World Health Organization

Improving uptake of cervical cancer screening and treatment					
Date	19 November 2026	**Time**	13:00-14:06 CET	**Location**	Zoom meeting

Key outcomes

- HIFA forum findings (based on 150 messages from 31 different participants in 21 countries across 6 WHO regions) show that cervical cancer is often unknown, perceived as a death sentence, and surrounded by misinformation, including beliefs that screening causes infertility or proves infidelity.
- Survivors are identified as highly effective messengers for encouraging screening and debunking stigmas.
- Trust in local, known health workers is more critical than the mere availability of information; posters and general awareness are insufficient to overcome deep-seated taboos.
- Systemic gaps include inconclusive screening results without follow-up, lack of compassionate communication, and limited access to reliable information in LMICs.

Discussion – summary only

Community Perceptions and Misinformation

- Awareness gaps: In some Indian contexts, up to 90% of women may have never heard of cervical cancer.
- Fatalism: Cancer is frequently viewed as an inevitable death sentence, particularly gynecological cancers.
- Screening misconceptions: Belief that screening is unnecessary without symptoms. Fear that screening is painful or may cause bleeding/affect sexual life. False belief that screening may itself cause cancer. Misconception that HPV vaccination causes infertility. Belief that abnormal results prove infidelity by either the woman or her partner.
- Cultural beliefs: In some Kenyan communities, cervical cancer is perceived as a result of being bewitched or cursed.
- Treatment fears: Beliefs exist that chemotherapy and radiation kill faster than the cancer itself.
- “I don’t think anyone is spreading misinformation on purpose” – It happens because they do not have access to reliable information

Information Sources and Trust

- Trusted messengers:
  - Local health workers, such as **Asha workers** and **Anganwadis** in India, who maintain one-on-one relationships with small groups of women.
  - Midwives, mothers, teachers and community health workers who provide early education to girls and young women.
  - Many women prefer to go to traditional healers, which can contribute to delays in presentation and poor health outcomes.
  - Pharmacists are also noted as potential agents of information and screening recommendation.
  - Faith leaders are trusted sources of information but may also provide misinformation..

- Role of survivors: Survivors provide "living proof" that screening can lead to curative treatment and are effective at hand-holding other women through the process.
- Structural barriers: For marginalized groups, such as undocumented Haitian patients in the Dominican Republic, trust in information must be paired with addressing structural barriers to care.

Gaps in the Care Continuum

- Screening follow-up: Inconclusive results (e.g., Pap smears) are sometimes not explained as requiring a return visit, leading patients to assume "nothing is wrong."
- Communication quality: The manner of delivering information significantly impacts patient willingness to continue care; blunt or hopeless messaging can discourage further treatment.
- Survivorship visibility: There are fewer visible cervical cancer survivors compared to other cancers, which reinforces stigma and reduces hope.
- Aging populations: Older women may fall through healthcare cracks and rely primarily on word-of-mouth information.
- Primary care integration: Screening is not yet a norm at the primary healthcare level in some Southeast Asian and Indian contexts, except for diabetes and hypertension.

Proposed Solutions and Actions

- Education: Start reproductive health education early, including in schools, so girls are aware of cervical cancer and the importance of HPV vaccination and screening . Use participatory learning activities for children and girls to build health literacy and agency.
- Governmental/Systemic interventions: Include HPV screening and regular Pap smears in national health programs. Conduct medical camps to raise awareness of prevention and treatment. Provide webinars and training for healthcare workers to improve case management. Advocate for screening to become a standard part of primary healthcare.
- Vaccination strategy: Consider offering the HPV vaccine to boys as well as girls to reduce the gendered stigma associated with the vaccine.
- Co-development: Involve girls in designing education resources to ensure they address their actual concerns and trust sources.

Questions raised during the Webinar

- How to effectively reach older and marginalized women in LMICs who rely on word-of-mouth and may not visit clinics or use mainstream media.
- How to measure whether improved knowledge actually translates into behavior change and increased screening uptake.
- Which specific questions the HIFA forum should prioritize for its final week of discussion.

Participants

86, including panelists