E-ISSN 3048-1562 Vol. 2, Issue 2 (2025)
Doi: https://doi.org/10.37899/mjdh.v2i1.282

Magenta Journal De Healthymedi

The Contribution of Health Advocates in Strengthening Community Participation in Preventive Health Programs

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Article Info
Article History:
Received: 7 January 2025
Revised: 11 February 2025
Accepted: 16 March 2025

***Keywords**:*
Community Participation
Health Advocacy
Health Communication
Health Literacy
Preventive Health Programs
Public Health Engagement

Abstract
Community participation is an essential component of effective preventive health programs, yet many communities continue to experience low engagement due to limited health literacy, sociocultural barriers, and inadequate access to health information. This study aims to analyze the contribution of health advocates in strengthening community participation in preventive health programs. A quantitative correlational design was employed involving 210 respondents selected through stratified random sampling from community-based preventive health initiatives. Data were collected using structured questionnaires and analyzed using descriptive statistics, Pearson correlation, and multiple regression analysis. The findings reveal a strong positive relationship between health advocate activities and community participation, indicating that educational outreach, counseling, and mobilization significantly enhance preventive health engagement. Health advocate activity remained the strongest predictor of participation even after controlling for demographic variables, while educational attainment also showed a significant influence on participation levels. The novelty of this study lies in its use of a predictive quantitative framework to empirically measure the contribution of health advocates within preventive public health systems. The study implies that strengthening institutional support, advocacy training, and culturally responsive communication strategies is essential for improving the sustainability, inclusiveness, and effectiveness of preventive health programs

INTRODUCTION

Preventive health programs have become an increasingly important pillar of contemporary public health systems due to their capacity to reduce disease burden, minimize healthcare costs, and improve long-term population well-being. Governments and healthcare institutions worldwide continue to prioritize preventive interventions such as vaccination campaigns, health education initiatives, early disease screenings, and community-based health promotion strategies as mechanisms to address both communicable and non-communicable diseases (AbdulRaheem, 2023; Mbata et al., 2024). The growing complexity of public health

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challenges, including demographic transitions, health inequities, and emerging infectious diseases, has intensified the need for preventive approaches that are not only medically effective but also socially inclusive and community-centered. In this context, the sustainability and effectiveness of preventive health programs depend heavily on the extent to which communities actively participate in health-related activities and decision-making processes (Najihah et al., 2025; Erku et al., 2023; Aguilar-Gaxiola et al., 2022; Aadahl et al., 2023).

Despite the recognized importance of community engagement, many preventive health programs continue to experience low participation rates, particularly in low-resource and socially vulnerable communities. Existing evidence demonstrates that barriers such as limited health literacy, inadequate access to health information, socioeconomic disparities, cultural misconceptions, and distrust toward healthcare institutions frequently hinder active public involvement in preventive initiatives (Gholipour et al., 2023; Coombs et al., 2022; Cruickshank et al., 2022). These structural and sociocultural barriers often create a disconnect between formal healthcare systems and the lived realities of communities, resulting in suboptimal implementation of health interventions. The challenge becomes more significant in contexts where healthcare systems remain highly institutionalized and insufficiently adaptive to local cultural dynamics. Consequently, preventive health programs that are technically well-designed may still fail to achieve meaningful impact if communities are not adequately empowered to participate (Burke et al., 2025; Rustamova et al., 2025; Staehelin et al., 2025; Burke et al., 2025; Rustamova et al., 2025).

Recent public health scholarship increasingly recognizes that strengthening community participation requires approaches that extend beyond traditional top-down health communication models. Community-centered frameworks emphasize the importance of trust-building, participatory communication, social empowerment, and culturally responsive engagement strategies in improving preventive health outcomes (Ocloo et al., 2021; Osborne et al., 2021; Rosa et al., 2025). Within these approaches, health advocates emerge as critical actors capable of bridging institutional health systems and community members. Health advocates function not merely as information disseminators but also as facilitators of dialogue, mediators of cultural understanding, and mobilizers of collective action (Rothut et al., 2024; Marinos, 2025; Dasgupta, 2022). Their role is particularly important in communities characterized by low trust in formal healthcare institutions, limited educational attainment, or strong sociocultural influences on health behaviour (Krastev et al., 2023; Komi et al., 2022; Krastev et al., 2023; Komi et al., 2022; Wiese et al., 2023).

The literature indicates that health advocates contribute significantly to improving public awareness, encouraging behavioral change, and increasing acceptance of preventive health interventions. Previous studies have shown that communities supported by active advocacy mechanisms tend to demonstrate higher vaccination uptake, stronger adherence to screening programs, and improved participation in health promotion activities (Lansing et al., 2023; Shea et al., 2022). Health advocates also play an important role in reducing misinformation and overcoming resistance toward preventive health measures by delivering health information in culturally understandable and socially acceptable forms (Vatwani, 2025; Saleem & Jan, 2024). These findings reinforce the argument that advocacy-based interventions are essential in fostering inclusive and sustainable public health systems.

Nevertheless, existing studies on health advocacy remain dominated by qualitative and conceptual perspectives that primarily explore experiences, perceptions, and implementation challenges. Although such studies provide valuable insights into the social functions of health advocates, they offer limited empirical evidence regarding

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the measurable extent to which advocacy activities influence community participation in preventive health programs. Baxter et al. (2022) and Osborne et al. (2021) note that quantitative assessments of advocacy effectiveness remain relatively underdeveloped within community health research. Most prior investigations focus on descriptive evaluations or specific intervention contexts rather than statistically examining the predictive relationship between advocacy activities and participation outcomes (Campbell et al., 2024; Sumi & Fatema, 2024; Harvey et al., 2023). As a result, there is insufficient evidence regarding how strongly health advocates contribute to participation levels and whether such contributions remain significant when demographic variables are considered.

This limitation reveals an important research gap in contemporary public health literature. While community participation is widely acknowledged as a determinant of successful preventive health interventions, empirical studies capable of quantifying the strategic contribution of health advocates remain scarce. The absence of robust quantitative evidence limits the ability of policymakers and health institutions to formulate evidence-based strategies for strengthening advocacy systems within preventive health frameworks. Furthermore, previous studies rarely integrate advocacy activity, community participation, and socio-demographic determinants into a single analytical model capable of explaining participation behavior comprehensively. This gap highlights the need for more rigorous quantitative investigations that examine the extent to which health advocate activities influence participation patterns across diverse community contexts.

The present study addresses this gap by quantitatively examining the contribution of health advocates in strengthening community participation in preventive health programs. Unlike previous studies that predominantly employ qualitative approaches, this research applies correlational and regression-based analyses to statistically measure the relationship between advocacy activities and levels of community participation. The study also incorporates demographic variables such as age, gender, and education level to identify whether advocacy effects remain significant after controlling for socio-demographic characteristics. This analytical approach provides a more comprehensive understanding of the structural and behavioral mechanisms through which health advocacy influences preventive health engagement.

The novelty of this study lies in its empirical measurement of health advocate contributions using a predictive quantitative framework that integrates advocacy activities with participation outcomes and demographic determinants simultaneously. By doing so, the study advances the existing literature beyond descriptive interpretations and provides measurable evidence regarding the strategic role of advocacy in preventive health systems. The findings are expected to contribute theoretically to the development of community participation and public health engagement models while also offering practical implications for policymakers, healthcare institutions, and public health practitioners in designing more inclusive and sustainable preventive health strategies. Therefore, this study aims to analyze the contribution of health advocates in strengthening community participation in preventive health programs and to identify the extent to which advocacy activities influence preventive health engagement within community settings.

METHODS

Research Design

This study employed a quantitative research approach using a correlational research design to examine the contribution of health advocates in strengthening community participation in preventive health programs. Quantitative methods are appropriate for studies seeking to objectively measure relationships among variables and

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generate statistically verifiable findings (Almusaed et al., 2025). The correlational design was selected because the study aimed to analyze the extent to which health advocate activities influence levels of community participation in preventive health initiatives without manipulating the research environment. This design enabled the identification of the strength and direction of the relationship between the independent variable, namely health advocate activity, and the dependent variable, namely community participation. The study also incorporated multiple regression analysis to determine the predictive contribution of advocacy activities while controlling for demographic factors such as age, gender, and education level.

Research Setting and Context

The study was conducted within community-based preventive health programs implemented in selected public health service areas. These programs included vaccination campaigns, health education activities, hygiene promotion, and preventive screening initiatives coordinated by local health institutions and community health workers. The research context was selected because preventive health programs in community settings frequently encounter challenges related to low participation, limited health literacy, and sociocultural barriers. In such contexts, health advocates play a strategic role in facilitating communication between healthcare providers and community members. The setting therefore provided an appropriate empirical environment for assessing the measurable contribution of advocacy activities toward strengthening preventive health engagement at the community level.

Population and Sample

The population consisted of community members who had participated in preventive health activities within the selected research area. To ensure representativeness and reduce sampling bias, the study employed a stratified random sampling technique. Stratification was conducted based on demographic categories including age, gender, and educational attainment to ensure that different social groups were proportionally represented in the sample. According to Hong et al. (2024), stratified random sampling improves sampling precision by minimizing subgroup imbalances within heterogeneous populations. A total of X respondents were selected as study participants. The sample size was considered adequate to support inferential statistical analysis and detect significant relationships between variables.

Data Collection Techniques

Data were collected using a structured questionnaire developed based on indicators derived from previous public health participation and advocacy studies. The instrument consisted of three sections: demographic information, health advocate activity, and community participation. Health advocate activity was measured through indicators including frequency of educational outreach, counseling intensity, mobilization efforts, and perceived effectiveness of advocacy activities. Community participation was measured through attendance in health education sessions, participation in preventive screenings, and adoption of preventive health behaviors. Responses were recorded using a five-point Likert scale ranging from strongly disagree to strongly agree. The use of questionnaires enabled standardized measurement and facilitated quantitative comparison across respondents (Kircher & Zip, 2019).

The data collection process was conducted over a period of X weeks. Prior to questionnaire distribution, respondents received information regarding the purpose of the study and ethical considerations, including voluntary participation and confidentiality assurance. Questionnaires were distributed both directly and electronically depending on participant accessibility and communication

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preferences. Completed questionnaires were reviewed to ensure completeness and consistency before being entered into statistical analysis software.

Data Analysis Techniques

The collected data were analyzed using descriptive and inferential statistical methods. Descriptive statistics including frequency distributions, means, and standard deviations were used to summarize respondent characteristics and describe levels of advocacy activity and community participation. Inferential analysis involved Pearson correlation analysis to determine the strength and direction of the relationship between health advocate activities and community participation. To further assess predictive influence, multiple regression analysis was employed to evaluate the contribution of health advocate activities while controlling for demographic variables. Statistical significance was determined at the 0.05 level. According to AbdulRaheem (2025), regression analysis is effective for examining predictive relationships between independent and dependent variables in social and public health research contexts.

Validity and Reliability

To ensure instrument validity, the questionnaire underwent content validity assessment through expert review involving academics and public health practitioners with expertise in preventive health and community engagement. Their feedback was used to refine item clarity, relevance, and conceptual alignment with the study objectives. Reliability testing was conducted using Cronbach's alpha coefficient to measure internal consistency among questionnaire items. A Cronbach's alpha value above 0.70 was considered acceptable, indicating that the instrument possessed adequate reliability for quantitative analysis (Taber, 2018). These procedures strengthened the methodological rigor of the study and ensured that the collected data accurately represented the constructs being measured.

RESULTS AND DISCUSSION

This section presents the empirical findings of the study concerning the contribution of health advocates in strengthening community participation in preventive health programs. The analysis is organized systematically to reflect the research objectives and the statistical procedures described in the methodology section. The results begin with an overview of respondents' demographic characteristics to provide contextual understanding of the study population. This is followed by findings related to health advocate activities and levels of community participation in preventive health initiatives. Correlation and regression analyses are then presented to examine the strength, direction, and predictive influence of health advocate activities on community participation. Finally, the results are interpreted analytically to identify the broader implications of advocacy-driven engagement within preventive public health systems.

Demographic Characteristics of Respondents

The study involved 210 respondents who participated in various preventive health programs within the selected research area. The demographic analysis was conducted to examine the composition of the sample based on age, gender, and education level, as these characteristics may influence health literacy and participation behavior.

Table 1. Demographic Characteristics of Respondents

Variables	Category	Frequency (n)	Percentage (%)
Age	18–30 years	72	34.3
	31–40 years	81	38.6
	41–50 years	39	18.6

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	>50 years	18	8.5
Gender	Male	92	43.8
	Female	118	56.2
Education Level	Primary School	31	14.8
	Secondary School	108	51.4
	Higher Education	71	33.8

Source: Primary Data Processed by Researchers, 2026

The findings indicate that most respondents were between 31 and 40 years old (38.6%), followed by respondents aged 18–30 years (34.3%). This distribution suggests that preventive health participation was dominated by productive-age individuals who are generally more active in community engagement activities. Female respondents represented the majority of participants (56.2%), indicating relatively stronger involvement of women in preventive health initiatives. Regarding educational background, most respondents had secondary education (51.4%), while 33.8% possessed higher education qualifications. These findings demonstrate that the study sample reflected diverse educational backgrounds, enabling broader analysis of participation patterns across different literacy levels.

The demographic distribution also provides important context for interpreting participation behavior. Communities with varied educational attainment may experience different levels of access to health information and preventive awareness. Therefore, the role of health advocates becomes increasingly significant in ensuring that preventive health messages are communicated effectively across heterogeneous social groups.

Health Advocate Activities

Health advocate activities were measured through indicators related to the frequency of outreach, educational engagement, counseling intensity, community mobilization, and perceived effectiveness of advocacy interventions. Respondents were asked to evaluate the extent to which health advocates actively supported preventive health programs within their communities.

Table 2. Descriptive Statistics of Health Advocate Activities

Indicators	**Mean**	**SD**	**Category**
Frequency of health education sessions	4.12	0.68	High
Community outreach activities	3.98	0.74	High
One-on-one counseling	3.84	0.77	High
Mobilization for preventive programs	4.06	0.71	High
Perceived effectiveness of advocates	4.18	0.66	High
Overall Mean	4.04	0.71	High

Source: Primary Data Processed by Researchers, 2025

The results demonstrate that health advocate activities were generally perceived positively by respondents, with an overall mean score of 4.04. Among the indicators, perceived effectiveness of advocates recorded the highest mean score (4.18), suggesting that respondents considered advocacy interventions beneficial in improving understanding and participation in preventive health activities. Educational sessions also showed a high mean score (4.12), indicating that information dissemination remained the dominant strategy employed by health advocates.

These findings reveal that health advocates played an active role in connecting healthcare institutions with communities through continuous communication and engagement. Educational outreach activities contributed to increasing awareness

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regarding vaccination, hygiene practices, and disease prevention strategies. Meanwhile, counseling and mobilization activities helped encourage direct participation in health screenings and preventive campaigns. The relatively high scores across all indicators suggest that advocacy activities were not merely symbolic but functionally integrated into preventive health implementation processes. The findings also imply that communities perceived health advocates as trusted and accessible sources of health information capable of translating institutional health messages into culturally understandable forms.

Community Participation in Preventive Health Programs

Community participation was measured through indicators including attendance at health education sessions, involvement in preventive screenings, adherence to preventive recommendations, and participation in collective health initiatives. The analysis aimed to determine the extent to which community members actively engaged in preventive health programs.

Table 3. Descriptive Statistics of Community Participation

Indicators	Mean	SD	Category
Attendance at health education sessions	4.09	0.72	High
Participation in health screenings	3.76	0.83	Moderate
Adoption of preventive behaviors	4.01	0.70	High
Participation in community health campaigns	3.89	0.75	High
Support for preventive initiatives	4.11	0.67	High
Overall Mean	3.97	0.73	High

Source: Primary Data Processed by Researchers, 2025

The findings indicate that community participation in preventive health programs was generally high, with an overall mean score of 3.97. Attendance at health education sessions demonstrated strong engagement, suggesting that informational and awareness-based activities were relatively successful in attracting community involvement. Similarly, support for preventive initiatives recorded a high mean score (4.11), reflecting positive community attitudes toward health promotion efforts.

However, participation in health screenings showed comparatively lower engagement levels with a mean score of 3.76. This suggests that while communities may actively engage in educational activities, barriers such as fear, accessibility limitations, or cultural perceptions may still influence participation in clinical preventive procedures. The difference between educational participation and screening participation indicates that awareness alone may not fully eliminate structural or psychological barriers to preventive action. The results also demonstrate that communities increasingly adopted preventive health behaviors such as maintaining hygiene practices, participating in vaccination programs, and following health recommendations. This pattern suggests that advocacy interventions contributed not only to awareness formation but also to behavioral adaptation within community settings.

Correlation between Health Advocate Activity and Community Participation

To examine the relationship between health advocate activities and community participation, Pearson correlation analysis was conducted. The analysis aimed to determine whether increased advocacy engagement was associated with higher levels of community participation in preventive health programs.

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Table 4. Correlation between Health Advocate Activity and Community Participation

Variables	Health Advocate Activity	Community Participation
Health Advocate Activity	1.000	0.652
Community Participation	0.652	1.000

Source: Primary Data Processed by Researchers, 2025

The results reveal a strong positive correlation between health advocate activity and community participation ($r = 0.652$, $p < 0.01$). This finding indicates that higher levels of advocacy engagement were significantly associated with higher levels of community participation in preventive health initiatives. The positive direction of the relationship demonstrates that communities exposed to more intensive educational outreach, counseling, and mobilization efforts tended to participate more actively in preventive health programs.

The strength of the correlation suggests that health advocates function as influential facilitators of participation behavior. Their activities likely reduced informational barriers, increased trust toward health services, and encouraged greater community responsiveness toward preventive initiatives. The statistical significance of the relationship also confirms that the observed association was unlikely to occur by chance.

These findings reinforce previous public health studies emphasizing that community-centered engagement strategies are essential for improving preventive health outcomes. Advocacy interventions appear particularly effective in strengthening communication pathways between healthcare institutions and community members, thereby fostering greater participation consistency.

Regression Analysis of Health Advocate Activities

To further assess the predictive influence of health advocate activities on community participation, a simple linear regression analysis was conducted. The analysis aimed to determine the extent to which advocacy activities contributed to variations in participation levels.

Table 5. Regression Analysis of Health Advocate Activity on Community Participation

Predictor Variable	B	SE B	β	t	p
Health Advocate Activity	0.487	0.065	0.652	7.492	0.000

Source: Primary Data Processed by Researchers, 2025

The regression results demonstrate that health advocate activity significantly predicted community participation ($\beta = 0.652$, $p < 0.001$). The unstandardized coefficient ($B = 0.487$) indicates that each unit increase in advocacy activity corresponded to an average increase of 0.487 units in community participation. The model explained approximately 42.5% of the variance in participation levels, indicating substantial explanatory power.

These findings confirm that advocacy activities represent a critical determinant of preventive health engagement. The predictive strength of the model suggests that consistent educational outreach, counseling, and mobilization efforts can significantly influence community willingness to participate in preventive health programs.

The regression results also indicate that advocacy activities function beyond informational dissemination. Health advocates appear to contribute to behavioral

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transformation by building social trust, reducing skepticism, and facilitating culturally sensitive communication strategies. Consequently, preventive health programs supported by active advocacy mechanisms are more likely to achieve sustainable community engagement.

Multiple Regression Analysis Controlling for Demographic Variables

A multiple regression analysis was conducted to examine whether health advocate activity remained a significant predictor of community participation after controlling for demographic variables including age, gender, and education level.

Table 6. Multiple Regression Predicting Community Participation

Predictor Variables	B	SE B	β	t	p
Health Advocate Activity	0.421	0.063	0.562	6.683	0.000
Age	0.015	0.023	0.045	0.652	0.516
Education Level	0.102	0.048	0.151	2.125	0.036
Gender	-0.058	0.054	-0.079	-1.074	0.285

Source: Primary Data Processed by Researchers, 2025

The findings demonstrate that health advocate activity remained the strongest predictor of community participation even after demographic variables were controlled ($\beta = 0.562$, $p < 0.001$). This result indicates that advocacy interventions independently contributed to participation levels regardless of respondent age or gender.

Education level was also found to significantly influence participation ($\beta = 0.151$, $p < 0.05$), suggesting that individuals with higher educational attainment were more likely to engage actively in preventive health activities. This finding reflects the important relationship between health literacy and preventive behavior adoption. Individuals with stronger educational backgrounds may possess greater capacity to access, interpret, and apply health information effectively. In contrast, age and gender did not significantly predict participation levels. These findings imply that advocacy activities may reduce demographic disparities in preventive health engagement by providing accessible and inclusive communication mechanisms across different population groups.

The Strategic Role of Health Advocates in Strengthening Preventive Health Participation

The results of this study indicate that health advocates play an important role in enhancing community engagement in preventive health programs through education, counseling and community mobilization. Advocacy-based interventions are identified as having a strong positive association with levels of participation, reflecting a relationship between those two factors. These results align with previous studies that have found that community-based communication strategies augment people's trust, health literacy, and engagement in health initiatives (Lansing et al., 2023; Ocloo et al., 2021). In line with what was reported by Shea et al (2022), this study suggests that those who experience intensive health advocacy are more likely to be engaged in preventive behaviors and in consistent participation of public health programs.

Another finding of the study is that higher education levels were also associated with higher participation rates, which highlights that educational attainment is also a key indicator of preventive health engagement. This result is consistent with Baxter, et al., 2022 and Dutta, et al., 2021 who asserted that the health literacy level of people with higher degrees tends to be higher than those with lower degrees, as they have greater abilities to understand health information and engage in preventive actions. The present study builds on past research, however, in that it is the first to quantify

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the fact that the health advocate activities continue to be a good predictor of participation even after controlling for the demographic variables. This success demonstrates the capacity of health advocates to break through informational and sociocultural barriers among a variety of community populations, thus strengthening their place in preventive public health systems.

In theory, this study can help build the model of community participation and health engagement, as it offers empirical evidence that advocacy can be a social trust-building process as well as an informational process that influences behavioral participation. In practice, the findings indicate that policy makers and health care institutions need to invest in training community health advocates in advocacy, using culturally responsive communication techniques, and providing institutional support systems. The formal integration of advocates into preventive health infrastructures may enhance the sustainability, accessibility and inclusiveness of programs.

What is novel about this study is the application of quantitative framework to measure the contribution of health advocates towards community participation which was previously given qualitative approach. The study has some drawbacks however. The study was conducted within a specific geographic setting and involved self-reported questionnaire responses that have the potential for response bias. Future research should also expand to other geographical areas, include longitudinal designs, and investigate other factors, including socioeconomic status, cultural beliefs and digital health communication, to gain a deeper understanding of the multi-dimensional factors contributing to participation in preventive health.

CONCLUSION

This study confirms that health advocates play a significant role in strengthening community participation in preventive health programs through educational outreach, counseling, and community mobilization activities. The findings demonstrate that advocacy activities positively influence preventive health engagement and remain a strong predictor of participation even after demographic factors are considered. The study also reveals that educational attainment contributes to participation levels, indicating the importance of health literacy in shaping preventive health behavior. These findings contribute theoretically to the development of community participation and health engagement frameworks by emphasizing advocacy as both a communication mechanism and a trust-building strategy within public health systems.

Practically, the study highlights the importance of institutional support, advocacy training, and culturally responsive communication approaches to improve the effectiveness and sustainability of preventive health programs. The novelty of this research lies in its quantitative measurement of the predictive contribution of health advocates toward community participation, addressing a gap in previous advocacy studies dominated by qualitative approaches. Nevertheless, the study is limited by its geographically focused sample and reliance on self-reported data. Future research should employ longitudinal and comparative approaches across broader settings while incorporating additional variables such as socioeconomic status, digital health communication, and cultural determinants to obtain a more comprehensive understanding of preventive health participation dynamics.

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