

Determinants of IV A screening behavior among women of childbearing age at pasar baru community health center Tangerang City

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ABSTRACT

Cervical cancer is the fourth leading cause of cancer-related deaths among women worldwide and ranks second among cancers affecting women in Indonesia. Participation in Visual Inspection with Acetic Acid (VIA) screening remains a public health concern. In Tangerang City and at Pasar Baru Community Health Center, VIA screening coverage has not reached the established targets. To examine factors associated with VIA screening behavior among women of reproductive age at Pasar Baru Community Health Center, Tangerang City. A cross-sectional study was conducted among 64 women of reproductive age selected using purposive sampling. Data were collected through questionnaires and interviews. Bivariate analyses were followed by multivariable logistic regression using a significance level of 0.05. Of the 64 respondents, 51 (79.7%) had undergone VIA screening, while 13 (20.3%) had not. In the bivariate analysis, age ($p = 0.062$) and occupation ($p = 0.123$) were not significantly associated with VIA screening behavior. Education ($p = 1.000$), parity ($p = 0.333$), knowledge ($p = 0.717$), attitude ($p = 0.203$), and husband's support ($p = 0.743$) were also not significantly associated with screening behavior. Access to information and health worker support showed no variation among respondents, precluding meaningful assessment of their associations with screening behavior. In the multivariable logistic regression model, age (adjusted OR [aOR] = 5.760; 95% CI: 1.289–25.733; $p = 0.022$) and occupation (aOR = 4.339; 95% CI: 1.100–17.116; $p = 0.036$) were statistically significantly associated with VIA screening behavior after mutual adjustment. Given the small sample size and the wide confidence intervals, these findings should be considered preliminary and require confirmation in larger studies. Community-based educational initiatives and cross-sector collaboration may be considered to support VIA screening participation among women of reproductive age.

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INTRODUCTION

Cervical cancer remains a major public health problem among women, although it can be prevented through early detection and appropriate treatment (Mupenzi et al., 2025). In Indonesia, Visual Inspection with Acetic Acid (VIA), known as Inspeksi Visual Asam Asetat (IVA), is one of the screening methods used to detect precancerous cervical lesions (Nuranna, 2022). However, screening participation remains suboptimal. In 2025, only 2,325 of 3,831 women aged 30–50 years in the Pasar Baru Primary Health Center area, Tangerang, had undergone VIA screening (60.69%). This indicates the need to identify factors associated with screening behavior.

Previous studies have reported various factors associated with VIA screening, including age, education, occupation, knowledge, attitudes, access to information, and support from husbands and healthcare workers. However, findings have not always been consistent (Khairani & Lubis, 2025). For example, Darsiah et al. (2025) reported no significant association between women's attitudes and VIA screening compliance, whereas Liana & Herlina (2023); and Putri et al. (2025) found a significant association. These differences suggest that screening behavior may be influenced by multiple factors that interact within individual and social contexts.

Nevertheless, further research is needed to examine these factors within an integrated framework. Studies that assess predisposing, enabling, and reinforcing factors simultaneously may provide a more comprehensive understanding of VIA screening behavior (Madiuw et al., 2025). Therefore, the research gap is not merely the difference in study location, but the need to evaluate the combined relationships of individual characteristics, knowledge and attitudes, information access, and social support with screening behavior.

This study applies Lawrence Green's PRECEDE-PROCEED framework, which explains health behavior through predisposing, enabling, and reinforcing factors. In this study, age, education, parity, occupation, knowledge, and attitudes are examined as predisposing factors; access to information as an enabling factor; and husband's support and healthcare worker support as reinforcing factors. This framework provides a theoretical basis for examining the relationship between these factors and VIA screening behavior. Accordingly, this study aims to analyze the associations between these nine factors and VIA screening behavior among women at Pasar Baru Primary Health Center, Tangerang, and to identify the factor most strongly associated with screening behavior. The findings are expected to support the development of more targeted strategies to improve VIA screening participation.

RESEARCH METHOD

This study employed a quantitative, cross-sectional design to examine factors associated with visual inspection with acetic acid (VIA) screening among women of reproductive age. The study was conducted at Pasar Baru Primary Health Center (Puskesmas Pasar Baru), Tangerang City, Indonesia, in July 2026. The study included 64 married women of reproductive age aged 30–50 years who met the study eligibility criteria. Participants were selected using purposive sampling. The study included 64 married women of reproductive age aged 30–50 years who met the study eligibility criteria. Participants were selected using purposive sampling.

The required sample size was calculated using the two-proportion approach described by Lemeshow et al. (1997), with the calculation performed using Sample Size 2.0 software. However, the original calculation output and the parameter values used in the calculation were unavailable. Consequently, the reproducibility of the reported sample size of 64 participants could not be independently verified. Because purposive sampling was used, the participants were not selected through probability sampling. The findings should therefore be interpreted in the context of the study population and setting, and their generalizability to women of reproductive age in other populations or health care settings may be limited.

The dependent variable was self-reported history of VIA screening at Puskesmas Pasar Baru during the three years preceding data collection. The independent variables comprised age, educational attainment, parity, employment status, knowledge, attitude, access to information, husband or family support, and health worker support. The selection of these variables was informed by the PRECEDE-PROCEED framework described by Green & Kreuter (2005). Within this framework, knowledge and attitude were considered predisposing factors; access to information was considered an enabling factor; and husband or family support and health-worker support were considered reinforcing factors. Age, educational attainment, parity, and employment status were included as sociodemographic or reproductive characteristics (Nareswari et al., 2025).

The variables were categorized according to the operational definitions used in the study, as follows:

Table 1. Operational definition and categorization of variables

Variable	Operational Definition and Categorization
Age	30-40 years and 41-50 years
Educational Attainment	Junior high school or lower and senior high school or higher
Parity	Three or fewer births and more than three births
Employment Status	Working and not working
Knowledge	Good: $\geq 75\%$; moderate: 56-74%; poor: $< 56\%$
Attitude	Positive: score above the mean; negative: score below the mean
Access to Information	Good: two responses classified as "a"; poor: fewer than two such responses
Husband or family support	Supportive: three "Yes" responses; not supportive: fewer than three "Yes" responses
Health worker support	Good: four "Yes" responses; poor: fewer than four "Yes" responses

The cutoffs above reflect the operational definitions used in the study. The underlying questionnaire and its scoring rules should be consulted when interpreting these categories. In particular, the operational definition for attitude does not specify how a score exactly equal to the mean was classified.

Data were collected using a structured questionnaire covering knowledge, attitude, access to information, husband or family support, and health worker support. The questionnaire was described in the study materials as having undergone validity and reliability assessment. However, the available information did not establish the exact source and development history of the instrument or provide the numerical results of its psychometric assessment. The outcome was participants' self-reported history of VIA screening at Puskesmas Pasar Baru during the preceding three years. Participants were classified as having previously undergone screening or as never having undergone screening, based on their questionnaire responses.

The outcome was not described as having been independently verified against clinical records or the health center's screening register. Data were analyzed using IBM SPSS Statistics version 25. Descriptive statistics were used to summarize participant characteristics and the distribution of the study variables. Categorical variables were presented as frequencies and percentages. Bivariate associations between each independent variable and VIA screening history were assessed using the chi-square test or Fisher's exact test, as appropriate to the observed cell counts. Variables with bivariate p-values below 0,25 were considered for entry into the backward logistic regression procedure used in the existing analysis. Statistical significance was defined as a two-sided p-value below 0,05.

RESULTS AND DISCUSSIONS

Participant Characteristics

A total of 64 women of reproductive age (WRA) were included. Fifty one respondents (79,7%) reported having undergone IVA screening and 13 (20,3%) had never undergone screening. There were 32 respondents (50,0%) in each age group (30-40 and 41-50 years). Most had higher education (56; 87,5%) and parity of ≤ 3 births (58; 90,6%). Thirty nine respondents (60,9%) were

employed. Good knowledge was reported by 51 respondents (79,7%), while 63 (98,4%) reported a positive attitude. All respondents reported good access to information and support from health workers; therefore, these two variables had no variation in this sample. Husband/family support was reported by 46 respondents (71,9%).

Table 2. Distribution of respondents according to IVA screening behavior and study variables

Variable	Category	n	%
IV A Screening Behavior	Ever Screened	51	79,7
	Never Screened	13	20,3
Age	30 – 40 Years	32	50
	41 – 50 Years	32	50
Education	High	56	87,5
	Low	8	12,5
Parity	≤3 Births	58	90,6
	>3 Births	6	9,4
Occupation	Employed	39	60,9
	Not Employed	25	39,1
Knowledge	Good	51	79,7
	Moderate/Poor	13	20,3
Attitude	Positive	63	98,4
	Negative	1	1,6
Access to Information	Good	64	100
	Poor	0	0
Husband/Family Support	Supportive	46	71,9
	Not Supportive	18	28,1
Health Worker Support	Supportive	64	100
	Not Supportive	0	0

Bivariate Analysis

Bivariate results are presented descriptively and should not be interpreted as evidence of causation. Percentages below are within each exposure category. For sparse 2×2 tables, Fisher's exact test is preferable to asymptotic chi-square tests. The p-values below are recalculated from the displayed counts using two-sided Fisher's exact tests; odds ratios (ORs) and Wald 95% confidence intervals (CIs) are calculated from the same 2×2 counts. Because exact-test p-values and Wald intervals use different methods, borderline results should be interpreted cautiously. The original SPSS output should be retained for a final software output audit.

Table 3. Bivariate associations between independent variables and IVA screening behavior

Variable	Comparison	Ever Screened, n/N (%)	Crude OR (95% CI)	p-value
Age	41-50 vs 30-40 years	29/32 (90,6%) vs 22/32 (68,8%)	4.394 (1.079 – 17.893)	0.060
Education	Higher vs Low	44/56 (78,6%) vs 7/8 (87,5%)	0.524 (0.059 – 4.682)	1.000
Parity	>3 vs ≤3	6/6 (100%) vs 45/58 (77,6%)	Not stable; zero cell	0.333
Occupation	Employed vs Not Employed	34/39 (87,2%) vs 17/25 (68,0%)	3.200 (0.908 – 11.281)	0.109
Knowledge	Good vs Moderate/Poor	41/51 (80,4%) vs 10/13 (76,9%)	1.230 (0.285 – 5.316)	0.717
Attitude	Positive vs Negative	51/63 (81,0%) vs 0/1 (0,0%)	Not stable; sparse cell	0.203
Access to Information	Good vs Poor	51/64 (79,7%) vs 0/0	Not estimable	Not testable
Husband/Family Support	Supportive vs Not Supportive	36/46 (78,3%) vs 15/18 (83,3%)	0.720 (0.173 – 2.990)	0.743
Health Worker Support	Supportive vs Not Supportive	51/64 (79,7%) vs 0/0	Not estimable	Not testable

Notes: p-values are two-sided Fisher's exact tests based on the displayed counts. ORs compare the first category with the second for the odds of ever having undergone screening. Wald CIs are unstable with sparse cells and should not be treated as definitive. For age, the recalculated Fisher p-value is approximately 0.060, while the Wald CI is above 1; this reflects the different inferential methods and should be verified against the original SPSS output before submission. The parity and attitude ORs are not reported as finite estimates because sparse/zero cells make conventional estimates unreliable. Access to information and health-worker support are constant variables and must be excluded from inferential and multivariable analyses.

In the sample, screening proportions were higher among respondents aged 41–50 years, employed respondents, and respondents with parity >3. However, these descriptive differences are imprecise and do not establish an association in the source population. Education, knowledge, and husband/family support showed comparatively similar screening proportions across categories. The attitude comparison is particularly limited because only one respondent reported a negative attitude. Non-significant p-values should not be interpreted as proof that an association is absent; they indicate that the data do not provide sufficiently precise evidence under the selected test.

Multivariable Analysis

The research reports a final logistic regression model containing age and occupation. After adjustment, age had an adjusted OR of 5.760 (95% CI 1.289–25.733; $p=0.022$) and occupation had an adjusted OR of 4.339 (95% CI 1.100–17.116; $p=0.036$). These are adjusted associations conditional on the variables retained in this particular model; they should not be described as causal effects, determinants, or dominant factors. The wide CIs indicate substantial uncertainty about the magnitude of both estimates.

The adjusted estimates differ from the bivariate results because adjustment estimates each variable's association conditional on the other included variable. Changes can arise from confounding, differences in the distribution of age and occupation, and statistical instability in a small dataset. The direction and size of the changes do not, by themselves, prove that confounding has been removed. Only 13 respondents had not undergone screening, so the number of non-events available to estimate regression coefficients was limited. This creates a risk of overfitting and unstable estimates, particularly when candidate variables are selected using bivariate p-values. The final model should therefore be treated as exploratory and requires cautious interpretation.

The research reports Nagelkerke $R^2=0.220$ for the final model. This is a pseudo- R^2 measure and should not be interpreted as a literal proportion of outcome variance explained. Variables with no variation (access to information and health-worker support) cannot be estimated and must not enter the inferential model. Attitude and parity have highly unbalanced distributions and sparse cells; their exclusion from a conventional model should be justified by estimability and model stability, not simply by a non-significant p-value. The final model and all table values should be checked against the original SPSS output, including coding/reference categories, test type, coefficient, standard error, p-value, OR, and CI.

IVA Screening Behavior among WRA

In this purposively selected sample of 64 WRA attending or connected with Puskesmas Pasar Baru, 79.7% reported previous IVA screening. This percentage describes the respondents enrolled in this study and should not be interpreted as the screening coverage of all eligible women in the health centre catchment area. Purposive sampling can over represent women who attend health services, have greater contact with health workers, or are easier to reach. The observed proportion may therefore differ from that of WRA who do not attend the facility. The cross-sectional design also limits conclusions to associations at the time of data collection and cannot establish temporal sequence or causality (Jamilah et al., 2022).

Age and IVA Screening Behavior

The observed screening proportion was 90.6% among respondents aged 41–50 years and 68.8% among those aged 30–40 years. The original SPSS table reports $p=0.062$, while the crude OR is 4.394 with a wide 95% CI. The adjusted model reports $aOR=5.760$ (95% CI 1.289–25.733; $p=0.022$), but the wide interval indicates considerable uncertainty. Adjustment may change the estimate because age and occupation are related or because the model is sensitive to the small number of non events (Martina et al., 2023). These data do not justify describing age as a determinant or dominant factor. Greater accumulated contact with health services among older respondents is one possible explanation, but it was not directly tested in this study.

Education and IVA Screening Behavior

Screening was reported by 78.6% of respondents with higher education and 87.5% with lower education. The two sided Fisher test was not significant ($p=1.000$), and the OR estimate was imprecise (0.524; 95% CI 0.059–4.682). Only eight respondents were in the lower education group, including one non screened respondent, limiting precision. The result does not demonstrate that education is unrelated to screening; rather, the sample cannot exclude potentially meaningful differences. Formal education and health literacy are distinct constructs, but health literacy was not separately measured here, so it should be presented only as a possible explanation.

The results of this study align with Wantini & Indrayani (2019), who stated that the level of formal education is not significantly directly associated with women's participation in IVA screening. Rather, the direct delivery of health information and encouragement from one's social environment are far more decisive factors regarding actual behavior than the respondent's formal educational background. Amalia et al. (2025) similarly noted that personal motivation and the perception of practical needs outweigh the factor of formal education status when it comes to preventive screenings. However, these results differ from the findings of Fadilah et al. (2023), who reported a significant relationship between education and IVA screening, noting that the highly educated group in their study demonstrated greater compliance due to their autonomy in seeking access to healthcare services.

Parity and IVA Screening Behavior

All six respondents with parity >3 reported previous screening, compared with 45 of 58 (77.6%) among respondents with parity ≤ 3 . The Fisher exact p -value was 0.333. Because the high parity group contained only six respondents and no non screening events, the conventional OR is not reliably estimable without a correction. The 100% observed screening proportion should not be interpreted as evidence of a strong or certain association. A larger sample with adequate numbers in each parity and outcome category would be needed to estimate this association more precisely. More frequent contact with reproductive health services is a plausible hypothesis, but service-contact history was not analysed as a mediator in this study.

The findings of this study align with previous research by Zailani et al. (2018), which indicated no significant association between parity and participation in IVA screening. That study suggested that, in the current era of national health insurance, an individual's internal motivation and encouragement from healthcare workers during visits to integrated health posts (Posyandu) exert a far greater influence on health-related behavior than a mother's history of childbirth. A similar view was expressed by Khoirunnisa & Yuliani (2025), who noted that parity status merely reflects reproductive history, whereas the decision to undergo IVA screening is primarily driven by the perceived threat of cancer itself. However, these results differ from the study by Sumarni & Hasanah (2020), which found a significant association; in that study, women with high parity (>3) were significantly more likely to comply with IVA screening, as they perceived their reproductive organs to have undergone repeated birth related trauma and thus felt more vulnerable to disease.

Occupation and IVA Screening Behavior

The screening proportion was 87.2% among employed respondents and 68.0% among respondents who were not employed. The crude OR was 3.200 (95% CI 0.908–11.281), and the two sided Fisher test gave $p \approx 0.109$; this differs from the continuity corrected chi-square p -value reported in the thesis (0.123), so the test used must be stated consistently in the final manuscript. In the adjusted model, the reported aOR was 4.339 (95% CI 1.100–17.116; $p = 0.036$). This change may reflect adjustment for age or model instability, it should not be interpreted as proof that employment causes screening. The broad CI and small number of non events mean the magnitude of the adjusted association remains uncertain.

The results of this study align with Siregar & Puspitarani (2025), who stated that there is no significant relationship between employment status and women's participation in IVA screening, internal motivation and husband's support play a more crucial role than employment status. Similarly, the study by Wewengkang et al. (2024) found that individual knowledge and attitudes were more dominant factors in driving screening behavior than the respondents' socioeconomic or employment status. Conversely, these findings differ from the study by Malindawati (2023), which reported a significant relationship between employment and IVA screening, based on the assumption that employed women have far greater exposure to information.

Knowledge and IVA Screening Behavior

Knowledge was not significantly associated with IVA screening behavior ($p = 0.717$). Screening participation was similar between respondents with good knowledge (80.4%) and those with moderate/poor knowledge (76.9%). The OR of 1.230 indicates only a modest difference in the observed odds of screening. These findings align with a study by Rizani (2021), which also found no association between the level of knowledge and participation in IVA screening. Fear of the results and feelings of embarrassment often act as stronger barriers; consequently, even when women are aware of the benefits of IVA (possessing good knowledge), they remain reluctant unless accompanied by strong external motivation or support. Rahayu et al. (2023) also noted that massive exposure to information via social media does not necessarily translate into a perceived need for action in the absence of a reinforcing factor, such as spousal support. Conversely, these findings differ from the research by Haryono et al. (2026), which asserts a strong link between knowledge and adherence to IVA screening, based on the premise that women with cognitive understanding will perceive a higher susceptibility to cervical cancer.

Attitude and IVA Screening Behavior

Nearly all respondents had a positive attitude toward IVA screening (63 of 64 respondents), and 80.9% of those with a positive attitude had undergone screening. Nevertheless, the association was not statistically significant ($p = 0.203$). Positive attitude may still be insufficient to produce actual screening when practical or psychological barriers remain. This distinction between intention or acceptance and actual health behavior is particularly relevant for preventive services such as IVA screening.

These research findings align with a previous study by Timang et al. (2026), which indicated no significant direct relationship between an individual's independent attitude and adherence to VIA screening. External factors such as direct encouragement from health volunteers and the availability of free screening services often motivate women to undergo screening, overriding the influence of their personal attitudes. Research by Maisarah et al. (2025) confirms that the link between positive attitudes and actual behavior is often more strongly bridged by social support from one's immediate environment. However, these results differ from the findings of Winata et al. (2023), who reported a significant relationship between mothers' attitudes and participation in VIA testing.

Information Access and Health Worker Support

All respondents reported good access to information and all reported receiving support from health workers. These findings represent an important descriptive characteristic of the study population but prevent meaningful statistical comparison because there was no unexposed/reference category.

Accordingly, the $p=0.000$ values reported in the original cross-tabulations should not be interpreted as evidence of a statistically significant association. The absence of variation means that an effect estimate cannot be reliably calculated. Instead, the finding indicates that information access and health-worker support were uniformly reported among the sampled respondents. From a program perspective, the uniformity of these two variables may indicate that information provision and health-worker engagement were already well established at the study site.

The findings regarding this high level of information exposure align with research conducted by Wewengkang et al. (2024), which indicates that in the digital era and with the active involvement of urban health volunteers access to information is no longer a primary obstacle for women of reproductive age (WUS) regarding early detection programs. Conversely, these results reinforce the study by Rizani (2021), which suggests that once information access is widespread within the community, the primary barriers shift to psychosocial factors and the availability of free time among WUS that aligns with healthcare service operating hours.

Husband/Family Support and IVA Screening Behavior

Husband/family support was not significantly associated with IVA screening behavior ($p=0.743$). Among respondents receiving support, 78.3% had undergone IVA screening, compared with 83.3% among those reporting no support. The observed OR was 0.720 (95% CI 0.173–2.990). The direction of this association differs from the expectation that social support facilitates preventive health behavior. The finding may reflect the relatively high overall screening participation in both groups, as well as the possibility that women in this setting could make screening decisions relatively independently of reported husband/family support. In addition, the cross-sectional design does not allow determination of the temporal sequence between social support and screening behavior.

This aligns with research by Siregar & Puspitarani (2025), which found no significant relationship between husband support and IVA screening coverage. Purely internal preventive motivation (self-motivation) and health insurance coverage are far more independent factors in determining early detection behavior. Similarly, Amalia et al. (2025) noted that in urban areas with open access to information, women possess greater agency and bodily autonomy to make their own health decisions without necessarily waiting for their husbands' instructions. Conversely, these results contrast with the findings of Malindawati (2023), who stated that husband support is strongly linked to participation in IVA testing, arguing that a husband's approval minimizes psychological barriers such as feelings of shame or guilt experienced by the wife.

CONCLUSION

In this study, 79.7% of women of reproductive age had undergone VIA screening. Multivariate analysis showed that age and occupation were significantly associated with VIA screening behavior. Women aged 41–50 years had higher odds of having undergone VIA screening than those aged 30–40 years (OR = 5.760; 95% CI: 1.289–25.733; $p = 0.022$). Similarly, employed women had higher odds of having undergone VIA screening than unemployed women (OR = 4.339; 95% CI: 1.100–17.116; $p = 0.036$). In the bivariate analysis, education, parity, knowledge, attitude, and husband/family support were not significantly associated with VIA screening behavior. The associations of access to information and health worker support could not be adequately assessed because all respondents reported good access to information and support from health workers. These findings suggest that targeted health education and communication strategies may prioritize

women aged 30–40 years and unemployed women to encourage VIA screening uptake. However, given the cross-sectional design and limited sample size, the findings should be interpreted as associations rather than causal relationships. The Nagelkerke R^2 value of 0.220 is reported as a model-fit measure and should not be interpreted as the proportion of screening behavior explained by the variables in the model.

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