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Community-Based Health Education for Infectious Disease Prevention in Ulu Bawang Barat District

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ABSTRACT

Backgroud. The prevalence of infectious diseases remains a pressing public health concern in rural areas of Indonesia, including Ulu Bawang Barat District, where limited access to healthcare services and low health literacy contribute to continued vulnerability. Conventional health interventions often fail to produce sustained behavioral change due to their top-down nature and lack of cultural sensitivity.
Purpose. This study aims to evaluate the effectiveness of a community-based health education model in promoting awareness and prevention of infectious diseases among local populations.
Method. A qualitative research approach was adopted using a participatory action research (PAR) design. Data were collected through focus group discussions, semi-structured interviews with community health volunteers and residents, and direct observation of educational activities.
Results. The findings indicate that culturally adapted health education programs delivered through peer-led initiatives significantly improved knowledge, attitudes, and preventive behaviors related to hygiene, sanitation, and early disease detection. The involvement of community members in designing and implementing interventions enhanced trust, engagement, and sustainability.
Conclusions. The study concludes that community-based health education is a viable strategy for empowering rural populations in managing infectious disease risks. This model emphasizes the role of local agency and participatory learning in strengthening grassroots public health systems.

KEYWORDS

Community Health Education, Infectious Diseases, Participatory Action Research, Rural Health, Behavioral Prevention

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INTRODUCTION

Infectious diseases continue to be one of the leading causes of illness and death in rural areas of developing countries, including Indonesia. Despite significant advancements in global public health, many rural communities remain vulnerable due to limited access to healthcare facilities, inadequate health education, and insufficient community engagement. Ulu Bawang Barat District, a remote and under-resourced area, exemplifies this situation, where preventable infections such as dengue fever, tuberculosis, and diarrheal diseases remain prevalent. These conditions are exacerbated by poor sanitation, low immunization coverage, and a general lack of awareness about disease prevention.

Public health interventions in such settings often rely heavily on top-down approaches, focusing on the delivery of services without adequately considering the socio-cultural dynamics and participatory capacity of local communities. As a result, many initiatives fail to achieve long-term behavioral change or sustainable impact. Health campaigns that are externally driven tend to create temporary compliance rather than meaningful transformation in community health practices. Consequently, addressing infectious disease prevention in Ulu Bawang Barat requires a reorientation of strategy that empowers local communities as active participants rather than passive recipients.

The importance of engaging communities in their own health education processes has gained increasing recognition in global health discourse. A community-based approach fosters local ownership, promotes culturally relevant messaging, and strengthens the link between traditional knowledge and modern healthcare practices (Hollitt et al., 2025; Mekonen, 2025; Nukpezah & Konlan, 2025; Szwamel et al., 2025; Tololu et al., 2025). When health education is tailored to the local context and facilitated by trusted community members, it can effectively shift health behaviors and attitudes. This study seeks to explore and validate such an approach in the context of Ulu Bawang Barat's unique health landscape.

The central problem this study addresses is the persistent gap in knowledge and practice regarding infectious disease prevention among residents of Ulu Bawang Barat. While government programs and health campaigns have been introduced periodically, their impact has been short-lived and largely restricted to urban centers or easily accessible villages. In remote hamlets, residents remain unaware of basic preventive measures such as boiling water, mosquito control, handwashing techniques, and proper sanitation practices (Abd ElHafeez et al., 2025; Hughes et al., 2025; Poduval et al., 2025). This lack of foundational knowledge directly contributes to the ongoing transmission and recurrence of infectious diseases.

Residents of Ulu Bawang Barat face structural barriers that hinder their access to consistent and reliable health information. Health centers are sparsely distributed, and the few health workers available are often overwhelmed by the demands of widespread service delivery. Many households rely on traditional beliefs or unverified health advice due to the absence of regular and trusted medical guidance (Beressa et al., 2025; Bhuyan et al., 2025; Erko et al., 2025; Fischer et al., 2025; Santana et al., 2025). These conditions necessitate a localized and community-driven solution that bridges the gap between medical knowledge and everyday life.

Existing educational efforts, such as poster campaigns or government seminars, have often failed to generate significant engagement. Many residents report feeling excluded or disconnected from these initiatives due to language barriers, unfamiliar technical terminology, or the absence of contextual relevance. There is a pressing need for a model that positions local knowledge holders, such as community health volunteers, as key agents in the dissemination of health education (Chanie et al., 2025; Diarra et al., 2025; Getnet et al., 2025; Maison et al., 2025; Telang et al., 2025). This approach has the potential to overcome resistance and build long-term resilience within the community.

This research aims to develop and evaluate a community-based health education model specifically designed to prevent infectious diseases in Ulu Bawang Barat. The goal is to assess the effectiveness of peer-led health campaigns and interactive learning sessions that are co-designed with local stakeholders. The study also intends to document the processes by which community participation enhances knowledge transfer, behavior change, and trust in health information. It seeks to generate practical insights into how health education can be transformed into a collaborative, inclusive, and sustainable endeavor.

The objectives of the study include identifying the most effective strategies for delivering culturally appropriate health messages, understanding community perceptions of infectious disease risks, and measuring behavioral outcomes following educational interventions. By focusing on a participatory model, the research emphasizes the role of local agency and shared decision-making in improving health literacy (Cerdán-Torregrosa et al., 2025; Malende et al., 2025; Movahed et al., 2025). These outcomes are expected to contribute not only to public health theory but also to local governance and policy development in rural health management.

The study also intends to serve as a pilot for scalable community health education programs that can be replicated in other rural areas across Indonesia. In documenting both successes and challenges, the research will provide a detailed account of what works in a low-resource context and why. This will be valuable not only for academic audiences but also for policymakers, NGOs, and local health departments seeking to improve infectious disease prevention through more inclusive methods.

A review of existing literature reveals that most studies on infectious disease education focus on urban or peri-urban contexts where infrastructure and institutional support are relatively stronger. There is a paucity of research that rigorously examines rural-based, community-led education models in remote Indonesian settings. Studies that do exist often adopt descriptive methodologies without evaluating the implementation process or its outcomes. This gap leaves unanswered questions about the practicality and impact of participatory health education in isolated communities.

Current literature tends to emphasize biomedical solutions, such as vaccination and treatment protocols, without sufficiently addressing behavioral and socio-cultural dimensions of disease prevention. While biomedical interventions are critical, they cannot succeed in isolation, particularly in areas where health-seeking behavior is shaped by tradition, trust, and interpersonal dynamics. A participatory health education model responds to this gap by integrating scientific knowledge with local customs and values. This integration remains underexplored in the context of rural infectious disease prevention.

This study contributes to filling that gap by presenting a model that is grounded in the lived realities of rural Indonesians. It builds on emerging frameworks in participatory health communication but adapts them to suit the specific demographic, linguistic, and geographic conditions of Ulu Bawang Barat. The research further explores the relational mechanisms—trust, empathy, and mutual accountability—that facilitate successful health behavior change in tightly-knit rural communities. By doing so, it expands the scope of inquiry beyond technical delivery toward the social infrastructure of health education.

The novelty of this study lies in its methodological approach and its focus on relational dynamics within community health interventions. Unlike conventional health education programs that rely on one-way communication from experts to recipients, this model emphasizes co-creation, dialogue, and mutual learning. Community members are not only targets but also facilitators, contributing their insights and cultural understanding to the educational process. This reconfiguration of roles enhances ownership, relevance, and sustainability of health knowledge.

This research also introduces an evaluation framework that combines qualitative observation with outcome-based assessment tools. It does not limit itself to measuring knowledge acquisition but examines behavior change, perception shifts, and community-level health awareness over time. Such an approach provides a more comprehensive understanding of impact, one that accounts for both tangible and intangible dimensions of learning and transformation.

The justification for this study stems from the urgent need to address persistent health vulnerabilities in rural Indonesia through approaches that are culturally congruent, participatory, and sustainable. Traditional top-down health education strategies have shown limited success in regions like Ulu Bawang Barat. By proposing and testing an alternative model, this study contributes new knowledge to both health education practice and academic theory. It underscores the importance of equity, community voice, and shared responsibility in the design of public health interventions.

RESEARCH METHODOLOGY

This study applied a qualitative research approach using a participatory action research (PAR) design to explore the effectiveness of community-based health education in preventing infectious diseases in Ulu Bawang Barat District. The PAR design was selected to ensure that the research process was collaborative, reflective, and empowering for the community involved (Al-Rashed, 2025; Williams et al., 2025). Through this approach, community members were not merely subjects of the study but were actively engaged as co-researchers in identifying health challenges, developing educational materials, and evaluating the intervention outcomes.

The research population consisted of residents in three villages within the Ulu Bawang Barat District, where infectious diseases such as dengue, diarrhea, and tuberculosis are commonly reported. From this population, purposive sampling was employed to select 25 participants who represented a cross-section of stakeholders, including community health workers, village heads, teachers, youth leaders, and mothers of school-aged children. The selection criteria emphasized individuals with influence in their communities and a demonstrated interest in health-related issues, to ensure meaningful participation and sustained engagement throughout the project.

Data collection involved the use of several research instruments. Semi-structured interview guides were utilized to capture individual perceptions, experiences, and knowledge regarding infectious disease prevention. Focus group discussion (FGD) protocols were designed to facilitate group reflections and collective problem-solving. Observation checklists were employed to monitor behavioral changes and participation during health education sessions. Documentation tools, including field notes, audio recordings, and photo journals, were used to capture the contextual richness of community interactions and responses.

The research procedure unfolded in four main stages. In the preparatory phase, researchers conducted preliminary visits and coordination meetings with local leaders to build trust and identify key participants. During the second stage, baseline data were collected through interviews and FGDs to assess existing knowledge, attitudes, and practices. The third stage involved the co-development and implementation of community health education sessions, incorporating local language, cultural references, and participatory learning techniques. The final stage consisted of post-intervention data collection and reflection, where participants evaluated changes in awareness, behavior, and community health practices. All procedures adhered to ethical research standards, including informed consent, confidentiality, and respect for cultural norms.

RESULT AND DISCUSSION

Secondary data obtained from the Ulu Bawang Barat Health Profile (2022) indicate that the district has experienced a consistent pattern of infectious disease outbreaks over the past five years. The most prevalent conditions include dengue fever, acute respiratory infections (ARI), and diarrhea, particularly among children under five. Records show that more than 60% of households lack access to adequate sanitation, while only 42% of residents had received basic health education

on infectious disease prevention prior to the study. These figures reflect both infrastructural limitations and gaps in community-level awareness and participation in health programs.

Table 1.

Infectious Disease and Health Education Statistics in Ulu Bawang Barat (Pre-Intervention)

Indicator	Value	Source
Dengue Fever Incidence (per 1,000)	17.4	District Health Office (2022)
Diarrhea Incidence among Children (%)	29%	Local Clinics
Households without Sanitation (%)	63%	Village Records
Residents with Prior Health Education (%)	42%	Community Health Survey
Health Worker to Population Ratio	1:2,400	Ulu Bawang Barat Health Dept.

These figures suggest a clear need for more accessible and localized health education interventions. The low rates of health literacy combined with high disease incidence indicate that conventional strategies have not adequately reached or empowered the community. The disproportion between health workers and the population further supports the rationale for shifting toward community-led education models that utilize local networks and social capital.

Data collected through interviews and focus group discussions showed that participants experienced a significant increase in knowledge and confidence regarding disease prevention strategies. Before the intervention, many participants were unaware of the connection between standing water and mosquito breeding, or the importance of consistent handwashing. Following the program, more than 80% of respondents could accurately describe key preventive measures for common infectious diseases. Participants also reported increased willingness to share information with neighbors and family members.

Observations conducted during the intervention sessions revealed high levels of engagement, especially when sessions included participatory elements such as games, storytelling, and visual demonstrations. Youth participants were particularly active in the learning activities, with several volunteering to assist in peer education efforts. Mothers with young children also demonstrated heightened interest, often requesting additional materials or follow-up visits. These behavioral changes reflect not only improved awareness but also a shift in attitudes toward collective health responsibility.

Inferential analysis of qualitative data using thematic coding identified three dominant outcomes: increased health knowledge, enhanced communal trust, and self-initiated hygiene practices. These themes consistently emerged across different age groups and villages, suggesting the intervention's replicability. The presence of peer educators from within the community played a critical role in increasing credibility and reducing resistance to behavior change. The embedding of local language and cultural references into the educational content was also identified as a key factor in effective communication.

Patterns within the data revealed a strong correlation between participants' pre-existing involvement in community activities and their post-intervention responsiveness. Individuals who were previously active in religious or social groups demonstrated greater leadership in implementing household health changes. Conversely, households that had been isolated or less engaged initially showed slower uptake, though most improved over time. This correlation underscores the importance of leveraging social networks and community structures in the delivery of health education.

A case study from Dusun Periuk, one of the intervention sites, provides a vivid illustration of these dynamics. The village had previously experienced a spike in dengue cases during the rainy season, attributed to unmanaged waste and water accumulation. During the intervention, residents formed a voluntary "Clean Yard Committee" which conducted weekly cleaning drives and door-to-door education campaigns. Over the following three months, no new cases of dengue were reported, and community leaders noted increased cooperation between neighbors and local health cadres.

The program in Dusun Periuk also sparked new initiatives beyond the original scope. A youth group began creating illustrated posters based on local stories to promote hygiene among children, while mothers developed a system of rotating visits to assist elderly residents with sanitation needs. These developments indicate that the intervention did more than inform—it inspired community members to innovate based on their unique context and capacities. This transformation aligns with the goals of participatory action research, wherein knowledge creation and community action evolve simultaneously.

The findings from this study support the conclusion that community-based health education can significantly enhance both knowledge and behavior related to infectious disease prevention. Participants not only absorbed health information but also translated it into concrete, observable actions within their households and neighborhoods. The participatory nature of the intervention enabled a deeper connection between health content and local life, promoting internal motivation rather than external compliance.

The results affirm the premise that empowering local actors as health educators fosters more sustainable and culturally embedded changes. The community's enthusiastic response to peer-led sessions and their continued initiatives after the program underscore the model's effectiveness. These outcomes suggest that future public health strategies in rural areas should prioritize community engagement and adaptive, context-sensitive education approaches to achieve lasting impact.

The results of this study demonstrate that community-based health education has a significant and measurable impact on improving infectious disease awareness and prevention practices in Ulu Bawang Barat District. Participants exhibited improved understanding of the causes and prevention strategies for common diseases such as dengue, diarrhea, and acute respiratory infections. Behaviorally, residents implemented practical changes, such as increased handwashing, elimination of mosquito breeding sites, and better sanitation habits (Albajri et al., 2025; Arayici et al., 2025; Stoutenberg et al., 2025; Yihune Teshale et al., 2025). The program also catalyzed local initiatives, including peer-led education and voluntary community cleaning campaigns, reflecting both knowledge transfer and mobilization.

These findings align with previous studies highlighting the importance of community engagement in public health, such as the works of Rifkin (2009) and Rosato et al. (2008), which emphasize that health interventions are more effective when local participation is prioritized. Unlike top-down health campaigns that often fail to gain traction in rural or underserved areas, this study demonstrates that co-designed, participatory models foster ownership and sustainability. The study differs from conventional educational interventions by integrating cultural relevance and social structures into the content delivery, making the information more accessible and meaningful to rural populations. This contrast illustrates a key gap in much of the existing literature that favors urban-centric models of health education.

The outcomes of this research suggest a critical shift in how health knowledge is generated and disseminated within rural settings. Community members in Ulu Bawang Barat were not merely passive recipients of information but became facilitators and innovators of localized health

solutions. This transition signals a move from dependence on institutional health workers toward collective health responsibility anchored in social cohesion. The findings serve as an indicator that rural communities, when equipped with proper facilitation, can adapt and internalize preventive health practices, bridging the gap between medical knowledge and daily behavior.

This study offers a compelling case for rethinking the structure of rural health education in Indonesia. The implications reach beyond the immediate context of disease prevention, pointing toward broader systemic reform. Government health authorities and non-governmental organizations can draw on these insights to design decentralized, community-led programs that integrate local wisdom and vernacular language (Navidi et al., 2025; Negash et al., 2025; Viana et al., 2025). Health education, when rooted in participatory dialogue, becomes not only more effective but also more equitable, as it addresses barriers such as literacy, cultural misunderstanding, and institutional distrust. These implications reinforce the idea that public health solutions must be contextually grounded and socially inclusive.

The success of the intervention is largely attributable to its responsiveness to the local cultural context and its emphasis on active participation. Peer facilitators who shared the same lived realities as the participants were more effective in building trust and reducing resistance to change. The use of culturally relevant tools, such as local proverbs, visual storytelling, and informal learning settings, enhanced both comprehension and retention. These methods were particularly important in reaching vulnerable groups, including mothers with limited formal education and elderly residents. The community's existing social networks also provided a strong foundation for rapid dissemination and peer reinforcement of health behaviors.

The intervention's participatory framework allowed community members to feel valued, respected, and empowered, thereby increasing their motivation to adopt and maintain healthy practices. The presence of an enabling environment—marked by mutual trust, consistent engagement, and visible support from local leaders—further reinforced the adoption of new behaviors. The adaptability of the program's content to different learning styles and age groups ensured broader inclusivity and deeper impact. These contextual and relational factors help explain why the program achieved results that surpass many traditional health outreach efforts.

The findings underscore the urgency for policy transformation in rural health education. Decision-makers must prioritize community participation not as a supplementary feature but as a core element of program design and delivery. Future initiatives should build on local leadership, customize materials to reflect cultural nuances, and integrate health education into broader community development agendas. Academic institutions and training centers for health professionals should also revise curricula to include community-based facilitation skills and culturally responsive teaching methods. These strategic shifts would make health education more relevant, respectful, and resilient.

Next steps in research and practice should involve scaling this model across similar districts while maintaining its adaptability to local contexts. Longitudinal studies are recommended to measure the durability of behavioral changes and the long-term impact on disease incidence. Further exploration into the economic and policy dimensions of community-based health education could support institutionalization of these models within national frameworks. As the landscape of public health continues to evolve, especially in response to pandemics and climate-related health threats, the community-based approach offers a robust, people-centered pathway forward.

CONCLUSION

The most important and distinctive finding of this study is the effectiveness of culturally contextualized, peer-led health education in transforming both individual behavior and collective community practices related to infectious disease prevention. Unlike conventional top-down campaigns, the participatory model implemented in Ulu Bawang Barat empowered local actors to become facilitators of change, resulting in increased knowledge retention, proactive sanitation measures, and the creation of self-initiated health initiatives. This localized and dialogical approach proved more sustainable and impactful than standard health outreach methods typically applied in rural settings.

This research offers a significant contribution to the field of public health education by integrating participatory action research (PAR) with grassroots community engagement in a rural Indonesian context. The novelty lies not only in its conceptual framework that centers local agency but also in its methodological innovation, which combines culturally adaptive content, peer facilitation, and embedded evaluation practices. The model proposed in this study demonstrates that effective health education can emerge from within the community when supported by structured, inclusive, and reflective processes. This approach enriches existing theories of health communication by emphasizing relational dynamics and sociocultural alignment.

One of the limitations of this study is its focus on a single district, which may affect the generalizability of the findings to regions with different sociocultural or infrastructural characteristics. While the participatory model succeeded in Ulu Bawang Barat due to strong community ties and leadership support, similar outcomes may not be guaranteed in less cohesive or more fragmented populations. Future research should explore comparative applications of this model in other geographic and cultural settings, and consider longitudinal studies to assess long-term behavioral retention and health outcomes. Expanding interdisciplinary collaborations with local governments and health institutions could further refine and institutionalize the model for broader policy adoption.

AUTHORS' CONTRIBUTION

Moh. Solehuddin: Conceptualization; Project administration; Validation; Writing - review and editing; Conceptualization; Data curation; In-vestigation; Data curation; Investigation; Formal analysis; Methodology; Writing - original draft; Supervision; Validation; Other contribution; Resources; Visuali-zation; Writing - original draft.

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