



SADARI-SHIFA: An Innovative Spiritual Integrated Model for Early Breast Cancer Detection through Community Empowerment of Family Empowerment and Welfare (PKK) and Women Farmer Groups (KWT)

Fitriana^{1,3}, Sukarni^{1,3}, Juwita Desri Ayu^{1,3}, Ani Kristianingsih^{1,3}, Desi Kumalasari^{1,3}, Siti Maesaroh^{1,3}, Eka Tri Wulandari^{1,3}, Taufiq Jamaan¹, Debby Heldayani², Radinal Yusivanandra Prayitno², Ro`ihatu Zahroh¹, Asfa Roza Suis¹, Salsa Amelinda Rahmasari²

¹Midwifery Study Program, Universitas Aisyah Pringsewu, Lampung, Indonesia

²Medicine Study Program, Universitas Aisyah Pringsewu, Lampung, Indonesia

³Wisma Rini Hospital, Lampung, Indonesia

Email korespondensi: juwitadesriayu@aisyahuniversity.ac.id



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ABSTRACT

Breast cancer is the most prevalent cancer among Indonesian women and a leading cause of death. Despite national campaigns, awareness and early detection practices remain low due to limited literacy and cultural barriers. This study aimed to evaluate the effectiveness of the SADARI SHIFA (Spiritual Health Integrated for Awareness) model in improving breast cancer awareness, integrating spiritual motivation, and empowering Women through Family Empowerment and Welfare/Pemberdayaan dan Kesejahteraan Keluarga (PKK) and Women Farmer Groups/ Kelompok Wanita Tani (KWT) in Pringsewu Regency, Indonesia. This mixed method community based participatory study involved 75 participants: 50 PKK cadres and 25 KWT members. Quantitative data were collected using pre-post knowledge tests and observation of SADARI practice. Qualitative data were obtained from semi structured interviews with 10 purposively selected participants to explore perceptions and experiences regarding the spiritualhealth integration. Quantitatively, knowledge scores increased from 54.0 to 84.1 (+30.1%), and 82% of participants could correctly perform all SADARI steps. Qualitatively, thematic analysis identified three dominant themes: (1) spiritual awareness as a motivator for selfcare, (2) enhanced emotional comfort through prayer and reflection, and (3) empowerment through community solidarity. Participants expressed reduced fear and increased responsibility to maintain health as a religious duty. The SADARI-SHIFA model effectively combines medical education, spirituality, and community participation to promote early breast cancer detection. The integration of qualitative insight strengthens understanding of its psychosocial impact and supports its scalability as a culturally appropriate innovation in women's health promotion.

Keywords:

Breast cancer;
Community
empowerment;
SADARI;
Spirituality;
woWomen's health.



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INTRODUCTION

Breast cancer remains one of the leading causes of morbidity and mortality among women worldwide and constitutes a major global health burden. According to the Global Cancer Observatory (Ferlay et al., 2024), breast cancer accounts for approximately 2.3 million new cases and 685,000 deaths each year (Arnold et al., 2022). In Indonesia, it represents the most common malignancy among women, with

65,858 new cases and 22,430 deaths annually, contributing significantly to premature mortality in women of reproductive and middle age (Osborne et al., 2025). Although breast cancer is highly treatable when detected early, many women are still diagnosed at advanced stages, largely due to limited awareness and delayed detection (Zhang et al., 2025).

Early detection remains the most effective strategy to reduce breast cancer morbidity and mortality (Barrios, 2022). The Indonesian Ministry of Health has long promoted two main screening approaches: SADARI (breast selfexamination) and SADANIS (clinical breast examination) (Icanervilia et al., 2023). However, the 2018 Indonesian Basic Health Research (Riskesdas) reported that only 22% of women aged 30–50 years had ever performed SADARI, and less than 10% had undergone SADANIS (Balitbangkes Kemenkes RI, 2018). More recent evidence including a 2023 metaanalysis reporting a pooled BSE prevalence of 43% and multiple provincial reports showing SADANIS/CBE coverage as low as 4–11% in some areas (Halim, 2023), highlights marked regional variation and overall insufficient clinical screening coverage. This low engagement indicates persistent challenges, including limited health literacy, cultural taboos surrounding women's bodies, and lack of motivation or support for preventive practices (Faiza et al., 2024). These barriers are particularly evident in rural settings, where social norms, modesty, and limited access to healthcare services further constrain women's participation in screening programs (Ayaad et al., 2025).

Beyond medical factors, spiritual and cultural dimensions play a crucial role in shaping women's health behavior in Indonesia's religiously oriented society (Gartika et al., 2024). Many women perceive health and illness within a spiritual framework, believing that maintaining bodily wellbeing is an act of faith and responsibility to God (Bano et al., 2025). Previous studies have shown that spiritually integrated health education improves adherence to preventive behaviors and reduces anxiety related to illness (Zhang et al., 2024). Despite this evidence, most breast cancer prevention programs remain biomedically focused and rarely incorporate spiritual motivation or cultural sensitivity (Malope et al., 2024). As a result, educational messages often fail to resonate with community values and daily practices (Hendrik, 2024).

To address these challenges, this community engagement project developed the SADARI SHIFA Model (Spiritual Health Integrated for Awareness) an innovative, communitybased participatory approach that combines medical education with spiritual reflection and empowerment of women through the Family Welfare Movement (PKK) and Women Farmer Groups (WFG). The program integrates practical training on SADARI and SADANIS with faithbased motivation, group prayer, and reflection, positioning health maintenance as an act of spiritual stewardship. Through participatory learning, peer modeling, and qualitative reflection, the SADARI–SHIFA model aims to strengthen both cognitive understanding and emotional motivation, promoting consistent early detection behavior among women.

The novelty of the SADARI–SHIFA model lies in its holistic integration of biomedical knowledge, spirituality, and community empowerment a combination rarely explored in Indonesia's breast cancer prevention landscape. It introduces a dual evaluation design that captures both quantitative improvements in knowledge and qualitative shifts in spiritual motivation and selfefficacy. This model not only enhances women's health literacy and screening behavior but also empowers local cadres as peer educators to ensure program sustainability. Furthermore, the SADARI–SHIFA initiative directly supports the Sustainable Development Goals (SDGs), particularly SDG 3 (Good Health and Wellbeing) by promoting preventive health practices, and

SDG 5 (Gender Equality) by empowering women to take active roles in protecting their own health and their families'. Thus, the SADARI–SHIFA model represents an innovative and culturally grounded strategy for advancing women's health promotion in Indonesia and similar low resource, faith.

METHODS

This study employed a mixed method community based participatory approach that combined quantitative pre–post evaluation with qualitative exploration (Guan et al., 2025). The quantitative component assessed changes in knowledge, attitudes, and self efficacy related to breast cancer early detection before and after the intervention. Meanwhile, the qualitative component involved in depth interviews with ten selected participants to explore their spiritual perceptions, emotional responses, and behavioral changes following the implementation of the SADARI–SHIFA model. This design allowed triangulation between numerical outcomes and lived experiences to capture a comprehensive understanding of the program's impact (Rana & Chimoriya, 2025).

The study was conducted in a rural subdistrict of Lampung Province, Indonesia, where women's participation in early breast cancer screening remains low. Participants were recruited purposively from two community organizations, namely the Family Welfare Movement (PKK) and Women Farmer Groups (KWT). Inclusion criteria included: (1) women aged 30–50 years, (2) no prior history of breast cancer, (3) willingness to participate in the full intervention process, and (4) ability to provide informed consent. A total of 50 women participated in the quantitative phase, while 10 women were purposively selected for qualitative interviews based on their engagement level and reflective depth during sessions.

The SADARI–SHIFA (Spiritual Health Integrated for Awareness) model was designed as a three stage community intervention integrating health education, spiritual reflection, and practical training.

1. Stage I. Health Education and Awareness Building:
Participants attended interactive sessions led by midwives and health educators focusing on breast cancer risk factors, the importance of early detection, and demonstration of SADARI techniques using anatomical models.
2. Stage II: Spiritual Reflection and Motivation:
Guided discussions and reflection sessions encouraged participants to view health maintenance as an act of faith and self responsibility before God. Qur'anic verses and local proverbs related to health and self care were introduced to foster internal motivation.
3. Stage III: Peer Empowerment and Practice:
4. Participants practiced SADARI in small peer groups under supervision and were encouraged to share experiences and reflections. Selected participants were trained as peer educators ("Sahabat Sehat") to ensure sustainability within the community.

The intervention was implemented over four weeks, consisting of weekly sessions lasting approximately 90–120 minutes each. Learning materials were culturally adapted and validated by three public health and religious education experts prior to implementation. Quantitative data were collected using a structured questionnaire covering three domains: (1) knowledge about breast cancer and early detection, (2) attitudes toward self examination, and (3) self efficacy in performing SADARI. The questionnaire had been previously validated in similar community studies with a Cronbach's alpha of 0.86.

Qualitative data were obtained through semi structured interviews with ten participants selected after the intervention. Each interview lasted 30–45 minutes and explored themes such as personal experiences, perceived spiritual meaning, barriers, and motivations related to breast health awareness. All interviews were conducted in Bahasa Indonesia, audio recorded, and transcribed verbatim. Quantitative data were analyzed using paired t-tests to examine pre–post differences in knowledge, attitudes, and self efficacy scores, with a significance level set at $p < 0.05$. Qualitative data were analyzed using thematic analysis following Braun and Clarke’s six step framework: familiarization, coding, theme generation, reviewing, defining, and reporting. Triangulation between the quantitative and qualitative findings was conducted to strengthen the validity of interpretations.

Ethical approval for this study was obtained from the Health Research Ethics Committee of Aisyah University of Pringsewu (approval number: 629/UAP.OTP/ KEP/ EC/ 2025). All participants were informed of the study objectives, voluntary participation, and confidentiality of their responses. Written informed consent was obtained before data collection. Pseudonyms were used during transcription to protect participant identity, and all data were stored securely in password protected files.

RESULT AND DISCUSSION

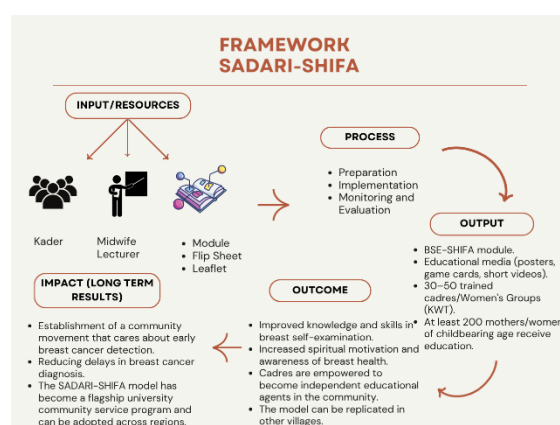


Figure 1. Frame work Sadari Shifa for community service

a. Participant Characteristics

A total of 50 women participated in the quantitative phase of the study, with an average age of 38.6 ± 6.7 years. Most participants were married (92%), had completed secondary education (68%), and were actively involved in community organizations such as the Family Welfare Movement (PKK) and Women Farmer Groups (KWT). All participants identified themselves as practicing Muslims and reported having no prior history of breast cancer or formal breast health education.

b. Quantitative Findings

Table 1. Effect of the SADARI–SHIFA Model on Participants’ Knowledge, Attitudes, and Self-Efficacy Toward Early Breast Cancer Detection

	Pretest	Posttest	<i>t</i> -value	<i>p</i> -value
	Mean $\pm$ SD	Mean $\pm$ SD		
Knowledge score	56.4 $\pm$ 12.3	84.2 $\pm$ 9.8	10.76	<0.002
Attitude score	60.1 $\pm$ 10.5	86.7 $\pm$ 8.6	11.21	<0.001
Self-efficacy (SADARI)	52.3 $\pm$ 13.1	82.9 $\pm$ 10.2	9.94	<0.000

All three domains demonstrated statistically significant improvements ($p < 0.001$) following the intervention. The largest gain was observed in self efficacy, indicating that participants not only gained knowledge but also confidence in performing breast self examination. The posttest mean knowledge score increased by 27.8 points, while attitude and self efficacy scores improved by 26.6 and 30.6 points, respectively. These findings suggest that integrating spiritual reflection and peer learning substantially enhanced the women's readiness to adopt early detection behaviors.

c. Qualitative Findings

Thematic analysis of the ten indepth interviews revealed three overarching themes that illustrate participants' experiences and internal transformations during the SADARI–SHIFA program:

1. "Awareness as a Form of Faith and Responsibility".

Participants expressed that the intervention helped them reinterpret health maintenance as a spiritual duty. Many described SADARI as an act of gratitude and obedience to God's command to care for one's body.

"I realized that checking my breasts is not just for health, but also part of being thankful to Allah for giving me this body." (Participant 3)

2. "Overcoming Fear and Shame through Faith Based Learning"

Prior to the program, several women admitted avoiding breast self examination due to embarrassment and fear of discovering illness. Spiritual discussions and group reflection sessions helped them replace fear with acceptance and courage.

"Before, I was afraid to know. Now I believe that early checking means trusting God and facing it with strength." (Participant 7)

3. "Empowerment and Sisterhood in Health Promotion"

Women reported that learning together and supporting peers fostered confidence and a sense of collective responsibility. Those trained as peer educators ("Sahabat Sehat") felt motivated to continue spreading awareness within their communities.

"We encourage each other. When we talk about it in prayer groups, other women start to ask how to do SADARI." (Participant 9)

d. Integration of Quantitative and Qualitative Findings

Triangulation of both data strands demonstrates that the SADARI–SHIFA model effectively enhanced women's knowledge, positive attitudes, and self efficacy, while simultaneously fostering spiritual motivation and emotional empowerment. Quantitative improvements in knowledge and confidence were supported by qualitative evidence showing deeper personal meaning and community solidarity. The integration of spiritual values and participatory learning not only improved cognitive outcomes but also transformed participants' perceptions of health from a biomedical necessity into a faith based, collective responsibility.

These results confirm that spiritually integrated health education can strengthen women's engagement in preventive health behaviors, particularly in communities where cultural and religious beliefs significantly influence daily life.

This study demonstrated that the SADARI–SHIFA (Spiritual Health Integrated for Awareness) model significantly improved women's knowledge, attitudes, and self

efficacy toward early breast cancer detection, while simultaneously fostering deeper spiritual meaning and community solidarity. The integration of health education and faith based reflection provided not only cognitive understanding but also emotional readiness to engage in preventive behaviors. Quantitative findings showed a significant increase across all domains, while qualitative insights revealed that women began to perceive breast health as a spiritual duty rather than merely a medical necessity. This highlights the effectiveness of integrating psychosocial and spiritual dimensions within health education for women in culturally religious contexts such as Indonesia.

The results align with previous studies emphasizing that spirituality can act as a catalyst for positive health behavior change. For example, Muthoharoh, et al (2023) reported that incorporating spiritual meaning into health education enhances individuals' motivation, resilience, and adherence to preventive care. Similarly, Ali, et al. (2022) found that religious based interventions improved self efficacy among Muslim women in chronic disease management. However, unlike prior programs that focused solely on individual faith or health literacy (Romanova et al., 2024), the SADARI–SHIFA model uniquely integrates both community participation and peer empowerment, transforming learning from a didactic process into a collective, value driven movement. This holistic approach supports the argument that sustainable health behavior change emerges when individuals experience both personal conviction and social reinforcement.

A key insight from the qualitative data was the transformation of fear and stigma surrounding breast examination (Kedida et al., 2024). Before the intervention, participants often avoided SADARI due to feelings of shame, fear of illness, or misconceptions about destiny and divine will. Through the spiritual reflection component, these fears were reframed into faith-based acceptance and proactive responsibility (Nasrin, 2025). This shift supports Bandura's social cognitive theory, in which self efficacy and outcome expectations influence behavioral intention (Koutroubas & Galanakis, 2022). In the context of SADARI–SHIFA, spiritual teachings served as a motivational enhancer, bridging the gap between knowledge and practice. Participants' narratives also indicated that group based learning strengthened interpersonal trust and normalized conversations about women's health an essential step in overcoming sociocultural barriers to early detection.

The findings also contribute to the broader global health agenda by supporting Sustainable Development Goal 3 (Good Health and Wellbeing) and Goal 5 (Gender Equality) (UNDP, 2024). By empowering women to take active roles in health promotion, the SADARI–SHIFA model not only improves individual health literacy but also strengthens the social fabric of communities. Women who participated as peer educators ("Sahabat Sehat") became multipliers of knowledge and motivation, extending the program's reach beyond its initial participants. This community empowerment component is critical for achieving long term behavioral change and aligns with the World Health Organization's (WHO) framework for people centered primary health care. Moreover, integrating faith-based messages ensures cultural acceptability, making this model adaptable for other low resource, religiously oriented settings across Southeast Asia and beyond.

Despite its promising outcomes, this study has several limitations. The sample size was relatively small and limited to one rural district, which may affect generalizability (Schneider & Wei, 2022). Additionally, the self reported nature of behavioral outcomes may introduce response bias (Latkin et al., 2018). Longterm follow up was not conducted to assess sustainability of the behavior changes. Future

research and community service program should include a larger, multisite sample with longitudinal design to evaluate retention of knowledge and sustained practice of SADARI. It would also be valuable to explore the role of local religious leaders in supporting program dissemination and to assess cost effectiveness for integration into regional health policy.

In summary, the SADARI–SHIFA model demonstrates that spiritually integrated, community-based education can serve as a powerful tool for women's empowerment and breast cancer prevention. The combination of biomedical information, reflective faith-based motivation, and peer support produced both measurable cognitive gains and qualitative transformations in self awareness and social engagement. This study highlights the need for culturally sensitive and spiritually grounded approaches to women's health education, offering a replicable model to strengthen preventive health initiatives in Indonesia and other similar settings.



Figure 2. Documentation of Socialization of the topic about SADARI SHIFA



Figure 3. Documentation of Demonstration of Breast Self-Examination using the SADARI SHIFA method

CONCLUSION

This study demonstrates that the SADARI–SHIFA (Spiritual Health Integrated for Awareness) model is an effective and culturally sensitive approach to improving women's awareness, attitudes, and self-efficacy regarding early breast cancer detection. By integrating health education with spiritual reflection and peer empowerment, the program transforms preventive behavior from a purely biomedical obligation into a meaningful spiritual practice and shared social responsibility. Quantitative gains in knowledge and confidence are reinforced by qualitative findings highlighting strengthened faith-based motivation, emotional readiness, and community solidarity, thereby enhancing preventive health engagement in low-resource, faith-oriented settings.

The model offers an innovative paradigm for bridging the gap between knowledge and practice while contributing to SDG 3 (Good Health and Well-being) and SDG 5 (Gender Equality) by empowering women as health promoters within their families and communities. Practically, SADARI–SHIFA provides a replicable and scalable framework for community-based health education that can be integrated into existing programs such as PKK or primary healthcare (Puskesmas) outreach, with peer educators ("Sahabat Sehat") supporting sustainability beyond the intervention period. Future efforts should adopt similarly integrative medical, spiritual, and social empowerment strategies, strengthen collaboration with religious leaders, midwives, and women's organizations, and pursue longitudinal, multisite evaluations and digital supports to sustain engagement and track behaviors over time.

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