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Active Participation in Community Health Services and Quality of Life in Elderly Populations in Rural Indonesia

A Cross-Sectional Study

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ABSTRACT

Access to community health services may support quality of life among older adults in rural settings. This study examined the association between participation in Posyandu Lansia (Integrated Healthcare Posts for Older Adults) and quality of life in Sempor District, Kebumen Regency, Central Java, Indonesia. This cross-sectional study included all 50 eligible adults aged 60 years or older from January to March 2025. Participation was assessed using attendance registers from the preceding six months. Attendance at 75% or more of scheduled activities was classified as active participation. Quality of life was assessed using the 26-item WHOQOL-BREF. Item scores were summed and transformed to a 0–100 scale, with scores of 60 or higher classified as high quality of life. Fisher's exact test assessed the association, and the phi coefficient and odds ratio quantified its magnitude. Overall, 72% of participants were active and 70% had high quality of life. High quality of life was observed in 94.4% of active participants and 7.1% of inactive participants. Active participation was strongly associated with high quality of life in the unadjusted analysis (*p* < 0.001, φ = 0.855, OR = 221.0, 95% CI 18.432–2649.817). The small sample, sparse cells, wide confidence interval, and potential confounding warrant cautious interpretation. The cross-sectional design limits conclusions about whether participation preceded better quality of life. These findings provide local evidence based on documented attendance and support longitudinal studies across multiple sites to clarify the direction of the association and assess its consistency across rural settings.

Keywords
Community health services
Older adults
Posyandu lansia
Quality of life
WHOQOL-BREF

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Introduction

In the twenty-first century, the ageing of the population has emerged as a significant global public health issue. The WHO projects that the global population aged 60 and above will increase from 1 billion in 2020 to 2.1 billion by 2050, primarily located in low- and middle-income countries. This demographic transition has resulted in increased demand for health care services, social protection and community-based support systems for older adults. Multidimensional changes in physical, psychological, and social functioning, associated with ageing, may hinder independence and adversely impact comprehensive wellness in elderly individuals [1].

Data from the Indonesian Central Bureau of Statistics indicates that the older adult population constituted approximately 11.75% of the total population in 2023, which suggests that the demographic structure is shifting fast to an ageing population structure This condition poses serious challenges to the health-care system, particularly in maintaining the quality of life and promoting healthy ageing among older adults. Older people often suffer from chronic diseases, poor physical functioning, psychological distress, and social disengagement, which can greatly affect their daily functions and quality of life [2].

The quality of life (QoL) in old age is a multifaceted notion encompassing physical, psychological, social, and environmental aspects that affect well-being and functional autonomy in later life [3]. Prior research has found that older adults who are more socially active and involved in their communities had higher psychological health, life satisfaction and functional health [4]. The notion of healthy ageing emphasizes the relevance of functional capacity, social participation and quality of life in advanced age [5].

Therefore, community healthcare interventions have become more important to support healthy ageing, and to improve the quality of life for the elderly. Community-based health services are essential to sustain well-being among the older adults through preventative, promotional and supporting health initiatives [6]. Integrated Healthcare Posts for Older adults (Posyandu Lansia) are community-based health programs in Indonesia that aim to provide promotional and preventative health services to older persons [7]. These programs comprise health screening, blood pressure monitoring, health education, physical activity, dietary advice and social interaction activities. Posyandu Lansia is also a crucial strategy to enhance

healthcare accessibility and increase community engagement among older persons, particularly in rural regions with restricted access to official healthcare services.

Evidence suggests that active participation in community-based health services is associated with better health outcomes, stronger social connections, and improved quality of life among older adults. Participation in community health programs offers routine health checks, health education, emotional support and social interaction, which can enhance self-care ability and promote healthier family living. Socially engaged older persons generally exhibit superior psychological well-being and social involvement relative to their socially inactive counterparts [8]. Moreover, The COVID-19 epidemic increased the demand for community-based health services for the elderly since the older persons have limited access to formal healthcare facilities and are at a higher risk of difficulties related to chronic diseases and social isolation [7].

Community health programs could have potential benefits but older persons' engagement is unpredictable particularly in rural regions. There are several impediments to participation including transportation concerns, physical restrictions, insufficient health literacy, inadequate familial support, and socio-economic barriers. Elderly living in rural regions typically experience higher obstacles to obtaining health care and preventative health services than older persons living in urban areas. This may reflect that many older adults may not receive the community support and health care interventions needed to maintain an optimal quality of life.

Although there are separate studies on older adults social engagement and living quality, research on the correlation between active engagement in community-based healthcare services and quality of life among older individuals residing in rural locations is limited., particularly in developing countries such as Indonesia. The results of this association may provide significant insights to improve community-based senior health care programs, promote healthy ageing efforts, and facilitate practice of evidence-based gerontological nursing. This cross-sectional study aims to assess the relationship between active participation in community health services and quality of life among older adults.

Previous studies provide relevant but incomplete evidence for the relationship between community participation and quality of life among older adults. In Semali Village, Sempor District, Sofiana et al. studied 327 older adults using a cross-sectional design and found that occupation ($p = 0.010$) and education level ($p = 0.016$) were associated with active visits to Posyandu Lansia, while age and sex were not significantly associated with active visits [9] . In Selokerto Village, Sempor District, a study involving 45 older adults examined the relationship between physical activity and quality of life and reported a significant association between these variables ($p = 0.015$). Although this study addressed quality of life among older

adults in the same district, it focused on physical activity rather than documented participation in Posyandu Lansia [10]. In Kalibeji Village, Sempor, Marsito and Sarwono studied 380 older adults and reported that 63.2% had never undergone a health examination, indicating an important local gap in routine health monitoring [11]. These studies are informative because they address local determinants of attendance, physical activity, or health monitoring, but they did not directly examine documented six-month participation in Posyandu Lansia using an explicit attendance threshold in relation to overall WHOQOL-BREF quality-of-life classification. All local studies were cross-sectional and addressed a specific aspect of elderly health-service engagement rather than the combined exposure-outcome question examined here. Their findings therefore provide local context but do not establish temporal direction. The present study therefore extends the local evidence by linking documented attendance records with a standardized quality-of-life measure among older adults in a rural Sempor setting. More broadly, evidence from Southeast Asia indicates that transportation, financial constraints, and family/social support can influence access to health services, with rural older adults particularly affected by these barriers [12].

The local context is important when interpreting participation. Evidence from Sempor has previously documented declining elderly visits to Posyandu in Semali and associations of attendance with occupation and education [9] , while a community study in Kalibeji found that 63.2% of 380 older adults reported never undertaking health examinations [11]. These findings do not describe the present study's 50 participants and are not used as baseline values for the current analysis; rather, they provide contextual evidence that regular engagement with preventive health services remains an important practical issue in the study area. Accordingly, the current study focuses on whether documented regular participation is associated with quality of life, while recognizing that access, social/family support, and individual capacity may influence participation.

Material and Methods

A. Study Design and Setting

A quantitative cross-sectional approach was utilised to examine the association between participation in community-based health services and quality of life among older adults in a rural setting. The study was conducted at selected Posyandu Lansia (Integrated Healthcare Posts for the Older adults) in the rural Sempor sub-district, Kebumen Regency, Central Java, Indonesia, from January to March 2025.

B. Population and Sampling

The target population comprised older adults registered in the Posyandu Lansia services at the study sites. A total population (census) sampling approach was used. All older adults who met the eligibility criteria during the study period were invited to participate. Inclusion

criteria were: (1) age ≥60 years; (2) registered as a Posyandu Lansia member; (3) able to communicate effectively; and (4) willing to participate. Older adults with significant cognitive or hearing impairment or major health conditions that prevented effective communication were excluded. A total of 50 eligible older adults were enrolled. Because the study included the entire accessible eligible population at the selected study sites, no separate probability-based sample-size calculation was performed.

C. Data Collection

Data were gathered using standardized questionnaires presented by qualified study assistants. Before data collection, the assistants were trained on the study protocol, communication techniques, and standardized questionnaire administration to minimize interviewer bias and ensure consistency. Interviews were conducted in a private, comfortable space at each Posyandu site and lasted approximately 15–20 minutes.

D. Measurement of Participation in Community Health Service

Participation in community health services was operationalized based on documented attendance at Posyandu Lansia activities during the preceding six months. Attendance data were obtained from the official Posyandu Lansia attendance registers rather than from participant recall. The attendance rate was calculated by dividing the number of sessions attended by the total number of scheduled Posyandu Lansia activities during the six-month observation period and multiplying by 100. Participants with attendance ≥75% were classified as active participants, whereas those with attendance <75% were classified as inactive participants. The ≥75% threshold was defined a priori as the operational criterion for regular individual participation in the present study, informed by previous Indonesian research that classified older adults as active Posyandu participants when they attended at least 75% of scheduled activities [13]. In the present study, this threshold was applied to individual attendance records over a six-month observation period. It was not interpreted as an individual-level classification established by the Ministry of Health.

E. Measurement of Quality of Life

Quality of life was assessed using the Indonesian-language 26-item WHOQOL-BREF version that was administered to all 50 participants during data collection. The instrument consists of two general items assessing overall quality of life and satisfaction with health, and 24 items covering four domains: physical health, psychological health, social relationships, and environment. Each item is rated on a five-point response scale. In accordance with the WHOQOL-BREF scoring procedure, the negatively phrased items (Q3, Q4, and Q26) were reverse scored using the formula 6 − the original score, so that higher scores consistently indicated better quality of life [14], [15] . For the present study, the scores of all 26 items were then summed to obtain a raw total score ranging from 26 to 130. The raw total score was

subsequently linearly transformed to a 0–100 scale using the formula [(raw total score − 26) / 104] × 100. The resulting score was used as the overall quality-of-life (OQoL) score for categorical analysis.

The classification of quality of life used a cut-off point of 60 as an operational reference based on[16] , who investigated the discriminatory capacity of the WHOQOL-BREF among older adults. Their receiver operating characteristic (ROC) analysis identified 60 as the critical value for distinguishing older adults with good/satisfactory versus poor/dissatisfactory perceived quality of life and health satisfaction. Accordingly, participants with an OQoL score ≥60 were classified as having high quality of life, whereas those with a score <60 were classified as having low quality of life. Although this cut-off provides an established reference for older populations, it was derived from a Brazilian older-adult population and was therefore interpreted in this study as an operational classification criterion rather than a universally applicable diagnostic threshold. All 50 participants completed the 26 WHOQOL-BREF items, and no item-level missing data were recorded.

F. Validity and Reliability

Because participation status was determined from documented attendance records rather than a self-report questionnaire, instrument-based validity and reliability testing was not applicable to the participation classification.

G. Statistical Analysis

Data were analyzed using SPSS version 25. Descriptive statistics were used to summarize demographic characteristics, participation status, and quality-of-life categories. The association between participation and quality of life was examined using a 2 × 2 contingency table. Fisher's Exact Test was used because both variables were categorical and at least one expected cell frequency was less than five. The strength of association was assessed using the Phi coefficient (φ). The odds ratio (OR) with a 95% confidence interval (CI) was reported to describe the magnitude and precision of the observed association. A p-value <0.05 was considered statistically significant. Because no multivariable model was performed, the reported association was considered unadjusted and was not interpreted as an independent association.

H. Ethical Considerations

The Health Research Ethics Committee of Universitas Muhammadiyah Gombong approved the study (No. 343.6/II.3.AU/F/KEPK/X/2024). Informed consent was acquired in writing from all individuals before to their involvement. Confidentiality, anonymity, voluntary involvement, and the ability to resign from the study at any moment were guaranteed throughout the research procedure.

Results

A. Respondent Characteristics

This study included 50 older adults. Most participants were female (78%). The largest age group was 60–69 years (54%), while 23 participants (46%) were aged ≥70 years. Thirty-six participants (72%) were classified as active participants based on attendance, while 14 (28%) were inactive. Using the OQoL cut-off of 60, 35 participants (70%) were classified as having high quality of life and 15 (30%) as having low quality of life.

Table 1. Distribution of respondent characteristics (n=50)

Characteristics	N	%
Age Group		
60-69 years	27	54
≥70 years	23	46
Gender		
Female	39	78
Male	11	22
Participation in Community Health Services		
Active (≥75% attendance)	36	72
Inactive (<75% attendance)	14	28
Quality of life		
High (OQoL ≥60)	35	70
Low (OQoL <60)	15	30

B. Association between Participation in Community Health Services and Quality of Life

Table 2 illustrates the association between participation in community health services and quality of life. Among active participants, 34 of 36 (94.4%) had high quality of life, whereas 2 (5.6%) had low quality of life. Among inactive participants, 1 of 14 (7.1%) had high quality of life and 13 (92.9%) had low quality of life.

Table 2. Association between participation in community health services and quality of life among older adults (n = 50)

Participation	High QoL n (%)	Low QoL n (%)	Total	p-value	OR(95% CI)
Active	34 (94.4)	2 (5.6)	36	p < 0.001	221(18.432-2649.817)
Inactive	1 (7.1)	13 (92.9)	14		
Total	35 (70)	15 (30)	50		
Fisher's Exact Test	φ = 0.855				

Fisher's Exact Test indicated a statistically significant association between participation status and quality-of-life category ($p < 0.001$). The Phi coefficient was 0.855, indicating a strong association in this sample. The odds ratio was 221.0 (95% CI: 18.432–2649.817). Because the confidence interval was very wide, the magnitude of the OR should be interpreted cautiously.

Discussion

This study found a statistically significant and strong unadjusted association between participation in community-based health services and quality of life among older adults in a rural setting (Fisher's exact test, $p < 0.001$; $\varphi = 0.855$). Older adults who actively participated in Posyandu Lansia activities had a higher proportion of high quality of life (94.4%) compared

with inactive participants, among whom 92.9% had low quality of life (OR = 221.0; 95% CI: 18.432–2649.817). These findings indicate a strong association between participation in community-based health services and overall quality of life among older adults in rural settings. However, the cross-sectional design does not establish temporal direction or causality, and the specific pathways underlying the observed association across physical, psychological, social, and environmental dimensions cannot be determined from the present analysis.

The classification of quality of life in this study should also be interpreted in relation to the cut-off point used. The overall quality-of-life score was categorized using a cut-off of 60 based on [16] , whose ROC analysis examined the discriminatory capacity of the WHOQOL-BREF among older adults. In the present study, this criterion resulted in 70 % of participants being classified as having high quality of life and 30 % as having low quality of life. However, because the cut-off was derived from a Brazilian older-adult population, its applicability to Indonesian older adults may be influenced by differences in cultural, social, and health-service contexts. Therefore, the ≥60 threshold should be understood as an operational classification criterion used for the present analysis rather than a universally applicable diagnostic threshold. Nevertheless, using a predefined cut-off provides a transparent and reproducible basis for categorizing quality of life in this study.

These findings correspond with the WHO healthy-aging framework, which emphasizes the significance of maintaining functional capacity, social engagement, and well-being in later life [5]. Posyandu Lansia offers routine health monitoring, health education, social engagement, and emotional support — elements aligned with healthy-ageing outcomes, particularly in rural areas where social resources and access to healthcare are often limited.

Two alternative explanations warrant caution. First, the cross-sectional design cannot establish direction: older adults with better quality of life may be more physically and psychologically able to attend Posyandu regularly, rather than attendance itself raising quality of life. Second, if the quality-of-life instrument includes a social-participation domain, the predictor (community participation) and that domain may overlap conceptually, which could partly inflate the observed association. The unusually strong association ($\varphi = 0.855$) should therefore be interpreted with these possibilities in mind

The link corresponds with studies indicating that social activity and interaction are significant correlates of quality of life in later years. Older adults with richer social interaction report higher quality of life than socially isolated peers [17] and participation in Posyandu Lansia has been linked to better social well-being through integration, acceptance, and support [18]. Broader evidence likewise associates strong social relationships with greater well-being and happiness [19], whereas social isolation and loneliness — heightened during the COVID-19 pandemic — were associated with poorer quality of life and psychological health [20].

Psychological resilience may also mediate the correlation between social engagement and life contentment [21].

The results underscore the significance of Posyandu Lansia as a community-oriented health initiative for older individuals in Indonesia. Participation in integrated older adults health posts has been associated with improvements across quality-of-life domains [22] and social interaction, environmental support, and psychological well-being have been shown to shape quality of life among institutionalized older adults [23]. From a biopsychosocial perspective, social support, health status, self-efficacy, and lifestyle are key determinants of older adults quality of life [24]; Posyandu activities may relate to these dimensions by encouraging healthier lifestyles and supportive social environments. Family support is also relevant, as stronger family support has been correlated with an enhanced quality of life [25] and may, in turn, facilitate regular attendance. Throughout the COVID-19 pandemic, social engagement and comprehensive health services for older adults were associated with enhanced quality-of-life outcomes [26], and strengthening community empowerment through Posyandu-based programs has been reported to increase older adults participation and family involvement [27].

Systematic reviews further support the multidimensional value of community-based interventions, which have improved Health behaviors, emotional well-being, and social engagement among elderly individuals residing independently [28], as well as psychosocial engagement and mental health within community-based care models, despite implementation barriers [29]. Community-based health promotion has supported physical activity and Self-management in elderly individuals with chronic illnesses [30]. Because Posyandu Lansia frequently incorporates physical exercise, the exercise literature is also relevant: exercise interventions have improved Quality of life and daily living activities in fragile elderly individuals [31], and telehealth- and exercise-based community programs have improved balance and fall-related outcomes [32].

This study contributes to gerontological nursing and community-based older adults care in developing countries by focusing on rural rather than institutionalized or urban populations. Rural older adults frequently face disparities in healthcare access and social support; strengthening community-based programs such as Posyandu Lansia may therefore help reduce inequalities and support healthy ageing among vulnerable groups. The results indicate that quality of life is not solely influenced by physical health; institutionalized elderly individuals often report diminished quality of life due to decreased autonomy and restricted social engagement [33], underscoring active social engagement as a potential protective factor.

Several limitations warrant acknowledgment. First, the cross-sectional design precludes causal inference regarding the direction of the association between participation

and quality of life. Second, the relatively small sample (n = 50) and limited number of Posyandu Lansia sites may restrict the generalizability of the findings beyond the study setting. Third, dichotomizing both participation and quality-of-life scores reduced the available statistical information and may have contributed to the large observed association. Fourth, potential conceptual overlap between community participation and the social relationships dimension of quality of life cannot be excluded. Longitudinal and multicenter studies involving larger and more diverse populations are needed to clarify the direction and mechanisms underlying this association

Conclusion

This cross-sectional study identified a statistically significant and strong unadjusted association between active participation in community-based health services and quality of life among older adults in rural Indonesia (Fisher's Exact Test, $p < 0.001$; $\varphi = 0.855$; OR = 221.0, 95% CI: 18.432–2649.817). A higher proportion of active participants reported high quality of life compared with inactive participants. However, the cross-sectional design, small sample, limited setting, wide confidence interval, and potential confounding factors preclude causal or independent-association interpretations. The findings indicate that participation in Posyandu Lansia is associated with quality of life and provide a basis for further longitudinal and multicenter research to clarify the direction, mechanisms, and contextual factors underlying this relationship.

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Conflict of Interest

The authors declare that they have no conflict of interest.

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