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The Experience of Social Stigma in Women with HPV: A Qualitative Systematic Review and Meta-ethnography

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Systematic Review

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Abstract

Background & Objective:

High-risk Human Papillomavirus (HPV) is the primary etiological driver of cervical neoplasia. However, its sexually transmitted nature enmeshes the clinical trajectory with profound social stigma, shame, and moral surveillance. This meta-ethnography systematically synthesized global qualitative evidence on women's lived experiences of HPV-related stigma across diverse sociocultural contexts.

Methods

Following Noblit and Hare's seven-phase meta-ethnographic framework and adhering to PRISMA and eMERGe/ENTREQ guidelines, systematic searches were executed across international (PubMed, Scopus, Web of Science, PsycINFO, CINAHL, Embase, ProQuest) and Persian databases up to 2026. After screening and JBI critical appraisal, 21 primary qualitative studies were synthesized via reciprocal translation, refutational exploration, and lines-of-argument synthesis.

Results

Analysis of first- and second-order constructs yielded nine descriptive themes and four overarching third-order analytical themes: (1) Gendered and Moralized Corporeal Stigma (pathology conflated with sexual promiscuity, asymmetric blame, and spoiled feminine identity); (2) Clinical and Institutional Stigma (secondary symbolic trauma, provider moral judgment, and commercial objectification); (3) Relational Stigma and the Disclosure Paradox (the dilemma between seeking spousal support and risking abandonment or marital rupture); and (4) Dynamic Trajectory and Transformative Agency (a dialectical shift from acute corporeal shame to cognitive decoupling, spiritual reframing, health literacy acquisition, and post-traumatic growth).

Conclusion

HPV-related stigma is a multi-layered, structural phenomenon that operates as a mechanism of gendered social control, substantially undermining screening and therapeutic adherence. Eliminating cervical neoplasia requires transcending purely biomedical approaches by implementing trauma-informed, destigmatizing clinical communication, protecting diagnostic privacy, providing couples-based psychoeducation, and reframing public health narratives away from moral culpability.

1. Introduction

Cervical cancer remains the fourth most common cancer among women globally, accounting for an estimated 660,000 new cases and approximately 350,000 deaths annually, with a disproportionate burden borne by low- and middle-income countries (World Health Organization, 2024). Persistent infection with high-risk human papillomavirus (HPV) genotypes is established as the principal etiological driver of virtually all cervical malignancies and their pre-invasive lesions (Cervical Intraepithelial Neoplasia [CIN]) (Baba et al., 2025). Despite significant advancements in prophylactic vaccination and cytology- or molecular-based screening technologies, the clinical trajectory from viral acquisition to invasive malignancy is deeply entangled with complex psychological distress, social stigmatization, and cultural taboo (Marlow et al., 2015; Villalona et al., 2025).

Unlike non-communicable malignancies, cervical cancer occupies a unique and precarious position at the intersection of sexually transmitted infections (STIs), reproductive health, and female sexuality (Morse et al., 2023). Because HPV is predominantly transmitted through sexual contact, a positive diagnosis is rarely perceived merely as a biomedical pathology; rather, it frequently triggers pervasive social judgments concerning personal morality, promiscuity, and sexual infidelity (Mohammadi et al., 2026). Sociological frameworks demonstrate that health-related stigma operates as a dynamic and discrediting social process that devalues individuals based on perceived deviations from sociocultural norms of cleanliness, chastity, and bodily integrity (Goffman, 1963; Link & Phelan, 2001). For women diagnosed with HPV or cervical malignancies, this stigmatization manifests across multiple ecological layers—from internalized self-blame and existential guilt to externalized ostracization, marital rupture, and institutional discrimination within healthcare settings (Ayşìn et al., 2026; Nyblade et al., 2017; Scambler, 2009).

The consequences of stigma in this population are profoundly damaging to both clinical outcomes and psychological well-being. Anticipated and enacted stigma significantly undermine secondary prevention efforts, leading to delayed cytology screening, high rates of

loss to colposcopy follow-up, concealment of diagnosis, and therapeutic non-adherence (Rahman et al., 2022; Wang & Hengudomsub, 2025). Furthermore, as the clinical trajectory progresses toward invasive treatments—such as radical hysterectomy, pelvic radiation, or systemic chemotherapy—the bodily alterations, loss of reproductive autonomy, and vaginal side effects generate a secondary layer of physical alienation and relational distress (Ginjupalli et al., 2022; Shrestha et al., 2020; Wapmuk et al., 2025).

Over the past two decades, a growing body of primary qualitative research has explored women's lived experiences of HPV and cervical cancer across diverse geographical and sociocultural environments. However, the existing literature remains fragmented, often confined to specific ethnic sub-populations, localized healthcare settings, or isolated stages of the disease continuum (e.g., exclusively asymptomatic HPV infection or terminal malignancy) (Guliam et al., 2025). Individual qualitative studies, while empirically rich, lack the capacity to conceptualize how sociocultural norms, patriarchal power dynamics, and healthcare institutional structures interact globally to construct and perpetuate stigma across the disease trajectory.

A qualitative meta-synthesis provides a rigorous, interpretive methodology to integrate disparate primary qualitative findings, allowing researchers to transcend mere empirical aggregations and construct higher-order conceptual models (France et al., 2019; Noblit & Hare, 1988). While previous systematic reviews have primarily focused on quantitative epidemiological prevalence or general quality-of-life parameters, there is a distinct lack of a comprehensive, theory-driven meta-synthesis dedicated explicitly to deconstructing the multi-layered architecture of stigma in women affected by HPV and cervical neoplasia.

Therefore, the present meta-synthesis was conducted to systematically integrate and interpret the global qualitative evidence regarding women's lived experiences of stigma associated with HPV infection, pre-invasive lesions, and invasive cervical cancer. By synthesizing disparate primary findings into a cohesive conceptual framework, this study seeks to elucidate the structural, relational, and psychological dimensions of this multifaceted phenomenon. Specifically, this meta-synthesis addresses the following research question: How do women across diverse socio-cultural contexts experience, internalize, and navigate the social stigma associated with HPV-related conditions, ranging from initial viral infection to invasive malignancy?

2. Methodology

2.1. Research Design

This study employed a meta-ethnography approach, an interpretive qualitative synthesis methodology originally developed by Noblit and Hare (1988), to integrate, translate, and conceptualize the existing qualitative evidence regarding the lived experiences of social stigma among women affected by Human Papillomavirus (HPV) and cervical neoplasia. Unlike descriptive aggregative syntheses, meta-ethnography was selected for its capacity to preserve the interpretive context of primary studies while generating a novel, higher-order conceptual model (Noblit & Hare, 1988). The review followed the seven-phase framework of Noblit and Hare and adhered to the PRISMA 2020 statement for systematic search reporting, as well as the eMERGe (Improving reporting of Meta-Ethnography) reporting guidance and ENTREQ framework for the synthesis and interpretive phases. The protocol for this systematic review and meta-ethnography was prospectively registered in PROSPERO (Registration ID: CRD420261517613; available at: https://www.crd.york.ac.uk/PROSPERO/view/CRD420261517613).

2.2. Eligibility Criteria (SPIDER Framework)

To ensure methodological rigor tailored to qualitative inquiry, study eligibility was defined a priori using the SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research type) framework:

- Sample (S): Adult women (≥ 18 years) diagnosed with high-risk or low-risk HPV, genital warts, pre-invasive cervical lesions (CIN), or invasive cervical cancer.
- Phenomenon of Interest (PI): Lived experiences, psychosocial dimensions, and manifestations of stigma (including internalized, anticipated, relational, somatic, and enacted stigma), moral labeling, shame, secrecy, and disclosure dilemmas.
- Design (D): Primary qualitative empirical designs (e.g., phenomenological analysis, grounded theory, qualitative content analysis, thematic analysis, ethnography, and framework analysis).
- Evaluation (E): In-depth participant narratives, first-order constructs (direct patient voices), and second-order constructs (author interpretations) capturing the trajectory and socio-structural mechanisms of stigma.
- Research Type (R): Peer-reviewed original qualitative or mixed-methods empirical investigations published in English or Persian up to the search date. For mixed-methods studies, inclusion was strictly conditional upon the presence of an independently extractable

qualitative component (e.g., verbatim transcripts, participant quotes, and thematic analyses); only qualitative first-order and second-order constructs were extracted into the meta-ethnographic matrix.

Exclusion Criteria: Studies employing purely quantitative designs (e.g., psychometric validations, cross-sectional epidemiological surveys, randomized trials) devoid of qualitative interpretive data were excluded from the formal Noblit and Hare synthesis. Where relevant, select quantitative epidemiological findings were utilized exclusively as contextual background in the Introduction and Discussion sections without entering the conceptual translation matrix.

Following the SPIDER criteria, study screening was conducted in sequential stages. As delineated in the PRISMA 2020 flow diagram (Fig. 1), a total of 4,164 records were initially identified across international and national databases (PubMed: n = 3,519; other international databases: n = 638; Persian databases: n = 7). Following the removal of 381 duplicate records, 3,783 unique records underwent title and abstract screening, resulting in the exclusion of 3,406 records that did not meet the qualitative focus or topical relevance.

Subsequently, 377 full-text reports were retrieved and rigorously appraised for eligibility. Of these, 356 articles were excluded with documented reasons grouped into four categories: (1) quantitative methodology or clinical trials lacking extractable qualitative findings (n = 198); (2) absence of focus on social stigma, moral labeling, or psychosocial impacts (n = 107); (3) ineligible target population, such as exclusively healthcare provider perspectives without patient lived experience (n = 31); and (4) conference abstracts, editorials, or inaccessible full texts (n = 20). Ultimately, 21 conceptually rich primary qualitative studies fulfilled all inclusion criteria (summarized in Table 1). In line with meta-ethnographic principles, studies were selected not for aggregative statistical representation, but for their conceptual capacity to explicate the lived, relational, and structural experiences of stigma.

[Insert Fig. 1 here]

Figure 1. **PRISMA Flow Diagram of the Study Selection Process**

Table 1
Characteristics of the Included Studies

Study (Citation)	Country	Data Collection Method	Analysis Method	Population/ Clinical Context	N	Age (Range / Mean)	Gender	Qualitative Data Richness
Armstrong & Murphy (2008)	United Kingdom	In-depth qualitative interviews	Constant comparative analysis (Grounded Theory)	Women receiving abnormal cervical smear results (HPV/CIN)	30	20–58	Female	High
White et al. (2012)	Zambia	Focus group discussions & in-depth interviews	Thematic content analysis	Women undergoing cervical screening and diagnosed with cervical neoplasia	48	18–59	Female	Moderate
Maar et al. (2013)	Canada	Semi-structured interviews & Sharing circles	Inductive thematic analysis	First Nations indigenous women and healthcare providers	38	21–65	Female	Moderate
Bellinger et al. (2015)	United States	Focus group discussions	Thematic analysis	African-American women navigating cervical cancer screening & stigma	36	21–60	Female	Moderate
Nyblade et al. (2017)	Multi-country (Tanzania & Uganda)	Key informant interviews & Focus groups	Qualitative content analysis	Women living with HPV/cervical cancer & healthcare providers	45	22–60	Female	Moderate
Sundstrom et al. (2019)	United States	In-depth semi-structured interviews	Inductive qualitative analysis	Women navigating HPV diagnosis and reproductive healthcare barriers	26	18–44	Female	High
Shrestha et al. (2020)	Nepal	In-depth qualitative interviews	Thematic analysis	Women receiving oncology treatment for cervical malignancy	16	30–58	Female	Moderate
Ginjupalli et al. (2022)	India	In-depth semi-structured interviews	Thematic content analysis	Women diagnosed with advanced cervical cancer	20	32–65	Female	Moderate
Morse et al. (2023)	United States	Semi-structured interviews	Thematic analysis	Women diagnosed with abnormal Pap smears / HPV	24	21–55	Female	High
Szamreta et al. (2024)	Multi-country (Brazil, China, Germany, US)	Semi-structured qualitative interviews	Framework & thematic analysis	Women diagnosed with locally advanced cervical cancer	44	26–70	Female	Low to Moderate
Adeli et al. (2024)	Iran	Face-to-face semi-structured interviews	Conventional qualitative content analysis	Women diagnosed with anogenital warts attending dermatology clinic	16	20–46	Female	High
Wapmuk et al. (2025)	Nigeria	Semi-structured interviews & Focus groups	Framework analysis	Women undergoing cervical cancer screening / precancer treatment	32	28–62	Female	Moderate

Study (Citation)	Country	Data Collection Method	Analysis Method	Population/ Clinical Context	N	Age (Range / Mean)	Gender	Qualitative Data Richness
Villalona et al. (2025)	United States	Focus group discussions & Individual interviews	Thematic analysis	Hispanic / Latina women with HPV & abnormal cytology	28	20–52	Female	High
Guliam et al. (2025)	Brazil	Semi-structured interviews	Inductive thematic analysis	Low-income socioeconomically marginalized women with high-risk HPV and CIN	22	19–46	Female	High
Wang et al. (2025)	China	In-depth semi-structured interviews	Phenomenological analysis	Women diagnosed with HPV and cervical precancerous lesions	25	23–50	Female	High
Aemehdoust et al. (2025a**)**	Iran	In-depth phenomenological interviews	Phenomenological thematic analysis	Women diagnosed with HPV navigating cyberspace and psychological distress	10	22–43	Female	High
Aemehdoust et al. (2025b**)**	Iran	Semi-structured in-depth interviews	Hermeneutic phenomenological analysis	Women with HPV confronting institutional judgment and screening barriers	10	21–45	Female	High
Mohammadi et al. (2026)	Iran	In-depth semi-structured interviews	Conventional qualitative content analysis	Women diagnosed with high-risk persistent HPV	18	22–48	Female	High
Ayşin et al. (2026)	Turkey	In-depth interviews	Interpretative phenomenological analysis (IPA)	Married women living with genital HPV	15	24–45	Female	High
Schneider-Kamp et al. (2026)	Denmark	Semi-structured qualitative interviews	Cultural & sociological thematic analysis	Women/Mothers negotiating taboos, propriety, and HPV preventive care	24	28–54	Female	Moderate
Bastanmehr et al. (2026)	Iran	In-depth phenomenological interviews	Descriptive phenomenological analysis (Colaizzi)	Women diagnosed with HPV experiencing self-concept injury and psychological distress	25	20–47	Female	High

*Note: Qualitative Data Richness was appraised using a 3-point categorical rating adapted from Ames et al. (2019): High = rich, extensive participant narratives with deep conceptual interpretive analysis; Moderate = adequate verbatim extracts illustrating key descriptive themes with moderate analytical depth; Low/Moderate = descriptive findings with limited participant quotes or secondary focus on broader informational/clinical needs (e.g., Szamreta et al., 2024).

2.3. Search Strategy and Information Sources

A comprehensive systematic search was executed from January 1, 1996, to September 16, 2026, without geographic restrictions. The lower bound of 1996 was selected on substantive methodological and epidemiological grounds: the mid-1990s marked the definitive consensus by the World Health Organization and the International Agency for Research on Cancer (IARC) establishing oncogenic HPV as the primary etiological agent of cervical neoplasia, alongside the commercial emergence of clinical HPV DNA testing. Consequently, empirical investigations into the psychosocial repercussions, disclosure dilemmas, and moral/social stigmatization of HPV diagnosis did not emerge in the Behavioural and qualitative literature prior to this threshold.

Seven international electronic databases were systematically queried: PubMed/MEDLINE, Scopus, Web of Science Core Collection, APA PsycINFO, CINAHL (via EBSCOhost), Embase (Elsevier), and ProQuest Dissertations & Theses Global. To mitigate Anglocentric

publication bias and ensure representation of sociocultural contexts with pronounced moral conservatism, three national Iranian databases (Scientific Information Database [SID], Magiran, and IranMedex/Noormags) were searched using standardized Persian search terms.

The search strategy was structured around three conceptual clusters connected by the Boolean operator AND: (1) clinical condition and etiology (e.g., *"Human Papillomavirus"*, *"HPV"*, *"cervical dysplasia"*, *"genital warts"*), (2) psychosocial phenomena (e.g., *"social stigma"*, *"stigmatization"*, *"moral labeling"*, *"shame"*, *"guilt"*, *"social isolation"*), and (3) qualitative methodology (e.g., *"qualitative research"*, *"phenomenolog"*, *"grounded theory"*, *"thematic analysis"*, *"lived experience"*, *"interview"*). Search syntax was customized to each platform's indexing architecture, incorporating Medical Subject Headings (MeSH), Emtree terms, APA Index Terms, truncation symbols, and field-specific tags (e.g., [tiab] in PubMed, TITLE-ABS-KEY in Scopus).

In compliance with PRISMA 2020 (Item 7), the complete, unabridged search strings, field limits, and database coverage parameters for all electronic sources are documented in Supplementary Appendix 1. To ensure bibliographic saturation, grey literature, clinical registers, and forward/backward citation chaining of all eligible articles and relevant reviews were hand-searched. All retrieved records were imported into EndNote 21 for automated and manual duplicate removal prior to screening.

2.4. Study Selection and Critical Quality Appraisal

The selection process was conducted in two sequential stages: initial title/abstract screening, followed by full-text evaluation against the inclusion criteria. Both stages were performed independently by two reviewers, with discrepancies resolved through iterative consensus discussions or consultation with a third senior reviewer.

Methodological quality of the included studies was independently evaluated by two reviewers using the Joanna Briggs Institute (JBI) Critical Appraisal Checklist for Qualitative Research (comprising 10 criteria assessing philosophical congruity, methodological rigor, researcher reflexivity, and ethical integrity). The overall methodological quality across all 21 studies was high to moderate, with scores ranging from 7 to 10 out of 10 (mean score: 8.6; see Table 2). The most frequent methodological limitations identified were the lack of explicit statements locating the researcher culturally/theoretically (Criterion 6) and insufficient documentation of researcher reflexivity (Criterion 7).

In accordance with meta-ethnographic guidance (Noblit & Hare, 1988), no study was excluded solely on the grounds of methodological quality scores. Methodological flaws do not necessarily negate the conceptual and interpretive value of qualitative narratives; instead, quality appraisal scores were used to contextualize findings and guide interpretive weight during reciprocal translation, ensuring that core analytical themes were anchored in high-integrity data.

Table 2
JBI Critical Appraisal of Included Qualitative Studies

Study (Citation)	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Total Score (/10)	Overall Quality
Armstrong & Murphy (2008)	Y	Y	Y	Y	Y	U	Y	Y	Y	Y	9/10	High
White et al. (2012)	Y	Y	Y	Y	Y	N	N	Y	Y	Y	8/10	High
Maar et al. (2013)	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	8/10	High
Bellinger et al. (2015)	Y	Y	Y	Y	Y	N	N	Y	Y	Y	8/10	High
Nyblade et al. (2017)	Y	Y	Y	Y	Y	N	N	Y	Y	Y	8/10	High
Sundstrom et al. (2019)	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	9/10	High
Shrestha et al. (2020)	Y	Y	Y	Y	Y	N	N	Y	U	Y	7/10	Moderate
Ginjupalli et al. (2022)	Y	Y	Y	Y	Y	N	N	Y	Y	Y	8/10	High
Morse et al. (2023)	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	9/10	High
Szamreta et al. (2024)	Y	Y	Y	Y	Y	N	N	Y	Y	Y	7/10	Moderate
Adeli et al. (2024)	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	9/10	High
Wapmuk et al. (2025)	Y	Y	Y	Y	Y	N	N	Y	Y	Y	8/10	High
Villalona et al. (2025)	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	9/10	High
Guliam et al. (2025)	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	9/10	High
Wang et al. (2025)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10/10	High
Aemehdoust et al. (2025a)	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	9/10	High
Aemehdoust et al. (2025b)	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	9/10	High
Mohammadi et al. (2026)	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	9/10	High
Ayşin et al. (2026)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10/10	High
Schneider-Kamp et al. (2026)	Y	Y	Y	Y	Y	N	N	Y	Y	Y	8/10	High
Bastanmehr et al. (2026)	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	9/10	High

JBI Criteria: Q1: Congruity between philosophical perspective and methodology; Q2: Congruity between methodology and research question; Q3: Congruity between methodology and data collection methods; Q4: Congruity between methodology and data analysis; Q5: Congruity between methodology and interpretation; Q6: Locating researcher culturally/theoretically; Q7: Researcher reflexivity; Q8: Representation of participant voices; Q9: Ethical approval; Q10: Relationship between conclusions and analysis. (Y = Yes; N = No; U = Unclear).

2.5. Data Synthesis

Data synthesis will follow the meta-ethnographic approach of Noblit and Hare (1988), involving three key stages: (1) Reciprocal Translation: comparing findings from one study to another to identify shared concepts and cross-study translations; (2) Refutational Synthesis: critically analyzing contradictory findings to refine conceptual boundaries; and (3) Lines of Argument Synthesis: integrating these translations into a final, higher-order conceptual framework that provides novel explanations for the phenomenon of social stigma in women with HPV.

To address the complexity of qualitative findings, we employed a *Reciprocal Translation* approach, which serves as the core of our meta-ethnography. Rather than merely aggregating narratives, we mapped 21 primary studies into four distinct analytical themes through a *Translation Matrix* (Table 2).

The translation process was conducted in three rigorous steps:

1. **Concept Mapping**: We identified recurring descriptive themes across the literature, focusing on shared nuances in the Iranian context (e.g., *moralized stigma* vs. *bodily shame*).
2. **Reciprocal Translation**: We examined how concepts from one study (e.g., *relational strain* in Adeli et al.) could be "translated" into the findings of another (e.g., *broken trust* in Study 4). This step ensured that our synthesis retained the idiographic depth of the original studies while building a higher-level theoretical framework.
3. **Third-Order Construction**: We developed final analytical themes that transcend the original findings. For instance, the "Disclosure Paradox" and "Agentic Reconstruction" were constructed by synthesizing conflicting data points across studies, demonstrating that Iranian women's experiences are not monolithic but form a *Dynamic Trajectory*—from initial stigmatized isolation to the tactical negotiation of their social and physical boundaries.

This rigorous translation matrix (see Table 3 for exemplars) ensures that our findings are rooted in evidence and move beyond descriptive summary, thus establishing the theoretical contribution of this meta-ethnography.

Table 3
Translation Matrix: Synthesis of Analytical Themes and Reciprocal Translation across Primary Studies

Analytical Theme	Descriptive Theme	First-Order (Participant Quote)	Second-Order (Author Interpretation)	Synthesis Logic (Reciprocal Translation)
Gendered and Moralized Corporeal Stigma	Root Attribution and Moralized Contagion	*"I felt as if an invisible mark was stamped on my forehead, and everyone would notice."* (Bastanmehr et al. 2026)	The infection is equated with a moral "stain" or "invisible mark," reflecting internalized stigma driven by cultural taboos regarding female sexual purity.	**Reciprocal Translation**: This study confirms that moralized contagion transcends cultural borders. While Western studies (e.g., Armstrong et al.) highlight sexual promiscuity, this study translates that into "family dishonor" in the Iranian context, creating a unified global construct of *Gendered Moral Stigma*.
Clinical and Institutional Stigma	Financial Exploitation and Institutional Indifference	*"I remember last year each vaccine was 18 million tomans… We couldn't afford it… The medical system sees patients as moving ATMs."* (Aemehdoust et al. 2025a)	The healthcare system, through commodification of treatment and lack of insurance support, reinforces the patient's stigma by reducing their human health crisis to a transactional, market-driven process.	**Reciprocal Translation**: While Western literature (e.g., studies on health literacy) focuses on "medical paternalism," this study translates the construct into "Institutional Indifference" in the Iranian context. Here, stigma is not just a doctor's attitude, but a structural barrier (cost/policy) that forces women into "financial isolation," confirming that institutional stigma acts as a multiplier of moral stigma.
Relational Stigma and the Disclosure Paradox	Spousal Suspicion and the Burden of Disclosure	*"I talked to my husband about it, but I didn't get a good feeling. He doubted me… It was like he was indirectly saying, 'This comes from sex.' Since I don't have relationships with others, how did you get it?"* (Adeli et al. 2024)	Disclosure functions as a double-edged sword; while it is a mechanism to seek emotional support, it inadvertently triggers the "stigma of suspicion" and relational strain, as partners equate the infection with infidelity.	**Reciprocal Translation**: This study translates "Interpersonal Stigma" into a "Disclosure Paradox." Unlike Western studies where disclosure is seen as an empowering coping mechanism, here disclosure is a risk-laden act that forces women to negotiate their moral reputation with their partners. This confirms that in Iranian family dynamics, the partner's "Suspicion of Infidelity" becomes a primary source of relational stigma.
Dynamic Trajectory and Transformative Agency	From Wound to Wisdom (Agentic Reconstruction)	*"This virus raised my standards; if a partner wants to judge me, they are simply not my type."* (Mohammadi et al. 2026)	The illness functions as a catalyst for cognitive reframing; the woman moves from "shame-laden identity" to a "boundary-setting agent."	**Reciprocal Translation**: Unlike Western studies that emphasize "self-efficacy" as an individualistic psychological outcome, here, agency is "relational and boundary-driven." The "Wound" is the societal stigma; the "Wisdom" is the tactical reconstruction of self-worth and relational boundaries, proving that transformation in the Iranian context is not just internal, but a protective reaction against a judgmental social environment.

2.6. Researcher Reflexivity and Positionality

In qualitative synthesis and meta-ethnography, developing third-order interpretations is inherently an interpretive process shaped by the research team's disciplinary training, conceptual perspectives, and epistemological assumptions (Noblit & Hare, 1988). To ensure the credibility, authenticity, and empirical grounding of the synthesized constructs—such as transforming wounds into wisdom—systematic reflexive measures were implemented throughout all stages of translation and synthesis.

The research team comprises academic researchers specializing in health psychology and virology. While this multidisciplinary background provided profound insight into both the biological realities of the virus and the psychological distress, coping mechanisms, and relational ramifications of health-related stigma, it also introduced potential interpretive risks: a tendency to view participants' lived experiences either through a strictly biomedical lens or predominantly through individualized psychological pathology. To counterbalance these disciplinary lenses and ensure an inductive synthesis grounded strictly in participants' own lifeworlds, three key strategies were practiced:

1. **Reflexive Journaling and Audit Trails**: The primary reviewer maintained continuous reflexive notes during reciprocal and refutational translation, critically examining initial interpretive inclinations to pathologize emotional distress or over-attribute meanings to individual cognitive processes.

2. **Peer Debriefing and Team Consensus**: Emerging first- and second-order constructs were critically reviewed and discussed in regular debriefing sessions among the team members. Synthesis concepts and metaphors (e.g., transforming wounds into wisdom) were subjected to rigorous cross-examination to verify that they faithfully mirrored the participants' original narratives and primary authors' interpretations, rather than imposed therapeutic models.

3. **Theoretical Bracketing**: The synthesis team actively practiced bracketing (epoché) of preconceived psychological models, allowing socio-cultural dynamics, interpersonal moral labeling, and participant resilience to emerge authentically from the primary texts.

3. Results

Following the systematic meta-ethnographic synthesis approach outlined by Noblit and Hare (1988), the findings of the 21 included primary studies were analysed line-by-line. First-order constructs (direct participant narratives) and second-order constructs (original authors' interpretations) were systematically extracted, compared, and translated across studies.

Through reciprocal translation, refutational exploration, and lines-of-argument synthesis, these data were initially categorised into nine comprehensive descriptive themes representing the phenomenological and situational components of the stigma trajectory. Subsequently, by elevating the synthesis to a higher conceptual level (third-order interpretation), four overarching analytical themes were generated to theorize the socio-structural, relational, and intrapsychic mechanisms underlying HPV-related stigma.

3.1. Descriptive Themes

3.1.1. Root Attribution and Moralized Contagion

Across diverse geographical and cultural contexts, women diagnosed with HPV engage in an active cognitive and moral search for the "why" behind their infection. HPV is rarely interpreted as a common, ubiquitous sexually transmitted infection; rather, it is immediately moralized. Societal representations link the pathogen exclusively to sexual promiscuity, deviance, and marital infidelity (Armstrong & Murphy, 2008; Wapmuk et al., 2025).

In Middle Eastern and traditional collectivist societies, the diagnosis is perceived as an indelible "black mark" or "sticky stain" on the woman's moral character and family honor (*Abero*) (Bastanmehr et al., 2026; Mohammadi et al., 2026). Women observe that cultural norms hold the female body solely responsible for sexual purity, whereas male promiscuity is routinely rationalized or silenced, leaving women to shoulder the moral culpability of transmission (Morse et al., 2023; Nyblade et al., 2017).

3.1.2. Somatosensory Shame and Rupture of Feminine Integrity

The anatomical localization of the infection within the reproductive tract triggers severe somatosensory shame. Participants across multiple studies describe an acute sensation of physical contamination, feeling "dirty," "decayed," "unclean," or "ruined" (Ayşìn et al., 2026; Villalona et al., 2025; White et al., 2012).

The appearance of visible lesions or the requirement for cervical procedures (such as colposcopy, biopsy, or LEEP) shatters their embodied feminine identity. Women report feeling that their reproductive organs have been compromised, which severely impairs their

sexual self-image, evokes intense dyspareunia (both physical and psychological), and leads to profound sexual avoidance (Guliam et al., 2025; Wang & Hengudomsub, 2025).

3.1.3. Intrapsychic Turmoil, Existential Dread, and Oncological Catastrophizing

The receipt of an HPV-positive test result or abnormal cervical cytology elicits an acute wave of intrapsychic distress characterized by shock, panic, anger, and deep-seated guilt (Bastanmehr et al., 2026). A pervasive feature of this psychological turmoil is relentless rumination over the origin of the virus and obsessive dread of oncological progression.

In low- and middle-income settings where formal health literacy is constrained, women frequently catastrophize HPV as an immediate death sentence or equate it with the social and physiological fatality of HIV (Shrestha et al., 2020; White et al., 2012). This existential fear of premature death, combined with the shame of having a sexually transmitted virus, generates debilitating depressive symptoms and chronic anticipatory grief (Adeli et al., 2024; Bastanmehr et al., 2026).

3.1.4. Relational Strain, Asymmetrical Blame, and the Disclosure Paradox

The relational landscape of infected women is marked by severe friction and communication breakdown. When disclosing the diagnosis to male partners, women face a perilous relational paradox: seeking emotional solace and shared medical responsibility exposes them to the immediate risk of marital dissolution, accusations of unfaithfulness, verbal abuse, or abandonment (Adeli et al., 2024; Villalona et al., 2025).

In patriarchal settings, even when the viral transmission clearly originated from the male partner's extramarital relations, the blame is often projected back onto the woman (Mohammadi et al., 2026; Morse et al., 2023). To prevent familial disruption and protect their social standing, women frequently resort to total concealment within their broader social networks, resulting in profound relational loneliness (Ayşìn et al., 2026; Ginjupalli et al., 2022).

3.1.5. Institutional Indifference, Commercialized Exploitation, and Medical Judgment

Rather than serving as neutral spaces of healing, healthcare facilities frequently operate as environments of secondary victimization. Women report encountering moralistic judgment, dismissive non-verbal cues, and paternalistic attitudes from physicians and nursing staff during screening and treatment (Maar et al., 2013; Morse et al., 2023).

In privatized and commercialized healthcare contexts, women express deep distress over feeling objectified as financial commodities—being treated as "bags of money" by medical centers that impose exorbitant costs for repetitive diagnostic tests without providing empathetic explanations or clear prognostic reassurance (Aemehdoust et al., 2025). Furthermore, confusing, jargon-laden, or contradictory clinical communication exacerbates cognitive ambiguity, forcing patients to rely on unverified online forums that amplify cyber-stigma and anxiety (Armstrong & Murphy, 2008; Szamreta et al., 2024).

3.1.6. Intersectionality, Cultural Taboos, and Structural Vulnerabilities

The burden of HPV stigma is profoundly shaped by intersecting structural axes, including socio-economic status, race, and geographic marginalization. In Indigenous, rural, and racialized minority communities, the stigma of genital infection intersects with historical distrust of the medical system, structural poverty, and lack of insurance coverage (Bellinger et al., 2015; Maar et al., 2013; Sundstrom et al., 2019).

Cultural archetypes (such as the expectation of stoicism or the mandate to preserve the family's public reputation at all costs) compel women to suppress their physical symptoms and delay screening. Furthermore, the structural framing of HPV vaccination and screening solely as a female sexual responsibility perpetuates gendered taboos and absolves men and broader institutions from public health accountability (Schneider-Kamp et al., 2026).

3.1.7. Characteristics, Fluctuations, and Temporal Trajectory of Stigma

Stigma is not an invariant state; its nature, intensity, and manifestations fluctuate dynamically across the clinical continuum. In the immediate post-diagnostic phase, stigma presents as acute "anticipatory and moral terror"—dominated by fear of social exposure and guilt (Wapmuk et al., 2025).

As women move through invasive clinical interventions (e.g., repeated colposcopies, surgical excisions, or oncological therapies), the stigma transitions into an "embodied-somatic manifestation," marked by physical side effects, visible clinical marking, and chronic

medical fatigue (Wang & Hengudomsub, 2025). This trajectory fluctuates between periods of latent containment when asymptomatic and acute flare-ups of stigma during clinical follow-ups or relationship transitions (Bastanmehr et al., 2026).

3.1.8. Coping Strategies and Defensive Boundary Management

To navigate the distress of stigmatization, women employ diverse Behavioural, cognitive, and spiritual coping mechanisms.

• **Maladaptive and avoidant strategies**: Include absolute secretiveness, social withdrawal, emotional numbing, avoidance of follow-up Pap smears or HPV DNA testing, and somatic hypervigilance (Ayşin et al., 2026; Nyblade et al., 2017).

• **Adaptive and proactive strategies**: Involve selective boundary management (carefully curating a microscopic circle of trusted confidantes), independent health-literacy acquisition, and spiritual surrender (Bastanmehr et al., 2026; Villalona et al., 2025). In Middle Eastern studies, religious reframing (*Tawakkul*, prayer, and viewing the illness as a divine spiritual test rather than an unclean punishment) serves as a potent psychological shield that neutralizes internalized moral guilt (Bastanmehr et al., 2026; Mohammadi et al., 2026).

3.1.9. The Vicious Cycle and Divergent Outcomes: Acceptance vs. Despair

A substantial proportion of women become trapped in a self-reinforcing vicious cycle: perceived social stigma drives intense concealment; concealment precludes access to psychosocial support and health education; persistent ignorance fosters catastrophic rumination; and unabated emotional distress leads to clinical avoidance, delayed care, and heightened feelings of unworthiness and isolation.

Ultimately, the developmental trajectory of coping culminates in two divergent longitudinal pathways:

• **Non-Acceptance and Chronic Alienation**: Characterized by chronic depressive symptoms, persistent somatic shame, deep alienation from one's own body, permanent sexual shutdown, and fractured spousal bonds (Adeli et al., 2024). Women in this trajectory remain arrested in anticipatory dread, perceiving the virus as an irreversible moral condemnation.

• **Acceptance, Re-signification, and Agency**: Women cognitively decouple their personal moral worth from their viral status, normalize the biological reality of the pathogen, engage in proactive self-compassion, and reconstruct their life narratives. Through this epistemological shift, somatic vulnerability is transformed into existential resilience, renewed relational autonomy, and adaptive health-seeking Behaviour (Bastanmehr et al., 2026; Mohammadi et al., 2026).

3.2. Analytical Themes

3.2.1. Gendered and Moralized Corporeal Stigma

The first analytical theme indicates that HPV-related stigma is not simply a response to a biological condition. Rather, it is produced through a process in which the female body is interpreted, monitored, and evaluated according to gendered moral expectations. A viral infection becomes socially meaningful when it is associated with sexual conduct, fidelity, purity, and respectability.

This process transforms the body from a biological site of infection into a moralized social object. Women may consequently internalize public judgments and reinterpret the diagnosis as evidence of personal failure, impurity, or loss of femininity. The analytical significance of this theme lies in showing that stigma does not merely add emotional distress to the illness; it reorganizes the meaning of the illness and reshapes the woman's relationship with her body and identity.

3.2.2. Clinical and Institutional Stigma

A critical theoretical insight derived from the synthesis is the paradox of the clinical sanctuary. While the modern biomedical apparatus possesses the diagnostic and prophylactic technology to manage HPV and prevent cervical neoplasia, its institutional delivery frequently inflicts secondary symbolic trauma upon patients.

In clinical encounters, the biomedical gaze often strips the woman of her subjective personhood, reducing her to an infected anatomical site, an object of moral scrutiny, or a commercialized revenue unit (Aemehdoust et al., 2025; Maar et al., 2013).

The lack of empathetic, stigma-sensitive communication from healthcare providers creates a biopolitical failure: the institution tasked with eradication of disease inadvertently becomes a structural driver of patient alienation, driving vulnerable women away from life-saving screening regimens and regular follow-ups (Morse et al., 2023; Nyblade et al., 2017).

3.2.3. Relational Stigma and the Disclosure Paradox

At the interpersonal level, the synthesis uncovers an intractable structural dilemma termed the safety-support paradox. In conventional chronic illness models, self-disclosure is the primary vehicle through which patients mobilize social, emotional, and physical support from their primary attachments. In the context of HPV, however, the very mechanism required to obtain relational safety is itself the primary catalyst of social risk.

Because the virus is tied to cultural narratives of betrayal and sexual promiscuity, disclosing one's diagnostic status to a spouse or family member risks triggering acute relational destruction—ranging from emotional rejection and financial abandonment to physical violence and reputational ruin (Adeli et al., 2024; Villalona et al., 2025).

Women are thus coerced into an agonizing trade-off: enduring the psychological suffocation of total secrecy to preserve social survival, or risking relational catastrophe for the uncertain hope of empathy.

3.2.4. Dynamic Trajectory and Transformative Agency

Contradicting earlier models of stigma that portray stigmatized individuals solely as passive, subjugated victims, this meta-ethnography reveals that the lived experience of HPV stigma is fundamentally dialectical and transformative.

Although women initially experience acute psychological fragmentation, corporeal shame, and systemic marginalization, the trajectory does not terminate in chronic helplessness. Through a dialectical encounter with their diagnosis, women actively mobilize counter-narratives of resistance.

By leveraging spiritual reframing (reclaiming moral innocence through divine connection), engaging in autonomous health-literacy acquisition (demystifying viral biology), and enacting strategic boundary management, women deconstruct internalized stigma.

This process represents an epistemological shift from "wound to wisdom"—a transformation wherein somatic and social suffering is reconstructed into moral agency, post-traumatic resilience, and peer-advocacy (Bastanmehr et al., 2026; Guliam et al., 2025; Mohammadi et al., 2026).

[Insert Fig. 2 here]

Figure 2. **Illustrates the synthesis logic, mapping the nine descriptive themes to the four overarching analytical themes, demonstrating the progression from first- and second-order constructs to third-order theoretical interpretation.**

4. Discussion

This meta-ethnographic synthesis provides a comprehensive, multi-layered understanding of how women experience, internalize, and navigate stigma associated with Human Papillomavirus (HPV) infection across diverse socio-cultural contexts. By systematically synthesizing qualitative evidence from 21 primary studies, our findings transcend purely biomedical descriptions, revealing that HPV-related stigma operates as a dynamic, deeply moralized, and structurally mediated phenomenon. The synthesis generated four overarching analytical themes: (1) Gendered and Moralized Corporeal Stigma, characterized by the moralization of infection, somatic contamination, and spoiled identity; (2) Clinical and Institutional Stigma, driven by secondary symbolic trauma, commercialized objectification, and healthcare provider judgment; (3) Relational Stigma and the Disclosure Paradox, manifested through asymmetrical blame, abandonment fears, and the safety-support dilemma; and (4) Dynamic Trajectory and Transformative Agency, highlighting the dialectical transition from acute psychological fragmentation to moral resistance, post-traumatic resilience, and autonomous empowerment. Together, these dimensions demonstrate that the psychosocial burden of HPV is fundamentally shaped by gendered power dynamics, cultural purity codes, and healthcare delivery failures.

4.1. Theoretical Integration: Spoiled Identity and the Sociological Mechanics of Stigma

The lived experiences synthesized in this study strongly align with and expand classic sociological and psychological conceptualizations of health-related stigma. According to Goffman's (1963) foundational framework on spoiled identity, stigma arises when an attribute discredits an individual, reducing them from a whole and usual person to a tainted, discounted one. In our synthesis, an HPV diagnosis serves as a potent trigger for identity degradation (*Moralized Self-Perception*). Because HPV is sexually transmitted, the diagnosis is rarely received as a neutral biomedical event; rather, it is immediately translated into moral transgression, promiscuity, and personal failure

(Marlow et al., 2015; Mohammadi et al., 2026). Women internalize these societal judgments, shifting from viewing themselves as respectable, virtuous members of their communities to carrying an enduring, dirty "stain" (Ayşìn et al., 2026; Morse et al., 2023).

This ontological disruption is further explained through Link and Phelan's (2001) conceptualization of stigma as the co-occurrence of four interrelated components: labeling, stereotyping, separation ("us" vs. "them"), status loss, and discrimination, all unfolding within unequal power distributions:

• **Labeling and Stereotyping**: The clinical designation of HPV is conflated with sexual promiscuity and infidelity, reinforcing rigid gender double standards where women are disproportionately blamed for acquiring and transmitting the infection (Villalona et al., 2025; Wang & Hengudomsub, 2025).

• **Separation and Social Distance**: Women perceive a distinct boundary between the "morally pure" community and their own compromised state, prompting severe self-imposed isolation and secrecy to prevent anticipated social death (Ginjupalli et al., 2022).

• **Status Loss and Structural Discrimination**: Within family networks and patriarchal kinship systems, the disease compromises women's social capital and relational security, often manifesting in spousal abandonment, domestic hostility, or diminished marital value (Nyblade et al., 2017; Wapmuk et al., 2025).

Crucially, our findings extend Scambler's (2009) distinction between *felt (internalized) stigma*—the shame and anticipatory fear of encountering prejudice—and *enacted stigma*—overt acts of discrimination. The synthesis demonstrates that felt stigma often precedes and exceeds enacted stigma in early diagnostic phases, leading to voluntary social withdrawal and delayed screening. However, as the condition progresses through invasive clinical interventions (e.g., colposcopy, biopsies, surgical excisions), somatic alienation becomes prominent, demonstrating that the nature of stigma is inherently fluid and tied to diagnostic staging and bodily alterations.

4.2. Reconstructing Agency: From Stigmatized Victimhood to Meaning-Making and Post-Traumatic Growth

Crucially, our findings extend conventional health-stigma paradigms—which frequently portray diagnosed individuals merely as passive recipients of social subjugation—by documenting the dialectical emergence of transformative agency and meaning reconstruction (Tedeschi & Calhoun, 2004). Rather than remaining permanently trapped in chronic helplessness, many women mobilize cognitive, spiritual, and relational counter-strategies to actively challenge internalized stigma.

Through spiritual reframing (e.g., *Tawakkul*, prayer, and viewing illness as a sanctifying trial rather than a punitive moral failure) and proactive health-literacy acquisition, women effectively demystify viral biology and decouple their fundamental self-worth from their viral status (Bastanmehr et al., 2026; Mohammadi et al., 2026). This cognitive-existential shift mirrors the mechanics of Post-Traumatic Growth (PTG) and biographical renewal (Bury, 1982), wherein navigating the adversity of corporeal shame serves as an epistemological catalyst—transforming somatic vulnerability into moral empowerment, selective interpersonal boundary management, and informal peer-advocacy (Guliam et al., 2025).

4.3. Cross-Cultural Variations and Gendered Power Structures

A paramount insight emerging from this meta-synthesis is that HPV-related stigma does not operate in a socio-cultural vacuum; rather, its intensity, expression, and consequences are heavily mediated by localized gender norms, family honor codes, and structural inequities. Across the analysed contexts—spanning the Middle East, Sub-Saharan Africa, Latin America, Asia, and marginalized communities in high-income settings—stigma fundamentally serves as a mechanism of gendered social control.

In conservative, collectivistic, and patriarchal contexts (e.g., Iran, Turkey, and rural regions of South Asia and Africa), a woman's social worth is deeply tied to culturally defined notions of sexual purity, marital modesty, and familial reputation (*Abero*) (Ayşìn et al., 2026; Mohammadi et al., 2026; Nyblade et al., 2017). In these settings, an HPV diagnosis transcends individual pathology; it is weaponized as collective shame (*Familial & Marital Shame*). Women are subjected to intense spousal scrutiny, fear of divorce or abandonment, and ostracization by extended in-laws who view the illness as an infraction against family honor (Morse et al., 2023; Wapmuk et al., 2025). Importantly, this dynamic reflects a pervasive sexual double standard: while women are routinely presumed guilty of marital infidelity and held solely responsible for introducing infection into the household, men's antecedent sexual networks are systematically obscured or culturally excused (Guliam et al., 2025; Wang & Hengudomsub, 2025).

Conversely, in high-resource Western contexts and among urban populations (e.g., studies in the United States and the United Kingdom), the overt manifestations of familial honor shame are less pronounced; however, stigma shifts toward internalized moral failure,

psychological distress, and interpersonal awkwardness (Marlow et al., 2015; Villalona et al., 2025). Yet, when examining immigrant or historically marginalized sub-populations within Western societies—such as Somali immigrant women or ethnic minorities—the synthesis reveals striking parallels with traditional settings (Rahman et al., 2022). For these women, intersecting vulnerabilities, linguistic barriers, and protective community modesty norms compound perceived stigma, creating profound reluctance to participate in routine cervical cytology screening or disclose abnormal test results.

Furthermore, Parker and Aggleton's (2003) structural stigma model helps elucidate why women across diverse economic landscapes experience somatic and psychological isolation. Stigma functions to reproduce pre-existing social hierarchies (Parker & Aggleton, 2003). When women experience disruption to their bodily integrity, reproductive self-image, or sexual functionality due to visible lesions or invasive procedures, they face dual marginalization: first as individuals carrying a sexually transmitted viral marker, and second as women who perceive a failure in fulfilling cultural expectations of reproductive health and sexual companionship (Ginjupalli et al., 2022; Shrestha et al., 2020). Consequently, coping mechanisms such as hyper-vigilant concealment, selective disclosure, and medical non-adherence are rational defensive strategies deployed to survive oppressive social surveillance.

4.4. Implications for Clinical Practice, Healthcare Policy, and Interventions

The identification of *Clinical and Institutional Stigma* as a core analytical theme underscores that healthcare environments are not inherently neutral therapeutic spaces; frequently, they act as primary sites of stigmatization, secondary trauma, and patient alienation. Addressing these entrenched barriers requires multi-level, trauma-informed interventions spanning micro-clinical encounters, institutional protocols, and broad macro-policy frameworks:

1. Provider Sensitization and Anti-Stigma Training:

Clinical encounters must move away from moralistic, accusatory, or dismissive communication patterns (*Institutional Indifference*). Healthcare professionals—including gynecologists, general practitioners, oncologists, and nursing staff—require mandatory, continuous training on destigmatizing diagnostic communication (Batabyal et al., 2025; Nyblade et al., 2017). Framing HPV infection as a ubiquitous, highly prevalent human virus rather than an exceptional marker of sexual deviance can significantly alleviate initial moral distress and anticipatory panic (Marlow et al., 2015; Rahman et al., 2022).

2. Confidentiality, Privacy, and Integrated Care Models:

Given the intense familial and community surveillance documented across conservative and rural settings, institutional infrastructures must rigorously safeguard visual and auditory privacy during gynecological consultations and specimen collection. Integrated service delivery models—where cervical screening, HPV DNA testing, and vaccination are routinely embedded within comprehensive, general primary healthcare or reproductive health visits—can normalize service utilization and effectively circumvent the stigma of visiting specialized STI or oncology clinics (Batabyal et al., 2025; Villalona et al., 2025).

3. Psychosocial Support and Spousal Counseling:

Because the psychosocial burden of HPV frequently centers on marital dissolution, somatic alienation, and relational hostility, healthcare programs must incorporate couples-based psychoeducation and culturally sensitive counseling (Ayşin et al., 2026; Mohammadi et al., 2026). Engaging male partners in educational sessions regarding HPV transmission, natural clearance, latency, and the asymptomatic carrier state can de-escalate unfounded marital accusations and mitigate domestic abandonment.

4. Patient Education on HPV Natural History:

Counseling should explain that most HPV infections become undetectable within one to two years and that a later positive test cannot establish when the infection was acquired or prove recent infidelity.

5. Public Health Messaging and Destigmatized Screening Policies:

At the macro level, national cervical cancer prevention campaigns must critically evaluate their public health narratives. Educational materials should emphasize widespread epidemiological exposure, high-risk oncogenic viral biology, and the preventive efficacy of HPV

vaccination and routine cytology, explicitly decoupling disease narratives from personal morality, sexual purity, and character judgments (Wang & Hengudomsub, 2025).

4.5. Strengths and Limitations

This meta-synthesis exhibits several methodological and conceptual strengths:

• **Methodological Rigor**: By adhering strictly to the meta-ethnographic synthesis approach established by Noblit and Hare (1988) and following the eMERGe reporting guidelines, this review maintains transparent, line-by-line reciprocal and refutational translation, avoiding superficial thematic aggregation.

• **Hierarchical Depth**: The explicit differentiation between primary descriptive building blocks (Descriptive Themes) and third-order conceptual interpretations (Analytical Themes) ensures robust analytical validity and grounded credibility.

• **Global Socio-Cultural Scope**: Synthesizing qualitative evidence across diverse geographic and cultural landscapes (spanning the Middle East, Sub-Saharan Africa, Latin America, Asia, and North America) allows for nuanced cross-cultural comparisons while identifying universal structural drivers of stigma.

Nevertheless, some limitations should be acknowledged:

• **Language Bias**: Inclusion was restricted to peer-reviewed qualitative studies published in English and Persian, potentially omitting relevant findings documented in other languages (such as Spanish, French, or Portuguese).

• **Heterogeneity of Disease Trajectory**: The synthesized sample encompassed women diagnosed with asymptomatic HPV, precancerous cervical intraepithelial neoplasia (CIN), and advanced clinical lesions. Although this trajectory provided valuable longitudinal insights into how stigma evolves across clinical stages, specific physical manifestations (e.g., surgical interventions vs. asymptomatic diagnostic shock) carry distinct phenomenological nuances that warrant future stage-specific qualitative investigation.

• **HPV Genotype Heterogeneity**: The included studies did not consistently distinguish between high-risk and low-risk HPV genotypes. Consequently, this synthesis could not examine whether stigma and psychological distress differ between women with visible genital warts and those with high-risk HPV detected through screening. Future qualitative research should explore these experiences separately.

• **Heterogeneity of Qualitative Data Richness**: A notable methodological limitation pertains to the heterogeneity of qualitative data richness across the included primary studies. While the majority of investigations provided conceptually dense, phenomenologically rich verbatim accounts of lived stigma (rated as 'High'), a few studies exhibited more descriptive or diluted qualitative depth (e.g., Szamreta et al., 2024, which primarily evaluated broad clinical and informational needs rather than the lived phenomenology of stigma per se). Although these less granular studies contributed valuable socio-structural context, their thinner narrative density meant they contributed primarily to lower-order descriptive mappings rather than driving higher-order third-order interpretations. Future qualitative syntheses could benefit from applying stricter conceptual threshold models during initial screening to maximize interpretive depth.

• **Under-representation of Male Partners' Perspectives**: The primary data reflects predominantly the lived experiences of affected women. Future qualitative inquiries should directly explore male partners' and extended family members' perspectives to capture a more complete dyadic picture of relational stigma dynamics.

5. Conclusion

This meta-ethnographic synthesis sought to answer the primary research question: How do women across diverse socio-cultural contexts experience, internalize, and navigate the social stigma associated with HPV infection? Our findings demonstrate that HPV-related stigma is not a static psychological reaction, but a dynamic, structurally mediated process of identity negotiation. It transitions from an initial "moral shock"—triggered by cultural taboos regarding female purity—into a multifaceted social burden perpetuated by institutional indifference and relational suspicion. The synthesis reveals that women's experiences are defined by a "disclosure paradox," where the vital need for support is systematically stifled by the fear of rejection and moral labeling. However, this trajectory is not one of permanent victimhood; it is marked by a transformative shift, where women actively employ cognitive, spiritual, and relational counter-strategies to reclaim their agency and move from a "spoiled identity" toward boundary-setting and post-traumatic growth.

Addressing the psychosocial burden of HPV requires a shift from viewing the infection solely as a biomedical event to recognizing it as a systemic issue requiring multi-level interventions:

• **Psychological & Counseling Interventions**: Given the profound impact of internalized stigma, moral shock, and the disclosure paradox, integrating specialized counseling services (e.g., individual, couple, and supportive group counseling) into the care pathway is essential. Professional psychological counseling can facilitate cognitive reframing, emotional regulation, and post-traumatic growth, helping patients navigate identity threats and relational distress effectively.

• **Clinical Interventions**: Healthcare providers must undergo mandatory, trauma-informed training to replace moralistic communication with evidence-based, non-judgmental counseling. Consultations must prioritize "invisible care"—ensuring absolute privacy in specimen collection and avoiding diagnostic environments that exacerbate patient shame.

• **Public Health & Education**: Public awareness campaigns should be redesigned to decouple HPV from sexual morality. Messaging must emphasize the epidemiological universality of the virus and the biological reality of its high prevalence, thereby shifting the narrative from individual "deviance" to public health management.

• **Policy & Structural Reforms**: National health policies must mitigate structural stigma by integrating HPV screening and vaccination into routine primary healthcare visits, thus removing the visibility of specialized STI-clinic visits. Furthermore, subsidizing vaccine costs is a critical policy lever to reduce the "financial exploitation" that currently frames the disease as a transactional burden, which reinforces feelings of powerlessness among patients.

Ultimately, this study confirms that clinical success in HPV management cannot be achieved through medical protocols alone. By validating women's lived realities and restructuring healthcare environments to prioritize dignity and privacy, clinical systems can mitigate the pervasive effects of stigma, fostering better screening adherence and holistic patient well-being.

Declarations

Data Availability Statement

Data sharing is not applicable to this article as no new datasets were generated or analysed during the current study. All data analysed are included within this article and it's cited primary studies.

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Figures

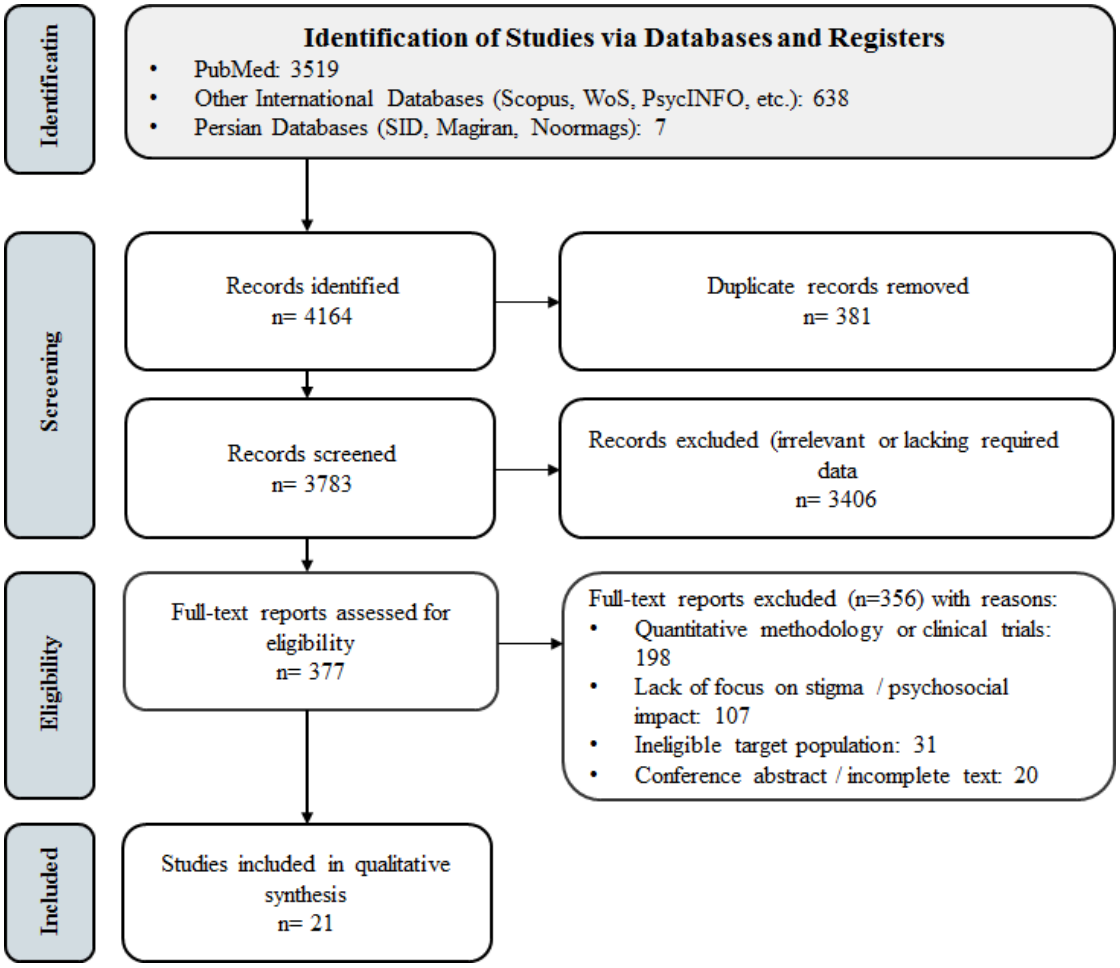


Figure 1

PRISMA 2020 Flow Diagram of the Study Selection Process.

Note: Depicts the flow of records identified, screened, assessed for eligibility, and included in the final meta-ethnographic synthesis.

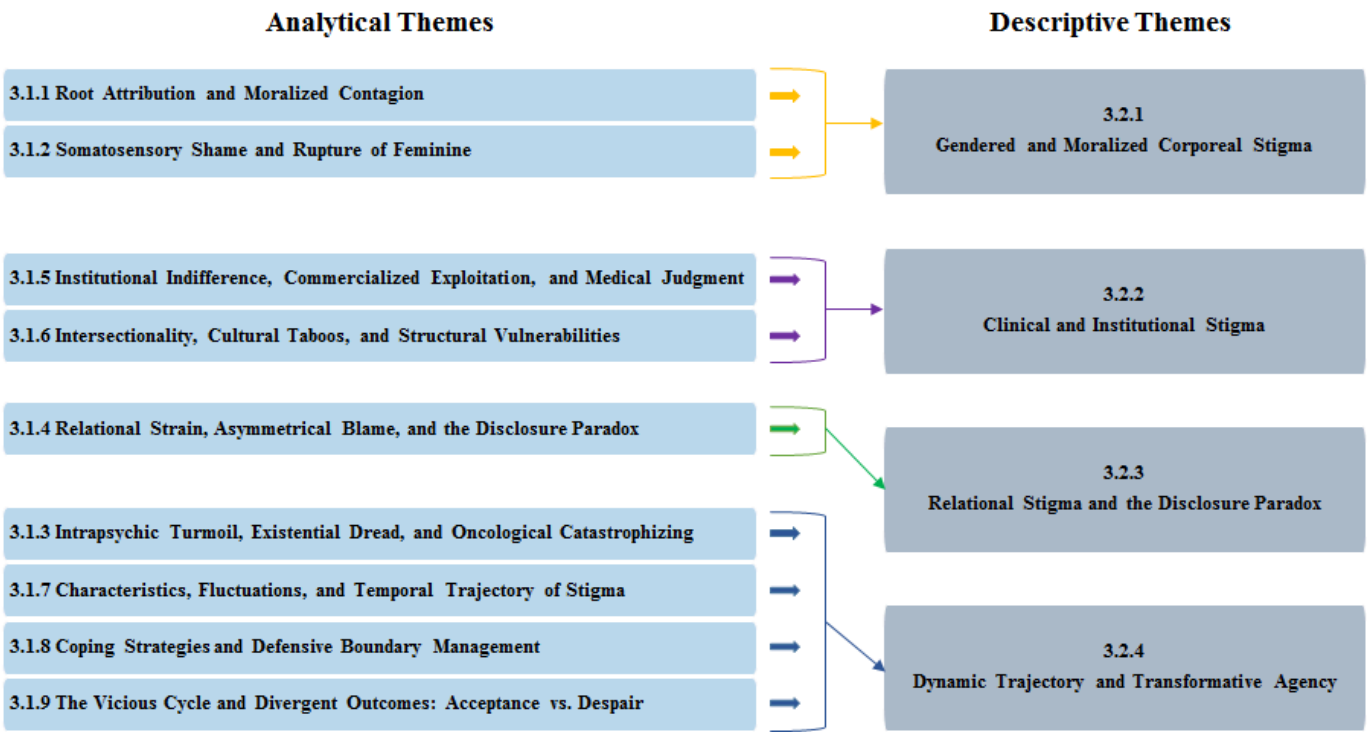


Figure 2

Conceptual Framework and Synthesis Logic.

Note: Illustrates the hierarchical progression mapping the nine descriptive themes to the four overarching third-order analytical themes.

Supplementary Files

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