

REVIEW SUMMARY

Experiences of Women who do not Participate in Breast Cancer Screening Programs: A Qualitative Study

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ABSTRACT

Aim: This study aimed to identify factors that prevent women from participating in breast cancer screening programs.**Method:** This study was conducted using a phenomenological design within the qualitative research tradition. The sample consisted of 20 women who visited the XXXX Family Health Center in XXXX between February and March 2024. Data were collected using a Personal Information Form and a “Semi-Structured Interview Form” prepared for one-on-one interviews. Qualitative data were analyzed through conventional content analysis, with MAXQDA 2020 software used to facilitate data coding and theme development.**Results:** The participants’ mean age was 52.3 ± 8.75 . Following the analysis, three themes, seven categories, and 98 codes were identified: “Perceptions,” “Knowledge and Awareness,” and “Participation Dynamics and Expectations for Support.”**Conclusion:** The main reasons for women’s nonparticipation in breast cancer screening were the absence of perceived discomfort and negligence, religious beliefs (prayer, destiny, breastfeeding), fear of unfavorable results, concerns about privacy, and lack of experience. In addition, practical issues, such as transportation difficulties and the cumbersome procedure of making appointments, also reduced participation. Insufficient knowledge, particularly a lack of accurate scientific information, prevents women from understanding the benefits of screening. Overcoming these barriers requires educational interventions, improved transportation options, and increased public trust in the healthcare system.

1 | Introduction

Breast cancer is the most common and fatal type of cancer in women worldwide. Early diagnosis and treatment improve survival rates and enhance the quality of life. The reduction in breast cancer mortality rates underscores the effectiveness of early screening methods. Primary methods for early screening include Breast Self-Examination (BSE), Clinical Breast Examination (CBE), and mammography (Republic of Turkey Ministry of Health, 2020). Organized breast cancer screening programs require high participation rates to achieve population-level benefits. Recent evidence suggests that participation rates of 70% or higher are widely regarded as an acceptable benchmark for the performance of organized breast cancer screening programmes (Ding et al. 2022; Özkan and Taylan 2021). In Türkiye, the rates of Breast Self-Examination (BSE) have been reported between

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9.2% and 65.3%, Clinical Breast Examination (CBE) between 14.5% and 17.2%, and mammography screening between 13.5% and 59.9%, according to recent national studies (Edis 2025; Günen and Kaymak 2025; Kırca et al. 2026; Onbaşı et al. 2026). These findings indicate that participation in breast cancer screening practices in Türkiye remains substantially below the 70% level recommended for effective screening programs.

In the existing literature, the reasons for not participating in breast cancer screening have predominantly been studied using quantitative methods (Babaoğlu et al. 2021; Ceyhan et al. 2022; Özcelik and Avcı 2025). However, this study was designed as a qualitative inquiry to gain a deeper understanding of why women do not participate in breast cancer screening programs. Qualitative research, which involves observing participants' experiences and perspectives, is effective in unearthing issues that may have previously gone unnoticed (Baltacı 2019). In this study, face-to-face interviews were conducted to explore participants' perceptions, knowledge, and awareness levels regarding breast cancer, as well as their reasons for not participating in screening programs. The findings will provide significant data for developing strategies to increase women's participation in breast cancer screening programs and inform healthcare policies. In doing so, this study ultimately aims to contribute to improving the overall community health in the fight against breast cancer.

2 | Method

Aim: This study aimed to identify factors that prevent women from participating in breast cancer screening programs.

2.1 | Research Questions

1. How do women perceive and understand breast cancer and screening programs?
2. What factors prevent women from participating in breast cancer screening programs?
3. What types of support do women need to participate in breast cancer screening programs?

2.2 | Research Design

This research was designed as a phenomenological qualitative study. Qualitative research is an interpretive method intended to understand social structure and dynamics in depth. It examines events in their natural context using observation, interviews, and discourse analysis techniques. This approach, which also involves the researcher's subjective viewpoint, aims to comprehend reality without distorting it (Baltacı 2019).

Phenomenology focuses on understanding individuals' shared experiences with a particular phenomenon. This approach analyzes reactions and perceptions pertaining to specific issues based on the in-depth experiences of a small number of participants (Yalçın 2022). Using a phenomenological design in this study aims to enhance our understanding of why women do not participate in breast cancer screening programs.

2.3 | Setting and Timing of the Research

The study was conducted between February and March 2024 with women who visited the XXXX Family Health Center in XXXX and met the inclusion criteria. Women generally visited the center for routine check-ups, prescription renewals, vaccination, and counseling services. Those who met the inclusion criteria and volunteered to participate were informed about the study and invited for interviews. The Family Health Center staff provided the researcher with a private and quiet room to ensure comfort and personal privacy, and all interviews were conducted in this room.

2.4 | Sampling

Since qualitative studies emphasize in-depth exploration, large samples are not necessary, and it is possible to conduct such research even with a single participant (Yıldız 2017). In this study, criterion sampling was used to select participants, and the study ended once data saturation was reached. Data saturation occurs when no new information emerges from a dataset (Baltacı 2018; Yıldız 2017). Criterion sampling involves analyzing all cases that meet predetermined criteria (Yağar and Dökme 2018). The inclusion criteria for this study were: being a woman aged 40–69, having no personal or first-degree family history of breast cancer, not having participated in a breast cancer screening program before, and voluntarily agreeing to participate in the study. After the two-person pilot study, in-depth interviews were conducted with 20 women. Participants in the pilot study were not included in the main dataset. The researchers agreed that the data had reached saturation and concluded the study. Each participant was assigned a code name for analysis.

2.5 | Data Collection Tools

Data were collected via a “Personal Information Form,” a “Semi-Structured Interview Form,” and audio recorder.

Personal Information Form: This form includes information about the participants' age, education level, marital status, economic status, health insurance, age at menarche, regularity of menstrual cycles, age at menopause, number of pregnancies, number of miscarriages, number of living children, age at first childbirth, total breastfeeding duration, and contraceptive use.

Semi-Structured Interview Form: This form was developed to elicit participants' thoughts on breast cancer and screening programs, reasons for not participating in breast cancer screening, and suggestions for increasing participation in breast cancer screening programs. Feedback was obtained from five academics—three specialists in the field of breast cancer and two experts in educational sciences—to evaluate the appropriateness of the questions. After this, the form was revised. A pilot study with two participants tested the clarity of the questions, and the form was finalized. The main study did not include the data from these two pilot interviews. The questions were as follows.

1. What do you know about the diagnosis, treatment, and risk of breast cancer? Could you explain?

2. What are the breast cancer screening programs? How often should they be done? Where can they be performed?
3. In your opinion, why do women choose not to participate in breast cancer screening programs?
4. What do you think can be done to increase women's participation in breast cancer screening programs?

2.6 | Data Collection Method and Process

Ethical approval was obtained from XXXXX (numbered 2023/09/20), and XXXXX Health Directorate (E-46743357-799235238176) secured institutional permission before commencing the study. After obtaining the necessary permissions, the researcher introduced herself and explained the study's purpose to the women visiting the XXXX Family Health Center in XXXX. Interviews were conducted in a private room with women who met the inclusion criteria and were willing to participate. This room offered a quiet environment to ensure the comfort and privacy of the participants. Before the interview began, participants were informed that all information gathered would be used solely for research purposes and that audio recording would be conducted to facilitate transcription. Written and verbal consent was obtained before the audio recordings. Throughout the interviews, the researcher also took observational notes in addition to recording audio recordings. The audio recordings were transcribed, and the transcripts were shared with the participants for review and approval. The audio recordings were transcribed verbatim by the researchers. To ensure transcription accuracy, each transcript was checked independently by two researchers, and participants were asked to review and confirm their transcripts. Data were collected using a Semi-Structured Interview Form that is commonly used in qualitative research. The interviews lasted approximately 17.39 minutes on average. Participants were coded from P1 to P20, and these codes were used to provide direct quotations.

2.7 | Data Analysis

Descriptive statistics, such as arithmetic means and frequency distributions for the data obtained via the Personal Information Form, were computed using Microsoft Excel. Audio recordings were transcribed into a Word document. The qualitative data were analyzed using conventional content analysis. Transcripts were independently coded by the researchers using MAXQDA 2020 software for systematic data organization, coding, and theme development. The researchers reached a consensus on the resulting themes and produced a final set of themes.

2.8 | Validity and Reliability of the Research

Validity and reliability in qualitative research demonstrate the scientific rigor of the methods and data analysis (Arslan 2022; Baltacı 2019). Guba and Lincoln suggested criteria such as credibility, transferability, dependability, and confirmability to enhance the reliability of qualitative studies (Başkale 2016). This study implemented several measures to ensure their validity and reliability.

The Semi-Structured Interview Form was developed based on a literature review, expert opinions were obtained, and participants provided feedback. For dependability, the data collection tools and themes were assessed through expert consultation, and the researcher explicitly described the entire process. For transferability, the data were presented in detail, and the limitations of the findings were noted. The transparency of data collection and analysis procedures, such as transcription and secure data storage, was emphasized for confirmability. These procedures enhance the scientific credibility of this research. Additionally, this study was systematically reported according to the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Tong et al. 2007).

3 | Results

3.1 | Findings on Personal Data

Twenty women participated in the study. Their ages ranged from 40 to 68 years, with a mean age of 52.3 ± 8.75 . Most participants were primary school graduates and married. More than half of the respondents reported that their income was equal to their expenses. All the participants had health insurance. The personal characteristics of the participants are presented in Table 1.

3.2 | Findings Related to Themes Derived From the Interviews

Based on the data obtained, three themes were developed with expert support, guided by the research questions: "Knowledge and Awareness," "Perceptions," and "Participation Dynamics and Expectations for Support" (Figure 1).

3.3 | Theme 1: Knowledge and Awareness

Under the Knowledge and Awareness theme, the participants' knowledge and awareness of breast cancer and screening programs were examined. This theme comprises three categories: "Risk Factors," "Signs and Symptoms," and "Screening Methods."

Risk Factors: Eleven participants (e.g. P1, P7, P11 etc) cited genetic predisposition, 10 (e.g. P3, P9, P13 etc.) mentioned smoking, nine (e.g. P4, P16, P20 etc.) noted psychological factors and nutrition, eight (e.g. P2, P8, P12 etc.) referred to not breastfeeding or insufficient breastfeeding, seven (e.g. P4, P15, P19 etc.) mentioned weight and birth control pill use, six (e.g. P7, P12, P20 etc.) mentioned age, and five (e.g. P2, P13, P16 etc.) cited faith and age at menopause as risk factors for breast cancer. Additionally, three participants (P3, P9, P20) mentioned alcohol; three (P3, P5, P13) pointed to sleep disturbances, one (P13) stated a history of a severe illness, one (P1) cited a weakened immune system, and one (P19) noted age at childbirth as a potential risk factor. Some illustrative quotes are provided below:

"I think irregular sleep can cause all sorts of diseases."
(P5)

TABLE 1 | Personal characteristics ($n = 20$).

Participants	Age	Education Level	Marital status	Income status	Health insurance
P1	58	Primary school	Married	High income	Yes
P2	68	Primary school	Married	Moderate income	Yes
P3	50	Primary school	Married	Moderate income	Yes
P4	49	Primary school	Married	Moderate income	Yes
P5	40	Secondary school	Married	Moderate income	Yes
P6	61	Primary school	Married	High income	Yes
P7	58	Primary school	Married	Moderate income	Yes
P8	60	Primary school	Married	High income	Yes
P9	68	Illiterate	Widowed	Moderate income	Yes
P10	45	Primary school	Widowed	Low income	Yes
P11	47	High school	Married	High income	Yes
P12	42	Primary school	Married	Moderate income	Yes
P13	53	Primary school	Married	Low income	Yes
P14	53	Primary school	Married	Moderate income	Yes
P15	53	Primary school	Married	Low income	Yes
P16	53	Primary school	Married	Moderate income	Yes
P17	61	Primary school	Widowed	Low income	Yes
P18	40	Primary school	Married	Moderate income	Yes
P19	47	High school	Married	Moderate income	Yes
P20	40	High school	Married	High income	Yes

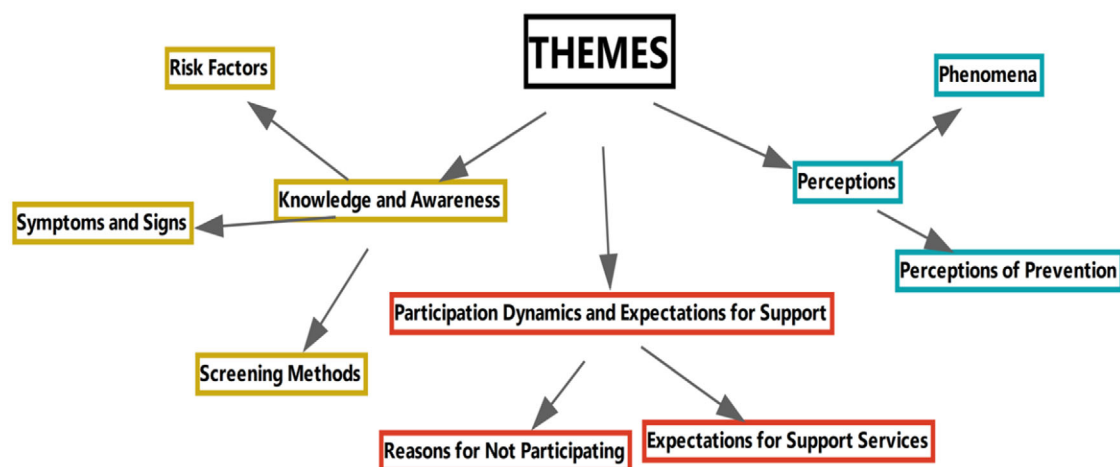


FIGURE 1 | Conditions that prevent participation in breast cancer screening programs.

“They say having a serious illness (can cause breast cancer). I’m not sure.” (P13)

“It’s from God. It’s not something that comes from smoking or alcohol.” (P14)

“I heard that having a child late rather than early can affect it. I’m not sure if I remember correctly, but I think it can.” (P19)

Signs and Symptoms: Sixteen participants (e.g. P2, P6, P9 etc.) mentioned a breast lump as a symptom of breast cancer, nine (e.g. P1, P2, P8 etc.) pointed to a lump under the armpit and nine (e.g. P3, P11, P14 etc.) mentioned discharge. Additionally, seven participants (e.g. P8, P14, P19 etc.) referenced pain; seven (e.g. P5, P16, P18 etc.) noted changes in breast shape, including swelling, differences in size, and sagging; six (e.g. P3, P10, P15 etc.) mentioned changes in the skin of the breast, such as bruising, dimpling, an orange-peel appearance, and wrinkles; five (e.g. P5, P12, P18 etc.) cited changes in the nipple, including color changes,

sores, and indrawing; two (P11, P16) reported fatigue, and one (P3) noted bleeding from the nipple. Some excerpts are:

“I guess it has something to do with milk ducts. Discharge comes from the nipple.” (P1)

“Maybe the breast grows in size. One appears larger than the other, possibly because there’s a lump in one.” (P5)

“...a dimple in the nipple. ...For some people, the nipple doesn’t protrude. ... that indentation might be a sign of cancer.” (P12)

“If I feel pain in my breast, I would realize (that I have breast cancer).” (P15)

Screening Methods: Participants’ knowledge of screening locations varied. Seventeen participants (e.g. P1, P7, P20 etc.) said screenings could be performed in hospitals, eight (e.g. P6, P8, P17 etc.) mentioned Cancer Early Diagnosis and Screening Centers (CEDSC), and four (e.g. P1, P9, P19 etc.) mentioned mobile screening vehicles. Regarding screening methods, fourteen participants (e.g. P4, P6, P14 etc.) mentioned BSE, ten (e.g. P2, P5, P11 etc.) cited mammography, and three (P5, P8, P14) mentioned CBE. Concerning the recommended frequency of participation, eighteen participants emphasized the importance of regular check-ups; one (P3) stated that check-ups should be performed only if there are symptoms, and one (P6) provided no opinion. The following are some of the participant’s comments:

“You can go if you feel unwell, but if there’s no problem, there’s no need.” (P3)

“They put your breast in something like a sandwich press.” (P11)

“At the hospital. Where else would it be done?” (P14)

“You go to the family physician. They direct you to CEDSC or something like that. They can guide you immediately.” (P19)

“Sometimes, vehicles come in front of family health centers. You can have your check-up there.” (P19)

3.4 | Theme 2: Perceptions

The Perceptions theme delves into how participants experience breast cancer and their sentiments regarding prevention. It is divided into two main categories: “Phenomena” and “Perceptions of Prevention.”

Phenomena: This category explores the ideas and emotions that come to mind by participants when thinking about breast cancer, as well as how these perceptions influence their willingness to participate in screening. Fourteen participants (e.g. P1, P5, P10 etc.) reported emotional responses related to the burden of the

disease. The “emotional burden” code includes fear, sadness, pity, and doubt. Sixteen participants (e.g. P3, P12, P17 etc.) referred to the severity and course of the disease, including codes such as mastectomy, death, treatment process, metastasis, and symptoms, and viewed it as an ordinary illness. Outside these two codes, two participants (P9, P11) fell under a code of “denial,” reflecting a refusal to think about breast cancer. Some excerpts are:

“I think it’s dangerous and that you could die.” (P2)

“Everyone says breast cancer is really bad. Apparently, they even remove the breasts.” (P3)

“I don’t want to think about it or even mention it.” (P11)

“When it comes, there’s nothing you can do. You’re just waiting for your day to come.” (P12)

“A woman’s deficiency.” (P13)

“Women’s worst nightmare.” (P17)

Perceptions of Prevention: This second category includes methods in which participants believe or engage in protecting themselves from breast cancer. Thirteen participants (e.g. P1, P8, P13 etc.) emphasized that breastfeeding was protective, nine (e.g. P4, P13, P19 etc.) highlighted avoiding harmful habits and maintaining a healthy diet, eight (e.g. P10, P15, P20 etc.) emphasized the importance of screening programs, seven (e.g. P4, P8, P17 etc.) noted physical activity and six (e.g. P3, P6, P19 etc.) mentioned weight management. Fewer participants mentioned sleep patterns (P13, P16), abstinence from hormonal drugs (P5, P11), psychological factors, interaction with nature (P11), mode of delivery (P11), and age at childbirth (P11). Some statements:

“I heard that normal delivery is really beneficial for a mother’s body. It cleans the body. Yes, a normal birth.” (P11)

“They say breastfeeding is protective. Longer breastfeeding is better because the ducts in the breast open. But not breastfeeding at all is a problem. I know that breastfeeding prevents cancer.” (P13)

3.5 | Theme 3: Participation Dynamics and Expectations for Support

This theme addresses the research questions directly and is subdivided into “Reasons for Not Participating” and “Expectations for Support Services.”

Reasons for Not Participating: Figure 2 shows the code distribution for reasons participants gave for not participating in the screening. Some of the participants repeated certain codes more than once.

The code matrix is shown in Figure 3.

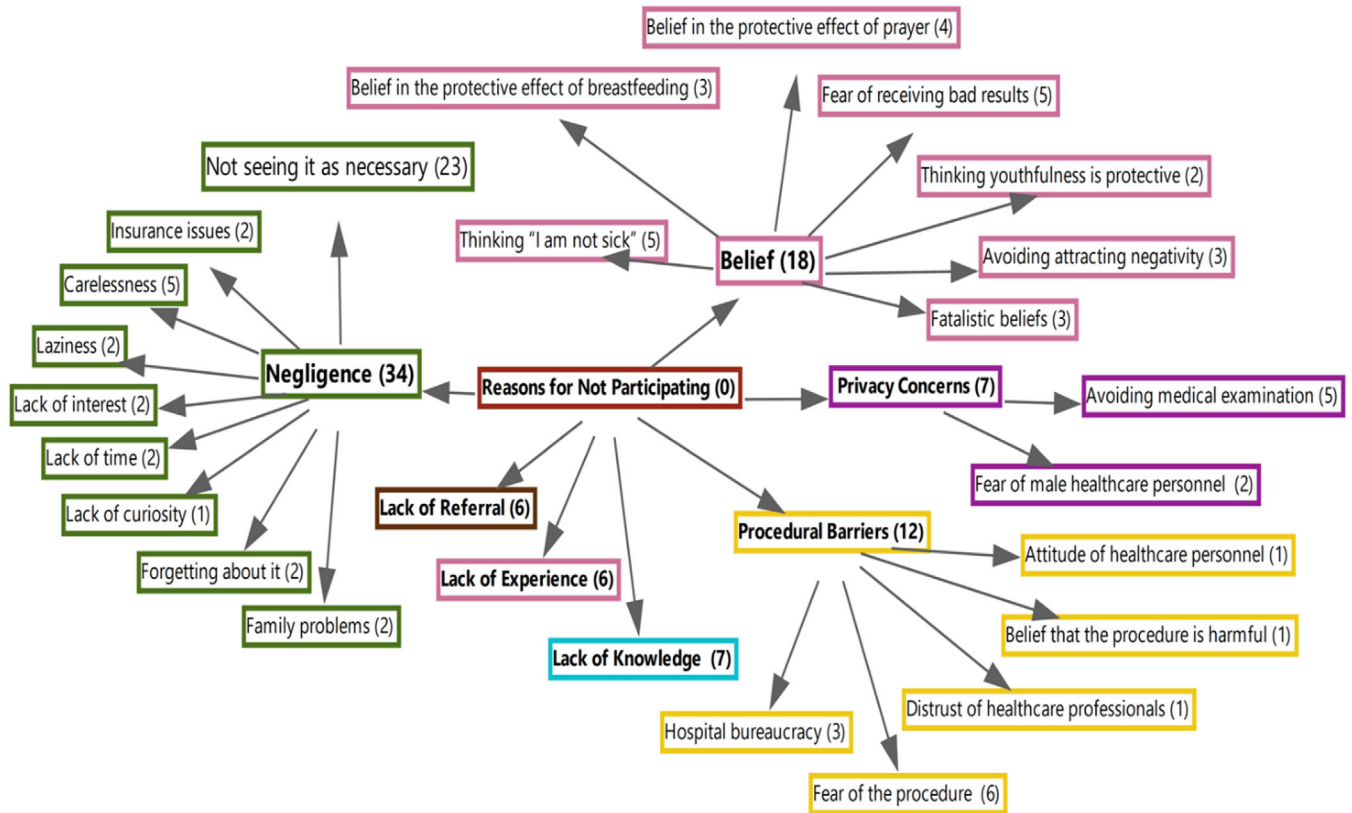


FIGURE 2 | Code distribution for reasons for not participating.

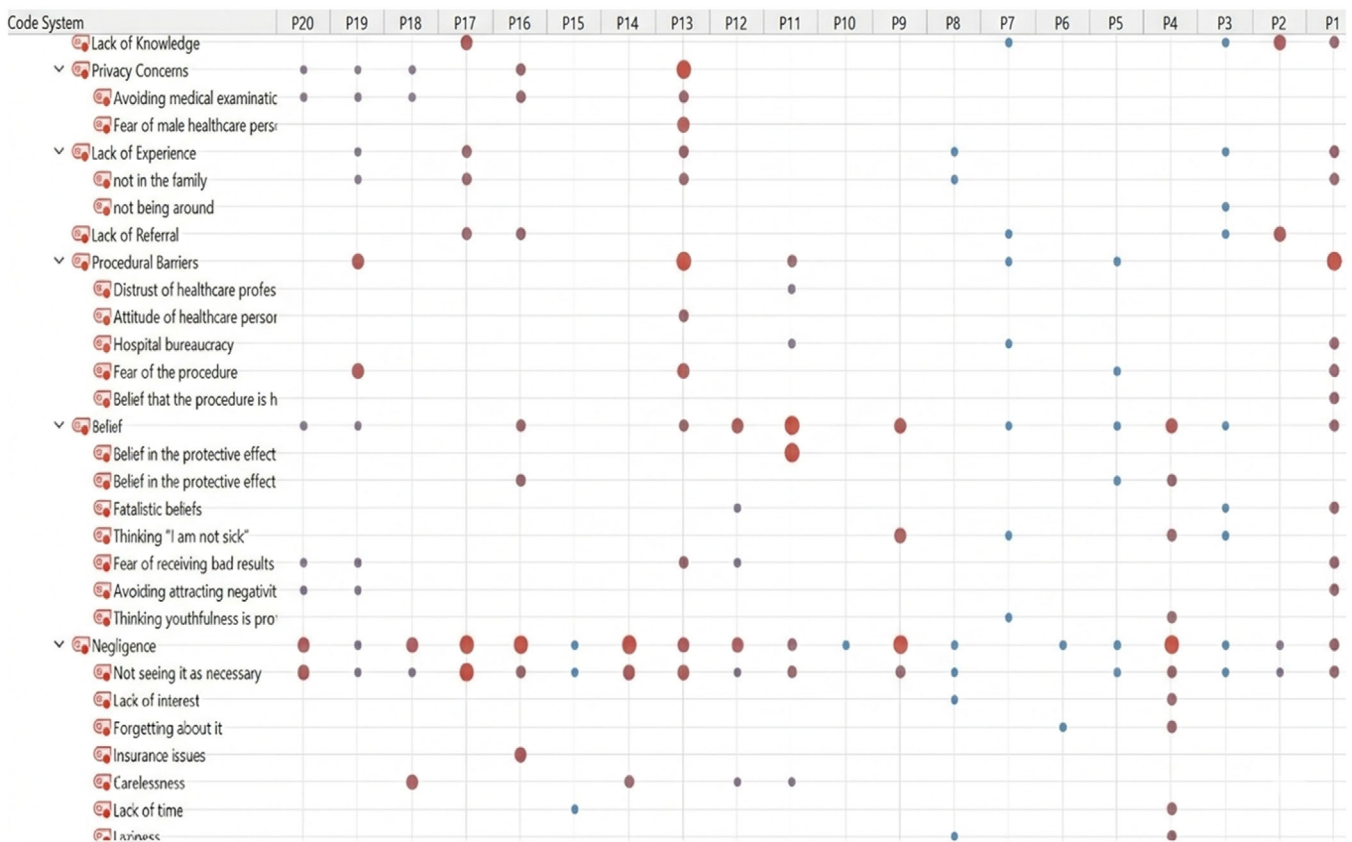


FIGURE 3 | Code matrix of reasons for not participating.

Upon examining the factors that hinder participation in screening programs, negligence stands out as the most prevalent reason. Next, in order are beliefs, the screening process, privacy, lack of knowledge, lack of experience, and lack of guidance.

Within the negligence code, several subcodes emerged: feeling no need, lack of desire, forgetting or not thinking about it, carelessness, insurance issues, lack of time, laziness, lack of curiosity, and family problems. The most prominent subcode feels that there is no need. Participants stated that they considered screening unnecessary because they perceived no health problems.

Under the belief code, various factors appear: belief in prayer as protective, fear of negative results, not wanting to “invite” bad news, thinking that youthfulness confers protection, believing breastfeeding is protective, thinking “I’m not sick,” and fatalistic views.

Some participants (e.g. P1, P13, P19 etc.) mentioned that hospital procedures and the attitudes of the healthcare staff deter them from attending screening programs. Moreover, fear of pain during mammography and beliefs about the potential harmful effects of the procedure were identified as discouraging factors. The “Screening Process” code covers fear of the procedure, thinking the procedure might be harmful, hospital protocols, distrust of healthcare personnel, and perceived negative attitudes of staff. Additionally, some participants (e.g. P13, P18, P20 etc.) indicated that they did not attend screenings because of discomfort with medical examinations and the possibility of encountering male healthcare personnel. Below are a few quotes from participants:

“It takes two minibuses to get there. Then you have to wait in that hospital. And all those procedures. Going there, coming back, waiting in line. How they treat you there. All of that is really discouraging, you know?” (P1)

“I just turned 58.” (P7)

“I always pray and say ‘Ya Shafi’ every day while stroking my body, so I don’t go or get it done.” (P11)

“I’m not in any discomfort, so why go now?” (P13)

“Frankly, I feel uncomfortable undressing in front of a doctor, even a female doctor. I’m ashamed, it’s private. Even during childbirth or a C-section, I was mortified.” (P18)

“...I don’t want to invite negativity. I feel like if I go and get it done, I might hear something bad.” (P19)

Expectations for Support Services: The figure below shows the sources of support that participants believed would be most effective in increasing participation in breast cancer screening programs. Four codes were identified: “Information and Awareness-Raising,” “Accessibility and Financial Support,” “Pressure and Compulsion,” and “Comfort and Security.”

Twelve participants (e.g. P1, P4, P6 etc.) emphasized the need for information and awareness raising, indicating that frequent and prominent media campaigns are crucial. Nine participants (e.g. P2, P10, P15 etc.) expressed the need for better access and financial support, including easier hospital transportation and free procedures. In addition, five participants (e.g. P9, P14, P19 etc.) supported the idea of exerting “pressure and compulsion,” suggesting that individuals should be compelled to attend screening programs through systematic follow-up and insistence. Another five participants (e.g. P1, P5, P18 etc.) mentioned “comfort and security,” highlighting the need to preserve privacy and ensure a painless and harmless experience during the procedure. Some remarks:

“I think they *should* go door to door and force people. Literally, they are taken by hand. I’m serious. Everyone should be contacted. If we don’t go, they should insist we do. It’s better that way. When I said I wouldn’t go, they just said, ‘Alright, it’s up to you,’ and hung up. They need to check everyone they consider at risk.” (P1)

“Honestly, I think advertisements. When you see those things on TV, it gives you chills. You get uneasy, so when you think of it, you say, ‘Maybe I should go, too.’ But since I don’t see it or know about it, it never crosses my mind. So yeah, more commercials. Because you see it. ‘Maybe I should go and check,’ you think. Because I don’t see or know about it, it never comes to mind.” (P4)

4 | Discussion

The study’s findings group the reasons preventing women’s participation in breast cancer screening programs under three themes: “Knowledge and Awareness,” “Perceptions,” and “Participation Dynamics and Expectations for Support.”

4.1 | Knowledge and Awareness Theme

Participants recognized factors such as genetic predisposition, stress, unhealthy eating, and alcohol use as potential contributors to breast cancer, in line with existing literature (Abbas and Baig 2023; Bilgin and Yiğit 2025; Obeagu and Obeagu 2024). Their awareness of common symptoms, such as breast lumps, swelling under the armpit, and nipple discharge, mirrors previous findings (Abbas and Baig 2023; El Maouchi et al. 2023). Although participants generally knew that free screening programs existed, their understanding of these programs and early detection methods was incomplete, corroborating studies in various contexts (Allo et al. 2019; Ceyhan et al. 2022).

4.2 | Perceptions Theme

Research indicates that women often harbor fears, thoughts of mortality, and apprehensions about the social stigma regarding breast cancer (Çiçek and Beydağ 2022; Kathrikolly et al. 2020;

Sekar et al. 2022). In some cultural contexts, breast cancer can be mistakenly associated with sexually transmitted infections or immoral behavior perceived as divine punishment, leading to feelings of shame and stigmatization (Ferdous et al. 2020; Getachew et al. 2020). In this study, participants appeared to be more knowledgeable, with no association between breast cancer and sexually transmitted infections or immoral behavior. Furthermore, consistent with other studies, some women avoided talking about the disease to “avoid attracting” something negative (Ferdous et al. 2020; Rajendram et al. 2022).

4.3 | Participation Dynamics and Expectations for Support Theme

These findings suggest a range of barriers to participation in breast cancer screening programs. In line with the literature, negligence emerges as a leading barrier and is occasionally linked to insufficient personal health attention, familial responsibilities, and time constraints (Kathrikolly et al. 2020; Lee and Schwartz 2021). Previous studies have also noted that many women believe screening is only necessary when symptoms arise (Abbas and Baig 2023; Abo Al-Shiekh et al. 2021; Ferdous et al. 2020; Ilaboya et al. 2018), echoing this study's conclusions.

Another key factor that dissuades women is their beliefs. As seen in other studies, the perception that cancer occurs only at older ages, that it is incurable, that it is predetermined by fate, or that fear of receiving bad news can inhibit screening participation (Allo et al. 2019; Babaoğlu et al. 2021; Kathrikolly et al. 2020; Rajendram et al. 2022; Saçıkara & Koçoğlu Tanyer 2021). Similarly, in Korean American women, the notion that breastfeeding offers complete protection exists, whereas among Nigerian women, screening behaviors appear to be shaped more by religious and socio-cultural beliefs than by perceived risk (Allo et al. 2019; Lee and Schwartz 2021; Olasehinde et al. 2019). The present findings reveal parallel views among participants.

Studies from Singapore, Ethiopia, among Korean American women, and in Türkiye indicate that misconceptions about mammography being painful or harmful deter many women from screening (Ceyhan et al. 2022; Getachew et al. 2020; Lee and Schwartz 2021; Ozcelik and Avci 2025; Rajendram et al. 2022; Saçıkara and Koçoğlu Tanyer 2021). This research similarly found that participants' anxieties and fears arose from negative information received through social networks.

Existing literature also identifies issues such as transportation difficulties, long waiting times, inconvenient appointment slots, and financial constraints as important barriers to screening (Ceyhan et al. 2022; Ferdous et al. 2020; Getachew et al. 2020; Hamed et al. 2022; Ilaboya et al. 2018). Although participants worried that those without health insurance might be excluded, financial barriers were not a problem, likely because breast cancer screening programs are provided free of charge in Türkiye. However, consistent with previous research (Abbas and Baig 2023; Ferdous et al. 2020; Getachew et al. 2020; Ilaboya et al. 2018; Lee and Schwartz 2021; Olasehinde et al. 2019; Rajendram et al. 2022; Saçıkara and Koçoğlu Tanyer 2021), privacy concerns, distrust of healthcare providers, and negative attitudes of health personnel deterred participants from attending screening.

Additionally, prior studies have confirmed that a lack of referral and limited knowledge are common reasons for nonparticipation in screening programs (Ferdous et al. 2020; Kathrikolly et al. 2020; Kolawole and Ong 2022; Ilaboya et al. 2018; Olasehinde et al. 2019). This study similarly shows that insufficient information and guidance pose major hurdles, and that women with a family history of breast cancer have a higher motivation to participate in screening programs.

Although the study mainly focused on barriers, a few participants mentioned potentially facilitating factors, such as being contacted by the Family Health Center or the presence of mobile screening services. However, these opportunities alone were insufficient to motivate attendance, indicating that structural facilitators may not always translate into participation when personal or cultural barriers persist.

4.4 | Strengths of the Study

This study has several strengths. The use of a phenomenological design allowed for an in-depth exploration of women's perceptions and experiences regarding nonparticipation in breast cancer screening programs. The methodological rigor was ensured through strategies such as member checking, double-coding, and adherence to the COREQ checklist. Furthermore, the study contributes to the limited qualitative literature on breast cancer screening in Türkiye and provides valuable insights for public health nursing practice, particularly in designing culturally sensitive interventions to improve screening participation.

5 | Limitations

This study was limited to data obtained from a single-family health center. The focus on a population with a low socioeconomic and educational status may have restricted the diversity of responses. During the interviews, some participants used colloquial expressions. Since the findings are based solely on participants' knowledge, perceptions, and experiences, they should not be generalized. Moreover, the use of audio recordings prompted security concerns among some participants, resulting in more reserved responses.

6 | Conclusion and Recommendations

This study demonstrated that health-related beliefs and insufficient knowledge primarily drive women's nonparticipation in breast cancer screening programs. Furthermore, transportation challenges, long waiting times, fear of pain during the procedure, and distrust in the healthcare system impede participation. Concerns about privacy and a lack of firsthand exposure to breast cancer in social circles serve as additional barriers. The absence of accurate scientific information and the influence of misleading guidance negatively affected screening participation. These findings underscore the necessity for multifaceted strategies that address cultural and individual barriers, deliver accurate information, and foster confidence in the healthcare system.

Midwives and other healthcare professionals can help increase participation in breast cancer screening by educating women to address knowledge deficits and fostering trusting and supportive environments. Attention to privacy, accessible transportation options, and cultural sensitivity can also be incorporated. Additionally, the strategic use of media can assist women in overcoming psychological barriers. These approaches are likely to enhance participation in screening programs.

Acknowledgments

This manuscript did not utilize artificial intelligence.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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