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Developing a Public Health Humanities-Based Health Promotion Model: Integrating Historical Analysis to Address Social Determinants of Health in Indonesia

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ABSTRACT

Health promotion in Indonesia must address the social, economic, cultural, and political determinants of health and historically rooted inequities. This study developed the Public Health Humanities-Based Health Promotion Model (PHH-HPM), integrating historical awareness, social determinants of health (SDOH) literacy, and inclusive communication to explain implementation readiness. Developed through a targeted narrative review, the model's analytic feasibility was assessed using simulated cross-sectional data from 320 participants and 22 Likert-scale items. Analyses included reliability testing, correlation, group comparisons, and multiple regression with robust standard errors and bootstrap confidence intervals. Internal consistency was acceptable (α = .772–.901). Readiness correlated with historical awareness (r = .258), SDOH literacy (r = .360), and inclusive communication (r = .324; all $p < .001$). Regression explained 18.3% of variance (adjusted R^2 = .167; $p < .001$). SDOH literacy (β = .241) and inclusive communication (β = .192) independently predicted readiness, whereas historical awareness was not statistically significant (β = .103, p = .071). PHH-HPM offers a six-stage pathway and testable measurement framework. However, simulated results demonstrate analytical procedures, not empirical evidence. Validation using ethically collected field data is essential.

Keywords : *Public Health Humanities, Health Promotion, Historical Analysis, Social Determinants of Health, Health Communication, Health Equity, Indonesia*

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INTRODUCTION

Contemporary public health recognises that health outcomes arise from interactions among individual behaviour, social relationships, economic resources, environments, institutions and political decisions. The World Health Organization (WHO) describes the social determinants of health (SDOH) as the conditions in which people are born, grow, live, work and age, together with people's access to power, money and resources, and it emphasises that monitoring these determinants requires action across sectors rather than within health services alone (World Health Organization [WHO], 2024). The World Report on Social Determinants of Health Equity concludes that avoidable gaps in health persist across social groups and that the targets set for reducing inequities by 2040 are likely to be missed without stronger action on the non-medical root causes of ill health (WHO, 2025).

Indonesia combines large geographic diversity, rapid urbanisation and uneven access to education, infrastructure and health services. Recent Indonesian studies illustrate how social conditions shape health. Using the Indonesian Family Life Survey, Aizawa (2022) showed that inequalities in underweight, overweight, hypertension and diabetes among adults aged 20–35 years are associated with household and parental circumstances in childhood and adolescence, largely through indirect pathways involving diet and exercise. Analysing the 2023 Indonesian Health Survey, Pasambo et al. (2025) reported that diabetes prevalence among 951 respondents with diabetes rose across higher wealth quintiles, while access to improved water sources and proximity to health centres were associated with lower prevalence. Ahsan et al. (2025) examined national health insurance claims from 2018 to 2022 to assess how insurance membership, used as a proxy for economic status, relates to the severity of type 2 diabetes. Qualitative evidence points in the same direction: in a grounded-theory study of 23 health professionals, 12 children living with HIV and eight family members, Qur'aniati and Sweet (2023) identified low socioeconomic status, complicated insurance procedures and weak care coordination as determinants of care quality. A progress report prepared by the Faculty of Public Health, Universitas Indonesia, with WHO support has also documented national action on SDOH (Septiono et al., 2023).

Health promotion practice does not always match this evidence. Fuady et al. (2024), in a mixed-methods study conducted between December 2022 and June 2023, identified gaps between the theory and practice of health promotion and disease prevention in Indonesia, including a limited scope of initiatives, insufficient direction and coordination between ministries, agencies and levels of government, and limited availability and capacity of health promoters. The difficulty is not unique to Indonesia. Gusoff et al. (2023) observe that healthcare interventions addressing social needs such as food and housing generally fail to reach the upstream inequalities of wealth and power that underlie those needs.

A further limitation is temporal. Social determinants are not produced only in the present; current distributions of education, employment, housing, environmental risk and social power reflect earlier policies, institutions and norms. Mold (2022) draws on historical research to show how the persistence of social and racial inequalities, and changing assumptions about who bears

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responsibility for health, mean that public health "never was (and never can be) solely an individual matter." Kehoe et al. (2023) argue that historical scholarship has rarely figured in health promotion practice and propose "public health humanities" as an interdisciplinary spectrum in which historical studies are integrated with existing health promotion disciplines, illustrated by the long-running tobacco control and skin cancer prevention campaigns in Australia. In an evaluation of an applied history of public health course, Talley et al. (2022) interviewed 12 alumni and 11 students and found that historical knowledge helped learners understand race, racism and the social determinants of health; the authors recommended that Master of Public Health programmes include historical perspectives.

Public health humanities is also maturing as a field of teaching and practice. Weston et al. (2026) define it as bringing the theories, methods and resources of the arts and humanities into conversation with public health concepts such as social and structural determinants, health equity and health promotion, and they describe seven teaching approaches across different settings. A scoping review by Carr et al. (2021) found that health humanities learning outcomes were inconsistently described, limiting comparison across curricula, and the same group subsequently proposed the InspirE5 curriculum and evaluation framework with 11 graduate capabilities (Carr et al., 2022). Evidence that humanities approaches can be delivered to frontline workers comes from Karachi, where Siddiqi et al. (2024) delivered a 12-session humanities curriculum to 48 lady health workers, 98% of whom completed the training and whose measured outcomes increased between baseline and follow-up. Bader et al. (2023) add a caution about evaluation: their scoping review of 44 studies found that evaluation approaches for community-based health promotion vary widely and that no accepted standards exist.

Communication is the mechanism through which historical and structural knowledge can become public understanding and collective action. Githinji et al. (2024) found that community leaders acted as trusted intermediaries who helped underserved communities access accurate information and counter misinformation during the COVID-19 crisis. Frampton et al. (2024) argue that the humanities and social sciences remain on the epistemological periphery of infectious disease and public health, despite their relevance to pandemic preparedness. Analysing 100,091 social media posts, Barroso-Moreno et al. (2024) showed that narratives about disability are shaped by diverse social actors whose reach differs markedly, a reminder that whose experiences circulate is itself unequal.

Taken together, these strands suggest a gap. Historical analysis, SDOH evidence and inclusive communication are usually treated separately, and none of the sources reviewed here proposes and tests a measurement structure that connects them to the readiness of practitioners and organisations to adopt a historically informed approach in Indonesia. This article therefore has two aims: (1) to develop the Public Health Humanities-Based Health Promotion Model (PHH-HPM) as a communication-centred framework, and (2) to demonstrate, with a simulated dataset, how its core constructs could be measured and tested. The research question is: How are historical awareness, SDOH literacy and inclusive health communication associated with readiness to

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implement a public health humanities-based health promotion model in Indonesia? Four hypotheses guide the analysis. H1: historical awareness is positively associated with model readiness. H2: SDOH literacy is positively associated with model readiness. H3: inclusive health communication is positively associated with model readiness. H4: the three constructs jointly explain significant variance in model readiness after adjustment for age, urban residence and higher education.

METHODS

The study combined two components. The first was conceptual model development. The second was a quantitative, cross-sectional explanatory demonstration in which the proposed measurement structure was analysed with a simulated dataset. Figure 1 presents the conceptual model and the hypothesised relationships. The target population for the future empirical study is Indonesian adults with experience of receiving, producing or participating in health-related communication, including community health workers, students in health programmes, public health and communication practitioners and community members.

The PHH-HPM was derived through a targeted, non-systematic narrative review of peer-reviewed articles and WHO technical documents published between 2021 and 2026. Sources were selected purposively across four domains: (a) public health humanities and historical analysis in health promotion; (b) SDOH frameworks and evidence on health inequity; (c) the Indonesian context of SDOH and health promotion implementation; and (d) health communication, community intermediaries and inclusive communication. Constructs were defined from this literature, and the implementation pathway was arranged as a six-stage logic model, from historical mapping to evaluation, in which each stage yields a communication output and an illustrative indicator (Table 8). Because the review was not systematic, it does not claim exhaustive coverage of the literature.

No respondent data were collected. The dataset used in this article was generated in advance for the sole purpose of demonstrating the analytic workflow. It contains 320 simulated cases and 34 variables: six descriptive variables (age, gender, residence, education, region, communication experience), 22 five-point Likert items, four composite scale scores and two derived binary indicators (urban residence; bachelor's degree or higher). The data-generating parameters were not calibrated against any Indonesian survey, and the cases do not describe real individuals. Consequently, every estimate, confidence interval and p-value in Section 3 describes how the analytic procedures behave on simulated data; none of them can be interpreted as evidence about the Indonesian population. The dataset is provided to allow replication of the analyses.

Four constructs were measured with 22 items rated from 1 (strongly disagree) to 5 (strongly agree); the items are listed in Appendix A. Historical awareness (HA; five items) captures recognition of the historical causes of health inequity, continuity between past policy and present conditions, and the perceived value of historical evidence. SDOH literacy (SDH; six items) captures

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understanding of determinants, upstream and downstream distinctions, structural mechanisms, multisectoral responsibility and the ability to explain health inequity to a public audience. Inclusive communication (IC; five items) captures participatory, culturally responsive, accessible and trust-based communication that connects individual action with social conditions. Model readiness (MR; six items) captures perceived feasibility, team capacity, cross-sector collaboration, evaluation capacity and support for adopting a public health humanities-based approach. Composite scores were the arithmetic mean of the items in each scale (range 1–5); they matched the composite variables supplied in the dataset exactly. Table 1 summarises the instrument.

Table 1. Constructs, items and measurement of the PHH-HPM questionnaire

Construct	Items	Scale	Core dimensions
Historical awareness (HA)	5	1–5 Likert	Historical causes of inequity; continuity between past policy and present conditions; policy memory; campaign trajectories; value of historical evidence
SDOH literacy (SDH)	6	1–5 Likert	Determinants; upstream versus downstream action; life-course interaction; explaining inequity; action beyond the health sector; public communication
Inclusive communication (IC)	5	1–5 Likert	Community participation; cultural adaptation; accessibility; trust and transparency; linking individual action with social conditions
Model readiness (MR)	6	1–5 Likert	Organisational feasibility; team capacity; usefulness of historical evidence; cross-sector collaboration; structural and communication evaluation; personal support

Note. HA = historical awareness; SDH = social determinants of health literacy; IC = inclusive communication; MR = model readiness. Full item wording is provided in Appendix A.

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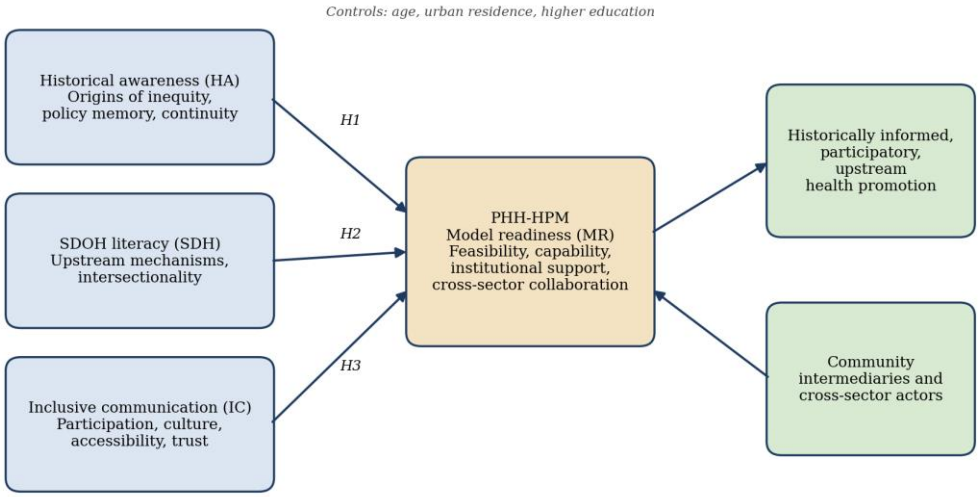

Figure 1. Conceptual model of the Public Health Humanities-Based Health Promotion Model (PHH-HPM). Arrows H1–H3 denote hypothesised positive associations with model readiness; H4 concerns their joint contribution after adjustment for age, urban residence and higher education.

Analyses were run in Python using pandas, SciPy and statsmodels. Descriptive statistics (mean, standard deviation, range, skewness) were computed for all scales. Internal consistency was assessed with Cronbach's alpha and corrected item–total correlations. Bivariate associations with model readiness were estimated with Pearson's r (95% confidence intervals via Fisher's z), with Spearman's ρ as a robustness check. Model readiness was compared by residence with Welch's independent-samples t-test (Cohen's d and a Mann–Whitney U test as sensitivity analyses) and across three levels of communication experience with one-way ANOVA (η^2 as effect size; Kruskal–Wallis and Levene's tests as sensitivity analyses). Region was examined in an exploratory ANOVA.

Hypothesis H4 was tested with the multiple linear regression $MR = \beta_0 + \beta_1 HA + \beta_2 SDH + \beta_3 IC + \beta_4 Age + \beta_5 Urban + \beta_6 Education + \varepsilon$, entered hierarchically (controls first, then the three predictors). Because preliminary checks indicated non-normal, heteroscedastic residuals, coefficient inference is reported with conventional OLS errors and with HC3 heteroscedasticity-consistent standard errors, complemented by percentile bootstrap 95% confidence intervals (2,000 resamples, seed = 42). Diagnostics comprised variance inflation factors (VIF), the Durbin–Watson statistic, the Breusch–Pagan test, the Shapiro–Wilk test on residuals and Cook's distance. The significance level was $\alpha = .05$ (two-tailed). No correction for multiple testing was applied to the confirmatory hypotheses; the regional analysis is exploratory.

Sample size for a real study should be justified explicitly rather than by rule of thumb (Lakens, 2022). Using the noncentral F distribution for a six-predictor regression with $\alpha = .05$ and power = .80, a medium effect (Cohen's $f^2 = .15$) requires about 98 respondents, whereas a small effect ($f^2 = .05$) requires about 279. The simulated sample of 320 could detect an effect of

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approximately f^2 = .044 with 80% power. A target of 300–400 respondents, with purposive and quota sampling for region, residence, age, education and communication experience, is therefore reasonable and leaves room for attrition and subgroup analyses.

No human participants were recruited and no personal data were processed for this demonstration, so ethics approval was not required. A real study must obtain institutional ethics approval and informed consent. Because historical analysis of health inequity may involve communities whose experiences have been marginalised or misrepresented in official records, a real study should also distinguish documented evidence from interpretation, acknowledge archival gaps, protect confidentiality and avoid attributing structural conditions to communities themselves.

RESULTS

1. Profile of the simulated sample

Table 2 summarises the simulated sample. The mean age was 30.04 years (*SD* = 7.90; median = 29; range = 18–53). Just over half of the cases were female (57.5%), two-thirds were urban (68.4%) and 62.5% held a bachelor's degree or higher. Java–Bali accounted for 47.8% of cases and Eastern Indonesia for 8.4%.

Table 2. Profile of the simulated sample (*N* = 320)

Characteristic	n	%
Gender		
Female	184	57.5
Male	129	40.3
Other / prefer not to say	7	2.2
Residence		
Urban	219	68.4
Rural / peri-urban	101	31.6
Highest education		
Senior high school	59	18.4
Diploma	61	19.1
Bachelor	172	53.8
Master / doctorate	28	8.8
Region		
Java–Bali	153	47.8
Sumatra	75	23.4
Kalimantan	33	10.3

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Characteristic	n	%
Sulawesi	32	10.0
Eastern Indonesia	27	8.4
Health-communication experience		
Low	102	31.9
Moderate	136	42.5
High	82	25.6

Note. Percentages may not sum to 100 because of rounding. All figures are simulated.

2. Descriptive statistics and reliability

Table 3 presents scale descriptives and reliability. Mean scores increased from historical awareness (M = 3.33) through SDOH literacy (M = 3.81) and inclusive communication (M = 4.21) to model readiness (M = 4.72). Cronbach's alpha ranged from .772 to .901, and corrected item–total correlations were .74–.79 (HA), .69–.76 (SDH), .70–.76 (IC) and .49–.54 (MR). Model readiness was strongly negatively skewed (skewness = −1.92; excess kurtosis = 4.17): 273 of 320 cases (85.3%) scored 4.5 or above and 98 cases (30.6%) scored the maximum of 5.00 (Figure 2). Shapiro–Wilk tests rejected normality for all four scales (all $p < .01$).

Table 3. Descriptive statistics and internal consistency of the scales

Scale	Items	M	SD	Min	Max	Skewness	α
Historical awareness	5	3.33	0.72	1.20	5.00	−0.17	.901
SDOH literacy	6	3.81	0.67	1.67	5.00	−0.39	.898
Inclusive communication	5	4.21	0.62	2.20	5.00	−0.71	.889
Model readiness	6	4.72	0.34	3.00	5.00	−1.92	.772

Note. N = 320. α = Cronbach's alpha. Simulated data.

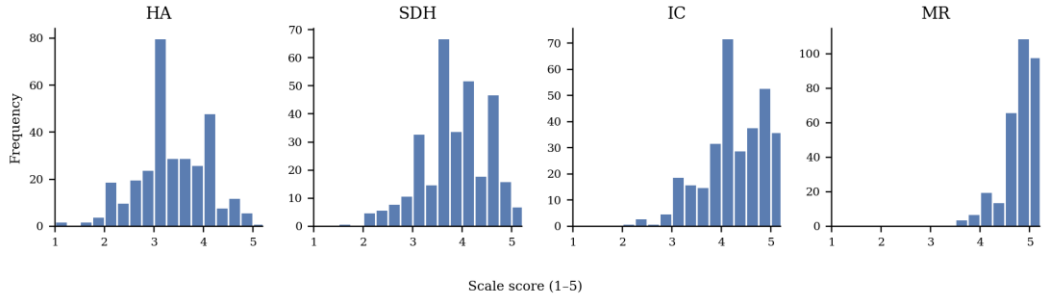

Figure 2. Distribution of the four scale scores in the simulated dataset. The concentration of model readiness scores near the upper limit indicates a ceiling effect.

3. Correlations

All three predictors correlated positively with model readiness (Table 4), which is consistent with H1–H3 in the bivariate case. SDOH literacy showed the strongest association (r =

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.360), followed by inclusive communication (r = .324) and historical awareness (r = .258). Spearman coefficients were smaller but in the same direction (ρ = .161, .304 and .195, respectively; all $p \leq .004$), which suggests that part of the Pearson association reflects the skewed distribution of readiness. The predictors were moderately intercorrelated (r = .348–.385), a point that becomes important in the regression.

Table 4. Pearson correlations among the scales and correlations with model readiness

Variable	1	2	3	4	r with MR [95% CI]
1. Historical awareness	—				.258 [.153, .357]
2. SDOH literacy	.368	—			.360 [.261, .452]
3. Inclusive communication	.348	.385	—		.324 [.223, .419]
4. Model readiness	.258	.360	.324	—	—

Note. N = 320. All correlations $p < .001$. Simulated data.

4. Group comparisons

Model readiness was slightly higher among urban cases (M = 4.75, SD = 0.32, n = 219) than rural or peri-urban cases (M = 4.67, SD = 0.36, n = 101), but the difference was not statistically significant (Welch $t(175.15) = 1.72$, $p = .087$; mean difference = 0.07, 95% CI [−0.01, 0.16]; Cohen's d = 0.22). The Mann–Whitney test agreed (p = .116). Readiness also did not differ across levels of health-communication experience ($F(2, 317) = 1.69$, $p = .187$, $\eta^2 = .011$); the Kruskal–Wallis test was likewise non-significant ($H(2) = 4.77$, $p = .092$), and variances were homogeneous (Levene p = .345). An exploratory ANOVA by region was nominally significant ($F(4, 315) = 2.50$, $p = .043$, $\eta^2 = .031$), but variances were unequal (Levene p = .035) and the rank-based test was non-significant ($H(4) = 4.32$, $p = .364$); this result should not be interpreted as robust (Table 5).

Table 5. Model readiness by residence, communication experience and region

Group	n	M	SD	Test
Residence				
Urban	219	4.75	0.32	Welch $t(175.15) = 1.72$, $p = .087$, $d = 0.22$
Rural / peri-urban	101	4.67	0.36	Mann–Whitney $p = .116$
Communication experience				
Low	102	4.72	0.37	$F(2, 317) = 1.69$, $p = .187$, $\eta^2 = .011$
Moderate	136	4.75	0.31	Kruskal–Wallis $H(2) = 4.77$, $p = .092$
High	82	4.67	0.34	

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Group	n	M	SD	Test
Region (exploratory)				
Java–Bali	153	4.76	0.28	$F(4, 315) = 2.50$, $p = .043$, $\eta^2 = .031$
Sumatra	75	4.75	0.33	Kruskal–Wallis $H(4) = 4.32$, $p = .364$
Sulawesi	32	4.66	0.37	Levene $p = .035$
Kalimantan	33	4.62	0.44	
Eastern Indonesia	27	4.61	0.42	

Note. Simulated data. The regional comparison is exploratory and was not corrected for multiple testing.

5. Multiple linear regression

The full model was statistically significant ($F(6, 313) = 11.68$, $p < .001$) and explained 18.3% of the variance in model readiness ($R^2 = .183$; adjusted $R^2 = .167$; Cohen's $f^2 = .22$, a medium-to-large effect by conventional benchmarks). The three control variables alone explained 1.4% of the variance ($F(3, 316) = 1.49$, $p = .218$); adding historical awareness, SDOH literacy and inclusive communication increased R^2 by .169 ($F(3, 313) = 21.59$, $p < .001$). H4 was therefore supported in the simulated data.

Table 6 shows that SDOH literacy ($B = 0.121$, $\beta = .241$) and inclusive communication ($B = 0.105$, $\beta = .192$) were significant independent predictors under both conventional and HC3 robust inference, and their bootstrap intervals excluded zero. Historical awareness ($B = 0.048$, $\beta = .103$) was not significant at $\alpha = .05$ (OLS $p = .071$; HC3 $p = .072$), and its bootstrap interval marginally included zero. Age, urban residence and higher education did not contribute independently. Figure 3 displays the standardised coefficients.

Table 6. Multiple linear regression predicting model readiness

Predictor	B	SE	β	95% CI (OLS)	*p* (OLS)	*p* (HC3)	95% bootstrap CI
Constant	3.639	0.146	—	[3.352, 3.927]	<.001	<.001	[3.265, 4.013]
Historical awareness	0.048	0.027	.103	[−0.004, 0.100]	.071	.072	[−0.002, 0.098]
SDOH literacy	0.121	0.029	.241	[0.064, 0.178]	<.001	<.001	[0.068, 0.175]

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Predictor	B	SE	β	95% CI (OLS)	*p* (OLS)	*p* (HC3)	95% bootstrap CI
Inclusive communication	0.105	0.031	.192	[0.044, 0.166]	.001	.005	[0.036, 0.174]
Age	−0.000	0.002	−.002	[−0.004, 0.004]	.977	.978	[−0.004, 0.004]
Urban residence	0.046	0.038	.064	[−0.028, 0.120]	.221	.248	[−0.028, 0.128]
Higher education	−0.015	0.036	−.021	[−0.086, 0.056]	.682	.674	[−0.083, 0.054]

Note. $N = 320$. Model: $F(6, 313) = 11.68$, $p < .001$; $R^2 = .183$; adjusted $R^2 = .167$. SE = conventional OLS standard error; HC3 = heteroscedasticity-consistent (HC3) *p*-value; bootstrap CI = percentile interval from 2,000 resamples. Reference categories: rural/peri-urban residence; education below bachelor's level. Simulated data.

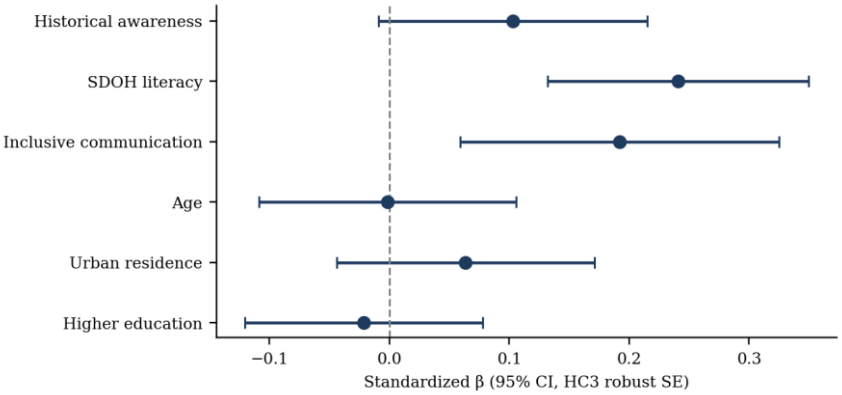

Figure 3. Standardised regression coefficients (β) with 95% confidence intervals based on HC3 robust standard errors. Simulated data.

6. Assumption checks and robustness

Multicollinearity was not a concern (VIF = 1.03–1.29), and residuals showed no first-order autocorrelation (Durbin–Watson = 2.16). Two assumptions were violated. Residuals departed from normality (Shapiro–Wilk $W = .904$, $p < .001$; residual skewness = −1.40), and the Breusch–Pagan test indicated heteroscedasticity ($LM = 31.93$, $p < .001$). Both problems are consistent with the ceiling effect in model readiness. For this reason HC3 errors and bootstrap intervals were reported alongside the conventional results; the substantive pattern did not change. No observation was influential by the conventional criterion (maximum Cook's D = .145), although 21 cases exceeded the more sensitive 4/n threshold. The regression *F*-test in the HC3 specification remained significant ($F(6, 313) = 8.12$, $p < .001$).

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7. Summary of hypothesis tests

Table 7. Summary of hypothesis tests in the simulated data

	Hypothesis	Key result	Decision
H1	Historical awareness is positively associated with readiness	r = .258, p < .001; adjusted β = .103, p = .071	Partially supported
H2	SDOH literacy is positively associated with readiness	r = .360, p < .001; adjusted β = .241, p < .001	Supported
H3	Inclusive communication is positively associated with readiness	r = .324, p < .001; adjusted β = .192, p = .001	Supported
H4	The three constructs jointly explain significant variance	ΔR^2 = .169, $F(3, 313)$ = 21.59, p < .001	Supported

Note. Decisions apply to the simulated dataset only.

DISCUSSION

The simulated analysis shows that the proposed measurement structure is analytically workable. The four scales were internally consistent, the three predictors were positively related to model readiness, and together they accounted for a meaningful share of its variance. The more instructive results, however, concern the limits of the structure. First, historical awareness was associated with readiness in the bivariate analysis but did not make an independent contribution once SDOH literacy and inclusive communication were controlled. Because the three predictors overlap (r = .35–.39), the shared variance is probably absorbed by SDOH literacy and inclusive communication. In a real sample, this pattern would raise the question of whether historical awareness is a distinct competency or a component of broader structural understanding, a question that only factor-analytic and longitudinal work can answer. Second, model readiness was heavily concentrated at the top of the scale, so differences between groups were compressed and the regression assumptions were strained. A real study should pilot more discriminating response formats, such as seven-point scales or items describing concrete implementation tasks, to reduce the ceiling. Third, none of the group comparisons was robust: neither residence nor communication experience nor, after sensitivity checks, region differentiated readiness. Given the simulated origin of the data and the number of tests performed, even nominally significant differences should not be over-read.

These observations should be read strictly as methodological. Because the data are simulated, they show what the workflow can detect and where it is fragile; they do not show that historical awareness, SDOH literacy or inclusive communication drive readiness among Indonesian practitioners.

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The model rests on a division of labour among three components. Historical inquiry identifies how present inequities were produced, which is the contribution Kehoe et al. (2023) argue is missing from health promotion. SDOH literacy translates those mechanisms into terms that practitioners, communities and policymakers can use, in line with WHO's emphasis on monitoring determinants and acting across sectors (WHO, 2024, 2025). Inclusive communication converts knowledge into action by deciding whose explanations are visible and by building on trusted intermediaries, as Githinji et al. (2024) observed for community leaders during a health information crisis. Model readiness is the outcome that indicates whether organisations and teams can carry this chain of reasoning into programme planning (Figure 1).

Table 8 translates the model into six iterative stages. Each stage poses a core question, specifies the main activity and produces a communication output, and for each an illustrative indicator is proposed so that implementation can be evaluated. The stages are iterative rather than linear: historical evidence is revisited when interventions produce unexpected results, and community narratives are treated as evidence for interpretation and adaptation rather than as illustrative quotations.

Table 8. Proposed six-stage implementation pathway of the PHH-HPM

Stage	Core question	Main activity	Communication output	Illustrative indicator
1. Historical mapping	How did the current problem emerge?	Policy, archival, oral-history and institutional analysis	Historical problem narrative	Documented timeline of policies and institutions for each priority problem
2. SDOH mapping	Which conditions reproduce the problem?	Disaggregate determinants by place, group and life course	Determinant pathway map	Pathway maps disaggregated by area and population group
3. Community interpretation	How do affected communities understand it?	Participatory dialogue and narrative inquiry	Community meaning map	Share of community-defined priorities carried into problem framing
4. Inclusive communication	How should evidence be communicated?	Co-design with communities and intermediaries	Accessible, culturally responsive messages	Accessibility and cultural-responsiveness checklist score

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Stage	Core question	Main activity	Communication output	Illustrative indicator
5. Intervention	What can change at multiple levels?	Integrated health promotion actions	Multilevel intervention plan	Number of sectors formally engaged; ratio of upstream to downstream actions
6. Evaluation	What changed and what was learned?	Outcome, process and historical-learning evaluation	Feedback loop for the next campaign	Reporting of both communication and structural outcomes

Note. Indicators are illustrative proposals for future validation, not established measures.

The model extends three lines of work. Public health humanities has so far been developed mainly as a teaching and methodological proposal (Kehoe et al., 2023; Weston et al., 2026), and health humanities curricula have been difficult to compare because learning outcomes are inconsistently described (Carr et al., 2021). The PHH-HPM contributes a set of constructs and items that could be used to describe and compare readiness across settings, complementing the capability framework of Carr et al. (2022). Evidence that a humanities curriculum grounded in local literature and cultural values can be delivered to frontline workers (Siddiqi et al., 2024) suggests that locally rooted historical and narrative material may be important for the Indonesian implementation of the model. Second, Indonesian evidence on socioeconomic inequality in diabetes, early-life circumstances and HIV care (Aizawa, 2022; Ahsan et al., 2025; Pasambo et al., 2025; Qur'aniati & Sweet, 2023) shows that health outcomes are unevenly distributed by social position, but it seldom asks how those distributions arose. The historical stage of the PHH-HPM is designed to fill this explanatory gap. Third, Fuady et al. (2024) and Gusoff et al. (2023) both describe difficulty in moving from downstream activity to upstream, multisectoral action. A readiness construct that explicitly includes cross-sector collaboration and evaluation capacity offers one way of diagnosing where that difficulty lies in a given organisation.

The emphasis on communication also connects to the humanities argument made by Frampton et al. (2024) that preparedness depends on history, values, trust and social meaning as well as biomedical capacity. The observation of Barroso-Moreno et al. (2024) that different social actors have unequal influence over online narratives reinforces the need for inclusive communication to attend to who speaks and who is heard, including people with disabilities, whose narratives in that dataset were voiced by a range of actors that included therapists, politicians and parents of children with disabilities. In Indonesia, health cadres, community organisations, educators, journalists, disability organisations and local government actors could

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plausibly act as intermediaries when appropriately trained, but this proposition requires empirical testing.

For communication practice, the model implies that campaign design should begin with an account of how the problem arose, explain determinants as pathways rather than lists, involve communities in defining problems, adapt messages to language, culture, disability access and digital conditions, and evaluate structural relevance as well as reach. For health policy, the model may complement existing multisectoral priorities by adding historical evidence and community narratives to programme design, particularly in primary care and community health settings where upstream determinants cross administrative boundaries, and by supporting the monitoring approach described in the WHO operational framework (WHO, 2024). For education and training, the questionnaire could serve as a baseline and follow-up instrument in public health humanities modules, following the applied-history teaching experience described by Talley et al. (2022) and the frontline training reported by Siddiqi et al. (2024). For evaluation, the indicators in Table 8 can be tested against the recognised difficulty of evaluating community-based health promotion (Bader et al., 2023).

The principal limitation is that the data are simulated. The numerical results therefore demonstrate the workflow but cannot support empirical claims, and their magnitudes carry no information about Indonesia. Additional limitations apply to the design of an eventual field study. A cross-sectional design cannot establish the direction of the associations, because readiness may also shape awareness and communication practice. Self-report measures are vulnerable to social desirability, which may be especially strong for socially valued constructs such as inclusive communication. The instrument has not undergone content validation, pilot testing or factor analysis, and the readiness scale showed a ceiling effect and lower reliability (α = .772) than the other scales. Finally, historical analysis depends on archives that are incomplete and that may reflect dominant perspectives; Kehoe et al. (2023) acknowledge that historical evidence may offer less certainty than some quantitative evidence, and triangulation with epidemiological, administrative, qualitative and community-generated evidence is essential.

Future work should (1) establish content validity with public health researchers, communication scholars, historians, practitioners and community representatives; (2) pilot the questionnaire and revise the response format to reduce the ceiling; (3) test the four-factor structure by confirmatory factor analysis; (4) collect real data with a justified sample and account for clustering by organisation and region; (5) add Indonesia-specific historical case studies, such as sanitation, maternal health, tobacco control, nutrition or universal health coverage, based on primary or archival sources; and (6) evaluate the six-stage pathway prospectively using mixed methods and longitudinal designs.

CONCLUSIONS

This article proposes the Public Health Humanities-Based Health Promotion Model as a communication-centred framework for addressing social determinants of health in Indonesia. The

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model links historical awareness, SDOH literacy, inclusive communication and implementation readiness, and it translates them into a six-stage pathway with proposed indicators. A simulated demonstration showed that the measurement structure can be analysed with reliability testing, correlation, group comparison and hierarchical regression, and it revealed practical design lessons: the need for a more discriminating readiness scale, robust inference under ceiling effects, and caution about the unique contribution of historical awareness once related constructs are considered. Those numerical results must not be presented as evidence from Indonesian respondents. The next step is to validate the instrument and to test the model with ethically collected field data. If confirmed, the practical implication is a shift from information delivery toward historically informed, participatory and upstream communication that helps explain why inequities persist, identifies responsibilities across sectors and links individual action to structural change.

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