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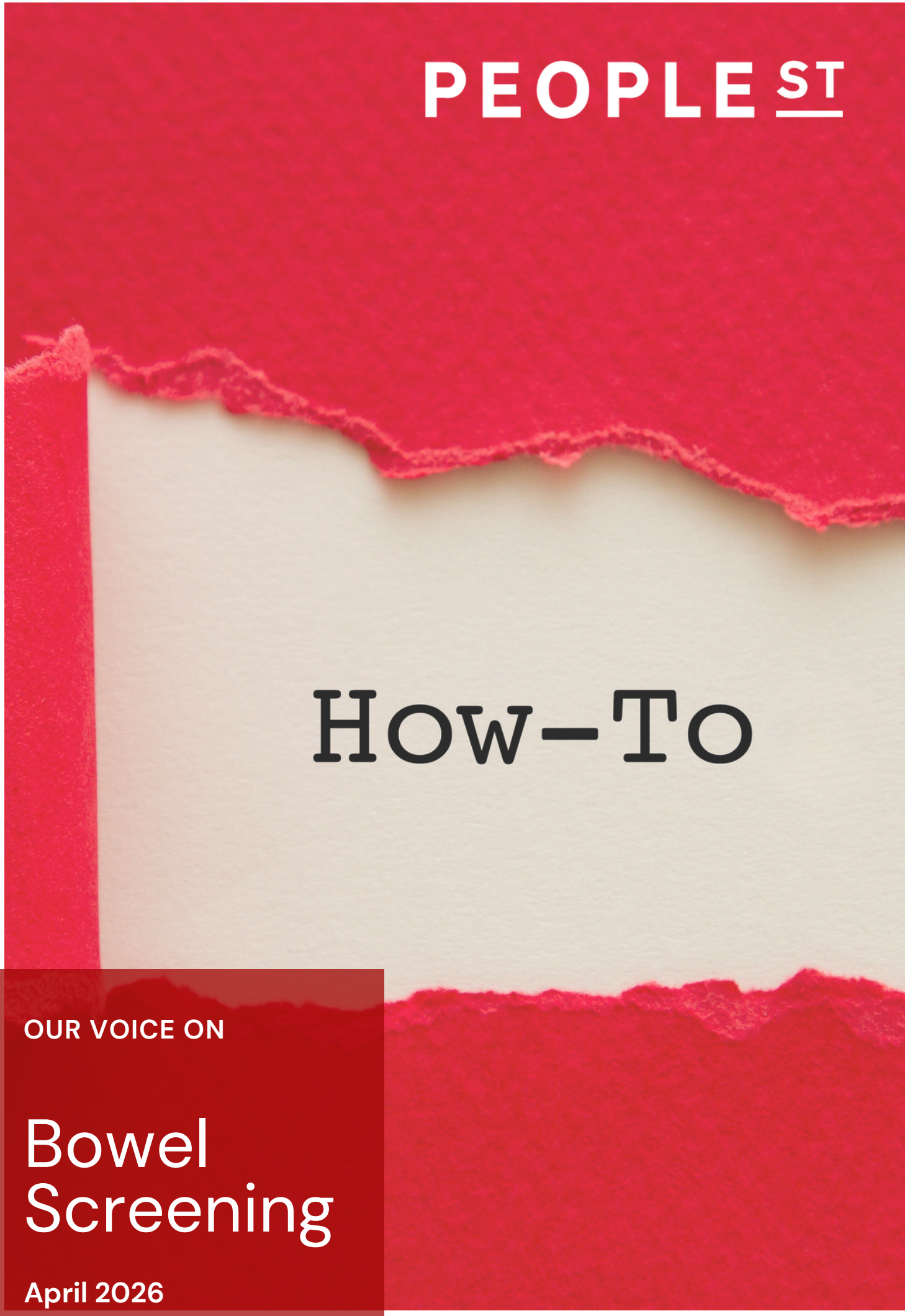

OUR VOICE ON

Bowel Screening

April 2026

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01 Introduction

Whilst this report will be shared with policy makers, decision makers, and researchers, we have designed this report for the communities we serve.

This report shares what 100 people from Sylheti-speaking Bangladeshi and Somali communities in Tower Hamlets and Newham told us about our pilot bowel screening videos.

The videos were made by People Street, working with community members and a local GP in Tower Hamlets. They were produced in English, Sylheti and Somali.

The evaluation was carried out in February 2026 by Community Researchers trained by People Street. The aim was simple:

- Do these videos work?
- Do they help people understand what bowel screening is, feel confident to do the test, and want to tell others?

The report uses the words of participants wherever possible. Their voices are at the heart of this work.

The problem we were trying to solve

Bowel cancer is one of the most common cancers in the UK. It is also one of the most preventable. The NHS offers a free bowel screening kit to everyone aged 45 and over. The kit is simple to use at home. When cancer is caught early, the chances of survival are much better.

But uptake of bowel screening is lower in some communities. People who do not speak English as a first language, who have low literacy, or who do not feel culturally connected to health services are less likely to do the test.

Our previous research showed that receiving a letter through the post is not enough. Many people do not understand what the kit is for, how to use it, or why it matters. Many kits end up in the rubbish. In response to this, we delivered a health literacy project designed to raise awareness of cancer screening. Our films were created through our cancer screening project.

People Street believes that information works best when it comes from someone who looks like you, speaks your language, and understands your life. That is why these videos were co-designed with community members and a Bangladeshi GP based in Tower Hamlets. The goal was to create something that felt familiar, trustworthy, and genuinely useful.

The videos covered:
•Why bowel screening matters and what bowel cancer is
•How to use the kit, step by step
•What to do once you have completed the sample

The videos were produced in English, Sylheti/Bengali and Somali. They were shared with participants via the Community Researcher.

This report captures the feedback from the community in their own words.

02 What we did

People Street works from the principle that communities are the experts on their own lives. Our research model puts community members at the centre not just as participants, but as the people who carry out the research itself.

We train local people as Community Researchers. They are recruited from the communities we work with. They speak the languages, know the cultural norms, and have the trust that professional researchers rarely have. This means we reach people who would never respond to a survey sent through the post, answer a phone call from an unknown number, or walk into a clinical research setting.

This model is rooted in the principles of proportionate universalism: reaching people according to the scale of their disadvantage and the barriers they face. It also reflects our commitment to co-production — research that is done with communities, not to them.

How the research was carried out
The research took place in two sprints.
Sprint 1: 26 January – 2 February 2026: 30 responses
Feedback from researchers to iterate the form before the second sprint.
Sprint 2: 4 February – 20 February 2026: 70 responses

Five Community Researchers carried out the research. They were based in Tower Hamlets and Newham, and worked within their own communities and networks.

Each Community Researcher showed the videos to participants. After watching, participants took part in a research conversation in mother tongue, making it accessible for people with low literacy or low digital confidence to take part.

In total, 100 people took part across the two sprints.

What we asked:

- An overall star rating for the video
- Which language video they watched
- Whether they had received a bowel screening kit or letter before
- Whether the video helped them understand why screening is important
- How they felt about doing the screening after watching
- How much the video helped them understand how to use the kit
- What they liked about the video
- How confident they now felt about using the kit
- Whether they would encourage family and friends to do the test
- Whether the videos were easy to follow
- What they liked most and what could be better
- What other topics they would like videos on

We also collected demographic information including age, ethnicity, home language, gender, postcode and digital confidence.

03 Who took part

We take an intersectional approach to participant recruitment.

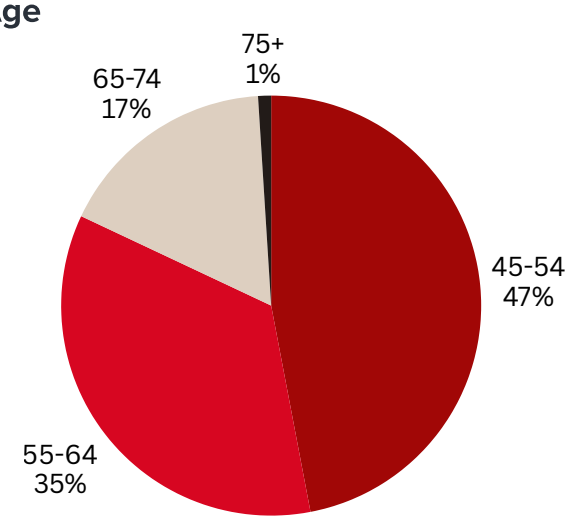
Taking an intersectional approach means we aim to reach people experiencing multiple, and intersecting barriers to inclusion. We therefore don't use ethnicity as a measure of diversity, but look to include other factors such as literacy, digital confidence, postcode, age, health and employment status.

Total Participants
100

Gender

47% Female
53% Male

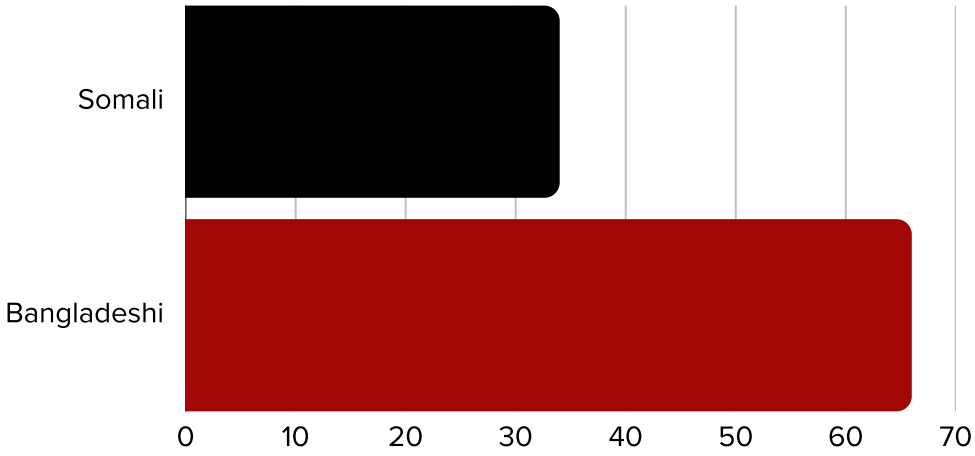
Age



Geography

43% Newham. **57%** Tower Hamlets

Ethnicity



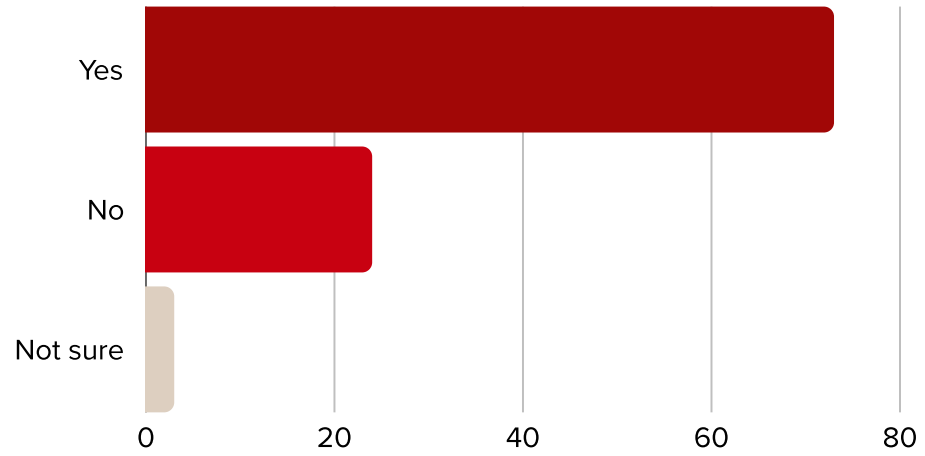
04 Who we spoke to

91% Would encourage friends & family

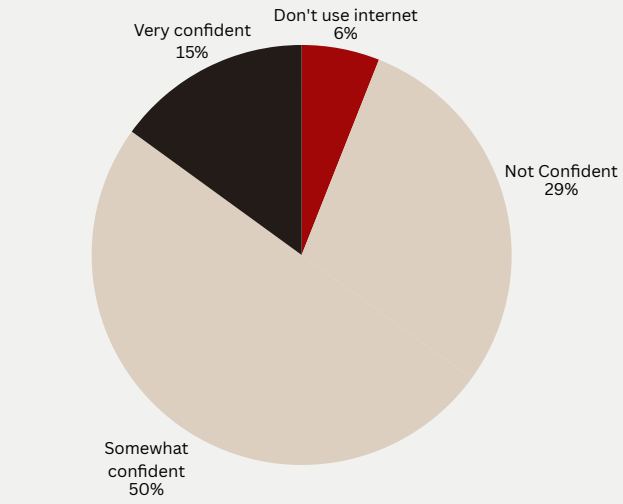
96% Migrant, refugee or asylum

79% Disability or LTC

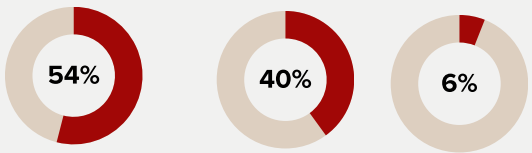
Previously receive letter or kit in post?



Digital Confidence



English Confidence



Confidence navigating healthcare

65% Low

35% High

05 What we heard

Language Is the Door to Health Literacy

The single most important factor that made the videos work was language. Across all responses, in both sprints, the ability to hear information in their own language was transformative. This was not just about convenience — it was about trust, dignity and belonging.

The emotional weight in many of these responses is significant. People were not simply saying they found the video easy to understand. They were expressing gratitude and relief.

For some, it was the first time they had received NHS health information orally in their language. One Somali participant said “When I heard it I was so happy”.

This reflects a pattern People Street sees consistently: communities that have historically been excluded from health communications do not take culturally attuned information for granted. When it arrives, it lands with real emotional force.

However, the data also shows that language alone is not sufficient if the dialect is wrong. Several Somali speaking participants noted that the video used a neutral dialect, which enabled both Northern and Southern speakers to understand.

This is important nuance. ‘Somali’ is not a single language experience. The dialects have variation, and may not be understood by all Somalis if a north or southern dialect is chosen. Future versions of the video will include producing a standard Bengali version alongside the Sylheti one, and both Somali dialects.

DETAILS OUTCOME

“The video was easy to understand because it was my mother tongue language. I was very happy to hear the Somali language”

“What I like the most is the Somali language. We don’t always get Somali translated videos like this so thank you”

“As the explanation was in Bangla, it helped me to understand the purpose of the video fully”

“The fact that the explanation was in a language I understand, I feel more confident when using the kit”

05 What we heard

Videos Work Better Than Letters

A consistent finding across both sprints was that video is far more effective than the NHS letter or leaflet for this group. Many participants had already received the screening kit in the post but had not used it. The letter had not worked. The video did. One participant explained the difference in simple but powerful terms:

“It was explained very well, much easier to understand than the letter. If we had this video earlier, it would’ve been more useful. But I’m happy we have an explanation video like this now”

This finding has direct implications for the NHS bowel screening programme. The current default — a letter through the post — is not reaching communities like these effectively. For people with low literacy, low English proficiency, or low digital confidence, a letter is not accessible. A short video in their language, shared by a trusted community member overcomes barriers.

Multiple participants selected ‘I like videos more than letters’ as one of their reasons for liking the video. This was among the most frequently selected options in the feedback form.

“Watching the video is more useful than reading from a letter or a leaflet, because it helps me to understand a lot more easily and quickly”

“A live demonstration is easier to follow than words from a letter, or diagrams on a leaflet”

“Yes, the videos were much easier to understand than reading a leaflet, making the information more accessible and clear”

“If I never had watched this tutorial I would never have attempted to try and use the kit. It’s given me some confidence”

05 What we heard

The Kit Feels Less Scary Now

One of the most powerful outcomes of the videos was a shift in how people felt about the test itself. Before watching, many participants had received the kit but had not used it. After watching, confidence was high.

75 out of 100 participants said they were now 'very confident' they could do the test. A further 24 said they were 'a bit confident'. Only 1 person said they were not confident at all.

"Yes, without the video I never realised how serious bowel cancer is. Now that I know the importance, I am ready to keep myself safe"

"I didn't know much about bowel cancer before. I had received the kit, but didn't know how to use it and was quite confused. The video helped me to understand it better"

The GP appearing on screen was also significant. Having a doctor, in their local area normalised the test and explain it calmly made a real difference:

Participants valued that the kit was demonstrated step by step, and that it was shown to be quick and simple:

"I liked how they person in the video described the kit in a very simple way, it was easy to understand"

"I particularly liked the clear explanation of the screening kit, including how they demonstrated the correct way to collect the sample"

"It takes no longer than 5 minutes to complete"

Several participants had specific concerns about the sample collection step, suggesting that this part needs more attention in future videos:

"It was not clear how much sample need to collect in the kit for test"

"Second part needs more clear, especially how will we take the sample"

In future iterations we will need to expand this section to address this feedback.

"Yes, the video has made me more confident in using the kit"

"The information was presented by a female doctor, as this felt reassuring and relatable"

"I understood the video how it explained about the symptom and early diagnosis saves lives"

05 What we heard

Figure 1. Intent to do bowel screening after watching the video

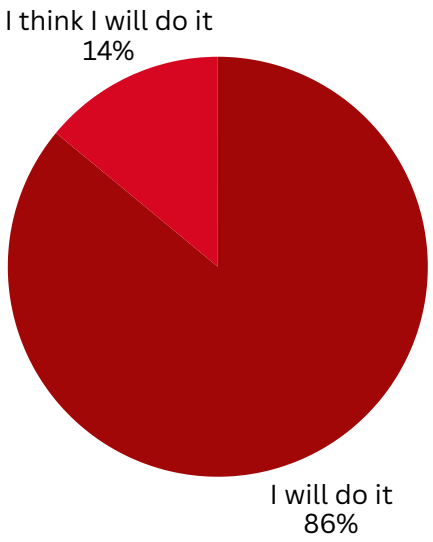


Figure 2. Would encourage family/friends to do the test

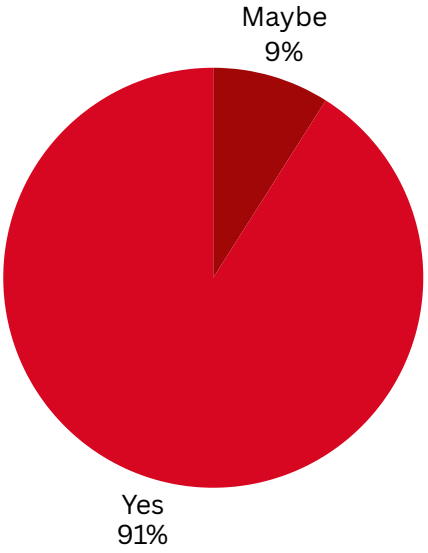


Figure 1 illustrates that 86 out of 100 participants said 'I will do it' when asked how they felt about bowel screening after watching. The remaining 14 said 'I think I will do it'. No one said they would not do the test. Figure 2 shows that 91 out of 100 said they would encourage family and friends to do the test. 9 said 'maybe'. This 'pass it on' effect is one of the most valuable outcomes of the research. Community health behaviour change does not only happen through individual decisions, it spreads through social networks. When people share health information with people they trust, the reach multiplies.

"I found it so useful that I showed my friends and family the video so they can be aware"

"Yes showed my family"

"Now I can do the test either with the help of the video, thank you"

"Yes, the video helped me understand the importance of bowel screening, particularly given my personal experience of having prostate cancer"

05 What we heard

What Could Be Better

While the responses were overwhelmingly positive, participants offered thoughtful and specific suggestions for improving the videos. These fall into several areas:

Sound and visual quality

A number of participants across both sprints noted that the audio quality and lip-sync were sometimes poor. This affected their ability to follow the video fully.

"The quality of the video needs to be addressed as it's not in sync with the voice"

"The quality of the speech and the mouth movement was not aligned together. Need to improve the quality of the video"

"The videos could be improved by eliminating the echo in the audio, which would enhance clarity"

Camera and zoom

Several participants wanted the camera to zoom in more on the kit during the demonstration, particularly for people with visual impairments.

"At times I felt as if the video was too far. If more parts were zoomed in, it would help to retain my attention"

"When the doctor was demonstrating the kit, the camera should focus and zoom into the kit with bright colours for patients who are partially blind and also use subtitles for the patients who are unable to hear clearly"

Step-by-step structure

A clear theme from Sprint 2 was a desire for numbered steps. Participants wanted the process to feel more structured and easier to reference.

"The videos could be improved by including numbered steps (for example, Step 1, Step 2, Step 3). Presenting the information in a clearly structured, step-by-step format would make the process easier to follow and reference"

"I think if the doctor explained it more step by step using for example step one, do this and step two do that etc. Also pictures would be more beneficial"

What to do if things go wrong

Several participants asked for guidance on what to do if they made a mistake, or if they needed a new kit.

"Maybe go tell us what to do if things go wrong, maybe requesting a new kit etc."

"If we could have an explanation for what could be done if any mistakes are made"

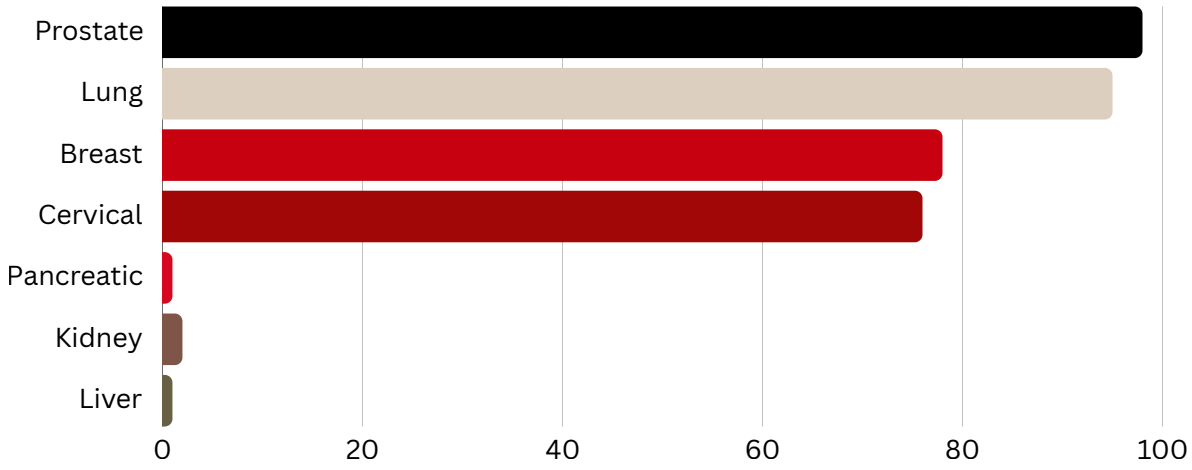
Persuasive framing

One participant felt the video should do more to address practical barriers to doing the test. This is a subtle but important point. For some communities, cost is a real concern, or a perceived one. Naming that the test is free, takes five minutes, and requires no appointment could remove barriers that the video does not currently address.

"The doctor should've used convincing words like it's free and doesn't cost you any money"

05 What we heard

Figure 3. Other cancer screening videos people want



We want more!

Figure 3 illustrates that 100% of participants said they would like more videos like this on other topics. There was a strong and consistent demand for videos covering other cancer screening programmes.

Breast screening, cervical screening, prostate screening and lung cancer screening were the four most requested topics. Virtually every participant selected all four. This reflects a clear message: the community wants this kind of information. They are not hard to reach — they have simply not been reached in the right way.

“Now that I know more about Bowel Screening, I would encourage family or friends to do the test? And I will do the test because of the video how easy and simple the video been explaining it is a big encouragement, thank you”

06 Implications for Service Design

The findings from this research have direct implications for how bowel screening — and cancer screening more broadly — is designed and delivered for communities who are currently not participating in national screening programmes.

Letters are not enough

Two thirds of participants had already received a bowel screening kit or letter. Many had not acted on it. The current NHS standard communication model is not working for these communities. This is not a failure of the individuals — it is a failure of the system to communicate in ways people can access and trust. By leaving these communities behind, we are exacerbating health inequalities and perpetuating late cancer diagnosis.

A video in someone's language, shared by a trusted community member, achieved in a short time what a printed letter had not achieved over years. This should prompt serious reflection about the default communication model for screening programmes in diverse urban areas.

Trusted messengers matter

The videos were not just effective because of their content. They were effective because they were delivered by someone from the community, in the community's language, in a setting that felt safe. The Community Researcher model is not incidental to these results — it is central to them.

Community Researchers do not simply distribute information. They translate it, contextualise it, answer questions, and create the kind of relational trust that institutional health communications rarely achieve. This model has implications for how health systems think about the 'last mile' of health communication.

Language must be specific, not generic

The data shows that 'translated' is not good enough. A Bengali video that uses Sylheti dialect will not serve all Bengali speakers equally. Standard Bengali, Sylheti, and other regional variants need to be considered as distinct communication needs. The same principle applies to Somali, Urdu, Arabic and any other language community. Producing a video in 'a language' is a starting point, not a solution.

06 Implications for Service Design

Video as standard, not supplement

This research provides evidence that short, accessible, multilingual video content can significantly shift knowledge, confidence and intent to act on health screening. Video should be considered a standard component of screening communication campaigns — not an optional extra for 'hard to reach' groups.

Co-production produces better outcomes

These videos were co-designed with community members and a local GP. That process matters. It is what makes the content feel familiar, authentic and trustworthy. Screening communications produced without community input will miss the nuances of how people talk about their bodies, what they trust, and what puts them off.

A note on the 'hard to reach' framing

People Street does not use the term 'hard to reach'. The communities who took part in this research are not hard to reach — they are easy to reach when you use the right approach. They responded warmly, generously and thoughtfully to this research. The challenge is not about them. It is about how health systems design and deliver their communications.

07 Recommendations

For whom	Recommendation
People Street	Improve audio quality, lip-sync and video resolution before wider distribution. These are technical fixes that will significantly improve accessibility for all viewers.
People Street	Add numbered, step-by-step on-screen captions to the kit use section to make the process easier to follow and reference after watching.
People Street	Add a short section on what to do if something goes wrong — requesting a replacement kit, for example. This would reduce anxiety about making mistakes.
People Street	Produce a standard Bengali version alongside the Sylheti version to serve all Bengali-speaking participants equitably.
People Street	Explicitly name that the test is free, takes around 5 minutes, and requires no appointment. This addresses common practical and perceived barriers.
People Street	Develop an active distribution strategy for the videos: GP waiting rooms, community centres, WhatsApp groups, faith settings, and social media channels trusted by each community.
People Street	Extend the video series to cover breast, cervical, prostate and lung cancer screening in response to the overwhelming demand from participants.

This research gives People Street a strong evidence base to build on. The next steps are:

- Work with the original GP and community co-designers to develop a second version of the bowel screening videos incorporating the improvements identified by participants.
- Develop the distribution plan for the existing videos, beginning with GP waiting rooms and community settings in Tower Hamlets and Newham.
- Document the Community Researcher training and research model used in this project as part of People Street's Centre for Health Empowerment methodology framework.
- Share this report as a case study for People Street's work on community-led research and digital health equity.

07 Recommendations

These recommendations have been co-produced with our community panel and are informed by the research insights with the communities of Newham and Tower Hamlets.

The voices amplified in this report are intersectional and varied. Mixed messaging from NHS services, difficulty accessing primary care and persistent and compounding barriers navigating healthcare perpetuate inequalities. Communities are not avoiding screening programmes because they don't believe they work. They aren't coming forward because health literacy around screening is poor. Screening letters are difficult to understand and don't address barriers to access.

For whom	
Local system (NEL Cancer Alliance, ICB, PCN)	Commission multilingual video content as a standard component of cancer screening outreach in diverse communities, rather than relying solely on postal communications.
Local system (NEL Cancer Alliance, ICB, PCN)	Fund and integrate community models into screening outreach work. The evidence from this research shows they reach people the system currently does not.
Local system (NEL Cancer Alliance, ICB, PCN)	Display bowel screening videos in GP practice waiting rooms, particularly in practices serving communities with high levels of non-English speakers.
Local system (NEL Cancer Alliance, ICB, PCN)	Share learnings from this model with NHS England's national bowel screening programme and cervical screening equity workstreams.
National programme (NHS England)	Review the standard bowel screening communication model in light of evidence that postal letters are not working for many diverse communities.
National programme (NHS England)	Fund the development of a community-led, multilingual video library covering all NHS cancer screening programmes, based on the co-production model used by People Street.
National programme (NHS England)	Use this research as evidence in the national bowel and cervical screening equity strategies, as part of the programme's commitment to reducing health inequalities.

About People Street

People Street is an East London based organisation working at the intersection of community, belonging, and health equity.

We believe communities have the knowledge, creativity, and capability to shape the services that affect their lives.

Our Community Researcher model trains local people to carry out meaningful research in their own communities.

Our Centre for Health Empowerment develops methods, tools and approaches to make health information and services genuinely accessible to everyone.

Find out more at www.peoplestreet.net

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Contact us for
more information.

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