



Integration of Community Strategies and Community Nurse Interventions in Health Crisis Handling Health Sociology Approach

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ABSTRACT

Introduction: Health crises require adaptive, socially grounded responses that integrate formal health systems with community capacity. In Makassar, Indonesia, disparities in access, social heterogeneity, and varying levels of health literacy intensify vulnerability during crises. This study aimed to develop and examine an integrative model combining community strategies and community nurse interventions using a health sociology approach, with social solidarity as a moderating variable to enhance community health resilience.

Methods: A mixed-methods, sequential, explanatory design was used. The quantitative phase involved a cross-sectional survey of 80 respondents selected through stratified random sampling. Data were analyzed using Pearson correlation and multiple linear regression. The qualitative phase included in-depth interviews and focus group discussions with 20 key informants (community nurses, community leaders, and health officials), analyzed using thematic analysis.

Results: Community strategies ($\beta = 0.41$; $p < 0.001$) and community nurse interventions ($\beta = 0.45$; $p < 0.001$) significantly influenced health resilience. Social solidarity moderated the relationship between community strategies and resilience ($p < 0.05$). The integrative model demonstrated strong predictive power ($R^2 = 0.62$). Qualitative findings identified four key themes: locally grounded community strategies, nurses as educators and facilitators, structural and cultural barriers, and integration as a determinant of effectiveness.

Conclusion: The integration of community-based strategies and community nursing interventions significantly enhances health resilience by strengthening social solidarity, improving service access, and enabling context-based adaptation. This model provides both theoretical contributions to community health nursing and practical implications for community-based health policy in crisis settings.

Keywords: community health nursing, community resilience, health crisis, social solidarity, sociology of health

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INTRODUCTION

Health crises ranging from infectious disease outbreaks to environmental disasters expose structural vulnerabilities in urban health systems, particularly in rapidly growing cities such as Makassar, Indonesia. These crises are not merely biomedical phenomena but are shaped by social determinants, including population density, socioeconomic inequality, and uneven access to healthcare services [1]. Empirical evidence demonstrates that urban populations with fragmented social structures and limited access to primary care experience disproportionately higher morbidity and delayed recovery during crises [2]. In Makassar, challenges such as overcrowding, disparities in health service distribution, and low health literacy among vulnerable groups amplify the impact of crises, necessitating a more integrated and context-sensitive response [3].

Existing literature highlights two dominant approaches in addressing community health crises: community-driven strategies and formal healthcare interventions [4]. Community-based strategies, often rooted in local wisdom and social cohesion, have been shown to enhance collective efficacy and adaptive capacity [5]. Studies grounded in health sociology emphasize the role of social capital, trust, networks, and norms in facilitating rapid information exchange, mutual aid, and coordinated local responses [6]. For instance, Putnam's framework on social capital and subsequent empirical studies indicate that communities with strong social ties exhibit higher resilience during public health emergencies [7]. Concurrently, the role of community health nurses has been widely acknowledged in bridging gaps between healthcare systems and populations. Community nurses function not only as clinical providers but also as educators, facilitators, and advocates, particularly in preventive and promotive health efforts [8].

However, prior research has largely examined these two dimensions in isolation. Quantitative studies tend to focus on the effectiveness of community nursing interventions without adequately accounting for the sociocultural context in which they operate [9]. Conversely, sociological analyses often emphasize community dynamics while overlooking the institutional and professional contributions of healthcare providers. This fragmented approach limits the development of comprehensive models capable of addressing complex health crises [10].

The explicit research gap, therefore, lies in the lack of integrative frameworks that systematically combine community strategies with community nursing interventions within a health sociology perspective. Moreover, the moderating role of social solidarity, a key construct in sociological theory, remains underexplored in empirical studies of community health resilience. While social solidarity has been conceptually linked to collective action and crisis response, its function as a mechanism that strengthens the relationship between community initiatives and health outcomes has not been adequately quantified or contextualized in urban Indonesian settings. This study addresses these gaps by proposing a novel integrative model that incorporates community strategies, community nurse interventions, and social solidarity as a moderating variable in enhancing health resilience. Unlike previous models, this approach explicitly situates health outcomes within the interaction between social structures and healthcare agents, drawing on health sociology and community-oriented primary care frameworks. The novelty of this study lies in its mixed-methods design, which not only quantifies relationships among variables but also elucidates the underlying sociocultural mechanisms through qualitative inquiry.

The objective of this research is fivefold: (1) to identify existing community strategies employed in Makassar in response to health crises; (2) to analyze the roles and activities of community nurses within these strategies; (3) to examine the influence of community strategies and nursing interventions on health resilience; (4) to assess the moderating effect of social solidarity; and (5) to develop an evidence-based integrative model for community health crisis management. By addressing these objectives, the study aims to contribute to both theoretical advancement in community health nursing and practical policy formulation for crisis-responsive, community-based health systems.

RESEARCH METHODOLOGY

Study Design

This study employed a mixed-methods, sequential explanatory design, integrating quantitative and qualitative approaches to provide comprehensive insights into the relationships among community strategies, community nurse interventions, and health resilience. The quantitative phase (cross-sectional design) was conducted first to test hypothesized relationships among variables, followed by a qualitative phase to explain and contextualize the statistical findings. This design was justified as it enables both the measurement of effect size and the in-depth exploration of sociocultural mechanisms underpinning community health resilience.

Setting and Participants

The study was conducted in Makassar, Indonesia, between January and June 2025. The target population included community members who had experienced health crises (e.g., COVID-19, floods, dengue outbreaks) within the past five years and registered community health nurses working under the Makassar City Health Office. Inclusion criteria for the quantitative phase were: (1) residents aged ≥ 17 years, (2) having experienced at least one health crisis event, and (3) willingness to participate. Exclusion criteria included incomplete responses and cognitive impairment that prevented completion of the questionnaire. A stratified random sampling technique was applied based on administrative districts to ensure representativeness. Sample size for the quantitative phase ($n = 80$) was determined based on a minimum requirement for multiple regression analysis (10–15 observations per predictor variable), ensuring adequate statistical power. For the qualitative phase, 20 key informants (10 community nurses, 5 community leaders, and 5 health officials) were selected purposively based on their roles and experience in crisis response.

Variables and Measurement

The independent variables were community strategies and community nurse interventions, while the dependent variable was community health resilience. Social solidarity was treated as a moderating variable. All variables were operationalized using Likert-scale instruments (1–5), adapted from validated community health and social capital frameworks. Instrument validity was assessed through content validity by expert review and construct validity using correlation analysis. Reliability was tested using Cronbach's alpha, with values ≥ 0.70 considered acceptable. Data sources were primarily primary data collected through structured questionnaires and qualitative interviews.

Data Collection

Quantitative data were collected through face-to-face structured questionnaires administered by trained enumerators. Qualitative data were obtained via in-depth interviews and focus group discussions (FGDs) using semi-structured interview guides. Quality control measures included enumerator training, pilot testing of instruments, standardized data collection protocols, and cross-checking of completed questionnaires. Interview recordings were transcribed verbatim to ensure data accuracy.

Data Analysis

Descriptive statistics (mean, standard deviation, frequency, percentage) were used to summarize respondent characteristics and variable distributions. Bivariate analysis was conducted using Pearson correlation to assess relationships between variables. Multivariate analysis was performed using multiple linear regression to determine the effect of independent variables on health resilience and to test the moderating role of social solidarity through interaction terms. Qualitative data were analyzed using thematic analysis following Braun and Clarke's approach. All statistical analyses were conducted using SPSS version 25. The level of significance was set at $\alpha = 0.05$.

Ethical Approval

This study received ethical approval from the Ethics Committee of Universitas Islam Makassar. All participants provided written informed consent before participation.

Confidentiality, anonymity, and voluntary participation were strictly maintained throughout the study.

RESULT

Table 1. Characteristics of Respondents (n = 80)

Variable	Category	n	%
Age	17–25 years	18	22.5
	26–45 years	45	56.3
	>45 years	17	21.2
Sex	Male	30	37.5
	Female	50	62.5
Education	Primary school	12	15.0
	Junior high school	18	22.5
	Senior high school	39	48.7
	Higher education	11	13.8
Occupation	Formal	39	48.8
	Informal	41	51.2

Most respondents were aged 26–45 years (56.3%) and female (62.5%). The majority had a senior high school education (48.7%) and were engaged in informal employment (51.2%), indicating a population with moderate educational attainment and socioeconomic variability.

Table 2. Bivariate Analysis (Pearson Correlation)

Variables	r	95% CI	p-value
Community strategies → Health resilience	0.62	0.45–0.75	<0.001
Community nurse interventions → Health resilience	0.65	0.49–0.77	<0.001
Social solidarity → Health resilience	0.68	0.53–0.80	<0.001

All independent variables demonstrated strong positive correlations with health resilience. Social solidarity showed the highest correlation ($r = 0.68$), indicating its potential central role in strengthening resilience outcomes.

Table 3. Multivariate Analysis (Multiple Linear Regression)

Variables	β	95% CI	p-value
Community strategies	0.41	0.25–0.57	<0.001
Community nurse interventions	0.45	0.29–0.61	<0.001
Social solidarity (moderator)	0.21	0.02–0.40	0.032

Model Summary: $R^2 = 0.62$

Community nurse interventions ($\beta = 0.45$) had the strongest effect on health resilience, followed by community strategies ($\beta = 0.41$). Social solidarity significantly moderated the relationship, indicating that higher solidarity enhances the effectiveness of community-based strategies. The model explained 62% of the variance in health resilience, suggesting strong predictive capacity.

Qualitative Findings Matrix

Table 4. Thematic Matrix of Qualitative Findings on Community Strategies and Community Nurse Interventions in Health Crisis Management

Theme	Description	Representative Evidence (Excerpt)	Interpretation	Implication
Locally Embedded Community Strategies	Community responses are grounded in local wisdom, mutual aid (gotong royong), and informal social	“Without mutual help in the neighborhood, it was very difficult to survive during the pandemic.”	Strong social capital enables rapid resource mobilization, information	Strengthening local community structures can enhance resilience and crisis responsiveness.

	networks that facilitate collective coping during health crises.		sharing, and emotional support.	
Community Nurses as Health Agents	Community nurses act beyond clinical roles as educators, facilitators, and trusted intermediaries between the health system and the community.	“Nurses who directly engage with residents are more trusted than information from media sources.”	Professional legitimacy and direct engagement increase trust, improving health literacy and service uptake.	Policies should reinforce community nurse roles in outreach, education, and advocacy.
Structural and Cultural Barriers	Barriers include limited healthcare access, stigma, socioeconomic inequality, and bureaucratic constraints affecting intervention effectiveness.	“Some people hesitate to seek care because of stigma and administrative difficulties.”	Structural inequities and cultural perceptions hinder timely healthcare utilization and diminish the impact of interventions.	Interventions must address systemic barriers and incorporate culturally sensitive approaches.
Integration as a Determinant of Effectiveness	Effective crisis management emerges from collaboration between community initiatives and formal health services.	“Collaboration between community members and health workers is key to handling crises effectively.”	Synergy between social systems and healthcare providers enhances adaptive capacity and sustainability.	Integrated, multi-level intervention models should be prioritized in health policy and practice.

The integration of quantitative and qualitative findings demonstrates a consistent pattern in which both structural and social determinants jointly shape community health resilience. Quantitative analysis confirms that community strategies and community nurse interventions significantly contribute to resilience outcomes, with nurse-led interventions showing slightly greater effect size. The moderating role of social solidarity further underscores the importance of cohesive social networks in amplifying the effectiveness of interventions. Qualitative findings provide contextual depth, revealing that locally grounded practices such as mutual aid and informal support systems function as adaptive mechanisms during crises. Community nurses are perceived as credible and accessible actors who translate health policies into culturally appropriate actions. However, persistent barriers such as limited healthcare access, social stigma, and administrative constraints may hinder optimal outcomes. Taken together, these findings suggest that resilience is not solely determined by formal healthcare inputs but emerges from the interaction between community capacity and professional support. The integrative model underscores the need to align health interventions with sociocultural contexts to achieve sustainable, effective crisis response strategies.

DISCUSSION

The findings of this study indicate that community health resilience in crisis settings is shaped by a dynamic interplay between social capacity and professional health interventions, rather than by clinical efforts alone. The statistical results demonstrate that both community strategies and community nurse interventions significantly contribute to resilience, with the latter showing a slightly stronger effect. This pattern suggests that while communities provide the foundational social infrastructure through trust, networks, and collective practices, community nurses act as key agents who operationalize these social resources into actionable health

responses. In this sense, resilience emerges not as an isolated outcome but as a product of interaction between community-driven initiatives and institutional health support.

A more nuanced understanding emerges from the moderating role of social solidarity. The analysis shows that the effectiveness of community strategies is amplified in contexts with strong social cohesion [11]. This implies that mutual trust, shared norms, and collective responsibility enhance the community's ability to mobilize resources and respond adaptively during crises [12]. Rather than functioning as a passive background condition, social solidarity operates as an active mechanism that strengthens the link between local initiatives and health outcomes [13]. The model's relatively high explanatory power further underscores the importance of integrating social dimensions into health system responses, particularly in urban settings characterized by structural complexity [14].

The qualitative findings deepen this interpretation by illustrating how these mechanisms operate in practice. Locally embedded strategies such as mutual aid and informal support networks were consistently identified as critical in sustaining community resilience. At the same time, community nurses were perceived as trusted intermediaries who translate formal health policies into culturally meaningful actions [15]. Their roles extend beyond clinical care to include education, facilitation, and advocacy, thereby enhancing both access and acceptability of health services [16]. However, these enabling factors coexist with persistent barriers, including limited access to healthcare, social stigma, and administrative constraints. These barriers highlight that resilience is not uniformly distributed but is mediated by broader structural and cultural conditions [17].

When situated within the broader literature, these findings align with established evidence on the role of social capital in shaping health outcomes [18]. Previous studies have consistently shown that communities with strong social networks and high levels of trust are better equipped to withstand and recover from crises [19]. The present study confirms this relationship while also demonstrating that social capital alone is insufficient without the support of professional health systems [20]. Similarly, the critical role of community nurses observed in this study is consistent with prior research that emphasizes their role as connectors between populations and healthcare institutions. However, the current findings extend this body of work by empirically demonstrating that these two domains interact rather than operate independently [21].

The identification of social solidarity as a moderating variable represents a notable conceptual contribution. While solidarity has long been discussed in sociological theory, its empirical application in community health research remains limited [22]. By demonstrating its moderating effect, this study provides a more concrete understanding of how social cohesion influences the effectiveness of interventions [23]. In addition, the emphasis on locally grounded practices reflects broader patterns observed in collectivist societies, where informal networks and cultural norms play a central role in shaping health behaviors [24]. At the same time, the persistence of structural barriers underscores the need to address systemic inequities that may undermine these social strengths [25].

Despite these contributions, several limitations should be acknowledged. The cross-sectional nature of the quantitative data limits causal inference, and the relatively small sample size may limit generalizability beyond the study setting [26]. The reliance on self-reported measures introduces the possibility of response bias, and the qualitative findings, while insightful, are based on a limited number of informants. Furthermore, the operationalization of social solidarity may not fully capture its multidimensional nature, suggesting the need for more refined measurement approaches in future research [27].

Future studies should therefore aim to build on these findings by employing longitudinal designs that can better capture the temporal dynamics of resilience. Expanding the scope of research to include diverse geographic and sociocultural contexts would also enhance the robustness of the proposed model. Methodologically, the use of advanced analytical techniques, such as structural equation modeling, could provide a more comprehensive understanding of the complex relationships among variables. Additionally, exploring emerging factors such as digital

health literacy and governance structures may offer new insights into the determinants of resilience in contemporary health systems.

From a practical standpoint, the findings highlight the importance of designing interventions that are both socially grounded and professionally supported. Policies that strengthen community engagement while simultaneously enhancing the capacity of community nurses are likely to be more effective in addressing health crises. The integration of these elements should not be viewed as an optional strategy but as a fundamental requirement for building resilient health systems. Overall, this study underscores the need for a holistic and context-sensitive approach to health crisis management, one that recognizes the interdependence of social and institutional factors in shaping health outcomes.

CONCLUSION

This study set out to develop and test an integrative model linking community strategies and community nurse interventions to enhance health resilience in crisis settings. The findings provide a clear answer to this objective. Both components independently and jointly contribute to resilience, with community nurse interventions exerting a slightly stronger effect, while social solidarity amplifies the impact of community strategies. Together, these factors explain a substantial proportion of variance in resilience, indicating that effective crisis response is not achieved through clinical action alone but through alignment between social capacity and professional support. The evidence suggests that resilience is strengthened when locally grounded practices, such as mutual aid and informal networks, are systematically integrated with nurse-led education, facilitation, and service navigation. However, structural barriers (access constraints, stigma, and administrative complexity) continue to limit optimal outcomes, underscoring the need for system-level adjustments. Policy implications are direct. Health systems should institutionalize community–nurse integration through community-oriented primary care models, invest in the deployment and training of community nurses as outreach leaders, and embed mechanisms that cultivate social solidarity (e.g., community groups, peer-support networks). Interventions should be context-sensitive, co-designed with communities, and supported by streamlined access pathways to services. Such measures are likely to produce more responsive, equitable, and sustainable crisis management.

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Conflict of Interest

The authors declare that there are no conflicts of interest related to this study.

Authors' Contributions (CRediT Taxonomy)

Baso Witman Adiaksa: Conceptualization; Methodology; Investigation; Data Curation; Formal Analysis; Writing – Original Draft; Supervision. Muhammad Ilyas: Validation; Resources; Writing – Review & Editing; Visualization.

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Declaration of Generative AI Use

The authors declare that generative artificial intelligence (AI) tools were used solely to support language refinement and structural editing of the manuscript. All intellectual content, data analysis, and interpretation of findings were developed independently by the authors. The authors take full responsibility for the accuracy, integrity, and originality of the work.

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