

# COMMUNITY PARTICIPATION IN HEALTH EMPOWERMENT THROUGH THE CLEAN AND HEALTHY LIVING BEHAVIOR (PHBS) PROGRAM IN BANDAR LAMPUNG CITY

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**ABSTRACT:** *This study aims to analyze community participation in health empowerment through the Clean and Healthy Living Behavior (PHBS) Program in Bandar Lampung City. The background of this study is based on the importance of active community involvement as a determining factor in the success of behavior-based health programs, especially in creating a clean, healthy, and sustainable environment. The problem formulation focuses on the form, level, and factors that influence community participation, as well as effective empowerment strategies in supporting the implementation of PHBS. Theoretically, participation theory discusses the form, principles, levels, and types of community involvement, while empowerment theory emphasizes strategies, stages, and principles of empowerment in the health sector, including elements and models relevant to PHBS. Health behavior theory is used to understand internal and external factors that influence the implementation of healthy behavior, while the concept of program evaluation plays a role in assessing the effectiveness of PHBS implementation in the field. The research method uses a qualitative approach with field research. The selection of informants was carried out purposively based on criteria that include mastery of the material through the enculturation process, active involvement in PHBS implementation, time availability, ability to provide information objectively, and initial proximity to the researcher. Primary data was obtained through interviews, observation, and documentation, while secondary data was collected from literature, official reports, and other relevant sources. Data analysis was conducted continuously through the stages of data reduction, data presentation, and conclusion drawing using triangulation, member checking, and audit trail techniques to ensure data validity. The results of this study are expected to provide a comprehensive picture of the dynamics of community participation in PHBS in Bandar Lampung City, as well as serve as a reference for developing community health empowerment strategies in other areas with similar characteristics..*

**Keywords:** Community Participation, Health Empowerment, Clean and Healthy Living Behavior (PHBS)

## 1 INTRODUCTION

Public health conditions in Indonesia exhibit complex dynamics and vary across regions. Prevalence is higher among women and increases with age. The study, "Readiness of Health Posts for Primary Health Care Integration in Indonesia," was published.[1] revealed a significant gap between urban and rural areas in the readiness of health posts to support primary care. Limited facilities, inadequate human resources, and inadequate infrastructure remain major obstacles to equitable service delivery.

PHBS is also a crucial component in health development, as it requires awareness, ability, and willingness to live a healthy lifestyle from every citizen, thereby achieving optimal public health. Overall, the PHBS situation in Indonesian society still faces structural and cultural challenges, necessitating a sustainable educational approach, increased access to sanitation facilities, and strengthened social support to ensure consistent implementation of PHBS practices across all levels of society.[2]

The lack of public awareness about PHBS impacts the health of everyone, including infants and the elderly. As a result, health-related behaviors remain minimal and worrying.[3] The success of PHBS requires a shared commitment within the family as well as support for counseling and repeated activities that form clean and healthy living habits.[4] PHBS emphasizes personal hygiene and the creation of a healthy environment for physical, mental, spiritual, and social well-being. Low public awareness, such as littering, poor diet, and lack of physical activity, demonstrates the need to develop a healthy mindset. PHBS is understood as a crucial step in maintaining and prioritizing health to achieve a better quality

of life. This PHBS program can be implemented from the smallest community level, namely the family.[5] Sometimes interesting problems arise in PHBS cases such as diarrhea.[6] According to H.L. Blum, there are four factors that influence health. The first factor states that environmental factors can influence health. These environmental factors include the physical, cultural, social, and political environment. The second factor is individual behavior. The third factor that can influence health is health services. The final factor, according to H.L. Blum, is genetics or heredity. An optimal condition or environment will result in optimal health.[7]

Community health empowerment is an active process, where the target community being empowered must play an active role (participate) in health activities and programs.[8] Health empowerment in the PHBS program uses a participatory development approach that places the community as the main actor in the process of identifying problems, planning, and implementing promotive actions.

In other words, maintain existing healthy behaviors. Health empowerment in Islam, Rasulullah SAW said:

وَالْفَرَاغُ الصَّحَّةُ ، النَّاسُ مِنْ كَثِيرٍ فِيهِمَا مَغْبُورٌ نَعَمَتَانِ

Meaning: "There are two blessings that many people are deceived about: good health and free time." (Narrated by Bukhari no. 6412, from Ibn 'Abbas)

One example of a PHBS village that has been implemented is in Tanjung Karang Pusat District, Bandar Lampung City. Its success in maintaining cleanliness has made it the first PHBS Village winner in Bandar Lampung City. The Bandar Lampung City Government also established the Bandar Lampung Healthy City Forum (FKBLS) based on Joint Regulations of the Minister of Home Affairs and the Minister

of Health Number 800/Kep.69.A-Bappeda/2010 and Number 800/Kep.152-Bappeda/2013. This forum aims to assess the implementation of PHBS Villages in every RT and RW throughout Bandar Lampung City.[9]

The implementation of community empowerment programs in health through the Clean and Healthy Living Behavior (PHBS) movement in Bandar Lampung City has so far still shown a top-down pattern, where planning, policies, and implementation are mostly determined by external parties such as the government, donor agencies, or implementing organizations.

Community participation in health programs, such as clean and healthy living behavior (PHBS) in Bandar Lampung City, reflects the application of Zimmerman's empowerment theory,[10] which emphasizes increasing individual, group, and community control over decisions that affect their well-being. This process emphasizes the role of community participation in building integrated social welfare and public health. [11]

Active community participation through the involvement of integrated health posts (posyandu), community groups, and local communities in the planning, implementation, and evaluation of the PHBS program strengthens collective capacity in decision-making, organizing activities, and joint action.

In fact, the success of PHBS (Clean and Healthy Living) depends heavily on the active involvement of residents from the planning, implementation, and evaluation stages. Therefore, this research aims to fill this gap by examining how community participation strengthens health empowerment through the PHBS program in Bandar Lampung City. This study also highlights the synergy between local government, health workers, and the community in fostering residents' independence in implementing clean and healthy lifestyles in a sustainable manner. [12]

**Research Objective**

This study aims to reveal the role of families, the level of knowledge, and the effectiveness of information strategies, education, infrastructure, cross-sector collaboration, and media utilization in forming and strengthening awareness of clean and healthy living. Finally, the study examines the sustainability of clean and healthy living practices that are still carried out by the community implementing the empowerment model, to assess the effectiveness of the model and its impact in forming a long-term healthy living culture, even though health interventions continue in different forms and program names.

**Methodology**

The research method used a mixed methods approach that integrates qualitative and Research and Development (R&D) methods. The qualitative approach was used to explore in-depth the forms, dynamics, and meaning of community participation in the implementation of PHBS through interviews, observations, and focus group discussions (FGDs). Meanwhile, the R&D method was applied to design, develop, validate, and test a community-based health empowerment model.

This research is field research with the researcher as the key instrument.[13] The research subjects were selected purposively and participatory, involving health workers, PHBS cadres, community leaders, religious leaders, and residents in the Permata Sukarame Community Health Center's work area. The research stages included a preliminary study, needs analysis, prototype model design, expert validation, revision, and limited trials using a pretest–posttest design. The instruments used included interview guidelines, observation, document analysis, and questionnaires. Through these stages, this research produced a contextual, participatory health empowerment model oriented toward sustainable PHBS behavior change at the family and community levels.

**RESULTS AND DISCUSSION**

**Model Feasibility Development**

The implementation of the PHBS program in Bandar Lampung City has been systematic and has involved the community and health workers. However, community participation tends to be technical and formal, especially during the program implementation phase, while a reflective and sustainable participatory understanding has not yet been fully established. This is evident in the low PHBS achievement due to smoking behavior in households, despite increasing public awareness of the dangers of smoking.

With the establishment of the PHBS pocket book based on participation, empowerment, and Islamic values, the final model of health empowerment developed is expected to be able to answer empirical problems in the field, especially the gap between PHBS knowledge and practice.

**Table 1. Case Processing Summary**

Statistics	Mark
Cronbach's Alpha	0.971
Number of Items	10
Number of Respondents	34

**a. Validity Test**

**Table 2. Validity Test Calculation Results**

N o	Statement	r (Item-Total)	r Table	Sig. (2-tailed)	Description
1	The language in this pocket book is easy to understand.	0.832	0.2869	< 0.001	Valid
2	The material in this healthy living empowerment pocket book is clear and not confusing.	0.879	0.2869	< 0.001	Valid
3	The explanation in this pocket book is not ambiguous.	0.870	0.2869	< 0.001	Valid
4	The arrangement of the material in this pocket book is easy to follow.	0.938	0.2869	< 0.001	Valid
5	This pocket book is easy to implement/practice.	0.901	0.2869	< 0.001	Valid

6	This pocket book is appropriate to community conditions.	0.898	0.2869	< 0.001	Valid
7	The moral values contained in this pocket book are easy to understand.	0.935	0.2869	< 0.001	Valid
8	This pocket book is beneficial as a guide for healthy living.	0.884	0.2869	< 0.001	Valid
9	This pocket book is feasible to be used as a community handbook.	0.824	0.2869	< 0.001	Valid
10	I am willing to use or recommend this pocket book.	0.941	0.2869	< 0.001	Valid

Based on the table above, all statement items in the questionnaire have a Pearson correlation value (calculated r) that is greater than the table r of 0.2869 with a significance level of less than 0.001. The correlation values ranged from strong to very strong. This indicates that all items accurately measured the understandability of the pocketbook, thus declaring the instrument valid and suitable for use in research.

**b. Reliability Test**

The reliability test results showed a Cronbach's Alpha value of 0.971. This value is well above the minimum threshold of 0.70, indicating a very high level of reliability for the instrument. This indicates that all items in the questionnaire consistently measure the understandability of the pocketbook. These results reinforce that each item supports each other in measuring the same construct.

**Dynamics of PHBS Implementation and Participation Gaps**

Theoretically, community empowerment in the health sector is understood as a process of redistributing power and increasing community capacity to control decisions and resources that affect their lives. From a participatory perspective, community involvement ideally extends beyond activity implementation to encompass collective planning, decision-making, and program oversight. [14]

Participatory practices in the implementation of PHBS remain at the information-consultation level. Communities have been involved in Self-Awareness Surveys (SMD), Village Community Deliberations, and promotional and preventive activities. However, data management, problem prioritization, and strategic decision-making are still dominated by health institutions. This situation indicates that participation has occurred formally, but has not yet fully reached the level of partnership.

From an empowerment perspective, this condition reflects a suboptimal process of increasing community control over the determinants of their own health. Zimmerman emphasizes that empowerment encompasses intrapersonal (self-awareness and confidence), interactional (understanding of

systems and resources), and behavioral (ability to act collectively) dimensions. [15]

In addition, Paulo Freire emphasized that social transformation requires critical consciousness that grows through a process of reflection and dialogue. [16] This is in line with research findings that although public knowledge about the dangers of smoking has increased, behavioral changes have not been consistent.

Based on this theoretical framework, the gap between empowerment theory and PHBS participation practices in this study can be formulated in three main aspects:

- a. **Information control gap**, where health data is still predominantly managed by institutions.
- b. **Collective reflection gap**, where participatory forums are not yet fully based on community data analysis.
- c. **Internalization gap of values**, where behavioral changes are not yet fully driven by intrinsic awareness and social norms.

Participatory theory emphasizes the importance of redistributing power and controlling information, while field practice still demonstrates institutional dominance in data management and decision-making. Empowerment theory calls for the development of critical awareness, collective reflection, and the ability of communities to control the determinants of their health, but existing participatory mechanisms are not fully based on community-led information management.

**Social Characteristics and Challenges of Behavior Change**

The low achievement of PHBS indicators, particularly regarding smoking behavior, indicates that the primary challenge lies not in the availability of sanitation programs or facilities, but rather in changing behaviors that are deeply rooted in the community's social life. Theoretically, changes in health behavior do not occur instantly, but rather through a process of internalizing values, establishing social norms, and strengthening a supportive environment. [17]

In health behavior theory, Green and Kreuter, through the PRECEDE-PROCEED model, explain that behavior is influenced by predisposing factors (knowledge, attitudes, beliefs), supporting factors (availability of facilities), and reinforcing factors (social support and norms). [18] Research findings show that although supporting factors such as environmental sanitation have been met, predisposing and reinforcing factors have not yet fully encouraged consistent changes in smoking behavior.

The finding regarding the weak role models of some local actors can also be explained through Bandura's social learning theory, which states that individuals tend to imitate the behavior of figures who have high authority or social status. [19] When community leaders or regional officials are still active smokers, the norm of a smoke-free area is difficult to internalize collectively.

The low achievement of PHBS indicators does not merely indicate a weak program, but reflects the complex interactions between customs, social norms, local leadership, and heterogeneous community characteristics. The challenge of behavior change in this context requires an approach that is not only informative but also reflective and based on community social control.

By presenting data as a reflection of the community's real-world conditions and discussing it in a deliberative forum, new social norms can be collectively established. This approach enables a shift from individual habits to social commitments based on shared awareness.

### **Transforming Participation through the Data-Driven Community Empowerment (DDCE) Model**

The Data-Driven Community Empowerment (DDCE) model was designed in response to the gap between administrative participation and reflective participation, enabling the redistribution of information control to the community

#### **a. Reflection and Critical Awareness**

The use of a PHBS checklist and Google Form as reflection tools encourages residents to systematically assess their household health conditions. This process aligns with Paulo Freire's concept of critical consciousness, which emphasizes reflection on concrete experiences as the basis for developing critical awareness.[20] The resulting data reflects the real conditions of the community and opens up space for awareness-based change when residents recognize the gap between their perception of "feeling healthy" and objective indicators of healthy living (PHBS).

#### **b. Shift Towards Partnership**

From Sherry Arnstein's perspective, authentic participation is characterized by increased citizen control in decision-making. The DDCE model facilitates citizens not only receiving information but also analyzing and determining follow-up actions based on the data they generate. Discussions on data recapitulation at the neighborhood association (RT) level indicate a shift from consultation to partnership.

#### **c. Redistribution of Information Control**

From the perspective of the relationship between knowledge and power, Michel Foucault asserted that the control of knowledge determines the dominant position in policymaking. In conventional health practices, data tends to be monopolized by institutions for administrative purposes. The DDCE model shifts this pattern by positioning citizens as both producers and users of data, thereby strengthening control over distributed information and strengthening the public's position in health program relations.

#### **d. Participatory Monitoring and Empowerment**

Participatory Monitoring and Evaluation (PM&E) emphasizes community involvement in data management to ensure program sustainability.[21] The DDCE model is implemented through Google Forms as a community monitoring tool. From Zimmerman's perspective, the ability to understand systems and influence decisions reflects empowerment that develops across intrapersonal, interactional, and behavioral dimensions.

Based on this theoretical framework, the transformation of participation in the DDCE model can be understood as a shift from:

- 1) Administrative participation → reflective participation
- 2) One-way information → data-driven dialogue
- 3) Program compliance → collective awareness

This transformation is the core of this research's conceptual contribution to the development of a community participation-based health empowerment model.

### **Integration of Islamic Values as a Moral and Social Strengthenener in Health Empowerment**

The integration of Islamic values into the health empowerment model serves not merely as a normative approach, but as an ethical and spiritual foundation that strengthens the internalization of healthy lifestyle behaviors. From the perspective of maqāsid al-syarī'ah, preserving life (ḥifz an-nafs) is one of the primary objectives of Islamic law. [22]

This concept aligns with the understanding that the body is a trust from Allah SWT that must be protected and nurtured. The Qur'an emphasizes the prohibition of self-harm (lā tulqū bi aydikum ilā at-tahlukah). [23] and the principle of not causing harm (lā ḍarar wa lā ḍirār). [24]

Thus, health is not merely viewed as an individual matter, but as a collective responsibility that impacts the well-being of society. This approach broadens the meaning of PHBS from mere compliance with indicators to become part of social worship.

Research findings indicate that communities are more receptive to PHBS messages when linked to religious teachings. The integration of Islamic values into the DDCE model is not intended to limit its universality, but rather to strengthen its social legitimacy and cultural relevance within a religiously diverse society. Thus, the Islamic values in this model function on three levels:

- a. Normative level, as the ethical basis for maintaining health
- b. Psychological level, as a reinforcement of intrinsic motivation
- c. Social level, as collective legitimacy in building healthy behavioral norms

This integration emphasizes that health empowerment requires a moral-spiritual foundation in addition to structural and technical aspects for sustainable behavior change. Within the Data-Driven Community Empowerment framework, the synergy of data control and values-based self-control makes participation more rational and ethically meaningful.

### **Comparison with Previous Research**

The development of the Data-Driven Community Empowerment (DDCE) model in this study does not exist in a vacuum, but rather builds on various previously developed approaches to health empowerment and community participation. Therefore, it is important to map this model's position within the context of previous research and models to emphasize its conceptual contribution and novelty.

- a. Comparison with Conventional Health Promotion Models  
In the context of PHBS, conventional approaches tend to focus on disseminating indicators and reinforcing healthy behavior messages. Activities such as outreach at integrated health service posts (Posyandu), home visits, and thematic campaigns are the main instruments for behavior change. However, research findings indicate that increased knowledge does not always translate into consistent behavior change, particularly for indicators related to long-term habits like smoking.

The fundamental difference between the conventional model and the Data-Driven Community Empowerment (DDCE) model lies in the repositioning of the role of data and information control. In the conventional model, data is institutionalized and serves as a program evaluation tool. Monitoring is not solely for reporting, but also for fostering collective reflection and community dialogue. Furthermore, conventional models tend to be linear: outreach → implementation → evaluation. Meanwhile, DDCE builds a cyclical mechanism through a data-driven feedback loop: residents fill in indicators → recapitulation → discussion at the neighborhood level → follow-up → re-monitoring. This pattern creates a recurring social learning process and strengthens sustainability.

Aspect of Comparison	Conventional Health Promotion Model	Data-Driven Community Empowerment (DDCE) Model
<b>Basic Paradigm</b>	Education and behavior change based on information	Empowerment based on reflection and community data control
<b>Institutional Role</b>	Dominant in planning, data management, and evaluation	Facilitator and data manager that is returned to the community
<b>Community Position</b>	Target of programs and implementer of activities	Subject of empowerment, data producer and user
<b>Function of Data</b>	Administrative reporting tool and institutional evaluation	Instrument for collective reflection and basis for community decision-making
<b>Form of Participation</b>	Informing–consultation	Moving toward partnership through data-based dialogue
<b>Monitoring Pattern</b>	Linear (education → implementation → evaluation)	Data-based feedback loop and deliberation
<b>Behavior Change Approach</b>	Education and thematic campaigns	Individual reflection + community dialogue + social control based on data
<b>Integration of Social/Religious Values</b>	Generally not structured systematically	Integrated as a source of moral energy and social legitimacy
<b>Program Sustainability</b>	Dependent on institutional intervention	Supported by participatory monitoring and sense of ownership

The table shows that the difference between conventional health promotion models and DDCE lies not in goals, but in the structure of relationships and participation mechanisms. The conventional model emphasizes information transfer and activity implementation, while DDCE fosters data-driven reflection and dialogue that distributes control of information to the community.

Thus, DDCE expands the health promotion paradigm from an educational approach to data-driven reflective empowerment, while strengthening conventional approaches through a more transparent and dialogical participatory monitoring system.

**b. Comparison with the Community-Based Participatory Research Model**

The Community-Based Participatory Research (CBPR) model is a research approach that positions the community as an equal partner in the entire research process, from problem identification, intervention design, implementation, to evaluation.

Because CBPR emphasizes collaboration in knowledge production, DDCE extends this to collaboration in the sustainable production and management of health information. This model integrates individual reflection (through checklists), community dialogue (through neighborhood association meetings), and a participatory digital monitoring system as a tool for long-term empowerment.

Aspect of Comparison	Community-Based Participatory Research (CBPR)	Data-Driven Community Empowerment (DDCE)
<b>Position</b>	Research approach/methodology	Conceptual-operational model of empowerment
<b>Main Focus</b>	Collaboration in the research process	Data-based community empowerment system
<b>Duration of Impact</b>	During and after the research (depending on design)	Designed for long-term sustainability
<b>Knowledge Production</b>	Co-creation between researchers and community	Data production and management by the community
<b>Monitoring Mechanism</b>	Not always digitally structured	Structured through Google Forms and reporting flow
<b>Information Control</b>	Shared within the research process	Decentralized through a participatory data-based system
<b>Integration of Religious Values</b>	Not a systematic component	Integrated as moral reinforcement and social legitimacy
<b>Output</b>	Research findings and recommendations	Applicable and sustainable empowerment model

This comparison demonstrates that DDCE is not simply an application of CBPR, but rather a further development that transforms collaborative principles into a data-driven

community monitoring and reflection system. Thus, this model's contribution is not only methodological but also structural in building sustainable community participation.

**c. Comparison with Participation Theory (Arnstein)**

The theory of participation proposed by Sherry R. Arnstein through the concept of the Ladder of Citizen Participation explains that public participation has levels that move from non-participation (manipulation and therapy), to tokenism (informing, consultation, placation), to citizen power (partnership, delegated power, citizen control). This theory emphasizes that the essence of participation is not merely involvement in activities, but rather the redistribution of power and control over the decision-making process.

In the context of PHBS implementation in the research area, community participation was previously at the information-consultation level. Communities received information, attended activities, and provided limited feedback, but control over data, policy direction, and program evaluation remained with health institutions. This situation indicates that participation remained administrative in nature and had not yet reached an equal partnership.

While Arnstein's theory emphasizes the importance of redistributing power, DDCE operationalizes this redistribution through data-driven community information control. Residents not only receive information but also complete PHBS indicators via Google Form, view the summary results, and discuss them in neighborhood association (RT) forums to determine joint follow-up actions. Through this comparison, the DDCE not only represents the application of participation theory but also represents an operational development that translates the principle of power redistribution into a data-driven system of dialogue and monitoring. Thus, this model strengthens the implementation dimension of participation theory in community health empowerment.

Aspect of Comparison	Participation Theory (Arnstein)	DDCE Model
<b>Main Focus</b>	Levels of participation and redistribution of power	Operationalization of redistribution of information control
<b>Level of Participation</b>	Non-participation → Tokenism → Citizen Power	Shifting from informing-consultation toward partnership
<b>Information Control</b>	Conceptual (redistribution of power)	Concrete through a data-based monitoring system
<b>Transition Mechanism</b>	Not operationally specified	Checklist + Google Form + neighborhood deliberation (Musyawarah RT)
<b>Aspect of Comparison</b>	<b>Participation Theory (Arnstein)</b>	<b>DDCE Model</b>
<b>Orientation</b>	Public policy in general	Community-based health programs
<b>Model Contribution</b>	Normative framework	Implementative and replicable system

**d. Comparison with Empowerment Theory (Zimmerman & Freire)**

Empowerment theory in the context of public health emphasizes increasing the capacity of individuals and communities to control the decisions and resources that affect their lives. Zimmerman explains that empowerment consists of three main dimensions: intrapersonal (awareness and self-confidence), interactional (understanding of systems and access to resources), and behavioral (concrete actions to influence social change).

In the practice of PHBS in the research area, empowerment has not yet been fully realized in these three dimensions. Although there has been an increase in knowledge (cognitive dimension), control over information and decision-making still rests with institutions. Critical awareness of the determinants of health has not yet fully developed into independent and sustainable collective action.

On the intrapersonal level, the use of the PHBS checklist encourages individual reflection on the health condition of their household. This process allows residents to conduct conscious and structured self-evaluation. On the interactional level, Google Forms and a data recapitulation system enable residents to understand the collective condition of their neighborhood based on measurable indicators. Previously administrative data is transformed into a source of community knowledge that can be discussed and understood collectively.

On the behavioral dimension, neighborhood association (RT) deliberation forums and data-driven follow-up priority setting create a space for collective action. Residents not only learn about the health conditions of their neighborhoods but also participate in collectively determining improvement measures.

DDCE expands the empowerment dimension by adding the redistribution of information control as a key element. Empowerment is understood not only as increased awareness, but also as the ability of communities to generate, access, and use their own health data in decision-making.

Comparison Aspect	Empowerment Theory (Zimmerman & Freire)	DDCE Model
<b>Main Focus</b>	Increasing awareness and social control	Community empowerment system based on data reflection
<b>Intrapersonal Dimension</b>	Self-awareness and self-confidence	Individual reflection through PHBS checklist
<b>Interactional Dimension</b>	Understanding systems and access to resources	Access and understanding of collective data through Google Forms
<b>Behavioral Dimension</b>	Collective action for change	Community meetings (RT level) and data-based priority setting

<b>Reflective Dialogue (Freire)</b>	Conscientization through dialogue	Community dialogue based on measurable indicators
<b>Information Control</b>	Conceptual	Operational through a participatory monitoring system
<b>Sustainability</b>	Dependent on social dynamics	Supported by data-based feedback mechanisms

From this comparison, it can be concluded that the DDCE integrates classical empowerment theory into a structured and digital implementation system. This model enriches empowerment theory by adding an operational dimension in the form of data-driven information control as a primary instrument of social transformation. Thus, the DDCE's contribution is not only practical but also conceptual in broadening the understanding of community-based health empowerment mechanisms.

**CONCLUSION**

The implementation of the Clean and Healthy Living Behavior (PHBS) Program in the Permata Sukarame Community Health Center (Puskesmas Permata Sukarame) area has demonstrated good administrative achievements, but community participation remains at the information-consultation level. The community plays a more active role as recipients of information and implementers of activities, while involvement in planning and decision-making remains limited. This highlights the gap between the achievement of program indicators and the quality of substantive empowerment, suggesting that administrative monitoring alone does not guarantee sustainable behavior change.

To address this gap, this study develops a Community Data-Based Empowerment Model through an integrated CBPR R&D approach. This model positions data as an instrument for collective reflection and redistribution of information control from institutions to the community, thereby encouraging reflective participation based on dialogue and shared decision-making. Theoretically, this model expands the concept of empowerment by emphasizing the dimension of information control as key to the quality of participation; practically, this model offers an applicable, deliberative, and sustainable implementation framework for strengthening the PHBS program.

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