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Understanding and Perceptions of Women of Reproductive Age towards Breast Self-Examination as an Effort for Early Detection of Breast Cancer

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ABSTRACT

Purpose: This study aims to analyze in depth the understanding and perceptions of women of childbearing age regarding breast self-examination (BSE) as an early detection measure for breast cancer. The primary focus is on technical knowledge, subjective meaning, and social and cultural influences that shape women's health behaviors.

Research Design and Methodology: This study employs a qualitative approach, grounded in a Systematic Literature Review (SLR). The articles analyzed were selected based on their relevance to the theme, the time frame of 2015-2024, and publication in reputable international journals such as SAGE, BMC, and Elsevier. The analysis process involved extracting thematic data from various sources to identify patterns, gaps, and determinants of behavior related to SADARI.

Findings and Discussion: The findings indicate that although most women of reproductive age are aware of SADARI, a significant gap remains between knowledge and practice. Factors such as shame, fear, social stigma, and cultural norms significantly influence the shaping of attitudes and behaviors. In addition, internal factors such as motivation and self-efficacy also influence the decision to perform SADARI regularly.

Implications: This study highlights the importance of a contextual and responsive educational approach to addressing the social realities faced by women of reproductive age. The findings can serve as a basis for designing community interventions and culturally informed health policies to increase participation in breast cancer early detection practices.

Introduction

Breast cancer is one of the significant challenges in women's health globally, with a substantial impact on morbidity and mortality rates. According to the Globocan report (2020), breast cancer accounts for approximately 11.7% of all new cancer cases worldwide and is the leading cause of cancer-related deaths among women. In Indonesia, breast cancer ranks first in terms of the highest number of cancer cases, with 68,858 new cases per year and approximately 22,000 deaths annually. This situation is exacerbated by low rates of early detection, leading to most cases being diagnosed at an advanced stage, thereby complicating treatment and reducing survival rates. Early detection is a crucial strategy in reducing breast cancer mortality rates, with self-breast examination (SADARI) being one of the simplest, cost-effective, and self-administered methods that can be performed by every woman at home (Waheeb, 2024). Despite its significant potential as an early detection tool,

the implementation of SADARI still faces numerous challenges in practice. Many women, particularly those in the reproductive age group, are still unaware of the importance of SADARI and how to perform it correctly. This issue is not merely technical but also reflects challenges in perception, knowledge, and attitudes toward breast health. Moreover, women in the reproductive age group are biologically at higher risk of experiencing breast tissue changes, including the development of cancer cells.

Previous studies have shown varied results regarding the understanding and practice of SADARI among women of reproductive age in Indonesia. Kristanti (2019) reported that only 7.9% of respondents had good knowledge about SADARI, while Patandianan et al. (2015) found that 98.9% of participants were aware of SADARI, but only 62.8% performed it regularly. This indicates a gap between knowledge and practice. Demonstration-based educational interventions have been proven to improve SADARI skills (Hastuti et al., 2020), as well as community-based education programs that enhance women's knowledge and skills regarding SADARI and breast cancer (Marfianti, 2021). Research by (Ayattulla et al., 2024; Siagian et al., 2024) showed that knowledge and attitudes do not always correlate with SADARI behavior, even among highly educated groups. Oktavia et al. (2024) confirmed a significant relationship between knowledge, attitudes, and SADARI practices among midwifery students. Educational interventions have proven effective in increasing awareness, knowledge, and SADARI practices (Marhaeni et al., 2024). However, barriers such as shame and a lack of understanding about its benefits remain significant challenges in breast cancer early detection efforts.

Although many studies have highlighted the importance of SADARI as a method for early breast cancer detection and identified key variables such as knowledge, attitudes, and practices, most existing research remains limited to quantitative approaches. Studies (Kristanti, 2019; Patandianan et al., 2017; Marfianti, 2021) emphasize the prevalence of knowledge and frequency of SADARI practice, but have not explored in depth how women's perceptions are shaped by their experiences, cultural values, and personal understanding. This indicates a gap between statistical measurements and the subjective reality faced by women of reproductive age in their daily practices. Even among educated populations, such as medical or midwifery students, high knowledge levels do not always translate into consistent SADARI behavior (Ayattulla et al., 2024; Siagian et al., 2024). From a theoretical perspective, most studies have not fully explained the relationship between individual perception dimensions and internal motivation, social norms, and contextual barriers in SADARI practices. The role of sociocultural factors, such as shame, taboos surrounding the body, and the lack of open discussions about breast health, is often overlooked in analyses.

The novelty of this study lies in its approach, which integrates a qualitative Systematic Literature Review (SLR) method to explore in depth the dimensions of perception and understanding of women of reproductive age toward SADARI practices, which have been under-explored in quantitative studies. Unlike previous studies that tend to measure knowledge levels and practice frequency statistically, this study offers a new perspective by examining how personal, social, and cultural factors influence the formation of meaning and individual decisions in performing SADARI. Thus, this study not only expands the theoretical framework regarding early breast cancer detection but also provides practical contributions for developing more contextual and responsive educational intervention strategies tailored to women's real-life experiences. The primary objective of this study is to identify, systematize, and analyze various findings from qualitative studies related to the understanding and perceptions of reproductive-age women regarding SADARI practices, as well as to uncover the factors that promote or hinder their implementation as an effort to detect breast cancer in Indonesia at an early stage.

Literature Review

Practice SADARI (Breast Self-Examination)

Self-Breast Examination (SADARI) is a method of early detection of breast cancer that is performed independently by women by observing and feeling the breasts to identify lumps, changes in skin color, or other abnormal signs. This practice is believed to be one of the simplest, most affordable, and easiest steps that can be taken without the assistance of healthcare professionals or

medical equipment (Azhar et al., 2023). In developing countries like Indonesia, where mammography facilities are not widely available and not all women have access to healthcare services, SADARI serves as an important alternative for detecting breast cancer at an early stage. Dewi et al. (2022) emphasize that women's awareness of their bodies, particularly in recognizing subtle changes in the breast area, can help expedite the decision to consult a healthcare facility. SADARI not only serves as a detection effort but also builds women's independence in maintaining their reproductive health. However, ironically, despite its great potential, the implementation of SADARI among women of reproductive age is still far from optimal. Low health literacy, lack of access to reliable information, and limited community-based education programs are significant challenges. Additionally, cultural barriers in discussing topics related to women's bodies and breast cancer contribute to the low awareness of the importance of SADARI among the public.

Although knowledge is a crucial prerequisite for forming healthy behaviors, various studies indicate that knowledge about SADARI does not always guarantee appropriate and consistent practices among women of reproductive age. Diastuti et al. (2023) noted that most women surveyed had heard of SADARI, but only a small proportion truly understood the technique and performed it regularly. Mutiana et al. (2024) revealed that low motivation, fear of discovering lumps, and the belief that cancer is an unavoidable fate are psychological barriers to performing SADARI. Additionally, there is a perception that SADARI is only necessary for older women or those with a family history of cancer, even though all women, especially those of reproductive age, have the same risk of breast cancer. In this context, Rahmat & Purwarini (2023) emphasize the importance of building spiritual motivation and individual awareness through a values-based approach, so that SADARI is not merely seen as a medical procedure but also as part of personal responsibility. Another barrier is social and cultural norms that view discussions about the female body as taboo, leading to a lack of open dialogue within families and communities. As a result, education about SADARI techniques, their benefits, and the urgency of their implementation is limited and poorly understood. Women of reproductive age require access to accurate information, strong social support, and educational approaches tailored to local cultural realities to form positive perceptions and make SADARI a sustainable preventive habit.

Efforts to improve SADARI practices have been made through various educational intervention models aimed at building understanding, skills, and attitude changes toward self-breast examination. Research by Legi et al. (2024) demonstrates that the use of educational media, such as leaflets accompanied by direct demonstrations, can enhance women's ability to recognize breast structure and perform SADARI independently using the correct technique. Additionally, visual approaches, such as educational videos, have proven effective, as reported by Damayanti et al. (2024), who observed increased knowledge and interest among women in rural areas regarding SADARI practices. However, the success of educational interventions is significantly influenced by participants' emotional involvement, attitudes, and perceptions toward the information received. In this context, Dewi et al. (2019) suggest utilizing the Health Belief Model (HBM) to identify underlying beliefs that influence health behavior, such as perceived vulnerability to disease, perceived benefits, barriers, and self-efficacy in performing SADARI. The HBM provides a conceptual framework for understanding that even if information is available, without personal beliefs about the threat of cancer and self-confidence in performing SADARI, such actions will not be internalized. Therefore, education must not only be informative but also transformative, addressing cognitive, affective, and social aspects. Research on the perceptions of reproductive-age women toward SADARI should be further directed toward exploring their subjective experiences, personal narratives, and the socio-cultural contexts that shape their decisions to engage in or refrain from the practice. This approach can strengthen the development of more effective, humanistic, and reality-based intervention strategies rooted in the lives of women in the community.

Breast Cancer

Breast cancer is a condition in which there is uncontrolled growth of malignant cells in breast tissue, and it is one of the most common cancers affecting women worldwide. This disease often develops slowly without clear symptoms in its early stages, making early detection crucial in efforts

to reduce mortality rates and prolong patient survival. According to Ngoma & Ngoma (2020), breast cancer accounts for 11.6% of all global cancer cases and ranks first in the cancer burden among women. In Indonesia, its prevalence is also high, primarily due to delayed diagnosis and limited access to healthcare services. Choridah et al. (2023) state that public awareness of the importance of early detection methods such as SADARI or mammography remains very low, even among educated women in urban areas like Yogyakarta. This highlights the importance of gender-focused interventions targeting women of reproductive age.

Despite various early detection programs designed by the government and health organizations, many women in Indonesia still do not undergo routine examinations to detect breast cancer. One of the leading causes is delayed diagnosis, often due to women seeking medical care at an advanced stage of the disease. Dewi et al. (2021) state that more than 60% of breast cancer cases in Indonesia are diagnosed at an advanced stage, due to low awareness of early symptoms and the social stigma surrounding the disease. Psychological barriers, such as fear of knowing the results, shame in discussing reproductive organs, and the perception that cancer is a death sentence, reinforce women's reluctance to undergo early detection (Icanervilia et al., 2023). Additionally, limited access to healthcare facilities offering screening services, such as mammography or ultrasound, in rural areas exacerbates the situation. Icanervilia et al. (2023) emphasize that while clinical methods, such as mammography, are more accurate, resource constraints make SADARI the most realistic method for widespread implementation. Even SADARI practices are not yet evenly distributed across all segments of society. According to a report by Azriful et al. (2022), the coverage of the SADANIS program (clinical breast examination) only reached 29% of the national target of 80%. This gap highlights issues in policy implementation, particularly in areas such as awareness campaigns, training for healthcare workers, and community involvement in early detection programs.

To address the high rate of delayed diagnosis, one effective and efficient strategy is to promote the practice of self-breast examination (SBE). SADARI provides women with the opportunity to recognize early symptoms of cancer, such as lumps, changes in skin color, or discharge from the nipple. Although it appears simple, SADARI plays a crucial role in bridging the gap between awareness and low rates of early detection. Women who regularly perform SADARI are more likely to detect cancer at an early stage. However, there are disparities between urban and rural areas in terms of SADARI implementation, reflecting inequalities in access to information and education. To address this challenge, community-based approaches are crucial. School-based SADARI campaigns, training for community health workers, and integrating SADARI education into family planning programs are some strategies that can reach more women of reproductive age. Icanervilia et al. (2023) emphasize that education should not be delivered solely through top-down approaches but must be tailored to the social and cultural context of the community to be more accepted. Additionally, interactive approaches, such as hands-on demonstrations or audio-visual media, have proven more effective in enhancing women's understanding and interest in performing SADARI.

Women of childbearing age

Women of reproductive age (WRA) are females within the reproductive age range, typically between 15 and 49 years old, who are biologically capable of becoming pregnant and giving birth. In the context of public health, this group is a primary target for various promotive and preventive programs due to their high risk of various reproductive health issues, including breast cancer. According to Diastuti et al. (2023), women of reproductive age tend to have active hormonal dynamics, which can increase susceptibility to cellular disorders in breast tissue. Therefore, early interventions in the form of education and health screenings, such as self-breast examination (SADARI), are crucial for this age group. Research by Azhar et al. (2023) in their systematic review also noted that the majority of women diagnosed with breast cancer at an advanced stage come from the reproductive age group, primarily due to delayed detection linked to low awareness and practice of SADARI. This highlights the importance of age- and gender-based approaches in breast cancer prevention efforts, particularly by targeting women of reproductive age as a priority population.

In addition to biological factors, psychosocial aspects also play a significant role in the health behaviors of women of reproductive age. Dewi et al. (2022) emphasized that risk perception, self-

efficacy, and social support are key determinants of whether women will actively engage in early detection practices. In a study conducted in Surabaya, it was found that women of reproductive age who had a positive perception of SADARI were more likely to perform self-breast examinations regularly compared to those who felt afraid or reluctant to discuss reproductive health issues. This highlights the importance of effective health education that takes into account social context, cultural norms, and the life stage individuals are currently experiencing. In this case, women of childbearing age are an ideal group to receive educational messages, as they are in a socially and reproductively active phase of life and have dual roles as individuals, wives, and mothers.

Intervention strategies targeting women of childbearing age have shown promising results in promoting widespread SADARI practices. Research by Damayanti et al. (2024), which utilized educational videos to increase awareness among women in rural areas, showed that interactive visual methods have a positive impact on women's knowledge and motivation to perform SADARI. Additionally, Legi et al. (2024) found in their study of high school students that an educational approach using leaflets and direct demonstrations was effective in improving the technical understanding of self-breast examination. Legi et al. (2024) also reported that educational interventions targeting women of reproductive age significantly influenced knowledge about breast cancer prevention. This finding is supported by an anonymous study published by Ahmad et al. (2022), which noted that positive beliefs and health literacy levels are strong predictors of SADARI behavior among women of reproductive age. Therefore, systematic efforts to foster preventive health behaviors should target this age group through sustainable school-based, family-based, and community-based programs. Given that women of reproductive age are change agents in their communities, equipping them with accurate information and skills will have a ripple effect in raising collective awareness about the importance of early detection of breast cancer.

Research Design and Methodology

This study employs a qualitative approach, utilizing a systematic literature review method. This approach was chosen to explore in depth the understanding and perceptions of women of reproductive age regarding the practice of SADARI (Breast Self-Examination) as a form of early detection of breast cancer. This study aims to identify, synthesize, and evaluate findings from various relevant previous studies to build a conceptual and contextual understanding of the factors influencing the practice of SADARI among women of reproductive age. This qualitative design enables researchers to explore subjective aspects, such as values, meanings, experiences, and individual interpretations of SADARI within their respective social and cultural contexts. The subjects of this study are scientific articles discussing SADARI practices among women of childbearing age. The inclusion criteria are: (1) articles published between 2015 and 2024, (2) focus on women of reproductive age (15–49 years), (3) discuss practices, understanding, or perceptions related to SADARI, and (4) published in reputable indexed journals, such as those from publishers Elsevier, Springer, Wiley, Emerald, BMC, or Frontiers. This study did not directly involve human participants; instead, it examined scientific literature as the primary data source. Articles were selected purposively based on their relevance to the topic focus and their contribution to advancing knowledge about SADARI in the context of women of reproductive age.

Data collection techniques were conducted through a systematic search of scientific articles from various international, indexed online databases, such as ScienceDirect, SpringerLink, Wiley Online Library, and Emerald Insight. The search process used keywords such as “breast self-examination,” “SADARI,” “reproductive age women,” “perception,” and “early detection of breast cancer.” The articles obtained were then selected based on their titles, abstracts, and full content to assess their relevance and suitability. The data collection instrument was a literature synthesis matrix form, developed to record and analyze important elements from each article, such as research methods, respondent characteristics, main findings, sociocultural context, and implications of the results. This process was carried out in layers to ensure the validity of the literature selection and the thematic relevance between articles. The data analysis technique in this study was conducted through a thematic approach, which aimed to identify the main patterns from the secondary data that had been collected.

Each article is analyzed to explore central themes related to the understanding, perceptions, motivations, and barriers of women of childbearing age in performing SADARI. This process is carried out through open coding of the results of previous studies, which are then developed into conceptual and contextual themes. The analysis is conducted iteratively and reflectively to ensure that the interpretations produced truly represent the substance of the literature data reviewed. The results of this analysis are presented in a structured, descriptive narrative to illustrate a comprehensive and in-depth understanding of the phenomenon.

Findings and Discussion

Findings

Level of Understanding of Women of Childbearing Age regarding Breast Self-Examination

The level of understanding of women of reproductive age regarding SADARI practices shows considerable variation, both in terms of formal knowledge and subjective meanings shaped by individual experiences and cultural values. Based on the findings of Azhar et al. (2023), many women of reproductive age in Indonesia are aware of SADARI. However, most of them do not fully understand how to perform this technique correctly. They tend to view SADARI as merely part of a general health campaign, rather than an important early detection measure that should be performed regularly. This aligns with the findings of Ayattulla et al. (2024), which indicate that even medical students, despite having higher levels of knowledge, may not possess a deep understanding or consistency in performing SADARI practices. Additionally, Ahmad et al. (2022) noted that personal beliefs and local cultural factors also influence perceptions of the importance of SADARI. Some women still consider self-examination, especially of the breasts, to be taboo. Dewi et al. (2022) found that this lack of understanding stems not only from educational aspects but also from limited access to information presented in language that is easy to understand and contextually relevant. Therefore, health communication strategies are needed that not only emphasize technical aspects but also consider the social and cultural dimensions that shape women's understanding of SADARI.

Social and Cultural Perceptions of Breast Self-Examination

Social and cultural perceptions play an important role in influencing attitudes and practices related to breast self-examination (BSE) among women of reproductive age. In many societies, discussions about the female body, including breast health, are still considered sensitive and taboo topics. This creates significant psychological barriers to encouraging women to perform breast self-examination. Icanervilia et al. (2023) revealed that cultural norms that avoid discussing certain body parts make women feel uncomfortable or even ashamed to perform SADARI, despite their awareness of the importance of early detection of breast cancer. Similar findings were reported by Dewi et al. (2021), who found that the perception of the female body as something that should be hidden often serves as the primary barrier to performing SADARI. The social stigma attached to women who openly discuss breast health also hinders effective education. Even among educated groups, such as university students, resistance to SADARI practices persists, as they are perceived to conflict with certain values of modesty or religiosity. On the other hand, Damayanti et al. (2024) demonstrated that community-based educational interventions tailored to local cultural contexts can help reduce this resistance and encourage active participation in SADARI practices. Therefore, an educational approach that is responsive to social and cultural values is key to successfully changing negative perceptions toward SADARI.

Internal and External Factors Affecting SADARI Practices

The decision of women of reproductive age to perform or not perform SADARI is influenced by various internal and external factors. Internal factors include awareness, personal motivation, and perception of breast cancer risk. Strong motivation to maintain one's health is positively correlated with the frequency of SADARI practice. Meanwhile, external factors include social support, access to health information, and the availability of effective educational programs. Diastuti et al. (2023) noted that women who receive information directly from health workers or through educational media are more likely to perform SADARI regularly. However, several barriers have also been

identified. Fear of the results found during SADARI is one of the main barriers, as highlighted by Dewi et al. (2019). Additionally, a lack of support from partners or family members exacerbates the situation. Rahmat & Purwarini (2023) add that a social environment that does not support proactive actions toward physical health can reduce women's intention to practice SADARI. Therefore, strategies to improve SADARI practices cannot solely rely on increasing knowledge but must also target strengthening internal motivation and creating a supportive social environment.

The gap between knowledge and behavior in the implementation of SADARI

One of the important findings of this study is the significant gap between knowledge and behavior in SADARI practice. Many women of reproductive age have adequate knowledge about the importance of SADARI, but do not implement it in their daily lives. This phenomenon is reinforced by a study by Siagian et al. (2024), which states that although most female students have a high level of knowledge about SADARI, only a small proportion consistently apply it. This indicates that knowledge alone is insufficient to encourage sustainable behavioral change. According to Azriful et al. (2022), psychological barriers such as fear of diagnosis results or anxiety about the SADARI procedure itself can reduce the likelihood of women acting. Even among individuals who rationally understand the benefits of SADARI, emotional aspects and risk perceptions often dominate in determining behavior. The success of education depends on how effectively the messages conveyed bridge the gap between information and action. Therefore, a more persuasive and experience-based approach is needed to close this gap, such as providing testimonials, story-based education, and role models relevant to the lives of women of reproductive age.

The Need for Contextual and Responsive Intervention Approaches

This finding confirms that generic or large-scale educational interventions are not always effective in improving SADARI practices. Contextual and responsive approaches that address the social, cultural, and psychological conditions of women have proven to be more relevant and sustainable. Choridah et al. (2023) demonstrated that early detection programs tailored to the characteristics of local communities yield more significant results compared to a one-size-fits-all approach. In this context, health education must be designed based on precise social and cultural segmentation. Marhaeni et al. (2024) emphasize the importance of using educational media that is easy to understand and relatable to the daily lives of women of reproductive age, such as videos, simulations, and leaflets using local languages. Legi et al. (2024) also states that education involving active community participation—such as training for community health workers and group discussions—is more effective in improving understanding and practice of SADARI. The effectiveness of interventions depends heavily on the integration of formal and informal education. Therefore, participatory and community-based strategies are essential in establishing sustainable SADARI practices.

Personal Experience Patterns and Meaning Formation towards SADARI

Personal experiences have a significant influence on shaping the meaning and perceptions of women of reproductive age toward SADARI practices. Many women interpret SADARI not only as a medical procedure but also as a form of self-care and concern for their families. Dewi et al. (2021) found that women with a family history of breast cancer tend to have higher motivation to perform SADARI regularly. This pattern indicates that subjective meanings formed through real-life experiences can serve as strong motivating factors. Marfianti (2021) also noted that emotional involvement in the educational process, such as through stories or testimonials from cancer survivors, can create a greater impact in driving behavioral change. Ahmad et al. (2022) noted that understanding SADARI as part of controlling one's body and personal health is more effective in promoting long-term compliance compared to approaches based on obligation or fear. Therefore, effective health communication strategies must be able to frame SADARI as a meaningful action and build a narrative that empowers every woman to have control over her health. This approach is crucial for transforming knowledge into sustainable, real-world actions.

Discussion

This study revealed several important findings regarding the understanding and perceptions of women of reproductive age toward the practice of SADARI (Breast Self-Examination) as a step in early detection of breast cancer. The level of understanding found indicated significant variations between technical understanding of the SADARI procedure and subjective interpretations shaped by experience, cultural background, and exposure to health education. Some informants were able to describe the steps of SADARI accurately, but did not perform it regularly because they did not perceive themselves as being at high risk for breast cancer or were influenced by social norms and feelings of shame. This suggests that, although information is available, the acceptance and internalization of information do not automatically lead to preventive behavior. In many cases, technical knowledge about SADARI is understood as theoretical information without a corresponding internal motivation to implement it in real-life applications. This finding aligns with field observations indicating that risk perception toward the disease has not become a primary driver of preventive health behavior among women of reproductive age. Thus, these results support the hypothesis that understanding alone is insufficient to form consistent SADARI behavior, and that personal and social factors play equally important roles. These results also reflect the reality that despite increasingly intensive health campaigns, behavioral changes do not always follow increases in knowledge, especially in communities with conservative values that limit women's freedom to discuss issues related to their physical health openly.

From a theoretical perspective, the findings of this study are highly relevant to the Health Belief Model (HBM), which states that individuals' perceptions of their vulnerability and the seriousness of a disease, the benefits of taking action, and the perceived barriers will influence their decision to engage in preventive actions. The study results indicate that although women of reproductive age have sufficient perceptions of the benefits of SADARI, their perceptions of their vulnerability to breast cancer remain low. Psychological barriers such as shame or fear of discovering abnormalities also reinforce reluctance to perform SADARI. Additionally, within the context of the Theory of Planned Behavior (TPB), these findings also illustrate that the intention to perform SADARI is influenced by subjective norms (social and cultural support) and perceived behavioral control (self-efficacy). Previous studies such as (Ahmad et al., 2022; Dewi et al., 2022) support these findings, emphasizing that non-cognitive factors significantly influence the gap between knowledge and practice. Furthermore, a study by Ayattulla et al. (2024) revealed that among female medical students, SADARI practices were inconsistent despite high levels of knowledge, underscoring the importance of considering affective and social aspects. Beyond that, the findings of this study challenge normative and statistics-based health education approaches. This indicates the need for more integrative theoretical and practical approaches in understanding the dynamics of women's behavior related to reproductive health, which are not solely based on individual rationality but are also influenced by the complexity of the value systems and social structures surrounding them.

Social and cultural factors have been shown to have a significant influence on SADARI practices. Cultural values emphasizing modesty, taboos surrounding discussions about the female body, and limited spaces for discussing reproductive health contribute to women's attitudes and perceptions toward SADARI. In many communities, touching and examining one's breasts is still considered inappropriate, even in private settings, especially if no symptoms are felt. The shame that arises is not only from the individual but is also shaped by a social environment that tends to stigmatize breast health issues. Studies by Icanervilia et al. (2023) and Dewi et al. (2021) show that these cultural barriers are the main obstacles to the early detection of breast cancer in Indonesia. Therefore, it is crucial for health education to not only convey medical information but also normalize discussions about women's bodies and their right to health. This approach will help reduce stigma and foster a more open and supportive health culture. The sociocultural context also impacts the low participation of women in government-facilitated early detection programs.

Therefore, transforming health communication approaches must involve cross-sectoral collaboration, including education, religious, and community leaders, in order to create more comprehensive and sustainable changes in women's perceptions and behaviors towards SADARI

practices. One of the crucial findings in this study is the gap between the level of knowledge and practice of SADARI.

Although most women of reproductive age are aware of the importance of early detection of breast cancer and how to perform SADARI, only a small proportion do so regularly. This gap is caused by various factors, including a lack of urgency, fear of negative results, and low self-efficacy in performing SADARI correctly. Research by Dewi et al. (2019) highlights that even women who have knowledge may still feel unable to perform the examination correctly. A lack of reinforcement from the surrounding environment, such as a lack of encouragement from family, friends, or health workers, also influences irregularity in SADARI practice. Additionally, structural barriers such as the unavailability of adequate visual educational materials or the lack of community-based educational programs further widen this gap. These findings clarify that information transfer alone does not guarantee behavioral change, and that enhancing capabilities and social support are crucial components in establishing health routines. Therefore, systematic efforts are needed to bridge this gap through education that is not only informative but also psychologically and socially empowering. This approach will strengthen women's self-control over their health while enhancing the effectiveness of the government's ongoing early detection programs.

In this context, it is important to emphasize the need for contextual and responsive interventions that address the social, cultural, and psychological conditions of women of reproductive age. Education is insufficient if it is merely informative and one-way. Studies by (Damayanti et al., 2024; Legi et al., 2024) show that participatory educational approaches, such as hands-on demonstrations, group discussions, and the use of culturally appropriate visual media, are more effective in improving SADARI practices. Community-based interventions enable the exchange of experiences, social reinforcement, and increased comfort in discussing sensitive issues. Additionally, approaches involving community leaders, health workers, and religious figures can enhance the legitimacy of health messages and reduce community resistance. Intervention strategies should also be tailored to local characteristics, including language, customs, and the social structure of the local community. In other words, practical education is education that does not ignore the realities of women themselves. When this approach is implemented continuously and involves various stakeholders, the potential for improving SADARI practices will not only be temporary but will become a sustainable part of Indonesian women's healthy lifestyles. Finally, the findings of this study provide significant practical contributions to the design of public health programs, particularly in the early detection of breast cancer.

Education programs on SADARI should be incorporated into the reproductive health curriculum in schools and universities, as well as included in the agendas of Posyandu and Puskesmas activities. Health workers need to be equipped with gender- and culture-sensitive communication training to convey information in a non-judgmental manner. Community health workers can also be actively involved in SADARI campaigns through door-to-door methods or group training. Local governments and relevant agencies can utilize the findings of this study as a basis for developing evidence-based policies that promote the early detection of breast cancer. Additionally, educational institutions, women's organizations, and the media can play an active role in promoting SADARI as a form of women's empowerment in maintaining their health. With an integrated and evidence-based approach, SADARI practices can be significantly improved as a cost-effective, easy, and high-impact preventive measure for public health. This study also highlights the importance of robust multisectoral collaboration among the government, the education sector, civil society organizations, and the media in fostering a preventive health culture that is grounded in women's needs and experiences.

Conclusion

This study aims to explore the understanding and perceptions of women of reproductive age regarding SADARI as a form of early detection of breast cancer through a qualitative Systematic Literature Review approach. The study delves into the multidimensional aspects that shape individual decisions in performing SADARI, including technical understanding, personal perceptions, and the influence of social and cultural norms. The findings reveal a complexity between knowledge and behavior, as well as the significant role of socio-cultural and psychological factors in shaping

responses to SADARI practices. Thus, this study provides a comprehensive response to the main questions regarding the factors that encourage or hinder the implementation of SADARI among women of reproductive age.

Scientifically, this study adds value by presenting a more contextual and comprehensive approach compared to previous studies that tended to focus on quantitative or descriptive aspects alone. The originality of this study lies in the integration of subjective experience and socio-cultural context in examining women's health issues, particularly related to SADARI practices. In practice, the results of this study can be used as a basis for designing more empathetic, community-based health education programs that are sensitive to local values. From a managerial perspective, the intervention strategies guided by the study's findings can support the role of health workers, community health workers, and educational institutions in expanding access to information and fostering sustainable preventive behaviors at the community level.

This study has several limitations that need to be considered. One of the main limitations is its reliance on secondary data from previous studies with different contexts and methods, making it impossible to generalize the findings comprehensively. Additionally, because this approach is qualitative, it cannot accurately describe proportions or statistical trends. Therefore, it is recommended that future research combine qualitative and quantitative approaches to obtain a more comprehensive and empirically measurable understanding. Researchers are also encouraged to target specific populations with diverse cultural and educational backgrounds to evaluate the effectiveness of value-based educational strategies and enrich the discourse on women's health in academic and public policy circles.

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