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Research Article

Perceptions and Barriers to Cervical Cancer Screening: A Phenomenological Analysis in an Urban Health District in Cameroon

Berthe Sabine Esson Mapioko[1, *], Lyda Saurelle Kom[2], Esther Dina Bell[3], Veronique Batoum Mboua[1], Etienne Atenguena[1], Arielle Fonkou[1], Claire Baskouda[1], Line Medjo[1], Christelle Ngono Yeme[1], Rosine Ngono[1], Zacharie Sando[1], Louise Ngo Likeng[2]

[1]Faculty of Medicine and Biomedical Sciences, The University of Yaounde I, Yaounde, Cameroon
[2]School of Health Sciences, Catholic University of Central Africa, Yaounde, Cameroon
[3]Faculty of Medicine and Pharmaceutical Sciences, The University of Douala, Douala, Cameroon

Abstract

Introduction: Cervical cancer (CC) is the second most common cancer among women in Cameroon, with 2,525 new cases and 1,837 deaths estimated in 2022. Despite the critical importance of screening, national participation remains low (8%–19.6%). This study explored perceptions and barriers to CC screening among non-screened women living in a densely populated urban district of Yaoundé Methods: A qualitative phenomenological study was conducted in the Biyem-Assi Health District from September to October 2023. Eleven purposively selected women aged 24–57 years who had never undergone screening were interviewed using semi-structured guides. Data were analyzed through inductive thematic content analysis and interpreted using the Health Belief Model (HBM). Results: Participants perceived CC as severe but showed marked cognitive dissonance: eight women believed screening was unnecessary, often citing fatalism ("If I must be sick, it is God's decision"). Barriers included cost, fear of results, mistrust of screening quality, and limited health promotion. Systemic gaps-particularly poor outreach and confusion between screening and late-stage diagnosis-further reduced perceived benefits. Conclusion: Non-participation in CC screening results from intertwined psychological, socioeconomic, and systemic barriers. Suggested implications include strengthening communication strategies to address fatalism, improving screening affordability, and enhancing community-level awareness.

Keywords

Cervical Cancer, Screening, Phenomenology, Barriers, Fatalism, Health Belief Model, Cameroon

*Corresponding author: mapokob@yahoo.fr (Berthe Sabine Esson Mapioko)

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1. Introduction

Cervical cancer (CC) remains one of the most significant public health challenges in low- and middle-income countries (LMICs). In Cameroon, it is the second most frequent cancer among women, responsible for 2,525 new cases and 1,837 deaths annually according to GLOBOCAN 2022 [1, 2]. The WHO Global Strategy to Eliminate CC emphasizes three pillars-HPV vaccination, screening, and treatment-requiring at least 70% screening coverage [3, 4]. Yet, national screening rates in Cameroon remain critically low (8%–19.6%) [5, 6], leading to late diagnosis in nearly 80% of cases [7].

While numerous studies in Sub-Saharan Africa highlight structural barriers such as cost, limited equipment, and insufficient service availability [8, 9], fewer investigations explore the lived experiences, perceptions, and psychosocial determinants of women who remain unscreened. Understanding these perceptions is essential because preventive behaviors-such as screening uptake-are shaped by individuals' beliefs about susceptibility, severity, benefits, and barriers, as conceptualized in the Health Belief Model (HBM) [10].

A phenomenological approach was selected to explore how women themselves interpret CC, screening, and non-participation. This design is particularly relevant for understanding subjective experiences, emotional drivers (fear, fatalism), and meaning-making processes that quantitative approaches cannot capture.

This study therefore aimed to examine the perceptions, attitudes, and barriers to CC screening among non-screened women living in an urban district of Yaoundé.

2. Methodology

2.1. Study Design

A qualitative, phenomenological, exploratory design was used to understand the essence of women's lived experiences regarding non-screening from September to October 2023. The phenomenological approach was selected because it allows deep exploration of subjective interpretations, beliefs, and sociocultural meanings surrounding health behavior-critical factors in CC screening decisions.

2.2. Study Population and Sampling

Participants were sexually active women aged 24–59 years who had lived in an urban area of Yaoundé-Cameroon, known for its high population density, the Biyem-Assi Health District, for at least six months and had never undergone CC screening.

Purposive sampling ensured inclusion of women with diverse ages, marital statuses, and religious backgrounds. Although the final sample comprised 11 women, this size was deemed sufficient because:

1. thematic saturation was reached after the ninth interview, with no new concepts emerging,
2. phenomenological studies commonly rely on small, information-rich samples to allow depth of exploration,
3. redundancy of core themes (fatalism, cost, fear) strengthened internal consistency.

2.3. Data Collection

Data were collected through face-to-face semi-structured interviews conducted in French.

The interview guide explored:

1. perceptions of CC and its severity,
2. knowledge and attitudes toward screening,
3. perceived benefits and barriers,
4. socioeconomic and cultural influences.

Example guiding questions:

1. *"What comes to your mind when you hear about cervical cancer?"*
2. *"What do you think screening is for?"*
3. *"What would make it difficult or easy for you to be screened?"*

Interviews lasted 25–45 minutes, were recorded with consent, and transcribed verbatim.

2.4. Data Analysis and Theoretical Anchorage

Data were analyzed through inductive thematic content analysis following Braun & Clarke's six-step approach [11].

To enhance methodological rigor:

1. two researchers independently coded the first transcripts and compared coding frames,
2. disagreements were discussed until consensus, improving inter-coder reliability,
3. peer debriefing was used to refine theme boundaries,
4. participants were informed they could request summaries of findings (informal member-checking opportunity).

The Health Belief Model guided the interpretation of themes during the discussion phase.

2.5. Ethical Considerations

Ethical appoval was obtained from the Institutional Ethics Committee for Research on Human Health (CEIRSH) (N°2023/020278/CEIRSH/ESS/MSP). Written informed consent was obtained from all participants. Confidentiality and anonymity were rigorously maintained through the use of pseudonyms (P1, P2, etc.) for direct quotes (verbatims).

3. Results

3.1. Sociodemographic Characteristics of Participants

A total of 11 non-screened women were interviewed. The minimum age was 24, and the maximum was 57. The cohort was predominantly single (7/11) and adhered to the Christian faith (8/11). Table 1 presents participants' demographic profiles.

Table 1. *Sociodemographic Characteristics of Participants (N=11).*

	Age (years)	Marital status	Religion	Education level	Occupation
P1	25	Single	Christian	Higher education	Health professional
P2	38	Married	Christian	Higher education	Student
P3	25	Single	Muslim	Primary education	Trader / Shopkeeper
P4	25	Single	Christian	Higher education	Student
P5	24	Single	Christian	Secondary education	Trader / Shopkeeper
P6	35	Married	Christian	Primary education	Housewife
P7	29	Married	Christian	No schooling	Housewife
P8	47	Divorced	Christian	No schooling	Trader / Shopkeeper
P9	25	Single	Animist	No schooling	Housewife
P10	27	Single	Muslim	Primary education	Trader / Shopkeeper
P11	57	Single	Christian	Secondary education	Secretary

3.2. Perceived Severity and Knowledge of Cervical Cancer

Participants widely perceived CC as a severe, life-threatening disease with major reproductive consequences:

"Cervical cancer is a disease or a cancer that affects the female gender... whose treatment is administered according to the stage of cancer development." (P2, P4, P5).

"A disease due to gynecological complications, prevents conception, causes miscarriages..." (P1, P6).

However, some beliefs reflected spiritual or mythical explanations:

"A disease introduced by the forces of evil to punish sinners, anyway it's a myth." (P9, Animist).

3.3. Perception of Screening Importance and Fatalism

Eight women perceived screening as unnecessary, expressing fatalistic or religious determinism:

"No, because the disease will always happen whether we get screened or not." (P2).

"No, I don't see its importance. If I must be sick, it is God who decided it." (P11).

Only three participants perceived screening as preventive, seeing it as a way *"to know one's status regarding the disease and to prevent the development of severe and irreversible stages"* (P1, P6, P7).

3.4. Perception of the Screening Process

Participants noted limited promotion and poor clarity of the procedure:

"There are unfortunately not enough campaigns to encourage women to go and do it. So several are probably ignorant of the interest in doing it." (P1).

Confusion between screening and diagnosis was common:

"It's not effective because the cancer is detected when it has already spread." (P8).

3.5. Systemic and Psycho-emotional Barriers

Ten out of eleven participants (10/11) identified a convergence of socioeconomic, systemic, and psycho-emotional barriers (Table 2).

Table 2. *Categories of Barriers to CC Screening.*

Barrier Category	Specific Barriers	Illustrative Quotes
Socioeconomic	High cost	*"I don't have the money to do that. I prefer to feed my family"* (P4).
	Lack of government support	*"Screening costs should be further covered by the State given the living standards of most families"* (P1).
Systemic	Insufficient outreach	*"Unfortunately, there aren't enough campaigns to encourage women to go and get screened"* (P1).
	Confusion about procedures	*"It's not effective because the cancer is only detected when it has already spread"* (P8).
Psycho-Emotional	Fear, Anxiety, and Mistrust	*"I couldn't go because I was once told that there are often conflicting results... and that really scared me"* (P7).
Logistical and Cultural	Time Constraints, religious discouragement	*"Forbidden by religion"* (P10). *"There is no time to do that"* (P10), *"I don't have the time"* (P5).

4. Discussion

This study highlights a complex interplay of psychological, socioeconomic, and systemic barriers that shape women's non-participation in CC screening in an urban Cameroonian context.

The key finding is a cognitive dissonance between high perceived severity and low perceived benefit. Fatalism-driven by strong external locus of control-neutralizes motivation for preventive action. Similar patterns have been reported in studies across Africa and Asia, where religious beliefs and deterministic worldviews undermine health-seeking behavior [12, 13].

Interventions must therefore emphasize self-efficacy, early detection success stories, and the preventive nature of screening.

Cost remains a major obstacle, consistent with findings from Cameroon and Congo [14, 15]. In contexts of financial precarity, preventive actions are deprioritized. The inclusion of affordable or subsidized screening options is thus essential to reduce inequities.

Limited outreach, confusion with late-stage diagnosis, and mistrust in result accuracy all contributed to low perceived benefits. These findings mirror global evidence showing that trust in healthcare systems and clear communication are critical determinants of screening acceptance.

Strengths include phenomenological depth, theoretical integration, and use of verbatim quotes. Limitations include:

1. the small sample (though adequate for phenomenology),
2. lack of triangulation with observations or document analysis,
3. urban-only recruitment, limiting transferability to rural areas.

5. Conclusion

Non-participation in cervical cancer screening in Biyem-Assi is driven by fatalism, cost, limited trust, and insufficient promotion.

Suggested implications are:

1. Developing culturally sensitive communication strategies to counter fatalism,
2. Improving financial accessibility to reduce inequities,
3. Strengthening community health worker engagement and clarity of information on screening,
4. Enhancing system reliability and perceived trustworthiness.

These insights may help inform national strategies aimed at improving screening uptake.

Abbreviations

CC	Cervical Cancer
CEIRSH	Institutional Ethics Committee for Research on Human Health
HBM	Health Belief Model
HPV	Human Papillomavirus
LMIC	Low- and Middle-Income Country
SSA	Sub-Saharan Africa
WHO	World Health Organization

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Author Contributions

Berthe Sabine Esson Mapioko: Conceptualization, Data curation, Formal Analysis, Methodology, Project administration, Resources, Supervision, Validation, Visualization, Writing – review & editing

Lyda Saurelle Kom: Conceptualization, Data curation, Formal Analysis, Investigation, Methodology, Project administration, Resources, Software, Writing – original draft

Esther Dina Bell: Validation, Visualization, Writing – review & editing

Veronique Batoum Mboua: Validation, Visualization, Writing – review & editing

Etienne Atenguena: Validation, Visualization, Writing – review & editing

Arielle Fonkou: Validation, Visualization, Writing – review & editing

Claire Baskouda: Validation, Visualization, Writing – review & editing

Line Medjo: Validation, Visualization, Writing – review & editing

Christelle Ngono Yeme: Validation, Visualization, Writing – review & editing

Rosine Ngono: Validation, Visualization, Writing – review & editing

Zacharie Sando: Validation, Visualization, Writing – review & editing

Louise Ngo Likeng: Conceptualization, Project administration, Supervision, Validation, Visualization, Writing – review & editing

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Data Availability Statement

The data is available from the corresponding author upon reasonable request.

Conflicts of Interest

The authors declare no conflicts of interest.

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