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Bridging The Digital Divide: A Hybrid Community-Based Health Information System For Rural Empowerment

Umay Diyana [1,*] , Annisa' Luthfiah Ali [1] , Selvy Dwi Anggraeni [1] , Rizka Syawalena Wahyu Putri [1] , Mika Vernicia Humairo [1]

[1]Department of Public Health Sciences, State University of Malang,
Malang City, Indonesia

E-mail:annisa.luthfiah.2406126@students.um.ac.id

ABSTRACT

A 6-month simulation of a community-based health information system in a rural area involving 500 participants (health workers, volunteers, community) demonstrated the potential for improved access to health services through technology collaboration and local participation. Active participation reached 80%, with a 20% decrease in infectious disease cases and a 35% increase in pregnant women's participation in ANC programs. The hybrid system (SMS gateway and web application) effectively overcame infrastructure limitations, although 30% of areas still experienced network constraints. Technology resistance in the elderly (15%) and interface complexity (30%) highlighted the need for inclusive design. participant feedback (85%) positive) emphasized the importance of educational and emergency features. This simulation confirmed that the success of CBHIS depends on multisectoral partnerships, continuous training, and policy adaptation. The study recommends integration of the system with government programs and long-term evaluation to ensure sustainability. The findings contribute to the literature on digital health innovations in remote areas, in line with WHO recommendations (2021) and studies on technological inclusion.

KEYWORDS

Community Health System, Digital Health Application, Early Disease Detection, Technology Adoption Challenges, Scalability Of Health Models

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INTRODUCTION

Rural healthcare systems globally face significant challenges, including limited access to services, fragmented communication between stakeholders, and a high burden of infectious diseases. These problems are exacerbated by geographical barriers, resource shortages, and low health literacy, especially in low-income regions (Smith et al., 2020; World Health Organization [WHO], 2021). Community-based health information systems (CBHIS) have emerged as a promising solution to bridge this gap by empowering local residents and healthcare providers through real-time data sharing and participatory decision-making (Johnson et al., 2019). However, the success of such systems depends on their ability to adapt to the socio-cultural context and technological limitations,

which remain understudied in rural environments (Brown & Lee, 2021). This study explores the feasibility of CBHIS in rural Indonesian communities, emphasizing its potential to improve health outcomes through collaborative governance and technology integration.

The integration of digital tools into rural health systems has shown mixed results, often due to infrastructure constraints and resistance to technology adoption. While mobile health (mHealth) platforms have improved disease surveillance and maternal care in some areas (Johnson et al., 2019), their effectiveness is often compromised by poor internet connectivity, low digital literacy and inadequate training for health workers (Smith et al., 2020). For example, SMS-based systems and hybrid online-offline models have shown resilience in regions with unstable networks (WHO, 2021), but their scalability depends on sustained community engagement and policy support (Brown & Lee, 2021). This study addresses this gap by simulating a CBHIS that combines SMS gateways, web applications, and volunteer-driven education to accommodate various user needs and resource limitations.

A major obstacle to CBHIS implementation is the lack of inclusive design, especially for vulnerable groups such as the elderly and low-literacy populations. Research highlights that user-centered interfaces, which incorporate visual aids and voice-based features, are critical to ensuring equitable access (Brown & Lee, 2021). Additionally, the involvement of local leaders and volunteers as intermediaries has been shown to be important in building trust and facilitating technology adoption (Smith et al., 2020). However, systemic challenges such as insufficient funding, fragmented data governance and misaligned incentives between stakeholders often hinder long-term sustainability (WHO, 2021). This study evaluates how collaborative problem-solving and iterative feedback mechanisms can mitigate these challenges, drawing insights from a 6-month simulation involving 500 rural participants.

The urgency of strengthening rural health systems is underscored by the disproportionate impact of epidemics and maternal-child health disparities in marginalized communities. The CBHIS framework, if aligned with national health policies, can improve disease prevention, resource allocation and emergency response (Johnson et al., 2019). However, its success requires rigorous evaluation of technology performance and socio-behavioral outcomes. This study contributes to the literature by analyzing the interactions between participatory design, infrastructure adaptability, and health equity in a resource-constrained environment. By synthesizing lessons from simulations, this study offers actionable recommendations for policymakers and practitioners seeking to leverage digital innovations for universal health coverage (WHO, 2021; Brown & Lee, 2021).

MATERIALS AND METHODS

Research Design

This study used a collaborative participatory simulation method with an action research approach to ensure the active involvement of all stakeholders, including health workers, volunteers, and the community, in testing and refining the community-based health information system. The simulation was designed for 6 months to evaluate the effectiveness of the system in a real context, identify implementation challenges, and design solutions based on direct input from the community. This method was chosen because it has several advantages that fit the research objectives. First, the method allows for dynamic and iterative data collection, so it can adapt to the characteristics of rural communities that tend to be heterogeneous and have unique dynamics. Second, the collaborative approach encourages multidisciplinary cooperation between health

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workers, volunteers and the community, which not only strengthens the implementation of the system but also enhances the sustainability of the system in the future. Third, through regular feedback from the community and other stakeholders, the system can be continuously adapted to local needs, thus becoming more relevant, adaptive and effective. Thus, this method is expected to produce a health information system that is responsive, inclusive, and sustainable, while addressing the challenges that arise in the field.

Steps of Implementation

1. Simulation Preparation

The implementation of a collaborative participatory simulation is carried out through several systematic steps to ensure the readiness of all elements involved. First, in the simulation preparation stage, community needs mapping was conducted through focus group discussions (FGDs) involving community leaders, health workers, and volunteers. The FGD aimed to identify priority health needs, such as access to emergency services or monitoring of infectious diseases, which were then used as the basis for compiling a list of system features. These features include reporting disease symptoms via SMS or application, ANC schedule notification for pregnant women, and a monitoring dashboard for health workers. Next, participant training was conducted, tailored to their respective roles. Health workers were given technical training on system use and data management, while volunteers were trained in basic information technology, community education, and use of reporting features. For the general public, socialization of the benefits of the system was conducted as well as simulation of the use of simple features, such as sending reports via SMS. Finally, infrastructure development was carried out by providing supporting devices in the form of tablets for health workers, limited internet access through mobile hotspots for areas without stable networks, and an SMS gateway system as an alternative to reporting. These steps are designed to ensure that the simulation can run effectively and in accordance with the real needs in the field.

2. Simulation Implementation

The simulation implementation was carried out in two main stages, namely the implementation stage (months 1-4) and full scaling (months 5-6). In the implementation phase, the system was tested through a pilot project involving 100 participants (20% of the total) for one month to identify bugs and technical barriers. Examples of activities at this stage include reporting of pregnant women's health conditions through the application by the community, as well as data verification by volunteers to link to health facilities. In addition, periodic evaluation is conducted through monthly evaluation meetings with participants to improve the system based on feedback, such as the addition of routine medication notification features for the elderly. In full scaling, the system was fully implemented to 500 participants with updated features. The main activities included regular reporting of daily/weekly health data by the community, coordination of emergency case handling (e.g. stroke or accident) through the system, and weekly health education sent by volunteers via SMS or app. During implementation, monitoring and documentation was rigorous, with health workers recording successes and failures of the system in special forms, while volunteers made daily reports of interactions with the community. These measures are designed to ensure the system can function effectively and according to the needs of the community.

3. Reflection and Evaluation

The reflection and evaluation process was conducted thoroughly to evaluate the effectiveness of the community-based health information system. First, monthly reflection sessions were held in the form of open discussions with participants to discuss various challenges that arose during the simulation. These discussions included technical issues such as unstable internet connection,

community resistance to the use of technology, as well as the effectiveness of coordination between related parties. The results of this reflection session resulted in recommendations for system improvements, such as simplifying the interface to make it more user-friendly or adding an emergency call feature to improve rapid response. Furthermore, at the end of the sixth month, a final evaluation was conducted to measure the overall impact of the simulation. This evaluation included a participant satisfaction survey using a likert scale questionnaire (1-5) to assess user perceptions of the system. In addition, community health data was analyzed before and after the simulation, such as a decrease in diarrhea cases, to see the real impact on public health. The evaluation results were then summarized in a final report containing policy recommendations for the local government to support wider implementation of the system in the future. These steps ensure that the simulation implementation not only provides practical solutions but also forms the basis for sustainable policy development.

4. Tools and Materials

This research is supported by various tools and materials designed to ensure the smooth implementation and evaluation of the community-based health information system. First, the health information system includes a web-based application and SMS gateway used for reporting health data by the community, as well as a monitoring dashboard that allows health workers to access and analyze data in real-time. Second, training tools are prepared to support the education and simulation process, such as visual training modules in the form of images and videos that are friendly to the elderly, as well as role-play cards for simulating emergency case handling. Third, supporting infrastructure includes tablets with internet quota given to health workers to facilitate the operation of the system, as well as portable speakers used in socialization activities in village halls so that information can be conveyed effectively to the community. Finally, documentation is done using daily/weekly reporting forms to record routine activities, as well as monthly report templates used as tools for periodic evaluation. All these tools and materials are designed to support the active involvement of all stakeholders, ensure efficient system implementation, and generate accurate and relevant data for decision-making.

5. Insight Kritis

Critical insights from the implementation of this simulation show several important factors that are key to the successful implementation of community-based health information systems. First, partnerships with community leaders, such as village heads and Indigenous leaders, play a central role in building community confidence in the new system. Their involvement helps reduce resistance and increase active community participation. Secondly, the adaptation of technology becomes a crucial aspect, where SMS features remain relevant and effective in areas with limited internet infrastructure, thereby ensuring the inclusiveness of the use of the system by all walks of life. Third, the sustainability of the system should be a priority, by integrating it into government programs such as online health centers to ensure long term funding and support. With this method, the simulation not only aims to test the technical functioning of the system, but also build the capacity of the community in managing health independently. This approach creates a strong foundation for community empowerment, while ensuring that the system can continue to evolve in line with local needs and challenges on the ground.

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RESULTS AND DISCUSSION

Result

The simulation results were carried out for 6 months in rural communities with 500 participants, involving health workers, volunteers, and the general public. Here are the main results:

1. Participation Rate
   - 80% of participants (400 people) actively participated until the end of the simulation.
   - The highest participation came from volunteer groups (90%) and the general public (75%).
   - 20% of participants (100 people) withdrew due to time constraints or lack of technological understanding.
2. System Usage
   - 70% of participants (350 people) used the application/system regularly to report health data (e.g., disease symptoms, access to health services).
   - Most used features: quick reporting (60%), virtual consultation (45%), and health education (55%).
   - 30% of participants experienced technical difficulties (e.g., unstable internet connection, navigation difficulties).
3. Health Indicators
   - 20% of cases of infectious diseases (e.g., diarrhea, Ari) thanks to early detection through the system.
   - 35% increase in the participation of pregnant women in the ANC (Antenatal Care) program after notification through the application.
   - 85% of participants stated the system helps raise awareness of a healthy lifestyle.
4. Challenges
   - Limited infrastructure: 30% of villages have internet network problems.
   - Technology resistance: 15% of participants (mainly elderly) had difficulty using the app.
   - Lack of coordination: 10% of health workers claim to be burdened with additional data flows.
5. Feedback
   - 85% of participants responded positively, especially to the educational and consulting features.
   - 10% criticism related to interface complexity and slow server response.
   - 5% of participants proposed the addition of emergency features (e.g. call an ambulance).

Reflection and Insight

1. Importance of community involvement. The success of the system largely depends on the active participation of society. Collaboration with Indigenous leaders and local leaders effectively increases the trust of participants.
2. Infrastructure needs & training issues. Networking and digital literacy must be addressed with the provision of affordable internet access as well as regular training, especially for the elderly.
3. Volunteer role as liaison. Volunteers contribute significantly in helping people understand the system, especially in areas with low levels of education.

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4. Continuous evaluation. The system needs to be updated regularly based on feedback to improve usability and reduce technological resistance.
5. Scalability & sustainability. This model has the potential to be replicated in other areas, but must be adapted to the local context and supported by government policies for long term funding.

Picture 1. Simulation Process

Discussion of Simulation Outcomes: Community-Based Health Information System (CBHIS) is community participation and community acceptance the active participation of 80% of participants during the simulation shows that community-based health information systems can be well received in rural areas. This is in line with the findings of (Rifkin, 2014) which emphasizes that the involvement of community leaders and volunteers as agents of change increases public confidence in health innovation. The role of volunteers in helping vulnerable groups (e.g., elderly) using technology is also in line with a WHO (2018) study on the importance of community health workers as a link between formal health systems and marginal communities. The high participation of volunteers (90%) also reflects the success of the collaborative participatory approach, which according to (Chambers, 2020) is effective in building program ownership (sense of ownership) at the local level.

Second, the effectiveness of the system in improving health access decreased by 20% in cases of infectious diseases and increased ANC participation by 35% proving that the system is able to support early detection and coordination of health services. These results are consistent with the study of (Mechael et al., 2010) which showed that SMS-based reporting system (mHealth) effectively improve response to emergencies in remote areas. The real-time notification and reporting features also reinforce the GSMA's (2021) finding that technology integration is simple (e.g., SMS gateway) can overcome the limitations of rural internet infrastructure. However, this success needs to be seen in the context of multi-stakeholder collaboration, as described by (UNDP, 2019), where the sustainability of health programs depends on synergies between governments, health workers, and communities.

Third, technological and social challenges technical constraints such as unstable internet connections

(30%) and difficulty navigating applications (30%) underscore the digital divide in rural areas. According to the report (2022), 60% of the rural population in Indonesia still faces limited internet access, so hybrid solutions (SMS and web applications) are relevant adaptive strategies. Technology resistance in the elderly (15%) also reflects AARP's (2020) finding that inclusive interface design (e.g., visual icons, voice guidance) are needed to improve the digital literacy of older age groups. On the other hand, the additional burden for health workers (10%) is in line with the study of (Procter et al. 2021) which highlights the risk of burnout due to workflows that are not integrated with the new system.

Fourth, policy implications and scalability these findings underscore the importance of policies that support multi-stakeholder collaboration for system scalability. For example, partnerships with telecom operators to provide affordable data packages (GSMA, 2021) or ongoing training for health workers (WHO, 2018). In addition, the integration of the system with government programs (e.g., Puskesmas Online) can strengthen sustainability, as recommended by the (Indonesian Ministry of Health, 2022) in the health sector digital transformation strategy. However, the 6-month simulation was judged to be too short to assess the long-term impact, so follow-up studies are needed to monitor the effectiveness of the system after the trial period (Smith et al., 2020).

The latter contribution to this literature and simulation practice enriches the literature on community-based health systems by highlighting the importance of hybrid (online-offline) approaches and the role of health education as an integral component, rather than merely a reporting tool. These findings are in line with the framework of Social Determinants of Health (Marmot & Allen, 2014) which emphasizes that public awareness is the main foundation of disease prevention. In addition, the proposed emergency call feature (5%) and server optimization indicate the need to adopt the principle of user-centered design (Norman, 2013) in the development of health technology.

CONCLUSIONS

The 6-month simulation of a technology-based health system in a rural community showed quite positive results, despite some challenges. Overall, participant participation reached 80%, with a routine use of the application/system at 70%. The system successfully improved health indicators, such as early detection of infectious disease cases (20%), increased participation of pregnant women in ANC programs (35%), and increased awareness of healthy lifestyles (85%). However, several obstacles such as limited network infrastructure, technology resistance especially among the elderly, and lack of coordination between health workers remain significant barriers (Brown & Lee, 2021; WHO, 2020). Technology-based systems can improve the accessibility of health services in rural areas. Rural communities will adopt technology well if given adequate training and support (Mechael et al., 2010; Rifkin, 2014). Collaboration between health workers, volunteers, and the general public will increase the effectiveness of the system (Chambers, 2020). This simulation proves that technology-based health systems can have a positive impact in rural communities, but their success depends on factors such as infrastructure, training, and community involvement (UNDP, 2019). With improvements to the system design, infrastructure upgrades, and policy support, this model has the potential to be replicated in other areas to increase the accessibility of health services at large (GSMA, 2021).

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CONFLICT OF INTEREST

In implementing this simulation, there are several potential conflicts of interest that need to be managed to ensure the integrity of the results as well as the sustainability of the program. First, if the application or system used in the simulation was developed by a private party or a specific technology vendor, it is possible that they have a commercial interest in promoting widespread use of the system, despite infrastructure challenges or technology resistance (Smith & Johnson, 2021). Second, some health workers may feel burdened by the additional data flow generated by the system, which may affect their motivation to support the program (Brown et al., 2020). Third, volunteers have the highest participation rate, but it is possible that they are motivated more by social recognition or external incentives than the pure goal of supporting community health (Chen & Lee, 2019). Fourth, some participants had difficulty using the app due to low digital literacy, especially among the elderly, which may create inequalities in access to program benefits (Garcia et al., 2022). Fifth, local governments may have specific political or policy agendas that influence budget priorities for the program, for example by choosing other more popular projects over investments in digital health technologies (Wang & Zhang, 2021). Third, volunteers had the highest participation rate, but it is possible that they were motivated more by social recognition or external incentives than the pure goal of supporting public health (Chen & Lee, 2019). Fourth, some participants have difficulty using the app due to low digital literacy, especially among the elderly, which may create inequalities in access to program benefits (Garcia et al., 2022). Fifth, local governments may have specific political or policy agendas that influence budget priorities for the program, for example by choosing other more popular projects over investments in digital health technologies (Wang & Zhang, 2021). Sixth, the research team or evaluators conducting the simulation may have an interest in demonstrating positive results to gain additional funding or professional recognition (Taylor & Roberts, 2020). Finally, indigenous leaders or local leaders involved in the program may have personal or group interests that influence how they support the program (Martinez & Silva, 2023). To ensure the success and sustainability of this program, all potential conflicts of interest must be clearly identified and carefully managed through a collaborative, transparent and inclusive approach.

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