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A qualitative study on the experiences of stigmatisation and spiritual coping among women diagnosed with cervical cancer in Turkey

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Abstract

Background Cervical cancer is one of the most common gynecological cancers among women worldwide and stands out as a significant public health issue, particularly in low- and middle-income countries. Despite the preventable nature of the disease, access to early diagnosis and treatment is often limited by structural, individual, and societal barriers. Stigma associated with cervical cancer and HPV is at the forefront of these barriers. Furthermore, spiritual resources are known to play a critical role in coping with the psychosocial burden of the disease. The aim of this study is to examine how women diagnosed with cervical cancer in Turkey experience stigma and how they use spiritual coping strategies.

Methods This qualitative study employed a phenomenological design to explore lived experiences of women diagnosed with cervical cancer in Turkey. Fifteen women aged between 28 and 55 years, with diverse marital, educational, and treatment backgrounds, participated in the study. Data were collected through semi-structured, in-depth interviews and analyzed using Braun and Clarke's reflexive thematic analysis approach. Data collection continued until thematic saturation was reached, with no new themes emerging in the final interviews. The COREQ checklist was used to enhance methodological rigor.

Results The analysis revealed four main themes: "Stigmatization and Social Judgment," "Spiritual Coping Strategies," "Social Support and Solidarity," and "Experiences Related to the Treatment Process." Most participants described experiences of social isolation and moral judgment, often linked to perceptions of immorality and feelings of guilt. Spiritual coping strategies such as prayer, worship, reading the Qur'an, and remembrance of God were commonly used to sustain hope and emotional resilience, while collective religious practices fostered a sense of social solidarity. Social support from family members, friends, and peer support groups alleviated loneliness for many women, although stigma limited support-seeking for some. Supportive communication and clear information from healthcare professionals enhanced trust and treatment adherence, whereas transportation difficulties, physical fatigue, and communication gaps posed significant challenges.

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Conclusions The study reveals that the experiences of women diagnosed with cervical cancer are shaped not only by biomedical factors but also by social and spiritual dimensions. Stigmatization negatively affects women's social lives and psychological well-being, while spirituality and social support mechanisms emerge as powerful coping resources. Therefore, healthcare services provided to women living with cervical cancer should not focus solely on medical treatment but should be structured with a holistic approach that also includes psychosocial support and spiritual counseling. By simultaneously examining stigma and spiritual coping within a phenomenological framework, this study offers a culturally grounded understanding of cervical cancer experiences that extends beyond biomedical perspectives.

Keywords Cervical Cancer, Stigmatisation, Qualitative research, Spiritual coping, Turkey

Introduction

Cervical cancer is one of the most common types of gynecological cancer in women worldwide and is a significant public health issue for women's health, particularly in low- and middle-income countries [1, 2]. According to cancer statistics published by the International Agency for Research on Cancer's Global Cancer Observatory (GLOBOCAN), cervical cancer ranks fourth among female cancers. GLOBOCAN's 2022 global cervical cancer incidence rate (per 100,000 people) is 14.1, and the mortality rate is 7.1 [3]. Turkey's cervical cancer incidence rate (per 100,000 people) is 13.8, and the mortality rate is 6.6 [4].

In Turkey, the number of women undergoing human papillomavirus (HPV) screening tests is quite low. The European Union recommends screening for cervical, breast, and colorectal cancer, and in some EU countries, screening is mandatory and free of charge under various policies [5].

Early diagnosis and treatment programs for cervical cancer constitute one of the fundamental strategies of health systems aimed at eliminating the disease [6]. However, despite cervical cancer being a preventable disease, access to early diagnosis and treatment remains limited for many women due to various structural, individual, and societal barriers [7]. Among these barriers, psychosocial factors particularly stigma and shame related to HPV play a central yet often underexplored role. Since many women have limited knowledge about HPV, they may struggle to understand the link between the virus and cervical cancer and may experience intense feelings of shame, particularly because HPV is a sexually transmitted infection [8]. The thought of being diagnosed with a sexually transmitted virus increases women's fear of social stigmatization and can lead to significant distress at the psychosexual level [9, 10]. Here, stigmatization is defined as "a social process characterized by exclusion, rejection, blame, or devaluation, whether experienced or anticipated" [11]. It has been shown that negative psychological reactions such as fear, shame, stigmatization, self-blame, and anxiety in women diagnosed with HPV can negatively affect help-seeking behaviors, motivation to seek healthcare, and the likelihood of participating

in future screening programs [12]. These psychosocial effects may be more pronounced in women with mental health issues or those predisposed to such issues, thereby increasing the emotional burden of the diagnosis [9, 13]. In sociocultural contexts where discussions of sexuality are restricted, these dynamics become even more pronounced. In some regions of Turkey where traditional and cultural norms are more prevalent, topics such as sexuality and HPV cannot be discussed due to the sexually transmitted nature of the virus [14]. These cultural patterns increase women's concerns about hiding the disease, stigmatization, and the deterioration of emotional relationships in many countries, while also deepening feelings of social isolation and guilt [15–19].

Within this broader sociocultural context, the meanings attributed to HPV infection itself play a critical role in shaping women's experiences of stigma. HPV infection is a benign infection that the vast majority of women experience at least once in their lifetime and is generally controllable [20]. However, from a woman's perspective, HPV is often associated with abnormal Pap tests and cervical cancer, leading to feelings of immorality, guilt, self-blame, social judgment, rejection, and fear of discrimination by healthcare professionals or social circles [21, 22]. It has even been suggested that the stigma associated with having HPV can be a more intense source of fear than receiving a cervical cancer diagnosis in some cases [23]. Studies conducted in low- and middle-income countries in particular have found that women associate HPV with immorality, prostitution, and infidelity, and therefore have serious concerns that an HPV or cervical cancer diagnosis could result in blame and rejection by partners or social circles [24, 25]. Therefore, the higher rates of cervical cancer in low- and middle-income countries compared to high-income countries (18.8 per 100,000 vs. 11.3) indicate that stigma is a critical barrier to preventability [26]. Importantly, such stigma does not only affect prevention behaviors but also shapes how women emotionally interpret and cope with their diagnosis. Such social stigma and psychosocial burden deeply influence how women make sense of their illness and shape the coping strategies they adopt throughout the cancer experience [27].

Various factors may play a role in mitigating the negative effects of stigmatisation at both the individual and societal levels. Spirituality, one such factor, emerges as a powerful coping mechanism that supports the quality of life of individuals diagnosed with cancer [28, 29]. With its dimensions of meaning, peace and faith, spirituality contributes to individuals maintaining feelings of hope, wholeness and peace despite life's difficulties [30–32]. Meaning is defined as finding a purpose in life; peace, coping by accepting difficulties; and faith, finding solace by connecting with a greater being or power [33, 34]. Spiritual coping also plays an important role in the experiences of women from different ethnic and cultural groups living with cancer [35], and the literature provides strong evidence of the relationship between spirituality and psychosocial and physical health outcomes, particularly in women diagnosed with breast cancer [36, 37]. However, coping behaviours themselves are shaped by how the individual evaluates the current stressor and which coping resources they perceive as accessible. Emmons' conceptualisation of spirituality as a cognitive-motivational capacity that supports problem-solving and goal-directed behaviour suggests that awareness of spiritual needs can be an important driving force in initiating coping processes [38]. This approach aligns with Kenneth Pargament's theoretical framework, which defines religious coping as a complementary coping style that comes into play, particularly when other support resources are insufficient [39, 40]. According to Pargament, religious and spiritual coping are among the fundamental mechanisms individuals use to sustain their lives; processes such as religious perseverance and spiritual support aid in making sense of and building resilience in the face of stressful life events [41].

While previous qualitative studies have examined stigmatization or spiritual coping in women diagnosed with cervical cancer as separate phenomena, limited attention has been given to how these experiences are lived simultaneously and shape one another. This study advances existing qualitative literature by exploring stigmatization and spiritual coping together within a single phenomenological framework, focusing on how social judgment, meaning-making, and faith-based coping co-occur in women's everyday lives. Rather than treating stigma and coping as parallel or independent processes, the study illuminates their dynamic interconnection as part of a unified lived experience. By doing so, it moves beyond descriptive accounts and contributes a more integrated understanding of cervical cancer experiences within a sociocultural context.

Methods

This study was conducted using a qualitative research approach to understand how women diagnosed with cervical cancer experience stigma and how they use spiritual coping strategies. The study used a phenomenological design, which aims to reveal how individuals experience a particular phenomenon and how they attribute meaning to this experience.

Settings and participants

This study employed a maximum diversity sampling approach, aiming to present the experiences of women diagnosed with cervical cancer from as broad a perspective as possible, considering various socio-demographic and clinical characteristics. Therefore, when creating the sample, care was taken to ensure diversity among participants in terms of age, marital status, education level, employment status, number of children, place of residence (rural/urban) and treatment experiences (chemotherapy, radiotherapy, surgery, completion of treatment). Furthermore, spirituality or level of religious belief was not determined as an inclusion criterion in this study. Participants were included in the study through natural referral, referral, and encounter at clinical centers; they were not selected based on their religious practices or level of spirituality. The sample included women who practiced their religion regularly, as well as those who practiced less frequently or defined their faith more at a cultural level. This diversity was taken into account during the analysis process, and the diversity of experiences revealed by the differences in beliefs among the participants was specifically reflected when determining the themes. The women were reached through oncology and radiotherapy clinics, cancer support associations, and community health centers. Participation was entirely voluntary, and interested women contacted the research team directly after receiving the research invitation. Participants were selected based on the criterion of having been diagnosed with cervical cancer at least six months prior to the study, ensuring that participants had overcome the initial shock phase and had sufficient time to experience the psychosocial, emotional, and social consequences of their diagnosis. Those with cognitive impairment or psychiatric disorders that hindered effective communication, those in the final stages of the disease, and those who refused to have the interview audio recorded were excluded from the study. Data were collected between July and September 2025 in an environment that ensured participant confidentiality and lasted approximately 45–60 min. The interviews were recorded with a voice recorder after obtaining the participants' written and verbal consent, and were then transcribed verbatim by the researcher to prepare them for content analysis. Data saturation was achieved during the

interviews when no new codes or themes emerged after the 13th participant. Subsequently, two additional interviews were conducted and the sample was finalized with 15 participants. This situation was included in the study as an important factor that strengthens validity in qualitative research.

Ethical principles

The necessary approval has been obtained from the Non-Interventional Clinical Research Ethics Committee of Hakkari University, and institutional permissions have been obtained to conduct this research. The study was conducted in accordance with the ethical standards outlined in the Declaration of Helsinki. Written and verbal informed consent was obtained from all women participating in the study. The consent forms clearly stated the purpose of the study, that it was based on voluntary

participation, and that participants could withdraw from the interview at any time. Participants' identity information was kept confidential, and the data obtained were used solely for scientific purposes.

Data collection

Data were collected using a semi-structured in-depth interview form developed based on the literature and expert opinions [42, 43] (Table 1). The interview questions aimed to reveal participants' experiences of stigmatization, the emotional and social repercussions of these experiences, and the meaning they attributed to spirituality and spiritual beliefs in coping. The in-depth interviews were conducted by a researcher (EKC) trained in qualitative research and experienced in the field of women's health and obstetrics nursing. The interviewer holds a doctoral degree and has professional experience in women's health, cancer experiences, and qualitative research methods. The researcher had no prior clinical, social, or academic relationship with any of the participants; this was intended to minimize power imbalances, risk of bias, and participant influence during the data collection process.

The interviewer provided all participants with detailed information about the purpose of the research, the principles of voluntariness, and confidentiality principles prior to the interviews; thus, the goal was to establish a relationship of trust with the participants. The researcher being of the same gender (female interviewer–female participants) facilitated the more comfortable expression of sensitive topics, particularly those related to privacy, shame, stigma, and spiritual coping. Non-directive, open-ended questions were used during the interviews, and all statements were recorded in a way that did not distort the participants' perspectives.

Data analysis

The audio recordings obtained from the interviews were transcribed and read repeatedly by the researchers to develop a holistic perspective. Data were analyzed following the six-phase reflexive thematic analysis framework proposed by Braun and Clarke (2021) [44]. This analytic approach was deliberately chosen because reflexive thematic analysis is well suited to phenomenological research aiming to explore lived experiences and the meanings individuals attribute to those experiences. Rather than seeking objective truth, this approach prioritizes participants' subjective interpretations and allows themes to emerge inductively from the data. In this study, reflexive thematic analysis guided the researchers to focus on how women made sense of stigma and spiritual coping within their sociocultural context.

Table 1 Semi-structured interview guide

1. How did you learn about your cervical cancer diagnosis and how did you feel during this process? "What was this moment like for you?" "How did it make you feel?" "What went through your mind?"
2. Did you experience any changes in your relationships with family, friends or your community after receiving your diagnosis? "Could you elaborate a bit more on these changes?" "How did this situation affect your relationships?" "What was the most noticeable change from your perspective?"
3. What were the most challenging situations you encountered during your illness and treatment process? "Could you describe how you experienced these challenging situations?" "How did you cope with these difficulties?"
4. Did you feel judged, blamed or excluded by those around you? "Can you give an example of a time when you felt this?" "How did this situation make you feel?" "How did it affect your social life?"
5. Did you experience people's prejudices towards cervical cancer or HPV? "How did you experience these prejudices?" "What was said or done to you?" "What did this mean to you?"
6. How did stigma or prejudice affect your access to healthcare or your social life? "Could you describe how this has affected your daily life?" "How has it shaped your search for healthcare?" "What have you experienced during this process?"
7. What role did spirituality, faith, or spiritual resources play for you during this process? "In what situations did these resources help you?" "What strengthened you spiritually?"
8. Did your thoughts about the meaning of life change during your illness? "How has the meaning of life changed for you?" "What experiences led to this change?"
9. Is there any other experience that is important to you that you would like to share? "Is there anything important to you that we haven't asked about?" "Is there any other feeling or experience you would like to add?"

- (1) Familiarization: The researchers repeatedly read the transcripts to gain an in-depth understanding.
- (2) Generating initial codes: Two researchers coded the transcripts independently using inductive, line-by-line coding.
- (3) Searching for themes: Codes with conceptual similarities were grouped to form preliminary themes.
- (4) Reviewing themes: Themes were refined by comparing them against coded extracts and the entire data set.
- (5) Defining and naming themes: Themes and subthemes were clearly defined, labeled, and supported with representative data extracts.
- (6) Producing the report: A final thematic structure was produced, and findings were interpreted within the sociocultural context. This process was conducted meticulously to enhance the reliability of the research and ensure that the data was evaluated from a holistic perspective. The COREQ checklist, accepted as standard in qualitative studies, was used as a basis for the reliability of the research [45]. Findings were supported by quotations taken directly from participants' statements. To minimize researcher bias, the principle of reflexivity was adopted during the analysis process; researchers regularly assessed the impact of their own sociocultural positions on data interpretation. Additionally, member validation was performed with three participants to assess the validity of the developed themes; participants confirmed that the themes reflected their experiences. To enhance methodological transparency, an audit trail was maintained throughout the analytic process. This audit trail included detailed documentation of initial codes, decisions made during code clustering, iterative refinements of themes, and analytic memos that captured emerging interpretations and reflexive considerations. A preliminary codebook was developed during the early coding phase and was continuously revised as new meanings emerged from the data. Theme development occurred iteratively across multiple analytic meetings, allowing themes to be refined, merged, or redefined over time. Beyond gender considerations, the researchers' professional backgrounds in nursing and public health and their familiarity with the sociocultural context of eastern Türkiye were acknowledged as potential sources of interpretive influence. Analytic decisions were therefore continuously questioned to minimize the imposition of pre-existing beliefs and to privilege participants' lived experiences. Inter-coder reliability was calculated using percentage agreement, based on the number of identical codes independently

assigned by the two researchers divided by the total number of coding decisions. This agreement was calculated during the initial inductive coding phase, prior to theme development. Coding discrepancies were discussed collaboratively until consensus was achieved, resulting in a final agreement rate of 87%. In this study, reflexivity was approached as an ongoing and iterative process rather than a single methodological step. The researchers are academics in nursing and health sciences with prior experience in women's health and qualitative research, which facilitated sensitivity to participants' narratives while also requiring continuous awareness of potential preconceptions related to cervical cancer, stigma, and spirituality. Throughout the analysis, reflexive discussions were held to critically examine how professional background, cultural familiarity, and prior assumptions might shape interpretation. These reflections informed analytic decisions and supported a balanced and transparent interpretation of participants' lived experiences.

Results

A total of 15 women participated in the study, with ages ranging from 28 to 55 and an average age of 41.2 years. The vast majority of participants were married ($n=10$), three were single, and two were widowed. In terms of educational background, two women were illiterate, three had primary school education, three had secondary school education, four had high school education, and three were university graduates. The number of children among the participants ranged from 0 to 6; some participants had no children, while others had up to six children. Regarding treatment processes, it was determined that four participants underwent chemotherapy, three underwent radiotherapy, three underwent surgical treatment, two underwent both surgery and radiotherapy, and three had completed their treatment process. These findings indicate that women diagnosed with cervical cancer constitute a heterogeneous group with varying ages, educational levels, marital statuses, and living conditions, but that the majority are married women with low to medium educational levels living in rural areas (Table 2).

Based on the analysis of the data presented in Table 3; Fig. 1, four main themes were identified: Stigmatisation and Social Judgement, Spiritual Coping Strategies, Social Support and Solidarity, and Experiences Related to the Treatment Process. Participants' experiences were examined in detail in the context of themes, sub-themes and codes.

Theme 1: stigmatization and social judgment

This experiential pattern reveals that women diagnosed with cervical cancer experience the disease not only as a

Table 2 Characteristics participants

ID	Age	Marital status	Education	Employment	Residence	Number of children	Treatment status
P1	44	Married	High School	Housewife	Rural	3	Radiotherapy
P2	48	Married	Primary School	Housewife	Rural	5	Chemotherapy
P3	52	Married	University	Employed	Urban	0	Surgery
P4	46	Married	Secondary School	Housewife	Rural	4	Chemotherapy
P5	50	Married	High School	Employed	Urban	2	Surgery + RT
P6	55	Widowed	Illiterate	Housewife	Rural	6	Completed
P7	42	Married	University	Employed	Urban	1	Completed
P8	44	Married	Secondary School	Housewife	Rural	3	Radiotherapy
P9	47	Single	High School	Housewife	Urban	0	Chemotherapy
P10	48	Married	Primary School	Housewife	Rural	5	Completed
P11	55	Married	University	Employed	Urban	2	Surgery
P12	52	Widowed	Secondary School	Housewife	Rural	4	Chemotherapy
P13	49	Married	High School	Housewife	Urban	3	Surgery + RT
P14	38	Single	University	Employed	Urban	0	Chemotherapy
P15	50	Married	Primary School	Housewife	Rural	6	Completed

Table 3 Themes, sub-themes, and codes

Themes	Sub-themes	Codes
1. Stigmatization and Social Judgment	1.1 Social Isolation	Being perceived as contagious Isolation Being left alone
	1.2 Social Judgment and Guilt	Being associated with immorality Guilt and self-blame
	2.1 Prayer and Worship	Praying and turning to God Positive thinking and reliance on God (tawakkul)
2. Spiritual Coping Strategies	2.2 Spiritual Practices	Reading the Qur'an and remembrance (dhikr) Collective worship and support from religious communities
	3.1 Family Support	Support from spouse Support from children
3. Social Support and Solidarity	3.2 Friends and Social Network Support	Support from friends Community support groups
	4.1 Access to Health System and Support	Support from doctors and nurses Challenges during treatment process
4. Experiences Related to Treatment Process	4.2 Treatment Information and Education	Lack of information and anxiety Increased confidence through information

biological process but also as a social experience intertwined with society's moral, cultural, and sexual norms. Most participants stated that they struggled to cope with the stares, suggestive comments and distancing behaviours they encountered from those around them after their diagnosis; they developed intense feelings such as guilt, shame and self-questioning during this process. Stigmatisation emerges not only as an external process that weakens women's social relationships, but also as an internalised experience that transforms their self-worth perceptions and self-image; thus, it transcends the

treatment process and becomes a multi-layered phenomenon that shapes women's entire experience of illness.

Social isolation

Social isolation emerged as a common experience shared by approximately two-thirds of participants, leading women to withdraw from both their social circles and close relationships. In particular, misconceptions about HPV and cervical cancer being contagious have significantly affected women's daily lives in terms of contact and intimacy. Both the withdrawal of neighbors and friends and the women's own withdrawal due to "fear of judgment" have deepened social isolation.

Women stated that the perception of their illnesses as contagious led to distant and exclusionary attitudes from those around them, which over time turned into a voluntary withdrawal.

"My neighbors take a step back as soon as they see me. They don't even come close when I extend my hand. Their behavior, as if touching me would infect them, hurt me deeply; I felt as if I were dirty." (P14, 38 years old, single)

Similarly, another woman stated that even the most ordinary contact in daily life had become a source of anxiety for those around her:

"Some of my friends even pulled away when I reached out my hand or wanted to hug them. Some changed their route when they saw me. At that moment, I realized that I was no longer seen as I used to be." (P3, 52 years old, married)

Social isolation has been reinforced not only by others distancing themselves, but also by women withdrawing

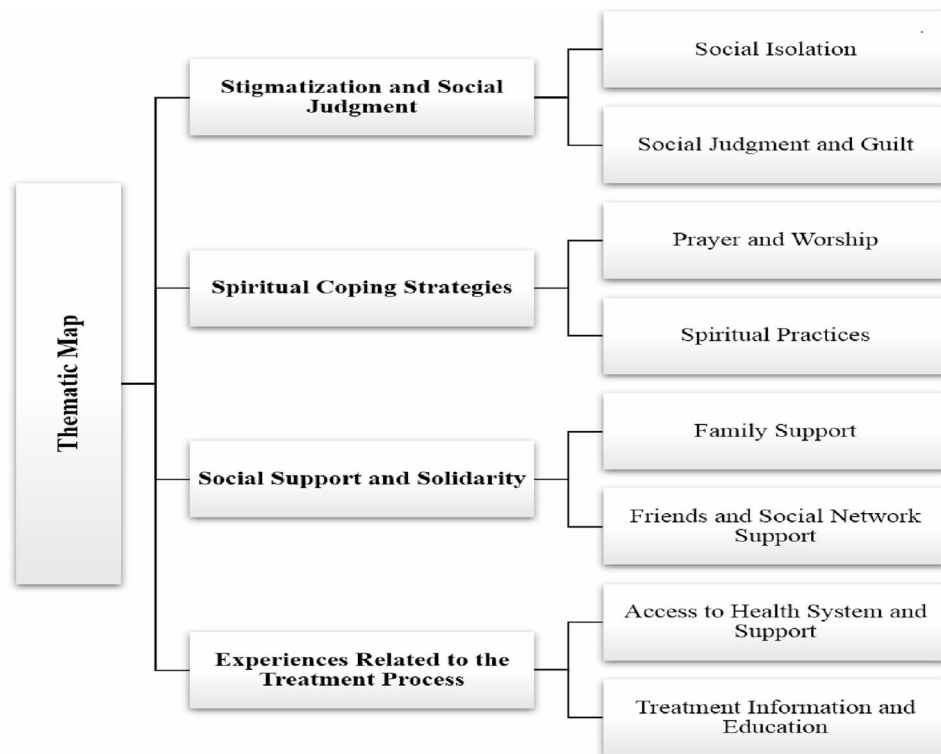


Fig. 1 Thematic map of women's lived experiences with cervical cancer

into themselves. Some participants stated that they limited their social relationships because they felt constantly judged:

"I don't call my friends anymore, and they don't call me either. I don't want to leave the house because people look at me as if they are questioning me with their eyes. That's why I shut myself in the house." (P7, 42 years old, married)

Emotional loneliness intensified when spouses and close family members failed to provide the expected support:

"My spouse should have been by my side, but they kept saying they were busy. I often went to treatment alone. When I came home from the hospital and no one asked me anything, I felt completely alone." (P2, 48 years old, married)

These accounts show that not only external stigmatization but also women's increasing feelings of loneliness and worthlessness during this process deepen their social isolation.

Social judgment and guilt

Social judgement and the accompanying sense of guilt were observed as a common pattern in more than half of the participants and were particularly associated with the

fear of moral labelling. Participants stated that their environment interpreted cervical cancer as a situation that was "not without cause," and therefore they faced implied guilt, even if it was not directly expressed. This situation caused women to feel as if they had "done something wrong" and even sometimes attributed the disease to their own mistakes. Some women have stated that, due to direct or indirect insinuations from those around them, they view their illness as a personal mistake or negligence, and that this creates intense feelings of guilt.

"One day, my closest relative said, 'This illness did not happen for no reason.' She looked me straight in the eye when she said this. She didn't actually say anything explicitly, but I understood very well what she meant; it felt like I had made a mistake, committed a sin, and it burned inside me." (P7, 42 years old, married).

Social judgment is reflected not only in words but also in looks:

"Everyone looks at me as if I have done something wrong. Some who heard about my illness didn't even look me in the face when they spoke; I felt so ashamed at that moment and withdrew into myself." (P9, 47 years old, single)

Some participants internalized these social perceptions and attributed their illness to their own negligence, viewing not going for regular checkups or delaying treatment as a kind of personal flaw:

"After I learned I had the disease, I couldn't sleep at night. I blamed myself, thinking, 'If only I had gone to the hospital earlier, if only I hadn't neglected it so much.' I felt as if everything was my fault." (P4, 46 years old, married)

Similarly, another participant expressed feeling responsible both medically and morally:

"I think my illness is due to my own negligence; I always put off my check-ups. Now I can't forgive myself; it's as if I wounded both my body and my soul." (P12, 52 years old, widowed).

These narratives show that women experience stigmatization not only as a process they are "subjected to" from the outside, but also as something they live with, accompanied by internalized feelings of guilt and shame, which deeply affect their mental well-being.

Theme 2: spiritual coping strategies

Spiritual coping strategies were reported by the majority of participants, although the meanings and intensity attributed to these practices varied. Women described spirituality, faith, and practices such as prayer, worship, reading the Quran, and participation in religious discussions as important resources for coping with uncertainty and fear following diagnosis. These practices often provided emotional comfort and a sense of meaning during the illness process. However, some participants also expressed spiritual ambivalence, reporting moments of doubt and questioning, such as asking "why me?". This indicates that spirituality was not a uniformly empowering experience but rather a dynamic coping process shaped by both faith and existential struggle.

Prayer and worship

Although prayer and individual worship were described by most participants as a coping mechanism, the intensity and meaning of this experience differed among women. Many participants stated that when faced with illness, they first experienced an emotional breakdown, and then turning to God provided them with a "space to breathe deeply."

While some women describe prayer and worship as a source of emotional comfort and hope, for others this process has been an experience that has developed over time and deepened alongside their illness.

However, the participants' narratives show that prayer and worship are not always experienced as uniform or merely protective. Although spiritual practices often provide relaxation, hope and emotional strength, some women have stated that they experienced moments of inner questioning, emotional tension or uncertainty during their spiritual processes. These narratives indicate that spiritual coping functions as a dynamic and evolving process that, while reassuring, also contains ambivalent aspects as women deal with the emotional difficulties of their illness.

"When tears flowed because of my illness, I took refuge in my Lord, and it was as if peace filled my heart. When I felt alone and started praying, I felt that 'someone hears me,' and this helped me hold on to life." (P14, 38 years old, single)

Prayer and worship have become both a daily ritual and a way to regain a sense of control for some women:

"I pray every night and perform my prayers; this gives me strength and makes me feel that I am not alone. Even when I am afraid of treatment, the thought that 'God is with me' calms me down." (P5, 50 years old, married)

Furthermore, framing the illness as a "test" has helped soften negative feelings for some participants:

"Sometimes I am very afraid, but then I think, 'This is a test from Allah,' and the anger and rebellion inside me diminish. It doesn't go away completely, but at least I find the strength to endure." (P14, 38 years old, single)

However, several women mentioned experiencing "mixed feelings" even while praying, feeling both sheltered and questioning; this shows that spirituality is not a homogeneous experience (for example, statements such as "Sometimes when I pray, I have to force myself not to say 'why me?'").

Spiritual practices

Group worship and relationships established with religious communities emerged as an experience that reduced feelings of loneliness and strengthened the sense of social belonging in approximately half of the participants.

Participants stated that these practices provided them with inner peace and made them feel like 'understood and accepted individuals' rather than 'lonely patients'. Women expressed that they found both spiritual support

and human contact through the mosque, religious discussions or spiritual sharing.

"I read the Quran and perform zikr; at that moment, it's as if the world stops. I feel a calmness inside, my heart slows down. It's as if my fears recede for a while." (P8, 44 years old, married)

Some participants stated that they felt the spiritual practices performed before treatment even reflected in physical symptoms:

"I read the Quran before every treatment, and I feel peace and relaxation within me. It's as if my body responds to this; my blood pressure drops, and the trembling in my hands and feet seems to decrease." (P15, 50 years old, married)

Group worship and religious discussion environments provided not only spiritual strength but also a strong sense of social support:

"Going to the mosque to pray and praying together with the women makes me feel very good. No one there looks at me badly because of my illness; on the contrary, they hug me and say, 'May Allah grant you healing.'" (P1, 44 years old, married)

"When I attended a religious discussion, those there embraced me. They said, 'You are not alone.' At that moment, I felt the indescribable loneliness inside me ease a little; for the first time, I felt understood." (P13, 49 years old, married)

Although most participants described these practices as supportive, a small number of women stated that they were uncomfortable with the implication that illness was "sinful" in some conversation settings and therefore preferred to stay away from certain religious groups. This situation shows that spirituality is not always solely protective; in some cases, it can also create a new area of tension.

Theme 3: social support and solidarity

Many participants stated that they received emotional and practical support from their families and friends, while some women indicated that they experienced this support to a limited extent due to fear of stigmatisation. The findings show that social support plays both a protective and a vulnerable role in women's coping processes with illness. Social support not only provides physical assistance; it also stands out as a fundamental resource that strengthens emotional resilience and nurtures motivation for recovery. Women stated that when they received support, they approached the treatment process

with more hope, whereas when deprived of support, their loneliness, exhaustion, and emotional burden increased significantly. However, social support experiences are not homogeneous; while some relationships play an empowering and protective role, others are characterised by vulnerability, disappointment, and withdrawal.

Family support

Family support has been identified as a fundamental source of strength for the majority of participants. However, some women have indicated that they do not receive sufficient emotional and practical support from their families. While family is described as the 'greatest source of strength' for many women, a smaller number of participants described family relationships as an experience that also causes anger and disappointment. Women emphasised that the physical presence of their husbands and children, their words and their behaviour are an important source of morale and motivation for them.

"My husband is always by my side, cheering me up and accompanying me to doctor's appointments. When he takes my arm and says, 'We'll get through this together,' I feel a power rising within me, as if I were invincible. At times like these, even the disease seems small in my eyes." (P10, 48 years old, married)

Some women described their children's support not only as emotional comfort but also as a motivation for life:

"When my angel-faced daughter strokes my hair at night and says, 'Mommy, you will get better, we are always here,' it's as if the sun rises inside me at that moment. Without my children's love, I couldn't have endured this process." (P5, 50 years old, married)

However, some participants noted that family support was not what they expected, and in some cases, it was even emotionally destructive:

"In the early days of my illness, I thought my husband would be by my side the most, but he was always busy. When I came home from treatment, no one asked how I was feeling. At that moment, I realized I would have to go through this illness alone." (P2, 48 years old, married)

These statements show that while family support has a healing effect, its absence increases women's psychosocial burden.

Friends and social environment support

Support from friends and social circles has been identified as a resource that alleviates feelings of loneliness and

reduces psychological burden for a significant proportion of participants. Many women have stated that small but meaningful gestures from their social circles, such as visits, messages or brief conversations, have significantly improved their emotional well-being.

However, some women have indicated that they did not receive sufficient support from their friends or that this support was limited due to fear of stigmatisation. Women emphasised that some people in their social circles distanced themselves after the diagnosis, while some friends continued to be there for them with small but consistent gestures of support. This situation demonstrates that support from friends and social circles is experienced by women as a two-sided experience that is both empowering and, at times, disappointing.

"My closest friend made soup every week and brought it to my door. Without hesitation, without getting tired... 'Just get back on your feet, I'm here for you,' she said. The warmth of that little bowl of soup sometimes feels better than all the medicine." (P2, 48 years old, married)

Support groups have also been a source of both information sharing and emotional solidarity for women:

"I attend a cancer support group. Everyone there is like me... No one judges, no one excludes. That's where I can pour out my heart the most. It was there that I first felt that pain becomes lighter when shared." (P12, 52 years old, widowed)

However, some participants mentioned that they had to distance themselves from these groups due to the stigmatising attitudes of their social circles:

"Some people excluded me because of my illness. Where we were sitting, someone pulled their arm away, someone moved their chair further away. But then a friend knocked on my door with hot soup in her hand and said, 'You are valuable to us,' and I recovered." (P2, 48 years old, married)

These findings show that social support is a two-way experience; acceptance can be healing, while exclusion can be destructive.

Theme 4: experiences related to the treatment process

Almost all participants reported experiencing various difficulties related to the treatment process; in particular, transportation barriers and communication gaps with healthcare workers were highlighted among women living in rural areas. The findings indicate that the treatment experience is not limited to medical practices

alone, but is shaped by women's relationships with the healthcare system, their level of access to information, and the attitudes of healthcare workers. The quality of information provided, accessibility, and compassionate communication play a decisive role in women's psychological well-being and adherence to treatment. Women's narratives reveal that the treatment process can, in some cases, create a sense of trust and empowerment, while in other cases, it can become a debilitating experience that deepens feelings of fatigue, uncertainty, and emotional exhaustion.

Access to the healthcare system and support

This sub-theme reflects how the structural difficulties women encounter in accessing healthcare services and the relationships they establish with healthcare workers shape their motivation for treatment. Women living in rural areas in particular stated that they found it difficult to continue treatment due to long distances, transport difficulties, physical exhaustion associated with treatment, and economic burdens.

Conversely, women's narratives indicate that healthcare workers' attitudes play a decisive role in the treatment experience. It has been emphasised that a compassionate, attentive, and explanatory approach makes women feel safe and strengthens their motivation to continue treatment. Women have stated that supportive communication positively affects not only the medical process but also their ability to cope with illness.

"Every time the nurse saw the helplessness on my face, she would smile and say, 'Don't worry, we are here.' Those words kept me going even on the most painful days of treatment. Knowing that someone is by your side makes even the heaviest medicine easier to bear." (P7, 42 years old, married)

Doctor and nurse support are fundamental elements for many women in trusting their treatment:

"My doctor answers every question I have, explaining even the smallest details. His calm demeanor is so comforting that I feel safe every time I come to the hospital." (P12, 52 years old, widowed)

In contrast, for some women, access difficulties have been more exhausting than the treatment process itself:

"I have to travel two hours to get to my treatment. Fatigue aside, sometimes I can't even afford the travel expenses. I get so worn out that some days it's the journey, not the treatment, that makes me sick." (P15, 50 years old, married)

These statements show that access to the healthcare system is a critical factor that directly affects treatment compliance.

Treatment information and education

Information about treatment has been described as an element that reduces anxiety and strengthens the sense of control for most participants.

Women stated that when they received sufficient information, they approached the process more consciously, while a lack of information increased uncertainty and fear.

"On days when I didn't know what to expect from the treatment, I was shaking with fear. I was reluctant to ask the doctor questions because they often glossed over things. Everything I didn't understand turned into a greater fear inside me." (P9, 47 years old, single)

Detailed information, on the other hand, strengthened the sense of control:

"When my doctor explained the treatment process step by step, I felt an incredible sense of relief. Even saying 'Now I know what to expect' makes you feel strong." (P10, 48 years old, married)

Some women mentioned that they couldn't get answers to their questions due to healthcare workers' time constraints, which created a sense of insecurity:

"When I tried to ask something, the nurse would say, 'We'll talk later,' and leave. That 'later' never came. This made me feel worthless; as if no one cared about me anymore." (P2, 48 years old, married)

These findings show that informing patients is not just about sharing information, but also about building a relationship of trust that supports women's emotional resilience and compliance with treatment.

Discussion

This study contributes to qualitative research by offering an integrated phenomenological account of how stigmatization and spiritual coping are simultaneously experienced and negotiated by women diagnosed with cervical cancer. Rather than conceptualizing stigma and coping as separate or sequential phenomena, the findings demonstrate that these processes are deeply intertwined and mutually shaping. Experiences of stigma often intensified women's turn toward spiritual meaning-making, while spiritual coping, in turn, influenced how women interpreted social judgment, isolation, and suffering. This

integrated perspective extends prior qualitative studies by highlighting how stigma and spirituality function together as a unified experiential process rather than as isolated dimensions of illness. Consistent with existing literature, cervical cancer and HPV remain historically stigmatized due to their association with sexuality, moral norms, and gendered expectations [46]. This stigma is not limited to external judgment but becomes internalized, shaping women's self-perceptions, emotional responses, and social behaviors [10, 47–49]. Particularly in societies characterized by conservative cultural norms, the association of HPV with sexual behavior intensifies women's fear of moral judgment within both family and community contexts [5, 6, 8, 29, 30]. Qualitative studies have repeatedly shown that women diagnosed with cervical cancer feel labeled as "sexually irresponsible," which deepens feelings of shame, embarrassment, and self-blame [50–53]. Current findings suggest that the fear of criminalisation and moral judgement in the Turkish context may shape the stigma associated with HPV in a manner similar to patterns identified in societies with strong sexual taboos, but in some cases more intensely. Qualitative studies have shown that in low- and middle-income, culturally conservative environments, HPV is associated with 'immorality,' 'infidelity,' and 'promiscuity'; therefore, women fear blame and rejection from their partners and social circles [8]. On the other hand, studies conducted on high-income Western samples reveal that HPV-related stigma is more often associated with 'irresponsibility' or 'risky sexual behaviour,' but even in situations where concepts such as 'feminine honour' are prominent in the cultural context, feelings of guilt are not reported as being so intertwined with religious/spiritual discourse [10]. This comparative framework indicates that cultural taboos and honour/privacy-centred norms in Turkey may reinforce feelings of guilt and shame associated with HPV compared to more secular samples in the West; however, as the current study is based on a qualitative design and a limited sample, these differences are only addressed at an interpretative level and are not quantitatively tested.

Therefore, caution is required when generalising the findings to non-Islamic, more secular contexts or contexts with different religious majorities. The experiences of participants in Turkey are shaped within a cultural sphere where Islam is strongly embedded in daily life and sexuality norms, and where concepts of family/honour are closely linked to female sexuality [15]. This structure may not be present with the same intensity in, for example, more individualistic and secular Western countries or in societies with different theological traditions (e.g., Christian, Buddhist, or those with high religious diversity), and may alter the source, expression, and coping mechanisms of HPV stigmatisation [16]. Therefore, the

study presents an in-depth but context-specific picture of how stigmatisation and spiritual coping intersect in an Islamic-conservative context; findings regarding different religious/cultural environments can only be theoretically analogous and cannot be directly generalised.

Beyond confirming these patterns, the present study extends previous research by illustrating how stigma actively restructures women's social worlds. Stigmatization was found to contribute not only to emotional distress but also to social withdrawal, erosion of family support, and heightened psychological vulnerability. In this sense, stigma operates as a disabling social force that undermines women's access to relational resources precisely at a time when support is most needed. This finding adds phenomenological depth to prior studies that have often conceptualized stigma as an individual psychological burden rather than a dynamic social process shaping everyday interactions.

Within this context of social vulnerability, spiritual coping emerges as a critical meaning-making strategy. The findings demonstrate that spirituality does not function merely as a personal belief system but as a relational and cultural resource through which women interpret suffering, negotiate uncertainty, and restore a sense of coherence. Previous studies have emphasized spirituality as a source of hope, comfort, and emotional regulation in cancer experiences [54, 55]. Similarly, Ambikile et al. (2025) reported that prayer, belief in divine healing, and participation in religious practices provided encouragement and emotional strength for women with cervical cancer [56]. These findings are consistent with Pargament and Brant's [57] theoretical approach, which emphasises that spirituality emerges as a distinct support mechanism, particularly in challenging and stressful life conditions where other coping resources are limited or inadequate. The present study supports this literature while extending previous research by revealing how spiritual coping strategies become more visible and functional in contexts where stigmatisation and social isolation are intensely experienced.

Importantly, spiritual practices in this study were not confined to individual rituals but were embedded within communal religious contexts. Religious communities functioned simultaneously as spaces of spiritual meaning and social belonging, offering emotional validation and collective support. This dual role of religious spaces as both spiritual and social resources has been emphasized in prior research [58–61]. However, the current findings deepen this understanding by showing that religious communities can partially compensate for social exclusion experienced in broader societal contexts, thereby mitigating the isolating effects of stigma.

At the same time, this study adopts a balanced analytical stance by acknowledging that spiritual coping is

not uniformly protective. While spirituality strengthened psychological resilience for many women, the literature cautions that certain forms of fatalistic belief may delay health-seeking behaviors and weaken engagement with preventive care [62, 63]. In Muslim societies, fatalism represents a complex and nuanced construct. Ethnographic research suggests that trust in divine will often coexists with active engagement in medical treatment rather than replacing it [64]. Nevertheless, in specific subgroups, excessive fatalism may contribute to delayed screening and treatment by framing illness as predetermined fate [62]. By situating women's spiritual coping within this broader cultural and theological context, the present study avoids idealizing spirituality and instead underscores the importance of culturally sensitive, clinically integrated spiritual care. While family, spouse, and child support facilitate women's psychological adjustment, lack of social support, fear of stigmatization, or mistreatment from the social environment have increased women's emotional burden and affected their access to both social and health services [12, 43, 65–67].

Social support processes further illustrate the interconnectedness of stigma and coping. Family, spousal, and peer support played a critical role in buffering psychological distress and facilitating treatment engagement. Consistent with prior research, strong social support was associated with improved quality of life, emotional adjustment, and treatment adherence [68–72]. However, the present study reveals that stigma often disrupts these support networks. Fear of judgment, disclosure concerns, and experiences of exclusion limited women's ability to seek or receive support, echoing findings from previous qualitative studies among HPV-positive women [12, 73–75].

Notably, this study contributes to the literature by demonstrating that social support does not merely coexist with stigma but actively moderates its impact. When social support was present, women exhibited greater resilience and adaptive coping; when absent, stigma exerted a more destructive influence on emotional well-being and help-seeking behaviors. This dynamic interaction advances existing models that treat stigma and support as parallel but independent constructs.

Treatment experiences represent the final layer of this interconnected framework. Women's engagement with healthcare systems was deeply influenced by prior experiences of stigma, levels of social support, and spiritual meaning-making. Supportive, empathetic, and informative communication by healthcare professionals enhanced trust, reduced anxiety, and strengthened treatment adherence [17, 76–78]. Conversely, inadequate information, communication gaps, transportation difficulties, and systemic barriers undermined women's

capacity to cope and remain engaged in care, particularly in low- and middle-income settings [77, 78].

Rather than viewing treatment barriers as purely structural, the present study highlights how these challenges intersect with social and cultural factors. Stigma-related silence, fatalistic beliefs, and weakened support networks amplify the effects of systemic constraints, demonstrating that access to care cannot be separated from broader sociocultural contexts. This integrative perspective represents a key theoretical contribution, illustrating how previously fragmented findings in the literature stigma, spirituality, social support, and treatment adherence are experienced as a unified lived reality by women diagnosed with cervical cancer.

Although this study was conducted within a specific sociocultural context, the findings may offer insights that are transferable to other culturally conservative or low-resource settings. However, the transferability of these findings to non-Islamic or more secular contexts is necessarily limited. The strong moralisation of HPV as evidence of “immorality”, the centrality of family honour, and the integration of prayer, Qur’an recitation and religious community life into coping are closely tied to the Turkish Muslim sociocultural environment, where sexuality is a sensitive and often silenced topic [16]. In more secular Western settings, women with HPV or cervical cancer may also experience stigma, anxiety and self-blame, yet the language of “sin”, divine testing and honour may be less prominent, and religious communities may not function as primary sites of both spiritual and social support [29]. Rather than assuming universality, the present study therefore offers a culturally bounded model of how stigma, spirituality and social support intersect in a conservative Turkish Muslim context, which requires empirical testing, adaptation and possible revision in non-Islamic or highly secular societies. In contexts where women’s health, sexuality, and HPV-related conditions are similarly shaped by moral norms, stigma, and limited access to healthcare, comparable patterns of social withdrawal, spiritual coping, and reliance on informal support networks may emerge. The interplay observed between stigmatization, spirituality, social support, and treatment engagement highlights the importance of culturally sensitive, holistic care models that extend beyond biomedical treatment. From an international perspective, these findings suggest that addressing stigma, strengthening patient–provider communication, and integrating culturally meaningful coping resources may be relevant strategies in other low- and middle-income or socially conservative contexts, while acknowledging that local adaptations are essential.

Strengths and limitations

One of the strengths of this study is the use of a phenomenological design and qualitative data collection techniques to deeply understand the experiences of stigma and spiritual coping among women diagnosed with cervical cancer. Findings derived from participants’ direct statements reflect the holistic experiences of women living with cervical cancer across social, psychological, and spiritual dimensions. Furthermore, the inclusion of women of different ages, educational backgrounds, marital statuses, and living conditions through maximum diversity sampling has increased the diversity and scope of the results obtained.

However, the study has some limitations. Firstly, the research was conducted only with women in a specific region, and the findings cannot be generalised to all cervical cancer patients. Secondly, the relatively small number of participants indicates that caution should be exercised in interpreting the results. Furthermore, the discussion of personal and sensitive topics such as stigmatisation and spiritual coping during the interviews may have caused some participants to be reluctant to share their experiences. This situation can be considered a factor limiting the depth of the data.

Regarding contextual transferability, the findings of this study are most applicable to culturally conservative and faith-oriented settings where moral norms surrounding sexuality and illness strongly shape women’s social experiences. In such contexts, stigmatization and spiritual coping are likely to be closely intertwined, as observed in the present analysis. In more secular or religiously plural settings, where spirituality may play a less central role in daily life, the meanings attributed to stigma and coping may differ. Therefore, the findings should be interpreted cautiously when transferred to sociocultural contexts that differ substantially from the one examined in this study.

Despite all these limitations, the study contributes to holistic care approaches applicable in nursing and public health by presenting important and original findings on the stigmatisation processes and spiritual coping mechanisms of women diagnosed with cervical cancer.

Conclusion

This qualitative study offers a comprehensive and contextually grounded understanding of how women diagnosed with cervical cancer experience stigma, mobilize spiritual coping strategies, negotiate social support, and engage with the healthcare system. Rather than representing isolated dimensions, these experiences emerged as inter-related and mutually reinforcing processes embedded within broader sociocultural and moral frameworks.

Stigma was identified as a central and organizing force shaping women’s illness experiences, influencing not only

social withdrawal and internalized guilt but also access to emotional, familial, and professional support. The findings demonstrate that stigma extends beyond external judgment to become internalized, thereby intensifying psychological distress and complicating coping efforts. Within this context, spirituality functioned as a critical yet complex resource: for many women, spiritual beliefs and practices fostered meaning, emotional resilience, and a sense of continuity, while in some cases they also intersected with fatalistic interpretations that risked delaying care. This dual role underscores the need to approach spiritual coping as a dynamic and culturally situated process rather than a uniformly protective factor.

Social support particularly from family members, spouses, and religious communities emerged as a key moderator that could either buffer or exacerbate the impact of stigma. Women who experienced consistent emotional and practical support demonstrated greater psychological adaptation and engagement with treatment, whereas those facing social exclusion or ambivalence reported heightened vulnerability. Experiences within the healthcare system further revealed that compassionate communication and clear information provision strengthened trust and treatment adherence, while structural barriers such as transportation difficulties and inadequate explanations compounded existing psychosocial burdens.

By integrating these findings, this study advances the literature by illustrating how stigma, spirituality, social support, and treatment experiences intersect to shape the lived reality of cervical cancer. The results highlight that cervical cancer care cannot be reduced to biomedical management alone; instead, it requires holistic, culturally sensitive approaches that address moral meanings, relational dynamics, and spiritual needs alongside clinical treatment. Recognizing and responding to these interconnected dimensions is essential for improving women's well-being, treatment engagement, and overall quality of care.

Relevance to clinical practice

The findings of this study underscore the need for a coherent, patient-centred, and culturally responsive approach to cervical cancer care. First, addressing stigma should be recognised as a core component of clinical practice rather than a peripheral concern. Nurses and physicians play a pivotal role in reducing women's social anxiety by providing clear, accurate, and culturally sensitive explanations that correct widespread misconceptions about HPV and cervical cancer, particularly beliefs related to contagion, moral judgement, and blame.

Within this context, integrating women's cultural and religious coping practices into care planning becomes essential rather than supplementary. Many women draw

strength from spiritual resources during the illness trajectory; therefore, access to spiritual counselling services and, when appropriate, collaboration with trusted religious or community structures may enhance psychological resilience especially in conservative social settings where spirituality constitutes an important meaning-making framework.

Equally important, patient education emerges as a central determinant of treatment adherence and emotional adjustment. Clear, comprehensible, and repeated explanations regarding treatment stages, potential side effects, and expected outcomes should be provided throughout the care process. As insufficient or fragmented information was shown to heighten anxiety and uncertainty, clinicians should continuously assess women's informational needs at each clinical encounter.

In addition to individual-level interventions, strengthening women's social support networks represents a critical clinical responsibility. Establishing constructive collaboration with family members, offering family-centred education, and facilitating referrals to psychosocial support services when needed can substantially ease women's emotional burden and reinforce coping capacity.

Furthermore, the findings highlight the necessity of addressing structural barriers to care. Practical facilitative measures such as transportation support, coordinated appointment scheduling, and mobile health services are particularly important for women living in rural or resource-limited areas and may significantly improve access to and continuity of treatment.

Taken together, these clinical implications support the development of a comprehensive, culturally sensitive, and holistic model of cervical cancer care that not only addresses biomedical needs but also actively responds to stigma, uncertainty, and the broader social realities shaping women's lived experiences.

Based on these findings, the following actionable recommendations may guide clinical practice

- **Stigma-sensitive communication:** Healthcare professionals should proactively address misconceptions related to HPV and cervical cancer by using non-judgmental, neutral language and explicitly reassuring patients that the disease is not a result of moral failure or personal blame.
- **Culturally responsive patient education:** Education about diagnosis, treatment, and side effects should be tailored to women's cultural context and health literacy levels, with opportunities for repeated clarification to reduce fear, uncertainty, and withdrawal from care.
- **Integration of spiritual support when appropriate:** When patients express spiritual needs, clinicians

should acknowledge these resources respectfully and, if desired by the patient, facilitate access to spiritual counselling or community-based support, ensuring that spiritual care complements rather than replaces medical treatment.

Abbreviations

HPV Human Papilloma Virus

RT Radiotherapy

CT Chemotherapy

ST Spiritual Therapy / Spiritual Coping Strategies

P Participant

COREQ Consolidated Criteria for Reporting Qualitative Research

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Authors' contributions

NA, EKC and SK conceived and designed the research. NA and EKC collected the data; NA and MY analysed and interpreted the data. Each contributed equally to the writing and editing of the article and approved the final version.

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Data availability

Additional data files in Turkish are available upon request to the corresponding author.

Declarations

Ethics approval and consent to participate

This study was conducted with the approval of the Non-Interventional Clinical Research Ethics Committee of Hakkari University (Date: 30.06.2025 No:115164-2025/135). Institutional permissions were obtained from the relevant institutions for the conduct of the study. The study was conducted in accordance with the principles of the Declaration of Helsinki. All participants were informed about the purpose of the study, their right to withdraw at any time, and the confidentiality of their personal information. Written informed consent was obtained from all participating women.

Consent for publication

Written consent was obtained from all participants for the use of study data in scientific publications.

Competing interests

The authors declare no competing interests.

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