89.8%) of those who were tested of HIV were aware of their HIV status as shown in figure 17 below:

Figure 24: HIV and AIDS Practices and Access to Services



The majority of respondents were tested for HIV and AIDS in the 12 months preceding the baseline survey (63%) while only 37% reported that they were not tested of HIV in the 12 months preceding the survey. The relationship between being tested for HIV and age of respondents is statistically significant with a p-value of 0. The following table shows the number of women who reported having been tested for HIV according to their age groups.

Table 18: Tested for HIV in the past 12months

			Were you tested for HIV in the past 12 months?		Total	
			Yes	No		
Age of Respondent	15-19 years	Count	35	39	74	
		% within Age of Respondent	47%	53%	100%	
	20-24 years	Count	57	19	76	
		% within Age of Respondent	75%	25%	100%	
	25-29 years	Count	49	14	63	
		% within Age of Respondent	78%	22%	100%	
	30-34 years	Count	37	10	47	
		% within Age of Respondent	79%	21%	100%	
	35-39 years	Count	46	19	65	
		% within Age of Respondent	71%	29%	100%	
	40-44 years	Count	14	22	36	
		% within Age of Respondent	39%	61%	100%	
	45-49 years	Count	18	26	44	
		% within Age of Respondent	41%	59%	100%	
	Total		Count	256	149	405
			% within Age of Respondent	63%	37%	100%

(Statistically significant p-value = 0)

The challenges being faced in accessing HIV and AIDS services are less compared to challenges faced in accessing cancer services. Most of the respondents (37.2%) reported that they had no challenges in accessing HIV and AIDS related services while 29.6% reported that stigma and discrimination is a barrier in accessing HIV related services. Very insignificant proportion reported that gender imbalance (1%, [4]), transport to service points (1.7%, [7]), Unavailability of services (1.5%, [6]) and Cost of service (0.2%, [1]) are barriers in accessing HIV and AIDS services in the community as shown in table 22 below:

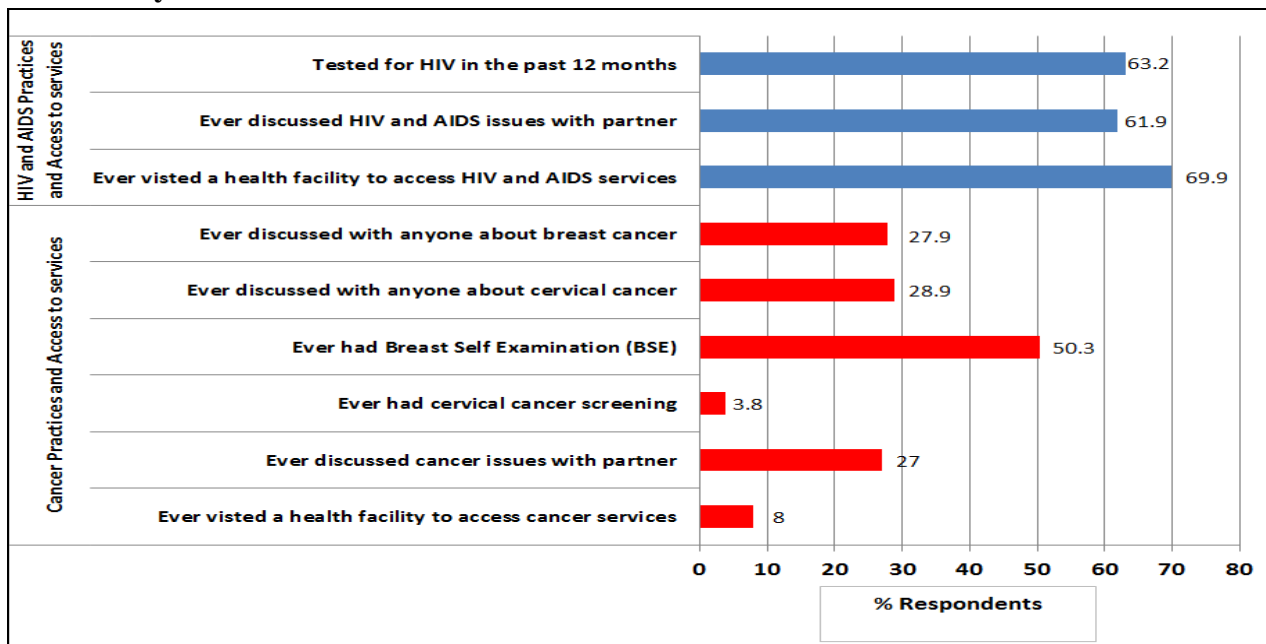
Table 19: Challenges faced in accessing HIV related services

Challenges	n	%
Unavailability of services	6	1.5
Cost of services (very high)	1	0.2
Transport to service points	7	1.7
Gender imbalances	4	1
Myths and misconceptions behind	16	3.9
Stigma and discrimination at community level	121	29.6
None	152	37.2
Other (specify)	43	11
Do not know	68	16.6

2.6 COMPARISON BETWEEN CANCER AND HIV AND AIDS PRACTICES AND ACCESS TO SERVICES

Generally, there are more positive HIV and AIDS practices as compared to cancer practices and Cancer services are less available/accessible in the Mudzi community than HIV and AIDS services. Nearly 70% (69.9%) of respondents had visited a health facility or any other place to discuss HIV and AIDS issues as compared to only 8% who reported ever visiting a health facility or any other place to discuss cancer issues. More respondents (61.9%) indicated that they had ever discussed HIV and AIDS issues with a partner/spouse as compared to only 27% who reported ever discussing cancer issues with a partner/spouse. Figure 20 below shows comparative analysis between cancer and HIV and AIDS practices and accessibility of both cancer (Breast and Cervical) and HIV and AIDS related services

Figure 25: Comparative analysis between HIV and AIDS and Cancer practices and accessibility to services



To further support the inequality between HIV and Cancer services in the district stakeholders KII participants highlighted that services on other diseases are readily available as compared to cancer. The Executive Officer-Administration and Health for Mudzi Rural District Council outlined that cancer awareness raising is sporadically done in some clinics and went onto highlight that the community's hope on cancer is hinged on the new pilot project by the Cancer Association of Zimbabwe. The following quotations by the KII show that cancer services are not readily available in the district.

The health service providers also noted the existing gap in the provision of cancer related services in the respective wards and the whole district. Most of the rural clinic authorities concurred with the household questionnaire respondents and maintained that they only do physical examinations such breast examinations and refer all suspicious cases to the district hospital (Kotwa). PCN at Kapotesa Clinic, Goronga B Ward said *“We just examine for known signs and symptoms and refer suspected cases to Kotwa”*. The skills gap in offering cancer services and shortage of health staff and cancer services related equipment were also noted at the rural clinics and the district hospital. The following quotations help to illustrate the inadequacy cancer services in the district.

<p><i>“We only have one speculum which when used is send to Kotwa Hospital for sterilization. This may take more than three days leading to few examinations being conducted”- RGN Kotwa Clinic</i></p>	<p><i>“We run so many programmes such that we end up neglecting some other areas. With the introduction of other programs, this will mean more staff shortages”- PCN Kapotesa Clinic Goronga B Ward</i></p>	<p><i>“At the District Hospital we only have two staff members fully capacitated</i></p>
<p><i>“We don’t have any equipment here, once we suspect a cancer case we refer to Kotwa”- PCN Goromonzi Clinic Masahwa Ward</i></p>	<p><i>“As staff we have limited skills to provide cancer services to women who come in”- PCN Goromonzi Clinic Masahwa Ward</i></p>	<p><i>which is not adequate”- DMO Mudzi District</i></p>

3 BASELINE SURVEY CONCLUSIONS

3.1 Knowledge on cancers among community members

Cancer knowledge levels are very low in the district. Although, the majority (84.4% [345]) of the respondents reported ever having heard about cancer while only 15.6% [64] had never heard about cancer, the cancer knowledge levels (knowledge on risk factor, cancer prevention and early detection and treatment) is very low among the community members.

The majority of respondents reported that they don't know any breast cancer risk factor (45.7%). Although tobacco consumption is a well-documented risk factor responsible for almost a third of the cancer worldwide (WCR, 2008), only one 1% of the respondents could identify tobacco as a risk factor for both cervical and breast cancer. None of the respondents identified "reducing alcohol intake" as a way of preventing breast and cervical cancer. Ninety two (92) of the total respondents who had heard about breast cancer reported that they don't know how breast cancer can be detected early.

A relatively significant proportion of respondents show no knowledge of the link between cervical cancer and HIV and AIDS (38.6% [158]). More than half of the respondents (51%) reported that they don't know the common signs and symptoms of cervical cancer. Although a significant proportion (22.2%, [91]) rightfully identified "insertion of herbs into the vagina" as one of the common risk factors of cervical cancer, the majority of the respondents (34.2%, [140]) reported that they don't know any cervical cancer risk factor. The majority of the respondents reported that they were not aware of how cervical cancer could be prevented (29.9%, [122]).

3.2. Attitudes on Breast and Cervical Cancer

The baseline survey concluded that there are both positive and negative attitudes on breast and cervical cancer. The main detrimental attitude that emerged from the baseline survey is that of low self-risk perception of developing cervical cancer. A significant proportion of the respondents (14.3%) strongly disagreed while 1.6% disagreed and 4.8% neither agreed nor disagreed with the statement that "*any adult women including me can develop breast and cervical cancer*". A significant percentage (17.5%) agreed while 3.2% strongly agreed and 28% neither agreed nor disagreed with the statement that "*cervical cancer is a disease for the prostitutes*". Respondents perceived that post-menopausal women were safe from cervical cancer since they are no longer sexually active. Considering cervical cancer as the disease of prostitutes can also fuel stigma and discrimination against cervical cancer patients.

3.3. Cancer Related Practices

The baseline survey found out that health seeking behaviours on cancer health issues are poor. The majority (92%) of respondents had never visited a health facility to get cancer related services for the past 12 months. Only a small proportion (8%) had visited a health facility to access cancer related service. The baseline survey also concluded that the majority of women do not discuss cancer related issues with their partners/spouses. Five (5) in every ten (10) respondents (54.8%) reported that they had never discussed cancer issues with their partners in the past 12 months. Community dialogue on cancer issues in Mudzi district is very low. Seven (7) in every ten (10) respondents (70.2%) reported that they had never discussed cervical cancer issues with other community members and 70.8% of the respondents had never discussed breast cancer related issues with other community members. Most of the respondents (96.2%, [302]), had never received cervical cancer screening in their lifetime. Thus, there is low uptake of cervical cancer screening services in the rural community. However, the majority of respondents had performed breast self-examination (50.3%) while 4.9.7% had never done breast self-examination.

3.4. Availability and Accessibility of Cancer Related Services

The baseline survey found that cancer related services are not readily available in the district and the available health institutions including the main district hospital (Kotwa Hospital) are not fully capacitated to offer comprehensive cancer services. Most of the respondents (48%, [160]) reported that in their communities there are no places they can visit to talk and find out more about cancer and 11.1% indicated that they don't know if such a place does exist in their communities. Most of the respondents (23.7%, [97]) reported that unavailability of cancer services was the main challenge while 9.3%, [38] cited the high cost of services as a barrier in accessing cancer related services. The health service providers are also facing number of challenges in trying to offer cancer services which include shortage of staff, screening equipment and knowledge gaps.

3.5. HIV and AIDS Practices and Access to Services

The baseline survey concluded that HIV and AIDS practices are more positive than cancer practices and that HIV and AIDS services are readily available as compared cancer services. A remarkably significant proportion (69.9%) of the respondents had visited a health facility or any other place to discuss HIV and AIDS issues as compared to only 8% who reported ever visiting a health facility or any other place to discuss cancer issues. More respondents (61.9%) indicated that they had ever discussed HIV and AIDS issues with a partner/spouse as compared to only 27% who reported ever discussing cancer issues with a partner/spouse. Most of the respondents (63.2%) were tested for HIV in the previous twelve months. Nine in every ten (89.8%) of those who were tested for HIV were aware of their HIV status.

4 BASELINE SURVEY RECOMMENDATIONS

Category	Recommendations
Overall	<p><i>i.</i> Investments should be made towards mainstreaming integrated cancer and HIV and AIDS services in all health structures and existing programmes such PMTCT, Male Circumcision, and Demand Generation;</p> <p><i>ii.</i> Develop clear, context informed strategies to encourage male participation in the female cancer programmes since men also play a part in perpetuating some of the commonly reported risk factors of female;</p> <p><i>iii.</i> Design specific strategies to target and reach women and men belonging to the Apostolic sect which constitutes the majority of the population within the district. Strategies should be sensitive to their value systems while also ensuring women prioritize early detection and treatment of cancer.</p>
Cancer Knowledge Levels, Attitudes and practices on cancers	<p><i>iv.</i> Conduct community awareness and education on cancers. Sustainable approaches of cancer information dissemination should be contextually devised for the correct cancer information to be disseminated. Lessons learned can be drawn from other programmes like VMMC and PMTCT;</p> <p><i>v.</i> Prioritize messages that reinforce the need to avoid common risk practices such as multiple and concurrent sexual partnerships and insertion of herbs in the vagina for sexual pleasure and for enlarging the birth canal, for pregnant women. More research needs to be carried on the gynaecological effects of insertion of herbs and its relationship with cervical cancer.</p>
Availability and cost of cancer services	<p><i>vi.</i> Invest in programmes that ensure women receive free cancer screening services within their communities;</p> <p><i>vii.</i> There is need to prioritize support towards capacitating District Health staff to offer cancer services as well as to provide adequate information;</p> <p><i>viii.</i> Prioritize lobbying Government for provision of equipment that allows Health facilities to provide Cancer services locally.</p>
Long referral chain (resulting in lost to follow-up)	<p><i>ix.</i> Explore possibilities of providing treatment services after screening since the referral chain is longer and cancer treatment is currently being provided in the main cities (Harare and Bulawayo only);</p> <p><i>x.</i> Facilitate transportation of biopsies and their examination in the capital (Harare- Parirenyatwa) and bring back the results to the district hospital to reduce transport cost. This will ultimately reduce lost to follow-up clients.</p>

5. ANNEXES

5.1 References

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Baseline Survey Data Collection Tools



Baseline Survey for the Mudzi District Ward Based Cervical Cancer Screening and Education Project Household Survey Data Collection Tool

Introduction

Cancer Association of Zimbabwe, with support from the Bristol Myers Squibb Foundation (BMSF) Secure The Future Technical Assistance Programme, is implementing an 12 months Mobile Cancer Screening and Education Project in Zimbabwe's Mudzi District. The project is meant to educate the Mudzi community especially sexually active women and men about risk factors and preventive measures of cancer; screen women of cancer, treat precancerous lesions and facilitate treatment of identified cases; and provide psychosocial support and referral channels to rural women diagnosed of cancer.

VeCancer Association of Zimbabwe, nerubatsiro rwunobva kuBristol Myres Squibb Foundation vari kuparura chironywa chemwedzi gumi nemiviri chekuongororwa kwegomarara nedzidziso muMudzi District. Chironywa ichi chakananga kudzidzisa vagari veMudzi kunyanya madzimai achiri kubara nevarume nezvenjodzi uye kudzivirirwa kwegomarara, kuongorora madzimai gomarara, kurapa richangotanga uye kubatsira kurapwa kweriya ratobuda, pamwe chete nekupa rutsigiro kune vayanonetseka nepfungwa nekuda kweizvi uye kuzivisa nzvimbo dzingawanikwa rubatsiro kune vanegomarara.

This Baseline Survey sets the project baseline and informs project implementation strategies. As a member of this community, you have been randomly selected to provide your objective responses regarding knowledge, attitudes, behaviors and practices on cancer. The interview comprises a series of questions and should take 30 minutes to complete. Your participation in this Baseline Survey is entirely voluntary.

Tsvakurudzo ino ichataridza mamiriro enharaunda parizvino uye ichabatsira pakuparurwa kwechironywa. Semugari wenharaunda ino, masarudzwa zvisina tsvete kuti mutipewo humbowo hwenyu zvisina kugombedzerwa maringe neruzivo, mafungiro, maitiro uye tsika zvinoenderana negomarara remuromo wechibereko uye mazamu. Nhaurirano ino ine mibvunzo yakarongwa yamuchabvunzwa ingangotora maminiti makumi matatu. Zviri kwamuri kutenda kana kuramba kuva mutsvakurudzo ino.

Do you want to participate in this interview Yes No If "No" proceed to the next household.

Mungada here kuva mutsvakurudzo ino?

Name of Interviewer: _____

Household Number: _____

Ward: _____

Starting Time: _____ **Ending Time:** _____ **Total Time** _____

Section A: Demographic Information

No.	Question	Response Options	Circle Response(s)	Skip Instruction
1.	Age of Respondent (<i>Mune makore mangani?</i>)	(a) 15-19 years (b) 20-24 years (c) 25-29 years (d) 30-34 years (e) 35-39 years (f) 40-44 years (g) 45-49 years	1 2 3 4 5 6 7	
2.	Marital Status (<i>Makaroorwa here?</i>)	(a) Married/Cohabiting (b) Never Married (c) Divorced/Separated (d) Widowed	1 2 3 4	
3.	How many children have you delivered up to date? (<i>Makabatsirwa vana vangani kusvika parizvino?</i>)	_____		
4.	Highest level of education attained (<i>Circle only one</i>) (<i>Makadzidza kusvika papi?</i>)	(a) None (b) Adult literacy (c) Primary (d) Ordinary Level (e) Diploma (f) Degree and above (g) Don't Know	1 2 3 4 5 6 7	
5.	What is the employment status of the Respondent? (<i>Munoshanda here?</i>)	(a) Formally employed (b) Informally employed (c) Student (d) Not employed	1 2 3 4	
6.	What is the Religion of the Respondent? (<i>Munotenda kuchitendero chipi?</i>)	(a) Apostolic Sect (b) Pentecostal (c) Roman Catholic (d) Traditional (e) Muslim (f) Protestant (g) Jehovah's Witness (h) None	1 2 3 4 5 6 7 8	

		(i) Other, (<i>Specify</i>) _____	9	
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Section B: Cervical and Breast Cancer Knowledge

7.	Have you ever heard about cancer? (<i>Makambonzwa nezvechirwere chegomarara here?</i>)	(a) Yes (b) No	1 2	<i>Go to Q8</i> <i>Go to Section G</i>
8.	Which types of cancers do you know? (<i>Ndedzipi mhando/ndudzi dzegomarara dzamunoziva?</i>) (MULTIPLE RESPONSES)	(a) Breast Cancer (b) Cervical Cancer (c) Bladder Cancer (d) Kaposi sarcoma (e) Colon and Rectal Cancer (f) Endometrial Cancer (Uterus lining) (g) Kidney (Renal Cell) Cancer (h) Leukaemia (White Blood Cells) (i) Lung Cancer (j) Melanoma/Skin Cancer (k) Non-Hodgkin Lymphoma (Brain) (l) Pancreatic Cancer (m) Prostate Cancer (n) Thyroid Cancer (o) Other (specify)_____	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15	<i>Go to Q9</i> <i>Go to Q16</i> <i>If Respondent does not mention Breast and Cervical Cancer Go To Section E</i>

NB: If Respondent does not mention Breast and Cervical Cancer Go To Section E

BREAST CANCER KNOWLEDGE				
Now I am going to ask you questions regarding your knowledge on breast cancer (<i>Ikozvino ndava kukubvunzai mibvunzo ine chekuita neruzivo rwenyu maererano negomarara remazamu</i>)				
<i>ONLY ASK RESPONDENTS WHO KNOW ABOUT BREAST CANCER FROM Q8 ABOVE</i>				
No.	Question	Response Option	Circle Response(s)	Skip Instruction
9.	Where did you hear about breast cancer? (<i>Makanzwepi zvegomarara remazamu? Domai Kwese kwamakazvinzwira.</i>) (MULTIPLE RESPONSES)	(a) Media (TV, Radio, Newspapers) (b) Brochures, posters and other printed materials (IEC Material) (c) Health workers (d) Family member (e) Friends (f) Religious leaders (g) Teachers/School (h) Community Gatherings/Campaigns (i) Community Member (j) Other (please specify)_____	1 2 3 4 5 6 7 8 9 10	
10.	In the last 6 months can you remember seeing or hearing	(a) Yes (b) No	1 2	

	anything about breast cancer? (<i>Mumwedzi mitanhatu yapfuura, munorangarira here muchinzwa kana kuona chimwe chine chekuita negomarara remazamu?</i>)	(c) Do not remember	3	
11.	Which symptoms of breast cancer do you know? (<i>Ndezvipi zviratidzo zvegomarara remazamu zvamunoziva?</i>) (MULTIPLE RESPONSES)	(a) A lump or thickening in or near the breast or in the underarm that persists through the menstrual cycle (b) A mass or lump, which may feel as small as a pea (c) A change in the size, shape, or contour of the breast (d) A blood-stained or clear fluid discharge from the nipple (e) Redness of the skin on the breast or nipple (f) Other (specify) _____ (g) Do not know	1 2 3 4 5 6 7	
12.	What are the risk factors/causes for breast cancer? (<i>Ndezvipi zvamunoziva zvinokonzera gomarara remazamu?</i>) (MULTIPLE RESPONSES)	(a) Family history (b) Multiporus (5 or more births) (c) Age progression (d) Alcohol abuse (e) Lack of physical activity (exercise) (f) Overweight/Obesity (g) Diet (h) Tobacco (i) Environmental factors (j) Other (Specify) _____ (k) Do not know	1 2 3 4 5 6 7 8 9 10 11	
13.	How can a woman prevent getting breast cancer? (<i>Mudzimai angadzivirira sei kuti asabata gomarara remazamu?</i>) (MULTIPLE RESPONSES)	(a) Breast cancer screening (Self breast examination or mammogram) (b) Avoid exposure to environmental carcinogens (c) Reduce alcohol intake (d) Quit smoking (e) Exercising regularly (f) Balanced diet (g) Other (Specify) _____ (h) Do not know	1 2 3 4 5 6 7 8	
14.	How can breast cancer be detected? (<i>Zvingaonekwa sei kuti munhu ava negomarara</i>)	(a) Breast Self Examination (b) Clinical Breast Examination (c) Mammography	1 2 3	

	<i>remazamu?</i>	(d) Ultrasound scan of the breast (e) Other (Specify)_____	4 5 6	
15.	How can breast cancer be treated? (<i>Gomarara remazamu ringarapwa sei?</i>) (MULTIPLE RESPONSES)	(a) Herbal remedies (b) Surgery (c) Chemotherapy (d) Radiotherapy (e) Immuno Therapy/Biological (f) Faith Healing (g) Other (Specify)_____	1 2 3 4 5 6 7 8	
CERVICAL CANCER KNOWLEDGE				

Now I am going to ask you questions regarding your knowledge on cervical cancer

(*Ikozvino ndava kukubvunzai mibvunzo ine chekuita neruzivo rwenyu maererano negomarara remuromo wechibereko*)

ONLY ASK RESPONDENTS WHO KNOW ABOUT CERVICAL CANCER FROM Q8 ABOVE

No.	Question	Response Option	Circle Response(s)	Skip Instruction
16.	Where did you first hear about cervical cancer? (<i>Ndekupi kwamakatanga kunzwa nezvegomarara remuromo wechibereko?</i>) (MULTIPLE RESPONSES)	(a) Media (TV, Radio, Newspapers) (b) Brochures, posters and other printed materials (IEC Material) (c) Health workers (d) Family member (e) Friends (f) Religious leaders (g) Teachers/School (h) Community Gatherings/Campaigns (i) Community Member (j) Other (please specify)_____	1 2 3 4 5 6 7 8 9 10	
17.	In the last 6 months do you remember seeing or hearing anything about cervical cancer? (<i>Mumwedzi mitanhatu yapfuura munorangarira here muchiona kana kunzwa nezvegomarara remuromo wechibereko?</i>)	(a) Yes (b) No (c) Don't remember	1 2 3	
18.	Have you ever heard of the link between cervical cancer and HIV? (<i>Makambonzawo here nezvekudyidzana kwegomarara</i>)	(a) Yes (b) No (c) Not sure	1 2 3	Go to Q19 Go to Q20 Go to Q20

	<i>remuromo wechibereko neHIV?)</i>			
19.	What do you know regarding the link of cervical cancer and HIV and AIDS? (<i>Ndezvipi zvamunoziva maererano nekudyidzana kwegomarara remuromo wechibereko neHIV?)</i> (MULTIPLE RESPONSES)	(a) HIV infected women are at risk of HPV infection (which causes cervical cancer) (b) HIV prevention efforts reduce incidences of cancers (c) Other (Specify)_____ (d) Don't remember	1 2 3 4	
20.	Which symptoms of cervical cancer do you know? (<i>Ndezvipi zviratidzo zvegomarara remuromo wechibereko zvamunoziva?)</i> (MULTIPLE RESPONSES)	(a) Vaginal bleeding (b) Vaginal foul smelling discharges (c) Back ache (d) Pain during and after sexual intercourse (e) Other (Specify)_____ (f) Do not know	1 2 3 4 5 6	
21.	What are the risk factors for cervical cancer? (<i>Ndezvipi zvamunoziva zvinowedzera mukana wekuita gomarara remuromo wechibereko?)</i> (MULTIPLE RESPONSES)	(a) Having multiple sexual partners (b) Early onset of sexual activity (c) STIs (e.g. HPV virus) (d) Tobacco use (e) Insertion of herbs (f) Dry sex (g) Other (Specify)_____ (h) Do not know	1 2 3 4 5 6 7 8	
22.	How can a person prevent developing cervical cancer? (<i>Munhu angadzivirira sei kubata gomarara remuromo wechibereko?)</i> (MULTIPLE RESPONSES)	(a) Early treatment of STIs (b) Avoid multiple sexual partners (c) Avoid early sexual intercourse (d) Quit Tobacco use (e) Through vaccination of HPV vaccine (f) Practice safe sex (g) Avoid insertion of herbs/dry sex (h) Encourage Partner to go for Male Circumcision (i) Regular Screening (j) Other (Specify)_____ (k) Do not know	1 2 3 4 5 6 7 8 9 10 11	
23.	How can someone with cervical cancer be treated? (<i>Munhu ane gomarara remuromo wechibereko angarapwa sei?)</i> (MULTIPLE RESPONSES)	(a) Herbal remedies (b) Surgery (c) Chemotherapy (d) Radiotherapy (e) Immuno therapy/Biological (f) Faith healing (g) Do not know	1 2 3 4 5 6 7	

	(h) Other (Specify) _____	8	
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Section C: Attitudes on Breast and Cervical Cancer

No.	Question	Response Option	Circle Response(s)	Skip Instruction
24.	Any adult woman including me can develop breast or cervical cancer (<i>Mudzimai wese akura kusanganisira ini anokwanisa kubatwa negomarara remazamu kana muromo wechibereko.</i>)	(a) strongly agree (b) agree (c) neither agree nor disagree (d) disagree (e) strongly disagree	1 2 3 4 5	
25.	Cervical cancer is a disease for prostitutes (<i>Gomarara remuromo wechibereko chirwere chepfambi</i>)	(a) strongly agree (b) agree (c) neither agree nor disagree (d) disagree (e) strongly disagree	1 2 3 4 5	
26.	Breast and cervical cancer are diseases for the elderly women (<i>Gomarara remazamu kana muromo wechibereko zvirwere zvemadzimai achembera</i>)	(a) strongly agree (b) agree (c) neither agree nor disagree (d) disagree (e) strongly disagree	1 2 3 4 5	
27.	I would rather not know if I had breast or cervical cancer (<i>Ndingada kusaziva hangu kuti ndine gomarara remuromo wechibereko kana mazamu</i>)	(a) strongly agree (b) agree (c) neither agree nor disagree (d) disagree (e) strongly disagree	1 2 3 4 5	
28.	Getting breast and cervical cancer is a death sentence. There is not much that can be done when someone has breast or cervical cancer (<i>Kubatwa negomarara remazamu kana muromo wechibereko kutongerwa rufu chaiko. Hapana zvizhinji zvingaitwe kana munhu abatwa nezvirwere izvi</i>)	(a) strongly agree (b) agree (c) neither agree nor disagree (d) disagree (e) strongly disagree	1 2 3 4 5	
29.	Talking to family/friends about symptoms of breast or cervical cancers is embarrassing. (<i>Kutura nehama kana shamwari nezve zviratidzo zvegomarara remuromo wechibereko kana mazamu chinhu chinonyadzisa</i>)	(a) strongly agree (b) agree (c) neither agree nor disagree (d) disagree (e) strongly disagree	1 2 3 4 5	

Section D: Cervical Cancer and Breast Cancer Practices

No.	Question	Response Option	Circle Response(s)	Skip Instruction
30.	Have you ever had a cervical cancer screening performed on you? (<i>Mati mamboongororwa here zvegomarara remuromo wechibereko?</i>)	(a) Yes (b) No	1 2	Go to Q31 Go to Q32
31.	If Yes, When was the last time that you had a screening exercise? (<i>Ndiriini pamakapedzisira kuitwa wongororo iyi?</i>)	(a) In the last 12 months (b) In the last 18 months (c) In the last 2 years (d) More than 2 years ago	1 2 3 4	
32.	Have you ever had breast self-examination? (<i>Mati mambozvingorora mazamu enyu here?</i>)	(a) Yes (b) No	1 2	Go to Q33 Go to Q34
33.	When was the last time that you performed breast self-examination? (<i>Ndiriini pamakapedzisira kuzvingorora mazamu enyu ?</i>)	(a) In the last month (b) In the last 2 months (c) In the last 3 months (d) More than 3 months ago	1 2 3 4	
34.	Have you ever talked with anybody about breast cancer? (<i>Pane wamakambotaura naye here nezvegomarara remazamu?</i>)	(a) Yes (b) No (c) Do not remember	1 2 3	
35.	Have you ever talked with anybody about cervical cancer? (<i>Pane wamakambotaura naye here nezvegomarara remuromo wechibereko?</i>)	(a) Yes (b) No (c) Do not remember	1 2 3	

Section E: General Cancer Practices

36.	Have you ever visited a health facility or other place to get cancer related services during the last year? (<i>Mati mamboshanyira chipatara here kana imwe nzvimbo kuti muwane rubatsiro kana ruzivo maererano negomarara?</i>)	(a) Yes (b) No	1 2	
37.	Did you ever discuss cancer issues with your partner or spouse in the last three months? (<i>Mati mambotaura here nezvegomarara nemudiwa kana murume wenyu?</i>)	(a) Yes (b) No (c) Do not remember (d) Not Applicable	1 2 3 4	

Section F: Availability of Cancers Related Services

No.	Question	Response Option	Circle Response(s)	Skip Instruction
38.	Is there a place in your community where people like you are able to visit to talk and find out about cancer issues? (<i>Pane nzvimbo here munharaunda muno apo vanhu vakaita semi vanoenda kunokurukura kana kunotsvaka ruzivo maererano nenyaya dzegomarara?</i>)	(a) Yes (b) No (c) Don't Know	1 2 3	Go To 39 Go To 41 Go To 41
39.	What kind of a place is this? (<i>Inzvimbo yakaita sei iyoyi?</i>)	(a) Clinic (b) Hospital (c) Church (d) School (e) Household/Family (f) Support Group (g) Community gatherings/campaigns (h) Workplace (i) Other (Specify) _____	1 2 3 4 5 6 7 8 9	
40.	Which cancer services (including referrals) are provided in this community/ward/district? (<i>Nderwupi rubatsiro maererano nechirwere chegomarara rwunowanikwa munharaunda, ward kana district rino?</i>)	(a) Education and counselling regarding Cancers (b) Cancer Screening (c) Cancer treatment (d) Cancer Referrals (e) No response (f) Do not know	1 2 3 4 5 6 7	
41.	What are the challenges/barriers for accessing cancer related services in this community? (<i>Ndeapi matambudziko amunosangana nawo mukuedza kutsvaka rubatsiro rwakarerekerwa kunyaya dzegomarara munharaunda muno?</i>) (MULTIPLE RESPONSES)	(a) Unavailability of services (b) Cost of services (very high) (c) Transport to service points (d) Gender imbalances (e) Myths and misconceptions behind (f) Stigma and discrimination at community level (g) None (h) Other (specify) _____ (i) Do not know	1 2 3 4 5 6 7 8 9	

Section G: HIV and AIDS Practices and Access to Services

42.	Have you ever visited a health facility or other place to get HIV related services during the last year? (<i>Mati mamboshanyira chipatara here kana imwe nzvimbo kuti muwane rubatsiro kana ruzivo maererano neHIV?</i>)	(a) Yes (b) No	1 2	
43.	Did you ever discuss HIV issues with your partner or spouse in the last three months? (<i>Mati mambotaura here nezveHIV nemudiwa kana murume wenyu?</i>)	(a) Yes (b) No (c) Do not remember (d) Not Applicable	1 2 3 4	
44.	Were you tested for HIV in the past 12 months (<i>Mumwedzi gumi nemiviri yapfuura makamboongororwa HIV here?</i>)	(a) Yes (b) No	1 2	<i>Go to Q45</i> <i>Go to Q46</i>
45.	If “Yes, do you know your HIV status (<i>Munoziva pamumire maererano neHIV here?</i>)	(a) Yes (b) No	1 2	
46.	What are the challenges faced in accessing HIV related services in this community? (<i>Ndeapi matambudziko amunosangana nawo mukuedza kuwana rubatsiro rwakarerekera kunyaya dzeHIV munharaunda muno?</i>)	(a) Unavailability of services (b) Cost of services (very high) (c) Transport to service points (d) Gender imbalances (e) Myths and misconceptions behind (f) Stigma and discrimination at community level (g) None (h) Other (specify) _____ (i) Do not know	1 2 3 4 5 6 7 8 9	

End of Questionnaire

Thank you for the invaluable time and input
Bristol-Myers Squibb Foundation

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Baseline Survey for the

Mudzi District Ward Based Cervical Cancer Screening and Education Project Health Providers-Facility Assessment Key Informant Tool

Introduction

Cancer Association of Zimbabwe, with support from the Bristol Myers Squibb Foundation (BMSF) Secure The Future Technical Assistance Programme, is implementing an 12 months Mobile Cervical and Breast Cancer Screening and Education Project in Zimbabwe's Mudzi District. The project is meant to educate the Mudzi community especially sexually active women and men about risk factors and preventive measures of cervical and breast cancer; screen women of cervical cancer, treat precancerous lesions and facilitate treatment of identified cases; and provide psychosocial support and referral channels to rural women diagnosed of cancer.

As key stakeholders in the provision of health services in this community, you have been selected to provide objective responses regarding your human resource and institutional to provide cervical and breast cancer services to the community. This interview takes between 20 and 30 minutes to complete.

Name of Interviewer: _____

Name of Respondent: _____

Position of Respondent: _____

Cellphone Number of Respondent: _____

Ward _____

Name of Health Facility: _____

Starting Time: _____ **Ending Time:** _____ **Total Time** _____

1. Are there breast and cervical cancer services in this community? *(if “Yes”, probe for the type of services provided including referrals)*

2. Is there adequate human resource capacity with skills to provide breast and cervical cancer services in this community?*(Probe for number of staff, and available related skills and unavailable skills)*

3. Are there adequate facilities/equipment to provide breast and cervical cancer services in this community? *(Probe on what type of equipment is available or unavailable)*

4. What are the key human resource capacity gaps in providing breast and cervical cancer services in this community?

5. What are the key equipment gaps in providing breast and cervical cancer services in this community?

6. What challenges do you face in providing breast and cervical cancer services in this community?

7. What challenges does this community face in accessing breast cancer and cervical cancer services?

8. What recommendations do you have for programs that seek to improve access to breast and cervical cancer services (i.e. knowledge, prevention, screening, treatment and referrals) in this community? *(Probe for strategies and activities)*

End of the Key Informant Assessment Tool
Thank you for the invaluable time and input





Baseline Survey for the

Mudzi District Ward Based Cervical Cancer Screening and Education Project District and Community Stakeholders Key Informant Tool

Introduction

Cancer Association of Zimbabwe, with support from the Bristol Myers Squibb Foundation (BMSF) Secure The Future Technical Assistance Programme, is implementing an 12 months Mobile Cervical and Breast Cancer Screening and Education Project in Zimbabwe's Mudzi District. The project is meant to educate the Mudzi community especially sexually active women and men about risk factors and preventive measures of cervical and breast cancer; screen women of cervical cancer, treat precancerous lesions and facilitate treatment of identified cases; and provide psychosocial support and referral channels to rural women diagnosed of cancer.

VeCancer Association of Zimbabwe, nerubatsiro rwunobva kuBristol Myres Squibb Foundation vari kuparura chironywa chemwedzi gumi nemiviri chekuongororwa kwegomarara rechibereko uye mazamu nedzidziso muMudzi District. Chironywa ichi chakananga kudzidzisa vagari veMudzi kunyanya madzimai achiri kubara nevarume nezvenjodzi uye kudzivirirwa kwegomarara rechibereko uye mazamu, kuongorora madzimai gomarara rechibereko, kurapa richangotanga uye kubatsira kurapwa kweriya ratobuda, pamwe chete nekupa rutsigiro kune vayanonetseka nepfungwa nekuda kweizvi uye kuzivisa nzvimbo dzingawanikwa rubatsiro kune vanegomarara.

As key stakeholders in this community, you have been selected to provide objective responses regarding your human resource and institutional to provide cervical and breast cancer services to the community. This interview takes between 20 and 30 minutes to complete.

Sevakuru venharaunda ino, masarudzwa kuti mutipewo humbowo hwenyu maringe nemamiriro enhau dzegomarara rechibereko uye mazamu. Nhairirano ino ingangotora maminitisi makumi maviri kana matatu.

Name of Interviewer: _____

Name of Respondent: _____

Position of Respondent: _____

Cell phone Number of Respondent: _____

Ward _____

Starting Time: _____ Ending Time: _____ Total Time _____

1. In your view, is this community (or District) aware of cancer issues? (*probe on specific issues*)

(Sekuona kwenyu nyaya dzegomarara dzinozivikanwa here munharaunda muno?)

2. What are the knowledge levels on breast and cervical cancer in this community?

(Ruzivo maererano negomarara remazamu uye rechibereko rwakamira sei munharaunda ino?)

3. Are there any practices that increase the risk of breast and cervical cancer in this community? (*Probe for specific practices*)

(Pane tsika here dzinoitwa munharaunda muno dzinowedzera njodzi yekuti vanhu vabatwe negomarara remazamu kana rechibereko?)

4. What breast and cervical awareness, prevention, screening, referrals and treatment services are available in this community?(*Probe on the types of services and respective service providers*)

(Pane rubatsiro here rwunoenderana neruzivo, kudzivirirwa, kuongororwa kana kurapwa kwegomarara remazamu kana chibereko rwunowanikwa munharaunda ino?)

5. What challenges are faced by the community in accessing breast and cervical cancer services?

(Ndeapi matambudziko anosanganikwa nawo munharaunda ino pakuwana rubatsiro panyaya dzegomarara remazamu uye rechibereko?)

6. What recommendations do you have for programs that seek to improve access to breast and cervical cancer services (i.e. knowledge, prevention, screening, treatment and referrals)in this community?(*Probe for strategies and activities*)

(Ndedzipi kurudziro dzamungava nadzo kana zvamungashuvira kuona zvichiitwa muzvirongwa zvinotsvaga kuvandudza nekuunza rubatsiro rwunoenderana negomarara remazamu kana rechibereko munharaunda ino? Izvingava zvinoenderana neruzivo, kudzivirirwa, kuongororwa uye kurapwa kwegomarara?)

End of the Key Informant Tool
Thank you for the invaluable time and input
Bristol-Myers Squibb Foundation

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Baseline Survey for the

Mudzi District Ward Based Cervical Cancer Screening and Education Project
Focus Group Discussion (FGD) Tool

Introduction

Cancer Association of Zimbabwe, with support from the Bristol Myers Squibb Foundation (BMSF) Secure The Future Technical Assistance Programme, is implementing an 12months Mobile Cervical and Breast Cancer Screening and Education Project in Zimbabwe's Mudzi District. The project is meant to educate the Mudzi community especially sexually active women and men about risk factors and preventive measures of cervical and breast cancer; screen women of cervical cancer, treat precancerous lesions and facilitate treatment of identified cases; and provide psychosocial support and referral channels to rural women diagnosed of cancer.

VeCancer Association of Zimbabwe, nerubatsiro rwunobva kuBristol Myres Squibb Foundation vari kuparura chironywa chemwedzi gumi nemiviri chekuongororwa kwegomarara rechibereko uye mazamu nedzidziso muMudzi District. Chironywa ichi chakananga kudzidzisa vagary veMudzi kunyanya madzimai achiri kubara nevarume nezvenjodzi uye kudzivirirwa kwegomarara rechibereko uye mazamu, kuongorora madzimai gomarara rechibereko, kurapa richangotanga uye kubatsira kurapwa kwerya ratobuda, pamwe chete nekupa rutsigiro kune vayanonetseka nepfungwa nekuda kweizvi uye kuzivisa nzvimbo dzingawanikwa rubatsiro kune vanegomarara.

As members of this community, you have been randomly selected to provide objective responses regarding your knowledge, attitudes, behaviors and practices on cervical and breast cancer. This

Focus Group Discussion takes 45 minutes to complete. Your participation in this Baseline Survey is entirely voluntary.

Sevagari wenharaunda ino, masarudzwa zvisina tsvete kuti mutipewo humbowo hwenyu zvisina kugombedzerwa maringe neruzivo, mafungiro, maitiro uye tsika zvinoenderana negomarara rechibereko uye mazamu. Nhaurirano ino ine mibvunzo ingangotora maminitsi makumi mana nemashanu. Zviri kwamuri kutenda kana kuramba kuva mutsvakurudzo ino.

Name of Facilitator: _____

Name of Note taker: _____

Type of FGD Participants: Community Members OR Health Committee

Number of Participants _____ Male ____ Females _____

Ward: _____

Starting Time: _____ **Ending Time:** _____ **Total Time** _____

1. Have you ever heard of Cancer (Y/N)? If “Yes”, what do you know about cancer? (*Mati mambonzwa nezvegomarara here? Ndezvipi zvamunoziva maererano negomarara?*)

2. In your view, what causes breast cancer? (*Sekuona kwenyu, ndezvipi zvinokonzera gomarara remazamu?*)

3. In your view, what causes cervical cancer? (*Sekuona kwenyu, ndezvipi zvinokonzera gomarara rechibereko?*)

4. Are there any specific women (age, marital status, number of sexual partners etc) who have a higher risk of getting cancer? (Y/N) (*Probe for the specific women and reasons*) (*Pane mazera here emadzimai amungati aya ari panjodzi huru yekubatwa negomarara? Imhando ipi yemadzimai yamunoti iri panjodzi yekubatwa negomarara?*)

5. How do you prevent breast cancer? (*Munhu angadzivirira sei kubatwa negomarara remazamu?*)

6. How do you prevent cervical cancer? (*Munhu angadzivirira sei kubatwa negomarara rechibereko?*)

7. What are the symptoms of breast cancer? (*Ndezvipi zviratidzo zvegomarara remazamu zvamunoziva?*)

8. What are the symptoms of cervical cancer? (*Ndezvipi zviratidzo zvegomarara rechibereko zvamunoziva?*)

9. Are there any practices that take place in this community that expose women to breast and or cervical cancers? (*Probe for the specific practices*) (*Pane here tsika kana zvinoitwa nemadzimai munharaunda muno zvinovaisa panjodzi yekubatwa negomarara remazamu kana rechibereko? Ndedzipi tsika idzi?*)

10. Does this community have access to any breast cancer or cervical cancer services? (*Probe for types of services accessed (including referrals) and service provider(s)*) (*Nharaunda ino ine mukana here wekuwana rubatsiro rwunoenderana negomarara remazamu kana rechibereko? Nderwupi rwubatsiro rwunowanikwa?*)

11. If someone in this community had cancer, where would they go to get treatment? (*Probe for nearest public or private, traditional or any other provider they would get services from*) (*Kana munhu akabatwa nechirwere chegomarara munharaunda muno angaindepi kunorapwa?*)

12. What challenges does this community face in accessing breast cancer and cervical cancer services? (*Ndeapi matambudziko anosanganikwa nawo munharaunda ino panyaya dzekuwana rubatsiro rwunoenderana negomarara remazamu kana rechibereko?*)

13. What services would like to see being offered about any cancer in this community? (*Probe for information, treatment and support*) (*Nderwupi rubatsiro rwamungada kuona rwuchipihwa kunharaunda ino rwunoenderana negomarara?*)

End of the FGD Tool

Thank you for the invaluable time and input

Demographic Information

Date:		Ward:	Time:
Participant No.	Gender (Female-F, Male-M)	Age (Years)	Level of Education (0-None, 1-Primary, 2- Secondary, 3- Tertiary/Graduate)
1			
2			
3			
4			
5			

6			
7			
8			
9			
10			
11			
12			
13			
14			
15			