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Shame, Fear, and the Husband's Word: A Qualitative Health Belief Model Study of VIA Screening in a Banjar Regency Village

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ABSTRACT

Background: Cervical cancer is largely preventable, yet in Indonesia coverage rather than availability remains the constraint. Quantitative studies identify Health Belief Model constructs associated with screening, but the reasoning within reported barriers is less clearly described.**Objective:** To explore how women of reproductive age in a Banjar Regency village neighbourhood perceive visual inspection with acetic acid screening through the six Health Belief Model constructs.**Methods:** An exploratory qualitative descriptive study was conducted in August 2026. Six purposively selected women varied in prior visual inspection with acetic acid experience. Semi-structured interviews and field notes were analysed through construct-directed thematic analysis. Reporting followed COREQ, sample adequacy was considered through information power, and no inferential statistics were used.**Results:** Six married informants (median age, 37.0 years; range, 26-45; five unscreened) provided 10 quotations. Barriers were the only construct expressed by more than one informant: five women in five quotations. The barriers were shame at exposure, fear of the result, anticipated pain, unreadiness, and the husband's word. Each was raised by one informant. One woman described cervical cancer as dreadful, another considered herself healthy and therefore not at risk, and a previously screened woman described the procedure as painless.**Conclusion:** Barriers, rather than lack of information, dominated these accounts. Counselling should address each barrier before the woman must raise it and should preserve her decision-making. Whether perceived severity and susceptibility diverge within individuals remains a hypothesis that this study cannot test.*All authors have reviewed and approved the final version of the manuscript.***COPYRIGHT.** © 2026 The Author(s). Authors retain copyright and grant AMCR the non-exclusive right of first publication. Published by HM Publisher in collaboration with CMHC Research Center.**ACCESS LICENSE.** This article is distributed under the Creative Commons Attribution-NonCommercial-ShareAlike 4.0 International License (CC BY-NC-SA 4.0).

1. Introduction

Cervical cancer remains among the most common cancers in women worldwide and one of the most unequally distributed. The most recent global estimation rounds place it among the leading cancers in women, with incidence and mortality concentrated in countries of lower Human Development Index^{1,2}, and the projection of the global landscape to 2030 shows that gap widening rather than closing in the absence of effective intervention³. The baseline analysis prepared for the World Health Organization elimination initiative shows a rate gradient of roughly an order of magnitude between the highest- and lowest-burden countries⁴. The disease is not undetectable; it is undetected. Coverage of screening in low- and middle-income countries is a small fraction of that achieved in high-income settings and is patterned by socioeconomic position, and the existence of a national programme does not by itself predict its coverage⁵. Indonesia's own experience makes that point directly: after twelve years of a national cervical and breast cancer screening programme, coverage remained far below the national target⁶.

The aetiology is settled. Persistent infection with high-risk human papillomavirus is the necessary cause of essentially the entire cervical cancer burden⁷. What matters for screening policy is the natural history that follows. Progression from persistent infection through cervical intraepithelial neoplasia to invasive disease runs over years to decades, and it is clinically silent through precisely the phase in which it is most treatable. Secondary prevention therefore asks a woman to act on a risk that produces no sensation. Every construct in the Health Belief Model that concerns perceived threat is being asked, in this

disease, to operate without the bodily evidence people ordinarily use to populate it⁸.

Screening policy is moving toward primary human papillomavirus DNA testing, on the strength of its higher sensitivity and longer safe screening interval, and the operational conditions a transition requires are now well described^{9,10}. Indonesia is undertaking that transition while visual inspection with acetic acid (VIA) remains in service in many districts, and the interventions tried so far to raise VIA uptake have been catalogued¹¹. Qualitative studies of Indonesian stakeholders find the constraints on the programme to be coverage, accessibility, facility and workforce readiness and women's awareness, not the choice of test alone^{12,13}. Those studies document the supply side in detail. The demand side, in the language women themselves use, remains comparatively thin.

Indonesian evidence on the demand side is consistent and, by now, repetitive. A national scoping review reports embarrassment, absence of symptoms, limited knowledge, fear of the result and access problems as barriers, and spousal, family and peer support and proximity to services as facilitators¹⁴. A Southeast Asian systematic review reproduces that profile regionally, a regional synthesis organised by capability, opportunity and motivation reaches the same barrier set, and systematic reviews across low- and middle-income countries and across Africa reproduce it globally¹⁵⁻¹⁸. Quantitative and qualitative Indonesian work has established the associations — knowledge, attitude and partner support with VIA practice; Health Belief Model constructs with cytological screening intention in rural Indonesia; the factors associated with actually undergoing VIA among women of reproductive age; and the

beliefs, benefits and barriers reported by Indonesian Muslim and married women¹⁹⁻²³. Cultural framing and stigma have been reviewed for the same setting²⁴. The barrier list, in other words, is no longer a finding. What a barrier list cannot supply is the reasoning inside it: what a woman takes shame to be about, what she believes a result will do to her, and whose permission she understands herself to need.

The Health Belief Model is the natural frame for that question. It originates in Rosenstock's account of readiness to act as a function of perceived susceptibility and severity, modified by perceived benefits and barriers and triggered by a cue to action, with self-efficacy added in later formulations⁸. Applied to cervical screening, a systematic review and meta-analysis of a decade of studies finds perceived susceptibility, perceived benefits and self-efficacy positively associated with screening participation or intention and perceived barriers negatively so; a meta-analysis in a low- and middle-income setting and a third focused on women of reproductive age reproduce that pattern; and recent primary studies reproduce it again²⁵⁻²⁹. Self-efficacy in particular appears to act as a mediator rather than as an independent determinant^{30,31}. Two qualifications matter. The model has no vocabulary for the response in which a woman who does perceive a grave threat responds by not wanting to know, and both experimental and observational work show that people avoid screening information they expect to be unwelcome, with information avoidance associated with lower screening adherence^{32,33}. And the meta-analytic evidence on fear appeals is that they change behaviour only when they carry efficacy information alongside the threat³⁴. Both qualifications bear directly on what these interviews contain.

Two gaps follow. First, Indonesian qualitative work on VIA is typically sited in a health-facility catchment, where the women interviewed have already made some contact with the service, so the population that never arrives may be under-sampled^{35,36}. Second, the demand-side account that would complement the stakeholder evidence on the DNA-based transition has not been assembled at the level at which women actually decide — the neighbourhood¹³. The present study was conducted in RT 9, Desa Gudang Hirang, Kecamatan Sungai Tabuk, Kabupaten Banjar, South Kalimantan; a rukun tetangga is the smallest administrative unit of Indonesian residential life and the unit within which the cadre network of the integrated health post operates.

The aim of this study was to explore how women of reproductive age in RT 9, Desa Gudang Hirang perceive VIA screening, read through the six constructs of the Health Belief Model. What the study contributes is not a new barrier but a demonstration of how unevenly the constructs are populated when women speak for themselves, and two hypotheses that

follow from that unevenness. Readings of how the constructs relate to one another are reported in the Discussion as hypotheses, not as answers to a pre-specified question.

2. Methods

2.1. Design

This was an exploratory qualitative study using a qualitative descriptive design³⁷. Qualitative description was chosen because the research question concerns what women say and mean about an examination, and because it permits low-inference, data-near reporting that stays close to the informants' own words. The Health Belief Model supplied the analytic frame from the outset: the interview guide was constructed around the six constructs and the analysis was directed at them, while the material within each construct was allowed to take its own shape at the sub-theme level. The analysis is therefore described as construct-directed rather than inductive. Reflexive thematic analysis warns against treating themes as pre-existing entities waiting in the data, and a six-theme structure mapping onto six constructs is exactly the pattern that warning describes³⁸; the coded evidence is therefore published in full, in Table 3 and Table 4, so that a reader can judge the mapping rather than accept it. The study flow and analytic pipeline are shown in Figure 1.

2.2. Setting

Fieldwork was conducted in RT 9, Desa Gudang Hirang, Kecamatan Sungai Tabuk, Kabupaten Banjar, in August 2026. A rukun tetangga is the smallest administrative subdivision of an Indonesian village, typically comprising a few dozen households whose residents know one another. Care in this part of Indonesia is delivered through the puskesmas and its network of integrated health posts staffed by midwives and volunteer cadres, within the national health insurance framework³⁹. Interviews were conducted within the neighbourhood; the specific venue of each interview was not recorded.

2.3. Informants and sampling

Six women of reproductive age resident in RT 9 were selected by purposive sampling, on fit with the aim of the study together with variation on prior VIA experience. Five informants had never undergone VIA and one had. Informant characteristics are given in Table 1. Age, marital status and prior VIA experience were recorded; education, occupation, parity, income, distance to the nearest screening service and religion were not, and are not supplied here from what is usual in this setting. The route by which women were approached, the number approached and the number who declined were not recorded; the consequences for interpretation are set out in the Limitations.

Table 1. Characteristics of the six informants.

Code	Age (years)	Marital status	Prior VIA experience	Analytic role of the case
I1	34	Married	Never	Perceptions before any examination
I2	26	Married	Never	Perceptions before any examination
I3	40	Married	Never	Perceptions before any examination
I4	42	Married	Never	Perceptions before any examination
I5	30	Married	Never	Perceptions before any examination
I6	45	Married	Ever	Perceptions after direct experience
All (n = 6)	median 37.0	6/6 married	5 never · 1 ever	Variation on prior VIA experience

Ages: 34, 26, 40, 42, 30, 45 years; median 37.0, range 26–45 (width 19 years). Values are reported as counts out of six, with no percentages and no confidence intervals: a purposively selected sample of six has no superpopulation, and a proportion computed on it would not estimate anything. Age, marital status and prior VIA experience are the only informant characteristics recorded; education, occupation, parity, income, distance to the nearest screening service and religion were not recorded.

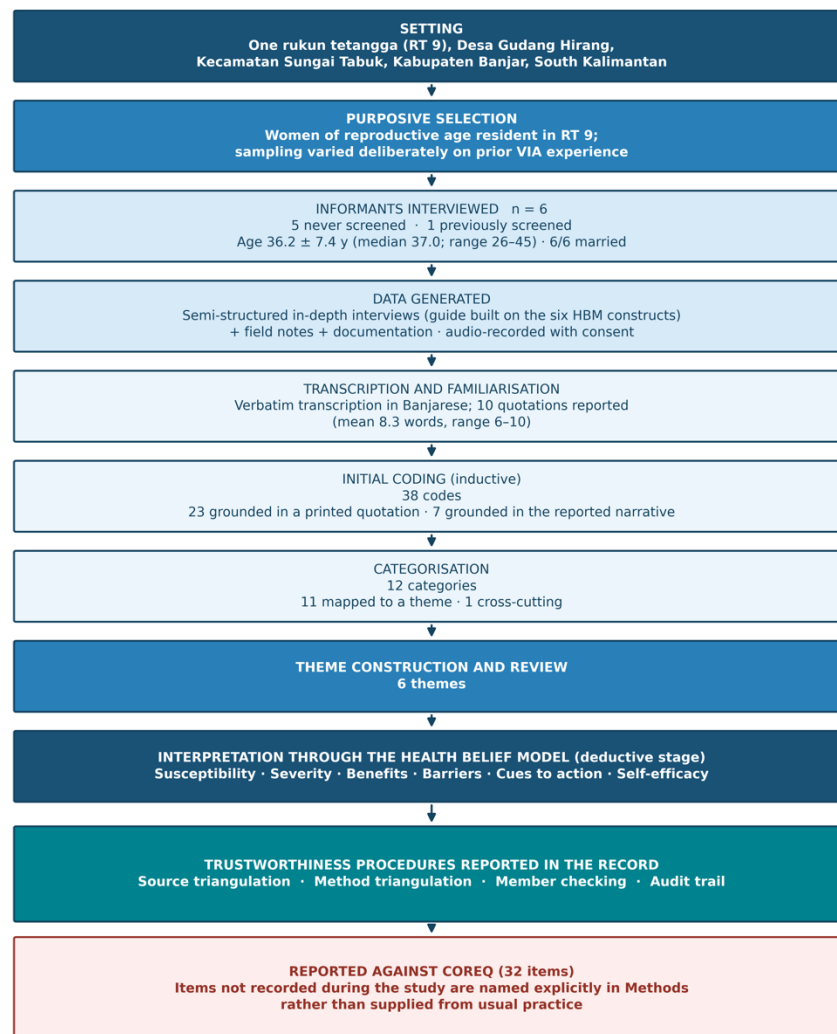


Figure 1. Study flow and analytic pipeline, from the micro-community sampled to the interpretation of six themes through the Health Belief Model, with the trustworthiness procedures used and the reporting standard against which the study is presented.

2.4. Information power in place of a sample-size calculation

No sample-size calculation is reported, because a purposive qualitative sample is not drawn in order to estimate a parameter and a formula applied to it would yield a number with no interpretation. Adequacy was instead assessed against Malterud's information-power model across its five dimensions⁴⁰, set out in Table 2. Two qualifications govern how that table should be read: the model is prospective, a tool for deciding when to stop recruiting, and it is applied here to a sample size fixed before the model was consulted; and the model supplies no scoring rule, so the table reports a dimension-by-

dimension assessment and no total. On that assessment, six informants carry sufficient information power for a descriptive account of how VIA screening is talked about in this micro-community, and insufficient information power for cross-case comparison, for statements about subgroups, for the three constructs that rest on the single previously screened informant, or for transfer to Indonesian women of reproductive age in general. Empirical work on saturation is consistent with that reading: most codes in a homogeneous group with a narrow aim appear within the first six to twelve interviews, while code saturation across published empirical tests typically requires nine to seventeen^{41,42}.

Table 2. Information power assessed across Malterud's five dimensions, in place of a sample-size calculation.

Dimension	Assessment for this study	Information power needed	Evidence and reasoning
Study aim	Narrow	Lower	How women in one RT perceive one screening modality, read through one specified theoretical frame. The aim is not to describe cervical screening behaviour in Indonesia, nor to compare subgroups.
Sample specificity	Dense for the pre-examination question; n = 1 for the post-examination question	Lower, then higher	All six informants are married women of reproductive age in the same RT, and sampling varied deliberately on prior VIA experience. But five of the six have never been screened, so for perceived benefits, cues to action and self-efficacy — the three constructs that carry most of the practice implications — the sample is sparse, not dense.
Use of established theory	Applied, and applied from the outset	Lower	The Health Belief Model is a mature theory with six defined constructs, and it structured the interview guide and directed the analysis. That supplies an analytic scaffold, and it is also why the analysis is described as construct-directed rather than inductive.
Quality of dialogue	Not recorded	Cannot be assessed	Interview duration was not recorded and the guide is not reproduced. The ten quotations average 8.3 words (range 6–10), but that reflects the selection of illustrative excerpts and cannot be read as evidence about the interviews.

Dimension	Assessment for this study	Information power needed	Evidence and reasoning
Analysis strategy	Cross-case	Higher	Six themes were constructed across all six informants rather than by in-depth analysis of one or two narratives, which is the strategy that demands more participants.

The model is prospective — a tool for deciding when to stop recruiting — and is applied here to a sample size fixed before the model was consulted; and it supplies no scoring rule, so no dimension is scored and no total is given. Read together, the five dimensions support a descriptive account of how VIA screening is talked about in this one micro-community, and do not support cross-case comparison, statements about subgroups, the three constructs that rest on the single previously screened informant, or transfer to women of reproductive age in Indonesia generally. Empirical work places code saturation in comparable interview studies at roughly nine to seventeen interviews.

2.5. Data generation

Data were generated through semi-structured in-depth interviews, supported by field notes and documentation. The interview guide was constructed around the six Health Belief Model constructs, with open questions so that informants could describe their experience and perceptions in their own language. The guide covered perceived risk of cervical cancer, the seriousness of the disease, the benefits of VIA, the obstacles to being examined, sources of prompting to act, social support and confidence in one's own ability to undergo the examination. Interviews were audio-recorded after the informant's agreement to recording had been obtained. The researcher was the primary instrument, with the interview guide, the recorder, an informant characteristics sheet and field notes as supporting instruments. Interview duration, the number of sessions per informant and whether the guide was piloted were not recorded.

2.6. Analysis

Transcripts were produced verbatim and analysed by thematic analysis following the sequence of familiarisation, initial coding, grouping of codes into categories, construction

and review of themes, and interpretation⁴³. The code book is given in Table 3, which sets out 38 codes in 12 categories mapped onto 6 themes and the six constructs; Table 4 traces every reported quotation to its codes, its construct and its theme, so that the path from ten quotations to six themes can be audited rather than taken on trust.

Codes are classified by what grounds them, because the distinction bears on what may be counted. A code is *quotation-grounded* when it derives from one of the ten verbatim quotations reported (23 codes); *narrative-grounded* when it derives from a descriptive statement about these informants (7 codes); and *prescriptive* when it derives from an interpretation or a recommendation rather than from something an informant said (8 codes). Prescriptive codes are printed for completeness and are excluded from every count reported as evidence, because a recommendation that becomes a datum will then appear to justify itself. No code derives from expectation, from the theory, or from what a woman in this setting might plausibly have said.

Table 3. Code book: 38 codes grouped into 12 categories and mapped onto 6 themes and the six Health Belief Model constructs.

Category	Category label	n	Initial codes	Q / N / P	HBM construct	Theme
Cat 1	Bodily self-assessment as evidence of risk	3	C01 Self-assessed bodily wellness taken as evidence of safety; C02 Absence of symptoms equated with absence of disease; C03 Risk judged from felt sensation rather than from exposure	2 Q / 1 N / 0 P	Perceived susceptibility	Theme 1: Feeling well, low risk
Cat 2	Dread and fear of cancer	3	C05 Cervical cancer named as dreadful (ngeri); C06 Fear as the dominant affect toward the disease; C07 Consequences of the disease perceived as grave	2 Q / 1 N / 0 P	Perceived severity	Theme 2: Cancer serious and frightening
Cat 3	Certainty as the benefit sought	2	C09 Examination yields certainty about one's own condition; C12 Learning that one is not ill as the desired result	2 Q / 0 N / 0 P	Perceived benefits	Theme 3: Certainty and relief
Cat 4	Emotional calm alongside the medical purpose	2	C10 Relief (lega) named as the benefit obtained; C11 Benefit framed as certainty and emotional calm in addition to, not instead of, a medical procedure	1 Q / 1 N / 0 P	Perceived benefits	Theme 3: Certainty and relief
Cat 5	Shame at bodily exposure	2	C13 Shame at bodily exposure (supan); C14 Exposure of the genital area to another person	2 Q / 0 N / 0 P	Perceived barriers	Theme 4: Barriers, and the partner's word
Cat 6	Fear of the result and deliberate avoidance	3	C15 Fear of an adverse result; C16 Deliberate preference for not knowing; C17 Anticipated brooding after an adverse result	3 Q / 0 N / 0 P	Perceived barriers	Theme 4: Barriers, and the partner's word
Cat 7	Anticipated pain and outright refusal	2	C18 Anticipated procedural pain; C19 Refusal voiced as plain unwillingness (indah)	2 Q / 0 N / 0 P	Perceived barriers	Theme 4: Barriers, and the partner's word
Cat 8	Fear and unreadiness under provider prompting	4	C20 Fear arising when directed to attend; C21 Psychological unreadiness despite repeated prompting; C22 Repeated prompting by the midwife; C26 Barriers extending beyond the procedure to psychological readiness	3 Q / 1 N / 0 P	Perceived barriers	Theme 4: Barriers, and the partner's word
Cat 9	The partner's word in the screening decision	3	C23 Husband's word functioning as permission; C24 Courage (wani) framed as the precondition for attending; C25 Screening decision referred to the partner	3 Q / 0 N / 0 P	Perceived barriers	Theme 4: Barriers, and the partner's word
Cat 10	Disconfirming bodily experience of the procedure	5	C27 Procedure shorter than anticipated (baya satumat); C28 Procedure painless, contrary to expectation; C29 Direct bodily experience disconfirming anticipated pain; C30 Lived experience more persuasive than second-hand information; C31 Potential for peer transmission of the disconfirming experience	2 Q / 1 N / 2 P	Cues to action	Theme 5: Positive experience as trigger
Cat 11	Reassuring communication and the conditions of willingness	6	C32 Conditional willingness contingent on credible reassurance; C33 Provider's explanation conferring a sense of safety; C34 Reassurance reducing anticipatory fear; C35 Readiness rising when the procedure is explained beforehand; C36 Assurance of privacy as a component of feeling safe; C37 Non-judgemental communication as a condition of willingness	1 Q / 2 N / 3 P	Self-efficacy	Theme 6: Communication and willingness
Cat 12	Cross-cutting appraisal dynamics	3	C38 High severity in one account alongside low susceptibility in another; C39 Benefits weighed against barriers before deciding; C40 Screening decision embedded in marital and social relations	0 Q / 0 N / 3 P	—	Cross-cutting

Codes are classified by what grounds them. **Q** = quotation-grounded, derived from one of the ten verbatim quotations (23 codes). **N** = narrative-grounded, derived from a descriptive statement about these informants (7 codes). **P** = prescriptive, derived from an interpretation or a recommendation rather than from something an informant said (8 codes); these are printed for completeness and are **excluded from every count reported as evidence**. Category 12 consists entirely of prescriptive codes, maps to no construct and contributes to no count. Counts of codes reflect the coding granularity applied and are not measurements of how salient a construct was to the informants. Theme titles are abbreviated in the final column; each theme is stated in full in the Results and in Table 7.

Table 4. Traceability of every reported quotation to its codes, its Health Belief Model construct and its theme.

ID	Informant	Verbatim quotation (Banjarese)	English gloss	Construct	Theme	Codes
Q1	I1	Aku nang takutan... amun bidan ni manyuruh ai tarus.	I am the one who is afraid... the midwife just keeps on telling me to go.	Barriers	Theme 4	C20, C21, C22
Q2	I1	Bujuran kada sakit kalo bu ayu ai amun kaitu.	If it really does not hurt, ma'am, then all right, in that case I will.	Self-efficacy	Theme 6	C32
Q3	I2	Aku ni sehat haja pang... kada ada nang sakit...	I am simply well... there is nothing that hurts...	Susceptibility	Theme 1	C01, C02

ID	Informant	Verbatim quotation (Banjarese)	English gloss	Construct	Theme	Codes
Q4	I2	Sakit lo di periksa ni indah aku.	Being examined hurts, does it not; I do not want to.	Barriers	Theme 4	C18, C19
Q5	I3	Amunnya sudah diperiksa kan lega kalo tahu... kada garing.	Once you have been examined you feel relieved to know... that you are not ill.	Benefits	Theme 3	C09, C10, C12
Q6	I3	Aku rasa supan amun dibuka urang...	I feel ashamed if someone uncovers me...	Barriers	Theme 4	C13, C14
Q7	I4	Ngeri kalo lah penyakitnya... kalo kanker kanker nih... takutan aku.	The disease is dreadful, is it not... cancer, this cancer... I am afraid.	Severity	Theme 2	C05, C06
Q8	I4	Amun sakalnya aku garing timbul bapikiran pulang baik kada tahu.	If it turns out that I am ill I would start brooding; better not to know.	Barriers	Theme 4	C15, C16, C17
Q9	I5	Ujar lakiku amun kada wani kada usah.	My husband said that if you are not brave enough, then do not bother.	Barriers	Theme 4	C23, C24, C25
Q10	I6	Uma baya satumat ha kada sakit jua...	Goodness, it was only a moment, and it did not hurt either...	Cues to action	Theme 5	C27, C28

All ten quotations appear here; none has been omitted, abridged or paraphrased. No back-translation was performed, and the Banjarese original is printed alongside every gloss so that a reader competent in Banjarese can check the reading directly; three glosses turn on readings the Banjarese leaves open and are flagged in section 2.9. Quotation length (Banjarese, words): mean 8.3, range 6–10, total 83.

2.7. Trustworthiness

Credibility, transferability, dependability and confirmability were addressed through source triangulation, method triangulation, member checking and documentation of the analytic process in an audit trail⁴⁴. Member checking takes several distinct forms with different epistemic value, and an unqualified statement that it was performed is uninformative⁴⁵; the form used in this study was not specified, and the claim should be read accordingly. Member checking covered the themes and the quotations; the English glosses and the interpretation offered in the Discussion were not returned to informants.

2.8. Reporting standard

The study is reported against the 32-item Consolidated Criteria for Reporting Qualitative Research (COREQ)⁴⁶,

completed as Table 5, which lists each of the thirty-two items and how it is answered here. Reporting quality in qualitative research improved measurably after that checklist appeared, and journals that endorse it still vary in how completely their papers answer it^{47,48}. STROBE is not used, because it is a reporting standard for observational studies with quantitative outcomes and none of its central items — sample size, effect measures, confounding, bias, statistical methods — has a referent in this design. Seventeen of the thirty-two items could not be answered and are marked as not reported rather than answered by inference; they concern the identity and training of the interviewer, the venue, duration and language of the interviews, the number of coders and the use of software, the assessment of informational redundancy, and the recruitment and non-participation figures. Their bearing on the findings is set out in the Limitations.

Table 5. COREQ 32-item checklist for this study.

No	Domain	Item	What the item requires, and how it is answered here	Status
1	Research team and reflexivity	Interviewer / facilitator	Which author conducted the interviews	Not reported
2	Research team and reflexivity	Credentials	Credentials of the interviewer	Not reported
3	Research team and reflexivity	Occupation	Occupation of the interviewer at the time of the study	Not reported
4	Research team and reflexivity	Gender	Gender of the interviewer	Not reported
5	Research team and reflexivity	Experience and training	Training of the interviewer in qualitative methods	Not reported
6	Research team and reflexivity	Relationship established	Whether a relationship existed before the study	Not reported
7	Research team and reflexivity	Participant knowledge of the interviewer	What informants were told about the interviewer	Not reported
8	Research team and reflexivity	Interviewer characteristics	Reported characteristics, assumptions and interests of the interviewer	Not reported
9	Study design	Methodological orientation and theory	Qualitative descriptive design; thematic analysis; Health Belief Model as analytic frame	Reported
10	Study design	Sampling	Purposive sampling with variation on prior VIA experience	Reported
11	Study design	Method of approach	How informants were approached and invited	Not reported
12	Study design	Sample size	Six informants; justified by information power (Table 2)	Reported
13	Study design	Non-participation	Number who refused or dropped out, and reasons	Not reported
14	Study design	Setting of data collection	Village and administrative unit named; the venue of each interview is not	Partial
15	Study design	Presence of non-participants	Whether anyone other than informant and interviewer was present	Not reported
16	Study design	Description of the sample	Age, marital status and prior VIA experience reported; education, occupation, parity, income and distance to services are not	Partial
17	Study design	Interview guide	Guide built on the six constructs; questions not reproduced and no pilot documented	Partial
18	Study design	Repeat interviews	Whether any informant was interviewed more than once	Not reported
19	Study design	Audio or visual recording	Audio recording used after obtaining the informant's agreement	Reported
20	Study design	Field notes	Field notes made and used as supporting data	Reported
21	Study design	Duration	Length of the interviews	Not reported
22	Study design	Data saturation	Whether informational redundancy was assessed and against what stopping rule	Not reported
23	Study design	Transcripts returned	Whether transcripts were returned to informants for comment	Not reported
24	Analysis and findings	Number of data coders	How many researchers coded, and whether independently	Not reported
25	Analysis and findings	Description of the coding tree	Code book of 38 codes in 12 categories, mapped to themes and constructs (Table 3)	Reported
26	Analysis and findings	Derivation of themes	Coding sequence stated; the analysis was construct-directed rather than fully inductive, with inductive latitude at sub-theme level	Partial
27	Analysis and findings	Software	Whether coding software was used, or coding was manual	Not reported
28	Analysis and findings	Participant checking	Member checking undertaken; the form it took is not specified	Partial
29	Analysis and findings	Quotations presented	Ten verbatim Banjarese quotations, each identified by informant code, with English glosses	Reported

No	Domain	Item	What the item requires, and how it is answered here	Status
30	Analysis and findings	Data and findings consistent	Every theme is grounded in a printed quotation or a stated descriptive finding	Reported
31	Analysis and findings	Clarity of major themes	Six themes presented and named	Reported
32	Analysis and findings	Clarity of minor themes	Sub-barriers within theme 4 are distinguished and traced to their quotations	Partial

Reported = the item is answered in this article. Partial = the item is answered incompletely, and the gap is stated. Not reported = the information was not recorded during the study and is not supplied here by inference. Totals: 9 reported, 6 partial, 17 not reported. The seventeen unanswered items concern the interviewer, the venue, duration and language of the interviews, repeat interviews, the return of transcripts, the number of coders and the use of software, the assessment of informational redundancy, and recruitment and non-participation. Their bearing on interpretation is set out in the Limitations.

2.9. Language and translation

The quotations are in Banjarese, the vernacular of Kabupaten Banjar. Whether the interviews were conducted wholly in Banjarese, wholly in Indonesian, or with code-switching between them was not recorded, and no back-translation was performed. The English glosses were produced in preparing this report, and every gloss is printed alongside the Banjarese original, in Table 4 and at every point in the Results, so that a reader competent in Banjarese can check the reading rather than take it on trust; how much of a clinical account is shaped by the language it is given in has been shown directly⁴⁹. Three glosses require explicit caution. In the quotation from I5, the Banjarese conditional carries no pronoun, so *if you are not brave enough* and *if I am not brave enough* are both available readings, and the two support quite different accounts of the husband's role. In the quotation from I2, *sakit* spans both pain and illness, and the reading taken here rests on which sense is intended. In the quotation from I1, *bu ayu* is read as a term of address, but *Ayu* is also a common Indonesian given name and the phrase may name a specific person. Each caution is repeated where the quotation is interpreted.

2.10. Reflexivity

The authors are midwifery academics at a university in Banjarmasin, within the same province as the study site. That position gives familiarity with the language, the cadre network and the service pathway, and it also carries a professional commitment to screening uptake that could incline an interviewer to hear reluctance as a deficit to be corrected rather than as a reasoned position, and could incline the same team toward construct assignments that make the model fit. The first author has previously conducted community programme evaluations using thematic analysis^{50,51}. Reflexive practice during data collection was not formally documented, so this is a statement of position rather than a report of a procedure.

2.11. Statistical analysis

No inferential statistic appears in this study: no p value, confidence interval, odds ratio, effect size or measure of diagnostic accuracy. A purposively selected sample of six women from one neighbourhood is not a draw from a superpopulation, so a proportion computed on it estimates nothing and an interval around it has no coverage interpretation; there is no outcome variable, no comparison group and no reference-standard test in the design; and no informant was measured twice on any scale. Counts are reported as counts, and as fractions where a share of the coded evidence is at issue. Because such shares depend on how finely each quotation was coded, and no coding-granularity rule was fixed in advance, they are reported with a sensitivity analysis across alternative coding rules (Table 6) rather than as single numbers, and no claim in this paper rests on them.

2.12. Ethical considerations

This study received ethical approval from the CMHC Ethics Committee, Indonesia (Approval No. 2026/322). Written

informed consent was obtained from all participants before data collection, including consent to audio recording, obtained before recording began, and consent to the publication of anonymised verbatim quotations. The study was conducted in accordance with the Declaration of Helsinki.

One matter is specific to this design. Informants are identified by a code, an age and a marital status, and also by whether they have ever been screened; one informant is the only woman in the sample who had undergone VIA. In a small *rukun tetangga* that combination carries a residual risk of recognition by a neighbour, a cadre or the local midwife. No names, addresses, household details or other direct identifiers are reported, and quotations are printed without any detail that would locate the speaker. One quotation reports the speech of an informant's husband, who is likewise not identified.

3. Results

3.1. Informants

Six women of reproductive age were interviewed. Their median age was 37.0 years (range 26 to 45 years, a width of 19 years; individual ages are listed in Table 1). All six were married. Five had never undergone VIA and one had been examined previously.

3.2. Structure of the evidence

Ten verbatim quotations are reported, distributed across the six informants as two each from I1, I2, I3 and I4 and one each from I5 and I6. Five of the ten concern perceived barriers, and those five come from five different informants. Each of the other five constructs is represented by a single quotation from a single informant: perceived susceptibility by I2, perceived severity by I4, perceived benefits by I3, cues to action by I6 and self-efficacy by I1. That asymmetry is the most consequential feature of the evidence base, because it means that only the barrier theme is supported by more than one woman. It is displayed cell by cell in Figure 2 and construct by construct in Figure 3, and the analytic sequence that produced both is summarised in Figure 1.

From those quotations and from the descriptive findings, 38 codes were constructed, of which 23 are quotation-grounded, 7 narrative-grounded and 8 prescriptive; the last group is excluded from every count below. The codes were grouped into 12 categories. The full code book is Table 3, and Table 4 traces every quotation to its codes, its construct and its theme. Among the 23 quotation-grounded codes, 13 fall under perceived barriers (13/23); against all 38 codes the barrier share is 14/38. These shares depend on coding granularity: barrier quotations carry 2.6 codes on average and the other quotations 2.0, so the barrier construct was coded about a third more finely than everything else. Across five defensible coding rules the share ranges from 36.8% to 56.5% and exceeds one half under three of them, as Table 6 sets out; no claim below rests on it. What does not depend on coding granularity is the distribution itself: five of ten quotations, from five of six informants.

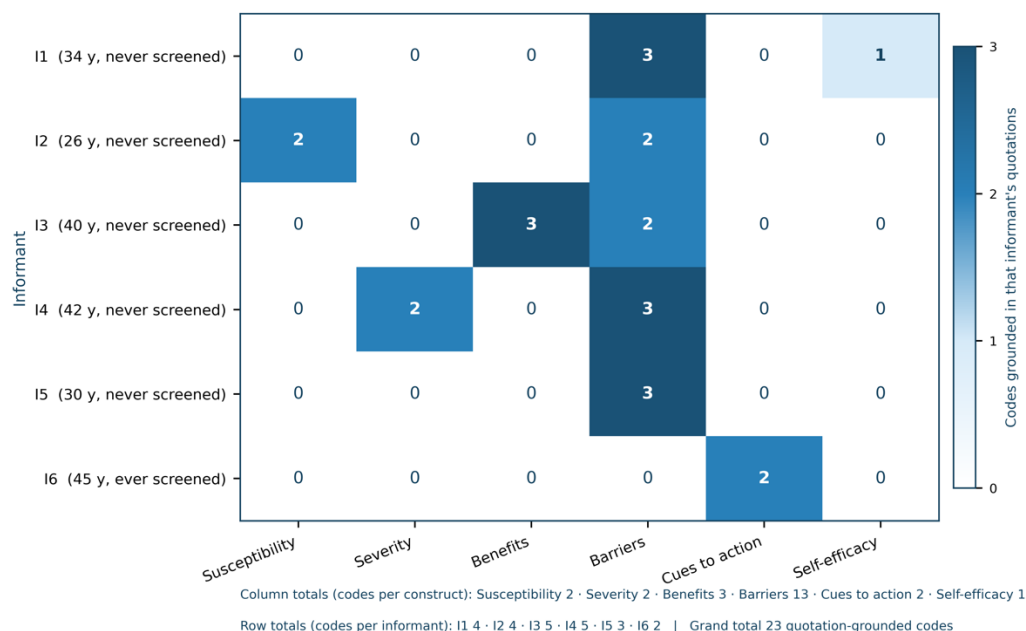


Figure 2. Quotation-grounded codes by informant and Health Belief Model construct. Each cell counts the codes derived from that informant's quotations for that construct; row and column totals are given beneath the matrix. Counts reflect the ten quotations reported and the coding granularity applied, and are not measurements of how salient each construct was to the informants. Perceived barriers is the only construct to which more than one informant contributed a quotation.

Table 6. Sensitivity of the barrier share to the coding rule.

Rule applied to the coded evidence	Barriers / total	Share	Exceeds one half?
As coded: quotation-grounded codes	13 / 23	56.5%	Yes
One code per quotation	5 / 10	50.0%	No
At most two codes per quotation	10 / 19	52.6%	Yes
C22 (repeated midwife prompting) reassigned to cues to action	12 / 23	52.2%	Yes
All codes, quotation- and narrative-grounded	14 / 38	36.8%	No

Codes per quotation were not governed by a rule fixed in advance: barrier quotations carry 2.6 codes on average and the other quotations 2.0, so the barrier construct was coded about a third more finely than everything else. Across 5 defensible rules the share ranges from 36.8% to 56.5%, and it exceeds one half under 3 of them. **No conclusion in this article rests on the share.** What does not depend on coding granularity is the distribution itself: five of the ten quotations concern barriers, and barriers are the only construct to which more than one informant contributed a quotation.

3.3. Theme 1: feeling well produces a low perception of risk

One informant grounded her judgement of her own risk in the state of her body as she experienced it, treating the absence of any complaint as evidence of being unaffected. I2, aged 26, said:

"Aku ni sehat haja pang... kada ada nang sakit..." [I am simply well... there is nothing that hurts...]

The reading taken here — that risk is inferred from felt sensation — depends on *sakit* carrying the sense of pain rather than of illness. Two features of this account bound it. It is the only utterance in the study that speaks to perceived susceptibility, and its speaker is 26 years old and therefore below the age at which the programme offers screening, so her judgement that examination is not yet for her is in part a correct reading of her eligibility.

3.4. Theme 2: cervical cancer is perceived as serious and frightening

The disease itself was described as grave, and the register in which it was spoken of was fear rather than calculation. I4, aged 42, said:

"Ngeri kalo lah penyakitnya... kalo kanker kanker nih... takutan aku." [The disease is dreadful, is it not... cancer, this cancer... I am afraid.]

The consequences of the disease were described as severe, and no benefit of examination was named alongside that description.

3.5. Theme 3: VIA is perceived to give certainty and relief

Where benefit was described, it was described in emotional terms. What the examination was expected to yield was certainty about one's own condition and the relief that follows from it. I3 said:

"Amunnya sudah diperiksa kan lega kalo tahu... kada garing." [Once you have been examined you feel relieved to know... that you are not ill.]

The construction is additive: the examination is understood *not only* as a medical procedure *but also* as a route to certainty and emotional calm. It is not an account in which the emotional meaning displaces the clinical one.

3.6. Theme 4: shame, fear of the result, anticipated pain and unreadiness; and the partner's word

Perceived barriers is the only construct to which more than one informant contributed, and it contains five distinguishable strands — although each strand comes from one informant alone. The first was shame at bodily exposure. I3 said:

"Aku rasa supan amun dibuka urang..." [I feel ashamed if someone uncovers me...]

The second was fear of what the examination might reveal, expressed as a preference for not knowing. I4 — the same informant who described the disease as dreadful — said:

"Amun sakalnya aku garing timbul bapikiran pulang baik kada tahu." [If it turns out that I am ill I would start brooding; better not to know.]

The third was anticipated pain, voiced as plain unwillingness. I2 said:

"Sakit lo di periksa ni indah aku." [Being examined hurts, does it not; I do not want to.]

The fourth was fear together with psychological unreadiness in the face of repeated prompting. I1 said:

"Aku nang takutan... amun bidan ni manyuruh ai tarus." [I am the one who is afraid... the midwife just keeps on telling me to go.]

The fifth was the husband's word. I5 said:

"Ujar lakiku amun kada wani kada usah." [My husband said that if you are not brave enough, then do not bother.]

Across these accounts the obstacle described was not the availability of the service. It was exposure, the anticipated result, the anticipated sensation, the woman's own sense of not being ready, and the position taken by her husband.

3.7. Theme 5: a positive examination experience becomes a trigger of acceptance

The single informant who had undergone VIA described the procedure in terms that contradicted what the others anticipated. I6, aged 45, said:

"Uma baya satumat ha kada sakit jua..." [Goodness, it was only a moment, and it did not hurt either...]

Two features were named: that it was brief, and that it did not hurt. Both are the specific expectations that other informants gave as reasons for not attending. The theme is named for the acceptance such an experience may trigger, but nothing in these data shows that this account reached, or moved, any other informant; it is a disconfirming experience reported by the woman who had it.

3.8. Theme 6: communication that confers a sense of safety supports willingness

Willingness to undergo the examination was described as conditional, and the condition was credible reassurance from

the health worker. I1, who had earlier described being afraid, said:

"Bujuran kada sakit kalo bu ayu ai amun kaitu." [If it really does not hurt, ma'am, then all right, in that case I will.]

Willingness was thus contingent rather than absent, and the contingency was on the explanation given before the procedure. Whether this is best read as self-efficacy — confidence in one's capability — or as the removal of an anticipated barrier is taken up in the Discussion; the utterance itself will support either. Read strictly, therefore, four of the six constructs — susceptibility, severity, benefits and barriers — carry unambiguous quotation-grounded evidence in this study, and two do not.

3.9. What no informant said

Two absences bound what can be concluded. In the quotations reported, no informant described herself as at risk of cervical cancer; and no informant expressed both a judgement about the gravity of the disease and a judgement about her own susceptibility to it. Those two judgements come from I4 and I2 respectively, and no utterance in this study has one woman making both.

3.10. The relation between the themes

Read across the sample, the accounts stand in a relation that invites an interpretation. Cervical cancer was described as dreadful by one woman; another judged herself unaffected because nothing hurt. Figure 3 displays that pattern together with the evidential base of each construct, and Figure 4 places it within the structure of the Health Belief Model — in both cases recording which informant supplied which component rather than asserting a joint appraisal. What can be said with confidence is narrower than the pattern suggests: the benefit described in theme 3 and the barriers described in theme 4 are the terms in which these women discussed the decision, and the barriers are the only terms more than one of them used. Themes 5 and 6 identify two points at which the comparison might shift — direct experience that the procedure is brief and painless, and communication that makes a woman feel safe — each on the evidence of a single account.

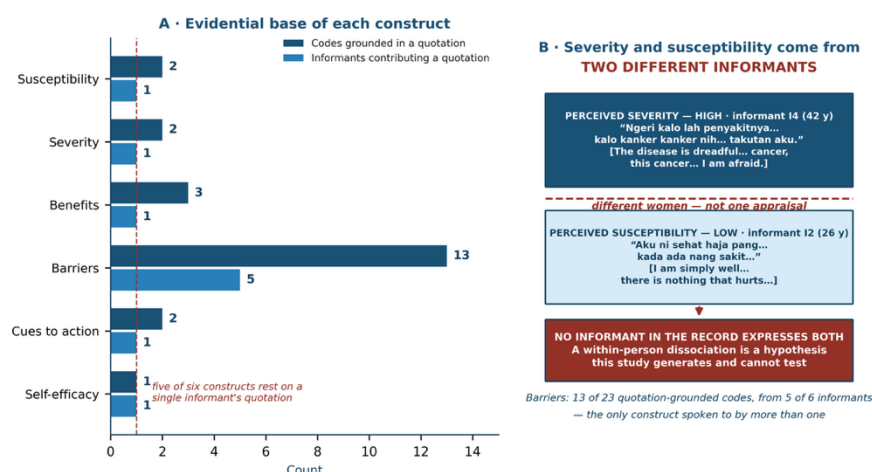


Figure 3. The evidential base of the study. Panel A gives, for each construct, the number of codes grounded in a quotation and the number of informants who contributed one; five of the six constructs rest on a single informant's quotation. Panel B shows that high perceived severity and low perceived susceptibility come from two different informants, I4 and I2, and that neither expresses both — so a within-person dissociation is a hypothesis this study generates and cannot test.

4. Discussion

4.1. Principal findings

Among six women of reproductive age in RT 9, Desa Gudang Hirang, what was said about VIA screening was overwhelmingly about barriers. Five of the ten quotations concern them, from five of the six informants, while every other Health Belief Model construct is represented by one woman's words. The barriers named were shame at bodily exposure, fear of what the result would show, anticipated pain, the woman's own sense of not being ready, and her husband's word. Alongside them, one informant described the disease as dreadful, another judged herself well and therefore unaffected, a third described the benefit of the examination as certainty and relief, a fourth reported that the procedure had been brief and painless, and a fifth made her willingness conditional on being reassured. None described herself as at risk.

4.2. The barrier profile is confirmatory; the asymmetry of the evidence is what is worth reporting

Each of the five strands found here is already documented. Embarrassment, absence of symptoms, limited knowledge, fear

of the result and access difficulty are the standard Indonesian set, reproduced in the national scoping review, in the Southeast Asian systematic review and in the systematic review across low- and middle-income countries^{14,15,17}. Fear of the procedure and of the result, with husband and health worker as facilitators, is the profile reported from a Puskesmas Cinere catchment³⁵, and fear of the result is reported again from the Riau Islands²². This study adds no new barrier to that list. What it adds is a picture of how unevenly a small qualitative account can be distributed: one construct spoken to by five women, five constructs by one each. That is worth reporting because it is the kind of fact a thematic write-up conceals — six themes presented in parallel look like six comparably supported findings — and because it is exactly what determines which conclusions can bear weight. Figure 2 shows the same asymmetry cell by cell, and Table 7 sets each theme against the published evidence and states whether it is confirmatory, extending, or a hypothesis.

Table 7. Each theme set against the published evidence, with an explicit judgement of what is confirmatory and what is new.

Theme	What this study found	What the literature reports	Judgement
1. Feeling well produces a low perception of risk	Informants judge their risk from felt bodily health; absence of symptoms is read as absence of disease, and screening is therefore not urgent.	Absence of symptoms is a recurrent barrier in the Indonesian scoping review, the Southeast Asian systematic review and the LMIC systematic review; the Indonesian qualitative study at Puskesmas Cinere reports the same reasoning (section 4.2).	Consistent. Grounded in one quotation from one informant (I2), who is below the age at which screening is offered.
2. Cervical cancer is perceived as serious and frightening	Cancer is named as dreadful and the dominant affect is fear.	The pooled Health Belief Model analyses report perceived severity as generally high in screening populations and generally the weakest of the constructs as a predictor of behaviour (section 1).	Consistent. Grounded in one quotation from one informant (I4). What follows from pairing it with theme 1 is treated as a hypothesis, not a finding (section 4.3).
3. VIA gives certainty and relief	Benefit is described as certainty about one's condition and relief (<i>lega</i>) in addition to the examination's medical purpose; the construction is additive (<i>tidak hanya... tetapi juga</i>).	Meta-analyses find perceived benefits positively associated with screening participation, but measure benefit with items about disease prevention rather than about emotional resolution (section 4.5).	Extends the literature, at the level of a hypothesis. The benefit named is not the benefit the instruments measure. Grounded in one quotation from one informant (I3).
4. Shame, fear of the result, fear of pain and unreadiness; and the partner's word	Barriers are the only construct to which more than one informant contributed a quotation: five of the ten quotations concern barriers, from five of the six informants. Each individual sub-barrier, however, comes from one informant only.	Embarrassment, fear of result, fear of pain, low knowledge and absent spousal support are the standard barrier set in the Indonesian, Southeast Asian and LMIC reviews; the Denpasar study finds partner support associated with VIA practice (sections 4.2 and 4.6).	Consistent in content. The barrier list is not new. What is worth reporting is the asymmetry of the evidential base: barriers are spoken to by five informants and every other construct by one.
5. A positive examination experience becomes a trigger of acceptance	The one previously screened informant reports that the procedure was brief and did not hurt, which disconfirms the anticipated pain that two other informants gave as a reason not to attend.	Cues to action are the least studied construct in the screening literature and are usually operationalised as provider reminders or campaigns rather than as bodily experience.	Suggestive, not established. Whether this functions as a cue to action or as the removal of a perceived barrier cannot be settled from one retrospective account, and nothing here shows it prompted anyone. Both readings are reported.
6. Communication that confers a sense of safety supports willingness	Willingness is conditional on credible reassurance from the midwife.	Self-efficacy is positively associated with screening in the pooled analyses; the Indonesian qualitative literature identifies health-worker support as a facilitator.	Consistent, with a caveat about the construct. The grounding quotation states conditional willingness once pain is ruled out, which is arguably the removal of a barrier rather than a judgement of capability; self-efficacy in the strict sense has no unambiguous quotation-grounded evidence here.
Cross-cutting: severity and susceptibility	High perceived severity is expressed by I4 and low perceived susceptibility by I2. These are two different women, and neither expresses both.	Both appraisals are documented separately in the Indonesian and regional literature. A within-person dissociation between them is not established anywhere, including here.	A hypothesis this study generates and cannot test (section 4.3).

The judgements in the final column are the authors' own and are stated so that a reader can disagree with them specifically. Four themes are confirmatory. One extends the literature at the level of a hypothesis about what benefit means to the woman. Two — the cue-to-action reading and the self-efficacy reading — are reported with the alternative interpretation printed beside them. The severity-susceptibility pattern is a hypothesis, not a finding. The comparator literature in the third column is cited at the sections named.

4.3. Severity and susceptibility: a hypothesis, not a finding

It is tempting to read these accounts as showing a dissociation: a woman who thinks the disease grave and herself safe, so that the two components of perceived threat never combine and the decision falls to barriers. That reading does not hold on this evidence. In the Health Belief Model, and in the Champion and Skinner formulation used here⁸, perceived threat is a within-person quantity, so a dissociation between its components is a statement about one person's appraisal. The evidence available is a severity utterance from I4 and a

susceptibility utterance from I2 — two different women — and no informant supplies both. To infer a within-person configuration from a between-person distribution is an ecological inference, and the pattern observed is equally compatible with a sample in which threat appraisal operates perfectly within every individual. The dissociation is therefore reported as a hypothesis that this study generates and cannot test; the question it poses — whether Indonesian women who judge cervical cancer grave nonetheless judge themselves unaffected — is answerable, and the design that would answer it is described below.

Two things do survive, and they are worth separating from the hypothesis. The first is an absence: no informant described herself as at risk, which is consistent with the pooled finding that low perceived susceptibility accompanies non-participation^{25,26}. The second is a theoretical point that does not depend on any single woman. In a disease whose treatable phase is silent, the susceptibility construct is being asked to operate without the bodily evidence people ordinarily use to populate it. Across the pooled and the recent primary literature, perceived benefits and perceived barriers are the constructs that carry most of the predictive weight, while perceived susceptibility and perceived severity carry less^{27,28,29}; a screening behaviour for a condition that is silent while it is treatable is a plausible place for that weakness to be at its worst.

4.4. Information avoidance: what the model has no vocabulary for

One informant supplies two utterances, and together they form a configuration the Health Belief Model cannot easily describe. This is a single case, and what follows is offered on that basis. I4 called the disease dreadful, and I4 said that if it turned out she was ill she would start brooding, so it was better not to know. That is not perceived threat failing to assemble. It is a grave threat producing avoidance of the information rather than action on it, and that response has an empirical literature of its own: in a field experiment people actively avoided medical screening information they expected to be unwelcome, and in a screening population cancer information avoidance is associated with lower adherence^{32,33}. The distinction is not academic. The implicit recommendation of a threat-based reading, when susceptibility is low, is to raise it; the recommendation that follows from an avoidance reading, when threat is already high, is to raise efficacy instead — and the meta-analytic evidence on fear appeals is that they change behaviour only when they carry self-efficacy and response-efficacy information alongside the threat, and otherwise provoke defensive responses³⁴. One informant's words cannot decide between the two readings. They are reported because a study framed entirely within one model will not otherwise notice that its single richest case argues for another.

4.5. What the benefit was said to be

Perceived benefit in the pooled literature is operationalised through items about preventing disease or detecting it early^{23,25}. The benefit named here was *lega* — relief — and certainty about one's own condition, offered as something the examination provides as well as its medical purpose, not instead of it. The distinction is worth pursuing. A woman who values an examination for the resolution of a present unease has a reason to avoid it that a woman who values it for future risk reduction does not: an examination that might return bad news cannot deliver relief, it can only put it at risk. On that reading, the benefit and one of the barriers are not independent terms on either side of a balance but two aspects of the same anticipated emotional outcome — which would explain why an intervention that raises perceived benefit without addressing fear of the result might move nothing. The two utterances that suggest this come from two informants, I3 and I4, so it is offered as a hypothesis and not as a finding; it is also the reading in this study least anticipated by the instruments the literature uses, and the one this study most invites others to test.

4.6. The partner's word

One informant reported that her husband had told her that if she was not brave enough, there was no need. The Denpasar

study found partner support associated with VIA practice¹⁹, and both the Indonesian scoping review and the Southeast Asian systematic review place spousal support among the facilitators^{14,15}. Read against that literature, this utterance does something narrower than encourage or discourage: it *permits*, and the permission is framed in terms of the woman's own courage. An Indonesian study found that husband support mediates the association between self-efficacy and screening, which places the husband inside the efficacy pathway rather than beside it^{52,53}. One caution attaches to the reading: the Banjarese conditional carries no pronoun, so the sentence may equally report the husband's acceptance of his wife's own hesitation rather than an instruction to her. What can be said is that a programme treating partner support purely as an attitude to be improved by information may not reach a decision structure in which permission is the operative category. The recommendation that follows — engage the partner while reinstating the woman as the decision-maker over her own body — rests on the wider literature and not on this single sentence.

4.7. Cues to action and self-efficacy: two contested assignments

Two of the six construct assignments are less secure than a six-theme presentation implies, and both are reported with the alternative reading beside them, as Table 7 records, rather than defended. The account of a brief and painless examination is assigned to cues to action. A cue to action is a trigger that precipitates behaviour; this is a retrospective description by a woman who had already been screened, and nothing here shows it prompted anyone. It may equally be the disconfirmation of an anticipated barrier. The account of conditional willingness is assigned to self-efficacy, but on its own gloss it says that if the pain is absent she will go — which is a statement about a barrier being removed rather than about capability, and the code derived from it is labelled conditional willingness for that reason. Read strictly, self-efficacy has no unambiguous quotation-grounded evidence in this study. A third assignment is contestable in the other direction: repeated prompting by a midwife, which appears here inside the barrier theme, is the textbook operationalisation of a cue to action in the screening literature, and a provider's recommendation is among the strongest measured determinants of screening uptake^{25,54}; reassigning it would give cues to action a second informant and lower the barrier share further, as Table 6 shows. Figure 4 places each theme on the model, and Figure 5 sets out the counselling sequence they imply.

4.8. Implications for practice in Indonesia

The implications are set out construct by construct, with the actor and setting named, in Table 8, which also grades the evidence behind each one; they are proposals derived from six interviews rather than evidence of effectiveness. Three deserve emphasis. First, information alone is unlikely to be sufficient: what these women described was not an absence of information about cancer but exposure, dread of a result, pain, unreadiness and permission, and a scoping review of demand-side interventions reaches the same conclusion about education delivered without action on structural and social barriers^{11,55}. Counselling should open on personal risk rather than disease knowledge, and state that precancer is silent and that screening happens before symptoms — while continuing to teach symptom awareness, which is what brings a symptomatic woman to care and must not be displaced. Second, each barrier should be raised by the midwife before the woman has to raise

it: privacy and draping, what the speculum will feel like and for how long, what happens if the result is positive, and that she may stop at any point. This is the recommendation with the widest evidential base here, since five of the six informants spoke to a barrier, and the one most consistent with the international literature^{56,57}. Third, where a woman's stated benefit is certainty, the offer should say what a negative result means and

also what it does not: VIA does not exclude disease, its sensitivity is moderate and operator-dependent, and the interval to the next screen and the instruction to return if symptoms appear belong in the same conversation⁹. Community reproductive-health education delivered through the cadre network is an established channel in this province for conversations of that kind⁵¹.

Table 8. Construct-specific implications for midwifery and primary-care practice in Indonesia, with the evidence behind each.

Construct	Finding in this study	Recommended action	Who acts, and where	Evidence grade, and what it does not establish
Perceived susceptibility	One informant judged her risk from felt bodily health.	Open the counselling conversation on personal risk rather than on knowledge of the disease, and state that precancer is silent and that screening is done before symptoms appear. This is guidance about screening communication and does not displace symptom-awareness education: post-coital or intermenstrual bleeding and offensive discharge must still be taught, because they are what brings a symptomatic woman to care.	Midwife or cadre, at the posyandu or during a home visit	One informant; supported by the wider literature. A screening message built only on symptom awareness reinforces the reasoning that keeps an asymptomatic woman away; a message that omits symptoms altogether would delay presentation of invasive disease. Both messages are needed and they are different messages.
Perceived severity	Fear of cancer was the dominant register in which one informant spoke of the disease, and the same informant preferred not to know a result.	Do not escalate. Move the conversation from how grave cancer is to how treatable a screen-detected lesion is, and pair any statement of threat with a statement of what the woman can do about it.	Midwife, Puskesmas health promotion staff	Wider literature; one informant is consistent with it. Fear appeals raise protective behaviour only when accompanied by high-efficacy messages; without them they raise defensive avoidance. That evidence, not this study's single case, is what supports the recommendation.
Perceived benefits	One informant described the benefit as certainty and relief (<i>lega</i>), alongside the examination's medical purpose.	Use the woman's own frame: say what a negative result will mean, and what it does not mean — a negative VIA does not exclude disease, its sensitivity is moderate and operator-dependent, and it falls with age as the squamocolumnar junction recedes — and state when she would next be screened and that she should present if symptoms occur.	Midwife at the point of offer	One informant; the limits of the test are established. Aligning the offer with the value the woman already holds is unlikely to help if it produces over-reassurance, so the limits of the test have to travel with the reassurance.
Perceived barriers	Shame at exposure, fear of the result, anticipated pain, unreadiness, and the husband's word — one informant each.	Raise each barrier before she has to: privacy and draping, what the speculum will feel like and for how long, what happens if the result is positive, and that she may stop at any point.	Midwife, before the examination begins	Five of six informants; consistent with the LMIC literature. This is the recommendation with the widest evidential base in the study.
Cues to action	One previously screened informant described the procedure as brief and painless.	Consider recruiting previously screened women as peer voices, with explicit consent and without disclosure of any result — and only where enough women have been screened that no individual is identifiable by her participation.	Cadre network, coordinated by the Puskesmas	One informant; a hypothesis to evaluate, not an established intervention. In a neighbourhood where only one woman has been screened, this cannot be implemented without identifying her.
Self-efficacy	One informant's willingness was conditional on credible reassurance that the procedure would not hurt.	Explain the steps before starting, invite questions, confirm privacy, keep a non-judgemental manner, and state that she may ask to stop.	Midwife at the point of care	One informant; the action is the same under either reading. Whether this is self-efficacy or the removal of a perceived barrier is unsettled, but it is a property of the encounter rather than of the woman.
System level	Availability of the service was not what the informants described as the obstacle.	Plan the transition to HPV-based screening with the demand-side barriers in view. Where exposure is the binding barrier, self-collected sampling removes the speculum examination at the screening step ; a positive self-sample still requires triage and treatment involving a pelvic examination, so exposure is deferred rather than eliminated.	Puskesmas management, district health office	Wider literature; not tested here. The participation gains reported for self-sampling come largely from organised programmes with population registries and mail-to-all invitation, neither of which exists in a rural Indonesian neighbourhood.

These are proposals for practice derived from six interviews, not evidence of effectiveness; none has been evaluated here. The final column states, for each row, whether it rests on this study, on the wider literature, or on both. This table is a communication aid, not a clinical algorithm. It does not cover screening eligibility, what a positive VIA result requires, eligibility for ablative treatment, or the rule that suspected invasive cancer is referred and not ablated; those belong to the national clinical guidance and are outside the scope of a study of perceptions. Note also that the informant whose account grounds the susceptibility theme is 26 years old and below the age at which screening is offered in the programme, which is relevant to how her judgement should be read.

4.9. Implications for the Indonesian screening system

These findings sit inside a system in transition. The national cancer plan and the movement toward DNA-based screening set the direction, and the stakeholder studies of that transition identify coverage, accessibility, facility readiness and awareness as the constraints^{12,13}. Screening is delivered in primary care within the national health insurance framework, whose gatekeeping structure makes the Puskesmas and its midwives the point at which the offer is or is not made^{6,39}. Two consequences follow. Where shame at bodily exposure is the binding barrier — and it was the most vividly expressed barrier here — self-collected sampling removes the speculum examination at the screening step, and the meta-analysis of self-sampling offers shows increased participation relative to

standard invitation, with women citing privacy and avoidance of a pelvic examination as their reasons^{58,59}. That gain should not be over-read here: a positive self-sample still requires triage and treatment involving a pelvic examination, so exposure is deferred rather than eliminated, and the reported gains come largely from organised programmes with population registries and mail-to-all invitation, neither of which exists in a rural Indonesian neighbourhood^{60,61}. Where fear of the result is the binding barrier, self-collection changes nothing at all, and the counselling and the treatment pathway must carry the weight^{9,62}. A demand-side account that distinguishes the two barriers is therefore not a supplement to the transition plan but a condition of designing it. Figure 5 sets out the communication sequence that follows, and Table 8 names the actor for each step.

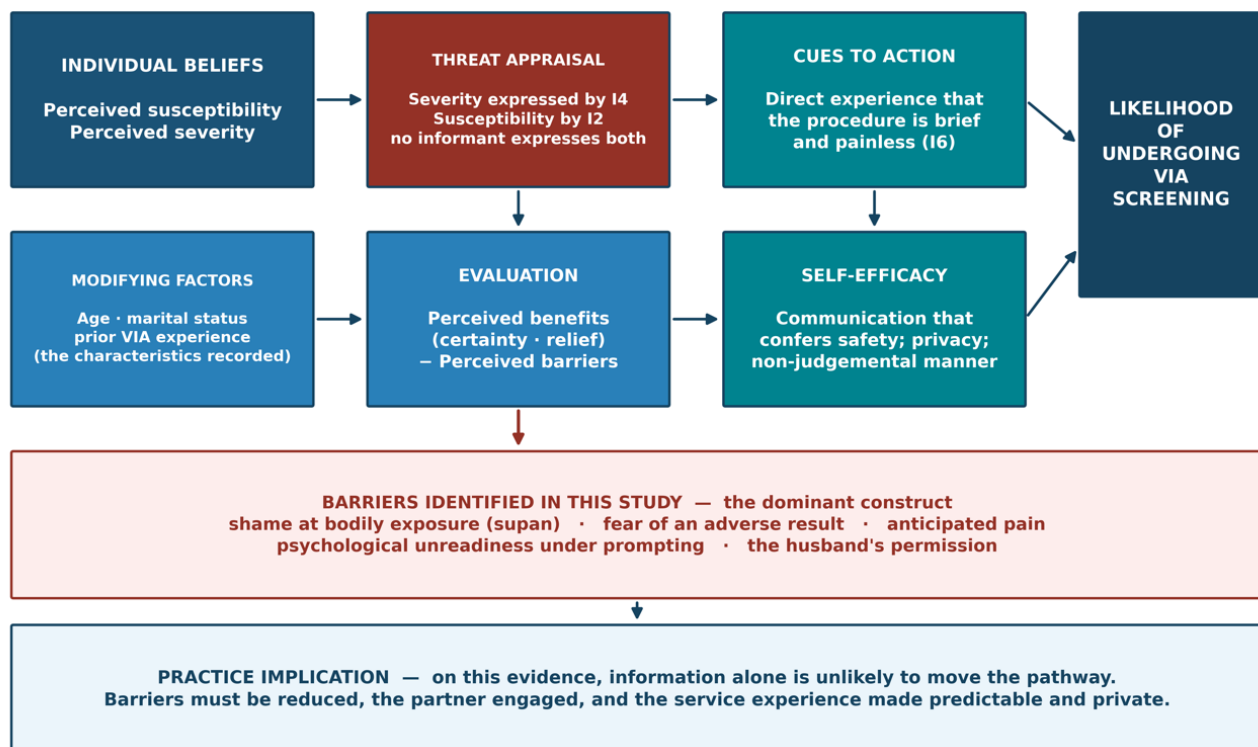


Figure 4. The Health Belief Model pathway annotated with the themes of this study. Constructs follow Rosenstock and the six-construct formulation of Champion and Skinner; the annotations are this study's findings, and each rests on one or two informants. The threat-appraisal panel records which informant expressed which component rather than asserting a joint appraisal.

4.10. Strengths

The study has three strengths, and one of them must be qualified. It samples at the level of the neighbourhood rather than the clinic list, which is the right place to look for women who have never presented — although it cannot claim to have reached them, because the recruitment route was not recorded and one informant describes herself as under repeated prompting from a midwife, which places her in contact with the service. It preserves the informants' own language and prints the Banjarese alongside every English gloss, so that the interpretation can be checked rather than trusted. And it publishes the coded evidence in full — a code book, a quotation-level traceability table and a density matrix — with a sensitivity analysis for the one proportion it computes, so that a reader can see which conclusions depend on analytic choices and which do not⁴⁶. Figure 4 places the study's own findings on the model rather than reproducing a generic diagram of it.

4.11. Limitations

Six limitations bear on how these findings should be used. First, the evidential base is thin and unevenly distributed: five of the six constructs rest on a single informant's quotation, so the characterisation of susceptibility, severity, benefits, cues to action and self-efficacy each rests on one woman's words, and only the barrier theme is supported across informants — and

even there, each individual barrier comes from one woman. The whole primary evidence base is 10 quotations, totalling 83 words of verbatim material. Second, six informants in one rukun tetangga support a descriptive account of that neighbourhood and do not support cross-case comparison, subgroup statements or transfer to Indonesian women in general; code saturation in published empirical tests typically requires nine to seventeen interviews, and no saturation assessment was made here^{41,42} (Table 2). Third, the shares of coded evidence depend on a coding granularity that was not fixed in advance and move between 36.8% and 56.5% across defensible rules (Table 6); they are reported for completeness and carry no conclusion. Fourth, seventeen COREQ items could not be answered (Table 5), including the identity and training of the interviewer, the venue and duration of the interviews, the number of coders, and how many women were approached and declined; non-participation is the most consequential of these, because the women least willing to discuss screening are the women such a study most needs to hear. Fifth, the quotations are short, averaging 8.3 words, which reflects the selection of illustrative excerpts and cannot be read as evidence about the depth of the interviews in either direction. Sixth, no back-translation was performed; three glosses turn on readings the Banjarese leaves open, and one may contain a proper name (section 2.9).

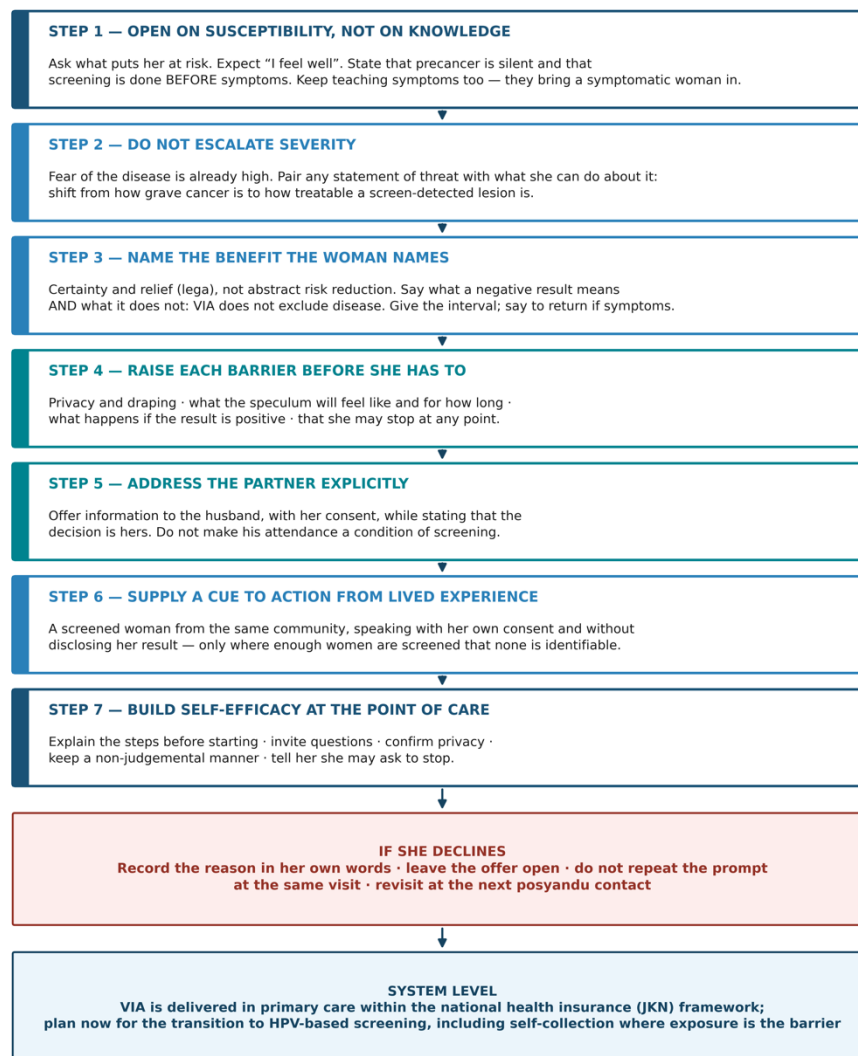


Figure 5. Construct-directed communication aid for VIA counselling in a village setting. Each step addresses one Health Belief Model construct found to be operative in this study. It is a communication aid and not a clinical algorithm: screening eligibility, management of a positive result, criteria for ablative treatment and referral of suspected invasive cancer follow national clinical guidance and are outside its scope.

4.12. Future research

Four studies follow directly. A study sampling non-attenders across several rukun tetangga, with documented interviewer characteristics, interview duration and an explicit saturation strategy, would establish whether the barrier profile reported here generalises within the district. A study designed to elicit both susceptibility and severity judgements from every participant — which requires only that the interview guide ask for both and that the analysis report them per person — would settle the within-person question this study can only pose. A study interviewing husbands alongside wives would test whether the permission structure observed in one account is a general feature of screening decisions in this setting. And a pilot of self-collected sampling in a community where shame at exposure has been documented, with the triage pathway made explicit to participants at the outset, would test the participation gain in the population for which the mechanism is specified^{58,59,62}.

5. Conclusion

Among women of reproductive age in RT 9, Desa Gudang Hirang, what was said about VIA screening was predominantly about barriers: shame at bodily exposure, fear of what a result would show, anticipated pain, not feeling ready, and the

husband's word. Barriers were the only Health Belief Model construct that more than one informant spoke to; every other construct rests on a single woman's words, and in the quotations reported no informant described herself as at risk of cervical cancer. Raising knowledge alone is unlikely to change that. Counselling in Indonesian primary care should open on personal risk rather than disease knowledge while continuing to teach symptom awareness, name each barrier before the woman has to, state what a negative result does and does not mean, engage the partner while keeping the decision with her, and treat willingness as a property of the encounter rather than of the woman; Table 8 grades how far each of these rests on this study and how far on the wider literature. Two hypotheses are offered for testing: that the benefit a woman seeks may be relief, which fear of a result can itself remove, so that benefit and barrier are not independent; and that perceived severity and perceived susceptibility may come apart within individual women — a reading this study invites but cannot support, because the two utterances come from two different informants.

6. Declarations

Statement on the Use of Artificial Intelligence

None declared.

Author Contribution Statement

RW: Conceptualization, Methodology, Investigation, Data curation, Formal analysis, Writing - original draft, Writing - review and editing. FY: Conceptualization, Methodology, Investigation, Data curation, Formal analysis, Writing - original draft, Writing - review and editing. NW: Conceptualization, Methodology, Investigation, Data curation, Formal analysis, Writing - original draft, Writing - review and editing. DD: Conceptualization, Methodology, Investigation, Data curation, Formal analysis, Writing - original draft, Writing - review and editing. All authors read and approved the final manuscript and accept accountability for the work.

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Conflict of Interest

The authors declare that they have no competing interests.

Data Availability Statement

The data supporting the findings of this study — the informant characteristics and all ten verbatim quotations — are contained within the article and its tables. The interview transcripts and field notes are held by the corresponding author and are available on reasonable request, subject to the confidentiality undertakings given to the informants.

Ethical approval and consent to participate

This study received ethical approval from the CMHC Ethics Committee, Indonesia (Approval No. 2026/322). Written informed consent was obtained from all participants before data collection, including consent to audio recording, obtained before recording began, and consent to the publication of anonymised verbatim quotations. The study was conducted in accordance with the Declaration of Helsinki.

Consent for publication

Informants are identified by a code, an age, a marital status and their prior screening status; no names, addresses, household details or other direct identifiers are reported, and no quotation carries detail that would locate the speaker. Because one informant is the only woman in the sample who had undergone VIA, a residual risk of recognition within a small neighbourhood remains. One quotation reports the speech of an informant's husband, who is likewise not identified.

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