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The Influence of Cultural Differences on Cervical Cancer Screening:

A systematic literature review

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Abstract/Summary

Background: Cervical cancer screening (CCS) is important for early discovery and prevention of cervical cancer. Yet, some women from different geographical areas are unable to participate in the screening process due to socio-cultural, religious, and language obstacles. This study analyses the influence of cultural differences on CCS, delving into how cultural beliefs, norms, and perceptions change women's attitudes toward screening in different cultural areas.

Aim: The study investigates how cultural differences influence cervical cancer screening in women. The study focuses on social beliefs, norms, and practices that inform women's perception and access to healthcare. Also, the study stresses the need for culturally responsive healthcare. Challenges such as stigma, misinformation, and patriarchal traditions will be discussed in this study.

Methodology: Using a qualitative approach, this study conducts a systematic literature review (SLR) to investigate the influence of cultural differences on cervical cancer screening in women. Peer-revied articles were searched through academic journals resulting in 1407 hits. However, 12 out of the 1407 articles found met the inclusion criteria.

Results: Cultural perspectives were the highlights of the hurdles to CCS in different cultural settings as represented consistently in the 12 articles analysed for the studies. The study focuses on two important themes: **Cultural Barriers to screening and Strategies to Promote Participation**. These topics are further divided into sub-themes. These sub-themes further explain the challenges to CCS and provide practical solutions to increase screening rates among diverse populations.

Language: English Keywords: Cervical cancer, screening, cultural perceptions, cultural background, systematic literature review

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1 Introduction

Research has identified that after heart disease, cancer is the world's second leading cause of death, and this puts a financial burden on healthcare systems. According to the Centre for Disease Control, cancer is a disorder in which the cells in the body grow abnormally. Cancer is named according to where it first occurs in the body even if it metastases. Cervical cancer starts in the cervix. The cervix is the opening to the uterus from the vagina. Women 30 years and above can have cervical cancer (CDC, 2023).

In 2023, 1,958,310 new cancer cases and 609,820 cancer deaths are expected to occur in the United States**.** According to the World Health Organization, worldwide cervical cancer ranks as the fourth most common cancer among women. Approximately 604,000 new cases and 342,000 deaths in 2020, and this is a threat to public health. Also, about 660,000 new cases were reported in 2022. The WHO stated that almost 90% of the 342,000 cervical cancer cases were found among low- and middle-income countries. These figures attest to the fact that the occurrence of cervical cancer and mortality rates are higher in sub-Saharan Africa (SSA), Central America, and Southeast Asia. Cultural differences, access to vaccines, screening, socio-economic factors, and gender prejudices are all contributing factors to cervical cancer burdens across different settings (WHO,2024).

The Finnish Cancer Registry recommends that as much as possible every five years women between the ages of 30 to 65 should partake in cervical cancer screening since screening detects cancerous precursors. The Finnish Cancer Registry revealed that in Finland, the Screening programs bring to light about 600 precursors and early-stage malignancies each year. Thus, there is a decrease in the cases of cervical cancer. This has also seen a reduction in many emerging cancer cells diagnosed and deaths in the population each year. Generally, yearly in Finland, 170 new cases of cervical cancer are spotted, and circa 55 women die from cervical cancer yearly (Finnish Cancer Registry, 2021).

The motivation behind writing about the **Influence of Cultural Differences on Cervical Cancer Screening** stems from the actualisation that culture influences people's perspectives and healthcare decisions. Cultural elements can have an impact on a patient’s interest in seeking medical care, following up with treatment, how to communicate with healthcare providers, etc. It is important to note that understanding and addressing cultural issues paves the way for healthcare professionals to ensure that all patients receive the best treatment despite their cultural differences.

2 Background

Cervical cancer is a global health issue (WHO, 2024). Despite the introduction of many interventions for prevention and treatment, cervical cancer remains a burden. This chapter will cover the risk factors, screening techniques, prevention, consequences, screening and diagnosis, and a definition of cervical cancer.

2.1 Towards the Understanding of Cervical Cancer

Cervical cancer begins in the cells of the cervix. The cervix is the bottom, thin end of the uterus (womb) which joins the uterus and the vagina (birth canal). Cervical cancer grows gradually over time. The start of cancer in the cervix begins with the growth of abnormal cells in the cervical tissue, and this process is known as dysplasia. These abnormal cancer cells may become cancer cells that multiply and spread into the cervix and adjoining tissues if not eliminated (Fowler et al., 2003).

2.2 Pathology

The cervix is made up of the ectocervix and the endocervix. The ectocervix is the outer part of the cervix and coated with squamous cells whereas the endocervix forms the inner section of the cervix that creates a passage between the vagina and the uterus. The endocervix is covered by column-shaped glandular cells that produce mucus. The squamocolumnar junction or transformation zone is where the endocervix and ectocervix meet. Many cervical cancers start in the squamocolumnar junction. (National Cancer Institute, 2023). There are two major types of cervical cancer:

Squamous Cell Carcinoma: About 90% of squamous cell carcinomas are malignancies. These malignancies come about from cells in the ectocervix (National Cancer Institute, 2023).

Cervical adenocarcinoma: This grows in the glandular cells of the endocervix. This type of cancer is not common. Cervical cancer can show signs of both squamous cell carcinoma and adenocarcinoma, and this is known as mixed carcinoma or adenosquamous carcinoma (National Cancer Institute, 2023).

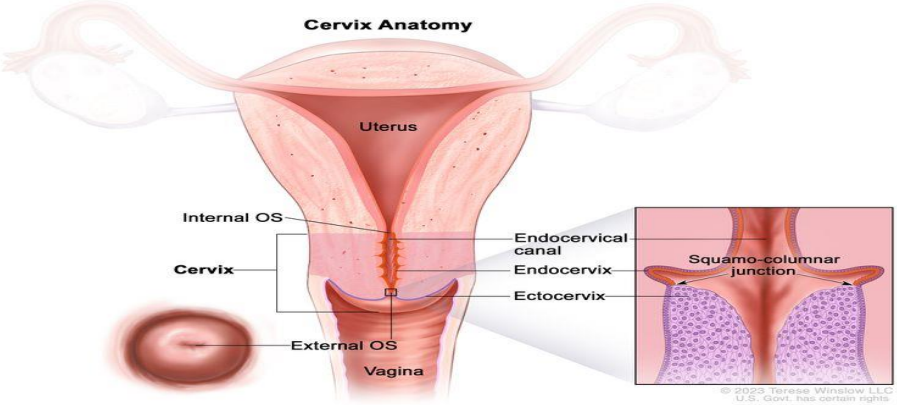

Figure1 (Healthy cervix)

Figure 2 (Cancerous Cervix)

Source: (National Institute, 2023)

2.3 Clinical Presentation and Diagnosis

Patients with cervical cancer do not show any symptoms at the beginning stage of the disease. To diagnose a patient with cervical cancer first a medical history must be checked. The sexual history of the patient must be investigated. This includes the patient's age at the time of their first sexual interaction and inquiries concerning postcoital bleeding and discomfort during intercourse. It is also important to ask questions about previous sexually transmitted infections (STIs), including HPV and HIV, the number of lifetime sexual

partners, tobacco use, and the HPV vaccine. Also, questions about menstrual cycles, irregular bleeding, recurrent vaginal discharges, irritations, and known cervical abnormalities are essential. Medical history is then followed by a physical examination to make a concrete diagnosis of the onset of the disease. A clinical examination of both the exterior and internal genitalia must be conducted. Some indications of cervical cancer are a friable cervix, visible cervical lesions, erosions, lumps, bleeding during inspection, and fixed adnexa (Waggoner, 2003).

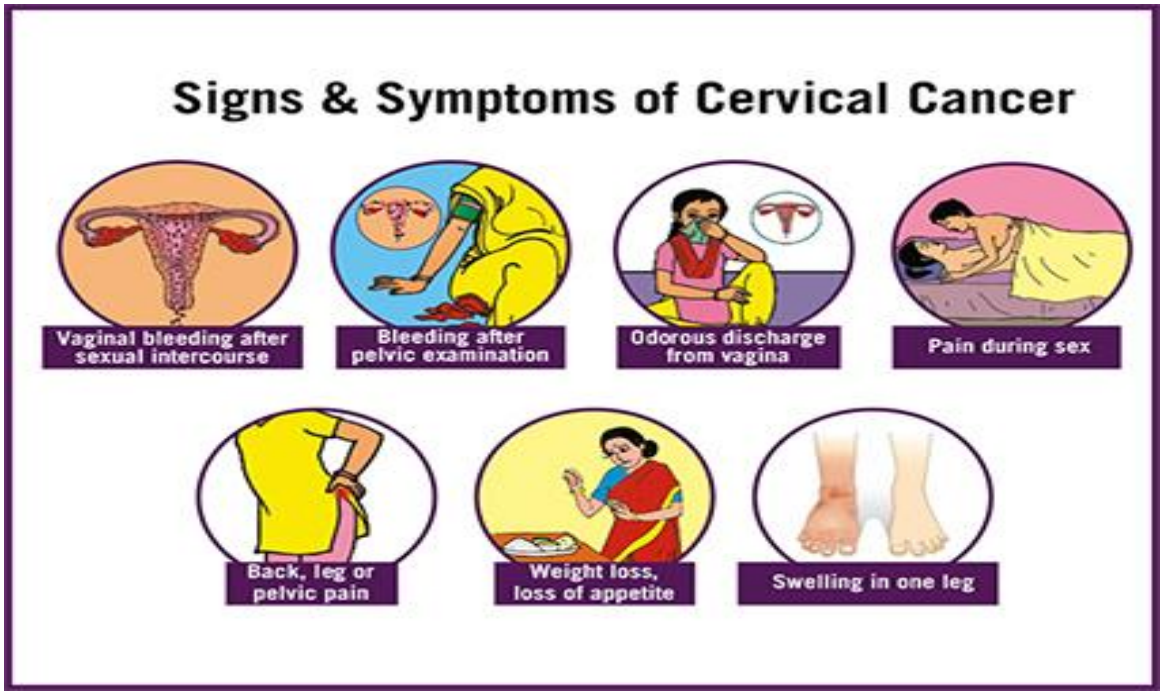

Figure 3

Signs and symptoms of cervical cancer

Source: (Indian Cancer Society, 2024)

2.4 Epidemiology and Risk Factors

Cervical cancer is one of the most prevalent malignancies among women globally. Around the globe, cervical cancer is known to be the fourth most common cancer in women. Chronic infection coupled with high-risk strains of human papillomavirus (HPV) are mostly connected to cervical cancer instances (WHO, 2024). This section will discuss the epidemiology and risk factors of cervical cancer.

2.4.1 Epidemiology

Research has established that cervical cancer is ranked as the fourth most frequent malignancy among women worldwide (WHO, 2024). This accounts for about 80% of cases in developing countries. According to the American Cancer Society, in 2002, 13,000 cases of cervical cancer were uncovered in women in the United States of America (USA), leading to 4100 deaths. Also in North America, diagnosis is normally done at the age of 47 and this makes it possible to spot about half of all cases before the age of 35. Women who are 55 years and above and diagnosed at the later stage of the disease are at a higher risk of dying from the disease. Current developments have it that women who have not had HPV vaccinations and have not been screened for the past 5 years have a higher mortality rate. Similarly, women diagnosed with precancerous cervical lesions and do not adhere to follow-ups have a higher death rate (Waggoner, 2003). Comparatively, 122,844 women were diagnosed with cervical cancer, and 67,477 deaths in India (Sreedevi, 2015).

The National Cancer Institute (2023) revealed that the main causes of cervical cancers are some forms of HPV. Squamous cervical tumours have up to 90% HPV DNA. HPV is a sexually transmitted infection that can be transmissible through vaginal, anal, or oral sex. It causes anal, cervical, oropharyngeal, penile, vaginal, and vulvar cancer. There are more than 200 HPV types. Approximately 40 of these HPV cause genital infections. These types are put into two categories, low and high-risk. There are 12 high-risk types which are HPV 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, and 59. The common HPV types identified to cause cancers are 16 and 18. On the other hand, low-risk HPVs can cause warts in the genital area, anus, mouth, and throat but are probable not to cause cancer. The contributing cause of the growth of abnormal cancer cells is the continuous infection with high-risk HPV, which can develop into cancer. HPV vaccination is recommended by the CDC Advisory Committee on Immunization Practices as it prevents HPV infections, HPV-associated cancers, and other diseases. The vaccine prevents circa 90% of cancers that are gotten through infections and genital warts (National Cancer Institute, 2023).

Engaging in sexual activities before the age of 16, having multiple sexual partners, as well as having a medical history of genital warts are also risk factors for cervical cancer. In addition, the use of Immunosuppressive drugs and people living with HIV-positive are predisposed to acquiring cervical cancer. Also, cigarette smokers and people exposed to ambient smoke have a chance of acquiring cervical dysplasia and invasive carcinoma. Research has proved that tobacco-specific carcinogens and polycyclic aromatic hydrocarbons have been found in the cervical mucus and epithelium of people who smoke.

These substances tend to destroy cellular DNA. This cellular DNA meets HPV to cause malignant mutation (Waggoner, 2003).

2.4.2 Cervical Cancer Screening Recommendations

Cervical cancer screening aims at detecting premalignancy anomalies in the cervix and reducing morbidity and death. Mass cervical cancer screening programs are organised for women in countries such as Finland, the Netherlands, and the United Kingdom. It should be noted that target age groups and screening intervals vary from country to country. (Wearn et al., 2024).

To begin with, the WHO recommends that women be screened every 5-10 years for cervical cancer at the age of 30. The WHO also suggests that Women who have HIV should undergo screening every three years from the age of 25 years. The global strategy recommends that at age 35 a high-performance HPV test should be done and repeated at age 45. Precancers are asymptomatic so there is a need for yearly screening to detect and treat precancers (WHO, 2023). Also, the United States Preventive Services Task Force (USPTF) posits that Pap screening should begin at age 21 (Fowler, et al., 2003).

Furthermore, the International Federation of Gynaecology and Obstetrics (FIGO) staging system employs different ways of assessing illness. It is required that patients with invasive illnesses go through the FIGO staging system. Initially, the staging was combined with pelvic examination, cystoscopy, chest x-ray, and lab test. In recent times, MRI and PET scans have been utilised for staging. A pelvic MRI identifies the extent of the local tumour and monitors tumour response whereas PET scans are used to detect nodal and visceral metastases (Fowler, et al., 2003).

Finally, in 2003, the Food and Drug Administration (FDA) consented to the use of high-risk HPV testing with cytology for CCS in women who are 30 years and above. Colposcopy is a preferable method employed to diagnose unusual cytology and chronic high-risk HPV infection. Currently, women between the ages of 21-29 are encouraged to undergo only cytology in conjunction with screening every three years. Co-testing combined with cytology and high-risk HPV testing is endorsed every five years for women aged 30 to 65 years (Bedell, et al., 2020).

2.4.3 Cervical Cancer Screening Recommendations for Transgender and Non-Binary Individuals

Transgender refers to people who identify differently from the gender given to them at birth. Some transgender individuals may not necessarily go through medical treatments but identify as their proclaimed gender. On the other hand, some go through physical changes by undergoing hormone therapy and gender-affirming surgery. Trans men (TM) are females who identify as males. Non-binary refers to a broad category of transgender people who are designated as neither male nor female. The cancer screening needs of transgender patients depend on the stage of their transformation. (Sterling et al., 2020).

The Canadian Cancer Society recommends screening for TM aged twenty-one years and above and are sexually active. Similarly, the American College of Obstetricians and Gynaecologists (ACOG) suggests that TM with their cervix still in place should follow the same guidelines for CCS as cisgender women. These recommendations are important since some TM may still have organs such as the cervix, ovaries, etc, and need to be monitored (Dhillon et al., 2020).

In contrast, some trans women and non-binary people born male undergo vaginoplasty. Vaginoplasty is when tissue from the penis, colon, or skin, is used to form the vagina. According to research, trans women and non-binary persons are not at risk of cervical cancer, so do not need cervical cancer screening. Nevertheless, they may acquire other forms of cancer in the tissues used to build the vagina which needs to be closely observed (Sterling et al., 2020).

The risk of cancer can be affected by the type and extent of gender-affirming medical intervention. Also, the screening needs for TM and non-binary individuals are impacted by genital processes such as hysterectomy and non-genital surgeries such as chest reconstruction they have had. Transgender men who have had an oophorectomy (removal of the ovaries) or hysterectomy are at lower risk for gynaecological cancers. However, the results of long-term testosterone treatment on other organs need to be monitored (Sterling et al., 2020).

In conclusion, transgender and non-binary people need cancer screening recommendations that cover gender-affirming therapies. Healthcare professionals need to take into consideration the needs and challenges transgender people may face while trying to seek cancer screening services.

2.5 Cervical Cancer Staging and Treatment Options

Staging is very important in controlling cervical cancer. It helps with treatment options and predicts prognosis. The International Federation of gynaecology and Obstetrics (FIGO) is the most widely used staging method. This staging method categorises cervical cancer according to the extent to which the cancer has spread. The treatment option for cervical cancer depends on the stage of the disease. This section will discuss the stages of cervical cancer and delve into available treatment options.

2.5.1 Cervical Cancer Staging: Understanding the FIGO Classification System

Staging identifies a malignancy depending on its size and location at diagnosis. This is sometimes referred to as the extent of cancer. Test and exam results are used to assess the size of the tumour, whether sections of the organ contain cancer, and whether cancer has spread from where it began and where it has spread. Cervical cancer has four stages; the higher the stage number, the more the disease has spread (Canadian Cancer Society, 2024). The following are the stages of cervical cancer according to the National Cancer Institute (2022):

FIGO stage I cancer is defined as cancer that has progressed only to the cervix. There are two sub-stages of this stage of cervical cancer.

- Stage IA: The cancer is in its preliminary stages and has not progressed beyond the cervix. It can be seen only through a microscope. There are two subcategories of this level.
- Stage IA1: The malignancy is less than 3 millimetres (mm) deep into the cervix.
- Stage IA2: The cancer is around 3 to 5 mm deep into the cervix.
- Stage IB: The cancer is still localised to the cervix but has spread beyond 5mm depth. This stage has three subdivisions.
- Stage IB 1: The cancer measures 2 cm or less.
- Stage IB2: The size of the cancer ranges between 2 and 4cm
- Stage IB3: The tumour is larger than 4cm.

In the second stage of cervical cancer, the cells have spread to the tissue surrounding the uterus. There are two FIGO sub-stages for this stage. They consist of

- Stage IIA: The Cancer cells have extended over the upper two-thirds of the vagina.
- Stage IIA1: The carcinoma measures below 4 cm.
- Stage IIA2: The cancer measures 4cm and more

- ❖ Stage IIB: Cancer cells have spread to the tissues surrounding the uterus.

In the third stage, the cancer has spread to the bottom third of the vagina. It might have gotten to the pelvic wall. This may affect renal function. This stage comprises three FIGO sub-categories.

- ❖ Stage IIIA: The malignant cells have migrated to the bottom portion of the vagina but have not yet reached the pelvis.
- ❖ Stage IIIB: The pelvic wall harbours malignant cells at this stage. During this stage, the kidneys may expand, which may affect their functioning, and the malignant tumour may be big enough to obstruct one or both ureters.
- ❖ Stage IIIC: This stage is divided into two substages based on the lymph nodes where malignant cells have progressed.
- ❖ Stage IIIC1: This stage includes the lymph nodes in the pelvis.
- ❖ Stage III-C2: This stage includes abdominal lymph nodes around the aorta.

In the fourth stage, the cancer has spread beyond the pelvis. This stage is referred to as metastatic cervical cancer. It might have spread to the bladder lining, the wall of the rectum, and other distant organs. Stage IV cervical cancer consists of two sub-stages.

- ❖ Stage IVA: Cancer cells have progressed to pelvic organs such as the rectum and bladder.
- ❖ Stage IVB: Cancer cells have spread beyond the cervix to other parts of the body such as the bones, distant lymph nodes, or the lungs

In a nutshell, the FIGO staging method plays an important role in the management and prognosis of cervical cancer. It tells the growth and extent to which the cancer has spread and aids in choosing the right treatment option.

2.5.2 Treatment Options for Cervical Cancer

There are different treatment options for cervical cancer depending on the stage of cancer, the total well-being of the patient, and the patient's choices. The treatment patient's care team collaborates and comes up with a treatment plan. The treatment plan for a cervical cancer patient comprises details on the cancer, treatment goals, treatment choices, long-term adverse effects, and the expected time of treatment

To begin with, one treatment option for stage IA1 cervical carcinoma is cold knife conization. This process involves the removal of a cone-shaped part of abnormal tissue from

the cervix. Patients whose cancer may reoccur are suggested to undergo a total hysterectomy (National Cancer Institute, 2024).

Also, radical hysterectomy combined with lymphadenectomy is a treatment option for stage IA2 cervical cancer. With this treatment option the uterus, cervix, upper section of the vagina, lymph nodes, surrounding tissues, and ligaments are removed. Radical trachelectomy is another treatment option for IA2 cervical cancer but is mostly recommended for patients who do not want to lose their fertility. In this treatment process, the cervix, upper section of the vagina, and surrounding tissues are removed. Patients who for some reason cannot undergo surgery can have internal radiation therapy (brachytherapy)as a treatment option. Radiation therapy involves the elimination of cancer cells by compressing radioactive chemicals in needles, wires, or catheters and inserting them directly where the cancer is located (Burmeister, et al., 2022).

In addition to the above, radiation therapy together with chemotherapy can be used to treat IB and stage IIA cervical cancer. Another treatment option for this stage is radical hysterectomy, and radical trachelectomy. In some cases, the pelvic lymph nodes are removed through pelvic radiation. Radiation therapy can be combined with Chemotherapy medications, such as cisplatin and carboplatin. These medications when combined with radiation therapy make treatment effective (Ames, 2023).

To continue, Radiation therapy can also be used to treat stage IIB, stage III, and stage IVA cervical cancers. Radiation therapy can be used with chemotherapy for this stage of cancer. Another alternative is to remove the pelvic lymph nodes through surgery. Radiation treatment with or without chemotherapy follows surgery, has been done (National Cancer Institute, 2024).

Furthermore, Radiation therapy and chemotherapy with targeted drugs such as bevacizumab can be used as a treatment option for IVB cervical cancer. Targeted therapy drugs are used in the treatment of cancer to manage how cancer cells multiply and divide. They work by targeting proteins in the cell. These treatment options help in palliative care to prevent cancer-related bleeding (National Cancer Institute, 2024).

Finally, the recurrence of cancer in the pelvis can be treated with an immunotherapy medication (Pembrolizumab). Radiation, chemotherapy, and targeted treatment options can also be employed. Patients who cannot have radiation treatment can undergo pelvic

exenteration instead. Pelvic exenteration is done to remove cancer to where it has progressed. (National Cancer Institute, 2024).

To conclude, Cervical cancer treatment options differ depending on the stage of cancer. These treatment options help manage cancer and give hope to cancer patients. The advancement in medicine has helped improve the lives of cancer patients and their families in their entirety.

2.5.3 Complications after treatment

People who go through cervical cancer treatment have aftermath complications. The holistic health, stage of the cancer, can be a contributory factor to the severity and complications one may have after treatment of cervical cancer.

Some challenges faced by people after cervical cancer treatment include discrimination, loss of body image, loss of sexual functionality, loss of femininity, loss of income, anguish, and employment issues. All stakeholders such as families, government institutions, healthcare professionals, etc. must join hands to help ease these burdens on patients who go through cervical cancer treatment (Endale, et al., 2022)

2.6 Comprehensive Strategies for Cervical Cancer Prevention

Screening and vaccination are effective ways of preventing cervical cancer. These preventive measures help reduce the chance of developing cervical cancer. The prevention of cervical cancer prevention includes a multifaceted approach, including primary, secondary, and tertiary prevention. This section discusses the cervical cancer prevention strategies (Aggarwal, 2014).

To start with, the primary way to prevent cervical cancer is HPV vaccination. HPV is known to be the main cause of cervical cancer. HPV, if not treated early, can lead to the growth of abnormal cells in the cervix and eventually lead to cancer. A recommendation by the CDC is that children between the ages of 11 and 12 should be vaccinated before they begin their sexual life. Also, the Food and Drug Administration has approved the use of three different vaccinations for HPV and they are Cervarix, Gardasil, and Gardasil 9. Cervarix is a bivalent vaccine that protects against HPV 16 and 18. Gardasil protects against HPV 6, 11, 16, and 18. On the other hand, Gardasil 9 covers a larger range of HPV vaccines including 6, 11,

16, 18, 31, 33, 45, 52, and 58. It has been proven by several research that the HPV vaccines are efficient, secure, and immunogenic (National Cancer Institute, 2021).

To continue, another preventive strategy is secondary prevention. This involves the screening of people who are positive to find out if they have precancerous lesions. This approach helps in taking preventive measures before these precancerous lesions develop into cancer. The introduction of routine screening programs lowers the prevalence of cervical cancer and death rate as proven by observational studies. The enforcement of organised cervical cancer screening programmes in Nordic countries has decreased cancer cases by 10% to 80%. Screening methods such as pap tests in combination with HPV testing or HPV testing only are usually used in developed countries. Developing countries on the other hand can use high-risk HPV DNA testing in place of Pap tests. Also, in areas where culture hinders them from seeking clinical-based screening methods, the HPV self-collection method can be introduced (Bogdanova et al., 2022). A pap smear is a procedure that healthcare professionals may employ to find cancer cells. This method makes it easier to take cervix samples. Before the sample is taken one is made to lie on the back and a speculum is put into the vagina to hold the vagina walls open to get access to the cervix. A swab is then used to collect a cervical cell sample. The collected cell samples are put in a petri and taken to the lab for analysis (Smith, 2023).

Furthermore, tertiary prevention is another means of preventing cancer. Tertiary prevention minimises the damage of cervical cancer and boosts recovery as well. Cryotherapy or large loop excision of the transition zone (LLETZ) is useful in the prevention of the extension of cancer to other surrounding tissues. For tertiary prevention to be effective, a referral system should be established. This referral system should provide the appropriate treatment option in connection with the diagnosis made. Also, palliative care treatments should be provided for patients who have advanced cancer. (Bogdanova et al., 2022).

Finally, behavioural changes and education are part of the ways that can lower the chance of HPV infection and cervical cancer. Education on safe sex practices, which includes condom use and not having multiple sexual partners, is a way of preventing the spread of HPV. Also, behavioural lifestyles such as smoking must be halted. This is because smoking makes the immune system weak and is not able to fight HPV infections. (WHO, 2023).

To summarize, vaccination, frequent screening, and behavioural changes help reduce the chances of getting cervical cancer, and in effect save a lot of lives.

2.7 A Global Perspective of the Barriers to Cervical Cancer Screening

Cervical cancer screening is hampered for various reasons. These reasons differ according to the geographical location. Barriers to cervical cancer screening range from socioeconomic, language, cultural beliefs, and differences in access to healthcare (Petersen et al., 2022). This section will discuss the cultural barriers to cervical cancer screening worldwide.

Research conducted among immigrant women in Canada discovered that cultural instances impacted their participation in CCS. These women found it unacceptable to openly discuss topics such as pap testing and issues about sexuality because their families and community members frown on such acts. Also, they believe that talking or even thinking about these issues will make them ill. These cultural views held by the women have made it impossible for them to give important information about their sexual lives for important clinical decisions. They also feel ashamed, uncomfortable, and embarrassed to expose their body parts during screening examinations irrespective of the gender of the healthcare professional (Ferdous et al., 2018).

Ferdous et al stated in their studies that the challenge faced by Chinese immigrants in Canada to cervical cancer screening was ethnicity. Their preference for Chinese medicine over Western medicine was influential on their low turn-up to screening exercises. The same study continued to reveal that they did not participate in screening programs because they had limited knowledge about the disease. This owes to the patriarchal system where men solely make decisions concerning the health of their wives and in some situations, women must seek the approval of their husbands to access healthcare. The study went on to show that language was a barrier to cervical cancer screening among some Canadian immigrants. Some of the immigrants were not able to communicate properly in English or French and this was a huge barrier to participating in CCS (Ferdous et al., 2018). Similarly, language was also a challenge among immigrant women in Queensland, Australia, and European states such as Denmark, Norway, and Finland (Afsah et al, 2023).

In addition, a study conducted among women in Zimbabwe revealed that stigma was a major obstacle to cervical cancer screening. HPV, which is a sexually transmitted disease, is said to be the primary cause of cervical cancer, and so many people liken HPV to sexual immorality. Women were terrified to take part in cervical cancer screening because of stigmatisation by friends, family members, and neighbours. Similarly, many immigrant Muslims also faced the same challenge. They believe that it is not necessary to participate

in cervical cancer screening if one does not have multiple sexual partners since cervical cancer is linked to promiscuity and it is against their religion (Gutusa et al., 2023).

The study also found that women were embarrassed to go naked in front of male health professionals. This is because it is unacceptable to show one's nakedness to strangers. Also, in Ethiopia and Zimbabwe, women usually use traditional medicine as an additional treatment for cancer. Africans are known to be deeply rooted in their religion. This is evident among Christians of the apostolic faith in Zimbabwe. They believe that holy water can cure any form of sickness, including cancer. They also believe that the prayers offered by prophets and church leaders heal and protect them from cancer. They attribute cervical cancer to punishment for wrongdoings (Gutusa, et al., 2023).

Furthermore, Muslims in the United States, Denmark, and Norway presume that death is Allah's will and so dying out of an illness is Allah's will. Muslim women in the United States have stated that living in a country where Muslims are few is a challenge to taking part in CCS. Islamic religion promotes decency and so it is difficult for women to go for screening because cervical cancer screening involves exposing the vagina. They also have a misconception that CCS comprises the virginity of women and so should not be done before marriage. These misconceptions deter Muslim women from taking part in CC (Afsah et al, 2023).

The World Health Survey data show that cervical cancer screening rates in urban and rural regions in Ghana are extremely low for several reasons. An investigation was done among men in Kumasi, Ghana to find out what they know and their perceptions about cervical cancer. The study found that some married men feel awkward having their wives attended to by a male doctor during CCS. The men believe that it is taboo for a woman to show her nakedness to another man. Some men also had the notion that their wives must go to the hospital only when they are sick, so they don't understand why their wives should go to the hospital to be examined by a doctor when they are physically fit with the risk of anything happening between them. Furthermore, Ghanaian women do not trust the healthcare system because of the fear that healthcare providers may not keep their screening results private. These challenges are the reasons for the low participation in CCS among Ghanaian women (Williams et al., 2012).

Research done in Nigeria found similar challenges discussed in other studies such as modesty, religious beliefs and the desire to be examined by female health professionals as the main hindrances to CCS. Research in Uganda uncovered similar barriers to CCS

(Uchendu et al., 2021). Similarly, most immigrant Muslim women in the United States, Canada, Scotland, Norway, and Dubai, prefer a female doctor to a male doctor when it comes to CCS. Some also would like a healthcare professional of the same religion (Afsah et al, 2023).

3 Aim and research questions

Aim

This study aims to investigate the influence of cultural differences on cervical cancer screening among women. A systematic literature review is used for the study to bring to the fore how culture influences people's perceptions toward cervical cancer screening among different populations. This study will further suggest interventions that will improve screening participation among women through the review and analyses of articles.

Research questions

- What are the cultural perspectives affecting cervical cancer screening among women?
- How can cervical cancer screening be promoted among women from different backgrounds?

4 Theoretical Framework- Leininger’s Transcultural Nursing Theory

Leininger is the brain behind the transcultural theory in the late 1940s. Leininger's theory is the key to the start of the quest for cultural care. The theory aims at pinpointing cultural diversity and universal care that influence the well-being of individuals. This theory has also created an awareness of a culturally health approach in the nursing field. This theoretical model is made up of variables such as religious and philosophical beliefs, social structures, cultural beliefs, technological breakthroughs, and political and legal frameworks. This model is suitable for the assessment and provision of care for people worldwide, taking into consideration their cultural values. Leininger's Transcultural Nursing Theory gives an insight into cultural differences in CCS among diverse populations and provides practical solutions to how these issues can be tackled through the cultural lens (Sagar, 2011). This section will discuss the principles of Leininger’s theory.

Cultural Care Diversity and Universality

People around the globe have divergent perceptions about diseases and their preventive interventions. For instance, a pap smear is considered needless in certain cultures if one does not exhibit any symptoms. In other cultures, it is forbidden to talk about one's sexuality publicly. Adopting a culturally sensitive approach would assist in coming up with ways that will involve women irrespective of their cultural backgrounds. Women, irrespective of their cultural backgrounds, prioritise their health and will take measures to get cured of any form of disease. Nurses need to stand on their feet and educate women on the benefits of screening to increase participation (Leininger, 1991).

Culturally Congruent Care

This principle preaches the need to align healthcare in accordance with the cultural needs of the patient. Relaying the importance of cervical cancer screening in a way that is in line with the cultural values of women by healthcare workers will positively influence their participation. In a situation where it is forbidden to discuss sexual health issues openly appropriate words should be used when talking about this topic. Educational materials, if possible, can be provided in the language that the patient can understand. This will make the process smooth and ease any form of tension. Religious beliefs and gender preferences are some of the cultural barriers to CCS. Leininger's theory provides practical ways of finding out how to handle these barriers in a way that is compatible with the patient's culture. For example, A female health provider may be assigned to women who do not feel comfortable with male healthcare providers because of their cultural background (Leininger, 1991).

Ethnohistory and Worldview

Leininger's theory stresses that people's perceptions of healthcare are guided by their cultural background, which comprises their experiences, family, social structure, religious beliefs, practices, language, etc. For example, cervical cancer screening programs are not known in certain cultural settings, and so immigrants, for instance, may not attend screening programmes. Also, some may have had an unpleasant experience with a previous medical treatment. Healthcare providers must investigate the cultural background of a patient while giving care to be well informed about the patient's history, attitudes, and views on healthcare. This will allow for effective delivery of care (Leininger, 1991).

Cultural Assessment

Leininger's theory advocates that a detailed cultural assessment must be conducted while cooperating with people, families, and institutions in order to give culturally congruent care. The cultural assessment allows the nurse to delve deeply into the patient's world to understand their cultural views about healthcare. For example, cancer is believed by some women to be a divine will. This belief prevents them from partaking in screening programs. These beliefs can be addressed by employing culturally suitable interventions that do not diminish the cultural values of the women (Leininger, 1991).

Cultural Care Modes

Leininger's theory recommends three approaches that nurses can adopt for culturally befitting care:

- **Cultural Preservation/Maintenance:** Nurses can use this approach to help women keep their cultural values while receiving care. For example, nurses can achieve this by organising screening programmes in a more culturally accepted environment.
- **Cultural Accommodation/Negotiation:** Nurses can consider making screening more appealing to women who have cultural limitations. Information about screening procedures can be relayed in a culturally suitable language. Also, a different method of testing like the HPV self-sampling kits can be proposed for women who, because of certain cultural barriers cannot attend clinical-based screening programmes.
- **Cultural Repatterning/Restructuring:** This approach helps reshape the beliefs people have about healthcare so they do not make decisions that may be detrimental to their health. The belief that screening is for only married women and the belief that women who do not show signs of illness must not go for screening can be a threat to the health of women. Nurses can reshape the beliefs some women have about health issues by educating them on the importance of attending screening programmes using a cultural approach as stated by Leininger (Leininger, 1991).

In conclusion, Leininger's Transcultural Nursing Theory is a model that is culturally centered. This theory is aimed at improving the quality of care by bridging the cultural gap so everyone can have equal access to care despite cultural variations.

5 Methodology

A qualitative research approach was used to investigate the influence of cultural differences on cervical cancer screening in women. This method is instrumental in investigating the cultural differences that influence cervical cancer screening in women and how cervical screening can be promoted among women from different backgrounds.

Polit and Berk (2010) described qualitative research as an approach to understanding the experiences, behaviours, and social situations of people in their natural environment. The collection and analyses of non-numerical data including interview transcripts, field notes, and observational data are components of qualitative research (Polit & Beck, 2010:222-223). This study did not conduct fieldwork, but proof from reviewed articles would help understand the perspectives of people about their social world.

5.1 Systematic Literature Review

Systematic literature review (SLR) is a method used to gather, find, and carefully analyse studies such as articles, conference proceedings, and dissertations. An SLR ensures that the researcher gets the latest details about publications that are related to the study. The review of articles on a subject associated with the research questions is aimed at finding areas that need to be further investigated (Carrera-Rivera, et al, 2022).

A literature review is an important aspect of academic research. This study will augment previous studies. The reviewing of relative studies will help the author identify areas for future research and help in understanding the details of recent studies. The quality and authenticity of previous studies will be examined by the author of this study. (Xiao, & Watson, 2019).

5.2 Data Collection Strategy

Articles relatable to the research topic were searched within academic journals such as PubMed, Scopus, CINAHL, and EBSCO through *Tritonia*. The search focused on articles published between 2018 to August 2024 to ensure that the findings represent the most current developments in research and practice. The key terms included in the search were **cervical cancer screening, cultural barriers, and health inequities.** Boolean operators like **AND** and **OR** were used to narrow search results.

The inclusion and exclusion criteria were used in the selection process to ensure prioritisation and quality. The inclusion criteria considered peer-reviewed articles in English, qualitative studies, studies focusing on the cultural influence on cervical cancer screening, full-text articles, and abstracts related to the research questions. On the other hand, the exclusion criteria comprised non-English papers, studies that are not qualitative, studies unrelated to the topic, and articles that are not full text.

1407 hits were made on an initial search about the cultural influence on cervical cancer screening among women. A systemic screening method was used to delete the duplicates. The inclusion and exclusion criteria were used to access titles, abstracts, and full texts. These methods employed helped in the selection of twelve studies that met all the criteria. The selection process will be presented in a PRISMA Flow Chart to ensure transparency. Also, an appendix that lists the articles chosen for the study, the year they were published, the aim of the studies, the method used to collect data, and the results of the studies can be found in the later part of the work.

Inclusion criteria	Exclusion criteria
Peer-reviewed articles in English	Articles not peer-reviewed and in other languages other than English
Qualitative studies related to the research topic: The Influence of Cultural Differences on Cervical Cancer Screening	Other methods such as quantitative articles, commentaries, and conference abstracts were not used.
Full-text articles	Articles were not full text
Abstracts relevant to the research questions were selected because they discuss the subject matter related to the topic	Abstracts were not relevant because they didn’t relate to the research topic.

Figure 4: Presentation of the Inclusion and Exclusion Criteria

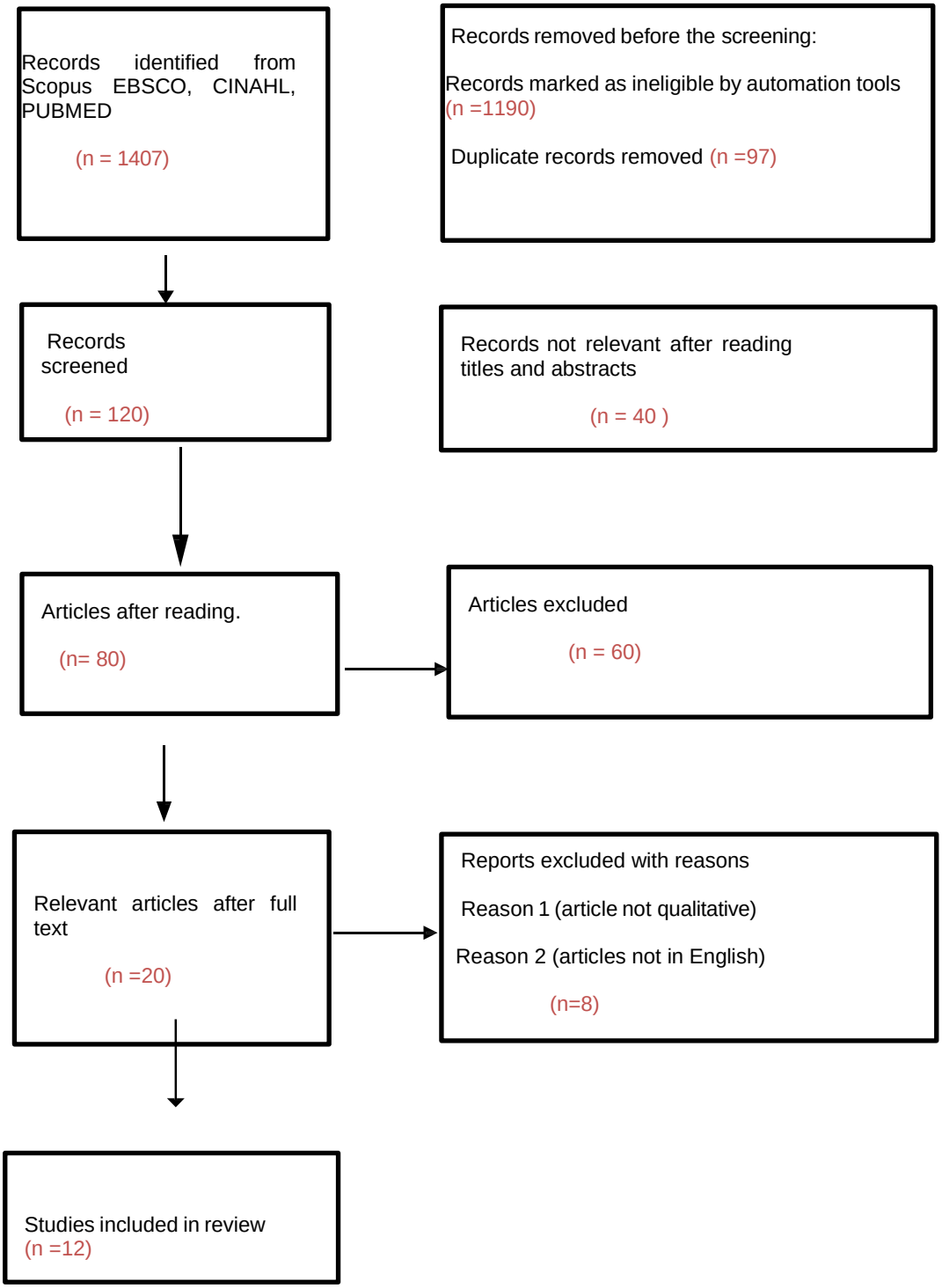

Figure 5: Prisma Flow Chart

Source: (Page et al., 2021)

5.3 Content analysis

Content analysis is a scientific method that helps develop detailed results from texts and enhances the researcher's knowledge about a particular happening (Krippendorff, 2018). Weber (1990) claims that content analyses foster the study of an individual, a group, an institution, and a society at large. Additionally, content analyses allow room for other data collection methods to be used to supplement the initial data collection method used. Content analyses help to identify bias in documents.

A content analysis strategy was employed for this study to identify instances and themes in the studies. The aim and research questions of this study were clearly stated from the beginning of the study. Also, subsequent topics discussed in this study conformed with the aim of the study.

Overused situations such as stigma, mistrust, and access barriers which are challenges to CCS were identified whilst analysing the studies. For further analyses, the study was put into phrases and paragraphs. The phrases and paragraphs were assigned codes. These codes represent issues such as cultural shame, and access constraints. The coding method helped to put concerns such as stigma and distrust under the theme of **Cultural barriers** and developed outreach strategies and community interventions were grouped as **Effective strategies for participation**. These themes state the challenges to cervical cancer screening and the way forward.

The studies were reviewed after the various patterns were categorised into themes. The review of the studies was done by highlighting the significance of the finding, and the possible effects and the benefits of finding solutions to the challenges. The researcher further looked at the relationship between the themes to find out underpinning concerns. For example, language was found to be an obstacle to the low turnout of screening programmes. The analyses of these findings uncovered the interplay between cultural and structural elements. Finally, the results were organised according to empirically based topics that made it easy to understand and relatable in real life.

5.4 Ethical consideration

Ethics can be described as the study of good and bad behaviours according to philosophical principles. It is aimed at determining what is rewarding for everyone. Ethical behaviour implies that one follows established approved norms that exceed the individual's desire. Ethical principles that must be observed during research encompass freedom from harm, freedom from exploitation, risk/benefit ratio, respect for human dignity, transparency, anonymity, confidentiality, and privacy (Rani, & Sharma, 2012).

The Finnish Advisory Board on Research Integrity (TENK) spelled out in their guidelines for conducting research that the ground for earnest research behaviour is correctness, thoroughness, and integrity in the recording, presentation, and analyses of study findings. In conducting research, the method used in gathering data, and analysis must conform to ethical and scientific criteria. Researchers must follow approved empirical knowledge and acknowledge and refer to supporting studies in the planning, collection of data, and documentation of the data (TENK 2023).

Also, it is the responsibility of the researcher to abide by the moral and ethical values of the community in which the research is conducted, the people involved in the study, etc. The research community is guided by regulations and recommendations for the conduct of research. Research misconduct is unlawful and against scientific practice (TENK 2023).

The author of this study is guided by the ethical guidelines of NOVIA University of Applied Sciences and the Finnish National Board on Research Integrity (TENK) guidelines. Throughout the study, the researcher took into consideration the risk of bias and fraud. The study’s flaws and ethical considerations were checked during the data analysis process. To avoid plagiarism, the findings of the study were paraphrased without misstating the authors’ words. All sources used were correctly referenced in line with Novia University of Applied Sciences thesis writing guidelines.

6 Result

This study examined 12 studies that gave an insight into the influence of culture on cervical cancer screening among women. This research considered studies from different geographical locations, study techniques, and cultural contexts. These studies from Ghana, Norway, Finland, Iran, India, Malawi, Ethiopia, and Uganda give a worldview of the influence of culture on CCS among women. Also, two major themes were derived from the thematic analysis of the 12 selected articles. The first theme which is **Cultural Perceptions and Barriers to Cervical Cancer Screening** is broken down into three sub-themes. The second theme **Strategies for Encouraging Cervical Cancer Screening Among Diverse Populations** is also broken down into three sub-themes. Figure 6 displays the findings of the inquiry.

Themes	**Subthemes**
Cultural Perceptions and Barriers to Cervical Cancer Screening	Influence of Cultural Beliefs and Misconceptions
	Role of Male Influence and Support
	Access and Structural Barriers
Strategies for Encouraging Cervical Cancer Screening Among Diverse Populations	Tailoring Health Communication and Education
	Engaging Community Leaders and Male Advocates
	Improving Accessibility and Offering Flexible Screening Options

Figure 6: Themes and subthemes

6.1 Cultural Perceptions and Barriers to Cervical Cancer Screening

Many women across the globe experience cultural and structural barriers to CCS. Lack of knowledge about the disease, misconceptions, cultural beliefs, lack of spousal support, stigma, etc. are some of the obstacles that prevent women from participating in screening programmes. Structural issues, for example, lack of accessibility to healthcare, aggravate the aforementioned obstacles. This theme discusses how cultural perceptions and barriers influence the participation of women in cervical cancer screening among different cultures (Bula et al., 2022).

6.1.1 Influence of Cultural Beliefs and Misconceptions

Cultural beliefs and misconceptions greatly influence the decision-making and attitudes of women toward healthcare. These beliefs and misconceptions influence women to take part in screening programmes.

Research conducted among Immigrant African women in Finland revealed that women had misconceptions regarding the risk factors of CC. Some of the women believed that the likelihood of older women getting cancer is high, as well as those with a family history of cancer. They were also of the belief that eating certain kinds of foods and the use of tampons, as well as other factors such as eating specific foods or using tampons for a longer period. Some women did not understand the causes of CC (Idehen et al.,2020). These are what some women said about CC:

"Most people that have these things (CC) are older people"(Idehen et al.,2020:8).

"I do not know much since it can come from our daily activities, food intake, and genetics" (Idehen et al.,2020:8).

In addition to the above, some Iranian women attached a superstitious belief to cervical cancer. They believe that *Hesadat*, meaning evil eye, may be the cause of cervical cancer. *Hesadat* refers to the wish that sickness befalls the other due to jealousy. In effect, the women thought this could make them develop cervical cancer. *Bezanbetakhteh* is also another word in Iran that means "God remove its evil effect" and is used to counteract the effect of *Hesadat*. Some of the participants claimed that *Benzanbetakhteh* heals patients with cancer (Khazaee-Pool et al., 2018). As one woman explained:

"They believe that we can catch cervical cancer due to Hesadat … people look at others … They use hesadat … Concerning cancer, they believe the cause is Hesadat ... Since they didn't say "Bezanbetakhteh" (Khazaee-Pool et al., 2018:4).

Furthermore, women in Rural Lilongwe, Malawi are deterred from participating in screening programmes because of the unpleasant experience they had from some gynaecological examination. Many of the participants also shun CCS because they think that healthcare providers are 'vampires who suck the blood of patients for diabolical reasons' and hence refer to healthcare providers as 'bloodsuckers.' The women also have a perception that healthcare professionals sold the cervical sample they collected (Bula et al., 2022). Below are the quotes from participants.

''*People were scaring my sister that the metal inserted for screening is painful''"* (Bula et al., 2022:6).
"They were saying if I have cancer signs, they will deliberately make us go to the hospital so that they can be sucking my blood and eventually I die…they say it's satanic" (Bula et al., 2022:7).
"They say…those people who came were collecting vaginal discharge, and they were collecting from those who had sex…then they say they sell it at the hospital" (Bula et al., 2022:7).
"Anything that has the name cancer in it is deadly regardless of the type and no cure for it. It is a disease that rots, spoils, makes you thin, and kills" (Bula et al., 2022:7).

Bouskill et al (2024) and de Fouw et al (2023) posit in their research that screened and unscreened women in Uganda had misconceptions about cervical cancer screening. Most women assume that screening involves the removal of the uterus and roasting it. They connected CC to syphilis and had the misconception that CCS causes tightness of the vagina. Some also believe that the process of putting the uterus back may cause infertility. Also, some of the women likened the cause of CC to uncleanliness, irregular menstrual patterns, and the use of contraceptives. Others are disturbed about the displeasure caused by the equipment used for the screening. Below are some quotes:

"Yes, when people talk about screening, they say that they pull out the uterus and put it on the table to have it checked, and it makes them change their mind about screening"
(Bouskill et al., 2024:5).

"The water in the condoms can burn the inside parts or reproductive parts of women and then cause cervical cancer." (de Fouw et al., 2023:6)

To conclude, cultural beliefs and misconceptions hinder women from participating in cervical cancer screening as revealed in the studies discussed above. These misconceptions can be addressed in a culturally appropriate manner.

6.1.2 Role of Male Influence and Support

Men play an influential role when it comes to the health of their spouses. The support of men is very important in helping women seek healthcare, especially attending health preventive programmes such as cervical cancer screening. This section will discuss studies conducted in rural Ghana and Uganda, which revealed the role of male support in CCS among women.

To begin with, research done in Uganda found that misconceptions and lack of trust were the challenges that prevented men from supporting their wives. The studies highlighted that men were disturbed about not having sexual relations with their wives in situations where precancerous lesions are removed. They were not comfortable with male healthcare workers attending to their wives when they went for CCS because of the view that the male healthcare staff would take advantage of their wives sexually. (Bouskill et al., 2024).

"*It brought serious problems and misunderstanding between me (husband) and her. I told my wife that if it is like this, then you better go back to your parents' home because I can't stay with a person without doing "the work I do" (having sexual intercourse). She explained her issues to me privately. I said, "You are lying to me. Why haven't you been telling me?" She replied, "I have been waiting to tell you, but I was afraid." I said I would take her to the doctor to prove whether she is telling me the truth*" (Bouskill et al., 2024:7).

"*A male health worker enters the room with my wife, and they close the door. Even if the health workers didn't have any thoughts of an affair, I, as a man, am still in fear…You can't know whether the health worker is having sex with your wife. Health workers are human beings– they are not bishops! Therefore, only female health workers should work with fellow women in the cancer department*" (Bouskill et al., 2024:7).

Furthermore, a study in Ghana discovered that some male partners did not support their partners in the cervical cancer journey. Some women who had cervical cancer said had no assistance from their spouses. One woman was distressed when her partner left her because of the disease (Binka et al., 2019). This is revealed in the quote below:

"*Because of the disease, my husband left me and went to marry another woman. So, we are no longer together. Only my child is helping me*" (Binka et al., 2019:6).

Finally, in Iranian culture, Women put their family and especially their spouse's needs first over their health. These cultural values influence women to disregard their health since they devote their time to taking care of their families and meeting family demands. Women may postpone or not attend screening programmes at all because of family responsibilities or the stigma connected to choosing health over family needs (Khazaee-Pool et al., 2018). Below is a quote:

"In Islam, being a woman and being a mother has a special value. In Iran, women also have commitments to their families. I believe that I need to do everything for everyone … I need to do things for my son … I need to take care of my son … take care of my husband … I need to do things for my husband … My family members' lives have priority *over my own life."* (Khazaee-Pool et al., 2018:7).

In conclusion, the support of men is necessary for women's participation in cervical cancer screening, particularly in patriarchal settings such as rural Ghana, Uganda, and Iran. Educating men about cervical cancer and cervical cancer screening will help them understand the condition and its preventive measures better. This will further make men allow women to attend screening programmes to improve their health.

6.1.3 Access and Structural Barriers

Access and structural barriers are impediments to cervical cancer screening among people worldwide. These barriers include financial constraints, poor healthcare facilities, language, etc. Research conducted among immigrant women of African origin in Finland and India highlights access and structural barriers that hinder women from taking part in screening programmes.

To begin with, a study in Finland discovered that a challenge faced by women was the difficulty in understanding Finland's official languages, that is Finnish/Swedish, was a threat to attending screening programmes. They stated that it was difficult to read and understand the letter sent to them for screening invitations. They sometimes have to get someone to interpret the message in the letter to them. The language barrier made communication with healthcare workers during the procedure difficult. Also, some women complained about having unpleasant experiences due to their skin colour (Idehen et al.,2020).

''I am motivated to go but the language is a barrier. If the letter comes in Finnish, I will not read it, and I will throw it away because I do not understand'' (Idehen et al.,2020:10).

''In my case, she did not explain the text. Only she asked if I have done the test before or not'' (Idehen et al.,2020:10).

''If you look at me differently because of my skin colour and treat me like that, I will not be likely to encourage my fellow sisters to go for screening'' (Idehen et al.,2020:10).

To continue, many women who have not been screened reported that they were unaware of the availability of CCS programmes. The women lamented that despite having lived long and had given birth in Finland, they did not receive an invitation to cervical cancer screening. According to the study, the women indicated they first became aware of the screening after participating in the focus group discussions (Idehen et al., 2020).

"*I have been here (Finland) for like seven years and given birth to two children. I have always had a permanent address and never got that kind of letter''* (Idehen et al.,2020:10).

Similarly, in rural Lilongwe, Malawi, and Woltaita zone, southern Ethiopia, most of the women had limited knowledge about cervical cancer. The women did not know why screening was done. The women also reported that they got to know about cervical cancer on the radio, from friends who have undergone CCS, and sometimes from family planning centres. Some women in the Woltaita zone in Ethiopia linked cervical cancer with *Barka.* Barka is a word in Woltaita which means fistula. Correspondingly, some participants in North Gonder, Ethiopia related cervical cancer to haemorrhoids (Kintarot), uterine prolapse, and fistula (Demissie et al., 2022; Megersa et al., 2020). This is expressed in the statement below:

"I heard nothing [about cervical cancer] before health workers came to our village. I was anxious and afraid since I knew that cancer is a deadly disease and has no cure." (Demissie et al., 2022:4).

Similarly in India, inadequate skilled healthcare workers to perform Pap tests was a major barrier to cervical cancer screening in remote communities. Also, the government hospitals were not equipped with adequate and standard screening tools as compared to the private hospitals. This difference in the healthcare system discouraged especially women living in rural areas from participating in screening programs since they have to spend more money and time seeking healthcare in private hospitals. Also, government hospitals are often congested so the long waiting times prevent women from attending screening programmes (Dsouza et al.,2020).

"*People come from far places and when they come here, they don't get satisfactory things because manpower is very less*" (Dsouza et al.,2020:2213).

"*Even for delivery, they are reluctant to come so far because they have to spend for bus expenses*" (Dsouza et al.,2020:2213).

In a nutshell, language, unawareness, and financial constraints are some of the structural challenges to CCS among women in different geographical areas. Some ways in which these obstacles can be solved to increase screening participation and provide equal access to health care are bridging the language gap, giving healthcare professionals adequate training, establishing logistical support systems, etc, to increase cervical cancer screening participation and provide equal access to preventive treatment.

6.2 Strategies for Encouraging Cervical Cancer Screening Among Diverse Populations

This theme concentrates on how CCS may be promoted in women from different cultural backgrounds by addressing both individual and structural barriers.

6.2.1 Tailoring Health Communication and Education

It is important to tailor health communication and education in a cultural approach. This approach will help improve the participation of women in CCS programs. This section will discuss the benefits of tailoring health communication and education in the context of culture.

To begin with, most educational materials for CCS are geared toward making women aware of the benefits of screening. However, the perception gap study discovered that these materials that aim at empowering women to make decisions about their health sometimes leave out the cultural elements that impact women's health choice decisions. For example, in the Western world where individuals can make decisions about their health freely without interference, it is not the same in some cultures where decisions concerning healthcare are culturally centered. (Byskov et al., 2020).

Furthermore, Byskov et al (2020) argued that some of these materials may use medical jargon which may not be familiar to the people for which it was intended. This can lead to misinterpretation and misunderstanding, especially among women who do not know about cervical cancer. For instance, in cultures where cervical cancer is seen as a curse, people may see screening as a threat since they do not understand the material. It is important to use culturally sensitive methods in communicating issues regarding health, especially CCS. Illustrations, pictures, and narratives from community leaders, women who have been screened, healthcare workers, and religious leaders can help women understand health issues better.

To continue, Khazaee-Pool et al (2018) and Byskov et al (2020) agree that media plays a pivotal role in education about cervical cancer and its prevention measures. For example, TV shows that emphases the risks of cervical cancer, and narratives of real-life situations motivated some women to go for screening. Furthermore, the media also increased awareness about the importance of Pap tests. These instances are seen in the quote below.

"I was informed by a TV program that even some young females had cervical cancer or another type of cancer. After hearing this information, I was very scared, thus I decided to do a checkup. Anyway, as a woman, I've observed this cancer with a friend of mine. She had to take out her uterus and ovaries due to cervical cancer ... I found it essential to perform a checkup immediately to understand whether I was healthy or not …" (Khazaee-Pool et al., 2018:8)

To conclude, the above discussion stresses the importance of having education programmes on cervical cancer and screening in a cultural context. This will help to properly understand and appreciate the benefit of screening programmes and enhance participation.

6.2.2 Engaging Community Leaders and Male Advocates

Male advocates and community leaders can serve as ambassadors for educating women on CCS specifically in developing countries. These people are very influential and respected in their communities, so adding their voices to the campaign of regular screening will significantly increase the screening rate and eventually improve the health outcomes of women. This section will discuss engaging community leaders and male advocates in CCS. Studies from Ghana, Uganda, and African American (AA) and Sub-Saharan African Immigrants (SAI) will be used for this discussion (de Fouw et al., 2023; Binka et al., 2019; Adegboyega et al., 2022).

A study on male perspectives on cervical cancer prevention conducted in Uganda stated that involving men in the raising of awareness of HPV vaccinations and CCS can help in the recognition of these interventions. It is reported in the study that men in Mid-Western Uganda are the topmost decision-makers concerning the health of women. This means that the men need to be given extensive education on the preventive measures for CC as well as CCS screening procedures. This will help erase any misconception they have about the disease and allow their women to participate actively in screening programmes by giving them all the necessary support be it financially psychologically or emotionally. (de Fouw et al., 2023).

Similarly, research done in rural Ghana discovered that some men who supported their spouses in cervical cancer screening and treatment have improved the health of their spouses tremendously. Ghanaian men who are given education about cervical cancer risks, prevention, and CCS procedures can be beneficial in advocating the need for screening. The study found that men who consider cervical cancer as a family concern instead of a burden for women only are in place to support their spouses wholeheartedly (Binka et al., 2019). This is reflected in the following quotes:

"I gave her all the necessary things that she needed. Sometimes, I borrowed money; sometimes too, I had to sell my things. Luckily enough, her employers also came in and helped her a lot. But it has been five months now without working and as the head of her department, someone had to replace her" (Binka et al., 2019:6).

"I assisted her financially and when it came to cooking, I gave money to the kids to take care of that. Also, I had to take a casual leave to assist her in managing her shop and accompany her to the hospital for treatment" (Binka et al., 2019:6).

Additionally, male activists such as religious and civic leaders are very much revered in their communities, so they can help change the mindset of women towards CC and CCS. Some

AA and SAI women argued that the inclusion of religious leaders in the promotion of CCS is very valuable in helping woman reshape their minds towards CCS. (Adegboyega, et al., 2022). This is expressed in the quote below:

'*Our churches can play a big role because as Africans we know, we have faith, we believe in God. So, we can use our churches to give access to people, the information to make people know about it, we can get some flyers, we can have some information session*' (Adegboyega, et al., 2022:8).

Furthermore, Adegboyega, et al. (2022) stated in their studies that personalities such as peer educators, community health workers, lay health workers, and natural helpers may also be included in the CCS campaign. Peer educators who are well vexed with their cultural values and understand the cultural barriers faced by women about CCS can help women overcome these barriers whilst respecting their cultural beliefs. The study revealed the success of involving peer educators in HIV/AIDS prevention and management thereby their involvement in other health promotion programmes.

In a nutshell, these findings highlight the inclusiveness of stakeholders in the community in boosting women's interest in CCS. People such as peer educators can be instrumental in advocating the modification of some cultural beliefs that deter women from taking part in screening programmes, and also educating women on CC and the benefits of CCS.

6.2.3 Improving Accessibility and Offering Flexible Screening Options

There are numerous ways to make screening attractive to women. This can be achieved by improving accessibility and providing alternative screening options such as mobile clinics, community-based services, self-sampling, etc. Studies from Ethiopia and Norway will be considered for this discussion.

To begin with, a study conducted in Ethiopia's Dabat district asserted that a home-based HPV self-sampling was introduced to promote access to CCS among women living in rural communities. Women living in rural areas must travel far distances to CCS programmes and so they face financial problems, loss of reproductive time, transportation problems, etc. The study uncovered that the home-based self-sampling had its shortcomings. The women did not know how to use home-based HPV self-sampling, and also there was no follow-up care.

The use of home-based sampling kits can be used effectively when sufficient education is given on how to use them, also assistance can be given to some women to enhance proper appreciation of the intervention (Megersa et al, 2020).

Similarly, a study conducted in Norway revealed that some healthcare professionals in Norway stated that the provision of flexible access and organising screening programmes in a culturally accepted manner may increase screening rates among immigrant women. The common barriers that prevent immigrant women from attending screening programmes include language, cultural differences, inadequate knowledge of the healthcare system, and screening programmes. The introduction of self-sampling kits and community engagement programmes were some of the interventions proposed by some healthcare professionals in Norway to curb the challenges faced by immigrants (Møen et al., 2018).

Similarly, African immigrant women in Finland agreed that screening invitation letters and test results should be communicated in a language that they comprehend. This they say will increase their participation in screening programmes. They suggested that the screening invitation letters could be written in example English (Idehen et al.,2020).

Finally, Khazaee-Pool et al. (2018) agreed that other ways to boost women's interest in CCS are introducing health insurance and a stable economy. This helps the financial situation of women. Health insurance gives a better opportunity to women to access screening programmes without having to rely on their pockets. When the economy is stable, it allows women to confidently take some time off work and also plan for childcare to go for appointments. These two interventions help reduce financial distress and also guarantee that follow-up treatment is assured.

Concisely, these findings highlight the importance of introducing flexible accessibility and alternative screening options such as language, and mobile clinics, which is a way of bringing healthcare closer to the people, the provision of logistics are ways that can promote CCS among women.

7 Discussion of Result

This study sought to investigate the influence of cultural differences on cervical cancer screening among women from 12 studies done in some African, Nordic, and Asian countries. The challenges were described from the views of women, men, healthcare providers, and the authors of the analysed studies. Lack of awareness about screening and the importance of screening, limited access to screening facilities, cultural barriers, and misconceptions were notable barriers to cervical cancer screening worldwide.

To begin with, Lack of awareness was one of the challenges that ran through almost all the countries understudied. Studies in Ghana, Uganda, Ethiopia, Iran, and among immigrants in Finland have demonstrated equivalent findings. Healthcare workers not giving adequate education to both women and men extensively on cervical cancer and cervical cancer screening was a leading cause of unawareness and misconceptions about cervical cancer. Efficient health education can be achieved by equipping nurses with the required skills in the prevention of cervical cancer screening. Also, the service of community health workers can be employed in this awareness creation initiative. On the community level, available resources can be used to educate men extensively in a culturally suitable manner on CC and CCS. A better understanding of CCS can help clear the misconceptions women have about the disease and screening leading to massive participation.

To continue, the findings of these analyses highlighted that a lack of community-based health institutions that offer screening services, and inaccessibility to screening are some of the prominent barriers to CCS. These obstacles to CCS must be addressed collectively without disregarding the other. If one challenge is alleviated leaving one, the complication will continue. For example, in a country where lack of awareness and lack of resources are a hindrance to CCS screening, both must be solved concurrently to enhance the demand for the service. A lack of resources can prevent women from accessing CCS so there is a need to improve and provide adequate, efficient resources in healthcare centres (Mantula et al., 2024).

Furthermore, the findings also revealed that some women were faced with cultural barriers, and this limited their access to screening programmes. For example, in patriarchal societies where men make health decisions on behalf of their spouses, women must be permitted and supported financially by their partners before they seek healthcare. This is a great challenge because women cannot attend screening programmes when their partners turn down their

permission. Also, women are very secretive about their reproductive health and therefore feel uncomfortable discussing issues related to their reproductive health with their partners. It is important to educate men on reproductive healthcare to enhance screening participation in women.

In some cultures, women feel uncomfortable when attended to by male health professionals. Men are also stressed by the thought of male healthcare workers examining their spouses during CCS. This is because in some African communities it is a taboo for a woman to expose a body part to another man outside a marital union. On the other hand, some women prefer to be attended to by healthcare workers who are of the same cultural background irrespective of their gender. These priorities by women bring to the fore that healthcare, especially screening services, must be conducted in a culturally appropriate manner to ensure trust throughout the process. It is also important that healthcare workers familiarise themselves with the cultural values of their patients to be able to give them the best care they deserve. As revealed by the findings, cultural beliefs seriously influence how some women perceive healthcare and preventive measures such as screening. To curb this challenge, there is the need to employ healthcare professionals with similar cultural backgrounds or give healthcare professionals additional training on how to approach healthcare in a culturally tailored manner. This approach may lead to the success of screening programmes worldwide.

Healthcare workers have an important role in educating women about cervical cancer in any available opportunities. This is because healthcare workers are very respectable people in society and their views and suggestions are adhered to by all and sundry. Healthcare professionals can use their personalities to shape the cultural perception women have about CC and CCS, and this must be done appropriately. It is a difficult task to modify the cultural views of people about a disease, so education on cervical cancer should not only target women but also families, the community at large, religious or traditional leaders, politicians, etc. These people, when educated on cervical cancer and its preventive measures, can augment the role of healthcare providers in the promotion of CCS in women.

Mantula et al. (2024) stated that African countries must adhere to some guidelines established by the WHO. These guidelines stipulate that sustainability is a gateway to the realisation of comprehensive screening programmes. The study continued to reveal that the World Health Organization believes that fixing cervical cancer screening problems needs a country-led action measure specifically in African countries.

Suggestions for future research have been drawn based on the findings of this study. Future research should come up with ways of tackling the obstacles to cervical cancer unanimously. More research can be done about HPV self-sampling to measure its effectiveness, especially in societies where cultural barriers are a challenge to CCS. Also, the interaction between the various hurdles and how they affect women's behaviour toward screening should be further examined as that will help in creating better interventions. Finally, future research should assess the persistent potency of interventions that aid in increasing screening rates, especially in countries where screening rates are low.

7.1 Comparing the results with Leininger's Transcultural Theory

Cultural barriers and misconceptions influence women's attitudes toward screening programmes. Leininger's transcultural theory places emphasis on targeting these cultural barriers through a cultural lens by health professionals to increase screening participation in women. This section compares the results of this study to Leininger's Transcultural Theory.

To begin with, studies in Ethiopia and Malawi suggest that education on CCs should be culturally related. Also, the involvement of famous community leaders is very important in debunking misconceptions about CCS. Education on CCS can be in the form of storytelling and the language used should be precise, polite and should conform to the beliefs of the people (Demissie et al., 2022). Leininger's theory supports that education on CCS is conveyed in a culturally appropriate manner incorporating the traditional values of the people to ensure the appreciation of the educational activity. In effect, this may improve health preventive outcomes (Leininger, 1991).

To continue, studies in Uganda, Iran, and African immigrants in Finland established that healthcare workers must tackle the issue of misconceptions about CCS and HPV vaccinations at the community level. Men must also be educated on CCS to broaden their knowledge of the disease and screening procedures. This will help erase any misconceptions men have about CCS so they can support their wives throughout the screening journey. Leininger's theory stresses that healthcare workers consider individual cultural differences when giving education on health, particularly CCS.

Furthermore, the use of HPV self-sampling and bringing screening services to the doorstep of women who have distance and certain cultural beliefs as a hindrance to participating in

the screening programme, is an alternative method to encourage women to participate in CCS. This is evident in a study conducted in Ethiopia where an HPV self-sampling kit was made available to women who could not access clinical-based screening programmes. When a government is making policies concerning structural barriers such as providing mobile clinics, a constant supply of HPV test kits, and transportation issues must be in line with traditional beliefs and practices (Megersa et al., 2020). Leininger theory advocates for treatment at the community level that is geared toward the needs of the people. For example, Leininger suggests healthcare workers consider a decentralised community-based screening system. Also, in Leininger's theory, there is a need for policies made at the local level to be culturally centered (Leininger, 1991).

Finally, providing healthcare professionals with adequate training on the management of insufficient resources and understanding the cultural background of their patients will make screening programmes more effective. Leininger theory suggests that health policies consider making healthcare systems in a culturally accepted way that will help healthcare workers provide the best care (Leininger, 1991).

To conclude, Leininger's Transcultural Nursing Theory highlights the importance of providing healthcare in relation to the culture of the people. The discussion revealed that not only healthcare should be culturally centered, but health policies should be created in a culturally accepted approach.

8 Discussion of Method

A qualitative research method was employed to investigate the influence of cultural differences on cervical cancer screening among women. The study of cultural occurrences requires the use of qualitative research methods. Qualitative research method provides an in-depth understanding of the meanings people attach to social realities (Polit & Beck, 2010).

To begin with, a systematic literature review (SLR) was utilised as the principal method of collecting data to satisfy the aim of the study. A systematic literature review (SLR) is an efficient method that helps gather and analyse peer-reviewed articles to investigate the cultural barriers to cervical cancer screening. To be able to find, evaluate, and merge quality studies it is appropriate to use SLR. This helps in analysing cultural behaviours in healthcare. The SLR approach helps to understand and assess various studies which further

helps to discover common themes, trends, and gaps. This method ensures the reliability of the results since the findings are based on different works of literature representing a larger population across different cultural settings. The inclusion criteria were limited to 2018 to represent recent happenings owing to the changes in healthcare practices, policies, and cultural changes due to technological advancements and challenges faced by the healthcare system. Also, this ensures that findings portray current perspectives and barriers to cervical cancer screening.

Also, content analysis was used to analyse the chosen articles for the study. The use of content analysis is the right method for this study because it helps to detect, classify and analyse patterns and themes. Content analyses help the researcher to understand the various ways in which cultural barriers influence cervical cancer screening in diverse populations. This can be achieved by concentrating on repeating things in the data. This method is important in qualitative research because identifying changes in attitudes helps to better understand complex social phenomena. Also, content analysis helps to disclose themes across various research. This is in line with the aim of the study that investigates the influence of cultural differences on CCS among women. It must be noted that content analysis allows researchers to find trends and connections among various studies. For example, connecting research from different countries gives insight to the researcher on whether cultural beliefs prevent screening or if some healthcare approaches are more efficient with some particular cultural groups. This helps healthcare workers make suggestions that will support screening and also the identification of cultural patterns and differences helps to create culturally accepted ways to increase screening rates.

Furthermore, the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) chart was used in the selection and review process to enhance transparency. The transparency of the system boosts the reliability of the review. The PRISMA chart helps to document every stage of the selection step that is from the beginning to the final inclusion to ensure the prevalence of the systematic review. Also, it gives a clear, visual summary of the search strategy, and the criteria used, in the study selection. This gives the reader a better understanding of the inclusion and exclusion criteria used.

In sum, the technique used ensured comprehensive analyses of the influence of cultural differences on cervical cancer screening among women. The qualitative method used looked at the individual experiences in relation to their cultural beliefs. The systematic literature analysis employed gave a general picture of existing knowledge. The content analysis helped

identify practical solutions to the cultural barriers to CC. The methods used gave a clear understanding of the obstacles to CCS and the implementation of inclusive and efficient healthcare practices in different cultural settings.

8.1 Limitations of the Study

This study solely used the qualitative research method and systematic literature review to investigate the influence of cultural differences on cervical cancer. Even though the methods used for the study provide an understanding of the topic it has some limitations that are discussed below.

To begin with, a limitation of the study is that there was no direct contact with individuals through interviews, focus groups, and fieldwork. The study only used secondary data from existing literature. The reliance on secondary data may underrepresent individual personal experience. The collection of primary data might have expanded the findings by providing information about first-hand information on the perspectives of individuals on cervical cancer screening. Also, grey literature, such as government reports, newsletters, speeches, conference papers, community-based research, etc, that may provide important information about cultural elements and health behaviours were not considered in the study.

Furthermore, the review only included peer-reviewed literature written in English. The scope of the study is limited by reviewing only peer-reviewed articles written in English. This may also result in the removal of important research written in other languages. Non-English-speaking countries may be underrepresented and cultural influence on CCS in those countries may not be considered in the study. Finally, the reliance on peer-reviewed articles may lead to the consideration of research that follows current academic trends over research that is exceptional but from an under-resourced setting.

To conclude, despite the limitations discussed above, the study gave a clear picture of the impact of culture on cervical cancer screening. Future studies can include non-English papers, grey literature, and primary data collection to improve the inclusiveness and relevance of the findings.

9 Conclusion

This study gives a detailed understanding of how cultural beliefs, myths, and misconceptions coupled with structural and accessibility barriers contribute to low screening rates among women worldwide. The influence of cultural differences on cervical cancer screening among women emphasises the relationship between cultural beliefs and attitudes toward healthcare. A multifaceted and culturally tailored approach may help in handling these problems.

Some effective ways in which the cultural obstacles to CCS may be curbed and make screening acceptable to women are by engaging respected community leaders, adopting a suitable communication approach, and involving male supporters. Nurses, as front-line healthcare workers, can be also influential in the promotion of cervical cancer screening by promoting trust, providing care that takes into consideration the cultural values of the patient, and providing a community-based education on CCS. Health-care systems should draw policies that consider the cultural beliefs of the people. Also, the government should provide adequate resources, provide financial support to bridge the structural and accessibility gap. These initiatives when put in place will make women prioritise their health and improve their health tremendously.

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Appendix- Chosen Articles

Author/Title/Year	Aim	Method	Result
Byskov et al.(2020) The perception gap: how the benefits and harms of cervical cancer screening are understood in information material focusing on informed choice	Develop educational material based on the best current data about risk communication and cervical cancer screening. Investigate how women comprehend and interpret this new information to make an educated decision about participating in cervical cancer screening.	Qualitative research- Semi-structured interviews. Participants were contacted via a post on Facebook. Others by self-referral in response to a flyer. A total. 17 women aged 25-55 participated in the study	Participants found numerical risk information difficult to understand and apply. The new pamphlet was considered a helpful resource for increasing awareness about the screening program, though its content on cervical cancer and potential screening harms was unexpected for many. Participants interpreted the information through the lens of their existing perceptions of screening.
Adegboyega et al.(2022) Qualitative assessment of attitudes toward cervical cancer (CC) screening and HPV self-sampling among African American (AA) and Sub-Saharan African Immigrant (SAI) women	The goal of this study was to understand better AA/SAI women's attitudes toward CC screening, as well as to investigate their willingness, acceptance, and concerns about the HPV self-sampling approach for CC.	Qualitative study: Focus group discussion. Six focus groups comprising 5-6 women were held via Zoom video conferencing. Semi-structured interviews guided sessions.	Barriers identified to CC comprise inadequate knowledge, conservative culture and upbringing, Socio-economic factors, trust, etc.

Idehen et al.(2020) Barriers and Facilitators to Cervical Screening among Migrant Women of African Origin: A Qualitative Study in Finland	The study sought to investigate the challenges and facilitators to CCS Pap testing participation among women of Nigerian, Ghanaian, Cameroonian, and Kenyan ethnicity in Finland.	Qualitative study: Focus group discussion. 30 women of African origin such as Ghana, Cameroon, and Kenya in Finland participated in the FGD. FDGs comprising 3-5 participants and one pair discussion.	Migrant women in Finland face barriers to cervical cancer screening due to language issues, lack of awareness, and cultural challenges. Many misunderstand the purpose or results of screening, deterring participation. Better communication, cultural sensitivity, and targeted awareness efforts could improve screening rates and health outcomes.
Dsouza et al.(2020) Exploring the Barriers to Cervical Cancer Screening through the Lens of Implementers and Beneficiaries of the National Screening Program: A Multi-Contextual Study	This study sought to explore the individual, social, economic, and cultural obstacles and facilitators to cervical cancer screening faced by Indian women in the target populations. Furthermore, it considers health professionals' understanding of these obstacles and facilitators when implementing the NPCDCS in various contexts across India.	Qualitative study: a qualitative exploratory multi-centric cross-sectional study was performed in three Indian states: Himachal Pradesh, Meghalaya, and Karnataka, using FDG and structured interviews.	Poor awareness of cervical cancer, the advantages of screening service availability, and an overall sense of well-being were significant hurdles to screening uptake. Other barriers included embarrassment or anxiety about the screening process, fear of being evaluated for lack of modesty, and stigma, while geographical inaccessibility of screening poses a barrier to participation in cervical cancer screening in specific places.
Khazaee-Pool et al. (2018) Exploring Iranian women’s perceptions and experiences regarding cervical cancer-preventive behaviours	The study aims to investigate Iranian women's attitudes and experiences with cervical cancer-prevention behaviours.	Qualitative study: In-depth interviews and FDG. 19 women participated in semi-structured interviews, and 12 out of the 19 participated in the FGDs.	Misconceptions and superstitions regarding cervical cancer, along with fear, humiliation, and embarrassment, serve as obstacles to screening. Concerns regarding marital fulfillment, sexuality, and femininity also hindered involvement. Religion, on the other hand, was perceived as a motivator for engaging in preventative behaviours.

Bouskill et al.(2024) Understanding women's and men's perspectives on cervical cancer screening in Uganda: a qualitative study	The study aimed to understand the factors influencing screening decisions and inform a peer-led intervention for promoting CC screening.	Qualitative study: Seven focus group discussions, 3 groups of women who have been screened, 3 groups of women who have not been screened and one group included men.	Several factors influenced women's decisions to screen, including stigma, availability of screening, false beliefs about the procedure and side effects, and the role of spousal support. Male spouses showed varying attitudes, from full support to hesitancy about male-performed exams and concerns about possible prolonged periods without intercourse.
Binka et al.(2019) Male support for cervical cancer screening and treatment in rural Ghana	This study investigates men's understanding of cervical cancer and the assistance they have offered to their cervical cancer patient partners during the screening and treatment stages in a rural community in Ghana.	Qualitative study: FDG Cervical cancer patients and their partners were purposively selected via phone calls using the Gynaecological Department of the Battor Catholic Hospital. 15 cervical cancer patients and 10 partners willingly participated in the study. 16 married men in the Battor district participated in 2 different group discussions.	The study highlights that male partner generally supported their wives during cervical cancer treatment, providing financial and emotional assistance. Some abstained from sex to aid recovery, while others struggled with intimacy concerns. However, a few women received no support, with some partners abandoning them. Many men were willing to help but lacked knowledge about the disease and wanted more information to assist their wives better.
de Fouw et al.(2023) Involving men in cervical cancer prevention; a qualitative enquiry into male perspectives on screening and HPV vaccination in Mid-Western Uganda	Understanding the perspectives of males regarding cervical cancer screening and HPV vaccination in Western Uganda.	Qualitative study- FDGs Men aged 25-60 who were married and had daughters. The FGD participants were grouped according to age: 25-35, 36-45, and 46-60. One group comprised local leaders and the other influential men in the community.	Eleven focus group discussions with 67 men revealed that they were generally willing to support their wives for cervical cancer screening and their daughters for HPV vaccination. However, common misconceptions included the belief that cervical cancer is caused by family planning or poor personal hygiene and a lack of understanding regarding the preventative benefits of screening and vaccination.
Demissie et al. (2022)	Explore communities' perceptions of cervical cancer	Qualitative study: Qualitative descriptive study design using FDG and in-depth	Most participants lacked awareness of cervical cancer, associating it with multiple births and

Communities' perceptions towards cervical cancer and its screening in Wolaita zone, southern Ethiopia: A qualitative study	and screening among women in the Wolaita Zone, Southern Ethiopia.	interviews. Purposive sampling was used to get the study participants. The participants consisted of men and women who were not health professionals and were 18 years of age and older.	unprotected sex rather than with HPV. They viewed the disease as incurable but preventable, with many believing they were not at risk and thus saw no need for screening.
Møen et al. (2018) Cervical cancer Screening among immigrant women in Norway- The Healthcare Providers' perspectives	To investigate health care professionals' (HCPs) experiences with cervical cancer screening (CCS) among immigrant women, their techniques for facilitating these consultations, and their need for further knowledge.	Qualitative Study-Exploratory qualitative design using focus groups and personal in-depth semi-structured interviews. Participants included 27 gynaecologists and 3 midwives. 3 focused groups comprising structured interviews with gynaecologists and two personal semi-structured. interviews with midwives.	Healthcare providers reported shared experiences with all women regarding cervical cancer screening, such as understanding preventive routines. Unique challenges for immigrant women included organizational issues, language barriers, low health literacy, cultural differences, and gender norms. Strategies like extended consultations, interpreter use, anatomy models, and cultural sensitivity were employed to address these barriers.
Megersa et al. (2020) Community cervical cancer screening: Barriers to successful home-based HPV self-sampling in Dabat district, North Gondar, Ethiopia. A qualitative study	Explore the barriers to successful home-based human papillomavirus (HPV) self-sampling in North Gondar, Ethiopia.	Qualitative study- Qualitative descriptive study. Applied purposive and convenience sampling. 22 women participated in in-depth interviews and 27 participated in four focused group discussions.	Husband disapproval was the primary barrier to home-based HPV self-sampling, alongside social influence, lack of cervical cancer awareness, insufficient health education, feeling healthy, and religious beliefs. Fear of using the Evalyn brush, improper usage, and difficulty understanding instructions led to poor sample quality. Recommendations included improving health education, involving men in screening programs, and integrating self-sampling services into local health facilities.
Bula et al. (2022)	Explore perceptions and motivations for screening among women participating in a cervical	Qualitative study - qualitative sub-study using one-on-one interviews. 17 women who had undergone screening participated	Findings revealed limited knowledge of cervical cancer, with prevalent misconceptions but a unique understanding of screening as a preventive

Perceptions of cervical cancer and motivation for screening among women in Rural Lilongwe, Malawi: A qualitative study	cancer screening and treatment pilot study in rural Malawi.	in the study. Semi-structured guide was used for in-depth interviews	measure, likely influenced by HIV prevention concepts. Motivations for screening included the desire to know one's health status, the convenience of community-based screening, and peer encouragement.