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Original Research

Barriers and Enablers to Cancer Screening Uptake among Women in Urban Slums of Karnataka: A Qualitative Exploration

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Abstract

Background: Despite the National Programme for Prevention and Control of Cancer, Diabetes, CVD and Stroke (NPCDCS), cancer screening proportions in urban slums remain sub-optimal. **Objectives:** To identify the socio-behavioral and systemic barriers hindering cancer screening among women in urban slums of Karnataka. **Methods:** A descriptive qualitative study was conducted with 57 key informants, including community women, healthcare providers, and cancer survivors. Data were analyzed via manual descriptive thematic analysis through a deductive lens. **Results:** The primary barriers identified were psychosocial nihilism, the "wage-loss paradox," and systemic gender-discordant care. Enablers include decentralized female-led mobile units and financial compensation for lost wages. **Conclusion:** Bridging the screening gap requires shifting from a facility-centric model to a community-integrated "social movement" approach.

Keywords: Early Detection of Cancer; Qualitative Research; Urban Health; Healthcare Disparities; Karnataka.

Introduction

In India, breast and cervical cancers contribute to over 50% of the oncology burden in women. While the NPCDCS aims for population-level screening,[3] the translation of policy into clinical uptake in the high-density urban slums of Karnataka remains a significant challenge.[8,14] Information asymmetry, economic constraints, and deeply rooted psychosocial factors act as deterrents. This study utilizes a qualitative framework to explore these barriers to inform evidence-based public health interventions.

Materials And Methods

Study Design: A descriptive qualitative study design was utilized, following the COREQ guidelines for reporting.[2]

Study Setting: Purposively selected urban slum clusters across Karnataka.

Participants: Fifty-seven (57) Key Informants (KI) were recruited using purposive sampling to ensure a triangular perspective (Community Women, Service Providers, and Cancer Survivors).

Data Collection: In-depth interviews were conducted in the local language (Kannada) using a semi-structured guide.

Data Analysis: Manual thematic analysis was performed. Coding was done iteratively; thematic saturation was achieved at N=50, with 7 additional interviews conducted to confirm the absence of new codes.

Ethical Considerations: Approved by the Institutional Ethics Committee (IEC). Written informed consent was obtained from all participants.

Results

Box 1: Comprehensive Semi-Structured Questionnaire (25 Items)

Domain 1: Knowledge and Perceived Susceptibility

1. Have you heard of cancer screening (early check-up)?
2. Do you believe a healthy-looking person can have cancer?
3. In your opinion, what causes "Gadde" (tumors)?
4. Can cancer be cured if found very early?
5. Do you know where the nearest government cancer screening center is?

Domain 2: Psychosocial Barriers

6. What is the first thought that comes to mind when you hear "Cancer"?
7. Do you feel that a cancer diagnosis is a death sentence?
8. Are you afraid of the pain involved in screening (e.g., Mammography)?
9. Do you worry about being isolated by your family if you are diagnosed?
10. Is there a fear that "looking for a problem" will actually cause the disease?

Domain 3: Socio-Economic Constraints

11. How much time does it take you to reach the nearest Primary Health Center (PHC)?
12. If you go for a check-up, do you lose your daily wages?
13. How much do you estimate the "indirect costs" (travel, food, loss of work) to be?
14. Do you need permission from your husband/elders to go for a medical test?
15. Is someone available to look after your children if you spend a day at the hospital?

Domain 4: Systemic and Healthcare Factors

16. How would you describe your last interaction with a government doctor?
17. Does the long waiting time at the clinic discourage you from attending?
18. Do you feel comfortable being examined by a male doctor?
19. Have you ever felt shamed or disrespected by hospital staff?
20. Is the language used by doctors easy for you to understand?

Domain 5: Cultural Beliefs and Enablers

21. Do you believe cancer is a result of past sins (Karma)?
22. Would you prefer a mobile screening van that comes directly to your street?
23. Would a small financial incentive (wage compensation) motivate you to attend?
24. How much do you trust the advice given by local ASHA workers?
25. Would seeing a "cured survivor" from your own slum change your mind about screening?

Thematic Analysis and Verbatim Responses

The analysis of 57 informants revealed a multifaceted barrier hierarchy.

Theme 1: Psychosocial Nihilism

Fear of diagnosis was often associated with the stigma that "cancer is equivalent to death." (4,12)

- *Verbatim:* "If it is cancer, I will die. Why find out and suffer mentally before the body gives up?" (KI_24)

Theme 2: The Wage-Loss Paradox

The indirect cost of "free" screening emerged as a primary economic deterrent.(13,15)

- *Verbatim:* "The test is free, but the loss of work means no milk for my children tonight. The 'free' test costs me 500 rupees." (KI_41)

Theme 3: Systemic Gender Discordance

Cultural shyness regarding male practitioners remains a significant roadblock.\$^{[7,9]}\$

- *Verbatim:* "I left the clinic because the doctor was a man. My husband would not allow me to be checked by him." (KI_18)

Discussion

The findings from this qualitative exploration involving 57 informants in Karnataka's urban slums underscore that screening barriers are rooted in a complex "Psychosocial-Economic Nexus." For these women, a cancer diagnosis is feared not merely as a clinical illness, but as a catastrophic event leading to the immediate loss of their role as the household's primary economic pillar.(4) Our results align with national observations that the "opportunity cost" of missing work remains the single greatest economic deterrent for the urban poor.[13] Comparative literature suggests that while awareness has increased, the uptake remains stagnant due to persistent nihilism, where a diagnosis is equated with an inevitable death sentence.[12,15] To move the needle on screening proportions, Karnataka must adopt a "Social Movement" strategy mirroring the successful polio eradication campaign.[5,11]

This necessitates a transition toward Incentivization to offset daily wage losses and a strategic "Pink Shift"—ensuring 100% female-led screening teams to mitigate gender-based hesitation and cultural shyness.[7,14] Furthermore, the study reveals that the "free" nature of government screening is an insufficient motivator when contrasted with the logistical hurdles of navigating overcrowded tertiary centers. Similar studies in urban India have noted that decentralized, community-based "screen-and-treat" models significantly outperform facility-based approaches by reducing the "time-poverty" experienced by slum dwellers.[12,13] By integrating screening into the existing maternal and child health infrastructure, we can normalize the procedure and reduce the profound stigma currently associated with oncology wards.\$^{[6,8]}\$ This shift from a passive clinical approach to an active, localized health mission is vital for achieving the universal health coverage goals outlined in the NPCDCS.[3]

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