



Challenges Faced by Obstetricians and Gynecologists in Cervical Cancer Screening Among Rural Malaysian Women - Pilot Case Study

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Abstract

Introduction: There are many challenges to the cervical cancer screening in Malaysia. In the past, a paper of the situation in Malaysia in 2009 stated that there was no national call-recall system which has been established. Women are informed about cervical screening primarily through mass media rather than being individually invited. Smears are free of charge if taken in public hospitals and clinics, but the waiting times are often long. The health care system is unequally dense, with rural states being underserved compared to their urban counterparts.

Methods: This study is a qualitative study, piloting the interview guide which is conducted in Malaysia where a Consultant Obstetricians and Gynecologists was interviewed, utilising phenomenological study to explore the challenges he faced with uptake of cervical cancer screening among rural Malaysian women. This study is conducted from November 2025 to January 2026.

Results: The theme of the findings was challenges with subthemes being professional challenges, socio-cultural challenges, and patient-related challenges. The codes identified for professional challenges were acceptance of population, gender of physician, cost, and long waiting time. The codes identified for socio-cultural challenges were lower social group, husband's role, culture, family structure, and hierarchy of women. The codes identified for patient-related challenges were knowledge, and lack of follow up.

Discussion: Literature have shown the role of professional challenges, socio-cultural challenges, and patient-related challenges in determining the rate of uptake of cervical cancer screening among rural Malaysian women, backed by previous research which showed the factors associated with low uptake of cervical cancer screening.

Conclusion: In conclusion, this study is able to validate the interview guide used to explore the challenges associated with cervical cancer screening among rural Malaysian women.

Keywords: Cervical Cancer Screening, Challenges, Rural Malaysian, Women

Introduction

Study Background

There are many challenges to the cervical cancer screening in Malaysia. In the past, a paper of the situation in Malaysia in 2009 stated that there was no national call-recall system which has been established. Women are informed about cervical screening primarily through mass media rather than being individually invited. Smears are free of charge if taken in public hospitals and clinics, but the waiting times are often long. The health care system is unequally

dense, with rural states being underserved compared to their urban counterparts [1]. If the screening coverage was to increase, a shortage of smear-readers would become increasingly apparent. To tailor the global roadmap towards eliminating cervical cancer and to achieve the elimination goal of new cases of cervical cancer at less than [2]. It is noted that cervical screening remains a much-needed intervention where 70% of eligible women are recommended to be tested towards achieving the global benchmark by 2100. However there still exists challenges to the cervical screening even as we have moved on from those 2009 days in Malaysia.



There is a research which looked at why there exists such a high prevalence of cervical cancer in this country, and the reason was because it used targeted, opportunistic screening rather than population-based approaches [3]. It was also found in this research that based on ethnic stratification, there is a 4.66-fold increase in risk which was found in Malay females, but is not found in other ethnic groups. In another study in Malaysia, it was shown that only 6% of the study participants who consist of university female students have had pap smear done, which reflects a relatively low rate. There was similar findings reported among university students consisting of Nigerian females which report 8.3% of the participants having had Pap smear test before [4]. This relatively low rate of uptake of cervical screening among Malaysian women, which is equivalent to the rates from other Lower Middle-Income Countries (LMICs) show that there exist barriers within the community itself with regards of cervical screening uptake.

The study by *Al-Naggar, et al.*, [4] showed that poorest knowledge about risk factors of cervical cancer was HPV. This is in consistence with findings of the National Cancer Institute's 2005 Health Information National Trends Survey in the United States which reported that 20% of American women were aware that the virus HPV could cause cancer. However, the study quoted was conducted in 2010, and since the advent of HPV vaccine, the knowledge of cause of cervical cancer should have improved by leaps and bounds. However, in a study conducted by *Ulasan, et al.*, [5], the overall result of the study in a group of Malaysian women showed that majority of women in Malaysia still has poor knowledge about HPV and cervical cancer which echoes the findings in other countries [5].

Research Gap

Although many studies have been conducted which delineated the challenges in cervical cancer screening, there exists a research gap in qualitative studies conducted amongst Consultants Obstetricians and Gynaecologists on the challenges of cervical cancer screening among rural Malaysian women. Hence the literature review covered in this paper mainly consist of published findings of general challenges encountered by women which affect their uptake of cervical cancer screening, and not limited to rural settings or urban settings.

Problem Statement

As such, there has been many studies which have been conducted and there are according to the study background above countless factors which drive the poor uptake of cervical cancer screening, both nationally and internationally. However, there exists a study gap whereby there is a lack of systematic classifications, and there is a lack of nationally conducted qualitative studies among Obstetricians and Gynaecologists in Malaysia to explore their valuable expert insights into the causes of the lack of national uptake of cervical cancer screening especially among rural Malaysian women.

Research Justification

Although there are a lot of literature out there with regards

to barriers or challenges which are faced in the pursue of 70% of cervical cancer screening, in tandem with WHO recommendation, there still exists limitation when it comes to expert opinions of Consultant Obstetricians and Gynaecologists, and their input could be game-changing as they are on the ground seeing patients. We have many literatures from women themselves but limited when it comes to expert opinions. Other than that, this study is novel exploring the challenges encountered in rural Malaysian women. Other than that, there still is a gap of proper classifications of challenges encountered in these rural Malaysian women, hence this study offers an opportunity to explore the concept.

Objectives

The objectives of this study are as follows:

a. General Objective: To explore the challenges faced by Obstetricians and Gynaecologists in promoting cervical cancer screening.

b. Specific Objectives: To understand the professional challenges of Obstetricians and Gynaecologists in dealing with cervical cancer screening among rural Malaysian women.

To understand the socio-cultural challenges of Obstetricians & Gynaecologists in dealing with cervical cancer screening among rural Malaysian women.

To understand the patient-related challenges of Obstetricians & Gynaecologists in dealing with cervical cancer screening among rural Malaysian women.

Research Questions

1. What are the professional challenges of Obstetricians and Gynaecologists in cervical cancer screening among rural Malaysian women?
2. What are the socio-cultural challenges of Obstetricians and Gynaecologists in cervical cancer screening among rural Malaysian women?
3. What are the patient-related challenges of Obstetricians and Gynaecologists in cervical cancer screening among rural Malaysian women?

Literature Review

Definition of Challenge

The definition of a challenge according to *Elhami & Roshan* [6] is a task, a duty, or a situation that is difficult to handle: a lot of effort, determination, and skill is required to face it and overcome it successfully [6].

Professional Challenges

It is noted that in earlier research, several types of barriers to screening, either perceived or objective, have been identified by the authors. Women fail to be screened due to insufficient resources, inability to access the health care delivery system [7]. Limited access to healthcare, poor access to information and empowerment, and poverty have been identified as barriers to cervical cancer

screening uptake. It is reiterated that these factors are paramount in determining a woman's intention to seek healthcare services particularly associated with cervical cancer screening. It is thus vital to not only evaluate the cervical screening practices among this underserved community, but also to identify the positive and negative factors that may be associated with their compliance, so that more targeted approaches can be initiated to address poor screening attendance among women from these communities [8]. Previous research has placed great focus on factors hindering women from attending cervical cancer screening.

Socio-Cultural Challenges

Patients also have individual psycho-social and cultural contexts, or limited family support and community participation, which in turn limits them to go for cervical cancer screening [7]. A nationally representative cross-sectional study of non-institutionalized women in Spain reported that women who were older, had received a higher level of education and were from a higher social class were more likely to have cytology testing for cervical cancer screening [9]. In a study by *Chan, et al.*, the NHMS 2019 showed 35.2% of respondents had undergone a Pap smear test in the past three years. This figure represents just half of the target set by WHO's Global Strategies for Cervical Cancer Elimination, which aims for 70% of women worldwide to be screened regularly for cervical diseases with a high-performance test.

Patient-Related Challenges

Patients are known to lack knowledge, or having fear which deter them from accessing cervical cancer screening services [7]. Since the 1960s, Malaysia has been implementing opportunistic Pap smear for all sexually active women aged 20–65 years [10]. According to the 2006 National Health and Morbidity Survey (NHMS III), only 47.3% of Malaysian women have ever undergone Pap smear screening (Health, 2008) [11]. In a study conducted in Sarawak, Malaysia, it was found that only 18.7% reported regular cervical cancer screening, with a substantial proportion of individuals never having undergone the screening test. 25.1% of the participants demonstrated satisfactory knowledge of cervical cancer, while 7.8% exhibited adequate knowledge regarding cervical cancer screening. Importantly, only 40% expressed an intention to undergo screening. Factors significantly associated with screening intention were educational level and low perceived barriers to screening [12].

Past quantitative studies showed the barriers for not having cervical cancer screening among Malaysian women were due to lack of awareness and knowledge related to cervical cancer and its screening; embarrassment and fear of pain; lack of exposure from health professionals; careless attitude of not being at risk and fear of a positive result [13-15]. The study by *Romli, et al.*, [16] highlighted the perceived vulnerability by witnessing the cervical cancer patient dying and fear of stigma as perceived severity. Emphasis on the importance of sufficient knowledge and correcting the misconceptions towards cervical cancer screening could positively impart motivation on response efficacy and perceived self-efficacy among women. Undergo screening regularly even

though asymptomatic will make a change of behavior as protection motivation. Simultaneously with women's views, the emphasis by health provider related to correct perception of cervical cancer risk, etiology, nature, and outcome could guide intervention program development to enhance cervical cancer screening in the future. Traditional approaches alone such as health education talks are no longer sufficient for health promotion. Highlighting the motivational focus using interesting approaches such as role-play, short films, and electronic health videos might be more effective for motivating women towards health change [16].

According to *Chua, et al.*, [17], they found that the top barrier category to cervical cancer screening is psychological or emotional factors, namely embarrassment and fear. This is followed by knowledge, which includes the lack of knowledge and awareness to cervical cancer and cervical cancer screening. This study is a systematic review conducted on barriers and facilitators of cervical cancer screening of women in South East Asia [17]. However, the study by *Chan, et al.*, showed that women in the rural areas in Malaysia are more likely to undergo cervical cancer screening. Their study indicated that respondents from rural localities were more likely to receive a Pap smear test. This could be due to rural Malaysians are more likely to undergo a Pap smear test. Cervical screening uptake was 48.9% among rural Malaysians, which was higher than the overall prevalence found in the study. It could be that frequent and regular visits to healthcare facilities can lead to increased testing opportunities. In Malaysia, rural areas have greater fertility rates than urban areas [18]. Higher fertility might increase demand for maternal healthcare services, and causing more frequent healthcare visits, which in turn provide more opportunities for testing.

Methodology

Study Site

This study will be conducted in Malaysia, where respondents will be clustered from all the four regions in Malaysia, namely the northern region, middle region, southern region, east coast of Peninsular Malaysia, and West Malaysia, where consultants from each region will be contacted to participate in the study.

Study Design

This study is a phenomenological study conducted in the whole of Malaysia, including private and public hospital Obstetricians and Gynaecologists.

Target Population

The target population of this study will be the Obstetricians and Gynaecologists working in the public or the private sector in Malaysia.

Study Population

The study population of this study will be consultants randomly sampled from the study frame of exhaustive list of Obstetricians and Gynaecologists from each region of Malaysia, and the method of sampling will be purposive sampling, until saturation is reached.

Sampling Frame

The sampling frame will be all the Obstetricians and Gynaecologists consultants from the whole of Malaysia, in the five regions of Malaysia.

Sampling Method

Purposive sampling will be done, where the sampling method was based on cluster sampling, where researcher contacts consultants Obstetricians and Gynaecologists based on the five regions in Malaysia, i.e the northern region, middle region, southern region, east coast of Peninsular Malaysia, and consultants from the West Malaysia. The sample size obtained will be interview conducted until saturation point is reached. Data collection method will be individual in-depth interviews.

Sampling Unit: Inclusion

The inclusion criteria include:

1. They must have worked as consultant O&G for more than a year in Malaysia.

Sampling Unit: Exclusion

Exclusion criteria include:

1. Highly-specialist consultant Obstetricians and Gynaecologist in fetal-medicine.
2. Consultant Obstetrician and Gynaecologists who are no longer in clinical practice

Sample Size Calculation

Recruitment will take place until saturation point is reached. This is when additional interviewees will give the same findings as the existing interviews from preceding participants.

Study instrument

Study instrument includes the interview guide which has been carefully designed for this study. The validity of this qualitative interview guides relies on ensuring the questions are clear, relevant, unbiased, and elicit rich, authentic data reflecting participants' realities. This is assessed through expert review, piloting (pilot testing) the interview guide with a fellow expert, and researcher reflexivity to build trustworthiness (credibility, dependability, confirmability, transferability). This guide uses open-ended, logically ordered questions, moving from general to sensitive topics, and is continuously refined through rigorous development processes to minimize bias and capture intended meanings.

Biases

To avoid biases in the study, an interview guide has been adapted to the interview settings, and all participants will be asked a specific set of questions. The interview guide has been developed with the help of experts in Qualitative research. The researcher has been trained to not introduce biases in the questioning style and open questions are asked to the participants.

Statistics

The qualitative data were analyzed using NVivo (e.g., Version 15) to ensure a systematic and rigorous thematic analysis. Following the six-step framework by Braun and Clarke, interview transcripts were first imported into the software as Internals for familiarization. An initial process of Open Coding was conducted to identify recurring concepts, which were subsequently organized into Nodes and sub-nodes representing specific themes. Throughout the analysis, Memos were utilized to document emerging theoretical reflections and ensure an audit trail. To validate the findings, Matrix Coding Queries and Coding Stripes were employed to examine the distribution of themes across different participant demographics and to visualize patterns within the dataset.

Ethical considerations

This study has been conducted following the ethical principles laid out in Belmont's principles. The ethical attributes are respect for persons, beneficence, and justice. This study has will show respect for persons by delineating to the participants they are free to withdraw from the study at any time, without giving any reason. This study will be beneficial to understand the barriers and challenges faced by consultants Obstetricians and Gynaecologists in the uptake of cervical cancer screening among rural Malaysian women. Other than that, the findings of the study will do justice if steps are taken to rectify the issue deemed to have been identified. This study also practises informed consent, where the objectives and purpose of the study are delineated to the participants prior to consent. It also ensures anonymity by protecting its participants' identity.

Rigour

To ensure rigour of the data, interviews will be conducted with multiple interviewees until data saturation is reached. Other than that, respondent validation has been done, where the transcribed interview was given to the interviewee to be proofread and he has agreed with the verbatim transcription. This provides researchers with a method of checking for inconsistencies, challenges the researchers' assumptions, and provides us with an opportunity to re-analyze our data. This brings us to the third method of validation, which is the researchers' own mind, being close to the truth, where analysis is done with an open mind and based on multiple sources of information and sources which are expected to be reliable.

Results

Classifications of Themes, Subthemes, and Codes

(Table 1)

Table 1: Classification of themes, subthemes, and codes which emerged from initial coding of data analysis.

Themes	Sub Themes	Codes
Challenges	Professional	Acceptance of population
		Gender of O&G
		Cost
	Socio-cultural	Long waiting time
Lower social group		

		Husband's role
		Culture
		Race
		Family structure
		Hierarchy of women
Patient-related	Knowledge	
	Lack of follow up	

Professional Challenges

For acceptance of population, according to the O&G consultant interviewed. So, one of the challenges I would put is. The acceptance, acceptance of different population. I noticed that my my main patients are majority are. Chinese and Malay. Malay are good, a good proportion of my Malays. In the good old days, my when I was an active obstetrician and gynae, I got about, I would say about 80% Chinese, 10 percent, 15% Malay patients, only 2-3% of Indian patients. Gender of the consultant treating was also noted as a challenge in the expert opinion which posed as a hindrance to uptake of cervical screening among rural Malaysian women.

I'm sure the Malay patients, educated, they will go, they will go. For female gynae, they go to the government. I I advise them to go to the government. Go to government to be done by trained nurses. The, the Klinik Kesihatan. You know, all from olden days I advise them because they are, they are shy and different. In terms of cost, our interviewee informed us, mind you, there are still a lot of, a lot of I will put B40 B40 B40 Malay and Chinese population where they cannot go to the screening in a big hospital that will be very costly. But if I choose to use the liquid cytology, my cost at this very moment is \$38 Malaysian Ringgit, which is very cheap. I'm not saying it's expensive, it's very cheap compared to overseas. I don't know that, but I know it's very expensive. How much can I charge for a patient \$100? Of course, if I charge \$100, my profit increase without any consultation. Mind you, no consultation, no consultation at all. My profit increased and then I get about \$60.00 whereas for a for a simple pap smear, I only get maybe \$30. Other than that, the long waiting time at governmental clinics and hospitals pose a challenge to the uptake of cervical cancer screening in governmental facilities. They don't, they don't want to go to hospital. Long waiting queue.

Socio-Cultural Challenges

Lower social group is a challenge to seeking timely cervical cancer screening among rural Malaysian women.

I don't know. So, none of the patients. I got a lot of patients but I see the lower, lower social economic group. When you see the social, lower social group, the husband does not practice safe sex and not know the danger.

So, I would put, I would put HPV infection, very common among them, very, common. So, I think not much progress among the B40. I'm talking about B40, you know, because I am my whole life is B40, you know. Husband's role in the community is also one of the barriers to seeking cervical screening services. The husband role in in in this is very important, very important because in private

practice in government service and private practice whenever we do open the in the good old days back in 1979,1980. We still ask permission from the husband, especially among Malay patients."

So, as long as your husband is, why doesn't involve or if he practices safe sex, use condom, you'll be all right. And I tell them of course HPV, but I won't mention it specifically because it involves a lot, a lot of explanation, a lot of. In terms of culture, he has put it straightforwardly, No, no, no, not at all. It is cultural. It is culture, social, cultural because human being. So, in addition, in addition, allow me to say that not only this, the most important thing is the social, cultural, cultural, different ethnic group cultural is very important. Misogyny means the miserable female, miserable female. Why miserable? Because from olden days you get major culture, major culture females always occupy the lower position. Because the take up rate among other races other than Chinese very low. This is further intertwined with racial difference in the uptake of cervical cancer screening among rural Malaysian women. So similarly, when I was in government service, in terms of gyn, gyn screen screening, it's the same majority are still Chinese patients, very rare you get other races coming for Pap smear services and counseling. Reference 2 - 0.59% Coverage.

So, in addition, in addition, allow me to say that not only this, the most important thing is the social, cultural, cultural, different ethnic group cultural is very important. Abnormal cytology treatment is far, far better among the Chinese population because there are the other races are more difficult, more difficult for the female to bring it up because one you know nowadays, you know 99% is associated with HPV. Because the take up rate among other races other than Chinese very low. So not receptive. I am doing very well for with the poorer Chinese patient because they see me, they see a gynae, experienced gynae. And of course I don't think, I don't think anybody does it in Malaysia. Certain cultural, social, cultural, racial groups, racial groups. Family structure was also one of the subthemes which emerged. With the Malay community is the family structure. Family structure means that husband, the, the, the, the, the kampung, the Penghulu, the importance whether the men accept it or not that it is. Other than that, hierarchy of women in the social structure is also a challenge to seeking cervical screening services. Misogyny means the miserable female, miserable female. Why miserable? Because from olden days you get major culture, major culture females always occupy the lower position.

Patient-Related Challenges

Knowledge was also shown to be a barrier in seeking cervical cancer screening by rural Malaysian women. Basically, our knowledge at that time is totally different from now when we got AI, I think there is not much progress from back from my young days in obs and gynae 1979 until, until recently. They know, they know this information, but this information to them is not knowledge because they do not have basic knowledge. A lot of them, even my patients, simple patients know they their children get access to it, their children, their children will teach them they cannot, they cannot understand. There's no point, no, no point turning to AI to get that type of information. Final barrier is lack of follow up by

the patients. I tell you have a good GP, have a good senior, a good specialist, that you can afford it. You follow up. Don't need too much. Trust them. Trust them. So, you ask me this. I think it's very, very, very, very important because it's not lack of knowledge now. No, no, it's not low risk perception. No, no, no. Basically no. Basically no. For those the most important thing I tell them you must follow up.

You must follow up. You must even if I'm not around, let's say I close my clinic or I die but you must follow up.

Treemap

(Figure 1)

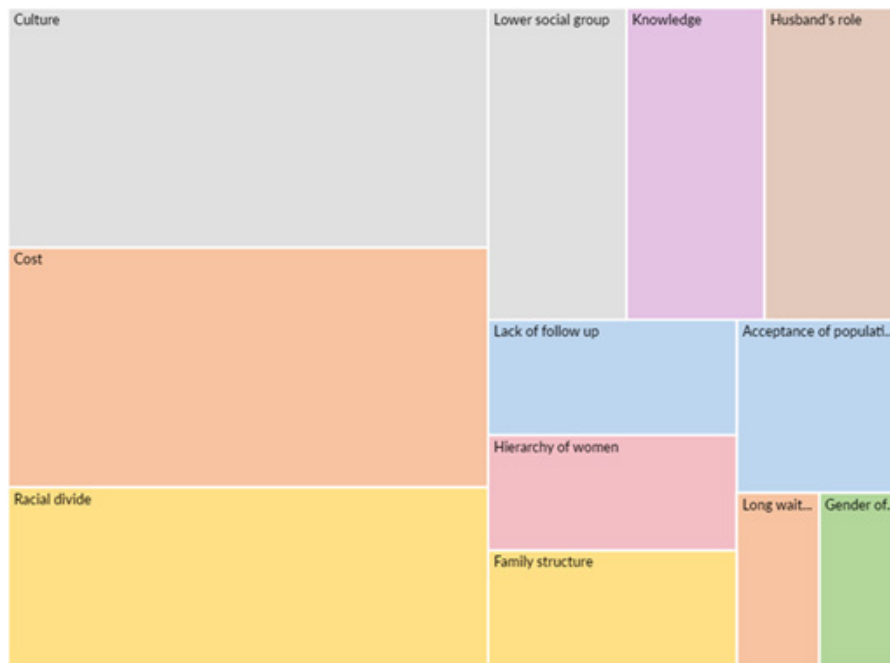


Figure 1: Treemap of codings.

The above treemap shows that the challenges which are mostly encountered in the rural Malaysian women are firstly related to culture. Other than that, cost and racial difference also make up higher hierarchy of importance when it comes to challenges surrounding cervical cancer screening uptake among rural Malaysian women. It seems that professional challenges make up

the least important factor when it comes to the impact on women in terms of cervical screening uptake.

Wordcloud

(Figure 2)



Figure 2: Wordmap showing word frequency in the data.

This word cloud shows the word frequency which appear in the in-depth interview. It shows that cultural, Malay, Chinese, miserable, and lower, with B40 tend to appear more frequently than other words. This goes to show that culture and race play a big part in the uptake of cervical cancer screening among rural Malaysian women. Other than that, social group plays an important role as well, as manifested by the word B40.

Discussion

Acceptance of Population

In terms of acceptance of population, it is noted that giving accessible and precise information with reduced waiting times during screenings, women are more likely to come forward for cervical cancer screening [19]. This particular intervention will increase the acceptance of the population to the cervical cancer screening. It is noted that pap smear is yet to reach the majority of the women population in Malaysia. It is simple, cheap, safe, and readily acceptable by Malaysian women, Pap smear is still unpopular. Human factors including the negative attitude of women and health-care professional and unsatisfactory service are part of the reasons of insufficient coverage and poor acceptance of the screening in Malaysia [20,15].

Gender of Consultants

It is further noted that the female physicians had higher women who come to them for cervical cancer screening. There are many studies which have gone to show the preference of female population for female physicians to see them especially when it comes to something intimate like cervical cancer screening [21]. It is noted in a separate study that ten percent increases in the regional female doctor ratio will increase the probability of using Pap tests by over five percent for women aged below 30. It is important to recognize that some Taiwanese women especially younger ones may not want to take Pap tests because most obstetricians and gynaecologists are males [22].

It is noted that the cost of cervical cancer screening in women in Malaysia is free in the government sector. However, the same population of women have to pay some sum of fees for the screening uptake in the private sector. Here, it seems that it is interplayed with the length of waiting time in the public facilities, which drive women to seek for cervical cancer screening in the private. It is noted that the convenience of a good experience of cervical cancer screening is able to be experienced in the private sector, with comprehensive cervical screening test done in the private [1]. These women do not have to wait for long queues but have to pay from out-of-pocket for the test to be done.

Lower Social Group

Despite the strong evidence that cervical screening does save lives, evidence suggests that the uptake for cervical screening for women from socially deprived areas still remains low. A qualitative approach using four focus groups was undertaken with 48 women living in socially deprived areas who had accessed a mobile screening unit to receive cervical screening. Analysis of

the data was undertaken using thematic content analysis. The women's knowledge of cervical cancer including associated risks, and preventative factors were extremely limited. The women expressed a negative attitude towards their experiences of cervical screening, describing negative feelings of 'fear', 'embarrassment' and feeling 'stigmatised'. Practical issues such as the timing of the appointments, issues of time and having to find child care were identified as the main barriers to screening for this group. It is further noted that areas of high prevalence of wealth showed disparities in cervical screening uptake in India with those who has higher socio-economic status showing better uptake of cervical cancer screening in India [23-25]. Semistructured interviews were conducted with six healthcare providers. Analysis of these interviews reveals several institutional support [26]. challenges which healthcare providers encountered in their clinical practice. These include the physicians' cultural awareness about the private body, patient's low socioeconomic status, the healthcare provider-patient relationship, and limited.

Hierarchy of Women, Husband's Role, Culture, Family Structure

It is found that in most communities in sub-Saharan Africa, which are primarily patriarchal, men have the primary authority in decision-making, directly or indirectly affecting women's ability to obtain and utilise health services. Gendered societal roles influence men's participation in sexual and reproductive health problems, particularly in cancer screening programs that include examining private areas such as the cervix, breasts, and anus of women. These factors play a significant role in shaping an individual's understanding and awareness of cervical cancer and cervical cancer screening, which in turn leads to reduced engagement in cancer screening initiatives. Women, on the other hand, tend to think of cancer as a disease that can only be cured by using alternative remedies and medicines. For a long time, people all over the globe have turned to traditional medicine as an additional line of defence against cancer. The influence of certain religious beliefs, which attribute cancer to retribution for past misdeeds, was noted concerning women's decisions on cancer screening. Consequently, there is no justification for doing cancer screening since it yields no benefits, and no efforts should be made to avoid it [27]. Next, due to a lack of male awareness of the advantages of early screening, they frequently delay or decline to permit their women to avail themselves of the service. Women consequently postpone undergoing screening due to their requirement for consent from their spouses [28]. Hence the systematic literature review by *Sathiyaseelan, et al.* [27]. goes to show that hierarchy of women in a certain community, roles of husband, family structure, and culture go hand in hand in attributing women's susceptibility to cervical cancer by preventing them from taking up the screening before the CIN turns aggressive.

Role of Religion

Religious leaders (cultural factor) play a crucial role in interpreting sources of knowledge to clarify which decisions and behaviours align with the principles of a specific religion. Religion

can be a barrier to cancer screening, as a supplemental therapy for cancer treatment and illness prevention. Holy water is commonly used by Christians of the apostolic faith. Participants of the studies included in this study prayed to prophets and religious leaders in the hopes that their faith would protect them from deadly diseases like cancer [28]. It is also found that certain ethnicities had higher incidence of cervical cancer. Based on ethnic stratification, there is a 4.66-fold increase in risk found in Malay females, but not in other ethnic groups.

Knowledge

Malaysians were found to have limited knowledge of Pap smears as a preventative measure to detect and prevent Cervical Cancer in its early stages. Malaysian women still had inadequate knowledge and awareness of cervical and screening [3]. In a study by Mustafa et al. (2025), it was found that over half of the women demonstrated poor knowledge of both breast (55 percent) and cervical (69 percent) cancer symptoms, while only a smaller proportion exhibited good knowledge, 12 percent for breast cancer and 6 percent for cervical symptoms, respectively. Commonly recognized symptoms included a "lump or thickening in the breast 'and 'persistent, unpleasant-smelling vaginal discharge" [3]. It was noted in another study that, 82.5% of respondents in the study showed there was the lack of information about the correct age for Pap smear screening. Other study also revealed that respondents felt they lacked adequate knowledge about cervical cancer, the existence of cervical screening, eligibility, and the details of where and when it should be conducted [29].

Lack of Follow Up

It was shown in another study that patient-identified barriers to hospital care were mainly: (1) a limited patient understanding of follow-up or treatment steps (both prior to and after the hospital visit), and (2) administrative challenges to obtaining appointments or follow-up care at the hospital. Patients identified the utility of a patient navigator for this process to reduce these barriers. The healthcare professionals concurred with the barriers identified by the patients and the suggestion of a patient navigator, but further elucidated suggestions for change, including

- 1) differentiating referral for those with suspicion for cancer to prioritize those patients when referred to the hospital,
- 2) increasing information flow between the different levels of care through an integrated patient registry, and
- 3) improving provider education regarding HPV and the standard of care [30].

A study by *Alemayehu, et al.* [31]. shows that the most common reasons given by women who did not attend rescreening one year after treatment for precancerous lesions were not being aware of the follow-up, forgetfulness, perceiving follow-up as not needed, feeling healthy, moving to another place, being temporarily away, and lack of time. The findings from the in-depth interviews conducted with health professionals aligned around barriers to posttreatment follow-up, including lack awareness, forgetfulness,

poor health-seeking behavior, residency-related barriers, and lack of time due to household responsibilities. Moreover, the health professionals reported health-facility-related barriers such as a shortage of trained healthcare providers, a poor counseling service, and the lack of a reminder system [31-35].

Conclusion

Conclusion

In conclusion, this study has been able to show the different challenges that Senior Obstetricians and Gynaecologists encounter in terms of cervical cancer screening uptake by rural Malaysian women and that the interview guide as per tested is appropriate for use among the Consultants Obstetricians and Gynaecologists in Malaysia. These challenges can be divided into three subthemes, i.e. professional challenges, socio-cultural challenges, and patient-related challenges. It is noted that there could be many interventions which can be carried out at the population level to close the gap between the lack of cervical cancer screening uptake between the rural Malaysian women and the standard set by WHO, i.e. 70% of the population of women being screened for cervical cancer. For example, health literacy of cervical cancer and its screening can be increased by education and health promotion done nationwide, by physicians, midwives, and community nurses, provided that healthcare providers are well-trained to do so. Other than that, a better call-recall system can be implemented to remind the women to follow up after their first cervical cancer screening. These are methods which do not need much budget, and hence can be done, provided government and private sectors have the manpower to do so. More studies in the future can be conducted on the feasibility of these programs in the community.

Strengths and Limitations

The strength in this study lies in the fact that it is a novel study conducted in Malaysia. There were previous systematic literature review which shows the barriers and challenges to cervical cancer screening in Malaysia but there has not been a qualitative study exploring the challenges that Senior Obstetricians and Gynaecologists encounter in rural Malaysian women. The limitation in this study is that the study is based on the expert opinions of the Consultant Obstetricians and Gynaecologists. Another study can be conducted to investigate the perceptions from the women's point of view of what are the actual hindrance preventing them from seeking cervical cancer screening services.

Public Health Significance

This study will add value in terms of public health impact. This study will be able to explore the experiences, challenges, and barriers of Consultant Obstetricians and Gynaecologists in encounters with uptake of cervical cancer screening among rural Malaysian women. This is in line with SDG 3: Good health and wellbeing. This SDG is iterated on ensuring healthy lives and promotion of wellbeing for all ages. This includes the promotion and uptake of health surveillance activities by the population served. This study will be able to strengthen the health promotion activities undertaken by the Ministry of Health in ensuring that cervical cancer screening

continues to be undertaken by the eligible females in Malaysia. Other than that, knowledge has to be disseminated to the rural Malaysian women in terms of aetiology of cervical cancer, so that steps can be taken to prevent or treat CINs in its early stage.

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None.

Conflict of Interest

None.

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