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Motivations and experiences of women who accessed ‘see and treat’ cervical cancer prevention services in Zambia

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Abstract

Background—In Zambia, a country with a generalized HIV epidemic, age-adjusted cervical cancer incidence is among the highest worldwide. In 2006, the UAB-Center for Infectious Disease Research in Zambia and the Zambian Ministry of Health launched a visual inspection with acetic acid (VIA)-based “see and treat” cervical cancer prevention program in Lusaka. All services were integrated within existing government-operated primary health care facilities.

Objective—Study aims were to: 1) identify women's motivations for cervical screening; 2) document women's experiences with screening; and 3) describe the potentially reciprocal influences between women undergoing cervical screening and their social networks.

Design & Methods—Focus group discussions (FGD) and in-depth interviews (IDI) were conducted with women who accepted screening and with care providers. Low-level content analysis was performed to identify themes evoked by participants. Between September, 2009 and July, 2010, 60 women and 21 care providers participated in 8 FGD and 10 IDI.

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DECLARATION OF INTEREST

None of the authors report any conflict of interest.

Results—Women presented for screening with varying needs and expectations. A majority discussed their screening decisions and experiences with members of their social networks. Key reinforcing factors and obstacles to VIA screening were identified.

Conclusions—Interventions are needed to gain support for the screening process from influential family members and peers.

Keywords

Zambia; cervical cancer; mass screening; HIV/AIDS; access to care; experience with care; social network

INTRODUCTION

Invasive cervical cancer (ICC) is the leading cause of cancer-related morbidity and mortality among women in developing countries¹. A growing body of evidence has demonstrated that women can be effectively screened and clinically managed for precancerous lesions of the cervix using direct visualization techniques or human papillomavirus (HPV) DNA testing, coupled with immediate treatment using cryotherapy²⁻⁶.

The need for effective cervical cancer screening programs is especially urgent in global regions impacted by high female HIV infection rates such as sub-Saharan Africa. Compared to HIV-uninfected women, HIV-infected women (on HAART or not) are at higher risk for chronic infection with oncogenic strains of HPV, for development of cervical intraepithelial neoplasia (CIN), and for persistence and recurrence of CIN post-treatment⁷⁻⁹. As a result, once-in-a-lifetime screening strategies are unlikely to substantially reduce ICC risk in HIV-infected women¹⁰. This poses a unique challenge for program developers in Africa, because it implies that post-treatment follow-up visits and repeated screening are needed to effectively prevent ICC in HIV-infected women^{11, 12}.

In Zambia, HIV prevalence among women 15-49 years is 16.1% nationally and 23.1% in the capital of Lusaka;¹³.disproportionately high rates of HPV and CIN have been reported among HIV-infected women;^{14, 15} and age-adjusted ICC incidence rate is 52.8 per 100,000 women¹. In response, a visual inspection with acetic acid (VIA)-based “see and treat” cervical cancer prevention program was established in 2006, integrating ICC prevention activities within existing primary health care facilities in Lusaka and, for HIV positive women, linking them with HIV treatment and prevention services¹⁶.

Most of the literature regarding women's perceptions of and experiences with cervical cancer screening, has focused on Papanicolaou (Pap) smear testing, Western settings, or both¹⁷. As other cervical screening modalities are becoming increasingly available to women in resource-poor settings, it is necessary to update our appreciation of the psychosocial factors that influence women's screening decisions. Exploratory, qualitative research allows for documentation of a wide range of representations, opinions, and preferences considered by women who choose to undergo cervical screening. In studies conducted among African populations to date, women conveyed limited understanding or appreciation of disease prevention through existing cervical screening programs or HPV

vaccine coverage¹⁸⁻²¹. This study employed a descriptive inquiry approach to: 1) identify screening motivations among women recently screened using VIA methodology; 2) document women's screening experiences; and 3) describe the potential influences of social networks on women's initial screening decisions and the potential reciprocal influences of women's screening experiences on future screening decisions made by members of their social network.

MATERIALS AND METHODS

Study design

A descriptive design was employed using qualitative research methods, focus group discussions (FGD) and in-depth interviews (IDI) to elicit detailed perceptions from women eligible for VIA screening and health care providers affiliated with the cervical screening program. Descriptive inquiry approaches seek to comprehensively depict a phenomenon of interest using the direct language of the participants, with low-level interpretation by the researchers²². This approach was well suited to provide insights on an under-studied health issue in a low-income African setting from the perspective of multiple stakeholders (nurses, peer educators, screen-eligible women).

Study setting

This study was conducted at a Zambian Ministry of Health primary health center in a densely populated settlement (Kanyama) located on the outskirts of Lusaka²³. Recruitment of women from a single clinic was primarily based on practical considerations, such as the availability of clinic rooms to conduct private discussions and interviews as well as provision of administrative rooms to accommodate our research team

Study sample

Women eligible for the study were local residents 18-49 years of age; able to undergo VIA cervical screening¹⁵; and conversant in either Bemba or Nyanja, the two languages most commonly spoken in the capital. All women who participated in FGD and IDI had recently undergone cervical screening. To obtain the opinions of health care personnel, separate FGD were held with screening nurses and peer educators from several Lusaka screening clinics. Due to the limited number of health care personnel at a single clinic, screening nurses and peer educators were invited from VIA screening clinics throughout Lusaka. This also provided an opportunity for the research team to assess consistency of findings amongst personnel from several clinics.

VIA screening procedures

A single nurse is responsible for daily clinical management of the cervical screening program. Volunteer, lay peer educators circulate daily throughout the clinic to provide educational talks and invite women for screening. Their messages emphasize that: cervical cancer has an early stage and a late stage; symptoms occur only during the late stage; it is best for women to be screened before they experience cancer-related symptoms; and ICC occurs mainly in women who have never been screened. Directly following this session, women are invited to direct any questions or concerns to the screening nurse who provides

detailed explanation of screening procedures. Once women provide verbal consent for screening, they are escorted to a private exam room and undergo VIA screening procedures according to international accepted standards²⁴. When immediate treatment by cryotherapy is contraindicated, women are referred to a gynecology clinic at a local tertiary care center for further evaluation and management²⁵.

Focus group discussion procedures

Ethics committees from the University of Alabama at Birmingham (UAB) and the University of Zambia (UNZA) reviewed and approved the research protocol. Women who met eligibility criteria were referred by the screening nurse to study team members who subsequently invited women to participate in the study. Women who agreed to take part in the FGD were instructed to return to the clinic and were given date/time reminder cards. Upon their return, women were given information about the study and asked to sign the informed consent indicating their willingness to participate. Women were grouped according to their stated language preference. A pair of FGD was conducted for each group of women (Bemba, Nyanja) in order to compare responses from the initial discussions using member checking techniques and to further investigate unclear or unresolved topics. Two FGD were held specifically with HIV positive women, also divided according to language preference.

Each discussion was led by an experienced Zambian female facilitator who asked a series of pre-scripted, open-ended questions, encouraged balanced group discussions, and probed respondents. An observer/recorder documented the general atmosphere, group dynamics, and individuals' non-verbal cues. Discussions were recorded on a digital recorder with participants' permission and were conducted in a private room at the clinic. Each FGD lasted approximately 1.5 hours.

In-depth interview procedures

Following the completion of FGD, the research team gathered to identify recurrent themes and compiled a prioritized list of topics to be explored through IDI. Interview questions were scripted into a semi-structured format and translated into local languages. All women who participated in the FGD were asked to consider participating in an interview. Women who agreed to an IDI were given an appointment reminder card to return for the interview. Upon her return, after obtaining written consent, each woman was escorted to a private room in the clinic along with an interview moderator and observer/recorder who conducted each of the interviews. Each interview lasted no more than 2 hours.

Data analysis

Qualitative content analysis was performed using English translations of verbatim transcripts as the primary dataset. For qualitative descriptive studies, qualitative content analysis is the method of choice²². Briefly, this is an iterative process whereby coding schema are generated from the data themselves, and the role of the researcher is to organize and summarize the informational contents of the data through formulation of categories, themes, and patterns²⁶. Three investigators (2 U.S.-based and 1 Zambian-based) independently coded and sorted the data using QSR Nvivo 8.0[®] software. The team then met (by phone and in person) to reach consensus on a final coding scheme of dominant

themes. A fourth U.S. investigator was used to adjudicate any disagreements amongst the research team as to the coding scheme. Internal consistency of findings was checked using within-method triangulation of FGD and IDI of three groups, e.g., screening nurses, peer educators, and women invited for screening.

RESULTS

Between September, 2009 and July, 2010, a total of 60 women (20 Bemba speakers, 20 Nyanja speakers, and 20 self-reported HIV+ women) participated in 6 FGD and 10 IDI. A total of 11 peer educators and 10 screening nurses participated in two separate FGD. Responses elicited from both groups indicate that women's reasons for screening were diverse and often prompted by peers and family members. Women clearly described the aspects of the screening process that they liked and disliked the most. These data also suggested that most women discuss their screening decisions and experiences with members of their social networks. Contrary to our preconceived idea, opinions of HIV-infected and HIV-uninfected women on the topics of interest were similar. This may reflect the fact that the HIV/AIDS epidemic has affected the life of every woman in Lusaka one way or another.

Initial motivation for screening

Women described four primary motivations for cervical screening: 1) to know their VIA status; 2) to facilitate or protect future pregnancy; 3) to utilize free reproductive services; and 4) to seek resolution of an existing health problem (Table 1).

Most women presented for screening to determine whether they had ICC or not. Many women confirmed that they were motivated by the fact that gynecological services were provided at no cost, stating that similar services were 'expensive elsewhere'. When asked, "Do you think a woman would come for [cervical] screening even if she feels fine?", our respondents held the opinion that generally women do not come to the clinic unless prompted by physical pain or illness.

Nurses stated that some women come solely for free STI treatment (women who are found with genital infections are provided with standard course of treatment at no charge and asked to return for screening following resolution of symptoms). A minority of women explained that people are sometimes 'suspicious' of free health services because such services often carry an attached stigma of being offered for 'Satanic reasons'.

Contributors to positive experience with the screening process

When asked, "What did you like most about the screening exam?", comfort and supportive attitudes of the screening staff were most commonly cited by respondents. Women described clinic staff as unusually 'caring' and 'hospitable', offering words of encouragement and taking time to explain procedures in detail. These statements were supported by direct observations from the research team.

In Lusaka, ICC is not considered to be a disease which women can discuss openly. Hence, confidential communication with staff was also highly valued amongst respondents. Nurses, in particular, were viewed as reliable confidantes with whom women could discuss problems

related to their 'private areas'. Respondents credited the support offered by staff members, both peer educators and nurses, as facilitating their screening experience, especially during painful or embarrassing parts of the exam (Table 2, Quotes 1-3).

Women positively described the experience and excitement of viewing images of their cervix on a screen, perceived to be both a technological novelty and an informative tool to enhance their understanding of clinical findings (Table 2, Quotes 4-6). Providers agreed that women were motivated by viewing pictures of their cervix; they also indicated, however, that in a few cases women found with extensive lesions were upset by the images. Several women also said they enjoyed the feeling of vinegar being applied to their cervix, describing this process as 'cleaning the mouth of the womb' (Table 2, Quote 9). Nurses confirmed that women reported that they enjoyed this aspect of the exam. One nurse offered an explanation: 'Maybe it even feels dry because vinegar is a bit acidic, so somehow it gives one a kind of sensation like constricting, so maybe [women] like that feeling'. Finally, women appreciated that the screening exam was performed quickly (Table 2, Quote 10). In other outpatient clinics women typically wait for several hours before being seen by clinic staff.

Directly following the exam, women commonly remarked that they were relieved to know their screening status. (Table 2, Quotes 7-8). However, while the majority of women associated positive feelings of relief with being told that they were free of cervical abnormalities, others expressed a sense of frustration because they had come seeking resolution of an ongoing health problem. This scenario is described by a nurse: "When you say she is negative she will still insist to say, 'What is this that I am feeling because I thought that when I come here I would be found with something.'" In this sense, cervical screening seemed to be viewed as a last resort for a minority of women with unresolved health concerns.

Contributors to negative experience with the screening process

When asked "Which aspects of the screening exam did you like the least?", respondents cited three categories of negative experiences: 1) having to undress for the exam; 2) fear of pain caused by the vaginal speculum, referred to as a *chishimbi* or 'steel rod'; and 3) belief that they could contract diseases, e.g., HIV, from the screening instruments.

Women objected to undressing both for cultural and pragmatic reasons. Zambian cultural norms do not permit women to be seen nude by anyone but her husband, unless during childbirth (Table 3, Quote 1). Nurses stated that women unaware of having to undress for screening refused on the grounds that they needed to bathe before doing so (Table 3, Quote 2).

The most commonly cited negative aspect of screening was women's fear of the vaginal speculum or "*chishimbi*". Women were afraid of the pain when the speculum was inserted during the pelvic exam, based on stories heard within the community (Table 3, Quotes 3 and 6). Following the exam, women often stated that the pain of the speculum described by other women in the community was grossly exaggerated: 'Some say that the *chishimbi* used in the exam pains. This is a lie'. Other reasons given for why women were afraid of the speculum were associated with a minority of women who believed the speculum was used to both

remove and re-insert the cervix after it had been cleaned by a nurse (Table 3, Quote 4). Finally, nurses stated that they were forced to spend considerable time explaining to women how instruments are sterilized daily.

The respondents offered additional concerns not directly related to the screening exam itself; these included a fear of testing for HIV and cancer-related stigma. (Table 3, Quotes 9-10). Women stated that ICC is perceived to be closely associated with HIV/AIDS in the community, so women were hesitant to present for cervical screening for fear of being tested for HIV (Table 3, Quote 9). Similarly, women did not want to be seen at a 'cancer clinic' because, as some suggested, '...people think when you come for screening then you are HIV positive'. Others believed that stigma would be directly related to cancer itself: 'when [others] just see you at the cancer clinic they start saying, 'we saw her at the cancer clinic' and they start stigmatizing you'. Finally, women perceived that the clinic was understaffed (Table 3, Quote 11). Each of these barriers was considered serious enough to discourage some women to attend screening.

Interpersonal communication regarding cervical cancer

We enquired about social norms regarding interpersonal communication on ICC. When asked, "Do women in your community feel comfortable discussing ICC?" respondents uniformly replied "no", because the disease occurs in 'private areas' of the body. The disease has, until recently, been extremely stigmatized in the general population: 'Before everybody was scared even when you have relatives who have cervical cancer, it was just like someone who has HIV.' When asked to whom, if anyone, a woman might confide if she felt that she may have this disease, women said that husbands, other family members, friends, clinic staff, and members of the church could be considered as potential confidantes. Friends were the most commonly described confidantes, though women had mixed views as to whether their friends could be trusted with personal information: 'With us women when we quarrel, we even talk about confidential information, and thus most women hesitate to tell their friends'. Because of fears of gossip among friends, clinic staff members were viewed as confidential resources for women. Women stated that the most important quality in a potential confidante is that they be trustworthy.

Influence of peers on decision to undergo screening

Women were asked whether they were influenced by others concerning their decision to undergo screening. Not surprisingly, coming from women who had made the decision to be screened, most participants indicated having been encouraged rather than discouraged by members of their social networks, most often close friends and husbands (Table 4, Quotes 1-3). Seeking approval or permission for screening from a spouse was a source of debate among our respondents. Some women described the need to seek permission as precautionary, e.g., in the event of screening positive and needing treatment: 'After the screening, if you are found with the lesion and you are treated, your husband will understand if he gave you permission'. Others felt that approval from their husbands was a means of garnering emotional support.

A premise of this study is that women who undergo screening might share their positive and negative screening experiences, thereby influencing other women's decision to undergo cervical screening. Our results indicated both a positive and negative influence on peers. On the positive side, several women who underwent screening described a sense of responsibility to act as screening role models; that is, to impart their experience to other women in the community, to convey the benefits of screening, and to dispel rumors related to the screening process. Care providers confirmed that women who had undergone screening were likely to encourage others because they had "become knowledgeable" about the process (Table 4, Quotes 4-5). On the negative side, both providers and women felt that stories of women's negative screening experiences were widespread in the community. Participants also believed that these stories and related rumors were likely to impact community perceptions of cervical screening negatively and thereby deter some women to come for cervical screening (Table 4, Quotes 6-8).

DISCUSSION

The present study sought to clarify relations among motivations for cervical screening, screening experiences, and social influences on the decision for cervical screening among women who accepted to undergo a VIA exam at a peri-urban primary health center in Lusaka, Zambia. Our results indicate that women presented for screening with variable needs and expectations, often prompted by friends and family members. Women articulated a wide range of screening experiences and reported often discussing these experiences, both positive and negative, with others in the community.

Most study participants sought cervical screening to find out their VIA status. In line with the core educational message of the program, some women explicitly stated that the disease can exist in the absence of symptoms. Conversely, though, and as in other African studies,¹⁷⁻¹⁹ participants suggested that some women may be reluctant to come to the clinic if not prompted by physical symptoms of illness. If widespread, this attitude could reduce the effectiveness of the screening program.

Women were motivated to present for screening by factors other than cervical disease itself. Some women wanted to be reassured of their reproductive health and their ability to bear children. Loss of fertility as grounds for divorce has been cited as a major concern among African women²¹. Based on our results, addressing fertility-related concerns is a priority among women and could be an entrée into emphasizing the importance of general cervical health and the role of cervical screening. Finally, a minority of women sought diagnosis for unresolved symptoms and became frustrated when told that they were screen-negative. By presenting with health problems beyond the scope of the program, these women may develop misaligned perceptions of program utility and effectiveness.

Our study sought to document women's experiences with the screening process. Women in this population had extremely positive perceptions of health providers associated with the screening program. Lay peer educators, who have proven to be successful in increasing cervical screening uptake among minority U.S. populations, were viewed as informative and supportive prior to screening²⁷. Nurses were seen as professional confidantes with whom

women could express their health concerns freely in a private setting. These experiences contrast sharply with other African studies in which women felt intimidated, rushed, or unwelcomed by care providers^{28, 29}. Trust in care providers has been cited as one of the crucial factors in a woman's decision to undergo cervical screening³⁰. Our data suggest that successful measures were taken in Lusaka to engaging with women throughout the screening process and, thus, ensure that they have a positive experience of care.

In relation to the actual exam, women conveyed both positive and negative opinions. Having the opportunity to see one's cervix was a clear motivating factor among respondents. Care providers viewed digital cervicography as a useful education tool, while women appreciated the novelty of viewing these images. Given the additional practical benefit of using enhanced images for quality control and diagnostic purposes,^{31, 32} cervicography may be a feature of cervical screening to be emphasized in future screening promotion messages. Both screening participants and nurses stated that women seemed to enjoy the application of vinegar to the cervix, likely due to its acidity and because it seemed to impart of feeling of 'constriction' and 'cleanliness' among women. This preference may reflect a cultural predilection for vaginal astringent products used in dry sex practices among Zambian populations.³³

Negative aspects of the screening exam included women's discomfort from having their genitals exposed during the exam, viewed as a cultural taboo among our respondents and cited elsewhere as a barrier to cervical screening³⁴⁻³⁶. Women objected to the use of the vaginal speculum for fear of pain and a belief that it was used to remove and clean the cervix¹⁹. Also, women associated the speculum with potential transmission of STIs, including HIV, a significant concern for screening participants in a country with high HIV disease prevalence.

Our data indicate that women communicate their screening experiences with others, possibly influencing community perceptions of need for screening both positively and negatively. Although many women, after being screened, appear to become role models for other women in their social networks, some women disseminate messages that may reinforce 'attitudinal barriers'³⁷. Because only women who evaluate their experience positively are likely to become natural helpers, it is crucial to monitor women's experiences with the screening process and address any area of concern.

Women's responses indicated that the decision to undergo screening was influenced by social networks. A proportion of women sought their husband's explicit permission for cervical screening, signaling a need to create screening promotion messages and cervical educational materials targeted to women's partners. While few attempts have been made yet to formally influence or include a women's family into cervical screening promotion efforts in Zambia, individual screening programs should determine the suitability and impact of communication messages to educate influential individuals regarding the risks and benefits of cervical screening and treatment.

When assessing the significance of our results, one should keep in mind that information consisted primarily of self-reports obtained from a convenient sample of women who

presented at one screening clinic. These women may have had more positive views of cervical screening than members of the general community. Furthermore, VIA testing is offered in fifteen government clinics in various neighborhoods of Lusaka; we cannot exclude that women recruited from other clinics than Kanyama might have reported different motivations and experiences. To offset these limitations, however, and obtain a broader view of the cervical screening program we interviewed care providers representing a total of ten screening clinics.

CONCLUSION

Confidential communication and support of care providers are as crucial to the success of cervical cancer screening programs in resource-limited settings as they are in resource-rich settings; they might also be a prerequisite of effective retention of HIV-infected women into preventive care. Cervical screening professionals should carefully account for women's motivations and fears when articulating the objectives and limitations of cervical cancer screening. Misalignments between women's expectations and program goals and procedures may result in negative experiences, drop outs, and bad press for the program in the community. Further research is needed to understand the role played by family members and peers into women's decisions to present for initial screening and subsequent care, as indicated.

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Current knowledge on this subject

Once-in-a-lifetime “screen and treat” protocols based on low-technology visualization techniques, or human papillomavirus DNA testing, can effectively reduce global rates of invasive cervical cancer among women in resource-limited countries.

Special challenges are encountered in regions with generalized HIV epidemic such as sub-Saharan Africa, because post-treatment follow-up visits and repeated screening are needed to effectively prevent cervical cancer in HIV-infected women.

In resource-rich countries, cervical cancer screening causes embarrassment, fear, discomfort and inconvenience that act as deterrent in many women.

What this study adds

Women who attended a cervical cancer prevention program in Lusaka, Zambia, cited trust in screening personnel as the most important determinant of a positive screening experience.

In the context of screening by visualization of the cervix, being offered the possibility to see a digital picture of one's cervix, along with receiving brief explanations from the screening nurse, was a strong motivator for many women.

Most Zambian women discuss their screening decisions with members of their social networks before attending screening. After screening, women who had mainly positive screening experiences tend to promote screening in their networks, whereas women who had mixed experiences are more likely to exert a negative influence on their peers.

Table 1

Quotes from focus group discussions and interviews with providers and women on initial motivation for cervical cancer screening.

Number	Quote	Theme	Respondent
1.	Women want to know if they have cervical cancer.	Know VIA status	Woman
2.	You will be able to know if you have the lesions that cause cancer or not.	Know VIA status	Woman
3.	I came for tests because I want to have children.	Protect future pregnancy	Woman
4.	It made me happy with the help they gave. It was absolutely free.	Free services	Woman
5.	They will come because they have an STI and feel we are the right people who will not disclose to other people.	Resolution of existing health problem (genital symptoms)	Nurse
6.	I wanted to know the reason why my health was deteriorating.	Resolution of existing health problem	Woman
7.	When one is sick and does not know what is wrong with her, [she] is hoping they tell her she has cancer, and that's why she is sick.	Resolution of existing health problem	Woman

Table 2

Quotes from focus group discussions and interviews with care providers and women on positive contributors to the cervical screening experience.

Number	Quote	Theme	Respondent
1.	We feel free and comfortable when we come here, and this encourages us a lot.	Comfort from providers	Woman
2.	They feel more comfortable to talk to us because they know that whatever we do is confidential.	Confidentiality of exam	Nurse
3.	When the nurse told me I was found with a problem I was afraid, but the nurse calmed me and encouraged me.	Encouragement of providers	Woman
4.	I loved it when I was shown the picture of my womb and how it is.	Digital cervicography	Woman
5.	The fact that they can see their cervix which they have never seen really excites women.	Digital cervicography	Nurse
6.	The nurse showed me how my womb was. I was happy because I know the problem I have.	Digital cervicography	Woman
7.	Knowing my [screening] results. You are relieved once you know.	Relief of screening result	Woman
8.	Also me, [after] knowing my results I was happy.	Relief of screening result	Woman
9.	[Women] know that the vinegar applied on their cervix helps to clean it.	Effects of vinegar	Woman
10.	At Kanyama clinic, they do not take too much time to do their work.	Screening performed quickly	Woman

Table 3

Quotes from focus group discussions and interviews with care providers and women on negative contributors to the screening experience.

Number	Quote	Theme	Respondent
1.	It is not acceptable for someone to see your vagina except for when you're giving birth.	Undressing	Woman
2.	Some say they need a bath before being examined. They think they are not clean enough to open their private parts.	Undressing	Nurse
3.	[Women] do not want pieces of metal inserted in the vagina.	Fear of speculum/pain	Peer educator
4.	The uterus is pulled out cleaned and treated and put back inside.	Fear of speculum/procedure	Woman
5.	Even just hearing the sound of the instrument [a woman] will jump.	Fear of speculum/procedure	Nurse
6.	The chisimbi (steel rod) when inserting in the vagina pains.	Fear of speculum/pain	Woman
7.	People say they use the same instruments on all women.	Fear of infection from instruments	Woman
8.	The object that they push into the vagina, it brings other infections if it's not well cleaned.	Fear of infection from instruments	Woman
9.	Other women in the community they do not know that they screen for cancer here, they think that they only do HIV test.	Fear of HIV testing	Woman
10.	[Women] don't want to be seen at the cancer clinic. They want it to be a secret.	Stigma	Peer Educator
11.	There is only one nurse to do the screening, there are times when she is not there.	Understaffing	Woman

Table 4

Quotes from focus group discussions and interviews with care providers and women regarding influence of social network on the decision to undergo screening.

Number	Quote	Theme	Respondent
1.	For me, I was constantly ill so my friends encouraged me to come for screening.	Encouragement from friends	Woman
2.	Most [women] are coming because they have a complaint which they told a friend and the friend told them to try the cervical cancer clinic.	Encouragement from friends	Nurses
3.	I took the [screening] pamphlet to my husband, and he told me to come for screening.	Encouragement from husbands	Woman
4.	I was motivated [after screening], and I wanted to encourage my friends as an example.	Positive influence of others' screening experiences	Nurse
5.	It is important for us women to encourage one another to come for screening.	Positive influence of others' screening experiences	Woman
6.	Patients tell their friends that the steel [speculum] is very big and is put as if it can kill a person.	Negative influence of others' screening experiences	Woman
7.	Most women are scared to come because of the stories they hear from those who have been here before. They are very discouraging.	Negative influence of others' screening experiences	Peer Educator
8.	To be honest, there is so much that has been said in our compounds with regard to screening. It puts so much fear in most of us that you think twice before coming.	Negative influence of others' screening experiences	Woman