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RESEARCH ARTICLE

The Psychological Burden of Cervical Cancer in Sub-Saharan Africa: Distress, Shame, and the Case for Integrated Task-Sharing Mental Health Care — A Narrative Review

Hrvoje Cvija[1]

[1] Together Women Can, Vienna, Austria

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Background/Aims

Cervical cancer is the leading cause of cancer death among women in sub-Saharan Africa, where late diagnosis, limited treatment infrastructure, and culturally specific shame linked to HPV aetiology compound its physical burden. Psychosocial care remains largely absent from cervical cancer programmes across the region despite growing evidence of its clinical importance. This narrative review synthesises evidence on the prevalence, determinants, and clinical consequences of psychological distress in women with cervical cancer in sub-Saharan Africa, and examines the evidence base for task-sharing mental health interventions applicable to this context.

Methods

PubMed, PsycINFO, and Global Health databases were searched for peer-reviewed literature published through December 2024, combining terms for cervical cancer, sub-Saharan Africa, psychological distress, depression, anxiety, task-sharing, and psycho-oncology. Systematic reviews, observational studies, qualitative research, and intervention trials were included and narratively synthesised.

Results

Depression affects 20–38% and anxiety 30–52% of women with cervical cancer in sub-Saharan Africa. Distress is shaped by advanced disease stage, financial toxicity, HIV co-infection, and HPV-related stigma and shame. Standard screening instruments (PHQ-9, HADS) are widely used but lack formal validation in local languages. Task-sharing interventions delivered by community health workers, nurses, and social workers demonstrate consistent reductions in distress with high acceptability, though cervical-cancer-specific trials in the region remain scarce.

Conclusions

Psychological distress in this population is prevalent, culturally distinctive, and clinically consequential. Culturally adapted task-sharing interventions should be integrated into cervical cancer care pathways as a clinical and ethical priority. Validated screening tools and rigorous trials are urgently needed.

1. Introduction

Cervical cancer is the fourth most common cancer in women globally and the leading cause of cancer death among women in eastern and southern Africa.[1] In 2020, an estimated 604,000 new cases and 342,000 deaths were recorded worldwide; the majority of these deaths occurred in low- and middle-income countries (LMICs), and sub-Saharan Africa accounted for a disproportionate share. The reasons are well documented: limited coverage of HPV vaccination, the near-absence of organised screening programmes, high rates of HIV co-infection that accelerate disease progression, and substantial barriers to timely diagnosis and treatment. The consequence is that most women in sub-Saharan Africa present with locally advanced or metastatic disease — a clinical reality with profound implications not only for survival but for the lived experience of illness.

The psychological dimensions of this experience have attracted increasing research attention over the past decade, yet psychosocial care remains structurally marginalised within cervical cancer programmes across the region. This marginalisation reflects a persistent — and arguably false — hierarchy of clinical priorities, in which physical disease management is treated as the domain of legitimate medical concern while psychological distress is addressed, if at all, as secondary or incidental. The evidence reviewed in this paper challenges that hierarchy: depression and anxiety in women with cervical cancer are prevalent, clinically consequential, and responsive to evidence-based intervention.[2]

The present narrative review builds on a body of qualitative and conceptual work — including practitioner accounts from community health initiatives in Kenya — that has articulated, with considerable precision, the psychological phenomenology of cervical cancer diagnosis in LMIC settings.[3] That work has described diagnosis as an existential rupture, shame as a primary and culturally specific response, and the healthcare encounter as frequently inadequate to address the psychological dimensions of what patients bring to it. The aim of the present review is to situate these observations within the broader empirical literature: to establish what is known about the prevalence and determinants of psychological distress in this population, to appraise the tools available for its identification, and to examine the evidence for task-sharing mental health interventions applicable to the realities of sub-Saharan African health systems.

2. Methods

This narrative review was conducted in accordance with published guidance for narrative synthesis in health research.[4] Electronic searches of PubMed/MEDLINE, PsycINFO, CINAHL, and the WHO Global Index Medicus were performed in January 2025, covering all records from database inception to 01 August 2024. Search terms combined Medical Subject Headings and

free-text terms across three domains: (1) cervical cancer and related neoplasms; (2) sub-Saharan African countries and regions; and (3) psychological outcomes including depression, anxiety, distress, quality of life, shame, stigma, and psychosocial intervention. Reference lists of all relevant systematic reviews and included primary studies were hand-searched for additional sources.

Studies were included if they reported on psychological outcomes — prevalence, screening, determinants, or intervention — in women with confirmed cervical cancer in a sub-Saharan African country, regardless of study design. We included quantitative studies (observational and interventional), qualitative studies, and mixed-methods designs. We also drew on systematic reviews addressing psychological distress in cancer populations in LMICs more broadly, where cervical-cancer-specific or sub-Saharan-Africa-specific data were limited. Studies were excluded if they focused exclusively on screening uptake or HPV vaccination without reporting psychological outcomes, or if they aggregated cancer types without permitting subgroup analysis for cervical cancer.

Given the heterogeneity of study designs and the narrative intent of the review, formal risk of bias scoring and meta-analytic synthesis were not performed. The quality of evidence is discussed contextually throughout. The review is structured around four thematic domains: (1) prevalence and clinical consequences of psychological distress; (2) cultural determinants of distress specific to cervical cancer in sub-Saharan Africa; (3) screening instruments and their limitations; and (4) task-sharing interventions. A summary of key evidence by domain is presented in Table 1.

3. Prevalence and Clinical Consequences of Psychological Distress

3.1. Depression and Anxiety

The most comprehensive estimates of depression and anxiety prevalence across cancer populations in oncological and palliative care settings derive from a meta-analysis of 94 interview-based studies by Mitchell and colleagues, which found rates of major depression of approximately 16% and any depressive disorder of 29% across oncological settings, with higher rates in more advanced disease.[5] Studies focusing specifically on gynaecological cancers and on LMIC settings consistently report rates at the upper end of, or exceeding, these estimates. A systematic review of psychological morbidity in gynaecological cancer patients in LMICs found depression prevalence of 20–45% and anxiety of 25–52%, with cervical cancer patients reporting among the highest rates — a finding attributed to the advanced stage at presentation, the intensity of treatment required, and the social consequences of the diagnosis.[6]

In sub-Saharan Africa specifically, cross-sectional studies from Ethiopia, South Africa, Uganda, and Kenya have documented depression rates ranging from 24% to 38% and anxiety rates from 31% to 52% in women with cervical cancer, using validated instruments including the Hospital Anxiety and Depression Scale (HADS), the Patient Health Questionnaire-9 (PHQ-9), and the Kessler Psychological Distress Scale (K10).[7] Rates are consistently higher in women with stage III–IV disease, in those with concurrent HIV infection, and in those facing catastrophic out-of-pocket healthcare expenditure — a pattern that reflects the intersection of disease burden, social vulnerability, and structural inequality characteristic of cervical cancer in this region.

Post-traumatic stress symptoms, while less frequently measured in this population, are documented in survivors of radical treatment — particularly in women who have undergone pelvic radiotherapy, which is associated with significant and sometimes permanent changes in sexual, urinary, and bowel function.[8] The bodily alterations associated with treatment compound the pre-existing disruption to bodily integrity described in qualitative accounts of diagnosis, producing what some investigators have characterised as a protracted experience of embodied alienation.

3.2. Clinical Consequences of Untreated Distress

Psychological distress in cancer patients is not a background condition that can be addressed after the priorities of physical disease management are attended to. Evidence across cancer types and settings consistently demonstrates that untreated depression and anxiety reduce treatment adherence, increase emergency healthcare utilisation, extend inpatient stays, and are independently associated with reduced survival.[9] In the context of cervical cancer in sub-Saharan Africa, where treatment abandonment rates are already high due to financial and logistical barriers, the additive effect of unaddressed psychological distress on treatment non-completion represents a clinical problem of considerable magnitude.

The mechanisms linking depression to poorer cancer outcomes are multiple and interacting. Behavioural pathways — reduced self-care, impaired appetite, disrupted sleep, social withdrawal — compound the physical effects of treatment. Neuro-immunological mechanisms, including depression-associated dysregulation of natural killer cell activity and inflammatory cytokine profiles, may influence tumour biology directly.[10] In HIV-positive women — who represent a substantial proportion of cervical cancer patients in sub-Saharan Africa — depression is also associated with reduced antiretroviral therapy adherence, creating additional biological risk. These pathways underscore the clinical urgency of integrating psychological screening and support into cervical cancer care, not as an optional supplement but as a component of disease management.

4. Cultural Determinants of Distress: Shame, Stigma, and the HPV Aetiology

Understanding psychological distress in women with cervical cancer in sub-Saharan Africa requires engagement with the cultural frameworks through which illness is interpreted and experienced. Two dimensions are particularly salient and have been documented with consistency across qualitative and mixed-methods research in the region: the stigmatising moral meaning attached to cervical cancer because of its HPV aetiology, and the cultural shaping of distress expression through somatic idioms and collectivist grief norms.

4.1. HPV Stigma and Moral Shame

Human papillomavirus is a sexually transmitted infection, and this aetiological fact — when known to patients, their families, or their communities — introduces a moral dimension to cervical cancer diagnosis that distinguishes it psychologically from most other cancers. In many communities across sub-Saharan Africa, sexually transmitted infection carries connotations of promiscuity, infidelity, or moral transgression. Women may internalise the diagnosis as evidence of their own sexual impropriety, even when their actual sexual history provides no grounds for such an interpretation.[11]

This internalised shame has specific psychological and behavioural consequences. Unlike fear — which may motivate help-seeking — shame tends to produce concealment, withdrawal, and delay. Women may avoid disclosing their diagnosis to partners, family members, or community networks for fear of social exclusion, marital dissolution, or ostracism. They may delay seeking care or abandon treatment to avoid the disclosure that clinic attendance would require. They may experience the diagnosis as a confirmation of unworthiness that undermines the psychological resources needed to engage actively with treatment.

These dynamics are not merely attitudinal — they are embedded in community belief systems and in the design of health communication strategies that have historically failed to disaggregate the moral from the biological dimensions of HPV. Anti-stigma communication that addresses the high population prevalence of HPV, its non-discriminatory transmission dynamics, and the absence of any moral significance in a viral infection has been shown to reduce shame-related barriers to care-seeking in other LMIC settings and deserves systematic evaluation in sub-Saharan Africa specifically.[12]

4.2. Somatic Idioms, Collectivist Grief, and the Limits of Western Diagnostic Frameworks

A second culturally specific dimension concerns the ways in which distress is expressed and communicated. The global mental health literature has established that psychological suffering is culturally patterned: the idioms through which distress is articulated, the somatic or affective channels through which it is expressed, and the social contexts in which it is deemed appropriate to disclose it vary significantly across cultural settings.[13] Instruments developed and validated in Western, predominantly English-speaking clinical contexts — including the PHQ-9 and HADS, the two most widely used screening tools in this population — operationalise depression and anxiety primarily through cognitive and affective items (hopelessness, worry, loss of interest) that may not correspond to the primary channels of distress expression in many sub-Saharan African contexts, where somatic complaints (pain, fatigue, heart disturbance, bodily heaviness) may be the predominant idiom.

Collectivist orientations to selfhood and suffering are also relevant. In many communities across the region, individual psychological distress is embedded within relational and communal frameworks: the illness of one person is a crisis for the family and the network, and the appropriate response involves collective mourning, communal support, and shared meaning-making rather than the individual therapeutic work privileged by Western psychotherapy models.[14] This observation has direct implications for intervention design: group-based and community-embedded approaches may be not merely more scalable than individual therapy in LMIC settings, but more culturally congruent — and therefore potentially more effective — for this population.

5. Psychological Screening Instruments: Applicability and Limitations

Systematic psychological distress screening is a prerequisite for any meaningful integration of mental health support into cervical cancer care. Without screening, distress goes undetected: clinicians underestimate the psychological burden of their patients, and patients — particularly those for whom disclosure of distress carries social risk — do not raise it unprompted. Several studies have demonstrated that oncology clinicians substantially underestimate the rates of depression and anxiety in their patients in the absence of structured screening.[5]

The PHQ-9, the HADS, and the Kessler K-10 are the instruments most commonly used in cancer populations in sub-Saharan Africa. Each has been translated into multiple African languages, including Swahili, Amharic, Zulu, Luganda, and Twi, and has been used in general population and primary care samples across the region. However, formal psychometric validation —

including sensitivity and specificity analysis against a gold-standard diagnostic interview — in women with cervical cancer specifically has not been reported in the peer-reviewed literature to date.[15]

This gap matters for two reasons. First, cancer patients are a clinically distinct population in whom somatic symptoms of disease (fatigue, anorexia, sleep disturbance, pain) overlap substantially with the somatic items of standard depression instruments, potentially inflating prevalence estimates. Second, as discussed above, the conceptual validity of these instruments — their capacity to capture distress as locally experienced and expressed — has not been established for this population. A cross-sectional prevalence study using an unvalidated translation of the PHQ-9 in Amharic-speaking women with cervical cancer in Ethiopia may be measuring something real and important, but the precision and comparability of its estimates cannot be established without validation data.

The Distress Thermometer — a single-item visual analogue scale with an associated problem list — offers an alternative approach with lower respondent burden and less dependence on conceptual translation of multi-item constructs.[16] Its simplicity makes it particularly suited to integration into routine clinical care by non-specialist health workers. However, its sensitivity and specificity in sub-Saharan African cancer populations have been inconsistently reported, and there is no consensus on appropriate cut-off thresholds in these settings. The development of brief, culturally adapted, locally validated screening tools — ideally co-designed with affected communities — is a research priority that this field has articulated for many years without adequate response.

6. Task-Sharing Mental Health Interventions: Evidence and Application

6.1. The Task-Sharing Model and Its Evidence Base

Task-sharing — the systematic delegation of mental health assessment and intervention to non-specialist health workers under appropriate training and supervision — has emerged as the primary strategy for addressing the treatment gap for mental disorders in LMICs, where specialist psychiatric and psychological services are profoundly insufficient to meet population need.[17] The evidence base for task-sharing in LMIC mental health care has grown substantially over the past two decades. Randomised controlled trials conducted in India, Zimbabwe, Pakistan, Uganda, and Chile have demonstrated that non-specialist workers trained in structured psychological interventions — including adaptations of cognitive behavioural therapy (CBT), problem-solving therapy, and behavioural activation — can achieve outcomes comparable to specialist-delivered care for depression and anxiety in primary care and community settings.

The landmark PREMIUM trials in India demonstrated that a brief psychological treatment for depression (Healthy Activity Programme) delivered by lay counsellors was superior to enhanced usual care in a large RCT, with effect sizes comparable to those achieved by specialist-delivered antidepressants in high-income settings.[18] Similar findings have been reported for the Common Elements Treatment Approach (CETA), a transdiagnostic task-sharing intervention developed for use in LMIC settings including sub-Saharan Africa, which has demonstrated efficacy for depression, anxiety, PTSD, and functional impairment in conflict-affected and general community populations.

6.2. Task-Sharing in Cancer Care in LMICs

The application of task-sharing principles to psycho-oncological care in LMICs is less advanced than its application in primary and community mental health, but the evidence is accumulating. A systematic review by Rwegerera and colleagues examined psychosocial interventions in cancer patients in Africa and found that nurse-delivered and community health worker-delivered psychoeducational programmes consistently improved quality of life and reduced distress scores over short-term follow-up, with high patient acceptability across diverse cultural contexts.[19]

Group-based formats have shown particular promise. Group interventions leverage peer witnessing and shared narrative — processes that, as discussed in the cultural analysis above, align naturally with collectivist approaches to suffering and healing in many sub-Saharan African communities. In a feasibility study of a nurse-facilitated group support programme for women with gynaecological cancers in South Africa, participants reported that the opportunity to hear others articulate experiences similar to their own — including shame, fear of abandonment, and uncertainty about the future — was itself a primary mechanism of psychological benefit, independent of any specific technique employed.[20]

Peer support programmes — in which women with lived experience of cervical cancer are trained to provide structured emotional support to newly diagnosed patients — have been evaluated primarily in high-income settings but are increasingly implemented programmatically in sub-Saharan Africa, including within community health volunteer frameworks analogous to those used in initiatives such as Together Women Can in Kenya.[3] The principles are clinically sound: social support is robustly associated with psychological resilience in cancer populations, and peer support by definition carries cultural authenticity that professional-delivered interventions may lack. Rigorous evaluation of these programmes is now needed.

6.3. Pharmacological Considerations

Pharmacological treatment of depression and anxiety in women with cervical cancer in sub-Saharan Africa raises specific considerations. Antidepressant availability in LMICs has improved considerably, but access at the point of care in oncology settings remains inconsistent.[21] Drug interactions with cisplatin-based chemotherapy and with antiretroviral regimens used in HIV-positive patients require clinical attention: SSRIs with significant CYP450 inhibitory potential may affect the metabolism of both oncological and antiretroviral drugs, and potential QTc effects require monitoring in patients receiving cardiotoxic chemotherapy. These considerations do not argue against pharmacological treatment — whose evidence base for depression in cancer patients is well established — but they underscore the importance of integrated, medically supervised prescribing rather than task-sharing antidepressant therapy to fully non-specialist workers without pharmacological training.

7. Summary of Evidence by Domain

Table 1. Summary of Key Evidence Domains, Findings, and Research Gaps

Domain	Key Finding	Primary Evidence	Research Gap
Prevalence of depression	20–38% of women with cervical cancer in sub-Saharan Africa meet clinical threshold	Mitchell et al., Lancet Oncol 2011; Tadesse et al., BMC Cancer 2018	LMIC-validated cut-offs absent; cross-sectional design dominates
Prevalence of anxiety	30–52%; peaks at diagnosis and relapse	Bhatia et al., Psychooncology 2017; Grassi et al., Psychooncology 2023	Longitudinal data scarce; HIV interaction understudied
Cultural determinants	HPV-related shame central; collectivist grief norms; somatic idioms of distress	Kohrt et al., Int J Epidemiol 2014; Ludermir et al., Soc Sci Med 2003	Cervical-cancer-specific qualitative research limited in West Africa
Screening instruments	PHQ-9 and HADS most used; neither formally validated in SSA languages	Cholera et al., J Affect Disord 2014; Peltzer et al., Afr J Psychiatry 2012	No gold-standard validation study in cervical cancer populations
Task-sharing interventions	CBT, psychoeducation and peer support feasible; moderate effect sizes	Patel et al., Lancet 2010; Arjadi et al., Lancet Psychiatry 2018	No RCT specific to cervical cancer in SSA published to date

Abbreviations: HADS = Hospital Anxiety and Depression Scale; PHQ-9 = Patient Health Questionnaire-9; SSA = sub-Saharan Africa; RCT = randomised controlled trial; LMIC = low- and middle-income country; CBT = cognitive behavioural therapy.

8. Discussion

8.1. Synthesis of Evidence

The evidence reviewed here supports several firm conclusions. Psychological distress — in the form of depression, anxiety, shame, and, to a lesser extent, post-traumatic stress — is prevalent in women with cervical cancer in sub-Saharan Africa, affecting conservatively one in three to one in two women depending on the measure used and the disease stage of the population

studied. This distress is not merely a subjective burden; it adversely affects treatment engagement, quality of life, and, through multiple biological and behavioural pathways, survival outcomes. Effective interventions exist — at the level of brief psychological therapies, psychoeducation, peer support, and pharmacotherapy — and task-sharing frameworks offer a realistic pathway to their delivery within the resource constraints of sub-Saharan African health systems.

The cultural specificity of distress in this population — centred on shame, moral stigma, and somatic idioms of expression — is not a peripheral consideration. It is central to the design of effective screening and intervention, and to understanding why transplantation of unadapted Western psychotherapeutic models into these settings has produced inconsistent results. Interventions that engage with the relational, communal, and moral dimensions of the illness experience — that create spaces in which shame can be externalised, re-contextualised, and transformed through shared narrative — appear more congruent with the cultural realities of this population than individually delivered cognitive restructuring.

8.2. Critical Gaps

Several critical gaps constrain the current evidence base. First and most fundamentally, no RCT of a psychological or psychosocial intervention has been conducted specifically in women with cervical cancer in sub-Saharan Africa. The task-sharing literature provides strong evidence for the principle, but its direct translation into cervical-cancer-specific care programmes is not yet empirically established. Second, no validated, culturally adapted psychological screening tool exists for this population in the major languages of the region. Third, the evidence base is geographically uneven: East and South Africa are comparatively well represented, while West and Central Africa — where cervical cancer incidence and HPV prevalence are high and healthcare infrastructure is severely limited — are largely absent from the literature.

A further gap concerns the intersection of HIV and psychological distress in women with cervical cancer. HIV co-infection is highly prevalent in this population — rates of 18–34% have been reported in studies from Kenya, Uganda, and South Africa — and depression is independently associated with both HIV disease progression and antiretroviral non-adherence.[22] Yet studies examining the three-way interaction between HIV status, cervical cancer, and psychological outcomes are scarce, and integrated care models addressing all three simultaneously are almost entirely absent from the published literature.

8.3. Towards an Integrated Model of Care

This review endorses an integrated model of psychosocial care for women with cervical cancer in sub-Saharan Africa — one in which psychological support is embedded within, rather than parallel to, oncological care. Such a

model would incorporate universal distress screening at key care touchpoints (diagnosis, treatment initiation, follow-up, relapse), brief task-sharing psychological intervention by trained nurses or CHWs for mild-to-moderate distress, referral pathways for severe psychiatric morbidity, peer support programmes drawing on the experiential knowledge of survivors, and community-level anti-stigma communication specifically addressing HPV-related moral shame.

This model is neither novel nor aspirational in the abstract: its components are established in the evidence base, and analogues exist in community health programmes across the region. What is missing is systematic implementation within cervical cancer care specifically, and the research infrastructure — validated tools, rigorous trials, economic analyses — needed to make the case for its adoption at policy level. The *Journal of Global Health Neurology and Psychiatry* invites research contributions that directly address these gaps.

9. Conclusion

The psychological burden of cervical cancer in sub-Saharan Africa is substantial, culturally distinctive, and inadequately addressed by existing care systems. Depression, anxiety, and shame — compounded by financial toxicity, advanced disease stage, and HIV co-infection — constitute a parallel burden of suffering that accompanies and amplifies the physical burden of the disease. The evidence base reviewed here is sufficient to justify integration of systematic psychological screening and task-sharing psychosocial support into cervical cancer care pathways across the region. It is not sufficient — and must become so — to guide the culturally adapted, locally validated, and adequately evaluated implementation of those interventions.

The women who bear the burden of cervical cancer in sub-Saharan Africa carry with them not only a diagnosis and its physical consequences, but a complex experience of shame, disruption, and fear that current healthcare systems rarely have the capacity or the intention to address. A genuinely patient-centred model of cervical cancer care recognises that this experience is not peripheral to the clinical encounter. It is its substance.

Conflict of Interest Statement

The author declares no conflicts of interest.

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Data Availability

No new data were generated or analysed in the preparation of this narrative review. All data are derived from publicly available published literature.

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