

Community Health Promotion Program: Evaluating the Impact of Health Interventions in the Community

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ABSTRACT

Community health promotion programs are essential for improving public health outcomes by addressing both individual behaviors and environmental determinants. This study evaluates the impact of a community-based health intervention implemented in Indonesia, focusing on changes in health behaviors, risk factors, and community engagement. A mixed-methods approach was employed, combining quantitative data from pre- and post-intervention health screenings and self-report surveys with qualitative insights gathered through focus groups and interviews. The intervention targeted middle-aged adults at risk of cardiovascular disease, involving ten group sessions facilitated by trained community health workers. Quantitative results demonstrated significant improvements in body weight, blood pressure, smoking cessation, and physical activity, with 30% of participants achieving the intended reduction in cardiovascular risk factors. Qualitative findings highlighted increased community awareness, sustained behavioral changes, and the importance of cultural appropriateness and ongoing support. The study underscores the effectiveness of community engagement and robust evaluation frameworks in health promotion initiatives. Challenges included ensuring broad participation and addressing adverse selection. The results support the continued investment in community-based health interventions and emphasize the need for ongoing evaluation and adaptation to maximize impact and sustainability. This research contributes to the growing body of evidence on the value of participatory, culturally sensitive health promotion strategies in diverse settings.

Keywords: health promotion, community intervention, evaluation, Indonesia, cardiovascular risk, behavioral change.

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INTRODUCTION

Public health remains a fundamental pillar of societal development, particularly in countries like Indonesia, where the dual burden of communicable and non-communicable diseases (NCDs) continues to challenge healthcare systems. The World Health Organization (WHO) has consistently emphasized the importance of health promotion and disease prevention as cost-effective strategies to improve population health outcomes and reduce the strain on healthcare resources. In Indonesia, rapid urbanization, lifestyle changes, and an aging population have contributed to a significant increase in NCDs such as cardiovascular diseases, diabetes, and hypertension. These conditions are often preventable through community-based interventions that target modifiable risk factors such as poor diet, physical inactivity, tobacco use, and harmful alcohol consumption (Goswami, 2024).

Despite the recognized importance of health promotion, the implementation and evaluation of community-based health programs in Indonesia face several challenges. These include limited resources, cultural diversity, varying levels of health literacy, and geographic barriers that hinder access to healthcare services. Moreover, the effectiveness of health promotion initiatives often depends on the degree of community engagement, the appropriateness of intervention design, and the availability of robust evaluation frameworks to measure impact. This article aims to contribute to the growing body of evidence on the effectiveness of community health promotion programs by evaluating the impact of a health intervention implemented in an Indonesian community.

The concept of health promotion is rooted in the Ottawa Charter for Health Promotion (1986), which defines health promotion as the process of enabling people to increase control over and improve their health. This involves not only individual behavior change but also the creation of supportive environments, community action, and the development of personal skills. In the context of Indonesia, where community values and social cohesion are strong, leveraging community engagement is particularly promising for health promotion initiatives. Community-based interventions have the potential to address health disparities, empower individuals and groups, and foster sustainable behavioral changes (Vidal et al., 2024).

Recent decades have seen a global shift towards preventive healthcare, with increasing recognition of the social determinants of health. These determinants—such as socioeconomic status, education, environment, and social support networks—play a critical role in shaping health outcomes. Community health promotion programs that address these determinants can lead to more equitable health outcomes and reduce the burden on healthcare systems. In Indonesia, where disparities in health outcomes persist between urban and rural areas, as well as across socioeconomic groups, community-based interventions are especially relevant.

The burden of NCDs in Indonesia is substantial. According to the Indonesian Ministry of Health, NCDs account for more than 70% of all deaths in the country, with cardiovascular diseases, cancer, diabetes, and chronic respiratory diseases being the leading causes. Risk factors such as unhealthy diets, physical inactivity, tobacco use, and harmful alcohol consumption are widespread, particularly among adults. These risk factors are often interrelated and influenced by social, economic, and

environmental conditions. For example, urbanization has led to increased consumption of processed foods and sedentary lifestyles, while economic pressures and cultural norms may perpetuate tobacco use.

Given the complexity of these challenges, health promotion programs must be tailored to the local context, taking into account cultural beliefs, social norms, and community structures. In Indonesia, community health workers (CHWs) play a vital role in bridging the gap between healthcare providers and the community. CHWs are often trusted members of the community who can effectively communicate health messages, mobilize community resources, and facilitate behavior change. Their involvement in health promotion programs is critical for ensuring cultural appropriateness, community buy-in, and sustainability.

The effectiveness of health promotion programs depends not only on the quality of intervention design but also on the rigor of evaluation. Evaluation frameworks should assess both process and outcome indicators, including changes in knowledge, attitudes, and behaviors, as well as improvements in health status and risk factors. Mixed-methods approaches—combining quantitative data (such as pre- and post-intervention health screenings and surveys) with qualitative insights (such as focus groups and interviews)—are increasingly recognized as best practice for evaluating complex community interventions. These approaches allow researchers to capture the multifaceted nature of health promotion, including contextual factors, participant experiences, and unintended consequences (Javanmardi et al., 2025).

Despite the potential of community health promotion programs, several barriers to implementation and evaluation persist in Indonesia. Limited funding, inadequate training for CHWs, and weak health information systems can hinder the scale-up and sustainability of interventions. Additionally, ensuring broad and representative participation in health promotion programs is challenging, as only the most motivated individuals may enroll, leading to adverse selection and limited generalizability of results. Addressing these challenges requires a multi-sectoral approach, involving collaboration between government agencies, non-governmental organizations (NGOs), academia, and the private sector.

The current study evaluates the impact of a community health promotion program implemented in an Indonesian setting, with a focus on cardiovascular risk reduction. The program was designed to address multiple risk factors through group-based education, skill-building, and the creation of supportive environments for behavior change. The evaluation framework incorporates both quantitative and qualitative methods to assess changes in health behaviors, risk factors, and community engagement. By examining the processes and outcomes of this intervention, the study aims to identify best practices, challenges, and lessons learned for future health promotion initiatives in Indonesia.

The findings of this study have important implications for public health policy and practice. Evidence-based health promotion programs can inform the development of national strategies for NCD prevention and control, as well as guide the allocation of resources to maximize impact. Furthermore, the lessons learned from this evaluation can be applied to other settings in Indonesia and beyond, contributing to the global knowledge base on effective community health promotion.

METHOD

This study was designed as a mixed-methods research project to evaluate a community health promotion program targeting non-communicable disease (NCD) risk factors in an Indonesian community. The research was conducted over a period of 18 months, from initial planning through data collection and analysis. The approach was chosen to provide both quantitative evidence of program impact and qualitative insights into contextual factors, participant experiences, and implementation challenges. This dual focus is consistent with best practices in public health evaluation, where understanding both outcomes and processes is essential for meaningful interpretation and future program improvement.

Study Design

A concurrent mixed-methods design was employed, meaning that both quantitative and qualitative data were collected simultaneously rather than sequentially. This design allows for triangulation of data sources and a more comprehensive understanding of the intervention's effectiveness and the mechanisms by which it operates. The quantitative component focused on measuring changes in health behaviors and risk factors, while the qualitative component explored participant perceptions, barriers, facilitators, and the broader context of the intervention. This approach is robust for evaluating complex community-based health interventions, as it enables researchers to ask both confirmatory and exploratory questions (Purssell & McCrae, 2024).

Setting and Participants

The study was conducted in a semi-urban district in Central Java, Indonesia, selected for its high prevalence of NCD risk factors and its representative demographic profile. The community health program was implemented through local Puskesmas (primary health centers), with support from community health volunteers (kader). The target population included adults aged 25–65 years, with at least one modifiable risk factor for NCDs (e.g., hypertension, obesity, smoking, physical inactivity). Individuals with severe comorbidities or those unable to attend group sessions were excluded.

Participants were recruited through community outreach, announcements at Puskesmas, and collaboration with local leaders. Eligibility was assessed using a brief screening questionnaire. Informed consent was obtained from all participants, with additional parental consent for those aged 15–17 years (though this age group was not the primary focus). The sample size was determined using power analysis for the primary quantitative outcome (reduction in cardiovascular risk score), aiming for a minimum detectable effect size of 0.3 with 80% power and 95% confidence. Based on these calculations, a target of 500 participants was set, with an anticipated attrition rate of 20%.

Intervention

The health promotion program consisted of a series of ten group-based sessions held biweekly over five months. Each session lasted approximately two hours and was facilitated by trained community health workers and local healthcare providers. The

curriculum was adapted from evidence-based guidelines for NCD prevention and included the following core components:

- Health Education: Topics included understanding NCD risk factors, healthy eating, physical activity, smoking cessation, and stress management.
- Skill-Building Activities: Practical demonstrations and group exercises on healthy cooking, portion control, and safe physical activity.
- Behavioral Goal Setting: Participants worked in small groups to set personal health goals and develop action plans.
- Social Support and Peer Mentoring: Opportunities for participants to share experiences, challenges, and successes.
- Referral and Follow-Up: Linkages to Puskesmas for further assessment and management of identified risk factors.

Sessions were held in community halls, Puskesmas, and other accessible venues. Each session included interactive discussions, group activities, and take-home materials. Participants were encouraged to involve family members and friends to enhance social support and community engagement.

Data Collection

Quantitative Data:

Pre- and post-intervention assessments were conducted using standardized instruments. Baseline and follow-up data included:

- Anthropometric Measurements: Height, weight, waist circumference, and body mass index (BMI).
- Blood Pressure: Measured using validated automated devices.
- Biochemical Markers: Fasting blood glucose and lipid profiles for a subsample (n=100), collected at local laboratories.
- Behavioral Surveys: Validated questionnaires assessing diet, physical activity, smoking status, alcohol consumption, and self-reported health status.
- Knowledge and Attitudes: Short quizzes and self-report scales to assess changes in health knowledge and attitudes toward healthy behaviors.

Qualitative methods included:

- Focus Group Discussions (FGDs): Conducted with participants at three time points (pre-intervention, mid-intervention, and post-intervention) to explore perceptions, experiences, and barriers to behavior change. Each FGD included 8–10 participants and lasted 60–90 minutes.
- In-Depth Interviews: Semi-structured interviews with key informants, including community health workers, local leaders, and healthcare providers, to gain insights into implementation challenges and facilitators.
- Observations: Field notes from research assistants attending sessions to document group dynamics, engagement, and contextual factors.
- All qualitative data were audio-recorded, transcribed verbatim, and translated into English for analysis.

*Data Analysis**Quantitative Analysis*

Descriptive statistics (means, standard deviations, frequencies) were used to summarize baseline and follow-up data. Paired t-tests and McNemar's tests were used to assess changes in continuous and categorical variables, respectively. Multivariate regression models adjusted for potential confounders (age, sex, education, baseline risk factors). Subgroup analyses were conducted for high-risk groups (e.g., those with hypertension or obesity).

Qualitative Analysis:

Transcripts and field notes were analyzed using thematic analysis. Initial coding was performed independently by two researchers, followed by collaborative theme development. NVivo software was used to organize and manage qualitative data. Themes were mapped to the RE-AIM framework (Reach, Effectiveness, Adoption, Implementation, Maintenance) to assess program impact and sustainability.

Integration of Quantitative and Qualitative Data

Findings from both data sources were integrated at the interpretation stage. Quantitative results were contextualized using qualitative insights, and vice versa. For example, quantitative improvements in health behaviors were explored in relation to qualitative themes such as social support, cultural appropriateness, and implementation barriers. This integration provided a more nuanced understanding of the intervention's effectiveness and the factors influencing its success..

RESULTS AND DISCUSSION

A total of 486 participants were enrolled in the community health promotion program, with 423 (87%) completing both pre- and post-intervention assessments. The majority of participants were female (72%), reflecting the typical demographic of community health initiatives in Indonesia, where women are often more actively engaged in health-related activities. The mean age of participants was 46.2 years (SD = 8.7), with a range from 25 to 64 years. Baseline characteristics are summarized in Table 1.

Table 1. Baseline Characteristics of Participants

Variable	Value (n=486)
Gender (Female)	350 (72%)
Age (years, mean $\pm$ SD)	46.2 $\pm$ 8.7
Education ($\leq$ Elementary)	312 (64%)
Employment (Housewife)	276 (57%)
Smoking (Current)	98 (20%)
Hypertension	182 (37%)
Obesity (BMI $\geq$ 25)	204 (42%)

Quantitative Outcomes*Health Behaviors and Risk Factors*

Quantitative data revealed significant improvements across multiple health indicators. The proportion of participants with controlled blood pressure increased from 41% at baseline to 67% post-intervention ($p < 0.001$). The percentage of current smokers decreased from 20% to 12% ($p = 0.003$). Physical activity levels, measured as the proportion of participants engaging in at least 150 minutes of moderate exercise per week, increased from 28% to 52% ($p < 0.001$). Similarly, the proportion of participants with a healthy BMI (18.5–24.9) increased from 42% to 51% ($p = 0.002$). Table 2 summarizes these changes.

Table 2: Changes in Health Indicators Pre- and Post-Intervention

Indicator	Baseline (%)	Post-Intervention (%)	p-value
Controlled Blood Pressure	41	67	<0.001
Current Smokers	20	12	0.003
Adequate Physical Activity	28	52	<0.001
Healthy BMI	42	51	0.002

Self-reported knowledge about NCD risk factors improved significantly. The mean knowledge score (on a 0–100 scale) increased from 56.3 (SD = 12.1) at baseline to 78.9 (SD = 9.8) post-intervention ($p < 0.001$). Attitudes toward healthy behaviors also improved, with a higher proportion of participants expressing confidence in their ability to maintain a healthy lifestyle (from 45% to 68%, $p < 0.001$).

Qualitative Findings

Focus group discussions and in-depth interviews provided rich insights into the intervention’s impact. Participants reported increased awareness of the importance of healthy eating and physical activity. Many highlighted the value of group sessions in providing social support and motivation. One participant stated:

Several barriers to behavior change were identified, including limited access to healthy food, time constraints, and cultural preferences for certain foods. However, facilitators such as peer support, practical demonstrations (e.g., healthy cooking workshops), and regular follow-up by community health workers were frequently mentioned as key drivers of change.

Community members were actively involved in the intervention, with many participants bringing family members or friends to sessions. This not only increased program reach but also created a supportive environment for sustained behavior change. Local leaders and health workers played a crucial role in mobilizing participation and reinforcing health messages.

The integration of quantitative and qualitative findings provided a comprehensive understanding of the intervention’s impact. While quantitative data demonstrated significant improvements in health behaviors and risk factors, qualitative data revealed the mechanisms behind these changes, such as increased social support,

practical skill-building, and enhanced self-efficacy. For example, the decrease in smoking prevalence was not only reflected in the survey data but also described in interviews as a result of group support and ongoing encouragement from peers.

Subgroup analyses were conducted to explore differences in intervention effects by age, gender, and baseline risk factors. Older participants (≥ 50 years) showed greater improvements in blood pressure control compared to younger participants ($p = 0.02$). Women reported higher levels of satisfaction with the program and were more likely to maintain behavior changes ($p = 0.01$). Participants with baseline hypertension or obesity demonstrated significant reductions in these risk factors, with 62% of hypertensive participants achieving controlled blood pressure and 38% of obese participants achieving a healthy BMI by the end of the intervention.

Process evaluation revealed high levels of participant engagement, with an average attendance rate of 82% across all sessions. Facilitators reported that the most effective sessions were those that combined interactive discussions with practical activities, such as cooking demonstrations and group exercise. Feedback from participants and facilitators was used to refine session content and delivery methods throughout the intervention.

Case Studies

Two illustrative case studies are presented to highlight the intervention's impact on individual participants:

Case Study 1: Mrs. S, 52 years old, Hypertension

Mrs. S joined the program with poorly controlled blood pressure and limited knowledge about healthy eating. Through the intervention, she learned to monitor her blood pressure, reduce salt intake, and incorporate more vegetables into her diet. By the end of the program, her blood pressure was within the normal range, and she reported feeling more energetic and motivated to maintain her new habits.

Case Study 2: Mr. R, 47 years old, Smoker

Mr. R had been smoking for over 20 years and had previously tried to quit without success. The group support and practical advice provided during the intervention helped him reduce his cigarette consumption and eventually quit smoking. He credited the program's emphasis on peer support and regular follow-up for his success.

Further quantitative analysis explored the relationship between program engagement and health outcomes. Participants who attended at least 8 of the 10 sessions ($n=352$) showed greater improvements in blood pressure control (74% vs. 58%, $p < 0.001$) and physical activity levels (58% vs. 40%, $p = 0.002$) compared to those who attended fewer sessions. This suggests a dose-response relationship between program participation and health benefits.

Qualitative Insights on Implementation

Interviews with community health workers revealed several key factors contributing to the program's success:

- **Cultural Appropriateness:** Sessions were tailored to local customs and dietary preferences, making the content more relevant and acceptable.

- **Community Ownership:** Local leaders and volunteers were actively involved in planning and implementing the intervention, fostering a sense of ownership and sustainability.
- **Ongoing Support:** Regular follow-up and access to health services ensured that participants received continued support beyond the formal program period.

Challenges and Lessons Learned

Despite the overall success of the intervention, several challenges were identified:

- **Recruitment and Retention:** Some participants dropped out due to personal or family commitments, highlighting the need for flexible scheduling and targeted outreach.
- **Resource Limitations:** Limited access to healthy food and recreational facilities in some areas posed barriers to sustained behavior change.
- **Measurement Limitations:** Self-reported behaviors may be subject to bias, underscoring the importance of triangulating data sources.

Table 3: Summary of Key Results

Domain	Baseline	Post-Intervention	p-value
Blood Pressure Control	41%	67%	<0.001
Smoking Prevalence	20%	12%	0.003
Physical Activity	28%	52%	<0.001
Healthy BMI	42%	51%	0.002
Mean Knowledge Score	56.3	78.9	<0.001

Discussion

The findings of this mixed-methods evaluation of a community health promotion program in Indonesia demonstrate significant improvements in health behaviors, risk factors, and community engagement among participants. The results are consistent with the growing body of evidence supporting the effectiveness of community-based interventions for non-communicable disease (NCD) prevention and control. This discussion section contextualizes the study’s findings, compares them with existing literature, explores the mechanisms underlying the observed changes, and discusses the implications for public health practice and policy.

Interpretation of Key Findings

The quantitative results revealed substantial improvements in several key health indicators. The proportion of participants with controlled blood pressure increased from 41% to 67%, while the prevalence of current smokers decreased from 20% to 12%. These changes are clinically meaningful and suggest that the intervention was effective in addressing modifiable risk factors for cardiovascular disease and other NCDs. The increase in physical activity levels (from 28% to 52%) and the shift toward a healthier BMI (from 42% to 51%) further underscore the program’s impact on lifestyle behaviors.

Qualitative data provided valuable insights into the mechanisms driving these changes. Participants reported increased awareness of NCD risk factors, enhanced self-

efficacy, and greater motivation to adopt healthy behaviors. The emphasis on social support, practical skill-building, and ongoing follow-up by community health workers emerged as critical facilitators of behavior change. These findings align with the principles of the Ottawa Charter for Health Promotion, which highlights the importance of enabling environments, community action, and personal skill development (Simone et al., 2024).

Comparison with Existing Literature

The results of this study are consistent with previous research on community health promotion programs in low- and middle-income countries (LMICs). For example, a systematic review by van Vliet et al. (2024) found that community-based interventions targeting NCD risk factors were associated with significant improvements in physical activity, dietary behaviors, and smoking cessation. The group-based interventions were particularly effective in fostering social support and sustained behavior change (van Vliet et al., 2024).

However, the present study also highlights some unique aspects of the Indonesian context. The strong emphasis on community engagement, cultural appropriateness, and the involvement of local leaders and health workers contributed to the program's success. This aligns with findings from other studies in Southeast Asia, where community ownership and tailored interventions have been shown to enhance program acceptability and sustainability (Tadesse et al., 2025).

Mechanisms of Change

The integration of quantitative and qualitative data allowed for a nuanced understanding of the mechanisms underlying the observed changes. The group-based format of the intervention facilitated peer learning and mutual encouragement, which are known to enhance motivation and adherence to healthy behaviors. Practical activities, such as cooking demonstrations and group exercise sessions, provided participants with hands-on experience and increased their confidence in adopting new habits.

The role of community health workers was particularly noteworthy. As trusted members of the community, they were able to deliver health messages in a culturally sensitive manner and provide ongoing support to participants. This finding is consistent with the literature on task-shifting and community health worker models in LMICs, which emphasize the importance of local knowledge and trust in promoting health behavior change (Watson et al., 2023).

Implications for Public Health Practice

The results of this study have important implications for public health practice in Indonesia and similar settings. First, the findings support the continued investment in community-based health promotion programs as a cost-effective strategy for addressing the rising burden of NCDs. Such programs can reach large populations, empower individuals and communities, and foster sustainable behavior change (Van Vleet et al., 2025).

Second, the study highlights the value of mixed-methods evaluation frameworks for assessing complex interventions. By combining quantitative and qualitative

approaches, researchers can capture both the outcomes and the processes of change, providing actionable insights for program improvement. This is particularly relevant in the context of Indonesia, where cultural diversity and contextual factors play a significant role in health promotion.

Third, the findings underscore the importance of community engagement and local ownership in program design and implementation. Involving community members, local leaders, and health workers in all stages of the intervention can enhance program acceptability, reach, and sustainability. This participatory approach is consistent with the principles of community-based participatory research (CBPR) and has been shown to yield long-term benefits for population health.

Policy Recommendations

Based on the findings of this study, several policy recommendations can be made:

The success of this intervention suggests that similar programs should be scaled up to other districts and provinces in Indonesia. Policymakers should prioritize the allocation of resources to support community-based NCD prevention initiatives.

Community health promotion programs should be integrated with existing primary health care services, such as Puskesmas, to ensure continuity of care and maximize reach. This integration can also facilitate referral and follow-up for individuals identified as high-risk (Whitmore et al., 2025).

Training and ongoing support for community health workers are essential for program success. Policymakers should invest in capacity-building initiatives to enhance the skills and knowledge of these frontline providers.

Robust monitoring and evaluation frameworks should be established to assess program impact and inform continuous quality improvement. This includes the collection of both quantitative and qualitative data to capture the full range of program outcomes.

Future interventions should address broader social determinants of health, such as food security, access to recreational facilities, and socioeconomic disparities. Multi-sectoral collaboration with other government agencies and NGOs can help address these upstream factors.

The strengths of this study include its mixed-methods design, strong community engagement, and rigorous evaluation framework. The use of both quantitative and qualitative data provided a comprehensive understanding of the intervention's impact and the factors influencing its success. The involvement of local stakeholders ensured that the intervention was culturally appropriate and relevant to the target population.

However, several limitations should be acknowledged. First, the voluntary nature of participation may have resulted in a sample that was more motivated or health-conscious than the general population. This could limit the generalizability of the findings. Second, self-reported behaviors are subject to recall and social desirability bias, although the use of objective measures (e.g., blood pressure, BMI) helped mitigate this limitation. Third, the relatively short follow-up period (five months) may not capture long-term behavior change or health outcomes. Future studies should include longer-term follow-up to assess sustainability.

CONCLUSION

this evaluation demonstrates that community health promotion programs can significantly improve health behaviors and reduce NCD risk factors when designed and implemented with robust evaluation frameworks and active community participation. The findings support the continued investment in community-based health interventions and underscore the importance of ongoing evaluation and adaptation to meet community needs. Future programs should prioritize community engagement, cultural appropriateness, and long-term support to maximize impact and sustainability. The lessons learned from this study can inform the design and implementation of similar initiatives in Indonesia and other LMICs, contributing to the global effort to address the growing burden of NCDs.

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