International Scholars Journals

African Journal of Gender and Women Studies ISSN: 2736-1578, Vol. 11 (11), pp. 001-005, November, 2026. Available online at www.internationalscholarsjournals.org © International Scholars Journals

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Research Article

Reproductive Health, Cervical Cancer Screening, and Gendered Healthcare Access in Rural Communities

Bosede Adeyemi[1], Rajeshwari Nair[2], & Hannah McKenzie[3]

[1]Department of Obstetrics and Gynaecology, Obafemi Awolowo University, Ile-Ife, Nigeria; [2]Department of Community Health, Christian Medical College, Vellore, India; [3]School of Public Health, University of Sydney, Sydney, Australia.

Received: 5 October 2026; Revised: 3 November 2026; Accepted: 7 November 2026; Published: 16 November 2026.

ABSTRACT

Cervical cancer remains one of the leading causes of preventable cancer mortality among women in low- and middle-income countries (LMICs), reflecting stark global inequities in human papillomavirus (HPV) vaccination and early screening coverage (Sung et al., 2021; Arbyn et al., 2020). Beyond shortages of rural diagnostic clinics and trained nurses, patriarchal household decision-making, fear of spousal abandonment following positive diagnoses, and stigma surrounding pelvic examinations deter rural women from accessing preventive care. This paper investigates the socio-cultural and structural barriers to cervical cancer screening in rural southwestern Nigeria and Tamil Nadu, India. Grounded in reproductive justice and feminist health equity frameworks, the research combines clinic utilization data with 65 interviews involving rural women and community health workers (CHWs). We demonstrate that HPV self-sampling kits delivered through trusted female community health networks substantially increase screening uptake, but only when confidentiality, linkage to triage and treatment, and respectful engagement with households are treated as core design features rather than afterthoughts. The article argues that screening is not merely a technical problem of test availability; it is a gendered social process shaped by who decides, who is seen, who is believed, and who bears the consequences of a positive result.

Keywords: Cervical cancer screening; reproductive health; healthcare access; feminist health equity; rural women; HPV self-sampling; Nigeria; India

1. Introduction

Cervical cancer is almost entirely preventable through HPV vaccination, timely screening, and treatment of precancerous lesions, yet it continues to kill disproportionately in settings where those interventions are least accessible (World Health Organization [WHO], 2020; Sung et al., 2021). In 2020, the WHO launched the Global Strategy to Accelerate the Elimination of Cervical Cancer as a Public Health Problem, with the 90-70-90 targets: 90% of girls fully vaccinated against HPV by age 15, 70% of women screened with a high-performance test by age 35 and again by age 45, and 90% of women with cervical disease receiving treatment by 2030 (WHO, 2020). The strategy reframes cervical cancer from an inevitable tragedy to a measurable equity failure. Where a woman lives, how much money her household controls, whether she can travel alone, and whether she can negotiate a pelvic examination without social penalty powerfully predict whether she will be screened at all (Bruni et al., 2022; Singh et al., 2023).

Nigeria and India together account for a substantial share of the global cervical cancer burden. Nigeria introduced HPV vaccination into routine immunisation in October 2023, initially targeting girls aged 9-14, and has since reported vaccinating more than 17-18 million girls, a remarkable scale-up supported by Gavi, UNICEF, and WHO (Federal Ministry of Health, Nigeria, 2025). Screening coverage for adult women, however, has lagged far behind vaccination. In India, Tamil Nadu has been a frontrunner in introducing population-based screening, first through visual inspection with acetic acid (VIA), yet coverage remained only around 10.1% in 2019-2021 and 11.06% in 2023, far below the WHO 70% target (Sankaranarayanan et al., 2007; Ministry of Health and Family Welfare, India, 2023; Murugan et al., 2024). The contrast is instructive: a state with relatively strong primary care and an early screening programme still struggles to reach most eligible women. The problem, therefore, cannot be reduced to the absence of a test.

This article asks three questions. First, what socio-cultural and structural barriers shape screening decisions for rural women in southwestern Nigeria and Tamil Nadu? Second, how do gendered

household relations, stigma, and health-system design interact to produce non-uptake, delayed care, and loss to follow-up? Third, under what conditions does HPV self-sampling delivered through female CHWs increase uptake without reproducing new forms of harm, such as breaches of confidentiality or screening without treatment? Drawing on clinic utilization data and 65 semi-structured interviews with rural women and CHWs, we argue that self-sampling works best as a relational intervention, not merely a device. Its power lies in shifting where, by whom, and under what social conditions screening happens.

2. Theoretical Framework: Reproductive Justice and Feminist Health Equity

Reproductive justice, as articulated by Black feminist organisers and scholars, insists on three interrelated rights: the right to have children, the right not to have children, and the right to parent in safe and sustainable communities, with attention to the structural conditions that make choice real (Ross & Solinger, 2017; Ross, 2020). Applied to cervical cancer, reproductive justice rejects a narrow focus on individual compliance. It asks whether women have the material conditions, bodily autonomy, freedom from coercion, and trustworthy services needed to act on health knowledge. Feminist health equity similarly treats gender not as a demographic variable but as a relation of power that organises access to money, mobility, information, and decision-making (Sen & Östlin, 2008; Morgan et al., 2018).

Three implications follow for this study. First, non-screening is not ignorance. Many women in our interviews understood that cervical cancer is serious and that early detection matters, yet faced constraints that made screening costly in social as well as financial terms. Second, the household is a health institution. Decisions about travel, expenditure, and exposure of the body are negotiated within patriarchal norms that often vest formal authority in husbands, mothers-in-law, or elders, even as women exercise influence through negotiation, timing, and selective disclosure (Nnaemeka, 2004; Adeyemi & Okonkwo, 2023). Third, the clinic is not neutral. The gender of the provider, the availability of privacy, the tone of counselling, and the fear that results will be shared in a small community shape whether a woman returns. Figure 1 summarises this framework. It shows structural, socio-cultural, and health-system factors converging on autonomy and perceived safety, which in turn mediate uptake and linkage to care.

Figure 1. Conceptual framework: *gendered pathways to screening uptake.*

Source: *Authors' synthesis based on reproductive justice and feminist health equity literature.*

3. Literature Review

3.1 Global burden and the limits of cytology and VIA

Globally, cervical cancer was the fourth most common cancer among women in 2020, with an estimated 604,000 new cases and 342,000 deaths, about 90% occurring in LMICs (Sung et al., 2021; Arbyn et al., 2020). Persistent infection with high-risk HPV types, especially HPV 16 and 18, causes nearly all cases. Cytology (Pap smear) reduced mortality where organised programmes with recall, quality assurance, and treatment existed, but it performs poorly in low-resource rural settings because it requires laboratories, repeated visits, and reliable follow-up (Sankaranarayanan et al., 2007). VIA, which allows same-visit assessment, expanded access in India and parts of Africa, yet it is subjective, provider-dependent, and still requires a pelvic examination in a facility (Sankaranarayanan et al., 2007; Bhatla et al., 2021). High-performance HPV DNA testing is more sensitive and allows longer intervals, and WHO now recommends HPV testing as the primary screening method where feasible (WHO, 2021).

3.2 Why screening remains low in rural Nigeria and Tamil Nadu

In Nigeria, rural women face long distances, transport costs, user fees, and facilities without trained staff or equipment. Systematic reviews of rural Nigeria identify five overlapping barrier clusters: knowledge gaps and misconceptions, health-system limitations including lack of provider recommendation, psychosocial and cultural constraints such as fear and stigma, economic barriers, and low perceived risk (Ogunbayo et al., 2024; Eze et al., 2025). Qualitative work in Nigeria further highlights religious and cultural obligations of modesty, concern about the gender of providers, fear of disclosure, and fear of nosocomial infection (Modibbo et al., 2016; Adebayo et al., 2022). In southwestern Nigeria, Yoruba cultural norms around respect, family honour, and female modesty interact with Pentecostal, Islamic, and traditional moral discourses about sexuality, making a pelvic examination socially legible as sexual exposure rather than routine prevention.

In Tamil Nadu, despite early VIA scale-up through primary health centres and the Makkalai Thedi Maruthuvam (MTM) programme for doorstep non-communicable disease care, screening coverage has remained low and loss to follow-up high. Recent assessments find that only about 57% of screen-positive women in some Tamil Nadu surveys were referred for colposcopy, and many women dropped out midway due to fear, confusion, and lack of guidance (Murugan et al., 2024; ICMR-National Institute of Epidemiology, 2026). NFHS-5 analyses show that tribal women, poorer women, and women with less education are significantly less likely to be screened (Singh et al., 2023). Studies of families in Tamil Nadu show that stigma, familial hierarchies, and gendered norms delay care for gynaecological symptoms and hinder screening, even when services are nominally available (Vijayalakshmi et al., 2024).

3.3 HPV self-sampling: evidence and equity promise

HPV testing on self-collected vaginal samples has comparable accuracy to clinician-collected samples for detection of high-grade precancer when validated assays are used (Arbyn et al., 2014; Arbyn et al., 2018). Meta-analyses in LMICs find that offering self-sampling increases uptake compared with standard care or VIA, with one review reporting a risk ratio of 1.93 (95% CI 1.66-2.25) versus routine VIA and another reporting higher uptake in most included studies (Tin et al., 2023; Tesfaye et al., 2024). Self-sampling reduces embarrassment, travel, and dependence on a pelvic examination, and it can be delivered at home or in community camps (Arbyn et al., 2018; Gupta et al., 2022). Its equity promise, however, depends on what happens after a positive result. Without affordable triage, colposcopy, and treatment, self-sampling risks creating anxiety without care, a form of screening without justice that reproductive justice frameworks warn against (Ross, 2020).

3.4 Community health workers as relational infrastructure

In India, Accredited Social Health Activists (ASHAs), Women Health Volunteers, and multipurpose health workers are often the first and most trusted point of contact. In Tamil Nadu, frontline

workers reported that self-collection could reduce fear and embarrassment and could be delivered through CHWs or nurses (Murugan et al., 2024). In Nigeria, community health extension workers, traditional birth attendants, and women's associations play analogous bridging roles. Research on CHWs in India notes gaps in cancer training except in Tamil Nadu and Kerala where screening initiatives have been implemented, underscoring that trust alone is insufficient without training, supervision, and supplies (Kaur et al., 2023). Our study treats CHWs not as cheap substitutes for nurses but as relational infrastructure: people whose embeddedness makes a biomedical test socially safe to accept.

4. Methods

This study used a convergent mixed-methods design in rural communities in southwestern Nigeria (Osun and Oyo States) and Tamil Nadu (Madurai and Tiruvannamalai districts). Clinic utilization data for cervical screening visits from January 2024 to June 2025 were reviewed from primary health centres and outreach camps, with attention to age, screening modality, result, and referral completion. The qualitative component comprised 65 semi-structured interviews: 42 rural women aged 30-60 (22 in Nigeria, 20 in Tamil Nadu) and 23 CHWs (12 in Nigeria, 11 in Tamil Nadu). Women were purposively sampled to include never-screened, previously screened, and self-sampling participants. Interviews were conducted in Yoruba, Tamil, or English by trained female researchers, audio-recorded with consent, transcribed, and thematically analysed using framework analysis informed by WHO barriers-to-care domains and feminist health equity concepts (Gale et al., 2013). Ethical approvals were obtained from institutional review boards in Nigeria, India, and Australia; pseudonyms are used and identifying details removed. Limitations include purposive sampling, reliance on routine clinic data of variable completeness, and the cross-sectional nature of utilization data, which cannot establish causality. Findings on self-sampling uptake are interpreted alongside published trials rather than as a randomised effect estimate.

Table 1. Study sites and qualitative sample.:

Site	Setting	Screening context	Interview participants
Osun, Nigeria	Rural agrarian communities	PHC + outreach camps, VIA and HPV pilot	12 women; 6 CHWs
Oyo, Nigeria	Peri-rural market towns	PHC, VIA, referral to secondary care	10 women; 6 CHWs
Madurai, Tamil Nadu	Rural + tribal villages	PHC, VIA, MTM doorstep NCD care	10 women; 5 CHWs/WHVs
Tiruvannamalai, Tamil Nadu	Rural villages	PHC, VIA, camp-based screening	10 women; 6 CHWs/ASHAs

Source: *Fieldwork records, 2024-2025.*

5. Findings

5.1 Structural barriers: distance, cost, and fragile services

Women described screening as a journey, not a visit. A return trip to a facility could cost a day's earnings, require childcare, and depend on a husband's motorcycle or a shared taxi. When facilities lacked female providers, acetic acid, specula, or electricity on the day of the visit, women who had overcome those costs left unscreened and were reluctant to return. CHWs in both countries described stock-outs and staff transfers as routine disruptions. One Nigerian CHW said, 'We mobilise, they come, and the nurse is not there. Next time they will not listen.' In Tamil Nadu, a WHV noted that VIA camps were announced, but follow-up depended on whether the referral hospital had a working colposcope and whether transport was arranged. These accounts align with health-system assessments showing VIA readiness scores above 70% in facilities, yet coverage and follow-up remained inadequate (Murugan et al., 2024).

5.2 Socio-cultural barriers: patriarchy, modesty, and fear of abandonment

The most salient barrier was not lack of interest but the social cost of being screened. In both settings, women feared that a pelvic examination would be read as evidence of sexual activity or infidelity, that a positive HPV result would be equated with promiscuity or HIV, and that disclosure would invite blame or abandonment. A 38-year-old woman in Osun said she delayed screening because 'if they say something is there, my husband will say I brought disease.' A woman in Tiruvannamalai described similar anxiety: 'My mother-in-law will ask why I needed that test.' These fears are rational in contexts where women's economic security depends on marriage and where HPV is poorly understood as a common, often transient infection (Modibbo et al., 2016; Vijayalakshmi et al., 2024). Modesty was not merely personal preference; it was a moral and relational practice. Being examined by a male provider, in a room without a curtain, in front of waiting neighbours, violated it.

Household decision-making was negotiated rather than simply imposed. Several women described telling husbands after, rather than before, seeking care, or framing screening as a general women's health check rather than a test for a sexually transmitted infection. Others sought permission and were refused or told to wait. CHWs described engaging husbands and mothers-in-law as essential work, not optional outreach. In Tamil Nadu, family focus groups have similarly shown that involving families, while respecting women's privacy, can enable rather than block screening when done carefully (Vijayalakshmi et al., 2024). The implication is not that men should control screening, but that programmes that ignore household power leave women to bear the negotiation alone.

5.3 Health-system barriers: privacy, provider gender, and loss to follow-up

Privacy failures were repeatedly described as deterrents. Women recalled results being announced loudly, neighbours seeing them enter a 'cancer room,' and CHWs being asked by relatives about who had tested positive. Fear of disclosure was especially acute in small villages where CHWs are neighbours. At the same time, women trusted female CHWs precisely because they were neighbours who could be held accountable. The tension is productive: trust is local, but confidentiality must be procedural, through coded results, private return visits, and clear rules about who sees what. Loss to follow-up was the second health-system failure. Even when women screened, many did not complete triage. Reasons included distance to referral centres, cost, fear of biopsy, and lack of clear explanation. Tamil Nadu data showing low referral completion mirror this pattern (ICMR-National Institute of Epidemiology, 2026). Screening without a supported pathway to treatment, participants argued, is worse than no screening because it leaves women with fear and no plan.

Table 2. Synthesis of barrier domains from 65 interviews and clinic data.:

Barrier domain	Manifestation in Nigeria	Manifestation in Tamil Nadu	Illustrative consequence
Structural	Distance, transport cost, stock-outs	Distance, camp timing, referral gaps	Visit attempted but not completed
Socio-cultural	Modesty, fear of abandonment, HPV stigma	Modesty, family hierarchy, stigma	Screening delayed or hidden
Health system	Male provider, no privacy, weak referral	Loud result disclosure, colposcopy bottleneck	Loss to follow-up
Economic	User fees, lost daily earnings	Transport + wage loss, treatment cost	Positive result without care

Source: *Authors' thematic analysis.*

5.4 HPV self-sampling through trusted female networks

When HPV self-sampling kits were offered through known female CHWs, women described three shifts. First, the body was no longer publicly exposed: 'I did it myself, in my room, nobody saw me,' said a participant in Oyo. Second, the decision became more private and reversible: women could take the kit, discuss it with a trusted person, and return it without a facility visit. Third, the CHW became a companion rather than a gatekeeper, explaining the test in local language, demonstrating the swab, and promising to return results privately. CHWs reported that self-sampling reduced their own discomfort in mobilising women, because they were not asking neighbours to undress for a stranger. These qualitative mechanisms are consistent with trial evidence that self-sampling increases uptake compared with VIA or clinician sampling (Tin et al., 2023; Tesfaye et al., 2024).

Uptake increased most where four conditions were met: kits were free or heavily subsidised, CHWs were trained and paid, results were returned privately within a stated timeframe, and transport or accompaniment to triage was arranged for HPV-positive women. Where any condition was missing, enthusiasm faded. In one Tamil Nadu camp, women who waited weeks for results concluded the test had been lost. In one Nigerian site, women who tested positive but could not afford transport to the referral hospital described feeling abandoned. Figure 2 maps the pathway that made self-sampling work as a system, not a kit.

Figure 2. HPV self-sampling pathway through trusted female community health networks.:

Source: *Authors' synthesis of interview and clinic pathway data.*

Table 3. Comparison of screening modalities. Sources: *WHO (2021); Arbyn et al. (2014, 2018); Sankaranarayanan et al. (2007).*

Modality	Requires pelvic exam	Where done	Key advantage	Key limitation
Cytology (Pap)	Yes	Facility / lab	Established, specific	Needs lab, repeat visits
VIA	Yes	Facility / camp	Same-visit result	Subjective, provider-dependent
HPV clinician-collected	Yes	Facility	High sensitivity	Same barriers as VIA for access
HPV self-collected	No	Home / camp, private	Privacy, reach, uptake	Needs triage linkage + lab transport

6. Discussion

Our findings support a relational reading of screening uptake. HPV self-sampling did not succeed because it was technologically superior in isolation; it succeeded because it rearranged the social conditions of screening. It moved the test from a public facility to a private room, from a stranger's hands to a woman's own hands, and from an isolated visit to a CHW-accompanied pathway. That rearrangement matters for feminist health equity: it redistributes control over the body and over information. Yet self-sampling is not a substitute for health-system strengthening. Without laboratory capacity, sample transport, result-return systems, and funded triage, it can widen the gap between knowing and being treated.

Comparison across the two countries sharpens this point. Tamil Nadu has stronger primary care and earlier screening scale-up, yet still faces low coverage and loss to follow-up, suggesting that facility-based VIA alone reaches a ceiling (Murugan et al., 2024). Southwestern Nigeria faces more basic access gaps, yet its women's associations and community health structures offer a dense network for distribution, suggesting that self-sampling could leapfrog facility constraints if linked to secondary care. In both settings, engaging families without surrendering women's confidentiality is delicate. Programmes should train CHWs to negotiate with households, offer couple and family education that frames HPV as common and preventable, and protect a woman's right to receive her result first and decide disclosure. This aligns with reproductive justice: autonomy is exercised within relationships, not outside them (Ross & Solinger, 2017).

Policy implications follow. First, national programmes should adopt HPV testing as the primary method and explicitly include self-sampling as an offered option, not only as a pilot, with validated assays and clear triage algorithms (WHO, 2021). Second, CHWs should be formally recognised, trained, supervised, and remunerated for screening work, with confidentiality protocols and protection from community pressure to disclose results. Third, screening budgets must include transport vouchers, accompaniment, and treatment subsidies for HPV-positive women, otherwise uptake gains will not translate into mortality gains. Fourth, HPV vaccination and screening should be linked programmatically: Nigeria's vaccination scale-up offers a platform to reach mothers and older sisters of vaccinated girls with screening messages, while Tamil Nadu's MTM doorstep model offers a platform to add self-sampling to routine NCD visits. Finally, monitoring should track not only number screened but also result-return time, triage completion, and treatment completion, disaggregated by age, caste/tribe, and rurality, to detect who is being left behind.

7. Conclusion

Cervical cancer screening in rural Nigeria and Tamil Nadu fails when it is organised as a facility-based pelvic examination that women must negotiate alone, at high social and financial cost, with uncertain follow-up. It succeeds more often when it is organised as a private, woman-controlled test delivered through trusted female networks, with a funded pathway to care. HPV self-sampling is therefore best understood not as a technological fix but as a feminist health equity intervention: it changes who controls the encounter. Realising its promise requires investing in

the people and systems around the kit - CHWs, laboratories, transport, confidentiality, and treatment - and in the household and community norms that shape whether a woman can say yes without fear. If those investments are made, the WHO 90-70-90 targets become not merely aspirational but achievable for rural women who have been most excluded.

Acknowledgements

We thank the women and community health workers who shared their experiences, and the primary health centre staff in Osun, Oyo, Madurai, and Tiruvannamalai. This research received no specific commercial funding; institutional support was provided by the authors' universities.

Conflict of Interest

The authors declare no conflict of interest.

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