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Barriers and facilitators to breast cancer screening among women in Côte d'Ivoire: A qualitative study

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Abstract

This study examines breast cancer screening behaviors among women in a working-class neighborhood of Bouaké, Côte d'Ivoire, within the context of economic insecurity and therapeutic pluralism, where biomedical, traditional, and religious care practices coexist. A qualitative interpretive approach was used, based on 23 semi-structured interviews with women aged 18 and above, selected through purposive sampling and analyzed thematically. The findings reveal uneven knowledge of screening, particularly among older and economically vulnerable women, due to limited media exposure and social isolation. Breast cancer is widely associated with mutilation and death, generating ambivalent responses ranging from avoidance to heightened vigilance among women. Screening practices are shaped by intersecting economic, institutional, and time constraints, alongside enabling factors such as social support, prenatal care interactions, and media- and school-based awareness. These findings highlight the need for context-sensitive prevention strategies that integrate local social dynamics and diverse therapeutic landscapes. *(Afr J Reprod Health 2026; 30 [11]:87-97).*

Keywords: Breast cancer, screening, therapeutic pluralism, social determinants of health, qualitative research, Côte d'Ivoire.

Résumé

Cette étude analyse les comportements de dépistage du cancer du sein chez des femmes d'un quartier populaire de Bouaké (Côte d'Ivoire), dans un contexte de précarité économique et de pluralisme thérapeutique marqué par la coexistence de recours biomédicaux, traditionnels et religieux. Elle repose sur une approche qualitative interprétative fondée sur 23 entretiens semi-directifs analysés thématiquement. Les résultats montrent une connaissance socialement différenciée du dépistage, défavorable aux femmes âgées et économiquement vulnérables, en lien avec une faible exposition aux médias et un isolement social. Les représentations du cancer, associées à la mutilation et à la mort, produisent des attitudes ambivalentes entre évitement et recours préventif. Les pratiques sont contraintes par des facteurs économiques, institutionnels et temporels, mais facilitées par le soutien social, les consultations prénatales et l'information. Ces résultats soulignent la nécessité de stratégies de prévention adaptées aux réalités sociales et aux configurations thérapeutiques locales. *(Afr J Reprod Health 2026; 30 [11]: 87-97).*

Mots-clés: cancer du sein, dépistage, pluralisme thérapeutique, déterminants sociaux de la santé, étude qualitative, Côte d'Ivoire**.**

Introduction

Breast cancer is the most commonly diagnosed cancer among women worldwide and remains a leading cause of female mortality, with an estimated 2.3 million new cases reported in 2020.[1] Its burden is particularly high in low- and middle-income countries, where late diagnosis significantly limits treatment options and reduces survival rates.[2] In sub-Saharan Africa, most cases are detected at advanced stages, reflecting a combination of low screening uptake, poorly organized prevention programs, and persistent economic, geographic, and sociocultural barriers.

In West Africa, particularly in Côte d'Ivoire, epidemiological data confirm this concerning trend. According to the International Agency for Research on Cancer, breast cancer accounts for nearly one-third of all female cancers in the country.[3] However, screening remains largely opportunistic and concentrated in urban and hospital-based settings, while prevention initiatives targeting women in economically vulnerable areas are fragmented. Studies conducted in Abidjan highlight significant disparities in the acceptability and uptake of screening, shaped by place of residence, access to information, health insurance coverage, and interactions with healthcare providers.[4] These findings point to the socially differentiated nature of access to screening in urban contexts.

However, such urban-based analyses only partially capture the diversity of lived experiences across different socio-spatial settings. In secondary cities such as Bouaké, particularly in working-class neighborhoods like Odiennékourani, women's health behaviors are embedded in distinct social configurations marked by economic precariousness, limited institutional resources, and therapeutic pluralism. In these contexts, biomedical care coexists with traditional healing practices and religious recourse, shaping plural and sometimes competing health-seeking strategies. Understanding how these local dynamics influence screening behaviors requires moving beyond aggregated urban data to focus on the situated social worlds.

Beyond structural constraints, a growing body of research emphasizes the role of knowledge, social representations, and everyday life conditions in shaping decisions regarding screening. Studies in sub-Saharan Africa show that limited awareness, fear of diagnosis, financial constraints, and health system shortcomings remain major barriers, particularly among women in marginalized settings.[5-9] However, much of this literature relies on quantitative or hospital-based approaches, often overlooking the meanings, experiences, and social logics underlying women's practices.

From a socio-anthropological perspective, screening behaviors cannot be reduced to individual choices or knowledge deficits. They are produced at the intersection of symbolic representation, social relations, and material constraints. Therefore, a qualitative and interpretive approach is essential to capture how women make sense of breast cancer, negotiate competing therapeutic options, and arbitrate between health, economic survival, and family responsibilities in their daily lives.

The present study was conducted in Odiennékourani, a densely populated working-class neighborhood in Bouaké, within this analytical framework. This setting provides a particularly relevant site for examining how breast cancer screening practices are shaped by local social conditions and diverse therapeutic landscapes. Drawing on a qualitative, comprehensive, and interpretive approach grounded in the principles of social science inquiry,[10,11] this study seeks to document women's perspectives based on their lived experiences, illness narratives and interactions with healthcare institutions.

This article is to analyze how breast cancer screening behaviors are socially constructed in Odiennékourani at the intersection of knowledge, representation, and everyday constraints. More specifically, it aims to examine how social and behavioral factors influence the use or non-use of screening and identify contextually grounded levers for prevention strategies. By providing an in-depth socio-anthropological analysis of screening practices in a working-class neighborhood, this study contributes to ongoing debates on breast cancer control in West Africa and underscores the importance of aligning biomedical interventions with the social realities in which they are implemented in the Global South.

Methods

Study setting and design

This study was conducted in the Odiennékourani neighborhood, located in the municipality of Bouaké in north-central Côte d'Ivoire. This densely populated working-class area is characterized by economic precariousness and the coexistence of multiple therapeutic practices, including biomedical, traditional and religious care. The selection of this site was informed by preliminary field observations and local health actors' reports indicating low engagement with breast cancer screening services, particularly among women in socioeconomically vulnerable conditions. These contextual elements, combined with the diverse therapeutic landscape, make Odiennékourani a relevant setting for examining socially embedded health behaviors.

This study adopted a qualitative, interpretive design to understand the meanings, social representations, and rationales underlying women's screening practices. This approach is grounded in interpretive socio-anthropology, which emphasizes empirical rigor, actors' perspectives, and the contextualized interpretation of social practices.[10]

Participants and data collection

The study population consisted of women aged 18 years and above residing in Odiennékourani, with diverse profiles in terms of age, education, marital status and occupation. A total of 23 participants were recruited using purposive sampling based on the relevance of their experiences to the research topic. This strategy ensured the inclusion of women with varied relationships to screening, including those who had never been screened and those with prior screening experience. Sample size was determined by the principle of theoretical saturation, whereby data collection was discontinued once no substantially new themes emerged.[10-12]

Data were collected in November 2025 as part of the defined fieldwork period corresponding to the final phase of the research project. Semi-structured, face-to-face interviews were conducted to allow for an in-depth exploration of participants' perceptions, experiences, and decision-making processes regarding screening. Interviews were conducted in participants' homes or in neutral locations within the neighborhood to ensure privacy and comfort. Depending on the participants' preferences, interviews were conducted in French or local languages to facilitate open and meaningful communication. Each interview lasted approximately 45–60 min.

From an ethical standpoint, all participants were informed of the study objectives, procedures, and exclusive scientific use of the data. Verbal informed consent was obtained prior to each interview, as many participants had limited literacy levels, making written consent less appropriate than verbal consent. Consent was systematically documented by the researcher through audio recordings and field notes. Participants were assured of anonymity and confidentiality through the use of identification codes and were informed of their right to withdraw at any time without any consequences. Particular care was taken to minimize emotional distress, given the sensitivity of this topic.

Data management and analysis

All interviews were audio-recorded with the participants' consent and transcribed verbatim in accordance with qualitative research standards.[11] The transcripts constituted the primary dataset for analysis. A thematic analysis was conducted to identify, organize, and interpret patterns of meaning within the data.[11,13]

The analysis followed an inductive approach. An initial reading of the corpus enabled familiarization with the data and the identification of preliminary meaning units. Open coding was then performed to generate categories related to knowledge, perceptions, constraints, and facilitating factors associated with breast cancer screening. These codes were progressively refined and organized into broader themes and subthemes.

A constant comparative approach was used to relate verbatim extracts to the emerging categories, ensuring that the interpretations remained grounded in the participants' accounts. Particular attention was paid to contradictions, ambivalence, and variations across individual experiences to preserve the complexity of social practices. This analytical process aligns with comprehensive qualitative approaches that seek to reconstruct actors' meanings within their social context.[11,14]

Finally, the findings were interpreted in relation to the existing literature using a triangulation approach that combined empirical data and scientific evidence.[15] This strategy strengthened the validity of the interpretations and enabled the situating of the results within the broader sociological dynamics observed in African and global contexts.

Ethics approval and informed consent

This study was conducted in accordance with the principles of the Declaration of Helsinki. Ethical approval was granted by the Dean of the Communication and Society Training and Research Unit at Alassane Ouattara University (Côte d'Ivoire), who acted as the institutional review board for this research. All participants were informed of the study objectives, terms of participation, and scientific use of the data. Free, informed, and verbal consent was obtained prior to each interview. Anonymity, confidentiality, and privacy were guaranteed.

Results

This section presents the findings, highlighting the close relationship between knowledge, perceptions, social constraints, and motivating factors that shape breast cancer screening behavior among women in Odiennékourani. Qualitative analysis revealed that screening practices are embedded in a complex social world characterized by ambivalent representations, economic hardship, cultural logics, and relational dynamics, including both social support and individual agency.

Level of knowledge and practices of breast cancer screening

The data collected revealed a high degree of heterogeneity in the level of knowledge about breast cancer screening among the women interviewed. Older women appear to be less informed. Some explain that they have never heard of this practice, which is closely linked to historically limited access to media and awareness campaigns. An elderly participant describes her relationship with information as follows:

We stay at home, and we do not go out anymore, so we do not know about these things. When we were young, not everyone had a TV as they do now; it was expensive. Even today, we don't understand anything on TV. (F1, around 70 years old, unemployed).

This statement shows how aging, relative withdrawal from public life, and unequal exposure to health information contribute to a lack of knowledge about breast cancer screening.

Conversely, some younger women, particularly those who are employed or involved in women's associations, say they have learned about screening through information sessions organized at their workplaces or within their groups. One participant who works at the market explains:

Where I work at the market over there, we always talk about it in our women's association, that we have to go to the hospital. (F2, 32 years old, saleswoman).

Thus, membership in organized social networks appears to be an important channel for biomedical information.Overall, most women surveyed have partial, fragmented, or inaccurate knowledge of screening. This uneven distribution of information has a direct impact on the actual practice. A large proportion of the participants reported that they had never been screened. Some cite economic insecurity and the priority given to daily emergencies. One participant explains:

I'm here with my many children. I can't find food for them every morning. We only eat here at noon and in the evening, and I'm the one who's going to pay 3,000 CFA francs just to have my breasts examined. It's complicated. I'm not even thinking about that right now. (F3, 40 years old, housewife).

This testimony highlights how prevention is often relegated to the background in a context characterised by food insecurity. Other women expressed an intention to get screened but were hampered by insufficient financial resources:

I would like to go to the hospital, where the doctors will examine me thoroughly, but I don't have the money. What can I do? (F10, 38 years old, street vendor).

This gap between desire and possibility renders screening a socially selective practice.

In contrast, some women report regular screening as part of medical visits at work or school:

In any case, I always do it at my workplace. (F4, 29 years old, service employee).

Employment thus creates concrete opportunities for prevention, in contrast to most women in the most precarious situations and do not seek screening.

Perceptions of breast cancer and effects on health behaviors

Beyond knowledge level, perceptions of breast cancer play a central role in understanding the observed health behaviors. The interviews reveal that, for a large proportion of participants, this disease is primarily associated with an image of bodily deterioration and decay. Cancer is frequently described as an internal condition that gradually eats away at the breast and manifests itself in the form of sores. One participant summarized her understanding of the disease as follows:

For me, at least, it means having your breast amputated, because you can't live with a rotten breast that's oozing. (F5, 45 years old, shopkeeper).

Thus, breast cancer is immediately equated with bodily mutilation and a symbolic attack on femininity.

These negative perceptions are reinforced by the widely shared view of breast cancer as a serious, destructive, and often fatal disease. Several participants describe the disease in emotional and serious terms. One states:

It is a nasty disease that ruins women's breasts and often kills them. (F6, 37 years old, seamstress).

This seriousness is reinforced by the experience of the death of loved ones, which has a lasting impact on perceptions of the disease itself. One woman recalls the loss of her aunt:

I already have a relative who had breast cancer, my aunt, my uncle's wife, and she died, leaving her 6-month-old and 2-year-old children with us. It has significantly affected me. (F7, 34 years old, unemployed).

Another participant recounted the death of her childhood friend:

This disease killed my childhood friends. She used to tell us that she often had pain in her breast. One day, her husband took her to the hospital, and they said it was breast cancer, but it didn't last long. She died. It hurt me so much. She was my best friend. (F8, 30 years old, domestic helper).

These stories contribute to the construction of a collective memory of breast cancer as a painful and often fatal disease.In Odiennékourani, these catastrophic representations play a deeply ambivalent role in health behavior. For some women, the association of breast cancer with death and mutilation leads to a strategy of avoiding screening altogether. Conversely, for others, an acute awareness of the disease's seriousness acts as a driver of vigilance. One young woman expressed this mobilizing fear:

I am too scared, so I always get screened. (F9, 28 years old, student).

Thus, fear sometimes appears as an obstacle and sometimes as a catalyst for preventive action.These factors indicate that perceptions of breast cancer are part of a complex social and symbolic field, structured by personal experiences, collective narratives of death, cultural beliefs, and relationships with health institutions. These perceptions profoundly influence screening-related behaviors.

Social and cultural constraints on screening

Screening practices are strongly influenced by economic, institutional, psychological, and cultural constraints. Women first mentioned the burden of financial difficulties and the perceived cost of hospital services. One participant sums up this dilemma:

When I think about the price, I get discouraged. (F11, 42 years old, hairdresser).

Thus, prevention is relegated to a secondary priority behind subsistence needs. In addition to economic constraints, there are perceived limitations in the healthcare system.

Experiences of long waits, disorganization, and lack of empathy fuel mistrust of institutions. One participant stated:

I am discouraged by the hospital. You go there, they pass you around and around, and you end up forgetting your illness, which is serious, and then they're not friendly. (F13, 36 years old, informal sector worker).

These experiences produce a feeling of weariness and disenchantment that tends to discourage screening, which is perceived as costly in terms of time and effort. In addition to these factors, fear of the results fuels avoidance strategies. One participant explained:

I cannot get screened for breast cancer and have a heart attack. Even if I have it and I don't know, it's better, because where I am now, I don't want a problem that will make me think and think and then die. (F14, 33 years old, food vendor).

This type of discourse illustrates an avoidance strategy in which the preservation of immediate psychological well-being takes precedence over anticipating biological risk.

Additionally, time management is another significant constraint stemming from the overload of domestic and economic responsibilities. One participant summarized her situation as follows:

I want to do it, but it's just not the right time. I have to take care of my children without forgetting my husband, and on top of that, I must earn money, so *it's not easy. When will I ever find the time to go there? (F15, 31 years old, shopkeeper).*

In this context, screening appears to be an additional burden on top of an already heavy workload, and it is difficult to fit into everyday life. Finally, cultural constraints highlight the competition between biomedical care and traditional medicine. Some women prefer traditional care and resort to hospitals as a last resort. One participant said:

We do not go to the hospital where we live. If you have breast pain, there's an old woman who treats people with medicines she makes herself. I'm here talking to you now, but I had lumps in my breast, and it hurt a lot, and she treated me. When she tapped it, white stuff came out of my breast like this. (F16, 39 years old, reseller).

These data show that the barriers to screening are a combination of material, symbolic, and organizational factors.

Factors motivating women to undergo screening

Mirroring the constraints, the interviews also revealed the existence of motivating factors that led women to undergo breast cancer screening in certain biographical and relational contexts. Family support, particularly spousal support, appears to be an important lever in several accounts. One participant explains:

I always undergo screening at the university hospital, thanks to my husband. He always tells me to go, that the disease is very serious, so I do. (F17, 35 years old, married, employee).

In this case, the spouse's words served as a symbolic and emotional resource that helped reduce anxiety and legitimize the screening process. Beyond couples, friends and relatives play crucial roles in the decision to undergo screening. One young woman reported:

I wasn't even interested in breast cancer screening myself, but it was because of my friend that I did it; she motivated me so much to go and get it done. (F18, 22 years old, student).

Others explain that the loss of a loved one to breast cancer has profoundly changed their relationship with the disease and prevention. One of them says:

I've always done it since my sister-in-law died of this disease and left us with her 5- and 2-year-old children to take care of. Hmm, it's beyond me, so I get breast cancer screening. (F19, 41 years old, shopkeeper).

These experiences suggest that individual experiences and family histories can transform an initially paralyzing fear into motivating fear, leading to the long-term adoption of preventive behaviors. The pursuit of personal well-being is an important source of motivation. Some women say they get screened to avoid discovering a silent disease too late, while one participant emphasizes the peace of mind that a reassuring result gives her:

I always get screened for breast cancer for my health. If I do it and they tell me I do not have anything, I feel better. (F20, 26 years old, apprentice).

Screening is viewed as a strategy for managing anxiety and transforming uncertainty into a feeling of security. Furthermore, pregnancy appears to be a key moment that facilitates entry into screening because of prenatal consultations. Some women explain that they have had breast cancer screening during prenatal consultations, as motherhood creates a biomedical anchor that encourages entry into the healthcare system. One pregnant woman explains:

In my case, it was because of my pregnancy that I had breast cancer screening. I don't have time, but because of my pregnancy, I must go to the hospital, so when I arrived at the maternity ward, they did it for me. (F21, 30 years old, pregnant).

Therefore, pregnancy monitoring opens up opportunities to integrate screening into routine healthcare practices. Ultimately, the media and schools have a significant impact on people's willingness to be screened. One participant stated that she was deeply affected by television messages:

I was motivated by TV. The photos of rotten or amputated breasts that they show us are too scary. I *don't want that to happen to me. So, when I see them talking about it on TV in October, I'm going to get it done. (F22, 27 years old, hairdresser).*

One young woman emphasized the central role of educational institutions:

I've already had breast cancer screening and I still do it at my school. It was actually because of school that I started; otherwise... (F23, 19 years old, high school student).

The impact of television messages and educational institutions illustrates the central role of socialization and information in the adoption of preventive behaviors. Overall, motivations result from a combination of relational support, biographical experiences, the search for reassurance, biomedical opportunities and exposure to information. These levers coexist with powerful constraints, making screening a practice that results from a constant balancing act between obstacles and resources.

Discussion

Breast cancer screening as a socially embedded practice

The findings of this study show that breast cancer screening in Odiennékourani cannot be understood independently of socioeconomic conditions, gender relations, or local healthcare configurations. In Côte d'Ivoire, where breast cancer is the most frequently diagnosed cancer among women and accounts for nearly one-third of all female cancers, the situation observed in Odiennékourani reflects a broader pattern of late diagnosis and limited preventive coverage documented across West Africa and sub-Saharan Africa.[1,2,7] Low screening uptake must therefore be understood as part of a wider chain of vulnerability involving unequal access to care, limited organized screening programs, health system weaknesses, and persistent social and economic constraints.[8,9] Rather than being a purely individual or biomedical decision, screening emerges here as a socially situated practice, shaped by women's positions within local structures of inequality and by the meanings they attribute to illness, prevention, and care.

Knowledge disparities and social differentiation

The first major finding concerns the unequal distribution of knowledge about breast cancer screening. Older and more economically vulnerable women were more likely to remain excluded from channels of health information, whereas women integrated into employment, women's groups, or school settings had greater access to formal and informal information. This pattern is consistent with studies from Ghana, South Africa, and East Africa showing that education, media exposure, and participation in organized social networks increase both awareness and uptake of screening services.[6,9,16,17]

In the Ivorian context, these findings also converge with evidence showing that the acceptability of mammography varies according to place of residence, access to information, and health coverage.[4] In Odiennékourani, knowledge of screening appears to function as a socially differentiated resource shaped by age, educational level, and forms of professional and community integration.

This uneven access to information translates into contrasting screening practices, ranging from long-term non-use to regular screening through school- or work-related medical encounters. The findings therefore confirm the deeply social character of preventive behavior.[18-22]

The ambivalent role of perceptions and lived experience

The study also shows that the representation of breast cancer plays a central role in shaping screening behavior. Participants frequently associated the disease with bodily deterioration, mutilation, suffering, and even death. These representations are not abstract beliefs but are rooted in biographies marked by the illness or death of relatives, friends, and acquaintances. In this sense, breast cancer is embedded in a collective emotional memory that gives the disease a particularly dramatic social significance.

This finding is consistent with research from South Africa showing that low health literacy, rumors, and experiences of loss contribute to stigma, fatalism, and fear, thereby discouraging participation in screening.[23-25] Similar observations have been made in Europe and North America, where women's perceptions of breast cancer and screening are often plural, emotionally charged, and sometimes contradictory.[26,27]

In Odiennékourani, fear operates in an ambivalent manner. For some women, the prospect of diagnosis threatens their emotional stability and leads to avoidance. For others, the seriousness of the disease was a reason for vigilance and repeated screening. This double movement is consistent with studies in Ghana showing that breast cancer may be viewed as both incurable and socially devastating, thereby generating fear that can either delay or motivate care-seeking.[28]

Structural constraints and therapeutic pluralism

These findings further highlight the cumulative weight of material and institutional barriers. Financial hardship makes screening a socially selective practice, making it more accessible to women who can mobilize time and economic resources for preventive care. This observation is consistent with previous work documenting the role of direct and indirect healthcare costs in delayed diagnosis and low screening uptake.[5,7,29,30]

Institutional experiences are also important. Participants' accounts of long waiting times, disorganized services, and unfriendly treatment revealed how interactions with health facilities may discourage preventive engagement. Similar barriers have been documented in rural South Africa, where overcrowding, lack of equipment, and poor reception reduce women's willingness to seek screening.[31] In Nigeria, the limited integration of breast cancer screening into frontline services and the attitudes of some healthcare providers have also been shown to undermine trust.[32]

Time constraints, largely shaped by gendered divisions of labor, constitute another important barrier. Women described having to balance income-generating work, childcare, household duties, and marital responsibilities, leaving little room for preventive health care. This reflects broader findings on how domestic and reproductive workloads structure women's trade-offs between prevention and everyday survival.[33]

This study also sheds light on therapeutic pluralism. In Odiennékourani, biomedical care coexists with traditional healing and religious forms of recourse to health. Some women first turn to traditional or community-based healers and consider hospital care only as a later option. Similar circular care pathways have been described in Cameroon and Ghana, where movement between hospitals, traditional practitioners, and faith-based healing may delay diagnosis and treatment.[34,35] These findings suggest that prevention strategies should not solely rely on expanding biomedical services. They must also account for the legitimacy of local therapeutic actors and the social worlds in which women interpret symptoms and make decisions about care.

Motivating factors and levers for intervention

In addition to these barriers, the findings identified several factors that facilitated screening. Family support, especially from husbands, is an important enabling factor. Emotional encouragement, practical support, and financial assistance may help transform screening from a feared act into a shared, protective practice. This aligns with evidence from Tanzania showing that supportive spouses can positively influence early detection, diagnosis, and continuity of care.[36]

Friends, peers, and family members' histories of illness also play a significant role. Testimonies from participants show that social interactions and the experience of losing a loved one can transform fear into preventive engagement. These findings are consistent with studies indicating that peer exchanges, survivor narratives, and social influence shape women's decisions to seek screening.[37,38]

This study further highlights the importance of specific life stages and institutional entry points. Pregnancy and prenatal consultations create opportunities for contact with the healthcare system and may facilitate inclusion in screening programs. This observation is consistent with multi-country analyses showing that recent contact with health services, including antenatal care, increases the likelihood of screening uptake.[21]

Media exposure and school-based socialization also emerged as significant facilitators. Television campaigns, especially during Pink October, and school-based health information help shape favorable attitudes toward prevention. Similar dynamics have been observed in Lesotho and Kenya.[18,19] In Côte d'Ivoire, previous work has likewise shown that media exposure and support from healthcare personnel can enhance the acceptability of mammography.[4]

These findings point to several levers for action: strengthening community information channels, integrating breast cancer awareness into routine maternal and reproductive health services, improving the quality of reception in health facilities, and mobilizing family and peer support as part of prevention strategies.

Socio-anthropological implications

From a scientific perspective, this study confirms the relevance of a socio-anthropological approach to health behavior. Drawing on the interpretive traditions of Olivier de Sardan, Weber, and Denzin,[10,11,13,14,15] the analysis shows that non-use of screening should not be interpreted simply as a lack of knowledge or an irrational refusal of biomedical care. Rather, it reflects situated choices constrained by social inequalities, institutional experiences, symbolic representations, and therapeutic alternatives.

By focusing on women's meanings, biographies, and everyday negotiations, this study makes visible the rationalities underlying screening practices in the context of economic precariousness and therapeutic pluralism. Therefore, the findings call for prevention strategies that do more than just disseminate information. They point to the need to reduce economic barriers, improve women's experiences in healthcare settings, engage with local therapeutic actors, and strengthen existing relationships. In this respect, the study supports broader calls to articulate biomedical intervention with social justice and contextual understanding in order to improve breast cancer prevention and care in Africa.[7,8]

Limitations and strengths

This study has several limitations that should be considered when interpreting the findings. First, it is based on a single field site in a working-class neighborhood of Bouaké and a relatively small sample of 23 women. Therefore, the findings cannot be generalized to all women in Côte d'Ivoire or to all urban and rural contexts. Second, the data relied on self-reported interviews and may have been influenced by memory bias or social desirability, particularly regarding sensitive topics such as illness, death, family relationships, and care-seeking practices. In addition, the absence of prolonged direct observation limited the possibility of systematically comparing reported practices with the observed behavior.

Despite these limitations, this study has important strengths. The richness of the narratives collected, the diversity of participants' profiles, and the interpretive depth of the analysis provide transferable insights for other low-income settings marked by economic insecurity and therapeutic pluralism. The study also offers contextually grounded evidence that may inform breast cancer prevention policies that are more attentive to women's lived experiences.

Conclusion

This study highlights the complex interplay of informational, symbolic, economic, relational, and institutional factors that shape breast cancer screening behavior among women in Odiennékourani. Screening is not a purely individual or biomedical act but a socially embedded practice rooted in living conditions, gender relations, family norms, and trust in healthcare institutions. Access to information remains socially differentiated, to the disadvantage of older and economically vulnerable women, while integration into school, work, and community networks enhances exposure to preventive messages.

Representation of breast cancer, which is widely associated with mutilation, suffering, and death, plays a central role in shaping behaviors. These representations, grounded in personal and collective experiences of loss, generate ambivalent responses, ranging from avoidance to heightened vigilance. Simultaneously, structural constraints, including financial insecurity, negative healthcare experiences, time limitations, and therapeutic pluralism, significantly hinder regular screening. Conversely, relational support, life experiences, institutional contact (e.g., pregnancy), and exposure to media and education are key enabling factors.

These findings underscore that screening decisions are embedded in relational dynamics and life trajectories. Therefore, policymakers and public health practitioners should prioritize integrated and context-sensitive prevention strategies that address economic barriers, improve the quality of care, strengthen community-based support systems, and

engage with local perceptions of illness. Future research should further explore the interactions between communities and healthcare systems through approaches such as participatothrough approachesand mixed-methods designs to develop culturally grounded and socially responsive interventions. More broadly, empowering women through accessible information, supportive social environments, and respectful healthcare services is essential for advancing equitable and patient-centered prevention in West Africa.

Consent to publish

The qualitative data used in this study consists of sensitive and confidential interviews. Therefore, it is not publicly available. However, anonymized excerpts may be provided by the author upon reasonable request in accordance with ethical principles and the protection of participants.

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Competing interests

The author declares that she has no conflicts of interest in relation to this study.

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