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Influences of Cultural Beliefs and Taboos in Family Planning Decisions Among Women in Pariaman, West Sumatra: A Phenomenological Study

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Abstract

Objectives: Family planning is a form of service program for reproductive health aimed at regulating birth spacing and/or limiting the total number of children to improve the health of the mother and child. Family planning programs have long been conducted in Indonesia and are still influenced by societal factors, including culture and norms. The study aimed to understand and analyze cultural beliefs and taboos as determinants of the use of family planning among reproductive-age women in Pariaman, West Sumatra, Indonesia.

Methods: The study employed a qualitative study design using a phenomenological approach. A total of twelve women of reproductive age were included in this research using a purposive sampling method with inclusion and exclusion criteria pre-set. Data were collected using an in-depth interview technique guided by a semi-structured questionnaire, field notes, and recordings. Data were thematically analyzed so as to discover patterns and meaning regarding beliefs, social influences, and practices of family planning.

Results: Five main themes were identified in this research, namely: (1) women's understanding of family planning; (2) cultural beliefs that having a lot of children means a bless/fortune of abundant prosperity; (3) believing in myths and taboos about contraceptive usage; (4) the role of the husband and other family members in deciding; and (5) the way women overcome social pressures. Despite most women being aware of the benefits of family planning use, their attitude toward being contraceptive users was affected by local culture, myths, fears of negative consequences, and less male involvement. Beliefs that having more children means greater fortune, as well as strengthening family prosperity, were still considered barriers. Husbands, parents, and religious and traditional leaders took an important role in deciding family planning usage for women in their community.

Conclusions: Beliefs, social norms, culture, and family support contribute significantly to determining acceptance and practice of family planning for women. To overcome misconceptions and social barriers, and to increase the success of family planning program acceptance, there is a strong need to promote health in culturally sensitive neighborhoods, participation of the community, and finally, the involvement of men in the program.

Keywords: Family planning, Contraception, Culture, Women, Reproductive health

Introduction

Family planning is a well-established intervention that controls the number and spacing of births as a way of minimizing the risk of pregnancies and thus decreasing mortality rates at both the maternal and neonatal level (1). Besides that, the role of family planning programs is paramount in helping reach the sustainable development goals by ensuring that everybody has access to safe, quality, and effective methods of contraception and reproductive health services all over the world (2). In Indonesia, family planning is considered a national priority program in controlling the population and enhancing family welfare (3). Contraceptive use coverage is nonetheless uneven across various areas, and it has been shown to be correlated with socio-cultural and economic factors (4).

This implies that the implementation of family planning programs is not simply related to access in health facilities but to community social acceptance. Studies show that family planning utilization decisions rely not only on medical issues but also on partners' support and norms embedded in society; cultural values are of great importance (5). It is quite significant that culture often emerges as the greatest influencing factor and determinant of utilization choices towards contraception, particularly in societies characterized by a patriarchal value system with a strong sense of group orientation (4).

Many of the studies reveal that myths related to the utilization of family planning in various parts of Indonesian communities pose an impediment to the utilization of family planning programs. It is known that certain communities believe that the utilization of contraceptives can trigger infertility and various kinds of health-related illnesses, and their symptoms, fears, and anxiety about its undesirable consequences differ from actual scientific facts (6,7). In most communities that are characterized by a patriarchally organized family with a social structure, the

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husband and their other relatives (extended family) play an important role in decision-making about contraceptive utilization. Therefore, such limitations, which affect the willingness and rights of women in selecting methods of Family planning, affect the choice and utilization of family planning by women, as cultural values are a major factor that influences women's decisions concerning their reproductive health and rights (8).

The engagement of the partner has been proven to be an essential element in the efficient use of contraception by women of reproductive age (9). Low levels of husband support are a major barrier to the acceptance of modern contraception because the husband is the central figure of decision-making in family planning in Indonesia (10,11). In West Sumatra, including Pariaman DIstrict, community health behaviors are highly influenced by the Minangkabau traditional values and Islamic religion (12). It is recognized that in several communities, children are still perceived to be as symbols of good luck and blessings to the family system in Minangkabau, which is structured by social and cultural values, and so strengthens the assumption that reproductive health behavior cannot be separated from the value system, cultural life, and what is adopted by society (13). This finding showed that there are also social, structural, and cultural barriers to practicing family planning, and all are mutually intertwined in the daily life of the community.

Therefore, an approach is needed to explore the lived experiences of women in depth to understand the meanings of family planning related to their cultural contexts. Phenomenological qualitative research is the right approach because phenomenology is expected to reach subjective experience and meaning held by the person in routine activity and to investigate the lived experience directly and thoroughly (14,15). Such an approach assists the researchers in understanding reproduction decisions as complex phenomena comprising the result of personal experience, cultural values, and social norms.

A lot of research has looked at what influences contraceptive use, much of it centering on education and access to healthcare. Studies in these fields have usually been concerned with socio-economic factors such as education and availability of health care services. However, there is still a lack of research at the community level with regard to women's experience of cultural taboo regarding family planning. Previous studies have mainly focused on demographic factors and contraceptive-related factors that did not enable us to explore the influence of local cultural traditions on contraceptive use in Pariaman, where local customs (*adat*) and Islamic values have a significant role in the social life of the community (16). The present study fills the gap by applying phenomenology to explore women's experience of using contraception in terms of cultural beliefs and related taboos through the lens of phenomenology in Pariaman, West Sumatra, Indonesia.

Methods

Study Design

A phenomenological qualitative design was used in this study to find out how women of reproductive age in Pariaman, West Sumatra, Indonesia perceived their cultural beliefs and taboos about family planning. The phenomenological qualitative design was selected for its ability to bring out the subjective experiences of women. The study was carried out in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines.

Phenomenological Framework and Bracketing

The descriptive phenomenological approach helped in recounting the experiences lived by the participants. During data collection and analysis, the researchers practiced *epoché* (bracketing) to keep away from preconceived notions about family planning and its cultural significance.

Study Setting and Participants

Data collection for this study was conducted in Pariaman, West Sumatra, Indonesia. Participants in this research were women aged between 25 and 47 years who had lived in Pariaman long enough to have had previous experiences with family planning, who participated in interviews in Bahasa Indonesia, and who provided their informed consent.

Data collection was conducted using individual, semi-structured in-depth interviews, and it was required that the setting be private and comfortable to make participants willing to share their personal lived experience. Each interview lasted approximately 60 minutes and was audio-recorded with participants' written informed consent. The interview guide contained open questions regarding experience in the domain of family planning, the influence of cultural beliefs and taboos, etc. In addition, the researchers took field notes during and shortly after each interview in order to be able to record contextual information, the non-verbal behavior of the interviewee, and their impressions after the interview.

Sample Size

Twelve women participated in this study. Recruitment and preliminary analysis occurred concurrently. Sampling ceased when subsequent interviews did not generate new meaning units or themes relevant to women's experiences of cultural beliefs and taboos related to family planning.

Measures and Instruments

Researchers served as the major instruments in the research. Data were collected using a semi-structured interview guide, which was developed by adapting research objectives and concepts pertaining to family planning, cultural beliefs, prohibitions or taboos, and family influences and social pressures.

The semi-structured interview guide consists of 5 broad questions with some probing questions asking women about: (a) women's understanding or perception regarding family planning, (b) cultural beliefs influencing decisions to accept or refuse using family planning methods, (c) cultural prohibitions or taboos against the use of family planning, (d) influences of husband, other family members, traditional and religious leaders, and (e) obstacles faced, social pressures, and women's strategies for facing taboo and beliefs in family planning utilization. A detailed question guide is presented in Table 1.

Pilot Test

Before the main data collection, the semi-structured interview guide was piloted with women of reproductive age in Pasaman, West Sumatra, Indonesia. Pasaman was selected because it was outside the main sampling area in Pariaman, thereby minimizing the likelihood that pilot participants would also be eligible for the main study, while its population shared broadly comparable Minangkabau cultural traditions and social influences.

Pilot interview data were used solely to refine the interview guide and were not included in the final analysis. None of the pilot participants was recruited into the final study sample.

Data Collection and Analysis

All participants were given an overview of the study aims, the interview process, voluntary participation, confidentiality, and participants' right to refuse to answer any questions or to withdraw from the study at any point without any detriment. Written, informed consent was obtained prior to interviews.

The recorded interview content was transcribed verbatim in full by the researcher. The researcher reviewed the transcripts repeatedly to gain a deep overview of the participants' experiences and to identify significant statements. Thematic analysis was a process in several stages: familiarization with the data; identification of significant statements; initial coding; sorting and grouping codes into themes; exploring the patterns within participants; and developing and refining themes. All developed themes were compared against the transcripts to ensure they adequately reflected participants' experiences and beliefs.

Thematic analysis explored patterns of meaning associated with cultural proscriptions, taboos, familial expectations, and cultural pressures, and the strategies women employed to inform their decision-making concerning family planning. Selected, representative direct quotes from the interviews were used to support the interpretation of each theme while ensuring confidentiality.

Researchers started by transcribing the audio interviews word for word and read the transcripts repeatedly. The team then identified and coded important statements that reflected women's experiences with cultural beliefs, norms, taboos, and how they approached family planning. After identifying these statements, they grouped similar codes into categories, which eventually became broader themes showing what the women actually went through. Throughout the process, the team kept going back to the transcripts, comparing codes, categories, and themes, making sure every finding stayed true to what the participants shared.

Results

The five main themes, according to the focus of the study,

Table 1. Interview Guide Questions

No.	Main Questions	Probing Questions
1	What are your views regarding the use of Family Planning in the community where you live?	• What do you know about Family Planning? • Where do you obtain information about Family Planning? • How does the community view women who use Family Planning? • Why do you hold that view?
2	What cultural beliefs influence your decision to use or not use Family Planning?	• Are there any specific beliefs related to Family Planning in the community? • From whom did you learn about these beliefs? • How do these beliefs influence your decision? • Can you describe any experiences related to these beliefs?
3	Are there any cultural prohibitions or taboos related to the use of Family Planning among women?	• What prohibitions or taboos have you heard about? • Why do people believe in these prohibitions? • How does the community react if someone violates these prohibitions? • What is your opinion about these prohibitions?
4	How do your husband, family, traditional leaders, or religious leaders influence your decision regarding Family Planning use?	• What is your husband's opinion about Family Planning use? • What are the views of your parents or in-laws regarding Family Planning? • What do traditional or religious leaders think about Family Planning use? • To what extent do their opinions influence your decision?
5	What obstacles or challenges do you face related to cultural beliefs and prohibitions in using Family Planning?	• Have cultural beliefs ever made you hesitate to use Family Planning? • Have you ever experienced pressure from family or the community regarding Family Planning use? • How do you deal with such situations? • In your opinion, what can be done to help women make decisions about Family Planning more easily?

were identified from in-depth interviews conducted with 12 respondents: The first is the meaning of family planning from a local cultural perspective, concerning how women understand family planning in the context of cultural values and their social lives and daily activities. The second is cultural beliefs that affect family planning usage, focusing on various myths and traditional perceptions that shape the process of women making choices about contraception. The third theme is cultural taboos and prohibitions against family planning usage, identifying any social regulations or rules that restrict and discourage women from using family planning methods. The fourth theme is the effects of families and community figures in family planning decision-making, indicating the influence of spouses, families, and traditional leaders or figures of the local religion in determining women's family planning choices. The fifth is women's coping strategies for facing cultural myths and prohibitions about family planning, describing ways in which women are able to adjust, respond to, or overcome cultural pressures in making decisions about using contraception. Overall, the five themes are very appropriate to apply to the phenomenological approach in that they present an in-depth understanding of the lived experiences of women in understanding cultural beliefs and taboos surrounding family planning in West Sumatra.

Table 2 shows information about 12 participants in the reproductive years, all between 25 and 47 years old. Most of the participants were homemakers, had three or more children, and had finished senior high school. Even women (58.3%) were not using any method of contraception when interviewed, while five women (41.7%) reported using contraception such as injectable contraception, IUDs, and pills. Contraception is still rejected by many, even in larger families. Most of the interviewees said that family planning is a program to control number and birth spacing instead of protecting the health of mothers and children when asked about family planning.

Theme 1. Women's Views on Family Planning Use in the Community

Participants obtained family-planning information from midwives, *posyandu* cadres, *puskesmas* staff, social media, and from the experience of others in the family. Several women described family planning as a way to regulate births, protect maternal health, and support household economic stability. However, participants commonly portrayed family planning as a woman's responsibility, while husbands were described as having limited involvement in obtaining information or initiating discussions.

"I know family planning is to regulate birth spacing so that maternal health is maintained. I first received information from a midwife after giving birth to my first child." (R1)

"In our village, people mostly talk about family planning for women. There is rarely discussion about the role of husbands in family planning*." (R2)*

"I learned about family planning from posyandu and health education sessions at the puskesmas. In my opinion, family planning is important so that the family economy can also be more stable." (R5)

Of the 12 participants, 9 participants demonstrated a good understanding of the benefits of family planning, while 3 participants (R1, R2, and R5) showed how sources and depth of information varied, and several participants perceived family planning as primarily a woman's responsibility within their communities.

Theme 2. Cultural Beliefs Influencing Family Planning Decisions

The interviews showed that decisions regarding family planning use were not only based on health considerations but were also influenced by cultural beliefs passed down through generations. Some women also described the view that the number of children is determined by God and should not be deliberately limited.

Table 2. Frequency Distribution of Respondent Characteristics (n=12)

Respondent Code	Age (y)	Education	Occupation	Number of Children	Family Planning Use Status
R1	25	Junior High School	Housewife	1	Using injectable contraception
R2	27	Senior High School	Housewife	2	Not using family planning
R3	29	Senior High School	Trader	2	Not using family planning
R4	31	Senior High School	Housewife	3	Using IUD
R5	33	Junior High School	Farmer	3	Not using family planning
R6	35	Senior High School	Housewife	4	Not using family planning
R7	37	Junior High School	Farmer	3	Not using family planning
R8	39	Senior High School	Trader	4	Using implant
R9	41	Elementary School	Housewife	5	Not using family planning
R10	43	Senior High School	Housewife	4	Using pills
R11	45	Junior High School	Farmer	5	Not using family planning
R12	47	Senior High School	Entrepreneur	3	Using IUD

"My parents often said that having many children means having more blessings. So I was once hesitant to use family planning." (R3)

"In my community, people still believe that limiting births means rejecting the fortune given by God." (R7)

"My grandmother said that a woman should accept however many children God gives, because it is destiny." (R10)

These findings indicate that cultural beliefs surrounding childbearing can shape women's perceptions and decisions regarding family planning. These beliefs sometimes caused women to hesitate when considering contraceptive use. Thus, family planning decisions were experienced within a broader cultural and spiritual context in which childbearing was viewed as both a blessing and a matter of destiny.

Theme 3. Cultural Prohibitions and Taboos Related to Family Planning

The findings indicate that various cultural prohibitions and taboos were still believed by some community members. These prohibitions were generally related to negative perceptions of contraceptive methods. Some participants mentioned beliefs that family planning can cause infertility, chronic illness, or marital problems.

"I once heard from a neighbor that using injectable contraception for too long can cause infertility." (R4)

"Some people say that using family planning can make the body sick and make it difficult to get pregnant again after stopping." (R6)

"Some parents in the village still forbid their daughters from using family planning because they are afraid they will not be able to have children later." (R11)

"If a woman does not have many children because of FP, sometimes people still talk behind her back." (R8)

Women's concerns were shaped not only by their own experiences but also by stories shared by relatives, neighbors, and other community members. Such beliefs can contribute to uncertainty and reluctance toward contraceptive use, while social expectations and fear of community judgment may further reinforce these concerns.

Theme 4. Influences of Husbands, Family, Customary Leaders, and Religious Leaders

All participants stated that husbands play an important role in family planning decision-making. In addition, parents, in-laws, customary leaders, and religious leaders also influenced participants' decisions.

"I only agreed to use family planning after my husband approved it, because decisions like this are usually discussed together." (R2)

"My mother-in-law was initially against it because she wanted more grandchildren." (R9)

"When religious leaders explain that family planning is allowed for maternal health, people are usually more accepting." (R12)

"My husband's support made me more confident to use family planning even though some family members disagreed." (R5)

These accounts suggest that women did not make family-planning decisions independently. Husband support appeared to provide confidence and legitimacy for contraceptive use, while disagreement or expectations from extended family might create pressure and uncertainty. The perspectives of customary and religious leaders also influenced how family planning was understood and accepted within the community.

Theme 5. Women's Challenges and Strategies in Facing Cultural Beliefs and Taboos

Participants described various challenges in using family planning, including family pressure, community comments, and fear of side effects rising from word-of-mouth information. To cope with these issues, participants sought advice and guidance from health workers, discussed options with their husbands, and attended health education sessions.

"At first I was afraid because there were many stories about family planning side effects, but after the midwife explained it, I felt calmer." (R1)

"I often discuss with my husband before deciding which type of family planning to use." (R7)

"Whenever I receive scary information, I immediately ask health workers." (R6)

"I think health education should be done more often so that people do not only believe unverified stories." (R10)

Women actively sought reassurance from trusted sources when they encountered uncertainty or misinformation. Concerns arising from family pressure, community narratives, and fears about contraceptive side effects can be reduced through communication with husbands and direct consultation with health workers.

Discussion

The study revealed that family planning practices are understood by most women as efforts by the family to control the timing and spacing of pregnancy to maintain a healthy reproductive cycle and ensure the well-being of the child and the entire family. It was disclosed by the study participants that most of them get the information from health workers, community health cadres, and family and social networks. However, family planning still seems to be conceived in this community as strictly women's business. Similar results have been reported by previous studies where, despite the increase in the level of knowledge of family planning services among women, the participation of husbands in reproductive decision-making remains very low in many communities (9). Such conditions may reinforce the dominant role of women in contraceptive practices and maintain traditional gender norms surrounding reproductive health.

Health professionals are a key factor in empowering women to gain higher knowledge on family planning practices. The findings obtained by Amin et al were consistent in that education given by professional health workers on family planning benefits could increase the knowledge level of women and, at the same time, prevent risky pregnancies and promote women's health (17). Likewise, increased exposure to mass media and service availability in formal primary health care centers contribute to improved family planning knowledge (18). However, increased level of knowledge does not influence the dual use of modern contraceptives due to the limitation of couple communication based on prevailing gender-based norms in reproductive health care. This could still be so in a similar community where women are still heavily dependent on informal networks such as family and community support for their reproductive information and also likely shape their decisions on modern contraception (19). Information sharing through health professionals still must be accompanied by improving couple communication and the gender imbalances related to family planning in a society.

Additionally, cultural norms play a prominent role in informing women's decisions on family planning. Most still feel that "the number of children means the amount of prosperity or blessing as many as God gives them"; they believe that the number of children is an aspect of divine decree. While multiple children could also indicate wealth, fortune, or social status and respect, several previous research studies still point to the existence of cultural norms strongly encouraging higher birth rates through social values that promote large numbers of children or the perceived value that higher parity implies blessing or fortunes (20). Access to comprehensive family planning services is just one determinant of use of modern contraceptives. While individual fertility preferences and needs are important factors for reproductive decision-making, reproductive behaviors are determined by both personal needs and cultural context (21,22). Informal sources of information, including family members and the community, have an important role in the level of knowledge about and attitudes to contraceptive methods (23). Health care workers need to reinforce their role to ensure that individuals and couples get accurate information regarding modern contraceptive use so that women might not rely solely on their traditional beliefs.

Cultural prohibitions, myths, and taboos also played a role in restricting the usage of modern family planning. Perceptions of the risk of infertility and illness, and subsequent disruption of sexual and marital lives with the use of modern family planning, were found to positively influence their willingness not to try planning methods. The idea of becoming infertile after using contraceptives is of high significance to any woman. It is often mentioned by respondents as a fear, which was also identified by Sedlander et al (24). Common myths and fears about infertility as side effects, among females who still reside in the villages, are closely tied to contraceptive myths, which further reinforce stigma towards family planning users and reluctance to use the plan (25). This implies that strong norms and social practices might act as structural barriers to contraception (8). Later, Suveren et al highlighted how misinformation further reinforced negative community views towards modern contraceptive methods (26). So, education could only be effective if it directly tackled negative myths and strong cultural views.

Decisions with regard to the use of modern family planning were found to be highly influenced by men, extended family, religious and customary leaders. Husband approval appeared particularly important in determining whether women felt able to use contraception. Male partner involvement is recognized as an important determinant of contraceptive decision-making, particularly in settings where reproductive decisions are traditionally negotiated within the household. A few previous research results also support the significance of religious leaders, who can influence community attitudes toward family planning and may contribute positively to acceptance when reproductive health and family well-being are emphasized (25). Communication between spouses influences modern contraceptive acceptance and utilization (27); parents as well as in-laws (specifically in patriarchal society) also influence their fertility expectations, particularly in multigenerational households where family norms and expectations can shape reproductive decisions (28). Therefore, a woman's decision-making cannot be thought of as purely individual behavior or as her personal belief alone, and couple family planning promotion has to include the decision-making involvement of husbands, parents, and extended families, together with considering the religious and customary leaders' beliefs, rather than focusing on women only.

Despite various influences from culture and society, women were resilient in adopting a number of measures when faced with challenges posed by circumstances related to their family planning needs. In doing so, observed women consulted healthcare workers, communicated their views to men in order to achieve mutual respect concerning modern contraception, and assessed cultural beliefs with information given through healthcare providers. They likely used a combination of: (a) access to relevant services, consultation from family planning social workers for gaining confidence in their decisions and reducing misconceptions (29); (b) improved communication with the husband and family members to increase trust, willingness, and mutual understanding of the advantages of modern contraceptive use (30); and (c) the structured learning provided by community training sessions aimed at helping men overcome their fears of modern contraceptives by providing knowledge and awareness (31). The use of repeated supportive communication from healthcare providers would perhaps

boost women's confidence in their use of modern family planning and alleviate the pressure encountered from social network stigma; whereby, taken together, these findings suggest that effective family planning promotion requires a combination of accurate health education, couple-centered communication, community engagement, and sustained support from healthcare providers.

Implications of the Study

Some key implications may be drawn from the study. First, family planning education for the community must be context-specific, addressing not only information regarding family planning methods, their safety, efficiency, and effectiveness but also the socio-cultural contexts (i.e., myths, taboos, and specific women's beliefs toward it). Second, husbands and key family members should be addressed through active community-based health education interventions to integrate male participation in reproductive decision-making. Thirdly, religious and traditional leaders should be mobilized as community advocates toward reproductive health and modern planning in a culturally appropriate manner. Finally, health workers in family planning provision should work more on individual counseling to take women's myths and fears into account, while educating couples on modern planning evidence-based advantages, which could then provide women enough leverage in the negotiation process with their husbands and families.

Limitations of the Study

Several limitations are associated with this study which must be taken into account when concluding: Firstly, the current study included only 12 women from a particular geographical and cultural group in Pariaman, West Sumatra. Therefore, the findings from this sample may not be readily transferable to women in other groups or other regions. Secondly, the sampling was purposive, which may mean overlooking women who had different experiences or outlooks from those who did not choose to participate. Thirdly, the study was mainly based on individual experiences as reported by women, which may be subject to recollection bias and socially desirable responses, especially given the sensitive nature of contraceptive use, familial expectations, and religious or cultural beliefs and expectations. Fourthly, the views of the husband and family, healthcare providers, and local religious and traditional leaders were not interviewed directly. Thus, what is presented are women's perceptions of the cultural influences on family planning use rather than actual views and perspectives of influential stakeholders. Future work could aim to incorporate multiple stakeholder groups and conduct multi-community studies.

Conclusions

The study concluded that there is a generalized perception among women that family planning involves family size regulation to achieve better maternal and child health and family welfare. Cultural, mythological, and taboo influences continue to play a role in the use of family planning. They include the belief that a larger family brings blessings, and concerns about side effects associated with the use of contraception. Husbands, extended family, traditional and religious leaders, and elders are important factors influencing women's decisions about using family planning. There is a significant effect of couple interaction on family planning issues in women's decision-making processes. In responding to social and cultural pressures, women employed strategies such as seeking additional health information from healthcare providers and discussing the matter with their husbands. Therefore, family planning programs should adopt culturally sensitive approaches that combine accurate health education, couple-centered communication, family involvement, and engagement with community, religious, and customary leaders to improve informed and acceptable family planning practices.

Authors' Contribution

Conceptualization: Novi Maya Sari and Novi Maya Sari.
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Writing–review & editing: Novi Maya Sari and Novi Maya Sari.

Conflict of Interests

Authors declare that they have no conflict of interests.

Data Availability Statement

The qualitative data that were generated and/or analyzed during this study are not publicly available because they contain information that could be identifying to the participant and are constrained by privacy, ethical, and confidentiality concerns. Data may be available from the corresponding author upon reasonable request in accordance with the relevant ethical and privacy requirements.

Declaration of Generative AI and AI-Assisted Technologies in the Writing Process

The authors declare that no generative artificial intelligence (AI) or AI-assisted technologies were used in the writing, editing, proofreading, or preparation of this manuscript. Language and grammar proofreading was performed by a native English speaker. The authors take full responsibility for the accuracy, originality, interpretation, and overall integrity of the manuscript and its scientific findings.

Ethical Issues

The study was approved by the Ethics Committee of Baiturrahmah University, Indonesia (Approval Reference Number: 004590/KEP STIKes Panrita Husada Bulukumba/2025). Each participant was provided with information relating to the purposes of the study, procedures, benefits, confidentiality, potential harm/discomfort, and the voluntary nature of participation before giving informed written consent to proceed. Participants were assured that participation was voluntary and that they may choose not to participate, refuse to answer any interview question, or withdraw from the study at any stage, without any liability. The recordings of the interviews, any transcripts made, and personal

details collected from participants will be stored securely and will only be used for this research. Any personal identifiers will be removed from the transcription and replaced by participants' identifiers to ensure anonymity.

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