

Empowering older adults through health education and community-based screening for coronary heart disease risk factors

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ABSTRACT

Coronary heart disease (CHD) is a major health problem among older adults and is influenced by aging, metabolic changes, and lifestyle-related risk factors. Limited knowledge of CHD risk factors and low awareness of routine health examinations may contribute to delayed detection and prevention. This community engagement program aimed to improve older adults' knowledge and awareness of CHD risk factors, signs and symptoms, prevention, and the importance of early detection. The activity was conducted in Lorong Kampung Kawah, Jongaya Village, Tamalate District, Makassar City, involving community-dwelling adults aged ≥ 50 years. The intervention consisted of health education using presentations and leaflets, interactive discussions, and simple health screening through blood pressure and blood glucose measurements. Evaluation was conducted through observation, question-and-answer sessions before and after education, and activity documentation. The results showed an 85% increase in participants' knowledge following health education and screening. Participants also demonstrated improved understanding of healthy lifestyle practices, recognition of early CHD warning signs, blood pressure control, and the importance of regular health examinations. The program positively contributed to improving health literacy and awareness of CHD prevention among older adults. In conclusion, integrating health education with community-based risk-factor screening represents a practical approach to strengthening older adults' knowledge, awareness, and preventive behavior regarding coronary heart disease.

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INTRODUCTION

Cardiovascular diseases (CVDs) remain a major public health challenge and contribute substantially to premature mortality, disability, and healthcare utilization worldwide. Coronary heart disease (CHD), as one of the principal manifestations of CVD, is particularly relevant among older adults because cardiovascular risk accumulates with age and frequently coexists with hypertension, diabetes mellitus, physical inactivity, unhealthy dietary patterns, smoking, and other metabolic or behavioral factors. These conditions may progress without clear symptoms, making prevention and early identification of cardiovascular risk particularly important in community-dwelling older populations. Recent evidence therefore emphasizes a shift from treatment-oriented approaches toward primary prevention, health literacy, risk-factor identification, and sustained healthy behavior at the community level (Hassen, 2023).

The Indonesian context illustrates the importance of this preventive approach. The 2023 Indonesian Health Survey (*survei kesehatan indonesia*) incorporated interviews, physical measurements, and biomedical examinations to assess major health conditions and behavioral risk factors at national and subnational levels (Ministry of Health of the Republic of Indonesia, 2024). Of particular concern, hypertension prevalence among adults aged ≥ 18 years was 30.8% when determined through blood-pressure measurement, whereas only 8.6% reported having been diagnosed by a physician. Diabetes showed a similar discrepancy: among individuals aged ≥ 15 years, prevalence based on physician diagnosis was 2.2%, compared with 11.7% based on blood-glucose examination. These substantial differences indicate that many individuals may be unaware of cardiovascular risk conditions unless active screening is performed. Hypertension and diabetes are also recognized nationally as important risk factors for cardiovascular and vascular diseases.

This problem is particularly relevant for older adults living in community settings. The partner community in Lorong Kampung Kawah, Jongaya Village, Tamalate District, Makassar City, consists of older residents who require accessible information and practical preventive measures related to heart health. Initial observations documented in the community engagement activity indicated that many participants had limited understanding of CHD, particularly its risk factors, early warning signs, and preventive measures. The original community assessment also identified the need to strengthen awareness of routine examinations and healthy lifestyle practices. Thus, the problem was not limited to the presence of cardiovascular risk factors but also involved inadequate health literacy and limited opportunities for simple community-based risk assessment.

The partner's needs consequently encompass two interconnected dimensions. First, older adults require understandable and contextually appropriate education about CHD, including modifiable risk factors, early signs and symptoms, healthy dietary practices, physical activity, smoking avoidance, blood-pressure control, and the importance of regular health examinations. Second, health education needs to be accompanied by practical screening that allows participants to recognize their individual risk profile. This combination is important because knowledge alone does not necessarily lead to preventive action. Effective cardiovascular risk communication should enable individuals

to understand what the risk means for them and what practical actions can be taken to reduce it (Mustaking et al., 2026).

A key gap identified in the partner community was therefore the limited integration of cardiovascular health education with accessible risk-factor screening. Conventional health promotion may provide information, but older adults also need opportunities to relate that information to measurable indicators of their own health. Evidence from a systematic review indicates that community-based cardiovascular interventions generally improve knowledge of CVD and its risk factors, supporting the use of community settings as strategic environments for preventive education (Sousa et al., 2026). More recent evidence concerning older adults at risk of atherosclerotic cardiovascular disease also suggests potential benefits from integrated health education programs, although effects on clinical outcomes remain variable and require longer-term evaluation (Z. Huang et al., 2026). These findings highlight the importance of combining education, active participation, screening, and continued follow-up rather than relying solely on one-way information delivery.

To address this gap, the community engagement program offered an integrated approach consisting of health education, interactive discussion, educational materials, and community-based screening of CHD risk factors. Blood-pressure and blood-glucose measurements were incorporated as practical screening components, while educational sessions addressed CHD risk factors, early warning signs, prevention, and healthy lifestyle practices. This approach was designed not to establish a clinical diagnosis but to empower older adults to recognize potential risks, improve their health literacy, and seek further assessment from healthcare facilities when necessary (L. Huang et al., 2026). Such activities are consistent with Indonesia's broader emphasis on measuring and controlling non-communicable disease risk factors through community and population-based strategies.

Accordingly, this community engagement program aimed to empower older adults through health education and community-based screening for coronary heart disease risk factors. Specifically, the activity sought to improve participants' knowledge of CHD, strengthen their ability to recognize risk factors and early warning signs, increase awareness of routine cardiovascular health examinations, and encourage preventive lifestyle practices. By integrating education with simple risk-factor screening, the program is expected to provide a practical model for strengthening cardiovascular disease prevention among older adults and supporting sustainable community participation in maintaining heart health.

METHOD

The community engagement program was implemented using a structured community-based approach that integrated health education, early cardiovascular risk screening, participant engagement, and evaluation. The implementation methods were designed to increase older adults' knowledge and awareness of coronary heart disease (CHD) while supporting early identification of cardiovascular risk factors. The detailed components of the program implementation are presented in the following table.

Table 1. Implementation components of the community-based health education and early screening program for coronary heart disease among older adults

Component	Description
Location	The community engagement activity was conducted in Lorong Kampung Kawah, Jalan Kumala, Jongaya Village, Tamalate District, Makassar City, South Sulawesi, Indonesia.
Time	The activity was implemented on 27 April 2026, covering preparation, initial observation, implementation, monitoring, and evaluation.
Community Partner	The program involved the local community of Lorong Kampung Kawah, local community representatives, and elderly <i>Posyandu</i> cadres who supported participant mobilization and implementation.
Participants	Participants were 15–20 community-dwelling older adults aged ≥ 50 years, both men and women. The activity was implemented with the involvement of 45 Level III-B nursing students under lecturer supervision.
Program Design	A community-based health education and early screening program was applied to improve older adults' knowledge, awareness, and preventive behavior related to coronary heart disease (CHD).
Program Stages	The activities consisted of preparation → community coordination and socialization → initial assessment → health education → CHD risk-factor screening → interactive discussion → monitoring → evaluation → follow-up planning.
Delivery Methods	Health information was delivered through face-to-face education, interactive lectures, question-and-answer sessions, and group discussions. Participants were encouraged to actively discuss CHD risk factors, warning signs, prevention, and healthy lifestyle practices.
Educational Media	Educational materials included PowerPoint presentations and leaflets containing information on the definition of CHD, risk factors, signs and symptoms, prevention, and early detection.
Screening Activities	Community-based screening included blood pressure and blood glucose measurements. Field implementation also included observation of pulse/heart rate as a basic indicator of cardiovascular health.
Evaluation Instruments	Evaluation was conducted using direct observation, simple question-and-answer assessments before and after education, attendance records, field notes, and activity documentation.
Data Collection	Data were collected through participant observation, responses during question-and-answer sessions, results of simple health examinations, and documentation of the activity.
Data Analysis	Data were analyzed descriptively through data reduction, systematic presentation of findings, and interpretation of changes in participants' knowledge and awareness before and after the intervention.
Success Indicators	Program success was indicated by increased participant knowledge and awareness regarding CHD risk factors, early warning signs, healthy lifestyle practices, blood-pressure control, and routine health examinations. The

source activity reported an 85% increase in knowledge following education and screening.

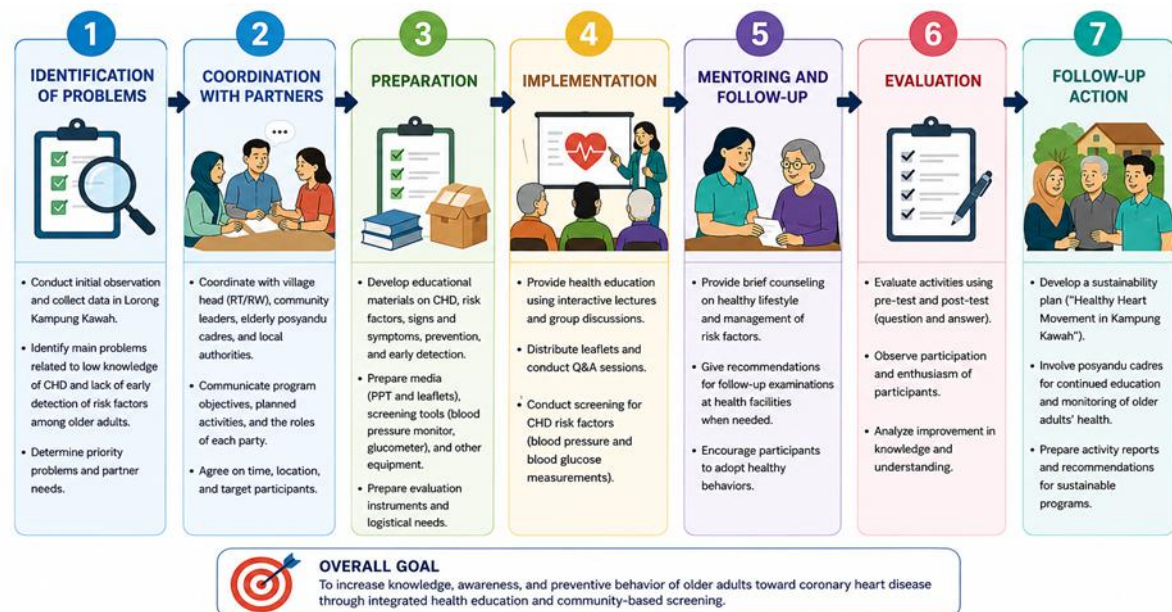


Figure 1. Stages of the community engagement program for empowering older adults through health education and community-based screening for coronary heart disease risk factors.

RESULT

The effectiveness of the intervention was assessed by comparing participants' knowledge and awareness before and after the community-based health education and CHD screening activities. The assessment focused on understanding of CHD, recognition of risk factors and early warning signs, preventive behaviors, and awareness of routine health screening. The observed changes are summarized in Table 2.

Table 2. Changes in participants' knowledge and awareness of coronary heart disease before and after the community-based education and screening intervention

Theme	Pre-test / Before Intervention	Post-test / After Intervention	Observed Change
Understanding of Coronary Heart Disease	Participants had limited understanding of CHD and its potential health consequences.	Participants were able to explain the basic concept of CHD and its importance for older adults.	Improved basic CHD knowledge.
Recognition of Risk Factors	Knowledge of cardiovascular risk factors was relatively limited.	Participants showed better awareness of lifestyle and health-related CHD risk factors.	Increased risk-factor awareness.
Recognition of Early Warning Signs	Participants had difficulty identifying early signs and symptoms of CHD.	Participants demonstrated improved ability to recognize early warning signs that require further examination.	Improved early recognition.
Healthy Lifestyle Awareness	Preventive lifestyle practices were not fully	Participants better understood the importance of healthy eating, physical activity,	Strengthened preventive awareness.

Theme	Pre-test / Before Intervention	Post-test / After Intervention	Observed Change
Awareness of Blood Pressure Control	understood as part of CHD prevention. Routine blood-pressure monitoring was not consistently perceived as an important preventive measure.	adequate rest, and other heart-healthy behaviors. Participants understood the importance of blood-pressure control and regular monitoring.	Increased screening awareness.
Awareness of Routine Health Screening	Awareness of regular health examinations and early detection was limited.	Participants recognized the importance of routine health checks and early risk-factor screening.	Increased intention toward early detection.
Response to Screening Results	Participants had limited experience linking health measurements with cardiovascular risk.	Screening allowed participants to become aware of their blood pressure and pulse and the need for further examination when risk signs were identified.	Improved practical health awareness.
Overall, Knowledge and Awareness	Baseline observations indicated incomplete understanding of CHD prevention.	The activity report documented an 85% improvement in participants' knowledge following education and screening.	Substantial educational improvement.

The findings suggest that the intervention moved participants beyond simply receiving health information toward developing greater preventive readiness. The combination of education and direct screening helped participants relate cardiovascular risk to their own health conditions, making the learning process more personally relevant. This is particularly important for older adults because early cardiovascular risks may not always be recognized without routine monitoring. The observed changes also indicate that community-based activities can reduce the gap between health knowledge and practical preventive action by providing participants with opportunities to discuss concerns, recognize potential warning signs, and understand when further examination is necessary. Participant engagement further indicates that an interactive and locally delivered approach was acceptable to the target community. Rather than functioning solely as a one-time educational session, the activity created an opportunity to strengthen self-awareness and encourage greater responsibility for maintaining cardiovascular health. However, the findings primarily reflect immediate educational outcomes; the available data do not establish whether these changes were sustained or resulted in long-term behavioral or clinical improvements. Therefore, periodic screening, continued education, and follow-up through local health services are important for translating the immediate benefits into sustainable CHD prevention.

DISCUSSION

The community engagement activity demonstrated that combining health education with simple cardiovascular risk screening can strengthen older adults' awareness of coronary heart disease (CHD) prevention. The observed improvement should not be interpreted merely as an increase in factual knowledge but as an indication of greater preventive readiness. Participants became more capable of connecting information about

CHD risk factors with practical actions, including recognizing early warning signs, monitoring blood pressure, undergoing routine health examinations, and adopting healthier daily behaviors. This finding is consistent with (Burka et al., 2026), whose systematic review of 16 controlled studies involving 34,845 participants found that most community-based cardiovascular interventions significantly improved knowledge of cardiovascular disease and its risk factors.

Several factors may explain the positive outcomes observed in this program. Delivering the intervention directly within the community reduced access barriers for older adults and created a familiar environment in which participants could interact with educators and discuss their health concerns. The use of presentations, leaflets, interactive discussions, question-and-answer sessions, and simple health examinations also provided multiple pathways for participants to understand the information. Such multimodal approaches are particularly relevant for older populations because health literacy varies considerably according to educational, cognitive, social, and health-related characteristics. A recent systematic review by (Sin et al., 2026) emphasized the importance of appropriately designed interventions for improving health literacy among older adults, supporting the need for educational strategies adapted to the characteristics of this population.

The integration of education with risk-factor screening represents another important feature of the program. Participants did not receive cardiovascular information in isolation; they were given opportunities to relate the educational content to measurable indicators such as blood pressure and blood glucose. This approach can increase the personal relevance of preventive messages and encourage individuals to consider their own cardiovascular risk (Suprpto et al., 2025). Evidence from community-based cardiovascular prevention programs supports this integrated strategy. (X. Chen et al., 2026), in a systematic review and meta-analysis of 48 studies, reported that community-based cardiovascular prevention programs were associated with improvements in several cardiometabolic indicators, including systolic and diastolic blood pressure, blood glucose, lipid profiles, and body-weight measures (Cao et al., 2026). Although the present activity was not designed to demonstrate clinical changes in these indicators, providing screening alongside education may represent an important first step toward risk recognition and appropriate referral.

The findings also support the importance of active participant involvement rather than relying solely on conventional one-way health education. Community-based cardiovascular interventions have demonstrated benefits not only for knowledge but also for health behaviors. A systematic review and meta-analysis involving 64 controlled studies and 98,919 participants found that community-based interventions improved the likelihood of achieving recommended physical activity levels and produced improvements in several measures of physical activity over follow-up periods of up to 24 months (Braun et al., 2025). Similarly, community-based interventions have shown potential for improving dietary behaviors relevant to cardiovascular disease prevention (Alexander et al., 2026). These findings suggest that education becomes more meaningful

when participants are encouraged to translate knowledge into achievable preventive behaviors.

The involvement of nursing students, lecturers, community representatives, and elderly-health cadres also contributed to the participatory character of the intervention. Community health workers and trained community members can act as important links between formal healthcare systems and populations requiring sustained prevention and monitoring. (Thapa et al., 2026) highlighted the potential contribution of community health-worker training to cardiometabolic disease prevention and control in low- and middle-income countries. This evidence provides a rationale for strengthening the role of elderly-health cadres in future implementation, particularly for routine education, blood-pressure monitoring, early recognition of risk factors, and referral to primary healthcare services.

Despite these positive outcomes, several limitations and implementation barriers should be considered. Participants differed in educational background, previous exposure to cardiovascular health information, and their ability to understand medical terminology. Older adults may also experience sensory limitations, reduced information retention, or difficulties applying health recommendations consistently. These considerations indicate that educational materials should remain simple, visually accessible, repetitive when necessary, and connected to everyday activities. Evidence from culturally tailored community education programs also suggests that interventions adapted to participants' social and community contexts can facilitate engagement and improve chronic disease-related outcomes (Shin et al., 2025).

The short duration of the activity represents another important limitation. Immediate improvements in knowledge cannot automatically be interpreted as sustained behavioral change or reduced cardiovascular risk. The available activity data also did not provide detailed numerical mean pre-test and post-test scores or longitudinal clinical indicators. Consequently, the findings primarily demonstrate an immediate educational and empowerment effect (F. Chen et al., 2025). This distinction is important because integrated health education programs among community-dwelling older adults at cardiovascular risk have shown variable effects across clinical outcomes. An integrative review published in 2024 found potential short-term benefits of combined health education and physical activity programs for weight management among older adults at risk of atherosclerotic cardiovascular disease, while effects on several other clinical indicators were less consistent (Wang et al., 2026). Longer follow-up is therefore necessary before concluding that educational improvements translate into measurable cardiovascular risk reduction.

Nevertheless, the activity generated meaningful changes at the participant level. Older adults developed greater understanding of CHD, modifiable risk factors, warning signs, and preventive measures. They also gained practical exposure to basic cardiovascular screening and became more familiar with the purpose of blood-pressure and blood-glucose assessment. These experiences can strengthen the ability to interpret personal health information and recognize circumstances requiring further examination.

The impact therefore extends beyond knowledge acquisition toward greater health awareness, self-monitoring, and willingness to engage in preventive practices. This direction is consistent with broader evidence from East and Southeast Asia showing the value of community interventions and health-promotion programs in addressing non-communicable disease prevention (Hamed et al., 2026).

Changes in attitudes toward prevention are equally important. Participants became more receptive to routine health examinations and healthy lifestyle practices, including dietary regulation, physical activity, adequate rest, and cardiovascular risk control (M. Chen et al., 2026). Behavioral counselling evidence indicates that interventions addressing healthy diet and physical activity can produce modest but meaningful improvements in cardiovascular health behaviors and intermediate outcomes (Diep et al., 2026). Therefore, strengthening knowledge should be considered an initial component of a broader behavioral pathway in which awareness is reinforced through counselling, repeated practice, monitoring, and supportive community environments.

At the community level, the program strengthened interaction among older adults, students, lecturers, community representatives, and health cadres. This collaborative process created a foundation for subsequent cardiovascular prevention activities and demonstrated that basic education and screening can be implemented within a community setting without complex clinical infrastructure. Community-based approaches are particularly relevant in settings where healthcare access and preventive service utilization remain uneven because they can bring basic risk identification and health-promotion activities closer to the population (Nam, 2025). Nevertheless, community screening should complement rather than replace professional clinical assessment. Participants with abnormal screening results or suspected cardiovascular risk should therefore be referred to appropriate healthcare facilities for further evaluation.

Program sustainability requires transforming the initial activity from a one-time intervention into a periodic community-based cardiovascular health initiative. Regular mentoring and screening could be conducted monthly or every three months in collaboration with community leaders, elderly-health cadres, Posbindu PTM, and nearby primary healthcare services. Follow-up sessions could include blood-pressure monitoring, blood-glucose assessment, reinforcement of healthy lifestyle messages, review of individual risk factors, and referral of participants requiring further assessment (Zhao et al., 2026). This approach is consistent with evidence showing that community-based cardiovascular programs can influence knowledge and modifiable risk factors when interventions are structured and sustained over time (Dibello et al., 2026).

Sustainability could be further strengthened through the development of community cardiovascular health cadres. Selected elderly-health cadres could receive structured training on CHD risk factors, healthy lifestyle counselling, accurate blood-pressure measurement, identification of warning signs, documentation, and referral procedures. Standardized educational resources including CHD prevention modules, leaflets, screening cards, and visual materials should also be maintained to ensure consistency across repeated activities. Digital communication through WhatsApp reminders, short

educational videos, or simple electronic educational materials could complement face-to-face activities, although the accessibility and digital literacy of older participants should be considered when selecting these approaches.

Finally, a simple monitoring framework should be established to evaluate whether the benefits of the intervention are maintained. Indicators could include attendance at follow-up activities, repeat blood-pressure and blood-glucose monitoring, participation in physical activity, adherence to routine health examinations, completion of referrals, and changes in knowledge and preventive practices over time. Follow-up assessments at three and six months would provide stronger evidence regarding the sustainability of the intervention. Through regular mentoring, cadre involvement, standardized educational materials, integration with local healthcare services, and longitudinal monitoring, the proposed Healthy Heart Movement in Kampung Kawah could evolve from a single community engagement activity into a sustainable community-based model for coronary heart disease prevention among older adults.

CONCLUSION

The community engagement program successfully strengthened older adults' knowledge and awareness of coronary heart disease through integrated health education and community-based risk-factor screening. The main achievement was the reported 85% improvement in participants' knowledge, accompanied by better understanding of CHD risk factors, early warning signs, healthy lifestyle practices, blood-pressure control, and the importance of routine health examinations. The activity also provided participants with practical experience in simple cardiovascular screening, helping them relate health information to their own risk conditions. For the community partner, the program provided an accessible and applicable model for strengthening cardiovascular health literacy and preventive behavior among older adults. The involvement of community representatives, elderly-health cadres, students, and supervisors also created a foundation for more collaborative prevention activities at the local level. Further program development should focus on periodic health education, regular blood-pressure and blood-glucose monitoring, cadre training, standardized educational modules, and stronger collaboration with local puskesmas and Posbindu PTM. Follow-up assessments at three to six months are recommended to determine whether improvements in knowledge are sustained and translated into healthier behavior, routine screening, and appropriate referral. With continuous mentoring and monitoring, the program has the potential to develop into a sustainable Healthy Heart Movement in Kampung Kawah for community-based coronary heart disease prevention.

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Conflict of Interest

The authors declare that they have no conflicts of interest related to the implementation, evaluation, or publication of this community engagement activity.

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