

Preventive Lifestyle Interventions for Non-Communicable Diseases: Community-Based Innovations

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Abstract

Non communicable diseases (NCDs) remain a leading global health challenge, disproportionately affecting low- and middle-income countries and placing substantial burdens on healthcare systems and communities. Increasing evidence shows that preventive lifestyle interventions embedded in community settings can mitigate behavioral risk factors, yet empirical analyses of innovative community-based models remain limited. This study aims to examine the effectiveness of community-driven preventive lifestyle interventions in reducing modifiable NCD risk indicators and strengthening local health resilience. A mixed-methods design was employed, integrating quantitative assessment of biometric and behavioral indicators with qualitative exploration of community participation, program acceptability, and perceived benefits. Findings demonstrate that structured community interventions such as peer-led education, culturally adapted physical activity programs, and neighborhood health monitoring resulted in significant improvements in dietary behavior, physical activity levels, and blood pressure profiles across participating groups. The study concludes that community-based innovations play a critical role in promoting sustainable lifestyle modification and offer scalable models for NCD prevention, particularly in resource-constrained settings.

Keywords: Lifestyle Modification, Preventive Interventions, Public Health



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INTRODUCTION

Non communicable diseases (NCDs) have become the dominant global health burden, accounting for the majority of premature mortality and long-term disability across both developed and developing countries. Rising prevalence of cardiovascular diseases, diabetes, chronic respiratory illnesses, and cancers is closely associated with lifestyle patterns embedded in modern living environments, including sedentary behavior, unhealthy dietary habits, insufficient physical activity, and persistent exposure to psychosocial stressors. The epidemiological shift toward lifestyle-related conditions signals a profound transformation in the nature of public health challenges confronting contemporary societies (Effinger et al., 2023; Mallick et al., 2023).

Communities in low-and-middle income regions experience disproportionate impacts due to limited access to healthcare resources, reduced health literacy, and socio-economic vulnerabilities that restrict opportunities to adopt healthier lifestyles. National health systems are increasingly strained by escalating costs of long-term treatment for chronic diseases, prompting policymakers to re-examine preventive approaches that address risk factors before disease onset. Community settings provide natural environments where lifestyle behaviors are shaped, negotiated, and reinforced, making them strategic platforms for preventive health interventions (Grunseit et al., 2023; Pengpid & Peltzer, 2023).

Preventive lifestyle interventions grounded in community participation have gained international attention as sustainable and contextually relevant solutions. These interventions aim to modify risk behaviors through locally appropriate educational strategies, culturally informed physical activity programs, and peer-supported health monitoring initiatives. The background signals a growing recognition that community-based approaches may offer more effective and equitable pathways to preventing NCDs compared to clinical or policy-level interventions alone.

The persistent rise of NCD prevalence despite increasing national awareness campaigns indicates that conventional top-down health education strategies remain insufficient to influence long-term behavioral change. Many populations struggle to sustain healthy lifestyle practices when interventions fail to account for cultural norms, community dynamics, and socio-economic constraints that impede the adoption of healthier habits. The disconnect between national health programs and community realities creates a gap between intended behavioral outcomes and actual lived experiences (Kiran, 2023; Rada & Cabieses, 2023).

Barriers in accessing preventive resources further exacerbate the problem. Communities lacking structured social support networks or local health facilitation often experience difficulties in initiating and maintaining lifestyle changes, resulting in persistent vulnerability to chronic diseases. Technological and infrastructural disparities also limit the scalability of preventive programs, creating uneven health opportunities across regions. These challenges underscore the need for innovations that situate preventive interventions within community structures rather than external institutions (Kiran, 2023; Nguyen et al., 2023).

The absence of systematic evaluation of community-based lifestyle interventions adds complexity to the problem. Limited empirical studies have assessed the effectiveness of community-driven innovations through rigorous measurement of behavioral outcomes or biometric improvements. Without evidence-based assessment, policymakers and practitioners struggle to determine which community approaches produce the most sustainable preventive results. This lack of clarity defines the central problem addressed by the present research.

The first objective of this study is to examine the effectiveness of community-based lifestyle interventions in reducing modifiable risk indicators associated with NCDs. The study seeks to understand how educational, behavioral, and participatory program elements influence individual lifestyle choices and collective health outcomes. Identifying which components generate meaningful behavioral change is essential for designing scalable public health strategies (Khaltaev & Axelrod, 2023; Mandal et al., 2023).

The second objective is to explore community participation, social cohesion, and cultural alignment as mediating factors that determine the success of preventive interventions. Understanding the depth of community engagement provides insight into the mechanisms through which health-promoting behaviors become normalized and sustained over time. These insights offer valuable contributions to theories of community empowerment and participatory health development.

The third objective is to provide a comprehensive analytical framework that integrates quantitative biometric measures with qualitative assessments of community experience and program acceptability. This integration is intended to generate a holistic interpretation of intervention outcomes, offering practical guidance for refining community-based health models and informing broader preventive health policy. The objectives collectively emphasize the study's aim to advance both empirical evidence and conceptual understanding within preventive public health research (Greenberg et al., 2023; Hassen et al., 2023).

Existing scholarship on preventive interventions often focuses on clinical or school-based programs, with insufficient attention given to community settings where lifestyle decisions are deeply embedded. The literature offers limited insight into how community networks, informal peer environments, and cultural practices interact with preventive behaviors. This gap restricts understanding of how grassroots initiatives can complement national health systems in reducing NCD risks (Bhanja et al., 2023; Kakoschke et al., 2023).

Studies that document community interventions frequently provide descriptive accounts without systematic evaluation of health outcomes or rigorous measurement of behavioral change. The lack of standardized indicators and mixed-method assessment tools results in fragmented evidence that is difficult to compare across contexts. These limitations hinder the capacity of researchers and policymakers to identify successful models or replicate effective programs in broader settings.

Comparative analysis between different forms of community-based innovations is also underrepresented in the literature. Many studies examine isolated interventions without exploring how combination approaches such as integrating educational modules with physical activity and social reinforcement produce synergistic effects. The absence of holistic frameworks leaves a significant theoretical and practical gap that this study seeks to address through integrated methodological design (Bhanja et al., 2023; Martínez-Leyva et al., 2023).

The novelty of this research lies in its examination of preventive lifestyle interventions specifically within community-driven contexts, offering an analytical lens that foregrounds collective agency, localized knowledge, and cultural adaptation. The study contributes new insights by demonstrating how community-based innovations function not only as support mechanisms but also as transformative environments where health behaviors are co-constructed. This perspective enriches existing preventive health literature that often centers on individual-level behavior change.

The methodological design provides an additional layer of innovation through its integration of quantitative biometric indicators with qualitative evaluations of community participation. This mixed-methods approach enables a more nuanced understanding of the interplay between physical health outcomes and psychosocial dimensions of community involvement. Such integration advances the field by offering a comprehensive model that captures both measurable and experiential dimensions of preventive interventions (Kerr et al., 2023; Pándics et al., 2023).

The justification for the study rests on the urgent global demand for cost-effective and scalable preventive strategies to address the accelerating NCD burden. Community-based innovations offer a promising pathway for strengthening public health resilience, particularly in resource-limited environments where formal healthcare infrastructures are strained. The research provides empirical and conceptual contributions that can inform policymakers, health practitioners, and community leaders seeking sustainable strategies for NCD prevention (Masharipova et al., 2023; Njiro et al., 2023).

RESEARCH METHOD

This study adopted a mixed-methods approach that integrates quantitative measurement of biometric and behavioral indicators with qualitative exploration of community engagement and program acceptability. The rationale for employing this design lies in its ability to simultaneously capture objective health outcomes and the broader social and cultural factors shaping preventive lifestyle practices. On the quantitative side, the research assessed changes in modifiable risk factors, including blood pressure, levels of physical activity, and dietary habits. In parallel, the qualitative component examined participants' lived experiences, the extent of community participation, and the cultural appropriateness of the implemented interventions. By combining these two strands, the study provided a holistic evaluation of community-based initiatives aimed at preventing non-communicable diseases (Moshi et al., 2023; Zhao et al., 2023).

Research Design

The research employed a convergent mixed-methods design in which quantitative and qualitative data were collected and analyzed in a complementary manner. The quantitative component focused on measuring physiological and behavioral changes associated with intervention exposure, while the qualitative strand sought to uncover contextual insights related to participant perceptions and social dynamics. Both datasets were integrated at the interpretation stage to ensure a comprehensive understanding of how community-based interventions influence health outcomes and behavioral change. This design allowed for triangulation of findings, thereby enhancing the validity and depth of the study (Moshi et al., 2023; Zhao et al., 2023).

Research Target/Subject

The study population consisted of individuals aged 18 to 60 years residing in three community clusters categorized as high-risk for non-communicable diseases according to regional health surveillance reports. A purposive sampling technique was employed to ensure inclusion of participants representing diverse baseline health conditions, socio-economic statuses, and levels of community involvement. The final sample included 180 respondents participating in the quantitative phase and 36 participants engaged in qualitative interviews and focus group discussions. This sampling approach was aligned with the study's aim of capturing

varied behavioral patterns and community-driven health responses within specific local contexts (Mogo et al., 2023; Thomas et al., 2023).

Research Procedure

The research process was conducted through four systematic stages. Initially, baseline data were collected through biometric assessments and the distribution of lifestyle questionnaires. Subsequently, community-based interventions were implemented, including peer-facilitated educational sessions, culturally adapted physical activity initiatives, and localized health monitoring activities. The third stage involved post-intervention data collection using the same instruments to evaluate changes in health indicators and behavioral outcomes. Finally, qualitative data were obtained through in-depth interviews and focus group discussions, followed by thematic analysis and integration with quantitative findings. This structured procedure ensured methodological consistency and enabled a comprehensive assessment of both health impacts and community participation.

Instruments and Data Collection Techniques

A range of instruments was utilized to collect both quantitative and qualitative data systematically. Quantitative measurements were obtained using standardized biometric devices such as digital sphygmomanometers and body composition analyzers to assess blood pressure, body mass index, and waist circumference. In addition, a validated questionnaire was administered to evaluate dietary habits, frequency of physical activity, and levels of health literacy. For the qualitative component, semi-structured interview guides and focus group discussion protocols were employed to explore participants' perceptions of the intervention, community support mechanisms, and motivational drivers of lifestyle change. All instruments underwent pilot testing to ensure their reliability and suitability within the study context (Ghazihosseini et al., 2023; Mogo et al., 2023).

Data Analysis Technique

Quantitative data were analyzed using statistical methods to identify changes in biometric and behavioral indicators before and after the intervention. Descriptive statistics and inferential analyses were applied to determine the significance of observed differences in risk factors. Meanwhile, qualitative data were processed through thematic analysis, involving coding, categorization, and interpretation of recurring patterns and themes derived from interviews and focus group discussions. The integration of quantitative and qualitative findings was conducted during the interpretation phase to provide a comprehensive understanding of the effectiveness of the intervention and the socio-cultural factors influencing its implementation. This combined analytical strategy strengthened the overall validity and interpretive depth of the study (Moshi et al., 2023; Zhao et al., 2023).

RESULTS AND DISCUSSION

Table 1 presents the quantitative outcomes derived from 180 participants across three community clusters. Baseline data show that 64% of participants had elevated blood pressure, 52% demonstrated low physical activity levels, and 49% reported inadequate daily fruit and vegetable intake. Post-intervention measurements indicate substantial improvements: the proportion of participants with elevated blood pressure decreased to 41%, while low physical activity levels dropped to 28%. Dietary improvements were also observed, with 63% of participants reporting adherence to recommended nutritional guidelines.

Table 1. Changes in Biometric and Behavioral Indicators Pre and Post Intervention (N = 180)

Indicator	Baseline (%)	Post-Intervention (%)	Difference (%)
Elevated Blood Pressure	64	41	-23
Low Physical Activity	52	28	-24
Inadequate Diet	49	37	-12
BMI Above Normal	58	46	-12

The distribution pattern suggests consistent improvements across clusters, with Cluster C showing the largest reductions in blood pressure and sedentary behavior. Cluster B demonstrated the most significant dietary improvements, likely reflecting higher participation rates in community cooking demonstrations and nutrition workshops. The descriptive statistics illustrate the overall positive trajectory of behavioral change associated with community-based preventive strategies.

The data trends indicate that community-based interventions exert substantial influence on modifiable lifestyle factors. The drop in low physical activity levels aligns with the widespread adoption of culturally adapted group exercise programs, which participants reported as accessible and socially motivating. The biometric shifts, particularly in blood pressure, support evidence that moderate lifestyle adjustments can yield measurable physiological benefits within relatively short intervention periods.

The improvements in dietary indicators reflect increased exposure to health education through peer-led sessions that emphasized local and affordable food options. The smaller magnitude of dietary change compared to physical activity may be attributed to structural constraints such as food access and household economic conditions. The data suggest that while behavioral knowledge increases rapidly, structural barriers still play a role in shaping nutrition outcomes.

The qualitative dataset provides insights into participant engagement, revealing that 78% of participants attended more than half of the scheduled program activities. Attendance records show a correlation between consistency in program participation and magnitude of behavioral improvements. Physical activity sessions were the most attended component, followed by peer-led discussion circles focusing on stress reduction and lifestyle planning.

Feedback forms indicate that 84% of participants found the intervention culturally relevant, while 71% reported increased confidence in their ability to maintain healthy habits independently. Participants emphasized the value of social accountability and emotional support provided by community peers. These qualitative patterns complement the quantitative biometric results, highlighting social dimensions of behavioral change.

Regression analysis demonstrates that participation intensity significantly predicts changes in blood pressure, with $\beta = -0.42$, $p < 0.01$, suggesting that higher engagement leads to greater physiological benefit. Physical activity improvements also show a strong association with reduced sedentary behavior scores ($r = -0.55$, $p < 0.01$). Dietary changes exhibit a moderate association with improved BMI outcomes ($r = -0.31$, $p < 0.05$), indicating that multi-component interventions influence multiple risk markers simultaneously.

A paired-sample t-test comparing pre- and post-intervention biometric scores confirms statistically significant improvements across all measured indicators. Blood pressure reductions yielded $t(179) = 6.87$, $p < 0.001$, while BMI reductions yielded $t(179) = 3.44$, $p < 0.01$. These

inferential results demonstrate that the community-based approach produced changes unlikely to have occurred by chance alone, reinforcing the program's effectiveness.

The relationship between physical activity participation and reductions in blood pressure is pronounced, suggesting that group-based exercise fosters both behavioral consistency and physiological benefits. Participants who attended more than 70% of sessions showed the largest improvements across all health indicators, implying a threshold at which community engagement becomes strongly associated with health outcomes. The relational pattern underscores the role of social reinforcement in sustaining lifestyle change.

The relationship between dietary education and BMI improvements appears weaker compared to other behavioral linkages. Participants often reported structural obstacles such as limited access to affordable fresh produce, which moderated the impact of nutritional guidance. These relational dynamics indicate that while community-based support is influential, environmental factors exert parallel influence on the translation of knowledge into sustained dietary practice.

A case study of Cluster C highlights the benefits of integrating culturally meaningful physical activities, such as traditional dance-based exercise routines, into preventive health interventions. Participants in this cluster demonstrated a 29% reduction in sedentary behavior and a 26% decrease in elevated blood pressure status. Interview excerpts reveal enthusiastic support for activities perceived as culturally familiar and socially inclusive.

A contrasting case from Cluster A shows slower improvement, with only a 10% reduction in inadequate dietary intake. Participants cited irregular attendance at educational sessions and competing work demands that limited engagement. Interviews also reveal lower initial levels of social cohesion within the community, limiting peer support and collective motivation. The comparative cases illustrate how context shapes intervention effectiveness.

The success observed in Cluster C can be attributed to strong community cohesion and active participation from local leaders who facilitated and promoted program activities. Cultural tailoring appears to have enhanced participant motivation, making behavioral changes easier to adopt and sustain. The case underscores the importance of aligning preventive interventions with cultural practices and community identity.

The weaker outcomes in Cluster A highlight the structural and motivational challenges that undermine the impact of lifestyle interventions. Limited social engagement and inconsistent participation reduced the opportunity for collective reinforcement of healthier behaviors. The case suggests that intervention success is heavily dependent on social infrastructure and community readiness, not solely on program design.

The collective results demonstrate that community-based innovations possess strong potential for reducing modifiable risk indicators associated with non-communicable diseases. Behavioral and biometric improvements observed across multiple clusters indicate that preventive interventions rooted in community participation and cultural relevance can generate meaningful health outcomes. The interplay between social support and individual behavior emerges as a central mechanism driving program success.

The findings also suggest that intervention effectiveness is not uniform across contexts, with outcomes influenced by community cohesion, cultural alignment, and structural barriers. Preventive lifestyle programs require contextual adaptation and sustained engagement strategies to maximize long-term impact. The results affirm the value of community-based

approaches while highlighting the need for targeted support to address variability in community readiness.

The findings demonstrate that community-based preventive lifestyle interventions produced measurable improvements in both behavioral and biometric indicators related to non-communicable disease risk. Participants showed notable reductions in elevated blood pressure, increased physical activity levels, and modest yet meaningful improvements in dietary patterns. These results confirm that structured community programs can effectively modify health-related behaviors within relatively short implementation periods.

The qualitative component reveals strong participant engagement and a high level of perceived cultural relevance, indicating that community ownership and shared identity enhance motivation for lifestyle change. Participants consistently reported feeling more confident and supported in maintaining healthy behaviors when interventions were embedded within familiar social structures. These subjective experiences complement the quantitative results and point to the multi-dimensional nature of behavioral transformation.

The case comparisons indicate that clusters with strong social cohesion and leadership participation achieve greater improvements in all measured outcomes. Clusters with weaker community ties show slower progress, highlighting the influential role of community infrastructure in shaping behavioral outcomes. This variability underscores that community-based interventions are highly context-dependent rather than uniformly effective.

The combination of biometric, behavioral, and qualitative results illustrates that lifestyle interventions rooted in community engagement serve as an effective mechanism for reducing modifiable NCD risk factors. The integration of cultural tailoring, peer support, and participatory structures contributes to a comprehensive model of preventive health practice with substantial practical relevance.

Existing literature emphasizes the effectiveness of community-driven health interventions in promoting physical activity and improving cardiovascular indicators. The present findings align closely with research conducted in South Asia and Latin America demonstrating that community empowerment enhances adherence to preventive behaviors. These similarities suggest that community mechanisms play a universally significant role in shaping long-term health practices.

Studies on lifestyle modification programs in clinical settings often show slower behavioral adoption due to limited social reinforcement outside the treatment environment. The current research diverges from such findings by illustrating the magnitude of behavioral change when interventions occur in socially embedded environments. This divergence highlights the unique strength of community-based models in generating consistent engagement.

Research on cultural tailoring in health promotion supports the claim that interventions grounded in local traditions such as dance-based or community-relevant exercise routines promote greater acceptance. The success observed in Cluster C reinforces this theory, demonstrating that cultural resonance is not merely an aesthetic feature but a structural driver of behavioral commitment. The alignment with past studies strengthens the generalizability of this insight.

Literature describing barriers to nutrition improvement also aligns with observed outcomes in the present study. Structural constraints, including economic limitations and food access challenges, often moderate the impact of education-based interventions. The smaller dietary shifts recorded in some clusters support this trend, suggesting that community

education must be complemented by structural improvements to generate substantial dietary outcomes.

The findings indicate that preventive lifestyle interventions achieve optimal results when supported by strong community structures that facilitate social accountability, shared motivation, and consistent participation. Communities that possess high levels of collective efficacy are better positioned to produce sustained behavioral change. This suggests that community cohesion is a critical determinant of preventive health success.

The data point to the importance of culturally grounded intervention design. The positive outcomes associated with culturally meaningful activities signal that behavioral change is more readily adopted when linked to familiar practices and shared values. Cultural adaptation emerges as a core component of effective preventive health strategy rather than a supplementary feature.

The variability in outcomes across clusters reflects deeper social inequalities and structural differences. Communities with limited cohesion or fewer social resources may require additional support to achieve the same level of progress. This variation indicates that community-based interventions cannot be implemented uniformly and must be tailored to local realities.

The reflection highlights that community-based health innovations represent more than short-term behavioral programs; they symbolize collective capacity-building processes. These processes contribute to long-term resilience and empower communities to actively shape their health trajectories beyond the duration of formal interventions.

The findings have significant implications for public health planning, indicating that sustainable NCD prevention requires embedding interventions within community contexts rather than relying solely on clinical or institutional approaches. Policymakers must recognize community structures as essential platforms for behavioral change, not peripheral actors. This shift in perspective can enhance the scalability and effectiveness of national health strategies.

Program designers should incorporate culturally meaningful activities into preventive interventions to strengthen participant motivation and increase adherence. Cultural adaptation must be a formal component of intervention design, supported by collaboration with local leaders and community members. The implications extend to curriculum development, resource allocation, and long-term program sustainability.

The results suggest that health systems must invest in strengthening community cohesion and leadership capacity. Interventions are most effective when communities possess internal organizational structures that reinforce collective action and peer support. Strengthening these capacities can amplify intervention outcomes and expand the long-term impact of preventive programs.

Health practitioners and NGOs can use the findings to guide the development of multi-component intervention models that combine education, physical activity, and social reinforcement. The implications underscore that addressing NCD risk requires coordinated, community-centered strategies rather than isolated health campaigns.

The strong outcomes observed in clusters with cohesive community structures result from high levels of social reinforcement, which promote consistent participation and reduce attrition. Social ties encourage accountability and collective motivation, reinforcing health behaviors more effectively than individual-level interventions. This dynamic explains why such clusters outperform communities with weaker social bonds.

The effectiveness of culturally tailored interventions arises from the sense of familiarity and relevance they provide. When preventive practices resonate with cultural identity, individuals find them easier to adopt and sustain. This alignment bridges the gap between health theory and daily lived experience, increasing engagement and reducing resistance to behavior modification.

The modest dietary improvements, compared to physical activity outcomes, stem from external constraints such as household income, food availability, and market conditions. Behavioral knowledge alone cannot counteract structural barriers, which explains the slower progress in nutritional indicators. The findings reflect broader socio-economic dynamics that influence community health outcomes.

The observed variability across clusters is rooted in differences in local leadership, resource availability, and historical patterns of community participation. Communities with established traditions of collective action adapt more quickly to new health initiatives, while communities with fragmented social structures require more intensive preparatory support. These underlying factors shape the trajectory of intervention effectiveness (Manderson & Jewett, 2023; Moore & Daaleman, 2023).

Future interventions must prioritize strengthening community readiness before program implementation. Conducting community readiness assessments can help identify gaps in cohesion, leadership, and resources, enabling more targeted support. This step will ensure that interventions begin on a foundation that promotes success rather than inefficiency.

Public health policymakers should integrate community-based preventive programs into long-term national health strategies. Institutionalizing such programs ensures continuity, funding stability, and alignment with broader public health goals. Embedding preventive practices into local governance structures can reinforce sustainability (Ling et al., 2023; Manderson & Jewett, 2023).

Researchers should expand the evidence base by conducting longitudinal studies to examine whether behavior changes observed during interventions persist over time. Understanding long-term adherence patterns will help refine program designs and identify which components contribute most to sustained health improvement. The integration of geospatial and socioeconomic data could further enhance predictive insights (Brera et al., 2023; Lundin Gurné et al., 2023).

Communities, NGOs, and governments must co-develop intervention models that address structural barriers such as food access and income limitations. Strengthening economic and environmental conditions alongside behavioral programs can create a supportive ecosystem for healthy living. Future efforts should integrate preventive health initiatives with broader social development agendas (Hamrah et al., 2023).

CONCLUSION

The most significant finding of the study lies in the differentiated impact of community-based lifestyle interventions, demonstrating that clusters with strong social cohesion, cultural alignment, and active local leadership achieve substantially greater behavioral and biometric improvements than those lacking these characteristics. This distinction highlights that preventive health outcomes are not merely functions of program content but are profoundly shaped by community readiness, cultural resonance, and social infrastructure. The evidence affirms that sustainable lifestyle modification emerges most effectively when interventions

operate within socially meaningful and collectively supported environments, making the community itself an essential mechanism of change rather than a passive setting.

The primary contribution of this research rests in its integrated conceptual methodological framework, which combines quantitative biometric assessment with qualitative exploration of cultural relevance, social engagement, and collective motivation. The study advances current preventive health scholarship by illustrating how community participation functions as a mediating mechanism linking intervention design to behavioral outcomes. The mixed-method approach offers a replicable model for evaluating multi-dimensional health interventions, providing researchers and practitioners with a more holistic lens through which to analyze the interplay between individual behavior, social structures, and cultural adaptation in NCD prevention.

The study's limitations stem from its reliance on purposive sampling within selected communities and the relatively short intervention duration, which restrict the generalizability of findings and prevent evaluation of long-term behavioral sustainability. Future research should employ longitudinal designs to assess the persistence of lifestyle changes and expand sampling across diverse socio-economic and cultural contexts to capture broader variability. Further investigations should also address structural determinants such as food access, economic constraints, and built environments that interact with community-based strategies, enabling the development of more comprehensive preventive models that integrate behavioral, social, and environmental dimensions.

AUTHOR CONTRIBUTIONS

Author 1: Conceptualization; Project administration; Validation; Writing - review and editing.

Author 2: Conceptualization; Data curation; Investigation.

Author 3: Data curation; Investigation.

Author 4: Formal analysis; Methodology; Writing - original draft.

CONFLICTS OF INTEREST

The authors declare no conflict of interest

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