Together We Prevent: Youth Participatory Action on HPV

healthwatch Greenwich

Contents

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Executive Summary

Human Papillomavirus (HPV) is a sexually transmitted infection (STI) that can cause many health problems, including cervical cancer, genital warts, and cancers of the mouth, throat, and anus. The HPV vaccine is free for young people up to age 25, yet uptake across south-east London is lower than it could be. This report shares what young people in Greenwich, especially those in Thamesmead, told us about their understanding of HPV, their experiences of HPV vaccination, and the barriers that make it harder to feel confident about getting protected.

For many, HPV was an unfamiliar term. Even those who had been vaccinated often struggled to explain what the virus is, how it spreads, or why the vaccine is important. Confusion about risk and transmission was widespread, with some mistaking HPV for HIV or believing it could be caught through everyday contact. The lack of clear, consistent information meant that many relied on fragmented messages from schools, families, peers, and social media. HPV was often seen as something that affects women alone, reinforcing gendered assumptions that girls are responsible for sexual health while boys are not as directly at risk.

Parents played a central role in decision-making, but communication from schools with families on HPV vaccination was often minimal or inaccessible. In many cases, parents received only brief consent forms with little explanation. Young people described this as a 'tick-box' process that left some families uncertain and mistrustful. For parents who speak English as a second language or who are less confident engaging with schools or health services, this lack of communication deepened barriers and reinforced suspicion.

Within schools, opportunities to inform and prepare young people were often missed. Sexual health lessons were described as limited or inconsistent, and teachers themselves were sometimes unsure how to explain HPV or the purpose of vaccination. When vaccination day arrived, the experience was often stressful and impersonal, characterised by long queues, anxious peers, and little opportunity to ask questions or receive reassurance. For some, this experience left a lasting sense of fear or alienation towards preventive health programmes.

Cultural and social norms also shaped attitudes to HPV. Many young people said that sexual health is a difficult or even taboo topic, awkward to raise with friends, and sensitive within families. Myths about the HPV vaccine, particularly that it causes infertility, were widespread, more so among young women from global majority communities. For many, deciding to get vaccinated involved navigating not just personal beliefs, but questions of identity, loyalty, and belonging. In these contexts, health messages that emphasise individual choice can feel at odds with cultural expectations around modesty, family authority, or faith.

Experiences of the COVID-19 pandemic further complicated trust. Young people recalled rapidly changing messages about risk, rules, and vaccines, leaving them uncertain about what, and who, to believe. Some described feeling "talked at" and said the constant stream of pandemic information left them fatigued or cynical about all health campaigns. These feelings were strongest among communities who felt ignored or misrepresented during the pandemic and the legacy of suspicion of public institutions remains powerful. Overall, hesitancy about the HPV vaccine was rarely outright refusal. It was shaped by uncertainty, low awareness, practical hurdles, and a lack of opportunities to talk and learn.

Despite this, young people said they trust healthcare professionals more than any other health information source, yet few knew where to go for reliable information about HPV. Many were unsure whether to ask their GP, pharmacist, or sexual health clinic, and some felt embarrassed or anxious about raising questions. Access barriers such as inconvenient opening times, long waits, or intimidating environments made it harder to seek advice. For young women, the fear of being judged or misunderstood was a strong deterrent. Improving HPV awareness and uptake, therefore, requires more than simply sharing information.

Young people were clear about what would help: opportunities for open discussion, better communication between schools or vaccination services and parents, more inclusive messaging for both boys and girls, and services that feel approachable and youth friendly. Above all, they want to feel respected, listened to, and informed, not instructed. For young people, building trust through genuine engagement, cultural sensitivity, and equitable communication is key to enabling families and young people to have the information and confidence they need to make an informed choice.

Methodology

Understanding what influences HPV vaccine uptake among young people begins with listening to their views and experiences, voices that are underrepresented in public health discussions. Peer research offers a way to do this authentically. It enables insight to be gathered by people who share similar experiences, cultures, or communities with those they are speaking to, helping to build trust and uncover perspectives that might otherwise remain hidden.

This project was led by five young peer researchers aged 16–21 from Thamesmead. They explored what helps or stops young people aged 16–25 from getting the HPV vaccine. Acting as informed insiders, they helped shape the design and delivery of the work.

Recruiting and Supporting Peer Researchers

To deliver this youth-led approach we recruited five young people through community partners in Thamesmead, social media, and targeted outreach. Thamesmead was selected as the project focus because of its demographic diversity, higher levels of deprivation, and history of lower vaccination uptake. The area also has strong community networks that could support meaningful youth engagement. Of our peer researchers, four identified as Black or Black British and one as Asian or Asian British, groups which are disproportionately affected by health inequalities.

Peer researchers received tailored training covering safeguarding and boundaries, data protection and confidentiality, community engagement, lone-working safety, and ethical research practice. They also developed practical skills in interviewing, note-taking, and effective communication. Ongoing mentoring and support helped to maintain their confidence and wellbeing.

This project depended on building strong relationships between Healthwatch Greenwich as coordinators and young people as peer researchers, creating spaces for reflection, and maintaining ongoing supervision to develop confidence and skills. In practice, this meant significant time investment, as well

as flexibility to adapt around young people's school, work, and personal commitments.

While peer research takes longer and requires more hands-on facilitation than other methods, we suggest it produces richer, more authentic insight and helps build capacity within communities. Through the process, our peer researchers developed as local ambassadors, strengthening relationships between residents, community organisations, and local services. In this way, the method not only gathers insight but leaves behind greater awareness, connection, and capability within the community itself.

Moreover, peer research also achieves a depth of understanding that system-led engagement rarely reaches. When health and care organisations rely solely on their own staff to gather feedback, responses are often shaped by perceptions of authority, professional boundaries, or fear of judgement. By contrast, peer researchers draw on shared experience and trust, generating more open, honest conversations that people might not express to officials or professionals. This produces insight that is grounded in lived experience rather than filtered through service expectations.

Discussion Groups and Interviews

Peer researchers were actively involved in designing and delivering the data collection process. Their insight shaped how we approached young people, where conversations took place, and which formats felt most appropriate. Working together, we planned a mixed approach using discussion groups and one-to-one interviews to explore young people's HPV awareness, understanding, and experiences of HPV vaccination.

We found young people to take part through community partners, local events, and online outreach. Face-to-face engagement and snowballing through peer and social networks proved the most effective way to reach young people.

In total, a combination of discussion groups and interviews were held with 37 young people aged 16–25 who live in or have links to Thamesmead. More detail on the young people we spoke to can be found in the appendix.

Findings

Knowledge, Awareness and Perception of Risk

Limited Understanding of HPV and Confusion About Risk

For most young people we spoke to, understanding of HPV was very limited. Many had never heard the term before, and those who had often struggled to explain what the vaccine protects against. Even among those who had already been vaccinated, knowledge was shallow.

"When I think of HPV, I didn't actually know what it even stood for or what it even meant."

Most young people said that HPV was linked somehow to sexual contact, yet confusion about transmission was widespread. Some believed it could also be spread through non-intimate touching, while others confused it with HIV.

"... I think it might also spread through non-sexual contact, like sharing drinks – but I'm not entirely sure."

Many saw HPV as something that only affected women's bodies, particularly in relation to cervical cancer. Few were aware that HPV can also cause cancers in men. As a result, young men frequently assumed the vaccine was *"for girls,"* and young women carried the emotional and social weight of responsibility.

"Girls would more likely get it [HPV] because it affects women more. Boys, on the other hand, might think they don't need it because we weren't told much about how it affects men."

Low Sense of Urgency and Invulnerability

Because HPV causes no immediate symptoms, young people found it hard to view it as a serious issue. Many described HPV as "invisible" and therefore easy to ignore. Without a sense of risk, prevention in adolescence felt disconnected from potential health issues in adulthood.

"If you don't feel like you need it or if something doesn't feel urgent, you won't take that step."

Some young people associated HPV with promiscuity. Those not sexually active, particularly from faith-based backgrounds, did not see themselves as at risk and felt vaccination unnecessary. Young women explained the social risks of even talking about HPV as these conversations could imply sexual experience. In these contexts, the assumption that "HPV is about promiscuity" created both stigma and complacency.

"If you ask about sexual health, people think you're pregnant."

Young people from minoritised ethnic backgrounds described another layer of distance that reduced a sense of urgency. They did not always see people who looked like them represented in sexual health materials or vaccination campaigns. Young people noted that this lack of representation contributed to a sense that HPV was not relevant for them.

Post-COVID Mistrust

For many young people, COVID-19 was their first experience of large-scale public health messaging. They watched governments, health systems, and media outlets issue urgent warnings, introduce strict rules, and then later relax or reverse them. As the messaging changed, some interpreted that as proof that the risks had been exaggerated or that the health system could not be trusted. Others used their own experience of not catching COVID-19 to justify why vaccines are unnecessary. A number of young people explicitly linked their reluctance to get vaccinated against HPV to their experience during the

pandemic, saying that if they didn't need the COVID-19 vaccine, the same must be true for HPV.

"With the COVID vaccine, they said you had to take it to fly. And here we are in 2025, I can get on any flight without it."

The pandemic also changed the emotional context of vaccination. In global majority and disadvantaged communities, where families felt marginalised or underserved during the pandemic, the reversal of COVID-19 policies reinforced long-standing suspicions that public health priorities shift according to political convenience rather than science or community need. For the young people we spoke to, this layering of past and present mistrust amplifies HPV vaccine hesitancy.

"During COVID, our community felt ignored. Now, when they say 'HPV vaccination is important - trust the science,' people remember how quickly everything changed back then, so they don't believe it's [HPV vaccination] really about helping us."

Misinformation

Rumours that the HPV vaccine itself causes infertility or cancer circulated widely through friends, family networks, and social media. These myths were particularly strong amongst young people from global majority communities, where parents and relatives also expressed general distrust of vaccines.

"Some people say that if you get the HPV vaccine, you'll have an increased chance of having cancer, not preventing it."

Young people described hearing cautionary stories within their families, parents and grandparents warning against vaccines or urging them to rely instead on "natural ways." These messages were often rooted in the belief that the body should heal itself or that faith, diet, and traditional remedies were safer than vaccination. Some said relatives viewed vaccines as "unnatural" or "tampering with what God created," while others recalled being told that "you don't need all

those chemicals in your body." In some cases, these family stories linked vaccines to historical harms, reinforcing a belief that the health system could not always be relied upon to act in their best interest.
Within this context, young people from global majority backgrounds spoke of feeling caught between two competing sources of authority, their families and the health system. Choosing to trust one could feel like rejecting the other. Some described feeling conflicted, wanting to believe that it was important to have the HPV vaccination, but they struggled to reconcile that with the cautionary narratives they had heard. These tensions highlight how health decisions are not only individual choices for young people but also expressions of identity, belonging, and loyalty within families and cultural groups.

Gender also played a role in how these myths took hold. Rumours about infertility were disproportionately aimed at girls and young women, reinforcing long-standing patterns where women's bodies are used as symbols of moral and cultural purity. Against this backdrop, fears that the HPV vaccine might damage fertility carry extra emotional weight.

"People say it can cause problems, like it'll stop you from having kids later. They don't really say the same things to boys. It's always girls who get warned. For us [girls] it hits harder, it's about reputation."

Peer Influence and Social Norms

Silence and Social Discomfort

Peers are a major source of social learning, but conversations about HPV are limited by embarrassment, gender norms and fear of judgement. Low awareness of HPV sits within a wider culture of silence; young people told us that sexual health is difficult to talk about even with close friends. HPV and sexual health were rarely discussed, the topic was seen as awkward or embarrassing, particularly in mixed-gender settings. As a result, myths went unchallenged, and few had accurate knowledge to share.

Young people described a strong sense of taboo around sexual health conversations among peers. Even within friendship groups that were otherwise

open about personal matters, HPV, sexually transmitted infections, or anything related to sexual activity were often avoided altogether.

"I don't really speak to people about [this type of thing]. It's not something that would just pop up in conversation."

Peer Pressure and Gendered Stigma

Young people said that raising such topics risked uncomfortable jokes, teasing, or being judged. For girls, there was a fear of being labelled as "too interested in sex" or inappropriate, while for boys, it was seen as unmasculine or "weird" to talk seriously about health or sexuality. This silence meant that misinformation, such as the idea that HPV only affects women or that it causes infertility was left uncorrected.

While few young people said they spoke to friends about sexual health or related topics, they consistently described how peer opinions still shaped what felt normal within their social groups. In some friendship circles, rejecting vaccines had become the default position, a kind of social shorthand for independence, scepticism, or resistance to authority. For others, showing too much interest in health issues was seen as uncool, unnecessary, or even pretentious. Young people explained that going along with the group often meant avoiding health discussions altogether, or downplaying their own choices to fit in. Those who asked questions about vaccines or health were sometimes labelled "overthinkers," "paranoid," or "trying to act older than they are." This peer dynamic created subtle social pressure to conform to a position of apathy or doubt.

Some young people also described how religious and cultural beliefs influenced them. In faith-based peer groups, rejecting vaccination was sometimes framed as a demonstration of spiritual strength or obedience to God's will. If most peers viewed vaccination with suspicion, it became riskier to be seen supporting it. Some young people who had chosen to get vaccinated described keeping that decision private to avoid gossip or backlash. Other young people who got vaccinated said they were occasionally accused of "not trusting God, putting science before faith," or "believing in the government more than in prayer." These

comments reinforced stigma around vaccination as a moral or faith-based choice rather than a health one. They also placed young people in a difficult position, having to justify a personal health decision as peers might interpret it as a statement about identity, belief, or loyalty. For some, the fear of being judged or misunderstood outweighed the perceived health benefits.

The Role of Family, Cultural Beliefs, and the Boundaries of Choice

Parental Influence

While peers shape what feels normal, families often shape what is allowed. Across every group, parents were central to decisions about vaccination. For those under 18, a parent's signature determined whether they could receive the HPV vaccine at school. But even for older young people, those legally able to make their own medical decisions, family expectations continued to shape their attitudes toward vaccines and health in general. The family home was often described as the first and most influential source of health information. Where parents spoke positively about vaccines, their children tended to be confident about getting vaccinated. Where parents were sceptical or uncertain, vaccination was unlikely to happen, regardless of school influence or wider health messaging.

"Teachers tell you it's safe, but what your parents say sticks more. You trust them, so even when you're old enough to decide yourself, it's hard to go against that."

Young people repeatedly said that their parents' stance on vaccination was "final." Many young people explained that conversations about sex, sexual health, or the body were considered private, inappropriate, or even shameful within their families.

"It's just not talked about in my community."

Cultural and Gender Expectations

For some, any topic connected to sexual activity was seen as morally sensitive or in conflict with religious values. Young people said that parents who wanted to protect their children from "inappropriate" information often avoided the subject entirely, assuming that abstinence or good behaviour would shield them from risk. As a result, sexual health was treated as something that didn't apply to their children, particularly daughters. Some young women described how the absence of open discussion was tied to broader expectations around modesty and purity. Talking about sexual health, or even asking questions, was seen as inappropriate, while boys faced fewer restrictions.

"If a girl talks about this stuff, people act like she's done something wrong... It's like girls aren't supposed to even ask questions."

In families with strong hierarchies or cultural norms emphasising respect and obedience, questioning a parent's view felt inappropriate or even disrespectful. For young people growing up in these environments, the HPV vaccine carried social and moral weight that extended beyond its medical purpose. Even when young people had accurate information about HPV and wanted to protect their health these social norms made it difficult to act independently. Several young people described feeling caught between their personal understanding of what was beneficial and their parents' beliefs or fears about vaccination. One young woman explained that although she trusted doctors and wanted to be vaccinated, she knew her parents believed vaccines could "interfere with God's plan" and therefore felt she had no choice but not to have the vaccination. Others described anticipating conflict or emotional consequences if they defied parental wishes, including being accused of disobedience or bringing shame to the family. For many, maintaining family harmony took precedence over individual health decisions.

"I was raised on the basis that if my parents say no, it's a no. Although it's my body, I still can't make those choices."

Parental influence also extended beyond explicit decisions to subtle cues about what could or could not be discussed. For some, particularly young women, obedience was tied to notions of modesty and purity, being "good" meant avoiding topics connected to sex or intimacy. This left them unable to ask questions or seek information about HPV for fear of judgement.

Experiences of Vaccination and Health Services

Missed Opportunities to Raise Awareness

Young people said that sexual health lessons in schools were limited, often one-off sessions that focused mainly on contraception and pregnancy. HPV was rarely discussed in depth, and many could not recall HPV being mentioned at all. For young people from faith or global majority backgrounds, lessons often failed to acknowledge their cultural values or perspectives, making it harder to engage meaningfully.

"Not really [useful]. It was basically just listening to someone give a speech...."

Young people said that teachers themselves were not always well informed and were sometimes unsure about what the vaccine was for or who young people should direct questions to.

Girls described feeling singled out in school sessions that focused only on contraception or pregnancy, reinforcing the idea that responsibility for sexual health lies with them. Boys, meanwhile, said they were rarely engaged in conversations about HPV or other infections, leaving them uninformed about their own risks and their role in prevention. This left young women with the burden of protecting others while being judged for seeking protection themselves.

For young women, this dynamic also reinforced feelings of pressure and unequal accountability. Several girls said they felt it was "their job" to know about HPV, to

protect themselves, and by extension, to protect their future partners. At the same time, they felt judged or stigmatised for talking about sexual health at all. Some said that if a girl asked questions about HPV or vaccination, classmates might assume she was sexually active or "not innocent." This double standard, expecting girls to take responsibility for sexual health but punishing them socially for doing so, created anxiety and silence.

Without clear understanding young people felt left in the dark and relied on fragments of information that were often incomplete or inaccurate. Home educated young people were especially disadvantaged. Several had never heard of HPV until taking part in this project.

"I'm home-schooled, so I haven't been taught about it. I've never heard of HPV before."

They described feeling excluded from both the vaccination process and the information that accompanies it. This gap is especially concerning in areas like Greenwich, where homeschooling rates are rising.

Communication with Families

Young people from families where English was not the first language, or where parents were less confident engaging with schools or health services, were more likely to suggest their parents didn't know or understand what the HPV vaccination protected against. Several said their parents received minimal information before being asked to sign consent forms for their children to have the vaccine. They described this as a 'tick-box' process that did not explain the purpose, benefits, or importance of the HPV vaccine.

"Our parents get a permission form and it's either yes or no to taking the vaccine. There isn't enough education or guidance on what the vaccine is or what HPV is about."

"My parents have to work, so you'll need to call them to explain why the vaccine is important."

Young people suggested that parents were often expected to make a decision based on a brief letter sent home. Many said their families either skimmed the material, misunderstood it, or ignored it altogether due to time pressures, language barriers, or lack of clarity. Some young people said their parents relied on them to explain the form, a reversal of roles that added to uncertainty.
For parents who already had concerns about vaccines, young people told us the lack of information reinforced parents fears that they were being pushed into something they did not fully understand.

School Vaccination Environment

By the time young people are offered the HPV vaccination in school, many are already navigating confusion and silence on sexual health. For many young people, school vaccination left a lasting impression. While the intention of school-based vaccination programmes is to make access easy and universal, many described these sessions as stressful, embarrassing, and at times, chaotic. The environment , crowded halls, long queues, and the presence of peers, often heightened anxiety rather than reducing it. Several young people recalled vividly the atmosphere of nervous laughter, whispered rumours about pain or side effects, and visible distress among classmates.

"It was painful. A lot of people did cry. One girl in particular, I never forgot. She was screaming..."

Seeing others in distress, faint, cry, or panic reinforced fear and avoidance, especially for those who were already anxious about needles or medical settings.

Lack of Explanation or Reassurance

Young people said that schools often treated vaccination as a logistical task rather than a health or learning experience. Staff focused on moving students through quickly, leaving little time for explanation or reassurance. The result was a process that felt impersonal and mechanical. A few young people said they skipped attending, not because they opposed vaccination itself, but because they feared the environment. Others told us that this memory has stopped them from participating in other preventive health interventions.

Trust in Professionals but Barriers to Access

Many young people said they rarely reached out to healthcare professionals, even when they had questions or concerns about vaccination or sexual health. Most young people were uncertain about where to go for information. They were aware that healthcare professionals were experts but did not know if HPV was something they could ask about at their GP practice, community pharmacy, or sexual health clinic. Interestingly, some suggested they would feel more comfortable talking to pharmacists, as these were more informal and approachable environments in comparison to GP surgeries or the stigma associated with contacting a sexual health clinic.

For issues like HPV or vaccination advice, the effort required to speak to someone simply did not feel worth it. Many also said they were reluctant to do so, fearing that they would be seen as an inconvenience by busy healthcare professionals.

"They make you feel like you're wasting their time …"

Moreover, young people said they often felt nervous or intimidated when talking to healthcare professionals. Others worried that they would be dismissed or not taken seriously because of their age. Several young people shared stories of doctors or nurses interrupting them, using overly technical language, minimising their concerns, or belittling them.

"'No one wants a fat girlfriend,' she said… the appointment wasn't even about that."

One young woman recounted how a GP told her she was "too young to worry about that" when she tried to discuss sexual health. Another said that when she asked about HPV, the nurse seemed surprised she even knew what it was and did not encourage further questions.

Sexual Health Clinics and Access

When asked where they would go if they had questions about HPV, very few mentioned sexual health services as an option. Many associated these clinics

solely with contraception, pregnancy testing, or treatment for sexually transmitted infections, not prevention or education.

"If you go to one of those places [sexual health clinic], people assume something's wrong."

The small number who did try to access sexual health clinics found the process confusing and frustrating. Appointments were described as difficult to book, with limited availability that often clashed with school or college hours. Walk-in sessions, where they existed, were rare and filled up quickly. One young person explained that by the time students in Thamesmead could travel to the Woolwich clinic after school, "the slots were already gone." Others described helplines that were inconsistent or unhelpful. Some were transferred between departments or told to call back another day, while others said staff seemed unsure whether HPV advice was part of the service's remit. For young women in particular, visiting a sexual health clinic carried social risk; some worried about being seen entering a clinic and what others might assume.

"If someone saw me going there, they'd start talking, like, 'why is she there?', they think I've done something wrong."

What Young People Say Needs to Change

Young people were clear that increasing HPV awareness and uptake needs more than information; it requires trust, relevance, and better engagement. They told us they wanted approaches that speak to their lived reality, respect their family and cultural contexts, and for services to be more approachable and accessible.

1. Make Information Relevant and Interactive

Young people said current education in schools on HPV felt abstract and disconnected from their lives. They wanted clear explanations about why the HPV vaccine matters and how it protects both men and women. Framing HPV as a cancer prevention measure, rather than a sexual health issue was viewed as more inclusive and less stigmatising. Knowing what to expect before, during, and after vaccination would help reduce anxiety and fear.

They wanted interactive learning rather than passive listening, opportunities that invite participation, questions, and open discussion. Activities like quizzes or myth-busters were seen as more interesting and memorable ways to learn.

"I'd make it so that the students get more involved. Maybe activities … to make it more engaging."

They suggested that sessions should be led by trusted, relatable figures such as youth workers, or peer educators rather than teachers or authority figures.

2. Improve Communication with Parents and Families

Young people told us that parents need accessible, clear, and personalised information before consent is requested. Letters or leaflets sent home were often lost, misunderstood or ignored, particularly in households where English is an additional language or where time is limited. Instead, they suggested short videos, phone calls, text reminders, and translated materials written in plain, simple language.

They also stressed that human connection matters more than written information. Parents were said to be more likely to trust information delivered verbally by familiar figures such as teachers, community leaders, or health professionals. Hearing directly from a trusted figure, someone who could explain things in a family's preferred language, was described as the most effective way to build parental confidence and reduce misinformation.

"If you just send a letter home, it gets lost. My parents trust it more when someone explains it to them, in person, in their language."

3. Create Supportive Vaccination Environments

Many young people said their school vaccination experience was stressful and impersonal. They suggested ways to make the process feel safer and more respectful:

- Smaller group sizes and the option to bring a friend
- Greater privacy
- Get clear information in advance about what to expect and what aftercare involves.

Young people suggested these changes would reduce fear and normalise HPV vaccination as a positive health choice, not a frightening event.

"It would help if it felt calmer, not everyone watching or laughing. Just someone explaining what's happening and talking to you, so you're not just a number in a queue."

4. Engage Both Genders and Normalise Discussion

Young people called for open, inclusive conversations that normalise sexual health for everyone. They suggested gender-specific sessions in co-educational schools, where boys and girls could ask questions freely, without embarrassment, followed by mixed sessions reinforcing shared responsibility.

They felt that male role models could help challenge the perception that HPV is only relevant to women. Making it clear that HPV affects everyone would help remove stigma and create a more equal sense of responsibility for prevention.

"People act like HPV is only a women's thing, but it affects everyone. We should all learn about it, not just girls."

5. Make Services More Visible, Youth-Friendly, and Accessible

Young people want health services to feel approachable and designed with them in mind. They said they would be more likely to seek HPV advice and information and consider getting the HPV vaccination (if they missed it or refused it at school) if they knew where to go and felt confident, they would be listened to.

Suggestions included:

- Promoting local places young people could go to for information, advice, and to receive the HPV vaccine
- Extending clinic hours into evenings or weekends
- Offering confidential text, WhatsApp, or online chat advice lines
- Training staff to be more welcoming and sensitive to young people's concerns

Young people told us these changes would help reduce stigma, particularly for those who fear being judged or misunderstood.

"If there was somewhere I knew I could just ask questions about HPV without feeling judged, I'd probably have it [catch-up HPV vaccine]... It's not that we don't care; it's just that sometimes we don't know where to go."

6. Balance Individual Autonomy with Family and Cultural Context

Young people were very clear that improving HPV uptake cannot rely solely on individual motivation. Engaging parents in culturally respectful dialogue that builds understanding within their cultural context would help to build trust.

Young people explained that communication should align with shared values, such as family wellbeing and HPV vaccination, as an act of family responsibility, rather than individual responsibility, would resonate more deeply. Health messages that focus only on personal responsibility risk alienating these families and communities.

"When people talk about the HPV vaccine only as my choice, it feels like they don't understand our culture. If it was explained as caring for your family and community, my parents would see it differently."

Testing Youth-Led Approaches to HPV Awareness

Findings show that young people want information about HPV that feels relatable, trustworthy, and easy to access outside formal health settings. In response, the peer researchers designed and delivered a short awareness campaign to test different ways of communicating key messages with their peers and local families. The campaign aimed to improve how information is shared to resonate with young people and build confidence in the HPV vaccine. Peer researchers chose to design a leaflet as a simple, low-cost way to reach both young people and parents, and could easily be shared or discussed in person. Two designs were co-created using insights from the discussion groups and interviews. To understand which might work best, peer researchers took both versions to Thamesmead and spoke with young people to compare and identify which design was clearer and more appealing. The preferred leaflet was then used at seven community events across Thamesmead to promote HPV awareness. Each leaflet included a QR code linking to an online Q&A page featuring clear, youth-friendly answers supported by insight from peer researchers to common questions about HPV and the vaccine.

Alongside in-person outreach, a social media campaign was launched to reach young people online. Two peer researchers created short, myth-busting videos for Instagram and Facebook, addressing common misconceptions and making HPV more relevant to young people.

The campaign reached over 8,000 viewers across social media, with more than 60% of engagement coming from the target age group of 16–25. For a locally produced, organic campaign focused on the Thamesmead community, this represented strong reach and sustained interaction with the intended audience.

This phase of the project demonstrated how peer-led communication can translate insight into action. By combining community in person presence with digital engagement, the campaign showed that when messages are shaped and delivered by young people themselves, they are more likely to be noticed, shared, and trusted.

Heath and Community Partners

After hearing directly from young people, we turned to those working within local health services and community organisations to explore where their experiences align or differ from what young people told us. Listening to these perspectives was important for understanding how the system itself experiences the barriers and opportunities around HPV awareness and vaccination.
With local health and care providers, system partners, and community stakeholders, we explored a range of ideas to improve HPV awareness and vaccine uptake among young people. Stakeholders acknowledged that while digital platforms have shifted how information is shared, challenges around access, trust, and availability still persist for some. These conversations offered a window into the practical challenges of sharing information, building trust, and the ways local partners are trying to reach young people.

Locating Support Where Young People Are

Stakeholders reflected on the importance of reaching young people through the spaces where they already spend time such as youth hubs, sports clubs, faith settings, and other community venues. Some described how, in the past, informal drop-in spaces provided opportunities for advice and conversation for young people without fear of stigma or being seen. These familiar, non-clinical environments were viewed as effective in building trust and encouraging early engagement with health information.

Conversations also highlighted the potential of peer and community approaches, for example, using youth ambassadors, community leaders, or creative activities such as theatre and workshops to make information about HPV feel more relatable and accessible. While some of these initiatives exist, stakeholders noted that they make up only a very small part of local efforts and are not being systematically built upon. There was broad agreement that more could be done to strengthen and sustain these community-based approaches, embedding trusted health conversations within the everyday spaces where young people live, learn, and socialise.

Reaching Beyond Mainstream Education

In discussions with local partners, we highlighted that young people outside mainstream education, such as those home-schooled, had fewer opportunities to receive HPV information and take part in vaccination programmes. Although provision exists to support these groups, awareness among young people themselves was low.

Stakeholders acknowledged this as an equity gap within current approaches. They recognised that reaching these young people requires stronger coordination to enable HPV information and opportunities to access HPV vaccination to be more consistently available beyond the school environment.

Tailoring Communication and Accessibility

Through these discussions, partners were prompted to consider how existing approaches to HPV communication could be more effectively tailored to reflect the diversity of local communities. Our insight from young people helped to frame this conversation, highlighting that messages often fail to connect because they feel distant, overly clinical, or not relevant to young people's lives.

Stakeholders acknowledged that while national campaigns provide consistent information, they rarely speak to local contexts or community experience. This prompted reflection on the need to make communication feel more personal and trusted, for example, through the involvement of young people in codesigning new approaches. Partners also noted that how messages are received and trusted extends beyond how information is delivered, who is sharing the message is just as important.

System Readiness and Delivery Opportunities

The conversations also created space for local partners to reflect on how prepared services are to deliver HPV vaccinations, and where opportunities exist to strengthen delivery. Vaccination leads described good local readiness, with stock available and clinics planning after-school or weekend sessions to support HPV catch-up vaccination. However, discussions highlighted that operational preparedness alone is not enough when awareness, confidence, and engagement among young people remains uneven. Stakeholders recognised

the need to create more time and space for questions and reassurance, allowing young people to feel HPV vaccination as a supported choice.

Partnership and Next Steps for Collaboration

Stakeholders expressed a clear appetite for continuing to work together. Opportunities were identified with local services and partners reflected on the potential of peer-to-peer communication to build trust and engagement. There was also recognition that future collaboration should reflect the diversity of local contexts and HPV awareness needs to be embedded within wider youth-focused conversations about health, wellbeing, and prevention. Stakeholders also suggested strengthening this work by linking it more clearly to wider system priorities, such as women's and girls' health hubs and South East London vaccination strategies and plans.

Recommendations

The conversations with young people and local partners have generated a shared understanding of the barriers and opportunities surrounding HPV awareness and vaccination in Greenwich. Together, they point to the need for more coordinated, inclusive, and youth-centred approaches that extend beyond traditional health settings. The following recommendations draw on both sets of insights, combining young people's lived experience with the perspectives of those delivering and shaping services. They are intended to inform practical next steps for local partners and to support wider system learning on how trusted, community-based engagement can improve HPV health literacy, HPV vaccination uptake and health equity.

1. Make Information Relevant and Interactive

- Co-design youth-friendly HPV education materials (plain language, visual, culturally sensitive) with young people.
- Partner with schools and youth organisations to encourage more discussion on HPV and HPV vaccination.
- Use interactive formats (Q&A, myth-busting activities, short videos) rather than traditional classroom style approaches, framing HPV as cancer prevention for everyone.

2. Improve Communication with Parents and Families

- Develop a family communication toolkit including short multilingual videos, FAQs, WhatsApp message templates, and plain-language leaflets that explain HPV in simple, culturally sensitive terms.
- Work with community leaders, faith-based organisations, and parent networks to host information sessions where health professionals can answer questions in-person or via trusted intermediaries.

3. Create Supportive Vaccination Environments

- Develop staff guidance or a 'youth experience checklist' for vaccination teams covering communication, reassurance, privacy, and aftercare.

4. Engage Both Genders and Normalise Discussion

- Develop inclusive HPV awareness campaigns featuring both boys and girls, using relatable peer ambassadors.
- Support male-focused outreach (e.g. sports clubs, youth mentoring, or community organisations) to raise awareness that HPV affects everyone and to challenge the idea that HPV is 'for girls only'.

5. Make Services More Visible, Youth-Friendly, and Accessible

- Promote simple mobile-friendly information showing where and how young people can access HPV catch-up vaccination or information locally.
- Offer extended hours or youth drop-in sessions for catch-up HPV vaccination.
- Support development of youth-friendly communication channels (e.g. confidential text or WhatsApp advice lines).

6) Embed Youth Voice and Peer Approaches in Future System Work

- Establish a youth advisory group/peer researcher pool to inform ongoing HPV and wider prevention work.
- Resource training and mentoring so young people can act as local health ambassadors and co-designers of communication.

7) Coordinate and Monitor Progress through Local System Partnership

- Create an HPV Awareness & Uptake Working Group (Public Health, Primary Care, School Immunisation, SEL partners, VCSE) to coordinate actions and share learning.

Conclusion

This report demonstrates that understanding of the HPV vaccine among young people is affected by more than awareness or access. It is influenced by the social and structural conditions in which people live and is shaped by trust in institutions, and the quality of relationships that connect families, schools, and health services. These findings highlight that decisions to have/not have the vaccine is not simply a matter of individual preference. Families who already feel unheard by institutions are less likely to accept messages delivered through those same systems. HPV vaccination uptake, therefore, becomes a lens through which wider inequalities can be seen.

Addressing these challenges requires a shift from transactional delivery to relational public health, moving away from communication as a one-way transfer of information to an ongoing dialogue built on respect, cultural understanding, and shared ownership. This cannot be achieved through national campaigns or school programmes alone. It depends on place-based collaboration where public health teams, schools, community organisations, and families work together to create inclusive, trusted spaces for conversation and decision-making.

Neighbourhood working offers a potential framework for this transformation. It offers the opportunity to connect prevention with the everyday fabric of community life and relationships that endure beyond a single vaccination drive. In local networks, information can be shared in familiar languages, by trusted figures, and within the cultural contexts that make it meaningful. When prevention is rooted in neighbourhood and community relationships rather than imposed from above, it becomes both more equitable and more effective.

The challenge is to design a system where every young person, regardless of background, has equitable opportunity to understand, question, and choose. Achieving this will mean embedding equity into the structures that plan and deliver prevention, aligning local priorities with community voice, and recognising that trust is built through connection, not instruction.

Provider Response

Improving uptake of the HPV vaccination supports both the national and global ambition to eradicate cervical cancer and is one of the national priorities for Cancer Alliances. We're really pleased to have been able to fund this piece of work by Greenwich Healthwatch to understand the barriers that young people face in order to access HPV vaccination, as well as the recommendations set out in the report.

We will work with system partners across South East London to share the recommendations and look to incorporate these in health promotion plans moving forward.

Appendix

healthwatch Greenwich

Join us as a Young Person's Researcher!

1 The Project

We are doing a project led by young people to help more young people aged 16–25 learn about the HPV vaccine. This project is supported by the South East London Cancer Alliance.

2 What you will do

- Help to find young people.
- Lead discussion groups to find out what young people think about the HPV Vaccine.
- Work with community leaders

3 Who can apply

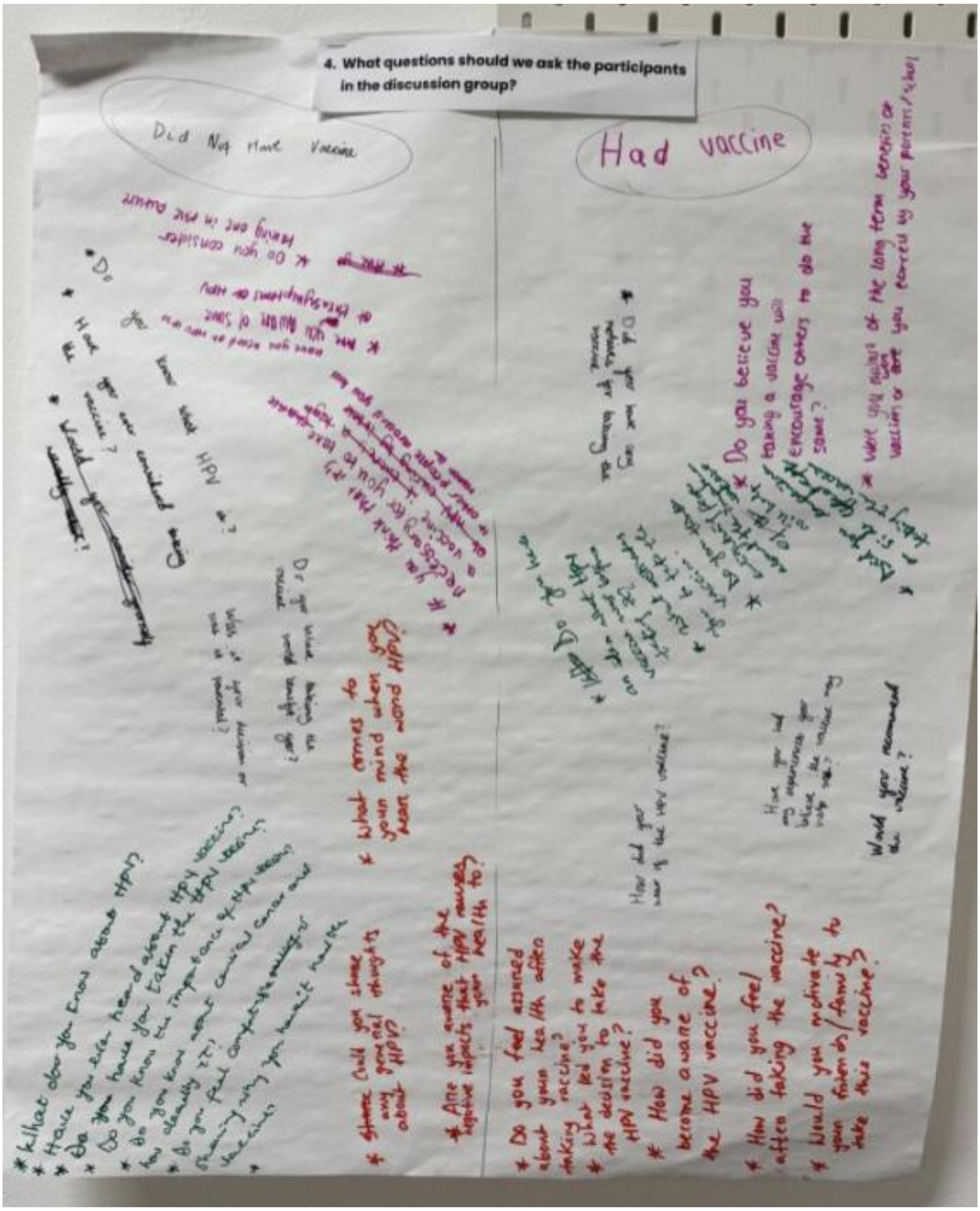
- Age 16–25
- Living in Thamesmead area
- Passionate about community health, research, and helping young people.

4 What's involved

- Commit to 10-15 hours per month from Feb-Aug 2025.
- Training sessions on team building, communication, research, and organising events.
- Leading in community events and workshops.
- You will be paid the London living wage for your time.

How to Apply

Please email your name, age, contact details, full address and a short paragraph (200 words) about yourself and why you want to be a young person's researcher. Candidates are interviewed on a rolling basis. Please apply as soon as possible.
Email: deepa@healthwatchgreenwich.co.uk

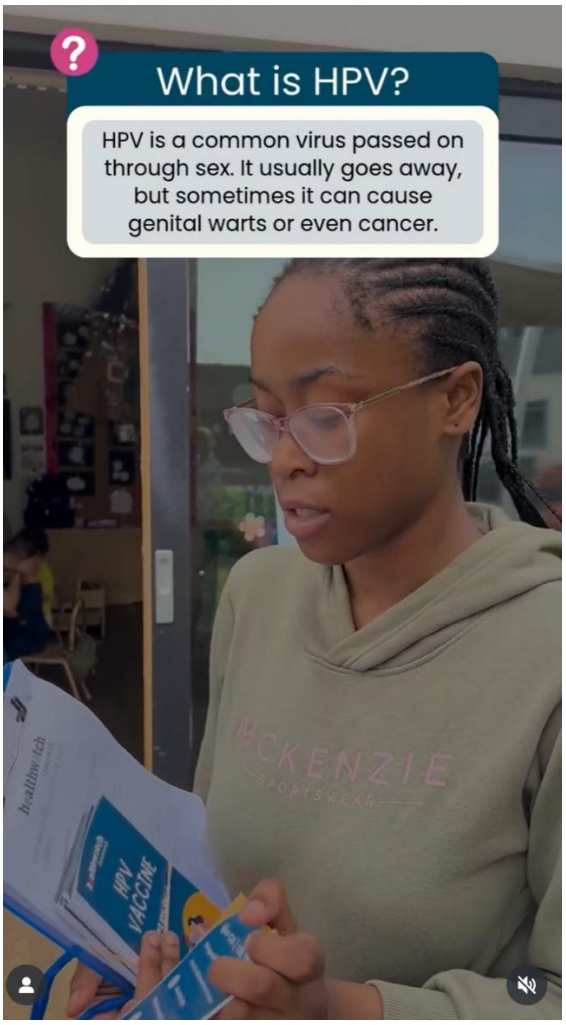

4. What questions should we ask the participants in the discussion group?
Did Not Have Vaccine
Had vaccine

HPV Vaccine	Number of People	Percentage
Yes	22	59%
No	12	32%
Not sure	3	8%
Total	37	

Gender	Number of People	Percentage
Female	21	57%
Male	16	43%
Total	37	

Ethnicity	Number of People	Percentage
Black/Black British	26	70%
White/White British	5	14%
Asian/Asian British	4	11%
Arab	2	5%
Total	37	

Age	Number of People	Percentage
16	11	30%
17	10	27%
18	4	11%
19	4	11%
20	3	8%
21	1	3%
22	1	3%
23	1	3%
24	1	3%
25	1	3%
Total	37	
Average	18	



Links to Peer Researcher YouTube Videos

- What Do Young People Know About HPV and the HPV Vaccine?
- How Do Young People Feel About the HPV Vaccine?
- Young People's Experiences with Health Services
- What Would Support Young People to Get the HPV Vaccine?
- What Young People Say Boosts Vaccine Awareness and Uptake

Where can I get the vaccine ?

Still in school?

You can get the vaccine in Year 8 with the school vaccination team.

Missed the school vaccine or not in school?

No worries. You can still get it, just ask your:

- Local health clinic
- School nurse
- GP

Who can I talk to?

Got questions? That's OK.

Chat 1:1 with a local youth worker:

020 8301 8920

Prefer to explore online?

Scan the QR code to check out our Q&A

healthwatch Greenwich

HPV VACCINE

Helping you decide

Your Health, Your choice

It's normal to feel nervous about making health choices. Many people feel this way. We're here to help you make the best choice for your body. Let's start with the basics...

What is HPV?

- HPV is a common virus
- Most people get it at some point after having sex
- It often has no symptoms
- Some types can lead to cancer
- It can affect both men and women
- The vaccine can help prevent the types that cause harm

HPV vaccine, A big step for your future

How does it work?

- Injection in your arm
- FREE if you're under 25
- Helps protect you from cervical cancer and some throat, mouth, anus and genital cancers.

You don't need to be having sex to get the vaccine. It's actualy best to get it before.

What people are saying about their experience...

> I had zero side effects after getting the vaccine.
>
> Sofiat. 21

> It's not that scary and I only got one jab!
>
> Yemi. 16

> I got the vaccine in Year 8 to stay safe and healthy.
>
> Mia. 24

> I got the vaccine a few years ago as part of a sexual health check. I'm reassured that me and my future partners are now protected.
>
> John. 29

healthwatch Greenwich

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