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Original Research Article

Religiousness, Spirituality and the use of Healthcare Services in the Management of Prostate Cancer in Côte d'Ivoire

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Abstract: This study interrogates the interrelations between religious practices, spirituality and biomedical health-care seeking in the management of prostate cancer in Côte d'Ivoire (Abidjan), within a context characterised by therapeutic pluralism and the pronounced salience of religion. The central problematisation examines how socially and spiritually constructed symbolic meanings of illness shape patients' care trajectories. The objective is to understand how faith, religious beliefs and spiritual practices influence therapeutic decision-making, medical adherence, and the temporalities of engagement with health services. Employing a qualitative methodology, the study draws on semi-structured interviews with men living with prostate cancer, health-care professionals and religious leaders, complemented by an interpretative discourse analysis. Findings indicate that the illness is frequently construed as a spiritual trial, a sanction, or a divine test, legitimising concurrent or alternating recourse to prayer, religious interventions and biomedical care. The discussion highlights logics of complementarity, alongside tensions between medical rationality and religious rationality. In conclusion, the study underscores the social utility of an integrative approach to care that is attentive to patients' symbolic universes, thereby enhancing therapeutic adherence and the effectiveness of prostate cancer control policies in Côte d'Ivoire.

Keywords: Spirituality, Religious Practices, Health-Care Seeking, Prostate Cancer, Sociology of Health.

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INTRODUCTION

The empirical findings from the survey highlight the close interconnection between religious practices, spirituality and the use of healthcare services in the treatment of prostate cancer in Côte d'Ivoire. The disease is predominantly interpreted by patients as a spiritual ordeal, a divine test or the manifestation of an invisible disorder, thereby conferring upon religious practices a central role in providing reassurance, explanation and reorientation of treatment pathways. Prayer, deliverance rituals and consultations with religious leaders thus coexist with the use of biomedicine, revealing a therapeutic pluralism based as much on the search for meaning as on the search for a cure.

A fundamental paradox emerges from these observations: whilst spirituality constitutes a major symbolic resource that fosters moral resilience, acceptance of illness and social support, it can also come into conflict with biomedical prescriptions by legitimising delays in seeking medical advice or interruptions to treatment. This paradox forms the basis for the following research question: how do religious and spiritual frameworks, as matrices of meaning, simultaneously shape both adherence to and resistance towards biomedical interventions in the therapeutic management of prostate cancer?

The scientific significance of the study lies in the insights it provides for a sociological understanding of the relationship between health and religion, by demonstrating that care pathways are socially and symbolically constructed. From a practical perspective, it examines strategies for integrative care, bringing together healthcare professionals and religious figures, with a view to improving early access to care, treatment adherence and the effectiveness of policies to combat prostate cancer in Côte d'Ivoire.

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The state of knowledge in the field of health converges on the view that therapeutic trajectories should not be regarded merely as individual decision-making sequences, but rather as social and symbolic configurations mediated by historically and culturally constituted systems of meaning. The work of Fassin (2001: 45–67), grounded in an ethnographic and socio-anthropological methodological approach attentive to everyday care practices and the moral economies of health, demonstrates that experiences of illness are structured by regimes of legitimation that bring together biomedical knowledge, social norms and moral references. The author shows that the experience of illness is mediated by regimes of legitimation articulating biomedical knowledge, social norms and moral references. However, although this perspective remains heuristically valuable for analysing healthcare trajectories in the Ivorian context, it presents certain limitations in relation to the subject of this study: *Religious Practices, Spirituality and Healthcare-Seeking in the Therapeutic Management of Prostate Cancer in Côte d'Ivoire (Abidjan)*.

First, Fassin's work gives central importance to processes of moral hierarchisation and to the government of bodies, within a perspective shaped by the analysis of power and inequalities. Although relevant, this orientation tends to underestimate the experiential and existential dimension of cancer, particularly when the disease is imbued with spiritual meaning. In the case of prostate cancer in Abidjan, the disease does not merely involve inscription within moral regimes; it also entails an active process of meaning-making involving prayer, fasting, deliverance, prophetic or pastoral consultations. Religious rationality is therefore not reduced to a moral filter through which biomedicine is interpreted; rather, it constitutes an autonomous register of understanding and action.

Second, Fassin's approach, centred on institutional arrangements and normative frameworks, primarily analyses the ways in which biomedicine is received, negotiated or contested in contexts characterised by social inequalities. However, in the study of prostate cancer in Côte d'Ivoire, the issue is not limited to the reception of medical rationality. Rather, it concerns a dynamic co-construction between biomedical and religious rationalities. Patients do not simply occupy a position in which they symbolically filter the medical provision available to them; instead, they develop hybrid therapeutic pathways in which urological examinations, oncological treatments and spiritual practices are combined in complementary and sometimes simultaneous ways.

Third, the Fassinian focus on "moral economies" tends to privilege the analysis of relationships between the state, health institutions and populations. It sheds less light on microsocial interactions within religious communities Pentecostal churches, Catholic parishes, mosques and prayer groups which play a structuring role in decisions to seek, continue or discontinue treatment. In the Abidjan context, these religious spaces function as arenas of therapeutic legitimation, psychological support and identity redefinition in the face of a disease often associated with masculinity, sexuality and male dignity.

Fourth, Fassin's perspective, by emphasising the effects of domination and moral hierarchisation, may obscure patients' capacity for therapeutic decision-making and their practices of self-determination. In the case under study, patients with prostate cancer are not merely subjected to normative regimes; they strategically mobilise several systems of knowledge in order to maximise their chances of recovery, reduce anxiety and preserve their social status. Spirituality thus emerges not merely as a response to biomedical uncertainty, but as a therapeutic resource in its own right.

Finally, although Fassin highlights the non-neutral character of medical rationality, he primarily analyses the ways in which it is socially framed. The study of prostate cancer in Abidjan instead reveals a productive dialectic between religious and biomedical worlds: rather than existing solely in tension or competition, these registers may be articulated through forms of stabilised therapeutic pluralism. This articulation goes beyond a logic of moral hierarchisation and instead reflects a pragmatic approach to care based on complementarity.

Thus, Fassin's contribution remains fundamental for conceptualising the political and moral dimensions of therapeutic trajectories. Nevertheless, when applied to the case of prostate cancer in Côte d'Ivoire, it requires an analytical shift: from the government of bodies towards the co-construction of rationalities; from moral hierarchisation towards therapeutic hybridisation; and from a primarily institutional reading towards a sociology of religious practices as active matrices shaping healthcare-seeking behaviour.

From a complementary perspective, Kleinman (1988 : 25–42) employs a clinical and interpretative methodology centred on the analysis of *illness narratives* to demonstrate that illness constitutes a biographical disruption requiring a process of meaning-making. These findings highlight the fact that patients develop hybrid explanatory models combining biomedical, spiritual and social causalities. This approach directly illuminates the subject under study, insofar as the narratives of men living with prostate cancer reveal an ongoing negotiation between religious and medical explanatory frameworks. However, the limitation of this perspective lies in its primary focus on individual narrative reconstruction, leaving in the background the analysis of collective religious settings churches, prayer groups and spiritual

authorities as structuring institutions within therapeutic trajectories.

In the African context, Criel and Waelkens (1999: 215–239), drawing on field research in public health and medical anthropology, demonstrate that religious and spiritual practices constitute genuine normative institutions capable of shaping the timing of healthcare-seeking and prescribing legitimate therapeutic sequences. Their findings converge with those of the present study insofar as they reveal the interweaving of religious and biomedical logics. Nevertheless, their analyses focus primarily on the organisation of health systems and general community dynamics, without examining the gendered and symbolic dimensions specific to a condition such as prostate cancer. The disease studied here affects an organ strongly associated with masculinity, sexuality and virility, thereby intensifying the role of religious references in managing shame, silence and bodily vulnerability dimensions that are less central to their work.

The ambivalence of religious networks is also highlighted by Whyte (1997: 102–125), based on an ethnographic study of therapeutic practices in a context of medical pluralism. The author's findings show that these networks simultaneously provide social protection and impose normative constraints. This interpretation finds a direct empirical echo in the subject under study: faith may legitimise adherence to biomedical treatments when they are perceived as compatible with spiritual prescriptions, but it may also generate delays or resistance when healing is understood as belonging exclusively to the religious sphere. However, the limitation of this approach lies in its grounding in an ethnography of therapeutic pluralism in general, without focusing on serious chronic conditions carrying a strong masculine symbolic burden. The analysis of prostate cancer in Abidjan reveals more complex pragmatic negotiations, in which sexuality, performance and marital status redefine the very modalities of medical pluralism.

The work of Becker (1995: 78–95), grounded in an interactionist approach to so-called deviant behaviour, provides a methodological framework for understanding therapeutic engagement as a negotiated process. Becker demonstrates that practices are always embedded in multiple normative systems. Applied to the subject under study, this perspective makes it possible to understand the therapeutic choices of patients with prostate cancer as socially situated acts aimed at preserving moral, religious and bodily integrity. However, the limitation of this approach lies in its original grounding in the analysis of deviance and social careers, which does not fully capture the ontological and spiritual dimensions of cancer. The present study therefore shifts the analysis towards a normality of therapeutic pluralism that is constitutive of healthcare trajectories in Côte d'Ivoire, rather than towards an interpretation in terms of transgression or labelling.

However, the hermeneutic approaches of Bury (1982: 170–180) and the functionalist sociology of Parsons (1951: 372–388), although methodologically distinct, converge in recognising the role of social meanings in the experience of illness. Drawing on a qualitative analysis of patients' narratives, Bury highlights illness as a disruption of the ordinary course of life, whereas Parsons, through a normative theoretical approach, conceptualises the sick role as a mechanism of social regulation. Nevertheless, both frameworks present limitations in relation to the subject under study: Bury does not centrally incorporate institutionalised religion as an active therapeutic resource, while Parsons tends to universalise the "sick role" without taking into account the reconfigurations produced by specific religious norms and by the strong symbolic significance attached to masculinity in the Ivorian context. The study of prostate cancer thus demonstrates that religious norms simultaneously redefine the status of the patient, marital and community expectations, and the concrete modalities of healthcare-seeking, thereby eluding a strictly biographical or functionalist interpretation.

Ultimately, the epistemological specificity of this study lies in its integrative and situated approach, which brings together the sociology of health, the anthropology of religion and the analysis of socially produced forms of bodily masculinity. By incorporating both the contributions and the limitations of these authors, it demonstrates that therapeutic trajectories associated with prostate cancer in Côte d'Ivoire can only be understood by taking into account the negotiated co-presence of religious and biomedical rationalities, in a context where spirituality constitutes neither a mere symbolic filter nor a normative constraint, but rather a structuring and performative resource shaping healthcare-seeking behaviour.

THEORETICAL AND METHODOLOGICAL FRAMEWORK

Understanding this subject of study is based on a comprehensive sociological approach, which brings together the theory of religious culture and the interpretative frameworks used in the sociology of health, in order to enrich the analysis of practices and experiences related to illness. According to Berger and Luckmann (1966: 51–78), social reality unfolds as a symbolic and institutional construct, through artefacts, rituals and norms that confer intelligibility and legitimacy on lived experiences.

Applied to prostate cancer, this line of thinking shows that religion and spirituality are not merely a matter of personal or private beliefs. They constitute genuine frameworks of understanding that profoundly influence the way in which patients perceive the disease,

experience treatments and guide their therapeutic decisions. Religious practices, prayers, collective rituals and the advice of spiritual leaders thus play a part in the practical organisation of care pathways. For patients, religious commitment is therefore not limited to mere moral comfort in the face of suffering. It becomes a way of making sense of the ordeal of illness and of better coping with the physical and psychological changes it brings about.

Through faith, patients seek to understand what is happening to them, maintain hope and preserve a certain degree of inner balance despite the uncertainties associated with cancer. Religion also acts as a space of mediation between medical requirements and patients' spiritual values. It enables them to integrate biomedical treatments into a broader understanding of their existence, in which healing is conceived simultaneously as a medical, moral and spiritual process. Patients thus construct their therapeutic pathways by combining doctors' recommendations with practices and norms derived from their religious environment.

This reflection can be better understood through the notion of the 'healthworld' developed by Germond and Cochrane (2010: 134–152), which refers to the worlds of meaning through which individuals interpret their health, their bodies and their experience of illness. In the case of prostate cancer, religious and spiritual beliefs therefore constitute genuine frameworks of interpretation that influence how patients experience their therapeutic pathways.

These religious and spiritual worlds do not remain separate from modern medicine. They coexist with biomedical knowledge, interact with it and influence patients' decisions. For some patients, faith may strengthen adherence to medical treatments when it encourages trust in doctors and hospitals. In other situations, certain religious or spiritual practices, such as prolonged fasting, intensive prayer sessions or recourse to traditional healers, may alter the pace of medical follow-up or lead patients to favour alternative forms of care.

Care pathways therefore emerge as spaces in which several forms of reasoning constantly intersect. Patients are not only managing a disease of the body; they must also negotiate their beliefs, spiritual values and the expectations of those around them. The therapeutic experience is thus constructed both through the physical reality of the disease and through the symbolic meanings that individuals attribute to their experience.

Understanding therapeutic trajectories therefore requires recognising that care-related decisions are always situated within a specific social, cultural and spiritual context. Medical practices, religious beliefs and personal experiences intertwine to produce particular ways of living with, understanding and confronting illness.

Pattison's (2000: 211–230) approach further reinforces this critique by emphasising the prescriptive and normative dimension of religion in African societies, particularly its capacity to structure time and regulate patterns of healthcare utilisation. Religious and spiritual networks thus constitute ambivalent spaces, combining structuring functions with normative constraints. On the one hand, they provide essential moral, emotional and social support to patients facing the bodily and existential ordeal of cancer; on the other hand, they establish prescriptive frameworks that impose temporal and symbolic obligations which may delay, modify or redirect adherence to biomedical protocols.

Applied to this study, this theoretical approach makes it possible to understand that the therapeutic pathway of patients with prostate cancer does not follow a straightforward or exclusively medical course. It is progressively constructed through social relationships, religious beliefs, the expectations of those around them and the prescriptions of healthcare professionals. Patients therefore operate within an environment in which several forms of reasoning intersect and influence their choices in relation to illness.

Each healthcare-related decision such as taking medication regularly, participating in religious practices or seeking the advice of a spiritual leader often results from a balance between different influences. Patients continually seek to reconcile medical recommendations with their religious convictions and the norms of their community. The care pathway thus becomes a space of ongoing negotiation, in which individuals attempt to find responses adapted to their social, spiritual and therapeutic realities.

This perspective also highlights the importance of religious and community networks in the experience of illness. These spaces influence how patients interpret their health condition, justify their therapeutic choices and maintain a degree of personal stability despite the transformations brought about by cancer and its treatments. Religious beliefs and social relationships therefore contribute to preserving patients' sense of identity and strengthening their capacity to cope with the ordeal of illness.

Ultimately, therapeutic trajectories emerge as complex spaces in which medicine, religion and social norms intersect and become intertwined. Care experiences therefore do not rest solely on biomedical decisions, but also on symbolic, moral and relational dimensions that give meaning to patients' experiences and shape their behaviour in relation to illness.

The study adopts a qualitative approach, making it possible to capture the complexity of the

meanings attributed to illness and treatment. It is conducted in Abidjan (Yopougon), the economic and healthcare capital of Côte d'Ivoire, characterised by a high concentration of specialised hospitals, marked therapeutic pluralism and a strong presence of religious institutions. This context provides a relevant setting for examining how religious and spiritual forms of reasoning interact with biomedical systems in the management of prostate cancer.

Data are collected through semi-structured interviews with 25 participants: 15 men diagnosed with prostate cancer, 5 relatives actively involved in providing support, and 5 religious leaders or spiritual figures. The eligibility criteria for participation in the study include the following: for patients, having been diagnosed with prostate cancer and undergoing or having undergone biomedical treatment; for relatives, being actively involved in the therapeutic support process; and for religious leaders, holding a recognised position of influence within the community.

To strengthen the validity and reliability of the data, the study employs a triangulation technique combining: (i) source triangulation, involving patients, relatives and religious leaders; (ii) methodological triangulation, combining semi-structured interviews with participant observation in healthcare and community settings; and (iii) theoretical triangulation, confronting the empirical data with interpretative frameworks relating to religion, spirituality and health. Data analysis follows a hermeneutic and interpretative approach, using thematic and narrative analysis to identify tensions, complementarities and negotiation strategies between religious and biomedical rationalities (Riessman, 2008: 12–35; Morse & Field, 1995: 32–50). This methodology makes it possible to link an understanding of social and symbolic dynamics with the actual conduct of care pathways, highlighting how religious and spiritual forms of reasoning simultaneously shape adherence, resistance and therapeutic trajectories.

RESULTS

Faith and Medicine: How Spirituality Supports and Legitimises Treatment Adherence

Spiritual practices and religious beliefs strengthen the perception of biomedicine as complementary to divine action. Rituals and prayer are not viewed as being in opposition to therapeutic treatments; rather, they legitimise and support the continuation of treatment.

Verbal data collected:

> "I pray every morning, and then I take my medication as prescribed by the doctor. Faith and medicine work together." *(G.L., patient, Yopougon)*

> "My pastor told me that God helps those who seek treatment. I cannot stop my treatment." *(Y.V., patient, Yopougon)*

> "Before each chemotherapy session, I pray for strength and healing. It gives me confidence to continue with the treatment." *(K.P., patient, Yopougon)*

> "I believe that God can heal, but He also uses doctors as His instruments." *(G.N., patient, Yopougon)*

> "My prayer group encourages me to continue with my medical appointments because faith does not replace medicine." *(Y.B., patient, Yopougon)*

These accounts show that, in the management of prostate cancer, religion and medicine are not experienced by patients as two opposing worlds. On the contrary, they intersect and complement each other in the ways in which patients understand their illness, endure treatment and make sense of their therapeutic pathways. Faith therefore does not appear as a rejection of modern medicine, but rather as an important resource that helps patients cope with the ordeal of illness and deal with the uncertainties associated with care.

For many patients, religion constitutes an essential source of moral and psychological support. It enables them to interpret their illness, maintain hope and achieve a degree of emotional stability in the face of pain, demanding treatments and anxiety about the future. Through prayer, spiritual guidance and exchanges with religious communities, patients are able to make their suffering more bearable and place their experience within a meaningful framework. Illness is therefore no longer perceived solely as a biological condition, but also as a human, moral and spiritual ordeal.

In this context, faith often supports adherence to biomedical care. Religious beliefs strengthen patients' trust in doctors, hospitals and prescribed treatments. Many patients regard healthcare professionals as instruments of God or view medical treatment as a potential means of healing granted through divine will. Religion therefore does not replace medicine; rather, it contributes to strengthening patients' engagement with therapeutic follow-up and compliance with medical prescriptions.

The analysis also reveals a form of practical combination of religious and scientific knowledge. Patients continuously navigate between medical advice, recommendations from their religious communities and cultural beliefs surrounding illness. Their therapeutic decisions therefore result from ongoing adjustments between several forms of reasoning: following medical treatment, engaging in spiritual practices, listening to

relatives and complying with certain religious prescriptions. This way of managing illness reflects a practical adaptation to the realities of everyday life and to the constraints associated with the therapeutic experience.

These pathways also demonstrate that health cannot be reduced to a purely biological matter. It is also constructed through social relationships, bonds of trust and the meanings that individuals attribute to their experiences. Through their therapeutic practices, patients seek not only to treat their bodies, but also to preserve their dignity, identity and inner balance despite the upheavals caused by illness.

Ultimately, religion plays a central role in care pathways related to prostate cancer. It shapes representations of illness, influences healthcare-seeking behaviours and helps patients maintain a sense of coherence throughout their life trajectories. Religious and spiritual networks thus become spaces of support, interpretation and legitimation of therapeutic practices. Within this dynamic, medicine and religion appear less as opposing realities than as complementary resources mobilised by patients to cope with the ordeal of illness.

The Normative Influence of Religious Networks on Healthcare Choices and the Timing of Care

Religion can produce norms that prescribe putting faith to the test or prioritising spiritual interventions, thereby delaying or undermining adherence to biomedical treatments.

Verbal data collected:

> "My traditional healer told me to wait for his blessing before starting the medication." *(T.M., patient, Yopougon)*
>
> "I wanted to have a special seven-day prayer first before undergoing surgery." *(G.N., patient, Yopougon)*
>
> "My pastor advised me to continue praying before starting radiotherapy." *(N.M., patient, Yopougon)*
>
> "I did not take all the prescribed medication because I thought that God could heal me on His own." *(T.G., patient, Yopougon)*
>
> "My family encouraged me to consult the marabout before seeing the doctor." *(D.L., patient, Yopougon)*

These accounts show that religious networks play an important role in the way patients with prostate cancer organise their care pathways. Beyond the moral support and spiritual encouragement they provide, these religious spaces also transmit rules, advice and expectations that concretely influence patients' behaviours. Beliefs, recommendations from religious leaders and collective practices often define what is considered appropriate or desirable when facing illness.

Within this dynamic, religious practices sometimes impose their own rhythm on the management of illness. Periods of fasting, intensive prayer and certain forms of spiritual trial may occupy a central place in patients' lives and alter the organisation of care. However, religious time does not always correspond to medical time, which is structured around specific appointments, regular medication intake and adherence to therapeutic protocols.

Thus, some patients may delay a consultation, temporarily interrupt treatment or reorganise their medication schedules in order to participate in religious activities considered important. These situations reveal a discrepancy, and sometimes even a tension, between the demands of medicine and those of religious practice. Patients are therefore required to reconcile two normative worlds that simultaneously shape their decisions and behaviours.

This reality shows that religious networks are not merely spaces of comfort in the face of illness. They also function as social frameworks that produce norms and influence therapeutic choices. Community expectations, the authority of religious leaders and even the fear of being perceived as lacking faith may weigh heavily on patients' decisions. Religious prescriptions thus acquire considerable influence over the conduct of care pathways.

However, this does not necessarily imply a rejection of biomedicine. In most cases, patients instead seek to reconcile religious and medical requirements in order to preserve both their physical health and spiritual equilibrium. Their therapeutic pathway consequently becomes a space of continuous negotiation between beliefs, community expectations and medical prescriptions.

The resistance observed in these contexts should therefore not be interpreted as irrational rejection or ignorance of medical knowledge. Rather, it resembles a strategy of social and identity negotiation through which patients attempt to navigate multiple and sometimes contradictory normative regimes. Positioned at the intersection of medical rationality, community expectations and their own spiritual convictions, individuals develop adaptive practices involving postponements, partial adherence or selective appropriation of biomedical prescriptions. These hybrid practices constitute pragmatic compromises aimed at preserving both perceived therapeutic effectiveness and the patient's relational and symbolic coherence within their social and religious environment.

These tensions also reveal the dual and ambivalent function of religious networks in care pathways. On the one hand, they provide decisive moral, emotional and symbolic support, enabling patients to cope with suffering, prognostic uncertainty and the bodily transformations induced by treatment. On the other hand, they impose normative frameworks that may restrict patients' decision-making autonomy, introduce delays or adjustments in the implementation of biomedical care and, in some cases, reinforce forms of therapeutic vulnerability. This ambivalence highlights the fact that religious support cannot be understood in a univocal manner, but must instead be analysed as a social mechanism with differentiated effects, both protective and constraining.

In summary, this analysis shows that patients do not make their decisions alone or automatically. They rely on relatives, religious leaders and those around them to understand their illness and determine how to seek treatment. They continually use and adjust the resources and advice available to them in order to cope with their situation. Therapeutic choices are therefore not simply medical decisions. They depend on the context, social norms, religious beliefs and personal constraints. The care trajectory is not guided solely by biomedicine; rather, it is constructed at the intersection of medical, religious and symbolic forms of reasoning. These findings suggest that medical support should take greater account of the role of religious networks and their normative influence. By thoughtfully incorporating these dimensions into patient care, it may be possible to strengthen treatment adherence, reduce tensions between religion and medicine and improve the overall effectiveness of care.

Religious Capital and Engagement with Treatment: The Role of Community Networks in Therapeutic Persistence

Religious networks provide moral support, social cohesion and emotional accompaniment, thereby fostering persistence with treatment.

Verbal data collected:

> "During prayer meetings, we share our experiences, and this encourages me to continue with my treatment." *(F.K., patient, Yopougon)*
>
> "The pastor calls me to ask how I am doing and encourages me not to stop taking my medication." *(S.M., patient, Yopougon)*
>
> "My church organises visits to sick people. It makes me feel supported and understood." *(N.H., patient, Yopougon)*
>
> "I am surrounded by fellow believers who remind me of the importance of following my medical prescriptions." *(S.S., patient, Yopougon)*
>
> "The prayer community gives me strength to cope with the pain and side effects." *(D.E., patient, Yopougon)*

In this configuration, religion can be understood as a mobilisable form of social and symbolic capital, in the Bourdieusian sense, constituting a structured relational resource that patients activate in order to consolidate their engagement with biomedical treatment. Far from being limited to individual beliefs, religion is embedded within organised community networks that generate trust, recognition and social legitimacy. These networks provide continuous moral support, practical advice adapted to the experience of illness and collective validation of therapeutic choices, thereby helping to alleviate the feelings of isolation, vulnerability and uncertainty that frequently accompany the diagnosis and management of prostate cancer. In this sense, religious capital functions as a mechanism of social resilience, enabling patients to maintain continuity in their therapeutic pathways despite the demanding nature of treatment, side effects, changes in body image and the enduring emotional tensions induced by the disease.

The mobilisation of religious and community capital highlights individuals' capacity to negotiate and strengthen their agency in contexts characterised by uncertainty and biographical vulnerability. Regular interactions with members of religious communities, prayer groups and spiritual authority figures constitute more than emotional support; they function as genuine instances of symbolic mediation that help make medical prescriptions intelligible, legitimise adherence to them and adjust their temporal implementation. Through these mediations, therapeutic decisions are reintegrated into a shared framework of meaning in which recourse to biomedicine is interpreted not as a rupture with faith, but as a legitimate, and sometimes even morally valued, course of action.

Thus, religion extends well beyond the sphere of spirituality to become a genuine resource in the experience of illness. It provides patients with moral and emotional support while also offering reference points, behavioural guidelines and forms of accompaniment that influence how they follow their treatment. Through religious communities, prayer and spiritual guidance, patients find not only comfort but also a source of strength that helps them continue treatment and cope with the difficulties associated with prostate cancer.

Religion also plays an important role in maintaining patients' social ties and personal equilibrium. It enables patients to preserve a degree of continuity in their identity despite the physical, psychological and social transformations caused by illness. Religious practices thus provide a space in which individuals can feel supported, recognised and understood as they confront the ordeal they are experiencing.

This reality shows that care pathways are never constructed in a completely individual manner. Therapeutic decisions, attitudes towards illness and engagement with treatment are profoundly influenced by social surroundings, community networks and shared beliefs. Social relationships, collective norms and the meanings attributed to illness all contribute significantly to the ways in which patients experience and manage their therapeutic journeys.

Understanding care trajectories therefore requires attention to these social and symbolic dimensions surrounding illness. Religious and community networks are not peripheral to biomedical care; on the contrary, they contribute to its appropriation, acceptance and, in some cases, its social effectiveness among patients.

Religious Beliefs and the Meaning of Cancer: How Spirituality Influences the Experience of Illness and Healthcare Choices

Religious beliefs provide an interpretative framework for illness, which may transform the experience of cancer into a spiritual ordeal, a punishment or a test of faith. These meanings influence attitudes towards biomedical care.

Verbal data collected:

> "I consider my illness to be a test from God. This gives me the patience to continue with the treatment." *(A.K., patient, Yopougon)*
>
> "For me, cancer is an ordeal, but God accompanies me through the doctors." *(D.M., patient, Yopougon)*
>
> "I see my medication as an instrument of divine will." *(Y.L., patient, Yopougon)*
>
> "I pray to understand why I have this illness; it helps me accept chemotherapy." *(G.P., patient, Yopougon)*
>
> "My faith makes me see the treatment as a path towards healing that God has permitted." *(N.V., patient, Yopougon)*

These accounts illustrate that religious forms of reasoning occupy a central position in the process of subjectification of illness, understood as the set of processes through which patients integrate, interpret and rework their bodily, emotional and therapeutic experiences. Spirituality is not limited to an intimate belief or a psychological refuge; it constitutes a structuring cognitive, narrative and symbolic framework through which individuals reconfigure the meaning of illness and its effects on the body. This framework helps reduce the uncertainty inherent in treatment, organise the interpretation of symptoms, pain and side effects, and incorporate altered bodily experiences into an intelligible narrative endowed with continuity and biographical coherence. Illness consequently ceases to be understood as a mere organic dysfunction and becomes an experience socially and symbolically negotiated, within which patients weigh religious injunctions, biomedical recommendations and social expectations.

From this perspective, spirituality acts as both an emotional and cognitive mediator, shaping how illness is felt, named and evaluated, while also concretely influencing adherence to therapeutic arrangements. It may promote medical adherence by conferring moral legitimacy and transcendent meaning upon treatment, but it may also generate forms of selective resistance to certain biomedical prescriptions perceived as incompatible with spiritual obligations or personal convictions. This ambivalence demonstrates that religious rationality does not mechanically oppose medical rationality; rather, it contributes to a situated reconfiguration of therapeutic norms in which patients seek to preserve their moral and identity integrity in the face of bodily vulnerability, loss of control and the transformations imposed by illness and its treatments.

These dynamics therefore highlight that therapeutic trajectories cannot be understood as strictly biomedical, linear and decontextualised pathways. They are co-constructed within hybrid spaces of rationality where medical science, religion and ordinary social norms intersect, combine and sometimes come into conflict. Religious and spiritual practices consequently function as active matrices of meaning, action and social legitimation, enabling patients to make their experiences intelligible, sustain their engagement with care and maintain a coherent moral and social identity. In this sense, the subjectification of illness appears as a fundamentally interpretative and relational process in which health is constructed at the intersection of expert knowledge, shared beliefs and symbolic frameworks, revealing the full social complexity of contemporary care pathways.

DISCUSSION

The care pathways of men living with prostate cancer unfold within spaces in which patients themselves attribute meaning to their experience of illness. Within these trajectories, medical knowledge and religious beliefs do not systematically oppose one another; rather, they intersect, adjust to one another and complement each other throughout the experience of illness.

Religious practices prayer, participation in rituals and interactions with faith communities are not limited to providing comfort. They play a concrete role in how patients understand their health condition, accept treatment and navigate periods of uncertainty. Religion often helps to organise emotions, strengthen hope and situate illness within a broader narrative, in which healing is understood both as a medical reality and as a human, moral and spiritual experience.

Within this dynamic, patients mobilise different resources to cope with illness. They combine doctors' recommendations with spiritual advice and the expectations of those around them. The therapeutic pathway thus becomes a process of continuous adjustment, constructed through everyday practices at the intersection of several logics of life.

However, religious networks are not exclusively spaces of support. They may also introduce rules and obligations that influence the timing of care. Periods of fasting, intensive prayer, consultation with spiritual leaders or certain faith-related requirements may sometimes alter the organisation of medical treatment. This creates situations in which patients must negotiate between several temporalities: that of medicine and that of religious life.

These realities show that patients are not merely passive executors of medical prescriptions. They continually negotiate their choices, adapt their behaviours and seek to preserve their health, identity and spiritual equilibrium simultaneously. Religion thus emerges as an important resource that gives meaning to the ordeal of illness while also concretely influencing therapeutic decisions.

Care pathways are therefore constructed within hybrid spaces in which medicine, religious beliefs and social norms become intertwined. Within this configuration, patients primarily seek to make their experience of illness understandable, bearable and consistent with their worldview.

In light of the findings presented, we prioritise a discursive corpus delimited by an analytical and economical purpose, aimed not at descriptive exhaustiveness but at identifying the structuring and operative elements capable of illuminating the underlying dynamics of care pathways. This methodological positioning follows a selective and synthetic logic, whereby the reduction of discursive redundancies does not constitute an empirical limitation but rather an effect of analytical focus, enabling interpretation to concentrate on the phenomena that are genuinely constitutive of the therapeutic experience. From this perspective, the object of the study is defined as a pivotal analytical nexus: 'Religious Social Capital and Therapeutic Resilience: Community Mediations and Persistence in Biomedical Care Pathways'**.** This operational choice situates the study within a situated hermeneutic approach, in which participants' accounts are read as instruments of social construction and legitimation, simultaneously revealing strategies for activating relational and symbolic resources and strategies for maintaining agency within a context of biomedical and existential vulnerability. Focusing on religious capital as a vehicle of symbolic mediation thus makes it possible to uncover processes of therapeutic resilience by articulating the normative dimension, community recognition and adherence to biomedical protocols. Through this analytical selection, the discursive corpus becomes a tool for decoding the logics of engagement and persistence, providing a structured reading of the interactions between religious networks, moral meaning and continuity of care practices, while also revealing the tensions, trade-offs and compromises that structure therapeutic trajectories.

This finding forms part of an analysis combining structural and interpretative perspectives, making it possible to understand how symbolic and relational resources are mobilised to support continuity of care in contexts of bodily and existential vulnerability.

Drawing on Berger and Luckmann (1966 : 51–78), religious networks can be understood as symbolic institutions that construct and legitimise patients' social reality: faith, collective practices and community rituals structure a cognitive and normative universe that makes the experience of illness and biomedical protocols intelligible. This perspective demonstrates that religious capital is not limited to isolated moral support, but constitutes a mechanism of social and symbolic mediation through which patients reassert their agency within differentiated and constrained therapeutic pathways, articulating medical prescriptions with the normative, moral and symbolic requirements of their communities of affiliation.

The conceptualisation of religious capital as a vehicle for therapeutic resilience is in strong analytical convergence with the seminal works of Bury (1982 : 167–182) and Kleinman (1988 : 25–42), which conceptualise the experience of illness as a biographical disruption and a space for identity reconfiguration. Consistent with these authors, the findings of this study show that religious and community practices function as mechanisms of narrative continuity, enabling individuals to reorder episodes of suffering, contain therapeutic uncertainty and maintain a coherent sense of self challenged by illness. However, a first point of divergence emerges: whereas Bury and Kleinman favour an approach centred on individual experience and the subjective management of disruption, the object under study highlights the structuring role of collective norms and religious moral economies, which shape therapeutic trajectories beyond the biographical sphere. This shift constitutes an epistemological departure by moving the analysis from the reconstruction of meaning alone towards a relational and socially embedded understanding of therapeutic resilience.

In the African context, the works of Criel and Waelkens (1999 : 215–239) and Pattison (2000 : 211–230) find direct empirical resonance in the findings, insofar as they emphasise the role of normative and symbolic networks in shaping the temporality of care and prescribing socially legitimate forms of action. The present research confirms this convergence by showing

that religious capital structures ongoing negotiations between biomedical rationality, spiritual obligations and community expectations. Nevertheless, it introduces an analytical shift by revealing that these registers operate neither in strict complementarity nor in direct opposition, but through a logic of negotiated co-presence, whereby patients strategically mobilise religious resources to stabilise their therapeutic trajectories. This intermediate positioning strengthens the internal validity of the findings, grounded in the coherence between the empirical material, analytical categories and theoretical frameworks mobilised in the study.

The normative and performative dimension of religious capital also resonates critically with the analyses of Whyte (1997 : 102–125) and Fassin (2001 : 45–67), which demonstrate that incorporation into social and normative networks simultaneously produces social protection and moral constraints. The findings confirm this dual effect by highlighting that persistence with biomedical treatment does not arise from either strictly individual adherence or instrumental rationality, but from continuous negotiation between community support, symbolic obligations and therapeutic imperatives. However, whereas Whyte and Fassin primarily emphasise mechanisms of constraint and normalisation, this study highlights forms of active appropriation of religious capital through which patients transform these constraints into resources for moral endurance and social legitimation. This recognition of contextualised agency opens up a productive analytical debate while contributing to the explanatory capacity of the analysis.

Becker's work (1995 : 78–95) provides further insight by conceptualising therapeutic engagement as a performative practice embedded within multiple normative regimes. Consistent with this perspective, the findings show that each therapeutic decision constitutes a socially embedded act through which patients seek to preserve their moral, social and bodily integrity. However, the study moves beyond a focus on deviance or marginality by demonstrating that these normative adjustments are not confined to social margins but constitute an ordinary mode of illness management in contexts of therapeutic pluralism. This reasoned generalisation provides a basis for contextualised external validity, making the observed mechanisms potentially transferable to other settings characterised by the coexistence of heterogeneous normative frameworks.

Overall, the mobilisation of the concept of healthworlds proposed by Germond and Cochrane (2010 : 134–152) enables an epistemological synthesis of the findings. This approach closely aligns with the object of the study by demonstrating that religious capital should be understood as a world of meaning embedded in patients' social realities. Within this world, representations of illness, spiritual obligations and medical prescriptions are not separate but influence and articulate with one another in everyday life. Patients therefore navigate between multiple reference points in order to make sense of their experience of cancer and their care pathways.

The accounts collected cannot therefore be reduced to mere personal narratives. They also constitute means through which patients justify their choices, give coherence to their trajectories and mobilise their social and spiritual relationships to cope with illness. Discourse thus becomes both a social and symbolic resource, helping to illuminate how individuals adapt and endure throughout the experience of illness.

This perspective makes it possible to move beyond strictly biomedical approaches that tend to regard health behaviours as exclusively individual or rational. Instead, it demonstrates that the capacity to cope with illness is constructed through a network of social relationships, beliefs and shared values. Resilience in the face of cancer thus emerges as a collective process shaped by social surroundings, religious beliefs and interactions with the healthcare system.

Ultimately, the robustness of these findings rests on the coherence between the field data, the theoretical frameworks employed and the analysis of patients' narratives. Their scope may also extend to other contexts in which modern medicine coexists with a plurality of beliefs. Thus, patients' capacity to persist throughout their care pathways appears to result from a balance between religious resources and medical requirements, revealing the profoundly human, social and moral dimensions of the experience of illness.

CONCLUSION

The analysis of the care pathways of patients with prostate cancer shows that the management of the disease cannot be understood solely through the lens of medicine. Patients experience their illness within a context in which religious beliefs, spiritual practices and biomedical care are constantly intertwined. Religion therefore represents more than moral or emotional support; it becomes an important resource that helps patients make sense of their illness, cope with treatment and maintain personal equilibrium in the face of the upheavals caused by cancer.

The findings highlight the central role of religious and community networks in therapeutic trajectories. Through prayer, rituals, spiritual guidance and interactions with relatives or religious leaders, patients find reference points that help them cope with the uncertainty associated with illness. These practices contribute to strengthening hope, reducing anxiety and placing treatment within a broader framework in which healing is perceived not only as a medical process, but also as a human and spiritual ordeal.

The participants' accounts also show that patients continuously seek to reconcile several demands: following medical recommendations, remaining faithful to their religious convictions and responding to the expectations of those around them. Therapeutic decisions are therefore never made in isolation. They result from ongoing negotiations between biomedical prescriptions, religious obligations and community norms. This articulation between faith and medicine reveals a pragmatic way of managing illness, in which patients mobilise different resources to cope with their situation.

However, religion can play an ambivalent role in care pathways. On the one hand, it supports patients, strengthens their engagement with treatment and promotes therapeutic persistence. On the other hand, certain religious practices, such as periods of fasting, spiritual retreats or prolonged periods of prayer, may sometimes modify or delay certain forms of medical care. Patients must therefore find a balance between the requirements of medical follow-up and those of their spiritual practices.

Furthermore, recourse to spirituality emerges as a genuine strategy of resilience in the face of illness. Faith helps patients better cope with physical and psychological suffering, maintain hope and preserve continuity in their lives despite the transformations associated with cancer and its treatments. Illness is thus experienced not only as an impairment of the body, but also as a social, moral and spiritual experience that reshapes individuals' relationships with themselves, with others and with the future.

This study also shows that religious networks are not merely spaces of consolation. They constitute influential social frameworks that shape behaviours, strengthen bonds of solidarity and contribute to legitimising therapeutic practices. Care pathways are therefore constructed within relational environments where social support, religious beliefs and medical knowledge intersect.

Ultimately, taking the religious and spiritual dimensions into account when supporting patients may contribute to improving treatment adherence and the quality of care. A better understanding of patients' beliefs, religious practices and community realities would enable healthcare professionals to adapt their interventions more closely to patients' lived experiences.

Finally, this research opens up several important avenues for further investigation. Longitudinal studies would be useful for gaining a better understanding of how religious beliefs influence the evolution of therapeutic pathways over time. Combining qualitative and quantitative approaches would also make it possible to assess more precisely the impact of religious networks on treatment adherence and patients' psychological well-being. From a practical perspective, these findings highlight the value of a more integrated approach to care, based on dialogue between healthcare professionals, religious actors and communities, in order to develop therapeutic strategies that respect patients' beliefs while remaining responsive to their social and spiritual realities.

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