Jurnal Ilmiah Kesehatan Sandi Husada

Volume 15 Number 2 December 2026
DOI: https://doi.org/10.35816/jiksh.v15i2.375

Original Articles *Open Access*

Social solidarity determinant of community nursing achievement in disaster areas: Sequential explanatory mixed methods study

Baso Witman Adiaksa[1]✉, Syamsu A Kamaruddin[2], Arlin Adam[3], Ahmadin[2]
[1] Universitas Islam Makassar, South Sulawesi, Indonesia
[2] Univeritas Negeri Makassar, South Sulawesi, Indonesia
[3] Universitas Mega Buana, South Sulawesi, Indonesia

Received: 22 April 2026 ○ Revised: 27 June 2026 ○ Accepted: 30 June 2026 ○ Published: 12 December 2026

ABSTRACT

Introduction: Social solidarity remains an underexplored determinant in the implementation of community nursing practices, particularly in disaster-prone settings. While prior studies have examined post-disaster social dynamics, limited evidence exists on how social solidarity directly influences the achievement of community nursing interventions. This study aimed to analyze the effect of social solidarity on the achievement of community nursing practice in disaster mitigation contexts.

Research Methodology: This study employed a mixed-methods approach with a sequential explanatory design. The quantitative phase used a cross-sectional design with purposive sampling of community members involved in disaster-prone coastal areas. Data were collected using a structured questionnaire and analyzed using univariate tests, Pearson correlation, and linear regression ($\alpha = 0.05$). The qualitative phase involved in-depth interviews, which were analyzed using thematic analysis to inform the interpretation of quantitative findings.

Results: The quantitative findings showed a significant positive relationship between social solidarity and achievement in community nursing practice ($r = 0.62$; $p = 0.001$). Regression analysis indicated that social solidarity was a significant predictor ($\beta = 0.45$; $p < 0.001$). Higher levels of social solidarity were associated with increased community participation and improved service coverage. Qualitative findings revealed three key mechanisms: cooperation, trust in healthcare workers, and local leadership, which collectively strengthened implementation outcomes.

Conclusion: Social solidarity functions as a critical social determinant that enhances the effectiveness of community nursing practice in disaster settings. Integrating social-based strategies into community health interventions can improve participation, acceptance, and sustainability of care delivery.

Keywords: community health nursing; disaster mitigation; social cohesion; social solidarity; trust.

✉Corresponding author. Email: basowitmanadiaksa.dty@uim-makassar.ac.id
Universitas Islam Makassar, South Sulawesi, Indonesia

INTRODUCTION

Indonesia continues to experience frequent natural disasters, particularly in coastal and hazard-prone regions, which significantly disrupt community health systems and service delivery. Recent evidence indicates that disaster exposure is associated with increased morbidity, service disruptions, and reduced healthcare accessibility, especially among vulnerable populations (Abuhammad, 2025). Within this context, community nursing plays a critical role in ensuring continuity of care and promoting adaptive responses at the community level (Beyrer et al., 2024). However, the effectiveness of community nursing interventions in disaster settings remains inconsistent, indicating that technical and clinical preparedness alone are insufficient determinants of success (Cuadra & Rämgård, 2025).

Recent studies emphasize that community-based disaster preparedness and response are strongly influenced by social dynamics such as trust, participation, and collective efficacy. Social capital has been consistently identified as a key predictor of disaster resilience, influencing how communities respond to, cope with, and recover from crises (Gibb et al., 2024). Furthermore, empirical findings suggest that communities with strong social cohesion exhibit higher participation in health programs and better recovery outcomes (Halse et al., 2026). These findings indicate that social solidarity is not merely contextual but functions as an active mechanism shaping health intervention outcomes (Hawash et al., 2024).

Despite this recognition, disaster nursing literature remains largely dominated by technical and operational perspectives, focusing on preparedness, emergency response, and workforce competencies (Herrera et al., 2025). While these aspects are essential, they often overlook how collective social processes influence the uptake, acceptance, and sustainability of health interventions (Ireland, 2024). In addition, emerging research highlights the importance of trust in health systems and local leadership in facilitating effective community engagement during crises (Hertelendy et al., 2024). However, these variables are rarely integrated into models assessing the performance of community nursing practice.

A critical synthesis of the literature reveals several limitations. First, social solidarity is often embedded within broader constructs such as social capital or resilience, leading to conceptual ambiguity and limiting its analytical specificity (Jayawickreme et al., 2025). Second, empirical studies rarely examine the direct relationship between social solidarity and measurable health service outcomes, particularly within community nursing contexts. Third, methodological limitations persist, as many studies employ either quantitative or qualitative approaches in isolation, thereby failing to capture the complex and dynamic mechanisms underlying social solidarity (Lee et al., 2024).

These limitations indicate a clear research gap: the absence of integrative, mixed-methods research that positions social solidarity as a measurable determinant of the achievement of community nursing practice in disaster settings. Moreover, there is limited empirical evidence explaining how specific dimensions of social solidarity, such as cooperation, trust in healthcare providers, and local leadership, interact to influence community participation and service delivery outcomes (Li & He, 2025).

This study offers several novel elements. First, it operationalizes social solidarity as a measurable predictor within the domain of community nursing, thereby bridging sociological theory and applied health research. Second, it employs a sequential explanatory mixed methods design to capture both statistical relationships and underlying social mechanisms. Third, it contextualizes social solidarity within local cultural practices, such as cooperation, which are

increasingly recognized as essential components of community resilience (Michaud-Tétreault et al., 2026).

Based on these considerations, this study aims to analyze the influence of social solidarity on the achievement of community nursing practice in disaster-prone areas. Specifically, this study aims to quantify the relationship between social solidarity and community nursing outcomes and to explore the mechanisms through which social solidarity influences participation and service effectiveness. By integrating quantitative and qualitative evidence, this research contributes to the development of socially responsive and evidence-based community nursing models in disaster contexts.

RESEARCH METHODOLOGY

Study Design

This study employed a mixed-methods approach using a sequential explanatory design, integrating quantitative and qualitative data across two distinct but connected phases. The initial phase involved a quantitative cross-sectional analysis to examine the relationship between social solidarity and the achievement of community nursing practice. This was followed by a qualitative phase aimed at explaining and contextualizing the quantitative findings through an in-depth exploration of social mechanisms. The integration occurred at the interpretation stage, allowing for a comprehensive understanding of both statistical associations and contextual dynamics.

Setting and Participants

The study was conducted in a disaster-prone coastal area characterized by recurrent environmental hazards and high community vulnerability. The quantitative phase involved community members who had been exposed to community nursing interventions in disaster mitigation contexts. Participants were selected using purposive sampling based on predefined inclusion criteria, including residence in the study area and prior involvement in community health activities. For the qualitative phase, a subset of participants was recruited using maximum variation sampling to capture diverse perspectives, including community members, local leaders, and health workers.

Variables and Measurement

The primary independent variable was social solidarity, operationalized through dimensions such as cooperation, trust in health providers, and collective participation. The dependent variable was the achievement of community nursing practice, measured through indicators such as service coverage, participation rates, and perceived effectiveness of interventions. Data were collected using a structured questionnaire developed based on relevant theoretical constructs and previous empirical studies. The instrument underwent content validation and reliability testing before use. Qualitative data were collected through semi-structured interviews guided by a protocol focused on social interaction, trust, and community engagement.

Data Analysis

Quantitative data were analyzed using descriptive and inferential statistics. Descriptive analysis included measures of central tendency and dispersion, while inferential analysis involved Pearson correlation and linear regression to assess the strength and direction of relationships between variables. Statistical significance was determined at a p-value of <0.05. Qualitative data were analyzed using thematic analysis, which involved coding, categorization, and the

identification of recurring patterns. Data integration was conducted using a connecting approach, where qualitative findings were used to explain and enrich the quantitative results.

Ethical Approval

This study adhered to established ethical principles for research involving human participants, including respect for autonomy, confidentiality, and voluntary participation. Ethical clearance was obtained from the Institutional Review Board of Universitas Islam Makassar, with protocol number 00206012026 and approval letter number 002/LPPMUIM/B.07/KET/I/2026, before data collection. The study was conducted in the coastal area of Kuta Beach, Bali, in February 2026. All participants were fully informed about the purpose, procedures, and potential risks of the study, and written informed consent was obtained before participation. To ensure privacy and confidentiality, all data were anonymized and used solely for research purposes.

RESULT

Quantitative Findings

Table 1. Univariate Analysis

Variable	Mean	SD	Min	Max
Social Solidarity	78.5	8.2	60	95
Practice Achievement	82.1	7.5	65	96

The mean score of social solidarity (78.5) indicates a relatively high level of social cohesion within the community. Similarly, the mean score for community nursing practice achievement (82.1) suggests that community nursing practices have been implemented optimally. The relatively small standard deviations indicate low variability among respondents, suggesting a homogeneous distribution of data.

Table 2. Correlation Analysis (Pearson)

Variables	r	p-value
Social Solidarity vs Practice Achievement	0.62	0.001

There is a strong and statistically significant positive correlation between social solidarity and the achievement of community nursing practice ($r = 0.62$; $p < 0.05$). This finding indicates that higher levels of social solidarity are associated with greater effectiveness in implementing community nursing practices in disaster settings.

Table 3. Linear Regression Analysis

Variable	β	SE	t	p-value
Constant	25.3	5.1	4.96	0.000
Social Solidarity	0.45	0.08	5.62	0.000

The regression analysis demonstrates that social solidarity is a significant predictor of community nursing practice achievement ($\beta = 0.45$; $p < 0.001$). This implies that for every one-unit increase in social solidarity, the achievement of community nursing practice increases by 0.45 units. These findings confirm that social solidarity is a key determinant rather than a mere supporting factor in the success of community-based health interventions in disaster areas.

Qualitative Findings

Table 4. Themes and Subthemes

Main Theme	Subtheme	Code
Community Solidarity	Cooperation	Collective action
Trust	Relationship with health workers	Trust
Local Leadership	Role of community leaders	Leadership

Themes 1. Community Solidarity – Mutual Cooperation (Collective Action)

The interviews consistently illustrated that community solidarity is operationalized through cooperation (gotong royong) as a routine, organized, and collectively endorsed practice. Participants emphasized that joint activities, such as beach cleaning, waste management, and hazard preparedness, are conducted on a scheduled basis and involve broad community participation. One participant explained,

"We help each other clean the beach, and there is even a fixed schedule for community service."

Indicating institutionalized collective action rather than sporadic volunteering. Another informant noted,

"*When there is a warning about strong waves, everyone comes together to secure the area and assist vulnerable residents."*

Highlighting the role of collective action in disaster preparedness and response. This pattern suggests that cooperation functions not only as a cultural norm but also as a practical mechanism that enhances responsiveness, resource mobilization, and continuity of community nursing interventions.

Themes 2. Trust – Relationship with Healthcare Workers (Trust)

Trust emerged as a central relational construct shaping community engagement with health services. Participants described trust as built through healthcare workers' consistent presence, responsiveness, and culturally sensitive communication. An informant stated,

"We trust the nurses because they are always present when needed, especially during emergencies."

emphasizing reliability as a key determinant of trust. Another participant added,

"They explain things in a way we understand, so we are willing to follow their advice."

Illustrating how effective communication strengthens adherence to health programs. Trust was also associated with perceived competence and empathy, as reflected in the statement,

"The nurses treat us with respect, so we feel comfortable participating in their programs."

These accounts indicate that trust serves as a facilitator, bridging social solidarity and active participation, ultimately improving the acceptance and effectiveness of community nursing practices.

Themes 3. Local Leadership – Role of Community Leaders (Leadership)

Local leadership was identified as a critical enabler of social mobilization and program uptake. Informants highlighted the influential role of religious and traditional leaders in legitimizing health initiatives and encouraging participation. One participant explained,

"Religious leaders play a very important role in encouraging people to join health activities."

demonstrating the persuasive power of culturally respected figures. Another informant noted,

"If the community leader supports a program, people are more likely to participate without hesitation."

indicating that leadership endorsement reduces resistance and increases compliance. Additionally, leaders were described as coordinators who facilitate communication between healthcare providers and the community, as reflected in the statement,

"Community leaders help organize meetings and ensure that information reaches everyone."

These findings suggest that local leadership strengthens social cohesion, enhances coordination, and serves as a catalyst for sustaining community nursing interventions.

Table 5. Integration (Joint Display Table)

Quantitative Findings	Statistical Evidence	Qualitative Themes	Key Quotes	Integrated Interpretation
High level of social solidarity (Mean = 78.5)	Descriptive statistics	Community Solidarity – Mutual Cooperation	"We help each other clean the beach, and there is a fixed schedule for community service."	High social solidarity is reflected in structured and routine collective actions (gotong royong), indicating strong social cohesion that supports community-based health activities.
High achievement of community nursing practice (Mean = 82.1)	Descriptive statistics	Trust – Relationship with Healthcare Workers	"We trust the nurses because they are always present when needed."	Effective implementation of community nursing practice is facilitated by strong trust between community members and healthcare providers, enhancing program acceptance and participation.
Significant positive correlation ($r = 0.62$; $p < 0.05$)	Pearson correlation	Community Solidarity & Trust	"Everyone comes together during emergencies and follows health advice."	The positive correlation indicates that increased social solidarity is associated with higher participation and adherence, which is explained qualitatively by collective action and trust in health workers.
Social solidarity as a significant predictor ($\beta = 0.45$; $p < 0.001$)	Linear regression	Local Leadership – Role of Community Leaders	"If the community leader supports a program, people are more likely to participate."	Social solidarity operates through leadership structures, in which local leaders mobilize participation and legitimize health interventions, thereby strengthening implementation outcomes.
Strength of the model indicating the social determinant effect	Regression model	Integration of all themes	"Community leaders, cooperation, and trust all work together."	Social solidarity influences practice achievement through three main mechanisms: (1) collective action, (2) trust-building, and (3) leadership-driven mobilization, forming a comprehensive social support system.

The joint display demonstrates convergence between quantitative and qualitative findings. Quantitative results confirm the statistical significance of social solidarity as a determinant of community nursing practice achievement, while qualitative findings explain the underlying social mechanisms. This integration indicates that social solidarity is operationalized through cooperation, trust in healthcare workers, and local leadership, which collectively enhance participation, acceptance, and effectiveness of community-based nursing interventions in disaster settings.

DISCUSSION

The findings of this study underscore the centrality of social solidarity as a foundational driver in the successful implementation of community nursing practices in disaster settings. Rather than functioning as a peripheral or contextual variable, social solidarity emerges as an embedded structural force that shapes how health interventions are received, enacted, and sustained within communities. The quantitative results demonstrate a strong and statistically significant association, yet it is through the qualitative insights that the operational dynamics of this relationship become more intelligible.

In practice, social solidarity manifests through interconnected social processes, including cooperation, trust, and leadership. These elements do not operate independently; instead, they form a cohesive system of interaction that reinforces collective action (Opoku et al., 2024). Cooperation, deeply rooted in local cultural values such as gotong royong, facilitates shared responsibility and rapid mobilization in times of crisis. This collective orientation enables communities to respond more efficiently to health needs, particularly when formal systems are constrained (Patrick et al., 2025).

Building upon this, trust serves as the relational glue that strengthens engagement between healthcare providers and community members. Trust reduces uncertainty, enhances communication, and increases adherence to health interventions. Without trust, even well-designed programs may encounter resistance or apathy. In this sense, trust transforms technical interventions into socially accepted practices (Pooyan & Hokugo, 2025). At a broader level, local leadership acts as a coordinating and legitimizing force that amplifies both cooperation and trust. Community leaders bridge institutional and social domains, translating health initiatives into culturally meaningful actions (Puri & Yohannes, 2026). Their influence not only enhances participation but also stabilizes collective behavior during uncertain conditions. Taken together, these findings suggest that social solidarity operates across relational, collective, and structural dimensions, forming an integrated social infrastructure that underpins effective community nursing practice (Rakha et al., 2025).

This interpretation contributes to a conceptual shift in understanding community nursing in disaster contexts. It suggests that effectiveness is not solely determined by clinical competence or resource availability, but also by the strength of social systems that enable or constrain implementation (Ronael & Oruç Ertekin, 2025). In fragile and disrupted environments, these social systems often serve as the primary mechanism for delivering and sustaining care (Slick & Hertz, 2024).

These findings resonate with a growing body of literature emphasizing the role of social capital and community resilience in disaster response (Toma & Crişan, 2025). Previous studies have consistently shown that communities characterized by strong networks and shared norms tend to recover more rapidly and exhibit greater adaptive capacity (Suar et al., 2024). However, much of this work has approached social solidarity as a broad contextual factor rather than examining its direct influence on specific health service outcomes.

In this regard, the present study extends existing knowledge by empirically demonstrating that social solidarity is not only associated with resilience but also directly contributes to the achievement of community nursing practices (Van Ryneveld et al., 2024). This distinction is important, as it shifts the analytical focus from general community characteristics to specific mechanisms that influence health service delivery (Wu et al., 2024). From a theoretical perspective, the findings also reaffirm the relevance of classical sociological frameworks, particularly those associated with Durkheim. While Durkheim distinguished between mechanical

and organic forms of solidarity, the current study suggests that both forms coexist and interact within disaster-affected communities (Zink et al., 2026). Cooperation reflects shared values and collective identity, whereas trust in healthcare professionals reflects interdependence based on specialized roles. This hybrid configuration appears to be especially adaptive in crisis contexts, where both familiarity and expertise are required (Hijrah et al., 2026).

Moreover, the emphasis on trust aligns with broader research on health systems, which has identified trust as a key determinant of service utilization and adherence. What distinguishes the present study is its demonstration that trust is not merely an individual-level perception but a socially constructed phenomenon reinforced through repeated interactions and collective experience (Novi Angraeni et al., 2025). Similarly, the role of local leadership identified in this study is consistent with prior findings that highlight the importance of community figures in facilitating program acceptance. However, rather than treating leadership as an isolated variable, this study situates it within a broader system of social solidarity, thereby offering a more integrated explanatory model (Hill et al., 2025).

Despite these contributions, several limitations should be acknowledged to ensure a balanced interpretation of the findings. First, the cross-sectional design of the quantitative component limits the ability to establish causal direction. While the results indicate a strong predictive relationship, it remains possible that the relationship between social solidarity and practice achievement is reciprocal. Second, the reliance on self-reported data introduces the potential for response bias. Participants may have expressed socially desirable views, particularly regarding culturally valued concepts such as cooperation and trust. Although the qualitative findings provide contextual depth, they are not immune to similar influences. In addition, the qualitative sample, while sufficient to reach thematic saturation, represents a specific sociocultural context. As such, caution should be exercised in generalizing the findings to other settings with different cultural or institutional characteristics.

Another consideration relates to the measurement of social solidarity. The use of a context-specific instrument enhances relevance but may limit comparability with other studies. Further validation is necessary to strengthen its applicability across diverse contexts. Finally, although the integration of quantitative and qualitative data is methodologically advantageous, it involves interpretive judgment. The synthesis of findings is influenced by the researcher's analytical perspective, which may shape the way relationships are understood and presented.

Recommendations for Future Research

Building on these limitations, future research should prioritize longitudinal designs to better understand the temporal dynamics of social solidarity and its influence on health outcomes. Such approaches would allow for the examination of how solidarity evolves across different phases of disaster response and recovery. Additionally, comparative studies across different regions and cultural contexts would provide valuable insights into the universality and variability of these findings. Understanding how social solidarity operates in diverse settings can inform more context-sensitive interventions. There is also a need to develop standardized, psychometrically robust instruments to measure social solidarity in health research. Improved measurement tools would enhance the rigor of future studies and facilitate cross-study comparisons. From an applied perspective, future research should explore intervention models that actively strengthen social solidarity. Programs that foster community engagement, build trust between healthcare providers and communities, and leverage local leadership structures may prove effective in enhancing health outcomes. Finally, interdisciplinary approaches that integrate insights from sociology, public health, and disaster management are essential for advancing this

field. By combining theoretical and practical perspectives, future research can contribute to more holistic, sustainable strategies to improve community health in disaster-prone environments. Overall, this study highlights the importance of moving beyond a purely clinical lens and recognizing the critical role of social structures in shaping the outcomes of health interventions. In doing so, it offers a more comprehensive framework for understanding and strengthening community nursing practice in complex and dynamic contexts.

CONCLUSION

This study demonstrates that social solidarity is a key determinant in achieving effective community nursing practice in disaster settings. The findings confirm that higher levels of social solidarity are significantly associated with improved implementation outcomes, as reflected in stronger community participation, better acceptance of health interventions, and wider service coverage. These results directly address the study objective by establishing that social solidarity is not merely a contextual factor but an active driver influencing the success of community-based nursing practices. The integration of quantitative and qualitative findings further reveals that social solidarity operates through three interrelated mechanisms: cooperation, trust in healthcare providers, and local leadership. Together, these elements create a supportive social environment that enhances responsiveness, coordination, and sustainability of health interventions in disaster-prone communities.

Based on these findings, it is recommended that community nursing programs incorporate strategies to strengthen social solidarity, such as fostering community engagement, building trust through the continuous presence of healthcare workers, and actively involving local leaders in program implementation. Policymakers should also integrate social-based approaches into disaster health planning to ensure that interventions are not only clinically effective but also socially adaptive and sustainable.

Funding Statement

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors. All activities related to study design, data collection, analysis, and manuscript preparation were conducted independently by the authors.

Conflict of Interest

The authors declare that there are no conflicts of interest related to this study. The research was conducted without any financial or personal relationships that could inappropriately influence the results or interpretation of the findings.

Authors' Contributions

Conceptualization: Baso Witman Adiaksa, Syamsu A. Kamaruddin
Methodology: Baso Witman Adiaksa, Arlin Adam
Formal Analysis: Baso Witman Adiaksa
Investigation: Baso Witman Adiaksa, Syamsu A. Kamaruddin
Data Curation: Arlin Adam
Writing – Original Draft: Baso Witman Adiaksa
Writing – Review & Editing: Syamsu A. Kamaruddin, Ahmadin
Supervision: Syamsu A. Kamaruddin
Project Administration: Baso Witman Adiaksa

All authors have read and approved the final manuscript.

Acknowledgments

The authors would like to express their sincere appreciation to all participants who generously shared their time and experiences. Gratitude is also extended to local community leaders and stakeholders in Kuta, Bali, for their support during the research process. The authors acknowledge the contributions of all individuals and institutions involved, directly or indirectly, in facilitating this study.

Declaration of Generative AI Use

The authors declare that generative AI tools were used solely for language refinement and formatting. All scientific content, data interpretation, and conclusions were developed independently by the authors. No AI tools were used in data analysis or decision-making processes.

References

Abuhammad, S. (2025). Celebrating five decades of pediatric nursing progress: Achievements, persistent challenges and future directions. *Journal of Pediatric Nursing*, *85*, 69–74. https://doi.org/10.1016/j.pedn.2025.07.007

Beyrer, C., Kamarulzaman, A., Isbell, M., Amon, J., Baral, S., Bassett, M. T., Cepeda, J., Deacon, H., Dean, L., Fan, L., Giacaman, R., Gomes, C., Gruskin, S., Goyal, R., Mon, S. H. H., Jabbour, S., Kazatchkine, M., Kasoka, K., Lyons, C., … Rubenstein, L. (2024). Under threat: the International AIDS Society–Lancet Commission on Health and Human Rights. *The Lancet*, *403*(10434), 1374–1418. https://doi.org/10.1016/S0140-6736(24)00302-7

Cuadra, C. B., & Rämgård, M. (2025). A community-based response to the COVID-19 pandemic: Social capital in action. *International Journal of Disaster Risk Reduction*, *116*, 105158. https://doi.org/10.1016/j.ijdrr.2024.105158

Gibb, C., Meltzer, G., Campbell, N., & Fothergill, A. (2024). Digital and analogue spaces of care: How older adults are redefining care practices in the COVID-19 pandemic. *Digital Geography and Society*, *6*, 100091. https://doi.org/10.1016/j.diggeo.2024.100091

Halse, I., Leach, M. J., & Oates, L. (2026). A qualitative study of Naturopaths and Herbalists' experiences of the 2022 Northern New South Wales and Southeast Queensland flood events. *Complementary Therapies in Clinical Practice*, *62*, 102043. https://doi.org/10.1016/j.ctcp.2026.102043

Hawash, M. M., Mohamed, A. A. E.-R., El-Sayed, M. M., El-Ashry, A. M., & Hafez, S. A. (2024). Association between health-related empowerment and health-protective behaviors among community-dwelling older adults. *Archives of Psychiatric Nursing*, *48*, 59–67. https://doi.org/10.1016/j.apnu.2024.01.012

Herrera, C. A., Bascolo, E., Villar-Uribe, M., Houghton, N., Bennett, S., Castro, M. C., Massuda, A., Bauhoff, S., Cunningham Kain, M. K., Figueroa, J. P., Flores, W., Gaitán-Rossi, P., Garcia Elorrio, E., Giovanella, L., Guanais, F., Haggerty, J., Peña, S. H., Luna, D., Macinko, J., … Jimenez, C. Z. (2025). No time to wait: resilience as a cornerstone for primary health care across Latin America and the Caribbean, a World Bank-PAHO Lancet Regional Health Americas Commission. *The Lancet Regional Health - Americas*, *50*, 101240. https://doi.org/10.1016/j.lana.2025.101240

Hertelendy, A. J., Howard, C., Sorensen, C., Ranse, J., Eboreime, E., Henderson, S., Tochkin, J., & Ciottone, G. (2024). Seasons of smoke and fire: preparing health systems for improved performance before, during, and after wildfires. *The Lancet Planetary Health*, *8*(8), e588–e602. https://doi.org/10.1016/S2542-5196(24)00144-X

Hijrah, Nur Syamsi Norma Lala, Natalia Datu, Sethiana Dewi Ruben, & Shao Ling Wang. (2026). Optimizing the Role of Family Nurses in Improving Community Health: A Holistic Approach: Literature Review. *Jurnal Ilmiah Kesehatan Sandi Husada*, *14*(1), 73–86. https://doi.org/10.35816/jiksh.v14i1.312

Hill, L. S., Pittman, J., & Armitage, D. (2025). Fostering effective intersectional disaster risk governance in Dominica: the role of social networks and trust in information dissemination. *International Journal of Disaster Risk Reduction*, *126*, 105612. https://doi.org/10.1016/j.ijdrr.2025.105612

Ireland, K. A. (2024). Wash your hands: CDC, WHO, and NHS tweets in the #COVID19 pandemic. *Applied*

Corpus Linguistics, *4*(2), 100094. https://doi.org/10.1016/j.acorp.2024.100094
Jayawickreme, N., Jayawickreme, E., McCaffrey, A. Z., & Thiruvarangan, M. (2025). Mental health futures in post-war Sri Lanka: Resilience, relational pluralism, and implementation pathways. *SSM - Mental Health*, *7*, 100465. https://doi.org/10.1016/j.ssmmh.2025.100465
Lee, Y., Chung, F., Liao, P., Wang, P., & Lin, M. (2024). Exploring the Care Experiences Among Clinical Staffing During Emerging Infectious Disease: From the COVID-19 Pandemic Approach. *Asian Nursing Research*, *18*(3), 222–230. https://doi.org/10.1016/j.anr.2024.06.002
Li, Y., & He, B.-J. (2025). Biophilic street design for urban heat resilience. *Progress in Planning*, *199*, 100988. https://doi.org/10.1016/j.progress.2025.100988
Michaud-Tétreault, J., Bouchard-Bastien, E., Peel, M.-A., & Perron, S. (2026). Emergency evacuations during wildfires: a public health perspective in Québec (Canada). *Disaster Prevention and Management: An International Journal*, *35*(1), 130–143. https://doi.org/10.1108/DPM-03-2025-0067
Novi Angraeni, W. O., Suprapto, S., & Alshammari, S. (2025). Workload, job satisfaction, and salary satisfaction in relation to turnover intention among health workers. *Jurnal Edukasi Ilmiah Kesehatan*, *3*(2), 63–69. https://doi.org/10.61099/junedik.v3i2.113
Opoku, C. B., Kwofie, J., & Asirifi, M. A. P. (2024). Critical factors impacting the psychosocial well-being of mining-induced displaced and resettled persons in Ghana. *The Extractive Industries and Society*, *19*, 101499. https://doi.org/10.1016/j.exis.2024.101499
Patrick, R., Noy, S., McKew, M., Lee, S., Kanda, M., Edwards, S. J., Ali, A., & Bowen, K. (2025). Rapid review on healthy ageing interventions that incorporate action on climate change and sustainability in cities and communities. *Health & Place*, *93*, 103435. https://doi.org/10.1016/j.healthplace.2025.103435
Pooyan, Z., & Hokugo, A. (2025). Community resilience and social capital: Hindering vs fostering factors. *International Journal of Disaster Risk Reduction*, *118*, 105213. https://doi.org/10.1016/j.ijdrr.2025.105213
Puri, N., & Yohannes, S. (2026). Organization and Management of Critical Care Services. *Critical Care Clinics*, *42*(2), 425–440. https://doi.org/10.1016/j.ccc.2025.11.005
Rakha, A., Jabbar, A., Rasheed, H., Tul-Muntaha, S., Munir, A., Fatima, A., Anwar, R., Sohail, M., & Aadil, R. M. (2025). Nutrition crisis management after floods: A multisectoral perspective. *International Journal of Disaster Risk Reduction*, *116*, 105141. https://doi.org/10.1016/j.ijdrr.2024.105141
Ronael, M., & Oruç Ertekin, G. D. (2025). Public spaces for future cities: Mapping urban resilience dimensions in place-based solutions. *Sustainable Cities and Society*, *133*, 106870. https://doi.org/10.1016/j.scs.2025.106870
Slick, J., & Hertz, G. (2024). Gender and gender-based violence in disaster contexts in Canada: A systematic review of the literature. *International Journal of Disaster Risk Reduction*, *108*, 104529. https://doi.org/10.1016/j.ijdrr.2024.104529
Suar, D., Kar, N., & Panigrahi, G. S. (2024). Natural hazards, trauma, and their amelioration: Lessons learned from India. *International Journal of Disaster Risk Reduction*, *108*, 104548. https://doi.org/10.1016/j.ijdrr.2024.104548
Toma, A., & Crișan, O. (2025). Building an Ethical Framework for European Pharmacists in e-Pharmacies. *Journal of Medical Internet Research*, *27*, e64750. https://doi.org/10.2196/64750
Van Ryneveld, M., Schneider, H., Brady, L., & Whyle, E. (2024). Every loaf of bread is political – Reflections on collective care responses to Covid-19 in Cape Town. *Social Science & Medicine*, *349*, 116881. https://doi.org/10.1016/j.socscimed.2024.116881
Wu, M., Yan, J., Qiao, C., & Yan, C. (2024). Impact of Concurrent Media Exposure on Professional Identity: Cross-Sectional Study of 1087 Medical Students During Long COVID. *Journal of Medical Internet Research*, *26*, e50057. https://doi.org/10.2196/50057
Zink, M., Nakoinz, A., Krol, U., Jansen, N., Jung, F., Riedel-Heller, S. G., & Gabriel, K. M. A. (2026). Heat-related challenges and interventions in hospitals: A future-oriented, qualitative approach to improve nurses' working conditions. *The Journal of Climate Change and Health*, *28*, 100659. https://doi.org/10.1016/j.joclim.2026.100659