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Barriers in cancer risk reduction in community in Indonesia: a qualitative study

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ABSTRACT

Integrated development post of non-communicable diseases (*Posbindu penyakit tidak menular*/PTM) is one of the strategies implemented by the MOH of Indonesia for prevention, screening, and early detection through community empowerment and community involvement in reducing the number of non-communicable diseases (NCDs), including cancer. This study aimed to explore the barriers to reducing the risk of cancer. Twelve participants were involved in this study using in-depth interviews and participant observations. All the interviews and discussions were recorded using an audio tape recorder and also using field notes, and then a transcript was transcribed verbatim. Five themes emerged namely providing funding for the program, obtaining appropriate support from the government based on the community's needs and a health workforce shortage, sharing and discussing the health information, and cultural practices of the community as barriers to reducing the risk of cancer in the community. The study results can be used as evidence to develop and sustain effective strategies to address the barriers to reducing the risk of cancer in communities in Indonesia.

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1. INTRODUCTION

Cancer is a leading cause of morbidity and mortality in all countries, it is estimated 19.3 million cancer and almost 10.0 million occurred in 2020 [1]. By 2018, the increasing burden of cancer is higher in countries with high human developing index (HDI) than in low or medium HDI around 2-3 times higher [2], and cancer in Asia was around 49.3% of total cancer incidence estimated 169.1 per 100.000 persons [3]. However, 3 types of cancer show different preventable in low, medium, or HDI, sequentially: lung cancer was preventable in medium to very high countries, cervical cancer in low HDI countries, and colorectal and breast cancer were in all four tiers of HDI [4]. GLOBOCAN 2018 reported that the incidence of cancer in Indonesia is 348,809 cases (136.2/100,000 population) and that the number of cancer deaths was 207,210 cases (84.1/100,000 population), including breast, cervix uteri, lung, colorectum, and liver cancers as the most frequent cancers [2]. On the other hand, cancer prevalence in Indonesia increased from 1.4 per million

in 2013 to 1.8 per million in 2018 [5]. Thus, the burden of health expenditures for cancer as a catastrophic disease in Indonesia is one of the highest for national health insurance [6].

Every person has a possible risk for cancer, and having one or more risk factors does not mean that a person will develop cancer; however, several risk factors have been proven to have increased risks of cancer growth, such as tobacco use, lack of physical activity, poor nutrition, excessive alcohol consumption, and the risk factors are rising vastly at early midlife [7]. The risk for cancer is different for each type of cancer, and it is influenced by life span. More than three-fourths of cancer incidence and one-third of cancer deaths have been associated with behavioral lifestyle factors [8], including aging and socioeconomic factors [9]. In 2010, Indonesia's aging population was almost 5% of the population, which is expected to increase to 11% [10].

Globally, there are two strategies to decrease cancer incidences, which are risk reduction and screening and early detection [11]. Primary risk reduction is the first step to decreasing the development of cancer by changing modifiable risk factors. The purpose of primary risk reduction is to reduce exposure to carcinogens and self-awareness of risk factors, including a healthy diet, weight management, regular exercise, reduction in alcohol consumption, and smoking cessation [12], [13]. Avoiding risk factors and/or changing behaviors and lifestyles are most effective regarding cost and a long-term strategy to control cancer [14].

Most people are not aware of the risks of non-communicable diseases (NCDs), particularly cancer. Therefore, the active involvement of healthcare providers, volunteers, and other related stakeholders is needed to reach the target population for the monitoring and early detection of risk factors of NCDs. The Ministry of Health of the Republic of Indonesia has developed a Strategic Plan of the Ministry of Health 2015-2019 by focusing on health promotion and prevention programs to achieve the National Medium-Term Development Plan 2015-2019 of the Republic of Indonesia [15]. One of the programs is integrated development post of non-communicable diseases (*Posbindu penyakit tidak menular*/PTM). *Posbindu* PTM, developed in 2011, is a community-based health strategy at the district level that aims to increase community participation in early detection, screening, monitoring, and controlling NCDs risk factors, which are carried out in integrated, routine, and periodic activities [16], [17]. In *Posbindu* PTM, early detection is performed by a healthcare provider as well as through community involvement by identifying the level of risk factors for community members as a low risk, medium risk, or high risk of NCDs. For cancer screening, this program focuses on the highest incidences: cervical cancer and breast cancer. The target population of *Posbindu* PTM is healthy people, people at risk, and people with NCDs or degenerative diseases aged 15 years or older. Several studies have discussed the barriers to conducting *Posbind*u PTM in the community in Indonesia; Majority of research focused on particular issues i.e hypertension, stroke, and diabetes mellitus; however, to date, limited studies have discussed or reported the *Posbindu* PTM program specifically for cancer risk reduction [18]. Also, several studies discussed reducing risk factors with changing behaviors and lifestyles to explore the barriers faced by the community to reduce the risk of cancer through the *Posbindu* PTM program in Indonesia. Understanding the barriers in the community is pivotal in order to ensure the program and strategies following *Posbindu* PTM worked to reduce the risk of cancer. We report findings from an ethnographic study that was conducted from various 12 participants within the period October 2017 to June 2018. This study aimed to explore how the community faced the barriers to cancer risk reduction in Indonesia. To our knowledge, this is one study in Indonesia that explores the barriers to cancer risk reduction through community elements, healthcare providers, residents, and heads of neighborhoods. The present study highlights the cultural, social, and economic factors that might help the community face the barriers to cancer risk reduction in Indonesia.

2. METHOD

2.1. Study design

A critical ethnography was used to explore and understand the barriers to implementing cancer risk reduction in the community through the *Posbindu* PTM program. Thomas [19] explained that critical ethnography is an ethnography approach that examines culture, knowledge, and efforts to enhance positive social changes It is essential for researchers to thoroughly understand culture, beliefs, and social behaviors based on a variety of participant viewpoints in communities in relation to efforts to reduce the risk of cancer for future improvements in the health of a community. This study was approved by the Ethical Review Board of Khon Kaen University (No. HE602164).

2.2. Participants and setting

Purposive sampling was used to select the participants in this study. The inclusion criteria for participants included being actively involved in the *Posbindu* PTM activities for a minimum of one year. In this study, data saturation was achieved when there was no new additional information gained from the participants and the researcher did not find a new perspective regarding a given issue [20]. Sampling is not always about the

amount of participants, but it enhances the quality of the data to see the phenomena, then there is no one-size-fits-all method in order to achieve the saturation of data [21]. Twelve participants participated in this study, consisting of four healthcare providers, four health volunteers, and four neighborhood leaders because efforts devoted to cancer risk reduction in a community require cooperation between people, the community, the government, cross sectors, and NGOs as well as other related stakeholders. The 12 participants were responsible for collaborating to implement the *Posbindu* PTM program in the community. The characteristics of the participants were as follows. There were four males and eight females with ages ranging from 32 to 65 years. All participants were married, of which three participants were housewives. Other participants were government and private employees, a pensioner, a teacher, a mechanic, and a motorcycle taxi driver. All the participants signed informed consents as an agreement to be involved in this study, and they could opt out at any time.

This study was conducted in one of the urban villages in Palembang Municipality that had an active *Posbindu* PTM program under coordination with the public health center (PHC) of *Pembina* Palembang, South Sumatera, from October 2017 to June 2019. A grand tour was conducted to become familiar with the community and to select the gatekeeper. The researcher selected the gatekeeper (female, 40 years, the secretary of a neighborhood leader of 26) to assist in selecting participants.

2.3. Data collection

Participant observations and in-depth interviews were used in this study. The researcher attempted to bracket or control for the interpretation of the observation results by joining the participant activities without any added personal explanations or interpretations to the result of participant observations. Observational data collected by the researcher were used to analyze the activities related to cancer risk reduction in several settings, including *Posbindu* PTM activities, activities at the home and traditional market, physical activities of *Posbindu* PTM, wedding party activities, and Islamic celebration activities (Idul Fitri). During participant observations, the researcher conducted general observations by building trusting relationships with people in the community and then documenting them in field notes to analyze participant observations, interactions, and experiences related to reducing the risk of cancer. The field notes were expanded after collecting participant observations into a transcript verbatim as soon as possible to avoid memory loss of the experiences.

In-depth interviews were conducted for 45-50 minutes for each participant, and open-ended questions following the interview guidelines were used. The interview guidelines were developed by the researcher and the expert (qualitative expert), whereas the questions were developed by the researcher based on the participants' answers. The questions and answers were relevant to the research question and to the aims of study. When there were questions that previous participants were not asked, the researcher returned to the previous participants to ask and to develop other questions until achieving the saturation of the answers.

Bahasa Indonesia (Indonesia Language) was used during the interviews, which began with an open-ended question: Would you mind sharing your experiences during the implementation of the *Posbindu* PTM program that aimed to reduce the risk of cancer? This was followed by other questions: What makes the program run well? Were there any obstacles during the program's implementation? How did you address the emerging problems? The interviews took place in the participants' homes and workplaces and during *Posbindu* PTM activities. Most of the participants were interviewed unaccompanied with only the participant and the researcher present during the interview. All the interviews and discussions were recorded using an audio tape recorder and also using field notes, and then a transcript was transcribed verbatim. To ensure the participants' answers were accurate, the transcript that was transcribed verbatim was returned for correction to reduce missed data.

2.4. Data analysis

A thematic analysis was chosen for this study. It was performed by organizing the data into transcripts, including data from the in-depth interviews and participant observations. The recorded interviews were transcribed as soon as possible after the completion of each interview. The researcher attempted to become immersed in the data by reading the data transcripts and field notes of participant observations at least twice. The researcher read the data and coded them individually, word by word, and line by line to identify the initial coding based on the quotes of the participants without any additional words or meaning changes. The data were arranged into codes that described the participants' statements. The researcher then listed all the categories and grouped them into similar meanings. The researcher developed subcategories and categories of similar data based on the raw data from the initial coding. The names given to themes or categories were chosen according to the existing data to provide an understanding for other researchers or readers. Lastly, a thematic analysis was performed to identify and to develop the themes, and all data were saved in Microsoft word. When analyzing the data, the researcher always consulted the qualitative expert and made corrections and revisions according to the advice given. As a final step, the researcher shared the results with the participants to obtain feedback on the findings.

2.5. Trustworthiness

The trustworthiness of a study describes the quality of the data, interpretation, and methods used in the study, consisting of credibility, transferability, dependability, and conformability. Prolonged engagement, triangulation (data and expert), and member checking (the researcher crosschecked with the participants for the results of the transcription based on the participants' answers recorded in the voice recorder) were used to achieve the credibility. Transferability refers to findings that could be used in other settings with the same results, and thick description with detailed description during interviews is used to achieve it. The researcher also asked for permission to follow their daily activities and to make field notes during the participant observations, which allowed for recording detailed descriptions of their activities that aimed to reduce cancer risks. Reflexivity was used to achieve conformability (findings that represent the participant's perspective and not the researcher's views) by reading and rereading the results beginning from the initial coding, categorization, and themes several times to ensure the results reflected the participants' descriptions.

3. RESULTS AND DISCUSSION

The results of this study revealed five categories of barriers to cancer risk reduction through *Posbindu* PTM in Indonesia as follows: providing funding for the program, obtaining appropriate support from the government based on the community's needs, a health workforce shortage, sharing and discussing the health information, and cultural practices of the community.

3.1. Providing funding for the program

Financial problems were one of the barriers in cancer risk reduction for *Posbindu* PTM implementation. Financing is needed to continue and to improve the program in the community, such as for preparing and providing foods and beverages to attract people's attention to join and to follow the *Posbindu* PTM program, providing fees/salaries for healthcare volunteers, and for screening and early detection. The limited budget of the program led to many activities being conducted inappropriately. Consequently, the healthcare providers had to merge several programs by setting up a similar time the schedule for *Posbindu* PTM, integrated service post for children under five years (*Posyandu balita*) and integrated service post for elderly (*Posyandu lansia*). In addition, to entice more people to join the program, food and beverages were provided during the implementation of *Posbindu* PTM as needed:

> *"We* must *manage the money to provide weaning food for children under five years old. We also allocate that money to provide some snacks and beverages for the healthcare providers. We have to manage little money from "dana sehat.""* (P8_Vol)

> *"Rp 2,000 was used for the mineral water, "tekwan," and other foods. Those who have no money do not have to pay. We are not pushing for payment."* (P10_RT)

> *"In fact, financial problems turn into the obstacles. All activities could be running well with sufficient funds."* (P1_HCP)

Nonetheless, no budget plan was provided by the public health center (PHC) or the government. To solve the problems, they agreed to donate a voluntary fee, or "*dana sehat*," to keep the programs running and operating properly. Unfortunately, the "*dana sehat*" could not cover all the *Posbindu* PTM program needs, i.e., providing food and beverages for the participants to entice people to engage in *Posbindu* PTM activities:

> *"The fee from the visitors will be allocated to the snacks provided during the Posbindu program. The snacks may be for the cadres or the patients. Even in some circumstances when many patients come, the healthcare service is still free of charge.* (P4_HCP)

> *"However, if we only got Rp 20,000, what would we like to buy? The voluntary fee "dana sehat" will not be enough to buy them all, so I used my own money to cover it every month."* (P5_Vol)

Support from the local government was suggested to seek the help of certain donors near the area; however, few people were willing do this, and they preferred donating money to the orphanage rather than for the continuity of the healthcare program.

> *"Honestly, finding donors in this area was difficult. People…they still think that it is better for them to donate their money for the orphans or orphanage instead of for voluntary fees in Posyandu because of the direct benefits they will get by doing so."* (P8_Vol)

3.2. Appropriate support from the government based on the needs of the community

Government support was any support from the local government used for the cancer risk reduction program to operate well. To achieve the government's visions and goals, good cooperation from all government levels and related stakeholders is required. In contrast, while the *Posbindu* PTM implemented, it became more difficult, and the field officers faced many obstacles and barriers during the implementation of *Posbindu* PTM.

> *"If I could "knock on the door" of the Ministry of Health, I would suggest to them that they must do the observation in the field directly to determine how the program should be run so that they can develop an advanced program."* (P1_HCP)

For instance, the implementation of the *Posbindu* PTM program required much more support from the urban village government as well as inter-sectional cooperation; however, there was no follow-up program conducted by the local government after the *Posbindu* PTM program had been implemented. In addition, it did not provide any equipment for *Posbindu* PTM activities. This circumstance occurred because the urban village government did not have specific funds allocated for developing and solving the health problems in the society:

> *"We really do not know about it. What we know is that the existing activities are created for the society's need. Unfortunately, tables and chairs for Posyandu were not provided by the local government."* (P1_HCP)

> *"For budgets or grants, the local government gave us nothing. They only gave us permission to conduct the IDP of NCD: "With our pleasure, and we are helpful." That's it. Obviously, there was no fund or something like that."* (P2_HCP)

> *"I had submitted a* proposal, *but there was no result. We proposed a public lamp a long time ago, but we never got it."* (P9_RT)

> *"We never submitted a proposal for the health program; however, I proposed to repair the road, ditches, and streetlights."* (P12_RT)

3.3. Healthcare workforce shortage

There was a healthcare shortage in implementing the *Posbindu* PTM, including healthcare providers, health volunteers, and other stakeholders, as a part of cancer risk reduction activities. The *Posbindu* PTM staff of PHC held many jobs (providing healthcare services at PHC, reporting data of surveillance of diseases, participating in the hajj health services, member of the *Posbindu* PTM team, and so on), and each healthcare worker could hold six-eight jobs. Thus, they could not manage their work as successfully as was needed:

> *"My job includes providing health service at the adult clinical ward and health services at the emergency room. The services are in different rooms. If there is a patient in the emergency room, I will go there, leaving the adult clinical ward, and vice versa. My job also involves me providing Hajj health services. If there is any high-risk hajj, I also take care of them (chuckle) outside. I also have some jobs in Posyandu and Posbindu, such as investigating the surveillance of epidemiology and SIMPUS (information system of PHC), ensuring the smooth running of SIMPUS, and submitting all the patient data to the application. As I remember my jobs, it reminds me of Mrs. Rini; she even has more jobs than me!"* (P3_HCP)

> *"The target is not suitable for the situations and the conditions in the field. That was the problematic thing. We want to be informed regarding the situations and how and what the target is."* (P1_HCP)

Moreover, the workforce shortage also caused a lack of health volunteers for *Posbindu* PTM. The health volunteers of the *Posbindu* PTM program hold all posts in the community: *Posbindu* PTM, *Posyandu lansia*, and *Posyandu balita*. Nonetheless, a few people registered themselves as cadres or healthcare volunteers based on their own consent.

> *"It was not easy to get cadres in this area. What happened here was that there are only a few people who have desire to be cadres."* (P8_HCP)

3.4. Sharing and discussing crucial cancer information

This barrier refers to obtaining health information in the community. Cancer information was obtained from the internet, other social media, and also during the *Posbindu* PTM activities; however, the understanding of cancer risk prevention remained low:

> *"As we know, health promotion is essential, but the people still have little understanding that it is substantial."* (P3_HCP)

> *"Sometimes, the PHC staff told the people to consume vegetables. It is not all the vegetables. What is it? Do not consume too many nuts. They also informed the women who have children to keep their children healthy."* (P9_RT)

> *"Yes, sometimes I want to remind them; however, it doesn't matter. I would just let the authority from the health institution do it so they may accept the advice."* (P6_Vol)

Most people in the community still ignored the "Gerakan Masyarakat Sehat/GERMAS" (Health Community Movement) program and followed the health promotion by the PHC. The health volunteers reminded people to become involved in physical activities. Sadly, few people engaged in physical activity due to people's negative views and perspectives of the importance of exercise. During the implementation of the PHC program, the healthcare workers and health volunteers always reminded people to consume sufficient fruits and vegetables and promoted good health. Unfortunately, even with health promotion in the community, mostly people did not take it seriously:

> *"It really requires some tricky attempts to tell and to invite the people to do physical activities. It's not too bad because many housewives may have a lot of activities."* (P2_HCP)

> *"Perhaps the housewives are so busy with their household activities that they do not want to come to Posyandu. Just after they finished their "jobs," the Posyandu had finished, too, so they missed the event."* (P6_Vol)

3.5. Cultural practices in the community

Cultural practices in the community refer to health awareness and health treatments believed to be barriers to cancer risk reduction based on the community's points of view. Those engaged in *Posbindu* PTM had informed people continuously regarding good health, but they were not always interested. They belief in having good health conditions due to no emerging signs or symptoms:

> *"The people were afraid when they got an IVA test and gained positive results. They said, "I am so anxious that I will know my sickness." (P5_Vol)*

> *"The obstacles were their interest to the other people interest is lower because they do not understand the essentials of the program." (P4_HCP)*

> *"When we did the blood examination, a lot of people came (chuckle)."* (P1_HCP)

Nonetheless, many people continued to disbelieve in the benefits of the health services or to feel skeptical about the health services and instead believed in the traditional alternatives, such as Chinese medicine, beehives, traditional massage, coining (in the Indonesian language, usually it is called *kerokan*), herbs ("*jamu*," "*jintan hitam*," "*sari kurma*," "*akar benalu*," and ginger water), and spiritual power treatment. According to the people's viewpoints, receiving no medication was equal to receiving no health services or health treatment.

> *"The shaman may apply spells (mantra/jampi-jampi) and all herb potions and eggs as media for their treatment. Another treatment is that they would eat something."* (P12_RT)

> *"Something like turmeric, but it was not the instant one. The natural herbs they took are fresh turmeric, rose-apple leaves, Africa leaves, and seri leaves. I saw some people drinking a mixture of those herbs."* (P9_RT)

> *"They still combine the treatment. They believe in and trust the combination. Sometimes, particularly for herbs, people drink the extract of specific leaves every day two or three times a day."* (P8_Vol)

The healthcare workers and health volunteers needed to improve the people's understanding and mindset regarding the use of treatments. They must also attempt to remind and convince them of the adverse effects of the therapies and also to have such discussions with the people to convince them to try medical treatment as their first choice.

> *"I also reminded them by saying, "While you can have the best final treatment for you in the hospital, why do you waste your time to take medication and treatment in other places? You just wasted your time, energy, and money!""* (P8, 38 years)

Cancer is one of the most prevalent NCDs and catastrophic diseases in Indonesia [6], and the implementation of a risk reduction program would have a significant impact on reducing the costs of NCDs in the next several decades [22]. Providing adequate financial assistance for early detection and screening as prevention approaches is needed to improve a community's health status. The allocation of health budgeting by the Ministry of Health and the government of Indonesia was raised yearly and was approximately 5% of the state budget in 2018. This study showed that financial issues also occurred in the community, such as providing food and beverages used to attract people to join the PHC program for screening and early detection of NCDs. Budget allocation for health financing in Indonesia is used for curative and infrastructure purposes compared to public health and prevention funds [23], respectively. For most lower- and middle-income countries (LMICs), cancer screening and early detection programs do not exist, and there is also a lack of health insurance [24]. On the other hand, financial issues are often addressed by the health volunteers, and the government does not cover the provision of assistance for health volunteers. It is widely known that financial support for health volunteers sustains their participation [25]. Currently, several cities in Indonesia have provided incentives for health volunteers between Rp 100,000-Rp 200,000 per month based on regional budgets, but the majority of cities in Indonesia lack incentives. Providing funds for healthcare volunteers must be discussed by the government for a successful health program. Hence, reforming the health financing scheme is a critical change to achieve excellent healthcare services from healthcare providers and healthcare volunteers in the community as well as to sustain the healthcare volunteers of *Posbindu* PTM.

The urban village government examined in this study did not have specific funds allocated for developing or solving health problems in the community. A lack of facilities, lack of monitoring, and lack of evaluation of the program from the regional department of health and local government and a lack of cooperation among cross-sectors served as obstacles during the implementation of *Posbindu* PTM [26]. Moreover, the local government must identify their priority policies according to the community culture to close the gap in public healthcare [27] however, by 2018, the budget committee of the house of representative (DPR) along with the Indonesian ministry of finance (MoF) agreed to allocate funds for urban village governments at three trillion rupiahs in the National Budget (RAPBN) Draft of 2019, and the urban village government funds must be used to develop facilities, infrastructures, and policies. The existence of this policy has a positive impact on the community regarding the support of the local government and the development and progress of cancer risk reduction. All levels of government play a crucial role in implementing cancer risk reduction in addition to other government agencies. The government plays a vital role in a healthy environment for people, who can change their health behaviors through improved policies and regulations, health promotion, and other support programs. Therefore, community empowerment following people's cultures as supportive care in cancer risk reduction is needed with support from the government and other social institutions [28]. Integration among the government, researchers, and multiple stakeholders as transdisciplinary support can facilitate cancer risk reduction to sustain a high-quality cancer care delivery system.

Nurses and other health volunteers are key actors in conducting promotion and prevention activities successfully to screen for cancer risk factors of individuals or of the community [29]. It is well-known that a healthcare shortage, including healthcare providers and health volunteers, is a major issue in the improvement of the quality of health services provided [30]. One-fourth of countries worldwide are faced with a health workforce shortage, which is a challenge for countries of all income levels [31]. Healthcare shortage is critical in low and middle-income countries (LMICs), which is caused by a lack of financial and non-financial incentives provided by the government [32], the lack of a supporting management system of healthcare infrastructures, also a demand-capacity mismatch [33]. All the factors are associated with the increasing healthcare system dmands and healthcare expenditures [34]. According to the results of this study, financial and non-financial incentives have been identified as fundamental factors in sustaining community health workers while addressing the large number of public community health problems. Consequently, financial and non-financial rewards are crucial in addressing the healthcare workforce shortage to improve the health delivery system.

On the other hand, when seeking health information, the Internet is becoming a main source of information. The Internet has been used to improve healthcare services and communication between people and healthcare providers [35]. Using social media on the Internet helps promote cancer prevention to achieve

a good health status in a community [36] however, the quality of shared information on the internet and other social media remains unqualified and unscientific [37]. Thus, a solution is needed to sustain campaigns using social media as part of health promotion to reduce cancer risks in a community.

Furthermore, cultural, spiritual, belief, values, and religious factors are recognized as important determinants of cancer prevention, and they control behavior outcomes following a cancer diagnosis and treatment [38]. Cultural beliefs, ethnicities [39], faith, traditions, cultural taboos, and stigmatism [40] could lead to a lack of information regarding cancer. Iskandarsyah *et al*. stated that people commonly go to a traditional healer as a first option to treat their diseases [41]. When treatment using modern medication fails, people choose traditional treatment [42]. The use of traditional healers and or alternative treatments in Indonesia is associated with ethnicity and sociocultural factors [43]. According to the Indonesia Family Life Survey in 2014-2015, around 14.4% people used traditional medicine for cancer treatment [44]. Riskesdas (2018) found that the household proportion that used traditional health services using instruments (acupuncture, chiropractic, cupping therapy, aromatherapy, and acupressure treatments) with the main reason being "trial and error" was around 20.7% [45]. In contrast, in several rural areas in Indonesia, certain people continue the use of traditional healers, "dukun," and or alternative treatments, partly as a result of limited access to and high costs of medical care, cultural beliefs, and distrust of healthcare services [46]. It is indicated that many people still believe that spiritual power or traditional treatments can cure diseases faster. Thus, cultural, spiritual, belief, values, and religious factors related to health beliefs should be considered while implementing health promotion and prevention strategies and promoting adherence to medical treatments [47] to reduce the risk of cancer in the community because they affect their perspectives of health awareness. However, this study also followed by the limitations, the number of participants in this study is very limited so it can influence the results of the cultural practice in the community of involved people. In addition, one of the limitations of this qualitative research is the subjectivity of the results obtained from the results of interviews adjusted to the issue being studied. This limitation can be overcome by data triangulation, in-depth interviews, participant observation and focus group discussions.

4. CONCLUSION

This study has shown that cultural practices constitute an essential barrier in reducing the risk of cancer in a community. In addition, the findings also suggest that more financial funding allocations must be provided for program implementation and other related activities to achieve cancer risk reduction effectively. There is a need to develop and to maintain new strategies by encouraging the people in the community to actively participate and to continue efforts to prevent and to decrease cancer risks following their cultural beliefs and cultural practices. In addition, a health system transformation is needed to improve the effectiveness and efficiency of the services given. This could be done by focusing on prevention and promotion and the adjustment of the health environment in the community according to people's cultural backgrounds, faith, and beliefs and also through collaborations among stakeholders and other related sectors.

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