



HEALTH LITERACY AND VISUAL INSPECTION WITH ACETIC ACID SCREENING BEHAVIOR AMONG WOMEN OF REPRODUCTIVE AGE IN PANCORAN MAS COMMUNITY HEALTH CENTER, DEPOK: A CROSS-SECTIONAL STUDY

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ABSTRACT

Cervical cancer incidence has been increasing and has become an emerging threat to women's health particularly in developing countries. Visual inspection with acetic acid (VIA) is a cost-effective screening method, however its utilization remains suboptimal. This study aimed to analyze the factors associated with women's participation in VIA screening. An observational analytic study using a cross-sectional design was conducted among 152 women of reproductive age (30-50 years) in the Pancoran Mas Community Health Center area. Data were analyzed using the Chi-Square test and multiple logistic regression. Bivariate analysis revealed that attitudes, health literacy, perceived health belief model components (susceptibility, severity, benefits, barriers and self-efficacy), access to health services, support (from husband, families and community health workers) were significantly associated with VIA testing ($p < 0.05$). A multivariate analysis identified three significant factors: health literacy (OR = 11.203; 95% CI = 3.079-40.763), perceived susceptibility (OR = 3.943; 95% CI = 1.090-14.265), and perceived barriers (OR = 4.466; 95% CI = 1.358-14.687). Health literacy is the most dominant factor associated with VIA screening behavior. Notably, women with adequate health literacy were 11 times more likely to participate in screening. Enhancing screening participation can be achieved by fostering adequate health literacy through optimized health promotion targeting women of reproductive age. This strategy involves the distribution of educational media, such as informative leaflets and posters within the community health center area.

Keywords: cervical cancer screening, health belief model, health literacy, visual inspection with acetic acid, women of reproductive age

Introduction

Cervical cancer is a major public health issue both globally and within Indonesia. Among various malignancies, cervical cancer remains highly prevalent in Indonesia, with an estimated mortality rate of 57 deaths per day.¹ Given the severe mortality and morbidity associated with this disease, to strengthen efforts to promote early detection and prevention, particularly among sexually active women. As a cornerstone of the national prevention strategy, the Indonesian government recommends the visual inspection with acetic acid (VIA) screening method. This method enables early identification of cervical abnormalities due to its simplicity and cost-effectiveness. Furthermore, VIA screening has been extensively implemented across primary health centers as part of a national initiative to reduce the cancer burden among Indonesian women.^{2,3}

According to the WHO global strategy to eliminate cervical cancer, 70% of women aged 35-45 years are targeted for screening by 2030.⁴ However, data from the Indonesian Ministry of Health revealed that the VIA screening achievement rate in Indonesia between 2020 and 2022 reached only 9.3%. This figure is even lower in West Java Province, where only 3.7% of the target population has undergone VIA screenings, a low rate that certainly warrants urgent attention.⁵ VIA screening remains underutilized, largely due to minimal public interest in adopting the method. Behavioral changes and the development of health-seeking behaviors are influenced by various internal and external factors. Based on previous research, several factors can either encourage or hinder a woman from undergoing a VIA screening. Predisposing, enabling, and reinforcing factors significantly impact the tendency of women of reproductive age to seek early detection. For instance, women with a positive attitude are generally more receptive to participating in VIA screenings. Additionally, health literacy is a crucial determinant, as it influences an individual's ability to acquire the knowledge and skills necessary for making informed decisions regarding disease prevention.⁶⁻⁹ Despite its importance, there remains limited research in Indonesia examining the specific relationship between health literacy and VIA screening uptake.

Furthermore, the Health Belief Model (HBM) introduced by Rosenstock, Strecher, and Becker (1988), provides a theoretical framework for understanding and influencing health behavior transitions.¹⁰ Previous studies have found that proximity to healthcare facilities significantly enhances the likelihood of women participating in VIA screening. Additionally, interpersonal support from husbands, family members and community health workers acts as a critical reinforcing factor that fosters positive health-seeking behaviors among women of reproductive age.¹¹⁻¹³

Based on 2022 data from the Depok City Health Office, VIA screening coverage in Depok City reached only 0.9% of the target population for women aged 30-50 years. This figure is significantly lower than that of other major cities in West Java, such as Bandung, which achieved a coverage rate of 1.5% in the same year.¹⁴ This suboptimal trend is further reflected at the Pancoran Mas Community Health Center, despite serving a substantial population of 17,604 women of

reproductive age, it recorded only 38 VIA screenings throughout 2022. Preliminary observations conducted by the researchers corroborated these findings and revealed that among 30 women surveyed in the Pancoran Mas area, only 12 had previously undergone VIA screenings.¹⁵

The low coverage of VIA screening in Depok City (0.9%) suggests that current socialization efforts have yet to effectively drive behavioral change. While numerous studies have examined fundamental factors such as education¹⁶, knowledge¹⁷, attitude^{18,19}, access to health service^{20,21}, perception²², research focusing on health literacy remains limited in Indonesia. This study seeks to bridge this gap by utilizing the health belief model (HBM) as a framework to evaluate how women in urban areas, specifically in Pancoran Mas process health information and perceive cervical cancer risks. The suboptimal success rate of VIA screening underscores the necessity for evidence-based research to identify the drivers of screening behavior. It is anticipated that these findings will contribute to the development of effective interventions that promote early detection. Ultimately, this study aims to analyze the factors associated with VIA screening behavior among women of reproductive age at the Pancoran Mas Community Health Center.

Method

This analytic observational study employed a cross-sectional design and was conducted at the Pancoran Mas Community Health Center, Depok, in June 2024. The study included 152 women of reproductive age (30-50 years). A non-probability purposive sampling approach was used due to the absence of a formal sampling frame for women in this demographic residing in Pancoran Mas. Furthermore, the inclusion of specific study criteria justified the use of this method. Despite utilizing a non-probability sampling method, the sample size was calculated using the formula for hypothesis testing of the difference between two proportions to ensure statistical adequacy. The data collection process began by screening women of reproductive age who visited the Pancoran Mas Community Health Center during the data collection period. Potential respondents were verified based on specific inclusion criteria: women reproductive age 30-50 years domiciled in the Pancoran Mas area, who are currently or were previously married, have no prior diagnosis of cervical cancer, and are not currently undergoing related therapy or treatment. Eligible candidates received a detailed explanation regarding the study's objectives; those who voluntarily signed the informed consent form then proceeded to complete the research instrument.

The sample size for this study was determined using Lemeshow's formula for hypothesis testing of the difference between two proportions within a cross-sectional design. The calculation was based on a significance level (α of 0.05) and a statistical power ($1-\beta$ of 0.80). Based on previous literature, the assumed proportions for the exposed group (P1) and the non-exposed group (P2) were 0.75 and 0.51, respectively.²³ Using statistical sample size software, a minimum sample size of 63 respondents per group was determined, totaling 126 respondents. To account for potential data

incompleteness or non-response, a 20% inflation rate was applied, resulting in a final sample size of 152 respondents.

In this study, VIA screening behavior served as the dependent variable, while the independent variables included attitude, health literacy, perceived components (susceptibility, severity, benefits, barriers, and self-efficacy). Additionally, access to health services, support from husbands, families and community health workers (cadres) were analyzed. Data were collected via self-administered questionnaires, that took approximately 10 minutes to complete. To ensure data accuracy, the instruments underwent validity and reliability testing. Most variables were categorized using the third quartile (Q3) value.^{24,25}

The dependent variable (VIA screening behavior) was measured dichotomously, whether or not respondents had undergone a VIA screening. The attitude variable was measured using 10 Likert-scale questions and categorized based on the Q3 value as positive (≥ 38.75) or negative (< 38.75). Health literacy, measured with 16 questions, was categorized as adequate (13-16) or inadequate (≤ 12). Perceived susceptibility and perceived barriers were measured using 5 Guttman-scale items and categorized as high (≥ 4) or low (< 4). Similarly, perceived severity, perceived benefits and perceived self-efficacy were each measured using 5 Guttman-scale items and categorized as high (≥ 5) or low (< 5). Access to health services was measured with 3 Guttman-scale questions and categorized as easy (≥ 3) or difficult (< 3). Support from husband and families was measured using 5 Likert-scale items and categorized as supportive (≥ 10) or not supportive (< 10), while support from community health workers (cadre) was categorized as supportive (≥ 11) and not supportive (< 11).

Data were analyzed descriptively, followed by a chi-square test and multiple logistic regression for hypothesis testing using statistical data processing software. This study received ethical approval from the Ethics Commission of the Faculty of Public Health, University of Jember (No.519/KEPK/FKM-UNEJ/V/2024).

Results

Table 1 presents the distribution of respondents. The data revealed that the majority of women in this study (67.8%) have never undergone a VIA screening. Most respondents exhibited a negative attitude (75.0%) and possessed inadequate health literacy (71.7%). Regarding health perceptions, respondents reported low perceived susceptibility (67.8%), high perceived severity (56.6%), low perceived benefits of the VIA screening (73.7%), high perceived barriers (71.7%), and low self-efficacy (70.4%). Furthermore, while respondents reported easy access to health services (65.8%), the majority cited a lack of support from husbands (74.3%), families (72.4%), and community health workers (cadres) (72.4%) to undergo a VIA screening.

Table 1. Frequency distribution of research variables

Variables		Frequency (n)	Percentage (%)
VIA Screening	Yes	49	32.2
	No	103	67.8
Attitude	Positive	38	25
	Negative	114	75
Health Literacy	Adequate	43	28.3
	Inadequate	109	71.7
Perceived Susceptibility	High	49	32.2
	Low	103	67.8
Perceived Severity	High	86	56.6
	Low	66	43.4
Perceived Benefits	High	40	26.3
	Low	112	73.7
Perceived Barriers	Low	43	28.3
	High	109	71.7
Perceived Self-Efficacy	High	45	29.6
	Low	107	70.4
Access to Health Services	Easy	100	65.8
	Difficult	52	34.2
Husband's Support	Supportive	39	25.7
	Not Supportive	113	74.3
Family Support	Supportive	42	27.6
	Not Supportive	110	72.4
Cadre Support	Supportive	42	27.6
	Not Supportive	110	72.4

Table 2 presents the difference in probability between independent variables and the VIA screening. The chi-square test showed a statistically significant relationship between VIA screening uptake and all tested factors, including attitude, health literacy, perceived susceptibility, perceived severity, perceived benefits, perceived barriers, perceived self-efficacy, access to health services, and support from husbands, families and cadres ($p < 0.05$).

Consequently, 11 variables were analyzed using the logistic regression model: attitude, health literacy, perceived susceptibility, perceived severity, perceived benefits, perceived barriers, perceived self-efficacy, access to health services, and support from husband's, families and cadres.

Table 2. Bivariate Analysis of Factors Associated with VIA Screening Behavior

Variables		VIA Screening				COR (95% CI)	P-value
		Yes		No			
		n	%	n	%		
Attitude	Positive	29	76.3	9	23.7	4.350	<0.001*
	Negative	20	17.5	94	82.5	(2.814 – 6.725)	
Health Literacy	Adequate	35	81.4	8	18.6	6.337	<0.001*
	Inadequate	14	12.8	95	87.2	(3.807 - 10.548)	
Perceived Susceptibility	High	27	55.1	22	44.9	2.580	<0.001*
	Low	22	21.4	81	78.6	(1.647 - 4.040)	
Perceived Severity	High	41	47.7	45	52.3	3.933	<0.001*
	Low	8	12.1	58	87.9	(1.980 – 7.813)	
Perceived Benefits	High	29	72.5	11	27.5	4.060	<0.001*
	Low	20	17.9	92	82.1	(2.613 – 6.308)	
Perceived Barriers	Low	33	76.6	10	23.3	5.228	<0.001*
	High	16	14.7	93	85.3	(3.230 - 8.463)	
Perceived Self-Efficacy	High	29	64.4	16	35.6	3.448	<0.001*
	Low	20	18.7	87	81.3	(2.197 – 5.212)	
Access to health services	Easy	39	39.0	61	61.0	2.028	0.022*
	Difficult	10	19.2	42	80.8	(1.102 – 3.727)	

Variables		VIA Screening				COR (95% CI)	P-value
		Yes		No			
		n	%	n	%		
Husband’s Support	Supportive	28	71.8	11	28.2	3.863	<0.001*
	Not Supportive	21	18.6	92	81.4	(2.505 - 5.958)	
Family Support	Supportive	30	71.4	12	28.6	4.135	<0.001*
	Not Supportive	19	17.3	91	82.7	(2.633 – 6.495)	
Cadre Support	Supportive	31	73.8	11	26.2	4.511	<0.001*
	Not Supportive	18	16.4	92	83.6	(2.849 – 7.140)	
Description: * (significant/p-value ≤ 0.05), COR = Crude Odds Ratio, Source: Primary Data, 2024							

Description: * (significant/p-value ≤ 0.05), COR = Crude Odds Ratio, Source: Primary Data, 2024

Meanwhile, table 3 presents factors associated of VIA screening among women of reproductive age at the Pancoran Mas Community Health Center after multivariate adjustment. The analysis revealed that health literacy (p-value <0.001), perceived susceptibility (p-value 0.037) and perceived barriers (p-value <0.014), were found to be significantly associated with women who undergo a VIA screening (p < 0.05) after the variables for perceived severity, perceived benefit, perceived self-efficacy, husband's support, and cadre support. Based on the final multivariate model, health literacy was identified as dominant factor associated with VIA screening. Women with adequate health literacy were 11.203 times more likely to undergo VIA screening (AOR = 11.203; 95% CI = 3.079 – 40.763).

Table 3. Multivariate Logistic Regression of VIA Screening Behavior Among Women of reproductive age

Variables		P-value	AOR (95%CI)
Health Literacy	Adequate	<0.001*	11.203 (3.079 – 40.763)
	Inadequate		
Perceived Susceptibility	High	0.037*	3.943 (1.090 – 14.265)
	Low		
Perceived Severity	High	0.579	1.429 (0.405 – 5.040)
	Low		
Perceived Benefits	High	0.383	1.902 (0.449 – 8.054)
	Low		
Perceived Barriers	Low	0.014*	4.466 (1.358 – 14.687)
	High		
Perceived Self-Efficacy	High	0.142	2.321 (0.755 – 7.131)
	Low		
Husband's Support	Supportive	0.616	1.436 (0.349 – 5.919)
	Not Supportive		
Cadre Support	Supportive	0.104	3.022 (0.797 – 11.461)
	Not Supportive		

Description: * (significant/p-value ≤ 0.05), AOR = Adjusted Odds Ratio, Source: Primary Data, 2024

Discussion

Visual inspection with acetic acid (VIA) is an important screening method for cervical cancer, particularly among sexually active women of reproductive age. The analysis revealed that only 32.2% of respondents had undergone a VIA screening, which indicates low screening coverage. This finding is comparable to prior research from the Gedong Tataan Community Health Center, which reported a coverage rate of 34.7%,²⁶ and with a study from the Tanah Abang Banyuasin Community Health Center, which showed a rate of 48.0%.¹⁹ The consistently low coverage across different

settings suggests that cervical cancer screening participation remains a challenge in many community health contexts.

The low participation rate in VIA screening observed in this study is associated with the prevalence of negative influencing factors among participants. These factors include negative attitudes (75.0%), inadequate health literacy (71.7%), and low perceived susceptibility (67.8%) and perceived benefit (73.7%), high perceived barriers (71.7%), low self-efficacy (70.4%), and a lack of support from husbands (74.3%), families (72.4%) and community health workers (72.4%). These results align with Lawrence Green's theory and Health Belief Model (HBM), which posit that health-related behavior is determined by predisposing, enabling, and reinforcing factor, specifically subjective perceptions and beliefs.^{27,10}

Chi-Square test results indicated that several factors were significantly associated with VIA screening uptake at the Pancoran Mas Community Health Center, including attitude, health literacy, perceived susceptibility, perceived severity, perceived benefit, perceived barriers, perceived self-efficacy, access to health services, husband support, family support and cadres support. However, when these variables were analyzed simultaneously using multiple logistic regression, only three factors remained significantly associated: health literacy, perceived susceptibility and perceived barriers. Health literacy essentially encompasses an individual's ability to gather health information and use it as a basis for medical decisions in daily life for themselves and their families. This comprehensively includes the ability to search, analyze and utilize health information in everyday situations.²⁸ Meanwhile, perceived susceptibility refers to an individual assessment of their risk of developing a health condition based on their subjective perception and perceived barriers refer to an individual's assessment of the influences that hinder or inhibit changing behavior in taking action.²⁹ Among the three variables, health literacy was identified as the most dominant factor associated with VIA screening in the study area.

The result of this study showed a significant correlation between the level of health literacy and women's participation in VIA screenings ($p < 0.05$). Specifically, women with adequate health literacy were 11.203 times more likely to undergo a VIA screening than women with inadequate health literacy (AOR = 11.203; 95% CI = 3.079 – 40.763). The level of health literacy in the participants regarding cervical cancer is significantly correlated with involvement in early detection, which is a crucial element for the effectiveness of prevention measure.^{30–32} Our findings are consistent with previous studies suggesting that limited health literacy creates knowledge gaps that hinder preventive practice and lead to irregular screening patterns.^{31,33,34} Health literacy challenges are reflected in the respondent's responses, which indicate difficulties in understanding instructions from healthcare providers regarding VIA screenings, processing information for decision making and processing health advice from family members. Therefore, a low level of health literacy can act as a barrier to cervical cancer screening, as inadequate literacy may hinder participation and

potentially reduce compliance with screening guidelines. Conversely, higher health literacy promotes better engagement and participation.^{35,36}

The findings of this study indicate a significant correlation between perceived susceptibility and women's participation in VIA testing ($p < 0.05$), where women with high perceived susceptibility were 3.943 times more likely to undergo a VIA screening compared to those with low perceived susceptibility (AOR = 3.943; 95% CI = 1.090 – 14.265). Previous research found that women with high perceived susceptibility were more likely to undergo a VIA screening than women with low perceived susceptibility.^{37, 38,39} However, 67.8% of participants had a low perceived susceptibility, primarily because the participants considered themselves healthy, believed their lifestyles were risk-free and had no family history of cervical cancer. This finding is consistent with previous studies which indicate a lack of symptoms often leads to a lower perception of risk.^{31,40} Women who perceive themselves as being at risk for cervical cancer are more motivated to adopt preventive behaviors, such as VIA screenings as a form of proactive self-protection.^{41,42}

Another factor that showed a significant simultaneous relationship with VIA screenings is perceived barriers. The findings of this study indicate a significant correlation between perceived barriers and women's tendency to undergo VIA screenings ($p < 0.05$), women with low perceived barriers are 4.466 times more likely to undergo VIA screenings than those with high perceived barriers (AOR = 4.466; 95% CI = 1.358 – 14.687). This result is consistent with a prior study that reported a significant relationship between perceived barriers and VIA screenings.^{43–45} The majority of women (71.7%) had a high-perceived barriers, primarily driven by concern about the accuracy of test accuracy (70.4%), fear and embarrassment (64.5%), lack of information (62.5%) and financial constraints (52.6%). Theoretically, perceived barriers to preventive behavior will influence the extent of effort individuals make; the greater the perceived barriers, the less likely the individual is to adopt health behaviors, in this case the VIA screening.^{46,47} This is reinforced by other studies that fear, shame, busy work and household chores are the main reasons for avoiding screening.⁴¹ Thus, the existence of these barriers can weaken women's intention and participation, thus hindering the achievement of the target coverage of early detection of cervical cancer.

Despite its contributions, this study has several limitations. First, this research uses the cross-sectional design, which means that both independent and dependent variables were observed simultaneously, which precludes the determination of temporal precedence between variables. Consequently, the results are limited to explaining the Odds Ratio (OR) as a measure of association (odds) rather than as a direct measure of risk factors. Second, the use of purposive sampling limits the generalizability of the findings, as the sample may not fully represent the entire population of women of reproductive age in Pancoran Mas. To address these limitations, future research should move beyond observational studies and adopt an experimental design. Such an approach is necessary

to identify which promotional methods and media channels are more effective in driving actual VIA screening behavior.

Conclusion

Participation in the Visual Inspection with Acetic Acid (VIA) screening among women in the Pancoran Mas Community Health Center work area remains relatively low. This study found that health literacy, perceived susceptibility, and perceived barriers are negatively associated with screening uptake. Notably, while the prevalence of inadequate health literacy was high (71.7%), 81.4% of women with adequate health literacy participated in VIA screening. Therefore, the Community Health Center should intensify health promotion efforts to enhance health literacy among women of reproductive age. Practical interventions include integrating health education at admission, distributing informative leaflets on the importance of VIA, and displaying posters highlighting the benefits and screening schedule within the facility. Furthermore, future research should adopt an experimental design to identify the most effective promotional methods and media for increasing VIA screening behavior.

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Conflict of Interest

The author declares that there is no conflict of interest.

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