

ARTICLE INFORMATION

Received: May, 25, 2026

Revised: June, 20, 2026

Available online: June, 24, 2026

at: <https://e-jurnal.iphorr.com/index.php/mhc>

Health promotion model based community nursing for improving psychological well-being and treatment adherence among patients with hypertension

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Abstract

Background: Hypertension is one of the most prevalent non-communicable diseases in Indonesia, with a prevalence rate of 34.1% in 2023. At Silat Hilir Primary Health Center, Kapuas Hulu Regency, West Kalimantan, adherence to antihypertensive medication is only 43%, far below the 70% target established by the Minimum Service Standards (MSS). This gap is exacerbated by geographical barriers in remote rural areas, limited health literacy, and the absence of a structured community-based monitoring system.

Purpose: To improve psychological well-being and treatment adherence among patients with hypertension through the implementation of “**BAKSO CERDIK**”, an innovative community nursing approach based on the Health Promotion Model (HPM).

Method: This article presents a community nursing innovation paper using a descriptive-analytic approach. Program development was based on evidence synthesized from a systematic literature review (2014–2024) and an analysis of the local epidemiological situation. The theoretical framework was derived from Pender’s Health Promotion Model (1982, revised 2011), which was operationalized through two complementary pillars: “**BAKSO**” (**Bina-Awasi-Kontrol-Support-Observasi**) for medication adherence monitoring and “**CERDIK**” (**Cek-Enyahkan-Rajin-Diet-Istirahat-Kelola**) for healthy lifestyle promotion.

Results: The program is implemented by trained community health cadres through a monthly cycle integrated into the Integrated Primary Care (ILP) system of the Primary Health Center. Based on evidence from the literature, the program is projected to increase medication adherence from 43% to $\geq 70\%$, improve blood pressure control rates from 30% to $\geq 60\%$, and reduce treatment dropout rates by up to 50% within the first year of implementation.

Conclusion: The intervention is a theoretically grounded, contextually relevant, and systemically integrated community nursing innovation that addresses the gap between high service coverage and low treatment adherence through proactive community-based interventions aligned with the national ILP policy and hypertension MSS targets.

Keywords: Health Promotion Model; Psychological Well-Being; Treatment Adherence.

INTRODUCTION

Hypertension is one of the chronic conditions with the highest global disease burden. The World Health Organization (2023) reported that 1.28 billion adults worldwide are living with hypertension; however, only 23% have successfully achieved optimal blood pressure control, a figure that reflects a systemic failure extending beyond the mere availability of medications. Uncontrolled hypertension is a leading

cause of stroke, heart failure, and chronic kidney disease, contributing to approximately 7.5 million deaths annually, or 12.8% of total global mortality (Unger, Borghi, Charchar, Khan, Poulter, Prabhakaran, & Schutte, 2020). In Indonesia, the epidemiological trajectory of hypertension has become increasingly alarming. Data from the Indonesian Health Survey (IHS) 2023 reported a

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hypertension prevalence of 34.1% among adults aged ≥ 18 years, representing an increase of more than eight percentage points from the 25.8% prevalence recorded in the 2013 Basic Health Research Survey (Frassetto, Madera, Siebert, Megrnahan, Roberts, & Plugge, 2020). This increase reflects not only a growing morbidity burden but also the failure of control programs to address the underlying structural and behavioral determinants of hypertension.

The most critical challenge lies not in case detection but in long-term treatment adherence. The IHS (2023) revealed that among hypertensive patients receiving treatment, 62.8% discontinued medication because they felt healthy, 19.3% due to boredom or forgetfulness, 7.9% switched to traditional remedies, and 3.5% stopped because of adverse effects. These findings indicate that non-adherence is not merely a medical issue but also a behavioral and socio-cognitive phenomenon that requires interventions grounded in behavioral change theory. This situation is clearly reflected at Silat Hilir Public Health Center, Silat Hilir District, Kapuas Hulu Regency, West Kalimantan. With 5,664 recorded hypertension cases, making it the most prevalent disease within the service area, the rate of adherence to antihypertensive medication was only approximately 43% in 2024. Ironically, hypertension service coverage in Kapuas Hulu Regency reached 92.2%, ranking second among the 14 regencies/cities in West Kalimantan Province (Erlandi, Saraswati, & Rahardjoputro, 2024). This paradox demonstrates that while the health system has succeeded in screening and diagnosis, it has failed in sustaining treatment retention. Poor treatment retention in remote rural areas is not a single issue but rather the result of multiple structural barriers, including long geographical distances and high transportation costs to healthcare facilities, passive service models that rely on patients seeking care independently, limited understanding of the chronic nature of hypertension, and the absence of a structured community-based monitoring system (Wakil, Asmi, Ma'rifah, Faizah, Aprilya, Muhlis, & Savira, 2025). These layered barriers cannot be adequately addressed through clinical approaches alone and require proactive interventions that operate within the patient's social ecosystem (Ardayani, Saragih, Melia, Rejeki, Sinaga, Adie, & Tanti, 2023).

Within the framework of Indonesia's national health policy, the Minister of Health Regulation No. 12 of 2022 concerning Primary Care Integration (PCI) provides a strategic opportunity for community nursing innovations based on community health volunteers (cadres). PCI mandates the strengthening of cadres' roles throughout the healthcare continuum, including early detection, monitoring, health education, and referral processes, as part of the transformation toward a more responsive and proactive primary healthcare system. However, the operationalization of this mandate in remote areas remains limited and requires contextualized innovative models. In response to this gap, the innovation program was developed as a cadre-based community nursing model theoretically grounded in Nola J. Pender's Health Promotion Model (HPM). HPM was selected because of its ability to explain health behavior as the result of interactions among individual characteristics, cognitive-perceptual constructs (perceived benefits, perceived barriers, and self-efficacy), and contextual influences (social support and commitment to action), making it an appropriate framework for addressing the complexity of hypertension treatment adherence within community settings (Haynes, Yao, Degani, Kripalani, Garg, & McDonald, 2025).

RESEARCH METHOD

This article is a community nursing innovation paper employing a descriptive-analytic approach based on evidence synthesis. The program was developed through three systematic stages. The first stage involved situation analysis and problem identification. This process included: (1) a review of local epidemiological data from the Silat Hilir Primary Health Center in 2024, including patient visits, medication adherence rates, and sociodemographic characteristics of individuals with hypertension; (2) an analysis of Minimum Service Standards (MSS) indicators and service coverage data in Kapuas Hulu Regency; and (3) a literature review examining factors contributing to poor treatment adherence in remote rural settings. The second stage focused on the development of a theory-based conceptual framework. Pender's Health Promotion Model (HPM) was selected as the theoretical foundation due to its demonstrated effectiveness in explaining and

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improving hypertension treatment adherence, particularly within Southeast Asian populations. Each component of the '**BAKSO CERDIK**' program was explicitly mapped to specific HPM constructs to ensure a clear behavioural change mechanism.

The third stage involved the design of the operational framework, including the monthly implementation cycle, the roles and responsibilities of community health cadres, the development of program tools (**BAKSO CERDIK** handbook, educational flipcharts, and referral forms), integration pathways with the Integrated Primary Care (ILP), P-

Care, and SIMPUS systems, evaluation mechanisms, and a three-year sustainability and replication roadmap (2026–2028). The evidence base was derived from PubMed, Google Scholar, Cochrane Library, and official policy documents from the Indonesian Ministry of Health and the World Health Organization (WHO). Literature published between 2014 and 2024 was reviewed, with priority given to systematic reviews, meta-analyses, and randomized controlled trials related to hypertension treatment adherence in developing countries and Southeast Asian settings.

RESEARCH RESULTS

Table 1. Hypertension Service Adherence Gap Profile in Silat Hilir Primary Health Center, 2024

Indicator	Data/Value	Description
District hypertension prevalence	34.1% (national prevalence, 2023)	Third highest in West Kalimantan
Total registered cases (Silat Hilir)	5.664 cases (2024)	Leading disease in the service area
Hypertension service coverage in Kapuas Hulu District	92.2%	Ranked second among 14 districts/cities in West Kalimantan
Medication adherence (Silat Hilir)	43%	National Minimum Service Standard target: ≥70%
Adherence gap	27 percentage points	Indicates an urgent need for proactive intervention
Reason for discontinuing medication #1	62.8% felt healthy	Source: Indonesian Health Survey (IHS) 2023
Reason for discontinuing medication #2	19.3% boredom/forgetfulness	Dominant psychosocial factor
Primary healthcare access barriers	Geographic constraints and transportation costs	Passive service delivery model is inadequate

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Table 2. Operationalization of Health Promotion Model (HPM) Constructs within the Program Components

Code	Component	Targeted HPM Construct	Behavioral Change Mechanism
B	Patient Mentoring	Perceived Self-Efficacy + Interpersonal Influences	Community health volunteers establish therapeutic rapport, enhancing intrinsic motivation and confidence in medication adherence.
A	Medication Monitoring	Perceived Barriers to Action	Addresses practical barriers through active monitoring and rescheduling.
K	Blood Pressure Monitoring	Perceived Benefits of Action	Improved blood pressure results provide tangible feedback regarding adherence benefits.
S	Family Support	Interpersonal Influences	Family members are engaged as structured social support agents.
O	Condition Observation	Commitment to a Plan of Action	Early detection of treatment dropout and side effects.
C	Routine Health Check-ups	Perceived Benefits of Action	Regular follow-up reinforces treatment benefits.
E	Eliminate Tobacco Smoke Exposure	Perceived Barriers to Action	Motivational counseling addresses smoking cessation barriers.
R	Regular Physical Activity	Perceived Self-Efficacy	Community exercise groups enhance self-efficacy.
D	Healthy Diet	Perceived Benefits + Perceived Barriers	Locally adapted dietary guidance reduces practical barriers.

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I	Adequate Rest	Perceived Self-Efficacy	Sleep hygiene education improves self-management.
K	Stress Management	Interpersonal Influences + Self-Efficacy	Relaxation techniques and peer support improve coping.

Table 3. Monthly Operational Cycle of the Program

Phase	Timeline	Main Activities	Outputs
Phase I – Preparation	Week 1	Review data, identify dropouts, coordinate with PHC.	Priority patient list
Phase II – BAKSO Home Visit	Week 2	Implement BAKSO protocol during home visits.	Completed records and BP documentation
Phase III – Support Group/CERDIK Session	Week 3	Group meetings and education.	Improved healthy lifestyle literacy
Phase IV – Referral and Reporting	Week 4	Referral, data compilation, integration into ILP.	Reports and data entry

Table 4. Projected Impact and Success Indicators of the Program

Indicator	Baseline (2024)	Year-1 Target	Evidence Base
Antihypertensive medication adherence	43%	≥70%	Nieuwlaat et al. (2014); Pilcher et al. (2019)
Controlled blood pressure (<140/90 mmHg)	~30%	≥60%	Pilcher et al. (2019); Pan et al. (2023)
Treatment dropout rate	High (estimated >40%)	Reduced by ≥50%	Win et al. (2021); Rahmawati & Bajorek (2019)
Patient self-efficacy score	Low (not yet measured)	Increased by ≥25%	Goudarzi et al. (2020); Widayani et al. (2024)
Completeness of BAKSO CERDIK documentation	0%	≥85% of patients assisted	Program process indicator

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Data integration into ILP/SIMPUS	None	100% integrated	Ministry of Health Regulation No. 12/2022
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DISCUSSION

The program is grounded in Pender's Health Promotion Model (HPM), a nursing theory developed in 1982 and revised in 2011 to explain the determinants of health-promoting behaviors. Unlike disease-prevention models that primarily focus on reducing risk reduction, HPM emphasizes individuals' motivation to achieve positive health outcomes through self-efficacy, perceived benefits, and social support (Pender, Murdaugh, & Parsons, 2016). Several HPM constructs are particularly relevant to hypertension treatment adherence, including perceived benefits of action, perceived barriers to action, perceived self-efficacy, interpersonal influences, and commitment to a plan of action. These constructs have been shown to significantly influence adherence behavior among patients with hypertension. A study involving 380 hypertensive patients demonstrated that HPM variables explained 42.2% of the variance in medication adherence behavior, indicating the model's strong predictive ability (Gultom, Batubara, & Sihombing, 2025). Research conducted among older adults with hypertension in Indonesia identified perceived benefits, self-efficacy, and interpersonal influences as the strongest predictors of treatment adherence (Yuningsih, Marpatmawati, Suprpti, & Rismawan, 2025).

The program operationalizes these theoretical constructs through structured community-based interventions. Blood pressure monitoring activities reinforce patients' perceptions of treatment benefits, patient coaching activities strengthen self-efficacy, family involvement enhances interpersonal influences, and routine follow-up activities promote commitment to long-term treatment plans. Therefore, the program provides a clear theoretical pathway for behavioral change rather than relying solely on conventional health education approaches. The disparity between high hypertension service coverage (92.2%) and low medication adherence (43%) in Kapuas Hulu Regency reflects a common challenge known as the hypertension care cascade. Although patients successfully enter the healthcare system and initiate treatment, many fail to maintain long-term

adherence, resulting in poor blood pressure control. Several interrelated barriers contribute to this situation, including geographical isolation, inadequate understanding of hypertension as a lifelong condition, the absence of community-based monitoring systems, weak social support, and limited feedback regarding treatment benefits. Evidence from developing countries has shown that inadequate knowledge, weak social support, and limited healthcare access are among the most common modifiable barriers affecting treatment adherence (Villarino, 2024). Social support and trust in healthcare services have been identified as significant predictors of medication adherence among hypertensive patients (Patriyani, Rohimah, & Rahayu, 2021). These findings suggest that addressing adherence challenges requires strengthening the community support system in addition to improving healthcare services.

The implementation design of the program adopts a structured monthly cycle that allows continuous monitoring and timely intervention. The program begins with a review of patient records and identification of individuals at risk of treatment dropout. This is followed by home visits conducted by trained community health cadres, during which patients receive guidance, medication monitoring, blood pressure assessments, family support, and screening for potential complications. Community-based home visit interventions have been shown to significantly improve blood pressure outcomes compared with standard care (Proboningsih, Joeliantina, & Novitasari, 2023). The program also incorporates peer-support group activities that promote healthy lifestyles through the framework, including regular health checks, avoidance of risk factors, physical activity, healthy diet, adequate rest, and stress management. Peer-support interventions have been associated with improvements in self-efficacy, motivation, and long-term treatment adherence through social learning and collective problem-solving mechanisms (Dennis, 2023). The final stage of the cycle involves referral management, documentation, and reporting to ensure integration with the Integrated Primary Care P-Care, and

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SIMPUS systems (Safarina, Lila, Saragih, Indriani, Husniati, Septiani, & Dewi, 2024).

Community health cadres play a central role in the program as agents of behavioral change within the community. Their effectiveness is supported by their social credibility, accessibility, and ability to maintain regular contact with patients. Unlike healthcare professionals who interact with patients only during clinical visits, cadres provide continuous support within patients' everyday environments. Evidence from community health worker interventions has demonstrated significant reductions in both systolic and diastolic blood pressure compared with standard care, particularly in programs that combine medication monitoring and lifestyle education (Ratu, 2026). The integration of cadre-generated data into the ILP framework ensures that community-level information contributes to planning, monitoring, and evaluation processes at both primary healthcare and district levels.

A key innovation of the program is the development of the Handbook, which functions as an educational resource, monitoring tool, motivational aid, and community health record. The handbook includes patient information, medication adherence checklists, blood pressure monitoring charts, symptom records, and monthly evaluation forms. Its design follows health literacy principles through the use of simple language, visual illustrations, and color-coded blood pressure indicators, making it accessible for populations with limited literacy levels. Such approaches have been shown to improve health information comprehension and retention among vulnerable populations (Berkman, Sheridan, Donahue, Halpern, & Crotty, 2021). The monthly evaluation process also promotes participatory monitoring by encouraging patients to actively assess their own health progress, thereby strengthening self-efficacy and commitment to treatment.

The projected impact of the program is supported by evidence from community-based hypertension interventions. Multi-component interventions have been shown to improve medication adherence by approximately 15–30%, making the program's target of increasing adherence from 43% to at least 70% within one year both ambitious and achievable (Mills, Bundy, Kelly, Reed, Kearney, Reynolds, & He, 2016). Improvements in medication adherence are expected to contribute directly to better blood pressure control.

Based on previous evidence regarding community health worker interventions, increasing the proportion of patients with controlled blood pressure from 30% to at least 60% within the first year is considered realistic (Ito, Vaidya, Kakizaki, & Takahashi, 2023).

Beyond its clinical impact, the program is highly relevant to Indonesia's national health priorities. The program directly supports the implementation of the Integrated Primary Care policy by strengthening community participation and expanding the role of community health cadres. It also contributes to achieving the Minimum Service Standards (MSS) for hypertension management, particularly the target of medication adherence among patients with hypertension. Furthermore, the program aligns with Sustainable Development Goal 3 by addressing one of the most important modifiable risk factors for cardiovascular morbidity and mortality through community-based interventions.

The sustainability of the program is supported through integrated financing, human resource development, institutional commitment, and community participation. Funding mechanisms are expected to combine Primary Health Care Operational Funds, Village Funds, and district government budgets to ensure long-term implementation. Cadre sustainability is strengthened through regeneration systems, formal recognition by village authorities, and incentive mechanisms. Institutional sustainability is supported through integration into Primary Health Center operational plans and village regulations, while community sustainability is reinforced through peer-support groups and engagement of community and religious leaders. Through its strong theoretical foundation, evidence-based design, community-centered approach, and alignment with national health policies, and sustainable model for improving psychological well-being, treatment adherence, and blood pressure control among patients with hypertension in rural Indonesia (Suwito, Mu'afiro, Waluyo, & Hidayati, 2025).

CONCLUSION

The the program innovation program provides a theory-based solution to improve hypertension medication adherence at the Silat Hilir Primary Health Center. By applying Pender's Health Promotion Model (HPM) through trained community health cadres, the

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program targets key determinants of adherence, including self-efficacy, perceived benefits, perceived barriers, and social support. Its strength lies in the integration of theoretical, contextual, and systemic approaches, ensuring behavioral effectiveness, community acceptance, and sustainability within the Integrated Primary Care framework. Based on existing evidence, the program is projected to increase medication adherence from 43% to $\geq 70\%$ and improve blood pressure control from 30% to $\geq 60\%$ within the first year of implementation, contributing to the reduction of cardiovascular complications and the achievement of local hypertension service targets.

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