Effective and transparent communication with target populations and other stakeholders

3.1 Challenges in communication in the context of cervical screening

Screening programmes target very large numbers of people who are apparently well and are not seeking advice about the condition being screened for until they are informed by the programme or by their health professionals. This makes screening different from other usual medical encounters, which are initiated by patients with at least some symptoms. Screening may lead to risks (also called harms) as well as to benefits, although in cervical screening the benefits far outweigh the risks [35]. This means that there is a moral imperative to provide complete information that enables people to make

the right decision for themselves. This is informed decision-making or personal informed choice.

Informed decision-making encompasses a process that enables an individual to make a health-care decision for themselves after having learned about the intervention and its likely consequences and having considered their preferences. A communication strategy that is designed to describe the limitations and possible risks of screening as well as the benefits in a balanced and transparent manner can promote informed decision-making. The right balance in communication is essential to avoid raising expectations too high (by overemphasizing the benefits) or demotivating women from undergoing screening (by overemphasizing the risks). The content (i.e. what

to communicate) and the methodologies (i.e. how to communicate) of communication about cancer screening should be context-specific and are greatly influenced by the knowledge, attitudes, culture, and perceptions of the target population.

The health messages, such as the benefits, risks, and limitations of screening (Fig. 4), and the communication techniques need to be tailored to the audience and the context. It should be borne in mind that the communication skills of health professionals are highly variable. There are two main ways to conduct screening:

- via a whole-population approach, which requires invitations that are received as letters or digital communications or through community

Fig. 4. Benefits, risks, and limitations of screening. © IARC.
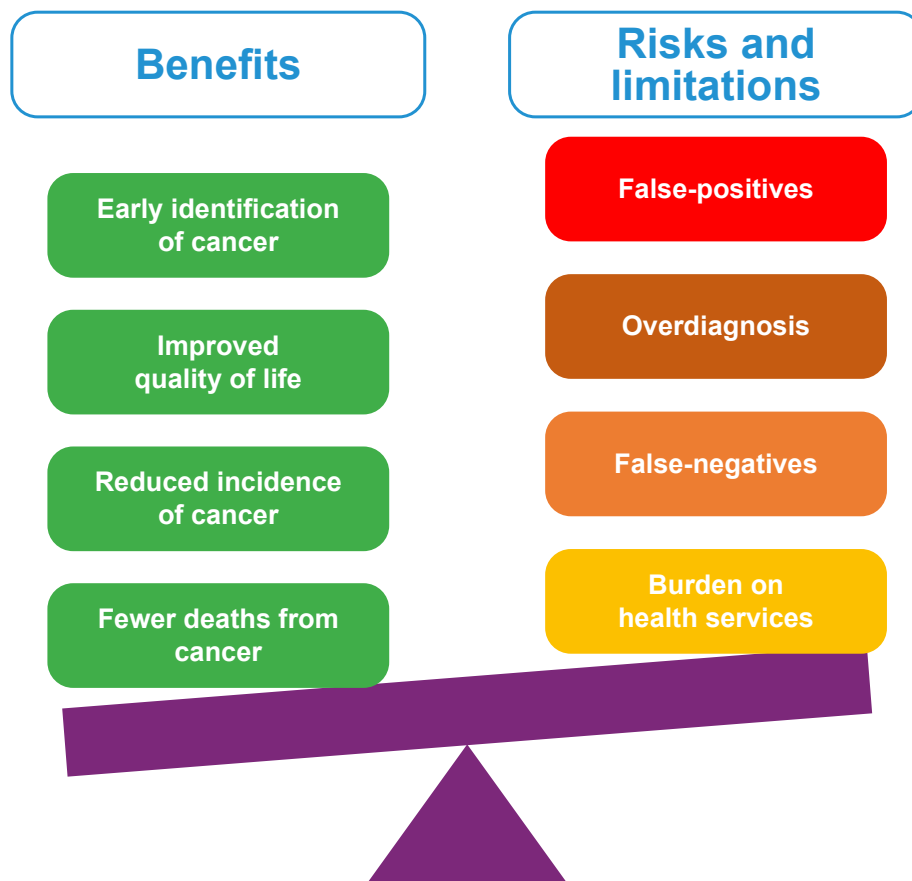
health workers (usually in limited-resource settings); or

• opportunistically, whereby an individual attends for a health-care consultation for another issue and is offered a screening test as part of that conversation.

Clearly, the one-to-one discussion in opportunistic screening will be different from that in a whole-population approach. Uptake of opportunistic screening is often facilitated by mass media campaigns that highlight the benefits of screening. Irrespective of the context, health messages

in cervical screening need to present the benefits, risks, and limitations of cervical screening in a balanced way based on evidence. Communicating with honesty about how much an individual stands to benefit and including a description of the potential risks in a manner that is appropriate to the knowledge, beliefs, and attitudes of the target population helps to retain trust and makes the programme more effective in the long run. However, this is not an easy task.

Many aspects of screening are not intuitive or easy to discuss, for

example population and individual risk, false-positive and false-negative test results, and the benefit versus risk of treatment of precancers. Therefore, programmes need to keep critical stakeholders and the relevant workforce up to date so that they can understand the benefits, risks, and limitations of screening (Box 6). This will enable them to communicate more confidently with the public, with those who are offered screening, with the media, with legal professionals, and with the government.

Box 6. Benefits, risks, and limitations of cervical screening

Benefits of cervical screening

- Studies nested in population-based cervical screening programmes in Europe reported a cervical cancer **mortality reduction** of 41% to 92% for women who attended screening compared with non-attenders [59].
- Women in whom cervical precancers are detected and treated appropriately are **saved from having a cancer** diagnosis, thus avoiding cancer treatment and associated side-effects and saving the direct and indirect costs likely to be incurred for cancer treatment.
- Women in whom cancer is **detected at an early stage** undergo less-aggressive treatment (which is also cost-saving), survive longer, and have improved quality of life.
- Cervical screening is a **highly cost-effective** public health strategy. It has been estimated that for every US$ 1 invested in a cervical screening programme at least US$ 3.20 is returned to the economy [60].

Risks and limitations of cervical screening

- The result of a screening test (or downstream investigations) may be falsely negative in some women. A **false-negative** result provides false reassurance, which may lead to late detection of cancer and resultant consequences *(limitation).*
- Every screening test may have results that are **falsely positive**, leading to possible adverse physical impacts (because of unnecessary investigations and interventions), psychological trauma, and inconvenience *(risk).*
- For some women, undergoing screening may be an **unpleasant emotional experience**, because of fear and anxiety associated with undergoing the test and apprehension about being diagnosed with cancer, being stigmatized, or losing fertility *(risk).*
- A screening programme that is implemented inefficiently will not have the desired benefit and will **drain health-care resources** *(societal risk).*

3.2 Communications targeting women eligible for cervical screening – underlying principles of designing communication messages and strategies

Designing effective communication messages (i.e. what to communicate) and strategies (i.e. how to communicate) requires a thorough understanding of the target audience's perception of cervical screening. This can vary widely, from a belief that the test is essential to a total denial of its value in saving lives. Other factors also influence an individual's decision-making process.

3.2.1 Women's perceptions of cervical screening

Studies have evaluated women's knowledge about and attitudes to cervical screening. Although the results are highly heterogeneous,

they indicate that a negative attitude to screening is strongly linked with a low level of knowledge about cervical cancer or the screening procedures. A pooled estimate from eight studies conducted in different countries in Africa reported that 57% of women living with HIV did not have any knowledge of cervical cancer screening and that only 38% had a positive attitude to cervical cancer screening [61]. A recent systematic review of studies on attitudes and perceptions of women to breast cancer screening reported a strong association between negative perceptions of screening and the following factors: low literacy level, negative attitude to a cancer diagnosis (i.e. cancer will invariably be fatal, will affect the relationship with their partner, is shameful to have), and denial (i.e. "normal women cannot have cancer") [62]. Interestingly,

"partners having a good knowledge of breast cancer" has been shown to be associated with a positive attitude to breast cancer screening in women [63]. The same factors are likely to influence perceptions of cervical screening.

Studies also show that women and men who undergo screening in higher-resource settings and where screening services are easily available generally have a positive attitude to screening. However, the participants and the clinicians often tend to overestimate the benefits of screening, believing that more is better when it comes to medical tests. Two large surveys, one in Great Britain and one in the USA, indicated that women and men were so committed to frequent screening that 58% of women would overrule a physician who suggested less-frequent cervical screening and 77%

of men would continue with prostate screening even if their physician recommended against it [64, 65]. This strong motivation to undergo frequent screening may be explained by an eagerness to be in control of their own health, a feeling of social obligation to follow peer groups, or a need for reassurance of protection against cancer. These attitudes may be based on unrealistic expectations arising from overestimation of the benefits of screening and underestimation of the risks. Such perceptions of the infallibility of the cervical screening process in preventing cervical cancer, which may be propagated through miscommunication, may lead to discontent in those screening participants who are subsequently diagnosed with cancer. This results in a loss of trust in the programme [56]. It is rarely explained to the patients in whom cervical precancer was detected through screening and who underwent treatment that they may still develop cancer, sometimes as long as 20 years after treatment [66].

3.2.2 Factors that influence decision-making by individuals

An individual woman's decision about whether to undergo screening is influenced by two major considerations: the perceived relevance of screening to the woman herself, and the perceived value of screening. A systematic review that synthesized the qualitative literature on women's perceptions and experiences of cervical screening included 39 studies, mainly in Australia, the Republic of Korea, Sweden, and the United Kingdom [67]. A substantial proportion of the studies involved immigrants, socioeconomically deprived populations, and other vulnerable populations. The review observed that the perceived **relevance of cervical screening to an individual woman** ("Do I need the test?") appeared to fluctuate during a person's lifetime

and was influenced largely by four factors: beliefs related to the cause of cancer, life stage, current health status, and family history. Women perceived their risk of cervical cancer to be low (and hence that screening was not required) if they were in a stable marriage or belonged to certain ethnic and religious groups. Some women reported feeling more vulnerable during menopause; others reported that being postmenopausal meant that screening was no longer important for them. For many women, a lack of gynaecological symptoms was a reason for non-attendance. Family history was often identified as a risk factor for cervical cancer, and women interpreted the absence of a family history as an indication that screening was less important for them [67].

The same systematic review also highlighted the finding that many women tend to question the **value of cervical screening** ("What is the point of having the test?"). Some women believed that screening was not important, either because they felt that they would know if they were ill or because they felt that if there was something wrong, it would resolve by itself. Some described a lack of trust in the test results, potentially based on an experience of false-positive results in earlier screening rounds. Other women expressed a general cynicism about the motives of cervical screening programmes; some suggested that they were being "used to fulfil quotas" [67]. Other studies have reported **fatalistic attitudes** to cancer ("I will die of the disease in any case") and screening being of low priority compared with other health issues as common reasons for women not finding any value in cervical screening, especially in low- and middle-income countries [68].

In the same systematic review, women who believed that screening

had value said that it enabled cancer to be detected early, which was beneficial, and that they appreciated the reassurance provided by a negative screening result. However, it was observed that some of these women did not understand the limitations of screening; some felt that a negative result provided a "certificate of health", indicating that there was "nothing untoward happening" and that they were "free of cancer". Many women had misperceptions about the purpose of cervical screening; some saw it as a general cancer test, a test for genital infections, or a reproductive check-up. This highlights the knowledge gaps that may exist even in well-organized screening programmes [67].

Decision-making by an individual woman about screening participation is also heavily influenced by the barriers to accessing screening services that she has to face, at an individual level (e.g. lack of transportation, long distance from home to health-care facility, absence of family support), at the provider level (e.g. provider too busy, poor communication skills), and at the system level (e.g. poor quality of services, long waiting times). These barriers also influence the woman's perception of screening (Fig. 5).

3.2.3 Designing communication strategies

From the earlier review of perceptions of screening, the members of the TWGs noted that the target population for screening is a highly heterogeneous group in any country. Thus, the approaches to screening and downstream management are variable across settings, and so are the access barriers encountered by potential participants. These differences need to be considered when developing messages and designing communication strategies to promote uptake of cervical screening.

Fig. 5. Women's experiences of cervical screening and barriers to participation. Source: [67]. Adapted from Chorley et al. (2017). © 2016 Chorley AJ et al. Psycho-Oncology. Published by John Wiley & Sons Ltd.
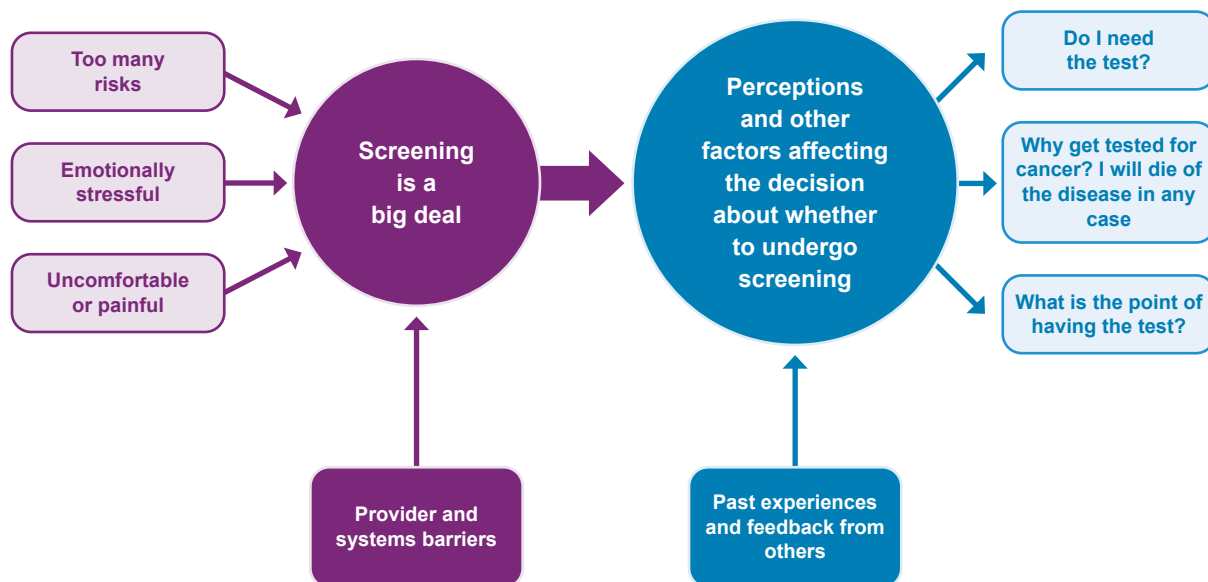
To enable people to make individual decisions about participation in screening, both the advantages and the disadvantages of screening need to be communicated. This requires a range of approaches. Such approaches need to take into consideration the sociodemographic profile of the target population (especially the average literacy level), cultural issues and the local ethos, levels of trust between the service provider and the service users, levels of organization of cancer screening, the medium being used for such communication, and whether communication is one-to-one or population-based (one-to-many).

The use of a stage-based behaviour change model such as the precaution adoption process model (PAPM) has been found to be of value when considering ways to support informed decision-making about cervical screening. The PAPM can be used to develop targeted interventions for behaviour change communication in cervical screening; it categorizes people into the following stages (Fig. 6):
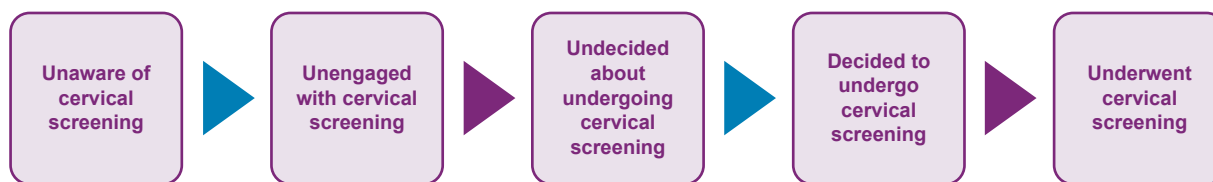
1. those who are unaware of cervical screening (unaware);
2. those who have learned about cervical cancer and screening but have not considered whether they need to do anything about it (unengaged);
3. those who have learned about cervical cancer and screening but have not decided to act because they do not find any relevance (undecided); and
4. those who have decided to undergo cervical screening (decided to act).

For individuals to progress from one PAPM stage to the next, they need to take deliberate actions. Such actions are influenced by the person's health beliefs, such as perceived susceptibility, severity, barriers, benefits, and self-efficacy. The primary aim of a communication strategy is to inform a person's health beliefs appropriately and to help them to progress through the stages.

The local context plays a substantial role in determining the PAPM stage at which most individuals are. For example, in low- and middle-income countries with scarce availability of screening, most women will be at stage 1 (unaware) and a few will be at stage 2 (unengaged). The communication programmes and materials designed to change informed behaviour related to cervical screening need to consider this qualitative difference in eligible women. It is also important to consider this during one-to-one communications between a potential participant and a health professional.

Fig. 6. The stage-based precaution adoption process model (PAPM) for cervical screening uptake. © IARC.

| Unaware of cervical screening | → | Unengaged with cervical screening | → | Undecided about undergoing cervical screening | → | Decided to undergo cervical screening | → | Underwent cervical screening |

The members of the TWGs noted other evidence relating to participants' perspectives about the uptake of, follow-up of, and adherence to the cervical screening programme that are relevant in the design of communication messages and strategies. These are summarized as follows:

- When communicating the risks and limitations, it may be useful to inform people that the government or health authorities have carefully evaluated the benefits and risks and have decided to offer screening to all eligible women because the benefits outweigh the risks.
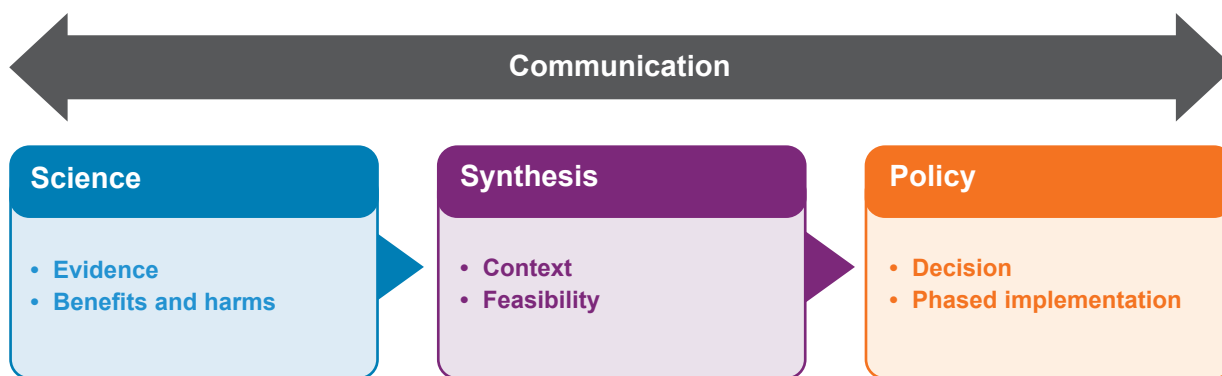- Communication should emphasize the value of any changes in testing methods (this is highly relevant for programmes adopting screening based on HPV detection), citing appropriate recommendations from recognized international or national expert groups, because people may view changes in practice as "less care" or cost-cutting measures [69].
- The communication strategy needs to consider the competing priorities of the participants (e.g. parental duties or occupation) and existing barriers (e.g. transportation to the health-care facility and opportunity costs, including time missed from work) [70].
- Use of a contact point that women are more familiar with (e.g. community health workers) improves acceptance of the messages [71].
- In countries where different languages are spoken in different regions, use of the screening participant's language is important for a culturally competent encounter. Lack of understanding of the importance of language and socio-cultural needs has been shown to result in dissatisfaction and inadequate participation [72].

Communication materials and strategies should be designed based on the evidence of the benefits and risks and with a clear objective (e.g. to move people across the PAPM stages). The final product and strategies will be heavily influenced by the local context in terms of the target population and the feasibility and organization of the screening programme. The tools and strategies will need to be fine-tuned based on feedback obtained through pilot testing in the target population before they are fully implemented (Fig. 7).

Fig. 7. The context of communication. © IARC.

Communication

Science	Synthesis	Policy
• Evidence • Benefits and harms	• Context • Feasibility	• Decision • Phased implementation

3.3 Developing screening information materials and communication strategies

3.3.1 Key principles and strategies

The members of the TWGs reviewed evidence from Al-Khudairy et al. [73], who used mixed-methods research involving systematic rapid evidence synthesis, primary research, and a consensus principles workshop with international representation to prepare a set of principles to support the development of screening information materials for breast cancer and fetal anomaly screening for Public Health England. The members of the TWGs suggest the following strategic guidance for the development of cervical screening information materials.

Screening information materials need to:

- clearly highlight that screening is a personal choice and that the health authorities are offering the tests because the benefits of undergoing the tests outweigh their risks and limitations;
- include clear statements on the benefits, risks, and limitations* of screening, supplemented by visual aids (infographics); and
- provide a clear statement on the estimates of probabilities of the condition and potential positive and negative outcomes from screening using prevalence estimates, event rates, or treatment success rates (for precancers).

* Benefits include detection of disease at a premalignant stage that requires simple treatment, prevention of cancer and cancer death, greater chances of survival from the cancer (if the disease has already occurred), less-invasive treatment because of earlier diagnosis of cancer, and improved knowledge. Risks include anxiety, false-positive test results, and overtreatment, and the consequences that flow from these. False-negative test results are a limitation of screening.

When developing screening information materials:

- use easy-to-read and simple language, supported by visual aids to improve understanding;
- make the information materials simple to understand by individuals of all literacy levels;
- provide information using a tiered approach, starting with basic concepts and building up to more complex information; and
- seek behavioural science support to develop a decision-making approach (e.g. the use of interactive worksheets) for decision-making about participation in screening.

A multipronged delivery strategy will be capable of:

- using digital media and online tools, depending on the local setting, to make information widely accessible and interactive;
- ensuring the availability of a printed version for people who are unable to access online materials;
- delivering information to those who are offered screening either by letter (in invitation-based screening programmes) or at the time of clinical interactions;
- using a campaign approach (e.g. observation of Cervical Cancer Awareness Month) when appropriate, and using mass media (both print and digital) to support the campaign;
- adopting innovative strategies (e.g. identifying a brand ambassador or adopting health branding) appropriate to the local context [74];
- obtaining feedback on the appropriateness of the content and the acceptability of the delivery modes; and
- encouraging frank and fair discussions between potential participants and health-care professionals to support informed decision-making.

When communicating with individuals about their informed choice, it is also important to highlight that the health authorities have decided to implement the screening programme after careful evaluation of the benefits and risks and that this exercise has been done in consultation with all relevant stakeholders. In many higher-resource settings, communication about cancer screening involves sending a letter of invitation from the health authority (which may be seen as a recommendation in itself) and a leaflet that provides more information about benefits and risks. The content of the leaflet should encourage people to assess the offer of screening, rather than simply encourage them to undergo screening, and should make it clear that they can choose to decline the offer.

The development of information material and the development of communication strategies are highly context-specific and will vary with the stakeholders' expectations. The methodology used in England to develop new information about breast cancer screening provides a useful example (Box 7) [75].

3.3.2 Communicating risks and limitations

There is no reference standard on how to communicate risks and limitations effectively. The programmes should use evidence and pilot test the information to assess the comprehensibility and acceptability of the information by the target audience. Studies have shown that even clinicians find it difficult to interpret information about numerical risk [76]. Information materials need to take this barrier into account and should be consistent with the following guidance:

1. Use natural frequencies (absolute numbers) and absolute risk reductions instead of conditional

1. Form an advisory committee

An advisory committee was constituted to support the editorial team. The committee included academic and professional experts in screening, experts in informed choice and public communications, third-sector stakeholders, and representative members of the public eligible for screening.

2. Obtain initial input from women through a citizens' jury

A sample of the target population for breast cancer screening with adequate representation from various occupational and ethnic groups deliberated together about how the benefits and risks should be communicated. They were supported by the experts and the service providers. The citizens' jury made a set of recommendations supported by appropriate rationale. One of the key recommendations was that risks should be described using the word "risks" rather than "harms".

3. Obtain input from professional experts in screening, public engagement, informed choice, and communicating risk

The experts developed the draft information leaflet after debating about the scientific precision and adequacy of the content, the mode of presentation, the typography and imagery included, and the general appearance.

4. Obtain further input from women on the draft information, through cognitive testing

Drafts of the new breast cancer screening invitation letter and information leaflet were tested in women in the age group offered breast screening to check how well these were understood and whether they would be useful in helping the women to make a choice. This involved two rounds of one-to-one, face-to-face cognitive interviews with 20 women, half of whom had accepted the offer of screening and half of whom had not.

5. Integrate the input from the women and the professional experts

The content was finalized, ensuring that the messages were simple, that appropriate images were included, and that the views of the women who participated in the cognitive tests were respected. A link to an online source of information was included in the leaflet to enable interested women to receive further information.

probabilities and relative risk reductions [77, 78].

2. Avoid presenting estimates of risk reduction in relative terms (e.g. "screening reduces the risk of developing cervical cancer by 75%") and using verbal qualifiers without numbers (e.g. "women who have abnormal cells removed from the cervix are slightly more likely to have their baby early") [78].

3. Use a common denominator to support the use of natural frequencies. Because readers tend to focus on the size of the numerator without considering the denominator, the denominators used for the presentation of risks and the presentation of benefits should be the same [79].

4. Use visual presentations, such as pictographs or diagrams, to help people understand the information about numerical risk [77, 80]. This will be especially useful for people with low literacy levels and low numeracy skills. However, bear in mind that not everyone intuitively understands visual presentation, and thus these images should be pilot tested for comprehension [80].

3.3.3 How much information on benefits, risks, and limitations should be included?

When communicating the benefits, risks, and limitations of screening, it is always challenging to achieve the right balance of adequate information with appropriate messaging without overloading the contents. In a study of subgroups of Dutch women eligible for cervical screening, van der Meij et al. ranked the benefits, risks, and limitations according to how important the women considered them to be for decision-making about participation in screening

based on HPV detection [80]. The results are summarized in Table 1. These benefits and risks need to be appropriately highlighted in the screening information materials.

3.3.4 Framing of messages

Traditionally, public communications about cancer screening have the primary aim of maximizing the number of people who undergo screening and the number who complete the downstream management. Often, persuasive techniques are used, which largely reflect the positive views of screening held by clinicians, academicians, public health organizations, and patient advocacy groups. These persuasive communication strategies usually highlight the positive aspects of screening and downplay the risks and limitations. Framing of messages may have a strong influence on women's understanding of the implications of screening.

The persuasive communication approach usually induces a feeling of vulnerability to the cancer and then offers hope by framing screening as a simple method of protection, emphasizing the benefits and downplaying the risks [81]. Such communications have successfully created positive community views of screening and have propagated the normative expectations that screening is the right thing to do. These positive community views have led to high participation in cancer screening, especially in countries that have been able to deliver quality-assured cancer screening services. However, transparent communication about the possible risks, rather than framing that promotes screening as a foolproof intervention for cervical cancer prevention, may reduce discontent in women who are affected by the limitations

Table 1. Ranking of benefits, risks, and limitations according to their importance in women's decision-making about participation in cervical screening based on HPV testing

Benefits, risks, and limitations	Ranking
Benefits	
Reduced risk of developing cervical cancer	1
Reduced risk of dying from cervical cancer	2
Knowing where you stand and being reassured	3
Initial test is free	5
Risks and limitations	
Abnormal result, but turns out later that nothing was wrong	4
Follow-up test is not free	5
Falsely reassuring result	6
Unnecessary treatment	7
Having a positive HPV test result can lead to questions and worry	8
Having a smear taken can be unpleasant	9

Source: [80]. Adapted from van der Meij et al. (2019). © 2019 van der Meij et al.

of screening (e.g. diagnosed with an interval cancer). Acknowledging that screening has risks and describing the benefit-to-risk balance through a pragmatic communication strategy is likely to build long-lasting trust in the programme and ensure autonomy in decision-making by every potential screening participant.

The information materials and decision-making aids for the screening participants need to consider the framing effect when communicating risks (e.g. whether to explain that only 2 out of every 100 women who undergo a LLETZ procedure may have serious bleeding or that 98 out of every 100 women treated by the LLETZ procedure will have no serious complications) to assist with personal informed choice based on reliable information.

An example of framing a message about the benefits and risks of screening in simple, straightforward language is given in Box 8 [82].

Box 8. Independent UK Panel on Breast Cancer Screening estimates

Among **10 000** women invited to screening in the United Kingdom from age 50 years for 20 years, about **681** breast cancers will be detected and **43** deaths from breast cancer will be prevented. Prevention of one death from breast cancer will be associated with diagnosis of approximately three patients with breast cancer that would not have caused any symptoms in the woman's lifetime (overdiagnosis), and these women would be treated unnecessarily [82].

3.4 Stakeholder engagement and communication with stakeholders

Stakeholders are actors (people or organizations) with a vested interest in the health policy and/or programme that is being promoted. Effective communication with stakeholders is essential for the success and sustainability of any health programme, and cervical screening is no exception [83]. Stakeholders can be either primary or secondary. **Primary stakeholders** are people or organizations whose continuing participation in the policy or programme is essential to its success. For example, in cervical screening, women in the target age group are primary stakeholders. **Secondary stakeholders** are people or organizations who have some influence on the policy or programme or are somewhat affected by it. However, their engagement is not essential for the policy or programme to succeed or the issue to be addressed. For example, in cervical cancer screening, public health researchers might be secondary stakeholders.

Effective engagement with stakeholders (both primary and secondary) is an indicator of good governance and increases accountability to the clients of a screening programme. It also enables the programme managers to assess support for and opposition to a policy, gives the programme visibility and legitimacy, empowers the stakeholders, increases collaboration, improves use of resources, and ensures the sustainability of the programme.

3.4.1 Identifying the stakeholders

For a cervical cancer screening programme, stakeholders (other than the target population and their partners) include the programme managers, service providers, professional bodies, patients, policy-makers from the ministries of health and finance, other politicians, health insurance agencies, other funding agencies, civil society organizations and patient groups, journalists and other media representatives, and health-care industry representatives.

Screening policy planners need to conduct a stakeholder mapping and analysis to ensure that the correct individuals and organizations are listed. This mapping exercise should consider factors such as stakeholders' knowledge and experience, their levels of interest and influence, and their power to facilitate effective engagement. It is also helpful to define the roles that a particular stakeholder will play in the screening programme and the resources that the stakeholder will contribute (expertise, information, knowledge, funding, alliances, and/or advocacy). The policy of engagement with a particular stakeholder will depend on their position in the influence versus interest matrix (Fig. 8):

- **High power, low interest group:** Provide sufficient and accurate information to ensure that they are kept up to date but are not overwhelmed with data.

- **Low power, high interest group:** Keep them adequately informed, and gather feedback to ensure that no major issues arise. The greatest communication efforts should be made during special situations (e.g. a policy launch).

- **Low power, low interest group:** Provide information only when relevant. Monitor whether this group moves to another profile.

- **High power, high interest group:** This group requires full engagement and the highest efforts to satisfy them.

Fig. 8. Stakeholder influence versus interest matrix.
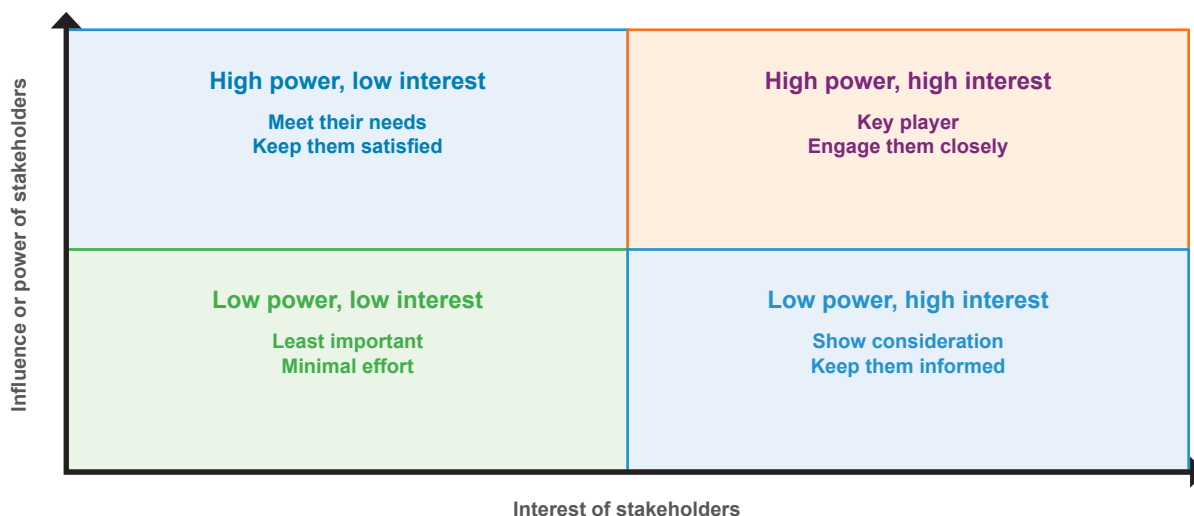
3.4.2 Engaging with the stakeholders

Stakeholder engagement aims to raise awareness of the programme and to accelerate action by stakeholders by:

- developing an understanding of the underlying objectives and core values of the programme;
- increasing stakeholder commitment to the programme;
- calling for investments in resources (workforce, infrastructure, information systems, effective regulations, and accountability) to support the programme; and
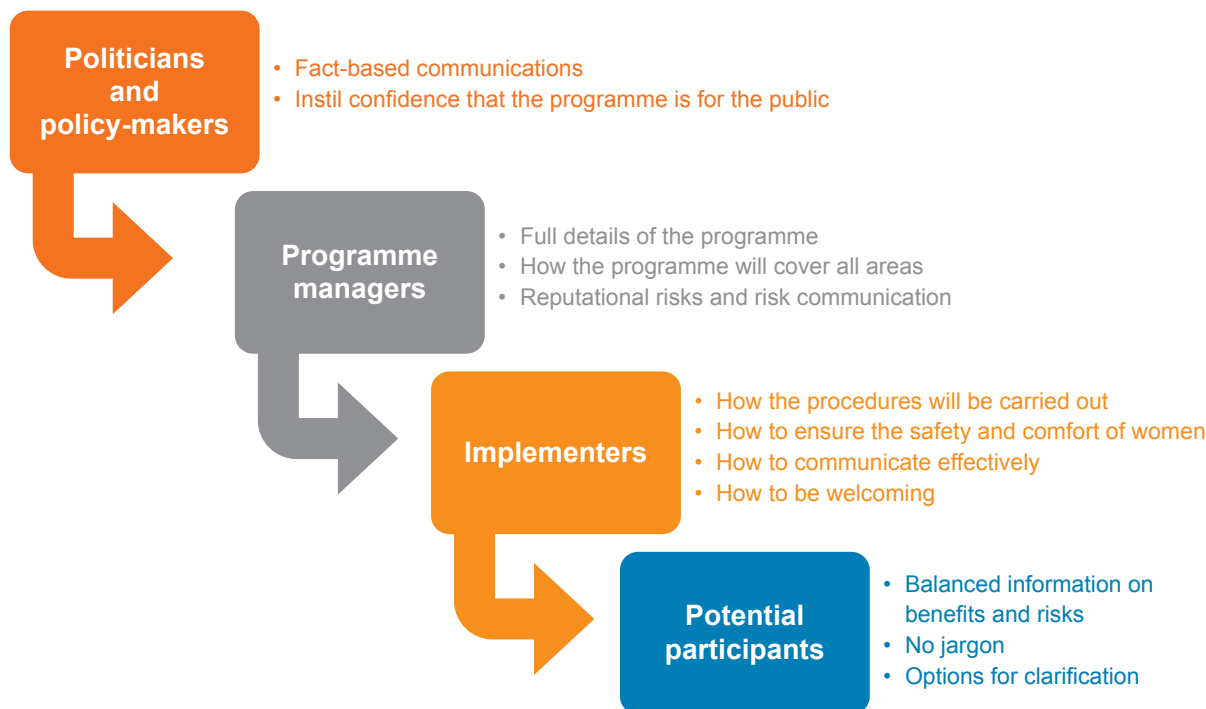- building trust in the programme and between the stakeholders.

Once the stakeholder analysis is complete, a documented **stakeholder engagement strategy** needs to be developed. Given the value of and the reputational risk to cervical cancer screening programmes, such a strategy, if implemented correctly, improves trust in the screening policies, increases buy-in, and may help to mitigate any short- and long-term issues with the programme.

Communication and engagement activities must have a clear objective and should be planned based on the positions of the stakeholders in the influence versus interest matrix and their preferred information sources and channels. An example of such a plan is given in Fig. 9. Stakeholder engagement can be implemented at different stages. However, it is more likely to be effective when it is developed in the early stages of the programme. The level of engagement with the stakeholders can be categorized as informing, consulting, involving, collaborating, or empowering. These levels are defined as follows:

- *Inform:* Stakeholders are informed or educated in one-way communication without expecting a response. It will be useful to receive feedback.
- *Consult:* Information and feedback are obtained from stakeholders to inform decisions. Two-way communication may be limited.
- *Involve:* Stakeholders are involved by working directly with stakeholders throughout the process to ensure that issues and concerns are understood and considered. Communication is two-way or multiway, and learning takes place on both sides.
- *Collaborate:* Partnerships are formed with the stakeholders and/or groups to develop mutually agreed solutions and a joint plan of action. Communication is two-way or multiway, and learning, negotiation, and decision-making take place on both sides. Stakeholders work together to take action.

Fig. 9. Engagement with different stakeholders in cancer screening programmes. © IARC.

Politicians and policy-makers
- Fact-based communications
- Instil confidence that the programme is for the public

Programme managers
- Full details of the programme
- How the programme will cover all areas
- Reputational risks and risk communication

Implementers
- How the procedures will be carried out
- How to ensure the safety and comfort of women
- How to communicate effectively
- How to be welcoming

Potential participants
- Balanced information on benefits and risks
- No jargon
- Options for clarification

- ***Empower:*** Decision-making on a particular issue is delegated to the stakeholders. Stakeholders are enabled or equipped to actively contribute to the achievement of outcomes.

Any stakeholder may be involved in multiple levels of engagement depending on their position in the influence versus interest matrix. Table 2 provides examples of engagement with various stakeholders in a cervical screening programme. However, this list is not meant to be exhaustive, and the levels of engagement may change in certain circumstances (e.g. policy-makers may get involved when a new policy is being planned.

Additional levels of engagement also exist, such as:

- ***Monitoring:*** There is no active relationship with this group of stakeholders. An example of individuals and organizations who would potentially be in this group is those who have protested or expressed views against continuation of the programme.
- ***Transaction:*** This group includes those who have a contractual relationship whereby one partner directs the objectives and provides funding.

Building relationships of trust between the stakeholders will facilitate the cooperation needed to implement and operate a screening programme. Stakeholder analysis helps to define various audiences, their level of sophistication, and their willingness to hear the messages that are communicated. The content and delivery mode of the messages must be tailored to the intended audience and must consider cultural norms and sensitivities [84].

Table 2. Examples of engagement with various stakeholders in a cervical screening programme

Stakeholders	Level of engagement				
	Inform	Consult	Involve	Collaborate	Empower
Politicians	Share policy briefs, programme reports, updates	Consult via existing advisory groups, bilateral meetings			Provide categorical information to enable decision-making on policies, priorities, and finances through regular meetings or sharing reports
Programme managers	Share policies, programme guidelines, training plans	Consult on perceived barriers to programme implementation	Involve through technical committees, implementation, quality assurance teams		Provide categorical information to enable decision-making on policies, priorities and finances and also to advocate for the programme through regular meetings or sharing reports
Civil society	Share policies, fact sheets, programme guidelines	Consult via public and bilateral meetings	Involve through participatory decision-making via consultative committees, workshops	Collaborate through joint programmes and partnership initiatives to implement a screening programme	Empower through integration of civil society in the governance structure of screening committees
People eligible for screening and their partners or spouses	Share fact sheets, websites, bulletins, community events, media releases	Consult via surveys, focus groups, public meetings	Involve through participatory decision-making via consultative committees, workshops, citizens' juries	Collaborate through joint programmes and partnership initiatives to implement a screening programme	Empower through integration of participants in the governance structure of screening committees
Media	Provide media guides, policy updates	Consult via media sessions on the latest information about burden, prevention, actions taken			

3.4.3 Communication with political stakeholders

Communication with political stakeholders should aim to educate them about the structure and operation of the cervical screening programme and the potential benefits and possible risks to those participating in the programme. The political stakeholders should have confidence in the organization and effectiveness of the programme but understand its unavoidable limitations (and that no screening programme is perfect). Political stakeholders should have key experts to contact when they have a question or concern or when communication with the media is a possibility. Technical advisory groups may be created to provide regular feedback not only on the benefits of implementation in a local context but also on the challenges faced in the local health system. Whenever a major change is planned in the protocol and/or the organization of a screening programme or there is a crisis situation, communication with political stakeholders should be established early; appropriate facts and action plans should be provided, and the need for support should also be emphasized [85].

3.4.4 Communication with professional societies

Maintaining the public's trust in their health-care workers is important. Efforts are needed to keep the professional societies up to date, confident about what the programme does, and aware of what its benefits and unavoidable limitations are. Members of these professional bodies are often skilled and trusted public communicators, and their support should be sought in times of difficulty. Commitment from the top leadership of such societies can help to garner support for the programme from the members. Communication with professional societies can be carried out through stakeholder workshops, dissemination of scientific evidence, inclusion of these societies in advisory groups or technical groups, and effective use of cancer and screening data and research.

3.4.5 Communication with civil society organizations

Civil society organizations have a multifaceted role to play and can make important contributions to building stakeholder confidence. Obtaining buy-in from the top management of such organizations can help to garner support from the members.

The following guidelines are useful when engaging with civil society organizations:

- Discussion should focus on how to ensure that the client is at the centre of the programme and how the design of the screening programme can reflect this.
- Conversations should include how best to engage underserved target groups (e.g. people living in rural and remote regions; culturally and linguistically diverse people; Indigenous people; refugees and asylum seekers; people with disability; people who are lesbian, gay, bisexual, trans, or queer; intersex people; and people from socially or economically disadvantaged backgrounds).
- The organizations should be kept informed about the measures taken to improve the quality of services across the programme.

Communication with civil society organizations can be carried out through bilateral meetings, stakeholder workshops, mass media, dissemination of programme policies and reports, and inclusion of these organizations in advisory groups or technical groups to represent the public and the programme participants.

3.4.6 Communication with health professionals

Health-care providers play key roles in ensuring the success of a prevention programme. Effective communication with health professionals is essential to disseminate the correct messages to front-line staff and to support their buy-in and confidence in the programme. Thus, regular communication should be maintained with the implementers at all levels of the health system. The communication should answer their scientific questions, inform them about policy changes for implementation and training opportunities, and provide pragmatic implementation solutions.

3.4.7 Communication with journalists and other members of the media

Communications with journalists and other members of the media should focus on raising their awareness of cervical cancer prevention through screening, of the public health value of the programme, and of any policy updates. Such communication should encompass the following:

- Messages should provide a comprehensive view of various aspects of cervical screening based on themes such as [86]:
  ◦ readers' interest in screening tests;
  ◦ the ingredients of a good news story (e.g. adoption of a new policy, data showing the impact of the programme);
  ◦ knowledge of the potential risks and the limitations of screening tests;
  ◦ factors that influence the framing of media coverage of screening tests; and
  ◦ barriers to and enablers of critical media coverage of screening tests.
- Messages should be:
  ◦ clear, consistent, and credible;
  ◦ honest and transparent, providing information on all aspects of the screening programme, including benefits and risks; and
  ◦ tailored to the various target audiences and types of media.

- An updated list of media contacts in various media (scientific, mainstream, medical, etc.) should be maintained, and a relationship of trust should be developed with some key media contacts so that they can be briefed when necessary.
- A wide range of materials should be produced that are tailored to different media channels, including articles, opinion pieces, interviews, news items, press releases, maps, videos, photographs, infographics, talking points, questions and answers, and briefing notes.
- Efforts should be made to proactive liaise with the media whenever possible by organizing press briefings and proposing opinion pieces or articles to editors.
- Opportunities to communicate with potential media interest should be identified, planned, and/or created

(e.g. events, conferences, specific days, launches of reports or results).
- Risks of misrepresentations should be mitigated. Although it is not possible to fully counter all distortions, the communication strategy should help to mitigate the risk of misrepresentations by:
  ◦ ensuring that results and activities are understood by the media;
  ◦ developing clear messages and avoiding jargon and technical terms;
  ◦ responding to the media or to questions or allegations when necessary or possible;
  ◦ identifying, briefing, and training spokespersons (e.g. programme managers) in communication and interview techniques when necessary;
  ◦ supporting spokespersons and

helping them to identify, prepare, and deliver media-friendly messages for journalists;
  ◦ preparing reactive lines when faced with sensitive questions, to be ready to respond to the media and address misconceptions quickly;
  ◦ when relevant, preparing communication materials (e.g. questions and answers, fact sheets, flyers, infographics, briefing notes, and talking points) that provide information to various audiences and target audiences (scientific or mainstream media); and
  ◦ monitoring criticisms in the public domain (blogs, press releases, articles, media, and social media).

Another important type of communication in a screening programme is crisis communication (Box 9).

Any screening programme is likely to face incidents that have the potential to threaten both trust in screening and the continuity of the programme itself. Such incidents may be related to risks of screening, a change in the screening criteria or the interval of screening, or any occurrence after screening, which may not be directly related to the screening programme itself. It is vital that the programme is well prepared and has a communication strategy in place for events that may evolve into a crisis. Each crisis will be different and will require a response that is tailored to the sociocultural context.

The WHO communication plan for a vaccine crisis may be adapted to the screening context (Fig. 10). Communication during a public health crisis must be consistent, clear, timely, and based on credible evidence. The designation of a spokesperson is a critical early step in controlling the messaging that goes out to the public and the media. Crisis communication needs to be tailored and should anticipate a diverse group of stakeholders, including the media, who may best be informed through an official statement that provides facts and credible information.

Fig. 10. How to communicate in a crisis situation. Source: [87]. Adapted from WHO Regional Office for Europe (2022). © World Health Organization 2022. Licence: CC BY-NCSA 3.0 IGO.

How to communicate in a crisis situation

Be prepared	Respond in a planned manner	Evaluate
Create a stakeholder network	Coordinate and engage	Conduct a review
Establish a coordination mechanism	Design a communication response	Share lessons learned
Create a crisis communication plan	Implement the crisis communication plan	Revise the crisis communication plan based on lessons learned
Monitor public opinion	Monitor public opinion and media	
Prepare messages		
Communicate with the public		