



University of Wales
Trinity Saint David
LONDON

UNDERSTANDING THE ROLE OF LANGUAGE AND HEALTH LITERACY IN CERVICAL CANCER SCREENING AMONG NON-ENGLISH SPEAKING MIGRANT WOMEN (18 TO 30 YEARS OLD) IN EAST LONDON

by

Himanshi Patel

Student ID – 2428692

Word count – 27,676

Date of Submission – 02/02/2026

A Dissertation submitted in partial fulfilment of the requirements for the degree of Master of
Science in Public Health and Social Care in Practice

The Institute of Inner City Learning

University of Wales Trinity Saint David – London Campus

[February 2026]

DECLARATION

I, Himanshi Patel declare that this dissertation has been composed by myself, that the work contained herein is entirely my own except where explicitly stated otherwise in the text, and that this work has not been submitted for any other degree or qualification, in whole or in part, except as specified.

Signed: Himanshi Patel.....

Date: 2/02/2026.....

Acknowledgements

I would like to express my sincere gratitude to my supervisor for their invaluable guidance, academic insight, and continued support throughout the development of this dissertation. Their constructive feedback and encouragement, and patience were instrumental in shaping the research design, strengthening the analysis, and enhancing the overall quality of this work. I am deeply grateful to the participants who generously agreed to take part in the interviews for this study. I truly appreciate the time they devoted and their openness to sharing their experiences and perspectives. Their contributions were essential to the completion of the primary research and have greatly enriched the findings of this dissertation.

I would also like to acknowledge the academic staff of the University of Wales Trinity Saint David for providing a supportive and intellectually stimulating learning environment throughout my MSc in Public Health and social care. The knowledge and skills gained during this programme have strongly informed the theoretical and methodological approach of this research. Finally, I wish to thank my family and friends for their patience, understanding, and unwavering support throughout the dissertation process. Their encouragement and reassurance played a vital role in enabling me to complete this work successfully.

Abstract

Introduction

Cervical cancer among women is a global health issue, while migrant women have low participation in screening programmes. Analysis the problems experienced by migrant young women in East London reflects language barriers, influence of culture, health literacy, inadequate access to healthcare information, and other factors affect their participation. The research highlights the aim to understand how language and health literacy impact non-English speaking migrant women's participation in cervical cancer screening within East London.

Methods

The research methodology has depicted the primary qualitative strategy by conducting interviews with two participants for the interview session. The qualitative research approach with descriptive research design and interpretivist research philosophy have been chosen to find the outcomes of this primary qualitative research. The purposive sampling has been beneficial for this research to conduct semi-structured interviews with open-ended questionnaires. Furthermore, the ethical consideration has been strongly adhered to by safeguarding participants' personal details and their insights throughout this research process to further employ potential outcomes.

Results

The key findings have been achieved from an interview transcript of two participants to gather data on the relationship between cervical cancer screening and the barriers faced by migrant women that impact the treatment outcome. Low levels of medical term understanding hinder understanding of risks, benefits, and procedures of cervical cancer screening that lead to poor involvement in treatment procedures. The availability of bilingual staff at GP practices can assist in addressing the potential risks associated with cultural, language and communication gaps between professionals and care seekers.

Conclusion

The research concludes that the challenges that have impacted the accessibility of non-English speaking women to uptake of cervical cancer screening including financial barriers, social stigma, discrimination, Language and communication barriers and Poor health literacy. This suggests that focusing on the participant's views and key points such as enhancing written communication, the number of interpreters and bilingual staff members, cultural competencies, community-based interventions and health literacy planning with policy improvements

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List of Abbreviations

CC - Cervical Cancer

CCS – Cervical Cancer Screening

CHWs - Community Health Workers

GDPR – General Data Protection Regulation

GPs – General Practitioners

HCWs – Health Care Workers

NHS – National Health Service

UK – United Kingdom

Chapter 1: Introduction

1.1 Establish research topic

Topic introduction

Cervical cancer is affecting women around the world because it is one of the few cancers that can be prevented if early screening is done. Screening for cervical cancer is crucial for detecting abnormal cells that can allow women to take early treatment and enhance their survival rate. A record shows 604,000 new cases of cervical cancer and 342,000 deaths worldwide, which made it a major global health problem (Dickson *et al.*, 2023). However, in the UK, participation of women in cervical cancer screening is minimal, especially among non-English speaking migrant women. The research is focused on understanding how language and health literacy are creating barriers for women's participation in cervical cancer screening within East London for migrant women. This research aims to explore language and health literacy-related issues among migrant women in East London that affect their participation in cervical cancer screening.

Research background

Screening is crucial for cervical cancer prevention, while the inequalities among different women in East London have resulted in an increased rate of cervical cancer. Considering the age-based factor, in the UK, cervical cancer screening is lower in young to middle-aged women compared to older women. In 2024, 74.3% women aged between 50 and 64 have received cervical cancer screening coverage, while for the age group of 25 to 49, the rate is 66.1% (Statista, 2025). Besides the age factor, literacy and language barriers have a significant impact on migrant women's participation in cervical cancer screening programmes. More specifically, migrant women in East London are less likely to attend cervical cancer screening compared to native-born women, while a minimal ability to understand health messages is the main reason. As per the views of Ozturk *et al.* (2024), migrant women faced language barriers during appointment booking, which affects their communication with healthcare professionals as well as cervical cancer screening. East London has been selected for the research to accomplish the stated objectives because of its mixed culture, languages and residence of migrant women from South Asia, the Middle East and other countries.

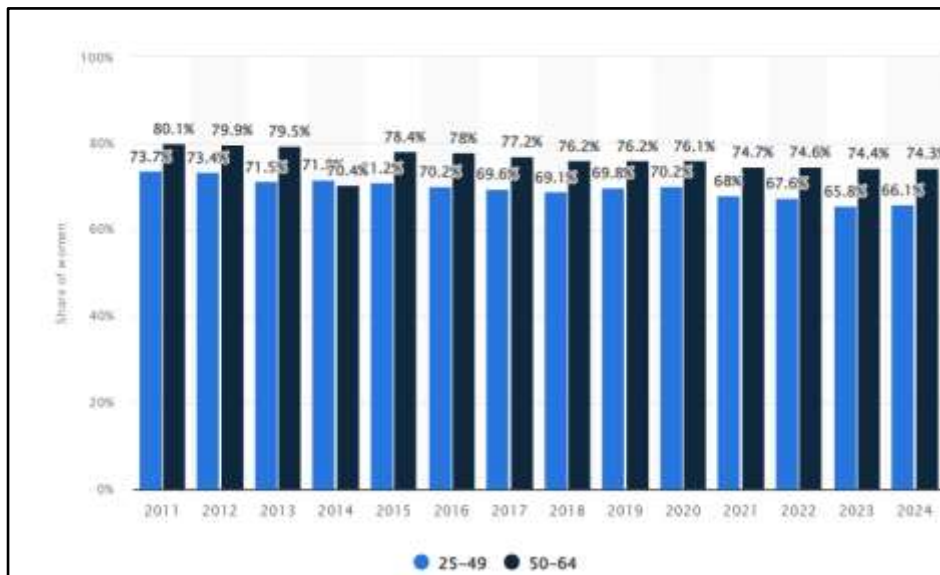


Figure 1.1: Cervical cancer screening by age in the UK

(Source: Statista, 2025)

1.2 Discussion of existing research

Current state of knowledge

Accessing healthcare to detect cervical cancer shows that language and communication barriers are the major problem, which is experienced by migrant women. English is a commonly spoken language by healthcare professionals in East London, while women who cannot speak or understand English fluently. Based on the argument of Barrio-Ruiz *et al.* (2024), a lack of knowledge of a specific language prevents women from understanding invitations to screening programmes and communicating with healthcare providers properly. More than that, migrant women in East London may misunderstand an invitation to screening and avoid healthcare visits if they feel confused during a consultation with a healthcare professional.

According to the WHO, health literacy is crucial for equitable access to education and lifelong learning, such as information provided by healthcare professionals and enabling access to information (WHO, 2025). Despite the availability of cervical cancer screening programmes, language and health literacy influence migrant women's participation in East London. Specifically, poor health literacy creates difficulties for migrant women in understanding cervical cancer screening properly, and it can lead to mistrust and fear.

Relevance to a broader problem

Health equality is a major concern at present in terms of providing equal access to healthcare information to native and migrant populations. The UK government is focused on bringing equity in healthcare by addressing avoidable differences in health among different groups of people (Office for Health Improvement & Disparities, 2025). Inclusive communication and community engagement are a primary focus of the UK healthcare system, although some significant challenges for migrant women are still present. In other words, understanding medical information and maintaining fluency in communication with healthcare providers is difficult for migrant women who speak English limited. As highlighted by Sudhinaraset *et al.* (2023), limited fluency in English has created problems for patients in understanding the health system and medical terminology, which has resulted in missed clinical appointments. The language and health literacy problem is not only causing difficulties in cervical cancer screening among migrant women, but also affecting preventive health programmes, increasing deaths. Hence, understanding the major problems related to language and health literacy can help implement adequate strategies in improving migrant women's wellbeing in East London.

1.3 Narrow down focus

Focusing on a specific area

The research has been conducted by selecting migrant women in East London aged between 18 to 30 years who do not speak English. This age group has minimal awareness about cervical cancer screening in comparison to older women because of having minimal knowledge about the importance of taking early preventive measures. According to the viewpoint of Alam *et al.* (2022), a major factor that is contributing to the lack of awareness among women is the perception of cervical cancer as a common type of cancer. Considering the fact that age and literacy influence women's participation in cervical cancer screening, the research is focused on highlighting specific problems faced by this group in getting familiar with the UK healthcare system. NHS England is focused on improving communication by changing screening intervals, such as providing translation of updated cervical screening information in 30 common languages (Department of Health & Social Care, 2025). The initiative of the NHS may help migrant women to access valuable information about cervical cancer screening, but improving health literacy is quite difficult, which affects their participation significantly.

Scope of the research

The research has been designed to represent difficulties or factors that contribute to poor cervical cancer screening among non-English speaking migrant women in East London. However, the research scope is limited as it is only focused on valuing the problems of women aged between 18 to 30 years. Specifically, the research has not included other groups such as English-speaking migrant women and women aged more than 30 years. Apart from women who have proper knowledge about cervical cancer screening, in terms of adequate health literacy are also not a part of the research. Based on the argument of Restivo *et al.* (2025), women from low-income countries faced challenges in accessing the healthcare system because of language barriers and a lack of awareness of screening programmes. Besides language barriers, other factors such as education or culture influence the health literacy of young migrant women, which has been explored in the research. Understanding young migrant women's personal experiences and challenges has been valued in the research to answer the stated research question.

1.4 Research questions and objectives

Questions

What major effects do language and health literacy have on the cervical cancer screening rates among non-English speaking migrant women in East London aged between 18 to 30 years?

Objectives

Specific	Measurable	Achievable	Realistic	Time-bound
To explore the understanding level of cervical cancer screening among migrant women aged 18 to 30 years in East London	Measuring awareness and understanding among non-English speaking migrant women through interviews.	Recruitment of participants through community organisations, place, migrant support service and faith-based organisations.	Focusing on a specific group has made the research manageable.	Completion of data collection within 1 to 2 months.

To identify challenges faced by migrant women due to language, culture and system barriers that made it difficult to participate in cervical cancer screening	Identifying barriers and recording it through interview responses and thematic analysis.	Supporting participation by designing simple interview methods and using translated questions.	Non-English-speaking women commonly experience these barriers, and the research can help to clearly explore them.	2 to 3 months
To examine the ways cervical cancer screening services can be more accessible and appropriate to the culture of migrant women, considering practical methods	Feedback from participants is crucial to be considered to implement suggestions for improvement.	Forming recommendations based on collected data and existing services.	The key focus is on practical improvements , which are also low-cost in nature.	3 months

Table 1: SMART objectives

1.5 Overview

- **Chapter 1: Introduction**

The chapter provides an overview of the topic by highlighting its importance, background and relevance apart from representing the objectives and questions. Outlining the specific focus of the research involved in the chapter, valuing non-English speaking migrant women groups.

- **Chapter 2: Literature review/theoretical framework**

Reviews existing literature related to cervical cancer screening among migrant women is critically evaluated in the chapter, taking different theories into account to explain language and help literacy barriers.

- **Chapter 3: Methodology**

The chapter discusses the design of the research in terms of the stages that have been completed to achieve aim and objectives. Representing data collection and analysis techniques is valued in this section to maintain reliability and transparency of the research.

- **Chapter 4: Results and Discussion**

Representing findings from data analysis in terms of summarising the information gathered from sources is included in the chapter, focusing on the perspective of migrant women about cervical cancer screening. Interpreting research findings in relation to the literature review and research objectives has been recorded in this section. The chapter explains the results sufficiently to answer research questions, valuing language barriers, cultural influence and health literacy among migrant women in East London.

- **Chapter 5: Conclusion**

The section highlights a summarising statement of the whole research, considering findings, objectives, apart from adequate recommendations to overcome communication barriers faced by migrant women. The chapter includes the research limitations and suggestions for future research for increasing migrant women's participation in cervical cancer screening.

Chapter 2: Literature review/theoretical framework

2.1 Chapter introduction

This chapter focuses on the existing literature on cervical cancer screening across non-English migrant women in East London by emphasizing the language and health literacy. The review evaluates the significance of the early detection of cervical cancer screening since the preventive measure especially for the 18 to 30 aged women could demonstrate lower participation rates. The current studies concentrate that limited English proficiency and poor health literacy inhibit understanding of the screening invitations with access to healthcare services and engagements with health professionals. The cultural norms, stigma and misinformation are exacerbating the differences in increasing uptake across migrant people. Furthermore, the systemic barriers such as inadequate translation services limiting culturally sensitive healthcare and financial contractions are often included in this research.

This literature review analyses interventions aimed at improving participation, including culturally concordant community health workers, multilingual educational materials, digital literacy programs and culturally tailored health education. The theoretical frameworks are used to interpret the way social, cultural and systemic factors encourage healthcare access. This chapter establishes the foundation for recognising knowledge gaps by developing a conceptual framework and designing strategies to improve cervical cancer screening uptake among non-English speaking migrant women in East London to synthesise evidence from peer-reviewed journals and government reports.

2.2 Evaluating non-English speaking migrant women's awareness and comprehension of cervical screening initiatives in East London

The awareness of cervical cancer screening initiatives is one of the significant initiatives in the UK healthcare sector for strengthening the non-English speaking migrant awareness of healthcare issues. Ozturk (2024) has outlined that the cervical cancer screening and awareness campaign among migrant women in their native language is crucial for improving healthcare to become aware. Zhang *et al.* (2022) highlighted that the screening initiatives and programs, along with cervical cancer awareness campaigns, are effective for improving comprehension of their effectiveness to enhance healthcare outcomes.

Accordingly, Khatri *et al.* (2025) outlined that cancer is a major healthcare issue in countries such as the UK among the migrant populations that consist of 14% of the overall population. Alam *et al.* (2023) highlighted that the screening initiatives for cervical cancer in this regard are efficient for improving awareness among migrant women for reducing the risks of cervical

cancer rates. Alam *et al.* (2022) have identified that native women with a lack of English proficiency and literacy rely on family members for translating the information in cervical cancer screening. Thus, interpretation of information regarding cervical cancer among native women with less English proficiency is a significant aspect for improving knowledge and understanding of the issues.

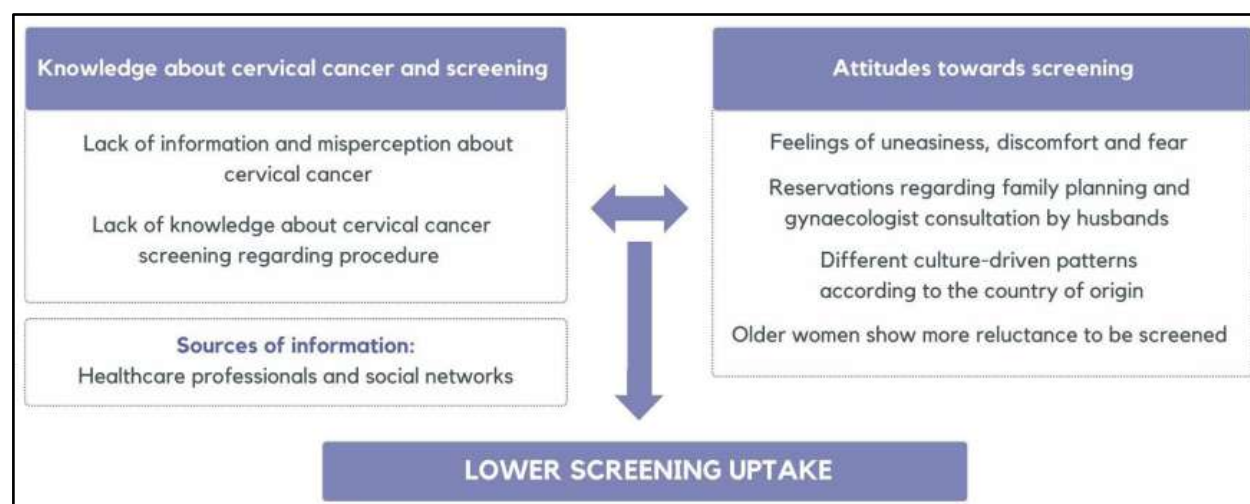


Figure 2.1: Literacy and knowledge of cervical screening among native women

(Source: Silva *et al.* 2024)

Improving non-English speaking migrant women's awareness regarding the screening of cervical cancer is crucial to be enhanced through improving information sharing and building engagement. Silva *et al.* (2024) have outlined that cultural barriers in accessing healthcare services impact the uptake of cervical cancer screening among migrant women, including linguistic barriers. This reflects that low health literacy and poor English proficiency of the women regarding cervical screening have also impacted on the overall healthcare outcome of the individuals in the UK. On the other hand, the lack of cultural knowledge and proficiency is also a major aspect that impacts the accessibility of screening services to the women in migrant communities of the UK. Bolarinwa and Holt (2023) analysed that barriers to effective cervical cancer screening for native women include poor medical knowledge, inaccessibility to care and health professionals' lack of cultural knowledge.

Improving the knowledge and awareness of native women regarding cervical cancer screening can be improved through adapting a culturally holistic approach. Chandrakumar *et al.* (2022) have outlined that GPs in gynaecology departments have emphasised that personalised communication provided to women in their own native language is effective for ensuring information accuracy. Providing information regarding cervical cancer screening and

its effective role in enhancing women's overall health outcomes in their native language enhances awareness of healthcare issues.

Cancer literacy among native women is also a major factor that influences the awareness of cervical cancer issues among women in the UK. Cha and Chun (2021) outlined that cancer literacy, along with inefficient knowledge of English and lower educational levels among non-English speaking women are a major barrier to cervical cancer screening. This indicates that social networks, connectedness and support systems play a major role in influencing the perception of native women towards up-taking cervical cancer screening.

Moyce *et al.* (2025) have also emphasised cultural differences as a large part of the disparity, restricting the use of native languages that hamper women's accessibility to cancer screening. In contrast, Wigham *et al.* (2022) have outlined that despite offering incentivisation and initiatives of health check-ups and screening, the low uptake among women is due to low knowledge of the effectiveness of health check-ups for issues such as cervical cancer. Thus, addressing the cultural gap in the healthcare sector through reducing language and linguistic barriers is crucial for enhancing health outcomes.

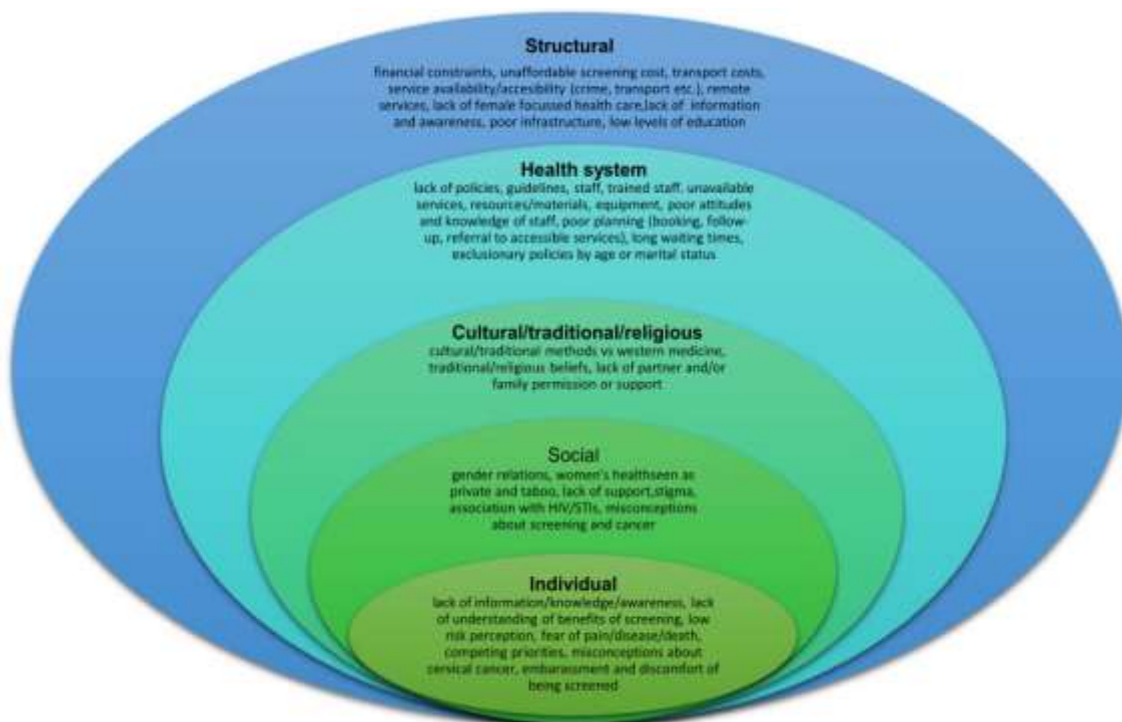


Figure 2.2: Key constraints and barriers for women to access cervical cancer screening

(Source: Petersen *et al.* 2022)

As compared to women speaking English in developed nations such as the UK and the US, the rates of cervical cancer among women with limited English proficiency is high due to a lack of accessibility. Twersky *et al.* (2024) outlined cervical screening studies and identified that the limited English proficiency women population have lower rates of Pap smear exams as compared to English-speaking populations. The author emphasised the significance of strengthening proficiency and English literacy in the global context to address the issues of low uptake rates of cervical cancer screening in the UK.

Accordingly, Petersen *et al.* (2022) have outlined that cultural, traditional and religious barriers drive misconceptions among women regarding health screening that hamper the uptake of cervical cancers among native women. Thus, comprehension and awareness among non-English speaking women regarding the effectiveness of uptaking cervical cancers in the UK is low, hampering healthcare outcomes.

2.3 Role of health literacy, language in creating awareness among the Non-English Speaking Migrant Women related to Cervical Cancer Screening

The role of health literacy within the Cervical Cancer Screening is to create awareness among the non-English speaking migrant women in the UK by mitigating the individual, cultural, and systemic barriers (Hakim *et al.* 2025). As highlighted in the report of Dougherty *et al.* (2021), Health literacy can be defined as the set of knowledge, motivation, and competencies needed by people to access health services in the migrant population. It is determined from the article that the migrant population are more likely to have lower health literacy than non-migrant populations, which leads to poorer health outcomes for the screening of cervical cancer. Moreover, Khatri and Assefa (2022) argued that the health literacy among the non-English speaking migrant women is lower and has created a lack in awareness efforts for the system to have effective Cervical Cancer Screening.

As mentioned in the report of Gogoi *et al.* (2025), the non-English-speaking migrant might lack access to the health facilities due to a lack of information and a language barrier. This indicated that the non-English-speaking migrants might lack health literacy due to a lack of support and financial issues in accessing the service from the healthcare organisation. Therefore, the application of healthcare health literacy to increase awareness regarding the Cervical Cancer Screening among non-English-speaking migrant women in the UK.

- ***Improves comprehension of risks and benefits of Cervical Cancer Screening***

Health literacy and language is considered important factors for the awareness of the Cervical Cancer Screening among the non-English-speaking migrant women to overcome the language barrier (Afsah and Kaneko, 2023). As mentioned by Barrio-Ruiz *et al.* (2024) in the report, the non-English speaking women in the UK is facing the cultural and language barrier that native English speakers face due to poor communication with the practitioner. This determined that the language broker has reduced access to the screening service for women from the non-English speaking migrant group. However, the health literacy interventions bridge the gap in the screening process by providing vital information in a simple and culturally resonant manner to determine the benefit of Cervical Cancer Screening.

As highlighted in the report of Woods *et al.* (2022), limited English proficiency is a common issue facing patients from the immigrant in the UK healthcare as a lack of language proficiency has impacted the intervention process. Thus, the health literacy has created an opportune impact among the non-English-speaking migrant women to determine the benefits and potential risk associated with Cervical Cancer Screening

- ***Increases ability to seek and evaluate information related to screening of Cervical Cancer***

Health literacy initiatives incorporate cultural understanding to counteract stigma and misinformation related to the risk in the screening process of Cervical Cancer among non-English-speaking migrants. As mentioned in the report, Ghorbanian Zolbin *et al.* (2022), health literacy has helped in developing customers among the patients seeking for better interventions to have quality life. It can be interpreted that the culturally adapted education related to the screening of Cervical Cancer clarifies that screening is a form of prevention for asymptomatic individuals. Moreover, the application of digital literacy is empowering non-English-speaking migrants to take part in the securing process and engage in the acceptable interventions.

According to the opinion of Khatri *et al.* (2025), non-English-speaking individuals have low participation rates in breast, cervical, and colorectal cancer screening due to factors such as lack of awareness, cultural stigma, and invasive procedures. Thus, the increase in health literacy among non-English-speaking women in the UK could help to increase awareness about the importance of screening for cervical cancer to prevent the disease.

- ***Boosts adherence to screening schedules for Cervical Cancer Screening***

The health literacy related to screening of Cervical Cancer could help the migrant women to schedule an appointment in the healthcare service for early detection (Zayed *et al.* 2025). The culturally tailored health education has included multilingual communication interventions that could help the non-English-speaking women from the migrant growth in the UK to have screening schedules under the NHS. As per the view shared by Nwafor *et al.* (2025), the cultural backgrounds and speaking languages have an impact on the health life of non-English speaking women due to difficulties in understanding of medicines into their healthcare, often contributing to poorer health outcomes. As illustrated by Kim *et al.* (2025) in the report, lower health literacy has created awareness among the patients from migrant groups, also associated with socioeconomic factors, including immigration and low levels of income. Thus, health literacy could help to remove barriers in the screening schedules for Cervical Cancer among the non-English speaking women that prevent from worse health outcomes.

- ***Reduces barriers to care***

The increase of healthcare literacy could improve the care efficiency among the non-English speaking women from the immigrant community in the UK through healthcare awareness (Brownell *et al.* 2022). As mentioned by Scott and Hoskin (2024), in the report that Health literacy plays a crucial role in timely healthcare awareness among non-English speakers related to cervical cancer screening. Moreover, the awareness regarding the screening process of cervical cancer can help non-English speaking immigrant women that helps to prevent the spread of cancer at an early stage. As illustrated in the report of Afsah and Kaneko (2023), the screening process of cervical cancer is extremely low among immigrant women due to barriers from the diverse religious values, beliefs, and fatalism that have created an impact on the outcome. Thus, the increase of the health care literacy among non-English speaking women in the UK could help to reduce the negative impact on the care process.

2.4 Evaluating the issues of limited participation in cervical cancer screening due to cultural, language and systemic challenges

- ***Language and communication barriers among the non-English-speaking women***

The lack of awareness related to the screening of cervical cancer is due to an unclear understanding of English by the migrant women in the UK, which has hampered the healthcare outcome. As mentioned in the report of Yong and Germain (2022), communication barriers in the interaction between healthcare providers to their patients in health services due to a lack of foreign language skills impacted the minority group. The non-English speaking ethnic

minority is unable to understand invitations for screening and treatment of cervical cancer increased the risk of infection and health deterioration. As per the opinion of Rana (2023), the language barrier in the UK healthcare is due to the limited proficiency in English has led to serious health issues and consequences. Thus, the non-English-speaking migrant people are unable to have access to equal health care services due to lack of English proficiency.

- ***Poor health literacy among the non-English-speaking women***

The poor health knowledge and literacy among the non-English speaking women is lower than that of the native English speakers due to lack of awareness related to CCS. As per the view of Monani *et al.* (2021), non-English speaking immigrants have low socioeconomic status and low education level, that is affecting the healthcare outcome. This indicated that poor health literacy has impacted the knowledge regarding the needs of screening of CC among the women from the migrant group. Therefore, the non-English-speaking migrant women are facing a barrier to the CCS due to the campaign being mainly based on the English language across the UK.

- ***Discrimination, stigma and misinformation***

The increased issues of discrimination social stigma are a major barrier that impacts women's accessibility to required care and screening initiatives for cervical cancers (LeBlanc *et al.* 2025). Apart from this, Twersky *et al.* (2024) have outlined that social stigma is a major barrier in ensuring accessibility to quality care and cervical screening for women, stemming from cultural beliefs. This reflects that the social stigma including negative perception of the cervical cancer screening, reduces participation of women to uptake screening initiatives for cervical cancer. For example, Muslim communities consider cervical cancer screening entities as a sexual activity and restrict the involvement of women in screening initiatives (Twersky *et al.* 2024). This reflects that the poor engagement and participation of the women in cervical cancer screening is majorly influenced by misconceptions, misinformation and cultural beliefs, causing social stigma. On the other hand, Barrio-Ruiz *et al.* (2024) have outlined that, women from Asian origin significantly relied on the partners for accessing healthcare services and interpreting healthcare information. Thus, the social stigma and culture barriers are the major issues that impact the accessibility to required care, improving knowledge regarding cervical cancer detection.

- **Financial constraints**

The cost of care is a major barrier that restricts the participation and accessibility of women from non-English speaking communities in accessing cervical cancer screening activities. Farajimakin (2024) has outlined that Underserved populations such as racial and ethnic minorities, experience financial constraints regarding cancer screening due to financial reliance on partners and family members. The author emphasised that women from racially different cultures relied on their partners and family members for fulfilling basic needs such as care and education, which limits attraction in healthcare screening such as cervical cancer screening. On the other hand, Mosquera *et al.* (2023) have outlined that non-English speaking women have significant financial barriers to access cancer screening services due to no health insurance. Thus, financial constraints impact the accessibility of non-English speaking women's accessibility to uptake cervical cancer screening.

Employing “culturally concordant community health workers” and providing “cultural competency training”

Recruiting “culturally concordant community health workers” and arranging “cultural competency training” for non-English speaking migrant women in East London can be feasible for elevating service accessibility and improving information delivery during “cervical cancer screening” (CCS). Employing culturally concordant CHWs (community health workers) belonging to the same cultural backgrounds and language can be helpful for building trust and navigating complicated health service systems (Eluka *et al.* 2021).

Improvement in in-person communication among non-English speaking migrant women and CHWs with strategic recruitment can be useful for delivering “culturally appropriate health education” for streamlining information sharing and improving CCS service accessibility. On the contrary, initiating “cultural competency training” for healthcare staff can be beneficial for delivering required services and providing necessary information by ensuring patient engagement and elevating ‘quality of care’ (Afulani *et al.* 2023). This can be beneficial for healthcare workers (HCWs) associated with CCS to understand perspectives of non-English speaking migrant women patients and considering social and cultural values of patients for better service accessibility.

Providing culturally sensitive care and improving digital literacy

Offering culturally sensitive, along with inclusive care by incorporating women-centred services and arranging necessary training facilities for healthcare providers can be fruitful for increasing cultural awareness and health literacy (Rodriguez-Cuevas *et al.* 2023). Providing

strategic direction along with guidance to HCWs regarding cultural awareness, empathy, respect and unconscious bias has been found to be supportive for increasing healthcare service accessibility among non-English speaking migrant women. Inversely, emphasising digital literacy by arranging “mobile-first digital literacy programs” by utilising a co-design approach can be fruitful for increasing health literacy among patients, resulting in better service accessibility (Lewis *et al.* 2024). Improvement in digital literacy can empower non-English speaking women across East London to access necessary health-related information by using online platforms, ensuring seamless information accessibility and service delivery.

Offering multilingual along with accessible resources and involving migrants into service design

Designing resources in native language of migrants, utilising innovative visuals and creating culturally adapted along with accessible text-formats found to be purposeful for communicating necessary information (Peguero, 2024). Facilitating trust along with disclosure by organising “health education sessions” across community settings such as schools or local events can also be beneficial for elevating healthcare service accessibility for non-English speaking migrant women. Contrarily, developing partnerships with community leaders and involving migrant community members in healthcare program design can aid in strengthening capacity for exchanging necessary information and incorporating trusted services (Lansing *et al.* 2023). Developing a strategic partnership with community leaders can be useful for addressing communication gaps, offering ‘culturally appropriate care’ and eliminating mistrust among non-English speaking migrant women for elevating accessibility of CCS services.

Conducting ‘language needs assessment’ and utilising technological tools to outreach healthcare services

Regular assessment of the linguistic landscape of migrant communities prioritising the most needed language for increasing the reach of healthcare services can be beneficial for boosting healthcare service accessibility (Khatri and Assefa, 2022). Consequently, leveraging community resources, collaborating with community organisations, involving “culturally competent staff” and designing tailored programming can be fruitful for increasing CCS service reach for non-English speaking migrant women with better information delivery. Inversely, incorporation of advanced technological tools including “real-time translation tools” and multilingual chatbots, can be impactful for providing simultaneous interpretation to migrant communities for avoiding communication errors and eliminating information misuse (Al Anakrih, 2025). In this regard, integrating the aforementioned tools into “electronic health records”, integrating visual features, prioritising human interpreters and seeking feedback from

migrant women can be advantageous for improving healthcare accessibility by offering relevant information.

Considering policy reforms and establishing an accountability mechanism

Prioritising policy reforms by considering necessary changes for eliminating structural inequalities, addressing legal barriers and improving resource allocation for strengthening “professional interpretation services” can help in equitable resource distribution (Forray *et al.* 2024). This can be beneficial for CCS to offer necessary healthcare services to marginalised community women for increasing service accessibility while ensuring seamless information delivery. Conversely, establishing accountability mechanisms by integrating continuous feedback and reviewing service delivery on a regular basis can be purposeful for ensuring accurate service delivery (Matlala, 2024). In this regard, healthcare leaders are supposed to strengthen accountability mechanisms and ensure policy reforms as per the requirements of migrant communities, which can be beneficial for offering adequate CCS services to non-English speaking women.

2.6 Theoretical framework

Cultural Competence Model

Cultural competence plays a vital role in health literacy. It has been recognised that lower health literacy and communication barriers have reduced the effectiveness of cervical cancer screening among migrant women. Application of cultural competence models can be helpful for dealing with the social determinants in an effective manner. The Cultural Competency Model has emphasised the needs of understanding the social and cultural nuances to healthcare delivery during care (Liu and Li, 2023). Treatment for the diverse population can be handled in an effective manner in the healthcare field through an effective application of this competence model. Cultural competency is important for healthcare teams to ensure equity within treatment. In the case of cervical cancer, women generally faced health-related stigma, which was also promoted through communication issues. The application of this competence theory or model needs to start from the medical learning avenue. Healthcare practices are required to participate in training sessions for addressing the health literacy of migrant women. It can lead the flow of cervical cancer screening as well as ensure the establishment of cultural development.

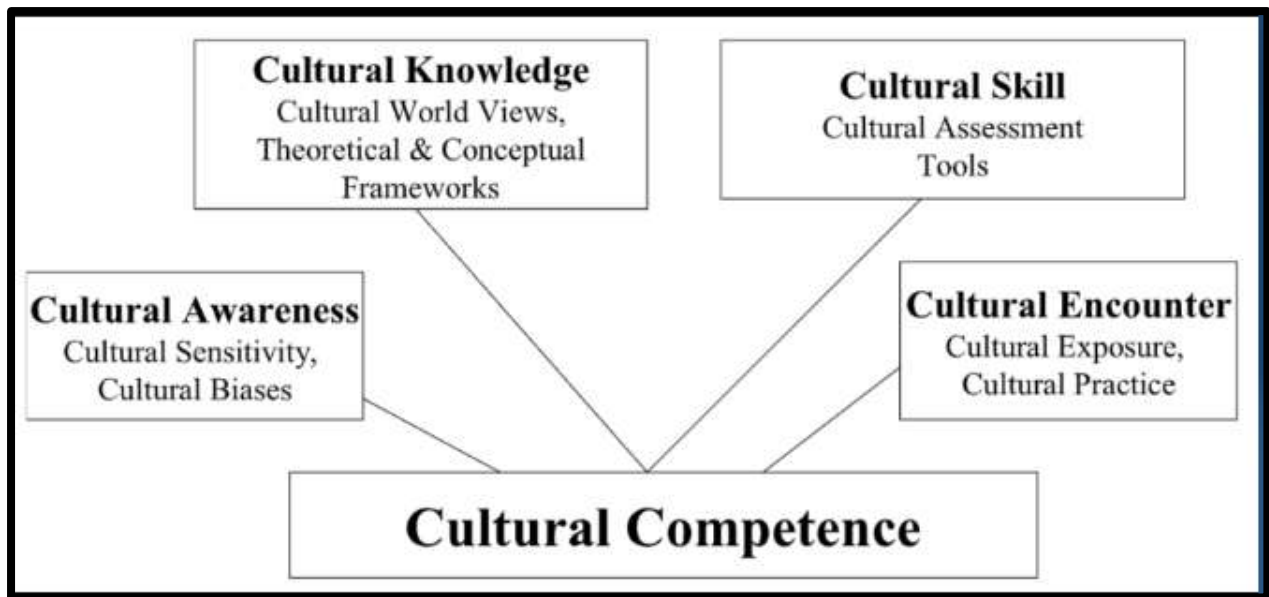


Figure 2.3: Factors of Cultural Competency Model

(Source: Inspired by Liu and Li, 2023)

A multifaceted approach has been used for applying the Cultural competence Model in the healthcare segment for addressing the language barriers. Based on the views of Liu and Li, (2023), Clinicians can engage in self-reflection to understand their own cultural biases and improve their communication style during cancer screening in a structured way. Migrant women who have lower health literacy and difficulty in understanding English can be guided by the non-verbal communication skill of healthcare practitioners. Effective cross-cultural communication. On the other hand, the improvement of cross-cultural communication can promote the professionalism of healthcare practitioners.

Gradellini *et al.* (2021) have stated that cultural competencies are directly related to cultural sensitivity in the medical field. Furthermore, healthcare professionals can focus on the health-related beliefs and cultural norms of the migrant women during cervical cancer screening. Stating the medical point by avoiding stereotyping can be met during cervical cancer screening through an effective application of this model. Therefore, the above figure has highlighted the different traits of the Cultural Competency Model that can lower the effectiveness of lower health literacy populations.

Andersen's Behavioural Model of Health Services Use

Different factors contribute to and control the behavioural approaches of migrant women in terms of accessing healthcare services. A better understanding of the factors that control the migrant women's health accessibility can be achieved with the help of Andersen's behavioural

model of health services use. As mentioned by Lederle *et al.* (2021), there are three core factors that evaluate healthcare utilisation predisposing factors, enabling factors, and need factors. Considering the aspects of predisposing factors like age, language and education, it became evident that limited English proficiency of migrant women discourages them from discussing cervical screening. Apart from that social stigma with reproductive examination also restricts them from consulting about their health condition with professionals.

The enabling factor to healthcare utilisation relies on the availability of healthcare resources that facilitate access to care services. As mentioned by Kabir (2021), enabling factors have strong mutable characteristics that influence the use intentions of and approaches of healthcare services. Due to a lack of health care literacy and poor knowledge of the English language, many migrant women failed to understand health information. The mentioned incapability also restricts them from understanding rigid appointment schedules and the absence of female practitioners contributes to that. Need factors encompassed with perceived and actual benefits of health care services, which help to improve the healthcare awareness among migrant women.

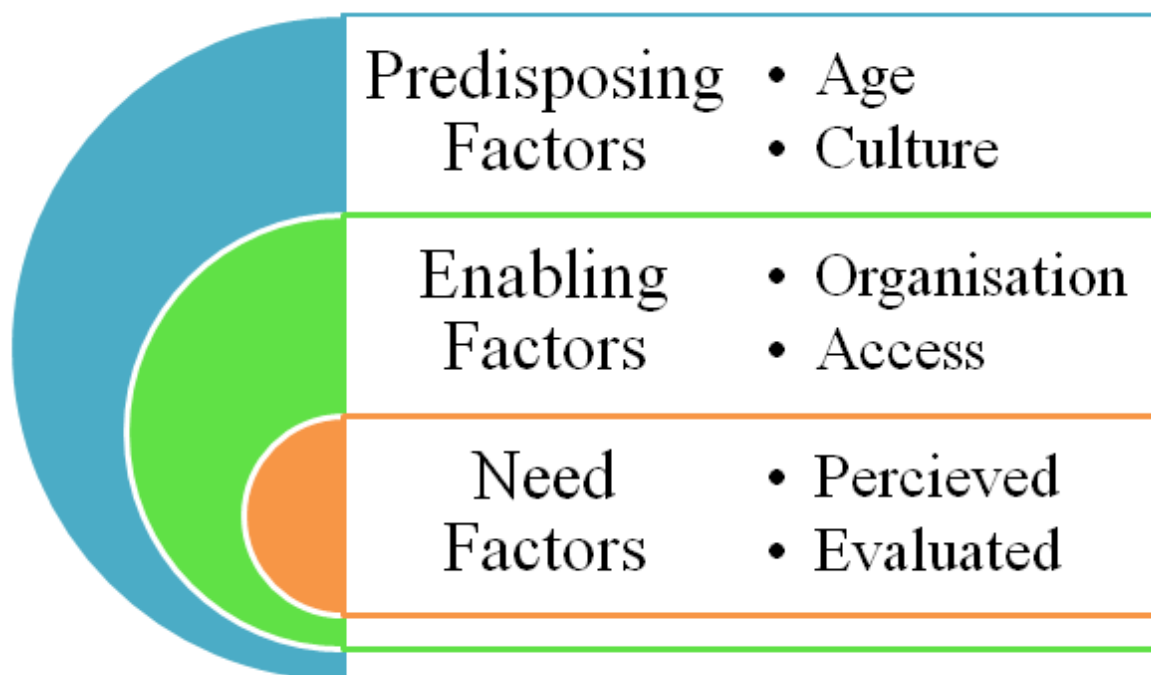


Figure 2.4: Andersen's Behavioural Model of Health Services Use

(Source: Influenced by Lederle *et al.*, 2021)

The lack of knowledge as well as participation of the partners in cervical cancer initiatives impacts the accessibility of non-English speaking and migrant women to cervical cancer screening stages. This social stigma has included a negative perception that cervical cancer screening reduces participation of women to uptake screening initiatives for cervical cancer. Application of this “Andersen’s Behavioural Model of Health Services” can be helpful for improving the cervical cancer screening process along with making the patients involved within these medical procedures.

2.7 Conceptual framework

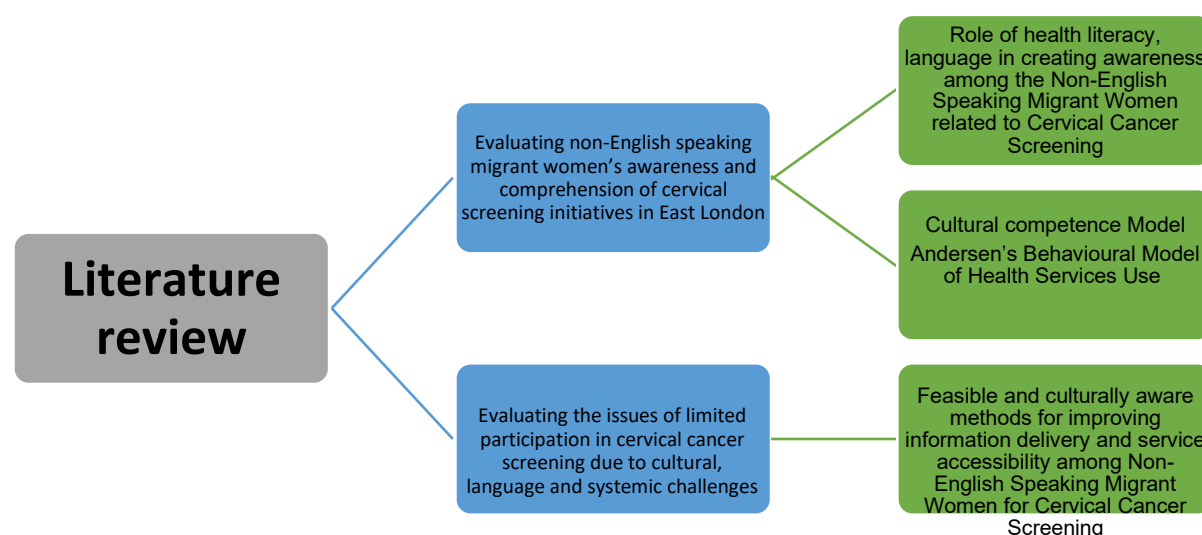


Figure 2.5: Conceptual Framework

The conceptual framework has depicted the language proficiency, health literacy, cultural beliefs and systemic factors for explaining cervical cancer screening behaviours across non-English speaking migrant women in East London. The language proficiency has encouraged comprehension of screening invitations and communication with healthcare professionals while health literacy determines comprehensive risks, benefits and procedures. The cultural beliefs and social stigma affect willingness to participate, whereas systemic factors, including access to culturally sensitive services, translation and financial resources, shape overall engagement. The framework has described the alignment between these variables, guiding the design of interventions such as multilingual education, culturally competent healthcare provision and digital literacy programs for improving cervical cancer screening uptake.

2.8 Strength and weakness of the previous study

Previously done studies have used empirical findings, which have helped the study to include prior information that can be used for improving the understanding of this research. Better qualitative insights of the subject have been gained from the previously done studies, which can also be considered as one of the major strengths of the previously done studies. However, in most of the previously done studies, the sample sizes for the RCTs are small, which has enhanced the chances of being affected with bias. Use of such studies in developing background ideas of the subject in the current study might impact the reliability of the current study.

2.9 Research Gap

The significant gaps remain in comprehending the experiences of non-English speaking migrant women or general migrant populations, sometimes overlooking the unique barriers faced by the younger women in this extensive research on cervical cancer screening. On the other hand, language proficiency and health literacy are often involved as determinants of screening uptake by limiting empirical evidence investigating the way these factors interact with the cultural norms, social stigma and systemic barriers in the UK context. The existing interventions such as community health workers or translation services, are sometimes analysed without assessing their long-term effectiveness for the specific migrant subgroups. There is also a lack of integration between theoretical frameworks for designing and evaluating intervention strategies. This has addressed the gaps which have developed culturally sensitive, evidence-based strategies which enhance awareness, comprehension and participation in the cervical cancer screening across non-English speaking migrant women in East London. This research has filled these gaps by focusing particularly on younger women with their lived experiences and strategies for improving screening uptake.

2.10 Summary

Limited healthcare accessibility is significantly associated with low health literacy rate and limited English proficiency which further influence the cervical cancer screening approaches among the migrant women. Cultural beliefs and language barriers create a social stigma and stimuli that restrict the migrant women from trusting the health care services. Improvement in healthcare literacy with community outreach approaches with multilingual education and culturally sensitive, improves the health outcome significantly among the migrant women.

Chapter 3: Research Methodology

3.1 Introduction on overall approach

3.1.1 Research approach

This chapter has adopted a ***qualitative research approach*** to explore the way language and health literacy influence cervical cancer screening across the non-English speaking migrant women aged 18 to 30 years in East London. The qualitative research approach is suitable since the research seeks to understand lived experiences, perceptions and meanings over the measured variables numerically (Dani and Al Quraan, 2023). The issues including language barriers, cultural beliefs and health literacy are socially implemented and subjective in nature requiring in-depth exploration through the participant's narratives. This primary qualitative research allows rich, contextual data to be developed providing insight into the way women interpret healthcare information by interacting with cervical cancer screening services across the UK healthcare systems.

3.1.2 Type of research design

The research has chosen a ***qualitative descriptive research design*** using semi-structured interviews. This research design is suitable as limited empirical research exists depending specifically on young non-English speaking migrant women's experiences of cervical cancer screening in East London. This design has enabled the researcher to investigate under-researched issues without imposing predefined hypotheses. The descriptive element supports detailed documentation of participant's views, experiences and challenges ensuring that the findings properly reflect their perspectives (Lim, 2024). The semi-structured interviews provide flexibility to address the emerging issues while maintaining consistency within the participants through the utilisation of an interview guide.

3.1.3 Specific terms for methodological orientation

The methodological orientation of this research has been associated with the conventions utilised in public health and social care research. An interpretivism research philosophy's aspects identifying that the health behaviours and healthcare experiences are shaped by social, cultural and linguistic contexts underpin the research. This orientation supports the use of primary qualitative methods to understand complexity and diversity among the participant's experiences (Skilbeck *et al.* 2023). Thus, the selected overall approach has ensured primary qualitative methodological adherence with the research aim and objectives. This helps to

enable a comprehensive understanding of challenges and facilitators influencing cervical cancer screening participation among the target populations.

3.2 Research Design, Recruitment, Sampling & Study Participants

3.2.1 Research design

This research has chosen a ***qualitative descriptive research design*** to investigate the way language and health literacy influence cervical cancer screening participation among non-English speaking migrant women aged 18-30 years in East London. This research design has been chosen since the research aiming to explore subjective experiences, perceptions and meanings over the quantitative relationships between variables. The cervical cancer screening behaviours are influenced by complex social problems. Cultural, linguistic and systemic factors, which are suitably understood through in-depth qualitative inquiry (Ruslin *et al.* 2022).

The descriptive nature of design has allowed participant's experiences to be reported in their own worlds without imposing predetermined theoretical interpretations. This approach has ensured that the findings accurately reflect participants' realities while remaining associated with the public health research conventions. This primary qualitative research has been conducted in community-based contexts across East London with no systematic components like those that PRISMA has been employed here. East London is a region characterised by high migrant populations and linguistic diversity to get potential results of this research.

3.2.2 Recruitment strategy

Since this primary qualitative research, the participants have been recruited utilising purposive sampling to ensure that the individuals with direct experience relevant to the research aim have been included here. The recruitment has taken place through religious place, community organisations, migrant support services, women's health charities and faith-based has focused on operating across East London. These organisations have acted as gatekeepers, facilitating access to populations which have been underrepresented in their health research (Bashir, 2023).

The recruitment materials such as participant information sheets have been changed into commonly spoken languages across the community to improve accessibility. The bilingual community workers have been assisted in explaining the purpose of the study to address any concerns that have been enhanced by potential participants (Mistry *et al.* 2023). This culturally sensitive recruitment approach has been beneficial to build trust and encourage voluntary participation. In addition to this, the eligibility criteria have included being a migrant woman

aged 18-30 years having limited or no English proficiency residing in East London and having experience or awareness of cervical cancer screening services. The women who have been fluent in English or outside the specified age range have been excluded from the study.

3.2.3 Sampling method and sample size

The ***purposive sampling*** has been utilised as this has enabled the selection of participants who have possessed specific characteristics relevant to the research questions. This method is commonly used in qualitative public health research when the objective is to gain in-depth understanding rather than achieve statistical representativeness (Ahmad and Wilkins, 2025). The ***two participants*** have been chosen for recruitment in this research in which this sample size has been considered suitable for primary qualitative research as this has been beneficial for detailed exploration of individual experiences while remaining manageable for in-depth analysis. Furthermore, the data saturation has been monitored throughout the primary data collection process with saturation deemed to have been achieved when no new themes emerged from subsequent interviews, hence PRISMA would not be done in this research. The diversity across the sample includes differences in cultural background, length of residence in the UK and previous healthcare experiences by enhancing the richness and transferability of the findings.

3.2.4 Study participants

Their research participants have been non-English speaking migrant women aged between 18 and 30 years residing in East London. The participants have originated from South Asia, the Middle East and Africa showing the multicultural demographic profile of the research settings. The interviews took place in religious place. The majority of the participants have reported limited familiarity with the National Health Service on varying levels of understanding regarding cervical cancer on screening processes. The several participants had received screening invitations but experienced challenges understanding written communication or navigating appointment systems due to language issues. Others have reported reliance on family members or community networks for health-related information. The two participants' characteristics enabled exploration of how language proficiency, health literacy and cultural norms interact to influence screening behaviours and healthcare engagement.

3.2.5 Materials and data collection methods

Data collected using ***one-to-one semi-structured interviews*** have been conducted ***face-to-face*** in community venues that have been familiar and accessible to participants. The semi-structured linen reviews have been chosen as they allow flexibility while ensuring consistency

across participants through use of an interview guide with **open-ended questions** (Shoozan and Mohamad, 2024). The reason behind choosing primary vs secondary has been justified here to get first-hand data from the participants based on their views in this study context to avoid bias. The information accumulated by two participants were in non- English language [Hindi].In this respect, the information were further translated in English language in terms of interpreting the information within the research findings. Hence, the interview guide has been developed based on the research objectives and existing literature on cervical cancer screening and migrant health.

The questions explored participant's understanding of cervical cancer, experiences of receiving screening information, communication with healthcare professionals, perceived language barriers, cultural beliefs and suggestions to improve service accessibility. The interviews have been conducted in two participants' preferred languages. Conducting interviews among the participant's native languages has facilitated open discussion of sensitive topics by improving data accuracy (Cassim et al. 2022). Likewise, the interviews lasted between 15-20 minutes with audio-recorded as taking consent of the two participants.

3.2.6 Data analysis technique

The primary qualitative data has been collected through semi-structured interviews by evaluating the **thematic analysis**. This method has been selected due to their flexibility and suitability for recognising patterns across the qualitative datasets. The analysis has followed the six-phase framework proposed by Braun and Clarke (Byrne, 2022). This primary qualitative research has been followed with repetition of reading all interview transcripts initially to achieve familiarisation with the data and to gain an overall understanding of participant's experiences. The preliminary ideas and reflections have been recorded during this phase of thematic data analysis (Braun and Clarke, 2022). The insights have been gained from the participants and the themes have been compared and contrasted to get the main outcomes of their research.

Furthermore, the second phase has been involved to generate initial codes by identifying meaningful segments of text related to the language barriers, health literacy, cultural beliefs and healthcare access. The related codes have been collaborated and organised into potential themes representing shared experiences across the participants during the third phase (Ahmed *et al.* 2025). These themes have been reviewed and refined to ensure the internal coherence and clear distinction between themes. The fifth phase has involved defining and naming each theme based **on interview responses** to understand their core meaning as well. The themes have been interpreted in relation to the research objectives and existing literature.

This analytical approach of primary interview based thematic analysis has been supported with the peer-reviewed articles to provide a comprehensive and transparent investigation of the way language and health literacy influence cervical cancer screening participation.

3.2.7 Tools and materials used

There are several tools and materials utilised to support the effective data collection, management and analysis of these methods. The semi-structured interview guide has been generated to ensure consistency across the interviews while allowing flexibility for participants to share their experiences. In addition to this, the audio-recording devices have been used to accurately understand interview data by ensuring that participant's responses have been recorded in full length. The interview recordings have been transcribed verbatim to maintain data accuracy also (Ahmed *et al.* 2025). The standard word processing software has been also utilised to organise transcripts by supporting manual coding during thematic analysis (Christou, 2022). The reflexive considerations throughout the research process. The secure, password-protected digital storage systems have been used to store all audio files, transcripts and consent forms (Eftekhari, 2024). These tools have ensured systematic data handling by enhancing transparency and supporting the overall rigour of the qualitative research procedures.

3.2.8 Ethical considerations

The ethical approval for the research has been obtained from the Research Ethics Committee of the University of Wales Trinity Saint David prior to data collections. The ethical principles of autonomy, beneficence, non-maleficence and justice guided the research process. The participants have been provided with detailed information about the research aims, procedures, potential risks and benefits before the participant (Nii Laryeafio and Ogbewe, 2023). The verbal and written informed consent have been obtained from all participants.

The participation was voluntary and participants have been informed of their right to withdraw from the research at any stage without providing a reason (Mathews, 2022). The confidentiality has been maintained by anonymising all data by assigning pseudonyms to participants. The identifiable information has been kept securely and separately from the interview transcripts. The interviews have been conducted with cultural competence, empathy and respect to reduce distress by considering the sensitive nature of the topic.

Furthermore, this research has ensured lawful, fair and transparent processing of personal data to comply with UK GDPR and the Data Protection Act (DPA) 2018 (Roselin and Putra, 2025). Only data necessary for the research purpose have been collected following data

minimisation principles. The participants have been informed about the way their data would be utilised, stored and retained, All identifiable data have been anonymised and stored on password protected, encrypted devices accessible only to the researcher. The data have not been shared with third parties and will be retained for the required institutional period before secure deletion. These measures have ensured confidentiality, integrity and accountability throughout the research process in alignment with the legislation.

3.3 Evaluation of the methods

3.3.1 Challenges encountered and overcoming ways

Several significant challenges have been encountered during the research process. The participant recruitment has been challenging due to language barriers, limited trust in academic research and competing responsibilities including employment, childcare and domestic commitments. Some potential participants have been hesitant to discuss sensitive reproductive health topics especially cervical cancer screening. These challenges have been explored through collaboration with community organisations and migrant support groups which have acted as trusted gatekeepers.

In addition to this, reassuring participants about confidentiality and voluntary participation have assisted the bilingual community workers in explaining the purpose of the research. The scheduling challenges have been overcome by providing flexible interview times to conduct interviews in familiar community-based contexts.

3.3.2 Effectiveness of the research approach

This primary qualitative research approach has been selected for this research with efficacy in addressing the research aim and objectives. The semi-structured interviews have allowed the participants to share detailed accounts of their experiences with cervical cancer screening and healthcare communication. This approach has been beneficial to explore the complex interactions between language, health literacy, cultural beliefs and healthcare navigation. The interpretivist orientation has supported an in-depth understanding of the way social and cultural contexts shape screening behaviours (Wu *et al.* 2025). However, the small sample size could limit research generalisability, qualitative research prioritises depth and meaning. The richness of the data and recurrence of key themes indicate that the methodological approach has been strong and suitable for this public health research.

3.3.3 Justification of the methods

The primary qualitative method has been employed well-suited to the research population and context. Conducting interviews in participant's preferred languages have enhanced data quality and reduced power imbalances. Community-based recruitment has supported inclusion of marginalised voices often excluded from health research (Charles-Rodriguez *et al.* 2025). The thematic analysis has provided a systematic, yet flexible framework to identify patterns across the participant's narratives. On the other hand, the quantitative methods could measure screening uptake, they would not understand lived experiences or contextual barriers. Thus, the chosen qualitative approach is most suitable for answering the research question to meet the research objectives.

3.4 Summary

This chapter has presented the methodological framework underpinning the research by providing a clear rationale for the research approach, design and methods adopted. The qualitative, interpretivist philosophy has been chosen to explore the way language and health literacy influence cervical cancer screening participation across non-English speaking migrant women aged 18-30 years in East London. The chapter has explained the utilisation of a descriptive exploratory qualitative research design supported by purposive sampling and semi-structured interviews. The recruitment through religious place have enabled access to a marginalised population and supported culturally sensitive engagements. Conducting interviews in participant's preferred languages with the emotional support where enhanced comfort, trust and data quality.

The thematic analysis has been employed as the interview data analysis by providing transparent methods to identify patterns across the participant's narratives. The utilisation of established analytical stages has strengthened rigour by supporting coherence between the research objectives, findings and interpretations. The tools including audio recording, transcription, reflexive journaling and secure data storage have supported methodological transparency and data integrity also.

The ethical considerations have been integral to the research process in which the ethical approval from the Research Ethics Committee of the University of Wales Trinity Saint David has ensured adherence to the ethical standards. The informed consent, confidentiality, voluntary participation and compliance with UK GDPR and the Data Protection Act 2018 has protected participant's rights and well-being. The methodology has been suitable, strong and associated with the public health research conventions to provide a strong foundation for the

presentation and interpretation of findings in this research. This has ensured methodological credibility, reflectivity and transparency while clearly linking research design choices to the research aim, objectives and data requirements of the target population groups.

Chapter 4: Results and discussion

4.1 Introduction

The findings chapter is going to evaluate the overall approach through which the information is accumulated within this research. Based on this aspect, an interview has been conducted within this chapter in terms of accumulating primary qualitative information. Two interview participants, having working experience within the UK in the healthcare sector, have been selected to conduct the interview *[refer to appendix 1 and 2]*. The data analysis chapter is going to be a crucial aspect as it transforms raw data into actionable insights, forming the evidence base for conclusions and guiding strategic decisions in research, by uncovering patterns, predicting outcomes, improving efficiency, and providing a competitive edge through an objective, data-driven understanding. The accumulated information will further be interpreted through a thematic analysis in terms of evaluating its relevance towards the thesis topic. The evaluation of this chapter is considered to be as crucial as interpreting the thesis findings, explaining significance, connecting them to existing literature, and demonstrating critical thinking.

4.2 Primary qualitative findings

Question 1: How much knowledge do you have about cervical cancer screening?

Participants	Respondents
Participant 1	<i>"I had heard about cervical cancer, but did not have much information. However, after visiting the UK, I have learned about the availability of screening techniques for detecting cervical cancer."</i>
Participant 2	<i>"Honestly, I did not have much information about it at all...about the process, and time variations...I just know the term cervical cancer screening."</i>

Table 4.1: Responses of Interview question 1

Question 2: What has been your experience communicating with healthcare professionals (doctors or nurses) about cervical cancer screening?

Participants	Respondents
Participant 1	<i>"I believe that the experience with healthcare professionals regarding cervical cancer is generally good, but language is a problem. I do not fully understand the UK English accent, and they may not understand us properly, which has made me feel nervous."</i>
Participant 2	<i>"I recognize some problems during screening time...The staff and nurses are nice, but we do not understand their language... Even if we want to ask something, we cannot, the medical terms are difficult... There are also many words that we cannot understand."</i>

Table 4.2: Responses of Interview question 2

Question 3: What were your thoughts about cervical cancer before migrating to the UK?

Participants	Respondents
Participant 1	<i>"I believe that cancer is one of the most serious diseases in our country, which has made the population feel scared, and I also felt afraid thinking about cervical cancer"</i>
Participant 2	<i>"Back home, people never talk about tests for private body parts, as well as their importance... We mostly show ourselves only to female doctors in critical times.... We didn't have any information about screening at all....in many countries, screening is still not common...but in the UK, there is a lot of focus on screening and its importance."</i>

Table 4.3: Responses of Interview question 3

Question 4: What difficulties do you face when talking to healthcare staff?

Participants	Respondents
Participant 1	<i>"I believe that language barriers have made me feel uncomfortable while communicating with healthcare practitioners regarding the screening of cervical cancer. Staff mostly speaks English, which makes us confused and stressed because we miss important information."</i>
Participant 2	<i>"It's actually the language barriers...I get very confused when I do not understand what they are saying...the medical words are very difficult to understand and I cannot ask questions....A gap within the screening process has arisen.."</i> <i>by them, and our English is also not that good."</i>

Table 4.4: Responses of Interview question 4

Question 5: Do cultural beliefs affect your decision to participate in screening?

Participants	Respondents
Participant 1	<i>"Yes, I believe that topics related to women's body parts are not discussed openly, which makes us uncomfortable. Additionally, routine screening is not common unless there are serious symptoms."</i>
Participant 2	<i>"Based on my experiences and knowledge, in many families these topics are not discussed at all...that does not mean that family members are not concerned...we just feel awkward to talk about this health issue"</i>

Table 4.5: Responses of Interview question 5

Question 6: How did you feel when you received the screening invitation letter?

Participants	Respondents
Participant 1	<i>"I have received the screening letter, but my English is not very good. This has made me feel nervous as well as had difficulty understanding the information".</i>
Participant 2	<i>"Normally, when I saw the letter, I got very tense...the term cervical cancer and seeing such letters is very scary. Many times, I do not understand what to do or which doctor to see..."</i>

Table 4.6: Responses of Interview question 6

Question 7: Do privacy concerns related to culture or religion affect your comfort?

Participants	Respondents
Participant 1	<i>"Yes, I believe that privacy has been very important to us. We feel more comfortable if a female doctor examines us and if there is a private and respectful environment."</i>
Participant 2	<i>"Actually, we never talk about these things at home and in public places with anyone. It feels really awkward to go for a screening...if the appointment shows a male doctor's name...it feels very uncomfortable. Many times, I have booked an appointment and then cancelled it, just because of this fact"</i>

Table 4.7: Responses of Interview question 7

Question 8: What kind of support would you like from our side to better understand cervical cancer screening?

Participants	Respondents
Participant 1	<i>"I have realised that if information is explained in our own language, or through videos, it would help us understand screening better and reduce nervousness."</i>
Participant 2	<i>"If you consider my vision, I would say, when someone explains about the treatment process calmly in our own language. Value our viewpoints... and if there are video or visual materials to explain the conditions properly...it would be much better."</i>

Table 4.8: Responses of Interview question 8

Question 9: How would it be if there were bilingual staff at GP practices who could speak two languages?

Participants	Respondents
Participant 1	<i>"I believe that this would be very helpful, as I would make information easier to understand and reduce anxiety, encouraging more women to participate in cervical cancer screening comfortably."</i>
Participant 2	<i>"I feel very good as we could ask questions freely, and they easily understand us...We can understand them better, able to support the screening process...ultimately benefit"</i>

Table 4.9: Responses of Interview question 9

4.3 Primary analysis (Thematic)

Theme 1: Non-English speaking migrant women are getting aware of cervical cancer screening initiatives, and it's important after moving to the UK

According to the primary qualitative findings, an interview participant has stated that the communication gap between healthcare practitioners and patients can hinder care quality services, especially in the case of cervical cancer screening **[refer to appendix 1]**. As per the analysis of Chandrakumar *et al.* (2022), cervical cancer is considered to be the fourth most common cancer found within women in both incidence and mortality. This creates a burden on women belonging to diverse cultures and linguistic backgrounds. Similar to the context, the interview participant has agreed to this fact by stating that “we never talk about these things at home and in public places with anyone. It feels really awkward to go for a screening”. This signifies that the availability of female doctors in the case of cervical cancer screening tests helps women to feel encouraged as well as motivates them to communicate clearly. On the other hand, Yuill *et al.* (2024) have highlighted that healthcare literacy among women is necessary for strengthening communication between practitioners and care seekers. However, the interview participants have highlighted that communicating with healthcare professionals in a similar language can be helpful in understanding the key aspects of cervical cancer screening treatment.

According to the interview outcome, the participant has stated a lack of knowledge of cervical cancer screening. Siseho *et al.* (2022) have highlighted that the lack of knowledge about cervical cancer screening signifies the rarity of the treatment within the country. It has been recognised that the interview participant has agreed to the fact that the communication gap between healthcare professionals and patients leads to hindered care quality services. As per the analysis of Renwick *et al.* (2024), poor literacy contributes to poor knowledge about risk factors and screening importance, despite general awareness campaigns. Al-Ghunaim *et al.* (2022) have stated that the lack of communication between professionals and patients leads to increased workload, burnout as well as misunderstanding of care. Thus, Poor communication during handoffs between providers can cause critical information loss, leading to harm.

It has been recognised that both of the interview participants have supported that the lack of communication between healthcare professionals and care seekers can hinder the treatment of cervical cancer screening **[refer to appendix 1]**. For instance, the interview participant has stated that staff and nurses work within a collaborative environment; however, language barriers have hindered the quality-of-care services to a great extent. As per the analysis of

Olani *et al.* (2023), language barriers in healthcare lead to miscommunication, increased medical errors, poorer patient safety, reduced quality of care, lower patient satisfaction, decreased access to services, treatment delays, and higher readmission rates. Similar to the context, the interview participant has stated that language barriers have led to reduced understanding of cervical cancer screening. Inability to describe symptoms accurately or understand instructions leads to diagnostic inaccuracies, wrong medications, and adverse drug events.

Theme 2: Language, culture and system barriers are the main challenges to migrant women during cervical cancer screening

Poor English proficiency or a lack of translated materials hinders understanding of the importance, process, and results of screening (Colina *et al.* 2022). However, as per the interview participants, the understanding of the UK English language within the healthcare system has developed a challenging aspect for most of the migrant care seekers in the UK. As per the key findings of Abu-Odah *et al.* (2022), have highlighted that the utilisation of knowledge generated from health research has guided clinical practitioners to respond to rapid increases in evidence production and knowledge base development. On the other hand, Barrio-Ruiz *et al.* (2024) have argued that cultural and systemic barriers are major challenges for migrant women seeking cervical cancer screening, stemming from taboo subjects such as sexual health and family control over healthcare decisions.

On the contrary, the interview participant, has highlighted that communicating with the UK's healthcare professionals was a good experience; however, the UK English accent has created a challenging situation for migrant care seekers or practitioners. Similar to the context, Opia and Matthew (2025) have argued that cultural issues create knowledge gaps, increase fear and embarrassment as well as hinder access, necessitating tailored, multilingual, and culturally sensitive interventions in terms of improving screening uptake, especially in the case of cervical cancer among women. Similar to the context, Mansour *et al.* (2024) have contradicted that adequate service accessibility and information delivery by bilingual staff helps to enhance information delivery, resulting in clarity as well as reducing the risk of misinformation.

The interview participant has stated that "Back home, people never talk about tests or private body parts" [*refer to appendix 2*]. This signifies that fear of judgment, embarrassment as well as cultural interpretations of health can deter women from seeking care. As per the key findings of Choukou *et al.* (2022), lack of health information in native languages as well as low health literacy impede understanding of screening's importance, particularly in the case of

cervical cancer. This signifies that, women feel comfortable in consulting female clinical practitioners rather than males in the case of cervical cancer screening. On the other hand, Collie *et al.* (2022) have stated that complex scheduling, lack of female practitioners as well as difficulties in accessing family doctors create structural hurdles. Similar to the context, the interviewee has highlighted that “She used to consult female practitioners, however have no idea regarding the screening process. This showcases that negative past experiences or general distrust within unfamiliar healthcare systems reduce participation to a great extent. Thus, cultural barriers significantly challenge migrant women seeking cervical cancer screening, alongside language issues, lack of knowledge, stigma, fear, and structural hurdles like navigating healthcare systems, requiring tailored, culturally sensitive programs with translated materials, female providers, and community engagement for better uptake.

The interview participant has stated that rising language barriers result in a developing knowledge gap. This further results in making care seekers confused and stressed due to the development of an extensive knowledge gap regarding the screening process of cervical cancer. As per the analysis of Bartlett Ellis *et al.* (2023), difficulties in understanding treatment plans lead to low adherence to medications as well as follow-up care. On the other hand, the second participant has stated that “Medical words are very difficult, and we cannot ask questions” [*refer to appendix 2*]. This signifies the presence of a poor communication gap and language barriers between healthcare professionals and care seekers belonging from different cultures. On the contrary, Parry *et al.* (2024) have argued that language barriers within the healthcare system hinder access to care, longer wait times as well as increased likelihood of missing appointments. Thus, culturally tailored education, awareness campaigns in native languages as well as community-based strategies.

Theme 3: Adequate service accessibility and information delivery by bilingual staff at GP practices promote the cervical cancer screening initiatives to non-English speaking migrant women

According to the first interview participant, “Privacy is very important to us. We feel more comfortable if a female doctor examines us and if there is a private and respectful environment. As per the analysis of Chandrakumar *et al.* (2022), adequate service accessibility and information delivery by bilingual staff at GP practices are indeed crucial in promoting cervical cancer screening initiatives to non-English speaking migrant women. This is evidence that a significant barrier for migrant women is the language gap, whereas bilingual staff can effectively communicate the importance of screening, explain the procedure, and address concerns, which helps build trust and ensures informed consent. On the contrary, Henriksen *et al.* (2023) have argued that Bilingual healthcare providers often share cultural

backgrounds or are trained to understand the cultural sensitivities surrounding women's health issues. Similar to the context, the first interview participant has agreed to the fact that the availability of bilingual staff can help in making healthcare information easier to understand as well as reduce anxiety among care seekers.

The second interview participant has stated that the use of videos and visual materials can significantly enhance healthcare information understanding. As per the key findings of Otaigboria (2024), bilingual staff at GP practices are crucial for bridging language and cultural gaps, improving patient safety by preventing misunderstandings, increasing access to care for diverse populations, and building trust. Similar to the context, Horvath and Molnar (2022) have highlighted that Bilingual healthcare staff translate medical terms and concepts that help in ensuring both patients and providers understand each other accurately, which reduces errors in diagnosis and treatment. On the other hand, Mavreles Ogradnick *et al.* (2024) have highlighted that the use of qualified interpreters or bilingual staff is considered a best practice to achieve health literacy regarding screening. According to the findings of the second interview participant, the availability of bilingual staff at GP practices can be helpful in asking questions freely. This can help in addressing the potential risks that are associated with cultural, language and communication gaps between professionals and care seekers.

The first interview participant has highlighted that, interventions designed to overcome language and cultural barriers are effective in increasing the uptake of cancer screening services among migrant populations **[refer to appendix 1]**. However, the second participant has highlighted that adequate service accessibility and information delivery by bilingual staff at GP practices are indeed crucial in promoting cervical cancer screening initiatives to non-English speaking migrant women. As per the analysis of Vallone *et al.* (2022), healthcare providers and public health bodies often emphasise the need for culturally appropriate cervical cancer screening information to improve participation. Thus, targeted, culturally and linguistically sensitive outreach, including the use of bilingual healthcare providers and translated materials, can significantly improve screening rates and overall health outcomes for women with cervical cancer.

4.4 Discussion

4.4.1 Discussion of themes

Discussion of theme 1

It has been recognised from the findings section that language barriers, along with the low literacy of the migrant women, hinder the cervical cancer screening process. Poor understanding of this target group and the cultural barriers leads to insufficient knowledge about cervical cancer and screening. However, contradicting with existing literature, Chandrakumar *et al.* (2022) have highlighted that cervical cancer is the fourth most common disease among women in both incidence as well as mortality. This disease rate has not only created a burden on migrant women as these individuals belong to diverse cultures and linguistic backgrounds. Similar to this context, Yuill *et al.* (2024) have discussed the poor health literacy of migrant women that creates barriers while strengthening communication between practitioners and care seekers. Participant 1 has stated the belief on cancer, that “it is one of the most serious diseases in our country, which has made the population feel scared, and I also felt afraid thinking about cervical cancer”. The low awareness level of participants about this health risk has been recognised from the interview analysis.

The cervical cancer screening process, healthcare team members such as GPs and nurses face issues in making the patient understand the significance regulator check-up. As per the findings of Renwick *et al.* (2024), poor literacy leads to poor knowledge about risk factors. The screening, despite general awareness campaigns, is the use of policies to promote the awareness of migrant women about the cervical cancer screening process. Participant 2 has mentioned that “I did not have much information about it at all about the process, and time variations...I just know the term cervical cancer screening”. However, the existing literature review contradict that the rising issues of social discrimination and stigma are considered to be a major barrier that impacts women’s accessibility to required care and screening initiatives for cervical cancers (LeBlanc *et al* 2025). Contrarily, Siseho *et al.* (2022) have highlighted that the lack of knowledge about cervical cancer screening signifies the rarity of the treatment within the country.

The literature review section has highlighted the hindrances towards cervical screening initiatives for migrant women due to lower awareness and health literacy. As per Ozturk (2024), the cervical cancer screening as well as awareness campaign, among migrant women in their native language and promote the awareness level. However, analysing the qualitative information, the screening for cervical cancer is effective for improving awareness among

migrant women in order to reduce the risk of death. It can be stated from the above context that the poor literacy and understanding level of the migrant women not only affects their health, but also impacts the cervical cancer screening system in the UK. The literary sources have highlighted that improving non-English speaking migrant women's awareness within the field of the screening of cervical cancer information sharing and building engagement has been considered as fundamental. As per Silva *et al.* (2024), cultural barriers while accessing healthcare services, including linguistic barriers, affect the uptake of cervical cancer screening among migrant women.

It has been reflected from this context that low health literacy as well as poor English proficiency, negatively affected women's cervical screening as well as overall disrupted the healthcare outcome of the individuals in the UK. However, it has been argued that Poor English proficiency or a lack of translated materials hinders understanding of the importance, process, and results of screening (Colina *et al.* 2022). From the interview transcript, the belief of participant 1 regarding the effective healthcare system of cervical cancer in the UK has been recognised. The respondents of participant 1 on the communication experiences during the scoring process include 'healthcare professionals regarding cervical cancer as generally good, but language is a problem. I do not fully understand the UK English accent, and they may not understand us properly, which has made me feel nervous.

According to Olani *et al.* (2023), language barriers in the field of healthcare lead to miscommunication. However, contradicting existing literature, initiating "cultural competency training" for healthcare staff can be beneficial for delivering required services and providing necessary information by ensuring patient engagement and elevating 'quality of care' (Afulani *et al.* 2023).

The migrant women commonly misunderstand the cervical cancer screening procedures by not understanding the clear instructions of the GP. Al-Ghunaim *et al.* (2022) have also stated that the lack of communication between professionals and patients promoted unnecessary workload and burnout. Poor communication during handoffs among providers can be the reason for critical information loss, leading to harm. Contrary to existing literature, Afsah and Kaneko (2023) have argued that health literacy and language have been important factors for the awareness of the Cervical Cancer Screening among the non-English-speaking migrant women to overcome the language barrier. Similarly, Cha and Chun (2021) have outlined cancer literacy along with inefficient knowledge among migrant people due to lower educational levels.

Participant 2 has provided the respondents with the language experiences. Participant 2 has stated that “I recognise some problems during screening time... The staff and nurses are nice, but we do not understand their language... Even if we want to ask something, we cannot, the medical terms are difficult”. However, Mansour *et al.* (2024) have contradicted that adequate service accessibility and information delivery by bilingual staff helps to enhance information delivery, resulting in clarity as well as reducing the risk of misinformation. It can be stated from the above discussion that migrant women who are non-English speakers are less aware of the cervical cancer screening process, which is led by the language gap.

Discussion on theme 2

According to the primary qualitative analysis, the lack of communication between healthcare professionals and care seekers arises due to cultural aspects. Practitioners from different cultural backgrounds face difficulties in communicating with care seekers, resulting in developing conflicting situations. However, contradicting existing literature, Dougherty *et al.* (2021) have argued that health literacy can be defined as the set of knowledge, motivation, and competencies needed by people to access health services in the migrant population. This is especially crucial as well as often challenging for migrant populations navigating new healthcare systems, cultures, as well as languages. However, the interview participant has highlighted that healthcare literacy is necessary for enhancing the care service, especially regarding the screening process of cervical cancer. On the other hand, Gogoi *et al.* (2025) have argued that the non-English-speaking migrant might have the option to gain access to health facilities due to a lack of information and a language barrier. This signifies that the non-English-speaking migrants might lack health literacy due to a lack of support and financial issues in accessing the service from the healthcare organisation.

According to the interview transcript, language, cultural, and system barriers are consistently identified as major obstacles preventing migrant women from participating in cervical cancer screening, leading to lower uptake due to communication issues, cultural beliefs, stigma, lack of culturally sensitive information, and difficulties navigating healthcare systems. Barrio-Ruiz *et al.* (2024) have stated that cultural and systemic barriers are major challenges for migrant women seeking cervical cancer screening, stemming from taboo subjects such as sexual health and family control over healthcare decisions. However, contradicting existing literature, Woods *et al.* (2022) have argued that limited English proficiency is considered to be a common issue facing patients from immigrant backgrounds in UK healthcare, as a lack of language proficiency has impacted the intervention process.

According to the key findings, poor English proficiency or a lack of translated materials hinders understanding of the importance, process, and results. Individuals might not understand medical instructions, public health warnings, or safety protocols, leading to potential health risks and accidents. Thus, Limited English proficiency can prevent people from engaging fully in their communities, understanding their rights, or participating in democratic processes such as voting.

The qualitative findings state that A lack of English proficiency or translated materials can indeed create significant barriers to understanding crucial information, processes, and results in various sectors such as healthcare, legal systems, and public services. For instance, the interview participant has stated that “I believe that language barriers have made me feel uncomfortable while communicating with healthcare practitioners regarding the screening of cervical cancer. Stagg mostly speaks English, which makes us confused and stressed because we miss important information.” However, contradicting existing literature, Ghorbanian Zolbin *et al.* (2022), health literacy has helped in developing customers among the patients seeking better interventions to have a quality life. It can be interpreted that the culturally adapted education related to the screening of Cervical Cancer clarifies that screening is a form of prevention for asymptomatic individuals. Similar to the context, Nwafor *et al.* (2025) have argued that the cultural backgrounds and speaking languages have an impact on the health outcomes of the non-English speaking women due to difficulties in understanding medicines in their healthcare, often contributing to poorer health outcomes. Thus, poor English proficiency or a lack of translated materials hinders understanding of the importance, process, and results.

The qualitative findings highlight that lack of communication between healthcare professionals and patients leads to serious consequences like medical errors, misdiagnosis, treatment delays, poor patient outcomes, decreased patient satisfaction, increased complaints, and higher costs due to repeated tests or ineffective care. However, contradicting existing literature, Scott and Hoskin (2024), have highlighted that Health literacy plays a pivotal role in timely healthcare awareness among the non-English speakers in the case of cervical cancer screening. Similar to the context, the interview participants have highlighted that “Medical words are very difficult to understand and I cannot counter questions”. The existing literature suggests that the screening process of cervical cancer is extremely low among immigrant women due to barriers from the diverse religious values, beliefs, and fatalism that have created an impact on the outcome (Afsah and Kaneko, 2023). Additionally, adopting the concept of the Cultural Competence Model can help reduce the effectiveness of cervical cancer screening among migrant women and enhance treatment quality. Thus, a multifaceted

approach has been used for applying the Cultural Competence Model in the healthcare segment for addressing the language barriers.

Discussion of theme 3

Coming to this theme, 3 has depicted the comparison and contrast of the literature review and findings inferences. The way adequate service accessibility and information delivery by bilingual staff influences cervical cancer screening across non-English speaking migrant women. This section also reinforces the argument from the literature review and findings to establish potential results on language and cultural barriers. On the contrary, Parry *et al.* (2024) have argued that language barriers within the healthcare system hinder access to care, longer wait times as well as increased likelihood of missing appointments. These are central factors for screening participation while also adding experiential depth through the participant narratives.

The literature review has provided insights that bilingual healthcare provision improves communication, trust and informed consent especially across the preventive services including cervical cancer screening (Chandrakumar *et al.* 2022; Vallone *et al.* 2022). In aligning with the findings, the both interview participants have identified language accessibility as essential for understanding the screening process to minimise anxiety. One of the participants majorly focused on privacy. Gender preference and respectful environments reflected in the argument of Henriksen *et al.* (2023)'s reports in which the culturally informed bilingual providers are better positioned for addressing sensitivities surrounding women's reproductive health. Hence, the insights from this comparison agree that bilingual staff facilitate culturally suitable explanations supporting patient comfort and engagement.

On the other hand, the literature review inferences have provided practice information in which these barriers are experienced at the individual level. The participants have described proper consequences such as hesitation to ask questions, fear of misunderstanding and avoidance of appointments, while the literature broadly discussed communication gaps and structural inequalities (Otaigboria, 2024). This experiential evidence has enhanced strengths of the literature by enhancing the way theoretical barriers translate into real behavioural outcomes.

On the contrary, some of the views placed a higher focus on professional interpreters rather than bilingual staff implemented across the GP practices. The accurate translation as a mechanism to minimise clinical errors (Horváth and Molnár, 2022). Whereas findings suggest that continuity and cultural familiarity provided by bilingual staff might be equally significant in developing trust. In a similar context.

In addition to this, this has discussed the service accessibility largely at organisational and policy levels, whereas the thematic findings have provided patient perceived accessibility. The outreach strategies and system-level adaptations, while participant accounts focus on interpersonal reassurance, gender sensitivity and emotional safety across the consultations (Vallone *et al.* 2022). This contrasting view suggests that policy-driven accessibility initiatives might be insufficient when not accompanied by relational, culturally responsible practice. Thus, the complementary views of literature review and findings have demonstrated that the effective information delivery depends on the availability of services on the way care is experienced. The integration of both perspectives has supported a more holistic understanding of screening behaviour. This has also reinforced that the bilingual staffing functions simultaneously as a communication tool, cultural bridge and trust-building mechanism across the primary care settings nationally.

The challenges of the language and culture gap in cervical cancer screening for migrant women in the UK have been evaluated through the Cultural Competence Model. The Cultural Competency Model has emphasised the needs of understanding the social as well as cultural nuances in healthcare delivery during care (Liu and Li, 2023). Medical learning avenue establishment that promotes healthcare practices required to participate in training sessions for addressing the health literacy of migrant women. On the other hand, the findings section has highlighted the respondents of Participant 1 regarding the realisation “if information is explained in our own language, or through videos, it would help us understand screening better and reduce nervousness.” Similar to the context, Horvath and Molnár (2022) have discussed that Bilingual healthcare staff have the ability to address the language barriers in the cervical screening process. Bilingual healthcare staff translate medical terms and concepts that support in ensuring both patients and providers understand each other accurately, which reduces errors in diagnosis and treatment. The availability of bilingual staff at GP practices can help ask questions freely, which can help in addressing the potential risks associated with cultural, language and communication gaps between professionals and care seekers.

On the other hand, the literature review section has highlighted Andersen’s Behavioural Model of Health Services Use to better understand the factors that control the migrant women’s health accessibility. Application of this model can help in dealing with the aspects of predisposing factors like age, language and education. It became evident that the limited English proficiency of migrant women discourages this group of individuals from discussing cervical cancer screening. This signifies addressing the cultural issues in the medical segment that create knowledge gaps, increase fear and embarrassment as well as hinder access, dealing with sensitive interventions.

4.5 Reason why the outcome matters

It has been found from exploring and illustrating the literary sources and interview transcripts that migrant women in the UK have low health literacy. The difficult medical terms and conditions of cervical screening are difficult to understand for this specific group. On the other hand, the cultural and language barriers are a hindrance to understanding the importance of cervical cancer screening under the support and guidance of GPs and nurses. This finding is important as it highlights the areas of improvement in the UK cervical cancer screening system for migrant patients. Bilingual aspect integration during the screening process is the only way to address the language gap, as well as supporting the non-English speakers to be involved in the screening process in an effective manner. The findings or outcome of this research can make the UK GPs and nurses aware of the current gap in cervical screening. With the support of GPs, the migrant woman can address the cultural barriers as well as freely share about the problem with the healthcare team. Screening outcomes for cervical cancer can be promoted for migrant women in the UK healthcare system.

4.6 Practical Implications of the Findings

Practical implications of findings can include improving the UK healthcare system regarding the cervical cancer screening method. The healthcare team within the UK system, who are responsible for cervical cancer screening among migrant women, can focus on the cultural barriers and understand the issues. For instance, bilingual staff who can make the migrant women understand the cervical cancer screening process can be involved. This specific healthcare team can shape the algae barrier issues and ensure the cervical cancer screening process for non-English speaking and migrant women in an effective manner.

4.7 Chapter summary

The above-mentioned chapter concludes that language is one of the pivotal aspects in the healthcare system that helps in maintaining relationships between professionals as well as care seekers. Apart from this, increasing the literacy level can help healthcare practitioners and care seekers to learn about cervical cancer screening techniques. On the other hand, language and health literacy have been recognised as a crucial aspect in cervical cancer screening. Low levels of understanding hinder understanding of risks, benefits, and procedures, leading to poor participation, even with awareness. Poor literacy affects accessing, understanding, appraising, and applying health information, making women less likely to get screened, while effective communication using plain language as well as culturally sensitive materials is vital for informed decisions and improving screening uptake, especially

in vulnerable groups. Additionally, informed choices about Pap tests or HPV vaccines require comprehending risk, prevention, and treatment, which is challenging with low literacy.

It can be concluded from the above discussion that cervical cancer is the fourth most common disease among women in both incidence and mortality. Poor knowledge of the migrant women group has promoted an information and communication gap between patients and the health team. The screening, despite general awareness campaigns, is the application of policies to promote the awareness of migrant women about the cervical cancer screening process. The non-English speaking migrant women commonly misunderstand the cervical cancer screening procedures by not understanding the clear instructions of the GP.

According to the interview transcript, language, cultural, and system barriers are consistently identified as major obstacles preventing migrant women from participating in cervical cancer screening. It leads to lower uptake due to communication issues, cultural beliefs, stigma, lack of culturally sensitive information, as well as difficulties navigating healthcare systems. Therefore, the bilingual aspect integration in the screening process is the only way to address the language gap, and it can support non-English speakers to be involved in the screening process.

Chapter 5: Conclusion

5.1 Conclusion

This dissertation has addressed the way language barriers and health literacy influence cervical cancer screening participation across non-English speaking migrant women aged 18-30 years living in East London. The research has provided in-depth insights from two participants, providing their understanding of the way communication, cultural norms and healthcare experiences shape screening behaviours. The findings describe limited English proficiency. Low familiarity with preventive healthcare and culturally implemented perceptions of productive health significantly restrict access to and engagement with cervical cancer screening services.

Both of the participants have reported the challenges on understanding NHS screening invitations, medical terminology and verbal explanations provided during GP consultations. These challenges have been closely aligned with anxiety, fear and delayed decision-making. The cultural expectations surrounding privacy, modesty and gender preferences further influenced participants with expressing strong motivation to engage in screening when information has been delivered in an accessible and culturally sensitive manner.

This research has highlighted that language and health literacy are not peripheral challenges but central determinants of preventive healthcare access. This barrier has been addressed by reducing health inequalities to improve cervical cancer screening uptake among migrant women. This chapter concludes by answering the main research question, reflecting on the research process, presenting practical recommendations and focusing on the contribution of the research to public health knowledge.

5.2 Answering the main research question

The research questions on assessing factors of language barriers and low health literacy mainly encourage cervical cancer screening participation across non-English speaking migrant women. These two women as participants, have experienced issues on understanding screening information and communicating with healthcare professionals to direct the NHS systems. These issues can contribute to fear, confusion and reduced confidence, especially delaying or discouraging screening updates. Hence, the research question has addressed that language and health literacy with critical factors shaping screening behaviours.

5.3 Reflecting on the research

This has identified the research process, the primary qualitative design proving suitable to understand the lived experiences of migrant women, recognising cervical cancer screening. This research has conducted semi-structured interviews among two participants to express their emotional, cultural and linguistic challenges in their own words. The reflexive approach has adopted throughout data collection and analysis supported credibility and ethical sensitivity. However, the time constraints and reliance on self-reported data also shaped the depth of findings. The research process has enhanced understanding of the way personal experiences are divided with structural barriers in public health contexts despite these limitations.

5.4 Recommendations

Recommendation 1: Enhancing written communication and translated materials

This recommendation depends on enhancing written communication through the provision of translated and simplified cervical cancer screening information. The two participants have provided insights on the challenges understanding NHS invitation letters, medical terminologies and appointment instructions which made anxiety and delayed decision making. In this context, Hanrahan *et al.* (2025) stated that the GP practices need to provide screening invitations, reminders and informational leaflets in commonly spoken community languages.

The translated materials need to be routinely reviewed for accuracy and cultural relevance, engaging community representatives where possible. In such context, Horváth and Molnár, 2021) mentioned that the implementation has standardised multilingual communication by reducing confusion, increasing confidence and supporting informed participation. This has improved written accessibility by directly addressing language barriers. This has also been identified by representing the cost-effective strategy to improve equitable access in cervical cancer screening services (Sun *et al.* 2023).

This approach has aligned with public health equality duties by promoting consistent messaging across the primary care context for migrant women while supporting trust, engagement and long-term preventive health behaviour change across the diverse urban communities across the NHS nationally.

Recommendation 2: Increasing strengths of interpreter services and bilingual staff members

This has focused on strengthening access to the professional interpreters and bilingual healthcare staff across the primary care services. The participants have described feeling unable to ask questions to express concerns during GP appointments due to limited English proficiency. On this point, Wearne and Shepherd, (2024) mentioned that this has reduced confidence and discouraged engagement with cervical cancer screening. GP practices serving diverse populations need to ensure timely access to trained interpreters during consultation especially for preventive services. The interpreter support needs to be proactively offered rather than to require patients requesting this.

In addition to this, Sharma *et al.* (2023) highlighted that the bilingual staff can further improve communication by explaining processes clarifying medical terminology and providing emotional reassurance. The effective interpreter supports informed consent by reducing misunderstandings, which might result in missed appointments or screening avoidance. Staff members need to receive guidance on working effectively with interpreters to balance confidentiality and patient dignity (Martinez *et al.* 2025).

The continuity of interpreter provision can enhance trust and patient satisfaction. Furthermore, Beauchamp *et al.* (2022) opined that the services acknowledge language as a structural barrier rather than an individual deficit to implement language support into routine care. This has strengthened interpreter services directly responding to participant experience by promoting equitable access to cervical cancer screening. This suggestion supports inclusive healthcare delivery improving patient experience and contributing to reducing health inequalities across the migrant women within primary care systems across England.

Recommendation 3: Improving cultural competence and gender sensitive care

This can be beneficial to improve cultural competence and gender sensitive care across the cervical cancer screening services. Both participants have been highlighting cultural beliefs related to modesty, privacy and discomfort discussing reproductive health that influenced screening participation. In this regard, Yu *et al.* (2023) reported that the healthcare professionals need to receive structured cultural competence training which addresses diverse beliefs, values and communication styles. The training needs to emphasise respect for privacy, awareness of stigma and sensitivity to emotional concerns related to screening. On this point, Kitole *et al.* (2025) asserted that gender preference has emerged as a significant factor with participants expressing strong preference for female healthcare professionals.

The person has centred approaches, which encourage open discussion, and reassurance can be beneficial to women feeling safe and respected. Cultural competence needs to be viewed as an ongoing professional skill rather than a onetime intervention (Chu *et al.* 2022). This has implemented culturally sensitive practices by supporting trust building to improve patient engagement. This has also addressed the cultural and gender related barriers along with the language needs which could enhance accessibility. This can ensure cervical cancer screening services for responsive to the needs of migrant women from diverse backgrounds.

Recommendation 4: Expanding virtual, digital and community-based education

This can promote the expansion of the utilisation of visual, digital and community-based educational approaches to improve understanding of cervical cancer screening. The participants have expressed a preference for visual explanations and videos over the written information. NHS services need to develop short multilingual videos explaining the aim of screening, which can occur during appointments, reassurance about the safety and confidentiality (Husain and Greenhalgh, 2025). The visual resources can reduce fear and support comprehension among people with lower literacy.

The digital materials can be shared through GP websites, text message links and social media platforms to enhance research. The community-based education delivered in collaboration with local organisations can further improve the engagement (Chowdhury and Alzarrad, 2025). Trusted community settings can provide safe spaces for discussion to reduce stigma associated with reproductive health. The peer educators and community health workers can drive information in culturally appropriate ways (Komi *et al.* 2022). The education could be delivered outside clinical environments which might influence earlier engagement with services. This recommendation can identify that the health information needs to be accessible, relatable and culturally relevant to influence preventive health behaviours effectively.

Recommendation 5: Integrating health literacy into policy and service planning

This can emphasise integration of health literacy into policy and service planning to support sustainable improvements in screening uptake. This can describe that limited health literacy influenced fear, misunderstanding and delayed decision-making. Health literacy needs to be identified as a core public health priority rather than an individual responsibility. NHS commissioners and Integrated Care Systems need to assess population language and literacy needs when planning services (Goddard, 2023). The screening programs need to be designed using health literacy principles, including clear communication, repetition and opportunities for questions.

Monitoring screening uptake across the migrant populations can also support targeted interventions. The policies need to mandate minimum standards for language accessibility, interpreter provision and culturally appropriate information. The investment in workforce development and multilingual resources needs to be protected across the budgets (Schroedler *et al.* 2023). The evaluation mechanisms can include patient feedback to ensure services remain responsive. The implementation of health literacy across the policy frameworks can support equity. Accountability and long-term improvement. This recommendation can ensure that cervical cancer screening services are inclusive, effective and associated with national goals to minimise health inequalities across underserved populations.

5.5 Emphasising the contribution

This research has contributed qualitative evidence on the way language barriers and health literacy shape cervical cancer screening experiences across young migrant women in East London. This research has highlighted communication, cultural sensitivity and service design as critical determinants of equitable preventive healthcare access and informed participation across the public health.

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Appendix 1: Interview of participant 1

Project Title

Understanding the role of language and health literacy in cervical cancer screening among non- English speaking migrant women (18-30 years old) in East London

Participant: Female 24, Migrant Women

Interview Language: Hindi

Researcher: Himanshi (MSc public health student)

Supervisor: Shepherd Ziko

Participant Identification Number : A

My name is Himanshi Patel. I am studying in a Master of Public Health at the University of Wales Trinity Saint David. My campus is in London, and I am currently in my third and final year. In my last semester, I am working on a research project. My main research topic is cervical cancer screening among women living in East London whose first language is not English. I am conducting this study to understand the importance of public health and how language barriers can sometimes prevent people from accessing healthcare benefits. Many times, cultural practices and traditions also influence decisions and prevent women from participating in screening. That is why I am doing this study.

During this study, I want you to feel comfortable. I understand that some questions may feel a bit uncomfortable, but I want to learn how language can create difficulties for people in accessing tests and healthcare, and what improvements can be made. Once again, I welcome you to my research study.

Before you decide anything, I would like to explain again why I am conducting this study. First of all, I want you to feel comfortable and fully supported. Please do not hesitate at any point. Some questions may relate to your personal experiences, and you can take your time to answer them. If you feel uncomfortable at any stage, you are free to ask questions or stop me. Your participation is extremely valuable to me. Your voice will definitely help improve healthcare services and will be very useful for other women like you in the future.

I am doing this study to understand how language and cultural traditions influence healthcare decisions. My special focus is on women aged 18 to 30 living in East London. Through this study, I want to learn about experience and challenges related to different cultures, and how

emotional factors also affect healthcare decisions. My goal is help ensure that services are accessible, comfortable, supportive, and safe for you and for other women in the future.

You might be wondering why I invited you to participate. I invited you because my study focuses on women aged 18 to 30 years living in East London whose first language is not English. Your experience are very important to me and will help me understand how to improve support and services for women like you. Based on answers, I will analyze how improvements can be made.

Participant- okay, it is compulsory for me to take part in this study?

Himanshi – No, participant is completely voluntary. If you choose to take part, I will ask you some questions. You can leave the interview at any time, and you do not have to explain your reason.

Participant – What will happen if I take part?

Himanshi – I will conduct a 15 to 20 minute interview with you. If extra time is needed, we can extend it. We can speak in your mother tongue, Hindi, with your permission. If you agree, I will audio- record the interview and take some notes. Your privacy will be respected, and the interview will be conducted in a private room.

Participant – Is there any risk involved?

Himanshi – No, there is no physical risk. Some questions may be sensitive or related to privacy, but I am happy to provide clarification at any time. Everything you share will remain completely confidential and will only be used for research purposes. Your personal details will not be shared, and any reports will not include identifiable information. Only my research team will have access to the data.

If you have any questions in the future, you can contact me. My name is Himanshi Patel, and my email address is 2428692@student.uwtsd.ac.uk. If at any point you feel uncomfortable, you may take a break or stop the interview. Your comfort is my priority. Please read the information sheet carefully and sign the consent form. If you are ready, I will begin the interview.

Participant: Yes, I am ready to take part. I want to support you because you truly care about us. I am grateful that you chose this topic, and I believe it will help many people.

Himanshi – Thank you. I will now begin the interview. There will be about 8 to 9 questions. If you need a break at any point, please let me know.

My first question is – How much knowledge do you have about cervical cancer screening?

Participant – Before coming to the UK, I had heard about cervical cancer but did not have much information. After coming here, I learned that screening is available.

Himanshi – That is very common. Many people only have limited information before coming to the UK. There are many awareness programs here, which help people learn more.

My second question is – What has been your experience communicating with healthcare professional (doctor or nurses) about cervical cancer screening ?

Participant – The experience is generally good, but language is a problem. We do not fully understand their English, and they may not understand us properly. This makes us feel nervous.

Himanshi – I understand. Language barriers can naturally cause anxiety, and you are not alone in feeling this way.

My third question is – what were your thoughts about cervical cancer before migrating to the UK ?

Participant – In our country, cancer is consider a very serious disease. People feel scared just hearing the word cancer and I also felt afraid thinking about cervical cancer.

Himanshi – Thank you for sharing openly. With clear information and support, fear can be reduced.

My fourth question is – What language challenges do you face when communicating about cervical cancer screening?

Participant – It is very difficult when all information is in English. Medical terms are very hard to understand. Stagg mostly speak English, which makes us confused and stressed because we miss important information.

Himanshi – I understand, Clear information, and I will try to work on ways to improve this.

My fifth question is – Do cultural beliefs affect your decision to participate in screening?

Participant – Yes, In our culture, topics related to women's body parts are not discussed openly, which makes us uncomfortable. Also, routine screening is not common unless there are serious symptoms.

Himanshi – Thank you for explaining this. I respect your culture and appreciate your honest response.

My sixth question is – How did you feel when you received the screening invitation letter?

Participant – I received the screening letter, but my English is not very good, so felt nervous and had difficulty understanding the information.

Himanshi – Thank you for sharing. Receiving information only in English can be stressful, and your feedback is very important.

My Seventh question is – Do privacy concerns related to culture or religion affect your comfort?

Participant – Yes, Privacy is very important to us. We feel more comfortable if a female doctor examines us and if there is a private and respectful environment.

Himanshi – I completely understand, and your concerns are valid. I respect your cultural and religious needs.

My eighth question is – What kind of support would help you most?

Participant – If information was explained in our own language, or through videos, it would help us understand screening better and reduce nervousness.

Himanshi – Clear translated information would definitely provide better support.

My ninth question is – How would you feel if bilingual staff were available?

Participant – That would be very helpful. It would make information easier to understand and reduce anxiety, encouraging more women to participate in cervical cancer screening comfortably.

Himanshi – I agree. Bilingual support can greatly improve confidence and participation.

Participant – Thank you for choosing me for this study. I truly appreciate your work, as it will help us feel more comfortable accessing healthcare services.

Himanshi – Thank you so much for your time and for sharing your experiences honestly. Your valuable contribution will help improve healthcare communication and support for migrant women in the future. If you have any questions later, please feel free to contact me at 2428692@student.uwtsd.ac.uk.

I hope you feel comfortable and supported. Thank you very much for being part of my study.

Appendix 2: Interview of participant 2

Project Title

Understanding the role of language and health literacy in cervical cancer screening among non- English speaking migrant women (18-30 years old) in East London

Participant: Female 26, Migrant Women

Interview Language: Hindi

Researcher: Himanshi (MSc public health student)

Supervisor: Shepherd Ziko

Participant Identification Number : B

My name is Himanshi Patel. I am doing a Master's in Public Health, and I am currently studying at the University of Wales trinity saint David. My campus is in London. As I told you earlier, this is my third and final year project, which is a research project. For this project, I am doing some research on cervical cancer screening. For this, I need participants, and I have selected you as one of them. There are some specific criteria for this study. I will only include people who are non- English speakers and who are not originally from this country. I want to say that my research topic is very important from a health perspective, because through this research I want to understand how language can affect us, especially how we are sometimes unable to receive or understand healthcare information properly. I also want to know why people do not participate in cervical cancer screening and what difficulties they face. To understand this better, I want to explore what kinds of challenges you face that stop you from accessing healthcare professionals or understanding health information properly, I want to find out whether language really is a major barrier that prevents you from communicating whether this true or not.

I also want to know that even after you decide to become my participant, you should think calmly again and make sure you do not feel later that you did something wrong. I want to explain one again that this study may not give you any direct benefits right now, and you may feel a uncomfortable at times. However, in the future, it can be beneficial, For example, it may help you visit your GP, feel more comfortable, and gain better knowledge about healthcare services. I am here to help you. If you need any help during the interview, you can tell me at any time, This is the participant sheet, which you need to sign. I have explained what this study involves, but if you face any difficulty, please let me know and I will explain everything ageing clearly. I want to identify the gaps that we are currently unable to fill, due to which people are not able to participate properly, The aim of my research study is to understand

cervical cancer screening and see how I can increase awareness, help people participate more easily, understand how decision making can be influenced, and identify the concerns that need better solutions. Once again, thank you for taking part in my research program. You fit in my all criteria because your age is between 18 to 30, you have recently come to East London, and your first language is not English, which is why I selected you, I have explained everything once again, please think calmly, read this page, and then we will proceed further.

Himanshi – Are you ready for the interview?

Participant – Yes, I am ready, but I want to ask one question. What are the benefits and what are the disadvantages of this?

Himanshi – Of course, there is no physical risk involve and nothing will happen to your body. However, some questions may be emotionally sensitive, and you may feel a little uncomfortable. If at any time during the interview you feel that you do not want to answer a question, or stop completely. You do not need to give any reason.

As for benefits, there is no direct benefits that I can give you personally. But in the future, this research can be very beneficial for people like you whose first language is not English. Through this interview, we will understand what problems people face, and based on that I will create a project suggesting solutions. Everything you share will be strictly confidential. Your name, age, or any personal details will not be revealed to anyone. Only my supervisor and I will have access to this information.

Are you now ready for the interview?

Participant – Yes, I am ready.

Himanshi – If you have any questions at any time, you can ask me.

My first question is – What information did you have about cervical screening before coming to the UK?

Participant – Honestly, I did not have much information about it at all.

Himanshi – Yes, this screening is still relatively new, so not everyone has enough information.

My second question is – What has your experience been when you visit the GP and talk to healthcare professionals such as doctors or nurses?

Participant – There are some problems, The staff and nurses are nice, but we do not understand the language. Even if we want to ask something, we cannot, because we do not understand their language properly. There are also many words that we cannot understand.

Himanshi – I understand that language can be a very big reason.

My third question is – What were your thoughts when you came to the UK, considering the situation back home?

Participant – Back home people never talk about tests or private body parts. We mostly show ourselves only to female doctors. We had no information about screening at all. In many countries, screening is still not common. But in the UK, there is a lot of focus on screening and its importance.

Himanshi – My fourth questions is – what difficulties do you face when talking to healthcare staff?

Participant – I get very confused. I do not understand what they are saying. Medical words are very difficult, and we cannot ask questions. Our language is not understood by them, and our English is also not that good.

Himanshi – I understand that this can feel very heavy, because health information is something we understand much better in our own language.

My fifth question is – Do you feel that cultural beliefs or traditions stop you from participating in cervical screening programs?

Participant – Yes, in many families these topics are not discussed at all.

Himanshi – I understand, Family pressure plays a big role, especially when it comes to health.

My sixth question is – Have you ever received a letter from the NHS for a test? If you, what were you saw it?

Participant – When I saw the letter, I got very tense. When I hear cervical cancer and see such letters, we get scared. Mant times, I do not understand what to do or which doctor to see.

Himanshi – That is completely natural. Many women feel overwhelmed when they receive such letters for the first time.

My seventh questions is – What are your throughs about privacy and cultural values related to screening?

Participant – We never talk about these things at home or with anyone. It feels awkward to go for screening. If the appointment shows a male doctor's name, it feels very uncomfortable. Many times, I have booked an appointment and then cancelled it after seeing a male doctor's name.

Himanshi – That is very genuine and absolutely understandable. Many women do this even when we were younger, our mothers did the same. In our cultures, this is a very sensitive issue.

My eight question is – What kind of support would you like from our side to better understand cervical cancer screening?

Participant – If someone explains it calmly in our own language, and if there are video or visual materials, and if our conditions is explained properly, it would be much better.

Himanshi – That is absolutely right. When someone speaks in our own language, we can ask questions freely and feel emotionally connected. Your suggestions is very good, and I will keep it in mind.

My last question is – How would it be if there were bilingual staff at GP practices who could speak two languages?

Participant – That would be very good. Then we could ask question freely, and they would understand us, and we would understand them better.

Himanshi – That is a very good idea. I want to say thank you from my heart. When I meet people like you, it feels like there are good people in this world with whom we can share things openly. If you ever need me, feel free to contact me. Thank you so much for sharing your experiences and give your time.

I assure you that all your details will remain private between me and my professor. I hope that your contribution will bring many benefits in the future and help improve services so that you do not face problems later. I will give my student ID and contact number, so if at any time you want to withdraw from this research program, you can inform me without any hesitation. You do not need to give any reason.

Once again, thank you so much for talking part in my research program. Thank you very much.

Appendix 3: Ethics Form

APPLICATION FOR ETHICAL APPROVAL

RESEARCH STUDENTS

This form is to be completed by the student within **SIX** months for full-time students and **TWELVE** months for part time students, after the commencement of the research degree or following progression to Part Two of your course.

Once complete, submit this form via the **MyTSD Doctoral College Portal** at (<https://mytsd.uwtsd.ac.uk>).

This document is also available in Welsh.

RESEARCH STAFF ONLY

All communications relating to this application during its processing must be in writing and emailed to pgresearch@uwtsd.ac.uk , with the title 'Ethical Approval' followed by your name.

STUDENTS ON UNDERGRADUATE OR TAUGHT MASTERS PROGRAMMES should submit this form (and receive the outcome) via systems explained to you by the supervisor/module leader.

In order for research to result in benefit and minimise risk of harm, it must be conducted ethically. A researcher may not be covered by the University's insurance if ethical approval has not been obtained prior to commencement.

The University follows the OECD Frascati manual definition of **research activity**: "creative work undertaken on a systematic basis in order to increase the stock of knowledge, including knowledge of man, culture and society, and the use of this stock of knowledge to devise new applications". As such this covers activities undertaken by members of staff, postgraduate research students, and both taught postgraduate and undergraduate students working on dissertations/projects.

The individual undertaking the research activity is known as the "principal researcher".

Ethical approval is not required for routine audits, performance reviews, quality assurance studies, testing within normal educational requirements, and literary or artistic criticism.

Please read the notes for guidance before completing ALL sections of the form.

This form must be completed and approved prior to undertaking any research activity.
Please see Checklist for details of process for different categories of application.

SECTION A: About You (Principal Researcher)

1	Full Name:	Himanshi Chetankumar Patel			
2	Tick all boxes that apply:	Member of staff:	☐	Honorary research fellow:	☐
	Undergraduate Student	☐	Taught Postgraduate Student	☒	Postgraduate Research Student

3	Institute/Academic Discipline/Centre:	Institute of Inner- City Learning
4	Campus:	London
5	E-mail address:	2428692@student.uwtsd.ac.uk
6	Contact Telephone Number:	07459238066
	For students:	
7	Student Number:	2428692
8	Programme of Study:	MSc Public Health and Social Care in Practice
9	Director of Studies/Supervisor:	Shepherd Ziko

SECTION B: Approval for Research Activity

1	Has the research activity received approval in principle? (please check the Guidance Notes as to the appropriate approval process for different levels of research by different categories of individual)	YES	☐	NO	☒
					Date
2	If Yes, please indicate source of approval (and date where known): Approval in principle must be obtained from the relevant source prior to seeking ethical approval	Research Degrees Committee	☐		
Institute Research Committee		☐			
Other (write in)		☐			

SECTION C: Internal and External Ethical Guidance Materials

	Please list the core ethical guidance documents that have been referred to during the completion of this form (including any discipline-specific codes of research ethics, location-specific codes of research ethics, and also any specific ethical guidance relating to the proposed methodology). Please tick to confirm that your research proposal adheres to these codes and guidelines. You may add rows to this table if needed.	
1	UWTSD Research Ethics & Integrity Code of Practice	☒
2	UWTSD Research Data Management Policy	☒
3	<i>[List any other relevant documents here]</i>	☐

SECTION D: External Collaborative Research Activity

If there are external collaborators then you should gain consent from the contact persons to share their personal data with the university. If there are no external collaborators then leave this section blank and continue to section E.

1	Institution	Not Applicable			
2	Contact person name				
3	Contact person e-mail address				
4	Is your research externally funded?	YES	☐	NO	☐

5	Are you in receipt of a KESS scholarship?		YES	☐	NO	☐
6	Are you specifically employed to undertake this research in either a paid or voluntary capacity?	Voluntary	YES	☐	NO	☐
7		Employed	YES	☐	NO	☐
8	Is the research being undertaken within an existing UWTSD Athrofa Professional Learning Partnership (APLP)?	If YES then the permission question below does not need to be answered.	YES	☐	NO	☐
9	Has permission to undertake the research has been provided by the partner organisation?	(If YES attach copy) If NO the application cannot continue	YES	☐	NO	☐

Where research activity is carried out in collaboration with an external organisation

10	Does this organisation have its own ethics approval system?	YES	☐	NO	☐
If Yes, please attach a copy of any final approval (or interim approval) from the organisation (this may be a copy of an email if appropriate).					

SECTION E: Details of Research Activity

1	Indicative title:	Understanding the Role of Language and Health Literacy in Cervical Cancer Screening Among Non-English Speaking Migrant Women (18 to 30 years old) in East London			
2	Proposed start date:	6 th October 2025	Proposed end date:	2 nd February 2026	
Introduction to the Research (maximum 300 words per section) Ensure that you write for a <u>Non-Specialist Audience</u> when outlining your response to the points below: <i>Purpose of Research Activity</i> <i>Proposed Research Question</i> <i>Aims of Research Activity</i> <i>Objectives of Research Activity</i> Demonstrate, briefly, how <u>Existing Research</u> has informed the proposed activity and explain <i>What the research activity will add to the body of knowledge</i>					

	<i>How it addresses an area of importance.</i>
3	Purpose of Research Activity Two key barriers to screening are limited health literacy and language difficulties (Ozturk et al., 2024). Research on screening in the UK seldom concentrates on women aged 18 to 30. Highlighting personal experiences can support the development of targeted initiatives that directly address the real inequalities faced by communities in East London. (this box should expand as you type)
4	Research Question What effects do health literacy and language have on the cervical cancer screening rates of non-English speaking migrant women in East London between the ages of 18 and 30? (this box should expand as you type)
5	Aims of Research Activity The aim of this research is to investigate the way literacy issues and communication limitations affect screening-related awareness, perceptions, and decisions. (this box should expand as you type)
6	Objectives of Research Activity To evaluate this group's awareness and comprehension of cervical cancer and screening initiatives To determine the language, cultural, and systemic challenges preventing participation To provide feasible, culturally aware methods for enhancing service accessibility and information delivery (this box should expand as you type)
	Proposed methods (maximum 600 words) Provide a brief summary of all the methods that may be used in the research activity, making it clear what specific techniques may be used. If methods other than those listed in this section are deemed appropriate later, additional ethical approval for those methods will be needed. You do not need to justify the methods here, but should instead describe how you intend to collect the data necessary for you to complete your project.
7	Research Philosophy

	This study adopts an interpretivist research philosophy. Justification: The focus is on understanding lived experiences, perceptions, and barriers faced by non-English speaking migrant women. Interpretivism acknowledges that reality is socially constructed and best understood through in depth engagement with participants, making it suitable for qualitative exploration of sensitive health topics like cervical cancer screening. Research Design A primary, qualitative Structure: Semi-structured interviews will be conducted Data Collection Method: One-on-one semi-structured interviews (face-to-face) Language Support:- I will took interview in their own language for they feel comfortable Rationale: Allows participants to speak freely about sensitive topics in a safe environment, helping to reveal personal and cultural influences on screening behaviour. Sample Size – two participant Data Analysis Technique - Thematic Analysis will be used. Ethical Considerations Honest Reporting: Findings will be presented accurately without data fabrication or manipulation. Transparency: Methodology, limitations, and researcher positionality will be disclosed. Plagiarism Avoidance: All sources cited and referenced using appropriate academic style.
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	Informed Consent: Participants will be fully informed of the study's aims, methods, risks, and benefits before agreeing to participate. Confidentiality: Data anonymized; identifiable information stored securely and separately from transcripts. Sensitivity: Given the personal and potentially emotional nature of the topic, interviews will be conducted with cultural competence and empathy, with the option to withdraw at any time without penalty. (this box should expand as you type)
	Location of research activity Identify all locations where research activity will take place.
8	The London borough of East LONDON (this box should expand as you type)
	Research activity outside of the UK If research activity will take place overseas, you are responsible for ensuring that local ethical considerations are complied with and that the relevant permissions are sought. Specify any local guidelines (e.g. from local professional associations/learned societies/universities) that exist and whether these involve any ethical stipulations beyond those usual in the UK (provide details of any licenses or permissions required). Also specify whether there are any specific ethical issues raised by the local context in which the research activity is taking place, for example, particular cultural and/or legal sensitivities or vulnerabilities of participants. If you live in the country where you will do the research then please state this.
9	(this box should expand as you type)

SECTION F: Scope of Research Activity

	Will the research activity include:	YES	NO
1	Use of a questionnaire or similar research instrument?	☐	☒
2	Use of interviews?	☒	☐
3	Use of focus groups?	☐	☒
4	Use of participant diaries?	☐	☒
5	Use of video or audio recording?	☐	☒
6	Use of computer-generated log files?	☐	☒
7	Participant observation with their knowledge?	☐	☒
8	Participant observation without their knowledge?	☐	☒
9	Access to personal or confidential information without the participants' specific consent?	☐	☒
10	Administration of any questions, test stimuli, presentation that may be experienced as physically, mentally or emotionally harmful / offensive?	☐	☒
11	Performance of any acts which may cause embarrassment or affect self-esteem?	☐	☒
12	Investigation of participants involved in illegal activities?	☐	☒
13	Use of procedures that involve deception?	☐	☒
14	Administration of any substance, agent or placebo?	☐	☒
15	Working with live vertebrate animals?	☐	☒
16	Procedures that may have a negative impact on the environment?	☐	☒
17	Other primary data collection methods. Please indicate the type of data collection method(s) below.	☐	☒
	Details of any other primary data collection method: (this box should expand as you type)		

If NO to every question, then the research activity is (ethically) low risk and **may** be exempt from **some** of the following sections (please refer to Guidance Notes).

If YES to any question, then no research activity should be undertaken until full ethical approval has been obtained.

SECTION G: Intended Participants

If there are no participants then do not complete this section, but go directly to section H.

	Who are the intended participants:	YES	NO
1	Students or staff at the University?	☐	☐
2	Adults (over the age of 18 and competent to give consent)?	☐	☐
3	Vulnerable adults?	☐	☐
4	Children and Young People under the age of 18? (Consent from Parent, Carer or Guardian will be required)	☐	☐
5	Prisoners?	☐	☐
6	Young offenders?	☐	☐
7	Those who could be considered to have a particularly dependent relationship with the investigator or a gatekeeper?	☐	☐
8	People engaged in illegal activities?	☐	☐
9	Others. Please indicate the participants below, and specifically any group who may be unable to give consent.	☒	☐
	Details of any other participant groups: Participants in the age of 18 – 30 years from religious setting (temple) and networking through distant social contacts . (this box should expand as you type)		

	Participant numbers and source Provide an estimate of the expected number of participants. How will you identify participants and how will they be recruited?	
10	How many participants are expected?	2 <i>(this box should expand as you type)</i>
11	Who will the participants be?	Participants from religious setting (temple) and networking through distant social contacts . <i>(this box should expand as you type)</i>
12	How will you identify the participants?	From community religious meeting and community social network <i>(this box should expand as you type)</i>

	Information for participants:	YES	NO	N/A
13	Will you describe the main research procedures to participants in advance, so that they are informed about what to expect?	☒	☐	☐
14	Will you tell participants that their participation is voluntary?	☒	☐	☐
15	Will you obtain written consent for participation?	☒	☐	☐
16	Will you explain to participants that refusal to participate in the research will not affect their treatment or education (if relevant)?	☒	☐	☐
17	If the research is observational, will you ask participants for their consent to being observed?	☐	☐	☒
18	Will you tell participants that they may withdraw from the research at any time and for any reason?	☒	☐	☐
19	With questionnaires, will you give participants the option of omitting questions they do not want to answer?	☐	☐	☒

20	Will you tell participants that their data will be treated with full confidentiality and that, if published, it will not be identifiable as theirs?	☒	☐	☐
21	Will you debrief participants at the end of their participation, in a way appropriate to the type of research undertaken?	☒	☐	☐
22	If NO to any of above questions, please give an explanation			
	<i>(this box should expand as you type)</i>			

	Information for participants:	YES	NO	N/A
24	Will participants be paid?	☐	☒	☐
25	Is specialist electrical or other equipment to be used with participants?	☐	☒	☐
26	Are there any financial or other interests to the investigator or University arising from this study?	☐	☒	☐
27	Will the research activity involve deliberately misleading participants in any way, or the partial or full concealment of the specific study aims?	☐	☒	☐
28	If YES to any question, please provide full details			
	<i>(this box should expand as you type)</i>			

SECTION H: Anticipated Risks

	Outline any anticipated risks that may adversely affect any of the participants, the researchers and/or the University, and the steps that will be taken to address them. If you have completed a full risk assessment (for example as required by a laboratory, or external research collaborator) you may append that to this form.		
1	Full risk assessment completed and appended?	Yes	☐
		No	☒
2	Risks to participants For example: sector-specific health & safety, emotional distress, financial disclosure, physical harm, transfer of personal data, sensitive organisational information		
	Risk to participants: A level of emotional distress may be imposed <i>(this box should expand as you type)</i>	<i>How you will mitigate the risk to participants:</i> Participants will be informed about mental health support services <i>(this box should expand as you type)</i>	
3	If research activity may include sensitive, embarrassing or upsetting topics (e.g. sexual activity, drug use) or issues likely to disclose information requiring further action (e.g. criminal activity), give details of the procedures to deal with these issues, including any support/advice (e.g. helpline numbers) to be offered to participants. Note that where applicable, consent procedures should make it clear that if something potentially or actually illegal is discovered in the course of a project, it may need to be disclosed to the proper authorities		
	N / A <i>(this box should expand as you type)</i>		
4	Risks to the investigator For example: personal health & safety, physical harm, emotional distress, risk of accusation of harm/impropriety, conflict of interest		
	Risk to the investigator:	<i>How you will mitigate the risk to the investigator:</i>	

	A level of emotional distress <i>(this box should expand as you type)</i>	Take breaks and regular meeting with supervisor. <i>(this box should expand as you type)</i>
5	University/institutional risks For example: adverse publicity, financial loss, data protection	
	Risk to the University: Data protection issues of participants <i>(this box should expand as you type)</i>	<i>How you will mitigate the risk to the University:</i> The files will be password protected and encrypted and stored securely. <i>(this box should expand as you type)</i>
6	Environmental risks For example: accidental spillage of pollutants, damage to local ecosystems	
	Risk to the environment: Overuse of resources <i>(this box should expand as you type)</i>	<i>How you will mitigate the risk to environment:</i> Ensure to keep use of resources (electricity, paper, data centres..) a minimum <i>(this box should expand as you type)</i>

	Disclosure and Barring Service			
	If the research activity involves children or vulnerable adults, a Disclosure and Barring Service (DBS) certificate must be obtained before any contact with such participants.	YES	NO	N/A
7	Does your research require you to hold a current DBS Certificate?	☐	☐	☒
8	If YES, please give the certificate number. If the certificate number is not available please write "Pending"; in this case any ethical approval will be subject to providing the appropriate certificate number.			

SECTION I: Feedback, Consent and Confidentiality

1	Feedback What de-briefing and feedback will be provided to participants, how will this be done and when?
	Via email I will shared information about research. (this box should expand as you type)
2	Informed consent Describe the arrangements to inform potential participants, before providing consent, of what is involved in participating. Describe the arrangements for participants to provide full consent before data collection begins. If gaining consent in this way is inappropriate, explain how consent will be obtained and recorded in accordance with prevailing data protection legislation.
	Participant will be informed before hand about the research by handing a research information sheet and consent form and to be signed. Participants will receive study code. (this box should expand as you type)
3	Confidentiality / Anonymity Set out how anonymity of participants and confidentiality will be ensured in any outputs. If anonymity is not being offered, explain why this is the case.
	Participants will receive study code. (this box should expand as you type)

SECTION J: Data Protection and Storage

	Does the research activity involve personal data (as defined by the General Data Protection Regulation 2016 “GDPR” and the Data Protection Act 2018 “DPA”)?	YES	NO
1	“Personal data” means any information relating to an identified or identifiable natural person (‘data subject’). An identifiable natural person is one who can be identified, directly or indirectly, in particular by reference to an identifier such as a name, an identification number, location data, an online identifier or to one or more factors specific to the physical, physiological, genetic, mental, economic, cultural or social identity of that natural person. Any video or audio recordings of participants is considered to be personal data.	☒	☐
	If YES, provide a description of the data and explain why this data needs to be collected:		
2	Age in order to comply with study objectives. (this box should expand as you type)		
	Does it involve special category data (as defined by the GDPR)?	YES	NO
3	“Special category data” means sensitive personal data consisting of information as to the data subjects’ – (a) racial or ethnic origin, (b) political opinions, (c) religious beliefs or other beliefs of a similar nature, (d) membership of a trade union (within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992), (e) physical or mental health or condition, (f) sexual life, (g) genetics, (h) biometric data (as used for ID purposes),	☒	☐
	If YES, provide a description of the special category data and explain why this data needs to be collected:		
4	Race because it must must be investigated as factor of relevant for this condition and research. (this box should expand as you type)		

	Will data from the research activity (collected data, drafts of the thesis, or materials for publication) be stored in any of the following ways?	YES	NO
5	Manual files (i.e. in paper form)?	☐	☐
6	University computers?	☐	☒
7	Private company computers?	☐	☒
8	Home or other personal computers?	☒	☐
9	Laptop computers/ CDs/ Portable disk-drives/ memory sticks?	☐	☒
10	"Cloud" storage or websites?	☒	☐
11	Other – specify:	☐	☐
12	For all stored data, explain the measures in place to ensure the security of the data collected, data confidentiality, including details of backup procedures, password protection, encryption, anonymisation and pseudonymisation:		
	The files will be password protected and encrypted and stored in the university OneDrive (cloud) Participants will receive a study code, and privacy / anonymisation will be ensured <i>(this box should expand as you type)</i>		

Data Protection			
	Will the research activity involve any of the following activities:	YES	NO
13	Electronic transfer of data in any form?	☐	☒
14	Sharing of data with others at the University outside of the immediate research team?	☐	☒
15	Sharing of data with other organisations?	☐	☒
16	Export of data outside the UK or importing of data from outside the UK?	☐	☒
17	Use of personal addresses, postcodes, faxes, emails or telephone numbers?	☐	☒
18	Publication of data that might allow identification of individuals?	☐	☒
19	Use of data management system?	☒	☐
20	Data archiving?	☐	☒

21	If YES to any question, please provide full details, explaining how this will be conducted in accordance with the GDPR and Data Protection Act (2018) (and any international equivalents, where appropriate):
	The files will be password protected and encrypted and stored in the university OneDrive (cloud) Participants will receive a study code, and privacy / anonymisation will be ensured and data will be discarded after the end of the research (May 2026). <i>(this box should expand as you type)</i>
22	List all who will have access to the data generated by the research activity:
	The student researcher and the supervisor <i>(this box should expand as you type)</i>
23	List who will have control of, and act as custodian(s) for, data generated by the research activity:
	The student researcher <i>(this box should expand as you type)</i>
24	Give details of data storage arrangements, including security measures in place to protect the data, where data will be stored, how long for, and in what form. Will data be archived – if so how and if not why not.
	The files will be password protected and encrypted and stored in the university OneDrive (cloud) Participants will receive a study code, and privacy / anonymisation will be ensured and data will be discarded after the end of the research (May 2026). <i>(this box should expand as you type)</i>
25	Please indicate if your data will be stored in the UWTSD Research Data Repository (see https://researchdata.uwtsd.ac.uk/). If so please explain. <i>(Most relevant to academic staff)</i>
	N/A

	<i>(this box should expand as you type)</i>		
26	Confirm that you have read the UWTSD guidance on data management (see https://www.uwtسد.ac.uk/library/research-data-management/)	YES	☒
27	Confirm that you are aware that you need to keep all data until after your research has completed or the end of your funding	YES	☒

SECTION K: Declaration

	The information which I have provided is correct and complete to the best of my knowledge. I have attempted to identify any risks and issues related to the research activity and acknowledge my obligations and the rights of the participants. In submitting this application I hereby confirm that I undertake to ensure that the above named research activity will meet the University's Research Ethics and Integrity Code of Practice which is published on the website: https://www.uwtsd.ac.uk/research/research-ethics/		
1	Signature of applicant:	H.C.Patel	Date: 17/08/25

For STUDENT Submissions:

2	Director of Studies/Supervisor:	Shepherd Ziko	Date: 18/08/25
3	Signature:	S.Ziko	

For STAFF Submissions:

4	Academic Director/ Assistant Dean:		Date:
5	Signature:		

Checklist: Please complete the checklist below to ensure that you have completed the form according to the guidelines and attached any required documentation:

☒	I have read the guidance notes supplied before completing the form.
☒	I have completed ALL RELEVANT sections of the form in full.
☐	I confirm that the research activity has received approval in principle
☐	I have attached a copy of final/interim approval from external organisation (where appropriate)
☐	I have attached a full risk assessment (where appropriate) ONLY TICK IF YOU HAVE ATTACHED A FULL RISK ASSESSMENT
☒	I understand that it is my responsibility to ensure that the above named research activity will meet the University's Research Ethics and Integrity Code of Practice.
☒	I understand that before commencing data collection all documents aimed at respondents (including information sheets, consent forms, questionnaires, interview schedules etc.) must be confirmed by the DoS/Supervisor, module tutor or Academic Director.

RESEARCH STUDENTS ONLY

Once complete, submit this form via the **MyTSD Doctoral College Portal** at (<https://mytsd.uwtsd.ac.uk>).

RESEARCH STAFF ONLY

All communications relating to this application during its processing must be in writing and emailed to pgresearch@uwtsd.ac.uk , with the title 'Ethical Approval' followed by your name.

STUDENTS ON UNDERGRADUATE OR TAUGHT MASTERS PROGRAMMES should submit this form (and receive the outcome) via systems explained to you by the supervisor/module leader.