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Narrative Review of Cervical Cancer-Related Stigma in China (2015-2025)

Zhou. Yuqin[1], Mohd. Shariff[1], Mastura Bt Mohd. Mujar[1], Rohayu. Binti Hami[1*]

1 Universiti Sains Malaysia, Malaysia.

Corresponding author email address:
rohayuhami@usm.my

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ABSTRACT

Objective: The Stigma of cervical cancer in China is linked with poor well-being and health-seeking behaviour. Nonetheless, studies on culturally specific contributing factors and interventions are scarce. This narrative review investigates stigma-related issues and interventions in Chinese cervical cancer patients based on the socio-ecological model.

Methods and Materials: The databases (PubMed, ScienceDirect, CNKI, WanFang, VIP, PsycINFO, Scopus, Web of Science) and grey literature sources were searched using narrative methods to identify studies published between 2015 and 2025. Chinese research on cervical cancer patients on the issue of stigma was included. The narrative synthesis was conducted using qualitative, quantitative, and mixed-method studies to identify patterns within the socio-ecological context. A total of 126 records were identified; 42 were duplicates, leaving 84 for screening. Following the full-text review, 26 studies met the inclusion criteria.

Findings: Stigma was observed across multiple ecological tiers. The individual factors involve younger age, advanced disease, and low self-efficacy. Interpersonal ones include family dynamics and social networks; community ones include work-related discrimination and healthcare providers' attitudes. The social reasons are associated with cultural perceptions that associate cervical cancer with sexuality and moral values. Several interventions have been outlined, but there is little evidence of effectiveness.

Conclusion: Pervasive stigmatization of cervical cancer in China is rooted in cultural beliefs on sexuality and traditional gender roles. The interventions that address these aspects, including family-centred education, online campaigns, and training for health-care providers, have potential but require further assessment. Future studies must develop culturally grounded interventions and conduct trials that are representative of China's sociocultural context.

Keywords: Stigma, cervical cancer, China, socio-ecological model, narrative review, cultural beliefs.

Introduction

Cervical cancer is a significant health burden in China as well as the world at large. Recent estimates indicate that approximately 604,000 new cases and 342,000 deaths occurred worldwide in 2020 (Zhao et al., 2024). In China, it was estimated that in 2020, 109,741 people had cervical cancer, with 59,060 dying, and that this is about 18% of the world (Shen et al., 2022). In 2020, the incidence rate among 100,000 Chinese women was 10.7 (M. Li et al., 2023).

In addition to its physical weight, cervical cancer is also linked to significant psychological impacts, such as illness stigma, that can impede its prevention, screening, and treatment, with associated effects on patient outcomes and quality of life (Wang & Hengudomsub, 2025). The stigma is a complicated psychosocial process where there is an experience of shame, inferiority, and fear of rejection or discrimination (Heley et al., 2024; Johnson & Samson, 2024). To make our review concise and to the point, we mention perceived stigma (anticipation of negative treatment) and internalized stigma (self-directed negative beliefs). However, we acknowledge that stigma exists at multiple levels, including public, enacted, and structural stigma.

The stigma exists on several levels, of intrapsychic and social levels, and cultural values in the Chinese population can give this experience unique characteristics. Conventionally, Chinese notions of gender roles, morality, and sexuality may be used to interpret perceptions of cervical cancer (Bae & Temkin, 2025; Wang & Hengudomsub, 2025). Human papillomavirus (HPV) infection has been well-established as a cause of cervical cancer in different parts of the world (Zou et al., 2024). Nevertheless, there are differences in the cultural meanings of this relationship within biomedical contexts across societies. The fact that HPV is sexually transmitted may have a certain moral impact in the Chinese cultural context, with the traditional values of sexual modesty and restraint (Chinese cultural settings), and the interpretation of this phenomenon may vary (Bae & Temkin, 2025; Gu et al., 2017; Jia et al., 2013). Such culturally specific meanings can lead to shame and social stigma, which can draw in preventive healthcare interventions, prompt diagnosis, and treatment adherence (Fang et al., 2025; Q. Li et al., 2023; Ma et al., 2023).

Although the previously mentioned cancer stigma study has been conducted in the global sphere (Akin-Odanye & Husman, 2021; Heley et al., 2024; Johnson & Samson, 2024), there is a dearth of literature concerning the cultural aspects of cervical cancer stigma among Chinese people, specifically the intervention strategies applied in addressing the internalized stigma among Chinese cervical cancer patients (Wang & Hengudomsub, 2025). This review seeks to integrate the evidence available regarding the issue of cervical cancer stigma among Chinese patients, factors that are associated with it, and interventions used to address the problem in a socio-ecological framework. This review would form a basis to develop culturally sensitive interventions by addressing the issue of stigma at individual, interpersonal, community, and societal levels to meet the distinct needs of Chinese cervical cancer patients.

Methods and Materials

2.1 Study Design and Theoretical Framework

This narrative review summarizes existing literature on stigma-related factors and strategies for stigma interventions in Chinese cervical cancer patients. The narrative review methodology is appropriate for accounting for the heterogeneity of study designs and methods used in stigma research, thereby enabling the integration of quantitative, qualitative, and mixed-methods studies (Green et al., 2006; Sukhera, 2022). The narrative review allows consideration of large-scale psychosocial and cultural processes that would not typically fit within systematic review methods.

The socio-ecological model served as the conceptual framework for organizing and interpreting findings. The socio-ecological model often recognizes that health behaviours and outcomes result from dynamic interactions among individual characteristics, interpersonal factors, community factors, and societal factors. We apply the socio-ecological model to cervical cancer stigma to understand how stigma operates across multiple and interrelated levels, and a framework to inform the possible intervention strategies that could harness various levels of influence to achieve maximum effect.

2.2 Search Strategy

Electronic searches were conducted in the following databases: PubMed, ScienceDirect, CNKI (China National

Knowledge Infrastructure), WanFang Data, VIP (Chinese Scientific Journals Database), PsycINFO, Scopus, and Web of Science. Searches were completed in October 2025. Supplementary searches were conducted in Google Scholar and grey literature sources.

Search terms employed included: (cervical cancer OR cervical carcinoma OR cervix cancer OR HPV cancer) AND (stigma OR shame OR discrimination OR social rejection OR internalized stigma OR perceived stigma) AND (China OR Chinese OR Mainland China) AND (intervention OR program OR support OR therapy OR education OR factors OR determinants OR correlates); no language restrictions were applied to database searches, although only English and Chinese-language articles could be reviewed by the authors. Date limits were set to January 2015 through October 2025.

2.3 Eligibility Criteria

Inclusion criteria

Studies conducted with cervical cancer patients or survivors in Mainland China, Hong Kong, Macau, or Taiwan; Studies addressing stigma as a primary or secondary outcome, including measurement of stigma levels, factors associated with stigma, or interventions targeting stigma; Quantitative, qualitative, or mixed-methods study designs; Published between January 2015 and October 2025; Full-text available in English or Chinese.

Exclusion criteria

Studies not specific to cervical cancer or combining cervical cancer with other cancers without separate analysis; Studies conducted outside Chinese populations; Conference abstracts, editorials, or opinion pieces without original data; Studies not addressing stigma-related constructs.

2.4 Study Selection and Data Extraction

Title and abstract screening was conducted in two rounds, in which two authors independently identified discrepancies in titles and abstracts, which were resolved through discussion. Two reviewers also conducted a full-text review, as the narrative review design is distinct and did not require dual extraction or formal inter-rater reliability calculations. However, essential data were triangulated among reviewers. PRISMA-style flow diagram is presented in Figure 1.

The information that was obtained was as follows: study characteristics (author, year, location, design), participant demographics (sample size, age, disease stage), stigma measurement tools and domains assessed, theoretical frameworks used, essential results of factors that are related to stigma, and intervention strategies and outcomes, where necessary.

2.5 Quality Appraisal and Synthesis.

In line with the narrative review methodology, a formal quality appraisal using standardized tools was not conducted (Green et al., 2006; Sukhera, 2022). Nevertheless, during synthesis, the study design, sample characteristics, and measurement methods were recorded for interpretation of the findings.

Thematic synthesis was used to identify patterns across studies. Themes were organized within the socio-ecological model according to ecological level (individual, interpersonal, community, societal). Synthesis of findings with respect to intervention approaches: differentiated between those that had been tested and those that were hypothesized. Because the measures of stigma, study designs, and populations were heterogeneous, meta-analysis was not conducted.

Findings and Results

3.1 Search Results and Study Characteristics

The search yielded 126 records. After removing 42 duplicates, 84 records underwent title and abstract screening. Following full-text review, 26 studies met the inclusion criteria and were included in this narrative synthesis. Reasons for exclusion included: not specific to cervical cancer (n=23), not conducted in Chinese populations (n=18), stigma not addressed (n=12), and full text unavailable (n=5). Below is a Prisma-style flow diagram for the source selection process. Characteristics of the included studies is presented in Table 1. Moreover, themes and sub-themes identified in this research is presented in Table 2.

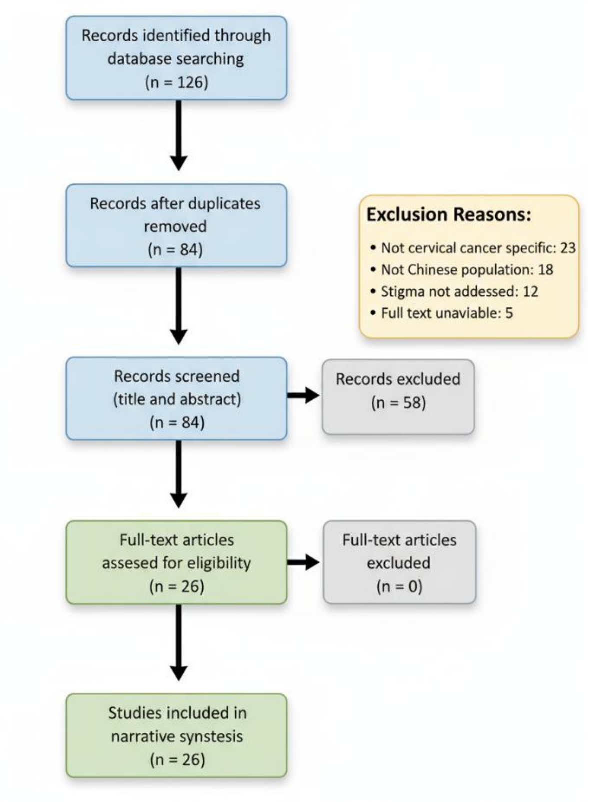

Figure 1

PRISMA-Style Flow Diagram

Table 1

Characteristics of Included Studies (n=26)

No.	Author(s), Year	Study Design	Setting/Location	Sample Size	Stigma/Psychosocial Measure	Key Domains	Main Findings Related to Stigma
1	Wang et al., 2025 [2]	Cross-sectional	China (multiple hospitals)	203 cervical cancer patients post-chemotherapy	Stigma scale	Perceived stigma, self-stigma	Younger age, advanced stage, and low self-efficacy are associated with higher stigma levels.
2	Wang et al., 2024 [5]	Literature review	China	N/A (review)	Various stigma measures reviewed	Perceived, internalized, enacted stigma	Identified gaps in stigma research among Chinese cervical cancer patients; emphasized cultural factors.
3	Ma et al., 2025 [8]	Cross-sectional	China (radiotherapy centers)	186 patients during radiotherapy	HADS (anxiety/depression), uncertainty scale	Anxiety, depression, uncertainty	Psychological distress correlated with illness uncertainty; indirect stigma implications through social withdrawal
4	Yang et al., 2014 [18]	Cross-sectional	China (multiple provinces)	178 cervical cancer patients	Depression/anxiety scales, positive psychological variables	Depression, anxiety, and coping	Higher depression/anxiety associated with lower social support; suggests stigma-related isolation.
5	Ma et al., 2023 [20]	Cross-sectional	China (urban hospitals)	156 women <35 years with cervical cancer	Patient delay questionnaire, barriers assessment	Healthcare delay, disclosure concerns	Younger patients experienced greater delays due to shame, fear of judgment, and stigma concerns.
6	Jia et al., 2013 [22]	Cross-sectional	Wufeng County, China (rural)	1,023 women (screening context)	Knowledge and barriers questionnaire	Cultural beliefs, misconceptions	Rural women held misconceptions about cervical cancer transmission, which were associated with moral judgments.
7	Szamreta et al., 2022 [23]	Qualitative (multi-country)	Brazil, China, Germany, USA	40 patients (China subset: 10)	Semi-structured interviews	Information needs, disclosure	Chinese patients reported concerns about disclosure and social judgment, as well as limited family communication.

8	Zhang et al., 2022 [25]	Cross-sectional	China (oncology centers)	202 patients receiving chemoradiotherapy	QoL scale, illness perception questionnaire	Illness perceptions, symptom burden	Negative illness perceptions (viewing cancer as shameful) correlated with lower QoL
9	Yang et al., 2019 [28]	Qualitative	Eastern China (rural areas)	30 rural women	In-depth interviews	Screening barriers, cultural beliefs	Identified shame, sexual morality concerns, and fear of community judgment as barriers to screening
10	Li et al., 2023 [29]	Cross-sectional	China (multiple hospitals)	245 cervical cancer patients	Social support scale, sense of coherence scale, anxiety/depression measures	Social support, coping	Perceived social support mediated depression/anxiety; suggests stigma reduces support perception.
11	Kong et al., 2025 [30]	Cross-sectional	China (tertiary hospitals)	312 cervical cancer patients	Health literacy scale, stigma scale, and decision-making barriers	Stigma, health literacy, and healthcare access	Stigma-mediated relationship between health literacy and healthcare decision-making barriers
12	Zhao et al., 2023 [32]	Cross-sectional	Yunnan Province, China (Han and ethnic minorities)	396 patients (Han: 198, minorities: 198)	QoL scale (EORTC QLQ-C30)	Quality of life, ethnic differences	Ethnic minorities reported lower QoL; cultural beliefs about sexuality influenced experiences.
13	Gu et al., 2017 [34]	Qualitative	China (urban and rural)	60 women at risk	Focus groups and interviews	Risk perception, screening behaviour	Fear of stigma and social judgment influenced screening avoidance, stronger in rural areas
14	He et al., 2024 [35]	Cross-sectional	China (oncology departments)	180 cervical cancer patients and their spouses	Stigma scale, marital satisfaction scale	Stigma, marital relationships	Higher stigma correlated with lower marital satisfaction; couples therapy is recommended
15	Tam et al., 2011 [41]	Cross-sectional	Hong Kong, China	87 cervical cancer survivors	QoL questionnaire (SF-36, FACT-Cx)	Quality of life, social functioning	Survivors reported social isolation and concerns about sexual stigma affecting QoL.
16	Wang et al., 2025 [42]	Cross-sectional	China (multiple provinces)	268 cervical cancer patients and their families	Family resilience scale, family functioning	Family dynamics, resilience	Family resilience influenced patients' coping; within-family stigma reduced resilience.
17	Zhi et al., 2024 [43]	Cross-sectional (dyadic)	China (cancer centers)	212 patient-spouse dyads	Dyadic communication scale, dyadic coping	Couple communication, coping	Poor dyadic communication is associated with higher patient distress; stigma reduces open communication.
18	Zhao et al., 2021 [44]	Cross-sectional	Southwest China (Sichuan)	351 cervical cancer patients	EORTC QLQ-C30, QLQ-CX24	Quality of life, functional status	Patients reported social and emotional functioning impairments; stigma was implied through social withdrawal.
19	Zhao et al., 2023 [45]	Cross-sectional	Yunnan Province, China	420 patients (precancerous and cancer)	Psychological status questionnaire (SAS, SDS)	Anxiety, depression, and ethnic differences	Han and ethnic minority women showed different anxiety/depression patterns; cultural beliefs influenced psychological distress.
20	Di et al., 2015 [46]	Cross-sectional	China (urban, suburban, rural)	1,557 women	Knowledge and attitude questionnaire	Knowledge, screening barriers	Lower knowledge in rural areas; stigma and misconceptions about sexual transmission were identified.
21	Li et al., 2025 [47]	Cross-sectional	China (surgical/radiation centers)	189 cervical cancer survivors	QoL scale, sexual function assessment	Quality of life, treatment impact	Treatment type influenced QoL; hysterectomy patients reported femininity concerns and stigma.
22	Yang et al., 2025 [48]	RCT	Hubei Province, China	120 female medical students	HPV vaccination intention scale	Prevention knowledge, stigma reduction	Educational intervention reduced stigma around HPV and improved vaccination intentions.
23	Fang et al., 2025 [49]	Qualitative	China (tertiary hospitals)	25 cervical cancer patients	Semi-structured interviews	Healthcare delay, health-seeking behaviour	Shame, stigma, and fear of judgment caused significant delays in seeking medical care.
24	Chen et al., 2023 [50]	Dyadic cross-sectional	China (gynecologic oncology centers)	186 patient-spouse dyads	Family resilience scale, communication quality	Couple communication, family resilience	Communication quality influenced family resilience; stigma reduced openness to communication.
25	Liu et al., 2017 [51]	Cross-sectional	Eastern China (rural areas)	1,200 rural women	Knowledge and attitude questionnaire	Screening knowledge, cultural attitudes	Identified misconceptions linking cervical cancer to promiscuity; stigma is a barrier to screening.
26	Wang et al., 2022 [52]	Cross-sectional	China (screening centers)	298 women with abnormal screening	Resilience scale, social support scale, anxiety scale	Resilience, social support, anxiety	Women with abnormal results experienced anxiety and reduced social support; stigma was anticipated.

Table 2

Themes and Sub-themes Identified

Theme	Sub-theme
Individual-level factors	Age, education level, disease stage, treatment type, self-efficacy, self-esteem, illness perception
Interpersonal factors	Family support, social support, and healthcare provider relationships
Community-level factors	Workplace discrimination, healthcare system accessibility, and rural-urban disparities
Societal factors	Cultural beliefs about sexuality, traditional gender roles, misconceptions about transmission, and moral judgments
Interventions	Educational programs, psychosocial support, family-centred approaches, and digital health platforms

3.2 Individual-Level Factors Associated with Stigma

Several individual-level factors were associated with stigma experiences among Chinese cervical cancer patients, though the direction and strength of associations varied across studies.

Age: Younger patients (18-35 years) were associated with higher stigma levels in several studies (Ma et al., 2023; Wang & Hengudomsub, 2025; Yang et al., 2019). Ma et al. found that younger patients experienced greater delays due to shame, fear of judgment, and stigma concerns (Ma et al., 2023). Wang et al. reported that younger age was associated with higher stigma levels among post-chemotherapy patients (Wang & Hengudomsub, 2025). Younger patients reported concerns about career, marriage prospects, and fertility preservation that may intensify stigma experiences (Yang et al., 2019). However, not all studies found consistent age-related patterns.

Education: The relationship between education and stigma showed mixed patterns. Other studies have proposed that improved health literacy in higher education protects it (Jia et al., 2013; Q. Li et al., 2023), whereas others have found increased awareness of social consequences among educated patients (Ma et al., 2023).

Disease stage: Multiple studies have found that advanced disease is linked to increased stigma (Ma et al., 2025; Wang & Hengudomsub, 2025). Wang et al. discovered that increased levels of stigma were linked to advanced stage among the post-chemotherapy patients (Wang et al., 2025). Ma et al. had found that illness uncertainty in the context of radiotherapy was associated with psychological distress and had indirect implications of stigmatization, with social withdrawal (Ma et al., 2023).

Type of treatment: Different treatments were associated with varying levels of stigma. Patients undergoing chemotherapy reported visible side effects, such as hair loss (Ma et al., 2023). Patients of hysterectomies reported issues related to femininity and loss of reproduction (Li et al., 2025).

Psychological Factors: Greater self-efficacy was associated with greater coping with stigma (Kong et al., 2025; Wang & Hengudomsub, 2025). Kong et al. (2025) showed that stigma mediated the association between health literacy and barriers to healthcare decision-making. Self-esteem was found to be protective against internalized stigma, but it was not always reported to have specific effects. The perception of illness affected the stigma, where patients who perceived cervical cancer as manageable reported lower levels of stigma compared to those who perceived it as shameful (He et al., 2024; Zhang et al., 2022).

3.3 Interpersonal Factors Influencing Stigma.

Support networks and family dynamics were also important interpersonal factors that have been associated with the experience of stigma among the Chinese cervical cancer patients.

Family support: In Chinese collectivist cultures, family intervention on health-related issues is expected (Wang et al., 2025). Wang et al. (2025) found that family resilience affected patients' coping with family stigma, with lower family resilience associated with greater coping difficulties. Favourable family support, open communication, and emotional support were associated with reduced stigma (Kong et al., 2025; Q. Li et al., 2023). On the other hand, those families that responded by blaming, shaming, or avoiding were found to increase patient stigmatization experiences (He et al., 2024; Q. Li et al., 2023).

Misconceptions in families: The misconceptions of family members about the transmission or the cause of cervical cancer led to discriminatory practices in the family (Jia et al., 2013). According to Jia et al., rural women had misconceptions concerning the transmission of cervical cancer that have links with moral judgments

(Jia et al., 2013). Conventional gender role expectations occasionally added pressure on patients to continue household chores even when ill (He et al., 2024).

Social networks: Relationships with friends and the community were favourable and positively affected coping and social isolation (Q. Li et al., 2023; Zeng et al., 2011). Li et al. have reported that sense of coherence did mediate the effect of perceived social support and depressive and anxiety symptoms among cervical cancer patients (Q. Li et al., 2023). The quality of support, however, was based on health literacy within social networks. Perceived support was found to have a more substantial effect than quantitative measures of received support (Wang et al., 2022).

Relations between healthcare providers: Culturally competent and empathetic care by healthcare providers was associated with lower patient stigma (Gu et al., 2017; Kong et al., 2025; Szamreta et al., 2022). Providers who addressed misconceptions, provided emotional support, and showed respect also appeared to protect against stigma. On the other hand, experiences of in-group stigma were exacerbated by judgmental attitudes among healthcare providers (Gu et al., 2017; Jia et al., 2013; Yang et al., 2019). The findings of Szamreta et al. indicated that Chinese patients reported issues with disclosure and social judgment, as well as a lack of family communication (Szamreta et al., 2022).

3.4 Community-Level Factors that Lead to Stigma.

Discrimination at work: Patients reported experiencing workplace-related stigma, including altered job roles, social exclusion by coworkers, job insecurity, and perceived lower productivity (Ma et al., 2023). The Chinese work ethos of steering clear of diagnoses due to their performance-driven and resiliency-based workplace culture can be a stressor that encourages patients to be silent about their health issues. Specifically, Ma et al. (2023) observed that younger patients exhibited delays and concerns related to workplace stigma.

Factors within the healthcare system: Rural patients had difficulty with such factors as the lack of local resources, the necessity to travel to the city to receive treatment, and possible exposure to the rest of the bigger community networks (Di et al., 2015; Gu et al., 2017; Jia et al., 2013; Yang et al., 2019). There was also inconsistency in the quality of care across facilities, as some settings exhibited low cultural competence or stigmatizing attitudes (Gu et al., 2017; Yang et al., 2019). Lower levels of knowledge in rural settings were reported by Di et al., where stigma and misconceptions about sexual transmission were found (Di et al., 2015).

Community misconceptions: There were some misconceptions among communities living in rural areas or ethnic minorities that cervical cancer was either contagious or a result of poor hygiene (Jia et al., 2013; Liu et al., 2017). Jia et al. discovered that misconceptions towards the transmission of cervical cancer were witnessed among rural women in Wufeng County (Jia et al., 2013). Poor understanding of the relations between cervical cancer and promiscuity was identified as a barrier to screening, according to Liu et al. (2017). Such misunderstandings led to social causes of exclusion and avoidance among community members.

Traditional beliefs: Some communities have explained cervical cancer through conventional models, such as karma, retribution, or spiritual punishment (Jia et al., 2013; Zhao et al., 2024). As Zhao et al. discovered, the ethnic minorities reported variations in the patterns of quality of life, and the cultural beliefs about sexuality affected the experience (Zhao et al., 2024). Although some traditional beliefs brought relief, others heightened shame and self-blame.

3.5 Cultural Factors at the Society Level.

The societal level in Chinese cultures showed that cultural belief systems in sexuality, morality, and gender roles played a role in cervical cancer stigma.

Cultural beliefs on sexuality: The Chinese conservative values on sexual modesty and restraint might affect the understanding of the sexual transmission of HPV (Bae & Temkin, 2025; Gu et al., 2017; Jia et al., 2013). According to Gu et al. (2017), screening avoidance was influenced by fear of stigma and social judgment, which was stronger in rural settings. Yang et al. have found that shame, sexual morality issues, and fear of oppression by the community are barriers to screening in rural women in eastern China (Yang et al., 2019). The correlation of cervical cancer to sexual behaviour might have moral implications, which are distinct from other disease situations.

Gender role requirements: Classical ideas of female virtue and sexuality appeared pertinent to understanding the experience of stigma (He et al., 2024; Li et al., 2025; Yang et al., 2019). Higher stigma was associated with less marital satisfaction among cervical cancer patients, according to the findings of He et al. (He et al., 2024). Li et al. found that hysterectomy patients were faced with femininity concerns and stigma (Li et al., 2025). Nevertheless, how the traditional gender norms contribute to the modern stigma experiences needs to be determined.

Urban-rural differences: Cultural beliefs and experiences of stigma differed between urban and rural environments (Di et al., 2015; Gu et al., 2017; Jia et al., 2013). The countryside may exhibit more conservative attitudes towards sexuality and the role of women (Jia et al., 2013; Liu et al., 2017; Yang et al., 2019), whereas in cities, patients may have distinct interests in workplace effects and anonymity (Ma et al., 2023). Di et al. (2015) have shown that knowledge and screening barriers differ across urban, suburban, and rural regions.

Generational differences: Younger and older patients also appeared to experience different types of stigma (Ma et al., 2023; Yang et al., 2019). Younger urban patients were less affected by family-based stigma, and older rural patients were more affected by community-level stigma (Ma et al., 2023). In contrast, older women may have had more family-based stigma and less workplace discrimination (Gu et al., 2017; Yang et al., 2019).

3.6 Intervention Approaches

Several intervention strategies are mentioned in the literature. Still, the effectiveness of each of them, in particular in relation to cervical cancer stigma among Chinese populations, is not researched rigorously.

Educational Interventions: Educational programs to enhance knowledge of the etiology, transmission, and treatment of cervical cancer have been outlined (Di et al., 2015; Jia et al., 2013; Zhang et al., 2025). In a randomized controlled trial, Yang et al. found that an online educational intervention based on protection motivation theory reduced stigma associated with HPV and increased the intention to vaccinate among female medical students in Hubei province (Yang et al., 2019). Although there has been evidence of improvements in knowledge (Di et al., 2015), there is little evidence of a direct relationship between educational interventions and lowered stigma in Chinese cervical cancer patients. Research has not always shown that, even with greater knowledge, ingrained culture and emotionally driven reactions diminish.

Psychosocial interventions: Psychosocial interventions, such as cognitive-behavioural therapy, stress management, and coping-skills training, have been used among cancer populations (Ma et al., 2025; Yang et al., 2014; Zhang et al., 2022). Wang et al. observed that women who had abnormal screening results were full of anxiety and a lack of social support, implying that they require psychosocial interventions (Wang et al., 2022). Psychosocial interventions were promising when delivered in group settings to support peers and minimize isolation (Akin-Odanye & Husman, 2021). Nevertheless, the limited effectiveness data on reducing cervical cancer stigma in the Chinese environment are limited.

Family-based interventions: Given that family is central to Chinese culture, the family has been proposed as the primary focus for studying misconceptions, communication, and support skills (Chen et al., 2023; Wang et al., 2025; Zhi et al., 2024). Zhi et al. showed that unfavourable dyadic communication was associated with increased patient distress and that stigma diminished free communication between patients and spouses (Zhi et al., 2024). Chen et al. discovered that family resilience among Chinese gynecologic cancer patients and their spouses depended on the quality of the communication (Chen et al., 2023). Family-focused interventions that involved understanding family dynamics and reducing blame demonstrated the potential to enhance family and patient outcomes in general cancer settings. Strict assessment of the populations of cervical cancer is required.

Digital health platforms: Chinese social media such as WeChat and Weibo have been proposed as channels through which stigma-reduction programs can be implemented (Zhang et al., 2025). Such platforms provide access to anonymity, culturally adapted materials, and peer support groups. But even the majority of digital interventions have not undergone rigorous testing as to their effectiveness in reducing the stigma of cervical cancer specifically.

Training of healthcare providers: It has been suggested that provider training in clinical competency and cultural sensitivity should be implemented (Gu et al., 2017; Kong et al., 2025; Szamreta et al., 2022). Kong et al. highlighted the role of health professionals in managing healthcare stigmatization that hinders medical decision-making (Kong et al., 2025). Providing training to help providers recognize and challenge stigmatizing attitudes and to demonstrate empathy could improve patient experiences. There is no systematic review of provider training interventions used in Chinese cervical cancer settings.

Discussion and Conclusion

This narrative review shows that cervical cancer stigma among Chinese patients is a multi-level phenomenon that seems to be affected by cultural beliefs concerning sexuality and morality as well as gender roles. The evidence indicates that addressing the problem of stigma will require approaches that extend beyond individual psychological variables to encompass family processes, community misconceptions, and social attitudes. These multiple levels of influence and the combination of intervention strategies are possible through the socio-ecological framework.

The Chinese cultural background appears to differ from that of the West, in which most cervical cancer stigma studies have been conducted (Bae & Temkin, 2025; Heley et al., 2024; Johnson & Samson, 2024). The correlation between cervical cancer and sexual transmission can be understood in terms of a culture that values female virtue and sexuality in terms that cannot be fully addressed using biomedical education. This aligns with studies that argue for the use of culturally specific methods to address cancer stigma, which acknowledge and address latent ideologies and beliefs (Akin-Odanye & Husman, 2021; Heley et al., 2024).

The disparities in cervical cancer stigma experienced in urban and rural communities are mirrors of inequalities in access to health care, education, and social attitudes in all of China (Di et al., 2015; Gu et al., 2017; Jia et al., 2013). Farmers may face additional challenges, including limited access to medical services in rural areas, the need to travel to receive treatment in cities, and the risk of exposure to a much wider community (Jia et al., 2013; Yang et al., 2019). The rural region might still be more conservative about sexuality and the role of women (Jia et al., 2013; Liu et al., 2017). Urban patients face a range of issues, including workplace implications, anonymity in healthcare, and exposure to cultural diversity (Ma et al., 2023). Such differences can also be mediated by generation, with younger urban patients experiencing less family stigma. Older rural patients may be more stigmatized by their communities, whereas traditional family support networks may also work to their advantage (Gu et al., 2017; Ma et al., 2023; Yang et al., 2019).

The family's involvement in the creation and reduction of stigma also demonstrates the collectivist culture of the Chinese, in which illness-related suffering is shaped socially rather than individually (Chen et al., 2023; Wang et al., 2025; Zhi et al., 2024). This has significant implications for intervention design, suggesting that family-based interventions would be more culturally relevant than individually based interventions, which are generally modelled in Western contexts. The finding that the quality of family support is associated with patient outcomes is consistent with the broader literature on social support and health among Chinese people (Q. Li et al., 2023; Wang et al., 2022).

The current intervention strategies are promising but need a significant cultural adjustment to overcome the cervical cancer stigma in China, in particular. Interventions aimed at education should extend beyond medical education to encompass cultural beliefs and ethical frameworks related to the disease (Yang et al., 2014). Culturally-relevant coping strategies and meaning-making processes may also be valuable in psychosocial interventions (Akin-Odanye & Husman, 2021; Ma et al., 2025; Zhang et al., 2022). Interventions based on family dynamics necessitate an understanding of Chinese family communication patterns, role structures, and family responses to cancer diagnosis (Chen et al., 2023; Zhi et al., 2024).

Digital health platforms have significant potential to reduce stigma in China, given the high rates of mobile technology and social media use (Yang et al., 2014). These platforms would have the capacity to reach large populations with culturally adapted messages without requiring anonymity, given patient concerns about stigma. Nevertheless, digital interventions must be designed to address misinformation and disseminate accurate health information.

Another significant area of intervention is provider education, as providers play a major role in shaping patient and family attitudes and experiences (Gu et al., 2017; Kong et al., 2025; Szamreta et al., 2022). Provider training should encompass clinical and cultural competence, enabling providers to recognize and challenge stigmatizing attitudes and to offer nonjudgmental, empathetic care. This is especially relevant in Chinese healthcare settings where the patient-provider relations might be based on more general social inequalities and power structure (Gu et al., 2017; Kong et al., 2025).

The limitations of this review are numerous and should be taken into account when interpreting the findings. The narrative format does not involve the systematic quantitative synthesis of the effect sizes and standardized quality evaluation (Green et al., 2006; Sukhera, 2022). There is no formal quality appraisal, which implies that the study's rigour cannot be used to assess the weight of the conclusions. Although the study was well conducted, it was initially restricted to English-language databases (later expanded to Chinese-language databases), which are subject to publication bias favouring positive results. Most of the included studies were cross-sectional (Di et al., 2015; He et al., 2024; Kong et al., 2025; Q. Li et al., 2023; Ma et al., 2025Yang et al., 2019; Yang et al., 2014; Zeheterogeneity across studies precludes direct comparisons of results and impedes Yang et al., 2019; Yang et al., 2014; Zeng et al., 2011; Zhao et al., 2023), which restricts causal inference. The heterogenacross studies precludes direct comparisons of results and impedesw direct comparison of the results and inhibits synthesis. Part of the studies provided cited were also with wider populations of cancers or non-Chinese situations, which could have restricted the application of the results to patients of Chinese cervical cancer. Given the rapid social changes in China, the nature of stigma experiences may be evolving, and ongoing research is required to monitor these trends and demands (Xia et al., 2023; Yan et al., 2024).

The absence of controlled intervention studies that are unique to cervical cancer in China does not allow for conclusive information regarding the effectiveness of interventions. Most descriptions of interventions are conceptual rather than formally assessed programs, and only one randomized controlled trial was identified (Yang et al., 2019). There may be an English-language bias that has excluded important Chinese-language literature, although there were attempts to include such works in the databases. Differences in stigma between urban and rural areas were observed, but were not synthesized systematically, with comparative estimates of the effects of these differences across subgroups.

Conclusion

The cultural beliefs about sexuality, morality, and gender roles cause cervical cancer stigma in China, which occurs at individual, family, community, and societal levels. To address this stigma, culturally sensitive interventions should be implemented in the Chinese context, including family-based education, online health promotion, provider training, and community-based interventions. Nevertheless, these strategies should be subjected to rigorous analysis to determine their effectiveness.

Future studies are required to establish and test culturally based interventions, particularly through randomized controlled trials with follow-up. The focus areas of study must be generational differences, rural-urban variations, and the effects of traditional beliefs on health behaviours. Validated stigma measurement tools should be used to assess multiple domains of stigma.

The piloting intervention programs must be evaluated before general implementation. Cervical cancer and HPV educational programs must not violate Chinese cultural values and must not use stigmatizing language. By working with patients, families, healthcare professionals, and community leaders, cultural relevance will be achieved.

Training cultural competence among healthcare providers through healthcare reforms should account for concepts such as family honour and relationship-building. Sensitive care pathways should be investigated; the treatment of stigma should incorporate families into the decision-making process. Any future intervention mustheterogeneity across studies precludes direct comparisons of results and impedes address collective stigma, prioritizing family and community over individual autonomy, and should include policy mechanisms conducive to collective care. Every suggestion must be empirically validated through controlled research.

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Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Declaration of Helsinki, which provides guidelines for ethical research involving human participants. Ethical considerations in this study included the fact that participation was entirely optional.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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Authors' Contributions

All authors equally contribute to this study.

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